

# Determinants of health—access to services

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Aboriginal and Torres Strait Islander community-controlled health services

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## **Indicator 24**

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## Introduction

There are 10 indicators in this subdomain. The first five indicators relate to Indigenous access to health services – Aboriginal and Torres Strait Islander community-controlled health services, community health centres, hospitals, health services for small homeland communities and services for key health conditions. These indicators provide a measure of the extent to which Aboriginal and Torres Strait Islander people have access to the range of different health services that most non-Indigenous people can access.

The next four indicators relate to health services workforce availability and training. Indicators on the number of Indigenous people in the health workforce and the numbers of Indigenous people with higher education and training in key health professions are being developed to assess the extent of the capacity of Indigenous people to deliver health services to Indigenous people. There are two indicators on workforce availability in services providing health care to a significant proportion of Indigenous people – one for primary health care services and one for hospitals. These provide measures of these services to provide care for a large population of Indigenous people. The last indicator in this subdomain is the extent to which hospital staff are trained to provide culturally appropriate services to Indigenous people.

## Indicator 15. Aboriginal and Torres Strait Islander community-controlled health services

### Indicator:

- (a) The number of primary health care services that are community-controlled
- (b) The per person funding for primary health care services provided by government to Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).

### Purpose

This indicator is intended to measure the extent to which primary health care for Aboriginal and Torres Strait Islander people is community-controlled, and the capacity of such services to provide comprehensive primary health care. The Australian Government has joint responsibility with state and territory governments for funding and/or direct provision of Aboriginal and Torres Strait Islander primary health care services. The indicator allows monitoring of state, territory and Australian Government allocation to these services.

### Data

Data are provided on the funding for Aboriginal and Torres Strait Islander primary health care services (ATSIPHCS). This includes ACCHOs, as well as other Indigenous primary health care services. Most of the data relates to community-controlled services but it was not possible to provide data only on these services.

The table includes Australian Government expenditure from OATSIH and state government expenditure on Aboriginal and Torres Strait Islander primary health care services. Australian Government data are from the SAR annual data collection project. State government numbers and expenditure data were provided separately by each jurisdiction.

- The number of ATSIHCS in Australia increased from 159 in 2000–01 to 162 in 2001–02.
- The Northern Territory (34 in 2000–01 and 38 in 2001–02) and Victoria (34 in 2000–01 and 33 in 2001–02) had the largest number of ATSIHCS.
- Most expenditure on ATSIHCS services came from the Australian Government. In 2000–01, 73% of total expenditure and in 2001–02, 77% of expenditure on these services was from the Australian Government.
- Australian Government expenditure across Australia increased by \$19 million between 2000–01 and 2001–02. Expenditure by state governments decreased by \$1.37 million over the same period.
- In 2000–01, the highest per capita expenditure on ATSIHCS was in the Northern Territory (\$653) and South Australia (\$651), and in 2001–02 the highest per capita expenditure was in the Northern Territory (\$755). The lowest per capita expenditure was in Tasmania, where there was no expenditure by the state government on these organisations (\$164 in 2000–01 and \$171 in 2001–02).

**Table 15.1: Number of and expenditure on Aboriginal and Torres Strait Islander primary health care services, 2000–01 and 2001–02**

	NSW & ACT <sup>(a)</sup>	Vic	Qld	WA	SA	Tas	NT	Australia
<b>2000–01</b>								
<b>No. of ATSIPHCS</b>	28	34	29	21	8	5	34	159
<b>Expenditure (\$'000)</b>								
- Australian Govt <sup>(b)</sup>	20,367.1	10,640.2	19,505.3	24,469.2	13,157.1	2,847.0	26,825.5	117,811.4
- State/territory	4,641.8	6,760.2	4,199.5	13,737.1	3,470.6	—	10,328.7	43,137.9
<i>Total</i>	<i>25,008.9</i>	<i>17,400.4</i>	<i>23,704.7</i>	<i>38,206.4</i>	<i>16,627.7</i>	<i>2,847.0</i>	<i>37,154.1</i>	<i>160,949.3</i>
<b>Estimated population<sup>(c)</sup></b>	138,797	27,846	125,910	65,931	25,544	17,384	56,875	458,287
<b>Per person expenditure (\$)</b>	<b>180</b>	<b>625</b>	<b>188</b>	<b>579</b>	<b>651</b>	<b>164</b>	<b>653</b>	<b>351</b>
<b>2001–02</b>								
<b>No. of ATSIPHCS</b>	27	33	30	21	8	5	38	162
<b>Expenditure \$'000</b>								
- Australian Govt <sup>(b)</sup>	25,864.4	11,563.7	20,630.4	28,179.0	15,043.7	2,974.1	32,418.3	137,097.0
- State/territory	5,229.3	7,141.8	3,711.4	11,898.4	3,251.0	—	10,540.6	41,772.5
<i>Total</i>	<i>31,093.7</i>	<i>18,705.5</i>	<i>24,341.8</i>	<i>40,077.5</i>	<i>18,294.7</i>	<i>2,974.1</i>	<i>42,958.9</i>	<i>178,869.4</i>
<b>Estimated population<sup>(c)</sup></b>	138,797	27,846	125,910	65,931	25,544	17,384	56,875	458,287
<b>Per person expenditure (\$)</b>	<b>224</b>	<b>672</b>	<b>193</b>	<b>607</b>	<b>716</b>	<b>171</b>	<b>755</b>	<b>390</b>

ATSIPHCS Aboriginal and Torres Strait Islander primary health care services.

- (a) New South Wales and Australian Capital Territory data have been combined to avoid the identification of a single service's data.
- (b) Australian Government data are from the SAR data collection. The Australia total figure includes a service not allocated to a particular state. The expenditure figures are an underestimate as two services did not have data available.
- (c) At the time of publication, Indigenous population projections were not available. The population estimate for 30 June 2001, excluding the Other Territories, has been used for both financial years to calculate per capita expenditure. This estimate is based on the final results of the 2001 Census.

Source: Australian Government data provided by OATSIH. State data provided by each jurisdiction.

### **Box 15.1: Data issues**

*The data provided included all Aboriginal and Torres Strait primary health care services, not just those that were community-controlled, as it was not possible to obtain data only for community-controlled organisations. It is suggested that the indicator specifications be changed to include all Indigenous primary health care services.*

## Indicator 16. Distance to a primary health care centre

**Indicator:** The proportion of Aboriginal and Torres Strait Islander communities that are more than 25 kilometres from a primary health care centre.

### Purpose

This indicator reveals geographic access to primary health care services. A primary health care centre is the first point of contact with a health service for most Aboriginal and Torres Strait Islander people living in discrete Indigenous communities. Distance to a primary health care centre is an important determinant of whether people are able to seek treatment. Delayed diagnosis and treatment can lead to poor health outcomes.

### Data

The data for this indicator come from the ABS 2001 CHINS. This CHINS collected data on a total of 1,216 discrete Indigenous communities. A complete description of the collection method is available in the principal publication outlining the 2001 CHINS – *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001* (ABS 2002).

The survey collected information on discrete Indigenous communities (not all communities as specified in the indicator) 25 kilometres or more from a community health clinic. This information was only collected for those communities that were 10 kilometres or more from the nearest hospital.

The CHINS definition of a community health clinic differs somewhat from a primary health care centre, which is the specified facility identified for this indicator. A community health clinic is defined as a facility which provides a range of health services, such as nursing, medical, dental and nutritional services. In remote areas not all of these services may be available; however, generally the centre would have nurses, health workers and/or doctors in regular attendance (ABS 2002).

**Table 16.1: Discrete Indigenous communities<sup>(a)</sup> by distance to nearest community health clinic, for selected states and territories, 2001**

Distance to nearest community health clinic	NSW	Qld	WA	SA	NT	Australia <sup>(b)</sup>
	<b>Number</b>					
Less than 25 km	17	48	117	43	254	481
25 km	10	72	139	42	342	606
<b>Total<sup>(c)</sup></b>	<b>60</b>	<b>142</b>	<b>283</b>	<b>96</b>	<b>632</b>	<b>1,216</b>
	<b>Per cent</b>					
<b>Proportion of communities 25 km or more from the nearest community centre and 10 km or more from the nearest hospital</b>	<b>17</b>	<b>51</b>	<b>49</b>	<b>44</b>	<b>54</b>	<b>50</b>

(a) Data applicable to communities that were 10 kilometres or more from the nearest hospital.

