

SUMMARY

SCOPE

This publication presents an overview of the health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. The data and other information used were the most up-to-date available at the time of writing, and include the results of national censuses and surveys, as well as information held in the administrative datasets of various government departments and national statistical collection agencies. The majority of the information presented is at the national level, with State and regional data included where the quality of the information is adequate, and where comparative material illustrates significant variations between regions or populations. A separate chapter has been included which examines the nature and prevalence of diabetes in the Indigenous population.

DATA QUALITY, AVAILABILITY AND RECENT DEVELOPMENTS

The data available about Aboriginal and Torres Strait Islander people are limited by the extent to which Indigenous people are included in national surveys, the accuracy with which they are identified in both surveys and administrative datasets, uncertainties about Indigenous population estimates, and concerns about whether the survey methods employed are always the most suitable. It is also difficult to point to trends with confidence because the availability and quality of data about the Indigenous population have varied considerably over time.

The Australian Bureau of Statistics (ABS), in consultation with government agencies and other key stakeholders, including representatives of the Aboriginal and Torres Strait Islander community, has developed a strategy for collecting Indigenous statistics which is currently being implemented. Some of its key elements are: the six-yearly Indigenous Social Survey (to be conducted first in 2002); the inclusion of a supplementary Indigenous sample in the National Health Survey (the first supplement was included in the 2001 cycle of this survey); regular identification of Indigenous people in the Labour Force Survey; improved identification of Indigenous people in administrative datasets; and continued high priority given to improving the quality of Indigenous data from the five-yearly Census of Population and Housing and for annual Indigenous population estimates and projections. For the 2001 Census ABS has implemented a special Indigenous enumeration strategy and is using a range of evaluation techniques and strategies to monitor, report on and improve the quality of Census measures. The ABS is also conducting, on behalf of the Aboriginal and Torres Strait Islander Commission, the 2001 cycle of the Community Housing and Infrastructure Needs Survey (first conducted in 1999).

THE DEMOGRAPHIC, SOCIAL AND ECONOMIC CONTEXT

The 1996 Census showed that Aboriginal and Torres Strait Islander people comprised approximately 2% of the total population of Australia. This represented a 33% increase in the Indigenous population from the 1991 Census. The magnitude of this increase can only be partially explained in terms of 'natural' increases, determined by births, deaths and migration levels. Much of the additional change appears to be the result of increasing numbers of Aboriginal and Torres Strait Islander people recording their Indigenous status on census forms. This trend, and the fact that the components of natural increase are poorly reported for the Indigenous population, makes the estimation of the Indigenous population difficult to determine for the intercensal periods. In addition, the calculation of incidence and prevalence rates for specific diseases in a population depends upon reliable population estimates, and the experimental nature of these for the Indigenous population means any rate calculations must be treated with caution.

In 1996, the Indigenous population, with a median age of 20 years, was younger than the general Australian population, which had a median age of 34 years. More than half of all Indigenous people lived in New South Wales and Queensland, with the majority residing in urban areas. New South Wales had the greatest number of Indigenous people (110,000) and the Northern Territory had the highest proportion, with around 28% of its population reporting Indigenous status. Nearly 20% of the Indigenous population lived in areas classified as 'very remote', compared with only 1% of the non-Indigenous population.

Aboriginal and Torres Strait Islander people were disadvantaged across a range of socioeconomic factors reported upon in the 1996 Census. They experienced lower incomes than the non-Indigenous population, higher rates of unemployment, poorer educational outcomes and lower rates of home ownership, all of which can impact upon a person's health and sense of wellbeing.

COMMUNITY SERVICES

Aboriginal and Torres Strait Islander people were over-represented in several areas of community services, although poor data quality makes an accurate measure of their use of services difficult to determine. Available data show that Indigenous people were more highly represented in the Supported Accommodation Assistance Program than non-Indigenous people, and Indigenous children were more likely to be placed under care and protection orders, or in out-of-home care, than their non-Indigenous counterparts. Aged care services were accessed by Indigenous people at younger ages and in proportionally lower numbers than the non-Indigenous population.

