Australian Government
Australian Institute of Health and Welfare

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Healthy Communities

Patients' out-of-pocket spending on Medicare services, 2016–17

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This new report shows variation in the total annual out-of-pocket costs for patients for their Medicare-subsidised health care delivered outside a hospital. It shines a spotlight on how much patients pay out-of-pocket for specialist, general practitioner (GP), diagnostic imaging and obstetric services (otherwise known as the 'gap'). It also looks at where patients have reported delaying or not using health services because of cost.

Key findings

In 2016–17:

- Half of all patients—10.9 million people—incurred out-of-pocket costs for non-hospital Medicare services
- For these patients with costs, the median amount spent in the year was $142 per patient. The median out-of-pocket cost per patient varied across Primary Health Network (PHN) areas, from $104 to $206 per patient
- The 10% of patients with the highest costs spent at least $601 or more in the year. Across PHN areas, this ranged from $432 to $876 per patient
- Patients were more likely to pay for specialist and obstetric services. These services also attracted the highest out-of-pocket costs per service
- 8% of people aged 15 years and over, or an estimated 1.3 million people, said the cost of services was the reason that they delayed or did not seek specialist, GP, imaging or pathology services when they needed them. This percentage ranged from 5% to 13% across PHN areas. [1]

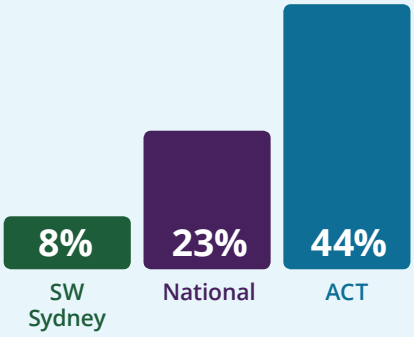
Visit www.myhealthycommunities.gov.au for more detailed results

Variation across PHN areas

Percentage of patients with any out-of-pocket costs for **Medicare services outside hospital**

Median out-of-pocket cost per **specialist attendance** (for patients with costs)

Percentage of patients with out-of-pocket costs for **diagnostic imaging services**



AIHW

About the report

This report looks at the out-of-pocket costs for patients in 2016–17, for health services that were delivered outside hospitals and subsidised by Australia's universal public health insurance scheme, Medicare. In 2016–17, around 9 in 10 Australians used one or more of these services, including GP, specialist, diagnostic imaging and pathology services (Box 1). While governments contributed $19.0 billion towards these non-hospital Medicare services in 2016–17, around $3.0 billion was paid for out-of-pocket by patients.

The report identifies differences between local areas in out-of-pocket costs for patients and areas where patients reported barriers to care due to cost. It uses data from two sources:

- Medicare Benefits Schedule (MBS), 2016–17
- Australian Bureau of Statistics (ABS) *Patient Experiences in Australia 2016–17 Survey*.

The ABS survey is based on a sample of people aged 15 and over who reported needing health services in the previous 12 months. See the Technical Note for more information about the ABS sample.

The report presents the proportion of patients with out-of-pocket costs, the total out-of-pocket cost per patient at the 50th (median) and 90th percentile (see Box 2), the amount patients spent out-of-pocket per service, and the proportion of people who delayed or did not use a service when needed due to cost.

Box 1: Out-of-pocket costs for non-hospital Medicare services

Medicare provides free or subsidised access to many treatments and diagnostic tests provided by health professionals outside of hospitals. This includes GPs and specialists, and diagnostic imaging, obstetric, radiotherapy, pathology and some allied health services. If the doctor or health service provider bills Medicare directly (bulk-billing), the patient pays no out-of-pocket cost. However, if the doctor or health service provider charges more than the Medicare rebate, the patient pays the 'gap', which is known as an out-of-pocket cost. Out-of-pocket costs for non-hospital Medicare services cannot be claimed through private health insurance.

Out-of-pocket spending on health care

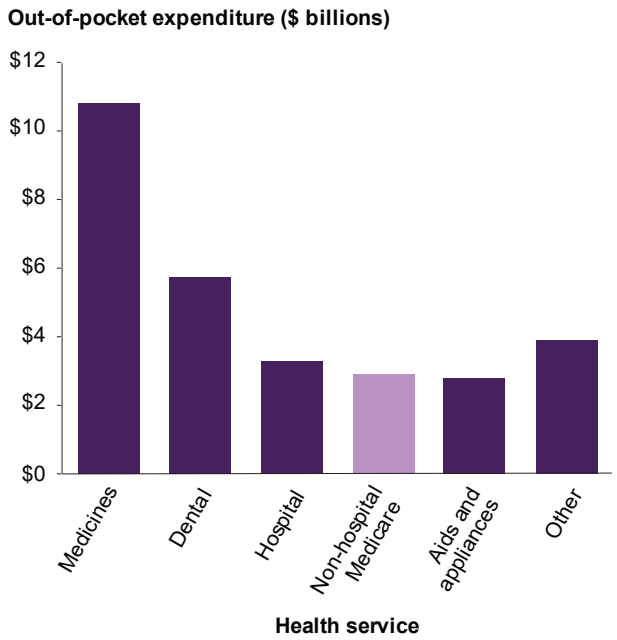
Medicare does not always cover the full cost of medical services. Doctors and other health care providers are free to set their own fees for consultations and procedures and the patient may need to contribute to the cost of those services.

Nationally, it is estimated that Australians spent $29.4 billion out-of-pocket on all their health-related expenses in 2015–16—**or about $1,195 per person**. This compares with $141 billion spent on health by governments, private health insurers and accident compensation schemes (AIHW 2017).

Out-of-pocket costs in 2015–16 included spending on:

- prescription and non-prescription medicines ($10.8 billion)
- dental services ($5.7 billion)
- hospital services ($3.3 billion)
- non-hospital Medicare-subsidised services ($2.9 billion)
- aids and appliances, including glasses, wheelchairs and hearing aids ($2.8 billion)
- other expenses, including allied health services not subsidised by Medicare ($3.9 billion) (Figure 1).

Figure 1: Total patient out-of-pocket spending on health in Australia, 2015–16 ($ billions)



