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National Summary
of the 2000 jurisdictional reports against
the Aboriginal and Torres Strait Islander health
performance indicators

NATIONAL SUMMARY

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the Aboriginal and Torres Strait Islander
health performance indicators



**National summary of the 2000
Jurisdictional reports against the
Aboriginal and Torres Strait Islander
Health performance indicators**

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**The National Health Information Management Group for Australian Health
Ministers' Advisory Council, prepared and funded by the Commonwealth Office for
Aboriginal and Torres Strait Islander Health**

Canberra

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Abbreviations

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
ACT	Australian Capital Territory
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
ATSIC	Aboriginal & Torres Strait Islander Commission
BEACH	Bettering the Evaluation & Care of Health
CPI	Community Partnership Initiative
DETYA	(Commonwealth) Department of Education, Training & Youth Affairs (now Department of Education, Science and Training)
DOGIT	Deed of Grant in Trust
EEO	Equal Employment Opportunity
FTE	full time equivalent
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
KSIS	Koori Services Implementation Strategy
MOIR	Minimum Obligatory Reporting Requirements
NATSIS	National Aboriginal and Torres Strait Islander Survey
NCVER	National Centre for Vocational Education Research
NGOTGP	Non-Government Organisation Treatment Grants Program
OATSIH	office of Aboriginal and Torres Strait Islander Health
SLA	statistical local area
STD	sexually transmittable disease
VET	Vocational Education and Training
n.a.	not applicable
..	not available
n.y.a.	not yet available
n.p.	not provided

Executive summary

Aboriginal and Torres Strait Islander people are more likely to experience disability and reduced quality of life due to ill health, and die at younger ages than other Australians.

This is the final edition of three reports (previously released for the 1998 and 1999 periods) by jurisdictions against the interim set of Aboriginal and Torres Strait Islander health performance indicators, which includes more than 50 indicators across nine categories of mortality, morbidity, access to health services, health service impacts, workforce developments, risk factors, intersectoral issues, community development and quality of service provisions. For many jurisdictions, the data required to report on the indicators are not available or are of poor quality. In such cases, jurisdictions have agreed to report on initiatives to improve data quality and availability. Improving data to facilitate reporting on health performance indicators is therefore a key driver of the implementation process for the National Indigenous Health Information Plan.

Incomplete coverage of Aboriginal and Torres Strait Islander status in administrative data sources such as deaths registrations and hospital separations records, and the experimental nature of population estimates, remain the major obstacles to producing a detailed description of mortality, morbidity, health risk factors, living conditions and service delivery for Indigenous Australians. While these limitations present difficulties for jurisdictions to report all indicators on an annual basis, and in monitoring trends over time, data reported against the interim set of national Aboriginal and Torres Strait Islander health performance indicators provide a comprehensive outline of Aboriginal and Torres Strait Islander health status and health service utilisation.

Life expectancy and mortality

Life expectancy is a widely used summary measure of current health and mortality conditions for a particular population. Data from those jurisdictions able to report this indicator (Indicator 1.1), and from routine reporting of deaths for the 2000 calendar year by the Australian Bureau of Statistics (ABS 2001) indicate that life expectancy for Aboriginal and Torres Strait Islander people is 19–20 years lower than the comparable figures for the total Australian population. Life expectancy was estimated for the 2000 calendar year to be 56 years for Indigenous males and 63 years for Indigenous females, compared with 76 years for all-Australian males and 82 years for all-Australian females (ABS 2001). The indicator was reported by Victoria, Western Australia and the Northern Territory for Indigenous men at 56 years, 61 years and 59 years respectively for each jurisdiction. Similarly, those jurisdictions reported life expectancy for Indigenous women at 65 years, 67 years and 64 years respectively.

Indicators of mortality include age-standardised and age-specific mortality rates for all causes of death. For all age groups, mortality rates are higher for the Indigenous population than for the non-Indigenous population. The mortality rate is more than seven times greater for Indigenous women aged 25–44 years in the Northern Territory and in Queensland Aboriginal communities, than for non-Indigenous women in those jurisdictions. For Indigenous men aged 25–44 years the mortality rate in Western Australia, South Australia, the Northern Territory and in Queensland Aboriginal communities is four to six times

greater than for non-Indigenous men, and for young Indigenous men in Queensland Aboriginal communities aged 15–24 years, the rate is seven times greater.

Death rates are higher for Indigenous people than for other Australians as a whole, for almost all causes of death, however diseases of the circulatory system, neoplasms (cancer), deaths resulting from external causes (self-harm, assaults, accidents) and endocrine/metabolic diseases account for the greatest numbers of deaths among Indigenous people (ABS & AIHW 2001). Reports against the health performance indicators from Queensland, Western Australia, South Australia and the Northern Territory show that the death rates among Indigenous people for ischaemic heart disease (Indicator 1.7a) are up to two-and-one-half times as great, and for injury and poisoning (Indicator 1.7b) are between one-and-one-half to three times as great for Indigenous people.

The indicators reported by jurisdictions include a number of diseases that, while less common as an underlying cause of death in the general population, have a substantial impact within the Indigenous population. However, it is noted that where few deaths are notified for some diseases, rates can fluctuate widely between jurisdictions and over time. Reported death rates for rheumatic heart diseases showed wide variation across the jurisdictions (Indicator 1.7a), the Northern Territory reporting a rate for Aboriginal men 33 times greater than that for non-Aboriginal men and South Australia reporting much smaller differences, of one-and-one-half to three times the rate for Indigenous men and women in that jurisdiction compared to non-Indigenous men and women. Age-standardised death rates for pneumonia (Indicator 1.7c) indicate that Indigenous men experience three times the rate of death and Indigenous women twice the rate of death as the rate of deaths for other Australians. For diabetes (Indicator 1.7d), death rates for Indigenous people ranged from 5 to 13 times higher than the respective groups of men and women in the general population. Death rates for cancer of the cervix (Indicator 1.7e) show that, compared with other women, Indigenous women die from this disease at approximately twice the rate in South Australia and the Northern Territory, and at more than five times the rate in Queensland and Western Australia.

Indigenous mothers are more likely to have their babies at younger ages than non-Indigenous mothers, and to have a low birthweight baby. The national perinatal mortality rate for babies of Indigenous mothers remains at about twice the rate for babies of non-Indigenous mothers, but varies considerably across regions and may be underestimated due to problems with data collection (ABS & AIHW 2001). Jurisdictional reports show that in Queensland, Western Australia and the Northern Territory, stillbirths (foetal deaths, Indicator 1.5) for Indigenous mothers occurred at almost twice the rate as stillbirths for non-Indigenous mothers. Infant mortality (deaths from birth to 1 year of age, Indicator 1.6) occurred in Western Australia for babies born to Indigenous mothers at a rate that was three times higher than that for non-Indigenous mothers. The comparative rates in Queensland and the Northern Territory were two and two-and-one-half times higher, respectively.

Morbidity

Indicators of morbidity in the Aboriginal and Torres Strait Islander population include rates of notifications for selected communicable diseases, proportions of low birthweight babies, hearing loss in young children, and hospital separation rates for acute myocardial infarction, injury and poisoning, respiratory diseases and diabetes.

Surveillance of communicable diseases is an essential public health strategy for prevention and control of infectious diseases. Since not all such cases of infectious disease lead to

hospitalisation or death, notifications data are a valuable source of information on the incidence of these conditions in the community. Notification rates also provide an indicator of uptake and access to immunisation programs.

Notification rates for three vaccine-preventable diseases are included as indicators of Indigenous health (Indicator 2.1a). The diseases selected for reporting against this indicator are pertussis (whooping cough), measles and hepatitis B. However, Western Australia and the Northern Territory were the only jurisdictions able to report Indigenous/non-Indigenous rates for these diseases, and the limitations of data quality mean that rates and comparisons of rates between groups should be treated with caution. In Western Australia the notification rate for pertussis was approximately two-and-one-half times greater for both Indigenous men and Indigenous women compared with non-Indigenous men and women. The notification rate for hepatitis B was six times greater for Indigenous men and 10 times greater for Indigenous women than for non-Indigenous men and women respectively; notification rates were higher for Indigenous men than for Indigenous women, as is the case for the comparison between non-Indigenous men and women. Rates for measles in Western Australia and for each of these three notifiable diseases in the Northern Territory were too low to make any reliable comparisons.

There were very few notifications for meningococcal infection (Indicator 2.1b) in Western Australia and the Northern Territory, the only jurisdictions to report against this indicator. For the two sexually transmitted diseases used as indicators in this report, gonorrhoea and syphilis, notification rates were reported by Western Australia, the Northern Territory and South Australia only (Indicator 2.2). The notification rates for these diseases in Western Australia and the Northern Territory were extremely high for the Indigenous population when compared to the very low rates reported for the non-Indigenous population in those jurisdictions (up to 100 times the rate for gonorrhoea and up to 75 times for syphilis). South Australia did not provide comparative data (that is, for non-Indigenous people) for these diseases.

Hearing loss among Indigenous children is widespread. It can be the result of repeated bouts of otitis media, and is thought to be more severe among Indigenous children due to crowded housing conditions and lack of access to primary health care. Hearing loss often leads to increased learning difficulties and behavioural problems in school, adding to existing social disadvantages experienced by Indigenous people. There were no jurisdictional reports available on the proportion of Aboriginal and Torres Strait Islander children at school entry having greater than 25 dB hearing loss averaged over three frequencies (Indicator 2.3). The Northern Territory screened 95 Indigenous children for hearing loss, in the calendar year 2000, and reported that 18% failed, the proportion ranging from 15% to 80% among communities.

Low birthweight is a risk factor for infant death and ill health in childhood, and is a key predictor of health problems in later life, such as cardiovascular diseases, type 2 diabetes and kidney disease (Barker & Clark 1997). Most jurisdictions were able to report the proportions of low birthweight newborns (that is, weighing less than 2,500 grams) born to Indigenous mothers (Indicator 2.4), and several also provided a comparative figure for babies of non-Indigenous mothers. These comparisons show that, across jurisdictions, 10-14% of babies born to Indigenous mothers weigh less than 2,500 grams at birth, compared to 6-7% of babies born to non-Indigenous mothers. Low birthweight may be a result of premature birth, foetal growth retardation, or a combination of the two (Alberman 1994). Factors influencing a baby's birthweight may include socioeconomic disadvantage, the size and age of the mother, the number of babies previously carried, the mother's poor nutrition or health

status, smoking and other risk behaviours, illness during pregnancy, and the duration of pregnancy.

Hospital use, measured as hospital separation rates, provides an indicator of the relative magnitude between Indigenous and non-Indigenous people in the community of illnesses and medical conditions where symptoms are severe enough to warrant admitted-patient care or treatment. Reports from jurisdictions on the age-standardised hospital separation rate (Indicator 2.6) for all diagnoses and procedures show that Aboriginal and Torres Strait Islander people separate from hospital at approximately twice the rate as non-Indigenous Australians. In the two jurisdictions (Western Australia and South Australia) able to provide a breakdown of elective and emergency treatment and care, the separation rate for elective hospital treatment is up to four times the rate for non-Indigenous people and emergency treatment and care is up to six times the rate.

Age-standardised hospital separation rate for acute myocardial infarction (Indicator 2.6a) was up to four times the separation rate for Indigenous men and up to six times the rate for Indigenous women when compared with the respective non-Indigenous men and women. For injury and poisoning (Indicator 2.6b), the rates were up to three times greater for Indigenous men and up to five times greater for Indigenous women. Separation rates for respiratory diseases (Indicator 2.6c) were up to four times greater for Indigenous men and up to five times greater for Indigenous women, for diabetes (Indicator 2.6d) the rates were up to nine and 14 times greater, respectively, and for tympanoplasty (Indicator 2.6e) up to five and nine times greater, respectively.

Access

There were differing proportions of Aboriginal and Torres Strait Islander people across jurisdictions who had restricted access to primary health care due to the amount of travel distance between services and residences. The indicator for access to primary health care requires that travel between the service and an ordinary residence would take less than 30 minutes (Indicator 3.1) and is not well reported. Instead, jurisdictions have reported against distance between services and places of residence. In Western Australia, 6% of the Indigenous population is reported to live more than 80 km from a primary health care service, whereas in the Northern Territory 39% live more than 50 km from a service. The indicator for access to acute inpatient care measures travel between a service providing continuous availability of medical supervision and an ordinary residence which would take less than 1 hour (Indicator 3.2). Travel time was not able to be reported by jurisdictions and the proxy measure of 100 km distance has been used. Nationally, 30% of the Indigenous population live within 100 km of an acute inpatient service, and only 17% are reported within this distance for the Northern Territory. Access to health services for life-threatening conditions (Indicator 3.4), based on hospital separation rates for acute myocardial infarction and pneumonia, was not reported by jurisdictions due to small numbers of cases and concerns that the indicator is potentially misleading.

Expenditure on health services can provide an understanding of the way health services are delivered and used. Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people (Indicator 3.3) was not reported directly by most jurisdictions, other than for specific Indigenous targeted programs, and where reports were available data quality and data definitions differ across states and territories. The joint report of the Australian Institute of Health and Welfare and the Commonwealth Department of Health and Ageing provides

expenditure by governments on health services delivered to Aboriginal and Torres Strait Islander people for the reporting period 1998-99 (AIHW 2001). The report identified four types of health care (acute care, mental health, residential aged care, and community and public health services) and data were also reported for patient transport, health research and administration costs by jurisdiction.

In 1998-99 governments spent \$1,282 per capita on primary health care for Aboriginal and Torres Strait Islander people compared to \$735 per capita for other Australians, representing \$1.74 spent on Indigenous people for this level of care for every dollar spent on other Australians. For secondary health care delivery \$1,533 per capita was spent on Aboriginal and Torres Strait Islander people and \$1,061 on other Australians (\$1.44 for every dollar, respectively). Overall, an estimated \$1,245 million was spent on health services by, and for, Aboriginal and Torres Strait Islander people, an amount representing 2.6% of the health expenditure for all Australians. Patterns of expenditure from available data indicate clear differences between the Indigenous and other Australian populations in the way that health services are accessed. Greater amounts were spent on Indigenous Australians in relation to community and public health services, patient transport, public hospital care (both admitted and non-admitted patient services), and mental health institutions. Lesser amounts were spent through Medicare, the Pharmaceutical Benefits Scheme, high-level residential aged care and private health services than for other Australians.

Estimation of health resources in communities of less than 100 people (Indicators 3.8 and 3.9) cannot be separately identified by any jurisdiction and the indicators do not necessarily reflect the adequacy of health services.

The proportion of primary care services, and the resources allocated to these services (Indicator 3.5), is intended to measure the extent to which primary health care for Aboriginal and Torres Strait Islander people is community controlled, and the capacity of such services to provide primary health care. The indicator was not reported by many jurisdictions due to its scope, definitional problems and the capacity of systems to separately report against these services. Most of the Commonwealth funding for primary health care services is allocated to Aboriginal community controlled health care organisations. The total number of services managed by incorporated Indigenous organisations has increased since 1999. The Queensland Government participates in the development of models of health service provision that enhance community control and collaboration between government and the community. The Northern Territory policy supports and encourages stronger community involvement and control of health service provision by Indigenous communities, including a strategy to develop incorporated health services at the regional and local levels.

The extent of community participation in health services (Indicator 3.6) and representation of Aboriginal and Torres Strait Islander people on health/hospital boards, and whether membership is mandated by terms of reference (Indicator 3.7) are measures that indicate the level of participation in policy setting and resource allocation for health services, and the management and delivery of those services. Most jurisdictions reported against these indicators although the descriptive information provided was not standardised across jurisdictions and cannot be compared to establish progress over time. There was a range of programs and initiatives constituting community participation in health services. Membership on decision-making forums was not reported by South Australia, Tasmania and the Australian Capital Territory. However New South Wales reported 12 of its 20 health service boards had at least one Indigenous member, Victoria reported membership on five hospital boards, Queensland reported membership on 11 out of 38 district health service councils, Western Australia reported membership on seven out of 39 health service and

hospital boards, and the Northern Territory reported membership on three out of five hospital management boards. Indigenous membership on health service or hospital boards was not mandated in any jurisdiction.

Health service impacts

All jurisdictions provided qualitative information and some expenditure figures on their health promotion programs specifically targeting Aboriginal and Torres Strait Islander people (Indicator 4.1), including areas of nutrition, sexual health, women's health, maternal and child health, family planning, and alcohol and other drug interventions.

Public health initiatives are included in the jurisdictional reports, covering screening and immunisation programs. The proportion of Aboriginal and Torres Strait Islander women aged 18–70 years as a proportion of all Indigenous women in that age group having Pap smears (Indicator 4.2) is an indicator of their access to screening services for cervical cancer. However most jurisdictions were not able to report on the indicator due to the poor coverage of Indigenous identification in their Pap smear registers. Victoria provided information on Pap smears reported by the Victorian Aboriginal Health Service against all other women screened in Victoria. Results showed a consistently higher percentage of Pap smear tests were reported as positive by the Aboriginal Health Service than by other service providers.

For immunisation programs, neither the proportion of Aboriginal and Torres Strait Islander children aged between 2 and 6 years who are fully immunised (Indicator 4.3) nor the proportion of children aged between 2 and 6 years who are fully immunised against hepatitis B (Indicator 4.5), could be reported due to inadequate recording of Indigenous status in the Australian Childhood Immunisation Register. Similarly, no reliable data on pneumococcal vaccination for Aboriginal and Torres Strait Islander people aged older than 50 years (Indicator 4.4) could be reported. This means that evaluation of the National Indigenous Influenza and Pneumococcal Program will not have the advantage of comparing vaccination uptake rates with outcomes identified by morbidity and mortality data. Invasive pneumococcal disease is now notifiable and jurisdictions are working towards accurate recording of vaccination data.

A wide range of programs for the early detection and management of chronic conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension (Indicator 4.6) were reported by New South Wales, Queensland, Western Australia and the Northern Territory. Due to the greater frequency of chronic conditions among Aboriginal and Torres Strait Islander people, there are efforts across jurisdictions to ensure such programs are in place and are actively supported by health authorities.

The proportion of total consultations by condition and by care provider is intended as an indicator of government inputs to primary health care activity (Indicator 4.8). There is a wide variety of primary health care providers, and a lack of agreed national data protocols, which means that comprehensive information about primary care is difficult to collect, and states and territories were not able to report against this indicator. The Commonwealth is able to provide information on episodes of care in Aboriginal Medical Services, but not on the conditions or problems presented by patients. During 1998–99, approximately 30% of patient contacts were with general practitioners, 20% with nurses, 30% with Aboriginal health workers, and 20% with other health workers, such as specialists, dentists and allied health professionals. The Bettering the Evaluation and Care of Health (BEACH) survey has some limitations related to Indigenous identification, but is able to provide information on

conditions managed by general practitioners across the community. For Aboriginal and Torres Strait Islander patients from 1998 to 2000, the top five conditions managed by general practitioners were acute upper respiratory infection, asthma, acute bronchiolitis, hypertension and diabetes, which represented approximately 3–5% of all conditions.

Information on presentations at emergency departments of hospitals (Indicator 4.7) could not be reported by any jurisdiction, although some states and the Northern Territory reported efforts towards improving collection systems, particularly with regard to the completeness of Indigenous identification in the data.

Workforce development

Workforce development indicators describe progress in the availability of Aboriginal and Torres Strait Islander staff who are trained to provide health services. This workforce development is an important factor in the effectiveness of and access to health services for Indigenous people. Workforce development indicators identify the volume of Aboriginal and Torres Strait Islander people who have graduated, are training in key health-related fields (Indicator 5.1) or participating in accredited training programs (Indicator 5.2). As for other indicators, the accuracy of recording Indigenous identification is not known, and data quality and availability limits reporting. However, a number of jurisdictions are able to provide some information on workforce development. The number of enrolments and completions in higher education decreased in 1999 and 2000, however these decreases reflect general decreases across the sector as a whole for these years. The majority of Indigenous students who were enrolled in health-related training (81% in 1999 and 82% in 2000) are taking courses in health support activities, such as administration and counselling, and health sciences and technology, such as nursing, radiography, nutrition and dietetics, optometry and podiatry.

Measuring the number of vacant positions for health professionals in primary health care services and hospitals (Indicators 5.3 and 5.4) that care for large numbers of Aboriginal and Torres Strait Islander people can assist in understanding the gaps existing in the capacity of the health system to provide adequate services for this population group. However, most jurisdictions were unable to provide reports, partly due to the lack of information systems in place to record and report the data for these indicators. Jurisdictions reported that there were no policies or programs in place to ensure a critical mass of Indigenous identified positions in the health sector, and recording the Indigenous status of staff was not well developed (Indicators 5.5 and 5.6). New South Wales was the only jurisdiction with minimum targets for Aboriginal and Torres Strait Islander representation in the health sector workforce. Several jurisdictions have introduced hospital staff cultural awareness guidelines and training (Indicator 5.7). However, jurisdictions noted that cultural awareness training is not a requirement for hospital accreditation.

Risk factors

States and territories have been asked to report against three major determinants of poor health – smoking, overweight and obesity, and harmful alcohol consumption – which have been identified as key risk factors in the health status of Aboriginal and Torres Strait Islander people. Very little new data are available for the current report. New South Wales reported that 41% of Indigenous people aged 16 years and over reported smoking on a daily or occasional basis, but could not report on people aged 13 to 15 years as required by the

indicator (Indicator 6.1). The Northern Territory was the only jurisdiction that reported the proportion of Indigenous people who are overweight or obese (Indicator 6.2). A community survey of Indigenous people, conducted between 1992 and 1997, showed that 16% of men and 22% of women were overweight, with 7% and 17% obese, respectively. New South Wales was the only jurisdiction able to report on hazardous or harmful alcohol consumption (Indicator 6.3). Data collected in 1997-98 indicated that 28% of Indigenous people reported hazardous or harmful rates of alcohol consumption. Previous studies have shown that Indigenous people are more likely than non-Indigenous people to abstain from alcohol, but that those who do drink alcohol are more likely to do so at unsafe levels (AIHW 2000). The Northern Territory could not report against this indicator, but noted that most (95%) admissions to sobering-up shelters in urban and large regional centres are for Indigenous people.

Intersectoral issues

The intersectoral indicators refer to economic conditions that are known to affect health. However, most jurisdictions were not able to report on household poverty (Indicator 7.1) and disruption of essential utilities such as electricity and/or gas, water, and sewerage (Indicator 7.2). Poverty is not appropriately defined for this indicator and does not take account of household size, which is a key factor for Aboriginal and Torres Strait Islander families. The major source of data for the indicator is the 5-yearly Census of Population and Housing, which does not provide information on housing costs. It is widely accepted that all Australians should have access to essential utilities on a continuous basis and the indicator is intended to measure the extent to which there are different levels of access for Indigenous people compared to non-Indigenous people. However, none of the jurisdictions were able to report on this indicator.

Community involvement

Indicators of community involvement are designed to report the extent of representation from Aboriginal and Torres Strait Islander communities in health planning at the state and regional level. Several jurisdictions reported the establishment of forums or other mechanisms for Indigenous participation in the discussion of government health planning, resource allocation, and service delivery (Indicator 8.1). Jurisdictions are also working towards improving the level of Indigenous involvement in the development and implementation of regional planning processes (Indicator 8.2), focused on forums and partnerships established at the regional level.

Quality of service provision

Measuring the quality of health services for Aboriginal and Torres Strait Islander peoples is difficult and only one indicator has been developed for jurisdictional reports. Critical incident reporting and complaints mechanisms at all levels of health services (Indicator 9.1) can be provided by Health Complaints Commissioners and state/territory Ombudsman's Offices. Critical incident reporting is limited by resources and the capacity of states and territories to develop information systems that can capture complex information. Jurisdictional reports indicate that complaints procedures may need to be reviewed in order to provide more culturally appropriate services for Aboriginal and Torres Strait Islander people. In Victoria the employment of an Aboriginal Liaison Officer has increased the use of

the Office of the Health Services Commissioner. The Australian Health Ministers' Advisory Council is committed to the development of cultural security in health service delivery across all jurisdictions, and recognises that policy development aligned to these principles will increase awareness and result in better data quality and reporting.

Introduction

Aim

The aim of this report is to provide a summary of the state, territory and Commonwealth reports against the National Aboriginal and Torres Strait Islander health performance indicators. The 2000 report reflects, in most circumstances, activity in the calendar year 2000 or the financial year 1999–2000 and builds on the foundations of the 1998 and 1999 reports. As in the 1998 and 1999 national summary report, there is some discussion of the data quality issues related to the indicators. Revised indicators endorsed by the Australian Health Ministers' Advisory Council in October 2000 will be provided in the 2001–2002 report.

Scope of the report

This report focuses on indicators that were agreed to by Health Ministers and is not a comprehensive outline of the state of Aboriginal and Torres Strait Islander health. There is a range of documents, particularly the statistical reports published by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW), that provides a more complete picture of Aboriginal and Torres Strait Islander health status.

This report is limited by the availability of relevant data in state, territory and Commonwealth collections. For some indicators it was possible to include other data, from sources such as the ABS. These have been included as supplementary tables in some sections.

The data provided in the state, territory and Commonwealth reports allow for broad reporting at a national level and for limited comparisons between jurisdictions. However, there are problems with data quality for some items, and these have been noted, where appropriate, in the report.

Quality and limitations of the indicators

There is a number of limitations in the health performance indicators reported for 2000. First, it is acknowledged that a number of the indicator definitions require refinement and some of the indicators are not applicable in all jurisdictions. Second, collection and reporting of the indicators varies between the jurisdictions. While all jurisdictions are committed to reporting against the indicators, it is recognised that establishing comparable information systems will take a number of years. A third limitation relates to the appropriateness of the indicators measuring mortality or morbidity, particularly when the number of cases involving Indigenous Australians is quite small. Calculation of the Indigenous to non-Indigenous ratios for these indicators requires the use of indirect standardisation, rather than the more commonly used direct standardisation procedure. However, indirect standardisation has not been used for all indicators provided and this has been noted where relevant.

The indicator definitions do not specify a reference year for the data sources and consequently in some instances there are differing reference periods across jurisdictions for a number of the indicators. Therefore analyses involving comparisons within indicators

should be undertaken cautiously as they are not necessarily comparable measures. While changes are presented over time within jurisdictions, no attempt has been made to present national trends over time.

Reliable reporting of the health indicators depends on the accuracy of specified information related to indicators (for example, in hospital records and disease registers) as well as the accuracy of population estimates. The changing propensity to identify as Indigenous in censuses, together with poor recording of Indigenous status in births and deaths registers, 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 that rate calculations must be treated with caution (ABS & AIHW 2001).

The extent to which the identification of Indigenous people occurs in data collections is referred to as 'coverage' or 'completeness of coverage'. While there is incomplete coverage of Indigenous deaths in all state and territory collections, some jurisdictions (South Australia, Western Australia, the Northern Territory, Queensland) have assessed the quality of data as showing a sufficient level of coverage to enable statistics on Aboriginal and Torres Strait Islander mortality indicators to be produced.

