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# **Access to health services for Aboriginal and Torres Strait Islander people**

**May 2011**

Australian Institute of Health and Welfare  
Canberra

Cat. no. IHW 46

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# Abbreviations

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
CSO	Community Service Obligation
DoHA	Department of Health and Ageing (Australian Government)
GP	General practitioner
MBS	Medicare Benefits Scheme
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NBSCP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NIPS	National Immunisation Program Schedule
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OSR	Office of Aboriginal and Torres Strait Islander Health Services Reporting
PPH	Potentially preventable hospitalisation
VII	Voluntary Indigenous Identifier

# Summary

Aboriginal and Torres Strait Islander people (Indigenous Australians) typically die at much younger ages than other Australians and are more likely to experience disability and reduced quality of life because of ill health. One important contributor to health and wellbeing is access to health services. This paper examines Indigenous Australians' use of a range of health services, including those that provide preventive, primary and community health, hospital or specialised care. It is one of nine papers in the AIHW Indigenous Biennial Observatory series.

## Preventive health services

- In December 2009, Indigenous children were less likely than their non-Indigenous counterparts to be fully immunised at 1, 2 and 5 years of age.
- The number of Indigenous-specific health checks delivered to Indigenous children aged less than 15 years, and reimbursed by Medicare, more than doubled between September 2006 and September 2009.
- Indigenous women aged 50–69 years were less likely than all women in this target age group to have received a breast cancer screen from BreastScreen Australia programs in 2007 and 2008.

## Primary and community health services

- In 2009–10, general practice-type service use, reimbursed by Medicare, was similar for Indigenous Australians and non-Indigenous Australians.
- The rate of potentially preventable hospitalisations for Indigenous people was 4.9 times the rate for other Australians in 2008–09.

## Hospital services

- Compared with other Australians, Aboriginal and Torres Strait Islander people were more than two times as likely to be hospitalised than other Australians although less likely to undergo a procedure while in hospital.
- Indigenous Australians had longer waiting times than other Australians for a range of public elective surgeries, including cataract extraction, septoplasty and total hip replacement.

## Specialised services

- In 2009–10, Indigenous Australians had slightly lower usage rates of Medicare-reimbursed specialist services than non-Indigenous Australians.
- In 2008–09, around 17,000 treatment episodes for alcohol and/or other drugs were provided to clients of Aboriginal and/or Torres Strait Islander origin, accounting for 12% of all treatment episodes.
- Between 2003–04 and 2008–09, the number of hearing services provided to Indigenous clients under the Community Service Obligations program more than tripled.

# Introduction

Access to health services is an important influence on the health status of Aboriginal and Torres Strait Islander people. Access can be assessed by monitoring the use of health services and through measures such as waiting times for care. Ideally, assessment of access also includes consideration of need for care – because people with greater health-care needs are expected to access more, or more timely, health services. In practice, however, much of the available data on usage of health services by different populations – including the information presented here – does not fully account for differences in health-care needs.

Health services are delivered to Australians through multiple streams; encompassing preventive health services (including immunisation and screening programs), primary and community health services, and hospital care provided to admitted and non-admitted patients. Specialised health services, such as mental health care, alcohol and other drug treatment and hearing services, may be delivered across these three broad streams. Services may be mainstream or targeted to a specific population group (such as specialist Indigenous services and those delivered for men only).

This paper presents a range of information about the use of mainstream and Indigenous-specific health services by Indigenous Australians, drawing on examples across these broad streams and on the delivery of specialised health services where data are available. These data should be interpreted in the context of information about Indigenous Australians' health status and relative need for services and care which, broadly speaking, show that Indigenous people are generally less healthy than other Australians, die at much younger ages, and have more disability and a lower quality of life (AIHW 2010a).

## **Box 1: Measuring service utilisation by Indigenous people using administrative data sets**

Most health service administrative data sets include information about the Indigenous status of people who use the service. However, this information is not necessarily completed for each service user or occasion of service, and the degree of completeness of Indigenous identification varies between data sets and between jurisdictions within a single data set. Poor data quality creates the risk of under-identifying Indigenous Australians or making misleading comparisons between Indigenous and non-Indigenous Australians.

This paper limits its analyses to statistical information from data sets considered to be of sufficient quality. Known issues affecting specific data sources used here are detailed below.

With the exception of the Australian Childhood Immunisation Register, antenatal data and screening service data, data collections used in this paper report on counts of services, such as number of general practitioner consultations, episodes of care, hospital separations or mental health contacts. These are not necessarily equivalent to numbers of clients or patients as individuals may access a service more than once during the reference period.

### **Childhood immunisation**

Analysis of the Australian Childhood Immunisation Register (ACIR) is based on data from New South Wales, Victoria, Western Australia, South Australia and the Northern Territory. Indigenous status on the ACIR is as reported by the child's carer to Medicare Australia or by the immunisation provider to the ACIR.

*(continued)*

**Box 1 (continued): Measuring service utilisation by Indigenous people using administrative data sets****Screening services**

Of the three major cancer screening programs in Australia (BreastScreen, National Bowel Cancer Screening Program and the National Cervical Cancer Screening Program) administrative by-product data on Indigenous status are currently of sufficient quality for breast screening only.

**Medicare Benefits Scheme (MBS)**

Medicare data include information on those patients who have voluntarily identified as being Aboriginal or Torres Strait Islander. As at August 2010, 50% of the Indigenous population had voluntarily identified as Indigenous on the Medicare system. Some of the Medicare data presented by Indigenous status here were adjusted for under-identification in the Medicare Australia Voluntary Indigenous Identifier (VII) database. These Indigenous rates therefore should be interpreted with caution. Unadjusted data for Indigenous status are used for MBS item numbers only available for Indigenous people, such as the child health check (item number 708) or the adult health check (item number 710).

**Patients admitted to hospitals**

The level of Indigenous identification in admitted patient data is of sufficient quality for analysis (that is, greater than 80%) in New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory (AIHW 2010b). Data presented here by Indigenous status are therefore based on these jurisdictions only, and may not be representative of hospitals in Tasmania, the Australian Capital Territory or private hospitals in the Northern Territory.

**Public hospital emergency departments**

The quality of data reported for Indigenous status in national emergency department data has not been formally assessed for completeness and caution should therefore be exercised when interpreting these data. Most states and territories advised that the Indigenous status data collected in an emergency department setting in 2009–10 is an improvement on previous years but is still likely to be less accurate than the data collected for admitted patients.

**Public hospital elective surgery**

The quality of data reported for Indigenous status in the National Elective Surgery Waiting Times Data Collection has not been formally assessed for completeness; caution should therefore be exercised when interpreting these data. In addition, Indigenous status was not supplied by New South Wales for 2009–10. Elective surgery waiting times data and national rates by Indigenous status therefore exclude approximately one-third of all records in this period.

**Antenatal care**

The data reported on antenatal care is for New South Wales, South Australia and the Northern Territory only. No formal assessment has been undertaken to determine completeness of the coverage or identification of Indigenous mothers in the data presented.

**Mental health services**

This report includes statistics drawn from the National Community Mental Health Care Database; however, data quality has not been formally assessed and comparisons between Indigenous and non-Indigenous Australians should be made with caution. The quality of Indigenous status data for residential mental health care is also unknown.

*(continued)*

**Box 1 (continued): Measuring service utilisation by Indigenous people using administrative data sets**

**Alcohol and other drug treatment services**

In 2009, four jurisdictions were able to provide information about the Indigenous status of clients receiving pharmacotherapy treatment – New South Wales, Queensland, South Australia and the Australian Capital Territory. As statistics were not available from other jurisdictions, the number of Indigenous pharmacotherapy clients cited in this report underestimates the total number of clients nationally.