Accurate information about levels of disability among Aboriginal and Torres Strait Islander people is not available because definitions of disability which are meaningful in the Indigenous context have not been developed. There is also a need to ensure that Indigenous people are accurately identified in disability data collections. The best available information comes from the Commonwealth/State Disability Agreement Minimum Data Set, which indicates that Indigenous people access

COMMUNITY SERVICES
continued

disability services at similar rates to the rest of the population. Indigenous people with a disability who received assistance under the Open Employment Services program experienced poorer outcomes than non-Indigenous participants, with lower mean hourly rates of pay, fewer hours of work per week and, consequently, lower mean weekly incomes.

HOUSING AND
INFRASTRUCTURE

In 1999, Aboriginal and Torres Strait Islander people were more likely than the non-Indigenous population to live in conditions considered unacceptable by general Australian standards. In particular, overcrowding, high housing costs relative to income, poorly maintained buildings and facilities, and inadequate infrastructure were major issues associated with the housing of Indigenous people. Aboriginal and Torres Strait Islander people were also less likely to own their own homes than non-Indigenous Australians. Sewerage system malfunctions, water restrictions, and interruptions to power supplies were problems frequently reported by people living in discrete communities.

HEALTH SERVICE
PROVISION, ACCESS AND
USE

In 1998–99, an estimated \$1,245 million was spent on health services for Aboriginal and Torres Strait Islander people. This figure represented 2.6% of health expenditure for all Australians, but is an estimate only, largely because of the incomplete identification of Indigenous people in many administrative datasets. Patterns of expenditure indicate clear differences between the Indigenous and non-Indigenous populations in the way that health services are accessed. Greater amounts were spent on Aboriginal and Torres Strait Islander people in relation to community and public health, patient transport, public hospital services, mental health institutions, and government administration and research, and lesser amounts on Medicare, private hospitals, the Pharmaceutical Benefits Scheme and residential aged care than other Australians. Overall, for each dollar spent on health services for non-Indigenous people, \$1.22 was spent on health services for Indigenous people.

Overall, Indigenous people experienced lower levels of access to health services than the general population. Indigenous people were nearly twice as likely as members of the general population to live outside urban centres and were more likely to live further from a range of health services and facilities. A considerable number of the Indigenous communities included in the 1999 Community Housing and Infrastructure Needs Survey did not receive visits from a wide range of health professionals. Other factors which were likely to influence the level at which Indigenous people used health services were the socioeconomic status of patients, the availability of transport, the ability to speak English, and cultural factors such as the availability of same-sex Indigenous health workers.

Although the incomplete recording of Indigenous status in administrative records and the experimental nature of Indigenous population estimates remain barriers to the production of a true picture of Indigenous health in Australia, the available evidence suggests that Indigenous people continue to suffer a greater burden of ill health than the rest of the population.

Over the period 1997–99, the life expectancy at birth for an Indigenous male was 56 years, and for an Indigenous female, 63 years. Comparable life expectancies were experienced by males in the total population in 1901–10, and females in 1920–22. Today, males in the total Australian population have a life expectancy of 76 years and females 82 years.

This publication uses deaths registrations from Queensland, South Australia, Western Australia and the Northern Territory to form a 'quasi-national' picture of Indigenous mortality for the period 1997 to 1999. During this time, there were 4,379 Indigenous deaths registered in these jurisdictions. Death rates among Aboriginal and Torres Strait Islander people were higher than those recorded in the general population for almost all causes of death and for every age group. In the age group 35–54 years, the Indigenous death rate was 5–6 times higher than expected.

The leading causes of death in both the Indigenous and non-Indigenous populations were diseases of the circulatory system, cancer and external causes. Together these accounted for 60% of all identified Indigenous deaths, affecting Indigenous people at younger ages than in the total Australian population. There were 7–9 times more deaths of Indigenous people than expected from endocrine and metabolic diseases (of which 88% were related to diabetes) based on rates for the total Australian population.

