Australian Government
Australian Institute of Health and Welfare

Cultural safety in health care for Indigenous Australians: monitoring framework

Web report | Last updated: **07 Jul 2023** | Topic: First Nations people

About

The *Cultural safety in health care for Indigenous Australians: monitoring framework* brings together available data to assess progress in achieving cultural safety in the health system for Indigenous Australians. The framework includes measures on culturally respectful health care services; Indigenous patient experiences of health care; and access to health care services. The data are presented at the national, state and regional levels.

Cat. no: IHW 222

- Monitoring framework
- Data

Findings from this report:

- From 2013 to 2021, the number of Indigenous Australian medical practitioners increased from 247 to 604
- From 2001 to 2021, enrolments by Indigenous Australian students in health-related courses rose from 931 to 4,227
- In 2021–22, 50% of Indigenous patients waited 50 days to be admitted for elective surgery (39 days for non-Indigenous)
- In 2019–21, Indigenous Australians left against medical advice for 4.0% of admitted-patient hospitalisations

Summary

Summary and key findings

Improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. This means a health system that respects Indigenous cultural values, strengths and differences, and also addresses racism and inequity.

The *Cultural safety in health care for Indigenous Australians: monitoring framework* aims to measure progress in achieving cultural safety in the Australian health system. For this purpose, cultural safety is defined with reference to the experiences of Indigenous health care users, of the care they are given, their ability to access services and to raise concerns.

The cultural safety monitoring framework covers three modules:

Module 1: Cultural respectful health care services

How health care services are provided

Module 2: Patient experience of health care

Indigenous patients' experience of health care

Module 3: Access to health care services

Selected measures regarding access to health care

Data are reported from a wide range of available national and state and territory level sources to provide a picture of cultural safety, though there are significant data gaps. Sources include both national administrative data collections and surveys of Indigenous health care users.

For the 2023 release, 26 measures out of 48 were updated. New data for the other 22 measures were not available. This was due to discontinued surveys or data items, revisions to survey questions or frequency of data collection. Further detail about measures that could not be updated is available in the relevant modules and in the Technical notes.

Module 1: Culturally respectful health care services

New data were available to update 5 out of 12 measures reported in Module 1 in the 2023 release.

Cultural respect is achieved when the health system is a safe environment for Indigenous Australians, and where cultural differences are respected. This module reports on how health care is provided, and whether cultural respect is reflected in structures, policies and programs.

Between 2013 and 2021:

- the number of Indigenous medical practitioners registered in Australia increased from 247 to 604 (from 31 to 69 per 100,000)
- the number of Indigenous nurses and midwives registered in Australia increased from 2,833 to 6,160 (324 to 701 per 100,000).

Among Indigenous-specific primary health care organisations and maternal/child health services:

- 46% of full-time equivalent (FTE) health staff in 2021–22 were Indigenous (2,305 FTE) – this proportion varied by type of health staff, with higher proportions for Aboriginal Health Practitioners/Aboriginal Health Workers (960 FTE, 99.5%) and other health workers (1,114 FTE, 52%) and lower proportions for GPs (42 FTE, 6.1%) and nurses and midwives (189 FTE, 15%)
- 40% provided interpreter services, while around one third offered culturally appropriate services such as bush tucker, bush medicine and traditional healing in 2017–18.

Module 2: Patient experience of health care

New data were available to update 9 out of 23 measures reported in Module 2 in the 2023 release.

The experiences of Aboriginal and Torres Strait Islander health care users, including having their cultural identity respected, is critical for assessing cultural safety. Aspects of cultural safety include good communication, respectful treatment, empowerment in decision making and the inclusion of family members.

- In 2018–19, 91% of Indigenous Australians aged 15 and over in non-remote areas reported that doctors always/often showed respect for what was said.

- In 2018–19, of the 243,663 Indigenous Australians who did not access health services when they needed to, 32% indicated this was due to cultural reasons, such as language problems, discrimination and cultural appropriateness.
- The Australian Reconciliation Barometer showed that the proportion of Indigenous Australians reporting racial discrimination by doctors, nurses and/or medical staff in the last 12 months has increased since 2014 (11% in 2014 to 20% in 2022).

The differences in rates of Indigenous and non-Indigenous hospital patients who choose to leave prior to commencing or completing treatment are frequently used as indirect measures of cultural safety. Indigenous Australians left against medical advice for 4.0% (26,985) of admitted-patient hospitalisations from 2019–20 to 2020–21. This was over 5 times the proportion of non-Indigenous Australians (3.8% and 0.7%, age-standardised, respectively).

Module 3: Access to health care services

New data were available to update 12 out of 13 measures reported in Module 3 in the 2023 release.

Aboriginal and Torres Strait Islander people do not always have the same level of access to health services as non-Indigenous Australians. Disparities in use of health services may indicate problems with access to health services, such as:

- availability and distance travelled, especially in remote and very remote areas
- affordability
- cultural appropriateness
- previous experiences of racism in health care environments for themselves, family or community members.

Selected measures of access to health care services for Indigenous and non-Indigenous Australians are used to monitor disparities in access.

- Mammogram participation rates for Indigenous Australian women increased between 2010–2011 and 2018–2019. Rates decreased in 2019–2020, during the COVID-19 pandemic.
- In 2020–21, the rate of potentially preventable hospitalisations for Indigenous Australians was almost 3 times the rate for non-Indigenous Australians (66 compared with 23 per 1,000, based on age-standardised rates).
- In 2021–22, the median waiting time for emergency department presentations was similar for Indigenous Australians than for other Australians (19 and 20 minutes, respectively).
- Indigenous Australians waited longer to be admitted for elective surgery in 2021–22 than non-Indigenous Australians – 50% of Indigenous patients were admitted for elective surgery within 50 days, compared with 39 days for non-Indigenous patients.
- In 2021, of 6,749 registered cases of rheumatic heart disease, 78% were Indigenous Australians compared with 22% non-Indigenous Australians.
- In 2021, the avoidable mortality rate for Indigenous Australians was 208 per 100,000. The age-standardised rate for Indigenous Australians was over 3 times that for non-Indigenous Australians (296 and 91 per 100,000 respectively).

Data gaps

Monitoring cultural safety and cultural respect in the health system, and the impact it has on access to appropriate health care, are limited by a lack of national and state level data. This is particularly the case in relation to reporting on the policies and practices of mainstream health services, such as primary health care services and hospitals.

There are limited data on the experiences of Indigenous health care users. Most jurisdictions undertake surveys about patients' experiences in public hospitals, but there is not a lot of available data on Indigenous patient experience. A high proportion of Indigenous Australians use mainstream health services, so further data developments in this area are required to allow for more comprehensive reporting across the health sector.

Additionally, the ABS Indigenous health and social surveys, for example, the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018–19 and the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) 2014–15, are national surveys to collect cultural safety information/ patient experience. Both surveys contain questions relevant to patient experience and cultural safety. However, the infrequent data collection (around 5–6 years or more) do not allow for the timely update of data for the monitoring framework.

The current monitoring framework focuses on the experience on the patient in the health care system. However, the experience of health care professionals and the cultural safety for Indigenous Australians in the health workforce are important aspects of a system free from racism.

This report brings together data from a wide range of sources. All the data presented in this monitoring framework are available in Excel format under Data. The Excel tables also include all relevant footnotes, technical details and individual data sources.

Impacts of COVID-19 on data

Since the beginning of the COVID-19 pandemic, protecting the health, safety and wellbeing of Indigenous Australians has been a key national priority. However, there has been ongoing recognition that the changes to the health system and the restrictions and lockdowns necessary to prevent the spread of COVID-19 may have affected the need for, and use of, a broad range of health services by Indigenous Australians. This update presents data, where available, spanning the COVID-19 pandemic in Australia.

Specific impacts on the data are discussed in relation to relevant measures however, the full impact of COVID-19 may become apparent in the data for other measures in future years.

Impacts of COVID-19 on data used in this report are also explored in the AIHW reports:

- *Impacts of COVID-19 on data* – Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023
- Impacts of COVID-19 on Medicare Benefits Scheme and Pharmaceutical Benefits Scheme: quarterly data
- The first year of COVID-19 in Australia: direct and indirect health effects
- Antenatal care during COVID–19, 2020
- Cancer screening and COVID-19 in Australia: What was the impact of COVID-19 in Australia?
- Australia's hospitals at a glance: Impact of COVID–19 on hospital care
- Emergency department care activity
- Admitted patient activity.

For data and information that relate to COVID-19, please see the AIHW's COVID-19 resources.

Monitoring framework

The *Cultural safety in health care for Indigenous Australians: monitoring framework* is structured around three modules: Module 1 – Culturally respectful health care services; Module 2 – Patient experience of health care; and Module 3 – Access to health care services. Each of the three modules contains a number of domains, focus areas and measures, with the following structure:

Module → domain → focus area → measure

The three modules look at different dimensions of cultural safety – how health care is provided, experienced and accessed. The domains are topics within the modules; focus areas look at specific issues in the domains; and measures describe the data presented in the focus areas.

The modules and their domains are set out below.

Module 1: Culturally respectful health care services

- Organisational approach and commitment
- Communication and cultural services
- Workforce development and training
- Consumer engagement and stakeholder collaboration

Module 2: Patient experience of health care

- Communication
- Treated respectfully
- Unfair treatment and cultural barriers
- Empowerment
- Family inclusion
- Leave events

Module 3: Access to health care services

- Preventive health services
- Primary health care
- Hospital services
- Specialist services
- Overall health system

Origin and policy context

The concept of cultural safety has been around for some time, with the notion originally defined and applied in the cultural context of New Zealand. It originated there in response to the harmful effects of colonisation and the ongoing legacy of colonisation on the health and healthcare of Maori people – in particular in mainstream health care services.

A commonly accepted definition of cultural safety from the Nursing Council of New Zealand (2005:7) is the 'effective nursing practice of a person or family from another culture, and is determined by that person or family. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.'

A distinctive feature of this definition of cultural safety is its emphasis on the provision of culturally safe health care services as defined by the end users of those services, notably, the Maori people of Aotearoa New Zealand, not by the [non-Maori] providers of care.

The National Collaboration Centre for Indigenous Health in Canada (2013) notes that culturally safe health care systems and environments are established by a continuum of building blocks:

Cultural awareness ⟹ Cultural sensitivity ⟹ Cultural competency ⟹ Cultural safety

The Centre states that cultural safety '…requires practitioners to be aware of their own cultural values, beliefs, attitudes and outlooks that consciously or unconsciously affect their behaviours. Certain behaviours can intentionally or unintentionally cause clients to feel accepted and safe, or rejected and unsafe. Additionally cultural safety is a systemic outcome that requires organizations to review and reflect on their own policies, procedures, and practices in order to remove barriers to appropriate care.'

In Australia, there has been increasing recognition that improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. This means a health system where Indigenous cultural values, strengths and differences are respected; and racism and inequity are addressed.

There are difficulties in both defining and measuring generalised concepts such as cultural respect and cultural safety. They include lack of conceptual clarity and agreement on terms, the qualitative nature of the concepts, and the diversity of Indigenous Australians and their perceptions. The Australian literature uses various definitions of cultural safety, and related concepts such as cultural respect and cultural competency, and what these mean in relation to the provision of health care.

The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (DoH 2021:52) states:

> Cultural safety is about *how* care is provided, rather than *what* care is provided. It requires practitioners to deliver safe, accessible and responsive health care that is free of racism by:
>
> - recognising and responding to the power imbalance between practitioner and patient
> - reflecting on their knowledge, skills, attitudes, practising behaviours, and conscious and unconscious biases.

For the purpose of developing a monitoring framework, cultural safety is defined with reference to the experience of the Indigenous health care consumer, of the care they are given, their ability to access services and to raise concerns. Some of the essential features of cultural safety include an understanding of one's culture; an acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of this difference; and the ability to recognise, address and prevent racism. The presence or absence of cultural safety is determined by the experience of the recipient of care and is not defined by the caregiver (AHMAC 2016).

Two important aspects of culturally safe health care across the literature are, how it is *provided* and how it is *experienced*, and these form the basis for the monitoring framework (see AHMAC 2016; CATSINAM 2014; AIDA 2021; DHHS 2016; NACCHO 2011; DoH 2015).

How health care is *provided*

- behaviour, attitude and culture of providers: respects and understands Indigenous culture and people
- defined with reference to the provision of care, including governance structures, policies and practices
- providers' ability to recognise, address and prevent racism at the individual and organisational levels.

How health care is *experienced* by Indigenous people

- feeling safe, connected to culture and cultural identity is respected
- can only be defined by those who receive health care.

The importance of cultural respect and cultural safety is outlined in Australian government documents, such as:

- *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health*
- *National Aboriginal and Torres Strait Islander Health Plan 2021–2031*.
- *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*

The health plan was developed in genuine partnership with Aboriginal and Torres Strait Islander people and reflects their key priorities. It recognises the influence of social factors and the strengths of culture as protective factors for physical, social and emotional wellbeing.

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) also included six Aboriginal and Torres Strait Islander specific actions in the *National Safety and Quality Health Service Standards* to improve care for Aboriginal and Torres Strait Islander people in mainstream health services.

Increasing representation of Aboriginal and Torres Strait Islander people in the health workforce is a key pathway to improving cultural safety in health care. This is the focus of both the Department of Health and Aged Care's *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* and the Australian Health Practitioner Regulation Agency's (Ahpra) *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025*.

Development of a monitoring framework

The *Cultural safety in health care for Indigenous Australians: monitoring framework* aims to measure progress in achieving cultural safety in the Australian health system by bringing together data related to cultural safety. Specifically, to measure progress in achieving cultural safety in the health system under the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The framework can also assist in measuring progress in achieving cultural safety under the Cultural Respect Framework which commits the Commonwealth Government, and states and territories, to embed cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services.

The release of the *2020–2031 National Agreement on Closing the Gap* necessitated revisions to the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, in order for the Health Plan to be aligned with the objectives and timeframes of the National Agreement. Following the release of the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* the Implementation Plan will be revised and a new accountability framework will be created.

In consultation with key stakeholders, including the former National Aboriginal and Torres Strait Islander Health Standing Committee and the Implementation Plan Advisory Group, this monitoring framework was developed through a review of relevant policy documents, academic literature, and potential national and state level data sources.

The framework has 3 reporting modules which each include a range of measures focussing on culturally respectful health care services, patient experience of health care among Indigenous Australians, and access to health care as an indirect measure of cultural safety.

Module 1: Culturally respectful health care services

- includes measures about how health care is delivered and whether systems and providers are aware of and responsive to Indigenous Australians' cultural needs and experiences
- largely based on the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health*

Module 2: Patient experience of health care

- includes measures about Indigenous Australians' experiences of health care including communication, interpersonal treatment and empowerment, and is not defined by the caregiver
- based on a literature review and research on different aspects of Indigenous Australians' views on cultural safety

Module 3: Access to health care services

- includes broad measures of access to health care services to monitor disparities in access
- relates to different levels of the health system–preventive health services; primary health care; hospital and specialist services

Reporting against the framework

This monitoring framework brings together available national and state and territory level data to provide a picture of cultural safety in the health system. The scope of national and state and territory level data currently available are limited and further development is required to enable more comprehensive reporting. For more detail see information about data gaps in *Module 1: Culturally respectful health care services*, *Module 2: Patient experience of health care*, and *Module 3: Access to health care services*.

Monitoring cultural safety and cultural respect in the health system, and the impact it has on access to appropriate health care, is limited by a lack of national and state level data. This is particularly the case in relation to reporting on the policies and practices of mainstream health services, such as primary health care services.

There are also limited data on the experiences of Indigenous health care users. Most jurisdictions undertake patient experience surveys in public hospitals, but there is little data on Indigenous Australians for reporting. A high proportion of Indigenous Australians use mainstream health services, so further data developments in this area are required to allow for more comprehensive reporting across the health sector.

As data developments occur and more comprehensive data become available, the cultural safety monitoring framework will be expanded and updated.

Relevant data developments

Data development for cultural safety measures is ongoing. There are also research and developments in measurement of areas related to cultural safety, such as wellbeing and quality of life.

One such project is What Matters 2 Adults study, which aims to develop a new instrument to measure and value wellbeing dimensions that are important to Indigenous Australians (Howard et al. 2020). In 2021, the authors published findings from the qualitative component of the study, which involved 359 Aboriginal and Torres Strait Islander adults from around Australia. A thematic analysis identified 5 foundations of wellbeing: belonging and connection, holistic health, purpose and control, dignity and respect, and basic needs. These findings will inform the development of a new wellbeing measure (Garvey et al. 2021). This project is still underway.

Another example is the Mayi Kuwayu study, a national longitudinal survey of Indigenous Australians aged 16 years and above. It began in 2018 and could provide relevant data on cultural safety in the future. This survey, which was created by and for Indigenous people, focusses on the importance of culture and how it affects wellbeing, and includes a module on discrimination and racism in health care. Initial results from the study and the validity of the instrument used to measure discrimination in health care experienced by Indigenous Australians are discussed in Thurber and others (2021). There have been a number of publications released by the Mayi Kuwayu team. Links to these publications appear in the relevant domains within the monitoring framework.

Indigenous patients' experiences of health care could be reported through Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) surveys. The collection of patient-reported data through standardised PREMs and PROMs for Indigenous health care users' needs to consider the cultural adaptability of these tools and development work is underway to address this at hospital and primary health care service level.

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* includes the development of mechanisms to ensure that cultural safety training translates into improved experiences and outcomes for Aboriginal and Torres Strait Islander workers. The plan recognises that participation of Aboriginal and Torres Strait Islander peoples in the health workforce will promote culturally safe care and improve health outcomes for Aboriginal and Torres Strait Islander patients.

References

AHMAC (Australian Health Ministers' Advisory Council) 2016. Cultural Respect Framework 2016–26 for Aboriginal and Torres Strait Islander Health: a national approach to building a culturally respectful health system. Canberra: AHMAC.

AIDA (Australian Indigenous Doctors' Association) 2021. Position Paper: Cultural Safety. Canberra: AIDA.

CATSINaM (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives) 2014. Towards a shared understanding of terms and concepts: Strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander peoples. Canberra: CATSINaM.

DoH (Department of Health) 2015. Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. Canberra: DoH.

DoH 2021. National Aboriginal and Torres Strait Islander Health Plan 2021–2031. Canberra: DoH.

DHHS (Department of Health and Human Services) 2016. Improving cultural responsiveness of Victorian hospitals: Final Report. Victoria: DHHS.

Garvey G, Anderson K, Gall A, Butler TL, Cunningham J, Whop LJ, Dickson M, Ratcliffe J, Cass A, Tong A, Arley B and Howard K 2021. What Matters 2 Adults (WM2Adults): Understanding the Foundations of Aboriginal and Torres Strait Islander Wellbeing18:6193. doi: 10.3390/ijerph18126193.

Howard K, Anderson A, Cunningham J, Cass A, Ratcliffe J, Whop LJ et al 2020. What Matters 2 Adults: a study protocol to develop a new preference-based wellbeing measure with Aboriginal and Torres Strait Islander adults (WM2Adults). BMC Public Health 20: 1739. doi:10.1186/s12889-020-09821-z.

NACCHO (National Aboriginal Community Controlled Health Organisation) 2011. Creating the NACCHO Cultural Safety Training Standards and Assessment Process: A background paper. Canberra: NACCHO.

National Collaborating Centre for Indigenous Health 2013. Towards Cultural Safety for Métis: An Introduction for Heath Care Providers. Canada: University of Northern British Columbia.

Nursing Council of New Zealand 2005. Guidelines for cultural safety, the treaty of Waitangi, and Maori health in nursing and midwifery education and practice. Wellington: Nursing Council of New Zealand.

Thurber KA, Walker J, Batterham PJ, Gee GC, Chapman J, Priest N et al. 2021. Developing and validating measures of self-reported everyday and healthcare discrimination for Aboriginal and Torres Strait Islander adults. International Journal of Equity in Health 10: 14. doi:10.1186/s12939-020-01351-9.

Module 1: Culturally respectful health care services

Structures, policies and processes across the health system all play a role in delivering culturally respectful health care. The provision of culturally safe health care for Aboriginal and Torres Strait Islander people reflects the extent to which health care systems and providers are aware of and responsive to Indigenous Australians' cultural needs and experiences. Cultural safety cannot be improved in isolation from the provision of health care.

What data are available?

New data were available to update 5 out of 12 measures reported in Module 1 for the 2023 release. The other 7 measures could not be updated due to discontinued data items in the Online Services Report (OSR). For more information see Data gaps and limitations, Data sources and data gaps and Technical notes.

The main information source of data for this module is the Online Services Report (OSR). OSR data is collected from organisations funded by the Australian Government to deliver primary health care services to Aboriginal and Torres Strait Islander people under the Indigenous Australians Health Program. The OSR includes organisations providing comprehensive primary care services and organisations providing maternal and child health programs and services. Mainstream services are not included in the OSR data.

The numbers and proportions of Indigenous Australians in the health workforce can also be obtained from the National Health Workforce Data Set and the ABS Census of Population and Housing (the census). Data from the National Health Workforce Data Set are presented in domain 1.3 below. Health labour force data from the census are presented in Measure 3.12 of the Aboriginal and Torres Strait Islander Health Performance Framework. The data from the census differ from the National Health Workforce Data Set due to differences in methodology.

In addition, national data are also reported on Indigenous Australians enrolled in health-related training courses and those registered across the health system, including GPs, nurses and some specialist doctors. The Indigenous workforce is integral to ensuring that the health system addresses the health needs of Indigenous Australians in a culturally safe and sensitive way.

For further information on the data sources used in this module, see Module 1 – Data sources and data gaps.

Key findings

Among the Indigenous-specific primary health care organisations and maternal/child health services reporting to the OSR:

- Of the total 2,305 FTE employed in the services in 2021–22, 46% were Indigenous. This proportion varied by type of health staff:
  - Aboriginal Health Practitioners/ Aboriginal Health Workers (960 FTE, 99.5%)
  - other health workers including sexual health workers , traditional healers and trainees (1,114 FTE, 52%)
  - GPs (42 FTE, 6.1%)
  - nurses and midwives (189 FTE, 15%).
- Of the total 217 services, 40% provided interpreter services, while around one third offered culturally appropriate services such as bush tucker, bush medicine and traditional healing in 2017–18.

National health workforce data show that in Australia from 2013 to 2021, the number of Indigenous:

- medical practitioners registered increased from 247 to 604
- nurses and midwives registered increased from 2,833 to 6,160.

Higher education statistics from the Department of Education show that from 2001 to 2021, the rate of enrolment in health-related courses for Indigenous Australian students increased from 27 per 10,000 (931 students) to 71 per 10,000 (4,227 students).

See Module 1 data tables for all data presented in this module.

Data gaps and limitations

Following a review of the OSR and nKPI collections in 2018, the collection of specific OSR data items on cultural safety were paused (AIHW 2020). Data collected in 2017–18 reporting period are the latest data available on cultural safety from Indigenous specific primary health care services.

Data on cultural safety in mainstream health services, such as general practitioners, and public hospitals continue to be critical data gaps. Data on these services are required to provide a more comprehensive assessment of cultural safety across the Australian health system.

References

AIHW (Australian Institute of Health and Welfare) 2020. Review of the two national Indigenous specific primary health care datasets: The Online Services Report and the national Key Performance Indicators. Cat. no. IHW 222. Canberra: AIHW. Accessed 20 June 2023.

Module 1 domains

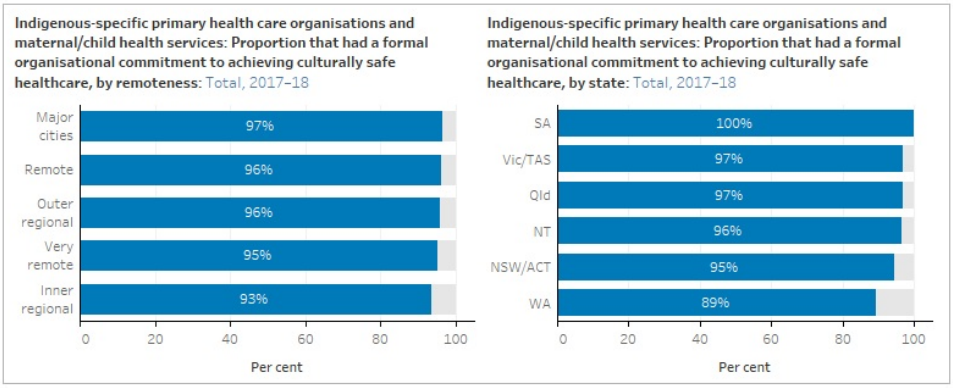
1.1 Organisational approach and commitment

An organisational approach and commitment to providing culturally respectful and safe health care at the highest level is necessary but not sufficient to ensure care is culturally safe. Aboriginal and Torres Strait Islander leadership at the board or executive level can be an indicator that services are culturally aware and respectful. Data on these measures are provided from organisations funded to deliver comprehensive primary health care and/or maternal and child health services to Indigenous Australians. Data on Indigenous leadership at the board/executive level are available for 2021–22, while the latest available data on organisational approach and commitment are for the 2017–18 collection period.

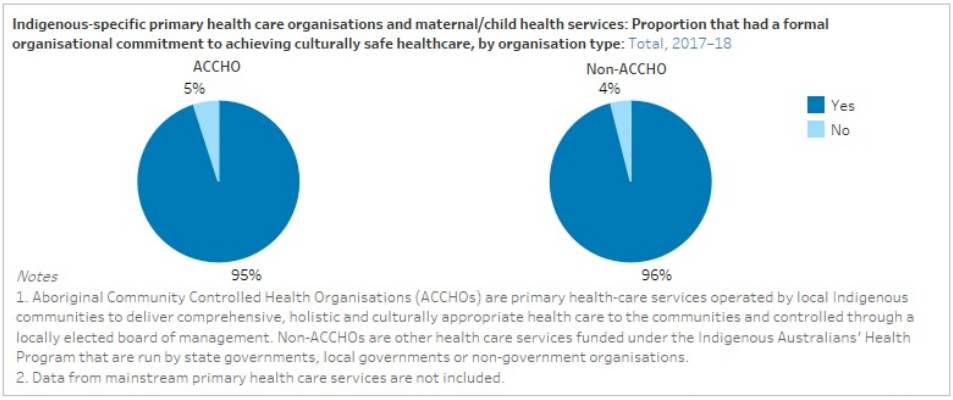
Organisational commitment to culturally respectful and safe healthcare

The data items below are no longer collected. The most recent collection period for these data was 2017–18. For a complete list of what data were available for the 2023 update, see Technical notes.