There is also considerable variation across and within jurisdictions in the coverage and completeness of Indigenous identification in hospital records. A study in the Northern Territory estimated that in 1997 there was 94% agreement between hospital records and patient reports, with respect to Indigenous status. The Health Department of Western Australia has undertaken an assessment of its hospital data in which face-to-face interviews were conducted with 10,000 patients with the information collected and compared to the patients' hospital records. However, the health departments in New South Wales, Victoria, Queensland, Tasmania, South Australia and the Australian Capital Territory considered their 1998-99 Indigenous hospital inpatient data to be in need of improvement (AIHW 2000).

Explanatory notes

The states and territories have standardised all age-adjusted rates in the report to the Australian total population from the 1991 Census, except where noted.

Table numbering corresponds to the indicator numbers. Data are not available from states and territories for all indicators, and there are gaps in the numerical sequence of tables. A number of supplementary tables, using data other than those provided by the jurisdictions, have been included in this report and are numbered sequentially, beginning with S1.

Most of the mortality and morbidity indicators in this report (Categories 1 and 2) are *rates* and are therefore calculated by dividing the number of *events* (deaths or hospital separations) by the *population* at risk, multiplied by an appropriate *base* (usually 1,000 or 100,000) for the given rate. The results are then *standardised*, using either direct or indirect methods as noted above, to account for differences in age structure, either between jurisdictions or between different reporting periods.

Note that 'the Commonwealth' refers to the Commonwealth Department of Health and Ageing.

Category one: Life expectancy and mortality

Mortality is an important measure of the health status of a population, in part because early death can be an outcome of poor health status or health risk behaviour. Mortality measures may not be sensitive to subtle changes in health status, and there may be relatively long periods between improvements in health and reductions in mortality. Nevertheless, an analysis of deaths by age, sex and cause still provides a useful indication of the pattern of health in a community.

In 1997-99, there were approximately three times as many deaths as expected for all causes of death, based on all-Australian rates, for both Indigenous males and females. The highest standardised mortality rates for Indigenous males and females were for endocrine and metabolic diseases, where there were seven to nine times more deaths, respectively, than expected. Most of these deaths (88%) were due to diabetes mellitus (Table S1) (ABS & AIHW 2001).

Table S1: Standardised mortality ratios of the Indigenous population for selected causes of death, 1997-99^(a)

Cause of death by major category (ICD-10 codes)	Males	Females
Circulatory diseases (I00-I99)	3.1	2.9
Injury (V01-Y98)	2.8	3.3
Respiratory diseases (J00-J99)	4.1	4.0
Neoplasms (C00-D48)	1.4	1.4
Endocrine, metabolic and nutritional diseases (E00-E99)	7.2	9.4
Digestive diseases (K00-K93)	4.7	4.9
Mental disorders (F00-F99)	2.4	2.3
Infectious and parasitic diseases (A00-B99)	4.2	5.4
Genitourinary diseases (N00-N99)	5.8	7.6
Nervous system diseases (G00-G99)	2.3	1.8
Ill defined	6.0	5.3
All causes (A00-Z99)	2.9	2.9

(a) Data from Queensland, South Australia, Western Australia and the Northern Territory combined. Based on year of registration.

Note: Standardised mortality rate = observed deaths divided by expected deaths, based on all-Australian age-, sex- and cause-specific rates.

Source: ABS & AIHW 2001.

Information on the number of deaths in a particular reporting period is obtained from death registration systems in the states and territories. The number of registered deaths of Indigenous people each year is known to be lower than the number of 'expected' deaths (based on experimental life tables), due to the lack of adequate identification during the registration of Indigenous deaths (ABS & AIHW 1999). As reported in previous years, the level of this under-reporting of deaths varies between jurisdictions, with Queensland, Western Australia, South Australia and the Northern Territory having the highest coverage.

The Australian Capital Territory, New South Wales and Victoria all report working actively with the ABS in activities aimed towards improving the identification of Indigenous deaths. Tasmania reports that the Registrar of Births, Deaths and Marriages is working with funeral directors to improve data collection on Indigenous status from 'third parties' (i.e. doctors, family and friends of the deceased). South Australia is intending to pursue the recording of the Indigenous status of deaths for all South Australian residents irrespective of place of registration, noting that eventually a time series of deaths for Indigenous South Australian residents should become available.

Western Australia and Queensland both note significant delays with recording deaths affects the ability to report in a timely fashion.

Several jurisdictions including Victoria and New South Wales report that substantial improvements in the recording of Indigenous deaths data are required before these two jurisdictions will release data for publications, however New South Wales is anticipating publishable deaths data for 2001. Tasmania has indicated also that publishable deaths data for 2001 will be likely. Correspondingly most of the indicators in this section and shown in the tables below include data for Queensland, Western Australia, South Australia and the Northern Territory only.

Based on 1997-99 death registrations, the three leading causes of death for Indigenous people living in Queensland, South Australia, Western Australia and the Northern Territory were diseases of the circulatory system, deaths due to external causes (predominantly accidents, self-harm and assault) and neoplasms (cancer). Deaths due to these causes accounted for 60% of all identified Indigenous deaths in these jurisdictions. These were also the leading causes of death among the Australian population as a whole accounting for 75% of all deaths. Indigenous males and females had higher death rates, and were more likely to die at much younger ages from these causes, than the general population (ABS & AIHW 2001).

Indicator 1.1: Life expectancy at birth by sex

Life expectancy at birth is a widely used summary measure of health and wellbeing. It is interpreted as the number of years of life a person born in the reference year can expect to live, if they experience the current age-specific death rates. Given the problems experienced in accurately measuring the death rates for the Aboriginal and Torres Strait Islander population, life expectancy indicators are difficult to calculate. Three jurisdictions have attempted these calculations using various methodologies (Table 1.1) with the others reporting that attempts to do so with their data at this stage would not provide meaningful estimates.

Table 1.1: State/territory estimated life expectancy at birth for Indigenous persons, by sex

State/territory	Reporting period	Males, years of life	Females, years of life
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria ^(a)	1999	56.1	65.2
Queensland	n.y.a.	n.y.a.	n.y.a.
Western Australia	1997-99	60.7	67.1
South Australia	..	..	..
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(b)	..	..	..
Northern Territory	1997-98	59.3	64.0

(a) ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census) were registered in 1999.

(b) Indigenous population too small for meaningful calculations.

In 2000, the life expectancy at birth for the Indigenous population was estimated to be 56 years for males and 63 years for females, 19-20 years lower than the comparable figures for the total Australian population for that period (76 years for males and 82 years for females). These estimates exclude Tasmania and the Australian Capital Territory (ABS 2001).

The Australian Capital Territory reported a low number of recorded deaths of Aboriginal and Torres Strait Islander people in the Australian Capital Territory and trend analysis of low average age of deaths is not yet possible. Due to small numbers of Indigenous deaths, any errors, although small in absolute terms, can have significant effects on the data.

Tasmania reported that the under-identification of Aboriginal and Torres Strait Islander status in death registrations was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased).

Queensland reports that further consolidation of deaths data is required before reporting on this indicator.

Indicator 1.2a: Age-standardised all-causes mortality rates by sex

The death rates for Aboriginal and Torres Strait Islander people were higher than those of non-Indigenous Australians. Males have higher death rates than females. Rate ratios presented in Table 1.2a compare the rate of death of the Indigenous population to that of the non-Indigenous population. All the values of these ratios are greater than one, which means death rates were higher for the Indigenous population compared to the non-Indigenous population.

Queensland reports that there can be significant delays in the registration of Indigenous deaths and in future reporting on Indigenous Queenslanders by year of death may provide a more accurate picture.

The Australian Capital Territory reported a low number of recorded deaths of Aboriginal and Torres Strait Islander people in the Australian Capital Territory and trend analysis of low average age of deaths is not yet possible. Due to small numbers of Indigenous deaths, any errors, although small in absolute terms, can have significant effects on the data.

Victoria reported that the ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census population figures) were registered in 1999.

Tasmania reported that there was under-identification of Aboriginal and Torres Strait Islander status in death registrations. This was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased).

South Australia currently only reports deaths of South Australian residents recorded in South Australia. Some deaths in the north of the state may be under-represented, as they could be recorded in the Northern Territory.

Table 1.2a: All-cause age-standardised death rates by sex and state/territory (per 100,000)

State/territory	Reporting period	Males		Females	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
New South Wales		n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria		n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland: (ICD10) ^(a)					
Aboriginal communities	1994-98	1,768		1,477	
Torres Strait Islander communities		n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders ^(b)	1998	1,386	774	1,070	470
Western Australia	1997-99	1,495	680	1,025	508
South Australia	1995-99	1,318	n.p.	975	n.p.
Tasmania		n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)		..	..	..	..
Northern Territory	1997-98	1,909	815	1,485	558

(a) Figures for Aboriginal community data are based on Aboriginal (DOGIT) (deed of grant in trust) communities, the Aurukun and Mornington Island (SLAs) statistical local areas. Torres Strait Islander communities are based on all communities in the Torres SLA.

(b) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous).

(c) Indigenous population too small for meaningful calculations

Note: Rates for the Northern Territory, Western Australia and Queensland are based on direct standardisation.

Indicator 1.2b: Age-specific all-causes mortality rates by sex

In all states and territories for which information is available, male Indigenous rates were higher than the female Indigenous rates (Table 1.2b). The exceptions were for 0-4 year olds in South Australia and the Northern Territory and 65+ in Queensland. The differential in Indigenous and non-Indigenous death rates is greatest between 25 and 64 years of age. In Northern Territory adult males (45-64 years) the Indigenous death rate was more than four times that for non-Indigenous males, while the rates for Indigenous females (45-64 years) are more than six times those for non-Indigenous females.

Queensland reports that there can be significant delays in the registration of Indigenous deaths and in future reporting on Indigenous Queenslanders by year of death may provide a more accurate picture.

Tasmania reported that there was under-identification of Aboriginal and Torres Strait Islander status in death registrations. This was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased.)

The Australian Capital Territory reported a low number of recorded deaths of Aboriginal and Torres Strait Islander people and trend analysis of low average age of deaths is not yet possible. Due to small numbers of Indigenous deaths, any errors, although small in absolute terms, can have significant effects on the data.

South Australia currently only reports deaths of South Australian residents recorded in South Australia. Some deaths in the north of the state may be under represented, as they could be recorded in the Northern Territory.

Victoria reported that the ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census population figures) were registered in 1999.

Table 1.2b: All-cause age-specific death rates (per 100,000) standardised within age groups

State/territory	Reporting period	Males		Females	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
New South Wales	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)					
Aboriginal communities	1994-98				
0-14 yrs		246	(b)	146	(b)
15-24 yrs		784	(b)	232	(b)
25-44 yrs		911	(b)	560	(b)
45-64 yrs		2,757	(b)	1,995	(b)
65+ yrs		6,815	(b)	7,494	(b)
Torres Strait Islander	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders ^(c)	1998				
0-14 yrs		115	71	32	52
15-24 yrs		164	93	15	44
25-44 yrs		370	158	170	70
45-64 yrs		1,293	579	1,173	337
65+ yrs		6,016	4,953	4,889	3,793
South Australia ^(d)	1995-99				
0-4 yrs		220	n.p.	224	n.p.
5-24 yrs		160	n.p.	32	n.p.
25-44 yrs		661	n.p.	332	n.p.
45-64 yrs		2,008	n.p.	1,316	n.p.
65+ yrs		5,783	n.p.	4,167	n.p.
Western Australia ^(e)	1997-99				
0-4 yrs		335	116	284	80
5-24 yrs		153	58	64	20
25-44 yrs		746	129	321	61
45-64 yrs		2,306	461	1,349	273
65+ yrs		6,582	4,642	5,515	3,755
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(e)	..	..	..	..	..
Northern Territory	1997-98				
0-4 yrs		399	145	568	113
5-24 yrs		171	81	115	37
25-44 yrs		858	204	546	76
45-64 yrs		2,730	605	1,999	324
65+ yrs		8,326	4,294	6,857	3,639

- (a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.
- (b) Non-Indigenous persons comprise a very small proportion of the population in Aboriginal communities.
- (c) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous). n.a. not applicable (non-Indigenous persons comprise a very small proportion of the population in Aboriginal communities).
- (d) Age-specific rates were not age adjusted.
- (e) Indigenous population too small for meaningful calculations.

Notes: These data should be used with caution, as the numbers of deaths in the numerators may be quite small and subject to large annual fluctuations. Rates for the Northern Territory are based on direct standardisation and those for Queensland are based on indirect standardisation.

Indicator 1.3a: Age-standardised all-causes mortality rate ratio by sex

Rates for both sexes in the Indigenous population were higher than the corresponding sex-specific rates for the non-Indigenous population (Table 1.3a).

Among Indigenous people in Queensland, in 1998, and Western Australia, in 1997-99, the standardised mortality rate was approximately three times that of non-Indigenous people. In the Northern Territory during the period 1997-98 the standardised mortality rate among Indigenous people was more than twice that of non-Indigenous people.

Victoria reported that the ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census population figures) were registered in 1999.

Queensland reports that there can be significant delays in the registration of Indigenous deaths and in future reporting on Indigenous Queenslanders by year of death may provide a more accurate picture.

Tasmania reported that there was under-identification of Aboriginal and Torres Strait Islander status in death registrations. This was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased.)

The Australian Capital Territory reported low number of recorded deaths of Aboriginal and Torres Strait Islander people and trend analysis of low average age of deaths is not yet possible. Due to small numbers of Indigenous deaths, any errors, although small in absolute terms, can have significant effects on the data.

South Australia currently only reports deaths of South Australian residents recorded in South Australia. Some deaths in the north of the state may be under-represented, as they could be recorded in the Northern Territory.

Table 1.3a: All-cause age-standardised death rate ratios^(a) by sex and state/territory

State/territory	Reporting period	Males	Females
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)			
Aboriginal communities	1994-98	3.5	3.7
Torres Strait Islander communities	n.y.a.	n.y.a.	n.y.a.
All Indigenous Queenslanders	1998	3.0	3.3
Western Australia	1997-99	3.2	3.0
South Australia	1995-99	2.0	1.7
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..
Northern Territory	1997-98	2.3	2.7

(a) The ratio of Indigenous death rates to non-Indigenous death rates. Ratios for the Northern Territory, South Australia and Western Australia are based on direct standardisation and those for Queensland on indirect standardisation; standardisation basis for Western Australia not stated.

(b) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(c) Indigenous population too small for meaningful calculations.

Indicator 1.3b: All-causes age-specific rate ratio by sex

Victoria reported that the ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census population figures) were registered in 1999.

Queensland reports that there can be significant delays in the registration of Indigenous deaths and in future reporting on Indigenous Queenslanders by year of death may provide a more accurate picture.

Tasmania reported that there was under-identification of Aboriginal and Torres Strait Islander status in death registrations. This was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased.)

The Australian Capital Territory reported low number of recorded deaths of Aboriginal and Torres Strait Islander people and trend analysis of low average age of deaths is not yet possible. Due to small numbers of Indigenous deaths, any errors, although small in absolute terms, can have significant effects on the data.

South Australia currently only reports deaths of South Australian residents recorded in South Australia. Some deaths in the north of the state may be under-represented, as they could be recorded in the Northern Territory. Indigenous deaths in the 25-44 age group are more than 4 times that of non-Indigenous people.

In Western Australia, aggregated data for 1997-99 showed that rate ratios were highest among the 25-44 and 45-64 years age groups. Ratios among males were similar to those among females for all ages.

In the Northern Territory the Indigenous death rate ratios indicate that the Indigenous death rates are generally several times that of the non-Indigenous rates at all ages. The 1997-98 data show a high rate ratio for Indigenous females. Indigenous females in the 25-44 years age group are 7.2 times more likely to die than non-Indigenous females. The highest rate ratio for Indigenous males was for the 45-64 years age group, where Indigenous males were 4.5 times more likely to die than non-Indigenous males.

Table 1.3b: All-cause age-specific death rate ratios^(a) by sex and State/territory

State/Territory	Reporting Period	Males	Females
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)			
Aboriginal communities	1994-98		
0-14 yrs		3.3	2.6
15-24 yrs		6.9	5.4
25-44 yrs		5.5	7.7
45-64 yrs		4.6	5.3
65+ yrs		1.5	2.3
Torres Strait Islander communities	n.y.a.	n.y.a.	n.y.a.
All Indigenous Queenslanders	1998		
0-14 yrs		2.2	1.1
15-24 yrs		2.3	1.1
25-44 yrs		2.9	3.3
45-64 yrs		2.7	3.8
65+ yrs		1.5	1.8
Western Australia ^(c)	1997-99		
0-4 yrs		2.9	3.6
5-24 yrs		2.6	3.1
25-44 yrs		5.8	5.2
45-64 yrs		5.0	4.9
65+ yrs		1.4	1.5
South Australia	1995-99		
0-4 yrs		1.7	2.8
5-24 yrs		3.1	1.5
25-44 yrs		4.6	5.0
45-64 yrs		3.5	3.9
65+ yrs		1.1	1.0
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..
Northern Territory	1997-98		
0-4 yrs		2.8	5.0
5-24 yrs		2.1	3.1
25-44 yrs		4.2	7.2
45-64 yrs		4.5	6.2
65+ yrs		1.9	1.9

(a) The ratio of Indigenous death rates to non-Indigenous death rates.

(b) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(c) Age-specific rates were not age adjusted.

(d) Indigenous population too small for meaningful calculations.

Note: Rates for the Northern Territory are based on direct standardisation.

Indicator 1.4: The chance of dying between 20 and 54 years by sex

Indicator 1.4 is designed to capture early adult mortality. As with Indicator 1.1, this indicator is based on values from a life table. Three jurisdictions (Victoria, Western Australia and the Northern Territory) have provided these estimates (Table 1.4).

The figures reported for the Northern Territory indicate that Indigenous males aged 20 years have a 29% chance of dying before reaching 55 years, while for Indigenous females the figure was 18%. For non-Indigenous people in the Northern Territory, the comparable chances of dying were much lower, 6% for males and 2% for females.

Western Australia reported the chances of dying for Indigenous people between ages 20 and 54 years: 29% for males and 16% for females. For non-Indigenous people in Western Australia, the comparable chances of dying were lower, 5% for males and 3% for females.

Victoria reported the chances of dying for Indigenous people between ages 20 and 54 years: 35% for males and 16% for females. For non-Indigenous people in Victoria, the comparable chances of dying were lower, 6% for males and 3% for females.

Victoria reported that the ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census population figures) were registered in 1999.

The Australian Capital Territory reported a low number of recorded deaths of Aboriginal and Torres Strait Islander people and trend analysis of low average age of deaths is not yet possible. Due to small numbers of Indigenous deaths, any errors, although small in absolute terms, can have significant effects on the data.

Tasmania reported that there was under-identification of Aboriginal and Torres Strait Islander status in death registrations. This was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased.)

Table 1.4: Chance of dying between 20 and 54 years of age by sex and state/territory (per cent)^(a)

State/territory	Reporting period	Males	Females
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	1999	35 (6)	16 (3)
Queensland	n.y.a.	n.y.a.	n.y.a.
Western Australia	1997-99	29 (5)	16 (3)
South Australia	n.y.a.	n.y.a.	n.y.a.
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory (b)	..	..	..
Northern Territory	1997-98	29 (6)	18 (2)

(a) Figures in parentheses for Western Australia and the Northern Territory indicate the percentage for the non-Indigenous population. This figure was not supplied for Victoria.

(b) Indigenous population too small for meaningful calculations.

Indicator 1.5: Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1,000 total births to Aboriginal and Torres Strait Islander mothers

The foetal death rate is the number of foetal deaths (or stillbirths) per 1,000 live births in the reference year. A foetal death is defined as the birth of a foetus weighing at least 400 grams (or, where birthweight is unavailable, of at least 20 weeks gestation), which shows no sign of life.

Foetal deaths (along with live births) are recorded as part of the perinatal data (Midwives' Collection) collected in each state and territory. In these collections, the Indigenous status of the mother is recorded, but not the status of the father. Thus it is not possible to report information (including stillbirth) on babies born to Indigenous fathers and non-Indigenous mothers.

Most jurisdictions have aggregated data to present a more consistent picture due to the small numbers involved. Most jurisdictions also report improvements to Indigenous identification in perinatal collections.

Several jurisdictions note the importance of training and education for both Indigenous communities and health professionals to correctly identify Indigenous mothers, and that they are actively pursuing monitoring, evaluation and/or training programs. Victoria particularly notes the need for ongoing training for midwifery staff and the importance of feedback regarding data quality.

Some jurisdiction-specific issues of note are as follows:

- In New South Wales mothers who had stillbirths and were interstate at the time of birth were not captured by the collection. The annual recorded number of stillbirths in New South Wales to Aboriginal mothers is too small to allow comparisons between reporting periods. In addition, an apparent greater propensity by Indigenous mothers to identify may affect results over time.
- The Australian Capital Territory validates all 'not stated' Indigenous status data in the perinatal collection against their hospital morbidity data.
- A 1998 study in Victoria showed that only 52% of the total estimated births by Aboriginal and Torres Strait Islander females in Victoria were correctly identified by midwives as such.
- Western Australia anticipates reliable data from 2002.
- Tasmania anticipates reliable data from 2002. This has been supported by: the training of admissions staff at public and private hospitals; and follow-up on records with missing Indigenous status resulting in an increase of completed records.

The Indigenous stillbirth rate (Table 1.5) was 8.5 per 1,000 total births in Victoria for the period 1997-99. In the Northern Territory during 1999 the Indigenous stillbirth rate was 21.0 per 1,000 total births. The Northern Territory reported a rise in stillbirths in 1999 for both Indigenous and non-Indigenous infants. During 1995-99 the South Australian Indigenous stillbirth rate was 12.9 per 1,000 total births.

In all jurisdictions, Indigenous rates were higher than rates for the non-Indigenous population. In addition, an apparent greater propensity by Indigenous mothers to identify may inaccurately indicate an increase in stillbirths over time.

Table 1.5: Foetal death rate (per 1,000 total births) by Indigenous status of mother by state/territory

State/territory	Reporting period	Indigenous	Non-Indigenous
New South Wales	1999	10.1	6.0
Victoria	1997-99	8.5	7.0
Queensland ^(a)			
Aboriginal communities	1995-98	19	
Torres Straits Islander communities		11	
All Queenslanders	1998	10	7.3
Western Australia	1997-99	14.8	6.2
South Australia	1995-99	12.9	
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory	1994-98	15.5	8.7
Northern Territory	1999	21.0	10.2

(a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

Indigenous foetal deaths per thousand total births in 1996-98 for South Australia, Western Australia and the Northern Territory were more than twice that of non-Indigenous foetal deaths in the respective jurisdictions. The data showed almost twice the rate of Indigenous foetal deaths compared to non-Indigenous foetal deaths for Australia (Table S2).

Table S2: Foetal deaths per 1,000 total births by state/territory of birth and Indigenous status of mother, 1996-98

State/territory	Indigenous	Non-Indigenous
New South Wales	11.5	6.5
Victoria	7.8	7.0
Queensland	12.9	7.0
Western Australia	15.3	6.4
South Australia	19.6	6.7
Tasmania	..	..
Australian Capital Territory	..	..
Northern Territory	14.7	5.0
Australia	13.2	6.8

Source: ABS & AIHW 2001.

Indicator 1.6: Death rate of Aboriginals and Torres Strait Islanders from birth to 1 year of age

Data on infant mortality (deaths of persons under 1 year of age per 1,000 live births) in the Indigenous population are reported by three jurisdictions only – Queensland, Western Australia and the Northern Territory. The other jurisdictions were unable to provide publishable estimates due to the data quality issues previously discussed (that is, poor Indigenous identification in birth and death registrations).

Table 1.6: Death rate from birth to 1 year of age (deaths per 1,000 live births)

State/territory	Reporting period	Indigenous	Non-Indigenous
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)			
Aboriginal communities	1995–98	13	
Torres Strait Islander communities	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1998	13.6	5.5
Western Australia	1997–99	13.3	3.7
South Australia	n.y.a.	n.y.a.	n.y.a.
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(b)	..	..	..
Northern Territory	1999	19.0	7.0

(a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs.

(b) Indigenous population too small for meaningful calculations

Infant mortality among Aboriginal and Torres Strait Islander people in Queensland was 13.6 per 1,000 live births in 1998. In Western Australia, for the period 1997–99, the death rate was 13.3 per 1000 live births. The Western Australian Indigenous infant death rate was more than three times the rate of the non-Indigenous population. The Indigenous infant death rates in Queensland and the Northern Territory were more than twice that of the respective non-Indigenous populations.

The Tasmanian Registrar of Births, Deaths and Marriages has agreed to notify the Perinatal Register of the deaths for children up to age 14, so that the state system will have the capacity to report this information by the time that reporting of Indigenous status is expected to improve.

Indicator 1.7: Age-standardised mortality rates for (a) ischaemic heart disease and rheumatic heart disease; (b) injury and poisoning; (c) pneumonia; (d) diabetes, by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians; (e) and cancer of the cervix among Aboriginal and Torres Strait Islander and non-Indigenous women

A recent ABS–AIHW publication (ABS & AIHW 2001) notes that the three leading causes of death for Indigenous people living in Queensland, South Australia, Western Australia and the Northern Territory combined (based on 1997–99 death registrations) were diseases of the

circulatory system, deaths due to external causes (predominantly accidents, self-harm and assault) and neoplasms (cancer). These three causes accounted for 60% of all Indigenous deaths in the four jurisdictions. The same report comments that, although these same causes were responsible for the majority of deaths in Australia as a whole, Indigenous people had higher death rates and were more likely to die at younger ages from these causes than the general population.

The indicators in this section (Tables 1.7a to 1.7e) report the mortality rates for some of these underlying causes, but because of the death registration problems for Indigenous people, data from only four jurisdictions (Queensland, Western Australia, South Australia and the Northern Territory) are considered adequate for publication. There may also be low numbers of deaths due to specific causes in a given year, so fluctuations in rates from year to year can be expected. To overcome this, some of the rates show average deaths over a 3-4 year period.

Victoria reported that the ABS estimates that only 58% of the expected number of deaths of Aboriginal and Torres Strait Islander people in Victoria (based on the 1996 Census population figures) were registered in 1999.

The Australian Capital Territory reported a low number of recorded deaths of Aboriginal and Torres Strait Islander people and trend analysis of low average age of deaths is not yet possible. Australian Capital Territory deaths audits have found inaccuracies in the recording of Indigenous deaths due to small numbers of Indigenous deaths; any errors, although small in absolute terms, can have significant effects on the data. Training/education have contributed to improvements in the recording of Indigenous status.

Tasmania reported that there was under-identification of Aboriginal and Torres Strait Islander status in death registrations. This was being addressed by the collaboration of the Registrar of Births, Deaths and Marriages with funeral directors and 'third parties' (i.e. doctors, family and friends of the deceased.)

South Australia currently only reports deaths of South Australian residents recorded in South Australia. Some deaths in the north of the state may be under represented, as they could be recorded in the Northern Territory.

Queensland noted three factors that may account for the differences in the data reported in 1999 and 2000: the change from ICD-9 to ICD-10 coding; use of ABS experimental Indigenous population projections in 2000; and the possibility that completeness of Indigenous identification may have fallen. It is estimated by the ABS that only 55% of Indigenous deaths in Queensland were identified correctly.