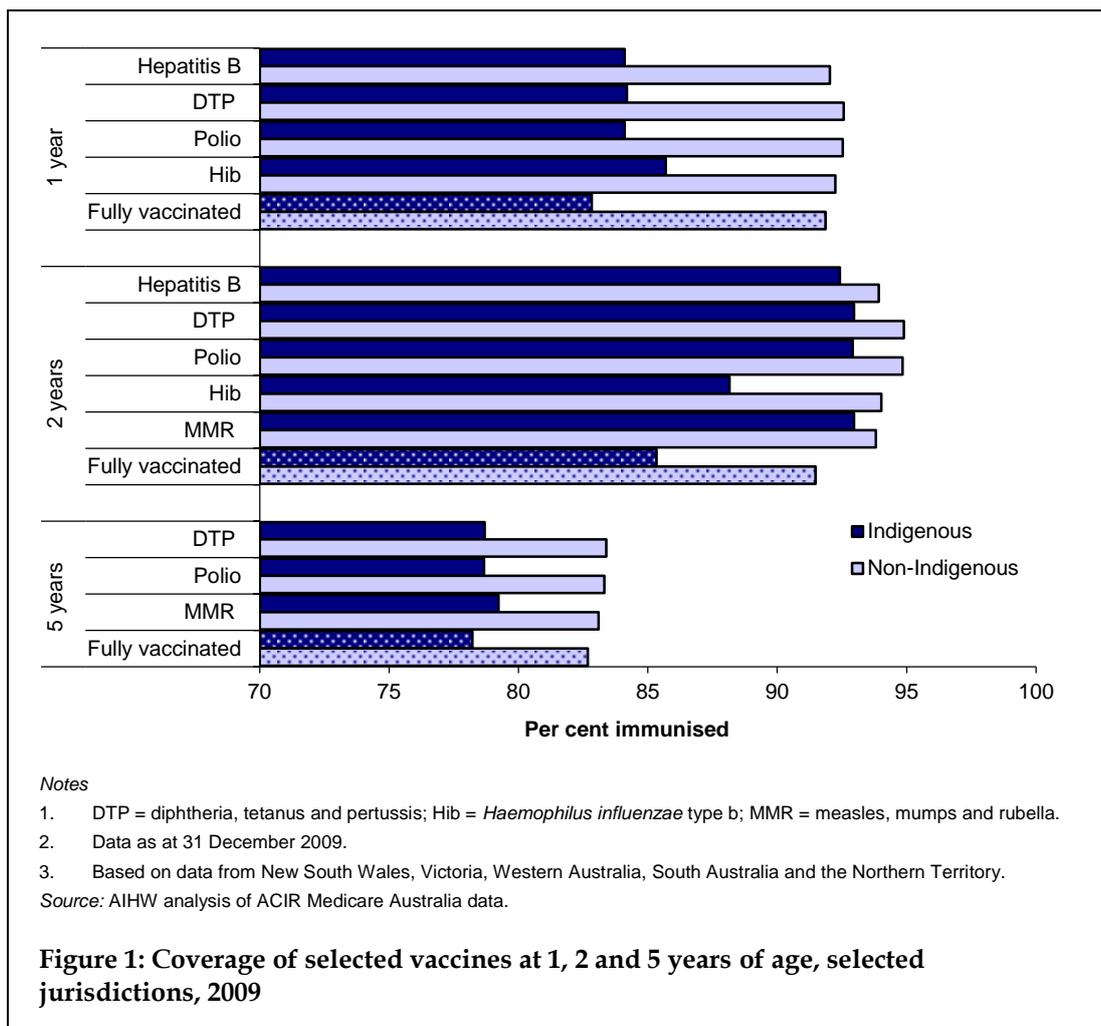
## Preventive health services

### Immunisation

The Immunise Australia Program aims to reduce morbidity and mortality associated with vaccine-preventable diseases. The program funds a series of age-specific vaccinations as outlined in the National Immunisation Program Schedule (NIPS) (DoHA 2010). Routine reporting of the effectiveness of the Immunise Australia Program focuses on the coverage of a subset of vaccines listed on the NIPS at key milestone ages. The Immunise Australia Program's target for population coverage is over 90% (Hull et al. 2010).

In December 2009, 92% of non-Indigenous 1 year olds, and 83% of Indigenous children of the same age were fully immunised (Figure 1). Among 2 year olds the gap was narrower, with coverage of several vaccines exceeding 90% for both Indigenous and non-Indigenous children. However, Indigenous children aged 2 years were still less likely than non-Indigenous children to be fully immunised. Note that 'fully immunised' does not include all vaccinations available for children of this age group. Complete definitions of 'fully immunised' for 1, 2 and 5 years are listed in the Glossary.

Coverage was below 90% for both Indigenous (78.2%) and non-Indigenous children (82.7%) aged 5 years.



In addition to the above vaccines, the Hepatitis A and pneumococcal disease vaccines are available to Indigenous children in Queensland, South Australia, Western Australia and the Northern Territory through the NIPS. Coverage rates for both vaccines have risen to over 50% since their addition to the schedule; however, there is a large variation in coverage by jurisdiction (Hull et al. 2010). The Hepatitis A vaccine requires two doses delivered between the ages of 12 and 24 months. In 2008, 52% of Indigenous children in Queensland, South Australia, Western Australia and the Northern Territory were fully vaccinated against Hepatitis A, with an additional 16% having received one dose by 24 months. The pneumococcal disease vaccine is a single dose, ideally delivered between 18 and 24 months. In 2008, 59% of Indigenous children in Queensland, South Australia, Western Australia and the Northern Territory had received the pneumococcal vaccination (Hull et al. 2010).

The timing of vaccinations given in childhood is an important factor in their efficacy. While overall coverage of many vaccines is similar for Indigenous and non-Indigenous 2 year olds, delayed delivery of vaccinations beyond the optimal age window is more common for Indigenous children (Hull et al. 2010).

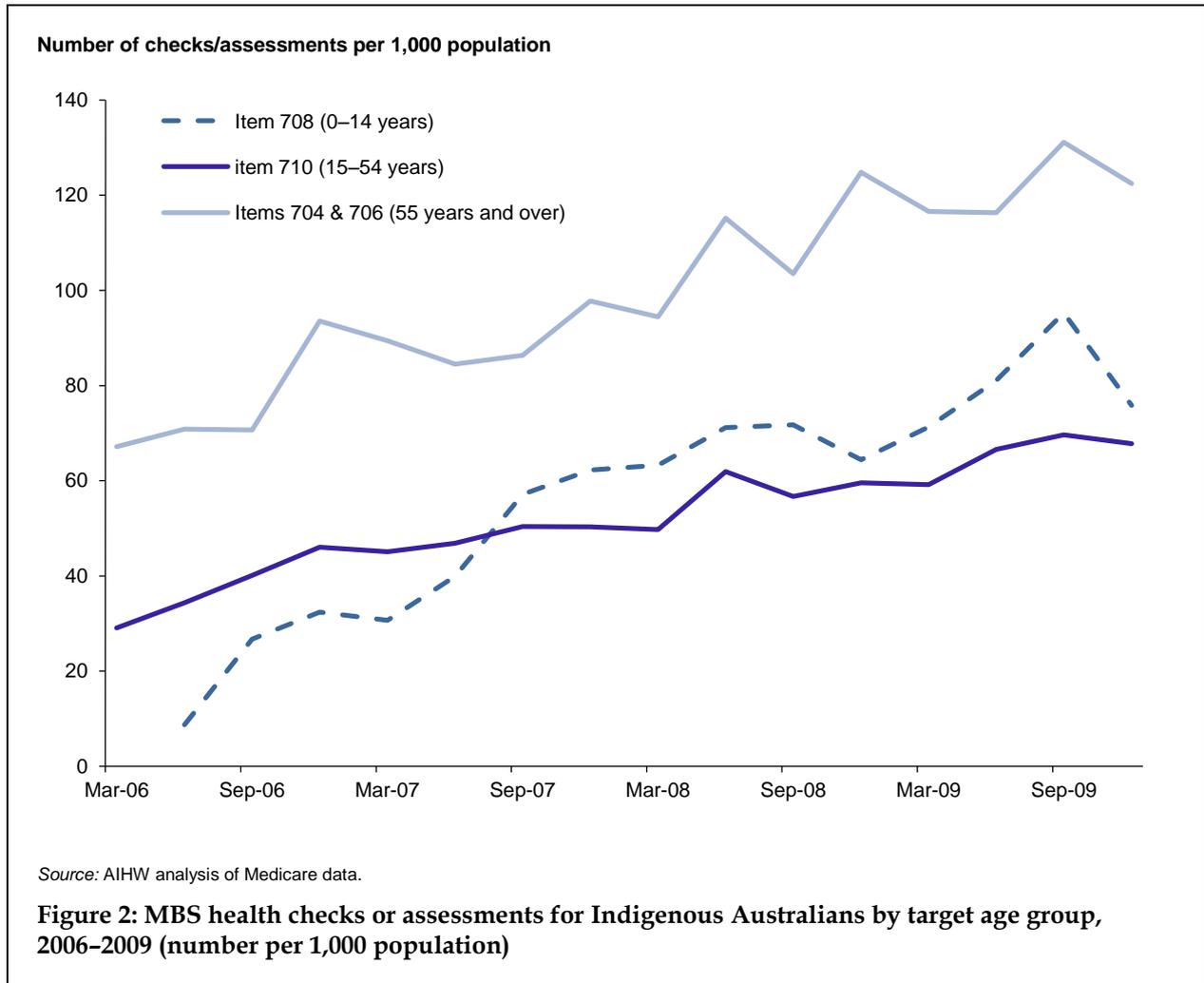
## Screening activities, health checks and assessments

Population-based screening activities focus on the detection of diseases in their early or pre-disease stages in order to reduce morbidity and mortality. Screening for a range of conditions is provided to people with no apparent symptoms.

