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Aboriginal and Torres Strait Islander health organisations

Online Services Report—key results **2015–16**

Aboriginal and Torres Strait Islander health services report no. 8

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Australian Institute of Health and Welfare

Board Chair
Mrs Louise Markus

Director
Mr Barry Sandison

Any enquiries about or comments on this publication should be directed to:

Digital and Media Communications Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Tel: (02) 6244 1000
Email: info@aihw.gov.au

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACHS	Australian Council on Healthcare Standards
ACT	Australian Capital Territory
AGPAL	Australian General Practice Accreditation Limited
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
ARIA	Accessibility/Remoteness Index of Australia
BSTL	Better Start to Life
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CSHISC	Community Services and Health Industry Skills Council
DoH	Department of Health
ENT	ear, nose and throat
FTE	full-time equivalent
GP	general practitioner
IAS	Indigenous Advancement Strategy
ISO	International Organization for Standardization
MBS	Medicare Benefits Schedule
NSW	New South Wales
NT	Northern Territory
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OSR	Online Services Report
PIRS	patient information and recall system
PM&C	Department of the Prime Minister and Cabinet
QIC	Quality Improvement Council
Qld	Queensland
RACGP	Royal Australian College of General Practitioners
SA	South Australia
SEWB	social and emotional wellbeing
Tas	Tasmania
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

Symbols

—	nil or rounded to zero
. .	not applicable
<	less than
>	greater than
n.a.	not available

Summary

This eighth national report presents information from 277 organisations, funded by the Australian Government to provide one or more of the following health services to Aboriginal and Torres Strait Islander people: primary health care; maternal and child health care; social and emotional wellbeing services; and substance-use services. These organisations contributed to the 2015–16 Online Services Report. Information is presented on the characteristics of these organisations; the services they provide; client numbers, contacts and episodes of care; staffing levels; and service gaps and challenges.

The good news

- In 2015–16, 204 organisations provided a wide range of primary health-care services to around 461,500 clients through 3.9 million episodes of care. Over 1 million episodes of care (26%) were in *Very remote* areas and these areas had the highest average number of episodes of care per client (10). Over time there has been an increase in the average episodes of care per client, from 5 in 2008–09 to 8 in 2015–16.
- Around 7,766 full-time equivalent staff were employed and just over half (53%) were Aboriginal and Torres Strait Islander. Nurses and midwives were the most common type of health worker, representing 15% of employed staff, followed by Aboriginal and Torres Strait Islander health workers and practitioners (13%) and doctors (7%). Nurses and midwives represented a higher proportion of employed staff in *Very remote* areas (24%).
- Many health promotion group activities were provided, including around 7,600 physical activity/healthy weight sessions, 3,300 chronic disease support sessions and 2,000 tobacco-use treatment and prevention sessions. With respect to maternal and child health care, around 12,900 home visits, 3,300 maternal and baby/child health sessions, 2,800 parenting skills sessions and 1,000 antenatal group sessions were done.
- In the 93 organisations funded specifically to provide social and emotional wellbeing services, 216 counsellors provided support services or Link Up services to around 18,900 clients through 88,900 client contacts.
- In the 80 organisations funded specifically to provide substance-use services, around 32,700 clients were seen through 170,400 episodes of care. Most clients (81%) and episodes of care (87%) were for non-residential substance-use services.

Things to note

- Over half the organisations providing primary health-care services reported mental health/social and emotional wellbeing services as a service gap (54%), and two-thirds (67%) reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff as a challenge in delivering quality health services.
- Some organisations felt clients with high needs had to wait too long for some services, in particular to access specialist and dental services. For example, 53 (28%) organisations providing on-site or off-site access to dental services still felt clients with high needs often had to wait a clinically unacceptable time for dental services. For most specialist and allied health services, more organisations in *Remote* and *Very remote* areas felt clients with high needs had to wait too long to access services.

1 Introduction

This eighth national report provides an overview of 277 organisations funded by the Australian Government Department of Health (DoH) and/or the Department of the Prime Minister and Cabinet (PM&C) to provide health services to Aboriginal and Torres Strait Islander people. These organisations contributed to the 2015–16 Online Services Report (OSR) data collection (see Box 1.1). This report presents the main findings from 2015–16, with some time series analyses. It includes information on the characteristics of these organisations; health services provided; client numbers, contacts and episodes of care; staffing levels; and service gaps and challenges.

Box 1.1: About the OSR data collection

The Australian Institute of Health and Welfare (AIHW) annually collects data from organisations funded by the Australian Government to provide one or more of the following health services to Aboriginal and Torres Strait Islander people: primary health care; maternal and child health care; social and emotional wellbeing services; and substance-use services.

Data collected includes staffing (both employed and visiting), the types of health services provided, the total number of individual clients seen (both Indigenous and non-Indigenous clients) and client contacts and episodes of care. The OSR also collects a range of contextual information about the organisation, for example, on governance, accreditation, information systems, advocacy, knowledge and research activities, policy and planning processes, and service gaps and challenges.

In 2015–16, 277 organisations provided data for the OSR, with 204 (74%) reporting on primary health-care services, 222 (80%) on maternal and child health services, 93 (34%) on social and emotional wellbeing services and 80 (29%) on substance-use services. Complete data were obtained from most (95%) organisations, while 5% (13 organisations) had some of their data excluded from national analyses.

The following should be kept in mind when using OSR data:

- The organisations in scope for reporting in the collection may change over time and the definition of an organisation in this report may differ slightly to the one used by the DoH and PM&C for funding purposes.
- The organisations submitting valid data for a data item may change over time.
- In some organisations, data on the number of clients and episodes of care are based on estimates.
- Analyses for each year are based on the organisations providing valid data in that year.

See Appendix A for more information on data quality and for a list of data exclusions.

1.1 Policy context

The health of Indigenous Australians

An estimated 744,956 Australians identified as Aboriginal and/or Torres Strait Islander in June 2016, representing 3% of the total Australian population (ABS 2014). In 2011, 10% of the Indigenous population identified as being of Torres Strait Islander origin, and almost two-thirds of the Torres Strait Islander population lived in Queensland. The Indigenous population has a younger age structure compared with the non-Indigenous population. In June 2011, the median age of the Indigenous population (the age at which half the population is older and half is younger) was 21.8, compared with 37.6 for the non-Indigenous population. The birth rate for Indigenous women is also higher (2.3 babies per woman in 2013 compared with 1.9 for all women) (AIHW 2015d). Most Indigenous Australians live in non-remote areas (79% in 2011); however, a higher proportion live in remote areas (21%), compared with non-Indigenous Australians (2%).

The gap in health outcomes between Indigenous and non-Indigenous Australians is well documented, especially around life expectancy, infant mortality, child mortality, chronic disease prevalence, potentially preventable hospitalisations and the burden of disease (AIHW 2015a). For example, a recent burden of disease study found that Indigenous Australians experienced a burden of disease 2.3 times the rate of non-Indigenous Australians, with diabetes 6 times as high.

Chronic diseases were responsible for more than two-thirds (70%) of the total health gap in 2011 and for 64% of the total disease burden among Indigenous Australians in 2011. The 5 disease groups that caused the most burden were mental and substance use disorders (19% of total disease burden), injuries (which includes suicide) (15%), cardiovascular diseases (12%), cancer (9%) and respiratory diseases (8%). The same study also suggests that much of this burden could be prevented and reducing exposure to modifiable risk factors may have prevented over one-third (37%) of the burden of disease in Indigenous Australians. The risk factors contributing most to the overall disease burden were tobacco and alcohol use, high body mass, physical inactivity, high blood pressure and dietary factors (AIHW 2016a).

While there have been improvements in the health and wellbeing of Indigenous Australians, they remain disadvantaged compared with non-Indigenous Australians. There are a number of interlinking issues that contribute to this gap, including the disadvantages Indigenous people experience in relation to the social determinants of health such as housing, education, employment and income; behavioural risk factors such as smoking, poor nutrition, and physical inactivity; and access to health services (AIHW 2015a). In addition, a broader range of social and emotional wellbeing issues result from colonisation and its intergenerational legacies: grief and loss; trauma; removal from family and cultural dislocation; racism and discrimination (DoH 2013).

Policy responses

In 2008 a framework was developed to tackle Aboriginal and Torres Strait Islander disadvantage, with 6 targets established to close the gap between Indigenous and non-Indigenous people. These targets were agreed with all states and territories through the Council of Australian Governments (COAG).

National Aboriginal and Torres Strait Islander Health Plan

Following on from the COAG targets, the Australian Government worked with Aboriginal and Torres Strait Islander people to produce the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. This sets out a 10-year plan for the direction of Indigenous health policy and provides a long-term, evidence-based policy framework to close the gap in Indigenous disadvantage. The vision outlined in the Health Plan around health system effectiveness is that the Australian health system delivers primary health care that is evidence-based, culturally safe, high quality, responsive and accessible to all Aboriginal and Torres Strait Islander people (DoH 2013).

An Implementation Plan sits alongside the Health Plan, detailing the actions to be taken by the Australian Government and other key stakeholders to implement the Health Plan (DoH 2015b). It identifies 20 goals to support the achievement of the COAG targets around the effectiveness of the health system and priorities across the life course, from maternal health and parenting, childhood health and development, adolescent and youth health, healthy adults and healthy ageing. A technical companion document to the Implementation Plan outlines these goals and how they will be measured (AIHW 2015b).

The second stage of the Implementation Plan will be released in 2018 and will further develop actions and goals in the domain of social and cultural determinants of health and health system effectiveness. It will also seek to increase engagement between Australian Government agencies, state, territory and local governments, the Aboriginal community-controlled health sector, the non-government sector and the corporate/private sector (DoH 2017).

Progress on achieving the Implementation Plan goals will be reported every two years in line with the release of the *Aboriginal and Torres Strait Islander Health Performance Framework*. The findings will be incorporated into the Department of Health's Annual Report and will inform the Prime Minister's annual *Closing the Gap report*. Progress on the goals will also be publically reported on the DoH and AIHW websites from mid-2017 (DoH 2015b).

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009

The Australian Government is also working with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group to renew the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009. This Framework aims to respond to the high incidence of social and emotional wellbeing problems and mental ill-health, by providing a national framework for action and holistic approaches to social and emotional wellbeing that will guide planning, commissioning and delivering services. It will be a critical part of ongoing reform to the mental health system to close the gap between Indigenous and non-Indigenous people.

Indigenous Advancement Strategy (IAS)

The IAS is the strategy through which the Australian Government funds and delivers 5 programs specifically for Indigenous Australians (PM&C 2015):

- Jobs, Land and Economy
- Children and Schooling
- Safety and Wellbeing
- Culture and Capability
- Remote Australia Strategies.

The IAS has the flexibility to ensure that Indigenous Australians are actively involved in the development and delivery of local solutions. It is administered through PM&C's Regional Network. The network has regional offices across Australia that support Indigenous Australians and other stakeholders to develop appropriate, community-led solutions that are tailored to local circumstances and are aiming for enduring outcomes consistent with Australian Government priorities.

The services provided under the IAS are designed to progress three priority areas:

- The positive impact that education has on the future success of individuals, families and communities is clear. Children who go to school have better life outcomes.
- Employment, economic development and social participation improve the lives of families and communities. The right conditions and incentives need to be in place for Indigenous Australians to participate in the economy and broader society.
- Growing up in a healthy and safe home and community is essential for families to thrive and reach their full potential. In particular, the violence that too many women and children face must be addressed.

More information on the IAS is available at <http://www.dpmc.gov.au/>.

Primary health-care services for Indigenous Australians

Primary health-care services play a critical role in helping to improve health outcomes for Indigenous Australians. Indigenous Australians may access either mainstream or Indigenous primary health-care services, which offer prevention, diagnosis and treatment of health issues in a range of settings. Indigenous primary health-care services are funded by the Australian Government and state and territory governments, and are available through hospitals, community clinics, Aboriginal Community Controlled Health Services and other health-care facilities (AIHW 2016b).

A recent report (AIHW 2015c) looked at spatial variation in Indigenous people's access to primary health care. It found that Australian Government-funded Indigenous primary health-care services were well positioned relative to the geographic distribution of Indigenous Australians and to the distribution of other general practitioner (GP) services. The services were mainly located in densely populated areas and regional areas with relatively large Indigenous populations in northern Queensland, the Northern Territory, northern South Australia and Western Australia. However, there were still some areas where Indigenous people with high need for health care experienced limited access to both Indigenous services and to GP services in general.

The AIHW has also undertaken work to analyse the distribution of maternal and child health services in relation to the geographic distribution of Indigenous women of childbearing age. This work found that around one-fifth of these women lived outside a 1-hour drive from the nearest hospital with a birthing unit, but that almost all women (97%) have access to at least one of the following maternal health services: hospitals with public birthing units; Indigenous primary health-care services; Royal Flying Doctor Service clinics; or GPs. Women in *Remote* and *Very remote* areas had the lowest levels of access. Associations between geographic accessibility to services, maternal behaviors, and birth outcomes were also examined. Initial results of this work appeared as a feature article in *Australia's Health 2016* (AIHW 2016b).

1.2 OSR organisations

In 2015–16, the Australian Government funded organisations across Australia to deliver one or more of the following services to Aboriginal and Torres Strait Islander people:

- **Primary health-care services**—funded by the DoH to provide access to doctors, nurses, allied health professionals and medical specialists outside of hospital. These services provide clients with clinical services and access to the broader health system, and also play a key role in maintaining and improving population health through health promotion, disease prevention, advice and referral. They also provide maternal and child health services (DoH 2015c).
- **New Directions: Mothers and Babies Services**— funded by the DoH to increase access to, and use of, child and maternal health services for Aboriginal and Torres Strait Islander families. The program funds organisations to provide: antenatal and postnatal care; information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring of developmental milestones, immunisation status and infections; and health checks for Aboriginal and Torres Strait Islander children before starting school (DoH 2015a).
- **Social and emotional wellbeing services**—funded by PM&C to improve the health, wellbeing and resilience of Aboriginal and Torres Strait Islander individuals, families and communities. This includes social and emotional wellbeing counselling and support services, as well as Link Up services that assist those affected by past practices of the forced removal of children from Aboriginal and Torres Strait Islander families, through counselling, family tracing and reunion support.
- **Substance-use services**—funded by PM&C to provide treatment, support and rehabilitation services to prevent harmful substance use among Aboriginal and Torres Strait Islander people. These services include residential and non-residential treatment and rehabilitation services, sobering-up shelters and transitional after-care resources.

In 2015–16, 277 organisations providing one or more of these services contributed to the OSR. For the purposes of this report 'organisations' are a count of the entities that provide these types of services (see Table 1.1). It should be noted, however, that the definition of an 'organisation' in the OSR collection may differ slightly to that used by the DoH and PM&C for the purposes of funding. Given this, the number of organisations reported in the OSR may differ from the number of funded organisations reported by the DoH and PM&C elsewhere.

It should also be noted that the Australian Government may not be the sole source of funding for these organisations. For example, if an organisation is in the OSR because they were funded by the Australian Government to provide Indigenous primary health-care services, they may also have received funding from other sources, such as state or territory governments. Organisations with multiple funding sources report on all their primary health-care activity in the OSR.

Table 1.1: Organisations in the OSR, by type of Australian Government funding, 2015–16

Indigenous health services	Organisations funded for primary health care	Organisations with other funding[a]	Total organisations
Primary health care (Chapter 3)	204	—	204
Maternal and child health (Chapter 4)	204[b]	18[c]	222
Social and emotional wellbeing (Chapter 5)	76	17[d]	93
Substance-use (Chapter 6)	38	42[d]	80
Total organisations[e]	**204**	**73**	**277**

(a) Includes organisations not funded for primary health, but funded for New Directions and/or social and emotional wellbeing services and/or substance-use services.

(b) Includes 81 organisations funded for primary health and New Directions, and 123 funded for primary health but not New Directions.

(c) Organisations funded for New Directions only.

(d) Includes 4 organisations funded to deliver social and emotional wellbeing services and substance-use services.

(e) Totals do not add because organisations may be funded to provide more than one service.

1.3 Data collection

Data from organisations funded to provide health services to Aboriginal and Torres Strait Islander people have been collected annually since the 2008–09 financial year. From 2008–09 to 2010–11, the data collection was known as the Office for Aboriginal and Torres Strait Islander Health (OATSIH) Services Reporting data collection and used a paper-based questionnaire. It became an online form in 2011–12 and was renamed the OSR.

The online form underwent revisions for the 2012–13 collection (see Appendix A). Other enhancements to the 2012–13 collection enabled some data items to be extracted and pre-populated automatically from an organisation's patient information and recall system (PIRS). Counts of clients, client contacts and episodes of care could be pre-populated directly from an organisation's PIRS. This was designed to improve the accuracy of the data and reporting response times and to reduce respondent burden. Organisations could overwrite this pre-population function, however, and not all organisations used this facility.

Organisations providing New Directions services were in scope for the OSR for the first time in 2013–14, although most already contributed to the data collection because they were also funded by the DoH to provide Indigenous primary health-care services. In 2015–16, there were 18 organisations in the collection that reported on their New Directions services only.

The number of organisations contributing to the OSR changes slightly from year to year for a range of reasons, such as administrative changes to funding arrangements, changes to the organisations funded, or changes in auspicing and reporting arrangements at the local level. The overall number of organisations submitting OSR data in 2015–16 (277) was 1 fewer than in 2014–15 (278 organisations). In 2015–16, 21 new organisations were in scope for the collection, while 22 organisations that submitted OSR data for the 2014–15 collection were not required to report in 2015–16.

Aims of the collection

The OSR provides a basic measure of activity, volume and coverage of a range of health services delivered to Aboriginal and Torres Strait Islander people. This information supports:

- evidence-based policy development and planning
- improved understanding of health service needs
- accountability for policy implementation of service delivery
- the assessment of access and levels of activity over time
- quality improvement, at the service level and nationally.

For individual organisations, OSR data support:

- evidence-based practice
- continuous quality improvement of service delivery
- benchmarking against national data
- an opportunity to provide feedback on key service gaps and health-service delivery challenges to policy makers/funders.

The OSR complements other work being done by the AIHW to measure and report on health outcomes. Although the OSR collects information on the types of health services provided to Aboriginal and Torres Strait Islander people and the number of clients getting these services, it does not collect data on health outcomes. This type of information is presented in other AIHW reports such as the *National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care* (AIHW 2017) and the *Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: detailed analyses* (AIHW 2015a).

Like the OSR, national Key Performance Indicator (nKPI) data is provided to the AIHW from organisations funded by the Australian Government to provide primary health-care services to Aboriginal and Torres Strait Islander people (see AIHW 2017 for more information). Many of the organisations contributing to the latest OSR (202) also contributed to the nKPI data collection (see Table 1.2). OSR data is also used in other reports including the Aboriginal and Torres Strait Islander Health Performance Framework (HPF), the annual Report on Government Services (RoGS) and in spatial analysis work. Together these data provide information to help monitor progress against the COAG commitment to closing the gap in health outcomes between Indigenous and non-Indigenous Australians.

Table 1.2: Organisations in the OSR and nKPI collections, 2015–16

Organisations	Number
Total OSR organisations reporting on primary health and/or maternal and child health[(a)]	222
Total nKPI organisations[(b)]	241
Total organisations reporting in both collections[(c)]	202

(a) Includes organisations funded by the Australian Government for primary health care and/or New Directions (see Table 1.1).

(b) Includes organisations funded by the Australian Government for primary health care and 22 organisations funded solely by the Northern Territory Government.

(c) Includes organisations reporting in both collections.

Data quality and validation

The AIHW examines all OSR data submissions for potential quality issues, and follows up any issues with each organisation to confirm data is correct or to request revised data. In 2015–16, there were data queries for 260 (94%) organisations and around three-quarters (74%) of these organisations resubmitted some data. Common data queries were around incomplete or inaccurate data, data discrepancies between two or more questions and big changes compared with previous submissions. By the cut-off date for data submissions, most organisations (95%) had submitted data that could be included in national analyses. The remaining 5% had in total 32 data items excluded from national analyses. Exclusion rates were higher for substance-use data. See Table A1 for a list of data exclusions for 2015–16.

As was noted earlier, the total number of organisations contributing to the OSR may change slightly from year to year. This may have an impact on some time series analyses. It should also be noted that in 2014–15 the reporting period was 1 June 2014 to 31 May 2015, rather than the financial year (1 July to 30 June) used in previous years and in 2015–16. In 2014–15, the Census date for the collection was brought forward by 1 month to 31 May 2015, rather than 30 June 2015, although organisations were asked to provide data for a 12-month period to enable time series analyses.

For more information on the collection and data quality, see Appendix A and the OSR Data Quality Statement.

1.4 Structure of the report

After this introduction, Chapter 2 brings together some of the key findings from the chapters that follow and the key messages coming out of the OSR collection. Chapters 3 to 6 report on the different types of services organisations are funded to provide to Aboriginal and Torres Strait Islander people.

Chapter 3 presents information on primary health-care services funded by the DoH.

Chapter 4 presents information on maternal and child health services funded by the DoH.

Chapter 5 presents information on social and emotional wellbeing services funded by PM&C.

Chapter 6 presents information on substance-use services funded by PM&C.

Appendix A presents additional information on data quality in the collection.

Appendix B presents a list of positions included as 'health' and 'other' staff.

Appendix C presents additional maps on service locations for the states and territories.

Appendix D presents a list of organisations contributing to the 2015–16 OSR.

See Box 1.2 for some general notes about this report.

Box 1.2: Notes about this report

The term 'Aboriginal and Torres Strait Islander people' is preferred in AIHW publications, however, the term 'Indigenous' is used interchangeably with 'Aboriginal and Torres Strait Islander' to assist readability.

Figures, tables and text contain numbers that have been rounded. In some cases, owing to this rounding, the components may not add to the total or to 100%.

Throughout this report, all references to tables that include an 'S' in the table number (for example, Table S3.1) are supplementary tables. These tables are available on the AIHW website < http://www.aihw.gov.au/publication-detail/?id=60129559185>.

A copy of the OSR questionnaire can also be found on the AIHW website.

2 Synthesis of key results

This chapter presents a synthesis of the key findings from the chapters that follow.

2.1 Key messages

1. There were 277 Australian Government-funded organisations that provided health services to Aboriginal and Torres Strait Islander people in 2015–16

The OSR provides information on the organisations delivering these services and their capacity to provide them. Of the 277 organisations:

- 204 (74%) provided a wide range of primary health-care services, to around 461,500 clients through 3.9 million episodes of care. Two-thirds (136 organisations) were Aboriginal Community Controlled Health Organisations (ACCHOs), and the other 68 included state and territory government-run organisations and other non-government-run organisations (see Chapter 3).
- 222 (80%) provided maternal and/or child health services through their primary health and/or New Directions funding. They saw around 8,500 Indigenous women through 42,000 antenatal visits—an average of 5 antenatal visits per client (see Chapter 4).
- 93 (34%) provided social and emotional wellbeing services. The 216 counsellors in these organisations saw around 18,900 clients, through 88,900 contacts—an average of around 5 contacts per client (see Chapter 5).
- 80 (29%) provided substance-use services to around 32,700 clients through 170,400 episodes of care. Most clients (81%) and episodes of care (87%) were for non-residential or after-care services (see Chapter 6).

2. Clients are being seen more often

Although there have been fluctuations in the number of organisations reporting in the OSR and in the number of clients reported over time, there have been increases in the average number of primary health episodes of care and client contacts with these organisations (see Table 2.1). Between 2008–09 and 2015–16:

- The average number of episodes of care per client increased from 5 to 8.
- The average number of contacts per client increased from 8 to 12. In particular, contacts with doctors increased from 1.9 to 3.3 per client and with nurses/midwives from 2.2 to 3.5 per client.
- Health full-time equivalent (FTE) staff reported increased from 2,878 to 4,738, while Health FTE staff per 1,000 clients increased from 7 to 10.

These changes may be related to an increased need for services, increased availability of health staff (as measured by FTE) and an increased range of services that were available and accessible. However, it is not possible from the OSR data to assess the relative contributions of these drivers.

While the average number of primary health episodes of care and contacts increased over time, in organisations funded to provide social and emotional wellbeing services, the average number of contacts per client has shown little change. It has consistently been around 5 contacts per social and emotional wellbeing client since 2008-09. Similarly, in organisations funded to provide substance-use services, since 2012–13, the average number of non-residential episodes of care per client was consistently between 6 and 7.

Table 2.1: Organisations providing Indigenous primary health-care services, 2008–09 to 2015–16

	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Number of organisations	205	223	235	224	205	203	203	204
Number of clients	370,222	430,691	430,446	445,419	416,971	418,910	434,610	461,483
Number of Indigenous clients	295,173	336,290	332,863	350,335	313,980	323,566	344,331	364,389
Total FTE staff	4,540	5,017	5,732	5,938	6,990	7,401	7,664	8,083
Health FTE staff	2,878	3,027	3,539	3,573	4,318	4,526	4,728	4,738
Health FTE staff per 1,000 clients	7	7	8	8	10	11	11	10
Average contacts per client	8	8	9	9	10	11	12	12
Average episodes per client	5	5	6	6	7	8	8	8

Note: Client contacts are a count of contacts with each type of health worker in an organisation and include transport contacts. All contacts with the same client on the same day are counted as one episode of care only, but if more than one health worker sees a client in the same day (for example, a nurse and a doctor) then one episode of care will count as multiple client contacts.

Source: AIHW analyses of OSR data collection, 2008–09 to 2015–16.

3. One-third of organisations provide services in *Very remote* areas

One-third (33%) of organisations providing primary health-care services did so in *Very remote* areas and they saw around 103,600 (22%) clients. Around one-quarter (26%) of employed FTE staff worked in *Very remote* areas, and compared with other areas, *Very remote* areas had a higher proportion of nurses and midwives (42%) and a lower proportion of doctors (12%), dental care staff (9%) and social and emotional wellbeing staff (13%). There were more FTE nurses and midwives per 1,000 clients in *Very remote* areas (4.7 compared with 2.6 overall), but fewer doctors (0.7 FTE doctors per 1,000 clients compared with 1.2 overall), perhaps reflecting a greater reliance on nurse-led clinics in these areas. Contacts by nurses represented half (52%) of all contacts in *Very remote* areas, compared with 30% overall.

Over 1 million episodes of care (26%) were provided to clients in *Very remote* areas and they had the highest average number of episodes of care per client (10). Despite this, organisations in *Very remote* areas were more likely to report staffing vacancies and to say they had clients that had to wait a clinically unacceptable time to access a number of specialist health services. For example, the proportion of organisations in *Very remote* areas saying clients with high priority needs had to wait too long to access services was higher with respect to cardiologists (46% compared with 22% in all organisations), renal specialists (39% compared with 20% in all organisations), and diabetes specialists (25% compared with 13% in all organisations). Organisations in *Very remote* areas were also more likely to report the recruitment, training and support of staff as one of the challenges they faced in providing quality care to clients (81% compared with 67% overall) as well as staff retention and turnover (75% compared with 54% overall).

4. A wider range of services are being provided

These organisations provide a wide range of primary health-care services including health promotion, clinical care, substance-use treatment and prevention, and social and emotional wellbeing support. They provide access to doctors, nurses, allied health professionals, social and emotional wellbeing staff and a range of specialists. In 2015–16:

- Organisations provided access to a range of specialist services, allied health and dental services, either on site or by facilitating off-site access. For example, most provided access to the following specialist services: cardiologists (94%); renal specialists (89%); ophthalmologists (92%); paediatricians (94%); psychiatrists (92%); diabetes specialists (94%); and ear, nose and throat (ENT) specialists (91%). Most also provided access to dental services (94%) and to the following allied health services: physiotherapists (91%); psychologists (93%); dieticians (95%); podiatrists (96%); optometrists (95%); and audiologists (94%).

- The proportion providing access to a number of specialist services has gradually increased since 2012–13. For example, those providing access to a cardiologist increased from 86% of organisations in 2012–13 to 94% in 2015–16, a renal specialist from 83% to 89%, a psychiatrist from 87% to 92% and a diabetes specialist from 88% to 94%.
- Despite this increase, some organisations still felt that clients with high needs had to wait too long for some services, in particular to access specialist and dental services. For example, the proportion of organisations providing on-site or off-site access to these services that felt clients with high needs had to wait a clinically unacceptable time was higher for dental services (28% or 53 organisations), and specialist services such as cardiologists (22%), renal specialists (20%), psychiatrists (19%) and ENT specialists (22%). For most specialist and allied health services, access was more of an issue for organisations in *Remote* and *Very remote* areas, but accessing dental services was an issue in all areas, except *Major cities*.

5. Many health promotion activities are conducted

Organisations delivered a range of health promotion activities and advocacy at both the client level and for the local community. These aim to improve the health of the community as a whole—for example, by providing appropriate health information and education and encouraging community development approaches. In 2015–16:

- Most organisations (95%) provided group activities as part of their primary health care. This included around 7,600 physical activity and healthy weight sessions by 141 organisations; around 3,300 chronic disease client support sessions by 106 organisations; nearly 2,000 tobacco-use treatment and prevention sessions by 121 organisations; and around 1,400 alcohol-misuse treatment and prevention sessions by 75 organisations.
- With respect to maternal and child health services, around 12,900 home visits, 3,300 maternal and baby/child health group sessions, 2,800 parenting group sessions and 1,000 antenatal group sessions were provided.
- In organisations funded to provide substance-use services, most provided community education (96%), group counselling (78%) and ran support groups (70%), while two-thirds (65%) did school visits. Around three-quarters ran alcohol-misuse treatment and prevention groups (79%), men's groups (75%) and physical activity or healthy weight programs (74%) and more than two-thirds ran tobacco-use treatment and prevention groups, living skills groups, and cultural groups (70% each).
- The proportion of organisations providing group activities has gradually increased since 2012–13. For example, in those providing primary health care, the proportion of organisations with chronic disease support groups increased from 46% in 2012–13 to 52% in 2015–16. Those providing men's groups increased from 49% to 66%, women's groups from 52% to 66% and tobacco-use treatment and prevention groups from 42% to 59%.

Other common primary health promotion activities done by organisations included campaigns to encourage immunisation services to children (77%) and adults (69%), sexual health/education activities (72%) and mental health promotion (62%). With respect to mental health, although the proportion of organisations saying they provided mental health promotion activities increased from 47% in 2014–15 to 62% in 2015–16, the proportion reporting self-harm/suicide as one of their most important social and emotional wellbeing issues in terms of staff time and organisational resources also increased, from 45% to 57%. Moreover, just over half of organisations providing primary health-care services (54%) still reported mental health/social and emotional wellbeing services as one of their service gaps, and this was even higher in organisations funded to provide substance-use services, but not primary health care (81%).

2.2 Related information

The key findings of this report should be read in the context of other work undertaken by the AIHW to measure and report on health outcomes. Although the OSR collects information on the types of health services provided to Aboriginal and Torres Strait Islander people, it does not collect data on health outcomes. This information is presented in other reports such as the *National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care* (AIHW 2017) and the *Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: detailed analyses* (AIHW 2015a).

Together these provide information to monitor progress against the COAG commitment to Closing the Gap in health outcomes between Indigenous and non-Indigenous Australians. They also support the vision of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

National Key Performance Indicators (nKPIs) for Aboriginal and Torres Strait Islander primary health care

The Australian Health Ministers' Advisory Council (AHMAC) endorsed 24 nKPIs around maternal and child health, preventative health risk factors and chronic disease. These are some of the key focus areas in achieving the objectives of closing the gap in life expectancy between Indigenous and non-Indigenous Australians by 2031 and in halving the gap in child mortality by 2018.

Like the OSR, nKPI data is provided to the AIHW from organisations funded to provide primary health-care services to Aboriginal and Torres Strait Islander people. The nKPIs have been collected since June 2012. The indicators have been progressively developed and the full set of 24 are expected to be included in the June 2017 data collection. Many organisations contribute to both the OSR and nKPI collections. In 2015–16, 202 organisations reporting on their primary health care and/or maternal and child health services in the OSR (91%), also contributed to the nKPI collection.

The purpose of the nKPIs is to support policy and service planning at the national and state/territory level by monitoring progress and highlighting areas for improvement. They can also be used to improve the delivery of primary health-care services by supporting continuous quality improvement activity at the organisation level. For the latest nKPI report see <http://www.aihw.gov.au/publication-detail/?id=60129559276>.

The Aboriginal and Torres Strait Islander Health Performance Framework

The Aboriginal and Torres Strait Islander HPF was developed to support a coordinated effort to deal with the complex and interrelated factors that contribute to health outcomes experienced by Aboriginal and Torres Strait Islander Australians. The biennial HPF report presents a high-level summary of data and policy analysis for 68 performance measures across three tiers:

- health status and outcomes
- determinants of health, including socioeconomic and behavioural factors
- health system performance.

The AIHW prepares statistical analyses, which are used by PM&C in their reporting against the HPF (see <http://www.dpmc.gov.au/indigenous-affairs/evidence/aboriginal-and-torres-strait-islander-health-performance-framework-hpf>). The AIHW also releases HPF data tables online, and publishes state and territory specific reports upon request (see <http://www.aihw.gov.au/indigenous-data/health-performance-framework/>).

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 provides a long-term, evidence-based policy framework as part of the COAG approach to Closing the Gap in Indigenous disadvantage. The Health Plan builds on other government plans and strategies that support better health outcomes for Aboriginal and Torres Strait Islander people, including the COAG National Indigenous Reform Agreement and the previous National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–13.

The Implementation Plan for the Health Plan includes 20 goals to measure progress in meeting the priorities expressed in the plan. These goals focus on prevention and early intervention across the lifespan, and have a strong link to the key performance indicators in the primary health sector (DoH 2013). The Implementation Plan represents the blueprint of the agreed strategies, actions and goals to be achieved in Aboriginal and Torres Strait Islander health through to 2023, and they have an agreed annual pathway or trajectory for each year from 2013 to 2023, which was based on historical trend analyses undertaken by the AIHW (see <http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-implementation-plan>). A technical companion document to the Implementation Plan developed by the AIHW outlines these goals and how they will be measured (see <http://www.aihw.gov.au/publication-detail/?id=60129552639>).

Some of the indicators developed to measure the Implementation Plan goals are similar to the nKPIs. In the most recent nKPI report, the relevant Implementation Plan goals are compared to some of the nKPI national results (see AIHW 2017 for more information).

3 Primary health care

This chapter reports on Indigenous primary health-care services funded by the DoH (see Box 3.1). In 2015–16, 204 organisations funded to provide these services were in the OSR, 1 fewer than in 2014–15 (203). There were 13 new organisations now in scope for reporting on their primary health-care services, while 12 organisations reporting in 2014–15, were not required to report.

This chapter includes a profile of these organisations and information on the types of services they provide, client numbers, client contacts and episodes of care, staffing levels and service gaps and challenges.

Box 3.1: Overview of primary health-care services

There were 204 organisations providing Indigenous primary health-care services. Of these:

- One-third (33%) provided services in *Very remote* areas, 23% in *Outer regional* areas, 21% in *Inner regional* areas, 13% in *Remote* areas and 10% in *Major cities*.
- The Northern Territory and New South Wales and the Australian Capital Territory combined had the most organisations (56 and 44, respectively).
- Two-thirds (136) were ACCHOs and they saw around 362,600 (79%) clients. The other 68 included state and territory government-run organisations and other non-government-run organisations and they saw around 98,900 (21%) clients.
- Over three-quarters (159) had a board and 72% of these (114) had 100% Indigenous board membership.
- Three-quarters (78%) provided access to a doctor, while half (50%) provided all of the following services: diagnosis and treatment of illness and disease; antenatal care; maternal and child health care; social and emotional wellbeing/counselling services; and substance-use programs; as well as on-site or off-site access to specialist, allied health and dental services.
- A range of group activities were provided, for example, 7,600 physical activity/healthy weight sessions and 3,300 chronic disease client support sessions.

These organisations employed 7,766 FTE staff, and 53% were Aboriginal and Torres Strait Islander. Health staff made up 57% of FTE positions and other staff 43%. Nurses and midwives were the most common type of health position (1,166 FTE or 15% of employed staff), followed by Aboriginal and Torres Strait Islander health workers and practitioners (13%) and doctors (7%). Other staff included managers and supervisors, administrative and support staff, and drivers and field officers.

The organisations made around 5.4 million contacts with 461,500 clients. Nurses and midwives made around 1.6 million contacts (30%) and doctors 1.5 million (29%). Contacts by nurses represented half (52%) of all contacts in *Very remote* areas, compared with 30% overall.

