



Access to health services by Australians with disability 2012

Summary

This bulletin examines the level of access to a range of health services by Australians with disability living in the community (excluding people living in institutions), and the experiences these people face in accessing health services.

Access to a range of health services by Australians with disability

In 2012, 95% of people with disability living in the community saw a general practitioner (GP), 22% saw a GP for urgent medical care, 59% saw a medical specialist and 49% visited a dentist. One-quarter (26%) visited a hospital emergency department (ED). One-third (32%) saw 3 or more different health professionals for the same health condition and 22% received assistance for coordination of their care provided by 3 or more different health professionals.

In that year, 1 in 5 (20%) people with disability who saw a GP waited longer than they felt was acceptable for a GP appointment; 17% who needed to see a GP delayed or did not go because of the cost.

Nearly one-fifth (18%) of people with disability who saw a medical specialist waited longer than they felt was acceptable to get the appointment. One in 5 (20%) people with disability did not see a medical specialist when they needed to, mainly because of the cost.

More than 1 in 10 (11%) people with disability who needed to see a dentist had been placed on a waiting list for an appointment at a public dental clinic, as with many other Australians. Of these, 32% were still waiting for the appointment at the time of the survey. Some 30% of people who needed to see a dentist delayed or did not go. Of these people, 67% delayed or did not go because of the cost.

Of people who saw 3 or more different health professionals for the same health condition, 16% had difficulties caused by a lack of communication or coordination among different health professionals.

About 13% of people with disability who reported a need for ongoing help or supervision with health-care activities (such as taking medication, manipulating or exercising muscles or limbs) had no source of assistance.

Differences in access to health services by Australians with disability

People with disability living in *Outer regional* and *Remote* areas had lower use rates of services from GPs, medical specialists, dentists and different types of health professionals than people with disability living in *Major cities*. They were more likely to visit a hospital ED for health issues that could potentially be dealt with by non-hospital services; to wait longer than they felt acceptable for a GP appointment; to delay seeing or not see a dentist; to be waiting for a medical specialist appointment and public dental care; and to face difficulties caused by a lack of communication among different types of health professionals in coordination of their care.

People with severe or profound core activity limitation (that is, sometimes or always needing help with activities of self-care, mobility or communication) were more likely than those with disability but without this level of limitation to use a range of health services, except for private dental services. They were more likely to be on a waiting list for public dental care and face difficulties caused by a lack of communication among different health professionals.

Females with disability were more likely than males with disability to use a range of health services.

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Introduction

One of the six priority outcomes of the National Disability Strategy 2010–2020 is ‘People with disability attain the highest possible health and wellbeing outcomes throughout their lives’ (Department of Social Services 2012). This bulletin is the third in a series about the health of Australians with disability, based on analysis of national population survey data.

The first bulletin of the series (*Health of Australians with disability: health status and risk factors*) examined health status and health risk factors of Australians with disability, finding that although there has been an overall improvement in population health, the gap between Australians with disability and those without disability remains large (AIHW 2010). The second bulletin (*The use of health services among Australians with disability*) examined the differences in the use of health services between people with disability and people without disability. It showed that Australians with severe or profound disability are extensive users of professional health services (AIHW 2011).

This bulletin looks at access to and use of health services: whether Australians with disability visit a general practitioner (GP), a medical specialist, a dentist or a hospital emergency department (ED); whether they experience waiting times they believe to be excessive; whether they believe the costs of services are affordable; and whether they have difficulties caused by a lack of communication among different health professionals in coordination of their care. It also looks at the need and unmet need for assistance with personal health-care activities, which are related to functional limitations of people with disability.

The analysis may contribute to a better understanding of the following questions and issues:

- (1) What are the levels of access to a range of health services among Australians with disability?
- (2) Are there any differences in the use of health services between people with different levels of disability severity?
- (3) Does where people with disability live make a difference to their use of health services?
- (4) What are the difficulties in access to health services for people with disability?
- (5) What are the needs and unmet needs for assistance with health-care activities of people with disability?

In 2012, an estimated 4.2 million Australians (18.5% of the population) had some form of disability. Among people with disability, 1.4 million (6.1% of the Australian population) had severe or profound core activity limitation (ABS 2013b).

Data source, scope of this analysis and statistical methods

The primary data source is the Australian Bureau of Statistics (ABS) 2012 Survey of Disability, Ageing and Carers (SDAC), which was the first time the survey included information about access to a range of health services. The 2012 SDAC data covered the use of health services provided by GPs, medical specialists, dentists and hospitals during the 12 months before the survey date. There are other types of health services from which people can receive appropriate health care not covered in the 2012 SDAC collection. The information about the use of health services was not collected among people living in cared accommodation (hospitals, nursing homes, aged care hostels, care components of retirement villages and group homes for people with disability). It was only collected among people living in households who had disability, or who were aged 65 and over, or were primary carers. Hence, this analysis focuses on people with disability living in households.

SDAC also collected information about ongoing need for help or supervision with personal health-care activities: foot care (such as cutting nails or washing or drying feet), taking medication or having injections, dressing wounds, using medical machinery and manipulating or exercising muscles or limbs. The need for help is often related to the level of functional limitations of people with disability.

SDAC generally follows the conceptual framework and major concepts of the International Classification of Functioning, Disability and Health (ICF). For ABS SDAC survey purposes, a person has disability if they have at least 1 of 17 limitations, restrictions or impairments that has lasted, or is likely to last, for at least 6 months and that restricts everyday activities. For details of the SDAC survey definitions of disability and severe or profound core activity limitation, see the ABS report on the 2012 SDAC (ABS 2013b).

Information about Indigenous status is not available from the confidentialised unit record file of the 2012 SDAC used for this analysis. A summary of the ABS 2012 SDAC data quality declaration can be viewed on the ABS website.

Statistical significance tests have been applied in comparative analyses of population subgroups of interest, such as a comparison between the proportions of males and females visiting a dentist. The 95% confidence interval for the difference between two estimated proportions is constructed using the SDAC survey estimates and their associated standard errors. If the confidence interval for the difference between two proportions does not include zero, the two proportions are deemed to be statistically significantly different at the 5% level.

Use of health services by Australians with disability

GPs are the most common first point of contact for health issues for Australians with disability, as with all Australians. In 2012, 95% (or 3.8 million) of people with disability living in households visited a GP at least once for their own health in the previous 12 months, including 22% who saw a GP for urgent medical care (Table A1).

In that year, 59% (or 2.3 million) of people with disability had seen a medical specialist for their own health in the previous 12 months.

Nearly half (49% or 1.9 million) of people with disability visited dental professionals in the previous 12 months—38% visited private dental clinics only, 9% visited government dental clinics only, and 1% visited both private and government dental clinics.

One-quarter (26% or 1 million) of people with disability had been to a hospital ED at least once for their own health in the previous 12 months, and 10% visited an ED twice or more.

