3.07 Health promotion

Interventions provided by clinicians and health promotion initiatives funded by governments and provided by a range of health professionals in the wider community for the Aboriginal and Torres Strait Islander population

Data sources

Health expenditure data

The report on expenditure on health services for Aboriginal and Torres Strait Islander people is produced every two years. The latest report covers expenditure for the 2006–07 financial year and was published in the AIHW report *Expenditure on health for Aboriginal and Torres Strait Islander people 2006–07* (AIHW 2009).

There are a number of difficulties in reporting on Indigenous health expenditure, including limitations in the scope and definition of health expenditure, as well as inconsistencies in reporting expenditure on health goods and services across data providers. Under-identification and under-coverage of Indigenous Australians in health data collections (such as hospital separations) are further issues that affect data quality. Although adjustments are made to the data to allow for under-identification, the adjusted estimates may be an overestimate or underestimate of actual health service use and expenditure by Indigenous people. The attribution of expenditure to Indigenous people either on an overall population or per capita basis should also be treated with caution, as Indigenous population estimates have similar issues of under-coverage and under-identification (AIHW 2009).

Expenditure is a measure of met need. Indigenous Australians have a significantly poorer health status (measured in terms of life expectancy, mortality rates and morbidity) than non-Indigenous Australians. It could therefore be expected that per capita investment of health resources to achieve equality for Aboriginal and Torres Strait Islanders should be higher than for other Australians.

Expenditure on health and high care residential aged care for Aboriginal and Torres Strait Islander people amounted to $2,976 million in 2006–07. This was equivalent to 3.1% of the national expenditure on health and high care residential aged care. In 2006-07, the average expenditure per person on health and high care residential aged care was $5,696 for Aboriginal and Torres Strait Islander people. For non-Indigenous people, the average expenditure per person was $4,557. The ratio of Indigenous to non-Indigenous expenditure per person was 1.25. For the Australian Government schemes of Medicare and the Pharmaceutical Benefits Scheme (PBS), total benefits paid per Aboriginal and Torres Strait Islander person were 59% of the amount spent on non-Indigenous people.

Divisions of GP Survey

Since 1997–98, the Annual Survey of Divisions (ASD) has been conducted by the Primary Health Care Research and Information Service (PHC RIS) on behalf of the DoHA. Along with the Annual Report, the ASD forms a component of the reporting requirements for all Divisions of General Practice. Divisions of General Practice are required to complete the

Survey, which includes questions about their membership, activities (including population health) and infrastructure for the previous financial year.

Bettering the Evaluation and Care of Health (BEACH) Survey

Information about encounters in general practice is available from the BEACH survey, which is conducted by the AIHW Australian General Practice Statistics and Classification Unit. Information is collected from a random sample of approximately 1,000 general practitioners (GPs) from across Australia each year. A sample of 100 consecutive GP-patient encounters is collected from each GP. A more detailed explanation of the BEACH methods can be found in General practice activity in Australia 2008–09, (Britt et al 2009).

The number of Indigenous patients identified in the BEACH survey is likely to be underestimated because some GPs might not ask the question on Indigenous status, or the patient may choose not to identify themselves (AIHW 2002). Further detailed analyses of this issue are covered in General practice in Australia, heath priorities and policies 1998–2008, (Britt H & Miller GC (eds) 2009, p101).

> "The findings of a BEACH substudy confirmed this suspected under-identification. In the data period reported here, 1.4% of patients encountered identified themselves as Indigenous. In contrast, in a BEACH substudy that asked 9,245 patients a complete set of questions about their cultural background (including Indigenous status) 2.2% (95% CI: 1.6–2.9) of respondents identified themselves as Indigenous (Britt H et al 2007). This rate is similar to the ABS estimates of Indigenous Australians as a proportion of the total population (ABS 2006).
>
> However, the BEACH substudy included Indigenous Australians seen at Community Controlled Health Services funded through Medicare claims, and the estimate of 2.2% could have been an overestimate for the proportion of encounters that are with Indigenous patients in general practice as a whole. Deeble et al. (2008) conducted further investigations on this data and estimated that the BEACH encounter identification was an underestimate of about 10%, and that a more reliable estimate of the Indigenous population would be about 1.6% of all encounters (Deeble et al 2008).
>
> The findings of these studies are that some GPs are not routinely asking patients at the encounter about their Indigenous status, even when this is a variable specifically collected for each patient encountered, as it is in BEACH encounter data."

Before the late inclusion of a 'not stated' category of Indigenous status in 2001–02, 'not stated' responses were included with non-Indigenous encounters. Since then, GP encounters for which Indigenous status was not reported have been included with encounters for non-Indigenous people under the 'other' category.

Data are presented for the 5-year period 2004–05 to 2008–09, during which there were 6,137 GP encounters with Aboriginal and Torres Strait Islander patients recorded in the survey, representing 1.3% of total GP encounters in the survey.

Community Housing and Infrastructure Needs Survey (CHINS)

The CHINS collects data from all Aboriginal and Torres Strait Islander housing organisations and discrete Aboriginal and Torres Strait Islander communities in Australia. The latest CHINS was enumerated from 1 March to 30 June 2006. The data were collected through personal interviews with key community and Indigenous Housing Organisation (IHO)

representatives knowledgeable about housing and infrastructure issues. In addition to the survey instrument and methodology testing conducted prior to the 2006 CHINS, aggregate data from the 2006 CHINS have been compared with that collected in 2001 CHINS. The survey collected information on all Aboriginal and Torres Strait Islander communities throughout Australia. The Australian Bureau of Statistics (ABS) conducted the 2006 CHINS on behalf of, and with full funding from, the Department of Families, Community Services and Indigenous Affairs (FaCSIA). Information collected includes:

- details of current housing stock, dwelling management practices and selected income and expenditure arrangements of Indigenous organisations that provide housing to Aboriginal and Torres Strait Islander peoples
- details of housing and related infrastructure, such as water, electricity, sewerage, drainage, rubbish collection and disposal, as well as other facilities such as transport, communication, education, sport and health services, available in discrete Aboriginal and Torres Strait Islander communities.

