



Australian Government

Australian Institute of
Health and Welfare

Aboriginal and Torres Strait Islander people and primary health care

Patterns of service use, preferences,
and access to services



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Summary

In 2023, the Department of Health and Aged Care funded the Australian Institute of Health and Welfare (AIHW) to look at Aboriginal and Torres Strait Islander people's use of primary health care.

For Aboriginal and Torres Strait Islander people, culturally responsive, comprehensive, high-quality and timely primary health care throughout life that acknowledges the impact of social, cultural and historical determinants is essential to improve health outcomes (AIHW 2023a, 2023b; Dudgeon et al. 2014; Griew et al. 2008; IAHA 2019).

While access to some aspects of primary health care has improved over time, data show that there are still challenges, such as:

- the spatial distribution of services and providers relative to where Aboriginal and Torres Strait Islander people live
- the unmet need for a range of specific services (such as general practitioners [GPs], dentists and counsellors, among others)
- the ability of Aboriginal and Torres Strait Islander people to access their preferred type of service provider (AIHW 2023a).

To enhance access to timely and culturally relevant primary health care, it is essential to:

- understand the individual and systemic factors underpinning the patterns of use of this care among Aboriginal and Torres Strait Islander people
- identify the groups or areas with the greatest unmet need (including for people who do not use health care at all).

This summary provides a high-level overview of the results of the project, with more details provided in the body of the report. The report is accompanied by detailed online supplementary data tables (see [Data](#)) and an online interactive dashboard with further results from the spatial analysis (see [Interactive dashboard](#)).

Project overview

This project brings together Aboriginal and Torres Strait Islander people's own lived experiences of primary health care use and unmet needs as reflected in national survey data with an analysis of the locations of primary health care services relative to where Aboriginal and Torres Strait Islander people live. The results can be used to identify geographic areas with service gaps, and subgroups within the population who have the highest levels of unmet need.

Specifically, data from the Australian Bureau of Statistics (ABS) 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) are used to explore factors associated with Aboriginal and Torres Strait Islander people's access to, preferences for, use of, and unmet need for, primary health care. The selection of the variables for the analysis was based on a conceptual framework and literature review, and includes:

- 10 national measures of primary health care availability, use and unmet needs. These measures were disaggregated by a set of independent variables from 4 domains: location/demographic factors, socioeconomic and social capital factors, cultural identity and experiences of racism/discrimination, and health/disability status
- 5 questions on people's experiences of primary health care, asked only of those in non-remote areas.

The spatial analysis uses 2022–23 data from the Online Services Report (OSR) collection on the service locations of Aboriginal and Torres Strait Islander specific primary health care organisations¹ – including 326 services/clinics provided by Aboriginal Community Controlled Organisations (ACCHOs), 120 service delivery sites funded by the Indigenous Australians' Health Programme (IAHP) but provided by government or non-government (NGO) organisations, and 2024 data on the practice locations of 7,192 mainstream GPs from the National Health Services Directory (NHSD) – to calculate drive times to the included primary health care services.

The results are used to identify Indigenous Areas (IAREs)² where at least 200 Aboriginal and Torres Strait Islander people live more than a 1-hour drive to a primary health care service (service gap areas).³ It is important to note that this is a baseline measure of access and captures only whether there is a service within that drive time – it does not take the current capacity of the practice to serve patients or the cultural safety of the services into account. It also does not reflect whether individuals have the resources to be able to travel to the locations.

The 2 streams of work (that is, the NATSIHS analysis and spatial analysis) were conducted separately, with the results brought together at the end to look at how people's perceptions of service availability in their local area matched with the drive time analysis.

Themes and key findings

The following section discusses the 5 main themes emerging from the results of the project.

Theme 1 – Service availability is good at a national level, but it is critical to look at lower level geographies and the availability of specific service types

One of the key questions for this project was the extent to which Aboriginal and Torres Strait Islander people have access to primary health care services, what types of services are available, and what groups/areas have service gaps.

The findings from both the NATSIHS analysis and the spatial analysis show that, at the national level, nearly all Aboriginal and Torres Strait Islander people have a service available within their perceived local area (NATSIHS) or within a 60-minute (1-hour) drive time (spatial analysis). For example, the survey data indicate that, in 2018–19, 99% of an estimated 814,000 Aboriginal and Torres Strait Islander people had access to some form of health service in their local area.⁴ The drive time analysis showed a similar pattern, with just over 972,000 of 983,000 people having a primary health care service within a 1-hour drive.

¹ Aboriginal and Torres Strait Islander specific primary health care organisations receive funding from the Australian Government through the IAHP to provide comprehensive and culturally safe care to Aboriginal and Torres Strait Islander clients. The majority of these organisations are managed by ACCHOs. Only ACCHOs that receive IAHP funding are included in the analysis as those that do not receive the funding are not required to report to the OSR.

² IAREs are medium-sized geographic areas built from whole Indigenous Locations. They are designed for the release and analysis of more detailed statistics for Aboriginal and Torres Strait Islander people. Whole IAREs aggregate to form Indigenous Regions (ABS 2021).

³ This includes drive times to particular service types as well as to any primary health care service.

⁴ The service types were AMS/CC, hospital, other doctor not from an AMS, traditional healer, other, none; respondents were asked to tick all that were available. Respondents defined local areas as they saw fit – they were not given instructions to use specific boundaries. Around 6,500 people would say there was no health service in their area, but the standard error is high and the estimate should be used with caution.

However, these national numbers mask important variation across Australia, both geographically and for particular subgroups of people.

What types of primary health care services are available in people's local areas and how does it vary?

The NATSIHS data showed that more people lived in areas with mainstream GPs than in areas with an Aboriginal Medical Service (AMS)/Community Clinic (CC) – 689,500 (85%) compared with 547,800 (67%).

The locations of these services were not randomly distributed – those living in more remote areas,⁵ who had lower incomes, and who lived in more disadvantaged areas were more likely to report having an AMS/CC in their local area, while mainstream GPs were more concentrated in more urban and more advantaged areas. This pattern is expected as AMS/CC services are targeted towards areas and populations of greater need.

Of course, people may live in areas with more than one type of service. Further analysis of the self-reported availability of primary care services showed that, in 2018–19, an estimated:

- 440,000 (54%) of the estimated 814,000 Aboriginal and Torres Strait Islander people lived in areas with both an AMS/CC and a mainstream GP
- 249,500 people (31%) lived in areas with only a mainstream GP
- 107,900 people (13%) lived in areas with only an AMS/CC
- 17,000 people (2.1%) lived in areas with neither an AMS/CC nor a mainstream GP.

Those living in *Very remote* areas and in *Major cities* were the least likely to report having both an AMS/CC and a mainstream GP in their local area (33% and 51%, respectively). Sixty per cent of those in *Very remote* areas had access only to an AMS/CC, and 45% of those in *Major cities* reported only mainstream GPs in their local areas. Those living in the Northern Territory were the most likely to report an AMS/CC as the only primary health care service in their area, followed by Queensland and Western Australia (53%, 17% and 14%, respectively).⁶

Where are the service gap areas and how does it vary?

While the NATSIHS focuses on perceived availability of services, the spatial analysis is used to look at where services are available within particular drive times. The drive time results showed that, overall, there were 131 IAREs (of 412) where more than 200 people lived outside a 1-hour drive to one or more service types (which include IAHP-funded ACCHOs, any IAHP-funded service, mainstream GPs). These are categorised as service gap areas.

From a policy perspective, the highest priority areas are likely to be those where Aboriginal and Torres Strait Islander people have little to no access to any primary health care service. Of the 131 service gap areas, there are 14 where more than 200 people live outside a 1-hour drive to any of the included primary health care services (Table 1), all but one of which are *Very remote*.⁷

⁵ Information about remoteness is summarised in this report by the Australian Statistical Geographical Standard (ASGS) for Remoteness Areas (RA). The ASGS's remoteness structure categorises geographical areas in Australia into 5 remoteness areas, which are characterised by a measure of relative geographic access to services: *Major cities*, *Inner regional*, *Outer regional*, *Remote*, *Very remote*. For more information, see the ABS's *Australian Statistical Geography Standard (ASGS)* (<https://www.abs.gov.au/statistics/statistical-geography/australian-statistical-geography-standard-asgs>).

⁶ Detailed tables of state/remoteness could not be constructed for this variable because of small numbers/suppression rules.

⁷ See Chapter 6 for the full results and discussion of the other 117 IAREs.

There are also an additional 46 IAREs with no IAHP-funded service. A higher proportion of these are regional IAREs (30), with 15 *Remote/Very remote* IAREs, and one IARE classified as a *Major city*, but where the majority of the population who live more than 1 hour from an IAHP-funded service are in regional Statistical Area Level 1 areas (SA1s).

Table 1: IAREs where more than 200 Aboriginal and Torres Strait Islander people live more than a 60-minute drive from any primary health care service

Rank	State/ territory	Remoteness	Indigenous Region (IREG)	IARE	No. living >60 min drive	% living >60 min drive	Estimated Aboriginal and Torres Strait Islander population in IARE
1	NT	Very remote	Nhulunbuy	Ramingining – Milingimbi and Outstations	2,278	100.0	2,278
2	NT	Very remote	Nhulunbuy	Gapuwiyak and Outstations	832	100.0	832
3	WA	Very remote	South Hedland	East Pilbara	606	25.2	2,405
4	WA	Very remote	Kununurra	Wyndham	596	100.0	596
5	NT	Very remote	Nhulunbuy	Laynhapuy – Gumatj Homelands	528	95.5	553
6	WA	Very remote	West Kimberley	Fitzroy Crossing	499	30.6	1,631
7	NT	Very remote	Jabiru – Tiwi	North-West Arnhem	392	16.0	2,447
8	WA	Very remote	West Kimberley	Fitzroy River	379	31.4	1,209
9	NT	Very remote	Jabiru – Tiwi	Maningrida and Outstations	373	11.9	3,118
10	WA	Very remote	Kununurra	Halls Creek – Surrounds	331	77.8	426
11	WA	Very remote	South Hedland	Exmouth – Ashburton	250	19.3	1,298
12	NT	Very remote	Tennant Creek	Barkly	243	46.5	522
13	NSW	Outer regional	North-Western NSW	Far West	241	7.8	3,079
14	NT	Very remote	Nhulunbuy	Marthakal Homelands – Galiwinku	233	8.1	2,886

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites only providing maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Theme 2 – Most Aboriginal and Torres Strait Islander people have a usual source of care, but are not always able to use the type of primary health care service they prefer (availability plays a key role)

Another key question for this project was not just whether Aboriginal and Torres Strait Islander people have primary health care services in their area, but whether they have a usual source of care and how that matches with their preferred source of care.

The NATSIHS results suggest that, in 2018–19, nearly all (92%) Aboriginal and Torres Strait Islander people had a usual source of care (751,400 of 814,000 people). It is not known whether those without a usual source of care used multiple sources or whether they had not needed health care.

What types of primary health care services would Aboriginal and Torres Strait Islander people prefer to use, and what factors are associated with those preferences?

People's preferences for primary health care service providers are related to a number of factors, including availability/accessibility, familiarity, costs, previous experiences, waiting times, and relationships with individual health practitioners. The NATSIHS asked respondents about the type of health service they would like to use if they had the choice (but did not ask why they selected that particular type of service). However, previous research has shown that Aboriginal and Torres Strait Islander clients of ACCHOs particularly value the welcoming/culturally safe environment in which care is delivered, its accessibility, and the flexibility and breadth of services offered (comprehensive primary health care) (Gomersall et al. 2021).

Nationally, the results indicate that 48% of Aboriginal and Torres Strait Islander people (390,600 of 814,000) would prefer an AMS/CC and 43% (350,000) a mainstream GP. Fewer than 7% preferred a hospital as their main source of care.

Preference for an AMS/CC was higher among those living in regional and *Remote/Very remote* areas, those living in areas with higher levels of disadvantage, females compared with males, adults who had experienced unfair treatment in the past 12 months and those reporting stronger cultural ties (highlighting the importance of culturally safe care).

It is important to note that preferences are strongly related to the types of services available in people's local areas. The results from a multivariate regression model on the factors predicting preference for an AMS/CC (compared with any other type of service) showed that, after controlling for other factors, the strongest predictor of preference for an AMS/CC was having one in a person's local area. Those who had only an AMS/CC in their area were 5.2 times as likely to prefer an AMS/CC as those without one, and those who had both an AMS/CC and a mainstream GP in their area were 2.3 times as likely to prefer an AMS/CC.

Where did people usually get their care?

Usual source of care is strongly related to the services available in a person's local area as well as preferences. However, it is also important to note that:

- some people will travel outside their local area for a service they prefer
- there may be different services in the area in which people work compared with the area in which they live (so they may access care near where they work)
- availability does not mean that a service will have the capacity to serve everyone in their area.

The results showed that of 814,000 Aboriginal and Torres Strait Islander people, 439,500 (54%) had a mainstream GP as their usual provider and 277,100 (34%) had an AMS/CC.

At a broad level, consistent with how primary health care services are distributed throughout Australia, there is a strong relationship between remoteness and usual source. Around 15% of those living in *Major cities* had an AMS/CC as their usual source of care, compared with 75% of those living in *Very remote* areas, while 75% of those in *Major cities* had a mainstream GP compared with 27% of those in *Remote* areas.⁸

⁸ The small number of Aboriginal and Torres Strait Islander people in *Very remote* areas with a mainstream GP meant that the estimate has a high standard error and should be used with caution.

How well does usual source match up with preferred source? Who has an unmet need for an AMS/CC?

Putting these numbers together with where people preferred to go shows that nearly all Aboriginal and Torres Strait Islander people who expressed a preference for a mainstream GP had one as their usual source of care (88%) – fewer than 3% used an AMS/CC.

However, of the 390,600 people who expressed a preference to attend an AMS/CC, 248,000 (64%) reported one as their usual source of care, meaning that 142,200 Aboriginal and Torres Strait Islander people did not use an AMS/CC even though that was their preferred source. Nearly 30% used mainstream GPs and another 5.7% reported that they had no usual source of care.

The findings indicate that among those who preferred an AMS/CC but did not have one as their usual source there were around:

- 87,000 people with a long-term and ongoing health condition
- 56,000 people with disability
- 30,000 adults with high/very high levels of psychological distress
- 24,000 adults who had experienced unfair treatment over the previous 12 months.

There were also considerable geographic variations in unmet need (which are a combination of both the distribution of where Aboriginal and Torres Strait Islander people live and where services are located). The highest numbers of Aboriginal and Torres Strait Islander people with an unmet need for an AMS/CC were:

- 68,000 people in *Major cities* and 42,000 people in *Inner regional* areas
- 57,000 people in New South Wales and 39,000 people in Queensland
- 65,000 people in areas in the lowest Socio-Economic Indexes for Areas (SEIFA) quintiles and 57,000 in the next 2 quintiles (noting that the proportions of people in these areas who used an AMS/CC is higher than for those in more advantaged areas).

The impact of having an AMS/CC in the local area is clear, with 91% of those with only an AMS/CC in their area using one. Notably, among those who said they had both an AMS/CC and a mainstream GP in their local area, 72% reported using an AMS/CC as their usual source.

Results from the multivariate regression for Aboriginal and Torres Strait Islander people aged 18 and over who preferred to use an AMS/CC found that the strongest predictor of being able to use an AMS/CC was having one in their local area. Controlling for all other variables:

- those who had only an AMS/CC available in their local area were 77 times as likely to be able to use an AMS/CC as those with no AMS/CC available
- those who had both an AMS/CC and a mainstream GP in their area were 24 times as likely to be able to use an AMS/CC as those without an AMS available.

Theme 3 – Satisfaction with primary health care is high, but Aboriginal and Torres Strait Islander people still have unmet needs for primary health care services (especially dental care)

Overall, people rated their own personal GP and experience with the health care they received in the past year quite highly – fewer than 10% rated the health care they received as either poor or fair (noting that these questions were asked only in non-remote areas).

Unmet need for primary health care can be measured in several ways. The NATSIHS asked respondents directly if there had been an occasion within the past 12 months when they

needed a service but did not access it (and to choose as many reasons from a list as applicable).⁹ Respondents were also asked the timing of their most recent visit to a selected set of primary care providers – these data can be used to compare timing against population-wide best practice guidelines (for example, seeing a GP at least once a year for a health check and seeing a dentist at least once a year for cleaning/a check-up).

What does the timing of most recent visits tell us?

The NATSIHS results show that a much higher proportion of Aboriginal and Torres Strait Islander people visited a GP in the past 12 months than saw a dentist. In 2018–19, out of 792,600 Aboriginal and Torres Strait Islander people, 688,200 had seen a GP in the past 12 months (87%), 95,500 (12%) had visited one more than 12 months ago, and 8,900 had never visited a GP (1.1%).

The pattern for dental visits is quite different. Out of 775,000 Aboriginal and Torres Strait Islander people aged 2 and over, 338,500 (44%) had seen a dentist in the past 12 months. Another 129,400 (17%) had seen a dentist between 12 months and 2 years before the survey, leaving one-quarter (194,600) who had not had a dental visit in the last 2 years and 94,600 (12%) who had never had a dental visit.

How many people had an unmet need for GP/dental services and what were their reasons?

The results from the direct questions on unmet needs show the same patterns. In 2018–19, out of 814,000 Aboriginal and Torres Strait Islander people, 101,400 (13%) had at least one instance in the past 12 months when they needed to see a GP but did not, while out of 774,600 Aboriginal and Torres Strait Islander people aged 2 and over, 146,800 (19%) had at least one instance in the past 12 months when they needed dental care but did not get it.

There are particular groups for whom unmet need for both GPs and dentists was higher, including those:

- in *Major cities* and regional areas
- in areas of greater disadvantage
- whose usual source of care was not an AMS/CC
- who had experienced unfair treatment/discrimination in the past 12 months
- with poorer self-assessed health status
- with a long-term health condition
- with disability.

Interestingly, the reasons cited for unmet need differed for GPs and for dentists:

- for GPs, the top 5 reasons were too busy; decided not to seek care; long waiting times; transport/distance; dislikes (service/professional, afraid, embarrassed)
- for dentists, the top 5 reasons were cost; too busy; dislikes (service/professional, afraid, embarrassed); long waiting times; decided not to seek care.

While cost was the top reason for unmet need for dentists, it was not in the top 5 reasons for unmet need for GPs, where more personal reasons (such as being too busy and deciding not to seek care) were the top 2. This is likely to reflect the impact of Medical Benefits Schedule (MBS) rebates for GP services but not for dental care, noting that the proportion reporting cost as a reason for unmet dental care was twice as high among those whose

⁹ There is no information about why the respondents felt they needed to see a GP (or dentist) in the first place, so caution must be used around these results.

usual source of care was a mainstream GP compared with those whose usual source was an AMS/CC.

Theme 4 – Importance of ACCHOs/IAHP-funded services

Both the spatial analysis and the NATSIHS results highlight the importance of ACCHOs and other IAHP-funded services in providing primary health care for Aboriginal and Torres Strait Islander people. Particularly in more remote areas, IAHP-funded services (both ACCHOs and non-ACCHOs) are often the only source of primary health care.

The drive time results showed that 15% of those in *Remote* areas and 64% of those in *Very remote* areas live more than a 1-hour drive to a mainstream GP. When IAHP-funded services are included, it means that 99% of those in *Remote* areas and 89% of those in *Very remote* areas live within a 1-hour drive of at least one primary health care service.¹⁰

The cultural and financial effects of AMS/CC services are shown throughout the NATSIHS results. As discussed previously in this summary, they are an important source of care for those who have experienced unfair treatment and those with stronger cultural ties.

Those whose usual source of care was an AMS/CC were more likely than those whose usual source of care was a mainstream GP to say their GP always spent enough time with them, listened to them, showed respect for them, and explained things clearly.¹¹

AMS/CCs also help to defray the costs of health care for their clients, particular for non-GP primary health care services. There are striking differences in who was required to provide a co-payment (among those who had seen a provider in the past 2 weeks), particularly for specialists and for other health providers (which includes allied health services):

- While co-payments for consultations with GPs were relatively infrequent overall, they were higher for those whose usual source of health care was a mainstream GP compared with those whose usual source of care was an AMS/CC (5.9% to <1%).
- There was a considerable difference in co-payments for specialists and other health providers between those whose usual source of care was a mainstream GP (28% and 29%, respectively) and those whose usual source of care was an AMS/CC (7.3% and 6.0%, respectively).

Theme 5 – What is considered ‘local area’ varies by remoteness

Another important question for the project was whether there was alignment between what people perceived as service availability in their local areas and what the spatial analysis showed (for example, whether or not there were services).

The NATSIHS results were compared with the drive time results using 2 different time boundaries (15 minutes and 30 minutes) across remoteness areas (acknowledging that the perception of what someone’s local area is may differ substantially between those in more urban and more remote areas).

All IAHP-funded services were included as the closest representation of AMS/CC because they capture the ‘community clinic’ side.

For those in *Major cities* and *Inner regional* areas, the 15-minute drive time matches closely with people’s perceived availability of services in local areas (it is also important to note that service locations themselves may have changed between 2018–19 and 2022–2024).

¹⁰ Again, it is important to note that there may be primary care services that are available on the ground but not included in either the NHSD or OSR.

¹¹ Questions were asked only of those in non-remote areas.

However, when the longer drive time of 30 minutes or less is considered, there is little to no alignment between the survey results and drive time results.

The results for those in *Outer regional* areas are not as clear cut. The survey respondents were more likely to indicate that the only source of primary care in their local area was an AMS/CC (17%), while the results from the spatial analysis indicate that it was less than 2%.

For those in *Remote* and *Very remote* areas, the 30-minute drive time limit seems to match more closely with the NATSIHS results. It is also interesting that in *Very remote* areas, 4.4% of Aboriginal and Torres Strait Islander people indicated that there was no primary care service in their local area, while the drive time results showed that for 16% of people there was no service within a 30-minute drive time. This may be due either to data gaps or that people in more remote areas consider a much larger area/larger drive time boundary to be their local area.

1 Introduction

Primary health care is often the first contact a person has with the health system outside of a hospital or specialist. It encompasses a range of services that aim to keep people well physically and emotionally (promote good health) as well as to identify and manage illnesses, injuries and chronic diseases when they arise. As well as care provided by general practitioners (GPs), examples of the large range of primary health care services include nursing care, midwifery, pharmacy, dentistry, allied health care (such as physiotherapy, psychology and counselling, and speech pathology) and dental care.

High-quality primary health care can contribute to improved health and wellbeing by:

- improving health literacy and the self-management of chronic disease (providing linkages to services within and outside the health system)
- improving screening for and treatment of acute and chronic illnesses
- providing preventive care such as immunisations.

For Aboriginal and Torres Strait Islander people, culturally responsive, comprehensive, high-quality and timely primary health care throughout life that acknowledges the impact of social, cultural and historical determinants is essential to improve health outcomes (AIHW 2023a, 2023b; Dudgeon et al. 2014; Griew et al. 2008).

Aboriginal and Torres Strait Islander people can access primary health care in different settings, such as:

- private practices, which are generally funded through a combination of Medical Benefits Schedule (MBS) rebates (for eligible items/practitioners) and patient contributions (including through private health insurance)
- Aboriginal and Torres Strait Islander specific primary health care organisations (PHCOs), which receive funding from the Australian Government through the Indigenous Australians' Health Programme (IAHP) to provide comprehensive and culturally safe care to Aboriginal and Torres Strait Islander clients. The majority of these organisations are managed by Aboriginal Community Controlled Health Organisations (ACCHOs)
- other community-based health care, which may be provided by government or non-government organisations (NGOs), and which are often low or no-cost.

While access to some aspects of primary health care has improved over time, data show that there are still challenges, such as:

- the spatial distribution of services and providers relative to where Aboriginal and Torres Strait Islander people live
- the unmet need for a range of specific types of primary health care services (such as GPs, dentists and counsellors, among others)
- the ability of Aboriginal and Torres Strait Islander people to access their preferred type of service provider (AIHW 2023a).

To enhance access to timely and culturally relevant primary health care, it is essential to:

- understand the individual and systemic factors underpinning the patterns of primary health care use among Aboriginal and Torres Strait Islander people
- identify the groups or areas with the greatest unmet need (including for people who do not use health care at all).

Conceptually, use (or non-use) of primary health care is complex, involving need, service availability, service accessibility, preferences, and experiences with the health system which can then affect both future health and health-care behaviours (Davy et al. 2016; Levesque et al. 2013).

Measuring primary health care use among Aboriginal and Torres Strait Islander people

Because primary health care encompasses such a wide range of types of services and service providers, estimating its use is quite complex. For example, at the national level, primary health care use could be measured by:

- the number of people and/or percentage of the population who used any/a specific primary health care service in a defined time period. For example, this could be the number of people who saw a GP in the past 12 months, who saw a dentist in the past 24 months, or who received an influenza vaccination in the past 12 months
- the number and types of primary health care services provided within a specified period, which provides a systems-level perspective. For example, this could include the number of Aboriginal and Torres Strait Islander specific health checks (health check) completed in the past 12 months or the number of occasions of service provided by GPs in the past 12 months
- the frequency of service use among individuals/groups, such as the number of times an individual used a particular type of primary health care service in a defined period (such as the number of times a person visited a GP in the past 12 months).

All of these measures could then be further disaggregated by other key factors, such as location (remoteness), populations of interest (young children, older people, those with chronic diseases), types of services delivered (immunisations, health checks, chronic disease management visits), or types of organisations providing the service (mainstream GPs, community clinics, Aboriginal and Torres Strait Islander PHCOs).

In practice, reporting on these measures is difficult because all require counts of services used/provided by type, date, client characteristics, and organisation characteristics. Ideally, data would also be available on the reasons why a person sought care (not just the services provided to the person) and on the number of people who needed care but were unable to obtain it.

Currently, however, there is no single national data source that includes all these aspects and can provide yearly estimates. Rather, there are 3 main national sources of data on primary care use among Aboriginal and Torres Strait Islander people (Box 1.1), each with their strengths and weaknesses.^{12,13}

¹² Data on use of antenatal care are part of the National Perinatal Data Collection but have not been included as their focus is only on a subsection of the population and one type of service.

¹³ The Bettering the Evaluation And Care of Health (BEACH) survey (now ceased) collected information on consultations with GPs, including GP and patient characteristics, patient reasons for the visit, problems managed and treatments provided. The survey was conducted annually between 1998 and 2016. Information was collected from a random sample of around 1,000 GPs from across Australia each year. Each participating GP provided details of 100 consecutive consultations.

Box 1.1 Primary health care data sources

- **Medicare Benefits Schedule (MBS)** data collection contains information on services that qualify for a benefit under the *Health Insurance Act 1973* and for which a claim has been processed. The database comprises information about MBS claims (including benefits paid), patients, and service providers. Medicare Australia collects the data, which are regularly provided to the Department of Health and Aged Care. Medicare seeks Indigenous status information in its enrolment forms, including the general enrolment application form and the Aboriginal and Torres Strait Islander Medicare enrolment form.
- **Online Services Report (OSR)** collects organisation-level information from the Aboriginal and Torres Strait Islander-specific PHCOs funded by the Australian Government under the IAHP. A small number of organisations with IAHP funding for maternal and child health services only also report to the collection. The OSR includes data on organisational characteristics, location, workforce, clients, and service activity and are reported yearly.¹⁴
- **National Aboriginal and Torres Strait Islander Health Surveys (NATSIHS)**¹⁵ are a set of periodic surveys run by the Australian Bureau of Statistics (ABS) and collect data on a range of health-related topics and social determinants. The most recent available data are from the 2018–19 NATSIHS which collected data between July 2018 and April 2019 from Aboriginal and Torres Strait Islander people of all ages in non-remote and remote areas of Australia, including discrete Indigenous communities.

MBS data

The advantages of the national MBS data are that they are regularly updated, available at unit record level, and provide some information on the type of service that had been provided (through item numbers). There are some item numbers (such as for Aboriginal and Torres Strait Islander health checks) that can only be claimed for services provided to Aboriginal and Torres Strait Islander people. However, there are issues with using MBS data as well:

- Although item numbers provide information on the type of service/type of provider (such as non-referred GP attendance), there are no data available on the reason for the visit or advice provided.
- For item numbers that are not Aboriginal and Torres Strait Islander-specific, the proportion of claims by Aboriginal and Torres Strait Islander people need to be estimated using the Voluntary Indigenous Identifier (VII), which was introduced into the Medicare database from November 2002. Not all Aboriginal and Torres Strait Islander people self-identify, however, and so the MBS data for Aboriginal and Torres Strait

¹⁴ The National Key Performance Indicators collection (nKPIs) also includes data collected from IAHP-funded organisations, but its focus is on clinical indicators collected for continuous quality improvement; it includes only Aboriginal and Torres Strait Islander regular clients (those who have had at least 3 occasions of service at an organisation within the past 2 years).

¹⁵ Previous versions have been known by different names. The first collection was the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS). The subject matter from the 1994 survey was later divided into 2 separate surveys – the National Aboriginal and Torres Strait Islander Social Survey (NATSISS, which included some health-related questions, and was collected in 2002, 2008 and 2014–15, which was the final collection) and health surveys, which include the 2004–05 NATSIHS, the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, and a recently completed NATSIHS collection which is expected to be released in late 2024.

Islander people are adjusted for under-identification (for example, they are modelled and should be interpreted with caution).

Estimates generated by the adjustment methodology for a given period will vary according to the point in time at which they are calculated, as the adjustment factors are updated regularly to account for the ongoing change in the population coverage of the VII sample. The most recently published VII adjusted data are for 2021–22 (Productivity Commission 2024).

- Even with the adjustment factors, MBS data do not give a comprehensive picture of actual service delivery for Aboriginal and Torres Strait Islander people, as some service delivery (particularly in remote areas) is not part of these systems. For example, MBS data do not include services provided in the public health system or under other arrangements that do not attract an MBS claim (for example, some Aboriginal Medical Services and state/territory health services).

OSR data

The strengths of the OSR data are that these are robust, collected yearly, and contain data on organisational characteristics as well as numbers and types of services delivered (to Aboriginal and Torres Strait Islander and non-Indigenous clients).

However, the data are available only at aggregate level, nor do they include any information on services provided at mainstream GPs or other mainstream primary health centres; further, the number of organisations reporting varies slightly each year (for more information, see AIHW 2024a). There are also a small number of ACCHOs who do not receive IAHP-funding and do not report to the OSR.

Because Aboriginal and Torres Strait Islander clients can attend more than one Aboriginal and Torres Strait Islander PHCO in a year, they will be counted as a client at each organisation they attend (so the total number of Aboriginal and Torres Strait Islander clients in a year may be higher than the number of Aboriginal and Torres Strait Islander individuals who used these services).

NATSIHS surveys

The NATSIHS surveys have the advantage of collecting detailed information from Aboriginal and Torres Strait Islander people on a range of topics, including social and cultural determinants, the need for primary health care, preferences, usage, and unmet needs, with the data available at unit record level and results able to be adjusted to the national level.

The downsides of the NATSIHS surveys primarily relate to the frequency of data collection and comparability with previous versions. Data are collected every 6 to 7 years; hence, while they can provide information on overall time trends for selected items that are collected consistently, they are unable to provide yearly data. There is also a lag between when the data are collected and when they are released.

Primary care use indicators

Data from the MBS, OSR and the 2018–19 NATSIHS highlight different aspects of recent primary care use among Aboriginal and Torres Strait Islander people.

General practice items

The most recent available MBS VII data show that, in 2021–22, there were:

- 5.2 million non-referred (GP) attendances claimed by Aboriginal and Torres Strait Islander people (at an average of 7.2 per person in the 12 months). Non-referred (GP) attendances include everything from providing health advice; diagnosing medical conditions; ordering tests or following up on test results, repeat or new prescriptions; and managing acute issues. Both the overall number of non-referred attendances and the average number per person have increased steadily since 2016–17 (when there were 4.5 million claims at an average of 6.8 per person)
- around 81,000 Chronic Disease Management Plans¹⁶ and 69,000 Team Care Arrangements (TCAs)¹⁷ prepared for Aboriginal and Torres Strait Islander people (Productivity Commission 2024).

As noted above, there are also Aboriginal and Torres Strait Islander-specific MBS items (that do not require VII adjustment). One of the key items is a specifically designed annual Medicare-funded health check, which supports engagement in comprehensive primary health care in a culturally safe way and is an opportunity to identify patients' health goals and priorities, provide risk assessment and healthy lifestyle information and supports, and encourage early detection and treatment of common conditions that cause ill health and early death – for example, diabetes and heart disease (AIHW 2023b, 2024c; Butler et al. 2022; NACCHO/RACGP 2018).

The 2023 MBS data showed that:

- 257,000 Aboriginal and Torres Strait Islander people (28% of the population) had a health check
- 78,000 of those with a health check (31%) received a chronic disease management service. That proportion was strongly related to age, with 77% of patients aged 75 or older having a chronic disease management service in the same year, compared with 5.0% of patients aged 0–4 (AIHW 2024c).

Analysis of data from the nKPIs data collection suggest that GPs at ACCHOs conduct around 44% of all health checks despite making up only about 2.2% of full-time equivalent GPs.

Aboriginal and Torres Strait Islander specific PHCOs

The 2022–23 OSR included 213 Aboriginal and Torres Strait Islander specific PHCOs, which provided care to 413,789 Aboriginal and Torres Strait Islander clients. The majority of the clients (82%) received care from an ACCHO.

¹⁶ A Chronic Disease Management Plan can help people with chronic medical conditions by providing an organised approach to care. It is a plan of action agreed between a patient and their GP which identifies the patient's health and care needs, sets out the services to be provided by the GP, and lists the actions the patient can take to help manage their condition.

¹⁷ TCAs are for patients with complex care needs requiring multidisciplinary care, and need a GP to collaborate with at least 2 other health or care providers who will deliver ongoing treatment or services. TCAs provide access to Medicare-subsidised care from selected allied health care providers for individual treatment services. Eligible allied health services include Aboriginal and Torres Strait Islander health services, diabetes education services, audiology, exercise physiology, dietetics, mental health services, occupational therapy, physiotherapy, podiatry, chiropractic services, osteopathy, psychology and speech pathology.

Client contacts can be used to highlight the amount of services received at the organisations as well as the multidisciplinary nature of the services. In 2022–23, the OSR indicated that the Aboriginal and Torres Strait Islander clients had around:

- 1.5 million contacts with a GP
- 1.5 million contacts with a nurse
- 562,000 contacts with an Aboriginal Health Practitioner or Aboriginal Health Worker
- 292,000 contacts with an Allied Health Worker
- 242,000 contacts with a Social and Emotional Wellbeing (SEWB) Worker
- 76,000 contacts with a midwife (AIHW 2024a).

Self-reported use

The NATSIHS data can be used to highlight the types of primary care services used by respondents, as well as whether or not they had a usual source of care. The data show that, in 2018–19:

- nearly everyone (750,300 or 92% of Aboriginal and Torres Strait Islander people) had a usual source of care
- 45% (368,000) of Aboriginal and Torres Strait Islander people had accessed some form of health care in the previous 2 weeks. In these 2 weeks, 23% (186,400) of Aboriginal and Torres Strait Islander people had consulted a GP, 22% (181,700) had consulted other health professionals, and 4.9% (38,000) of those aged 2 and over had seen a dentist
- 86% (698,300) of Aboriginal and Torres Strait Islander people had seen a GP in the past 12 months, and 44% of Aboriginal and Torres Strait Islander people aged 2 and over (338,200) had seen a dentist in the past 12 months.

Selection of main data sources for this project

While patterns of primary health care use are most often captured by looking at administrative data on those who used services, administrative data on service use only captures 'met need'; that is, data on service users are unable to count people who may have needed a service but were unable to access it. Administrative data also do not measure the quality or appropriateness of the care received. Exploring these other factors requires analyses of survey and/or qualitative data.

This project uses data from the 2018–19 NATSIHS collection (ABS 2019)¹⁸ to look at a number of key variables in the primary health care journey from the perspective of Aboriginal and Torres Strait Islander people. It supplements these findings with a spatial analysis on the geographic accessibility (as measured by drive times) of different types of primary health care services.

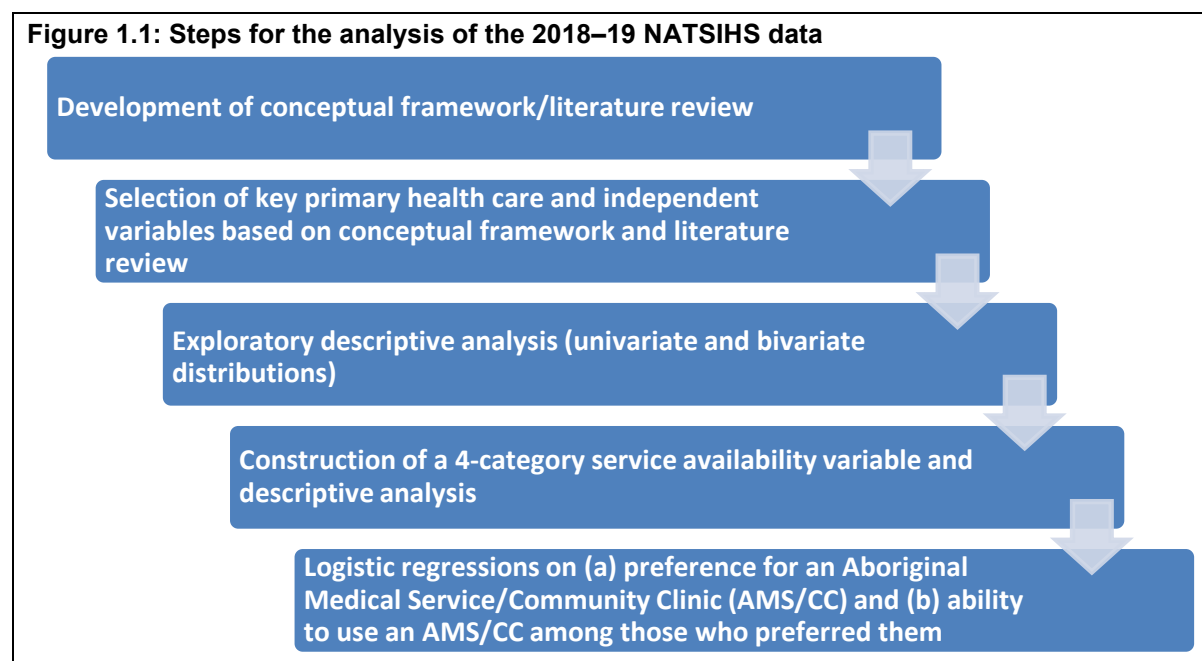
¹⁸ The results from the next NATSIHS collection (2023–24) are expected to be released in late 2024.

Approach

This project adopted a conceptually-based, multi-faceted approach by bringing together Aboriginal and Torres Strait Islander people's own lived experiences of primary health care use and their unmet needs (as reflected in the survey data) with an analysis of the current patterns of where primary health services are located relative to where Aboriginal and Torres Strait Islander people live. An overview of the 2 streams of work are presented in figures 1.1 and 1.2.

Overview of the analysis of the 2018–19 NATSIHS

Figure 1.1: Steps for the analysis of the 2018–19 NATSIHS data



The conceptual framework and literature review were used to drive the selection of the primary health-care variables and independent variables to include in the analyses. Univariate and bi-variate analyses were undertaken using the ABS's TableBuilder.¹⁹

One of the key variables in this project is the availability of primary health care services. The 2018–19 NATSIHS asked respondents to tick which ones from a selected list of health services²⁰ were available in their local area (noting that respondents defined their local areas themselves). This question thus captures perceived availability.

While the analysis in TableBuilder highlights how many people had each type of service in their local area, it cannot be used to look at whether there was **more than one** type of service in their area.

¹⁹ Weighted frequencies were used to provide population-level estimates of the distributions of key variables.

²⁰ Aboriginal Medical Service/Community Clinic (AMS/CC); mainstream GP; hospital; traditional healer; other; none.

Using the unit record level data in the ABS's DataLab environment, a variable was created which assigned respondents to one of 4 categories focusing on the types of GP services in their area:

- AMS/CC²¹ only
- mainstream GP (other doctor/GP not from AMS or hospital) only
- both AMS/CC and mainstream GP
- neither AMS/CC nor mainstream GP²² (no primary health services).²³

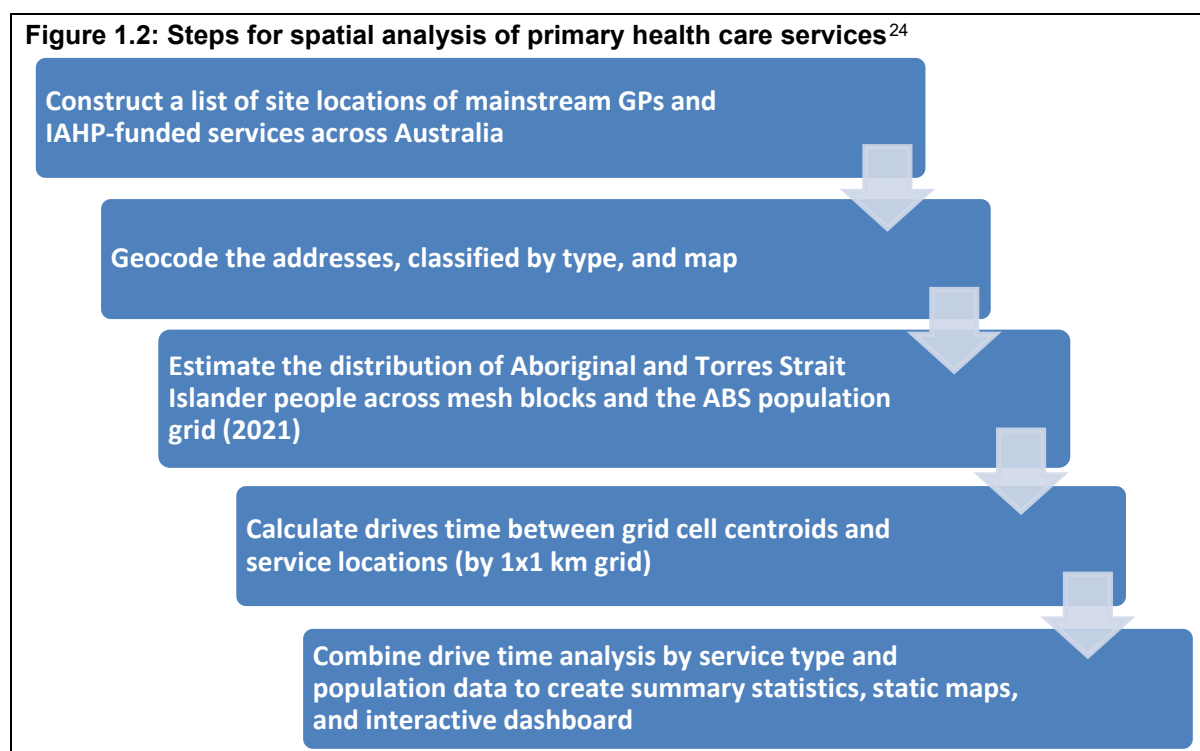
This variable is designed to capture not only the distribution of service availability, but how much choice respondents have in what type of primary health service they use.

Building on the descriptive analyses (which focused on the relationships between individual variables and the primary health variables), the final step used multivariate logistic regression to examine the relative impact of a subset of these variables on 2 selected outcomes:

- preference for an AMS/CC
- whether the respondent was able to use an AMS/CC (among those who expressed a preference for one).

Overview of the spatial analysis

Figure 1.2: Steps for spatial analysis of primary health care services²⁴



²¹ It is not known how the respondents interpreted this term (for example, whether they would have included all IAHP-funded services, or just those run by ACCHOs; nor is it known what proportion included mainstream community clinics).

²² They may have had a hospital in the area, but these analyses focus on the availability of primary health care services specifically.

²³ The spatial analyses include a similar set of categories.

²⁴ For more detail, see the AIHW's *Online Services Report for First Nations-specific primary health care* (www.aihw.gov.au/about-our-data/our-data-collections/online-services-report-osr).

Locations of mainstream GPs were taken from the National Health Services Directory (NHSD), and the locations of IAHP-funded organisations were taken from AIHW analysis of the OSR. For the purposes of the work presented here, mainstream services were defined as any GP service site in the NHSD that was not included in the OSR.

Population-to-service drive times from the midpoint of each populated cell in the ABS's 2021 population grid were calculated using Geographic Information System (GIS) software and a road network data set with speed limits. The population grid is made up of 1x1 km cells, which allows for a high resolution of where people live and how drive times to services vary. The available low-level Aboriginal and Torres Strait Islander population estimates were used in combination with the total population estimates for each grid cell to estimate the Aboriginal and Torres Strait Islander population in all populated grid cells.

It is important to note that service locations change and that the snapshot captured by these data sources is not 100% complete. Any service (including permanent clinics and outreach locations) not covered by the NHSD or the OSR has not been considered in the analysis presented here. This means that while the results included in this report will give a good indication of how access varies at a local level, further information about current activities on the ground may be needed to gain a full understanding of the access situation experienced by people living in identified service gap areas.

The detailed methodology is presented in Appendix 1.

Consultation during the project

Feedback on the approach and content was provided during the project by the Department of Health and Aged Care, the National Aboriginal Community Controlled Health Organisation (NACCHO) and the AIHW's Indigenous Statistical Information and Advisory Group (ISIAG). One of the key themes of this feedback was that the results needed to have practical implications, particularly in identifying population subgroups and geographic areas with unmet needs for, or low access to, primary health care (under-served populations).

Structure of the report

This report is organised as follows:

- Chapter 2 presents the conceptual framework, literature review, definitions of the outcome and independent variables, and an overview of the distribution of the independent variables.
- Chapters 3–5 include the findings from the NATSIHS analysis:
 - Chapter 3 looks at the perceived availability of services in respondents' local areas and identifies population subgroups who do not have access to an AMS/CC within their local area.
 - Chapter 4 focuses on preferred and usual source of care, and includes the multivariate logistic regression results on preferences for an AMS/CC. It also looks at the extent to which people's preferences and usual source of care match up, and presents multivariate logistic regression results on the factors that help to explain who was able to use an AMS/CC if that was their preferred source of care.
 - Chapter 5 examines patterns of primary health care use including continuity of care, timing of most recent visit to a GP or dentist, the levels of self-reported unmet needs for GP and dental care, and the reasons underpinning the unmet need.
- Chapter 6 presents the spatial analysis. The locations of individual services, population distributions and drive times to services are used to identify the numbers and locations of Aboriginal and Torres Strait Islander people within/outside selected drive times of

services by type (IAHP-funded ACCHO, any IAHP-funded service, mainstream GPs, or any primary care service). The results are used to identify service gap areas – Indigenous Areas (IAREs)²⁵ where more than 200 Aboriginal and Torres Strait Islander people live outside a 1-hour drive to a primary care service (by type of service). Chapter 6 also compares the results from the spatial analysis with the NATSIHS results on perceived availability of services in people's local areas.

There are 2 appendixes:

- Appendix 1 summarises the methodology used in the spatial analyses.
- Appendix 2 provides additional tables/maps.

There are also 2 main supplements to this report available online:

- supplementary data in Excel spreadsheets (see [Data](#)):
 - one presents descriptive results, organised by outcome variable
 - the other contains IARE-level data on drive times to IAHP-funded ACCHOs, all IAHP-funded services, mainstream GPs, and any primary health care service
- interactive dashboard on access to primary health services for Aboriginal and Torres Strait Islander people as at July 2024 (see [Interactive dashboard](#)).

²⁵ Indigenous Areas (IAREs) are medium-sized geographic areas built from whole Indigenous Locations. They are designed for the release and analysis of more detailed statistics for Aboriginal and Torres Strait Islander people. Whole Indigenous Areas aggregate to form Indigenous Regions (ABS 2021).

2 Factors affecting the use of primary health care by Aboriginal and Torres Strait Islander people

This chapter provides a conceptual overview of the factors that affect the use of primary health care use by Aboriginal and Torres Strait Islander people, including a summary of findings from previous research.

It is important to note that, for Aboriginal and Torres Strait Islander people, good health is more than just the absence of disease or illness. It is a holistic concept that includes physical, social, emotional, cultural, spiritual and ecological wellbeing, for both the individual and the community. This concept of health emphasises the connectedness between these factors and recognises the impact that social and cultural determinants have on health (Dudgeon et al. 2014; Gee et al. 2014; Parker and Milroy 2014; Social Health Reference Group 2004). This definition of health also implies a potentially different set of health needs and ways of meeting those needs than what may traditionally have been offered in mainstream services.

Conceptual overview

Use (or non-use) of primary health care is the end result of a complex set of interacting individual, community and health system factors that incorporates the perceived needs for health care, the ability and capacity of the system to meet those needs, and individuals' ability to access the system (Andersen 2008; Bharmal et al. 2015; Gulliford et al. 2002).

Statistics on the use of primary health care services (as seen in associated administrative data) reflect the interaction between these individual and systemic factors. This interaction was particularly highlighted by changes in the use of primary health care during the early part of the COVID-19 pandemic (AIHW 2022).

Understanding these factors is critical for highlighting gaps or areas for improvement (as well as recognising where services/the health system does well). Conceptual frameworks that explicitly lay out the key factors and their relationships provide a visual guide that can be used to drive the selection of variables and methodologies for empirical research projects, both qualitative and quantitative.

In 2013, Levesque and colleagues published their conceptual framework of health care access (the Framework) (Levesque et al. 2013), which highlighted the steps people generally go through in seeking and obtaining care; it also explicitly illustrated how each step is affected by individual and systemic factors (Figure 2.1). The Framework has since been widely used by other researchers (for example, Corscadden et al. 2016; Gordon et al. 2020). See Cu et al. 2021 for a review of studies using the Framework.

There are 2 other main conceptual models of health care use that also consider the importance of both individual/family and contextual/structural/policy factors:

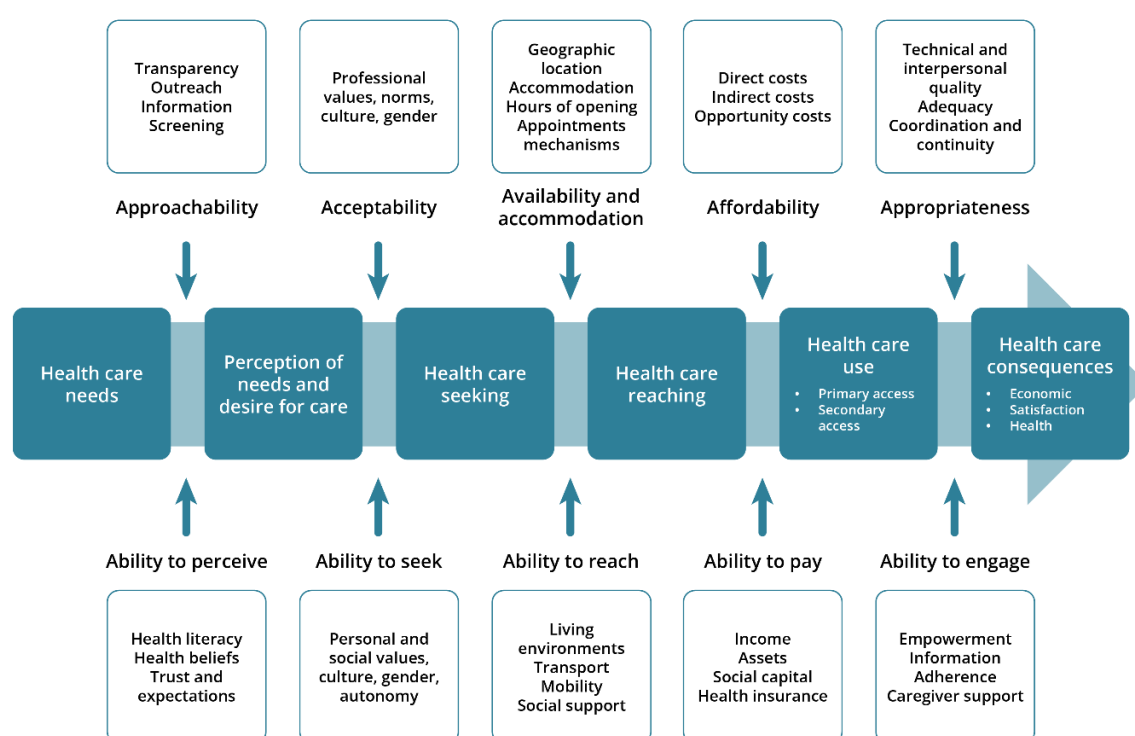
- Andersen's behavioural model of health service use (Andersen 2008; Artuso et al. 2013; Lederle et al. 2021; Travers et al. 2020)
- ecological models (Akbar et al. 2020; Kennedy et al. 2021; O'Keefe et al. 2022).

