

3.11 Competent governance

Measures of competent governance in mainstream and Indigenous-specific health services, including management of service delivery, compliance and accountability of services, and cultural responsiveness of service delivery for Indigenous clients

Data sources

Data related to competent governance come from the Office of the Registrar of Indigenous Corporations (ORIC), the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the Healthy for Life (HfL) data collection and the OATSIH Services Reporting (OSR) data collection.

Office of the Registrar of Indigenous Corporations (ORIC)

The ORIC is set up to help administer the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act) and to support and regulate corporations for Indigenous people throughout Australia. The ORIC collects data from Indigenous corporations registered under the CATSI Act, including the number of corporations, compliance status and deregistration of corporations.

The CATSI Act replaced previous legislation, the *Aboriginal Councils and Associations Act 1976* (ACA), on 1 July 2007 (ORIC 2010).

In 2008–09, compliance analysis was able to be completed for 84 companies incorporated under the CATSI Act and registered with ORIC.

The Registrar's office supports and regulates the corporations that are incorporated under the Act. It does this in a variety of ways: by advising them on how to incorporate; by training directors, members and key staff in good corporate governance; by making sure they comply with the law; and by intervening when needed.

National Aboriginal and Torres Strait Islander Social Survey (NATSISS)

The Australian Bureau of Statistics (ABS) conducted the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) between August 2002 and April 2003. The 2008 NATSISS was conducted between August 2008 and April 2009. The survey provides information about the Aboriginal and Torres Strait Islander population of Australia for a wide range of areas of social concern including health, education, culture and labour force participation. The 2008 NATSISS included for the first time children aged under 15. The NATSISS will be conducted every 6 years, with the next survey planned for 2013.

The 2008 NATSISS collected information by personal interview from 13,300 Indigenous Australians across all states and territories of Australia, including those living in remote areas. The sample covered persons aged 15 years and over who are usual residents in selected private dwellings. It collected information on a wide range of subjects including family and culture, health, education, employment, income, financial stress, housing, and law and justice.

Healthy for Life program

The Healthy for Life (HfL) program is an ongoing program funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) of the Australian Government Department of Health and Ageing (DoHA). The program aims to improve the capacity and performance of primary health-care services to deliver high-quality maternal, children's and chronic disease care to Aboriginal and Torres Strait Islander peoples. This is carried out through population health approaches using best-practice and quality improvement principles.

Services participating in the HfL program are required to submit de-identified, aggregate service data for 11 essential indicators. These indicators cover maternal health, child health and chronic disease care on a regular basis (6 and 12 months), as well as information about the characteristics of their service and organisational infrastructure. For the reporting period ending June 2009 reporting period, 72 HfL services submitted data to the AIHW.

OATSIH Services Reporting (OSR) data collection

In 2008–09, the Australian Institute of Health and Welfare (AIHW) collected the data from the Aboriginal and Torres Strait Islander primary health-care, substance use, and Bringing Them Home and Link Up counselling services funded by the Australian Government through the Office for Aboriginal and Torres Strait Islander Health (OATSIH). OATSIH funded services include both Indigenous Community Controlled Health Organisations and non-community controlled health organisations. Note that the OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some Australian Government funding to facilitate access to primary health care.

This collection, referred to as the OSR data collection replaces the Service Activity Reporting (SAR), Drug and Alcohol Services Reporting (DASR), and Bringing Them Home and Link Up counselling data collections previously collected by the OATSIH. The OSR data collection which was established in 2008–09 uses a new set of counting rules which treat all auspice services as individual services which yields a larger numerator and denominator on which the rates are based. While this change only marginally affects the aggregate rates, caution should be exercised when comparing rates based on earlier data collection periods.

The OSR data collection included 211 Australian Government-funded Aboriginal and Torres Strait Islander primary health-care services. Service-level data on health care and health-related activities were collected by survey questionnaire for the 2008–09 financial year reporting period and provided data on episodes of care, service population, clients and staffing. Response rates to the OSR questionnaire by Aboriginal and Torres Strait Islander primary health-care services in 2008–09 were around 97%.

Of the 86 Bringing Them Home and Link Up counselling services 81 (94%) responded to the OSR questionnaire, as well as 5 auspiced services. Many services providing Bringing Them Home and Link Up counselling are part of existing primary health-care or substance use service.

Forty five (90%) out of 50 stand-alone substance use services as well as 3 auspiced services responded to the OSR questionnaire.

Analyses

Office of the Registrar of Indigenous Corporations data

All corporations incorporated under the CATSI Act are required to submit certain documents to ORIC, including a list of members and financial reports.

- In 2008–09, compliance analysis was able to be completed for 84 companies incorporated under the CATSI Act and registered with ORIC. Of these 81, 96% were found to be compliant with providing these key documents (Table 3.11.1; Figure 3.11.1).
- Over the period 2000–01 to 2008–09, the proportion of Indigenous health corporations incorporated under the ACA or CATSI Act registered with ORIC that were fully or partially compliant with providing the key documents required remained between 94 and 99% (Table 3.11.2).

