



The health of Australia's females

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Australia's 12.4 million females (in 2017) experience varying health outcomes across population groups, including older Australians, Indigenous Australians, those in different socioeconomic groups, and those living in regional and remote areas. Females also experience different health outcomes than males.

For the accompanying report on male health visit [The health of Australia's males](#).

Cat. no: PHE 240

Findings from this report:

89% of females aged 15 and over reported visiting their GP in the last 12 months in 2017–18

57% of females had private health insurance in 2017–18

9.9% of mothers smoked at any time during pregnancy in 2016 (declining from 14.6% in 2009)

More than 1 in 3 Australian women (37%) have experienced violence since they turned 15

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Who are Australia's females?

As at 30 June 2017, there were 12.4 million females living in Australia (50.4% of the total population), which means there were 101.6 females for every 100 males (ABS 2018a). Most females (66%) were younger than 50 and 16% were aged 65 or over. Their median age was 38.1 years, which is higher than the median age for males (36.4 years) (ABS 2018i).

Females are a diverse population, with differing health behaviours, conditions and health service use across a range of characteristics. The characteristics of five particular population groups are described below.

Age group

In 2017, 22% of the total female population were aged under 18, 62% were aged 18–64, and 16% were aged 65 or over (ABS 2018a). The number of women aged 65 and over is increasing (by the year 2040 they are projected to account for about 20% of the total female population) (ABS 2018h), they outnumber males (116 females for every 100 males), 33% are widowed, 32% live alone and 20% need assistance with one or more of the core everyday activities of self-care, mobility and communication (ABS 2018c; ABS 2018d).

Aboriginal and Torres Strait Islander females

In 2016, the estimated residential population of Aboriginal and Torres Strait Islander females was nearly 400,000 (3.2% of the female population) (ABS 2018a). Indigenous females tend to be younger than non-Indigenous females (34% aged less than 15, compared with 18% of non-Indigenous females) (ABS 2018e). They are culturally diverse (19% speak an Indigenous language and 63% identify with a clan, tribal or language group), and they outnumber males in older age groups (122 females for every 100 males aged 65 or over) (ABS 2016; ABS 2018a).

Remoteness

From the 2016 ABS census, 71% of the Australian female population live in *Major cities*, 18% live in *Inner regional* areas, 8.3% live in *Outer regional* areas, and 1.9% live in *Remote* and *Very remote* areas (ABS 2018c). Females living in *Remote* and *Very remote* areas are outnumbered by males (89 females for every 100 males) and are community-minded (20% volunteer for a group or organisation, compared with 16% of females from *Major cities*) (ABS 2018c).

Socioeconomic disadvantage

Some Australian females are more disadvantaged than others. Fifteen per cent of females are experiencing poverty and around 49,000 are homeless (ABS 2018b; ACOSS 2016). There are around 3,300 Australian female prisoners in adult corrective services custody (ABS 2017b). Nearly 7 out of 10 females (69%) aged 15–64 are employed and 59% of 15–74 year old females have a non-school qualification (ABS 2017a; ABS 2018f).

Region of birth

Almost a third (29%) of the Australian female population were born overseas. Of those born overseas, the majority were born in England (followed by China, New Zealand and India), and overseas-born females outnumber males (104 females for every 100 males) (ABS 2018g).

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Lifestyle and risk factors of Australia's females

The lifestyles females lead can influence how healthy they are in the short and long term. A lifestyle including exercise, a well-balanced diet, and maintaining a healthy body weight, may reduce the risk of poor health. Risk factors such as smoking tobacco, misusing alcohol and illicit substance use, or exposure to violence, may increase the likelihood of poor health.

Physical activity

Regular physical activity helps maintain a healthy body weight and reduce the risk of many chronic conditions and injuries. Sport and other forms of physical activity can also improve mental wellbeing and may foster social networks which provide support and opportunities for development.

Sufficient physical activity, for 18–64 year olds, is defined in Australia's Physical Activity and Sedentary Behaviour Guidelines as accumulating at least 150 minutes of moderate physical activity every week, and being active on most, preferably all, days. The guidelines also recommend that adults complete at least two strength based training sessions each week. The guidelines provide separate recommendations for children (ages 0–5 and 5–12), young people (ages 13–17), and older Australians (ages 65+).

In this section we refer to 'sufficient activity' for 18–64 year olds as completing at least 150 minutes of physical activity over 5 or more sessions each week. For females aged 65 and over, 'sufficient activity' is completing at least 30 minutes of exercise on most days each week (reported here as 5 or more days).

