Australian Government
Department of Health and Aged Care

phn
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Primary Health Network Program Annual Performance Report 2021-22

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Disclaimer

Opinions expressed in PHN Program Performance Report 2021-22 are those of the authors and not necessarily those of the Australian Government Department of Health and Aged Care. Data may be subject to revision.

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Executive Summary

This is the fourth annual report on Primary Health Networks' (PHNs) Program Performance delivered under the PHN Program Performance and Quality Framework (PQF). This report measures how PHNs' activities are helping achieve the program's objectives across the priority areas identified in the PQF.

The report relies on data from the Australian Bureau of Statistics (ABS), Australian Digital Health Agency (ADHA), Australian Institute of Health and Welfare (AIHW), Primary Mental Health Care Minimum Data Set, Australian Immunisation Register, Medicare Benefits Scheme and data submitted by PHNs to the Department.

Results are presented by program areas where possible, and where appropriate and available by the socio-economic status, remoteness from services, and state/territory of PHN populations. The baseline year for PHN performance reporting is 2018-19 unless otherwise indicated.

The COVID-19 pandemic continued to disrupt the primary health care system from the previous year, including delivery of the PHN Program and its objectives. PHNs played a critical role in supporting and delivering pandemic response activities, while maintaining operations in their communities. In 2021-22 the Department invested $120.7m in PHNs to implement a range of pandemic response activities. With PHNs prioritising these activities and adapting to the change in the healthcare landscape, progress towards program outcomes was affected.

The total annual PHN Program funding increased 16.3% to $1.562 billion in the 2021-22 financial year. Almost a quarter of the $218 million funding increase was new investment in Aged Care services. Primary Mental Health Care represented the largest investment by funding schedule.

The results below should be read in conjunction with the Methodology section (page 5) which sets essential background information including definitions of socio-economic disadvantage, remoteness, and state groups.

Addressing the Australian National Audit Office (ANAO) Audit of PHN Performance Management[1]

Published in February 2024, the ANAO audit of the Department's performance management of PHNs included a number of recommendations to improve this and future PHN Annual Performance Reports. As the current report was already in development at the time the ANAO audit was received, not all recommended changes could be incorporated into this iteration. The remaining changes will be made in future editions of this report.

[1] *https://www.anao.gov.au/work/performance-audit/effectiveness-the-department-health-and-aged-cares-performance-management-primary-health-networks*

Funding and commissioned providers

PHNs coordinated and commissioned place-based primary health care services to address their region's local identified health needs.

In 2021-22, **4,777** providers were commissioned to deliver services.

Total annual PHN Program funding increased by 16.3% ($218mil) from $1.344 billion to **$1.562** billion in the **2021-22** financial year.

Emergency department and hospitalisations

PHN areas are monitored for rates of potentially preventable hospitalisations (PPH) and lower urgency emergency department (ED) presentations.

In 2021-22, there were **2,293 PPH per 100,000 population**, which is the lowest national rate since the PHN Program commenced in 2015-16.

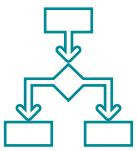
In the same year, lower urgency ED presentations decreased to 124 per 1,000 population; the largest decreases were in regional PHNs.

Program

PHNs are assessed against three program indicators that measure their ability to deliver the program's two key objectives and their function as a commissioning entity.

All PHNs have met these indicators since 2018-19

Organisational



PHNs are assessed on their inclusion of output and outcome measures in all contracts with commissioned service providers.

In 2021-22, the majority (**80.6%)** of PHNs achieved this, however this outcome is lower than the previous year.

Workforce

Drug and alcohol treatment service providers achieved **100% accreditation**, although there was a small reduction in reporting of support for drug and alcohol commissioned health professionals.

Maintenance of appropriate PHN Commissioning Frameworks continued at **100%.**

Alcohol and other drugs

PHNs are assessed against two alcohol and other drugs indicators that monitor active delivery of services and establishment of partnerships with local stakeholders.

All PHNs have met these indicators since 2019-20.

General practices

PHNs are monitored for rates of general practice accreditation and participation in the Practice Incentive Program (PIP) After-Hours incentive.

National general practice accreditation rates declined marginally in 2021-22, although 54.9% of PHNs did increase their proportion of accredited practices.

The percentage of general practices regularly uploading to My Health Record increased from 19.5% to 21.9%.

The national average PIP participation rate increased from 76.4% to 78.7% of general practices.

Digital Health

PHNs are assessed on the proportion of health care providers that are informed or use **My Health Record** and three other digital systems, in addition to the rate of general practice accreditation.

All PHNs met their performance target for My Health Record education, while most PHNs (**90.3%** and **77.4%** respectively) met their performance target for the latter two indicators.

First Nations Health

PHNs are assessed against seven First Nations health indicators, and the number of First Nations people who receive an annual Health Assessment is monitored.

Two targets relate to **Integrated Team Care** (ITC). Most (**90.3%**) PHNs met the delivery target for ITC services, and all PHNs had an appropriate range of organisations delivering ITC services.

Three targets relate to the **Cultural safety** of PHN-commissioned services. The number of PHNs meeting targets declined for each. Drug and alcohol service and mainstream primary health **service targets were met in 96.8% of PHNs.**

The growth target for **culturally safe mental health** services was met in 22.6% of PHNs; however, 38.7% of PHNs reported at least **90% of services were culturally safe.**

In 2021-22, **208,600 First Nations people** received Health Assessments, which is an 11.8% decrease from 2020-21. This decline is primarily attributable to the COVID-19 pandemic.

Two targets relate to providing support for First Nations people who are members of the health workforce or accessing coordinated care. There was no change in either area; **96.8% of PHNs met targets** for workforce support and all PHNs met targets for coordinated care access.

My Health Record

PHNs support My Health Record (MyHR) in general practices, pharmacies and among other health care providers to enable better coordinated care and better-informed treatment decisions for patients.

Uploading of documents by general practices increased from 19.5% to **21.9%** in 2021-22.

Cross-views by both general practices and pharmacies also increased in 2021-22 with the rate for pharmacies more than doubling.

Care for people with chronic conditions

PHNs are monitored on **continuity of care** and **care coordination GP services** provided to people with chronic conditions.

Nationally in 2021-22 the number of services provided **declined by 7.5%**; this decrease was smaller in regional PHNs.

Aged Care

The PHN Program is assessed against two aged care indicators that measure the number of general practice services in Residential Aged Care Homes, and rate of GP Health Assessments delivered to older people.

Overall, delivery of these primary care services **marginally declined** in 2021-22 from the previous year.

Mental Health

PHNs are assessed against six mental health performance indicators.

Three indicators relate to increasing or maintaining the number of people accessing three different levels of care delivered by commissioned mental health services.

The number of PHNs achieving these three indicators **declined** by varying percentages (**between 35.2% to 11.7%**) in 2021-22 from the previous year.

One indicator relates to formalised PHN partnerships with jurisdictional stakeholders on the development of joint foundational regional mental health and suicide prevention plans. **All PHNs met this performance indicator in 2021-22.**

One indicator relates to client outcome measures and the rate at which commissioned providers collect outcome measures at the beginning and end of each mental health care episode. The performance target is 70% of all episodes. **Few PHNs (16.1%) met this performance indicator.**

One indicator relates to suicide prevention and the rate at which commissioned providers follow up referrals where suicide risk is identified. The performance target is a 100% follow-up. No PHNs met this performance target, however **54.8% of PHNs did improve their performance** from the previous year.

Population health – Childhood vaccination

PHNs support health care providers to address factors impacting population health.

The rate of children fully immunised at five years **marginally decreased to 94.7%** - slightly below the national immunisation target of 95%.

Screening programmes are effective in the early detection of cancers in people with no symptoms. The proportion of the target population receiving bowel cancer screening **fell to 39.3%** in 2021-22, while breast cancer screening **decreased to 49.9%** of the target population in 2019-20.

The national participation rate for cervical cancer screening over the 4-year period 2018-19 to 2021-22 is **68.7%.**

Introduction

The PHN Program annual performance report aims to evaluate how the broad range of activities and functions delivered by PHNs contribute towards achieving the Program's objectives.

PHNs are independent organisations funded by the Australian Government to manage health regions. A board oversees their work, and clinical councils and community advisory committees provide advice. The 31 PHNs are responsible for identifying and addressing the primary health needs in their region. The PHNs are responsible for strategic planning, commissioning services, supporting general practices and other health care providers and supporting the integration of local health care services.

This is the fourth annual report on PHN Program Performance delivered under the PHN Program Performance and Quality Framework (PQF) available at: *https://www.health.gov.au/resources/publications/primary-health-networks-phn-performance-and-quality-framework*.

The PQF includes a set of performance indicators used to measure PHNs' progress towards outcomes (Appendix 4 – PQF indicators page 89). These indicators were selected to reflect areas where PHNs could contribute to improvements to the primary health system. PHNs are not solely responsible for influencing these measures. They contribute to ensuring that communities can access appropriate primary care.

This report provides an overall analysis of the PHN Program over 2021-22 via the outcome areas specified in the PQF. PHNs are assessed against all the organisational and other performance indicators reflecting areas where PHNs can have influence. Note that PHN Program performance was evaluated according to the PQF, without adjusting for the impacts of the COVID-19 pandemic. Readers should therefore be aware that PHN progress towards desired outcomes in this period were achieved in a disrupted setting. The outcomes presented in this report may not be representative of the true efforts and gains made by PHNs. Further contextual information is included below.

COVID-19

The COVID-19 pandemic continued to impact the primary health care system over 2021-22. Notable developments included the emergence of the Omicron COVID-19 variant in December 2021 which led to the fourth national wave of cumulative cases[2].

The introduction of Rapid Antigen Tests in November 2021 proved an efficient means of identifying cases and alleviating pressures on general practitioner (GP) and pathology services. Also, the roll-out of a 2-dose vaccination protocol resulted in 95% of the population aged 16+ years being fully vaccinated by April 2022.

Coinciding with COVID-19, a flood emergency[3] impacted much of eastern Australia in early 2022. This resulted in significant pressures on the primary care system, requiring both resilience and agility to respond to community needs.

The primary health care sector's response to COVID-19 was evident through material changes in the supply and demand of available healthcare.

The profile and delivery of GP services changed in 2021-22. Availability and permanence of telehealth and the vaccine rollout was a major contributor to a 10.3% increase, or additional

[2] Australian Institute of Health and Welfare (2022). *Australia's health 2022: data insights*.
[3] Satherley, T., and May, D., (2022). *Natural disasters and climate risk*.

17.6 million GP attendances, from the previous year[4]. However, of total GP services, attendances contributing to the detection and/or management of morbidity substantially decreased. For example, the Practice Incentive Program experienced a 20.4% decline across all services. This encompasses cervical screening (15.8% decrease), and the assessment, planning and review for patients with asthma (29.2% decrease) and diabetes (20.3% decrease)[5].

Further, GP Chronic Disease Management Plans also declined across all demographic cohorts, and by 7.8% nationally. Marginal reductions also occurred in diagnostic imaging (4.6% decrease), allied health attendances (4.7% decrease) and specialist attendances (2.4% decrease).

Jurisdictional delivery of the Essential Vaccine Schedule indicates that most states and territories faced challenges in meeting four vaccination coverage targets across different cohorts of children and adolescents[6]. Five jurisdictions were unsuccessful in maintaining or increasing vaccination coverage for 60-<63-month-old children. By contrast, vaccination coverage targets for Human Papilloma Virus in adolescents and targets for First Nations children were achieved nationally.

People faced major challenges maintaining mental health and wellbeing during the pandemic. The Australian National University found that average measures of psychological distress (K6 instrument[7]) increased for all age cohorts during the second half of 2021[8]. Levels were notably above those of pre-pandemic years in the 18-24 and 25-34 age cohorts. Despite the growing incidence of psychological distress, the percentage of the population accessing Medicare Benefit Schedule (MBS)-subsidised mental health-specific services remained consistent (11.0%)[9]. The rate of service delivery comparatively declined from 546 to 529 services per 1,000 people from the previous year.

The aged care sector, and people living in residential aged care homes (RACHs) were severely impacted by COVID-19 given increased vulnerability to infection and mortality. In 2022, nearly a third of COVID-19 related deaths in Australia were people living in RACHs[10]. Outbreak management became critical as 2,570 facilities experienced one or more outbreaks in 2021-22[11]. While measures including facility lockdowns and mobility restrictions were implemented, this has also been linked to poorer physical and psycho-social outcomes for residents. Outcomes included reduced balance and strength, reduced independent function, anxiety, and cognitive and nutritional decline[12].

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[4] Australian Institute of Health and Welfare (2022). *Impacts of COVID-19 on Medicare Benefits Scheme and Pharmaceutical Benefits Scheme*.
[5] Australian Institute of Health and Welfare (2024). *Medicare-subsidised GP, allied health and specialist health care across local areas: 2021-22*.
[6] Australian Institute of Health and Welfare (2023). *Essential vaccines: Performance report 2021-22*. Retrieved 1 April 2024.
[7] Australian Bureau of Statistics (2012). *Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys*.
[8] Biddle, N., and Gray, M. (2022) *Tracking wellbeing outcomes during the COVID-19 pandemic (January 2022): Riding the Omicron wave.*
[9] Australian Institute of Health and Welfare (2022). *Medicare-subsidised mental health specific services*.
[10] Australian Institute of Health and Welfare (2023). *Older Australians*.
[11] Australian Institute of Health and Welfare (2023). *Older Australians*.
[12] Department of Health and Aged Care (2022). *Interim Guidance on managing public health restrictions on residential aged care facilities*.

PHNs played a critical role in supporting and delivering pandemic response activities, while maintaining operations in their communities. In 2021-22 the Department invested $120.7m in PHNs to implement a range of pandemic response activities. These activities related to:

$26.7m

Delivering the **Commonwealth's vaccine strategy** to the primary healthcare, aged care, and disability sectors

$18.5m

Strengthening access to **Personal Protective Equipment** to the health workforce across primary care settings and residential aged care homes

$35.9m

Commissioning **mental health services** targeted at vulnerable populations and strengthening availability and access to mental health care for the broader population

$26.2m

Development of regional **community care pathways**, including home visitation programs to support COVID-19 positive patients living at home or in residential care

$6.2m

Supporting ongoing operations of **GP-led Respiratory Clinics** for testing and vaccination roll-out

$7.2m

Delivering or promoting **education** targeted at increasing use of allied health services for people living in residential aged care homes

The ability of PHNs to understand and respond to their community needs and leverage existing relationships with stakeholders enabled them to deliver critical pandemic response activities. Compared to other jurisdictions, Victoria faced challenges caused by extended lockdowns. However, Victorian PHNs were able to deliver successful response activities, as shown through the below case study[13].

Case Study: Western Victoria PHN (WVPHN)

> *"Recognising the limitations of vulnerable populations in accessing a COVID-19 vaccine, WVPHN allocated Commonwealth funding to establish the In-Home COVID-19 Vaccinations for Vulnerable Populations Grant….*
>
> *The program helped vulnerable community members in western Victoria boost their protection against COVID-19, while simultaneously improving workforce efficiency during a challenging period for primary healthcare. With the added pressures placed on GPs during the COVID-19 pandemic, in-home vaccination services have enabled qualified immunisation nurses to administer vaccines in residential aged care facilities (RACFs), residential disability facilities or at a patient's place of residence. This has significantly improved vaccine access for vulnerable communities while also enabling general practitioners to remain available to attend to routine patient care.*
>
> *Between the inception of the program in November 2021 and June 2022, WVPHN helped to deliver 1,178 in-home vaccinations in the western Victoria region. Vaccinations were*

[13] Western Victoria PHN (2022). *Annual Report 2021-22*.

provided to a diverse range of people, from the elderly or those living with a disability, as well as individuals experiencing homelessness or who were culturally, ethnically and linguistically diverse, or living in remote and rural communities."

PHNs are acknowledged for their valuable contribution to the national response against the continued challenges presented during the COVID-19 pandemic.

Methodology

This report measures how PHNs' activities are helping achieve the program's objectives across the priority areas identified in the PQF. This report and its contents should be read in conjunction with the PQF and related documentation available at: *https://www.health.gov.au/resources/publications/primary-health-networks-phn-performance-and-quality-framework*.

Appendix B of the PQF sets out the detail of the indicators used in this report, and all indicators are briefly listed at the end of this document (Appendix 4 – PQF indicators page 89).

Performance indicators have been presented under subheadings that align with PHN program priority areas. PHNs are assessed individually as to whether they met or did not meet the respective performance indicator in a reporting period. These assessments have been aggregated to offer an overview of the collective performance of PHNs and are presented as graphs. Where available, underlying quantitative data for performance indicators have also been presented. Data is generally presented to one decimal place, and rounded values may not sum to their non-rounded counterparts or add to 100% due to rounding. Additional tables are provided in Appendix 2 – Data Tables (page 76) to assist where graphs do not display specific values.

Performance and quality framework codes are commonly referenced in this report – including within graph and table titles – to denote the associated PHN performance and quality framework indicator. As an example, Figure 10 refers to indicator O12 which – in the PHN performance and quality framework – is the indicator code for the proportion of PHNs meeting the organisational indicator target for commissioned service contracts that include output and outcome indicators.

This report relies on data from the Australian Bureau of Statistics (ABS), Australian Digital Health Agency (ADHA), Australian Institute of Health and Welfare (AIHW), Primary Mental Health Care Minimum Data Set (PMHC MDS), Australian Immunisation Register (AIR), Medicare Benefits Schedule and data submitted by PHNs to the Department.

The baseline year for PHN performance reporting is 2018-19 unless otherwise indicated. Some indicators are based on an increase between years, and there is no evaluation of performance on these measures in a baseline year.

Results of individual PHNs are not published but are presented by program areas where possible. The communities that PHNs serve are diverse in demographics and in the determinants of health. PHNs are therefore not homogenous. To account for these differences the Department uses a series of indicators and factors to inform the funding of each PHN. Where appropriate and available, results are also presented by PHNs' level of socio-economic disadvantage, remoteness from services, and state group.

Disadvantage

PHN regions are assigned a level of disadvantage based on the most recent 2021 Index of Relative Socio-Economic Disadvantage (IRSD). IRSD is part of the Australian Bureau of Statistics' Socio-Economic Indexes for Areas (SEIFA) series and uses data from the 2021 Census. The 2021 SEIFA IRSD measure should not be compared with the 2016 SEIFA IRSD used in the *Primary Health Network Program Annual Performance Report 2020-21* which is based on the 2016 Census.

PHN levels of disadvantage are calculated by dividing the PHNs, ordered by disadvantage, into 5 equally sized groups as statistical quintiles. Quintile 1 – as 'level 1' – contains the most disadvantaged areas.

Remoteness

Categories of PHN remoteness are based on the AIHW classification. PHN regions with at least 85% of the population residing in Major cities are classified as metropolitan, as defined by the ABS, using the population distribution as of 30 June 2016. All other PHN areas are classified as regional PHN areas.

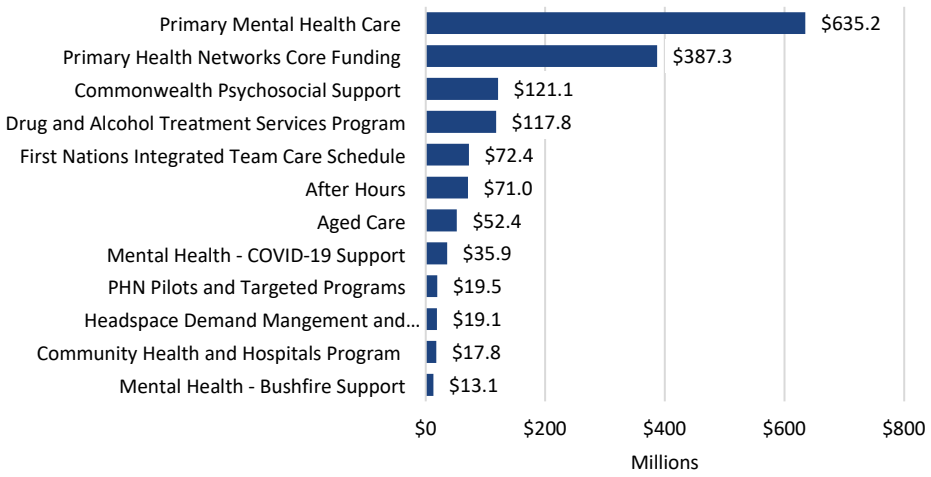
State groups

PHN state group categories are based on PHNs' state and territory locations. State groups are organised to preclude identification of individual PHNs. While most PHNs are solely within state and territory boundaries, Murray PHN is classified as Victorian but includes the New South Wales town of Albury.

Funding and commissioned providers

The total annual PHN Program funding increased by 16.3% ($218mil) from $1.344 billion to $1.562 billion in the 2021-22 financial year. Of the $218 million funding increase, nearly a quarter is new investment in Aged Care services, while funding for PHN Pilots and Targeted Program Schedules and headspace Demand Management and Enhancement Program increased by 46.7% and 48.5% respectively on previous year levels. The Primary Mental Health Care schedule remains the largest source of funding to the PHN Program.

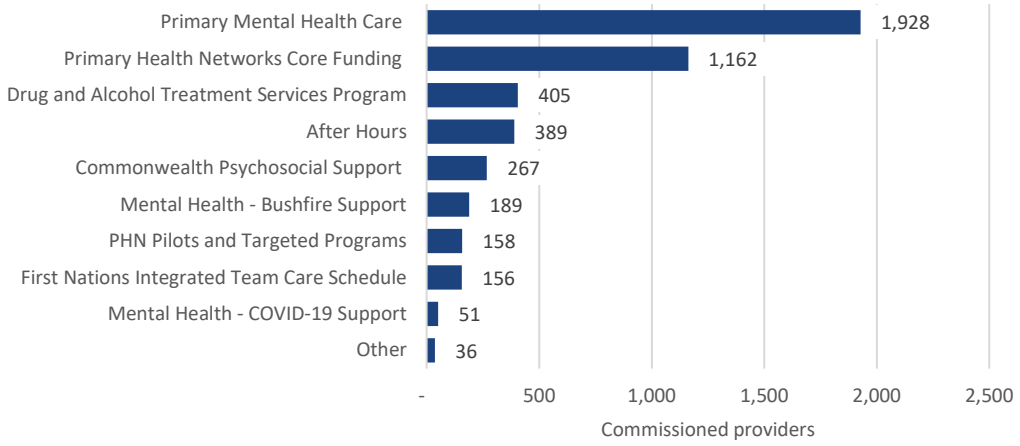
Figure 1: 2021-22 funding by schedule



Source: Annexure D (budget allocation) of PHN executed agreements

PHNs coordinated and commissioned place-based primary health care services to address their region's local identified health needs. In 2021-22, 4,777 providers were commissioned to deliver services. Figure 2 shows the number of commissioned service providers by schedule with Primary Mental Health Care representing the largest proportion (40.7%).

Figure 2: 2021-22 commissioned service providers by schedule



Source: Commissioned Services Report submitted by PHNs
Other includes headspace Demand Management and Enhancement Program, Aged Care, and Community Health and Hospitals Program commissioned service providers.

Emergency department and hospitalisations

Potentially preventable hospitalisations (P12)

Potentially preventable hospitalisations (PPH) are currently a health system performance indicator of accessibility and effectiveness in the National Health Reform Agreement[14] and an area of focus for PHNs. The PHN Program is assessed in the PQF on the ability for PHNs to reduce or maintain the rate of PPH in their regions (P12). While PHNs are not solely responsible for influencing this measure, they contribute to ensuring that communities can access appropriate primary care that reduces potentially preventable hospitalisations.

The indicator can be calculated using routinely collected hospital admission data and allows insight into the interface between primary and secondary health care. It can be disaggregated at various levels, including by geographic regions, population subgroups and conditions to highlight priority areas for further investigation.

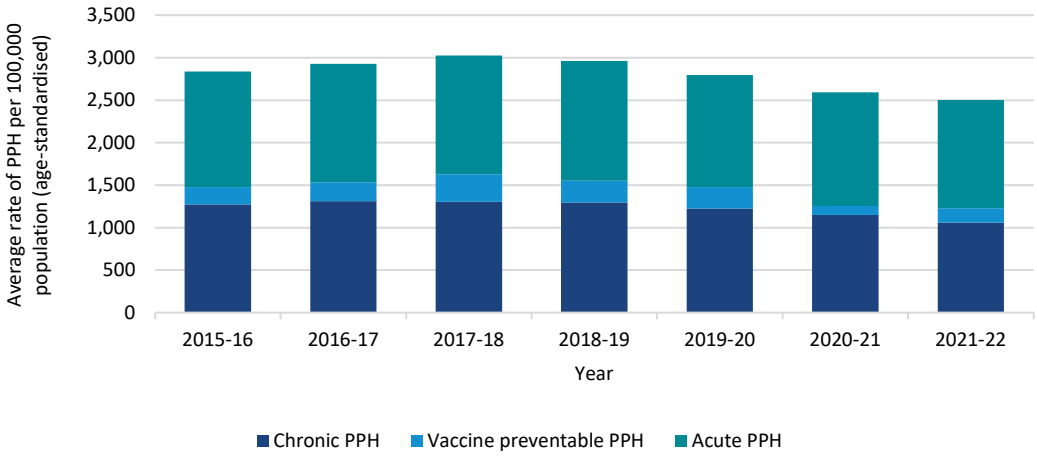
A hospital admission is classified as 'potentially preventable' when it is triggered by a condition (Appendix 1 – Selected potentially preventable hospitalisations, page 75) which could have been prevented through an individualised health or disease management intervention in a primary care or community care setting (e.g., by a GP, dentist or allied health professional).

Hospitalisations for COVID-19 were not counted as a vaccine-preventable condition in the 2021-22 data. Instead, the trend is attributed to a return to previously recorded population levels of pneumonia and influenza which were notably lower in the 2020-21 period due to COVID-19 preventative measures such as mask wearing and social distancing.

Adjusted for age

Figure 3 shows that, across all PHNs, the average age standardised rate of total PPH declined from 2,580 per 100,000 population in 2020-21 to 2,481 in 2021-22. This was a relatively small decrease in total PPH. In seven PHNs, potentially preventable hospitalisations rose between 2020-21 and 2021-22, and they declined in 24 PHNs. National increases in PPH were predominantly driven by increases in vaccine-preventable hospitalisations associated with pneumonia and influenza (15 per 100,000 people, after adjusting for age, in 2020-21 compared with 74 per 100,000 people in 2021-22).

Figure 3: Average PHN potentially preventable hospitalisations by type (P12) per 100,000 population age standardised, 2015-16 to 2021-22



Source: AIHW Potentially Preventable Hospitalisations data
For data details, see Table 1, page 76

[14] https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra

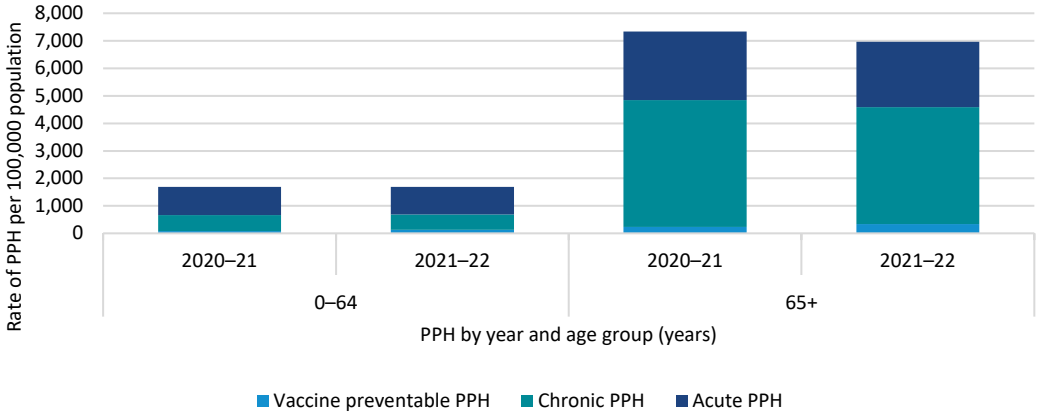
Age group comparison

Figure 4 illustrates PPH using a crude rate per 100,000 population to contrast two age groups: people aged 0-64 years and people aged 65+ years. The older population were four times more likely to have a PPH admission compared to the younger population. The older cohort (aged 65+ years) accounted for 6,923 PPH per 100,000 population in 2021-22. The younger (0-64 years) cohort accounted for 1,670 PPH per 100,000 population.

In 2021-22 Chronic PPH accounted for 557 (33.4%) of the total PPH amongst the younger 0-64 years cohort, but a much higher 4,252 (61.4%) of PPH for the older cohort. Both Chronic and Acute PPH decreased in 2021-22. For the younger cohort, Chronic PPH declined 21 (3.6%) hospitalisations per 100,000 population to 557, while the Acute PPH rate declined by 35 (3.4%) to 996. The 65+ years cohort rate decreased by 365 (7.9%) to 4,252 Chronic PPH per population and declined 110 (4.4%) to 2,375 Acute PPH per 100,000 population.

Vaccine preventable hospitalisations represent the smallest proportion of total PPH, but there was a large increase in 2021-22. The 0-64 years cohort rate increased to 132 per 100,000 population, an increase of 46 (53.5%). There was also an increase in the older 65+ years cohort to 342, an increase of 110 (47.4%).

Figure 4: Potentially preventable hospitalisations by type and age group (P12) per 100,000 population, 2020-21 to 2021-22



Source: AIHW Potentially Preventable Hospitalisations data
For data details, see Table 2, page 76

Lower urgency emergency department presentations (P7)

The PHN Program PQF indicator, Rate of lower urgency emergency department presentations (P7), is based on the 2022 National Healthcare Agreement specifications for 'Selected potentially avoidable GP-type presentations to emergency departments' (P19).[15] While PHNs are not solely responsible for influencing this measure, they contribute to ensuring that communities can access appropriate primary care that reduces the need for emergency department presentations.

Emergency departments (EDs) are a vital part of Australia's health care system, providing care for people requiring urgent, and often lifesaving, medical attention. However, a proportion of people present to the ED for health conditions that may be managed more appropriately and effectively through a different health care setting, such as their GP or community walk-in clinic. Understanding who uses emergency care services can inform

[15] For Identifying and definitional attributes, see National Healthcare Agreement: PI 19–Selected potentially avoidable GP-type presentations to emergency departments, 2022 on the Metadata Online Registry (METEOR) at *https://meteor.aihw.gov.au/content/740847*.

health care planning, coordination and delivery to ensure that people receive the right care, in the right place, at the right time.