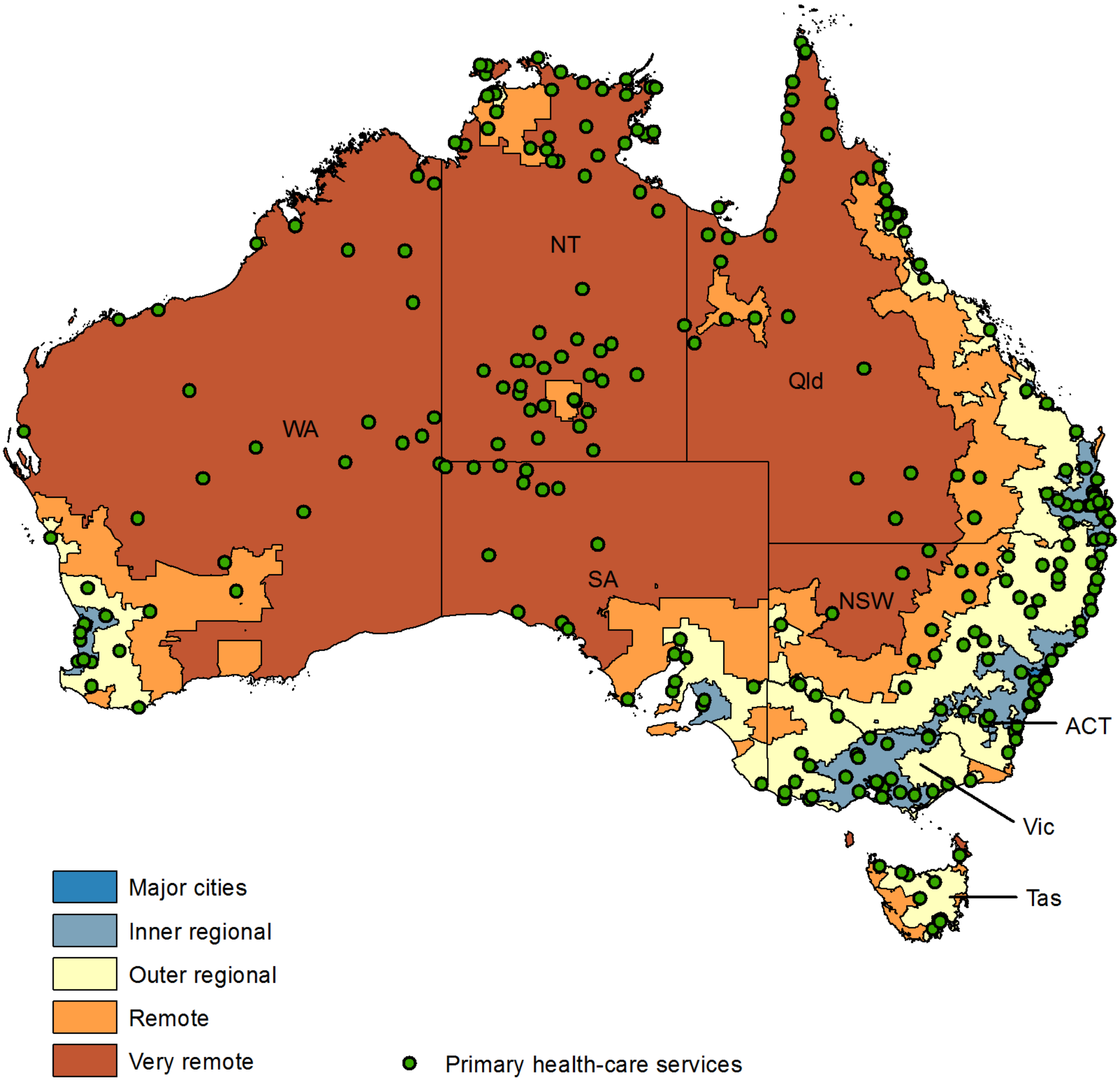
Around 3.9 million episodes of care were provided with over 1 million in *Very remote* areas.

Compared with 2014–15, client numbers and FTE staff employed increased by 6%, while average contacts (12) and episodes of care (8) per client were similar.

3.1 Organisation profile

Location

The 204 organisations providing Indigenous primary health-care services were spread across all states and territories and remoteness areas (see Figure 3.1).



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 3.1: Australian Government-funded organisations providing primary health-care services to Aboriginal and Torres Strait Islander people, by remoteness area, 2015–16

- One-third (33%) were in *Very remote* areas, 23% in *Outer regional* areas and 21% in *Inner regional* areas (see Table S3.1). Smaller proportions were in *Remote* areas (13%) and *Major cities* (10%).
- The Northern Territory had the most organisations with 56, followed by New South Wales and the Australian Capital Territory combined with 44 (see Figure 3.2). It should be noted that 36 (64%) organisations in the Northern Territory were small Northern Territory Government-run clinics that were counted in the OSR as separate organisations. Tasmania had the smallest number of organisations with 8.
- Three-quarters (77%) of organisations in the Northern Territory were in *Very remote* areas, as were 44% of those in Western Australia.
- Most organisations in Victoria were in either *Inner regional* (42%) or *Outer regional* (42%) areas, as were 68% of organisations in New South Wales and the Australian Capital Territory combined.

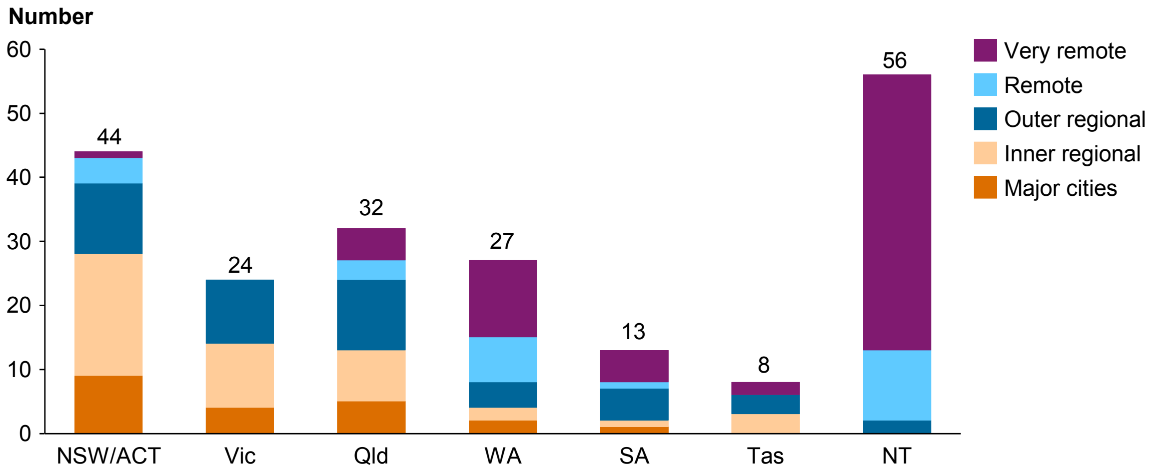


Figure 3.2: Number of primary health-care organisations, by state and territory and remoteness area, 2015–16

Compared with the distribution of the Indigenous population nationally, Indigenous clients from OSR organisations were over-represented in Western Australia and the Northern Territory (see Figure 3.3). The organisations in the Northern Territory and Western Australia saw a higher proportion of all OSR Indigenous clients compared with the distribution of the estimated Indigenous population as a whole. In contrast, although one-third of the estimated Indigenous population lived in New South Wales and the Australian Capital Territory combined (32%), a smaller proportion of OSR Indigenous clients were seen there (22%).

Note: In some cases OSR clients may be counted at more than one organisation. Estimated Indigenous population is the ABS estimated Indigenous population in June 2016 (series B estimate).

Figure 3.3: Proportion of OSR Indigenous clients and the estimated Indigenous population, by state and territory, 2015–16

Compared with the distribution of the Indigenous population nationally, Indigenous clients from OSR organisations were over-represented in *Remote* and *Very remote* areas and under-represented in *Major cities* (see Figure 3.4). Organisations in *Remote* and *Very remote* areas saw a higher proportion of all OSR Indigenous clients compared with the distribution of the estimated Indigenous population as a whole. Although around one-third of the estimated Indigenous population lived in *Major cities* (35%), a smaller proportion of OSR clients were seen there (19%).

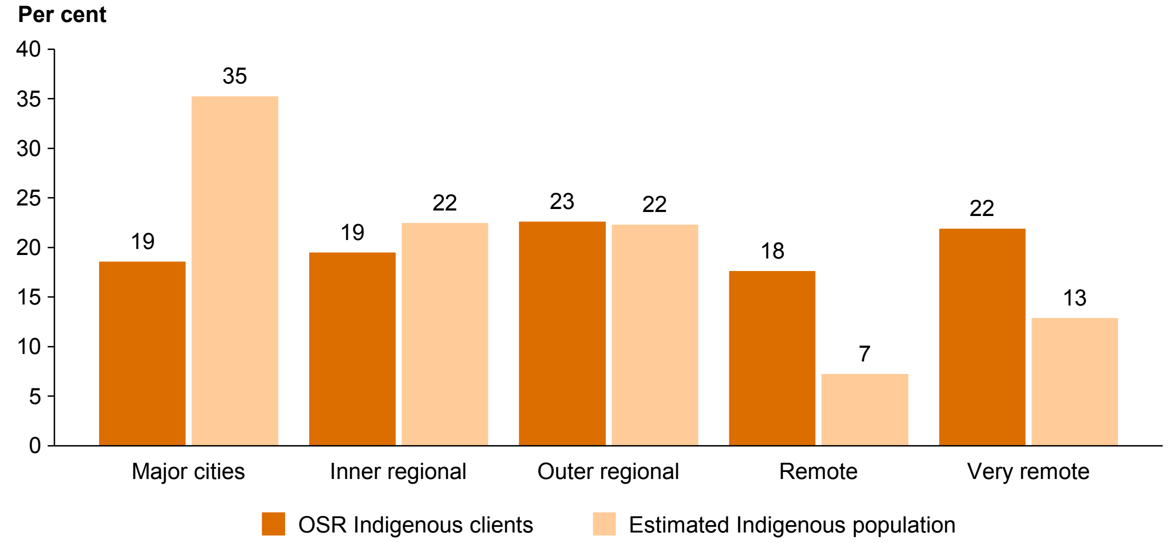


Figure 3.4: Proportion of OSR Indigenous clients and the estimated Indigenous population, by remoteness area, 2015–16

Key characteristics

Of the 204 organisations providing Indigenous primary health-care services:

- 72% (147) delivered services from 1 site, while 11% (23) had 2 sites and 17% (34) had 3 or more sites.
- 67% (136) were ACCHOs.
- 78% (159) had a governing committee or board and of these 72% had 100% Indigenous membership.
- 79% (162) were accredited against the Royal Australian College of General Practitioners (RACGP) and/or organisational standards.
- 28% (57) had more than 3,000 clients (see Table S3.2).

Type of organisation

These organisations can be broadly grouped into 3 types: ACCHOs, government-run organisations and other non-government-run organisations. ACCHOs are non-government organisations operated by local Aboriginal and Torres Strait Islander communities to deliver health care to the communities that control them, through an elected board of management (NACCHO 2015).

There were more ACCHOs than other types of organisations in all remoteness areas, except in *Very remote* areas and in all states and territories except the Northern Territory. This was due to the high number of small Northern Territory Government-run organisations in *Very remote* areas in the Northern Territory (see tables S3.3 and S3.4). In 2015–16:

- 67% (136 organisations) were ACCHOs. New South Wales and the Australian Capital Territory combined had the most ACCHOs with 36, followed by Queensland with 26 (see Figure 3.5).
- 26% (53 organisations) were government-run. Thirty-six of these (68%) were small Northern Territory Government-run clinics counted as separate organisations in the OSR. These 36 organisations represented 64% of organisations in the Northern Territory.
- 7% (15 organisations) were other non-government organisations, with 6 (40%) of these in New South Wales and the Australian Capital Territory combined.

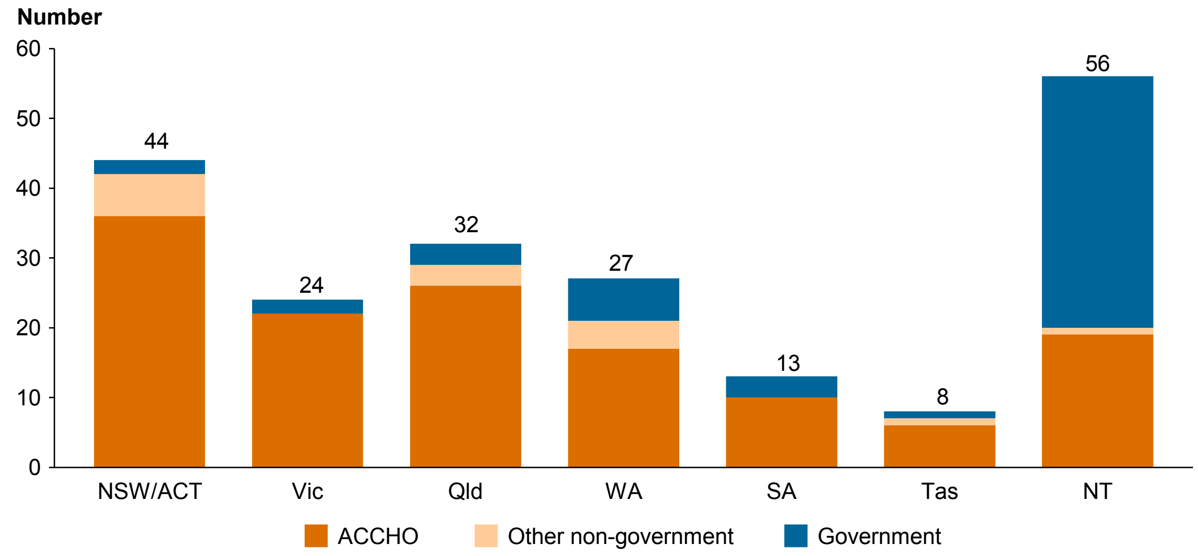


Figure 3.5: Number of primary health-care organisations, by type of organisation and state and territory, 2015–16

Governance

Most organisations (78%) had a governing committee or board. This was higher in ACCHOs (99%) than in other organisations (37%). Most ACCHOs with a governing committee or board had all Indigenous board members (85%). In other organisations with a governing committee or board, 32% had no Indigenous board members (see Table S3.5).

Accreditation

Organisations achieving accreditation or certification have been assessed as having reached defined standards of excellence in safety and quality in primary health care. In 2015–16, most (79%) organisations providing Indigenous primary health-care services were accredited by the Australian General Practice Accreditation Limited (AGPAL) against the RACGP standards for general practice and/or organisational standards such as the Quality Improvement Council (QIC), the International Organization for Standardization (ISO) or the Australian Council on Healthcare Standards (ACHS) (DoH 2014a). This was similar to 2014–15 (80%). An organisation may have both types of accreditation (clinical and organisational).

The proportion accredited varied by state and territory. In Queensland and South Australia, all organisations were accredited with the RACGP and/or against organisational standards, while in the Northern Territory and Tasmania this was 41% and 25% of organisations, respectively (see Table S3.6). This may be related to the size of these organisations. In the Northern Territory, the smaller government-run clinics were less likely to be accredited (11%) than were ACCHOs (100%).

The proportion accredited was higher in organisations with a doctor—GP (90%) compared with those without a doctor (41%). It was also higher in ACCHOs (97%) compared with other organisations (44%). A lower proportion of organisations in *Very remote* areas were accredited (54%), compared with other remoteness areas (see tables S3.7, S3.8 and S3.9).

Service size

Half (50%) the organisations providing primary health-care services had 1,500 or fewer clients and 22% had between 1,501 and 3,000 clients. Just over one-quarter (28%) were larger organisations with more than 3,000 clients and one-third of these were in Queensland (see Figure 3.6 and Table S3.10). Three-quarters (75%) of organisations in the Northern Territory had 1,500 clients or fewer while in Tasmania, half (50%) were very small with 500 or fewer clients.

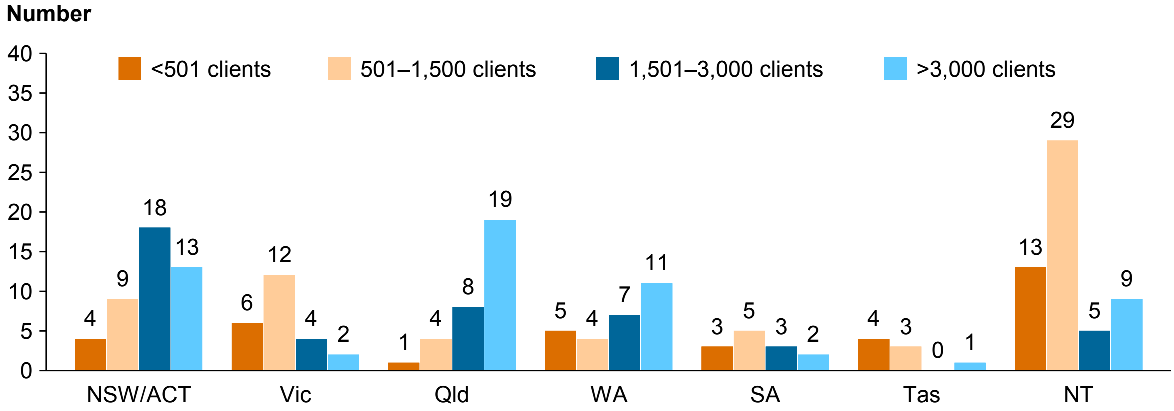
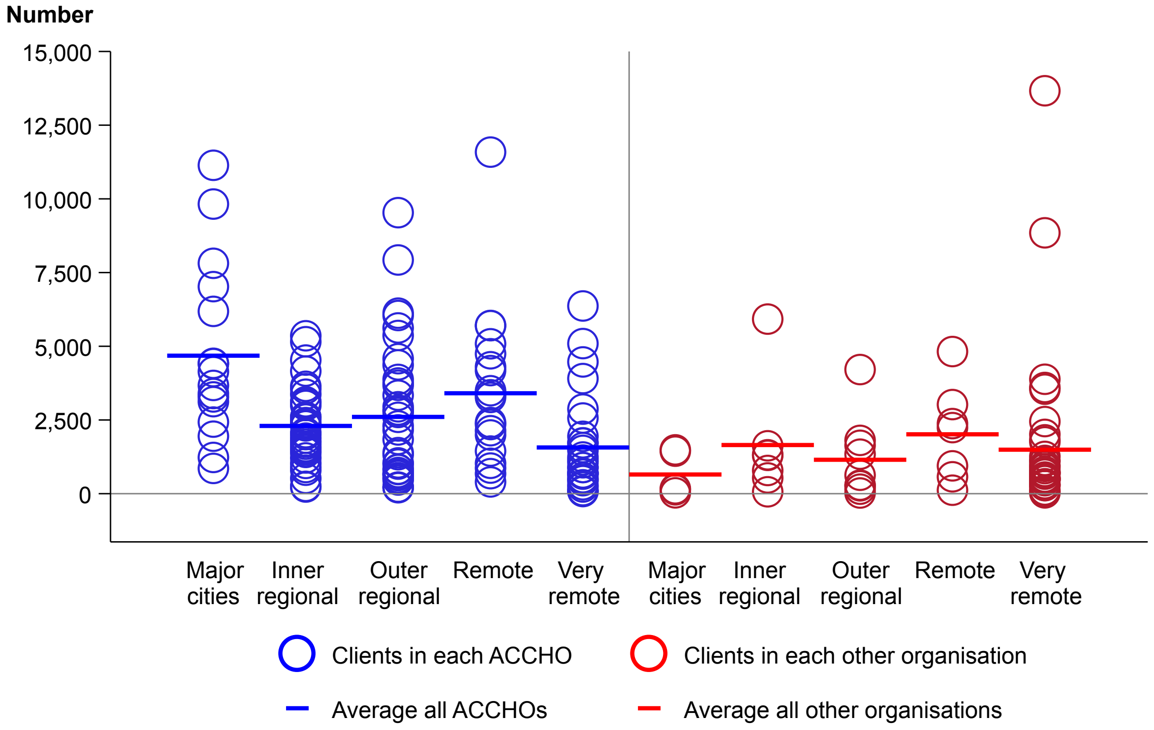


Figure 3.6: Number of primary health-care organisations, by size (number of clients) and state and territory, 2015–16

The proportion of organisations accredited with the RACGP or against organisational standards increased with service size. Forty-two per cent of organisations with 500 or fewer clients had neither form of accreditation, compared with 4% of those with more than 3,000 clients. The proportion with a governing committee or board also increased with service size. Although 56% of organisations with 500 or fewer clients had a board, this increased to 95% in those with more than 3,000 clients (see Table S3.11).

ACCHOs were generally larger than other organisations (see Figure 3.7 and Table S3.12). A higher proportion of ACCHOs had more than 3,000 clients (35% compared with 13% of other organisations), and a lower proportion had 1,500 or fewer clients (38% compared with 74% of other organisations).



Note: 'Other' organisations include both government-run organisations and non-government organisations (excluding ACCHOs).

Figure 3.7: Primary health-care organisations, by size (number of clients), type of organisation and remoteness area, 2015–16

3.2 Services provided

Organisations providing Indigenous primary health-care services generally provide access to doctors, nurses, allied health professionals, social and emotional wellbeing staff and medical specialists. Many provide a variety of services including health promotion, clinical care, substance-use treatment and prevention, and social and emotional wellbeing support. Some focus on specific activities such as health promotion. The vision outlined in the National Aboriginal and Torres Strait Islander Health Plan on health system effectiveness is that the Australian health system delivers primary health care that is evidenced-based, culturally safe, high quality, responsive and accessible (DoH 2013).

At a glance

In 2015–16, Indigenous primary-health care services were delivered by 204 organisations from 368 sites (see Table 3.1). Most sites (89%) operated 5 days or more per week, and 26% offered 24-hour emergency care, which was similar to 2014–15 (88% and 26%, respectively). Most sites provided clinical services, such as the diagnosis and treatment of chronic illnesses (85%), antenatal care (75%), maternal and child health care (80%), and mental health and counselling services (84%). Many also offered tobacco programs (61%) and substance-use programs (60%).

Three-quarters of organisations (78%) provided access to a doctor, while half (50%) delivered a wide range of services, including all of the following during usual opening hours: diagnosis and treatment of illness and disease; antenatal care; maternal and child health care; social and emotional wellbeing/counselling services; and substance use programs, as well as on-site or off-site access to a range of specialist, allied health and dental services.

Compared with 2014–15, Indigenous client numbers and FTE staff employed increased by 6%, while there were a similar average number of contacts (12) and episodes of care (8) per client.

Table 3.1: Indigenous primary health-care services, 2014–15 and 2015–16

	2014–15		2015–16	
	Number	**%**	**Number**	**%**
Total organisations providing services	**203**	**100.0**	**204**	**100.0**
Organisations providing a wide range of services[(a)]	86	42.4	101	49.5
Organisations with a doctor (employed/visiting)	157	77.3	160	78.4
Sites and services during usual opening hours				
Diagnosis and treatment of chronic illness/diseases	293	84.9	311	84.5
Diagnosis and treatment of infectious illness/diseases	266	77.1	286	77.7
Treatment of injury	251	72.8	283	76.9
Antenatal care	267	77.4	274	74.5
Maternal and child health care	280	81.2	293	79.6
Social and emotional wellbeing/mental health/counselling	277	80.3	310	84.2
Substance use/drug and alcohol programs	200	58.0	220	59.8
Tobacco programs	213	61.7	223	60.6
Transport	288	83.5	304	82.6
Total sites	**345**	**100.0**	**368**	**100.0**
Clients				
Indigenous clients	344,331	79.2	364,389	79.0
Total clients	**434,610**	**100.0**	**461,483**	**100.0**
Episodes of care/contacts				
Episodes of care	3,542,617	100.0	3,867,277	100.0
Average episodes per client	8	. .	8	. .
Client contacts	5,022,709	100.0	5,380,653	100.0
Average contacts per client	12	. .	12	. .
Employed staff (FTE)				
Health	4,454	60.5	4,457	57.4
Other	2,905	39.5	3,309	42.6
Total	**7,359**	**100.0**	**7,766**	**100.0**

(a) Includes all of the following services during usual opening hours: diagnosis and treatment of illness and disease; antenatal care; maternal and child health care; social and emotional wellbeing/counselling services; and substance use programs, as well as on-site or off-site access to a range of specialist, allied health and dental care services.

Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In 2015–16, it was the financial year from 1 July to 30 June.

Health promotion

Health promotion is the process of enabling people to increase control over and improve their health (WHO 2016). It may include for example, policy interventions, information to support healthy lifestyles, marketing and media campaigns and activities to empower individuals and strengthen communities (AHMAC 2015).

In 2015–16, organisations providing Indigenous primary health-care services ran a range of health promotion programs and activities (see Figure 3.8 and Table S3.13). Most (85%) had healthy lifestyle programs, ranging from 81% in *Major cities, Remote* and *Very remote* areas to 91% in *Inner regional* areas. Most also promoted immunisation services to children (77%) and adults (69%), and provided sexual health/education activities (72%). Generally, the proportions providing various health promotion activities were similar to 2014–15; however, there was an increase in the proportion providing mental health promotion activities (62% compared with 47% in 2014–15) and those working with food stores to encourage healthy eating (45% compared with 38%), and a decrease in the proportion promoting immunisation to adults (69% compared with 79%) and those giving advice and advocacy on environmental health issues (30% compared with 40%).

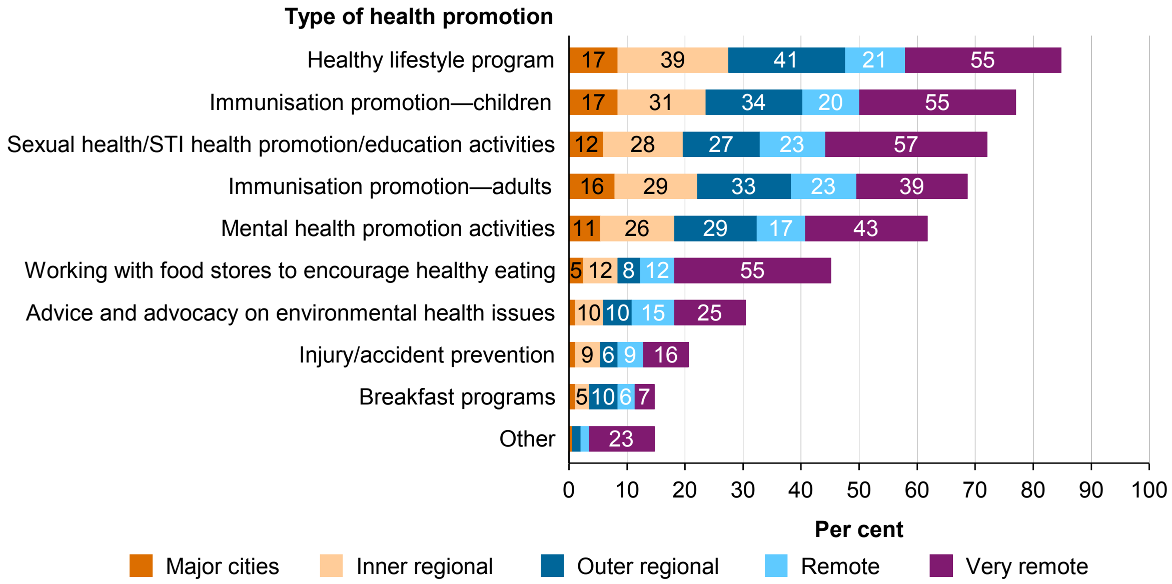
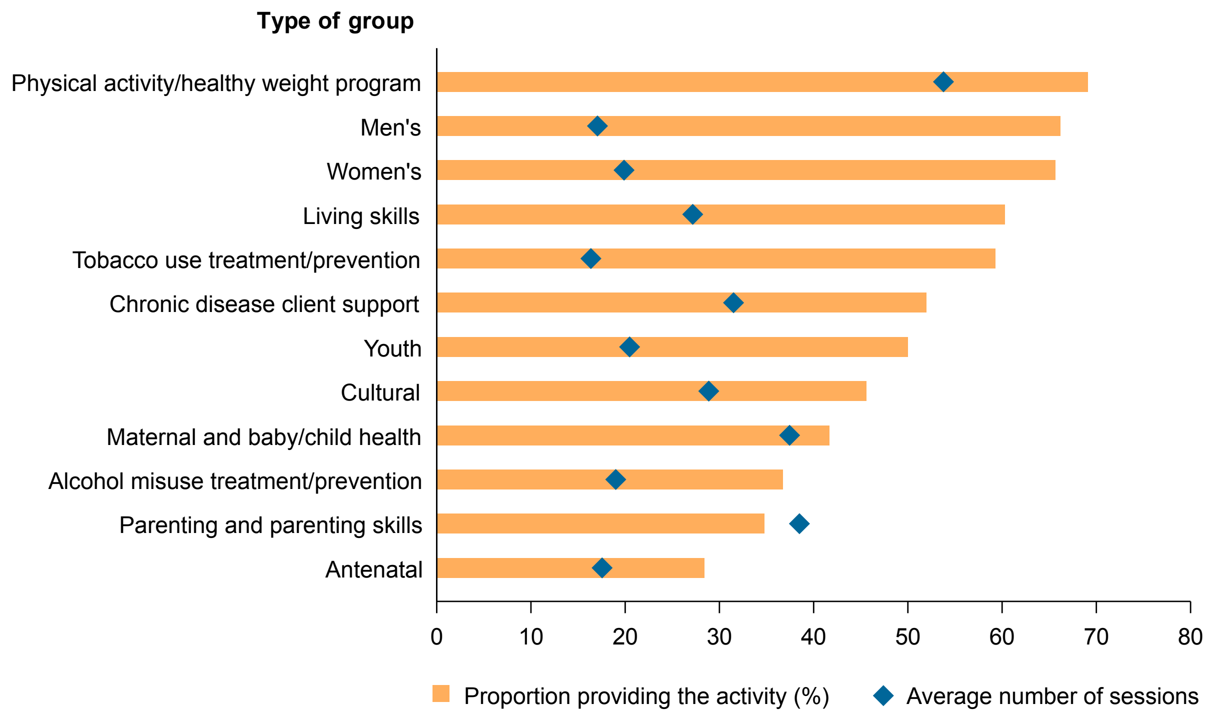


Figure 3.8: Number (as labelled) and proportion (in scale) of primary health-care organisations, by type of health promotion and remoteness area, 2015–16

Group activities

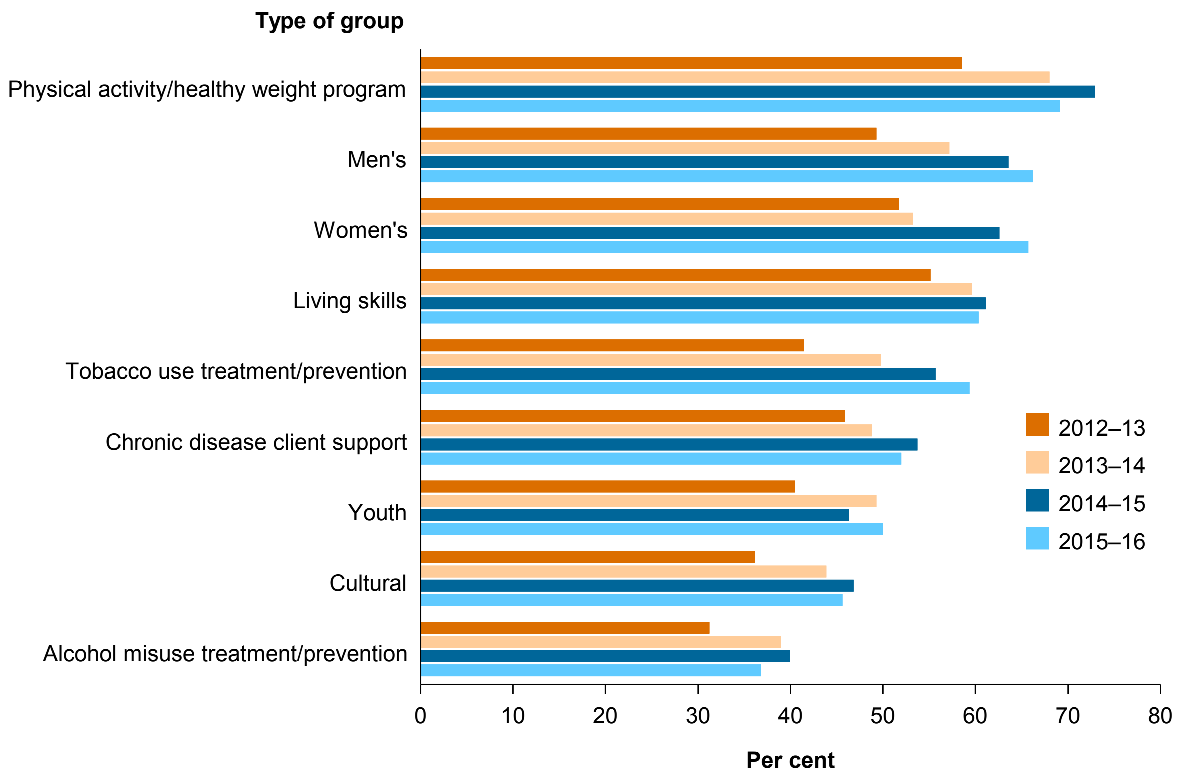
Most organisations (194 or 95%) provided at least one type of group activity as part of their health promotion and prevention work. For example, around 7,600 physical activity/healthy weight sessions, 3,300 living skills sessions, 3,300 chronic disease client support sessions and 2,000 tobacco-use treatment and prevention sessions were conducted (see Table S3.14). Around two-thirds (69%) ran physical activity and healthy weight programs, while living skills groups were run by 123 (60%) organisations, tobacco-use treatment and prevention groups by 121 (59%), chronic disease client support groups by 106 (52%) and alcohol-misuse treatment and prevention groups by 75 (37%) organisations. Two-thirds of organisations ran men's and women's groups (both 66%), half (50%) ran youth groups and 93 (46%) ran cultural groups (see Figure 3.9). With respect to maternal and child health care, 85 (42%) organisations ran maternal and baby/child health groups, over one-third ran parenting groups (35%) and did home visits (38%) and 28% ran antenatal groups (see Table S3.14).



Note: Averages are based on the number of organisations providing each type of individual group activity. Organisations not providing an activity were excluded from average calculations.

Figure 3.9: Proportion of primary health-care organisations providing selected group activities and the average number of sessions conducted, by type of group activity, 2015–16

The proportion of organisations providing various group activities has gradually increased since 2012–13 (see Table S3.15). For example, the proportion providing chronic disease support groups increased from 46% in 2012–13 to 52% in 2015–16; men's groups from 49% to 66%; women's groups from 52% to 66%; and tobacco-use treatment/prevention groups from 42% of organisations to 59% (see Figure 3.10).



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 3.10: Proportion of primary health-care organisations providing selected group activities, by type of group activity, 2012–13 to 2015–16

Clinical or health-related services

Organisations provided various clinical and health-related services. As in 2014–15, most organisations kept track of clients who needed follow-up (98%) and provided child immunisation (87%), free medical supplies and pharmaceuticals (83%), and routine screening for sexually transmitted infections (81%) to the local community (see Figure 3.11). Over half (57%) provided services for people with a disability, palliative care (52%) and aged care (58%). Organisations in *Remote* and *Very remote* areas were more likely to provide free medical supplies/pharmaceuticals (92% and 91%, respectively) and palliative care (65% and 60%, respectively) than organisations in other areas. Organisations in *Very remote* areas were also more likely to provide aged care services (77%) and medical evacuation services (75%) compared with other areas (see Table S3.16).

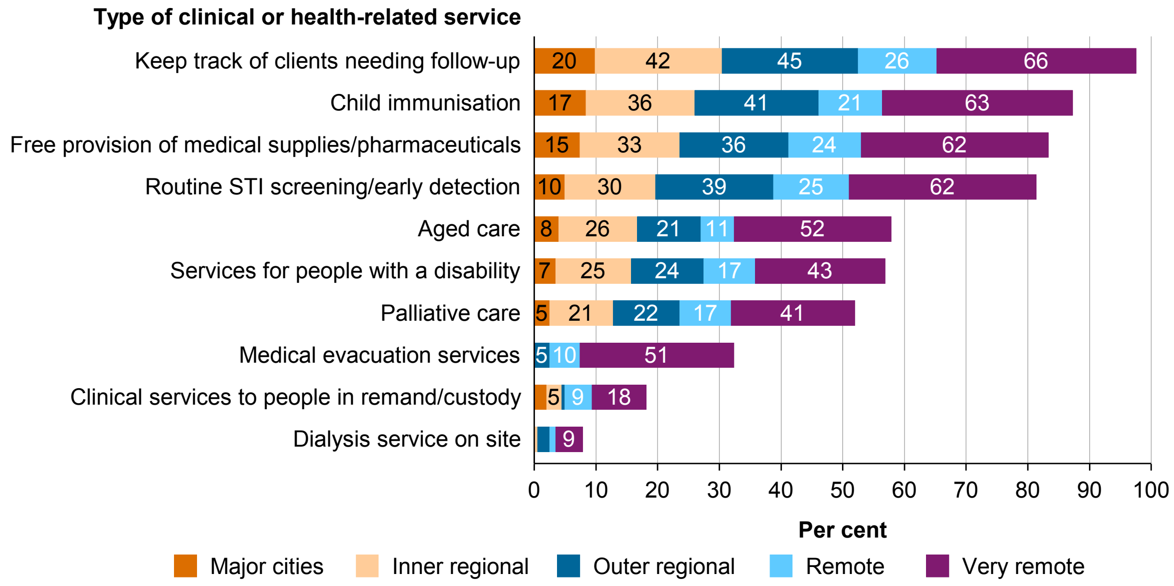


Figure 3.11: Number (as labelled) and proportion (in scale) of primary health-care organisations providing selected clinical or health-related services, by remoteness area, 2015–16

Most organisations (89%) had established relationships with Aboriginal liaison officers at local hospitals and 72% had shared care arrangements for chronic disease management with local hospitals. Around two-thirds (68%) reported that discharge planning was well coordinated and that staff regularly attended hospital/ specialist appointments with clients (65%), while 58% had staff that regularly visited clients in hospital (see Figure 3.12). These were similar to 2014–15. Organisations in *Major cities, Inner regional* and *Outer regional* areas were more likely to have staff who regularly attended hospital or specialist appointments with clients, or visited clients in hospital, compared with those in *Remote* and *Very remote* areas where access to hospitals would be more limited (see Table S3.17). The coordination of clinical care with other providers, such as hospitals, was reported as a challenge in delivering quality health services by 43% of organisations (see Section 3.7).

