

## REPORT SUMMARY

# Use, access to, and impact of Medicare services for Australian women: Findings from the Australian Longitudinal Study on Women's Health

Understanding how Australian women use Medicare services at different life stages can guide and improve the provision of health services. This major report from the Australian Longitudinal Study on Women's Health adopts a life course approach to investigate changes in women's health and health service use change across life stages.

Women's survey data were linked to Medicare Benefits Scheme (MBS) data, enabling analysis of women's health, health behaviours and social circumstances over time, and how these relate to health care use at different life stages. Using these data, the report provides detailed information on how and when women use health services, and their costs, throughout the women's life course. Here we provide a summary of some of the key findings.

**Download the full report at:**  
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## Use and Costs of General Practice Services

The annual number of GP visits increased with age, from an average of around 4-5 services per year at age 20, to around 15 services per year by age 90. The most rapid increase in GP service use occurred after the age of 55 years.

Today's young women (aged 21 in 2013) used fewer GP services but had higher out-of-pocket costs than similarly aged women from 1996.

Comparing GP use for women with different circumstances, we found:

- Women living in remote areas had the least number of GP services, and those living in major cities had the most.
- Women with difficulty managing on their income visited the GP 1-3 times more often, but had lower out-of-pocket costs. However, once other factors were taken into account these women had fewer services.
- University-educated women have the lowest number of GP services whereas those with less than Year 12 qualification have the highest.
- Women who have a health care card have more GP services each year, than women without a health care card, but lower out-of-pocket costs.

These differences are likely to reflect need for health care as well as women's ability to access health care services.

In terms of need, GP service use was higher for women with more chronic conditions particularly in the 1921-26 cohort. GP use was strongly related to depression in younger women, and diabetes, hypertension, heart disease, respiratory disease and arthritis in older women. After adjusting for need and other factors, both current and ex-smokers from the 1973-78 cohort visited the GP more than non-

smokers. However, in the 1946-51 cohort current smokers visited GPs less while ex-smokers visited the GP more often –consistent with quitting after developing a smoking related illness.

Body mass index (BMI) was significantly related to GP service use among women in the 1973-78 and 1989-95 cohorts, with overweight or obese women having higher service use.

Other factors associated with more GP use included partner status which worked in opposite directions for the 1946-51 cohort (with partnered women having less GP service use) and in the 1921-26 cohort (with partnered women having more GP service use).

The 12 month periods before and after the birth of the first child were associated with fewer GP services. This is probably due to maternity care being by a specialist obstetrician after the initial GP consultation, and is reflected in higher specialist visits for this life event.

In the 1946-51 cohort, at each age, women who were post-menopausal had the highest mean annual number of GP services, whereas women who were within 12 months of menopause had the least. Likewise, women who had previously had a hysterectomy had more GP services, with the number of services increasing with age.

In the 1921-26 cohort, women who had a past fall requiring medical attention had the highest mean number of GP and specialist services. However, in the 12 months prior to a fall women had fewer GP services and more specialist services compared to other women of the same age.

Until the age of 80, there was little difference in the number of GP services used by women in the 1921-26 cohort who were in their last 12 months of life and those who were not. From the age of 81, the number of GP services by women in their last year of life was much higher than for other women of the same age. This difference became greater with increases in age, largely due to progressively fewer services by surviving women at oldest ages. This finding is in stark contrast to the overall findings of increasing GP service use in older age. Importantly women who were not in their last year of life had

GP service use similar to women in the youngest cohorts.

Differences in Medicare benefits for GP services reflect differences in GP service use. However, out-of-pocket costs increased with age within each cohort and also increased with time across all cohorts, particularly for surveys 1 to 3. For women in the 1973-78 and 1946-51 cohorts, this increase in costs is disproportionate to the increase in services and the increase in benefit paid. There is a reduction in increase in costs at around the time of survey 3 for the 1921-26 cohort (2002) and survey 4 for the 1946-51 cohort (2004), but this deceleration in costs is not seen for the 1973-78 cohort.

## Use and costs of specialist services

The number of specialist services used (excluding obstetrics) remained stable until the age of 55 and then increased with age. With obstetrics included, the number of specialist services used, the Medicare benefit paid, and out-of-pocket costs peaked at around 33 years coinciding with the median age of mothers giving birth. In the 1973-78 cohort, women with university education had a higher peak benefit costs and higher out-of-pocket costs for specialist services in their 30's compared to other women, amplifying the age difference in use of specialist services.

Area differences in mean number and costs for specialist services are apparent across all cohorts, with higher use in major cities, and lowest use in remote areas.

For older women, those with university education used more specialist services than those with less education. This effect is opposite to the pattern for GP use. There was little difference in specialist use according to women's ability to manage on income.