The AIHW states that:

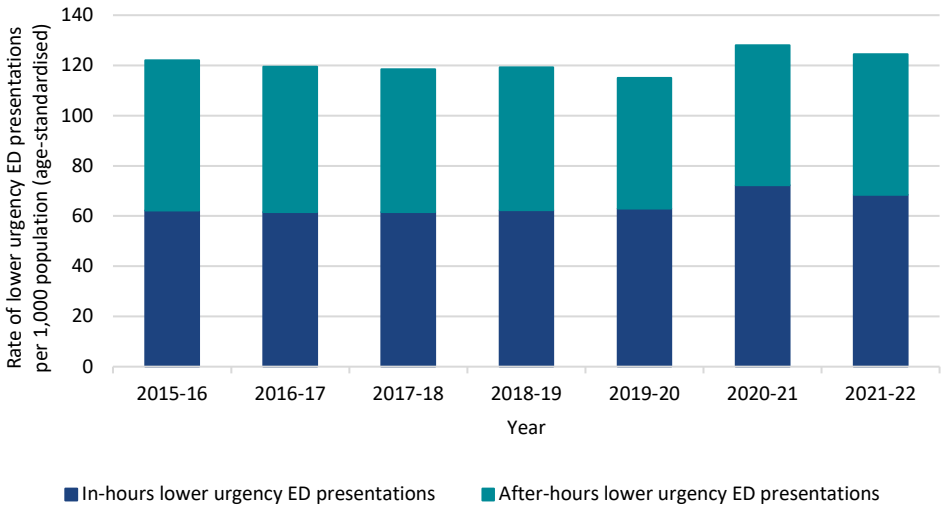
> *Care should be taken when using this data to identify 'avoidable GP type' or 'GP style' presentations because it is based on urgency (triage) categories which may not reflect the various factors that influence the use of EDs such as the complexity of a presentation, the patient's choice or condition, the most appropriate model of care for such presentations, or the accessibility and availability of primary and community health services.*[16]

The rate of lower urgency ED presentations measures the use of EDs for less urgent conditions, which may indicate that a proportion of these cases could have been attended to in a primary care setting. While it is not always clear why individuals choose to attend an ED for lower urgency conditions, it may imply a lack of general practice access and/or related information. PHNs have a responsibility to improve access to general practices, potentially decreasing demand on ED services.

'In-hours' or 'normal' hours presentation occur between 8:00am and 6:00pm on a weekday or between 8:00am and noon on a Saturday. Outside of these hours, and on public holidays, are classified as 'after-hours'.

Figure 5 illustrates a decrease of 2.8% in age-standardised lower urgency ED presentations– decreasing from 128 presentations per 1,000 population in 2020-21 to 124 in 2021-22. By time of presentation, in hours presentations decreased from 72 to 69 (down 5.3%). After hours presentations remained steady at 56 presentations per 1,000 population.

Figure 5: Lower urgency ED presentations (age-standardised) by hours of presentation (P7), rate per 1,000 population, 2015-16 to 2021-22

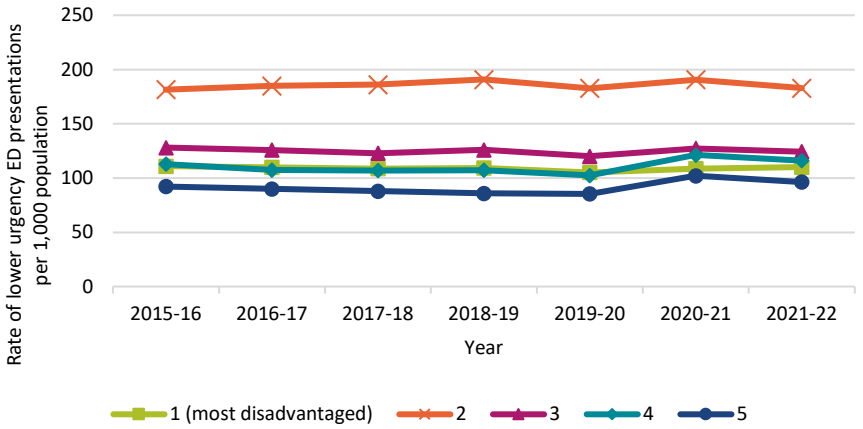


Source: AIHW, Use of emergency departments for lower urgency care, age-standardised, by Primary Health Network (PHN) area, 2021–22
Note: 'In-hours' or 'normal' hours presentation is between 8 am and 6 pm on a weekday or between 8 am and noon on a Saturday. Outside of these hours – and on public holidays – is classified as 'after-hours'. For data details, see Table 3, page 76

There was a reduction in lower urgency ED presentations (Figure 6), except PHN regions in areas of most disadvantage (level 1) recorded a 1.2% increase. By contrast, the average PHN recorded a 3.4% reduction in lower urgency ED presentations.

[16] Source: AIHW (2023), Use of emergency departments for lower urgency care: 2020–21.

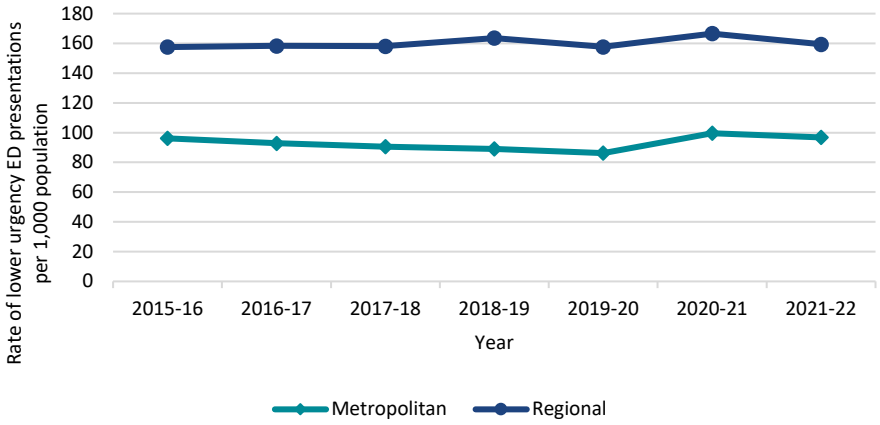
Figure 6: Lower urgency ED presentations (P7) by disadvantage, rate per 1,000 population, 2015-16 to 2021-22



Source: AIHW, National Non-admitted Patient Emergency Department Care Database, 2021-22
For data details, see
Table 4, Page 76

Both metropolitan and regional PHNs recorded a reduction in lower urgency ED presentations in 2021-22 (Figure 7). While metropolitan PHNs recorded a reduction of 2.9 (2.9%) presentations per 1,000 population, regional PHNs recorded a 7.2 (4.3%) reduction of presentations.

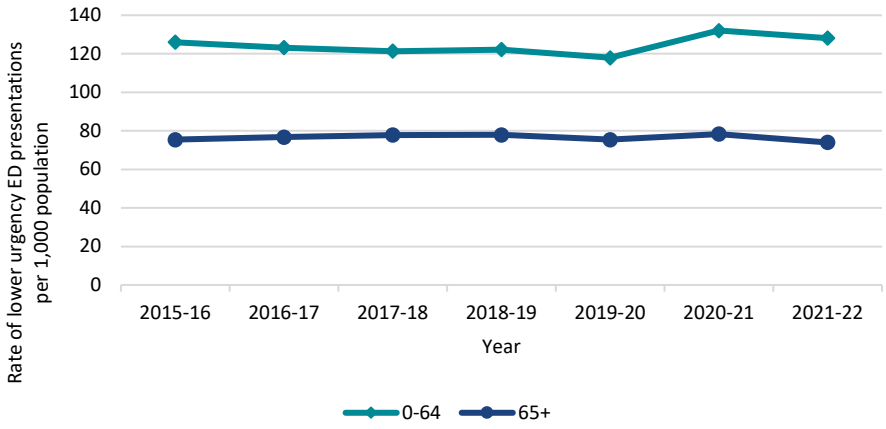
Figure 7: Lower urgency ED presentations (P7) (age-standardised) by remoteness, rate per 1,000 population, 2015-16 to 2021-22



Source: AIHW, National Non-admitted Patient Emergency Department Care Database, 2021-22
For data details, see Table 5, page 76

Figure 8 illustrates the reduction in lower urgency ED presentations by age group. In 2021-22, lower urgency ED presentations of patients aged zero to 64 years decreased by 3.0%, while presentations of patients aged 65 years or older decreased by 5.5%.

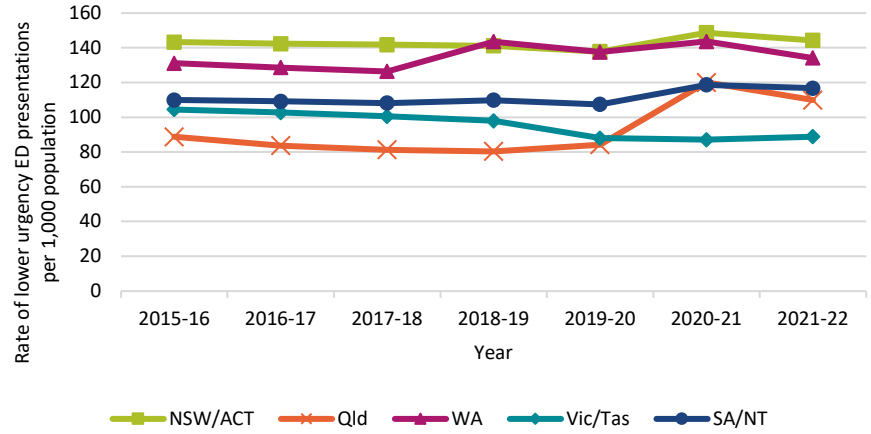
Figure 8: Lower urgency ED presentations (P7) by age group, rate per 1,000 population, 2015-16 to 2021-22



Source: AIHW, National Non-admitted Patient Emergency Department Care Database, 2021-22
For data details, see Table 6, page 76

Variability exists across PHN state groups (Figure 9) when comparing lower urgency ED presentations between 2020-21 and 2021-22. Queensland recorded the greatest reduction of 8.5% in 2021-22, having recorded the greatest increase the year before. All other states and territories recorded reductions between 1.7% and 3.0%, except Victoria/Tasmania recorded an increase of 1.9%.

Figure 9: Lower urgency ED presentations (P7) by PHN state group, rate per 1,000 population, 2015-16 to 2021-22



Source: AIHW, National Non-admitted Patient Emergency Department Care Database, 2021-22
For data details, see Table 7, page 77

Program (P1, P2, P4)

Individual PHNs are responsible for identifying and responding to the primary health needs in their region. They achieve this through commissioning health services, health system improvement and sector support activities. The following three indicators in the PQF are used to assess PHNs on their ability to provide these functions:

- ***Activities delivered by PHNs address prioritised needs (P1):*** All activities delivered by PHNs address prioritised needs identified in PHN Needs Assessments and/or national priorities. This is assessed by aligning information provided in PHN Activity Work Plans, Needs Assessments and Variance Reports. These PHN deliverables are received in the PHN Program Electronic Reporting System and manually cross-referenced by a team of Operations Officers.
- ***PHNs demonstrate health system improvement and innovation (P2):*** PHNs must contribute towards health system improvements, innovations and/or commissioning best practice in their region. PHNs are assessed based on their provision of qualitative data describing how they have undertaken these activities.
- ***PHNs deliver support activities to GPs and other health care providers (P4):*** PHNs must directly deliver or commission services that support general practices and other health care providers. This support can subsequently result in improvements to population health, workforce, aged care or digital health. PHN performance is assessed based on qualitative data that describes measures and levels of support provided by PHNs.

All PHNs have met these three program indicators from 2018-19 to 2021-22.

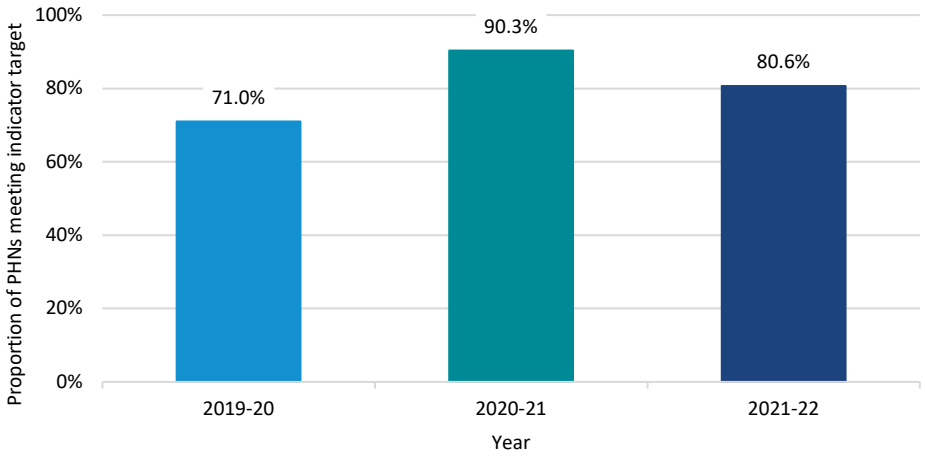
Organisational (O12)

A core function of PHNs is to commission health services appropriate for their community. To monitor the performance of commissioned service providers, the Department recommends that PHNs include both output and outcome indicators in their contracts (O12). In this context, output indicators describe the tangible activities of a service, for example, the number of clients who received a Health Assessment. Outcome indicators describe the effects of that service, for example, overall improvement in health markers such as blood pressure or psychological distress. PHNs are expected to increase the number of contracts containing both output and outcome performance measures annually.

To assess this indicator, PHNs are required to provide the number of contracts containing both output and outcome measures, and the total number of contracts executed in the reporting period. Calculations from this information are used to determine PHN performance.

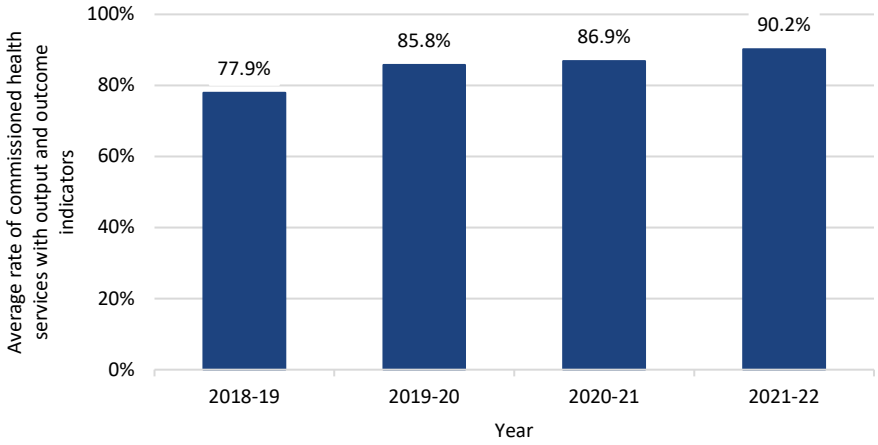
The majority (80.6%) of PHNs increased the rate of inclusion of output and outcome performance indicators in their contracts with commissioned service providers in 2021-22. This is a decrease from 90.3% in the previous year (Figure 10). However, there has been a consistent improvement in the rate of commissioned service providers with these performance indicators in their contracts from 77.9% to 90.2% over the four years to 2021-22 (Figure 11). Every PHN had performance measures in at least 57.7% of their contracts, which is the highest rate since the 2018-19 baseline.

Figure 10: Proportion of PHNs meeting organisational indicator target for commissioned service contracts that include output and outcome indicators (O12)



Source: Performance reporting data provided by PHNs
***This performance measure was collected as a baseline in 2018-19.**

Figure 11: Average rate of commissioned health services with output and outcome indicators (O12)



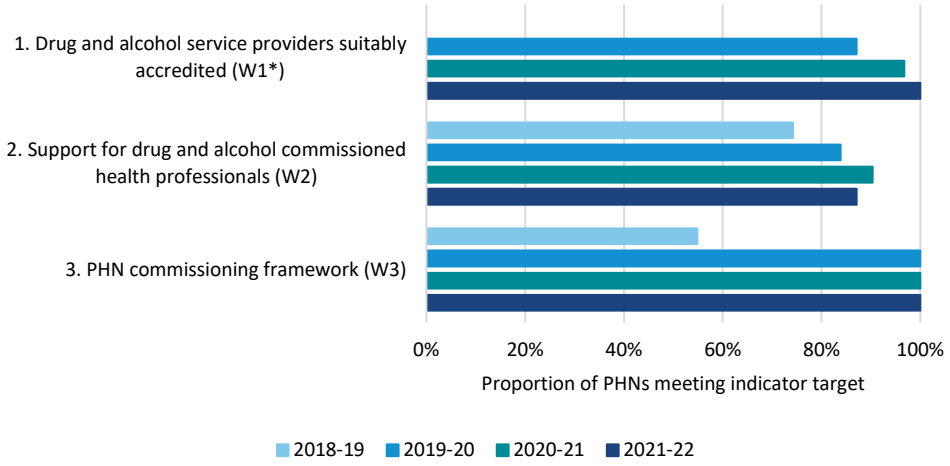
Source: Performance reporting data provided by PHNs

Workforce (W1, W2, W3)

In the workforce priority area, PHNs are assessed against three indicators. Two indicators (W1 and W2) aim to promote quality improvement approaches and support health professionals through education and training. Achievement against these three indicators was variable in 2021-22 compared to 2020-21 (Figure 15):

- The rate of drug and alcohol treatment service providers with suitable accreditation (W1) increased from 96.7% in 2020-21 to 100% in 2021-22.
- PHNs providing adequate evidence of support for drug and alcohol commissioned health professionals (W2) decreased from 90.3% of PHNs in 2020-21 to 87.1% in 2021-22.
- PHNs with appropriate Commissioning Frameworks (W3) remained at 100% with all PHNs maintaining frameworks in 2021-22. This framework assists PHNs to fulfil their commissioning role in a strategic way.

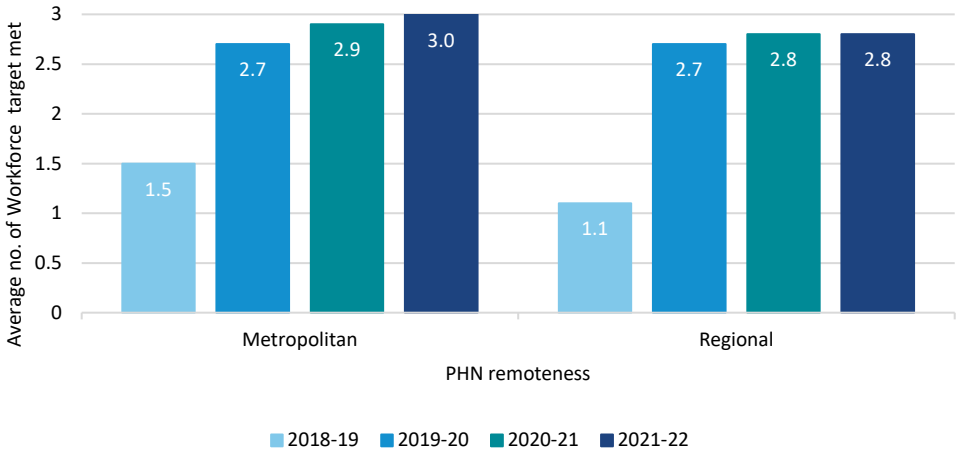
Figure 12: Proportion of PHNs that met performance targets by Workforce indicator (W1, W2 and W3)



Source: Performance reporting data provided by PHNs
***This performance measure was collected as a baseline in 2018-19.**
For data details, see Table 10, page 77

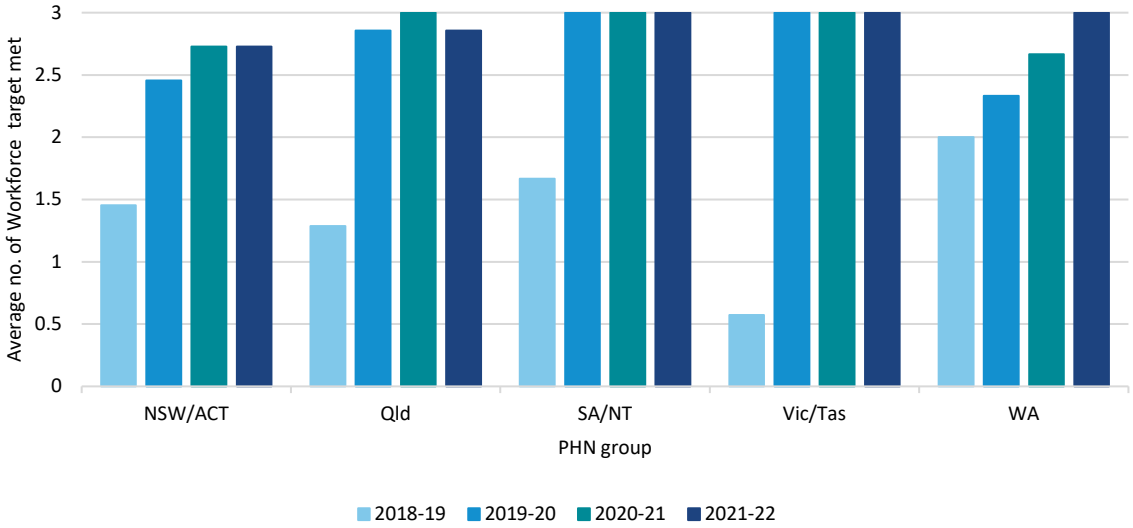
The average number of workforce performance targets met by PHNs continued to improve year-on-year in metropolitan areas and were maintained in regional areas compared to 2020-21 (Figure 16).

Figure 13: Average number of Workforce performance targets met (W1, W2 and W3) by PHN remoteness



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of 2 indicators, as one indicator (W1) was collected as a baseline in 2018-19.

Figure 14: Average number of Workforce performance targets met (W1, W2 and W3) by PHN state group



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of 2 indicators, as one indicator (W1) was collected as a baseline in 2018-19.
For data details, see Table 12, page 78

Alcohol and other drugs (AOD1, AOD2)

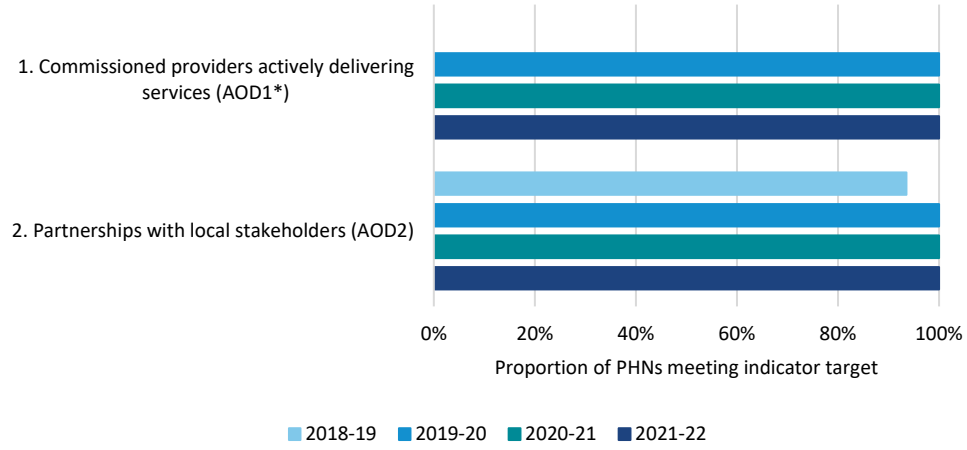
PHNs support increasing service delivery capacity of the alcohol and other drug (AOD) treatment sector through improved regional coordination and commissioning of treatment services. All PHNs remained consistent with the rate of AOD commissioned providers actively delivering services in their regions, whilst being flexible to COVID-19 restrictions. PHNs continued to nurture established partnerships with key local AOD treatment service stakeholders and worked with their commissioned service providers to improve the rate of suitable accreditation supporting best practice. PHNs continued to progress with professional development events and training and increased the number of commissioned services compared to the previous year.

Through the substantial efforts of the whole AOD sector in 2021-22, minimal disruptions to service provision were observed despite significant public health challenges.

All PHNs have continued to meet the two indicators in 2021-22 (Figure 19), specifically:

- The rate of drug and alcohol commissioned providers actively delivering services (AOD1), and
- Partnerships established with local key stakeholders for AOD services (AOD2).

Figure 15: Proportion of PHNs that met performance targets by Alcohol and Other Drugs indicator (AOD1 and AOD2)



Source: Performance reporting data provided by PHNs
***This performance measure was collected as a baseline in 2018-19.**
For data details, see Table 13, page 78

There is no comparative commentary on performance by disadvantage, remoteness and state group as both indicators were fully met nationally.

General practices

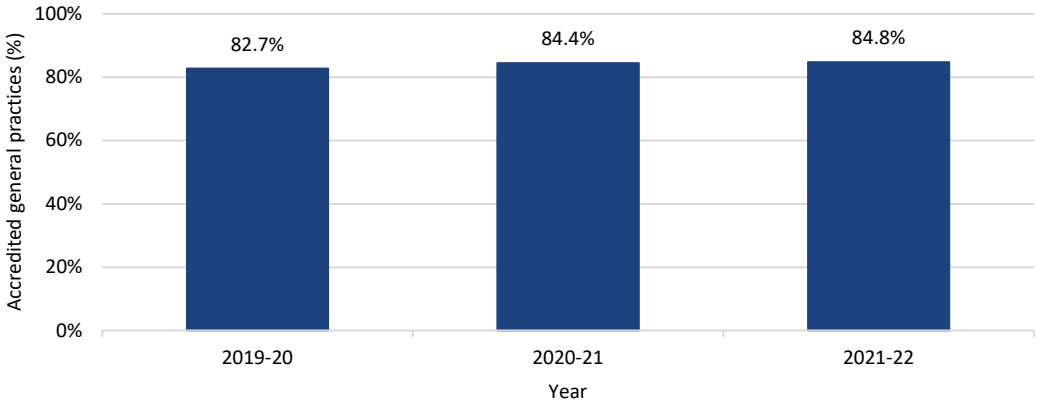
PHNs play an important role supporting general practices and other health care providers with quality improvement and accreditation, and patient centred care and best practice service delivery models.

Accredited general practices (P3)

Accreditation is voluntary for general practices to demonstrate they are meeting Royal Australian College of General Practitioners safety and quality standards[17]. The Australian Commission on Safety and Quality in Health Care's National General Practice Accreditation Scheme provides a method of ensuring the quality and safety of a general practice. Increasing the number of general practices which meet the requirements of this Scheme should improve quality of care, patient experience and health outcomes (P3). PHNs support general practices' provision of quality care through quality improvement activities.

The general practice accreditation rate increased to 84.8% in 2021-22, increasing 0.3 percentage points from 84.4% in 2020-21 (Figure 20). The accreditation rate increased in in 68% of PHNs.

Figure 16: Average general practice accreditation rate (P3)

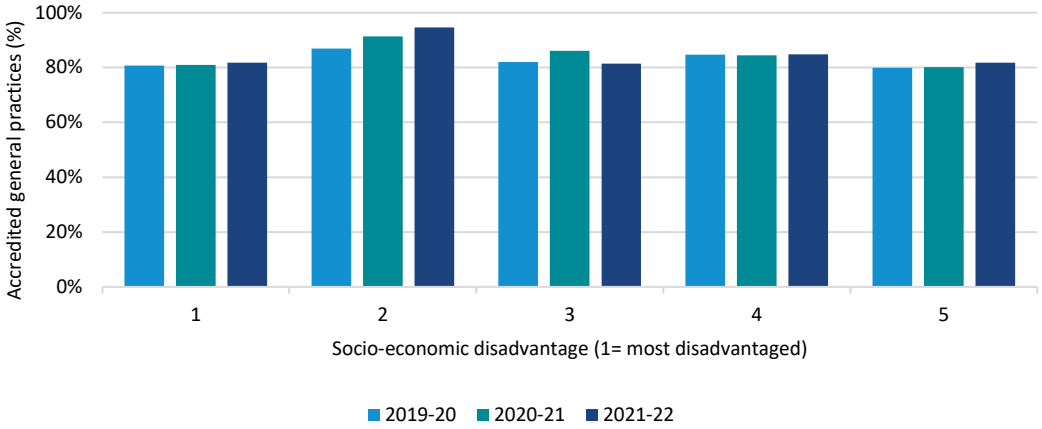


Source: Performance reporting data provided by PHNs

There was a large variance in accreditation rates by PHN socio-economic disadvantage in 2021-22 (Figure 21). The greatest increase in accreditation rates of 3.3 percentage points was recorded in the more disadvantaged PHN regions (group 2), which recorded an accreditation rate of 94.7% The median disadvantaged regions (group 3) recorded the largest decrease of 4.6 percentage points to 81.5% in 2021-22.

[17] Available at https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition

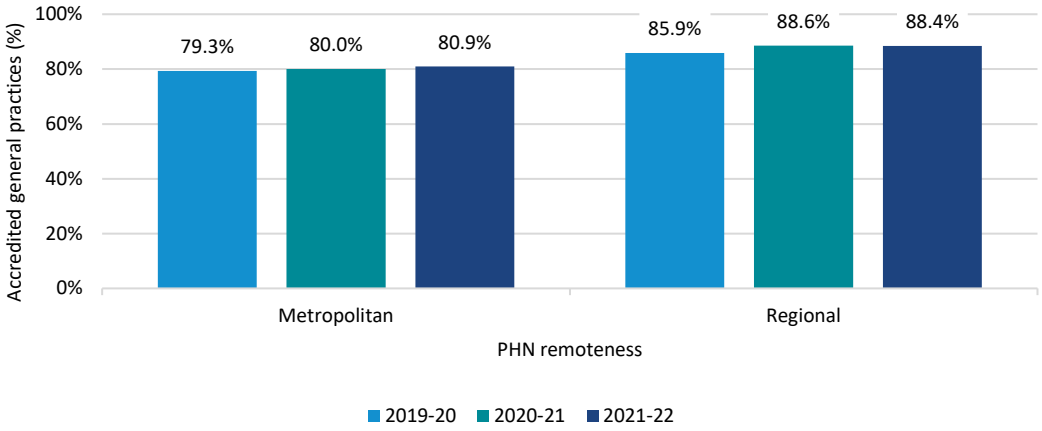
Figure 17: Average general practice accreditation rate (P3) by PHN socio-economic disadvantage



Source: Performance reporting data provided by PHNs
For data details, see Table 15, page 78

In 2021-22, accreditation rates in metropolitan PHN regions increased 0.9 percentage points to 80.9%, while regional PHN regions decreased 0.2 percentage points to 88.4% (Figure 22). Accreditation rates remain higher in regional areas.

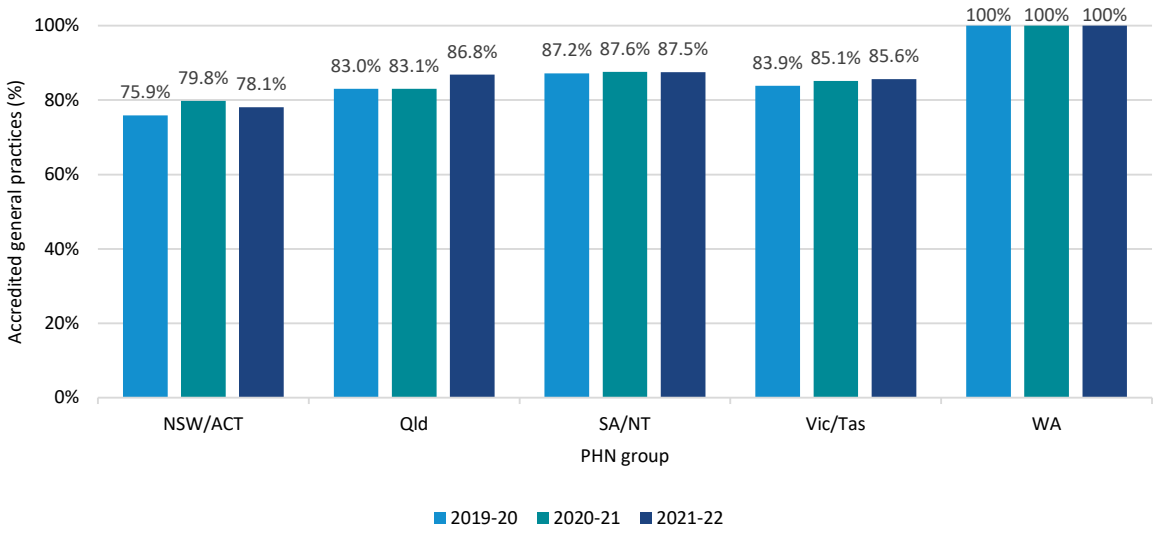
Figure 18: Average general practice accreditation rate (P3) by PHN remoteness



Source: Performance reporting data provided by PHNs

The greatest increase in accreditation rates of 3.8 percentage points was recorded in Queensland PHNs which recorded an accreditation rate of 86.8% (Figure 21). The NSW and ACT group recorded the largest decrease of 1.7 percentage points to 78.1% in 2021-22.

