

Determinants of health—risk markers

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Introduction

This subdomain includes 11 indicators, 8 of which were reported on.

Problem gambling and community grief cannot be reported on because there are no relevant data. Data for Indicator 27 – coverage of adult pneumococcal vaccine – is not available by jurisdiction. National data is provided in the 2001 National Health Survey which reports that in 2001, 25% of Indigenous persons aged 50 years and over were vaccinated for pneumonia in the last 5 years compared with 14% of non-Indigenous Australians, and 51% were vaccinated for influenza over the last 12 months compared to 47% of non-Indigenous people aged 50 years and over.

The indicators in this subdomain cover the major risk factors for disease. They include low birthweight, immunisation rates, Pap smear screening, smoking prevalence, alcohol consumption, injury, overweight and obesity, and child abuse and neglect.

The ABS provided data for three of these indicators. Data for the indicators on smoking prevalence, alcohol consumption and overweight and obesity were from the 2001 National Health Survey. These data were provided at the national level due to the small number of Indigenous people in the survey.

The AIHW provided data for two of the indicators. Data on low-birthweight infants comes from the AIHW National Perinatal Statistics Unit. The AIHW also provided data on child protection substantiations, a broad measure of child abuse and neglect.

The data on childhood immunisation rates were provided by the Health Insurance Commission from the Australian Childhood Immunisation Register. Children must have at least one immunisation to be included on this register.

The states and territories provided the data for two of the indicators – Pap smear screening and injuries presenting to hospital emergency facilities. No jurisdiction could provide quantitative data on the proportion of Indigenous women who have had a Pap smear, as Indigenous status is generally not recorded on pathology forms. Only four states and territories could provide quantitative data on the presentation of acute injuries at hospital accident and emergency facilities and the data are not strictly comparable because of differences in coding systems used.

Indicator 25. Pap smear screening

Indicator: The proportion of Aboriginal and Torres Strait Islander women within each eligible age group who have had a Pap smear within a 24-month period.

Purpose

Pap smear screening enables the early detection of cancer of the cervix, and most deaths due to cervical cancer are potentially avoidable. This indicator measures the success of government efforts to encourage Aboriginal and Torres Strait Islander women to have Pap smears, and their access to and utilisation of Pap smear services.

Data

No states and territories could provide quantitative data for this indicator, as Indigenous status is generally not recorded on pathology forms, and in some states and territories not recorded on Pap smear registers. Therefore only written responses were provided.

New South Wales

In 2000–01 and 2001–02, the Cervical Screening Program sponsored a range of activities to help Aboriginal and Torres Strait Islander women to participate in cervical screening. These included the development of a video for Aboriginal women, which encouraged and explained the importance of having a Pap test; the development of an accredited Aboriginal women's education program; the development of a comprehensive training program to provide Aboriginal Health Workers with the knowledge and skills that would enable them to conduct focus groups and interviews with their communities on the factors affecting the use of cervical screening services by Aboriginal women; the development of a resource for staff working with Aboriginal women aimed at providing information about Pap tests and issues related to cervical screening; and a series of educational sessions which were held around New South Wales to enable Aboriginal Health Workers to promote cervical screening within their communities and also included training sessions for Aboriginal women elders to act as catalysts within their communities.

The program also began a state-wide study into issues and strategies designed to improve cervical and breast screening services for Aboriginal and Torres Strait Islander women. This two-year project was commissioned to an Indigenous group of researchers in keeping with a culturally safe and appropriate approach to seeking and reporting on information from Indigenous communities.

Victoria

PapScreen Victoria does not record Indigenous status. There is also no Indigenous identifier in either the Victorian Cervical Cytology Register or on pathology request forms.

The Victorian Aboriginal Health Service has cooperated with PapScreen and BreastScreen to increase screening of Indigenous women through workshops for Koori women and health workers. PapScreen Victoria is committed to working with the Koori community to develop culturally appropriate and community-owned strategies to promote cervical screening. PapScreen funds a Koori health worker position based at the Victorian Aboriginal Health Service.