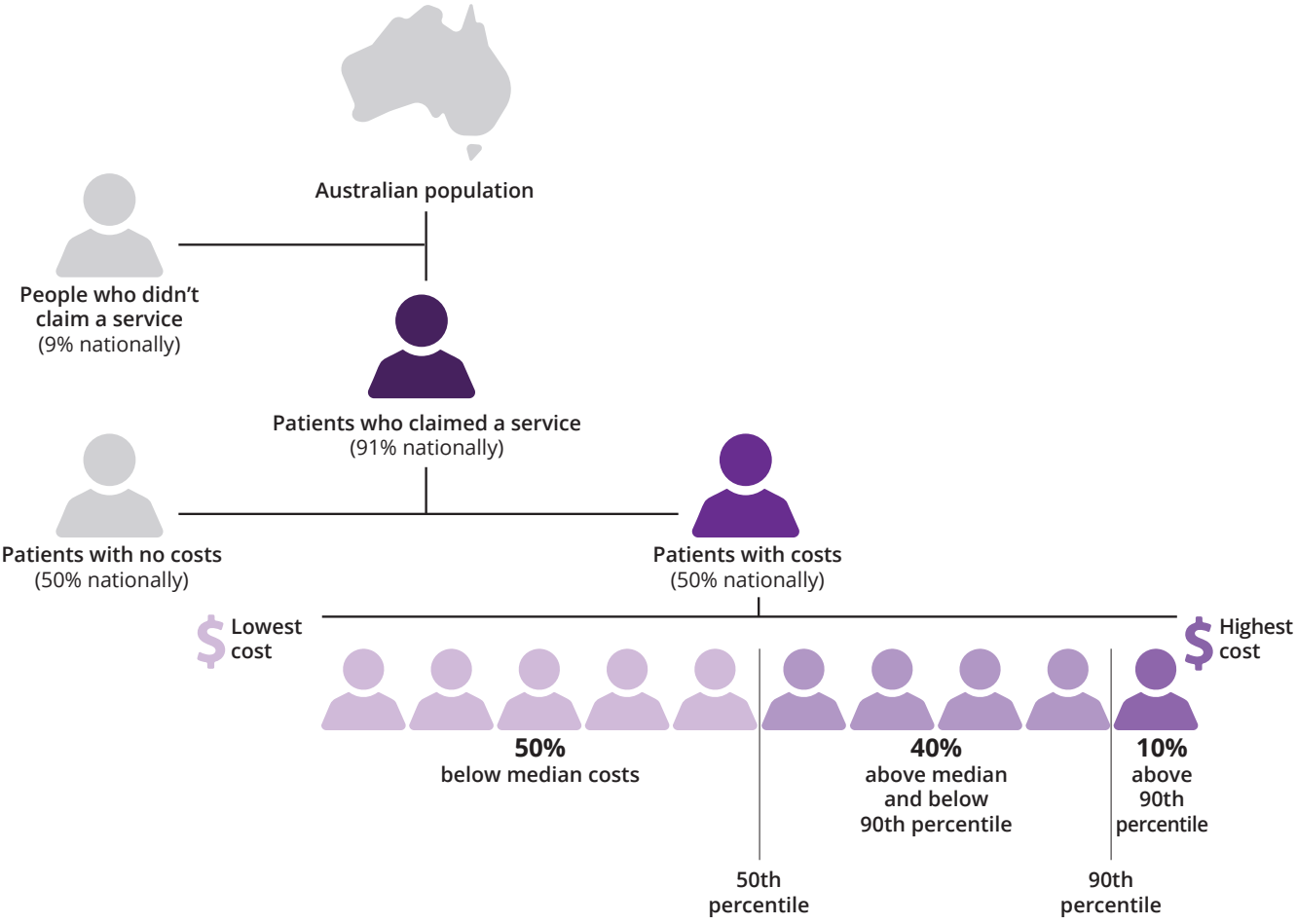
Sources: AIHW 2017; AIHW analysis of MBS claims data, 2015–16.

Patients may also incur personal expenses which are not identified in the data, such as taxes, travel, and private health insurance premiums.

The out-of-pocket costs for patients can affect their ability to get the care they need, when they need it. Being able to get health care 'at the right place and right time, taking account of different population needs and the affordability of care' (NHIPPC 2017) is a cornerstone of a high quality health system.

Box 2: Understanding the measures

In this report, we focus on the half of patients who had out-of-pockets costs and not on the half that had no costs. For those with costs, we report the out-of-pocket costs at the 50th (median) and 90th percentiles. A patient with out-of-pocket costs at the 50th percentile spent more than half of the patients with costs, but less than the other half. A patient at the 90th percentile spent more than 90% of patients with costs, but less than the remaining 10%.



Patients are defined as people who claimed at least one eligible service within the 2016–17 financial year. The total out-of-pocket cost and out-of-pocket cost per service includes only those patients who had costs. As such, these measures should be interpreted alongside the proportion of patients who had (or did not have) out-of-pocket costs in the year. Patients with costs may have had the cost of some of their services covered completely by Medicare (bulk-billed).

The out-of-pocket cost per service measures are the average out-of-pocket costs for each patient for a particular type of service, for example, specialist attendances. The median and 90th percentile cost for each area are presented.

Reporting percentiles (rather than just the average) provides information about the distribution of costs in local areas. This is useful when data are highly skewed, such as in this case, where the majority of Australians have low out-of-pocket costs, but a smaller number face much higher costs.

What are the geographic areas reported?

We show all measures broken down by the 31 PHN areas in Australia. PHNs are organisations that connect health services across specific geographic areas determined by the Australian Government. 'PHN area' refers to the population that lives in the geographic area covered by a particular PHN.

We show measures using data from the MBS broken down by smaller geographic areas known as Statistical Areas Level 3 (SA3s, or 'local areas' in the report)—there are 340 SA3s in Australia.

All results have been mapped to the area where people live, rather than the area where the services were provided.

To allow comparisons among more similar areas, PHN areas are grouped into metropolitan and regional areas. Results for the SA3s are grouped by similar socioeconomic status for SA3s in *Major cities*, and by the remoteness areas of *Inner regional*, *Outer regional* and *Remote* (including *Very remote*) for SA3s outside *Major cities*. PHN areas and SA3s were allocated to a group based on the greatest proportion of their population classified within that group, so their allocation may not reflect the circumstances of everyone in that area.

What's not included?

The sections of this report based on Medicare data do not include people who didn't use any out of hospital health care, or who used other types of health services not subsidised by Medicare (for example, hospital emergency departments).

Medicare only covers a small portion of allied health and dental services. Services that were paid for completely by the patient or subsidised by private health insurance are not included in the report. The report also does not include medications, or services funded under compensation arrangements or by the Department of Veterans' Affairs.

For more information about the measures, areas and data used, see the Technical Note at **www.myhealthycommunities.gov.au**

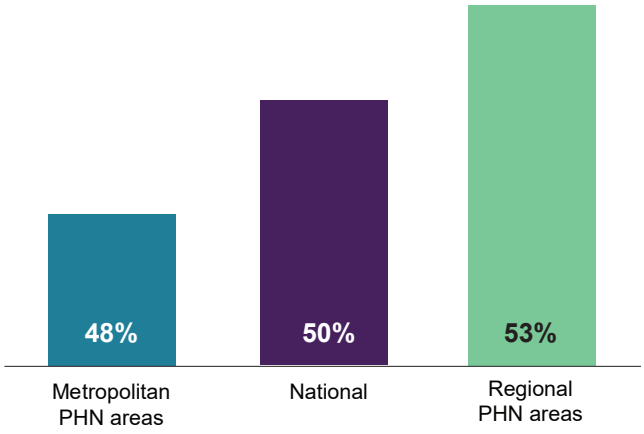
Total costs for non-hospital Medicare services

How many people had out-of-pocket costs?

In 2016–17, 50% of patients nationally (10.9 million patients) paid something from their own pockets toward their non-hospital Medicare services. The remaining 50%—or 11.0 million patients—had the full cost for all of their non-hospital Medicare services covered by the government (bulk-billed).

Across PHN areas, the percentage of patients with costs ranged from 31% of patients in Northern Territory PHN area, to 69% in ACT PHN area (Figure 4). Patients living in metropolitan PHN areas were less likely to have out-of-pocket costs (48%) than patients in regional PHN areas (53%) (Figure 2).

Figure 2: Percentage of patients with out-of-pocket costs for non-hospital Medicare services, metropolitan and regional PHN areas, 2016–17



Source: AIHW analysis of MBS claims data, 2016–17.

How much did patients with costs spend in a year?

Across Australia, 1.1 million people spent $601 or more during 2016–17.

The median amount spent by patients with costs was $142. This means that 5.5 million people spent more than $142 in the year, while 16.5 million people spent less (Figure 3).

Variation across PHN areas

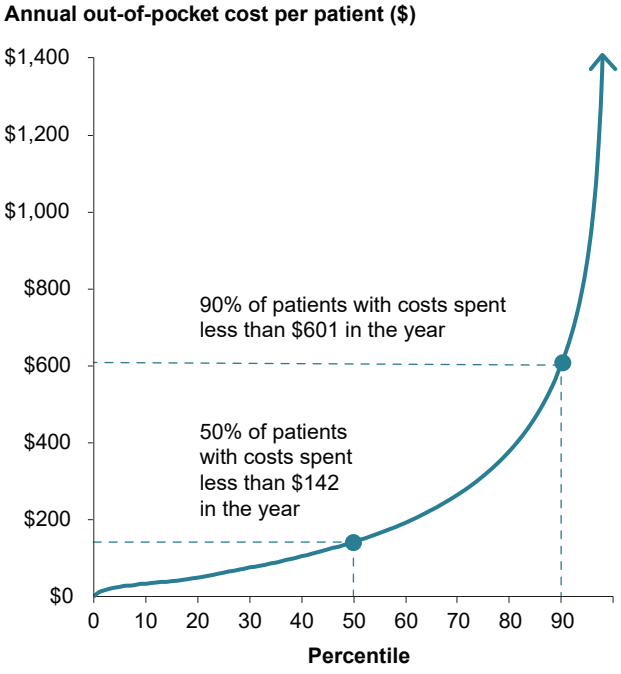
For patients with out-of-pocket costs, the amount spent by the 10% of patients with the highest costs ranged from at least $432 in Murray PHN area to at least $876 in Northern Sydney.