(b) The Australian Capital Territory has no discrete Indigenous communities, Tasmania and Victoria are included in the Australian total.

(c) Includes communities located within 10 kilometres of a hospital.

Source: ABS Community Housing and Infrastructure Needs Survey, 2001.

- In 2001, approximately half (606 or 50%) of all discrete Indigenous communities were located 10 kilometres or more from the nearest hospital and 25 kilometres or more from the nearest community health clinic.

- State and territories with the highest proportion of Indigenous communities located 25 kilometres or more from the nearest community health clinic were the Northern Territory (342 or 54%), Queensland (72 or 51%) and Western Australia (139 or 49%). These communities were also located 10 kilometres or more from the nearest hospital.

## Indicator 17. Distance to a hospital

**Indicator:** The proportion of Aboriginal and Torres Strait Islander communities which are more than 50 kilometres from the nearest acute hospital.

### Purpose

Indigenous people have more chronic illness, including diabetes, kidney disease and coronary heart disease, than the overall population. People with these conditions need to travel frequently to the nearest hospital. People who live at a distance from a hospital often need to move residence in order to receive regular treatment, or must find alternative means of care in their current residence, or must travel large distances to receive treatment. Improving the access of Aboriginal and Torres Strait Islander communities to acute hospital care is a goal for all states and territories.

### Data

The data for this indicator come from the ABS 2001 CHINS. The 2001 CHINS collected data concerning a total of 1,216 discrete communities. A complete description of the collection method is available in the principal publication outlining the 2001 CHINS—*Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001* (ABS 2002).

This survey collected information on discrete Indigenous communities (not all communities as specified in the indicator specification) 50 kilometres or more from the nearest hospital.

**Table 17.1: Discrete Indigenous communities by distance to the nearest acute hospital, for selected states and territories, 2001**

Distance to nearest hospital	NSW	Qld	WA	SA	NT	Australia <sup>(a)</sup>
	<b>Number</b>					
Less than 50 km	52	46	73	24	74	271
50 km or more	8	96	210	72	556	943
<b>Total<sup>(b)</sup></b>	<b>60</b>	<b>142</b>	<b>283</b>	<b>96</b>	<b>632</b>	<b>1,216</b>
	<b>Per cent</b>					
<b>Proportion of communities 50 km or more from the nearest hospital</b>	<b>13</b>	<b>68</b>	<b>75</b>	<b>74</b>	<b>88</b>	<b>78</b>

a) The Australian Capital Territory had no discrete Indigenous communities. Tasmania and Victoria are included in the Australian total.

b) Includes 'Distance to nearest hospital' not stated.

Source: ABS Community Housing and Infrastructure Needs Survey, 2001.

- In 2001, 943 or 78% of discrete Indigenous communities were located 50 kilometres or more from the nearest hospital.
- Northern Territory (88%), Western Australia (75%), South Australia (74%) and Queensland (68%) were the states and territories with the highest proportion of communities located 50 kilometres or more from the nearest hospital.

## **Indicator 18. Access to primary health care services—small homeland communities and outstations**

**Indicator:** The proportion of Aboriginal and Torres Strait Islander homeland communities/outstations, with an usual population of less than 50 people and that are more than 50 kilometres from a primary health care service, that have access to various types of health services on a regular basis.

### **Purpose**

Small and isolated communities create special health service delivery challenges. Improving the access of Aboriginal and Torres Strait Islander communities to primary health services in general is a goal for all states and territories. The indicators examined here combine isolation and size of communities.

### **Data**

The data for this indicator comes from the ABS 2001 CHINS. The survey collected information on discrete Indigenous communities with less than 50 people (not small homeland communities/outstations) which were more than 50 kilometres from a community health clinic. The survey collected data on access to health professionals, not health services as specified in the indicator.

The defined health professionals for this indicator were an Aboriginal Health Worker working in the community every day, a nurse visiting at least every fortnight and a doctor visiting at least every month. There were, however, no data available on the number of health professionals visiting these communities more frequently than at least once a month.

- There were a total of 374 communities in Australia with less than 50 people that were more than 50 kilometres from a community health clinic. Most of these were in the Northern Territory (239) and Western Australia (83).
- Over three-quarters (77%) of all such communities did not have any health professionals visiting at least once a month.
- In the Northern Territory, 27% of these communities were visited by health professionals at least once a month, while in Western Australia (24%) and Queensland (3%) were visited at least once a month. In South Australia, there were only 11 of these types of communities and none of these were visited by health professionals at least once a month.
- The most common health professional visiting these communities at least once a month was a registered nurse (18%), followed by a doctor (15%).

**Table 18.1: Number and proportion of communities with less than 50 people and more than 50 km from a community health clinic<sup>(a)</sup>, by access to selected health professionals, for selected states and territories, 2001**

Visited at least once a month	Qld	WA	SA	NT	Australia
<b>Number</b>					
Indigenous health worker	—	9	—	33	42
Registered nurse	1	14	—	52	68
Doctor	1	5	—	50	56
<i>By any selected health professionals<sup>(b)(c)</sup></i>	<i>1</i>	<i>20</i>	<i>—</i>	<i>65</i>	<i>87</i>
Not visited by selected health professionals	38	63	11	174	287
<b>Total</b>	<b>39</b>	<b>83</b>	<b>11</b>	<b>239</b>	<b>374</b>
<b>Percentage of communities with less than 50 people and more than 50 km from a community health centre</b>					
Indigenous health worker	—	10.8	—	13.8	11.2
Registered nurse	2.6	16.9	—	21.8	18.2
Doctor	2.6	6.0	—	20.9	15.0
<i>By any selected health professionals<sup>(b)(c)</sup></i>	<i>2.6</i>	<i>24.1</i>	<i>—</i>	<i>27.2</i>	<i>23.3</i>
Not visited by selected health professionals	97.4	75.9	100.0	72.8	76.7
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Percentage of all communities with less than 50 people</b>					
Indigenous health worker	0.0	4.5	0.0	6.5	4.7
Registered nurse	1.0	6.9	0.0	10.2	7.6
Doctor	1.0	2.5	0.0	9.8	6.3
<i>By any selected health professionals<sup>(b)(c)</sup></i>	<i>1.0</i>	<i>9.9</i>	<i>0.0</i>	<i>12.8</i>	<i>9.8</i>
Not visited by a medical service	38.8	31.2	15.7	34.3	32.3
<b>Total</b>	<b>39.8</b>	<b>41.1</b>	<b>15.7</b>	<b>47.0</b>	<b>42.1</b>

(a) Excludes communities within 10 km of a hospital.

(b) Including environmental health worker.

(c) Components may not add to total as communities may have access to more than one type of health profession.

Note: Australia includes New South Wales, Victoria, the Australian Capital Territory and Tasmania.

Source: ABS Community Housing and Infrastructure Needs Survey, 2001.

- Of all communities with less than 50 people, 32% were not visited by a health professional at least once a month. This percentage ranged from 15.7% in South Australia to 38.8% in Queensland.

## Indicator 19. Management of key conditions

**Indicator:** The extent to which there is systematic support for:

- (a) the development and implementation of evidence-based treatment protocols
- (b) presence of early detection programs
- (c) chronic disease management systems in Aboriginal and Torres Strait Islander people, using recommendations specifically developed for Aboriginal and Torres Strait Islander people (where appropriate).

### Purpose

Early detection and management of chronic conditions are recognised components of health care systems. This indicator is designed to reflect jurisdictional commitment to the dissemination and implementation of best practice recommendations for conditions that cause high levels of morbidity and mortality in Aboriginal and Torres Strait Islander populations.

### Data

Data for this indicator was provided by state and territory governments and the Australian Government.