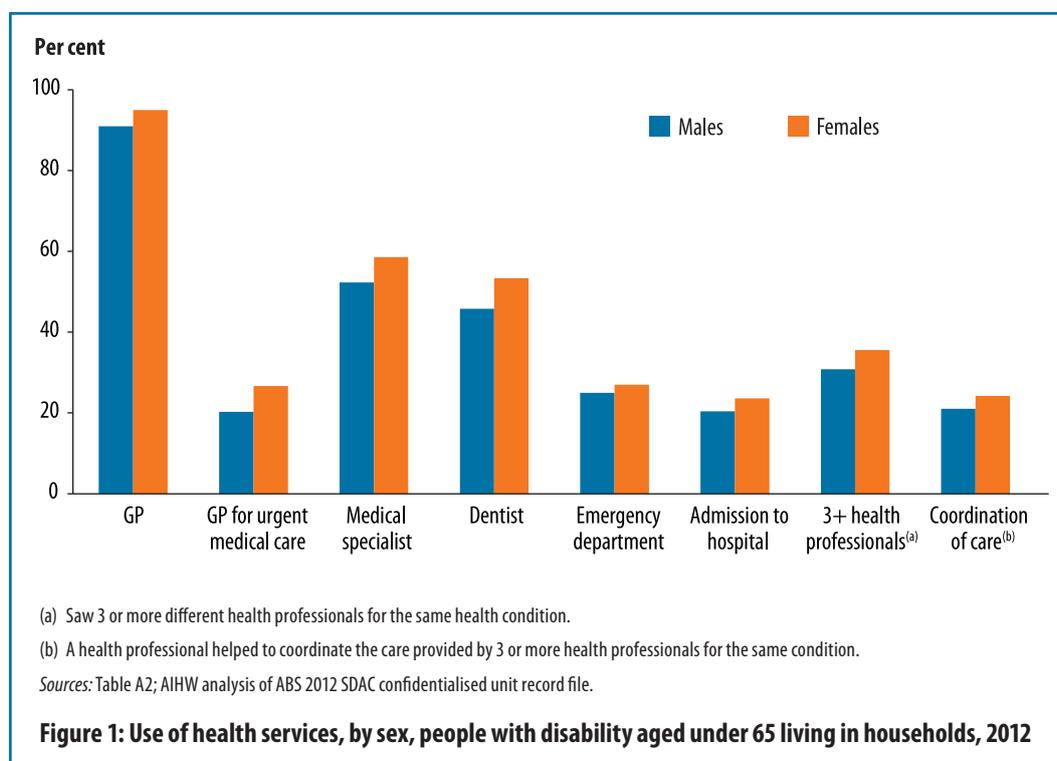
Around one-third (32% or 1.3 million) of people with disability saw 3 or more different types of health professionals for the same health condition in the previous 12 months. One in 5 (22%) people with disability reported that a health professional helped coordinate their care when they saw 3 or more different types of health professionals for the same condition.

Less than half (45% or 1.8 million) of people with disability had private health insurance cover.

Sex differences in the use of health services

The information about access to health services was not collected among people living in cared accommodation. These people generally need more health care than people living in households. Some 70% of people with disability aged 65 and over living in cared accommodation were females (AIHW analysis of ABS 2012 SDAC confidentialised unit record file). Hence, to minimise potential bias in the results, the analysis of sex differences in the use of health services focuses on people with disability aged under 65.

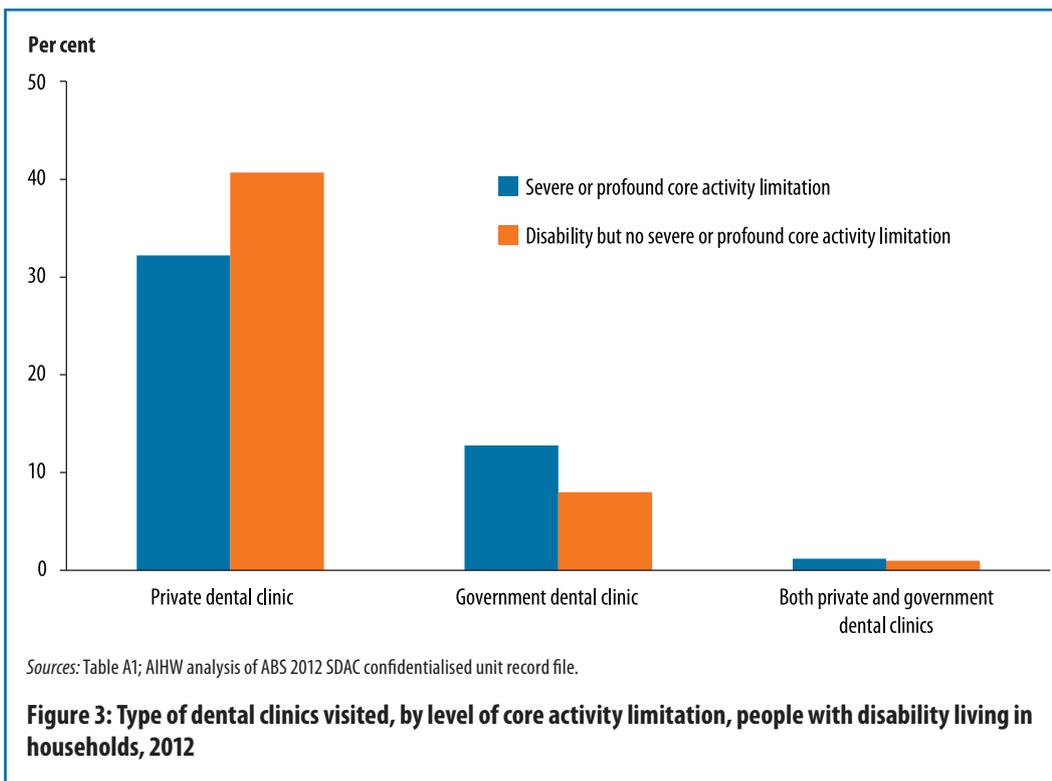
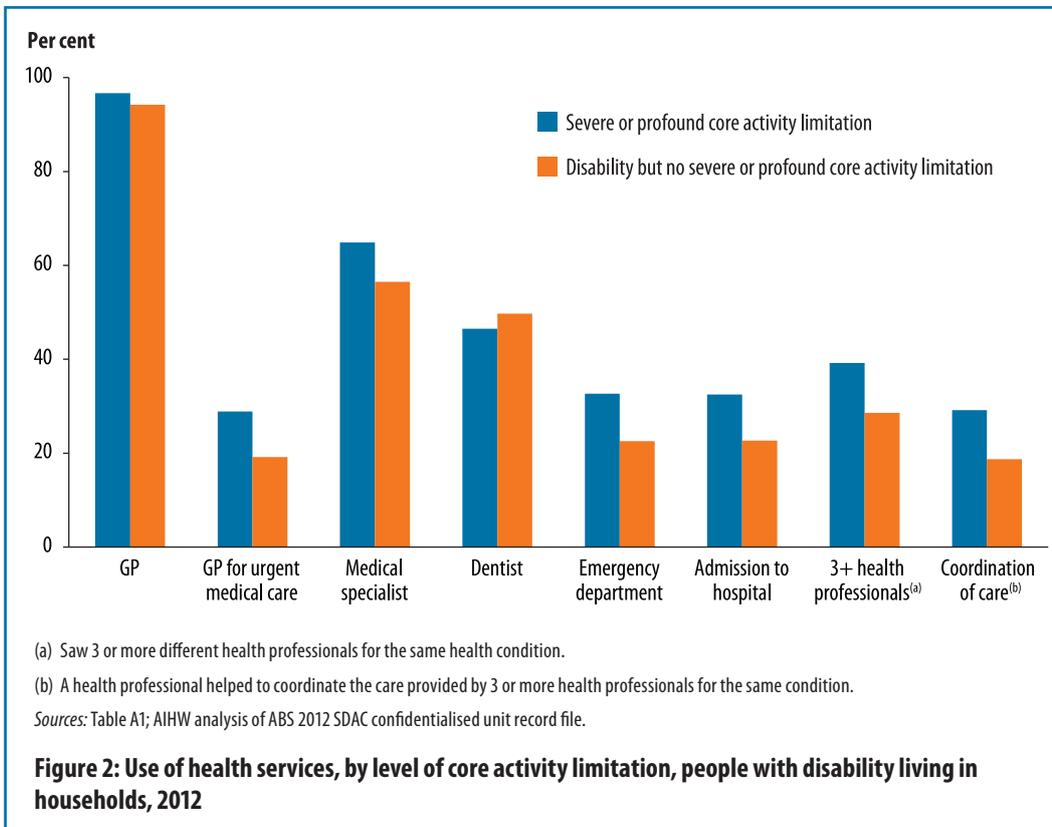
Females with disability aged under 65 were more likely than their male counterparts to: see a GP (95% versus 91%, respectively), see a GP for urgent medical care (27% versus 20%), visit a medical specialist (59% versus 52%), see a dentist (53% versus 46%), be admitted to a hospital (24% versus 20%), see 3 or more different health professionals for the same health condition (36% versus 31%), and receive help from a health professional to coordinate their care provided by 3 or more different health professionals (24% versus 21%) (Figure 1).



