

Part IX: Health services

Chapter 21: Health services to individuals

21. Health services to individuals

Australia has a complex health system, with a range of types and providers of services and a number of funding and regulatory mechanisms. Services are provided by medical practitioners, other health professionals, hospitals, and other government and non-government agencies. Funding is provided by the Commonwealth Government, State and Territory Governments, private health insurers, and individual Australians (AIHW 2000a).

Patients admitted to public hospitals are not charged for their treatment, food or accommodation, unless private treatment has been chosen. Emergency department and outpatient services are free. Australians treated as 'private patients' can choose their own doctors, but all hospital services must be paid for by the patient, their private health insurance, or other arrangements such as compensation. Patients who visit dentists and other private sector health professionals must meet the cost of these consultations themselves, or with the support of private health insurance (AIHW 2000a). Some dental hospitals and community health centres offer free treatment, but eligibility is restricted and the waiting times can be lengthy.

There are differences in the provision of health services to particular population groups. There is an uneven distribution of services between metropolitan, rural and remote areas, with a lack in many rural and remote communities. People in rural and remote areas may also have difficulty accessing health services, compared with those living in metropolitan areas, due to problems with distance, time, cost and transport (AIHW: Strong et al. 1998). These barriers to service provision are even greater for people living in poverty. Socioeconomic status can be a factor in whether or not people use health services, even in metropolitan areas where many services are available. Ward & Pratt (1996) found that in Perth, Western Australia, children were more likely to consult a doctor if their parents did not have to pay upfront for the consultation (that is, they were bulk-billed).

In metropolitan areas, there are 306 doctors per 100,000 population; in rural and remote areas, there are 144 doctors per 100,000 population (AIHW 2000a). Similarly, there are many more nurses and dentists per 100,000 population in metropolitan areas than in non-metropolitan areas. The Commonwealth Government has introduced a number of initiatives in an attempt to address this imbalance, such as increasing the number of medical students from rural and remote regions and from Aboriginal and Torres Strait Islander populations. Other strategies being used include telemedicine (telecommunication centres set up specifically for the delivery of health care services), increasing the number of temporary resident overseas-trained doctors, and using incentive schemes to attract doctors to rural and remote areas and to keep them there (AIHW 2000a).

People in rural and remote areas are less likely to use general practitioners, instead using services such as hospital in- or out-patient services, salaried community medical services (such as Aboriginal health services) and substitute primary care providers (such as Aboriginal health workers and registered nurses) (AIHW: Strong et al. 1998). People requiring specialist services must travel to larger towns, or wait for services to come to them on a rotation basis. Models of health care in rural and remote areas are quite different from those in metropolitan areas because of the distances that doctors, community care nurses, and patients have to travel. Rates of hospital admission and length of stay are greatly influenced by travel distances.

Factors such as poverty are compounded by cultural issues which affect Aboriginal and Torres Strait Islander communities (Hupalo & Herden 1999). Communities need to have control over health services, particularly population health interventions, in order for

them to be effective. To this end, in 1994 the Commonwealth Government established the Office for Aboriginal and Torres Strait Islander Health (OATSIH), which funds Aboriginal and Torres Strait Islander primary health and substance misuse services, such as those administered by the National Aboriginal Community Controlled Health Organisation (NACCHO). In 1998–99, over 80% of these services diagnosed and treated illness and disease (DHAC 2001b). Other services undertaken in Indigenous primary health care services include immunisation, monitoring of child health, and providing health-related community support services such as transport and school-based activities. In 1999, most health workers, substance misuse workers, dental assistants, and drivers or field officers in Indigenous health services were Indigenous Australians, while most doctors, nurses, specialists and dentists were other Australians.

This chapter provides an overview of health services using currently available national data, including information on specialist services in public hospitals, the labour force providing these services, and private health insurance coverage and health service use.

Provision of services

Specialist services in public hospitals

Information on specialist services for children in public hospitals is available from two national data collections. First, information on the number of certain specialised services is collected as part of the National Public Hospital Establishments Database, collated by the AIHW from data provided by each of the States and Territories. Second, information on the number of beds available in public hospitals for mental health services particularly targeting children and adolescents was included in the National Survey of Mental Health Services, conducted in 1998 for the Mental Health and Special Programs Branch of the then Commonwealth Department of Health and Aged Care.