This figure is a set of interactive graphs showing the proportion of Indigenous primary health care organisations and maternal/child health services that had a formal organisational commitment to achieving culturally safe healthcare, and the proportion of Indigenous primary health care services that had a mechanism for obtaining advice on cultural matters in 2017–18. Both measures are disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time. See data tables for Module 1 – tables 1.1.1a and 1.1.1b.

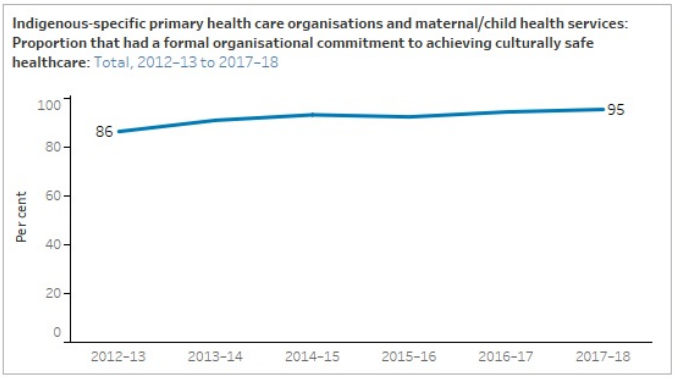


Note: Data from mainstream primary health care services are not included.



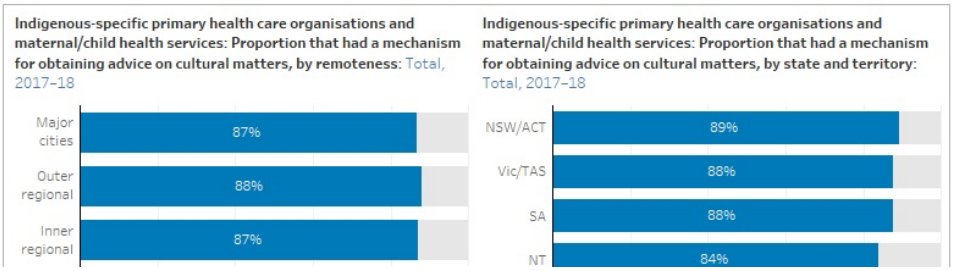
Notes

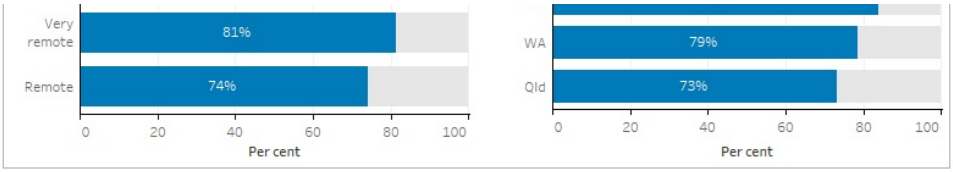
1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.



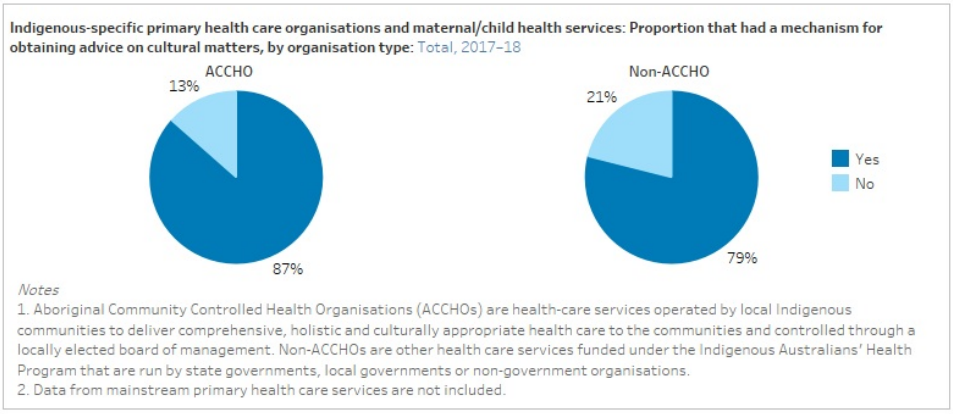
The proportion of organisations reporting to the OSR with a commitment to achieving culturally safe health care was **95% in 2017–18,** an increase from **86% in 2012–13**

Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.1.1a).

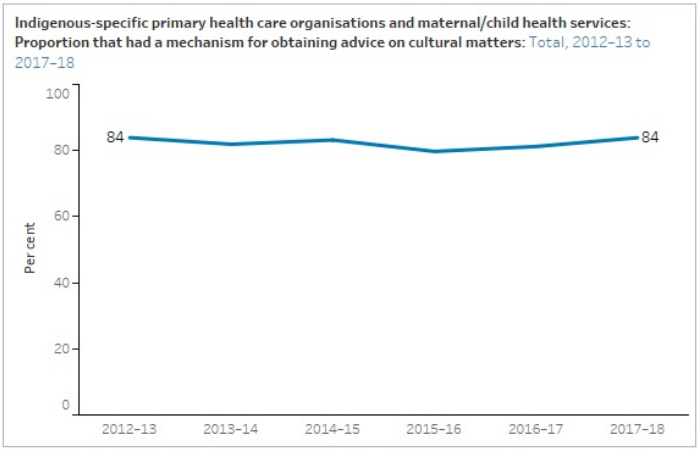




Note: Data from mainstream primary health care services are not included.



Notes
1. Aboriginal Community Controlled Health Organisations (ACCHOs) are health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.

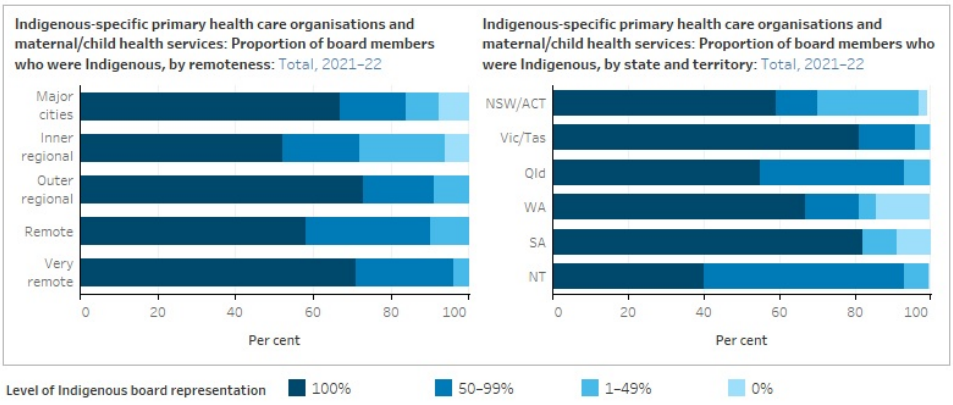


8 out of 10 organisations reporting to the OSR had mechanisms for obtaining **advice on cultural matters**

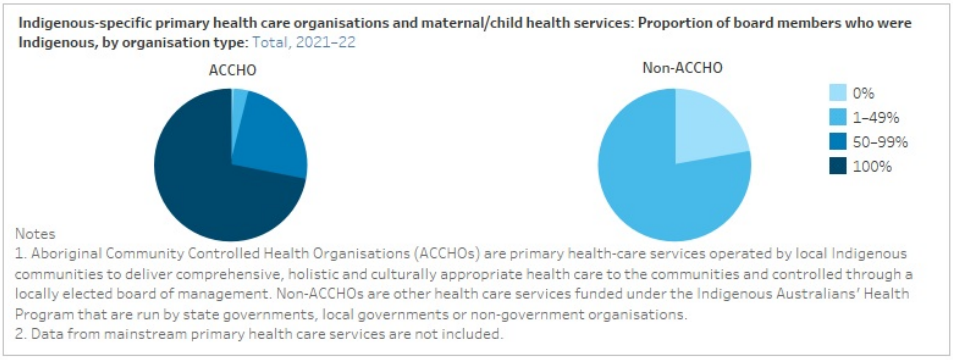
Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.1.1b).

Aboriginal and Torres Strait Islander leadership at Board/Executive level

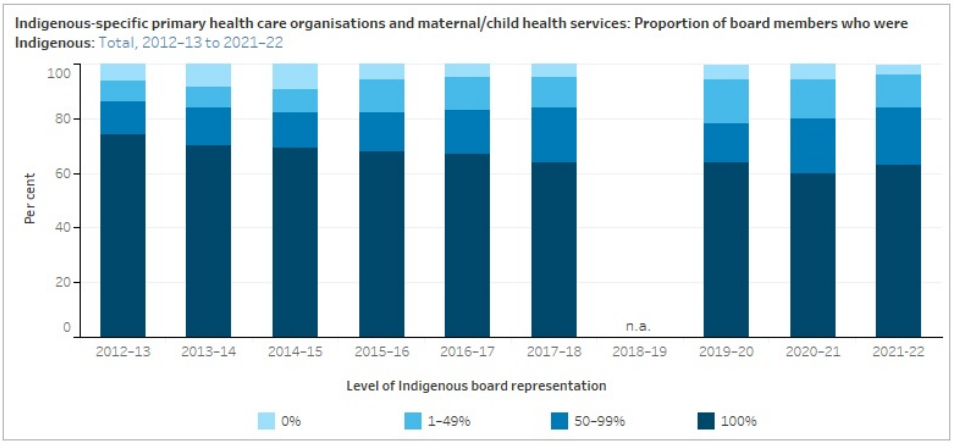
The figure is a set of interactive graphs showing the proportion of Indigenous primary health care organisations and maternal/child health services that had an Indigenous board in 2021–22, disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time. See data tables for Module 1 – Table 1.1.2.



Note: Data from mainstream primary health care services are not included.



Notes
1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.



n.a. = data not available for this year.
Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2021–22, previously unpublished (see data tables for Module 1 – Table 1.1.2).

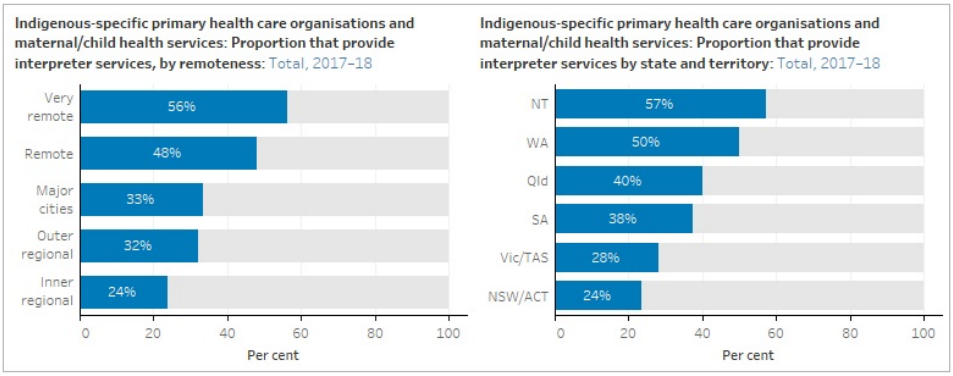
1.2 Communication and cultural services

Health service environments that value Aboriginal and Torres Strait Islander culture by displaying Indigenous artwork and providing culturally appropriate resources, communications and other services can help to make Indigenous people feel culturally safe.

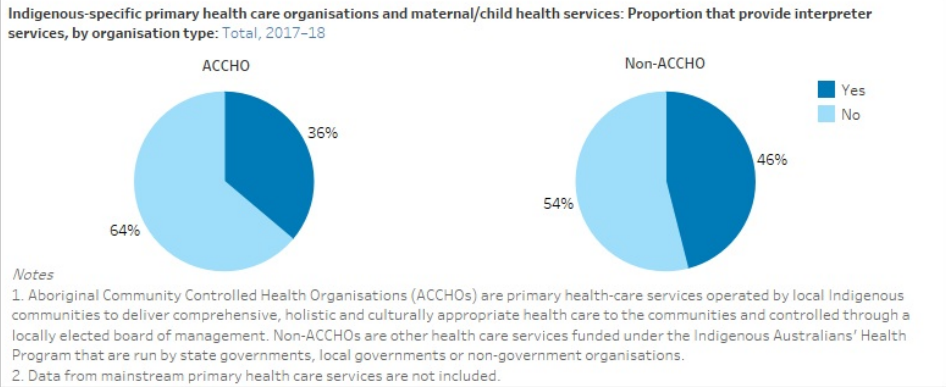
There are some data on communication and cultural services from organisations funded to provide comprehensive primary health care and maternal and/or child health services to Indigenous Australians. The latest data available from the OSR collection on communication and cultural services are for the 2017–18 collection period.

Culturally appropriate communication resources

The data items below are no longer collected. The most recent collection period for these data was 2017–18. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of Indigenous primary health care organisations and maternal/child health services that provided interpreter services in 2017–18, disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time. See data tables for Module 1 – Table 1.2.1

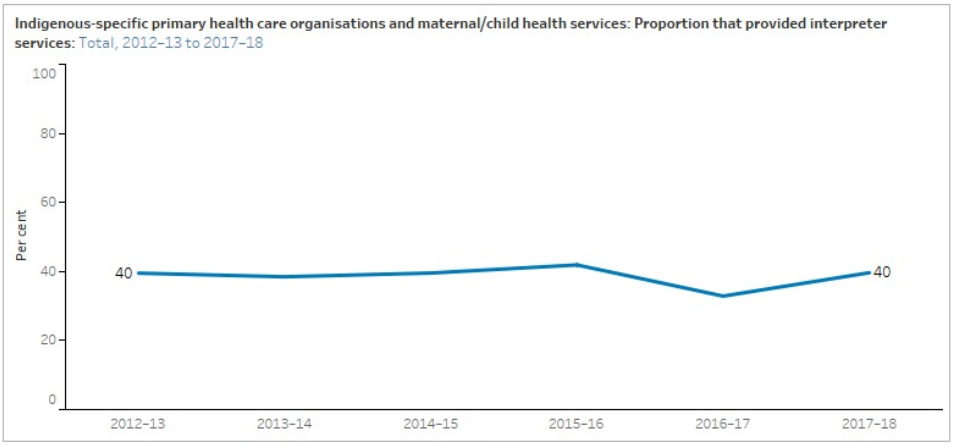


Note: Data from mainstream primary health care services are not included.



Notes

1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.



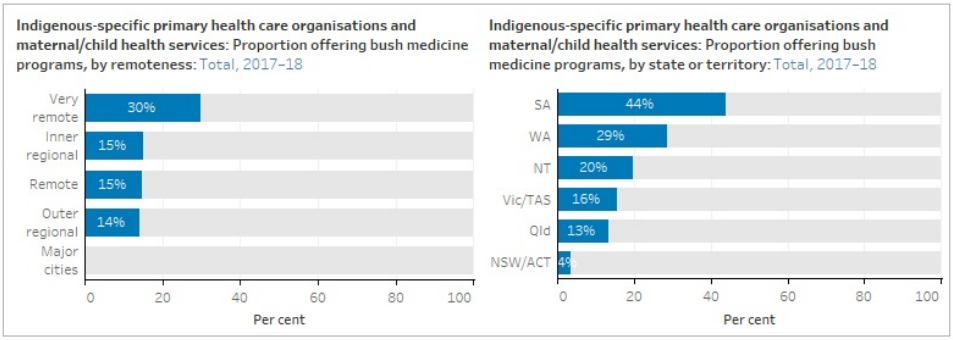
Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.2.1).

Offers culturally appropriate services

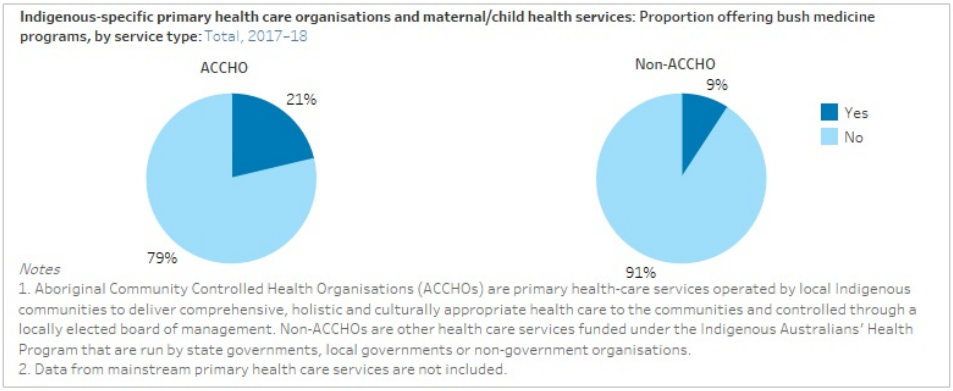
The data items below are no longer collected. The most recent collection period for these data was 2017–18. For a complete list of what data were available for the 2023 update, see Technical notes.

The figure is a set of interactive graphs showing the proportion of Indigenous primary health care organisations and maternal/child health services that provided culturally appropriate services (bush medicine, bush tucker or traditional healing) in 2017–18, disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time. See data tables for Module 1 – Table 1.2.2.

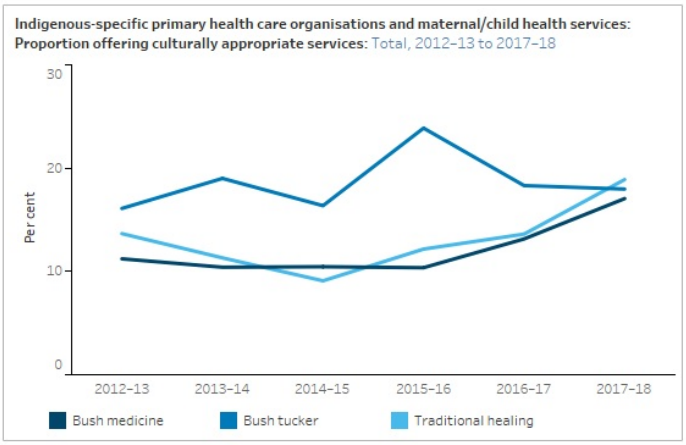
Choose service type:
Bush medicine



Note: Data from mainstream primary health care services are not included.



Notes
1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.



More than **one quarter (27%)** of organisations reporting to the OSR in **very remote** areas provided **bush tucker programs**

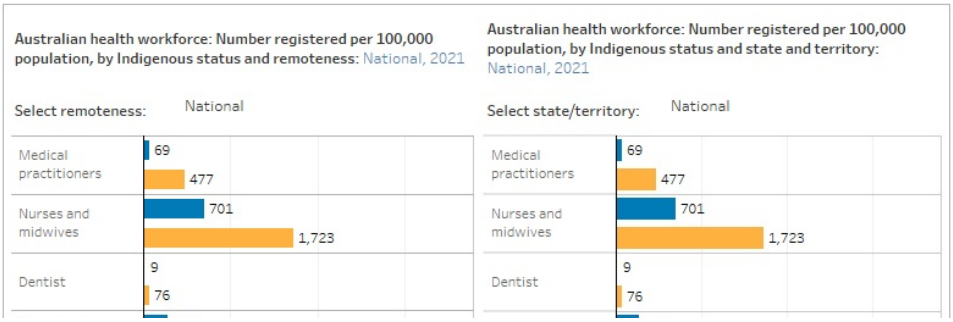
Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.2.2).

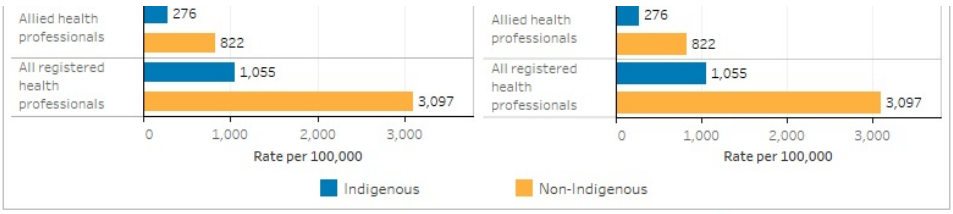
1.3 Workforce development and training

Aboriginal and Torres Strait Islander employees in the health workforce can increase the cultural safety of Indigenous patients because they understand the needs and priorities of Indigenous patients. National data are available on Indigenous enrolments in health-related courses and Indigenous participation in the health workforce for 2021 . Data on the health workforce and on cultural safety training among non-Indigenous staff are also available from organisations funded to provide comprehensive primary health care and/or maternal and child health services to Indigenous Australians with the latest data available from the OSR collection are for the 2017–18 collection period.

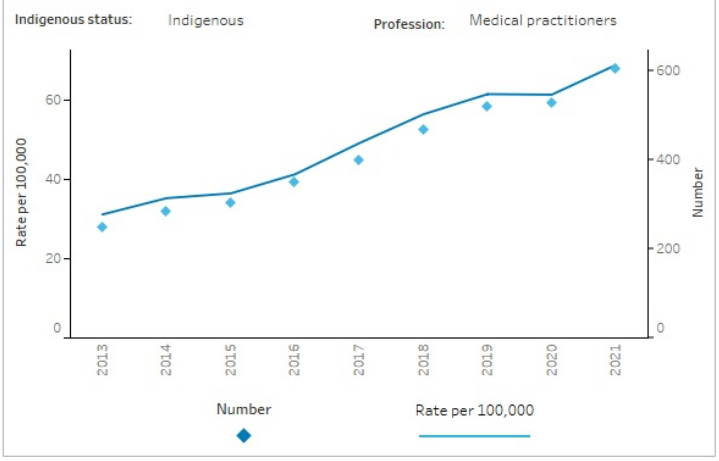
Aboriginal and Torres Strait Islander participation in the workforce

The figure is a set of interactive graphs showing the Australian health workforce by Indigenous status, remoteness, state and territory in 2021 and over time. It then shows the proportion of full time equivalent staff at Indigenous primary health care organisations and maternal/child health services that are Indigenous, by profession, remoteness, state and territory, ACCHOs or non-ACCHOs in 2021–22, and over time. See data tables for Module 1 – Tables 1.3.1a and 1.3.1b.





Australian health workforce: Number and rate of registered medical practitioners/nurses and midwives: National, 2013 to 2021

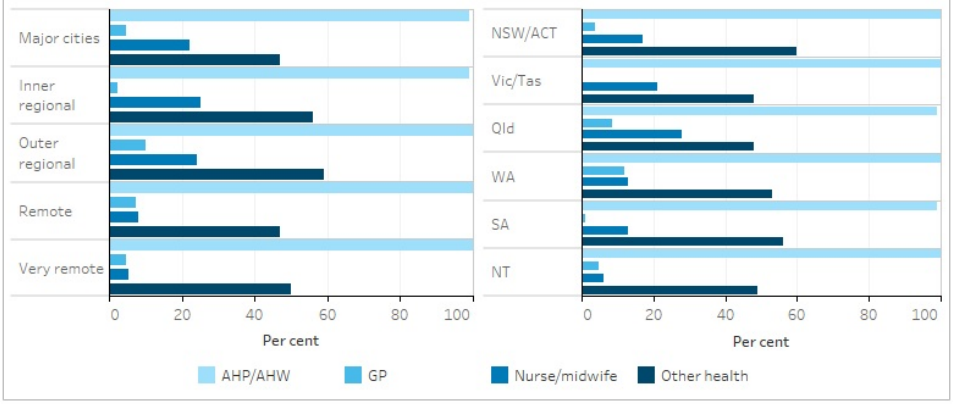


From 2013 to 2021 the number of Indigenous Australian medical practitioners increased from **247 to 604**

Source: AIHW analysis of National Health Workforce Data Set, as published in DHAC 2022 (see data tables for Module 1 – Table 1.3.1a).

Indigenous-specific primary health care organisations and maternal/child health services: Proportion of full time equivalent employees that are Indigenous, by remoteness: National, 2021–22

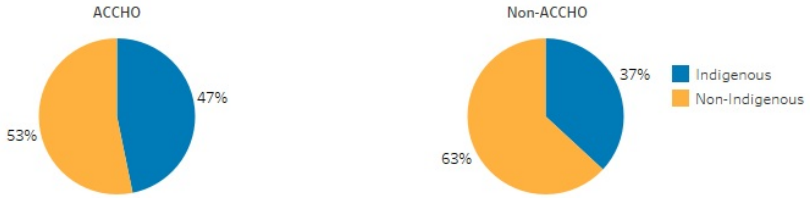
Indigenous-specific primary health care organisations and maternal/child health services: Proportion of full time equivalent employees that are Indigenous, by state and territory: National, 2021–22



Note: Data from mainstream primary health care services are not included.

Indigenous-specific primary health care organisations and maternal/child health services: Proportion of full time equivalent employees that are Indigenous, by organisation type: National, 2021–22

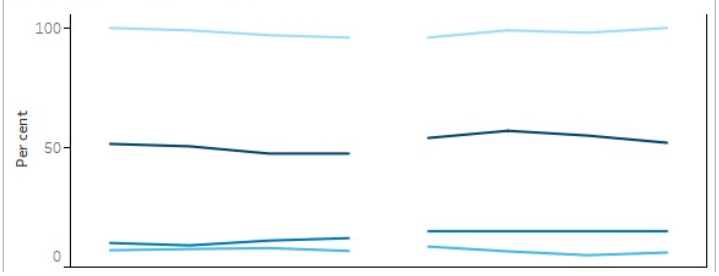
Select profession:
All health



Notes
1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.