Several items are available under the Medicare Benefits Scheme (MBS) to encourage general practitioners to carry out regular health assessments, including some specific item numbers for Indigenous patients. The assessments include recording the patient's medical history, a general physical examination, giving advice on healthy lifestyles, and arranging any necessary interventions or referrals.

- The child health check (item number 708) – introduced in May 2006 – is recommended to be conducted annually for children aged 0–14 years. In 2008–09, 72 child health checks per 1,000 population were recorded for Indigenous children aged under 15 years.
- The adult health check (item number 710) is provided to patients aged 15–54 years and is recommended to be conducted every 2 years. In 2008–09, 61 adult health checks per 1,000 population were recorded for Indigenous people aged 15–54 years.
- The older persons health check (item numbers 704 and 706) are recommended to be conducted annually for patients aged 55 years or over. 115 older persons health checks per 1,000 population were recorded for older Indigenous people in 2008–09 – almost twice the rate recorded in the first quarter of 2006.

Between 2006 and 2009 considerable increases were observed in the rate of usage of each of these MBS items (Figure 2).



In 2008-09, 201 Aboriginal and Torres Strait Islander primary health-care services (see below) provided information on the provision of screening services (AIHW 2010d). Pap tests/cervical screening and well person's checks were the most common types of screening activity provided by these primary health-care services (80%) (Table 1).

**Table 1: Aboriginal and Torres Strait Islander primary health-care services providing screening activities, 2001–02 to 2008–09 (per cent)**

	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09 <sup>(a)</sup>
Well person's checks	66	64	64	63	65	76	69	80
Pap tests/cervical screening	79	73	79	77	75	76	75	80
STI screening <sup>(b)</sup>	65	66	64	65	63	67	64	73
Hearing screening	72	73	72	70	71	76	71	72
Eye disease screening	63	66	65	70	64	73	65	69
Renal disease screening	44	46	50	50	43	51	50	54
Diabetic screening	77	79	82	80	77	79	76	78
Cardiovascular screening	49	54	57	60	53	64	59	66
Child growth monitoring	76	75	71	72	65	72	72	64

*Notes*

(a) Office of Aboriginal and Torres Strait Islander Services Reporting 2008–09 data counts include services outsourced by OATSIH-funded organisation for the provision of health services while data for previous years counted only those services directly funded by OATSIH. Therefore caution should be exercised when comparing rates with earlier data collection periods.

(b) STI=Sexually transmissible infection.

Source: AHMAC forthcoming.

BreastScreen Australia is a joint program of the Australian Government and state and territory governments that aims to reduce morbidity and mortality from breast cancer. Data for participation are provided by each state and territory BreastScreen program, and then compiled into national figures to allow national monitoring of BreastScreen Australia (AIHW 2010c).

The BreastScreen program is targeted at women aged 50–69 years, although women aged 40 years and over may receive free breast cancer screening. Rescreening is recommended every 2 years (AIHW 2010c).

In the 2-year period 2007–2008, 36% of Indigenous women in the target age group participated in BreastScreen Australia programs – considerably lower than the overall participation rate for this age group (55%) (Table 2).

**Table 2: Participation in BreastScreen Australia programs by age group, 2007–2008 (per cent)<sup>(a)(b)</sup>**

	Indigenous women	All women	Rate ratio <sup>(c)</sup>
50–69 years (target group)	36.0	54.9	0.7
40 years and over	23.1	32.9	0.7

(a) Number of women screened as a percentage of the average of the 2007 and 2008 ABS estimated resident population for females.

(b) Rates are directly age-standardised to the Australian 2001 standard population.

(c) Indigenous women: all women.

Source: AIHW analysis of BreastScreen Australia data.

The National Cervical Screening Program (NCSP) uses Pap tests to detect early stage cervical cancer. Cervical screening data are collected in each state and territory and coordinated nationally; however these registers do not currently include accurate information about the Indigenous status of women. Data on cervical screening rates for Indigenous women are

therefore sourced from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), which is conducted every 6 years.

In 2004–05, approximately 85% of Indigenous women aged 18 years and over reported ever having a Pap test and 58% reported having regular Pap tests (AHMAC 2008). In the same period, data from the NCSP shows that 61% of all Australian women (Indigenous and non-Indigenous) aged 20–69 years had received a Pap test in the previous 24 months (AIHW 2007). Note that data on cervical screening in the NATSIHS are ‘as reported’ by respondents and may differ from results that would be obtained from medical records or health registers.

Another national cancer screening program is the National Bowel Cancer Screening Program (NBCSP) that aims to detect and prevent bowel cancer. The NBCSP register currently includes self-reported information about Indigenous status. However, high non-response rates by participants for Indigenous status mean that this data item currently does not provide meaningful results.

## **Primary care and community health services**

Primary care and community health services include care from GPs, allied health professionals, pharmacists and other practitioners and are the first point of contact with the health system for most patients (AIHW 2010a). Indigenous Australians can access primary care and community health services through mainstream services, such as GP services, and Indigenous-specific services, such as the Aboriginal and Torres Strait Islander primary health-care services.

### **Aboriginal and Torres Strait Islander primary health-care services**

In 2008–09 the Australian Government provided funding through the Office of Aboriginal and Torres Strait Islander Health to 211 primary health-care services that target services for Aboriginal and Torres Strait Islander people. Two-thirds of the services were located in Outer regional, Remote and Very remote areas. Based on data from 191 of these services, 2.1 million episodes of care were provided, though one-fifth of contacts were for non-Indigenous Australians (AIHW 2010d).

Information about clinical health care in 2008–09 was provided by 201 services, describing a range of activities, including ongoing management of chronic disease (Table 3). The large majority (85%) of services provided diagnosis and treatment of illness and disease, and just over half provided outreach clinics (55%) or dental care (52%).

**Table 3: Selected clinical health activities provided by Aboriginal and Torres Strait Islander primary health-care services, 2008–09 (per cent)**

Type of activity	Per cent of services providing activity
Management of diabetes	88.6
Management of other chronic illness	86.1
Diagnosis and treatment of illness/disease	84.6
Management of cardiovascular disease	83.6
Immunisation and vaccination registers	79.6
Shared care arrangements for management of people with chronic conditions	77.6
Outreach clinic services	55.2
Dental care	51.7

Source: AIHW 2010d.

Almost all services (94%) provided access to one or more specialist support services. Much of this activity was provided by visiting specialists, including allied health professionals, nurses, doctors and medical specialists. In 2008–09, 176 services were visited by a specialist paid by another organisation. In addition, 85% of services provided referrals to hospitals and/or other specialist services (AIHW 2010d).

In 2008–09, the most accessible specialist services were audiologist services, optometrist services and podiatrist services, each of which were available at nearly three-quarters of primary healthcare services (73%). Around 6 in 10 services (61%) provided access to ear, nose and throat specialist services, and a similar proportion of services offered ophthalmologist services (60%). Physiotherapy services were available through a little over half of all primary health-care services (52%) (AIHW 2010d).

## General practice services

Indigenous people also access mainstream general practice services reimbursed by Medicare. Therefore, another measure of access to primary health care is relative usage rates of Medicare-reimbursed general practice-type services by Indigenous and non-Indigenous Australians. Based on 2009–10 Medicare data, general practice-type service use was similar for Indigenous Australians and non-Indigenous Australians (approximately 5,630 and 5,550 per 1,000 population respectively) (SCRGSP 2011). However, Indigenous Australians had a higher rate of long and complex consultations compared with non-Indigenous Australians (AHMAC forthcoming). Note that these Medicare data are adjusted for under-identification of Indigenous status and should be interpreted with caution (see Box 1).

## Potentially preventable hospitalisations

An indirect measure of access to primary care is the rate of potentially preventable hospitalisations (PPH) (Box 2). These are hospitalisations that could potentially have been prevented through the timely and appropriate provision of primary care or other non-hospital services. A high rate may indicate an inadequacy in non-hospital care; however, it may also reflect hospitals responding appropriately to a high prevalence of certain conditions.

