CHAPTER 4 HEALTH SERVICES: PROVISION, ACCESS AND USE

INTRODUCTION

This chapter focuses on the provision of health services, their level of accessibility, and the extent to which they are used. Health services include primary care and public health services such as those provided by general practitioners, nurses and allied health professionals, as well as acute care provided in hospitals, and specialist services, such as those provided by obstetricians and eye specialists. These services may be provided in a range of settings including community health centres and clinics, doctors' rooms and hospitals.

Health expenditure patterns are used to examine health service provision by governments and utilisation of services by clients, while aspects of access to health services are examined in relation to the distances clients must travel to access services and facilities. A range of other factors that affect access are also addressed, including the composition of the health and community service workforce. A section on the use of health services provides information on the activity of Aboriginal and Torres Strait Islander community-controlled health services, and services provided by general practitioners. Detailed information is presented in Chapter 3 about community services while information about the use of hospital services in presented in Chapter 6.

There are a number of difficulties in quantifying the provision of, access to and use of health services by Aboriginal and Torres Strait Islander people. The quality of administrative data sources is affected by the accuracy with which Indigenous people are identified in health service records (see Chapter 9). Administrative data are collected by all providers of health services including Commonwealth, State and local governments, community organisations and some private sector providers. The reasons for data collections are as diverse as the providers themselves. Generally there is a lack of comparability and consistency across collection methods and data items, which makes a comprehensive examination of service use difficult.

The 1999 edition of this publication included information about the availability of cars and proficiency in English, factors likely to influence access to health services. New information on these factors will not be available until after the 2001 Census. Data from the 1995 National Health Survey (NHS) regarding the use of health services was also included in the previous edition. It will be possible to update this information when the results of the 2001 National Health Survey (Indigenous) become available.

PROVISION OF HEALTH SERVICES

Expenditure on health services

Examining expenditure on health services is one way of understanding the way health services are delivered and used. Expenditure reflects not only differing client needs, but differing levels of access and modes of delivery that have developed in response to various policies and strategies. In 1998–99, an estimated $1,245 million was spent on health

Expenditure on health services *continued*

services by, and for, Aboriginal and Torres Strait Islander people (AIHW 2001e). This amount was for expenditure by Commonwealth, State and local governments as well as expenditure from private sources such as by patients or through private health insurance. It represents 2.6% of health expenditure for all Australians and translates into $3,065 for each Indigenous person, compared with $2,518 for each non-Indigenous person (AIHW 2001e). The figures are regarded as estimates, mainly because of the incomplete identification of Indigenous people in many administrative data sources (see Chapter 9). It is not possible to compare the 1998–99 figures directly with estimates previously published because of differences in the methodologies used in estimation.

In 1998–99, the pattern of health expenditure varied between Indigenous and non-Indigenous people. More money per person was spent on Indigenous people, compared with non-Indigenous people, in community and public health, patient transport, public hospital services (both admitted and non-admitted patient services), mental health institutions and government administration and research, but less was spent on private hospitals, Medicare, the Pharmaceutical Benefits Scheme and high level residential aged care (table 4.1)

4.1 ESTIMATED GOVERNMENT AND PRIVATE EXPENDITURE ON HEALTH SERVICES(a)—1998–99

	Indigenous				*Non-Indigenous*				
			$m	*$*			*$m*	*$*	
	Govt funding	Private funding	Total expenditure	Per Person	Govt funding	Private funding	Total expenditure	Per Person	Ratio(b)
Government programs									
Public hospitals—admitted patients	443	14	457	1 125	9 330	947	10 278	558	2.02
Public Hospitals—non-admitted patients	124	1	125	307	2 247	316	2 562	139	2.21
Mental health institutions	26	—	26	64	444	21	465	25	2.53
High level residential aged care(c)	34	7	40	99	3 025	828	3 853	209	0.47
Community and public health	340	15	355	874	2 970	168	3 137	170	5.14
Patient transport	40	3	43	106	244	333	577	31	3.39
Medicare and other medical	66	7	73	179	7 490	1 146	8 632	468	0.38
PBS medicines	20	4	25	61	3 014	597	3 611	196	0.31
Administration and research	37	4	41	101	1 162	159	1 324	72	1.40
Total government program expenditure	1 130	55	1 185	2 917	29 927	4 514	34 439	1 868	1.56
Non-government programs									
Private hospitals	2	8	10	25	1 052	3 040	4 092	222	0.11
Dental and other professional	1	16	17	42	182	3 746	3 928	213	0.20
Non-PBS medicines & appliances	—	27	27	66	50	2 603	2 653	144	0.46
Medical (compensable, etc)	—	4	4	11	—	688	688	37	0.30
Administration	—	1	2	5	129	494	622	34	0.14
Total non-government program expenditure	*3*	*57*	*60*	*148*	*1 412*	*10 570*	*11 982*	*650*	*0.23*
Total	**1 133**	**113**	**1 245**	**3 065**	**31 339**	**15 085**	**46 421**	**2 518**	**1.22**

(a) Government program expenditures includes expenditure through programs managed by the Commonwealth, State and local governments.