Indigenous-specific primary health care organisations and maternal/child health services: Proportion of the workforce that is Indigenous: National, 2014–15 to 2021–22

View data by: By type of health staff



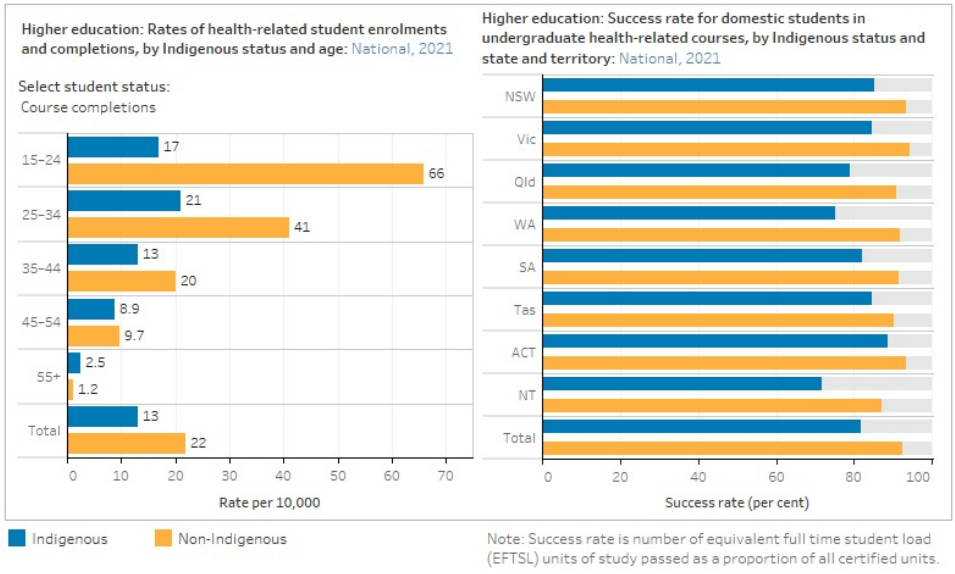
In 2021–22 **almost half** of full time equivalent employees in organisations reporting to the

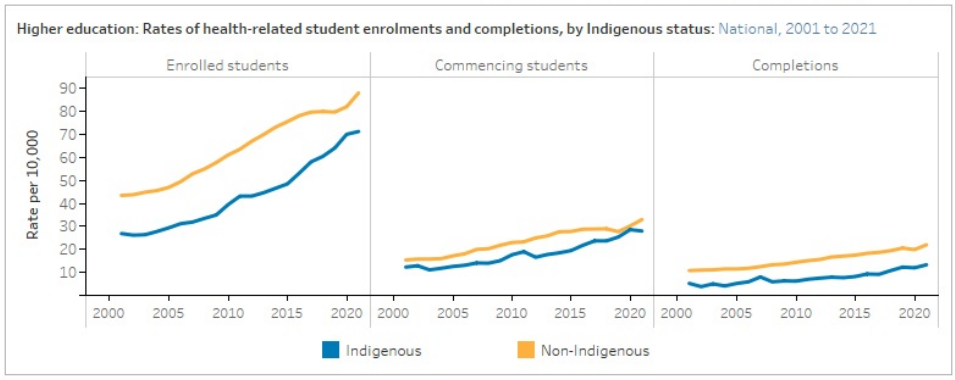
AHP/AHW = Aboriginal and Torres Strait Islander health workers and practitioners.
Source: Online Services Report, 2012–13 to 2020–21, previously unpublished (see data tables for Module 1 – Table 1.3.1b, 1.3.1c).

The Mayi Kuwayu team published a paper further describing trends in the Indigenous health workforce using ABS Census data from 2006, 2011 and 2016. The team found that while the number of Indigenous Health Workers had increased over this time (1,009 in 2006 to 1,347 in 2016), the rates showed a slight decrease (221 per 100,000 population in 2006 to 207 per 100,000 in 2016) (Wright et al. 2019). AIHW analysis of Census data also showed a slight decrease in the rate of Aboriginal and Torres Strait Islander Health Workers from 35 per 10,000 in 2006 to 30 per 10,000 in 2016. This increased to 32 per 10,000 in 2021 (AIHW forthcoming). See Measure 3.12 of the Aboriginal and Torres Strait Islander Health Performance Framework for more information. The rates published by the AIHW differ from those published by Mayi Kuwayu due to differences in methodology.

Aboriginal and Torres Strait Islander workforce development

The figure is a set of interactive graphs showing the rates of health-related student enrolments, commencing students and completions in higher education in 2021, by Indigenous status, age group and over time, as well as the success rate of students by Indigenous status and state and territory. It then shows the rates of health-related vocational education and training course enrolments and completions in 2021, by Indigenous status, state and territory, remoteness and over time. See data tables for Module 1 – Tables 1.3.2a, 1.3.2b, 1.3.2c and 1.3.2d.

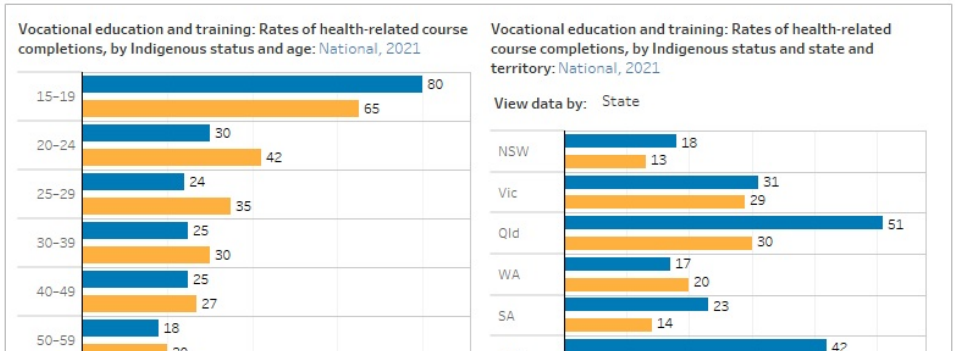


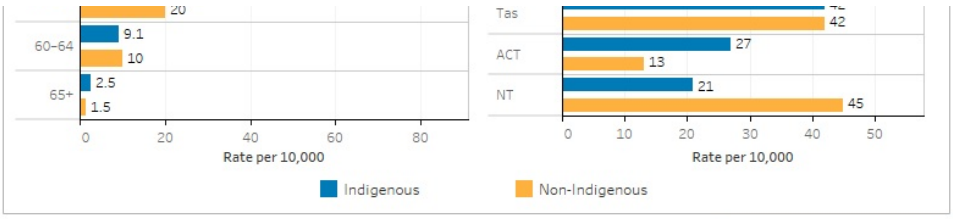


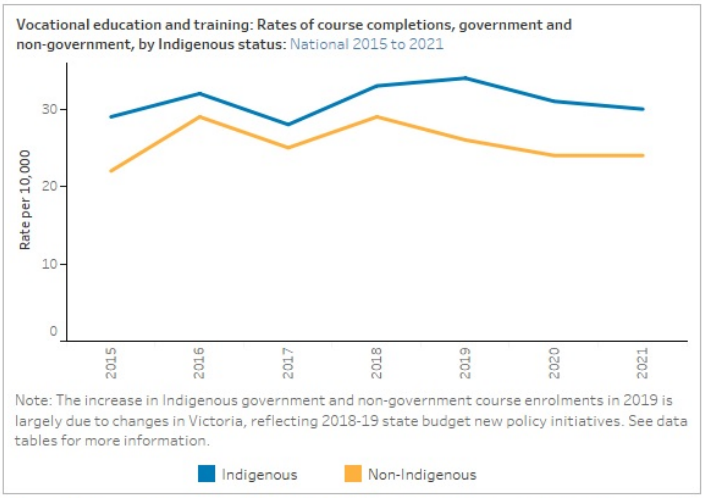
Source: Department of Education Higher Education Statistics (see data tables for Module 1 – Tables 1.3.2a, 1.3.2b).

Choose student status:
Course completions

Choose type of training:
Government and non-government







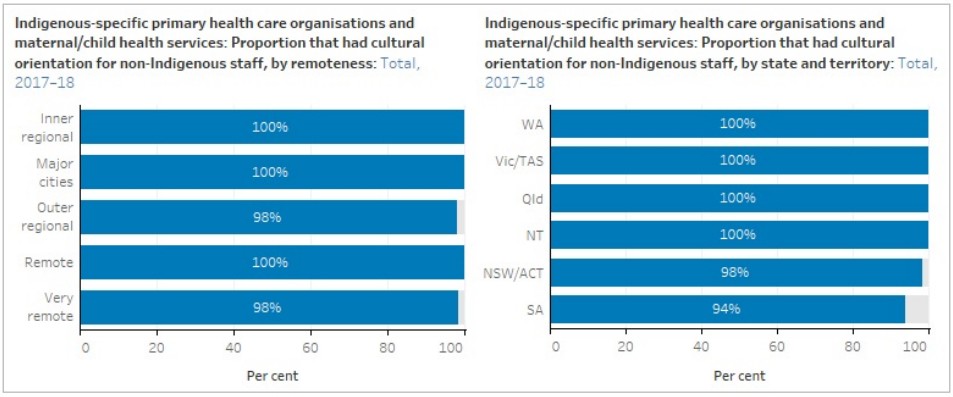
From 2015 to 2021, **Indigenous Australians** were **more likely to complete** health-related vocational education and training than non-Indigenous Australians

Source: AIHW analysis of National Vocational Education and Training Provider Collection, as published in NCVER 2022 (see data tables for Module 1 – Tables 1.3.2c, 1.3.2d).

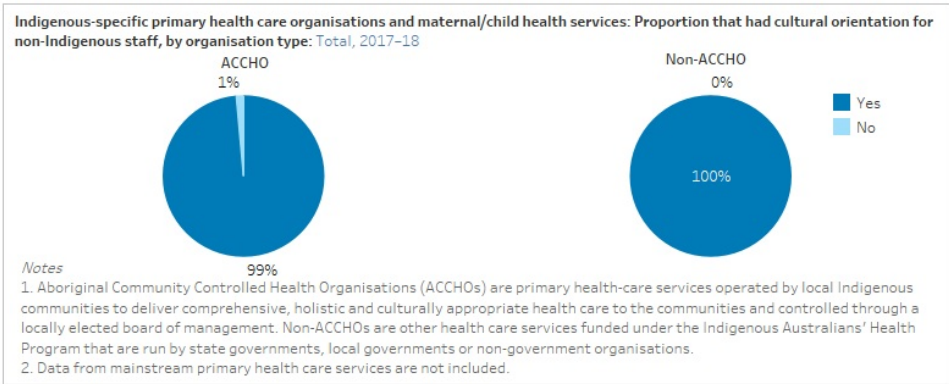
Cultural safety and responsiveness training for staff

The data items below are no longer collected. The most recent collection period for these data was 2017–18. For a complete list of what data were available for the 2023 update, see Technical notes.

The figure is a set of interactive graphs showing the proportion of Indigenous primary health care organisations and maternal/child health services that offered cultural orientation for non-Indigenous staff in 2017–18, disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time (from 2012–13). See data tables for Module 1 – Table 1.3.3.

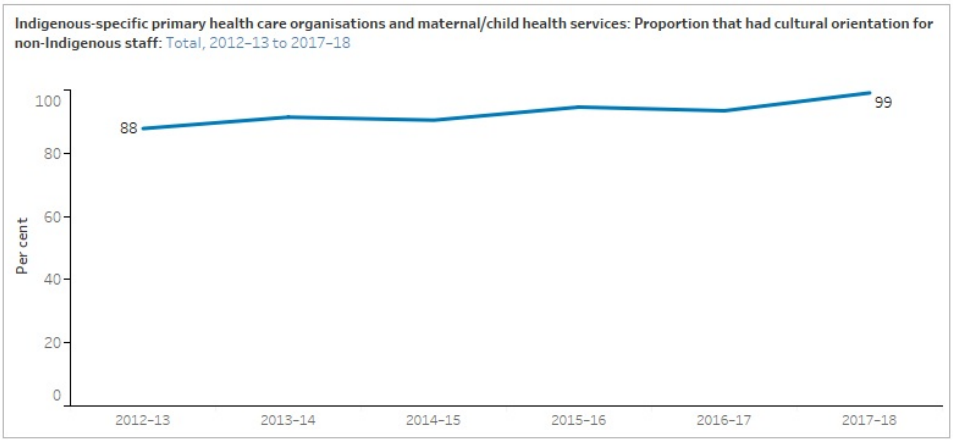


Note: Data from mainstream primary health care services are not included.



Notes

1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.



Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.3.3).

References

AIHW (Australian Institute of Health and Welfare) forthcoming. Measure 3.12: Aboriginal and Torres Strait Islander people in the health workforce. Aboriginal and Torres Strait Islander Health Performance Framework website.

DHAC (Department of Health and Aged Care) 2022. Health Workforce Data [TableBuilder]. DHAC website. Accessed 10 February 2023.

NCVER (National Centre for Vocational Education Research) 2022. VOCSTATS [TableBuilder]. NCVER website. Accessed 10 February 2023.

Wright A, Briscoe K and Lovett R 2019. A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006-2016. Australian and New Zealand Journal of Public Health. 43(1):24-26. doi:10.1111/1753-6405.12864.

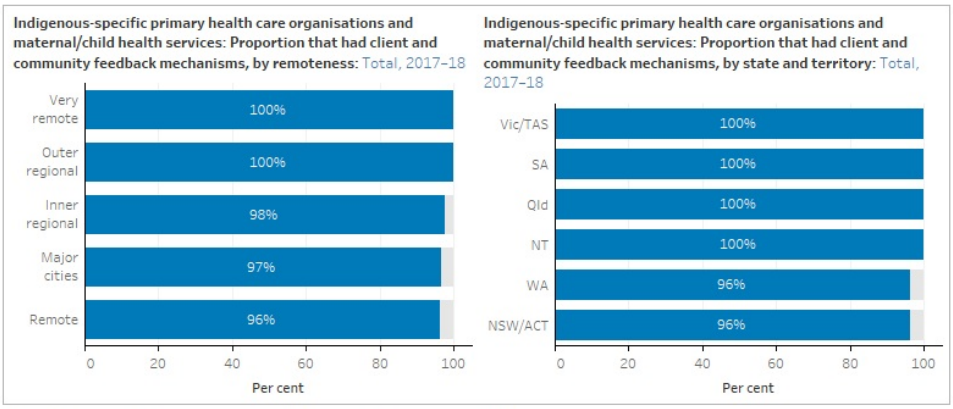
1.4 Consumer engagement and stakeholder collaboration

Client and community feedback is important for health services to ensure that their policies and programs are meeting the needs of Aboriginal and Torres Strait Islander communities. Collaboration with Indigenous organisations is also important for ensuring services are culturally respectful. Data on these measures are provided from organisations funded to provide comprehensive primary health care and/or maternal and child health services to Indigenous Australians. The latest data available from the OSR collection on consumer engagement and stakeholder collaboration are from 2017–18.

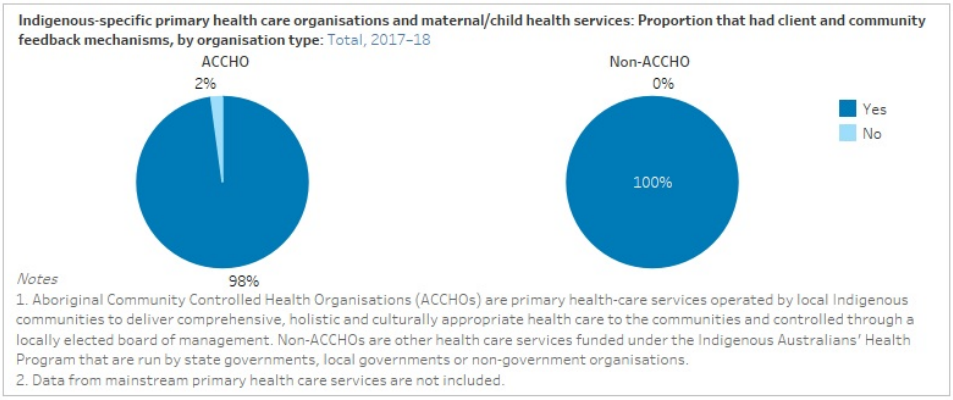
Client and community feedback mechanisms

The data items below are no longer collected. The most recent collection period for these data was 2017–18. For a complete list of what data were available for the 2023 update, see Technical notes.

The figure is a set of interactive graphs showing the proportion of Indigenous primary health care organisations and maternal/child health services that had formal cultural safety policies in 2017–18, disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time (from 2012–13). See data tables for Module 1 – Table 1.4.2.

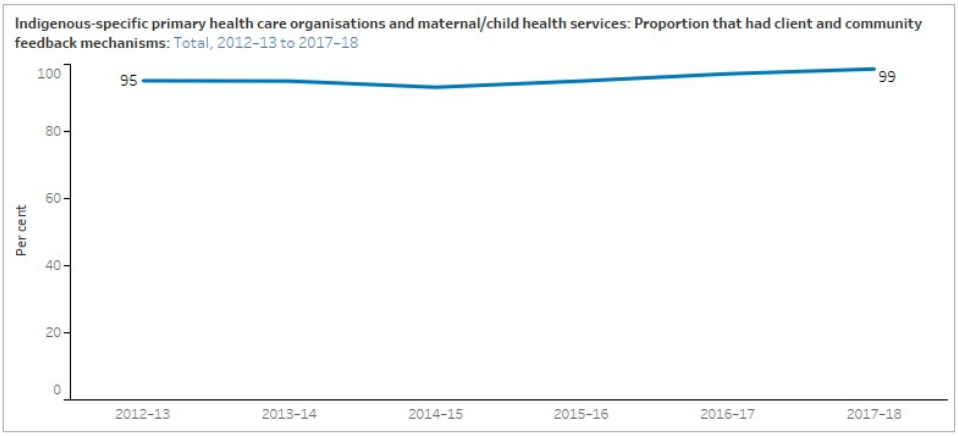


Note: Data from mainstream primary health care services are not included.



Notes

1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.

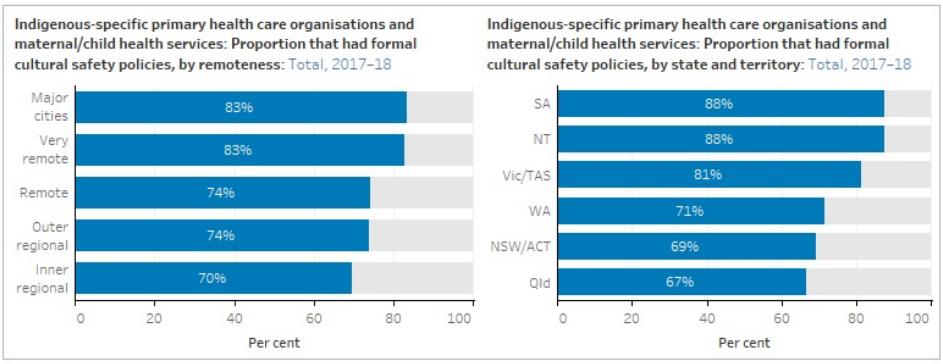


Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.4.1).

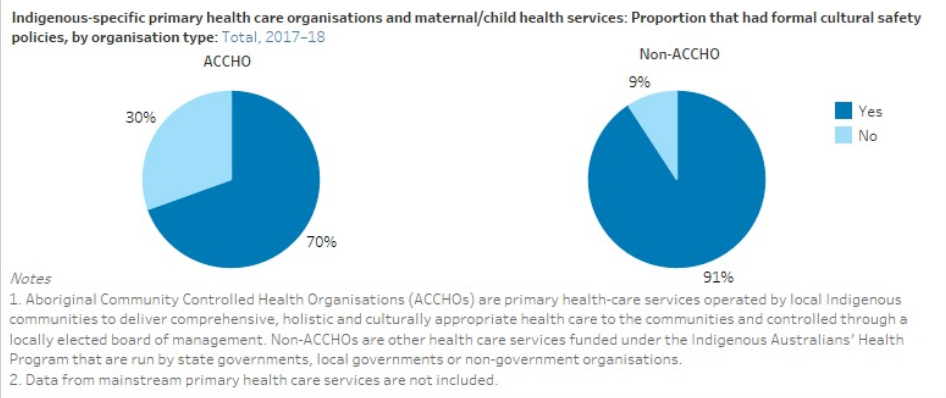
Consultation with Aboriginal and Torres Strait Islander communities

The data items below are no longer collected. The most recent collection period for these data was 2017–18. For a complete list of what data were available for the 2023 update, see Technical notes.

The figure is a set of interactive graphs showing the proportion of Indigenous primary health care services that had formal cultural safety policies in 2017–18, disaggregated by remoteness, state and territory, ACCHOs or non-ACCHOs, and over time (from 2012–13). See data tables for Module 1 – Table 1.4.2.

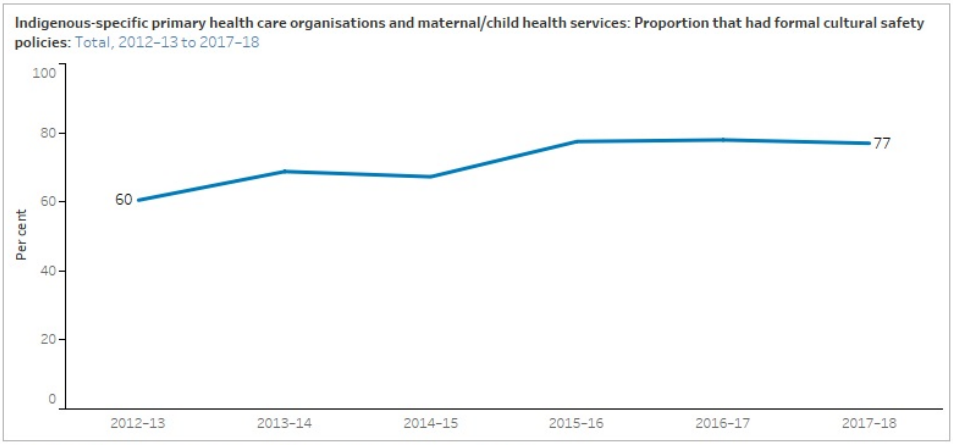


Note: Data from mainstream primary health care services are not included.



Notes

1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.



Note: Data from mainstream primary health care services are not included.
Source: Online Services Report, 2012–13 to 2017–18, previously unpublished (see data tables for Module 1 – Table 1.4.2).

Data sources and data gaps

The following sources were included for this module:

- Online Services Report (OSR) – for data on Indigenous-specific primary health care organisations and maternal/child health services funded through the Indigenous Australians' Health Program
- Higher Education Statistics and National Vocational Education and Training data – for data on enrolments in health-related courses
- National Health Workforce Dataset – for information on the characteristics of the health workforce.

Culturally respectful health care services – measures and data sources

Domains and measures	NHWD	HES/VET	OSR
1.1. Organisational approach and commitment			
Organisational commitment to culturally respectful and safe healthcare			✓
Aboriginal and Torres Strait Islander leadership at Board/Executive level			✓
1.2. Communication and cultural services			
Culturally appropriate communication resources (brochures, interpreters)			✓
Offers culturally appropriate services			✓

1.3. Workforce development and training			
Aboriginal and Torres Strait Islander participation in the workforce	✓		✓
Aboriginal and Torres Strait Islander workforce development		✓	
Cultural safety and responsiveness training for staff			✓
1.4 Consumer engagement and stakeholder collaboration			
Client and community feedback mechanism			✓
Consultation with Aboriginal and Torres Strait Islander communities			✓

Note: OSR – Online Services Report; HES – Higher Education Statistics; VET – Vocational Education and Training statistics; NHWD National Health Workforce Dataset; NHMD – National Hospital Morbidity Database.

Notes

Most of the available data for this module comes from the AIHW Online Services Report (OSR) data collection and relates to Indigenous-specific primary health care and maternal and child health services. These services include Aboriginal Community Controlled Health Organisations (ACCHOs), government and non-government organisations funded under the Indigenous Australians' Health Program (IAHP).

For 2019–20, 2020–21 and 2021–22, reporting to the OSR collection was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19, therefore data should be interpreted with caution. For more information see Impact of COVID-19.

Number of organisations reporting to OSR collection

Collection year	Number of primary care organisations	Number of organisations funded for maternal and child health services only
2017–18	198	19
2018–19	210	22
2019–20	196	19
2020–21	191	20
2021–22	211	19

For further information see OSR – summary over time.

The OSR has a module-based structure, with individual items that are a mix of counts of activities/services provided (such as number of clients seen), workforce information, questions with tick box answers, and some text responses. The OSR collection includes data on staffing levels, client numbers, client contacts, episodes of care and services provided.

Contextual information about each organisation is also collected. The OSR data presented in this monitoring framework are drawn from the:

- community engagement, control and cultural safety module, which consists of mostly tick box answers about activities undertaken by organisations to deliver culturally safe services to Indigenous clients
- corporate services/infrastructure module, workforce submodule, which consists mostly of counts of FTE staff by Indigenous status and various role/function categories.

See *Supplementary material: Cultural safety-related questions from the OSR data collection* for more information.

OSR data presented in the monitoring framework are also disaggregated by type of organisation – that is, by whether it is an ACCHO or other organisation receiving funding under the IAHP.

The OSR collection is being redeveloped and as a result some items have not had updated data since the 2017–18 reporting period. For more information about OSR see:

- Aboriginal and Torres Strait Islander-specific primary health care: results from the OSR and nKPI collections – Interpreting OSR data
- Online Services Report data collection.

The National Health Workforce Dataset provides national data on the Indigenous status of the health workforce for a wide range of professions, including GPs, nurses, and medical specialists. The Higher Education and Vocational Education and Training data provide information on the Indigenous status of student enrolments and completions for health-related courses, such as:

- nursing
- medical studies
- pharmacy
- dentistry

- some allied health; for example, rehabilitation therapies and optical science
- other health, which includes Aboriginal and Torres Strait Islander health workers.

These data are important for monitoring programs that aim to build an Indigenous health workforce to help improve the cultural safety of health services.

Data gaps

There are major data gaps for reporting on culturally respectful services. The data that are available were mostly collected from Indigenous-specific primary health care services through the Online Services Report (OSR). However, many of these data items are no longer collected, following a review of the OSR in 2018. Therefore, the most recent available data for many of these data items is for the 2017–18 data collection period.

There is little relevant data from mainstream services, such as primary health care and hospitals, across all levels of geography, from national to regional. A high proportion of Indigenous Australians use mainstream services, including in regional and remote areas.

There are also gaps in workforce data below state and territory levels of geography, such as at the Primary Health Network (PHN) level.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has included six Aboriginal and Torres Strait Islander specific actions in the National Safety and Quality Health Service Standards. The aims of the Standards are to protect the public from harm and to improve the quality of health service provision. However, data from the ACSQHC is not available to use for reporting in the monitoring framework.

The current monitoring framework focuses on the experience of the patient in the health care system. However, the experience of health care professionals and the cultural safety for Indigenous Australians in the health workforce are important aspects of a system free from racism.

Module 2: Patient experience of health care

Cultural safety is defined with reference to the experience of Aboriginal and Torres Strait Islander people who access and use health care services, including their treatment by health care professionals and their feelings of cultural safety. It also includes some indirect measures of cultural safety where clients take their own leave from hospitals. These measures suggest that there are situations where Indigenous patients do not find the hospital environment to be culturally safe.

What data are available?