Table 21.1: Number of public acute^(a) hospitals with certain specialised services, 1999–00

Specialised services	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Obstetric/maternity services	90	67	61	40	32	5	3	5	303
Specialist paediatric service	49	25	29	15	9	3	2	3	134
Neonatal intensive care unit (level III)	13	4	3	2	2	1	1	1	27

(a) Excludes psychiatric and drug and alcohol hospitals.

Note: Data for Victoria and South Australia may be slightly underestimated as some small multi-campus rural services reported at network rather than campus level. Consequently, if two campuses within the group had a specialised type of service, they were counted as one.

Source: AIHW 2001f.

- In 1999–00, there were 303 specialised obstetric/maternity services in public hospitals across Australia.
- Specialised paediatric services were provided in 134 hospitals, with most of these in the largest three States (New South Wales, Victoria and Queensland).
- There were 27 hospitals with neonatal intensive care units nationwide in 1999–00.

Table 21.2: Beds for specialised child and adolescent mental health services for children aged 0–18 years, 1997

Services subprogram	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Number									
Acute	54	70	25	36	15	—	—	—	200
Non-acute	31	—	15	—	—	—	—	—	46
<i>Total</i>	<i>85</i>	<i>70</i>	<i>40</i>	<i>36</i>	<i>15</i>	—	—	—	<i>246</i>
Beds per 100,000									
Acute	3.4	6.1	2.8	7.6	4.1	—	—	—	4.2
Non-acute	2.0	—	1.7	—	—	—	—	—	1.0

Source: DHAC 2000b.

- In 1997, there were 246 beds available across Australia for specialised child and adolescent mental health services. Of these, 81% were for acute care. No beds were available for these specialised services in Tasmania, the Australian Capital Territory or the Northern Territory.
- There were 4.2 beds for acute mental health care, and 1 bed for non-acute care, per 100,000 population aged 0–18 years. In Western Australia, there were more beds per 100,000 for acute care (7.6) than in any other State or Territory.
- Nationally, there was a 14% increase in the number of beds available for specialised child and adolescent mental health services between 1994 and 1997. The number increased in Victoria and Queensland, by 67% and 43%, respectively, while the number in New South Wales, Western Australia and South Australia fell by 5%, 3% and 25%, respectively (DHAC 2000b).

Labour force

Information is provided here on both medical practitioners and registered nurses specialising in areas directly relating to child health. Data come from State and Territory surveys and are compiled into a national data collection by the AIHW.

Medical practitioners

Data on medical practitioners come from the national medical labour force survey conducted by the AIHW in conjunction with the annual re-registration of medical practitioners. All medical practitioners registered in each State and Territory were included in the survey.

Table 21.3: Medical practitioners with specialties in child health areas, as a proportion of all medical specialists, 1998

Specialised services	Number	Per cent^(a)
All medical specialists practising in each speciality		
Paediatric medicine	865	4.6
Paediatric surgery	86	0.5
Obstetrics and gynaecology	1,081	5.7
Specialists for whom the speciality is their main field of practice		
Paediatric medicine	793	4.8
Paediatric surgery	77	0.5
Obstetrics and gynaecology	1,055	6.4
Specialists in training		
Paediatric medicine	397	8.9
Paediatric surgery	10	0.2
Obstetrics and gynaecology	273	6.1

(a) Percentages are determined within each specialised services group.

Note: In 1998, the response rate for the survey was 81.3%.

Source: AIHW 2000b.

- In 1998, 865 (4.6%) specialists worked in the area of paediatric medicine, and 86 (0.5%) in paediatric surgery. Most of these also listed these areas as their main specialty of practice (793 and 77, respectively). The number of doctors specialising in paediatric medicine increased from 790 in 1996, while the number of paediatric surgeons has remained constant.
- There were 397 doctors training in the specialty of paediatric medicine (8.9% of all specialists in training), and 10 in paediatric surgery (0.2%). These numbers are slightly lower than those in 1996.
- Of all specialist doctors, 1,081 (5.7%) were specialists in obstetrics and gynaecology. There were 273 doctors training in the specialty of obstetrics and gynaecology (6.1% of all specialists in training), an increase from 254 in 1996.

General practitioners (GPs) may also obtain further qualifications in particular areas, or have a special interest in these areas. Information is available from the survey on the number of GPs with interests in health services for children (paediatric medicine, obstetrics/gynaecology, adolescent health) and for certain population groups (rural and remote medicine, Aboriginal health).