In addition, in 2000–01 and 2001–02, the department funded community-based cervical screening projects within the Koori community. Grants were offered to Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) or organisations working collaboratively with ACCHOs. Evaluation showed that projects directly funded to ACCHOs were more effective at reaching Koori women than those given to mainstream organisations.

Queensland

Queensland Health has developed and implemented a range of strategies to reduce morbidity and mortality from cervical cancers. One such strategy is the Queensland Indigenous Women's Cervical Screening Strategy. This strategy has been in place since 2000 and during that time a number of key action areas to address participation in cervical screening by Indigenous women have been identified. These include community education, developing culturally appropriate models of service, cultural training for mainstream health workers, ongoing training and education of Indigenous Health Workers, and monitoring and evaluation of services to identify barriers to screening.

Indigenous status can be recorded on the Queensland Health Pap Smear Registry. However, data for Pap smear rates for Indigenous women are dependent on Indigenous status field being recorded on pathology request forms and in the vast majority of cases it is not recorded. Queensland Health is committed to addressing identification issues. The department has undertaken analysis on data from women living in 13 discrete rural and remote Indigenous communities. The identity of individual communities was concealed in this analysis. Women were identified, based on their reported place of usual residence, for any Pap smear taken during the 24-month period. Identifying Indigenous women in this way, rather than by 'Indigenous status' as reported on pathology forms, presents information on cervical screening participation rates for a large number of Indigenous women living in several different communities.

Western Australia

Indigenous identification is not collected or recorded on the Cervical Cytology Register, but its inclusion has been identified as a high priority for the Department of Health.

The Western Australian Cervical Cancer Prevention Program is committed to improving participation of Aboriginal and Torres Strait Islander women in cervical screening. This requires raising awareness among Indigenous women as well as the sharing of cultural information to program and service provision staff that will enhance their capacity to deal with Indigenous women. A range of measures have been implemented to address these issues including the development of specific health promotion resources, community education and enhanced partnerships with ACCHOs.

South Australia

The Aboriginal Services Division within the Department of Human Services manages the Indigenous Cervix Cancer Prevention program with funding directed from the Population Health Branch through Cervix Screening South Australia. Located with the Aboriginal Services Division is a Senior Indigenous Cervical Screening Project Officer who has been instrumental in developing promotional materials regarding the importance of Pap smear screening for Indigenous women across the state. It is anticipated that a promotional video and poster will be finalised within the next reporting period.

Strategies are also being developed within South Australia to encourage all health services who provide Pap smear screening to record Indigenous status when clients present at the services. The Aboriginal Services Division has also identified strategic planning for Indigenous Cervix Screening and additional health promotion emphasis in key locations in the state. It is anticipated that by the next reporting period an Indigenous cervical screening program will be operating in a number of locations.

Tasmania

Data are not currently collected in Tasmania.

Australian Capital Territory

Australian Capital Territory legislation for the Pap Smear Registry prevents the collection of Indigenous status in the Australian Capital Territory.

The Australian Capital Territory Aboriginal Health Service provided an Aboriginal Midwifery Access Program. Clients accessing the program are encouraged to have regular Pap smear tests.

Northern Territory

In the Northern Territory there is a centralised Pap Smear Register, which records results for all participating women across the territory. In 2001, 70% of women aged 20 to 69 years had had a registered Pap smear in the previous 24 months.

Indigenous status is not reliably recorded on pathology forms and is also not included as a data field in the Pap Smear Register. Estimates of rates of Pap smear screening for those areas with a high proportion of Aboriginal women are generally consistent with rates over the Northern Territory. Efforts are in progress to increase the number of women included on the Pap Smear Register and to increase the recording of Indigenous status on pathology forms.

Aboriginal Women's Health Workers and Women's Health Educators have been active in providing information to Aboriginal women in remote areas about the need for Pap smear screening. Special initiatives include the implementation of the Well Women's Screening Program that aims to:

- decrease preventable illness and preventable deaths
- promote early detection of disease, especially breast and cervical cancer
- be delivered in a culturally appropriate way on a twice-yearly basis.

Community-based 'Women's Health Days' are designed to encourage women to access basic health screening. Resources such as videos, flipcharts and pamphlets are available.

