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HEALTH SERVICES: PATIENT EXPERIENCES IN AUSTRALIA, 2009

AUSTRALIA

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INQUIRIES

For further information about these and related statistics, contact the National Information and Referral Service on 1300 135 070.

NOTES

ABOUT THIS PUBLICATION

This publication presents summary results from the 2009 Patient Experience Survey. The survey was conducted by the Australian Bureau of Statistics (ABS) from July to December 2009, collecting Australians' views of their health care experiences in the last 12 months. It provides data on characteristics and experiences of both people that accessed health services, and those that did not.

A representative sample of 7,124 households completed the survey. Information was given by people aged 15 years and over for a wide range of health services, including GPs, medical specialists and hospitals. Information on children's use of health services was also collected from households with children under 15.

Acknowledgement

ABS publications draw extensively on information provided freely by individuals, businesses, governments and other organisations. Their continued cooperation is very much appreciated - without it, the wide range of statistics published by the ABS would not be available. Information received by the ABS is treated in strict confidence as required by the Census and Statistics Act 1905.

The ABS would also like to thank the Patient Experience Survey Reference Group for their advice in the development of the survey.

Brian Pink
Australian Statistician

CHAPTER 1

USE OF HEALTH SERVICES

INTRODUCTION

Summary results of the 2009 Patient Experience Survey are presented thematically, as follows:

Use of health services

Chapter 1 provides an overview of health service usage in Australia. It contains data on:

- general practitioner (GP), or multiple health professional visits for a single condition;
- hospital admissions and visits to emergency departments;
- pathology and imaging tests; and
- advice sought from pharmacists in the last 12 months.

Barriers to health services

Chapter 2 contains information on various barriers to health care including:

- cost;
- views on waiting times for GP and medical specialist appointments;
- after hours access; and
- travel time.

General practitioners and medical specialists

Chapter 3 presents data on frequency of visits to GPs and specialists, as well as the following GP services:

- waiting times for appointments;
- prescription services;
- referrals to specialists; and
- rates of after hours and urgent visits to a GP.

Hospital and emergency

Chapter 4 includes data on the frequency of admission to hospital and visits to a hospital emergency department. In the case of people admitted to hospital, information is reported on whether they had been given the choice (and enough information to make the choice) to be treated as a public or a private patient. In relation to visits to a hospital emergency department, the chapter includes data on people's reasons for visiting an emergency department and whether they thought the care they went to the emergency department for could have been provided by a GP.

Communication with health providers

Chapter 5 presents data on the extent and clarity of communication with health providers in relation to medication, referrals to specialists, pathology and imaging tests, coordination of care by multiple health professionals and advice from pharmacists.

Harm and harmful side-effects

Chapter 6 presents data on any harm or harmful side-effects people may have suffered as a result of any medication, medical care, treatment or test in the past 12 months. Information is provided on the location in which the person had the medication, medical care, treatment or test that caused the harm or harmful side-effect. The chapter also includes information about whether people had been told of the risk of harm,

*Harm and harmful
side-effects continued*

whether they had received and completely understood an explanation of the most recent harm or harmful side-effect and whether they were satisfied with the treatment they received for it.

*Experiences of health
service provision for
children*

Chapter 7 contains data on households with children under the age of 15, where any child in the household had, in the last 12 months:

- visited a hospital emergency department;
- seen a GP for urgent medical care;
- seen a GP after hours; and/or
- needed to see a GP after hours but could not do so.

Data was collected on whether the household spokesperson thought the care provided for the child's most recent visit to an emergency department could have been provided by a GP, and the main reason the child was taken to an emergency department instead of a GP; as well as GP waiting times for urgent medical care, type of clinic visited for after hours care; and the main reason the child was unable to see a GP after hours.

Publication tables

Tables are provided to assist the reader with the information noted above. The tables are available in Excel spreadsheet form (data cubes), which can be found on the download tab of the publication, (cat. no. 4839.0.55.001).

Survey information

Information about the survey design and methodology, the quality and interpretation of results, and the range of publications and other data services available or planned is available in the Explanatory Notes.

USE OF HEALTH SERVICES: AN OVERVIEW

The Patient Experience Survey asked people about a range of health services they may have used for their own health in the past 12 months, and the experiences they had with each service. All persons aged 15 years and over were asked whether they had:

- seen a general practitioner (GP);
- seen three or more health professionals for a single condition;
- been admitted to hospital;
- visited a hospital emergency department;
- had a pathology test;
- had an imaging test; and/or
- asked a pharmacist for health-related advice.

People who had seen a GP were asked whether they had seen a GP for urgent medical care or after hours, received a prescription for medication, or been referred to a medical specialist (see Chapter 3). Households with children under 15 years of age were also asked about experiences of health provision for their children (see Chapter 7).

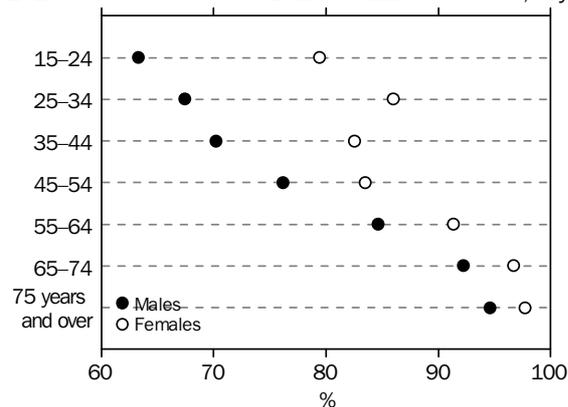
This chapter provides an overview of people's use of the health services listed above, by a range of economic and demographic characteristics.

General practitioner (GP)

Across Australia, approximately four out of five people aged 15 years and over had seen a general practitioner at least once in the year prior to the survey (around 81% or 14 million people).

As shown in Figure 1.1 below, women in every age group were more likely to have seen a GP than men, particularly in the younger age groups. Overall, 86% of Australian women had visited a general practitioner in the last 12 months compared with 75% of men. By the time people reached the age of 65, rates of visiting a GP were well over 90% for both men and women.

1.1 SAW A GP IN THE LAST 12 MONTHS, by Age and Sex



(a) Persons 15 years and over

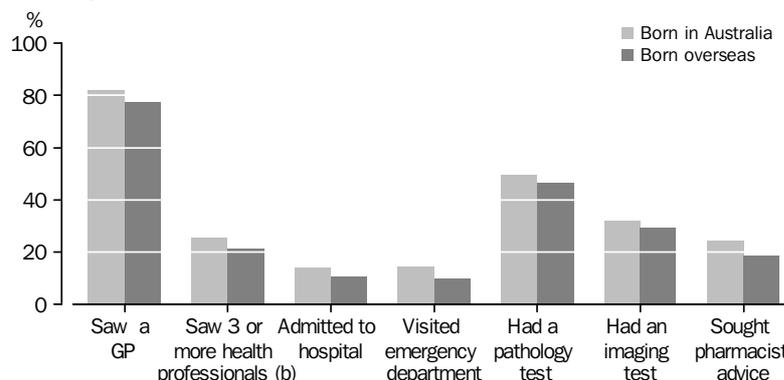
(See Table 1.2 for more detail)

*General practitioner (GP)
continued*

In general, people living in major cities were more likely to have seen a GP (82%) than those living in outer regional or remote areas (78%). Across the States and Territories, people living in the ACT were the most likely to have seen a general practitioner (87%) while people living in the NT (76%) and Victoria (79%) were the least likely (see Tables 1.1 and 1.3 for more detail).

People who were not born in Australia were a little less likely to have seen a GP than people born in Australia (77% and 82% respectively), a pattern that was repeated across all the health services discussed in this chapter (shown here in Figure 1.2).

1.2 USE OF HEALTH SERVICES IN THE LAST 12 MONTHS (a), by Country of birth



(a) Persons 15 years and over
(b) for a single condition

(See Table 1.1 for more detail)

Rates of seeing a GP clearly aligned with people's self-perception of their health - more people who felt their health was only fair or poor had seen a GP in the past year (95%) than people who felt their health was generally excellent, very good or good (79%).

More details of GP services (for example, prescriptions for medication) are available in Chapter 3. Details of people's experiences of communication with GPs (for example, whether received and understood an explanation of the reasons for prescribing medication) are available in Chapter 5.

Coordination of care

Around a quarter of Australians aged 15 years or more had seen three or more health professionals for a single condition in the past 12 months (24% or 4.2 million people). These conditions may have ranged from chronic conditions such as diabetes, cardiovascular disease or cancer, to pregnancies or injuries that required coordinated care for a shorter time.

Women aged 25-54 were more likely than men of the same age to have seen three or more health professionals for a single condition, however rates were not significantly different for men and women after the age of 55 (see Table 1.2 for more detail).

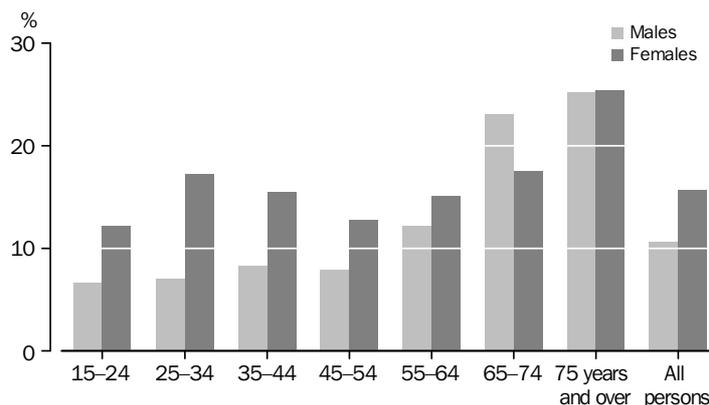
Chapter 5 discusses whether there were any issues caused by a lack of coordination between the health professionals people saw for their condition.

Hospital admissions and emergency visits

Approximately 13% of Australians aged 15 years and over (2.3 million people) reported being admitted to hospital in the previous 12 months. The same proportion of people had visited a hospital emergency department.

The survey showed that patterns of hospital admission were different for men and women. In fact, until the age of 55, women were around twice as likely to have been admitted to hospital as men (see Figure 1.3). Higher rates of hospitalisation for women are due in part to obstetric treatments (AIHW, 2010).

1.3 ADMITTED TO HOSPITAL IN LAST 12 MONTHS (a), by Age and Sex

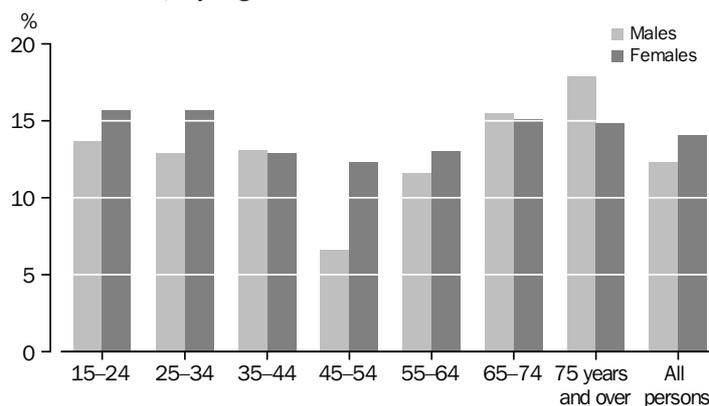


(a) Persons 15 years and over

(See Table 1.2 for more detail)

On the other hand, as shown in Figure 1.4, patterns of visiting an emergency department were quite similar for men and women except for the 45-54 year old age group.

1.4 VISITED HOSPITAL EMERGENCY DEPARTMENT IN LAST 12 MONTHS (a), by Age and Sex



(a) Persons 15 years and over

(Differences between men and women aged 75 years and over are not statistically significant (see Technical Note). See Table 1.2 for more detail)

Hospital admissions and emergency visits continued

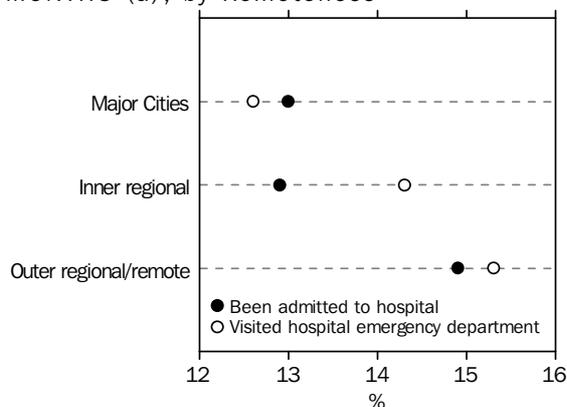
WA and Tasmania (16%) had the highest rates of people being admitted to hospital and NT had the lowest (10%) (keeping in mind that the survey did not go to very remote communities, which accounts for approximately 24% of the population of the NT). This was similar for rates of emergency visits, with people in WA (16%) and SA (14%) reporting the most visits to an emergency department in the previous 12 months and people in the NT reporting the least (12%).

Survey results show that relative disadvantage had some effect on rates of hospital admissions and emergency visits. People in areas of most disadvantage reported the most hospital admissions (15%) and they had the highest rate of visiting an emergency department (17% compared with the national average of 13%) (see Table 1.1 for more detail). They were also far more likely to consider their health only fair or poor than people from areas of least disadvantage. These rates may be due in part to age¹.

Across the board, people's estimation of their own health status was reflected in rates of both hospital admissions and emergency visits. People who rated their health as fair or poor were more than twice as likely to have been admitted to hospital or to visit an emergency department (27% and 26% respectively) as people who rated their health as excellent, very good or good (both 11%).

As shown in Figure 1.5, people in outer regional and remote areas of Australia had the highest rates of being admitted to hospital (15%) and visiting an emergency department (15%).

1.5 HOSPITAL ADMISSIONS AND EMERGENCY VISITS IN LAST 12 MONTHS (a), by Remoteness



(a) Persons 15 years and over

(See Table 1.1 for more detail)

¹ There are relationships between age and health service usage, and between age and socio-economic status. The SEIFA indices summarise different aspects of the socio-economic conditions of people living in an area. The Index of Relative Socio-economic Disadvantage is derived from Census variables related to disadvantage, such as low income and dwellings without motor vehicles. Patient Experience survey results show that people aged 65 years and over are slightly more likely to live in areas of more disadvantage, and are more likely to rate their health as fair or poor.