Table 3.11.1: Number and proportion of health corporations incorporated under the CATSI Act 2006 by compliance, 2008–09

	Number	Proportion
Compliant	81	96.4
Not compliant	3	3.6
Total	84	100.0

Note: Excludes two deregistered companies and four companies unable to be matched for compliance analysis.

Source: AIHW analysis of the Office of the Registrar of Indigenous Corporations unpublished data.

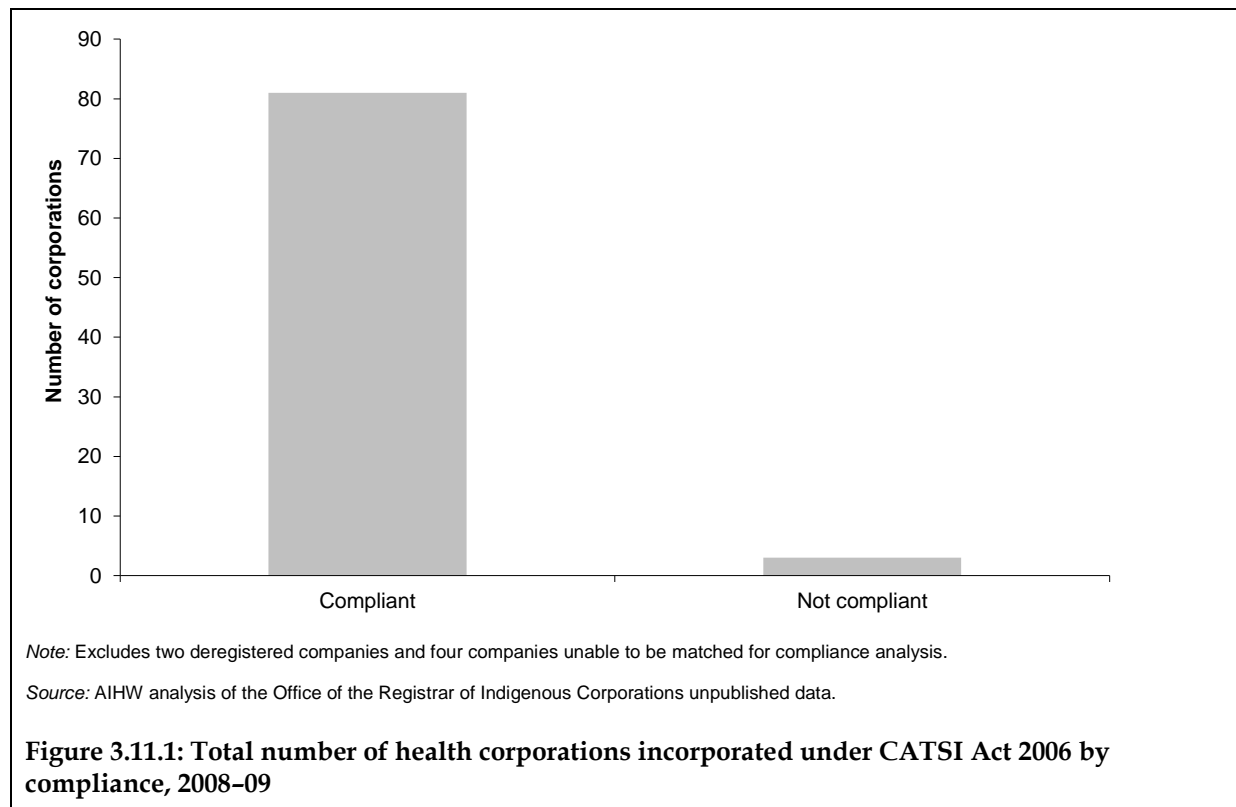


Table 3.11.2: Number and proportion of health corporations incorporated under the ACA or CATSI Act by compliance, 2000–01 to 2008–09

	Number of corporations			Not fully or partially compliant	
	Number	Number	Per cent	Number	Per cent
2000–01	77	74	96.1	3	3.9
2001–02	79	76	96.2	5	6.3
2002–03	80	75	93.8	1	1.3
2003–04	81	80	98.8	5	6.2
2004–05	82	77	93.9	5	6.1
2005–06	85	83	97.6	2	2.4
2006–07	86	85	98.8	1	1.2
2007–08	84	82	97.6	2	2.4
2008–09	84	81	96.4	3	3.6

Source: AIHW analysis of the Office of the Registrar of Indigenous Corporations unpublished data.

OATSIH Service Reporting (OSR) data

- In 2008–09, there were approximately 4,540 full-time equivalent (FTE) staff in Indigenous primary health-care services, 2,980 (66%) health staff and 1,433 (32%) administration and support staff. The majority of both health and administration staff were Indigenous (53% and 60%, respectively) (Table 3.11.3).
- In 2008–09, the majority of Indigenous primary health-care services had governing committees/boards that met regularly (86%), had detailed income and expenditure statements presented to them on at least two occasions (95%), consisted only of Indigenous members (77%), or received training (77%) (Table 3.11.4).
- In 2008–09, 40% of Indigenous primary health-care services had representatives on external boards (for example, hospitals); 57% participated in regional planning forums and 77% were involved in committees on health (for example, steering groups) (Table 3.11.5).