### **Box 2: Types of potentially preventable hospitalisation**

Potentially preventable hospitalisations are divided into three categories:

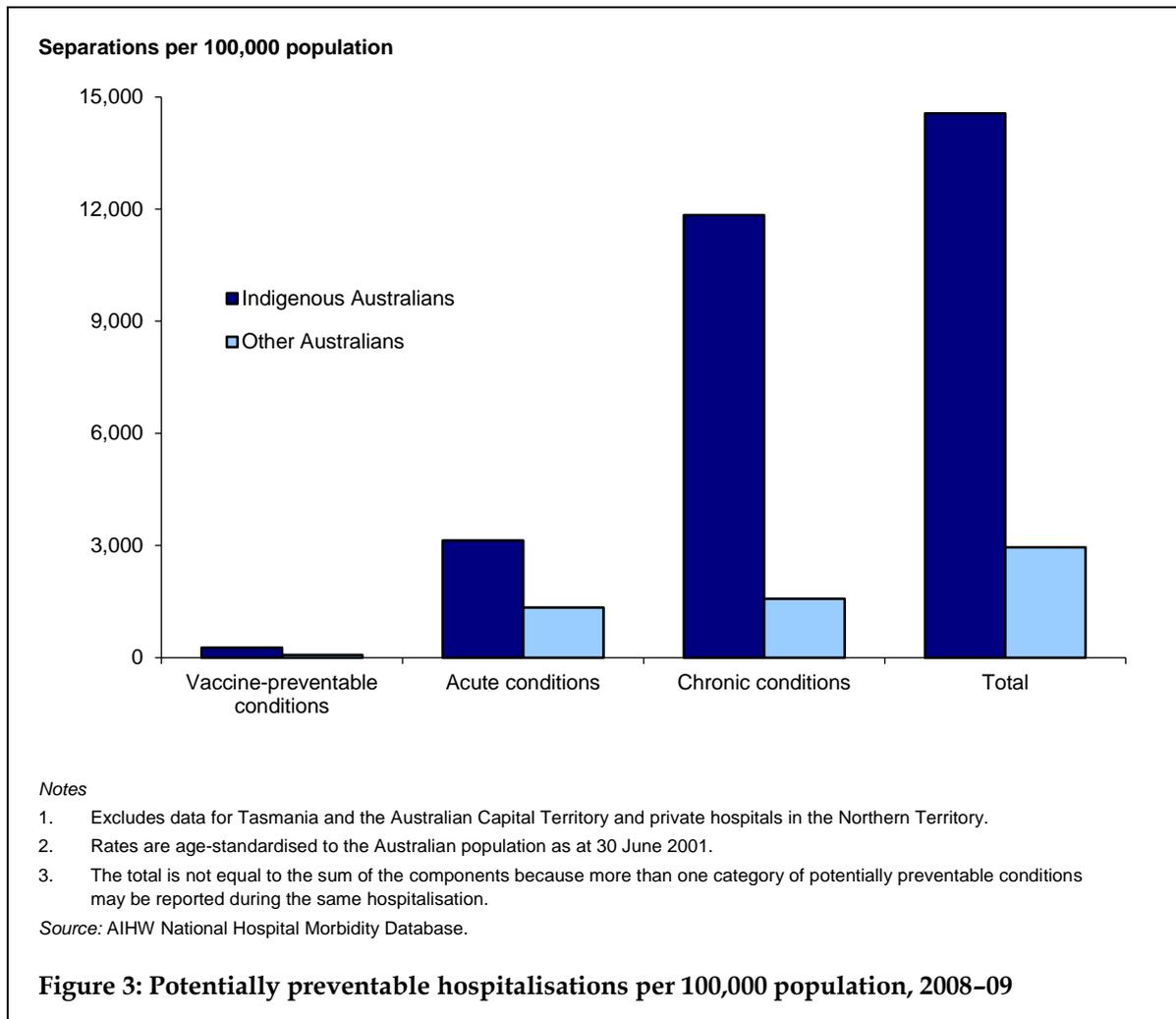
- Vaccine-preventable conditions, such as measles, mumps, whooping cough (pertussis), tetanus and influenza.
- Acute conditions that may not require hospitalisation given adequate and timely care, such as dehydration/gastroenteritis, pyelonephritis, pelvic inflammatory disease, ear, nose and throat infections and dental conditions.
- Chronic conditions that may be manageable in non-hospital care, such as diabetes complications, pyelonephritis, hypertension, congestive heart failure and chronic obstructive pulmonary disease.

*Source: AIHW 2010b.*

In 2008–09, more than 690,000 separations were recorded that could be classified as potentially preventable. More than half (55%) were hospitalisations for chronic conditions; 43% were for acute conditions and 2% were for vaccine-preventable conditions (AIHW 2010b). Excluding separations from hospitals in Tasmania and the Australian Capital Territory, 6.8% of potentially preventable hospitalisations were for people of Aboriginal and Torres Strait Islander origin. The age-standardised separation rate was higher for Indigenous people than other Australians for each category of PPH (Figure 3):

- 270 separations for vaccine-preventable conditions per 100,000 Aboriginal and Torres Strait Islander population compared with 71 per 100,000 for other Australians – a rate ratio of 3.8
- 3,134 separations for acute conditions per 100,000 population compared with 1,343 per 100,000 – a rate ratio of 2.3
- 11,844 separations for chronic conditions per 100,000 population compared with 1,575 per 100,000 – a rate ratio of 7.5.

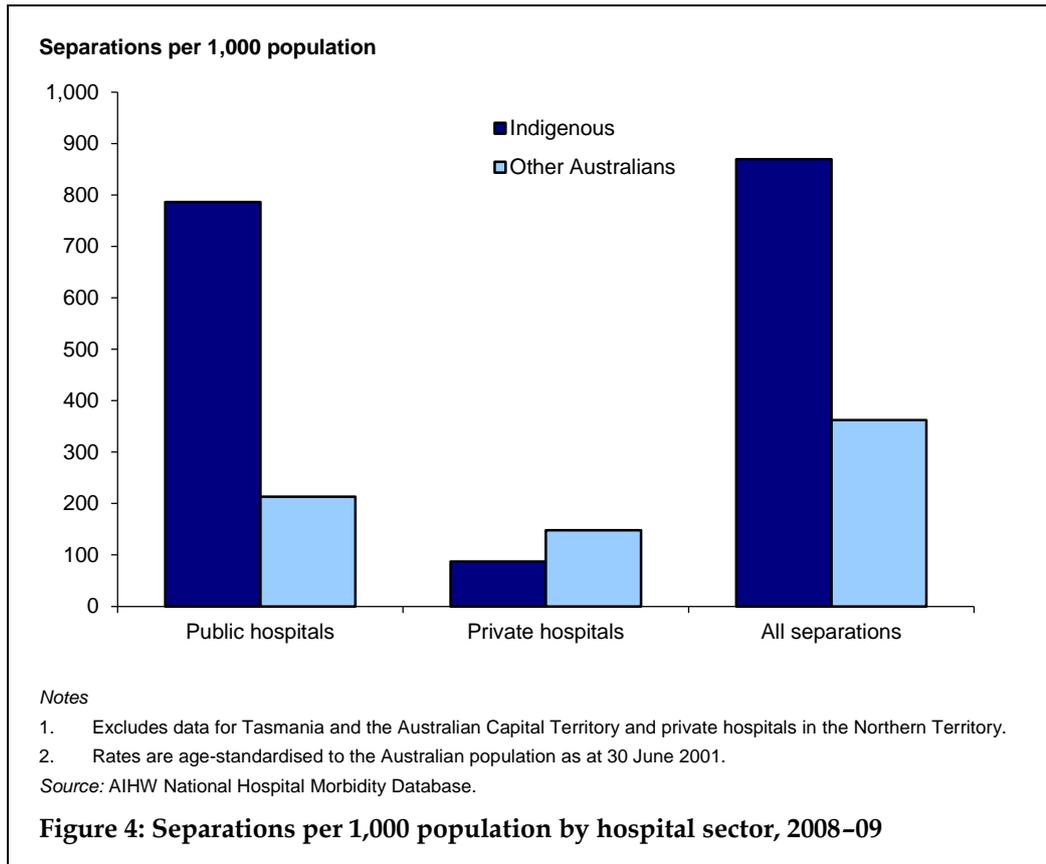
Overall, the PPH separation rate for Indigenous Australians (14,564 per 100,000 population) was 4.9 times the rate for other Australians (2,956 per 100,000) (AIHW 2010b).



## Hospital services

### Admitted patients

There were more than 8 million hospital separations recorded across Australia in 2008–09. Around 291,000 of these were for people of Aboriginal and Torres Strait Islander origin. Excluding data for Tasmania, the Australian Capital Territory and private hospitals in the Northern Territory, Indigenous Australians accounted for 3.6% of all separations from hospital. The Indigenous separation rate (870 per 1,000 population) was 2.4 times the rate for other Australians (363 per 1,000 population). This difference appeared to be due to Indigenous Australians' higher usage of admitted patient services in public hospitals, in which the separation rate (786 per 1,000 population) was 3.7 times the rate for other Australians (213 per 1,000 population; Figure 4). Indigenous people were relatively less likely than other Australians to be admitted to a private hospital (87 compared with 148 separations per 1,000 population); however these figures should be interpreted with caution as the quality of Indigenous identification in private hospital data is unknown.