(b) Ratio is equal to Indigenous expenditure per person divided by non-Indigenous expenditure per person.

(c) The level of residential aged care services described as nursing home care prior to the changes implemented by the 1997 Aged Care Act.

Source: AIHW Health Expenditure Database.

Expenditure on health services *continued*

Table 4.2 shows the ratio of expenditure per person, Indigenous to non-Indigenous, for each sector of government. Most government expenditure on Indigenous health is administered through local and State governments.

4.2 ESTIMATED HEALTH EXPENDITURE—1998–99

	Ratio(a)
Through State programs	2.40
Through Commonwealth programs	
MBS/PBS benefits	0.37
Other Commonwealth programs	0.50
Total Commonwealth (b)	0.74
Through local government programs	1.78
Through non-government programs	0.23
Total recurrent expenditure	**1.22**

(a) Ratio is equal to Indigenous expenditure per person divided by non-Indigenous expenditure per person.

(b) Excludes grants to States and includes Indigenous specific programs. Expenditure through government programs includes payments by patients as well as government funding of these programs.

Source: AIHW Health Expenditure Database.

ACCESS TO HEALTH SERVICES

The accessibility of health services for Aboriginal and Torres Strait Islander people is affected by a number of factors, involving both simple measures like proximity and availability of facilities and services, and complex issues, such as the degree of cultural appropriateness of service delivery.

Distance to and availability of health professionals, services and facilities

One measure of accessibility is taken by gauging where people live in relation to health services. Indigenous people are more likely to live outside urban areas than the total Australian population, 1 in 4 compared with 1 in 7 (ABS 1998b). Indigenous people are therefore more likely, as a population, to live further from health services than other Australians. In 1998, there were 144 medical practitioners per 100,000 population employed in rural and remote areas compared with 306 per 100,000 in capital city and other metropolitan areas (AIHW 2000g).

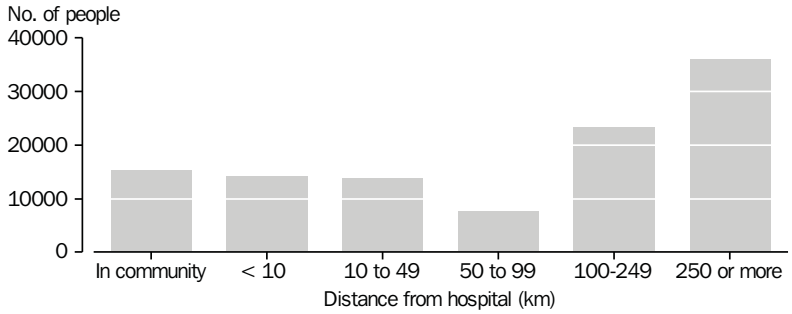
The 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS) showed that Indigenous people living in rural areas were less likely than their urban counterparts to live within 25 km of a range of health services and facilities (ABS & AIHW 1997).

Distance to health services in Aboriginal and Torres Strait Islander communities

Detailed information about the distance to, and the availability of, health services for people living in discrete Indigenous communities was collected by the 1999 Community Housing and Infrastructure Needs Survey (CHINS) (see inset 2.1). The 1999 CHINS collected data concerning a total of 1,291 discrete communities with a combined population of approximately 110,000 (ABS 2000f). Approximately 80% of these people lived in remote or very remote areas as classified by the Accessibility/Remoteness Index of Australia (see Glossary). Drawing from the CHINS data collection, the following section illustrates the number of people in discrete communities and the distances these communities are located from specified health facilities and services.

Of the 1,291 communities surveyed in CHINS, 59,056 Indigenous people, living in 895 discrete communities, were located 100 km or more from the nearest hospital. Of this group, almost 36,000 were located 250 km or more from the nearest hospital (graph 4.3).

4.3 DISTANCE TO NEAREST HOSPITAL(a), Persons Living in Discrete Indigenous Communities



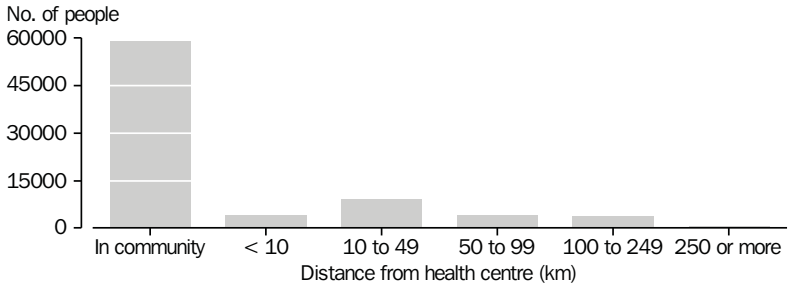
(a) Excludes communities that did not state distance.

