

Determinants of health—social equity

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Introduction

The subdomain Determinants of health – social equity comprises 10 indicators. The first two indicators are accepted health measures of social equity – life expectancy and infant mortality. These are followed by indicators that measure different aspects of social equity and government inputs in these areas: income poverty, secondary school education completion, employment status, housing with utilities, and imprisonment rates. The final three indicators relate to governance and capacity building for Indigenous people – the development of governance capacity, Indigenous representation on hospital boards and reporting of complaints. These three indicators measure government efforts to enable Indigenous people to contribute to the management and development of the health system.

The AIHW provided data for infant mortality. Like the other mortality data included in this report, coverage of Indigenous deaths is only complete enough for statistical reporting in four states and territories – Queensland, Western Australia, South Australia and the Northern Territory. This is also the case for the data on life expectancy that was provided by the ABS.

The ABS also provided the data for five of the other indicators in this subdomain: income, education and employment are from the 2001 Census of Population and Housing. The tables provided here are based on actual counts from the 2001 Census of Population and Housing and as such are not adjusted for under-enumeration. The data on imprisonment rates comes from the ABS Prisoners Census. The data on housing utilities comes from the ABS CHINS survey, 2001. This survey is limited in scope as it only captures data from discrete Indigenous communities and therefore does not include all Indigenous housing. The data for this survey are provided by key community informants and not by individual householders.

The data for the indicators on governance and capacity building were provided by the states and territories. The information provided for these three indicators is descriptive data only. There were no consistent quantitative data available on Indigenous representation on hospital boards or on the reporting of complaints in hospitals.

Indicator 5. Life expectancy at birth

Indicator: Life expectancy at birth for the Aboriginal and Torres Strait Islander population compared to the total Australian population, by sex.

Purpose

Life expectancy at birth is an internationally used summary measure of the health and wellbeing of populations. Life expectancy is determined by a range of different factors including socioeconomic status, biomedical risk factors, quality and access to the health system, and genetics.

Data

Information for this indicator was obtained from the ABS.

Life expectancy at birth is the number of years a person born in the reference year can expect to live if they experience the current age-specific death rates. Given the problems experienced in accurately measuring the death rates for the Aboriginal and Torres Strait Islander population, life expectancy indicators are difficult to calculate, so care should be taken when interpreting these data.

Table 5.1: Experimental estimates of life expectancy at birth (years), by Indigenous status and sex, selected states and territories, 1999–01

	Qld	WA	SA	NT
Males				
Indigenous males	57	56	55	56
All males	77	77	77	71
Females				
Indigenous females	63	63	61	62
All females	82	83	83	77

Notes

1. Data are presented for those states and territories with more complete coverage of Indigenous deaths.
2. Indigenous life expectancy estimates are experimental and actual life expectancy is expected to be within four years of the estimates provided.
3. The experimental life tables used to estimate life expectancy at birth are based on the 1996 Census.

Source: Tables 6.30, 6.31 from the Australian life table; Table 6.44 from the experimental life table of Indigenous people: ABS *Deaths, Australia 2002*.

- Over the period 1999–01, the life expectancy at birth for Indigenous people was estimated to be around 56 years for males and 63 years for females. This was some 19 to 21 years lower than life expectancy estimates for the total Australian population (77 years for males and 82 years for females).
- The life expectancy estimates reported in Table 5.1 are based on experimental population estimates based on the 1996 Census of Population and Housing. The Preston-Hill method was used by the ABS to construct an experimental model life table for the Indigenous population which gives an estimation of life expectancy at birth. The ABS is currently reviewing the appropriateness of this method and the assumptions involved.

- The estimated life expectancy of Aboriginal and Torres Strait Islander males and females was also much lower than that of Indigenous people in New Zealand and Canada. The life expectancy of Maoris for 1995–97 was 67.2 years for males and 71.6 years for females, while the life expectancy of Canadian First Nations people in 2000 was 68.9 years for males and 70.2 years for females (Statistics New Zealand 2003; Health Canada 2002).

Indicator 6. Infant mortality rate

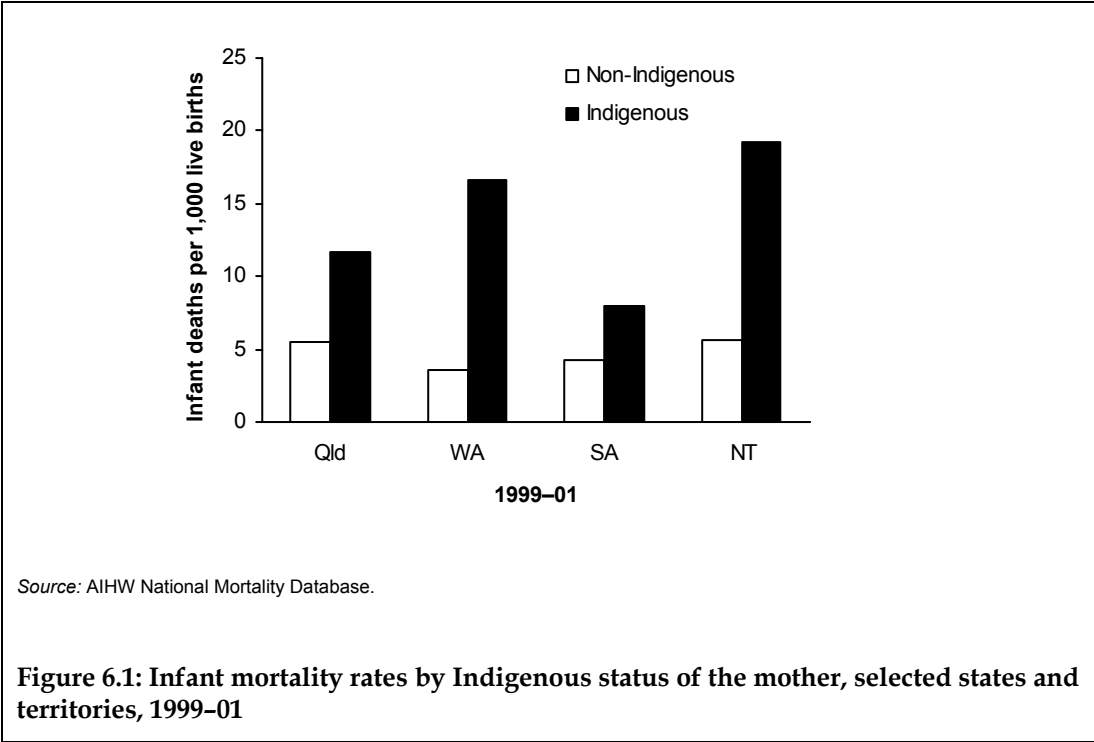
Indicator: The number of deaths of infants (children less than one year old) born to Aboriginal and Torres Strait Islander mothers, per 1,000 live births to Aboriginal and Torres Strait Islander mothers.