Differences in the use of health services between people with different levels of disability severity

The analysis shows that among people with disability, the use of health services was strongly associated with the level of core activity limitation. In 2012, people with severe or profound core activity limitation (that is, sometimes or always needing help with activities of self-care, mobility or communication) were more likely than those with disability but without this limitation to: see a GP (97% versus 95%, respectively), see a GP for urgent medical care (29% versus 19%), visit a medical specialist (65% versus 57%), visit a hospital ED (33% versus 23%), be admitted to a hospital (33% versus 23%), see 3 or more different health professionals for the same health condition (39% versus 29%) and receive help from a health professional to coordinate their care provided by 3 or more health professionals (29% versus 19%) (Figure 2).

However, people with severe or profound core activity limitation, in comparison with those with disability but without this limitation, were less likely to visit a dentist (47% versus 50%, respectively), especially a dentist in a private dental clinic (32% versus 41%) (Figure 3). They had lower private health insurance cover as well (37% versus 48%) (Table A1).



When people with disability were asked the main reason they went to an ED instead of a GP on their most recent visit, around 62% of people with severe or profound core activity limitation who visited a hospital ED felt their condition was serious or life-threatening, compared with 55% of people with disability but without this limitation (Table A3).

People with severe or profound core activity limitation who visited an ED were less likely than those without this limitation to think that the care they needed could have been provided by a GP (10% versus 15%, respectively) (Table A3).

Effect of age distribution on the differences in the use of health services

The differences in the use of health services between people with severe or profound core activity limitation and those without this limitation may be partly affected by the differences in age structures. The proportions of people aged 80 and over and under 15 years were higher for people with severe or profound core activity limitation living in households than for those with disability but without this limitation (AIHW analysis of ABS 2012 SDAC confidentialised unit record file). Older people with severe or profound core activity limitation are more likely to require health care. People aged under 15 with severe or profound core activity limitation are those with an early onset disability and more likely to need early intervention health services.

The differences in the use rates of health services between people with severe or profound core activity limitation and those without this limitation would be larger if people living in cared accommodation were included in the data collection. This is because most people living in cared accommodation had severe or profound core activity limitation, and 75% of them were aged 80 and over.

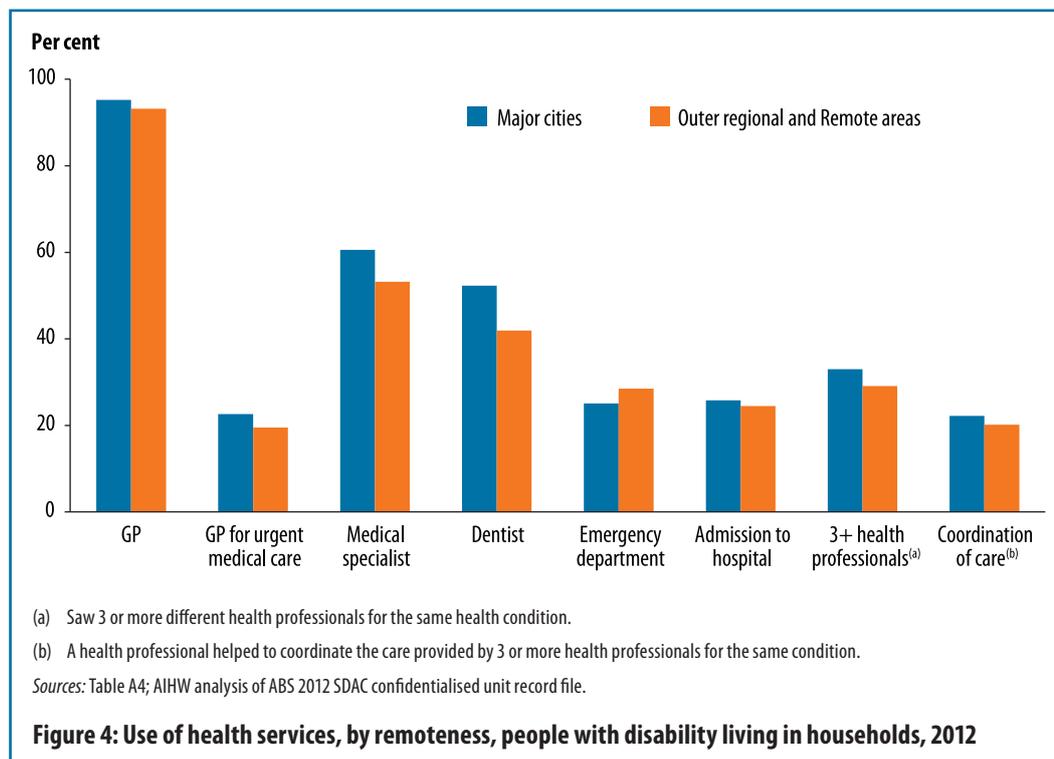
The high use of health services among people with severe or profound core activity limitation is associated with a high prevalence of multiple health conditions, and the combination of mental and physical health conditions (AIHW 2010). The high use of health services prevails even after taking into account the multiple health conditions and comorbidity of mental disorders and physical conditions. This suggests that the level of functional impairment, in addition to the presence of multiple health conditions, increases the likelihood of needing and seeking assistance from the health-care system (AIHW 2011).