The 2006 information was collected on 496 Indigenous housing organisations that managed a total of 21,854 permanent dwellings. Information was also collected on 1,187 discrete Indigenous communities with a combined population of 92,960. Most of these communities were in *Very remote* regions of Australia, with 73% (865) having a population of fewer than 50 people.

In the 2006 CHINS, a community questionnaire collected detailed infrastructure information from all discrete Indigenous communities with a reported usual population of 50 persons or more, as well as for communities that had a reported usual population of fewer than 50 persons but which were not administered by a larger discrete Indigenous community or Resource Agency (375 communities). The 812 other communities had reported usual populations of fewer than 50 persons and were asked a subset of questions from the community questionnaire form: the short community questionnaire (ABS 2007).

Results from this survey were published in August 2007. FaHCSIA and the ABS jointly hold the CHINS data.

OATSIH Services Reporting (OSR) data collection

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

This collection, referred to as the OSR data collection replaces the Service Activity Reporting (SAR), Drug and Alcohol Services Reporting (DASR), and Bringing Them Home and Link Up counselling data collections previously collected by the OATSIH. As pre 2008–09 questionaries are not fully compatible with the questionnaires used for the 2008–09 data collection, AIHW advises against building time-series comparisons with the data prior to 2008-09.

The OSR data collection included 211 Australian Government-funded Aboriginal and Torres Strait Islander primary health-care services. Service-level data on health care and health-

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

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

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

Analyses

Government expenditure

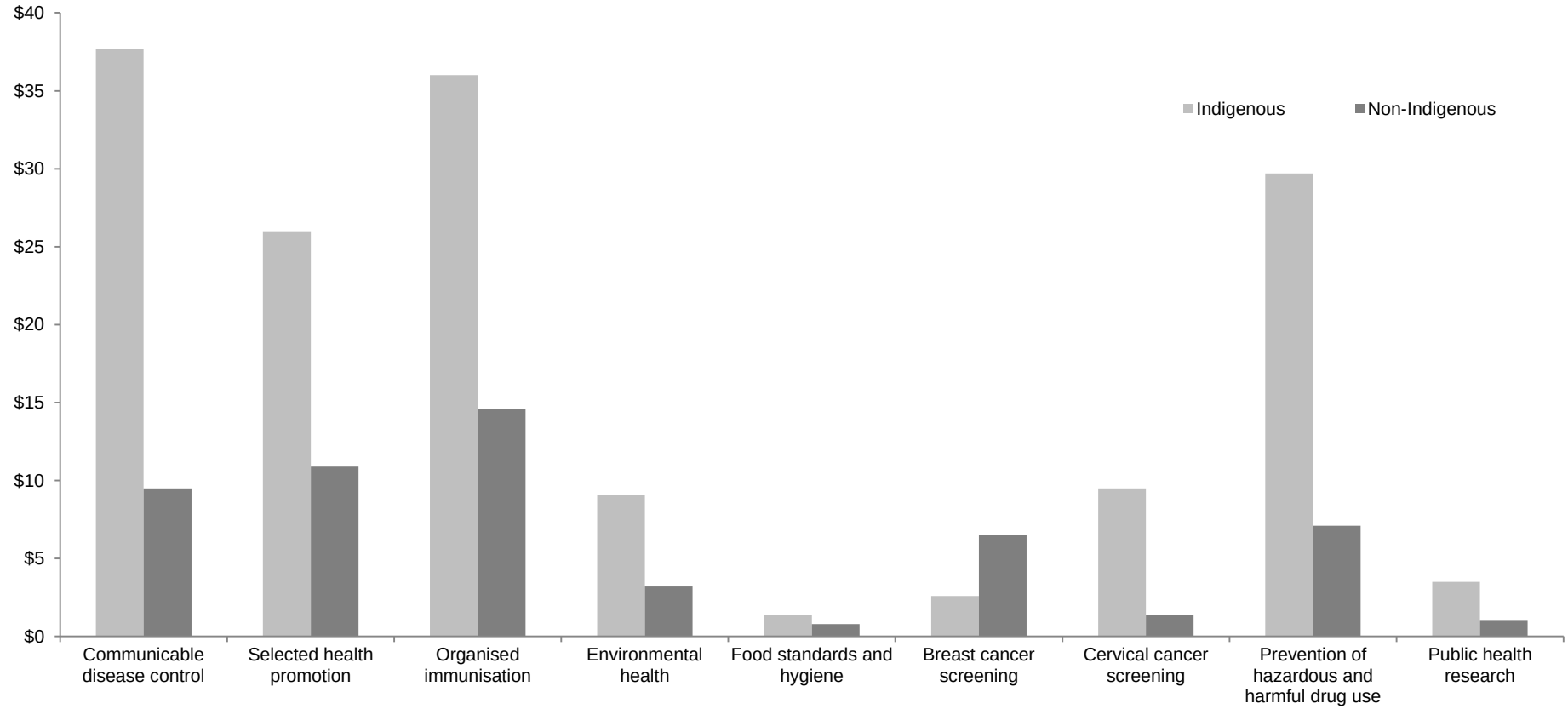
Government expenditure on selected public health activities for Indigenous and non-Indigenous Australians in 2006–07 is presented in Table 3.07.1 and Figure 3.07.1 below.