Purpose

This indicator is an internationally recognised measure of population health and is regarded as an important measure of general health and wellbeing. Infant mortality is an indicator of the quality of antenatal care, the effectiveness of obstetric services and the quality of infant care in the hospital and in the community. Infant mortality is also an indicator of maternal health, and a high infant mortality rate is associated with poor socioeconomic conditions.

Data

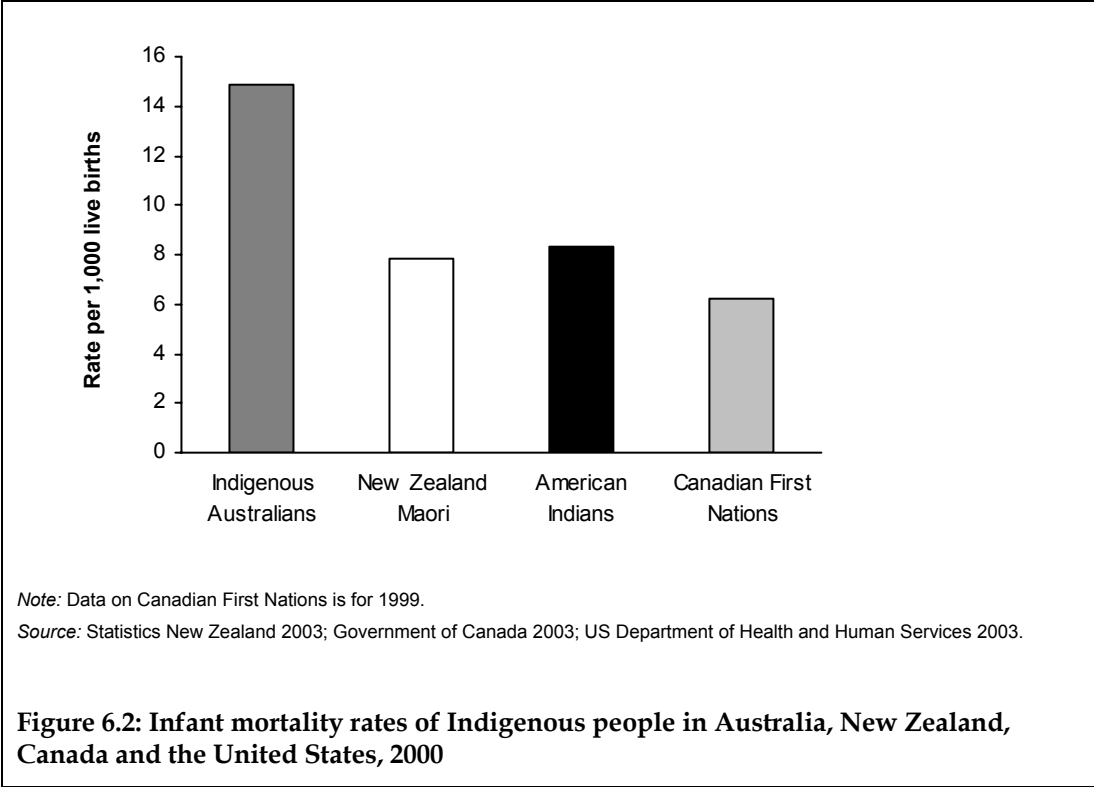
Information for this indicator was obtained from the AIHW National Mortality Database. The quality of the data on deaths of infants varies across states and territories and only data for Queensland, South Australia, Western Australia and the Northern Territory were considered to be sufficient to calculate rates. Three years of data (1999–2001) were combined in order to smooth out yearly fluctuations in the number of infant deaths, which can cause variability in rates.



- In 1999–2001, of the four states and territories with reliable data, the infant mortality rate ranged from 8.0 per 1,000 in South Australia to 19.2 per 1,000 in the Northern Territory. In Western Australia the rate was 16.6 per 1,000 and in Queensland 11.7 per 1,000.

International comparisons

- The overall mortality rate for Aboriginal and Torres Strait Islanders infants, in 2000 in the four states and territories with reliable data, was 14.9 per 1,000. (The three-year average infant mortality rate for 1999–2001 in the four states and territories was 14.2 per 1,000.)
- In comparison in 2000, the infant mortality rate was 7.8 per 1,000 for New Zealand Maori, 8.3 per 1,000 for American Indians and in 1999 was 6.2 per 1,000 for First Nations people in Canada (Statistics New Zealand 2003; Government of Canada 2003; US Department of Health and Human Services 2003).



Indicator 7. Income poverty

Indicator:

- (a) The proportion of Aboriginal and Torres Strait Islander households where household size-adjusted weekly income is less than the 20th percentile of all Australian household size-adjusted weekly income.
- (b) The proportion of Aboriginal and Torres Strait Islander households where household size-adjusted weekly income is less than the 50th percentile of all Australian household size-adjusted weekly income.

Purpose

The measures provide an indication of the level of relative economic disadvantage of Aboriginal and Torres Strait islander people compared to two national income measures for all Australians. The expected proportions, if there is no relative economic disadvantage, is that 20% will fall below the 20th percentile and 50% will fall below the 50th percentile.

Data

Information for this indicator was obtained from the ABS Census of Population and Housing. Data provided is for average weekly equivalised household income on a person basis, not on a household basis as specified in the indicator. Equivalence scales were used to adjust the incomes of people in a way that enabled the analysis of the relative wellbeing of people living in households of different size and composition.

Table 7.1: Proportion of persons with household size-adjusted weekly incomes below the Australian 20th and 50th percentiles, by Indigenous status and state and territory, 2001

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia ^(a)
Less than 20th percentile^(b)									
Indigenous	42	38	41	49	46	40	25	63	45
Non-Indigenous	19	19	20	19	22	25	10	11	19
Total^(c)	20	19	21	20	22	26	11	25	20
Less than 50th percentile^(d)									
Indigenous	76	72	79	83	82	77	52	90	80
Non-Indigenous	47	49	53	49	55	61	30	32	49
Total^(c)	48	49	54	50	55	62	31	49	50

(a) Total for Australia includes other territories.

(b) Adjusted weekly income threshold for 20th percentile of the total Australian population—\$265.

(c) Total includes persons for whom Indigenous status was not determined.

(d) Adjusted weekly income threshold for 50th percentile of the total Australian population—\$495.