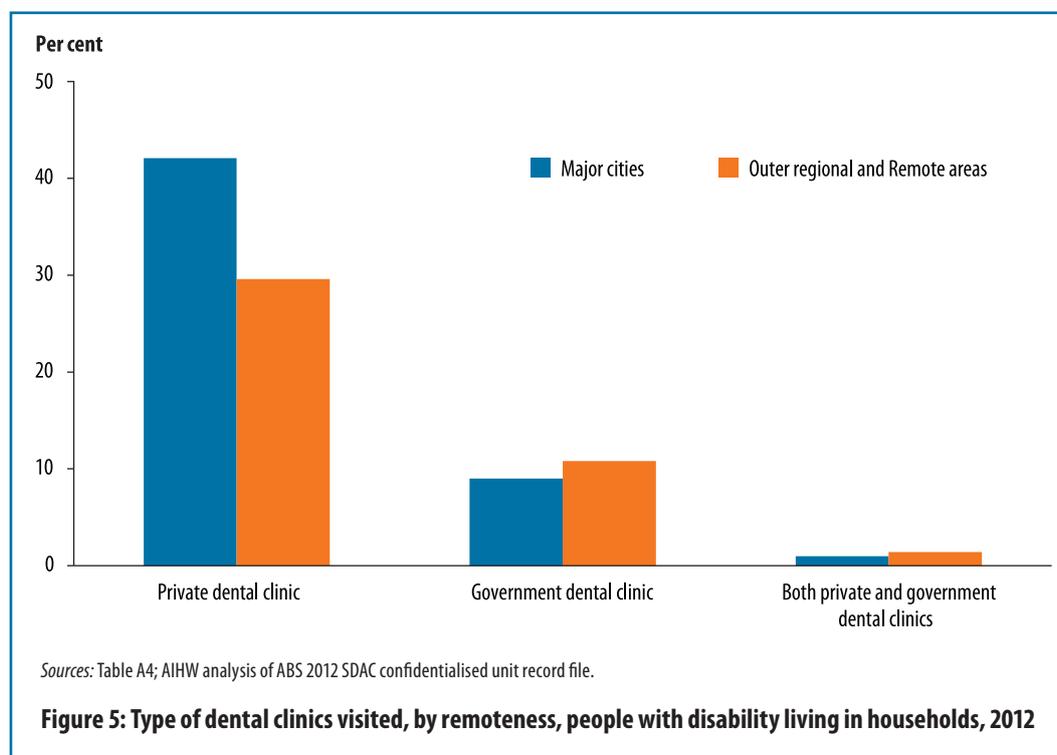
Where people with disability live makes a difference to their use of health services

The ABS Australian Statistical Geography Standard (ASGS) classifies geographical areas into 5 Remoteness Areas, depending on their distance from the nearest urban centre and the size of that centre, where population size of the urban centre is considered to govern the range and type of services available (ABS 2013a). Areas are classified as *Major cities*, *Inner regional*, *Outer regional*, *Remote* and *Very remote*. The SDAC excludes people living in *Very remote* areas and in discreet Aboriginal and Torres Strait Islander communities. The available 2012 SDAC data combined *Outer regional* and *Remote* areas into one category. Hence, this analysis focuses on comparisons of people living in this broad remoteness area and those living in *Major cities*. Data for *Inner regional* areas are presented in appendix tables.

Compared with people with disability living in *Major cities*, people with disability living in *Outer regional* and *Remote* areas were less likely to see: a GP (93% versus 95%, respectively), a GP for urgent medical care (20% versus 23%), a medical specialist (53% versus 61%), a dentist (42% versus 52%) and 3 or more different types of health professionals for the same condition (29% versus 33%) in the preceding 12 months (Figure 4). The difference in seeing a dentist was mainly due to the difference in visiting a private dental clinic (31% versus 43%) (Figure 5).

However, people with disability living in *Outer regional* and *Remote* areas were more likely to visit a hospital ED than people with disability living in *Major cities* (29% versus 25%, respectively).





Effect of demographic factors on the differences in the use of health services

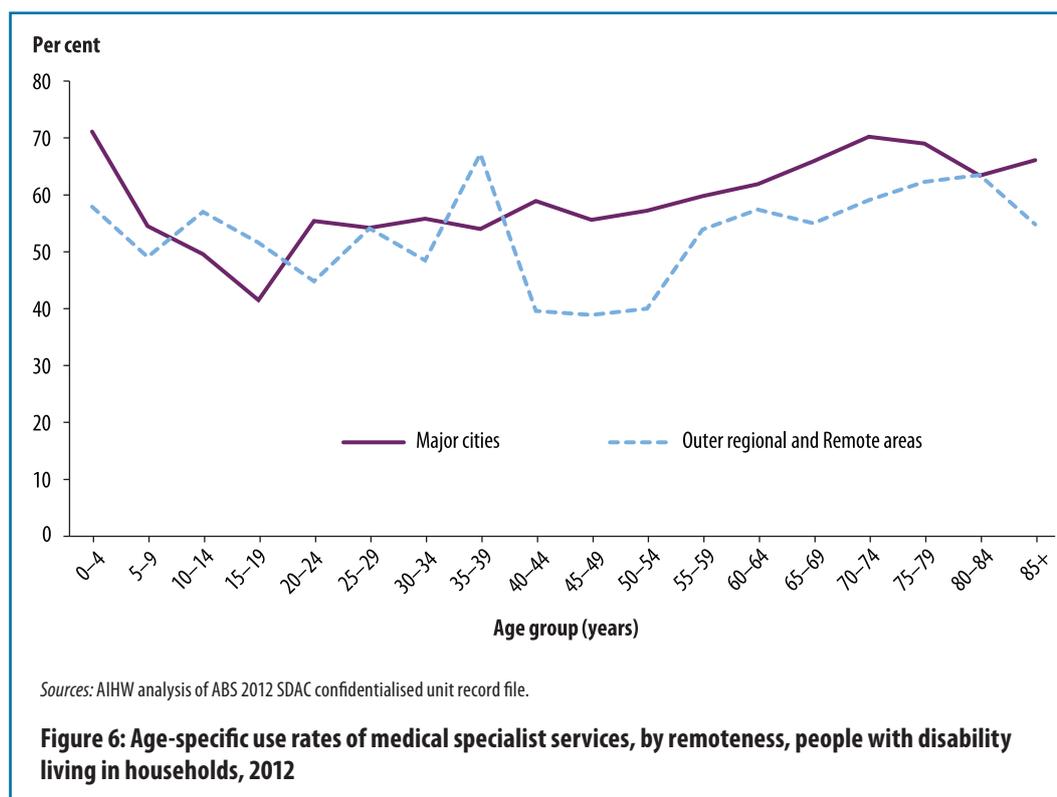
The differences in the use of health services between remoteness areas may be affected by various factors. These factors may include, for example, distance to service providers, availability of services, barriers for some special population groups and socioeconomic status of people living in different remoteness areas. This section examines some demographic characteristics that may, to some extent, contribute to the differences in the use of health services by people with disability living in *Major cities*, compared with those living in *Outer regional* and *Remote* areas (AIHW analysis of ABS 2012 SDAC confidentialised unit record file):