Compared with other Australians, Aboriginal and Torres Strait Islander people were 2.5 times as likely to be hospitalised for acute care, and slightly less likely to receive subacute and non-acute care in hospital (Table 4). Within the subacute and non-acute care types, Indigenous people had relatively lower rates of separations for rehabilitation than other Australians (6.0 compared with 9.6 separations per 1,000 population), but a higher rate of palliative care separations (2.0 per 1,000 population compared with 1.3 for other Australians).

**Table 4: Separations per 1,000 population<sup>(a)(b)</sup> by care type, 2008-09**

	Acute care <sup>(c)</sup>	Subacute and non-acute care			Total
		Rehabilitation	Palliative care	Other <sup>(d)</sup>	
Indigenous Australians	857.7	6.0	2.0	3.7	11.8
Other Australians	348.2	9.6	1.3	2.2	13.0
Rate ratio	2.5	0.6	2.1	1.7	0.9

(a) Excludes data for Tasmania and the Australian Capital Territory and private hospitals in the Northern Territory.

(b) Rates are age-standardised to the Australian population as at 30 June 2001.

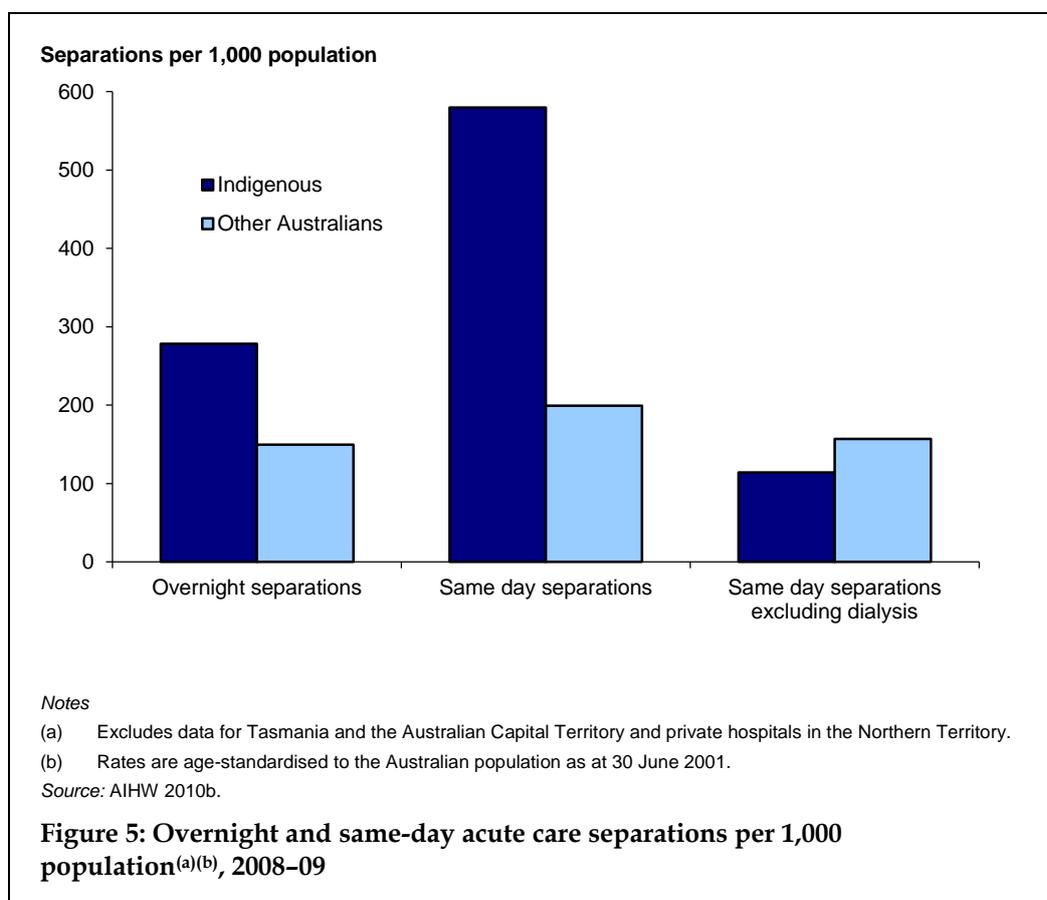
(c) Acute care includes newborn care with qualified days, or a mix of qualified and unqualified days.

(d) Other subacute and non-acute care includes geriatric evaluation and management, psychogeriatric care and maintenance care.

Source: AIHW 2010b; AIHW National Hospital Morbidity Database.

The gap between Indigenous and other Australians in acute care separation rates is considerably higher for same-day separations (rate ratio 2.9) than overnight separations (rate ratio 1.9). However, more than half of same-day separations for Aboriginal and Torres Strait Islander people were for care involving dialysis, reflecting the high prevalence of renal

disease among Indigenous people. When separations for dialysis are excluded, the same-day separation rate was slightly lower for Indigenous compared with other Australians (Figure 5).



## Procedures

### Box 3: Admitted patient procedures

A procedure is a clinical intervention that is surgical in nature, carries an anaesthetic risk, requires specialised training and/or requires special facilities or services available only in an acute care setting. Procedures may be surgical or non-surgical, investigative or therapeutic, and include client support interventions such as anaesthesia.

Differential rates of procedures are an indicator of health system performance under the Health Performance Framework for Aboriginal and Torres Strait Islanders.

Sources: AIHW 2010b; AHMAC 2008.

While hospital separation rates are relatively higher for Aboriginal and Torres Strait Islander patients, Indigenous Australians are less likely than other Australians to undergo a procedure while in hospital. Excluding separations for care involving dialysis and adjusting for differences due to population age structure, at least one procedure was recorded in 59% of separations for Indigenous Australians compared with 81% of separations for other Australians.

The differential between procedure rates for Indigenous and other Australians varied according to the patient's principal diagnosis (Table 5). Rates were lower for all diagnosis

groups except certain conditions originating in the perinatal period, and significantly lower for principal diagnoses related to diseases of the nervous system, respiratory system, digestive system, and mental and behavioural disorders. It is important to note that this analysis only accounts for principal diagnosis. It does not account for other factors that may be related to differences in procedure rates between Indigenous and non-Indigenous patients.

A major factor in differential rates of access to procedures may be private health insurance (AHMAC forthcoming). Indigenous Australians have significantly lower levels of private health insurance than other Australians (AHMAC 2008), meaning they are less likely to access surgery in private hospital settings. A thorough analysis of the factors influencing differential rates of access to procedures for Indigenous Australians will be available in the forthcoming Health Performance Framework, due for release in mid-2011 (AHMAC forthcoming).

**Table 5: Proportion of separations with a procedure reported by principal diagnosis in ICD-10-AM chapters, July 2006 to June 2008**

Principal diagnosis chapter	Indigenous Australians	Other Australians
Diseases of the eye and adnexa	92.6	98.4
Congenital malfunctions, deformations and chromosomal abnormalities	88.7	93.4
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	87.6	93.7
Neoplasms	86.3	95.9
Diseases of the ear and mastoid process	77.1	87.2
Factors influencing health status and contact with health services <sup>(a)</sup>	74.8	92.1
Certain conditions originating in the perinatal period	74.0	70.4
Diseases of the musculoskeletal system and connective tissue	69.6	92.2
Diseases of the genitourinary system	63.6	85.6
Endocrine, nutritional and metabolic disorders	63.5	82.3
Diseases of the digestive system	62.9	88.4
Injury, poisoning & certain other consequences of external causes	61.3	73.1
Pregnancy, childbirth and the puerperium	60.2	76.9
Diseases of the circulatory system	56.5	74.2
Diseases of the skin and subcutaneous tissue	55.5	71.8
Diseases of the nervous system	51.8	82.4
Diseases of the respiratory system	40.2	61.0
Mental and behavioural disorders	37.6	53.2
Certain infectious and parasitic diseases	37.3	39.6