The median amount spent per patient ranged from $104 in Western Queensland PHN area to $206 in Northern Sydney (Figure 4).

People in city areas spent more than people in regional areas

While a greater proportion of patients had out-of-pocket costs in regional PHN areas than in metropolitan PHN areas, patients with costs in metropolitan PHN areas tended to spend more than those in regional PHN areas. The median amount was $155 for patients living in metropolitan PHN areas, and $122 for patients in regional PHN areas (Figure 4).

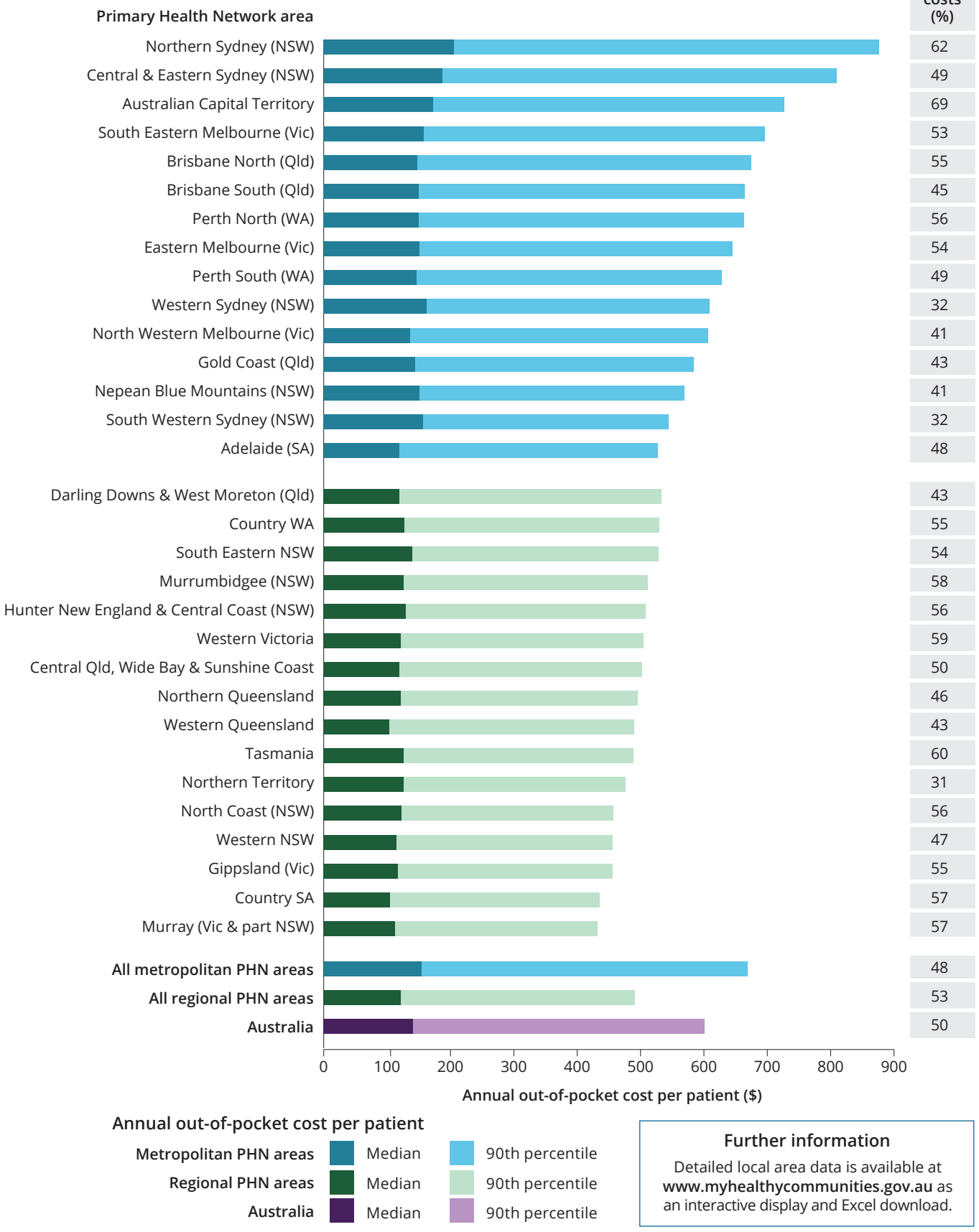
Figure 3: Distribution of total out-of-pocket costs per patient across Australia, for patients with costs, 2016–17



Note: Includes non-hospital Medicare-subsidised services only, and is calculated for patients with any out-of-pocket costs.

Source: AIHW analysis of MBS claims data, 2016–17.

Figure 4: Total out-of-pocket cost per patient for non-hospital Medicare services (for patients with costs), 50th (median) and 90th percentile, by PHN area, 2016–17



Further information

Detailed local area data is available at **www.myhealthycommunities.gov.au** as an interactive display and Excel download.

Patients with costs (%): Percentage of patients with out-of-pocket costs for non-hospital Medicare services.

Note: Non-hospital Medicare-subsidised services only, calculated for patients with any out-of-pocket costs. Metropolitan PHN areas have 85% or more of the population in *Major cities*. All other PHNs are classified as Regional.

Source: AIHW analysis of MBS claims data, 2016–17.

Variation across local areas in total out-of-pocket costs

How many people had out-of-pocket costs?

Patients in some local areas (SA3s) were more than 8 times as likely to have out-of-pocket costs than patients living in other areas. More than three-quarters of patients (78%) in South Canberra (ACT) had out-of-pocket costs, compared with 9% of patients in Barkly (NT).

There was considerable variation within similar local areas (Table 1). Across *Remote* local areas the percentage of patients with any out-of-pocket costs was 6 times as high in Mid-West (WA) (62%) than in Barkly (NT) (9%).

How much did patients with costs spend in a year?

For patients with out-of-pocket expenses, the median total cost was 3 times as high in some local areas than in others, ranging from $80 in Outback-North and East (SA), to $255 in Eastern Suburbs-North (NSW). Similarly, costs for patients at the 90th percentile were more than 3 times as high in Eastern Suburbs-North (NSW) ($1155) than in Katherine (NT) ($333).

Variation by socioeconomic status

In *Major cities*, the median total out-of-pocket cost per patient was generally greater in higher socioeconomic areas ($180), than in medium ($144) and lower ($131) socioeconomic areas (Table 1).

However, there was substantial variation within similar socioeconomic areas. For example, across lower socioeconomic areas, the median out-of-pocket cost per patient ranged from $84 in Playford (SA) to $168 in Botany (NSW). These local areas also had the lowest ($372) and highest ($682) out-of-pocket costs for patients at the 90th percentile (Table 1, Figure 5).

Variation by remoteness

The median total out-of-pocket cost per patient was highest in *Major cities* (Table 1). Outside of *Major cities*, the median cost was higher in *Inner regional* local areas ($123) than in *Outer regional* ($117) and *Remote* ($106) local areas.

There was also wide variation within similar local areas by remoteness category (Figure 5). For example, in *Inner regional* local areas, the median total out-of-pocket cost was almost twice as high in Southern Highlands (NSW) ($168) than in Gympie-Cooloola (Qld) ($93).