Indicator 26. Childhood immunisation rates

Indicator: The proportion of Aboriginal and Torres Strait Islander children who are fully immunised against vaccine-preventable diseases, according to the National Health and Medical Research Council's (NHMRC) recommendations at 12 months, 2 years and 6 years of age.

Purpose

Immunisation against childhood diseases that are preventable by vaccination is important to ensure the health and wellbeing of Indigenous children. The indicator provides a measure of access to and utilisation of immunisation services.

Data

Information for this indicator was obtained from the Australian Childhood Immunisation Register, which is managed by the Health Insurance Commission. 'Fully immunised' means a child has received all age-appropriate vaccines on the Australian Childhood Immunisation Schedule.

Children are added to the Australian Childhood Immunisation Register at their first immunisation. The rates reported here are the number immunised as a proportion of children on the register, not as a proportion of children in that age group as specified in the indicator.

Data were not provided for Queensland, Tasmania, the Australian Capital Territory and the Northern Territory because the coverage of Indigenous children on the register in these states and territories was not sufficient to calculate rates. Indigenous coverage on the register has improved over the last few years, therefore data were provided for children aged 6 years of age in 2002 but were not available for 2001.

Table 26.1: The proportion of Indigenous children who were fully immunised at 1, 2 and 6 years of age, for selected states and territories, 30 June 2001 and 30 June 2002 (per cent)

Age	NSW	Vic	WA	SA
		2001		
1 year	90	90	79	100
2 years	88	91	81	87
		2002		
1 year	87	89	79	88
2 years	86	85	73	84
6 years	79	87	74	70

Note: Data were not provided for Queensland, Tasmania, the Australian Capital Territory and the Northern Territory because the coverage of Indigenous children was not complete enough to calculate rates.

Source: Health Insurance Commission Australian Childhood Immunisation Register.

- In 2001, the proportion of Indigenous children on the register who were fully immunised at 1 year ranged from 79% in Western Australia to 100% in South Australia. In 2002, the proportion of Indigenous children on the register who were fully immunised at 1 year of age ranged from 79% in Western Australia to 89% in Victoria.

- In 2001, the proportion of Indigenous children on the register who were fully immunised at 2 years of age ranged from 81% in Western Australia to 91% in Victoria. In 2002, the proportion of Indigenous children on the register who were fully immunised at 2 years of age ranged from 73% in Western Australia to 86% in New South Wales.
- In 2002, the proportion of Indigenous children on the register who were fully immunised at 6 years of age was highest in Victoria (87%) and the lowest South Australia (70%).

Indicator 28. Low-birthweight infants

Indicator: The prevalence of low birthweight in live-born babies of Aboriginal and Torres Strait Islander women.

Purpose

The indicator reflects the health of Aboriginal and Torres Strait Islander women, their access to and utilisation of antenatal care, and the quality of antenatal care. It also indicates the health and development of Aboriginal and Torres Strait Islander babies, as low-birthweight babies are more prone to ill health during childhood, and may be more vulnerable to illness in adulthood (Alberman 1994; Barker & Clark 1997).