New data were available to update 9 out of 23 measures reported in Module 2 for the 2023 release. The other 14 measures could not be updated due to discontinued surveys and data items, or frequency of data collection. This information has been provided throughout this module. Additional information is available in Data sources and data gaps and Technical notes.

The data sources include the ABS national Aboriginal and Torres Strait Islander health and social surveys, surveys of public hospital patients in New South Wales and Queensland and Reconciliation Australia's Australian Reconciliation Barometer survey. There are also data from the national hospital data collections on indirect measures of cultural safety.

For further information on the data sources used in this module, see Module 2 – Data sources and data gaps.

Key findings

The National Aboriginal and Torres Strait Islander Health Survey shows that in 2018–19:

- 88% of Indigenous Australians aged 15 and over in non-remote areas reported that doctors always/often explained things in a way that could be understood.
- 91% of Indigenous Australians aged 15 and over in non-remote areas reported that doctors always/often showed respect for what was said.
- 32% of Indigenous Australians who did not access health services when they needed to, indicated this was due to cultural reasons, such as language problems, discrimination and cultural appropriateness.
- The Australian Reconciliation Barometer showed that the proportion of Indigenous Australians reporting racial discrimination by doctors, nurses and/or medical staff in the last 12 months has increased since 2014 (11% in 2014 to 20% in 2022).

The differences in rates of Indigenous and non-Indigenous hospital patients who choose to leave prior to commencing or completing treatment are frequently used as indirect measures of cultural safety.

- Indigenous Australians left against medical advice for 4.0% (26,985) of admitted-patient hospitalisations from 2019–20 to 2020–21. Age-standardised, this was over 5 times the proportion of non-Indigenous Australians (3.8% and 0.7%, respectively).
- In 2021–22, Indigenous Australians left at own risk or did not wait in 75,267 emergency department attendances. Age-standardised, this was 1.4 times the proportion of incomplete emergency attendances for non-Indigenous Australians (10.6% and 7.6%, respectively).

See Module 2 data tables for all data presented in this module.

Data gaps and limitations

Data from Indigenous health care users about the health care that they receive are limited. Data from surveys of hospital patients in all states and territories are required, as well as additional national data on patient satisfaction with different types of health care services. However, data from these surveys are not always available by Indigenous status and may not include questions that relate to cultural safety for Indigenous Australians.

Module 2 domains:

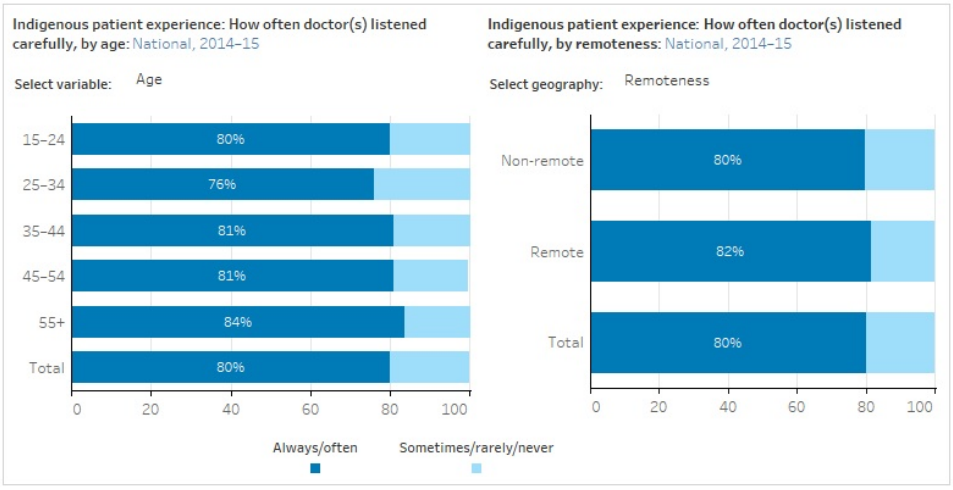
2.1 Communication

The quality of communication between health care providers and Aboriginal and Torres Strait Islander patients, including an awareness and interest in Indigenous culture, is important for ensuring patients feel culturally safe. Respectful communication makes it more likely that Indigenous Australians will access health care, and that the care they receive will be more effective. The data reported on Indigenous patient experiences of communication with health care providers come from national surveys, and public hospital patient surveys in some states.

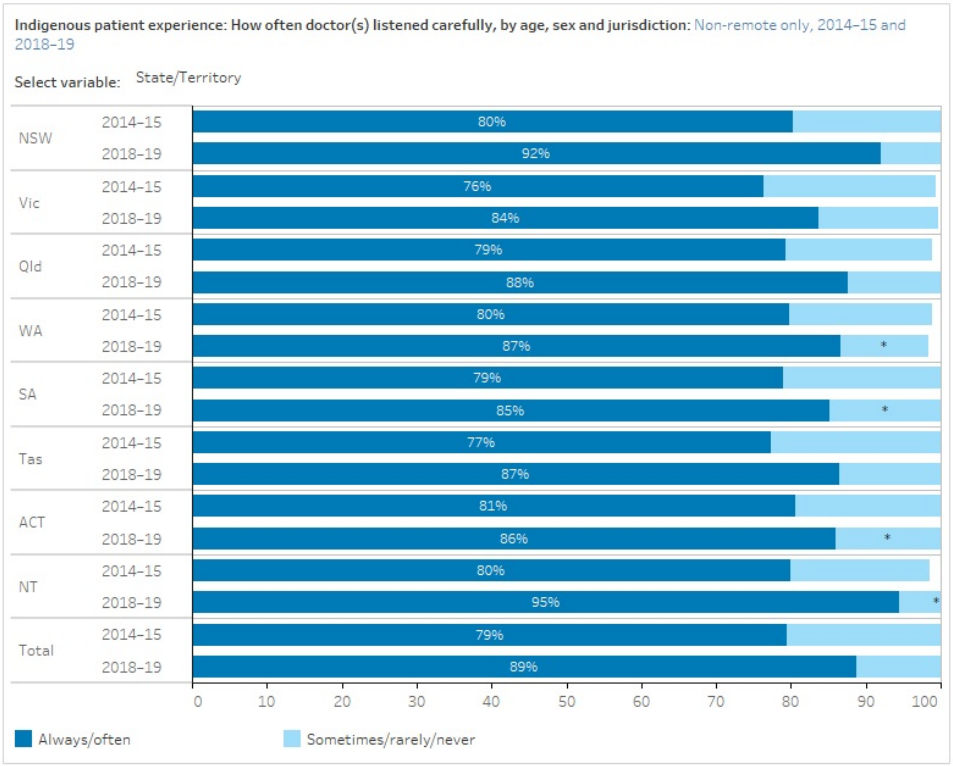
Interaction with health professionals

The data items below are from the NATSIHS, the NATSISS and the NSW Admitted Patient Survey. The ABS collects data for the NATSIHS every 5-6 years and the most recent available data is for the 2018–19 collection period. The NATSISS has been discontinued; the most recent collection period for these data was 2014–15. Some data items collected through NSW Admitted Patient Survey have been discontinued at different times; the most recent available data has been used in this report. For a complete list of what data were available for the 2023 update, see Technical notes.

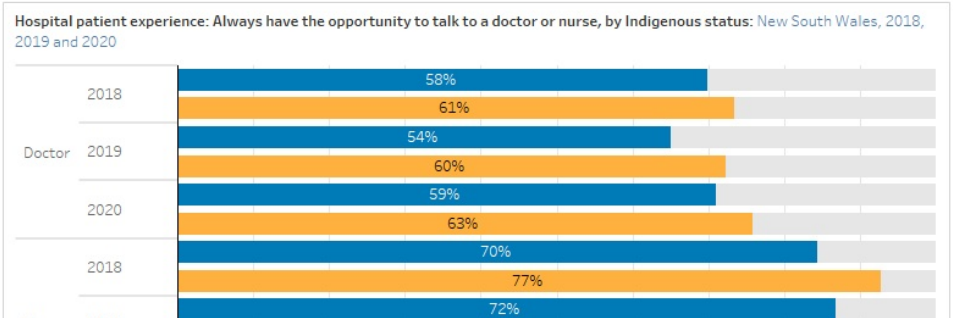
The figure is a set of interactive graphs showing the proportion of Indigenous people who thought doctors listened carefully to them, by age group, sex, remoteness, state and territory and over time. It then shows the proportion of hospital patients in New South Wales who had the opportunity to talk to a doctor or nurse when needed, by Indigenous status over time. Finally, it shows the proportion of Indigenous hospital patients in New South Wales who received support or the offer of support from an Aboriginal Health Worker. See data tables for Module 2 – Tables 2.1.1a, 2.1.1b, 2.1.1c and 2.1.1d.

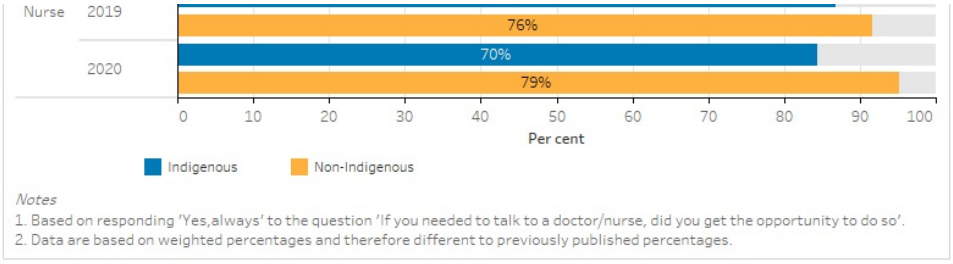


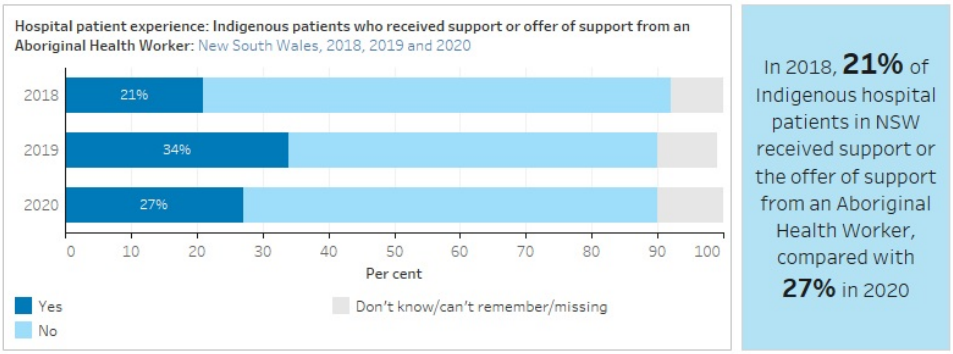
Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15, as published in AIHW & NIAA 2020 (see data tables for Module 2 – Table 2.1.1a).



* Estimate has RSE of 25% to 50% and should be used with caution.
Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15, National Aboriginal and Torres Strait Islander Health Survey 2018–19, from ABS 2016 and ABS 2019 (see data tables for Module 2 – Table 2.1.1b).







Note: Data are based on weighted percentages and therefore different to previously published percentages.
Source: NSW Adult Admitted Patient Survey 2018, 2019 and 2020, as published in BHI 2022 (see data tables for Module 2 – Tables 2.1.1c, 2.1.1d).

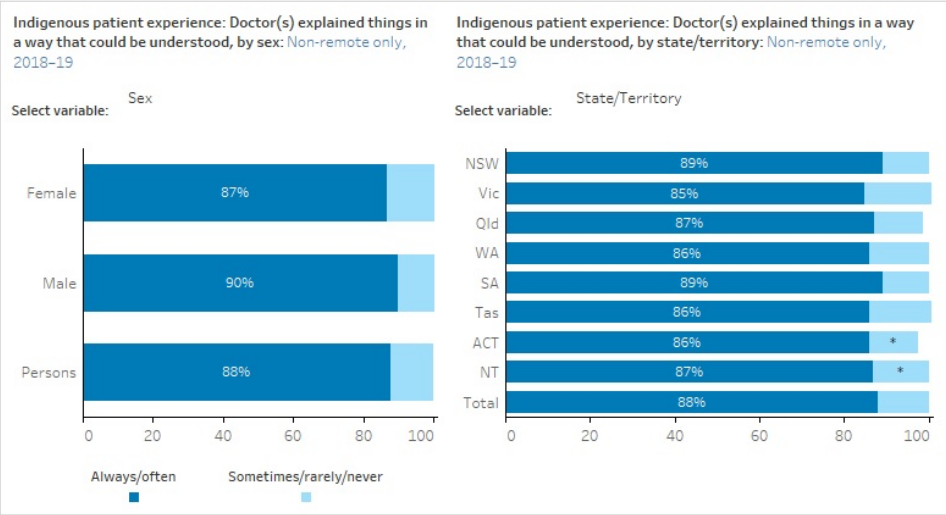
Results from the NSW 2019 Adult Admitted Patient Survey (AAPS) showed that the majority of Aboriginal and Torres Strait Islander patients said health professionals 'always' explained things in an understandable way (73%), although this result was lower than for non-Indigenous patients (81%) (BHI 2021).

The NSW 2019 AAPS also described aspects of care that were most strongly associated with Aboriginal and Torres Strait Islander people reporting that the overall care they received in hospital was 'very good'. These factors included that their care was 'very well' organised and that they were treated fairly based their Aboriginality or other reasons (BHI 2021).

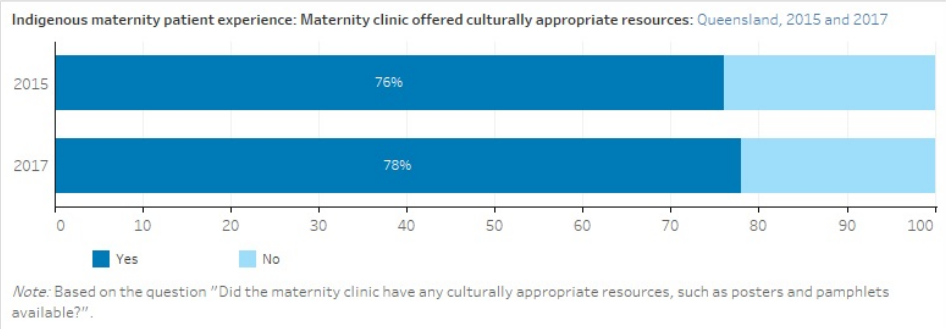
Results from the NSW 2019 Maternity Care Survey showed that 79% of Aboriginal and Torres Strait Islander women who had the support of an Aboriginal Health Worker rated their overall care during labour and birth as 'very good', significantly higher than those who were not supported by an Aboriginal Health Worker, 58%, after adjusting for age (BHI 2021).

Information provided in a way that could be understood

The data items below are sourced from the NATSIHS and the Qld Maternity Outpatient Clinic Patient Experience survey. The ABS collects data for the NATSIHS every 5–6 years and the most recent available data is for the 2018–19 collection period. The Qld Maternity Outpatient Clinic Patient Experience Survey has been discontinued. The most recent collection period for these data was 2017. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of Indigenous people who felt that doctors explained things in a way that could be understood, by sex, age group, state and territory and service type. It also shows Indigenous maternity patients in Queensland that had their maternity clinic offer culturally appropriate resources, in 2015 and 2017. See data tables for Module 2 – Tables 2.1.2a and 2.1.2b.



Source: National Aboriginal and Torres Strait Islander Health Survey 2018–19, ABS 2019 (see data tables for Module 2 – Table 2.1.2a).

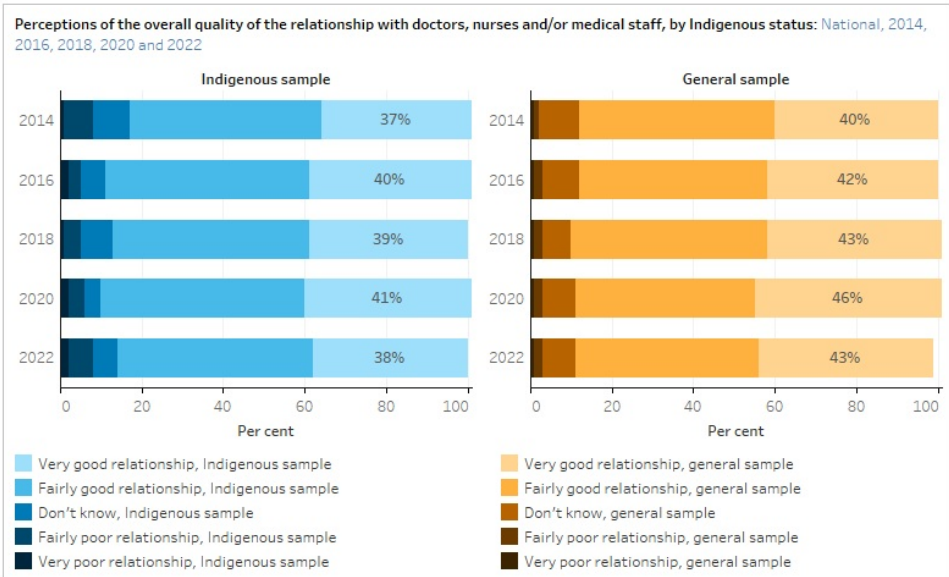


Note: Based on the question "Did the maternity clinic have any culturally appropriate resources, such as posters and pamphlets available?".

Source: Qld Maternity Outpatient Clinic Patient Experience Survey, 2015 and 2017, as published in Queensland Government 2017 and Queensland Government 2019 (see data tables for Module 2 – Table 2.1.2b).

Quality of relationship

The figure is a set of interactive graphs showing perceptions of the overall quality of the relationship with doctors, nurses and/or medical staff among an Indigenous sample and a total sample of Australians. See data tables for Module 2 – Table 2.1.3.



Note: Between 2014 and 2022 the Indigenous sample was between 495 and 532. The general sample ranges from 1,100 in 2014 to 2,522 in 2022. Both the general sample and Indigenous sample were weighted to be representative in terms of age group, Indigenous status, gender and location (state and territory populations), as per Australian Bureau of Statistics 2016 Census data.
Source: Australian Reconciliation Barometer survey as published in Reconciliation Australia 2015, 2017, 2019, 2020 and 2022 (see data tables for Module 2 – Table 2.1.3).

References

ABS (Australian Bureau of Statistics) 2016. National Aboriginal and Torres Strait Islander Social Survey. [TableBuilder]. Retrieved 9 November, 2020.

ABS 2019. National Aboriginal and Torres Strait Islander Health Survey 2018–19. [TableBuilder]. Retrieved 9 November, 2020.

AIHW & NIAA (Australian Institute of Health and Welfare & National Indigenous Australians Agency 2020. Aboriginal and Torres Strait Islander Health Performance Framework (HPF) report 2017 [archived]. Canberra: AIHW.

BHI (Bureau of Health Information) 2021. The Insights Series-Aboriginal people's experiences of hospital care. July 2021. Sydney (NSW): BHI.

BHI 2022. Adult admitted patient survey. Sydney (NSW): BHI. Retrieved 4 March, 2023.

Queensland Government 2017. 2015 Maternity Outpatient Clinic Patient Experience Statewide Report. Queensland: Queensland Health.

Queensland Government 2019. 2017 Maternity Outpatient Clinic Patient Experience Survey Report. Queensland: Queensland Health.

Reconciliation Australia 2015. 2014 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2017. 2016 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2019. 2018 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2020. 2020 Australian Reconciliation Barometer. Polity Research & Consulting.

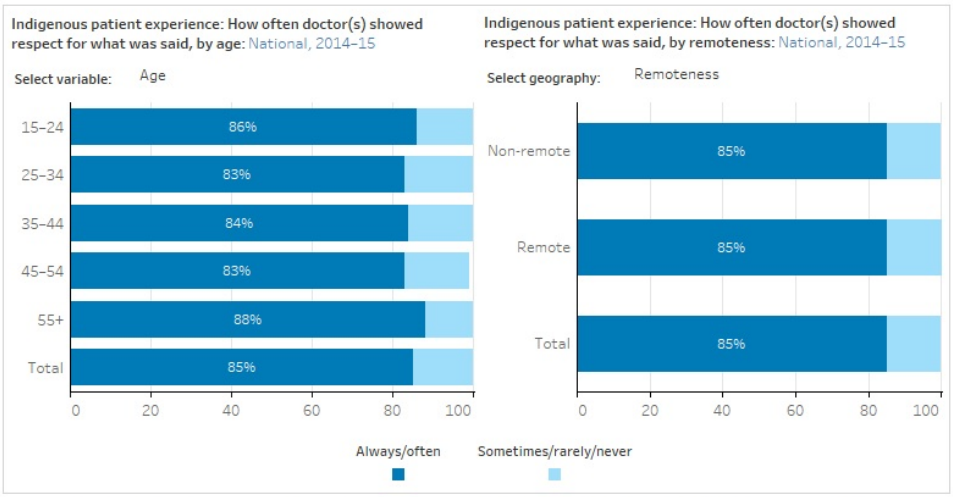
Reconciliation Australia 2022. 2022 Australian Reconciliation Barometer. Polity Research & Consulting.

2.2 Treated respectfully

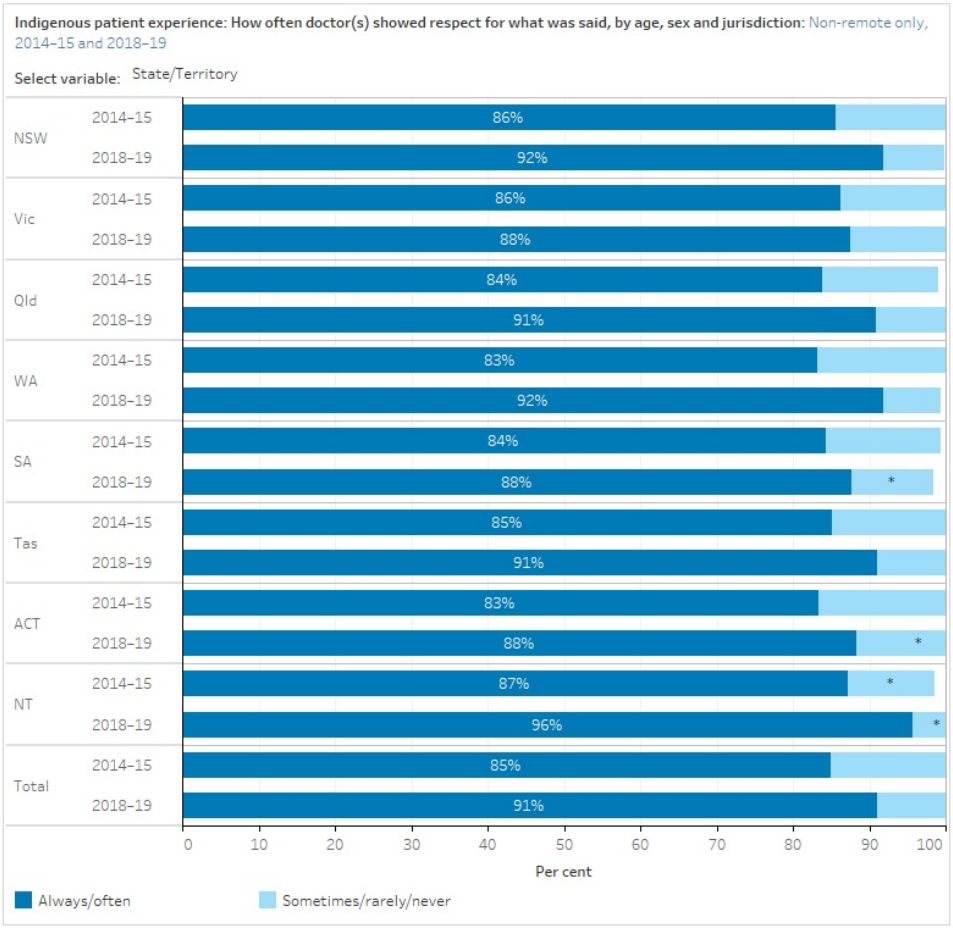
Aboriginal and Torres Strait Islander peoples are more likely to feel culturally safe when they are treated with understanding, respect and empathy by health care providers. This leads to more trust and confidence in the health care they receive. The data reported on Indigenous patient experiences of interpersonal treatment come from national surveys, and public hospital patient surveys in some states.

Respect

The data items below are sourced from the NATSIHS and the NATSISS. The ABS collects data for the NATSIHS every 5–6 years and the most recent available data is for the 2018–19 collection period. The NATSISS has been discontinued; the most recent collection period for these data was 2014–15. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of Indigenous people who felt doctors showed respect for what they said, by age group, sex, remoteness, state and territory and over time. See data tables for Module 2 – Tables 2.2.1a and 2.2.1b.



Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15, as published in AIHW & NIAA 2020 (see data tables for Module 2 – Table 2.2.1a).



* Estimate has RSE of 25% to 50% and should be used with caution.
Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15, National Aboriginal and Torres Strait Islander Health Survey 2018–19, from ABS 2016 and ABS 2019 (see data tables for Module 2 – Table 2.2.1b).

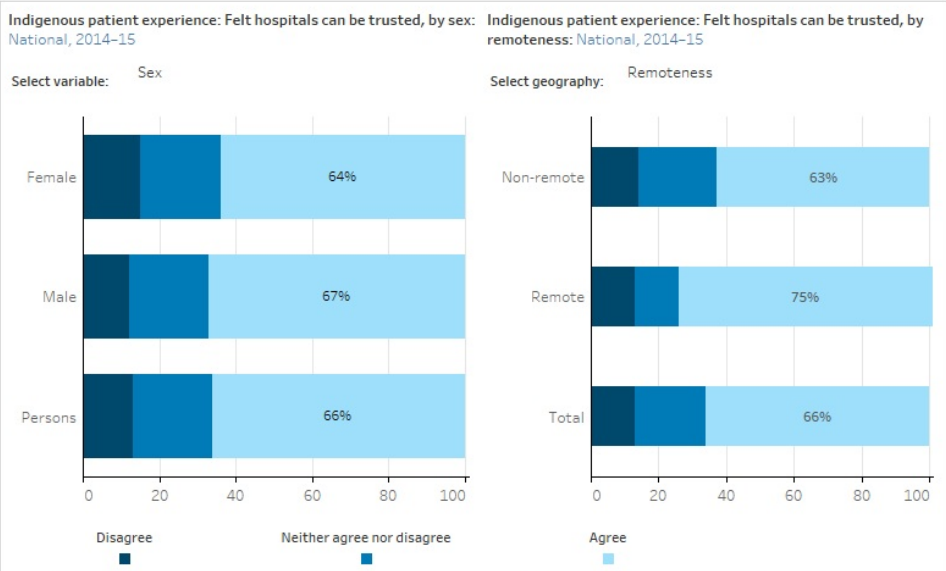
Results from the 2014–15 NATSISS and 2018–19 NATSIHS showed that the proportion of Indigenous Australians reporting that doctors always/often showed respect for what was said increased for all states and territories (ABS 2016, 2019). However, data from the Australian Reconciliation Barometer showed that trust in doctors, nurses and/or medical staff remained steady from 2014 to 2022 (Reconciliation Australia 2015, 2017, 2019, 2020, 2022).