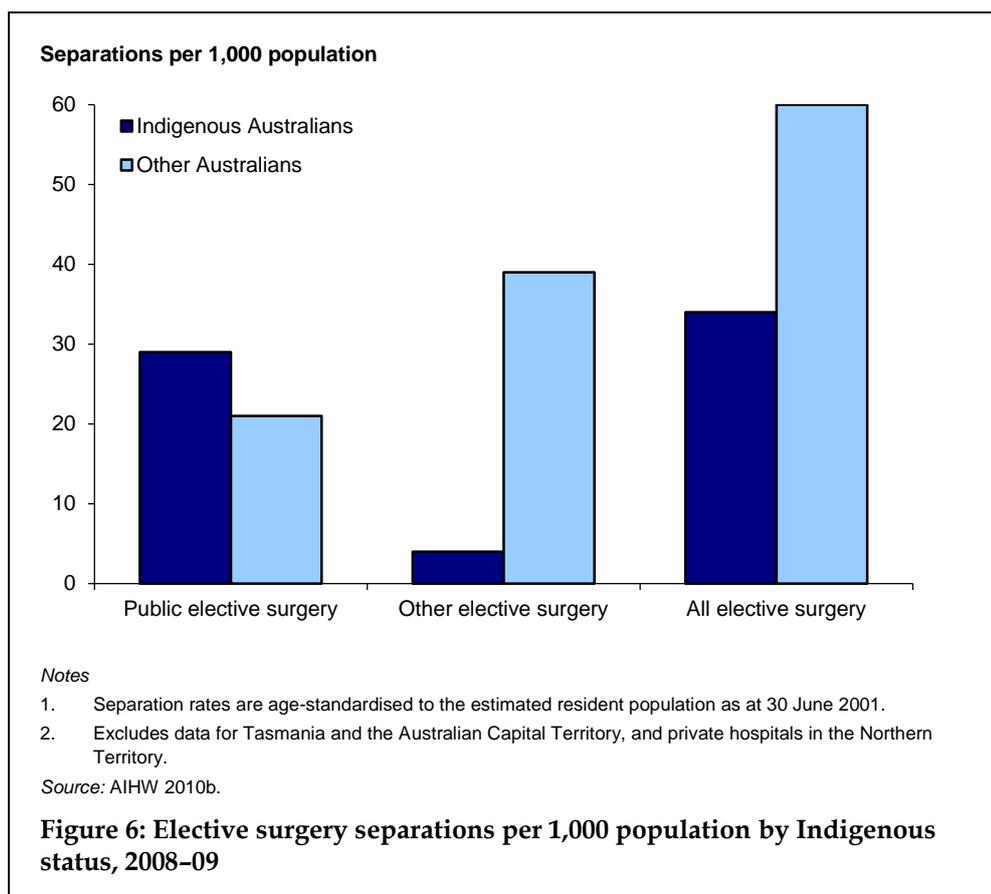
(a) Excludes care involving dialysis.

Note: Proportions are age-standardised using the age and cause-specific rates of other Australians.

Source: AIHW National Hospital Morbidity Database.

## Elective surgery

In 2008–09 there were close to 16,800 elective surgery separations for Indigenous Australians. Almost all (87%) of these separations were for public elective surgery – that is, surgery performed in a public hospital or for a public patient in a private hospital (AIHW 2010b). The separation rate for public elective surgery was higher for Indigenous Australians than other Australians, but this appears to be offset by a much lower separation rate as private patients in private hospitals (Figure 6). Overall, there were 34 elective surgery separations per 1,000 population for Aboriginal and Torres Strait Islander people compared with 60 per 1,000 for other Australians in 2008–09.



Elective surgery waiting times are reported for people who were placed on a public waiting list, and vary considerably between different types of procedures. Table 6 shows the median waiting time for Indigenous and other Australians for selected common procedures. In 2009–10, Indigenous people had notably longer waiting times than other Australians for cataract extraction, coronary artery bypass graft, cystoscopy, myringoplasty, prostatectomy, septoplasty, tonsillectomy and total knee and total hip replacement. There was little difference in median waiting times for cholecystectomy, hysterectomy, haemorrhoidectomy or inguinal herniorrhaphy, while Indigenous Australians had a shorter median waiting time for varicose veins stripping and ligations.

**Table 6: Waiting time statistics for patients admitted from waiting lists for elective surgery by Indigenous status and Indicator procedure, public hospitals, selected states and territories<sup>(a)</sup>, 2009–10**

Indicator procedure	Indigenous Australians		Other Australians <sup>(b)</sup>	
	Median waiting time (days)	% waited more than 365 days	Median waiting time (days)	% waited more than 365 days
Cataract extraction	105	6.7	56	1.8
Cholecystectomy	47	2.2	44	2.0
Coronary artery bypass graft	26	0.8	14	0.9
Cystoscopy	39	3.5	25	1.3
Haemorrhoidectomy	64	7.7	65	4.1
Hysterectomy	51	1.2	49	0.9
Inguinal herniorrhaphy	51	0.0	49	2.3
Myringoplasty	92	18.4	81	7.7
Myringotomy	49	0.3	46	1.0
Prostatectomy	61	0.0	41	2.5
Septoplasty	127	9.1	93	11.3
Tonsillectomy	89	7.0	77	5.3
Total hip replacement	135	12.0	101	8.3
Total knee replacement	151	17.1	132	13.4
Varicose veins stripping & ligation	89	11.8	110	16.3
<b>Total<sup>(c)</sup></b>	<b>38</b>	<b>4.5</b>	<b>33</b>	<b>2.7</b>

(a) Excludes data for New South Wales, which accounts for about a third of all admissions for elective surgery. Therefore waiting time statistics presented in this table are not directly comparable with 2009–10 waiting time statistics presented that include data for New South Wales.

(b) Other Australians includes records for which the Indigenous status was not reported.

(c) Total includes all procedures, including but not limited to the procedures listed above.

Source: AIHW 2010e.

## Emergency departments

Data about the Indigenous status of patients presenting to emergency departments is only available for a subset of all emergency department activity, as data coverage is low in outer regional and remote areas. Data in this section are limited to public hospitals that are classified as Principal referral and specialist women's and children's hospitals and Large hospitals (Peer group A and B hospitals). As most of the data relates to hospitals within major cities, the coverage may not include areas where the proportion of Indigenous people (compared with other Australians) may be higher than average.

In 2009–10 there were around 193,000 emergency department presentations by people identifying as Aboriginal or Torres Strait Islander to Peer group A and B hospitals, accounting for 3.8% of all presentations in these hospitals (AIHW 2010e).

Waiting times for emergency department care – the time elapsed between presentation at the emergency department and treatment – are reported for hospitals in Peer group A and B under the National Healthcare Agreement as an indicator of access to services. In 2009–10, as

in previous years, similar proportions of Indigenous and other Australians were seen within the recommended time for each triage category (Table 7).

**Table 7: Proportion of emergency department presentations seen on time by triage category and Indigenous status, 2009–10 (per cent)<sup>(a)</sup>**

	Triage category <sup>(b)</sup>					Total
	Resuscitation	Emergency	Urgent	Semi-urgent	Non-urgent	
Indigenous Australians	100	74	62	63	87	66
Other Australians	100	78	64	66	86	68

(a) Limited to public hospitals in Peer group A and B.

(b) Used in hospital emergency departments to indicate the urgency of the patient's need for medical and nursing care. Patients are categorised into one of five categories on the National Triage Scale: Resuscitation—immediate (within seconds); Emergency—within 10 minutes; Urgency—within 30 minutes; Semi-urgent— within 60 minutes; Non-urgent—within 120 minutes.

Source: AIHW 2010e.

## Specialised services

### Specialist services

Specialist services are delivered in a variety of settings within Australia, including hospitals (admitted and non-admitted care), private practice in the community and specialist services delivered or arranged by community health-care services. It is difficult to measure in a comparable way the use of specialist services across all settings, as national data are not available for some specialist care provided in public hospitals (such as outpatient services). This is particularly relevant when considering access by Indigenous status, as Aboriginal and Torres Strait Islander people are more likely to use public hospital services than other Australians.

Medicare-subsidised specialist services include those provided by specialists in private practices, as well as medical services for private patients in public and private hospitals. In 2009–10, Indigenous Australians had slightly lower usage rates of Medicare-reimbursed specialist services (5,600 per 1,000 population) than non-Indigenous Australians (6,300 per 1,000 population), with a rate ratio of 0.9 (unpublished analysis of Medicare data). Data on the use of specialist services funded under the Medicare Benefits Scheme is also available in the COAG Reform Council reports on the National Healthcare Agreement.

### Antenatal care

Maternal health is important for both mothers and their children; for example the proportion of low birthweight babies, pre-term (premature) babies and perinatal deaths is known to decrease as the number of antenatal visits increases (AHMAC 2008). In 2008, data on the number of antenatal visits during pregnancy were available for Queensland, South Australia and the Northern Territory. Of the Indigenous mothers who gave birth in these jurisdictions at 32 weeks gestation or more, 76.8% attended five or more antenatal visits, compared with 93.8% of non-Indigenous mothers (AIHW: Laws, Li & Sullivan 2010).