Table 3.11.3: Number and proportion of staff in Indigenous primary health-care services, by type of staff and Indigenous status, 2008–09

	Health staff		Admin and support staff		Other staff		Total staff	
	FTEs	Per cent	FTEs	Per cent	FTEs	Per cent	FTEs	Per cent
Paid staff								
Indigenous	1550.6	56.1	861.2	60.1	65.2	53.8	2477.0	57.4
Non-Indigenous	1187.4	43.0	567.4	39.6	42.6	35.2	1797.5	41.6
Unknown Indigenous status	26.5	1.0	3.4	0.2	13.3	11.0	43.2	1.0
Total	2764.5	100.0	1431.9	100.0	121.2	100.0	4317.6	100.0
Visiting staff								
Indigenous	36.1	16.8	0.5	100.0	2.8	39.4	39.3	17.7
Non-Indigenous	159.1	74.0	0.0	0.0	4.2	59.1	163.3	73.4
Unknown Indigenous status	19.9	9.2	0.0	0.0	0.1	1.4	20.0	9.0
Total	215.0	100.0	0.5	100.0	7.1	100.0	222.6	100.0
Paid and visiting staff								
Indigenous	1586.7	53.3	861.7	60.2	68.0	53.0	2516.3	55.4
Non-Indigenous	1346.5	45.2	567.4	39.6	46.8	36.5	1960.8	43.2
Unknown Indigenous status	46.4	1.6	3.4	0.2	13.4	10.5	63.2	1.4
Total	2979.6	100.0	1432.5	100.0	128.2	100.0	4540.3	100.0

Source: AIHW OSR data collection.

Table 3.11.4: Number and proportion of governing committee/board use, Aboriginal and Torres Strait Islander primary health-care services, 2008–09

	No.	Per cent
Governing committee or board met regularly	173	85.6
Income and expenditure statements were presented to committee or board on at least two occasions	169	94.9
All of the governing committee or board members were Aboriginal and/or Torres Strait Islander	136	76.8
Governing committee or board received training	137	77.4
Total number of services	202	..

Source: AIHW OSR data collection.

Table 3.11.5: Number and proportion of Aboriginal and Torres Strait Islander primary health-care services participating in mainstream processes, 2008–09

	No.	Per cent
Representation on external boards (e.g. hospitals)	81	40.3
Participation in regional planning forums (e.g. under the framework agreements)	115	57.2
Involvement in committees on health (e.g. steering groups)	154	76.6
Total number of services	201	..

Source: AIHW OSR data collection.

Drug and Alcohol Service Reporting data

- In 2008–09, the majority of Aboriginal and Torres Strait Islander substance-use-specific services had governing committees/boards that; met regularly (98%), consisted only of Indigenous members (57%), or received training (71%) (Table 3.11.6).

Table 3.11.6: Number and proportion of governing committee/board use, Aboriginal and Torres Strait Islander substance-use services, 2008–09

	No.	Per cent
Governing committee or board met regularly	44	97.8
Income and expenditure statements were presented to committee or board on at least two occasions	45	100
All of the governing committee or board members were Aboriginal and/or Torres Strait Islander	25	56.8
Governing committee or board received training	32	71.1
Total number of services	45	..

Source: AIHW OSR data collection.

Self-reported data

Barriers to accessing health-service providers

The 2008 NATSISS collected data on whether Indigenous Australians had problems accessing health services and the type of barriers they experienced, including discrimination.

- In 2008, 30% of Indigenous Australians aged 15 years and over reported that they had experienced problems accessing health-service providers. Of those who had problems

accessing services, 5% identified the barrier to access the service was that the service was not culturally appropriate (Table 3.11.7a).

- Further, 27% of Indigenous Australians aged 15 years and over felt that they had been discriminated against in the past 12 months, with regards to access to health services (Table 3.11.7b).
- Of these Indigenous Australians, 15% (13,102) felt that they had been discriminated against by doctors, nurses or other staff at hospitals or surgeries (Table 3.11.7b).
- Of the Indigenous Australians who did not feel discriminated against in the past 12 months, 0.6% (1,381 of 237,812) avoided situations with doctors, nurses or other staff at hospitals or surgeries and 5% (11,265 of 237,812) avoided other situations (Table 3.11.7b).

Indigenous persons who experienced barriers to accessing health services, by state/territory

- The Northern Territory had the highest proportion of Indigenous Australians over the age of 15 years reporting that they had experienced problems accessing services (40%) followed by Western Australia and New South Wales. The Australian Capital Territory had the lowest proportion (22%), followed by South Australia (24%) (Table 3.11.7a).
- Victoria and the Australian Capital Territory had the highest proportion of Indigenous Australians who identified the barrier to accessing health services as the service being culturally inappropriate (both 7%). The Northern Territory and Queensland had the smallest proportion of Indigenous Australians reporting cultural inappropriateness as a barrier to accessing services (4%) (Table 3.11.7a).
- In Western Australia, 34% of Indigenous Australians felt that they had experienced discrimination within the last 12 months when to accessing to health services. In contrast, only 9% of Indigenous Australians in Tasmania felt that they had been discriminated against.