Both of these models are also valid, and there is a great deal of overlap in the key concepts across all 3 conceptual frameworks. Levesque's model (Figure 2.1) was selected for this report as being the most useful from a practical perspective because of how it highlights the decision points along the way – from identifying a health care need through to using health

care (and then the potential impact the experience of using that care has on a person's health status and future health care use). Their work also provide examples of the details underpinning each of the concepts visually within the Framework.

The Framework shows that there are a range of systemic characteristics that can help to facilitate or hinder access to and use of health care, and that they may affect different points along the pathway. These include being approachable, acceptable, available, affordable and appropriate. Characteristics that indicate an individual's ability to interact with health care include the ability to perceive, seek, reach, pay and engage with health care, and there is interaction between the individual and systemic factors (Millar et al. 2023).

Figure 2.1: Model of health service access



Source: Levesque et al. 2013.

From a practical perspective, according to the Framework, in order for a person to get to the point of using health care:

- a health care need must exist (which could be as diverse as an injury, symptoms of an acute or chronic illness, chronic disease management items such as blood tests, being due for preventive care measures, and so on)
- the person must both perceive that this need exists and want to access care to resolve it (which may be affected by their and their community's previous experiences with health care)
- if the person does want to seek care, they need to know where and how to access it (Do they ring to make an appointment? Do they need a referral?)

- the person then needs to be able to access that health care – logistically and financially (while this includes transport, it also includes other aspects such as whether the person is able to get time off work or whether child care is available if needed)
- if the person is then able to use that health care when needed, the expectation is that there will be improvements in health. Although presented as a linear process, the person's experience with that care may also influence if/when/how they seek care in the future.

These 5 stages are affected by a person's individual and family circumstances as well as by the ways in which the health system itself is structured. For example, health promotion activities can make people aware of the need for preventive health care as well as how to access it, while health care costs are affected by government policies and funding. Individuals' health literacy, beliefs, and previous experiences with the health system can affect both how the person defines their own health needs and the type of health care they would prefer to attend. As originally conceived, the individual and system factors are paired at each point.

While the Framework was developed from a mainstream perspective, the key elements are applicable to Aboriginal and Torres Strait Islander people (with some adjustments and added perspectives). In 2016, Davy and colleagues used the Framework to guide their review and synthesis of literature on Aboriginal and Torres Strait Islander people's access to Aboriginal and Torres Strait Islander primary health care services, adding insights into the ways in which the individual and systemic factors operated as barriers or facilitators in each of the 5 stages (Davy et al. 2016).

These authors recommended 2 changes to the Framework – explicitly including the broader health system that sits behind and influences the local health care available to people in their own communities, and redrawing the Framework to make it clear that there are interactions between individual and systemic factors at all 5 stages. For example, their review found that some of the systemic factors (such as cost) have an effect throughout the stages, not just at the point of 'affordability'. In other words, there were not any issues with the elements themselves, but more with how they were defined for Aboriginal and Torres Strait Islander people and how they interact.

Another expansion of the Framework was recently published by Szymczak et al. (2023), with an explicit focus on the dynamic nature of the 5 stages along the primary health care pathway and the impact of systemic factors. Their framework (which was done for the United States) has been adapted to illustrate the key factors for Aboriginal and Torres Strait Islander people.

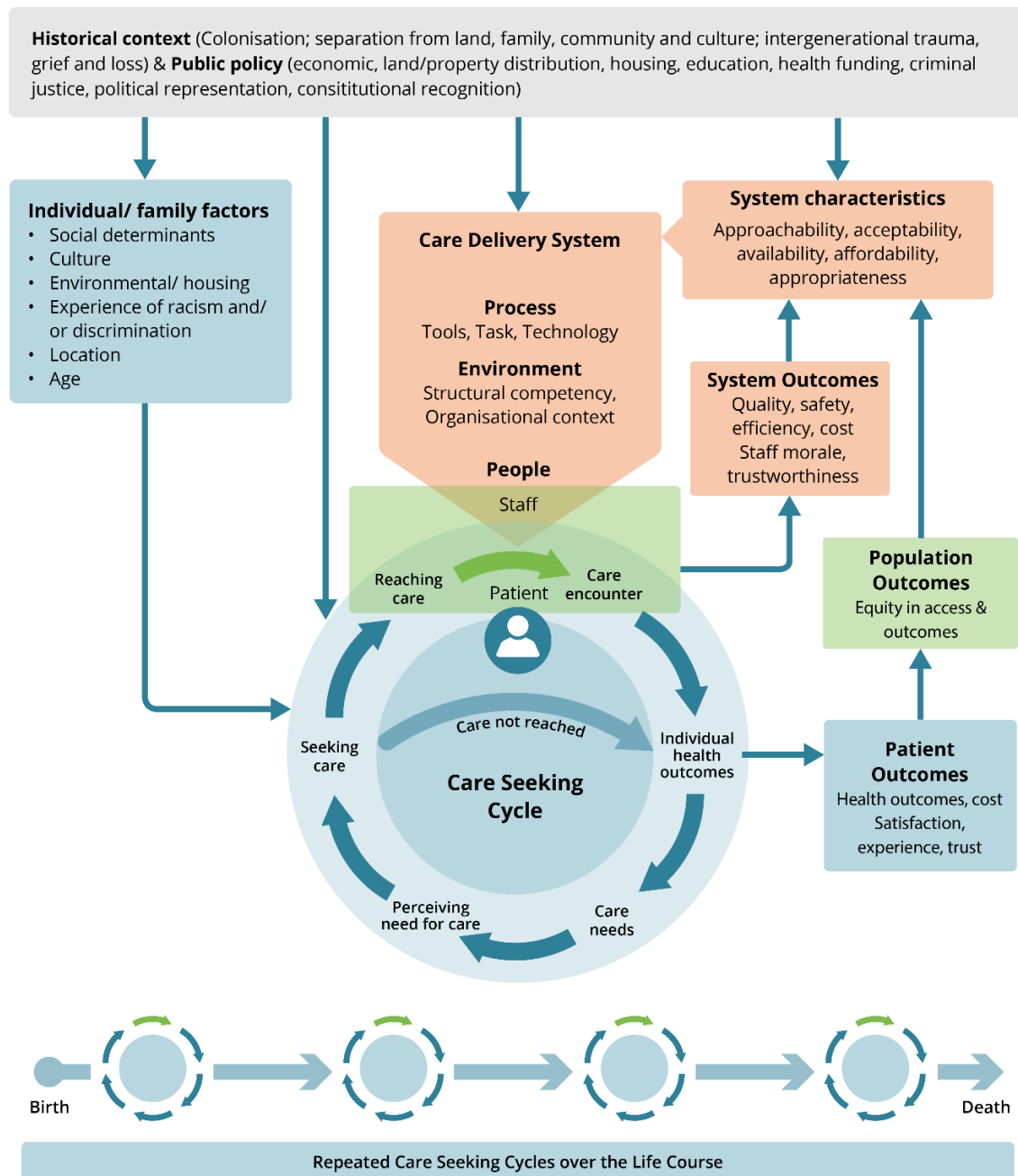
Figure 2.2 highlights that access to and use of primary health care is an ongoing process throughout a person's life. Although these cycles are experienced by individuals, the aggregate effect of them can affect population health outcomes. The model developed by Szymczak and colleagues also illustrates that, on the ground, each episode of health care use involves an interaction with a person, not just a system. The care-seeking cycle also shows that, on some occasions, care is not reached (that is, a person was unable to get the care they needed).

Further, Figure 2.2 shows that all 5 stages of the process along the primary care pathway are affected by broader social, historical, economic, and cultural contextual factors which in turn affect individuals' own health, health behaviours, access to resources, and health service use (or non-use).

For Aboriginal and Torres Strait Islander people, discussions of health status/health needs and the other stages in the health care journey cannot be separated from the historical and policy context. The long-term effects of colonisation and its ongoing impact on matters such as self-determination, the disruption of ties to land, and the adverse impact of direct and

systemic racism (Osborne et al. 2013; Reading and Wien 2009; Thurber et al. 2021) all continue to have an impact on Aboriginal and Torres Strait Islander people's health and wellbeing. Experiences of racism and discrimination within the health system and by individual health workers make people less able or willing to engage with the system (Baillie et al. 2015; Baker et al. 2021; Li 2017; McInman 2000).

Figure 2.2: Process model of health care access, quality and safety



Source: Adapted from Szymczak et al. 2023.

How do these factors affect the use of primary health care services?

Individual and family level factors and experiences

A recent review of the literature on the cultural determinants of health for Aboriginal and Torres Strait Islander people showed that family/community, country and place, cultural identity and self-determination all have strong protective effects on health and wellbeing (Verbunt et al. 2021).

The link between self-reported perceptions or experiences of racism and poorer physical and mental health is well established (Kelaheer et al. 2014). Racism can lead to reduced access to resources that are associated with good health outcomes, such as education, employment, housing and medical care. Studies have also found a strong association between experiences of racism and ill-health, psychological distress, mental health conditions and risk behaviours such as substance use (Paradies et al. 2015; Priest et al. 2011).

The Mayi Kuwayu Study of Aboriginal and Torres Strait Islander Wellbeing contained a number of questions about respondents' experiences of everyday discrimination, with 42% reporting no discrimination, 48% low discrimination and 11% moderate to high discrimination (Thurber et al. 2021). Those who reported no discrimination experienced better overall health; however, the authors found statistically significant associations between experiences of everyday discrimination and poorer outcomes across several domains, including:

- social and emotional wellbeing (SEWB) outcomes – frequent experience of pain, low life satisfaction, low happiness, high or very high psychological distress, doctor-diagnosed anxiety, doctor-diagnosed depression
- culture and identity outcomes – feeling low control over life; feeling torn between cultures; feeling disconnected from culture; choosing not to identify as Aboriginal and/or Torres Strait Islander in the Census, or within study, work, Centrelink, or real estate contexts
- health behaviours – smoking, gambling, alcohol dependence
- health outcomes – poor/fair general health, doctor-diagnosed heart disease, high cholesterol, high blood pressure, diabetes.

A number of studies have shown that experiences of racism in the health system also led to delays in seeking and receiving health care (Aspin et al. 2012; Baba et al. 2014; Ben et al. 2017; Durey and Thompson 2012).

Socioeconomic factors can affect health and health status in a number of ways, including through access to financial and social resources, psychosocial factors and health behaviours. A recent AIHW analysis indicates that social determinants of health explain 35% of the total health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, with household income and employment/hours worked explaining 14% and 13% of the gap, respectively (AIHW 2024b). Higher levels of income are associated with higher levels of health service use and with better overall health (AIHW 2023a; Ou et al. 2010, 2011).

Location factors

There are variations across Australia in the location of health services, so where people live affects how easy or difficult it is to access services in general (and timely, affordable and culturally responsive services in particular).

Modelling of how Aboriginal and Torres Strait Islander people's local access to Aboriginal and Torres Strait Islander specific PHCOs varies geographically across Australia found that this type of care appears to be well positioned relative to the geographic distribution of the Aboriginal and Torres Strait Islander population (AIHW 2023a); however, it also identified 29 medium-sized areas estimated to have at least 200 Aboriginal and Torres Strait Islander people who had no Aboriginal and Torres Strait Islander specific PHCO available within a 1-hour drive and relatively poor access to GP services in general. Lack of access to transportation has also been reported as a significant barrier to accessibility of care (Nolan-Isles et al. 2021).

Health system characteristics

The health system includes several levels – the individual workers with whom Aboriginal and Torres Strait Islander people engage, the characteristics of the organisation/facility, and higher level policy/funding requirements.

How the health system is funded (and subsequent costs to patients/clients), where services and providers are located, and the capacity of local providers to deliver culturally responsive and appropriate care directly affects the ability of Aboriginal and Torres Strait Islander people to access and use that care (Coombes et al. 2018; Pearson et al. 2020). For example, Beks and colleagues (2023) found that ACCHOs are often constrained from being responsive to local community needs by systemic rules. When an organisation wanted to implement a mobile clinic, one of the challenges was that MBS home care items could not be used to pay for visits because of the MBS funding rules for that item.

There is considerable evidence on systemic factors that affect not only the ability of Aboriginal and Torres Strait Islander people to access primary health care but also the ways in which the system can be more responsive in delivering health care to Aboriginal and Torres Strait Islander people. Nolan-Isles et al. (2021) identified 6 themes across 3 communities as being of critical importance (as either opportunities or barriers) – which are consistent with the findings of other studies (for example, Coombes et al. 2018). These themes were:

- improved coordination of health care
- better communication between providers and patients
- trust in providers and cultural safety
- importance of prioritising health care by Aboriginal and Torres Strait Islander people
- importance of reliable, affordable and sustainable care
- distance and transport availability.

It is important to note that ACCHOs in particular (Box 2.1) and other IAHP-funded services were developed and are funded to tackle these issues specifically.

Box 2.1: Role of ACCHOs

ACCHOs are primary health care services operated by local Aboriginal and Torres Strait Islander communities, and controlled through locally elected boards. They deliver comprehensive, holistic and culturally appropriate health care to their communities, particularly in areas where mainstream health services have failed to engage and empower their communities. The first ACCHO opened in Sydney in 1971; now there are over 140 ACCHOs operating more than 300 clinics across Australia (NACCHO 2024).

Over half of the full-time equivalent positions (FTEs) in the ACCHOs who reported to the 2022–23 OSR were Aboriginal and Torres Strait Islander people, making ACCHOs collectively one of the largest employers of Aboriginal and Torres Strait people in Australia.

ACCHOs respond to the health-care needs of Aboriginal and Torres Strait Islander people in a variety of ways; for example by:

- delivering culturally meaningful chronic disease care that other models of primary care do not (Wyber et al. 2023)
- providing specialised clinical care to Aboriginal and Torres Strait Islander people for conditions that are uncommon in other populations in Australia
- promoting the psychosocial health and wellbeing within the community.

ACCHOs also directly and indirectly respond to the social determinants of health, and drive change, such as by:

- reducing institutional racism
- meeting the social and cultural needs of their communities
- reducing inequities that disadvantage Aboriginal and Torres people
- providing training for Aboriginal and Torres Strait Islander staff to obtain qualifications (Pearson et al. 2020).

Having the option of attending ACCHOs is important to Aboriginal and Torres Strait Islander people who feel more comfortable using services where culturally safe care is delivered (Pearson et al. 2020), where they can talk to health professionals who understand that health is not only about physical health but a ‘whole-of-person’ concept, and where they have access to health providers who are themselves Aboriginal and Torres Strait Islander people (NACCHO 2021).

Through its focus on prevention, early intervention and comprehensive care, ACCHOs have reduced barriers to access health care and are improving individual health outcomes for Aboriginal and Torres Strait Islander people (Panaretto et al. 2014). During the COVID-19 pandemic, responses by Aboriginal and Torres Strait Islander communities were commended worldwide as a demonstration of how self-determination can achieve optimal health outcomes for Indigenous populations (Dudgeon et al. 2023).

For more details on the model of Aboriginal and Torres Strait Islander Community Controlled Comprehensive Primary Health Care, see NACCHO’s *Core Services and Outcome Framework* (NACCHO 2021).

The following section of this chapter provides an overview of the variables selected from the 2018–19 NATSIHS. It begins by outlining the ‘outcome’ variables (primary health care variables), before presenting a detailed discussion of the independent variables and their distributions (the distribution of the primary health variables are presented in Chapter 3).

Primary health care variables

The conceptual framework and literature review highlighted the multi-faceted nature of primary health care use (and non-use). Fifteen different primary health care variables were selected from the 2018–19 NATSIHS for the descriptive analysis. These range from a respondent's preferences and the availability of services in their local area, to their usual source of care/continuity of care, recency of primary health use (GPs and dental), experiences with the health-care system, and the level of unmet need for GP and dental services in the past 12 months.

The focus on timing of service use and unmet need in these analyses is for GPs and dentists as there are population-wide best practice guidelines around seeing a GP (such as at least once a year for a health check) and seeing a dentist (at least once a year for cleaning/a check-up).

Ten of the variables are available nationally (Table 2.1), while 5 of the variables were asked only of those in non-remote areas (Table 2.2).

Table 2.1: Included primary health variables and responses (national)

Concept	Variable(s)	Responses
Availability	Perceived availability of types of health care in the local area	AMS/CC; doctor/GP other than from AMS or hospital (mainstream GP); ²⁶ hospital; traditional healer; other
Preferences	Preferred source of health care	AMS/CC; mainstream GP; hospital; traditional healer; other
Usual provider type	Usual source of health care	AMS/CC; mainstream GP; hospital; traditional healer; other; none
Continuity of care	Always goes to the same health-care provider	Yes; no; no usual provider
Service use/non-use (GP)	Timing of most recent visit to a GP	<3 months; 3 months to <6 months; 6 months to <12 months; more than 12 months ago; don't know; never consulted a GP
Service use/non-use (dental)	Timing of most recent dental visit	<6 months; 6 months to <12 months; 12 months to <2 years; more than 2 years ago; don't know; never
Unmet need for GP	Any occasion when the respondent did not go to a GP when needed in the past 12 months	Yes; no; not applicable
Reasons underpinning unmet need for GP	Reasons why respondent did not go to a GP when needed in the past 12 months (respondents could select more than one)	Cost Waiting time too long or not available at time required Transport/distance Not available in area Discrimination Service not culturally appropriate Language problems Dislikes (service/professional, afraid, embarrassed) Felt it would be inadequate Does not trust the GP Too busy (including work, personal, family responsibilities) Decided not to seek care Other
Unmet need for dental services	Any occasion when the respondent did not attend a dental service when needed in the past 12 months	Yes; no; not applicable
Reasons underpinning unmet need for dental service	Reasons why respondent did not go to a dental service when needed in the past 12 months	Same as reasons underpinning unmet need for GP (see above)

²⁶ Mainstream GP will be used as the term throughout this report.

Table 2.2: Included primary health variables and responses (non-remote only)²⁷

Concept	Variable(s)	Responses
Experiences with GP(s)	In the past 12 months, how often did your GP(s): • listen to you • explain things in a way that you could understand • show respect for what you had to say • spend enough time with you	Always; usually; sometimes; rarely; never Only asked of those aged 15 and over answering for themselves
Rating of health care received	Overall, how good was the health care you got from GPs and health services in the last 12 months?	Excellent; very good; good; fair; poor Only asked of those aged 15 and over answering for themselves
Financial costs	Had to pay any money for seeing a: • GP • specialist • other health care provider²⁸ • at the most recent consultation in the past 2 weeks	Yes; no; don't know
Unfilled prescriptions	Any times in the past 12 months when respondent had a script that did not get filled	Yes; no; don't know
Reasons underpinning unfilled prescriptions	Reasons why prescription was not filled (respondents could select more than one)	Cost Transport issues Lost the prescription Decided didn't need it Didn't want to Too busy Other

Independent variables

Four domains (or sets of variables) were selected from the 2018–19 NATSIHS as the core independent variables (Table 2.3):

- demographic/location factors (for example, age, sex, remoteness, state/territory, Socio-Economic Indexes for Areas (SEIFA))
- socioeconomic/social capital (for example, equivalised income, financial stress, education, employment status)
- cultural factors/experiences of unfair treatment (for example, language spoken at home, cultural identification, experiences of racism/discrimination)
- health status/disability (for example, perceived health status, presence of particular conditions such as diabetes or mental health conditions, comorbidities).

²⁷ Because of small numbers, only high-level data are presented on these outcomes. We also examined whether there were differences by usual source of care and present these results where there are differences.

²⁸ Costs for GPs and specialists were asked only of respondents in non-remote areas, while the costs for 'other health professionals' were asked of all respondents. For the sake of consistency, we have included only the results for those in non-remote areas.

Table 2.3: High-level overview of independent variable domains and specific variables, 2018–19

Domain	Included variables	
Demographic and location factors	Sex	Remoteness
	Age	State/territory
	SEIFA quintile	
Socioeconomic and social capital	Equivalised household income	Financial stress
	Private health cover (non-remote)	Highest level of school completed ^(a)
	Non-school qualifications ^(a)	Labour force status ^(a)
	Housing tenure	
Cultural factors/experiences of unfair treatment	Language spoken at home	Satisfaction with own knowledge of culture ^(b)
	Identifies with a tribal group, language group or clan ^(b)	Whether experienced unfair treatment in the past 12 months ^(c)
Health and disability status	Self-assessed health ^(a)	Psychological distress (K5) ^(d)
	Any current or long-term health condition(s)	Presence of specific long-term health conditions (for example, asthma, diabetes)
	Aggregated long-term condition types (chronic disease; chronic respiratory condition; musculoskeletal conditions)	Whether has disability
	Main disability type	Disability status

(a) All people aged 15 and over.

(b) People aged 18 and over who were physically present at the time of the interview.

(c) People aged 15 and over who were physically present at the time of the interview. At the national level, the setting in which the unfair treatment took place and an additional variable (whether the respondent avoided certain situations because of past experiences of racism/discrimination) were also looked at. Because of small numbers, only the experienced/didn't experience unfair treatment variable is included in the descriptive analyses because of small numbers in the sub-categories.

(d) K5 = Kessler Psychological Distress Scale.

Distribution of independent variables by domain

Demographic/location factors

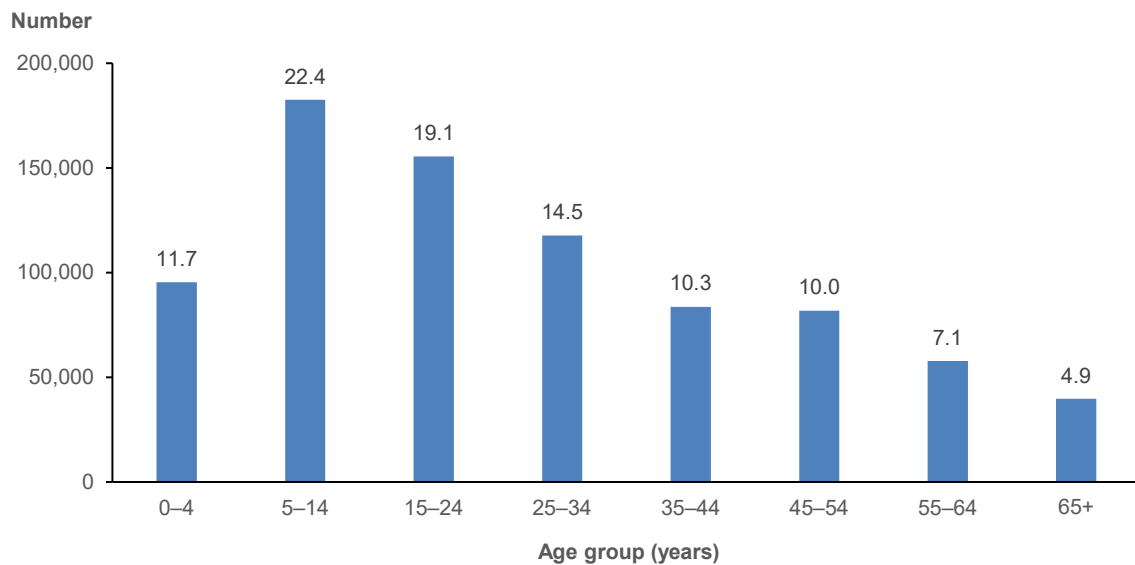
Five variables were included which capture respondents' sex, age, remoteness category, state/territory, and SEIFA quintile (which is a marker of area-level socioeconomic advantage/disadvantage) (Appendix 2, Table A2.1).

Use of primary health care tends to be higher among females than males. The data show that 51% of respondents were females (413,100) and 49% were males (400,900).

Patterns of the need for, and use of, primary health care also vary by age. Very young children, females of childbearing age, and the elderly have both the highest health needs and usage patterns. Health needs for very young children include a mix of acute and preventive care services (such as developmental health checks) while health needs among older age groups include acute, preventive and chronic disease management care.

Figure 2.3 highlights the young age distribution of the population, with more than 50% aged 0–24, and fewer than 5% aged 65 and older.

Figure 2.3: Distribution of Aboriginal and Torres Strait Islander population, by age, 2018–19

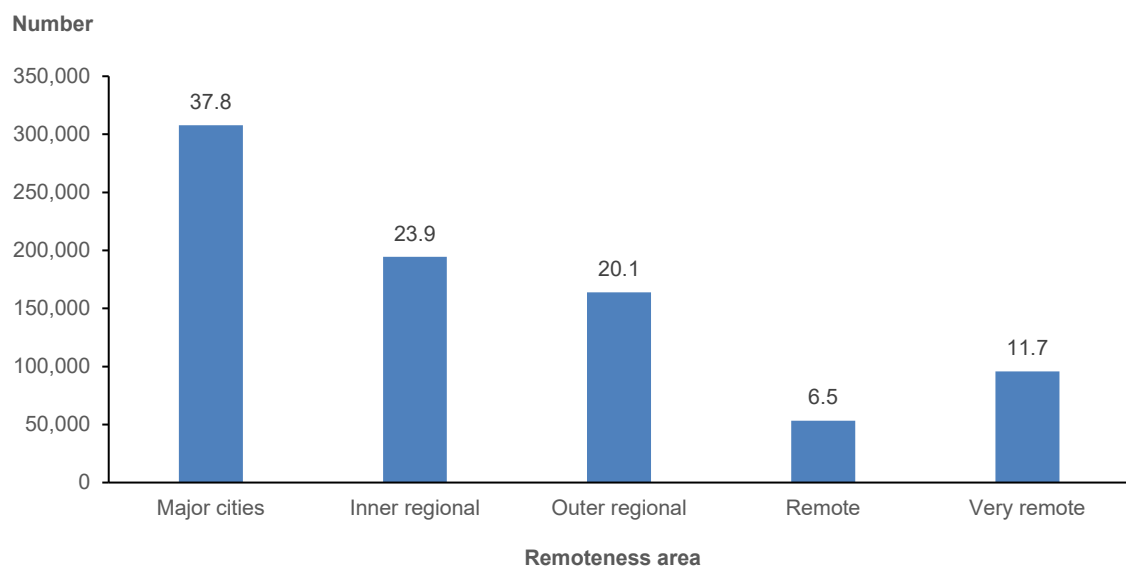


Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Previous research has shown that there is a strong association between remoteness and health service availability, social determinants, and health status among Aboriginal and Torres Strait Islander people (AIHW 2023a). It is important to note, however, that Aboriginal and Torres Strait Islander people living in more urban areas also have barriers to accessing primary health care, but the nature of some of these barriers differs from those in more remote areas (Scrimgeour and Scrimgeour 2007). As shown in Figure 2.4, more than 50% of people lived in *Major cities* or *Inner regional* areas, while 6.5% lived in *Remote* areas and 12% in *Very remote* areas.

Figure 2.4: Distribution of Aboriginal and Torres Strait Islander population, by remoteness, 2018–19

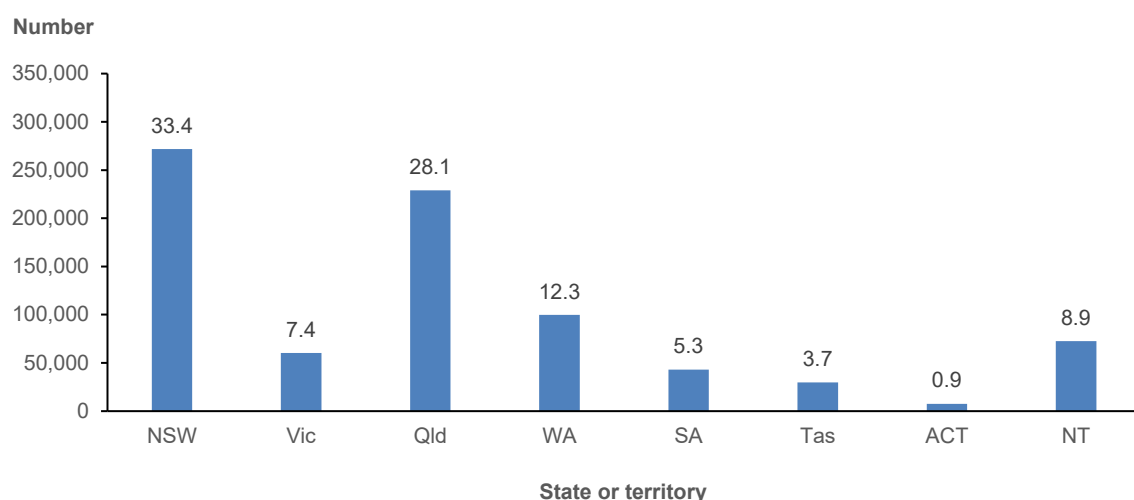


Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

The largest number of Aboriginal and Torres Strait Islander people lived in New South Wales, followed by Queensland, Western Australia and the Northern Territory. Fewer than 1% lived in the Australian Capital Territory and fewer than 4% in Tasmania (Figure 2.5).

Figure 2.5: Distribution of Aboriginal and Torres Strait Islander population, by state/territory, 2018–19

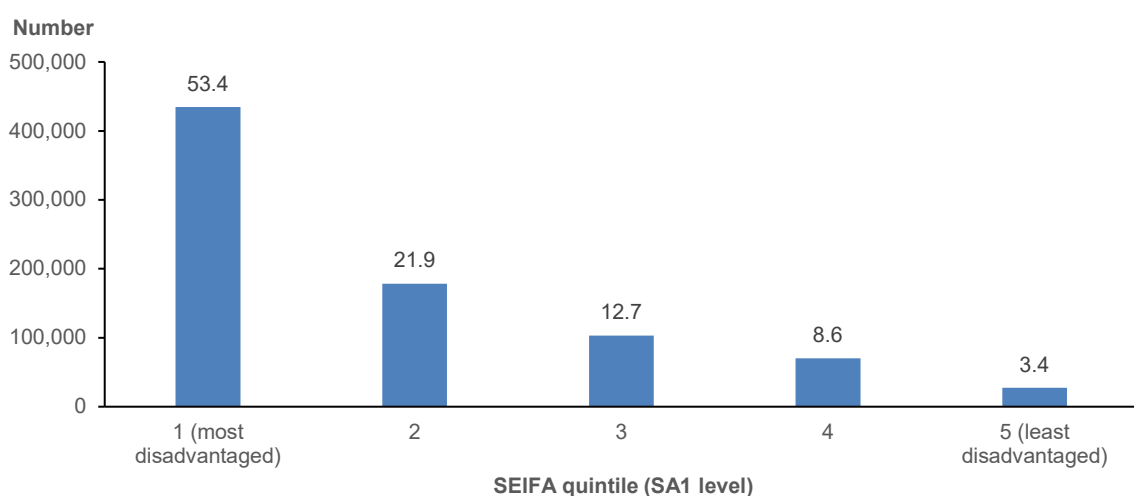


Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

The distribution of area-level SEIFA shows that over half of Aboriginal and Torres Strait Islander people lived in areas (Statistical Area 1 [SA1]) with the highest levels of disadvantage and fewer than 5% lived in areas that were the least disadvantaged (Figure 2.6). (Note that SEIFA is a contextual variable – it does not mean that everyone who lives in areas with the same SEIFA score are equally advantaged or disadvantaged.) Previous research has shown associations with a range of social determinants and health service availability measures, and there is a relationship between SEIFA and life expectancy (Zhao 2015).

Figure 2.6: Distribution of Aboriginal and Torres Strait Islander population, by SEIFA quintile, 2018–19



Note: The numbers above the column bars are percentages.

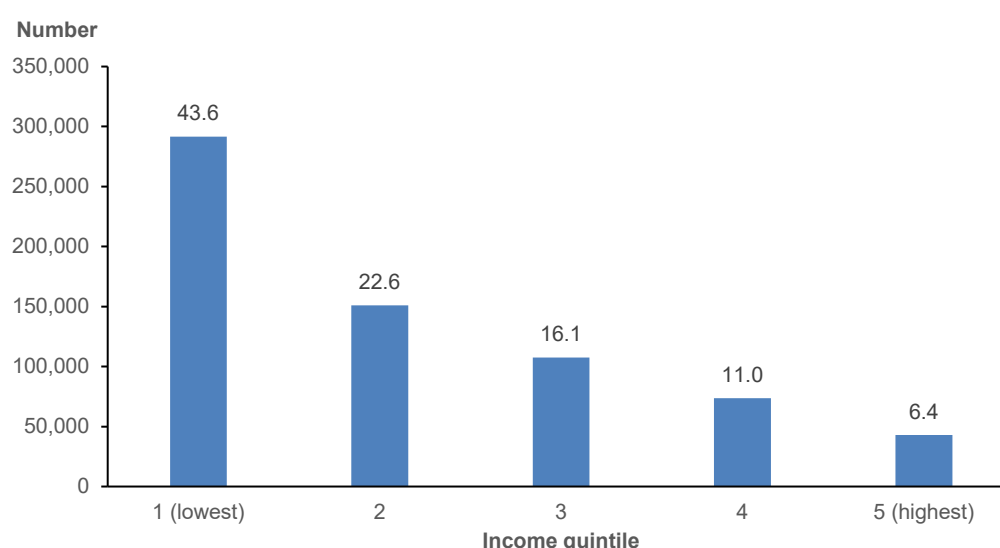
Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Socioeconomic/social capital

As discussed previously, socioeconomic and social capital can be either a protective factor for health and health service use or pose risks, with those people with fewer resources likely to both have higher needs and lower access to health services. The set of included socioeconomic and social capital variables reflects people's current financial circumstances and labour force status and their most recent educational attainment/qualifications (Appendix 2, Table A2.2).

Consistent with the area-level SEIFA measures, the individual/family measures of income and financial circumstances suggest a high level of financial vulnerability. Just under half (45%) of Aboriginal and Torres Strait Islander people would be able to raise \$2,000 in an emergency, over 60% had days without money for basic living expenses in the past 12 months, and only about a fifth of those in *Major cities* and regional areas had private health cover. When family income is considered, just over 65% had equivalised income in the lowest 2 quintiles (bottom 40%) (Figure 2.7).

Figure 2.7: Distribution of equivalised annual household income among Aboriginal and Torres Strait Islander people, 2018–19

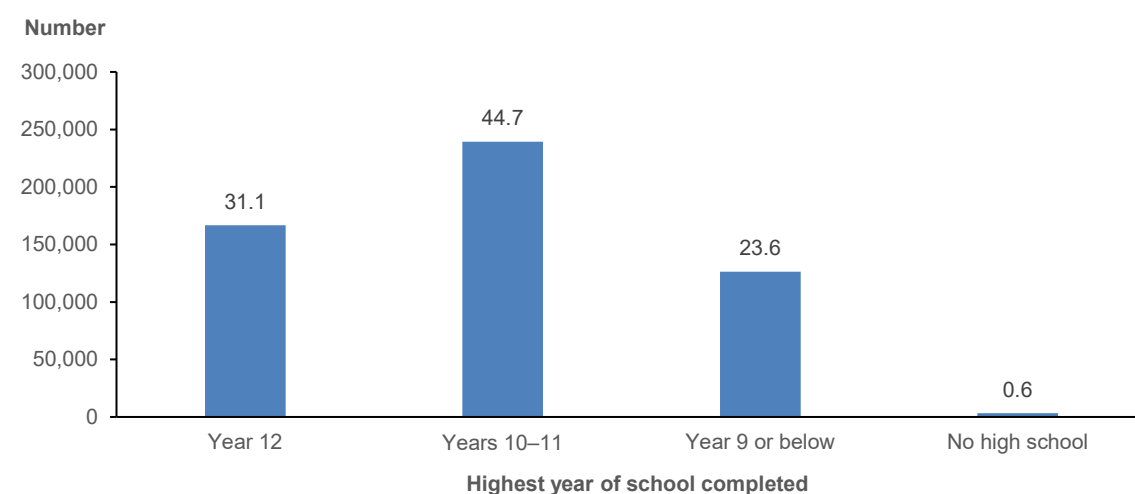


Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Educational attainment is closely linked with economic opportunities as well as with health literacy and protective health behaviours. Just over 30% of Aboriginal and Torres Strait Islander adults had completed year 12 (Figure 2.8), while nearly half (48% or 258,800) had a non-school qualification (post school qualification).

Figure 2.8: Distribution of highest year of school completed among Aboriginal and Torres Strait Islander people aged 15 and over, 2018–19



Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

These numbers shown in Figure 2.8 are likely to be higher in the next NATSIHS, as high school attainment has been increasing over time.

In terms of labour force status, 46% of Aboriginal and Torres Strait Islander people aged 15 and over were currently working full time or part time. About 29% were living in homes that were owned/mortgaged (235,700), with another 557,900 respondents living in rental accommodation (69%).

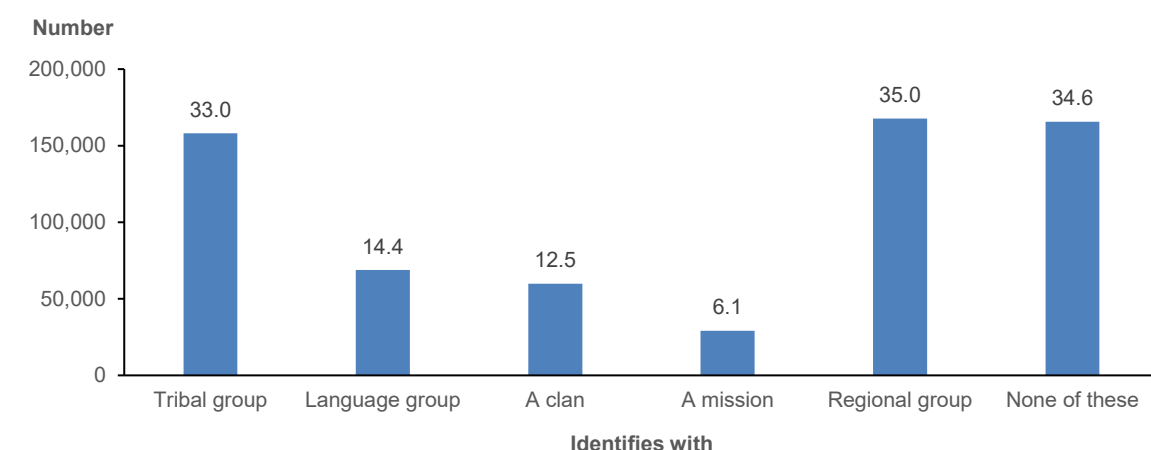
Cultural factors/experiences of unfair treatment

As noted previously, cultural identification, engagement and participation are protective factors for Aboriginal and Torres Strait Islander people. It may also affect their preferences for type of health care (such as preference for an ACCHO).

Two cultural identification and 2 language variables were selected for initial inclusion (see Appendix 2, Table A2.3). Several other cultural identification variables in the NATSIHS were asked only of those in non-remote areas, so were not included.

Identification with tribal group, language or group or clan variable was asked of all respondents aged 18 and over, and respondents could choose multiple responses (Figure 2.9). Of an estimated 479,000 Aboriginal and Torres Strait Islander adults, 313,400 (65%) identified at least one tribal group, language group, clan, mission or regional group. Respondents could tick as many categories as applied to them, and the categories with the highest responses were regional group and tribal group.

Figure 2.9: Aboriginal and Torres Strait Islander people aged 18 and over, by cultural identification, 2018–19



Notes

1. Respondents could select multiple responses.
2. The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

The second included item asked those aged 18 and over the extent to which they were satisfied with their own knowledge of culture, with 55% reporting they were satisfied or very satisfied with their own knowledge of culture, and 25% being not satisfied.

Two questions on language were included – main language spoken at home and, for those who spoke an Indigenous or other language at home, the extent to which they spoke English well. The data show that the main language spoken at home was English for 91% of respondents, with 8.4% speaking an Indigenous language as their primary language. The benefits of being able to speak a traditional language are well established; among those speaking an Indigenous language at home, the majority also reported being able to speak English well. Around 12,000 respondents in *Remote* and *Very remote* areas did not speak English well – they may be at risk of service access issues unless the primary health services are able to provide information and care either in language or through interpreters.

Experiences of unfair treatment

As discussed earlier, exposure to racism and discrimination poses risks to Aboriginal and Torres Strait Islander people's physical and mental health and affects all aspects of life (such as educational attainment, employment, and access to and use of health services).

Respondents aged 15 and over who were physically present at the time of the interview were asked whether they had experienced unfair treatment in the past 12 months because they were Aboriginal or Torres Strait Islander. The data showed that 116,200 people (23% of those with a response) did experience unfair treatment.

The most frequently cited type of unfair treatment was hearing racial comments or jokes, followed by being ignored or served last while accessing services or buying something and being called names, teased or sworn at (Figure 2.10).²⁹

²⁹ While the numbers were too small to look at the impact of each individual type of experience, situation, and whether people avoided situations because of unfair treatment, we have presented these here for context and to highlight their importance. Only the broad indicator of whether someone experienced unfair treatment was included in the analyses.

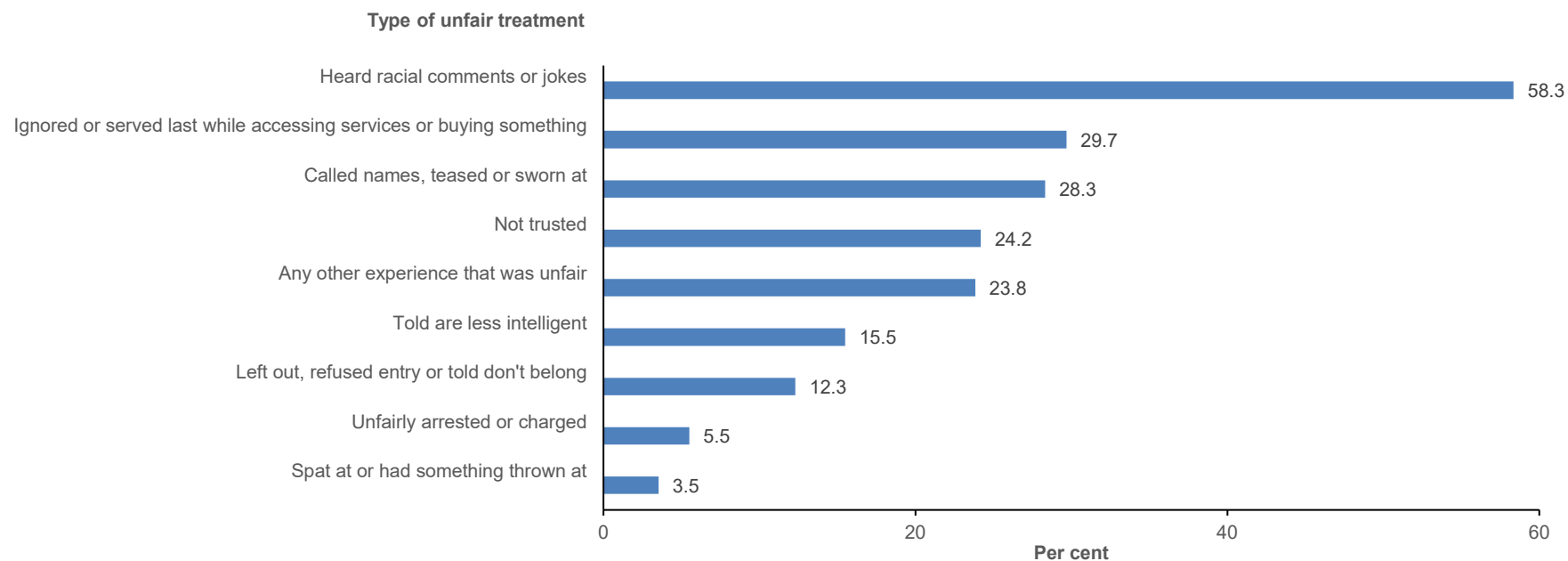
Although for 45% (53,000) of those who had experienced unfair treatment in the past 12 months it had only happened once or rarely, for another 20% it happened often or always (22,000).

The most frequent experiences of unfair treatment were by members of the public, and when either applying for work or at work. Unfair treatment by doctors, nurses or other staff at hospitals or doctors' surgeries was experienced by 5,900 respondents (highlighted in green) (Figure 2.11).

Avoiding situations because of past unfair treatment is another example of the long-term impact of exposure to discrimination and racism. Nearly 70,000 of those responding to the question (14%) reported that they had avoided situations in the past 12 months because of previously experiencing unfair treatment.

Among those who had avoided situations in the past 12 months, applying for work or going to a job and members of the public were the most frequently avoided situations (Figure 2.12). Nearly 13% reported avoided doctors, nurses or other staff at hospitals or doctors' surgeries (highlighted in green, 8,900 respondents).

Figure 2.10: Types of unfair treatment experienced in the past 12 months among Aboriginal and Torres Strait Islander people aged 15 and over who had experienced at least one incident of unfair treatment (n=116,200), 2018–19

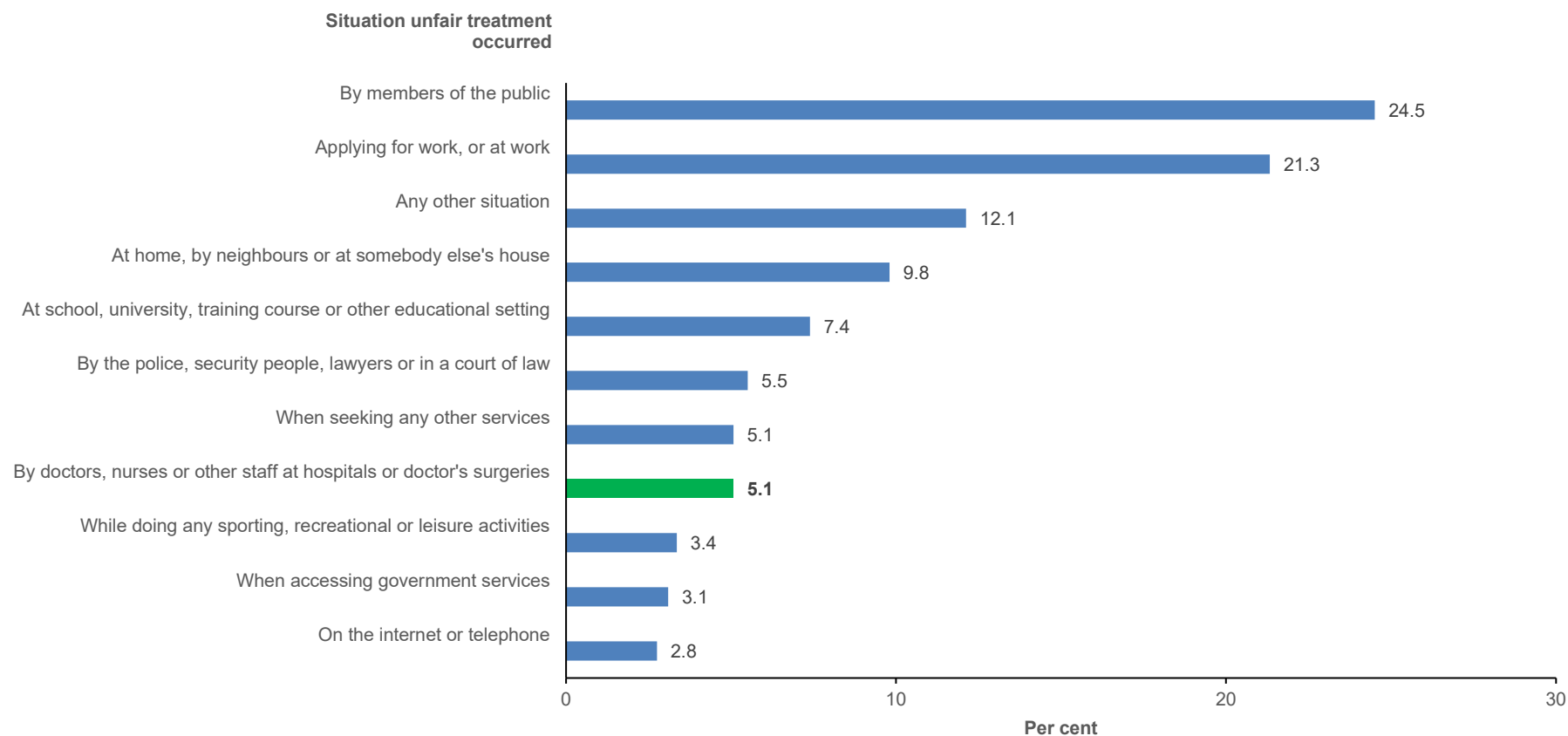


Notes

1. Only includes those aged 15 and over who were physically present at the time of the interview.
2. Respondents were asked to tick all the types they had experienced.
3. The numbers beside the bars are percentages. Percentages based only on those who reported that they had experienced at least one incident in the past 12 months.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Figure 2.11: Situation in which the most recent experience of unfair treatment occurred, among Aboriginal and Torres Strait Islander people aged 15 and over who had experienced at least one incident in the past 12 months (n=116,200), 2018–19

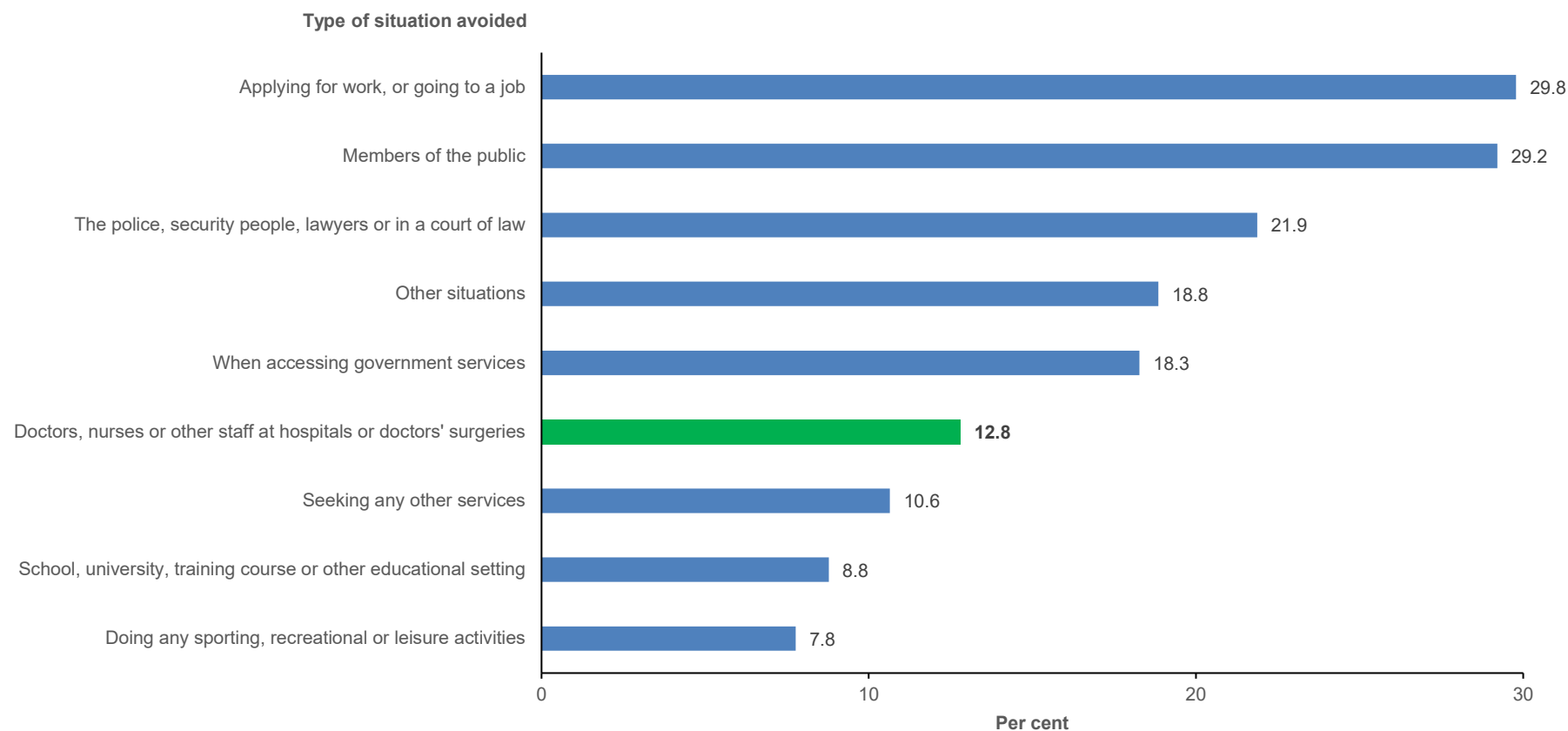


Notes

1. Only includes those aged 15 and over who were physically present at the time of the interview.
2. Respondents were asked to tick all the types they had experienced.
3. The numbers beside the bars are percentages. Percentages based only on those who reported that they had experienced at least one incident in the past 12 months.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Figure 2.12: Type of situation(s) avoided among Aboriginal and Torres Strait people aged 15 and over who avoided a situation due to unfair treatment in last 12 months (n=69,700), 2018–19



Notes

1. Only includes those aged 15 and over who were physically present at the time of the interview.
2. Respondents were asked to tick all the situations that they had avoided.
3. The numbers beside the bars are percentages. Percentages based only on those who reported that they had avoided at least one situation in the past 12 months.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Health/disability status

For Aboriginal and Torres Strait Islander people, health is a multidimensional concept (Dudgeon et al. 2014; Gee et al. 2014) and is directly affected by the other 3 domains (demographic/location factors, social determinants and social capital, and cultural factors).