Source: ABS 2000f.

The following graphs show the distance to community health centres (4.4), first aid clinics (4.5) and chemists or dispensaries (4.6) for communities that were located 10 km or more from the nearest hospital. This represented 1,142 of the communities surveyed in the CHINS, a total population of 80,341. Results previously published in *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia, 1999* (ABS 2000f) differ slightly from the results below because the previously published results included data derived for communities that had a hospital, or were less than 10 km from one, on the assumption that such communities had access to the types of services offered by first aid clinics or chemists or dispensaries.

Data collected in the CHINS found 62,944 people (living in 296 communities) either had a health centre within their community, or were located within 10 km of a community health centre. There were 433 communities (9,005 people) located between 10 km to 49 km from a health clinic. A further 199 communities, representing a total of 4,231 people, were located 100 km or more from a health clinic (graph 4.4).

4.4 DISTANCE TO NEAREST COMMUNITY HEALTH CENTRE(a), Persons Living in Discrete Indigenous Communities



(a) Excludes 'not stated' and communities that have a hospital located in or within 10 kms of the community. Some data values too small to graph.

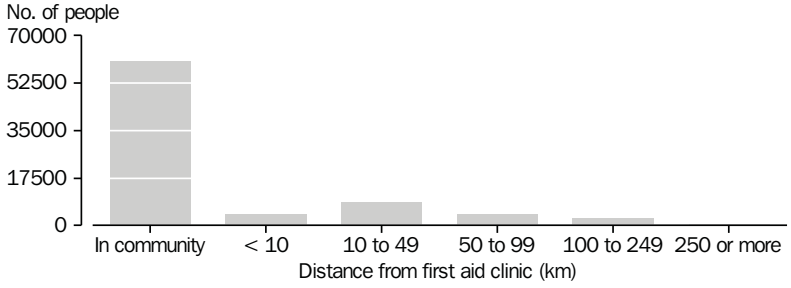
Source: ABS data available on request, CHINS 1999.

Distance to health services in Aboriginal and Torres Strait Islander communities *continued*

There were 846 communities, with a total population of 17,397 that were located 10 km or more from either a hospital or a community health centre. Of these, 199 communities (4,231 people) were located 100 km or more away from either a hospital or a community health centre.

CHINS data found that, for those communities that were 10 km or more from a hospital, first aid clinics were located in, or less than 10 km from 321 discrete Indigenous communities. These communities had a combined population of 64,669 people. There were 167 communities, with a total population of 3,038, located 100 km or more from the nearest first aid clinic (graph 4.5).

4.5 DISTANCE TO NEAREST FIRST AID CLINIC(a), Persons Living in Discrete Indigenous Communities

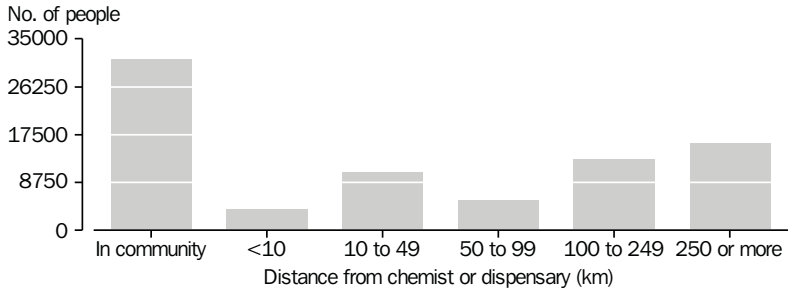


(a) Excludes 'not stated' and communities that have a hospital in or within 10 kms. of the community. Some data values too small to graph.

Source: ABS data available on request, CHINS 1999.

For those communities that were 10 km or more from the nearest hospital, a total of 35,008 people in 160 communities were located less than 10 km from a chemist or dispensary. A total of 29,068 people in 523 communities were located 100 km or more from the nearest chemist or dispensary (graph 4.6), although it should be noted that some health centres also act as dispensaries.

4.6 DISTANCE TO NEAREST CHEMIST OR DISPENSARY(a), Persons Living in Discrete Indigenous Communities



(a) Excludes 'not stated' and communities that have a hospital in or within 10 kms of the community.