Figure 19: Average general practice accreditation rate (P3) by PHN state group



Source: Performance reporting data provided by PHNs

Practice Incentives Program After-Hours payments (P6)

The Practice Incentives Program (PIP) After-Hours incentive aims to ensure patients have access to care throughout after-hours periods. PIP payments aim to improve access to care, detection and management of chronic conditions, along with quality, safety, performance and accountability where PHNs can play an important role. PHNs are assessed on their ability to support general practices to provide appropriate after-hours access. Assessment is based on the percentage of general practices receiving payment for after-hours services (P6).

A difference in methodology between the count of general practices and the count of general practices receiving PIP after-hours payments results in some reported figures in excess of 100%. This data should be read as indicative of a trend over time. The methodology of this indicator is under review.

All 5 levels of PIP payments are measured for this indicator:

Level	Aspect or Activity
1	Participation payment
2	Sociable after-hours cooperative coverage
3	Sociable after-hours practice coverage
4	Complete after-hours cooperative coverage
5	Complete after-hours practice coverage

More detail on these payments is available on the Services Australia website[18].

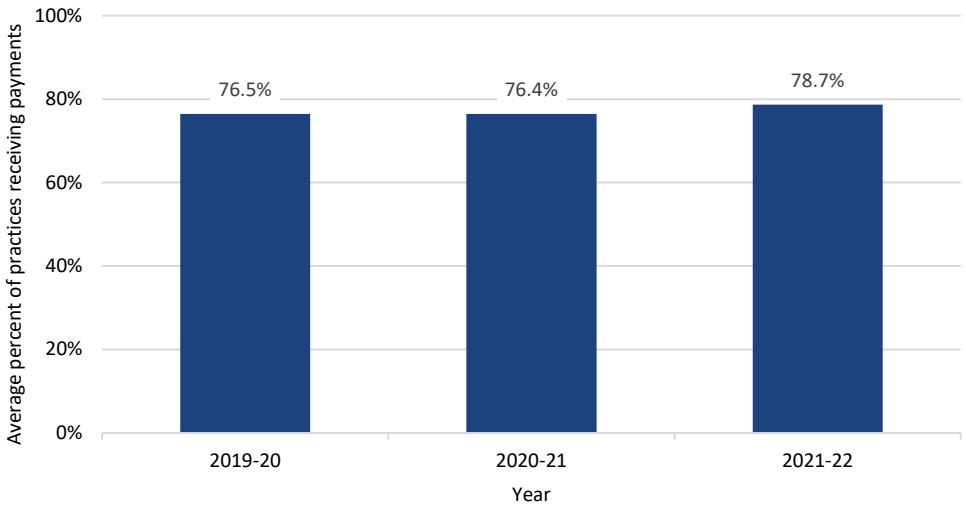
For the purposes of the PIP, an after-hours cooperative is defined as general practices working together to provide care to patients outside the normal opening hours of their practices.

The average percentage of general practices receiving PIP after hours payments in 2021-22 was 78.7%, up from 76.4% in 2020-21 (Figure 24), which remains similar across

[18] *https://www.servicesaustralia.gov.au/types-practice-incentives-program-payments?context=23046#pipcapacitystream*

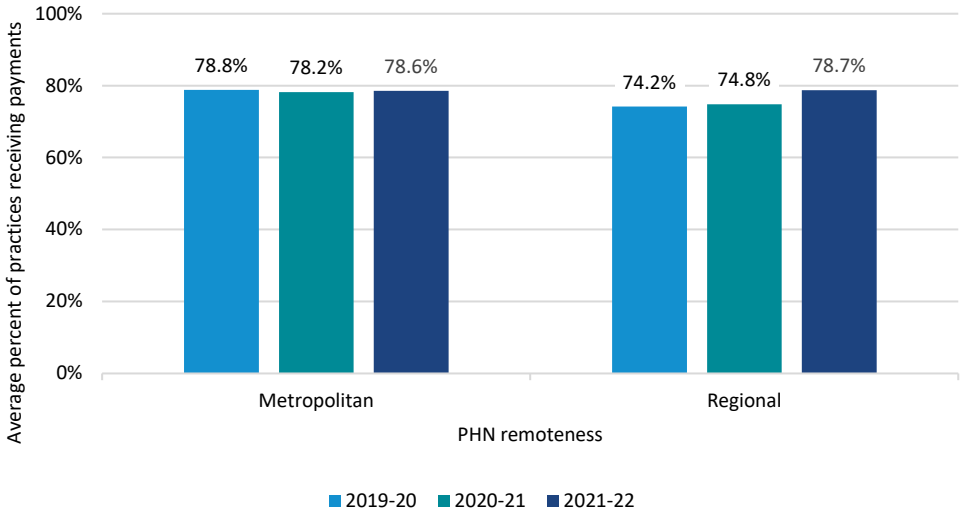
metropolitan and regional areas (Figure 25). PIP after hours payments in metro areas increased 0.4 percentage points to 78.6% in 2021-22, while payments in regional areas increased 3.9 percentage points to 78.7%.

Figure 20: Percentage of practices receiving PIP after-hours payments (P6)



Source: Department of Health and Aged Care and performance reporting data provided by PHNs

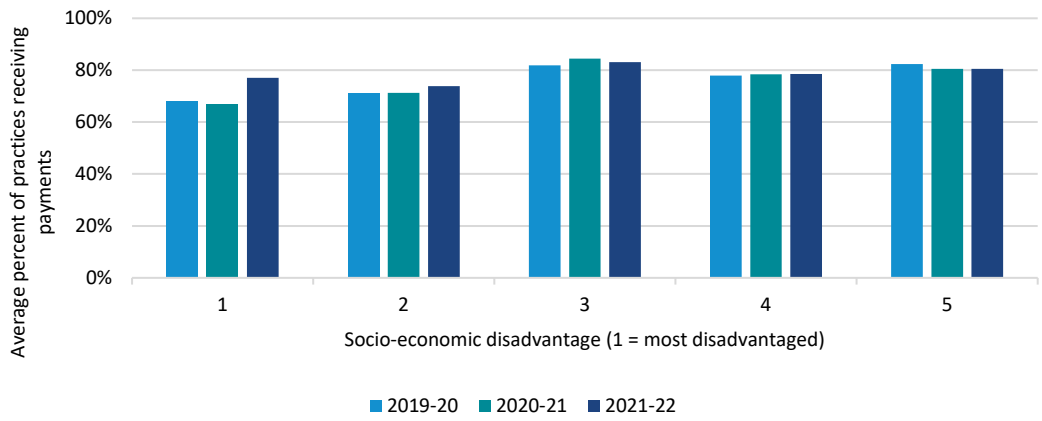
Figure 21: Percentage of practices receiving PIP after-hours payments (P6) by PHN remoteness



Source: Department of Health and Aged Care and performance reporting data provided by PHNs Northern Territory PHN not included.

The greatest PIP participation increase was recorded in PHN regions of greater socio-economic disadvantage (Figure 26). The most disadvantaged PHN regions (category 1) increased 10.2 percentage points to 77.1%. The second most disadvantaged PHN regions increased after-hours participation by 2.5 percentage points to 73.9%.

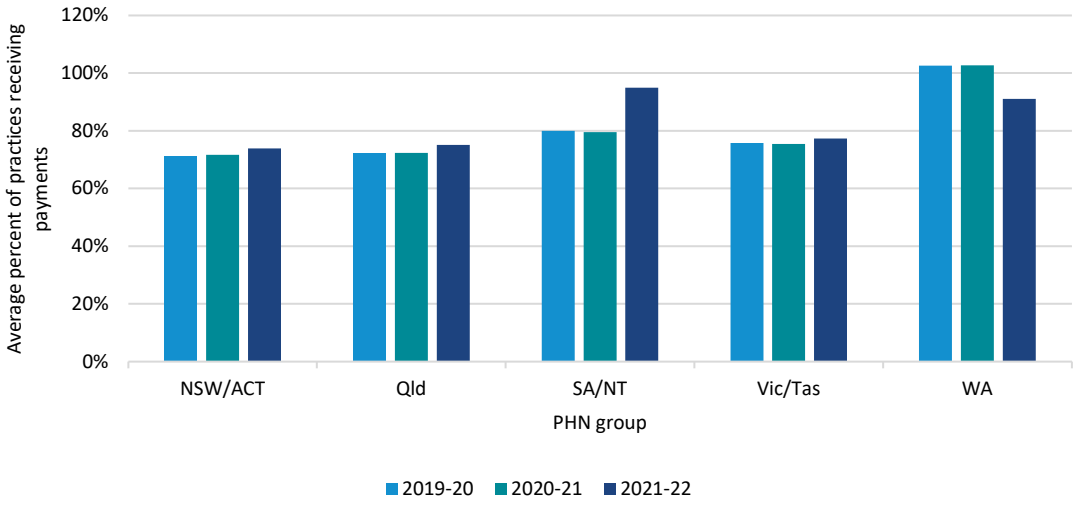
Figure 22: Percentage of practices receiving PIP after-hours payments (P6) by PHN socio-economic disadvantage



Source: Department of Health and Aged Care and performance reporting data provided by PHNs
For data details, see Table 15, page 78

By PHN state group, the greatest increase in practices receiving PIP after-hours payments was reported in South Australian and Northern Territory PHNs, which recorded a 15.5 percentage point increase to 95.0%. The most pronounced decrease was in Western Australian PHNs which recorded an 11.6% decrease to 91.1% of practices receiving after-hours payments in 2021-22.

Figure 23: Percentage of practices receiving PIP after-hours payments (P6) by PHN state group



Source: Department of Health and Aged Care and performance reporting data provided by PHNs
For data details, see Table 16, page 78

Digital health

Long term outcomes from digital health systems include coordinated care and better-informed treatment decisions. PHNs support health care providers (general practice, pharmacy and allied health) to use digital health systems to improve patient care and communication.

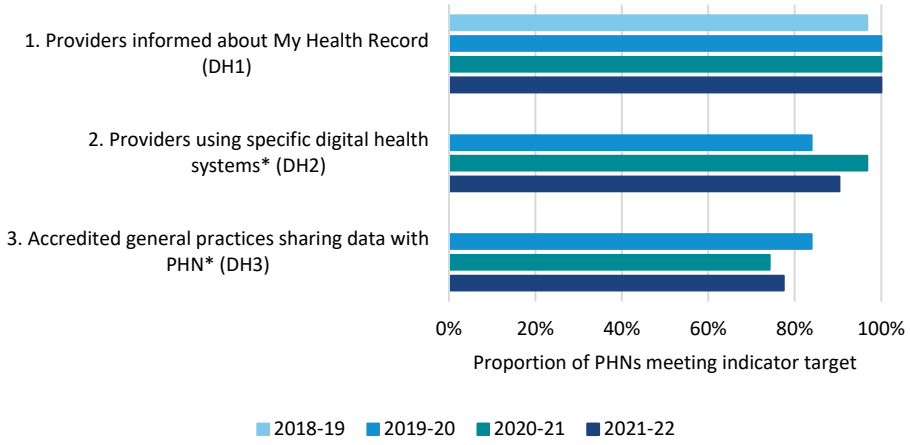
The three indicators (and related performance criteria) of PHN performance in the digital health priority area, are:

- The rate of health care providers informed about My Health Record (DH1): PHNs raise awareness and provide access to My Health Record education to 100% of general practices.
- The rate of health care providers using specific digital health systems (DH2): PHNs increase the rate of health care providers using e-referrals, smart forms and telehealth.
- The rate of accredited general practice sharing data with PHNs (DH3): PHNs increase the rate of accredited general practices sharing data by 5% annually.

Two thirds of PHNs (67.7%) achieved all three digital health indicators in 2021-22, a 4.7% decrease from the previous year (Figure 28). In addition, in 2021-22:

- All PHNs increased or maintained awareness of, and provided access to, My Health Record education to all general practices in their regions (DH1). This indicator was consistently met by all PHNs since 2019-20.
- Somewhat fewer PHNs increased the rate of health care providers that use digital health systems (DH2) in 2021-22 (90.3%) compared with 2020-21 (96.8%).
- Most (77.4%) PHNs have increased the rate of accredited general practices sharing data, up from 74% of PHNs in 2020-21 (DH3).

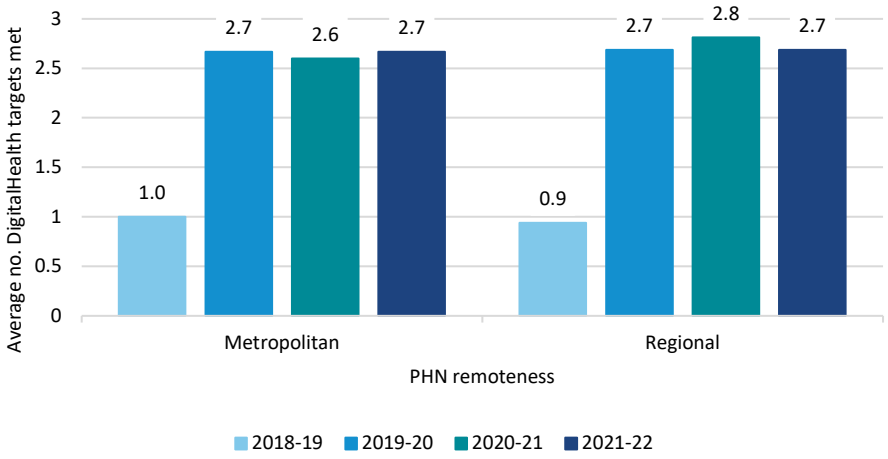
Figure 24: Proportion of PHNs that met performance targets by Digital Health indicator (DH1, DH2, and DH3)



Source: Performance reporting data provided by PHNs
***This performance measure was collected as a baseline in 2018-19.**
For data details, see Table 17, page 79

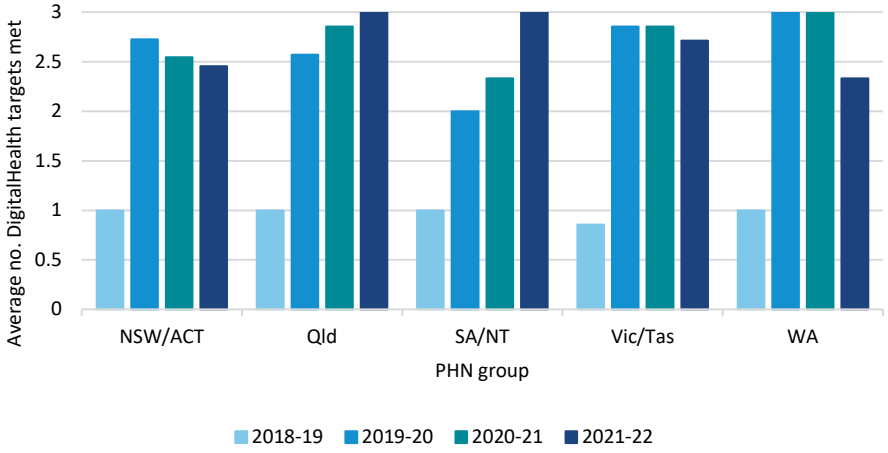
In 2021-22, the average number of digital health targets met was the same in metropolitan and regional PHNs (Figure 30). PHNs in Qld and SA/NT were the most likely to have met all three targets (Figure 31).

Figure 25: Average number of Digital Health performance targets met (DH1, DH2, and DH3) by PHN remoteness



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of one indicator, as 2 indicators (DH2 and DH3) were collected as a baseline in 2018-19.

Figure 26: Average number of Digital Health performance targets met (DH1, DH2, and DH3) by PHN state group



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of one indicator, as 2 indicators (DH2 and DH3) were collected as a baseline in 2018-19.
For data details, see Table 19, page 79

Digital health systems (DH2)

PHNs support general practice, pharmacy, and allied health providers to adopt digital systems which improve the delivery and experience of health care providers. These systems include:

- **E-referrals:** the reliable, secure transfer of referral information from one provider's client management system to another provider's client management system.
- **Smart forms:** electronic forms issued by receiving providers that sending providers use to extract information from their client management system and assemble that information into an e-referral or other communication.
- **Telehealth:** where health care is provided remotely by means of telecommunications technology (telephone or video).

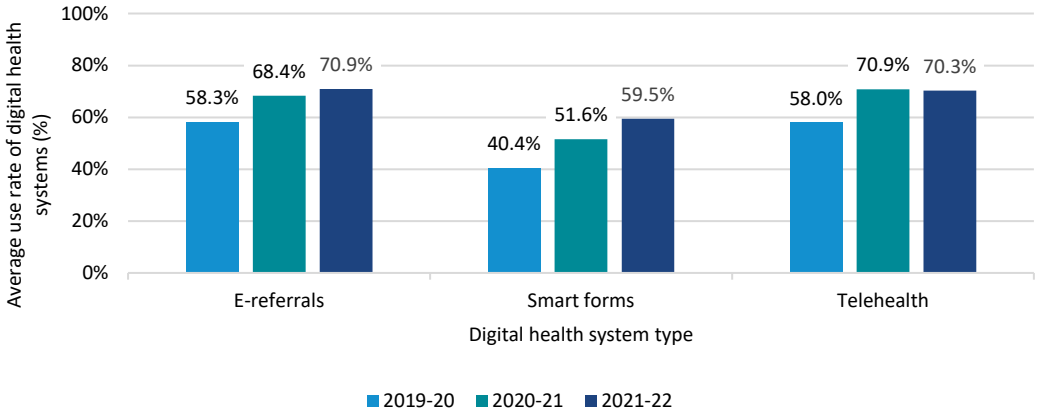
PHNs are assessed on increasing the rate of health care providers in their region using these digital systems.

There was an increase in the percentage of general practices using e-referral and smart forms in 2021-22 (Figure 32). E-referral use increased 2.5 percentage points to 70.9% of general practices, while smart form use increased 7.9 percentage points to 59.5%. There was a 0.5 percentage point reduction in practices using telehealth with the usage rate falling to 70.3%.

The following four figures provide breakdowns for each digital health system (e-referrals, smart forms and telehealth respectively) and their use by general practices in each PHN state group.

Due to differences in how digital health systems are used, as well as some inconsistencies in data collection, information for this item is not available for every PHN in every time period. The method of reporting this indicator is subject to ongoing improvement.

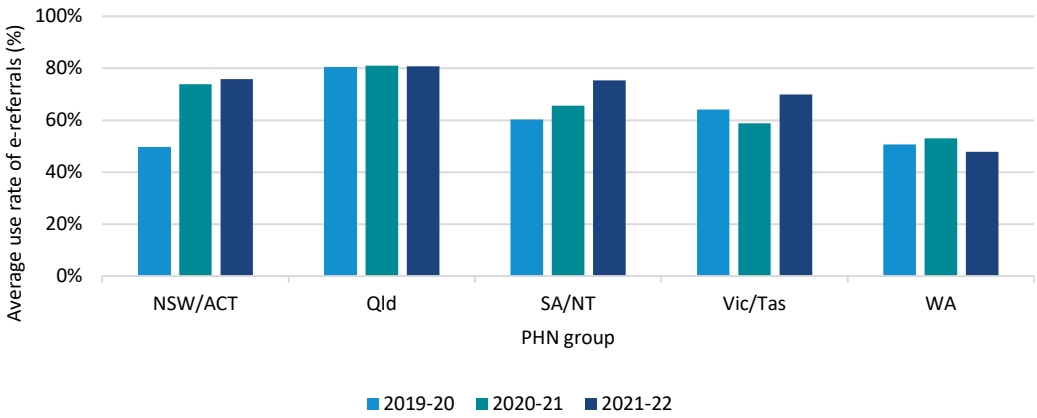
Figure 27: Percentage of general practices using specific digital health systems (DH2)



Source: Performance reporting data provided by PHNs
Number of observations for each year 2019-20 to 2021-22 is respectively 26, 27, and 26

A pronounced increase of 11.1 percentage points to 69.9% was reported in the use of e-referrals by Victorian and Tasmanian PHNs in 2021-22 (Figure 33). The greatest decrease was reported by Western Australian PHNs with a 5.2 percentage point reduction to 47.9% of general practices using e-referrals.

Figure 28: Percentage of general practices using e-referrals (DH2) by PHN state group

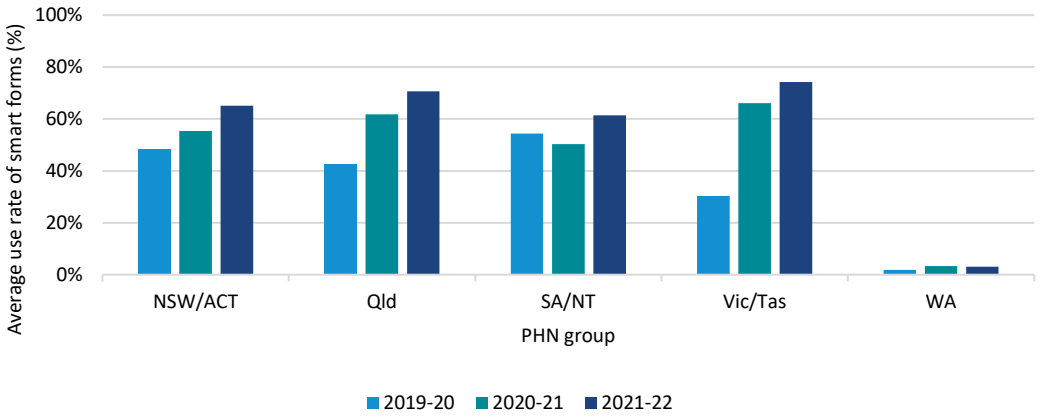


Source: Performance reporting data provided by PHNs
Number of observations for each year 2019-20 to 2021-22 is 28
For data details, see Table 20, page 79

Figure 34 illustrates that the percentage of health care providers using smart forms increased in all PHN state groups in 2021-22 except Western Australian PHNs. Very few Western

Australian service providers use smart form referrals, as is reflected in their data, below. The majority of providers in WA, including WA Health, use Secure Messages for e-referrals. Western Australian PHNs reported the use of smart forms declined 0.2 percentage points to 3.1% of general practices. The largest increase occurred in South Australian and Northern Territory PHNs which recorded an 11.1 percentage point increase to 61.4%.

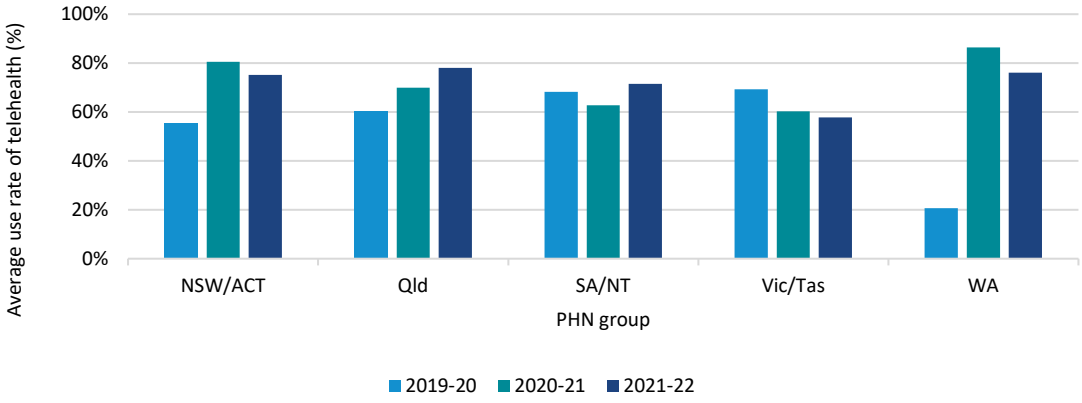
Figure 29: Percentage of general practices using smart forms (DH2) by PHN state group



Source: Performance reporting data provided by PHNs
Number of observations for each year 2019-20 to 2021-22 is respectively 27, 29 and 28
For data details, see Table 21, page 79

Western Australian PHNs reported the largest decrease in the percentage of general practices using telehealth, with a 10.3 percentage point reduction to 76.1% in 2021-22 (Figure 35). By contrast, South Australian and Northern Territory PHNs recorded the greatest increase of 8.8 percentage points to 71.6% of general practices.

Figure 30: Percentage of general practices using telehealth (DH2) by PHN state group



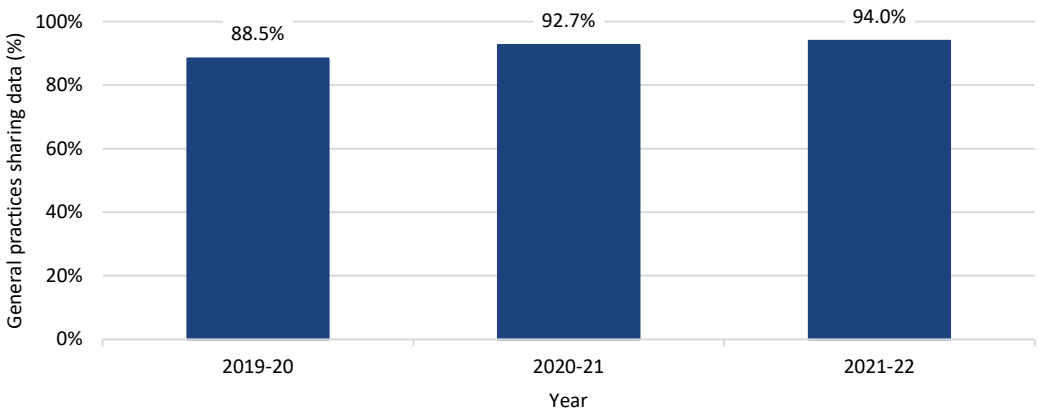
Source: Performance reporting data provided by PHNs
Number of observations for each year 2019-20 to 2021-22 is respectively 28, 30 and 29
For data details, see Table 22, page 80

General practices sharing data (DH3)

Sharing data describes where a general practice is actively sharing their de-identified patient data with their PHN. General practices are being encouraged to share their data with the PHN as part of quality improvement activities. PHNs can offer support and analysis to improve delivery and experience of health care. PHNs are assessed on their ability to increase the rate of general practices sharing data with the PHN each year, by 5% annually. Where the rate is over 60%, PHNs must maintain the existing rate.

The rate of accredited general practices sharing data with PHNs has steadily increased from 88.5% in 2019-20 to 94.0% in 2021-22 (Figure 36). In 2021-22, the sharing rate increased by 1.3 percentage points.

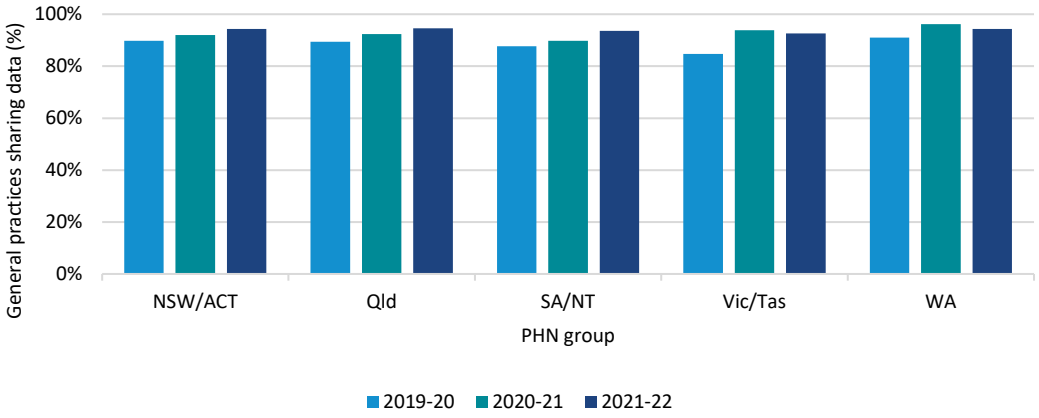
Figure 31: Percentage of accredited general practices sharing data with PHN (DH3)



Source: Performance reporting data provided by PHNs

Two PHN state groups recorded a decline in accredited general practices sharing data with PHNs in the 2020-21 to 2021-22 period (Figure 37). Victorian and Tasmanian PHNs saw a decline of 1.2 percentage points to 92.6%; and Western Australian PHNs recorded a decline of 1.8 percentage points to a rate of 94.4%. South Australia and Northern Territories PHNs recorded the greatest increase of 3.9 percentage points to 93.6%.

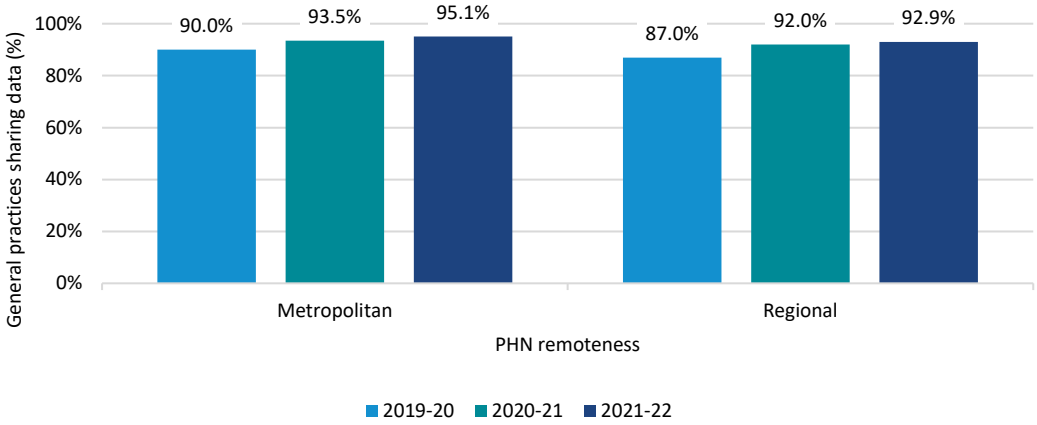
Figure 32: Percentage of accredited general practices sharing data with PHN (DH3) by PHN state group



Source: Performance reporting data provided by PHNs
For data details, see Table 23, page 80

By remoteness, Metropolitan PHNs recorded a data sharing increase of 1.6 percentage points to 95.1%, while Regional PHNs recorded an increase of 1.0 percentage points to 92.9% (Figure 39).

Figure 33: Percentage of accredited general practices sharing data with PHN (DH3) by PHN remoteness



Source: Performance reporting data provided by PHNs

My Health Record

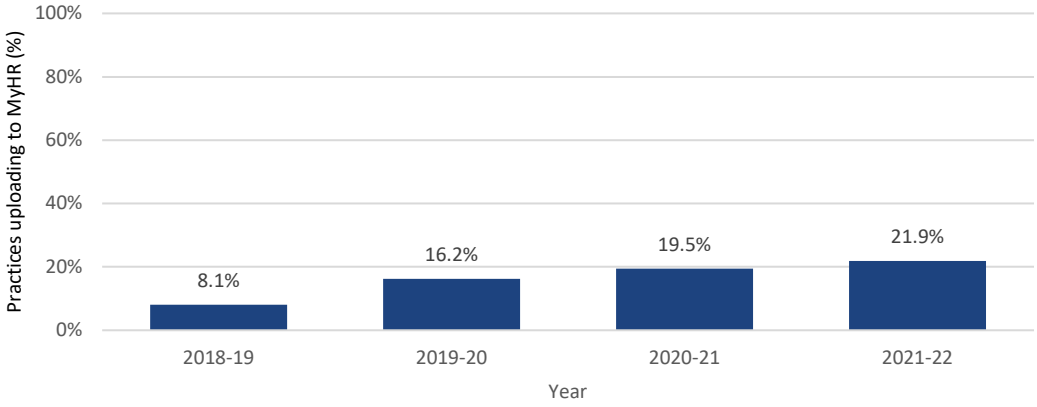
PHNs support and encourage the use of My Health Record (MyHR) in general practices, pharmacies and among other health care providers. The objective is to enable better coordinated care and better-informed treatment decisions for patients.