Note: Based on residents in occupied private dwellings where individual income was stated by all household members.

Source: ABS Census of Population and Housing 2001.

- In all states and territories a higher proportion of Indigenous persons than of non-Indigenous persons had household size-adjusted weekly incomes less than the 20th percentile—45% of Indigenous persons were below this point compared to 19% of non-Indigenous households.

- The extent of the economic disadvantage varied by state and territory but was most marked in the Northern Territory where 63% of Indigenous persons fell below the 20th percentile compared with 11% of non-Indigenous persons. By contrast, in the Australian Capital Territory only 25% of Indigenous persons fell below this mark, compared to 10% of non-Indigenous persons.
- Australia-wide, 80% of Indigenous persons had an adjusted weekly income below the 50th percentile, compared to 49% of non-Indigenous persons.
- The distribution by state and territory was similar to the 20% pattern described above. The proportion of Indigenous persons with a household size-adjusted weekly income that fell below the 50th percentile was highest in the Northern Territory (90%), followed by Western Australia (83%) and South Australia (82%).
- In the Australian Capital Territory, the proportion of Indigenous persons with a household size-adjusted weekly income below the 50th percentile was close to the overall Australian proportion (52% compared with 50%), whereas only 30% of non-Indigenous persons were below the 50th percentile.

Indicator 8. Completed secondary school education

Indicator: The proportion of Aboriginal and Torres Strait Islander people aged 20–24 years who have completed secondary school (or equivalent level of education), by sex.

Purpose

Education is important for the overall wellbeing of people. The completion of secondary school education helps young people to obtain gainful employment. Education increases an understanding of the determinants of good health.

Data

Information for this indicator was obtained from the ABS Census of Population and Housing.

Table 8.1: Number and proportion of people aged 20–24 years who completed Year 12 or equivalent, by sex, Indigenous status and state and territory, 2001

	Number				%			
	Indigen. males	Non-Indigen. males	Indigen. females	Non-Indigen. females	Indigen. males	Non-Indigen. males	Indigen. females	Non-Indigen. females
NSW	1,242	121,373	1,553	136,332	27.4	63.5	35.9	73.2
Vic	318	96,602	395	111,958	32.4	66.1	41.0	78.4
Qld	1,882	72,706	1,991	81,035	41.7	66.5	43.7	74.9
WA	514	34,777	606	38,703	22.4	60.2	24.9	69.7
SA	179	25,716	242	29,442	19.5	58.7	26.4	70.3
Tas	172	6,234	198	6,888	30.1	50.6	32.4	56.6
ACT	84	9,847	92	10,145	56.4	82.4	58.2	85.9
NT	192	2,756	250	2,899	7.9	55.4	10.5	66.1
Aust	4,588	370,047	5,330	417,438	28.0	64.1	32.6	74.2

Note: Totals used to calculate percentages include cases where Indigenous status was not stated.

Source: ABS Census of Population and Housing 2001.

- In 2001, the proportion of Indigenous males aged 20–24 years who had completed Year 12 or equivalent was less than half the non-Indigenous proportion (28% compared with 64%).
- The highest secondary school completion rate for Indigenous males was in the Australian Capital Territory where 56% had completed Year 12, and was lowest in the Northern Territory where only 8% had completed Year 12. The proportion of Indigenous males who completed Year 12 or equivalent was also low in South Australia (20%) and Western Australia (22%).
- The difference in the proportion of Year 12 completions between Indigenous and non-Indigenous males was greatest in the Northern Territory, South Australia and Western Australia.
- In 2001, the proportion of Indigenous females aged 20–24 years who had completed Year 12 or equivalent was less than half that for non-Indigenous females (33% compared with 74%).
- The Year 12 completion rate for Indigenous females was highest in the Australian Capital Territory (58%) and lowest in the Northern Territory (11%). The proportion of females

who completed Year 12 or equivalent was also low in Western Australia (25%) and South Australia (26%).

- The difference in the proportion of Year 12 completions between Indigenous and non-Indigenous females was greatest in the Northern Territory, Western Australia and South Australia.

Indicator 9. Employment status

Indicator: The proportions of Aboriginal and Torres Strait Islander people aged 20–64 years who were employed, unemployed or not in the labour force, by full-time and part-time status.

Purpose

The proportion of people of working age who are not in employment is an indicator of socioeconomic disadvantage for a population. Poor health is strongly associated with low socioeconomic status.

Data

Information for this indicator was obtained from the ABS Census of Population and Housing.

Table 9.1: Labour force status of Indigenous persons aged 20–64 years, by state and territory, 2001

Labour force status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust ^(a)
	Per cent								
Employed part-time ^(b)	14.2	14.0	17.6	20.1	17.5	17.5	14.4	17.6	16.7
Employed full-time ^(c)	26.6	33.3	27.6	21.6	21.8	31.3	45.1	16.3	25.3
Employed but did not work any hours	2.3	2.4	2.0	2.0	2.1	2.4	3.3	1.6	2.1
<i>Employed total^(d)</i>	<i>45.3</i>	<i>52.2</i>	<i>49.9</i>	<i>46.6</i>	<i>44.3</i>	<i>52.8</i>	<i>65.1</i>	<i>37.7</i>	<i>46.6</i>
Unemployed looking for full-time work	9.6	8.1	9.0	8.2	8.6	9.3	6.0	4.3	8.4
Unemployed looking for part-time work	2.6	1.9	2.2	2.0	1.8	2.3	1.8	1.2	2.1
<i>Unemployed total</i>	<i>12.2</i>	<i>9.9</i>	<i>11.2</i>	<i>10.2</i>	<i>10.5</i>	<i>11.6</i>	<i>7.8</i>	<i>5.4</i>	<i>10.5</i>
Total in the labour force	57.5	62.1	61.1	56.7	54.7	64.5	72.9	43.2	57.1
Not in the labour force	42.5	37.9	38.9	43.3	45.3	35.5	27.1	56.8	42.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number^(e)	55,084	11,689	51,480	26,928	10,951	7,260	1,737	24,166	189,423

(a) Total for Australia includes other territories.

(b) Part-time employed includes people who worked for 1–34 hours in the week preceding the Census.

(c) Full-time employed includes those who worked for 35 hours or more in the week preceding the Census.

(d) Total employed included those who did not state hours worked.

(e) Totals exclude those whose labour force status was not stated.

Note: Only those who identified as Indigenous were included in the table.

Source: ABS Census of Population and Housing 2001.