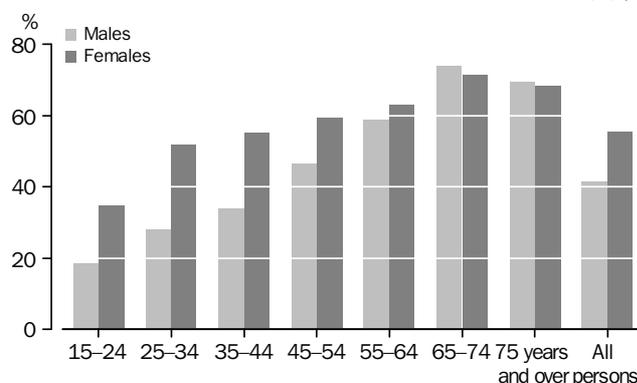
Imaging and pathology tests

Almost half of people aged 15 years and over (49% or 8.4 million people) had a pathology test sometime in the year prior to the survey. Across the States and Territories, the pathology testing rate was highest in Tasmania (53%) and lowest in the NT at 44%.

Nearly a third of Australians aged 15 years or more had an imaging test in the last 12 months (31% or 5.4 million people). This was significantly less for people in NT at 19% (see Table 1.3 for more detail).

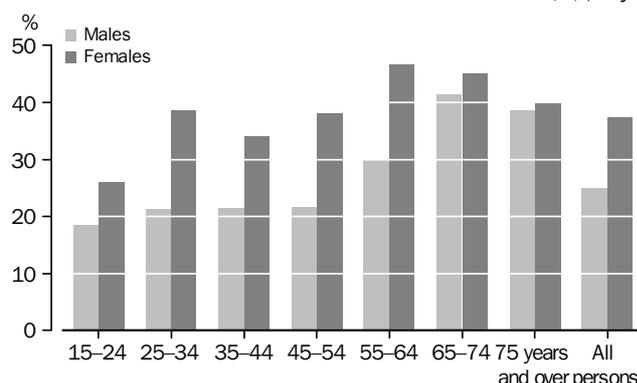
Women were more likely to have had diagnostic testing than men (55% of women compared with 42% of men for pathology tests, and 37% of women compared with 25% of men for imaging tests). Up to the age of 55 for pathology tests and 65 for imaging tests, women were much more likely to have had these tests.

1.6 PATHOLOGY TESTS IN LAST 12 MONTHS (a), by Age and Sex



(a) Persons 15 years and over who had a pathology test which was referred by a health professional, excluding tests had in hospital

1.7 IMAGING TESTS IN LAST 12 MONTHS (a), by Age and Sex



(a) Persons 15 years and over who had an imaging test, excluding dental tests and tests had in hospital

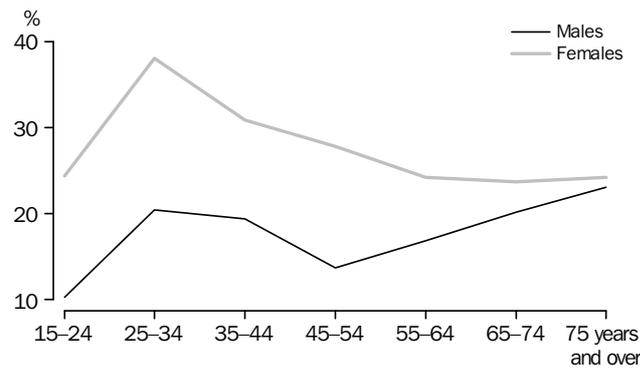
(See Table 1.2 for more detail)

As with other health services, more people who rated their health as fair or poor had diagnostic tests than people who rated their health as good or better; and more people who were born in Australia had these tests than people born overseas. Relative disadvantage and remoteness made no significant difference to rates of having diagnostic tests.

Seeking health-related advice from pharmacists

Around 23% of Australians aged 15 years or over (3.9 million people) reported asking a pharmacist for health-related advice at some time in the 12 months prior to the survey. Women were more likely to have asked for advice than men (28% and 17% respectively). Young men aged 15-24 were the least likely of any age group (either male or female) to have asked for advice (10%) (see Figure 1.8).

1.8 ASKED PHARMACIST FOR ADVICE IN LAST 12 MONTHS (a), by Age and Sex



(a) Persons 15 years and over

(See Table 1.2 for more detail)

Interestingly, people in areas of most disadvantage were less likely to have asked a pharmacist for health-related advice (19%) than people in areas of least disadvantage (25%).

As shown in Figure 1.2, people born overseas were less likely than people born in Australia to have asked a pharmacist for health-related advice (19% compared with 24%).

REFERENCES

Australian Institute of Health and Welfare 2010. *Australia's Health 2010*. Australia's Health series no. 12. Cat. no. AUS 122. Canberra: AIHW. (page 315).

BARRIERS TO HEALTH CARE

To measure barriers to accessing health services, all people aged 15 years and over in the survey were asked whether they had delayed seeing or not seen a GP at any time in the past year because of the cost, and whether they had delayed having or not had a pathology or imaging test at any time in the past year because of the cost. People were also asked whether in the past year they had:

- experienced unacceptable waiting times for an appointment with a GP for urgent medical care;
- travelled longer than an hour to see a GP; and
- needed any health service in the past year that they had not been able to access.

People who had been referred to a specialist by a GP were asked whether they had delayed seeing or not seen a specialist at any time in the past year because of the cost, and whether they felt the waiting time for their most recent specialist appointment was unacceptable².

People who had been prescribed medication by a GP were asked whether they delayed getting or did not get prescribed medication at any time in the last year because of the cost.

Barriers to seeing a GP

In 2009, approximately 1.1 million Australians aged 15 years or more (6%) delayed seeing or did not see a GP in the previous year because of the cost.

More people in Queensland (8%) and WA (8%) said they had delayed seeing or not seen a GP in the last 12 months because of the cost than people in Tasmania, NSW or SA (all 5.0%). There was no significant difference between people living in more disadvantaged areas and those in less disadvantaged areas, nor was there any particular difference between major cities, inner regional and outer regional/remote areas of Australia (see Tables 2.1 and 2.2).

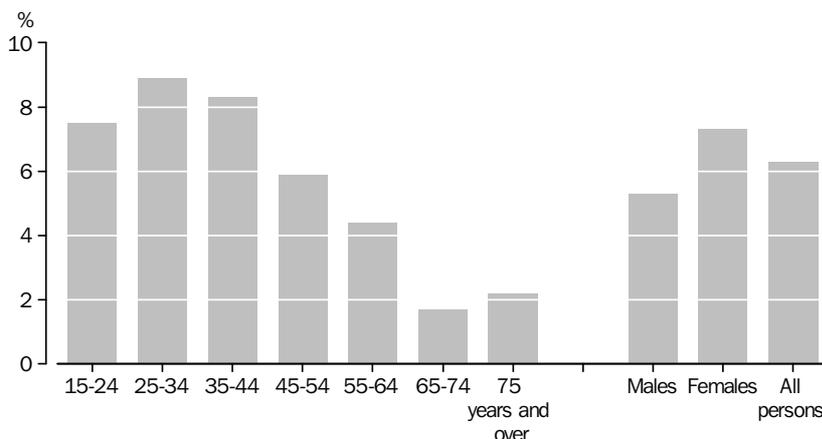
Whether or not a person had private health insurance had an effect, however, with almost twice as many people without private health insurance reporting cost as a barrier to seeing a GP as people with private health insurance (8% compared with 5%).

As shown in Figure 2.1, people under the age of 45 were more likely to have reported cost as a barrier to seeing a GP than people aged 45 years and over. After the age of 45, finding cost a barrier declined fairly steadily with age. Women were also more likely than men to have found cost a barrier to seeing a GP, which may relate to the fact that a greater proportion of women accessed GP services.

² People who had been interviewed by proxy were not asked questions that called for personal opinions.

Barriers to seeing a GP
continued

2.1 DELAYED SEEING OR DID NOT SEE GP IN PAST 12 MONTHS DUE TO COST (a), by Age and Sex



(a) Persons 15 years and over

(See Table 2.1 for more detail)

Almost one-sixth of people who saw a GP for their own health in the 12 months prior to the survey felt they had waited longer than was acceptable to get an appointment with a GP (18% or around 2.4 million people). Again this differed with age and sex, with more women than men (21% compared with 14%) and more young people than older people finding the waiting time unacceptable. Across the States and Territories, the ACT had the highest proportion of people who felt they had waited too long to see a GP (22%).

Excluding people living in very remote regions of Australia, 3% of Australians aged 15 years and over (414,400 people) had travelled longer than an hour to see a GP at some time in the past year.

Barriers to after hours GP care

Around 514,100 Australians (3%) had not been able to see a GP after hours when they had needed to, at some time in the last 12 months. The main reason given for this was that there was no service available at the time it was required (57%).

Almost twice as many women than men reported being unable to access a GP after hours when they needed one (4% and 2% respectively.)

There was no significant difference between people living in major cities and those living in regional and remote areas of Australia being unable to access an after hours GP, however 69% of people in outer regional and remote areas who had not been able to access an after hours GP said the main reason for this was that there was no service available at the time it was required (compared with the national average of 57%).

Cost barriers to prescribed medications

Almost 1 in ten people aged 15 years and over who had been prescribed medication in the past year delayed getting or did not get their prescribed medication because of the cost (9% or about one million people). Queensland had the highest incidence of people delaying or not getting prescribed medication (10%) and Tasmania and ACT had the lowest (5% and 4% respectively).

Cost barriers to prescribed medications continued

People without private health insurance were around twice as likely to have found cost a barrier to getting their medication than people with private health insurance (12% and 6% respectively).

This rate may be affected by people's age, as private health insurance coverage increases with age and older people were less likely than younger people to have found the cost of medication a barrier (due in part to concessions for PBS medication). People aged 65 years and over were less likely than people in any other age group to have delayed getting or not bought prescribed medication because of the cost (3%).

Men were less likely than women to have delayed getting or not got prescribed medication because of the cost (7% compared with 10%). More information can be found in Tables 2.1 to 2.3.

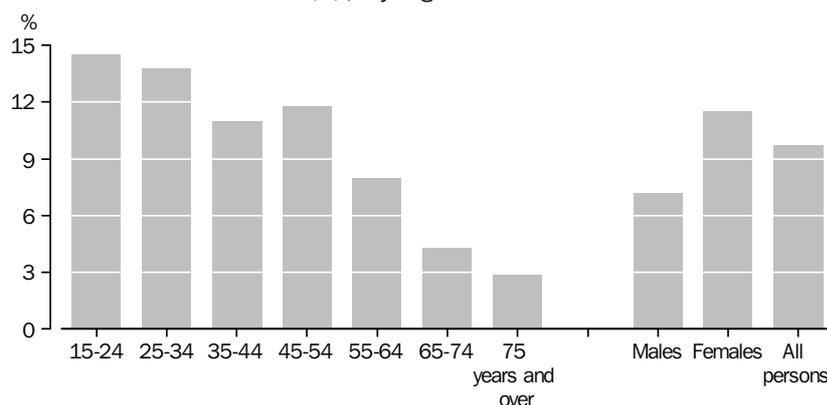
Barriers to specialists

Of people aged 15 years and over who were referred to a specialist by a GP, approximately 10% (545,500 people) delayed seeing or did not see the medical specialist in the last 12 months because of the cost.

More people without private health insurance delayed seeing or did not see a medical specialist because of the cost (12% compared with 8% of people with private health insurance), however neither income, relative disadvantage, nor employment status had a significant impact on rates of people finding cost a barrier to seeing a specialist (see Table 2.1).

As people got older they found cost less of a barrier to seeing a specialist than did people in younger age groups, particularly those people aged 65 years or more. As with GPs, more women than men delayed seeing or did not see a medical specialist due to the cost.

2.2 DELAYED SEEING OR DID NOT SEE SPECIALIST IN LAST 12 MONTHS DUE TO COST (a), by Age and Sex



(a) Persons 15 years and over

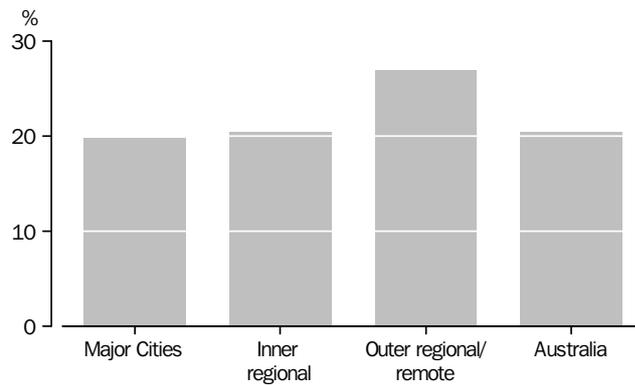
(See Table 2.1 for more detail)

Barriers to specialists
continued

One in five people who were referred to a medical specialist in the last 12 months (excluding people who had a proxy interview) felt they had waited longer than was acceptable to see the specialist (21% or 1,135,800 people). Across the States and Territories, the ACT had the highest rate of people who felt they had to wait too long to see a specialist (34%).

Figure 2.3 shows unacceptable waiting times were reported by more people in outer regional or remote areas of Australia than people in major cities (27% and 20% respectively).

2.3 UNACCEPTABLE WAITING TIMES FOR SPECIALIST APPOINTMENT (a), by Remoteness

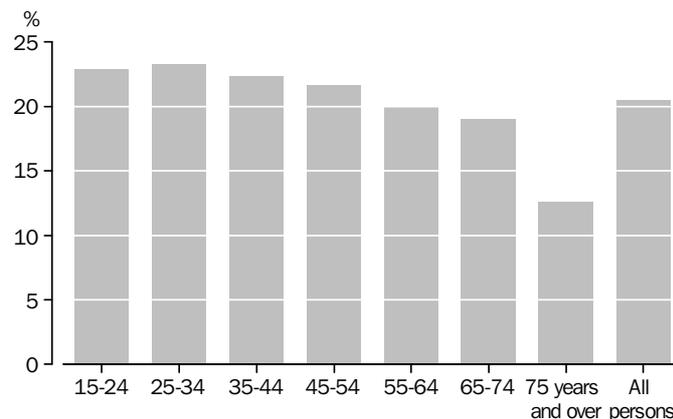


(a) Persons 15 years and over who had been referred to a medical specialist in the past 12 months

(See Table 2.4 for more detail)

People aged 75 years and over were less likely than any other age group to find waiting times for a specialist appointment unacceptable, as shown in Figure 2.4.

