6.8 Indigenous Australians' access to and use of health services

To evaluate whether the health system is adequately meeting the needs of Aboriginal and Torres Strait Islanders, it is important to understand their access to, and use of, health services. Indigenous Australians may access mainstream or Indigenous-specific primary health care services (ISPHCS), which offer prevention, diagnosis and treatment of ill health in a range of settings (see Chapter 7.5 'Primary health care'). The Australian Government and/or state and territory governments fund Indigenous-specific services. They are available through community clinics, services provided by Aboriginal Community Controlled Health Organisations (ACCHOs) and other health care facilities. There are also Indigenous-specific services offered within some public hospitals in Australia.

Conceptually, access can mean many things. It can refer to whether health services are geographically accessible (that is, within a reasonable travel time/distance), financially accessible, culturally accessible, or whether they have the workforce or capacity to see patients when they need assistance. From a systemic perspective, where health services are located and how often people access or use those that are available are important measures. Data on all these aspects are rarely available, however. In their absence, service use is often used as a proxy measure.

This snapshot focuses on three indicators of service access and use: the availability of services provided by ISPHCS, the use of selected health services claimed through Medicare, and the use of hospital services.

Indigenous-specific primary health care services

In 2015–16, ISPHCS were delivered by 204 organisations from 368 sites. Two-thirds (136 organisations) were ACCHOs; the other 68 comprised state and territory government-run organisations and other non-government-run organisations.

ISPHCS are an important service provider for Indigenous Australians throughout Australia. In 2015–16, one-third (33%) of services were located in *Very remote* areas, 23% in *Outer regional* areas and 21% in *Inner regional* areas. Smaller proportions were in *Remote* areas (13%) and *Major cities* (10%).

ISPHCS provided 3.9 million episodes of care to around 461,500 clients in 2015–16. However, because people may use several different ISPHCS, the number of clients is greater than the number of unique individuals who have used an ISPHCS (that is, if a person uses 2 different services, they will be counted as 2 clients—one at each service).

Most (89%) sites operated 5 days or more per week, and 26% offered 24-hour emergency care, which was similar to the scenario in 2014–15 (88% and 26%, respectively). Most sites provided clinical services, such as the diagnosis and treatment of chronic illnesses (85%), antenatal care (75%), maternal and child health care (80%), and mental health and counselling services (84%). Many also offered tobacco programs (61%) and substance-use programs (60%).

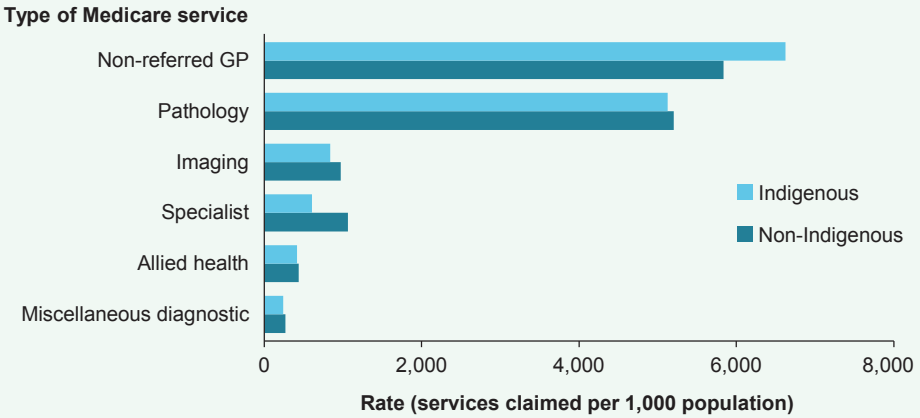
Australian Institute of Health and Welfare 2018. *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW.

Use of selected health services claimed through Medicare

Data from 2015–16 show that Medicare Benefits Schedule (MBS) claim rates for general practitioner (GP) visits were 10% higher for Indigenous than non-Indigenous Australians, but claim rates for specialist services were 43% lower. This may reflect difficulties in accessing specialist services (Figure 6.8.1).

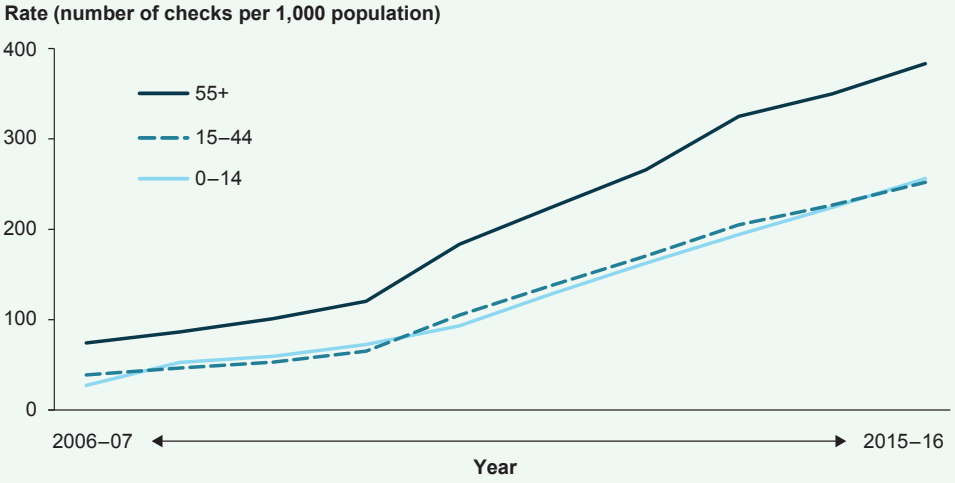
Both the number and rates of MBS health checks among Indigenous Australians rose significantly from 2006–07 to 2015–16 for all age groups (Figure 6.8.2; Table 6.8.1). In 2006–2007, there were around 22,500 health checks performed. By 2015–16, that number had risen to nearly 197,000.