- In 2006–07, state/territory government expenditure on core public health activities was $81.2 million for Indigenous Australians and $1,124.4 million for non-Indigenous Australians.
- State/territory government expenditure per person on core public health activities was higher for Indigenous persons than non-Indigenous persons ($156 compared with $55).
- The Indigenous share of state/territory government expenditure was 14.5% for cervical cancer screening, 9.7% for prevention of hazardous and harmful drug use, 9.2% for communicable disease control and 8.1% for public health research.
- Of the core public health activities, communicable disease control received the most state/territory government expenditure per person for Indigenous Australians ($38).
- State/territory government expenditure per person was higher for Indigenous Australians than for non-Indigenous Australians for all core public health activities, except breast cancer screening.
- The ratio of Indigenous to non-Indigenous per person expenditure was highest for cervical cancer screening (6.6) and lowest for breast cancer screening (0.4).

Table 3.07.1: Expenditure for Indigenous Australian and non-Indigenous Australians on selected public health activities, state and territory governments and total, 2006–07

Selected public health activities	Expenditure ($ million)			Expenditure per person ($)		
	Indigenous	Non-Indigenous	Indigenous share %	Indigenous	Non-Indigenous	Ratio
State/territory government expenditure						
Communicable disease control	19.7	193.8	9.2	37.7	9.5	3.97
Selected health promotion	13.6	222.4	5.8	26.0	10.9	2.38
Organised immunisation	18.8	298.0	5.9	36.0	14.6	2.46
Environmental health	4.8	66.0	6.7	9.1	3.2	2.81
Food standards and hygiene	0.7	17.2	4.0	1.4	0.8	1.63
Breast cancer screening	1.4	131.9	1.0	2.6	6.5	0.40
Cervical cancer screening	5.0	29.3	14.5	9.5	1.4	6.59
Prevention of hazardous and harmful drug use	15.5	145.1	9.7	29.7	7.1	4.17
Public health research	1.8	20.7	8.1	3.5	1.0	3.41
Public health expenditure	**81.2**	**1,124.4**	**6.7**	**155.4**	**55.2**	**2.81**

Source: AIHW health expenditure database.



Source: AIHW health expenditure database.

Figure 3.07.1: Total expenditure per person for core public health activities, by Indigenous status, 2006–07.

GP prevention and early intervention programs

The Annual Survey of Divisions collects data on prevention and early intervention programs run by Divisions of General Practice. The number and proportion of Divisions of General Practice aimed at Indigenous Australians for selected prevention and early intervention programs and activities in 2006–07 is presented in Table 3.07.2 and Figures 3.07.2a and b.

- In 2006–07, over 80% of general practice divisions ran programs for Type II diabetes and life-scripts; 75% ran programs for health promotion; 55% ran programs for physical activity, 46% for nutrition, 54% for alcohol and other drugs, 40% for smoking and 25% for injury prevention.
- In 2006–07, 35% of divisions focused on Indigenous Australians in their Type II diabetes programs, 25% in their health promotion programs, 14% in their life-scripts programs, 13% in their nutrition programs, 11% in their alcohol and other drug programs, and 10% in their physical activity programs. Only 8.4% of Divisions with activities or programs for smoking aimed at Indigenous Australians, and only 5.0% aimed at Indigenous Australians for injury prevention programs.

Table 3.07.2: Number and proportion of Divisions of General Practice with selected prevention/early intervention programs and number and proportion of Divisions targeting Indigenous Australians in their prevention and early intervention programs, 2006–07

	Divisions with program/activity		Indigenous Australians	
Selected prevention programs	Number	Per cent[(a)]	Number	Per cent[(a)]
Type II diabetes	105	88.2	42	35.3
Life-scripts	101	84.9	17	14.3
Health promotion	89	74.8	30	25.2
Physical activity	65	54.6	12	10.1
Nutrition	55	46.2	16	13.4
Alcohol and other drugs	64	53.8	13	10.9
Smoking	48	40.3	10	8.4
Injury prevention	30	25.2	6	5.0

(a) Proportion calculated in relation to total number of divisions.

Source: Hordacre et al. 2007a

- Between 2004–05 and 2006–07 there has been a continual decrease in the proportion of Divisions with nutrition, alcohol and other drugs, breast cancer screening and skin cancer screening programs and an increase in the number of Divisions with Type II diabetes and health promotion (Table 3.07.3; Figure 3.07.2a).
- Over the same period, there has been an increase in the proportion of Divisions that focused on Indigenous Australians in their immunisation, Type II diabetes, health promotion, physical activity, alcohol and other drugs, cervical screening and breast cancer screening programs (Table 3.07.3; Figure 3.07.2b).
- Between 2004-05 and 2005-06 there was an increase in the proportion of Divisions that focused on Indigenous Australians in their nutrition, smoking and bowel cancer screening but these proportions have decreased in 2006-07 (Table 3.07.3; Figure 3.07.2b).