Table 1: Total out-of-pocket spending on Medicare services, highest and lowest SA3s by socioeconomic status and remoteness, 2016–17

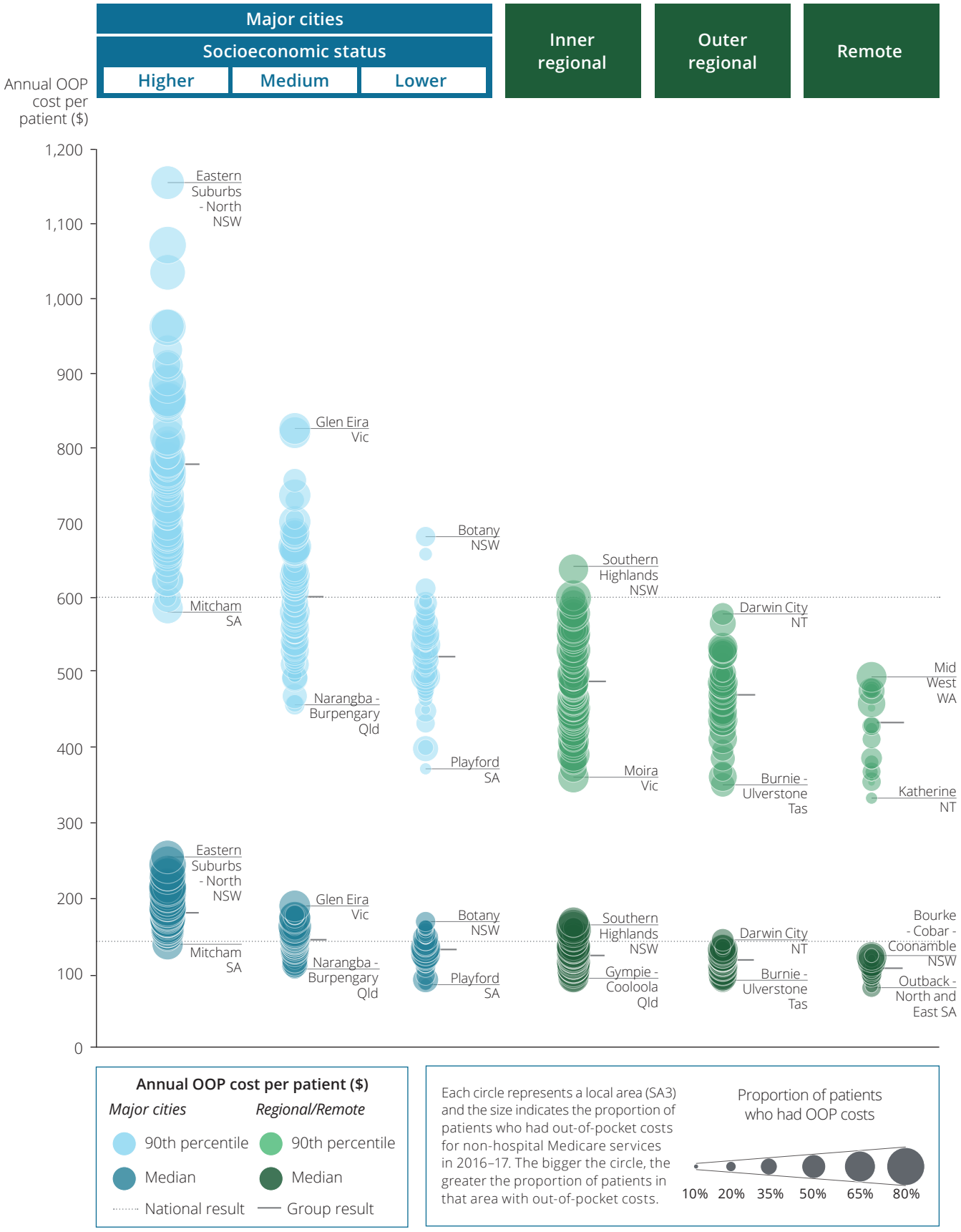
		Major cities – by socioeconomic status			Inner regional	Outer regional	Remote
		Higher	Medium	Lower			
Patients with costs (%)	Highest SA3	78%	69%	62%	73%	62%	62%
	Group result	62%	48%	37%	56%	50%	38%
	Lowest SA3	35%	26%	19%	33%	30%	9%
Median cost ($)	Highest SA3	$255	$189	$168	$168	$144	$123
	Group result	$180	$144	$131	$123	$117	$106
	Lowest SA3	$138	$105	$84	$93	$90	$80
90th percentile cost ($)	Highest SA3	$1,155	$827	$682	$639	$579	$495
	Group result	$779	$602	$522	$489	$471	$434
	Lowest SA3	$587	$458	$372	$361	$351	$333

Patients with costs (%): Percentage of patients with out-of-pocket costs for non-hospital Medicare services.
Median cost ($): Total out-of-pocket cost per patient for all non-hospital Medicare services (median).
90th percentile cost ($): Total out-of-pocket cost per patient for all non-hospital Medicare services (90th percentile).

Note: Includes non-hospital Medicare-subsidised services only. 'Median cost' and '90th percentile cost' is calculated for patients with out-of-pocket costs. This includes patients who had some of their services bulk-billed.

Source: AIHW analysis of MBS claims data, 2016–17.

Figure 5: Total out-of-pocket cost per patient for non-hospital Medicare services (for patients with costs), 50th (median) and 90th percentile, by local area (SA3), remoteness and socioeconomic status, 2016–17



OOP: Out-of-pocket

Note: Non-hospital Medicare-subsidised services only, and is calculated for patients with any out-of-pocket costs.

Source: AIHW analysis of MBS claims data, 2016–17.

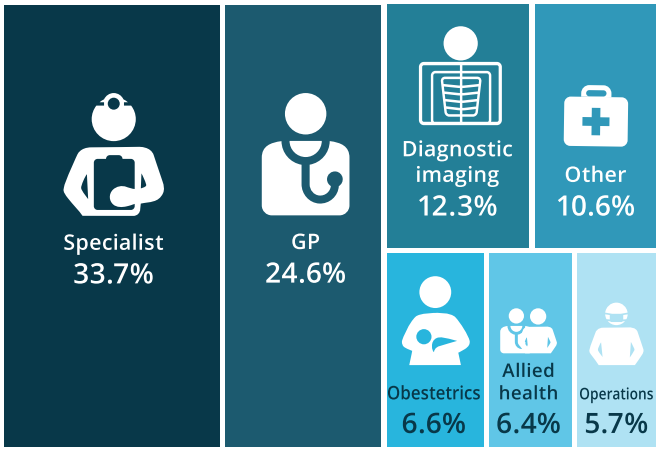
Patients' out-of-pocket costs per service

In 2016–17, Australians spent $3.0 billion out-of-pocket on non-hospital Medicare services—34% of which was spent on specialist services, 25% on GP services, 12% on diagnostic imaging services (including radiology) and 6.6% on obstetric services (Figure 6).

The relatively large share of spending on specialist services is set against the relatively fewer services provided to the Australian community. For example, 148.3 million GP services (subsidised by Medicare) were provided to 87% of the population in 2016–17, while around 23.0 million specialist services were provided to 31% of the population (7.4 million patients).

In addition, in the ABS Patient Experience Survey, a higher proportion of the population reported delaying or not getting specialist services due to cost than other health services (see pages 15–16).

Figure 6: Total out-of-pocket expenditure on non-hospital Medicare services in 2016–17, by service group (per cent)



Source: AIHW analysis of MBS claims data, 2016–17.

This report looks in detail at specialist services. National and PHN area information on the out-of-pocket costs associated with GP, diagnostic imaging and obstetric visits are summarised on pages 13–14. Interactive displays of PHN and local area (SA3) level data are available at **www.myhealthycommunities.gov.au**.

Specialist services

How many people had out-of-pocket costs for specialist services?

For patients who saw a specialist in 2016–17, more than 7 in 10 (72%, or 5.3 million) made some contribution to the cost of their appointment (Box 3).

Across PHN areas, this proportion ranged from 52% of patients in Northern Territory PHN area to 83% in Perth North and Northern Sydney (Figure 7).

Across all local areas, the percentage of patients who contributed to the cost of their specialist appointments was almost 6 times higher in some areas than in others, ranging from 15% to 87% of patients (Table 2).