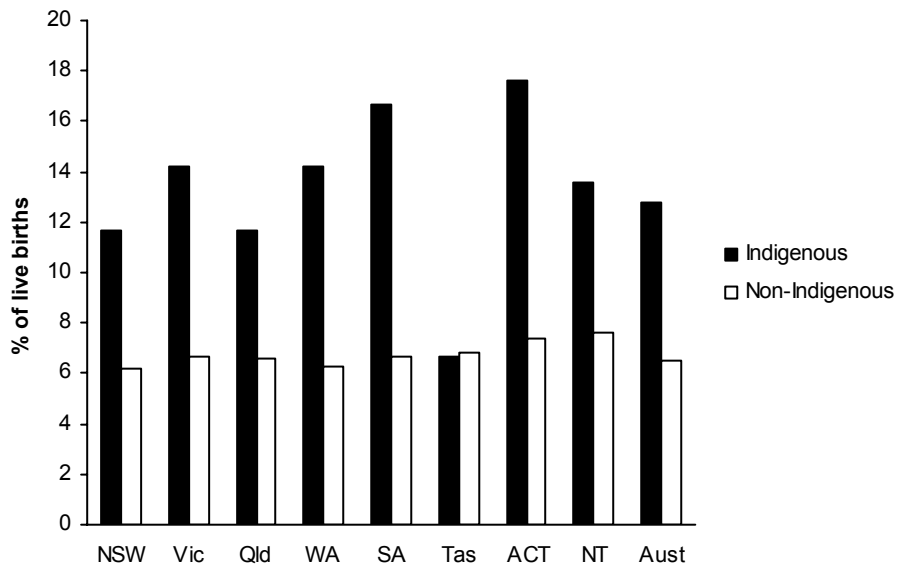
Babies born with a birthweight of less than 2,500 grams are classified as being of 'low birthweight'. Low birthweight may be a result of pre-term birth, foetal growth retardation, or a combination of the two (Alberman 1994). There are a range of factors that can affect a baby's birthweight, including socioeconomic disadvantage, the size and age of the mother, the number of babies previously born to the mother, the mother's nutritional status, smoking and other risk behaviours, illness during pregnancy, presence of a multiple birth and the duration of pregnancy.

Data

The data on the birthweight of babies are collected by the AIHW National Perinatal Statistics Unit. The data are likely to underestimate the number of births to Indigenous mothers, because Indigenous status is not always recorded in these data collections.

Three years of data were combined in order to smooth out yearly fluctuations in the number of births to Indigenous mothers, which can cause volatility in rates. Care should be taken in interpreting data from Tasmania and the Australia Capital Territory due to the small numbers.

- In the period 1998–00, the proportion of low-birthweight babies born to Indigenous mothers in Australia (12.8%) was almost twice as high as the proportion born to other Australian mothers (6.5%).
- The proportion of low-birthweight Indigenous babies ranged from 6.7% in Tasmania and 11.7% in New South Wales and Queensland to 16.7% in South Australia and 17.6% in the Australian Capital Territory.



Note: Data from the Australian Capital Territory and Tasmania should be treated with caution due to small numbers.

Source: AIHW National Perinatal Statistics Unit.

Figure 28.1: Proportion of low birthweight babies by mother's Indigenous status and state and territory, 1998-00

Indicator 29. Smoking prevalence

Indicator:

- (a) The proportion of Aboriginal and Torres Strait Islander adults aged 18 years and over who reported they were current smokers, by age and sex.
- (b) The proportion of Aboriginal and Torres Strait Islander adults who formerly smoked regularly (ex-smokers), by age and sex.

Purpose

Tobacco smoking increases the risk of coronary heart disease, stroke and peripheral vascular disease. Tobacco smoking also increases the risk to a range of cancers including lung, oesophagus, kidney, pancreas and the cervix. Tobacco smoking during pregnancy can lead to spontaneous abortion, low birth weight and sudden infant death syndrome. Exposure to tobacco smoke (passive smoking) can also lead to serious health conditions such as heart diseases in adults and respiratory diseases in children.

Data

States and territories were originally asked to provide data for this indicator but there were no consistent data available and data from the ABS was therefore used. These data come from the 2001 National Health Survey. Due to small numbers of Indigenous people in the survey only national totals can be provided.

- In 2001, 53% of Indigenous adults aged 18 years and over reported they were current smokers, a further 17% were ex-smokers and 30% reported they had never smoked.
- The proportion of current smokers was higher in males than females (56% compared with 52%).
- Among females the highest proportion of current smokers was among those aged 18-24 years (56% compared with 50% among those older than 24 years). Among males there was no observed aged difference in the proportion of current smokers (around 55%).
- In 2001, 17% of Indigenous adults reported that they were ex-smokers – with equal proportions among males and females.
- Among males, the highest proportion of ex-smokers was reported among those aged 35 years and over 34 where almost one-quarter (24%) reported that they were ex-smokers.
- Among females, the highest proportion of ex-smokers (22%) was among those aged 35 years and over.