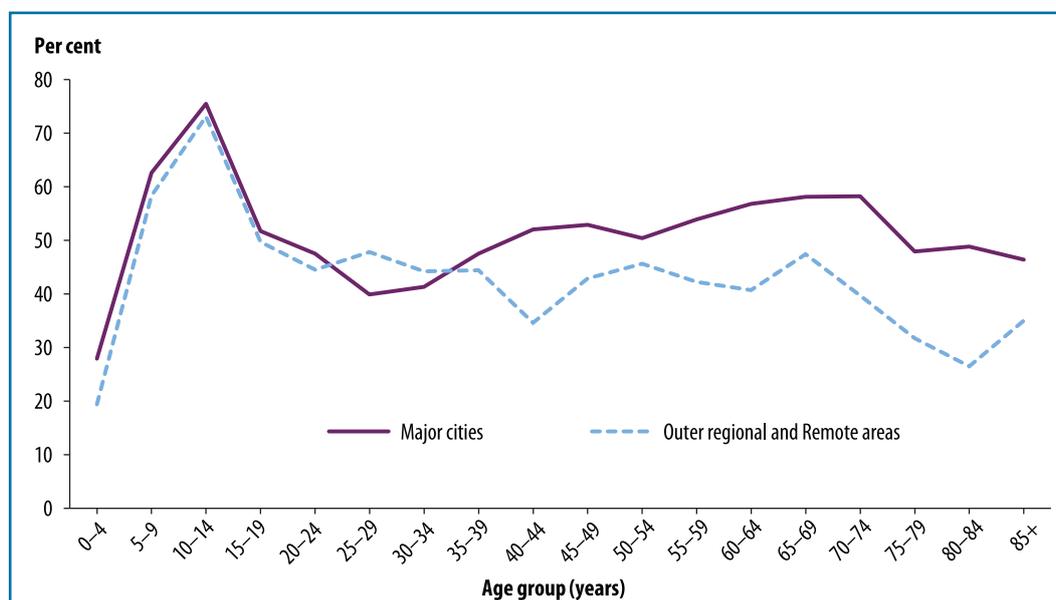
- People with disability living in *Major cities* were generally older compared with those living in *Outer regional* and *Remote* areas. Older people are much more likely to require health care. The proportion aged 75 and over among people with disability was higher for people living in *Major cities* than for those living in *Outer regional* and *Remote* areas (21% versus 16%, respectively). This difference was particularly marked among people with severe or profound core activity limitation (28% versus 19%).
- Of people with disability, the proportion who had severe or profound core activity limitation was higher for people living in *Major cities* than those living in *Outer regional* and *Remote* areas (31% versus 27%, respectively), especially among those aged 65 and over (34% versus 26%). People with severe or profound core activity limitation are extensive users of health services.

- Of people with disability living in *Major cities*, a higher proportion among those aged 40 and over were women, compared with people with disability living in *Outer regional* and *Remote* areas. Females are more likely than males to use health services.

The relatively low use rates of non-hospital health services among people with disability living in *Outer regional* and *Remote* areas were not simply because they had a relatively young age structure, or because they had low proportions of people with severe or profound core activity limitation and older females. When age structure was controlled for, the age-specific rates of visiting medical specialists and dentists showed that, among people with disability aged 40 and over, those living in *Outer regional* and *Remote* areas received lower levels of services from medical specialists and dentists than those living in *Major cities* (figures 6, 7). These patterns remained the same when age- and sex-specific use rates were examined (AIHW analysis of ABS 2012 SDAC confidentialised unit record file).

When analysis is restricted to people with severe or profound core activity limitation (that is, when the level of core activity limitation was controlled for), those living in *Outer regional* and *Remote* areas generally had lower use rates of non-hospital health services compared with those living in *Major cities* (Table A5).

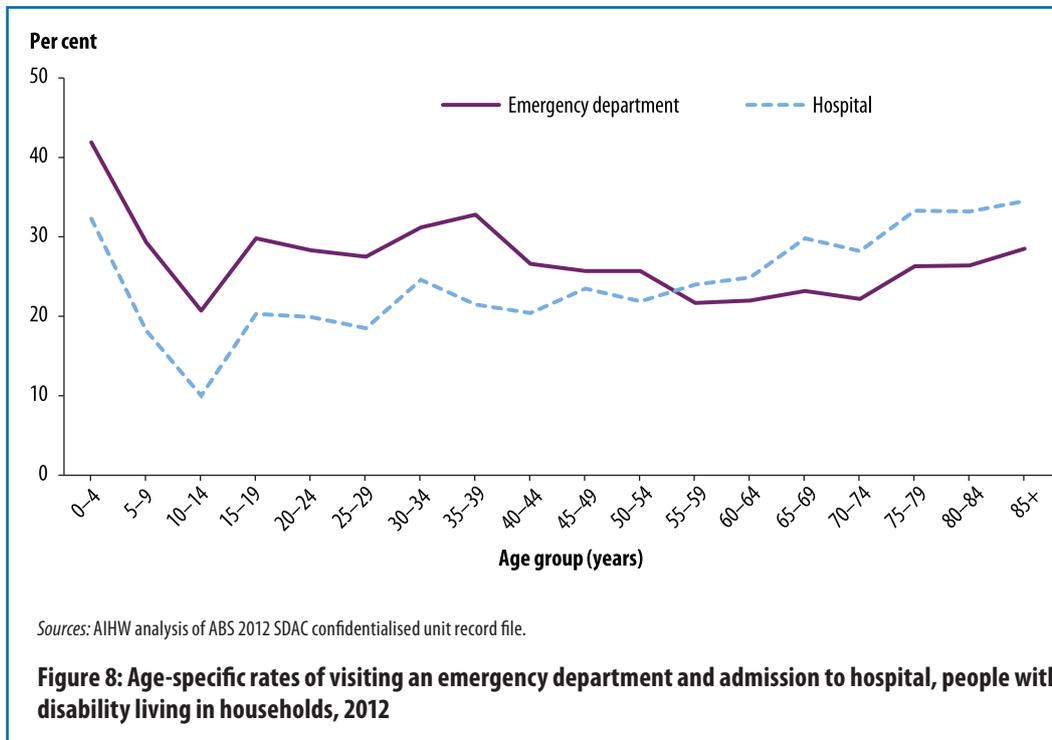




Sources: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Figure 7: Age-specific use rates of dental services, by remoteness, people with disability living in households, 2012

Overall, younger people with disability were more likely to visit a hospital ED and less likely to be admitted to a hospital than older people. Of people with disability aged under 55, the proportion of ED visits was higher than the proportion of hospital admissions, while the reverse pattern was observed among those aged 60 and over (Figure 8). The younger age structure of people with disability living in *Outer regional* and *Remote* areas might, to some extent, contribute to their higher rate of using a hospital ED compared with those living in *Major cities*. Of people with disability aged under 65 living in *Outer regional* and *Remote* areas, one-third (30%) visited a hospital ED, compared with one-quarter (25%) of people of that age living in *Major cities*. Among people with disability aged 65 and over, there were similar levels (around one-quarter) of ED visits between all remoteness areas (AIHW analysis of ABS 2012 SDAC confidentialised unit record file).



Some people use a hospital ED as the first or only point of contact with the health system because of personal preference or unavailability of other services (AIHW 2014). Less than half (47%) of people living in *Outer regional* and *Remote* areas who visited an ED said that the main reason they went to an ED instead of a GP on their most recent visit was that they felt their condition was serious or life-threatening, and the reason given by one-quarter (25%) was the time of day or day of the week. In contrast, 61% of people living in *Major cities* felt their condition was serious or life-threatening and just 15% indicated that the time of day or day of the week was their main reason (Table A6).