General practices regularly uploading to My Health Record (P5)

This measure reflects the usage of My Health Record (MyHR) by general practices. The full implementation of MyHR will enhance co-ordination and continuity of care. PHNs have an active role at a system level to encourage primary health care providers to use MyHR. Progress is measured by the proportion of MyHR registered general practices uploading documents at least once per week.

In 2021-22, the percentage of general practices uploading documents at least once per week to MyHR (P5) increased by 2.4% percentage points to 21.9% (Figure 40).

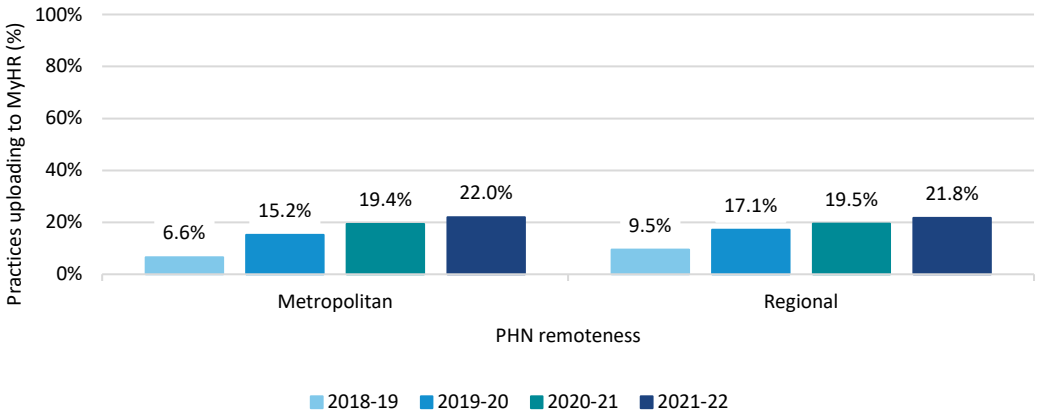
Figure 34: Percentage of general practices regularly uploading to MyHR (P5)



Source: ADHA

In 2021-22, the percentage of general practices regularly uploading documents to MyHR increased in both metropolitan and regional areas (Figure 41). The rate of uploads by metropolitan general practices increased by 2.6 percentage points to 22.0%, while regional general practices increased 2.3 percentage points to 21.8%.

Figure 35: Percentage of general practices regularly uploading to MyHR (P5) by PHN remoteness

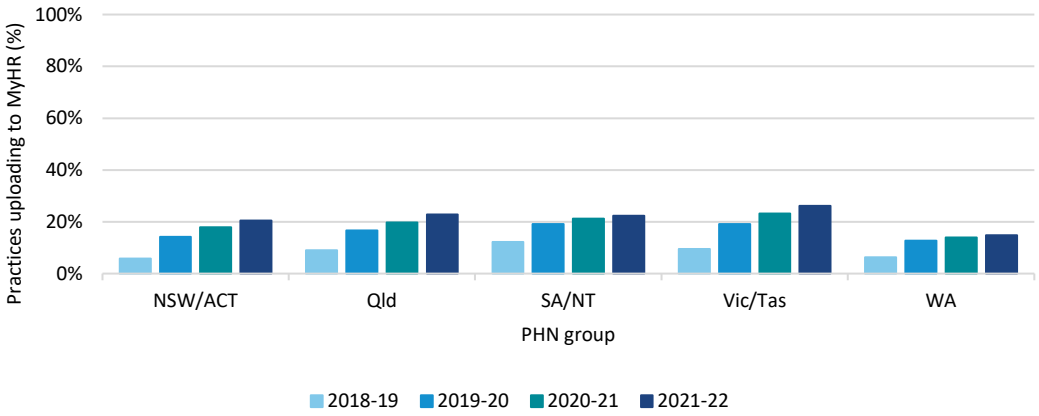


Source: ADHA.

The rate of regular MyHR uploads increased across all PHN state groups in 2021-22 (Figure 43). Queensland PHNs recorded the highest increase of 3.1 percentage points with 22.8% of general practices regularly uploading MyHR documents. Victoria/Tasmania PHNs

recorded an increase of 3 percentage points to 26.1%, the highest national average. Western Australian PHNs recorded the lowest increase of 0.9 percentage points to 14.8% in 2021-22.

Figure 36: Percentage of general practices regularly uploading to MyHR (P5) by PHN state group



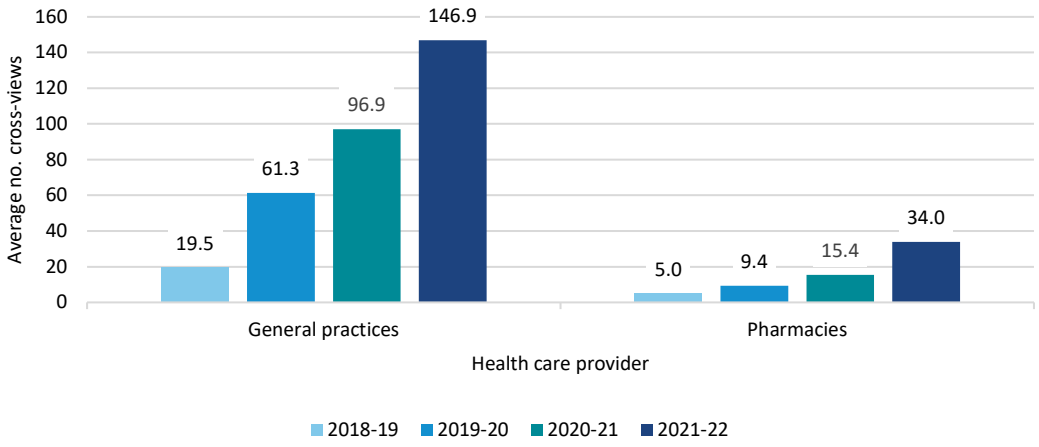
Source: ADHA.
For data details, see Table 26, page 80

Cross-views of My Health Record (P10)

A cross-view is when a My Health Record document uploaded by a member of one organisation is viewed by a member of a different organisation. Performance is measured by the number of cross-views recorded across MyHR registered general practices and pharmacies.

The number of MyHR documents cross-viewed per general practice and pharmacy has continued to grow over the four years to 2021-22 (Figure 44). The number of cross-views of MyHR (P10) per general practice increased in 30 PHNs in 2021-22, with an average increase of 51.5%. Pharmacy cross-views of MyHR increased by 120.1% overall to 34 cross-views per pharmacy.

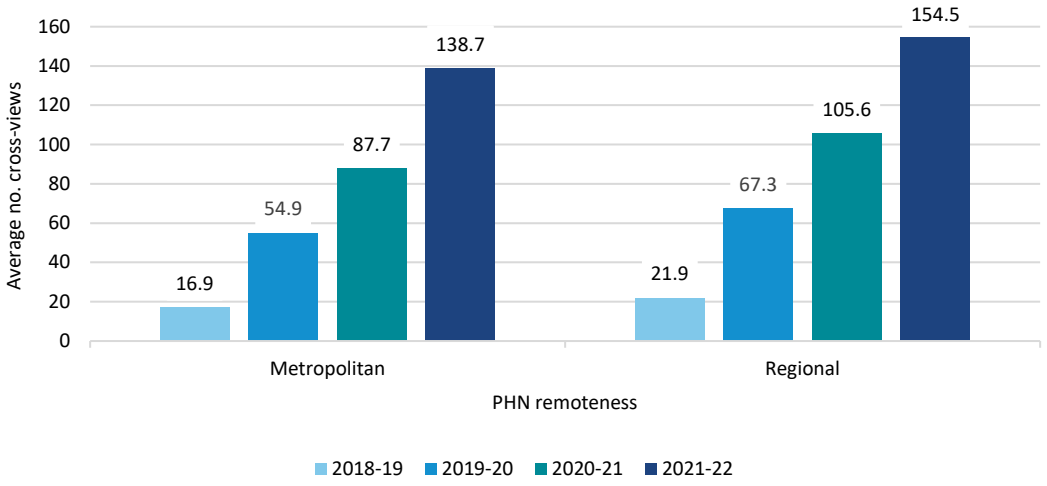
Figure 37: Average count of MyHR cross-views (P10) by general practices & pharmacies



Source: ADHA

Increases in cross-views of documents in MyHR for both general practices and pharmacies occurred across both metropolitan and regional areas in 2021-22. In metropolitan areas, general practice cross-views increased by 51 (or 58.1%) to 139 cross-views (Figure 45). Regional general practice cross-views increased by 49 (46.4%) to an average of 155 cross views in 2021-22.

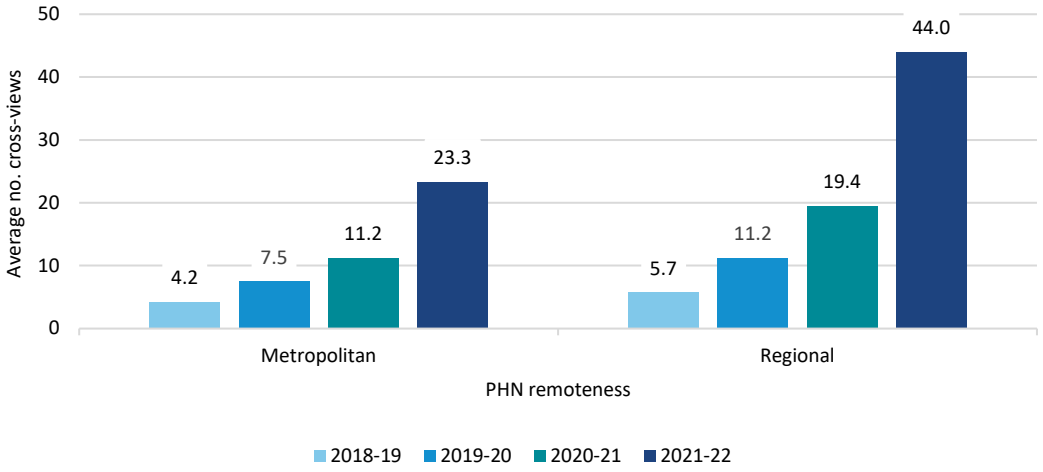
Figure 38: Average count of MyHR cross-views (P10) per general practice by PHN remoteness



Source: ADHA

MyHR cross-views by pharmacies more than doubled in 2021-22 (Figure 46). Metropolitan pharmacies increased cross-views by an average of 12 (108.2%) cross-views to 23 in 2021-22. Regional pharmacies increased cross-views by an average of 25 (126.5%) cross-views to 44.

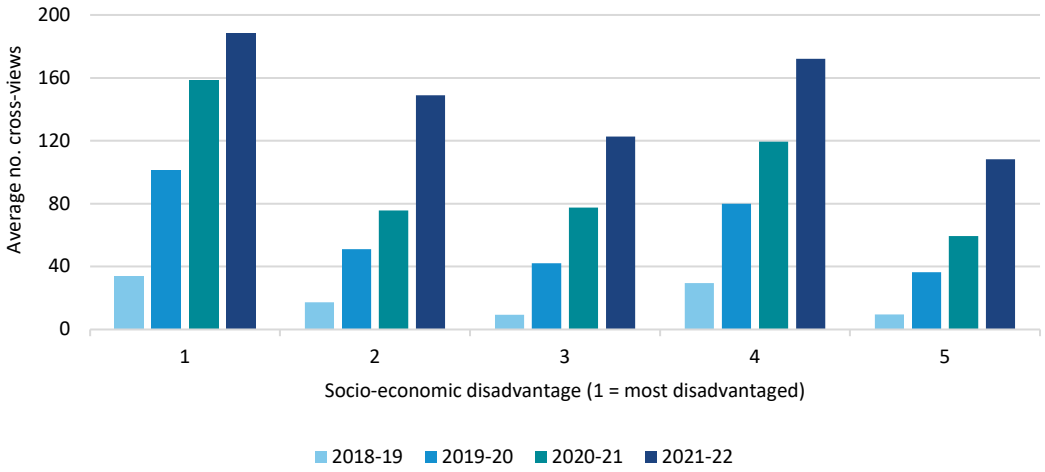
Figure 39: Average count of MyHR cross-views (P10) per pharmacy by PHN remoteness



Source: ADHA

By regions of PHN socio-economic disadvantage (Figure 47), general practices in the most disadvantaged PHN regions (category 1) retained the highest rate of cross-views, increasing by an average of 30 (18.7%) cross-views to 189. General practices in the second most disadvantaged regions (category 2) had the greatest improvement in cross-views, increasing by an average of 73 (96.7%) to 149 cross-views.

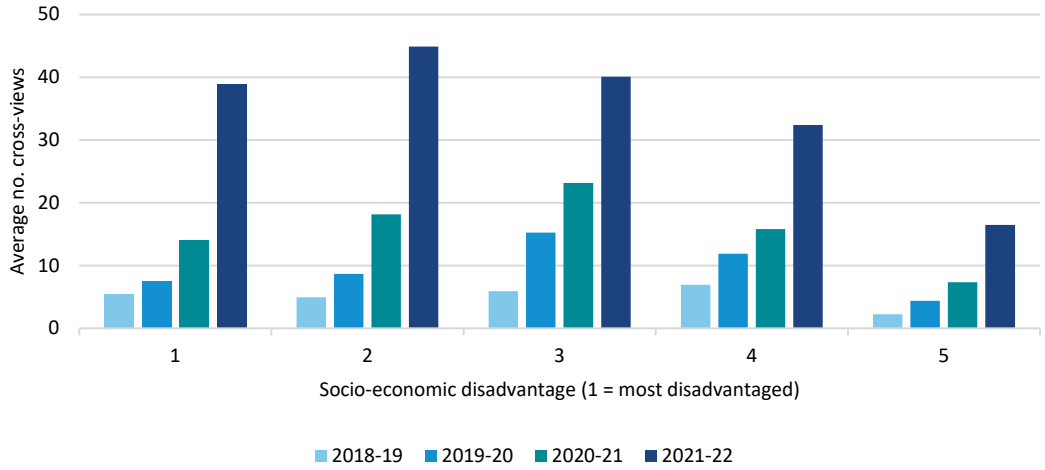
Figure 40: Average count of MyHR cross-views (P10) per general practice by PHN socio-economic disadvantage



Source: ADHA
For data details, see Table 27, page 81

Cross views of MyHR records by pharmacies more than doubled in all but category 3 of PHN socio-economic disadvantage (Figure 48). In the most disadvantaged PHN regions (category 1), pharmacies increased cross-views by an average of 25 (178.2%) to 39 cross-views. In the least disadvantaged PHN regions (category 5), pharmacies increased cross-views by an average of 9 (123.0%) cross-views to 16. The rate of cross-views remains lowest in the least disadvantaged PHN regions.

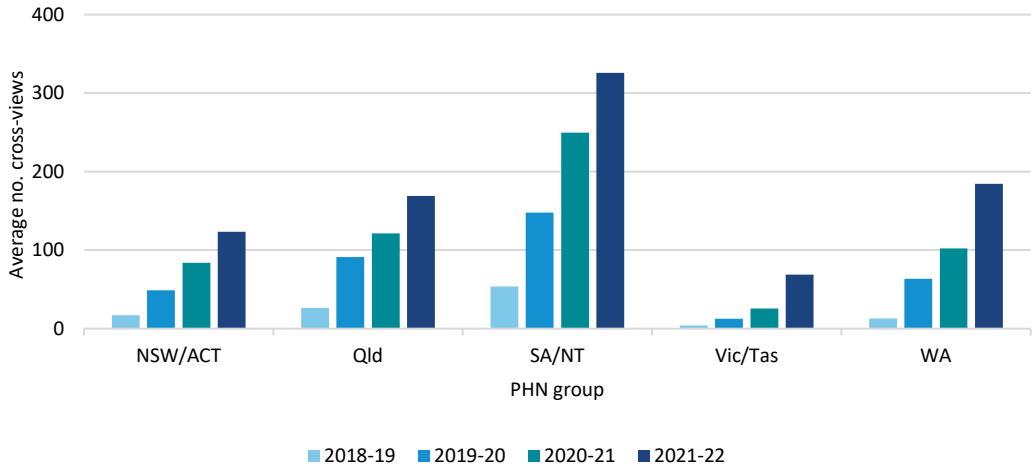
Figure 41: Average count of MyHR cross-views (P10) per pharmacy by PHN socio-economic disadvantage



Source: ADHA
For data details, see Table 28, page 81

In 2021-22, Victorian and Tasmanian general practices' cross-views more than doubled, increasing by an average of 43 (169.2%) cross-views to 69 (Figure 49). South Australian and Northern Territory general practices increased cross-views by an average of 76 (30.5%) cross-views to 326–the highest rate amongst state groups. Western Australian general practices increased cross-views by an average 83 (80.8%) cross-views to 185 in 2021-22.

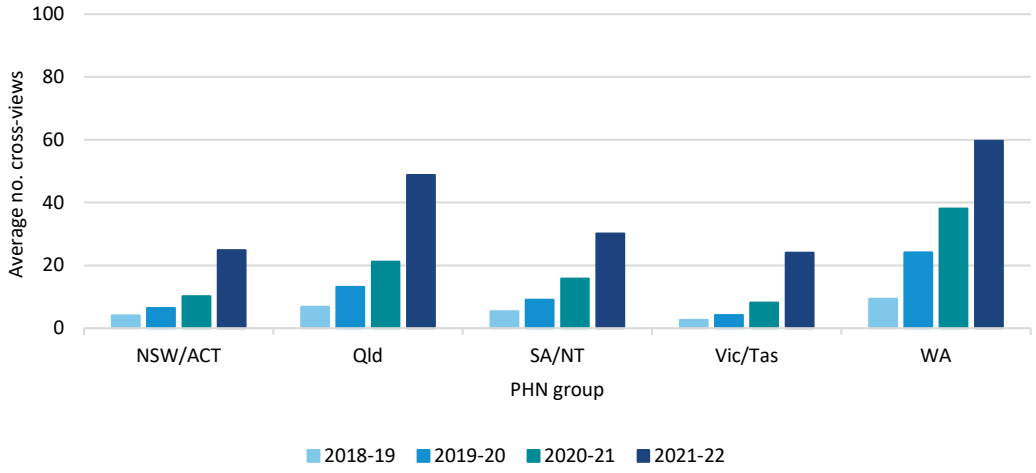
Figure 42: Average count of MyHR cross-views (P10) per general practice by PHN state group



Source: ADHA
For data details, see Table 29, page 81

The average number of MyHR cross-views by pharmacies more than doubled from 15 to 34 in 2021-22. Victorian and Tasmanian pharmacies recorded the greatest increase of cross-views, increasing by an average 16 (195.8%) to 24 (Figure 50). Cross views remained highest in Western Australian pharmacies, where cross-views increased by an average 22 (57.0%) to 60.

Figure 43: Average count of MyHR cross-views (P10) per pharmacy by PHN state group



Source: ADHA
For data details, see Table 30, page 81

First Nations health

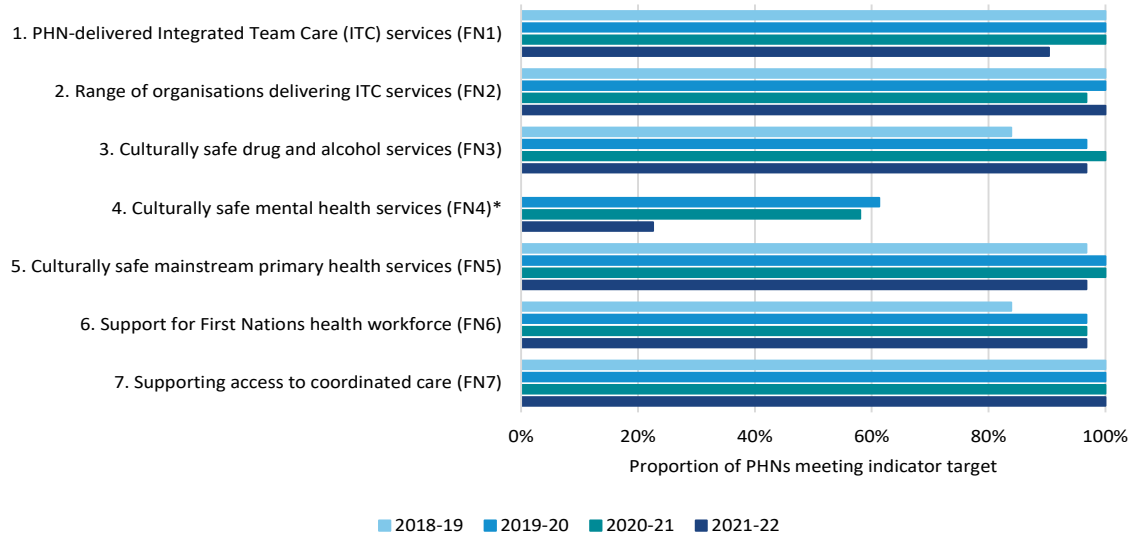
The PHNs are assessed for performance against seven indicators in the First Nations health priority area and the program performance is further informed by the health assessments indicator (FN8). In 2021-22, there was an average 7.4% decrease in the number of First Nations health targets met as compared to 2020-21.

The proportion of PHNs meeting delivery targets for Integrated Team Care (ITC) services (FN1) decreased from 100% to 90.3%, due to a reduction in the reported number of services being delivered in select PHNs. These declines were most likely a consequence of COVID-19 and some changes to the model of care. All PHNs met the target for having a range of organisations delivering ITC services (FN2), which is a return to the performance levels in 2018-19 and 2019-20.

There were decreases from 100% targets met in the delivery of culturally safe drug and alcohol services (FN3)[19] (96.8%) and culturally safe mainstream primary health services (FN5) (96.8%). The 5% growth target for culturally safe mental health services (FN4) was achieved by 22.6% of PHNs, which is a decrease from 58.1% (see page 50 for more information).

PHNs providing adequate evidence of support provided for First Nations Workforce (FN6) remained at 96.8%.

Figure 44: Proportion of PHNs meeting First Nations indicator targets (FN1 - FN7)

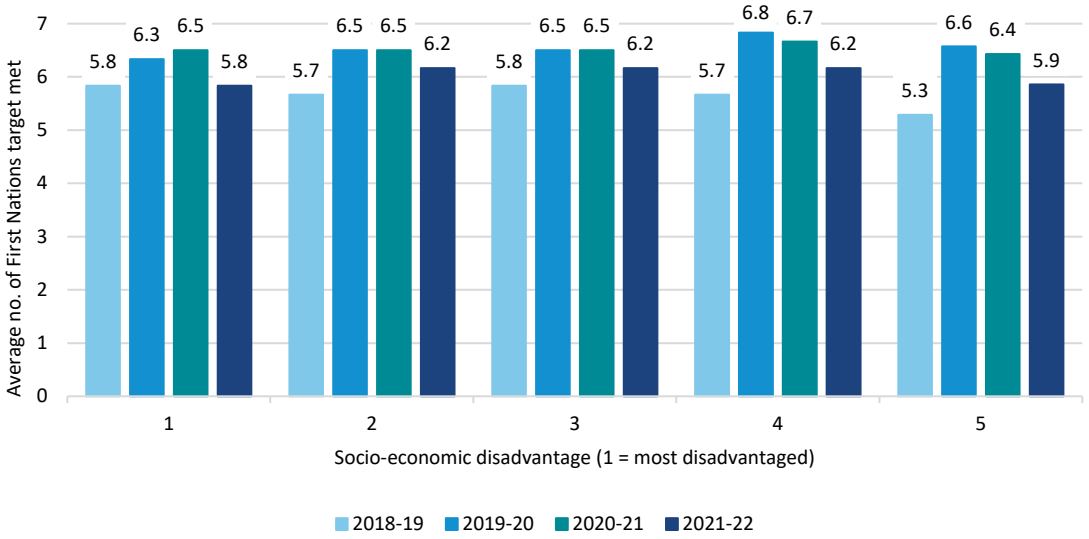


Source: Performance reporting data provided by PHNs
***This performance measure was collected as a baseline in 2018-19.**
For data details, see Table 31, page 82

In 2021-22, PHN state group SA/NT remained consistent in meeting First Nations health targets, while the most disadvantaged PHN areas saw the greatest decline at 10.3%.

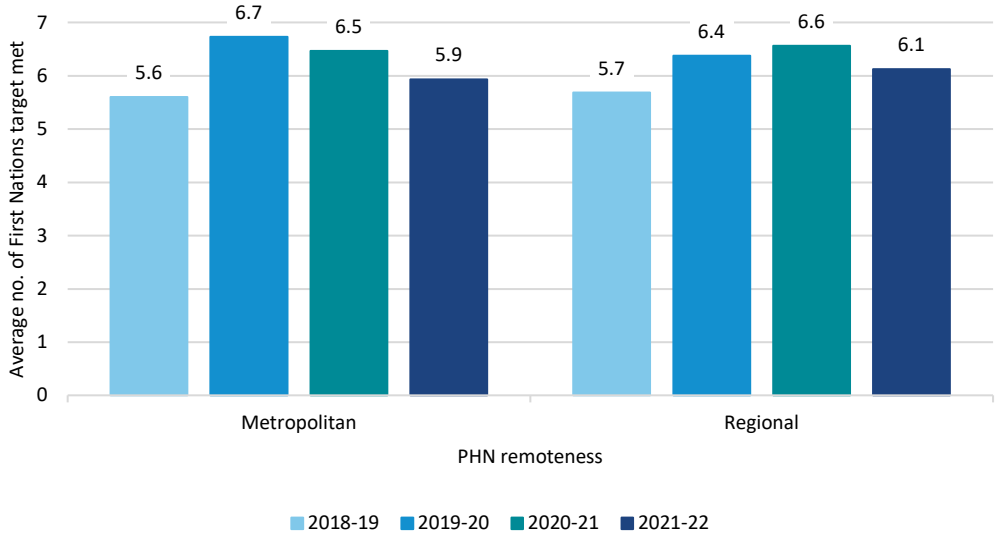
[19] Based on evidence supplied by PHNs that commissioned drug and alcohol services are culturally safe

Figure 45: Average number of First Nations Health performance targets (FN1 - FN7) met by disadvantage



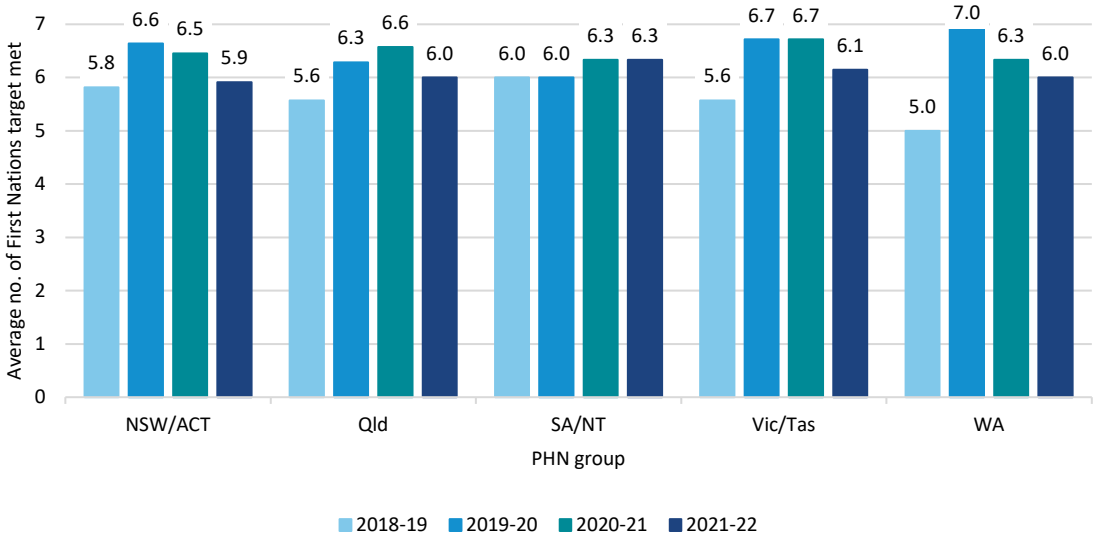
Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of 6 indicators, as one indicator (FN4) was collected as a baseline in 2018-19.

Figure 46 : Average number of First Nations Health performance targets (FN1 - FN7) met by PHN remoteness



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of 6 indicators, as one indicator (FN4) was collected as a baseline in 2018-19.

Figure 47: Average number of First Nations Health performance targets (FN1 - FN7) met by PHN state group



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of 6 indicators, as one indicator (FN4) was collected as a baseline in 2018-19.

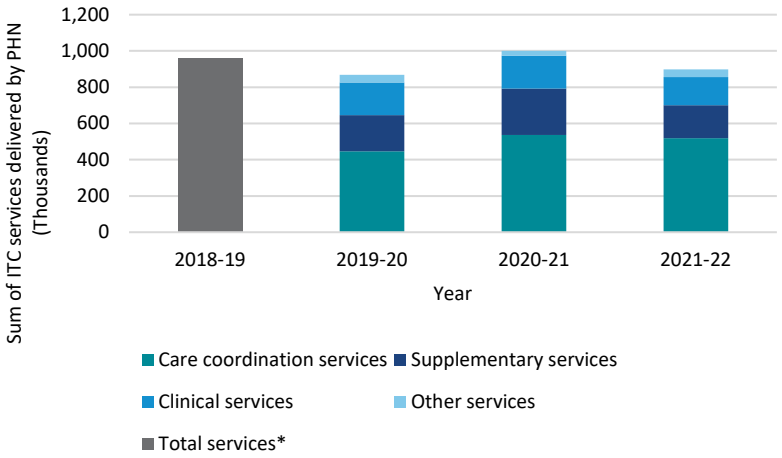
Integrated Team Care indicators (FN1, FN2)

Integrated Team Care (ITC) services comprise of care coordination services, supplementary services and clinical services (appointments organised for an ITC patient). Program funds are used to deliver ITC services across a range of Aboriginal Medical Services (AMS) and mainstream organisations or through direct engagement by PHNs through Indigenous Health Project Officers.

The two indicators, numbers of ITC services delivered by PHN (FN1) and types of organisations delivering ITC services (FN2) assist in understanding how services are delivered across PHN regions to address needs of local First Nations people.

Most services delivered under the ITC program are care coordination (Figure 55). The 520 thousand care coordination services delivered in 2021-22 accounted for 57.8% of all ITC services, an increase from 53.7% in the previous year. The 182 thousand supplementary services fell from 25.5% of all services in 2020-21 to 20.2% in 2021-22, while the 154 thousand clinical services saw a smaller decline from 18.3% to 17.1%. Delivery of 111 thousand other services doubled from 2.5% to 4.9%.