As for GP visits, specialists visits were higher among people with more conditions. After adjusting for need and other factors, current smokers were less likely to have specialist visits compared with non-smokers (1989-95, 1973-78 and 1946-51 cohorts), as were overweight and obese women (1946-51 and 1921-26 cohorts). Partnered women in the 1989-95 and 1973-78 cohorts had fewer specialist services

compared to unpartnered women, but partnered women in the 1921-26 cohort had more services. Having private health insurance was associated with more specialist services in the 1973-78 and 1946-51 cohort, but was not a factor for the 1921-26 cohort.

There was a higher rate of specialist services in the 12 months prior to first birth, with the number of services increasing with the age of the woman.

There was little difference in the number of specialist services according to menopause status, and a small increase in specialist services in the year preceding a hysterectomy.

Women who were in their last 12 months of life had an average of around 6-10 specialist services compared to 1-3 services by women who were not in their last year. The mean number of specialist services in the last year of life did not vary much by age.

## Use of pathology

The mean number of pathology claims, and the Medicare benefit paid, increased across cohorts and over time, suggesting increases may not be simply due to age.

Women living in remote areas of Australia had the least number of pathology services per year, and those living in major cities had the most. This area difference in pathology service use increased with age.

In the 1973-78 cohort, pathology claims were highest in 12 months prior to the birth of the first child, and were least 12 months following the birth of the first child.

In the 1946-51 cohort, pathology services were higher for post-menopausal women, compared to those who were pre-menopausal or peri-menopausal.

Pathology services were consistently higher for women who were in their last 12 months of life than those women who were not in their last 12 months of life, with service use declining with age for surviving women.

## Use of primary care, condition specific and allied health items

Many items designed to enhance prevention and health care for people with chronic conditions appear to be underutilised. For instance, the Better Access Scheme (BAS) which was introduced in 2006 to improve access to health services for people with mental health concerns has not been taken up by many women with poor mental health. The highest use of these items was among the younger cohorts, and within these cohorts the use of these items increased over time. In 2009, when the 1989-95 cohort were aged 14-19 years, around 7% of the women had used BAS services. Three years later in 2012 this proportion almost doubled to 13%, however another 30% of this cohort had reported depression or anxiety and had not used BAS services. In the 1973-78 cohort in 2008, when the women were aged 30-35 years, 7% accessed BAS services. By 2015, 11% had accessed services. Across all cohorts, women living in inner regional areas accessed more mental health services than those in metropolitan, outer regional, or remote/very remote areas.

Over time, the mean mental health scores increased for women with poor mental health who used the BAS, likely reflecting the benefit of the BAS. Use of Diabetes Annual Cycle of Care (DACC) items provide another example where women who may benefit from services are not accessing them. While diabetes is common in both the 1946-51 and 1921-26 cohorts, in 2015 only 15-22% of mid-aged and older women with self-reported diabetes had a claim for DACC items. Moreover, many women who reported having diabetes also had no claim for HbA1c testing.

We also saw a low use of Asthma Annual Cycle of Care (AACC) items among women with asthma. Asthma is most prevalent in young women, however only 10% of young women with asthma used AACC or CDM services. The use of these items among women with asthma was even lower in the older cohorts. The reason for the low uptake of ACC is not known and warrants investigation of possible causes such as systemic barriers, GP incentives and patient concerns about the program. There was better uptake of AACC and CDM items in mid-aged

and older women with asthma; up to 45% of these women made an AACC or CDM claim in 2015.

The most widely used group of items were those covering Health Assessments for women in the oldest cohort. There was a steady increase in uptake of health assessments among the 1921-26 cohort from the introduction of the items in 1999 (when the women were aged around 73 to 82 years), to 2003 by when around 35% of the cohort had at least one health assessment. However, there was little uptake of assessments after 2004 when the women were aged 78-83 years. Few baseline factors distinguished between women who had assessment and those who hadn't.

## Use of equity targeted items

Rates of bulk billing, increased with the age of the cohorts, and over time, particularly for the bulk billing incentive items. The greatest use of bulk billing was among the oldest cohort. The number of women who reached the service safety net was initially low in all cohorts, but increased over time. Increases began to reverse after around age 35 in the 1973-78 cohort, coinciding with the childbearing period, and tapered off after around age 80 in the 1921-26 cohort. Across all cohorts women with a university degree, those who had less difficulty managing on income, and those without health care cards were more likely to reach the safety net.

## About Women's Health Australia

Established in 1996, Women's Health Australia (also known as the Australian Longitudinal Study on Women's Health) is a national research resource that is widely used by researchers and policy makers to assess the health status of Australian women.

The longitudinal, population-based survey examines the health of over 58,000 Australian women. The study provides a rich evidence base to investigate the behavioural and socio-demographic characteristics that affect health and the use of health services at different life stages.

The study comprises four cohorts of women: three cohorts (born in 1921-26, 1946-51, 1973-78) have been repeatedly surveyed since 1996, and a new cohort (born in 1989-95) was first surveyed in 2013.

The survey data are linked to Medical Benefits Scheme (MBS), Pharmaceutical Benefits Scheme (PBS), and hospital inpatient data, providing information on health care use, aged care data (for women in the oldest cohort), and mortality data.

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Australian Longitudinal  
Study on Women's Health



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