NSW 2019 Adult Admitted Patient Survey showed that around 78% of Aboriginal and Torres Strait Islander patients said they were treated with respect and dignity. However, this was substantially lower than the percentage of non-Indigenous patients who reported this in answer to the same questions (86%) (BHI 2021).

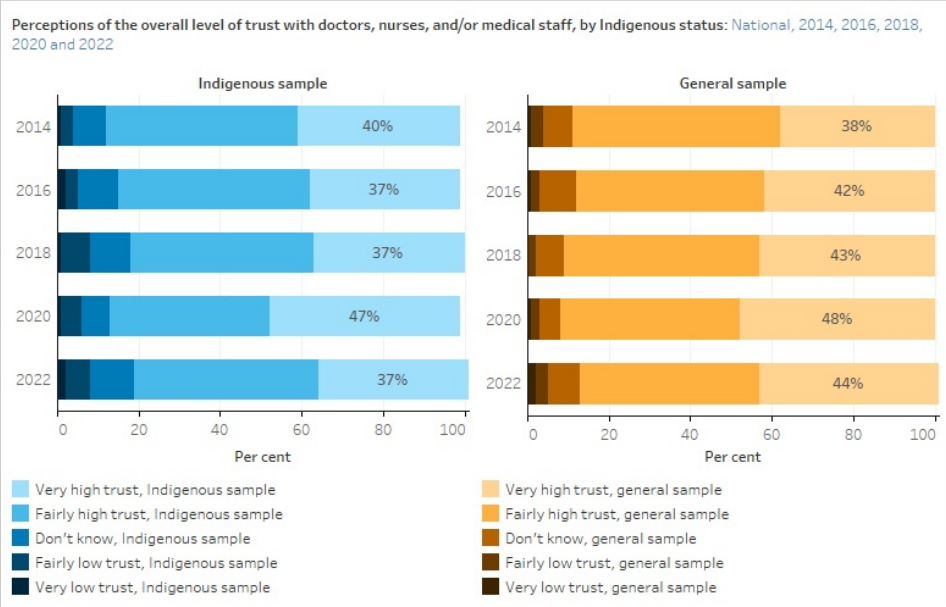
Trust and confidence

The data items below are sourced from the NATSISS and the Australian Reconciliation Barometer (ARB). The NATSISS has been discontinued and the most recent available data is for the 2014–15 collection period. The ARB collects data every 2 years and the most recent data is for the 2022 collection period. For a complete list of what data were available for the 2023 update, see Technical notes.

The figure is a set of interactive graphs showing the proportion of Indigenous people who felt that hospitals can be trusted, by age group, sex, remoteness, state and territory and over time. It also shows perceptions of the overall level of trust with doctors, nurses and/or medical staff among an Indigenous sample and a total sample of Australians. See data tables for Module 2 – Tables 2.2.2a and 2.2.2b.



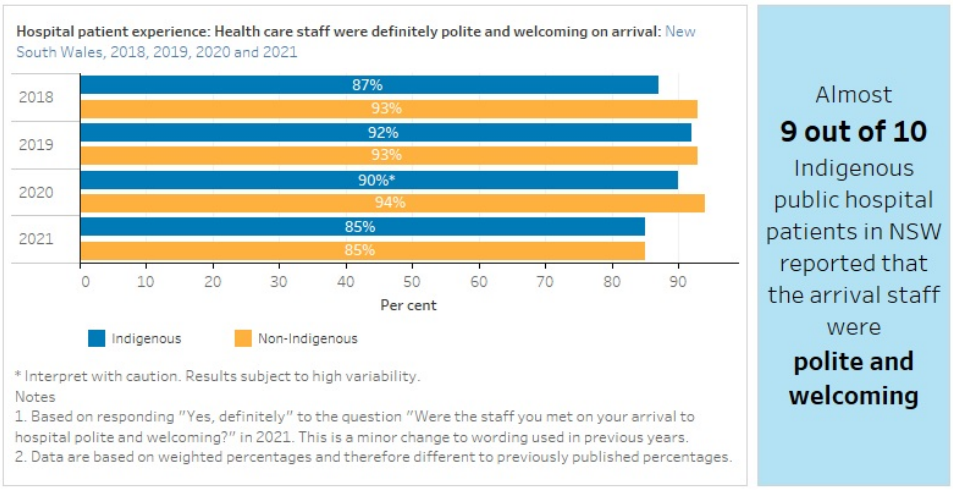
Source: National Aboriginal and Torres Strait Islander Survey 2008, National Aboriginal and Torres Strait Islander Social Survey 2014–15, as published in AIHW & NIAA 2020 (see data tables for Module 2 – Table 2.2.2a).



Note: Between 2014 and 2022 the Indigenous sample was between 495 and 532. The general sample ranges from 1,100 in 2014 to 2,522 in 2022. Both the general sample and Indigenous sample were weighted to be representative in terms of age group, gender and location (state and territory populations), as per Australian Bureau of Statistics 2016 Census data.
Source: Australian Reconciliation Barometer survey as published in Reconciliation Australia 2015, 2017, 2019, 2020 and 2022 (see data tables for Module 2 – Table 2.2.2b).

Staff were polite and welcoming

The figure is a set of interactive graphs showing the proportion of hospital patients in New South Wales who felt that health care staff were polite and welcoming on their arrival, by Indigenous status and over time. See data tables for Module 2 – Table 2.2.3.

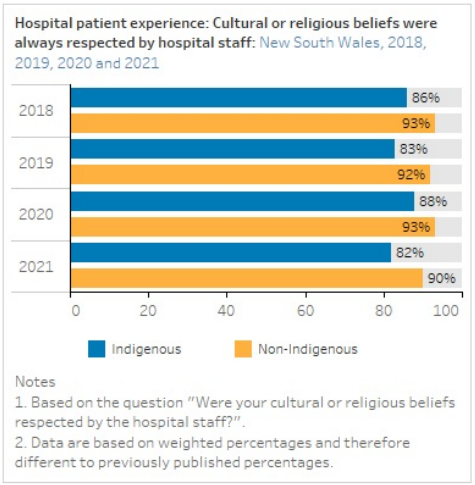


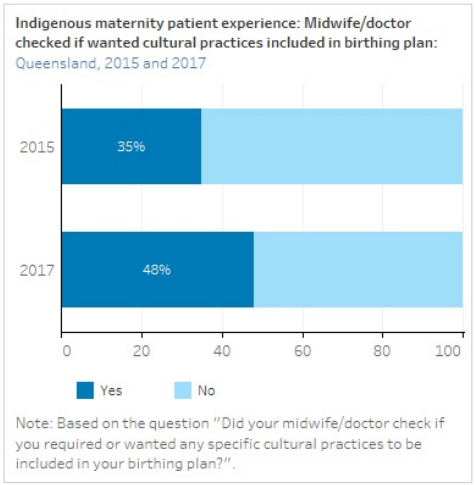
Source: NSW Adult Admitted Patient Survey, 2018, 2019, 2020 and 2022 (see data tables for Module 2 – Table 2.2.3).

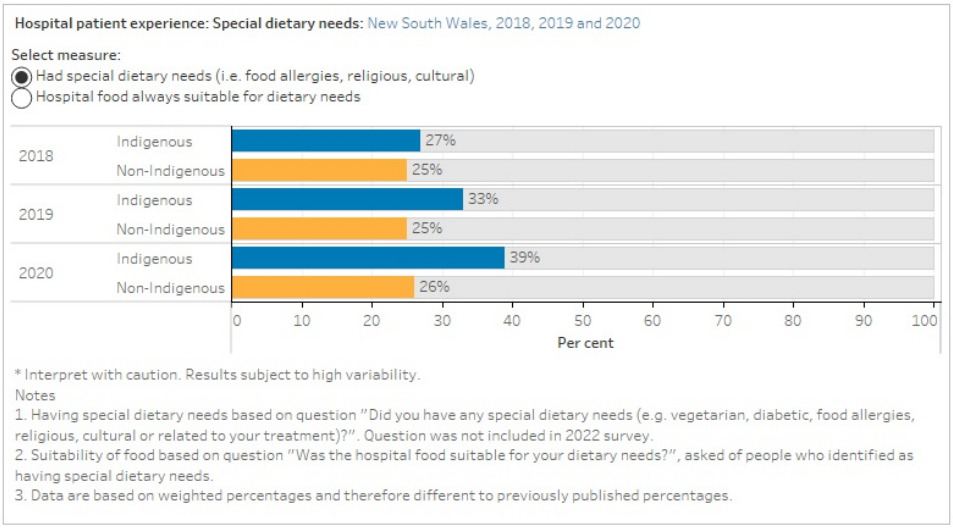
Respect for cultural or religious beliefs

The data items below are sourced from the NSW Admitted Patient Survey and the Qld Maternity Outpatient Clinic Patient Experience Survey. Some data items collected through NSW Admitted Patient Survey have been discontinued at different times. The most recent available data has been used in this report. The Qld Maternity Outpatient Clinic Patient Experience Survey has been discontinued. For a complete list of what data were available for the 2023 update, see Technical notes.

The figure is a set of interactive graphs showing the proportion of hospital patients in New South Wales who self that their cultural or religious beliefs were always respected by hospital staff, and whether hospital food was suitable for dietary needs, by Indigenous status and over time. It also shows the proportion of Indigenous maternity patients in Queensland whose midwife/doctor checked if they wanted cultural practices included in the birthing plan over time. See data tables for Module 2 – Tables 2.2.4a, 2.2.4b and 2.2.4c.







Sources: NSW Adult Admitted Patient Survey 2018, 2019, 2020 and 2021; Qld Maternity Outpatient Clinic Patient Experience Survey, 2015 and 2017 (see data tables for Module 2 – Tables 2.2.4a, 2.2.4b, 2.2.4c).

References

ABS (Australian Bureau of Statistics) 2016. National Aboriginal and Torres Strait Islander Social Survey. [TableBuilder]. Retrieved 11 November, 2020.

ABS 2019. National Aboriginal and Torres Strait Islander Health Survey 2018–19. [TableBuilder]. Retrieved 11 November, 2020.

AIHW & NIAA (Australian Institute of Health and Welfare & National Indigenous Australians Agency) 2020. Aboriginal and Torres Strait Islander Health Performance Framework (HPF) report 2017 [archived]. Canberra: AIHW.

BHI (Bureau of Health Information) 2021. The Insights Series-Aboriginal people's experiences of hospital care. July 2021. Sydney (NSW): BHI.

BHI 2022. Adult admitted patient survey. Sydney (NSW): BHI. Retrieved 23 February 2023.

Queensland Government 2017. 2015 Maternity Outpatient Clinic Patient Experience Statewide Report. Queensland: Queensland Health.

Queensland Government 2019. 2017 Maternity Outpatient Clinic Patient Experience Survey Report. Queensland: Queensland Health.

Reconciliation Australia 2015. 2014 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2017. 2016 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2019. 2018 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2020. 2020 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2022. 2022 Australian Reconciliation Barometer. Polity Research & Consulting.

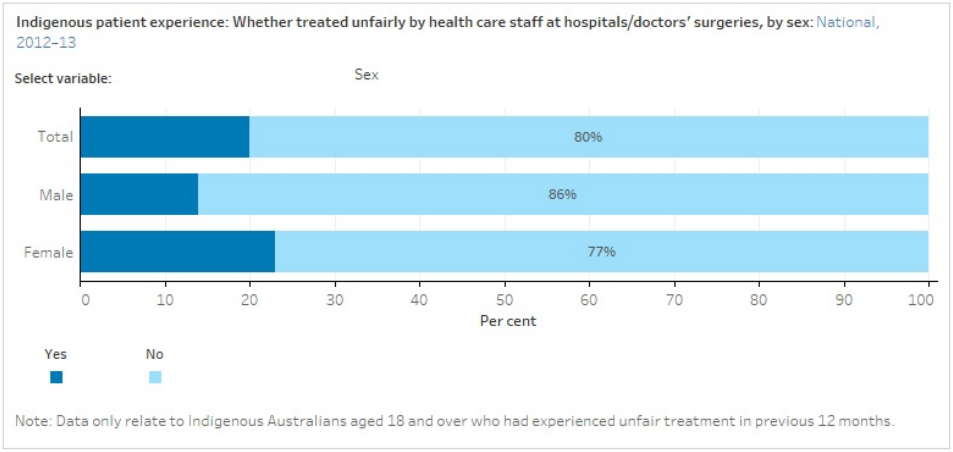
2.3 Unfair treatment and cultural barriers

Where Aboriginal and Torres Strait Islander peoples are treated badly, unfairly or unequally because of their race, culture or language they may be less likely to access health care, or to feel comfortable and culturally safe when receiving care. The data reported on Indigenous patient experiences of interpersonal treatment come from national surveys.

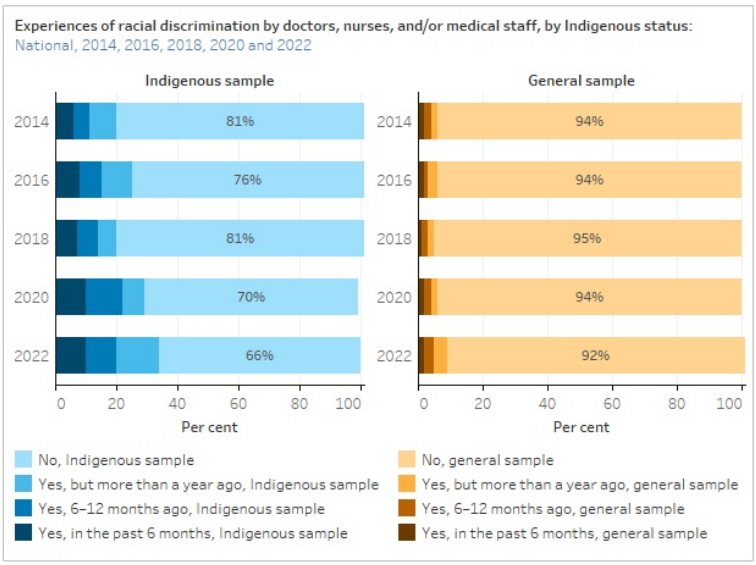
Analysis using data from the Mayi Kuwayu longitudinal study described the effects of discrimination towards Aboriginal and Torres Strait Islander people, across demographic characteristics, and how discrimination related to health and social and emotional wellbeing outcomes (Thurber at al. 2021).

Unfair treatment and discrimination

The data items below are sourced from the AATSIHS and the Australian Reconciliation Barometer (ARB). The AATSIHS has been discontinued and the most recent available data is for the 2012–13 collection period. The ARB collects data every 2 years and the most recent data is for the 2022 collection period. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of Indigenous people who were treated unfairly by healthcare staff at hospitals/doctors' surgeries, by sex, and remoteness. It also shows whether a person or their family has been racially discriminated against by doctors, nurses and/or medical staff among an Indigenous sample and a total sample of Australians. See data tables for Module 2 – Tables 2.3.1a and 2.3.1b.



Source: Australian Aboriginal and Torres Strait Islander Health Survey 2012–13, as published in AIHW & NIAA 2020a (see data tables for Module 2 – Table 2.3.1a).



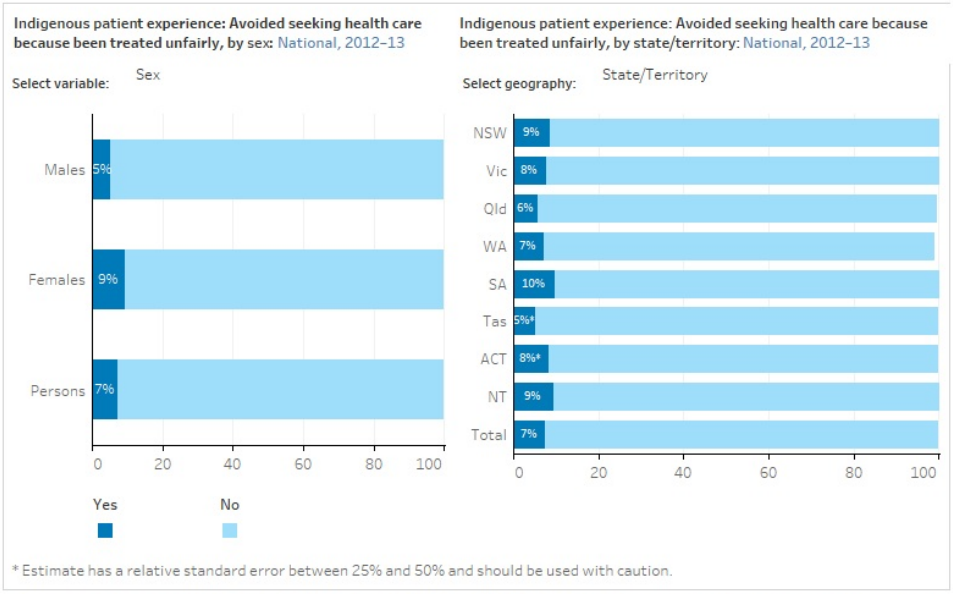
The proportion of Indigenous Australians reporting experiences of **racial discrimination** by doctors, nurses and/or medical staff has **increased** since 2014.

Note: Between 2014 and 2022 the Indigenous sample was between 495 and 532. The general sample ranges from 1,100 in 2014 to 2,522 in 2022. Both the general sample and Indigenous sample were weighted to be representative in terms of age group, gender, Indigenous status and location (state and territory populations), as per Australian Bureau of Statistics 2016 Census data.
Source: Australian Reconciliation Barometer survey as published in Reconciliation Australia 2015, 2017, 2019, 2020 and 2022 (Table 2.3.1b).

Results from the NSW 2019 Adult Admitted Patient Survey showed that most Aboriginal and Torres Strait Islander patients reported they were not treated unfairly (89%). However, this was lower than the percentage of non-Indigenous patients (95%) (BHI 2021). The Australian Reconciliation Barometer showed that the proportion of Indigenous Australians reporting racial discrimination by doctors, nurses and/or medical staff in the last 12 months has increased since 2014 (11% in 2014 to 20% in 2022) (Reconciliation Australia 2015, 2022).

Avoided health care due to poor treatment

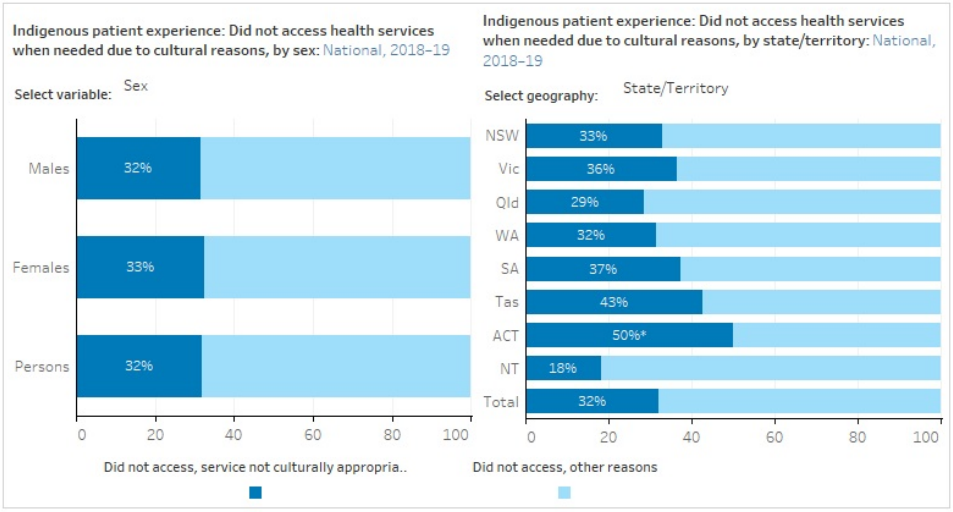
The data items below are sourced from the AATSIHS. The AATSIHS was discontinued after the 2012–13 collection period. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of Indigenous people who avoided seeking healthcare because they had been treated unfairly, by age group, sex, state and territory and remoteness. See data tables for Module 2 – Tables 2.3.2.



Source: Australian Aboriginal and Torres Strait Islander Health Survey 2012–13, as published in AIHW & NIAA 2020a (see data tables for Module 2 – Table 2.3.2).

Did not access health care due to cultural reasons

The data items below are sourced from the NATSIHS. The ABS collects data for the NATSIHS every 5–6 years and the most recent available data is for the 2018–19 collection period. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of Indigenous people who did not access health care due to cultural reasons, by age group, sex, state and territory and remoteness. See data tables for Module 2 – Tables 2.3.3.



* Estimate has RSE of 25% to 50% and should be used with caution.
Notes
1. Data only include those who did not access health services when needed (29.9% of Indigenous people) .
2. Cultural reasons include language problems, discrimination and cultural appropriateness.
Source: National Aboriginal and Torres Strait Islander Health Survey 2018–19, as published in AIHW & NIAA 2020b (see data tables for Module 2 – Table 2.3.3).

References

AIHW & NIAA (Australian Institute of Health and Welfare & National Indigenous Australians Agency) 2020a. Aboriginal and Torres Strait Islander Health Performance Framework (HPF) report 2017 [archived]. Canberra: AIHW.

AIHW & NIAA 2020b. Aboriginal and Torres Strait Islander Health Performance Framework. Canberra: AIHW.

BHI (Bureau of Health Information) 2021. The Insights Series-Aboriginal people's experiences of hospital care. July 2021. Sydney (NSW): BHI.

Reconciliation Australia 2015. 2014 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2017. 2016 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2019. 2018 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2020. 2020 Australian Reconciliation Barometer. Polity Research & Consulting.

Reconciliation Australia 2022. 2022 Australian Reconciliation Barometer. Polity Research & Consulting.

Thurber KA, Colonna E, Jones R, Gee GC, Priest N, Cohen R, Williams DR, Thandrayen J, Calma T, Lovett R, et al. 2021. 'Prevalence of Everyday Discrimination and Relation with Wellbeing among Aboriginal and Torres Strait Islander Adults in Australia'. *International Journal of Environmental Research and Public Health*. 18(12):6577. doi:10.3390/ijerph18126577.

2.4 Empowerment

Empowerment is related to the extent to which people feel included in decisions about their health care, and that they have some control over the care that they receive. Being provided with information about the rights of health care consumers also empowers patients. The data reported on empowerment come from New South Wales public hospital patient experience surveys.

Involved in health care decisions

The figure is a set of interactive graphs showing the proportion of hospital patients in New South Wales who were involved in decisions about their care or treatment, by Indigenous status over time. See data tables for Module 2 – Table 2.4.1.

Visualisation not available for printing

Results from the NSW 2019 Maternity Care Survey showed that 73% of Aboriginal and Torres Strait Islander women said their decisions about how they wanted to feed their baby were 'always' respected by health professionals. In contrast, when asked the same question, 82% of non-Indigenous women gave this response (BHI 2021).

Provided with information about patient rights

The data item below is sourced from the NSW Admitted Patient Survey and is no longer collected. The most recent available data is for the 2014 collection period. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of hospital patients in New South Wales received information about their rights as a patient, by Indigenous status. See data tables for Module 2 – Table 2.4.2.

Visualisation not available for printing

References

BHI (Bureau of Health Information) 2016. Patient Perspectives: Hospital care for Aboriginal people. 10 August 2016. Sydney: BHI.

BHI 2021. The Insights Series-Aboriginal people's experiences of hospital care. July 2021. Sydney (NSW): BHI.

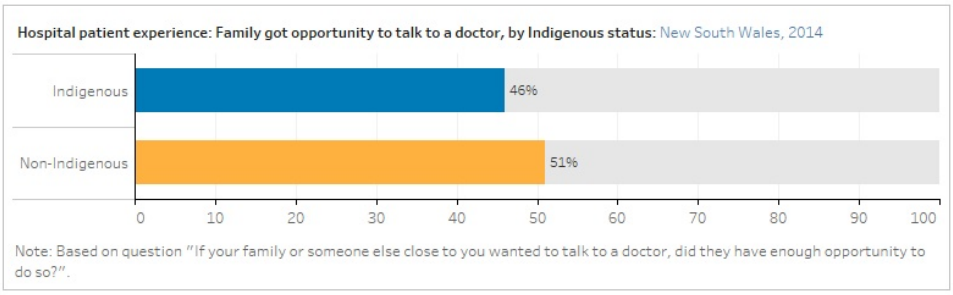
BHI 2022. Healthcare Observer. Sydney (NSW): BHI. Retrieved 4 March, 2022.

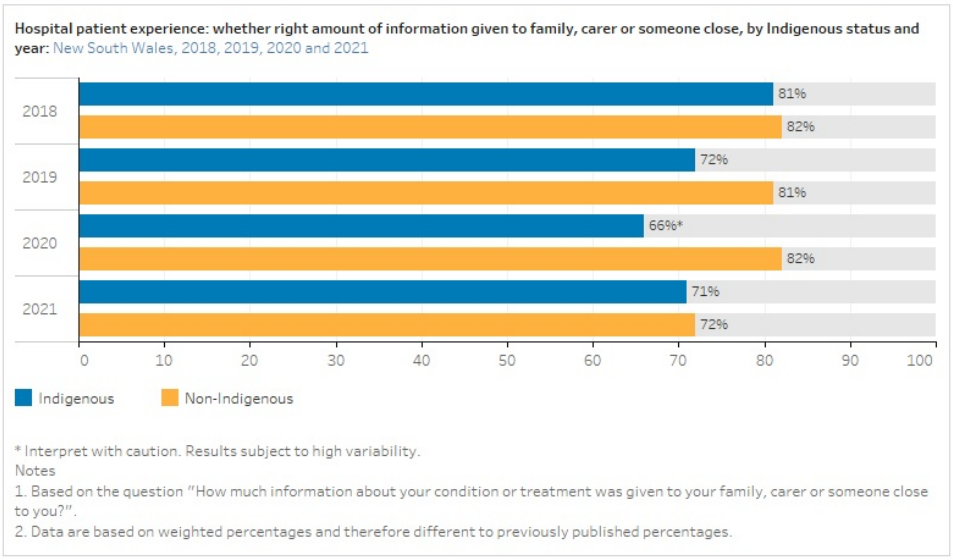
2.5 Family inclusion

Aboriginal and Torres Strait Islander patients are more likely to feel culturally safe when family members, or other people important to them, are included in the health care process and decisions about their care. This can help improve the quality of health care and ensure that it is more effective. The data reported on family inclusion come from New South Wales public hospital patient experience surveys.