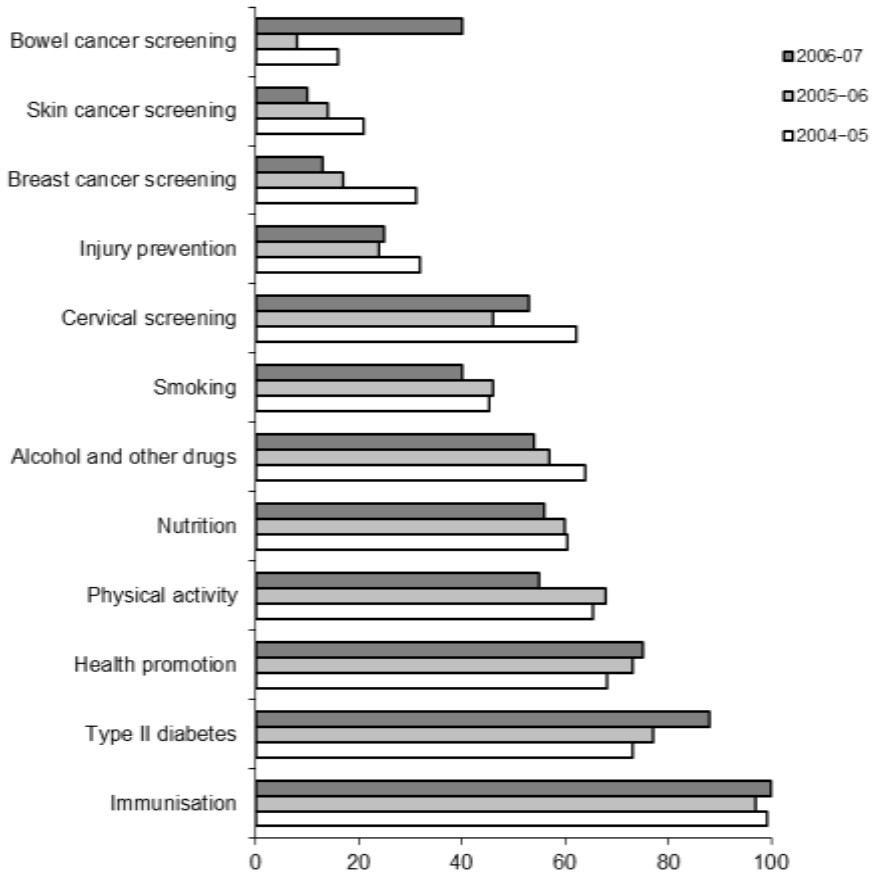
Table 3.07.3: Proportion of Divisions of General Practice with selected prevention/early intervention programs, and proportion of Divisions focusing on Indigenous Australians in their selected prevention/early intervention programs, 2004–05 to 2006–07.

	Immunisation	Type II diabetes	Health promotion	Physical activity	Nutrition	Alcohol and other drugs	Smoking	Cervical screening	Injury prevention	Breast cancer screening	Skin cancer screening	Bowel cancer screening
2004–05												
% with program	99.2	73.1	68.1	65.5	60.5	63.9	45.4	62.2	31.9	31.1	21.0	16.0
% focusing on Indigenous Australians	22.9	20.7	17.3	7.7	22.2	13.2	9.3	4.1	0	2.7	0	5.3
2005–06												
% with program	96.6	77.3	73.1	68.1	59.7	57.1	46.2	46.2	23.5	16.8	14.3	7.6
% focusing on Indigenous Australians	40.4	26.1	27.6	18.5	31.0	17.7	23.6	9.1	7.1	5.0	.0	11.1
2006–07												
% with program	100.0	88.2	74.8	54.6	46.2	53.8	40.3	52.9	25.2	12.6	10.1	40.3
% focusing on Indigenous Australians	43.7	40.0	33.7	18.5	29.1	20.3	20.8	19.0	20.0	20.0	16.7	8.3

Notes

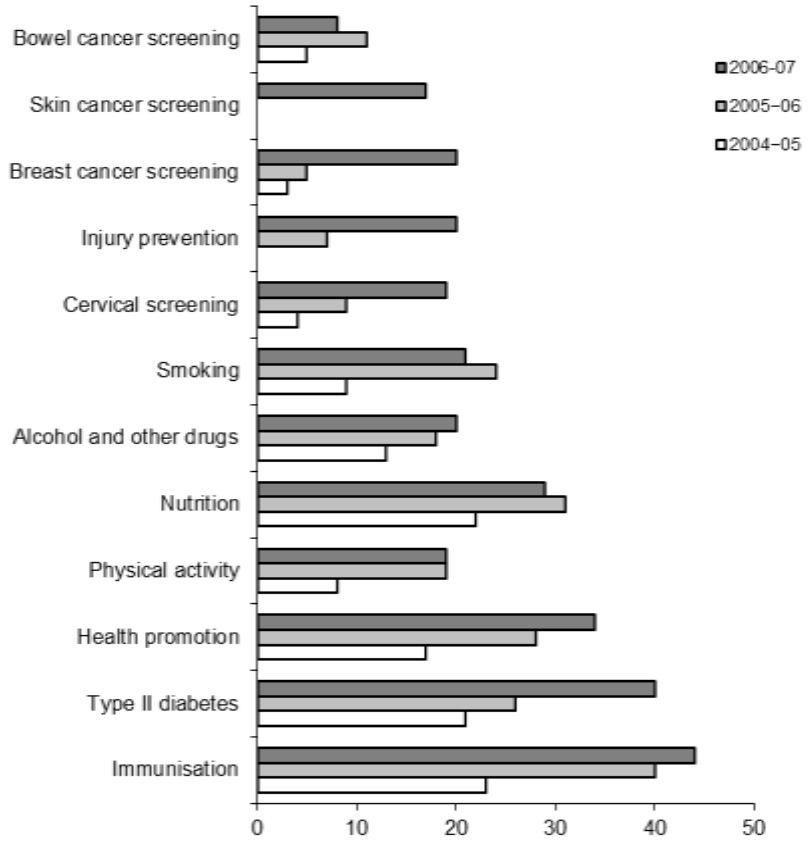
1. '% focusing on Indigenous Australians' calculated using the number of Divisions with the specified program as the denominator.
2. Prior to 2004–05, prevention was dealt with in a different question format which precludes longitudinal comparison with subsequent data.

Source: Hordacre et al. 2007b



Source: Hordacre et al. 2006; Hordacre et al. 2007a; Hordacre et al 2007b.