In their most recent visit to an ED, people with disability living in *Outer regional* and *Remote* areas were 2.5 times as likely as those living in *Major cities* to think that the care they needed could have been provided by a GP (25% versus 10%, respectively) (Table A6). This may indicate some non-hospital service gaps in *Outer regional* and *Remote* areas where some people visited an ED for health issues that could have been dealt with by non-hospital services.

The supply of all medical practitioners decreases with remoteness, with non-GP specialists tending to be concentrated in urban areas. This can mean that GPs in rural areas are required to provide a wider scope of services than in urban areas (AIHW 2014:367).

A previous publication in this series reported that the high use of health professionals other than GPs and medical specialists by people with severe or profound core activity limitation was particularly evident in the high use of services of occupational therapists, and social workers or welfare workers (AIHW 2011). The patient experience information collected in the 2012 SDAC did not include health professionals other than GPs, medical specialists and dentists. Hence, it is not possible to examine whether some needs for non-hospital health services in *Outer regional* and *Remote* areas were met by other allied health professionals.

In short, compared with people with disability living in *Major cities*, people with disability living in *Outer regional* and *Remote* areas had lower use rates of health services provided by GPs, medical specialists and dentists as well as coordinated care for the same health condition provided by different types of health professionals. They were more likely to visit a hospital ED for health issues that could potentially be dealt with by non-hospital services.

It is difficult to fully understand the relatively low service use rate of people with disability living in *Outer regional* and *Remote areas* without examining its relationship to the supply of health services in terms of type, volume and geographical distribution as well as a range of factors that might affect access to and use of services. The SDAC did not collect detailed information about health services provision.

Difficulties in access to health services for Australians with disability

Service accessibility is dependent on many factors, including service availability and potential barriers to access. This section analyses some difficulties in access to health services by people with disability, based on the available information from the 2012 SDAC.

GP services

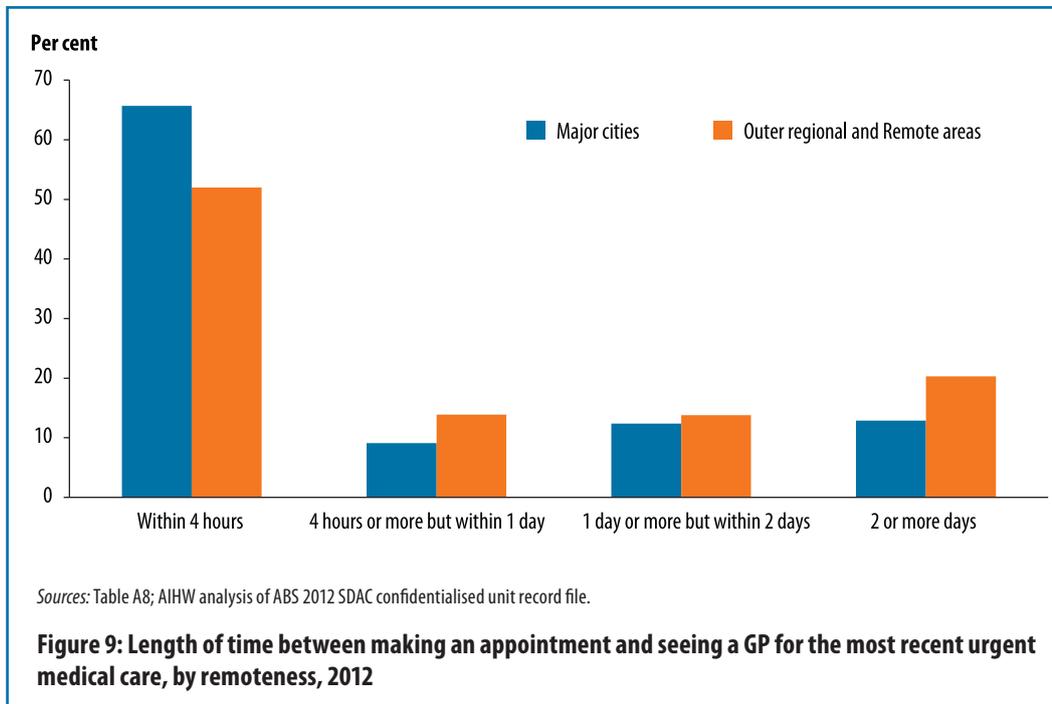
In 2012, 1 in 5 (20%) people with disability who saw a GP in the preceding 12 months waited longer than they felt was acceptable to get an appointment with a GP. People living in *Outer regional* and *Remote* areas were more likely to wait an unacceptable time compared with people in *Major cities* (24% versus 18%, respectively) (Table A7).

Among people with disability who saw a GP for urgent medical care in the previous 12 months, 20% of people living in *Outer regional* and *Remote* areas waited 2 or more days for their most recent appointment for urgent medical care, and just half (52%) of them saw a GP within 4 hours, compared with 13% and 66% for people living in *Major cities*, respectively (Figure 9).

Around 1.2 million people with disability who needed to see a GP delayed or did not go; of these, 17% (or 201,500 people) did so because of the cost (Table A9).

There were 793,600 people with disability who reported that there had been a time in the last year when they needed to see a GP but they did not go. The top main reason was long waiting times or services being unavailable when required (23%). Just under 1 in 10 (9%) said that cost was the main reason, and 23% decided not to seek care. (Table A10).

Long waiting times or services being unavailable when required was the main reason for 27% of people living in *Outer regional* and *Remote* areas, and 22% of people living in *Major cities* (Table A10).



Medical specialists

In 2012, 18% of people with disability who saw a medical specialist waited longer than they felt acceptable to get an appointment with a medical specialist (Table A11).

One in 5 (20%) people with disability did not go to see a medical specialist when they needed to mainly because of the cost; 8% did not go mainly due to long waiting times or services being unavailable when required. One-quarter (25%) of people were waiting for an upcoming appointment. Almost 1 in 3 (31%) people living in *Outer regional and Remote* areas who needed to see a medical specialist but did not go, were waiting for an upcoming appointment, compared with 1 in 5 (21%) people living in *Major cities* (Table A12).

Dental services

In 2012, overall, 11% of people with disability who needed dental services had been placed on a waiting list to visit a government dental clinic. People with severe or profound core activity limitation (14%) were more likely to be on the waiting list than those with disability but without this limitation (10%) (Table A13).

People with disability living in *Outer regional and Remote* areas were 1.7 times as likely as those living in *Major cities* to be on a waiting list for public dental care (17% versus 10%, respectively) (Table A13).

Almost one-third (32%) of people with disability who had been on a waiting list for public dental care were still waiting for the appointment. People with disability living in *Outer regional and Remote* areas were 1.5 times as likely as those living in *Major cities* to still be waiting for the appointment (41% versus 27%, respectively) (Table A14).

Around 30% (707,100) of people with disability who needed to see a dentist delayed seeing one, or did not visit a dentist. Of these people, 67% delayed or did not go because of the cost.

Some two-thirds (72%) of people with disability living in *Outer regional* and *Remote* areas who delayed seeing or did not see a dentist reported cost as the reason. The proportion of people living in *Major cities* was 66% (Table A15).