- In 2001, 46.6% of Indigenous people were employed in part-time or full-time work, 10.5% were unemployed and 42.9% were not in the labour force.
- The proportion of Indigenous people who were employed ranged from 37.7% in the Northern Territory to 65.1% in the Australian Capital Territory.
- The majority of Indigenous people who were employed were working full-time in all states and territories except in the Northern Territory where there was a similar proportion of people in part-time and full-time employment (17.6% compared to 16.3%). This probably reflects high rates of participation in the Community Development Employment Projects scheme that operates in regional and remote areas where there is a limited labour market.

- The proportion of Indigenous people who were unemployed ranged from 5.4% in the Northern Territory to 12.2% in New South Wales.
- While the Northern Territory had the lowest proportion of Indigenous people who were unemployed, it also had the highest proportion not in the labour force (56.8%).
- The Australian Capital Territory (27.1%) followed by Tasmania (35.5%) had the lowest proportions of Indigenous people not in the labour force.

Indicator 10. Housing with utilities

Indicator: The proportion of permanent dwellings in discrete Aboriginal and Torres Strait Islander communities that had sewerage system, water, electricity or gas supply.

Purpose

Inadequate housing and water, electricity sewerage provision are associated with poor health and higher rates of infectious and parasitic diseases, respiratory diseases, diarrhoeal diseases and rheumatic fever.

Data

Information for this indicator was obtained from the ABS CHINS survey, 2001. The survey did not collect information on gas supply and therefore this is not reported.

Table 10.1: Number and proportion of permanent dwellings in discrete Indigenous communities by type of connection to water and electricity supply and sewerage systems, by state and territory, 2001

	NSW	Vic	Qld	WA	SA	Tas	NT	Aust ^(a)
Sewerage								
Connected	1,325	42	4,021	2,947	1,071	30	6,912	16,348
Not connected	—	—	9	31	—	—	261	301
<i>% connected</i>	<i>100.0</i>	<i>100.0</i>	<i>99.8</i>	<i>98.9</i>	<i>100.0</i>	<i>100.0</i>	<i>96.4</i>	<i>98.2</i>
Water								
Connected	1,325	42	4,011	2,958	1,064	30	7,014	16,444
Not connected	—	—	18	11	7	—	98	134
No supply	—	—	—	9	—	—	4	13
<i>% connected</i>	<i>100.0</i>	<i>100.0</i>	<i>99.5</i>	<i>99.3</i>	<i>99.3</i>	<i>100.0</i>	<i>97.8</i>	<i>98.8</i>
Electricity								
Connected	1,325	42	4,019	2,948	1,049	30	6,910	16,323
Not connected	—	—	7	27	18	—	125	177
No supply	—	—	3	3	4	—	70	80
<i>% connected</i>	<i>100.0</i>	<i>100.0</i>	<i>99.7</i>	<i>99.0</i>	<i>97.9</i>	<i>100.0</i>	<i>96.3</i>	<i>98.0</i>
Total^(b)	1,325	42	4,030	2,978	1,071	30	7,173	16,649

(a) Includes the Australian Capital Territory (no Indigenous communities recorded).

(b) Includes not stated responses for 'Whether connected to community water supply' and 'Whether connected to community electricity supply'.

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

- In 2001, 16,348 or 98% of permanent dwellings in discrete Indigenous communities were connected to a sewerage system. There were 301 permanent dwellings which had no organised sewerage system.
- The majority of permanent dwellings in discrete Indigenous communities were connected to a community water supply (16,444 or 99%) and to a community electricity supply (16,323 or 98%).
- In communities where a water supply was available, 134 dwellings were not connected. Thirteen permanent dwellings were in places where no organised water supply existed.

- In communities where an electricity supply was available, 177 dwellings were not connected. Eighty permanent dwellings were in places where no organised electricity supply existed.
- In New South Wales, Victoria and Tasmania all permanent dwellings had sewerage, water or electricity supply.

Indicator 11. People in prison custody

Indicator: The imprisonment rate of Aboriginal and Torres Strait Islander adults aged 17 years and older.

Purpose

Imprisonment has a significant impact on the social and emotional wellbeing of individuals, their families and their communities. Indigenous people – males in particular – are overrepresented in the prison system. This impacts adversely on their health and wellbeing.

Data

Information for this indicator was obtained from the ABS.

Table 11.1: Rate of Indigenous imprisonment per 100,000, by state and territory, 30 June 2002

Age	NSW ^(a)	Vic	Qld	WA	SA	Tas	ACT ^(b)	NT	Australia
17	—	—	557	—	—	259	—	—	165
18	671	203	1,372	1,454	359	539	—	565	904
19	2,217	988	1,907	2,212	1,141	1,005	3,371	1,081	1,812
20–24	3,493	1,913	2,847	3,980	2,733	1,442	2,762	1,773	2,923
25–29	3,749	1,679	2,747	4,553	3,298	1,135	1,344	1,860	3,039
30–34	3,325	1,812	2,216	3,062	2,572	615	932	2,085	2,549
35–39	2,669	1,354	1,709	2,596	2,388	486	357	2,095	2,116
40–44	1,550	896	1,223	1,715	1,266	184	389	1,127	1,304
45–49	672	366	951	793	92	243	645	795	712
50–54	528	367	575	666	—	—	—	281	463
55–59	369	—	155	446	178	—	2,381	71	243
60–64	95	—	232	112	—	—	—	—	105
65 & over	97	—	202	61	—	—	—	—	90
Total	2,146	1,110	1,734	2,414	1,703	622	1,134	1,340	1,806

(a) Data for New South Wales excludes Australian Capital Territory prisoners held in New South Wales prisons.

(b) Data for the Australian Capital Territory includes Australian Capital Territory prisoners held in the Australian Capital Territory as well as Australian Capital Territory prisoners held in New South Wales.

Note: Rate per 100,000 adult Indigenous population.

Source: ABS *Prisoners in Australia 2002*.

- At 30 June 2002 there were 4,494 Aboriginal and Torres Strait Islander people in prison, the majority (92%) of whom were males. Imprisonment rates for Indigenous people were highest in the age groups between 20 and 34 years.
- The overall imprisonment rate for Aboriginal and Torres Strait Islanders in 2002 was 1,806 per 100,000. Western Australia had the highest imprisonment rate (2,414 per 100,000), followed by New South Wales (2,146), Queensland (1,734), South Australia (1,703) and the Northern Territory (1,340).

Indicator 12. The development of governance capacity in health

Indicator: The strategies used by the Australian Government and state and territory governments to develop community capacity in health planning, management and evaluation, including forms of governance for primary health care services that involve Aboriginal and Torres Strait Islander people, and the proportion of funding allocated to these.

Purpose

The indicator demonstrates the commitment by governments to invest resources and time to ensure that Aboriginal and Torres Strait Islander people are supported to develop governance skills in health and facilitate communities to take greater control over their health.