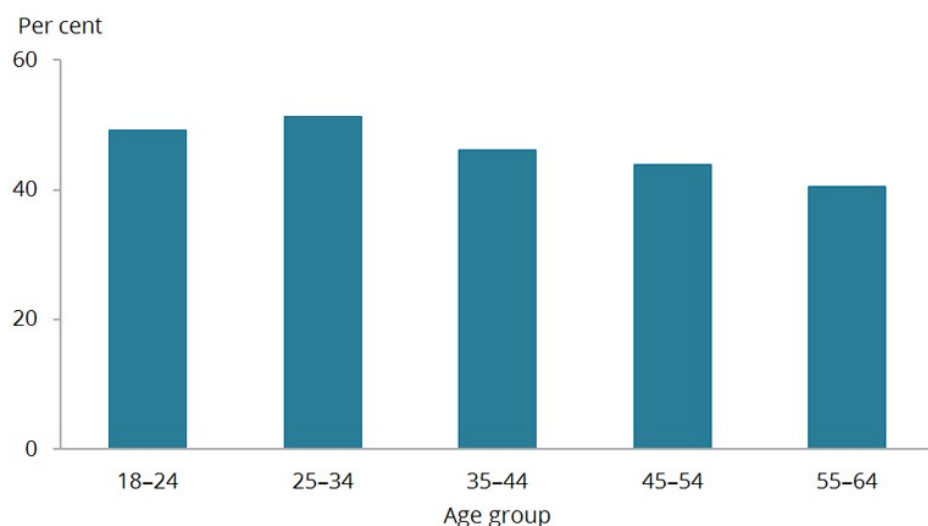
1 in 2

Australian women aged 18–64 get enough exercise

In 2014–15, 46% of women aged 18–64 exercised sufficiently (ABS 2015a). Exercise rates were highest among women aged 25–34 (51%) and lowest among women aged 55–64 (41%).

1 in 4 (23%) women aged 65 and over were sufficiently active.

Figure 1: Sufficient physical activity, women aged 18–64, by age-group, 2014-15



Note: "Sufficiently active" here refers to having completed at least 150 minutes of physical activity over 5 or more sessions in the previous week

Source: ABS 2015a ([Table S1](#)).

Overweight and obesity

Excess body weight, known as overweight and obesity, is a risk factor for many conditions, including cardiovascular disease, high blood pressure, Type 2 diabetes, sleep apnoea and osteoarthritis. Excess body weight can be measured using the body mass index (BMI).

6 in 10

Australian women are overweight or obese

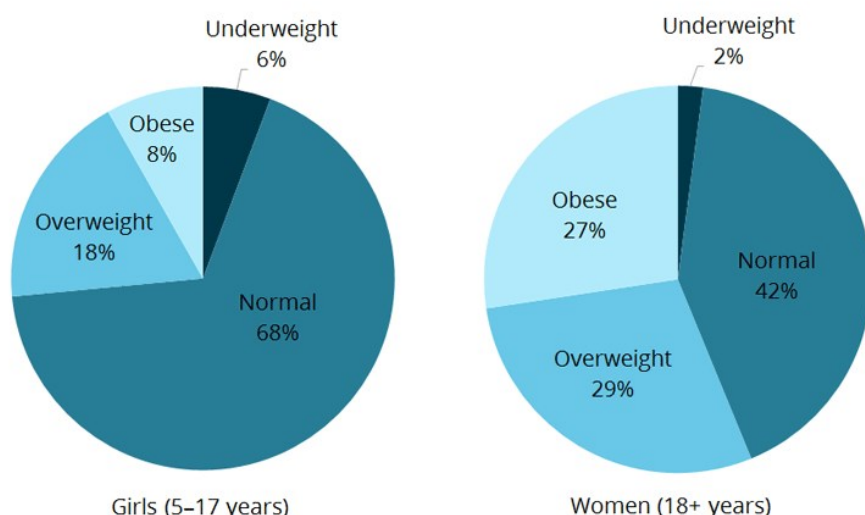
In 2014–15, almost 6 in 10 women in Australia (56%) were overweight or obese: 29% were overweight, and 27% were obese (ABS 2015a).

The proportion of women who are overweight or obese differs by population groups (ABS 2013; ABS 2015a; ABS 2015b):

- 33% of young women (aged 18–24) are overweight or obese, compared with 69% of women aged 65–74.
- 61% of women living in the lowest socioeconomic areas are overweight or obese, compared with 48% of women living in the highest socioeconomic areas.
- 64% of women living in *Outer regional and remote* areas are overweight or obese, compared with 53% of women living in *Major cities*.
- 70% of Aboriginal and Torres Strait Islander women were overweight or obese in 2012–13. After adjusting for differences in age structure, the rate of overweight and obesity in Aboriginal and Torres Strait Islander women was 1.3 times higher than for non-Indigenous women (73% compared to 55%).

The proportion who are overweight or obese differs between women and girls—more than half (56%) of women aged 18 or over are overweight or obese, compared with about a quarter (26%) of girls aged 5–17.

Figure 2: BMI, girls aged 5–17 and women aged 18 and over, 2014–15



Note: Girls and women have different cut-offs for BMI.

Source: ABS 2015a (Table S2).

While excess weight is commonly managed using dietary intervention and exercise, for those who are morbidly obese or who are obese and have other conditions related to their excess weight, weight loss surgery may be appropriate.

Weight loss surgery (bariatric surgery) is surgery that aims to help obese patients lose weight and lowers the risk of medical problems associated with obesity. It restricts the amount of food a recipient can eat or alters the process of food digestion so that fewer calories are absorbed.

In 2014–15 females accounted for 79% of hospital separations for weight loss surgery (18,000 separations) compared with 21% for males (4,800 separations) (AIHW 2017c).

For more information visit [Weight loss surgery in Australia 2014–15](#).

Tobacco smoking, alcohol and illicit drugs

Tobacco

Tobacco smoking is the leading preventable cause of poor health and death in Australia (AIHW 2016). The main data sources reporting on tobacco smoking in Australia are the ABS National Health Survey's (NHS), the National Australian Aboriginal and Torres Strait Islander Health Survey, and the AIHW National Drug Strategy Household Survey (NDSHS).