2.4 UNACCEPTABLE WAITING TIMES FOR SPECIALIST APPOINTMENT (a), by Age



(a) Persons aged 15 years and over who had been referred to a medical specialist in the past 12 months

(See Table 2.5 for more detail)

Cost barriers to pathology and imaging tests 281,400 people (2% of people aged 15 years or over) delayed having or did not have a pathology test in the past year because of the cost, and 329,000 people (2%) delayed having or did not have an imaging test in the past year because of the cost. Slightly more women than men found cost a barrier to pathology and imaging tests (see Tables 2.1 to 2.3 for more detail).

Barriers to access - general health services All survey respondents aged 15 years and over were asked whether there had been any time in the past year that they needed health care but could not get it. Across Australia, approximately 937,800 people (5%) reported there had been times they had been unable to access health services when they needed them. In 82% of cases, the health service unable to be accessed was a GP. Medical specialists (9%) and hospital care (4%) were the next highest types of service people reported being unable to access (see Table 2.4).

The main reasons reported for not being able to access health care when required were that waiting times were too long or there were no appointments available; or there was no service available in the area at the time it was needed (47% and 34% respectively) (see Table 2.5 for more detail).

GENERAL PRACTITIONERS
AND MEDICAL
SPECIALISTS

People who had seen a general practitioner in the past year were asked about the frequency of their visits, whether they had seen a GP for urgent medical care or after hours, whether they had received a prescription for medication, and whether they had been referred to a medical specialist at any time in the past 12 months.

People who had seen a GP for urgent medical care were asked how long they waited between making the appointment and seeing the GP; and people who had seen a GP after hours were asked where they had seen the GP.

People who had been referred to a medical specialist were asked about the frequency of their visits and whether they had actually seen the specialist they had most recently been referred to.

This chapter presents data on responses to these questions, by a range of characteristics. Aspects of communication with GPs and specialists, and barriers to accessing GPs and specialists are dealt with in Chapters 5 and 2 respectively.

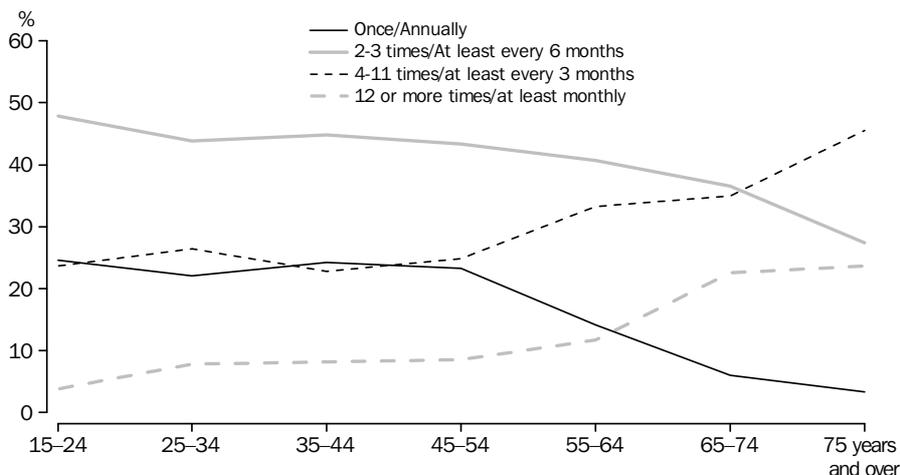
Frequency of visits to GP

Most people who had visited a general practitioner in the past year had seen their GP more than once in that time (81% or 11.4 million people). Until the age of 75, in fact, most people had visited a GP two to three times in the past year.

Around 70% of people aged 75 years and over had seen a GP four or more times in the year, with almost one in four people this age seeing a GP 12 or more times in the year (24%).

Less than nine percent of people aged under 55 had seen a GP 12 or more times in the year (see Figure 3.1).

3.1 FREQUENCY OF VISITS TO GP IN LAST 12 MONTHS (a), by Age



(a) Persons 15 years and over who had seen a GP

*Frequency of visits to GP
continued*

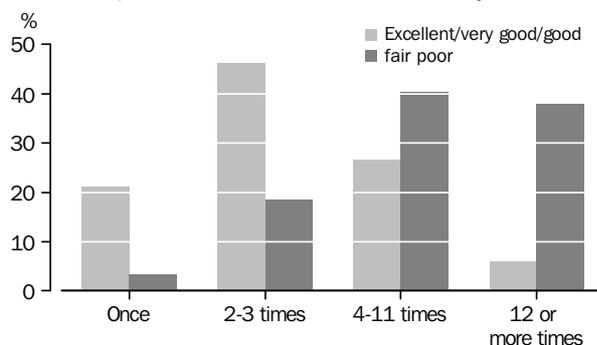
(See Table 3.2 for more detail)

Overall, one in ten people who had seen a GP in the past year made 12 or more visits in that time (11% or 1.5 million people). This was highest in areas of most disadvantage, for which the rate of seeing a GP more than 12 times a year (17%) was nearly three times that of people living in areas of least disadvantage (6%). Rates of seeing a GP less than 12 times a year, however, did not differ significantly between levels of disadvantage.

People from the Northern Territory had seen a GP less frequently than other Australians - for the most part, three times or less in a year (81% compared with the national average of 61%).

Throughout this publication, it can be seen that there is a clear relationship between people's self-assessed health and their use of health services. Figure 3.2 shows that people who rated their general health as fair or poor were more likely to see a GP more frequently than those who rated their health as good or better.

3.2 FREQUENCY OF GP VISITS (a), by Self-assessed health



(a) Persons 15 years or over who saw a GP in last 12 months, excluding a number of persons aged 15-17 who had a proxy interview

(See Table 3.1 for more detail)

Attended GP for urgent medical care

While 81% of Australians aged 15 years and over had seen a GP in the last 12 months, only 18% reported seeing a GP in this time for urgent medical care (around 2.5 million people).

Approximately 17% of men and 19% of women had seen a GP for urgent medical care in the 12 months prior to the survey. Males aged 45-54 years had the lowest rate of seeing a GP for urgent medical care, at 9% (see Table 3.2).

Across the states and territories, the proportion of people who had seen a GP for urgent medical care was lowest in NT, at 11% (see Table 3.3).

Time between making appointment and seeing a GP for urgent medical care

For the most part, people who had seen a GP for urgent medical care in the past year reported seeing the GP within four hours of making an appointment (60% or 1.5 million people). A further 15% had seen the GP after four hours but on the same day, and 13% had seen the GP the next day; but 12% (293,800 people) had not seen a GP until two or more days after making an appointment for urgent medical care.

People who rated their health as good or better were actually more likely to see a GP for urgent medical care more quickly than people who rated their health as fair or poor (62% seeing a GP within four hours, compared with 54% of people who rated their health as fair or poor).

People in WA were less likely to see a GP for urgent medical care within 4 hours than people in NSW, Victoria or Queensland, but differences between other states and other times were not statistically significant (see Explanatory Notes). People in major cities were more likely than people in regional and remote Australia to have seen a GP for urgent medical care within four hours.

After hours visits to a GP

Around a million people aged 15 years and over had seen a GP after hours in the 12 months prior to the survey (8% of people who had seen a GP). Slightly more women than men had seen a GP after hours (9% compared with 6%), but the general pattern of after hours visits for both sexes was that they declined with age (see Table 3.2).

More people living in major cities had seen a GP after hours than people living in regional and remote Australia (9% compared with 5% and 6%).

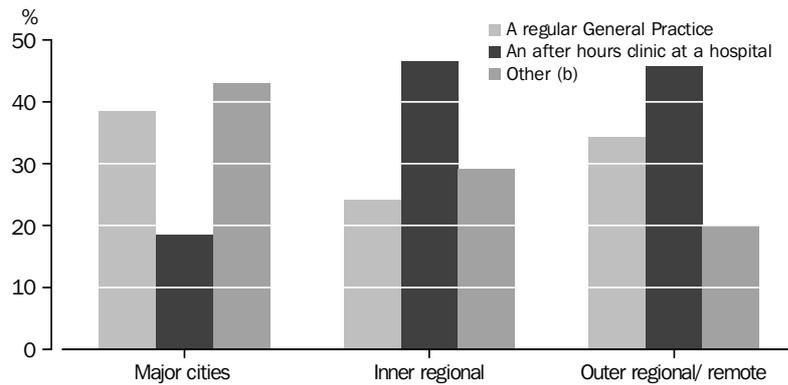
The rate of people who felt their health was fair or poor seeing a GP after hours was almost double that of people who thought their health was generally good, very good or excellent (10% compared with 7%).

South Australia had the highest rate of seeing a GP after hours (11%) and Tasmania had the lowest (6%). South Australians also had the highest rates of seeing a GP after hours for their children's health (see Chapter 7).

Around 1 in 3 people who reported seeing a GP after hours had seen them at a regular general practice (36%) and 24% had been to an after hours clinic at a hospital. Figure 3.3 shows that people from regional and remote areas of Australia who had seen a GP after hours were much more likely to do this at a hospital clinic than people in major cities (around 46% compared with 19%).

After hours visits to a GP
continued

3.3 TYPE OF AFTER HOURS GP CLINIC VISITED (a), by Remoteness



(a) Persons 15 years and over who visited a GP after hours in the last 12 months
(b) including late night clinic, home visit and other clinic or practice.

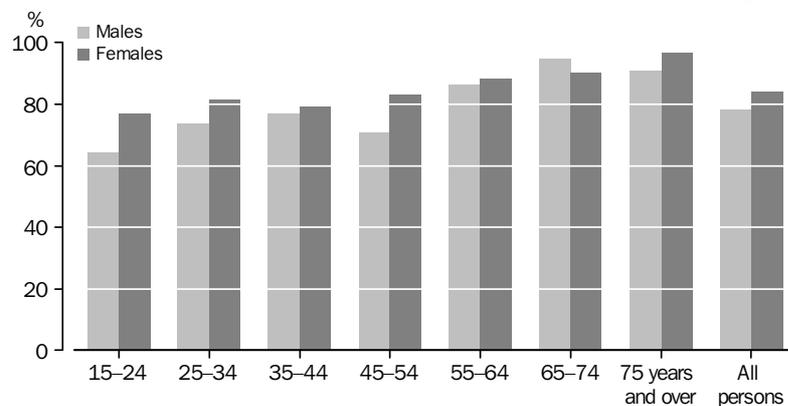
(See Table 3.1 for more detail)

Prescriptions for
medication

Of people aged 15 years and over who had visited a GP in the past 12 months, 81% (11.3 million people) had received a prescription for medication.

For the most part, women had received more prescriptions for medication than men. This was particularly noticeable in the 15-24 year age group (77% of women and 64% of men) and the 45-54 year age group (83% of women compared with 71% of men). The proportion of people who had been prescribed medication generally increased with age for both sexes, reaching 91% for men and 97% for women aged 75 years and over.

3.4 RECEIVED PRESCRIPTION FOR MEDICATION (a), by Age



(a) Persons 15 years and over who had visited a GP in last 12 months

(See Table 3.2 for more detail)

People who assessed their general health as fair or poor reported higher rates of receiving a prescription (94%, compared with 79% of people who rated their health as excellent, very good or good) (see Table 3.1).

Medical specialists

Of people aged 15 years and over who had been to a GP in the past year, around 5.6 million were referred to a medical specialist (40%). Rates of referral in the NT were the lowest in the country at 30% (keeping in mind that the survey did not collect data from very remote areas, which represents approximately 24% of the population of the NT).

Medical specialists
continued

Rates of referral to a medical specialist increased fairly steadily with age, from 23% of young men aged 15-24 to 56% of men aged 75 years and older; and from 33% of young women aged 15-24 to 49% of women aged 75 years and older.

People assessing their health as fair or poor were far more likely to have been referred to a specialist than people who rated their general health good or better (62% and 37% respectively) and were more likely to have seen a specialist 4 or more times.

Most people who had received a referral had visited a medical specialist more than once in the past year (59%). Around a quarter of people who had been referred had seen a specialist four or more times in the previous 12 months (25%).

Most people reported that they had actually seen the specialist they were most recently referred to (85%). This number was higher for people not born in Australia (88% compared with 83% of people born in Australia).

Rates of seeing a medical specialist were not significantly affected by levels of disadvantage or by remoteness (see Table 3.7).

HOSPITAL AND EMERGENCY

People who had been admitted to hospital in the past year were asked about the frequency of their hospital admissions, whether they had been treated as a public or private patient on their most recent admission, whether they had been given the choice to be treated a public or private patient on their most recent admission and whether they had been provided with enough information to make that choice.

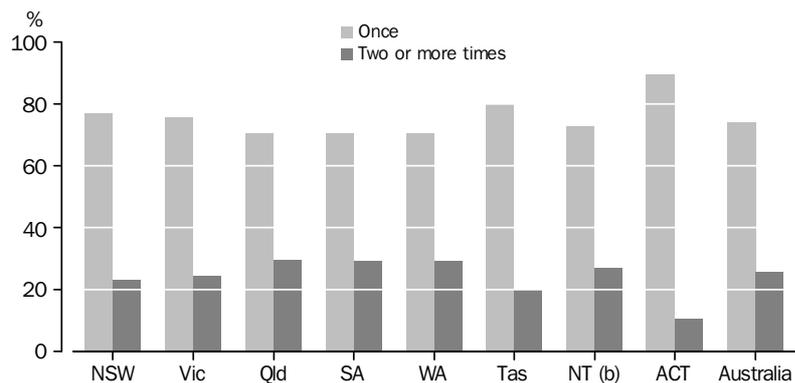
People who had visited a hospital emergency department in the past year were asked about the frequency of their visits, whether they thought the care they received on their most recent visit could have been provided by a GP, and the main reason they went to the hospital emergency department instead of a GP or thought the care could not have been provided by a GP.