### Australian Government

#### Patient Information and Recall System

The Patient Information and Recall (PIR) System program funded and administered by the OATSIH is intended to support the delivery of best practice and holistic primary health care to Aboriginal and Torres Strait Islander Communities throughout Australia. Custom-designed software is employed in the program and is built on the evidence-based concept of health care delivery. The funding provided under the program is non-recurrent and is designed to enable Australian Government-funded Aboriginal and Torres Strait Islander primary health care organisations to acquire and implement computer-based PIR systems.

PIR systems software includes a patient recall capacity that is designed to assist services in the implementation and maintenance of whole-of-life care plans. Initiatives that are enabled by this functionality include immunisation, diabetes screening and management, and cardiovascular disease detection and management. PIR systems also include the means of recording clinical summaries necessary for the effective tracking and control of chronic disease states.

Funding provided to organisations in 2000–01 amounted to \$1.93 million and, in 2001–02, \$2.77 million. The funding provided covers the costs of hardware, software, staff training and data management.

#### Otitis Media

The Australian Government spent approximately \$195,000 during 2000–01 for the publication and implementation of *Recommendations for Clinical Care Guidelines for the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations* and a package of supporting information. The Recommendations are based on the Systematic Review of Existing Evidence and Clinical Guidelines conducted by NACCHO. The package, including the Systematic Review, was made available to primary health care providers as a means of promoting greater

consistency in the management of otitis media by primary health care providers. In 2001–02, approximately \$40,000 was spent on reprinting the *Recommendations for Clinical Care Guidelines for the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations* and the package of supporting information, subsequent to sector demand.

### **Hearing health**

Approximately \$95,000 was spent on commissioning a review of the hearing health services provided to Aboriginal and Torres Strait Islander peoples under two Australian Government funded programs: the National Aboriginal and Torres Strait Islander Hearing Strategy, and the Australian Government Hearing Services Program. The review commenced in September 2000 and the final report was received in June 2001.

### **Central Australian Rural Practitioners Association Standard Treatment Manual**

The Central Australian Rural Practitioners Association (CARPA) is a multidisciplinary group supporting practice in remote and rural communities in Central Australia. The Standard Treatment Manual is a collection of standard protocols for the management of common conditions seen in remote localities (primarily Aboriginal health). The manual is intended for use by trained health professionals including Aboriginal Health Workers, nurses and doctors. It is primarily intended to be used in remote Indigenous communities, rural and urban Aboriginal health services, and for non-Indigenous people living in these communities.

During 2000–01, \$88,000 was spent for coordination, editing and initial printing of the fourth edition of the manual. A further \$55,000 was spent on the manual in 2001–02. These funds were provided by OATSIH in DoHA, in addition to funding by the Northern Territory Department of Health and Community Services.

### **Rheumatic heart disease program, Alice Springs, Northern Territory**

The Australian Government Department of Health and Ageing provided funding to meet the expenses for setting up this program in Alice Springs. This condition is highly prevalent in the Aboriginal and Torres Strait Islander population so is targeted to this population group. Expenditure in 2001–02 was \$187,000.

The main aims of the program are to:

- establish a computerised register of all known or suspected cases of acute rheumatic fever or rheumatic heart disease within the region;
- use the register to improve patient care, particularly secondary prevention, by establishing a reminder system for monthly penicillin injections and other clinical follow-up by the primary care system;
- organise and conduct education programs; and
- integrate these services into the existing primary care network.

### **New South Wales**

In the period 2000–01 to 2001–02 a range of initiatives were established centrally in New South Wales through the Chronic and Complex Care Program and the New South Wales Aboriginal Vascular Health Program.

There were also regional initiatives in area health services. A number of areas focused on local chronic and complex care activities to specifically target Aboriginal community members, for example the Greater Murray Aboriginal Diabetes Project, South Eastern Sydney Aboriginal

Chronic Disease Outreach Clinic in La Perouse, and Far West Chronic Care Network (with a very large Aboriginal population in the region).

In addition, numerous local initiatives have been undertaken through local area Aboriginal health plans, such as the New England Area Cardiovascular Screening Program. Other local collaborative initiatives were also undertaken between various service providers, including the Aboriginal Diabetes Project of the Shoalhaven Division of General Practice with South Coast Aboriginal Medical Service, Illawarra Area Health Service.

The New South Wales Aboriginal Vascular Health Program was established in July 2000 to address priority areas of the New South Wales Aboriginal Health Strategic Plan related to cardiovascular health. This includes heart disease, diabetes, hypertension, stroke and renal disease. A combined vascular approach has been adopted because of the shared risk factors, risk conditions and common lifestyle changes required to prevent and manage these conditions. A one-off allocation of \$1.4 million was made for initiatives under the program.

A central program focus is on close monitoring and evaluation to build the evidence base for effective interventions in the prevention and management of chronic disease in Aboriginal communities and disseminating examples and principles of best practice.

A series of demonstration site projects has been funded in area health services to work collaboratively with local services and organisations to develop improved models of prevention, early detection and care for Aboriginal people with or at risk of vascular diseases. Building the capacity of the Aboriginal health workforce is a core strategy.

In 2000–01, demonstration site projects were funded in eight area health services and Corrections Health Services to cover three correctional centres. A further four demonstration site projects were established in four areas in 2001–02, and four additional correctional sites.

All projects have been developed according to local priorities, resources and needs, and vary considerably across sites. The projects aim to increase access to care, improve service coordination and support improved disease self-management. Development of evidence-based assessment tools, clinical protocols, early detection and improved continuity of care and self-management in 2000–01 have featured in all projects.

State-wide initiatives to support project implementation include six-monthly networking and capacity-building forums for workers and a state-wide Vascular Health Network, and training programs in renal disease.

## **Victoria**

There are no overall plans for the management of key conditions and no Aboriginal-specific plans.

## **Queensland**

### **Health outcomes plans**

Health outcomes plans have been developed in the following National Health Priority Areas: cardiovascular health (coronary heart disease and stroke), diabetes, asthma, cancer control and injury prevention and control. The plans identify evidence-based strategies to address health issues for the general population as well specific population groups such as the Indigenous population where appropriate.

## **Enhanced model of primary health care**

The enhanced model of primary care is an initiative to improve the primary health care systems to manage major health conditions in the remote areas of the Northern Zone. This model includes a Chronic Disease Strategy comprising the prevention, early detection and management of chronic illness. The model is based on a collaborative approach, where Queensland Health works with community groups and other health organisations to identify barriers to access and ways of improving the delivery of primary health care services.

## **Patient Recall and Reminder System**

To enable better treatment for people with chronic conditions, audits in all health centres in the far northern area of the Northern Zone have been conducted to identify people in remote Indigenous communities with chronic disease. The system enables health professionals to identify when patients require routine follow-up care as defined in their care plans to ensure that health problems are prevented or minimised by identifying them at an early stage.

## **Queensland Health HIV/AIDS Strategy 1999-02**

This strategy aims to provide an integrated approach to the delivery of sexual health care services to Aboriginal and Torres Strait Islander peoples. Ongoing support through the Queensland and Torres Strait Health Partnership Forums under the Framework Agreements, and collaboration with the Community Controlled Health Services has ensured the effective implementation of the strategy. Successful implementation of this program is further assured by the establishment of Zonal Indigenous Health Coordinator positions.

## **The Adult Health Check**

As a follow-on from the Well Persons Health Check initiative, the Adult Health Check continues to enhance community understanding of disease processes through screening and brief interventions, and by providing information on community health status back to the community to facilitate planning and joint priority setting.

## **Renal service plans**

Each of the three Queensland Health Zones has developed renal service plans that recognise Aboriginal and Torres Strait Islander peoples as a priority population. The Northern and Central Zone Renal Services plans include specific strategies to address renal disease in Aboriginal and Torres Strait Islander peoples including health promotion, early detection, clinic management, renal replacement services, workforce management and information support actions. Queensland Health recognises that many rural remote areas of the state do not have ready access to a hospital renal unit or satellite unit and is working towards ensuring that high-quality home dialysis is available.