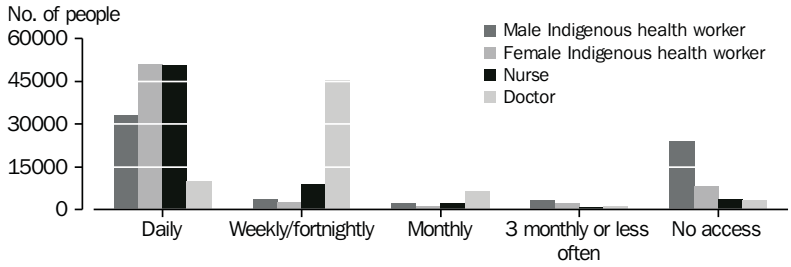
Source: ABS data available on request, CHINS 1999.

Health professionals and health promotion programs in remote communities

The 254 communities surveyed by the 1999 CHINS which reported a population of 50 or more and were located 10 km or more from the nearest hospital were asked how frequently a range of health professionals visited or worked in the community. These communities had a total population of 66,825. The following graphs refer to these communities. If a health professional visited or worked in a community this is referred to as 'access to'. 'No access' means the communities in question did not receive any visits from relevant health professionals, and that there were none working in the community.

Graph 4.7 shows that, for people in 132 of these communities (total population 50,771), a registered nurse was available daily. Very few communities (24 with a total population 10,132) had daily access to a doctor, although in 138 communities (total population 45,504) a doctor was available either weekly or fortnightly. In 152 communities (total population 51,049) there was daily access to a female Indigenous health worker. In 32 communities (total population 3,726) there was no access to a nurse and in 120 (total population 23,996) no access to a male Indigenous health worker. Access to a health professional of the same sex has been found to be an important factor in ensuring that health services provided are culturally appropriate (Ivers et al. 1997).

4.7 ACCESS TO HEALTH PROFESSIONALS(a), Persons Living in Discrete Indigenous Communities(b)



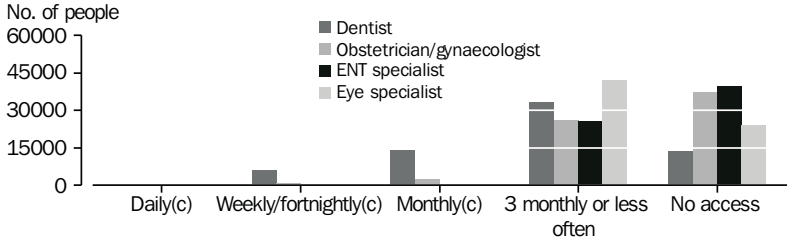
(a) Health professionals who worked in or visited communities.
(b) Communities with a population of 50 or more located 10 km or more from the nearest hospital. Excludes 'not stated'.

Source: ABS data available on request, CHINS 1999

Health professionals and health promotion programs in remote communities *continued*

Graph 4.8 shows how frequently people living in the 254 communities surveyed by CHINS, that had 50 or more people and were 10 km or more from the nearest hospital had the services of dentists, obstetricians or gynaecologists, ear, nose and throat (ENT) specialists, and eye specialists. There were 105 communities (total population 13,619) with no access to a dentist, and 191 (total population 39,681) with no access to an ENT specialist.

4.8 ACCESS TO HEALTH PROFESSIONALS(a), Persons Living in Discrete Indigenous Communities(b)

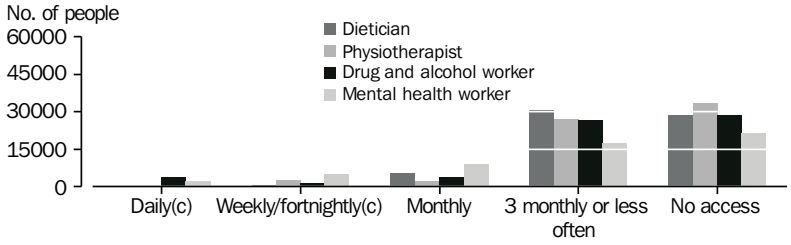


(a) Health professionals who worked in or visited communities.
(b) Communities with a population of 50 or more located 10 km or more from the nearest hospital. Excludes 'not stated'.
(c) Some data values=0

Source: ABS data available on request, CHINS 1999.

Graph 4.9 shows how frequently people in the 254 larger communities that were located 10 km or more from the nearest hospital had access to dietitians, physiotherapists, drug and alcohol workers, and mental health workers. A number of communities had no access to mental health workers (143 communities), drug and alcohol workers (149 communities), dieticians (151 communities) or physiotherapists (168 communities).