Indicator 1.7a: Age-standardised mortality rates for ischaemic heart disease and rheumatic heart disease by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians

Across Australia, Indigenous death rates for ischaemic and rheumatic heart disease are higher than those for non-Indigenous people.

In Western Australia, the number of annual deaths is relatively low for rheumatic heart disease compared to deaths from ischaemic heart disease, which was about twice that of non-Indigenous people.

Table 1.7a: Age-standardised death rates for ischaemic heart disease and rheumatic heart disease (per 100,000)

State/territory	Reporting period	Male		Female	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Ischaemic heart disease					
New South Wales	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)	1999				
Aboriginal communities	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Torres Strait Is. communities	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1999	258.0	174.6 ^(b)	200.6	110.9 ^(b)
South Australia	1995-99	308.3	154.8	171.6	127.9
Western Australia	1997-99	346.0	150.0	163.0	88.0
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..	..	..
Northern Territory	1997-98	337.5	144.7	185.7	91.7
Rheumatic heart disease					
New South Wales	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)					
Aboriginal communities	1994-98	0.0		27.0	
Torres Strait Is. communities	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1999	6.1	1.2 ^(b)	25.0	1.8 ^(b)
South Australia	1995-99	1.9	1.2	5.8	2.0
Western Australia	1997-99	10.0	1.0	21.0	1.9
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..	..	..
Northern Territory	1997-98	20.1	0.6	25.6	6.2

(a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(b) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous).

(c) Indigenous population too small for meaningful calculations.

Note: ICD-9 codes used for ischaemic heart disease: 410.0-414.9. ICD-9 codes used for rheumatic heart disease: 393.0-398.9.

Indicator 1.7b: Age-standardised mortality rates for injury and poisoning by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians

In Queensland the three factors noted under Indicator 1.7(a) also affect this indicator.

In the Northern Territory in 1997-98 Indigenous males were 1.4 times more likely than non-Indigenous males to die from injury or poisoning, and Indigenous females were 2.6 times more likely to die from this cause than non-Indigenous females during the same period. Road transport injury (primarily motor vehicle accidents) forms a large proportion of total Indigenous deaths in the Northern Territory from injury or poisoning, especially for Aboriginal and Torres Strait Islander men. Homicide is the second largest contributor to external causes of death for Aboriginal and Torres Strait Islander people in the Northern Territory (Dempsey and Condon 1999 quoted in the Northern Territory report).

1.7b: Age-standardised death rates for injury and poisoning (per 100,000)

State/territory	Reporting Period	Males		Females	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
New South Wales	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)					
Aboriginal communities	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Torres Strait Is. communities	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1999	99.3	67.2 ^(b)	59.1	24.2 ^(b)
South Australia	1995-99	144.0	43.8	44.8	16.9
Western Australia	1997-99	159.0	58.0	58.0	22.0
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..	..	..
Northern Territory	1997-98	166.5	116.6	107.2	40.8

(a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(b) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous). Queensland data are useable with restrictions.

(c) Population too small for meaningful calculations.

Note: Codes used for injury and poisoning: ICD-10 (V01-Y98); Queensland, Western Australia; Not stated: Northern Territory, South Australia.

Indicator 1.7c: Age-standardised mortality rates for pneumonia by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians

Changes to the ABS cause of death coding system from 1997 resulted in the recording of twice as many deaths attributable to pneumonia than previously. Use of ICD-10 in coding of cause of deaths in 1999 resulted in fewer deaths attributed to pneumonia than in 1997 or 1998.

Under ICD-10 some deaths are not coded to the range J12-J18 that would have been coded under ICD-9 into the range 480-486. Thus, numbers of deaths for pneumonia coded using ICD-10 are lower than those for ICD-9 for the same set of death certificates.

In Queensland the three factors noted under Indicator 1.7(a) also affect this indicator. For the Western Australian data it is suggested that no interpretation should be made because of the small absolute numbers, which fluctuate annually. Data supplied by Queensland and Western Australia should be interpreted with caution.

South Australian age-standardised death rates for Indigenous males are three times the rate of non-Indigenous males and for Indigenous females the rate is twice that of non-Indigenous females.

The Northern Territory reported that the mortality rate for 1997/98 was more than seven times higher for Indigenous males than non-Indigenous males, and more than 12 times higher for Indigenous females than non-Indigenous females.

Table 1.7c: Age-standardised death rates for pneumonia (per 100,000)

State/territory	Reporting period	Males		Females	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
New South Wales	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)					
Aboriginal communities		n.y.a.	n.y.a.	n.y.a.	n.y.a.
Torres Strait Is. communities		n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1999	34.2	8.1 ^(a)	0 ^(c)	7.2 ^(a)
South Australia	1995-99	51.8	15.9	43.0	20.9
Western Australia ^(b)	1997-99	67.0	19.0	45.0	16.0
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..	..	..
Northern Territory	1997-98	114.1	15.6	96.8	7.5

(a) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous).

(b) Data are useable with restrictions: Queensland, Western Australia. Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(c) Rounded to zero.

(d) Indigenous population too small for meaningful calculations.

Note: ICD-9 codes used for pneumonia: 480-486 (Queensland: 466.0-466.1, 480.0-486.9, 770.0-770.1; Western Australia: 480.0-487.0).

Indicator 1.7d: Age-standardised mortality rates for diabetes by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians

In Queensland the three factors noted under Indicator 1.7(a) also affect this indicator.

In Western Australia the numbers of deaths due to diabetes was lower among Indigenous males than observed in other jurisdictions. The rate of death among Indigenous females was highest across all jurisdictions and was 13 times higher than among non-Indigenous females over the period 1997-99, whereas for Indigenous males the rate was six times higher than non-Indigenous males for the same period.

South Australia reported that over the period 1995-99 death rates for diabetes for Indigenous men was six times higher than for non-Indigenous men, and more than seven times higher for Indigenous females than non-Indigenous females. The Northern Territory reported that death rates for diabetes as an underlying cause for Indigenous men is eight times higher than for non-Indigenous men, and more than five times higher for Indigenous women than non-Indigenous women. The most direct causes of death from diabetes are renal disease, infections and heart disease. The substantial increase in diabetes in Indigenous communities is attributed to the rapid change in lifestyle and low birthweights (AIHW 1998).

Table 1.7d: Age-standardised death rates from diabetes (per 100,000)

State/territory	Reporting period	Males		Females	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
New South Wales	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)					
Aboriginal communities		n.y.a.	n.y.a.	n.y.a.	n.y.a.
Torres Strait Is. communities		n.y.a.	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1999	143.7	15.0 ^(b)	124.5	12.2 ^(b)
South Australia	1995-99	100.7	15.7	102.9	13.8
Western Australia	1997-99	84.0	14.0	143.0	11.0
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..	..	..
Northern Territory	1997-98	141.6	16.9	103.0	18.4

(a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(b) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous).

(c) Indigenous population too small for meaningful calculations

Note: Data are useable with restrictions: Queensland, Western Australia.

Indicator 1.7e: Age-standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non-Indigenous women

In Queensland the three factors noted under Indicator 1.7(a) also affect this indicator.

In Western Australia deaths due to cancer of the cervix totalled six from 1997-99. It is suggested that no interpretation should be made because of the small absolute numbers, which fluctuate annually.

South Australia reported that over the period 1995-99 death rates due to cancer of the cervix were 4.9 for Indigenous women and 2.2 for non-Indigenous women.

In the Northern Territory, death rates calculated for this cause reflect less than 10 notified deaths per year, and thus can fluctuate widely from year to year. The higher death rate of Indigenous women compared to non-Indigenous women is primarily due to late presentation.

Table 1.7e: Age-standardised death rates from cancer of the cervix (per 100,000)

State/territory	Reporting period	Indigenous females	Non-Indigenous females
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(a)			
Aboriginal communities	n.y.a.	n.y.a.	n.y.a.
Torres Straits Is. communities	n.y.a.	n.y.a.	n.y.a.
All Queenslanders	1999	12.5	2.2 ^(b)
South Australia	1995-99	4.9	2.2
Western Australia	1997-99	14.0	2.6
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..
Northern Territory	1997-98	6.3	3.5

(a) Figures for Aboriginal community data are based on Aboriginal DOGIT communities, the Aurukun and Mornington Island SLAs. Torres Strait Islander communities are based on all communities in the Torres SLA.

(b) Figures for 'All Queenslanders (non-Indigenous)' are for the total population (Indigenous and non-Indigenous).

(c) Indigenous population too small for meaningful calculations.

Note: ICD-9 codes used for cancer of the cervix: 180.0-180.9.

Category two: Morbidity

Morbidity measures form a part of the total picture of the health status of a community. There are a number of measures of morbidity: incidences of a condition (number of new cases in a given time period); prevalence of a condition (number of cases at a particular time); and impact measures such as health service use, for example, hospitalisation.

As with the mortality measures in Category one, the measurement of morbidity also relies on accurate estimates of the numbers at risk in the population. Thus the problems in estimating mortality among Aboriginal and Torres Strait Islander people also occur in estimating morbidity. The numerators in many of the rates used in this section are drawn from sources such as hospital admissions, midwife records, school nurse records, and notifications of communicable diseases. The problems of adequately identifying Indigenous people in these records are similar to those for birth and death registrations mentioned in the previous chapter. The denominator is the Indigenous population, which is also an estimate, as discussed in the Introduction.

The indicators selected for reporting on morbidity include notification rates for a number of communicable diseases (Indicators 2.1 and 2.2), percentage of children with hearing loss (Indicator 2.3), proportion of newborns with low birthweight (Indicator 2.4), and hospital separation rates for a number of diseases and conditions (Indicators 2.5 and 2.6).

Specific comments that the jurisdictions made included the need for pathology requests and notifiable disease forms to record Indigenous status (the Australian Capital Territory, New South Wales), and the role that pathology laboratories (public and private), general practitioners and public health units have in improving identification of notifications. Provision of better demographic information to pathology laboratories was seen as a key issue. Victoria and Tasmania have made recent progress in this area, and Queensland reports undertaking awareness activities with general practitioners. The Australian Capital Territory noted issues of privacy in public reporting with its very small numbers.

Indicator 2.1a: Notification rates for selected vaccine-preventable diseases: pertussis, measles, hepatitis B

As in the previous national summaries, most jurisdictions were unable to report notification rates for the selected vaccine-preventable diseases with New South Wales and South Australia reporting counts only, and noting that there was still a high level of under-reporting of Indigenous status in their notifications data. Western Australia and the Northern Territory reported crude notification rates, which are not standardised by age for the selected vaccine-preventable diseases (Table 2.1a). Western Australia reported the data by sex, while the Northern Territory reported for both sexes combined.

For pertussis (whooping cough), the rates for Indigenous children in Western Australia were double the rates for non-Indigenous children. There were only a small number of measles notifications, so comparisons between Indigenous and non-Indigenous rates cannot be made. Hepatitis B rates among Indigenous people were much higher than for non-Indigenous people. There is difficulty in interpreting trends in hepatitis B, as new notifications of hepatitis B do not necessarily represent recently acquired disease (Table 2.1a).

In Western Australia there were few measles notifications among Aboriginals and Torres Strait Islanders in 1998 (two males). Notification rates of hepatitis B were higher among Indigenous males than Indigenous females as is the case for the non-Indigenous population. Pertussis rates vary over time, as epidemics do not occur every year. The Northern Territory had no Indigenous notifications for measles in the period 1998–2000. Notification rates during 2000 for pertussis were 2 per 100,000 for Indigenous people. In most years the rate is higher in non-Indigenous people. Indigenous people have a higher notification rate than non-Indigenous people. There have been no cases of hepatitis B in persons younger than 20 years, which reflects the success of the universal infant hepatitis B vaccination program. Stringent efforts are now being made to ensure that only acute cases of hepatitis B are notified.

Table 2.1a: Crude notification rates for selected vaccine-preventable diseases (per 100,000)

State/territory	Reporting period	Males		Females		Total population	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Pertussis							
New South Wales ^(a)	..	..	..	..	..	..	..
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
South Australia	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Western Australia	1997–99	60	24	70	29	..	..
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(b)	..	..	..	..	..	..	..
Northern Territory	2000	..	..	..	..	4	3
Measles							
New South Wales ^(a)	..	..	..	..	..	..	..
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
South Australia	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Western Australia	1997–99	2	3	0	3	..	..
Tasmania	..	..	..	..	..	..	..
Australian Capital Territory ^(b)	..	..	..	..	..	..	..
Northern Territory	2000	0	0	0	0	0	0
Hepatitis B							
New South Wales ^(a)	..	..	..	..	..	..	..
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
South Australia	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Western Australia ^(c)	1997–99	121	20	77	8	..	..
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(b)	..	..	..	..	..	..	..
Northern Territory	2000	..	..	..	..	14	1

(a) Notification counts supplied, not rates.

(b) Indigenous population too small for meaningful calculations.

(c) Western Australian data are useable with restrictions.

Indicator 2.1b: Notification rate for meningococcal infection

Issues with the collection of this indicator are similar to those for vaccine-preventable disease notifications, with a high level of under-reporting of Indigenous status.

For Western Australia Indigenous status was unknown for 3% of meningococcal cases although few notifications were recorded among Indigenous people (1997-99: 15 male and 4 female).

Queensland stated that of 93 reported cases in 1999, 6.5% were recorded as being Indigenous. Every case of meningococcal infection is followed up and an attempt to collect Indigenous status is made by each of the Public Health Units. However, there is still a proportion (approximately 13%) of 'unknowns' in the 1999 data.

South Australia reports that Aboriginality is very poorly identified on the disease notification system. During 1998-2000 the meningococcal infection rate was 16.6 per 100,000 persons.

Northern Territory data shows a notification rate for meningococcal infection of 12.6 per 100,000 in the Indigenous population and 2.1 per 100,000 in the non-Indigenous population.

Tasmania has requested that the Communicable Surveillance branch collect data for this item.

Table 2.1b: Crude notification rates (per 100,000) for meningococcal infection

State/territory	Reporting period	Males		Females		Total Population	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
New South Wales ^(a)	..	..	..	..	..	..	..
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
South Australia	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Western Australia ^(b)	1997-99	17	4	5	3		
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	..	..	..	..	..	..	..
Northern Territory	2000	..	..	..	..	13	2

(a) Notification counts supplied, not rates.

(b) Western Australian data are useable with restrictions.

(c) Indigenous population too small for meaningful calculations.

Indicator 2.2: Crude notification rates for gonorrhoea and syphilis by sex

For the two sexually transmitted diseases used as indicators in this report, gonorrhoea and syphilis, the notification rates for the Indigenous population were from 15 to 175 times higher than the non-Indigenous rates (Table 2.2).

Table 2.2: Crude notification rates for gonorrhoea and syphilis (per 100,000)

State/territory	Reporting period	Males		Females	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Gonorrhoea					
New South Wales ^(a)	..	..	..	..	..
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
South Australia	1996–2000	862	n.p.	762	n.p.
Western Australia ^(c)	1997–99	1,487	14	1,242	7
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(b)	..	..	..	..	..
Northern Territory	2000	1,534	103	2,007	47
Syphilis					
New South Wales ^(a)	..	..	..	..	..
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
South Australia	2000	83	n.p.	36	n.p.
Western Australia ^(c)	1997–99	67	4	74	1
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(b)	..	..	..	..	..
Northern Territory	2000	456	14	369	6

(a) Notification counts supplied, nor rates.

(b) Indigenous numbers small, may identify individuals.

(c) Western Australian data are useable with restrictions.

The Northern Territory reported that the notification rate for gonorrhoea among Indigenous men had increased in the three years up to 2000. 'This (increase) is likely to be reflecting a true increase in disease being detected by widespread testing with highly sensitive and more socially acceptable, polymerase chain reaction diagnostic technology.' Notification rates for Indigenous women were 2,007 per 100,000 in 2000.

As for Indicator 2.1(a), the Australian Capital Territory has difficulty reporting notifiable diseases by Indigenous status given that the information is potentially identifying, due to the small numbers involved. Queensland notes that no requirement currently exists for private laboratories to report Indigenous status and that this is unlikely to change in the near future. Victoria reported that the new Infectious Diseases Regulations would cover sexually transmitted disease notifications. South Australia stated that Aboriginality is fairly well identified on the sexually transmitted disease database.

In Western Australia Indigenous status was not recorded in 16% of gonorrhoea cases and 16% of syphilis cases and comparisons must be interpreted with caution. The crude notification rate of gonorrhoea among the Indigenous population remains much higher (over 100 times higher for both Indigenous males and females in Western Australia) than among the non-Indigenous population. The crude notification rate for syphilis was lower than the rate for gonorrhoea, but still much higher in the Aboriginal and Torres Strait Islander population than the non-Indigenous population. Indigenous males had higher rates of gonorrhoea than Indigenous females.

Tasmania has requested that the Communicable Surveillance branch collect data for this item.

Indicator 2.3: Percentage of Aboriginal and Torres Strait Islander children at school entry having greater than 25 dB hearing loss averaged over three frequencies

Hearing loss among Aboriginal and Torres Strait Islander children is widespread. It can be the result of repeated bouts of otitis media, and is thought to be more severe among Indigenous children due to crowded housing conditions and lack of access to primary health care. Hearing loss often leads to increased learning difficulties and behavioural problems in school, adding to existing social disadvantage experienced by Indigenous people.

Jurisdictions reported progress in data collection in the following areas: improvement of the school nurse program information systems to improve the understanding of Indigenous population coverage and accuracy of those identified (Victoria); state-wide piloting of an otitis media strategy (Western Australia); and promotion of Indigenous identification in school-age entry (Tasmania).

The Australian Capital Territory reported there was no data collected available. Queensland stated that this information is not available and there are no long-term strategies to collect these data.

The Northern Territory reports that school entry screening is not widespread. It is mostly performed in the Top End and many communities do not screen. Available data are confined to the percentage of children tested who fail the screening. Many children in the community miss the screen and some children who fail screening have normal hearing. The percentage of children failing screening varies from 80% in some communities to a low of 15% in several communities. Top End figures showed that in 2000, 95 children have been screened with 46% passing, 18% failing and 36% unable to be tested.

Tasmanian enrolment cards are completed by parents or nurses; asking Indigenous status is compulsory, however responding is voluntary. Children whose hearing loss has been detected and who attend the Australian Hearing Service have their Indigenous status collected.

Indicator 2.4: Proportion of Aboriginal and Torres Strait Islander newborns with birthweight less than 2,500 grams

Low birthweight (less than 2,500 grams) is a key predictor of an infant's probability of survival and of future health problems (ABS & AIHW 2001). A contributing cause of low birthweight is poor nutrition or health status of the mother during pregnancy. Birthweight is routinely collected for nearly all births in the midwives' data collections. However, adequate

Indigenous identification of the newborn is still problematic as the data on births are collected according to the Indigenous status of the mother, without regard to the status of the father, and thus excludes an unknown number of Indigenous children. Furthermore, as noted under Indicator 1.5 above, under-identification of Indigenous women in the midwives' data collections may also result in incorrect estimates of the proportion of Indigenous babies with low birthweight.

Most jurisdictions were able to report the proportions of low birthweight infants born to Indigenous mothers, and several also provided a comparative figure for infants of non-Indigenous mothers. These comparisons show that between 7% and 17% of infants born to Indigenous mothers weigh less than 2,500 grams, compared to about 6% of non-Indigenous infants (Table 2.4).

Most jurisdictions also report improvements to Indigenous identification in perinatal collections. Several jurisdictions note the importance of training and education for both Indigenous communities and health professionals to correctly identify Indigenous mothers. Refer to comments within Indicator 1.5.

Western Australia reported that the percentage of low birthweight babies among Indigenous people was more than double that of non-Indigenous people.

Aboriginal and Torres Strait Islander infants in the Northern Territory are 1.8 times as likely to be of low birthweight as non-Indigenous infants. In 1999 12.8% of babies were of low birthweight. The corresponding percentage for non-Indigenous infants was 7.1%.

Tasmania reported that there is significant under reporting of Indigenous status. Data quality issues reduce the reliability and accuracy of the data. The Australian Capital Territory noted that the rate for ACT residents for 1994-98 was 5.2% for Indigenous mothers and 5.3% for non-Indigenous mothers. Reporting is over a 5-year period due to the small annual numbers.

Table 2.4: Proportions (%) of low birthweight (less than 2,500 grams) for live babies by Indigenous status of the mothers by state/territory

State/Territory	Reporting Period	Indigenous	Non-Indigenous
New South Wales	1999	11.7	5.6
Victoria ^(a)	1997-99	12.7	6.2
Queensland:			
Aboriginal communities	1994-98	17.1	n.a.
Torres Strait Is. communities	1994-98	7.3	n.a.
All Queenslanders ^(b)	1997-98	10.4	6.4
South Australia	1995-99	14.0	
Western Australia	1997-99	13.0	5.8
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(c)	1994-98	9.5	6.3
Northern Territory	1999	12.8	7.1

(a) Under reporting of Indigenous status, only 52% correctly identified by midwives.

(b) Figures for Queensland are crude rates.

(c) For births within the Australian Capital Territory, includes births where the mother is not an ACT resident.

Indicator 2.5: Age-standardised all-causes hospital separation rate ratio by sex

A widely used indicator of morbidity status is the level of hospital use, the standard measure of which is the 'separation rate' – the number of hospital separations per 100,000 persons in the population. A hospital separation is defined as an episode of care ending in the patient being discharged, dying, transferring to another hospital or changing type of care (AIHW 2001).¹ Although separation rates are not directly linked with incidence or prevalence measures for diseases and conditions (as not all occurrences of a disease or condition will lead to hospital admission, and an individual may be hospitalised more than once for the same condition in a given time period), they do give some indication of the relative magnitude of some health problems in a community. As with other health data on the Aboriginal and Torres Strait Islander population, under-reporting of Aboriginal and Torres Strait Islander status is an issue for hospital separation statistics in all jurisdictions.² Different standardisation techniques were used by the various jurisdictions in the table below, which limit comparability.

All-cause separation rate ratios, as shown in Table 2.5, were greater than 1.0, indicating that Indigenous people were more likely to be hospitalised than non-Indigenous people.

New South Wales, Victoria, South Australia and Tasmania report that reliable data are not yet available, and in the Australian Capital Territory the magnitude of the data is too small to report.

New South Wales reports that large variations between Area Health Services are unlikely to be due to variations in underlying levels of illness (i.e. underlying demand for admitted-patient services). Separation rates have increased for Indigenous people which are unlikely to be due to an increase in illness and associated demand for admitted patient services, but rather reflect either improvements in the identification of Indigenous people in the morbidity collection, or an increase in the presentation of Indigenous clients previously not treated.

An audit in four Queensland metropolitan and near metropolitan hospitals revealed that 40% of admitted patients who identify as Indigenous are not recorded as Indigenous in hospital records. There continue to be problems with completeness of this data item particularly in the private sector. Victoria also acknowledged under reporting and inconsistency in recording Indigenous status.

All states and territories however report progress against developing information to report this indicator. New South Wales and Victoria reported a number of training and promotional initiatives to improve Indigenous identification including limited use of auditing and an implementation strategy for accreditation of hospitals with respect to their collection of Indigenous status. Accreditation is seen as a key initiative to assist improvement in Indigenous identification in morbidity data. Tasmania reported that hospital admission policies have changed and staff training was planned.

¹ The terms 'hospital admission' or 'hospitalisation' are often used synonymously with 'hospital separation' (discharge), although the latter is the technical term used, because key information about the episode of care (principal diagnosis and principal procedure) is not available at time of admission.

² Queensland reported hospital separations data but advised that the data be used with caution, due to the unknown level of under-reporting of Indigenous status. The data from the discrete Aboriginal and Torres Strait Islander communities also require caution due to a number of data quality issues.

Hospital separation rates from discrete Indigenous communities provide a reasonable proxy measure for Indigenous hospital separation rates in Queensland. However due to data quality issues these methods are not sensitive enough for monitoring hospital separations over time. Best practice in identification was being pursued through staff training. Staff training, cultural awareness and audit tools were being developed to monitor the quality of data on Indigenous status.

The Australian Capital Territory reported that its Department of Health, Housing and Community Cares was working with the Chief Minister's Department and the ACT Regional Office of the Australian Bureau of Statistics to identify, develop and implement measures to improve the capacity of health services in the Australian Capital Territory to identify Aboriginal and Torres Strait Islander persons accessing hospital and other health services. These measures include improvements to hospital admission forms, hospital staff training and orientation, medical record audits and consultations with the Aboriginal and Torres Strait Islander community. In April 2000 staff from both Australian Capital Territory public hospitals received training in Indigenous identification under the auspices of the ABS. The Canberra Hospital has also employed an Aboriginal liaison officer to assist with Aboriginal and Torres Strait Islander person identification. These measures have resulted in an observable increase in Indigenous identification in hospital separation data. Non-hospital health service providers are also taking steps to improve identification and recording of Aboriginal and Torres Strait Islander persons accessing services.

Due to relatively small numbers elective hospital admission rates vary. There was under-enumeration due to coding errors. Separations for care involving dialysis or dialysis catheter care were excluded. During 1999-2000 there was a lower public hospital separation rate for Australian Capital Territory Aboriginals and Torres Strait Islanders (47.96 per 1,000 population) in comparison to all Australian Capital Territory public hospital separations (66.41 per 1,000 population).

Preliminary data from Western Australia on the validation of Indigenous identification indicate 86% accuracy in reporting Aboriginal and Torres Strait Islander patients and 99% accuracy in reporting non-Indigenous patients. Indigenous males were discharged following elective admission at a rate nearly three times higher than non-Indigenous males, and females were discharged at a rate four times that of non-Indigenous females. Indigenous people were discharged following emergency admission at a rate of around six times that of non-Indigenous people.

South Australia reports that available data has been extracted from the ABS deaths database; only deaths of South Australian residents recorded in SA have been used, as these are the only data consistently available over the 5-year period used to base the estimates. It is therefore possible that deaths in the Aboriginal communities in the north of the state may be under represented, since some of these deaths could be expected to be recorded in the Northern Territory. At present Indigenous status is reported for 99.4% of deaths.

In the Northern Territory the hospitalisation rate for both Indigenous men and women fluctuates. The rate for Indigenous men was 31,484 per 100,000 population in 1999. The rate for Indigenous women was 38,934 per 100,000 population in 1999. The hospitalisation rates for Indigenous men and women were approximately twice that of non-Indigenous men and women in 1999.

Table 2.5: All-cause age-standardised hospital separation rate ratios^(a)

State/territory	Reporting period	Elective		Emergency		All	
		Males	Females	Males	Females	Males	Females
New South Wales	1998–99	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Queensland							
Aboriginal communities	1999–2000	n.p.	n.p.	n.p.	n.p.	3.6	3.6
Torres Strait communities	1999–2000	n.p.	n.p.	n.p.	n.p.	1.3	1.6
All Indigenous Queenslanders	1999–2000	n.p.	n.p.	n.p.	n.p.	1.7	1.9
South Australia	1999–2000	1.6	2.1	2.8	3.0	2.1	2.5
Western Australia	1998–1999	2.9	4.2	5.5	6.2	n.p.	n.p.
Tasmania	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory		Indigenous population too small for meaningful calculations					
Northern Territory	1999					1.9	2.1

(a) The ratio of Indigenous to non-Indigenous hospital separation rates. Ratios for New South Wales and the Northern Territory are based on direct standardisation and those for Queensland and Western Australia on indirect standardisation; Northern Territory not stated.