## **Rheumatic heart disease**

Queensland Health is working collaboratively with key health research bodies to develop clinical audits to examine how rheumatic heart disease is currently managed within the different Aboriginal and Torres Strait Islander communities as well as identifying the problems and barriers in coordinating management.

## **Better Health Outcomes Project**

An important component of this project is the patient information and recall system known as Ferret. Ferret is centred on clients and population-based, providing for opportunistic and planned service delivery. Ferret implementation supports the Chronic Disease Strategy and

model of service delivery for remote and rural Indigenous communities. A pilot project has been successfully completed and followed up at three sites in northern Queensland. The use of this system has been well accepted by the communities who see it as increasing accessibility to services. Post-pilot implementation in 10 other health services demonstrates this.

## **Western Australia**

### **Chronic disease prevention**

Western Australia's chronic disease prevention program recognises the importance of controlling risk factors in the health of the population. Some risk factors may be more prevalent in Indigenous people and prevention may target specific sections of the community as well as using a more broad-based approach to the health problems. Some of the strategies include:

- public education programs for health professionals as well as the general public;
- creating supportive environments in public places to promote good health;
- strengthening communities by giving them skills and resources to improve their own health;
- developing partnerships between government, non-government agencies and industry; and
- using the concept of 'capacity building' to ensure programs are sustainable in the long term by strengthening infrastructure.

## **South Australia**

South Australia has been actively involved in developing and implementing evidence-based treatment protocols for chronic disease as well as early detection programs for risk factors. A key factor in this work has been the facilitation of cultural awareness programs for medical practitioners involved in the diagnoses and treatment of chronic disease, and the active participation in ensuring that services and policy responses are inclusive of Aboriginal and Torres Strait Islander peoples.

During this reporting period the Standing Committee on Aboriginal and Torres Strait Islander Health has developed a cultural competency framework for all medical and allied health professionals. The framework, which has also been supported by AHMAC, is a resource which ensures that appropriate protocols are in place to ensure that responses to chronic disease is managed in an appropriate manner.

## **Tasmania**

Separate protocols on the management of key conditions are not developed for Aboriginal or Torres Strait Islander patients.

## **Australian Capital Territory**

Due to the geographic size of the Australian Capital Territory, and relatively small Aboriginal population, it is reasonable to assume that the majority of Aboriginal people in the Australian Capital Territory have access to the community-controlled Aboriginal Health Service, facilitating early detection of chronic disease.

## **Asthma**

The Australian Capital Territory Health government service provider utilises data obtained from the School Health Screening dataset to determine issues affecting the health of children. Comparisons are made between Aboriginal and Torres Strait Islander kindergarten children and other children entering school, with a particular focus on respiratory health and asthma. The data show that there is an excess of respiratory morbidity among Aboriginal kindergarten children and suggests that the prevalence of household smoking is greater in this community. However, evidence-based treatment protocols for respiratory health and for chronic disease management systems specific to Aboriginal and Torres Strait Islander community members are not in operation.

## **Diabetes**

Diabetes Service commenced the provision of monthly sessional multidisciplinary care for clients with, or at risk of, diabetes at the non-government Aboriginal Health Service in 2000. The sessions included basic clinical assessments for complications such as blood pressure, urinary microalbumin, HbA1c, foot screening and periodic eye screening. Comprehensive reviews were also provided which included advice on self-management, nutritional assessment and counselling, and podiatry foot treatment. Clients were referred to specialist services where indicated.

Services provided were based on the evidence-based recommendations for Early Detection and Primary Prevention and Management of Type 2 Diabetes. Multidisciplinary clinical pathways and standards were used, which incorporated best practice and information principles. All data was entered in the health service data system. The Australian Capital Territory Cancer Council supported the Diabetes Clinic with the Quit Coordinator attending each clinic to provide advice and support to those stopping smoking.

## **Northern Territory**

The Northern Territory has a well-established and comprehensive process of developing and implementing evidence-based treatment protocols, which are used by all Aboriginal health services. The fourth edition of CARPA Standard Treatment Manual was in development during this period. The new edition incorporates detailed chronic disease guidelines that were developed for the two Northern Territory Coordinated Care Trial sites. Implementation of the Standard Treatment Manual includes policy support by health services, introduction to the manual at the start of employment, inclusion of the manual in training, and provision of copies to all clinical staff.

All primary health care services have programs for 'Well persons' screening. These are holistic programs that aim to detect risk factors, chronic diseases, sexually transmitted infections and women's cancers. The extent of coverage and effective program delivery across the Northern Territory is currently not known, although individual services have some data. The program is provided both opportunistically by primary health care staff, and as part of organised screening weeks supported by visiting public health staff. Health assessments for Aboriginal people aged 50 years and older is encouraged through use of the enhanced primary care items, and by the use of a standard screening form.

All Northern Territory primary health care services have management systems including chronic disease registers and recall systems, either paper or computerised care plans, training programs and regular specialist visits to both remote and urban services.

## Indicator 20. Aboriginal and Torres Strait Islander people in the health workforce

**Indicator:** The proportion of the health workforce employed by states and territories that identify as Aboriginal or Torres Strait Islander.

### Purpose

This indicator monitors the proportion of Indigenous people employed as professional health care workers in order to assess the extent to which the capacity of Indigenous people to deliver health services to Indigenous people is being developed.

### Data

States and territories reported difficulties obtaining information on the proportion of doctors and nurses who were Indigenous, because ethnic identification was not required by the relevant registration boards and because identification may be understated. For several states and territories it was possible to gain some idea of these proportions from various staff surveys. However, in many cases the completion of such surveys is voluntary, as is the collection of Indigenous status information within these surveys.

Data from the ABS 2001 Census of Population and Housing is thought to be most reliable and was used for this indicator. These data are not restricted to the public sector employed health workforce, as stipulated in the definitions for this indicator.

- Aboriginal and Torres Strait Islander people are underrepresented in the Australian professional health workforce, representing 1.3% of the Australian health workforce.
- The states with the greatest proportion of Aboriginal and Torres Strait Islanders in their professional health workforce were the Northern Territory (9.0%) and Queensland (2.2%).
- Nursing was the most common profession for Aboriginal and Torres Strait Islander people working in the health services delivery sector.
- Queensland and the Northern Territory had the largest numbers of Aboriginal and Torres Strait Islander health workers.
- In the category of management and support staff, most Aboriginal and Torres Strait Islander people were employed as policy officers, project officers or administrative workers.

**Table 20.1: Aboriginal and Torres Strait Islander employment in the health workforce<sup>(a)</sup>, by state and territory, 2001**

	No. of Indigenous people employed	Total no. of people employed	Proportion of people employed, who were Indigenous (%)
<b>New South Wales and Australian Capital Territory</b>			
Health services delivery staff			
Medical staff	19	5,335	0.4
Nursing staff <sup>(b)</sup>	205	33,579	0.6
Aboriginal and Torres Strait Islander health worker	42	42	100.0
Welfare and community workers	149	1,837	8.1
Allied health	108	8,636	1.3
Dental practitioners	3	202	1.5
Pharmacists	0	457	0.0
Other	94	4,810	2.0
Management and support staff			
Program/service/unit managers	56	4,922	1.1
Policy/project officers and administrative workers <sup>(c)</sup>	455	23,296	2.0
Operational staff <sup>(d)</sup>	114	5,195	2.2
<b>Total</b>	<b>1,245</b>	<b>88,311</b>	<b>1.4</b>
<b>Victoria</b>			
Health services delivery staff			
Medical staff	6	3,771	0.2
Nursing staff <sup>(b)</sup>	57	24,557	0.2
Aboriginal and Torres Strait Islander health worker	11	14	78.6
Welfare and community workers	25	1,805	1.4
Allied health	20	6,048	0.3
Dental practitioners	0	173	0.0
Pharmacists	0	395	0.0
Other	9	2,979	0.3
Management and support staff			
Program/service/unit managers	10	3,197	0.3
Policy/project officers and administrative workers <sup>(c)</sup>	66	18,095	0.4
Operational staff <sup>(d)</sup>	19	3,322	0.6
<b>Total</b>	<b>223</b>	<b>64,356</b>	<b>0.3</b>