Table 3.11.7a: Barriers to access health-service providers, Indigenous persons aged 15 years and over who had problems accessing services, by state/territory, 2008

Barriers accessing service providers	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Whether had problems accessing services	Number								
Had problems accessing services	29,621	5,908	22,948	14,660	4,265	3,466	630	16,413	97,911
Did not have problems accessing services	66,746	16,030	67,639	29,166	13,683	8,885	2,180	24,861	229,190
Total	96,367	21,938	90,587	43,826	17,948	12,351	2,810	41,274	327,101
Type of barrier(s) to accessing any service									
Services not culturally appropriate ^(a)	5,629	1,591	3,420	2,632	957	542 ^(b)	203 ^(b)	1,425	16,400
Other ^(b)	29,376	5,750	21,983	14,529	4,200	3,414	613	16,211	96,075
<i>Total has problems accessing selected services^(c)</i>	<i>29,621</i>	<i>5,908</i>	<i>22,948</i>	<i>14,660</i>	<i>4,265</i>	<i>3,466</i>	<i>630</i>	<i>16,413</i>	<i>97,911</i>
Total number	96,367	21,938	90,587	43,826	17,948	12,351	2,810	41,274	327,101
Whether had problems accessing services	Per cent								
Had problems accessing services	30.7	26.9	25.3	33.5	23.8	28.1	22.4	39.8	29.9
Did not have problems accessing services	69.3	73.1	74.7	66.5	76.2	71.9	77.6	60.2	70.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Type of barrier(s) to accessing any service									
Services not culturally appropriate ^(a)	5.8	7.3	3.8	6.0	5.3	4.4 ^(b)	7.2 ^(b)	3.5	5.0
Other ^(c)	30.5	26.2	24.3	33.2	23.4	27.6	21.8	39.3	29.4
<i>Total has problems accessing selected services^(d)</i>	<i>30.7</i>	<i>26.9</i>	<i>25.3</i>	<i>33.5</i>	<i>23.8</i>	<i>28.1</i>	<i>22.4</i>	<i>39.8</i>	<i>29.9</i>
Did not have problems accessing services	69.3	73.1	74.7	66.5	76.2	71.9	77.6	60.2	70.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Includes people who were treated badly/discrimination and who don't trust services.

(b) Estimate has a relative standard error between 25% and 50% and should be used with caution.

(c) Includes access problems due to: transport/distance; cost of service; no services in the area; waiting time too long or not available at time required.

(d) Sum of components exceeds total because respondents may have provided more than one response.

Source: ABS analysis of 2008 NATSISS.

Table 3.11.7b: Discrimination, Indigenous persons aged 15 years and over, by state/territory, 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number									
Felt discriminated against in last 12 months									
By doctors, nurses or other staff at hospitals/surgeries	3,259	799	3,770	2,295	650	41	100	2,188	13,102
Other situations	22,769	5,996	25,286	14,403	5,646	1,146	1,007	10,802	87,054
<i>Total</i>	<i>23,688</i>	<i>6,064</i>	<i>25,664</i>	<i>14,784</i>	<i>5,799</i>	<i>1,146</i>	<i>1,007</i>	<i>11,138</i>	<i>89,289</i>
Did not feel discriminated against in the past 12 months									
Types of situations avoided due to past discrimination									
Doctors, nurses or other staff at hospitals/surgeries	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	1,381
Other situations	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	11,265
Did not avoid situations ^(a)	70,442	14,709	61,503	26,719	11,128	10,837	1,662	28,508	225,507
<i>Total</i>	<i>72,679</i>	<i>15,874</i>	<i>64,923</i>	<i>29,042</i>	<i>12,149</i>	<i>11,205</i>	<i>1,803</i>	<i>30,136</i>	<i>237,812</i>
Total	96,367	21,938	90,587	43,826	17,948	12,351	2,810	41,274	327,101
Per cent									
Whether felt discriminated against in last 12 months									
Felt discriminated against	24.6	27.6	28.3	33.7	32.3	9.3	35.8	27.0	27.3
Did not feel discriminated against	75.4	72.4	71.7	66.3	67.7	90.7	64.2	73.0	72.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Only asked of people who did not feel discriminated against.

Source: ABS analysis of 2008 NATSISS.

Barriers to accessing health-service providers, by remoteness

- In 2008, Indigenous Australians aged 15 years and over in remote areas were more likely than those in non-remote areas to report problems accessing health services (42% and 26%, respectively). Of those who reported problems, the most commonly identified barrier to accessing health services was distrust of services (12% in non-remote areas, 7.8% in remote areas) and the services not being culturally appropriate (8.8% in non-remote areas, 5.8% in remote areas) (Table 3.11.8a).
- In 2008, the percentage of Indigenous Australians aged 15 years and over who had experienced discrimination in the previous 12 months was similar for those in non-remote (28%) and remote areas (26%). Of these, 14% of those in non-remote areas, and 17% of those in remote areas felt discriminated against by doctors, nurses, or other staff at hospitals/surgeries. Two per cent of Indigenous Australians in both non-remote and remote areas said that they avoided doctors, nurses, or other staff at hospitals/surgeries because of past discrimination (Table 3.11.8b).