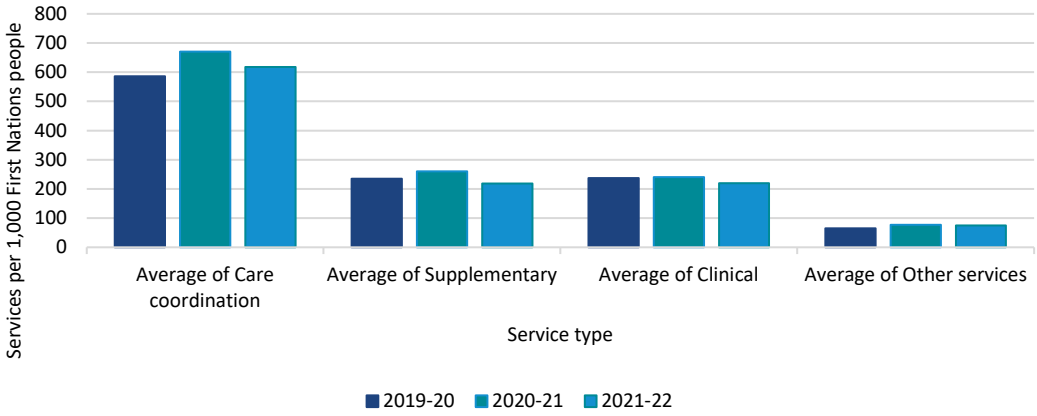
Figure 48: Number of ITC Services delivered by PHNs (FN1) by service type



Source: Performance reporting data provided by PHNs
*** Service type not available for 2018-19, all service types included in this figure**
For data details, see Table 32, page 82

The rate of ITC services per 1,000 population decreased by 3.1% to 1,138 in 2021-22. By ITC service type, Care Coordination services decreased from 671 to 618 services per population, a reduction of 7.9% (Figure 56). The greatest reduction was recorded in Supplementary services, which fell 16% to 219 services per population in 2021-22. Note that, the 2021-22 First National estimated resident population (ERP) was not available at the time of publication, and the 2020-21 ERP has been used as a substitute.

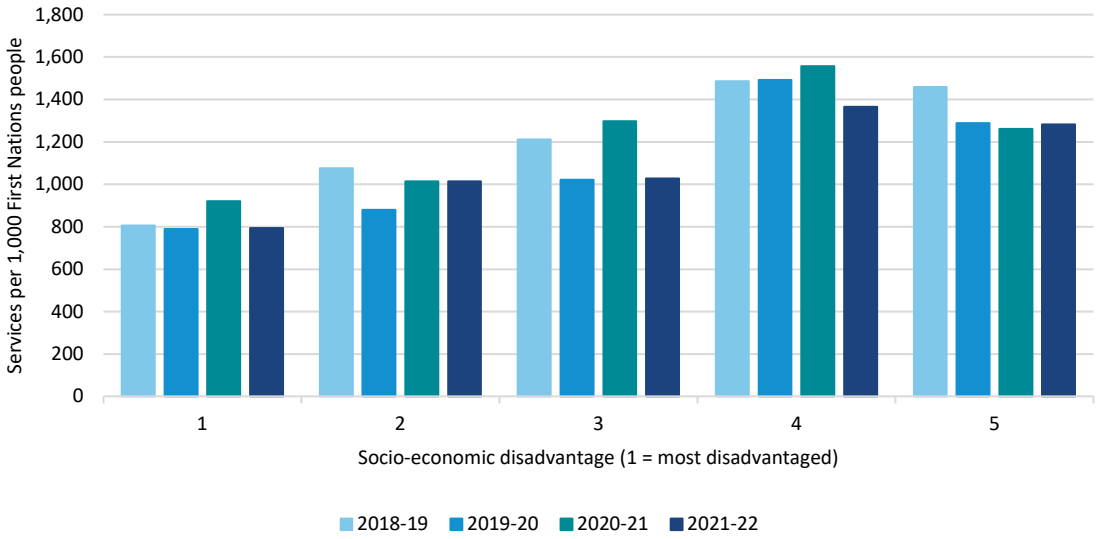
Figure 49: ITC services delivered per 1,000 First Nations population (FN1) by service type



Source: Performance reporting data provided by PHNs
For data details, see Table 33, page 82

There was continuing variability in the recorded rates of ITC services provided by PHN socioeconomic disadvantage in 2021-22 (Figure 57). There is a pattern over time of less disadvantaged PHN regions having higher rates of ITC services. In 2021-22, the only increase was recorded in the least disadvantaged PHNs, where the rate per 1,000 First Nations population increased 1.6% to 1,282. By contrast the largest decrease was recorded in the median disadvantage group (group 3), where a 21% decline was recorded. The most disadvantaged PHN regions recorded a decline of 14% to 793 services per population.

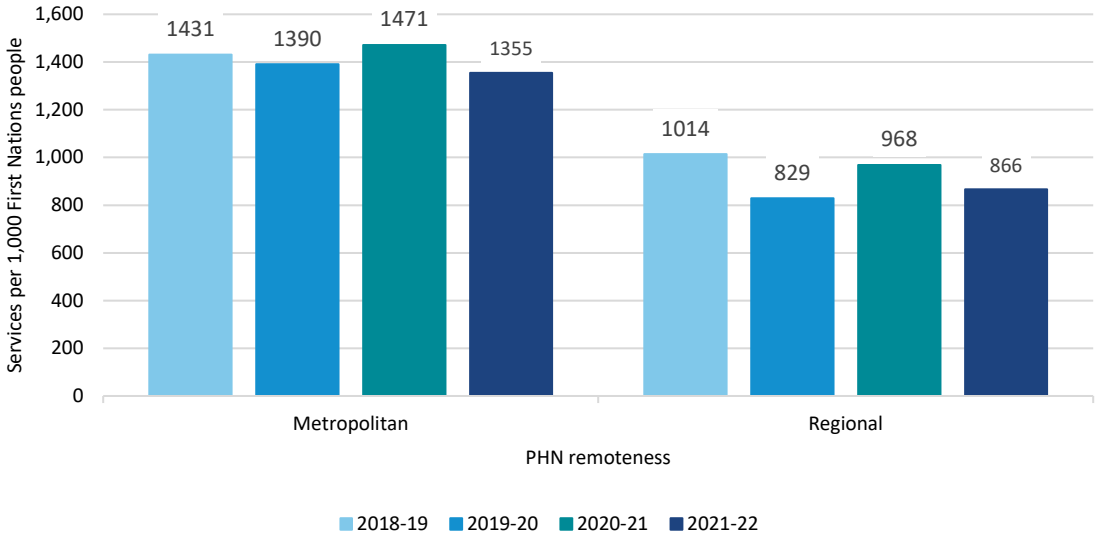
Figure 50: ITC services delivered per 1,000 First Nations population (FN1) by PHN disadvantage



Source: Performance reporting data provided by PHNs
For data details, see Table 34, page 82

The rate of ITC services delivered declined in both Metropolitan and Regional areas in 2021-22 (Figure 58). Metropolitan PHNs declined from 1,471 to 1,355 ITC services per 1,000 population, a reduction of 7.9%. Regional areas declined 11% to 866 services per population

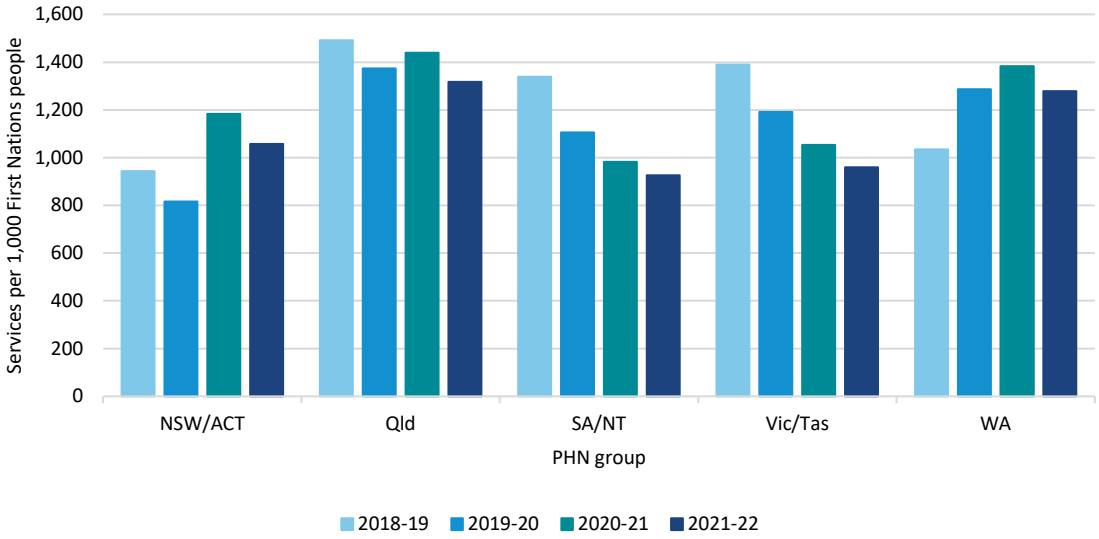
Figure 51: ITC services delivered per 1,000 First Nations population (FN1) PHN remoteness



Source: Performance reporting data provided by PHNs

The rate of ITC services delivered declined across all PHN state groups in 2021-22 (Figure 59). NSW and ACT PHNs decreased the most, recording a reduction of 127 to a rate of 1,057 services per 1,000 population – a decline of 11%. Queensland PHNs retained the highest rate of ICT services for First Nations people, despite an 8.5% decrease to 1,317 services per population.

Figure 52: ITC services delivered per 1,000 First Nations population (FN1) by PHN group

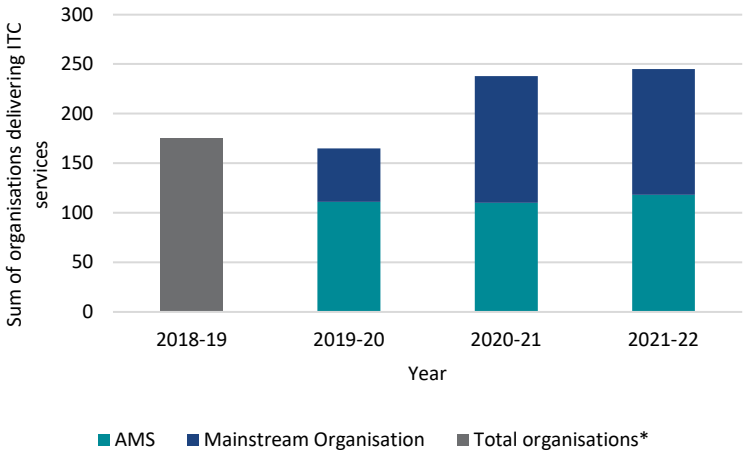


Source: Performance reporting data provided by PHNs
For data details, see Table 35, page 83

ITC program funds are used to deliver services across a range of organisations, including Aboriginal Medical Services (AMS), mainstream organisations and sometimes from the PHN, noting PHNs may engage Aboriginal and Torres Strait Islander Health Project Officers to undertake ITC activities. The FN2 indicator counts the number and type of organisations that the PHN is engaging with in the delivery of ITC services.

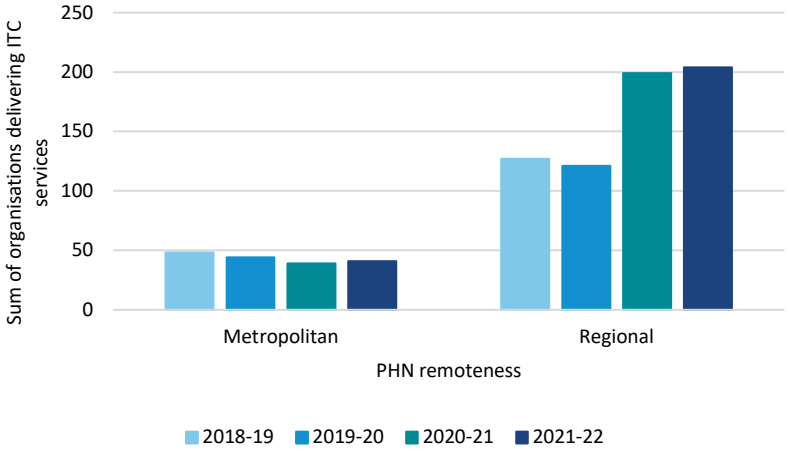
The number of organisations delivering ITC services increased to 245 in 2021-22, an increase of 7 (or 2.9%). AMS organisations increased by 8 (7.3%) to 118, and mainstream organisations decreased by 1 (0.8%) to 127. Of all 245 organisations delivering ITC services in 2021-22, 48.2% were AMS' and 51.8% were mainstream organisations.

Figure 53: Types of organisations delivering ITC services (FN2)



Source: Performance reporting data provided by PHNs
***Organisation type not available for 2018-19, both organisation types included in this figure**
For data details, see Table 36, page 83

Figure 54: Number of organisations delivering ITC services by PHN remoteness



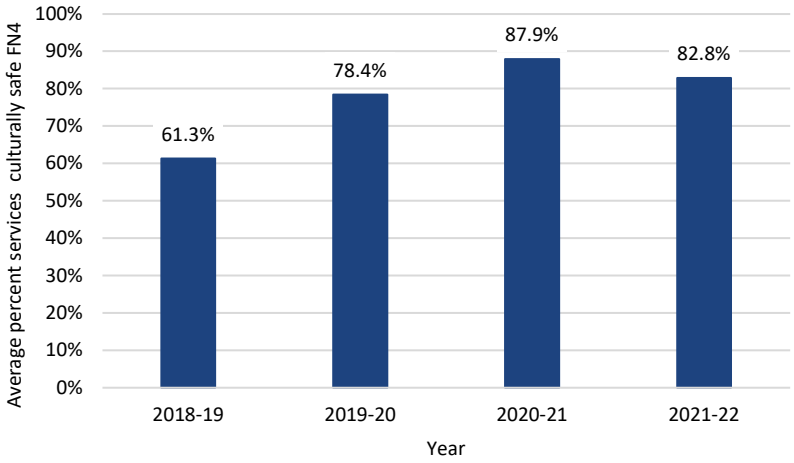
Source: Performance reporting data provided by PHNs
For data details, see Table 37, page 83

Cultural safety of mental health services (FN4)

The following figure presents more detailed data on the average rate across all PHNs of culturally safe mental health services for the First Nations populations of PHNs (FN4) for the period of 2018-19 to 2021-22.

To meet the indicator for culturally safe PHN commissioned mental health services delivered to First Nations people (FN4), PHNs must increase the proportion of culturally safe services by 5% compared to the previous year.[20] 38.7% of PHNs reported over 90% of services being culturally safe. There was a reduction in the proportion of PHNs achieving the 5% increase from 58.1% in 2020-21 to 22.6% in 2021-22 (Figure 62).

Figure 55: Proportion of PHN commissioned mental health services delivered to the regional First Nations population that were culturally safe (FN4)



Source: Primary Mental Health Care Minimum Dataset

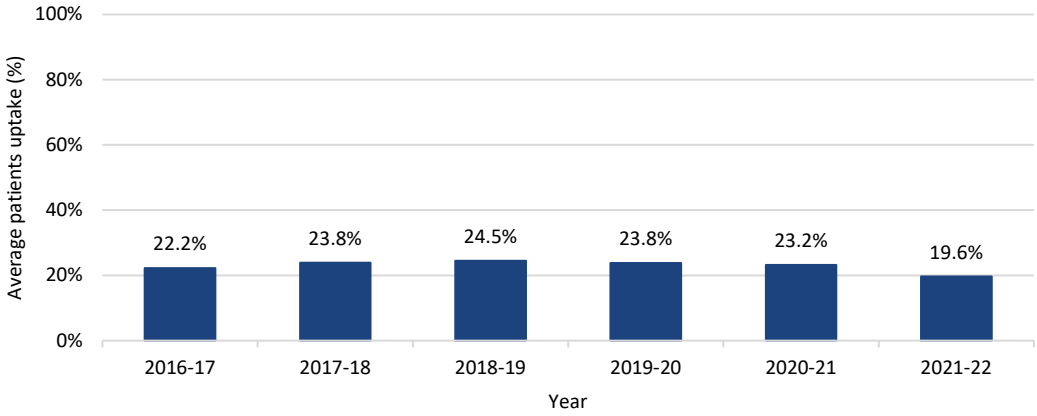
[20] A culturally safe mental health service is defined as one that is delivered by a service provider who is: a First Nations person, or employed by an Aboriginal Community Controlled Health Service, or has indicated that they have completed a recognised training program in the delivery of culturally safe services to First Nations peoples.

First Nations Health Assessments (FN8)

This indicator, the rate of population receiving specific Health Assessments (FN8) shows the degree to which First Nations people are accessing primary health care services designed to both identify and prevent health care problems, and to plan and manage treatment in a multidisciplinary manner (Appendix 3 – Medicare Benefit Schedule Items). PHNs have a role to inform practices and patients of the value of these services and to encourage their use.

Despite a long-term trend of rising health assessment uptake for First Nations patients, there was a considerable fall in uptake between 2020 and 2022 associated with the COVID-19 pandemic.[21] The percentage of First Nations patients who received specific Health Assessments decreased by 3.6 percentage points to 19.6% in 2021-22. The percentage has declined 4.8 percentage points since its peak of 24.5% in 2018-19.

Figure 56: Percentage of First Nations patients receiving Health Assessments (all ages) (FN8)



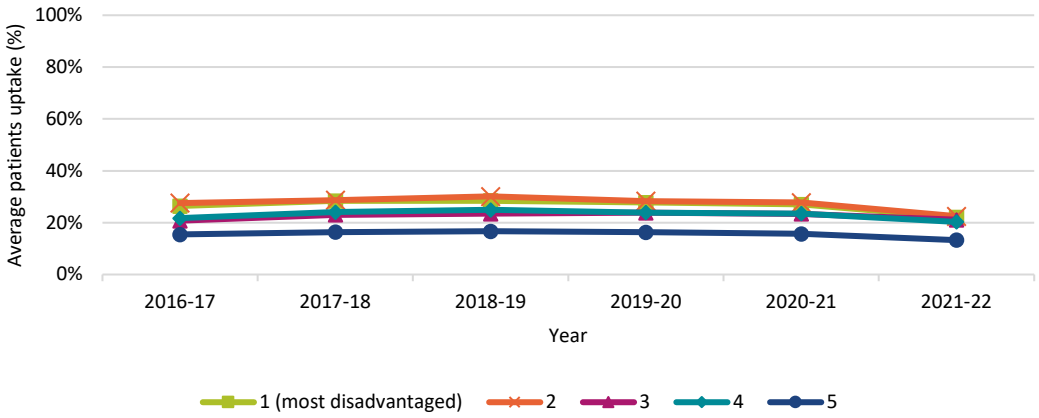
Source: AIHW analysis of MBS data; AIHW analysis of Australian Bureau of Statistics (ABS) population data
Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016–17 to 2021–22

The decline in First Nations patients receiving Health Assessments occurred across all regional classifications of socio-economic disadvantage, with the largest reductions recorded in the most disadvantaged regions (Figure 64). The most disadvantaged regions recorded a 5 percentage point reduction to 22.1% in the year to 2021-22. The second most disadvantaged regions recorded a 5.3 percentage point reduction to 22.51%.

All PHN state groups recorded reductions in First Nations patients receiving Health Assessments (Figure 65). The greatest reductions were a 5 percentage point fall to 20.6% in South Australian PHN regions. Queensland PHNs retained the highest rate but recorded a 3.9 percentage point reduction to 28.1%.

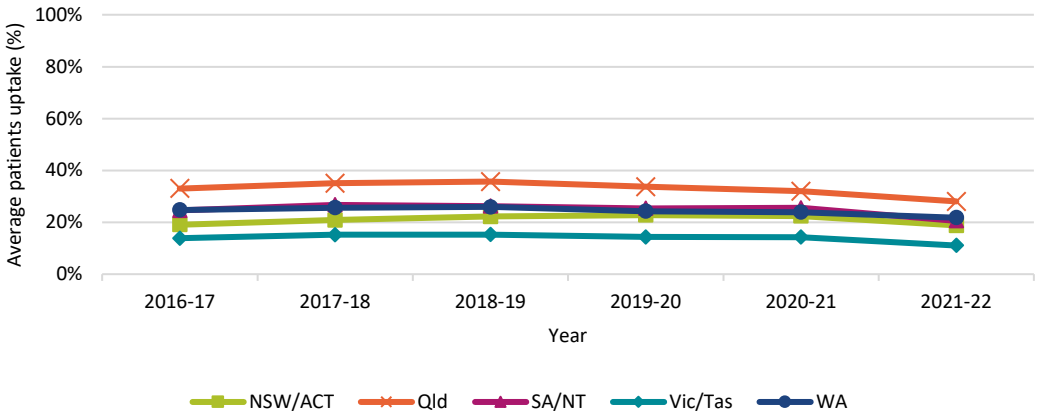
[21] AIHW. *Health checks and follow-ups for Aboriginal and Torres Strait Islander people*. Accessed 21 October 2024.

Figure 57: Percentage of First Nations patients receiving Health Assessments (all ages) by socio-economic disadvantage (FN8)



Source: AIHW analysis of MBS data; AIHW analysis of Australian Bureau of Statistics (ABS) population data
Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016–17 to 2021–22
For data details, see Table 38, page 83

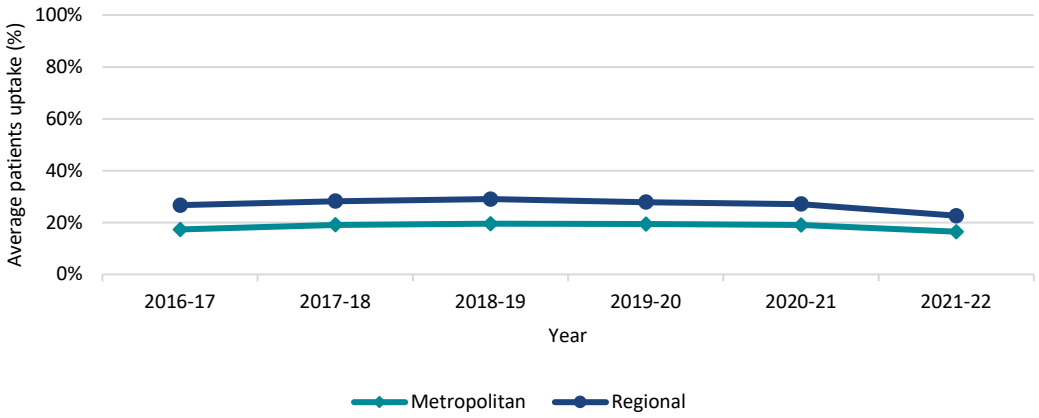
Figure 58: Percentage of First Nations patients receiving Health Assessments (all ages) by PHN state group (FN8)



Source: AIHW analysis of MBS data; AIHW analysis of Australian Bureau of Statistics (ABS) population data
Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016–17 to 2021–22
For data details, see Table 39, page 83

Both metropolitan and regional PHNs recorded reductions in First Nations patients receiving Health Assessments (Figure 66). Metropolitan PHN regions declined 2.6 percentage points to 16.4% in the year to 2021-22, and have declined 0.9 percentage points since 2016-17. Regional areas recorded a 4.5 percentage point reduction to 22.6%, and have declined 4.1 percentage points since 2016-17. Both regions peaked in 2018-19.

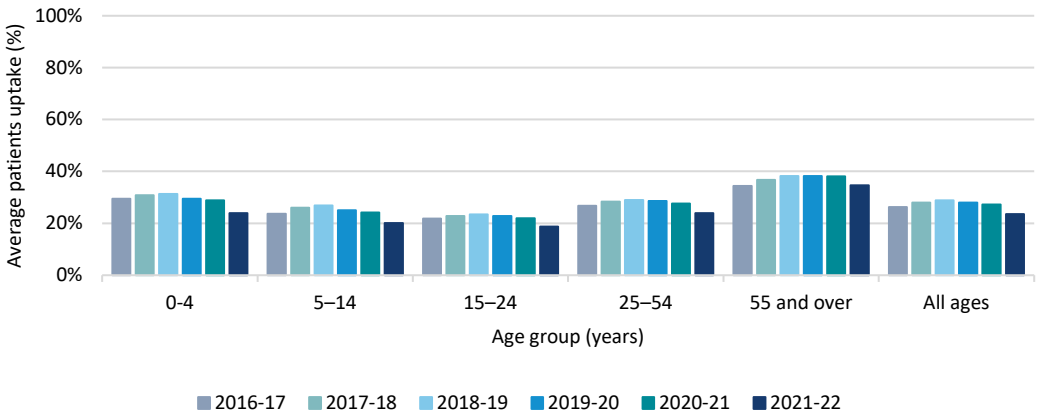
Figure 59: Percentage of First Nations patients receiving Health Assessments (all ages) by PHN remoteness (FN8)



Source: AIHW analysis of MBS data; AIHW analysis of Australian Bureau of Statistics (ABS) population data
Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016–17 to 2021–22
For data details, see Table 40, page 83

The percentage of First Nations patients receiving health assessments declined across all groups in 2021-22 (Figure 67). The greater declines were recorded in the younger age groups. The youngest First Nations group of children aged 0-4 years recorded a decline of 4.8 percentage points to 24%. Children aged 5-14 years recorded an annual decline from 24.1% to 20.1% in 2021-22. Other than First Nations patients 55 years and older, the percentage of patients receiving health assessments in 2021-22 was lower than in 2016-17.

Figure 60: Percentage of First Nations patients receiving health assessments (FN8) by age group



Source: AIHW analysis of MBS data; AIHW analysis of Australian Bureau of Statistics (ABS) population data
Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016–17 to 2021–22
For data details, see
Table 41, page 83

Care for people with chronic conditions (P9)

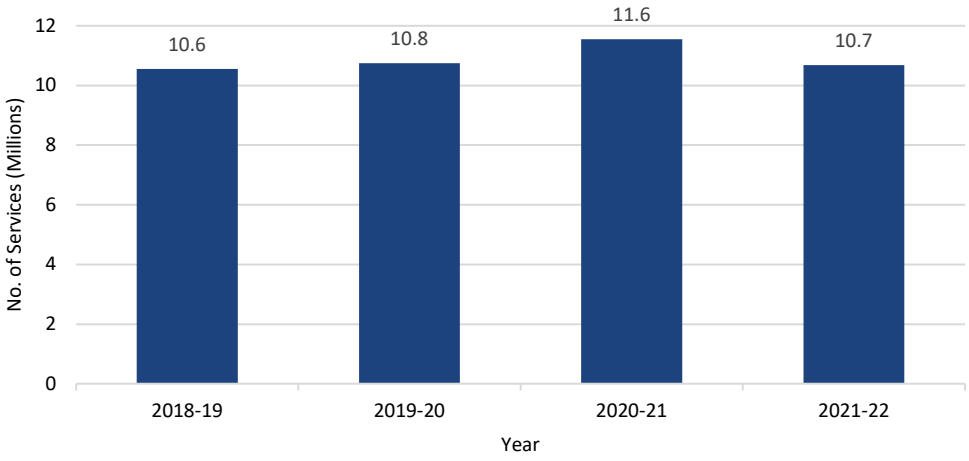
A Chronic Disease Management Plan (CDMP) offers patients with chronic conditions access to services that improve continuity and coordination of care between health care providers. There are several different types of CDMP available to health practitioners through the MBS (Appendix 3 – Medicare Benefit Schedule Items, page 87). This indicator specifically reports the following services:

- GP Health Assessments
- GP Chronic Disease Management Plans (which include Team Care Arrangements), and
- GP Multidisciplinary Case Conferences.

PHNs have capacity to influence GPs to consider the use of these services and improve linkages and communication to facilitate their use.

The number of these CDMP services provided to people with chronic health conditions in 2021-22 was 10.7 million. This was a decline of 7.5% from 2020-21 returning the number of services provided to a similar level seen in 2018-19 and 2019-20 (Figure 68), and the national decline was reflected in all three areas of service. The decline is consistent with a trend across primary health care in 2021-22 for decreases in preventive services including immunisation and cancer screening. See the COVID-19 section of this report for details.

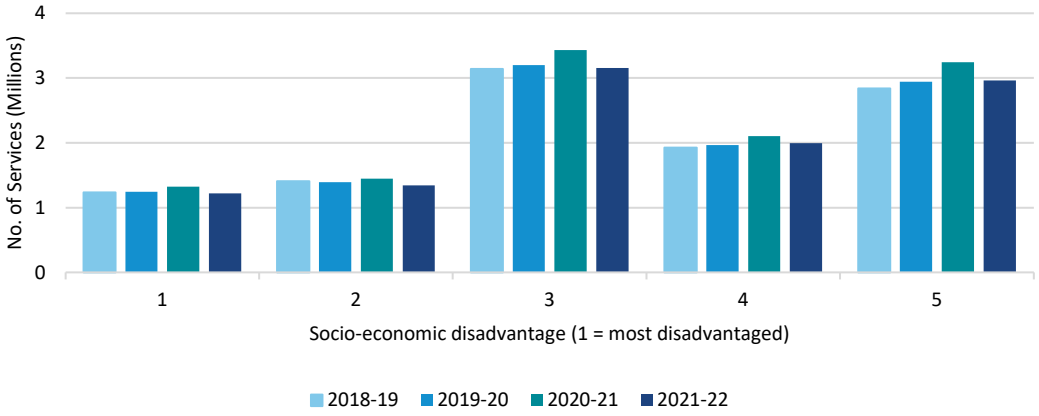
Figure 61: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9)



Source: AIHW analysis of Department of Health, MBS claims data; and ABS, Estimated Residential Population (ERP)
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 42, page 84

The number of services being delivered from general practices decreased across all levels of socio-economic disadvantage (Figure 69). The largest decrease was in the least disadvantaged PHNs (level 5), which saw a decrease of 8.8%. The smallest decrease, 5.2%, was in the group of PHNs with second-least disadvantage (level 4).

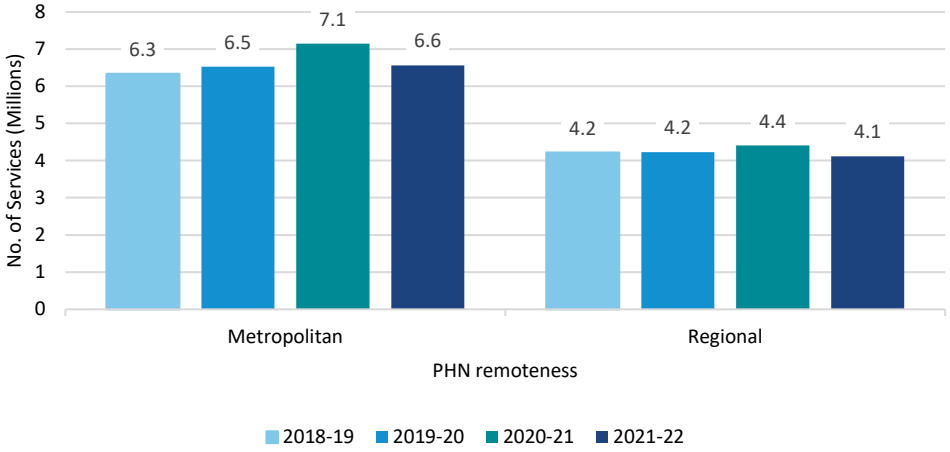
Figure 62: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9) by socio-economic disadvantage



Source: AIHW analysis of Department of Health, MBS claims data; and ABS, ERP
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 43, page 84

There was a greater decrease in the number of services in metropolitan (8.1%) than regional (6.6%) (Figure 70).

