



Health checks and follow-ups for Aboriginal and Torres Strait Islander people

Web report | Last updated: 27 Oct 2023 | Topic: [First Nations people](#)

About

Through Medicare, Aboriginal and Torres Strait Islander (First Nations) people can receive annual health checks from their doctor, as well as follow-up services from other health professionals, that are specifically for First Nations people. We will refer to these as First Nations health checks and First Nations follow-ups in this report.

- In 2021-22, 209,000 First Nations people had one of these health checks (24% of the estimated population).
- The proportion of patients who had a First Nations follow-up service within 12 months of their health check increased from 18% to 46% between 2011-12 and 2020-21.

Cat. no: IHW 209

Findings from this report:

- [In 2021-22, 24% of First Nations people had an annual health check - down from 29% in 2018-19](#)
 - [560,000 First Nations people received at least one health check in the 5-year period to 30 June 2022](#)
 - [46% of First Nations people who had a health check in 2020-21 had a First Nations follow-up within 12 months](#)
 - [In 2021-22, males aged 15-24 had the lowest uptake of First Nations health checks of any age and sex, at 15%](#)
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Summary

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Introduction

Aboriginal and Torres Strait Islander (First Nations) people have access to an annual health check specifically tailored to their needs, funded through Medicare. This health check aims to identify and treat common health conditions that disproportionately affect First Nations people, such as diabetes and heart disease, promoting early detection and intervention.

During the health check, a General Practitioner (GP) or a multidisciplinary team led by a GP will assess the individual's physical, psychological, and social wellbeing, providing necessary health-related information, advice and care. If required, the GP may also refer the person to other healthcare professionals, such as physiotherapists, podiatrists, or dietitians, for free follow-up care under a list of First Nations Medicare items.

This report, updated annually, presents the latest data and trends in the use of First Nations health checks and follow-up services, disaggregated by age, sex and geography. For the first time, it also presents exploratory analyses of patterns of health check and follow-up use across areas with different socioeconomic circumstances.

Note that many patient counts are presented as proportions of the First Nations population, based on the Australian Bureau of Statistics' (ABS) 2016 Census-based *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, Reference period 2006 - 2031* (ABS 2019b). When the corresponding 2021 Census-based population series is available for future updates, proportions presented here may change considerably.

A summary of the key findings is listed below.

Key findings

Health check uptake dropped for the third year in a row

24% of First Nations people (209,000 people) had a health check in 2021-22, compared with 27% in 2020-21 (237,000 people) and the peak uptake of 29% in 2018-19 (241,000 people). See [National use of health checks](#).

Older age groups had the highest health check uptake

In 2021-22, First Nations people aged 65 and over had the highest uptake of health checks, at 36% of the population. The age group with the lowest uptake of health checks was 15-24-year-olds, at 19%. See [National use of health checks](#).

More females than males had health checks

In 2021-22, First Nations females had higher uptake of health checks than males, overall (25% and 22%, respectively), and had substantially higher uptake than males among people aged 25-34. See [National use of health checks](#).

Health check uptake differed vastly between areas

In 2021-22, the area with the highest uptake of health checks was *Townsville (SA4)*, at 46% of the First Nations population. At the low end, less than 5% of the First Nations population had a health check in some areas, such as *Sydney - Northern Beaches (SA4)* and *Melbourne - Outer East (SA4)*. See comparisons of health check use by [states and territories](#), [PHN regions](#), [Remoteness Areas](#), [GCCSAs](#), [Indigenous Regions](#) and [SA4s](#).

Health check uptake fell further in more disadvantaged areas

The uptake of annual health checks fell from 35% to 23% between 2017-18 and 2021-22 in the most socioeconomically disadvantaged group of areas (SA3s). In comparison, the health check uptake in the most advantaged group of areas only fell from 15.7% to 14.5%. See [Comparison of areas grouped by socioeconomic similarity](#).

Over half of the First Nations population had a health check in 5 years

Over the 5-year period from 1 July 2017 to 30 June 2022, about 560,000 First Nations people received at least one health check. This is equivalent to over half (63%) of the projected First Nations population at 30 June 2022. See [Cumulative health checks](#).

People in more remote areas wait the longest between health checks

In 2021-22, the average First Nations health check patient living in *Very remote* areas had their previous health check 28 months earlier, compared with 23 months earlier among patients living in *Major cities*. See [Time between health checks](#).

Follow-up services fell for the second year in a row

Fewer First Nations people received First Nations follow-up services in 2021-22 than in 2020-21 (143,000 people in 2021-22 compared with 155,000 people in 2020-21). See [Numbers of follow-ups delivered](#).

Most follow-up services were delivered by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse

In 2021-22, the vast majority of First Nations follow-up services were delivered by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (256,000 out of the total 314,000 services, or 82%), as opposed to an allied health professional, with referral from a GP (58,000 services). See [Types of follow-up](#).

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

Among the patients who received a First Nations health check in 2020-21, 46% received a First Nations follow-up service in the 12 months following their health check (109,000 out of 237,000 patients). Patients aged 65-74 had the highest follow-up percentage, at 56%, and females had a higher follow-up percentage than males in every adult age group. See [National use of follow-ups](#).

The proportion of health check patients who received a follow-up service plateaued

From 2018-19 to 2020-21, the proportion of First Nations health check patients who had a follow-up service in the 12 months following their health check remained between 47% and 46%. In earlier years, the follow-up percentage increased annually. See [National use of follow-ups](#).

Data in this release

This report update includes the latest data and time-series outlined below in Table 1.

Changes in this edition:

- New exploratory analyses are presented for clusters of areas, grouped by socioeconomic similarity.
- Health check data for Primary Health Networks (PHNs) are newly disaggregated by age group.
- New Statistical Area Level 4 (SA4) data replaces Statistical Area Level 3 (SA3) data.
- New time-series data are added to all analyses.
- Patient counts are no longer disaggregated by telehealth status. A short analysis covers monthly health check services delivered via telehealth from 2020-2022.
- Temporary MBS items relating to services delivered in Residential Aged Care are removed from the analyses.

Table 1: Summary of data in this report update


Chapter	Results
Health checks	<p>National uptake by age and sex, 2011-12 to 2021-22⁽¹⁾</p> <p>State/territory and Primary Health Network (PHN) uptake by age, 2016-17 to 2021-22⁽¹⁾</p> <p>Remoteness Area, Indigenous Region (IREG), Greater Capital City Statistical Area (GCCSA) and Statistical Area Level 4 (SA4) uptake, 2016-17 to 2021-22⁽¹⁾</p> <p>Uptake by socioeconomic clusters, 2016-17 to 2021-22⁽¹⁾</p> <p>Cumulative health checks, July 2012 to June 2022⁽¹⁾</p> <p>Time between health checks by sex, by age, by state/territory, by Remoteness Area, 2016-17 to 2021-22</p> <p>Telehealth services per month, January 2020 to December 2022</p>
Follow-up services overview	<p>Follow-up use by age and sex, 2011-12 to 2021-22</p> <p>Follow-up use by practitioner type, 2016-17 to 2021-22</p>
Health checks resulting in a follow-up	<p>Follow-up percentages by age and sex, 2011-12 to 2020-21⁽²⁾</p> <p>State/territory, PHN, Remoteness Area, IREG, GCCSA and SA4 follow-up percentages, 2016-17 to 2020-21⁽²⁾</p> <p>Follow-up percentages by socioeconomic clusters, 2016-17 to 2020-21⁽²⁾</p> <p>Cumulative follow-ups, 2016-17 to 2020-21</p>

Notes:

1. Health check uptake shows patient numbers as a proportion of the First Nations population, based on the ABS' Aboriginal and Torres Strait Islander population estimates and projections for the 2006-2031 reference period (2016-based).
2. Follow-up percentages show the proportion of health check patients each year, who received a First Nations follow-up service within 12 months of their health check.

References

ABS (Australian Bureau of Statistics) (2019b) *Estimates and projections, Aboriginal and Torres Strait Islander Australians, 2006 - 2031*, ABS website, Australian Government, accessed 10 August 2023.

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Health checks

On this page:

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- [List of subchapters](#)
- [Medicare Benefits Schedule \(MBS\) items](#)
- [Notes on reporting](#)
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Background

Aboriginal and Torres Strait Islander (First Nations) people can receive an annual health check, designed specifically for First Nations people and funded through Medicare (DHAC 2022a). This health check was introduced in recognition that First Nations people, as a group, experience some particular health risks (see [Timeline of major developments in health check implementation](#)).

The aim of these health checks is to encourage early detection and treatment of common conditions that cause ill health and early death - for example, diabetes and heart disease.

During the health check, a General Practitioner (GP) - or a multidisciplinary team led by a GP - will assess a person's physical, psychological and social wellbeing (DHAC 2022a). The GP can then provide the person with health-related information, advice and care.

The GP may also refer the person to other health care professionals for follow-up care, as needed - for example, physiotherapists, podiatrists or dietitians (See [Follow-up services overview](#) and [Health checks resulting in a follow-up](#)).

Example health check templates for 5 different life stages can be downloaded from the [Royal Australian College of General Practitioners website](#).

As part of the Australian Government's COVID-19 response, telehealth items were introduced in March 2020 to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (DHAC 2022b). Telehealth consultations may be used for gathering information, but physical examination components are requirements of all health checks (RACGP 2020).

Data from the Aboriginal and Torres Strait Islander primary health care national Key Performance Indicators (nKPIs) data collection suggest that GPs at Aboriginal Community Controlled Health Services (ACCHSs) conduct nearly half of all health checks despite only making up about 1.8% of fulltime-equivalent general practitioners (GPs). See [Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013-2023](#) (AIHW 2021).

List of subchapters

- [National use of health checks](#)
- [State and territory comparisons](#)
- [Primary Health Network \(PHN\) comparisons](#)
- [Remoteness Area comparisons](#)
- [Greater Capital City Statistical Area \(GCCSA\) comparisons](#)
- [Indigenous Region \(IREG\) comparisons](#)
- [Statistical Area Level 4 \(SA4\) comparisons](#)
- [Comparison of areas grouped by socioeconomic similarity](#)
- [Comparison of areas by socioeconomic ranking](#)
- [Cumulative health checks](#)
- [Time between health checks](#)
- [Telehealth items](#)

Medicare Benefits Schedule (MBS) items

This chapter presents information on the use of the following MBS items:

Table 2: List of MBS items for First Nations health checks

MBS item no.	Description	Mode of delivery
715	Health check provided by a GP	Face-to-face
228	Health check provided by a medical practitioner other than a GP (available from 1 July 2018)	Face-to-face
92004	Health check provided by a GP (available from 30 March 2020)	Videoconference

92016	Health check provided by a GP (available from 30 March 2020 to 30 June 2021)	Telephone
92011	Health check provided by a medical practitioner other than a GP (available from 30 March 2020)	Videoconference
92023	Health check provided by a medical practitioner other than a GP (available from 30 March 2020 to 30 June 2021)	Telephone

Note: Outside of MBS item descriptions for health checks, the term 'GP' is used as a generic reference to all medical practitioners providing primary health care services.

The data include health checks billed to Medicare by Aboriginal Community Controlled Health Services (ACCHSs) or other First Nations health services, as well as by mainstream GPs.

Note that the data are limited to First Nations MBS items billed to Medicare, and do not provide a complete picture of health checks provided to First Nations people. For example, First Nations people may receive similar care through: mainstream MBS items (that is, items that are not specific to First Nations people); through MBS items delivered in residential aged care; through the Child Health Check Initiative (CHCI) under the Northern Territory Emergency Response (NTER) that ended in June 2012; or through a health care provider who is not eligible to bill Medicare. Those have not been included in this report.

The minimum time allowed between health checks is 9 months. People can therefore receive more than one health check in a year.

Notes on reporting

- Throughout the report, 'First Nations health check' is used interchangeably with 'health check' to assist readability.
- People who received an MBS service are referred to as 'patients'.
- All people who received a First Nations MBS service are assumed to be First Nations people.
- To show the proportions of First Nations people who received a health check in a given year, or 'health check uptake', the number of patients was divided by population data based on the Australian Bureau of Statistics' (ABS) [Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 - 2031](#) (ABS 2019b).
 - Calendar-year data (30 June estimates) were converted to financial-year data by averaging estimates from consecutive years (approximating a 31 December estimate).
 - Series B projections, based on the 2016 Census of Population and Housing and 2016 Post Enumeration Survey, were used for years following the 2016 Census. Backcast population data were used for years before the 2016 Census.
 - For Primary Health Networks (PHN), Remoteness Areas, Greater Capital City Statistical Areas (GCCSA), Statistical Areas Level 4 (SA4), and socioeconomic clusters, projections have been approximated by the AIHW using 'iterative proportional fitting', supported by 2016 Census counts. This technique produces estimates that match the ABS' published outputs when summed back up to larger areas.
 - The ABS does not produce estimates of non-demographic changes over time, such as changes in whether a person identifies as Aboriginal and/or Torres Strait Islander between Censuses. However, due to non-demographic changes, population estimates based on the 2016 Census may be considerably lower than those based on the 2021 Census, meaning many of the proportions presented in this report may be overestimated. For example, the ABS estimates that there were 984,000 Aboriginal and/or Torres Strait Islander people on 30 June 2021 based on the 2021 Census (ABS 2023), compared with a projected 879,000 people on 30 June 2021, based on the 2016 Census (ABS 2019b).
 - Population estimates from the ABS represent the population at a point in time (a stock measure), while patients in the MBS data are counted over a period of time (a flow measure). This mismatch can lead to bias since the population estimate may not accurately reflect the population able to receive an MBS service throughout the entire period.
- MBS health checks in this chapter are reported by date of service, which was not necessarily the date that the service was processed by Services Australia. MBS services in this chapter were processed on or before 30 April 2023, except for monthly data by telehealth status (on or before 30 June 2023).

References

ABS (Australian Bureau of Statistics) (2019b) [Estimates and projections, Aboriginal and Torres Strait Islander Australians, 2006 - 2031](#), ABS website, Australian Government, accessed 10 August 2023.

ABS (2023) [Estimates of Aboriginal and Torres Strait Islander Australians, 30 June 2021](#), ABS website, Australian Government, accessed 31 August 2023.


AIHW (Australian Institute of Health and Welfare) (2021) [Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013-2023](#), AIHW, Australian Government, accessed 10 August 2023.

DHAC (Department of Health and Aged Care) (2022a) [Annual health checks for Aboriginal and Torres Strait Islander people](#), DHAC website, Australian Government, accessed 10 August 2023.

DHAC (2022b) [COVID-19 temporary MBS telehealth services](#), DHAC website, Australian Government, accessed 10 August 2023.

RACGP (Royal Australian College of General Practitioners) (n.d.) [Resources to support health checks for Aboriginal and Torres Strait Islander people](#), RACGP website, accessed 10 August 2023.

RACGP (2020) [Telehealth - considerations for an effective Aboriginal and Torres Strait Islander health check](#), RACGP, accessed 10 August 2023.

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Health checks

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Latest data

In 2021-22:

- 209,000 people had a First Nations health check.
- 24% of the First Nations population projection had a health check.

By sex

In 2021-22:

- 25% of females had a health check (113,000 patients).
- 22% of males had a health check (95,500 patients).

By age

In 2021-22:

- Uptake of health checks generally increased with age, after an initial decline.
- People aged 75 years and over had the highest uptake of health checks, at 36% (5,000 patients).
- People aged 15-24 years had the lowest uptake of health checks, at 19% (31,700 patients).

By age and sex

In 2021-22:

- Males aged 15-24 had the lowest uptake of health checks of any male or female age group, at 15%.
- Females had higher uptake of health checks than males in nearly every age group. Males had slightly higher uptake in age groups, 0-4 and 5-14.
- People aged 25-34 had the highest difference in health check uptake between males and females, at 16% for males and 25% for females.
- Age groups, 0-4 and 75 and over, had the smallest differences in health check uptake between males and females.

Trends over time

Between 2011-12 and 2021-22:

- The proportion of people who had a health check increased from 13% in 2011-12 to 29% in 2018-19 (94,800 and 241,000 patients in respective years).
- Since 2018-19, the proportion who had a health check dropped each year - from 29% in 2018-19 to 24% in 2021-22 (or 241,000 patients to 209,000 patients).
 - The drop was particularly sharp in 2021-22, changing from 27% in 2020-21 (237,000 patients).
- A higher proportion of females had a health check in each year, compared with males.
- Younger age groups had relatively large falls in health check uptake since 2018-19, compared with older age groups.

Figure 1: Use of First Nations health checks, by age group, by sex, 2011-12 to 2021-22

A set of interactive graphs over 4 tabs. Refer to table HC01 in data tables. A long description is available below.

Health check uptake (%), Australia, 2021-22

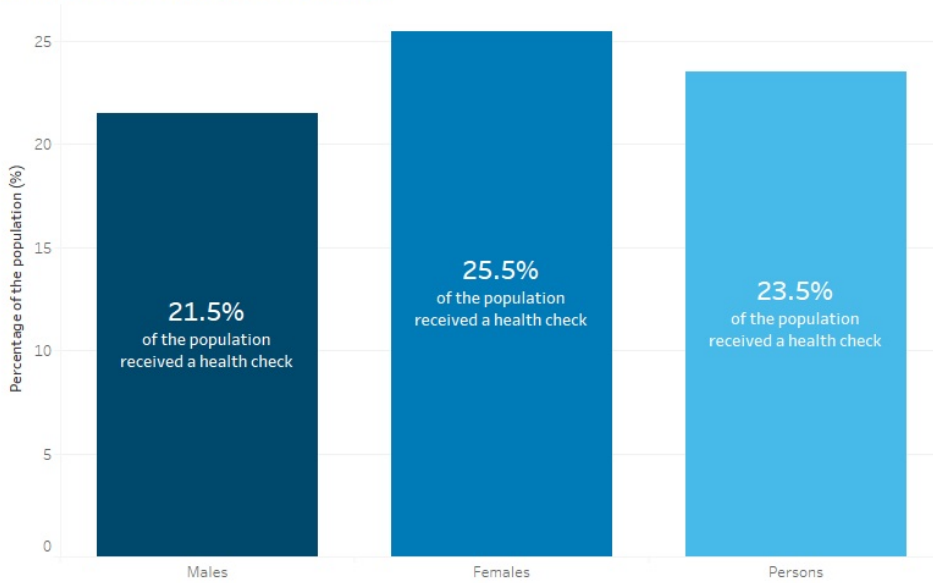


Figure 1.1: Use of First Nations health checks, by sex, 2011-12 to 2021-22

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; populations based on Australian Bureau of Statistics (ABS) data.
<https://www.aihw.gov.au/>

Long description for Figure 1

A set of interactive graphs over 4 tabs. The first is a column graph showing uptake of health checks by sex, showing females had higher uptake of health checks in 2021-22. The second is a column graph showing uptake of health checks increasing by age in 2021-22. The third is a line graph showing uptake by sex trending up from 2011-12 to 2018-19, then trending down to 2021-22. The fourth is a line graph showing uptake by age group trending up from 2011-12 to 2018-19, then trending down to 2021-22. Refer to table HC01 in data tables.

Health checks

On this page:

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Explore the data in the visualisation below.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- Queensland had the highest uptake of health checks, at 30% (75,200 patients).
- Victoria had the lowest uptake of health checks, at 11% (7,300 patients).

By age

In 2021-22:

- People aged 55 and over were the age group with the highest uptake of health checks in every state and territory.
- Tasmania had the widest range in uptake across age groups, with 7.8% among 5-14-year-olds and 29% among those aged 55 and over.

Trends over time

Between 2016-17 and 2021-22:

- In most states and territories, the proportion of people receiving a health check was lower in 2021-22 compared with 2016-17, after an initial rise in uptake.
- Tasmania had the largest percentage-point increase in health check uptake, rising from 10% in 2016-17 to 14% by 2021-22 (2,900 patients to 4,500 in respective years).
 - Tasmania's health check uptake surpassed that of Victoria and the Australian Capital Territory in recent years.
- The Northern Territory had the largest percentage-point decrease in health check uptake, falling from 37% in 2017-18 to 25% in 2021-22 (28,100 patients to 20,000 in respective years).