Table 29.1: Smoking status of Indigenous adults aged 18 years and over, by age and sex, 2001

	Indigenous males		Indigenous females		Total	
	%	RSE (%)	%	RSE (%)	%	RSE (%)
Smoker status^(a)			18–24 years			
Current smoker	55	16	56	12	56	10
Ex-smoker	^(b) 7	32	^(b) 9	39	^(b) 8	27
Never smoked	38	18	34	19	36	11
Total	100	7	100	4	100	4
Smoker status^(a)			25–34 years			
Current smoker	55	9	50	9	52	8
Ex-smoker	^(b) 13	30	14	20	14	18
Never smoked	32	16	36	12	34	11
Total	100	0	100	0	100	0
Smoker status^(a)			35 years and over			
Current smoker	56	6	50	6	53	4
Ex-smoker	24	13	22	14	23	10
Never smoked	20	16	28	11	24	8
Total	100	0	100	0	100	0
Smoker status^(a)			Total			
Current smoker	56	5	52	5	53	4
Ex-smoker	17	12	17	13	17	9
Never smoked	28	11	31	8	30	6
Total^(c)	100	2	100	1	100	1

(a) Smoking status refers to regular smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes but excludes chewing tobacco and smoking of non-tobacco products. Current smokers include daily and non-daily smokers.

(b) Estimate has a relative standard error of between 25% to 50% and should be used with caution. Data are subject to sampling variability too high for most practical purposes.

(c) Includes 'Smoker status unknown'.

Note: RSE refers to the relative standard error of the estimates.

Source: ABS National Health Survey 2001.

Indicator 30. Alcohol consumption

Indicator:

- (a) The proportion of Aboriginal and Torres Strait Islanders people aged 18 years and over who consumed alcohol in the week before the survey, by age and sex.
- (b) The proportion of Aboriginal and Torres Strait Islander drinkers aged 18 years and over who reported drinking at levels of medium or high risk in the week before the survey.

Purpose

While low levels of alcohol consumption appear to protect against some illness in adulthood, including coronary heart disease, stroke and hypertension, excessive use of alcohol can lead to harm both in the short and long term. Binge drinking can increase the risk of injury due to falls, assault, road accidents, fights and violence. Long-term excessive alcohol use can lead to alcohol addiction, poor diet, and stomach and liver problems as well as emotional and financial problems.

Data

States and territories were originally asked to provide data for this indicator but there were no consistent data available, and data from the ABS were therefore used. These data come from the 2001 National Health Survey. Due to small numbers of Indigenous people in the survey only national totals can be provided.

Proportion who consume alcohol

Table 30.1: Indigenous persons aged 18 years and over: by whether consumed alcohol, by age and sex, 2001

	Males		Females		Total	
	%	RSE (%)	%	RSE (%)	%	RSE (%)
18–24 years						
Consumed alcohol	61	14	40	15	51	11
Did not consume alcohol ^(a)	39	24	60	11	49	13
25–34 years						
Consumed alcohol	52	10	40	10	46	8
Did not consume alcohol ^(a)	48	11	60	7	54	6
35 years and over						
Consumed alcohol	52	7	37	9	44	6
Did not consume alcohol ^(a)	48	8	63	5	56	5
Total						
Consumed alcohol	54	4	39	7	46	3
Did not consume alcohol ^(a)	46	6	61	4	54	3
Total^(b)	100	2	100	1	100	1

(a) Includes those who had not consumed alcohol in the week before interview, and those who cannot remember when last consumed alcohol.

(b) Includes alcohol consumption unknown.

Note: RSE refers to the relative standard error of the estimates.

Source: ABS National Health Survey 2001.

- In 2001, 46% of Indigenous adults aged 18 years and over reported having consumed alcohol over the 7 days before the interview.
- Among Indigenous people, 54% of males compared to 39% of females consumed alcohol in the week before the interview.

Proportion who consumed alcohol at risky levels

Part b of the indicator relates to those drinkers who consume alcohol at risky levels. Table 30.2 shows the number of drinks for each alcohol risk level for the data reported in Table 30.3.