*(continued)*

**Table 20.1 (continued): Aboriginal and Torres Strait Islander employment in the health workforce<sup>(a)</sup>, by state and territory, 2001**

	No. of Indigenous people employed	Total no. of people employed	Proportion of people employed, who were Indigenous (%)
<b>Queensland</b>			
Health services delivery staff			
Medical staff	15	2,670	0.6
Nursing staff <sup>(b)</sup>	129	17,298	0.7
Aboriginal and Torres Strait Islander health worker	109	117	93.2
Welfare and community workers	74	764	9.7
Allied health	72	4,053	1.8
Dental practitioners	0	241	0.0
Pharmacists	0	202	0.0
Other	58	3,269	1.8
Management and support staff			
Program/service/unit managers	92	3,235	2.8
Policy/project officers and administrative workers <sup>(c)</sup>	351	11,075	3.2
Operational staff <sup>(d)</sup>	91	2,247	4.0
<b>Total</b>	<b>991</b>	<b>45,171</b>	<b>2.2</b>
<b>Western Australia</b>			
Health services delivery staff			
Medical staff	3	1,346	0.2
Nursing staff <sup>(b)</sup>	28	7,242	0.4
Aboriginal and Torres Strait Islander health worker	31	31	100.0
Welfare and community workers	29	393	7.4
Allied health	15	2,318	0.6
Dental practitioners	0	28	0.0
Pharmacists	0	117	0.0
Other	16	821	1.9
Management and support staff			
Program/service/unit managers	24	943	2.5
Policy/project officers and administrative workers <sup>(c)</sup>	94	5,834	1.6
Operational staff <sup>(d)</sup>	31	893	3.5
<b>Total</b>	<b>271</b>	<b>19,966</b>	<b>1.4</b>

(continued)

**Table 20.1 (continued): Aboriginal and Torres Strait Islander employment in the health workforce<sup>(a)</sup>, by state and territory, 2001**

	No. of Indigenous people employed	Total no. of people employed	Proportion of people employed, who were Indigenous (%)
<b>South Australia</b>			
Health services delivery staff			
Medical staff	0	1,326	0.0
Nursing staff <sup>(b)</sup>	24	8,206	0.3
Aboriginal and Torres Strait Islander health worker	43	49	87.8
Welfare and community workers	22	386	5.7
Allied health	3	1,736	0.2
Dental practitioners	0	87	0.0
Pharmacists	0	101	0.0
Other	9	1,307	0.7
Management and support staff			
Program/service/unit managers	18	1,289	1.4
Policy/project officers and administrative workers <sup>(c)</sup>	63	5,421	1.2
Operational staff <sup>(d)</sup>	17	1,124	1.5
<b>Total</b>	<b>199</b>	<b>21,032</b>	<b>0.9</b>
<b>Tasmania</b>			
Health services delivery staff			
Medical staff	3	317	0.9
Nursing staff <sup>(b)</sup>	20	2,198	0.9
Aboriginal and Torres Strait Islander health worker	3	3	100.0
Welfare and community workers	6	83	7.2
Allied health	9	485	1.9
Dental practitioners	0	11	0.0
Pharmacists	0	43	0.0
Other	3	237	1.3
Management and support staff			
Program/service/unit managers	12	253	4.7
Policy/project officers and administrative workers <sup>(c)</sup>	44	1,374	3.2
Operational staff <sup>(d)</sup>	6	369	1.6
<b>Total</b>	<b>106</b>	<b>5,373</b>	<b>2.0</b>

(continued)

**Table 20.1 (continued): Aboriginal and Torres Strait Islander employment in the health workforce<sup>(a)</sup>, by state and territory, 2001**

	No. of Indigenous people employed	Total no. of people employed	Proportion of people employed, who were Indigenous (%)
<b>Northern Territory</b>			
Health services delivery staff			
Medical staff	3	235	1.3
Nursing staff <sup>(b)</sup>	24	1,284	1.9
Aboriginal and Torres Strait Islander health worker	73	73	100.0
Welfare and community workers	21	91	23.1
Allied health	16	234	6.8
Dental practitioners	0	13	0.0
Pharmacists	0	8	0.0
Other	22	157	14.0
Management and support staff			
Program/service/unit managers	25	260	9.6
Policy/project officers and administrative workers <sup>(c)</sup>	88	789	11.2
Operational staff <sup>(d)</sup>	23	142	16.2
<b>Total</b>	<b>295</b>	<b>3,286</b>	<b>9.0</b>

(a) Includes health, community services, and health and community services undefined.

(b) Includes registered and enrolled nurses.

(c) Includes business and information professionals; accountants, auditors and corporate treasurers; sales, marketing and advertising professionals; computing professionals; miscellaneous business and information professionals; advanced clerical and service workers; intermediate clerical, sales and service workers; intermediate production and transport workers; and elementary clerical, sales and service workers.

(d) Includes labourers and related workers; cleaners; other labourers and related workers; and food tradespersons (includes cooks).

Source: ABS Census of Population and Housing 2001.

### **Box 20.1: Data issues**

*Specifications for this indicator stipulate EEO, affirmative action or workforce surveys conducted by state and territory health departments as the sources of data for this indicator. Most states and territories had limited information available to report against this indicator; surveys are often limited to the government-employed workforce and may not cover all professions listed above.*

*Census data covering the health and community services sectors was therefore used for this indicator. The distinction between the health and community service sectors in these data was not clear enough to allow for health services reporting only. Professional categories stipulated for reporting against this indicator were not neatly identifiable within Census data. Furthermore, the employment categories to be reported under 'management and support staff' were not defined in the technical specifications for this report.*

## Indicator 21. Higher education and training in key health professions

### Indicator:

- (a) The number of Aboriginal and Torres Strait Islander people who gained a health qualification in the previous academic year.
- (b) The number of Aboriginal and Torres Strait Islander people who are training in key health-related fields in the vocational education sector or the higher education sector.

### Purpose

This indicator measures vocational education and training, and entry into the health professional workforce. The numbers of Indigenous people training in key health professions, or who have recently qualified, are important measures of the participation of Indigenous people in delivering health services. These measures assist in assessing the extent to which the capacity of Indigenous people to deliver health services to Indigenous people is being developed.

### Data

The data are likely to understate the number of Aboriginal and Torres Strait Islanders enrolled and qualified. Data are presented for the 2002 calendar year only.

- The majority of Aboriginal and Torres Strait Islander students (57%) who qualified as Aboriginal Health Workers in 2002 completed the Certificate II course.
- Of the professions presented, enrolments in Aboriginal health work attracted the highest numbers of Indigenous students in 2002 (1,653). Allied health and university nursing studies also attracted larger numbers of students.
- The majority of Aboriginal and Torres Strait Islander people who held a health qualification (822) were Aboriginal Health Workers. This was also the case for the 1,653 Aboriginal and Torres Strait Islander people training.
- Queensland had the highest number of Aboriginal Health Workers (468 qualified and 306 enrolled), followed by New South Wales (301 qualified and 330 enrolled).
- There were 96 Aboriginal and Torres Strait Islander people who qualified as nurses in 2002, including university and non-university trained, and a further 586 were in training.
- There were 40 Aboriginal and Torres Strait Islander people who qualified as allied health workers in 2002, and a further 394 were in training.
- No Aboriginal and Torres Strait Islander people were qualified in dental health, and only two were enrolled in training.
- One Aboriginal and Torres Strait Islander was qualified as a pharmacist, and 10 were enrolled in training.