Figure 2: Use of First Nations health checks, by state and territory, by age group, 2016-17 to 2021-22

A set of interactive graphs over 4 tabs. Refer to table HC02 in data tables. A long description is available below.

Select measure
Percentage of population

Select age group
All ages

Select year
2021-22

Health check uptake (%), all ages, 2021-22

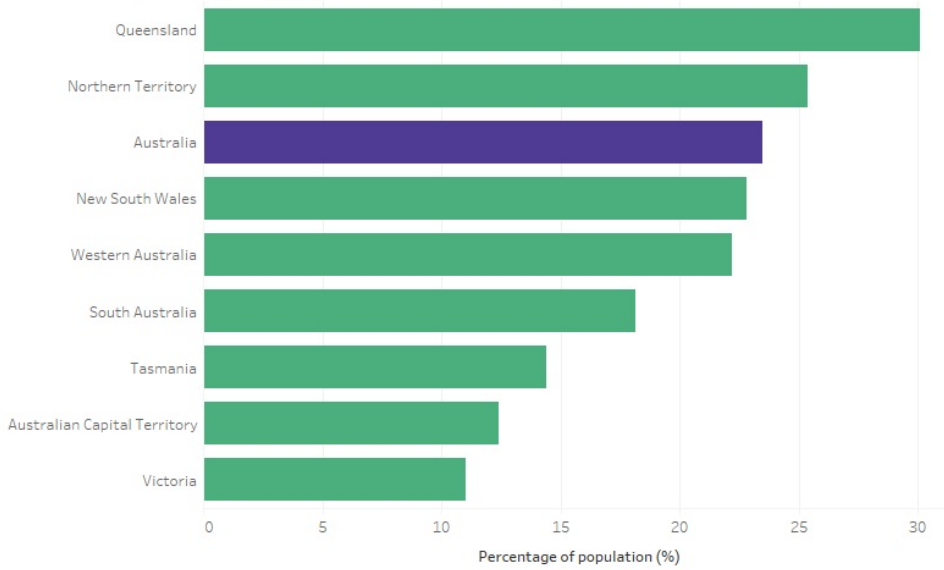


Figure 2.1: Use of First Nations health checks, by jurisdiction, by age group, 2016-17 to 2021-22

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; populations based on Australian Bureau of Statistics (ABS) data.
<https://www.aihw.gov.au/>

Long description for Figure 2

A set of interactive graphs over 4 tabs. The first is a bar graph showing uptake of health checks by jurisdiction, showing Queensland had the highest health check uptake in 2021-22. The second is a column graph showing uptake of health checks by age group, showing health check uptake was lowest among those aged 5-24 in 2021-22. The third is a line graph showing the varying uptake in health checks by jurisdiction from 2016-17 to 2021-22, decreasing across all jurisdictions from 2020-21 to 2021-22. The fourth is a line graph showing uptake of health checks by age group trending up from 2016-17 to 2018-19, then trending down to 2021-22. Refer to table HC02 in data tables.

Health checks

On this page:

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Explore the data in the visualisation below.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- Western NSW had the highest uptake of health checks, at 34% (13,300 patients).
- Northern Sydney had the lowest uptake of health checks, at 5.3% (238 patients).

By age

In 2021-22:

- People aged 55 and over were the age group with the highest uptake of health checks in every PHN.
- Tasmania had the widest range in uptake across age groups, with 7.8% among 5-14-year-olds and 29% among those aged 55 and over.

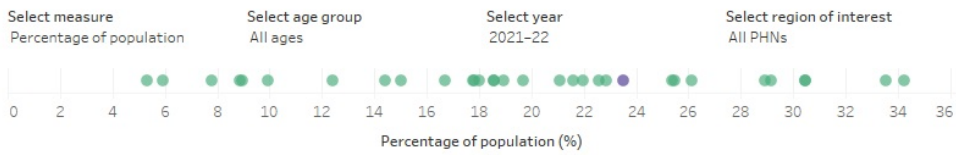
Trends over time

Between 2016-17 and 2021-22:

- In around three-quarters of PHNs (24 out of 31), the proportion of people receiving a health check was lower in 2021-22 compared with 2016-17, after an initial rise in uptake.
- Western Sydney had the largest percentage-point increase in health check uptake, rising from 9.4% in 2016-17 to 22% by 2021-22 (2,100 patients to 3,800 in respective years).
- Western Queensland had the largest percentage-point decrease in health check uptake, falling from 42% in 2017-18 to 22% in 2021-22 (5,400 patients to 3,400 in respective years).

Figure 3: Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016-17 to 2021-22

A set of interactive graphs over 5 tabs. Refer to table HC03 in data tables. A long description is available below.



Health check uptake (%), all ages, 2021-22

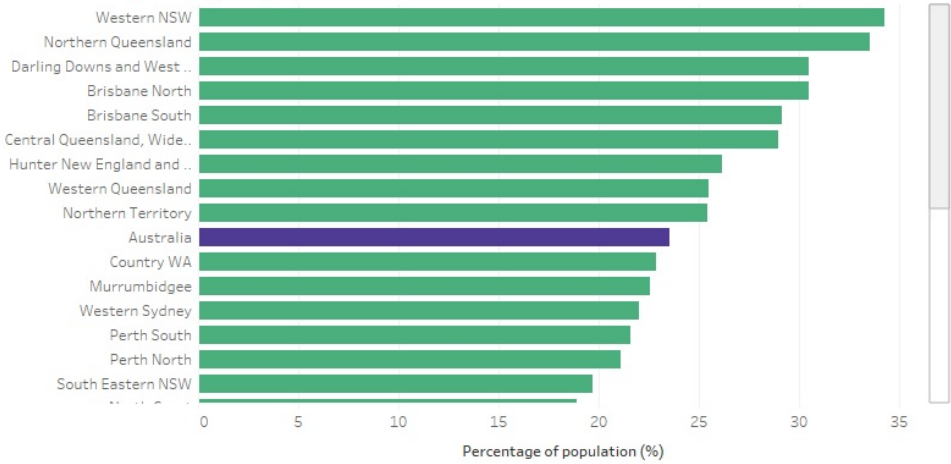


Figure 3.1: Use of First Nations health checks, by Primary Health Network (PHN), by age group, 2016-17 to 2021-22

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; AIHW analysis of Australian Bureau of Statistics (ABS) population data.
<https://www.aihw.gov.au/>

Long description for Figure 3

A set of interactive graphs over 5 tabs. The first is a bar graph showing uptake of health checks by PHN, showing Western NSW was the PHN with the highest health check uptake in 2021-22. The second shows health check uptake by PHN on a map. The third is a column graph showing uptake of health checks by age group, showing health check uptake was lowest among those aged 5-24 in 2021-22. The fourth is a line graph showing the varying uptake in health checks by PHN from 2016-17 to 2021-22, generally decreasing in the last year. The fifth is a line graph showing uptake of health checks by age group trending up from 2016-17 to 2018-19, then trending down to 2021-22. Refer to table HC03 in data tables.

Health checks

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Explore the data in the visualisation below.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- *Major cities* had the tied lowest uptake of health checks, at 21% (71,200 patients).
- *Inner regional* areas had a health check uptake of 23% (50,900 patients).
- *Outer regional* areas had the highest uptake of health checks, at 31% (51,600 patients).
- *Remote* areas had a health check uptake of 26% (15,000 patients).
- *Very remote* areas had the tied lowest uptake of health checks, at 21% (20,000 patients).

Trends over time

Between 2016-17 and 2021-22:

- In almost all Remoteness Areas, the proportion of people receiving a health check was lower in 2021-22 compared with 2016-17, after an initial rise in uptake.
- The only area with an increased health check uptake was *Major cities*, though the increase was smaller than 1 percentage-point.
- *Remote* areas had the largest percentage-point decrease in health check uptake, falling from 39% in 2017-18 to 26% in 2021-22 (21,500 patients to 15,000 in respective years).

Figure 4: Use of First Nations health checks, by Remoteness Area, 2016-17 to 2021-22

A set of interactive graphs over 2 tabs. Refer to table HC04 in data tables. A long description is available below.

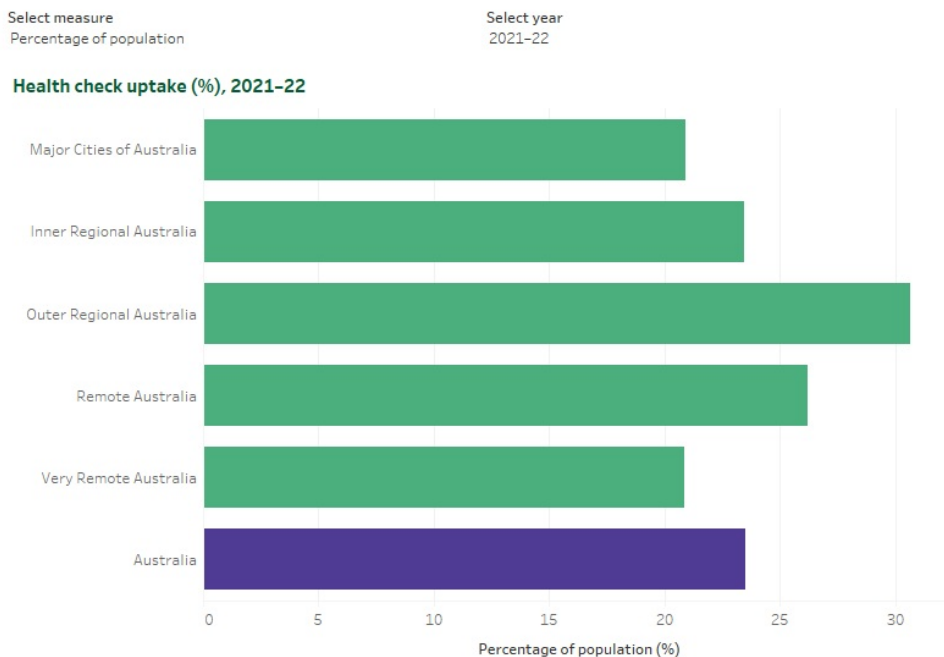


Figure 4.1: Use of First Nations health checks, by Remoteness Area, 2016-17 to 2021-22

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

<https://www.aihw.gov.au/>

Long description for Figure 4

A set of interactive graphs over 2 tabs. The first is a bar graph showing uptake of health checks by Remoteness Area, showing Outer Regional Australia had the highest uptake in 2021-22. The second is a line graph showing uptake of health check between 2016-17 and 2021-22, varying across Remoteness Areas. Refer to table HC04 in data tables.

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Health checks

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Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- *Greater Darwin* had the highest uptake of health checks, at 31% (5,900 patients).
- *Greater Melbourne* had the lowest uptake of health checks, at 7.7% (2,600 patients).

Trends over time

Between 2016-17 and 2021-22:

- In about three-quarters of GCCSAs (11 out of 15), the proportion of people receiving a health check was lower in 2021-22 compared with 2016-17, after an initial rise in uptake.
- *Greater Hobart* had the largest percentage-point increase in health check uptake, rising from 9.8% in 2016-17 to 16% by 2021-22 (1,000 patients to 1,800 in respective years).
- *Rest of NT* had the largest percentage-point decrease in health check uptake, falling from 37% in 2017-18 to 24% in 2021-22 (21,800 patients to 14,000 in respective years).

Figure 5: Use of First Nations health checks, by Greater Capital City Statistical Area (GCCSA), 2016-17 to 2021-22

A set of interactive graphs over 2 tabs. Refer to table HC05 in data tables. A long description is available below.

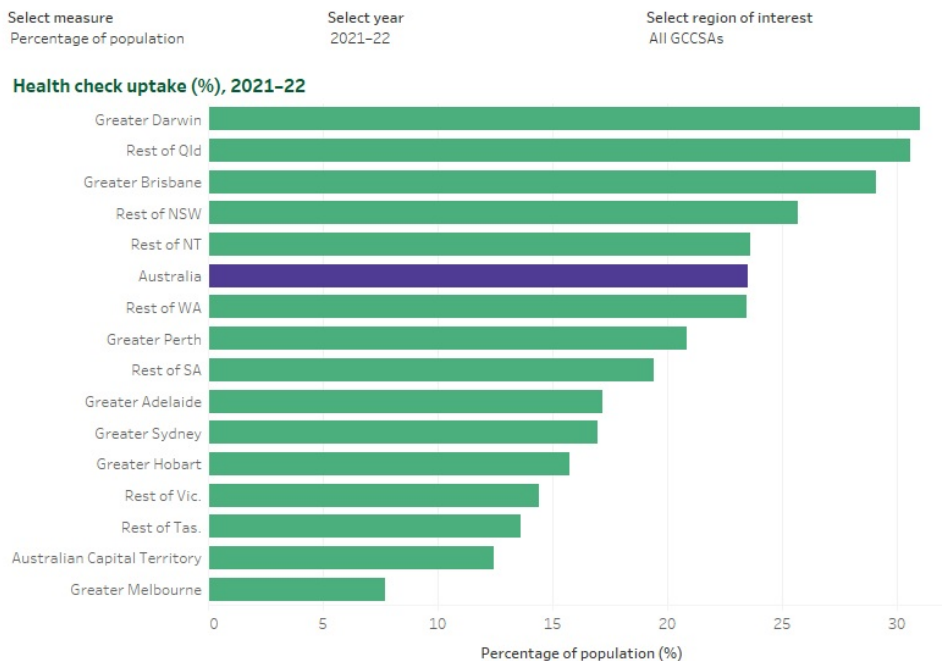


Figure 5.1: Use of First Nations health checks, by Greater Capital City Statistical Area (GCCSA), 2016-17 to 2021-22

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

<https://www.aihw.gov.au/>

Long description for Figure 5

A set of interactive graphs over 2 tabs. The first is a bar graph showing uptake of health checks by GCCSA, showing Greater Darwin was the GCCSA with the highest health check uptake in 2021-22. The second is a line graph showing the varying uptake in health checks by GCCSA from 2016-17 to 2021-22, decreasing across all GCCSA from 2020-21 to 2021-22. Refer to table HC05 in data tables.

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Health checks

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- *Alice Springs* had the highest uptake of health checks, at 40% (2,800 patients).
- *Melbourne* had the lowest uptake of health checks, at 7.8% (2,500 patients).

Trends over time

Between 2016-17 and 2021-22:

- In three-quarters of IREGs (28 out of 37), the proportion of people receiving a health check was lower in 2021-22 compared with 2016-17, after an initial rise in uptake.
- *Tasmania* had the largest percentage-point increase in health check uptake, rising from 10% in 2016-17 to 14% by 2021-22 (2,900 patients to 4,500 in respective years).
- *Alice Springs* had the largest percentage-point decrease in health check update, falling from 71% in 2017-18 to 40% in 2021-22 (4,900 patients to 2,800 in respective years).

Figure 6: Use of First Nations health checks, by Indigenous Region (IREG), 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to table HCO6 in data tables. A long description is available below.

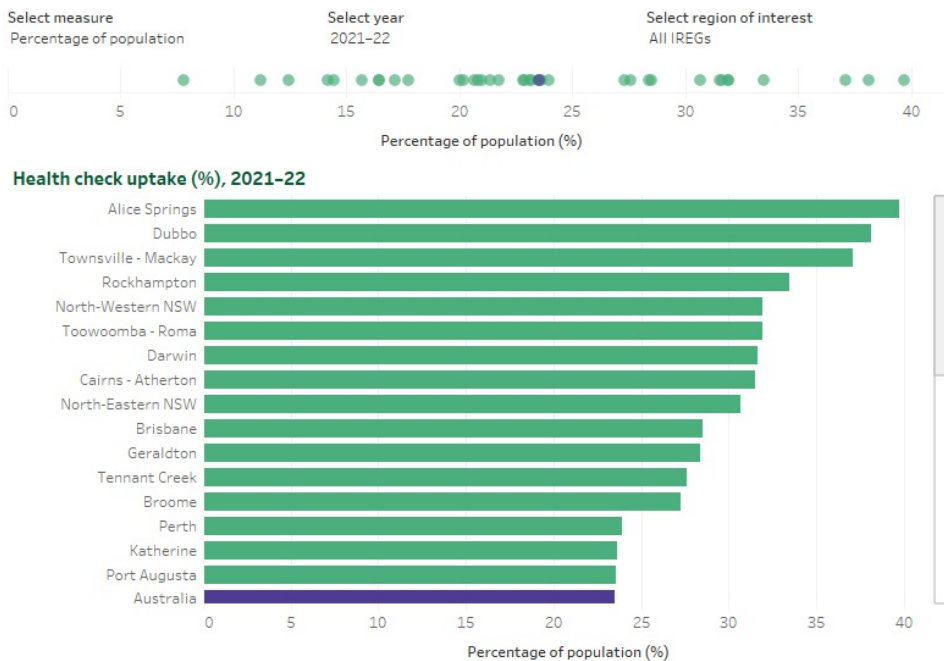


Figure 6.1: Use of First Nations health checks, by Indigenous Region (IREG), 2016-17 to 2021-22

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

<https://www.aihw.gov.au/>

Long description for Figure 6

A set of interactive graphs over 3 tabs. The first is a bar graph showing uptake of health checks by IREG, showing Alice Springs was the IREG with the highest health check uptake in 2021-22. The second shows health check uptake by IREG on a map. The third is a line graph showing the varying uptake in health checks by IREG from 2016-17 to 2021-22, generally decreasing in the last year. Refer to table HC06 in data tables.

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Health checks

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Geographic information

This analysis is based on the postcode of the patient’s given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- *Townsville* (Queensland) had the highest uptake of health checks, at 46% (10,300 patients).
- *Sydney - Northern Beaches* had the lowest uptake of health checks, at 3.2% (57 patients).

Trends over time

Between 2016-17 and 2021-22:

- In about two-thirds of SA4s (57 out of 88), the proportion of people receiving a health check was lower in 2021-22 compared with 2016-17, after an initial rise in uptake.
- *Sydney - Blacktown* had the largest percentage-point increase in health check uptake, rising from 14% in 2016-17 to 26% by 2021-22 (1,600 patients to 3,300 in respective years).
- *Shepparton* (Victoria) had the largest percentage-point decrease in health check update, falling from 33% in 2016-17 to 19% in 2021-22 (1,400 patients to 860 in respective years).

Figure 7: Use of First Nations health checks, by Statistical Area Level 4 (SA4), 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to table HC07 in data tables. A long description is available below.