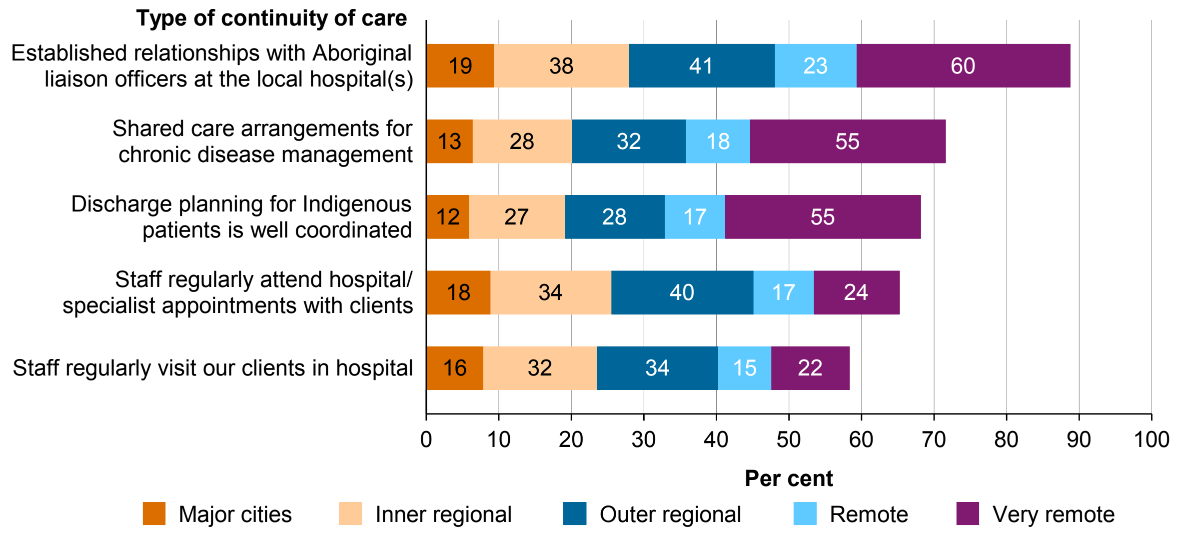


Figure 3.12: Number (as labelled) and proportion (in scale) of primary health-care organisations providing continuity of care with local hospitals, by remoteness area, 2015–16

Access to specialist, allied health and dental services

Organisations providing Indigenous primary health-care services also offered access to a range of specialist services (for example, paediatric, cardiology, renal, ophthalmologic, psychiatric, diabetes and ENT); allied health services (for example, physiotherapy, podiatry, optometry and audiology); and dental services. These were provided on site and/or through facilitating access to off-site services. A small proportion of organisations did not provide any access to these services (see Figure 3.13 and Table S3.18). In 2015–16:

- Paediatrician services were available at 94% of organisations (30% on-site only, 46% off-site only and 19% both on-site and off-site).
- Diabetes specialist services were available at 94% of organisations (32% on-site only, 49% off-site only and 13% both on-site and off-site).
- Podiatrist services were available at 96% of organisations (61% on-site only, 23% off-site only and 11% both on-site and off-site).
- Dental services were available at 94% of organisations (33% on-site only, 46% off-site only and 15% both on-site and off-site).
- ACCHOs were more likely than other organisations to provide on-site access to most specialist, allied health and dental services, while other organisations were more likely to provide off-site access to these services (see Table S3.19).

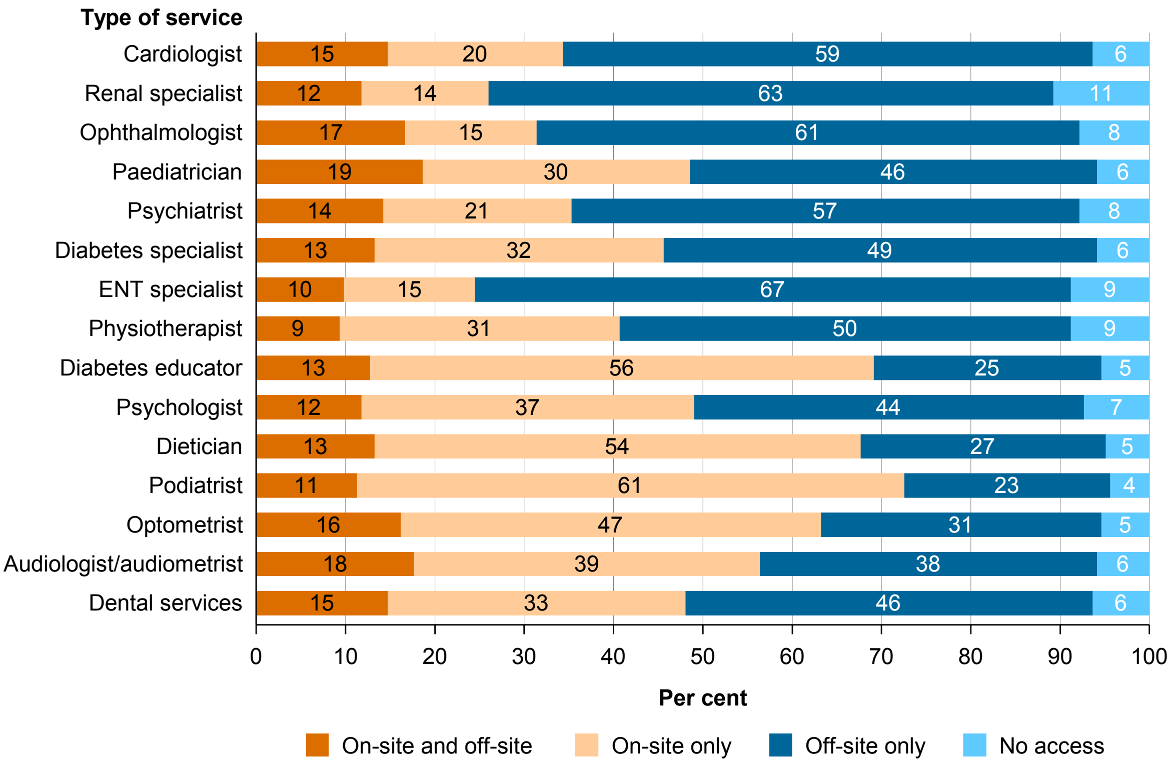
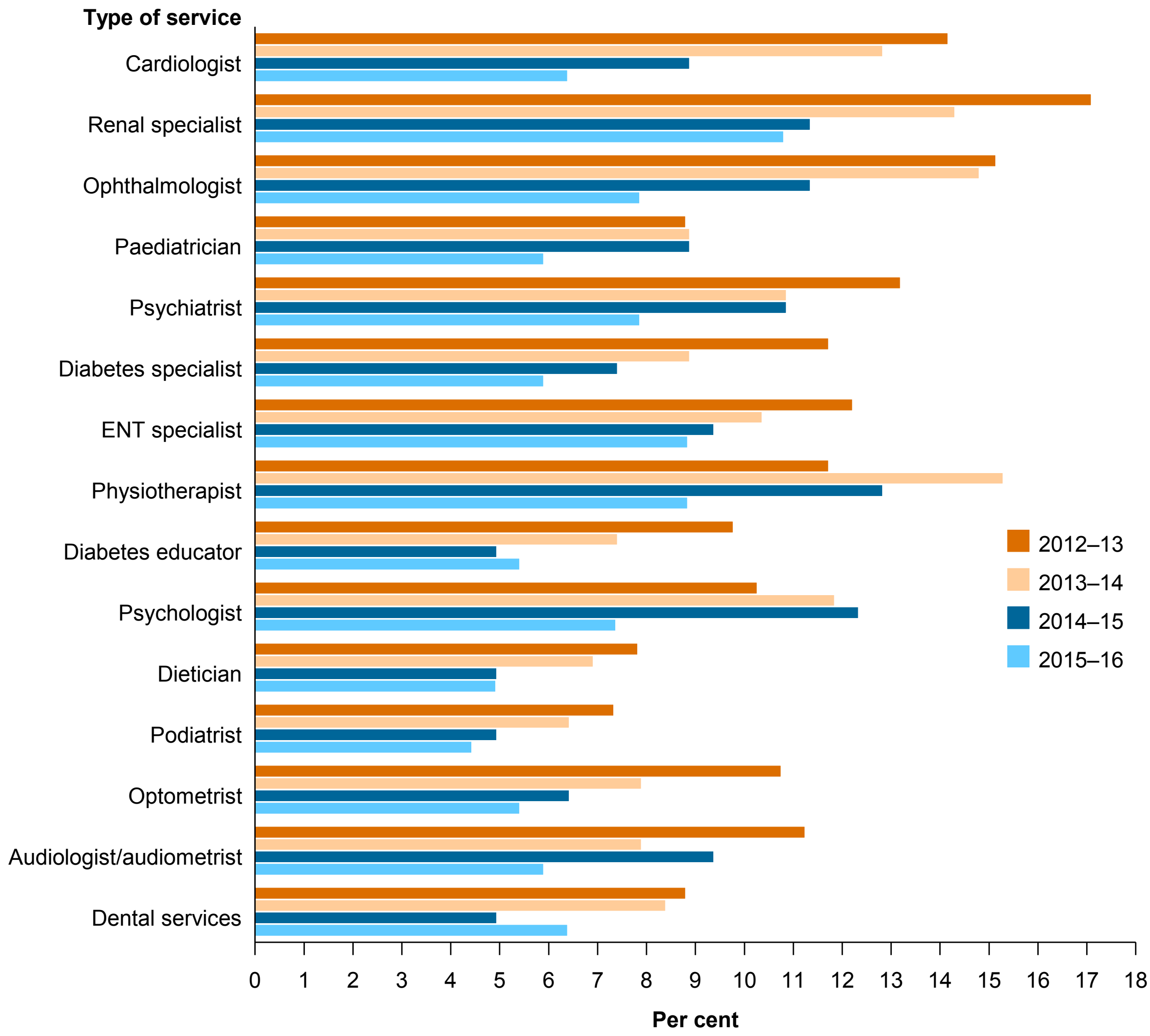


Figure 3.13: Proportion of primary health-care organisations, by type of access to specialist, allied health and dental services, by type of service, 2015–16

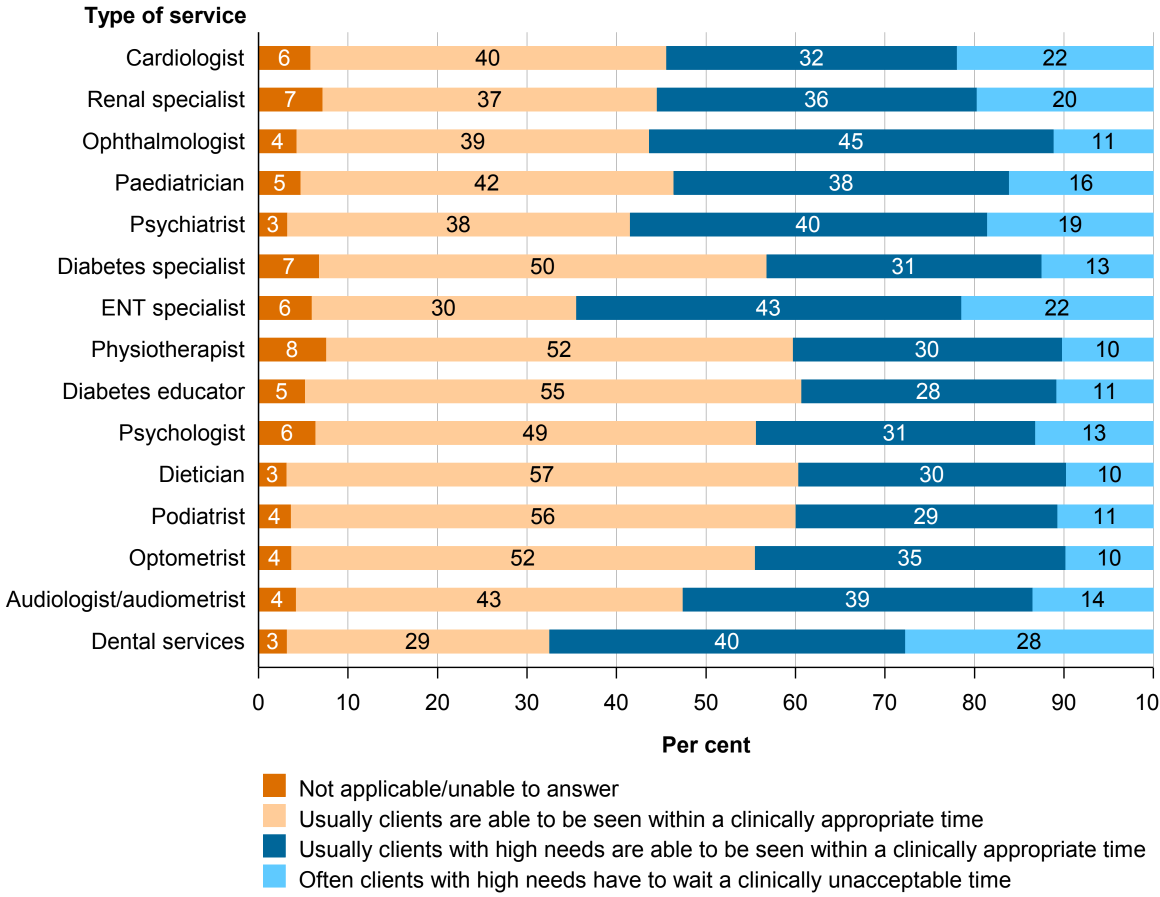
The proportion of organisations providing on-site or off-site access to a range of specialist and allied health services has increased gradually over the past 3 years. For example, in 2015–16, 94% provided access to a cardiologist compared with 86% in 2012–13, while 92% provided access to an ophthalmologist compared with 85% in 2012–13 (see Table S3.20). Conversely, the proportion of organisations with no on-site or off-site access to specialist and allied health services has gradually decreased since 2012–13 for most types of services (see Figure 3.14).



Note: Is the proportion of organisations with no on-site or off-site access to each type of service, in each year.

Figure 3.14: Proportion of primary health-care organisations offering no access to specialist, allied health and dental services, by type of service, 2012–13 to 2015–16

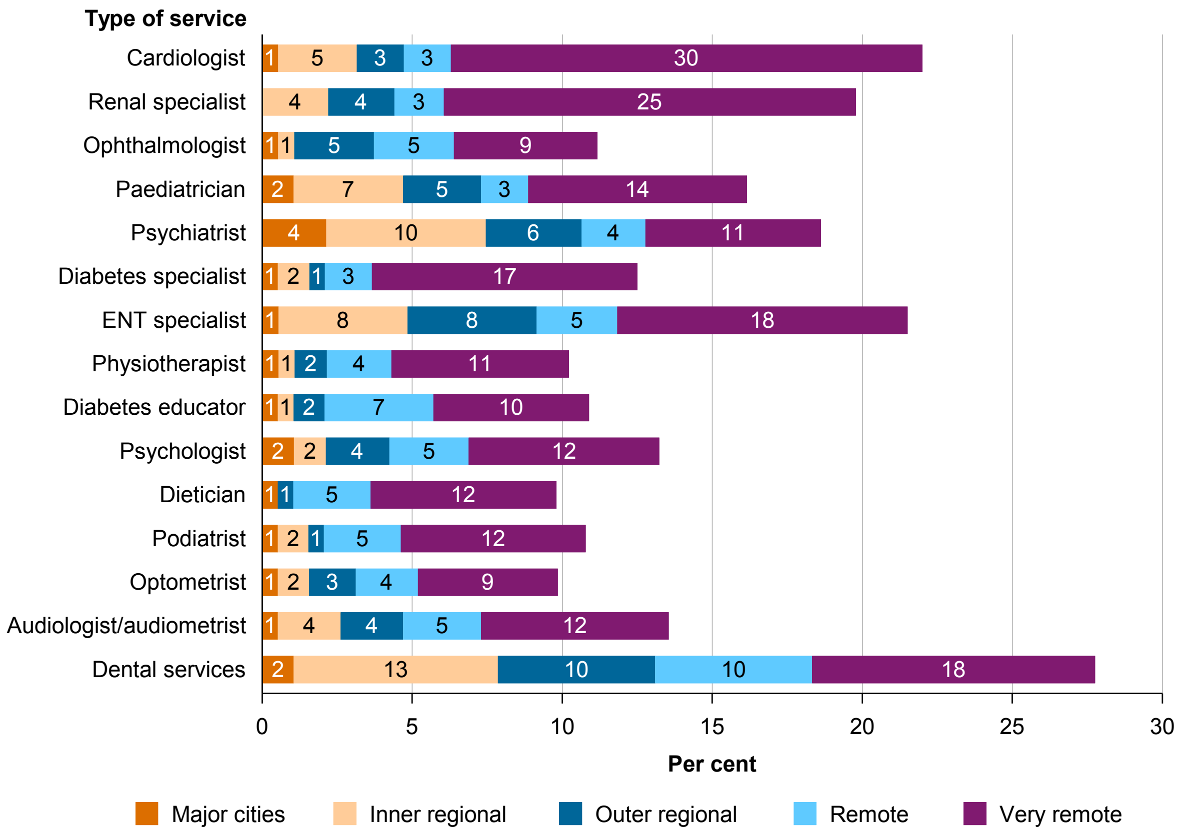
Organisations providing on-site or off-site access to specialist, allied health and dental services were asked to rate the level of access for their clients to these services, between 1 (usually clients were able to be seen within a clinically appropriate time) and 3 (clients with high priority needs often had to wait a clinically unacceptable time). In 2015–16, the proportion of organisations providing services that felt all clients or high priority needs clients were usually able to see these specialist or allied health professionals within a clinically appropriate time, ranged from 69% for dental services to 87% for dieticians (see Figure 3.15 and Table S3.21).



Note: Proportions are based on the number of organisations providing on-site or off-site access to that service only.

Figure 3.15: Proportion of primary health-care organisations offering access to specialist, allied health and dental services, by level of client access and type of service, 2015–16

The proportion of organisations providing these services that felt clients with high-priority needs often had to wait a clinically unacceptable time was higher for dental services (28% or 53 organisations), and specialist services such as cardiologists (22%), ENT specialists (22%), renal specialists (20%), and psychiatrists (19%). For many specialist services, organisations in *Very remote* areas were more likely to say that clients with high-priority needs had to wait a clinically unacceptable time (see Figure 3.16 and Table S3.22). For example, the proportion of organisations in *Very remote* areas that felt clients with high needs had to wait too long was higher for cardiologists (46% compared with 22% in all organisations), renal specialists (39% compared with 20% in all organisations), paediatricians (21% compared with 16% in all organisations), and diabetes specialists (25% compared with 13% in all organisations). For most allied health services, organisations in *Remote* and *Very remote* areas were more likely to say clients with high priority needs had to wait a clinically unacceptable time. For example, 20% of organisations in *Remote* areas and 19% in *Very remote* areas felt clients with high needs had to wait too long to see psychologists, compared with 13% overall. For dieticians this was 20% and 18%, respectively compared with 10% overall, and for podiatrists this was 19% each compared with 11% overall. For dental services, the proportion of organisations that felt clients with high priority needs had to wait a clinically unacceptable time was much lower in *Major cities* where only 2 organisations (11%) felt clients had to wait too long to access services.



Note: Proportions are based on the number of organisations that provided on-site or off-site access to that service. Organisations not providing access to that service were excluded from the calculations.

Figure 3.16: Number (as labelled) and proportion (in scale) of primary health-care organisations that felt that clients with high-priority needs had to wait too long for services, by type of service and remoteness area, 2015–16

Social and emotional wellbeing services

Many organisations provide social and emotional wellbeing support services to clients as part of their primary health-care delivery. In 2015–16, most (93%) organisations providing Indigenous primary health-care services provided social and emotional wellbeing or mental health or counselling services during usual opening hours, and 24% provided services outside usual hours. Around three-quarters (76%) reported providing services to members of the Stolen Generation.

Organisations were asked about their 5 most important social and emotional wellbeing issues in terms of staff time and organisational resources (see Table S3.23). The issues they provided the most assistance for were depression (82%), anxiety and stress (79%), grief and loss issues (64%), self-harm/suicide (57%) and family/relationship issues (57%). These were similar to the issues reported in 2014–15, although the proportion reporting self-harm/suicide increased from 45% of organisations in 2014–15 to 57% in 2015–16.

Organisations provided a range of social and emotional wellbeing support and mental health services to clients. For example, most (90%) provided short-term counselling; 74% long-term or ongoing counselling; 60% group activities; 58% self-harm and suicide prevention; and 42% outreach services (see Table S3.24).

It should be noted that 76 (37%) organisations providing primary health-care services were also funded by PM&C specifically to deliver social and emotional wellbeing services. More information on all organisations funded to provide these services is provided in Chapter 5.

Substance-use services

Many organisations provide substance-use services as part of their primary health-care delivery. Two-thirds of organisations providing Indigenous primary health-care services provided substance-use/drug and alcohol programs (68%) and tobacco programs (67%) during usual opening hours. Organisations were asked about their 5 most important substance-use issues in terms of staff time and organisational resources (see Table S3.25). The most common substance-use issues they provided services for were alcohol (96%), tobacco/nicotine (87%), cannabis/marijuana (79%), amphetamines (58%) and multiple drug use (45%). These were similar to those reported in 2014–15. Organisations provided a range of substance-use services (see Table S3.26). Most provided individual counselling (86%), community education (80%), school education and visits (65%) and crisis intervention services (63%). Around one-third provided support groups (36%), group counselling (35%), youth programs (34%) and a Tackling Indigenous Smoking and Healthy Lifestyle/Tackling Indigenous Smoking team (28%).

It should be noted that 38 (19%) organisations providing primary health-care services were also funded specifically by PM&C to provide substance-use services. More information on all organisations funded to provide these services is provided in Chapter 6.

3.3 Clients

In 2015–16, all organisations providing Indigenous primary health-care services in the OSR reported individual client numbers. It should be noted that 31 organisations (15%) estimated their client numbers. In some cases, individuals may be clients at more than one organisation and therefore counted twice, so the total client count is likely to overestimate the total number of individual clients seen. Some clients may also be clients of other mainstream primary health-care providers.

In 2015–16, these organisations saw around 461,500 clients. This was 6% higher than the number of clients reported in 2014–15 (around 434,600). Queensland had the highest number of clients (around 134,500), followed by New South Wales and the Australian Capital Territory combined (around 104,900). Tasmania had the lowest number, with around 4,500 clients (see Table S3.27). Just under half (45%) of all clients were seen in either *Outer regional* (106,700 clients) or *Very remote* areas (103,600 clients).

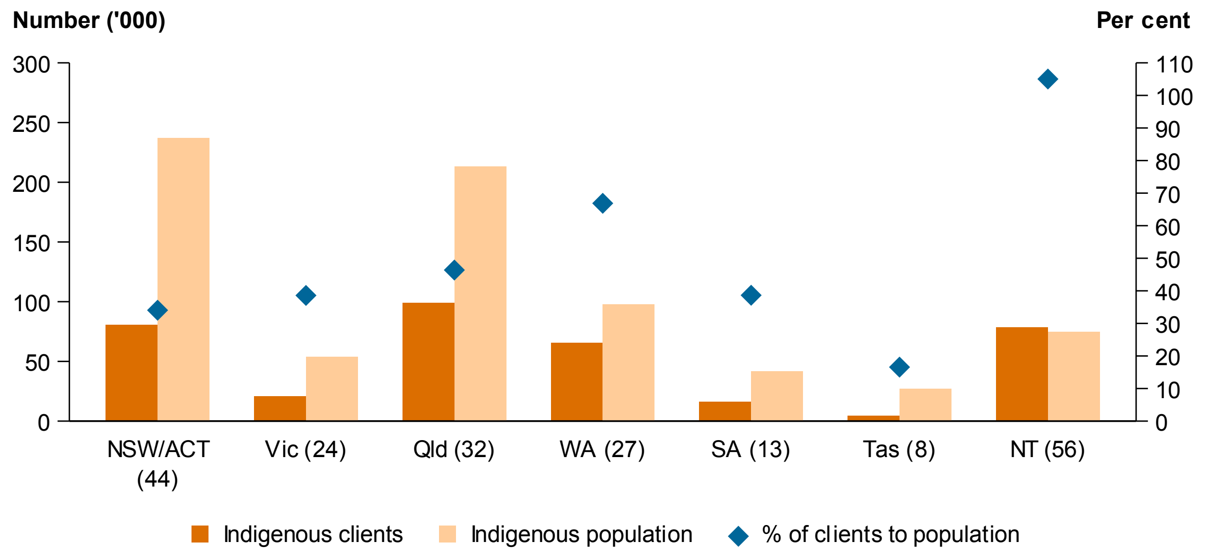
Indigenous status

Seventy-nine per cent of clients (around 364,400) were Indigenous, 18% were non-Indigenous and 3% had no Indigenous status recorded. These were similar proportions to 2014–15. Across the states and territories:

- Queensland had 16% of organisations and 27% of all Indigenous clients.
- New South Wales and the Australian Capital Territory combined had 22% of organisations and a similar proportion (22%) of all Indigenous clients.
- The Northern Territory had 27% of organisations and 21% of all Indigenous clients.
- Western Australia had 13% of organisations and 18% of all Indigenous clients.

Proportion of the estimated Indigenous population

The Indigenous clients of these organisations represented nearly half (49%) the total Indigenous population of Australia, estimated by the Australian Bureau of Statistics (ABS) to be around 745,000 in June 2016 (ABS 2014). Coverage of the Indigenous population varied by state and territory and ranged from an estimated 17% of the total Indigenous population in Tasmania to all of the Indigenous population in the Northern Territory (see Figure 3.17). It should be noted that clients may have attended more than one organisation and so the proportion of the total Indigenous population that were clients of these organisations is likely to be overestimated. This is most obvious in the Northern Territory where OSR Indigenous clients were more than the estimated Indigenous population of the Northern Territory. The Northern Territory had a relatively large number of organisations (56) contributing to the collection and some clients may have been counted at both an ACCHO and one of the Northern Territory Government-run clinics.



Note: In some cases, OSR clients may be counted at more than one organisation. The proportion of clients to population may therefore be overestimated. Indigenous population is based on the ABS estimated Indigenous population in June 2016 (series B estimate). The number of organisations in each state and territory is in brackets.

Figure 3.17: Indigenous clients, population and proportion of clients to population, by state and territory, 2015–16

Type of organisation

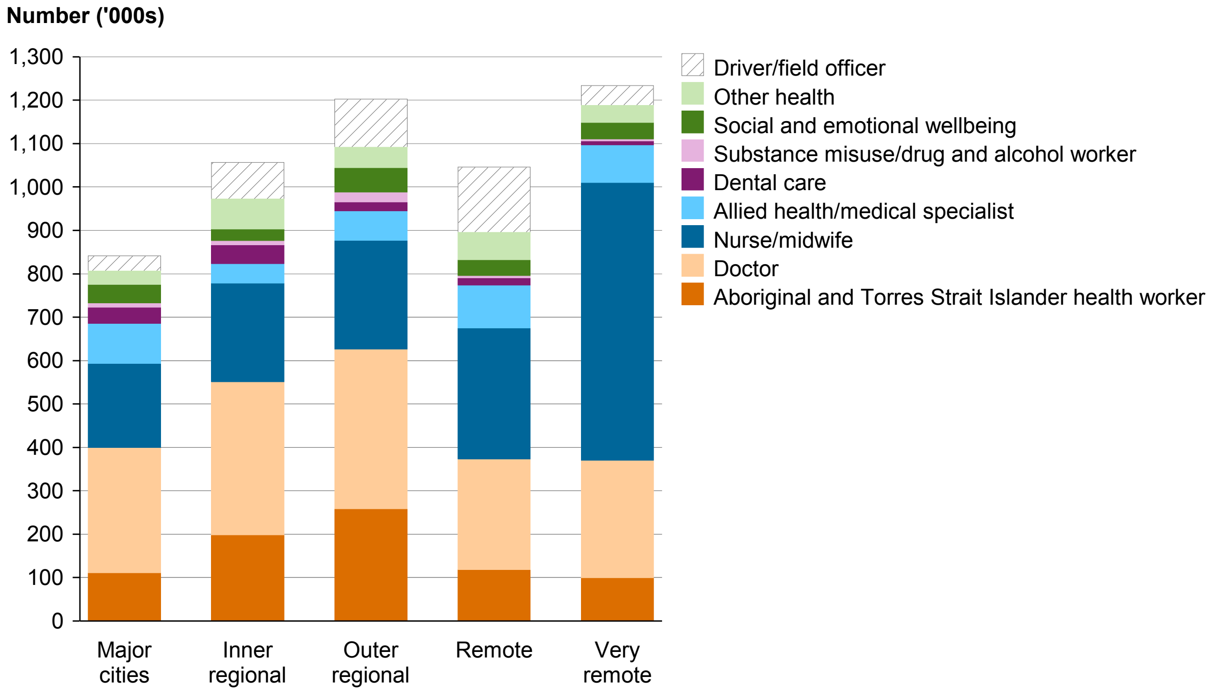
ACCHOs represented 67% of all organisations and saw around 362,600 (79%) clients, while other organisations saw around 98,900 (21%) clients (see Table S3.28). Indigenous clients represented 81% of ACCHOs' clients and 71% of other organisations' clients (see Table S3.29). ACCHOs had more Indigenous clients than other organisations in all states and territories and therefore saw a higher proportion of the total estimated Indigenous population (39%), compared with other organisations (9%).

3.4 Client contacts

Organisations providing Indigenous primary health-care services report on both their client contacts and episodes of care in the OSR. An episode of care is a contact between an individual client and one or more health workers within a calendar day. All contacts with the same client on the same day are counted as one episode of care only. Client contacts, however, are the number of individual contacts made with each client by each health worker and include contacts by employed and visiting health staff and those providing transport services. If more than one worker sees a client in the same visit (for example, a nurse and a driver) then one episode of care will result in more than one client contact.

In 2015–16, organisations providing Indigenous primary health-care services made around 5.4 million client contacts—an average of 11.7 contacts per client (see Table S3.30). The average number of contacts per client ranged from 10.3 in Queensland to 16.8 in South Australia (see Table S3.32). A higher proportion of all contacts were made in *Very remote* areas (23%) and *Outer regional* (22%) areas, and a smaller proportion (16%) in *Major cities*, reflecting the distribution of clients in these areas (see Figure 3.18). Nearly 6 in 10 (59%) contacts were with nurses/midwives or doctors:

- Nurses and midwives (15% of the total FTE workforce reported by organisations providing Indigenous primary health-care services) made around 1.6 million contacts (30% of all contacts). Of these, 40% were in *Very remote* areas and 19% in *Remote* areas. Contacts by nurses represented half (52%) of all contacts in *Very remote* areas and 29% of contacts in *Remote* areas—a higher proportion than in other areas.
- Doctors (7% of the total FTE workforce reported) made around 1.5 million contacts (29% of all contacts). Of these, 24% were in *Outer regional* areas (368,000). Contacts by doctors represented around one-third of all contacts in *Major cities* (34%), *Inner regional* areas (33%) and *Outer regional* areas (31%), but less than one-quarter of contacts in *Remote* (24%) and *Very remote* (22%) areas.
- Aboriginal and Torres Strait Islander health workers and practitioners (13% of the total FTE workforce reported) made around 782,000 contacts (15% of all contacts). One-third of these (258,000) were in *Outer regional* areas.
- Allied health professionals (4% of the total FTE workforce reported) made around 329,000 contacts (6% of all contacts).
- Social and emotional wellbeing staff (5% of the total FTE workforce reported) made around 201,000 contacts (4% of all contacts).
- Drivers and field officers (5% of the total FTE workforce reported) made around 428,000 contacts (8% of all contacts).



Notes

1. Aboriginal and Torres Strait Islander health practitioner positions are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
2. 'Other health' positions included sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.

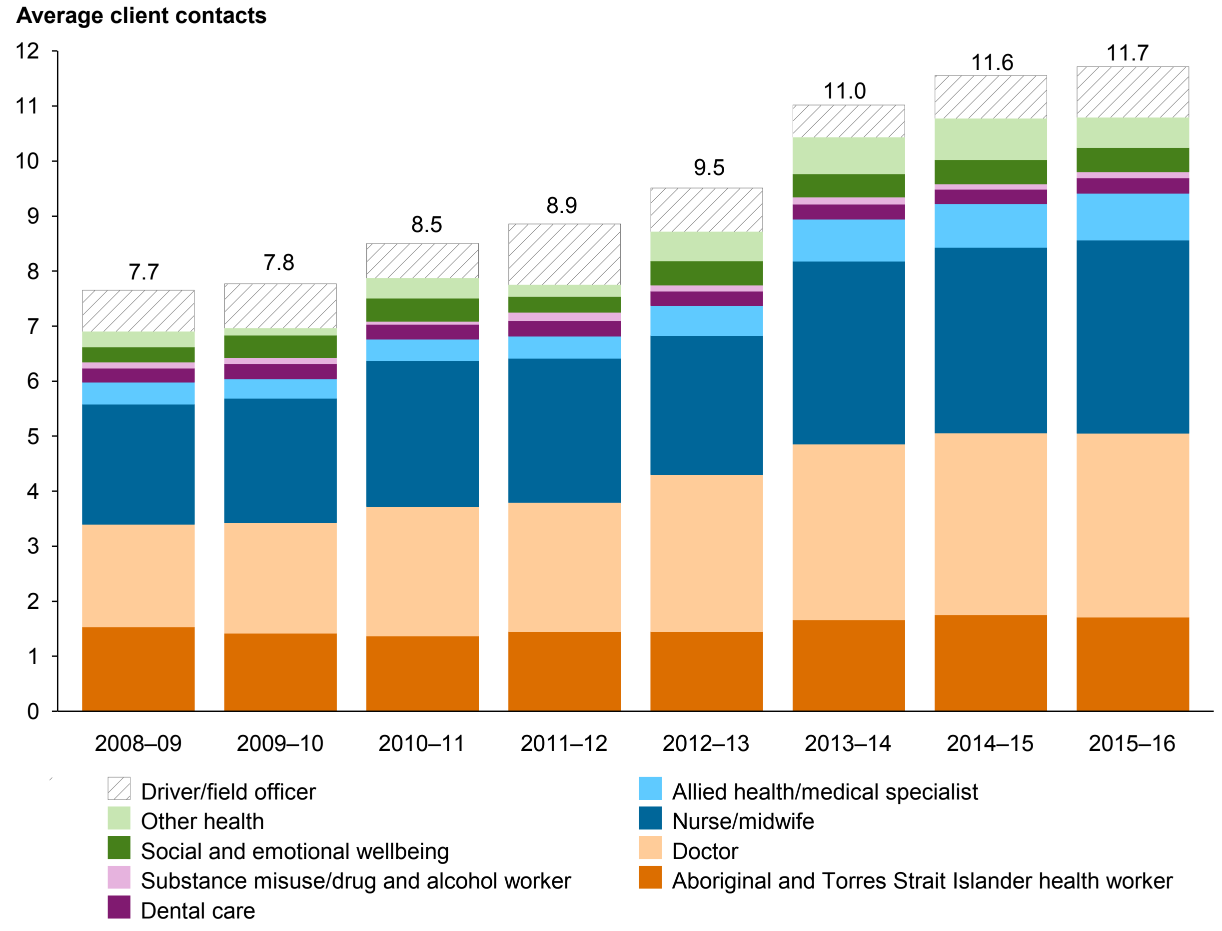
Figure 3.18: Number of client contacts, by position type and remoteness area, 2015–16

Time series

The total number of client contacts in 2015–16 (5.4 million) was 7% higher than in 2014–15 (5.0 million). There were increases in contacts across all remoteness areas (see Table S3.31). Some of this increase (13%) was a result of organisations reporting in 2015–16 that did not report in the previous year; however, most of the increase (87%) was in organisations reporting in both years.

Average number of contacts

The average number of contacts per client (11.7) was similar to 2014–15 (11.6) and was similar for most position types. The average number of contacts per client has steadily increased over the past 7 years, from 7.7 in 2008–09 to 11.7 in 2015–16 (see Figure 3.19 and Table S3.33). Since 2008–09, there has been an increase in the average number of contacts per client with doctors (from 1.9 in 2008–09 to 3.3 in 2015–16) and nurses and midwives (from 2.2 in 2008–09 to 3.5 in 2015–16).



Notes

1. In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.
2. Aboriginal and Torres Strait Islander health practitioner positions were new in 2012–13 and are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
3. 'Other health' positions included sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.

Figure 3.19: Average number of contacts per client, by position type, 2008–09 to 2015–16

3.5 Episodes of care

An episode of care is a contact between an individual client and one or more health workers within a calendar day. All contacts with the same client on the same day are counted as one episode of care. If more than one health worker sees a client on the same day, then one episode of care will result in more than one client contact. An episode of care may include health care provided on site, off site and over the phone. It does not, however, include residential care, group activities, administrative contacts (for example, a receptionist making an appointment) or transport only contacts.

In 2015–16, most organisations (99%) reported their episodes of care. It should be noted that 22 organisations (11%) estimated their episodes of care. Organisations providing Indigenous primary health-care services made around 3.9 million episodes of care, an increase from 3.5 million in 2014–15. Just over 1 million of these (26%) were in *Very remote* areas (see Table S3.34). Queensland had the most episodes of care (24%), followed by New South Wales and the Australian Capital Territory combined, and the Northern Territory (both 22%), reflecting the higher number of organisations and clients in these areas (see Table S3.35).

Type of organisation

ACCHOs provided around 3.1 million (80%) episodes of care and other organisations around 756,000 (20%). For ACCHOs, the number of episodes of care was higher in *Outer regional* (25%) and *Inner regional* (20%) areas. For other organisations, the number of episodes of care was higher in *Very remote* (65%) and *Remote* (12%) areas, reflecting the increasing number of other organisations by remoteness, in particular the Northern Territory Government-run clinics (see Figure 3.20 and Table S3.36).

Time series

The number of episodes of care has steadily increased since 2008–09, and increased by 9% in 2015–16 compared with 2014–15 (see Table S3.34). There were increases in all states and territories, except Victoria. Most of this increase (78%) was from organisations reporting in both years. This increase may be related to increases in both client numbers (6%) and FTE staff (6%) in 2015–16.