Data

Information for this indicator was obtained from the states, territories and the Australian Government. No quantitative data is provided for this indicator as jurisdictions had difficulties identifying expenditure on governance.

Australian Government

The Australian Government provides funding for management and governance support to Aboriginal Community Controlled Health Organisations (ACCHOs) through the state and territory offices of OATSIH in DoHA. Annual funding of around \$1.6 million per year is provided from a Management Support and Development funds pool. The main areas of support include the following:

- governance training for boards
- financial training for both boards and CEOs
- support for services in difficulty.

Service Activity Reporting (SAR) is an annual data collection project jointly supported by OATSIH and the National Aboriginal Community Controlled Health Organisation (NACCHO). Service-level data on health care and health-related activities covering a twelve-month period are collected from Aboriginal and Torres Strait Islander primary health care services. The results of the data collection are reported to individual contributing services along with de-identified information on similar services. OATSIH and NACCHO use SAR data for formulating policy and in planning, as well as to profile the work of Aboriginal and Torres Strait Islander primary health care services. SAR data is used by OATSIH, along with other information, to identify services with the highest need for additional recurrent funding. In 2000-01, 17 services received a total of \$1.5 million additional funding through this process. In this period an estimated total of 1,340,000 episodes of health care were provided to Indigenous and non-Indigenous clients by the 124 respondent Aboriginal and Torres Strait Islander primary health care services (DoHA & NACCHO 2003).

OATSIH also provides funds for an Aboriginal Health Management Training Program. This program supports 15 students to gain a certificate of management from the Australian College of Health Service Executives and/or a graduate diploma from the University of New England. In 2000-01 and 2001-02, \$114,584 and \$238,616, respectively, were spent on this Program.

The Primary Health Care Access Program (PHCAP) was introduced in the 1999–00 Budget to increase access to primary health care services for Aboriginal and Torres Strait Islander people. This is achieved through the objectives of the Program, which are to empower individuals and communities to take greater responsibility for their own health, to reform and strengthen the existing local health system to better meet the needs of Aboriginal and Torres Strait Islander people, and to increase the availability of appropriate primary health care services where these are currently inadequate. Under PHCAP, a high priority is given to funding capacity development for community-controlled organisations, including training and other management support activities.

During 2000–01, around \$100,000, and in 2001–02 around \$300,000, were spent in South Australia, Queensland and the Northern Territory for capacity-building activities, including the development of community representative steering groups and information provision, as well as training and support mechanisms. In addition, the former Aboriginal Coordinated Care Trials in the Northern Territory, New South Wales and Western Australia were provided with funding of \$981,000 in 2000–01 and \$688,659 in 2001–02 to provide support and sponsorship, for capacity-building activities, infrastructure and broad training.

New South Wales

The government's Aboriginal Health Strategic Plan was released in September 1999. It is an initiative under the Aboriginal Health Partnership and the Aboriginal and Torres Strait Islander Health Agreement (1996). Its purpose is to present strategies to improve health outcomes for Aboriginal and Torres Strait Islander peoples and to address the issues raised by the Indigenous health planning process in New South Wales.

The Aboriginal Health Strategic Plan has a conceptual framework which includes five supportive strategies – effective partnerships and cultural awareness, improved Australian Government and state coordination, support and development of the Aboriginal health workforce, effective monitoring of progress against agreed performance indicators, and improved collection of health information and informed decision making supported by a needs-based resource allocation model.

The New South Wales Aboriginal Health Partnership has been replicated in a number of area health services throughout the state with the establishment of local or area Aboriginal Health Partnerships. These partnerships play an important role in the organisation and coordination of resources to address Indigenous health issues identified in the Local Aboriginal Health Plans and the area health service Aboriginal Health Strategic Plans. While the partnerships are between the area health services and the local Aboriginal community controlled health services, the involvement of other service providers (for example GPs and other relevant organisations), through working groups, will enhance the effective coordination and delivery of health services.

Victoria

The Koori Services Improvement Strategy (1998–2001) provided a set of principles and objectives to direct the Department of Human Services' programs and regions in assessing and, if required redeveloping, policy, programs and services, in partnership with the Aboriginal community. Central to the strategy was the establishment of state-wide, regional and local reference groups to assist in the development of, and provide feedback on the implementation of, agreed Regional Aboriginal Services Action Plans.

The draft three-year Aboriginal Services Plan (effective from 2002) builds on and strengthens activities under the Koori Services Improvement Strategy at regional and program level. The

plan was developed in consultation with Aboriginal people, representatives of Aboriginal communities, peak Aboriginal organisations and ATSIC commissioners.

Through the plan the department is committed to empowering Aboriginal communities to collaborate as partners and to provide support to build the capacity of Aboriginal-managed community and health services across Victoria.

In the area of primary health care, the department is committed to using the Primary Care Partnership Strategy and Community Health Plans to encourage the development of services in partnership with Indigenous communities and agencies to meet the health needs of Aboriginal and Torres Strait Islander people. By 2003 seven Primary Care Partnerships had developed such strategies and a Koori Liaison Worker had been employed to support the process.

Queensland

Queensland Health informs and negotiates with three major Indigenous forums: the Queensland Aboriginal and Torres Strait Islander Health Partnership, the Torres Strait Health Partnership and the Queensland Aboriginal and Torres Strait Islander Health Alliance. All three forums include representatives of peak Aboriginal and Torres Strait Islander bodies and organisations. In addition to these, there is engagement at a more local level in each of the three zones in the state.

The Northern Zone has developed the Northern Zone Aboriginal and Torres Strait Islander Health Plan (2002–05). The plan outlines the establishment of regional and local forums as the mechanisms for community engagement. In areas where there is an ACCHO, they will be the community focal point.

The Central Zone has developed the Aboriginal and Torres Strait Islander Services Development Framework 2001–03. This document provides strategic direction and support in the planning, development and provision of appropriate and effective health services for Indigenous peoples.

The Southern Zone maintains ongoing consultation with Aboriginal and Torres Strait Islander Health Reference Groups. These consultations provide the opportunity for representatives to contribute to the development of policies that address Indigenous health. The Health Reference Groups will oversee the implementation of the Southern Zone Aboriginal and Torres Strait Islander Health Services Plan. Underpinning this plan are the principles of the Aboriginal and Torres Strait Islander Health Policy 1994.

Western Australia

The promotion of partnership building between mainstream and Aboriginal health services has resulted in the establishment of the South West Aboriginal Medical Service and subsequent collocation on the South West Health Campus. Support was given by the Department of Health during the negotiation phase with the Bunbury Health Service.