These surveys show that:

- based on the ABS NHS, in 2014–15, 12.1% of women aged 18 or over and 2.3% of girls aged 15–17 years smoked daily (ABS 2015a).
- based on the AIHW NDSHS, in 2016, 11% of women aged 18 or over and 3.2% of females aged 14–19 smoked daily (AIHW 2017b).

The proportion of females who smoke tobacco differs by age and between population groups (ABS 2015a; ABS 2015b; AIHW 2017a; AIHW 2018):

- 13.3% of younger women (18–44) smoked daily, compared with 11.0% of older women (aged 45 or over).
- 18.6% of women living in the lowest socioeconomic areas smoked daily, compared with 6.6% of women living in the highest socioeconomic areas.
- 16.7% of women living in *Outer regional and remote* areas smoked daily, compared with 10.1% of women living in *Major cities*.

- 38.2% of Aboriginal and Torres Strait Islander women smoked daily in 2014–15, compared to 12.2% of non-Indigenous women, after adjusting for differences in age structure.
- The proportion of mothers smoking at any time during pregnancy has steadily declined over time—from 14.6% in 2009 to 9.9% in 2016.
- 42% of Indigenous mothers smoked in the first 20 weeks of pregnancy, compared with 11% of non-Indigenous mothers in 2016, after adjusting for differences in age structure. This represents a reduction in smoking in both Indigenous and non-Indigenous mothers from 47% and 15% in 2011, respectively.

Alcohol

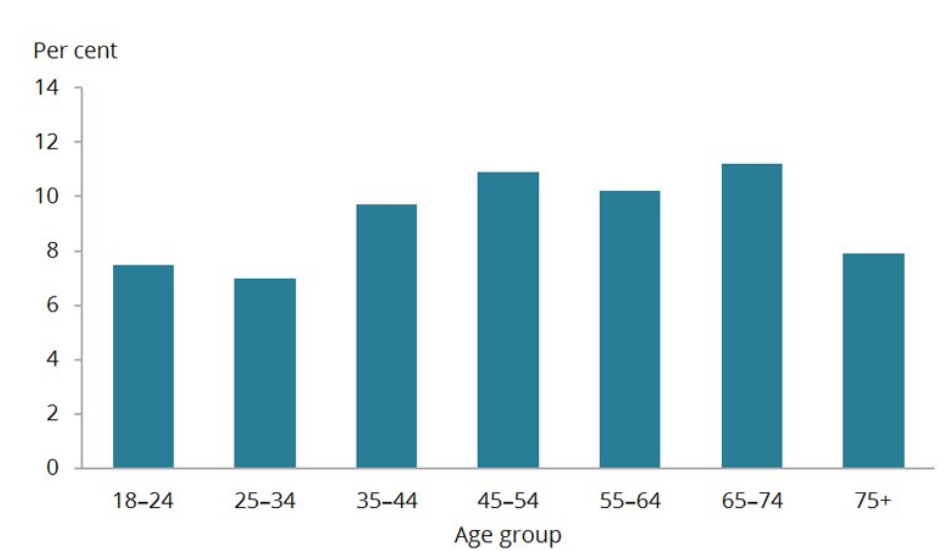
Excessive alcohol consumption is a major risk factor for a variety of health problems, including liver and heart conditions, and poor mental health. It also contributes to accident and injury, such as motor vehicle accidents, physical violence and homicide. The main data sources reporting on alcohol consumption in Australia are the AIHW National Drug Strategy Household Survey and the ABS National Health Survey. Although these surveys use different methodologies, they show similar results.

Based on the AIHW NDSHS, in 2016 10% of women (ages 18+) were lifetime risky drinkers (AIHW 2017b). Almost 3 in 10 women aged 18 and over (27%) exceeded the single occasion risky drinking threshold at least once in the last 12 months.

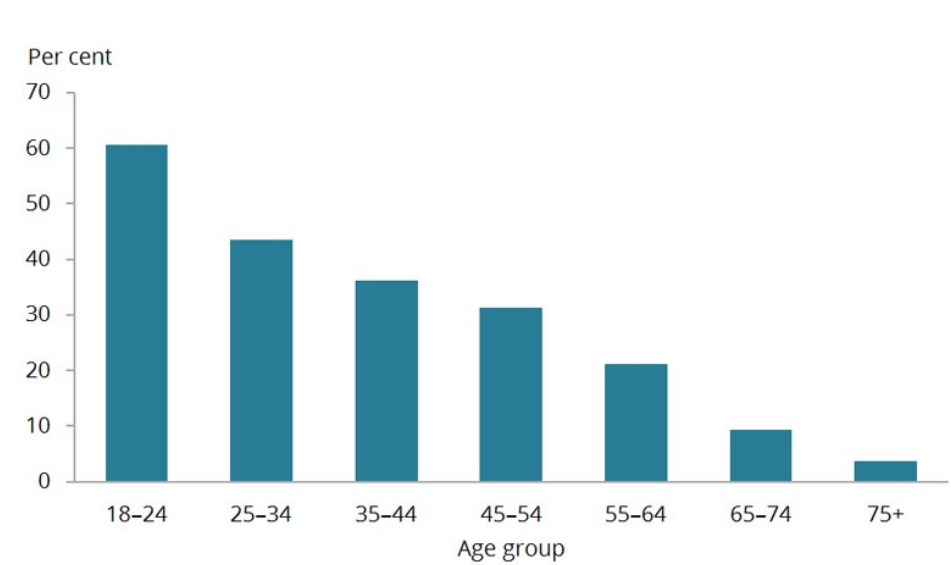
Based on the ABS NHS, in 2014–15, almost a third of women aged 18 and over (32%) were exceeding the single occasion risk threshold, and 9.3% exceeded the lifetime risk guideline. The rates of lifetime and single occasion risky drinking vary by age-group (see Figure 3) (ABS 2015a).