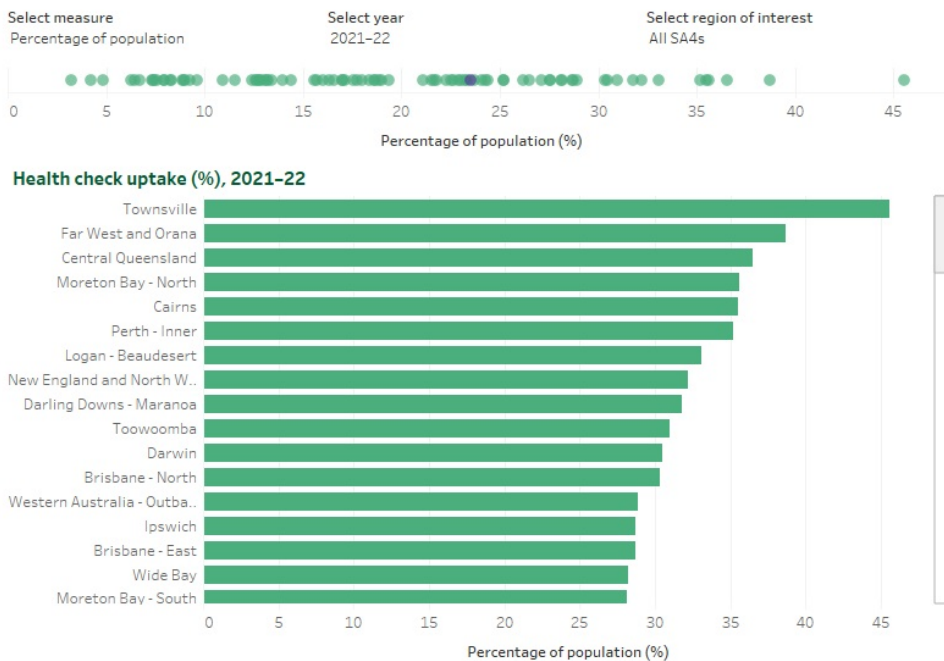


Figure 7.1: Use of First Nations health checks, by Statistical Area Level 4 (SA4), 2016-17 to 2021-22

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

<https://www.aihw.gov.au/>

Long description for Figure 7

A set of interactive graphs over 3 tabs. The first is a bar graph showing uptake of health checks by SA4, showing Townsville was the SA4 with the highest health check uptake in 2021-22. The second shows health check uptake by SA4 on a map. The third is a line graph showing the varying uptake in health checks by SA4 from 2016-17 to 2021-22. Refer to table HC07 in data tables.

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Health checks

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Exploratory analysis: Areas grouped by socioeconomic similarity

- Statistical Areas Level 3 (SA3s) were grouped into 5 clusters, based on the proportion of Aboriginal and/or Torres Strait Islander people counted in each decile from the ABS' 2016 Census-based Index of Household Advantage and Disadvantage (IHAD) analysis (ABS 2019a). All clusters contain some people from each of the 10 IHAD deciles, but the proportions vary considerably. Note that socioeconomic characteristics may have changed over time.
- The 5 socioeconomic clusters in this section contain different numbers of SA3s and different numbers of First Nations people.
- Clusters were designed to capture targeted population proportions. Population apportionment was based on the Aboriginal and/or Torres Strait Islander estimated resident population in 2016 by SA3 (ABS 2018). The first cluster contains approximately 10% of the First Nations population; the second, 20%; the third, 40%; the fourth, 20%; and the fifth, 10%.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

In 2021-22:

- The proportion of the population that received a health check decreased somewhat with increasing socioeconomic advantage.
- People living in the most advantaged (fifth) cluster of SA3s had the lowest health check uptake, at 14% (13,500 patients).
- The second cluster had the highest health check uptake, at 27% (44,800 patients).
- The most disadvantaged (first) cluster had health check uptake of 23% (18,100 patients).

By age

In 2021-22:

- Among young children (ages 0-4), those from the most disadvantaged cluster of SA3s had the highest uptake of health checks, at 30%, with uptake dropping in increasingly advantaged clusters.
- People in all other age groups had lower uptake of health checks in the most disadvantaged (first) cluster, relative to the second cluster.

Trends over time

Between 2016-17 and 2021-22:

- In earlier years, the most disadvantaged clusters tended to have comparatively high uptake of health checks.
- Between 2020-21 and 2021-22, health check uptake in the most disadvantaged (first) cluster fell from 30% to 23% (23,200 patients to 18,100).
 - The decrease was particularly sharp among 0-4-year-olds, whose uptake of health checks dropped from 43% in 2020-21 to 30% in 2021-22 (3,000 patients to 2,000).

Figure 8: Use of First Nations health checks, by socioeconomic cluster, by age group, 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to table HC08 in data tables. A long description is available below.

Select measure
Percentage of population

Select age group
All ages

Select year
2021-22

Health check uptake (%), 2021-22

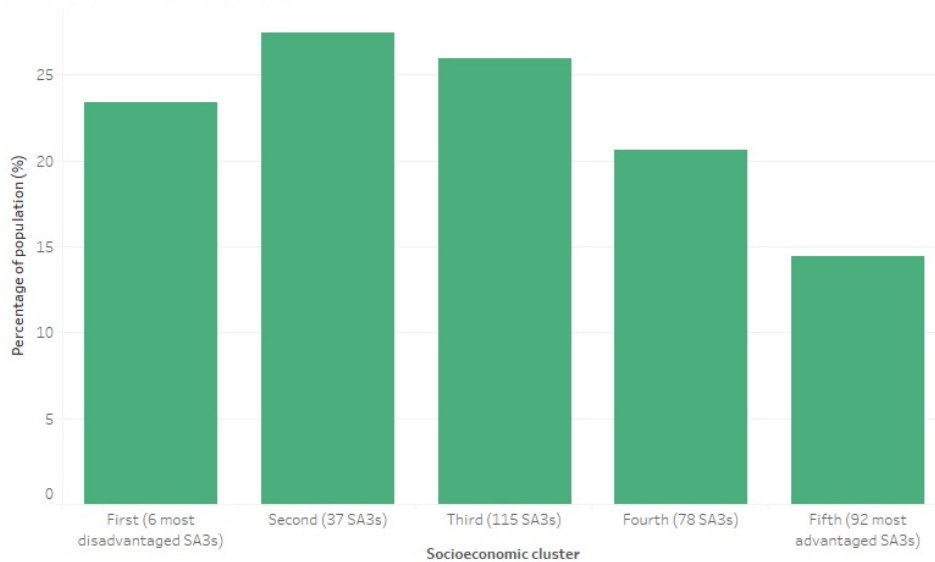


Figure 8.1: Use of First Nations health checks, by socioeconomic cluster, by age group, 2016-17 to 2021-22

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; AIHW analysis of Australian Bureau of Statistics (ABS) population data; AIHW analysis of ABS Census of Population and Housing data (2016).
<https://www.aihw.gov.au/>

Long description for Figure 8

A set of interactive graphs over 3 tabs. The first is a column graph showing uptake of health checks by socioeconomic cluster, showing health check uptake generally decreasing with increasing socioeconomic advantage in 2021-22. The second is a line graph showing uptake of health checks by socioeconomic cluster between 2016-17 and 2021-22, showing that between 2020-21 and 2021-22 the health check uptake dropped the most among people living in the most disadvantaged socioeconomic cluster. The third is a line graph showing age-specific uptake of health checks in the various socioeconomic clusters between 2016-17 and 2021-22, showing health check uptake has been trending down in every age group in the most disadvantaged socioeconomic cluster since 2017-18. Refer to table HC08 in data tables.

References

ABS (2018) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, ABS website, Australian Government, accessed 10 August 2023.

ABS (Australian Bureau of Statistics) (2019a) *Experimental Index of Household Advantage and Disadvantage, 2016*, ABS, Australian Government, accessed 10 August 2023.



Health checks

Exploratory analysis: Areas ranked by socioeconomic profile

- Relative socioeconomic scores were calculated for PHNs, IREGs and SA4s based on the number of Aboriginal and/or Torres Strait Islander people counted in each decile from the ABS' 2016 Census-based Index of Household Advantage and Disadvantage (IHAD) analysis (ABS 2019a).
- Effectively, the socioeconomic scores for each area give the average IHAD decile number for the First Nations population (living in private dwellings). Note that socioeconomic characteristics may have changed over time.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Between 2016-17 and 2021-22:

- While there was a considerable amount of deviation, First Nations people living in more disadvantaged PHNs and SA4s tended to have higher uptake of health checks than those living in more advantaged PHNs and SA4s.
 - This pattern was more pronounced in the earlier years of the time-series, becoming less noticeable in 2021-22.
 - This tendency did not hold when comparing IREGs.
- Some SA4 populations had relatively high uptake of health checks - compared with SA4s with similar socioeconomic profiles - many of which were in Queensland.

Figure 9: Use of First Nations health checks, by geographic area, by socioeconomic ranking, 2016-17 to 2021-22

An interactive graph. Refer to table HC09 in data tables. A long description is available below.

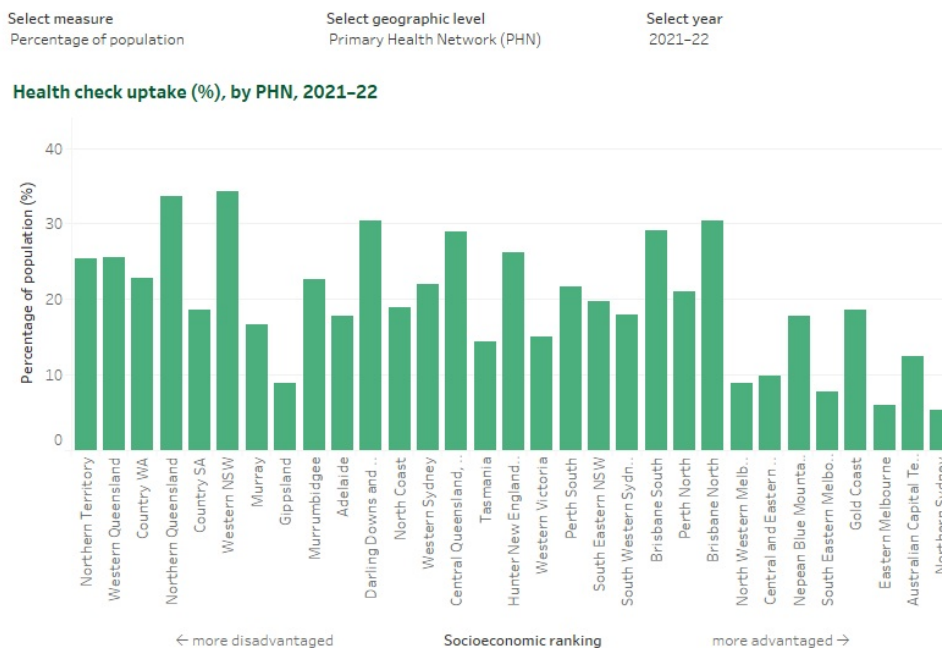


Figure 9.1: Use of First Nations health checks, by geographic area, by socioeconomic ranking, 2016-17 to 2021-22

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; AIHW analysis of Australian Bureau of Statistics (ABS) population data; AIHW analysis of ABS Census of Population and Housing data (2016).
<https://www.aihw.gov.au>

Long description for Figure 9

An interactive column graph showing uptake of health checks by geographic area, sorted by the socioeconomic scores of areas, which suggests that health check uptake generally decreases as socioeconomic advantage increases. Refer to table HC09 in data tables.

References

ABS (Australian Bureau of Statistics) (2019a) *Experimental Index of Household Advantage and Disadvantage, 2016*, ABS, Australian Government, accessed 10 August 2023.



Health checks

On this page:

- [National data by sex](#)
- [States and territories](#)

Explore the data in the visualisation below.

Notes

- Patients are counted by their number of health checks across 5-years.
- For comparisons by sex or by state and territory, patients are presented as a proportion of the estimated population at the end of the 5-years, and alternatively as a proportion of the total number of health check patients over 5-years.
- State or territory of residence was based on information from the most recent health check in the 5-year period. Patients may have received some or most of their earlier health checks in a different state or territory.
- Limitations: Some patients counted over the 5-years may have died or moved abroad, therefore proportions of the population may be overestimated. Children under 5 years old also skew the results, since they were born partway through the reference period.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

National data

Between July 2017 and June 2022:

- 560,000 First Nations people received at least one First Nations health check (equivalent to 63% of the projected population at 30 June 2022).
- The majority of those health check patients (59%) received at least 2 health checks over the 5-year period (330,000 out of 560,000).
- 15% of health check patients received 4 or more health checks over the 5-year period (85,000 out of 560,000).

By sex

Between July 2017 and June 2022:

- 294,000 (66%) of First Nations females received at least one health check.
- 267,000 (60%) of First Nations males received at least one health check.

Trends over time

Between July 2012 and June 2022:

- The proportion of the projected population who received at least one health check increased from 53% in the 5-year period ending 30 June 2017 to 63% in the 5-year period ending 30 June 2022 (428,000 patients, and 560,000, for the respective periods).
- Among those who had at least one health check, the proportion who received 2 or more health checks increased from 55% in the 5-year period ending 30 June 2017 to 59% in the 5-year period ending 30 June 2022 (237,000 patients, and 330,000, for the respective periods).

Figure 10: First Nations health check patients, by number of health checks over a 5-year period, by sex, July 2012 to June 2022

A set of interactive graphs over 3 tabs. Refer to table HC10 in data tables. A long description is available below.

Percentage of the population (%), by number of health checks over a 5-year period, July 2017 to June 2022

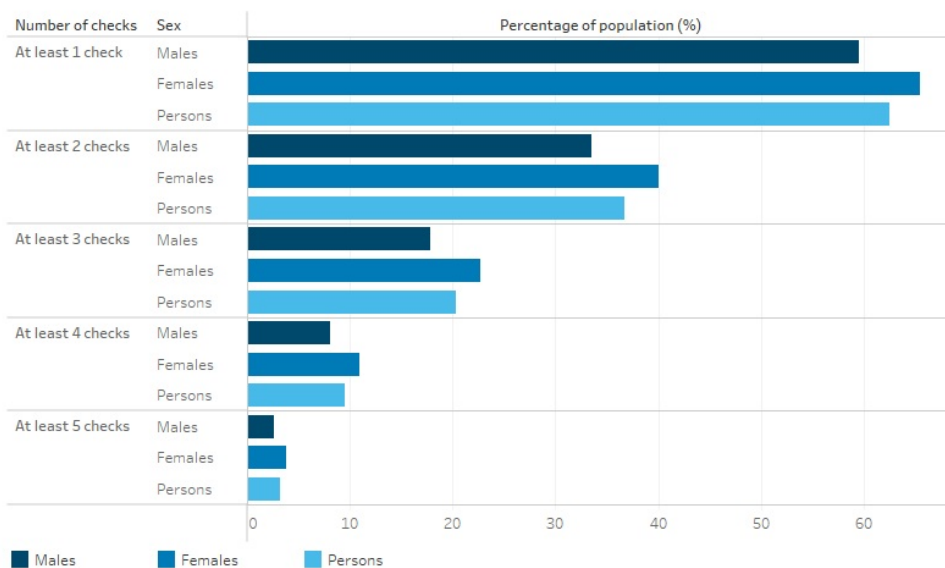


Figure 10.1: First Nations health check patients, by number of health checks over a 5-year period, by sex, July 2012 to June 2022

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

<https://www.aihw.gov.au/>

Long description for Figure 10

A set of interactive graphs over 3 tabs. The first is a bar graph showing the collective number of health checks received by patients over a period of 5 years, by sex. More than half of the First Nations population had at least one health check between July 2017 and June 2022. The second tab shows a line graph, following the use of health checks over 5-year periods by sex, starting at July 2012 to June 2017 and ending at July 2017 to June 2022. Collective health check use trended up in each 5-year period until July 2016 to June 2021, then decreased slightly for the period of July 2017 to June 2022. The third tab shows a line graph, with separate lines for each number of health checks received over 5 years, starting at July 2012 to June 2017 and ending at July 2017 to June 2022. There was little variation in how many people would have 5 or more health checks over a 5-year period, however, the proportion of people who had at least one health check during a 5-year period increased by 10 percentage points. Refer to table HC10 in data tables.

States and territories

Between July 2017 and June 2022:

- The Northern Territory had the highest proportion of people who had at least one health check, at 76% (59,700 patients).
- Tasmania had the lowest proportion of people who had at least one health check, at 36% (11,300 patients).

Trends over time

Between July 2012 and June 2022:

- The proportion of the projected population who received at least one health check increased in all states and territories from the 5-year period ending 30 June 2017 to the 5-year period ending 30 June 2022.
- Tasmania had the largest percentage-point increase in the proportion of the population who received at least one health check, rising from 20% in the 5-year period ending 30 June 2017 to 36% in the 5-year period ending 30 June 2022 (5,800 patients to 11,300, for the respective periods).
- The Northern Territory had the smallest percentage-point increase in the proportion of the population who received at least one health check, rising from 71% in the 5-year period ending 30 June 2017 to 76% in the 5-year period ending 30 June 2022 (53,800 patients to 59,700, for the respective periods).
- In the Australian Capital Territory, the proportion of total health check patients who received at 3 health checks over 5 years decreased from 35% at 30 June 2019 to 26% at 30 June 2022 (1,400 patients to 1,100, for the respective periods).

Figure 11: First Nations health check patients, by number of health checks over a 5-year period, by state and territory, July 2012 to June 2022

A set of interactive graphs over 4 tabs. Refer to table HC11 in data tables. A long description is available below.

Select measure
Percentage of population

Select number of health checks
At least 1 check

Select time period
July 2017 to June 2022

Percentage of the population who received at least 1 health check over a 5-year period (%), July 2017 to June 2022

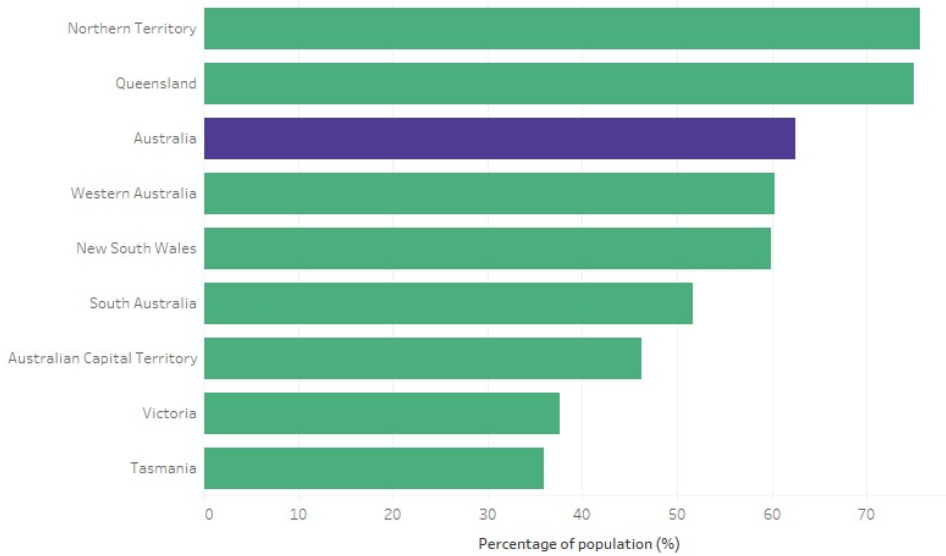


Figure 11.1: First Nations health check patients, by jurisdiction, by number of health checks over a 5-year period, July 2012 to June 2022

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; Australian Bureau of Statistics (ABS) population data.
<https://www.aihw.gov.au/>

Long description for Figure 11

A set of interactive graphs over 4 tabs. The first is a bar graph showing cumulative health checks over a 5-year period by jurisdiction, showing Northern Territory had the highest collective health check use between July 2017 and June 2022. The second is a bar graph showing the number of health checks had over a 5-year period within a selected jurisdiction, showing more than half of the First Nations population had at least one health check between July 2017 and June 2022. The third is a line graph, showing the cumulative use of health checks by jurisdiction in 5-year periods, starting at July 2012 to June 2017 and ending at July 2017 to June 2022. Collective health check use generally trended up, with only a few jurisdictions trending down in the more recent 5-year periods. The fourth is a line graph, showing separate lines for each number of health checks received over 5-year periods, starting at July 2012 to June 2017 and ending at July 2017 to June 2022. Refer to table HC11 in data tables.

Health checks

On this page:

- [National data](#)
- [Comparisons by sex](#)
- [Comparisons by age](#)
- [State and territory comparisons](#)
- [Remoteness Area comparisons](#)

Explore the data in the visualisations below.