Frequency of hospital admissions

Approximately 2.3 million Australians aged 15 years and over (13%) had been admitted to hospital in the past year. Almost three-quarters of those admitted to hospital had been admitted once only, while 586,500 people had been admitted more than once in that time (26%). Men were slightly more likely than women to have been admitted to hospital more than once (29% and 23% respectively).

Figure 4.1 shows frequency of hospital admissions by State or Territory:

4.1 NUMBER OF TIMES ADMITTED TO HOSPITAL IN THE LAST 12 MONTHS (a), by State/Territory



(a) Persons 15 years and over who had been admitted to hospital
 (b) excluding very remote

(See Table 4.3 for more detail)

Rates of being admitted to hospital multiple times in the past year were highest for people living in the areas of most disadvantage (29%). This rate decreased to 21% of those living in the areas of least disadvantage.

Frequency of hospital admissions continued

People who rated their general health as fair or poor were more likely than those who rated their health as good or better to have been admitted to hospital more than once (40% compared with 21%).

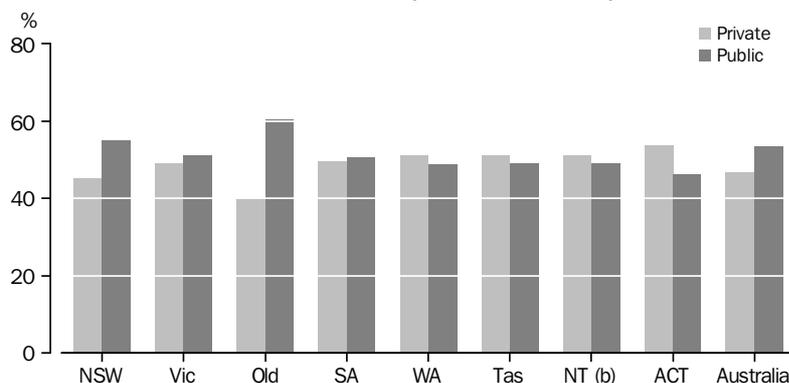
Frequency of hospital admissions was not significantly affected by age, remoteness or private health insurance status, however employed people were more likely to have been admitted to hospital only once compared with people who were unemployed or not in the labour force (see Tables 4.1 and 4.2 for more detail).

Treated as a public or private patient

In the 12 months before the survey, over a million people who were admitted to hospital had been treated as private patients on their most recent admission to hospital.

Queensland had the lowest rate of people being treated as private patients at just under 40%, while the ACT had the highest rate at around 54%. For most of the other states, the rate was around 50% (see Figure 4.2).

4.2 TREATED AS PUBLIC OR PRIVATE PATIENT ON MOST RECENT ADMISSION TO HOSPITAL (a), by State/Territory



(a) Persons 15 years and over who had been admitted to hospital in the last 12 months
 (b) excluding very remote

(See Table 4.3 for more detail)

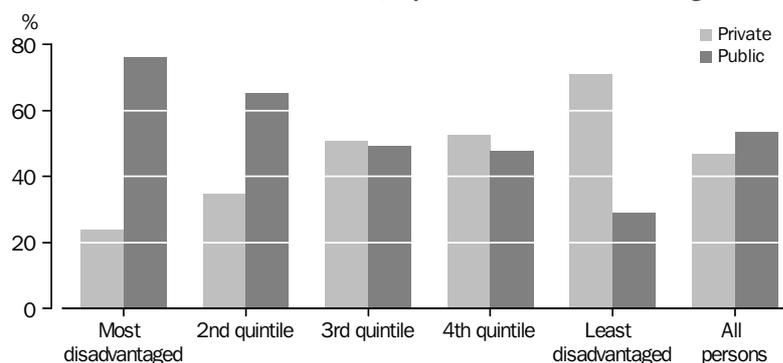
Almost half of the people living in major cities and inner regional Australia had been treated as private patients on their most recent admission to hospital, compared with around a third of people living in outer regional or remote areas of Australia.

Figure 4.3 below shows that the rate of people who had been treated as private patients on their most recent hospital admission was lowest for people living in the areas of most disadvantage. These people were in fact more than three times as likely to have been treated as public patients.

The rate of being treated as a private patient steadily increased for people living in less disadvantaged areas, with people living in the least disadvantaged areas more than twice as likely to have been treated as private rather than public patients.

Treated as a public or private patient continued

4.3 TREATED AS PUBLIC OR PRIVATE PATIENT ON MOST RECENT ADMISSION TO HOSPITAL (a), by Index of disadvantage (b)



(a) Persons 15 years and over who had been admitted to hospital in the last 12 months
(b) excluding a small number of persons for whom relative disadvantage was unable to be determined

(See Table 4.1 for more detail)

Younger people (aged between 15 to 34 years) were less likely to have been treated as private patients on their most recent admission to hospital than people aged 35 years and over.

Survey results showed a relationship with employment status and self-perception of health on whether or not people had been treated as private patients. Employed people were around one and a half times more likely than people who were unemployed or not in the labour force to have been treated as a private patient (57% compared to 38%).

Similarly, people who felt their health was excellent, very good or good were also one and a half times more likely than people who felt their health was fair or poor to have been treated as a private patient.

Not surprisingly, people with private health insurance were more likely to have been treated as private patients (76%) than people without private health insurance (8%) on their most recent admission to hospital. However, almost a quarter of people with private health insurance (24% or 298,800 people) chose not to be treated as a private patient on their most recent visit.

Given the choice to be treated as a public or private patient

Across Australia, two out of five people who were admitted to hospital had been given a choice to be treated as a public or private patient on their most recent hospital admission.

Geographical location and index of disadvantage did not have a significant impact on rates of being offered this choice, however rates were affected by private health insurance status, self-assessed health and age. For example:

- 46% of people with private health insurance that were admitted to hospital had been given the choice to be treated as a public or private patient on their most recent visit, compared with 30% of people without private health insurance (see Table 4.1);
- 42% of people admitted to hospital who rated their health as good or better had been given the choice, compared with 33% of people who rated their health as fair or poor (see Table 4.2); and

Given the choice to be treated as a public or private patient continued

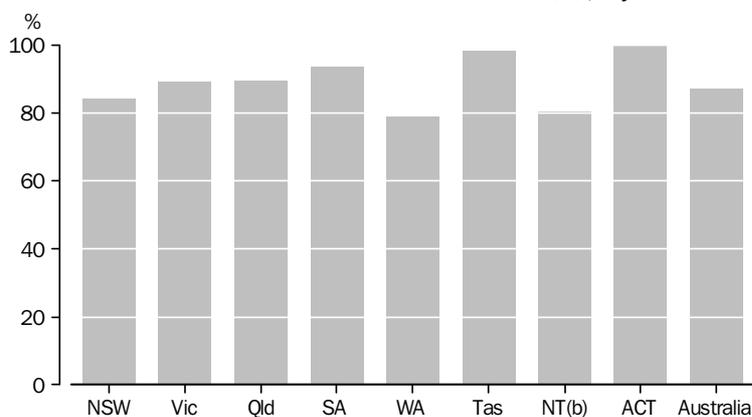
- people admitted to hospital aged between 35 to 44 years were more likely to have been given the choice to be treated as a public or private patient than people in other age groups (see Table 4.2).

Information to assist choice of being treated as public or private patient

Of the people who were given the choice to be treated as a public or private patient, approximately 87% (783,400 people) reported feeling they had been given enough information to choose. Men were more likely than women to report this (92% and 85% respectively).

Across the States and Territories, people living in WA (79%) were the least likely to report being given enough information to choose, while nearly all people living in the ACT (100%) and Tasmania (99%) felt they were given enough information, shown in Figure 4.4 below.

4.4 FELT WAS GIVEN ENOUGH INFORMATION TO CHOOSE TO BE TREATED AS PUBLIC OR PRIVATE PATIENT (a), by State/Territory



(a) Persons 15 years or over who were given the choice to be treated as a public or private patient on most recent admission to hospital
 (b) excluding very remote

(See Table 4.3 for more detail)

Less people in areas of least disadvantage reported receiving enough information to make a choice about being treated as a public or private patient than people in areas of more disadvantage (80% compared with, for example, 92% of people in the middle quintile of the index of disadvantage).

While people with private health insurance had been given the choice to be treated as a public or private patient more often than people without private health insurance, they were less likely to feel they had been given enough information to make the choice (84% and 93% respectively).

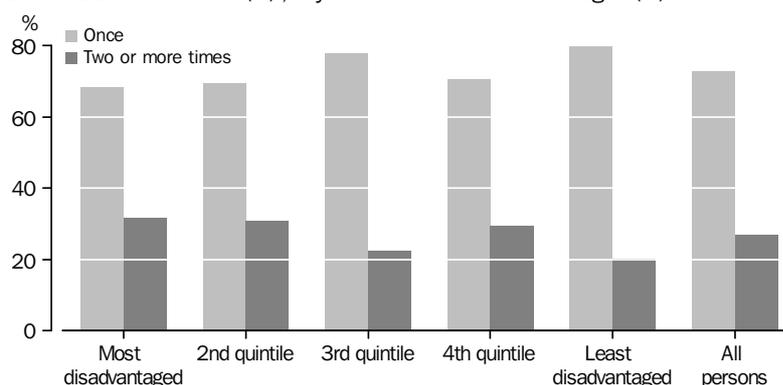
Employed people were less likely to feel that they had been given enough information to choose (83%) than people who were unemployed or not in the labour force (92%) (see Table 4.1 for more detail).

*Visits to a hospital
emergency department*

In 2009, approximately 2.3 million Australians aged 15 years and over visited a hospital emergency department. Around 73% of these people visited the emergency department only once in this time, however the remaining 27% (617,400 people) visited two or more times.

People from areas of most disadvantage were more likely to have visited a hospital emergency department more than once in the year than people from areas of least disadvantage (see Figure 4.5 below).

4.5 FREQUENCY OF VISITS TO HOSPITAL EMERGENCY DEPARTMENT IN LAST 12 MONTHS (a), by Index of disadvantage (b)



(a) Persons 15 years and over who had visited an emergency department in the last year
(b) excluding a small number of persons for whom relative disadvantage could not be determined

(See Table 4.4 for more detail)

People living in inner regional Australia (22%) were less likely to have visited a hospital emergency department two or more times in the year than people living in outer regional or remote parts of Australia (32%).

People who considered their health to be fair or poor were more likely to have visited an emergency department more often than people who rated their health as good or better (see Table 4.5). This was also the case for people who were unemployed or not in the labour force compared with those who were employed (see Table 4.4).

Age and sex did not appear to have a significant impact on the frequency of visits to a hospital emergency department.

*Hospital emergency
patients who thought care
could have been provided
by GP*

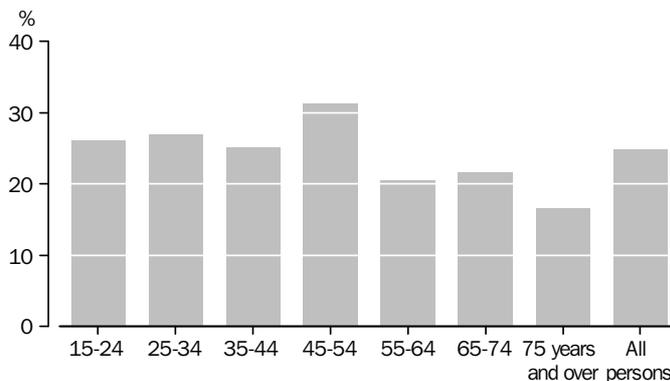
Around a quarter of the people who had visited a hospital emergency department in the past year (566,400 Australians aged 15 years and over) thought the care they had received on their most recent visit could have been provided by a general practitioner. This view was held equally by men (24%) and women (25%)

Employment status, self-assessed health and age had an effect on whether or not people thought the care they needed could have been provided by a GP. Employed people were more likely to feel that their care could have been provided by a GP than people who were unemployed or not in the labour force, and people who considered their health to be good or better were more likely to feel this than people who considered their health to be fair or poor (see Tables 4.4 and 4.5).

Hospital emergency patients who thought care could have been provided by GP continued

Figure 4.6 below shows almost a third of people aged 45 to 54 years thought the care they needed could have been provided by a GP compared with only one-sixth of people aged 75 years and over.

4.6 THOUGHT CARE COULD HAVE BEEN PROVIDED BY A GP ON MOST RECENT VISIT TO A HOSPITAL EMERGENCY DEPARTMENT (a), by Age



(a) Persons aged 15 years and over who had visited an emergency department in the last 12 months

(See Table 4.5 for more detail)

Main reason patients went to a hospital emergency department instead of a GP

All people who had visited a hospital emergency department in the past 12 months were asked whether they thought the care they received on their most recent visit could have been provided by a GP, and, depending on their answer, the main reason they thought the care could not have been provided by a GP, or the main reason they went to the emergency department instead of a GP.

Almost one in two people went to an emergency department on their most recent visit because they thought their condition was serious or life threatening (47%). Time of day or day of week was also a factor, with 23% of people providing this as their main reason.

The rate of people going to a hospital emergency department instead of a GP because they thought their condition was serious or life threatening was around one in two people in Queensland and NSW and around one in three people in Tasmania, the NT and the ACT.

Remoteness had an impact on people's reasons for going to a hospital emergency department instead a GP. Over 50% of people living in major cities went to an emergency department instead a GP because they thought their condition was serious or life threatening, compared with 37% of people living in outer regional or remote Australia.

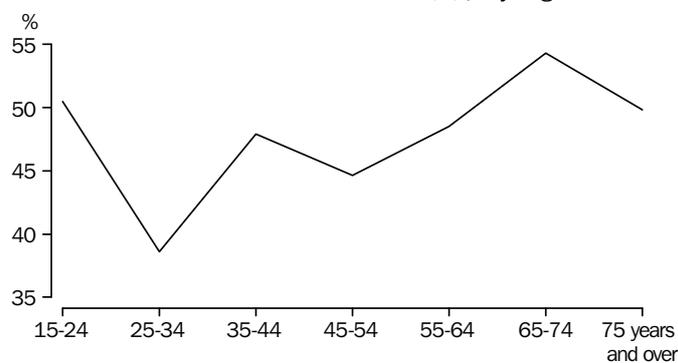
On the other hand, around 12% of people in outer regional or remote Australia went to an emergency department because the waiting time for a GP appointment was too long, compared with around 2% of people in major cities. People from inner regional Australia were more likely to go to a hospital emergency department instead a GP due to the time of day or day of week than people in other areas (see Table 4.5 for details).