4.9 ACCESS TO HEALTH PROFESSIONALS(a), Persons Living in Discrete Indigenous Communities(b)



(a) Health professionals who worked in or visited communities.
(b) Communities with a population of 50 or more located 10 km or more from the nearest hospital. Excludes 'not stated'.
(c) Some data values=0

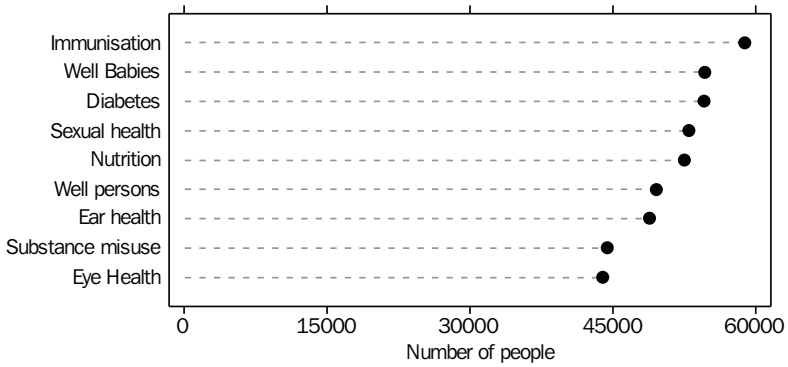
Source: ABS data available on request, CHINS 1999.

Health professionals and health promotion programs in remote communities *continued*

Of the 254 communities with a population of 50 or more, that were 10 km or more from the nearest hospital, 54 communities (total population 5,591) were also 10 km or more from a community health centre. Of these communities over 40 had no access to either a dentist, obstetrician/gynaecologist, ENT specialist, eye specialist, dietician, physiotherapist, drug and alcohol worker or mental health worker within their communities. Many of these 54 communities also had no access to a male Indigenous health worker (27 communities), female Indigenous health worker (16 communities), registered nurse (17 communities) or a doctor (21 communities) (ABS data available on request, CHINS 1999).

Graph 4.10 shows the number of people in communities with a population of 50 or more, that were located 10 km or more from the nearest hospital, who had access to health promotion programs in operation. The most commonly conducted were immunisation, diabetes and 'well babies' programs.

4.10 HEALTH PROMOTION PROGRAMS(a), Persons Living in Discrete Indigenous Communities



(a) Communities with a population of 50 or more located 10km or more from the nearest hospital. Excludes 'not stated'.

Source: ABS data available on request, CHINS 1999.

A reduced range of questions about health professionals was asked of communities with populations of less than 50 people. There were 943 of these communities, representing a total population of 14,571. Over 8,000 of the people living in these communities had no access to either a male or female Indigenous health worker, an environmental health worker, a registered nurse or a doctor. Approximately 3,800 people were in communities that had access to a registered nurse one day a month or more (ABS data available on request, CHINS 1999).

Of the 943 communities with fewer than 50 people, 792 (total population 11,806) were located more than 10 km or more from either a hospital or a community health centre. Many of these communities had no access within the community to a male Indigenous health worker (586 communities), a female Indigenous health worker (531 communities), environmental health worker (653 communities), registered nurse (556 communities) or doctor (626 communities) (ABS data available on request, CHINS 1999).

Health professionals and health promotion programs in remote communities *continued*

As outlined in inset 4.11, in some areas, new ways of delivering health services in Indigenous communities are being explored through 'coordinated care trials'.

4.11 COORDINATED CARE TRIALS IN FOUR ABORIGINAL COMMUNITIES

In 1997, a new model of service delivery was tested in four Aboriginal communities across Australia. Termed 'coordinated care trials' they were based on pooling funds across government sectors and involving community members in the development of innovative methods of delivering health services within their own communities. The trials, which took place in the Tiwi Islands (NT), Katherine West (NT), Wilcannia (NSW) and Perth/Bunbury (WA), aimed to integrate multiple levels and types of health care in ways that were flexible and responsive to community needs, including health promotion and preventive health measures.

An evaluation of the trials has recently been completed. It focussed on:

- access to, and appropriateness of, a range of health services;
- organisational capacity, appropriate funding and administrative arrangements; and
- client and community empowerment.

Some of the key findings of the evaluation were:

- taking local circumstances into account is essential;
- enhanced organisational and financial capacity are essential; and
- community-based organisations are an effective means of implementing health system reform.

Source: CDHAC 2001a.

Other factors affecting access

Access to medical services is also affected by factors such as the availability of transport, the affordability of private health insurance and clients' proficiency in English. Results of the 1996 Census show that Indigenous households were generally larger than other households, and less likely to have a motor vehicle (ABS & AIHW 1999), potentially restricting their access to health services. Overall, results from the 1995 NHS show 11% of Indigenous adults in non-remote areas had private insurance, compared with 43% of the non-Indigenous population (ABS 1999c), reducing the access of Aboriginal and Torres Strait Islander people to specialist care as a private patient in a hospital.