Notes

- This section looks at the length of time between consecutive health checks for different groups of First Nations people. Specifically, the analyses relate to the length of time between a patient's most recent health check in a given year and their previous most recent health check, if any, back to November 1999 (when First Nations health checks were first introduced for people aged 55 and over).
- Proportions in this section use the group of patients who had at least one health check in a given reference year (for example, 2021-22) as the denominator, and not the estimated First Nations population. Therefore, the proportions are specific to the health check patients assessed in the reference year, and do not reflect the time between health checks for the entire First Nations population.
- People without a previous health check on record (in other words, those with only one recorded MBS-billed First Nations health check in the relevant period) are included in the reporting of proportions, but do not factor into the reporting of mean and median months between consecutive health checks.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

National data

Among health check patients in 2021-22:

- 41,000 people (20%) had their previous health check less than 12 months earlier.
- 37,000 people (18%) had their previous health check 12 to 14 months earlier.
- 33,200 (16%) had no previous health check on record and received their first health check in 2021-22.
 - Note that this includes children under 5 years old, 47% (11,100) of whom had no prior health check (shown later on this page).
- On average, people with at least one health check in 2021-22 and at least one earlier health check on record had their 2 most recent health checks 24.3 months apart. The median time between health checks was 16.2 months, for comparison.

Among health check patients from 2016-17 to 2021-22:

- The largest percentage-point change was in the proportion of people who had no previous health check which fell from 25% in 2016-17 to 16% in 2021-22 (52,400 patients to 33,200 in respective years).
- The average length of time since the last health check increased, rising from 22.4 months in 2016-17 to 24.3 months in 2021-22. The median length of time also rose across the same period, increasing from 15.3 to 16.2 months.

By sex

Among health check patients in 2021-22:

- More males (18% or 16,800 patients) received their first health check in 2021-22 than females (15% or 16,400 patients).
- Females had slightly less time between their most recent health checks, on average, than males (23.8 months compared with 24.8 months, respectively).

Among health check patients from 2016-17 to 2021-22:

- The proportion of females receiving their first health check fell from 23% in 2016-17 to 15% in 2021-22. In comparison, 27% of males had their first health check in 2016-17, dropping to 18% in 2021-22.
- Males and females had the same increase in the average length of time between their most recent health checks, both increasing by about 2 months over the time series.

Figure 12: First Nations health check patients, by time between their 2 most recent health checks, by sex, 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to tables HC12 and HC16 in data tables. A long description is available below.

Select year
2021-22

Health check patients (%), 2021-22

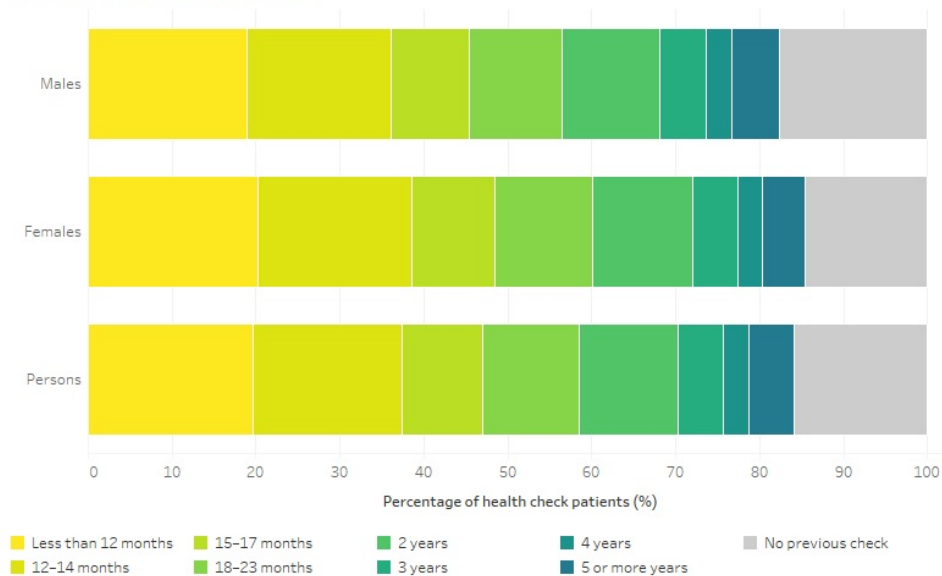


Figure 12.1: First Nations health check patients, by sex, by time since their previous health check, 2016-17 to 2021-22

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.

<https://www.aihw.gov.au/>

Long description for Figure 12

A set of interactive graphs over 3 tabs. The first is a stacked bar graph showing the proportion of health check patients by sex, by time since previous health check, showing that more than half of those who got a health check in 2021-22 last got a health check less than 2 years ago. The second is a bar graph, showing average and median time since previous health check, by sex. The third is a line graph, showing the development in time since previous health check between 2016-17 and 2021-22, by sex. Notably, the proportion of people who had no previous health trended down between 2016-17 and 2021-22. Refer to tables HC12 and HC16 in data tables.

By age

Among health check patients in 2021-22:

- Young children (0-4 years) were the most distinct group, with almost half (47%) receiving their first health check in 2021-22 (11,100 patients). This is partly due to their age, with young infants not being old enough to have received a second health check.
- Among those aged 5 and over, as age increased the time between health checks decreased with exception for those aged 15-24 years.
- People aged 15-24 years had the longest period between health checks (28.2 months on average) and highest proportion of patients without a previous health check on record (14%).

Between 2016-17 and 2021-22:

- The proportion of patients who had not received a previous health check, fell from 25% in 2016-17 to 16% in 2021-22 (52,400 patients to 33,200 in respective years).
- The average time between the 2 most recent health checks increased slightly by 1.9 months, from 22.4 months in 2016-17 to 24.3 months in 2021-22.
- The proportion of people with less than 15 months since their previous health check rose over 3 years (from 36% in 2016-17 to 40% in 2019-20, respectively) and then fell in the following 2 years (from 40% in 2019-20 to 37% in 2021-22 in respective years).

Figure 13: First Nations health check patients, by time between their 2 most recent health checks, by age group, 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to tables HC13 and HC16 in data tables. A long description is available below.

Select year
2021-22

Health check patients (%), 2021-22

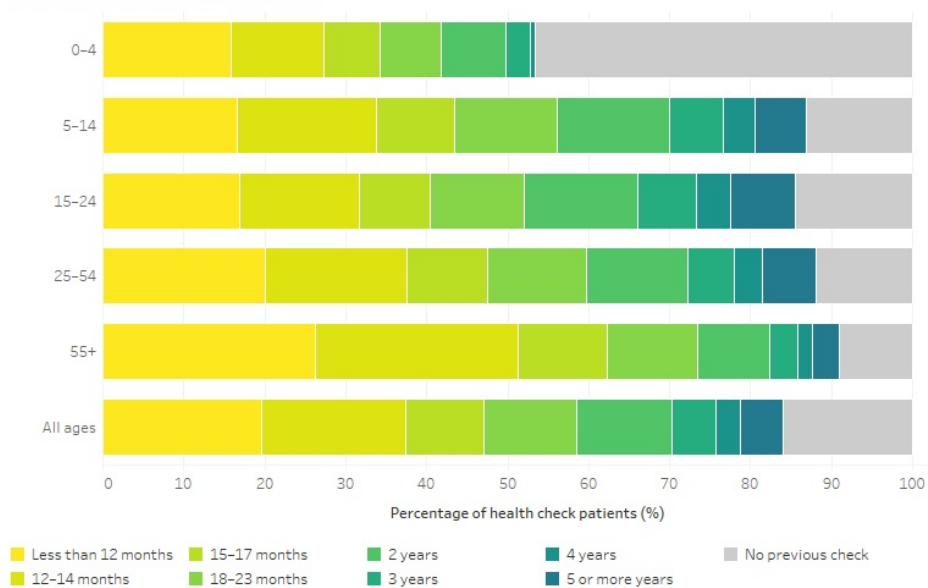


Figure 13.1: First Nations health check patients, by age group, by time since their previous health check, 2016-17 to 2021-22

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.

<https://www.aihw.gov.au/>

Long description for Figure 13

A set of interactive graphs over 3 tabs. The first is a stacked bar graph showing the proportion of health check patients by age group, by time since previous health check, showing that time since previous health check generally trended down as age increased, in 2021-22. The second is a bar graph, showing average and median time since previous health check, by age group. The average time since previous health check was longest for those aged 15-24 in 2021-22. The third is a line graph, showing the development in time since previous health check between 2016-17 and 2021-22, by age group. The average number of months since previous health check trended up for all age groups between 2019-20 and 2021-22. Refer to tables HC13 and HC16 in data tables.

Comparisons between areas

States and territories

Among health check patients in 2021-22:

- Victoria had the highest proportion of patients without a prior health check, at 25% (1,900 patients), as well as the longest average period between most recent health checks (27.2 months).
- The Northern Territory had the lowest proportion of patients without a prior health check, at 8% (1,700 patients), but also one of the longest periods between patients' most recent health checks (an average of 26.0 months).
- Tasmania had had the shortest average length of time between most recent health checks (21.9 months).

Between 2016-17 and 2021-22:

- Tasmania had the largest percentage-point increase in the proportion of people with less than 15 months since their previous health check, rising from 30% in 2016-17 to 37% in 2021-22 (7,500 patients to 12,300 in respective years).
- The Australian Capital Territory had the largest percentage-point decrease in the proportion of people with less than 15 months since their previous health check, falling from 42% in 2016-17 to 26% in 2021-22 (4,500 patients to 3,000 in respective years).
 - The drop was particularly sharp in 2021-22, falling from 33% in 2020-21 (4,200 patients).
- All states and territories experienced an overall decline in the proportion of patients without a prior health check - the largest percentage-point decrease being in Tasmania (from 39% or 7,500 patients in 2016-17 to 25% or 12,300 patients in 2021-22).
- Victoria had the largest percentage-point increase in the average time between patients' most recent health checks, rising from 22.3 months in 2016-17 to 27.2 months in 2021-22.

Figure 14: First Nations health check patients, by time between their 2 most recent health checks, by state and territory, 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to tables HC14 and HC16 in data tables. A long description is available below.

Select year
2021-22

Health check patients (%), 2021-22

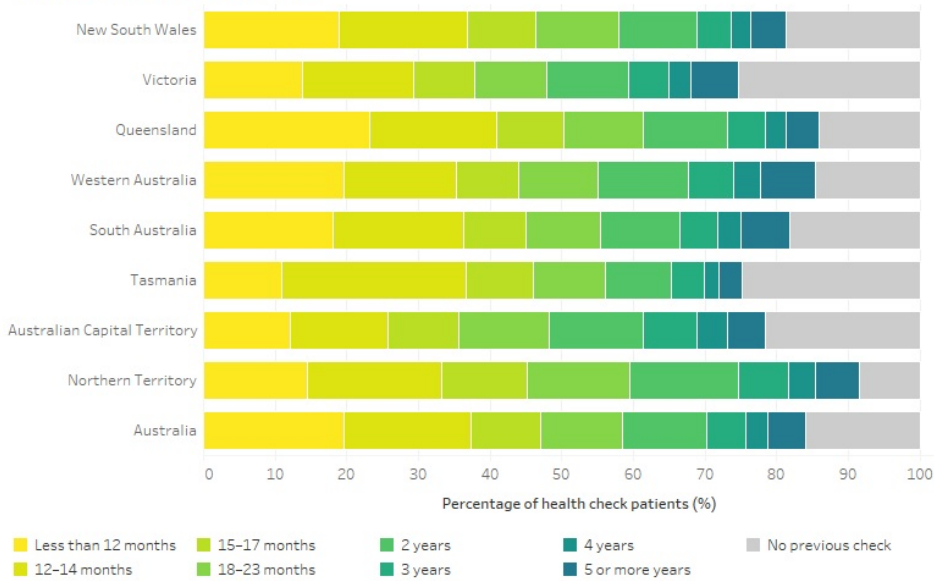


Figure 14.1: First Nations health check patients, by jurisdiction, by time since their previous health check, 2016-17 to 2021-22

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au/>

Long description for Figure 14

A set of interactive graphs over 3 tabs. The first is a stacked bar graph showing the proportion of health check patients by jurisdiction, by time since previous health check, showing that the Northern Territory had fewest patients with no previous health checks in 2021-22. The second is a bar graph, showing average and median time since previous health check, by jurisdiction. Time since previous health check on average was shortest in Tasmania in 2021-22. The third is a line graph, showing the development in time since previous health check between 2016-17 and 2021-22, by jurisdiction. Notably, the proportion of people who had no previous health check generally trended down between 2016-17 and 2021-22 across the jurisdictions. Refer to tables HC14 and HC16 in data tables.

Remoteness Areas

Among health check patients in 2021-22:

- A smaller proportion of patients from *Very remote* areas had a health check less than 15 months earlier (almost one-third or 31%) compared to other areas (ranging from 37% to 39%), but *Very remote* areas had one of the lowest proportions of people with no previous health check (10%).
- Time between health checks increased with increasing remoteness, and patients in *Remote* and *Very remote* areas had the longest average period between their most recent health checks (25.6 and 27.9 months, respectively).

Between 2016-17 and 2021-22:

- In all Remoteness Areas, the proportion of people without a previous health check decreased, with *Very remote* areas experiencing the largest percentage-point and relative decreases, falling from 21% in 2016-17 to 10% in 2021-22.
- Non-remote areas had the largest percentage-point increases to the average time between health checks, with *Major cities* rising from an average of 20.9 months in 2016-17 to 23.3 months in 2021-22.

Figure 15: First Nations health check patients, by time between their 2 most recent health checks, by Remoteness Area, 2016-17 to 2021-22

A set of interactive graphs over 3 tabs. Refer to tables HC15 and HC16 in data tables. A long description is available below.

Health check patients (%), 2021-22

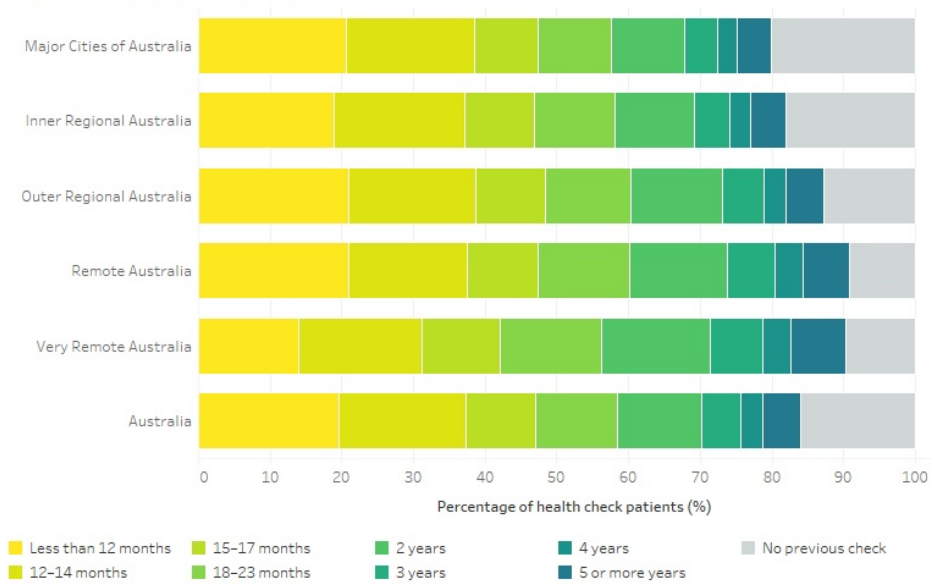


Figure 15.1: First Nations health check patients, by Remoteness Area, by time since their previous health check, 2016-17 to 2021-22

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au/>

Long description for Figure 15

A set of interactive graphs over 3 tabs. The first is a stacked bar graph showing the proportion of health check patients by Remoteness Area, by time since previous health check, showing that while Very Remote Australia has relatively few patients with no previous health checks, a relatively small number had their previous health check less than 15 months before. The second is a line graph, showing average and median time since previous health check, by Remoteness area. Average time since previous health check trended up with increasing remoteness in 2021-22. The third is a line graph, showing the development in time since previous health check between 2016-17 and 2021-22, by Remoteness Area. Notably, the proportion of people who had no previous health check trended down between 2016-17 and 2021-22 across all Remoteness Areas. Refer to tables HC15 and HC16 in data tables.

Health checks

Context

A telehealth option for First Nations health checks was introduced in March 2020 in response to COVID-19, with the aim to protect patients and health care providers.

Initially, both videoconference and telephone items were made available. From 1 July 2021, telephone items were discontinued.

Previous reporting showed telehealth activity and face-to-face activity separately. However, due to the relatively low use of telehealth items in 2021-22, data by telehealth status are only presented in this section at the national level. Monthly data are shown rather than annual data, to demonstrate the sharp decline in telehealth use over the time-series.

See [Indigenous-specific health checks during the COVID-19 pandemic \(AIHW 2023\)](#) for more information.

Between March 2020 and December 2022:

- Use of telehealth items peaked in April 2020 - the first full month after their introduction. In April 2020, 4,000 health checks were conducted via telehealth, amounting to one-quarter (25%) of total health checks in that month.
- By June 2020, the proportion of health checks conducted via telehealth was under 10%. The proportion stayed under 5% from February 2021, then remained under 2% from April 2022 to the end of the time-series.
- Among telehealth services, health checks were most frequently conducted via telephone from March 2020 to June 2021, outnumbering videoconference services by a factor of 10 in most months.
- From July 2021, telephone items were removed as a telehealth option. The number of videoconference services delivered per month peaked at 600 in September 2021 and dropped to 192 by December 2022.
- In January 2022, total health checks delivered per month dropped to a low point of 10,600 services, at the same time as COVID-19 cases surged during Australia's first Omicron wave.

Figure 16: Use of First Nations health checks, by telehealth status, by month, January 2020 to December 2022

A set of interactive graphs over 2 tabs. Refer to tables HC17 and HC18 in data tables. A long description is available below.

Select measure

Number of health checks by telehealth status

Number of health checks by telehealth status

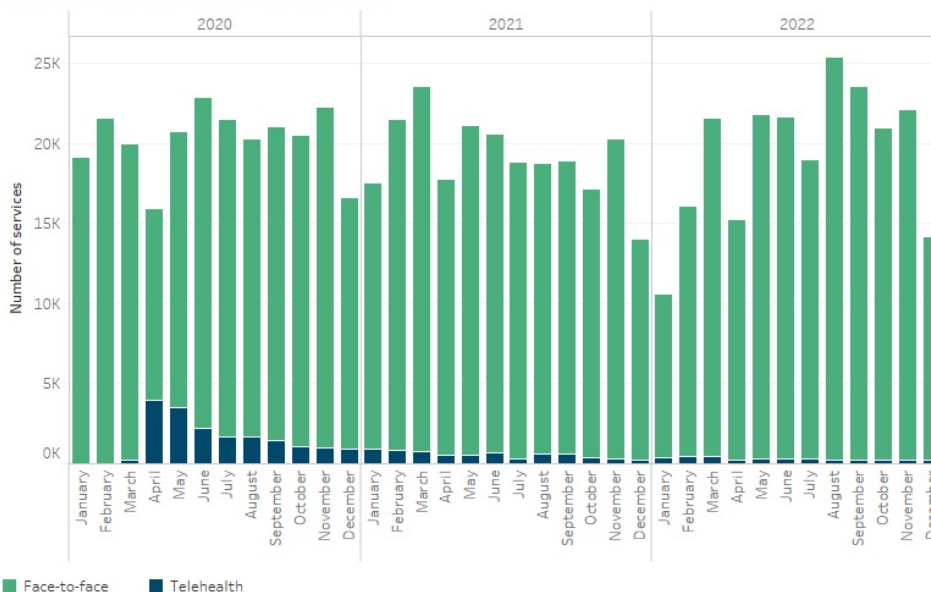


Figure 16.1: First Nations health checks, by telehealth status, January 2020 to December 2022

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.