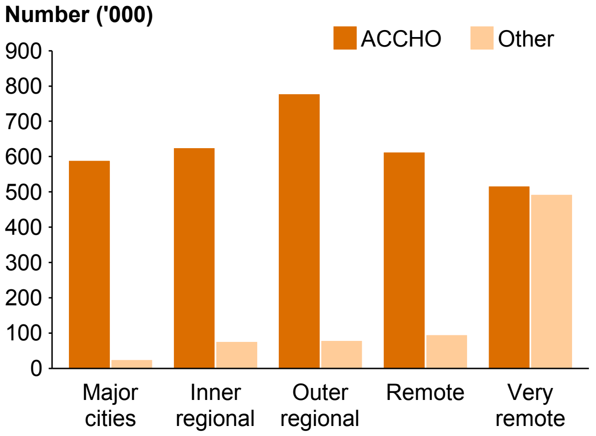
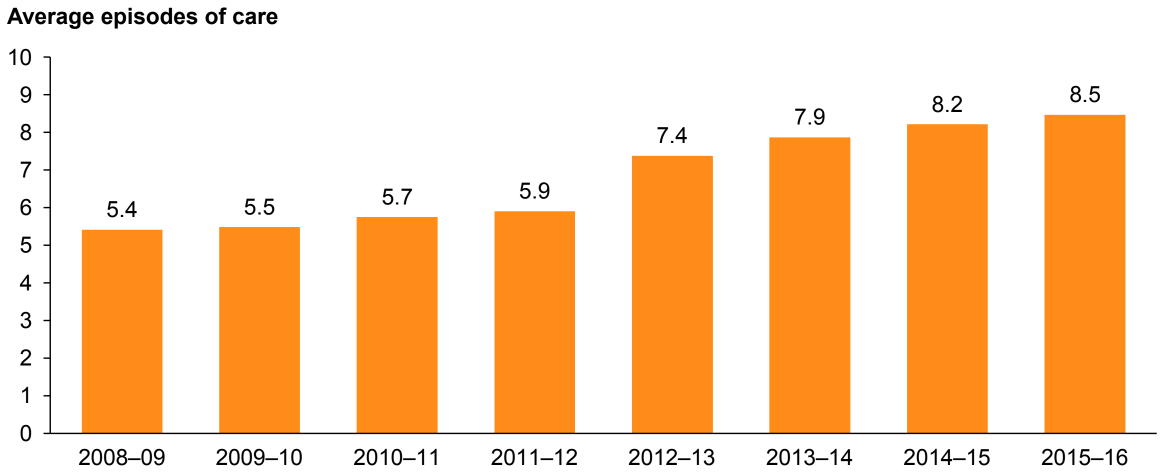


Figure 3.20: Number of primary health-care episodes of care, by type of organisation and remoteness area, 2015–16

Average number of episodes of care

The average number of episodes of care per client has steadily increased over the past 7 years from 5.4 in 2008–09 to 8.5 in 2015–16 (see Figure 3.21 and tables S3.37 and S3.38). This may suggest a demand for services, that organisations were following clients up more often, or that they were providing more services to them. The average increased by 0.3 compared with 2014–15 (8.2). The average number of episodes of care per client was higher in *Very remote* areas (9.7). It was also higher in South Australia (13.8) compared with other states and territories and may be related to the higher FTE per 1,000 clients reported in this state.



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

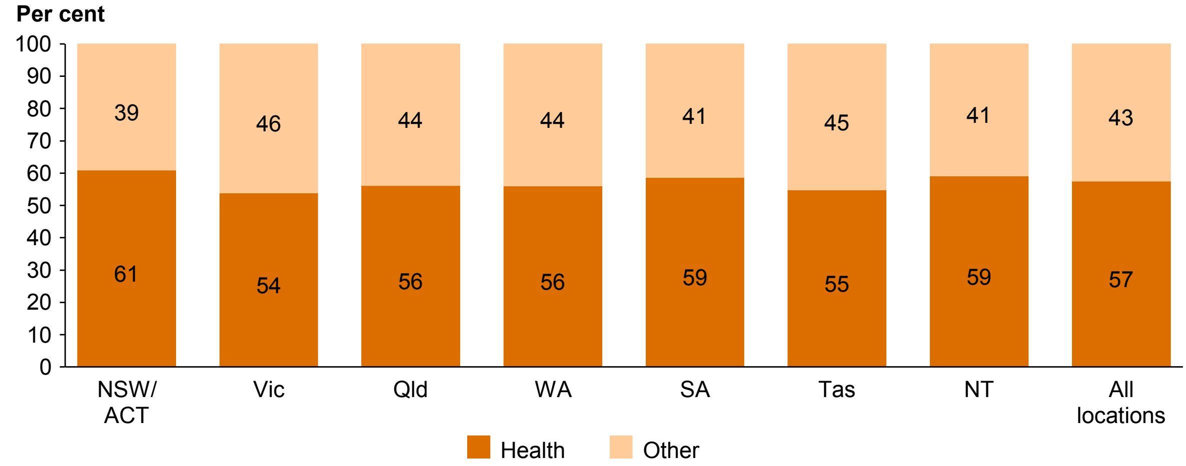
Figure 3.21: Average number of primary health-care episodes of care per client, 2008–09 to 2015–16

The average number of episodes of care per client is related to the number of FTE staff. As the number of FTE staff per 1,000 clients has increased, so too has the average number of episodes of care per client (see Table S3.39). The average number of episodes of care per health FTE staff was 826, compared with 762 in 2014–15. Since 2008–09, the average number of episodes of care per health FTE staff has ranged from 719 in 2010–11 to 826 in 2015–16.

3.6 Staffing

Organisations providing Indigenous primary health-care services employed 7,766 FTE staff as at 30 June 2016, which is 6% higher than at 31 May 2015 (7,359 FTE). Of these, 57% were health staff and 43% other staff (including managers and supervisors, administrative and support staff, and drivers and field officers). The proportion of health staff was lower compared with 31 May 2015 (61%).

In 2015–16, the proportion of health staff was higher in *Very remote* areas (60%) and lower in *Remote* areas (52%). There was also some variation by state and territory. The proportion of health staff ranged from 54% in Victoria to 61% in New South Wales and the Australian Capital Territory combined (see Figure 3.22). Victoria and Tasmania had a higher proportion of other staff (46% and 45% of all staff, respectively).



Note: Excludes visiting staff. See Appendix B for a list of positions included as 'health' and 'other' positions.

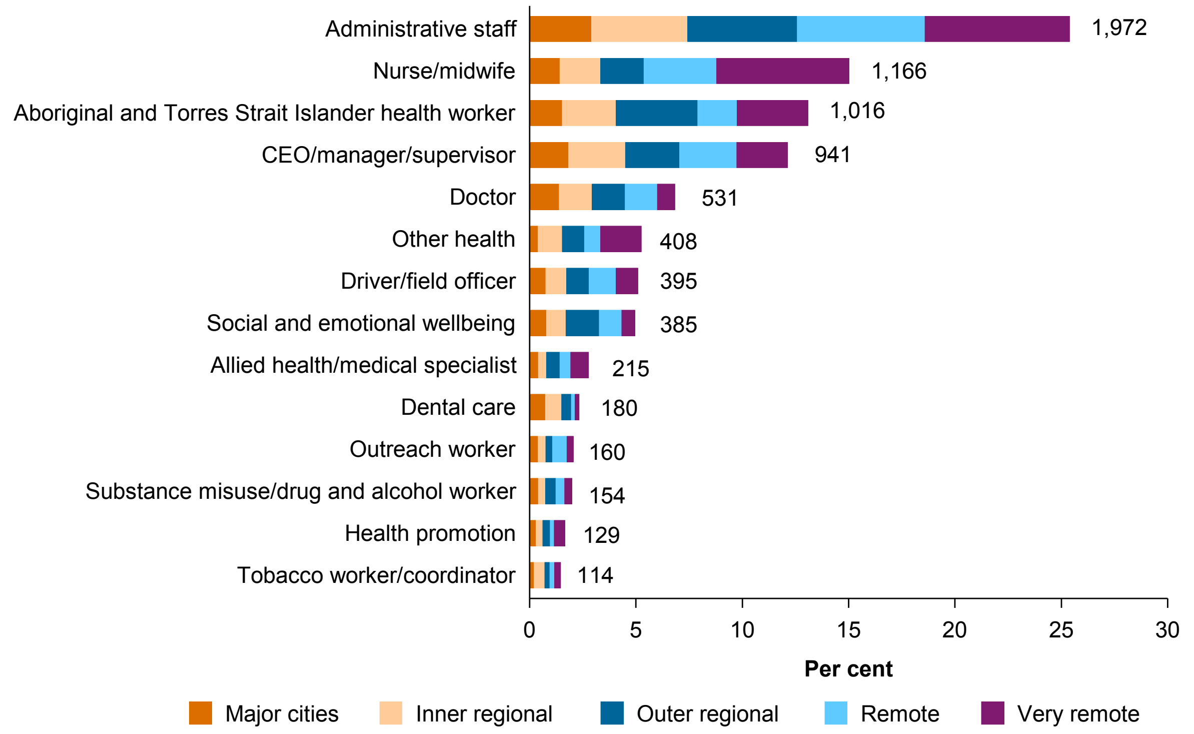
Figure 3.22: Proportion of FTE staff employed by primary health-care organisations, by position type and state and territory, as at 30 June 2016

Just over half (53%) of FTE staff employed were Indigenous, a similar proportion to 2014–15 (53%). Although smaller proportions of doctors and nurses were Indigenous (7% and 12%, respectively), nearly all Aboriginal and Torres Strait Islander health workers and health practitioners were Indigenous (98%), as were most drivers and field officers (87%), and outreach workers (87%). A high proportion of tobacco workers (74%), substance misuse workers (71%) and health promotion workers (71%) were also Indigenous (see Table S3.40).

These organisations were also assisted by an additional 317 FTE visiting staff not paid for by the organisations themselves, making a total workforce of 8,083 FTE staff (see Table S3.41). This equates to an average of 17.5 FTE staff per 1,000 clients in these organisations.

Type of positions

Health staff represented 57% of employed staff (4,457 FTE) and nurses and midwives were the most common type of health worker (1,166 FTE or 15% of employed FTE staff). Aboriginal and Torres Strait Islander health workers and health practitioners represented 13% of employed FTE staff and doctors 7% (see Figure 3.23). Administrative staff (including administrative and clerical, finance and accounting, information technology and data management, and support staff) made up one-quarter (25%) of employed positions (1,972 FTE).



Notes

1. Health practitioners are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
2. Administrative staff include administrative and clerical staff, finance and accounting staff, information technology and data management staff, and support staff.
3. 'Other health' positions include sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health staff not recorded elsewhere.
4. Excludes visiting staff.

Figure 3.23: Number (as labelled) and proportion (in scale) of FTE staff employed by primary health-care organisations, by position type and remoteness area, as at 30 June 2016

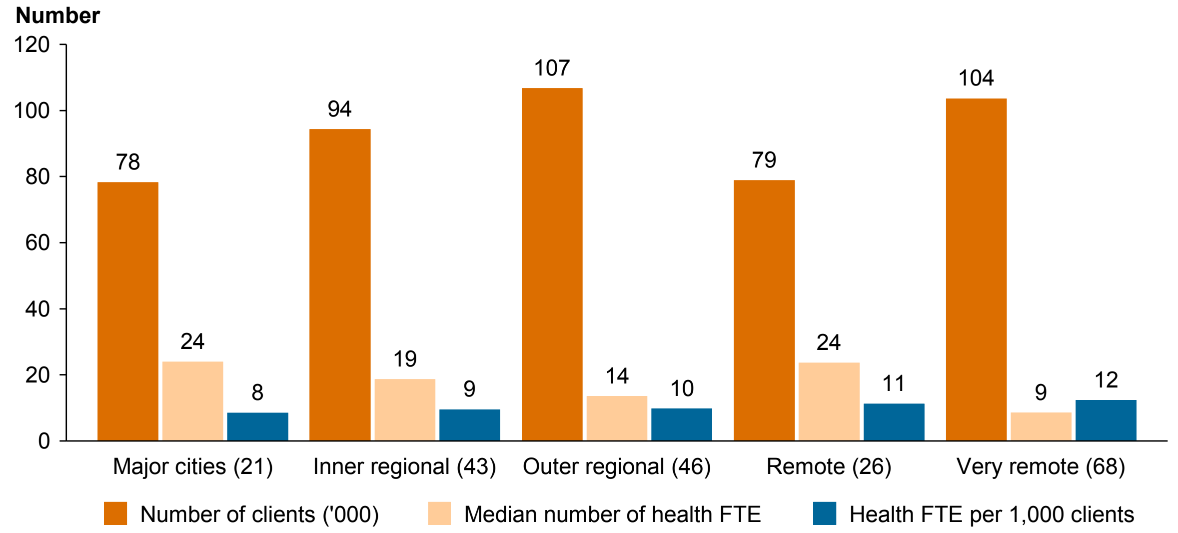
Remoteness area

The distribution of employed staff varied by remoteness area with over one-quarter (26%) employed in *Very remote* areas, followed by *Remote* and *Outer regional* areas with 21% each. *Major cities* had a smaller proportion of FTE staff (13%). There were also differences in the types of positions by remoteness area. *Major cities* and *Inner regional* areas had a higher proportion of all dental care staff employed, with 32% each (see Table S3.43). *Outer regional* areas had a higher proportion of Aboriginal and Torres Strait Islander health workers and practitioners (29%), and social and emotional wellbeing staff (32%) than other areas. *Remote* and *Very remote* areas had higher proportions of nurses and midwives (23% and 42%, respectively).

As at 30 June 2016:

- Aboriginal and Torres Strait Islander health workers and practitioners represented 13% of employed FTE positions. Of the 1,016 FTE health worker and practitioners employed, 29% (297 FTE) were in *Outer regional* areas and 26% (260 FTE) in *Very remote* areas.
- Nurses and midwives represented 15% of employed FTE positions. Of the 1,166 FTE nurses and midwives employed, 42% (485 FTE) were in *Very remote* areas and 23% (265 FTE) in *Remote* areas.
- Doctors represented 7% of employed FTE positions. The 531 FTE doctors were evenly spread across all remoteness areas except *Very remote* areas, which had a lower proportion (12%) compared with other areas.
- Social and emotional wellbeing staff represented 5% of employed FTE positions. Of the 385 FTE staff employed, 32% (122 FTE) were in *Outer regional* areas.
- Allied health professionals represented 2.5% of employed FTE positions. Of the 195 FTE allied health professionals employed, 32% (63 FTE) were in *Very remote* areas and 23% (46 FTE) in *Outer regional* areas.

Health FTE staff per 1,000 clients (including both employed and visiting staff) was higher in organisations in *Remote* and *Very remote* areas (11 and 12 per 1,000 clients, respectively) and lower in *Major cities* (8 per 1,000 clients). The median number of health FTE staff per organisation was higher in *Major cities* and *Remote* areas (see Figure 3.24).

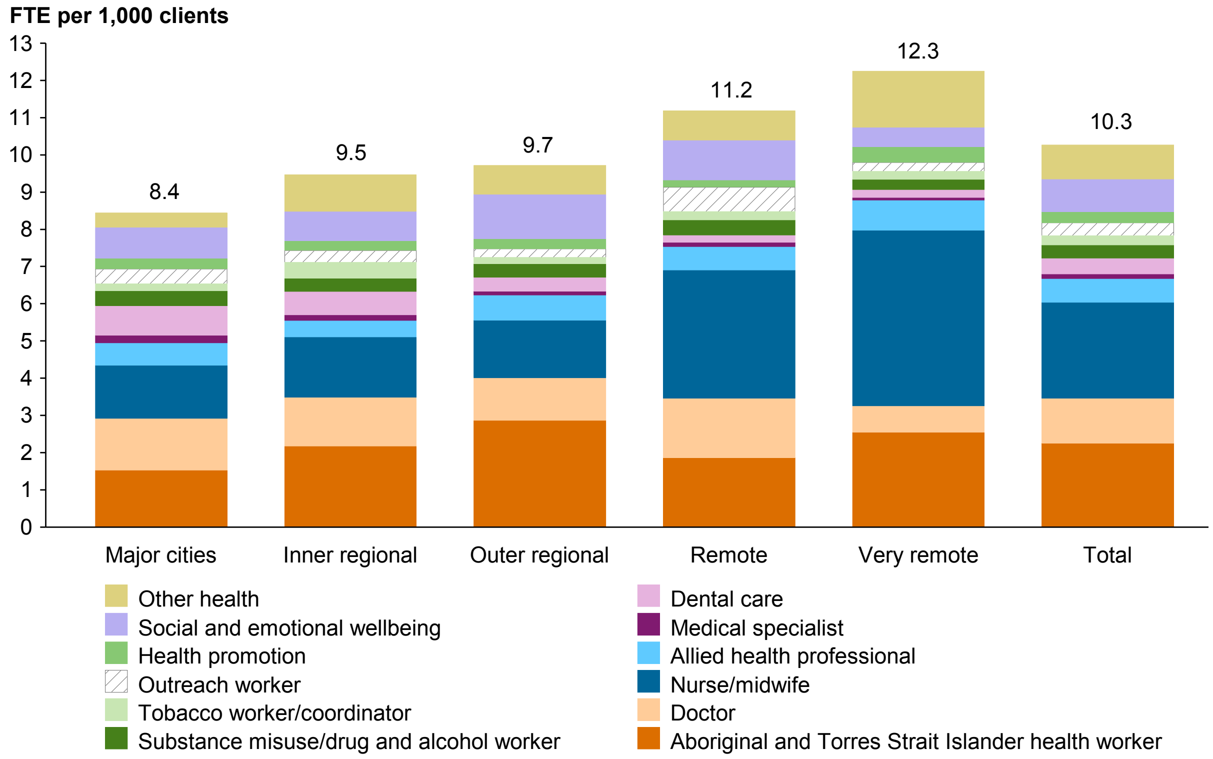


Note: The number of primary health-care organisations in each remoteness area is in brackets.

Figure 3.24: Number of clients, median number of health FTE staff and health FTE staff per 1,000 clients, by remoteness area, 2015–16

The ratio of staff to clients also varied by position type (see Figure 3.25 and Table S3.41):

- There were 4.7 FTE nurses and midwives per 1,000 clients in *Very remote* areas and 3.4 per 1,000 clients in *Remote* areas, which was higher than the average for all organisations (2.6), while the rate for doctors in *Very remote* areas was lower (0.7 compared with 1.2 for all organisations).
- There were 0.8 FTE dental care staff per 1,000 clients in *Major cities* and 0.6 in *Inner regional* areas, which was higher than the average for all organisations (0.4).
- There were fewer FTE social and emotional wellbeing staff per 1,000 clients in *Very remote* (0.5) areas, compared with the average for all organisations (0.9).



Notes

1. Aboriginal and Torres Strait Islander health practitioner positions are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
2. In 2015–16, 'Other health' positions included sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health staff not recorded elsewhere.
3. Includes visiting staff not paid for by the organisations themselves.

Figure 3.25: Number of health FTE staff per 1,000 clients, by position type and remoteness area, 2015–16

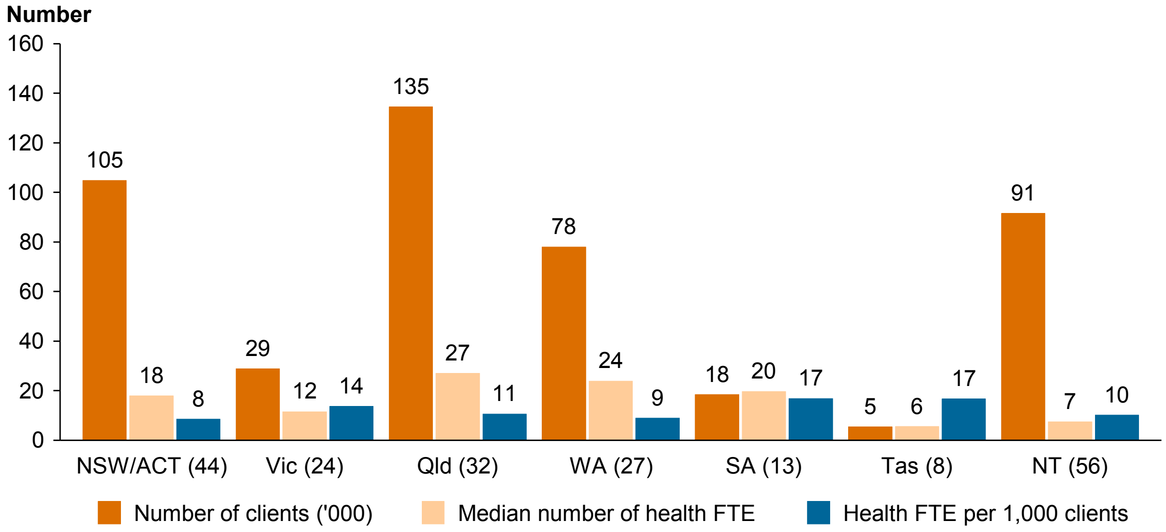
State and territory

The distribution of employed staff varied by state and territory, with Queensland having nearly one-third (31%) of FTE staff, followed by the Northern Territory (19%) and New South Wales and the Australian Capital Territory combined (18%) (see Table S3.44). New South Wales and the Australian Capital Territory combined had higher proportions of dental care staff (38%) and the Northern Territory higher proportions of Aboriginal health practitioners (32%) and drivers and field officers (26%). Queensland had higher proportions of social and emotional wellbeing staff (36%), doctors (33%), nurses and midwives (32%) and Aboriginal and Torres Strait Islander health workers (35%).

As at 30 June 2016:

- The 27% of organisations in the Northern Territory had 19% of employed FTE staff. A relatively high proportion of Aboriginal and Torres Strait Islander health practitioners (32%) and nurses (26%) were employed there. Nurses represented 20% of employed FTE staff in the Northern Territory, compared with 15% for all organisations. The higher number of nurses may be related to the fact that many Northern Territory organisations (77%) were located in *Very remote* areas where there may be more nurse-led clinics.
- The 22% of organisations in New South Wales and the Australian Capital Territory combined had 18% of employed staff. Around 24% of doctors and 38% of dental care staff were employed there.
- The 16% of organisations in Queensland had 31% of employed staff. Around 39% of allied health professionals, 36% of social and emotional wellbeing staff and one-third of doctors (33%), nurses and midwives (32%) and Aboriginal and Torres Strait Islander health workers (35%) were employed there.

Health FTE staff per 1,000 clients (including both employed and visiting staff) ranged from 8 in organisations in New South Wales and the Australian Capital Territory combined to 17 in South Australia (see Figure 3.26). The median number of health FTE staff ranged from 6 for organisations in Tasmania to 27 for those in Queensland and reflects the size and number of organisations in these states.



Note: The number of primary health-care organisations in each state and territory is in brackets.

Figure 3.26: Number of clients, median number of health FTE staff and health FTE staff per 1,000 clients, by state and territory, 2015–16

The ratio of staff to clients also varied by position type (see Table S3.42):

- There were 3.4 FTE nurses and midwives per 1,000 clients in the Northern Territory—higher than the average for all organisations (2.6).
- There were more FTE dental care staff per 1,000 clients in Victoria (1.3) and in New South Wales and the Australian Capital Territory combined (0.7), compared with the average for all organisations (0.4).
- There were more FTE social and emotional wellbeing staff per 1,000 clients in South Australia (1.8) and fewer in New South Wales and the Australian Capital Territory combined (0.7), compared with the average for all organisations (0.9).
- There were more FTE drivers and field officers per 1,000 clients in Tasmania (1.9), compared with the average for all organisations (0.9).

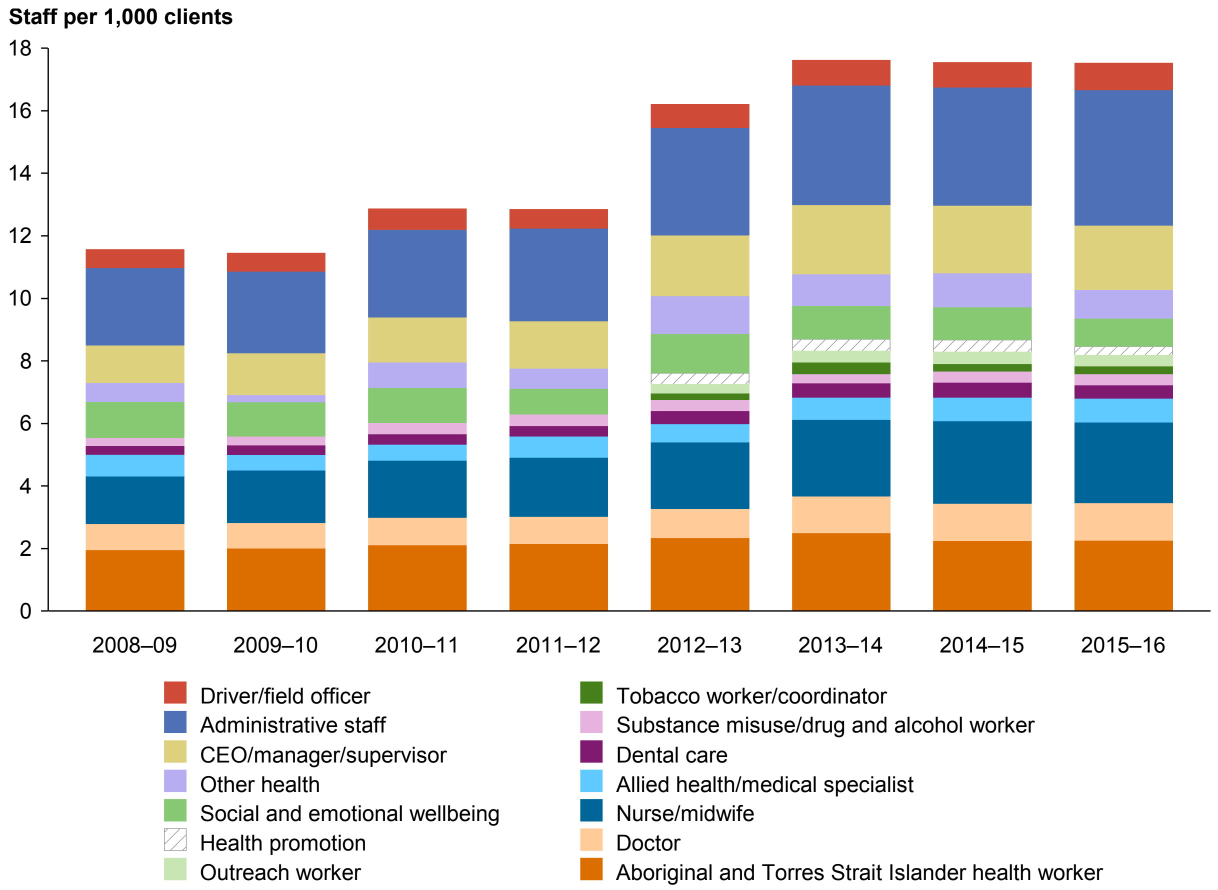
Type of organisation

In 2015–16, ACCHOs and other organisations had similar ratios of staff, with 17 and 18 FTE staff per 1,000 clients, respectively (see Table S3.45). Overall, ACCHOs had 10 health FTE staff per 1,000 clients, ranging from 9 in Queensland and in New South Wales and the Australian Capital Territory combined, to 17 in Tasmania and South Australia. Other organisations had 11 health staff per 1,000 clients.

ACCHOs had more FTE doctors—GPs per 1,000 clients than other organisations in all states and territories, except Queensland where the ratio for other organisations was affected largely by one organisation. The ratio of FTE doctors—GPs for ACCHOs ranged from 0.9 to 1.6 FTE. In other organisations, it ranged from 0 to 1.7 (see Table S3.46).

Time series

In 2015–16, the number of employed FTE staff (7,766) was higher than in previous years (see Table S3.47). It increased by 6% compared with 2014–15 (7,359). If visiting staff are included, the total number of FTE staff increased by 419 compared with 2014–15. However, the number of FTE staff per 1,000 clients was similar at 17.5 per 1,000 clients (see Figure 3.27 and tables S3.48 and S3.49). The number of FTE per 1,000 clients remained similar for most position types. It was higher in 2015–16 for administrative staff (4.3 compared with 3.8) and lower for social and emotional wellbeing staff (0.9 compared with 1.1). Since 2008–09, the total FTE staff per 1,000 clients reported, increased from 11.6 to 17.5, while health FTE staff per 1,000 clients reported, increased from 7.2 to 10.4.



Notes

1. In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.
2. Aboriginal and Torres Strait Islander health practitioner positions were new in 2012–13 and are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
3. In 2015–16, 'Other health' positions included sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health staff not recorded elsewhere. Before 2012–13, 'Other health' positions included all of these positions, but may also have included tobacco worker/coordinators, outreach workers and health promotion workers because these were not collected separately before 2012–13.
4. Includes visiting staff not paid for by the organisations themselves.

Figure 3.27: Number of FTE staff per 1,000 clients, by position type, 2008–09 to 2015–16

Aboriginal and Torres Strait Islander health workers

Aboriginal and Torres Strait Islander health workers have an important role in improving the health of Aboriginal and Torres Strait Islander people. In 2013, the Community Services and Health Industry Skills Council (CSHISC) released new health training packages that contained a suite of updated qualifications, skill sets and units of competency in first aid, workplace health and safety and telehealth (CSHISC 2014). As at 30 June 2016, 329 Aboriginal and Torres Strait Islander health workers held a Certificate IV practice stream qualification, 148 held a Certificate IV community stream qualification and 302 a Certificate III qualification (see Table S3.50).

Vacancies

Organisations providing Indigenous primary health-care services reported 364 vacant FTE positions as at 30 June 2016. This included 310 health and 55 other (administrative, managerial and support) positions (see Table S3.51). Nurses and midwives were the most common type of vacant position (27%), followed by Aboriginal and Torres Strait Islander health workers and practitioners (23%), social and emotional wellbeing staff (11%), doctors (8%) and health promotion workers (6%) (see Table S3.52).

The number of health vacancies increased with remoteness, reflecting perhaps the difficulties in getting trained staff out to more remote areas. Most health vacancies were reported in *Very remote* areas (45%), while *Major cities* and *Inner regional* areas had just 9% and 8% of vacancies, respectively. *Very remote* areas also had a higher proportion of their health positions vacant (10% compared with 7% overall) and more health vacancies per 1,000 clients (1.4) compared with 0.7 overall (see tables S3.51 and S3.53). It should be noted, however, that the number of vacancies in *Very remote* areas was affected by 2 large regional health organisations in Queensland representing 42% of all vacancies in *Very remote* areas and 20% of vacancies overall.

Half of all health vacancies (50%) were vacant for 13 weeks or less, but one-quarter (26%) were vacant for more than 40 weeks (see Table S3.52). The proportion vacant for more than 40 weeks increased with remoteness from 3% of vacancies in *Major cities* to 31% of vacancies in *Very remote* areas (see Figure 3.28 and Table S3.54).

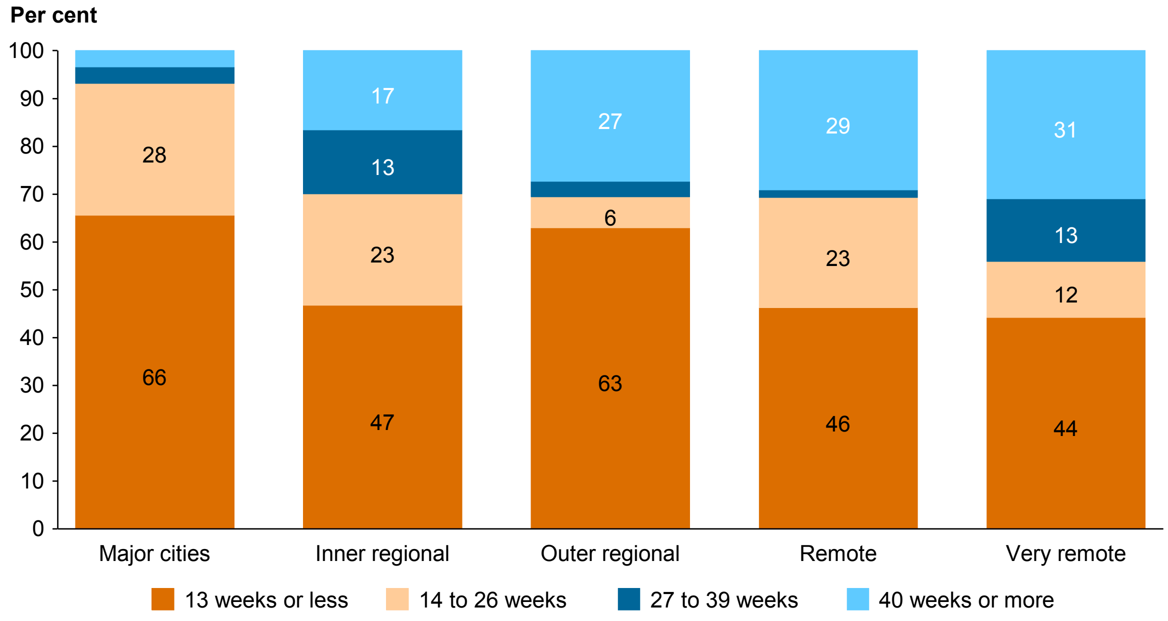
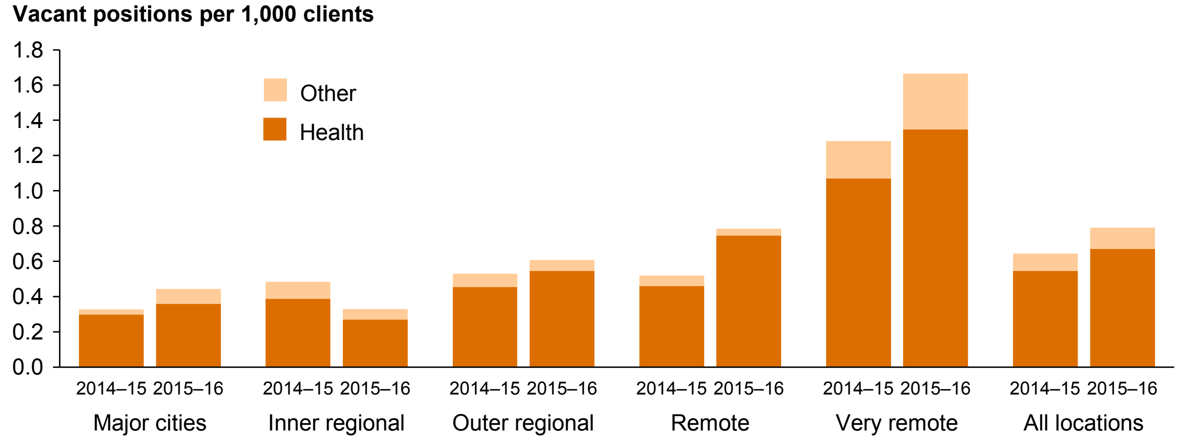


Figure 3.28: Proportion of vacant positions, by length of vacancy and remoteness area, as at 30 June 2016

ACCHOs had a lower vacancy rate than other organisations. The proportion of health vacancies was 6% compared with 9% for other organisations and the proportion of vacancies for other positions was 1% compared with 3% (see Table S3.55). ACCHOs also had a lower number of FTE vacant positions per 1,000 clients (0.7) compared with other organisations (1.2).

Time series

The number of vacancies (364) was higher than in 2014–15 (280) as was the number of vacant positions per 1,000 clients (0.8 compared with 0.6 in 2014–15), and the proportion of health-related vacancies (7% compared with 5% in 2014–15). Around 59% of the increase in vacant FTE came from organisations reporting in both years; the rest was mainly due to one organisation reporting in 2015–16 but not in 2014–15, that reported a large number of vacancies. *Very remote* areas had the most vacant positions per 1,000 clients in both years (see Figure 3.29).



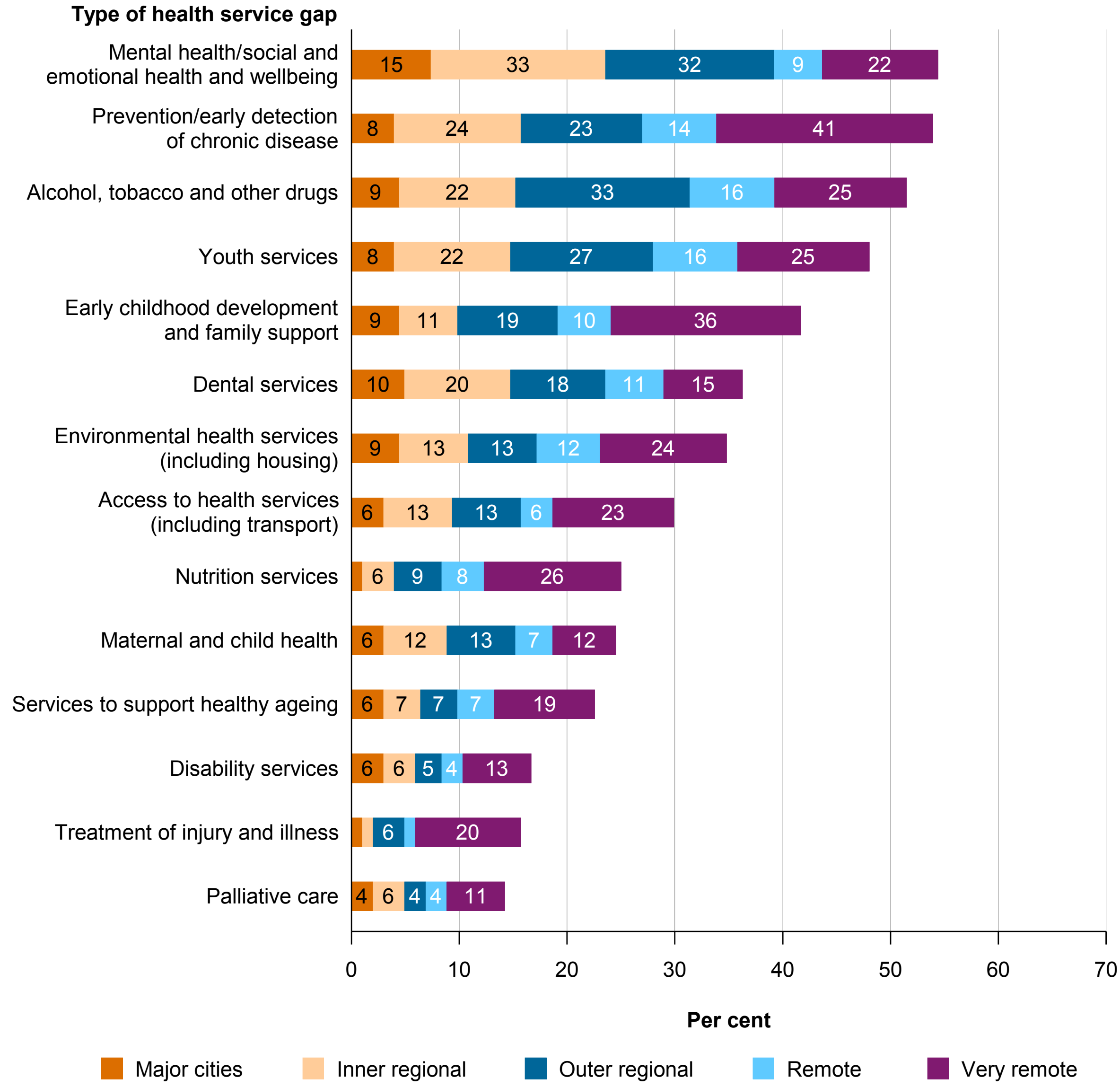
Notes
1. In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In 2015–16 it was the financial year from 1 July to 30 June.
2. See Appendix B for a list of positions included as 'health' and 'other' positions.