Indicator 2.6: Age-standardised hospital separation rate ratios for (a) acute myocardial infarction; (b) injury and poisoning; (c) respiratory diseases; (d) diabetes; (e) tympanoplasty

Indicators have been agreed for hospitalisations related to specific diseases or conditions, which are prominent among the Indigenous population (Indicators 2.6a–e): acute myocardial infarction (heart attack), injury and poisoning (including motor vehicle accidents), respiratory diseases, diabetes, and tympanoplasty (repair of ruptured ear drum). These indicators are expressed as ratios between the rates for the Indigenous and non-Indigenous populations (see Table 2.6 for Indicators 2.6a–e). Different standardisation techniques were used by the various jurisdictions in the tables below, which limit comparability. New South Wales reported that analysis of hospital separation rate ratios by Area Health Service (administrative geographical regions) within New South Wales indicated a large variation in separation rate ratios for Aboriginal and Torres Strait Islander people, probably due in part to variations in the degree of ascertainment of Indigenous status between hospitals. There were also large variations in Indigenous separation rates within Area Health Services over time, which were unlikely to be due to variations in underlying levels of illness or demand for admitted patient services.

In New South Wales, a number of initiatives were reported to be under way to improve the recording of Indigenous status in the admitted patient data collection, including the provision of training and promotional materials to all public hospitals. In the absence of other information, it is impossible to distinguish whether increases in the recorded separation rates for Indigenous patients are due to an increase in illness or demand for admitted patient services, or whether they are due to improvements in the identification of Aboriginal and Torres Strait Islander people in the admitted patient data collection.

Queensland Health reported that differences between figures reported in 1999 and in 2000 might be due to either the change from ICD-9 to ICD-10 coding or the use of ABS

experimental Indigenous population projections for Queensland in 2000 (which were not available in 1999).

In Victoria, problems with under-reporting and inconsistent reporting of Aboriginality have been recognised. Measures to improve data quality include staff training, audits, the application of principles for recording Aboriginality, and the development of data protocols.

The Australian Capital Territory reported that in 1998-99 and 1999-2000, Aboriginal and Torres Strait Islander separations might be under-enumerated due to coding errors occurring because of a national minimum data dictionary change. Private hospital data on usual area of residence was not sufficiently completed and therefore public hospital data only has been used for these indicators.

Tasmania reported that there is significant under reporting of Indigenous status. Data quality issues reduce the reliability and accuracy of the data. Training for hospital staff to improve data collection was provided.

The identification of Indigenous patients in South Australian data has improved following an enhancement to the Department's case mix payment system. A 30% loading is now applied to separations involving Indigenous patients.

Indicator 2.6a: Age-standardised hospital separation rate ratio for acute myocardial infarction by sex

In Western Australia Aboriginal and Torres Strait Islander males were hospitalised at a rate 3.8 times that of non-Indigenous people, while the separation rate among Indigenous females was 5.9 times higher than that of non-Indigenous females during 1998-99.

The Northern Territory reports that in the last 2 years there has been an increase in hospitalisation rates for both Indigenous men and women. In 1999 the rate for Indigenous men was 321 per 100,000, 2.9 times the rate of non-Indigenous men. The rate for Indigenous women was 2.6 times higher than that for non-Indigenous women.

The Australian Capital Territory reported that in 1999-2000 counts were too small to make analysis meaningful.

Indicator 2.6b: Age-standardised hospital separation rate ratio for injury and poisoning by sex

In Western Australia Aboriginal and Torres Strait Islander people were hospitalised at a higher rate than that of non-Indigenous people. The separation rate ratio among Indigenous females (4.8) was higher than among Indigenous males (3.0) during 1998-99. The Northern Territory reported that only a small proportion of Indigenous people who are injured are subsequently hospitalised. In 1999 the Indigenous male rate was 2.1 times the rate of non-Indigenous. Indigenous female rate was 3.4 times that of non-Indigenous females.

Australian Capital Territory reported that in 1999-2000 the indirect hospital separation rate for Australian Capital Territory Aboriginal males and Torres Strait Islanders (2.65 per 1,000) was lower than for all Australian Capital Territory separations (4.67 per 1,000) for injury and poisoning. This was the reverse of the previous year. Due to the relatively small number of elective hospital admissions some year-to-year variations would be expected.

South Australia reported that the jurisdiction is intending to pursue the supply of deaths for all South Australian residents regardless of where they were registered. Eventually a time

series of deaths for South Australian A residents should become available. The rate ratios are based on South Australian data not Australian data. For the 1995-99 calendar years all ages and all sexes had rate ratios greater than 1. The highest rate ratio was for the age group 25-44 for males (4.64) and for females (5.00).

Indicator 2.6c: Age-standardised hospital separation rate ratio for respiratory diseases by sex

In Western Australia during 1998-99, Aboriginal and Torres Strait Islander males were hospitalised for respiratory illness at 3.8 times the rate of non-Indigenous males. Indigenous females were hospitalised for respiratory illness at 4.6 times the rate of non-Indigenous females.

The Northern Territory reported that the hospitalisation rate for respiratory illness for Indigenous males in 1999 was 5,637 per 100,000, 3.8 times that of non-Indigenous males. In the last 2 years there has been an increase in the hospitalisation of Indigenous males and females. For Indigenous females in 1999, the hospitalisation rate was 4,927 per 100,000, 4.8 times the rate of non-Indigenous females.

The Australian Capital Territory reported that in 1999-2000 the indirect hospital separation rate for ACT Aboriginal and Torres Strait Islanders (0.33 per 1,000) was lower than for all ACT separations (1.89 per 1,000) for respiratory system diseases. Due to the relatively small number of elective hospital admissions some year-to-year variations would be expected.

Indicator 2.6d: Age-standardised hospital separation rate ratio for diabetes by sex

Western Australian Indigenous males were hospitalised with a diagnosis of diabetes at a rate nine times that of non-Indigenous males. The separation rate for diabetes for Indigenous females was 14.1 times that of non-Indigenous females.

In the Northern Territory, the rate of hospitalisation for diabetes for Indigenous males was 4.6 times that of non-Indigenous males. The rate of hospitalisation for diabetes for Indigenous females in 1999 was 5.7 times that of non-Indigenous females.

In South Australia the reported rate ratio in public hospitals for the 1999-2000 financial year for diabetes was 2.7 for males and 5.2 for females.

The Australian Capital Territory reported that the number of separations was too low to make analysis meaningful.

Indicator 2.6e: Age-standardised hospital separation rate ratio for tympanoplasty by sex

Western Australian Indigenous males were hospitalised with a diagnosis of tympanoplasty at 4.1 times the rate of non-Indigenous males. Indigenous females were hospitalised at 8.8 times the rate of non-Indigenous females. In Tasmania data were available but of poor quality. Training was being provided to hospital staff to improve data collection. The effectiveness of the collection will be systematically evaluated.

The Northern Territory reported that the hospitalisation rate for tympanoplasty for Indigenous females was 70 per 100,000 in 1999, which was five times higher than for non-Indigenous females. The rate for Indigenous males was 73 per 100,000 in 1999; this rate was three times that of the non-Indigenous male rate.

South Australia reported the rate ratio in public hospitals for the 1999–2000 financial year for tympanoplasty was 4.7 for males and 7.6 for females.

The Australian Capital Territory reported that the number of separations for tympanoplasty was too low to allow meaningful reporting of age-standardised rates. There were 20 separations for tympanoplasty in 1999–2000.

Table 2.6: Age-standardised hospital separation rate ratios^(a) for selected causes

State/territory	Reporting period	Males	Females
Acute myocardial infarction (ICD-9-CM principal diagnosis code: 410; ICD-10-AM: I21)			
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)	1999–2000	2.4	5.0
Western Australia ^(c)	1998–1999	3.8	5.9
South Australia	1999–2000	1.2	2.0
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..
Northern Territory	1999	2.9	2.6
Injury and poisoning (ICD-9-CM principal external cause code: E800–999; ICD-10-AM: V01–Y98)			
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)	1999–2000	1.6	1.9
South Australia	1999–2000	3.0	3.3
Western Australia ^(c)	1998–1999	3.0	4.8
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..
Northern Territory	1999	2.1	3.4

(continued)

Table 2.6 (continued): Age-standardised hospital separation rate ratios^(a) for selected causes

Respiratory diseases (ICD-9-CM principal diagnosis code: 460–519; ICD-10-AM: J00–J99)			
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)	1999–2000	2.1	2.2
South Australia			
Western Australia ^(c)	1998–1999	3.8	4.6
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..
Northern Territory	1999	3.8	4.8
Diabetes (ICD-9-CM principal diagnosis code: 250; ICD-10-AM: E10–E14)			
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)	1999–2000	6.2	7.1
South Australia	1999–2000	2.7	5.2
Western Australia ^{(c)(e)}	1998–1999	9.0	14.1
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..
Northern Territory	1999	4.6	5.7
Tympanoplasty (ICD-9-CM principal procedure code: 19.4–19.6; ICD-10-AM: blocks 311 & 313, procedure code 41542-00)			
New South Wales	n.y.a.	n.y.a.	n.y.a.
Victoria	n.y.a.	n.y.a.	n.y.a.
Queensland ^(b)	1999–2000	2.7	3.8
South Australia	1999–2000	4.7	7.6
Western Australia ^(c)	1998–1999	4.1	8.8
Tasmania	n.y.a.	n.y.a.	n.y.a.
Australian Capital Territory ^(d)	..	..	..
Northern Territory	1999	3.0	5.0

(a) The ratio of Indigenous to non-Indigenous hospital separation rates. Ratios for New South Wales, South Australia and the Northern Territory are based on direct standardisation and those for Queensland and Western Australia on indirect standardisation.

(b) Queensland used ICD-10-AM codes. Queensland Health indicates that 60–70% of all Indigenous separations were identified in the Queensland Admitted Patient Collection.

(c) Western Australia used ICD-9-CM code E800–995 for injury and poisoning, and 19.5–19.55 for tympanoplasty.

(d) Indigenous population too small for meaningful calculations.

(e) Western Australia diabetes: data useable with restrictions.

Note: ICD-9-CM codes used in South Australia and the Northern Territory not specified.

Category three: Access

Improving the access of Aboriginal and Torres Strait Islander individuals and communities to health services is a goal of all jurisdictions. Access to health services can be defined in a number of ways, and the nine indicators used in this section of the report attempt to cover a variety of these definitions. These include measures of the travel time to services, allocation of resources for services, mixture of services, and Indigenous participation in service management.

The 1998 and 1999 reports were unable to provide data on Indicators 3.1 and 3.2, which involve travel time to primary care service (3.1) or hospital (3.2). In general, jurisdictional collections on travel time to services have not yet been established. In the 2000 report, several jurisdictions reported that no new information on 'distance' from health facilities has been collected since the 1994 National Aboriginal and Torres Strait Islander Survey.

The Victorian report questions whether routine travel and distance to health care services fully reflect whether health care services are appropriate or accessible for Aboriginal or Torres Strait islander people. Both New South Wales and Tasmania suggested that a definition of primary care services is required as an initial data development before information can be adequately reported. New South Wales also suggested that indicators 3.1 and 3.2 might need to be recast to reflect the data available, that is distance rather than travelling time. To this end, the Commonwealth provided information based on distance rather than time.

The Community Housing and Infrastructure Needs Survey (CHINS) provided useful data on access measures. Indicators in this report are not defined in a way that fits with CHINS data items. Data are available from the 1999 CHINS and the 2001 CHINS.

Indicator 3.1: Proportion of Aboriginal and Torres Strait Islander people whose ordinary residence is less than 30 minutes routine travel time from a full-time permanent primary care service by usual means of transport

The indicator is designed to reveal geographical access to primary health care services, and population dispersal relative to primary health care service dispersal. For remote areas, 'routine travel times' differ considerably in wet and dry seasons. The Accessibility and Remoteness Index of Australia gives distance by road to the nearest service.

The Commonwealth report included information, that measures remoteness by distance rather than time (as data on time were unavailable). Data were based on relative remoteness and accessibility indicators provided by the Accessibility and Remoteness Index of Australia. The report indicated that 21.1% of the Aboriginal and Torres Strait Islander population live more than 80 kilometres from a Commonwealth-funded Aboriginal primary health care service. State and territory-funded health services that do not receive Commonwealth funding were not included in this survey.

The Commonwealth notes that the Remote Communities Initiative funded under the 1997 Budget provides additional funding for primary health care for 35 remote locations which previously had few services. The effective utilisation of resources has resulted in this

initiative being extended beyond the original target of 35 locations, with funding now approved for 40 locations.

In the Australian Capital Territory information is estimated on the assumption that all suburbs of the territory are within 30 minutes travel time from a full-time permanent primary care service by usual transport means.

According to data provided by Western Australia, 93.3% of the Indigenous population live within 80 km of the nearest primary health care centre.

In the Northern Territory, 56% of Aboriginal and Torres Strait Islander residents live within 50 km of primary health care services, against 59% nationally. A further 39% of the Indigenous population live more than 50 km from a primary health care service, compared with 69% nationally (ABS 1999).

Indicator 3.2: Proportion of Aboriginal and Torres Strait Islander people whose ordinary residence is less than 1 hour travel time from a hospital that provides acute inpatient care with the continuous availability of medical supervision

Most jurisdictions were unable to report this indicator. Similar to Indicator 3.1, the New South Wales report suggests that indicators based on travel time may need to be redeveloped to reflect the data available, using distance instead. The Victorian report questioned the validity of the indicator and whether routine travel time and distance to health care services fully reflected the appropriateness or accessibility of health services for Indigenous people. Western Australia noted that the development of the Accessibility and Remoteness Index of Australia (to measure distance to service taking into consideration road surface conditions and time of travel) reflects national progress in developing an appropriate classification. Most jurisdictions were unable to report this indicator. In addition, it is noted that almost all the residents of the Australian Capital Territory live in metropolitan areas and within 1 hour's routine travelling time. Tasmania suggested clarification be provided on what is considered routine travel time.

The Northern Territory supported the use of travel time as an appropriate indicator of access to health care in preference to distance, particularly in remote areas where travel may be by boat, by air from islands and isolated communities, or over unmade bush tracks. Unfortunately there are no data available on the actual travel time of people to their nearest health care service. Distance from the nearest service has been used as a proxy measure for this indicator, as data on distance from the nearest service was gained from the 1999 CHINS. Although the majority of Aboriginal people in the Northern Territory live in remote communities, they live in similar proximity to primary health care services (56%) as Aboriginal people throughout Australia (59%). As hospitals are found in regional centres, only 17% of the Indigenous population in the Northern Territory live within 100 km of a hospital compared to 30% of the Indigenous population throughout the rest of Australia.

Indicator 3.3: Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population

This indicator is designed to reflect resource allocation by governments on Aboriginal and Torres Strait Islander people relative to the total population. There are a number of difficulties in reporting on this indicator, including the issue of under-identification of Indigenous people in health databases (such as hospital separations and community clinic records). Some jurisdictions are able to report the amount of funding for programs specifically for Indigenous communities and individuals, while acknowledging that this is not a true measure of 'overall expenditure'.

The 2000 report uses figures for 1998-99 published by the Australian Institute of Health and Welfare (AIHW 2001) for this indicator. Expenditure was estimated separately for the Indigenous and other Australians of each jurisdiction according to four types of health care (acute care, mental health, residential aged care, and community and public health services). Data are also included for patient transport, health research and administration by jurisdiction.

Commonwealth reported expenditure data are survey-based while data from state and territory jurisdictions were generally based on patient services that were identified as Indigenous. As this is known to be variable, adjustments were made for under-identification in hospital data and the estimates were constructed in such a manner as to be consistent with both internal and external usage data in line with cost allocation principles.

Table 3.3: Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population, 1998-99

Aboriginal and Torres Strait Islander status/type of health care	Jurisdiction							
	NSW	Vic ^(a)	Qld	WA	SA	Tas	ACT	NT
Aboriginal and Torres Strait Islander people								
Acute-care institutions	1,197	1,003	1,410	1,929	1,725	1,129	2,090	1,475
Admitted patient services	945	793	1,068	1,516	1,434	836	1,206	1,219
Non-admitted patient services	253	210	342	414	291	294	885	256
Mental health institutions	74	..	74	79	193	..	n.a.	n.a.
High-care residential aged care	12	3	12	84	6	0	..	1
Patient transport	70	40	75	62	55	70	25	216
Community and public health	452	391	424	573	246	417	247	1,332
Health research	11	6	4	4	47	20	..	42
Administration	11	..	15	42	79	8	69	142
Total	1,829	1,444	2,014	2,772	2,350	1,644	2,431	3,208

(continued)

Table 3.3 (continued): Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population, 1998-99

Aboriginal and Torres Strait Islander status/type of health care	Jurisdiction							
	NSW	Vic ^(a)	Qld	WA	SA	Tas	ACT	NT
Non-Indigenous people								
Acute-care institutions	762	654	605	689	691	518	763	714
Admitted patient services	620	517	489	537	552	383	476	561
Non-admitted patient services	142	137	116	152	139	135	286	153
Mental health institutions	32	..	26	60	48	..	n.a.	n.a.
High-care residential aged care	12	9	30	41	25	0	..	0
Patient transport	40	21	35	11	21	32	24	50
Community and public health	147	139	153	102	59	292	124	290
Health research	10	6	4	4	47	12	..	3
Administration	8	..	9	22	44	6	39	81
Total	1,011	828	861	929	935	861	950	1,139

(a) Administration expenditure is reported across functional categories and is not reported separately.
Source: AIHW 2001:60-72.

In 1998-99 governments spent \$1,282 per capita on Indigenous people's primary health care as compared with \$735 for other Australians (a ratio of 1.74:1). Government expenditure on primary health care for Aboriginal and Torres Strait Islander people is similar to that of other Australians in low socioeconomic groups. In 1998-99 governments spent \$1,533 per capita on Indigenous people's secondary health care as compared with \$1,061 for other Australians (a ratio of 1.44:1).

The figures for 1998-99 are greater than the expenditure reported for 1995-96. In the 3-year period between the two reports there has been a real increase in government expenditure of at least 15% for Aboriginal and Torres Strait Islander people, compared with 10% for non-Indigenous people. The ratios reported below have increased from 1.73:1 for primary care in 1995-96, and 1.27:1 for secondary care.

The Commonwealth also noted that care must be taken when comparing the two expenditure reports, as there were differences in both data availability and methodology. However, the 15% real increase quoted above is conservative based on increases that can be substantiated. The actual increase is likely to be somewhat greater.

The Australian Capital Territory reported that a better understanding of estimate requirements led to better methods of data collecting. A departmental data quality committee is now responsible for ensuring accurate recording of data.

In Victoria, information is available only on funding for Indigenous-specific programs and public hospital admitted patient separations identified as Aboriginal or Torres Strait Islander. It is not available for Indigenous use of other mainstream services. Comprehensive data for reporting this indicator are not yet available for Victoria.

The total funding in Victoria of Indigenous-specific programs and identified hospital admissions increased by \$2.6 million (11%) from 1998-99 to 1999-2000. More work on definitions and methodology is required for reporting Indigenous program expenditure.

Queensland reports that a working group is addressing how data quality can best be improved, including audits of hospitals to improve estimates of in-patient and outpatient expenditure. Queensland has been funding the Indigenous population at twice the rate it funds the non-Indigenous population.

In Western Australia data are provided only as gross expenditure, and do not include primary care expenditure. Data quality is not consistent with other jurisdictions either for current reporting or within Western Australia over time. There has been an increase in both Indigenous and non-Indigenous gross expenditure on health on a per capita basis. In 1998-99, Indigenous gross per capita expenditure was estimated at \$2,876.71 and non-Indigenous gross per capita expenditure was \$936.94. Total Indigenous expenditure on health services was \$189 million, being 8.9% of total state health expenditure on health.

Tasmania reports difficulty in assessing expenditure on Aboriginal and Torres Strait Islander people in hospitals in Tasmania as data items are not effectively collected.

The Northern Territory reported during 1999-2000 that health expenditure was approximately \$372 million. Of this amount it was estimated that approximately \$210 million or 57% was attributed to the provision of health services for people who identified as Aboriginal or Torres Strait Islander. During 1999-2000 the provision of health services to Aboriginal and Torres Strait Islander people was estimated at \$3,789 per person (three times the rate for the non-Indigenous population). This amount has decreased slightly from the 1999 report (\$4,013 per person). The decrease was attributed to better identification of Indigenous status rather than a decrease in actual expenditure.

Twenty-eight per cent of the Northern Territory population identify as Indigenous in health service records, and 70% of the Indigenous population live in remote communities. The combination of remoteness, a small dispersed Indigenous population and the high burden of disease among Aboriginal and Torres Strait Islander people in the Northern Territory presents unique challenges in the provision of effective health services and the need for a high level of health expenditure.

Indicator 3.4: Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non-Indigenous people

This indicator attempts to illustrate access to health services for life-threatening conditions by measuring the proportion of hospital separations for sentinel conditions (acute myocardial infarction and pneumonia) that end in death in hospital. Confusion regarding definitional and methodological aspects of this indicator has continued (New South Wales, Tasmania, Queensland), along with difficulties in adequate identification of Indigenous status in hospital records (Victoria), with Queensland commenting that this indicator is potentially misleading.

Indicator 3.5: Proportion of primary health services, and the resources allocated to these services

This indicator is intended to measure the extent to which primary health care for Aboriginal and Torres Strait Islander people is community controlled, and the capacity of such services to provide primary health care. However, most jurisdictions found difficulty in reporting the indicator, due to a lack of clarity in scope and definition and the indicator is not included in the refined set to be reported for 2001. The Commonwealth, Victoria, Tasmania and New

South Wales all requested a more precise, standardised definition of primary health care services, particularly for general practitioners. If redeveloped in the future, specifications need to be clarified for this indicator, which states that 'Health services should be classified into those services managed by (a) incorporated Indigenous health organisations; (b) community councils; (c) state/territory governments'.

Several jurisdictions provided information on the amount of funding to Aboriginal community controlled health organisations, assuming that these mainly provide primary health services, however defined. Others provided descriptive information about the number and geographic distribution of health services targeting Indigenous people, and of the development of community involvement in such services.

Commonwealth information was drawn from the Office for Aboriginal and Torres Strait Islander Health (OATSIH) administrative data systems on funding for Aboriginal primary health care services and Indigenous substance use services. This represented a total of 161 primary health care services for the 1999-2000 financial year. The Commonwealth provides other direct funding for specific strategies to address Indigenous health to organisations/agencies primarily funded by state and territory governments. The Commonwealth envisaged that states and territories would provide reports on these services. The Commonwealth reported that 93% of the funding for primary health care services from OATSIH were provided to Aboriginal health organisations, 3% to state/territory/local governments, and a residual of 4% to other organisations. No funding was provided to community councils. Most of the Commonwealth funding for primary health care services continues to be allocated to Aboriginal community-controlled health care organisations. The total number of services managed by incorporated Indigenous organisations has increased since 1999.

In Victoria there was considerable variation in the staffing and services available as primary care and primary health care across Victoria. There was also wide variation in the staffing and services, which were provided by Aboriginal community controlled health organisations throughout the state. The total public health funding allocated to these services in 1999-2000 includes funding for Home and Community Care. In some instances it was not possible to divide regional funding to agencies by program. It is possible that there is considerable variation in the interpretation of terms such as 'primary health care services' and 'community controlled'.

In Queensland the Commonwealth (OATSIH) directly funds all 26 community-controlled primary health centres and a range of services provided in collaboration with Queensland Health and community-based organisations. Queensland Health provides primary health care services to over 300 community health centres, small rural hospitals, and dedicated facilities as well as outreach and mobile services. Due to the nature of service provision in Queensland, which is demonstrably geographically isolated in parts, there has traditionally been a reliance on the integration of services within mainstream health service infrastructure. This makes identification of resources allocated to primary health care services for Indigenous health difficult. A specific Indigenous finance/expenditure committee has been established to address this difficulty.

Queensland Health develops and coordinates Indigenous health policy initiatives through the Aboriginal and Torres Strait Islander Health Unit, which manages the policy interface across government and sectors (including community-controlled organisations). Queensland Health provides a range of Indigenous health services coordinated through Zonal Principal Indigenous Coordinators and delivered by District Health Service based Indigenous health Teams. Additional specific program resources are provided to the districts and community-

based organisations, both separately and in collaboration, with the specialist backup of Queensland Corporate Units, i.e. Communicable Diseases Unit and Public Health Unit.

Through the partnership (Queensland Health, OATSIH, Aboriginal and Torres Strait Island Commission (ATSIC) and the Queensland Aboriginal and Islander Health Forum, or QAIHF) and the Framework Agreements, Queensland Health participates in the development of a number of models of health service provision that enhance community control and collaboration. Queensland Health retains its existing staff as state government employees with all the entitlements that this entails. Consideration is being given to funding community organisations to purchase services or to employ new staff in community organisations. Ongoing negotiations on new models to enhance community control are under way in the following communities: Yarrabah, Doomadgee, Mornington Island, Normanton, Palm Island, Mt Isa, Cunnamulla, Coen, and Thursday Island (outreach). Cooperation between Community-Controlled Health Services and Queensland Health services is also being enhanced in Townsville, Cairns, Ipswich and Brisbane.

The Australian Capital Territory reported that the Aboriginal primary health care service was funded by the Commonwealth Department of Health and Ageing. The Australian Capital Territory Government funded a drug and alcohol worker at Gugan Gulwan Youth Aboriginal Corporation; a sex education worker at Canberra Rape Crisis Centre; two liaison officers at the Canberra Hospital and two mental health workers.

Tasmania reported that rates of identification in Home and Community Care data appear to be considerably lower than in the community, which may be because Indigenous people use the services less than non-Indigenous people. Funded positions to address Indigenous issues remains the same for 1999. There was a slight increase in HACC funding. Funds were provided to two organisations – South East Tasmanian Aboriginal Corporation and Wyndarra.

Northern Territory reported that the policy of the Department of Health and Community Services is to support and encourage stronger community involvement and control of health service provision by Indigenous communities. One strategy is to develop fully incorporated health services at both a regional level and as individual health services. Visiting staff from regional centres provide many services to each community.

Indicator 3.6: Extent of community participation in health services

This indicator is designed for descriptive rather than quantitative reporting, and there is a range of responses from the jurisdictions. Because it is a descriptive indicator, comparisons over time and between jurisdictions are not appropriate. The New South Wales report suggested that the current indicator was too broadly defined and also that community capacity equates poorly with community participation. It recommended that a tighter definition of community capacity and corresponding indicator might provide a better and more standardised report.

The main points from each jurisdiction are summarised below.