<https://www.aihw.gov.au/>

Long description for Figure 16

A set of interactive graphs over 2 tabs. The first is a stacked column graph showing the number of health checks by telehealth status between January 2020 and December 2022, showing that the vast majority of health checks were performed face-to-face, and that the telehealth health checks were concentrated in 2020. The second is a stacked column graph showing the distribution of telehealth health

checks by delivery mode between March 2020 and December 2022, showing that, while available, telephone was the preferred delivery mode of telehealth health checks. Refer to tables HC17 and HC18 in data tables.

References

AIHW (2023) *Indigenous-specific health checks during the COVID-19 pandemic*, AIHW, Australian Government, accessed 10 August 2023.

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Follow-up services overview

On this page:

- [Background](#)
- [List of subchapters](#)
- [Medicare Benefits Schedule \(MBS\) items](#)
- [Notes on reporting](#)
- [References](#)

Background

First Nations follow-up items were added to the MBS in November 2008 to support the First Nations health check, as checks alone have limited capacity to improve health outcomes.

Based on health needs identified during a health check, people can access a number of free First Nations MBS services from:

- an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of and under the supervision of a GP (up to 10 per calendar year)
- various allied health professionals (via referral from a GP), for example, physiotherapists, podiatrists or dietitians (up to 5 per calendar year).

Allied health professionals are required to report back to GPs: any investigations, tests, and/or assessments carried out on the patient; any treatment provided; and future management of the patient's condition or problem.

As part of the Australian Government's COVID-19 response, telehealth items were introduced in March 2020 to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (DHAC 2022b). Telehealth consultations may be used for gathering information, but physical examination components are required to be delivered face-to-face.

List of subchapters

- [Numbers of follow-ups delivered](#)
- [Types of follow-up](#)

Medicare Benefits Schedule (MBS) items

This chapter presents information on the use of the following MBS items:

Table 3: List of MBS items for First Nations follow-up services

MBS item no.	Description	Mode of delivery
10987	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP	Face-to-face
93200	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (available from 20 April 2020)	Videoconference
93202	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (available from 20 April 2020)	Telephone
81300	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal and Torres Strait Islander Health Worker (with referral from a GP)	Face-to-face
81305	Follow-up provided by a Diabetes Educator	Face-to-face
81310	Follow-up provided by an Audiologist	Face-to-face
81315	Follow-up provided by an Exercise physiologist	Face-to-face
81320	Follow-up provided by a Dietitian	Face-to-face
81325	Follow-up provided by a Mental health worker	Face-to-face

81330	Follow-up provided by an Occupational therapist	Face-to-face
81335	Follow-up provided by a Physiotherapist	Face-to-face
81340	Follow-up provided by a Podiatrist	Face-to-face
81345	Follow-up provided by a Chiropractor	Face-to-face
81350	Follow-up provided by an Osteopath	Face-to-face
81355	Follow-up provided by a Psychologist	Face-to-face
81360	Follow-up provided by a Speech pathologist	Face-to-face
93048	Follow-up provided by any eligible allied health professional (with referral from a GP) (available from 30 March 2020)	Videoconference
93061	Follow-up provided by any eligible allied health professional (with referral from a GP) (available from 30 March 2020)	Telephone

The data include First Nations follow-ups billed to Medicare by Aboriginal Community Controlled Health Services (ACCHSs) or other First Nations health services, as well as by mainstream health professionals.

Note that the data are limited to First Nations MBS items billed to Medicare, and do not provide a complete picture of follow-up services provided to First Nations people. For example, First Nations people may receive similar care through mainstream MBS items (that is, items that are not specific to First Nations people); through MBS items delivered in residential aged care; through a health care provider who is not eligible to bill Medicare; through follow-up items for patients with team care arrangements, a shared care plan, or a multidisciplinary care plan; or may have chosen to use private health insurance cover instead of Medicare. Those have not been included in this report.

For items relating to follow-up services from Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (10987, 92300, 93202), patients can receive up to 10 follow-up services in a calendar year.

For allied health items (81300-81360, 93048, 93061), patients need a referral from their GP, following a First Nations health check or mainstream health check (MBS items 701, 703, 705 or 707). Patients can receive up to 5 allied health services in a calendar year.

Notes on reporting


- For analysis on the proportion of health check patients who received a follow-up within 12 months of their health check, see the chapter, [Health checks resulting in a follow-up](#).
- Throughout the report, 'First Nations follow-up service' is used interchangeably with 'follow-up service' and 'follow-up' to assist readability.
- People who received an MBS service are referred to as 'patients'.
- All people who received a First Nations MBS service are assumed to be First Nations people.
- To show the proportions of First Nations people who received a follow-up in a given year, the number of patients was divided by population data based on the Australian Bureau of Statistics' (ABS) [Estimates and Projections, Aboriginal and Torres Strait Islander Australians \(Reference period 2006 - 2031\)](#) (ABS 2019b).
 - Calendar-year data (30 June estimates) were converted to financial-year data by averaging estimates from consecutive years (approximating a 31 December estimate).
 - Series B projections, based on the 2016 Census of Population and Housing and 2016 Post Enumeration Survey, were used for years following the 2016 Census. Backcast population data were used for years before the 2016 Census.
 - The ABS does not produce estimates of non-demographic changes over time, such as changes in whether a person identifies as Aboriginal and/or Torres Strait Islander between Censuses. However, due to non-demographic changes, population estimates based on the 2016 Census may be considerably lower than those based on the 2021 Census, meaning many of the proportions presented in this report may be overestimated. For example, the ABS estimates that there were 984,000 Aboriginal and/or Torres Strait Islander people on 30 June 2021 based on the 2021 Census (ABS 2023), compared with a projected 879,000 people on 30 June 2021, based on the 2016 Census (ABS 2019b).
 - Population estimates from the ABS represent the population at a point in time (a stock measure), while patients in the MBS data are counted over a period of time (a flow measure). This mismatch can lead to bias, since the population estimate may not accurately reflect the population able to receive an MBS service throughout the entire period.
- MBS follow-ups in this chapter are reported by date of service, which was not necessarily the date that the service was processed by Services Australia. MBS services in this report were processed on or before 30 April 2023.
- The term 'GP' is used as a generic reference to all medical practitioners providing primary health care services.
- Some records from a small number of service providers have been excluded due to data quality concerns.

References

ABS (Australian Bureau of Statistics) (2019b) *Estimates and projections. Aboriginal and Torres Strait Islander Australians, 2006 - 2031*, ABS website, Australian Government, accessed 10 August 2023.

ABS (2023) *Estimates of Aboriginal and Torres Strait Islander Australians, 30 June 2021*, ABS website, Australian Government, accessed 31 August 2023.

DHAC (Department of Health and Aged Care) (2022b) *COVID-19 temporary MBS telehealth services*, DHAC website, Australian Government, accessed 10 August 2023.

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Follow-up services overview

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects follow-up activity by year of delivery, independently of health checks.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Latest data

In 2021-22:

- 314,000 First Nations follow-up services were delivered to 143,000 patients - or 16% of the First Nations population.

By sex

In 2021-22:

- 181,000 follow-up services were delivered to 80,100 female patients - or 18% of the First Nations female population.
- 133,000 follow-up services were delivered to 62,800 male patients - or 14% of the First Nations male population.

By age

In 2021-22:

- Older age groups tended to have higher proportions of the population receiving follow-up services.
- People aged 75 and over had the highest proportion, with 37% receiving a follow-up service (5,000 patients).
- The lowest proportion of the population who received a follow-up service was among those aged 15-24, at 12% (19,600 patients).
- The youngest age group, 0-4-year-olds, had a slightly higher proportion of the population using follow-up services, at 14% (14,300 patients).

By age and sex

In 2021-22:

- More females had a follow-up service than males in all age groups, 15-24 and older.
- The largest difference was among 25-34-year-olds, where 11,800 females received a follow-up service, compared with 6,900 males (18% of the female population and 9.8% of the male population).

Trends over time

Between 2011-12 and 2021-22:

- The number of First Nations follow-up services delivered increased from 37,800 in 2011-12 to 388,000 in 2019-20 - or a factor of over 10.
- The number of follow-up services delivered then fell to 365,000 in 2020-21 and 314,000 in 2021-22.
- The number of patients who received a follow-up service followed a similar pattern, rising from 18,500 in 2011-12 to 164,000 in 2019-20, before falling to 143,000 by 2021-22.

Figure 17: Use of First Nations follow-up services, by age group, by sex, 2011-12 to 2021-22

A set of interactive graphs over 4 tabs. Refer to table FS01 in data tables. A long description is available below.

First Nations follow-up services, 2021-22

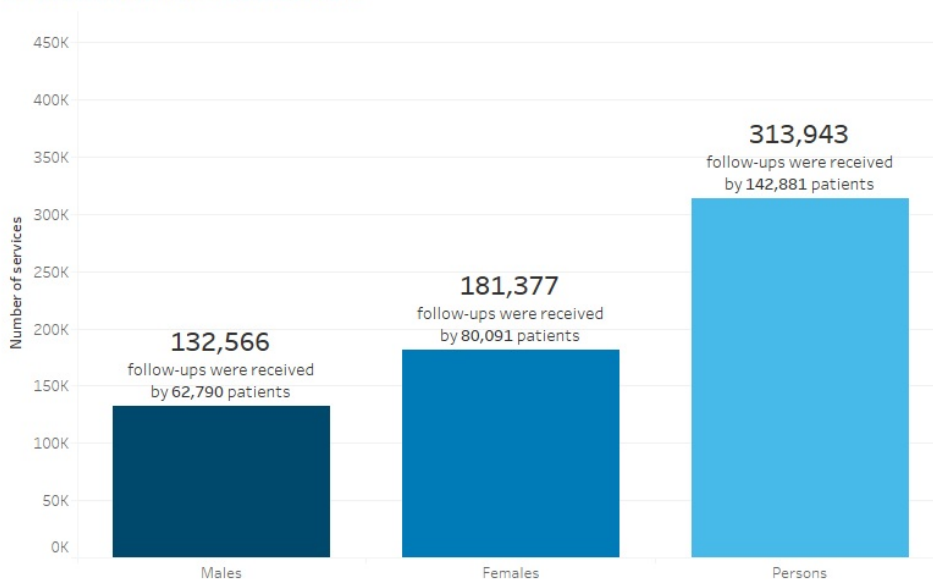


Figure 17.1: Use of First Nations follow-up services, by sex, 2011-12 to 2021-22

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; populations based on Australian Bureau of Statistics (ABS) data.
<https://www.aihw.gov.au>

Long description for Figure 17

A set of interactive graphs over 4 tabs. The first is a column graph showing follow-up services by sex, showing more females than males used follow-up services in 2021-22. The second is a column graph showing follow-up services by age and sex, showing males received the majority of follow-up services only among those aged 0-14 in 2021-22. The third is a line graph showing the number of follow-up services used trending up between 2011-12 and 2019-20 for both sexes, then trending down to 2021-22. The fourth is a line graph showing the number of follow-up services used trended up between 2011-12 and 2019-20 for all age groups, varied between age groups in 2020-21, then trended down for all age groups in 2021-22. Refer to table FS01 in data tables.

Follow-up services overview

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects follow-up activity by year of delivery, independently of health checks.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Latest data

In 2021-22:

- 256,000 services (or 82% of total follow-up services) were delivered by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse to 129,000 patients on behalf of a GP.
- 57,800 services (or 18% of total follow-up services) were delivered by an allied health professional to 28,100 patients (with referral from a GP).

Among the allied health items relating to separate health professions, the follow-up services most frequently provided in 2020-21 were:

- 13,700 services delivered by Physiotherapists to 6,200 patients.
- 11,300 services delivered by Podiatrists to 6,300 patients.
- 9,000 services delivered by an Aboriginal and Torres Strait Islander Health Practitioner or Health Worker to 7,400 patients (with referral from a GP).

Trends over time

Between 2016-17 and 2021-22:

- The number of follow-up services delivered by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP increased from 232,000 in 2016-17 to 325,000 in 2019-20, then fell to 256,000 by 2021-22.
- Similarly, the number of follow-up services delivered by an allied health professional (with referral from a GP) increased from 55,100 in 2016-17 to 67,800 in 2020-21, then fell to 57,800 by 2021-22.

Figure 18: Use of First Nations follow-up services, by practitioner type, 2016-17 to 2021-22

A set of interactive graphs over 2 tabs. Refer to table FS02 in data tables. A long description is available below.

Select measure
Number of patients

Select year
2021-22

First Nations follow-up service patients, 2021-22

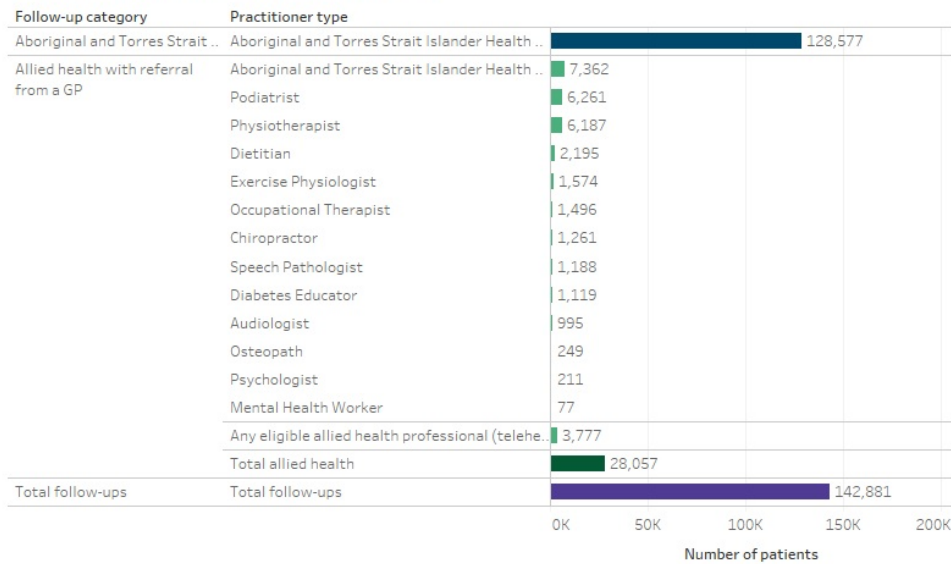


Figure 18.1: Use of First Nations follow-up services, by practitioner type, 2016-17 to 2021-22

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 18

A set of interactive graphs over 2 tabs. The first is a bar graph showing follow-up services used by practitioner type, showing that Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse was by far the most common practitioner type in 2021-22. The second is a line graph showing use of follow-up services trending up between 2016-17 and 2019-20, then trending down to 2021-22. Refer to table FS02 in data tables.

Health checks resulting in a follow-up

On this page:

- [Overview](#)
- [List of subchapters](#)
- [Medicare Benefits Schedule \(MBS\) items](#)
- [Notes on reporting](#)

Overview

This chapter presents the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered (or 'follow-up percentage'). The most recent year of health check delivery covered is 2020-21. Follow-up activity for health check patients from 2021-22 was not ready to assess at the time of this analysis, due to lag in processing some MBS claims.

The MBS data collection does not include any information about the outcomes of a health check. This means that it is not known how many people actually required follow-up care after their health checks. Not all First Nations people who have a health check will need follow-up services. Consequently, variation in follow-up percentages (for example, by age group or geographic regions), may partly reflect differences in health status, need for follow-up care and whether people are willing or able to attend recommended follow-up services.

For background information on First Nations health checks, see [Health checks](#) section.

For background information on First Nations follow-up services, see [Follow-up services overview](#) section.

List of subchapters

- [National use of follow-ups](#)
- [State and territory comparisons](#)
- [Primary Health Network \(PHN\) comparisons](#)
- [Remoteness Area comparisons](#)
- [Greater Capital City Statistical Area \(GCCSA\) comparisons](#)
- [Indigenous Region \(IREG\) comparisons](#)
- [Statistical Area Level 4 \(SA4\) comparisons](#)
- [Comparison of areas grouped by socioeconomic similarity](#)
- [Comparison of areas by socioeconomic ranking](#)
- [Cumulative follow-ups](#)

Medicare Benefits Schedule (MBS) items

This chapter presents information on the use of the following MBS items:

Table 4: List of MBS items for First Nations health checks and follow-up services

MBS item no.	Description	Mode of delivery
715	Health check provided by a GP	Face-to-face
228	Health check provided by a medical practitioner other than a GP (available from 1 July 2018)	Face-to-face
92004	Health check provided by a GP (available from 30 March 2020)	Videoconference
92016	Health check provided by a GP (available from 30 March 2020 to 30 June 2021)	Telephone
92011	Health check provided by a medical practitioner other than a GP (available from 30 March 2020)	Videoconference
92023	Health check provided by a medical practitioner other than a GP (available from 30 March 2020 to 30 June 2021)	Telephone
10987	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP	Face-to-face

93200	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (available from 20 April 2020)	Videoconference
93202	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (available from 20 April 2020)	Telephone
81300	Follow-up provided by an Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal and Torres Strait Islander Health Worker (with referral from a GP)	Face-to-face
81305	Follow-up provided by a Diabetes Educator	Face-to-face
81310	Follow-up provided by an Audiologist	Face-to-face
81315	Follow-up provided by an Exercise physiologist	Face-to-face
81320	Follow-up provided by a Dietitian	Face-to-face
81325	Follow-up provided by a Mental health worker	Face-to-face
81330	Follow-up provided by an Occupational therapist	Face-to-face
81335	Follow-up provided by a Physiotherapist	Face-to-face
81340	Follow-up provided by a Podiatrist	Face-to-face
81345	Follow-up provided by a Chiropractor	Face-to-face
81350	Follow-up provided by an Osteopath	Face-to-face
81355	Follow-up provided by a Psychologist	Face-to-face
81360	Follow-up provided by a Speech pathologist	Face-to-face
93048	Follow-up provided by any eligible allied health professional (with referral from a GP) (available from 30 March 2020)	Videoconference
93061	Follow-up provided by any eligible allied health professional (with referral from a GP) (available from 30 March 2020)	Telephone

Note: Outside of MBS item descriptions for health checks, the term 'GP' is used as a generic reference to all medical practitioners providing primary health care services.

The data include First Nations MBS items billed to Medicare by Aboriginal Community Controlled Health Services (ACCHSs) or other First Nations health services, as well as by mainstream GPs and other health professionals.

Note that the data are limited to First Nations MBS items billed to Medicare, and do not provide a complete picture of health checks or follow-up services provided to First Nations people. For example, First Nations people may receive similar care through: mainstream MBS items (that is, items that are not specific to First Nations people); through MBS items delivered in residential aged care; through the Child Health Check Initiative (CHCI) under the Northern Territory Emergency Response (NTER) that ended in June 2012; through a health care provider who is not eligible to bill Medicare; through follow-up items for patients with team care arrangements, a shared care plan, or a multidisciplinary care plan; or may have chosen to use private health insurance cover instead of Medicare. Those have not been included in this report.

The minimum time allowed between health checks is 9 months. People can therefore receive more than one health check in a year.

For items relating to follow-up services from Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse on behalf of a GP (10987, 92300, 93202), patients can receive up to 10 of these follow-up services in a calendar year.

For allied health items (81300-93061, 93048, 81360), patients need a referral from their GP, following a First Nations health check or mainstream health check (MBS items 701, 703, 705 or 707). Patients can receive up to 5 of these allied health services in a calendar year.

Notes on reporting

- For analysis of the number of people who received a follow-up service by year, see the chapter, [Follow-up services overview](#).
- Throughout the report, 'First Nations follow-up service' is used interchangeably with 'follow-up service' and 'follow-up' to assist readability.
- People who received an MBS service are referred to as 'patients'.