Table 3.11.8a: Barriers to access health-service providers, Indigenous persons aged 15 years and over who had problems accessing services, by remoteness, 2008

Barriers accessing service providers	Non-remote	Remote	Total
	Per cent		
Whether had problems accessing services			
Had problems accessing services	25.9	42.0	29.9
Did not have problems accessing services	74.1	58.0	70.1
Total	100.0	100.0	100.0
Total number	245,600	81,501	327,101
Type of barrier to accessing any service^(b)			
Services not culturally appropriate	8.8	5.8	7.7
Don't trust services	11.8	7.8	10.4
Treated badly / discrimination	4.9	3.4	4.4
Other ^(a)	97.7	98.9	98.1
<i>Total has problems accessing selected services^(c)</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>
<i>Total number</i>	<i>63,699</i>	<i>34,212</i>	<i>97,911</i>

(a) Includes access problems due to: transport/distance; cost of service; no services in the area; waiting time too long or not available at time required; and other.

(b) Proportions of those who experienced barriers to accessing services.

(c) Components may add to greater than the total because respondents can choose more than one category.

Source: AIHW analysis of 2008 NATSISS.

Table 3.11.8b: Discrimination, Indigenous persons aged 15 years and over, by remoteness, 2008

	Non-remote	Remote	Total
	Per cent		
Whether felt discriminated against in last 12 months			
Felt discriminated against	27.6	26.3	27.3
Did not feel discriminated against	72.4	73.7	72.7
Total	100.0	100.0	100.0
Situations or places felt discriminated against^(a)			
By doctors, nurses or other staff at hospitals / surgeries	14.0	16.9	14.7
Types of situations avoided due to past discrimination^(a)			
Doctors, nurses or other staff at hospitals / surgeries	1.5	1.6	1.5

(a) Proportions are of those who felt discriminated against.

Source: AIHW analysis of 2008 NATSISS.

Barriers to accessing health-service providers, by sex

- In 2008, Indigenous females aged 15 years and over in remote areas were more likely than their male counterparts to report problems accessing health services (33% and 27%, respectively) (Table 3.11.9a). Of those who reported problems, the most commonly identified barrier to accessing health services was distrust of services (3.3% each for males and 3.0% for females) and the services not being culturally appropriate (1.8% for males, 2.8% for females).
- In 2008, the percentage of Indigenous Australians aged 15 years and over who had experienced discrimination in the previous 12 months was similar for males (28%) and females (27%). Of these, 11% of males, and 18% of those in remote areas felt discriminated against by doctors, nurses, or other staff at hospitals/surgeries. 1.5% males and 1.6% females said that they avoided doctors, nurses, or other staff at hospitals/surgeries due to past discrimination (Table 3.11.9b).

Table 3.11.9a: Barriers to access health-service providers, Indigenous persons aged 15 years and over who had problems accessing services, by sex, 2008

Barriers accessing service providers	Males	Females	Persons
	Per cent		
Whether had problems accessing services			
Had problems accessing services	27.1	32.5	29.9
Did not have problems accessing services	72.9	67.5	70.1
Total	100.0	100.0	100.0
Total number	156,052.2	171,048.8	327,101.0
Type of barrier to accessing any service			
Services not culturally appropriate	1.8	2.8	2.3
Don't trust services	3.3	3.0	3.1
Treated badly / discrimination	1.2	1.4	1.3
Other ^(a)	26.4	32.0	29.4
<i>Total has problems accessing selected services</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>
<i>Total number</i>	<i>42,333.7</i>	<i>55,577.0</i>	<i>97,910.6</i>

(a) Includes access problems due to transport/distance; cost of service; no services in the area; waiting time too long or not available at time required; and other.

Source: AIHW analysis of 2008 NATSISS.

Table 3.11.9b: Discrimination, Indigenous persons aged 15 years and over, by sex, 2008

	Males	Females	Persons
	Per cent		
Whether felt discriminated against in last 12 months			
Felt discriminated against	27.9	26.8	27.3
Did not feel discriminated against	72.1	73.2	72.7
Total	100.0	100.0	100.0
Situations or places felt discriminated against^(a)			
By doctors, nurses or other staff at hospitals / surgeries	11.1	18.1	14.7
Types of situations avoided due to past discrimination^(a)			
Doctors, nurses or other staff at hospitals / surgeries	1.5	1.6	1.5

(a) Proportions are of those who felt discriminated against

Source: AIHW analysis of 2008 NATSISS.

Healthy for Life data

Information on involvement in service planning and quality improvement by services funded through the HfL program is available from the AIHW Healthy for Life data collection.