The Commonwealth reports that the 1998–99 Service Activity Reporting questionnaire collected data relating to board membership of Commonwealth-funded Aboriginal primary health care services. For the 1998–99 reporting period 113 Aboriginal primary health care services were asked to provide questionnaire data and 110 responded. Of the respondents, 98% held regular board meetings as outlined in their constitutions and 93% had boards comprised entirely of Aboriginal or Torres Strait Islander members.

In New South Wales Area Health Service Boards include an Aboriginal or Torres Strait Islander person. All Area Health Services consult with Indigenous communities in the development of Area Aboriginal Health Strategic Plans. Consumer and community participation in Area Health Services is a high priority for NSW Health. In 2000, there were 8.18% Aboriginal and Torres Strait Islander representation on Area Health Boards, 1.69% on Statutory Boards and 3.39% on all Government boards and Committees.

There is a high level of commitment in New South Wales to Aboriginal and Torres Strait Islander community participation in the planning and development of health services for Indigenous people. There has been a slight reduction in the percentage of Aboriginal and Torres Strait Islander representation on government and health boards.

The Australian Capital Territory reported that the Aboriginal and Torres Strait Islander Health Forum had representatives from the local Aboriginal Medical Service, the local Aboriginal Youth Corporation, and Aboriginal hospital liaison officers. The Forum was responsible for the production and implementation of the Australian Capital Territory Aboriginal and Torres Strait Islander Regional Health Plan.

Victoria had a partnership approach, which was being undertaken at local, regional and state level. This approach facilitated effective consultation on key health issues in Victoria via the Victorian Aboriginal Community Controlled Health Organisation, the peak body for Aboriginal community controlled health services in Victoria.

In 1998, the Department of Human Services through Aboriginal Affairs Victoria developed the *Koori Services Implementation Strategy (KSIS) – A Five Year Strategic Plan* to improve the health and wellbeing of the Indigenous community. Aboriginal Affairs Victoria was relocated to the Department of Natural Resources and responsibility for the implementation of KSIS was transferred to the Policy Development and Planning Division. This meant that there was no locus of responsibility for KSIS and implementation action ceased temporarily in head office and in most regions.

There was community participation in nine regions, through KSIS reference groups or representative bodies in collaboration with various branches or divisions.

Queensland reports numerous initiatives taking place across the government sector that will have an impact on capacity to participate in health service planning and delivery. Queensland Health has developed a community health planning approach in collaboration with the Department of Health and Ageing, ATSIC, and the Queensland Aboriginal and Islander Health Forum through the Queensland Aboriginal and Torres Strait Islander Health Partnership and the Torres Strait and Northern Peninsula Area Health Partnership. These planning processes involve local Indigenous organisations.

All health service districts in Queensland have a requirement to build partnerships with community controlled health services as stipulated in their service agreements. A number of the Health Service District Councils have appointed Indigenous councillors. Indigenous Health Forums and Health Action Groups have been established in many districts while other districts conduct Aboriginal liaison meetings. Collaborative activities undertaken have involved annual health planning and evaluation, coordinated care, project planning, health worker training and training in primary health care for forum members. Memorandums of understanding with key Indigenous organisations support much of this work. Local Indigenous health workers, recruited from the community, provide interpreter services.

The communities where projects under the Queensland Health Capital Works program have been developed include Mornington Island, Palm Island, Bamaga Hospital, Thursday Island Hospital and Primary Care Centre, Woorabinda and various primary health care centres in

Cape York and Torres Strait. Queensland Health is committed to maximising community participation in these projects, including local employment opportunities. Aboriginal and Torres Strait Islander communities are consulted during the planning and design phase of all projects in Indigenous communities through the Aboriginal and Torres Strait Islander district coordinators or the community controlled health centres.

The Queensland Health Indigenous Workforce Team works in conjunction with government agencies and universities to promote education, training, scholarships, work experience and increased employment for Indigenous people. Advertising and recruitment in Indigenous communities is a feature of the program. Dedicated Indigenous positions have been created in Queensland Health corporate office, the zonal health units and the districts including:

- 27 Aboriginal and Torres Strait Islander liaison officers in hospitals throughout the state
- 150 generalist health workers from Queensland Health and community controlled services received training about sexual health, and
- 58 positions funded by Queensland Health for mental health services targeting the Indigenous community, of which 13 are in community controlled organisations or DOGIT communities.

Western Australia reports extensive community-based and -driven planning processes were undertaken in the six regions of Western Australia in 1999 and incorporated community consultations informed by available local level data. The resulting plans are being used at the regional level to obtain further community input to priority setting and service implementation. Considerable efforts have been made in Western Australia to facilitate community input. No information was available from South Australia.

Tasmania reports that it is unclear to what extent reporting against Aboriginal and Torres Strait Islander participation in community consultation is required. Agencies aim to give the community an opportunity to participate in the policy- and decision-making processes as well as participate in the planning processes.

The Northern Territory reported that a range of approaches was used to increase community participation in health services and the facilitation of skill development in the community. The Tiwi Islands and Katherine West Coordinated Care trials are providing an opportunity for Indigenous people to undergo training and development in health administration and service management. The Tiwi and Katherine West Remote Health Boards are responsible for the financial management and purchase of health services for their respective populations.

A number of other communities in the Northern Territory also have community health boards or committees to advise on the activities of community health centres. One of the objectives of the Aboriginal Communities Health Information Project is to improve the storage of and access to health information about individual Indigenous communities, and the ability of community leaders and organisations to use information about the health status and services in their own community. When fully developed it will provide analysis of existing data sources (hospital morbidity, patient travel, Midwives Collection and chronic disease management systems) and integrate community health centre activity reports into a single summary of health information for each community.

Communities are encouraged to become involved in the operation of their food store through the establishment of store committees. Committees are assisted to develop food and nutrition policies to ensure an affordable supply of nutritious food. Community stores are monitored in regard to cost, availability and quality of food. Monitored information is

provided to the community. Communities are encouraged to implement nutrition programs and some funding is provided to employ local people to work on these programs. Training and support is provided for these local workers. Capacity building is identified as an area of organisational focus as one of the core goals in the latest departmental strategic plan.

Indicator 3.7: Representation of Aboriginal and Torres Strait Islander people on health/hospital boards, and whether membership is mandated by terms of reference

This indicator is designed to capture the extent to which Indigenous people participate in the policy setting and resource allocation for health services, and the management and delivery of those services. The responses indicate different interpretations of 'hospital/health service board', and also different practices in the jurisdiction regarding the collection of such data. No data were available for South Australia.

New South Wales reported that 12 of its 20 health service boards had at least one Indigenous member. This has fallen from 17 in the 1999 reporting period. All 20 boards reported at least one Indigenous member in the 1998 report. While Indigenous membership is not mandated by the relevant legislation, the state government has a commitment to increasing the number of people from minority groups on such boards.

Victoria reported that there is no requirement for hospitals and community health centres to record the Indigenous status of persons appointed to their boards, nor is this information routinely collected. Indigenous membership is not mandatory, however, five hospital boards have Indigenous members. Individual hospital boards no longer exist in the Melbourne metropolitan regions.

Hospital Boards of Management with an Aboriginal member in 1999-2000 were Heywood and District Memorial Hospital, Goulburn Valley Health, Echuca Regional Health Hospital Board, Swan Hill and District Hospital and Mildura Base Hospital.

Queensland Health is divided into three zones with a total of 38 Health Service Districts. Each district has a Health Service Council. All District Health Service Councillors are ministerial appointments and there is no requirement mandated by the terms of reference for Indigenous representation. Nor is there a requirement for District Health Council appointees to indicate Indigenous descent.

The Northern Zone in Queensland comprises 11 districts, of which five presently have Indigenous councillors appointed to the District Health Service Council (Tablelands, Torres Strait, Cape York, Innisfail and Mackay) with one District Council (Torres Strait) totally comprised of Indigenous councillors. Additionally, one district (Cairns) has requested of the minister the appointment of an Indigenous councillor.

The Central Zone in Queensland comprises 15 districts of which four were being re-constituted and the membership was not finalised. Two of these districts (North Burnett and Central West) have traditionally included an Indigenous appointment. Another four districts represent four of the major teaching hospitals in Brisbane and do not have appointed Indigenous councillors. Of the seven districts remaining one (Rockhampton) was known to have an appointed Indigenous councillor.

The Southern Zone in Queensland comprises 12 districts. Of these, three districts (Toowoomba, Roma and Charleville) have an appointed Indigenous councillor. West Moreton District, though presently without an Indigenous councillor, historically has had appointed Indigenous councillors.

In Western Australia, seven out of the state's 39 health service and hospital boards have Aboriginal and Torres Strait Islander representatives which amounts to 11 Aboriginal and Torres Strait Islander board members (3.1%) in a total of 356 positions. These data cover only state health services and do not include Aboriginal medical services.

In the previous reporting year there were 48 Western Australia hospital boards in addition to eight 'Departmental' boards. Of these boards 14.3% included Aboriginal or Torres Strait Islander representatives (a total of eight across all boards). During the 1999-2000 reporting year, there was a reduction in the number of boards (to 39) and a decrease in Aboriginal and Torres Strait Islander representation.

In the Australian Capital Territory, there is Indigenous representation on the Aboriginal and Torres Strait Islander Health Forum and on the Sexual Health and Blood Borne Diseases Advisory Committee.

Tasmania has a state-wide Hospitals and Ambulance Service Board, which has no identified positions for Aboriginal or Torres Strait Islander people. Indigenous status of board and committee members is not routinely collected in this agency however there are plans to identify whether there are targeted Aboriginal and Torres Strait Islander positions on boards or committees.

In August 1999, three of the five public hospitals operating in the Northern Territory had Aboriginal and Torres Strait Islander representatives on their management boards. Indigenous membership of management boards is not mandatory, although it is strongly encouraged. Indigenous members are selected on hospital boards for their knowledge of, and ability to, represent a diverse cross-section of their community. With the other members of the hospital management boards, the Indigenous members are involved in supporting the management of the hospital and in providing advice and supervision on any matters related to hospital operations. The Northern Territory hospital boards have five Indigenous members out of a total of 44 members.

Indicator 3.8: Proportion of communities with usual populations of less than 100 people within 1 hour usual travel time to primary health care services

As with Indicators 3.1 and 3.2, this indicator attempts to measure distance (in terms of travel time) to health services. This particular indicator focuses on this distance factor for small Indigenous communities. Most jurisdictions reported that no data were available to measure this indicator. While mapping of communities versus the location of primary health care services may be possible, the New South Wales report stated there would need to be a clear definition of a primary health care service and more accurate information available on the location and size of the communities. Tasmania also queried the lack of definitions of primary care, usual transport and community.

Several jurisdictions reported that some data sources could be used for this purpose. Victoria reported that all Indigenous communities were within 1 hour's travel time of a primary health care service. In New South Wales the number of discrete Indigenous communities in rural and remote areas ranges from 54 to 76 depending on the data source. In Western Australia a comprehensive Environmental Health Needs Survey in 1997 identified 166 communities of less than 100 people.

The Australian Capital Territory reported that there is no small Aboriginal and/or Torres Strait Islander community with a population of less than 100 within 1 hour's travel time to primary health care services.

Northern Territory-wide information on travel times from small communities to their local service community is not available at the time of reporting. However, data obtained from the Aboriginal Communities Health Information Project in Central Australia found that 86.3% of communities with populations of less than 100 are located within 1 hour's drive of a primary health care service. In this instance, 'primary health care service' is defined as a permanent health centre building with a permanent Aboriginal health worker and a visiting nurse as a minimum. There is a total of 79 outstations and one small community that fall into this category in the Central Australian region. This information does not include independent health centres in Alice Springs or some outstations associated with several communities serviced by Department of Health and Community Services health centres.

Indicator 3.9: Per capita recurrent expenditure by governments on health care services to communities with populations of less than 100 people compared with expenditure for the general population

This indicator examines the amount of health resources expended on small communities compared to expenditure for the whole population. However, comments in the 1998 and 1999 national summary reports that no processes exist to collect the data are still applicable. This performance indicator is not included in the refined set of indicators.

The Commonwealth report noted that there were major difficulties with estimating expenditures on small communities. The indicator did not necessarily reflect the adequacy or otherwise of health services and there was a need to determine a method for estimating resources expended specifically on small communities.

New South Wales noted in particular that there was no accurate information on the location and size of discrete Indigenous communities in New South Wales. The Northern Territory noted that the major limitations on reporting on per capita expenditure in small communities is the availability of accurate population and budget allocation at the community level. The Australian Capital Territory reported that there are no outstations within the Territory. Victoria reported that data are not currently available.

Category four: Health service impacts

The eight indicators included in this category are designed to gauge the 'outputs' of health services aimed at improving the health of Aboriginal and Torres Strait Islander people. The outputs measured range from health promotion expenditure, cervical cancer screening, immunisations, development of protocols for effective management of chronic diseases, accident and emergency activity and primary care activity.

Indicator 4.1: Expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander people

One part of this indicator is the monetary support of jurisdictions for programs to address key risk factors among Aboriginal and Torres Strait Islander people, while the other part is a description of such programs. Some jurisdictions have been able to provide total expenditure on Indigenous health promotion with some descriptive information; others have been able to divide this amount according to specific programs.

The expenditure figures provided are not always consistent with the size of the Indigenous population in each jurisdiction, indicating that 'health promotion activities' may be interpreted differently. In addition, while expenditure details for programs that have been identified as 'health promotion' are considered to be reliable, other programs that are mainly service delivery oriented (and therefore have been excluded from the current expenditure estimate) may also have a 'health promotion' component. The actual expenditure on 'health promotion' may therefore be under-reported.

Commonwealth

The Commonwealth report noted the following comments on an improving capacity to report:

National Child Nutrition Program: Organisations are required to report on project progress and outcomes on a 6-monthly basis. Information from the progress reports will be used to monitor the development and implementation of the projects in order to ensure projects are progressing as set out in the grant agreements and to ensure ongoing grant payments can be made. Information from the final reports will be analysed within the constraints of this type of grants program. Final reports will be used to help identify successful community interventions to improve child nutrition and case studies will be published and promoted with the consent of the relevant organisations. Up to six projects will be approached to participate in an in-depth evaluation focusing on their potential impact on health inequalities. The quality and scope of information provided by organisations varies greatly as a result of the wide range of project types, strategies, contexts and target groups, as well as the capacity of the organisation. Reports provided to the department are confidential and will not be made available unless the full consent of the relevant organisation has been obtained in writing.

National Illicit Drugs Strategy: In July 2000 the National Minimum Data Set for Alcohol and Other Drug Treatment Services was initiated. This data set is coordinated by the Australian Institute of Health and Welfare through the Intergovernmental Committee on Drugs. All

drug and alcohol treatment services funded by the Commonwealth and state and territory governments are required to collect data (against an agreed minimum data set) for each client that accesses the service. These data are reported annually to the Institute in a de-identified format. The first national data report (1999–2000) was presented by the Institute in December 2001. All organisations under the Non-Government Organisation Treatment Grants Program (NGOTGP) are required to provide client data in accordance with the national minimum data set. The data set provides for the self-identification of Indigenous clients.

Australians' Sexual Health Strategy: A mid-term review of the National Indigenous Australians' Sexual Health Strategy implementation was completed in September 2000. It made recommendations in key areas of national leadership in Indigenous Australians' sexual health, including monitoring and evaluation, and building the evidence base.

Jurisdictional reports on expenditure for health promotion programs specifically targeting Aboriginal and Torres Strait Islander people are summarised below.

Indigenous Parenting and Family Wellbeing: The Department of Health and Ageing continues to work in partnership with the Department of Family and Community Services in the ongoing development of the governments parenting and family wellbeing projects in response to the *Bringing Them Home* report. The Commonwealth committed \$5.9 million over 4 years to enhance Indigenous family support and parenting programs.

National Child Nutrition Program: The National Child Nutrition Program is a community grants program to encourage healthy eating patterns for children from prenatal to primary school age. A first round was advertised in early 2000 inviting applications from Indigenous and non-Indigenous community-based organisations. Grants of \$11.5 million to 93 organisations were announced in November 2000. Approximately \$2.5 million was allocated to projects focusing on Aboriginal and Torres Strait Islander children.

Women's health and alternative birthing services: Women's health services are a component of the Population Health Outcome Funding Agreements. In 1999–2000, most states and territories have improved their outreach medical services to women in rural and remote Indigenous communities. This has included improving access to culturally appropriate health care such as community education, general women's health, antenatal and postnatal care, birthing and maternity services. For example, additional Indigenous health workers and midwives have been employed at state and territory primary health clinics and progress has been made in advancing the training, support and coordination of Indigenous health workers.

- The Northern Territory has increased access to female practitioners, and therefore choice, for Indigenous women in the Barkly District by negotiating access to female practitioner services on a fly-in and fly-out basis. The Northern Territory has also developed Indigenous language books with information on antenatal care, health and nutrition in pregnancy, physiological change of pregnancy and labour (*Women's Business – Antenatal Book*) and information on birthing in hospitals, normal birthing, complications of labour/delivery and stillbirth (*Women's Business – Hospital Business Book*). Indigenous health workers and midwives were trained in the use of the books. Other jurisdictions have been investigating issues around outreach medical services for women in custodial settings (the Australian Capital Territory, Tasmania).
- The health of Aboriginal and Torres Strait Islander women is also addressed by hospital-based services such as health promotion, alternative birthing and drug treatment

programs as well as other women's health services. Some states are fostering linkages between services to promote better care for Indigenous women, for example, collaboration between mainstream obstetrics and drug/alcohol services (New South Wales). Other areas are strengthening support and social networks and building self-esteem of at-risk women through activities such as arts projects for Indigenous women, unemployed women and women in socially disadvantaged communities. In the Dubbo region of New South Wales Aboriginal Medical Services and Aboriginal community groups (e.g. Aboriginal Elders group, Gilgandra and Dubbo Aboriginal Women's groups) have been working together on a Stronger Womens project.

- Jurisdictions are working on improving data collection for Aboriginal and Torres Strait Islander women. For example, Victoria is improving the reporting and linkages between their Indigenous data sets (e.g. perinatal data) while Tasmania is working with the Australian Bureau of Statistics to develop and introduce a standard question for identifying Indigenous clients, and to advise about data collection methods. At present in Tasmania, clients are not required to identify their Indigenous status, so it is not possible to quantify the number of Indigenous women accessing health services.

Indigenous women in remote communities: The Jean Hailes Foundation is based in Victoria and its activities include researching the health concerns of Indigenous women living in remote communities, which has involved collaboration with Indigenous leaders in Victoria and Western Australia. Research issues include the prevalence of menstrual disorders and polycystic ovarian syndrome in Aboriginal women and an educational approach to the prevention and management of diabetes among Indigenous women. An education program, called 'You gotta look after yourself', has been developed with Indigenous women in the Kimberly region of Western Australia.

Family Planning: \$14.772 million was made available in 2000-01 to improve the sexual and reproductive health of all Australians. Through specialist non-government organisations, this program provides a range of services including community education, counselling and clinical services and professional training. There was a slight increase in the number of clinical visits to family planning organisations across Australia by Aboriginal and Torres Strait Islander people, increasing from 1.1% in 1997-98 to 1.3% in 1999-2000.

National Illicit Drugs Strategy: In 1999-2000, alcohol and other drug treatment services were provided to a total of 953 Aboriginal and Torres Strait Islander clients. The three NGOTGP projects, which specifically target petrol sniffing, have been slow to progress and outcomes are difficult to measure. This is in part due to the nature of implementing community development projects which require a great deal of ground work within communities before concrete results can be identified.

- In 1999-2000, under the Community Partnerships Initiative (CPI), \$295,466 was provided to projects specifically targeting Aboriginal and Torres Strait Islander people. First-round CPI projects are finishing in 2000-01 and 2001-02. Final reports are expected from these projects. Second-round projects are in their second year of funding and are progressing well. The National Drug Research Institute has been engaged to undertake an evaluation of the CPI program, which will identify outcomes from the program and inform future policy directions.
- In 1999-2000 under the NGOTGP, \$1,659,053 were provided to projects targeting Aboriginal and Torres Strait Islander people.

- Individual treatment, education and research projects relating to illicit drug use by Aboriginal and Torres Strait Islanders are incorporated across the National Illicit Drug Strategy. Such measures include the following projects and programs:
 - 10 projects under the CPI which have an Indigenous component;
 - 18 projects under the NGOTGP, which target Aboriginal and Torres Strait Islanders, include treatment services for heroin users, petrol sniffing projects and a methadone program. One of these projects has been included in an integrated funding agreement between the Population Health and Aged and Community Care Divisions of the Department of Health and Ageing, OATSIH and the Non-Government Organisation in an effort to streamline funding and accountability arrangements for the organisation;
 - a study to assess the attractiveness of new pharmacotherapies to Aboriginal and Torres Strait Islander illicit drug users; and
 - development of a training package(s) to increase the awareness, skills and knowledge of Indigenous health workers in responding to the needs of illicit drug users and those affected by the illicit drug use of significant others.

Sexual health: In 2000–01 the Commonwealth allocated \$8.4 million for Indigenous sexual health to allow for the implementation of the National Indigenous Australians' Sexual Health Strategy. Of this amount, the Commonwealth allocated \$7.5 million to services in states and territories for implementation of the Strategy. Projects funded under the Strategy include education and promotion initiatives both nationally and in each state and territory.

Eye health: State/territory regional eye health plans have been signed off by the partnership and are being implemented nationally (except by Tasmania, its regional plan was expected to be signed by 30 June 2001).

Chronic disease: OATSIH is currently developing a strategic approach to the prevention, early detection and management of chronic diseases in Aboriginal and Torres Strait Islander populations. OATSIH provided \$20,000 in 2000 to the National Heart Foundation for the establishment of a non-government organisation alliance on chronic diseases in Aboriginal and Torres Strait Islander populations.

New South Wales

\$2.7 million was allocated to the Aboriginal Health Promotion Program in 1999–2000. Funding targeted local Indigenous health programs and implementation of the *New South Wales Aboriginal Health Promotion Directions Paper*. Base allocation was the same as previous years.

Australian Capital Territory

Data from the August 1998–99 *Expenditure on Health Services for Aboriginal and Torres Strait Islander People*, showed an increased expenditure by the Australian Capital Territory Government on the provision of Indigenous health. Health promotions expenditure was \$47,168 (website). The report highlighted that expenditure for the Australian Capital Territory Indigenous population was 2.6 times the territory's per capita expenditure on the non-Indigenous population. The reason for the 1998–99 estimates improvement compared to the 1995–96 estimates was due to better understanding of the estimates requirements.

Victoria

A comprehensive definition of the type of programs to be included for this indicator is required if the data are to be comparable across jurisdictions and time.

Departmental funding for Indigenous-specific health promotion initiatives increased to \$3.2 million in 1999–2000, an increase of 25%. Total funding for Indigenous-specific health promotion initiatives was \$3.8 million in 1999–2000, an increase of 19% from 1998–99.

Victoria funded the following health promotion programs specifically targeting Aboriginal and Torres Strait Islander people in 1999–2000:

- Healthy eating \$50,000; mental health \$100,000; physical activity \$88,044; substance misuse \$3,000; tobacco control \$150,000; cross-cultural education \$192,280; Koori health research \$50,523. Total funded through VicHealth: \$613,867.
- Koori Women's and children's program 1999–2000. Total \$140,000.
- The Quit Aboriginal program focuses primarily on smoking cessation and smoking prevention. The Koori program coordinator collaborates with various Koori health and education organisations to raise awareness of health issues relating to smoking, and works closely with these organisations to develop relevant projects. A community grants scheme is offered to Koori organisations interested in running promotions and education programs. Workshops on smoking cessation are also run throughout the year for Koori health workers. A Koori-specific campaign is run each year focusing on various issues. In 2000 the issue was smoking and young people. Total funding for 1999–2000 was \$70,000.
- The Koori community continued to be a key target group for PapScreen Victoria in 1999–2000. PapScreen funded a Koori project officer who is based at the Victorian Aboriginal Health Service to provide a state-wide education and support service which includes individual and group education, a recall system, support for other Koori health workers and support for Koori women requiring follow-up for abnormal smears.

PapScreen and BreastScreen also co-funded a 12-month project shared between the Mildura Aboriginal Corporation and Coomealla Health Aboriginal Corporation. This project ran between December 1999 and December 2000 and aimed to build on previous efforts to increase awareness of PapScreen and BreastScreen amongst Koori women within the broader context of women's health promotion.

A Koori PapScreen brochure was redeveloped and reprinted, together with a Koori poster. These were distributed to community-controlled health services across the state, to complement the Koori flip chart. All PapScreen staff also attended Koori cross-cultural training to enable them to work more effectively with the Koori community. The Koori community is identified as a key target in PapScreen's 2000–2005 strategic plan.

Total PapScreen funding for 1999–2000 was \$85,000.

- Maternal and child health services specifically for the Indigenous community are provided under the Maternal and Child Health New Initiatives Project in Wodonga, Lakes entrance, Ballarat, Swan Hill, Dandenong and Horsham. Funding is also provided to the Victorian Aboriginal Health Service for maternal and child health services. Total funding for 1999–2000 was \$270,000.

- The Koori Community Alcohol and Drug Worker program includes a specific health promotion role. These workers undertake a number of activities based on a harm minimisation approach including health promotion, information provision, education activities, development and maintenance of community linkages, referrals, counselling interventions, the provision of advice to generalist services, liaising with relevant programs and fulfilling an advocacy role on behalf of the service user. Services are provided for both Koori adults and for Koori young people. Total funding for 1999–2000 was \$763,428 plus \$128,557 for youth workers.
- The Koori community alcohol and drug resource centres (formerly known as sobering-up centres) undertake a similar role to Koori alcohol and drug workers, with the additional major function of providing a 'safe place' with 24-hour access for Koori people to reduce their level of alcohol or drug intoxication within an environment of low interpersonal stress and under close supervision. Koori people using these centres are provided with options for after-care support, and short-term accommodation may be provided at the centre to facilitate access to other services. Total funding for 1999–2000 was \$1,157,328. Total Koori Alcohol and Drug Program funding for 1999–2000 was \$2,049,313.
- The Victorian Aboriginal Health Service is funded to employ two state-wide STD/HIV/hepatitis C workers. These staff work in conjunction with the VACCHO Sexual Health Team to provide community education and health promotion about blood-borne viruses and sexually transmitted diseases, and to minimise the transmission and personal and social impact of these conditions. Funding for 1999–2000 was \$100,000.
All other AIDS/STD programs funded by the Department of Human Services are expected to comply with the National HIV/AIDS strategies and to be aware of the specific cultural needs of Aboriginal and Torres Strait Islander people.
- Total funding for other regional programs was \$444,900, including National Youth Suicide Initiative; mental health workers; cardiovascular health promotion; Aboriginal men's health worker and youth suicide prevention.
- All mental health Koori-specific programs have a health promotion element. This is estimated at approximately 25% of expenditure (\$1.7million).
- A dental health project was funded at Murray Valley Aboriginal Health Service in partnership with the Mallee Division of General Practice (\$25,000).