**Table 21.1: Number of Aboriginal and Torres Strait Islanders qualifying<sup>(a)</sup> or currently enrolled in training and higher education, 2002**

Profession	Certificate II	Certificate III	Certificate IV	Diploma	Adv.Diplom /Ass. degree	Bachelor	Masters
<b>Aboriginal Health Worker</b>							
Qualified	468	260	30	39	2	20	3
Enrolled	369	731	257	163	40	81	12
<b>Nursing</b>							
Qualified	7	16	16	3	0	2	6
Enrolled	11	35	167	51	3	14	6
<b>Nursing (university)</b>							
Qualified						46	0
Enrolled						299	0
<b>Medicine</b>							
Qualified						6	0
Enrolled						104	0
<b>Allied health</b>							
Qualified					0	34	6
Enrolled				39	9	329	17
<b>Health management</b>							
Qualified					0	10	6
Enrolled				0	1	104	14
<b>Pharmacy</b>							
Qualified					0	1	0
Enrolled				0	0	10	0
<b>Dental</b>							
Qualified					0	0	0
Enrolled				0	0	2	0
<b>Public health</b>							
Qualified					14	0	2
Enrolled				57	92	28	13
<b>Total</b>							
<b>Qualified</b>	<b>475</b>	<b>276</b>	<b>46</b>	<b>42</b>	<b>16</b>	<b>119</b>	<b>23</b>
<b>Enrolled</b>	<b>380</b>	<b>766</b>	<b>424</b>	<b>310</b>	<b>145</b>	<b>971</b>	<b>62</b>

*Note:* Shading indicates that data quality is affected by some Indigenous students' decision not to identify as such. Therefore, these figures are likely to be an underestimate.

*Sources:* Higher Education Student Collection of the Department of Education, Science and Training; National Centre for Vocational Educational Research Ltd.

**Table 21.2: Number of Aboriginal and Torres Strait Islanders qualifying<sup>(a)</sup> or currently in training and higher education, by state and territory, 2002**

	Aborigin. Health Worker	Nurs. <sup>(b)</sup>	Nurs. (uni)	Medicine	Allied health	Health managemt	Pharmacy	Dental	Public health
<b>NSW</b>									
Qualified	301	34	13	3	18	7	—	—	1
Enrolled	330	84	80	46	70	41	—	—	4
<b>Vic</b>									
Qualified	10	6	5	—	6	—	—	—	—
Enrolled	67	69	33	5	77	9	2	—	6
<b>Qld</b>									
Qualified	468	5	16	1	6	5	1	—	—
Enrolled	306	50	89	20	95	46	6	2	9
<b>WA</b>									
Qualified	7	2	3	1	6	—	—	—	13
Enrolled	299	18	22	16	51	4	—	—	97
<b>SA</b>									
Qualified	2	—	3	1	1	—	—	—	1
Enrolled	249	8	30	14	29	12	—	—	4
<b>Tas</b>									
Qualified	4	3	3	—	2	—	—	—	—
Enrolled	4	8	14	3	3	1	2	—	—
<b>ACT</b>									
Qualified	4	—	1	—	—	3	—	—	1
Enrolled	12	—	2	—	5	3	—	—	—
<b>NT</b>									
Qualified	24	0	—	—	1	0	—	—	—
Enrolled	328	28	17	—	62	0	—	—	70
<b>Aust<sup>(c)</sup></b>									
<b>Qualified</b>	<b>822</b>	<b>50</b>	<b>46</b>	<b>6</b>	<b>40</b>	<b>16</b>	<b>1</b>	<b>—</b>	<b>16</b>
<b>Enrolled</b>	<b>1,653</b>	<b>287</b>	<b>299</b>	<b>104</b>	<b>394</b>	<b>119</b>	<b>10</b>	<b>2</b>	<b>190</b>

(a) 'Qualified' students are those who completed studies in 2002.

(b) These nursing students include enrolled nurses, nursing assistants and dental nurses.

(c) Includes multijurisdictional data and students whose residential postcode is unknown.

Sources: AVETMISS database for vocational education and training sector courses; Department of Employment, Science and Training for higher education courses.

## Quality of the data

Higher education institutions are autonomous, and the Australian Government exercises no control over their activities. However, institutions that receive funding from the Australian Government are responsible under the *Higher Education Funding Act 1988* for ensuring equity of access. The Australian Government monitors the achievement of equity objectives through the annual educational profiles process, for which institutions are required to provide an Indigenous education strategy. These strategies detail the approach adopted by institutions to

increase participation of Aboriginal and Torres Strait Islander students and to advance the goals of the National Aboriginal and Torres Strait Islander Education Policy.

Base operating grants to higher education institutions include allocations from the Indigenous Support Funding Program to meet the specific needs of Indigenous students. The program supports activities such as the establishment of Indigenous education and/or support units, assistance with study skills, counselling and cultural awareness activities. The allocation of funding is calculated on the basis of participation (Equivalent Full Time Student Units), student progress and completion of award courses. While encouraging Indigenous students to identify as such is the responsibility of individual higher education institutions, the Australian Government provides directions and incentives to the institutions to do so.

### **Australian Government programs**

The Australian Government has encouraged increased participation of Indigenous Australians in higher education, particularly through Indigenous Support Funding and the requirement for reporting Indigenous education strategies for the annual education profiles process. Indigenous Support Funding assists institutions to meet the specific needs of Indigenous students and advance the goals of the Aboriginal and Torres Strait Islander Education Policy.

In addition, the Australian Government provides financial assistance to Indigenous students in the form of ABSTUDY to target benefits to those students most in need of assistance.

ABSTUDY represents a major component of the Government's commitment to Indigenous education to:

- ensure Aboriginal and Torres Strait Islander involvement in educational decision making;
- provide equality of access for Aboriginal and Torres Strait Islander peoples to education services;
- raise the rates of Aboriginal and Torres Strait Islander participation in education to those for all Australians; and
- achieve equitable and appropriate educational outcomes for Aboriginal and Torres Strait Islander people.

The Aboriginal Tutorial Assistance Scheme is targeted at students requiring supplementary tutorial assistance. Under the scheme, 36 universities are funded to provide additional tutorial assistance to help students stay at university and complete award courses. Indigenous students who are assessed as requiring additional assistance with their studies may receive assistance from a tutor, either individually or in a small group.

The Vocational Education Guidance Assistance Scheme provides grants to sponsoring organisations to conduct projects for Indigenous students to foster positive attitudes towards participation in education and provide information to help students to consider their options for further study and career.

## Indicator 22. Workforce availability in primary health care services

**Indicator:** The number of health professionals working in primary health care centres that provide care in populations where more than 60% of the catchment population are Aboriginal and Torres Strait Islander people.

### Purpose

Providing adequate care to meet the needs of Aboriginal and Torres Strait Islander people is an important goal for all states and territories. This indicator measures the number and professional expertise of health workers employed in primary health care services that serve a majority of Aboriginal and Torres Strait Islander people.

### Data

Information for this indicator was obtained from OATSIH.

The concept of a 'catchment population', defined as the number of people resident within the catchment area of a service, was difficult to apply. A number of states and territories reported an inability to determine the catchment populations of primary health care services.

'Catchment population' should probably be redefined as 'service population', that is, the number of Aboriginal and Torres Strait Islander people attending a primary care service.

Therefore, instead of using data from the states and territories, data from the Australian Government's SAR annual data collection is used for this indicator. The SAR collects data on full-time equivalent positions in Australian Government-funded Aboriginal and Torres Strait Islander primary health care services. It also measures the number of people using these services. SAR does not record catchment proportions, nor is this able to be derived from the data. However, many of these services are in areas with a high proportion of Indigenous people.

- At 30 June 2001, 2,314 full-time equivalent positions were reported to exist in Australian Government-funded Aboriginal and Torres Strait Islander primary health care services.
- Western Australia reported the highest number of full-time equivalent positions (529), followed by the Northern Territory (494).
- Aboriginal Health Workers comprised 27% of this workforce, while Indigenous nursing staff and GPs represented 9.4% and 7.0% of the full-time equivalent positions in these services.