For this project, several variables were selected that capture different aspects of health:

- self-assessed health status
- level of psychological distress as measured by the K5, a subset of the Kessler Psychological Distress Scale –10 (K10) which was developed with Aboriginal and Torres Strait Islander stakeholders in 2003 (Brinckley et al. 2021)
- whether the respondent has any ongoing or long-term health conditions and the proportion of respondents who have specific conditions
- the proportion of respondents with chronic conditions, musculoskeletal conditions and respiratory conditions.

We have also included variables on whether respondents have disability and, if so, the type and the status (impact) of that disability (see Appendix 2, Table A2.4 and Table A2.5).

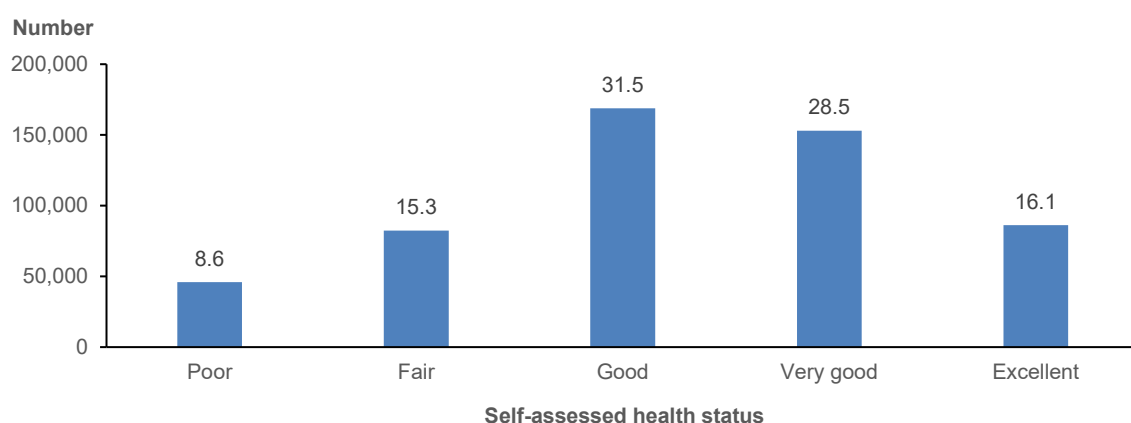
Health and disability status are associated with the need for primary health care (and the types/frequency of particular services). For example, best practice guidelines for those people with type 2 diabetes recommend relatively frequent contact with a wide range of primary and allied health care services to effectively manage and monitor their illness, such as GPs, practice nurses and Aboriginal Health Workers/practitioners as well as dieticians and podiatrists.

Health status can also affect a person's ability to access the services they need, with previous research showing that those with chronic conditions often have difficulties accessing care (Baillie et al. 2015; Coombes et al. 2018).

Self-assessed health status

Around 60% of those aged 15 and over say their health is either good or very good (321,800), and the proportion who self-identify as having excellent health is nearly twice that of those reporting that their health is poor (16% versus 8.6%; 86,300 people compared with 46,000) (Figure 2.13).

Figure 2.13: Distribution of self-assessed health status, Aboriginal and Torres Strait Islander people aged 15 and over, 2018–19



Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

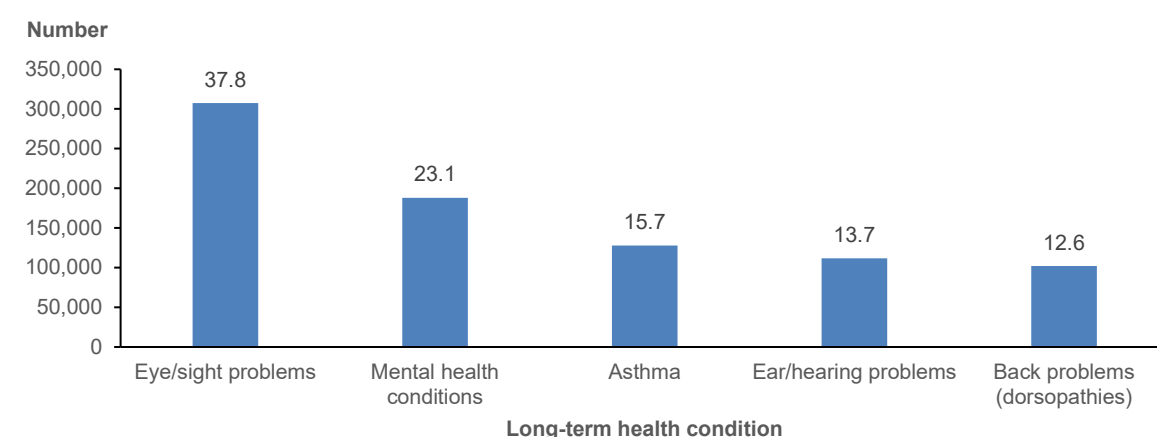
Psychological distress

The significance of psychological wellbeing/distress is also highlighted in the results from the K5, which shows that around one-third (32%, 149,400) of adult respondents with valid responses had high or very high levels of psychological distress, with 322,400 having low or moderate scores (68%).

Current and long-term health conditions

According to the responses to the 2018–19 NATSIHS, just under 60% of Aboriginal and Torres Strait Islander people (483,500) had at least one current and long-term health condition. Eye/sight problems were reported most often, followed by mental health conditions, asthma and ear/hearing problems (Figure 2.14).

Figure 2.14: Presence of specific long-term health conditions among Aboriginal and Torres Strait Islander people, 2018–19



Notes

1. Respondents could tick as many conditions as applicable.
2. The numbers above the column bars are percentages.

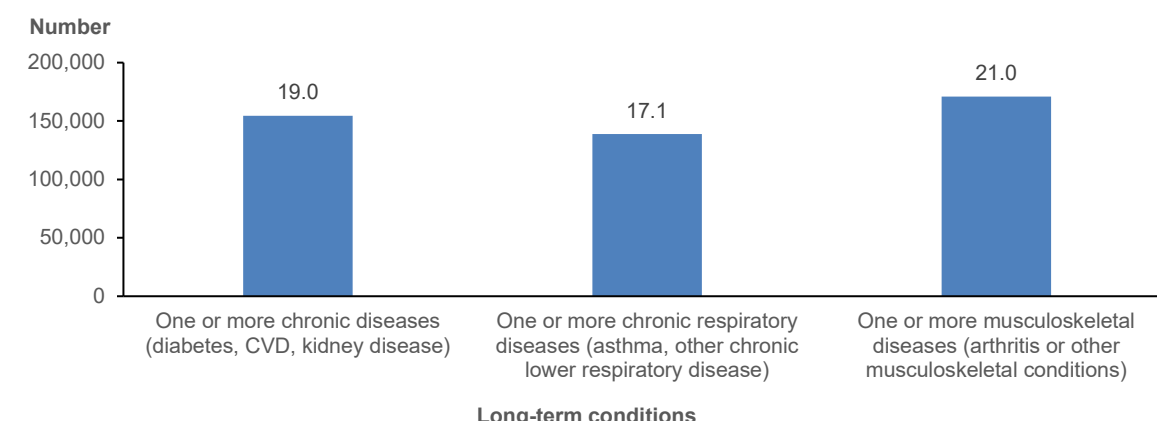
Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Aggregated long-term condition types

The responses to the individual condition types were further grouped into 3 broader categories – chronic diseases, chronic respiratory diseases, and musculoskeletal conditions.

The findings show that just under 20% of Aboriginal and Torres Strait Islander people (154,500) had one or more chronic diseases (diabetes, CVD, kidney disease), 17% (139,000) had one or more chronic respiratory diseases (asthma, other chronic lower respiratory disease) and 21% (171,000) had one or more musculoskeletal diseases (arthritis or other musculoskeletal conditions) (Figure 2.15).

Figure 2.15: Categories of long-term health conditions among Aboriginal and Torres Strait Islander people, by type, 2018–19



Notes

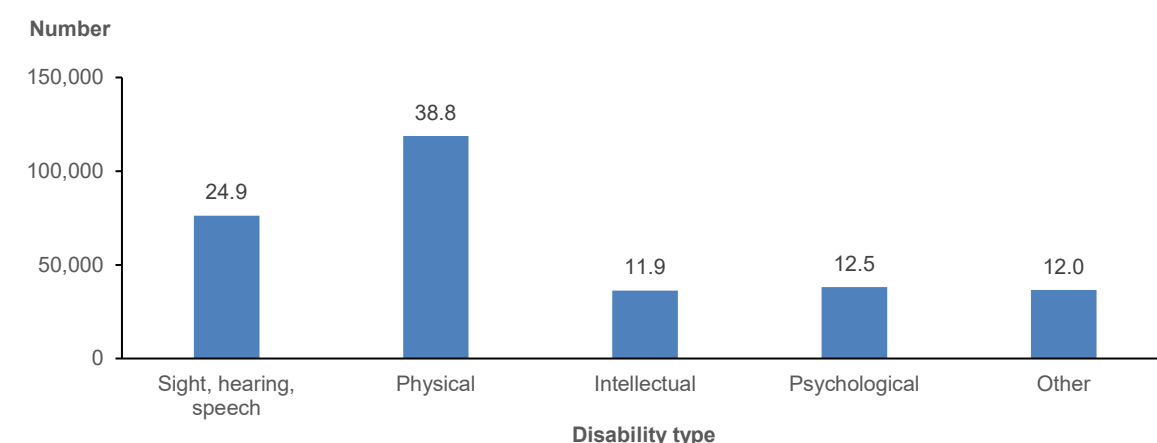
1. CVD = cardiovascular disease.
2. The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Disability

According to the responses to the 2018–19 NATSIHS, over 300,000 Aboriginal and Torres Strait Islander people had disability (38%). Among these, 39% had physical disability (118,100), 25% (76,200) reported that their disability centred on sight/hearing/speech, with the remainder reporting psychological, other, and intellectual disability (Figure 2.16).

Figure 2.16: Distribution of disability among Aboriginal and Torres Strait Islander people, by main disability type, 2018–19



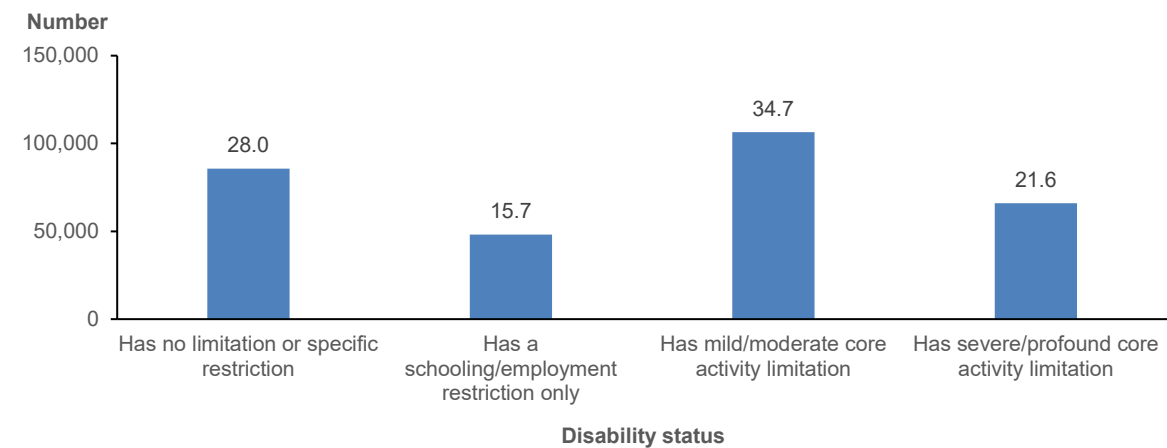
Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Of the 300,000 people reporting disability:

- 28% had no limitation or specific restrictions
- 16% had a school/employment restriction only
- 35% had a mild or moderate core activity limitation
- 22% had a severe/profound core activity limitation (Figure 2.17).

Figure 2.17: Aboriginal and Torres Strait Islander people with disability, by disability status, 2018–19



Note: The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

The next chapters in this report look at how these factors are associated with self-reported primary care service availability, use and unmet needs.

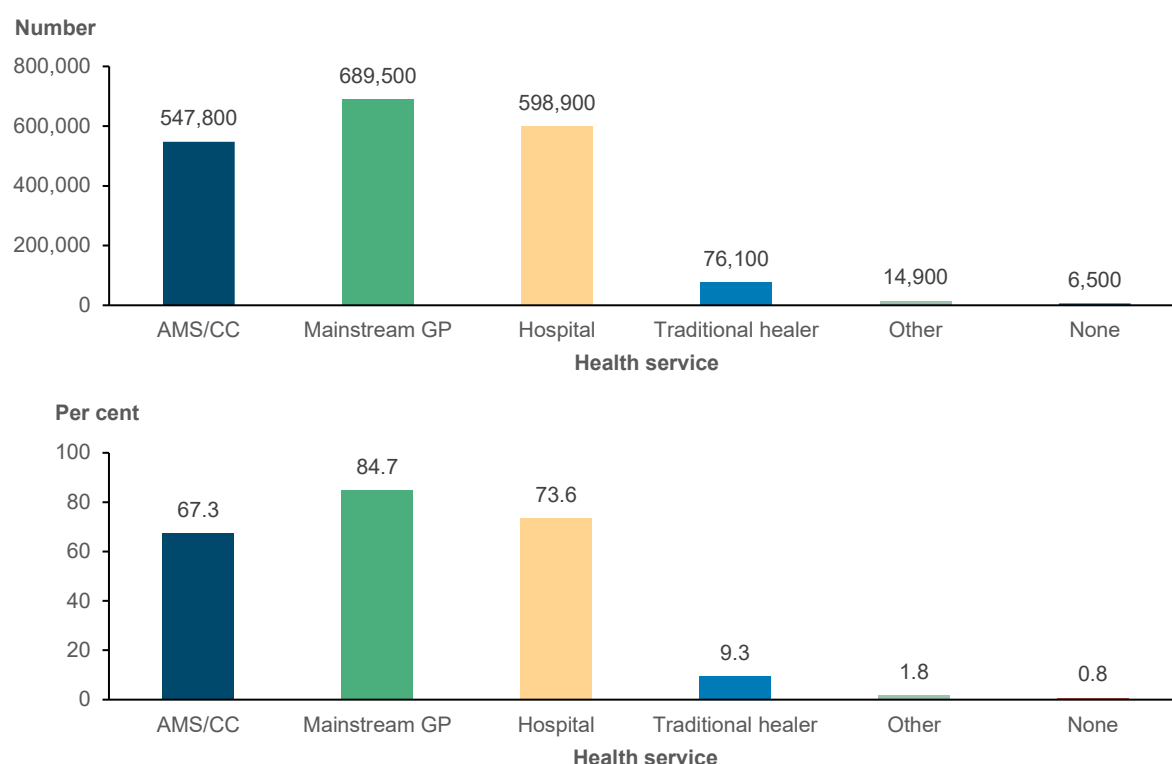
3 Availability of services in local areas

NATSIHS respondents were shown a list including *Aboriginal Medical Service / Community Clinic; Hospital; Doctor/GP (other than from Aboriginal Medical Service or hospital); Traditional healer; Other; None* and were asked ‘which of these are available in your local area?’ They were asked to tick all the types available in their local area. It is important to note that respondents were not given specific definitions of the individual service types and could define ‘local area’ however they saw fit.³⁰ This measure thus captures perceived availability of services in respondents’ local areas, and is the focus of this chapter.³¹

Perceived availability of health services in respondents’ local areas

The responses to the 2018–19 NATSIHS suggested that of 814,000 Aboriginal and Torres Strait Islander people, nearly everyone (99%) would say that they have at least one type of health service in their local area (Figure 3.1). The most frequently cited types of services were mainstream GPs, hospitals, and AMS/CCs.

Figure 3.1: Aboriginal and Torres Strait Islander people, services available in local area, 2018–19



Notes

1. Estimate for those reporting none has a relative standard error between 25% and 50% and should be used with caution.
2. Respondents were asked to tick all that were available.
3. The numbers above the column bars are percentages.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

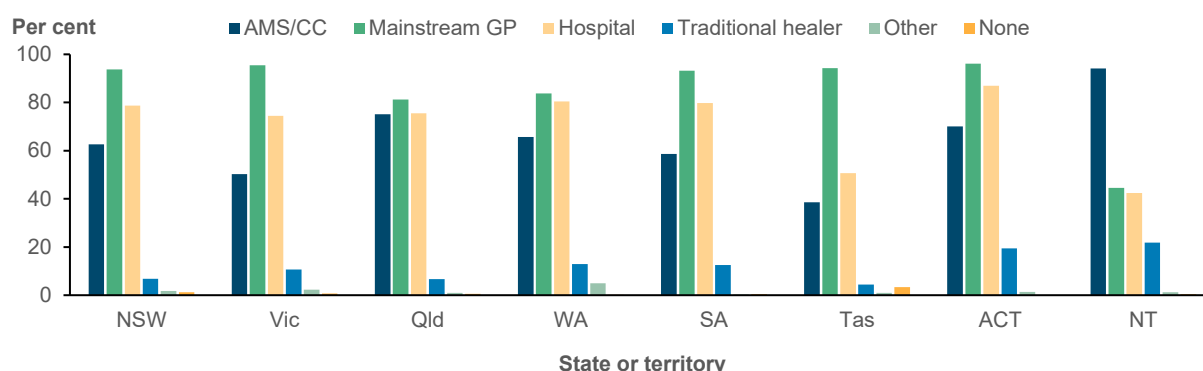
³⁰ This means that 2 people living in the same neighbourhood could define ‘local area’ in different ways.

³¹ It is important to note that a service may be located in a person’s local area, but they may not be aware of it.

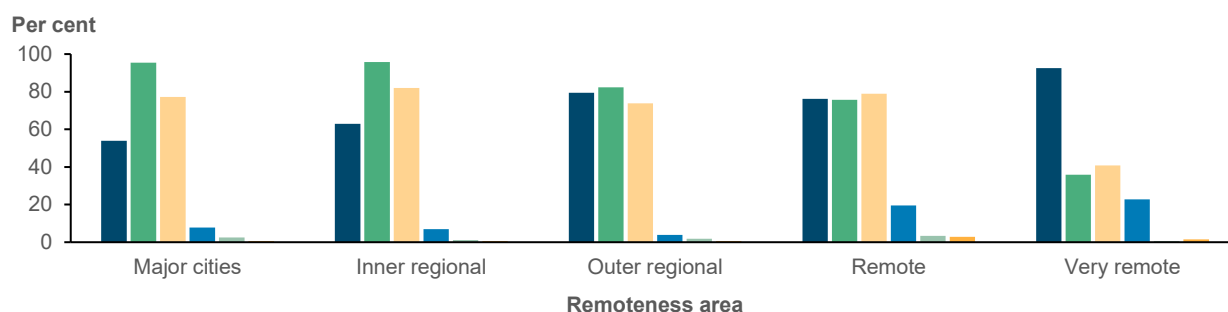
The different types of services were not universally distributed across Australia, however (Figure 3.2). Aboriginal and Torres Strait Islander people living in more remote areas, those who had lower incomes, and those who lived in more disadvantaged areas were more likely to report having an AMS/CC in their local area, while mainstream GPs were more concentrated in more urban and more advantaged areas. This pattern is expected as AMS/CC services are targeted towards areas and populations of greater need.³²

Figure 3.2: Aboriginal and Torres Strait Islander people, services available in local area, by selected characteristics, 2018–19

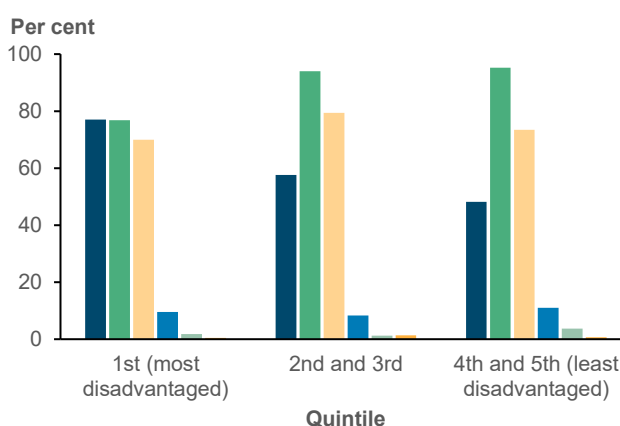
a) State/territory



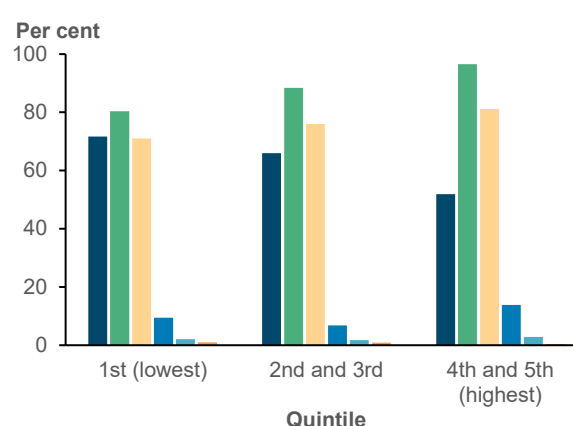
b) Remoteness



c) SEIFA



d) Equivalised household income



Notes

1. Estimate for those reporting none has a relative standard error between 25% and 50% and should be used with caution.
2. Respondents were asked to tick all that were available.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

³² More details on differences in the types of health services in respondents' local areas by other variables are available at [Data: Descriptive analysis supplementary tables, Table S.1](#)).

Perceived availability also varies within remoteness categories across states and territories (Table 3.1). The largest variations in the proportions of those indicating the presence of an AMS/CC in their local area were for those Aboriginal and Torres Strait Islander people living in *Inner regional* areas (where it ranged from a low of 29% in Tasmania to a high of 73% in South Australia) and for those living in *Major cities* (where it ranged from a low of 33% in Victoria to a high of 70% in the Australian Capital Territory).

Table 3.1: Aboriginal and Torres Strait Islander people, perceived availability of AMS/CCs and mainstream GPs in local area, by state and remoteness, 2018–19

State/ territory	Remoteness	Number saying available in local area		% saying available in local area		Total number of Aboriginal and Torres Strait Islander people in area
		AMS/CC	Mainstream GP	AMS/CC	Mainstream GP	
NSW	Major cities	67,400	119,500	53.4	94.7	126,200
	Inner regional	63,300	90,000	67.7	96.3	93,500
	Outer regional	34,500	37,200	81.2	87.5	42,500
	Remote	2,900†	6,300	37.7‡	81.8	7,700
	Very remote	2,100‡	2,000‡	87.5‡	83.3‡	2,400
Vic	Major cities	10,200	30,700	32.7	98.4	31,200
	Inner regional	13,300	19,500	62.7	92.0	21,200
	Outer regional	6,800	7,400	87.2	94.9	7,800
Qld	Major cities	52,000	75,500	66.6	96.7	78,100
	Inner regional	33,600	49,000	67.1	97.8	50,100
	Outer regional	51,800	41,800†	84.8	68.4†	61,100
	Remote	11,900	9,300	86.2	67.4	13,800
	Very remote	21,700	10,400	90.0	43.2	24,100
WA	Major cities	18,100	39,700	43.8	96.1	41,300
	Inner regional	3,300‡	7,000	46.5‡	98.6	7,100
	Outer regional	12,300	12,500	86.0	87.4	14,300
	Remote	11,200	13,000	82.4	95.6	13,600
	Very remote	20,700	11,400	86.3	47.5	24,000
SA	Major cities	12,500	21,200	55.8	94.6	22,400
	Inner regional	3,500	4,700	72.9	97.9	4,800
	Outer regional	3,900†	9,400	40.2†	96.9	9,700
	Remote	1,000†	1,700	58.8†	100.0	1,700
	Very remote	4,200	2,800	93.3	62.2	4,500
Tas	Inner regional	4,900	15,800	29.3	94.6	16,700
	Outer regional	6,600	11,400	54.5	94.2	12,100
	Remote	—	900	—	100.0	900
ACT	Major cities	5,400	7,400	70.1	96.1	7,700
NT	Outer regional	14,800	15,300	90.8	93.9	16,300
	Remote	13,500	9,300	86.0	59.2	15,700
	Very remote	40,200	7,700	99.0	19.0	40,600
Total		547,800	689,500	67.3	84.7	814,000

† Estimate has a relative standard error between 25% and 50% and should be used with caution.

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

Note: Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

How many people had multiple services in their area?

While figures 3.1 and 3.2 highlight the distribution of each individual type of health service provider, it is also important to know how many people have access to only one or more than one type of primary health care provider in their local area (Table 3.2).

In 2018–19, an estimated 439,700 Aboriginal and Torres Strait Islander people had both an AMS/CC and a mainstream GP in their local area (54%), 249,500 had a mainstream GP only (31%), 107,900 people had only an AMS/CC in their area (13%), and 17,100 had neither an AMS/CC nor a mainstream GP (2.1%).

Table 3.2: Aboriginal and Torres Strait Islander people, availability of primary care services in local area, by type, 2018–19

Type of primary care service	Number	%
AMS/CC only	107,860	13.2
AMS/CC and mainstream GP	439,704	54.0
Mainstream GP only	249,533	30.6
Neither	17,147	2.1
Total	814,244	100.0

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using Datalab.

There are clear geographic differences in where people have access to multiple services or where they have access only to a single service (and whether that is an AMS/CC or a mainstream GP) (Figure 3.3).³³

Those in *Very remote* areas and those in *Major cities* were the least likely to report having both an AMS/CC and a mainstream GP in their local area (33% and 51%, respectively). Sixty per cent of those in *Very remote* areas had access only to an AMS/CC, and 45% of those in *Major cities* reported only mainstream GPs in their local areas.

Those living in the Northern Territory were the most likely to report an AMS/CC as the only primary care service in their area, followed by Queensland and Western Australia (53%, 17% and 14%, respectively).³⁴

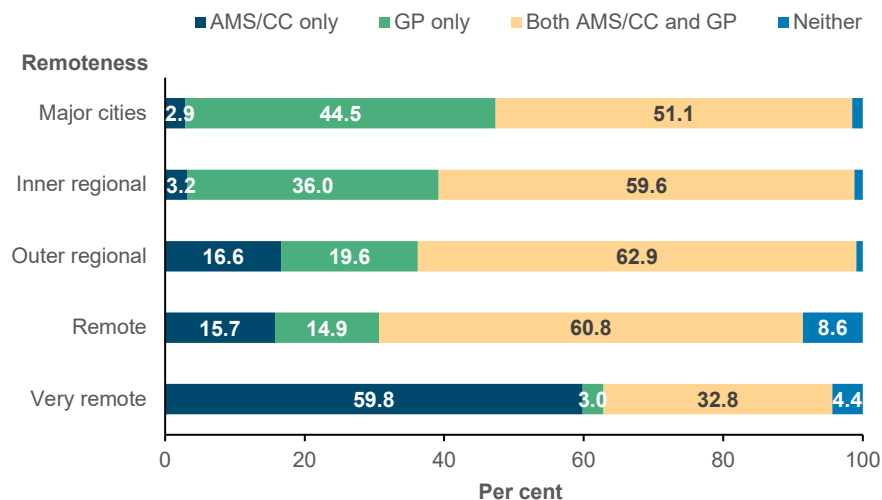
The effect of availability of services on preferred and usual source of care is explored further in Chapter 4.

³³ Full tables of the distribution by selected variables can be found in Appendix 2, Table A2.6.

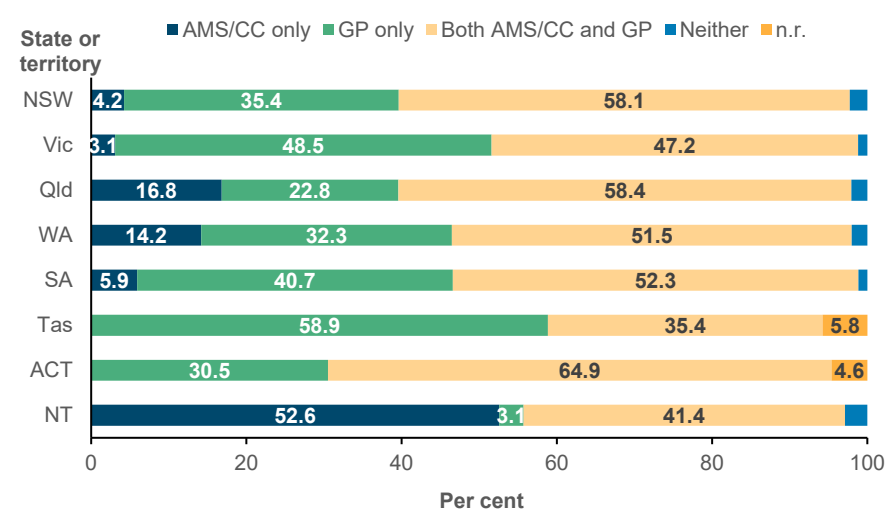
³⁴ Detailed tables of state/remoteness could not be constructed for this variable because of small numbers/suppression rules.

Figure 3.3: Aboriginal and Torres Strait Islander people, distribution of multiple service types in local area, by selected characteristics, 2018–19

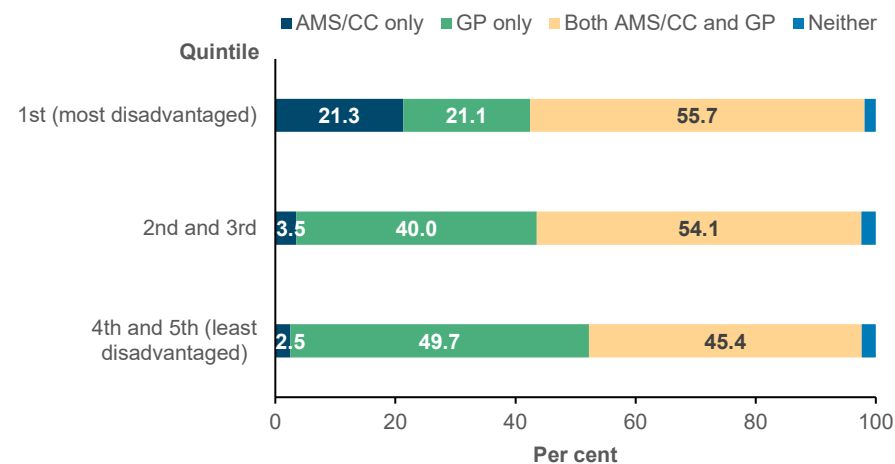
a) Remoteness



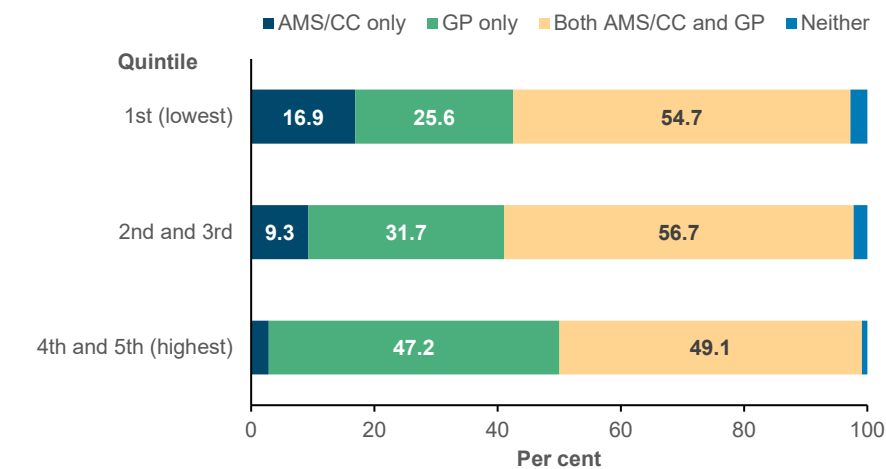
b) State/territory



c) SEIFA



d) Equivalised household income



Note: n.r. = not reported due to confidentiality issues. See Appendix 2, Table A2.6.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

4 Preferred and usual source of care

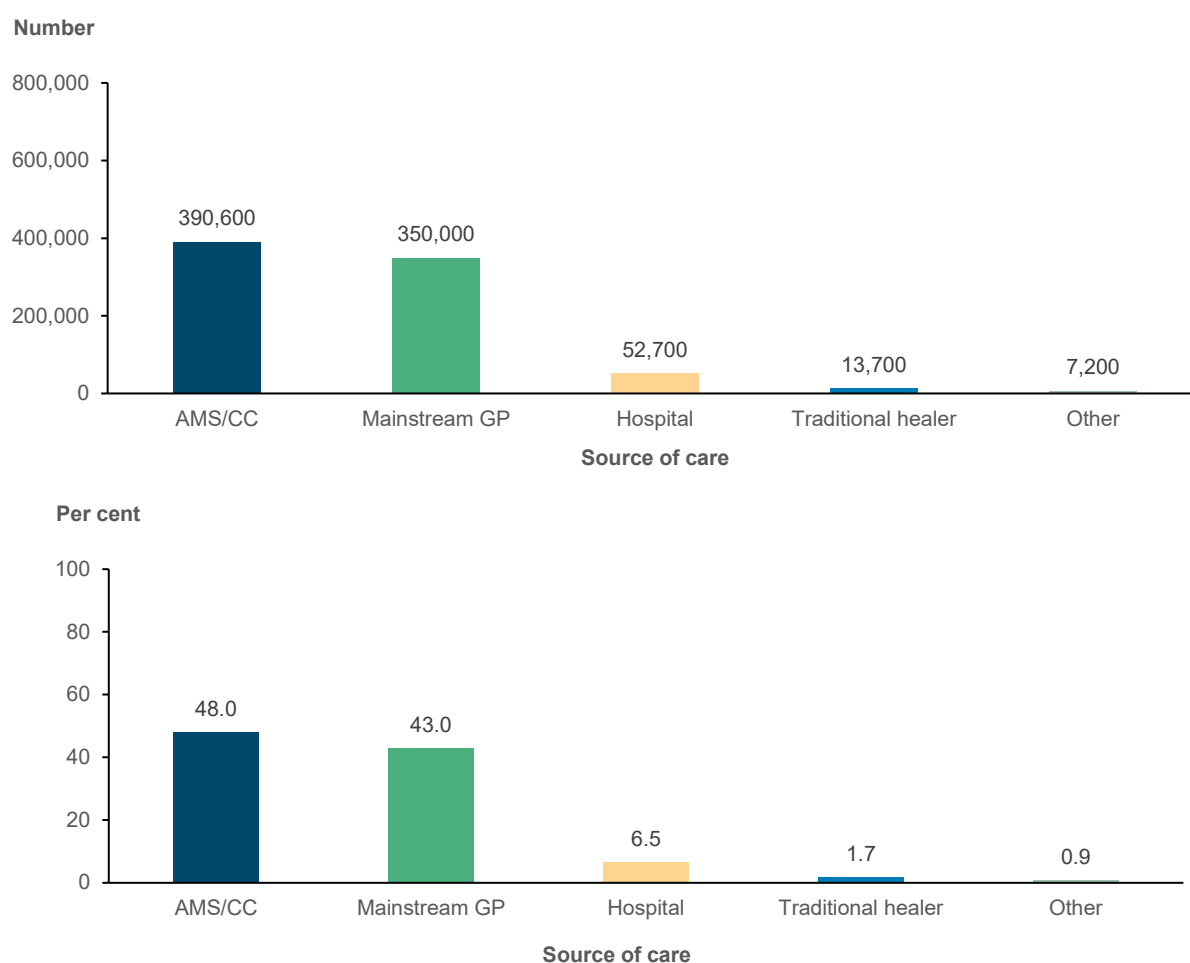
This chapter focuses on the preference of Aboriginal and Torres Strait Islander people for the type of health service they would like to use, their actual source of care, and on the factors that help explain who is able to use an AMS/CC among those who would prefer to do so.

Preferences for type of care

People's preferences for health service providers are related to a number of factors, including availability/accessibility, familiarity, costs, previous experiences, waiting times and relationships with individual health practitioners. The NATSIHS asked respondents about the type of health service they would like to use if they had the choice (but did not ask why they selected that particular type of service). However, previous research has shown that Aboriginal and Torres Strait Islander clients of ACCHOs particularly value the welcoming/culturally safe environment in which care is delivered, its accessibility, and the flexibility and breadth of services offered (comprehensive primary care) (Gomersall et al. 2021).

Nationally, the results indicate that 48% of Aboriginal and Torres Strait Islander people (390,600) would prefer an AMS/CC and 43% (350,000) a mainstream GP. Fewer than 7% preferred a hospital as their main source of care (Figure 4.1).

Figure 4.1: Aboriginal and Torres Strait Islander people, preferred source of care, 2018–19



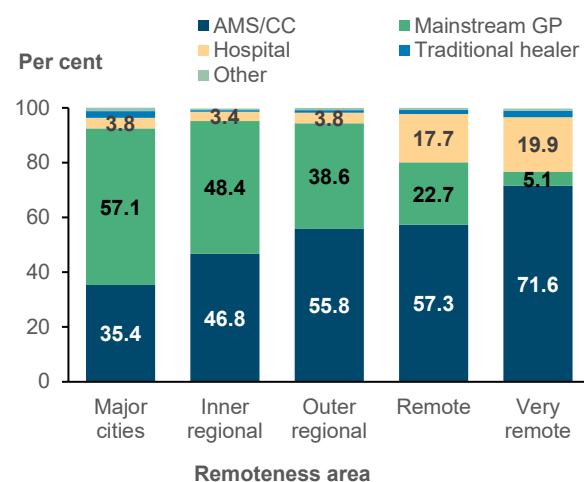
Note: Estimate for those reporting don't know has a relative standard error between 25% and 50% and should be used with caution.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

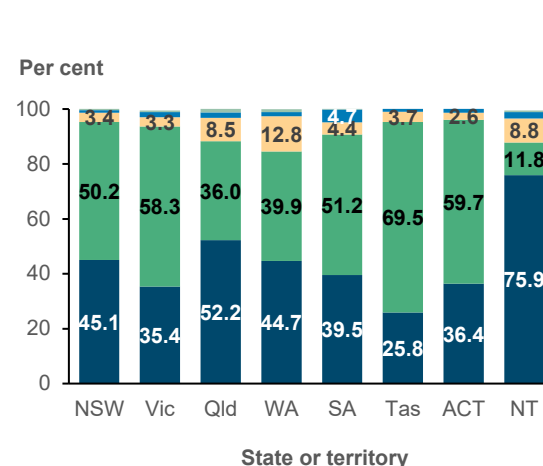
Preference for an AMS/CC was higher among those living in regional and *Remote/Very remote* areas, those living in areas with higher levels of disadvantage, and females compared with males (Figure 4.2). There were also variations by state/territory, ranging from a low of 26% in Tasmania to a high of 76% of those in the Northern Territory.

Figure 4.2: Aboriginal and Torres Strait Islander people, preferred source of care, by selected characteristics, 2018–19

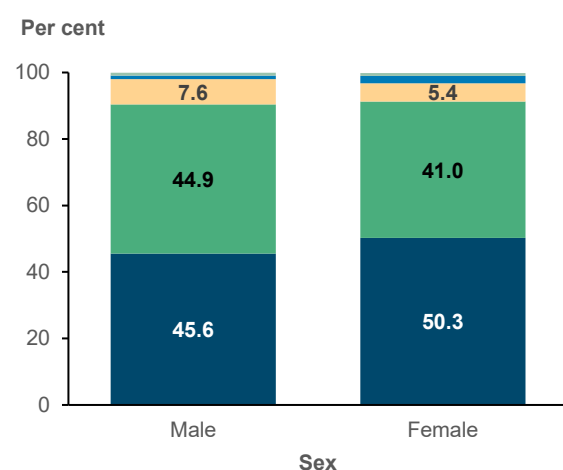
a) Remoteness



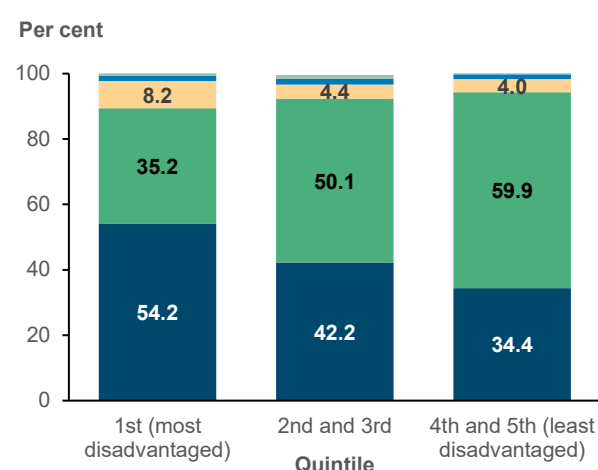
b) State/territory



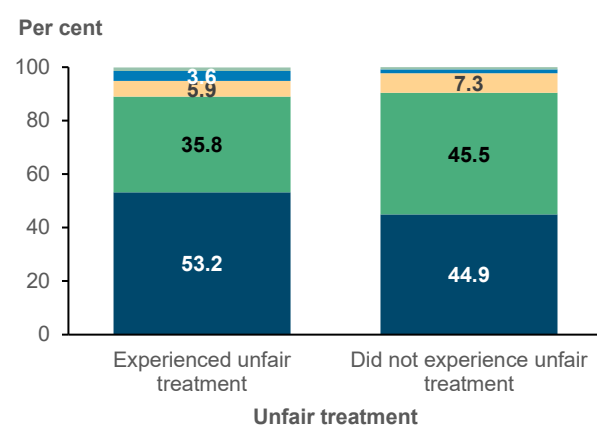
c) Sex



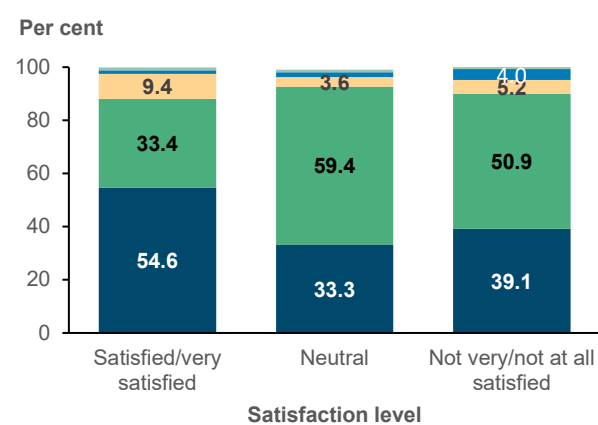
d) SEIFA



e) Experienced unfair treatment in the past 12 months (aged 18 and over)



f) Satisfaction with own level of knowledge about culture (aged 18 and over)



Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Preference for an AMS/CC was also higher among those who had experienced unfair treatment/discrimination in the past 12 months (53% compared with 45% of those who had not experienced unfair treatment), highlighting the importance of culturally safe care. Preference was also higher among those who were more satisfied with their own knowledge about their culture (55%) than among those who were neutral (33%) or not very/not at all satisfied (39%).

Preferences are also related to service availability – for example, the availability of AMS/CC is highest in more remote areas, as is preference for AMS/CCs, while the opposite pattern is seen for mainstream GPs. This relationship is seen at the local level (Table 4.1) – among the nearly 108,000 Aboriginal and Torres Strait Islander people with only an AMS/CC in their area, 82% listed that as their preferred source, while 12% preferred a hospital, and 3.1% a mainstream GP.

Table 4.1: Aboriginal and Torres Strait Islander people, preferred source of care, by primary care services in local area, 2018–19

Primary care in area	Number					%				
	AMS/CC	Main-stream GP	Hospital	All others	Total	AMS/CC	Main-stream GP	Hospital	All others	Total
AMS/CC only	88,867	3,393	13,391	2,209	107,860	82.4	3.1	12.4	2.0	100.0
Both AMS/CC and mainstream GP	225,557	179,914	25,245	8,988	439,704	51.3	40.9	5.7	2.0	100.0
GP only	72,140	160,670	8,390	8,332	249,532	28.9	64.4	3.4	3.3	100.0
Neither	3,774	6,163	5,808	1,402	17,147	22.0	35.9	33.9	8.2	100.0
Total	390,339	350,140	52,834	20,931	814,244	47.9	43.0	6.5	2.6	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

When both an AMS/CC and a mainstream GP were in people's local areas, 51% preferred an AMS/CC and another 41% preferred a mainstream GP. When only a mainstream GP was in their local area, 64% cited that as their preferred type. However, 29% of those in areas with only mainstream GPs expressed a preference for an AMS/CC. An estimated 76,000 Aboriginal and Torres Strait Islander people had a preference for an AMS/CC, but did not have one in their local area.

Modelling preference for an AMS/CC

In order to look at the impact of variables from all 4 domains (plus local availability) on preference for an AMS/CC compared with all other service types, we ran a series of multivariate logistic regression models on those aged 18 and over.³⁵

- Model 1 includes demographic and location variables only
- Model 2 is Model 1 + socioeconomic status/social capital + cultural/unfair treatment
- Model 3 is Model 2 + health status/disability
- Model 4 is Model 3 + GP services in local area by type.

The results (odds ratios) from 4 models are presented in Table 4.2. Odds ratios over 1 indicate a higher likelihood of preferring an AMS/CC relative to the omitted category, while

³⁵ Cross-tabulations of the included variables by the outcome variable (preference for an AMS/CC versus any other type of service) are available in Appendix 2, tables A2.11 to A2.14, organised by domain. The individual variables were selected based on the descriptive analyses, and include variables from each domain that measure different concepts. The patterns for those aged 18 and over were similar to the patterns for all ages.

odds ratios under 1 indicate a lower likelihood, holding all other variables constant. The cells are colour coded by level of statistical significance, making it easier to visualise any changes in statistical significance when new sets of variables are introduced into the model.

Findings by domain

Location and demographic variables

The findings for the location and demographic variables show that, holding other variables constant:

- males are consistently less likely than females to prefer an AMS/CC (odds ratio of 0.8)
- people aged 55–64 and 65 and over are less likely than those aged 18–24 to prefer an AMS/CC (odds ratios of 0.6 and 0.4, respectively)
- SEIFA is not statistically significant
- all categories of remoteness are statistically significant until Model 4 – that is, once local area availability of an AMS/CC is controlled for, remoteness itself is no longer significant (signalling that it was likely a proxy variable for availability)
- those in the Northern Territory are 1.4 times as likely to prefer an AMS/CC as those in New South Wales, while those in South Australia and Tasmania are less likely to prefer an AMS/CC than those in New South Wales.

Socioeconomic and social capital

Once other variables in the modelled are controlled for:

- equivalised household income is not statistically significant, although those who could raise \$2,000 in an emergency were 0.8 times as likely to prefer an AMS/CC as those who could not
- there was no significant effect for labour force status or non-school qualifications, but, compared with those who completed year 12, those whose highest completed year of high school was year 10 or 11 were 1.3 times as likely to prefer an AMS/CC, and those who finished at year 9 or below were 1.5 times as likely.

Cultural identity and experiences of unfair treatment

- The relationship between having experienced unfair treatment and preference for an AMS/CC holds even after controlling for other variables, with those having experienced it being 1.3 times as likely to prefer an AMS/CC.
- Those who did not identify with any tribal, clan or language group were half as likely to prefer an AMS/CC than those who did identify with at least one.
- There were mixed results for satisfaction with own level of knowledge about culture – in models 2 and 3 those who were not very/not at all satisfied and those who were neutral or did not express an opinion were significantly less likely to prefer an AMS/CC as those who were very satisfied with their own knowledge. Once the availability variables were added to the model, the odds ratio for those who were not very/not all satisfied was no longer significant.

Table 4.2: Logistic regression results (odds ratios) and level of statistical significance, preference for an AMS/CC (compared with any other service) for Aboriginal and Torres Strait Islander people aged 18 and over

Variable definition (omitted variable)	Variable modelled	Odds ratios			
		Model 1	Model 2	Model 3	Model 4
Sex (female)	Male	0.75	0.77	0.77	0.76
Age (18–24)	25–34	0.94	0.90	0.89	0.90
	35–44	0.87	0.72	0.71	0.74
	45–54	0.93	0.77	0.74	0.77
	55–64	0.86	0.57	0.55	0.57
	65 and over	0.61	0.39	0.38	0.41
Remoteness (Major cities)	Inner regional	1.39	1.38	1.40	1.30
	Outer regional	1.87	1.55	1.54	1.25
	Remote	1.94	1.47	1.48	1.32
	Very remote	2.92	2.12	2.15	1.30
State/territory (NSW)	Vic	0.78	0.74	0.74	0.78
	Qld	1.03	1.06	1.05	0.95
	WA	0.85	0.74	0.72	0.73
	NT	2.05	1.80	1.78	1.42
	SA	0.69	0.63	0.62	0.66
	Tas	0.32	0.38	0.37	0.47
	ACT	1.10	0.91	0.89	0.75
SEIFA (bottom quintile – most disadvantaged))	SEIFA 2 and 3	0.86	1.04	1.03	1.16
	SEIFA 4 and 5	0.57	0.83	0.82	0.93
Equivalised household (HH) income (bottom quintile)	HH Income 2 and 3		1.08	1.06	1.04
	HH Income 4 and 5		0.70	0.69	0.70
	HH Income unknown		0.74	0.72	0.67
Could not raise \$2,000/unknown	Could raise \$2,000		0.76	0.78	0.79
Labour force (employed)	Unemployed		1.17	1.16	1.13
	Not in labour force		1.21	1.21	1.19
Educational attainment (year 12)	Year 10 or 11		1.33	1.33	1.34
	Year 9 or below		1.50	1.48	1.46
Non-school qualifications (yes)	No non-school qualification		0.92	0.94	0.95
Identifies with any tribe, clan or language (yes)	Does not identify		0.47	0.46	0.50
Satisfaction with own knowledge of culture (satisfied/very satisfied)	Neutral/unknown		0.66	0.63	0.69
	Not very/not at all satisfied		0.73	0.73	0.82
Experienced unfair treatment in the past 12 months (did not/unknown/)	Experienced at least one instance of unfair treatment in past 12 months		1.33	1.34	1.30
Self-assessed health (very good/excellent)	Self-assessed health good			1.08	1.07
	Self-assessed health fair/poor			1.18	1.19
Level of psychological distress (low/moderate)	Level of psychological distress high/very high			0.95	0.97
	Level of psychological distress unknown/n.a.			1.87	1.71
Long-term health condition	Has a long-term condition (no long-term health condition)			1.11	1.11
Disability (no disability)	Has disability			0.86	0.87
GP in local area by service type (either mainstream GP only or neither)	AMS only				5.20
	Both AMS and mainstream GP				2.13

*p<0.05 **p<0.01 ***p<0.001

Source: AIHW analysis of 2018–19 NATSIHS using SAS Proc SurveyLogistic in Datalab, weighted n=486,444.