Queensland

The boundary between health promotion and other public health initiatives such as screening is not always clear. The total expenditure for health promotion programs identified as specifically targeting Aboriginal and Torres Strait Islander people for the 1999–2000 financial year was \$1,817,163.

It should be noted that a significant component of public health services' mainstream work incorporates strategies targeting the Aboriginal and Torres Strait Islander population but were not considered to 'specifically target' the population and have therefore been excluded in the information provided.

Western Australia

Health promotion programs are normally directed at high priority health condition areas such as diabetes and cardiovascular health, and their contributing factors such as smoking and nutrition for the total Western Australian population, with tailored component sub-

programs for those population groups particularly at risk. A cost breakdown of the Indigenous components of these broader population programs is not available. Specific data are available for Healthway and the Office of Aboriginal Health.

In 1999-2000 the Office of Aboriginal Health, Health Department of Western Australia purchased population-based health promotion programs to the value of \$1,683,641. Healthway provided funding for \$927,624 for health promotion programs.

Tasmania

Information is not available. An audit of health promotion programs would be required to report any Indigenous-specific programs.

South Australia

Data are not available.

Northern Territory

Growth assessment and action: This program aims to improve the growth of Indigenous children 0-5 years through regular monitoring of growth and early intervention if growth falters. The three components are: growth monitoring of children, growth promotion or growth promoting action, and growth surveillance at 6-monthly intervals.

Community Nutrition Worker Program: Community-based projects include stores projects, skinny/well babies projects and school-based projects in 12 territory communities.

Stores Project: This program promotes the quality, quantity and accessibility of food in remote stores by promoting the development of store nutrition policies and encouraging greater community control of the store through the adoption of a store manager's contract. An annual survey of remote community stores provides information on the cost, quality, variety and availability of foods in remote stores.

Strong Women, Strong Babies, Strong Culture Program: Strong Women workers and grandmothers provide support and traditional, culturally appropriate advice to mothers of children who are not growing well and to young pregnant women. They also encourage attendance for care at the health centre. Programs have been established in six communities in the Top End and four communities in Central Australia.

Alcohol and Other Drugs Program: Dedicated alcohol and other drug community support officers, including tobacco action project officers provide alcohol and other drug community development expertise. Workers support community-driven initiatives, help implement alcohol and other drug policies, as well as provide a range of brief interventions, social marketing and promotional activities. Brokerage funding, community grants and health promoting school grants are available to support these activities. Workshops, specifically designed for Aboriginal community based workers from remote communities, are funded annually. They provide information, peer support, networking and professional development opportunities.

Resources and information educative resources developed in consultation with Indigenous people include a graphic-based cannabis resource kit and an alcohol and other drug and pregnancy flipchart. Locally developed resources for smoking cessation have been purchased and widely distributed. Training has also been made available.

Indicator 4.2: Number of Pap smears among Aboriginal and Torres Strait Islander females aged 18–70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group

The proportion of Indigenous adult females having Pap smears is an indicator of their access to screening services for cervical cancer. Most jurisdictions stated that it was not possible to report on this indicator because of the lack of Indigenous identification in their Pap smear registers.

New South Wales reported that a number of initiatives have been introduced to increase the number of Indigenous women having Pap smears. While no data were available for New South Wales on the number of Aboriginal and Torres Strait Islander women screened, it would be expected that the screening rates would be below the average screening rate for women aged 18–70 years. The capacity to report against this indicator is unlikely to improve as general practitioners and pathology laboratories do not record Indigenous status when undertaking Pap smears.

Aboriginal and Torres Strait Islander women are one of the key target groups for the New South Wales Cervical Screening Program. A research project identifying Aboriginal and Torres Strait Islander women's cervical screening patterns and barriers to screening is under way.

In Victoria no data are available as there is no Indigenous identifier in either the Victorian cervical cytology register or on pathology request forms. PapScreen Victoria targeted Indigenous women in its 1996–99 plan; education sessions were funded which aimed to increase screening rates among Indigenous women. Trend analysis of the period 1994–98, comparing women screened at the Victorian Aboriginal Health Service against all other women screened in Victoria, showed that a consistently higher percentage of Pap tests were reported as positive by the Service than in the general population.

Queensland Health reports that one pathology service includes the Indigenous identifier on its pathology request forms. Currently 98.5% of data held on the Pap Smear Register do not supply information about Indigenous status. Measures to improve data quality include training for health service providers to ask clients about Indigenous status in an appropriate way; encouraging Indigenous women to self-identify at the time of having a Pap smear, and the inclusion of Indigenous identifiers on all pathology request forms.

In the Northern Territory, as Indigenous identification is not recorded on all pathology forms, it is difficult to report on this indicator. However, given that the population in rural/remote areas is predominantly Indigenous, regional analysis of participation gives an indication of coverage of Indigenous women. Approximately two-thirds of Indigenous women live in rural areas. Rural areas as a proportion of female population (aged 20–69 years) tend to have lower coverage than the same age group in urban areas. Screening rates vary from a low of 38% in the Barkly region to 72% in the Alice Springs (remote) region, with a Territory average rate of 65%.

Tasmania reported that data are not available as general practitioners do not report Indigenous status to the cytology (i.e. Pap smear) register.

South Australia reported that there is no Indigenous identifier. There are programs but no reliable data.

Indicator 4.3: Proportion of Aboriginal and Torres Strait Islander children aged 2 years and 6 years that are fully immunised as recorded in the Australian Childhood Immunisation Register

The Australian Childhood Immunisation Register (ACIR) commenced in January 1996, and contains immunisation status of all children aged 0-6 years in each jurisdiction. However Indigenous status is not a mandatory data item in this collection, and therefore it is not possible for jurisdictions to report against this indicator using the ACIR in a meaningful way. In addition, information on fully immunised children at age 6 years will not be available from the ACIR until 2002 (6 years after the date of commencement).

The Health Insurance Commission has established a designated liaison officer to manage and improve data quality for Indigenous children. Increased reporting of Indigenous status is expected with the introduction of the Commonwealth national pneumococcal program which commenced in mid-2001, and as state health departments undertake the role of encouraging capture of this data.

The New South Wales Aboriginal Partnership has recently agreed to the release of aggregated data, which will allow local Area Health Services to develop more targeted strategies to improve immunisation uptake.

The Australian Capital Territory immunisation record form now collects information regarding Indigenous status. The Australian Capital Territory Immunisation Register has also been amended to record this information and details are supplied to the ACIR. Progress has been made in some States/Territories in relation to the release of de-identified immunisation data on Aboriginal and Torres Strait Islander children. The Australian Capital Territory reported liaison activities with relevant organisations and representatives from the local Indigenous community during 2001 in an effort to reach an agreement about release of these data from the ACIR for local purposes.

Victoria notes that some Aboriginal community-controlled health services do not provide reports to ACIR.

Queensland reported that under-identification in both data sources exists. Furthermore, the perinatal numbers exclude those infants whose mother is non-Indigenous and father is Indigenous. There is no readily available information on children aged 6 years of age; 76.6% of 2 year olds were reported as fully immunised.

Ongoing awareness activities have been put in place to encourage service providers to record Indigenous status. A brochure targeting general practitioners, informing them of the importance of recording Indigenous status, has been produced and distributed.

The Northern Territory reported that doses are assessed for validity according to the ACIR due and overdue rules. Estimates of immunisation coverage for Northern Territory children tend to be more accurate in the Northern Territory Childhood Immunisation Database than the ACIR. The Northern Territory Database is unable to report on immunisation rates for Indigenous children, as this is precluded by the contracts for immunisation data reporting between the Department of Health and Community Services and some of Aboriginal Medical Services. However, the population of remote areas tends to be primarily Indigenous, therefore rates in those areas are good indicators of Indigenous children's immunisation rates. Under-reporting of immunisation is a problem for both the Northern Territory database and the ACIR. Additionally, children who move interstate before completion of their immunisations will be retained on the Northern Territory database as under-

immunised even though they complete elsewhere. Agreement is being sought with the Aboriginal Medical Services Alliance Northern Territory to transmit data on the Indigenous status of Northern Territory children aged 0 to 7 years to the ACIR. This would allow a more accurate ACIR assessment of the immunisation coverage of Indigenous children in the Northern Territory, which could be compared to the coverage rate estimated by the Northern Territory Database.

Indicator 4.4: Proportion of Aboriginal and Torres Strait Islander people aged older than 50 years who have received pneumococcal vaccine in the last 6 years

At present, there is no national register of pneumococcal immunisation although discussions are occurring. These vaccines are provided mainly to persons age 50 years and over in high-risk populations, including Indigenous persons, in an effort to prevent pneumonia morbidity and mortality. The National Indigenous Influenza and Pneumococcal Program began in 1999. Under this program, Commonwealth funds were provided to states and territories for the purchase of influenza and pneumococcal vaccines for Aboriginal and Torres Strait Islander people who are over 50 years and those 15-50 years who are at high risk of disease. The states and territories were asked to provide reports of coverage rates, but most were unable to do this.

The program is under evaluation. As of January 2000, invasive pneumococcal disease is now notifiable. The Department of Health and Ageing is collaborating with stakeholders to improve identification of Aboriginal and Torres Strait Islander people and the recording of vaccination data. Funding is calculated by the level of vaccination coverage during the previous year of the program for each state and territory and the vaccine price.

New South Wales reported a number of measures are being taken to improve the accountability and reporting on the program including:

- centralising the distribution of vaccines
- working with the Alliance of Divisions of General Practice to introduce an audit of vaccines each year
- developing a vaccine wastage reporting system.

New South Wales Health is currently evaluating the process of data collection for this program.

In the Australian Capital Territory in 1999, a total of 32 doses of pneumococcal vaccine were recorded as being administered to Aboriginal and Torres Strait Islander people aged 50 years and over. In 2000 only 14 people from the target group were reported as having received pneumococcal vaccine. The data collection sheet is not always completed by providers and pneumococcal vaccine is unaccounted for at the end of the program, indicating that people from the target group have been immunised but their details not provided, or the vaccine was administered to people outside of the target group. In addition it is important to note that this vaccine is recommended every 5 years and not annually (as with influenza vaccine), contributing to differing uptake rates each year. For Queensland a single year (2000) of data has been provided, indicating coverage of 7.5% of Indigenous people over 50 years. Given that Indigenous people over the age of 50 years are a target group for this vaccination, identification rates were good. However, the usual caveats for Indigenous data should be applied for the population data used in the denominator.

Ongoing awareness activities in the Northern Territory have been put in place to encourage service providers to record Indigenous status. A brochure targeting general practitioners, informing them of the importance of recording Indigenous status, has been produced and distributed.

The Northern Territory reported a discrepancy between the number of vaccines distributed and the number of vaccinations reported to the register, suggesting significant under-reporting. In 1999 pneumococcal vaccination coverage of Northern Territory Aboriginal and Torres Strait Islander people aged 50 years and older was reported to be 77%. The 1999 figure did not include data for East Arnhem. Although East Arnhem data are included in this report, older data from that region are incomplete. The resultant lower vaccination rate in 2000 (69%) is most likely due to low reporting of vaccinations to the register.

Improvements in the management of the Pneumococcal Vaccination Register allowing feedback of data to vaccine service providers should encourage reporting of vaccinations to the register resulting in a more accurate estimate of pneumococcal vaccination coverage.

Victoria reports that data are not currently available, as collection relies on self-reporting from doctors, who return data for approximately 50% of cases. An Aboriginality field is available but not used.

Data are not currently available for Western Australia, South Australia or Tasmania.

Indicator 4.5: Proportion of children aged between 2 and 6 years who are fully immunised against hepatitis B, as recorded in the Australian Childhood Immunisation Register

Hepatitis B vaccine is not yet included in the definition of 'fully immunised' for children, and thus is not covered by Indicator 4.3. The National Health and Medical Research Council endorsed the use of hepatitis B vaccine for infants in 1997, and recommended that it be offered to infants from groups with a carrier rate of over 2%, which includes Indigenous persons.

As discussed above under Indicator 4.3, the ACIR is a data source for use in reporting childhood immunisation coverage. However it is not possible for jurisdictions to report hepatitis B immunisation coverage for Indigenous children for the same reasons mentioned above under Indicator 4.3: lack of Indigenous identification in some immunisation records; restrictions on release of data from ACIR to the jurisdictions; and lack of compliance with reporting by some providers.

The New South Wales Aboriginal Partnership has recently agreed to the release of aggregated data, which will allow local Area Health Services to develop more targeted strategies to improve immunisation uptake in this susceptible population.

Data are not currently available for Victoria, the Australian Capital Territory, Western Australia, South Australia or Tasmania.

Queensland reported that under-identification in both data sources exists. Furthermore, the perinatal numbers exclude those infants whose mother is non-Indigenous and father is Indigenous. Queensland was able to provide 1998 data, which indicated that 81% of 2 year olds were fully immunised against hepatitis B, as recorded in the ACIR. There was no data available for 6 year olds.

In the Northern Territory, immunisation coverage data from the ACIR based on Indigenous status are not accurate due to poor identification of Aboriginal and Torres Strait Islander

children on the ACIR. The Northern Territory Childhood Immunisation Database is prohibited by contract agreement between the Department of Health and Community Services and some Aboriginal Medical Services to report Indigenous status. However, the population of remote areas tends to be primarily Indigenous, therefore rates in those areas are good indicators of Indigenous children's hepatitis B vaccination rates. For children aged 24–30 months the Northern Territory estimate is 95% fully immunised and 93% for children aged 72–80 months. Urban immunisation rates for Indigenous children are not included in these rates.

To improve the reporting of immunisations of Aboriginal and Torres Strait Islander children agreement is being sought with the Aboriginal Medical Services Alliance Northern Territory to report Indigenous status of Northern Territory children aged 0–7 years to the ACIR.

Indicator 4.6: Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension

Early detection and management of chronic conditions is a recognised component of health care systems. Due to the greater frequency of chronic conditions among Aboriginal and Torres Strait Islander communities, there is an imperative to ensure such programs are in place and are actively supported by the relevant authorities.

Commonwealth

Cardiovascular disease: The Department of Health and Ageing has agreed to provide up to \$250,000 on a matched basis to the National Heart Foundation for strategic research for the study of cardiovascular disease and related disorders in rural and remote populations and Aboriginal and Torres Strait Islander people. Successful research projects were to be announced in 2001.

Otitis media: Approximately \$195,000 has been allocated in 2000–01* for the publication and implementation of *Recommendations for Clinical Care Guidelines for the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations* and a package of supporting information. The recommendations are based on the Systematic Review of Existing Evidence and Clinical Guidelines conducted by National Aboriginal Community Controlled Health Organisation. The package, which includes the systematic review, will be made available to primary health care providers as a means of promoting greater consistency in the management of otitis media by primary health care providers. A substantial implementation strategy is planned.

Hearing health: The Department of Health and Ageing is undertaking a review of hearing health services provided to Aboriginal and Torres Strait Islander people under two Commonwealth-funded programs: the National Aboriginal and Torres Strait Islander Hearing Strategy; and the Commonwealth Hearing Services Program. The review commenced in September 2000 and the final report is due in June 2001.

Hearing, health and education: OATSIH is providing support for the development of the National Indigenous English Literacy and Numeracy Strategy 2000–2004, a Department of Education, Training and Youth Affairs initiative launched by the Prime Minister on 26 March 2000. This initiative aims to improve the educational outcomes of Aboriginal and Torres Strait Islander children and focuses in particular on specific health issues such as hearing and nutrition that can affect educational achievement.

Eye health: In support of the regional strategy (see Indicator 4.1), over \$4.3 million was provided nationally in 1999–2000 for equipment, coordinators, training and guidelines, and to facilitate greater access to eye health services in identified Aboriginal community controlled health services. This includes approximately \$30,000 for the development of Eye Care Guidelines for Specialists, covering cataracts, diabetic retinopathy and trachoma in Aboriginal and Torres Strait Islander patients. This will be available in mid-2001.

Dermatology: OATSIH agreed to provide \$60,000 to the Australian Dermatology Research and Education Foundation towards the costs of editing and publishing *A Handbook of Skin Conditions in Aboriginal Populations of Australia*. The handbook will be available in 2001.

Diabetes management: The pilot of diabetic monitoring equipment in Aboriginal community controlled health services was completed in December 2000. A rebate for the HbA1c test using the DCA2000 in this setting came into effect on 1 December 2000 and provides funding towards the costs incurred in conducting the tests. Usage of this rebate is being monitored, and results will inform future policy.

OATSIH has provided \$614,000 since 1998–99 (around \$225,000 in 2000) for a diabetes medical specialist to work as part of a diabetes team in the Torres Strait.

OATSIH continued to fund an Indigenous diabetes and nutrition coordinator position based with the National Aboriginal Community Controlled Health Organisation in 2000 (funding commenced in 1999, at a cost of \$120,000).

Renal disease: Two projects on early detection and treatment programs:

- A further \$300,000 per annum for 3 years from 2000 (following a grant of \$600,000 in 1999–2000) was provided to the Australian Kidney Foundation to assist health care providers to develop appropriate strategies to effectively address early detection, management and treatment of renal disease in four Indigenous communities. To date, the effort has been concentrated in three Northern Territory communities: Nauiyu Nambiyu (Daly River), Borroloola, and Wadeye (Port Keats).
- In 2000 a second grant of \$233,000 was provided to Flinders Medical Centre (South Australia) to complete the kidney project screening Aboriginal and Torres Strait Islander people in the Umoona community and to take the program into a long-term maintenance and support phase while handing it over to the community as self-sustainable. A survey undertaken as part of the final report indicated that participants increased their knowledge of renal health and disease, including ways to reduce the chance of developing kidney disease.

In addition, in recognition of the extent of end stage renal disease in remote communities and the significant stress caused by relocating to major urban areas for dialysis which often entails living away from families, friends and communities, OATSIH has provided capital (and some recurrent) funding towards the establishment of the following renal units:

- Up to \$500,000 as one-off capital funding on a matched basis with Western Australia Health for the establishment of a renal dialysis service at the Broome Regional Aboriginal Medical Service. Western Australia Health will fund the recurrent costs for operation of the unit. OATSIH also provided a further \$87,000 for 1999–2000 to support a project coordinator position at the Broome Service to help develop the Kimberley Renal Health Program.
- Up to \$1 million capital funds as one-off funding for the establishment of a renal disease prevention service at Weipa and capital infrastructure for a haemodialysis unit at

Bamaga, as part of Queensland Health's North Queensland Renal Plan. OATSIH has also agreed to provide \$160,000 per annum towards staffing the renal prevention service at Weipa.

The National Aboriginal and Torres Strait Renal Disease Scientific Working Group has developed draft protocols for screening, and guidelines for the community-based management of, renal disease in Aboriginal and Torres Strait Islander people. This group has now concluded. The draft guidelines will be further developed in the context of the chronic disease strategy.

Rheumatic heart disease: The Commonwealth provided a further \$35,000 for the Rheumatic Health Disease Register in the Northern Territory (Top End) in February 2000.

New South Wales

New South Wales reported that progress in the last year represents a major step forward to a comprehensive, focused, strategic approach to addressing Indigenous vascular health issues in the state. Some of the demonstration site projects are specifically looking at improving the quality of data collected by the Area Health Service for Indigenous vascular conditions as part of their overall project strategy.

A 12-month Aboriginal Diabetes Project funded by the Public Health Outcomes Funding Agreement was carried out between May 1999 and June 2000 to develop an overview of the current situation in relation to Indigenous people with or at risk of diabetes and other circulatory diseases in New South Wales. The project findings have been used to inform the development of the Aboriginal Vascular Health Program which is currently in place.

New South Wales Health established an Aboriginal Vascular Health Program in July 2000 to address the priority health issues of the New South Wales Aboriginal Health Strategic Plan related to circulatory disease. In response to the Plan's requirement for consistent approaches to the prevention, early detection and management of circulatory disease, a common vascular approach was adopted.

The program is overseen by a representative working group and has developed an extensive implementation plan. The key strategies currently in place include:

- allocation of funds for nine demonstration site vascular health projects
- development of an Aboriginal vascular health network (with a regular Aboriginal vascular health bulletin)
- development of an Aboriginal vascular health catalogue of resources for training, education, health promotion and clinical support from around Australia
- collaboration in the development of an area-wide Aboriginal diabetes project in the Greater Murray Area Health Service as the Area Chronic and Complex Care Cardiovascular Project
- technical support for the development of projects, funding proposals and so on in regional areas
- collaboration with non-government organisations and other organisations in the development of projects in Aboriginal vascular health.

The demonstration site projects are developing local models to improve the prevention, early detection and coordinated management of vascular disease in Aboriginal and Torres Strait Islander people. Community-based, culturally appropriate interventions to support disease self-management are being implemented in several areas.

The program is working closely with the Centre for Kidney Research Westmead to develop an educational package for Aboriginal health workers about kidney disease to complement a research project (Antecedents of Renal Disease in Aboriginal Children) being undertaken by the Centre. It is also working closely with the Chronic and Complex Care Program of the New South Wales Government Action Plan to ensure that the cardiovascular projects developed by Area Health Services address issues for Indigenous people.

New South Wales Health has developed a set of Aboriginal Vascular Health Indicators to monitor progress in the area at local and state levels. A new subset of indicators consistent with the revised National Aboriginal and Torres Strait Island Health Performance Indicators is proposed for local data collection to measure local interventions and capacity for delivery of quality services.

Victoria

Victoria reported that the Victorian Advisory Council on Koori Health has not discussed the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension in Victoria.

Australian Capital Territory

The Australian Capital Territory reported that in collaboration with a range of consumers, including representatives of the Indigenous community, a strategic plan for the detection and management of diabetes and children with asthma was developed. While no formal plans exist for the remainder of the mentioned conditions, the Australian Capital Territory funds a wide range of non-government service organisations to provide services for clients with these conditions.

Queensland

Queensland Health has developed Health Outcome Plans for chronic conditions including asthma and diabetes, which specifically identify the Indigenous population as a priority and identify specific strategies to address these conditions. A Cardiovascular Disease Health Outcome Plan has been similarly developed which addresses hypertension. Additionally, a number of Indigenous-specific strategies, which impact on chronic disease, have been developed and implemented targeting food and nutrition, cancer screening, immunisation and environmental health. Memorandums of understanding between a number of health service districts and community controlled health services support coordinated care practices for Indigenous people. An Aboriginal and Torres Strait Islander Strategic Policy Framework with a focus on chronic disease and injury was being developed.

Queensland Health Northern Zone has piloted an enhanced model of primary health care and chronic disease strategy in Napranum and Hopevale. The model requires input from communities and is developing evidence-based guidelines for acute and chronic disease management in primary health settings. Renal service initiatives are improving access to renal replacement services in Cape York and Torres. A renal physician provides outreach services to the Cape York Peninsula and an early detection/intervention program is planned for Indigenous communities. The Well Persons' Health Check initiative continues to enhance

community understanding of disease processes through screening, information feedback and joint priority setting.

The Better Health Outcomes Project (previously FERRET) continues to move towards a patient information and recall system, which provides a tool for primary health care planning and service delivery and which supports the Queensland Health Northern Zone Chronic Disease Strategy and model of service delivery for remote and rural communities. The project piloted on Thursday Island has developed and implemented care plans for diabetes, renal disease, hypertension, rheumatic fever, rheumatic heart disease and well person surveillance. Additional pilot sites (Bamaga and Badu Island primary health care strategies) and an implementation strategy to sites throughout Queensland are under way.

Western Australia

Western Australia reported that national protocols for relevant key conditions are used. Numerous protocols and care plans have been developed including three model population health care plans and eight model personal health care plans as part of the Western Australia Aboriginal Coordinated Care Trial. In addition, the following are used in the management of key conditions responsible for Aboriginal and Torres Strait Islander ill health and death:

- *A Medical Practitioner's Guide to Aboriginal Health* (Western Australian branch of Australian Medical Association, 1998);
- Central Australian Rural Practitioners' Association – *Standard Treatment Manual*;
- Health Department of Western Australia – *Guidelines for Managing Sexually Transmitted Diseases*;
- *Management of Non-insulin-dependent Diabetes in Aboriginal and Torres Strait Islander Populations* (S. Couzos, S. Metcalf, R. Murray, S. O'Rourke, OATSIH, 1998);
- information/data systems; and
- screening and information/data systems.

Tasmania

Tasmania reported that no information is available concerning targeted Aboriginal and Torres Strait Islander programs in any of the listed areas.

South Australia

South Australia reported that no data were available.

Northern Territory

In the Northern Territory, a local Preventable Chronic Disease Strategy was developed which aims to reduce the prevalence and impact of the five main chronic diseases: diabetes mellitus, hypertension, ischaemic heart disease, renal disease and chronic obstructive airways disease. The strategy consists of a three-point framework: primary prevention, early detection and best practice management.

The strategy incorporates evidence linking low birthweight and early childhood malnutrition with subsequent development of adult chronic diseases. This provides a strong evidence base for reorienting health service delivery in primary health, public health and tertiary care.

Implementation of the strategy has included multiple interrelated activities, with the initial focus on health services for remote Indigenous people. These activities include:

- staff orientation and in-service training
- guideline development and implementation
- standardisation of patient recall systems
- inclusion of the strategy in health centre business plans
- improving community awareness of health issues with appropriate community health profiles.

Further information is provided on two of these activities, which specifically meet Indicator 4.6:

Guideline development and implementation: The Central Australian Rural Practitioners' Association standard treatment manuals have been provided to all Department of Health and Community Services clinical staff and Department-funded health services. Specific training in the use of these guidelines is an ongoing commitment. Adult chronic disease management and screening guidelines, which were developed for the Coordinated Care Trials, have been distributed and implemented in all Top End health centres. These guidelines complement the Association and are integral to best practice management.

Standardised Patient Recall Systems: Territory Health Services is currently evaluating computerised patient information systems being used in the Coordinated Care Trials.

Further development in Community Care Information Systems has occurred.

As an interim strategy in remote areas, standardised paper-based recall systems have been implemented throughout the Northern Territory. Standardisation allows orientation and training of staff using the systems and provides information, which forms part of the Preventable Chronic Disease Strategy evaluation. Guidelines provide the information, which prompts timing of patient recall.

Indicator 4.7: Age-standardised Aboriginal and Torres Strait Islander and non-Indigenous accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders

Information on presentations at emergency departments of hospitals for lacerations, fractures, and trauma would be useful in gauging the levels of accidents and violence in a community. Presentations for respiratory infections, skin infections and nutritional disorders may reflect the community's living conditions. Some jurisdictions reported that they have systems to collect information on emergency department activity.

New South Wales collects data on emergency activity by Indigenous status, but noted that Indigenous identification in the data was not sufficient for it to be used for this indicator. Furthermore, the New South Wales data collection had gaps in coverage, with rural hospitals particularly under-represented. Another limitation of the collection is the lack of standard code lists to classify presenting problems.

New South Wales Health collects data from emergency departments in 52 hospitals across the state. This is approximately one-third of all emergency departments, including all major hospitals, and covers approximately 80% of all emergency department activity. It is not possible to calculate population-based rates of emergency department activity or presentations at the moment. New South Wales reported definitional problems in understanding which facilities are included for the purpose of calculating this indicator.