Measurement of the accessibility of health services involves other factors besides the distance people must travel and the financial costs incurred (Ivers et al. 1997). The perception of cultural barriers may cause Indigenous people to travel substantial distances in order to access health services delivered in a more appropriate manner than those available locally (Ivers et al. 1997). The willingness of Indigenous people to access health services may be affected by such factors as community control of the service, the gender of health service staff, and the availability of Aboriginal and Torres Strait Islander staff, particularly where the degree of proficiency in spoken and written English is limited (Ivers et al. 1997). Aboriginal and Torres Strait Islander people who speak English as a second language and those who speak Aboriginal English—a separate dialect from Standard Australian English—often experience difficulty in approaching services such as hospitals to obtain information and treatment (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 1993).

THE CURRENT AND FUTURE INDIGENOUS HEALTH WORKFORCE

This section presents information about the participation of Indigenous people in the health, welfare and community service workforce, and in higher education courses in health and welfare related fields. As discussed above, the availability of Aboriginal and Torres Strait Islander staff is an important factor in whether or not Indigenous people are able to effectively access services (Ivers et al. 1997).

Information about the number of Indigenous people employed in the health and welfare field was examined in detail in the 1999 edition of this publication. More recent information will be available when the results of the 2001 Census are published. In 1996, 0.7% of those employed in occupations classified as 'health professional or paraprofessional' (aged 15 years and over) were Indigenous (ABS & AIHW 1999). Of those employed, Indigenous adults (15 years and over) were less likely (1.1%) than non-Indigenous adults (2.3%) to be employed in health related occupations (ABS & AIHW 1999). Over 3% of those employed in community and welfare service-related occupations identified as Indigenous, and employed Indigenous adults were more likely than other adults to be employed in community and welfare related occupations (3.5% compared with 2.0%)(ABS & AIHW 1999).

In 1998–99, 68% of the full-time equivalent positions in Commonwealth-funded Aboriginal primary health care services were held by Aboriginal and Torres Strait Islander people. Nearly all Aboriginal health workers (98%), field officers and drivers (97%), environmental health workers (95%) and substance misuse workers (92%), were Aboriginal or Torres Strait Islander people, whereas nearly all doctors (99%), and dentists (94%) were non-Indigenous (OATSIH & NACCHO 2000).

Undergraduate studies in health and welfare-related courses

Table 4.12 presents information about tertiary students who completed, or enrolled in, a course in a health or welfare field in 1999–2000. Indigenous students made up a larger proportion of all undergraduate students enrolled in welfare-related courses (2.6%) than those enrolled in health-related courses (1.4%). In the health-related field, most Indigenous enrolments were in health support activities (e.g. health administration and health counselling) (41%) and nursing (33%). Most enrolments of Indigenous students in welfare-related courses were in the field of early childhood education (49%), social work (26%) and welfare studies (25%). Overall in 1999, 113 Indigenous students completed health-related undergraduate courses, and 40 completed welfare-related courses, representing 1.0% and 1.3% respectively, of all students completing undergraduate courses in these fields. In 1999, eight Indigenous students completed a degree in medicine, and 57 were enrolled in a medical undergraduate course in 2000.

The numbers of Indigenous students enrolling in and completing health and welfare related courses have fallen since 1997–98 (see appendix table A16), although increases have been recorded for medicine, medical science and rehabilitation services, and for commencements in welfare studies.

4.12 UNDERGRADUATE COMMENCEMENTS, ENROLMENTS AND COMPLETIONS(a)

	1999 Completions		2000 Commencements		2000 Enrolments	
	no.	Indigenous as % of total	no.	Indigenous as % of total	no.	Indigenous as % of total
Health						
Health, general(b)	—	—	3	0.9	5	0.7
Dentistry(c)	1	0.4	2	0.7	5	0.4
Health support activities(d)	56	8.0	156	9.3	300	8.1
Health sciences and technologies(e)						
Nursing (basic or post-basic)	30	0.5	85	1.1	241	1.1
Other	10	0.6	27	0.8	67	0.7
Total	*40*	*0.5*	*112*	*1.0*	*308*	*1.0*
Medical science, medicine						
Medical science	1	0.2	3	0.3	4	0.2
Medicine	8	0.7	13	1.6	57	1.2
Total medical science, medicine	*9*	*0.6*	*16*	*0.9*	*61*	*0.9*
Allied health(f)	7	0.4	10	0.4	50	0.6
Total health	113	1.0	299	1.7	729	1.4
Welfare						
Counselling(g)	1	5.0	—	—	—	—
Social work	20	1.8	30	1.6	95	1.8
Welfare studies	6	1.8	64	9.9	91	5.6
Early childhood education(h)	13	1.0	76	3.1	181	2.6
Special education(i)	—	—	2	0.8	4	0.6
Total welfare	40	1.3	172	3.3	371	2.6

(a) For students identified as Indigenous.