Health and disability

- None of the included health and disability variables were statistically significant.

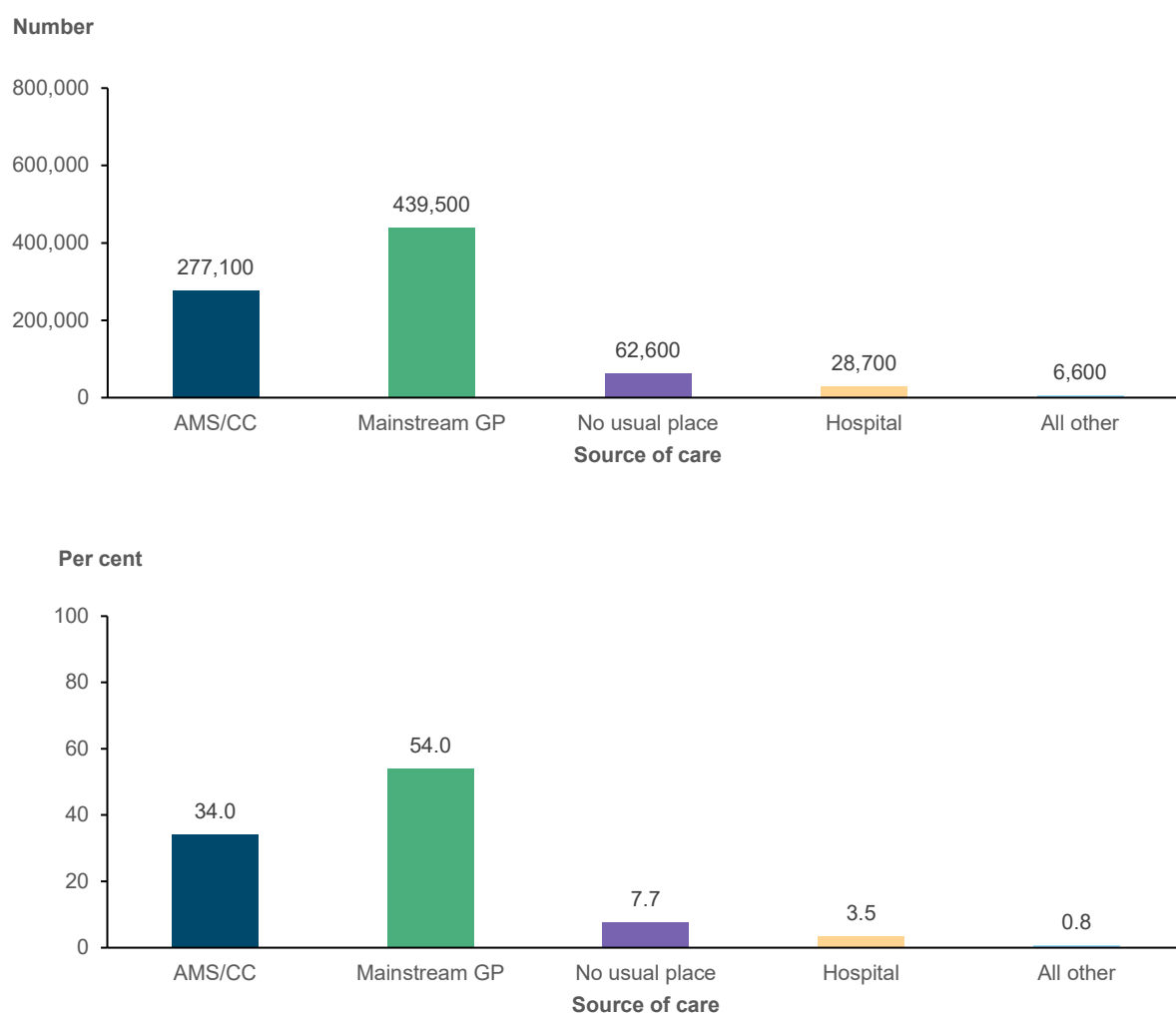
Services available in local areas

- The strongest predictor of preference for an AMS/CC was having one in a person's local area. Those who had only an AMS/CC in their area were 5.2 times as likely to prefer an AMS/CC as those without one, and those who had both an AMS/CC and a mainstream GP in their area were 2.3 times as likely to prefer an AMS/CC.

Usual source of care

The previous section focused on preference; this section looks at respondents' actual sources of care. The NATSIHS results suggest that, in 2018–19, nearly all Aboriginal and Torres Strait Islander people had a usual source of care, with 62,600 saying they had none (7.7%) (Figure 4.3). It is not known whether those without a usual source of care used multiple sources or whether they had not needed health care. Over half cited a mainstream GP as their usual source, with another 34% reporting an AMS/CC.

Figure 4.3: Usual source of health care among Aboriginal and Torres Strait Islander people, 2018–19



Note: Estimate for those reporting none has a relative standard error between 25% and 50% and should be used with caution.

Source: AIHW analysis of 2018–19 NATSIHS using TableBuilder (ABS 2019).

Usual source of care is strongly related to the services available in a person's local area. However, it is also important to note that some people will travel outside their local area for a service they prefer, there may be different services in the area in which people work compared with the area in which they live (so they may access care near where they work), and availability does not mean that a service will have capacity to serve everyone in their area.

At a broad level, and consistent with how primary care services are distributed throughout Australia (as shown in Chapter 3), there is a strong relationship between remoteness and usual source (Figure 4.4). Around 15% of those in *Major cities* had an AMS/CC as their usual source of care, compared with 75% of those in *Very remote* areas, while 75% of those in *Major cities* had a mainstream GP, compared with 27% of those in *Remote* areas.³⁶

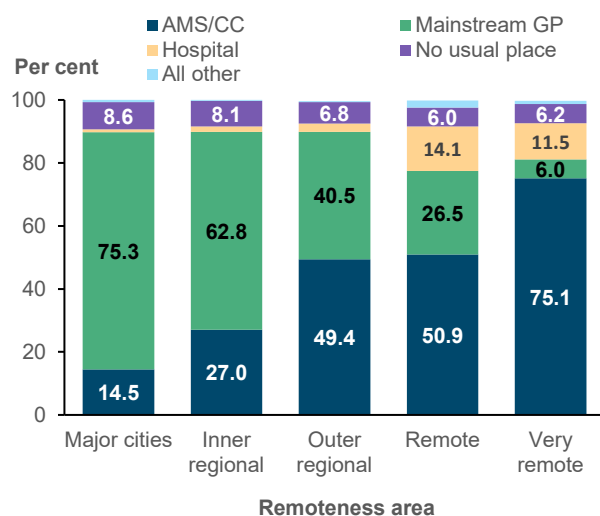
Area-level and family-level indicators of socioeconomic status showed similar patterns. Having an AMS/CC as their usual source was highest among those Aboriginal and Torres Strait Islander people living in the most disadvantaged areas (45%) and among those with lower household incomes (42%), while mainstream GP as the usual source was highest among those in more advantaged areas (90%) and who had higher incomes (75–77%).

AMS/CC use was slightly higher among adults who reported experiencing unfair treatment in the previous 12 months compared with those who had not (37% and 33%, respectively). For those aged 18 and over, AMS/CC was strongly related to satisfaction with one's own knowledge of culture – 46% of those who were satisfied/strongly satisfied had an AMS/CC as their usual source, compared with fewer than 20% of those who were less satisfied (noting that having an AMS/CC as a usual source could increase people's knowledge of culture).

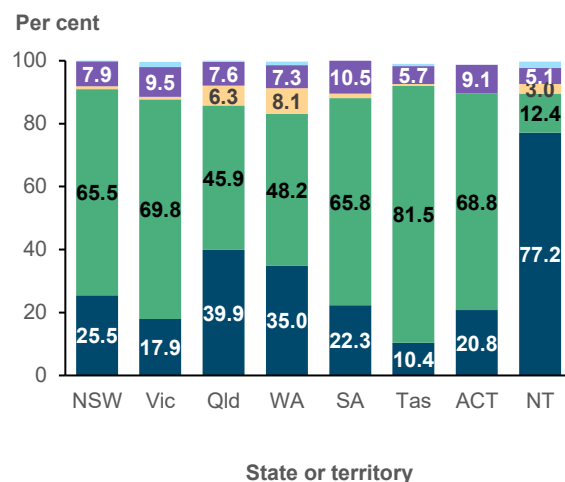
³⁶ The small number of Aboriginal and Torres Strait Islander people in *Very remote* areas with a mainstream GP meant that the estimate has a high standard error and should be used with caution.

Figure 4.4: Usual source of care among Aboriginal and Torres Strait Islander people, by selected characteristics, 2018–19

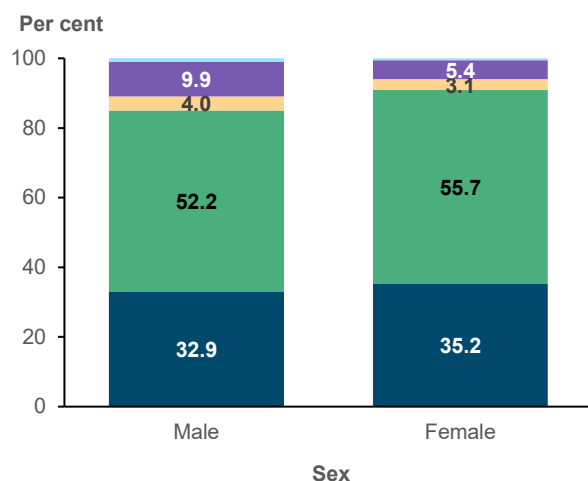
a) Remoteness



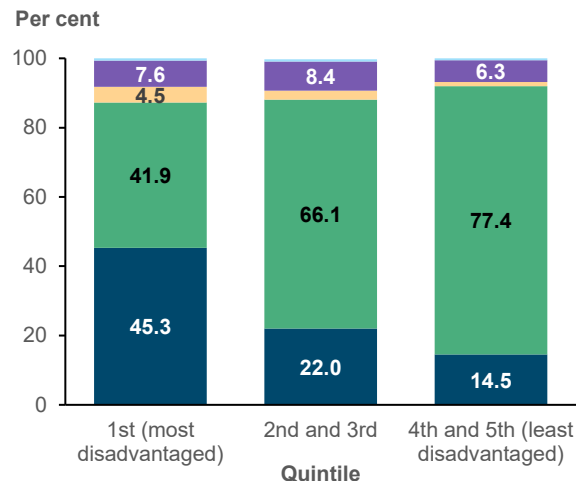
b) State/territory



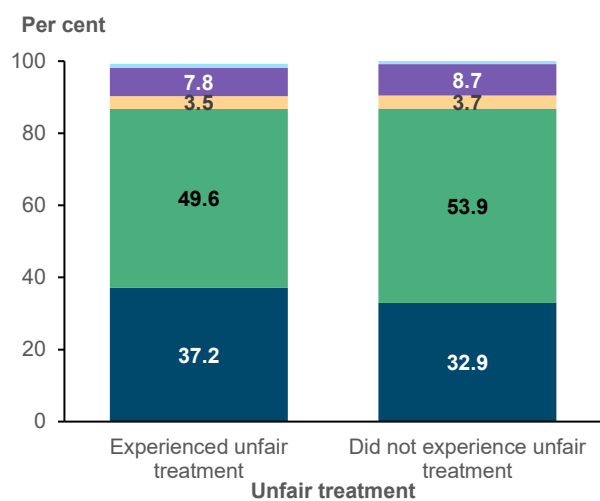
c) Sex



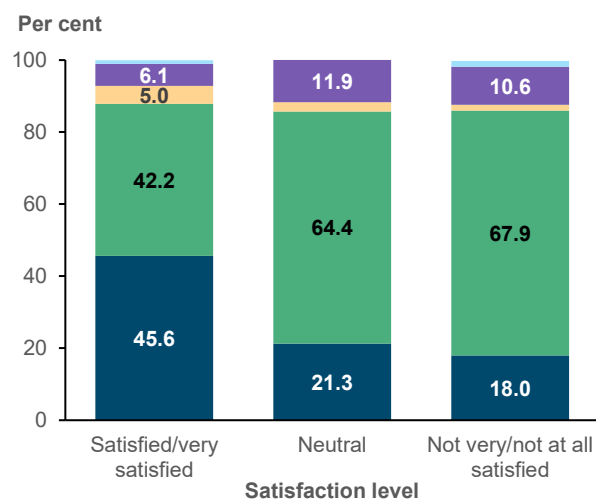
d) SEIFA



e) Experienced unfair treatment in the past 12 months (ages 18 and over)



f) Satisfied with own level of knowledge about culture (ages 18 and over living in non-remote areas)



Note: Estimate for those reporting All other has a relative standard error between 25% and 50% and should be used with caution.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Table 4.3 presents the distribution of usual source of care by local primary care sources. The results show that 86% of those with only an AMS/CC in their area have one as their usual source and that 85% of those with only a mainstream GP in their area reported their usual source as a mainstream GP. Where there are both AMS/CCs and GPs in their local area, 41% have an AMS/CC as their usual source and 50% have a mainstream GP.

Table 4.3: Usual source of care among Aboriginal and Torres Strait Islander people, by type of primary health service(s) in local area, 2018–19

Type of primary health service(s) in local area	Usual source of care (%)					Total	Number
	AMS/CC	Mainstream GP	Hospital	Other	None/don't know		
AMS/CC only	85.7	1.8	4.6	0.5	7.5	100.0	107,861
Mainstream GP only	1.7	84.7	2.3	0.8	10.5	100.0	249,532
Both AMS/CC and mainstream GP	40.7	50.2	3.0	0.4	5.7	100.0	439,703
Neither	10.9	30.4	28.8	5.2	23.2	98.4	17,146
Total	34.1	54.0	3.5	0.6	7.8	100.0	814,245

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Match between preferences and usual source

Of the 390,600 people who preferred an AMS/CC, 248,000 (64%) reported one as their usual source of care (Table 4.4), meaning that 142,200 Aboriginal and Torres Strait Islander people did not use an AMS/CC even though that was their preferred source. Nearly 30% used mainstream GPs and another 5.7% reported that they had no usual source of care.

Nearly all Aboriginal and Torres Strait Islander people who expressed a preference for a mainstream GP had one as their usual source of care (88%) – fewer than 3% used an AMS/CC.

Table 4.4: Preferred source of care among Aboriginal and Torres Strait Islander people, by usual source of care, 2018–19

Preferred source of care	Usual source of care					Total
	AMS/ CC	Mainstream GP	Hospital	All other/ don't know	No usual place	
	Number					
AMS/CC	248,200	112,300	5,800	1,800	22,200	390,600
Mainstream GP	9,100	306,100	1,800	1,200	32,200	350,000
Hospital	16,000	10,700	20,300	600	5,600	52,700
	Row %					
AMS/CC	63.5	28.8	1.5	0.5	5.7	99.9
Mainstream GP	2.6	87.5	0.5	0.3	9.2	100.0
Hospital	30.4	20.3	38.5	1.1	10.6	100.9

Notes

1. Excludes those with preferences for all other types of health services because of small numbers and high standard errors.
2. Shaded cells indicate a match between preferred and usual source of care.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Unmet need for an AMS/CC

The percentage distribution of who was able and unable to use an AMS/CC by the independent variables highlights differences in the likelihood of being able to use the preferred choice (Appendix 2, Table A2.15), but it is also important to look at the numbers of Aboriginal and Torres Strait Islander people who had an unmet need for an AMS/CC, particularly those from more vulnerable groups.

The findings indicate that among those who preferred an AMS/CC but did not have one as their usual source were around:

- 87,000 people with a long-term and ongoing health condition
- 56,000 people with disability
- 30,000 adults with high/very high levels of psychological distress
- 24,000 adults who had experienced unfair treatment over the previous 12 months.

There were also considerable geographic variations in unmet need (which are a combination of both the distribution of where Aboriginal and Torres Strait Islander people live and where services are located, as discussed in Chapter 3). The highest numbers of Aboriginal and Torres Strait Islander people with an unmet need for an AMS/CC were:

- 68,000 people in *Major cities* and 42,000 people in *Inner regional areas*
- 57,000 people in New South Wales and 39,000 people in Queensland
- 65,000 people in areas with the lowest SEIFA quintiles and 57,000 in the next 2 quintiles (noting that the proportions of people in these areas who used an AMS/CC is higher than for those in more advantaged areas).

The impact of having an AMS/CC in the local area is highlighted in Table 4.5, with 91% of those with only an AMS/CC in their area and 72% of those in areas with both an AMS/CC and a mainstream GP using an AMS/CC as their usual source.

Table 4.5: AMS/CC as usual source of care among Aboriginal and Torres Strait Islander people who preferred it, by availability of primary care services in local area, 2018–19

Primary care in local area	Number			%		
	AMS/CC as usual source	Other service/none	Total	AMS/CC as usual source	Other service/none	Total
AMS only	80,423	8,445	88,868	90.5	9.5	100.0
Both AMS/CC and mainstream GP	162,547	63,010	225,557	72.1	27.9	100.0
Mainstream GP only	3,769	68,371	72,140	5.2	94.8	100.0
Neither	1,680	2,094	3,774	44.5	55.5	100.0
Total	248,419	141,920	390,339	63.6	36.4	100.0

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

To examine the impact of availability on who had an AMS/CC as their usual source of care in the context of the other independent variables, we ran a series of multivariate logistic regressions on those aged 18 and over,³⁷ using a similar approach to that used in modelling preference. The results (odds ratios) from the 4 models are presented in Table 4.6.

³⁷ Cross-tabulations of the included variables by the outcome variable (used an AMS/CC versus used any other source/had no source) are available in Appendix 2, tables A.16 to A2.19, organised by domain.

Table 4.6: Logistic regression results (odds ratios) and level of statistical significance, Aboriginal and Torres Strait Islander people able to use an AMS/CC (compared with any other service)

Variable definition (omitted variable)	Variable modelled	Odds ratios			
		Model 1	Model 2	Model 3	Model 4
Sex (female)	Male	0.99	1.06	1.04	0.97
Age (18–24)	25–34	0.75	0.75	0.79	0.79
	35–44	0.82	0.75	0.78	0.80
	45–54	0.72	0.68	0.80	0.76
	55–64	1.16	0.84	1.03	1.06
	65 and over	1.93	1.20	1.41	1.24
Remoteness (Major cities)	Inner regional	2.37	2.65	2.65	2.06
	Outer regional	7.28	6.07	5.63	3.93
	Remote	4.88	4.02	3.87	3.47
	Very remote	6.58	4.92	4.67	2.37
State/territory (NSW)	Vic	0.78	0.72	0.76	1.00
	Qld	1.49	1.64	1.66	1.53
	WA	1.31	1.12	1.10	1.16
	NT	3.02	2.84	2.83	1.76
	SA	0.90	0.92	0.95	1.00
	Tas	0.27	0.27	0.30	0.60
	ACT	3.11	2.88	2.93	1.96
	SEIFA (bottom quintile – most disadvantaged))	0.57	0.77	0.79	0.97
Equivalised household (HH) income (bottom quintile)	SEIFA 4 and 5	0.48	0.66	0.63	0.65
	HH Income 2 and 3		1.21	1.18	1.16
	HH Income 4 and 5		1.02	0.93	0.87
	HH Income unknown		1.69	1.55	1.37
Could not raise \$2,000/unknown	Could raise \$2,000		0.62	0.62	0.58
Labour force (employed)	Unemployed		1.42	1.52	1.76
	Not in labour force		2.03	2.20	2.20
Educational attainment (year 12)	Year 10 or 11		0.85	0.84	0.77
	Year 9 or below		0.88	0.90	0.85
Non-school qualifications (yes)	No non-school qualification		0.86	0.90	1.03
Identifies with any tribe, clan or language (yes)	Does not identify		0.59	0.57	0.56
Satisfaction with own knowledge of culture (satisfied/very satisfied)	Neutral/unknown		0.79	0.76	0.97
	Not very/not at all satisfied		0.44	0.47	0.57
Experienced unfair treatment in the past 12 months (did not/unknown/NA)	Experienced at least one instance of unfair treatment in past 12 months		1.03	1.11	1.04
	Self-assessed health (very good/excellent)				
	health good			1.07	1.08
	Self-assessed health fair/poor			0.79	0.82
Level of psychological distress (low/moderate)	Level of psychological distress high/very high			0.82	0.80
	Level of psychological distress unknown/n.a.			2.25	2.37
Long-term health condition (none)	Has a long-term condition			0.95	0.80
Disability (no disability)	Has disability			0.79	0.86
GP in local area by service type (either mainstream GP only or neither AMS/CC or GP)	AMS only				77.10
	Both AMS and mainstream GP				23.58

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

Note: Regressions include only those aged 18 and over who had expressed a preference for an AMS/CC to be their usual source of care.

Source: AIHW analysis of 2018–19 NATSIHS using SAS Proc SurveyLogistic in Datalab, weighted $n=227,237$.

The results by domain show that, holding other variables constant:

Location and demographic variables

Only the remoteness categories are statistically significant (even after service availability is added), with those in every remoteness category at least 2 times as likely to have an AMS/CC as their usual source compared with those in *Major cities*.

Socioeconomic and social capital

Those who would be able to raise \$2,000 in an emergency were 0.6 times as likely to use an AMS/CC as those who would not be able to raise the funds (holding other variables constant), while those not in the labour force were 2.2 times as likely to use an AMS/CC as those who were employed.

Cultural identify and experiences of unfair treatment

Those who did not identify with any tribe, clan or language group were 0.6 times as likely to use an AMS/CC as those who did identify; a similar pattern is seen for those who were not very/not at all satisfied with their own knowledge of culture (odds ratio of 0.6 compared with those who were satisfied/very satisfied).

Health and disability

None of the included health and disability variables were statistically significant (except those whose level of psychological distress was unknown), but this was included as a control variable).

Services available in local areas

By far the strongest predictor of being able to use an AMS/CC when a person preferred one was having one in a person's local area. Those who had only an AMS/CC in their area were 77 times as likely to be able to use one as those without one, and those who had both an AMS/CC and a mainstream GP in their area were 24 times as likely to have an AMS/CC as their usual source.

This finding again highlights the importance of the local service environment in supporting Aboriginal and Torres Strait Islander people's preferences for type of health care. The next chapter looks at the use (and non-use) of primary health care.

5 Patterns of primary care use

This chapter focuses on patterns of primary care use, by looking firstly at continuity of care, before moving on to the timing of people's most recent GP and dental visits, and finally to self-reported unmet need for GPs and dental care. As in Chapter 4, national patterns are presented first, followed by variations in the outcome by selected variables (see also [Data](#)).

The chapter also includes a summary of patients' reported experiences of care, including those who incurred a co-payment at their most recent GP or specialist visit, and unfilled prescriptions (which were asked only of respondents in non-remote areas).

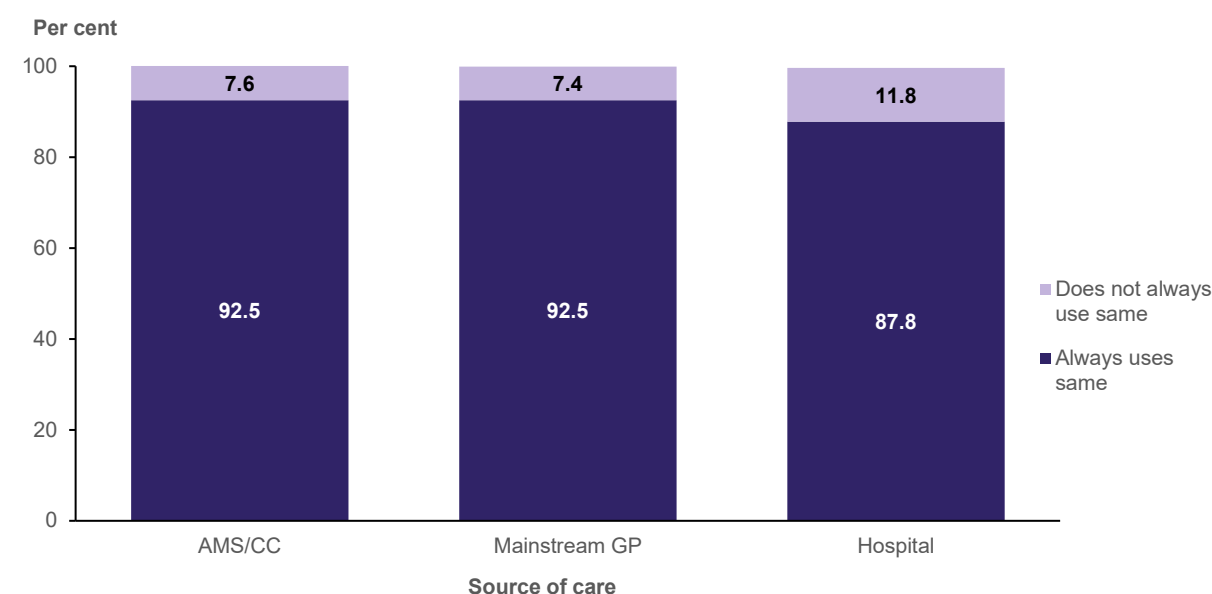
Continuity of care

Consistently seeing the same health-care provider can promote good health through better coordination of health-care services, and through the development of trust and strong relationships, which are particularly important for Aboriginal and Torres Strait Islander people (Nolan-Isles et al. 2021).

The NATSIHS results indicate that just under 693,000 Aboriginal and Torres Strait Islander people (85%) always used the same source of health care, with just under 58,000 (7.1%) using more than one source, and an additional 63,800 (7.8%) not having any usual source.³⁸

Nearly 93% of those who had an AMS/CC or a mainstream GP as their usual source of care always used them, compared with 88% of those whose main source of care was a hospital (Figure 5.1).

Figure 5.1: Aboriginal and Torres Strait Islander people, always used the same source of health care, by usual source of care, 2018–19



Note: Columns may not add to 100% because of rounding.

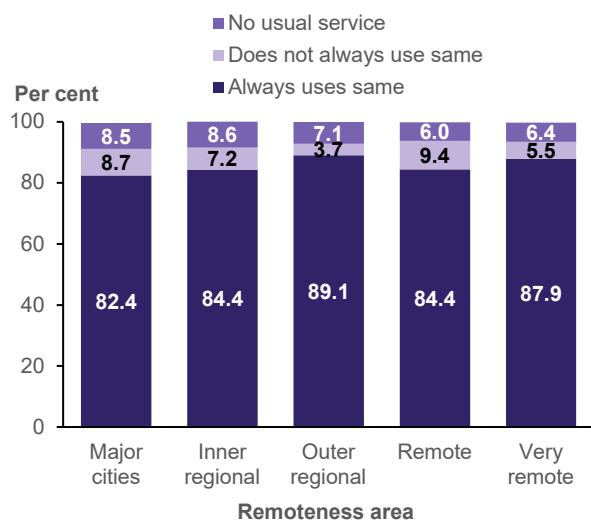
Source: AIHW analysis of 2018–19 NATSIHS using TableBuilder (ABS 2019).

The likelihood of always using the same source varied across a number of the independent variables (Figure 5.2; [Data](#): Descriptive analysis supplementary tables, Table S.4).

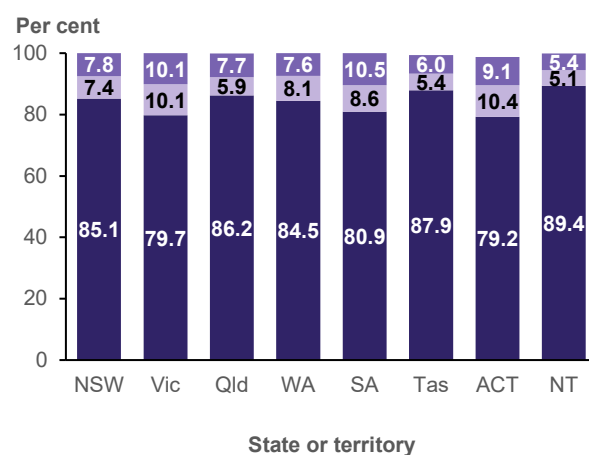
³⁸ This number differs slightly from the results in the 'usual source of care' question due to random adjustments in TableBuilder.

Figure 5.2: Aboriginal and Torres Strait Islander people, always used the same source of care, by selected characteristics, 2018–19

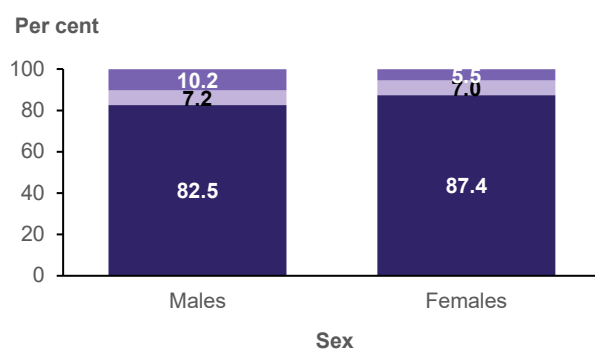
a) Remoteness



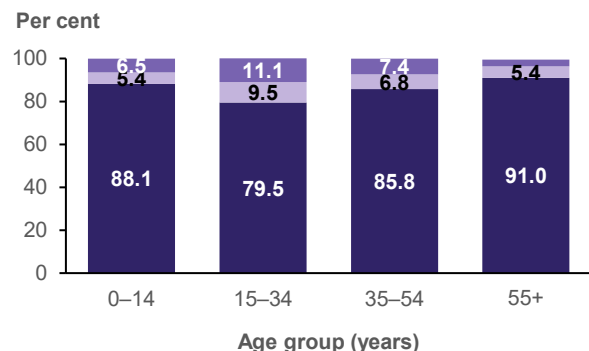
b) State/territory



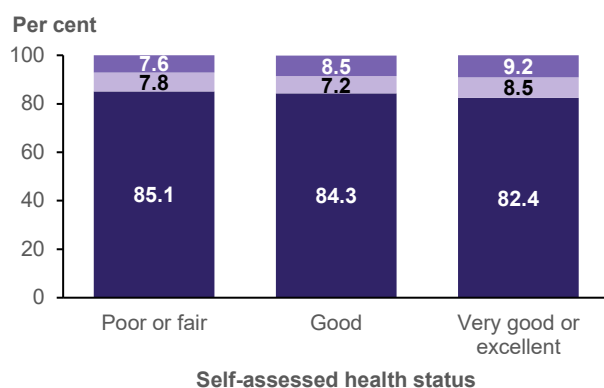
c) Sex



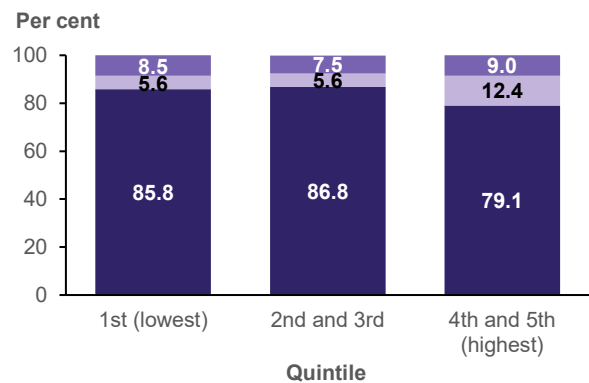
d) Age



e) Self-assessed health status (aged 15 and over)



f) Equivalised household income



Source: AIHW analysis of 2018–19 NATSIHS using TableBuilder (ABS 2019).

Continuity of care was higher among females than among males (87% and 83%, respectively), with 10% of males saying that they had no usual source of care (compared with 5.5% of females). Among age groups, it was lowest among those aged 15–34, at 80% (compared with 91% of those aged 55 and over). The 15–34 age group also was most likely to have no usual source of care (11%), which is consistent with other research on this age group in Australia and internationally.

Those in the Australian Capital Territory (79%) and Victoria (80%) were least likely to always use the same source of care, while those in the Northern Territory (89%) and Tasmania (88%) were most likely to always use the same source.

There was no clear pattern with remoteness – those in *Outer regional* (89%) and *Very remote* areas (88%) were most likely to have consistency of care, while those in *Inner regional* and *Remote* areas had the same proportions (84%). Those living in *Major cities* were least likely to always use the same source of care (82%).

Those with poor or fair self-assessed health were slightly more likely to always use the same health care source (85%) compared with those reporting their health as good (84%), or very good/excellent (82%), but the differences were small.

Whether people use more than one source of care may be related to the number of services available in a person's local area. While the NATSIHS data are unable to capture the absolute number of services in a person's local area, we do know whether there are multiple types of services. Table 5.1 shows that those with only an AMS/CC in their local area have the highest proportion who always use the same source (88%). In areas where there is only a mainstream GP, 83% use the same, 6.8% use more than one, and 11% either do not have a source of care or report that they don't know.

Table 5.1: Aboriginal and Torres Strait Islander people, always used the same source of care, by availability of primary health services in local area, 2018–19

Availability of primary care in area	Number				%			
	Always used the same	Doesn't always use the same	None or don't know	Total	Always used the same	Doesn't always use the same	None or don't know	Total
AMS/CC only	95,101	4,706	8,054	107,861	88.2	4.4	7.5	100.0
Both AMS/CC and mainstream GP	379,413	35,013	25,278	439,704	86.3	8.0	5.7	100.0
Mainstream GP only	206,018	17,071	26,444	249,533	82.6	6.8	10.6	100.0
Neither	12,205	901	4,041	17,147	71.2	5.3	23.6	100.0
Total	692,737	57,690	63,817	814,244	85.1	7.1	7.8	100.0

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

GP services

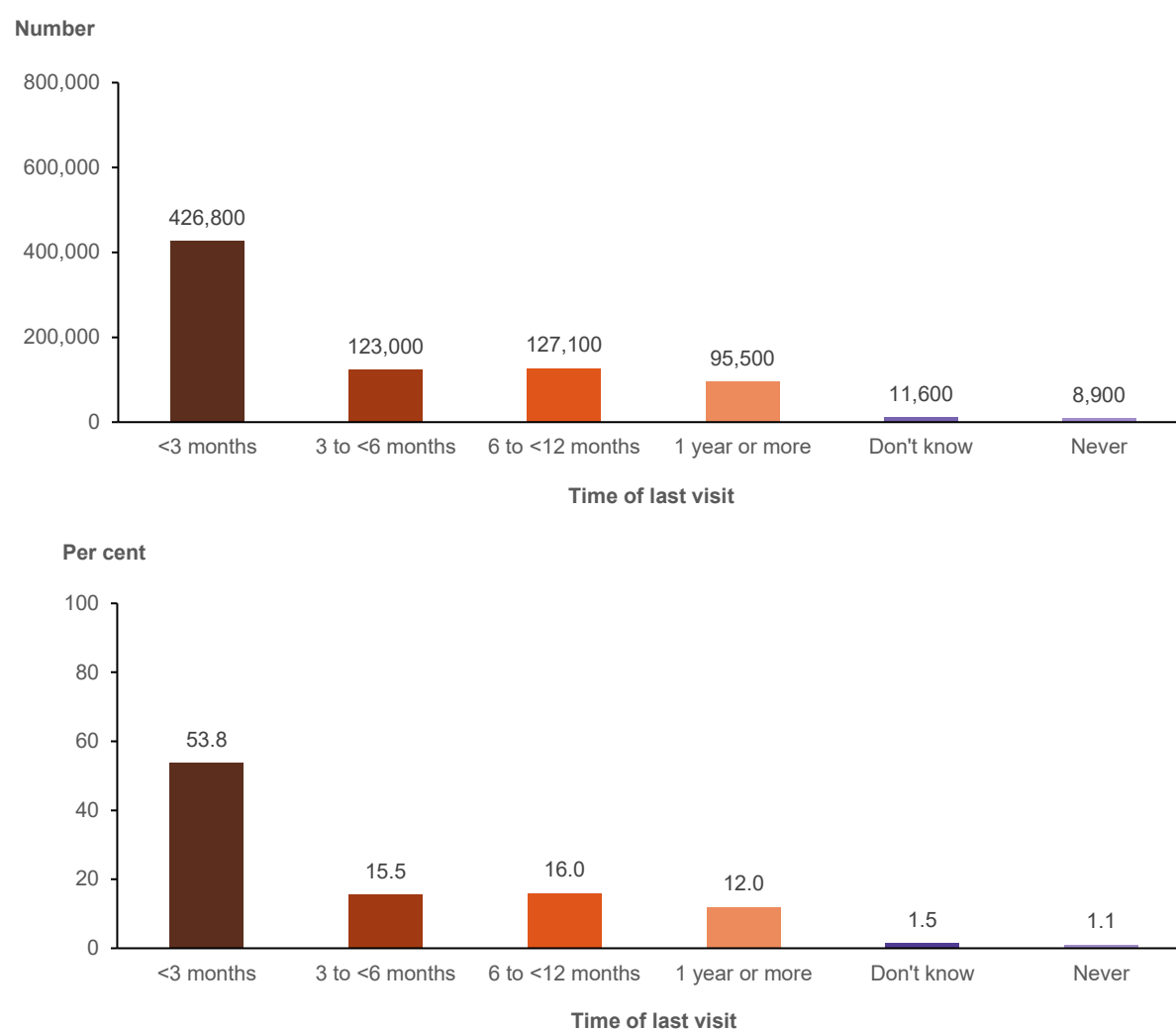
Timing of most recent visit

Clients may visit GPs for a number of reasons, including preventive care, immunisations and screening, acute illnesses or injuries, chronic disease management, antenatal care, palliative care, follow-up of test results, health education, referrals to specialist or multidisciplinary care, or for medical certificates. The NACCHO and the Royal Australian College of General Practitioners (RACGP) recommend that all Aboriginal and Torres Strait Islander people visit a GP at least once a year for a comprehensive health check.

The 2018–19 NATSIHS data show that for just over half of Aboriginal and Torres Strait Islander people their most recent visit to a GP was within the past 3 months (54%, 426,800 people).³⁹ At the national level, just over 12% report not having seen a GP within the past 12 months.

³⁹ The NATSIHS does not ask the reason for the most recent visit.

Figure 5.3: Aboriginal and Torres Strait Islander people, most recent visit to a GP, 2018–19



Notes

1. Excludes respondents who answered 'saw specialist in last 2 weeks but not a GP'.
 2. Estimate for those reporting 'Don't know' has a relative standard error between 25% and 50% and should be used with caution.
- Source: AIHW analysis of 2018–19 NATSIHS using TableBuilder (ABS 2019).

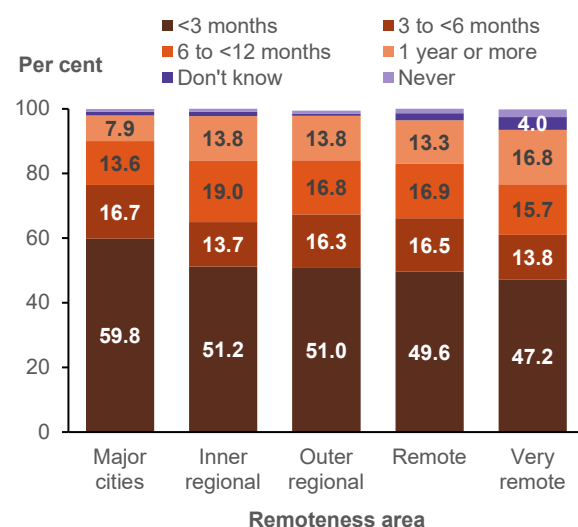
The timing of the most recent visit to a GP varies considerably by a number of the independent variables (Figure 5.4; [Data](#): Descriptive analysis supplementary tables, Table S.5). In terms of the location variables, those Aboriginal and Torres Strait Islander people living in *Major cities* were most likely to have had a recent visit (60%) and least likely to have gone more than a year without seeing a GP (7.9%). The pattern is reversed for those living in *Very remote* areas where 47% saw a GP in the past 3 months and 17% had not seen a GP in the past 12 months.

There are also variations by state and territory – for at least 13% of those in New South Wales, Western Australia, South Australia and the Northern Territory, their most recent GP visit was more than 12 months before the survey, compared with fewer than 7% of those in the Australian Capital Territory.

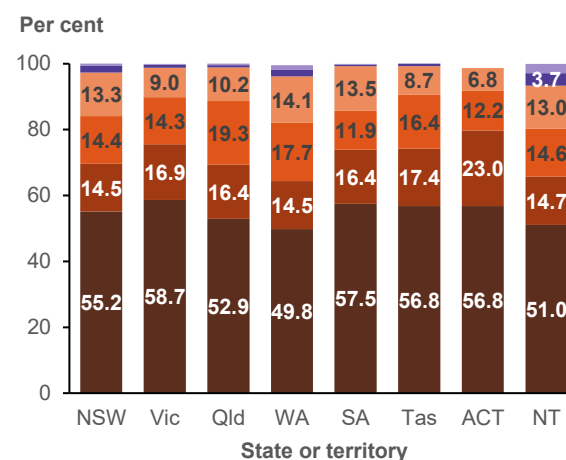
There are also a number of differences by individual-level characteristics. Females were more likely than males to have seen a GP in the past 3 months (58% compared with 50%), while 15% of males reported that their most recent visit was more than 12 months before the survey (compared with 9.3% of females).

Figure 5.4: Aboriginal and Torres Strait Islander people, timing of most recent visit to a GP, by selected characteristics, 2018–19

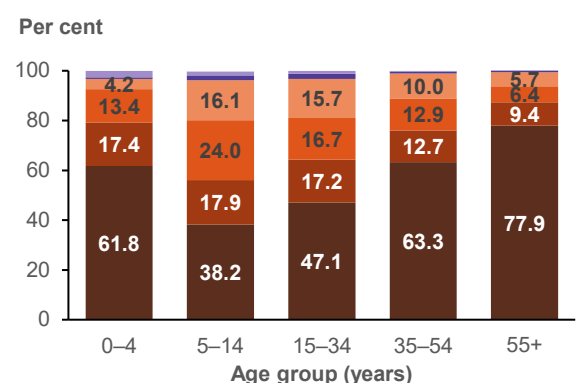
a) Remoteness



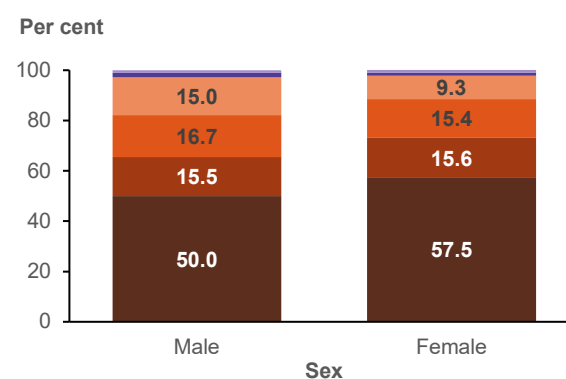
b) State/territory



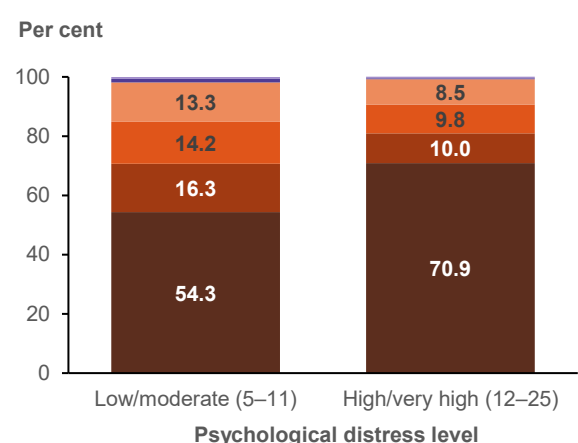
c) Age



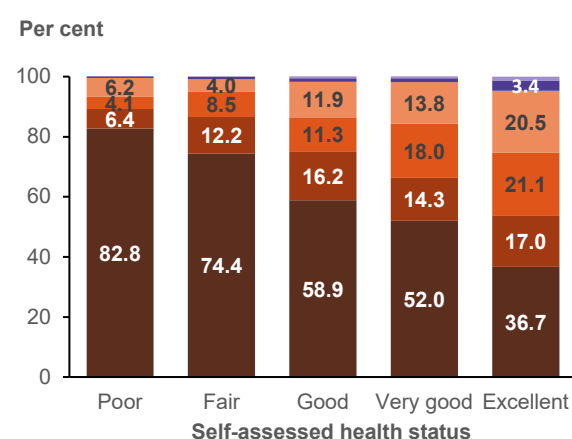
d) Sex



e) Level of psychological distress (K5), (aged 18 and over)



f) Self-assessed health status (aged 15 and over)



Notes

1. Excludes respondents who answered 'saw specialist in last 2 weeks but not a GP'.
2. Estimates for those reporting 'Don't know' or 'Never' have a relative standard error between 25% and 50% and should be used with caution.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

As would be expected, the very young (0–4-year-olds) and 55 and over age groups were more likely to have seen a GP in the past 3 months compared with teenagers and young adults, with 78% of those aged 55 and over seeing a GP in the past 3 months compared with 38% of 5–14-year-olds.

Recency of visit is also related to self-assessed health and to levels of psychological distress among adults. Eighty-three per cent of those with poor health saw a GP in the past 3 months, compared with 37% of those in excellent health; 71% of those with high/very high levels of psychological distress saw a GP in the past 3 months, compared with 54% of those with low/moderate levels.

Unmet needs

NATSIHS respondents were asked whether there was ever a time during the past 12 months where they (or their child) needed to go to a GP but did not. If they said there had been an occasion of unmet need, they were given a list of 13 potential reasons why they did not go and asked to tick as many as applied.

While the question does not provide any information on why the person (or their child) needed to go to the doctor in the first place (for example, whether it was for an acute event or illness, part of ongoing chronic disease care, for preventive care, or for something such as a medical certificate), it is a direct measure of the person's perceived unmet need.

The findings suggest that of 814,000 Aboriginal and Torres Strait Islander people in 2018–19:

- 712,600 (88%) had no unmet need for GPs
- 101,400 (13%) had at least one instance in the past 12 months when they needed to see a GP but did not.

Unmet need for a GP was slightly higher among those whose usual source of care was a mainstream GP (13%) than among those whose usual source of care was an AMS/CC (9.2%).⁴⁰

Figure 5.5 presents both the percentage of each included group with unmet need and the number of Aboriginal and Torres Strait Islander people with that characteristic who had at least one occasion of unmet need. It shows that:

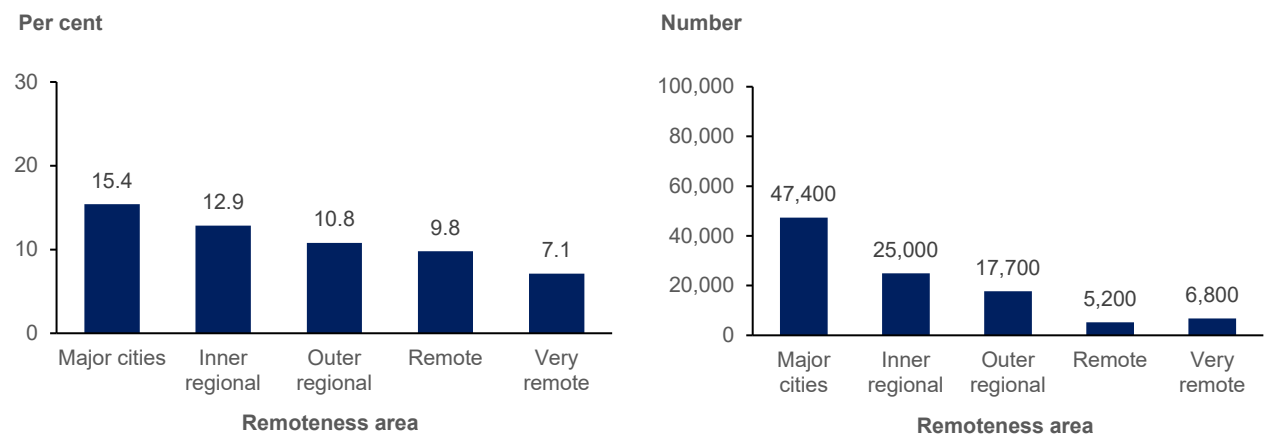
- those in *Major cities* had both the highest proportion (15%) and the highest number of people with unmet need (47,400), compared with all other remoteness areas
- while the Australian Capital Territory had the highest proportion of people with unmet need (25%), it also had the lowest number of people (1,900 people). In absolute terms, New South Wales and Queensland had the highest number of people with unmet needs (34,400 and 25,000, respectively)
- fewer than 2% of children (aged 0–14) had an occasion of unmet need in the past 12 months, compared with 21% of those aged 35–54. The highest number of people with an unmet need were in the 15–34 age group (nearly 43,000)
- there were 49,600 people living in the most disadvantaged areas with unmet need
- the proportion of adults who had experienced unfair treatment in the past year with unmet need was 31%, which is double the proportion of those who had not experienced unfair treatment
- those with disability and those with a long-term health condition had considerably higher rates of unmet needs than their counterparts. The results indicate that, in 2018–19, 86,100 Aboriginal and Torres Strait Islander people with a long-term health condition

⁴⁰ Among those who always used the same source of care.

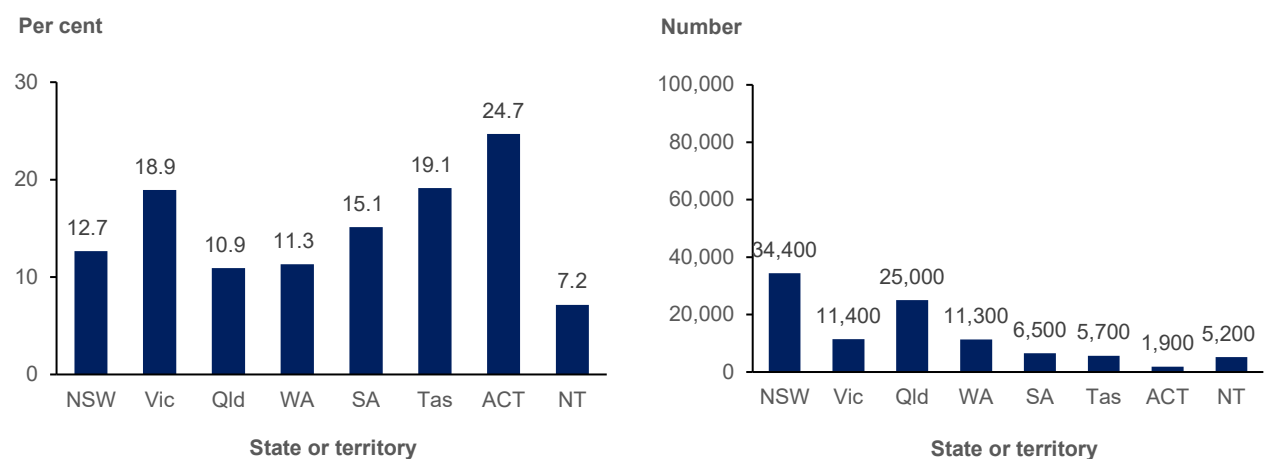
had at least one occasion of unmet need in the previous 12 months, and that 64,700 people with disability had unmet need.