## **Mental health services**

Aboriginal and Torres Strait Islanders generally have poorer social and emotional wellbeing than their non-Indigenous counterparts (AIHW 2010a). For example, the 2004–05 NATSIHS results showed that, in comparison with non-Indigenous Australians surveyed in the 2004–05 National Health Survey, Indigenous Australians were twice as likely to report high or very high levels of psychological distress.

This section presents data on specialised mental health-care services provided to Indigenous Australians in community, admitted patient (hospital), residential and prison settings. It does not include mental health care provided by psychiatrists, psychologists or counsellors outside these settings (for example, consultations with psychiatrists in private practice). Data for each type of service are based on numbers of contacts, separations or episodes of care. In addition, service use rates do not take into account possible differences in the prevalence of mental illnesses or need for care between population groups.

### **Community mental health care**

Community mental health services are government-funded specialised mental health services provided to non-admitted patients either in the community or through hospital outpatient and day clinics. In 2008–09 more than 366,000 community mental health service contacts were reported for people of Aboriginal and Torres Strait Islander origin, accounting for 6.5% of all service contacts for which Indigenous status was recorded (AIHW forthcoming). The age-standardised contact rate for Indigenous Australians (732 per 1,000 population) was 2.9 times the contact rate for non-Indigenous Australians (254 per 1,000 population).

### **Admitted patient mental health care**

In addition to outpatient services, hospitals provide mental health-related care to admitted patients on a same-day or overnight basis. Admitted patient care is provided by public acute hospitals, public psychiatric hospitals and private hospitals, and can be divided into three broad groups (Box 4).

#### Box 4: Broad groups of admitted patient care for mental health

##### Ambulatory-equivalent mental health-related care

These are same-day separations for patients with a mental health-related principal diagnosis or patients admitted to a specialised psychiatric unit or ward, in which the patient was discharged to their usual residence and no procedures or interventions were recorded other than a limited set appropriate to ambulatory mental health care. In 2008–09 ambulatory-equivalent mental health-related care accounted for 1.7% of all hospital separations and 38.1% of all mental health-related separations. Around four in five separations in this category were from private hospitals.

##### Non-ambulatory with specialised psychiatric care

These are separations for patients recorded as having spent one or more days in a specialised psychiatric unit or ward, excluding those counted in the ambulatory-equivalent category above. In 2008–09, non-ambulatory separations with specialised psychiatric care accounted for 1.7% of all hospital separations and 37.8% of all mental health-related separations. One in four separations in this category was from private hospitals.

##### Non-ambulatory without specialised psychiatric care

These are separations for patients with a mental health-related principal diagnosis who did not spend any time in a specialised psychiatric unit or ward, excluding those counted in the ambulatory-equivalent category above. In 2008–09, non-ambulatory separations without specialised psychiatric care accounted for 1.0% of all hospital separations and 24.0% of all mental health-related separations. One in ten separations in this category were from private hospitals.

Source: AIHW forthcoming.

More than 12,400 mental health-related separations were recorded for Indigenous Australians in 2008–09 (AIHW forthcoming). After adjusting for population size and structure, Aboriginal and Torres Strait Islanders had relatively fewer ambulatory-equivalent mental health-related separations than other Australians, but relatively more non-ambulatory separations – particularly without specialised psychiatric care (Table 8).

**Table 8: Hospital separations<sup>(a)</sup> for care related to mental health by Indigenous status, 2008–09**

	Number of separations	Per cent of separations	Rate <sup>(b)</sup> (per 1,000 population)	Rate ratio (Indigenous:Other)
<b>Ambulatory-equivalent mental health-related care</b>				
Indigenous Australians	1,872	1.5	3.9	
Other Australians <sup>(c)</sup>	125,412	98.5	6.1	0.6
<b>Non ambulatory with specialised psychiatric care</b>				
Indigenous Australians	4,951	3.9	10.6	
Other Australians <sup>(c)</sup>	122,255	96.1	6.0	1.8
<b>Non-ambulatory without specialised psychiatric care</b>				
Indigenous Australians	5,616	7.0	13.3	
Other Australians <sup>(c)</sup>	74,380	93.0	3.6	3.7

(a) Excludes separations in Tasmania, the Australian Capital Territory, and private hospitals in the Northern Territory.

(b) Rates are age-standardised to the Australian population as at 30 June 2001.

(c) Includes separations where Indigenous status was missing or not reported.

Source: AIHW National Hospital Morbidity Database.

## **Residential mental health care**

In 2008–09, around 3,500 episodes of care were provided by government-funded residential mental health-care facilities. Aboriginal and Torres Strait Islander residents accounted for 2.4% of episodes for which Indigenous status was recorded. The age-standardised episode rate for Indigenous Australians (1.7 per 10,000 population) was slightly higher than the rate for non-Indigenous people (1.5 per 10,000 population); however this difference should be interpreted with caution due to the varying quality of Indigenous identification among jurisdictions.

## **Mental health services in prison**

Prison mental health services are one of the target areas under the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011. Under the Action Plan jurisdictions have committed to improve services for people with mental illness in the criminal justice system, through measures such as stronger case management, more mental health workers, increased mental health beds and post-release support to people with mental illness.

The National Prisoner Health Census, which was conducted in mid-2009, collected data from 87 of the 93 public and private prisons in Australia over a 1-week period. The census found that a smaller proportion of Indigenous entrants (27%) were referred to prison mental health services than non-Indigenous entrants (32%). Indigenous prison entrants also reported lower levels of mental health issues than non-Indigenous prisoners (26% and 41% respectively) and were less likely to be currently taking medication for mental health-related conditions.

## **Drug and alcohol services**

This section presents data on three service categories:

- Publicly funded services (both state/territory government and non-government operated) that provide one or more specialist treatment services for alcohol and/or other drugs.
- Pharmacotherapy services for opioid dependence, provided by clinics and pharmacies approved by state and territory governments.
- Services funded by the Australian Government through the Office of Aboriginal and Torres Strait Islander Health (OATSIH) specifically to provide a range of services related to substance use targeted at Aboriginal and Torres Strait Islander people.

Data quality varies between jurisdictions. Comparisons between Indigenous and other Australians should be interpreted with caution.

## **Alcohol and other drug treatment services**

In 2008–09, around 17,000 treatment episodes were provided to clients of Aboriginal and/or Torres Strait Islander origin, accounting for 12% of all treatment episodes (AIHW 2010f). More than half of all episodes involving Indigenous clients (53%) were provided to people aged less than 30 years. In comparison, this age group accounted for relatively fewer (41%) treatment episodes for non-Indigenous clients.

The most common principal drug of concern identified by clients seeking treatment for their own drug use was alcohol, followed by cannabis and opioids. Compared with non-Indigenous clients Indigenous clients were:

- more likely to report alcohol as their principal drug of concern (54% versus 45%)
- about as likely to report cannabis as their principal drug of concern (23% versus 22%)
- less likely to report an opioid (heroin, methadone or morphine) as their principal drug of concern (10% versus 16%).

Counselling was the most common treatment type for Indigenous and non-Indigenous clients alike (37% of episodes within each client group). Indigenous clients were more likely to undergo assessment only (18% compared with 14%) and less likely to access withdrawal management (detoxification; 12% compared with 17%).

## **Pharmacotherapy for opioid dependence**

On a 'snapshot day' in 2009 there were 2,252 Indigenous clients receiving pharmacotherapy in New South Wales, Queensland, South Australia and the Australian Capital Territory (other jurisdictions were unable to provide information about clients' Indigenous status). Indigenous clients accounted for 8% of all clients in these jurisdictions. Most (80%) received methadone treatment (AIHW 2009b).