The Western Australian Aboriginal Coordinated Care Trial continued in 2001 and 2002. An evaluation of the trial identified a number of community development-related outcomes, including improved individual empowerment, through client involvement in the development and delivery of their care plan and greater understanding of the importance of community empowerment as a means of driving health service reform.

In 2000–01, the Department of Health provided technical support to the design and implementation of an IT system to meet both coordinated care trials and other organisational requirements. This will result in the establishment of a potentially uniform data collection and

reporting system from those organisations who receive the majority of their funding from the state, thus providing an improved picture of the morbidity and mortality rates for Indigenous people.

In 2001–03 the Joint Planning Forum continued to develop the implementation strategy for the state's six regional health plans.

South Australia

The South Australian Aboriginal Health Partnership, established in 1996, is a high-level coordination mechanism for supporting reforms in health care and community service provision in public, private and community-controlled health and community sectors. The South Australian Aboriginal Health Partnership through its structure (executive committee, management committee and secretariat team) approves the major commitments contained within the current framework agreement. These commitments are to undertake joint regional planning, increase resourcing to match need, increase access to public sector and community-controlled health and community services, and improve data collection, evaluation and accountability.

The South Australian government is planning a major review of health policy and delivery during the next reporting period (the Generational Health Review). Initial consultations regarding the focus of the review have ensured that the key directions articulated in the Generational Health Review reform agenda will support the focus of the South Australian Aboriginal Health Partnership in its aim to improve Aboriginal and Torres Strait Islander health status as a major priority. It is anticipated that the Reform Agenda will consider the needs of Aboriginal communities by recognising the need to improve the coordination between public, community-controlled and private health care service providers, and to focus on shared action that strengthens the capacity of Aboriginal and Torres Strait Islander individuals, families, organisations and communities to work in partnership with these organisations.

The Department of Human Services is currently developing an Aboriginal health framework which recognises the nine principles consistent with the National Strategic Framework for Aboriginal and Torres Strait Islander Health and acknowledges the South Australian Statement of Reconciliation.

Australian Capital Territory

In 2001–02, the Australian Capital Territory Aboriginal Health Service was funded by the Australian Capital Territory Government to develop a comprehensive strategic and operational plan. The object of the plan was to improve the capacity of the service to meet the demands of existing and future clients, strengthen links with other stakeholders, and improve access for Aboriginal peoples and Torres Strait Islanders within the Australian Capital Territory and region to health-related services.

Over the two years, the portfolio also contributed significant staff resources to work in partnership with Aboriginal community agencies. Staff assisted agencies through the provision of advice on the content and availability of Australian Capital Territory Government-funded governance training opportunities and provided assistance and support to agencies with regard to performance and financial accountability requirements and other contractual matters.

Northern Territory

The Northern Territory Aboriginal Health Forum is a state-level organisation formed to address Aboriginal and Torres Strait Islander health issues. It aims to facilitate improved community capacity in health planning and Indigenous involvement in health management and evaluation. The forum aims to improve health outcomes for Aboriginal and Torres Strait Islanders through improving access to health and health-related programs and increased health service resources that reflect the higher level of need for services among Aboriginal and Torres Strait Islander peoples. Joint planning processes allow for Indigenous participation in health decision making and priority setting, improved cooperation and coordination of service delivery, increased clarity with respect to roles and responsibilities, and enhanced service effectiveness and efficiency.

The forum operates by a formal agreement and brings together representatives from a number of agencies including DoHA, ATSIC, the Northern Territory Department of Health and Community Services, and the Aboriginal Medical Services Alliance of the Northern Territory.

In the Northern Territory, Aboriginal and Torres Strait Islander residents access primary care services through a variety of service delivery models. The Department of Health and Community Services funds primary health care through 90 health clinics. Included within these 90 services are 21 community-based, Aboriginal primary health care services. Of these, 14 organisations (around two-thirds) provide a range of general community services as well as health-specific services. Some 25 community-based services are funded by the Australian Government to provide health services to the local population. Of these, 14 funded organisations provide general community services as well as health specific services.

Aboriginal community-based services in the Northern Territory are controlled by management boards elected from among local residents. The majority of these boards are composed entirely of Indigenous persons.

Program initiatives by the Australian Government to improve Indigenous access to the Medical Benefits Scheme and PBS have allowed the development of jointly funded arrangements which also promote increased Indigenous control over primary health care services. Coordinated Care Trials were initially trialled at two Northern Territory sites (Tiwi Islands and Katherine West), and joint Australian Government-Northern Territory funding initiatives are being extended under both the Coordinated Care Trials initiative (in Katherine East) and the new PHCAP. Under PHCAP, plans are advancing to develop services in five Central Australian health zones and two Top End health zones.

Box 12.1: Data issues

It was agreed that no quantitative data be reported for this indicator as it was not clear what resources should be included under governance. States and territories and the Australian Government also found it difficult to separate out expenditure for governance from broader expenditure provided to Aboriginal and Torres Strait Islander people.

The definition of what is required for this indicator and the specifications need to be clarified.

Indicator 13. Aboriginal and Torres Strait Islander representation on health/hospital boards

Indicator:

- (a) The number of health/hospital boards that have Aboriginal and Torres Strait Islander representation.
- (b) The proportion of boards that have Aboriginal and Torres Strait Islander representation mandated by terms of reference or legislation.

Purpose

This indicator reflects commitment to mechanisms for Aboriginal and Torres Strait Islander representation in health system management at regional and/or institutional levels. The poor health status of Aboriginal and Torres Strait Islander people is reflected in a high level of need for mainstream hospital and health services. Accordingly, representation on hospital boards is needed to ensure Indigenous participation in decision-making processes and the determination of priorities.

Data

Information for this indicator was provided by the states and territories.

New South Wales

In New South Wales, health service boards have the overall responsibility for the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The boards guide and direct, establish policies, chart the course of their respective organisations and act as advocates for their organisations in the local communities. The boards are subject to the direction and control of the Minister except in relation to the context of a report or recommendation.

The 17 area health services provide the framework for the provision of public health services within their respective areas. Two health corporations – Corrections Health Service and The Children’s Hospital at Westmead – together with the Ambulance Service, provide health support services across the whole state.

In 2000–01, 16 out of the 20 Health Service Boards in New South Wales had at least one Aboriginal and Torres Strait Islander member. In 2001–02, this fell to 14 out of 20.

The *Health Services Act 1997* and the *Ambulance Service Act 1990* do not make provision for the makeup of membership on Health Service Boards, so Aboriginal and Torres Strait Islander membership is not mandated. However, the New South Wales Government has a commitment to increasing the number of women, Aboriginal and Torres Strait Islander people, people from culturally diverse backgrounds and young people on boards and committees under the Health portfolio.