Figure 6.8.1: Age-standardised rate of claimed Medicare services, by selected types of service and Indigenous status, 2015–16



Source: DHS 2017; Table S6.8.1.

Figure 6.8.2: Rate of MBS health checks for Indigenous Australians, by age, 2006–07 to 2015–16



Source: DHS 2017; Tables S.6.8.2.

Table 6.8.1: Number of MBS health checks/assessments for Indigenous Australians[a] (MBS item 715[b]), by age, 2006–07 to 2015–16[c]

Age	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
0–14	6,315	12,397	14,160	17,363	22,415	31,078	39,420	47,414	55,245	63,790
15–44	12,775	15,684	18,369	23,197	38,331	51,757	65,525	80,645	91,172	103,565
55+	3,473	4,262	5,254	6,602	10,623	13,744	17,216	22,295	25,369	29,404
Total[d]	**22,563**	**32,343**	**37,783**	**47,162**	**71,369**	**96,580**	**122,160**	**150,354**	**171,786**	**196,758**

(a) Indigenous identification not adjusted using Voluntary Indigenous Indicator (VII) data.
(b) As Item 715 started in May 2010, MBS codes 704, 706, 708 and 710 were reclassified as 715 for prior years.
(c) Financial year reporting.
(d) Total may not sum exactly due to rounding.

Source: DHS 2017.

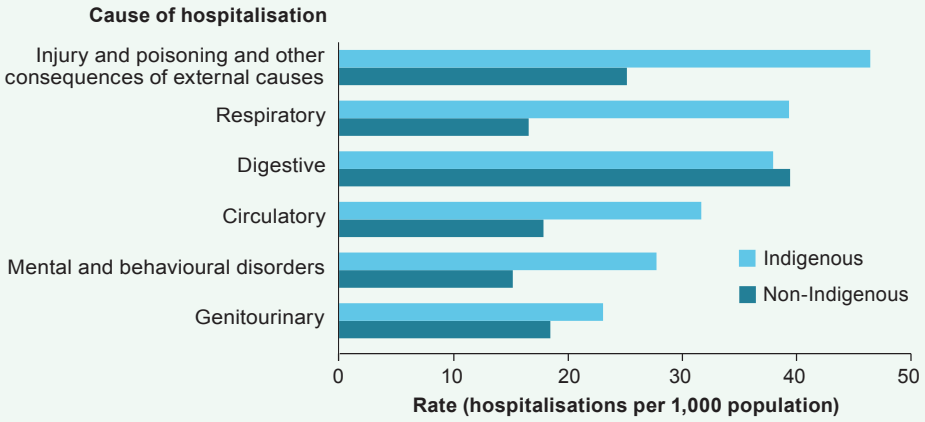
Hospital services

Indigenous Australians are relatively high users of hospital services, most of which are accessed through public hospitals. Between July 2013 and June 2015, there were around 458,000 hospitalisations (excluding dialysis) for Indigenous Australians; this equates to a rate that is 1.3 times the rate for non-Indigenous Australians. There were an additional 393,000 dialysis-related hospitalisations.

Admissions for potentially preventable conditions (PPHs) reflect hospitalisations that might have been prevented through the timely and appropriate provision and use of primary care or other non-hospital services (Li et al. 2009). In 2013–15, the rate for PPHs was 3 times as high for Indigenous Australians (69 per 1,000 compared with 23 per 1,000 for non-Indigenous Australians).

The leading cause of hospitalisation in 2013–15 for Indigenous Australians was injury, poisoning and other external causes, followed by respiratory system diseases (Figure 6.8.3). The only specific cause of hospitalisation where the rate for non-Indigenous Australians was higher than that for Indigenous Australians was for digestive conditions.

Figure 6.8.3: Age-standardised rates of the leading causes of Indigenous hospitalisation, by Indigenous status, 2013–15



Note: Excluding dialysis and pregnancy/childbirth.
Source: National Hospital Morbidity Database; Table S6.8.3.

What is missing from the picture?

Comprehensive data on Indigenous Australians' use of mainstream health services are lacking. This makes it difficult to determine patterns in the use of health services. Incomplete identification of Indigenous people in mainstream health services data can also lead to an underestimation of service use. Data are also missing on the number of unique individuals using ISPHCS as clients who use more than one service are counted within each service.

Where do I go for more information?

For more information on spatial access to services see the AIHW reports *Spatial variation in Aboriginal and Torres Strait Islander women's access to 4 types of maternal health services*, *Spatial variation in Aboriginal and Torres Strait Islander people's access to primary health services* and *Access to primary health care relative to need for Indigenous Australians*.

Data and information on ISPHCS are available from the AIHW website: <www.aihw.gov.au/reports-statistics/health-welfare-services/indigenous-health-welfare-services/overview>, and the interactive health check tool is available at <www.aihw.gov.au/reports/indigenous-health-welfare-services/indigenous-health-check-mbs-715-data-tool/contents/dynamic-data-displays>.

References

DHS (Department of Human Services) 2017. Medicare Item Reports. Data online at <http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp>.

Li SQ, Gray NJ, Guthridge SL & Pircher SBLM 2009. Avoidable hospitalisation in Aboriginal and non-Aboriginal people in the Northern Territory. Medical Journal of Australia 190(10):532–6.