- Throughout this chapter, ‘the proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check’ is used interchangeably with ‘follow-up percentage’ to assist readability.
 - All people who received a First Nations MBS service are assumed to be First Nations people.
 - MBS health check patients in this chapter are reported by date of service, which was not necessarily the date that the service was processed by Services Australia. MBS services in this chapter were processed on or before 30 April 2023.
 - Some records from a small number of service providers have been excluded due to data quality concerns.
 - A single follow-up service may follow (within 12 months) more than one health check, across consecutive years in some cases.
 - For patients with more than one health check in a given year, the 12-month follow-up window applies to both health checks.
 - Patients may move to a different location in Australia, move abroad or die in the 12 months following their health check. Age and place of residence are based on information at the time of their health check.
-



Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Latest data

Among health check patients in 2020-21:

- 109,000 people had a First Nations follow-up service in the 12 months following their health check(s).
- 46% of health check patients had a follow-up service within 12 months.

By sex

Among health check patients in 2020-21:

- 48% of females had a follow-up service within 12 months (60,700 patients with a follow-up).
- 44% of males had a follow-up service within 12 months (48,400 patients with a follow-up).

By age

Among health check patients in 2020-21:

- The proportion of people who had a follow-up service within 12 months generally increased with age.
- The age group with the highest proportion of people receiving a follow-up service within 12 months was ages 65-74, at 56% (7,400 patients with a follow-up).
- People aged 5-14 had the lowest proportion going on to have a follow-up service within 12 months, at 40% (18,000 patients with a follow-up).

By age and sex

Among health check patients in 2020-21:

- A higher proportion of females had a follow-up service within 12 months than males in all age groups, 15-24 and older.
- The largest difference was among 25-34-year-olds, where 47% of females received a follow-up service within 12 months, compared with 41% of males (8,800 females and 5,200 males).

Trends over time

Among health check patients from 2011-12 to 2020-21:

- There was a gradual increase in the proportion of health check patients going on to receive a follow-up service within 12 months from 2011-12 until 2018-19.
 - 18% of 2011-12's health check patients had a follow-up service (17,300 patients).
 - 47% of 2018-19's health check patients had a follow-up service (113,000 patients).
- From 2018-19 to 2020-21, the follow-up percentage was steady, falling less than 1 percentage-point from 46.8% to 46.1% (113,000 patients to 109,000 for respective years).
- Differences in follow-up percentages between the age groups and sexes were largely maintained throughout the time-series.

Figure 19: Use of First Nations follow-up services among health check patients, by age group, by sex, 2011-12 to 2020-21

A set of interactive graphs over 4 tabs. Refer to table F503 in data tables. A long description is available below.

Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

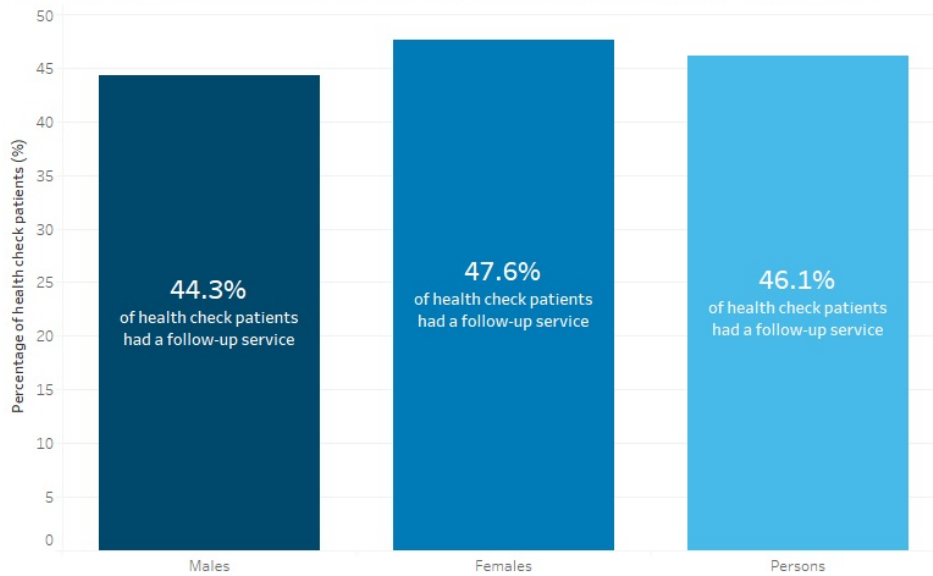


Figure 19.1: Use of First Nations follow-up services among health check patients, by sex, 2011-12 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 19

A set of interactive graphs over 4 tabs. The first is a column graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by sex, showing females had a higher follow-up percentage than males after their 2020-21 health check. The second is a column graph showing follow-up percentage, by sex and age group, where follow-up percentage among 2020-21's patients increased with age after an initial decline. The third is a line graph showing follow-up percentage by sex, trending up between 2011-12 and 2018-19, then plateauing to 2020-21. The fourth is a line graph showing follow-up percentage by age group, generally trending up between 2011-12 and 2018-19, then plateauing to 2020-21. Refer to table FS03 in data tables.

Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- The Northern Territory had the highest proportion of health check patients going on to receive a follow-up within 12 months, at 58% (14,500 patients with a follow-up).
- The Australian Capital Territory had the lowest follow-up percentage, at 17% (256 patients with a follow-up).

Trends over time

Among health check patients from 2016-17 to 2020-21:

- All states and territories had a higher follow-up percentage for 2020-21 compared with 2016-17.
- Western Australia had the largest percentage-point increase in follow-up use, rising from 30% for 2016-17 to 47% for 2020-21 (7,900 patients to 12,700 for respective years).
- South Australia had the smallest percentage-point increase in follow-up use, changing from 41.7% for 2016-17 to 42.2% for 2020-21 (3,500 patients to 4,300 for respective years).

Figure 20: Use of First Nations follow-up services among health check patients, by state and territory, 2016-17 to 2020-21

A set of interactive graphs over 2 tabs. Refer to table F504 in data tables. A long description is available below.

Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

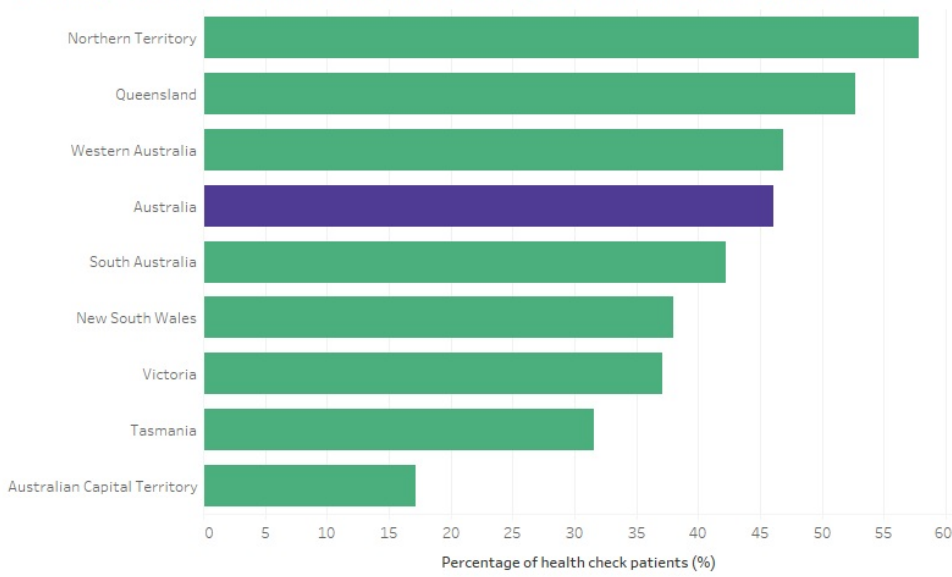


Figure 20.1: Use of First Nations follow-up services among health check patients, by state and territory, 2016-17 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 20

A set of interactive graphs over 2 tabs. The first is a bar graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by jurisdiction, showing the Northern Territory was the jurisdiction with the highest follow-up percentage for 2020-21's patients. The second is a line graph showing follow-up percentage between 2016-17 and 2020-21, varying by jurisdiction. Refer to table FS04 in data tables.

Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- Brisbane North had the highest proportion of health check patients going on to receive a follow-up within 12 months, at 65% (6,400 patients with a follow-up).
- The Australian Capital Territory had the lowest follow-up percentage, at 17% (256 patients with a follow-up).

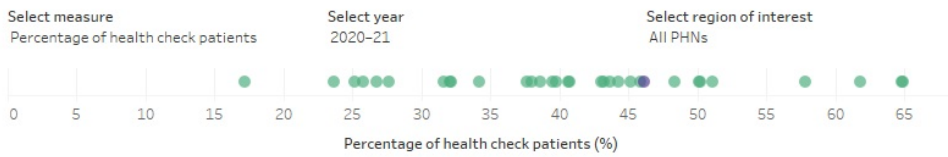
Trends over time

Among health check patients from 2016-17 to 2020-21:

- Around three-quarters of PHNs (24 out of 31) had a higher follow-up percentage for 2020-21 compared with 2016-17.
- Perth North had the largest percentage-point increase in follow-up use, rising from 27% for 2016-17 to 48% for 2020-21 (1,200 patients to 2,400 for respective years).
- Gippsland had the largest percentage-point decrease in follow-up use, falling from 32% for 2016-17 to 24% for 2020-21 (264 patients to 196 for respective years).

Figure 21: Use of First Nations follow-up services among health check patients, by Primary Health Network (PHN), 2016-17 to 2020-21

A set of interactive graphs over 3 tabs. Refer to table FS05 in data tables. A long description is available below.



Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

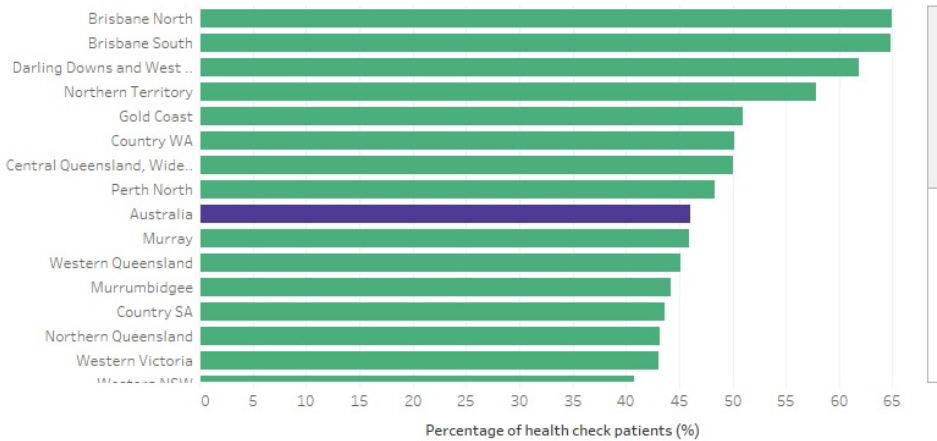


Figure 21.1: Use of First Nations follow-up services among health check patients, by Primary Health Network (PHN), 2016-17 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 21

A set of interactive graphs over 3 tabs. The first is a bar graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by PHN, showing Brisbane North was the PHN with the highest follow-up percentage for 2020-21's patients. The second shows follow-up percentage, by PHN, on a map. The third is a line graph showing follow-up percentage 2016-17 and 2020-21, varying by PHN. Refer to table FS05 in data tables.

Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- *Major cities* had a follow-up percentage of 46% (37,000 patients with a follow-up).
- *Inner regional* areas had a follow-up percentage of 45% (24,900 patients).
- *Outer regional* areas had the lowest follow-up percentage, at 44% (25,600 patients).
- *Remote* areas had a follow-up percentage of 49% (9,000 patients).
- *Very remote* areas had the highest follow-up percentage, at 50% (12,600 patients).

Trends over time

Among health check patients from 2016-17 to 2020-21:

- All Remoteness Areas had a higher follow-up percentage for 2020-21 compared with 2016-17.
- *Outer regional* areas had the largest percentage-point increase in follow-up use, rising from 39% for 2016-17 to 44% for 2020-21 (21,900 patients to 25,600 for respective years).
- *Remote* areas had the smallest percentage-point increase in follow-up use, rising from 47% for 2016-17 to 49% for 2020-21 (9,700 patients to 9,000 for respective years).

Figure 22: Use of First Nations follow-up services among health check patients, by Remoteness Area, 2016-17 to 2020-21

A set of interactive graphs over 2 tabs. Refer to table FS06 in data tables. A long description is available below.

Select measure
Percentage of health check patients

Select year
2020-21

Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

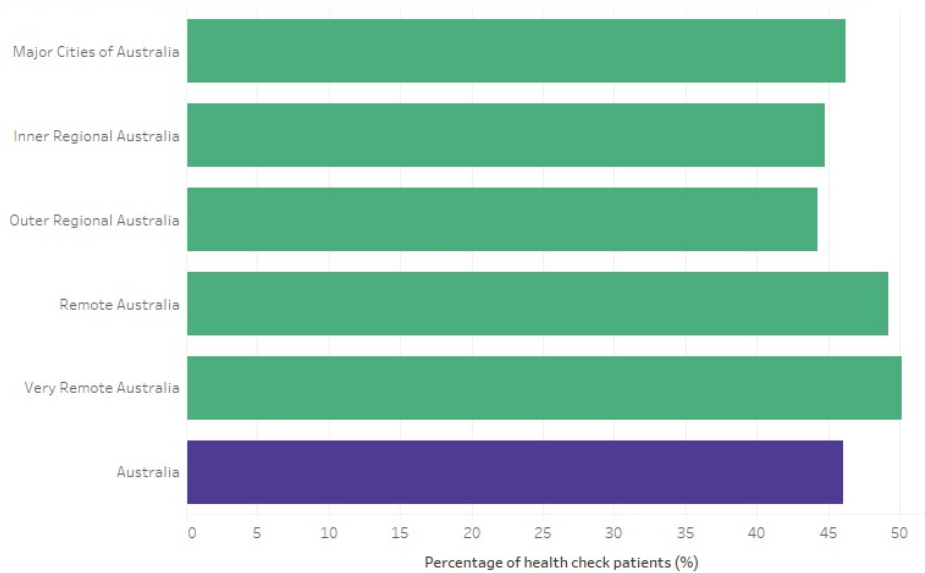


Figure 22.1: Use of First Nations follow-up services among health check patients, by Remoteness Area, 2016-17 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 22

A set of interactive graphs over 2 tabs. The first is a bar graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by Remoteness Area, showing Very Remote Australia was the Remoteness Area with the highest follow-up percentage for 2020-21's patients. The second is a line graph showing follow-up percentage by Remoteness Area trending up between 2016-17 and 2020-18, then plateauing to 2020-21. Refer to table FS06 in data tables.



Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- *Greater Brisbane* had the highest proportion of health check patients going on to receive a follow-up within 12 months, at 65% (16,900 patients with a follow-up).
- *Australian Capital Territory* had the lowest follow-up percentage, at 17% (256 patients with a follow-up).

Trends over time

Among health check patients from 2016-17 to 2020-21:

- Nearly every GCCSA (14 out of 15) had a higher follow-up percentage for 2020-21 compared with 2016-17.
- *Rest of WA* had the largest percentage-point increase in follow-up use, rising from 32% for 2016-17 to 50% for 2020-21 (5,300 patients to 7,700 for respective years).
- *Rest of SA* had the only percentage-point decrease in follow-up use, falling from 47% for 2016-17 to 44% for 2020-21 (2,300 patients to 2,200 for respective years).

Figure 23: Use of First Nations follow-up services among health check patients, by Greater Capital City Statistical Area (GCCSA), 2016-17 to 2020-21

A set of interactive graphs over 2 tabs. Refer to table F507 in data tables. A long description is available below.

Select measure
Percentage of health check patients

Select year
2020-21

Select region of interest
All GCCSAs

Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

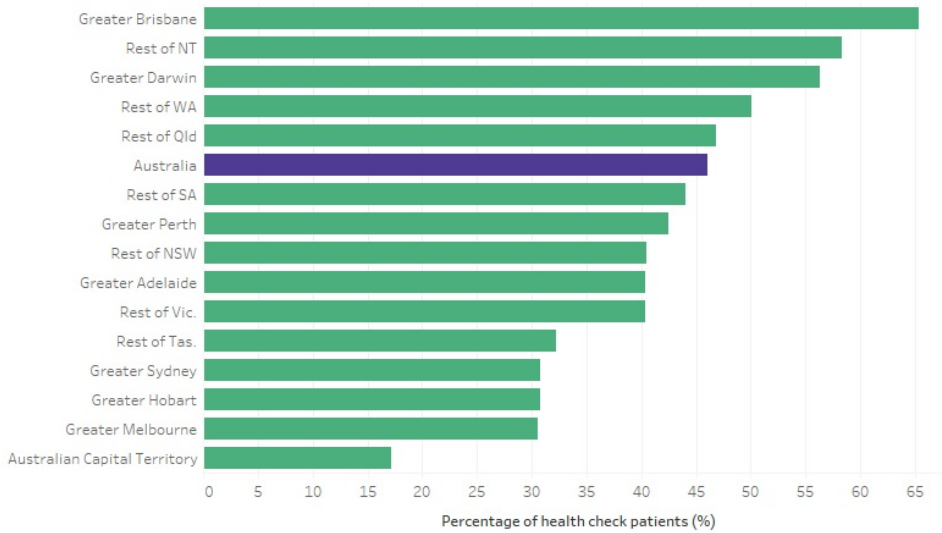


Figure 23.1: Use of First Nations follow-up services among health check patients, by Greater Capital City Statistical Area (GCCSA), 2016-17 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 23

A set of interactive graphs over 2 tabs. The first is a bar graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by GCCSA, showing Greater Brisbane was the GCCSA with the highest follow-up percentage for 2020-21's patients. The second is a line graph showing follow-up percentage between 2016-17 to 2020-21, varying by GCCSA. Refer to table FS07 in data tables.

Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- *Broome* (Western Australia) had the highest proportion of health check patients going on to receive a follow-up within 12 months, at 77% (1,400 patients with a follow-up).
- *ACT* had the lowest follow-up percentage, at 17% (256 patients with a follow-up).

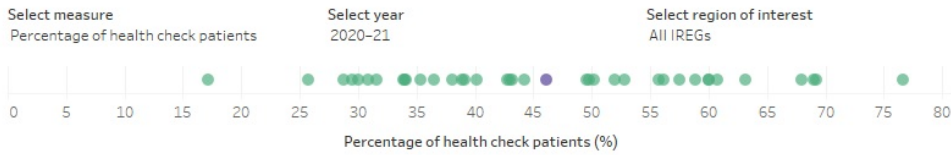
Trends over time

Among health check patients from 2016-17 to 2020-21:

- Most IREGs (30 out of 37) had a higher follow-up percentage for 2020-21 compared with 2016-17.
- *Broome* (Western Australia) had the largest percentage-point increase in follow-up use, rising from 20% for 2016-17 to 77% for 2020-21 (323 patients to 1,400 for respective years).
- *Cape York* (Queensland) had the largest percentage-point decrease in follow-up use, falling from 49% for 2016-17 to 34% for 2020-21 (840 patients to 750 for respective years).

Figure 24: Use of First Nations follow-up services among health check patients, by Indigenous Region (IREG), 2016-17 to 2020-21

A set of interactive graphs over 3 tabs. Refer to table F508 in data tables. A long description is available below.



Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

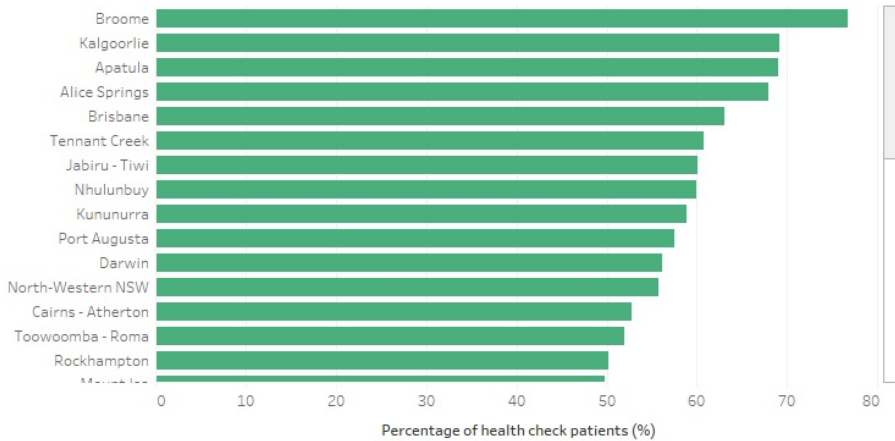


Figure 24.1: Use of First Nations follow-up services among health check patients, by Indigenous Region (IREG), 2016-17 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 24

A set of interactive graphs over 3 tabs. The first is a bar graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by IREG, showing Broome was the IREG with the highest follow-up percentage for 2020-21's patients. The second shows follow-up percentage, by IREG, on a map. The third is a line graph showing follow-up percentage between 2016-17 and 2020-21, varying by IREG. Refer to table FS08 in data tables.

Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- *Brisbane Inner City* had the highest proportion of health check patients going on to receive a follow-up within 12 months, at 68% (630 patients with a follow-up).
- *Bendigo* (Victoria) had the lowest follow-up percentage, at 14% (53 patients with a follow-up).

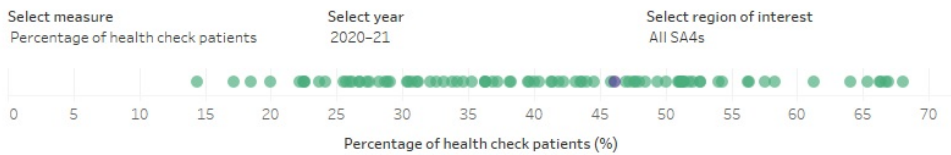
Trends over time

Among health check patients from 2016-17 to 2020-21:

- Around two-thirds of SA4s (60 out of 88) had a higher follow-up percentage for 2020-21 compared with 2016-17.
- *Mornington Peninsula* (Victoria) had the largest percentage-point increase in follow-up use, rising from 18% for 2016-17 to 49% for 2020-21 (41 patients to 156 for respective years).
- *Mandurah* (Western Australia) had the largest percentage-point decrease in follow-up use, falling from 54% for 2016-17 to 34% for 2020-21 (307 patients to 265 for respective years).

Figure 25: Use of First Nations follow-up services among health check patients, by Statistical Area Level 4 (SA4), 2016-17 to 2020-21

A set of interactive graphs over 3 tabs. Refer to table F509 in data tables. A long description is available below.



Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

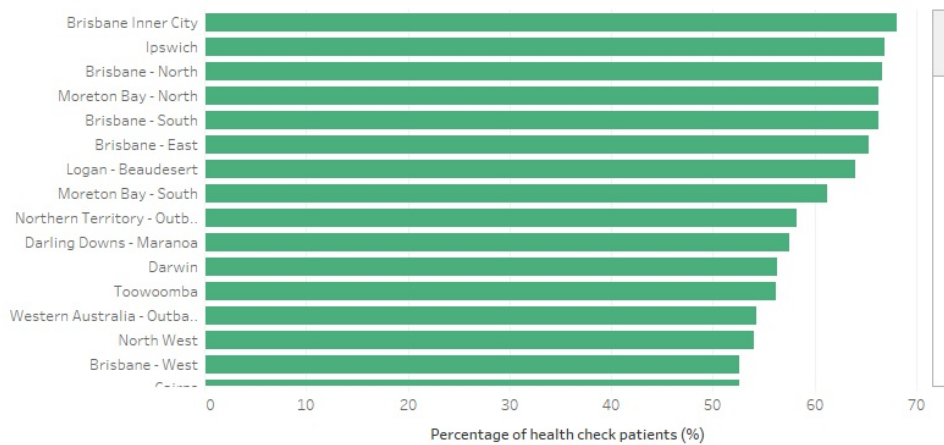


Figure 25.1: Use of First Nations follow-up services among health check patients, by Statistical Area Level 4 (SA4), 2016-17 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 25

A set of interactive graphs over 3 tabs. The first is a bar graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by SA4, showing Brisbane Inner City was the SA4 with the highest follow-up percentage for 2020-21's patients. The second shows follow-up percentage, by SA4, on a map. The third is a line graph showing follow-up percentage between 2016-17 to 2020-21, varying by SA4. Refer to table FS09 in data tables.

Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Exploratory analysis: Areas grouped by socioeconomic similarity

- Statistical Areas Level 3 (SA3s) were grouped into 5 clusters, based on the proportion of Aboriginal and/or Torres Strait Islander people counted in each decile from the ABS' 2016 Census-based Index of Household Advantage and Disadvantage (IHAD) analysis (ABS 2019a). All clusters contain some people from each of the 10 IHAD deciles, but the proportions vary considerably. Note that socioeconomic characteristics may have changed over time.
- The 5 socioeconomic clusters in this section contain different numbers of SA3s and different numbers of First Nations people.
- Clusters were designed to capture targeted population proportions. Population apportionment was based on the Aboriginal and/or Torres Strait Islander estimated resident population in 2016 by SA3 (ABS 2018). The first cluster contains approximately 10% of the First Nations population; the second, 20%; the third, 40%; the fourth, 20%; and the fifth, 10%.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Latest data

Among health check patients in 2020-21:

- There was a weak association between the socioeconomic cluster position and the proportion of health check patients who received a follow-up service within 12 months.
- People living in the most disadvantaged (first) cluster had the highest follow-up percentage, at 53% (12,300 patients with a follow-up).
- The most advantaged (fifth) cluster had the lowest follow-up percentage, at 42% (6,300 patients with a follow-up).
- The fourth cluster had the second-highest follow-up percentage, at 48%, bucking the trend (22,100 patients with a follow-up).

Trends over time

Among health check patients from 2016-17 to 2020-21:

- The only cluster of SA3s in which the follow-up percentage decreased over the time-series was the most disadvantaged (first) cluster. The percentage dropped in the most recent years from 59% for 2018-19 to 53% for 2020-21.
- The other 4 clusters had a higher follow-up percentage for 2020-21 than for 2016-17.

Figure 26: Use of First Nations follow-up services among health check patients, by socioeconomic cluster, 2016-17 to 2020-21

A set of interactive graphs over 2 tabs. Refer to table FS10 in data tables. A long description is available below.

Percentage of health check patients who received a follow-up service within 12 months (%), 2020-21

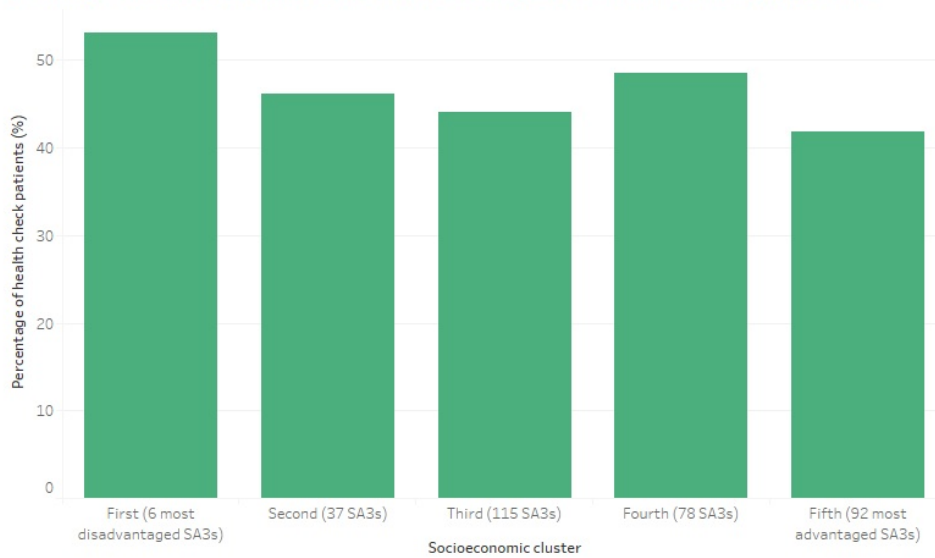


Figure 26.1: Use of First Nations follow-up services among health check patients, by socioeconomic clusters, 2016-17 to 2020-21

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; AIHW analysis of Australian Bureau of Statistics (ABS) Census of Population and Housing data (2016).
<https://www.aihw.gov.au>

Long description for Figure 26

A set of interactive graphs over 2 tabs. The first is a column graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by socioeconomic cluster, showing follow-up percentage was highest in the most disadvantaged socioeconomic cluster for 2020-21's patients. The second is a line graph showing follow-up percentage between 2016-17 to 2020-21, varying by socioeconomic cluster. Refer to table FS10 in data tables.

References

ABS (2018) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, ABS website, Australian Government, accessed 10 August 2023.

ABS (Australian Bureau of Statistics) (2019a) *Experimental Index of Household Advantage and Disadvantage, 2016*, ABS, Australian Government, accessed 10 August 2023.

Health checks resulting in a follow-up

Notes

- This section reflects the number and proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Exploratory analysis: Areas ranked by socioeconomic profile

- Relative socioeconomic scores were calculated for PHNs, IREGs and SA4s based on the number of Aboriginal and/or Torres Strait Islander people counted in each decile from the ABS' 2016 Census-based Index of Household Advantage and Disadvantage (IHAD) analysis (ABS 2019a).
- Effectively, the socioeconomic scores for each area give the average IHAD decile number for the First Nations population (living in private dwellings). Note that socioeconomic characteristics may have changed over time.

Geographic information

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not always reflect where the person actually lived - particularly for people who use PO boxes. This is likely to impact some areas more than others and will also have a generally greater impact on the accuracy of smaller geographic areas.

Among health check patients from 2016-17 to 2020-21:

- There was little consistency in the follow-up percentage for areas with similar socioeconomic profiles, however, First Nations people living in the most disadvantaged PHNs, IREGs and SA4s tended to have higher follow-up percentages than those living in the most advantaged areas.
- Some SA4 populations had relatively high follow-up percentages - compared with SA4s with similar socioeconomic profiles - many of which were in Queensland.

Figure 27: Use of First Nations follow-up services among health check patients, by geographic area, by socioeconomic ranking, 2016-17 to 2020-21

An interactive graph. Refer to table FS11 in data tables. A long description is available below.

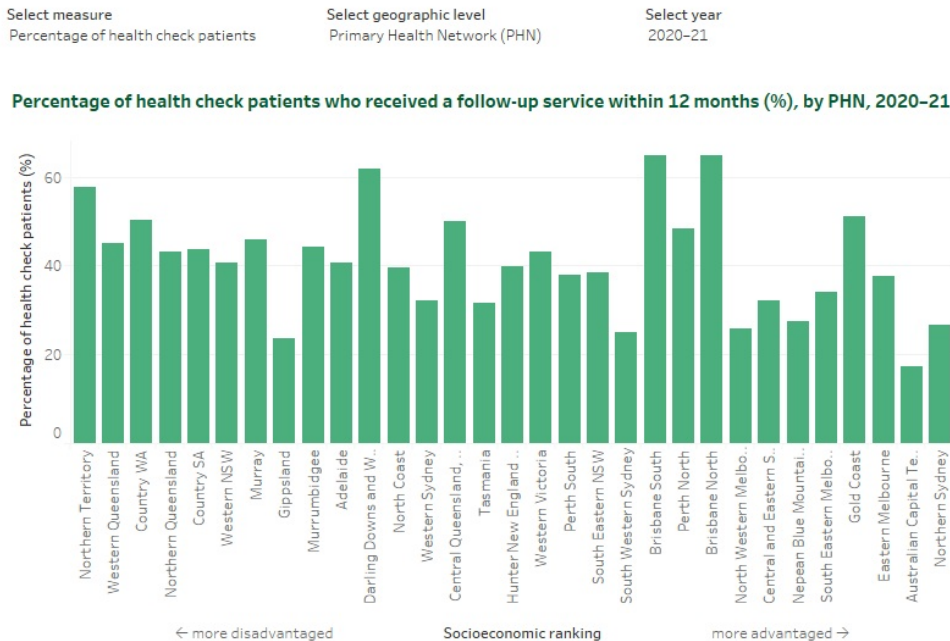


Figure 27.1: Use of First Nations follow-up services among health check patients, by geographic area, by socioeconomic ranking, 2016-17 to 2020-21

Sources: AIHW analysis of Medicare Benefits Schedule (MBS) data; AIHW analysis of Australian Bureau of Statistics (ABS) Census of Population and Housing data (2016).

<https://www.aihw.gov.au>

Long description for Figure 27

An interactive column graph showing the proportion of health check patients who had a follow-up within 12 months of their health check, by geographic area, showing possible indication that follow-up percentage decreases as socioeconomic status increases. Refer to table FS11 in data tables.

References

ABS (Australian Bureau of Statistics) (2019a) *Experimental Index of Household Advantage and Disadvantage, 2016*, ABS, Australian Government, accessed 10 August 2023.

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Health checks resulting in a follow-up

On this page:

- [Latest data](#)
- [Trends over time](#)

Explore the data in the visualisation below.

Notes

- This section reflects the number of follow-up services that patients received in the 12 months following their health check, in terms of patient counts and proportions, by the year that their health check was delivered.
- Some records from a small number of service providers have been excluded due to data quality concerns.

Latest data

Among the 237,000 people who had a First Nations health check in 2020-21:

- 46% (109,200 patients) received at least one First Nations follow-up within 12 months of their health check.
- 26% (60,600 patients) received at least 2 follow-ups.
- 16% (38,400 patients) received at least 3 follow-ups.
- 11% (25,900 patients) received at least 4 follow-ups.
- 7.7% (18,200 patients) received at least 5 follow-ups.

By category of follow-up

Among the 237,000 people who had a First Nations health check in 2020-21:

- 42% (98,900 patients) received at least one follow-up from an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse within 12 months of their health check (on behalf of a GP).
- 21% (49,900 patients) received at least 2 follow-ups from an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse within 12 months of their health check (on behalf of a GP).
- 11% (26,600 patients) received at least one follow-up from an eligible allied health professional within 12 months of their health check (with referral from a GP).
- 5.9% (14,000 patients) received at least 2 follow-ups from an eligible allied health professional within 12 months of their health check (with referral from a GP).

Trends over time

Among health check patients from 2011-12 to 2020-21:

- The proportion of patients who received at least 2 follow-up services within 12 months of their health check increased gradually from 9.0% for 2011-12 to 27% for 2018-19 (8,600 patients to 65,500 for respective years). The proportion then plateaued from 2018-19 to 2020-21.
- The proportion of patients who received at least one follow-up from an Aboriginal and Torres Strait Islander Health Practitioner or Practice Nurse (on behalf of a GP) within 12 months increased gradually from 15% for 2011-12 to 43% for 2018-19 (14,500 patients to 103,600 for respective years). The proportion then plateaued from 2018-19 to 2020-21.
- The proportion of patients who received at least one follow-up from an eligible allied health professional (with referral from a GP) within 12 months increased gradually from 4.5% for 2011-12 to 11% for 2016-17 (4,200 patients to 22,800 for respective years). The proportion then plateaued from 2016-17 to 2020-21.

Figure 28: First Nations health check patients, by number of follow-up services in the 12 months following their health checks, 2011-12 to 2020-21

A set of interactive graphs over 2 tabs. Refer to table FS12 in data tables. A long description is available below.

Percentage of health check patients (%), by number of follow-up services within 12 months, 2020-21

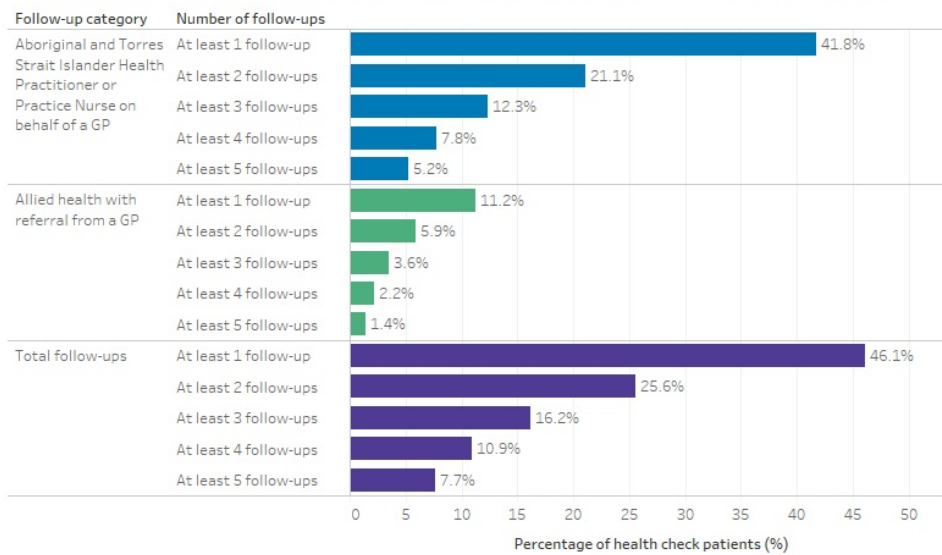


Figure 28.1: First Nations health check patients, by number of follow-up services in the 12 months following their health checks, 2011-12 to 2020-21

Source: AIHW analysis of Medicare Benefits Schedule (MBS) data.
<https://www.aihw.gov.au>

Long description for Figure 28

A set of interactive graphs over 2 tabs. The first is a bar graph showing the cumulative number of follow-up services within 12 months among those patients who had a health check, by type of follow-up service. The second is a line graph showing cumulative numbers of follow-ups trending up between 2011-12 and 2018-19, then plateauing to 2020-21. Refer to table FS12 in data tables.

Using this report - frequently asked questions

Below are some frequently asked questions.

We value your feedback. Did you find what you were looking for? Was the information relevant and easy to understand? Please provide comments using the feedback form:

How do I print the pages of the report?

You can print the web report using the 'Save web report' button near the top of the page.

You also can print pages by pressing Ctrl and P (or Cmd and P) on your keyboard (at the same time), or by heading to [:] at the top of your browser and selecting print. Note that the Tableau visualisations may not print correctly with this method.

To print a visualisation, select [↓] on the menu below the visualisation and choose to download as an image or PDF. The visualisation prints what is presented on the screen, with your selected filters.

You can also use a snipping tool to capture what is on your screen.

How do I interact with the graphs and maps?

The graphs and maps have been developed in Tableau. To see the data of interest, hover your mouse over the graph or map to display the Tooltip - your cursor will change to a hand selector. The Tooltip displays the underlying data. To highlight a specific data series, click a single data point from that data series.

You can filter the data on some graphs and maps. Filters are displayed as a drop-down list; select the data of interest to see it displayed. If you want to clear your selections and return the graph or map to its original appearance, click on the 'reset view' button at the bottom.

When you position your cursor over a Tableau map, a search option will appear in the top left, type a location name to zoom to that area on the map. Click on the home button to return to the map's default view.

How do I download data from visualisations?

All data visualisations have been created using Tableau.

To view the underlying data, go to the [Data](#) page where you can download an Excel file (.xlsx format) containing the data.

Where does the information come from?

This report uses data from:

- the Medicare Benefits Schedule (MBS), via the Department of Health and Aged Care's enterprise data warehouse (EDW)
- the Australian Bureau of Statistics' (ABS) Estimates and Projections, Aboriginal and Torres Strait Islander Australians, Reference period 2006 - 2031 (2016 Census-based) (ABS 2019b)
- the ABS' Census of Population and Housing, 2016 [TableBuilder].

Why do the statistics change over time?

The statistics in this report are updated annually from live databases, which are updated over time, with later data supply likely to have a greater level of completeness.

When newer population estimates are used as denominators, this can impact the calculation of proportions - for example, the proportion of the Aboriginal and Torres Strait Islander population who received an annual health check in a given year.

I want to do my own data analysis, where can I get more data?

To view the underlying data, go to the [Data](#) page where you can download an Excel file (.xlsx format) containing the data.