Main reason patients went to a hospital emergency department instead of a GP continued

People who considered their health to be excellent, very good or good were less likely to go to an emergency department instead of a GP because their condition was serious or life threatening than people who considered their health to be fair or poor. They were, however, more likely to go due to the time of day or day of week than people who considered their health to be fair or poor.

People aged 65 to 74 years had the highest rate of going to a hospital emergency department instead of a GP because of a serious or life threatening condition (54%), and people aged 25 to 34 years had the lowest rate (39%). People either side of the 25 to 34 year age grouping had a rate closer to the national average (50% for people aged 15 to 24 years and 48% for people aged 35 to 44 years), shown here in Figure 4.7.

4.7 WENT TO EMERGENCY INSTEAD OF GP BECAUSE CONDITION WAS SERIOUS OR LIFE THREATENING (a), by Age



(a) Persons 15 years and over who visited an hospital emergency department in the last 12 months, Main reason for visiting emergency department on most recent occasion

(See Table 4.5 for more detail)

COMMUNICATION WITH HEALTH PROVIDERS

This chapter explores in more detail people's experiences with communication around prescriptions for medication, pathology and imaging tests, and seeing three or more health professionals for a single condition.

For the most part, rates of receiving and completely understanding explanations were high (around 85% or greater) and did not significantly differ between categories for each characteristic. For example, there was no particular difference for people with and without private health insurance, or from areas of greater or lesser disadvantage, or even with differing levels of education in rates of receiving and understanding information about the health service they were using.

Where people were seeing multiple health professionals for a single condition, rates of reporting issues caused by a lack of communication between these health professionals were also steady across categories for most characteristics, at around 10%.

Where people had asked a pharmacist for health-related advice, the greater proportion found that advice completely met their needs. This was similarly unaffected by the range of population characteristics noted above.

Prescriptions for medication

Approximately 11.3 million people aged 15 years and over had been prescribed medication in the 12 months prior to the survey (81% of people who had seen a GP in the past year). The GP had explained the reasons for prescribing this medication in 98% of cases, and the explanation had been understood either completely or at least to some extent by 99% of people (92% and 7% respectively) (see Figure 5.1, below).

Around 9.8 million people (87%) were shown how to take or administer the medication that had been prescribed, generally by a GP (86%) or other health professional (10%). Slightly more people in major cities were shown how to take or administer their medication than people in outer regional and remote areas of Australia (87% compared with 83%). See Table 5.1 for more detail of communication around prescriptions for medication.

Pathology tests

In the 12 months prior to the survey, approximately 8.4 million Australians aged 15 years and over had a pathology test following referral by a health professional (49%), excluding tests had in a hospital.

In most cases (98%) the referring health professional had explained the reasons for the most recent pathology test. These reasons were well understood, with 93% of people understanding them completely and a further 6% understanding them to some extent. This high level of understanding was reported by both men and women, and across all age groups.

Pathology tests continued

Nearly half the people surveyed had received the results of their most recent pathology test at a follow up appointment (46%). Others had either been contacted by someone (27%) or had contacted someone (21%) to obtain their results. It was rare for results to be given at the time of the test (1%). Follow up appointments were more common among those aged 55 years and over.

People living in major cities (49%) were more likely than people in inner regional areas (42%) or outer regional or remote areas (35%) to have had a follow up appointment. Women were more likely than men to have contacted someone to obtain their test results (23% compared with 17%).

At the time of the survey, 5% of respondents had not received the results of their most recent pathology test, in some instances because it was too soon to do so. Of the people who had received their results, 94% had received an explanation of the results, predominantly from the referring health professional (90%).

As with reasons for the test, pathology results were well understood, although slightly less so than the reasons were. Results were understood completely by 90% of people and understood to some extent by a further 10% (see Figure 5.1, below).

Satisfaction with arrangements for receiving results of the most recent pathology test was generally high, with 51% of people very satisfied and a further 39% satisfied. Only 6% of people said that they were either dissatisfied or very dissatisfied.

More people in major cities were very satisfied with arrangements for receiving their results than people in inner regional and outer regional/remote Australia (52% compared with 49% and 44% respectively). People aged 45 years and over were more likely to have been very satisfied with arrangements for receiving their results than younger people.

See Table 5.2 for more detail of communication around pathology tests.

Imaging tests

Around 5.4 million Australians aged 15 years and over had an imaging test in the past year (31%). Only slightly more than half of these people had been told how much the out-of-pocket expenses would be prior to the test (57% or 3 million people).

More women than men had been informed of the out-of-pocket expenses prior to their test (60% compared with 51%), and more people in major cities had been told of the out-of-pocket expenses beforehand than people in outer regional and remote areas of Australia (58% and 46% respectively).

Most people (5.1 million) had been referred for their most recent test by a health professional, and of these, 99% had received an explanation of the reasons for the test. Understanding of these reasons was high for both men and women across all age groups, with 95% of people overall understanding the reasons completely, and a further 5% understanding them to some extent.

At the time of the survey, the results of the most recent imaging test had been explained to 93% of people, generally by the referring health professional (89%). Just over 90% of the people who had received an explanation of their test results understood them completely, and a further 9% understood them to some extent (as shown in Figure 5.1, below).

Imaging tests continued

See Table 5.3 for more detail of communication around imaging tests.

Coordination of care

Approximately 4.2 million people aged 15 years or over (24%) saw three or more health professionals in the past year for a single condition. Of these people, 61% reported that a health professional had helped to coordinate their health care, predominantly GPs (54%) and medical specialists (31%). People reported that this coordination of care had helped to a large extent in 71% of cases, and to some extent in 27% of cases.

About 11% of people who had seen three or more health professionals in the past year for a single condition reported that there had been issues caused by a lack of communication between the health professionals. People aged 75 years and over reported the least instances of this (5%).

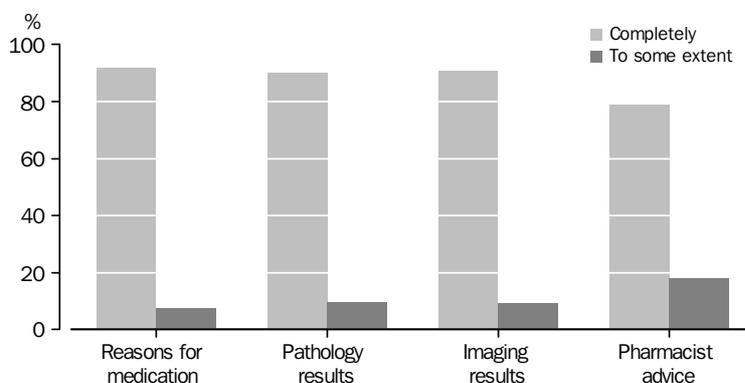
There were more issues caused by a lack of communication between health professionals for people who rated their health as fair or poor (14%) than people who rated their health as good or better (9%).

See Table 5.4 for more detail of communication around coordination of care.

Pharmaceutical advice

Around 3.9 million people aged 15 years and over (23%) had asked a pharmacist for health-related advice at some point in the past 12 months. Of these people, the great majority reported that the advice met their needs completely (79%) and a further 18% reported that it met their needs to some extent (see Figure 5.1).

5.1 EXPERIENCE OF COMMUNICATION WITH HEALTH PROVIDERS (a), Reasons/results understood or advice met needs



(a) Persons 15 years and over who had used selected health services or asked pharmacist for advice in the last 12 months

(Data for Figure 5.1 was drawn from Tables 5.1, 5.2, 5.3 and 5.5.)

See Tables 5.5 to 5.7 for more detail of seeking health-related advice from pharmacists.

HARM AND HARMFUL SIDE-EFFECTS

This chapter provides information about harm or harmful side-effects experienced by people in the past year. Respondents were asked whether they had experienced harm or harmful side-effects from any medication, medical care, treatment or test in that time, and if so:

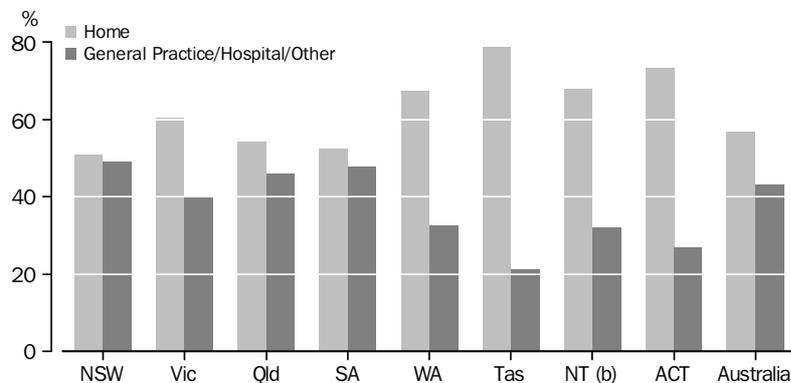
- where they had the medication, medical care, treatment or test that caused the harm or harmful side-effects;
- whether they received information beforehand of the possible risk of harm or harmful side-effects;
- whether they received an explanation of their most recent harm or harmful side-effect;
- how well they understood the explanation provided;
- whether they sought treatment from a health professional; and
- how satisfied they were with the way the situation was handled by the health professional for the most recent incident.

Experienced harm or harmful side-effect

Approximately 895,500 Australians aged 15 years and over (5%) reported that they had had medication, medical care, treatment or a test that had caused harm or a harmful side-effect at some time in the 12 months prior to the survey.

When people were asked where they had the medication, medical care, treatment or test the most recent time they had experienced harm or a harmful side-effect, the most common answer provided was at home (57%). This was consistent across all States and Territories, although rates were highest in Tasmania (79%) and lowest in NSW (51%) as can be seen in Figure 6.1.

6.1 WHERE HAD MEDICATION, MEDICAL CARE, TREATMENT OR TEST THAT CAUSED HARM OR HARMFUL SIDE-EFFECT (a), by State/Territory



(a) Persons 15 years and over who experienced harm or harmful side-effect in past 12 months
 (b) excluding very remote

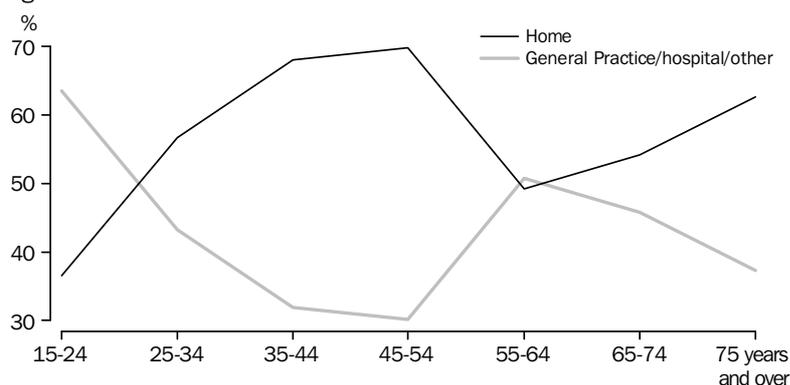
(See Table 6.2 for more detail)

Experienced harm or harmful side-effect continued

Around seven out of ten people aged 45 to 54 reported having the medication, medical care, treatment or test that caused harm or harmful side-effects at home. Men were slightly more likely than women to report this.

As shown in Figure 6.2, people aged 15 to 24 most commonly reported having the medication, medical care, treatment or test that caused harm or harmful side-effects in a GP clinic, hospital or other location, a pattern that was reversed for people aged 35 to 54.

6.2 WHERE HAD MEDICATION, MEDICAL CARE, TREATMENT OR TEST THAT CAUSED MOST RECENT HARM OR HARMFUL SIDE-EFFECT (a), by Age



(a) Persons 15 years and over who had experienced harm or harmful side-effect in past 12 months

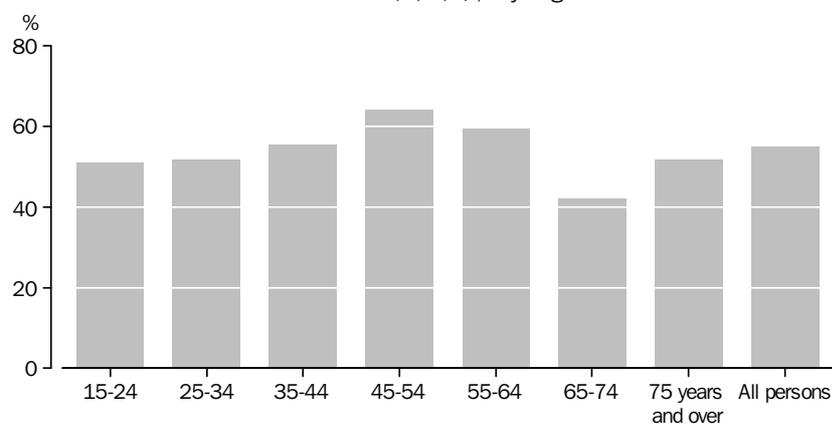
(See Table 6.1 for more detail)

Informed of risk

Across Australia, only 55% of people aged 15 years and over who experienced harm or harmful side-effects had been informed of the risk that the harm or side-effect might occur. Slightly more men (57%) than women (53%) had been informed of the risk.

Figure 6.3 shows that people aged 65 to 74 reported the lowest rate of being informed that the harm or harmful side-effects they experienced might occur (42%), while people aged 45 to 64 reported the highest rates (64% and 59% respectively).

6.3 RECEIVED INFORMATION THAT MOST RECENT HARM OR HARMFUL SIDE-EFFECT COULD HAPPEN (a) (b), by Age



(a) persons 15 years and over that had experienced harm or harmful side-effects in past 12 months
 (b) includes a very small number of persons who received written information but did not read it

*Informed of risk
continued*

(See Table 6.1 for more detail)

*Received explanation of
most recent harm or
harmful side-effect*

Of those who had experienced harm or harmful side-effects, approximately two-thirds had received an explanation about what happened in relation to their most recent incident (66% or 593,800 people). Across the States and Territories, people in Victoria were the least likely to have received an explanation (56%) while people in the NT were the most likely (79%).