- In the reporting periods ending 30 June 2007, 30 June 2008 and 30 June 2009, the most common formal mechanism for input into planning was via meetings of reference groups or other advisory committees (86%, 90% and 84%, respectively) (Table 3.11.10).
- Over the same periods, the most common formal mechanism for dissemination of health service performance information was via verbal and/or written reports presented at meetings other than the Annual General Meeting (83%, 82% and 80%, respectively).
- Over the same periods, the most common formal mechanism for assessing client satisfaction or dissatisfaction was a complaints mechanism (85%, 90% and 78%, respectively).

Services funded through the HfL program undertook quality improvement activities. Data for these activities are available for the reporting periods ending 30 June 2007, 30 June 2008 and 30 June 2009 and these indicate that:

- The services participated in formal quality improvement processes that involved repeated cycles of 'plan-do-study-act' in maternal health (between 30 June 2007 and 30 June 2009 this ranged from 56% to 72% of services), child health (ranging from 59% to 76% of services) and chronic disease (ranging from 70% to 81% of services) (Table 3.11.11).
- Health service data were used to review quality in maternal health (ranging from 61% to 68% of services), child health (ranging from 63% to 75% of services) and chronic disease (ranging from 70% to 78% of services).
- Staff participated in the interpretation of health service data and service planning/goal setting in relation to maternal health (ranging from 75% to 78% of services), child health (ranging from 74% to 80% of services) and chronic disease (ranging from 78% to 85% of services).

Table 3.11.10: Service population involvement in service planning and feedback, reporting periods ending 30 June 2007, 30 June 2008 and 30 June 2009

HfL services had strategies to involve their service population in service planning and feedback that included:	Jun-07			Jun-08			Jun-09		
	Per cent			Per cent			Per cent		
	Yes	No	No response	Yes	No	No response	Yes	No	No response
1. Formal mechanisms for input into planning									
a. Meeting(s) of reference group(s) or other advisory committee(s)	86.4	5.1	8.5	89.6	6.0	4.5	83.8	4.1	12.2
b. Input received at an Annual General Meeting	61.0	30.5	8.5	67.2	26.9	6.0	67.6	17.6	14.9
c. Other	35.6	13.6	50.8	31.3	20.9	47.8	35.1	23.0	41.9
2. Formal mechanisms for dissemination of health service performance information									
a. A current formal communication strategy	57.6	27.1	15.3	71.6	19.4	9.0	67.6	17.6	14.9
b. Verbal and/or written report(s) presented at an Annual General Meeting	69.5	13.6	16.9	76.1	9.0	14.9	71.6	10.8	17.6
c. Verbal and/or written reports(s) presented at other meeting(s)	83.1	3.4	13.6	82.1	6.0	11.9	79.7	5.4	14.9
d. Health service newsletter(s)	49.2	42.4	8.5	61.2	31.3	7.5	59.5	28.4	12.2
e. 'Column' in the newsletter(s) of other agencies	32.2	55.9	11.9	35.8	50.7	13.4	41.9	41.9	16.2
f. Ad hoc information on our health service website	32.2	52.5	15.3	43.3	43.3	13.4	43.2	41.9	14.9
g. Other	22.0	25.4	52.5	19.4	29.9	50.7	16.2	31.1	52.7
3. Formal mechanisms for assessing client satisfaction									
a. Client satisfaction survey	55.9	32.2	11.9	53.7	35.8	10.4	52.7	31.1	16.2
b. Client focus group(s)	42.4	40.7	16.9	53.7	35.8	10.4	45.9	37.8	16.2
c. Suggestions box	44.1	44.1	11.9	70.1	19.4	10.4	64.9	18.9	16.2
d. Complaints mechanism	84.7	1.7	13.6	89.6	1.5	9.0	78.4	4.1	17.6

Source: AIHW Healthy for Life data collection.

Table 3.11.11: Quality improvement, reporting periods ending 30 June 2007, 30 June 2008 and 30 June 2009

HfL services undertook quality improvement activities in relation to maternal and child health and chronic disease prevention and care that included:	Jun-07			Jun-08			Jun-09		
	Per cent yes	Per cent no	Per cent no response	Per cent yes	Per cent no	Per cent no response	Per cent yes	Per cent no	Per cent no response
1. Participation in formal quality improvement processes that involve repeated cycles of plan-do-study-act (PDSA)									
a. Maternal health	55.9	32.2	11.9	71.6	28.4	0.0	67.1	23.3	9.6
b. Child health	59.3	28.8	11.9	76.1	23.9	0.0	70.3	20.3	9.5
c. Chronic disease	74.6	16.9	8.5	80.6	19.4	0.0	70.3	20.3	9.5
d. Other	30.5	32.2	37.3	34.3	34.3	31.3	39.2	33.8	27.0
2. Quality improvement strategies included in current business plan	61.0	1.7	37.3	63.6	9.1	27.3	64.9	5.4	29.7
3. Health service data used to review quality									
a. Maternal health	61.0	8.5	30.5	65.7	20.9	13.4	67.6	8.1	24.3
b. Child health	62.7	6.8	30.5	74.6	11.9	13.4	68.9	8.1	23.0
c. Chronic disease	69.5	1.7	28.8	77.6	9.0	13.4	71.6	6.8	21.6
d. Other	22.0	22.0	55.9	23.9	26.9	49.3	31.1	28.4	40.5
4. Staff participation in interpretation of health service data and service planning/goal setting									
a. Maternal health	78.0	10.2	11.9	74.6	19.4	6.0	75.7	5.4	18.9
b. Child health	79.7	10.2	10.2	79.1	16.4	4.5	74.3	6.8	18.9
c. Chronic disease	84.7	5.1	10.2	85.1	10.4	4.5	78.4	4.1	17.6
d. Other	30.5	27.1	42.4	29.9	29.9	40.3	40.5	25.7	33.8

Source: AIHW Healthy for Life data collection.