Inclusion

The data items below are sourced from the NSW Admitted Patient Survey. Some data items collected through NSW Admitted Patient Survey have been discontinued. The most recent available data has been used in this report. For a complete list of what data were available for the 2023 update, see Technical notes.
The figure is a set of interactive graphs showing the proportion of hospital patients in New South Wales by whether the right amount of information was given to their family and whether their family got an opportunity to talk to a doctor, by Indigenous status. See data tables for Module 2 – Tables 2.5.1 and 2.5.2.





Source: NSW Adult Admitted Patient Survey 2014, 2018, 2019, 2020 and 2021 (see data tables for Module 2 – Tables 2.5.1, 2.5.2).

Results from the NSW 2019 Adult Admitted Patient Survey showed Aboriginal and Torres Strait Islander patients in rural hospitals were significantly more positive when asked how much information about their condition or treatment was given to their family or someone close to them (78% in rural hospitals said the 'right amount', compared with 69% in urban hospitals) (BHI 2021).

References

BHI (Bureau of Health Information) 2016. Patient Perspectives: Hospital care for Aboriginal people. 10 August 2016. Sydney: BHI.

BHI 2021. The Insights Series-Aboriginal people's experiences of hospital care. July 2021. Sydney (NSW): BHI.

BHI 2022. Adult admitted patient survey. Sydney (NSW): BHI. Retrieved 23 February 2023.

2.6 Leave events

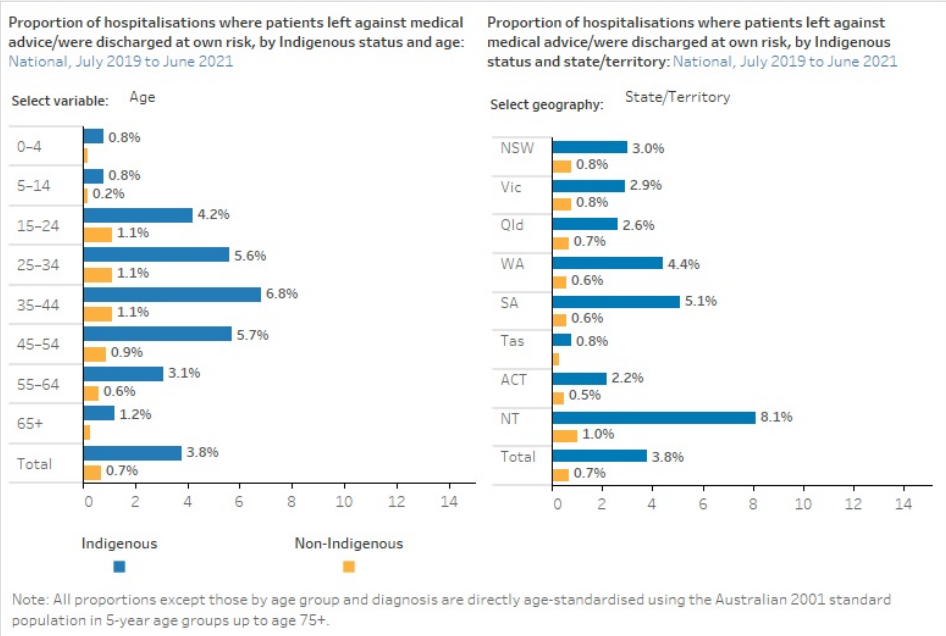
Leave events refer to situations where hospital patients choose to leave prior to commencing or completing their treatment. Patient experiences of health care services affect health-related behaviours and health outcomes. Leave event patients are more likely to re-present to emergency departments and have higher mortality rates (Shaw 2016). There have been a limited number of studies on Aboriginal and Torres Strait Islander peoples' reasons for leave events from hospital. However, common factors include institutionalised racism; a lack of cultural safety; a distrust of the health system; miscommunication; family and social obligations; isolation and loneliness; a lack of understanding of the treatment they were receiving and the feeling that the treatment had finished; and communication and language barriers between staff and the patient (Shaw 2016). For more information see Measure 3.09: Discharge against medical advice on the Aboriginal and Torres Strait Islander Health Performance Framework.

This domain includes two leave events measures: incomplete emergency attendances and discharge from hospital against medical advice. Leave events are more likely for Indigenous Australians – which may be due to feeling culturally unsafe – and this is therefore viewed as an indirect measure of cultural safety, or the extent to which hospitals are responsive to Indigenous Australian patients' needs.

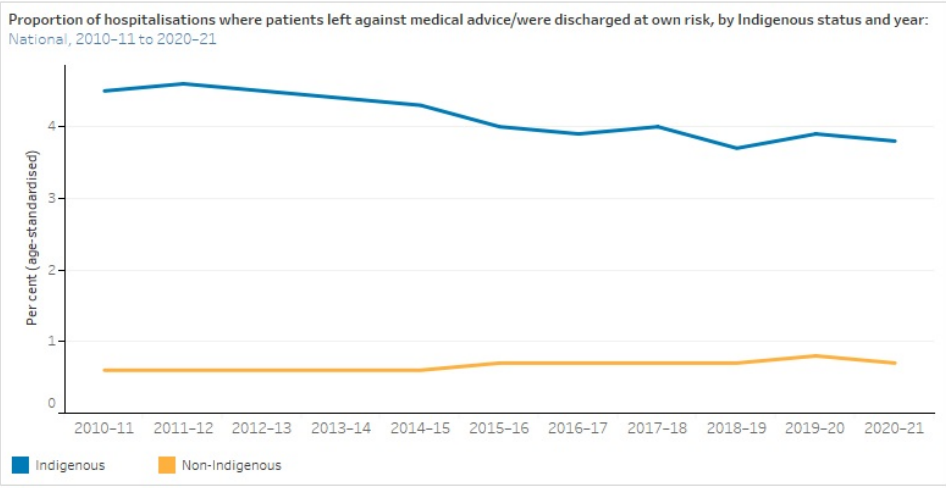
The data reported for these two measures come from hospitals administrative data.

Admitted patient leave events

The figure is a set of interactive graphs showing the proportion of hospitalisations where patients left against medical advice/were discharged at their own risk, by Indigenous status and age, sex, diagnosis, state and territory, remoteness and over time. See data tables for Module 2 – Tables 2.6.1a, 2.6.1b.



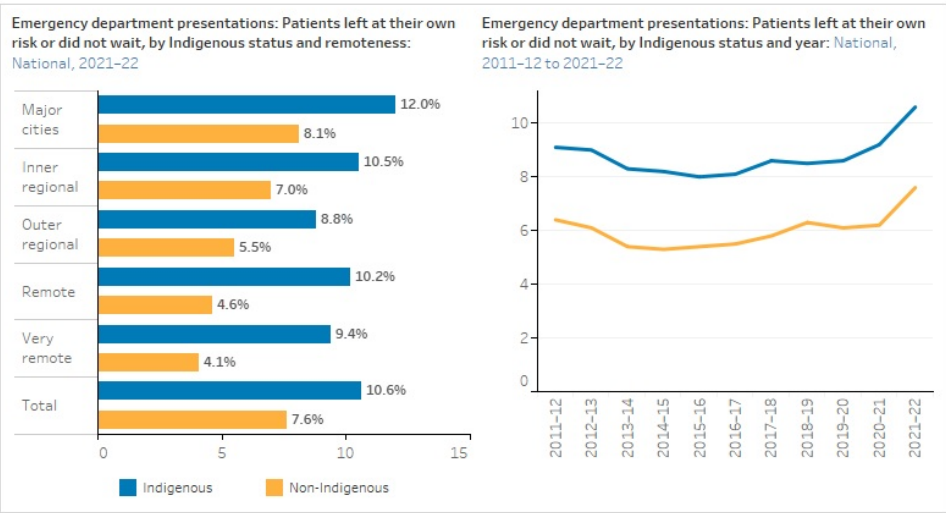
Note: All proportions except those by age group and diagnosis are directly age-standardised using the Australian 2001 standard population in 5-year age groups up to age 75+.



Source: AIHW analysis of National Hospital Morbidity Database, previously unpublished (see data tables for Module 2 – Tables 2.6.1a, 2.6.1b).

Emergency department leave events

The figure is a set of interactive graphs showing the proportion of emergency department presentations where patients left at their own risk or did not wait, by Indigenous status, remoteness and over time. See data tables for Module 2 – Table 2.6.2.



Note: Based on age-standardised data.
Source: AIHW analysis of National Non-admitted Patient Emergency Department Care Database, unpublished (see data tables for Module 2 – Table 2.6.2).

References

Shaw C 2016. An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients. Deakin, ACT: AHHA.

Data sources and data gaps

The data sources with relevant data items on patient experiences and with data available on Indigenous Australians were:

- ABS National Aboriginal and Torres Strait Islander Health Survey, 2018–19
- ABS National Aboriginal and Torres Strait Islander Social Survey, 2014–15
- ABS Australian Aboriginal and Torres Strait Islander Health Survey, 2012–13
- Australian Reconciliation Barometer, 2014, 2016, 2018, 2020, 2022
- National Hospitals Data Collection
  - National Hospital Morbidity Database, 2019–20, 2020–21
  - National Non-Admitted Patients Emergency Department Care Database, 2019–20, 2020–21, 2021–22
- New South Wales Adult Admitted Patient Survey, 2014, 2018, 2019, 2020, 2021
- Queensland Maternity Outpatient Clinic Patient Experience Survey, 2015, 2017.

Patient experience of health care – measures and data sources

Domains and measures	AATSIHS/ NATSIHS /NATSISS	NHMD /NNAPEDCD	Australian Reconciliation Barometer	NSW AAPS	Qld MOCES
2.1 Communication					
Interaction with health professionals	✓				
Information provided in a way that could be understood	✓				✓
Quality of relationship			✓		
2.2 Treated respectfully					
Respect	✓				
Trust and confidence	✓		✓		
Staff were polite and welcoming				✓	
Respect for cultural or religious beliefs				✓	✓
2.3 Unfair treatment and cultural barriers					
Unfair treatment and discrimination	✓		✓		
Avoided health care due to poor treatment	✓				
Did not access health care due to cultural reasons	✓				
2.4 Empowerment					
Involved in health care decisions				✓	
Provided with information about patient rights				✓	
2.5 Family inclusion					
Inclusion				✓	
2.6 Leave events					
Admitted patient leave events		✓			
Emergency department leave events		✓			

Note: AATSHIS – Australian Aboriginal and Torres Strait Islander Health Survey; NATSIHS – National Aboriginal and Torres Strait Islander Health Survey; NATSISS – National Aboriginal and Torres Strait Islander Social Survey; NHMD – National Hospital Morbidity Database; NNAPEDCD – National Non-admitted Emergency Department Care Database; NSW Adult Admitted Patient Survey (AAPS); Queensland Maternity Outpatient Clinic Experience Survey (MOCES).

Notes

The ABS national survey data sources were:

- Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) in 2012–13

- National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) in 2018–19
- National Aboriginal and Torres Strait Islander Social Survey (NATSISS) in 2014–15.

These surveys include data that relate to the domains of communication, respectful treatment and unfair treatment. The national ABS Patient Experience Survey (PES), which includes data related to communication and respectful treatment by general practitioners, is not available by Indigenous status. More information on ABS social and health surveys of Indigenous Australians is found in the Data sources and quality page of the Aboriginal and Torres Strait Islander Health Performance Framework.

Most jurisdictions undertake surveys about patients' experiences in public hospitals, but there is not a lot of publicly released data on Indigenous patients and their experiences.

The NSW Bureau of Health Information (BHI) collects and publishes data about the experiences of people admitted to NSW public hospitals. Data are reported for New South Wales from the Adult Admitted Patient Survey, a survey of patients who have recently been admitted to a NSW public hospital.

Number of Aboriginal and/or Torres Strait Islander respondents to the NSW Adult Admitted Patient Survey

Year	Aboriginal and/or Torres Strait Islander respondents
2014	2,682
2018	443
2019	3,454
2020	364
2021	551

Note: Aboriginal and/or Torres Strait Islander respondents oversampled in 2014 and 2019 surveys.

This report used data from the 2014, 2018, 2019, 2020 and 2021 surveys downloaded from the BHI's interactive data portal (previously hosted on the BHI Healthcare Observer). The NSW BHI also released a detailed report in 2021, Aboriginal people's experiences of hospital care, focussing on Aboriginal and Torres Strait Islander patient experiences using data from various BHI surveys in 2019. Some highlights from Aboriginal people's experiences of hospital care report are presented in this report.

The Queensland Maternity Outpatient Clinic Patient Experience Survey includes Aboriginal and Torres Strait Islander specific questions. Data on Aboriginal and Torres Strait Islander women are available from the 2015 (350 women) and 2017 (390 women) surveys. For more information see the 2017 Maternity Outpatient Clinic Patient Experience Survey Report. This survey has been discontinued.

Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) surveys could provide another opportunity to collect data on Indigenous patients' experiences of health care. The collection of patient reported data through standardised PREMs and PROMs for Indigenous health care users needs to consider cultural adaptability of these tools and development work is underway to address this at hospital and primary health care service levels for accountability and continued quality improvement.

Reconciliation Australia's Australian Reconciliation Barometer (ARB) was developed as a tool to measure the progress of reconciliation between Indigenous and non-Indigenous Australians. The first study was completed in 2008, with biennial reports since then. The results of surveys prior to 2014 are no longer included in the ARB, so that applicable tracking results are more directly comparable. For the 2014, 2016, 2018, 2020 and 2022 surveys, the Indigenous community sample ranged between 495 and 532, and the general community sample between 1,100 and 2,522. The general sample also includes Australians who are Indigenous or have Aboriginal and/or Torres Strait Islander heritage. Both the general and Indigenous samples are weighted to be representative in terms of age group, gender and location (state and territory populations), as per ABS 2016 Census data. Data from the 2020 report covers the period to July 2020 and therefore some responses to the survey questions may be in reference to approximately the first six months of the COVID-19 pandemic in Australia.

The two final measures in this module for leave events used data from the national hospitals and national emergency care data collections. See the Data sources and data gaps section in Module 3 for more information on hospital data collections.

Data gaps

Major data gaps in this module are the lack of hospital patient experience data from most jurisdictions, as well as data on patients of non-hospital health care services such as primary health care and specialist services. Regular, national data collections of Indigenous patient experiences are needed to enable monitoring of the impact of government initiatives and measuring of progress in achieving cultural safety. Such data collections should allow for reporting across small areas and in different health sectors.

Module 3: Access to health care services

Overall, Aboriginal and Torres Strait Islander people experience poorer health than non-Indigenous Australians, but they do not always have the same level of access to health services. This module includes some selected measures of access to health care services that cover the different levels of the health system. The measures compare use of various services for Indigenous and non-Indigenous Australians as a way of broadly monitoring disparities in access. Disparities in access and use of health services may indicate problems with the cultural safety of services, but there may be many other factors, such as remoteness, affordability, previous experiences of racism in health care environments for themselves, family or community members and fear of how they will be treated.

For example, potentially preventable hospitalisations (hospitalisations for conditions that can be effectively treated in a non-hospital setting) can serve as a proxy measure of access to timely, effective and appropriate primary and community-based care. Systematic differences in hospitalisation rates for Indigenous Australians and non-Indigenous Australians can indicate gaps in the provision of population health interventions, primary care services, and continuing care support. The rate of potentially preventable hospitalisations is affected by the interaction of a broad range of factors; however, culturally safe primary health care could help better detect and manage health risk factors and conditions and thereby reduce rates of potentially preventable hospitalisations.

What data are available?

New data were available to update 12 out of 13 measures reported in Module 3 for the 2023 release. One measure could not be updated as the Voluntary Indigenous Identifier (VII) was not updated. For more information, see 3.4 Specialist services and Technical notes.

The measures in this module are based on national administrative data collections covering immunisation, the Medicare Benefits Schedule (MBS), hospitals, mortality, perinatal and elective surgery waiting times.

For further information on the data sources used in this module, see Module 3 – Data sources and data gaps.

Key findings

Selected measures of access to health care services for Indigenous and non-Indigenous Australians are used to monitor disparities in access as they may indicate problems with the cultural safety of services, though many other factors can also impact on access to and use of services (for example, remoteness, affordability, previous experiences of racism, presence of co-morbidities).

- Mammogram participation rates for Indigenous Australian women increased between 2010–2011 and 2018–2019. Rates decreased in 2019–2020, during the COVID-19 pandemic.
- In 2020–21, the rate of potentially preventable hospitalisations for Indigenous Australians was almost 3 times the rate for non-Indigenous Australians (66 compared with 23 per 1,000, based on age-standardised rates).
- In 2021–22, the median waiting time for emergency department presentations was similar for Indigenous Australians than for other Australians (19 and 20 minutes, respectively).
- Indigenous Australians waited longer to be admitted for elective surgery in 2021–22 than non-Indigenous Australians – 50% of Indigenous patients were admitted for elective surgery within 50 days, compared with 39 days for non-Indigenous patients.
- In 2021, of 6,749 registered cases of rheumatic heart disease, 78% were Indigenous Australians compared with 22% non-Indigenous Australians.
- In 2021, the avoidable mortality rate for Indigenous Australians was 208 per 100,000. The Indigenous age-standardised rate was over 3 times that for non-Indigenous Australians (296 and 91 per 100,000 respectively).

See Module 3 data tables for all data presented in this module.

Data gaps and limitations

Disparities in access may be due to a range of factors other than a lack of cultural safety. The data provide overall measures of access, but do not include information on all the factors that can impact on access, such as affordability, previous experiences of racism, the presence of co-morbidities or patient choice.

Module 3 domains:

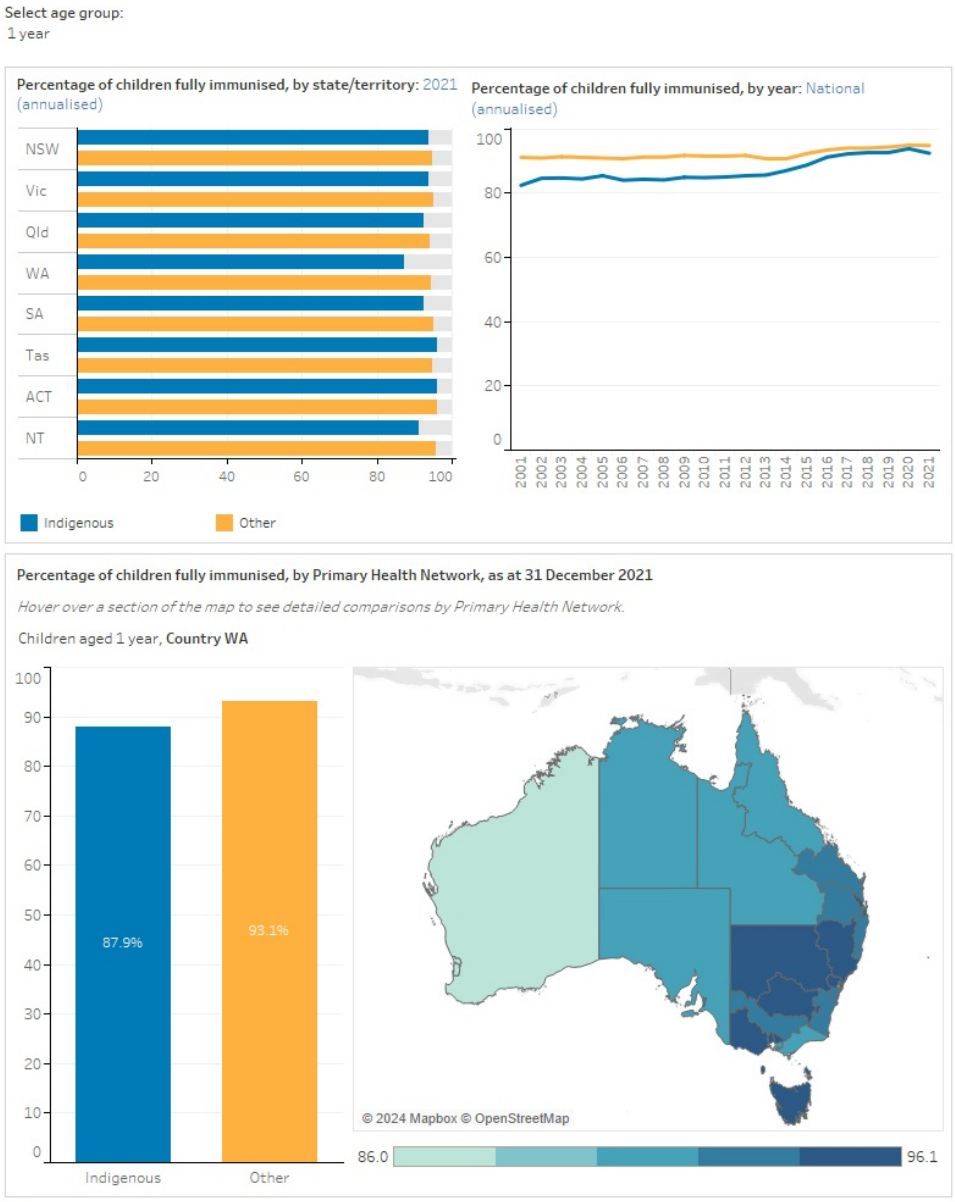
3.1 Preventive health services

Preventive health services, such as immunisation, can protect children and adults from harmful infectious diseases and prevent the spread of diseases amongst the community. Health screening services, such as breast screening, can help detect serious conditions and reduce mortality.

The data reported for these two measures come from the Australian Immunisation Register and BreastScreen Australia.

Rates of immunisation

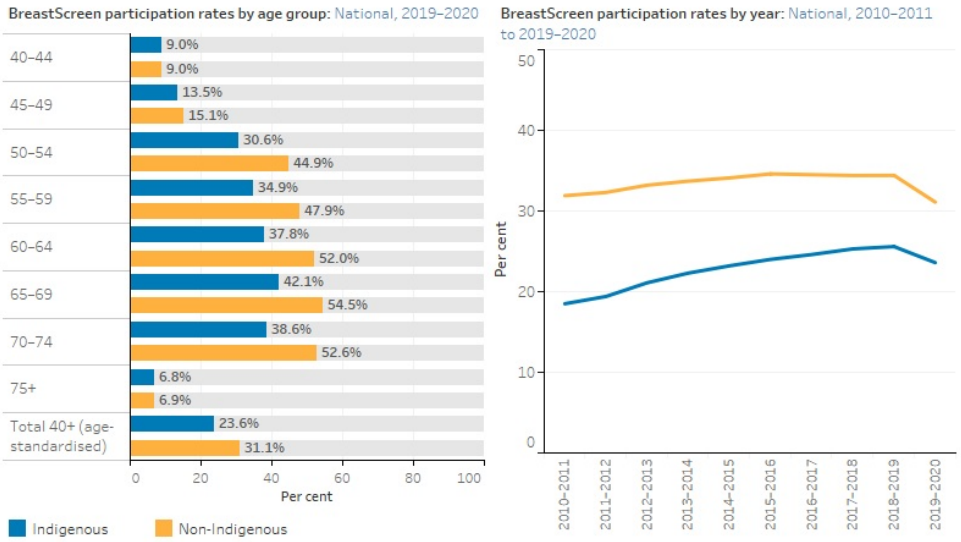
The figure is a set of interactive graphs showing the proportion of children that were fully immunised at age 1 year, 2 years and 5 years, by Indigenous status, state and territory, Primary Health Network and over time. See data tables for Module 3 – Tables 3.1.1a, 3.1.1b and 3.1.1c.



Notes
1. Suppression has been applied to data by PHN to protect the privacy of individuals.
2. In map by PHN, ≥95.0% and ≥99.0% values are treated as 95.0% and 99.0% respectively.
3. Data for children aged 5 years is only available from 2007.
Source: AIHW analysis of Australian Immunisation Register (AIR) (see data tables for Module 3 – Tables 3.1.1a, 3.1.1b, 3.1.1c).

Participation rates for breast screening

The figure is a set of interactive graphs showing BreastScreen participation by Indigenous status, age group and over time. See data tables for Module 3 – Tables 3.1.2a and 3.1.2b.



Source: AIHW analysis of BreastScreen Australia data, as published in AIHW 2022 (see data tables for Module 3 – Tables 3.1.2a, 3.1.2b).

References

AIHW (Australian Institute of Health and Welfare) 2022. BreastScreen Australia monitoring report 2022. Cat. no. CAN 150. Canberra: AIHW. Viewed 18 May 2023.

3.2 Primary health care

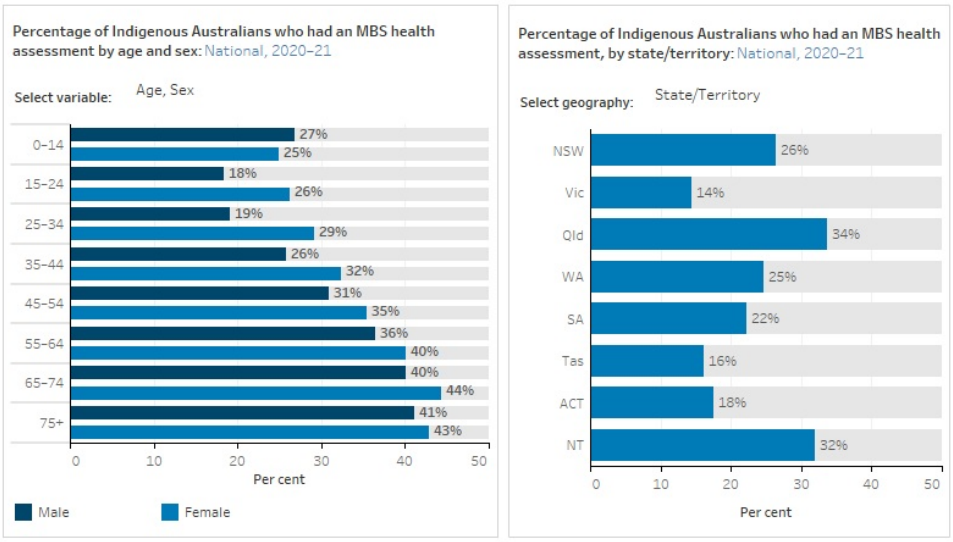
Primary health care services can help to keep people well and out of hospital by supporting them to manage their health issues in the community and at home, potentially avoiding health issues from becoming more serious. These services can reduce the need for specialist services and visits to emergency departments.