Figure 3.07.2a: Proportion of Divisions of General Practice with selected prevention/early intervention programs, 2004–05 to 2006–07.



Note: Data on skin cancer screening for 2004–05 and 2005–06, and injury prevention for 2004–05 are not available.

Source: Hordacre et al. 2006; Hordacre et al. 2007a; Hordacre et al. 2007b.

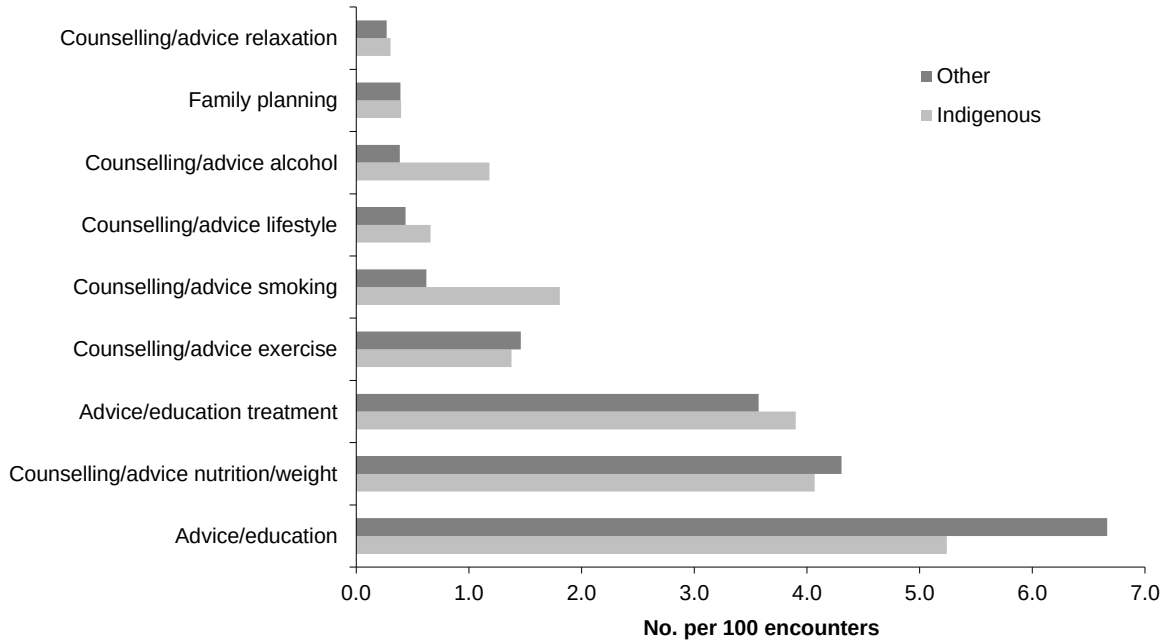
Figure 3.07.2b: Proportion of Divisions focusing on Indigenous Australians in their selected prevention/early intervention programs, 2004–05 to 2006–07.

Clinical treatments provided by general practitioners

Information on clinical treatments provided by general practitioners such as advice, education and counselling for factors such as smoking, alcohol, nutrition, weight, exercise and lifestyle are available from the BEACH survey. Data for the 5-year BEACH reporting periods April 2004–March 2005 to April 2008–March 2009 are provided below.

- Over the April 2004–March 2005 to April 2008–March 2009, of the 3,518 clinical treatments provided to Indigenous patients surveyed in the BEACH, 8.5% were for advice/education, 6.3% were for counselling/advice related to treatment, 6.2% were for advice/education related to nutrition and weight, 3.4% were for counselling/advice related to smoking, 2.2% were for counselling/advice related to alcohol and 2.0% were for counselling/advice related to exercise (Table 3.07.4).
- The selected clinical treatments related to health promotion outlined above were provided at a rate of 17.8 per 100 encounters for Indigenous patients. Of these, general advice/education (4.9 per 100 encounters) and counselling/advice related to nutrition and weight were the most common treatments provided (3.6 per 100 encounters) (Table 3.07.4).

- Both before and after age standardisation, Indigenous patients were more likely than other patients to receive counselling/advice related to alcohol (standardised ratio of 3.1) and smoking (ratio of 2.9) (Table 3.07.4).
- At encounters with Indigenous patients, advice and education related to treatment and relaxation was provided less often in the BEACH survey year April 2008–March 2009 than in April 1998–March 1999 for Indigenous patients (Table 3.07.5).
- Over the period April 2004–March 2005 to April 2008–March 2009, clinical treatments related to health promotion were most commonly provided by GPs to Indigenous patients in the management of endocrine/metabolic disorders (27 per 100 problems managed), followed by psychological problems (16 per 100 problems managed). For other patients, the clinical treatments related to health promotion most commonly provided by GPs were in the management of endocrine/metabolic problems (26 per 100 problems managed) and respiratory problems (11 per 100 problems managed) (Table 3.07.6).



Source: AIHW analysis of BEACH survey of general practice AGPSCC.