Table 21.4: Primary care practitioners mainly practising in a special interest area, as a proportion of all primary care practitioners, 1998

Special interest area	Vocational registered/ RACGP trainee ^(a)		OMPs ^(b)		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Paediatric medicine	23	2.3	25	4.0	48	2.9
Obstetrics and gynaecology	32	3.1	4	0.6	36	2.2
Adolescent health	14	1.4	5	0.8	19	1.2
Rural and remote medicine	11	1.1	8	1.3	19	1.2
Aboriginal health	37	3.6	4	0.6	41	2.5

(a) Royal Australian College of General Practitioners trainee: general practitioner trainee.

(b) OMPs: other medical practitioners not vocationally registered.

Source: AIHW 2000b.

- In 1998, 48 GPs (2.9%) stated they had a special interest in the area of paediatric medicine. A smaller number (19 or 1.2%) were particularly interested in adolescent health.
- Thirty-six GPs (2.2%) had an interest in obstetrics and gynaecology, and 41 (2.5%) in Aboriginal health.
- Fewer GPs were interested in rural and remote medicine (19 or 1.2%).
- For all special interest areas except paediatric medicine and rural and remote medicine, vocationally registered GPs or GP trainees made up the majority of primary care practitioners mainly practising in a special interest area.

Registered nurses

The AIHW compiles the national data on nurses used for this section in a similar manner as for the medical labour force information. The latest published data are for 1997.

Table 21.5: Registered nurses working in child health related areas, as a proportion of all registered nurses, 1997

	Number	Per cent
Area of clinical nursing^(a)		
Paediatric	3,826	2.5
Midwifery	13,675	8.9
Developmental disability	1,838	1.2
Child and family health	2,620	1.7
School children's health	628	0.4
Work setting of main job		
Developmental disability service	2,511	1.4
School	665	0.4

(a) For registered nurses employed as clinicians.

Note: In 1997, the response rate for the survey was 78.7%.

Source: AIHW 2001g.

- In 1997, there were nearly 4,000 registered nurses working in the clinical area of paediatrics (2.5% of all nurses), and another 2,620 in child and family health (1.7%).

- Of the clinical areas related to child health, midwifery had the highest number of registered nurses (13,675 or 8.9%).
- Over 600 registered nurses (0.4%) across Australia worked in a school.

Table 21.6: Registered nurses with qualifications in child health related areas, 1997

Post-basic qualifications ^(a)	Number
Midwifery	39,186
Child and family health	5,916
Paediatric	2,990
Neonatal intensive care	2,581
Developmental disability	1,257
Paediatric intensive care	576

(a) For NSW, Vic, Tas and the ACT, figures represent all post-basic qualifications held by registered nurses. For Qld, SA and the NT, figures represent post-basic qualifications held by registered nurses, where the skills learned have been used for 12 months or more in the previous 5 years. For WA, they represent post-basic qualifications held by registered nurses where the skills learned have ever been used.

Source: AIHW 1999b.

- In 1997, more nurses had post-basic qualifications in midwifery (39,186) than in any other area.
- Many nurses also had post-basic qualifications in child and family health (5,916).

Private health insurance

This section provides information on the health insurance coverage of Australian children.

In recent years, the Commonwealth Government has introduced a number of incentives in order to encourage Australians to take up private health insurance, with the stated aim of alleviating some of the burden on the public health system.

- In July 1997, the Commonwealth announced that, in families where the combined taxable income was greater than \$100,000 a year, a Medicare levy surcharge of 1%, in addition to the normal 1.5% Medicare levy, would be payable for families without private health insurance. This surcharge was introduced to encourage high-income earners to take out or retain private health insurance.
- In January 1999, the Commonwealth introduced the 30% Rebate Initiative, whereby all Australians who qualify for Medicare and who are members of a registered health insurance fund are entitled to receive a 30% rebate on any premiums they pay to the fund.
- The Lifetime Health Cover initiative commenced in July 2000. This initiative rewards people for taking out private hospital cover earlier in life and maintaining it. People who take out, and maintain, private hospital cover before their 31st birthday will always pay the lowest premium, while those who join later will pay a 2% loading on top of their premium for each year they are aged over 30 years at the date of joining.