Data from national surveys in 1994 and 1995 show that Indigenous people were more likely than non-Indigenous people to smoke, consume alcohol at hazardous levels, be exposed to violence, and to be categorised as obese, all of which are significant health risk factors.

Indigenous women gave birth at younger ages than non-Indigenous women, with the data for 1996–98 showing over 80% of Indigenous mothers having babies before the age of 30. The comparable figure for non-Indigenous mothers was 54%. Babies of Indigenous mothers were nearly twice as likely as babies of non-Indigenous mothers to be of low birthweight, a factor affecting health in childhood and, as some evidence suggests, throughout adult life also. Babies of Indigenous mothers were twice as likely to die at birth and during the early post-natal phase.

Measuring mental health in the Aboriginal and Torres Strait Islander population is a difficult undertaking because data definitions, standards and collection instruments have not yet been developed to adequately encompass the holistic view of health traditionally held by Indigenous people. There are, however, hospital data which indicate that Indigenous people suffer from higher levels of many mental and behavioural disorders. In 1998–99, there were about four times as many hospital separations as expected for mental disorders resulting from psychoactive drug use. Self-harm and assault may be indicators of social and emotional distress and psychological illness in a community. Hospitalisation data show that there were many more hospital separations than expected for intentional injury in the Indigenous population.

In 1998–99, Indigenous people were more likely than other people to be hospitalised for most diseases and conditions. Just over 26% of hospital separations for Indigenous people were for ‘care involving dialysis’; making this the main reason for hospitalisation of Aboriginal and Torres Strait Islander people. Other common reasons were injuries and poisoning, respiratory diseases, digestive disorders and mental and behavioural disorders. Pregnancy and childbirth accounted for 17% of hospital separations among Indigenous women.

Kidney disease is associated with diabetes, high blood pressure, infections, low birthweight and obesity, all of which are conditions found more commonly in the Indigenous population. Kidney disease can also lead to the need for dialysis or transplant. This situation is reflected in the fact that 44% of all principal procedures in hospital recorded for Indigenous people in 1998–99 were for haemodialysis.

Diabetes is a disease of particular importance in the Indigenous population and manifests in two primary forms—Type 1 diabetes and Type 2 diabetes. In 1998–99 about 75% of Aboriginal and Torres Strait Islander people who received hospital treatment for the disease had Type 2 diabetes. Based on rates for the total Australian population, there were 10–15 times more hospital separations for Type 2 diabetes than expected in the Indigenous population. Diabetes can cause serious complications such as cardiovascular disease, kidney disease, nerve damage, eye damage, ulceration and gangrene. Indigenous people who have Type 2 diabetes often develop the disease earlier than other Australians and often die at younger ages.

There are a number of health risk factors associated with diabetes, including obesity, poor nutrition, lack of physical activity and as yet unspecified genetic factors. The higher levels of obesity in the Indigenous population, may be a contributing factor to elevated levels of Type 2 diabetes.

MEASURES OF HEALTH
STATUS *continued*

As with much of the material presented in this report, information about the prevalence of diabetes in the Aboriginal and Torres Strait Islander population is limited by the availability and quality of the data. Incomplete identification of Indigenous people in administrative records would indicate an undercount of the number with the disease. In addition, current estimates suggest that 50% of all people with the disease are unaware of their condition.

RECENT INITIATIVES AND
FUTURE PLANS

A number of important initiatives have been undertaken in recent years, by the ABS, AIHW and other bodies, to improve the quality and availability of data about the Indigenous population drawn from administrative data sources. Concurrent with these developments has been an increased emphasis on the inclusion of an Indigenous identifier in a range of surveys and administrative datasets. The National Indigenous Health Information Plan adopted in 1997 continues to be implemented, and comparable developments are under way with respect to community services and housing. Regular social surveys, national surveys with supplementary Aboriginal and Torres Strait Islander samples, the regular identification of Indigenous people in the Labour Force Survey, targeted Census Indigenous enumeration strategies and evaluations, and an analytical work program investigating the modelling of various statistical measures all form part of a national commitment to improve the quality and scope of information about Australia's Aboriginal and Torres Strait Islander people.