Table 30.2: Alcohol risk level: estimated average daily consumption of alcohol during the previous week

Relative risk	Male drinkers	Female drinkers
Number of standard drinks		
Low risk	0–4	0–2
Risky	5–6	3–4
High risk	7 or more	7 or more

Notes

1. Risk levels were based on the levels for long-term harm.
2. One standard drink = 12.5 ml of alcohol.

- In 2001, of the Indigenous people who consumed alcohol, most did so at a low risk (72%). The remaining 28% consumed alcohol at risky or high-risk levels.

- Among Indigenous people who consumed alcohol, the proportion of males and females who consumed alcohol at risky or high-risk levels were similar (29% males, 27% females).

Table 30.3: Indigenous people aged 18 years and over who consumed alcohol: alcohol risk levels^(a) by age and sex, 2001

	Males		Females		Total	
	%	RSE (%)	%	RSE (%)	%	RSE (%)
18–24 years						
Alcohol risk level—7 day average						
Low risk	91	16	67	20	81	13
Risky/high risk	9	36	33	28	19	22
<i>Total consuming alcohol</i>	100	14	100	15	100	11
25–34 years						
Alcohol risk level—7 day average						
Low risk	64	17	77	14	70	12
Risky/high risk	36	20	23	21	30	15
<i>Total consuming alcohol</i>	100	10	100	10	100	8
35 years and over						
Alcohol risk level—7 day average						
Low risk	65	14	73	12	68	9
Risky/high risk	36	14	27	23	32	12
<i>Total consuming alcohol</i>	100	7	100	9	100	6
Total						
Alcohol risk level—7 day average						
Low risk	71	8	73	7	72	5
Risky/high risk	29	11	27	18	28	9
<i>Total consuming alcohol</i>	100	4	100	7	100	3

(a) These levels were calculated based on a 7-day average. Risk level as defined by the NHMRC is based on regular consumption levels of alcohol. The indicators derived from the 2001 National Health Survey assumed that the reported level of alcohol consumption in the reference week was typical.

Note: RSE refers to the relative standard error of the estimates.

Source: ABS National Health Survey 2001.

Indicator 31. Overweight and obesity

Indicator: The proportion of Aboriginal and Torres Strait Islander adults aged 18 years and over with a body mass index (BMI) in the overweight and obese category, by sex.

Purpose

Being overweight or obese is a risk for a number of chronic diseases including Type 2 diabetes, coronary heart disease, high blood pressure, stroke and certain types of cancer. Obesity can lead to premature deaths from certain chronic conditions.

Data

States and territories were originally asked to provide data for this indicator but there were no consistent data available, and data from the ABS were therefore used. These data come from the 2001 National Health Survey. Due to small numbers of Indigenous people in the survey only national totals can be provided.

BMI is weight (kg)/height (metres) squared. Overweight is a BMI of 25 to less than 30, and obese is a BMI of 30 and over.

Table 31.1: Weight status^(a): Indigenous adults aged 18 years and over based on body mass index^(b), Australia 2001

Weight status	Males		Females		Total	
	%	RSE (%)	%	RSE (%)	%	RSE (%)
Normal range or less	35	7	31	7	33	5
Overweight	30	9	22	9	26	7
Obese	22	10	22	7	22	6
Unknown	13	..	25	..	19	..
Total	100	2	100	1	100	1

(a) These data are based on self-reported height and weight.

(b) Overweight and obesity are measured by the body mass index (BMI), a measure of the person's weight relative to their height (weight in kilograms divided by height in meters squared: kg/m²). A BMI of between ≥ 25 and < 30 defines overweight while a BMI of ≥ 30 defines obesity.

Note: RSE refers to the relative standard error of the estimates.

Source: ABS National Health Survey 2001.

- Almost one in two Indigenous people (48%) aged 18 years and over were reported to be overweight or obese.
- A higher proportion of Indigenous adult males than females was reported to be overweight or obese (52% compared with 44%).

Indicator 32. Child abuse and neglect

Indicator: The number and rate of Aboriginal and Torres Strait Islander children aged 0–16 years who are subject to a substantiation of child abuse or neglect, compared to non-Indigenous children.