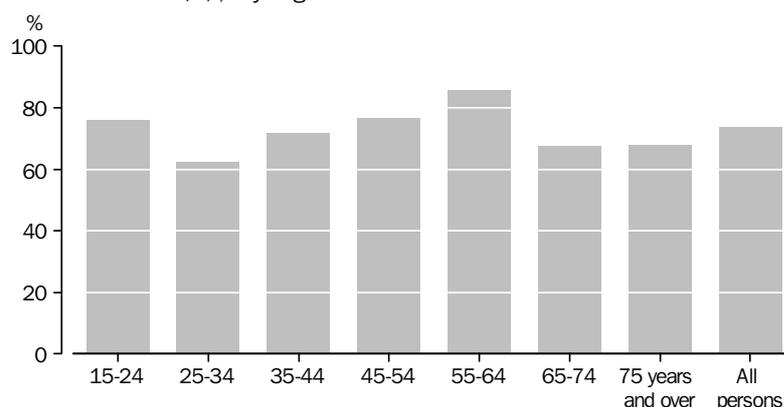
Most people who received an explanation of their most recent harm or harmful side-effect understood it completely (480,300 people or 81%).

*Visited a health
professional about harm
or harmful side-effect*

Nationally, around three-quarters of those that experienced harm or a harmful side-effect sought the attention of a health professional regarding their symptoms (74% or 658,600 people).

As shown in Figure 6.4, people aged 55 to 64 were the most likely to have seen a health professional after experiencing harm or harmful side-effects (86%), and people aged 25 to 34 were the least likely (62%).

6.4 SAW A HEALTH PROFESSIONAL ABOUT HARM OR HARMFUL SIDE-EFFECT (a), by Age



(a) persons 15 years and over who had experienced harm or harmful side-effect in last 12 months

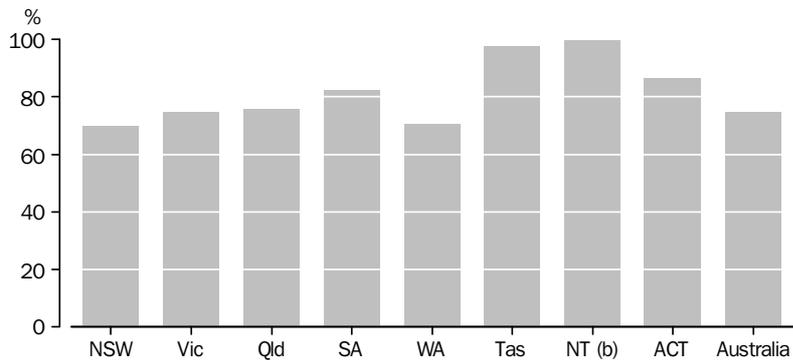
(See Table 6.1 for more detail)

*Satisfaction with the way
situation was handled for
most recent harm or
harmful side-effect*

Of the people who had seen a health professional for their most recent experience of harm or harmful side-effects, almost three-quarters (75%) were either very satisfied or satisfied with the way the situation was handled. The level of satisfaction varied markedly across the States and Territories, with 100% of people in the NT and almost that amount in Tasmania (98%) being satisfied, compared with NSW at 70% or WA at 71% (see Figure 6.5).

Satisfaction with the way situation was handled for most recent harm or harmful side-effect continued

6.5 SATISFIED WITH THE WAY SITUATION WAS HANDLED FOR MOST RECENT HARM OR HARMFUL SIDE-EFFECT (a), by State/Territory

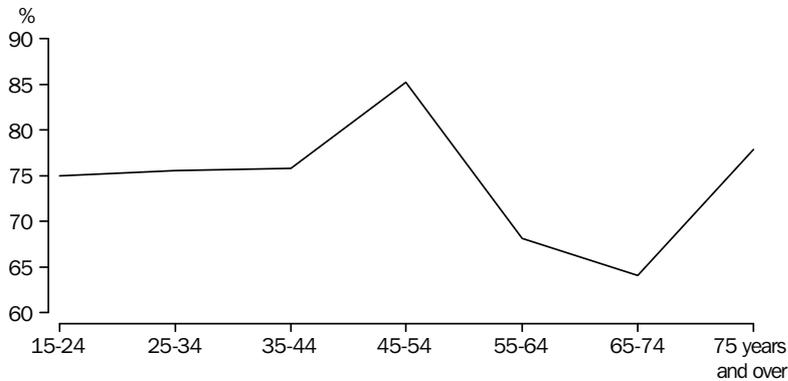


(a) Persons 15 years and over who had seen a health professional about their most recent harm or harmful side-effect
 (b) excluding very remote

(See Table 6.2 for more detail)

After the age of 35, levels of satisfaction with the way their situation had been dealt with by a health professional were quite varied, with people aged 45 to 54 being the most satisfied and people aged 65 to 74 being the least satisfied. Around three-quarters of people aged 15-34 were satisfied with the way their situation had been handled (see Figure 6.6).

6.6 SATISFIED WITH THE WAY SITUATION WAS HANDLED FOR MOST RECENT HARM OR HARMFUL SIDE-EFFECT (a), by Age



(a) Persons 15 years and over who had seen a health professional about their most recent harm or harmful side-effect

(See Table 6.1 for more detail)

Women (76%) were slightly more likely than men (73%) to have been either satisfied or very satisfied with the way the situation had been handled for their most recent experience of harm or a harmful side-effect.

EXPERIENCES OF HEALTH PROVISION FOR CHILDREN

Households with children aged 0 to 14 years were asked a number of questions concerning the use of selected health services in the past year for any of the children in the household. This data was collected by household, rather than person.

Hospital Emergency Department

Around a quarter of Australian households with children under 15 had at least one child that had visited a hospital emergency department in the 12 months prior to the survey (27% or 629,100 households). For the greatest proportion of these households, only one child had visited an emergency department in this time (87%).

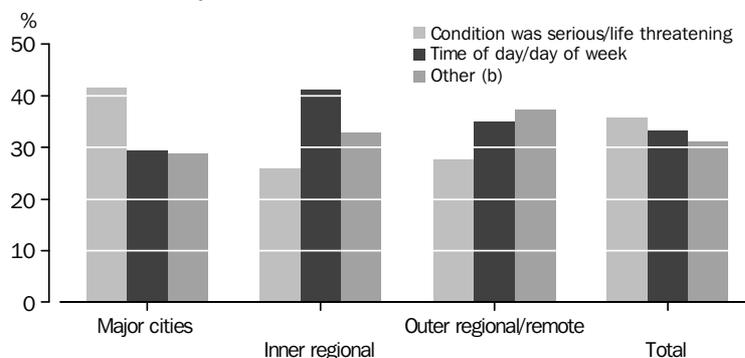
In households in areas of most disadvantage, 79% had one child visiting an emergency department in the 12 months prior to the survey and 21% had two or more children visiting. This was three times the rate of households in areas of least disadvantage, where the proportion that had two or more children visiting an emergency department in the last 12 months was 6%.

Tasmania had the lowest rate of hospital emergency visits for children (23% of households with children under 15) and WA, NT and Qld had the highest rates (around 32%).

When asked for the main reason the child was taken to an emergency department for the most recent visit, 36% of households responded that the child's condition was serious or life threatening and 33% of households said that it was due to the time of day or day of week.

As shown in Figure 7.1, a higher proportion of households in major cities reported taking their child to an emergency department because their child's condition was serious or life threatening than households in other areas of Australia.

7.1 MAIN REASON CHILD VISITED EMERGENCY DEPARTMENT RATHER THAN GP (a), by Remoteness



(a) Households with children under 15 where at least one child visited an emergency department in the last 12 months
 (b) Including sent by GP, cost, more confident in hospital than GP, emergency department recommended, GP not taking new patients, waiting time too long, no regular GP and unspecified reasons.

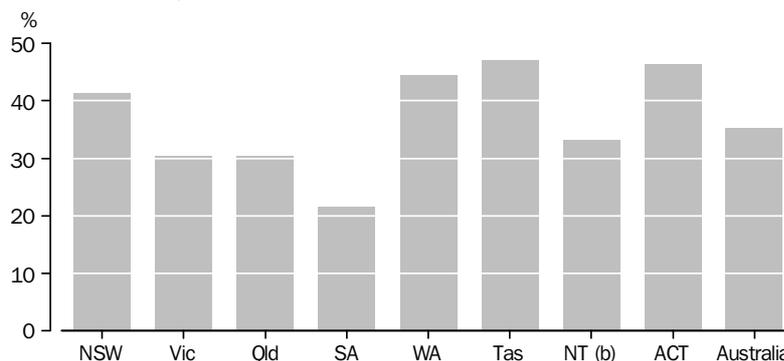
Hospital Emergency

Department continued

(See Table 7.1 for more detail)

Also in relation to the most recent time a child in the household had been to an emergency department, people were asked whether they thought, at the time, the care could have been provided at a general practice. In over a third of households asked, people thought that it could have been (35%). This belief was lowest in South Australia at 22%, around half the rate of households in Tasmania, ACT, WA and NSW which were all above 40% (see Figure 7.2 below).

7.2 THOUGHT CARE FOR CHILD COULD HAVE BEEN PROVIDED AT GENERAL PRACTICE FOR MOST RECENT VISIT TO EMERGENCY (a), by State/Territory



(a) Households with children under 15, where at least one child had visited an hospital emergency department in the last 12 months
 (b) excluding very remote

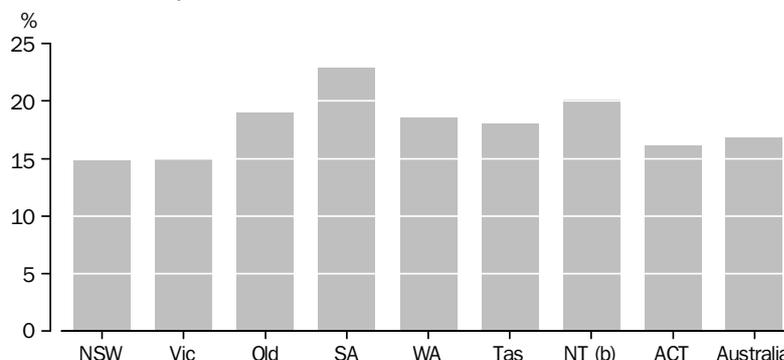
(See Table 7.2 for more detail)

*General Practitioner -
After hours*

In the 12 months before the survey, approximately one-sixth of Australian households with children aged under 15 needed to see a GP after hours for at least one child in the household (17% or 384,900 households). Of these households, 22% had two or more children that needed to see a GP after hours.

Figure 7.3 shows rates of seeing a GP after hours were highest in SA and lowest in NSW at 23% and 15% respectively.

7.3 CHILD SAW A GP AFTER HOURS IN LAST 12 MONTHS (a), by State/Territory



(a) Households with children under 15 where at least one child had seen a GP after hours in the last 12 months
 (b) excluding very remote

*General Practitioner -
After hours continued*

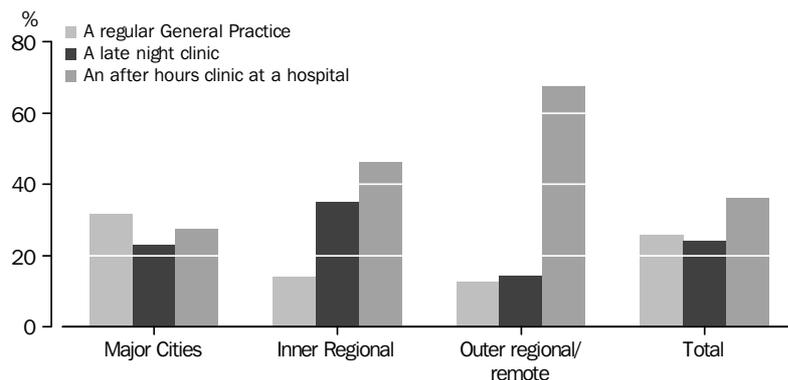
(See Table 7.2 for more detail)

Nationally, most visits were at an after hours clinic at a hospital (36%), followed by regular general practices (26%) and late night clinics (24%). This was particularly the case in WA, where more than half the visits were at an after hours clinic at a hospital, and less than ten percent were at a regular general practice. In Victoria, most after hours visits occurred at regular general practices.

More children in disadvantaged households had seen a GP in an after hours clinic at a hospital (46% and 54% of households in the two most disadvantaged quintiles, compared with 17% of households in the least disadvantaged quintile). Children from households in the least disadvantaged areas were most likely to have seen a GP at a regular general practice or a late night clinic.

Households in outer regional and remote areas of Australia were more likely to have used GP services for their children in after hours clinics at hospitals than other after hours services - 68% of visits compared with 28% reported for major cities, shown here in Figure 7.4.

7.4 TYPE OF SERVICE USED FOR AFTER HOURS GP VISITS (a), by Remoteness



(a) Households with children under 15 where at least one child in household saw a GP after hours in the last 12 months

(See Table 7.1 for more detail)

Nationally, about 1 in 20 households with children under 15 had at least one child who had not been able to see a GP after hours when they needed to in the last 12 months (5% or 108,900 households). The primary reason for this reported by households was that there had been no service available in the area at the time it was needed (64%). This was particularly the case in NSW, where 83% of households reported it as their main reason.

*General Practitioner -
Urgent medical care*

Across Australia, a quarter of all households with children under 15 had at least one child who had seen a GP for urgent medical care in the 12 months prior to the survey (25% or 579,900 households). Around 21% of these households had two or more children who had done so.

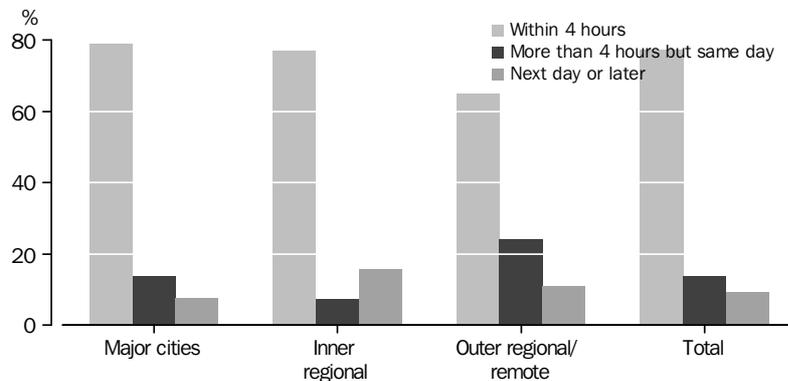
*General Practitioner -
Urgent medical care
continued*

Proportions of households with children who had seen a GP for urgent medical care did not differ significantly across States and Territories, nor were they greatly affected by degrees of relative disadvantage or remoteness.