Figure 3.29: Number of FTE vacant positions per 1,000 clients, by position type and remoteness area, as at 31 May 2015 and 30 June 2016

3.7 Service gaps and challenges

Organisations were asked to report on gaps in service provision and could list up to 5 gaps from a predefined list of service gaps. Since this question was introduced in 2012–13, the most commonly reported gap each year was a lack of mental health/social and emotional wellbeing services. In 2015–16, this was reported as a top 5 gap by 54% of organisations providing Indigenous primary health-care services, as was the prevention and early detection of chronic disease (54%). Around half reported alcohol, tobacco and other drugs (52%) and youth services (48%) as gaps (see Figure 3.30).

The service gaps reported varied by remoteness area (see Table S3.57). Although mental health and social and emotional wellbeing issues were reported by 54% of organisations as a gap, it was more often reported in *Inner regional* areas (77%), *Major cities* (71%) and *Outer regional* areas (70%), than in *Remote* (35%) and *Very remote* (32%) areas. In *Very remote* areas, early childhood development and family support services were more likely to be reported as a gap (53% compared with 42% for all organisations), as were nutrition services (including lack of access to affordable healthy food) (38% compared with 25% for all organisations), and treatment of injury and illness (29% compared with 16% for all organisations).



Note: Organisations were asked to select up to 5 health service gaps faced by the community they served.

Figure 3.30: Number (as labelled) and proportion (in scale) of primary health-care organisations, by type of top 5 health service gap and remoteness area, 2015–16

Organisations were also asked to select up to 5 challenges they faced in providing quality care to clients from a predefined list of challenges. Issues around staffing, rather than access to services or organisation administration, were most commonly reported. Two-thirds (67%) reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff as a challenge (see Table S3.58). The overall number of staff (staffing levels) were seen as a challenge by 63% of organisations, while over half (54%) reported staff retention and turnover as a challenge. These were similar to the challenges reported in 2014–15. Other common challenges were access to specialist medical services (50%), appropriate health-service infrastructure (47%) and the coordination of clinical care with other providers (43%).

Service challenges commonly reported also varied by remoteness area (see Table S3.59). Organisations providing primary health-care services in *Very remote* areas were more likely to report recruitment, training and support of staff as a challenge (81% compared with 67% overall). Organisations in *Remote* and *Very remote* areas were more likely to report staff retention/turnover (69% and 75%, respectively, compared with 54% overall) and staff housing as challenges (42% and 49%, respectively, compared with 27% for organisations overall).

4 Maternal and child health

Maternal and child health is a core component of primary health care. Access to high-quality antenatal care and maternal and child health services can reduce the risk of poor health outcomes for mothers and babies (AIHW 2012). These services also have a key role to play in realising the COAG target of halving the Indigenous child mortality gap within a decade.

The vision outlined in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 is that Aboriginal and Torres Strait Islander mothers and fathers get the best possible support to promote safe pregnancies and a good start to life for their newborns, and that Aboriginal and Torres Strait Islander children are in good health and meet key developmental milestones, laying the foundation for long and healthy lives (DoH 2013).

Maternal and child health has been a focus of funding from the Australian Government, with the announcement of $94 million in the 2014-15 Budget to implement the Better Start to Life (BSTL) approach. The aim of BSTL is to increase access to Aboriginal and Torres Strait Islander antenatal and postnatal care by increasing the availability of child and maternal health services. This includes increasing the number of sites providing New Directions: Mothers and Babies Services to increase foundational child and maternal health services and expanding the Australian Nurse Family Partnership Program to provide intensive support for high-need families (DoH 2016).

This chapter reports on 222 organisations funded by the DoH to provide maternal and/or child health services to Aboriginal and Torres Strait Islander people (see Box 4.1). This includes the 204 organisations providing primary health-care services from Chapter 3, plus 18 organisations funded for New Directions: Mothers and Babies Services only. The total number of organisations in scope for reporting on their maternal and child health activity (222) is 2 more than in 2014–15 (220). In 2015–16, there were 15 new organisations now in scope for reporting, while 13 organisations reporting in 2014–15 were not required to report.

Box 4.1: Overview of maternal and child health services

There were 222 organisations providing maternal and/or child health services. Half (55%) had DoH primary health funding, 81 had both primary health and New Directions funding and 18 had New Directions funding only. Key objectives of New Directions are: increased access to antenatal and postnatal care; standard information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring of developmental milestones, immunisation status and infections; and health checks and referrals for Indigenous children before starting school (DoH 2015a).

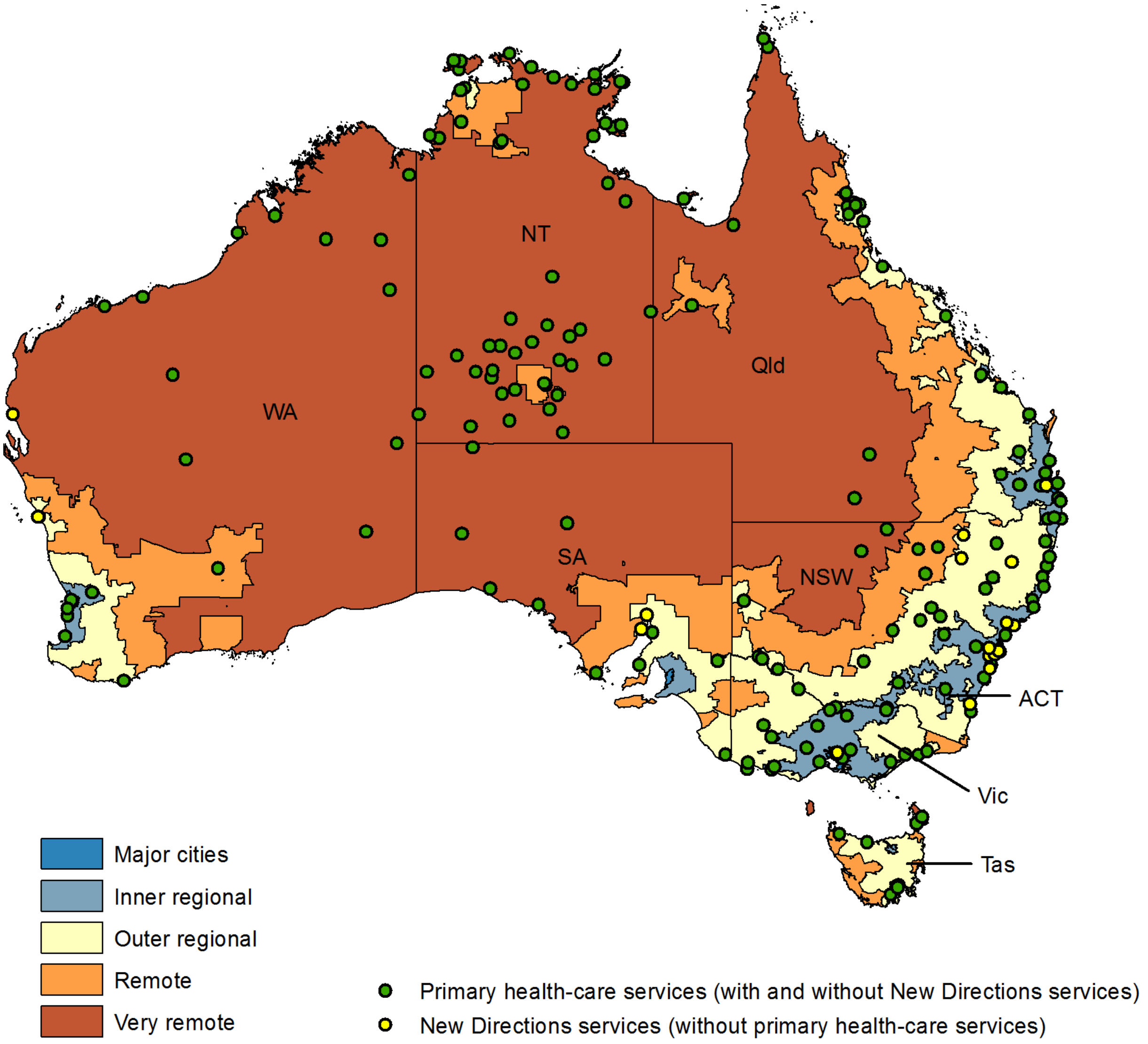
In these 222 organisations:

- Around 8,500 Indigenous women had in total 42,000 antenatal visits—an average of 5 visits per antenatal client.
- A range of services and group activities were provided including around 12,900 home visits, 3,300 maternal and baby/child health group sessions, 2,800 parenting group sessions and 1,000 antenatal group sessions.
- Around 22,700 health checks for Indigenous children aged 0–4 years were conducted.

4.1 Organisation profile

Location

The 222 organisations providing maternal and/or child health services were spread across all states and territories and remoteness areas (see Figure 4.1 and Table S4.1).



Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 4.1: Australian Government-funded organisations providing maternal and child health services to Aboriginal and Torres Strait Islander people, by remoteness area, 2015–16

At a glance

Over half (55%) these organisations (123) had DoH funding for primary health care only, 37% (81 organisations) were funded for both primary health care and New Directions, and 8% (18 organisations) were funded for New Directions only. In 2015–16, around 8,500 Indigenous clients had at least one antenatal visit and had on average 5 antenatal visits. Around 22,700 health checks for children aged 0–4 years were also conducted (see Table 4.1).

Table 4.1: Indigenous maternal and child health services, 2014–15 and 2015–16

	2014–15		2015–16	
	Number	**%**	**Number**	**%**
Total organisations providing services	220	100.0	222	100.0
New Directions funding	17	7.7	18	8.1
New Directions and primary health funding	73	33.2	81	36.5
Primary health funding	130	59.1	123	55.1
Antenatal clients/visits				
Indigenous clients	7,413	86.5	8,471	88.5
Total clients	8,573	100.0	9,568	100.0
Indigenous antenatal visits	34,134	86.6	41,963	89.0
Total antenatal visits	**39,419**	**100.0**	**47,157**	**100.0**
Average visits per Indigenous client	4.6	. .	5.0	. .
Average visits per client	**4.6**	**. .**	**4.9**	**. .**
Group activities (average number)				
Antenatal groups	15	. .	17	. .
Maternal and baby/child health groups	24	. .	36	. .
Parenting and parenting skills groups	26	. .	37	. .
Home visits	126	. .	142	. .
Child health checks				
Indigenous child health checks (0–4)	22,133	93.0	22,693	97.0
Healthy Kids checks	1,657	7.0	609	3.0
Total child health checks	**23,790**	**100.0**	**23,302**	**100.0**

Notes

1. In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In 2015–16, it was the financial year from 1 July to 30 June.
2. The definition of an ‘organisation’ in the OSR collection is different to that used by the DoH for the purposes of funding. As a result, the number of organisations reporting in the OSR may differ from the number of funded organisations reported by the DoH.
3. Group activity averages are based on the number of organisations providing each type of activity. Organisations not providing an activity were excluded from the calculations.

4.2 Services and clients

Antenatal care

Antenatal care includes giving advice and guidance on pregnancy and delivery, education on self-care during pregnancy, screening tests and referral if necessary. Having antenatal visits at least 4 times during pregnancy, as recommended by the World Health Organization (WHO), can improve health outcomes for mothers and babies (WHO 2011). The Implementation Plan acknowledges this recommendation by including the goal of increasing the rate of Aboriginal and Torres Strait Islander women attending at least 5 antenatal care visits from 84% to 90% by 2023 (DoH 2015b).

In 2015–16, 181 (82%) organisations providing maternal and/or child health services provided antenatal care. They saw around 9,600 women, most of whom (8,500 or 89%) were Indigenous. Just over one-quarter (27%) of these Indigenous women were in *Outer regional* areas (2,200) and 21% (1,800) were in *Very remote* areas (see Table S4.2).

Over one-quarter (28%) of Indigenous women with an antenatal visit were in Queensland. This was followed by 22% in the Northern Territory, 20% in New South Wales and the Australian Capital Territory combined and 19% in Western Australia (see Table S4.3).

Around 47,200 routine antenatal visits were reported, and most of these (89% or 42,000) were with Indigenous women (see Table S4.5). Half (50%) of all visits by Indigenous women were in either *Outer regional* areas (10,400) or *Very remote* areas (10,600). This was followed by *Inner regional* areas with 20% (8,500) visits (see Table S4.6). The Northern Territory, Western Australia, and New South Wales and the Australian Capital Territory combined each had 22% of all antenatal visits by Indigenous women (around 9,300 visits each). This was followed by Queensland with around 8,100 (19%) visits (see Table S4.9).

Indigenous antenatal clients had on average 5 antenatal visits. This varied by the type of DoH funding, remoteness area and state and territory (see tables S4.7, S4.8 and S4.10). In organisations funded for New Directions only, Indigenous antenatal clients had on average 7 antenatal visits, compared with around 5 in those funded for primary health only, and in those funded for primary health and New Directions (see Figure 4.2).

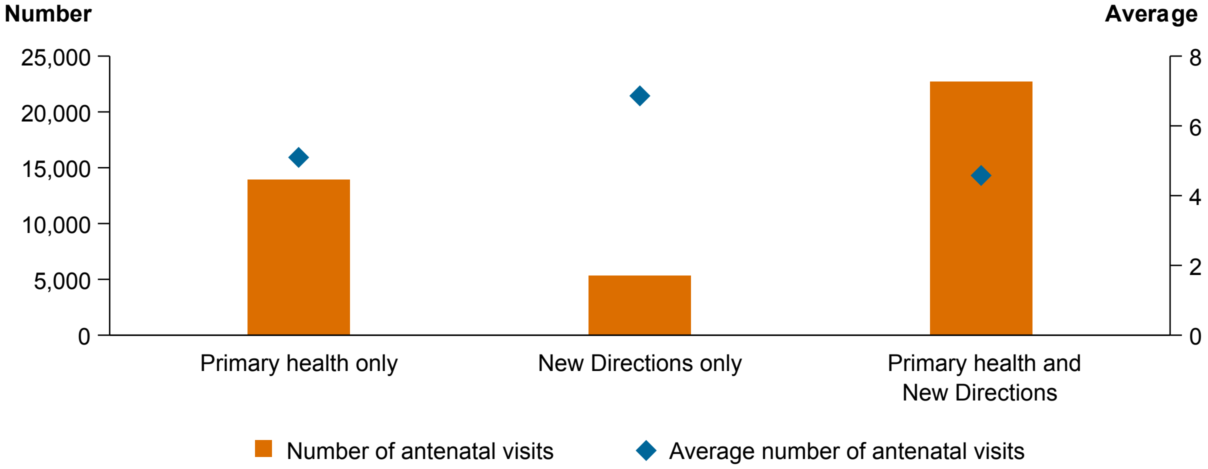


Figure 4.2: Number of antenatal visits by Indigenous clients and average antenatal visits per Indigenous client, by type of DoH funding, 2015–16

The average number of visits per Indigenous antenatal client was higher in *Very remote* areas (6.0) and lower in *Major cities* (3.4). It also showed some variation by state and territory (see Figure 4.3). It was higher in South Australia (8.7) and Western Australia (5.7) and lower in Queensland (3.4).

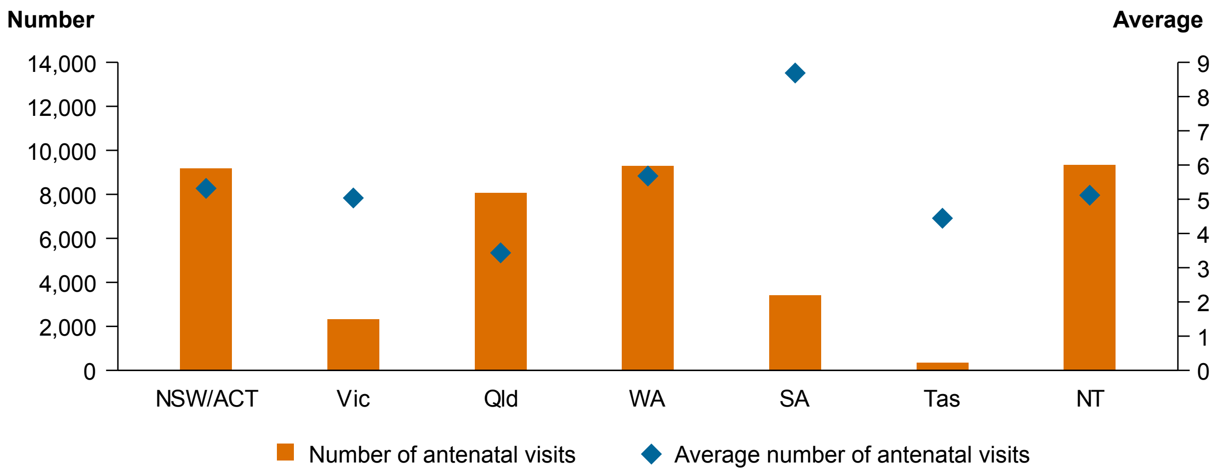
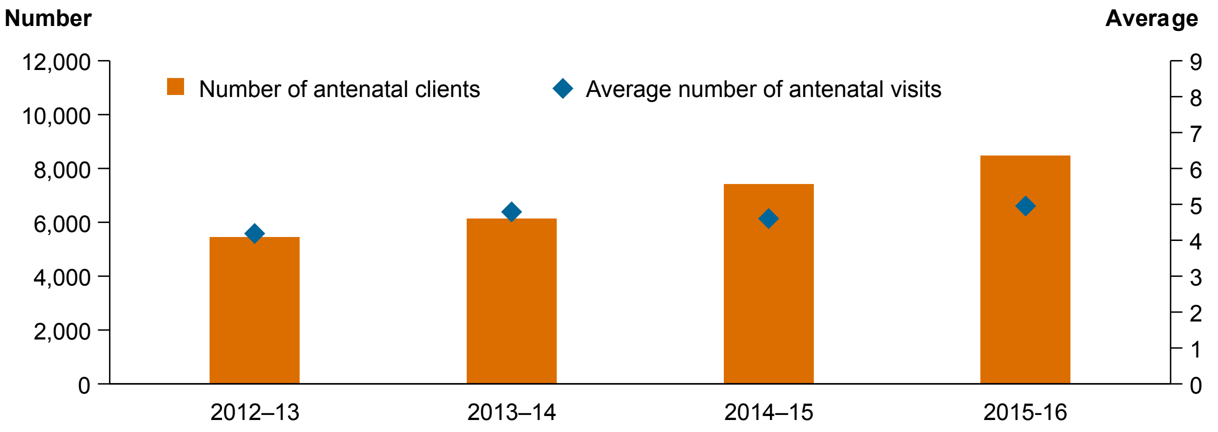


Figure 4.3: Number of antenatal visits by Indigenous clients and average antenatal visits per Indigenous client, by state and territory, 2015–16

Time series

In 2015–16, the total number of Indigenous antenatal clients (around 8,500) was 14% higher than in 2014–15 (around 7,400). The average number of antenatal visits per Indigenous client was 5.0 (see Figure 4.4 and Table S4.11). This was an increase of 0.8 compared with 2012–13 (4.2) and a small increase of 0.4 compared with 2014–15 (4.6).



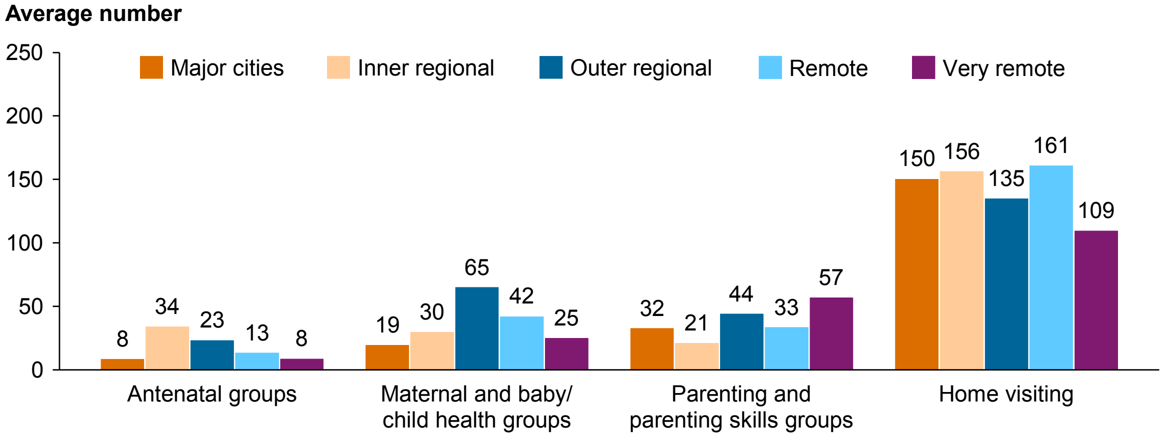
Note: In 2015–16, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 4.4: Number of Indigenous antenatal clients and average antenatal visits per Indigenous client, 2012–13 to 2015–16

Group activities

In 2015–16, 140 (63%) organisations providing maternal and/or child health services ran at least one type of antenatal or maternal group activity, such as antenatal groups, parenting groups, maternal and baby/child health groups or home visiting services. Around 12,900 home visits were reported by 91 organisations, 3,300 maternal and baby/child health sessions by 90 organisations, 2,800 parenting skills sessions by 77 organisations, and 1,000 antenatal sessions by 61 organisations. This meant the organisations providing these types of group activities made on average 142 home visits, conducted 17 antenatal group sessions, 36 maternal and baby/child health group sessions and 37 parenting skills group sessions (see Table S4.12).

In the organisations running antenatal groups, those in *Inner regional* areas had a higher average number of sessions (34 compared with 17 overall), while in organisations running parenting and parenting skills groups, those in *Very remote* areas had a higher average number of sessions (57 compared with 37 overall). In organisations running maternal and baby/child health groups, those in *Outer regional* areas had a higher average number of sessions (see Figure 4.5 and Table S4.13).



Note: Averages are based on the number of organisations providing each type of activity. Organisations not providing an activity were excluded from the calculations.

Figure 4.5: Average number of antenatal and maternal group activity sessions, by type of activity and remoteness area, 2015–16

Child health checks

Aboriginal and Torres Strait Islander child health checks involve taking a comprehensive health-related history, recording growth and undertaking a medical examination. They may also lead to advice, referral, vaccinations and treatment (Coleman et al. 2011). Information on three types of child health checks are collected in the OSR (see Box 4.2).

Box 4.2: Aboriginal and Torres Strait Islander child health checks

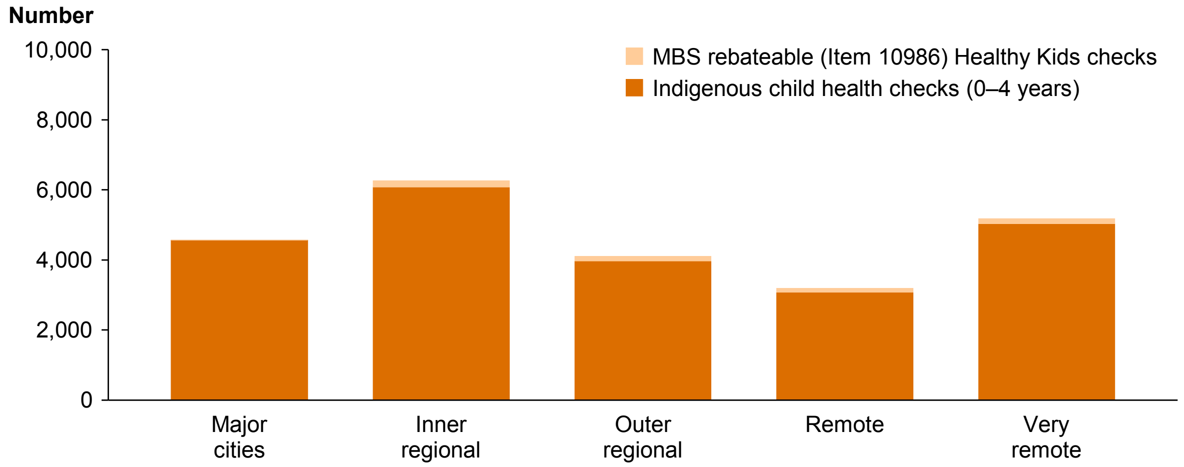
Indigenous child health checks: This Medicare Benefits Schedule (MBS) Item 715 covers health assessments of Aboriginal and Torres Strait Islander children aged 0–4 years. The item has no time or complexity requirements. The length of the assessment is at the medical practitioner's discretion (DoH 2014c).

Alternative child health checks: This is an alternative child health check for Aboriginal and Torres Strait Islander children aged 0–4 years as per local service guidelines. This check is aligned with the key elements of the MBS item 715 check, but is not rebateable under Medicare.

Healthy Kids checks (MBS Item 10986): A Healthy Kids check is an assessment of a child's physical health, general wellbeing and development, with the purpose of initiating medical interventions as appropriate. It is conducted by a practising nurse or Aboriginal and Torres Strait Islander health practitioner and was rebated under the MBS Item 10986 until 1 November 2015 (DoH 2014b).

In 2015–16, most (87%) organisations providing maternal and/or child health services undertook child health checks of Indigenous children. Around 22,700 child health checks for children aged 0–4 years and 600 Healthy Kids checks were conducted (see Table S4.14).

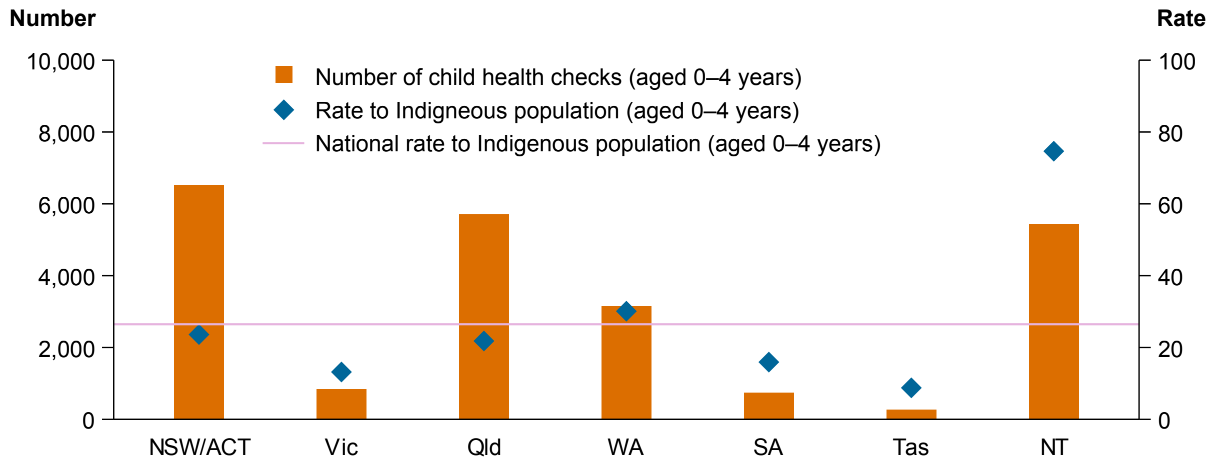
Over one-quarter (27%) of child health checks for children aged 0–4 years were conducted in *Inner regional* areas (around 6,100) and 22% (around 5,000) in *Very remote* areas (see Figure 4.6). *Inner regional* and *Very remote* areas had 31% and 24% of all Healthy Kids checks conducted, respectively.



Note: The number of Indigenous child health checks (0–4 years) includes both MBS rebateable (Item 715) checks and alternative Aboriginal and Torres Strait Islander child health checks conducted for children aged 0–4 years.

Figure 4.6: Number of Healthy Kids checks and Indigenous child health checks (aged 0–4 years), by type of health check and remoteness area, 2015–16

Organisations in New South Wales and the Australian Capital Territory combined conducted the most health checks for children aged 0–4 years (6,500), followed by Queensland (5,700) and the Northern Territory (5,400) (see Table S4.15). The proportion of total health checks provided by OSR organisations to the estimated Indigenous population aged 0–4 years was 26% (see Table S4.16). The proportion was higher in the Northern Territory (75%) and Western Australia (30%), compared with 26% overall, and may reflect the relatively high proportion of organisations from these areas (see Figure 4.7).



Note: The number of child health checks (0–4 years) includes both MBS rebateable (Item 715) checks and alternative Aboriginal and Torres Strait Islander child health checks conducted for children aged 0–4 years.

Figure 4.7: Number and rate of child health checks (aged 0–4 years), by state and territory, 2015–16

5 Social and emotional wellbeing

This chapter reports on social and emotional wellbeing services funded by PM&C (see Box 5.1). Social and emotional wellbeing is a holistic concept that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 stresses that social and emotional wellbeing is the foundation for Aboriginal and Torres Strait Islander physical and mental health. As such, there is a need to continue support for counselling, health promotion and early intervention services to promote social and emotional wellbeing among Aboriginal and Torres Strait Islander people, including members of the Stolen Generations (DoH 2013).

In 2015–16, 93 organisations funded to provide these services were in the OSR. This was 4 fewer than in 2014–15 (97). There were 8 new organisations in scope for reporting, while 12 organisations reporting in 2014–15 were not required to report. This chapter includes a profile of these organisations, information on the types of services provided, client numbers and contacts, counsellors employed and service gaps and challenges. Most of these 93 organisations (82%) were also funded by the DoH to provide primary health care services.

Collectively in this chapter, the 93 organisations are referred to as organisations providing social and emotional wellbeing services. Most of these organisations (86) provided social and emotional wellbeing support services with a focus on counselling, casework and other wellbeing activities. Collectively, these 86 organisations are referred to as SEWB support services. The other 7 organisations provided Link Up services, which assist clients with family tracing and provide reunion support. Collectively, these 7 organisations are referred to as Link Up services.

Box 5.1: Overview of social and emotional wellbeing services

There were 93 organisations providing social and emotional wellbeing services. Of these:

- 76 (82%) were also funded by the DoH to provide primary health-care services.
- 86 (92%) provided SEWB support services and 7 (8%) Link Up services.

In 2015–16, 216 counsellors in these organisations provided social and emotional wellbeing services, 60% of whom were Indigenous. There were more female (61%) than male (39%) counsellors.

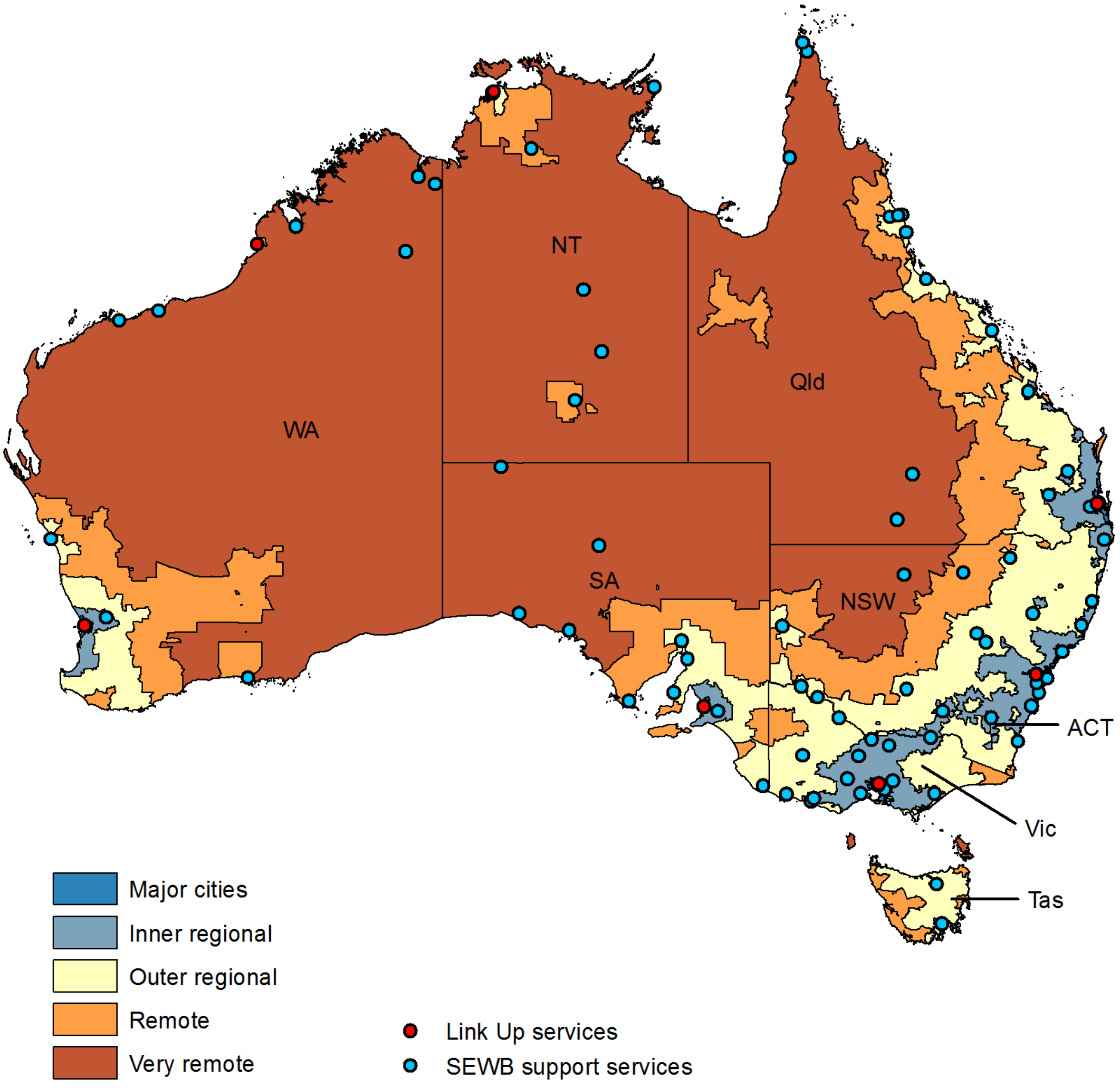
These counsellors saw around 18,900 clients and of these, 15,900 (84%) were SEWB support clients and 3,000 (16%) were Link Up clients.

Around 88,900 client contacts were made—an average of 5 contacts per client. This was similar to 2014–15 (4.6).

5.1 Organisation profile

Location

The 93 organisations providing social and emotional wellbeing services were spread across all states and territories. Of the 86 organisations providing SEWB support services, one-quarter (26%) were in New South Wales and the Australian Capital Territory combined, 21% were in Queensland and 19% in Victoria (see Table S5.1). There was a Link Up service in all states and territories, except Tasmania and the Australian Capital Territory (see Figure 5.1).



Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 5.1: Australian Government-funded organisations providing social and emotional wellbeing services to Aboriginal and Torres Strait Islander people, by remoteness area and type of service, 2015–2016

Organisations providing social and emotional wellbeing services were also spread across all remoteness areas (see Figure 5.2 and Table S5.2). Just over one-quarter (24 organisations) were in *Outer regional* areas, 24% (22 organisations) in *Inner regional* areas and 23% (21 organisations) in *Major cities*. Fewer were in *Very remote* (15) and *Remote* areas (11).

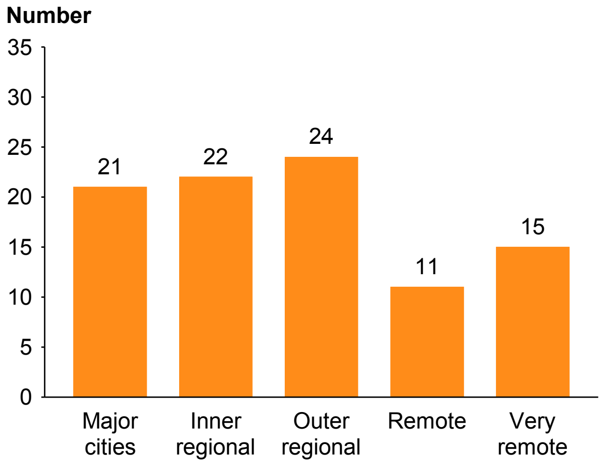


Figure 5.2: Number of organisations providing social and emotional wellbeing services, by remoteness area, 2015–2016

Key characteristics

Of the 93 organisations:

- 76 (82%) were also funded by the DoH to provide Indigenous primary health-care services.
- 82 (88%) were ACCHOs.
- All had a governing committee or board, and 73 (78%) had all Indigenous board members.
- All of those that were also funded for primary health-care were accredited with the RACGP and/or against organisational standards, and 53% of other organisations providing social and emotional wellbeing services had organisational accreditation only.
- 55 (59%) provided services from 1 site, 18 (19%) had 2 sites and 20 (22%) had 3 or more sites (see Table S5.3).

5.2 Services provided

At a glance

Social and emotional wellbeing services were provided through 164 sites and because most organisations providing these services were also funded for primary health care (82%), many services were delivered within a primary health-care setting (see Table 5.1). In 2015–16, 216 counsellors provided services to around 18,900 clients. The average number of contacts per client (4.7) was similar to 2014–15 (4.6).

Table 5.1: Indigenous social and emotional wellbeing services, 2014–15 and 2015–16

	2014–15		2015–16	
	Number	**%**	**Number**	**%**
Total organisations providing services	**97**	**100.0**	**93**	**100.0**
Organisations also funded for primary health care	82	84.5	76	81.7
Other organisations	15	15.5	17	18.3
Total number of sites providing services during usual hours	**165**	**. .**	**164**	**. .**
Clients				
Indigenous clients	16,471	77.9	16,812	88.9
Total clients[(a)]	**21,149**	**100.0**	**18,914**	**100.0**
Contacts				
Indigenous contacts	87,824	87.7	81,934	92.2
Total contacts[(a)]	**100,151**	**100.0**	**88,875**	**100.0**
Average contacts per client	4.6	. .	4.7	. .
Reunions				
Organisations with counsellors involved in reunions	38	39.2	35	37.6
Total reunions	**335**	**. .**	**200**	**. .**
Staffing	.		.	
Counsellors	221	. .	216	. .
Vacant counsellor positions	28	11.2	32	12.9

(a) Includes those who were identified as being Indigenous or non-Indigenous as well as those whose Indigenous status was unknown.