Figure 3.07.3: Age-Standardised rate (no. per 100) encounters for selected clinical treatments provided by general practitioners, by Indigenous status, BEACH years April 2004–March 2005 to April 2008–March 2009

Table 3.07.4: Selected clinical treatments provided by general practitioners, by Indigenous status, BEACH years April 2004–March 2005 to April 2008–March 2009[a]

	Number		Per cent		Crude rate (no. per 100 encounters)						Age standardised rate (no. per 100 encounters)[c]		
	Indig	Other[c]	Indig	Other[c]	Indig	95% LCL[d]	95% UCL[e]	Other[c]	95% LCL[d]	95% UCL[e]	Indig	Other[c]	Rate ratio[f]
Advice/education[g]	299	31,547	8.5	12.0	4.9	3.8	5.9	6.6	6.3	6.9	5.2	6.7	0.8
Advice/education treatment[h]	223	16,312	6.3	6.2	3.6	2.8	4.5	3.4	3.2	3.5	4.1	4.3	0.9
Counselling/advice nutrition/weight[i]	219	19,513	6.2	7.4	3.6	2.9	4.2	4.1	3.9	4.2	3.9	3.6	1.1
Counselling/advice smoking[j]	118	3,024	3.4	1.2	1.9	1.4	2.4	0.6	0.6	0.7	1.4	1.5	0.9
Counselling/advice alcohol[k]	77	1,858	2.2	0.7	1.3	0.9	1.6	0.4	0.4	0.4	1.8	0.6	2.9
Counselling/advice exercise[l]	71	6,710	2.0	2.6	1.2	0.8	1.5	1.4	1.3	1.5	0.7	0.4	1.5
Counselling/advice lifestyle[m]	37	2,029	1.1	0.8	0.6	0.3	0.9	0.4	0.4	0.5	1.2	0.4	3.1
Family planning[n]	31	1,873	0.9	0.7	0.5	0.3	0.7	0.4	0.4	0.4	0.4	0.4	1.0
Counselling/advice relaxation[o]	19	1,271	0.5	0.5	0.3	0.1	0.5	0.3	0.2	0.3	0.3	0.3	1.1
Total selected clinical treatments	*1,094*	*84,137*	*31.1*	*32.0*	*17.8*	*15.4*	*20.3*	*17.5*	*17.0*	*18.1*	*18.9*	*18.1*	*1.0*
All other clinical treatments	2,424	178,650	68.9	68.0	39.5	35.0	44.0	37.2	36.6	37.8	39.2	35.5	1.1
Total	**3,518**	**262,787**	**100.0**	**100.0**	**57.3**	**51.9**	**62.8**	**54.7**	**53.7**	**55.7**	**58.2**	**53.6**	**1.1**

(Continued)

Table 3.07.4 (continued): Selected clinical treatments provided by general practitioners, by Indigenous status, 2004–05 to 2008–09[(a)(b)]

(a) Data from five combined BEACH years April 2004–March 2005 to April 2008–March 2009 inclusive.
(b) Directly age-standardised rate using the total number of encounters for the period as the standard.
(c) Other includes non-Indigenous patients and patients for whom Indigenous status was not stated.
(d) LCL = Lower confidence limit
(e) UCL = Upper confidence limit
(f) Rate for Indigenous divided by rate for other Australians.
(g) IPCP-2 codes defining Advice/education codes A45002, B45002, D45002, F45002, H45002, K45002, L45002, N45002, P45002, R45001, S45002, T45002, U45002, W45004, X45002, Y45002, Z45002.
(h) IPCP-2 codes defining Counselling/advice treatment A45016, A45019, A45020, A45021, A45030, A48004, L45004, R45004, T45004, T45009.
(i) IPCP-2 codes defining Counselling/advice nutrition/weight T45005, T45007, T58002, A45006.
(j) IPCP-2 codes defining Counselling/advice smoking P58008, P45005.
(k) IPCP-2 codes defining counselling/ advice alcohol P45005, P58009.
(l) IPCP-2 codes defining counselling/ advice exercise A45004, A58005.
(m) IPCP-2 codes defining counselling/ advice lifestyle P45008, P58012.
(n) IPCP-2 codes defining family planning A98002, A98003, W14002, W45006, W45007, W45008,W58001, W58005, W58007, W58012, W58013,Y14001, Y45006, Y45007, Y58005, Y58006.
(o) IPCP-2 codes defining counselling/ advice relaxation P45007, P58011, P58017.

Source: AIHW analysis of BEACH survey of general practice AGPSCC.

Table 3.07.5: Selected clinical treatments provided by general practitioners, by Indigenous status, April 1998–March 1999 and April 2008–March 2009[a][b]