Figure 5.5: Aboriginal and Torres Strait Islander people, unmet need for GP in the past 12 months, by selected characteristics, 2018–19

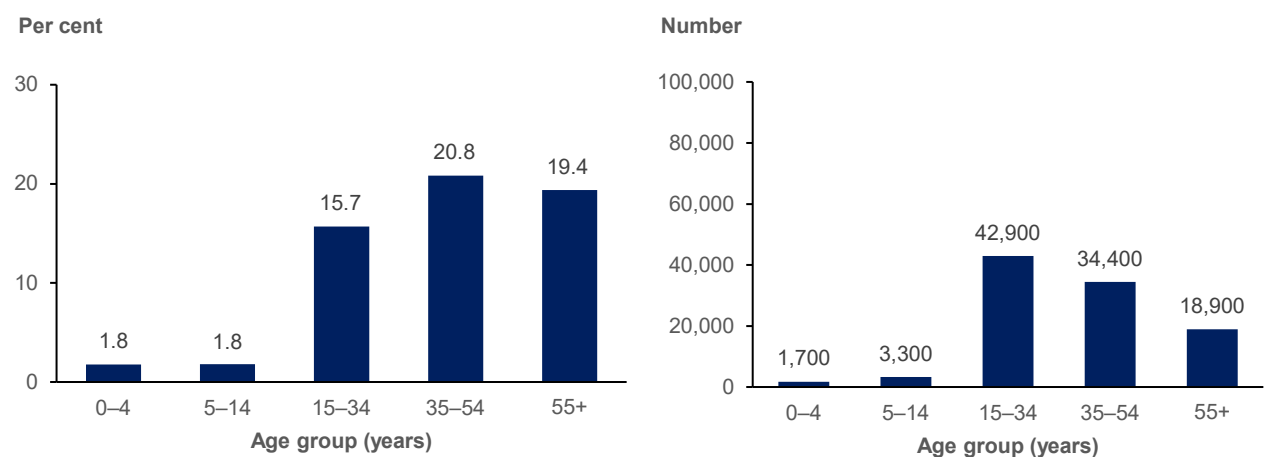
a) Remoteness



b) State/territory



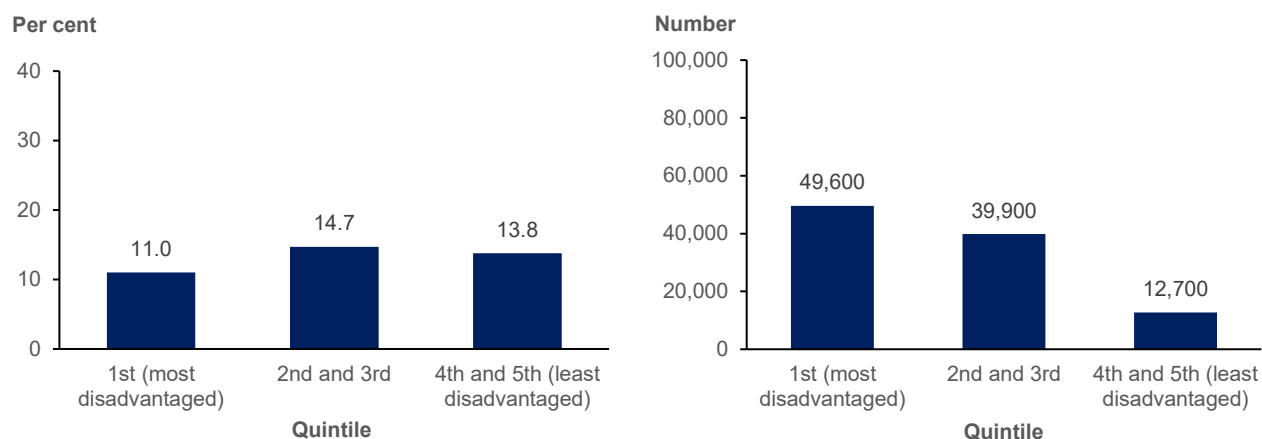
c) Age



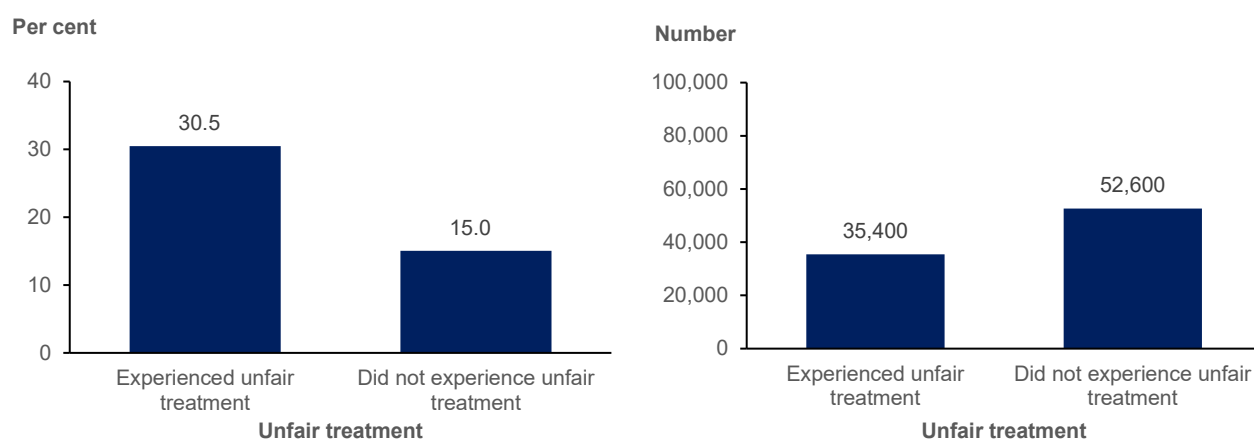
(continued)

Figure 5.5 (continued): Aboriginal and Torres Strait Islander people, unmet need for GP in the past 12 months, by selected characteristics, 2018–19

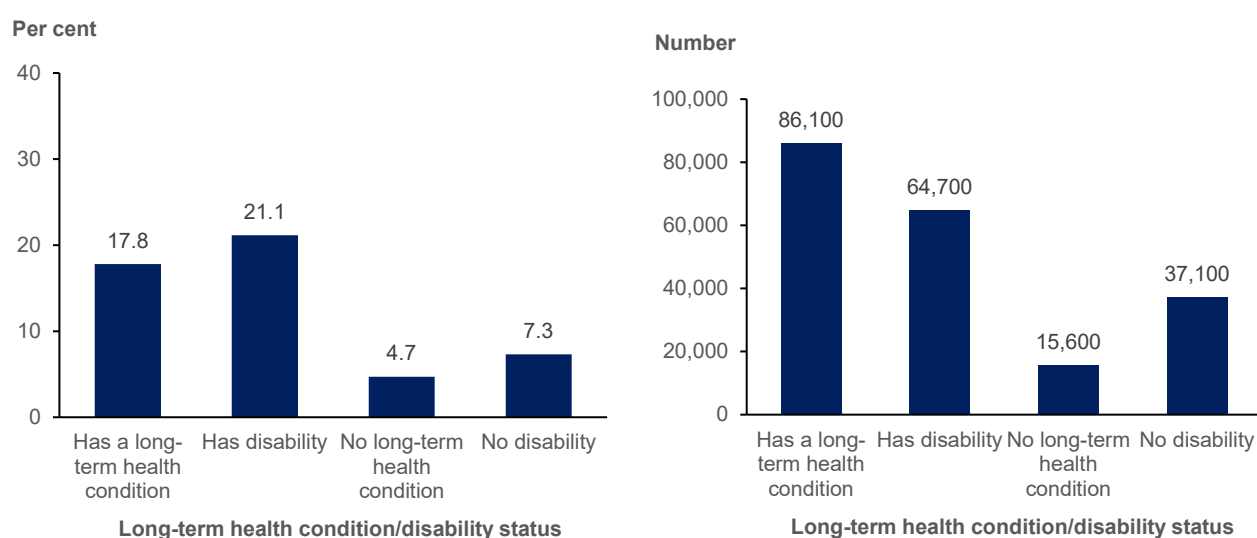
d) SEIFA



e) Experienced unfair treatment in the past 12 months (aged 18 and over)



f) Long-term health conditions/disability status



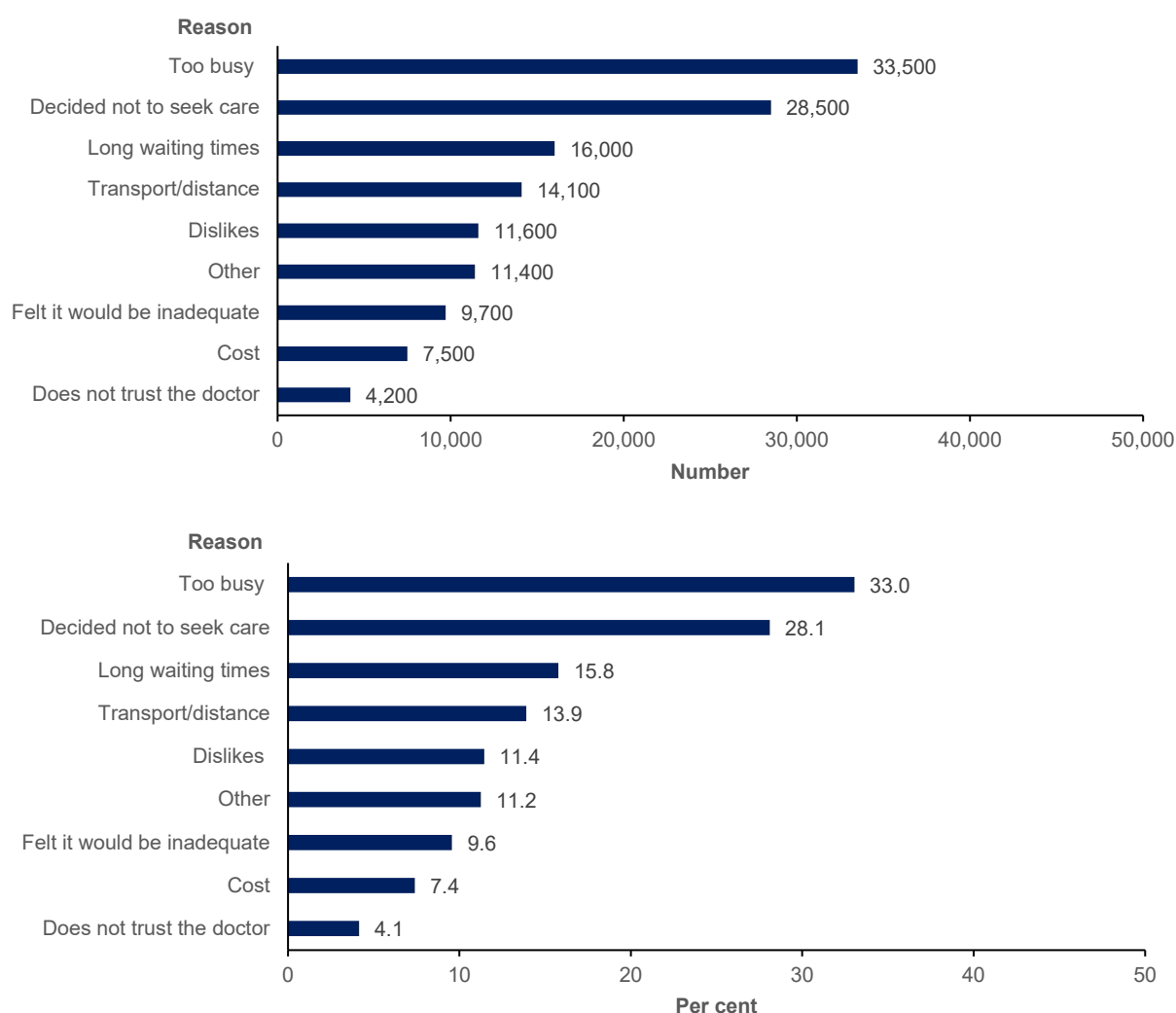
Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Reasons for unmet need

Respondents with unmet need could select as many of a set of 13 reasons as they wanted to explain why they were unable to obtain the care they needed. As shown in Figure 5.6, the most common reasons were being too busy, and deciding not to seek care. Without knowing the underlying reason for wanting to see a GP on the occasion, it is difficult to speculate why a person decided not to seek care, although it may be that the issue resolved itself (for example, an acute illness).

System factors, such as long waiting times and transport/distance were the next most frequently cited reasons. Cost was cited as a reason by only 7.4% of those with unmet need.⁴¹

Figure 5.6: Aboriginal and Torres Strait Islander people, reasons had unmet need for a GP, 2018–19



Notes

1. Percentage distribution is calculated only on those who said they had at least one occasion of unmet need in the past 12 months.
2. Only reasons with an acceptable standard error were included.
3. The full wording of the graph label 'Dislikes' is 'Dislikes (service/professional, afraid, embarrassed)'. Respondents were allowed to select multiple responses.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

⁴¹ The numbers citing each individual reason were too small to allow reliable disaggregation by many of the independent variables, so only the national patterns are presented here. For breakdowns with the level of standard errors flagged, see [Data: Descriptive analysis supplementary tables, Table S.7](#)).

Dental care

Timing of most recent visit

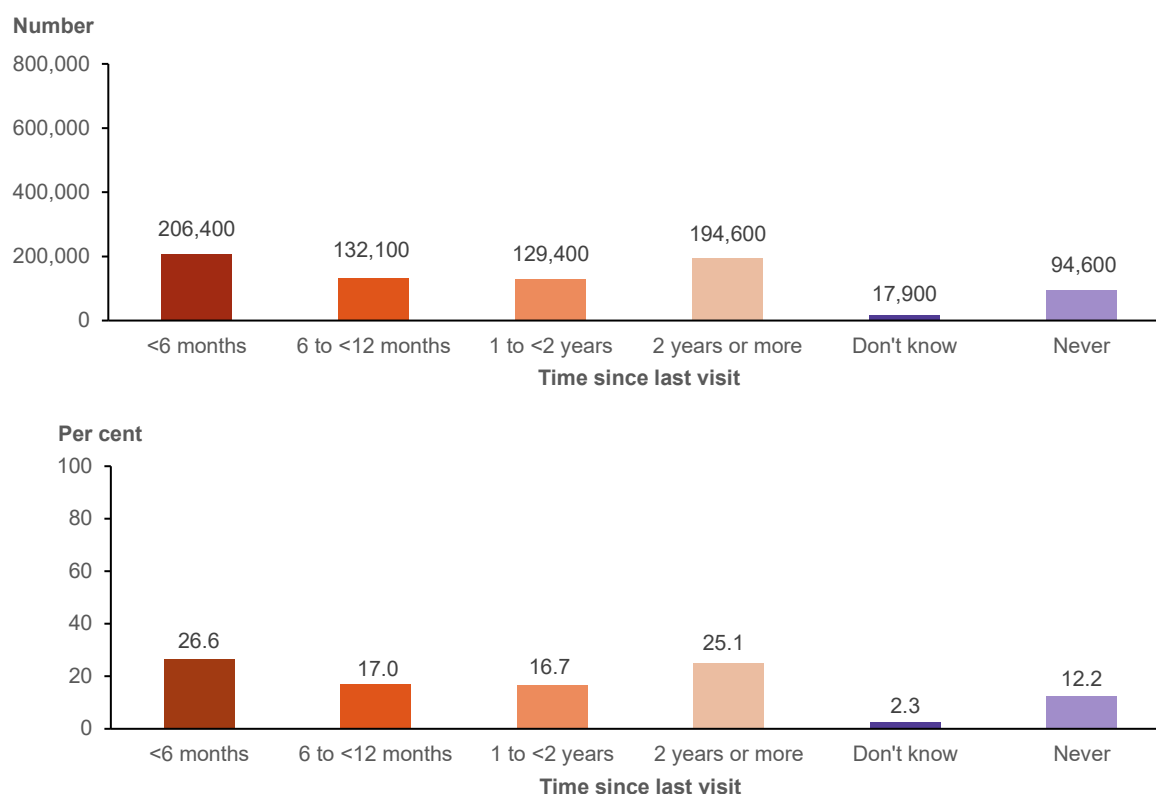
Oral health is an important component of overall health and quality of life. Poor oral health can affect adults and children alike, causing pain, embarrassment, and even social marginalisation. For children, the effects can be long term, and carry through to adulthood.

Many Aboriginal and Torres Strait Islander people experience poor oral health, such as multiple caries and untreated dental disease, and are less likely to have received preventive dental care (AHMAC 2017). Several factors contribute towards the poorer oral health of Aboriginal and Torres Strait Islander people, including social disadvantage and lack of access to appropriate diet and dental services.

Dental visits can be for preventive dental care, to maintain existing oral health, to reverse disease or to rehabilitate teeth and gums after damage has occurred. It is recommended that Aboriginal and Torres Strait Islander people visit the dentist at least once a year and have a usual dental provider (AIHW 2023c).

According to the 2018–19 NATSIHS, for 25% of Aboriginal and Torres Strait Islander people over the age of 2, it had been 2 years or more since their last visit to the dentist, with another 12% saying they had never been to a dentist (Figure 5.7)

Figure 5.7: Aboriginal and Torres Strait Islander people (aged 2 and over), timing of most recent visit to a dentist, 2018–19



Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

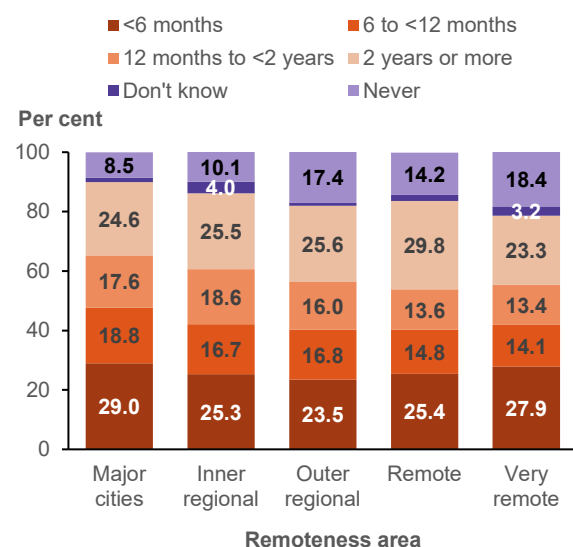
The proportion seeing a dentist within the past 2 years was highest among those in *Major cities* (65%) and lowest in *Remote* areas (54%), while those in *Very remote* areas were most likely to say they had never seen a dentist (18%) (Figure 5.8).

Young children were both most likely to have seen a dentist in the past 6 months (35%) and most likely to have never seen one (23%). Nearly 50% of those with fair or poor self-assessed health had either never seen a dentist or not seen one in the past 2 years,

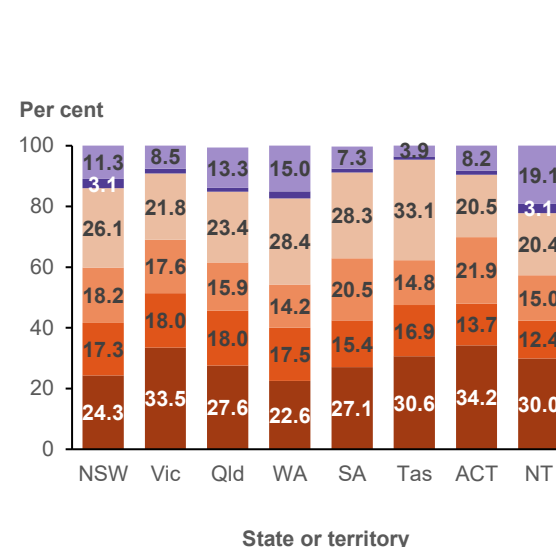
signifying considerable unmet need (noting that a lack of dental care can contribute to poor overall health as well).

Figure 5.8: Aboriginal and Torres Strait Islander people (aged 2 and over), timing of most recent visit to a dentist, by selected characteristics, 2018–19

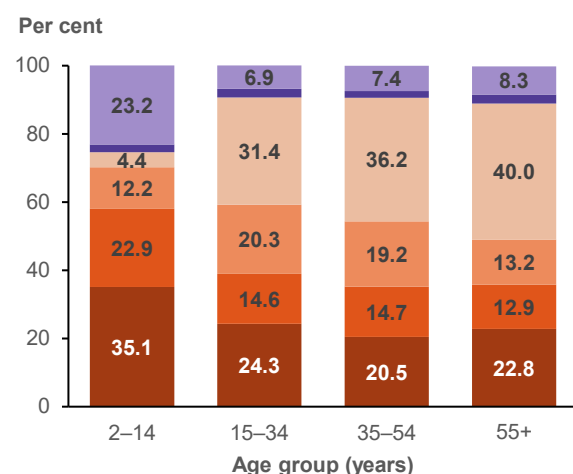
a) Remoteness



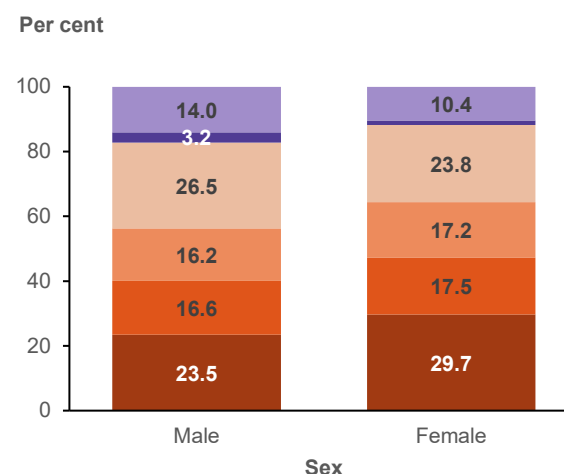
b) State/territory



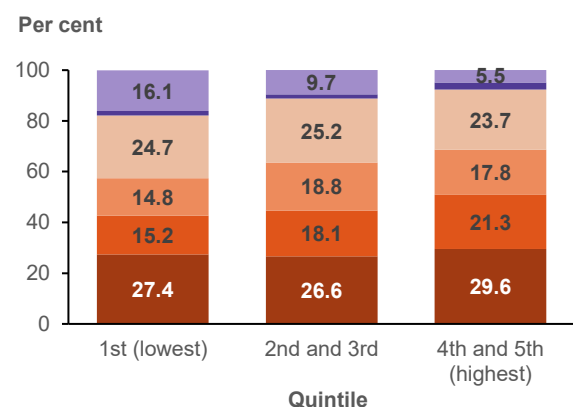
c) Age



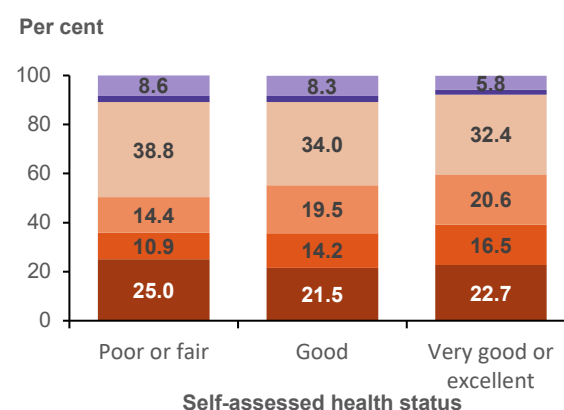
d) Sex



e) Equivalised household income



f) Self-assessed health status (aged 15 and over)



Source: AIHW analysis of 2018–19 NATSIHS using TableBuilder (ABS 2019).

Unmet needs

NATSIHS respondents were asked whether there was ever a time during the past 12 months where they (or their child) needed dental care but did not get it. If they said there had been an occasion of unmet need, they were given a list of 13 potential reasons why they did not go and were asked to tick as many as applied.

The findings suggest that, of 774,600 Aboriginal and Torres Strait Islander people aged 2 and over:

- 627,000 (81%) had no unmet need for dental services
- 146,800 (19%) had at least one instance in the past 12 months when they needed dental care but did not get it.

Unmet need for dental care was slightly higher among those whose usual source of care was a mainstream GP (18%) than among those whose usual source of care was an AMS/CC (16%).⁴²

Although the levels of unmet need for dental care were higher than those for GP care, the patterns are generally similar (Figure 5.9):

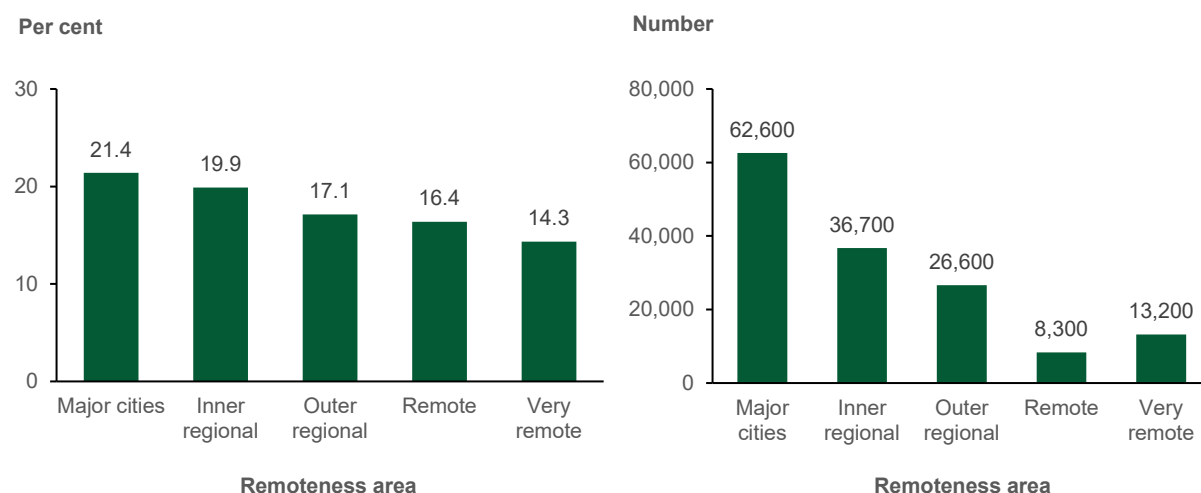
- Those in *Major cities* had both the highest proportion (21%) and the highest number of people with unmet need (62,600), compared with all other remoteness areas. However, there was less variation between remoteness areas than for unmet need for GPs – unmet need ranged from 14% in *Very remote* areas to 21% in *Major cities*.
- Again the Australian Capital Territory had the highest proportion of people with unmet need (25%), and the lowest number of people (1,800 people). In absolute terms, New South Wales and Queensland had the highest number of people with unmet needs (45,300 and 42,400, respectively).
- Young children had low rates of unmet need for dental care (which may be related to targeted children's dental programs). The highest number of people with an unmet need were in the 15–34 age group (71,300).
- There were 76,400 people living in the most disadvantaged areas with unmet need.
- The proportion of adults who had experienced unfair treatment in the past year with unmet need was 39%, which is higher than the proportion of those who had not experienced unfair treatment (24%).

Unmet need differed from that for GPs with regard to disability. While the pattern for those with long-term health conditions was similar (higher proportions and higher numbers than those without), those with disability had lower rates of unmet need for dental services than those without (14% versus 26%). However, there are still considerable numbers of Aboriginal and Torres Strait Islander people with disability who had unmet need (67,600).

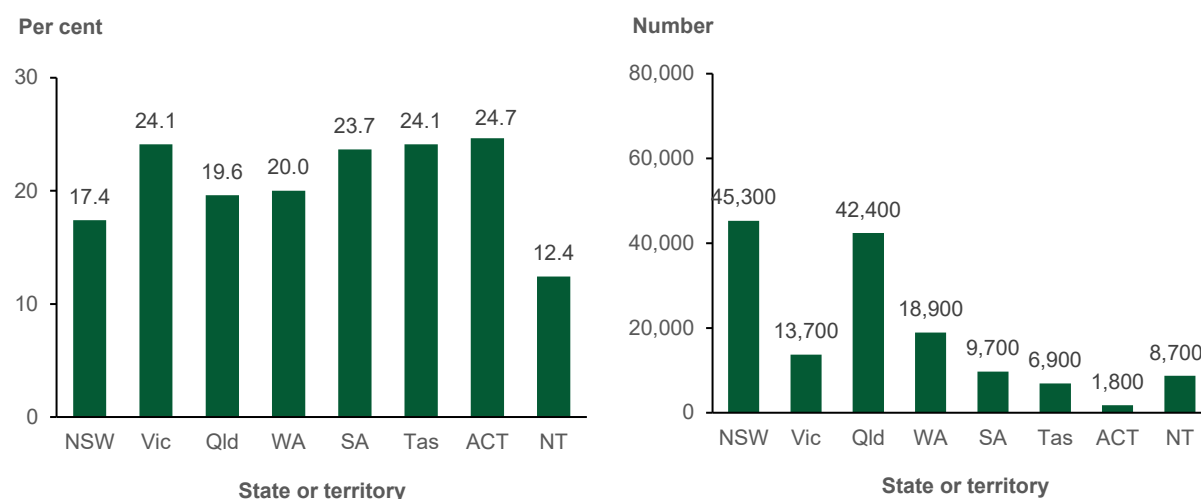
⁴² Among those who always used the same source of care.

Figure 5.9: Aboriginal and Torres Strait Islander people (aged 2 and over), unmet need for dental care in the past 12 months, by selected characteristics, 2018–19

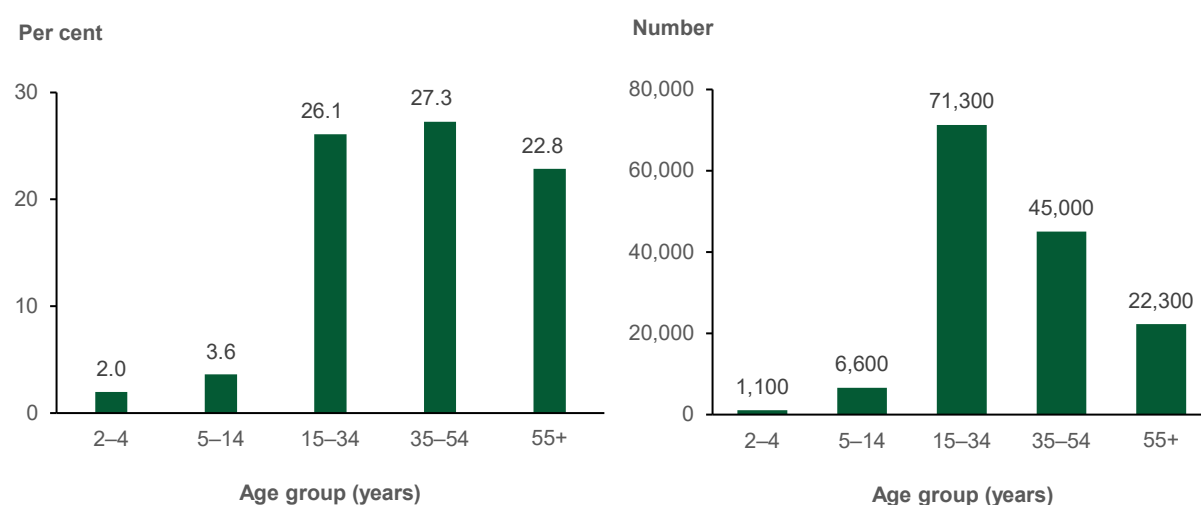
a) Remoteness



b) State/territory



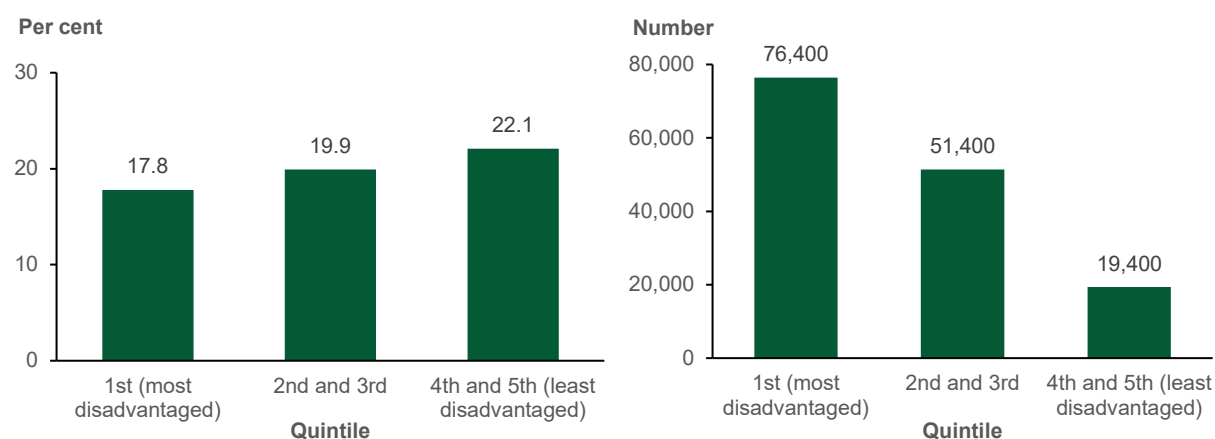
c) Age



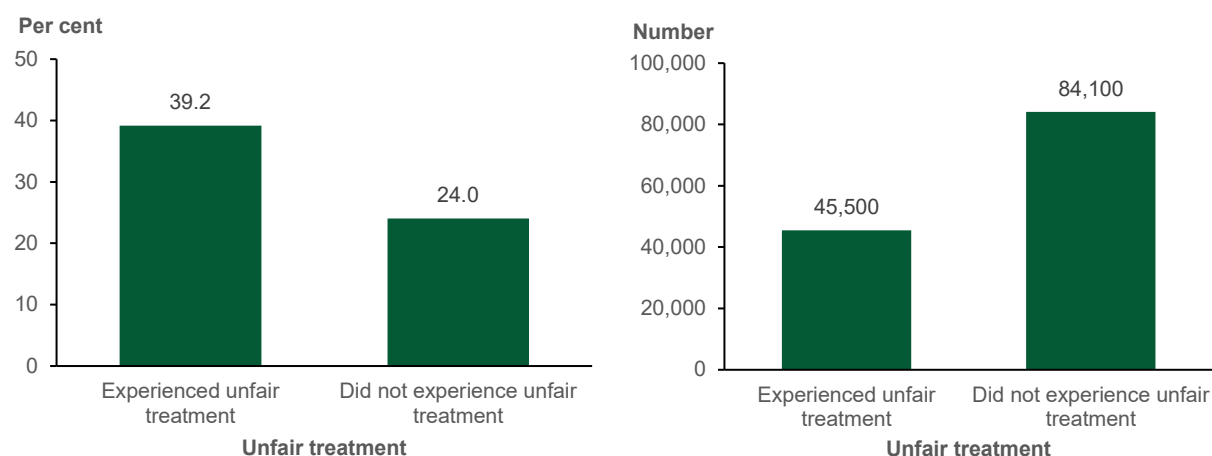
(continued)

Figure 5.9 (continued): Aboriginal and Torres Strait Islander people (aged 2 and over), unmet need for dental care in the past 12 months, by selected characteristics, 2018–19

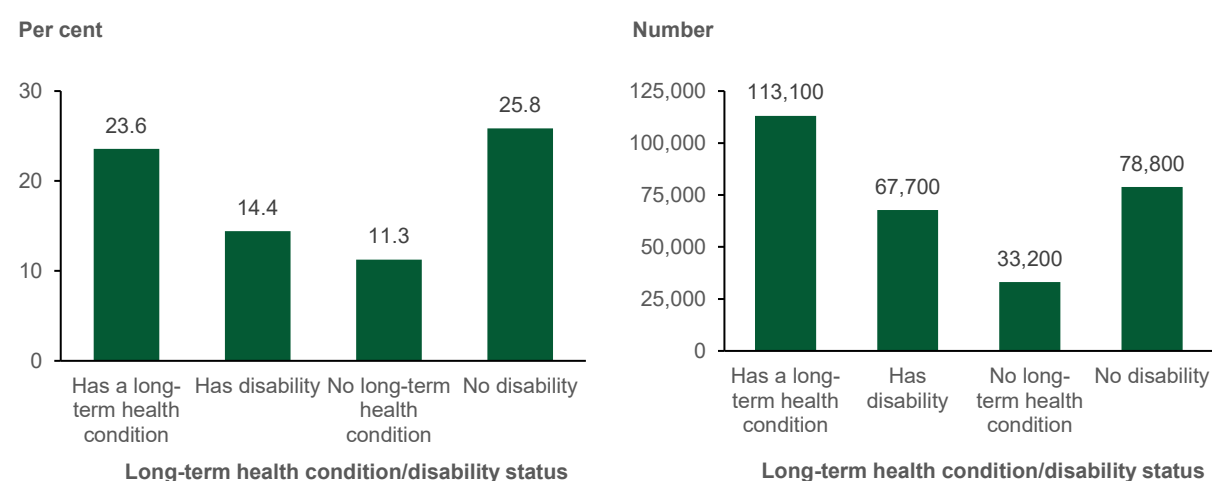
d) SEIFA



e) Experienced unfair treatment in the past 12 months (aged 18 and over)



f) Long-term health conditions/disability status

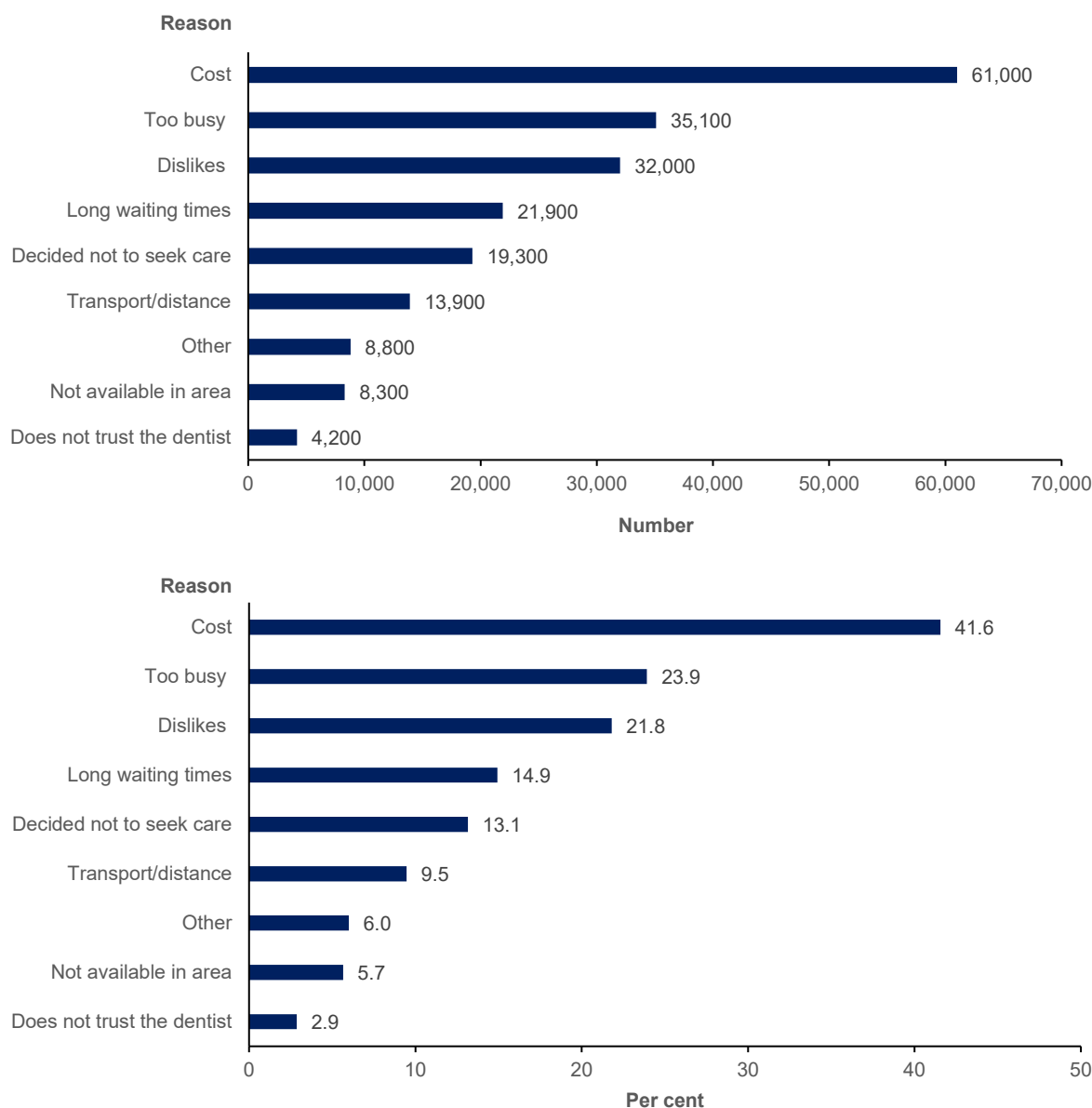


Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Reasons for unmet need

By far the most frequently cited reason for unmet need for dental care was cost, with 42% selecting it as an explanation for why they were unable to obtain care (Figure 5.10). As with the unmet need for GPs, 'too busy' was also a frequently cited explanation.

Figure 5.10: Aboriginal and Torres Strait Islander people (aged 2 and over), reasons for unmet need for dental care, 2018–19



Notes

1. The percentage distribution is calculated only on those who said they had at least one occasion of unmet need in the past 12 months.
2. Only reasons with an acceptable standard error were included.
3. The full wording of the y-axis label 'Dislikes' is 'Dislikes (service/professional, afraid, embarrassed)'.
4. Respondents were allowed to select multiple responses.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

The pattern for unmet need also differs from that for GPs with respect to the number/proportion of people saying that one of the reasons for the unmet need is that they dislike the service/professional, or that they are afraid or embarrassed about getting dental care, with 22% citing it as a reason. Understanding this fear and embarrassment is essential to overcome barriers to dental care, even when it is available.

Looking at whether these reasons differed by the person's usual source of care (AMS/CC and mainstream GPs only) shows that cost was much less of a barrier for those using AMS/CC (29% versus 48%) (Table 5.2).

Table 5.2: Aboriginal and Torres Strait Islander people (aged 2 and over), top reasons for unmet need for dental care, by usual source of care, 2018–19 (percentages)

	AMS/CC	Mainstream GP
Cost	29.4	48.2
Too busy (including work, personal, family responsibilities)	23.7	24.4
Dislikes (service/professional, afraid, embarrassed)	21.4	22.2
Waiting time too long or not available at time required	19.4	13.2
Decided not to seek care	9.8	13.6
Total with unmet need	45,900	79,400

Experiences with the health care system

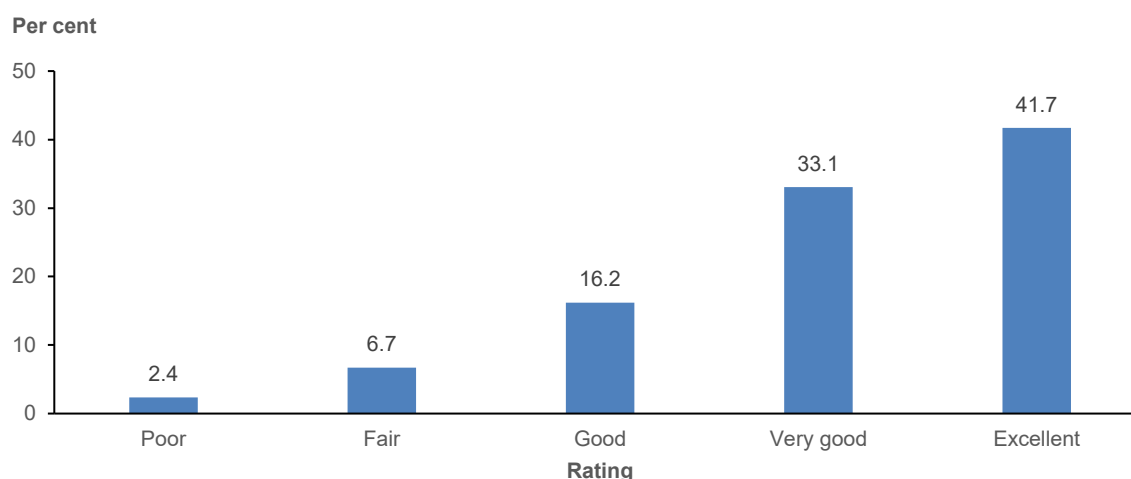
The set of questions in the NATSIHS that relate to respondents' experiences and satisfaction with the health care they receive were mainly asked only of those aged 15 and over who were present at the interview and who live outside remote areas.

Rating of overall health care received (non-remote only)

Respondents aged 15 and over living outside remote areas and who were present at the interview were asked to rate how good they felt the health care they got from GPs and other health services was in the last 12 months.

The majority of the included respondents rated their health care quite highly, with nearly 75% rating it very good or excellent (Figure 5.11). Fewer than 3% of included respondents rated it as poor.

Figure 5.11: Aboriginal and Torres Strait Islander people, rating of health care received in the past 12 months, 2018–19



Note: Includes only those aged 15 and over who were physically present at the time of the interview and lived in non-remote areas.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Disaggregation by usual source of care (AMS/CC and mainstream GPs) showed little difference in overall rating of health care.

Experiences with own GP(s) (non-remote only)

Respondents aged 15 and over who were physically present at the interview and who lived outside remote areas were asked to rate, in the past 12 months, how often their GP(s):

- explained things in a way they could understand
- listened to them
- showed respect for what they had to say
- spent enough time with them.

Overall, respondents rated their experiences with their GPs quite highly (Table 5.3).

Table 5.3: Aboriginal and Torres Strait Islander people, distribution of experiences with GP(s), 2018–19

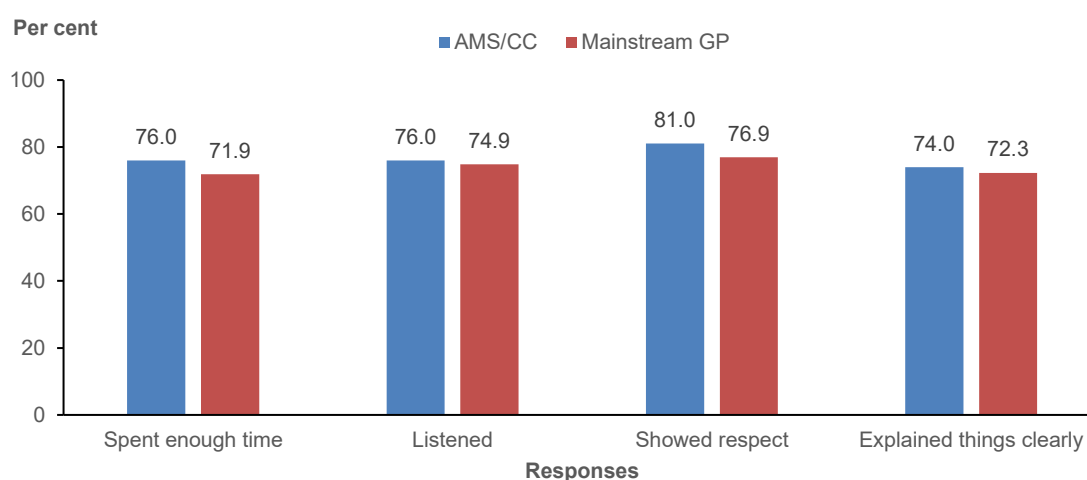
In the last 12 months, how often did GP(s)	Never	Rarely	Sometimes	Usually	Always	Total
Number						
Explain things clearly	4,800	12,600	24,500	62,400	239,700	344,000
Listen	4,600	8,000	26,200	57,500	247,000	343,300
Show respect	2,700	7,400	20,500	52,100	260,700	343,400
Spend enough time	5,800	14,600	22,400	61,700	238,900	343,400
%						
Explain things clearly	1.4	3.7	7.1	18.1	69.7	100.0
Listen	1.3	2.3	7.6	16.7	71.9	100.0
Show respect	0.8	2.2	6.0	15.2	75.9	100.0
Spend enough time	1.7	4.3	6.5	18.0	69.6	100.0

Note: Questions only asked of those aged 15 and over who were physically present at the interview and lived in non-remote areas.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Nearly 90% of respondents felt their GPs usually or always explained things in a way they could understand, spent enough time with them, and listened to them, while over 90% felt they usually or always showed respect for what they had to say (Figure 5.12).

Figure 5.12: Aboriginal and Torres Strait Islander people aged 15 and over in non-remote areas, proportion responding ‘always’ to aspects of their experiences with their GPs, by usual source of care, 2018–19



Note: Includes only those who always used the same source of care.

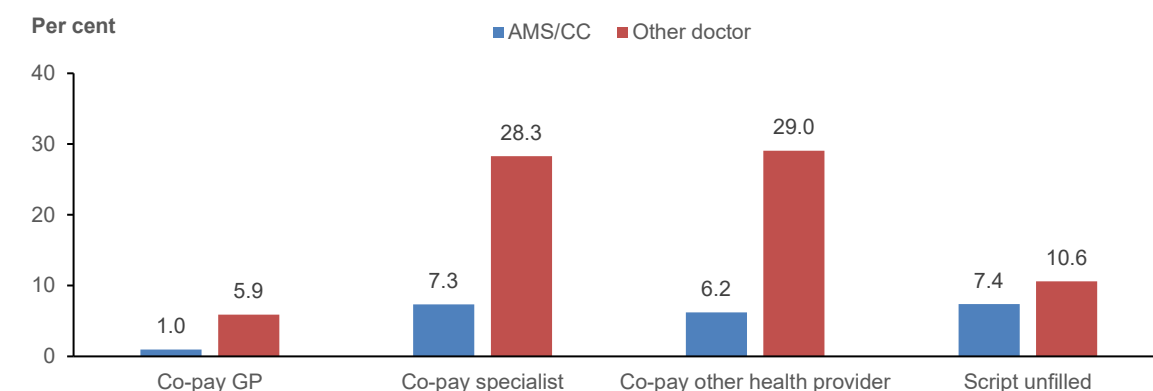
Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

While those with a consistent source of care were likely to rate their GPs highly (by giving them a score of 'always' on the 4 aspects), the proportions were higher for those who always used an AMS/CC than for those who always used a mainstream GP, with 81% saying their GP always showed respect in their interactions.

Co-pay for care and unfilled scripts (non-remote only)

One area where there were large differences in respondents' experiences by usual source of health care was in the payments required for consultations with specialists, with other health providers, and the likelihood of not filling a prescription (Figure 5.13).

Figure 5.13: Aboriginal and Torres Strait Islander people, co-payments at last consultation, by type of provider and unfilled scripts and usual source of health care, 2018–19



Notes

1. Includes only non-remote areas.
2. Percentages are calculated on the number of respondents who had a consultation with the provider in the past 2 weeks.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

While co-payments for consultations with GPs were relatively infrequent overall, they were higher for those whose usual source of health care was a mainstream GP. The largest differences were in the co-payments required to see specialists and other health-care providers, where nearly 30% of those seeing mainstream GPs were required to pay, compared with 7.3% of those using AMS/CC.

6 Spatial analysis

The NATSIHS provides important information on how individuals perceive the availability of services in their local area, but the data cannot reliably be disaggregated to small geographic areas.