Box 3: Specialist services

Non-hospital specialist visits accounted for 74% of all specialist services subsidised by Medicare. Costs incurred for these cannot be claimed through private health insurance. The remaining 26% of specialist services were provided to admitted hospital patients, so are not included in this report.

How much did patients spend per specialist service?

2.7 million people spent $64 or more per specialist service

Nationally, of patients with out-of-pocket costs for specialist services, the median out-of-pocket cost per service was $64 in 2016–17. The 10% of patients with the highest costs spent $137 or more out-of-pocket per service.

Variation across PHN areas

For patients with out-of-pocket costs for specialist services, the median cost per service ranged from $47 in Country SA PHN area to $87 in Northern Sydney (Figure 7). These two PHN areas also had the lowest ($97) and highest ($167) costs per specialist service at the 90th percentile.

Variation across local areas

Patients in some local areas spent 3 times as much as patients in other areas. For patients with out-of-pocket costs, the median amount spent per specialist service ranged from $36 in Mid North (SA) to $97 in Leichhardt (NSW) (Table 2).

For the 10% of patients with the highest costs, those living in Mid North (SA) spent $89 or more per service, while those in Sydney–Inner City spent $177 or more per visit (Table 2).

Variation by remoteness and socioeconomic status

Out-of-pocket costs per specialist service tended to be higher in the major city areas. Outside *Major cities*, the median out-of-pocket cost per service was higher in *Remote* local areas ($62) than in *Inner regional* and *Outer regional* ($57) local areas (Table 2, Figure 8).

There was particularly wide variation in out-of-pocket costs for specialist services within *Outer regional* local areas. Patients at the median in Central Highlands (Qld) spent more than twice as much per service ($81) as patients in Mid North (SA) ($36).

For local areas within *Major cities*, the median out-of-pocket cost per specialist service was generally greater in higher socioeconomic areas ($77) than in medium ($65) and lower ($60) socioeconomic areas. However, there was substantial variation in costs within all similar socioeconomic areas (Table 2, Figure 8).

Table 2: Out-of-pocket spending on specialist services, highest and lowest SA3s by socioeconomic status and remoteness, 2016–17

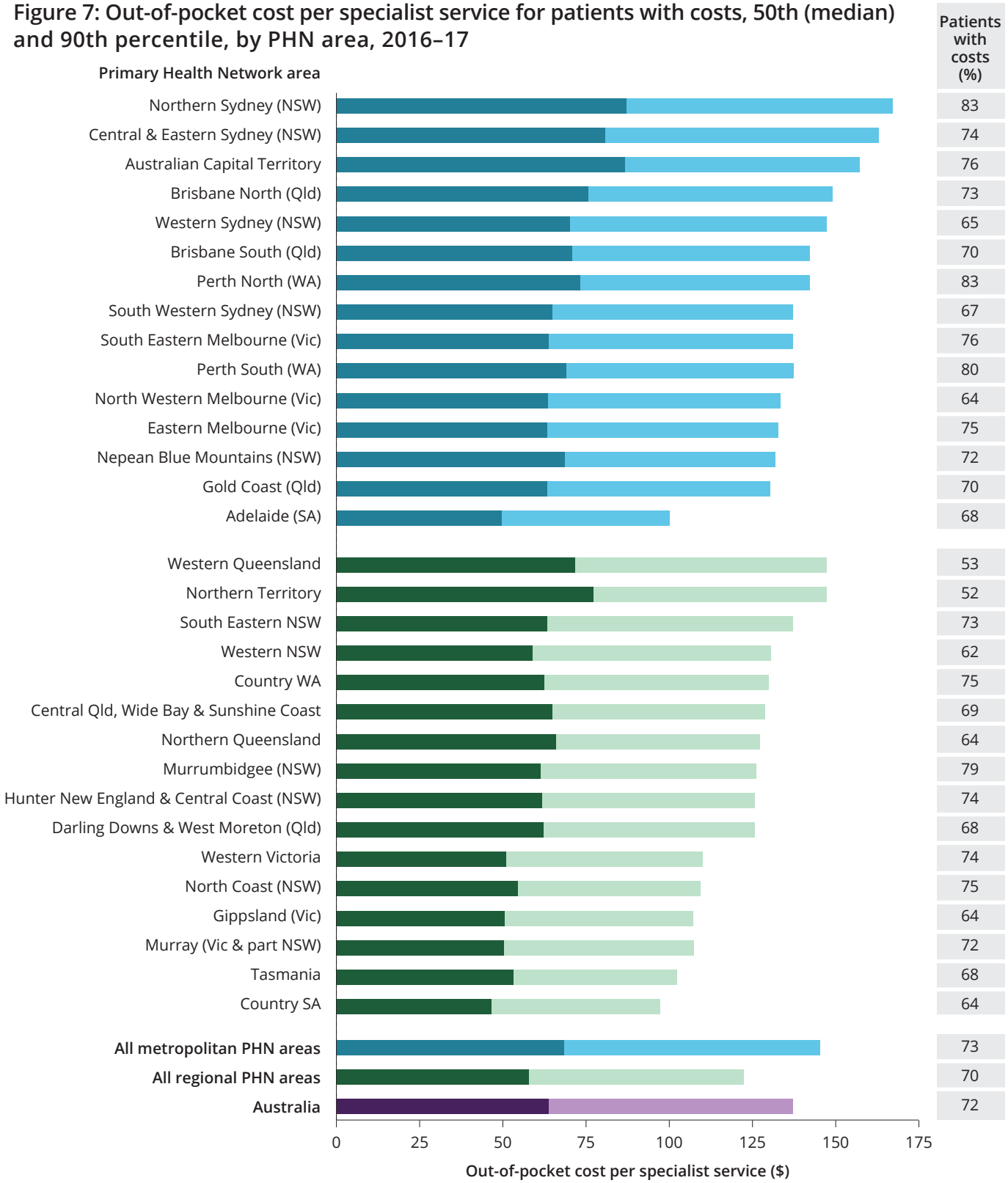
		Major cities – by socioeconomic status			Inner regional	Outer regional	Remote
		Higher	Medium	Lower			
Patients with costs (%)	Highest SA3	87%	83%	79%	85%	81%	75%
	Group result	79%	73%	65%	72%	67%	49%
	Lowest SA3	70%	59%	46%	57%	51%	15%
Median cost ($)	Highest SA3	$97	$84	$74	$75	$81	$89
	Group result	$77	$65	$60	$57	$57	$62
	Lowest SA3	$50	$48	$41	$44	$36	$45
90th percentile cost ($)	Highest SA3	$177	$167	$157	$152	$148	$172
	Group result	$155	$137	$127	$119	$122	$134
	Lowest SA3	$101	$97	$92	$94	$89	$102

Patients with costs (%): Percentage of patients with out-of-pocket costs for specialist services.
Median cost ($): Median out-of-pocket cost per specialist service.
90th percentile cost ($): 90th percentile out-of-pocket cost per specialist service.

Note: Includes non-hospital Medicare-subsidised services only. 'Median cost' and '90th percentile cost' is calculated for patients with out-of-pocket costs. This includes patients who had some of their services bulk-billed.

Source: AIHW analysis of MBS claims data, 2016–17.