Figure 3: Lifetime and single occasion risky drinking, women, by age-group, 2014–15

Lifetime risky drinking



Single occasion risky drinking



Source: ABS 2015a (Table S3).

The proportion of women who exceed the lifetime alcohol risk guidelines varies by age and between population groups (ABS 2013; ABS 2015a; ABS 2015b):

- 7.5% of younger women (aged 18–24) exceed the lifetime alcohol risk guidelines, compared with 11% of women aged 65–74
- 12% of women living in the most disadvantaged areas (first quintile) exceed the lifetime alcohol risk guidelines, compared with 7.8% of women living in the least disadvantaged areas (fifth quintile)
- 10% of women living in *Outer regional and remote* areas exceed the lifetime alcohol risk guidelines, slightly more than women living in *Major cities* (9.2%)
- 11% of Aboriginal and Torres Strait Islander women exceeded the lifetime alcohol risk guidelines in 2012–13. After adjusting for differences in age structure, there was no difference in the rates of risky drinking in Indigenous and non-Indigenous women (about 10%).

Illicit substances

Illicit substance use includes use of illegal drugs (such as cannabis and heroin), or inappropriate use of prescription pharmaceuticals (such as sleeping pills) or other substances (such as naturally occurring hallucinogens). Illicit use of drugs causes death and disability and is a risk factor for many diseases. The effects of illicit drug use can be severe, for example leading to poisoning, heart damage, mental illness, self-harm, suicide and death. Illicit drug use is also associated with risks to users' families and friends and to the community. It contributes to social and family disruptions, violence, and crime and community safety issues. The AIHW National Drug Strategy Household Survey reports on illicit drug use in Australia.

In 2016, 13% of Australian females aged 14 years and over had used an illicit drug in the previous 12 months ('recent use') (AIHW 2017b).

The pattern of illicit substance use differs by age groups—25% of women aged 20–29 had recently used illicit drugs compared with 5.9% of women aged 60 or over.

Violence

Violence is the intentional threat or actual use of physical force or power against oneself, another person, or a group, that results in injury, death, psychological harm, abnormal growth or deprivation. The main data source for violence is the ABS Personal Safety Survey.

Almost 2 in 5

Australian women have experienced violence since they turned 15

In 2016, for women aged 18 or over (ABS 2017):

- 37% had experienced violence since the age of 15—31% had experienced physical violence and 18% had experienced sexual violence
- 4.7% had experienced violence in the last 12 months, with the highest rates among women aged 18–24 (12%) and the lowest for women aged 65 and over (1.2%)
- 17% had experienced partner violence since the age of 15
- 17% had experienced an episode of stalking since the age of 15
- 23% had experienced emotional abuse by a partner since the age of 15
- 53% had experienced sexual harassment during their lifetime.

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How healthy are Australia's females?

A person's health status is their overall level of health, and can be measured through self-assessed health status; presence of chronic disease and comorbidities; mental health; sexual health; life expectancy; and level of disability.

Self-assessed health status

Self-assessed health status is a measure of health status, combining physical, social, emotional and mental health and wellbeing.

3 in 5

Australian females rated their health as excellent or very good.

In 2014–15, 58% of females (aged 15+) rated their health as excellent or very good (ABS 2015).

The proportion of females rating their health as excellent or very good varied with age-group: 67% of women aged 25–34 rated their health as excellent, compared with 36% of women aged 75 years and over.

Chronic disease, comorbidity and burden of disease

Chronic disease

The term chronic disease applies to a group of diseases that tend to be long-lasting and have persistent effects. Chronic diseases have a range of potential impacts on a person's individual circumstances, including quality of life, as well as broader social and economic effects. Chronic diseases also have a significant impact on the health sector.

Self-reported data from the Australian Bureau of Statistics (ABS) 2014–15 National Health Survey (NHS) provides an estimate of the prevalence of chronic disease among the Australian population. Chronic disease data is collected for arthritis, asthma, back problems, cancer, COPD (chronic obstructive pulmonary disease), CVD (cardiovascular disease), diabetes, and mental health conditions. These chronic diseases were selected for reporting because they are common, pose significant health problems, have been the focus of recent AIHW surveillance efforts, and action can be taken to prevent their occurrence. This survey data is self-reported and is therefore likely to under-report the true prevalence of chronic disease. However, using this data enables us to look at the comorbidity of chronic diseases across the Australian population, which is not possible using separate data sources. For more information on data quality visit [Data sources](#).

1 in 2

Australian females have a chronic disease

In 2014–15, 52% of females reported having one or more of 8 selected chronic diseases (arthritis, asthma, back problems, cancer, cardiovascular disease, COPD, diabetes and mental and behavioural problems) (ABS 2015).