For example, Table 3.1 highlighted that once remoteness areas within states/territories are considered, a number of the cells have small numbers and high standard errors, which means they should be used with caution or not at all. As well, the data are from 2018–19, while the locations of both IAHP-funded services and mainstream GPs may have changed since then as services move into and out of areas.

This chapter presents the results of the analysis of drive times to services, using data from 2022–23 on locations of IAHP-funded services and from 2024 on the practice locations of mainstream GPs.

Included services and their distribution

The drive time analysis includes over 7,600 service locations, the majority of which are mainstream GP practices (Table 6.1). The locations of 326 IAHP-funded ACCHO-provided services/clinics were included, along with 120 service delivery sites that were IAHP-funded but provided by government or non-government organisations (NGOs). The locations of the primary health care services are displayed on the maps in Figure 6.1.

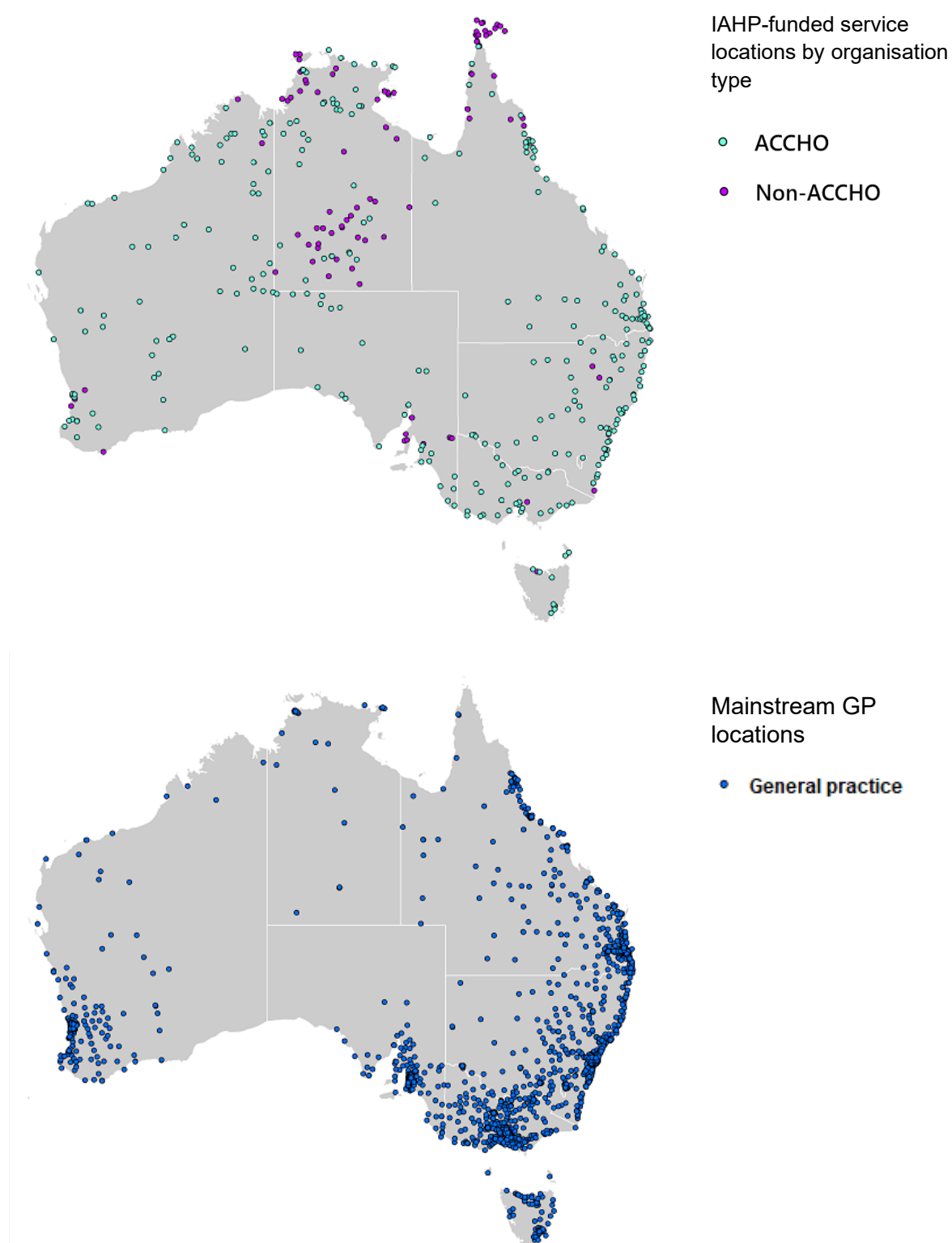
Table 6.1: Number of geocoded primary health care service locations, by state/territory and organisation type

State/territory	IAHP-funded services by organisation type		Mainstream GP practice	Total number of service locations
	ACCHO	Non-ACCHO		
New South Wales	72	8	2,402	2,482
Victoria	29	1	1,915	1,945
Queensland	69	37	1,428	1,534
Western Australia	67	18	676	761
Northern Territory	45	47	50	142
South Australia	28	8	470	506
Tasmania	13	1	146	160
Australian Capital Territory	1	—	102	103
Australia	326	120	7,192	7,638

Sources: IAHP-funded service locations were taken from the 2022–23 OSR collection – those organisations that provide maternal and child health services only (not comprehensive primary care) were excluded. Mainstream GP practice locations were extracted from the NHSD as at April 2024.

The maps shown in Figure 6.1 highlight the role that IAHP-funded services play as primary health providers, particularly in more remote areas where they are often the only providers.

Figure 6.1: Locations of primary health services, by type



Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details, see Appendix 1.

Drive times

Nationally, an estimated 99% of Aboriginal and Torres Strait Islander people have a primary care service within a 1-hour drive, with just over 11,100 people having no primary health service location within 60 minutes (Table 6.2).⁴³

It is important to note that this is a baseline measure of access and only captures whether there is a service within that drive time – it does not take the current capacity of the practice to serve patients or the cultural safety of the services into account. It also does not reflect whether individuals have the resources to be able to travel to the locations.

Table 6.2 also shows that there are an estimated 52,700 Aboriginal and Torres Strait Islander people who live outside a 1-hour drive to any IAHP-funded service location (5.4%), and over 90,200 who live outside a 1-hour drive to an IAHP-funded ACCHO specifically (9.2%). The analysis also found that 6.8% of Aboriginal and Torres Strait Islander people live outside a 1-hour drive to a mainstream GP practice location.

Table 6.2: Distribution of Aboriginal and Torres Strait Islander people, by drive time to nearest primary health service location and by provider type

Primary health service type	Drive time (mins) (number)				Drive time (mins) (%)			
	<=30	>30 to <=60	>60	Total	<=30	>30 to <=60	>60	Total
IAHP-funded ACCHO	793,085	99,633	90,246	982,964	80.7	10.1	9.2	100.0
Any IAHP-funded service	848,016	82,225	52,724	982,964	86.3	8.4	5.4	100.0
Mainstream GP	903,102	12,597	67,265	982,964	91.9	1.3	6.8	100.0
Any primary care	961,265	10,582	11,117	982,964	97.8	1.1	1.1	100.0

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024); Online Services Report 2022–23.

Variation by remoteness

As shown in Figure 6.1, there are considerable variations in service locations by remoteness. The impact of this variation is seen in the results of the drive time analysis: everyone in a *Major city* or *Inner regional* area was within a 1-hour drive of at least one type of primary care service, as were 99% of those in *Outer regional* and *Remote* areas, compared with 89% of those in *Very remote* areas (Figure 6.2).

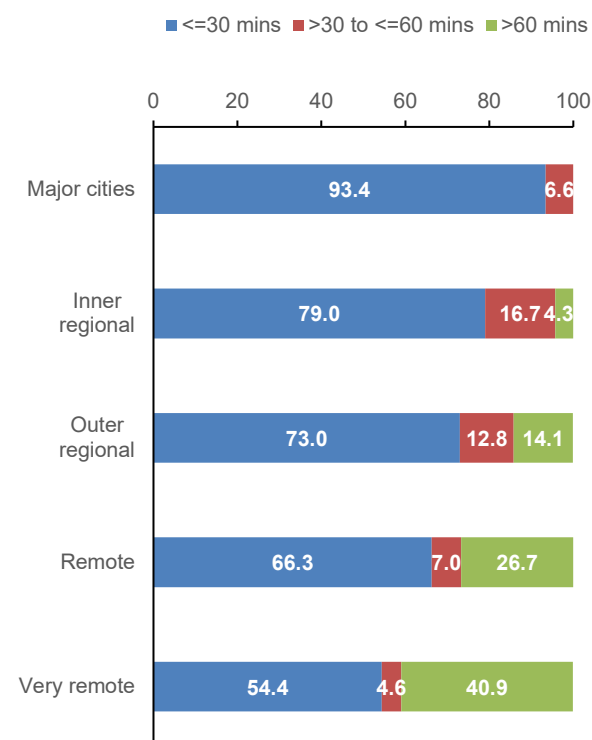
The importance of IAHP-funded services (both ACCHOs and non-ACCHOs) in providing access to primary health care in *Remote* and *Very remote* areas is highlighted in panels (c) and (d) of Figure 6.2. Fifteen per cent of those in *Remote* areas and 64% of those in *Very remote* areas live more than a 1-hour drive to a mainstream GP. When IAHP-funded services are included, however, 99% of those in *Remote* areas and 89% of those in *Very remote* areas live within a 1-hour drive of at least one of the included primary care services.⁴⁴

⁴³ Drive times over 60 minutes are commonly used as a threshold for no/poor access.

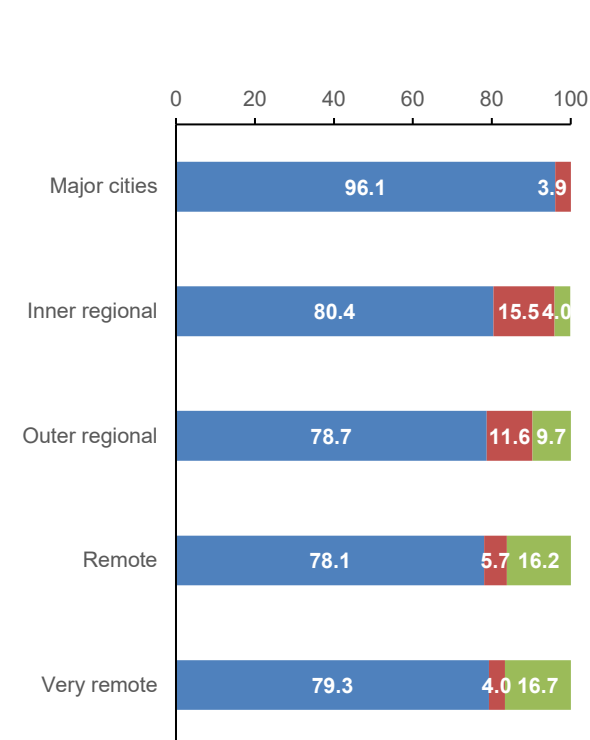
⁴⁴ Again, it is important to note that there may be primary care services that are available on the ground but not included in either the NHSD or the OSR.

Figure 6.2: Percentage distribution of Aboriginal and Torres Strait Islander people by drive time to nearest primary health service location and by provider type and remoteness

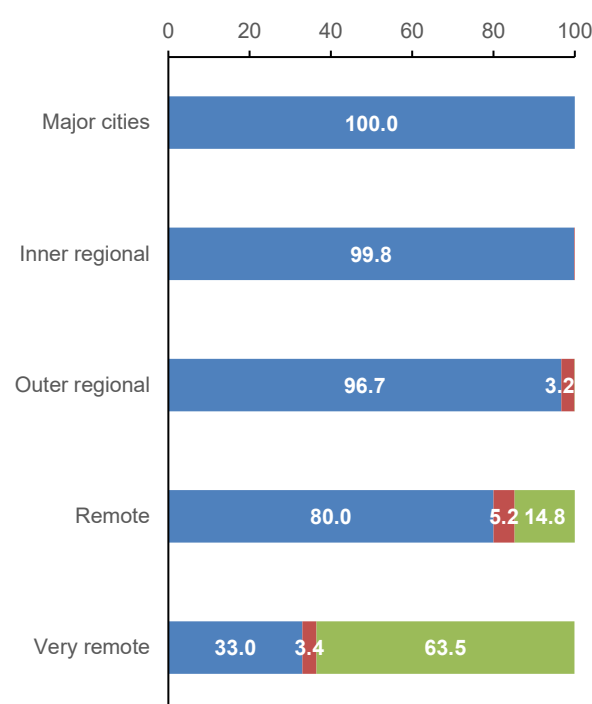
a) IAHP-funded ACCHO



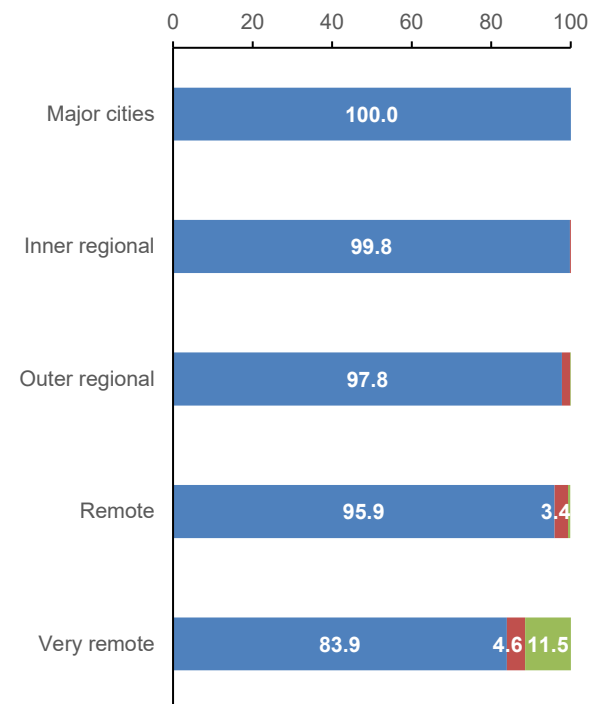
b) any IAHP-funded service



c) Mainstream GP



d) Any primary care service



Note: For more details see Appendix 1. Underlying numbers of people in each group are available in Appendix 2, Table A2.20.

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR.

Maps

The local-level distributions of Aboriginal and Torres Strait Islander people by drive times are illustrated in the following series of maps, beginning with the distribution across Australia as a whole and then with breakout maps of smaller areas.⁴⁵

The purple dots highlight locations for which Aboriginal and Torres Strait Islander people are more than a 1-hour drive from an IAHP-funded ACCHO (Figure 6.3), from any IAHP-funded service (Figure 6.4), from a mainstream GP (Figure 6.5), and from any primary health service (Figure 6.6), while the yellow dots represent those with drive times of 30 minutes or less.

The maps illustrate the importance of looking at availability at a local level and by provider type. The map of drive times to IAHP-funded ACCHOs (Figure 6.3) highlights that there is a great deal of variation across Australia, and within states/territories and remoteness areas – some cities and regional/remote areas have good access (yellow dots), while others have poor access (purple dots).

The addition of other IAHP-funded services to the IAHP-funded ACCHOs changes the picture slightly, particularly in the Northern Territory, where a number of the areas change from purple to yellow or orange (representing lower drive times/improved access) (Figure 6.4).

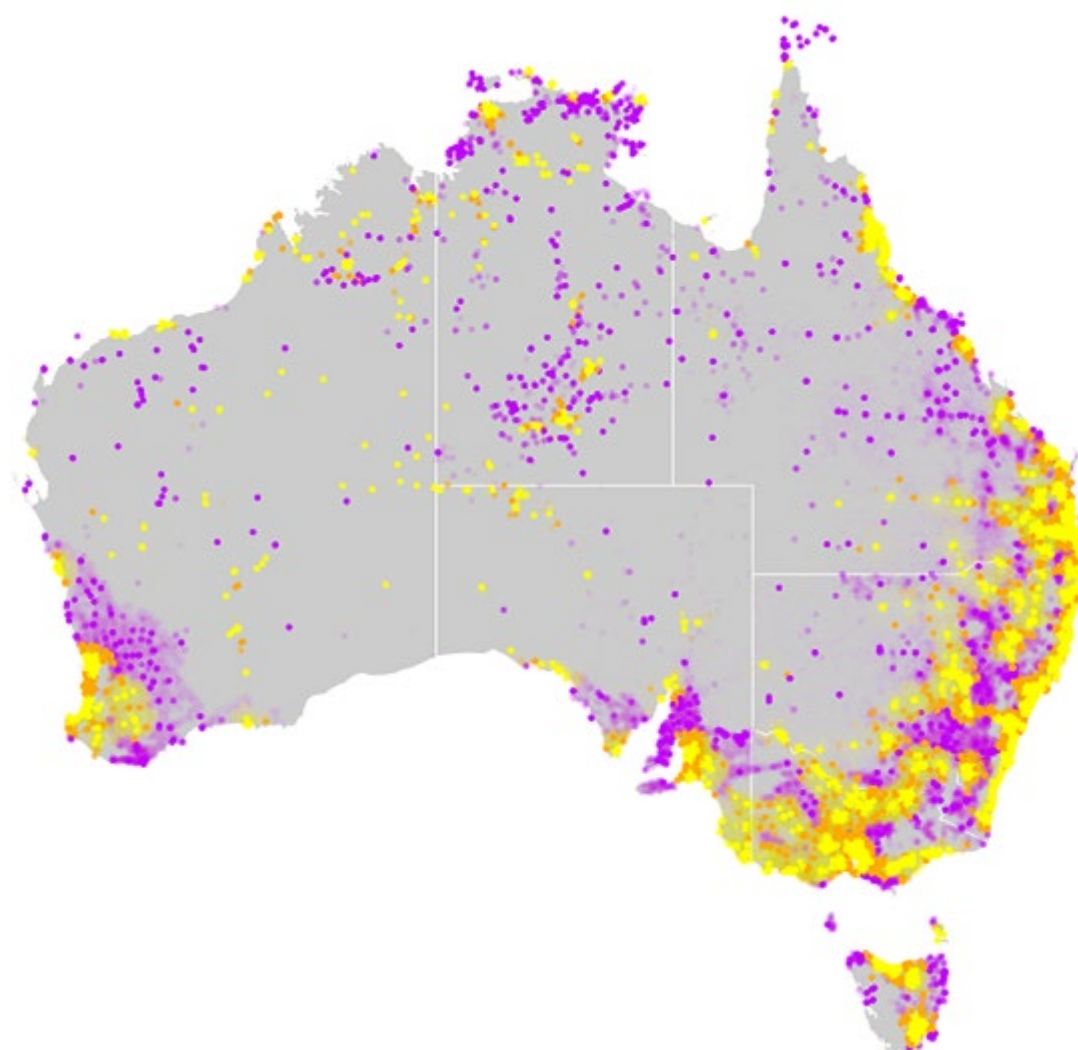
Figure 6.5 (drive times to mainstream GPs) presents a vastly different picture, with the map dominated by yellow dots in the urban and regional areas and with purple dots in northern Australia (including far north Queensland, the Northern Territory, and parts of Western Australia).

Drive times to any primary service show that there are small geographic areas within most states and territories where Aboriginal and Torres Strait Islander people live more than a 1-hour drive from any service (Figure 6.6).

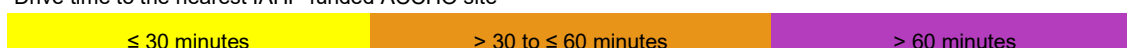
As it can be difficult to see variation within cities and regional areas in the larger national maps, breakout maps of selected cities/regional areas have been provided for drive times to IAHP-funded ACCHOs (Figure 6.7), any IAHP-funded service (Figure 6.8), and to mainstream GPs (Figure 6.9). No map of access to any primary health service is included because Figure 6.9 shows that every included area is within a 30-minute drive of a mainstream GP.

⁴⁵ The interactive dashboard can be used to drill down more into specific areas or types of services.

Figure 6.3: Drive times to IAHP-funded ACCHOs



Drive time to the nearest IAHP-funded ACCHO site

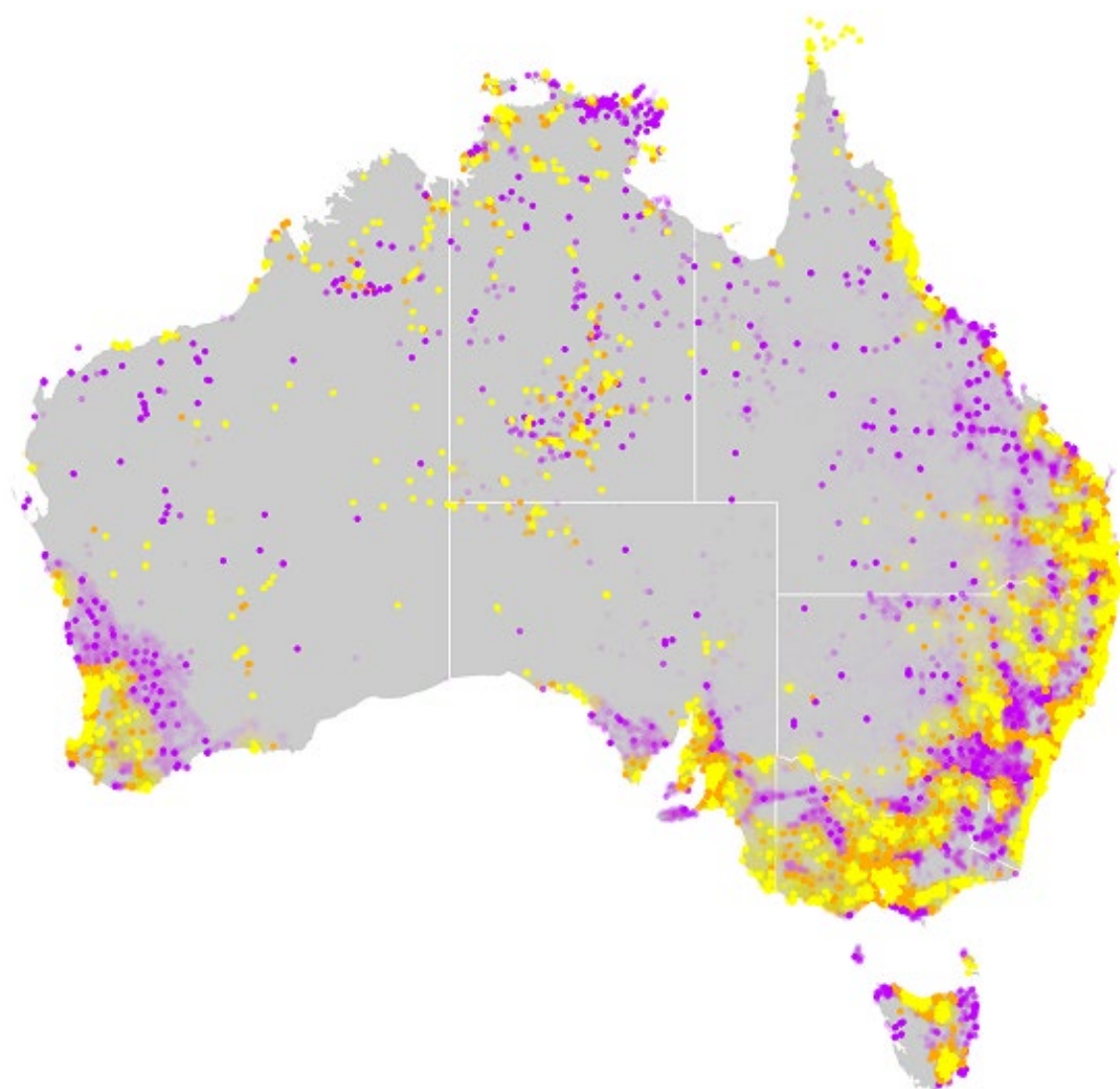


Notes

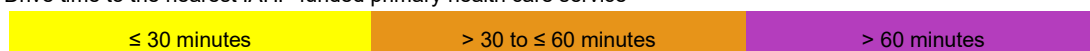
1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive times reflect the service locations in the 2022–23 OSR data collection. Service locations include only those with declared primary health care function (excluding sites providing only maternal and child health services). No modifications, including additions of service locations or adjustments to existing entries, have been made to the data.

Sources: AIHW analysis of ABS population data (30 June 2021); Online Services Report 2022–23.

Figure 6.4: Drive times to any IAHP-funded service



Drive time to the nearest IAHP-funded primary health care service

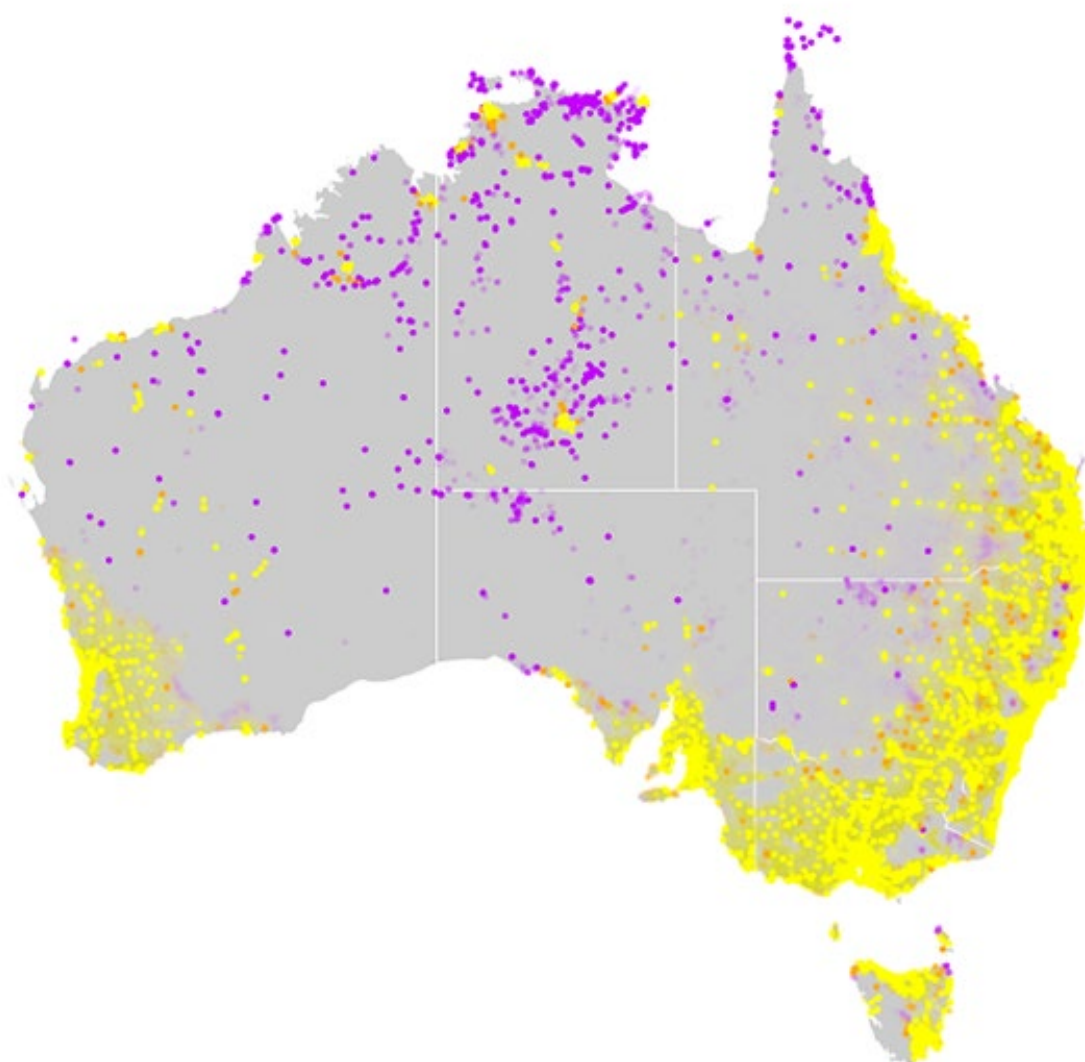


Notes

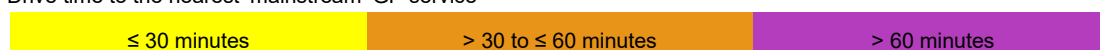
1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive times reflect the service locations in the 2022–23 OSR data collection. Service locations include only those with declared primary health care function (excluding sites providing only maternal and child health services). No modifications, including additions of service locations or adjustments to existing entries, have been made to the data.

Sources: AIHW analysis of ABS population data (30 June 2021); Online Services Report 2022–23.

Figure 6.5: Drive times to mainstream GPs



Drive time to the nearest 'mainstream' GP service

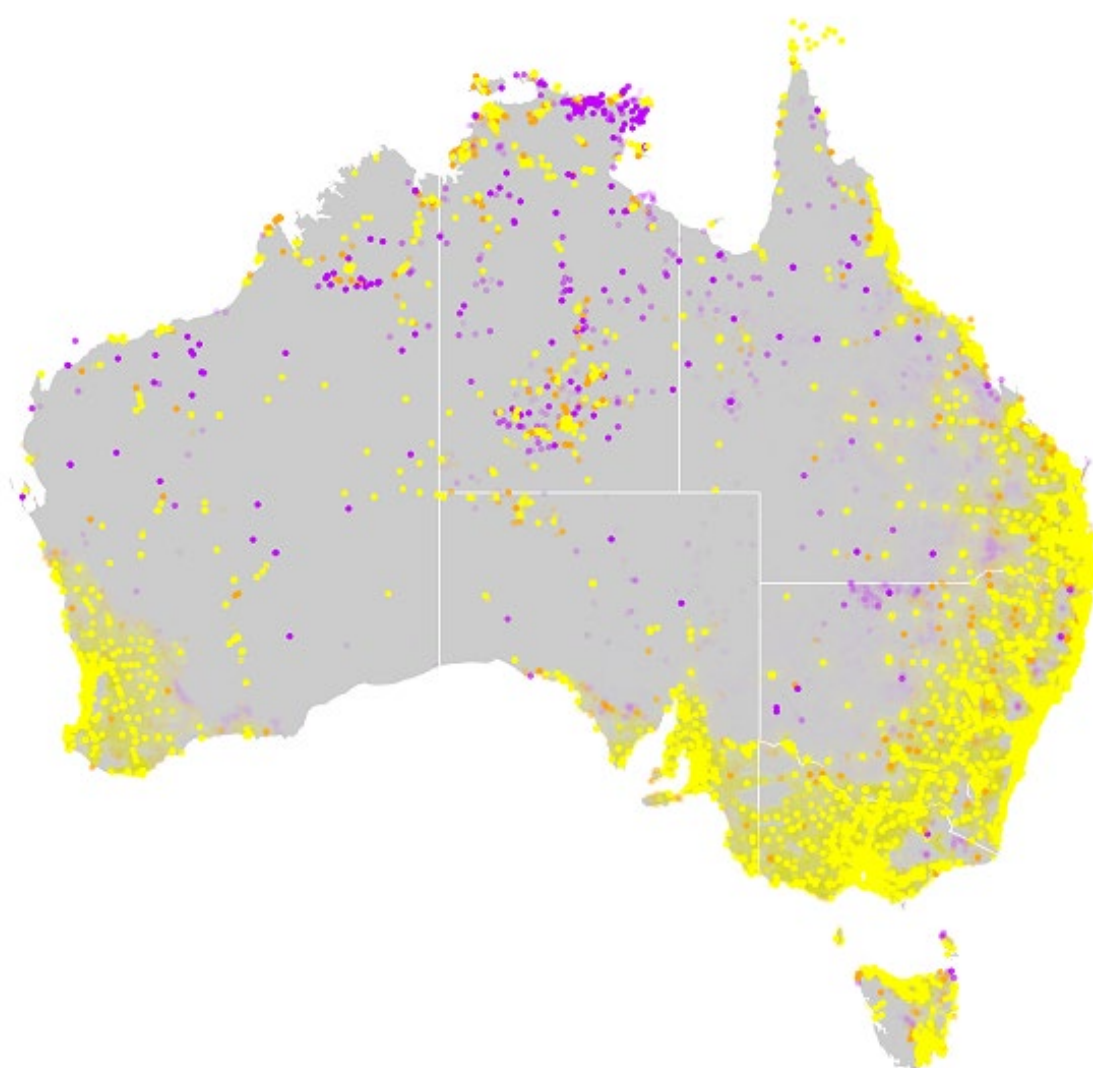


Notes

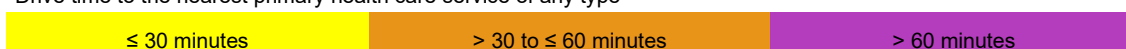
1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive time reflect the service locations in the NHSD, excluding sites also in the 2022–23 OSR data collection. Service locations include only those with Service category 'General practice/GP'. No modifications, including additions of service locations or adjustment to existing entries, have been made to the data.
3. Some of the remaining NHSD sites may either receive IAHP funding or belong to other organisations focused on Aboriginal and Torres Strait Islander health care. Other NHSD sites receiving IAHP funding may have been excluded, even if they typically provide mainstream services on site.

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024).

Figure 6.6: Drive times to any primary care service



Drive time to the nearest primary health care service of any type

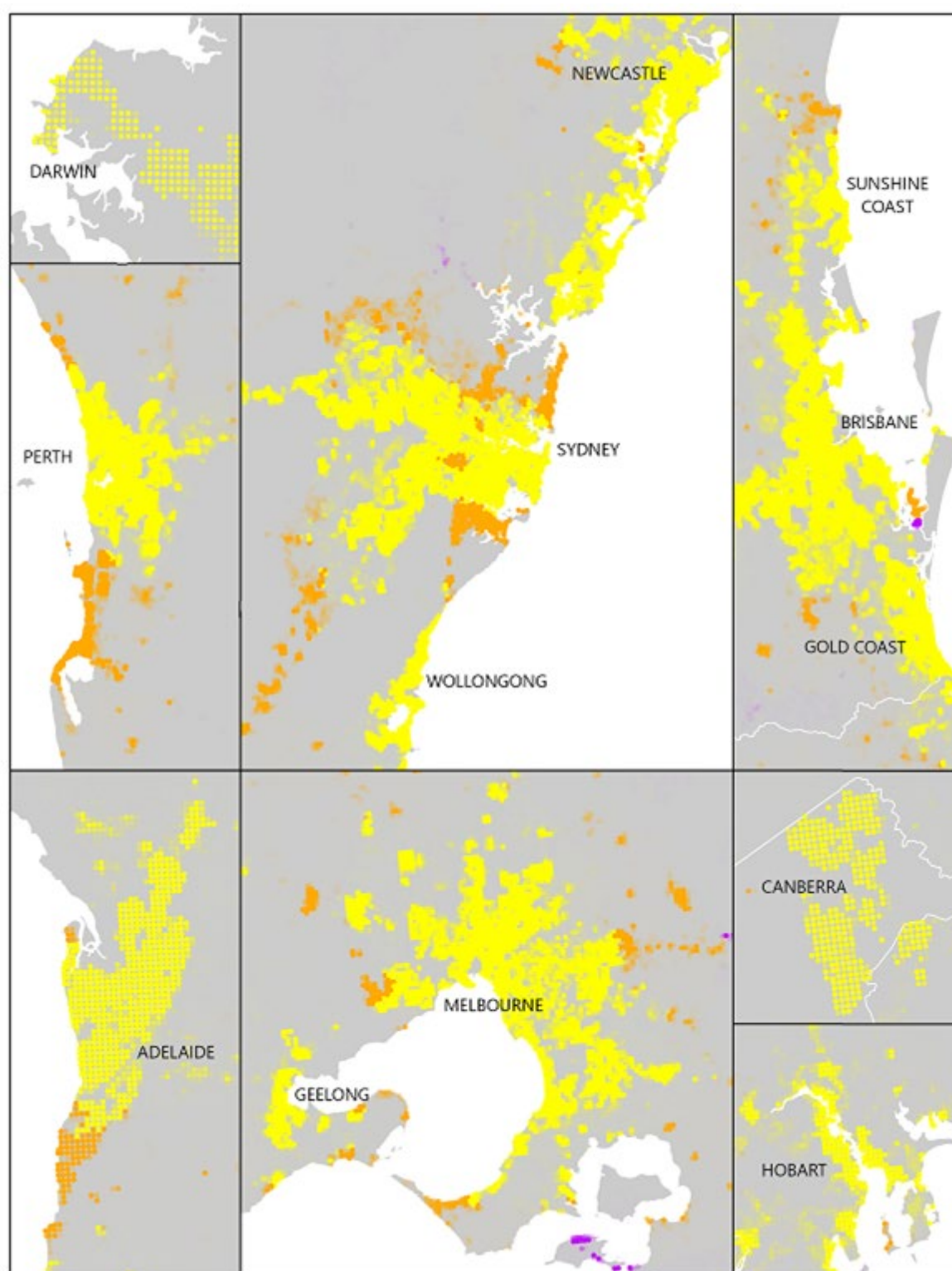


Notes

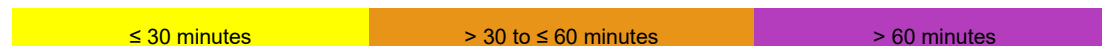
1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive times reflect the service locations in the 2022–23 OSR data collection and the NHSD. OSR service locations include only those with declared primary health care function (excluding sites providing only maternal and child health services). NHSD locations include only those with Service category 'General practice/GP'. No modifications, including additions of service locations or adjustments to existing entries, have been made to the data.

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024); Online Services Report 2022–23.

Figure 6.7: Drive times to IAHP-funded ACCHOs, small area breakouts



Drive time to the nearest IAHP-funded ACCHO site

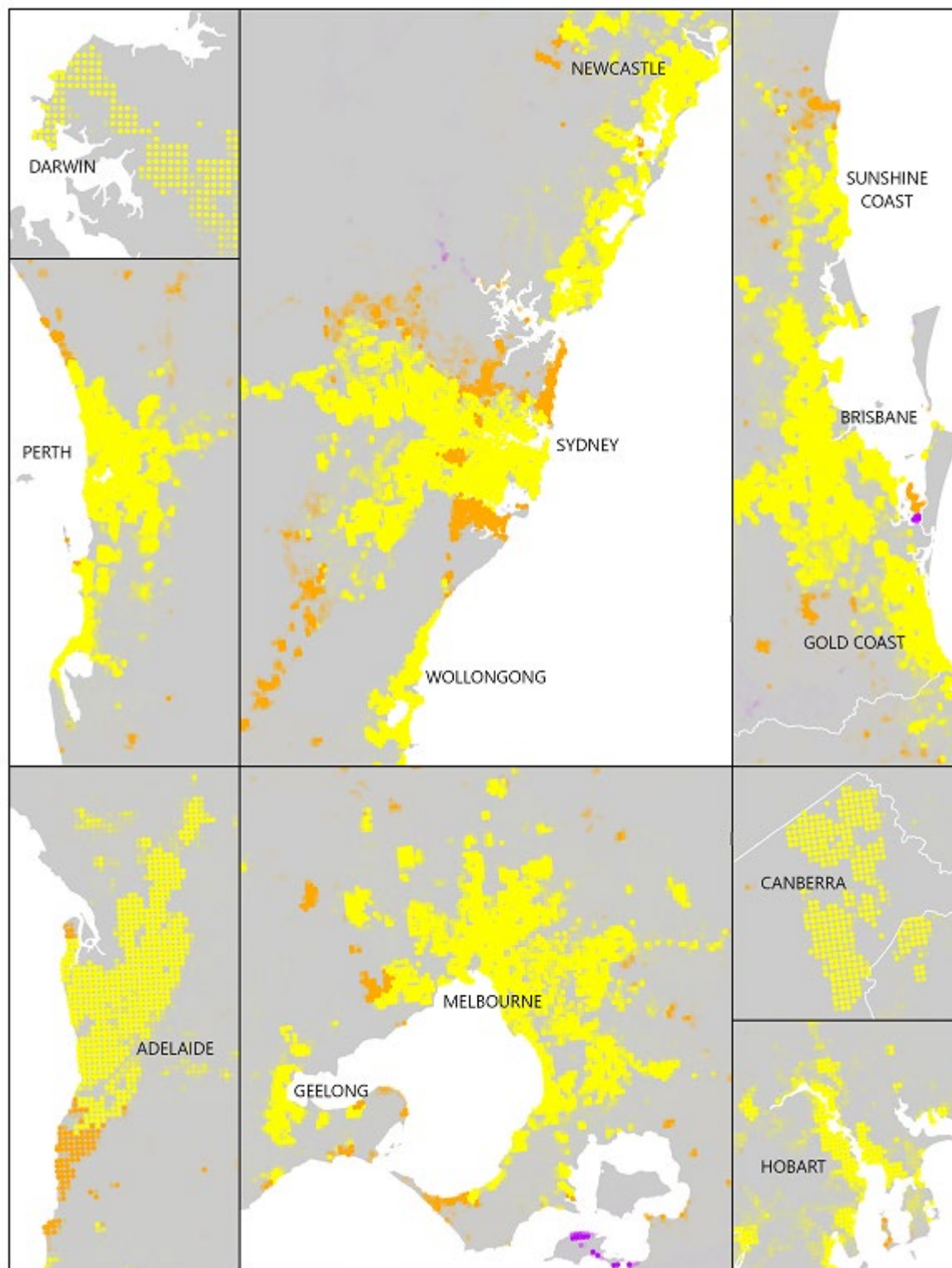


Notes

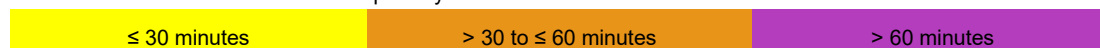
1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive times reflect the service locations in the 2022–23 OSR data collection. Service locations include only those with declared primary health care function (excluding sites providing only maternal and child health services). No modifications, including additions of service locations or adjustments to existing entries, have been made to the data.

Sources: AIHW analysis of ABS population data (30 June 2021); Online Services Report 2022–23.

Figure 6.8: Drive times to any IAHP-funded service, small area breakouts



Drive time to the nearest IAHP-funded primary health care service

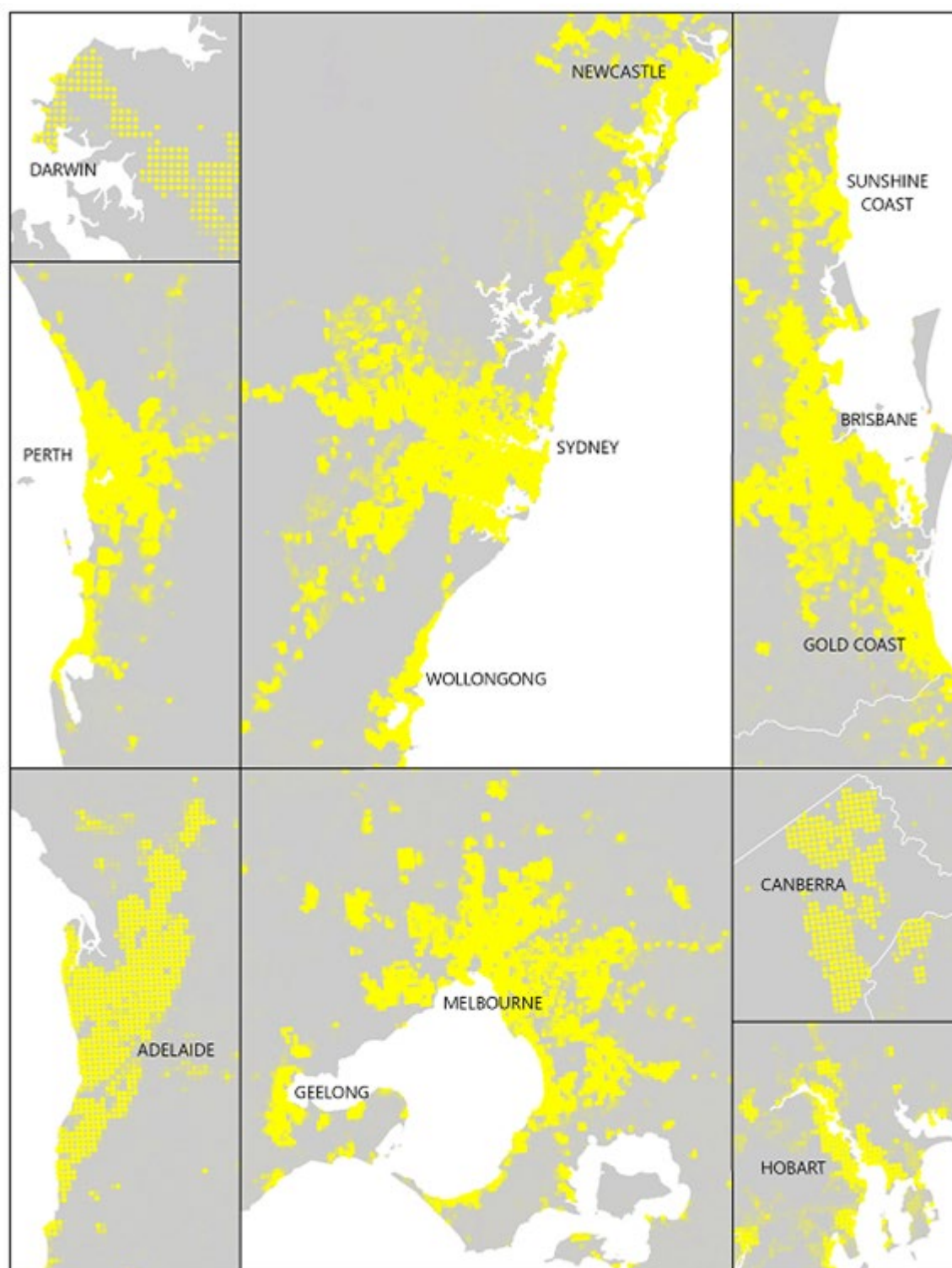


Notes

1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive times reflect the service locations in the 2022–23 OSR data collection. Service locations include only those with declared primary health care function (excluding sites providing only maternal and child health services). No modifications, including additions of service locations or adjustments to existing entries, have been made to the data.

Sources: AIHW analysis of ABS population data (30 June 2021); Online Services Report 2022–23.

Figure 6.9: Drive times to mainstream GPs, small area breakouts



Drive time to the nearest 'mainstream' GP service



Notes

1. Points represent locations with Aboriginal and Torres Strait Islander residents. Locations with very sparse populations (<10 people per sq km) are rendered transparent.
2. Drive times reflect the service locations in the 2022–23 OSR data collection. Service locations include only those with declared primary health care function (excluding sites providing only maternal and child health services). No modifications, including additions of service locations or adjustments to existing entries, have been made to the data.

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024);.

Service gap areas

This section focuses on the IARE-level estimates of the number and percentage of Aboriginal and Torres Strait Islander people who live inside/outside a 1-hour drive to a particular service type. Following the AIHW's previous work, a cut-off point of 200 people in an IARE who are outside a 1-hour drive was used to define a service gap area.⁴⁶

Table 6.3 shows that, of the 412 IAREs (Indigenous Areas) included in the analysis, there are 183 (34%) where everyone lives within a 1-hour drive to an IAHP-funded ACCHO, and 123 where between 1 and 199 people live outside a 1-hour drive (30%); there are 106 service gap areas where 200 or more people live outside a 1-hour drive (36%). Of these service gap areas, 25 are IAREs with more than 1,000 people who live outside a 1-hour drive to an IAHP-funded ACCHO.

Table 6.3: Indigenous Areas, by the number of Aboriginal and Torres Strait Islander people in the IARE who live outside a 1-hour drive to primary care service and by type of service

Number of Aboriginal and Torres Strait Islander people in the IARE outside a 1-hour drive	Primary care service type			
	IAHP-funded ACCHO	Any IAHP-funded service	Mainstream GP	Any included primary health care service
0	183	206	241	273
1–49	76	94	83	104
50–99	30	32	4	10
100–199	17	20	9	11
Subtotal IAREs with <200 people outside a 1-hour drive	306	352	337	398
200–299	21	14	10	4
300–399	17	9	7	4
400–499	8	3	9	1
500–599	10	6	12	2
600–699	8	6	5	1
700–799	7	3	6	—
800–899	8	5	3	1
900–999	2	1	2	—
1000–1999	16	8	13	—
2000–2999	8	4	7	1
3000–3200	1	1	1	—
Subtotal IAREs with 200+ people outside a 1-hour drive (service gap areas)	106	60	75	14
Total IAREs	412	412	412	412

Note: One IARE has more than 3,000 Aboriginal and Torres Strait Islander people living outside a 1-hour drive to an IAHP-funded ACCHO or any IAHP-funded service. That is a different IARE to the one with over 3,000 Aboriginal and Torres Strait Islander people living outside a 1-hour drive to a mainstream GP.

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

⁴⁶ Tables with results for each area for each of the 4 service types (IAHP-funded ACCHO, all IAHP-funded services, mainstream GPs, and any primary care service) are available at [Data](#). They can be used to identify areas with people outside a 30-minute drive to each service type and/or to identify IAREs with fewer than 200 people outside a 1-hour drive. Shorter drive times (15 minutes) are available in the dashboard.

When the broader category of all IAHP-funded services is considered, there are a smaller number of service gap areas – 60 (15% of all) IAREs have more than 200 people who live outside a 1-hour drive to an IAHP-funded service, with 13 of those having more than 1,000 people outside a 1-hour drive.

There are 75 IAREs (18%) where more than 200 people live outside a 1-hour drive to a mainstream GP, including 21 IAREs with more than 1,000 residents outside a 1-hour drive.⁴⁷ The number of IAREs where more than 200 people live outside a 1-hour drive to any of the included services is considerably smaller – 14, or 3.4% of IAREs.

Table 6.3 highlighted the service gap areas for each individual type of primary care service, but a single IARE can appear in all columns. When the unit of analysis is the IARE, there are 131 IAREs where an estimated 200 or more Aboriginal and Torres Strait Islander people live outside a 1-hour drive to at least one of the included service types. These are the service gap IAREs.

Distribution of the 131 service gap IAREs

Remoteness

There is a strong association between remoteness and being classified as a service gap area. Over half of all the 131 service gap areas were *Very remote* IAREs (74 IAREs, 57%), and those 74 service gap areas represent 78% of all *Very remote* IAREs (Table 6.4).

Table 6.4: Distribution of the 131 service gap IAREs^(a), by remoteness

Remoteness area	Number of service gap IAREs	% total service gap IAREs	Total number of IAREs in remoteness category	% IAREs in that remoteness category that are service gap IAREs
Major cities	1 ^(b)	0.8	107	0.9
Inner regional	16	12.2	87	18.4
Outer regional	25	19.1	95	26.3
Remote	15	11.5	28	53.6
Very remote	74	56.5	95	77.9
Total	131	100.0	412	31.8

(a) Service gap areas are defined as IAREs where 200 or more Aboriginal and Torres Strait Islander people live outside a 1-hour drive to the selected service.

(b) Snowy-Monaro. While the majority (≈60%) of the Aboriginal and Torres Strait Islander population live in Major cities SA1s, the service gap populations live in Inner and Outer regional areas.

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites only providing maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

While the next largest number of service gap areas are *Outer regional* (25) and *Inner regional* (16), they make up a much smaller proportion of all IAREs in those remoteness classifications (26% and 18%, respectively).

State/territory

Both the largest number of service gap areas and the highest proportion of all IAREs in the jurisdiction are in the Northern Territory, where 41 of the 62 IAREs (66%) are service gap areas, followed by Queensland (with 30 service gap areas, 35% of all IAREs) and Western Australia (with 25 service gap areas, 36% of all IAREs) (Table 6.5). These results are related to the remoteness distributions within these states/territories.