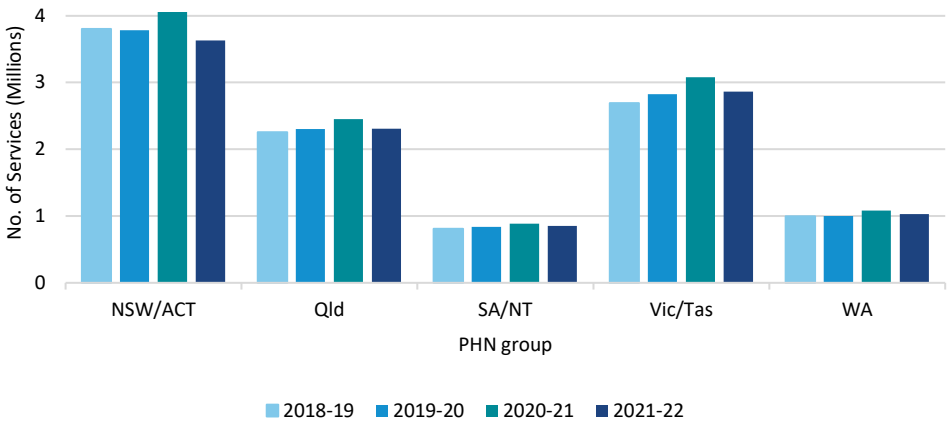
Figure 63: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9) by PHN remoteness



Source: AIHW analysis of Department of Health, MBS claims data; and ABS, ERP
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 44, page 84

A decline in services was also noted in all PHN state groups. The largest decrease of 10.6% was seen in NSW/ACT and the smallest in SA/NT with a decline of 3.9% (Figure 71).

Figure 64: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9) by PHN state group



Source: AIHW analysis of Department of Health, MBS claims data; and ABS, ERP
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 45, page 84

Aged care

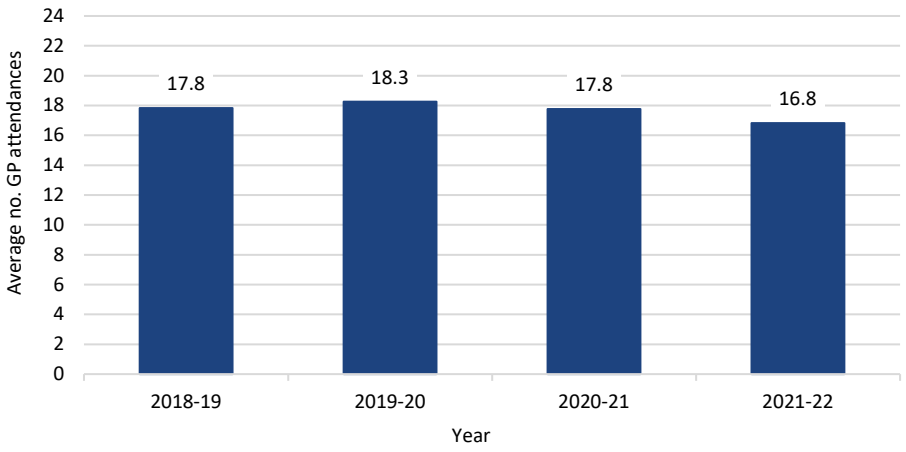
There are two broad indicators for aged care services and older Australians. The rate of MBS services provided by primary care providers in Residential Aged Care Homes (RACHs) (AC1) and the rate of people aged 65 and over with a GP Health Assessment (AC2) (Appendix 3 – Medicare Benefit Schedule Items, page 87) The intended outcome is that older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home.

PHNs contribute to the delivery of general practice services in RACHs through their networks and commissioning to reduce the need for care in the hospital setting and the associated costs. Indicator AC1 reflects delivery of these services. Indicator AC2 provides information on trends in usage of GP services by older people to identify gaps and weaknesses in the systems which PHNs may be able to influence.

General practice services in Residential Aged Care Homes (AC1)

The first indicator is the average number of Medicare-subsidised GP attendances provided in RACHs per patient that received any such services in a RACH (Appendix 3 – Medicare Benefit Schedule Items, page 87). In 2021-22, this rate decreased to the figure of 16.8 services per patient per year after reaching 18.3 in 2019-20 (Figure 72). This decline is not directly attributable to the impact of facility lockdowns and restrictions on visits during the COVID-19 pandemic because essential visits by medical staff continued during this period.

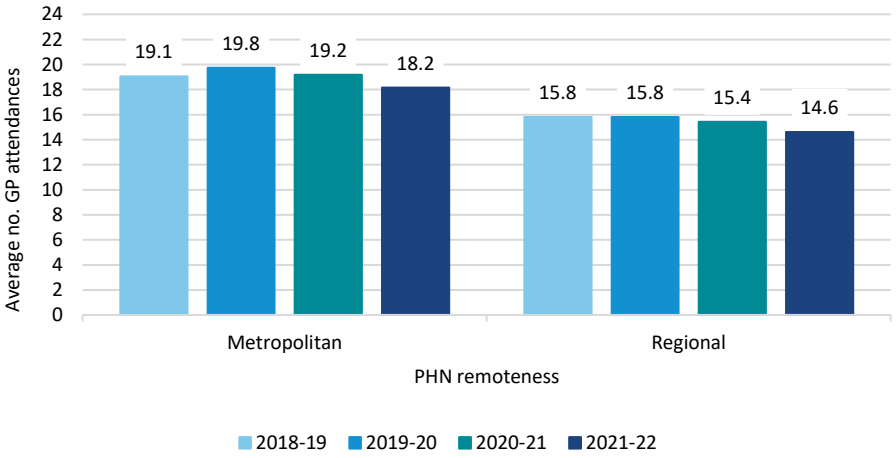
Figure 65: GP attendances in Residential Ages Care Homes per patient (AC1)



Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22

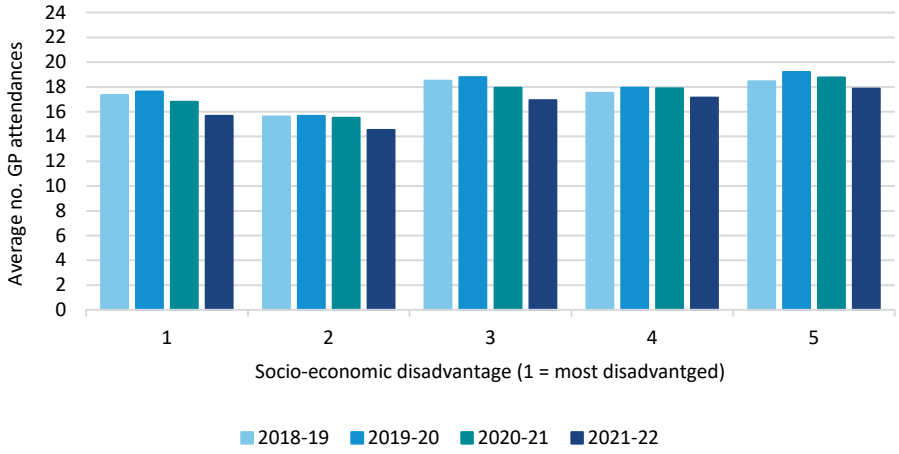
In 2021-22, Medicare-subsidised general practice services provided in RACHs were more utilised in facilities located in metropolitan areas (18.2 services per patient per year) than in regional areas (14.6 services per patient per year) (Figure 73).

Figure 66: GP attendances in Residential Aged Care Homes per patient (AC1) by PHN remoteness



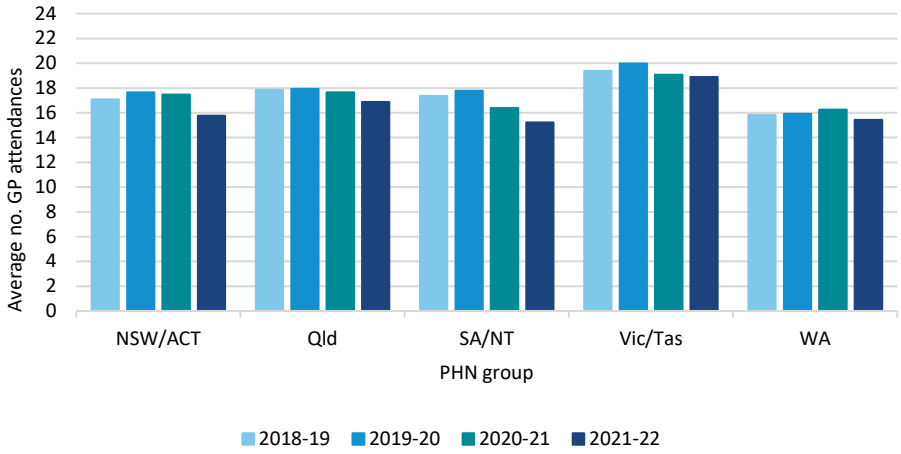
Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22

Figure 67: GP attendances in Residential Ages Care Homes per patient (AC1) by socio-economic disadvantage



Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 46, page 84

Figure 68: GP attendances in Residential Ages Care Homes per patient (AC1) by PHN state group

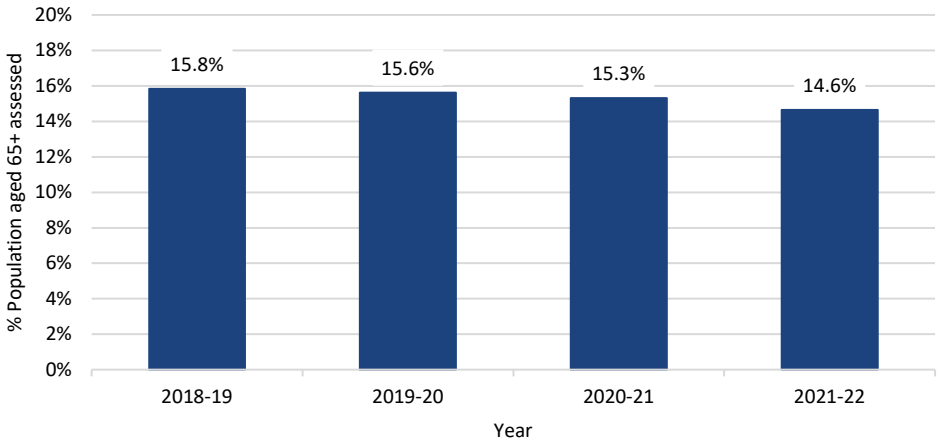


Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 47, page 84

GP Health Assessments (AC2)

The second indicator is the proportion of the older population (people aged 65 years and over) who have a recorded Health Assessment from an MBS-subsidised general or medical practitioner (see Appendix 3 – Medicare Benefit Schedule Items). This has slightly declined to 14.6% in 2021-22 from 15.3% in 2020-21 and 15.6% in 2019-20 (Figure 76).

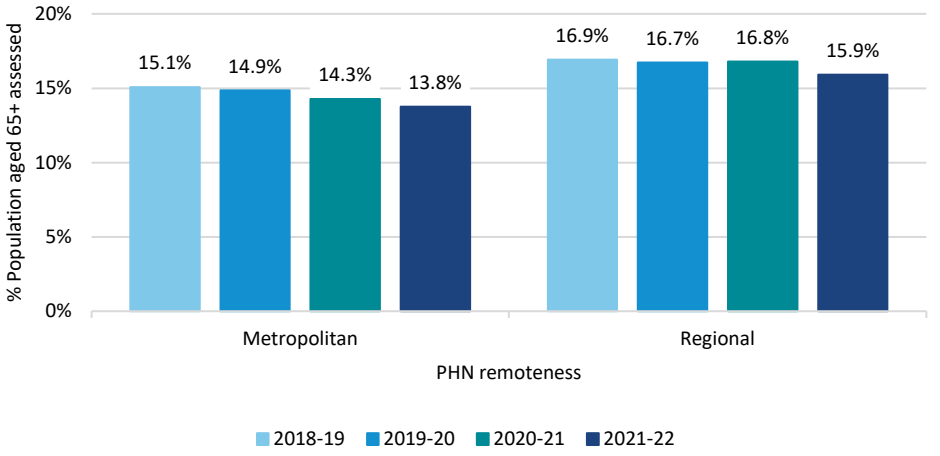
Figure 69: Proportion of people aged 65 years and over who have a recorded Health Assessment from a Medicare-subsidised general practice, allied health or specialist health care service (AC2)



Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22

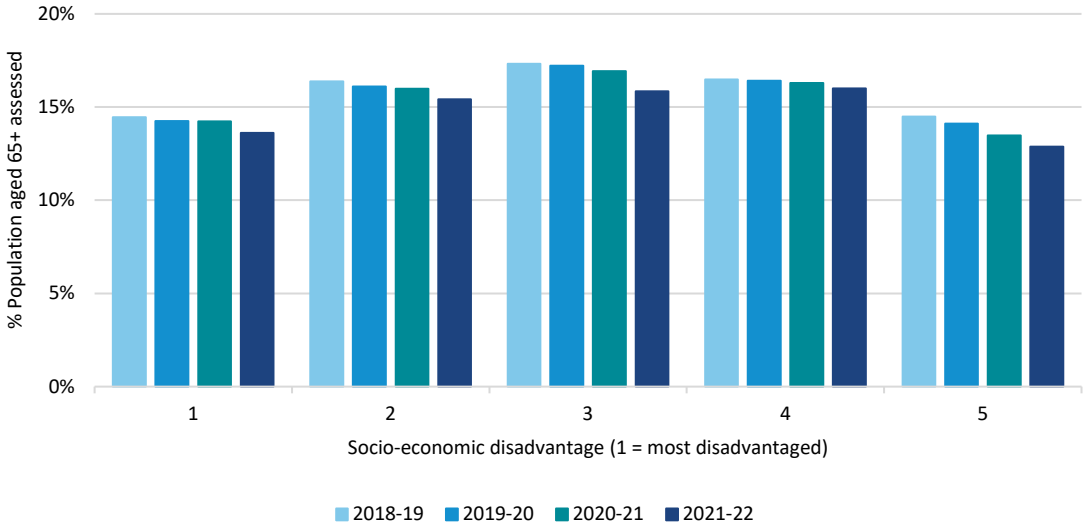
Older populations in regional areas had proportionally more Health Assessments (15.9% in 2021-22) than those in metropolitan areas (13.8% in 2021-22) (Figure 77).

Figure 70: Proportion of people aged 65 years and over who have a recorded Health Assessment from a Medicare-subsidised general practice, allied health or specialist health care service (AC2) by PHN remoteness



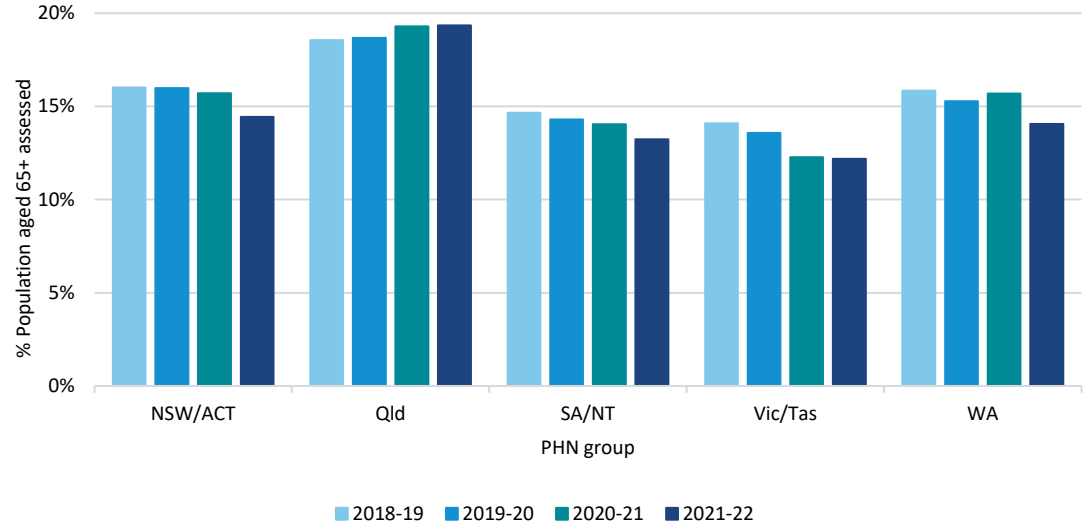
Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22

Figure 71: Proportion of people aged 65 years and over who have a recorded Health Assessment from a Medicare-subsidised general practice, allied health or specialist health care service (AC2) by socio-economic disadvantage



Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 48, page 85

Figure 72: Proportion of people aged 65 years and over who have a recorded Health Assessment from a Medicare-subsidised general practice, allied health or specialist health care service (AC2) by PHN state group



Source: AIHW analysis of Department of Health, MBS claims data
Medicare-subsidised services, age standardised, by PHN area: 2021–22
For data details, see Table 49, page 85

Mental health

During 2021-22, PHNs were an essential component of the Australian Government's emergency response capability, including being fast and adaptable in the delivery of services. PHNs were a valuable source of real-time, information about conditions on the ground during the COVID-19 pandemic, especially the impact on primary and mental health service delivery.

In 2021-22 no PHNs met the criteria for all six mental health performance indicators in the Primary Health Network Performance and Quality Framework[22]. All but one PHN improved their performance for at least one indicator. Despite this, an average decrease was reflected across regional PHN areas (Figure 81) and in most socio-economic PHN regions (Figure 82).

- MH1: 48.4% of PHNs met the 5% growth or maintenance target for an increase in the number of people accessing PHN-commissioned low intensity psychological interventions. Growth in this indicator may be affected by numerous factors not within the PHNs control, such as workforce and community demand.
- MH2: 35.5% of PHNs met the 5% growth or maintenance target for an increase in the number of people accessing PHN-commissioned psychological therapies. 48.4% PHNs improved on rates of access to PHN-commissioned psychological therapies compared to 2020-21. Growth in this indicator may be affected by numerous factors not within the PHNs control, such as workforce and community demand.
- MH3: 35.5% of PHNs met the 5% growth or maintenance target for an increase in the number of people accessing PHN commissioned clinical care coordination services for people with severe and complex mental illness. Growth in this indicator may be affected by numerous factors not within the PHNs control, such as workforce and community demand.
- MH4: 100% of PHNs, in collaboration with their respective state and territory government-funded commissioning bodies and other stakeholders, delivered their joint foundational regional mental health and suicide prevention plans.
- MH5: No PHNs met the target of 100% follow up of clients within one week of referral for clients at risk of suicide. However, 54.8% improved on the number of clients followed up compared to 2020-21.

  There are methodological challenges with this indicator including clients with unique personal preferences, availability or complexities related to their presentation, workforce capacity challenges, inaccurate information at referral or data capture, and a challenging business context.
- MH6: 16.1% of PHNs met the target rate of 70% of complete episodes having a clinical outcome measure at the start and end of an episode of care. The national median proportion of episodes with outcomes collected was 50.0% in 2021-22.
- Comparatively, during 2019–20, the National Outcome and Casemix Collection measures were collected for 42% of people who received clinical care from public sector specialised mental health services.

The Department continues to work with PHNs to refine the methodologies for the mental health performance indicators and undertake ongoing quality assurance to improve the Primary Mental Health Care Minimum Data Set. PHNs consider strategies to improve data quality and performance and liaise with the Department so examples of successful strategies can be shared with other PHNs.

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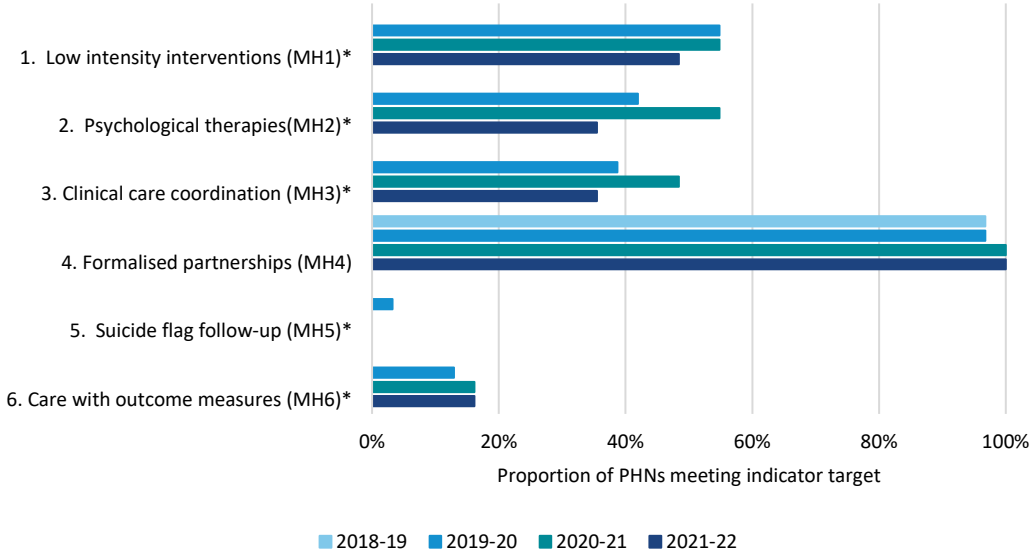
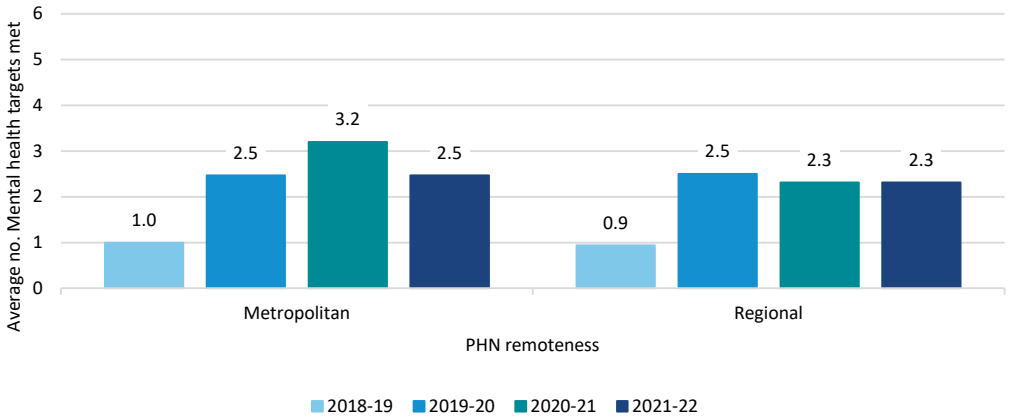
[22] MH1 Low intensity, MH2 Psychological Therapies, MH3 Clinical Care Coordination, MH4 Integrated Regional Planning, MH5 Suicide Risk, MH6 Outcome Readiness. The PHN Performance Quality framework can be found here: *Performance Quality Framework*.

Figure 73: Proportion of PHNs meeting Mental Health indicator targets (MH1 to MH6)



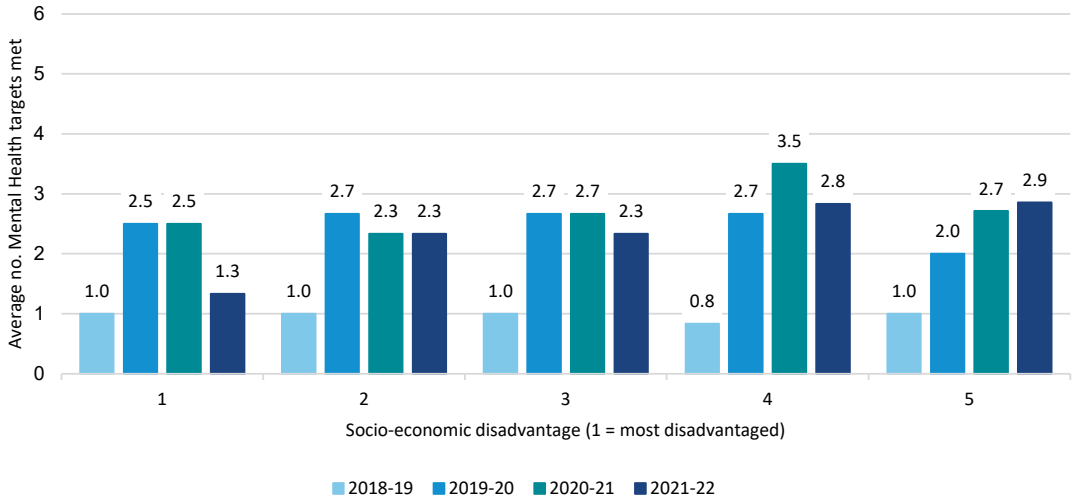
Source: Performance reporting data provided by PHNs
***This performance measure was collected as a baseline in 2018-19.**
For data details, see Table 50, page 85

Figure 74: Average number of Mental Health performance targets (MH1 to MH6) met by PHN remoteness



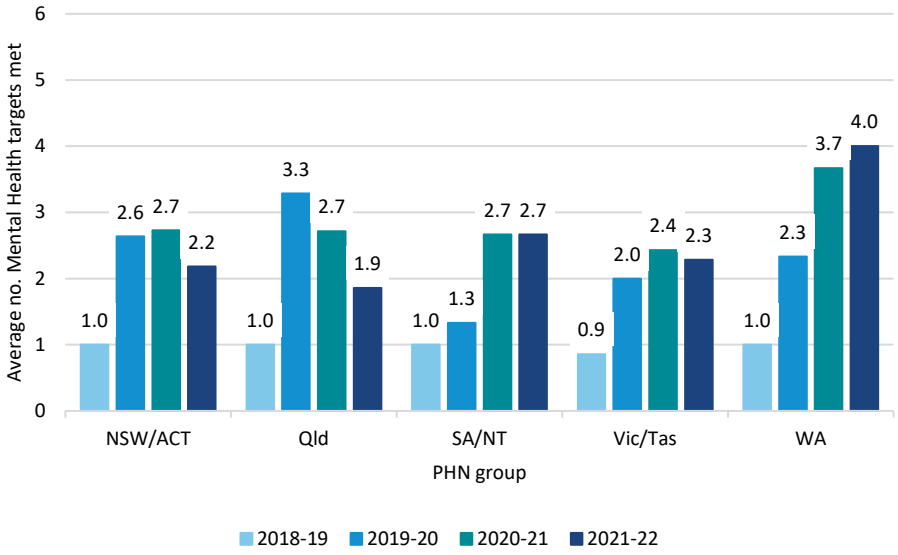
Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of one indicator, as 5 indicators (MH1, MH2, MH3, MH5, and MH6) were collected as a baseline in 2018-19.

Figure 75: Average number of Mental Health performance targets (MH1 to MH6) met by disadvantage



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of one indicator, as 5 indicators (MH1, MH2, MH3, MH5, and MH6) were collected as a baseline in 2018-19.

Figure 76: Average number of Mental Health performance targets (MH1 to MH6) met by PHN state group



Source: Performance reporting data provided by PHNs
Note: in 2018-19, PHNs could meet a maximum of one indicator, as 5 indicators (MH1, MH2, MH3, MH5, and MH6) were collected as a baseline in 2018-19.

The *Fifth National Mental Health and Suicide Prevention Plan 2017* directed PHNs and Local Hospital Networks to develop joint regional mental health and suicide prevention plans, to help strengthen joint planning and commissioning across all regions. In 2021-22, all PHNs, in collaboration with their respective state and territory government-funded commissioning bodies and other stakeholders, finalised their foundational plans which documented how they will work together to achieve agreed priorities and support integrated mental health service delivery, while laying foundations for future action (MH4). Note that, with agreement from the department, the Western Australia Primary Health Alliance coordinated a singular Plan for all three PHNs within the state of Western Australia.

COVID-19 continued to impact service provider performance in 2021-22 due to ongoing workforce shortages and high levels of staff turnover. This meant there was a higher need for provider education and training to support high quality data input.

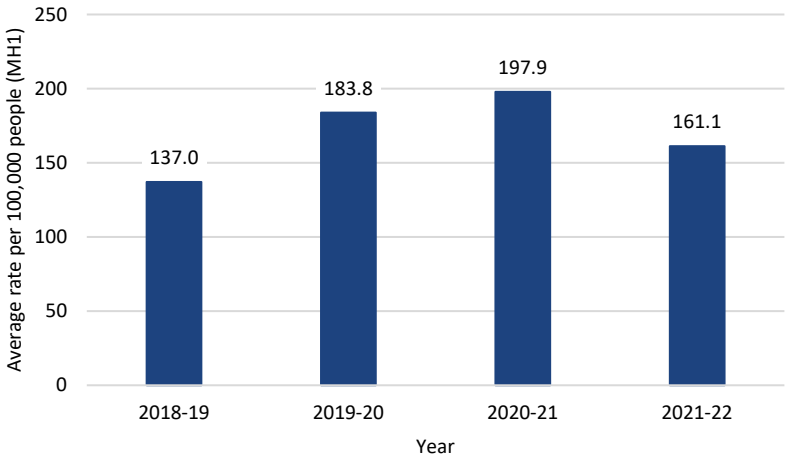
Also, as a result of COVID-19 in 2021-22, service models were required to pivot, for example, to more telehealth servicing and this made collection of outcome measures at episode start and end more challenging. In some PHNs, increasing rates of some service use were attributed to the impact of floods and COVID-19 and in other services, COVID-19 was considered to have contributed to reduced client volumes. For example, lower service usage may be reflective of reduced help-seeking and reluctance to return to face-to-face services.

PHN performance continued to be impacted by data quality and system issues and changes to commissioned service providers. PHNs are working internally with service providers to understand the barriers and challenges faced in data reporting. Activities are ongoing by PHNs to educate and support providers to improve data compliance, completeness and quality.

Mental health clients and service delivery (MH1, MH2, MH3, MH5, MH6)

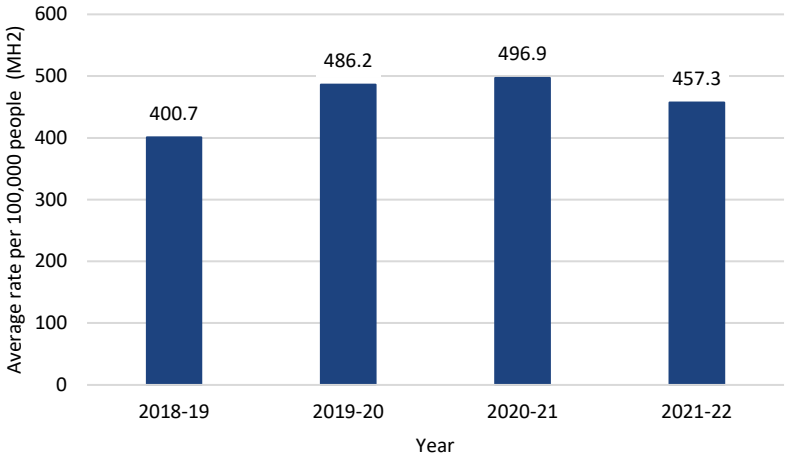
The following five figures present data for five of the six mental health indicators for the period of 2018-19 to 2021-22.