Aboriginal and Torres Strait Islander representation on health/hospital boards

Information on Aboriginal and Torres Strait Islander representation on health/hospital boards is available from the states and territories. Data presented below come from the *National summary of the 2003 and 2004 jurisdictional reports against the Aboriginal and Torres Strait Islander Health Performance Indicators* (SCATSIH & SIMC 2006).

New South Wales

In New South Wales, health service boards have the overall responsibility for the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The boards guide and direct, establish policies, chart the course of their respective organisations and act as advocates for their organisations in the local communities.

The boards are subject to the direction and control of the Minister except in relation to the context of a report or recommendation.

In 2002–03, 17 out of the 80 health service boards in New South Wales had at least one Indigenous member. In 2003–04, this fell to 6 out of 62. There were fewer boards/committees in 2003–04 because of the dissolution of 18 area health service boards in August 2004.

The *Health Services Act 1997* and the *Ambulance Service Act 1990* do not make provision for the make-up of membership on health service boards, so Aboriginal and Torres Strait Islander membership is not mandated. However, it should be noted that the constitution of the soon to be appointed area health service councils, which will replace the 18 dissolved area health service boards, states that ‘at least one member must be a person who has expertise, knowledge or experience in relation to Aboriginal health’.

Victoria

The functions of the board of a public hospital, denominational hospital or multi-purpose service are to oversee and manage the hospital and to ensure that the services provided by the hospital comply with the requirements of the *Health Services Act 1988* and the objectives of the hospital. Public hospitals must have a board of management of between six and 12 persons, whose names are submitted by the board and appointed by the Minister.

Metropolitan health services must have a board of management of between six and nine persons appointed by the Governor in Council on the recommendation of the Minister. The Minister must ensure that the board includes at least one person who is able to reflect the perspectives of users of health services and that women and men are adequately represented. Members of the boards of denominational public hospitals are not appointed by the Minister.

Information on the structure of health/hospital boards is not routinely collected by the Department of Human Services in Victoria, and there is no requirement for the hospital and community health centres to record the Indigenous status of board members. Available data show that six of the 84 health boards in Victoria reported Aboriginal and Torres Strait Islander representation in 2002–02 and 2003–04.

Individual boards no longer exist in the Melbourne metropolitan regions. In no case is Indigenous membership mandatory, although some hospitals seek a representative from the

local Aboriginal cooperative/community organisation and encourage members of minority groups when advertising opportunities for board appointments.

Opportunities also exist for community members to participate in hospital advisory committees. Information on the membership of these committees is not collected by the Department of Human Services.

Queensland

Queensland Health is divided into three zones containing 38 health service districts. Each district has a district health service council. The role of the District Health Service Council is to work in cooperation with the relevant health service district to ensure that the needs of the community are represented and reflected in the health services provided, and to monitor the performance of the district against a service agreement. The council should act as a direct link between the public and Queensland Health.

District health service councils facilitate community input into the planning, delivery, monitoring, and evaluation of hospital and community-based health services. The councils are established in legislation, with a direct reporting relationship to the Minister, and consist of up to 10 members with equitable community representation. Members are not elected, but are appointed by the Governor-in-Council. A term as member is for a period of 3 to 4 years. All district health service councillors are ministerial appointments. There is no requirement mandated by the terms of reference for Indigenous representation, nor is there a requirement for appointees to record Indigenous status. However, currently there are 26 Indigenous members serving on 11 of the district health service councils.

Western Australia

Health service boards are established under the Hospital and Health Services Act 1927 and derive their functions and responsibilities from the Act. The boards are responsible for the control, management and maintenance of the hospital and for providing health services as approved by the Minister under an Australian Government – state agreement.

In 2002–03, all existing hospital boards were disbanded. In 2003–04, 17 new district health advisory councils (DHACs) were established, 15 of which had Aboriginal and Torres Strait Islander members. The 17 DHACs have been established to achieve diverse representation from the community and have input into service planning, plus propose creative and community-based ideas for improving service access and quality.

South Australia

There were 73 incorporated hospitals and health centres under the South Australian Health Commission, at 30 June 2003. Information is available on 38 boards that have provision within the hospital's constitution for a ministerial nomination. In the 2002–03 and 2003–04 financial years, 13 health/hospital boards in the Hills Mallee Southern, Eyre, Northern and Far Western, Riverland and Mid-North regions of South Australia reported Aboriginal and Torres Strait Islander membership.