	April 1998 – March 1999									April 2008 –March 2009								
	Crude rate (no. per 100 encounters)						Age-standardised rate (no. per 100 encounters)[b]			Crude rate (no. per 100 encounters)						Age-standardised rate (no. per 100 encounters)[b]		
Selected clinical treatments	**Indig.**	**95% LCL[c]**	**95% UCL[d]**	**Other[e]**	**95% LCL[c]**	**95% UCL[d]**	**Indig**	**Other[e]**	**Rate ratio**	**Indig**	**95% LCL[c]**	**95% UCL[d]**	**Other[e]**	**95% LCL[c]**	**95% UCL[d]**	**Indig**	**Other[e]**	**Rate ratio[f]**
Advice/education[g]	2.4	1.1	3.6	3.7	3.2	4.2	1.9	3.7	0.5	6.0	2.3	9.6	6.4	5.7	7.1	6.0	6.4	0.9
Counselling/advice nutrition/weight[h]	3.5	2.2	4.7	3.7	3.4	4.0	3.8	3.7	1.0	4.3	3.0	5.7	4.0	3.6	4.3	4.3	3.9	1.1
Advice/education treatment[i]	6.2	3.9	8.5	6.3	5.8	6.8	5.5	6.2	0.9	2.7	1.2	4.1	3.3	3.0	3.6	2.0	3.3	0.6
Counselling/advice —exercise[j]	1.1	0.4	1.9	1.5	1.2	1.7	2.1	1.4	1.5	1.1	0.4	1.9	1.4	1.2	1.6	1.4	1.4	1.0
Counselling/advice smoking[j]	1.2	0.5	1.9	0.6	0.6	0.7	1.6	0.6	2.6	1.6	0.7	2.6	0.7	0.6	0.8	1.4	0.7	2.0
Counselling/advice —life style[l]	0.2	0.0	0.4	0.3	0.3	0.4	0.1	0.3	0.4	0.2	0.0	0.5	0.2	0.2	0.3	0.2	0.2	1.1
Counselling/advice —alcohol[m]	0.8	0.3	1.3	0.4	0.3	0.4	0.8	0.4	2.2	0.8	0.0	1.6	0.4	0.3	0.4	0.6	0.4	1.6
Family planning[n]	0.3	0.0	0.6	0.3	0.2	0.3	0.2	0.3	0.7	0.5	0.1	0.9	0.3	0.3	0.4	0.3	0.3	0.8
Counselling/advice relaxation[o]	0.4	0.1	0.8	0.4	0.3	0.4	0.4	0.4	1.1	0.0	0.0	0.0	0.2	0.2	0.2	0.0	0.2	0.0
Total selected clinical treatments	*16.1*	*12.2*	*19.9*	*17.1*	*16.0*	*18.1*	*16.5*	*16.9*	*1.0*	*17.3*	*12.4*	*22.1*	*16.9*	*15.7*	*18.0*	*16.2*	*16.8*	*1.0*
All other clinical treatments	23.0	19.0	27.1	27.8	26.7	28.9	23.4	27.6	0.8	44.4	33.4	55.5	39.2	37.8	40.6	44.3	38.9	1.1
Total	**39.1**	**32.9**	**45.3**	**44.9**	**43.1**	**46.6**	**39.9**	**44.5**	**0.9**	**61.7**	**51.5**	**72.0**	**56.1**	**53.9**	**58.2**	**60.6**	**55.7**	**1.1**

(Continued)

Table 3.07.5 (continued): Selected clinical treatments provided by general practitioners, by Indigenous status, April 1998–March 1999 and April 2008–March 2009 [(a)(b)]

(a) Data from five combined BEACH years April 2004–March 2005 to April 2008–March 2009 inclusive.
(b) Directly age-standardised rate using the total number of encounters for the period as the standard.
(c) LCL = Lower confidence limit.
(d) UCL = Upper confidence limit.
(e) Other includes non-Indigenous patients and patients for whom Indigenous status was not stated.
(f) Rate for Indigenous divided by rate for other Australians.
(g) IPCP-2 codes defining Advice/education codes A45002, B45002, D45002, F45002, H45002, K45002, L45002, N45002, P45001, P45002, R45002, S45002, T45002, U45002, W45004, X45002, Y45002, Z45002.
(h) IPCP-2 codes defining Counselling/advice nutrition/weight T45005, T45007, T58002, A45006.
(i) IPCP-2 codes defining Counselling/advice treatment A45016, A45019, A45020, A45021, A45030, A48004, L45004, R45004, T45004, T45009.
(j) IPCP-2 codes defining counselling/ advice exercise A45004, A58005.
(k) IPCP-2 codes defining Counselling/advice smoking P58008, P45005.
(l) IPCP-2 codes defining counselling/ advice lifestyle P45008, P58012.
(m) IPCP-2 codes defining counselling/ advice alcohol P45005, P58009.
(n) IPCP-2 codes defining family planning A98002, A98003, W14002, W45006, W45007, W45008,W58001, W58005, W58007, W58012, W58013,Y14001, Y45006, Y45007, Y58005, Y58006.
(o) IPCP-2 codes defining counselling/ advice relaxation P45007, P58011, P58017.

Source: AIHW analysis of BEACH survey of general practice AGPSCC.

Table 3.07.6: Selected clinical treatments provided by general practitioners: rate (no. per problems managed[a]), by Indigenous status, BEACH years April 2004–March 2005 to April 2008–March 2009[b]

Selected clinical treatments	Indigenous							Other						
	Respira-tory (n= 1,250)[d]	Musculo-skeletal (n= 872)[d]	Cardio-vascular (n= 802)[d]	Endocrine/ metabolic (n= 974)[d]	Psycho-logical (n= 901)[d]	Other[c] (n= 4,506)[d]	Total (n= 9,305)[d]	Respir-atory (n= 92,621)[d]	Musculo-skeletal (n= 82,911)[d]	Cardio-vascular (n= 84,270)[d]	Endocrine/ metabolic (n= 60,328)[d]	Psycho-logical (n= 58,291)[d]	Other[c] (n= 354,587)[d]	Total (n= 733,008)[d]
	No. per 100 problems managed[e]													
Advice/education[f]	4.0	4.7	2.1	1.3	2.1	3.5	3.2	4.7	5.4	2.6	2.3	3.1	4.9	4.3
Counselling/advice nutrition/weight[g]	0.0	0.6	2.2	13.9	0.3	1.3	2.4	0.2	0.7	3.1	15.8	0.3	1.8	2.7
Advice/education treatment[h]	4.8	2.3	0.6	5.3	1.0	1.7	2.4	5.5	2.6	0.6	2.1	0.6	2.0	2.2
Counselling/advice—exercise[i]	0.0	1.3	1.5	4.2	0.2	0.1	0.8	0.1	1.8	1.5	4.6	0.3	0.2	0.9
Counselling/advice smoking[j]	2.8	0.0	0.6	0.5	6.2	0.4	1.3	0.8	0.0	0.2	0.1	2.7	0.1	0.4
Counselling/advice—life style[k]	0.1	0.6	0.7	1.4	0.6	0.1	0.4	0.0	0.1	0.7	1.1	0.2	0.2	0.3
Counselling/advice—alcohol[l]	0.2	0.1	0.7	0.7	3.8	0.6	0.8	0.0	0.0	0.1	0.2	1.8	0.1	0.3
Family planning[m]	0.0	0.0	0.0	0.0	0.0	0.7	0.3	0.0	0.0	0.0	0.0	0.0	0.5	0.3
Counselling/advice relaxation[n]	0.1	0.1	0.0	0.0	1.7	0.0	0.2	0.0	0.0	0.1	0.0	1.7	0.1	0.2
Total selected clinical treatments	*12.0*	*9.6*	*8.6*	*27.4*	*15.9*	*8.5*	*11.8*	*11.3*	*10.6*	*9.0*	*26.3*	*10.9*	*9.9*	*11.5*
All other clinical treatments	19.8	28.0	15.5	15.4	35.5	29.7	26.1	20.9	24.6	11.2	11.8	37.1	28.4	24.4
Total treatments	**31.8**	**37.6**	**24.1**	**42.8**	**51.4**	**38.1**	**37.8**	**32.2**	**35.2**	**20.2**	**38.1**	**48.0**	**38.3**	**35.9**