Nationally, 77% of households reported that their children had seen a GP within 4 hours of making an appointment for urgent medical care, 14% reported that their children had seen a GP after 4 hours but on the same day, and 9% reported that their children had been unable to see a GP for urgent medical care until the day after making an appointment or later.

Waiting times for children seeing a GP for urgent medical care were longer for households in outer regional/remote areas, with 65% of households reporting that their children were seen within 4 hours, compared with 77% of households in inner regional areas and 79% of households in major cities (see Figure 7.5).

7.5 TIME BETWEEN MAKING APPOINTMENT FOR CHILD AND CHILD SEEING GP FOR URGENT MEDICAL CARE (a), by Remoteness



(a) Households with children under 15 where at least one child in household had seen a GP for urgent medical care in the last 12 months

(See Table 7.1 for more detail)

EXPLANATORY NOTES

INTRODUCTION

1 This publication presents results of the Patient Experience Survey, a topic on the 2009-10 Multipurpose Household Survey (MPHS).

2 The MPHS, conducted each year from July to June by the Australian Bureau of Statistics (ABS) as a supplement to the monthly Labour Force Survey (LFS), is designed to collect statistics for a number of small, self-contained topics. These include both labour topics and other social and economic topics. The topics collected in 2009–10 included:

- Education, personal and household income, and occupation and industry (core)
- Participation in sport and physical recreation
- Work related injuries
- Crime and safety
- Patient experience
- Family characteristics
- Attendance at selected cultural venues and events
- Sports attendance

3 Patient experience data was only collected between July and December 2009.

4 For all topics, information on labour force characteristics, education, income and other demographics are also available.

5 The Patient Experience Survey collected information from individuals about their experiences with selected aspects of the health system in the 12 months before interview. It is the first survey of this type and is expected to run annually from now on.

6 Data for other MPHS topics collected in 2009-10 will be released in separate publications.

7 The publication Labour Force, Australia (cat. no. 6202.0) contains information about survey and sample design, scope, coverage and population benchmarks relevant to the monthly LFS, and consequently the MPHS. This publication also contains definitions of demographic and labour force characteristics, and information about telephone interviewing.

Data collection

8 ABS interviewers conducted personal interviews during the 2009-10 financial year for the monthly LFS. Each month, one eighth of the dwellings in the LFS sample was rotated out of the sample and a sub-sample of these dwellings was selected for the MPHS.

9 In these dwellings, after the LFS has been fully completed for each person in scope and coverage, a person (usual resident) aged 15 or over was selected at random and asked the additional MPHS questions in a personal interview. If the randomly selected person was aged 15 to 17 years, permission was sought from a parent or guardian before conducting the interview. If permission was not given, the parent or guardian was asked the questions on behalf of the 15 to 17 year old (proxy interview).

10 Data was collected using Computer Assisted Interviewing (CAI), whereby responses are recorded directly onto an electronic questionnaire in a notebook computer, usually during a telephone interview.

- Data collection continued*
- 11** The number of fully responding households for the Patient Experience Survey was 7,124. One person aged 15 years or over from each household was asked questions in relation to their own health. A subset of questions on children's use of health services was also asked where the household included children aged 0-14. Proxy interviews for 154 people aged 15 to 17 were provided.
- Scope*
- 12** The scope of the Patient Experience Survey was restricted to people aged 15 years and over and households with children aged 0 to 14. It excluded the following people:
- members of the Australian permanent defence forces
 - diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
 - overseas residents in Australia
 - members of non-Australian defence forces (and their dependents).
- 13** The Patient Experience Survey also excluded people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons.
- 14** The survey was conducted in both urban and rural areas in all states and territories, but excluded people living in very remote parts of Australia. This is expected to have only a minor impact on any aggregate estimates that are produced for individual states and territories, with the exception of the Northern Territory where people living in very remote areas account for around 24% of the population.
- Coverage*
- 15** Coverage rules are applied to ensure that each person is associated with only one dwelling and hence has only one chance of selection in the survey. See Labour Force, Australia (cat. no. 6202.0) for more details.
- Estimation methods*
- 16** Weighting is the process of adjusting results from a sample survey to infer results for the total in scope population. To do this, a 'weight' is allocated to each sample unit, which, for the Patient Experience survey, can either be a person or a household. The weight is a value which indicates how many population units are represented by the sample unit.
- 17** The first step in calculating weights for each unit is to assign an initial weight, which is the inverse of the probability of being selected in the survey. The initial weights are then calibrated to align with independent estimates of the population of interest to ensure that the survey estimates conform to the independently estimated distribution of the population rather than the distribution within the sample itself.
- 18** The estimation process for this survey ensures that estimates of persons calibrate exactly to independently produced population totals at broad levels. The known population totals, commonly referred to as 'benchmarks', are produced according to the scope of the survey. The same is true for estimates of households produced in this survey, however, in these cases the household benchmarks are actually estimates themselves and not strictly known population totals.
- 19** Survey estimates are benchmarked to persons within the scope of the survey - for example, to the estimated civilian population aged 15 years and over living in private dwellings in each State and Territory excluding persons out of scope. Survey estimates of counts of persons or households are obtained by summing the weights of persons or households with the characteristics of interest.
- Reliability of the estimates*
- 20** Estimates in this publication are subject to sampling and non-sampling errors.
- 21** Sampling error is the difference between the published estimate and the value that would have been produced if all dwellings had been included in the survey. For more information see the Technical Note.

*Reliability of the estimates
continued*

22 Non-sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, and errors made in coding and processing data. These inaccuracies may occur in any enumeration, whether it be a full count or a sample. Every effort is made to reduce the non-sampling error to a minimum by careful design of questionnaires, intensive training and supervision of interviewers, and effective processing procedures.

23 An observed effect so large that it would rarely occur by chance is called statistically significant. To determine whether there was evidence of a 'true' difference between corresponding population characteristics, a statistical significance test was done on all comparisons of estimates. For more information see the Technical Note.

Classifications

24 Country of birth data are classified according to the Standard Australian Classification of Countries (SACC), 1998 (cat. no. 1269.0).

25 Remoteness areas are classified according to the Statistical Geography: Volume 1 - Australian Standard Geographical Classification (ASGC), 2006 (cat. no. 1216.0).

26 Education data are classified according to the Australian Standard Classification of Education (ASCED) (cat. no. 1272.0).

*Socio-economic Indexes for
Areas (SEIFA)*

27 Socio-economic Indexes for Areas (SEIFA) is a suite of four summary measures that have been created from 2006 Census information. Each index summarises a different aspect of the socio-economic conditions of people living in an area. The indexes provide more general measures of socio-economic status than is given by measuring income or unemployment alone, for example.

28 For each index, every geographic area in Australia is given a SEIFA number which shows how disadvantaged that area is compared with other areas in Australia.

29 The index used in the Patient Experience publication is the Index of Relative Socio-economic Disadvantage, derived from Census variables related to disadvantage such as low income, low educational attainment, unemployment, and dwellings without motor vehicles.

30 SEIFA uses a broad definition of relative socio-economic disadvantage in terms of people's access to material and social resources, and their ability to participate in society. While SEIFA represents an average of all people living in an area, it does not represent the individual situation of each person. Larger areas are more likely to have greater diversity of people and households.

31 For more detail, see the following papers:

- Information Paper: An Introduction to Socio-Economic Indexes for Areas (SEIFA), 2006 (cat. no. 2039.0)
- Socio-Economic Indexes for Areas (SEIFA) -Technical Paper, 2006 (cat. no. 2039.0.55.001).

Data quality

INTERPRETATION OF RESULTS

32 Information recorded in this survey is essentially 'as reported' by respondents, and may differ from that which might be obtained from other sources or via other methodologies. This factor should be considered when interpreting the estimates in this publication.

33 Information was collected on respondents' perception of their health status. Perceptions are influenced by a number of factors and can change quickly. Care should therefore be taken when analysing or interpreting the data.

Data quality continued

34 The definition of urgent medical care was left up to respondents, however, discretionary interviewer advice suggested that visiting a GP to get a medical certificate for work would probably not be considered urgent medical care. Care should be taken when analysing or interpreting this data.

35 Where questions called for personal opinions, such as self-assessed health or whether felt waiting times were inappropriate, responses from proxy interviews were not collected.

DATA COMPARABILITY

36 The ABS produces statistics regarding the private hospital sector (cat. no. 4390.0) and these can yield different results regarding the use of private hospitals by patients in Australia because of conceptual differences with the data collection. Caution should be taken in comparisons across ABS surveys and administrative by-product data that address the access and use of health services.

Products and services

DATA CUBES

37 Data cubes of all tables in Excel spreadsheet format can be found on the ABS website (from the download tab of cat. no. 4839.0.55.001), and have also been attached as links throughout the publication. The spreadsheets present tables of estimates and proportions, with shadow tables of the corresponding relative standard errors (RSEs).

CONFIDENTIALISED UNIT RECORD FILE (CURF)

38 Some data from the MPHS will be released as a Confidentialised Unit Record File (CURF) in 2011, (cat. no. 4100.0), subject to the approval of the Australian Statistician. This CURF will be accessible through the Remote Access Data Laboratory (RADL), in SAS, STATA and SPSS format. A full range of up-to-date information about the availability of ABS CURFs and about applying for access to CURFs is available via the ABS website (see Services - CURF Microdata). For inquiries regarding CURFs, contact the ABS CURF Management Unit via email at microdata.access@abs.gov.au, or telephone (02) 6252 7714.

CUSTOMISED DATA REQUESTS

39 Special tabulations of the data are available on request. Subject to confidentiality and sampling variability constraints, tabulations can be produced from the survey incorporating data items, populations and geographic areas tailored to individual requirements. These are provided in electronic form. Further information about the survey and associated products can be obtained from the contact officer listed at the front of this publication.

Next survey

40 The Patient Experience Survey is expected to be conducted annually from 2009-10.

Related publications

41 ABS publications which may also be of interest include:

- National Health Survey: Summary of Results, Australia (cat. no. 4364.0)
- National Health Survey: Summary of Results, State Tables (cat. no. 4362.0)
- Private Hospitals, Australia (cat. no. 4390.0)
- Private Health Insurance: A Snapshot (cat. no. 4815.0.55.001)
- Household Expenditure on Health: A Snapshot (cat. no. 4836.0.55.001)
- Self-assessed Health in Australia: A Snapshot (cat. no. 4828.0.55.001)
- Changes in Health: A Snapshot (cat. no. 4834.0.55.001)

TECHNICAL NOTE

RELIABILITY OF ESTIMATES

Sample Survey Errors

- 1** Two types of error are possible in estimates based on a sample survey; sampling error and non-sampling error.
- 2** Sampling error occurs because only a small proportion of the total population is used to produce estimates that represent the whole population. Sampling error can be reliably measured, as it is calculated based on the scientific methods used to design surveys.
- 3** Non-sampling error may occur in any data collection, whether it is based on a sample or a full-count (i.e. Census). Non-sampling error may occur at any stage throughout the survey process. Examples include:
 - non-response by selected persons;
 - questions being misunderstood;
 - responses being incorrectly recorded; and
 - errors in coding or processing the survey data.

4 Since the estimates in this publication are based on information obtained from occupants of a sample of dwellings, they are subject to sampling variability. That is, they may differ from those estimates that would have been produced if all occupants of all dwellings had been included in the survey. One measure of the likely difference is given by the standard error (SE), which indicates the extent to which an estimate might have varied by chance due to only a sample of dwellings being included. There are about two chances in three (67%) that a sample estimate will differ by less than one SE from the number that would have been obtained if all dwellings had been included, and about 19 chances in 20 (95%) that the difference will be less than two SEs.

Relative Standard Error

5 Another measure of the likely difference is the relative standard error (RSE), which is obtained by expressing the SE as a percentage of the estimate.

$$RSE\% = \left(\frac{SE}{estimate} \right) \times 100$$

- 6** RSEs for patient experience estimates (numbers or percentages) have been calculated using the Jackknife method of variance estimation.
- 7** RSEs were calculated for each separate estimate and are available to download free of charge as data cubes (Excel spreadsheets) from the ABS website <www.abs.gov.au> as an attachment to this publication.
- 8** In the tables in this publication, only estimates with RSEs less than 25% are considered sufficiently reliable for most purposes. However, estimates with larger RSEs have been included and are preceded by an asterisk (e.g. *2.2) to indicate they are subject to high SEs relative to their estimate and should be used with caution. Estimates with RSEs greater than 50% are preceded by a double asterisk (e.g. **1.5) to indicate that they are considered too unreliable for general use.

Replicate Weights Technique

9 A class of techniques called 'replication methods' provide a general method of estimating variances for the types of complex sample designs and weighting procedures employed in ABS household surveys.

*Replicate Weights Technique
continued*

10 The basic idea behind the replication approach is to select sub-samples repeatedly from the whole sample, for each of which the statistic of interest is calculated. The variance of the full sample statistic is then estimated using the variability among the replicate statistics calculated from these sub-samples. The sub-samples are called 'replicate groups', and the statistics calculated from these replicates are called 'replicate estimates'.

11 There are various ways of creating replicate sub-samples from the full sample. The replicate weights produced for the survey were created under the delete-a-group Jackknife method of replication. There are numerous advantages to using the replicate weighting approach, including the fact that:

- the same procedure is applicable to most statistics such as means, percentages, ratios, correlations, derived statistics and regression coefficients; and
- it is not necessary for the analyst to have detailed survey design information available if the replicate weights are included with the data file.

Derivation of replicate weights

12 Under the delete-a-group Jackknife method of replicate weighting, weights were derived as follows:

- 30 replicate groups were formed for both household and person weights, with each group formed to mirror the overall sample. Units from a cluster of dwellings all belong to the same replicate group, and a unit can belong to only one replicate group.
- For each replicate weight, one replicate group was omitted from the weighting and the remaining records were weighted in the same manner as for the full sample.
- The records in the group that was omitted received a weight of zero.
- This process was repeated for each replicate group (i.e. a total of 30 times).
- Ultimately each record had 30 replicate weights attached to it with one of these being the zero weight.