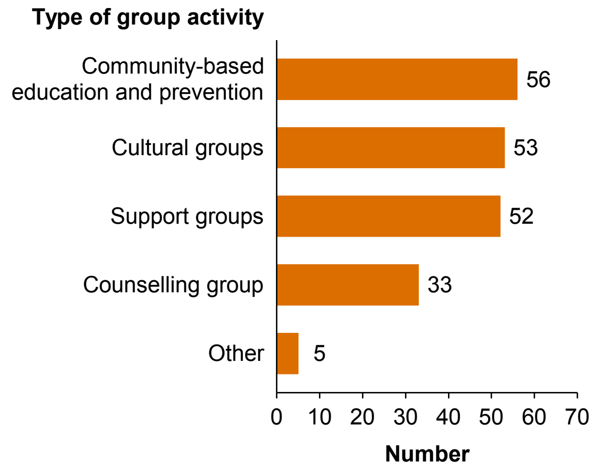
Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In 2015–16, it was the financial year from 1 July to 30 June.

SEWB support counsellors spent just over half their time on average (53%) working directly with individual clients providing counselling, support and advocacy. Other time was spent on administration (13%), working with groups (13%), and on outreach or travel (11%).

Link Up counsellors spent on average 26% of their time on reunion-related activities, 19% of their time researching family history and 18% working directly with individual clients providing counselling, support and advocacy (see Table S5.4).

Group activities

Organisations providing SEWB support services were asked about the group activities they offered. In 2015–16, 68 (79%) of these organisations ran group activities. Of these, 56 (82%) ran community-based education and prevention groups, 53 (78%) cultural groups, 52 (77%) support groups, and 33 (49%) counselling groups (see Figure 5.3 and Table S5.5).



Note: Only organisations providing SEWB support services were asked to report on these group activities, not those providing Link Up services.

Figure 5.3: Number of organisations providing social and emotional wellbeing support services, by type of group activity, 2015–2016

5.3 Clients

In 2015–16, 92 (99%) organisations providing social and emotional wellbeing services reported valid individual client and contacts data. Around 18,900 clients received social and emotional wellbeing services from these organisations. Of these, 15,900 (84%) were SEWB support clients and 3,000 (16%) were Link Up clients. Twenty-nine per cent of all social and emotional wellbeing clients were in *Major cities*, 22% were in *Remote* areas and a smaller proportion (15%) were in *Inner regional* areas (see Table S5.6).

Just over one-quarter (27% or 5,000 clients) were members of the first, second or third Stolen Generations (see Figure 5.4). First Generation clients are those who were removed from their families and communities, second Stolen Generation clients are those whose parents were first Stolen Generation members and third Stolen Generation clients are those whose grandparents were first Stolen Generation members or who are descended from people removed from their families.

A further 11,800 clients (62%) were ‘other’ Indigenous clients. It should be noted that this group may include clients who were Stolen Generation members, but this information was not recorded by the organisation. There were also around 1,500 non-Indigenous clients (8%) and a small number of clients (600) whose Indigenous status was not recorded (3%).

Over half of all clients (55%) were female and 38% were male. Around 7% of clients did not have their gender recorded (see Table S5.7).

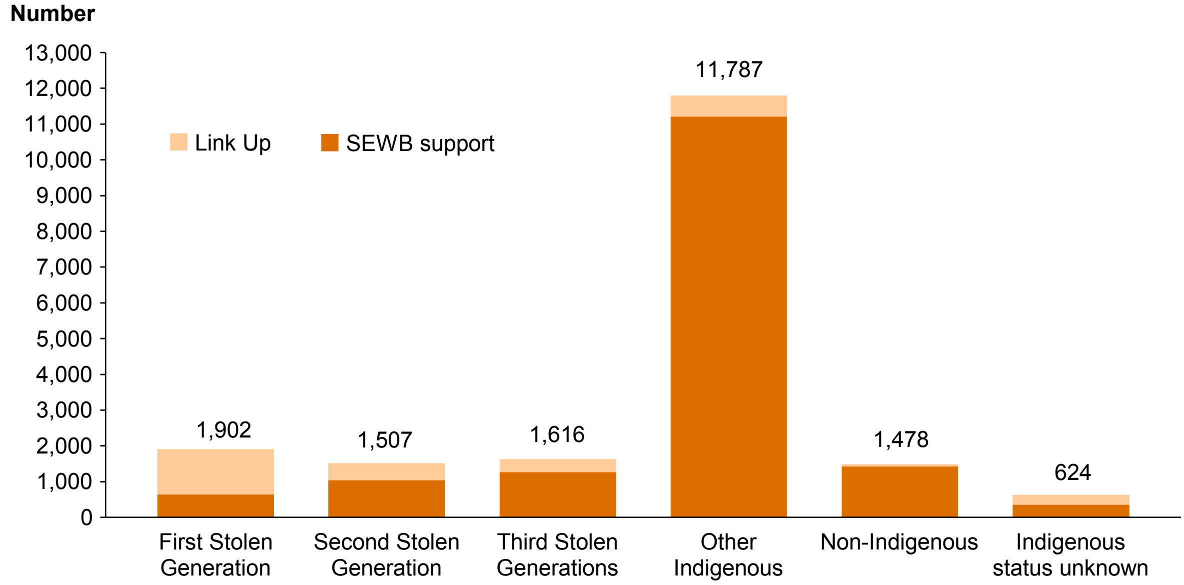


Figure 5.4: Number of clients of social and emotional wellbeing services, by Indigenous status and type of service, 2015–2016

Time series

The number of clients of social and emotional wellbeing services (around 18,900), was 11% lower compared with 2014–15 (around 21,100). This decrease was largely due to several organisations reporting lower client numbers, and fewer organisations submitting client data in 2015–16.

The total number of social and emotional wellbeing clients increased from 8,400 clients in 2008–09 to 18,900 in 2015–16. It should be noted that the number of organisations contributing to these counts also increased from 81 in 2008–09 to 92 in 2015–16 (see Table S5.8). The most significant increase in client numbers was between the 2011–12 and 2012–13 collection periods, and is likely due to changes in how data were collected and extracted, and the number of organisations in scope for the collection.

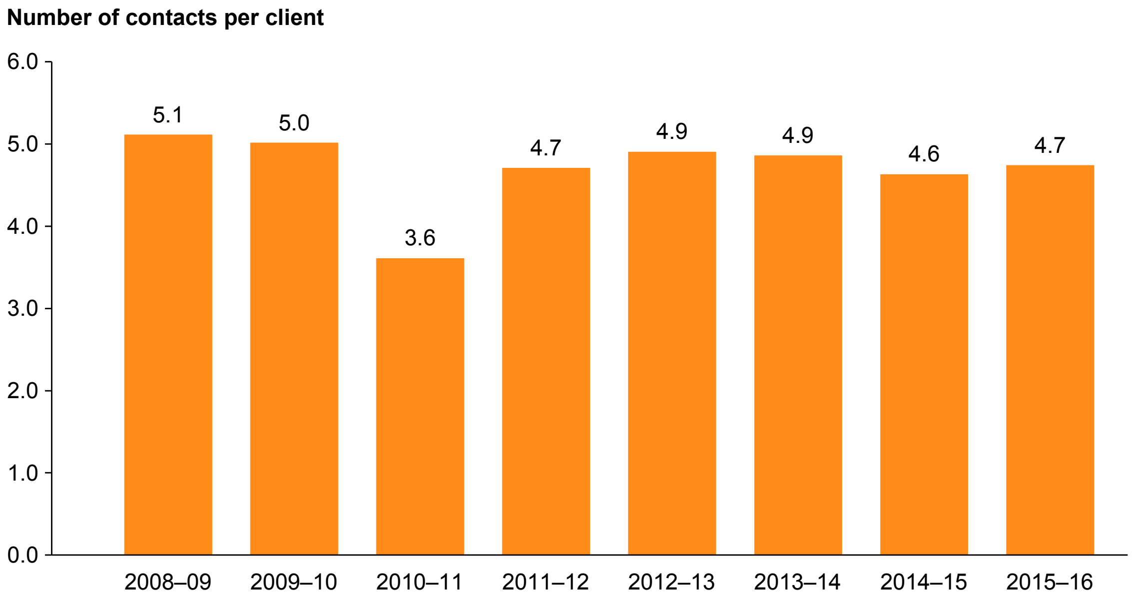
5.4 Client contacts

Counsellors providing social and emotional wellbeing services made around 88,900 contacts with clients in 2015–16, an average of 5 contacts per client. Most of these (90%) were made by SEWB support services (80,000 contacts), while 10% (8,800 contacts) were made by Link Up services (see Table S5.9). *Major cities* had a higher proportion of all client contacts (29%), followed by *Very remote* areas with 20% of all contacts (see Table S5.10).

Time series

The number of social and emotional wellbeing client contacts in 2015–16 (around 88,900) decreased by 11% compared with 2014–15 (around 100,200). This decrease was related to the smaller number of organisations reporting data in 2015–16 (92 compared with 95 in 2014–15) and to several organisations reporting lower client contact numbers.

Although the overall number of client contacts decreased, the average number of contacts per client (4.7) was similar to 2014–15 (4.6). Since 2008–09, the average number of contacts per client has generally been around 5, and has ranged from 3.6 in 2010–11 to 5.1 in 2008–09 (see Figure 5.5 and Table S5.11).



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 5.5: Average social and emotional wellbeing contacts per client, 2008–09 to 2015–16

5.5 Counsellors

Organisations funded to provide social and emotional wellbeing services were asked about the counsellors they employed through this funding to deliver these services. As at 30 June 2016, half (50%) had 1 counsellor position, one-quarter had 2 positions, and one-quarter had 3 or more positions (see Table S5.12). A total of 216 counsellors provided social and emotional wellbeing services, a small decrease compared with 31 May 2015 (221). As in 2014–15, around 60% of counsellors were Indigenous.

Almost one-quarter of counsellors worked in New South Wales and the Australian Capital Territory combined (23%), followed by 19% in Queensland and 18% in the Northern Territory (see Table S5.13). With respect to remoteness, *Inner regional* areas had the most counsellors (24%), followed by *Outer regional* areas and *Major cities* with 21% each (see Table S5.14). There were more Indigenous counsellors than non-Indigenous counsellors in all remoteness areas except *Remote* areas, where nearly three-quarters (73%) were non-Indigenous.

Of the 196 SEWB support counsellors, 112 (57%) were Indigenous and 84 (43%) were non-Indigenous, while 119 (61%) were female and 77 (39%) were male. Of the 20 counsellors in Link Up services, 18 (90%) were Indigenous and 2 (10%) were non-Indigenous, while 12 (60%) were female and 8 (40%) were male.

Overall, there were more female counsellors than male counsellors (61% compared with 39%), and more Indigenous counsellors than non-Indigenous counsellors (60% compared with 40%). One-third (33%) of counsellors were Indigenous women and 27% were Indigenous men (see Figure 5.6 and Table S5.15).

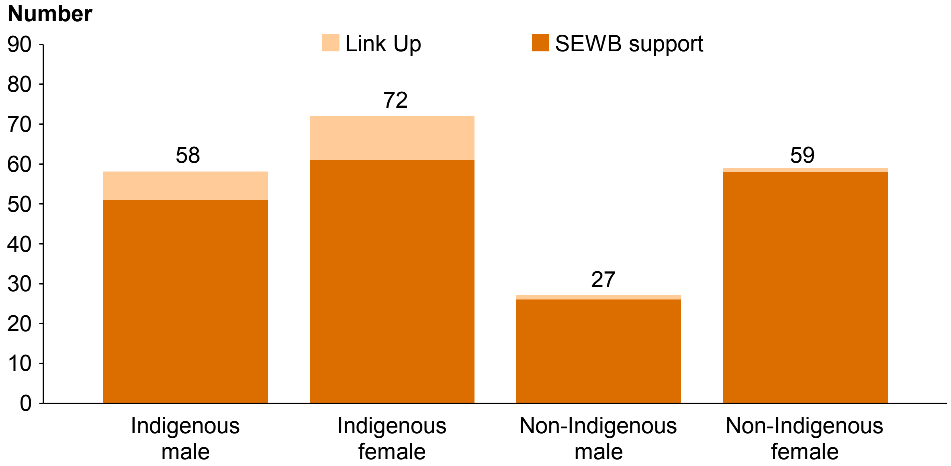


Figure 5.6: Number of counsellors in social and emotional wellbeing services, by Indigenous status, gender and type of service, as at 30 June 2016

Qualifications and training

Most counsellors (94%) had a certificate-level qualification or higher and 39% had a bachelor's degree or higher qualification (see Table S5.16). All counsellors in *Major cities* and nearly all counsellors in *Very remote* areas (97%) had a certificate-level qualification or higher. Around 6% had no qualification or were in the process of attaining a qualification. This was higher in *Inner regional* areas (12%).

Over half (55%) of organisations providing social and emotional wellbeing services had counsellors who undertook formal training courses in 2015–16, with a total of 132 training courses undertaken (see Table S5.17).

Supervision

Three-quarters (76%) of organisations providing social and emotional wellbeing services provided professional supervision to counsellors (see Table S5.18). In 42% of these organisations, supervision was for less than half an hour per week (see tables S5.19 and S5.20). Most organisations providing social and emotional support services provided support to counsellors, the most common including debriefing, case counselling, peer support (through work colleagues) and cultural mentoring (see Table S5.21). All 7 organisations providing Link Up services provided support to their staff including debriefing, casework assistance, telephone support, peer support (through work colleagues) and Link Up network meetings (see Table S5.22).

Vacancies

Organisations reported 32 vacant counsellor positions as at 30 June 2016 (see Table S5.23). Overall, 13% of counsellor positions were vacant. *Major cities* had a higher proportion of vacant counsellor positions (24%) compared with other areas (see Figure 5.7).

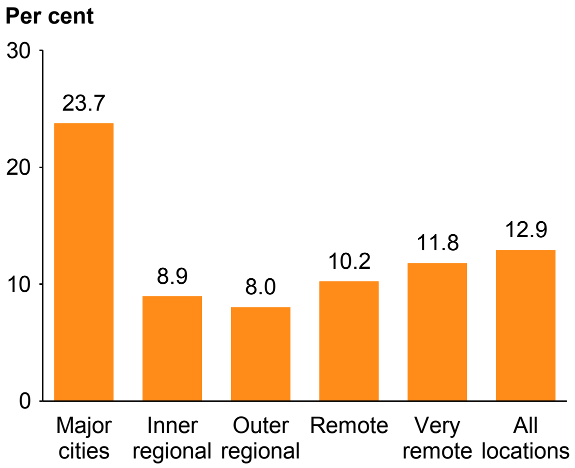
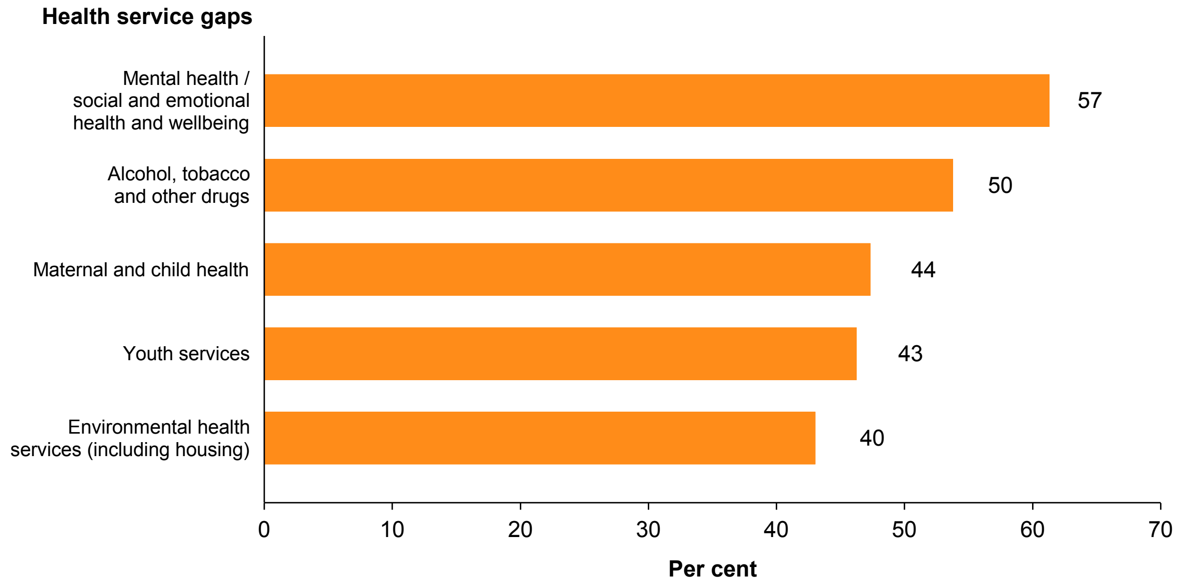


Figure 5.7: Proportion of counsellor positions that were vacant, by remoteness area, as at 30 June 2016

5.6 Service gaps and challenges

Over half (61%) of organisations providing social and emotional wellbeing services reported mental health and social and emotional wellbeing issues in their top 5 service gaps (see Figure 5.8 and Table S5.24). This was followed by alcohol, tobacco and other drugs (54%). Nearly half reported maternal and child health among their top 5 service gaps (47%), although this was much higher in the 76 organisations also funded for primary health care (51%) than in the 17 organisations not funded for primary health care (29%) Organisations not funded for primary health care were more likely to report mental health and social and emotional wellbeing issues as a gap (94% compared with 54% of those also funded for primary health care) as well as environmental health services (65% compared with 38%).



Note: Organisations were asked to select up to 5 health service gaps faced by the community they served.

Figure 5.8: Number (as labelled) and proportion (in scale) of organisations funded for social and emotional wellbeing services, by type of health service gap, 2015–2016

In relation to challenges, 62% of organisations reported staffing levels, 58% the recruitment, training and support of Aboriginal and Torres Strait Islander staff and 53% appropriate health service infrastructure in their top 5 challenges (see Table S5.25). Just under half of organisations reported the coordination of clinical care with other providers (47%) and staff retention/turnover (46%) as challenges. A higher proportion of organisations also funded for primary health care reported appropriate health service infrastructure as a challenge (62% compared with 12% in organisations not funded for primary health care), as well as staff retention/turnover (49% compared with 35%).

6 Substance-use

This chapter reports on substance-use services funded by PM&C (see Box 6.1). The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 suggests that promoting links across alcohol and other drug (AOD) and mental health services is an important strategy for improving Aboriginal and Torres Strait Islander health and wellbeing. Continuing to increase community awareness and education about the range of options for dealing with the use of drugs, alcohol and tobacco is also vital (DoH 2013). Many projects funded by the Australian Government are designed to reduce substance abuse through the provision of culturally appropriate AOD prevention, education, counselling, treatment, rehabilitation and after-care services for Aboriginal and Torres Strait Islander people.

In 2015-16, over 80 organisations were funded by PM&C to provide substance-use services under the IAS and 80 organisations contributed to the OSR. This was 13 more than the 67 organisations reporting in 2014–15. In 2015–16, there were 25 new organisations in scope for substance-use reporting that were not required to report in 2014–15, while 12 organisations from 2014–15 were not required to report in 2015–16. This chapter includes a profile of these organisations and information on the types of services they provide, client numbers and episodes of care, and service gaps and challenges.

Box 6.1: Overview of substance-use services

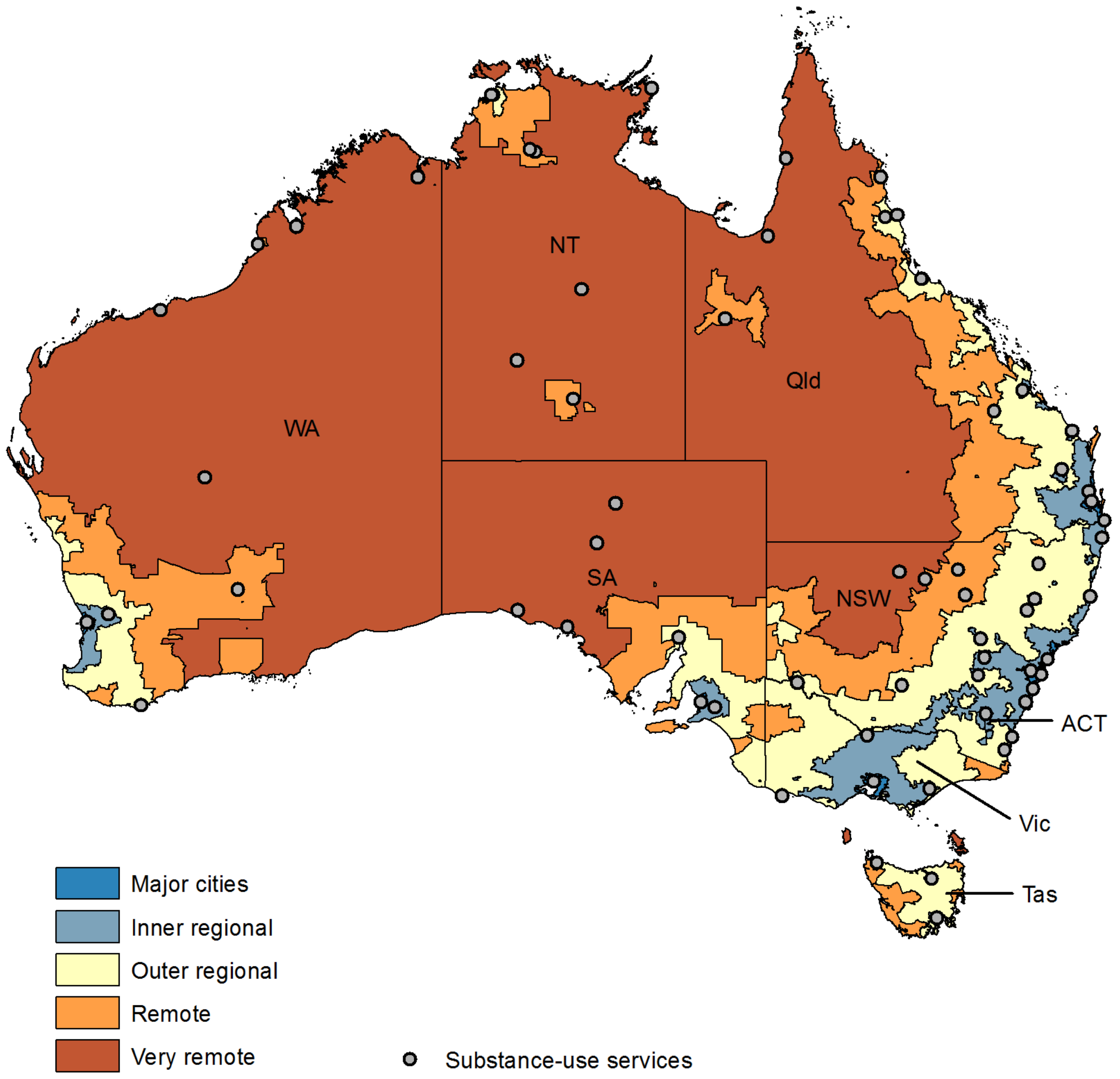
There were 80 organisations providing substance-use services, and of these 38 (47%) were also funded by the DoH to provide primary health-care services. It should be noted that in 2015–16, the number of organisations providing non-residential substance-use services in scope for the OSR was higher (77 compared with 61 in 2014–15). In these 80 organisations:

- Around 32,700 clients received at least one type of substance-use service. Most clients (around 26,500) received non-residential services, while 8,100 (25%) received sobering-up, residential respite or short-term care and 2,800 (9%) residential care services.
- Around 170,400 episodes of care were provided, with 87% of these for non-residential services, 11% for sobering-up, residential respite or short-term care, and 2% for residential care services.
- Clients of non-residential services had on average 5.6 episodes of care, while those receiving sobering-up, residential respite or short-term care had on average 2.3 episodes of care.
- Non-residential episodes of care were evenly split between males and females, as were sobering-up, residential respite or short-term care episodes of care. More males than females received residential episodes of care.

6.1 Organisation profile

Location

The 80 organisations reporting on substance-use services were spread across all states and territories, except the Australian Capital Territory (see Figure 6.1 and Table S6.1). There were 24 (30%) in New South Wales, 15 (19%) in Queensland, 14 (18%) in the Northern Territory and 11 (14%) in Western Australia. Smaller numbers were in South Australia (8), Victoria (5) and Tasmania (3).



Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 6.1: Australian Government-funded organisations providing substance-use services to Aboriginal and Torres Strait Islander people, by remoteness area, 2015–16

Organisations were spread across all remoteness areas, with 19 (24%) in *Outer regional* areas, 16 (20%) in both *Major cities* and in *Remote* areas, 15 (19%) in *Very remote* areas and 14 (18%) in *Inner regional* areas (see Figure 6.2 and Table S6.2).

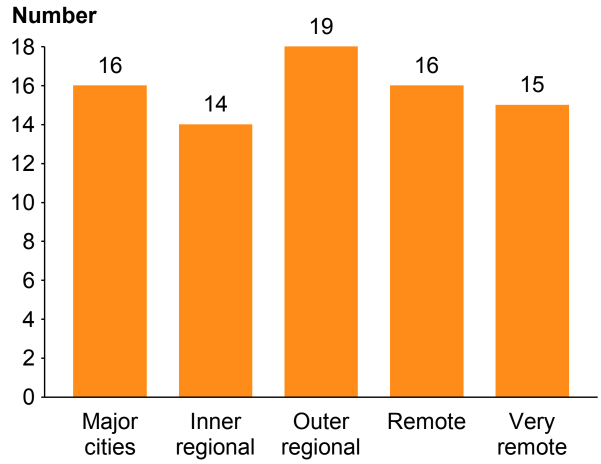


Figure 6.2: Number of substance-use organisations, by remoteness area, 2015–2016

Key characteristics

Of the 80 organisations:

- 38 (47%) were also funded by the DoH to provide Indigenous primary health-care services and 42 (53%) were not funded by the DoH for primary health-care services.
- 59 (74%) were ACCHOs and 21 (26%) were other non-government-run organisations.
- 78 (98%) had a governing committee or board and of these, 48 (62%) had all Indigenous board members.
- Most organisations (84%) were accredited with the RACGP and/or against organisational standards. This was higher in organisations also funded for Indigenous primary health care (97%) than in other organisations (71%). Just over two-thirds (69%) of other organisations providing substance-use services were accredited against organisational standards only.
- 58 (73%) had 500 or fewer clients.
- 51 (64%) provided services from 1 site and 36% had more than 1 site (see Table S6.3).

6.2 Services provided

At a glance

In 2015–16, the number of organisations providing non-residential substance-use services in scope for the OSR was higher (77 compared with 61 in 2014–15). In 2015–16 therefore, a higher proportion of all substance-use organisations provided non-residential services (96% compared with 91% in 2014–15) and more provided substance-use services in a primary health-care setting (48% compared with 30%). Most organisations (96%) provided non-residential services, 40% provided residential care services and 15% sobering-up, residential respite or short-term care services (see Table 6.1).

Services were delivered from 159 sites. Around two-thirds of these sites provided non-residential counselling services (69%) and around one-third (35%) residential counselling and residential group work. Around 32,700 clients were seen through 170,400 episodes of care. Compared with 2014–15, the number of organisations in the OSR increased by 19%, while total client numbers increased by 30%, and episodes of care by 13%.

Table 6.1: Indigenous substance-use services, 2014–15 and 2015–16

	2014–15		2015–16	
	Number	**%**	**Number**	**%**
Total organisations providing substance-use services	**67**	**100.0**	**80**	**100.0**
Organisation also funded for primary health care	20	29.9	38	47.5
Other organisation	47	70.1	42	52.5
Type of service(a)				
Residential	27	40.3	32	40.0
Sobering-up/respite care	12	17.9	12	15.0
Non-residential	61	91.0	77	96.3
Sites providing services during usual opening hours				
Receive referrals	109	97.3	152	95.6
Residential counselling	41	36.6	56	35.2
Non-residential counselling	74	66.1	109	68.6
Residential group work	43	38.4	56	35.2
Mobile assistance patrol/night patrol	8	7.1	10	6.3
Group work with clients not in residential care	76	67.9	97	61.0
Total sites(b)	**112**	**100.0**	**159**	**100.0**
Clients(c)				
Residential	2,663	10.6	2,844	8.7
Non-residential	19,938	79.1	26,467	80.8
Sobering-up/respite care	5,769	22.9	8,080	24.7
Total clients	**25,196**	**100.0**	**32,740**	**100.0**
Episodes of care				
Residential	2,932	1.9	3,173	1.9
Non-residential	133,731	88.5	148,842	87.4
Sobering-up/respite care	14,384	9.5	18,355	10.8
Total episodes of care	**151,047**	**100.0**	**170,370**	**100.0**

(a) Organisations may provide more than one type of service, so categories will not add to the total number of organisations.

(b) Includes all sites whether services were provided during normal hours or not.

(c) Clients may receive more than one type of service, so categories will not add to the total number of clients.

Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In 2015–16, it was the financial year from 1 July to 30 June.

Source: AIHW analyses of OSR data collection, 2015–16.

Types of services

The 5 most common substance-use issues reported, in terms of staff time and organisational resources, were alcohol, cannabis or marijuana, amphetamines, multiple drug use and tobacco or nicotine (see Table S6.4). These were similar to 2014–15. All organisations reported alcohol as one of their most common substance-use issues and 94% reported cannabis or marijuana. Those reporting amphetamines as a common substance-use issue increased from 70% of organisations in 2014–15 to 79% in 2015–16 (see Table S6.5).

Substance-use services are provided through a range of settings and types of treatment and may be broadly grouped into three types depending on the service setting: residential care; sobering-up, residential respite and short-term care; and non-residential care (see Box 6.2).

Box 6.2: Types of substance-use services

Residential care: includes culturally appropriate temporary live-in accommodation for clients requiring formal substance-use treatment and rehabilitation.

Sobering-up, residential respite or short-term care: includes overnight and short-term (1–7 days) care in residential settings. It includes mobile assistance patrols, night patrols and 'walk-in' services for clients who stay overnight. These clients do not receive formal rehabilitation.

Non-residential care: includes culturally appropriate treatment, rehabilitation and education without the option of residing in-house. This includes, for example, counselling, assessment, treatment, education, support, referral to other services and home visits. It also includes follow-up care from residential services after discharge. Follow-up care may include one-on-one support or case management for up to one year after exiting the rehabilitation program.

It should be noted that clients may receive more than one type of AOD service and may move between services. For example, residential clients may receive non-residential follow-up care after discharge, while sobering-up, residential respite or short-term care clients may receive services that include brief interventions and other non-residential services.

Organisations may provide one or more AOD services. In 2015–16, 46 (58%) organisations provided one type of service, mainly non-residential care, while 34 (42%) provided a combination of services (see Table 6.2). Seventy-seven organisations (96%) provided non-residential services, 32 residential services (40%), and 12 (15%) sobering-up, residential respite or short-term care services (see tables S6.6 and S6.7).

Table 6.2: Organisations providing substance-use services, by type of service, 2015–2016

Substance-use services	Number	%
One type of service		
Residential care only	2	2.5
Sobering-up, residential respite or short-term care only	1	1.3
Non-residential care only	43	53.8
More than one type of service		
Residential and non-residential care	23	28.8
Sobering-up, residential respite and non-residential care	4	5.0
All three types of care	7	8.8
Total	**80**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

Type of treatment

Various primary treatment methods were used by AOD counsellors (see Table S6.8). The main ones were harm reduction (31%), controlled or minimised substance misuse (23%) and abstinence (20%). The types of treatments used by nearly all organisations included support and case management (95%), information and education (95%) and counselling services (91%) (see Table S6.9).

There were, however, a wide range of AOD programs and activities provided. The most common included community education (96%), crisis intervention (79%), group counselling (78%), cultural groups (73%) and support groups (70%). School visits were made by 65% of organisations, and tobacco control programs provided by 59% of organisations (see Figure 6.3 and Table S6.10).

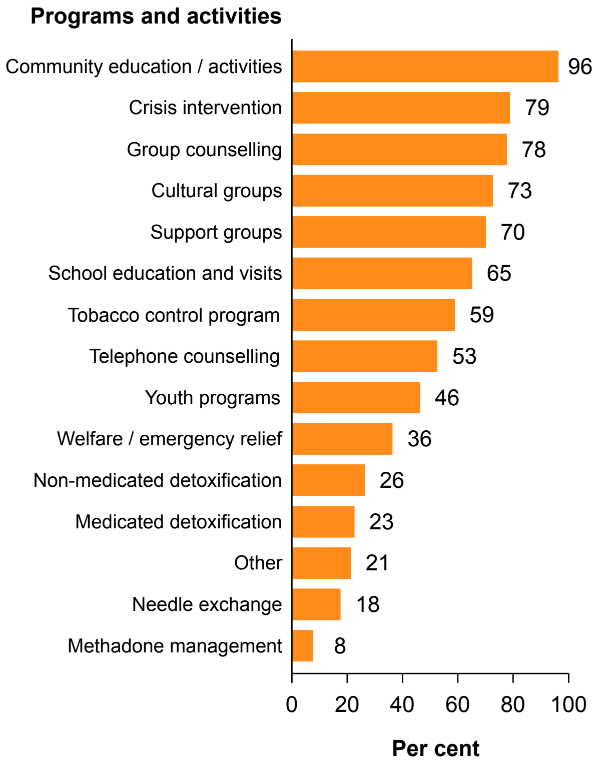


Figure 6.3: Proportion of substance-use organisations, by type of programs and activities provided, 2015–2016

Health promotion

In 2015–16, organisations providing substance-use services ran a range of health promotion group activities (see Figure 6.4). Most ran alcohol-misuse treatment and prevention groups (79%), men's groups (75%), and physical activity or healthy weight programs (74%). More than two-thirds ran tobacco-use treatment and prevention groups, living skills groups and cultural groups (70% each). A higher proportion of organisations funded for substance-use only provided alcohol-misuse treatment/prevention groups (91%) compared with organisations funded for both substance-use and primary health care (66%). They also had a higher average number of sessions per organisation (133 compared with 20). Organisations funded for substance-use only reported a higher average number of sessions per organisation for various group activities, compared with organisations funded for both substance-use and primary health care (see Table S6.11). This included, for example, living skills groups (123 sessions compared with 46), cultural groups (61 sessions compared with 18) and men's groups (69 sessions compared with 24).

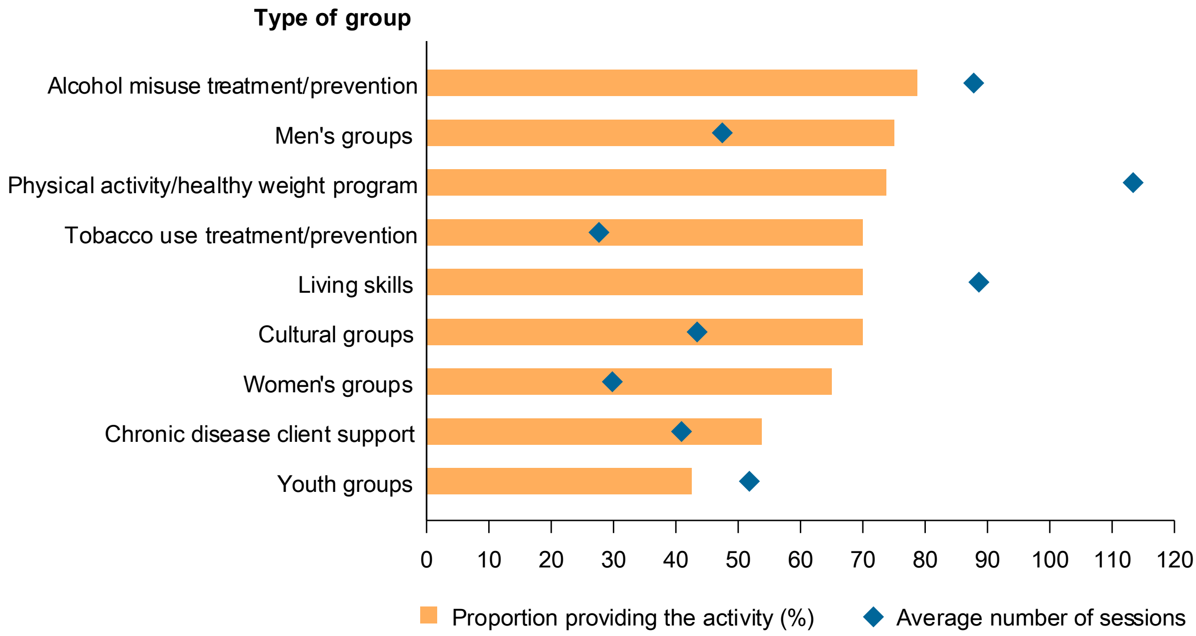
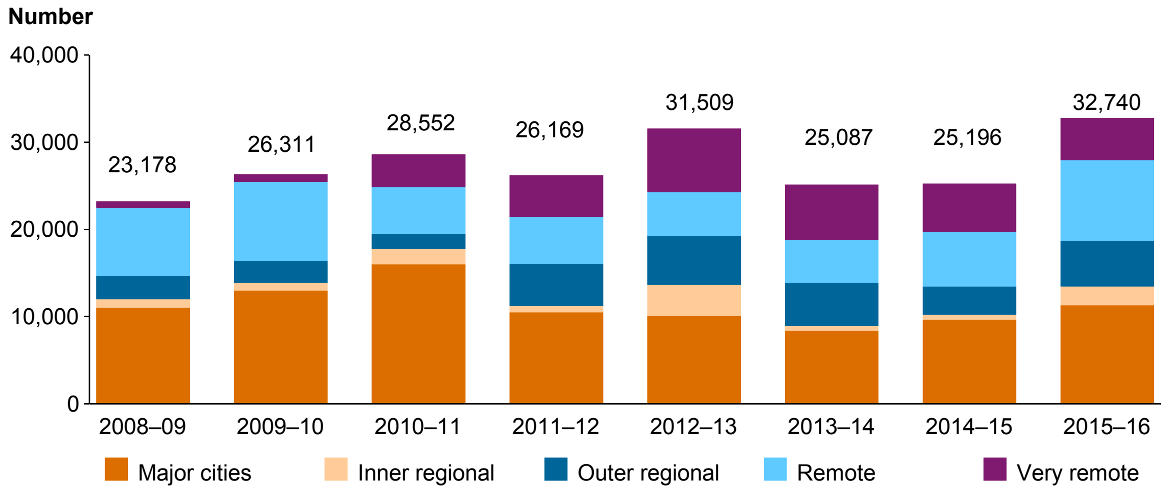


Figure 6.4: Proportion of substance-use organisations providing selected group activities and the average number of sessions conducted, by type of group activity, 2015–2016

6.3 Clients

In 2015–16, valid client numbers were provided by 75 (94%) organisations. They reported around 32,700 clients across all locations and types of services (see Figure 6.5). This was 30% more than 2014–15 (25,200). Around three-quarters (77%) of this increase was from existing organisations reporting higher client numbers in 2015–16; the rest was from organisations reporting in 2015–16 that did not report in 2014–15. Organisations in *Major cities* had around 11,300 (35%) clients, those in *Remote* areas around 9,200 (28%) clients and those in *Outer regional* areas around 5,200 (16%) clients (see Table S6.12).