Among people with disability who saw a dentist, those living in *Outer regional* and *Remote* areas were more likely to visit a government dental clinic (29% versus 19%, respectively) and less likely to visit a private dental clinic (71% versus 81%) compared with those living in *Major cities* (Table A16).

Communication issues relating to coordinated health care

People with complex long-term health conditions often require care from multiple professionals. Patients who access coordinated health care are more likely to receive higher quality of care than those who do not (Harris et al. 2011). Good communication among different health professionals is important for coordinated health care.

Among people with disability who saw 3 or more different health professionals for the same condition, people living in *Outer regional* and *Remote* areas were 1.5 times as likely as those living in *Major cities* to face difficulties caused by a lack of communication among health professionals in the coordination of their care (22% versus 15%, respectively) (Table A17). People with severe or profound core activity limitation were more likely to have difficulties caused by a lack of communication among health professionals than people with disability but without this limitation (18% versus 14%).

Need and unmet need for assistance with health-care activities for Australians with disability

In 2012, over 1.1 million (29%) people with disability living in households needed help or supervision with their health-care activities. Of these people, a large majority (87%) received assistance either from formal service providers or informal carers. Just over half (52%) received assistance either from formal services only (37%) or a combination of informal and formal sources of assistance (15%) (Table A18).

Around 145,000 (13%) people with disability who needed help with health-care activities had no source of assistance; 192,000 people (17%) had not had their need for help with health-care activities fully met (Table A18).

The reported reasons for people who needed but did not receive assistance from formal services for their health-care activities included 'do not know of service', 'service costs too much' and 'unable to arrange service', among other reasons.

The high reliance on formal and informal assistance with personal health-care activities for people with disability highlights the importance of the formal health service sector working hand-in-hand with informal carers and families to support the health-care needs of people with disability.

Appendix tables

Table A1: Use of health services, by sex, by level of core activity limitation, people with disability living in households, 2012

Health service	Males	Females	Severe or profound	Non-severe or profound	Total	Total Number (‘000)
			Per cent			
Consultations						
Saw a general practitioner (GP)	93.4	96.4	96.7	94.2	94.9	3,773.9
Saw GP for urgent medical care	20.3	23.8	28.9	19.2	22.0	876.5
Saw a medical specialist	58.2	59.8	64.9	56.5	59.0	2,344.9
Saw a dental professional	46.1	51.4	46.5	49.7	48.8	1,939.5
Hospital						
Visited hospital emergency department	25.3	25.9	32.7	22.6	25.6	1,017.8
Been admitted to hospital	25.2	26.0	32.5	22.7	25.6	1,019.1
Coordination of care						
Saw 3 or more health professionals for same condition	31.1	32.3	39.2	28.6	31.7	1,261.1
A health professional helped coordinate the care	21.4	22.2	29.2	18.7	21.8	866.2
Type of dental clinic visited						
Private dental clinic	35.7	40.5	32.2	40.7	38.2	1,517.4
Government dental clinic	9.3	9.5	12.8	8.0	9.4	373.3
Both private and government dental clinics	0.9	1.2	1.2	1.0	1.0	41.0
Private health insurance cover						
Has private health insurance	43.2	45.9	37.2	47.7	44.6	1,772.6
Total number (‘000)	1,953.3	2,022.5	1,176.8	2,799.1		3,975.8

Note: The response ‘Do not know’ or other applicable categories are included in the percentage denominator.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A2: Use of health services, by sex, people with disability aged under 65 living in households, 2012

Health service	Males	Females	Persons
Consultations			
Saw a general practitioner (GP)	91.0	95.0	93.0
Saw GP for urgent medical care	20.3	26.7	23.5
Saw a medical specialist	52.3	58.6	55.4
Saw a dental professional	45.8	53.4	49.6
Hospital			
Visited hospital emergency department	25.0	27.0	26.0
Been admitted to hospital	20.4	23.6	21.9
Coordination of care			
Saw 3 or more health professionals for same condition	30.8	35.6	33.2
A health professional helped coordinate the care	21.0	24.2	22.6
Total people with disability aged under 65 (‘000)	1,234.8	1,203.3	2,438.2

Note: The response ‘Do not know’ or other applicable categories are included in the percentage denominator.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A3: Main reason for visiting a hospital emergency department (ED) instead of a GP on the most recent occasion, whether felt GP could have provided the care, by level of core activity limitation, people with disability living in households who visited an ED, 2012

ED experience	Severe or profound	Non-severe or profound	Total
	Per cent		
Main reason for visiting an ED instead of a GP on the most recent occasion			
Condition was serious/life threatening	61.9	54.6	57.4
Time of day/day of week	16.4	19.6	18.4
Other	21.7	25.8	24.2
Total	100.0	100.0	100.0
Whether felt GP could have provided the care for the most recent ED visit			
Thought care could have been provided by GP	10.4	15.1	13.3
Thought care could not have been provided by GP	87.4	82.8	84.5
Didn't know	2.2	2.1	2.1
Total	100.0	100.0	100.0
Total number ('000)	384.9	632.8	1,017.8

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A4: Use of health services, by remoteness, people with disability living in households, 2012

Health service	Major cities	Inner regional	Outer regional and Remote areas
	Per cent		
Consultations			
Saw a general practitioner (GP)	95.2	95.0	93.2
Saw GP for urgent medical care	22.6	21.8	19.5
Saw a medical specialist	60.6	57.2	53.2
Saw a dental professional	52.3	42.6	41.9
Hospital			
Visited hospital emergency department	25.1	25.5	28.5
Been admitted to hospital	25.8	25.7	24.5
Coordination of care			
Saw 3 or more health professionals for same condition	33.0	29.6	29.1
A health professional helped coordinate the care	22.2	21.4	20.2
Type of dental clinic visited			
Private dental clinic	42.1	31.7	29.6
Government dental clinic	9.0	9.8	10.8
Both private and government dental clinics	1.0	*0.9	*1.4
Private health insurance cover			
Has private health insurance	47.9	38.6	38.6
Total number ('000)	2,569.2	974.7	431.9

* Estimate has relative standard error of 25–50% and should be used with caution.

Note: The response 'Do not know' or other applicable categories are included in the percentage denominator.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A5: Use of health services, by remoteness, people with severe or profound core activity limitation living in households, 2012

Health service	Major cities	Inner regional	Outer regional and Remote areas
			Per cent
Consultations			
Saw a general practitioner (GP)	96.6	97.2	96.0
Saw GP for urgent medical care	28.7	30.4	26.8
Saw a medical specialist	66.1	64.0	58.4
Saw a dental professional	49.8	40.2	38.8
Hospital			
Visited hospital emergency department	31.5	33.5	38.9
Been admitted to hospital	32.1	34.0	32.1
Coordination of care			
Saw 3 or more health professionals for same condition	39.8	37.9	38.0
A health professional helped coordinate the care	29.5	29.1	27.7
Total number ('000)	793.6	267.6	115.6

Note: The response 'Do not know' or other applicable categories are included in the percentage denominator.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A6: Main reason for visiting a hospital emergency department (ED) instead of a GP on the most recent occasion, whether felt GP could have provided the care, by remoteness, people with disability living in households who visited an ED, 2012