Table 1: Selected chronic diseases reported by females, 2014–15

Condition	Number	Per cent
Mental and behavioural problems	2,217,500	19.2
CVD (cardiovascular disease)	2,152,300	18.6
Arthritis	2,110,400	18.3
Back problems	1,872,100	16.2
Asthma	1,369,200	11.8
Diabetes	534,500	4.6
COPD (chronic obstructive pulmonary disease)	297,900	2.6
Cancer	171,400	1.5

Source: ABS 2015

Note: This survey data is self-reported and likely under-reports the true prevalence of chronic diseases. For more information on data quality visit [Data sources](#).

The prevalence of these chronic diseases varies with age:

- 87% of women aged 65 and over have a chronic disease, compared with 37% of females aged under 45.

Cancer

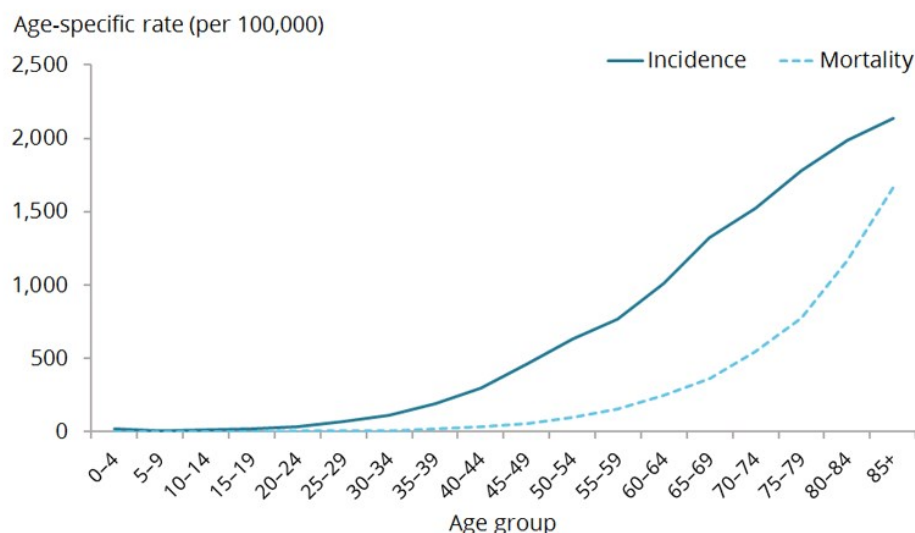
Cancer describes a diverse group of several hundred diseases in which some of the body's cells become abnormal and begin to multiply out of control. Some cancers are easily diagnosed and treated, others are harder to diagnose and treat, and most can be fatal. Cancers are named by the type of cell involved or the location in the body where the disease begins.

The primary source of national cancer incidence data is the Australian Cancer Database – a data collection of all primary, malignant cancers diagnosed in Australia since 1982.

17,586 estimated new cases of breast cancer will be diagnosed in 2017, the most common cancer among females.

In 2017, it is estimated that females will account for 46% of all new cancer cases (62,005 cases) (AIHW 2017a). The risk for Australian females being diagnosed with cancer before their 85th birthday is 1 in 2 (see Figure 4 below). The most common cancer diagnosis in females is breast cancer, followed by colorectal cancer, melanoma of the skin, and lung cancer.

Figure 4: Estimated age-specific incidence and mortality rate from all cancers, females, 2017



Source: AIHW 2017a (Table S4).

Mental health

The World Health Organisation defines mental health as 'a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.' Poor mental health may adversely affect any or all of these areas and has consequences for an individual, their family and society.

Nearly 1 in 2

Australian females have experienced a mental health problem

In 2007, more than 3.4 million (43%) females aged 16–85 had experienced a mental disorder in their lifetime (ABS 2008).

22% of females aged 16–85 experienced symptoms of a mental health disorder in the 12 months.

Chronic disease comorbidities

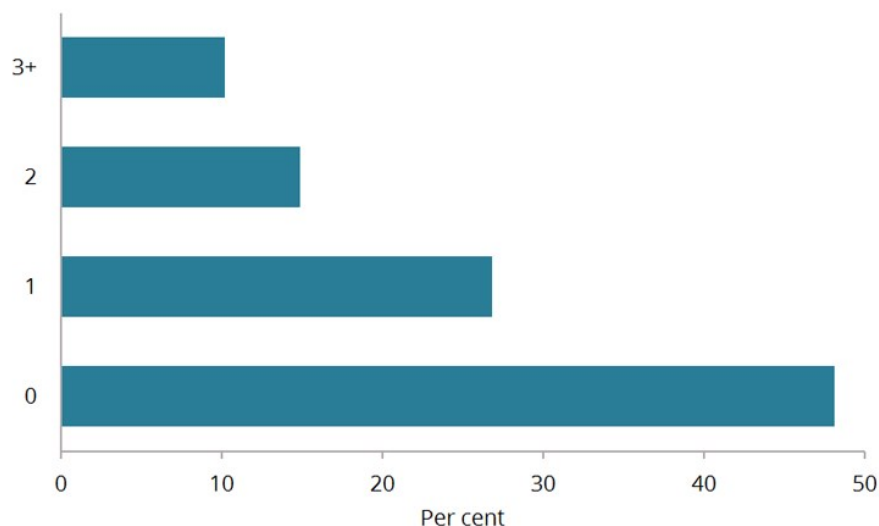
Some people have more than one chronic disease or health problem at the same time. This is referred to as a comorbidity. Having comorbid chronic conditions can have important implications for a person's health outcomes, quality of life and treatment choices.