Victoria

There are five classifications or schedules for Victorian hospitals. The functions of their boards vary, depending on their classification. Arrangements governing appointment and representation on the boards of hospitals also vary according to the classification. Arrangements generally stipulate that board representation should reflect the users of health

services with adequate representation of males and females on the board. Individual hospital boards no longer exist in the Melbourne metropolitan regions.

In no case is Indigenous membership mandatory on hospital boards, although some hospitals seek a representative from the local Aboriginal cooperative/community organisation and some encourage members of minority groups when advertising opportunities for Board appointments.

Information on the structure of health/hospital boards is not routinely collected by the Department of Human Services in Victoria and there is no requirement to record the Indigenous status of board members. Available data show that 5 of the 91 health boards in Victoria reported Aboriginal and Torres Strait Islander representation in 2000-01 and 6 of the 91 in 2001-02.

Queensland

Queensland Health is divided into three zones containing 37 health service districts. Each district has a district health service council. The role of the district health council is to work in cooperation with the relevant health service district to ensure that the needs of the community are represented and reflected in the health services provided, and to monitor the performance of the district against a service agreement. The council should act as a direct link between the public and Queensland Health. District health councils are to facilitate community input into the planning, delivery, monitoring and evaluation of hospital and community-based health services.

District health councils are established in legislation, with a direct reporting relationship to the Minister, and consist of up to 10 members with equitable community representation. Members of the district health council are not elected, but are appointed by the Governor-in-Council. A term as member of the district health council is for three to four years.

All district health service councillors are ministerial appointments. There is no requirement mandated by the terms of reference for Indigenous representation, nor is there a requirement for district health council appointees to record Indigenous status.

Western Australia

Health service boards are established under the *Hospital and Health Services Act 1927* and derive their functions and responsibilities from the Act. The boards are responsible for the control, management and maintenance of the hospital and for providing health services as approved by the Minister under a Australian Government-state agreement. There were 34 hospital boards in 2001-02.

During most of the 2000-01 financial year there were 41 Western Australian hospital boards with members and seven 'departmental' boards with no members. During this period the highest representation of Aboriginal and Torres Strait Islander people was 11 Indigenous board members out of a total of 356 positions, with seven of the 41 boards having Indigenous representatives (17%).

During 2002-03, it is expected that regional advisory mechanisms involving Indigenous representation will be implemented.

South Australia

There were 73 incorporated hospitals and health centres under the South Australian Health Commission, at 30 June 2003. Information is available on 38 boards that have provision within

the hospital's constitution for a ministerial nomination. Twelve of these 38 boards (32%) reported Aboriginal and Torres Strait Islander membership in 2003.

Tasmania

Tasmania does not have regional health or hospital boards. Services are administered by the Department of Health and Human Services.

Australian Capital Territory

All board/committee members are asked if they wish to identify their Aboriginal or Torres Strait Islander status at the time of initial appointment. However, some members may choose not to do so. The representation may, therefore, be higher than recorded. In 2000–01, two members of the 22 health boards and committees identified as Aboriginals and/or Torres Strait Islanders. In 2001–02, three members of the 24 boards and committees identified as Indigenous Australians.

Throughout 2001 and 2002 the Health portfolio encompassed Disability and Housing Services and their associated boards and ministerial advisory groups. Aboriginal and Torres Strait Islander representation is indicated in mental health, and drug and alcohol advisory forums.

Northern Territory

The Hospital Management Boards Act has established that each public hospital in the Northern Territory will have a board of eight members, five of whom are appointed by the Minister. Although the Act does not require hospitals to have Indigenous people on the hospital boards, all Northern Territory hospitals make every effort to include Aboriginal members. In 2001, three of the five public hospitals had a total of six Indigenous board members out of 40 total board members.

The Northern Territory has a wide array of representative health groups, many of which include Aboriginal representation and some of which require a majority of Aboriginal members. Examples of this latter group are the Northern Territory Aboriginal Ear Health Committee and the Northern Territory Aboriginal Eye Health Committee.

Box 13.1: Data issues

Responses to this indicator revealed different interpretations of 'hospital/health' boards. It was therefore agreed to only report descriptive data for this indicator.

Most states and territories indicated that there was no legislation governing appointments to hospital boards, and as a consequence the Indigenous status of members was not routinely collected. A number of states and territories stated that the composition of boards was intended to represent the users of the health service. Accordingly, the makeup of boards of hospitals with a high proportion of Aboriginal and Torres Strait Islander separations was recognised as particularly important to the provision of culturally appropriate services.

Indicator 14. Reporting of complaints in hospitals

Indicator:

- (a) The ratio of complaints to hospital separations in the Aboriginal and Torres Strait Islander population compared to the Australian population.
- (b) The structures and mechanisms available to assist Aboriginal and Torres Strait Islander people who want to make a complaint.

Purpose

Indigenous Australians may have undesired experiences in hospital and may also experience difficulties in making complaints or formal notifications. Because Aboriginal and Torres Strait Islander people have a high use of hospitals, it is important to assess Indigenous access to complaint mechanisms.

Data

Information for this indicator was obtained from the states and territories; however, many states and territories could not provide quantitative data.

New South Wales

New South Wales Health collects information about resolved complaints managed by the area health services. The Indigenous status of the complainant is not currently collected. A new complaints management system, to be implemented in 2004, will include this information.

The number of complaints reported to the collection during 2000–01 was 12,045 and during 2001–02 was 11,986. The complaint-to-patient ratio for 2000–01 was 1:272 and for 2001–02 was 1:274.

From February 1998, the State Continuous Improvement Steering Committee released the *Better Practice Guidelines for Frontline Complaints Handling*, based on comprehensive better practice models, to improve the level of customer satisfaction and frontline complaint-handling procedures.

Within New South Wales, each area health service appoints a complaints manager to handle complaints. Complaints which are resolved are recorded and submitted to the Department of Health quarterly. The Department of Health's Executive Support Unit coordinates the handling – receipt, logging, tracking and ultimately the resolution of complaints. The health service responsible for providing the service that is the subject of complaint will investigate and prepare a response on behalf of the Minister or Director General.

Complainants may choose to log their complaints direct to the Health Care Complaints Commission or Anti-Discrimination Commission and other Government bodies.