While there has been a steady increase in the number of emergency department presentations identified as being by Aboriginal and Torres Strait Islander people, the number of presentations for which Indigenous status is not stated is approximately five times greater.

The Australian Capital Territory, Victoria, Queensland and Western Australia report that data are not currently available, although Queensland notes that reporting on sentinel sites through the Queensland Injury Surveillance Unit as a possibility for lacerations, fractures and traumas. South Australia reported that the data quality of Aboriginal identification in accident and emergency databases is extremely poor and reporting will be doubtful for some time.

Western Australia notes that this is the only indicator where jurisdictions are encouraged to report whatever they might have available rather than adhering to a strict definition. Due to national data agreements and other Health Department requirements, it is anticipated that more representative emergency department and injury surveillance data will be available centrally some time in the future. Relevant statistics are not available for this submission.

Tasmania reported that data are not currently reliable as there is significant underreporting of Indigenous status in hospital morbidity collections.

In the Northern Territory an administrative information system for collecting accident and emergency data was recently implemented in all public hospitals in the Territory. During this reporting period, investigations continue into improving data collection, particularly for Indigenous status and in data systems management issues, which will enable reliable information in the future.

Indicator 4.8: Proportion of total consultations by condition and by care provider

Consultation with primary care providers is another indicator of health service inputs. There is a variety of such providers however, making the collection of this information difficult. As noted in the 1998 and 1999 reports, Indigenous-controlled health services collect this information for their own purposes, but no jurisdictions were individually able to report these data and the Commonwealth reported the data from Aboriginal medical services.

In 1997-98, 102 Commonwealth-funded Aboriginal primary health care services provided approximately 860,000 episodes of care. Information on the patient's condition or problem is not recorded in this database. During 1998-99, Commonwealth-funded Aboriginal primary health care services provided approximately 1,060,000 episodes of health care (service activity reporting data based on 110 (97%) respondent services).

The 1998-99 service activity reporting indicated that the median episodes of care per Aboriginal primary health care service were 5,300. There was a wide variation in episodes of care per health service (ranging from a median of 2,600 in Tasmania/Victoria to 10,700 in Western Australia). Approximately one-third of patient contacts were with Aboriginal health workers, approximately 30% with doctors and about 20% with nurses. Specialists, dentists, counsellors and other allied health professionals accounted for about 20% of contacts (these statistics overlap where patients saw more than one health professional at the same contact).

The BEACH survey (Bettering the Evaluation and Care of Health) contains information on general practice activity, with identification of patients according to Indigenous status. However, it is based on a sample of general practitioner visits, with resulting problems of small sample size for analysing the results for the Indigenous population. The data are also limited by the under-identification of Aboriginal and Torres Strait Islander clients. The

report gives the distribution of these encounters by state/territory. This shows some differences with the population distribution of Indigenous people.

It should be pointed out that due to a low sample size there was a high standard error for the data collected. Because of the small sample size, it is not possible to use the BEACH data to examine Indigenous encounters by state/territory. The BEACH data are limited to the activities of general practitioners and do not capture the activities of other health care providers such as Aboriginal health workers. In addition, only small numbers of Aboriginal medical services are picked up in the sample and it would be useful to expand the coverage to community health services.

The BEACH survey results from April 1998–December 2000 indicated that the top five conditions managed by general practitioners were acute upper respiratory infection, asthma, acute bronchitis/bronchiolitis, hypertension and diabetes (unspecified). These five conditions ranged from approximately 5% to approximately 3% of total conditions managed for Aboriginal and Torres Strait Islander clients.

The Department of Health and Ageing is liaising with the Australian Institute of Health and Welfare on the need to improve the capacity of the BEACH database to report on the health of Indigenous people (particularly in relation to presenting illness and treatment offered).

Northern Territory

Northern Territory wide information on this indicator is currently not available. Data based on the Katherine district found that 4% of consultations are by Aboriginal health workers, 88% by nurses and 8% by medical practitioners. Consultations were separated between Aboriginal health workers and nurses in one clinic only.

Data from the Katherine district provide some indication of the health service utilisation in this region indicating an increase in clinic visits. During 2000 there were more than 48,132 consultations recorded. In the absence of a definition of a consultation, limited reporting on conditions was attempted. However, a long-term prospective study in Central Australia found that during the period October 1998–June 1999, the main reasons for consultation were skin conditions, respiratory illness, and endocrine/metabolic/nutritional disorders.

Other states and territory

Tasmania reported data availability was unknown. Victoria reported that data were currently unavailable. The Australian Capital Territory did not report. South Australia reported that there was service performance data but that there were issues regarding data quality. Queensland reports that data will not be available in the foreseeable future unless Indigenous identifiers are introduced into the Medicare data set.

Category five: Workforce development

Seven indicators were agreed to examine workforce issues affecting the delivery of health services to Aboriginal and Torres Strait Islander people. Several of these indicators seek to understand the role that Indigenous people have in the health system, while others look at workforce vacancies. One indicator is designed to measure the commitment of hospitals to the awareness of Indigenous cultural issues regarding health.

The number of recent Indigenous graduates and enrolments in health training is a useful measure of the participation of Indigenous people in delivering health services. Two types of training are considered under Indicator 5.1: training at institutions of higher education, and vocational training (for example, at technical colleges). For Indicator 5.2, training of Aboriginal health workers is the focus. However, in the reports from some jurisdictions it is difficult to separate 'vocational training' from 'training of Aboriginal health workers'.

Information on the number of students involved in higher education is collected by the Commonwealth Department of Education, Training and Youth Affairs (DETYA), while information on those undertaking vocational training and Aboriginal health worker training is collected by the National Centre for Vocational Education Research (NCVER). As with other administrative data on the Indigenous population, there is an unknown level of under-enumeration of Indigenous people in these figures.

Decreases in completions in 1999 and enrolments in 2000 were part of general decreases in completions and enrolments across the whole higher education sector in those years.

Indicator 5.1: Number of Aboriginal and Torres Strait Islander people who have (a) graduated in the previous year; (b) are in training in key health-related fields

Higher education

Higher education data were provided to DETYA by the 40 higher education institutions to which operating grants were provided by the department plus the Australian Film Television and Radio School, the National Institute of Dramatic Art and the Australian Defence Force Academy. Data quality is affected by the choice of some Indigenous people in higher education not to identify themselves as such on administrative questionnaires.

In 1999, 159 Indigenous students completed health courses in higher education. This compares with 193 students in 1998. Of the 1999 cohort, approximately 45% completed courses in health support activities; 37% in health sciences and technologies; 12% in medical science/medicine; 4% in rehabilitation services; 0.6% in health support services, and 0.6% in dentistry.

For Indigenous students, decreases in health completions in 1999 and enrolments in 2000 were part of general decreases in completions and enrolments across the whole higher education sector in those years. In 1999 the number of Indigenous award course completions in the broad field of health decreased by approximately 18%.

In 2000, 972 Indigenous students were enrolled in health courses in higher education. This compares with 1,061 in 1999 and 868 in 1998. Proportions of total Indigenous students enrolled in 2000 by the major fields of study are shown in Table S3.

Table S3: Proportions of total Indigenous students enrolled by major fields of study by year (per cent)

Field of study	1999	2000
Health—general	4.1	1.5
Dentistry—dentistry, dental therapy	0.4	0.5
Health support activities—general, health administration, health counselling, health surveying, health support, other	45.5	44.2
Health sciences and technology—general, nursing, medical radiography, medical technology, nutrition and dietetics, optometry, podiatry, other	36.4	37.8
Medical sciences—medicine	7.9	10.5
Rehabilitation services—occupational therapy, physiotherapy, other; general, speech pathology/audiology	5.6	5.4
All major fields	100.0	100.0

Source: Data available upon request, Higher Education Collection, Department of Education, Training and Youth Affairs, data available upon request, National Centre for Vocational Education Research.

New South Wales reported that 159 Indigenous students completed health-related higher education courses in 1999. There has been an increase in the number of students enrolled in and completing higher education in health-related courses.

Victoria reported that the accuracy of reporting of Indigenous status on the DETYA Higher Education Student Statistics database is unknown. The number of students enrolled in health-related courses rose to 58 in 1999. The number of graduates was 16 in 1998.

Queensland reported that 22 students graduated in 1999, and in 2000 there were 181 students enrolled. The accuracy of this information is dependent upon the self-identification of students.

Tasmania and South Australia reported data availability was unknown. The Australian Capital Territory figures are small and rely on students' self-identification. In Western Australia data are not centrally located, easily accessible or complete, and the data was compiled from different sources. Improved communication/reporting mechanisms and liaison with the tertiary sector are being pursued. Indigenous enrolments in 2000 were 170, an increase of 105% over 1999 enrolments.

In the Northern Territory 101 Aboriginal and Torres Strait Islander students graduated from tertiary institutions in key health-related fields in 2000. These included general health, renal health, aged and disability services, environmental health, alcohol and other drug studies, Aboriginal community health, Aboriginal environmental health, social and behavioural health and nutritional health. During 2000 a total of 258 Aboriginal and Torres Strait Islander people were in training in the higher education sector in key health-related fields. The total Indigenous vocational education and training (VET) enrolment in 2000 was 320.

Vocational education and training

Publicly funded VET data are available from the NCVER. As with higher education, one problem with VET data quality is that there is a significant proportion of clients in NCVER's collection whose Indigenous status is unknown because they do not have to identify themselves as such on state/territory administrative questionnaires. It is hoped that through the implementation of *Partners in a Learning Culture: Australia's National Aboriginal and Torres Strait Islander Strategy for Vocational Education and Training 1999–2003* Indigenous people will be encouraged to self-identify, thereby improving data quality.

In 1999, 6,392 Indigenous students studied health through publicly funded programs at vocational institutions in Australia. This compares with 5,378 in 1998. VET courses in health include dental services, health support activities, health science and technologies, medical science, medicine, rehabilitation services, community care, family care and personal health care.

There was an increase in those receiving qualifications in health in 1999 compared to 1998. There was also an increase in the number of persons studying health in 1999 compared to 1998. In vocational training, 1,584 Indigenous people received qualifications in health from publicly funded vocational institutions in Australia in 1999. This compares with 1,204 in 1998. These figures may under-represent Indigenous students who completed their courses, as some do not go through the formal process of collecting their certificates.

Table S4: Number of Aboriginal and Torres Strait Islander people who have completed and who are enrolled in health courses in higher education and vocational training institutions, Australia, 1997, 1998 and 1999

Type of course	Completed			Enrolled		
	1997	1998	1999	1997	1998	1999
Higher education	198	193	159	784	868	1,061
Vocational training	810	1,204	1,584	4,212	5,378	6,392
Aboriginal health worker training	145	182	109	679	895	838

Source: Data available upon request, Higher Education Collection, Department of Education, Training and Youth Affairs, data available upon request, National Centre for Vocational Education Research.

The data reported by the Commonwealth are national totals only, with no breakdown by state/territory. Some of the states and territories provided the numbers graduating and training in tertiary and vocational courses and in Aboriginal health worker training, as shown in Table 5.2.

Indicator 5.2: Number and proportion of Aboriginal health workers who graduated in the previous year or are participating in accredited training programs

The significant proportion of clients in NCVER's data collection whose Indigenous status is unknown limits reliability of this data. This is largely because it is not compulsory to provide this information on state/territory administrative questionnaires. Data relating to Indigenous health workers qualifications may under-represent Indigenous students as some do not go through the formal process of collecting their certificate.

It is hoped that the implementation of Partners in a Learning Culture: Australia's National Aboriginal and Torres Strait Islander Strategy for Vocational Education and Training 1999-2003 will have the indirect effect of encouraging self-identification of Indigenous people, thereby improving data quality.

In 1999, 109 Indigenous Aboriginal health workers gained qualifications from publicly funded vocational institutions. This compares with 182 in 1998. In 1999, 838 Indigenous students were participating in training as Aboriginal health workers at publicly funded vocational institutions. This compares with 895 in 1998.

New South Wales reported that there were 106 course enrolments in 1999 and 13 qualifications were awarded. The number of students enrolled and graduated as Aboriginal

health workers has reduced since 1998. However data available indicates that the number of Indigenous students enrolled in health and community services (VET) courses has more than doubled between 1994 and 1999. The New South Wales Review of Aboriginal Education Training was to be completed in 2000 and implementation of recommendations was to commence in 2001.

In Victoria the first group of Aboriginal health workers attended the Victorian Aboriginal Controlled Community Health Organisation's Aboriginal health worker Training Program in 2000. Nineteen received Certificate III and three received Certificate IV in Aboriginal and Torres Strait Islander Health.

Queensland data were only available for the proportion of health workers undertaking training. The number of people graduating is not easily obtainable. In 1999–2000, 130 health workers or 47% of Indigenous health workers working for Queensland Health were undertaking study.

The Northern Territory reported that 38 Aboriginal health workers graduated in 2000 from accredited training institutions and 143 were participating in accredited Aboriginal health worker training.

Tasmania and South Australia reported data availability was unknown. The Australian Capital Territory reports that the department has established a data quality committee, which is responsible for ensuring the accurate recording of data. Student numbers are small.

Western Australia reported that there were 130 Indigenous health workers undertaking study. This was a reduction of 29.3% in the number of enrolments from 1999. Data were not centrally located, easily accessible or complete. Data are fragmented from some institutions and the quality may not be high due to the systems for recording this information.

Table 5.2: Number of Aboriginal and Torres Strait Islander students graduating and training in health courses, as reported by states and territories

State/territory	Tertiary and vocational education		Aboriginal health worker training	
	Graduating	In training	Graduating ^(a)	In training
New South Wales (1999)	159	972	13	106
Victoria (1998)	16	58	No program	
Queensland	n.p.	n.p.	n.p.	n.p.
Western Australia (1999–2000) ^(a)	..	130 ^(a)	..	..
South Australia	n.p.	n.p.	17	72
Tasmania	n.p.	n.p.	n.p.	n.p.
Australian Capital Territory	n.p.	n.p.	n.p.	n.p.
Northern Territory (2000)	101	258	38	143

(a) Western Australia—enrolments provided: data useable with restrictions.

Indicator 5.3: The proportion of vacant funded full-time equivalent positions for doctors, nurses and Aboriginal health workers in (a) Aboriginal health services; (b) other organisations providing primary care for Aboriginal and Torres Strait Islander people on a given date

Knowledge of the proportion of positions in the health workforce that are vacant can assist in understanding the gaps existing in the capacity to provide health services. A high proportion of vacant positions will negatively affect the amount and quality of services that can be provided. However, the jurisdictions were unable to provide very much information on this indicator.

The Commonwealth reported that the Royal Flying Doctor Service returns its data at the specific request of the Department of Health and Ageing. Data on full-time equivalent (FTE) positions in Commonwealth-funded Aboriginal primary health care services are provided through service activity reporting (SAR).

The Royal Flying Doctor Service reports four FTE vacancies for doctors, and one FTE vacancy for nurses as at 30 April 2001. These vacancies comprise 7.6% of the FTE workforce for doctors, and 1.0% of the FTE workforce for nurses. The Service does not employ Aboriginal health workers, although a new role of Aboriginal Liaison Officer is being tested at some Service bases. Currently two of four of these positions have been filled.

As at 30 June 1999 service activity reporting data indicate that of 110 Commonwealth-funded Aboriginal primary health care services that responded there were:

- a total of 545 FTE Aboriginal health worker positions, with 22 (4%) vacancies
- a total of 191 FTE nurse positions with 12 (6%) vacancies
- a total of 147 FTE doctor positions with 14 (10%) vacancies.

In Victoria a database of staffing levels and staff vacancies in Aboriginal community controlled health services is being considered.

The Northern Territory indicated that there is a serious problem with employment of Aboriginal health workers throughout the jurisdiction which continued in 2000 with 35 vacancies, slightly more than the 32 in 1999. Training institutions continue to train Aboriginal health workers, which should address this vacancy problem.

In addition, the Northern Territory indicated that the high turnover of remote area nurses remains a significant problem, however, at the time of this report only 16 nursing positions were unfilled. The number of doctors working in remote areas has increased considerably in the Northern Territory over the last 5 years. At the time of this report no vacancies were reported for doctors.

In South Australia, Western Australia and Tasmania no data were available. New South Wales reports that data were not available as there was no established database on vacant positions in the New South Wales health system. Queensland data were not collected at state-wide level, as Health Service Districts are responsible for local staffing and employment issues.

Indicator 5.4: Number of vacant funded full-time equivalent positions for doctors, nurses and Aboriginal health workers in hospitals where greater than 25% of separations are for Aboriginal and Torres Strait Islander people on a given date

This is another indicator looking at workforce vacancies, in this case, vacant medical staff positions in hospitals where more than one-quarter of the separations are for Indigenous people. Several jurisdictions (Victoria, Tasmania and the Australian Capital Territory) reported that none of their hospitals met this criterion of Indigenous people comprising more than 25% of all separations. Queensland reports that data were not collected.

The Northern Territory reported that staff turnover in all hospitals is very high, however, at 1 September 1999 there were relatively few vacancies – doctors (5), nurses (14) and Aboriginal health workers (8).

New South Wales reports that data was not available as there is no established database on vacant positions in the New South Wales health system. South Australia reported that data were not available.

Indicator 5.5: Number of Aboriginal and Torres Strait Islander identified positions in the health sector

This indicator attempts to measure the support or commitment of health service providers to employing Aboriginal and Torres Strait Islander staff. As noted in the 1998 national summary report, it is difficult to report on this indicator because some jurisdictions are legally restricted from having 'identified' positions. Several of the jurisdictions reporting that they had such positions noted that the term 'identified' means that Indigenous status is an essential criterion for the position.

The Department of Health and Ageing reported that its current human resources reporting system does not capture Aboriginal and Torres Strait Islander identified positions. The department had a total of eight Indigenous Cadets out of a total number of 3,429 staff in the department as at 30 December 2000.

In New South Wales information is not available on the total number of Aboriginal and Torres Strait Islander identified positions in the health sector. Some information is available on particular categories of Indigenous identified positions employed by Area Health Services, however this underestimates the total number of Indigenous identified positions in the health sector. It does not include Indigenous identified positions in non-government organisations or Aboriginal medical services.

There are currently 24 Aboriginal health coordinators and 12 Aboriginal employment coordinators employed in Area Health Services in New South Wales. The information available would indicate that there are 300–350 Aboriginal and Torres Strait Islander people employed in identified positions in the Area Health Services, however this is not collected data and probably an underestimate of the total number of Indigenous employees in NSW Health.

The Aboriginal Employment Strategy for New South Wales Health has been implemented across the New South Wales health system. The strategy sets a target for each Health Service of a minimum of 2% Aboriginal and Torres Strait Islander representation across its

workforce. The Strategy emphasises the importance of initiatives that increase the employment of Aboriginal and Torres Strait Islander people in mainstream health professions.

The Australian Capital Territory reports that the department has established a data quality committee, which is responsible for ensuring accurate recording of data and that there are limited data available. Program positions are funded by the Department of Health and Community Care; there were a total of five identified positions.

Victoria reported that under previous state legislation there was a mandatory requirement to report annually on Indigenous employment figures. However, this changed with an amalgam of Acts into the reconstituted *Public Sector Management and Employment Act 1998*. At the present time there is no reporting of Indigenous employment initiatives or figures, either state-wide or sector-by-sector.

Any health workers employed in the Victorian public service are located in the Department of Human Services. Departmental employees are not asked about their Indigenous status. There is a small number of identified positions in the department, but these are not in the health sector. There are 20 Koori hospital liaison officers or their equivalent in Victorian public hospitals but being of Indigenous origin is not mandatory.

Queensland Health does not have Indigenous identified positions. The only positions that require mandatory Indigenous descent are the Indigenous allied health cadetships. There is a number of specified positions that require a person to have demonstrated knowledge and skills to undertake duties in Indigenous-specific areas. The Queensland report noted that a report on the number of Indigenous people working for Queensland Health might be a more useful indicator.

Tasmania reported that only three identified positions, all customer services officers in Housing, are employed through the State Aboriginal Employment and Career Development Strategy. The report sought clarity on the definition of 'identified position'. Other positions within the agency (although not identified) that provide direct services to the Indigenous community are: Aboriginal health policy officer, Aboriginal community school visiting family and child health nurse, Cape Barren Island full-time nurse, Royal Hobart Hospital liaison officer, North West social worker, Northern Alcohol and Drug field worker, North West Community Options driver, and Southern Home and Community Care home maintenance worker.

South Australia reported that data were not available.

Western Australia reported that data were not readily available. The state proposed that the number of Section 50D positions does not reflect all positions where an Indigenous person is employed or preferred under exemptions in equal employment opportunity (EEO) legislation and a broader definition may yield a more accurate result.

In the Northern Territory there are no 'identified' positions for Indigenous staff. However, the intent is that Indigenous people occupy these positions. Although accurate data are not currently available for Indigenous participation in the total Northern Territory Department of Health and Community Services workforce, the number of people described in these classifications has decreased, predominately due to the decrease in Aboriginal health worker numbers. Much of this decrease in Aboriginal health workers can be attributed to the transfer of service provision to non-government health services providers such as the Tiwi Health Board and Community Government Councils. In addition to these positions there are now increased numbers of Aboriginal and Torres Strait Islander people working across a

range of roles within the Department of Health and Community Services such as policy, management, projects and administrative functions as well as physical grades. There were 262 positions specifically designated as Aboriginal health and community services professionals, as shown below.

Northern Territory Department of Health and Community Services—Position title	Number of positions
Aboriginal health worker	132
Aboriginal health promotions officer	13
Living With Alcohol worker	17
Strong Women coordinators and worker	25
Aboriginal mental health worker	12
Aboriginal environmental health worker	8
Hospital Aboriginal liaison officer	17
Cultural awareness program officer	5
Aboriginal disability resource officer	1
Aboriginal counsellor	1
Aboriginal ear health co-coordinator	1
STD/AIDS educator	4
Aboriginal nutrition advisor	2
Aboriginal specialist child protection officer/Aboriginal community workers (FACS)	17
Aged Care Assessment Team Aboriginal liaison officer	3
Aboriginal Male Health Unit officer	2
Aboriginal Employment and Career Strategy officer	2
Total	262

Note: Excludes services funded by the Department of Health and Family Services.
Source: Aboriginal Health Strategy Unit, Department of Health and Community Services.

Indicator 5.6: Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander

As noted in the 1998 and 1999 reports it is difficult to obtain information on the proportion of doctors and nurses who identify as Indigenous, because such identification is either not required by the relevant registration boards, or because identification is suspected of being greatly understated. For several jurisdictions it is possible to gain some idea of these proportions from various EEO surveys, but such surveys are often limited to the government-employed workforce.

In New South Wales the Aboriginal Employment Strategy for New South Wales Health has been implemented across the health system. The strategy sets a target for each Health Service of a minimum of 2% Aboriginal and Torres Strait Islander representation across its workforce. The strategy emphasises the importance of initiatives that increase the employment of Aboriginal and Torres Strait Islander people in mainstream health professions. There has been an increase in the proportion of Aboriginal and Torres Strait Islanders in the New South Wales Health system with Nursing (Registered) being the only area to remain stable.

Queensland reported that for 1999, 0.1% of Queensland-registered doctors identified as Indigenous, while 0.6% of nurses identified as Indigenous. The proportion of doctors and

nurses whose Indigenous status was reported as not stated were 4.5% and 2.6% respectively. Last year's data were obtained from the 1999 Equal Employment Opportunity Census. Data for the 2000 report were obtained from the 1999 labour force statistics. Differences between this year's and last year's results can be attributed to the fact that different sources were used.

Western Australia reported the Human Resources Minimum Obligatory Reporting Requirements (MOIR) survey indicated that 261 employees identified as Aboriginal and/or Torres Strait Islander, whereas the EEO survey responses indicated that there are 268 employees of Aboriginal and Torres Strait Islander descent. Respondents are reluctant to identify themselves as Aboriginal and Torres Strait Islander primarily due to confidentiality concerns, particularly in rural areas.

Amended data definitions under the MOIR were introduced in 2000 and will improve the availability of these data for the Western Australia Government health system. Strategies are also being developed to improve EEO survey response rates. Data from the MOIR survey suggests that the proportion of all employees in the Western Australia Government health system that identify themselves as Aboriginal and/or Torres Strait Islander was 0.05%. There was a reduction in the number of health professionals who identified as Aboriginal and/or Torres Strait Islander.

In the Northern Territory the Department of Health and Community Services has a significant commitment to an Indigenous health professional workforce. One of its goals is 'a significant increase in Indigenous involvement in the health and community services workforce'. Two department initiatives, which are practical examples of this, are Indigenous Cadetships and the Department of Health and Community Services Studies Assistance Program. Currently there are four Aboriginal and Torres Strait Islander people studying nursing, anthropology, physiotherapy and psychology. Two cadet graduates – a nurse and social worker – are now employed in the Department which is currently assisting 17 Aboriginal and Torres Strait Islander people to gain a health professional or related qualification.

A total of 138 Aboriginal and/or Torres Strait Islanders are employed in the Northern Territory Department of Health and Community Services including 132 Aboriginal health workers, two doctors, two nurses, a social worker, and a nutritionist.

Tasmania reported Aboriginality in the nursing labour force was self-identified and reliability was unknown. The Australian Capital Territory reported that the department had established a data quality committee that has responsibility for ensuring the accurate recording of data. Victoria reported that neither the Medical Practitioners Board nor the Nurses Registration Board collects this information. South Australia reported that data were not available.

Indicator 5.7: Proportion of accredited hospitals for which the accreditation process required Aboriginal and Torres Strait Islander cross-cultural awareness programs for staff to be in place

This indicator is designed to capture the support within hospital staff training programs for cross-cultural awareness. It is not designed to measure the proportion of hospitals that have Indigenous cultural awareness training programs in place, rather the proportion required by their accreditation board to have such programs. No jurisdiction provided information on accredited hospitals with such programs, because it is not part of the requirements of the

Australian Council on Health care Standards accreditation guidelines for hospitals. For this reason, the New South Wales report suggested that the definition of the indicator should be modified. The Tasmanian report stated that the indicator has too much emphasis on a process, i.e. putting a program in place, rather than outcome, i.e. number of staff who have attended cross-cultural awareness programs, or who have demonstrated cross-cultural sensitivity in service provision.

In New South Wales the implementation of staff cultural awareness guidelines was a mandatory item in all Health Service Performance Agreements for 1999-01. Cross-cultural awareness training is routinely provided to staff with 13 Health Services conducting cultural awareness training. In a number of Health Services cultural awareness training is included as part of the induction program for new staff. There has been a reduction in the number of Health Services providing cross-cultural training to all staff.

Queensland reported that no accreditation system requiring cross-cultural awareness programs for staff is presently utilised by hospitals. Queensland Health, however, requires all staff to participate in cross-cultural awareness training under the revised minimum standards for cultural awareness. Corporate office and all health service districts now provide facilitator training and cultural awareness programs for staff. Additionally, the Reconciliation Program is presently being implemented within the corporate office as well as all District Health Services. A target of 800 staff participants has been set for 2001.