⁴⁷ Some of the IAREs may have access to an IAHP-funded ACCHO or other IAHP-funded service.

Table 6.5: Distribution of the 131 service gap IAREs^(a), by state/territory

State/territory	Number of service gap IAREs	% total service gap IAREs	Total number of IAREs in state/territory	% IAREs in that state/territory that are service gap IAREs
NSW	20	15.3	107	18.7
VIC	2	1.5	39	5.1
Qld	30	22.9	85	35.3
WA	25	19.1	69	36.2
SA	10	7.6	32	31.3
Tas	3	2.3	11	27.3
ACT	—	—	3	—
NT	41	31.3	62	66.1
Other territories	—	—	4	—
Total	131	100.0	412	31.8

(a) Service gap areas are defined as IAREs where 200 or more Aboriginal and Torres Strait Islander people live outside a 1-hour drive to the selected service.

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Number/type of service gaps

As indicated previously, an IARE is classified as a service gap area if 200 or more Aboriginal and Torres Strait Islander people live more than a 1-hour drive to at least one of the included primary care services. From a policy perspective, it is important to further group the 131 IAREs by the number and types of service gaps. For example, having access to no primary care service at all is different from having access to at least one type of service (acknowledging that it may not be people's preferred service).

Table 6.6 presents the distribution of the service gap IAREs by the number and type of service gaps and also how they are distributed across remoteness areas.

Table 6.6: Distribution of the 131 service gap IAREs^(a), by the number/types of gaps they have and remoteness

Number of service gap IAREs	Whether a service gap area				Remoteness					Rows in Table 6.7
	IAHP-funded ACCHO	Any IAHP-funded	Mainstream GP	Any included primary care service	Major cities	Inner regional	Outer regional	Remote	Very remote	
12	Yes	No	No	No	—	3	7	—	2	1–12
44	Yes	Yes	No	No	1	13	17	7	6	13–56
34	Yes	No	Yes	No	—	—	—	6	28	57–90
2	Yes	Yes	Yes	No ^(b)	—	—	—	—	2	91–92
14	Yes	Yes	Yes	Yes	—	—	1	—	13	93–106
25	No	No	Yes	No	—	—	—	2	23	107–131

(a) Service gap areas are defined as IAREs where 200 or more Aboriginal and Torres Strait Islander people live outside a 1-hour drive to the selected service.

(b) These 2 IAREs had 200 or more people outside a 1-hour drive to an IAHP-funded ACCHO, any IAHP-funded service, or a mainstream GP, but, because of the distribution of the individual services and population within those areas, fewer than 200 people lived outside any service (both were *Very remote* areas in South Australia – Eyre in the Port Augusta IREG and Ceduna-West Coast in the Port Lincoln-Ceduna IREG).

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Table 6.6 shows that there are:

- 12 IAREs that are service gap areas only for IAHP-funded ACCHOs (that is, there is no service gap for IAHP-funded services or mainstream GPs). Ten of those are in regional areas and 2 in *Very remote* areas
- 44 IAREs that are service gap areas for IAHP-funded ACCHOs and for any IAHP-funded service (there is no service gap for mainstream GPs). One of those is a *Major city*,⁴⁸ 30 are regional areas, and 13 are *Remote/Very remote* areas
- 34 IAREs that are service gap areas for IAHP-funded ACCHOs and for mainstream GPs (but not for other IAHP-funded services). Six are *Remote* and 28 are *Very remote* areas
- 2 IAREs that are service gap areas for IAHP-funded ACCHOs, any IAHP-funded service, and for mainstream GPs. Because of the locations of the individual services and distribution of the population within the IARE, fewer than 200 people live outside a 1-hour drive to any type of service. Both are *Very remote* areas
- 14 IAREs that are service gap areas across all categories – that is, at least 200 Aboriginal and Torres Strait Islander people in those IAREs live outside a 1-hour drive to any included primary health service. All but one are *Very remote* areas (the other is an outer regional area in New South Wales)
- 25 IAREs that are service gap areas only for mainstream GPs. Two of these are *Remote* areas and 23 are *Very remote* areas (that is, they are not service gap areas for IAHP-funded ACCHOs/other IAHP-funded services).

More detailed information on each of the 131 service gap IAREs is presented in Table 6.7. Each row includes:

- identifying information about the IARE (state/territory, remoteness, IREG, IARE name)
- an indication of whether the IARE is a service gap area for each type of included service (Yes/No). Service gaps are highlighted in yellow
- the number of Aboriginal and Torres Strait Islander people outside a 1-hour drive to the service type.⁴⁹

The table has an internal ordering following the categories in Table 6.6, beginning with the 12 IAREs that have been identified as service gap areas for IAHP-funded ACCHOs only. Within each of the groupings, the rows are sorted by the number of Aboriginal and Torres Strait Islander people outside a 1-hour drive to an IAHP-funded ACCHO.^{50,51}

More information on each individual IARE can be found using the AIHW's Regional Insights for Indigenous Communities website (www.rific.gov.au).

⁴⁸ As noted in Table 6.4, while the majority (~60%) of the Aboriginal and Torres Strait Islander population within the IARE lives in *Major cities* SA1s, the service gap populations live in *Inner and Outer regional* areas.

⁴⁹ <10 is used for IAREs where the estimated number of Aboriginal and Torres Strait Islander people outside a 1-hour drive is between 1 and 9.

⁵⁰ Except for the final grouping, where IAREs have been sorted by the number of people outside a 1-hour drive to a mainstream GP.

⁵¹ The same information is presented separately for each state/territory in Appendix 2, tables A2.23 to A2.29.

Table 6.7 shows that:

- the IARE with the highest number of Aboriginal and Torres Strait Islander people outside a 1-hour drive to an IAHP-funded ACCHO is Central Capricorn, an *Outer regional* area in the Rockhampton IREG in Queensland. All 3,062 people in the IARE live outside a 1-hour drive to an IAHP-funded ACCHO and to any IAHP-funded service. An estimated 11 people live outside a 1-hour drive to a mainstream GP, so it is not classified as a service gap area for mainstream GPs or for access to any included primary care service (Row 13)
- Kaiwalagal – Inner Islands, a *Very remote* IARE within the Torres Strait IREG in Queensland, has the second highest number of Aboriginal and Torres Strait Islander people outside a 1-hour drive to an IAHP-funded ACCHO (all 2,926 of the local population, who also live outside a 1-hour drive to a mainstream GP). Nearly everyone, however, lives within a 1-hour drive to an IAHP-funded service, so the area is not classified as a service gap area for IAHP-funded services or for any included service (Row 57)
- Ramingining – Milingimbi and Outstations, a *Very remote* IARE within the Nhulunbuy IREG in the Northern Territory, has an estimated population of 2,278 Aboriginal and Torres Strait Islander people. Looking across the row shows that no-one lives within a 1-hour drive of any of the included service types – IAHP-funded ACCHO, any IAHP-funded service, or mainstream GP (Row 93).

Table 6.7: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	NSW	Outer regional	North-Eastern NSW	Narrabri	Yes	2,343	No	47	No	—	No	—	2,442
2	WA	Outer regional	South-Western WA	Albany	Yes	1,978	No	<10	No	—	No	—	1,978
3	SA	Outer regional	Adelaide	Yorke Peninsula	Yes	1,287	No	28	No	—	No	—	1,287
4	Qld	Very remote	Cape York	Kowanyama	Yes	1,015	No	—	No	—	No	—	1,015
5	SA	Outer regional	Adelaide	Berri – Barmera	Yes	712	No	—	No	—	No	—	712
6	SA	Outer regional	Adelaide	Loxton – Waikerie – Mid Murray	Yes	480	No	28	No	—	No	—	673
7	SA	Outer regional	Adelaide	Renmark Paringa	Yes	382	No	—	No	—	No	—	382
8	WA	Outer regional	South-Western WA	Manjimup – Denmark – Plantagenet	Yes	366	No	32	No	—	No	—	747
9	Vic	Inner regional	Vic exc. Melbourne	Upper Goulburn Valley	Yes	332	No	159	No	—	No	—	1,040
10	WA	Inner regional	South-Western WA	Northam	Yes	295	No	—	No	—	No	—	805
11	NT	Very remote	Tennant Creek	Elliott	Yes	289	No	—	No	—	No	—	289
12	SA	Inner regional	Adelaide	Wakefield – Clare and Gilbert Valleys	Yes	216	No	114	No	—	No	—	453
13	Qld	Outer regional	Rockhampton	Central Capricorn	Yes	3,060	Yes	3,060	No	11	No	11	3,062
14	NSW	Inner regional	North-Eastern NSW	Muswellbrook	Yes	2,316	Yes	2,316	No	—	No	—	2,316
15	NSW	Inner regional	South-Eastern NSW	Southern Tablelands	Yes	2,272	Yes	2,272	No	<10	No	<10	4,450
16	Qld	Remote	Townsville – Mackay	Palm Island	Yes ⁵²	2,083	Yes	2,083	No	—	No	—	2,083

(continued)

⁵² There is an ACCHO on Palm Island (Bwgcolman Healing Service) which is not IAHP-funded.

Table 6.7 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
17	Tas	Outer regional	Tas	Tas – West Coast	Yes	1,904	Yes	1,904	No	<10	No	<10	5,475
18	Qld	Outer regional	Townsville – Mackay	Bowen (Qld)	Yes	1,670	Yes	1,670	No	13	No	13	1,670
19	Qld	Outer regional	Rockhampton	Nebo – Clermont	Yes	1,649	Yes	1,649	No	51	No	51	1,658
20	NSW	Inner regional	Riverina – Orange	Mudgee	Yes	1,647	Yes	1,647	No	<10	No	<10	2,329
21	NSW	Inner regional	Riverina – Orange	Cowra	Yes	1,333	Yes	1,333	No	—	No	—	1,398
22	Qld	Outer regional	Townsville – Mackay	Burdekin – Ayr	Yes	1,246	Yes	1,246	No	—	No	—	1,291
23	Qld	Remote	Mount Isa	Cloncurry –McKinlay	Yes	1,126	Yes	1,126	No	96	No	96	1,130
24	Qld	Outer regional	Townsville – Mackay	Proserpine – Whitsunday	Yes	938	Yes	938	No	—	No	—	938
25	WA	Outer regional	South-Western WA	Avon	Yes	888	Yes	511	No	<10	No	<10	1,363
26	NSW	Outer regional	Dubbo	Warrumbungle Shire	Yes	882	Yes	866	No	—	No	—	1,174
27	Qld	Outer regional	Rockhampton	Banana	Yes	873	Yes	873	No	<10	No	<10	922
28	SA	Outer regional	Port Augusta	Flinders	Yes	857	Yes	297	No	—	No	—	1,875
29	NSW	Outer regional	Riverina – Orange	Narrandera	Yes	812	Yes	812	No	—	No	—	912
30	NSW	Remote	North-Western NSW	Cobar – Murrin Bridge	Yes	784	Yes	784	No	35	No	34	856
31	NSW	Inner regional	Riverina – Orange	Young	Yes	781	Yes	781	No	—	No	—	781
32	NSW	Major cities	South-Eastern NSW	Snowy – Monaro	Yes	738	Yes	734	No	<10	No	<10	3,397
33	WA	Outer regional	South-Western WA	Moora – Chittering	Yes	685	Yes	662	No	—	No	—	1,004
34	Qld	Very remote	Rockhampton	Barcaldine – Blackall – Longreach	Yes	651	Yes	651	No	21	No	21	651

(continued)

Table 6.7 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
35	NSW	Outer regional	Riverina – Orange	Coolamon – Temora – West Wyalong	Yes	645	Yes	645	No	—	No	—	1,189
36	WA	Very remote	Geraldton	Meekathara – Karalundi	Yes	628	Yes	628	No	51	No	51	631
37	Vic	Inner regional	Vic exc. Melbourne	South Gippsland – Bass Coast	Yes	601	Yes	601	No	—	No	—	972
38	NSW	Inner regional	North-Eastern NSW	Upper Hunter	Yes	573	Yes	573	No	<10	No	<10	1,188
39	NSW	Remote	Dubbo	Bogan	Yes	533	Yes	533	No	12	No	12	534
40	Tas	Outer regional	Tas	Tas – North-East Coast	Yes	488	Yes	488	No	43	No	43	1,228
41	WA	Remote	South-Western WA	Campion	Yes	484	Yes	484	No	<10	No	<10	484
42	NSW	Inner regional	Riverina – Orange	Lithgow – Oberon	Yes	376	Yes	376	No	—	No	—	2,326
43	Qld	Very remote	Townsville – Mackay	Flinders – Richmond – Dalrymple	Yes	350	Yes	350	No	144	No	144	561
44	Qld	Very remote	Mount Isa	Boulia – Diamantina – Winton	Yes	344	Yes	344	No	168	No	168	344
45	Tas	Inner regional	Tas	Tas – South-East Coast	Yes	338	Yes	338	No	—	No	—	1,320
46	WA	Remote	Geraldton	Irwin – Morawa	Yes	318	Yes	318	No	—	No	—	512
47	NSW	Outer regional	Riverina – Orange	Central Murray	Yes	286	Yes	286	No	<10	No	<10	895
48	NSW	Inner regional	Riverina – Orange	Upper Murray	Yes	279	Yes	279	No	—	No	—	1,211
49	NSW	Inner regional	Riverina – Orange	Gundagai – Junee – Harden	Yes	274	Yes	274	No	—	No	—	1,180
50	WA	Very remote	Geraldton	Shark Bay – Coral Bay – Upper Gascoyne	Yes	268	Yes	268	No	139	No	139	276
51	Qld	Outer regional	Toowoomba – Roma	Goondiwindi – Stanthorpe	Yes	264	Yes	264	No	<10	No	<10	1,352

(continued)

Table 6.7 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
52	WA	Remote	Geraldton	Central West Coast	Yes	257	Yes	257	No	<10	No	<10	494
53	Qld	Inner regional	Rockhampton	Gladstone	Yes	235	Yes	235	No	—	No	—	4,508
54	NSW	Inner regional	North-Eastern NSW	Tamworth	Yes	228	Yes	227	No	11	No	10	10,035
55	NSW	Very remote	North-Western NSW	Brewarrina	Yes	219	Yes	219	No	36	No	36	939
56	Qld	Outer regional	Cairns - Atherton	Kuranda – Croydon	Yes	216	Yes	216	No	180	No	180	2,461
57	Qld	Very remote	Torres Strait	Kaiwalagal - Inner Islands	Yes	2,926	No	<10	Yes	2,926	No	<10	2,926
58	NT	Remote	Jabiru – Tiwi	Tiwi Islands	Yes	2,485	No	16	Yes	2,485	No	16	2,485
59	NT	Remote	Jabiru – Tiwi	Thamarrurr inc. Wadeye	Yes	2,184	No	49	Yes	2,131	No	—	2,184
60	NT	Very remote	Nhulunbuy	Anindilyakwa (Groote)	Yes	1,972	No	25	Yes	1,972	No	25	1,972
61	NT	Very remote	Jabiru – Tiwi	Douglas-Daly	Yes	1,411	No	129	Yes	1,292	No	24	1,615
62	Qld	Very remote	Torres Strait	Kalalagal – Western Islands	Yes	1,381	No	—	Yes	1,381	No	—	1,381
63	Qld	Very remote	Torres Strait	Kulkalgal – Central Islands	Yes	1,011	No	—	Yes	1,011	No	—	1,011
64	Qld	Very remote	Cape York	Mapoon – Napranum – Weipa	Yes	995	No	—	Yes	281	No	—	2,294
65	Qld	Very remote	Torres Strait	Meriam – Eastern Islands	Yes	806	No	—	Yes	806	No	—	806
66	NT	Very remote	Nhulunbuy	Numbulwar and Outstations	Yes	777	No	22	Yes	777	No	22	777
67	NT	Very remote	Apatula	Yuendumu and Outstations	Yes	738	No	—	Yes	738	No	—	738
68	NT	Very remote	Katherine	Borrooloola	Yes	705	No	—	Yes	705	No	—	705
69	NT	Very remote	Apatula	Anmatjere	Yes	698	No	52	Yes	699	No	52	699
70	Qld	Very remote	Torres Strait	Kalakawal – Top Western Islands	Yes	654	No	—	Yes	654	No	—	654
71	Qld	Very remote	Cape York	Lockhart River	Yes	571	No	<10	Yes	571	No	<10	571

(continued)

Table 6.7 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
72	NT	Very remote	Apatula	Atitjere –Akarnenehe – Engawala	Yes	555	No	52	Yes	555	No	52	555
73	NT	Remote	Jabiru – Tiwi	Kakadu – Marrakai – Jabiru	Yes	533	No	—	Yes	533	No	—	621
74	NT	Very remote	Apatula	Papunya and Outstations	Yes	531	No	19	Yes	531	No	19	531
75	Qld	Very remote	Cape York	Pompuraaw	Yes	526	No	<10	Yes	526	No	<10	526
76	NT	Very remote	Katherine	Gulf	Yes	497	No	179	Yes	1,422	No	179	1,422
77	NT	Very remote	Apatula	Haasts Bluff – Mount Liebig (Watiyawanu)	Yes	406	No	31	Yes	406	No	31	406
78	NT	Very remote	Tennant Creek	Ali Curung	Yes	402	No	—	Yes	402	No	—	402
79	WA	Very remote	Kununurra	Kalumburu	Yes	398	No	—	Yes	398	No	—	398
80	NT	Very remote	Tennant Creek	Alpurrurulam	Yes	385	No	—	Yes	385	No	—	385
81	NT	Very remote	Apatula	Nyirripi and Tanami Outstations	Yes	325	No	57	Yes	329	No	57	329
82	Qld	Very remote	Cape York	Cape York	Yes	317	No	40	Yes	777	No	40	784
83	NT	Very remote	Apatula	Kaltukatjara and Outstations	Yes	310	No	46	Yes	321	No	45	322
84	NT	Very remote	Tennant Creek	Wutunugurra – Canteen Creek	Yes	305	No	—	Yes	305	No	—	305
85	NT	Remote	Apatula	Amoonguna – Santa Teresa – Titjikala	Yes	296	No	12	Yes	949	No	12	2,105
86	Qld	Remote	Cairns – Atherton	Wujal Wujal and Outstations	Yes	274	No	—	Yes	274	No	—	296
87	NT	Very remote	Apatula	Willowra	Yes	241	No	—	Yes	241	No	—	241
88	NT	Remote	Darwin	Cox – Finnis – Coomalie	Yes	213	No	73	Yes	214	No	73	799
89	NT	Very remote	Apatula	Apatula (Finke) and Homelands	Yes	202	No	<10	Yes	202	No	<10	202
90	NT	Very remote	Apatula	West MacDonnell Ranges	Yes	201	No	102	Yes	617	No	102	818

(continued)

Table 6.7 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
91	SA	Very remote	Port Augusta	Eyre	Yes	503	Yes	503	Yes	219	No	196	689
92	SA	Very remote	Port Lincoln – Ceduna	Ceduna – West Coast	Yes	233	Yes	233	Yes	459	No	27	1,008
93	NT	Very remote	Nhulunbuy	Ramingining – Milingimbi and Outstations	Yes	2,278	Yes	2,278	Yes	2,278	Yes	2,278	2,278
94	NT	Very remote	Jabiru – Tiwi	North-West Arnhem	Yes	1,608	Yes	392	Yes	2,447	Yes	392	2,447
95	WA	Very remote	South Hedland	Exmouth –Ashburton	Yes	1,298	Yes	1298	Yes	250	Yes	250	1,298
96	NSW	Outer regional	North-Western NSW	Far West	Yes	843	Yes	843	Yes	241	Yes	241	3,079
97	NT	Very remote	Nhulunbuy	Gapuwiyak and Outstations	Yes	832	Yes	832	Yes	832	Yes	832	832
98	WA	Very remote	South Hedland	East Pilbara	Yes	606	Yes	606	Yes	1,516	Yes	606	2,405
99	WA	Very remote	Kununurra	Wyndham	Yes	596	Yes	596	Yes	596	Yes	596	596
100	NT	Very remote	Nhulunbuy	Laynhapuy – Gumatj Homelands	Yes	528	Yes	528	Yes	528	Yes	528	553
101	WA	Very remote	West Kimberley	Fitzroy Crossing	Yes	499	Yes	499	Yes	499	Yes	499	1,631
102	NT	Very remote	Tennant Creek	Barkly	Yes	448	Yes	247	Yes	413	Yes	243	522
103	WA	Very remote	West Kimberley	Fitzroy River	Yes	379	Yes	379	Yes	379	Yes	379	1,209
104	NT	Very remote	Jabiru – Tiwi	Maningrida and Outstations	Yes	373	Yes	373	Yes	3,118	Yes	373	3,118
105	WA	Very remote	Kununurra	Halls Creek – Surrounds	Yes	341	Yes	341	Yes	416	Yes	331	426
106	NT	Very remote	Nhulunbuy	Marthakal Homelands – Galiwinku	Yes	251	Yes	251	Yes	233	Yes	233	2,886
107	Qld	Very remote	Cape York	Northern Peninsula Area	No	—	No	—	Yes	2,611	No	—	2,611
108	SA	Very remote	Port Augusta	Anangu Pitjantjatjara	No	<10	No	<10	Yes	2,325	No	<10	2,325
109	WA	Very remote	Broome	Broome – Surrounds	No	<10	No	<10	Yes	1,673	No	<10	1,680
110	WA	Very remote	Kununurra	Halls Creek	No	—	No	—	Yes	1,483	No	—	1,483

(continued)

Table 6.7 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) (n=131)

Row number	State/territory	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
					Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
111	NT	Very remote	Katherine	Ngukurr	No	—	No	—	Yes	1,183	No	—	1,183
112	Qld	Very remote	Mount Isa	Carpentaria – Burke – Mornington	No	189	No	189	Yes	1,135	No	189	3,475
113	WA	Very remote	Kununurra	Great Sandy Desert	No	82	No	53	Yes	1,113	No	53	1,113
114	Qld	Very remote	Cape York	Aurukun	No	—	No	—	Yes	1,047	No	—	1,047
115	WA	Very remote	Kalgoorlie	Laverton – Ngaanyatjaraku	No	167	No	167	Yes	1001	No	167	1,353
116	Qld	Remote	Cape York	Hope Vale	No	0	No	0	Yes	941	No	—	941
117	NT	Very remote	Katherine	Elsey – Roper	No	25	No	25	Yes	825	No	25	1,843
118	WA	Very remote	West Kimberley	Outer Derby – West Kimberley	No	17	No	17	Yes	792	No	17	1,217
119	NT	Very remote	Katherine	Lajamanu	No	—	No	—	Yes	704	No	—	704
120	WA	Very remote	Kununurra	Argyle – Warmun	No	—	No	—	Yes	622	No	—	730
121	NT	Very remote	Katherine	Daguragu – Kalkarindji and Outstations	No	—	No	—	Yes	617	No	—	617
122	NT	Very remote	Apatula	Urapuntja	No	—	No	—	Yes	591	No	—	591
123	NT	Very remote	Apatula	Hermannsburg	No	—	No	—	Yes	588	No	—	588
124	Qld	Remote	Cape York	Cooktown	No	—	No	—	Yes	520	No	—	520
125	NT	Very remote	Katherine	Vic River	No	152	No	152	Yes	513	No	152	606
126	NT	Very remote	Apatula	Ampilatwatja and Outstations	No	17	No	17	Yes	505	No	17	505
127	WA	Very remote	Kalgoorlie	Warburton	No	—	No	—	Yes	499	No	—	499
128	NT	Very remote	Katherine	Walangeri	No	27	No	27	Yes	485	No	27	485
129	NT	Very remote	Apatula	Walungurru and Outstations	No	—	No	—	Yes	447	No	—	447
130	SA	Very remote	Port Augusta	Cooper Pedy – Umoona	No	—	No	—	Yes	331	No	—	331
131	WA	Very remote	Kununurra	North Kimberley	No	85	No	82	Yes	203	No	82	358

Note: Service gap areas are defined as IAREs where 200 or more Aboriginal and Torres Strait Islander people live outside a 1-hour drive to the selected service.

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Comparison of findings from NATSIHS and spatial analysis

While the NATSIHS captures Aboriginal and Torres Strait Islander people's own experiences and their perceived availability of what services are available in their local area, the spatial analysis provides a distance/drive time-based measure of service availability and service gaps.

One of the other differences between the 2 data sources is in how services that are specific to Aboriginal and Torres Strait Islander people are defined. NATSIHS respondents were asked whether there was an AMS/CC in their area and whether there was a GP other than in an AMS. The spatial analysis included IAHP-funded services (disaggregated by ACCHO/non-ACCHO governance) and mainstream GP service locations.

Figure 6.10 sets the results side by side to see how they compare, and provides an overview of the congruence in the perceived availability of services with the drive time results.⁵³

Because there is no set definition of what people would consider their 'local area' (and it may differ across remoteness areas), 2 drive times were included – 15 minutes and 30 minutes. 'All IAHP-funded services' was selected as the closest representation of AMS/CC because it captures the 'community clinic' side.

For those in *Major cities* and *Inner regional* areas, the 15-minute drive time matches closely with people's perceived availability of services in local areas (it is important to note that service locations themselves may have changed between 2018–19 and 2022–2024). However, when the longer drive time of 30 minutes or less is considered, there is little to no alignment between them.⁵⁴

The results for those in *Outer regional* areas are not as clear cut. The survey respondents were more likely to indicate that the only source of primary care in their local area was an AMS/CC (17%), while the results from the spatial analysis indicate that it was less than 2%.

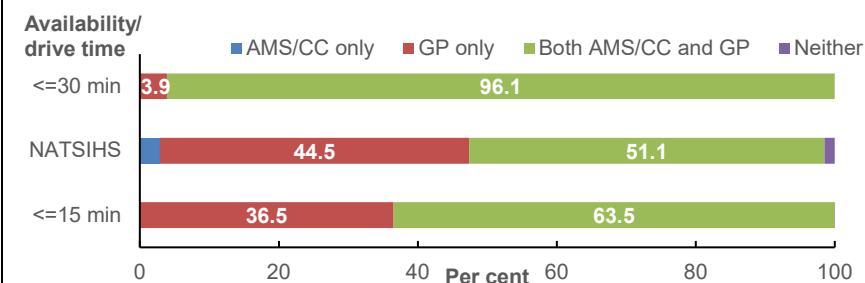
For those in *Remote* and *Very remote* areas, the 30-minute drive time limit seems to match more closely with the NATSIHS results. It is also interesting that in *Very remote* areas, 4.4% of Aboriginal and Torres Strait Islander people indicated that there was no primary care service in their local area, while the drive time results showed that for 16% of people there was no service within a 30-minute drive time. This may be due either to data gaps or that people in more remote areas consider a much larger area/larger drive time boundary to be their local area.

⁵³ Appendix 2, Table A2.30 presents the distribution of AMS/CC and mainstream GPs individually by remoteness category within each state and territory.

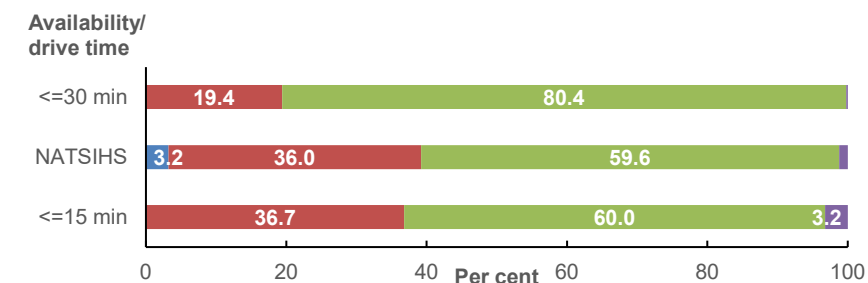
⁵⁴ See Appendix 2, Figure A2.1 for a map of the 15-minute boundaries for selected small areas.

Figure 6.10: Percentage distribution of availability of service types in local area, NATSIHS and drive time results, by remoteness and drive time

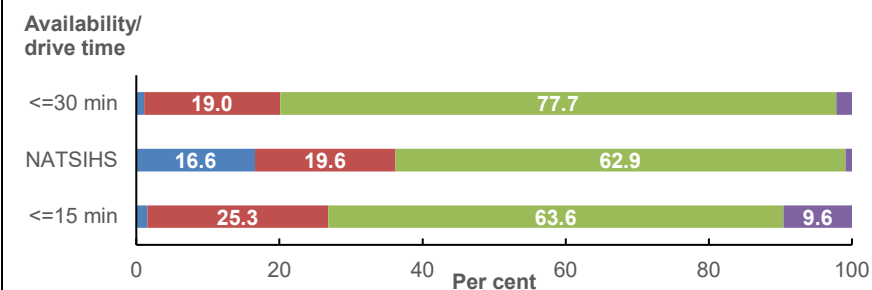
a) Major cities



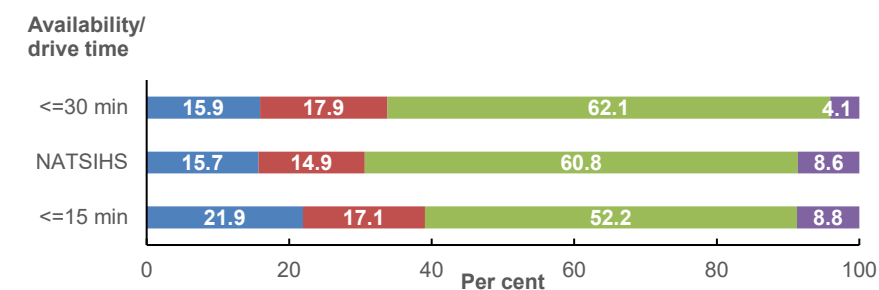
b) Inner regional



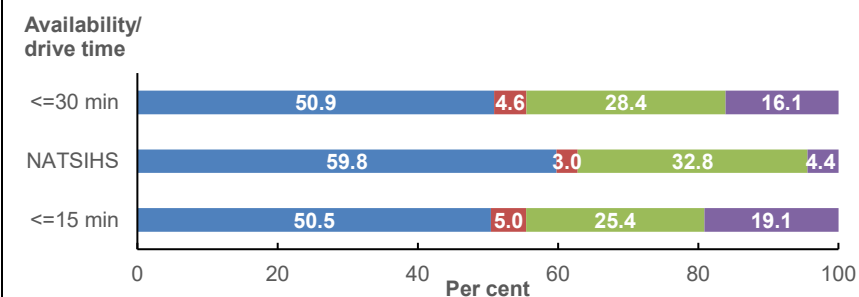
c) Outer regional



d) Remote



e) Very remote



Sources: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab; Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites that are also in the OSR. For more details see Appendix 2.

Appendix 1 Spatial analysis methodology

Populations-to-services drive times

Overview

Drive times refer to the estimated time it takes to travel by car from one location to another, based on the road network and speed limits, via the fastest route. This estimate may differ from the actual travel time.

Drive times between population centroids (ABS Population Grid 2021) and nearest service locations (in terms of time) were calculated using Esri software. Drive times were adjusted for the distance to the road network and imputed in the absence of a valid route.

Details

Origins: Land centroid of each populated grid cell from the ABS Population Grid 2021.

Destinations: Service locations (geocoded and checked).

Road network: ArcGIS StreetMap Premium Asia Pacific 2023 Release 1.

Barriers: None (people may use any service, nationally).

Traffic consideration: None (driving unimpeded).

Adjustments and imputation

In the vast majority of cases, drive times needed little adjustment: geodesic distances from population centroid to road network (start journey) and from road network (end journey) to service location ('snapping distance') were penalised at 1 minute per kilometre (equivalent to 60 km/h). It was especially important to consider the snapping distances in remote areas, where the Esri road network could be incomplete. A speed of 60 km/h was chosen to return moderately conservative results.

For locations where the road network analysis detected no service within a 2-hour drive, the geodesic distance to the closest service was used to impute a drive time, at 2 minutes per kilometre (equivalent to 30 km/h). It was especially important to impute results for islands where ferry routes were missing from the road network. A speed of 30 km/h was chosen to return extra conservative results. The use of a 2-hour drive time cut-off for this treatment resulted in some population centroids scoring potentially 'false positive' access to services when farther than a 2-hour drive but within 30 km of a service.

For locations where the snapping distance accounted for more than 25% of the total drive time: the lesser of total drive time and the geodesic distance time was used. This was applied in case any populated location had a nearby service but incomplete road network data.

Limitations

The drive time analysis is very accurate in most cases. However, there are some general limitations:

- Minimum drive times are employed as an objective measure relating to the ease with which people can use services, where distance presents a barrier. In reality, there:
 - may be more important, non-spatial barriers affecting access to services
 - are subjective differences of opinion relating to the same travel time
 - are many unmeasured spatial factors, such as traffic, parking, road quality, fuel costs, people movements (for work or other activities).
- People are assumed to be able to travel by motor vehicle, when necessary. For people without this option or for whom this is more burdensome, distance presents additional challenges.
- As well, the digital road network may be missing potential routes, or may include routes that are not accurate.

More specifically to this analysis:

- Residents within each 1×1 km grid square are assumed to have the same drive times to services. This does not account for the differences in how people are distributed within those grid squares, which can have a considerable impact in certain areas (for example, where water or other barriers separate 2 communities).
- Grid squares with between 0 and 0.5 estimated residents (Aboriginal and Torres Strait Islander people) are not shown on the map, but their modelled populations still contribute to results when aggregated to larger geographic areas.

Population

Overview

Aboriginal and Torres Strait Islander population estimates for each cell in the ABS Population Grid (2021) were calculated in the following way:

- Population estimates at the SA1 level were disaggregated (spread out) across the Population Grid and Mesh Block areas (Australian Statistical Geography Standard Edition 3) using probabilistic methods, partly based on 2021 Census counts (person-level).
- With this level of disaggregation, drive times and population estimates could be calculated for small areas (one square kilometre resolution), and results could be produced for any geographic level based on Mesh Blocks.

Details

Note: Where relevant, geographic boundaries refer to the Australian Statistical Geography Standard Edition 3.

Data inputs

- [A1] Address counts (Geocoded National Address File, G-NAF), by Australian Population Grid and Mesh Block, May 2022⁵⁵
- [P1] Persons, by Australian Population Grid, 30 June 2021⁵⁶
- [P2] Persons, by Statistical Area Level 1 (SA1), 30 June 2021 (preliminary)⁵⁷
- [C1] Persons (Census counts), by Mesh Block, 2021⁵⁸
- [I1] Persons, by Indigenous status, by Statistical Area Level 1 (SA1), 30 June 2021⁵⁹

Procedure summary

Below, square brackets are used to indicate inputs and curly brackets are used to indicate results.

- [A1] used to split [P1] by Population Grid and Mesh Block → {R1} Persons, by Population Grid and Mesh Block
- [C1] used to adjust [R1] → {R2} Persons, by Population Grid and Mesh Block
- [P2] used to benchmark [R2] → {R3} Persons, by Population Grid and Mesh Block
- [P1] used to benchmark [R3] → {R4} Persons, by Population Grid and Mesh Block
- [I1] used to approximate Indigenous splits within [R4] → {R5} Persons, by Indigenous status, by Population Grid and Mesh Block

Limitations

The smallest geographic level for which Estimated Resident Populations (ERPs) are officially prepared and validated by the ABS is SA2. In this report, population estimates that are low, cover small areas, or are more geographically isolated are subject to greater relative error. For example, estimates of the number of Aboriginal and Torres Strait Islander people in small remote communities should be treated as indicative only.

Population disaggregation via proxy data (in this case: Census counts, total populations and G-NAF addresses) is an imperfect process. Proxy data may not be accurate or representative of the target population's distribution.

Population data from 2021 were used, as these were the best available at the time of analysis. Where preliminary ERPs have been used, there may be discrepancies with other revised or final ABS estimates.

⁵⁵ Geoscape Australia (May 2022) Geocoded National Address File (G-NAF) [data set], accessed [via Data.gov.au] 19 May 2022.

⁵⁶ ABS (2021) 'Australian population grid in ESRI Grid format, 2016 to 2021' [Population grid files], Regional population, accessed 7 September 2022.

⁵⁷ ABS (2023) 'Estimated Resident Population by Statistical Area Level 1 – 30 June 2011 to 2022' [customised report], Queensland Government Statistician's Office, accessed 31 March 2023.

⁵⁸ ABS (2021) '2021 Census Mesh Block counts' [data set], Census mesh block counts, accessed 29 July 2022.

⁵⁹ IPF estimates prepared by the AIHW (AIHW 2024d).

Appendix 2 Additional tables/figures

Distribution of Independent variables by domain

Table A2.1: Distribution of selected demographic/location variables, 2018–19

Category	Value	Number	%
Sex	Male	400,900	49.3
	Female	413,100	50.7
State/territory	NSW	271,900	33.4
	Vic	60,200	7.4
	Qld	228,900	28.1
	WA	99,800	12.3
	SA	43,000	5.3
	Tas	29,800	3.7
	ACT	7,700	0.9
	NT	72,700	8.9
Remoteness	Major cities	307,700	37.8
	Inner regional	194,400	23.9
	Outer regional	163,900	20.1
	Remote	53,200	6.5
	Very remote	95,700	11.7
Age group (years)	0–4	95,400	11.7
	5–14	182,500	22.4
	15–24	155,500	19.1
	25–34	117,800	14.5
	35–44	83,700	10.3
	45–54	81,800	10.0
	55–64	57,800	7.1
	65 and over	39,700	4.9
SEIFA quintiles (SA1 level)	1 (most disadvantaged)	434,800	53.4
	2	178,300	21.9
	3	103,200	12.7
	4	70,000	8.6
	5 (least disadvantaged)	27,300	3.4
Total (weighted)		814,000	..

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Table A2.2: Distribution of selected socioeconomic/social capital variables, 2018–19

Category	Value	Number	%
Equivalised annual household income (quintile) ^(a)	1 (lowest)	291,700	43.6
	2	151,100	22.6
	3	107,400	16.1
	4	73,600	11.0
	5 (highest)	43,000	6.4
	Unknown or n.a.	147,800	n.a.
Household could raise \$2,000 in an emergency	Yes	353,600	43.4
	No	416,000	51.1
	Unknown	44,700	5.5
Had days without money for basic living expenses in last 12 months	Yes	324,700	39.9
	No	490,000	60.1
Has private health cover ^(a)	Yes	89,200	20.7
	No	342,600	79.3
	Unknown or n.a.	382,700	n.a.
Highest year of school completed ^(a)	Year 12	166,600	31.1
	Years 10–11	239,300	44.7
	Year 9 or below	126,400	23.6
	No high school	3,400	0.6
	n.a.	278,100	n.a.
Has non-school qualifications ^(a)	Yes	258,800	48.3
	No	277,500	51.7
	n.a.	278,100	n.a.
Labour force status ^(a)	Working full or part time	245,800	45.8
	Unemployed	55,800	10.4
	Not in labour force	234,600	43.8
	n.a.	278,100	n.a.
Housing tenure	Owner	235,700	28.9
	Renter	557,900	68.5
	All others	20,900	2.6
Total (weighted)		814,000	..

(a) Percentages are calculated only on valid responses.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Table A2.3: Distribution of selected cultural identification and language variables, 2018–19

Category	Value	Number	%
Identifies with tribal group, language group or clan (aged 18 and over) ^(a)	Tribal group	158,100	33.0
	Language group	68,800	14.4
	A clan	59,800	12.5
	A mission	29,200	6.1
	Regional group	167,700	35.0
	None of the above	165,600	34.6
	n.a.	165,200	n.a.
Satisfaction level with own knowledge of culture (aged 18 and over) ^(a)	Satisfied/very satisfied	263,700	54.9
	Neutral	97,300	20.2
	Not very/not at all satisfied	119,600	24.9
	n.a.	333,800	n.a.
Main language spoken at home	English	741,600	91.1
	Indigenous language	68,200	8.4
	Other	4,600	0.6
Proficiency in English among those with Indigenous/other language ^(b)	Well/very well	56,500	82.2
	Not at all/not well	12,200	17.8
Experienced unfair treatment in the past 12 months (aged 15 and over and interviewed in person)	Had unfair treatment	116,200	23.3
	Has not had unfair treatment	349,800	70.2
	Does not know if had unfair treatment	32,200	6.5
	Not applicable ^(a)	316,000	n.a.
Total (weighted)		814,000	..

(a) Percentages are calculated only on valid responses.

(b) Percentages are calculated only on those who spoke an Indigenous or other language at home.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Table A2.4: Distribution of selected health status variables, 2018–19

Category	Value	Number	%
Self-assessed health status (aged 15 and over)	Poor	46,000	8.6
	Fair	82,300	15.3
	Good	168,900	31.5
	Very good	152,900	28.5
	Excellent	86,300	16.1
	n.a.	278,100	n.a.
Level of psychological distress (K5) (aged 18 and over and present at interview) ^(a)	Low/moderate (5–11)	322,400	68.3
	High/very high (12–25)	149,400	31.7
	Unable to determine	9,400	n.a.
	n.a.	333,800	n.a.
Has a current and long-term health condition	Yes	483,500	59.4
	No	330,600	40.6
Has specific long-term health condition ^(b,c)	Eye/sight problems	307,300	37.8
	Mental health conditions	188,200	23.1
	Asthma	127,700	15.7
	Ear/hearing problems	111,700	13.7
	Back problems (dorsopathies)	102,200	12.6
Self-reported comorbidity by type ^(b, c)	One or more chronic diseases (diabetes, CVD, kidney disease)	154,500	19.0
	One or more chronic respiratory diseases (asthma, other chronic lower respiratory disease)	139,000	17.1
	One or more musculoskeletal diseases (arthritis or other musculoskeletal conditions)	171,000	21.0
Total (weighted)		814,000	. .

Note: CVD = cardiovascular disease.

(a) Percentages are calculated only on valid responses.

(b) Percentages are calculated on the total population.

(c) Respondents were asked to tick as many as applied to them, so a single individual may appear in multiple categories.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Table A2.5: Distribution of selected disability variables, 2018–19

Category	Value	Number	%
Disability	Does not have disability	508,300	62.4
	Has disability	306,100	37.6
Disability status ^(a)	Has no limitation or specific restriction	85,700	28.0
	Has a schooling/employment restriction only	48,100	15.7
	Has mild/moderate core activity limitation	106,400	34.7
	Has severe/profound core activity limitation	66,000	21.6
Disability type ^(a)	Sight, hearing, speech	76,200	24.9
	Physical (includes head injuries)	118,800	38.8
	Intellectual	36,300	11.9
	Psychological	38,200	12.5
	Other	36,600	12.0
Total (weighted)		814,000	..

(a) Percentages are calculated only on those reporting disability.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder.

Available primary care service categories in local area by selected characteristics

Table A2.6: Distribution of availability of primary care services in local area, by selected variables, 2018–19

Variable/categories		Number					%				
		AMS/ CC only	AMS/CC and main- stream GP	Main- stream GP only	Neither	Total	AMS/ CC only	AMS/CC and main- stream GP	Main- stream GP only	Neither	Total
Sex	Male	53,407	212,991	126,417	8,455	401,270	13.3	53.1	31.5	2.1	100.0
	Female	54,453	226,713	123,116	8,692	412,974	13.2	54.9	29.8	2.1	100.0
Age group (years)	0–14	37,678	149,431	85,876	5,123	278,107	13.5	53.7	30.9	1.8	100.0
	15–24	20,477	84,681	46,771	3,658	155,587	13.2	54.4	30.1	2.4	100.0
	25–34	15,015	66,445	34,207	2,327	117,994	12.7	56.3	29.0	2.0	100.0
	35–44	12,260	43,473	25,950	1,934	83,617	14.7	52.0	31.0	2.3	100.0
	45–54	10,761	42,112	26,349	2,336	81,558	13.2	51.6	32.3	2.9	100.0
	55–64	7,987	31,419	17,096	1,085	57,587	13.9	54.6	29.7	1.9	100.0
	65 and over	3,681	22,144	13,285	684	39,794	9.2	55.6	33.4	1.7	100.0
Remoteness	Major cities	8,932	157,169	136,670	4,617	307,389	2.9	51.1	44.5	1.5	100.0
	Inner regional	6,128	115,930	70,027	2,307	194,392	3.2	59.6	36.0	1.2	100.0
	Outer regional	27,232	102,948	32,055	1,500	163,736	16.6	62.9	19.6	0.9	100.0
	Remote	8,361	32,285	7,927	4,561	53,134	15.7	60.8	14.9	8.6	100.0
	Very remote	57,206	31,372	2,852	4,163	95,593	59.8	32.8	3.0	4.4	100.0
State/territory	NSW	11,579	158,312	96,369	6,201	272,460	4.2	58.1	35.4	2.3	100.0
	Vic	1,854	28,379	29,144	715	60,092	3.1	47.2	48.5	1.2	100.0
	Qld	38,423	133,456	52,102	4,685	228,667	16.8	58.4	22.8	2.0	100.0
	WA	14,141	51,396	32,249	2,007	99,793	14.2	51.5	32.3	2.0	100.0
	SA	2,555	22,551	17,534	488	43,128	5.9	52.3	40.7	1.1	100.0
	Tas	n.a.	10,519	17,516	n.a.	29,756	n.a.	35.3	58.9	n.a.	100.0
	ACT	n.a.	5,021	2,363	n.a.	7,741	n.a.	64.9	30.5	n.a.	100.0
	NT	38,182	30,071	2,256	2,099	72,607	52.6	41.4	3.1	2.9	100.0
SEIFA quintile	Lowest quintile	96,046	251,381	95,346	8,499	451,272	21.3	55.7	21.1	1.9	100.0
	Middle quintiles (2 and 3)	9,513	146,420	108,311	6,498	270,743	3.5	54.1	40.0	2.4	100.0
	Top quintiles (4 and 5)	2,300	41,903	45,875	2,150	92,229	2.5	45.4	49.7	2.3	100.0

(continued)

Table A2.6 (continued): Distribution of availability of primary care services in local area by selected variables, 2018–19

Variable/categories		Number					%				
		AMS/CC only	AMS/CC and main-stream GP	Main-stream GP only	Neither	Total	AMS/CC only	AMS/CC and main-stream GP	Main-stream GP only	Neither	Total
Equivalised household income (quintiles)	Lowest quintile (1)	49,303	159,640	74,829	8,015	291,787	16.9	54.7	25.6	2.7	100.0
	Middle quintiles (2 and 3)	24,067	146,628	82,020	5,679	258,395	9.3	56.7	31.7	2.2	100.0
	Top quintiles (4 and 5)	3,299	57,128	54,900	1,044	116,371	2.8	49.1	47.2	0.9	100.0
	Not stated/not known	31,191	76,307	37,784	2,409	147,691	21.1	51.7	25.6	1.6	100.0
Financial stress (household could raise \$2,000 in an emergency)	Yes	19,920	191,156	137,918	4,735	353,729	5.6	54.0	39.0	1.3	100.0
	No	78,580	228,215	97,682	11,409	415,886	18.9	54.9	23.5	2.7	100.0
	Not known	9,360	20,333	13,933	1,003	44,629	21.0	45.6	31.2	2.2	100.0
Any long-term health conditions	Yes	49,611	270,891	154,710	8,428	483,640	10.3	56.0	32.0	1.7	100.0
	No	58,249	168,813	94,823	8,720	330,604	17.6	51.1	28.7	2.6	100.0
Has disability	Yes	35,210	167,405	96,789	6,602	306,006	11.5	54.7	31.6	2.2	100.0
	No	72,650	272,299	152,744	10,545	508,238	14.3	53.6	30.1	2.1	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Table A2.7: Preferred source of care, by primary care services in local area, 2018–19

Primary care in area	Preferred source of care									
	Number					%				
	AMS/CC	Mainstream GP	Hospital	All others	Total	AMS/CC	Mainstream GP	Hospital	All others	Total
AMS/CC only	88,867	3,393	13,391	2,209	107,860	82.4	3.1	12.4	2.0	100.0
Both AMS/CC and mainstream GP	225,557	179,914	25,245	8,988	439,704	51.3	40.9	5.7	2.0	100.0
GP only	72,140	160,670	8,390	8,332	249,532	28.9	64.4	3.4	3.3	100.0
Neither	3,774	6,163	5,808	1,402	17,147	22.0	35.9	33.9	8.2	100.0
Total	390,339	350,140	52,834	20,931	814,244	47.9	43.0	6.5	2.6	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Table A2.8: Usual source of care, by primary care services in local area, 2018–19

Primary care in area	Usual source of care											
	Number						%					
	AMS/CC	Main-stream GP	Hospital	All other	None or don't know	Total	AMS/CC	Main-stream GP	Hospital	All other	None or don't know	Total
AMS/CC only	92,445	1,895	4,918	549	8,054	107,861	85.7	1.8	4.6	0.5	7.5	100.0
Both AMS/CC and mainstream GP	178,783	220,932	13,005	1,812	25,171	439,703	40.7	50.2	3.0	0.4	5.7	100.0
GP only	4,144	211,310	5,800	1,976	26,302	249,532	1.7	84.7	2.3	0.8	10.5	100.0
Neither	1,903	5,294	5,011	897	4,041	17,146	11.1	30.9	29.2	5.2	23.6	100.0
Total	277,275	439,432	28,735	5,235	63,568	814,245	34.1	54.0	3.5	0.6	7.8	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Table A2.9: Any occasion of unmet need for GP in the past 12 months, by primary care services in local area, 2018–19

Primary care in area	Number			%		
	Unmet need	No unmet need	Total	Unmet need	No unmet need	Total
AMS/CC only	8,034	99,826	107,860	7.4	92.6	100.0
Both AMS/CC and mainstream GP	55,863	383,841	439,704	12.7	87.3	100.0
GP only	36,159	213,374	249,533	14.5	85.5	100.0
Neither	1,736	15,411	17,147	10.1	89.9	100.0
Total	101,792	712,452	814,244	12.5	87.5	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Table A2.10: Any occasion of unmet need for dental care (ages 2 and over) in the past 12 months, by primary care services in local area, 2018–19

Primary care in area	Number			%		
	Unmet need	No unmet need	Total	Unmet need	No unmet need	Total
AMS/CC only	14,533	87,610	102,143	14.2	85.8	100.0
Both AMS/CC and mainstream GP	76,155	342,824	418,979	18.2	81.8	100.0
GP only	53,478	183,550	237,028	22.6	77.4	100.0
Neither	2,591	14,018	16,609	15.6	84.4	100.0
Total	146,757	628,001	774,758	18.9	81.1	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Preferences for an AMS/CC

Demographic and location variables

Table A2.11: Preference for an AMS/CC (ages 18 and over), by selected demographic and location variables, 2018–19

Variable/categories		Number			%		
		Preferred an AMS/CC	Preferred other type of health service	Total	Preferred an AMS/CC	Preferred other type of health service	Total
Sex	Male	101,098	132,361	233,459	43.3	56.7	100.0
	Female	126,140	126,845	252,985	49.9	50.1	100.0
Age group (years)	18–24	51,154	54,740	105,894	48.3	51.7	100.0
	25–34	56,449	61,545	117,994	47.8	52.2	100.0
	35–44	39,112	44,505	83,617	46.8	53.2	100.0
	45–54	38,782	42,776	81,558	47.6	52.4	100.0
	55–64	26,605	30,982	57,587	46.2	53.8	100.0
	65 and over	15,135	24,659	39,794	38.0	62.0	100.0
Remoteness	Major cities	64,695	120,366	185,061	35.0	65.0	100.0
	Inner regional	48,418	62,873	111,291	43.5	56.5	100.0
	Outer regional	51,537	44,420	95,957	53.7	46.3	100.0
	Remote	19,277	13,838	33,115	58.2	41.8	100.0
	Very remote	43,311	17,709	61,020	71.0	29.0	100.0
State/territory	NSW	70,414	92,597	163,011	43.2	56.8	100.0
	Vic	12,874	22,750	35,624	36.1	63.9	100.0
	Qld	65,607	66,928	132,535	49.5	50.5	100.0
	WA	27,055	32,407	59,462	45.5	54.5	100.0
	SA	9,673	16,089	25,762	37.5	62.5	100.0
	Tas	4,478	13,710	18,188	24.6	75.4	100.0
	ACT	1,632	3,189	4,821	33.8	66.2	100.0
	NT	35,505	11,536	47,041	75.5	24.5	100.0
SEIFA (IRSAD)	Lowest quintile (1)	140,394	125,481	265,875	52.8	47.2	100.0
	Middle quintiles (2 and 3)	68,858	94,218	163,076	42.2	57.8	100.0
	Top quintiles (4 and 5)	17,986	39,507	57,493	31.3	68.7	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using Datalab.