**Table 22.1: Full-time equivalent positions employed by Australian Government-funded Aboriginal and Torres Strait Islander primary health care services<sup>(a)</sup>, 30 June 2001**

	NSW & ACT	Vic	Qld	WA	SA	Tas	NT	Australia
<b>Aboriginal Health Workers</b>	106.9	57.6	94.1	147.6	84.3	11.1	122.2	623.8
<b>Medical staff</b>								
GPs	30.3	9.1	33.6	38.4	14.5	2.1	34.2	162.1
Specialists	1.3	—	0.1	0.6	—	—	—	2.0
Nursing staff	28.5	16.8	27.1	62.3	33.5	2.5	47.4	218.0
Allied health <sup>(b)</sup>	15.7	7.5	28.1	19.9	12.1	4.0	19.5	106.7
<b>Dental</b>								
Dentists	15.4	4.0	6.8	1.8	3.0	0.4	2.1	33.5
Dental assistants	21.3	5.0	12.0	1.6	2.0	0.5	2.1	44.5
Orthodontists	0.2	—	—	—	—	—	—	0.2
<b>Pharmacy</b>	—	0.5	—	—	—	—	0.4	0.9
<b>Other health</b>								
Traditional healers	—	1.0	—	—	3.8	—	3.6	8.4
Substance misuse workers	13.2	12.5	5.6	21.2	8.8	0.7	10.0	71.9
Environmental health workers	0.6	1.0	—	18.2	3.0	—	3.0	25.8
Drivers/field officers	29.9	11.9	20.8	15.2	6.5	0.4	25.0	109.7
Other health staff	2.5	4.3	16.0	10.0	15.0	0.5	21.5	69.8
<b>Management/administrative staff</b>								
CEO/administrator/managers	37.0	28.1	43.0	44.6	28.5	4.8	56.8	242.7
Secretaries/receptionists	41.9	13.4	51.1	49.5	26.5	8.0	54.0	244.4
Accountants/bookkeepers	22.9	11.6	16.3	25.2	11.0	2.0	17.6	106.7
Information systems/data staff	1.9	—	3.0	11.5	4.0	0.4	14.0	34.8
Trainers/educators	0.5	1.0	1.0	12.5	8.0	—	25.8	48.8
Cleaners/cooks/gardeners	20.2	4.3	11.6	36.1	12.2	2.8	20.1	107.3
Other	6.7	3.1	6.9	13.0	7.4	—	15.0	52.0
<b>Total</b>	<b>396.8</b>	<b>192.6</b>	<b>376.9</b>	<b>529.0</b>	<b>284.1</b>	<b>40.1</b>	<b>494.4</b>	<b>2,313.9</b>

(a) Only respondent Australian Government-funded SAR services are included.

(b) Includes qualified counsellor, audiologist, chiropractor, dietitian, naturopath, nutritionist, optometrist, physiotherapist, podiatrist, remedial therapist and speech therapist.

Source: Department of Health and Ageing Service Activity Reporting 2000–01.

**Box 22.1: Data issues**

*The concept of a catchment area where more than 60% of the population are Aboriginal and Torres Strait Islander people was difficult for states and territories to measure. It was agreed to use Australian Government SAR data on Aboriginal and Torres Strait Islander community-controlled health services. These organisations provide services to mainly to the Indigenous population, yet some of these services may be located in areas where Indigenous people make up only a small proportion of the total population.*

*The provision of culturally appropriate health services and the employment of Indigenous staff in these services may affect the access of Aboriginal and Torres Strait Islander people. Therefore, it is important to report information on the proportion of this workforce who are Aboriginal and Torres Strait Islander people..*

*The definition of a 'Primary health care service' in the indicator specifications says that these services must include all of the following: 24 hour service, treatment, access to registered health worker, access to a doctor, immunisation services, antenatal care, screening and early interventions services, women's and men's health programs, sexually transmitted infection and communicable disease control. If applied strictly, this definition would have seriously limited the number of services for which data were reported.*

## Indicator 23. Workforce availability in hospitals

**Indicator:** The number of positions for medical officers, nurses, Aboriginal Health Workers and Aboriginal liaison officers in acute care hospitals where more than 25% of the separations are for Aboriginal and Torres Strait Islander people.

### Purpose

Providing adequate care for Aboriginal and Torres Strait Islander people in hospitals dealing with a high proportion of Indigenous people is important in addressing their needs for health care. This indicator describes the medical and nursing capacity and the availability of special support services in hospitals that provide care for Aboriginal and Torres Strait Islander peoples.

### Data

Data was provided by the states and territories. Victoria, Tasmania and the Australian Capital Territory do not have any acute care hospitals that reported more than 25% of separations for Aboriginal and Torres Strait Islander people.

- In 2001–02, 76 hospitals in Australia reported that more than one-quarter of their separations were for Aboriginal and Torres Strait Islander people.
- Queensland had 33 hospitals with 598 full-time and 439 part-time nurses; 160 full-time and 35 part-time medical staff, 91 full-time and 9 part-time Aboriginal Health Workers and 17 full-time Aboriginal Liaison Workers.
- In Western Australia there were 18 hospitals with more than 25% Indigenous separations. These employed 416 full-time and 237 part-time nursing staff, 43 full-time and 1 part-time medical staff, 32 full-time and 1 part-time Aboriginal Health Workers, and 11 full-time and 2 part-time Aboriginal Liaison Workers.
- In the Northern Territory there were 5 such hospitals, with 716 full-time and 255 part-time nursing staff, 238 full-time and 25 part-time medical staff, 18 full-time and 1 part-time Aboriginal Health Workers, and 16 full-time and 1 part-time Aboriginal Liaison Officers.
- In New South Wales there were 14 hospitals reporting more than 25% Indigenous separations, but data were only provided for four of these. This was because some hospitals did not meet the definition of an 'acute care hospital' and some hospitals/area health services did not respond to requests for information on workforce availability. In the four hospitals for which data was provided, there were 94 full-time and 41 part-time nurses, 2 full-time and 2 part-time medical staff, 4 full-time Aboriginal Health Workers and 2 part-time Aboriginal Liaison Officers.
- In South Australia there were 6 hospitals reporting more than 25% Indigenous separations, but no data on the workforce were available.

**Table 23.1: Medical workforce numbers in acute care hospitals where more than 25% of separations are for Aboriginal and Torres Strait Islander people<sup>(a)</sup>, for selected states and territories, 2002**

	NSW <sup>(b)</sup>	Qld <sup>(c)</sup>	WA	NT
<b>Aboriginal Liaison Officers</b>				
Full-time	—	17	11	16
Part-time	2	—	2	1
<b>Aboriginal Health Workers</b>				
Full-time	4	91	32	18
Part-time	—	9	7	1
<b>Medical staff</b>				
Full-time	2	160	43	238
Part-time	2	35	1	25
<b>Nursing staff</b>				
Full-time	94	598	416	716
Part-time	41	439	237	255
<b>Total</b>	<b>145</b>	<b>1,349</b>	<b>749</b>	<b>1,270</b>
<b>Total number of hospitals</b>	<b>4</b>	<b>33</b>	<b>18</b>	<b>5</b>

(a) Victoria, Tasmania and the Australian Capital Territory do not have any acute care hospitals that report more than 25% of separations for Aboriginal and Torres Strait Islander people. South Australia has 6 hospitals that report more than 25% of separations for Aboriginal and Torres Strait Islander people, but no data were available.

(b) Data for New South Wales was only provided for 4 of the 14 hospitals.

(c) The data provided for Queensland relate to 30 June 2003 workforce data. The number of casual positions within these hospitals was also provided; however, for consistency, these have not been reported. Queensland numbers presented are for 'Welfare and community workers'. This is the category to which Aboriginal and Torres Strait Islander Hospital Liaison Officers are assigned. It is unknown what proportion of this category comprises Aboriginal and Torres Strait Hospital Liaison Officers.

Source: Data provided by the states and territories.

## Recruitment of health workers

In New South Wales one hospital reported that recruitment of medical staff has not been an issue as GP staff have been complemented by GP registrars. Recruitment of nursing staff to vacant positions has at times been difficult, but agency nurses were used until recruitment took place. Specific reasons include limited numbers of suitably qualified people, both Aboriginal and non-Aboriginal, to fill advertised positions; difficulty in providing inducements for people to relocate for jobs (this is influenced by the current economic climate); and problems holding Aboriginal staff in rural areas after they have completed their training because they wish to live in larger towns. Some health services use various recruitment strategies and devote additional resources to identifying potential staff and recruiting them to the service.