Western Australia reported that it had surveyed hospitals to obtain this information. Although the response rate improved to 91% (from 50% in the previous report), there was a reduction in the proportion of acute care hospitals that have cross-cultural aspects in their orientation program, however in the previous reporting year, only accredited hospitals were counted. Central collection of data will be included with end-of-financial-year reports.

Tasmania reported that cross-cultural awareness training within the hospitals is one of the Aboriginal Liaison Officer roles with sessions set as part of the agency training calendar. The department's policy area is progressing the development of a broad flexible Indigenous cross-cultural awareness program that will be used across the agency, including hospitals.

In the Northern Territory the Department of Health and Community Services' Aboriginal Cultural Awareness Program is currently being delivered in Alice Springs, Tennant Creek, Darwin, Katherine and Gove Hospitals. There was a total of 1,474 departmental attendees across the Northern Territory to the program between November 1999 and May 2001, including 979 from Top End hospitals and 495 from central hospitals.

South Australia reported that data were not available.

Category six: Risk factors

This section reports information on three major determinants of poor health, or 'risk factors': smoking, overweight and excessive alcohol consumption. There are other major health risk factors, such as lack of exercise and poor nutrition, but these three have been selected because they are particularly important among Indigenous Australians.

Indicator 6.1: Proportion of Aboriginal and Torres Strait Islander people aged greater than 13 years who currently smoke by age and sex

The main source of data for information on smoking levels among Indigenous people has been the National Aboriginal and Torres Strait Islander Survey (NATSIS) conducted in 1994. Several jurisdictions reported that it might be possible to obtain data for this indicator in the future from the 2001 National Health Survey, or through state-level health surveys. However, some jurisdictions also noted the small samples of Indigenous people in such surveys made it difficult to derive reliable estimates of the proportions who smoked. The 2001 National Drug Strategy Household Survey also provides information on smoking status within the Indigenous population although not at the state or territory level.

The New South Wales Chief Health Officer (2000) reported that 41% of Indigenous people aged 16 years and over reported smoking on a daily or occasional basis. In the NATSIS 51% of people aged 13 years and over reported that they smoked daily. The variance in report results may be explained through the variety in sampling and interview techniques, as well as differences in Indigenous participation and self-identification.

Victoria, Queensland, Tasmania, South Australia and the Northern Territory report no new data since NATSIS 1994. NATSIS 1994 was relevant to the broader Queanbeyan ATSI region and not specific to the Australian Capital Territory due to apparent sampling difficulties, the Australian Capital Territory will be excluded from the next survey and therefore not be in a position to report on this indicator in the future. The Cancer Council of Tasmania conducts a triennial report on smoking in high schools, although the report does not identify Indigenous respondents. A request has been made to the Cancer Council to include this data item.

Indicator 6.2: Proportion of Aboriginal and Torres Strait Islander people with a body mass index greater than 25 by sex and age

Body mass index is an internationally recognised measure to determine overweight or obese status in adults. The index is constructed by dividing an individual's weight in kilograms by his or her height in metres squared. An index value of 30 or greater indicates obesity, while a value between 25 and 30 indicates overweight. The most recent data for this measure were from the 1994 NATSIS, and were reported (by sex) for each jurisdiction in the 1998 report.

The Northern Territory reported that a community survey (W Hoy, unpublished data) of a population of approximately 1,100 people performed between 1992 and 1997 found that nearly 16% of males and 22% of females had a body mass index between 25 and 30. The age group most affected was between 45 to 64 years (33% of overweight men and 27% of overweight women). The highest proportion of men with a body mass index greater than

30 were aged between 24 to 44 years. The highest proportion of obese women was aged between 45–64 years. This study found that 7% of males and 17% of females were obese. In this community, 27% of the obese women were in the 25–44 age group (W Hoy, unpublished data).

Indicator 6.3: Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming more than four drinks on the occasions when they drank alcohol in the last 2 weeks relative to the total numbers who reported on consumption

As noted in the 1998 and 1999 reports, data on alcohol consumption are not recorded as specified in the indicator. Some survey data are available to measure this, but the sample sizes preclude estimates for the Indigenous population in each jurisdiction. A finding of some surveys is that Indigenous people are more likely than non-Indigenous people to abstain from alcohol, but those who do drink alcohol are more likely to do so at unsafe levels (AIHW 2000).

The New South Wales Report of the Chief Health Officer (2000) reported that in 1997–98, 28.2% of Indigenous people reported alcohol consumption at a hazardous or harmful rate (females consuming three or more, and males consuming five or more, standard drinks in a day).

The Northern Territory reports that admissions to sobering-up shelters provide some indication of hazardous or harmful alcohol consumption. To help minimise the harm associated with such consumption patterns, AODP funds sobering-up shelters in four centres: Darwin, Katherine, Tennant Creek and Alice Springs. Aboriginal and Torres Strait Islander people represent 95% of the admissions at these shelters and were admitted on average 3.5 times in 2000. However, overall, 70% were admitted only once or twice.

Category seven: Intersectoral issues

'Intersectoral issues' refers to economic conditions which are known to affect health. Two indicators have been selected to represent intersectoral issues: household income below the poverty level, and residential amenities (supplies of standard utilities).

Indicator 7.1: Proportion of households where after-tax income available to the household after paying mortgage or rent is less than the amount specified by the poverty line

Poverty is a multi-faceted problem and thus can be difficult to measure. This indicator as currently stipulated incorporates concepts such as household income, after-tax income, net income after housing costs, and the poverty line. However the indicator does not include the concept of household size. Due to these difficulties and the lack of clear definitions, most jurisdictions are unable to report against this indicator. In addition, the major sources for data on Indigenous poverty, the 5-yearly national censuses and the National Aboriginal and Torres Strait Islander Survey, do not have information about housing costs.

New South Wales reported that currently the term 'poverty line' is undefined in this indicator. As there is a number of different income measures of poverty this indicator needs to be carefully defined. The same measurement methodology must be applied over time in order to measure trends and differences between states. There is a number of papers available from the Centre for Aboriginal Economic Policy Research, which discuss different measures of poverty and their appropriateness and application to Indigenous households. Most importantly the differences in household sizes need to be properly accounted for. Income-based measures should not be solely relied on as a measure of disadvantage due to the multi-faceted nature of poverty.

Western Australia determined non-housing income need using updated poverty lines from the Henderson poverty inquiry. A household whose income after paying housing costs is reduced below its non-housing income need is said to be in poverty after housing. Because of limitations of the use of the Henderson poverty line, limited available analysis of census income data, and approximations involved in the calculations, the ATSIC report indicates that figures should be treated as estimates only of the level and extent of poverty in Indigenous households.

Indicator 7.2: Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives

It is widely accepted in Australia that all households should have access on a continuous basis to essential utilities (electricity and/or gas, water, sewerage). This indicator is designed to measure if Indigenous households have access to the same standards of such services, as does the general population.

Category eight: Community involvement

Two indicators in this category are designed to examine the inclusion of representatives from Aboriginal and Torres Strait Islander communities in health planning at the state and regional level.

Indicator 8.1: Establishment of a forum representing the Indigenous health sector, Aboriginal and Torres Strait Islander Commission and the state jurisdiction in each state and territory

Forums to discuss health issues at the Commonwealth, state, or territory level are designed to bring about participation of Indigenous communities in government health planning, resource allocation and service delivery.

The Commonwealth reported that the National Aboriginal and Torres Strait Islander Health Council was reconstituted in early 1999. This represents the National Forum under the Aboriginal and Torres Strait Islander Framework Agreements. During 2000 the Health Council held four meetings. New South Wales reported that in addition to the Forum it has a range of other functioning partnerships to address Indigenous health issues. They are:

- The New South Wales Aboriginal Health Partnership Agreement between the Aboriginal Health and Medical Research Council, the peak body for Aboriginal community controlled health services in New South Wales, and the New South Wales Government through its health portfolio, was originally formed in 1995. Following a review a strengthened agreement was signed in May 2001. The partnership aims to ensure that the expertise of Indigenous communities is brought to the health care process through the development of agreed positions regarding health policy, strategic planning and broad resource allocation issues for Aboriginal health.
- Local/Regional Area Health Service Partnership Agreements. Under the terms of the Aboriginal Health Partnership Agreement, each Area Health Service is required to establish an agreement with each Aboriginal Community Controlled Health Service. There are also working arrangements to formalise the input of a range of other stakeholders (for example, the Division of general practitioners) to the business of the partnership.

The forum is only one of the high-level partnership arrangements currently implemented in New South Wales to address Indigenous health issues. It would be useful to broaden this indicator so that it can fully capture significant partnership initiatives undertaken by states and territories.

The Australian Capital Territory reported that its Aboriginal and Torres Strait Islander Health Forum comprises representatives from Winnunga Nimmityjah Aboriginal Health Service, Gugan Gulwan Aboriginal Corporation, Canberra Hospital Aboriginal liaison officers, Commonwealth Department of Health and Ageing, Aboriginal and Torres Strait Islander Council and Australian Capital Territory Department of Health, Housing and Community Care. Meetings are held every 8 weeks.

In Victoria meetings of the Victorian Advisory Council on Koori Health have been held every 8 weeks. These provide an opportunity for sharing of information and for joint decision making on key issues such as the processes required to develop the state plan for Koori health built up from local community priorities. The Council has provision for six representatives from the Victorian Aboriginal Community Controlled Health Organisation, two representatives each from Department of Human Services and the Department of Health and Family Services and three representatives from ATSIC.

Queensland Health develops and coordinates Indigenous health policy initiatives through the activity of the Aboriginal and Torres Strait Islander Health Unit, which manages the policy interface across government and sectors. Forums include the Queensland Government and Aboriginal and Torres Strait Islander people Ten-Year Partnership, The Crime Prevention Strategy, the Queensland Aboriginal and Islander Health Partnership, the Torres Strait and Northern Peninsula Area Health Partnership and the Queensland Aboriginal and Torres Strait Islander Health Alliance (improved integration of primary health care services). These partnerships have resulted in a number of planning initiatives including and based on the Queensland Framework for Action on Aboriginal and Torres Strait Islander Health, the Torres Framework for Action and the Aboriginal and Torres Strait Islander Ten-Year Plan.

Western Australia reported that the 1996 Western Australia Framework Agreement was extended in 1999, pending its renegotiation by all parties involved. The Western Australian Joint Planning Forum with membership from the Western Australian Aboriginal Controlled Community Health Organisation, the Health Department of Western Australia, ATSIC and the Commonwealth Department of Health and Ageing met during the reporting year. In addition there were numerous other related Joint Planning Forum meetings on a range of topics at the state level.

Work on developing the six Regional Aboriginal Health Plans involved considerable local level collaboration between ATSIC, Aboriginal community controlled health organisations, and state and Commonwealth agencies. These plans were completed in 2000. In addition, the Western Australian Aboriginal Health Strategy was completed and endorsed by State Cabinet in 2000. The Strategy is a long-term approach for improving the health of Aboriginal people living in Western Australia. The Strategy was developed by the Joint Planning Forum and is based on the six Regional Aboriginal Health Plans.

Tasmania reported that the State Forum holds face-to-face quarterly meetings and the outcomes of the Agreement are progressing. A draft State Health Plan, produced by the Tasmanian Aboriginal Centre, was tabled at the final meeting for 1999. The Department of Health and Human Services is reviewing its data collection systems so as to implement more effective systems. Membership of the Forum group is: a Commonwealth Health Department representative, State Director of Health Advancement an Administrator from the Tasmanian Aboriginal Centre as the state National Aboriginal Controlled Community Health Organisation affiliate, Tasmanian Regional Aboriginal Council and ATSIC. Observers include the Aboriginal Health Policy Officer and the State Office of Aboriginal Affairs.

Indicator 8.2: Cooperative community planning with the implementation of the regional planning processes

The level of Indigenous involvement in strategic community planning is examined in this indicator. A key objective of the current regional planning process is to identify opportunities for the improvement of data quality and data collection procedures for future planning exercises.

The Commonwealth reported that regional plans have now been completed in Central Australia (July 1997), South Australia (November 1997), Queensland (July 1999), the Australian Capital Territory (October 2000), New South Wales (December 2000), Western Australia (five of six regions completed in 2000) and the Top End of the Northern Territory (April 2001). Regional plans continue to be developed in Victoria and Tasmania. Community involvement has been facilitated through the joint regional planning forums established in each State and Territory under the provisions of the Aboriginal and Torres Strait Islander Health Agreements. These forums include representatives of the Aboriginal community controlled health sector, the Commonwealth, state and territory governments and ATSIC. Reporting is against the Framework Agreements.

In New South Wales the Aboriginal Health Regional Plans have been signed by all parties. Area Aboriginal Health Strategic Plans were developed in consultation with a wide variety of Indigenous organisations and community groups. Performance continues to improve.

The Australian Capital Territory reported that whole of government planning is undertaken by the Chief Minister's Department within the Australian Capital Territory. To assist the Chief Minister in issues pertaining to the local Indigenous community the Chief Minister has appointed a representative of the Indigenous community to the Chief Minister's Consultative Council. The Council's terms of reference include advising the Chief Minister on matters relating to the interest and wellbeing of Aboriginal and Torres Strait Islander people living in the Australian Capital Territory.

In Victoria the Department of Human Services released a Koori Services Improvement Strategy in 1998, and implementation of the strategy commenced in most of the regions in 1999. Activities were reported for the regions of Barwon South Western, Grampians, Loddon Mallee, Hume, Gippsland, and the Western, Eastern, Southern and Northern Metropolitan Regions. There were also forums and partnerships involving aged care, mental health, home and community care and dental health.

Queensland Health continues to contribute to across-government regional planning via Regional Services Planning, Primary Health Care Access Program, Social and Emotional Wellbeing, and Rural and Remote Communities Initiative. Under the Primary Health Care Access Program planning process four communities have been selected as ready for implementation and two as ready for capacity building based on priorities identified through the Framework for Action. The fifth community health plan (St George) has been completed.

Western Australia reported that in 1999 cooperative community planning was undertaken in the six Aboriginal Health Planning regions. These are the Kimberley, Pilbara, Goldfields, Ngaanyatjarra, Mid-West and Gascoyne, and Metropolitan and South-West. The resulting Regional Aboriginal Health Plans have now been endorsed by each of the planning teams, which are made up of representatives from the Western Australian Aboriginal Controlled Community Health Organisation, the Health Department of Western Australia, the Office for Aboriginal and Torres Strait Islander Health and other groups such as ATSIC and the Aboriginal Affairs Department. The Regional Aboriginal Health Planning Teams have an ongoing role in implementation and evaluation.

The Western Australian Aboriginal Health Strategy was developed by the Joint Planning Forum and is based on the six Regional Aboriginal Health Plans. The Strategy is a long-term strategic approach for improving the health of Indigenous people living in Western Australia. Changes to performance relate to the progression of work towards ensuring

participation of Aboriginal and Torres Strait Islander communities in government health planning, resource allocation and service delivery.

In Tasmania the Department of Health and Human Services is in the process of establishing its community consultative mechanisms.

In the Northern Territory the Department of Health and Community Services works in cooperation with Aboriginal Health Boards to plan and manage health service delivery. The Coordinated Care Trials established in the Tiwi Islands and Katherine West are an example.

Significant outcomes of the Northern Territory Aboriginal Health Framework Agreement include the completion of the Top End Regional Planning Study.

The forum has established an increasing number of regional health planning sub-committees as another part of reforming the Aboriginal health planning process in the Northern Territory. These sources of planning information have assisted governments and communities in identifying key funding sources for the development of health zones in Central Australia under the Primary Health Care Access Program. To date the Commonwealth Minister for Health has approved funding for three health zones in the Central Australian region. Further discussions are being held with key partners to attract funding for the identification and development of further sites throughout the Top End and central regions of the Northern Territory.

Category nine: Quality of service provision

This final category looks at quality of health services for Aboriginal and Torres Strait Islander people. Quality measurement is difficult in all environments, and therefore only one indicator, the existence of mechanisms for complaints and critical incidents, has thus far been formulated for this category.

Indicator 9.1: Critical incident reporting and complaints mechanisms at all levels of health services

As the 1998 national summary report noted, mechanisms for formal notification of adverse incidents are in place in hospitals, but not uniformly in other types of health services. Furthermore, Indigenous people may experience difficulties in accessing these mechanisms, and also are not always identified as Indigenous in the records. A number of the jurisdictions reported progress on improving access to the mechanisms for Indigenous people.

The Commonwealth reported that the National Health Priorities and Quality Branch has contributed to the development of a national health complaints information system. This funding has been discontinued at this stage as the states and territories need to improve their collections to ensure consistency of the data.

In New South Wales, the New South Wales Ombudsman and New South Wales Health Care Complaints Commission receive complaints. The findings of the New South Wales Health Care Complaints Commission visiting program will be available in 2001. Information is not available on the extent to which the mechanisms in place at the health services are culturally appropriate.

The Australian Capital Territory has two Acts, which provide mechanisms for incidents reporting and complaints – the *Community and Health Services Complaints Act 1993*, and the *Discrimination Act 1991*. Clients of health services are encouraged to present their complaints directly to the provider, however, if the provider fails to give proper consideration to the complaint, or if the client is unhappy with the response, they are able to have the matter fully investigated by the Community and Health Services Complaints Officer, or the Human Rights Office.

Queensland Health through the Quality Improvement and Enhancement Program is developing a state-wide complaints and consumer satisfaction system over the next 2 years.

In Victoria an Aboriginal liaison officer commenced in February 1999, with support from the Victorian Aboriginal Controlled Community Health Organisation and the Department of Human Services. The Health Services Commissioner was aware that, prior to this, her office was not accessible to Indigenous people. The role of the Aboriginal Liaison Officer is to assist Indigenous people to define their complaints, provide support during processing, advise the commissioner and staff at each stage of the complaint, educate the Koori community about their rights under the Act and analyse the cause of complaints, making suggestions to remove or minimise them.

Twenty-eight complaints were lodged by Aboriginal and Torres Strait Islander people between July 1999 and June 2000, compared to four in the period February–June 1999. Eighty-three informal enquiries were received, compared to 23 in February–June 1999. In

these instances advice was given and appropriate referrals made. A major part of the role of the Aboriginal liaison officer has involved creating awareness of the Office of the Health Services Commissioner within the Indigenous community.

The Aboriginal liaison officer and the Commissioner have been meeting with Indigenous health service users and providers. A valuable relationship has also been established with Koori hospital liaison officers. Outreach to Koori communities has been identified as a high priority. Experience has shown that informal information sessions are often more comfortable and productive for all parties.

Many of the Health Services Commissioner's standard procedures were culturally inappropriate for Aboriginal and Torres Strait Islander people who are often reluctant to complain. Common concerns about the provision of health services raised during community visits included attitudes of hospital staff and racism; culturally inappropriate hospital admission practices; access to medical records; administration of Home and Community Care programs; difficulties in understanding clinical terminology; and putting complaints in writing.

An important factor in making the Office of the Health Services Commissioner accessible to Aboriginal and Torres Strait Islander people is the capacity of non-Indigenous staff to provide appropriate support and assistance. Aboriginal and Torres Strait Islander cultural awareness training has been organised to give non-Indigenous staff a basic knowledge of relevant issues and to discuss ways in which the Office can best accommodate particular needs of Aboriginal people.

The employment of the Aboriginal liaison officer has increased the number of enquiries Indigenous people have made to the Office of the Health Services Commissioner. It is expected that the number of enquiries and complaints to the Office by Indigenous people will continue to increase as the existence of the Office and its processes becomes more widely known in the Indigenous community.

In Western Australia a draft cultural security policy has been developed for the Western Australian Government Health System. This policy will lead to increased awareness and better data quality and reportability.

Tasmania reported that the State Ombudsman's Office deals with concerns regarding the functioning of State agencies. Within the Department of Health and Human Services, concerns by staff regarding issues arising from Indigenous status are dealt with by human resource managers. Tasmania also has a Human Rights and Equal Opportunities Commissioner to whom the whole community has access about any issues arising from Indigenous status. The current State Health Complaints Commissioner's Office has an Indigenous staff member with a generic role. General complaints about treatment within the health sector are directed to this office.

The Northern Territory reported that the Health and Community Services Complaints Commission is an independent statutory body, co-located within the Office of the Ombudsman for the Northern Territory. The Commission was developed to provide a means of making official complaints about health services and community services (aged services and service to the disabled). These services include public and private services, alternative or complementary services and services provided by unregistered providers (e.g. patient care assistants, ambulance officers).

Of total enquiries/complaints made during the reporting period, 52% related to public providers (mainly hospitals), 44% to private providers (mainly medical practitioners) and 4%

were outside the Commission's jurisdiction. During the reporting period 1999-2000, of 86 complaints received 14, or 16%, were Indigenous.

The Commission's ability to effectively service Indigenous people throughout the Territory is limited due to its current resources and will remain so unless additional funding is provided. However the Commission has improved its services to Aboriginal and Torres Strait Islander people over the past 12 months by:

- increasing the number of visits made by staff to remote Indigenous communities;
- commissioning a poster specifically targeting Aboriginal and Torres Strait Islander people; and
- developing complaint-handling protocols with major independent Indigenous health services.

There was an increase in the number of Indigenous people accessing the Commission this financial year (5 in 1998-99 compared to 14 in 1999-2000), which would tend to suggest that the above measures are having some success.

Independent Aboriginal Health Services throughout the territory have also developed complaint mechanisms and protocols with the Commission to ensure that Indigenous people, accessing these services have a means to resolve complaints.

The Department of Health and Community Services has an internal complaints procedure to address client dissatisfaction and suggestions for improvement of the provision of services. Indigenous status of complainant is not recorded, although the need for an interpreter is. The issue of collecting Indigenous status is the subject of some debate within the health service, and may be considered in the future.

Critical incident reporting is covered by a standardised department incident reporting process. Incidents are reported verbally to the head of branch. Those of a critical nature are reported to the CEO and Minister. In these cases a written report is required.

Appendix

Aboriginal and Torres Strait Islander health performance indicators

- 1.1: Life expectancy at birth by sex
- 1.2a: Age-standardised all-causes mortality rates by sex
- 1.2b: Age-specific all-causes mortality rates by sex
- 1.3a: Age-standardised all-causes mortality rate ratio by sex
- 1.3b: All-causes age-specific rate ratio by sex
- 1.4: The chance of dying between 20 and 54 years
- 1.5: Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1,000 total births to Aboriginal and Torres Strait Islander mothers
- 1.6: Death rate of Aboriginals and Torres Strait Islanders from birth to 1 year of age
- 1.7a: Age-standardised mortality rates for ischaemic heart disease and rheumatic heart disease by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians
- 1.7b: Age-standardised mortality rates for injury and poisoning by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians
- 1.7c: Age-standardised mortality rates for pneumonia by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians
- 1.7d: Age-standardised mortality rates for diabetes by sex for Aboriginals and Torres Strait Islanders and non-Indigenous Australians
- 1.7e: Age-standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non-Indigenous women
- 2.1a: Notification rates for selected vaccine-preventable diseases: pertussis, measles, hepatitis B
- 2.1b: Notification rate for meningococcal infection
- 2.2: Crude notification rates for gonorrhoea and syphilis by sex
- 2.3: Percentage of Aboriginal and Torres Strait Islander children at school entry having greater than 25dB hearing loss averaged over three frequencies
- 2.4: Proportion of Aboriginal and Torres Strait Islander newborns with birthweight less than 2,500 grams
- 2.5: Age-standardised all-causes hospital separation rate ratios by sex
- 2.6a: Age-standardised hospital separation rate ratio for acute myocardial infarction by sex
- 2.6b: Age-standardised hospital separation rate ratios for injury and poisoning, by sex
- 2.6c: Age-standardised hospital separation rate ratio for respiratory diseases by sex
- 2.6d: Age-standardised hospital separation rate ratio for diabetes by sex
- 2.6e: Age-standardised hospital separation rate ratio for tympanoplasty by sex

- 3.1: Proportion of Aboriginal and Torres Strait Islander people whose ordinary residence is less than 30 minutes routine travel time from a full-time permanent primary care service by usual means of transport.
- 3.2: Proportion of Aboriginal and Torres Strait Islander people whose ordinary residence is less than 1 hour travel time from a hospital that provides acute in-patient care with the continuous availability of medical supervision
- 3.3: Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population
- 3.4: Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non-Indigenous people
- 3.5: Proportion of primary health services, and the resources allocated to these services
- 3.6: Extent of community participation in health services
- 3.7: Representation of Aboriginal and Torres Strait Islander people on health/hospital boards, and whether membership is mandated by terms of reference
- 3.8: Proportion of communities with usual populations of less than 100 people, within 1 hour usual travel time to primary health care services
- 3.9: Per capita recurrent expenditure by governments on health care services to communities with populations of less than 100 people compared with expenditure for the general population
- 4.1: Expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander people
- 4.2: Number of Pap smears among Aboriginal and Torres Strait Islander females aged 18–70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group
- 4.3: Proportion of Aboriginal and Torres Strait Islander children aged 2 years and 6 years that are fully immunised as recorded in the Australian Childhood Immunisation Register
- 4.4: Proportion of Aboriginal and Torres Strait Islander people aged older than 50 years who have received pneumococcal vaccine in the last 6 years
- 4.5: Proportion of children aged between 2 and 6 years who are fully immunised against hepatitis B, as recorded in the Australian Childhood Immunisation Register
- 4.6: Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension
- 4.7: Age-standardised Aboriginal and Torres Strait Islander and non-Indigenous accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders
- 4.8: Proportion of total consultations by condition and by care provider
- 5.1: Number of Aboriginal and Torres Strait Islander people who have (a) graduated in the previous year; (b) are in training in key health-related fields
- 5.2: Number and proportion of Aboriginal health workers who graduated in the previous year or are participating in accredited training programs

- 5.3: The proportion of vacant funded full-time equivalent positions for doctors, nurses and Aboriginal health workers in (a) Aboriginal health services; (b) other organisations providing primary care for Aboriginal and Torres Strait Islander people on a given date
- 5.4: Number of vacant funded full-time equivalent positions for doctors, nurses and Aboriginal health workers in hospitals where greater than 25% of separations are for Aboriginal and Torres Strait Islander people on a given date
- 5.5: Number of Aboriginal and Torres Strait Islander identified positions in the health sector
- 5.6: Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander
- 5.7: The proportion of accredited hospitals for which the accreditation process required Aboriginal and Torres Strait Islander cross-cultural awareness programs for staff to be in place
- 6.1: Proportion of Aboriginal and Torres Strait Islander people aged greater than 13 years who currently smoke by age and sex
- 6.2: Proportion of Aboriginal and Torres Strait Islander people with a body mass index greater than 25 by sex and age
- 6.3: Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming more than four drinks on the occasions when they drank alcohol in the last 2 weeks relative to the total numbers who reported on consumption
- 7.1: Proportion of households where after-tax income available to the household after paying mortgage or rent is less than the amount specified by the poverty line
- 7.2: Proportion of dwellings where one or more Aboriginal or Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives
- 8.1: Establishment of a forum representing the Indigenous health sector, Aboriginal and Torres Strait Islander Commission and the state jurisdiction in each state and territory
- 8.2: Cooperative community planning with the implementation of the regional planning processes
- 9.1: Critical incident reporting and complaints mechanisms at all levels of health services

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