Comorbidity data are presented for the following eight chronic diseases because they are common, pose significant health problems, have been the focus of recent AIHW surveillance efforts, and action can be taken to prevent their occurrence:

- arthritis
- asthma
- back problems
- cancer
- COPD (chronic obstructive pulmonary disease)
- CVD (cardiovascular disease)
- diabetes
- mental health conditions.

In 2014–15, half of all females (52%) had one or more of these chronic conditions: 27% had one, 15% had two, and 10% had three or more. Chronic disease comorbidity was higher for females than it was for males (25% of all females had two or more chronic conditions, compared with 21% for males) (ABS 2015).

Figure 5: Number of chronic conditions, females, 2014–15



Note: based on the selected chronic conditions; arthritis, asthma, back pain and problems, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and mental health conditions.

Source: ABS 2015 ([Table S5](#)).

The most common comorbidities in females (all ages) were:

- 983,000 females reported CVD and arthritis (8.5% of all females)
- 669,600 females reported arthritis and back problems (5.8%)
- 602,600 females reported mental and behavioural problems and back problems (5.2%).

Burden of disease

Burden of disease quantifies the health impact of disease on a population in a given year—both from dying early and from living with disease and injury. The summary measure ‘disability-adjusted life years’ (or DALY) measures the years of healthy life lost from death and illness.

In 2011, females experienced a smaller share of the total disease burden (46%) than males (54%) (AIHW 2016). The distribution of overall burden between the sexes varied by disease group. Compared with males, females experienced a greater proportion of the total burden from blood and metabolic disorders (59%), neurological conditions (58%) and musculoskeletal conditions (55%). Nearly half (44%) of the burden of disease in females is from cancer, musculoskeletal conditions, and cardiovascular disease.

Reproductive and maternal conditions were characterised by predominantly female-related conditions, which accounted for the high proportion of burden in females.

After cancer, the ranking of disease groups contributing to total burden of disease differed for females and males. For females, musculoskeletal conditions ranked second, followed by cardiovascular disease, mental & substance use disorders, and musculoskeletal conditions (see Table 2). For males, cardiovascular diseases ranked second, followed by mental & substance use disorders, injuries, and musculoskeletal conditions (AIHW 2016).

For more information visit [Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011](#).

Table 2: Leading causes of burden, DALY and proportions, by disease group, females, 2011

Disease group	DALY	Proportion (%)
Cancer	363,140	17.4
Musculoskeletal	289,242	13.9
Cardiovascular	268,898	12.9
Mental & substance use disorders	258,902	12.4
Respiratory	190,688	9.2
Neurological	178,136	8.6
Injuries	111,226	5.3
Gastrointestinal	64,296	3.1
Infant/congenital	51,739	2.5
Oral	48,286	2.3

Source: AIHW 2016

Mothers

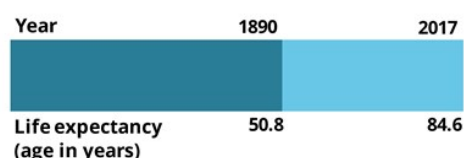
An important life stage for many women is when they become a mother. The health of a mother and baby can be affected by a mother's age, where she lives, the socioeconomic conditions in which she lives, the presence of pre-existing or pregnancy related medical conditions, and her risky behaviours such as smoking and drinking alcohol during pregnancy (Bywood, Raven & Erny-Albrecht 2015; WHO 2015). Data on almost every birth in Australia are collected by midwives and other birth attendants and included in the National Perinatal Data Collection at the AIHW. Among Australian women (AIHW 2018a):

- In 2016, 310,247 women gave birth in Australia—an increase of 12% since 2006 (277,440 women)
- The rate of women giving birth decreased from 64 per 1,000 women of reproductive age (15–44 years) in 2006 to 62 per 1,000 in 2016. The rate has declined from a recent peak of 66 per 1,000 in 2007
- The average age of all women who gave birth continues to rise: from 29.8 years in 2006, to 30.5 years in 2016
- 1 in 10 women (30,104 or 9.9%) who gave birth in 2016 smoked at some time during their pregnancy, a decrease from 15% in 2009
- Almost half (45%) of women who gave birth in 2016 were overweight or obese at their first antenatal visit
- 2 in 3 mothers had vaginal births, and 1 in 3 had caesareans in 2016. Mothers aged 40 and over were almost 3 times as likely to deliver by caesarean section as teenage mothers (53% and 18%)
- Almost half (49%) of pregnant women in 2016 consumed alcohol before they knew they were pregnant and 1 in 4 (25%) of these women continued to drink after they knew they were pregnant (AIHW 2017c).

For more information visit [Mothers and babies](#).

Life expectancy and mortality

Life expectancy is expressed as either the number of years a newborn baby is expected to live, or the expected years of life remaining for a person at a given age, and is estimated from the death rates in a population.



Australian females born in 2015–17 can expect to live 34 years longer than females born in 1881–1890 did

Life expectancy changes over time, and differs between population groups (ABS 2018a; ABS 2018b):

- females born in Australia in 2015–2017 can expect to live to the age of 84.6 years on average (an increase of 0.9 years in the past 10 years).
- for Aboriginal and Torres Strait Islander females born in 2015–2017, life expectancy was estimated to be 75.6 years (an increase of 1.9 years since the last ABS estimates of Indigenous life expectancy in 2010–2012). While the gap between Indigenous and non-Indigenous female life expectancy narrowed by 1.7 years from 2010–2012 to 2015–2017, life expectancy for Indigenous females is 7.8 years less than for non-Indigenous females (83.4 years).
- International comparisons of life expectancy at birth projected for females in 2015–2020 indicate that Australian females have the 8th highest life expectancy in the world (85.0 years). Japan is ranked 1st with 87.2 years.