ED experience	Major cities	Inner regional	Outer regional and Remote areas	Total
			Per cent	
Main reason for visiting an ED instead of a GP on the most recent occasion				
Condition was serious/life threatening	61.0	53.3	46.7	57.4
Time of day/day of the week	14.7	24.8	24.9	18.4
Other reasons	24.3	21.9	28.4	24.2
Total	100.0	100.0	100.0	100.0
Whether felt GP could have provided the care for the most recent ED visit				
Thought care could have been provided by a GP	9.6	17.2	25.0	13.3
Thought care could not have been provided by a GP	88.4	80.8	71.9	84.5
Didn't know	2.0	*2.0	*3.1	2.1
Total	100.0	100.0	100.0	100.0
Total number ('000)	646.0	248.7	123.0	1,017.8

* Estimate has relative standard error of 25–50% and should be used with caution.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A11: Whether waited longer than felt acceptable to get an appointment with medical specialist, by remoteness, people with disability living in households who saw a medical specialist, 2012

Waiting experience	Major cities	Inner regional	Outer regional and Remote areas	Total
			Per cent	
Did wait longer than felt acceptable	16.8	20.5	18.2	17.8
Did not wait longer than felt acceptable	64.2	66.6	65.8	64.9
Has responded by proxy	19.0	12.9	16.0	17.3
Total	100.0	100.0	100.0	100.0
Total people who saw a medical specialist ('000)	1,557.6	557.3	230.0	2,344.9

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A12: People with disability living in households who did not see a medical specialist when needed to, main reason for not seeing a medical specialist, by remoteness, 2012

Reason	Major cities	Inner regional	Outer regional and Remote areas	Total
			Per cent	
Cost	21.8	16.8	17.9	20.1
Appointment upcoming	21.3	30.3	31.1	24.6
Waiting time too long or not available at time required	7.8	6.0	*9.6	7.6
Other	49.1	47.0	41.2	47.7
Total	100.0	100.0	100.0	100.0
Total number ('000)	291.7	110.4	53.4	455.5

* Estimate has relative standard error of 25–50% and should be used with caution.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A13: Whether had been placed on a waiting list to see a dentist at a government dental clinic, by level of core activity limitation, by remoteness, people with disability living in households who needed to see a dentist, 2012

Waiting list status	Severe or profound	Non-severe or profound	Major cities	Inner regional	Outer regional and Remote areas	Total
					Per cent	
Had been on a waiting list	14.3	9.8	9.5	13.2	17.4	11.1
Had not been on a waiting list	85.7	90.2	90.5	86.8	82.6	88.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total people who needed to see a dentist ('000)	689.3	1,699.9	1,613.1	533.4	242.7	2,389.2

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A14: People who were still waiting for seeing a dentist at a government dental clinic, as a per cent of total people with disability who had been on a public dental waiting list in the previous 12 months, by remoteness, 2012

Waiting status	Major cities	Inner regional	Outer regional and Remote areas	Total
			Per cent	
Still waiting (had not been seen)	26.8	36.4	41.1	31.6
Total people who had been on a waiting list ('000)	152.6	70.2	42.2	264.9

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A15: People with disability living in households who delayed seeing or did not go to see a dentist, by whether it was due to the cost, by remoteness, 2012

Reason	Major cities	Inner regional	Outer regional and Remote areas	Total
	Per cent			
Delayed seeing or did not see a dentist due to cost	66.3	68.2	72.2	67.4
Delayed seeing or did not see a dentist due to other reasons	33.7	31.8	27.8	32.6
Total	100.0	100.0	100.0	100.0
Total people who delayed seeing or did not see a dentist ('000)	459.6	172.7	74.9	707.1
	Per cent of total people who needed to see a dentist			
Total people who delayed seeing or did not see a dentist	28.5	32.4	30.9	29.6
Total people who needed to see a dentist ('000)	1,613.1	533.4	242.7	2,389.2

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A16: Type of clinic visited for the most recent time saw a dentist, by remoteness, people with disability living in households who saw a dentist, 2012

Type of dental clinics	Major cities	Inner regional	Outer regional and Remote areas	Total
	Per cent			
Private dental clinic	80.5	74.3	70.6	78.2
Government dental clinic	17.2	23.1	25.8	19.2
Both private and government dental clinics	1.9	2.2	3.2	2.1
Don't know	*0.4	**0.5	**0.4	*0.4
Total	100.0	100.0	100.0	100.0
Total people who saw a dental professional ('000)	1,342.9	415.4	181.2	1,939.5

* Estimate has relative standard error of 25–50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A17: Whether there were issues caused by a lack of communication among different health professionals, by level of core activity limitation, by remoteness, people with disability living in households who saw 3 or more different health professionals for the same condition, 2012

Issues caused by a lack of communication	Severe or profound	Non-severe or profound	Major cities	Inner regional	Outer regional and Remote areas	Total
	Per cent					
Yes	17.8	14.4	14.7	15.8	22.0	15.7
No	79.5	83.8	82.9	82.6	76.7	82.2
Can't remember	2.7	1.8	2.4	*1.6	**1.4	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total people who saw 3+ health professionals ('000)	461.5	799.6	847.4	288.0	125.7	1,261.1

* Estimate has relative standard error of 25–50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

Table A18: Type of health-care assistance received, extent to which need for health-care assistance met, people with disability in households who needed help with health-care activities, 2012

Type/extent	Number ('000)	Per cent
Type of health care assistance received		
None	145.2	12.7
Informal assistance only	401.2	35.0
Formal services only	427.3	37.2
Informal help and formal services	173.8	15.2
Total received formal services	601.1	52.4
Total received informal services	575.0	50.1
Extent to which need for health care assistance met		
Fully	955.9	83.3
Partly	131.8	11.5
Not at all	59.8	5.2
Total people with disability who needed assistance	1,147.5	100.0
Per cent of total people with disability in households^(a)		28.9
Total people with disability in households	3,975.8	..

.. not applicable

(a) People who needed assistance with health care activities as a per cent of total people with disability.

Source: AIHW analysis of ABS 2012 SDAC confidentialised unit record file.

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ED	emergency department
GP	general practitioner
SDAC	Survey of Disability, Ageing and Carers

References

- ABS (Australian Bureau of Statistics) 2013a. Australian Statistical Geography Standard (ASGS): volume 5—remoteness structure, Australia, July 2011. ABS cat. no. 1270.0.55.005. Canberra: ABS.
- ABS 2013b. Disability, ageing and carers: summary of findings, Australia 2012. ABS cat. no. 4430.0. Canberra: ABS.
- AIHW (Australian Institute of Health and Welfare) 2010. Health of Australians with disability: health status and risk factors. Bulletin no. 83. Cat. no. AUS 132. Canberra: AIHW.
- AIHW 2011. The use of health services among Australians with disability. Bulletin no. 91. Cat. no. AUS 140. Canberra: AIHW.
- AIHW 2014. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.
- Department of Social Services 2012. National Disability Strategy 2010–2020. Canberra: Commonwealth of Australia.
- Harris MF, Jayasinghe UW, Taggart JR, Christl B, Proudfoot JG, Crookes PA et al. 2011. Multidisciplinary Team Care Arrangements in the management of patients with chronic disease in Australian general practice. Medical Journal of Australia 194(5):236–9.

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