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 6.5: Number of substance-use clients, by remoteness area, 2008–09 to 2015–16

Residential clients

In 2015–16, the 32 organisations providing residential care reported around 2,800 clients (see Table S6.13). This was 7% higher than in 2014–15 (2,700 clients). Most residential care clients (82%) were Indigenous and just over two-thirds of these Indigenous clients (69%) were male (See Table 6.3). Almost half (48%) of Indigenous clients were aged between 19 and 35, 37% were aged 36 and over and 15% were aged 18 and under (see Table S6.14). Nearly three-quarters of organisations (72%) had a waiting list for services and 445 people were reported to be waiting for services as at 30 June 2016 (see Table S6.15). This was similar to 2014–15 (456).

Table 6.3: Estimated clients of residential treatment services, by Indigenous status and gender, 2015–2016

				Total	
Indigenous status	**Male**	**Female**	**Gender not recorded**	**Number**	**%**
Indigenous	1,603	663	70	2,336	82.1
Non-Indigenous	377	115	1	493	17.3
Indigenous status not recorded	4	4	7	15	0.5
Total	**1,984**	**782**	**78**	**2,844**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

Around one-third of clients in residential care (34%) had a length of stay of 2–8 weeks and 37% had a length of stay of 9–16 weeks. Very short or long stays were less common, with fewer clients staying less than 2 weeks (18%) or 17 weeks or more (10%). This was similar to 2014–15 (see Table S6.16).

Sobering-up, residential respite and short-term care clients

In 2015–16, 11 of the 12 organisations providing sobering-up, residential respite and short-term care reported valid client numbers (92%). They saw around 8,100 clients, which was a 40% increase from 2014–15 (around 5,800 clients). This increase is mostly due to one organisation reporting in 2015–16 whose data was excluded in 2014–15. Most clients were Indigenous (78%) and just over half (52%) of these Indigenous clients were male (see Table 6.4). Two-thirds (66%) of Indigenous clients were aged 36 and over (see Table S6.17).

Table 6.4: Estimated clients of sobering-up, residential respite and short-term care services, by Indigenous status and gender, 2015–2016

				Total	
Indigenous status	**Male**	**Female**	**Gender not recorded**	**Number**	**%**
Indigenous	3,298	3,028	0	6,326	78.3
Non-Indigenous	193	191	0	384	4.8
Indigenous status not recorded	492	876	2	1,370	17.0
Total	**3,983**	**4,095**	**2**	**8,080**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

Non-residential and after-care clients

In 2015–16, 65 of the 77 organisations providing non-residential and after-care services reported valid client numbers (84%), while 6 had their data excluded and another 6 reported on their non-residential group activities only. Around 26,500 clients were reported from these 65 organisations, a 33% increase from 2014–2015 (around 19,900 clients). Part of this increase was from more organisations reporting client data in 2015–16 (65 compared with 57 in 2014–15). Most of the increase, however, was from more clients being reported in several organisations that reported in both years.

Three-quarters of non-residential care clients were Indigenous (77%) and just over half of these (53%) were male and 45% were female (see Table 6.5). Forty-five per cent of all Indigenous clients were aged 19 to 35 and 43% were aged 36 and over. Clients aged 18 and under made up a smaller proportion (12%) of all Indigenous clients (see Table S6.18).

Table 6.5: Estimated clients of non-residential and after-care services, by Indigenous status and gender, 2015–2016

Indigenous status	Male	Female	Gender not recorded	Total Number	Total %
Indigenous	10,960	9,139	392	20,491	77.4
Non-Indigenous	1,817	1,125	102	3,044	11.5
Indigenous status not recorded	1,307	1,487	138	2,932	11.1
Total	**14,084**	**11,751**	**632**	**26,467**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

Referrals

Substance-use clients are referred to services from different sources. In 2015–16, most organisations had clients that walked in or referred themselves (92%), and clients referred by a family member, elder or friend (93%). Most also had clients referred by mental health services (87%), Aboriginal medical services (86%) and hospitals (82%) (see Table S6.19).

6.4 Episodes of care

In 2015–16, around 170,400 substance-use episodes of care were reported (see tables S6.20 and S6.21). This was an increase of 13% from 2014–15 (around 151,000 episodes). This increase was mainly due to 19 organisations reporting in the OSR in 2015–16, that did not report in 2014–15 as well as small increases in episodes of care in some organisations reporting in both years.

Residential episodes of care

A residential episode of care refers to one treatment period, from the time of admission into treatment through to discharge. If a client receives treatment on two separate occasions, then this is counted as two episodes of care.

In 2015–16, the 32 organisations providing residential care provided around 3,200 episodes of care (see Table S6.22). This was 8% higher than in 2014–15 (2,900 episodes). Indigenous clients received 82% of all residential episodes of care and over two-thirds of these (68%) were with Indigenous males and 29% with Indigenous females (see Table 6.6).

Table 6.6: Estimated residential episodes of care by residential substance-use services, by Indigenous status and gender, 2015–2016

Indigenous status	Male	Female	Gender not recorded	Total Number	Total %
Indigenous	1,778	764	71	2,613	82.4
Non-Indigenous	418	126	1	545	17.2
Indigenous status not recorded	4	4	7	15	0.5
Total	**2,200**	**894**	**79**	**3,173**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

Sobering-up, residential respite and short-term care episodes of care

A sobering-up, residential respite or short-term care episode of care, starts at admission into a program and ends at discharge. Each time a client comes to stay is counted as a separate episode of care.

In 2015–16, 11 of the 12 organisations providing this type of service reported valid episodes of care data. They reported around 18,400 episodes of care, which was 28% higher than the number reported in 2014–15 (around 14,400 episodes). Around half this increase was due to one organisation reporting valid data in 2015–16 that did not report in 2014–15, and the other half is from several organisations reporting higher episodes of care in 2015–16.

Indigenous clients received 88% of all sobering up, residential respite or short-term care episodes of care, and just over half (53%) of these were with male clients (see Table 6.7). Almost two-thirds of all episodes of care (64%) were with Indigenous clients aged 36 and over (see Table S6.23). Each sobering-up, residential respite or short-term care client, had on average 2.3 episodes of care.

Table 6.7: Estimated episodes of care by sobering-up, residential respite and short-term care services, by Indigenous status and gender, 2015–2016

				Total	
Indigenous status	**Male**	**Female**	**Gender not recorded**	**Number**	**%**
Indigenous	8,568	7,498	0	16,066	87.5
Non-Indigenous	344	194	0	538	2.9
Indigenous status not recorded	674	1,075	2	1,751	9.5
Total	**9,586**	**8,767**	**2**	**18,355**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

Non-residential and after-care episodes of care

A non-residential or after-care episode of care is each occasion a client accesses services such as substance-use counselling, assessment, treatment, education, and support or follow-up from residential services (after discharge). In 2015–16, 65 (84%) organisations providing non-residential services reported valid episodes of care data. These organisations provided around 148,800 episodes of care. This is 11% higher than in 2014–15 (around 133,700 episodes) and is largely due to more organisations reporting in 2015–16.

Indigenous clients received 82% of all non-residential episodes of care, non-Indigenous clients 9% and clients with their Indigenous status not recorded 8% (see Table 6.8). Episodes of care with Indigenous clients were evenly split between males (50%) and females (50%). Over half (55%) of all non-residential episodes of care with Indigenous clients were with clients aged 36 and over, while 37% were with clients aged 19–35. Around 8% of episodes of care with Indigenous clients were with clients aged 18 and under (see Table S6.24). Each non-residential and after-care client, had on average, 5.6 non-residential and after-care episodes of care.

Table 6.8: Estimated episodes of care by non-residential services, by Indigenous status and gender, 2015–2016

				Total	
Indigenous status	**Male**	**Female**	**Gender not recorded**	**Number**	**%**
Indigenous	60,796	61,305	605	122,706	82.4
Non-Indigenous	8,361	5,390	118	13,869	9.3
Indigenous status not recorded	6,568	5,193	506	12,267	8.2
Total	**75,725**	**71,888**	**1,229**	**148,842**	**100.0**

Source: AIHW analyses of OSR data collection, 2015–16.

6.5 Service gaps and challenges

Services for mental health and social and emotional wellbeing issues were among the top 5 service gaps reported for 71% of organisations funded to provide substance-use services (see Figure 6.6 and Table S6.25). This was followed by services for alcohol, tobacco and other drugs (65%), youth services (49%) and environmental health services (48%).

The 42 organisations not funded by the DoH for primary health care were more likely to report mental health and social and emotional wellbeing issues as a gap than those also funded for primary health care (81% compared with 61%, respectively). They were also more likely to report alcohol, tobacco and other drugs as a gap (74% compared with 55%), access to health services (45% compared with 29%) and environmental health services (57% compared with 37%) than those also funded for primary health care.

The 38 organisations also funded for primary health care were more likely to report dental services as a gap than those not funded for primary health care (45% compared with 19%, respectively). They were also more likely to report early childhood development and family support (37% compared with 26%) and nutrition services (including lack of access to affordable healthy food) as a gap (26% compared with 17%).

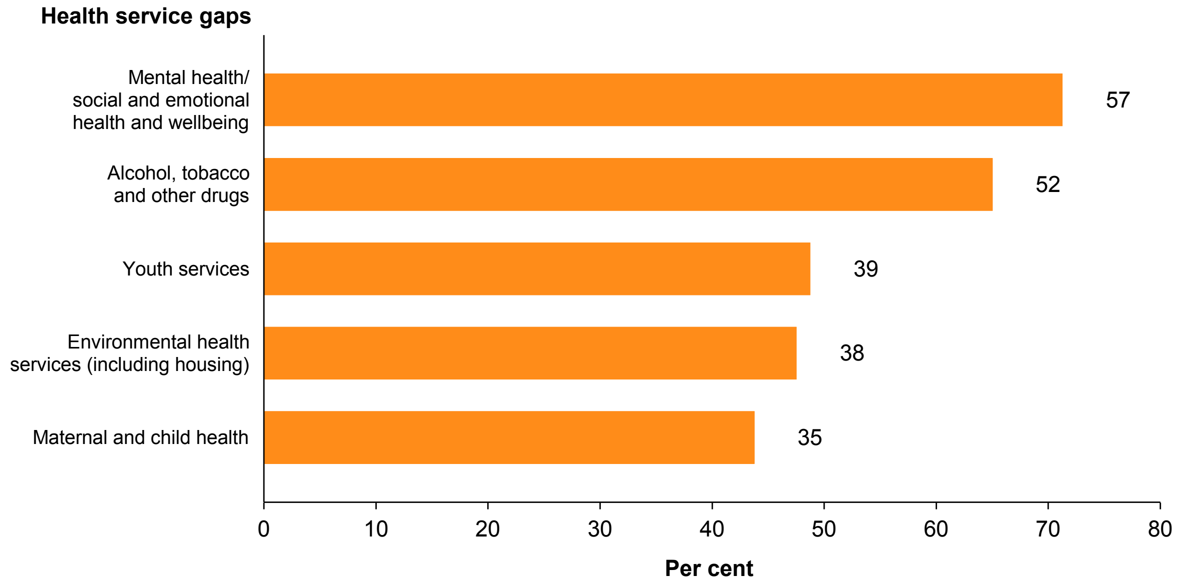


Figure 6.6: Number (as labelled) and proportion (in scale) of organisations funded for substance-use services, by type of health service gap, 2015–16

Two-thirds (69%) of organisations reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff among their top 5 service challenges and 59% reported staffing levels as challenges (see Table S6.26). Around half reported the coordination of clinical care with other providers (50%), and appropriate health service infrastructure (49%) as challenges.

Appendix A: Data quality

The OSR collects aggregated organisation-level data. There are a number of things about the collection that should be kept in mind when using OSR data.

1. The organisations submitting data may change over time

The total number of organisations submitting data changes slightly each year. Although for the most part, it is the same organisations contributing to the collection, the number of organisations may change due to changes in funding, auspicing or reporting arrangements at the local level. For example, the total number of organisations submitting data in 2015–16 was 277, a decrease of 1 from 2014–15 (278 organisations). There were 22 organisations reporting in 2014–15 that were no longer in scope for reporting in 2015–16, while 21 organisations not reporting in 2014–15 were in scope for reporting in 2015–16.

2. The organisations submitting valid data for a particular data item may change over time

Each year some organisations have data that is partially accepted, rather than fully accepted. This is because the AIHW analyses the data submitted by each organisation and does internal consistency checks and comparisons with previous submissions. Any queries about the data submitted are followed up with each organisation and they may be requested to clarify issues or to provide additional or corrected data.

Common data quality queries in the 2015–16 collection were around incomplete data and discrepancies between two or more questions. There were queries raised with most organisations (94%). Where significant data quality issues remained after follow-up, these data items were excluded from national analyses. In 2015–16, 13 (5%) organisations had data that was partially accepted. In total, 32 data items from these 13 organisations were excluded from national analyses (see Table A1).

Table A1: Data exclusions, 2015–16

Data item	Number of issues	Number of organisations with data excluded	Total organisations	Proportion of organisations
Primary health episodes of care	2	2	204	1.0
Primary health client contacts	1	1	204	0.5
Antenatal care clients and visits	1	1	182	0.5
Social and emotional wellbeing clients	1	1	86	1.2
Social and emotional wellbeing episodes of care	1	1	86	1.2
Substance-use total clients	5	5	80	6.3
Residential clients/episodes of care	5	2	80	2.5
Sobering-up clients/episodes of care	2	2	80	2.5
Non-residential clients/episodes of care	12	6	80	7.5
Total	**32**	**13**	**277**	**4.7**

It should also be noted that time series analyses are based on the organisations that provided valid data in each year, and not on a subset of organisations with valid data over all years.

3. Organisations may estimate some of their data

Some organisations providing primary health-care services are unable to provide exact data and provide estimates of their client numbers and episodes of care. This may be because some staff (for example, visiting staff), could not record their data or provide complete data, or because multiple systems are used and data needs to be estimated from these. Also, some organisations may be able to generate total numbers from their PIRs but need to estimate Indigenous or gender breakdowns. In 2015–16, there were 22 organisations (11%) that estimated their primary health episodes of care and 31 (15%) that estimated their primary health client numbers. This data was accepted unless the AIHW assessed that data were likely to overestimate actual numbers.

4. Reporting period changes

For most years, including 2015–16, the reporting period was for the financial year from 1 July to 30 June. In 2014–15, the Census date for the collection was brought forward by 1 month to 31 May 2015, rather than 30 June 2015. This was done to allow organisations to use the PenCAT data extraction tool, which would not be available for OSR reporting after 30 June 2015. Organisations were still asked to provide data for a 12 month period (1 June 2014 to 31 May 2015) to enable time series analyses. However, this meant that data for June 2014 may have been reported in both the 2013–14 and 2014–15 collections for clients, contacts and episodes of care. Nevertheless, comparing 2013–14, 2014–15 and 2015–16 data did not show any obvious underreporting for any data items at the national level.

5. Substance-use validation

In 2014–15, some additional validation checks were added to the collection. One such check suggested that some substance-use counts (mainly non-residential) were being extracted incorrectly from the PIRS of a few organisations. This was largely an issue with non-residential substance-use client and episode of care numbers extracted from one type of PIRS. Where substance-use data for these organisations could not be corrected, they were excluded from national analyses. To enable time series analyses, the substance-use data extracted by these organisations in previous years were also investigated, which resulted in a revision of substance-use client and episodes data for 2012–13 and 2013–14. These revisions have been applied to any time series data presented since 2014–15, including in this report.

6. Changes to the collection

There have been other changes to the collection that are worth noting:

- Before 2011–12, only stand-alone substance-use services that were not funded to provide Indigenous primary health–care services were required to report on their substance-use clients and episodes of care. This meant the collection did not capture all of the substance-use work being done. In 2011–12, the scope for reporting on substance-use services changed. Organisations funded by the Australian Government to provide both primary health-care and substance-use services could now report on both types of services, whereas previously they could only report on their primary health-care services. The number of organisations reporting substance-use data therefore increased between 2010–11 and 2011–12. It should be noted, however, that since then not all organisations funded to provide substance-use services have been able to or required to report on this activity.
- In 2012–13, following a review of the OSR collection, a revised collection instrument was introduced that subdivided the questionnaire into modules for ease of completion. The wording and response categories of some existing questions also changed, which resulted in a break in time series data for some questions (see Table A2 for a list of major changes).
- From 2012–13, the collection was assisted by the introduction of the PenCAT audit tool and OCHREStreams online reporting facilities. This meant some questions could be pre-populated directly from an organisation's PIRS. This was designed to improve data quality and ease of reporting for organisations; however, it may have led to some differences in the data reported for some organisations. It should also be noted that organisations could overwrite this pre-population function and that not all organisations used this facility.

- From 2012–13, more information was collected at the site level, including the address of each service delivery site and the range of services provided from each site. This information can be used to identify service delivery locations and for data validation. Using this information in 2015–16 resulted in a few organisations having their remoteness category changed to better reflect service delivery, rather than being based on an administrative address.

7. Other issues

It should also be noted that the quality of OSR data submitted by organisations depends on whether they are recording data correctly, have sufficient management resources to support the data collection and can use their PIRS, reporting tools and the OCHREStreams online reporting facilities effectively.

Further information on the collection can be found on the AIHW's METeOR website <http://meteor.aihw.gov.au/content/index.phtml/itemId/661847>.

Table A2: Changes to the OSR questionnaire in 2012–13

Items	Details	Notes
Accreditation	The category of 'not accredited' was no longer collected.	The 2012–13 questionnaire asked whether health organisations were accredited with RACGP and/or organisational standards. It did not ask whether an organisation was accredited with other standards or did not have accreditation.
Clinical health activities	A few types of activities were no longer collected, such as: • outreach clinic services • interpreting services • immunisation and vaccination registers • maintains health registers.	
Population health programs	A few types of programs were no longer collected, such as: • regularly organise pneumococcal immunisations • routinely organise influenza immunisations • dietary and nutrition programs • child growth monitoring.	The 2012–13 questionnaire collected data on population health programs at the organisational level, which previously were collected only for primary health-care organisations.
Screening programs	Most programs were no longer collected, such as, eye screening and renal screening.	
Community services	A few types of services were no longer collected, such as: • school-based activities • medical evacuation services • youth camps.	The 2012–13 questionnaire collected data on advocacy, planning and policy, research and cultural promotion activities at the organisation level, which previously were collected only for primary health-care organisations.

Appendix B: Workforce

This following is a list of staff included as ‘health’ and ‘other’ positions in this report.

Health staff

Aboriginal and Torres Strait Islander health worker

Aboriginal and Torres Strait Islander health practitioner

Doctor or general practitioner (GP)

Nurse or midwife

Substance misuse or drug and alcohol worker

Tobacco worker or coordinator

Dentists or dental therapists

Dental support (for example, dental assistant, dental technician)

Sexual health worker

Outreach worker

Traditional healer

Environmental health worker or officer

Medical specialist (for example, paediatrician, endocrinologist, ophthalmologist, obstetrician or gynaecologist, ENT specialist, cardiologist; renal medicine specialist, psychiatrist, dermatologist, surgeon)

Social and emotional wellbeing staff or counsellor (for example, psychologist, counsellor, social worker, welfare worker, Link Up caseworker)

Allied health professional (for example, audiologist or audiometrist, diabetes educator, dietician, optometrist, pharmacist, physiotherapist, podiatrist, speech pathologist)

Health promotion or prevention worker

Training or trainee position

Other (general) staff

Chief Executive Officer (CEO)

Manager or supervisor

Driver or field officer

Finance and accounting staff

Administrative and clerical staff

Information technology (IT) and data management staff

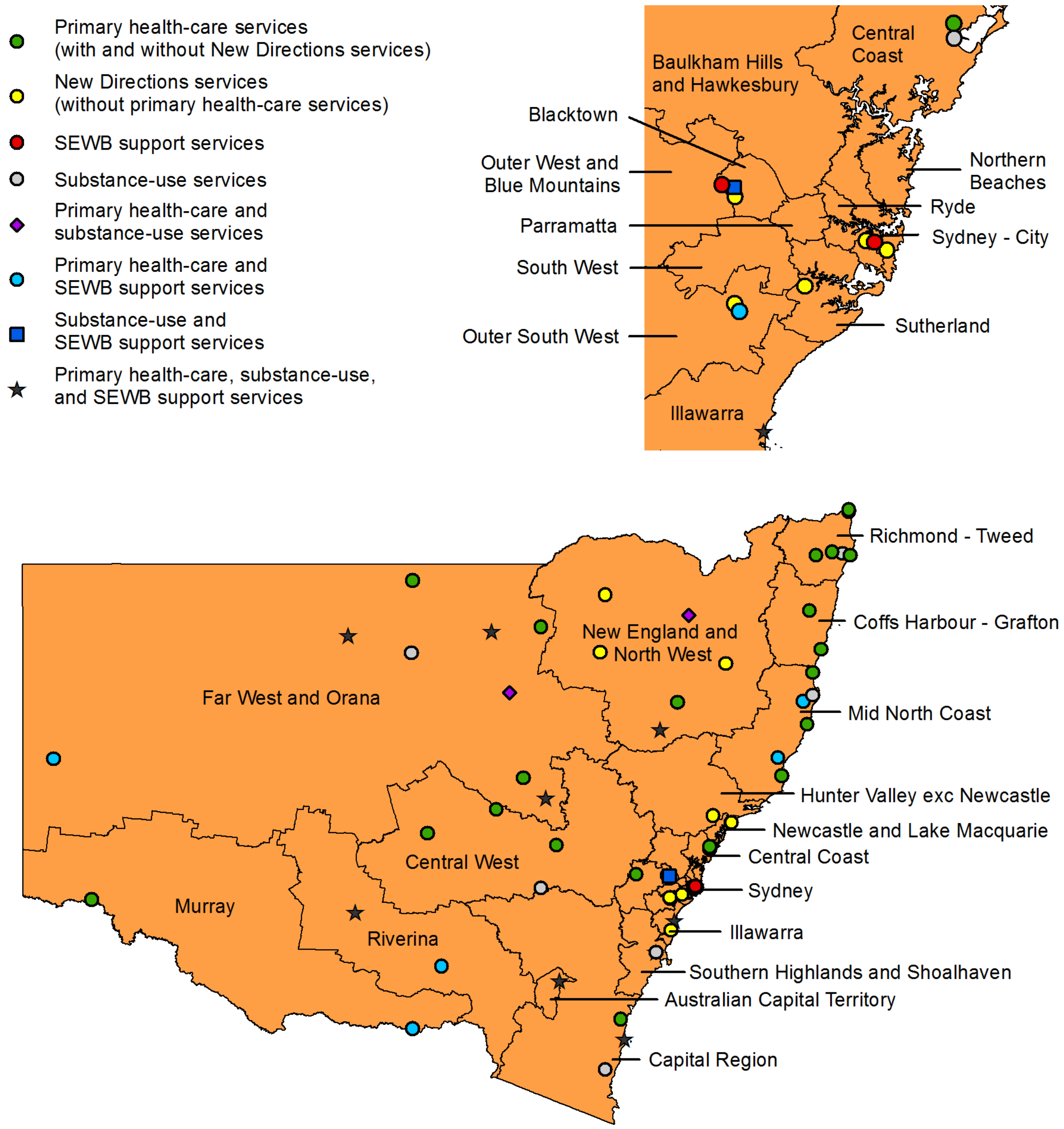
Cleaner, security or other support staff

Administrative or support trainees

Appendix C: Maps of organisations for states and territories

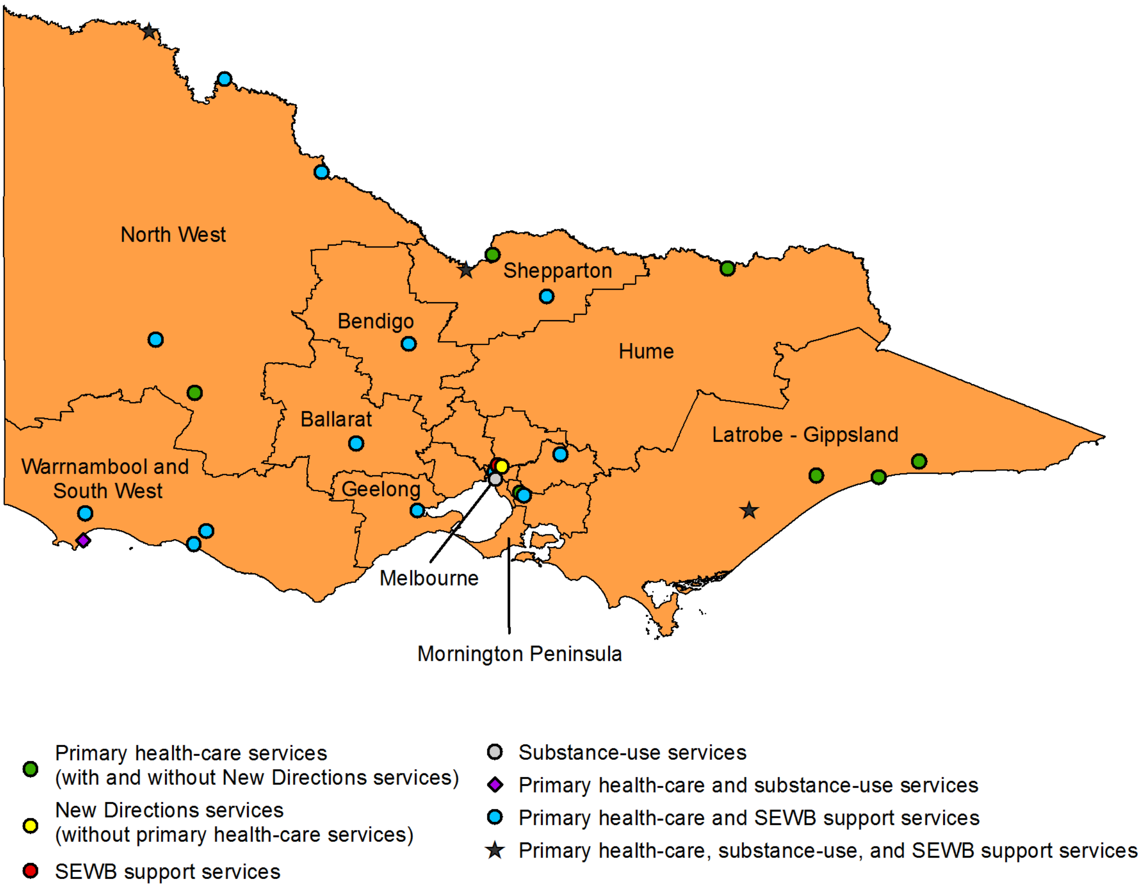
The following state and territory maps show the locations of organisations in the 2015–16 OSR collection. Each organisation is represented by a symbol which describes the combination of services provided by that organisation.

OSR organisations were funded by the Australian Government to provide one or more of the following services to Aboriginal and Torres Strait Islander people: primary health care; New Directions: Mothers and Babies Services; social and emotional wellbeing services; and substance-use services. Some organisations provided only one of these services, while other organisations provided multiple services. For example, the green circles indicate organisations which were funded to provide primary health-care services (with or without New Directions funding), while the purple diamonds indicate organisations which were funded to provide both primary health-care services and substance-use services.



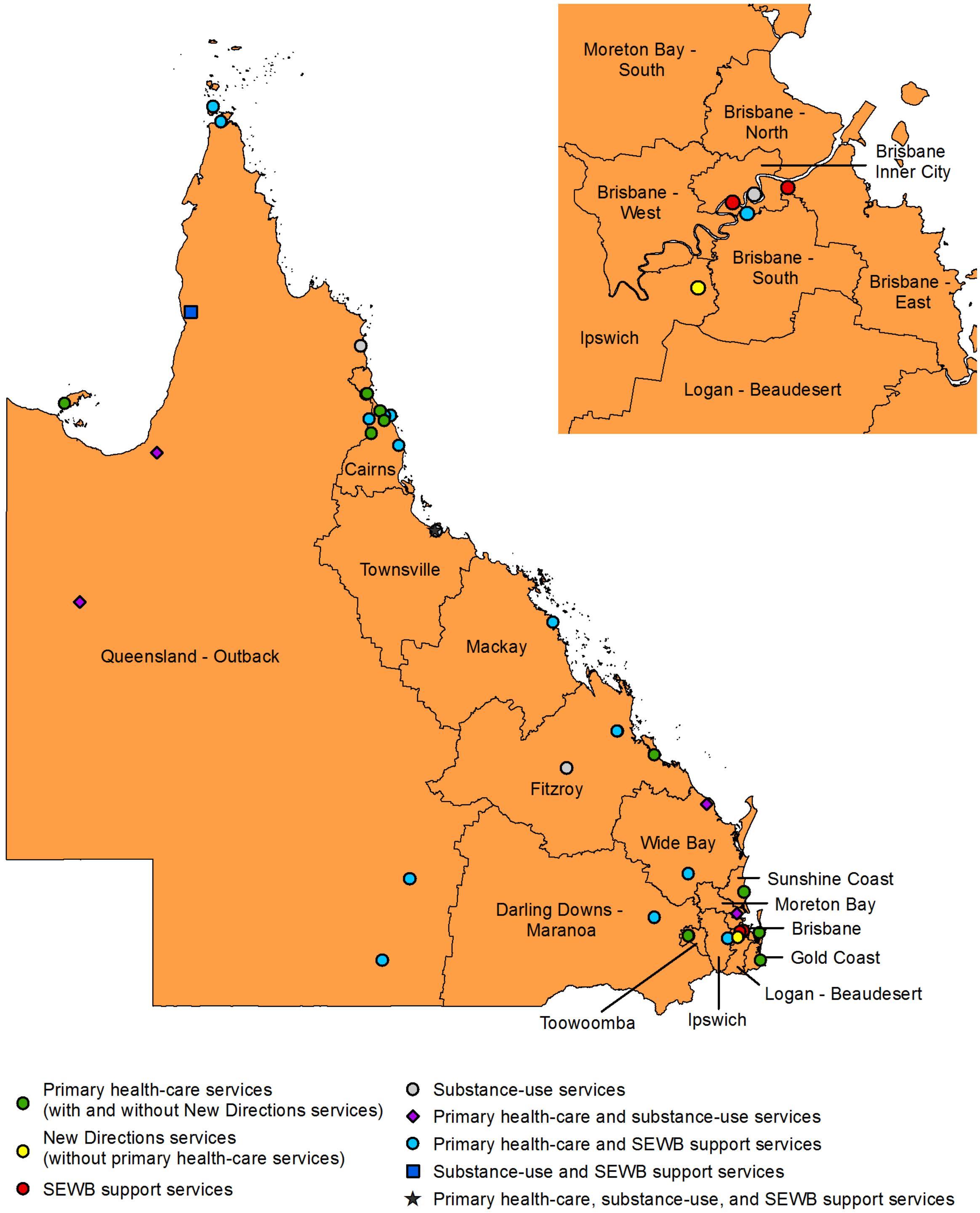
Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C1: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, New South Wales and the Australian Capital Territory, 2015–16



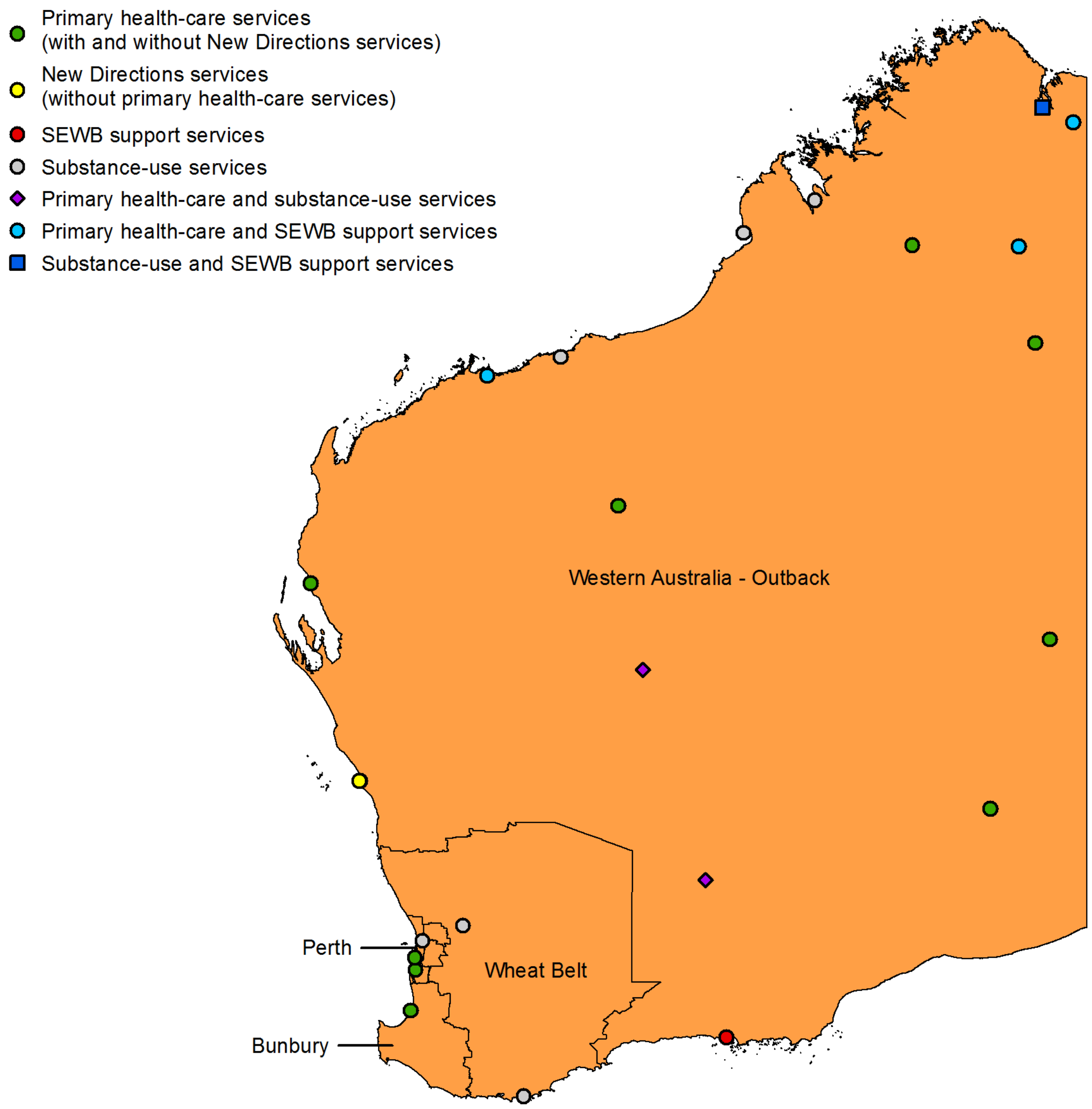
Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C2: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Victoria, 2015–16



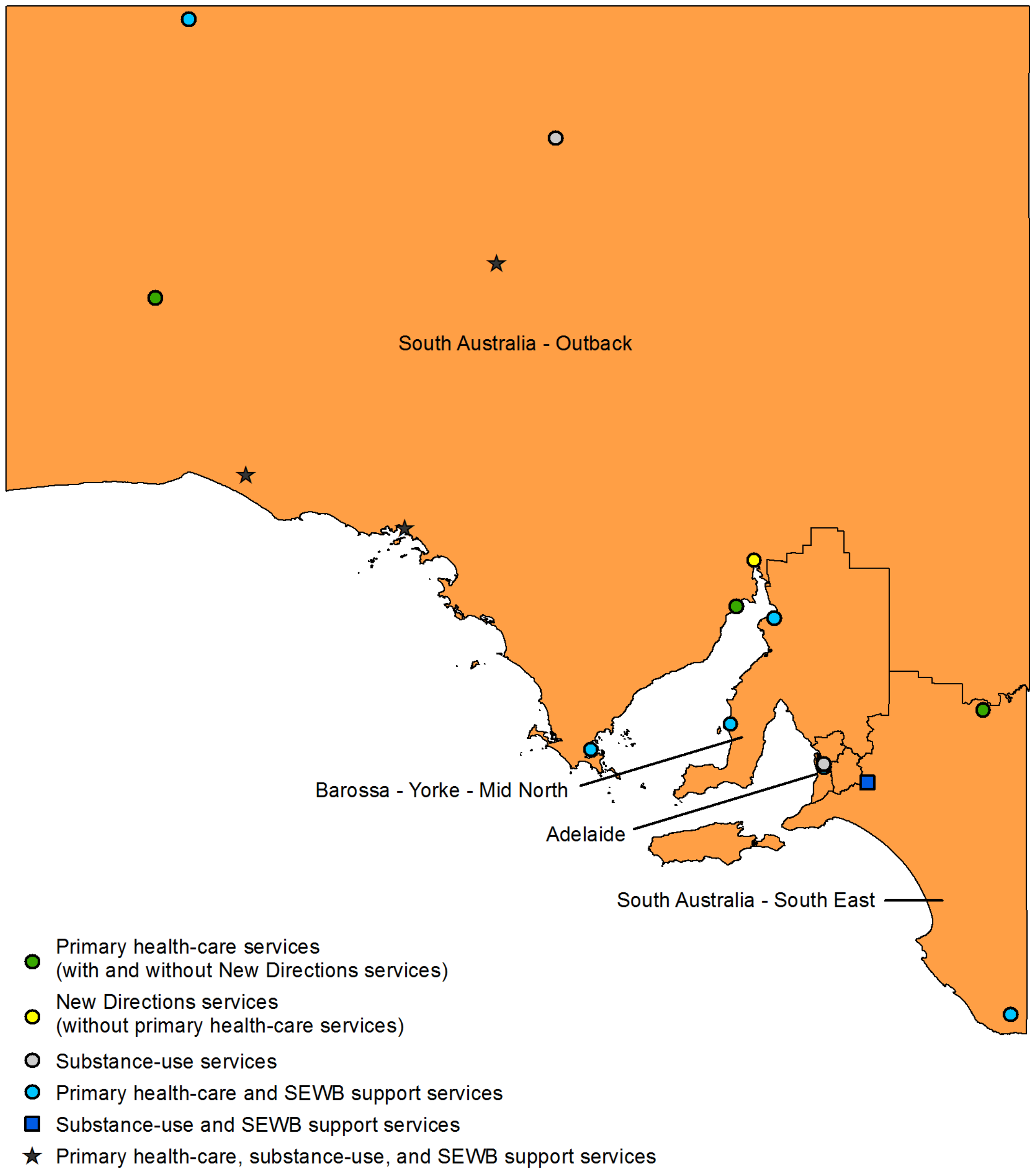
Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C3: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Queensland, 2015–16