Figure 77: Rate of regional population receiving PHN commissioned low intensity psychological interventions (MH1)



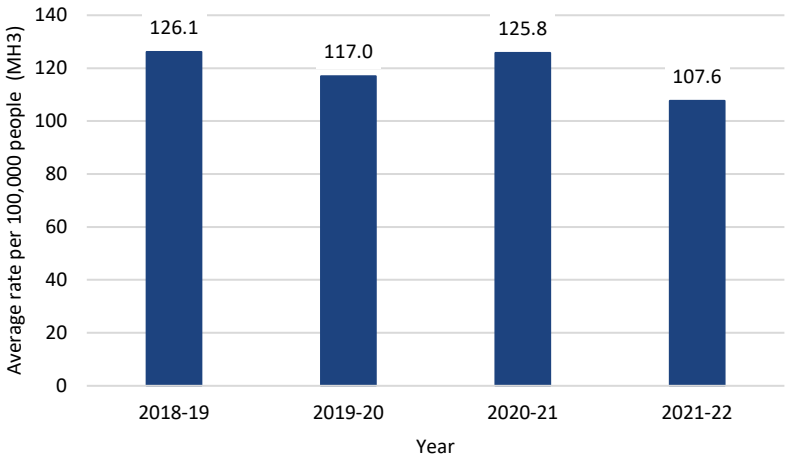
Source: Primary Mental Health Care Minimum Dataset

Figure 78: Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals (MH2)



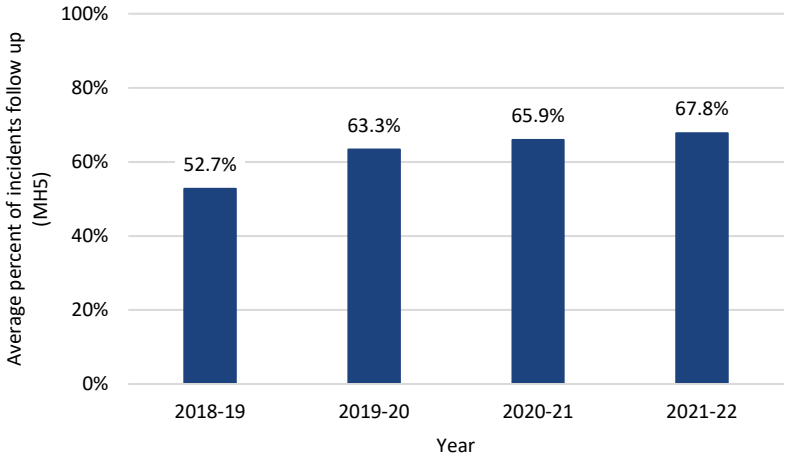
Source: Primary Mental Health Care Minimum Dataset

Figure 79: Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness (MH3)



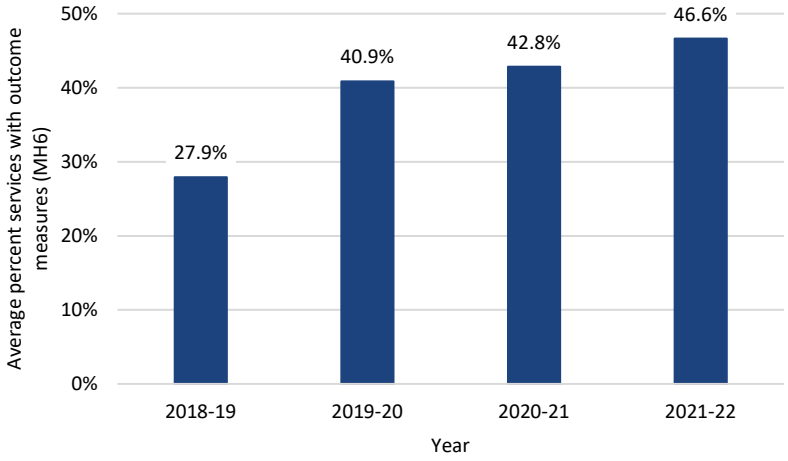
Source: Primary Mental Health Care Minimum Dataset

Figure 80: Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral (MH5)



Source: Primary Mental Health Care Minimum Dataset

Figure 81: Outcomes Readiness - Completion rates for clinical outcome measures (MH6)



Source: Primary Mental Health Care Minimum Dataset

Population health

PHNs offer activities and support to general practices and other health care providers to improve quality of care for patients. PHNs contribute to improving quality of care by working with stakeholders to identify and address specific population health issues, including preventative health initiatives. There are two population health indicators in the PQF:

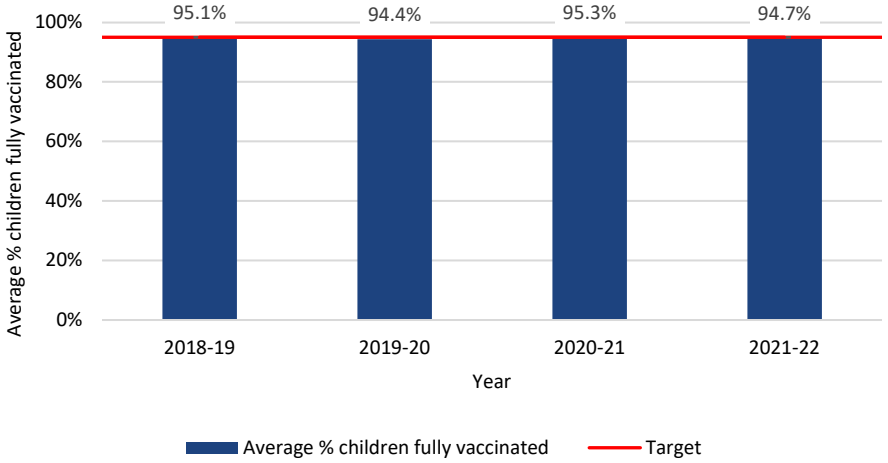
- PH1: Rate of children fully immunised at 5 years.
- PH2: Cancer screening rates for cervical, bowel and breast cancer

Childhood vaccination (PH1)

PHNs support health care providers to address factors impacting population health. The rate of children fully immunised at five years (PH1) is a measure of this outcome. Australia has generally high immunisation rates. In 2021-22, the average percentage of five-year-olds fully vaccinated decreased to 94.7% from the 95.3% peak attained in 2020-21 (Figure 89).[23] This is below the national immunisation target of 95%. All PHN areas achieved an immunisation rate of 90% or more, ranging from a low of 91.1% to a high of 97.0%. Fourteen PHNs (45%) met the national immunisation target for this age cohort.

Vaccine coverage rates declined in all age groups for all children in 2022 compared with 2021, potentially reflecting the impact of COVID-19 on routine childhood immunisation. The decline in vaccine coverage was steeper amongst First Nations children.

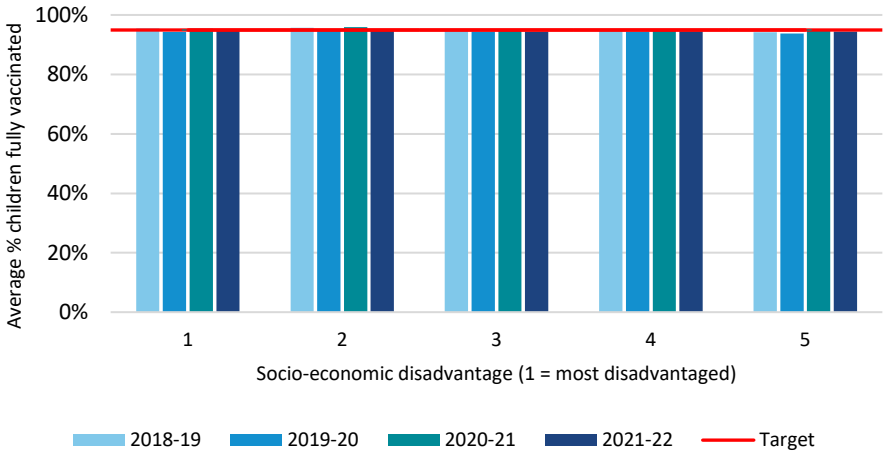
Figure 82: Average proportion across all PHNs of fully immunised five-year-olds (PH1)



Source: 2023 PHN Childhood immunisation coverage data, Australian Government Department of Health and Aged Care
Primary Health Network (PHN) coverage by age group

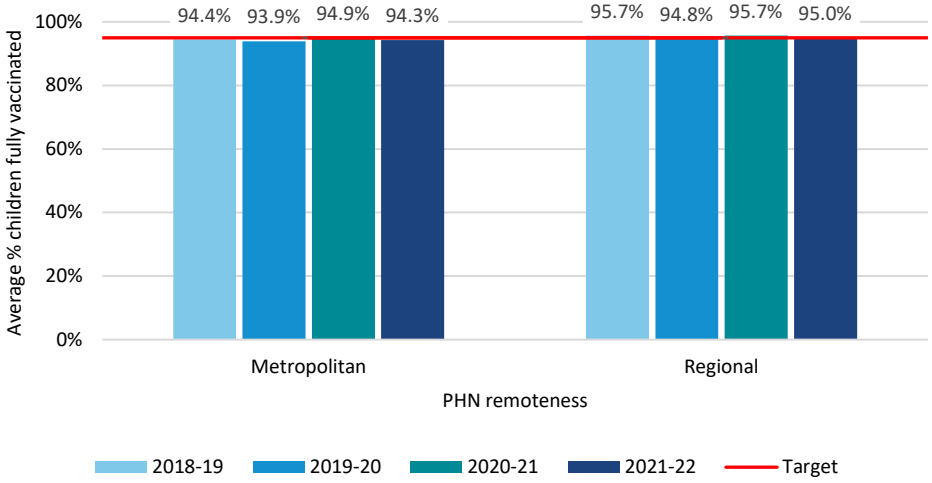
[23] Source: Australian Immunisation Register, retrieved 01/12/2023 from https://www.health.gov.au/resources/publications. Notes and caveats: 1) All data is based on vaccinations reported to the Australian Immunisation Register (AIR) as at COB 01/12/2023; 2) cohort immunisation status is assessed at 12 months of age (for vaccines due at six months), 24 months of age (for vaccines due at 12 and 18 months) and 60 months of age (for vaccines due at 48 months); 3) Coverage Assessment for 5-year-olds includes Dose 4 or 5 of DTP and Dose 4 of Polio; 4) a minimum three-month lag period is allowed for late notification of vaccinations to the AIR, but only vaccines given on or before a child's first, second or fifth birthdays, respectively, are included in coverage calculations.

Figure 83: Average proportion across all PHNs of fully immunised five-year-olds (PH1) by socio-economic disadvantage



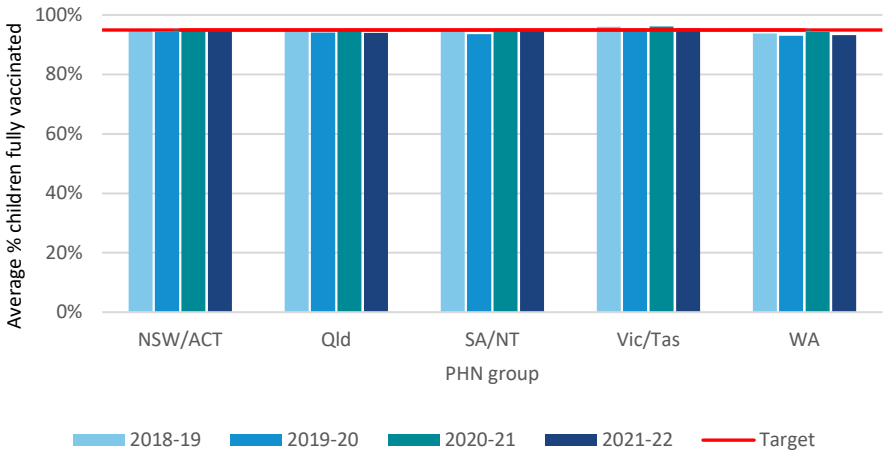
Source: 2023 PHN Childhood immunisation coverage data, Australian Government Department of Health and Aged Care
Primary Health Network (PHN) coverage by age group
For data details, see Table 51, page 85

Figure 84: Average proportion across all PHNs of fully immunised five-year-olds (PH1) by PHN remoteness



Source: 2023 PHN Childhood immunisation coverage data, Australian Government Department of Health and Aged Care
Primary Health Network (PHN) coverage by age group

Figure 85: Average proportion across all PHNs of fully immunised five-year-olds (PH1) by PHN state group



Source: 2023 PHN Childhood immunisation coverage data, Australian Government Department of Health and Aged Care
Primary Health Network (PHN) coverage by age group
For data details, see Table 52, page 85

Cancer screening (PH2)

Screening programmes are effective in the early detection of cancers in people with no symptoms. This allows for the early treatment of discovered cancers and reduces death rates. Participation in screening programmes is the single most important factor in achieving these outcomes and can be measured and reported for target populations.

PHNs can help to improve participation rates in the national breast, bowel and cervical cancer screening programmes, particularly in regions with low screening participation rates. They can do this by engaging with general practitioners as part of quality improvement activities. These activities subsequently support healthcare providers to encourage people to seek and participate in cancer screening programs through provision of education and accessible resources. The AIHW is currently reviewing cancer screening reporting options, and the latest available data is reported below.

Bowel cancer screening

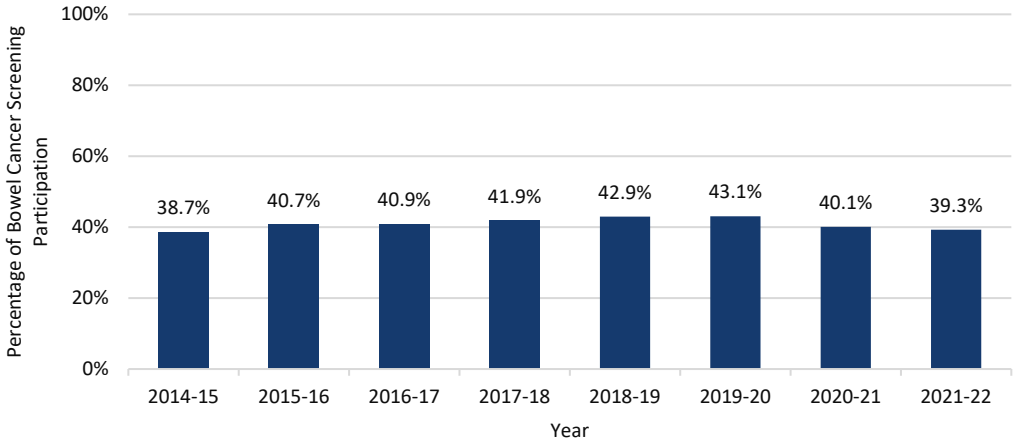
Target population: People aged 50 to 74 years.

Participation: People from the target population who returned a completed test within the reporting period or the following six months.

The proportion of the target population receiving bowel cancer screening continued to decrease in 2021-22, falling to 39.3% (Figure 93). Screening rates declined in the two years coinciding with the onset of COVID-19 pandemic. The decreases in 2020-21 and 2021-22 are consistent across all levels of PHN socio-economic disadvantage (Figure 94), remoteness (Figure 95), and state groups (Figure 96) except for South Australia and the Northern Territory in 2021-22.

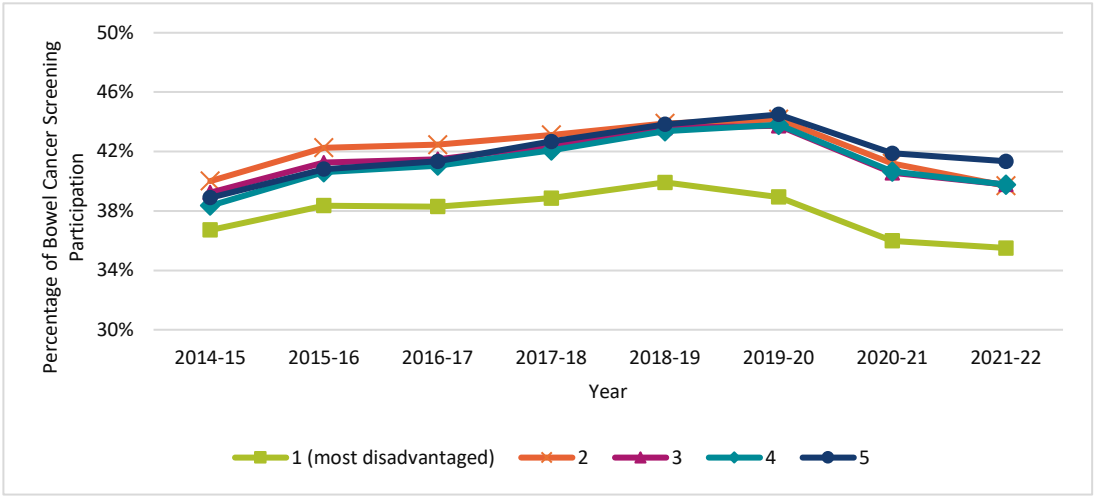
Bowel cancer screening rates remain consistently lower in PHNs with the most socio-economic disadvantage across all years, compared to all other levels of disadvantage. This was not the case when comparing metropolitan and regional PHNs, which have had comparatively similar average rates of screening participation.

Figure 86: Bowel Cancer Screening rate (proportion of target population) (PH2)



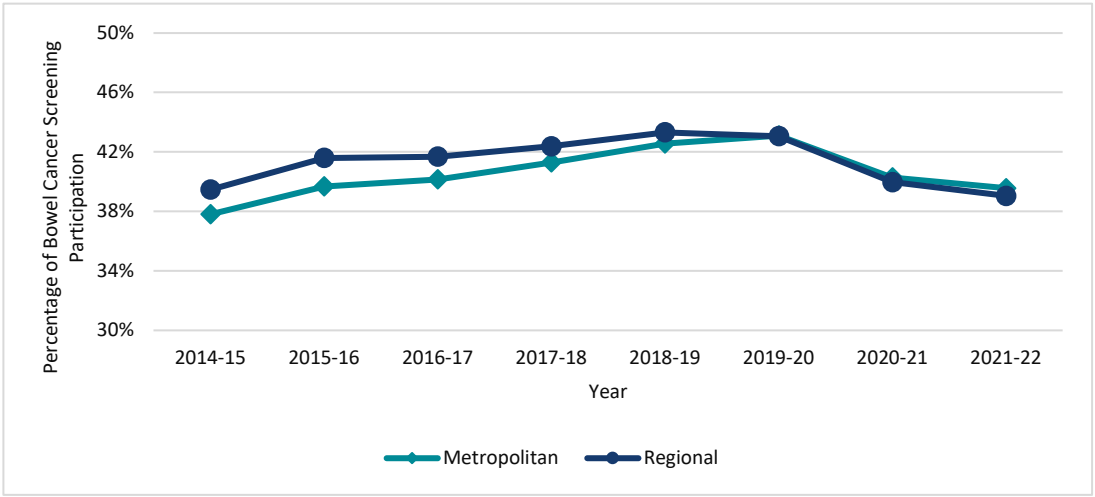
Source: AIHW Cancer screening programs: quarterly data
Note: target population is people aged 50 to 74 years who are invited to screen in a 24 month period

Figure 87: Bowel Cancer Screening rate (PH2) by disadvantage (proportion of target population)



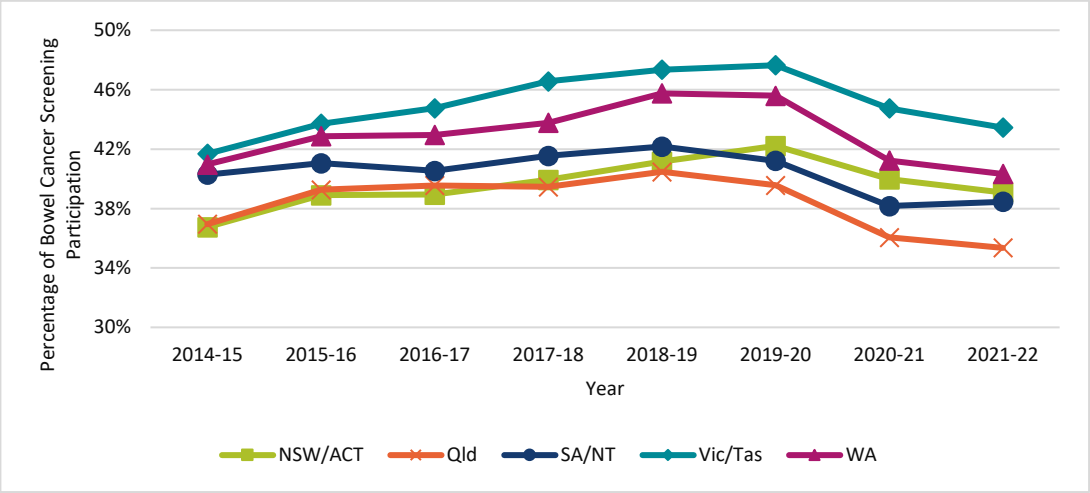
Source: AIHW Cancer screening programs: quarterly data
Note: the per cent axis ranges from 35% to 50% rather than 0% to 100% for legibility
For data details, see Table 53, page 86

Figure 88: Bowel Cancer Screening rate (PH2) by PHN remoteness (proportion of target population)



Source: AIHW Cancer screening programs: quarterly data
Note: the per cent axis ranges from 30% to 50% rather than 0% to 100% for legibility.
For data details, see Table 54, page 86

Figure 89: Bowel Cancer Screening rate (PH2) by PHN state group (proportion of target population)



Source: AIHW Cancer screening programs: quarterly data
Note: the per cent axis ranges from 30% to 50% rather than 0% to 100% for legibility.
For data details, see Table 55, page 86

Breast cancer screening

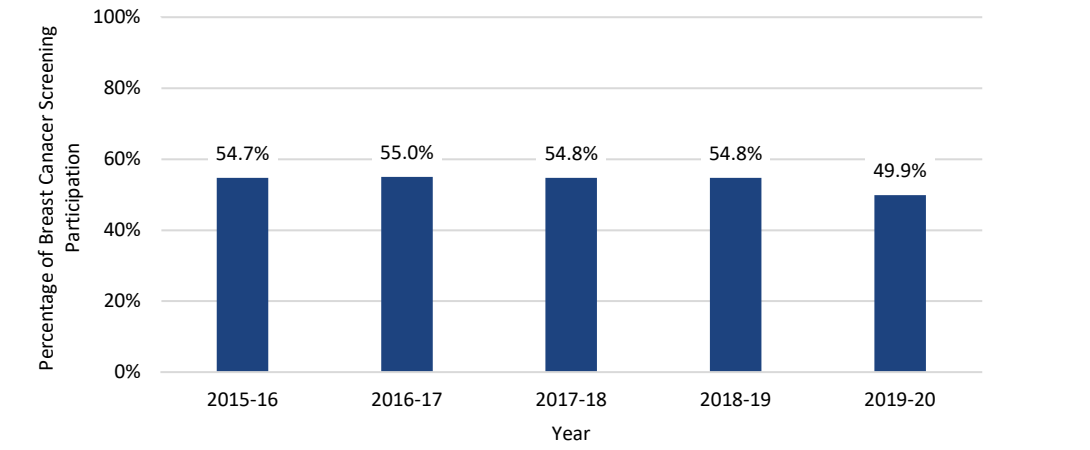
Target population: Women aged 50 to 74 years.

Participation: People from the target population who are screened in a 2-year period.

Note on data availability: Data on breast cancer screening was not available at the time of writing for 2020-21 or 2021-22 at the PHN level. The most recent data (2015-16 to 2019-20) is presented below.

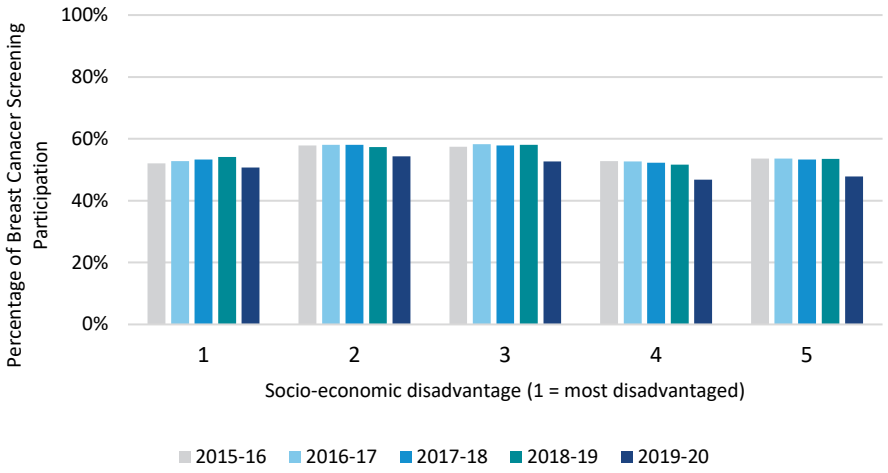
The proportion of the target population receiving breast cancer screening decreased 4.9 percentage points to 49.9% in 2019-20 (Figure 97). The COVID-19 pandemic impacted participation in the BreastScreen Australia Program due to service suspensions, staged approaches to screening, and the reduced capacity of services due to the need to implement COVID-19 safety measures. The decrease in 2019-20 was reflected across all levels of socio-economic disadvantage (Figure 98), with the greatest decrease in PHNs with least disadvantage (10.8%), and in both regional (6.6%) and metropolitan (10.4%) regions (Figure 99). There was also a decrease across all PHN state groups, which was least pronounced in Qld (4.7%) and greatest in SA/NT (11.6%) and Vic/Tas (13.2%) (Figure 100). In all cases, this is a much larger change than observed in previous years.

Figure 90: Breast Cancer Screening rate (proportion of target population) (PH2)



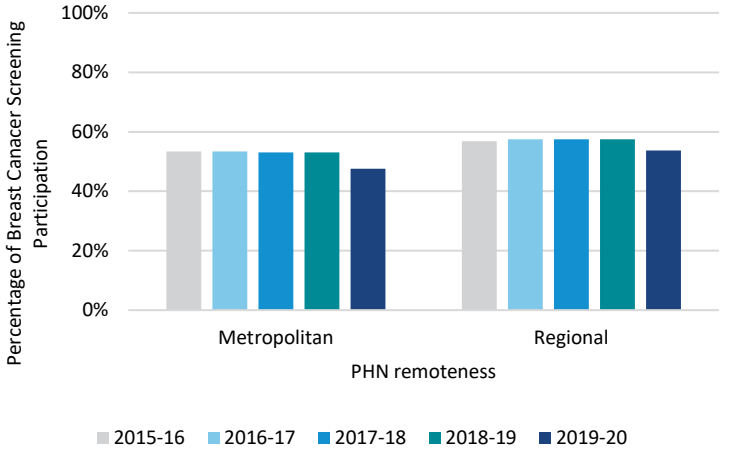
Source: AIHW Cancer screening programs: quarterly data
Note: target population is women aged 50 to 74 years

Figure 91: Breast Cancer Screening rate (PH2) by disadvantage (proportion of target population)



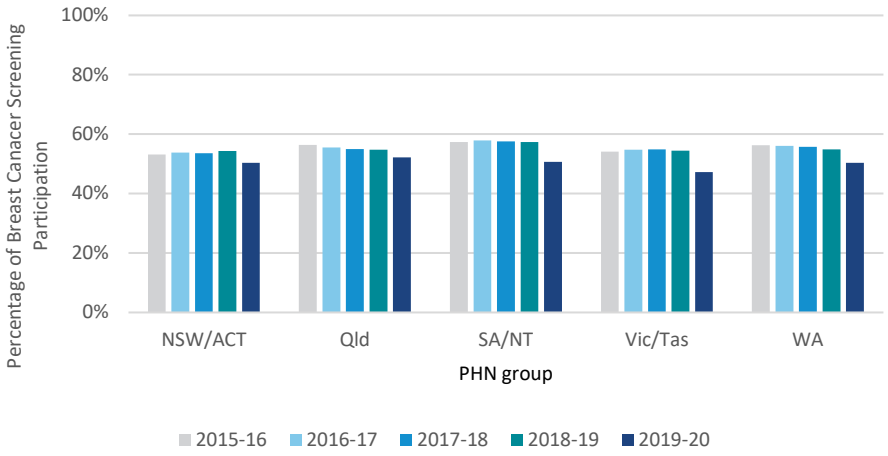
Source: AIHW Cancer screening programs: quarterly data
For data details, see Table 56, page 86

Figure 92: Breast Cancer Screening rate (PH2) by PHN remoteness (proportion of target population)



Source: AIHW Cancer screening programs: quarterly data
For data details, see Table 57, page 86

Figure 93: Breast Cancer Screening rate (PH2) by PHN state group (proportion of target population)



Source: AIHW Cancer screening programs: quarterly data
For data details, see Table 58, page 86

Cervical cancer screening

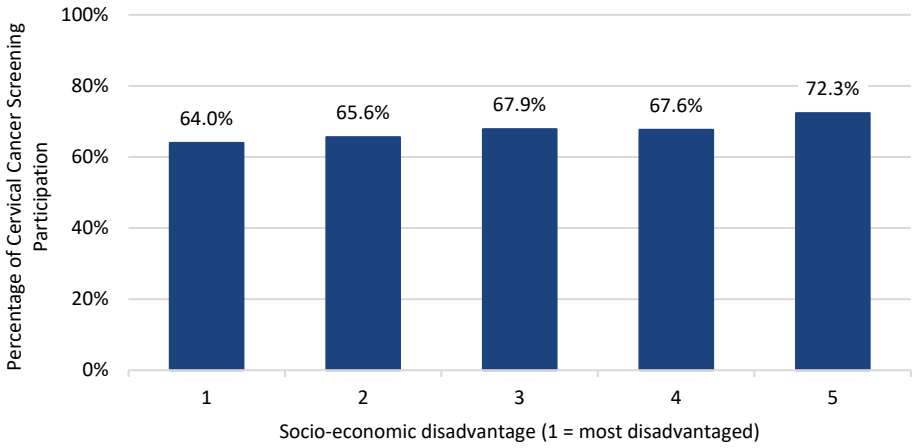
Target population: Women and people with a cervix aged 25 to 74 years.

Participation: People from the target population who undertake the Cervical Screening Test every 5 years or undertake screening every 2 years.

Note on data availability: Data is only available at the PHN level for the aggregate years of 2018-19 to 2021-22, and is not comparable to years prior due to the renewal of the National Cervical Screening Program (NCSP). NCSP data are available monthly, but many performance indicators require follow-up to allow them to be calculated accurately. Further, there are delays in the completeness of some data, which limits how soon data can be used.

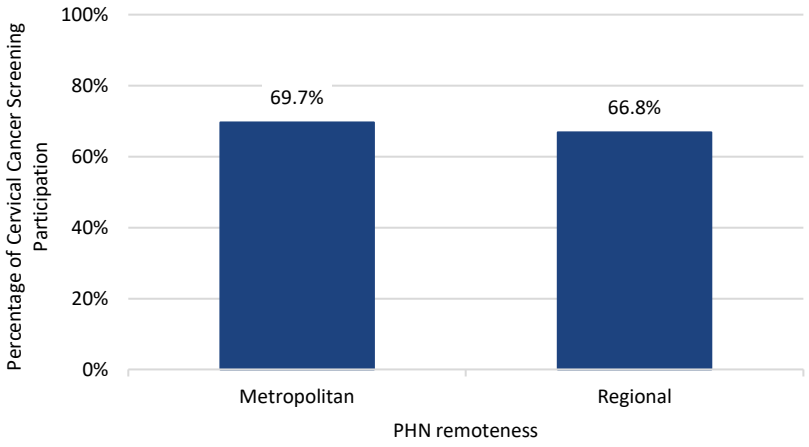
The national participation rate over the 4-year period 2018-19 to 2021-22 is 68.7%. Patients living in least disadvantaged PHN areas were more likely to participate in cervical cancer screening compared to other socioeconomic PHN areas (Figure 101). This is similarly the case for metropolitan PHN areas (Figure 102) and the WA, and Vic/Tas state groups (Figure 103).