Victoria

In 2000–01, 14 complaints by Aboriginal and Torres Strait Islander people (1.1% of all complaints made in writing) were managed by the Health Services Commission. In the same period 80 enquiries were made by Aboriginal and Torres Strait Islander people, representing 1.5% of all enquiries received in 2000–01. The Commission managed substantially more complaints by Aboriginal and Torres Strait Islander people during 2001–02; 62 or 4.7% of complaints were made by Indigenous Australians. Indigenous enquiries of the Commission

represented 2.1% of all enquiries in 2001–02, which is higher than the 0.6% of hospital separations that were of Aboriginal and Torres Strait Islanders. Hospitals also have their own internal complaints systems, but there is no central record of Indigenous complaints handled by hospitals.

In Victoria, the Office of the Health Services Commissioner assists people making their concerns known to health service providers. The office manages disputes that arise between users and providers of health services in Victoria.

The office has an Aboriginal Liaison Officer who is employed to create awareness within Indigenous communities of its services and to deal with complaints and enquiries that it receives from Aboriginal and Torres Strait Islander people. Enquiries are complaints that are made verbally, either in person or on the telephone, and are not confirmed in writing. Formal complaints must be confirmed in writing.

The Aboriginal Liaison Officer is available to help an Indigenous person to formalise a complaint in writing. Complaints that have been confirmed in writing have tended to relate to issues of a serious nature that have required a certain amount of investigation in the form of obtaining medical records, medical reports and opinions, and ongoing negotiations between the parties.

Complaints of a less serious nature can generally be dealt with informally, on the basis of a person simply making an enquiry without having to confirm the matter in writing. The Aboriginal Liaison Officer is able to follow the matter up on the same day and, if possible, tries to obtain a resolution informally within a matter of days at most.

It has been the experience of the Aboriginal Liaison Officer that Aboriginal and Torres Strait Islander people find confirming complaints in writing, even with assistance, to be a difficult and bureaucratic process and much prefer to deal with complaints as informally as possible. This has therefore dictated changes to the office's standard procedures in dealing with complaints, to be more culturally appropriate to the needs of Aboriginal and Torres Strait Islander people.

Queensland

The Queensland Health Quality Improvement and Enhancement Program has developed a Queensland Health Complaints Management Policy that provides a complaint handling model, performance standards and criteria, and responsibility and specific accountability. This policy was effective from August 2002. Each health service district is responsible in setting up a complaints system within their area. While some health service districts have the capacity for recording Indigenous status on their complaints system, the majority do not collect this information.

Individuals have the right to independently complain to external agencies at any time. Relevant statutory agencies include, but are not limited to, the Official Visitors, the Health Rights Commission, police, Ombudsman, Crime and Misconduct Commission, and professional registration boards.

Mechanisms to assist Indigenous people

Queensland Health Hospital Liaison Officers provide advice and support to Aboriginal and Torres Strait Islander clients and their families in negotiations with medical staff in hospital and clinical settings. The Hospital Liaison Officers also have access to skilled interpreters through networks within the community. It is the responsibility of all Queensland Health employees to assist any client with documenting a complaint.

Western Australia

In Western Australia, the complaints procedure varies from hospital to hospital. Many hospitals accept verbal complaints and have Aboriginal Liaison Officers or social workers to assist Aboriginal and Torres Strait Islander people if they wish to make a complaint. Complaint data recorded at the hospital level do not identify if complainants are Indigenous Australians. Anecdotal information suggests that very few Aboriginal people make complaints. In the 2001-02 financial year, data from the metropolitan hospitals were collated by the Office of Safety and Quality in Health Care to provide information regarding types of complaints. The data system does not contain Aboriginal identification. There were 4,165 complaints from metropolitan hospitals.

The Office of Health Review is a state government body that provides a means of having complaints about health and disability services reviewed, conciliated and dealt with. It provides a free service to all users of health and disability services in Western Australia. However, it encourages complainants to make a direct approach to the service provider first and therefore represents only those complaints that were not resolved through the hospital complaints system.

Complaints must be lodged in writing to the office, although staff can assist consumers to submit a complaint, and there are also interpreters available if needed. The complaint form includes a question regarding Indigenous identification. In the 2000-01 financial year there were 404 complaints about public hospitals and none were recorded as being from Aboriginal people. In the 2001-02 financial year there were 196 complaints about public hospitals and two were from Aboriginal people.

South Australia

There is currently no uniform complaints system within hospitals for Aboriginal and Torres Strait Islander peoples. However, South Australia is currently drafting a Health Complaints Bill which will aim to ensure that complaints by Aboriginal and Torres Strait Islander peoples will be dealt with in an appropriate way.

Tasmania

The Health Complaints Commission was established in 1997 in Tasmania to investigate complaints against providers of health services. The commission covers all aspects of health services that are provided in the public and private sector. Indigenous status is not collected when patients make a complaint. Structures and mechanisms to support all patients making a complaint have been developed, but none of these are specific to ethnic background.

Two of the three major hospitals in Tasmania employ Aboriginal Liaison Officers to assist in the promotion of cultural awareness and to facilitate the reporting of complaints.

Australian Capital Territory

Data could not be provided for this indicator as acute hospital service facilities in the Australian Capital Territory did not incorporate an Aboriginal and Torres Strait Islander identifier within their complaints database. The Commission for Health Complaints received nil complaints in 2001-02. The fact that all complaints to the Commission are required to be written may be a determining factor.

Two Aboriginal Liaison Officers were located in the larger hospitals. The officers were in a position to address patient complaints.

Northern Territory

Public hospitals have established formal processes for complaint handling. These processes are monitored within the Northern Territory by the Complaints Handling Group and are a requirement for national hospital accreditation. Information on complaints is available for all public hospitals and in all cases the rate of complaints per hospital separation is much higher for Indigenous patients than for non-Indigenous patients. At the Royal Darwin Hospital in 2000, the non-Indigenous to Indigenous rate ratio for complaints was 10 to one, while at Alice Springs Hospital it was 14 to one.

A range of hospital initiatives is helping to improve communication with Aboriginal clients. These include Aboriginal Liaison Officers, hospital-based Aboriginal Health Workers, the Aboriginal Interpreter Service and cross-cultural training for hospital staff. While Aboriginal staff help communication with Aboriginal clients in matters such as informed consent and improved treatment, they also resolve difficulties that arise outside the formal complaints system.

Box 14.1: Data issues

Most states and territories could not provide quantitative data for this indicator and it was agreed to report descriptive and quantitative information. There were no consistent processes for managing and recording Aboriginal and Torres Strait Islander complaints about hospital services across states and territories. A number of states and territories reported progress towards developing systems for reporting and managing complaints. These systems may relate solely to hospitals, or the broader health services sector. Most states and territories reported the employment of Aboriginal Liaison Officers to help Indigenous people who wanted to make a complaint.