Socioeconomic and social capital variables

Table A2.12: Preference for an AMS/CC (ages 18 and over), by selected socioeconomic and social capital variables, 2018–19

		Number			%		
		Preferred an AMS/CC	Preferred other type of health service	Total	Preferred an AMS/CC	Preferred other type of health service	Total
Equivalised household income	Lowest quintile (1)	85,994	68,505	154,499	55.7	44.3	100.0
	Middle quintiles (2 and 3)	73,676	79,796	153,472	48.0	52.0	100.0
	Top quintiles (4 and 5)	24,846	56,211	81,057	30.7	69.3	100.0
	Income not known	42,721	54,694	97,415	43.9	56.1	100.0
Could raise \$2,000 in an emergency	Yes	77,750	139,150	216,900	35.8	64.2	100.0
	No	136,125	106,454	242,579	56.1	43.9	100.0
	Not known	13,362	13,603	26,965	49.6	50.4	100.0
Labour force status	Employed	93,301	139,021	232,322	40.2	59.8	100.0
	Unemployed	26,997	24,110	51,107	52.8	47.2	100.0
	Not in the labour force	106,940	96,076	203,016	52.7	47.3	100.0
Highest level of school completed	Year 9 or below/none/ unknown	58,799	51,332	110,131	53.4	46.6	100.0
	Year 10 or 11	104,092	108,124	212,216	49.0	51.0	100.0
	Year 12	64,347	99,750	164,097	39.2	60.8	100.0
Non-school qualifications	Yes	108,115	146,977	255,092	42.4	57.6	100.0
	No	119,122	112,230	231,352	51.5	48.5	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Cultural variables/experiences of unfair treatment

Table A2.13: Preference for an AMS/CC (ages 18 and over), by selected cultural variables and experience of unfair treatment, 2018–19

		Number			%		
		Preferred an AMS/CC	Preferred other type of health service	Total	Preferred an AMS/CC	Preferred other type of health service	Total
Identifies with a tribe, language group or clan	Yes	173,579	141,813	315,392	55.0	45.0	100.0
	No/unknown/refused	53,659	117,394	171,053	31.4	68.6	100.0
Satisfaction with own knowledge of culture	Satisfied/very satisfied	144,179	119,542	263,721	54.7	45.3	100.0
	Not very/not at all satisfied	47,139	72,744	119,883	39.3	60.7	100.0
	Neutral/not applicable	35,920	66,920	102,840	34.9	65.1	100.0
Experienced unfair treatment at least once in the past 12 months	Yes	59,493	52,471	111,964	53.1	46.9	100.0
	No	152,214	185,658	337,872	45.1	54.9	100.0
	Don't know/not applicable	15,530	21,077	36,607	42.4	57.6	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Health and disability variables

Table A2.14: Preference for an AMS/CC (ages 18 and over), by selected health and disability variables, 2018–19

		Number			%		
		Preferred an AMS/CC	Preferred other type of health service	Total	Preferred an AMS/CC	Preferred other type of health service	Total
Self-assessed health status	Excellent/very good	89,479	113,625	203,104	44.1	55.9	100.0
	Good	77,515	82,628	160,143	48.4	51.6	100.0
	Fair/poor	60,243	62,953	123,196	48.9	51.1	100.0
Level of psychological distress (K5)	High/very high (12–25)	72,755	76,469	149,224	48.8	51.2	100.0
	Low/moderate (5–11)	145,277	176,864	322,141	45.1	54.9	100.0
	Unable to determine/not applicable	9,206	5,874	15,080	61.0	39.0	100.0
Has a long-term health condition	Yes	168,701	199,503	368,204	45.8	54.2	100.0
	No	58,537	59,703	118,240	49.5	50.5	100.0
Has disability	Yes	107,966	125,495	233,461	46.2	53.8	100.0
	No	119,272	133,712	252,984	47.1	52.9	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Able to use AMS/CC (all ages)

Table A2.15: Able to use an AMS/CC among those who preferred one, by selected demographic and location factors, 2018–19

Variable		Number			%		
		Yes	No	Total	Yes	No	Total
Sex	Female	130,797	76,828	207,625	63.0	37.0	100.0
	Male	117,622	65,092	182,714	64.4	35.6	100.0
Age group (years)	0–14	88,590	53,062	141,652	62.5	37.5	100.0
	15–24	46,890	25,714	72,604	64.6	35.4	100.0
	25–34	34,600	21,849	56,449	61.3	38.7	100.0
	35–44	24,569	14,543	39,112	62.8	37.2	100.0
	45–54	23,540	15,242	38,782	60.7	39.3	100.0
	55–64	18,545	8,060	26,605	69.7	30.3	100.0
	65 and over	11,686	3,450	15,136	77.2	22.8	100.0
Remoteness	Major cities	40,576	68,195	108,771	37.3	62.7	100.0
	Inner regional	49,185	42,056	91,241	53.9	46.1	100.0
	Outer regional	75,278	16,223	91,501	82.3	17.7	100.0
	Remote	24,209	6,225	30,434	79.5	20.5	100.0
	Very remote	59,170	9,221	68,391	86.5	13.5	100.0
State	NSW	65,280	56,999	122,279	53.4	46.6	100.0
	Vic	9,735	11,543	21,278	45.8	54.2	100.0
	Qld	80,707	38,737	119,444	67.6	32.4	100.0
	WA	29,523	15,044	44,567	66.2	33.8	100.0
	SA	8,566	8,431	16,997	50.4	49.6	100.0
	Tas	3,026	4,577	7,603	39.8	60.2	100.0
	ACT	1,471	1,375	2,846	51.7	48.3	100.0
	NT	50,112	5,215	55,327	90.6	9.4	100.0
SEIFA	1st quintile (most disadvantaged)	179,470	65,074	244,544	73.4	26.6	100.0
	2nd and 3rd quintiles	57,020	57,247	114,267	49.9	50.1	100.0
	4th and 5th quintiles	11,929	19,600	31,529	37.8	62.2	100.0
Equivalised household income	1st quintile (lowest)	112,310	52,220	164,530	68.3	31.7	100.0
	2nd and 3rd quintiles	70,416	51,661	122,077	57.7	42.3	100.0
	4th and 5th quintiles	13,856	22,840	36,696	37.8	62.2	100.0
	Not stated or not known	51,837	15,199	67,036	77.3	22.7	100.0
Financial stress	Could not raise \$2,000 in a week	167,284	70,700	237,984	70.3	29.7	100.0
	Could raise \$2,000 in a week	63,628	64,670	128,298	49.6	50.4	100.0
	Not known	17,506	6,550	24,056	72.8	27.2	100.0
Long-term health conditions	No	112,601	54,908	167,509	67.2	32.8	100.0
	Yes	135,818	87,012	222,830	61.0	39.0	100.0
Disability status	No disability	160,537	86,171	246,708	65.1	34.9	100.0
	Has disability	87,882	55,749	143,631	61.2	38.8	100.0
Whether there is a GP in local area by type	AMS only	80,423	8,445	88,868	90.5	9.5	100.0
	Both	162,547	63,010	225,557	72.1	27.9	100.0
	GP only	3,769	68,371	72,140	5.2	94.8	100.0
	Neither	1,680	2,094	3,774	44.5	55.5	100.0
Total		248,419	141,920	390,339	63.6	36.4	63.6

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Able to use an AMS/CC (ages 18 and over)

Demographic and location variables

Table A2.16: Able to use an AMS/CC among those who preferred one (ages 18 and over), by selected demographic and location variables, 2018–19

Variable		Number			%		
		AMS/CC as usual source	Other/none	Total	AMS/CC as usual source	Other/none	Total
Sex	Male	32,833	18,321	51,154	64.2	35.8	100.0
	Female	34,600	21,849	56,449	61.3	38.7	100.0
Age group (years)	18–24	24,569	14,543	39,112	62.8	37.2	100.0
	25–34	23,540	15,242	38,782	60.7	39.3	100.0
	35–44	18,545	8,060	26,605	69.7	30.3	100.0
	45–54	11,686	3,450	15,136	77.2	22.8	100.0
	55–64	32,833	18,321	51,154	64.2	35.8	100.0
	65 and over	34,600	21,849	56,449	61.3	38.7	100.0
Remoteness	Major cities	22,350	42,345	64,695	34.5	65.5	100.0
	Inner regional	26,950	21,468	48,418	55.7	44.3	100.0
	Outer regional	42,920	8,617	51,537	83.3	16.7	100.0
	Remote	15,410	3,866	19,276	79.9	20.1	100.0
	Very remote	38,142	5,169	43,311	88.1	11.9	100.0
State/territory	NSW	36,950	33,464	70,414	52.5	47.5	100.0
	Vic	5,170	7,704	12,874	40.2	59.8	100.0
	Qld	45,177	20,430	65,607	68.9	31.1	100.0
	WA	18,623	8,432	27,055	68.8	31.2	100.0
	SA	5,024	4,649	9,673	51.9	48.1	100.0
	Tas	1,701	2,777	4,478	38.0	62.0	100.0
	ACT	832	800	1,632	51.0	49.0	100.0
	NT	32,295	3,209	35,504	91.0	9.0	100.0
SEIFA (IRSAD)	Lowest quintile (1)	103,910	36,484	140,394	74.0	26.0	100.0
	Middle quintiles (2 and 3)	35,181	33,678	68,859	51.1	48.9	100.0
	Top quintiles (4 and 5)	6,682	11,304	17,986	37.2	62.8	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using Datalab.

Socioeconomic and social capital variables

Table A2.17: Able to use an AMS/CC among those who preferred one (ages 18 and over), by selected socioeconomic and social capital variables, 2018–19

Variable		Number			%		
		AMS/CC as usual source	Other/ none	Total	AMS/CC as usual source	Other/ none	Total
Equivalised household income	Lowest quintile (1)	60,920	25,074	85,994	70.8	29.2	100.0
	Middle quintiles (2 and 3)	42,984	30,692	73,676	58.3	41.7	100.0
	Top quintiles (4 and 5)	9,213	15,633	24,846	37.1	62.9	100.0
	Income not known	32,656	10,066	42,722	76.4	23.6	100.0
Could raise \$2,000 in an emergency	Yes	37,971	39,780	77,751	48.8	51.2	100.0
	No	97,503	38,622	136,125	71.6	28.4	100.0
	Not known	10,298	3,064	13,362	77.1	22.9	100.0
Labour force status	Employed	49,018	44,284	93,302	52.5	47.5	100.0
	Unemployed	16,790	10,207	26,997	62.2	37.8	100.0
	Not in the labour force	79,965	26,975	106,940	74.8	25.2	100.0
Highest level of school completed	Year 9 or below/none/unknown	42,999	15,800	58,799	73.1	26.9	100.0
	Year 10 or 11	64,608	39,484	104,092	62.1	37.9	100.0
	Year 12	38,166	26,181	64,347	59.3	40.7	100.0
Non-school qualifications	Yes	59,645	48,471	108,116	55.2	44.8	100.0
	No	86,128	32,995	119,123	72.3	27.7	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Cultural variables/experiences of unfair treatment

Table A2.18: Able to use an AMS/CC among those who preferred one (ages 18 and over), by selected cultural variables and experience of unfair treatment, 2018–19

		Number			%		
		AMS/CC as usual source	Other/ none	Total	AMS/CC as usual source	Other/ none	Total
Identifies with a tribe, language group or clan	Yes	119,372	54,207	173,579	68.8	31.2	100.0
	No/unknown/ refused	26,401	27,258	53,659	49.2	50.8	100.0
Satisfaction with own knowledge of culture	Satisfied/ very satisfied	105,046	39,133	144,179	72.9	27.1	100.0
	Not very/ not at all satisfied	19,905	27,234	47,139	42.2	57.8	100.0
	Neutral/ not applicable	20,822	15,098	35,920	58.0	42.0	100.0
Experienced unfair treatment at least once in the past 12 months	Yes	35,240	24,254	59,494	59.2	40.8	100.0
	No	100,350	51,864	152,214	65.9	34.1	100.0
	Don't know/ not applicable	10,183	5,347	15,530	65.6	34.4	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Health and disability

Table A2.19: Able to use an AMS/CC among those who preferred one (ages 18 and over), by selected health and disability variables, 2018–19

		Number			%		
		AMS/CC as usual source	Other/ none	Total	AMS/CC as usual source	Other/ none	Total
Self-assessed health status	Excellent/ very good	57,588	31,891	89,479	64.4	35.6	100.0
	Good	52,119	25,396	77,515	67.2	32.8	100.0
	Fair/poor	36,066	24,178	60,244	59.9	40.1	100.0
Level of psychological distress (K5)	High/very high (12–25)	42,879	29,876	72,755	58.9	41.1	100.0
	Low/moderate (5–11)	94,935	50,342	145,277	65.3	34.7	100.0
	Unable to determine/ not applicable	7,959	1,247	9,206	86.5	13.5	100.0
Has a long-term health condition	Yes	42,353	16,184	58,537	72.4	27.6	100.0
	No	103,420	65,281	168,701	61.3	38.7	100.0
Has disability	Yes	66,084	41,882	107,966	61.2	38.8	100.0
	No	79,689	39,584	119,273	66.8	33.2	100.0

Note: Data are weighted frequencies.

Source: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using DataLab.

Additional drive time analysis results

Remoteness

Table A2.20: Distribution of Aboriginal and Torres Strait Islander population, by drive times to nearest service and by service type and remoteness

Remoteness	Drive time boundaries (minutes)												Estimated Aboriginal and Torres Strait Islander population
	IAHP-funded ACCHO			Any IAHP-funded			Mainstream GP			Any primary care			
	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	
Major cities	374,737	26,577	—	385,747	15,567	—	401,314	—	—	401,314	—	—	401,314
Inner regional	192,842	40,686	10,472	196,294	37,937	9,769	243,624	374	1	243,625	373	1	244,000
Outer regional	136,502	24,004	26,454	147,230	21,644	18,086	180,800	5,988	172	182,834	3,961	165	186,960
Remote	38,960	4,122	15,692	45,882	3,366	9,526	47,005	3,070	8,699	56,376	2,022	377	58,774
Very remote	50,043	4,244	37,628	72,863	3,711	15,342	30,357	3,165	58,393	77,116	4,226	10,573	91,915

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024), Online Services Report 2022–23.

State/territory

Table A2.21: Percentage distribution of Aboriginal and Torres Strait Islander population, by drive times to nearest service and by service type and state/territory

State/territory	Drive time boundaries (minutes)												Estimated Aboriginal and Torres Strait Islander population
	IAHP-funded ACCHO			Any IAHP-funded			Mainstream GP			Any primary care			
	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	
NSW	81.1	13.1	5.8	82.6	12.3	5.1	98.5	1.4	0.2	98.9	1.0	0.2	339,327
Vic	84.3	13.8	1.9	85.9	12.6	1.6	99.6	0.4	—	99.6	0.3	—	78,696
Qld	84.9	5.4	9.7	89.2	4.9	5.9	92.8	1.2	6.0	98.9	0.7	0.4	273,116
WA	76.0	14.7	9.3	89.2	4.3	6.5	88.2	1.7	10.1	95.8	1.5	2.7	119,979
SA	78.8	11.9	9.3	86.1	11.3	2.6	93.0	0.6	6.4	98.8	0.7	0.4	52,069
Tas	80.9	10.6	8.5	81.1	10.4	8.5	98.3	1.5	0.2	98.4	1.4	0.2	33,857
ACT	99.9	0.1	—	99.9	0.1	—	100.0	—	—	100.0	—	—	9,525
NT	66.4	2.8	30.9	88.7	3.4	7.9	52.4	1.9	45.7	88.9	3.4	7.6	76,121
Australia	80.7	10.1	9.2	86.3	8.4	5.4	91.9	1.3	6.8	97.8	1.1	1.1	982,964

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024); Online Services Report 2022–23.

State/territory and remoteness

Table A2.22: Percentage distribution of Aboriginal and Torres Strait Islander population, by drive times to nearest service and by service type, remoteness, and state/territory

State/territory	Drive time boundaries (minutes)												Estimated Aboriginal and Torres Strait Islander population
	IAHP-funded ACCHO			Any IAHP-funded			Mainstream GP			Any primary care			
	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	
Major cities													
NSW	95.1	4.9	—	95.1	4.9	—	100.0	—	—	100.0	—	—	164,088
Vic	93.1	6.9	—	94.4	5.6	—	100.0	—	—	100.0	—	—	41,533
Qld	99.3	0.7	—	99.3	0.7	—	100.0	—	—	100.0	—	—	102,898
WA	79.6	20.4	—	98.7	1.3	—	100.0	—	—	100.0	—	—	54,897
SA	86.8	13.2	—	86.8	13.2	—	100.0	—	—	100.0	—	—	28,398
ACT	99.9	0.1	—	99.9	0.1	—	100.0	—	—	100.0	—	—	9,525
Inner regional													
NSW	75.2	17.5	7.3	75.2	17.5	7.3	99.8	0.2	—	99.8	0.2	—	122,784
Vic	71.2	25.5	3.3	73.8	23.8	2.4	99.9	0.1	—	99.9	0.1	—	27,560
Qld	88.2	11.7	0.1	88.2	11.7	0.1	99.9	0.1	—	99.9	0.1	—	62,564
WA	62.7	32.7	4.6	87.5	12.2	0.3	100.0	—	—	100.0	—	—	9,937
SA	71.3	26.3	2.4	77.6	20.7	1.7	100.0	—	—	100.0	—	—	4,441
Tas	97.9	2.1	—	97.9	2.1	—	100.0	—	—	100.0	—	—	16,492

(continued)

Table A2.22 (continued): Percentage distribution of Aboriginal and Torres Strait Islander population by drive times to nearest service, by service type, remoteness, and state/territory

State/territory	Drive time boundaries (minutes)												Estimated Aboriginal and Torres Strait Islander population
	IAHP-funded ACCHO			Any IAHP-funded			Mainstream GP			Any primary care			
	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	<=30	>30 to <=60	>60	
Outer regional													
NSW	51.4	30.5	18.2	63.3	24.0	12.7	91.8	7.9	0.2	94.8	4.9	0.2	43,438
Vic	84.2	10.1	5.7	84.2	10.3	5.5	97.5	2.3	0.2	97.6	2.2	0.2	9,534
Qld	82.1	6.3	11.6	82.1	6.3	11.6	97.6	2.4	—	98.6	1.4	—	70,622
WA	66.9	7.7	25.3	80.0	11.5	8.5	99.2	0.8	—	99.2	0.8	—	15,329
SA	61.7	7.6	30.7	90.1	6.8	3.1	99.4	0.6	—	99.4	0.6	—	12,256
Tas	67.4	19.4	13.1	67.8	19.1	13.1	97.6	2.2	0.2	97.6	2.2	0.2	16,497
NT	99.7	0.3	—	99.7	0.3	—	99.7	0.3	—	99.7	0.3	—	19,285
Remote													
NSW	47.4	26.1	26.5	47.5	26.5	26.0	90.8	7.7	1.4	91.6	7.3	1.1	6,121
Vic	—	35.5	64.5	—	35.5	64.5	46.0	52.2	1.9	46.0	52.2	1.9	69
Qld	52.7	7.5	39.8	59.3	3.8	36.8	82.2	3.0	14.8	95.8	3.3	0.9	14,445
WA	90.6	1.5	7.9	90.6	1.5	7.9	93.7	6.3	0.1	98.5	1.4	0.1	15,452
SA	65.3	7.0	27.7	65.3	9.7	25.0	95.7	3.8	0.5	95.7	3.8	0.5	2,186
Tas	0.0	0.1	99.9	—	0.1	99.9	85.2	13.1	1.7	85.2	13.1	1.7	663
NT	65.7	5.2	29.1	95.7	3.6	0.7	62.5	5.0	32.4	95.9	3.4	0.7	19,839
Very remote													
NSW	51.4	4.5	44.1	51.4	4.5	44.1	72.7	12.3	15.0	72.7	12.3	14.9	2,897
Qld	39.5	5.3	55.3	87.6	1.4	11.0	31.7	5.6	62.7	94.2	1.5	4.2	22,587
WA	69.7	7.1	23.2	73.5	5.1	21.4	46.6	3.9	49.6	80.7	5.8	13.5	24,365
SA	88.9	3.5	7.7	88.9	3.5	7.7	27.1	3.5	69.4	91.1	4.4	4.6	4,788
Tas	56.9	12.8	30.4	56.9	12.8	30.4	62.7	29.2	8.1	82.9	8.9	8.1	206
NT	49.4	2.7	47.9	79.2	5.0	15.8	22.3	1.0	76.7	79.6	5.1	15.3	36,997

Sources: AIHW analysis of ABS population data (30 June 2021); NHSD (downloaded 2 April 2024); Online Services Report 2022–23.

Table A2.23: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in New South Wales (n=20)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Inner regional	North-Eastern NSW	Tamworth	Yes	228	Yes	227	No	11	No	10	10,035
2	Inner regional	South-Eastern NSW	Southern Tablelands	Yes	2,272	Yes	2,272	No	<10	No	<10	4,450
3	Major cities	South-Eastern NSW	Snowy – Monaro	Yes	738	Yes	734	No	<10	No	<10	3,397
4	Outer regional	North-Western NSW	Far West	Yes	843	Yes	843	Yes	241	Yes	241	3,079
5	Outer regional	North-Eastern NSW	Narrabri	Yes	2,343	No	47	No	—	No	—	2,442
6	Inner regional	Riverina – Orange	Mudgee	Yes	1,647	Yes	1,647	No	<10	No	<10	2,329
7	Inner regional	Riverina – Orange	Lithgow – Oberon	Yes	376	Yes	376	No	—	No	—	2,326
8	Inner regional	North-Eastern NSW	Muswellbrook	Yes	2,316	Yes	2,316	No	—	No	—	2,316
9	Inner regional	Riverina – Orange	Cowra	Yes	1,333	Yes	1,333	No	—	No	—	1,398
10	Inner regional	Riverina – Orange	Upper Murray	Yes	279	Yes	279	No	—	No	—	1,211
11	Outer regional	Riverina – Orange	Coolamon – Temora – West Wyalong	Yes	645	Yes	645	No	—	No	—	1,189
12	Inner regional	North-Eastern NSW	Upper Hunter	Yes	573	Yes	573	No	<10	No	<10	1,188
13	Inner regional	Riverina – Orange	Gundagai – Junee – Harden	Yes	274	Yes	274	No	—	No	—	1,180
14	Outer regional	Dubbo	Warrumbungle Shire	Yes	882	Yes	866	No	—	No	—	1,174
15	Very remote	North-Western NSW	Brewarrina	Yes	219	Yes	219	No	36	No	36	939
16	Outer regional	Riverina – Orange	Narrandera	Yes	812	Yes	812	No	—	No	—	912
17	Outer regional	Riverina – Orange	Central Murray	Yes	286	Yes	286	No	<10	No	<10	895
18	Remote	North-Western NSW	Cobar – Murrin Bridge	Yes	784	Yes	784	No	35	No	34	856
19	Inner regional	Riverina – Orange	Young	Yes	781	Yes	781	No	—	No	—	781
20	Remote	Dubbo	Bogan	Yes	533	Yes	533	No	12	No	12	534

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites only providing maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites in the also in the OSR. For more details see Appendix 1.

Table A2.24: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in Victoria (n=2)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Inner regional	Vic exc. Melbourne	Upper Goulburn Valley	Yes	332	No	159	No	—	No	—	1,040
2	Inner regional	Vic exc. Melbourne	South Gippsland – Bass Coast	Yes	601	Yes	601	No	—	No	—	972

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites only providing maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites in the also in the OSR. For more details see Appendix 1.

Table A2.25: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in Queensland (n=30)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Inner regional	Rockhampton	Gladstone	Yes	235	Yes	235	No	—	No	—	4,508
2	Very remote	Mount Isa	Carpentaria – Burke – Mornington	No	189	No	189	Yes	1,135	No	189	3,475
3	Outer regional	Rockhampton	Central Capricorn	Yes	3,060	Yes	3,060	No	11	No	11	3,062
4	Very remote	Torres Strait	Kaiwalagal – Inner Islands	Yes	2,926	No	<10	Yes	2,926	No	<10	2,926
5	Very remote	Cape York	Northern Peninsula Area	No	—	No	—	Yes	2,611	No	—	2,611
6	Outer regional	Cairns – Atherton	Kuranda – Croydon	Yes	216	Yes	216	No	180	No	180	2,461
7	Very remote	Cape York	Mapoon – Napranum – Weipa	Yes	995	No	—	Yes	281	No	—	2,294
8	Remote	Townsville – Mackay	Palm Island ⁶⁰	Yes	2,083	Yes	2,083	No	—	No	—	2,083
9	Outer regional	Townsville – Mackay	Bowen (Qld)	Yes	1,670	Yes	1,670	No	13	No	13	1,670
10	Outer regional	Rockhampton	Nebo – Clermont	Yes	1,649	Yes	1,649	No	51	No	51	1,658
11	Very remote	Torres Strait	Kalalagal – Western Islands	Yes	1,381	No	—	Yes	1,381	No	—	1,381
12	Outer regional	Toowoomba – Roma	Goondiwindi – Stanthorpe	Yes	264	Yes	264	No	<10	No	<10	1,352
13	Outer regional	Townsville – Mackay	Burdekin – Ayr	Yes	1,246	Yes	1,246	No	—	No	—	1,291
14	Remote	Mount Isa	Cloncurry – McKinlay	Yes	1,126	Yes	1,126	No	96	No	96	1,130

(continued)

⁶⁰ There is an ACCHO on Palm Island (Bwgcolman Healing Service) which is not funded by the IAHP.

Table A2.25 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in Queensland (n=30)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
15	Very remote	Cape York	Aurukun	No	—	No	—	Yes	1,047	No	—	1,047
16	Very remote	Cape York	Kowanyama	Yes	1,015	No	—	No	—	No	—	1,015
17	Very remote	Torres Strait	Kulkalgal – Central Islands	Yes	1,011	No	—	Yes	1,011	No	—	1,011
18	Remote	Cape York	Hope Vale	No	—	No	—	Yes	941	No	—	941
19	Outer regional	Townsville – Mackay	Proserpine – Whitsunday	Yes	938	Yes	938	No	—	No	—	938
20	Outer regional	Rockhampton	Banana	Yes	873	Yes	873	No	<10	No	<10	922
21	Very remote	Torres Strait	Meriam – Eastern Islands	Yes	806	No	—	Yes	806	No	—	806
22	Very remote	Cape York	Cape York	Yes	317	No	40	Yes	777	No	40	784
23	Very remote	Torres Strait	Kalakawal – Top Western Islands	Yes	654	No	—	Yes	654	No	—	654
24	Very remote	Rockhampton	Barcaldine – Blackall – Longreach	Yes	651	Yes	651	No	21	No	21	651
25	Very remote	Cape York	Lockhart River	Yes	571	No	<10	Yes	571	No	<10	571
26	Very remote	Townsville – Mackay	Flinders – Richmond – Dalrymple	Yes	350	Yes	350	No	144	No	144	561
27	Very remote	Cape York	Pormpuraaw	Yes	526	No	<10	Yes	526	No	<10	526
28	Remote	Cape York	Cooktown	No	—	No	—	Yes	520	No	—	520
29	Very remote	Mount Isa	Boulia – Diamantina – Winton	Yes	344	Yes	344	No	168	No	168	344
30	Remote	Cairns – Atherton	Wujal Wujal and Outstations	Yes	274	No	—	Yes	274	No	—	296

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Table A2.26: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in Western Australia (n=25)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Very remote	South Hedland	East Pilbara	Yes	606	Yes	606	Yes	1,516	Yes	606	2,405
2	Outer regional	South-Western WA	Albany	Yes	1,978	No	<10	No	—	No	—	1,978
3	Very remote	Broome	Broome – Surrounds	No	<10	No	<10	Yes	1,673	No	<10	1,680
4	Very remote	West Kimberley	Fitzroy Crossing	Yes	499	Yes	499	Yes	499	Yes	499	1,631
5	Very remote	Kununurra	Halls Creek	No	—	No	—	Yes	1,483	No	—	1,483
6	Outer regional	South-Western WA	Avon	Yes	888	Yes	511	No	<10	No	<10	1,363
7	Very remote	Kalgoorlie	Laverton – Ngaanyatjarra-ku	No	167	No	167	Yes	1,001	No	167	1,353
8	Very remote	South Hedland	Exmouth – Ashburton	Yes	1,298	Yes	1298	Yes	250	Yes	250	1,298
9	Very remote	West Kimberley	Outer Derby – West Kimberley	No	17	No	17	Yes	792	No	17	1,217
10	Very remote	West Kimberley	Fitzroy River	Yes	379	Yes	379	Yes	379	Yes	379	1,209
11	Very remote	Kununurra	Great Sandy Desert	No	82	No	53	Yes	1,113	No	53	1,113
12	Outer regional	South-Western WA	Moora – Chittering	Yes	685	Yes	662	No	—	No	—	1,004
13	Inner regional	South-Western WA	Northam	Yes	295	No	—	No	—	No	—	805
14	Outer regional	South-Western WA	Manjimup – Denmark – Plantagenet	Yes	366	No	32	No	—	No	—	747
15	Very remote	Kununurra	Argyle – Warmun	No	—	No	—	Yes	622	No	—	730
16	Very remote	Geraldton	Meekathara – Karatundi	Yes	628	Yes	628	No	51	No	51	631

(continued)

Table A2.26 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in Western Australia (n=25)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
17	Very remote	Kununurra	Wyndham	Yes	596	Yes	596	Yes	596	Yes	596	596
18	Remote	Geraldton	Irwin – Morawa	Yes	318	Yes	318	No	—	No	—	512
19	Very remote	Kalgoorlie	Warburton	No	—	No	—	Yes	499	No	—	499
20	Remote	Geraldton	Central West Coast	Yes	257	Yes	257	No	<10	No	<10	494
21	Remote	South-Western WA	Campion	Yes	484	Yes	484	No	<10	No	<10	484
22	Very remote	Kununurra	Halls Creek – Surrounds	Yes	341	Yes	341	Yes	416	Yes	331	426
23	Very remote	Kununurra	Kalumburu	Yes	398	No	—	Yes	398	No	—	398
24	Very remote	Kununurra	North Kimberley	No	85	No	82	Yes	203	No	82	358
25	Very remote	Geraldton	Shark Bay – Coral Bay – Upper Gascoyne	Yes	268	Yes	268	No	139	No	139	276

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Table A2.27: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in South Australia (n=10)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Very remote	Port Augusta	Anangu Pitjantjatjara	No	<10	No	<10	Yes	2,325	No	<10	2,325
2	Outer regional	Port Augusta	Flinders	Yes	857	Yes	297	No	—	No	—	1,875
3	Outer regional	Adelaide	Yorke Peninsula	Yes	1,287	No	28	No	—	No	—	1,287
4	Very remote	Port Lincoln – Ceduna	Ceduna – West Coast	Yes	233	Yes	233	Yes	459	No	27	1,008
5	Outer regional	Adelaide	Berri – Barmera	Yes	712	No	—	No	—	No	—	712
6	Very remote	Port Augusta	Eyre	Yes	503	Yes	503	Yes	219	No	196	689
7	Outer regional	Adelaide	Loxton – Waikerie – Mid Murray	Yes	480	No	28	No	—	No	—	673
8	Inner regional	Adelaide	Wakefield – Clare and Gilbert Valleys	Yes	216	No	114	No	—	No	—	453
9	Outer regional	Adelaide	Renmark Paringa	Yes	382	No	—	No	—	No	—	382
10	Very remote	Port Augusta	Coober Pedy – Umoona	No	—	No	—	Yes	331	No	—	331

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Table A2.28: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in Tasmania (n=3)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Outer regional	Tas	Tas – West Coast	Yes	1,904	Yes	1,904	No	<10	No	<10	5,475
2	Inner regional	Tas	Tas – South-East Coast	Yes	338	Yes	338	No	—	No	—	1,320
3	Outer regional	Tas	Tas – North-East Coast	Yes	488	Yes	488	No	43	No	43	1,228

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details see Appendix 1.

Table A2.29: Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in the Northern Territory (n=41)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
1	Very remote	Jabiru – Tiwi	Maningrida and Outstations	Yes	373	Yes	373	Yes	3,118	Yes	373	3,118
2	Very remote	Nhulunbuy	Marthakal Homelands – Galiwinku	Yes	251	Yes	251	Yes	233	Yes	233	2,886
3	Remote	Jabiru – Tiwi	Tiwi Islands	Yes	2,485	No	16	Yes	2,485	No	16	2,485
4	Very remote	Jabiru – Tiwi	North-West Arnhem	Yes	1,608	Yes	392	Yes	2,447	Yes	392	2,447
5	Very remote	Nhulunbuy	Ramingining – Milingimbi and Outstations	Yes	2,278	Yes	2,278	Yes	2,278	Yes	2,278	2,278
6	Remote	Jabiru – Tiwi	Thamarrurr inc. Wadeye	Yes	2,184	No	49	Yes	2,131	No	—	2,184
7	Remote	Apatula	Amoonguna – Santa Teresa – Titjikala	Yes	296	No	12	Yes	949	No	12	2,105
8	Very remote	Nhulunbuy	Anindilyakwa (Groote)	Yes	1,972	No	25	Yes	1,972	No	25	1,972
9	Very remote	Katherine	Elsey – Roper	No	25	No	25	Yes	825	No	25	1,843
10	Very remote	Jabiru – Tiwi	Douglas – Daly	Yes	1,411	No	129	Yes	1,292	No	24	1,615
11	Very remote	Katherine	Gulf	Yes	497	No	179	Yes	1,422	No	179	1,422
12	Very remote	Katherine	Ngukurr	No	—	No	0	Yes	1,183	No	—	1,183
13	Very remote	Nhulunbuy	Gapuwiyak and Outstations	Yes	832	Yes	832	Yes	832	Yes	832	832
14	Very remote	Apatula	West MacDonnell Ranges	Yes	201	No	102	Yes	617	No	102	818

(continued)

Table A2.29 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in the Northern Territory (n=41)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
15	Remote	Darwin	Cox – Finniss – Coomalie	Yes	213	No	73	Yes	214	No	73	799
16	Very remote	Nhulunbuy	Numbulwar and Outstations	Yes	777	No	22	Yes	777	No	22	777
17	Very remote	Apatula	Yuendumu and Outstations	Yes	738	No	—	Yes	738	No	—	738
18	Very remote	Katherine	Borrooloola	Yes	705	No	—	Yes	705	No	—	705
19	Very remote	Katherine	Lajamanu	No	—	No	—	Yes	704	No	—	704
20	Very remote	Apatula	Anmatjere	Yes	698	No	52	Yes	699	No	52	699
21	Remote	Jabiru – Tiwi	Kakadu – Marrakai – Jabiru	Yes	533	No	—	Yes	533	No	—	621
22	Very remote	Katherine	Daguragu – Kalkarindji and Outstations	No	—	No	—	Yes	617	No	—	617
23	Very remote	Katherine	Vic River	No	152	No	152	Yes	513	No	152	606
24	Very remote	Apatula	Urapuntja	No	—	No	—	Yes	591	No	—	591
25	Very remote	Apatula	Hermannsburg	No	—	No	—	Yes	588	No	—	588
26	Very remote	Apatula	Atitjere – Akarnenehe – Engawala	Yes	555	No	52	Yes	555	No	52	555
27	Very remote	Nhulunbuy	Laynhapuy – Gumatj Homelands	Yes	528	Yes	528	Yes	528	Yes	528	553
28	Very remote	Apatula	Papunya and Outstations	Yes	531	No	19	Yes	531	No	19	531
29	Very remote	Tennant Creek	Barkly	Yes	448	Yes	247	Yes	413	Yes	243	522

(continued)

Table A2.29 (continued): Indigenous Areas (IAREs) with at least 200 Aboriginal and Torres Strait Islander people who live more than a 60-minute drive from at least one type of selected primary care service (service gap area) in the Northern Territory (n=41)

Ranking by IARE population	Remoteness	IREG	IARE	IAHP-funded ACCHO		Any IAHP-funded service		Mainstream GP		Any primary care service		Estimated Aboriginal and Torres Strait Islander population in IARE
				Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	Service gap area	No. living >60 min drive time	
30	Very remote	Apatula	Ampilatwatja and Outstations	No	17	No	17	Yes	505	No	17	505
31	Very remote	Katherine	Walangeri	No	27	No	27	Yes	485	No	27	485
32	Very remote	Apatula	Walungurru and Outstations	No	—	No	—	Yes	447	No	—	447
33	Very remote	Apatula	Haasts Bluff – Mount Liebig (Watiyawanu)	Yes	406	No	31	Yes	406	No	31	406
34	Very remote	Tennant Creek	Ali Curung	Yes	402	No	—	Yes	402	No	—	402
35	Very remote	Tennant Creek	Alpururulam	Yes	385	No	—	Yes	385	No	—	385
36	Very remote	Apatula	Nyirripi and Tanami Outstations	Yes	325	No	57	Yes	329	No	57	329
37	Very remote	Apatula	Kaltukatjara and Outstations	Yes	310	No	46	Yes	321	No	45	322
38	Very remote	Tennant Creek	Wutunugurra – Canteen Creek	Yes	305	No	—	Yes	305	No	—	305
39	Very remote	Tennant Creek	Elliott	Yes	289	No	—	No	—	No	—	289
40	Very remote	Apatula	Willowra	Yes	241	No	—	Yes	241	No	—	241
41	Very remote	Apatula	Apatula (Finke) and Homelands	Yes	202	No	<10	Yes	202	No	<10	202

Sources: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). Mainstream GP locations are from the NHSD, excluding sites also in the OSR. For more details, see Appendix 1.

Table A2.30: Availability of AMS/CC and mainstream GPs in local area in 2018–19, by drive times to nearest IAHP-funded site (minutes) and by state and remoteness

State/ territory	Remoteness	AMS/CC				Mainstream GP			
		% saying available (NATSIHS)	% drive time 0–30 min	% drive time >30–60 min	% drive time >60 min (no available service)	% saying available (NATSIHS)	% drive time 0–30 min	% drive time >30–60 min	% drive time >60 min (no available service)
NSW	Major cities	53.4	95.1	4.9	—	94.7	100.0	—	—
	Inner regional	67.7	75.2	17.5	7.3	96.3	99.8	0.2	—
	Outer regional	81.2	63.3	24.0	12.7	87.5	91.8	7.9	0.2
	Remote	37.7‡	47.5	26.5	26.0	81.8	90.8	7.7	1.4
	Very remote	87.5‡	51.4	4.5	44.1	83.3‡	72.7	12.3	15.0
Vic	Major cities	32.7	94.4	5.6	—	98.4	100.0	—	—
	Inner regional	62.7	73.8	23.8	2.4	92.0	99.9	0.1	—
	Outer regional	87.2	84.2	10.3	5.5	94.9	97.5	2.3	0.2
	Remote	n.a.	—	35.5	64.5	n.a.	46.0	52.2	1.9
Qld	Major cities	66.6	99.3	0.7	—	96.7	100.0	—	—
	Inner regional	67.1	88.2	11.7	0.1	97.8	99.9	0.1	—
	Outer regional	84.8	82.1	6.3	11.6	68.4†	97.6	2.4	—
	Remote	86.2	59.3	3.8	36.8	67.4	82.2	3.0	14.8
	Very remote	90.0	87.6	1.4	11.0	43.2	31.7	5.6	62.7
WA	Major cities	43.8	98.7	1.3	—	96.1	100.0	—	—
	Inner regional	46.5‡	87.5	12.2	0.3	98.6	100.0	—	—
	Outer regional	86.0	80.0	11.5	8.5	87.4	99.2	0.8	—
	Remote	82.4	90.6	1.5	7.9	95.6	93.7	6.3	0.1
	Very remote	86.3	73.5	5.1	21.4	47.5	46.6	3.9	49.6
SA	Major cities	55.8	86.8	13.2	—	94.6	100.0	—	—
	Inner regional	72.9	77.6	20.7	1.7	97.9	100.0	—	—
	Outer regional	40.2†	90.1	6.8	3.1	96.9	99.4	0.6	—
	Remote	58.8†	65.3	9.7	25.0	100.0	95.7	3.8	0.5
	Very remote	93.3	88.9	3.5	7.7	62.2	27.1	3.5	69.4
Tas	Inner regional	29.3	97.9	2.1	—	94.6	100.0	—	—
	Outer regional	54.5	67.8	19.1	13.1	94.2	97.6	2.2	0.2
	Remote	0.0	0.0	0.1	99.9	100.0	85.2	13.1	1.7
	Very remote	n.a.	56.9	12.8	30.4	n.a.	62.7	29.2	8.1
ACT	Major cities	70.1	99.9	0.1	—	96.1	100.0	—	—
NT	Outer regional	90.8	99.7	0.3	—	93.9	99.7	0.3	—
	Remote	86.0	95.7	3.6	0.7	59.2	62.5	5.0	32.4
	Very remote	99.0	79.2	5.0	15.8	19.0	22.3	1.0	76.7
Total		67.3	86.3	8.4	5.4	84.7	91.9	1.3	6.8

† Estimate has a relative standard error between 25% and 50% and should be used with caution.

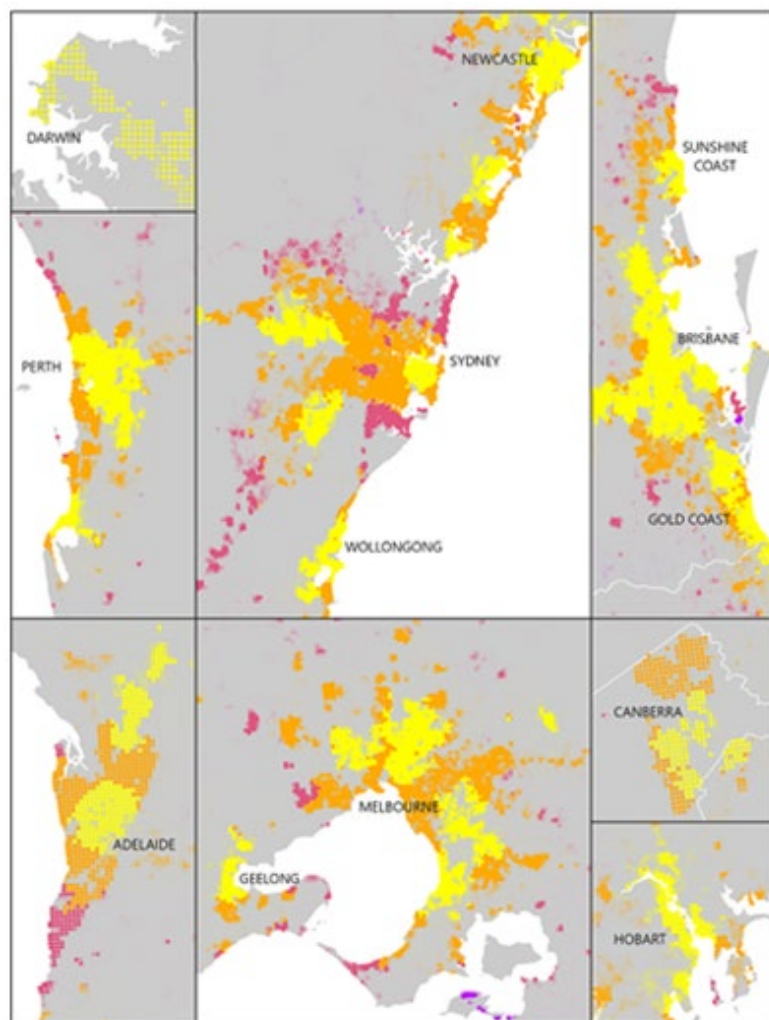
‡ Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Note: Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Sources: AIHW analysis of 2018–19 NATSIHS (ABS 2019) using TableBuilder; NHSD (downloaded 2 April 2024); Online Services Report 2022–23.

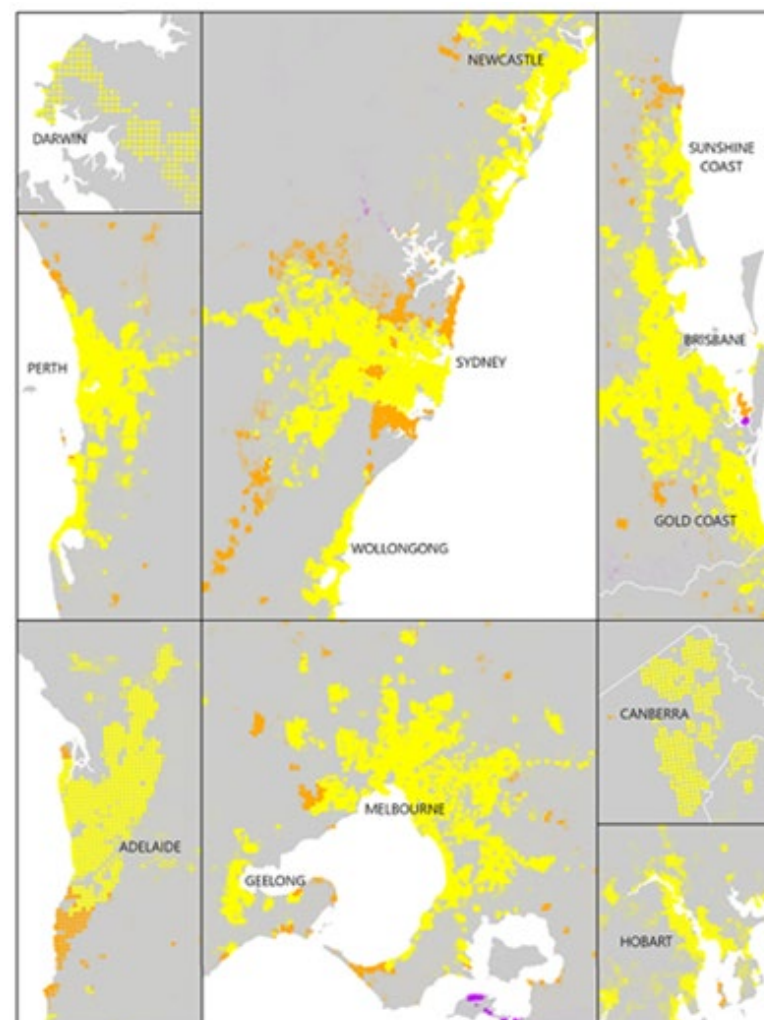
Additional maps

Figure A2.1: Comparison of 15-minute and 30-minute drive time boundaries to any IAHP-funded service, small area breakouts



Drive time to the nearest IAHP-funded primary health care service

≤ 15 minutes > 15 to ≤ 30 minutes > 30 to ≤ 60 minutes > 60 minutes



Drive time to the nearest IAHP-funded primary health care service

≤ 30 minutes > 30 to ≤ 60 minutes > 60 minutes

Source: Service locations for the IAHP-funded services are from the 2022–23 OSR data collection and include only those with declared primary health functions (excluding sites providing only maternal and child health services). For more details see Appendix 1.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
AMS/CC	Aboriginal Medical Service/Community Clinic
CVD	cardiovascular disease
ERP	Estimated Resident Population
FTE	full-time equivalent
GIS	geographic information software
GP	general practitioner
IAHP	Indigenous Australians' Health Programme
IARE	Indigenous Area
ISIAG	AIHW's Indigenous Statistical Information and Advisory Group
K10	Kessler Psychological Distress Scale – 10
K5	Kessler Psychological Distress Scale – 5
MBS	Medical Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIS	National Aboriginal and Torres Strait Islander Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NGO	non-government organisation
NHSD	National Health Services Directory
nKPI	National Key Performance Indicator
OSR	Online Services Report
PHCO	Primary health care organisation
SA1	Statistical Area Level 1
SA2	Statistical Area Level 2
SEWB	social and emotional wellbeing
TCA	Team Care Arrangement
VII	Voluntary Indigenous Identifier

Symbols

Symbol	Definition
n.a.	not available, not applicable
no.	number
n.r.	not reported due to confidentiality issues
. . (2 spaced full stops)	no data/insufficient data
— (em dash)	rounded to zero (for example, in a table showing whole numbers, the statistic is less than 0.5) including null cells
– (minus)	negative or minus values

Glossary

Aboriginal and Torres Strait Islander specific primary health care organisations:

Primary health care organisations that provide **primary health care services** mainly to Aboriginal and Torres Strait Islander people. They include **Aboriginal Community Controlled Health Organisations (ACCHOs)**, state and territory managed organisations, Primary Health Networks and other non-government organisations.

Aboriginal Community Controlled Health Organisation (ACCHO): An organisation operated by local Aboriginal and Torres Strait Islander communities, and controlled through a locally elected board, to deliver comprehensive, holistic and culturally appropriate health care to their communities. ACCHOs vary in size and composition, from large organisations with several medical practitioners who provide a range of services, through to small organisations that rely on nurses and/or Aboriginal Health Workers to provide most services.

Aboriginal Medical Service/Community Clinic (AMS/CC): See ACCHO/IAHP.

General Practitioner (GP): A medical practitioner who provides primary comprehensive and continuing care to patients and their families in the community.

Indigenous Areas (IAREs): Medium-sized geographical areas used to report data about Aboriginal and/or Torres Strait Islander people. Indigenous Areas are one of 3 levels of geographic units within the Indigenous Structure of the Australian Bureau of Statistics' Australian Statistical Geography Standard (ASGS). Indigenous Areas are aggregates of one or more Indigenous Locations. In ASGS Edition 3 (2021), 412 Indigenous Areas are defined to cover the whole of geographic Australia (excluding non-spatial special purpose codes).

Indigenous Australians' Health Programme (IAHP): A program established by the Australian Government on 1 July 2014 that consolidated 4 existing funding streams: **primary health care**, child and maternal health programs, Stronger Futures in the Northern Territory (Health), and programs covered by the Aboriginal and Torres Strait Islander Chronic Disease Fund.

mainstream GP: A GP who does not work for an **Aboriginal and Torres Strait Islander specific primary health care organisation**.

primary health care: Services delivered in many community settings, such as general practices, community health centres, Aboriginal health services and allied health practices (for example, physiotherapy, dietetic and chiropractic practices) and which come under numerous funding arrangements.

primary health care provider: A health care practitioner who provides **primary health care**, such as a general practitioner (GP) at general practices, a nurse or a dentist.

primary health care services: Services delivered by **primary health care providers** that aim to keep people well physically and emotionally (promote good health) as well as to identify and manage illnesses, injuries and chronic diseases when they arise. See also **primary health care**.

unmet need: A need that exists when a person needed/wanted to use a service but were unable/did not access that service.

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Access to culturally responsive, high-quality and timely primary health care throughout life that acknowledges the impact of social, cultural and historical determinants is essential to improve health outcomes for Aboriginal and Torres Strait Islander people. This report brings together Aboriginal and Torres Strait Islander people's own lived experiences of primary health care use and their unmet needs as reflected in national survey data with an analysis of the locations of primary health care services relative to where Aboriginal and Torres Strait Islander people live. The results are used to identify geographic areas with service gaps and subgroups within the population who have the highest levels of unmet need.

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