(b) Courses that prepare, or develop further the abilities of, individuals to assist in and support the operations of health care facilities.

(c) Includes dentistry and dental therapy.

(d) Includes health support activities (general), health administration, health counselling, health surveying and environmental health, and health support activities (other).

(e) Includes health sciences and technologies (general), nursing (basic), nursing (post-basic), medical radiography, medical technology, nutrition and dietetics, optometry, pharmacy, podiatry, and health sciences and technologies (other).

(f) Includes rehabilitation services, occupational therapy, physiotherapy, and speech pathology/audiology.

(g) Includes educational counselling and other counselling (excluding health or educational).

(h) Includes early childhood education and post-initial early childhood education.

(i) Includes initial special teacher education and post-initial special teacher education.

Source: Department of Education, Training and Youth Affairs.

USE OF HEALTH SERVICES

Self-reported health actions

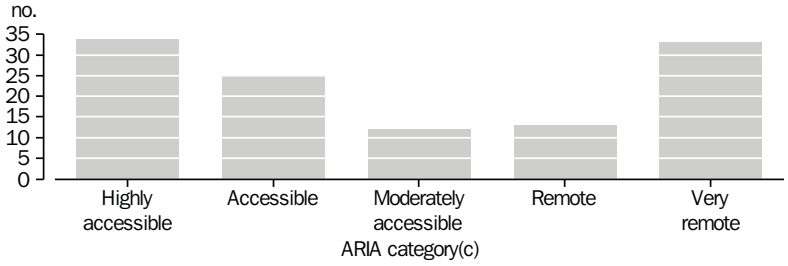
Self-reported information on the use of health services is available from the 1995 NHS and the 1994 NATSIS (ABS 1999c, ABS 1996b). In each survey, respondents were asked about health-related actions they had taken in the previous two weeks. Age-standardised results from the NHS showed that Indigenous people in non-remote areas were slightly less likely to report taking a health-related action than non-Indigenous people. The types of actions taken varied considerably. Indigenous people were more likely to attend hospital, either as inpatients or outpatients, or to seek emergency or day clinic services, than non-Indigenous people, but were less likely to visit a dentist. Results from the 1994 NATSIS showed broadly similar levels of service use to those reported in the 1995 NHS (ABS & AIHW 1999).

Community-controlled health services

Health services that are initiated, controlled and operated by the Indigenous community have the potential to increase the level of access to health services for Aboriginal and Torres Strait Islander people by providing holistic and culturally appropriate care. A study by Keys Young (1997) found that some of the reasons for this might include the provision of services at no cost, a sense of ownership, the staff being likely to speak the local language, the centres playing a social role and the provision of a wide range of services. In 1998–99, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Aged Care funded 117 Aboriginal health organisations which had responsibility for providing or facilitating access to primary health care.

Graph 4.13 shows the location of these services throughout Australia. (See Chapter 1 for more information on the distribution of the Aboriginal and Torres Strait Islander population).

4.13 LOCATION OF ABORIGINAL PRIMARY HEALTH CARE SERVICES(a)(b)—1998–99

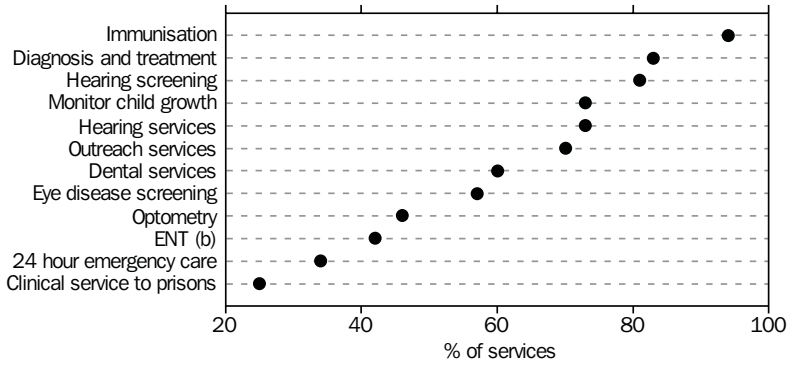


(a) Commonwealth funded.
(b) No. of services.
(c) See Glossary for definitions relating to ARIA.

Source: OATSIH (1998--99) administrative data.

Graph 4.14 shows the proportion of services offering various types of clinical care and preventative health care activities. In addition to these roles and activities, Aboriginal primary health care services provide health promotion activities, social and emotional wellbeing services, substance misuse services, counselling and health-related community support roles such as men's and women's support groups, transport to medical appointments, and school based activities.