This domain has data on:

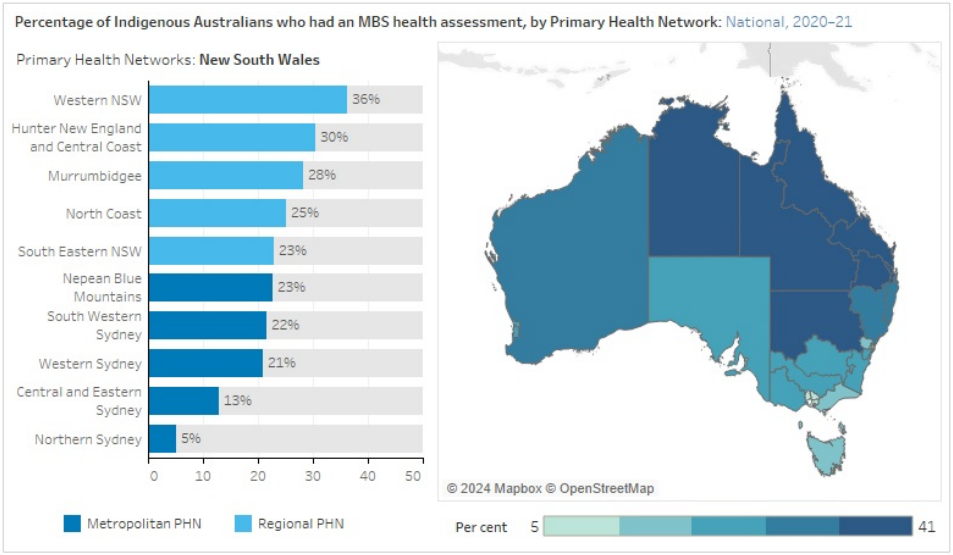
- Indigenous health checks: MBS items 715 and 228 (face-to-face), 92004 and 92011 (video-conference, available from March 2020), and 92016 and 92023 (teleconference, available from March 2020 to July 2021)
- antenatal care
- potentially preventable hospitalisations.

Indigenous health checks

The figure is a set of interactive graphs showing the proportion of Indigenous Australians who had an Indigenous-specific health assessment face-to-face (MBS items 715 and 228), video-conference (92004 and 92011, available from March 2020) and teleconference (92016 and 92023, available from March 2020 to July 2021), by age group, sex, remoteness, state and territory, Primary Health Network and over time. See data tables for Module 3 – Tables 3.2.1a, 3.2.1b, 3.2.1c and 3.2.1d.



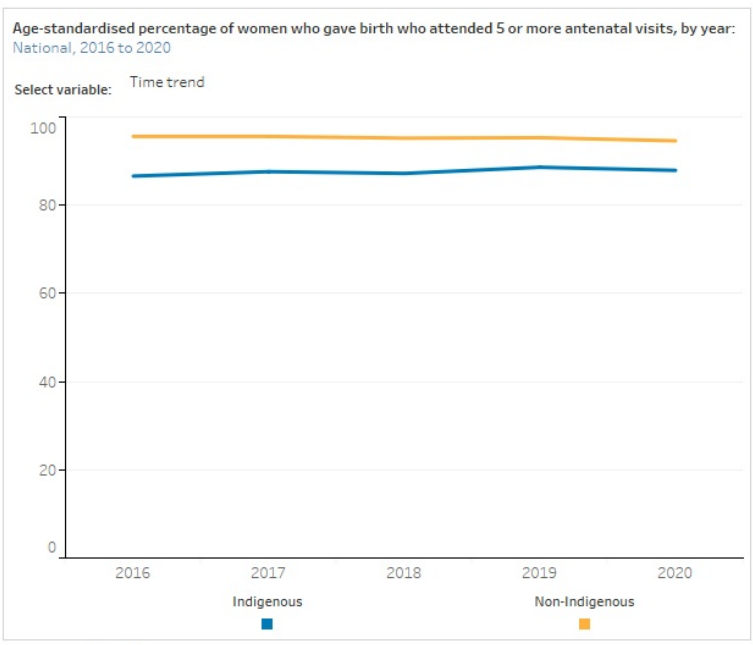
Hover over a section of the map to see comparisons by state/territory.



Source: AIHW analysis of Medicare Benefits Schedule data, as published in AIHW 2023 (see data tables for Module 3 – Tables 3.2.1a, 3.2.1b, 3.2.1c, 3.2.1d).

Access to antenatal care

The figure is a set of interactive graphs showing the proportion of women who gave birth who attended 5 or more antenatal visits by Indigenous status, remoteness, state and territory and over time. See data tables for Module 3 – Tables 3.2.2a and 3.2.2b.



The percentage of Indigenous women who attended 5 or more antenatal visits has **remained steady** since 2016

n.p. = not published
Source: AIHW analysis of the National Perinatal Data Collection, time trend as published in AIHW 2022, data by state/territory and remoteness as published in Productivity Commission 2023 (see data tables for Module 3 – Tables 3.2.2a, 3.2.2b).

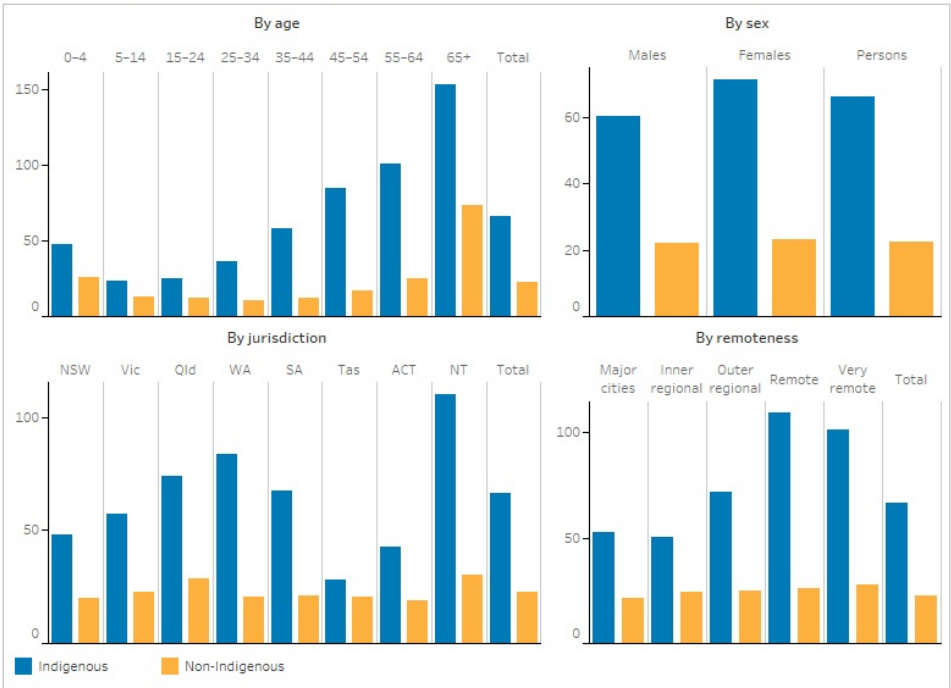
Potentially preventable hospitalisations

Potentially preventable hospitalisations are hospitalisations for conditions that can be effectively treated in a non-hospital system. These hospitalisations serve as a proxy measure for access to timely, effective and appropriate primary and community-based care. For more information, see Measure 3.07: Selected potentially preventable hospital admissions on the Aboriginal and Torres Strait Islander Health Performance Framework.

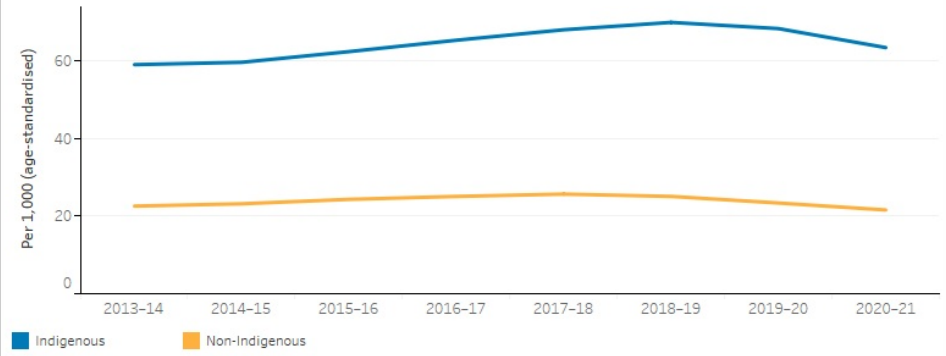
The figure is a set of interactive graphs showing the rate of potentially preventable hospitalisations (disaggregated by hospitalisations for acute conditions, chronic conditions, vaccine preventable conditions and total potentially preventable hospitalisations), by Indigenous status, age group, sex, state and territory, remoteness and over time. It also shows the rate of potentially preventable hospitalisations by condition type. See data tables for Module 3 – Tables 3.2.3a, 3.2.3b, 3.2.3c and 3.2.3d.

Select potentially preventable hospitalisation category:
Total potentially preventable hospitalisations

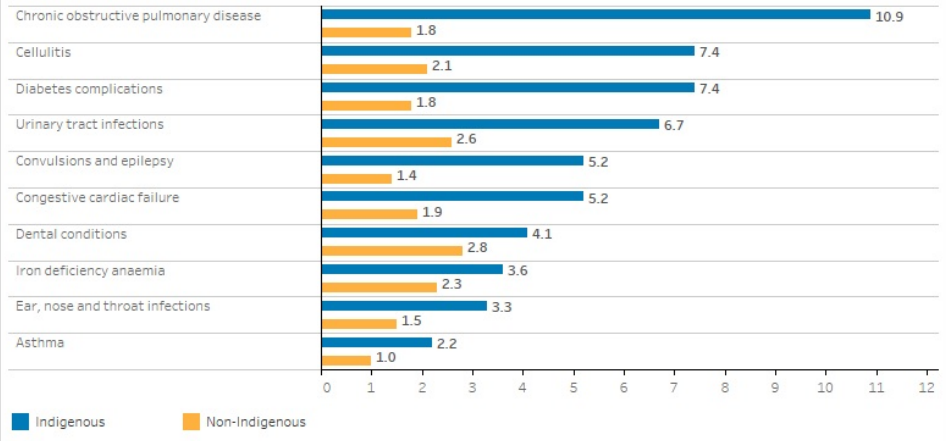
Total potentially preventable hospitalisations per 1,000, by age, sex, jurisdiction and remoteness: National, July 2019 to June 2021



Total potentially preventable hospitalisations, by Indigenous status, timetrend: National, July 2013 to June 2021



Rates of potentially preventable hospitalisations (PPH) per 1,000, by condition type: National, July 2019 to June 2021



Note: Only top 10 PPH conditions for Indigenous Australians are shown.

Source: AIHW analysis of National Hospital Morbidity Database (see data tables for Module 3 – Table 3.2.3a, 3.2.3b, 3.2.3c, 3.2.3d).

References

AIHW (Australian Institution of Health and Welfare) 2022. Australia's mothers and babies. Cat. No. PER 101. Canberra: AIHW. Accessed 18 May 2023.

AIHW 2023. Eye health measures for Aboriginal and Torres Strait Islander people 2022. Cat. No. IHW 271. Canberra: AIHW. Accessed 18 May 2023.

Productivity Commission 2023. Socioeconomic outcome area 2: Aboriginal and Torres Strait Islander children are born healthy and strong. Closing the Gap Information Repository website. Canberra: Productivity Commission. Accessed 25 May 2023.

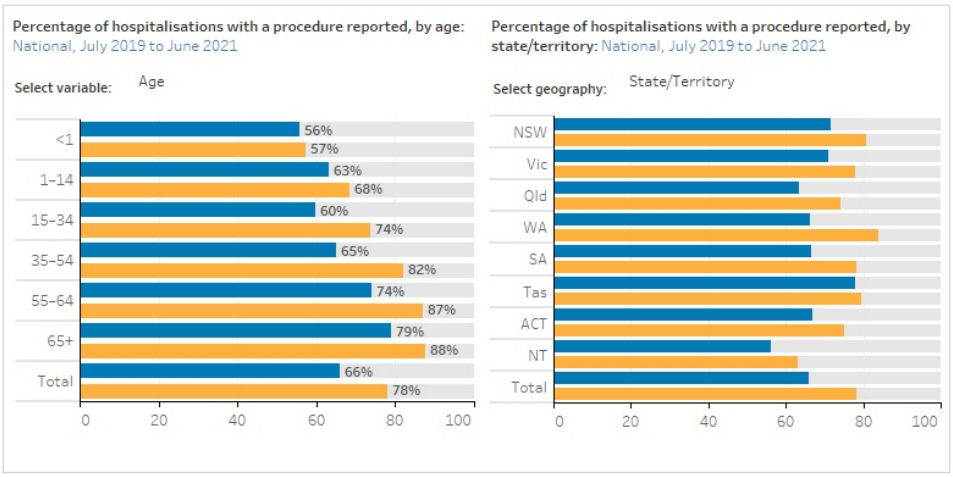
3.3 Hospital services

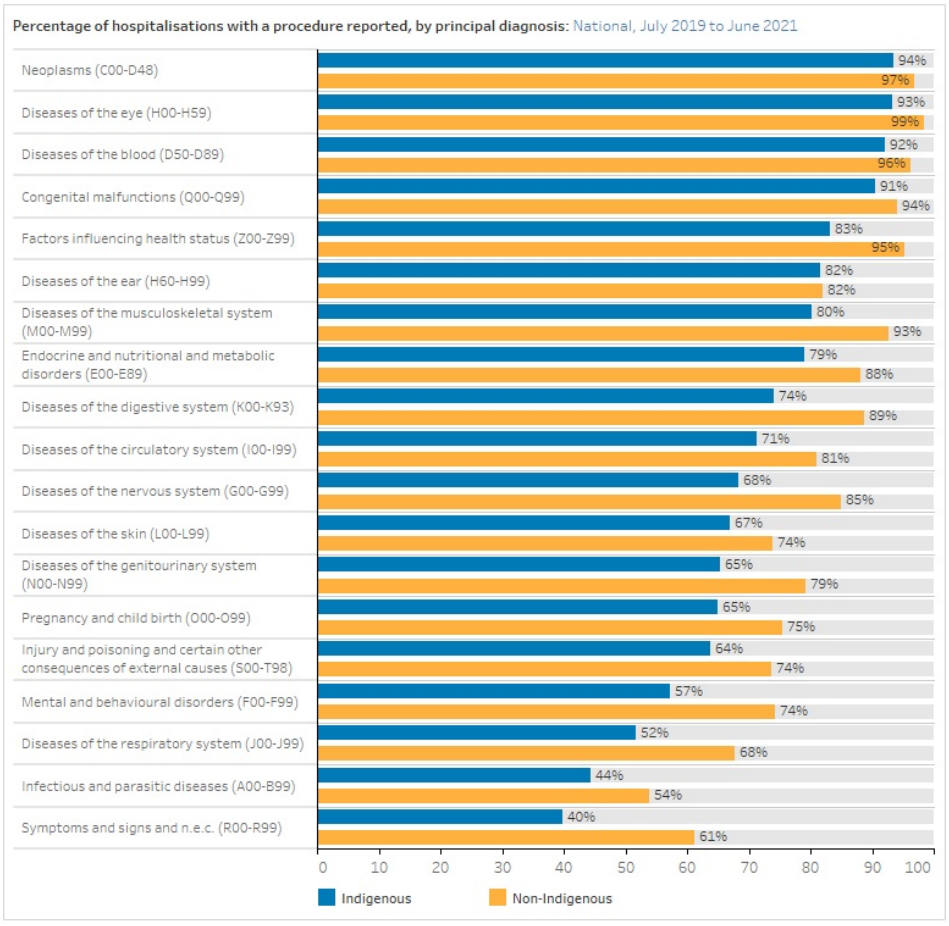
There are various measures that can be used to assess access to hospital services. Emergency department waiting times are one indicator of the accessibility of hospital services as they reflect how long patients have to wait for urgent medical attention, or to receive care as an admitted hospital patient. Access to medical procedures while in hospital are another indicator as studies have shown that while Aboriginal and Torres Strait Islander people are more likely to be hospitalised than other Australians, they are less likely to receive certain medical or surgical procedures. The data on waiting times for elective surgery also show that Indigenous Australians often wait longer to receive surgery.

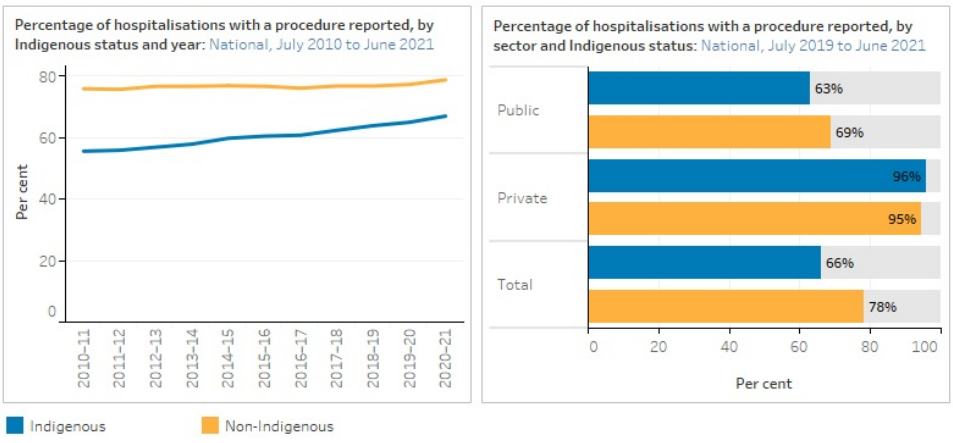
Waiting times for almost all elective procedures became shorter between 2020–21 and 2021–22. However, as part of the early response to COVID-19, restrictions were placed on elective surgery in 2019–20, which led to longer waiting times for most intended procedures in 2020–21 (AIHW 2023).

Access to hospital procedures

The figure is a set of interactive graphs showing the proportion of hospitalisations with a procedure report, by Indigenous status, age, sex, remoteness, state and territory, principal diagnosis and over time. See data tables for Module 3 – Tables 3.3.1a, 3.3.1b and 3.3.1c.



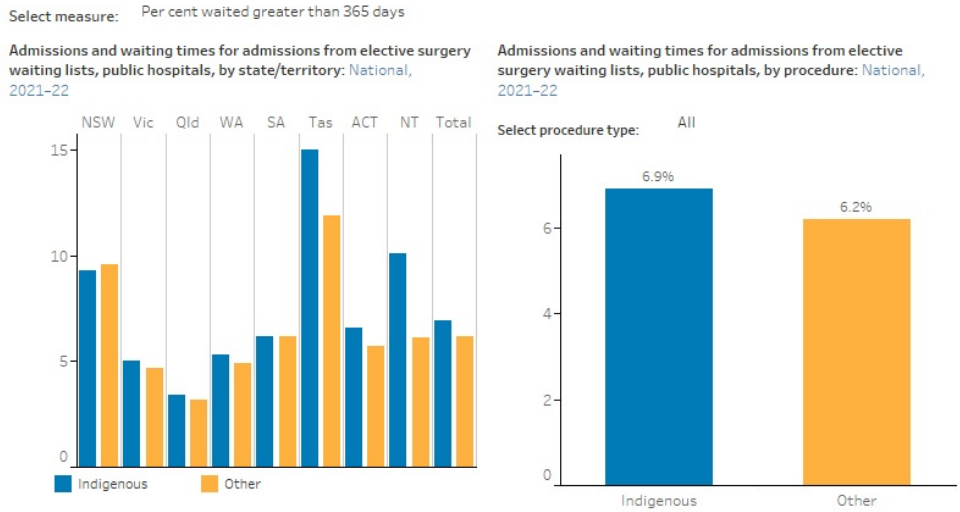




Source: AIHW analysis of National Hospital Morbidity Database (see data tables for Module 3 – Tables 3.3.1a, 3.3.1b and 3.3.1c).

Waiting times for elective surgery

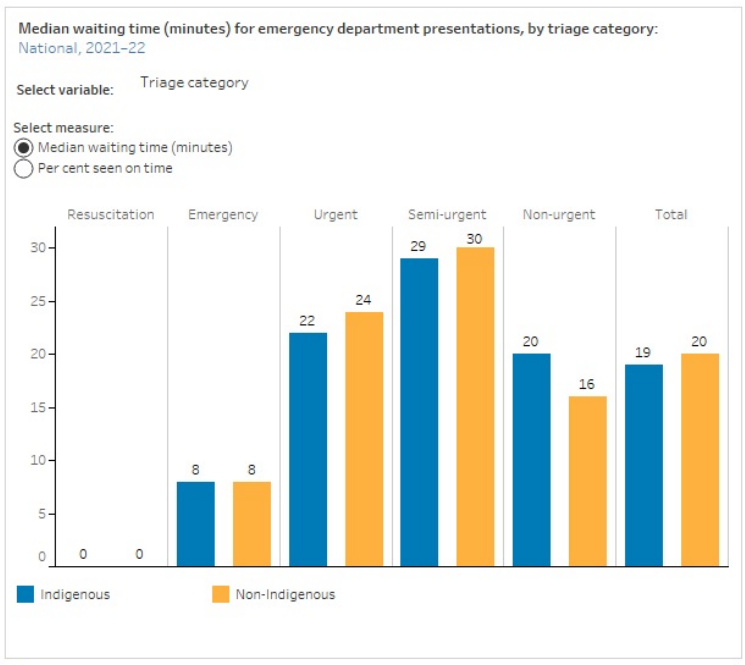
The figure is a set of interactive graphs showing admissions for elective surgery, days waited at the 50th percentile, days waited at the 90th percentile and per cent who waited greater than 365 days, by Indigenous status and state and territory. See data tables for Module 3 – Tables 3.3.2a and 3.3.2b.



Note: 'Other Australians' includes patients for whom Indigenous status was 'Not reported'.
Source: AIHW analysis of National Elective Surgery Waiting Times Data Collection, as published in AIHW 2022a (see data tables for Module 3 – Tables 3.3.2a, 3.3.2b).

Emergency department waiting times

The figure is a set of interactive graphs showing the median waiting time (minutes) and per cent seen on time for emergency department presentations by Indigenous status, triage category and state and territory. See data tables for Module 3 – Tables 3.3.3a and 3.3.3b.



The median waiting time for emergency department presentations was **slightly lower for Indigenous Australians** than for other Australians (19 and 20 minutes, respectively).

Notes
1. 'Other Australians' includes patients for whom Indigenous status was 'Not reported'.
2. Waiting time is defined by the elapsed time from presentation to commencement of clinical care.
Source: AIHW analysis of the National Non-Admitted Patient Emergency Department Care Database, as published in AIHW 2022b (see data tables for Module 3 – Tables 3.3.3a, 3.3.3b).

References

AIHW (Australian Institute of Health and Welfare) 2022a. Elective surgery. MyHospitals. Canberra: AIHW. Viewed 7 February 2023.

AIHW 2022b. Emergency department care. MyHospitals. Canberra: AIHW. Viewed 7 February 2023.

3.4 Specialist services

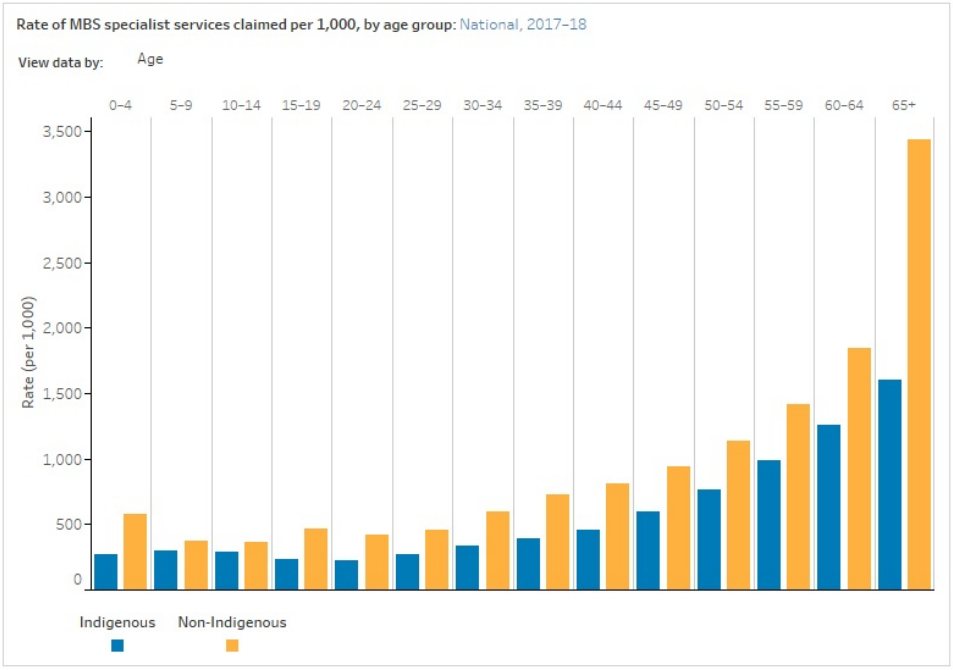
The Australian health system provides specialist treatment services to help people with a range of health concerns. Data are reported on specialist services claimed through the Medical Benefits Schedule (MBS), and on treatment of kidney failure, rheumatic heart disease and cataract surgery.

The MBS data presented here was derived using the Voluntary Indigenous Identifier (VII). Current VII data were not available in time for this report and therefore these measures have not been updated. For more information about the VII, see Voluntary Indigenous Identifier (VII) Framework on the Department of Health and Aged Care website.

MBS specialist services

This measure is calculated using VII data, which has not been updated. For a complete list of what data were available for the 2023 update, see Technical notes.