Figure 94: Cervical Cancer Screening rate by disadvantage (proportion of target population) (PH2)



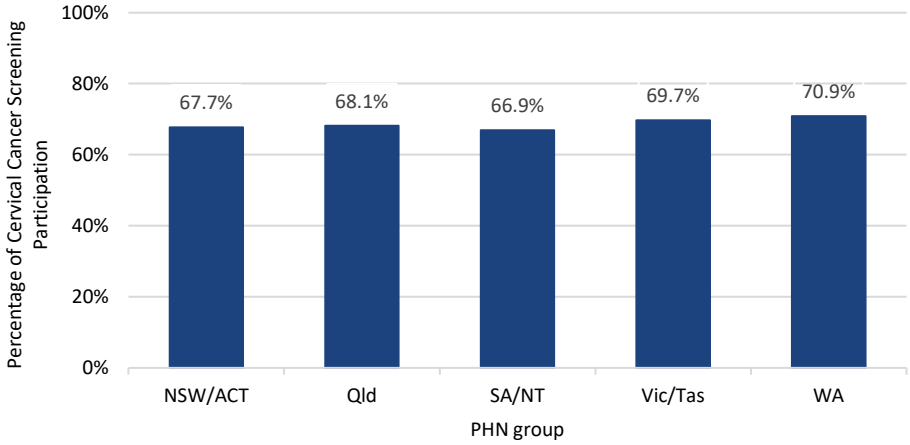
Source: AIHW Cancer screening programs: quarterly data
Note: target population is women and people with a cervix aged 25 to 74 years

Figure 95: Cervical Cancer Screening rate (PH2) by PHN remoteness (proportion of target population)



Source: AIHW Cancer screening programs: quarterly data

Figure 96: Cervical Cancer Screening rate (PH2) by PHN state group (proportion of population eligible)



Source: AIHW Cancer screening programs: quarterly data

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Appendices

Appendix 1 – Selected potentially preventable hospitalisations

Acute PPH
Cellulitis
Convulsions and epilepsy
Dental conditions
Ear, nose and throat infections
Eclampsia
Gangrene
Pelvic inflammatory disease
Perforated/bleeding ulcer
Pneumonia (not vaccine-preventable)
Urinary tract infections, including pyelonephritis

Chronic PPH
Angina
Asthma
Bronchiectasis
Congestive cardiac failure
Chronic Obstructive Pulmonary Disease
Diabetes complications
Hypertension
Iron deficiency anaemia
Nutritional deficiencies
Rheumatic heart disease

Vaccine preventable PPH
Other vaccine-preventable conditions
Pneumonia and influenza (vaccine-preventable)

Source: AIHW, National Healthcare Agreement: PI 19–Selected potentially avoidable GP-type presentations to emergency departments, 2022 *https://meteor.aihw.gov.au/content/740851*

Appendix 2 – Data Tables

Emergency Department and Hospitalisations

Table 1: Average PHN potentially preventable hospitalisations by type (P12) per 100,000 population age standardised, 2015-16 to 2021-22

PPH by type	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Chronic	1273.3	1312.6	1302.7	1297.2	1224.1	1148.5	1060.9
Vaccine preventable	205.8	221.6	327.1	257.3	254.3	106.9	167.6
Acute	1358.5	1393.7	1397.0	1405.9	1318.8	1338.9	1273.9
Total	2810.4	2897.8	2984.1	2930.7	2767.5	2580.4	2480.7

Table 2: Potentially preventable hospitalisations by type and age group (P12) per 100,000 population, 2020-21 to 2021-22

Age	Year	Vaccine preventable	Chronic	Acute	Total
0–64	2020–21	86	578	1031	1686
	2021–22	132	557	996	1670
65+	2020–21	232	4617	2485	7304
	2021–22	342	4252	2375	6923

Table 3: Lower urgency ED presentations (age-standardised) by hours of presentation (P7), rate per 1,000 population, 2015-16 to 2021-22

Presentation	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
In-hours	62	62	62	62	63	72	69
After-hours	60	58	57	57	52	56	56
Total	122	120	119	119	115	128	124

Table 4: Lower urgency ED presentations (P7) by disadvantage, rate per 1,000 population, 2015-16 to 2021-22

Disadvantage	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
1	111.1	110.0	108.8	109.4	105.2	108.8	110.1
2	181.6	185.0	186.2	190.9	182.8	190.7	182.9
3	128.1	125.9	122.9	126.0	120.2	127.4	124.4
4	113.0	107.4	107.0	107.3	102.4	121.2	116.2
5	92.3	90.1	88.0	86.0	85.5	102.1	96.4

Table 5: Lower urgency ED presentations (P7) by remoteness, rate per 1,000 population, 2015-16 to 2021-22

Remoteness	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Metropolitan	96	93	91	89	86	100	97
Regional	158	158	158	164	158	167	159

Table 6: Lower urgency ED presentations (P7) by age group, rate per 1,000 population, 2015-16 to 2021-22

Age Group	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
0-64	126	123	121	122	118	132	128
65+	75	77	78	78	75	78	74

Table 7: Lower urgency ED presentations (P7) (age-standardised) by PHN state group, rate per 1,000 population, 2015-16 to 2021-21

State Group	2015-16	2016-17	2018-19	2019-20	2020-21	2021-22
NSW/ACT	143	142	142	141	138	149
Qld	89	84	81	80	84	120
WA	131	129	126	143	138	144
Vic/Tas	104	103	100	98	88	87
SA/NT	110	109	108	110	107	119

Organisational

Table 8: Average rate of commissioned health services with output and outcome indicators (O12) by socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	76.2%	70.3%	77.0%	87.5%
2	65.3%	92.1%	88.5%	90.8%
3	75.7%	79.9%	89.9%	86.0%
4	79.2%	92.4%	94.9%	95.0%
5 (least disadvantaged)	91.0%	93.2%	84.6%	91.5%

Table 9: Average rate of commissioned health services with output and outcome indicators (O12) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	75.9%	92.8%	87.7%	91.3%
Qld	72.3%	77.5%	81.0%	89.7%
SA/NT	66.7%	66.0%	82.0%	85.9%
Vic/Tas	95.6%	97.6%	96.7%	95.2%
WA	68.3%	71.8%	79.6%	79.9%

Workforce

Table 10: Proportion of PHNs that met performance targets by Workforce indicator (W1, W2 and W3)

Indicator	2018-19	2019-20	2020-21	2021-22
Drug and alcohol service providers suitably accredited (W1)*	n.a.	87.1%	96.8%	100.0%
Support for drug and alcohol commissioned health professionals (W2)	74.2%	83.9%	90.3%	87.1%
PHN commissioning framework (W3)	54.8%	100.0%	100.0%	100.0%

***This performance measure was collected as a baseline in 2018-19.**

Table 11: Average number of Workforce performance targets (W1, W2 and W3) met by PHN socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	1.3	2.8	2.8	3.0
2	0.7	2.7	2.8	2.5
3	1.7	2.5	2.7	2.8
4	1.5	2.5	3.0	3.0
5 (least disadvantaged)	1.3	3.0	3.0	3.0

Table 12: Average number of Workforce performance targets (W1, W2 and W3) met by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	1.5	2.5	2.7	2.7
Qld	1.3	2.9	3.0	2.9
SA/NT	1.7	3.0	3.0	3.0
Vic/Tas	0.6	3.0	3.0	3.0
WA	2.0	2.3	2.7	3.0

Alcohol and Other Drugs

Table 13 Proportion of PHNs that met performance targets by Alcohol and Other Drugs indicator (AOD1 and AOD2)

Indicator	2018-19	2019-20	2020-21	2021-22
Commissioned providers actively delivering services (AOD1)*	n.a.	100.0%	100.0%	100.0%
Partnerships with local stakeholders (AOD2)	93.5%	100.0%	100.0%	100.0%

***This performance measure was collected as a baseline in 2018-19.**

Practice Incentives Program After-Hours payments (P6)

Table 14: Average general practice accreditation rate (P3) by PHN socio-economic disadvantage

Disadvantage	2019-20	2020-21	2021-22
1 (most disadvantaged)	80.7%	80.9%	81.8%
2	87.0%	91.4%	94.7%
3	81.9%	86.0%	81.5%
4	84.7%	84.5%	84.8%
5 (least disadvantaged)	79.9%	80.2%	81.7%

Table 15: Percentage of practices receiving PIP after-hours payments (P6) by socio-economic disadvantage

Disadvantage	2019-20	2020-21	2021-22
1 (least disadvantaged)	68.0%	66.9%	77.1%
2	71.2%	71.3%	73.9%
3	81.9%	84.5%	83.1%
4	77.9%	78.4%	78.5%
5 (most disadvantaged)	82.4%	80.5%	80.5%

Table 16: Percentage of practices receiving PIP after-hours payments (P6) by PHN state group

State Group	2019-20	2020-21	2021-22
NSW/ACT	71.4%	71.7%	73.9%
Qld	72.4%	72.3%	75.1%
SA/NT	80.0%	79.5%	95.0%
Vic/Tas	75.8%	75.5%	77.4%
WA	102.6%	102.7%	91.1%

Digital Health

Table 17: Proportion of PHNs that met performance targets by Digital Health indicator (DH1, DH2, and DH3)

Indicator	2018-19	2019-20	2020-21	2021-22
Providers informed about My Health Record (DH1)	96.8%	100.0%	100.0%	100.0%
Providers using specific digital health systems* (DH2)	n.a.	83.9%	96.8%	90.3%
Accredited general practices sharing data with PHN* (DH3)	n.a.	83.9%	74.2%	77.4%

***This performance measure was collected as a baseline in 2018-19.**

Table 18: Average number of Digital Health performance targets met by disadvantage (indicators DH1, DH2, and DH3)

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	1.0	2.7	2.8	2.8
2	1.0	2.7	2.7	2.5
3	1.0	2.5	2.5	2.5
4	0.8	2.7	2.8	2.8
5 (least disadvantaged)	1.0	2.9	2.7	2.7

Table 19: Average number of Digital Health performance targets met by PHN state group (indicators DH1, DH2, and DH3)

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	1.0	2.7	2.5	2.5
Qld	1.0	2.6	2.9	3.0
SA/NT	1.0	2.0	2.3	3.0
Vic/Tas	0.9	2.9	2.9	2.7
WA	1.0	3.0	3.0	2.3

Table 20: Percentage of general practices using e-referrals (DH2) by PHN state group

State Group	2019-20	2020-21	2021-22
NSW/ACT	49.7%	73.9%	75.8%
Qld	80.3%	81.0%	80.8%
SA/NT	60.3%	65.6%	75.3%
Vic/Tas	64.1%	58.8%	69.9%
WA	50.7%	53.0%	47.9%

Table 21: Percentage of general practices using smart forms (DH2) by PHN state group

State Group	2019-20	2020-21	2021-22
NSW/ACT	48.5%	55.3%	65.1%
Qld	42.6%	61.8%	70.7%
SA/NT	54.4%	50.4%	61.4%
Vic/Tas	30.3%	66.1%	74.2%
WA	1.8%	3.3%	3.1%

Table 22: Percentage of general practices using telehealth (DH2) by PHN state group

State Group	2019-20	2020-21	2021-22
NSW/ACT	55.6%	80.5%	75.1%
Qld	60.1%	70.0%	78.1%
SA/NT	68.3%	62.7%	71.6%
Vic/Tas	69.3%	60.2%	57.8%
WA	20.6%	86.4%	76.1%

Table 23: Percentage of accredited general practices sharing data with PHN (DH3) by PHN state group

State Group	2019-20	2020-21	2021-22
NSW/ACT	89.8%	92.0%	94.4%
Qld	89.4%	92.4%	94.7%
SA/NT	87.7%	89.8%	93.6%
Vic/Tas	84.7%	93.8%	92.6%
WA	91.1%	96.2%	94.4%

Table 24: Percentage of accredited general practices sharing data with PHN (DH3) by PHN socio-economic disadvantage

Disadvantage	2019-20	2020-21	2021-22
1 (most disadvantaged)	86.8%	91.3%	93.4%
2	85.8%	92.9%	92.9%
3	89.6%	93.6%	95.7%
4	91.0%	92.5%	94.6%
5 (least disadvantaged)	89.1%	93.0%	93.3%

Table 25: Percentage of general practices regularly uploading to MyHR (P5) by PHN socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	11.7%	17.5%	19.7%	21.0%
2	9.2%	17.6%	20.0%	22.6%
3	6.8%	14.8%	18.5%	21.1%
4	7.2%	16.2%	19.4%	22.3%
5 (least disadvantaged)	5.9%	15.2%	19.7%	22.3%

Table 26: Percentage of general practices regularly uploading to MyHR (P5) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	5.9%	14.2%	17.9%	20.4%
Qld	9.1%	16.6%	19.7%	22.8%
SA/NT	12.2%	19.1%	21.2%	22.3%
Vic/Tas	9.5%	19.1%	23.2%	26.1%
WA	6.3%	12.8%	14.0%	14.8%

Cross-views of My Health Record (P10)

Table 27: Average count of MyHR cross-views (P10) per general practice by PHN socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (least disadvantaged)	33.7	101.3	158.9	188.6
2	17.2	51.0	75.8	149.0
3	9.3	42.1	77.6	122.7
4	29.4	79.9	119.4	172.2
5 (most disadvantaged)	9.5	36.4	59.3	108.2

Table 28: Average count of MyHR cross-views (P10) per pharmacy by PHN socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (least disadvantaged)	5.4	7.5	14.0	39.0
2	5.0	8.7	18.2	44.9
3	5.9	15.3	23.2	40.1
4	6.9	11.9	15.8	32.4
5 (most disadvantaged)	2.3	4.4	7.4	16.5

Table 29: Average count of MyHR cross-views (P10) per general practice by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	17.1	48.8	83.8	123.5
Qld	26.6	91.4	121.3	168.8
SA/NT	53.9	148.0	249.6	325.7
Vic/Tas	4.2	12.7	25.6	68.8
WA	12.9	63.7	102.1	184.6

Table 30: Average count of MyHR cross-views (P10) per pharmacy by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	4.0	6.4	10.2	24.9
Qld	6.9	13.2	21.1	48.8
SA/NT	5.4	9.1	15.8	30.2
Vic/Tas	2.6	4.1	8.1	24.1
WA	9.4	24.1	38.0	59.7

First Nations Health

Table 31: Proportion of PHNs meeting First Nations indicator targets (FN1 - FN7)

Indicator	2018-19	2019-20	2020-21	2021-22
PHN-delivered Integrated Team Care (ITC) services (FN1)	100.0%	100.0%	100.0%	90.3%
Range of organisations delivering ITC services (FN2)	100.0%	100.0%	96.8%	100.0%
Culturally safe drug and alcohol services (FN3)	83.9%	96.8%	100.0%	96.8%
Culturally safe mental health services (FN4)*	n.a.	61.3%	58.1%	22.6%
Culturally safe mainstream primary health services (FN5)	96.8%	100.0%	100.0%	96.8%
Support for First Nations health workforce (FN6)	83.9%	96.8%	96.8%	96.8%
Supporting access to coordinated care (FN7)	100.0%	100.0%	100.0%	100.0%

***This performance measure was collected as a baseline in 2018-19.**

Table 32: Number of ITC Services delivered by PHNs (FN1) by type

Service Type	2018-19*	2019-20	2020-21	2021-22
Care coordination services	n.a.	446,278	536,880	519,675
Supplementary services	n.a.	199,144	254,604	181,514
Clinical services	n.a.	179,985	183,143	153,808
Other services	n.a.	42,113	25,304	43,583
Combined services*	962,136	n.a	n.a	n.a
Total Services	962,136	867,520	999,931	898,580

***Service type not available for 2018-19, all service types included in this figure**

Table 33: ITC services delivered per 1,000 First Nations population (FN1) by service type

Values	2019-20	2020-21	2021-22
Average of Care coordination	586	671	618
Average of Supplementary	235	261	219
Average of Clinical	237	240	219
Average of Other services	65	78	75

Table 34: ITC services delivered per 1,000 First Nations population (FN1) by disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	806	789	920	793
2	1076	880	1014	1013
3	1211	1022	1298	1028
4	1485	1493	1557	1366
5 (least disadvantaged)	1458	1289	1261	1282

Table 35: ITC services delivered per 1,000 First Nations population (FN1) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	944	817	1183	1057
Qld	1492	1374	1439	1317
SA/NT	1339	1106	982	926
Vic/Tas	1390	1192	1053	959
WA	1034	1287	1383	1279

Table 36: Types of organisations delivering ITC services (FN2)

Organisation type	2018-19*	2019-20	2020-21	2021-22
AMS	n.a.	111	110	118
Mainstream organisation	n.a.	54	128	127
Combined organisations*	175	0	0	0
Toral organisations	175	165	238	245

***Organisation type not available for 2018-19, both organisation types included in this figure**

Table 37: Number of organisations delivering ITC services (FN2) by PHN remoteness

Remoteness	2018-19	2019-20	2020-21	2021-22
Metropolitan	48	44	39	41
Regional	127	121	199	204

Table 38: Percentage of First Nations patients receiving Health Assessments (all ages) (FN8) by socio-economic disadvantage

Disadvantage	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
1 (most)	26.4%	28.4%	28.5%	27.8%	27.0%	22.1%
2	27.6%	28.7%	30.1%	28.4%	27.8%	22.5%
3	20.8%	23.0%	23.5%	23.9%	23.4%	21.1%
4	21.8%	24.1%	24.9%	23.9%	23.5%	20.3%
5 (least)	15.5%	16.3%	16.7%	16.3%	15.7%	13.3%

Table 39: Percentage of First Nations patients receiving Health Assessments (all ages) (FN8) by PHN state group

State Group	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
NSW/ACT	19.1%	20.9%	22.3%	22.8%	22.4%	18.8%
Qld	33.1%	35.1%	35.7%	33.8%	32.0%	28.1%
SA	24.6%	26.8%	26.2%	25.4%	25.6%	20.6%
Vic	13.9%	15.2%	15.3%	14.4%	14.3%	11.1%
WA	24.8%	25.7%	26.0%	24.3%	23.9%	21.8%

Table 40: Percentage of First Nations patients receiving Health Assessments (all ages) by PHN remoteness (FN8)

Remoteness	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Metropolitan	96	93	91	89	86	100	97
Regional	158	158	158	164	158	167	159

Table 41: Percentage of First Nations patients receiving health assessments (FN8) by age group

Age group	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
0-4	29.5%	30.8%	31.2%	29.4%	28.8%	24.0%
5–14	23.6%	26.0%	26.9%	25.0%	24.1%	20.1%
15–24	21.8%	22.8%	23.4%	22.8%	22.0%	18.7%
25–54	26.8%	28.4%	29.0%	28.6%	27.6%	24.0%
55 and over	34.3%	36.7%	38.2%	38.2%	38.1%	34.6%
All ages	26.2%	28.0%	28.8%	28.0%	27.2%	23.5%

Care for People with Chronic Conditions

Table 42: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9)

	2018-19	2019-20	2020-21	2021-22
Sum of services	10,551,555	10,751,061	11,550,351	10,679,554

Table 43: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9) by socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	1,237,972	1,246,446	1,323,755	1,219,551
2	1,407,680	1,394,720	1,446,435	1,346,003
3	3,141,627	3,200,918	3,428,804	3,156,540
4	1,927,222	1,966,128	2,106,079	1,996,088
5 (least disadvantaged)	2,837,054	2,942,849	3,245,278	2,961,372

Table 44: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9) by PHN remoteness

Remoteness	2018-19	2019-20	2020-21	2021-22
Metropolitan	6,337,034	6,526,355	7,143,512	6,562,398
Regional	4,214,521	4,224,706	4,406,839	4,117,156

Table 45: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences (P9) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	3,802,444	3,784,627	4,054,442	3,626,896
Qld	2,253,755	2,302,853	2,450,637	2,309,017
SA/NT	810,259	838,713	887,163	852,223
Vic/Tas	2,689,281	2,823,080	3,077,478	2,863,780
WA	995,816	1,001,788	1,080,631	1,027,638

Aged Care

Table 46: GP attendances in Residential Ages Care Homes per patient (AC1) by socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	17.3	17.6	16.8	15.7
2	15.6	15.7	15.5	14.5
3	18.5	18.8	17.9	16.9
4	17.5	17.9	17.9	17.1
5 (least disadvantaged)	18.5	19.2	18.8	17.9

Table 47: GP attendances in Residential Ages Care Homes per patient (AC1) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	17.1	17.7	17.5	15.8
Qld	17.9	17.9	17.7	16.9
SA/NT	17.4	17.8	16.4	15.2
Vic/Tas	19.4	20.0	19.1	18.9
WA	15.8	15.9	16.3	15.4

Table 48: Proportion of people aged 65 years and over who have a recorded Health Assessment from a Medicare-subsidised general practice, allied health or specialist health care service (AC2) by socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	14.5%	14.3%	14.2%	13.6%
2	16.4%	16.1%	16.0%	15.4%
3	17.3%	17.2%	16.9%	15.8%
4	16.5%	16.4%	16.3%	16.0%
5 (least disadvantaged)	14.5%	14.1%	13.5%	12.9%

Table 49: Proportion of people aged 65 years and over who have a recorded Health Assessment from a Medicare-subsidised general practice, allied health or specialist health care service (AC2) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	16.0%	16.0%	15.7%	14.4%
Qld	18.6%	18.7%	19.3%	19.4%
SA/NT	14.7%	14.3%	14.0%	13.2%
Vic/Tas	14.1%	13.6%	12.3%	12.2%
WA	15.9%	15.3%	15.7%	14.1%

Mental Health

Table 50: Proportion of PHNs meeting Mental Health indicator targets (indicators MH1 to MH6)

Indicator	2018-19	2019-20	2020-21	2021-22
Low intensity interventions (MH1)*	n.a.	54.8%	54.8%	48.4%
Psychological therapies (MH2)*	n.a.	41.9%	54.8%	35.5%
Clinical care coordination (MH3)*	n.a.	38.7%	48.4%	35.5%
Formalised partnerships (MH4)	96.8%	96.8%	100.0%	100.0%
Suicide flag follow-up (MH5)*	n.a.	3.2%	0%	0%
Care with outcome measures (MH6)*	n.a.	12.9%	16.1%	16.1%

***This performance measure was collected as a baseline in 2018-19.**

Population Health

Table 51: Average proportion across all PHNs of fully immunised five-year-olds (PH1) by socio-economic disadvantage

Disadvantage	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	95.5%	94.3%	95.4%	94.7%
2	95.7%	95.1%	95.9%	95.3%
3	94.8%	94.4%	95.2%	94.4%
4	95.1%	94.5%	95.2%	94.5%
5 (least disadvantaged)	94.3%	93.8%	94.9%	94.4%

Shaded cells indicate national target of 95% met.

Table 52: Average proportion across all PHNs of fully immunised five-year-olds (PH1) by PHN state group

State Group	2018-19	2019-20	2020-21	2021-22
NSW/ACT	94.9%	94.5%	95.3%	94.8%
Qld	95.0%	94.2%	94.7%	94.0%
SA/NT	94.8%	93.6%	95.4%	95.1%
Vic/Tas	96.1%	95.3%	96.2%	95.5%
WA	93.8%	93.1%	94.3%	93.3%

Shaded cells indicate national target of 95% met.

Table 53: Bowel Cancer Screening rate (PH2) by disadvantage (proportion of population invited to participate)

Disadvantage	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
1 (most disadvantaged)	36.7%	38.4%	38.3%	38.9%	39.9%	38.9%	36.0%	35.5%
2	40.0%	42.3%	42.5%	43.1%	43.9%	44.2%	41.2%	39.7%
3	39.2%	41.3%	41.5%	42.4%	43.6%	43.7%	40.6%	39.8%
4	38.4%	40.6%	41.1%	42.1%	43.4%	43.8%	40.7%	39.8%
5 (least disadvantaged)	38.9%	40.8%	41.3%	42.7%	43.8%	44.5%	41.9%	41.3%

Table 54: Bowel Cancer Screening rate (PH2) by PHN remoteness (proportion of population invited to participate)

Remoteness	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Metropolitan	37.8%	39.7%	40.1%	41.3%	42.6%	43.1%	40.3%	39.6%
Regional	39.5%	41.6%	41.7%	42.4%	43.3%	43.1%	40.0%	39.0%

Table 55: Bowel Cancer Screening rate (PH2) by PHN state group (proportion of population invited to participate)

State Group	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
NSW/ACT	36.7%	38.9%	38.9%	39.9%	41.2%	42.2%	40.0%	39.1%
Qld	36.9%	39.3%	39.6%	39.5%	40.5%	39.6%	36.1%	35.4%
SA/NT	40.3%	41.1%	40.5%	41.5%	42.2%	41.2%	38.2%	38.5%
Vic/Tas	41.7%	43.7%	44.8%	46.6%	47.4%	47.6%	44.7%	43.5%
WA	41.0%	42.9%	43.0%	43.8%	45.8%	45.6%	41.2%	40.3%

Table 56: Breast Cancer Screening rate (PH2) by disadvantage (proportion of target population)

Disadvantage	2015-16	2016-17	2017-18	2018-19	2019-20
1 (most disadvantaged)	52.1%	52.8%	53.4%	54.1%	50.8%
2	57.9%	58.1%	58.1%	57.4%	54.3%
3	57.5%	58.3%	57.9%	58.1%	52.7%
4	52.8%	52.7%	52.3%	51.7%	46.8%
5 (least disadvantaged)	53.6%	53.6%	53.3%	53.6%	47.8%

Table 57:Breast Cancer Screening rate (PH2) by PHN remoteness (proportion of target population)

Remoteness	2015-16	2016-17	2017-18	2018-19	2019-20
Metropolitan	53.4%	53.4%	53.1%	53.1%	47.5%
Regional	56.9%	57.5%	57.4%	57.5%	53.7%

Table 58: Breast Cancer Screening rate (PH2) by PHN state group (proportion of population invited to participate)

State Group	2015-16	2016-17	2017-18	2018-19	2019-20
NSW/ACT	53.2%	53.8%	53.6%	54.3%	50.3%
Qld	56.3%	55.6%	55.0%	54.8%	52.2%
SA/NT	57.3%	57.9%	57.6%	57.3%	50.7%
Vic/Tas	54.1%	54.8%	54.9%	54.5%	47.3%
WA	56.3%	56.0%	55.7%	54.8%	50.4%

Appendix 3 – Medicare Benefit Schedule Items

Reported service groups	Description	Broad Type of Service /Group/subgroup/item included	PQF Indicator
Aboriginal And Torres Strait Islander Peoples Health Assessment **Source: MBS online**	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a Health Assessment of a patient who is of Aboriginal or Torres Strait Islander descent-not more than once in a 9-month period. This Health Assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for Health Assessments for the following age categories: • An Aboriginal or Torres Strait Islander child who is less than 15 years. • An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years. • An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.	Group A14, Item 71	FN8
GP attendances relating to residential aged care facilities. **Source: AIHW**	Professional attendance by a GP, non-specialist practitioner or other medical practitioner at a residential aged care facility or consulting room situated within such a complex where the patient is accommodated in the residential aged care facility (Group A35).	Group A35; Items 232, 249, 731, 772, 776, 788, 789, 829, 869, 881, 892, 903, 2125, 2138, 2179, 2220, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267, 92102, 92071, 92058, 92027	AC1
GP Health Assessment **Source: AIHW**	Health Assessment of a patient's physical and psychological health and function and recommendation of preventive health care or education to improve that patient's health and physical, psychological and social function. Eligible patients include: people of Aboriginal and Torres Strait Islander descent, people who have an intellectual disability, refugees and humanitarian entrants, residents of residential aged care facilities, people aged 75 years or older, and people aged 40-49 years with a high risk of developing type 2 diabetes or at risk of developing another chronic disease. From 1 April 2019, Heart Health Assessments were added for people who have or are at risk of developing cardiovascular disease.	Group A14; Subgroups A7.5, A40.11, A40.12; Items 93470, 93479	AC2, P9

GP Chronic Disease Management Plan **Source: AIHW**	Services relating to the preparation, coordination and review of a GP Management Plan or Team Care Arrangements, or the contribution to a Multidisciplinary Care Plan for patients with a chronic or terminal medical condition. A chronic medical condition is one that has been, or is likely to be, present for six months or longer.	Subgroups A15.1, A40.13, A40.14; Items 229, 230, 231, 232, 233, 93469, 93475	P9
GP Multidisciplinary Case Conference **Source: AIHW**	Service where a medical practitioner (not including a specialist or consultant physician) organises and coordinates, or participates in, multidisciplinary case conferences for patients who have a chronic condition that has been (or is likely to be) present for 6 months or longer, or is terminal, and who has complex multidisciplinary care needs. Case conferences generally involve the patient's usual GP, or non-specialist medical practitioner, and at least two other providers, such as allied health professionals, other medical practitioners, home and community service providers, and care organisers (e.g., "meals on wheels" providers).	Items 235, 236, 237, 238, 239, 240, 243, 244, 735, 739, 743, 747, 750, 758	P9

AIHW: *https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-and-specialis/contents/technical-information*

Appendix 4 – PQF indicators

Program

Code	Description
P1	PHN activities address prioritised needs
P2	Health system improvement and innovation
P3	Rate of general practice accreditation
P4	Support provided to general practices and other health care providers
P5	Rate of regular uploads to My Health Record
P6	Rate of general practices receiving payment for after-hours services
P7	Use of emergency departments for lower urgency care
P9	Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences
P10	Cross-views of My Health Record
P12	Rate of potentially preventable hospitalisations

Mental Health

Code	Description
MH1	Rate of regional population receiving PHN commissioned low intensity psychological interventions
MH2	Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals
MH3	Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness
MH4	Formalised partnerships with other regional service providers to support integrated regional planning and service delivery
MH5	Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral
MH6	Outcomes Readiness - Completion rates for clinical outcome measures

First Nations Health

Code	Description
FN1	Numbers of ITC services delivered by PHN
FN2	Types of organisations delivering ITC services
FN3	Evidence that all drug and alcohol commissioned services are culturally safe for First Nations people
FN4	Proportion of PHN commissioned mental health services delivered to the regional First Nations population that were culturally safe
FN5	ITC improves the cultural safety of mainstream primary health care services
FN6	PHN provides support for First Nations health workforce
FN7	ITC processes support First Nations people enrolled in the program to access coordinated care
FN8	Rate of population receiving specific health assessments

Population Health

Code	Description
PH1	Rate of children fully immunised at 5 years
PH2	Cancer screening rates for cervical, bowel and breast cancer

Workforce

Code	Description
W1	Rate of drug and alcohol treatment service providers with suitable accreditation
W2	PHN support for drug and alcohol commissioned health professionals
W3	PHN Commissioning Framework

Digital Health

Code	Description
DH1	Rate of health care providers informed about My Health Record
DH2	Rate of health care providers using specific digital health systems
DH3	Rate of accredited general practices sharing data with PHN

Aged Care

Code	Description
AC1	Rate of MBS services provided by primary care providers in residential aged care facilities
AC2	Rate of people aged 75 and over with a GP health assessment

Alcohol and Other Drugs

Code	Description
AOD1	Rate of drug and alcohol commissioned providers actively delivering services
AOD2	Partnerships established with local key stakeholders for drug and alcohol treatment services

Organisational

Code	Description
O12	Rate of contracts for commissioned health services that include both output and outcome performance indicators

Appendix 5 – Acronyms and abbreviations 2021-22

Acronym	Meaning
ABS	Australian Bureau of Statistics
ADHA	Australian Digital Health Agency
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
AMS	Aboriginal Medical Service
AOD	Alcohol and Other Drug
CDMP	Chronic Disease Management Plan
COVID	Coronavirus Disease (2019)
ED	Emergency Department
ERP	Estimated Resident Population
GP	General Practitioner
IRSD	Index of Relative Socio-Economic Disadvantage
ITC	Integrated Team care
MBS	Medicare Benefits Schedule
MDS	Minimum Data Set
MyHR	My Health Record
NCSP	National Cervical Screening Program
PHN	Primary Health Network
PIP	Practice Incentive Payment
PMHC	Primary Mental Health Care
PPH	Potentially Preventable Hospitalisations
PQF	(PHN) Performance and Quality Framework (2018)
RACH	Residential Aged Cate Home
SEIFA	Socio-Economic Indexes for Areas