4.14 ABORIGINAL PRIMARY HEALTH CARE SERVICES(a), Roles and Activities—1998–99



(a) Commonwealth funded.
(b) Ear, Nose and Throat specialist services.

Source: OATSIH & NACCHO 2000.

Community-controlled health services *continued*

In 1998–99 an estimated 1,060,000 episodes of health care were provided by community controlled health services, 91% of which were to Aboriginal and Torres Strait Islander clients. Of these, approximately 40% were provided to men and 60% to women (OATSIH & NACCHO 2000).

General practice

Some information about the extent to which general practitioners (GPs) are used by both Indigenous and non-Indigenous people is available from a survey being undertaken by the University of Sydney and the Australian Institute of Health and Welfare (AIHW). Known as Bettering the Evaluation And Care of Health (BEACH), the survey is a study of general practice activity in Australia.

BEACH is conducted through a random sample of about 1,000 general practitioners, each of whom records the details of 100 consecutive GP-patient encounters. Details include patient reasons for each consultation, problems managed, medications and other treatments, referrals made, and tests ordered. Patient demographic information is also recorded, including each patient's Indigenous status. The GPs also record information about themselves and their practice.

The results presented here are for April 1998 to December 2000. There were 277,600 encounters, of which 2,783 (1%) were for patients who identified as Aboriginal and/or Torres Strait Islander (table 4.15). This is low, relative to the proportion of Indigenous people in the total population (2.2% at 30 June 1999), and may be the result of lower use of private GP services by Indigenous people, failure by GPs to record the Indigenous status of patients, or reluctance of patients to identify as Indigenous. The quality of Indigenous identification in the collection is unknown, although a change in the design of the form between 1998–99 and 1999–2000 appears to have had a negative impact on the extent to which GPs recorded Indigenous status. This may have resulted in an under-estimation, for the 1999–2000 data, of the numbers of Indigenous people visiting general practitioners (Britt et al. 2000). This issue has been addressed for the 2001–02 collection.

4.15 PATIENT ENCOUNTERS IDENTIFIED AS INDIGENOUS—1998–2000

	Encounters for patients identified as Indigenous	*Encounters for patients identified as Indigenous as a % of all State/Territory encounters*	*Indigenous people as a % of total State/Territory population*
New South Wales	695	0.7	1.8
Victoria	254	0.4	0.5
Queensland	825	1.6	3.2
South Australia	265	1.1	1.6
Western Australia	509	2.2	3.2
Tasmania	33	0.5	3.4
Northern Territory	183	6.8	28.3
Australian Capital Territory	19	0.4	1.1
Australia	**2783**	**1.0**	**2.2**

(a) Based on postcode of the practising GP. Data are for April 1998 to December 2000.

Source: BEACH data supplied by the AIHW General Practice Statistics and Classification Unit (GPSCU); ABS 2000a, ABS 1998d.

General practice *continued*

Of those identified in the survey, Indigenous patients were on average younger than other patients, with 27% of encounters being for children aged less than 15 years, compared with 14% for non-Indigenous children. Only 6% of encounters were for Indigenous patients aged 65 years or over, compared with 25% for non-Indigenous patients. This reflects the younger age structure of the Indigenous population (see Chapter 1). Indigenous patients were more likely to hold a Health Care Card (57%) than non-Indigenous patients (39%) (GPSCU).

Upper respiratory infection, diabetes, hypertension, asthma, acute bronchitis/bronchiolitis and acute otitis media/myringitis were the six most frequent problems managed by GPs for Indigenous people. The six most common problems managed for non-Indigenous patients were hypertension, upper respiratory infection, immunisation, depression, asthma and acute bronchitis/bronchiolitis (GPSCU).

SUMMARY

A range of factors that could affect Indigenous people's access to, and use of, health services have been presented in this chapter. Indigenous people are more likely to live outside urban areas than non-Indigenous people and are therefore more likely to live further from health services than other Australians. Community controlled health services, operating in many parts of the country, including remote areas, go some way to addressing the gaps in health service provision.

Expenditure on health services is another area which may reflect levels of access to, and use of particular services. In 1998–99, more was spent on Indigenous people compared with non-Indigenous people in some areas, such as community and public health, patient transport, and public hospital services but less was spent on private hospitals, Medicare, the Pharmaceutical Benefits Scheme and high level residential aged care.

The provision of culturally appropriate health services, and the employment of Indigenous staff in services, may also affect the likelihood of an Indigenous person seeking assistance. The 1999 CHINS showed that male Indigenous health workers were not available in many remote communities, which could affect the willingness of Indigenous men to seek help for their health problems.

The future involvement of Indigenous people in health and welfare services will be influenced by their current participation in health and welfare-related education. However, the numbers of Indigenous students enrolled in and completing undergraduate courses has not increased in recent years.