Table 21.7: Children aged 0–14 years living in families with private health insurance, June 1999 to June 2001

Age (years)	1999		2000		2001	
	Number	Per cent of all children	Number	Per cent of all children	Number	Per cent of all children
0–4	326,095	25.6	482,912	38.2	490,684	39.0
5–9	366,110	27.5	560,146	42.1	585,144	44.1
10–14	404,906	30.8	606,723	45.7	644,944	48.2
0–14	1,097,111	28.0	1,649,781	42.1	1,720,772	43.9

Source: Private Health Insurance Administration Council 2001.

- In June 2001, over 1.7 million Australian children aged 0–14 years were covered by private health insurance. This was 43.9% of the child population.

Table 21.8: Percentage change in insurance status of children aged 0–14 years living in families with private health cover, June 1999 to June 2001

Age (years)	June 1999 to June 2000	June 2000 to June 2001
0–4	48.1	1.6
5–9	53.0	4.5
10–14	49.8	6.3
0–14	50.4	4.3

Source: Private Health Insurance Administration Council 2001.

- Between June 1999 and June 2000, there was a considerable increase (50.4%) in the number of children covered by private health insurance, most likely due to anticipation of the introduction of the Lifetime Health Cover initiative in July 2000.
- The number of children covered by private health insurance also increased between June 2000 and June 2001, although the percentage change (4.3%) was far smaller than that for the year before.

Use of services

This section provides information on the use of services such as hospitals, sight and hearing tests, and baby health clinics, and on Medicare use.

Hospital admissions

Information on the patient status of hospital admissions to public and private hospitals is available from the AIHW National Hospital Morbidity Database. Of all hospital admissions in 1999–00 of children aged 0–14 years, 82% were to public hospitals, and 18% to private hospitals (Table 21.9).

Table 21.9: Hospitalisations of children aged 0–14 years, 1999–00

Patient status	Public hospitals ^(a)		Private hospitals ^(b)		All hospitals	
	Number	Per cent	Number	Per cent	Number	Per cent
Eligible public patient	397,387	89.4	7,541	7.7	404,928	74.7
Eligible private patient	42,237	9.5	89,389	91.2	131,626	24.3
Other eligible patient ^(c)	2,315	0.5	467	0.5	2,782	0.5
Ineligible patient	2,334	0.5	136	0.1	2,470	0.5
Unknown	20	<.1	446	0.5	466	0.1
Total	444,293	100.0	97,979	100.0	542,272	100.0

(a) Includes public psychiatric hospitals.

(b) Includes private free-standing day hospital facilities.

(c) Includes eligible Department of Veterans' Affairs patients.

Source: AIHW National Hospital Morbidity Database.

- In 1999–00, 89.4% of hospitalisations of children aged 0–14 years in public hospitals were of public patients. Of children in private hospitals, 7.7% were public patients.
- Of hospitalisations of children in private hospitals, 91.2% were of private patients. Hospitalisations of private patients in public hospitals made up 9.5% of public hospital admissions.

Sight and hearing tests

The indicator for sight and hearing tests is the number of children aged 0–14 years who had their sight or hearing tested as a percentage of all children aged 0–14 years.

Data on sight and hearing tests were collected in the 1995 ABS Children's Health Screening survey (ABS 1996c). These data are presented in the following tables.

Table 21.10: Percentage of children aged 0–14 years having sight and/or hearing tests, 1995 (per cent)

	Age group (years)				
	Less than 2	2–4	5–9	10–14	0–14
Both sight and hearing tests	28.4	33.7	63.1	63.1	52.6
Sight tests only	4.9	4.7	9.1	16.2	10.0
Hearing tests only	17.3	22.6	12.0	7.5	13.3
Neither sight nor hearing tests	48.7	38.2	14.9	11.8	23.1
Other ^(a)	0.7	0.9	0.9	1.4	1.0
Total	100.0	100.0	100.0	100.0	100.0

(a) Includes not known if tested, and type of test not stated.

Source: ABS 1996c.

- Among children aged 0–14 years in 1995, 52.6% had had both sight and hearing tests. This percentage was higher among those aged 5–14 years (63.1%) than among those under 5 years.
- Of all children, 23.1% had had neither sight nor hearing tests.