Purpose

This indicator provides a broad measure of the rates of Indigenous children who were abused, neglected or otherwise harmed, relative to the non-Indigenous population. This is a risk factor for poor health and wellbeing.

Data

A 'substantiation' is a report of child abuse or neglect or harm to a child that is investigated and formally confirmed by a legally recognised child protection agency.

Major differences exist in child protection policies and practices across states and territories and these are reflected in the child protection data. The data from the states and territories are therefore not strictly comparable and should not be used to compare jurisdictions. In addition, the practices used to identify and record the Indigenous status of children varies across states and territories, with some states and territories recording a large number of unknowns. The quality of the data on Indigenous status has, however, improved over the last few years (see Box 32.1).

While data on Indigenous children in substantiations are available for 2000–01, the published data used population data from the 1996 Census and are not comparable with the data provided here. Data for 2001–02 is presented for this indicator.

Table 32.1: Children in child protection substantiations: number and rates per 1,000 children, by Indigenous status, by state and territory, 2001–02

State/territory	Number of children			Rate per 1,000 children			Indig. non-Indig. rate ratio
	Indigen.	Other	Total	Indigen.	Other	Total	
NSW	913	6,361	7,274	15.3	4.3	4.8	3.6
Vic	579	6,569	7,148	48.1	6.1	6.5	7.9
Qld	795	6,553	7,348	14.3	7.9	8.3	1.8
WA	386	718	1,104	13.5	1.7	2.4	7.9
SA	346	1,407	1,753	31.6	4.4	5.3	7.2
Tas	2	151	153	0.3	1.4	1.4	0.2
ACT	11	191	202	6.5	2.6	2.7	2.5
NT	222	109	331	9.7	3.2	5.8	3.0

Source: AIHW.

- Aboriginal and Torres Strait Islander children were much more likely to be the subject of child protection substantiations than other Australian children.
- In 2001–02, in all states and territories except Tasmania the substantiation rate for Indigenous children was higher than the rate for other children.

- In Victoria and Western Australia the rate of Indigenous children in substantiations was nearly eight times higher than the rate for other children, while in South Australia it was 7.2 times higher. These higher rates may in part be related to the quality of the data on Indigenous status (see Box 32.1).
- In New South Wales the rate for Indigenous children was 3.6 times higher than the rate for other Australian children and in the Northern Territory it was 3 times higher.

Box 32.1: Data issues

The variation in the rate ratios across states and territories may in part reflect differences in the quality of the data on Indigenous status due to differences in practices adopted to identify and record Indigenous status. Some states and territories are using the standard ABS question (for example Queensland have just introduced this as a requirement for all child protection workers) but in others the information appears to be acquired in a more ad hoc way. Although the Indigenous status field is mandatory in all states and territories, there is a 'not known' option when entering the information onto the data system in all jurisdictions except Victoria. The proportion of 'unknowns' varies considerably across states and territories.

The quality of the child protection data on Indigenous status has improved in recent years as states and territories have introduced measures to improve the identification of Indigenous children in the child protection system. For example in New South Wales in 1998–99 and in Western Australia in 2001–02 practices were introduced to improve the identification of Indigenous children and this resulted in an increase in the number of children who were identified as Indigenous in both states and territories.

A number of states and territories are currently undertaking work to improve the quality of the Indigenous child protection data such as through the adoption of the standard ABS question to identify Indigenous status.

Indicator 35. Injuries presenting to hospital accident and emergency facilities

Indicator: The proportion of consultations at accident and emergency facilities by Aboriginal and Torres Strait Islander people that are for acute injury conditions.

Purpose

The indicator provides an estimate of the frequency of injury of sufficient severity to seek hospital care and reflects access of Aboriginal and Torres Strait Islander peoples to hospital.

Data

Information for this indicator was obtained from the states and territories; however, only four states and territories could provide data for this indicator. The Queensland data are from only 14 hospitals. Western Australia was only able to report total injury attendances and not the cause of the injury. The Northern Territory also does not report the cause of the injury. The data provided are not comparable across states and territories because of differences in the coding systems that were used.