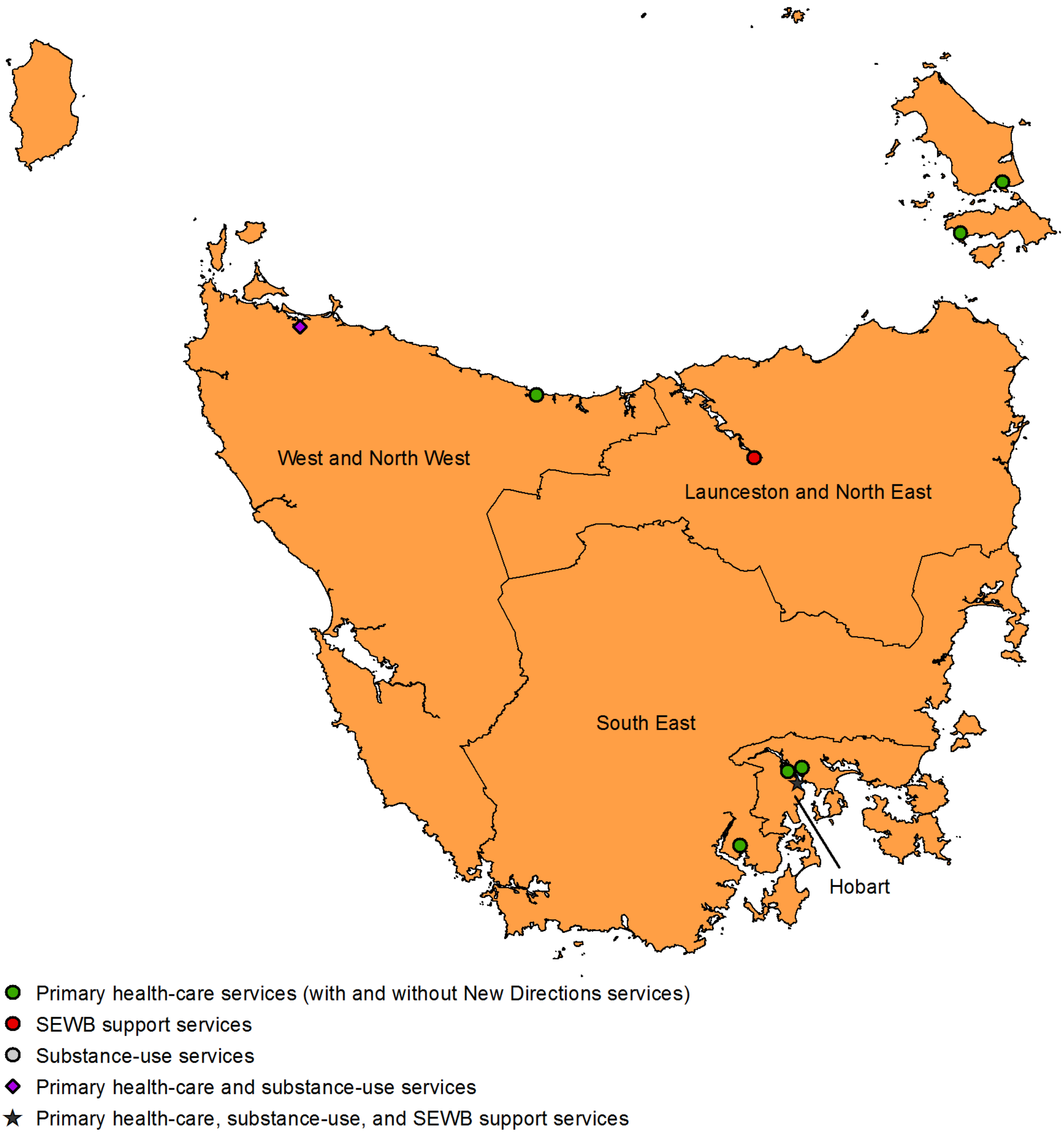
Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C4: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Western Australia, 2015–16



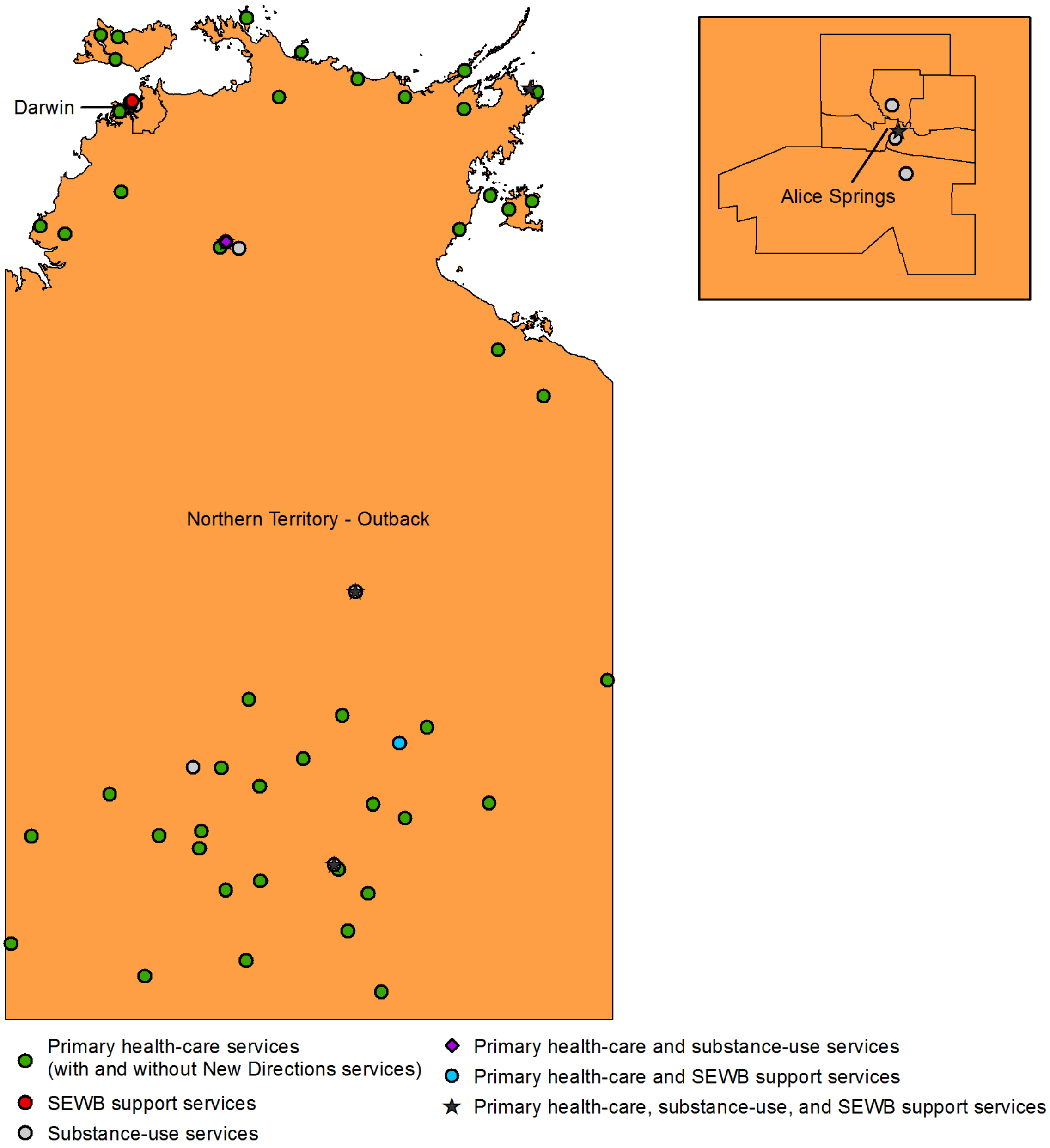
Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C5: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, South Australia, 2015–16



Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C6: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Tasmania, 2015–16



Note: Multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure C7: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Northern Territory, 2015–16

Appendix D: List of organisations

Table D1 lists the 277 organisations that contributed to the 2015–16 OSR collection.

Table D1: OSR organisations[(a)], by state and territory, 2015–16

Organisation name	State/ territory
Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited	Qld
Aboriginal Alcohol and Drug Service (AADS) Incorporated	WA
Aboriginal Drug and Alcohol Council SA Incorporated	SA
Aboriginal Medical Service Co-Operative Limited	NSW
Aboriginal Sobriety Group Incorporated	SA
Aboriginal and Torres Strait Islanders Community Health Service Limited (Mackay)	Qld
Albury Wodonga Aboriginal Health Service Incorporated	NSW
Amoonguna Community Health Service	NT
Ampilatwatja Health Centre Aboriginal Corporation	NT
Anglicare WA Incorporated	WA
Anyinginyi Health Aboriginal Corporation	NT
Apunipima Cape York Health Council Aboriginal Corporation	Qld
Armajun Aboriginal Health Service	NSW
Armidale Child and Family Team, Armidale Community Health Service (HNELHD)	NSW
Awabakal Limited	NSW
Ballarat and District Aboriginal Co-Operative	Vic
Balunu Foundation Limited	NT
Barkly Region Alcohol & Drug Abuse Advisory Group Incorporated	NT
Bega Garnbirringu Health Service Aboriginal Corporation	WA
Bendigo and District Aboriginal Co-Operative	Vic
Benelong's Haven Limited	NSW
Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region	Qld
Binjari Community Health Service	NT
Biripi Aboriginal Corporation Medical Centre	NSW
Birra-Li Aboriginal Maternal, Infant and Child Health Service (HNELHD)	NSW
Bloodwood Tree Association	WA
Boab Health Services	WA
Bourke Aboriginal Health Service	NSW
Brewarrina Aboriginal Health Service	NSW
Broome Regional Aboriginal Medical Service	WA
Budja Budja Aboriginal Cooperative	Vic

continued

Table D1 (continued): OSR organisations[(a)], by state and territory, 2015–16

Organisation name	State/ territory
Bulgarr Ngaru Medical Aboriginal Corporation	NSW
Bulgarr Ngaru Medical Aboriginal Corporation—Richmond Valley	NSW
Bullinah Aboriginal Health Service	NSW
Bushmob Incorporated	NT
Cairns and Hinterland Hospital and Health Service	Qld
Cape Barren Island Aboriginal Association Incorporated	Tas
Carnarvon Medical Service Aboriginal Corporation	WA
Ceduna/Koonibba Aboriginal Health Service (Aboriginal Corporation)	SA
Central Australian Aboriginal Alcohol Programmes Unit	NT
Central Australian Aboriginal Congress Aboriginal Corporation	NT
Central Queensland Indigenous Development Limited	Qld
Centrecare Incorporated	WA
Cessnock/Kurri Kurri Community Health Service (HNELHD)	NSW
Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health Limited	Qld
Cherbourg Regional Aboriginal and Islander Community Controlled Health Services Limited	Qld
Circular Head Aboriginal Corporation	Tas
City of Greater Dandenong	Vic
Condobolin Aboriginal Health Service Incorporated	NSW
Coomealla Health Aboriginal Corporation	NSW
Coonamble Aboriginal Health Service Incorporated	NSW
Cornerstone Youth Services	Tas
Council for Aboriginal Alcohol Program Services Incorporated	NT
Cummeragunja Housing and Development Aboriginal Corporation	Vic
Cunnamulla Aboriginal Corporation for Health	Qld
Dandenong and District Aborigines Co-Operative Limited—Bunurong Health Service	Vic
Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation	NT
Darling Downs Shared Care Incorporated (Carbal Medical Centre)	Qld
Darrimba Maarra	NSW
Department of Health and Human Services	Tas
Derbarl Yerrigan Health Service Incorporated	WA
Derby Aboriginal Health Service	WA
Dhauwurd-Wurrung Elderly and Community Health Service Incorporated	Vic
Drug and Alcohol Services Association Alice Springs Incorporated	NT
Dubbo Regional Aboriginal Medical Service	NSW
Dunjiba Community Council	SA
Durri Aboriginal Corporation Medical Services	NSW
Eyre Region (CHSALHN)	SA

continued

Table D1 (continued): OSR organisations[(a)], by state and territory, 2015–16

Organisation name	State/ territory
Flinders Island Aboriginal Association Incorporated	Tas
Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties Corporation	NT
GP Down South General Practice Network	WA
Galambila Aboriginal Health Service Incorporated	NSW
Gallang Place Aboriginal and Torres Strait Islander Corporation	Qld
Garl Garl Walbu Alcohol Association Aboriginal Corporation	WA
Geraldton Regional Aboriginal Medical Service	WA
Gindaja Treatment and Healing Indigenous Corporation	Qld
Gippsland and East Gippsland Aboriginal Co-Operative Limited	Vic
Goolburri Aboriginal Health Advancement Company Limited	Qld
Goolum Goolum Aboriginal Co-Operative	Vic
Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services	Qld
Grand Pacific Health	NSW
Griffith Aboriginal Medical Service Aboriginal Corporation	NSW
Gunditjmara Aboriginal Cooperative	Vic
Gurriny Yealamucka (Good Healing) Health Services Aboriginal Corporation	Qld
Healthy North Coast Limited (North Coast Primary Health Network)—Bugalwena General Practice	NSW
Healthy North Coast Limited (North Coast Primary Health Network)—Jullums Lismore Aboriginal Medical Service	NSW
Holyoake Australian Institute for Alcohol and Drug Addiction Resolutions Incorporated	WA
Hunter New England and Central Coast Primary Health Network	NSW
Illawarra Aboriginal Medical Service Aboriginal Corporation	NSW
Illawarra Shoalhaven Local Health District	NSW
Inala Indigenous Health Service	Qld
Independent Practitioners Network (IPN) Pty Limited	Qld
Indigenous Wellbeing Centre Limited	Qld
Institute for Urban Indigenous Health Limited	Qld
Kalano Community Association Incorporated	NT
Kalwun Health Service	Qld
Kambu Aboriginal and Torres Strait Islander Corporation for Health	Qld
Karadi Aboriginal Corporation	Tas
Katherine West Health Board Aboriginal Corporation	NT
Katungul Aboriginal Corporation Community and Medical Services	NSW
Kimberley Aboriginal Medical Service Incorporated	WA
Kimberley Stolen Generation Aboriginal Corporation	WA
Kinchela Boys Home Aboriginal Corporation	NSW
Kirrae Health Service Incorporated	Vic

continued

Table D1 (continued): OSR organisations[a], by state and territory, 2015–16

Organisation name	State/ territory
Lake Tyers Health and Children Services Association Incorporated	Vic
Laynhapuy Homelands Aboriginal Corporation	NT
Link-Up (NSW) Aboriginal Corporation	NSW
Link-Up (Queensland) Aboriginal Corporation	Qld
Lives Lived Well—Brighter Futures (in Cherbourg)	Qld
Lives Lived Well—Shanty Creek (in Mareeba)	Qld
Maari Ma Health Aboriginal Corporation—Broken Hill and Wilcannia	NSW
Mallee District Aboriginal Services	Vic
Mamu Health Service Limited Innisfail	Qld
Marrin Weejali Aboriginal Corporation	NSW
Marthakal Homeland and Resource Centre Association	NT
Mawarnkarra Health Service	WA
Mercy Public Hospitals Incorporated	Vic
Mid North—Port Pirie (CHSALHN)	SA
Milliya Rumurra Aboriginal Corporation	WA
Miwatj Health Aboriginal Corporation	NT
Moogji Aboriginal Council East Gippsland Incorporated	Vic
Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation	Qld
Moree Community Health Service (HNELHD)	NSW
Mount Isa Aboriginal Community Controlled Health Services Limited	Qld
Mpwelarre Health Aboriginal Corporation	NT
Mulungu Aboriginal Corporation Medical Service	Qld
Mungabareena Aboriginal Corporation	Vic
Murdi Paaki Drug and Alcohol Network (The Lyndon Community)	NSW
Murray Valley Aboriginal Co-Operative (Robinvale)	Vic
Mutijulu Community Health Service	NT
NPA Family and Community Services Aboriginal and Torres Strait Islander Corporation	Qld
NT Department of Health—Alpurrurulam Community Health Centre	NT
NT Department of Health—Amunturrngu Community Health Centre	NT
NT Department of Health—Angurugu Community Health Centre	NT
NT Department of Health—Aputula Community Health Centre	NT
NT Department of Health—Atitjere Community Health Centre	NT
NT Department of Health—Belyuen Community Health Centre	NT
NT Department of Health—Bonya Community Health Centre	NT
NT Department of Health—Borroloola Community Health Centre	NT
NT Department of Health—Engawala Community Health Centre	NT
NT Department of Health—Gapuwiyak Community Health Centre	NT

continued

Table D1 (continued): OSR organisations(a), by state and territory, 2015–16

Organisation name	State/ territory
NT Department of Health—Gunbalanya Community Health Centre	NT
NT Department of Health—Ikuntji Community Health Centre	NT
NT Department of Health—Imanpa Community Health Centre	NT
NT Department of Health—Julanimawu (Nguiu) Community Health Centre	NT
NT Department of Health—Laramba Community Health Centre	NT
NT Department of Health—Maningrida Community Health Centre	NT
NT Department of Health—Milikapiti Community Health Centre	NT
NT Department of Health—Milyakburra Community Health Centre	NT
NT Department of Health—Minjilang Community Health Centre	NT
NT Department of Health—Nauiyu (Daly River) Community Health Centre	NT
NT Department of Health—Numbulwar Community Health Centre	NT
NT Department of Health—Nyirripi Community Health Centre	NT
NT Department of Health—Palumpa Community Health Centre	NT
NT Department of Health—Papunya Community Health Centre	NT
NT Department of Health—Pirlangimpi Community Health Centre	NT
NT Department of Health—Ramingining Community Health Centre	NT
NT Department of Health—Robinson River Community Health Centre	NT
NT Department of Health—Tara Community Health Centre	NT
NT Department of Health—Ti Tree Community Health Centre	NT
NT Department of Health—Titjikala Community Health Centre	NT
NT Department of Health—Umbakumba Community Health Centre	NT
NT Department of Health—Wadeye Community Health Centre	NT
NT Department of Health—Warruwi Community Health Centre	NT
NT Department of Health—Willowra Community Health Centre	NT
NT Department of Health—Yuelamu Community Health Centre	NT
NT Department of Health—Yuendumu Community Health Centre	NT
NT Stolen Generations Aboriginal Corporation	NT
Namatjira Haven Limited	NSW
Narrabri Community Health Service (HNELHD)	NSW
Ngaanyatjarra Health Service	WA
Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women’s Council Aboriginal Corporation	NT
Ngaimpe Aboriginal Corporation (The Glen)	NSW
Nganampa Health Council Incorporated	SA
Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	WA
Ngnowar-Aerwah Aboriginal Corporation	WA
Ngwala Willumbong Co-Operative Limited	Vic
Nhulundu Wooribah Indigenous Health Organisation Incorporated	Qld

continued

Table D1 (continued): OSR organisations[(a)], by state and territory, 2015–16

Organisation name	State/ territory
Nindilingarri Cultural Health Services	WA
Njernda Aboriginal Corporation	Vic
North Coast Aboriginal Corporation for Community Health	Qld
North West Hospital Health Service	Qld
North and West Remote Health	Qld
Northern NSW Local Health District	NSW
Northern Territory AIDS and Hepatitis Council Incorporated	NT
Nunkuwarrin Yunti Incorporated	SA
Nunyara Aboriginal Health Service Incorporated	SA
Oak Valley (Maralinga) Incorporated	SA
On Track Community Programs Limited	NSW
Orana Haven Aboriginal Corporation	NSW
Orange Aboriginal Medical Service	NSW
Ord Valley Aboriginal Health Service Aboriginal Corporation	WA
Palmerston Association Incorporated	WA
Pangula Mannamurna Incorporated	SA
Paupiyala Tjarutja Aboriginal Corporation	WA
Peak Hill Aboriginal Medical Service Incorporated	NSW
Pika Wiya Health Service Aboriginal Corporation	SA
Pintupi Homelands Health Service	NT
PiusX Aboriginal Corporation	NSW
Pormpur Paanth Aboriginal Corporation	Qld
Port Augusta Substance Misuse Service—Mobile Assistance Patrol Service	SA
Port Lincoln Aboriginal Health Service Incorporated	SA
Primary Health Tasmania	Tas
Puntukurnu Aboriginal Medical Service Aboriginal Corporation	WA
Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services	Qld
Ramahyuck and District Aboriginal Corporation	Vic
Rekindling The Spirit Limited	NSW
Relationships Australia Tasmania	Tas
Riverina Medical and Dental Aboriginal Corporation	NSW
Riverland Region (CHSALHN)	SA
Royal Flying Doctor Service of Australia (Queensland Section)	Qld
Royal Hospital for Women (Malabar Community Midwifery Link Service)	NSW
Rumbalara Aboriginal Co-Operative	Vic
South Coast Medical Service Aboriginal Corporation	NSW
South Coast Women's Health and Welfare Aboriginal Corporation (Waminda)	NSW

continued

Table D1 (continued): OSR organisations[(a)], by state and territory, 2015–16

Organisation name	State/ territory
South Coastal Women's Health Services Association Incorporated	WA
South East Tasmanian Aboriginal Corporation	Tas
South West Aboriginal Medical Service Aboriginal Corporation	WA
South Western Sydney Local Health District	NSW
Southern NSW Local Health District	NSW
St George/Sutherland (Narrangy-Booris Menai Service)	NSW
Sunrise Health Service Aboriginal Corporation	NT
Swan Hill Aboriginal Health Service	Vic
Sydney Local Health District	NSW
Tamworth Aboriginal Medical Service	NSW
Tasmanian Aboriginal Centre Incorporated	Tas
Tharawal Aboriginal Corporation	NSW
The Gumbi-Gumbi Aboriginal and Torres Strait Islanders Corp	Qld
The Oolong Aboriginal Corporation	NSW
The Uniting Church In Australia Property Trust (Queensland)	Qld
The Uniting Church In Australia Property Trust (Queensland)—Cape York Family Centre	Qld
Tobwabba Aboriginal Medical Service Incorporated	NSW
Torres and Cape Hospital Health Service—Torres Strait and Northern Peninsula	Qld
Townsville Aboriginal and Torres Strait Islanders Health Services Limited	Qld
Tullawon Health Service Incorporated	SA
Umoona Tjutagku Health Service Aboriginal Corporation	SA
Uniting Care Children Young People and Families	NSW
Uniting Care Wesley Adelaide	SA
Urapuntja Health Service Aboriginal Corporation	NT
Utju Medical Service	NT
Victorian Aboriginal Child Care Agency Co-Operative Limited (Link-Up Victoria)	Vic
Victorian Aboriginal Health Service Co-operative Limited	Vic
WA Country Health Service—Great Southern Aboriginal Health Service	WA
WA Country Health Service—Kimberley Population Health Unit (Fitzroy Crossing) Healthy for Life	WA
WA Country Health Service—Kimberley Region (West Kimberley)—Sexual Health	WA
WA Country Health Service—Kimberley Region—Primary Health Care	WA
WA Country Health Service—Midwest Region (Carnarvon)—New Directions	WA
WA Country Health Service—Midwest Region (Gascoyne) —Geraldton Sexual Health	WA
WA Country Health Service—Midwest Region (Geraldton)—New Directions	WA
WA Country Health Service—Pilbara	WA
WA Country Health Service—Wheatbelt Aboriginal Health Service	WA
Walgett Aboriginal Medical Services	NSW

continued

Table D1 (continued): OSR organisations[(a)], by state and territory, 2015–16

Organisation name	State/ territory
Walhallow Aboriginal Corporation	NSW
Wandarma Aboriginal Drug and Alcohol Service—Bega and Region (The Lyndon Community)	NSW
Warlpiri Youth Development Aboriginal Corporation	NT
Wathaurong Aboriginal Co-operative	Vic
Weigelli Centre Aboriginal Corporation	NSW
Wellington Aboriginal Corporation Health Service	NSW
Wentworth Healthcare Limited	NSW
Werin Medical Centre (Port Macquarie)	NSW
Western Aranda Health Aboriginal Corporation (WAHAC)	NT
Western NSW Local Health District	NSW
Western Sydney Local Health District	NSW
Whyalla Flinders and Far North (CHSALHN)	SA
Winda Mara Aboriginal Corporation	Vic
Winnunga Nimmityjah Aboriginal Health Clinic/Health Service Incorporated (ACT)	ACT
Wirraka Maya Health Services Aboriginal Corporation	WA
Wuchopperen Health Service (Midin Clinic)	Qld
Wuchopperen Health Service (Reef House)	Qld
Wurli Wurlinjang Aboriginal Corporation	NT
Yaandina Family Centre Incorporated	WA
Yarra Valley Community Health Service (Eastern Health)	Vic
Yerin Aboriginal Health Services Incorporated	NSW
Yorgum Aboriginal Corporation	WA
Yorke Peninsula Health Service (CHSALHN)	SA
Yulu-Burri-Ba Aboriginal Corporation for Community Health	Qld
Yura Yungi Medical Service Aboriginal Corporation	WA

(a) As advised by the Department of Health. This does not include every organisation that received Australian Government funding, because not all organisations were part of the OSR collection.

Glossary

Aboriginal Community Controlled Health Organisations (ACCHOs): Health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. They range from large services with several medical practitioners who provide a range of services, to small services that rely on nurses and/or Aboriginal health workers to provide most services. For more information see <www.naccho.org.au>.

Aboriginal and Torres Strait Islander health worker: An Aboriginal and/or Torres Strait Islander person with a minimum qualification in the field of primary health-care work or clinical practice. This includes Aboriginal and Torres Strait Islander health practitioners who are one speciality stream of health worker. Health workers liaise with patients, clients and visitors to hospitals and health clinics, and work as a team member to arrange, coordinate and provide health-care delivery in community health clinics.

Aboriginal and Torres Strait Islander health practitioner: A person who has completed a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. The practitioner may undertake higher levels of clinical assessment and care within their agreed scope of practice. This role became nationally registered from 1 July 2013 under the National Registration and Accreditation Scheme for health professions.

Accessibility/Remoteness Index of Australia (ARIA): ARIA measures the remoteness of a point based on the physical road distances to the nearest urban centre in each of 5 size classes. Therefore, not all remoteness areas are represented in each state or territory.

There are 6 remoteness areas in this structure:

- *Major cities*—collection districts (CDs) with an average ARIA index value of between 0 and less than or equal to 0.2
- *Inner regional* areas—CDs with an average ARIA index value greater than 0.2 and less than or equal to 2.4
- *Outer regional* areas—CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92
- *Remote* areas—CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53
- *Very remote* areas—CDs with an average ARIA index value greater than 10.53
- *Migratory*—composed of offshore, shipping and migratory CDs.

For more information, see ABS 2006.

aged care: This is defined in the OSR as the organisation routinely provides clinical and support services to older people, including any of the following: coordination of care; assessment, case management, therapy and review; routine management of acute and chronic medical conditions; referral and support to access aged care services; specific group activities for older people; and visiting services to older people at home or in residential aged care facilities.

allied health professionals: Professionals working in audiology, dietetics and nutrition, hospital pharmacy, occupational therapy, orthoptics, orthotics and prosthetics.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

client: An individual receiving heath care by an organisation during the collection period. Each individual is counted as a client once only, regardless of how many times they are seen. Visitors and transient clients are included in client counts, but any clients attending group activities only (who do not receive individual care) are excluded.

client contacts: A summation of the individual client contacts that were made by each type of worker involved in the provision of health care by the service.

episode of health care: Contact between an individual client and a service by one or more staff members to provide health care.

first Stolen Generation clients: Clients who were removed from their families and communities.

full-time equivalent (FTE): A standard measure of the size of a workforce that takes into account both the number of workers and the hours that each works. For example, if a workforce comprises 2 people working full time 35 hours a week and 2 working half time, this is the same as 3 working full time—an FTE of 3.

Indigenous: A person of Australian Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander.

medical specialists: Medical practitioners who are registered as specialists under a law of state or territory or recognised as specialists or consultant physicians by a specialist recognition advisory committee, such as paediatricians, ophthalmologists, cardiologists, ear, nose and throat specialists, obstetricians and surgeons.

non-Indigenous: A person who has declared they are not of Aboriginal and/or Torres Strait Islander descent.

non-residential service: Substance-use services that offer substance-use treatment, rehabilitation and/or education for clients predominantly without the option of residing in-house.

non-residential, follow-up or after-care episode of care: Care provided to a client not in residential care, such as substance-use counselling, assessment, treatment, education, support or follow-up from residential services.

palliative care: This is defined in the OSR as the organisation provides clinical management and care coordination, including assessment, triage and referral using a palliative approach for patients with uncomplicated needs associated with a life-limiting illness or end of life care. The organisation also has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary.

program: A planned, regular activity organised by a service.

remoteness areas: The remoteness areas divide Australia into broad geographic regions that share common characteristics of remoteness for statistical purposes. Each state and territory is divided into several regions based on their relative accessibility to goods and services (such as GPs, hospitals and specialist care) as measured by road distance. These regions are based on the ARIA. Individual states and territories may not contain areas of every class: for example the Northern Territory does not contain a *Major city* or an *Inner regional* classification.

remoteness structure: One of 7 geographical structures listed in the Australian Standard Geographic Classification (ASGC). Its purpose is to classify collection districts (CDs) that share common characteristics of remoteness into broad geographical regions called remoteness areas.

residential service: Drug and alcohol services that offer temporary, live-in accommodation for clients requiring substance-use treatment and rehabilitation.

residential treatment or rehabilitation episode of care: Commences at admission into residential treatment or rehabilitation and ends at discharge.

second Stolen Generation clients: Those clients whose parent(s) are first Stolen Generation members.

shared care: Where care is shared between practitioners and/or services in a formalised arrangement, with an agreed plan to manage the patient. Details surrounding this arrangement depend on the practitioner involved, patient needs and the health-care context.

Sobering-up or residential respite clients: Clients who are in residential care overnight to sober up, or those who stay in residential care for 1 to 7 days for respite, and who do not receive formal rehabilitation.

Sobering-up, residential respite or short-term episode of care: Commences at admission into a sobering up, residential respite or short-term care program and ends at discharge. One episode of care can last 1–7 days.

social and emotional wellbeing and Link Up counsellors: Counsellors who provide a support service to Aboriginal and Torres Strait Islander communities, prioritising members of the Stolen Generations who have been directly or indirectly affected by the removal and separation of children from their families, and those going through the process of being reunited. Counsellors must possess at commencement of employment, or within 12 months of commencing employment, formal tertiary or vocational qualifications to a minimum of a Certificate IV qualification from a nationally recognised course of study in counselling, social work, mental health or a related area.

social and emotional wellbeing (SEWB) staff: These include (but are not limited to) psychologists, counsellors, mental health workers, social workers and welfare workers.

Tackling Indigenous Smoking and Healthy Lifestyle Program: A program funded by the Australian Government focusing on health promotion around smoking and healthy lifestyles to help close the gap between the health of Indigenous Australians and non-Indigenous Australians, and to reduce chronic disease in Aboriginal people. The team is made up of regional tobacco action workers and healthy lifestyle workers, and all are trained outreach Aboriginal health workers.

Tackling Indigenous Smoking Program: A targeted activity funded by the Australian Government that aims to prevent the uptake of smoking and supports smoking cessation among Aboriginal and Torres Strait Islander people. It is a multi-component program that focuses on evidence-based activities and tobacco reduction outcomes. It uses proven approaches to change smoking behaviours, with activities being delivered at multiple levels, including health service funding, workforce training and organisational support, and support for smokers through Quitline funding. The Tackling Indigenous Smoking Program replaces the previous Tackling Indigenous Smoking and Healthy Lifestyle Program.

third and subsequent Stolen Generation clients: Those clients whose grandparent(s) are first Stolen Generation members or who are directly descended from people who were removed from their families and communities in subsequent Stolen Generations.

References

ABS (Australian Bureau of Statistics) 2006. Statistical geography volume 1—Australian Standard Geographical Classification (ASGC). ABS cat. no. 1216.0. Canberra: ABS.

ABS 2014. Estimates and projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026. ABS cat. no. 3238.0. Canberra: ABS. Viewed 25 November 2014, <http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/0027DFC5FE7089C2CA257CC900143DE5/$File/32380do007_2011.xls>.

AHMAC (Australian Health Ministers' Advisory Council) 2015. Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report. Canberra: AHMAC.

AIHW (Australian Institute of Health and Welfare) 2012. Australia's health 2012. Australia's health series no. 13. Cat. no. AUS 156. Canberra: AIHW.

AIHW 2015a. Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: detailed analyses. Cat. no. IHW 167. Canberra: AIHW.

AIHW 2015b. Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023: technical companion document. Cat. no. IHW 158. Canberra: AIHW. Viewed 8 January 2017, <http://www.aihw.gov.au/publication-detail/?id=60129552639>.

AIHW 2015c. Spatial variation in Aboriginal and Torres Strait Islander people's access to primary health care. Cat. no. IHW 155. Canberra: AIHW.

AIHW 2015d. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015. Cat. no. IHW 147. Canberra: AIHW.

AIHW 2016a. Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011—Summary report. Australian Burden of Disease Study series no. 7. Cat. no. BOD 8. Canberra: AIHW.

AIHW 2016b. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

AIHW 2017. National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results from June 2016. Cat. no. IHW 177 Canberra: AIHW.

Coleman J, Spurling G, Askew D & Hayman N 2011. Indigenous child health checks: the view from the city. Medical Journal of Australia 194(10):535–36.

CSHISC (Community Services Health Industry Skills Council) 2014. Implementation guide for HLT Health Training Package. Sydney: CSHISC.

DoH (Department of Health) 2013. National Aboriginal and Torres Strait Islander Health Plan 2013–2023. Canberra: DoH. Viewed 20 December 2015, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc>.

DoH 2014a. Accreditation manual. A handbook for Aboriginal and Torres Strait Islander Community Controlled Health Organisations. Canberra: DoH. Viewed 10 December 2015, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatish-accreditation-manual_toc>.

DoH 2014b Healthy Kids check—fact sheet. Canberra: DoH. Viewed 10 December 2015, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health_Kids_Check_factsheet>.

DoH 2014c. Medicare health assessment for Aboriginal and Torres Strait Islander People (MBS Item 715). Canberra: DoH. Viewed 10 December 2015, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_ATSI_MBSitem715>.

DoH 2015a. Child and maternal health. Canberra: DoH. Viewed 10 December 2015, <http://www.health.gov.au/internet/main/publishing.nsf/Content/irhd-child-maternal-health>.

DoH 2015b. Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023. Canberra: DoH. Viewed 5 December 2016, <http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-implementation-plan>.

DoH 2015c. Primary health care. Canberra: DoH. Viewed 10 December 2015, <http://www.health.gov.au/internet/main/publishing.nsf/Content/irhd-primary-health-care>.

DoH 2016. Indigenous health. Canberra: DoH. Viewed 6 January 2017, <https://www.health.gov.au/Indigenous>.

DoH 2017. Close the Gap. Canberra: DoH. Viewed 24 February 2017, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mc15-002185-close-the-gap>.

NACCHO (National Aboriginal Community Controlled Health Organisation) 2015. About us. Canberra: NACCHO. Viewed 8 December 2015, <http://www.naccho.org.au/about-us/>.

PM&C (Department of the Prime Minister and Cabinet) 2015. Indigenous Advancement Strategy. Canberra: PM&C. Viewed 27 November 2015, <http://www.dpmc.gov.au/indigenous-affairs/about/indigenous-advancement-strategy>.

WHO (World Health Organization) 2011. Indicator code book: world health statistics—world health statistics indicators. Geneva: WHO.

WHO 2016. What is health promotion? Geneva: WHO. Viewed 19 December 2016, <http://www.who.int/features/qa/health-promotion/en/>.

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Related publications

This report is part of an annual series. Earlier editions can be downloaded for free from the AIHW website <http://www.aihw.gov.au/publications/>.

AIHW (Australian Institute of Health and Welfare) 2010. Aboriginal and Torres Strait Islander health services report, 2008–09: OATSIH Services Reporting—key results. Cat. no. IHW 31. Canberra: AIHW.

AIHW 2011. Aboriginal and Torres Strait Islander health services report 2009–10: OATSIH Services Reporting—key results. Cat. no. IHW 56. Canberra: AIHW.

AIHW 2012. Aboriginal and Torres Strait Islander health services report, 2010–11: OATSIH Services Reporting—key results. Cat. no. IHW 79. Canberra: AIHW.

AIHW 2013. Aboriginal and Torres Strait Islander health services report 2011–12: OATSIH Services Reporting—key results. Cat. no. IHW 104. Canberra: AIHW.

AIHW 2014. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2012–13. Cat. no. IHW 139. Canberra: AIHW.

AIHW 2015. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2013–14. Aboriginal and Torres Strait Islander health services report no. 6. Cat. no. IHW 152. Canberra: AIHW.

AIHW 2016. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15. Aboriginal and Torres Strait Islander health services report no. 7. Cat. no. IHW 168. Canberra: AIHW.

This is the eighth national report on organisations funded by the Australian Government to provide health services to Aboriginal and Torres Strait Islander people. In 2015–16:

- 204 organisations provided primary health-care services to around 461,500 clients through 5.4 million client contacts and 3.9 million episodes of care.
- 216 counsellors from 93 organisations provided social and emotional wellbeing services to around 18,900 clients through 88,900 client contacts.
- 80 organisations provided substance-use services to around 32,700 clients through 170,400 episodes of care.