Figure 7: Out-of-pocket cost per specialist service for patients with costs, 50th (median) and 90th percentile, by PHN area, 2016–17



Further information

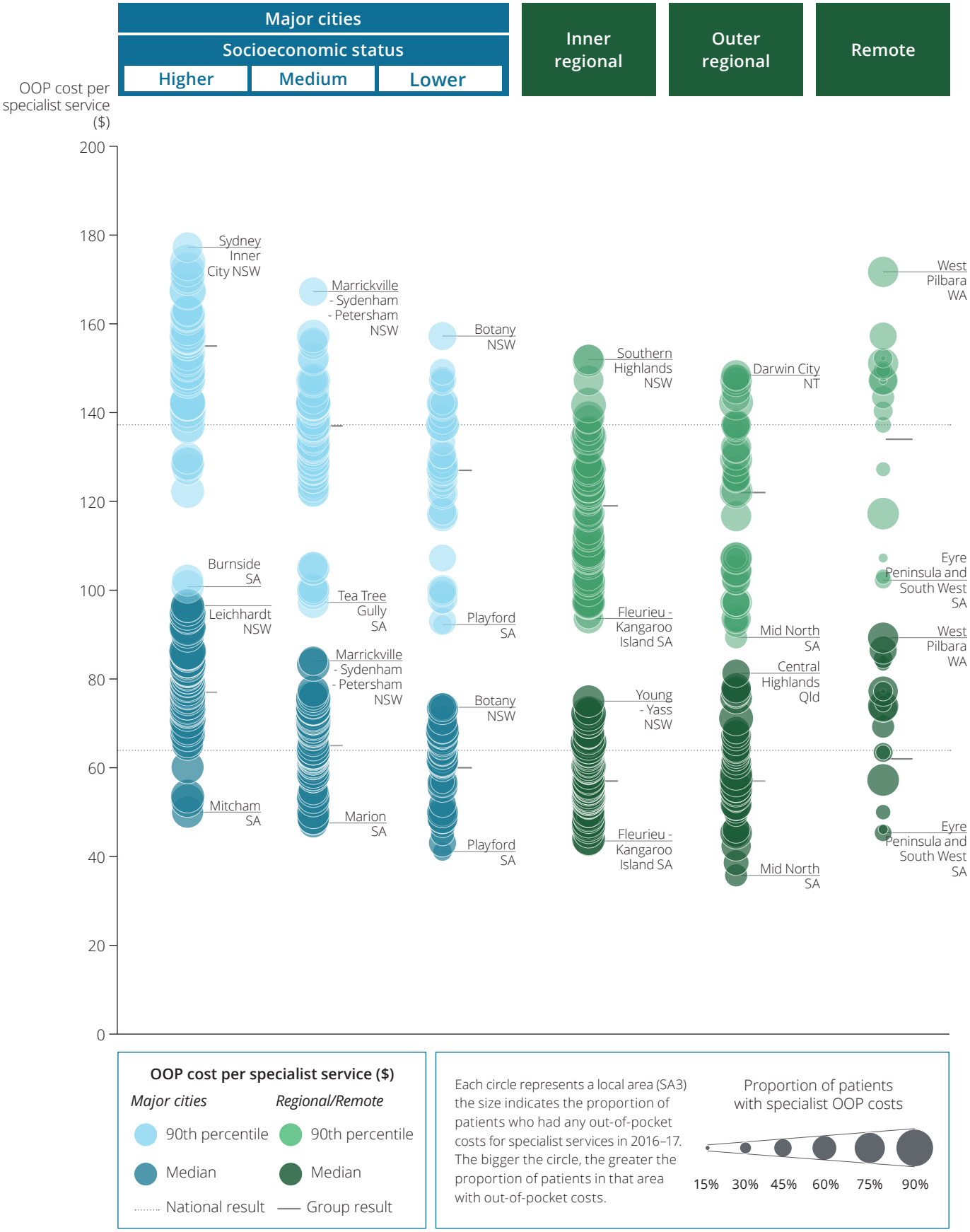
Detailed local area data is available at **www.myhealthycommunities.gov.au** as an interactive display and Excel download.

Patients with costs (%): Percentage of patients with out-of-pocket costs for specialist services.

Note: Includes non-hospital Medicare-subsidised services only. Measure is calculated per patient (patients' out-of-pocket cost for specialist attendances, divided by the number of specialist attendances that patient claimed), for patients with out-of-pocket costs. This includes patients who had some of their services bulk-billed.

Source: AIHW analysis of MBS claims data, 2016–17.

Figure 8: Out-of-pocket cost per specialist service for patients with costs, 50th (median) and 90th percentile, by local area (SA3), remoteness and socioeconomic status, 2016–17



OOP: Out-of-pocket

Note: Includes non-hospital Medicare-subsidised services only. Measure is calculated per patient (patients' out-of-pocket cost for specialist attendances, divided by the number of specialist attendances that patient claimed), for patients with out-of-pocket costs. This includes patients who had some of their services bulk-billed.

Source: AIHW analysis of MBS claims data, 2016–17.

GP services

Nationally, 21.1 million people had at least one Medicare-subsidised GP visit in 2016–17, and 34% of these patients paid something in the year toward the cost of their services. This proportion ranged from 10% of patients living in South Western Sydney and Western Sydney PHN areas to 64% of patients in ACT (Figure 9).

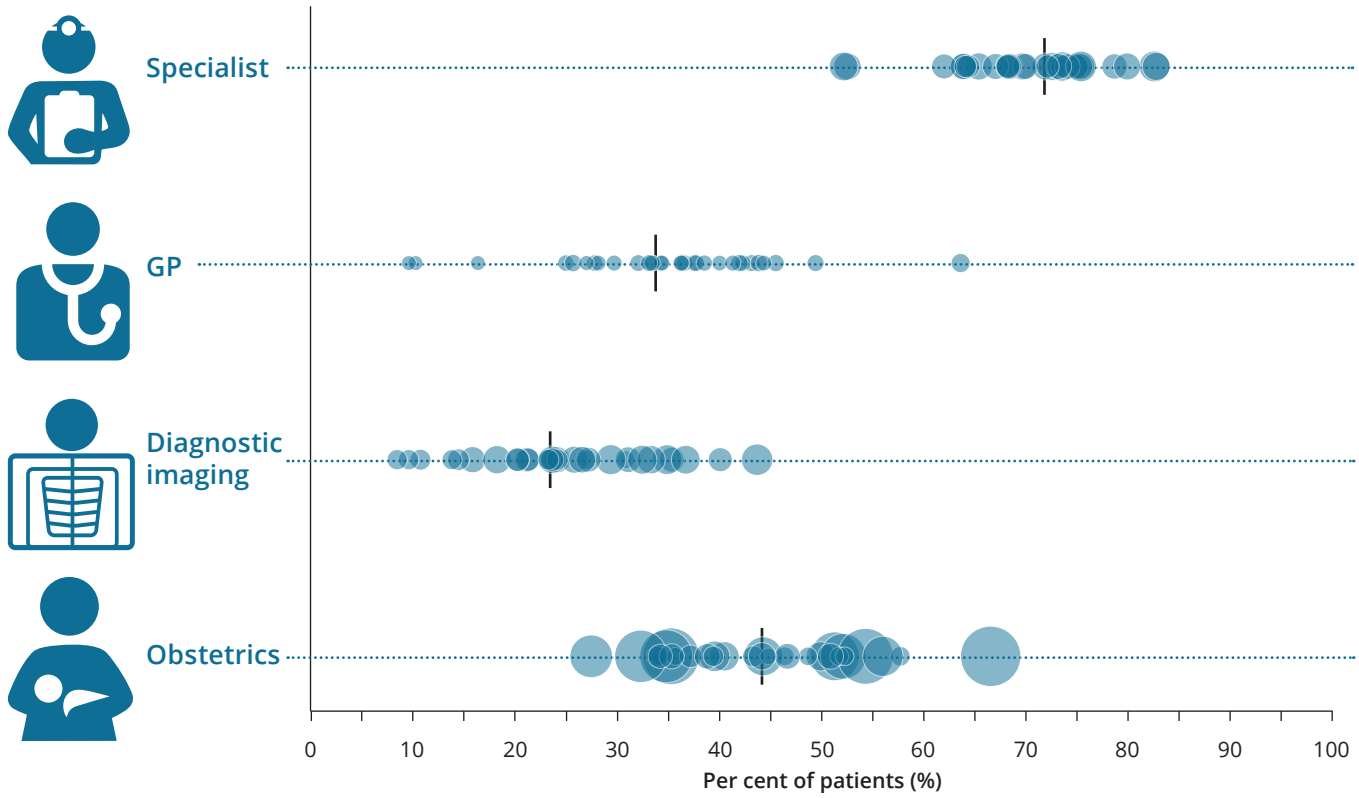
For patients with out-of-pocket costs, the median cost per GP service ranged from $12 in Western Sydney PHN area to $32 in ACT. Ten per cent of patients with costs across Australia spent an average of $42 or more per service. This ranged from $33 in Nepean Blue Mountains PHN area to $51 in ACT (Figure 10).