Disability free life expectancies

Life expectancies and disability free life expectancies at age 65 are used for monitoring healthy ageing. In 2013–15, life expectancy for women at age 65 (that is, the number of additional years a person aged 65 could expect to live) was just over 22 years (AIHW 2017b). Women aged 65 in 2015 could expect to live an additional 10 years free of disability and around 12 years with some level of disability, including 6 years with severe or profound core activity limitation. This equates to these women living 55% of their remaining life with disability, including 25% with severe or profound core activity limitation (AIHW 2017b).

Mortality

Mortality data, such as premature deaths, potentially avoidable deaths and mortality rates can help in understanding death and the fatal burden of disease in the population at a point in time.

Mortality rates vary between population groups. In 2016 (AIHW 2018c):

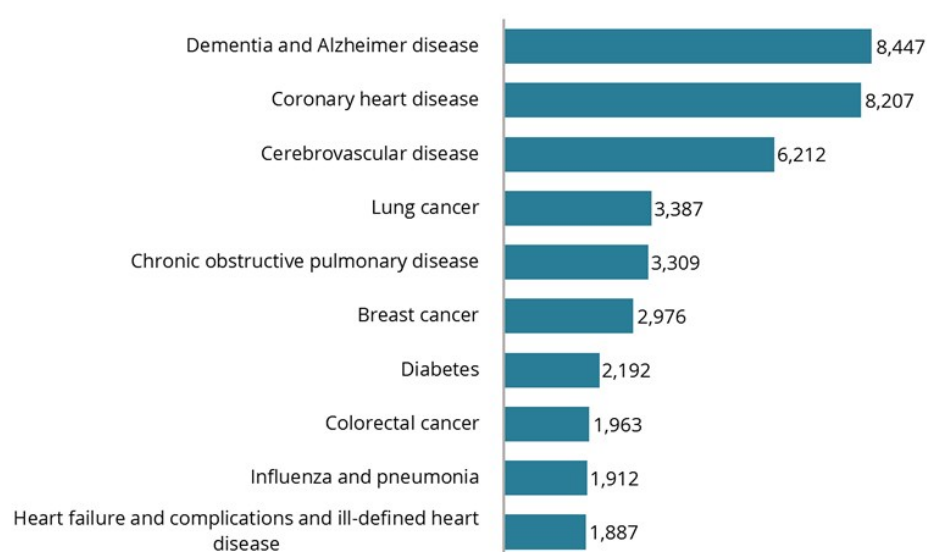
- females accounted for 38% of premature deaths.
- females in *Very remote* areas had a higher percentage of potentially avoidable deaths, with 59% of premature deaths being potentially avoidable, compared with 47% in *Major cities*.
- the median age at death for females decreased with increasing remoteness: from 85 in *Major cities* to 70 in *Very remote* areas.
- the median age at death for females also decreased with increasing socioeconomic disadvantage: from 86 years in the highest socioeconomic group to 83 in the lowest socioeconomic group.

Causes of death

Monitoring causes of death helps to measure the health status of a population. Causes of death can be used to assess the success of interventions to improve disease outcomes, signal changes in community health status and disease processes, and highlight inequalities in health status between population groups.

In 2016, there were 76,637 deaths among Australian females. The leading cause of death was dementia and Alzheimer disease, followed by coronary heart disease, and cerebrovascular disease (AIHW 2018b).

Figure 6: Leading causes of death among females, 2016



Notes:

1. Data are based on year of registration of death; deaths registered in 2016 are based on the preliminary version of cause of death data and are subject to further revision by the ABS.
2. Leading causes of death are based on underlying causes of death and classified using an AIHW-modified version of Becker et al. 2006. International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) codes are presented in parentheses.

Source: AIHW 2018b (Table S6).

Breast cancer mostly affects females and is the 6th leading cause of death for females. Between 1985–1989 and 2010–2014, 5-year relative survival from breast cancer improved from 73% to 91% (AIHW 2018b).

For more information visit [Leading causes of death](#).

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How do Australia's females access health care?

The Australian health system provides a wide range of preventive, treatment and palliative health care services. Monitoring people's health needs, their help-seeking behaviours, and their patterns of health service use helps government and health service providers identify inequalities in access and predict future health care needs.

Medicare

The Medicare Benefits Schedule (MBS) records information on medical services and tests subsidised by the Australian Government. People who reside in Australia and are Australian or New Zealand citizens or hold a permanent visa are eligible for Medicare enrolment.

In 2017–18, Australia's females claimed over 240 million services through Medicare, and received an average of 19 Medicare services per person in that year. By comparison, males claimed 14 Medicare services per person (Department of Health 2018).