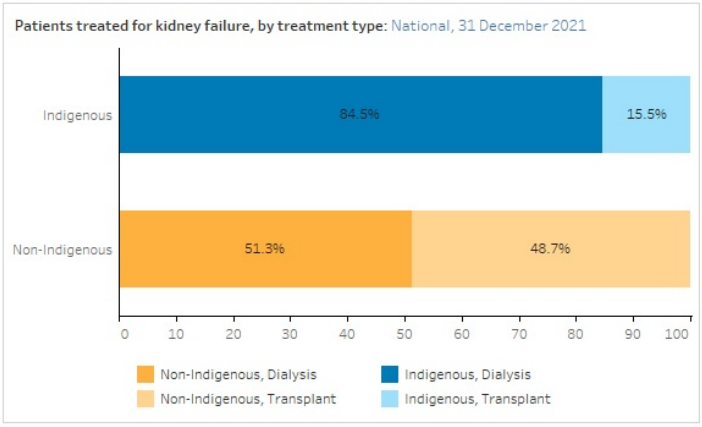
The figure is a set of interactive graphs showing the rate of MBS specialist services claimed, by Indigenous status, age group, service type and over time. See data tables for Module 3 – Tables 3.4.1a, 3.4.1b and 3.4.1c.



Source: AIHW analysis of Medicare data (see data tables for Module 3 – Tables 3.4.1a, 3.4.1b, 3.4.1c).

Treatment of kidney failure

The figure is a set of interactive graphs showing the treatment of kidney failure (either dialysis or transplant) by Indigenous status. See data tables for Module 3 – Table 3.4.2.

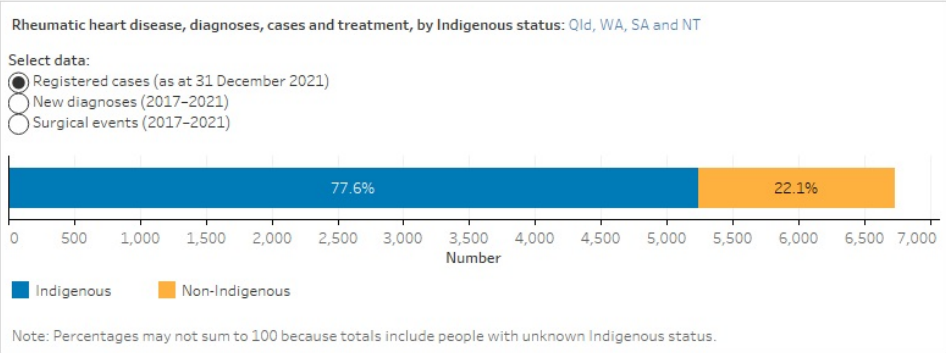


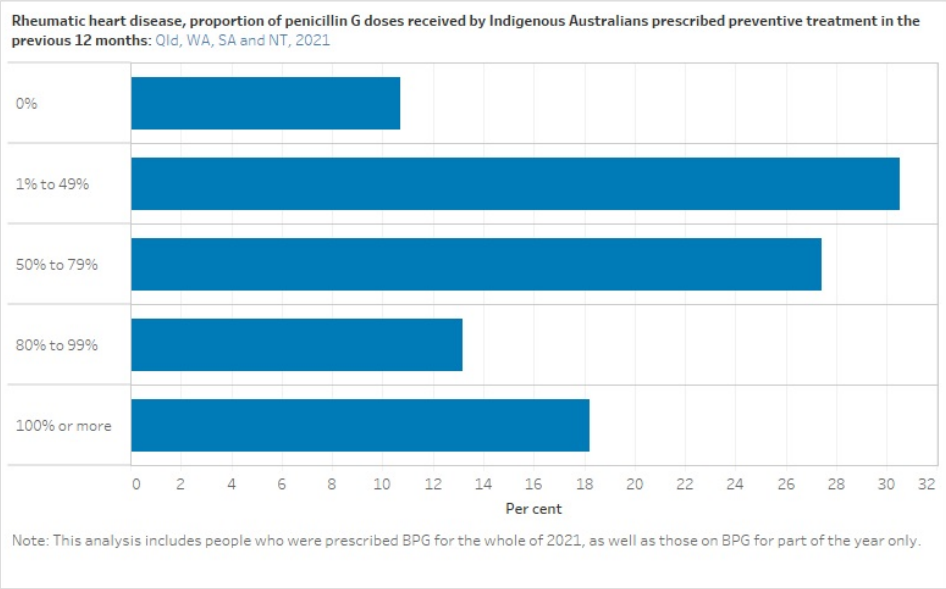
In 2021, among patients treated for kidney failure, a **lower** proportion of **Indigenous Australians** received transplants **(16%)** than **non-Indigenous Australians (49%)**

Source: AIHW analysis of ANZDATA data (see data tables for Module 3 – Table 3.4.2).

Rheumatic heart disease

The figure is a set of interactive graphs showing various indicators relating to Rheumatic heart disease, including registered cases, and proportion receiving prescribed penicillin doses, by Indigenous status. All data is only for Queensland, Western Australia, South Australia and Northern Territory. See data tables for Module 3 – Tables 3.4.3a, 3.4.3b.



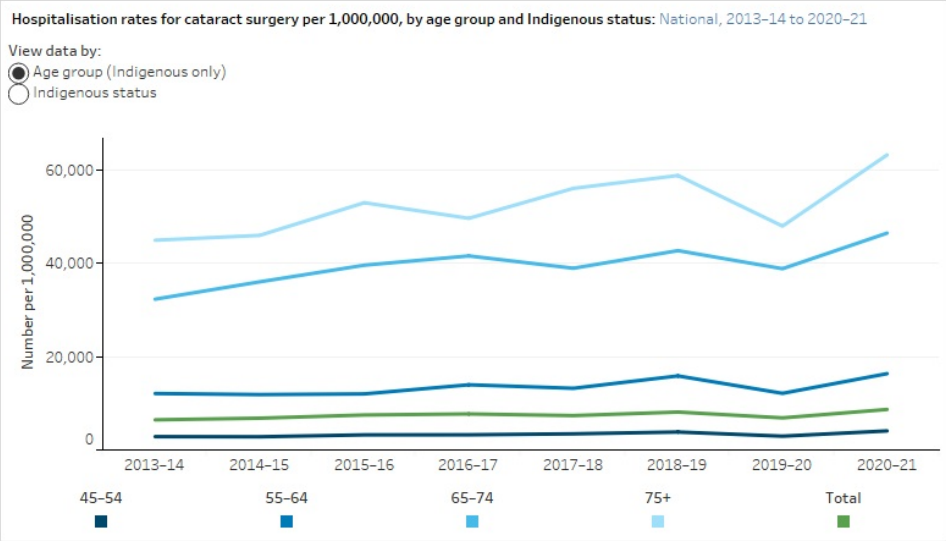


Source: AIHW analysis of National Rheumatic Heart Disease data collection, as published in AIHW 2023 (see data tables for Module 3 – Tables 3.4.3a, 3.4.3b).

For more information on rheumatic heart disease, see AIHW reports Acute rheumatic fever and rheumatic heart disease in Australia 2017-2021 and Better Cardiac Care measures for Aboriginal and Torres Strait Islander people: seventh national report 2022 (data update).

Cataract surgery

The figure is a set of interactive graphs showing hospitalisation rates for cataract surgery over time, by age (for Indigenous Australians only) or Indigenous status. Rates are presented per 1,000,000. See data tables for Module 3 – Tables 3.4.4a, 3.4.4b.



Source: AIHW analysis of National Hospital Morbidity Database (see data tables for Module 3 – Tables 3.4.4a, 3.4.4b)

References

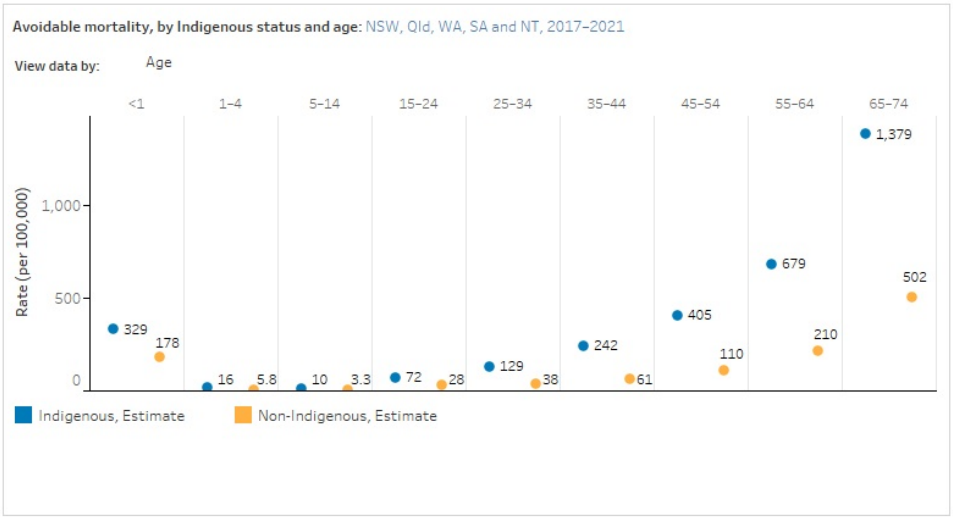
AIHW (Australian Institute of Health and Welfare) 2023. Acute rheumatic fever and rheumatic heart disease in Australia 2017-2021. Cat. no. CVD 99. Canberra: AIHW. Viewed 16 March 2023.

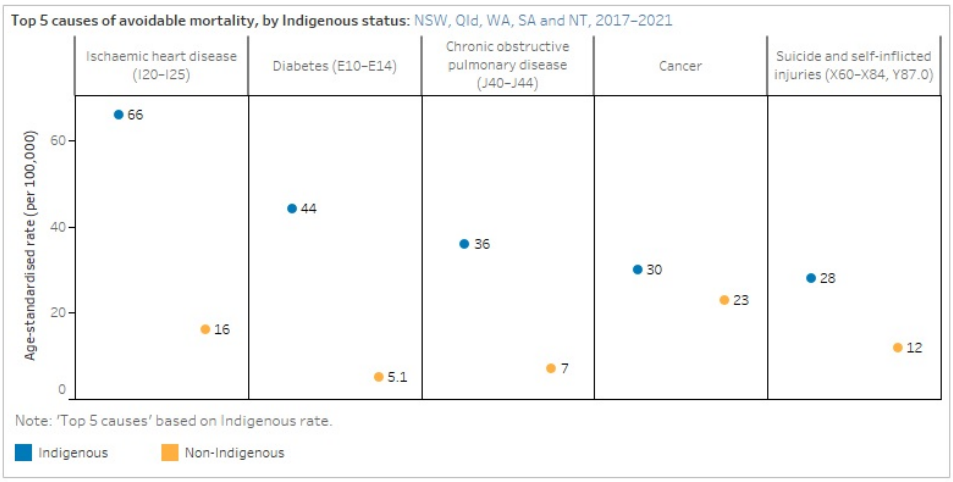
3.5 Overall health system

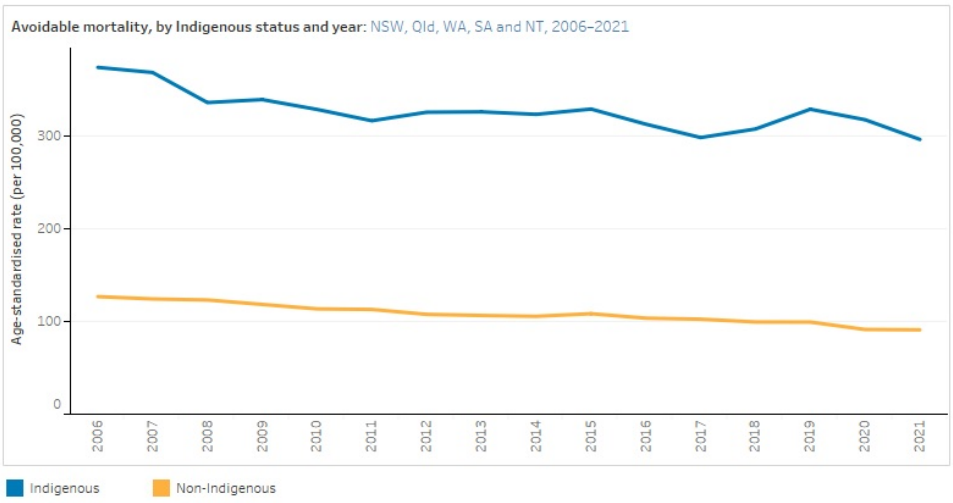
Avoidable mortality refers to deaths from conditions that are considered avoidable, given timely and effective health care, including disease prevention and population health initiatives. Avoidable mortality is one measure of the quality, effectiveness and accessibility of the health system. It should be noted, however, that deaths from most conditions are also influenced by factors other than access to health system services, including the underlying prevalence of conditions in the community, environmental and social factors, and health risk factors.

Avoidable deaths

The figure is a set of interactive graphs showing potentially avoidable deaths by Indigenous status and age, sex, state and territory, cause of death and over time. All data is only for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. See data tables for Module 3 – Tables 3.5.1a, 3.5.1b, 3.5.1c and 3.5.1d.







Source: AIHW analysis of National Mortality Database (see data tables for Module 3 – Tables 3.5.1a, 3.5.1b, 3.5.1c, 3.5.1d).

For more information, see Measure 1.24: Avoidable and preventable deaths on the Aboriginal and Torres Strait Islander Health Performance Framework.

Data sources and data gaps

The main data sources for the access to services measures were national data collections, mainly administrative data:

- Australian and New Zealand Dialysis and Transplant Registry
- Australian Immunisation Register
- BreastScreen Australia data
- Medicare Benefits Schedule data
- National Hospitals Data Collection
  - National Elective Surgery Waiting Times Data Collection
  - National Hospital Morbidity Database
  - National Non-admitted Patient Emergency Department Care Database
- National Mortality Database
- National Perinatal Data Collection
- National Rheumatic Heart Disease data collection.

There were data available for reporting on all measures in this module as they were based on existing national indicators or data collections.

Access to health care services: measures and data sources

Domains and measures	Data sources
3.1 Preventive health services	
Rates of immunisation	Australian Immunisation Register
Participation rates for breast screening	BreastScreen Australia data
3.2 Primary health care	
Indigenous health checks	Medicare Benefits Schedule data
Access to antenatal care	National Perinatal Data Collection
Potentially preventable hospitalisations	National Hospital Morbidity Database
3.3 Hospital services	
Access to hospital procedures	National Hospital Morbidity Database
Waiting times for elective surgery	National Elective Surgery Waiting Times Database
Emergency department waiting times	National Non-Admitted Patient Emergency Department Care Database
3.4 Specialist services	
Specialist services claimed	Medicare Benefits Schedule data
Treatment of kidney failure	Australian and New Zealand Dialysis and Transplant Registry
Rheumatic heart disease	Rheumatic Heart Disease data collection
Cataract surgery	National Hospital Morbidity Database
3.5 Overall health system	
Avoidable mortality	National Mortality Database

Notes

The National Hospitals Data Collection includes the major national hospitals databases held by the AIHW. This report includes data from the following hospital data collections:

- The National Hospital Morbidity Database (NHMD), a compilation of episode-level records from admitted patient morbidity data collection systems in Australian public and private hospitals.
- The National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), a compilation of episode-level records (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals.
- The National Elective Surgery Waiting Times Data Collection (NESWTDC), which holds episode-level information on patients added to or removed from elective surgery waiting lists managed by public hospitals.

For more information about these hospitals collections and the data quality statements see National Hospitals Data Collection and MyHospitals ‘About the Data'.

See the Aboriginal and Torres Strait Islander Health Performance Framework ‘Data sources and quality’ page for more information on AIHW data collections and other data collections presented in this module.

Technical notes

Data availability

The monitoring framework relies on the availability of source data. At the time of the 2023 release, updated data were available for 26 measures and unavailable for 22 measures, including 14 for which data are no longer collected.

Module 1: Culturally respectful health care services

Domain	Focus area	Measure	Table	Data source	Latest available data	Comments
1.1 - Organisational approach and commitment	i) Organisational commitment to culturally respectful and safe healthcare	Proportion of organisations with a formal commitment to culturally safe health care	1.1.1a	Online Services Report	2017-18	Data item no longer collected in the Online Services Report
1.1 - Organisational approach and commitment	i) Organisational commitment to culturally respectful and safe healthcare	Proportion of organisations with mechanisms for obtaining advice on cultural matters	1.1.1b	Online Services Report	2017-18	Data item no longer collected in the Online Services Report
1.1 - Organisational approach and commitment	ii) Aboriginal and Torres Strait Islander leadership at Board/Executive level	Proportion of organisations with board members who were Indigenous	1.1.2	Online Services Report	2021-22	Updated
1.2 - Communication and cultural services	i) Culturally appropriate communication resources	Proportion of organisations providing interpreter services	1.2.1	Online Services Report	2017-18	Data item no longer collected in the Online Services Report
1.2 - Communication and cultural services	ii) Offers culturally appropriate services	Proportion of organisation providing cultural services (bush medicine, bush tucker, traditional healing)	1.2.2	Online Services Report	2017-18	Data item no longer collected in the Online Services Report
1.3 - Workforce development and training	i) Aboriginal and Torres Strait Islander participation in the workforce	Health professionals by profession type	1.3.1a	National Health Workforce Dataset	2021	Updated
1.3 - Workforce development and training	i) Aboriginal and Torres Strait Islander participation in the workforce	Proportion of full-time employees who are Indigenous in Indigenous primary health care organisations	1.3.1b, 1.3.1c	Online Services Report	2021-22	Updated

1.3 - Workforce development and training	ii) Aboriginal and Torres Strait Islander workforce development	Rates of higher education student enrolments and completions in health-related courses and success rates	1.3.2a, 1.3.2b	Higher Education Statistics	2021	Updated
1.3 - Workforce development and training	ii) Aboriginal and Torres Strait Islander workforce development	Vocational education and training health-related course enrolment/completions	1.3.2c, 1.3.2d	NCVER National Vocational Education and Training Provider Collection	2021	Updated
1.3 - Workforce development and training	iii) Cultural safety and responsiveness training for staff	Proportion of organisations that provide cultural orientation for non-Indigenous staff	1.3.3	Online Services Report	2017-18	Data item no longer collected in the Online Services Report
1.4 - Consumer engagement and stakeholder collaboration	i) Client and community feedback mechanisms	Proportion of organisations that had client and community feedback mechanisms	1.4.1	Online Services Report	2017-18	Data item no longer collected in the Online Services Report
1.4 - Consumer engagement and stakeholder collaboration	ii) Consultation with Aboriginal and Torres Strait Islander communities	Proportion of organisations that had cultural safety policies developed in consultation with communities / Indigenous staff	1.4.2	Online Services Report	2017-18	Data item no longer collected in the Online Services Report

Module 2: Patient experience of health care

Domain	**Focus area**	**Measure**	**Table**	**Data source**	**Latest available data**	**Comments**
2.1 - Communication	i) Interaction with health professionals	How often doctors listened (carefully)	2.1.1a, 2.1.1b	NATSISS NATSIHS	2014-15 (NATSISS) 2018-19 (NATSIHS)	NATSISS has been discontinued NATSIHS is run approximately every 5-6 years
2.1 - Communication	i) Interaction with health professionals	Opportunity to talk to a doctor or nurse	2.1.1c	NSW Adult Admitted Patient Survey	2020	Data item was not collected in the 2021 collection period
2.1 - Communication	i) Interaction with health professionals	Hospital patient experience, received support or offer of support from an Aboriginal Health Worker	2.1.1d	NSW Adult Admitted Patient Survey	2020	Data item was not collected in the 2021 collection period

2.1 - Communication	ii) Information provided in a way that could be understood	How often doctor(s) explained things in a way that could be understood	2.1.2a	NATSIHS	2018-19	No updated data available for 2023 release
2.1 - Communication	ii) Information provided in a way that could be understood	Maternity clinic offered culturally appropriate resources	2.1.2b	Qld Maternity Outpatient Clinic Experience Survey	2017	Survey has been discontinued
2.1 - Communication	iii) Quality of relationship	Overall quality of relationship with doctors, nurses and other medical staff	2.1.3	Australian Reconciliation Barometer	2022	Updated
2.2 - Treated respectfully	i) Respect	How often doctors showed respect for what was said	2.2.1a, 2.2.1b	NATSISS NATSIHS	2014-15 (NATSISS) 2018-19 (NATSIHS)	NATSISS has been discontinued NATSIHS is run approximately every 5-6 years
2.2 - Treated respectfully	ii) Trust and confidence	Trust in hospitals	2.2.2a	NATSISS	2014-15	Survey has been discontinued
2.2 - Treated respectfully	ii) Trust and confidence	Overall levels of trust with doctors, nurses and medical staff	2.2.2b	Australian Reconciliation Barometer	2022	Updated
2.2 - Treated respectfully	iii) Staff were polite and courteous	Health care staff were polite and welcoming at arrival	2.2.3	NSW Adult Admitted Patient Survey	2021	Updated
2.2 - Treated respectfully	iv) Respect for cultural or religious beliefs	Cultural or religious beliefs were respected	2.2.4a	NSW Adult Admitted Patient Survey	2021	Updated
2.2 - Treated respectfully	iv) Respect for cultural or religious beliefs	Midwife/doctor checked if wanted cultural practices in birthing plan	2.2.4b	Qld Maternity Outpatient Clinic Experience Survey	2017	Survey has been discontinued
2.2 - Treated respectfully	iv) Respect for cultural or religious beliefs	Special dietary needs/suitability of food	2.2.4c	NSW Adult Admitted Patient Survey	2020	Data item was not collected in the 2021 collection period
2.3 - Unfair treatment and cultural barriers	i) Unfair treatment and discrimination	Treated unfairly by healthcare staff	2.3.1a	AATSIHS	2012-13	Survey has been discontinued
2.3 - Unfair treatment and cultural barriers	i) Unfair treatment and discrimination	Patient or family racially discriminated by doctors, nurses or medical staff	2.3.1b	Australian Reconciliation Barometer	2022	Updated
2.3 - Unfair treatment and cultural barriers	ii) Avoided health care due to poor treatment	Avoid seeking health care for being treated unfairly	2.3.2	AATSIHS	2012-13	Survey has been discontinued

2.3 - Unfair treatment and cultural barriers	iii) Did not access health care due to cultural reasons	Did not access health services when needed due to cultural reasons	2.3.3	NATSIHS	2018-19	NATSIHS is run approximately every 5-6 years
2.4 - Empowerment	i) Involved in health care decisions	Involved in decisions about care or treatment	2.4.1	NSW Adult Admitted Patient Survey	2021	Updated
2.4 - Empowerment	ii) Provided with information about patient rights	Received information about rights as a patient	2.4.2	NSW Adult Admitted Patient Survey	2014	Data item no longer collected through this survey
2.5 - Family inclusion	i) Family members were informed and included	Family had an opportunity to talk to a doctor	2.5.1	NSW Adult Admitted Patient Survey	2014	Data item no longer collected through this survey
2.5 - Family inclusion	i) Family members were informed and included	Right amount of information given to family	2.5.2	NSW Adult Admitted Patient Survey	2021	Updated
2.6 – Leave events	i) Admitted patient leave events	Hospitalisations where patients left against medical advice/were discharged at own risk	2.6.1a 2.6.1b	National Hospital Morbidity Database	2020-21	Updated
2.6 - Leave events	ii) Emergency department leave events	Public hospital emergency department patients who left at their own risk or did not wait	2.6.2	National Non-admitted Patient Emergency Department Care Database	2020-21 and 2021-22	Updated

Note: AATSIHS – Australian Aboriginal and Torres Strait Islander Health Survey; NATSIHS – National Aboriginal and Torres Strait Islander Health Survey; NATSISS – National Aboriginal and Torres Strait Islander Social Survey.

Module 3: Access to health care services

Domain	**Focus area**	**Measure**	**Table**	**Data source**	**Latest available data**	**Comments**
3.1 - Preventive health services	i) Rates of immunisation	Proportion of children fully immunised	3.1.1a, 3.1.1b, 3.1.1c	Australian Childhood Immunisation Register	2021	Updated
3.1 - Preventive health services	ii) Participation rates for breast screening	BreastScreen participation rates	3.1.2a, 3.1.2b	BreastScreen Australia	2019-2020	Updated
3.2 - Primary health care	i) Indigenous health checks	Proportion of Indigenous Australians who had an MBS Indigenous health assessment	3.2.1a, 3.2.1b, 3.2.1c, 3.2.1d	Medicare Benefits Schedule data	2020-21	Updated
3.2 - Primary health care	ii) Access to antenatal care	Proportion of women who gave birth who attended five or more antenatal visits	3.2.2a, 3.2.2b	National Perinatal Data Collection	2020	Updated

3.2 - Primary health care	iii) Potentially preventable hospitalisations	Rates of potentially preventable hospitalisations	3.2.3a, 3.2.3b, 3.2.3c, 3.2.3d	National Hospital Morbidity Database	2020-21	Updated
3.3 - Hospital services	i) Access to hospital procedures	Proportion of hospitalisations with a procedure reported	3.3.1a, 3.3.1b, 3.3.1c	National Hospital Morbidity Database	2020-21	Updated
3.3 - Hospital services	ii) Waiting times for elective surgery	Waiting times for admissions from waiting lists for elective surgery	3.3.2a, 3.3.2b	National Elective Surgery Waiting Times Data Collection	2021-22	Updated
3.3 - Hospital services	iii) Emergency department waiting times	Proportion of emergency presentations seen on time, by triage category	3.3.3a, 3.3.3b	National Non-admitted Emergency Department Care Database	2021-22	Updated
3.4 - Specialist services	i) MBS specialist services	MBS specialist services claimed	3.4.1a, 3.4.1b, 3.4.1c	Medicare Benefits Schedule data	2017-18	This measure is calculated using VII data, which has not been updated
3.4 - Specialist services	ii) Treatment of kidney failure	Total patients with kidney failure	3.4.2	Australian and New Zealand Dialysis and Transplant Registry	2021	Updated
3.4 - Specialist services	iii) Rheumatic heart disease	Incidence and treatment of rheumatic heart disease	3.4.3a, 3.4.3b	National Rheumatic Heart Disease data collection	2017-2021	Updated
3.4 - Specialist services	iv) Cataract surgery	Rates of hospitalisation for cataract surgery	3.4.4a, 3.4.4b	National Hospital Morbidity Database	2020-21	Updated
3.5 - Overall health system	i) Avoidable deaths	Avoidable mortality	3.5.1a, 3.5.1b, 3.5.1c, 3.5.1d	National Mortality Database	2021	Updated

Note: VII – Voluntary Indigenous identifier.

Supplementary material

Cultural safety-related questions from the OSR data collection

Supplementary material (PDF 1.6MB)

Data

Archived content