Diagnostic imaging

In 2016–17, 9.1 million patients claimed 23.7 million diagnostic imaging services through Medicare, and 23% of these patients paid something toward the cost of their services. The percentage of patients with out-of-pocket costs for diagnostic imaging services ranged from 8% of patients living in South Western Sydney PHN area to 44% of patients in ACT (Figure 9).

For patients with out-of-pocket costs, the median cost per service ranged from $25 in Western NSW to $90 in ACT PHN area. There was also considerable variation for patients at the 90th percentile—those in Country WA PHN area spent nearly 3 times as much ($199) as those in Western NSW ($70).

Figure 9: Percentage of patients with out-of-pocket costs, by PHN area and service type, 2016–17



Further information

Detailed local area data is available at **www.myhealthycommunities.gov.au** as an interactive display and Excel download.

Each circle represents a PHN area and the size indicates the median out-of-pocket cost per service (for patients with costs). The bigger the circle, the greater the out-of-pocket cost.

Median out-of-pocket cost per service

$10 $100 $225

National result

Note: Includes non-hospital Medicare-subsidised services only.

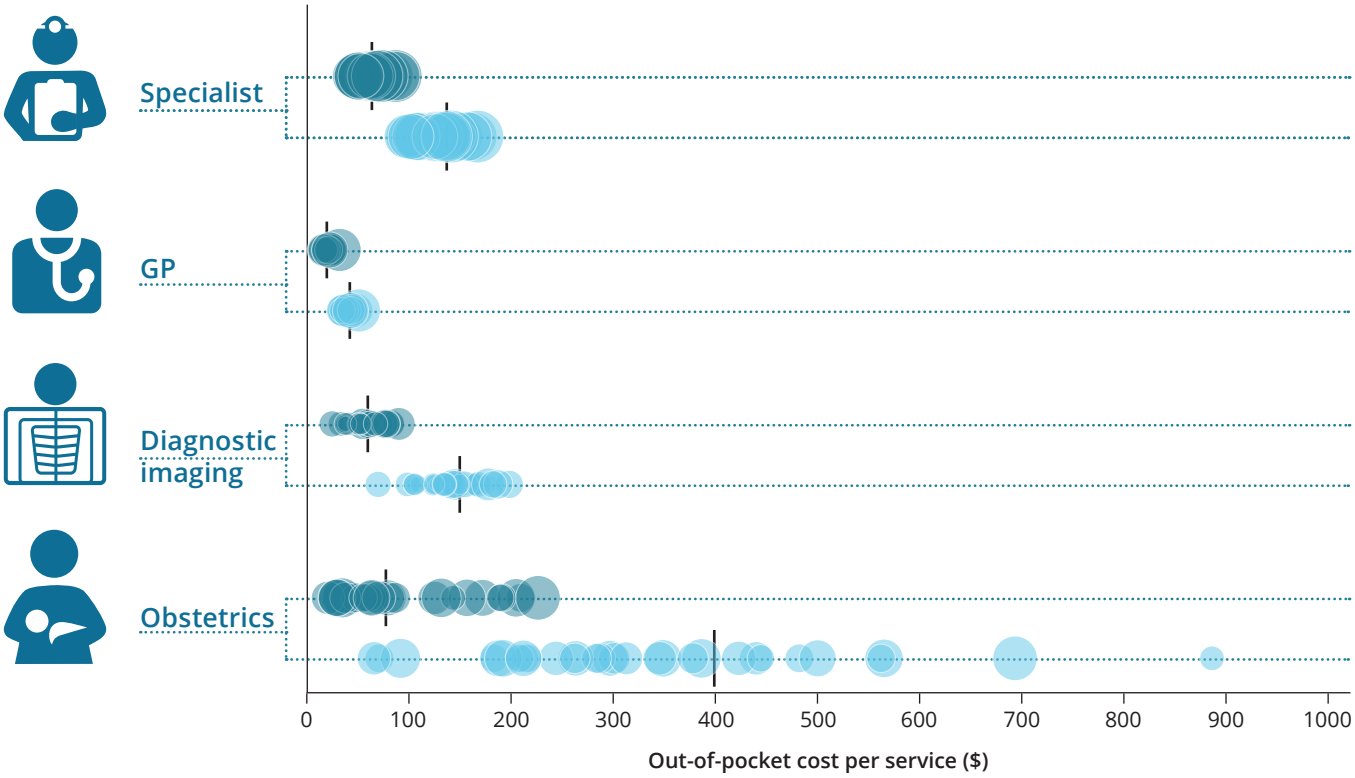
Source: AIHW analysis of MBS claims data, 2016–17.

Obstetric services

Nationally, 361,000 people claimed 1.8 million non-hospital obstetric services in 2016–17, and 44% of these patients paid something toward the cost of their services. This proportion ranged from 27% in Northern Territory PHN area to 67% in Northern Sydney (Figure 9).

Of all the services examined, obstetrics showed the largest variation in out-of-pocket costs per service across PHN areas (Figure 10). The median out-of-pocket cost per service was more than 10 times as high in Northern Sydney PHN area ($227) than in Gippsland ($21). Patients at the 90th percentile in Northern Territory PHN area spent 13 times as much per service ($887) as those in Gippsland ($66).

Figure 10: Out-of-pocket cost per service for patients with costs, 50th (median) and 90th percentile, by PHN area and service type, 2016–17



Each circle represents a PHN area and the size indicates the proportion of patients who had any out-of-pocket costs for the health service in 2016–17. The bigger the circle, the greater the proportion of patients in that area with out-of-pocket costs.

Out-of-pocket cost per service
- Median
- 90th percentile
- National result

Proportion of patients with out-of-pocket costs
10% 50% 80%

Further information

Detailed local area data is available at **www.myhealthycommunities.gov.au** as an interactive display and Excel download.

Note: Includes non-hospital Medicare-subsidised services only. Measure is calculated per patient (patients' annual out-of-pocket cost for the service type, divided by the number of relevant services that patient claimed), for patients with out-of-pocket costs. This includes patients who had some of their services bulk-billed.

Source: AIHW analysis of MBS claims data, 2016–17.

How many people delayed or did not get care because of cost?

In the 2016–17 ABS Patient Experience Survey, 7.6% of people aged 15 years and over reported delaying or not having either a specialist, GP, imaging or pathology service when they needed it in the last 12 months due to cost (which represents an estimated 1.3 million people). [1]

Across PHN areas, people living in South Eastern NSW PHN area were almost 3 times as likely to report delaying or not having at least one of these services when needed due to cost (12.6%), compared with people in Western Sydney (4.5%) (Figure 12). [1]

Cost barriers to specific types of health care

While the number of Australians who delayed or did not get care when needed due to cost was highest for GPs, a larger proportion of people who needed a specialist delayed or did not get care due to cost.

Due to small numbers of responses for questions about more specific types of care, results are presented by the remoteness categories of *Major cities*, *Inner regional* and *Outer regional/remote/very remote* (Figure 11). These groupings do not directly correspond to the local area groupings used in earlier sections of the report. See the accompanying Technical Note for more information.