Table 21.11: Reason for most recent sight or hearing test among children aged 0–14 years, 1995 (per cent)

Reason for last test	Age group (years)			
	0–4	5–9	10–14	0–14
Sight tests				
Known/suspected vision problems	11.2	20.0	30.1	22.6
Check-up	86.6	76.9	65.2	73.8
Other/not stated	2.2	3.1	4.7	3.6
Hearing tests				
Known/suspected hearing problems	8.7	14.0	13.0	12.2
Other medical ear problems	4.2	5.7	5.9	5.4
Check-up	85.3	78.2	78.9	80.3
Other/not known	1.8	2.0	2.2	2.0

Source: ABS 1996c.

- In 1995, the majority of children aged 0–14 years having sight tests were having a routine check-up (73.8%).
- Known or suspected vision problems were the reason for a sight test for 22.6% of children.
- A routine check-up was also the most common reason for hearing tests (80.3%).
- Known or suspected hearing problems led to a hearing test for 12.2%, while other medical ear problems were the reasons for hearing tests for 5.4% of children.

Baby health clinic visits

The indicator for baby health clinic visits is the number of children aged 0–3 years who visited a baby health clinic as a percentage of all children aged 0–3 years.

Table 21.12: Proportion of children aged 0–3 years who have visited a baby health clinic, 1995 (per cent)

Whether visited a baby health clinic	NSW	Vic	Qld	WA	SA	Tas	ACT	NT ^(a)	Australia
Yes	89.4	97.4	73.3	94.9	86.5	95.1	86.3	96.5	88.9
No	9.9	2.36	25.8	5.1	13.2	4.5	10.9	3.5	10.6
Not known	0.7	*	0.9	*	0.3	0.3	2.8	*	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* subject to sampling error variability too high for most practical uses.

(a) Estimates relate to predominantly urban areas.

Source: ABS 1996c.

- In 1995, among children aged 0–3 years, 88.9% had visited a baby health clinic.
- The proportions were highest in Victoria (97.4%), the Northern Territory (96.5%) and Tasmania (95.1%).
- It should be noted that baby health screening also occurs at places other than baby health clinics, and so these data may be an underestimation of actual screening levels.

Table 21.13: Frequency of visits to baby health clinics among children aged 0–3 years, 1995 (per cent)

	Age group (months)					
	0–2	3–5	6–11	12–18	18+	0–18+
Had regular checks ^(a)	55.9	61.8	59.6	46.9	57.6	56.4
Had irregular checks	*	18.9	28.7	42.3	30.6	29.5
Not checked/not stated	9.0	4.4	1.9	2.7	2.6	3.1
Had visited baby health clinic	64.9	85.1	90.2	91.8	90.8	88.9
Had not visited baby health clinic	35.1	14.8	9.5	8.2	8.5	10.6
Not stated	*	0.1	0.3	*	0.7	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

* subject to sampling error variability too high for most practical uses.

(a) Received checks as per NHMRC recommendations.

Source: ABS 1996c.

- In 1995, only 56.4% of children aged 0–3 years had received regular health checks. Children aged 3–5 months were most likely to have had them (61.8%).
- Of all children, 10.6% had not visited a baby health clinic. Among infants aged 0–2 months, the proportion was 35.1%.

Medicare use

Medicare items cover services provided outside hospitals by medical practitioners, either general or specialised, and treatment as a public patient in a public hospital.

Table 21.14: Average number of Medicare items per child aged 0–14 years, 1999–00

Sex	Age group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Males	0–4	10.2	9.7	9.8	8.4	9.3	8.3	8.3	5.3	9.6
	5–9	5.1	5.0	4.7	4.0	4.3	4.1	4.2	2.5	4.8
	10–14	4.5	4.3	4.3	3.9	3.8	3.7	3.8	2.1	4.2
Females	0–4	9.4	8.8	9.0	7.7	8.5	7.7	7.7	4.8	8.8
	5–9	5.1	5.0	4.7	4.2	4.3	4.2	4.3	2.5	4.4
	10–14	4.5	4.4	4.5	4.1	4.1	4.0	4.1	2.3	4.4

Source: HIC 2000.

- In 1999–00, there were nearly 10 Medicare items claimed for every boy under 5, and 9 items claimed for every girl under 5. For boys and girls aged 5–14 years, there were between 4 and 5 items claimed for each child.
- For every age group, the average number of Medicare items claimed for children in the Northern Territory was lower than the national average, and lower than in all other States and the Australian Capital Territory. It is likely that this relates to the shortage of general practitioners in rural and remote areas, and the tendency of people in these areas to seek medical care from other health professionals.