Tasmania

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

Australian Capital Territory

All board/committee members are asked if they wish to identify their Aboriginal or Torres Strait Islander status at the time of initial appointment. However, some members may choose not to do so. The representation may, therefore, be higher than recorded. In 2002–03, four members of the 10 health boards and committees identified as Aboriginals and/or Torres Strait Islanders. In 2003–04, five members of the 14 boards and committees identified as Indigenous Australians.

In February 2002, the ACT Government announced a review of the structural and governance arrangements for the health and community care system. As a result of the review, the ACT Health and Community Care Board was abolished, and legislation to formally repeal the purchaser/provider arrangements in health was passed by the ACT Legislative Assembly in December 2002. The health portfolio has been restructured into a simplified model, and the ACT Health Council established to provide a consultative mechanism involving health consumers and professionals in ACT health policy and planning processes. There was Aboriginal and Torres Strait Islander representation on the Council in both 2002–03 and 2003–04.

Northern Territory

Under the *Hospital Management Boards Act 2001*, each public hospital in the Northern Territory is to have a board of eight members, five of whom are to be appointed by the Minister. Although the Act does not require hospitals to have Indigenous people on the boards, all Northern Territory hospitals make every effort to include Aboriginal members.

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

Data quality issues

National Aboriginal and Torres Strait Islander Social Survey (NATSISS)

The NATSISS is conducted in all states and territories and includes remote and non-remote areas. The 2008 sample was 13,300 persons in 6900 households, with a response rate of 82% of households. Up to three randomly selected Indigenous people were chosen from selected households to participate in the survey. Trained ABS interviewers conducted the survey using face-to-face interviews. In non-remote areas interviewers used a notebook computer to record responses, while in remote areas a paper questionnaire was used. Interviewers obtained the consent of a parent or guardian before interviewing those aged 15 to 17 years. Indigenous persons usually resident in non-private dwellings such as hotels, motels, hostels, hospitals, short-stay caravan parks, prisons and other correctional facilities were excluded. The NATSISS uses the standard Indigenous status question. The NATSISS sample was specifically designed to select a representative sample of Aboriginal and Torres Strait Islander Australians.

Information recorded in this survey is 'as reported' by respondents, and therefore may differ from information available from other sources or collected using different methodologies.

Data on health-related indicators have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the states and territories and the Indigenous and non-Indigenous population.

Time series comparisons for the 2008 survey are available through the 1994 National Aboriginal and Torres Strait Islander Survey and the 2002 NATSISS. However, not all data elements align across the three (1994, 2001 and 2008) NATSISS surveys, hence care is required when reviewing results across the three surveys. There are no strictly comparable non-Indigenous results available for the 2008 NATSISS because the latest General Social Survey (which has been used in the past to compare with Indigenous results from the NATSISS) was run in 2006, with the next being run in 2010. Data from other ABS surveys run in 2008 may, however, be used to obtain rough non-Indigenous comparisons for some data items. Where possible, the ABS has provided recommendations for non-Indigenous data comparisons these have been adopted in this report.

There was a relatively large level of under-coverage and caution should be exercised when interpreting the survey results. The under-identification of Indigenous persons in non-community areas is estimated to be up to 31% of those screened. This estimate is the remaining level of under-coverage when all other known sources of under-coverage have been removed. Part of this percentage is likely to be due to other factors which are unknown (ABS 2010).

Further information on NATSISS data quality issues can be found in the 2008 NATSISS User's guide (ABS 2010).

Healthy for Life data

For the July 2008 to June 2009 reporting period, 72 services submitted data as part of the Healthy for Life Program.

Services started submitting their data through an electronic interface (OSCAR) for the February 2008 reporting period. This has improved the quality of data submitted.

Not all of the services were able to provide data for all of the essential indicators and service profile questions. The number of services who were able to provide data varies across the qualitative and quantitative indicators.

OATSIH Services Reporting (OSR) data collection

The data were collected using the OSR questionnaire, (surveying all auspice services) which combined previously separate questionnaires for primary health, substance use, and Bringing Them Home and Link up counselling services.

OATSIH sent a paper copy of the 2008–09 OSR questionnaire to each participating service and asked the service to complete the relevant sections. The participating services sent their completed OSR questionnaires directly to the AIHW.

The AIHW examined all completed questionnaires received to identify any missing data and data quality issues. Where needed, AIHW staff contacted the relevant services to follow up and obtain additional or corrected data. After manually entering the data on the data repository system, staff conducted further data quality checks.

The AIHW identified three major problems with the data quality: missing data, inappropriate data provided for the question, and divergence of data from two or more questions. The majority of 2008–09 OSR questionnaires received had one or more of these data quality issues. Further information can be found in the data quality statement in the Aboriginal and Torres Strait Islander Health Services Report, 2008-09 (AIHW 2010).

List of symbols used in tables

n.a. not available

– rounded to zero (including null cells)

0 zero

.. not applicable

n.e.c. not elsewhere classified

n.f.d. not further defined

n.p. not available for publication but included in totals where applicable, unless otherwise indicated

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