Specialists

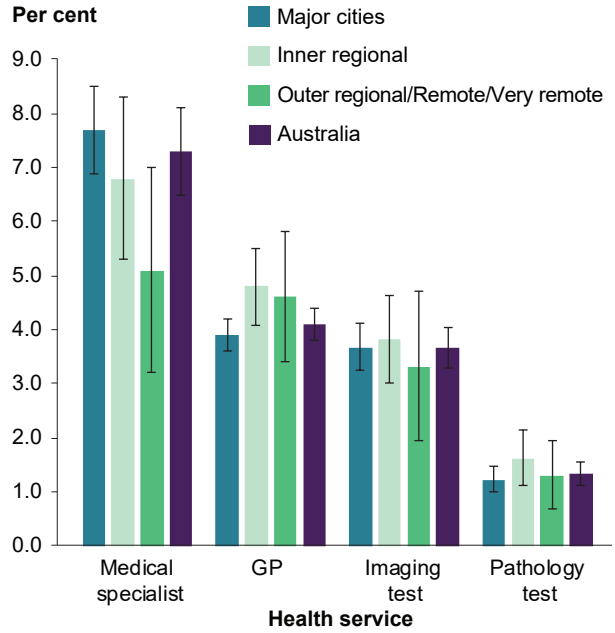
Across Australia, 7.3% of people aged 15 and over who needed to see a medical specialist delayed or did not see a medical specialist due to cost (which represents an estimated 538,000 people). This proportion was highest for people living in *Major cities* (7.7%) and lowest for people in *Outer regional, remote* and *very remote* areas (5.1%).

GPs

Nationally, 4.1% of people aged 15 and over who needed to see a GP (an estimated 663,000 people) delayed or did not see a GP due to cost. This proportion was highest for people living in *Inner regional* areas (4.8%) and lowest for people in *Major cities* (3.9%).

Results for the proportion of people who delayed or did not see a GP when needed due to cost are also available by PHN area (due to larger numbers of responses). There was considerable variation across PHN areas—people living in Tasmania PHN area (7.5%) were almost 3 times as likely as those living in Central and Eastern Sydney (2.7%) to delay or not see a GP due to cost.

Figure 11: Percentage of people who delayed or did not seek care when needed due to cost in the last 12 months, by type of care and remoteness area, 2016–17



⊢⊣ 95% confidence interval

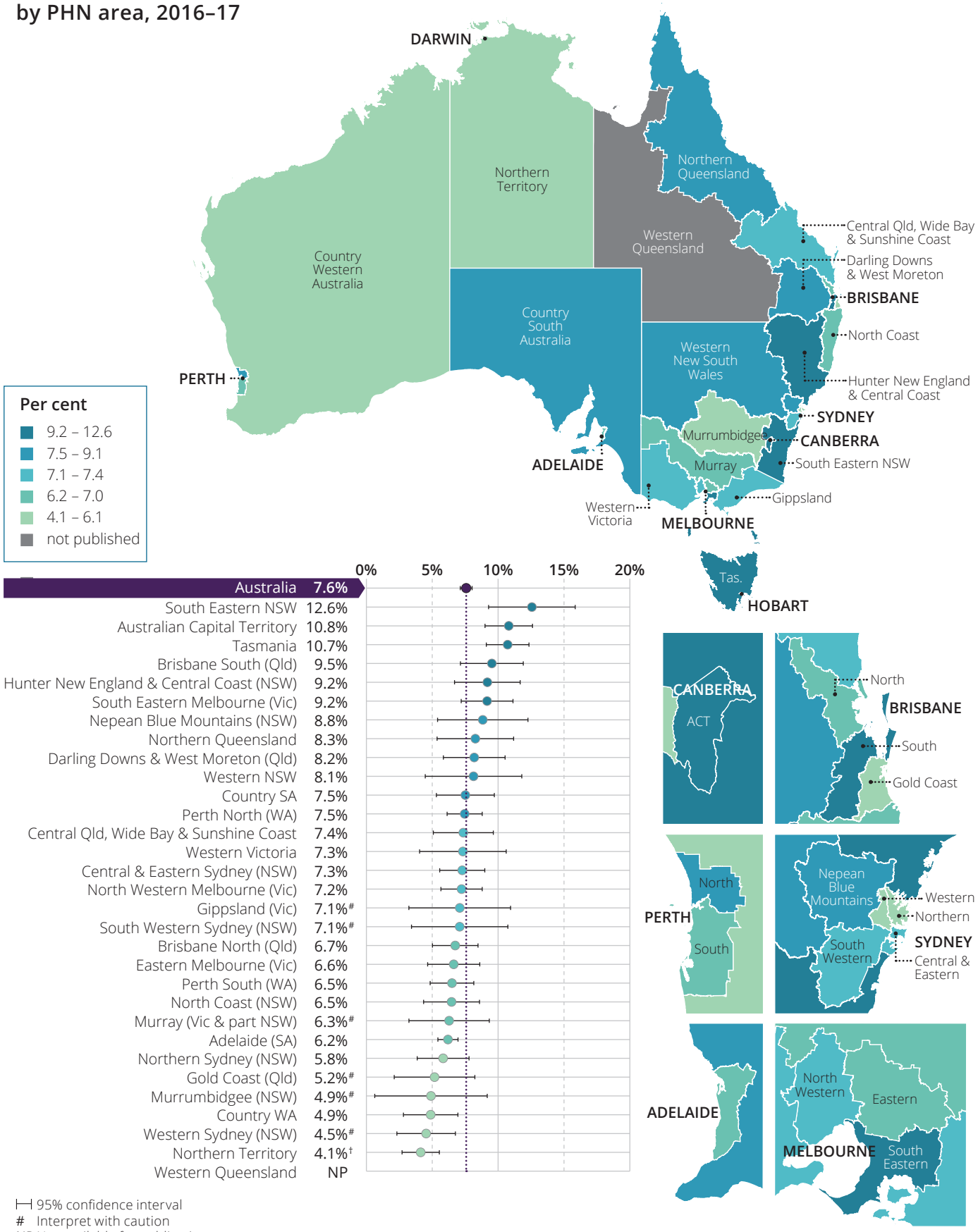
Note: Survey excludes persons aged less than 15 years, persons living in non-private dwellings and the Indigenous Community Strata (encompassing discrete Aboriginal and Torres Strait Islander communities). Excludes pathology and imaging tests conducted in hospital, and any dental imaging tests.

Source: ABS, Patient Experience Survey 2016–17.

Diagnostic imaging and pathology

Nationally, 3.7% of people who needed an imaging test (an estimated 274,000 people) delayed or did not get one when needed due to cost. Cost was reported as a reason for delaying or not getting a pathology test for 1.3% of people who needed a pathology test (an estimated 144,200 people).

Figure 12: Percentage of people who delayed or did not see a medical specialist, GP, get an imaging test and/or get a pathology test when needed due to cost in the last 12 months, by PHN area, 2016–17



⊢ 95% confidence interval
\# Interpret with caution
NP Not available for publication
† Data for Northern Territory should be interpreted with caution as the Patient Experience Survey excluded the Indigenous Community Strata, which comprises around 25% of the estimated resident population of the Northern Territory living in private dwellings.

Note: Survey does not include persons aged less than 15 years, persons living in non-private dwellings and the Indigenous Community Strata (encompassing discrete Aboriginal and Torres Strait Islander communities). Excludes pathology and imaging tests conducted in hospital and any dental imaging tests.

1. Data revision: Since publication in August 2018, data for this measure have been revised.

Source: ABS, Patient Experience Survey 2016–17.

Factors that affect out-of-pocket costs

Local area variation in the amount that patients spend out-of-pocket on health services is influenced by a number of factors, including:

- the type and amount of health services required to meet a patient's needs
- income and lifestyle, which can influence a patient's ability to pay fees
- the fees charged by health providers in a local area (at the discretion of the health provider and may be influenced by differences in operating costs)
- the availability of bulk-billed services
- differences in the availability and use of non-hospital primary and specialist services that are subsidised by Medicare (some people may use services not funded by Medicare, including allied health services or a hospital emergency department, or may be unable to get services due to other factors, such as the availability of nearby health care providers).

Variation in out-of-pocket costs and patients' experiences of cost barriers can highlight gaps in access to affordable health services. However, if an area has high out-of-pocket costs, it does not necessarily mean that people living there have difficulty obtaining these services, as service use is also influenced by a person's financial situation and needs. Knowledge of the local area can assist in understanding results for individual areas.

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Data revision

1. Since publication in August 2018, data for the 'percentage of patients who delayed or did not see a medical specialist, GP, get an imaging test and/or get a pathology test when needed due to cost in the last 12 months' have been revised. All relevant content has been updated.

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