- Around one-quarter of presentations at hospital and emergency facilities by Aboriginal and Torres Strait Islander people were due to acute injuries – in Victoria they represented 26% of presentations in 2000–01 and 24% in 2001–02; in Western Australia they represented 22% and 21% for the two years, and in the Northern Territory they represented 22% and 18% respectively (Table 35.1).
- Almost three-quarters of Indigenous presentations to hospital emergency and accident facilities were therefore not due to injury. This is consistent with other findings that suggest that Indigenous people frequently use accident and emergency facilities as an initial point of contact for their health concerns, rather than GPs.
- The large variation between states and territories in the cause of injury presentations may reflect differences in methods used for the coding of injuries.
- In Victoria about half of injury presentations by Indigenous people were for assaults (51% in 2000–01, 49% in 2001–02).
- In Queensland most injury presentations were for ‘other accidents’ (71% in 2000–01, 67% in 2001–02).
- New South Wales Health collects data from 54 emergency departments across the state. While this represents just over one-third of all emergency departments, it covers around two-thirds of total presentations. Rural emergency departments are underrepresented in the collection. This incomplete and unequal coverage invalidates reporting on this indicator at a state level. In addition, a number of studies have shown that Aboriginal people are under identified in emergency department injury data.

Table 35.1: Aboriginal and Torres Strait Islander presentations at hospital accident and emergency facilities, for selected states and territories, by injury type, 2000–01 and 2001–02

Injury type	Vic ^(a)		Qld ^(b)		WA ^(c)		NT ^(d)	
	No.	%	No.	%	No.	%	No	%
2000–01								
Road vehicle-related injury	106	5.4	n.a.	5.6	n.a.	n.a.	n.a.	n.a.
Other accidents	793	40.1	n.a.	70.9	n.a.	n.a.	n.a.	n.a.
Self-harm	78	3.9	n.a.	1.5	n.a.	n.a.	n.a.	n.a.
Assault	1,000	50.6	n.a.	22.0	n.a.	n.a.	n.a.	n.a.
Total injury presentations	1,977	100	n.a	100	2,109	100.0	8,162	100
All accident and emergency presentations	7,587	26.1	n.a.	n.a.	9,807	21.5	37,100 ^(d)	22
2001–02								
Road vehicle-related injury	122	6.1	n.a.	5.4	n.a.	n.a.	n.a.	n.a.
Other accident	832	41.6	n.a.	67.2	n.a.	n.a.	n.a.	n.a.
Self-harm	76	3.8	n.a.	3.2	n.a.	n.a.	n.a.	n.a.
Assault	970	48.5	n.a.	24.2	n.a.	n.a.	n.a.	n.a.
Total injury presentations	2,000	100	n.a.	100	2,521	100	7,091	100
All accident and emergency presentations	8,290	24.1	n.a.	n.a.	11,871	21.2	39,400 ^(d)	18

(a) Data collected through the Victorian Emergency Minimum Dataset is coded by a combination of ICD-10 and injury codes.

(b) Data from the Queensland Injury Surveillance and refer to calendar years 2001 and 2002, not financial year. Data are from 14 hospitals which comprise three sample regions: metropolitan (South Brisbane); regional (Mackay and Moranbah Health Districts) and remote (Mt Isa).

(c) Western Australia was not able to provide data by cause of injury.

(d) Injury presentations are classified on the basis of 'body part' and not by cause of the injury. Data on the total number of accident and emergency presentations for Aboriginal and Torres Strait Islanders were not provided and were estimated.

Note: There were problems with the reliability of the data from the Australian Capital Territory and these were not included.

Source: Data provided by the jurisdictions.

Box 35.1: Data issues

The data provided by some of the states and territories were not comparable as different classification systems were used and a number of states and territories could not provide quantitative data for this indicator.

The purpose of this indicator is to measure frequency of injury and access of Indigenous people to hospitals, but there is no comparison group specified for the indicator. A more useful measure would be injury presentations in hospital emergency sections per 100,000 populations for Indigenous Australians and other Australians, classed by severity.