**Box 23.1: Data issues**

*The definition of 'Acute care hospital' included in the specifications for this indicator was problematic. 'Acute care hospital services' are defined as having a 24-hour staffed emergency department, 24-hour medical supervision or on-call roster, round-the-clock comprehensive nursing and other necessary professional services, and a referral network to specialist services to promote continuity of care. It is recommended that the National Health Data Dictionary definition of an 'acute care episode for admitted patients' be used for this indicator. Throughout this report the definition of a hospital in the National Health Data Dictionary was used.*

*The specifications called for workforce data in even-numbered calendar years. Information on workforce provided generally related to a point in time, usually 30 June 2002. As separations data are normally calculated on a financial year basis, the data were requested for hospitals reporting more than 25% Indigenous separations in 2001-02.*

## Indicator 24. Cross-cultural training for hospital staff

### Indicator:

- (a) The proportion of acute care hospitals where staff receive information about Aboriginal and Torres Strait Islander values and cross-cultural issues, as part of orientation.
- (b) The proportion of new staff in acute care hospitals who have completed appropriate orientation training in the past year.

### Purpose

This indicator provides a measure of the commitment of acute care hospitals to provide staff with cross-cultural training and orientation for working with Aboriginal and Torres Strait Islander people. Such training will assist in improving Indigenous access to services, through the delivery of culturally sensitive services.

### Data

Information for this indicator was obtained from the states and territories. States and territories could not provide quantitative data for this indicator and only written responses are provided.

#### New South Wales

New South Wales reported difficulty collecting this information given the lack of defined curricula regarding the content and delivery of orientation programs in area health services.

A review was held in New South Wales Health in 1999 to examine 'The effectiveness of cultural awareness training in the New South Wales public health system'. It found these programs did not always include skills and knowledge needed for staff to become competent to work in cross-cultural situations. Recommendations from this review have not been implemented to date.

In consideration of the draft Cultural Respect National Framework 2003–08 being developed by SCATSIH, New South Wales Health is currently undertaking a comprehensive survey throughout all Health Services to determine numbers of staff who have attended courses, and the duration, content and assumed effectiveness of cultural awareness programs. Information from the survey will not be available until late August 2003.

In some area health services orientation is limited to between 5 and 15 minutes for Aboriginal health, and some orientation programs have no Aboriginal health content at all. Specific cultural issues are seldom addressed. New South Wales Health and many health services do not have a policy of mandatory or compulsory training for additional cultural awareness.

The New South Wales Health Department has identified the need for a shift in emphasis from shaping attitudes to changing behaviour in order to deliver effective services. A program is being devised in a twelve-month project. This will include a framework of principles and protocols and be linked to the Australian National Training Authority competency standards Health Unit HLTHIR4A 'Work in a cross-cultural setting with Aboriginal and Torres Strait Islander people and organisations'.

A review was commissioned to investigate the effectiveness of cultural awareness training in New South Wales Health. In commissioning the review, it was recognised that there had been no agreement about the goals of cultural awareness training and inconsistent approaches to evaluation.

The report from the review, entitled 'Regarding the effectiveness of cultural awareness training' (1999), by Dench McClean for New South Wales Health, includes the following key recommendations:

- agreeing common goals for the training;
- providing this type of training for all managers and frontline staff;
- developing consistent evaluation procedures;
- linking it more closely to recruitment, induction, performance management and other Departmental initiatives (such as the Aboriginal Employment Strategy);
- providing support and qualified resources for current CAT trainers; and
- developing a flexible 'toolkit' for trainers which provides content or references to nationally and internationally available materials, techniques and ideas.

## **Victoria**

Victoria reported cross-cultural training in only 14 out of 112 hospitals during 2000-01, and 15 of 112 hospitals in 2001-02. Cross-cultural training was not necessarily provided as part of the orientation program. Some hospitals use external providers to train all staff, not just new starters. A number of hospitals had elements of cross-cultural training in their regular training program but did not know how many staff received training. In smaller hospitals with low staff turnover training programs are conducted as needed. Liaison officers provide formal training as part of the orientation or staff development program and also informal training as required.

## **Queensland**

There were no accreditation systems utilised by Queensland public hospitals that require mandatory cross-cultural awareness programs for hospital staff. All existing accreditation systems would support hospitals implementing such programs.

While individual hospitals are not required to have cross-cultural awareness programs in place, Queensland Health requires all Queensland Health staff to participate in the Queensland Health Aboriginal and Torres Strait Islander Cultural Awareness Training Program under the revised Minimum Standards for Cultural Awareness.

The Rural Health Training Units in each of Queensland Health's three zones facilitate the training program. Over 6,000 staff have completed the Queensland Health Aboriginal and Torres Strait Islander Cultural Awareness Training Program across all health service districts and corporate offices. In addition to cross-cultural awareness, Queensland Health has trained 178 facilitators to conduct the Reconciliation Learning Circle Program throughout the state. Currently 800 Queensland Health staff have participated in this program.

Two other initiatives support increased accessibility and appropriateness of health services for Aboriginal and Torres Strait Islander peoples. The first of these is the development of a Queensland Health Aboriginal and Torres Strait Islander Cultural Respect Implementation Plan. This plan will effect systemic change within the health system. The second is the 'One Talk' Aboriginal and Torres Strait Islander Community Participation Manual. This manual outlines protocols for effective engagement between Queensland Health staff and Aboriginal and Torres Strait Islander peoples and communities.

## **Western Australia**

Of the 77 acute care hospitals in Western Australia, 65 reported cross-cultural aspects within training programs in 2000-01, and 67 in 2001-02. In 2000-01, a total of 2,748 (53% of the total

5,191) new staff completed orientation in the previous year. The proportion was the same in 2001–02, with 2,852 (53% of the total 5,378) of the new staff undergoing orientation.

Western Australia noted some difficulties in providing this information, and suggests caution in the interpretation. Furthermore, they highlighted inconsistencies between hospitals in their interpretation of ‘cross-cultural aspects’ in training programs.

### **South Australia**

Cross-cultural awareness training is undertaken in South Australia by hospitals and health services on an ad hoc basis. During the reporting periods there was no uniform cultural-awareness training strategy. However, a Cross Cultural Awareness Training Tool is being developed and will be used in hospitals and health services from 2003.

### **Tasmania**

Tasmania could not provide data for this indicator. It was noted that formal cross cultural-training was not provided to hospital staff in 2000–01 and 2001–02. However, Aboriginal Liaison Officers in two major public hospitals assist in raising cultural awareness with hospital staff.

### **Australian Capital Territory**

The Australian Capital Territory’s two acute care facilities did not provide specific Aboriginal and Torres Strait Islander values and cross cultural issues in their workplace diversity modules of their orientation programs. However, in 2001 the health portfolio conducted cultural awareness training for portfolio staff including acute care facility staff.

### **Northern Territory**

Cross-cultural training is provided at all five Northern Territory public hospitals through the Aboriginal Cultural Awareness Program (ACAP). This course was developed by the department in collaboration with the Northern Territory University’s Faculty of Indigenous Research and Education. There are various ACAP programs to accommodate the needs of staff. One-day courses are compulsory for all staff and are usually included as part of formal staff orientation. Hospital staff may choose to attend other programs, such as a two-day course that focuses on remote communities.

High staff turnover is a problem for extended courses, which are run in Darwin every month, and less often in other locations. There are plans to trial a two hour program.

#### **Box 24.2: Data issues**

*States and territories generally did not collect quantitative data for this indicator and it was agreed to report descriptive data.*

*A variety of interpretations of ‘cross-cultural training’ resulted in inconsistencies in reporting both across states and territories and within states and territories. For example, some hospitals may report training that includes a brief mention of cross-cultural issues, whereas other hospitals report half-day workshops about Aboriginal cultural issues. There were also difficulties about whether to include agency staff or short-term staff when reporting on cross-cultural training.*