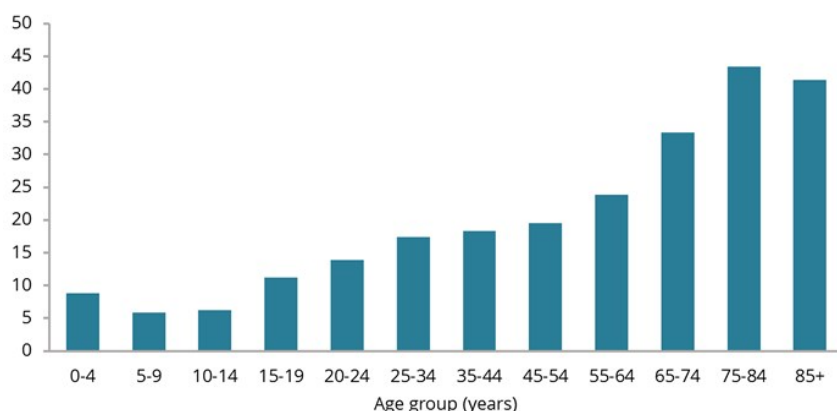
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Medicare services claimed on average by females aged 75–84 in 2017–18

The average number of services claimed by females varies by age group. In 2017–18:

- those aged under 45 claimed fewer than 12 services per person.
- those aged 75 and over claimed more than 42 services per person.

Figure 7: Average number of Medicare services claimed, per person, females by age group, 2017–18



Source: Department of Health 2018 ([Table S7](#)).

Primary health care

In Australia, primary health care is usually a person's first encounter with the health system when they have a health concern. Primary health care broadly encompasses health care that is not related to a hospital visit.

9 in 10

females reported visiting a GP in the previous 12 months

In 2017–18, 89% of females aged 15 and over reported visiting their GP in the last 12 months (ABS 2018).

Barriers to accessing health services may impede the best possible health outcomes for women. In 2017–18, among females aged 15 and over (ABS 2018):

- 0.5% reported not seeing a GP when they needed to in the previous 12 months
- over 1 in 5 (21%) waited longer than they felt acceptable to get an appointment with a GP
- over 1 in 20 (5.1%) delayed seeing, or did not see, a GP when needed due to cost reasons at least once in the past 12 months
- more than 8 in 10 (8.6%) delayed getting, or did not get prescribed medication, due to cost.

Of Australian women aged 45 years and over who had at least one GP visit in the 12 months between November 2014 and November 2015 (ABS 2017):

- about 1 in 4 (26%) reported that they had spoken to their GP about their emotional and psychological health

- almost half (49%) indicated that they received care from a health professional other than their GP or specialist doctor or nurse for their physical health (e.g. physiotherapist, podiatrist, dietitian)
- more than 1 in 10 (11%) indicated that they received care from a health professional other than their GP or specialist doctor or nurse for their emotional or psychological health (e.g. psychologist, counsellor or social worker)
- over 8 in 10 (84%) reported they were currently taking at least one medication on a regular and ongoing basis
- Almost 8 in 10 (79%) indicated they were always or usually involved in making decisions about their medications for their own health.

Private health insurance

In Australia, private health insurance is available for those who wish to fully or partly cover the costs of being admitted to hospital as a private patient and/or the costs of other ancillary health services.

In 2017–18, 57% of females reported having some form of private health insurance (ABS 2018). 46% had both hospital and extras cover, 6% had hospital only and 5% had extras only cover.

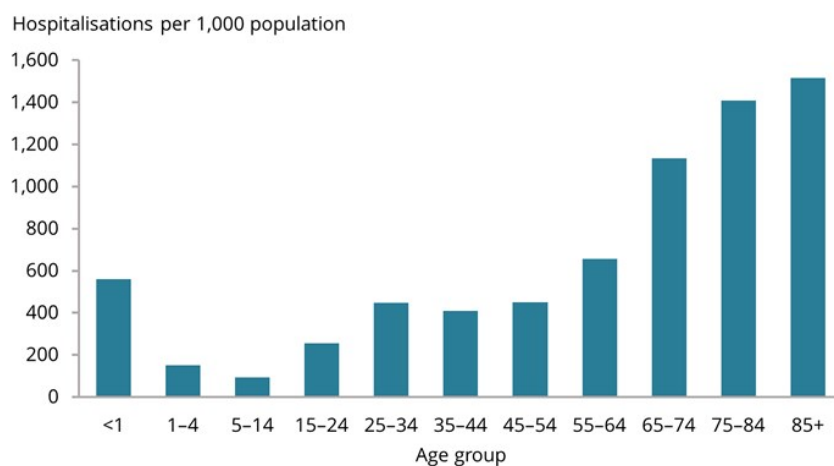
Admitted patient care

Admitted patient care refers to care provided by public and private hospitals to admitted patients. A hospitalisation is an episode of hospital care that starts with the formal admission process and ends with the formal separation process.

In 2016–17, there were 5.8 million hospitalisations among females, accounting for 53% of all hospitalisations (AIHW 2018).

Hospitalisation rates generally increase with age, and are highest among women aged 85 and over.

Figure 8: Hospitalisation rate, females by age group, 2016–17



Source: AIHW 2018 (Table S8).

Note: See boxes 1.1, 1.2 and appendixes A and B of *Admitted patient care 2016–17: Australian hospital statistics* for notes on data limitations and methods.

In 2013–14 to 2014–15, Aboriginal and Torres Strait Islander females experienced 73 potentially preventable hospitalisations per 1,000 population (compared to 66 for Indigenous males, after adjusting for differences in age-structure). The Indigenous female rate of potentially preventable hospitalisations was 3.1 times higher than for non-Indigenous females, after adjusting for differences in age-structure (AIHW 2017).

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Data

- [Data tables: Male and female data tables](#)
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