## **Aboriginal and Torres Strait Islander substance use services**

In 2008–09, 50 services received funding from OATSIH specifically to provide substance use services to Indigenous Australians. The following data relate to the 45 services that responded to the 2008–09 OATSIH Services Reporting questionnaire (AIHW 2010d):

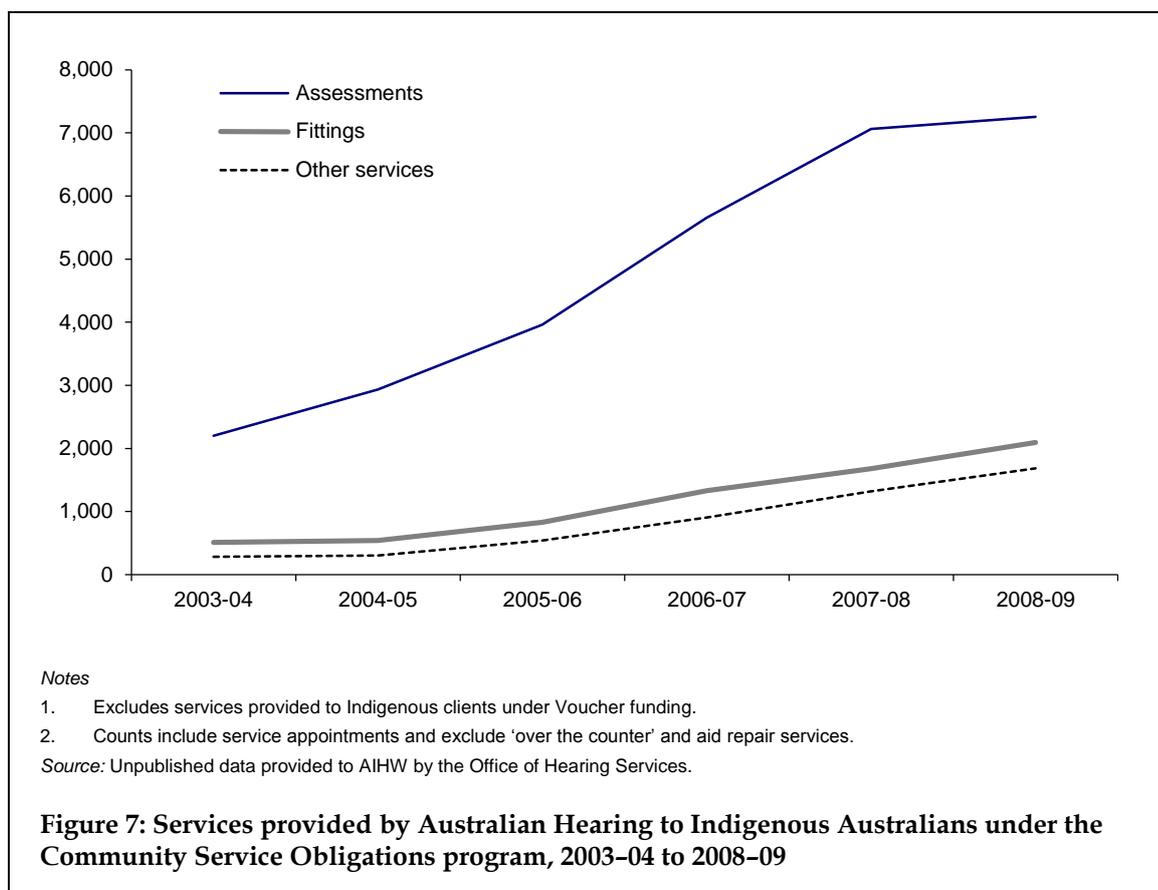
- services were provided to 23,200 clients, of whom 77% were Indigenous Australians
- specifically targeted programs were most commonly available for alcohol use (provided by 91% of services), cannabis/marijuana (80%), multiple drug use (58%) and tobacco/nicotine (49%)
- most (87%) services included traditional cultural elements in their treatment approach, such as bush camps, traditional healing, and mentor programs with elders.

## **Hearing services**

Hearing services in Australia are provided by both public and private practitioners. These services include hearing checks and assessments, training in communication skills, and supply, fitting, monitoring and replacement of hearing devices (AIHW 2010a). The Australian Government's Office of Hearing Services is responsible for the largest public program – a voucher scheme providing a range of services and equipment to eligible groups. In addition to the voucher scheme, the Office funds Australian Hearing to provide free services under its Community Service Obligations (CSO) program. This program covers all Australians under 21 years of age, adults with complex rehabilitation needs, and eligible Indigenous adults.

In 2008–09 Australian Hearing provided more than 11,000 services to Indigenous clients under the Community Service Obligations program. Almost 60% of these services were provided to clients under 21 years of age. The most common type of service provided was hearing assessment (around 7,300 services) followed by fitting of hearing devices (almost

2,100 services). Between 2003–04 and 2008–09 the number of services provided to Indigenous clients more than tripled (Figure 7).



Indigenous Australians' access to hearing services is also facilitated by outreach visits to local communities. In 2008–09, Australian Hearing delivered services including hearing tests, support for babies and children, school programs, community education and health worker training at 221 outreach sites. The number of outreach visits has increased by 70% since 2005–06 when services were delivered at 130 sites (DoHA 2009).

# Glossary

**Aboriginal:** A person of Aboriginal descent who identifies as an Aboriginal and is accepted as such by the community in which he or she lives.

**asthma:** A common, chronic inflammatory disease of the air passages that presents as episodes of wheezing, breathlessness and chest tightness due to widespread narrowing of the airways and obstruction of airflow. The symptoms may reverse without treatment, but often treatment is required. Different medications can prevent the episodes or relieve them.

**cataract:** A cloudy or opaque area in the lens of the eye.

**cholecystectomy:** Surgical removal of the gallbladder.

**chronic obstructive pulmonary disease:** Serious, progressive and disabling long-term lung disease where damage to the lungs, usually because of both emphysema and chronic bronchitis, obstructs oxygen intake and causes increasing shortness of breath. By far the greatest cause is cigarette smoking.

**congestive heart failure:** Occurs when the heart cannot pump enough blood to satisfy the needs of the body. Weakened chambers allow blood to pool inside the heart and nearby veins. This triggers fluid retention, particularly in the lungs, legs and abdomen.

**coronary artery bypass graft (CABG):** Surgical procedure using blood vessel grafts to bypass blockages in the coronary arteries and restore adequate blood flow to the heart muscle.

**cystoscopy:** Endoscopy of the urinary bladder via the urethra.

**diabetes:** A chronic condition in which the body cannot properly use its main energy source, the sugar glucose. This is due to a relative or absolute deficiency in insulin, a hormone that is produced by the pancreas and helps glucose enter the body's cells from the bloodstream and then be processed by them. Diabetes is marked by an abnormal build-up of glucose in the blood, and it can have serious short and long-term effects. The three main types of diabetes are Type 1 diabetes, Type 2 diabetes and gestational diabetes.

**emergency department waiting time:** The time elapsed for each patient from presentation to the emergency department to commencement of service by a treating medical officer or nurse. It is calculated by deducting the date and time the patient presents from the date and time of the service event.

**endoscopy:** A medical procedure that allows a doctor to observe the inside of the body without performing major surgery.

**'fully immunised' at 1 year of age:** Defined by ACIR as a child having a record on the ACIR as having received each of the following:

- a 3rd dose of a diphtheria (D), tetanus (T) and pertussis-containing (P) vaccine
- a 3rd dose of polio vaccine
- 2 or 3 doses of PRP-OMP containing Hib vaccine or 3 doses of any other Hib vaccine
- 2 or 3 doses of Comvax hepatitis B vaccine or 3 doses of any other hepatitis B vaccines.

**'fully immunised' at 2 years of age:** Defined by ACIR as a child having a record on the ACIR as having received each of the following:

- a 3rd dose of a DTP-containing vaccine

- a 3rd dose of polio vaccine
- 3 or 4 doses of PRP-OMP containing Hib vaccine or 4 doses of any other Hib vaccine
- 3 or 4 doses of Comvax hepatitis B vaccine or 4 doses of any other hepatitis B vaccines
- the 1st dose of a measles, mumps and rubella-containing (MMR) vaccine.

**‘fully immunised’ at 5 years of age:** Defined by ACIR as a child having a record on the ACIR as having received each of the following:

- a 4th or 5th dose of a DTP-containing vaccine
- a 4th dose of polio vaccine
- a 2nd dose of an MMR-containing vaccine.

**gastroenteritis:** An illness triggered by the infection and inflammation of the digestive system. Typical symptoms include abdominal cramps, diarrhoea and vomiting.

**hysterectomy:** The surgical removal of the womb (uterus), with or without the removal of the ovaries.

**inguinal herniorrhaphy:** Surgical correction of an inguinal hernia (a protrusion of abdominal-cavity contents through the inguinal canal).

**myringoplasty:** Surgical reconstruction of the hearing mechanism of the middle ear, with restoration of the drum membrane.

**myringotomy:** A surgical procedure in which a tiny incision is created in the eardrum, so as to relieve pressure caused by the excessive build-up of fluid, or to drain pus.

**neoplasm:** An abnormal (‘neo’, new) growth of tissue. Can be ‘benign’ (not a cancer) or ‘malignant’ (a cancer). Same as a tumour.

**perinatal:** Pertaining to or occurring in the period shortly before or after birth (usually up to 28 days after).

**pyelonephritis:** An ascending urinary tract infection that has reached the pyelum (pelvis) of the kidney.

**separation:** An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.

**septoplasty:** A surgical procedure done to straighten the septum (the partition between the two nasal cavities) of the nose.

**tonsillectomy:** The surgical removal of the tonsils.

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