The information in this report is free to download but must be used in accordance with our data use policy. Most information released by AIHW is made available under a Creative Commons BY 4.0 licence. For more information see [copyright at AIHW](#).

Patient and service counts in this report are generally suitable for aggregation, for example, summation of patient counts by age groups or geographic areas. Note that rounding errors may affect aggregation of geographic data.

If you have suggestions for data not currently available here, please submit a feedback form:

References

ABS (Australian Bureau of Statistics) (2019b) *Estimates and projections, Aboriginal and Torres Strait Islander Australians, 2006 - 2031*, ABS website, Australian Government, accessed 10 August 2023.

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Technical notes

On this page:

- [Counting services and people](#)
- [Dates and reference periods](#)
- [Geographic information](#)
- [Measuring time between health checks](#)
- [Comparability with other reports](#)

For information about the MBS items and population data used, see [Health checks](#) and [Follow-up services overview](#).

Counting services and patients

This report presents data using 2 different counting units:

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

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

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

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

- For counts of patients who received a health check or follow-up: where patients had more than 1 service in a financial year, age was calculated from the date of the first service for odd-numbered personal identifier numbers (PINs) and from the last service for even-numbered PINs in that financial year.
 - This tactic was used to reduce bias in the derivation of age, and was used to select from multiple patient postcodes as well. Upward bias on age is introduced when age is calculated at the date of the last health check in a financial year for patients with more than 1 service, because birthdays are likely to have passed by the time of the last service. A PIN's final digit is effectively random, so this tactic splits the patient records into 2 groups, with upward bias on half and downward bias on the other half. Age could otherwise have been calculated at the 31st of December to reduce bias, but then a separate tactic would need to be used for infants born after the midpoint and for managing multiple postcodes.
- For numbers of health checks over 5-years: where patients had more than 1 health check over the period, age was calculated from the date of the last health check in the reference period.
 - This tactic was used to better align with the population structure at the end of the reference period.
- For time between health checks: where patients had more than 1 health check in a financial year, age was calculated from the date of the last health check in the financial year.
 - This tactic was used to capture the time between the most recent 2 consecutive health checks on record.

Note: Since patients are assigned to only one age group in a given year, it is safe to combine data from multiple age groups if required. Similarly, combining data from multiple regions is generally safe, however rounding errors may compound to give slightly inaccurate sums.

Dates and reference periods

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

Most data in this report relate to services provided between 1 July 2011 and 30 June 2022, which were processed on or before 30 April 2023 (except for monthly data by telehealth status, processed on or before 30 June 2023, and the analysis of 'time between health checks', which covers activity back to 1999). Data are reported by date of service as this more accurately reflects when the service was provided. Due to lags between date of service and date of processing, there will be a small proportion of services provided during the reference period that are not captured in these data. For example, if a service was provided on 29 June 2022, but not processed until after the cut-off date, it will not be included in the data.

Data in this report are generally presented for financial years (1 July to 30 June). These are written with the second year abbreviated - for example, 2021-22 refers to the period from 1 July 2021 to 30 June 2022.

Geographic information

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

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

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

Due to these issues, various decisions need to be made about how best to allocate the postcode data to geographic regions. There will be some degree of inaccuracy in the resultant estimates, which will affect data in certain areas more than others - see [Box 1](#) later on this page.

For this report, postcodes were re-assigned to 7 different geographies (based on the 2016 Australian Statistical Geography Standard) - Statistical Areas Level 4 (SA4s), Indigenous Regions (IREGs), Primary Health Networks (PHNs), Remoteness Areas, Greater Capital City Statistical Areas (GCCSAs), states and territories, and clusters of Statistical Areas Level 3 (SA3s). Where postcodes fell across the boundaries of multiple areas (for example, multiple SA4s), data were apportioned based on the population distribution of Indigenous Australians, according to AIHW analysis of ABS population estimates at 30 June 2016. Records with invalid postcode information could not be assigned to sub-national areas.

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

For certain geographic levels (PHN, IREG and SA4), some of the Tableau figures allow areas to be filtered according to remoteness categories (Major cities, Inner and Outer regional, Remote and Very remote). These categories were assigned for each area based on the proportion of the Aboriginal and/or Torres Strait Islander Census count in 2016, across the 3 remoteness categories.

Box 1: Limitations of using postcode data to derive health check and follow-up use by geographic area

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

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

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

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

- the following SA4s: *Adelaide - Central and Hills (SA), Brisbane - West (Qld), Darwin (NT), Melbourne - Inner (Vic), Perth - Inner (WA), Sydney - Baulkham Hills and Hawkesbury (NSW), Sydney - City and Inner South (NSW)*
- the following IREGs: *Alice Springs (NT), Apatula (NT), Darwin (NT), Jabiru - Tiwi (NT), Katherine (NT), Nhulunbuy (NT), Tennant Creek (NT)*
- *Remote and Very remote* areas in the analysis by remoteness.

Measuring time between health checks

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

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

For example, a patient who received a health check on both 1 January 2021 and 1 January 2022 saw 12 calendar months elapse between health checks, whilst a patient who received a health check on both 1 January 2021 and 31 December 2021 saw only 11 calendar months elapse between health checks.

For mean and median time intervals: days were converted to months based on the average number of days per month {days ÷ (365÷12)}. This allowed for higher precision and accuracy compared with calculating means and medians from the number of fully elapsed months. Estimates were rounded downward to 0.1 of a month.

Comparability with other reports

As described in the [Dates and reference periods](#) section, the data in this report are based on the date of service (rather than date of processing), as this more accurately reflects when the service was provided. Data in this report may differ to those published elsewhere based on date of processing, including previous editions of this report. It may also differ to data published elsewhere based on date of service, where the date of processing cut-off is different. In certain cases, data with the same processing cut-off date may also differ slightly if patients' sex or date of birth are changed on the live patient dataset linked to MBS records. Age and location were also determined in a slightly different way to some other reports (see [Counting services and people](#) and [Geographic information](#), presented earlier).

In addition, this report primarily uses population estimates and projections, based on the 2016 Census, when calculating proportions. The proportions presented here may differ to those released in future updates of this report (or in other reports) when revised estimates based on the 2021 Census are used instead.

Temporary MBS items for people living in residential aged care facilities (RACF) are also excluded from this report.

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Technical notes

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AIHW	Australian Institute of Health and Welfare
COVID-19	coronavirus disease 2019
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DHAC	Department of Health and Aged Care
GCCSA	Greater Capital City Statistical Areas
GP	general practitioner
IHAD	Index of Household Advantage and Disadvantage
IREG	Indigenous Regions
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
nKPI	national Key Performance Indicators
PHN	Primary Health Network
PIN	personal identifier number
PO box	post office box
RACF	residential aged care facilities
RACGP	Royal Australian College of General Practitioners
SA3	Statistical Area Level 3
SA4	Statistical Area Level 4
SES	socioeconomic status

Timeline of major developments in health check implementation

Table 5: Major developments in health check implementation

Timing	Change	Details
November 1999	55 years and over annual health check (MBS items 704 and 706) introduced	The original First Nations health check was established as the First Nations equivalent of health checks for non-Indigenous people aged 75 years and over.
May 2004	15-54 years 2-yearly adult health check (MBS item 710) introduced	The extension of health checks to adults recognised that the conditions responsible for early deaths of First Nations people started before the age of 55.
May 2006	0-14 years annual child health check (MBS item 708) introduced	With this addition, First Nations people of all ages were eligible for preventive health checks.
November 2008	Follow-up health services (MBS items 10987 and 81300-81360) introduced	Allowed First Nations people who received a health check to receive subsidised follow-up care with a Practice Nurse, registered Aboriginal and Torres Strait Islander Health Worker or a range of allied health professionals.
December 2008	National Partnership Agreement implemented	The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes included the Indigenous Chronic Disease Package . This package was funded by the Australian Government over 4 years from 2009-2013 and included a number of elements relevant to improving uptake of First Nations health measures.
July 2009	Medicare Local Closing the Gap workforce established	Part of the Indigenous Chronic Disease Package , this workforce comprised: <ul style="list-style-type: none"> • 86 full-time equivalent First Nations outreach workers to support First Nations people access primary health-care services and follow-ups • 86 full-time equivalent First Nations health project officers to lead First Nations health issues within Medicare Locals, and raise awareness of Closing the Gap initiatives relevant to mainstream primary care. <p>This workforce assisted with the delivery of the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs.</p>
March 2010	Practice Incentive Program Indigenous Health Incentive introduced	Part of the Indigenous Chronic Disease Package , the Indigenous Health Incentive was included under the Practice Incentives Program .
May 2010	Health check items 704, 708 and 710 combined	The 3 separate item numbers were replaced by a single item: MBS item 715. The frequency of health checks was standardised to annual, so First Nations people aged 15-54 were able to have a health check every year, instead of every 2 years.
2010	Indigenous status required by Royal Australian College of General Practitioners Standards	Existing requirements were strengthened, so practices seeking accreditation had to demonstrate they were routinely recording Indigenous status in their active patient records.
July 2011-12	Divisions of General Practice transitioned to Medicare Locals	Divisions of General Practice (n=112), as well as their national and jurisdiction level support structures (the Australian General Practice Network and 8 state-based organisations) were replaced with Medicare Locals (n=62), as part of the National Health Reform Agenda.
2013	National Aboriginal and Torres Strait Islander Health Plan 2013-2023	As part of efforts to close the gap, since 2011, the Australian Government worked with First Nations people to produce the National Aboriginal and Torres Strait Islander Health Plan , providing an opportunity to collaboratively set out a 10-year plan for the direction of Indigenous health policy
June 2014	Australian Medicare Local Alliance abolished	Australian Medicare Local Alliance (the national coordination body for Medicare Locals) was abolished. Regional coordination and support of the Closing the Gap workforce undertaken by the Alliance also ceased.

2015	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023	The Implementation Plan outlines the actions to be taken by the Australian Government and other key stakeholders to give effect to the vision, principles, priorities and strategies of the Health Plan , including goals for increasing the use of First Nations health checks.
July 2015	Medicare locals replaced by Primary Health Networks	Medicare Locals (n=62) were replaced by Primary Health Networks (n=31). In 2015-16, funding for the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs was provided through Primary Health Networks.
July 2016	Integrated Team Care Activity started	Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care program funding was combined into new Integrated Team Care Activity.
July 2018	MBS health check item, 228, introduced for non-VR Medical Practitioners	Allows eligible non-vocationally recognised medical practitioners (other than GPs and specialists) to claim MBS subsidies for First Nations health checks.
March 2020	COVID-19 temporary telehealth health check and follow-up items introduced	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (available until 30 September 2020).
September 2020	COVID-19 temporary telehealth items extended until 31 March 2021	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 30 September 2020).
December 2020	COVID-19 temporary health check items, 93470 and 93479, and follow-up items, introduced for residential aged care facilities	To improve access to multidisciplinary care for residents of residential aged care facilities (RACF) during the COVID-19 pandemic (available until 30 June 2022).
March 2021	COVID-19 temporary telehealth items extended until 30 June 2021	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 31 March 2021).
April 2021	COVID-19 temporary videoconference (telehealth) items extended until 31 December 2021	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 30 June 2021).
July 2021	COVID-19 temporary telephone (telehealth) items were discontinued at the end of June	Videoconference services were the preferred approach for substituting a face-to-face consultation.
2021	Health check templates	The National Aboriginal Community Controlled Health Organisation (NACCHO) and Royal Australian College of General Practitioners (RACGP) released 5 First Nations health check templates for testing, designed for different age groups, and downloadable from the RACGP website .
2021	National Aboriginal and Torres Strait Islander Health Plan 2021-2031	The National Aboriginal and Torres Strait Islander Health Plan 2021-2031 is the updated national policy to improve health and wellbeing outcomes for First Nations people over 10 years.
December 2021	Some COVID-19 temporary telehealth items became permanent	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 31 December 2021).
July 2022	COVID-19 temporary RACF items were discontinued at the end of June	—
2021-2023	Health check Smart Form development	The Department of Health commissioned CSIRO to develop Smart Forms for health checks, using Item 715 as a proof of concept. Smart Forms are intended to streamline the collection and sharing of clinical information to improve patient outcomes.



Glossary

Aboriginal and/or Torres Strait Islander: In most data collections, a person who identified themselves, or was identified by another household member, as being of Aboriginal or Torres Strait Islander origin. For a few data collections, information on acceptance of a person as being Indigenous by an Indigenous community may also be required. See also **First Nations**.

Aboriginal and Torres Strait Islander health practitioner: An Aboriginal and/or Torres Strait Islander person who has gained a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. For more information, see the [Aboriginal and Torres Strait Islander Health Practice Board of Australia](#) website.

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

Aboriginal Community Controlled Health Services (ACCHSs): Primary health care services initiated and operated by local Indigenous communities to deliver comprehensive, holistic and culturally-appropriate health care to the community that controls it through a locally elected board of management. These services range from large multi-functional services employing several medical practitioners to small services that rely on nurses and/or Aboriginal and Torres Strait Islander health workers. For more information, see the [National Aboriginal Community Controlled Health Organisation \(NACCHO\)](#) website.

allied health: Health care provided by a medical professional who is not a doctor, dentist, nurse, or midwife. For more information, see [Healthdirect](#) website.

average: Sum of all the values in a set of values, divided by the number of values in that set. Often used as a representative value of that set.

First Nations: Used interchangeably with Aboriginal and Torres Strait Islander. See also **Aboriginal and/or Torres Strait Islander**.

First Nations follow-up: A Medicare-rebated service following a health check, available specifically to Aboriginal and Torres Strait Islander people. Patients can receive up to 10 follow-up services from an Aboriginal and Torres Strait Islander health practitioner or practice nurse on behalf of a general practitioner (GP) per calendar year, and up to 5 follow-up services from eligible allied health professionals with referral from a GP per calendar year. See also **First Nations health check**.

First Nations health check: A health assessment available specifically to Aboriginal and Torres Strait Islander people through a limited list of Medicare item numbers, provided by a general practitioner (GP). The minimum time allowed between services is 9 months. The aim of health checks is to assess patients' physical, psychological and social wellbeing, and to support patients in accessing subsequent health care services. For more information, read about [Annual health checks for Aboriginal and Torres Strait Islander people on the Department of Health and Aged Care](#) website. See also **First Nations follow-up**.

follow-up percentage: The proportion of health check patients who received a First Nations follow-up service in the 12 months following their health check. Derived from the number of health check patients with a follow-up divided by the number of total health check patients in a given year.

general practitioner (GP): Medical practitioners who have completed a specialist training program in general practice and have obtained a fellowship from an Australasian specialist college. They are registered as specialists in general practice with the Medical Board of Australia. See also **medical practitioners other than GPs**.

Greater Capital City Statistical Area (GCCSA): Geographical areas designed to represent the functional areas of Australian capital cities through population who regularly interact with, but not necessarily live within, the capital cities. The remainder of the State or Territory which is not included in the capital city is represented by a Rest of State region. Part of the Australian Statistical Geography Standard.

health check uptake: The proportion of First Nations people who received a health check in a given year. Derived from the number of health check patients divided by the estimated resident population or projected population at the midpoint of the year.

Index of Household Advantage and Disadvantage (IHAD): An experimental analytical index developed by the ABS. It provides a summary measure of relative socioeconomic advantage and disadvantage for households, based on the characteristics of dwellings and the people living within them. For more information, read about the [IHAD on the Australian Bureau of Statistics](#) website.

Indigenous Region (IREG): Indigenous Regions are large geographical areas used to report data about First Nations people. Part of the Indigenous Structure in the Australian Statistical Geography Standard. Compared with other structures in the Australian Standard Geography Standard, the Indigenous Structure better reflects the distribution of the Indigenous population.

mean: Average of a group of numbers. See also **average**.

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

medical practitioners other than GPs: Medical practitioners who have not completed a specialist training program in general practice or have not obtained a fellowship from an Australasian specialist college. They may be working towards becoming general practitioners or pursuing other career paths. See also **general practitioners**.

Medicare: A national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care.

Medicare Benefits Schedule (MBS): The Medicare Benefits Schedule (MBS) is the listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme (Medicare).

national Key Performance Indicators (nKPI): The national Key Performance Indicator collection is a set of primary health indicators for First Nations people which focuses on maternal and child health, preventative disease management. The collection commenced in June 2012 and is ongoing with data collection occurring every 6 months from more than 200 First Nations-specific primary health organisations across Australia.

Primary Health Network (PHN): Independent organisation funded by the Australian Department of Health and Aged Care to coordinate primary health care. Each PHN cares for a corresponding geographical region. Together, the PHNs geographically cover the whole of Australia.

Remoteness Area: Classification that divides each state and territory into several regions based on their relative accessibility to goods and services (such as general practitioners, hospitals and specialist care) as measured by road distance. These regions are based on the Accessibility/Remoteness Index of Australia and defined as Remoteness Areas by the Australian Statistical Geography Standard.

residential aged care facility: Australian Government-approved aged care home, including accommodation (bedding and other furnishings, meals, laundry, social activities), personal care (bathing, showering, toileting, dressing, eating, moving about), and nursing and allied health services if required.

socioeconomic cluster: For the purposes of this report, Statistical Areas Level 3 (SA3s) were grouped into 5 clusters, based on the proportion of Aboriginal and/or Torres Strait Islander people counted in each decile from the ABS' 2016 Census-based Index of Household Advantage and Disadvantage (IHAD) analysis. All clusters contain some people from each of the 10 IHAD deciles, but the proportions vary considerably. Clusters were designed to capture targeted population proportions. Population apportionment was based on the Aboriginal and/or Torres Strait Islander estimated resident population in 2016 by SA3. The first cluster contains approximately 10% of the First Nations population; the second, 20%; the third, 40%; the fourth, 20%; and the fifth, 10%. See also **Index of Household Advantage and Disadvantage**.

socioeconomic ranking: The order of geographic areas when sorted by socioeconomic score. See also **socioeconomic score**.

socioeconomic score: The average Index of Household Advantage and Disadvantage (IHAD) decile number for those persons who identified as Aboriginal and/or Torres Strait Islander, had a valid IHAD score in 2016, and were at home on Census night 2016. For a given area, the lowest possible score would be 1, if all people lived in households in the first (most disadvantaged) decile; the highest possible score would be 10, if all people lived in households in the tenth (most advantaged) decile. The average for the total First Nations Census count was 3.88, while the average for the total Australian Census count was 6.14. See also **Index of Household Advantage and Disadvantage**.

socioeconomic status: The social and economic position of an individual or group within the larger society. In exploratory analysis as part of this report, socioeconomic status was factored in using the Index of Household Advantage and Disadvantage (IHAD) based on the 2016 Census, to determine which areas were the most disadvantaged (lowest socioeconomic status areas) and which were the most advantaged (highest socioeconomic status areas). See also **Index of Household Advantage and Disadvantage**.

statistical areas: Geographical classifications forming part of the main Australian Statistical Geography Standard structure. They encompass four levels, with increasing size and population: Statistical Areas Level 1 (SA1s); Statistical Areas Level 2 (SA2s); Statistical Areas Level 3 (SA3s); and Statistical Areas Level 4 (SA4s).

telehealth status: Whether a health service was performed face-to-face or via telehealth, through telephone or videoconference.



Data





Related material

Resources

Related topics

- [Primary health care](#)
-





Notes

Acknowledgements

This edition of the [Health checks and follow-ups for Aboriginal and Torres Strait Islander people](#) web report was prepared by Hayden Stevens, Natalia Eiré Sommer and Amelia Cook of the Australian Institute of Health and Welfare (AIHW), with guidance from Martin Edvardsson and Fadwa Al-Yaman.

The Department of Health and Aged Care funded this work and provided valuable advice and input.





Archived content

19 August 2022 release - web report and data tables

2 July 2021 release - web report and data tables

24 June 2019 release - web report and data tables

Cat. no: WEB 125 (superseded)

6 December 2017 release - web report and data tables