Application of replicate weights

13 As noted above, replicate weights enable variances of estimates to be calculated relatively simply. They also enable unit record analyses such as chi-square and logistic regression to be conducted, which take into account the sample design.

14 Replicate weights for any variable of interest can be calculated from the 30 replicate groups, giving 30 replicate estimates. The distribution of this set of replicate estimates, in conjunction with the full sample estimate, is then used to approximate the variance of the full sample.

15 This method can also be used when modelling relationships from unit record data, regardless of the modelling technique used. In modelling, the full sample would be used to estimate the parameter being studied (such as a regression coefficient); i.e. the 30 replicate groups would be used to provide 30 replicate estimates of the survey parameter. The variance of the estimate of the parameter from the full sample is then approximated, as above, by the variability of the replicate estimates.

CALCULATION OF STANDARD ERROR

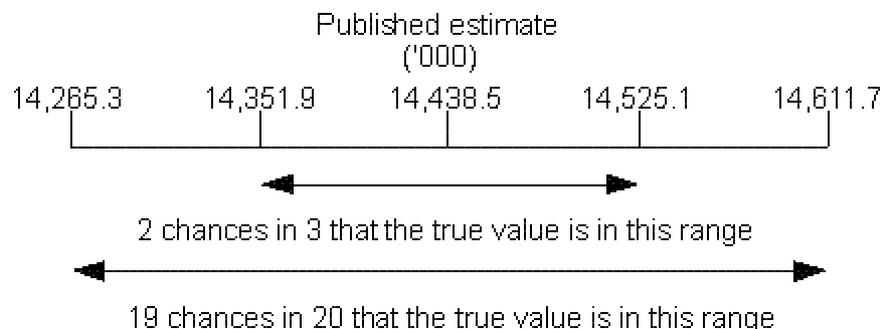
Standard error of an estimate

16 Standard errors can be calculated using the estimate and the corresponding RSEs. For example, Table T1 at the end of this Technical Note shows the estimated number of persons aged 15 years and over who rated their health as excellent, very good or good in the last 12 months is 14,438,500. The RSE table corresponding to the estimate in Table T2 (also below) shows the RSE for this estimate is 0.6%. The SE is calculated by:

$$\begin{aligned}
 &\text{SE of estimate} \\
 &= \left(\frac{\text{RSE}}{100} \right) \times \text{estimate} \\
 &= 0.006 \times 14,438,500 \\
 &= 86,600 \text{ (rounded to nearest 100)}
 \end{aligned}$$

Standard error of an estimate
continued

17 Therefore, there are about two chances in three that the value that would have been produced if all dwellings had been included in the survey will fall within the range 14,351,900 to 14,525,100 and about 19 chances in 20 that the value will fall within the range 14,265,300 to 14,611,700. This example is illustrated in the diagram below:



RSES OF COMPARATIVE
ESTIMATES

Proportions

18 Proportions formed from the ratio of two estimates are also subject to sampling error. The size of the error depends on the accuracy of both the numerator and the denominator. A formula to approximate the RSE of a proportion is given below. This formula is only valid when x is a subset of y.

$$RSE\left(\frac{x}{y}\right) = \sqrt{[RSE(x)]^2 - [RSE(y)]^2}$$

19 As an example, using estimates from Table T1, 11,357,800 persons aged 15 years and over who rated their health as excellent, very good or good saw a general practitioner in the last 12 months, representing 78.7% of the 14,438,500 persons aged 15 years and over who rated their health as excellent, very good or good. As can be seen in Table T2, the RSE of the estimated number of persons aged 15 years and over who rated their health as excellent, very good or good and saw a general practitioner in the last 12 months is 1.2%, and the RSE of the estimated number of persons aged 15 years and over who rated their health as excellent, very good or good is 0.6%. Applying the above formula, the RSE of the proportion is:

$$RSE\left(\frac{x}{y}\right) = \sqrt{1.2^2 - 0.6^2} = 1.0\%$$

20 Therefore, the SE for persons aged 15 years and over who rated their health as excellent, very good or good and saw a general practitioner in the last 12 months as a proportion of persons aged 15 years and over who rated their health as excellent, very good or good is 0.8 percentage points (=78.7×(1.0/100)). Therefore, there are about two chances in three that the proportion is between 77.9% and 79.5% and 19 chances in 20 that the proportion is within the range 77.1% to 80.3%.

21 The exact RSEs of various proportions for patient experience can be found in the data cubes in the download tab of this publication.

Sum of Differences between
estimates

22 Published estimates may also be used to calculate the sum of or difference between two survey estimates. Such estimates are also subject to sampling error. The sampling error of the difference between two estimates depends on their SEs and the correlation between them. An approximate SE of the difference between two estimates (x-y) may be calculated by the following formula:

$$SE(x - y) = \sqrt{[SE(x)]^2 + [SE(y)]^2}$$

23 The sampling error of the sum of two estimates is calculated in a similar way. An approximate SE of the sum of two estimates (x+y) may be calculated by the following formula:

Sum of Differences between estimates continued

$$SE(x+y) = \sqrt{[SE(x)]^2 + [SE(y)]^2}$$

24 As an example, from paragraph 16, the estimated number of persons aged 15 years and over who rated their health as excellent, very good or good in the last 12 months is 14,438,500 and the SE is 86,600. Performing the appropriate calculations, the estimated number of persons aged 15 years and over who rated their health as fair or poor is 2,308,600 and the SE is 73,900 (rounded to nearest 100). The estimated number of persons aged 15 years and over who provided a self-assessed health status rating is: $14,438,500 + 2,308,600 = 16,747,100$

25 The SE of the estimated number of persons aged 15 years and over who provided a self-assessed health status rating is:

$$SE = \sqrt{(86,600)^2 + (73,900)^2} = 113,800 \text{ (rounded to nearest 100)}$$

26 Therefore, there are about two chances in three that the value that would have been produced if all dwellings had been included in the survey will fall within the range 16,633,300 to 16,860,900 and about 19 chances in 20 that the value will fall within the range 16,519,500 to 16,974,700.

27 While these formulae will only be exact for differences between separate and uncorrelated characteristics or subpopulations, it is expected to provide a good approximation for all differences likely to be of interest in this publication.

STATISTICAL SIGNIFICANCE TESTING

28 To determine whether, with a certain level of confidence, there was evidence of a true difference between corresponding population characteristics, a statistical significance test for comparisons between estimates was performed. The standard error of the difference between two corresponding estimates (x and y) can be calculated using the formula in paragraph 22. This standard error is then used to calculate the following test statistic:

$$\left(\frac{x-y}{SE(x-y)} \right)$$

29 If the value of the test statistic is greater than 1.96, there is statistical evidence (with 95% confidence) of a difference in the two populations with respect to that characteristic. Otherwise, it cannot be stated with confidence that there is a real difference between the populations.

SELECTED ESTIMATES AND RSES

SELECTED ESTIMATES AND
RSES *continued*

TABLE T1 ESTIMATES

ESTIMATE ('000)	Self-assessed health status	
	Excellent/very good/good	Fair/poor
Consultations		
Saw a general practitioner	11357.8	2188.2
Saw 3 or more health professionals for a single condition	2989.6	1151.3
Hospital		
Been admitted to hospital	1614.4	622.0
Visited hospital emergency department	1575.7	593.0
Other Services		
Had a pathology test (c)	6628.0	1670.7
Had an imaging test (d)	4136.2	1168.8
Asked pharmacist for advice	3198.3	668.5
Total persons ('000)	14438.5	2308.6

Source: ABS Patient Experience Survey 2009

TABLE T2 RSES OF ESTIMATES

RSE of ESTIMATE (%)	Self-assessed health status	
	Excellent/very good/good	Fair/poor
Consultations		
Saw a general practitioner	1.2	3.1
Saw 3 or more health professionals for a single condition	2.1	4.2
Hospital		
Been admitted to hospital	3.5	6.9
Visited hospital emergency department	3.8	6.9
Other Services		
Had a pathology test (c)	1.6	4.3
Had an imaging test (d)	2.4	4.4
Asked pharmacist for advice	3.6	5.6
Total persons (%)	0.6	3.2

Source: ABS Patient Experience Survey 2009

GLOSSARY

After hours	After hours care is care that is received after the standard business hours of the health service on a public holiday; or a Sunday; or before 8am or after 1pm on a Saturday; or before 8am or after 8pm on any other day.
Coordination of care	<p>In this survey, coordination of care refers to help with the following, provided by one or more health professionals treating a person for a single condition:</p> <ul style="list-style-type: none">■ booking or coordinating appointment times;■ finding relevant specialists or other health professionals;■ scheduling diagnostic tests; and/or■ collating medical history information.
Harm or harmful side-effect.	<p>The terms 'harm' and 'harmful' were left to the respondent's interpretation. Discretionary interviewer advice was to include:</p> <ul style="list-style-type: none">■ any harm or side-effect the respondent perceived as harmful caused by any kind of medical treatment.■ harmful side-effects cause by prescribed medications (including problems with dosage, timing or incorrect medication).■ harmful side-effects from diagnostic tests (such as x-rays, blood tests, endoscopy).■ harmful side-effects from anaesthesia in hospital.■ harm caused by error or incompetence during surgery or other medical procedure.■ harm caused by rough physical treatment by medical staff. <p>and to exclude any side-effect the respondent did not personally consider harmful.</p>
Health professional	<p>A health professional is a person who helps in identifying or preventing or treating illness or disability. Health professionals may include, but are not limited to:</p> <ul style="list-style-type: none">■ general practitioners;■ medical specialists;■ physiotherapists;■ dieticians;■ nurses;■ pharmacists;■ surgeons;■ optometrists;■ chiropractors;■ cardiologists;■ dermatologists;■ gastroenterologists;■ haematologists;■ neurologists;■ obstetricians;■ oncologists; and■ psychiatrists.
Hospital admission	A hospital admission is the formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with room, board, and continuous nursing service in an area of the hospital or facility where patients generally reside at least overnight.
Hospital emergency department visit	Any time a person went to an emergency department for their own health, whether it was within normal GP practising hours or after hours.

Imaging test	Imaging tests or diagnostic imaging include all tests that produce images or pictures of the inside of the body in order to diagnose diseases. Tests involve the use of radiant energy, including x-rays, sound waves, radio waves, and radioactive waves and particles that are recorded by photographic films or other types of detectors.
Issues caused by lack of coordination between health professionals	<p>The definition of an 'issue' was left to the respondent's interpretation. Discretionary interviewer advice was to include:</p> <ul style="list-style-type: none"> ■ test results or other records not reaching the health professional's office in time for an appointment; ■ having to provide the same details about a medical condition to different health professionals; ■ being sent for the same tests by different health professionals; ■ given contradictory information about a condition by different health professionals; ■ not being told by a pharmacist or other health professional that the medication prescribed might be harmful because of other drugs they were taking.
Index of disadvantage	This is one of four Socio-economic Indexes for Areas (SEIFAs) compiled by the ABS following each Census of Population and Housing. This index summarises attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. The first or lowest quintile refers to the most disadvantaged areas, while the 5th or highest quintile refers to the least disadvantaged areas. For further information about SEIFAs see SEIFA: Socio-Economic Indexes for Areas on the ABS website.
Medical specialist	A medical specialist is a doctor that practices one branch of medicine. Patients are usually referred to a specialist by their general practitioner or by a specialist from another branch of medicine.
Out-of-pocket expense	Out-of-pocket expenses refer to expenses of services or procedures less the Medicare rebate. The person did not have to have been aware of the exact amount they would pay, rather an approximate amount of what was not covered by Medicare.
Pathology test	A pathology test is laboratory medicine that includes analysis of specimens such as urine and blood in order to diagnose disease.
Pharmaceutical care	For the purposes of this publication, this relates to instances where a person sought health-related advice from a pharmacist (chemist) either on their own or someone else's behalf. Discretionary interviewer advice was to exclude information asked of or received from pharmacy assistants.
Prescription medication	A drug that requires a prescription from a medical practitioner before it can be dispensed. This differs from over-the-counter medication, which can be purchased without a prescription.
Private health insurance	Refers to voluntary coverage through the private health care system (e.g. Medibank Private, MBF, NIB, HCF and Manchester Unity). Private health insurance supplements the Medicare system, which provides a tax-financed public system that is available to all Australians. Depending on the type of cover purchased, private health insurance provides cover against all or part of hospital theatre and accommodation costs in either a public or private hospital, medical costs in hospital and costs associated with a range of services not covered under Medicare, including private dental services, optical, chiropractic, home nursing, ambulance and natural therapies.
Private patient	Patients admitted to public or private hospitals can choose their treating doctor. Medicare pays 75 per cent of the Medicare schedule fee for services and procedures provided by the nominated doctor. For patients who have private health insurance, some or all of the outstanding balance may be covered.

Public patient	Patients admitted to public hospitals as public (Medicare) patients receive treatment by doctors and specialists nominated by the hospital. Public patients are not charged for care and treatment or after-care by the treating doctor, as the schedule fee for services and procedures is fully subsidised by Medicare.
Remoteness	The Australian Standard Geographical Classification (ASGC) is used by the ABS for the collection and dissemination of geographically classified statistics. The classification divides Australia into six broad regions called Remoteness Areas. The ASGC Remoteness classification was developed by the ABS in response to a demand for a statistical geography that allows quantitative comparisons between 'city' and 'country' Australia, where the defining difference between 'city' and 'country' is physical remoteness from goods and services.
Self-assessed health status	A person's impression of their own health against a five point scale from excellent through to poor.
Statistical significance	Differences between population estimates are said to be statistically significant when it can be stated with 95% confidence that there is a real difference between the populations. (See the Technical Note for more information).
Urgent medical care	In this question, the term 'urgent' was left to the respondent's interpretation. Discretionary interviewer advice was to include health issues that arose suddenly and were serious, e.g. fever, headache, vomiting, unexplained rash; but that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

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PHONE 1300 135 070

EMAIL client.services@abs.gov.au

FAX 1300 135 211

POST Client Services, ABS, GPO Box 796, Sydney NSW 2001

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