(continued)

Table 3.07.6 (continued): Selected clinical treatments provided by general practitioners: rate (no. per problems managed[(a)]), by Indigenous status, BEACH years April 2004–March 2005 to April 2008–March 2009[(b)]

(a) Classified according to ICPC-2 chapter codes (Classification Committee of the World Organization of Family Doctors (WICC) 1998).

(b) Data from five combined BEACH years April 2004–March 2005 to April 2008–March 2009 inclusive.

(c) Other problems include: skin, general and unspecified, digestive, female genital system, ear, pregnancy and family planning, neurological, urology, eye, male genital system, blood and social problems.

(d) Total problem managed in that problem chapter, for selected subgroup of patients.

(e) Directly age-standardised rate using total encounters in the period as the standard.

(f) IPCP-2 codes defining Advice/education codes A45002, B45002, D45002, F45002, H45002, K45002, L45002, N45002, P45001, P45002, R45002, S45002, T45002, U45002, W45004, X45002, Y45002, Z45002.

(g) IPCP-2 codes defining Counselling/advice nutrition/weight T45005, T45007, T58002, A45006.

(h) IPCP-2 codes defining Counselling/advice treatment A45016, A45019, A45020, A45021, A45030, A48004, L45004, R45004, T45004, T45009.

(i) IPCP-2 codes defining counselling/ advice exercise A45004, A58005.

(j) IPCP-2 codes defining Counselling/advice smoking P58008, P45005.

(k) IPCP-2 codes defining counselling/ advice lifestyle P45008, P58012.

(l) IPCP-2 codes defining counselling/ advice alcohol P45005, P58009.

(m) IPCP-2 codes defining family planning A98002, A98003, W14002, W45006, W45007, W45008,W58001, W58005, W58007, W58012, W58013,Y14001, Y45006, Y45007, Y58005, Y58006.

(n) IPCP-2 codes defining counselling/ advice relaxation P45007, P58011, P58017.

Source: AIHW analysis of BEACH survey of general practice, AGPSCC.

Indigenous communities

Health promotion programs

Health promotion programs are defined in the CHINS as 'a series of planned group activities conducted by a health professional within the community'. They are designed to change knowledge, attitudes, beliefs, behaviours or susceptibility to disease through a combination of educational and environmental measures, screening or immunisation (ABS 2007).

For the 2006 CHINS, data on health promotion programs were only collected from communities that completed the long community questionnaire. The health promotion questions in the CHINS do not collect information on the extent or quality of these activities —only that they have occurred. Therefore, these data are limited in their contribution to our understanding of the health promotion activities occurring in these discrete Indigenous communities.

- In 2006, most discrete Indigenous communities reported that one or more health promotion programs (67%) had been conducted, with women's health programs reported by 58%, well babies programs by 54%, immunisation programs by 54% and men's health programs by 52% of communities (Table 3.07.7; Figure 3.07.4).
- The proportion of discrete Indigenous communities reporting at least one health promotion program varied across jurisdictions. Queensland had the highest proportion (89%) and New South Wales the lowest proportion (50%) of communities who reported one or more health promotion programs had been conducted (Table 3.07.8).
- The proportion of discrete Indigenous communities, with a population of 50 or more located more than 10 kilometres from a hospital, that reported conducting at least one health promotion program conducted decreased from 82% in 2001 to 75% in 2006 (Table 3.07.9; Figure 3.07.5).
- The three programs run in the most communities in 2001 and 2006 were women's health, well babies and immunisation (Table 3.07.9; Figure 3.07.5).

Table 3.07.7: Discrete Indigenous communities[(a)] located 10 kilometres or more from a hospital: selected health promotion programs conducted in community, 2006

	Health promotion program conducted		Health promotion program not conducted	
	Communities (Number)	Communities (per cent)	Communities (Number)	Communities (per cent)
Well babies	155	53.8	132	45.8
Women's health	168	58.3	119	41.3
Men's health	149	51.7	138	47.9
Youth's health	88	30.6	199	69.1
Sexual health	119	41.3	168	58.3
Substance misuse	89	30.9	198	68.8
Immunisation	154	53.5	133	46.2
Trachoma control	69	24.0	218	75.7
Eye health	91	31.6	196	68.1
Ear health	107	37.2	180	62.5
Nutrition	129	44.8	158	54.9
Stop smoking	74	25.7	213	74.0
Domestic and personal hygiene	92	31.9	195	67.7
Emotional and social wellbeing or mental health	84	29.2	203	70.5
Sub-total	*194[(b)]*	*67.4*	*93[(c)]*	*32.3*
Not stated	1	0.3	1	0.3
Total no. communities[(d)]	**288**	**100.0.**	**288**	**100.0.**

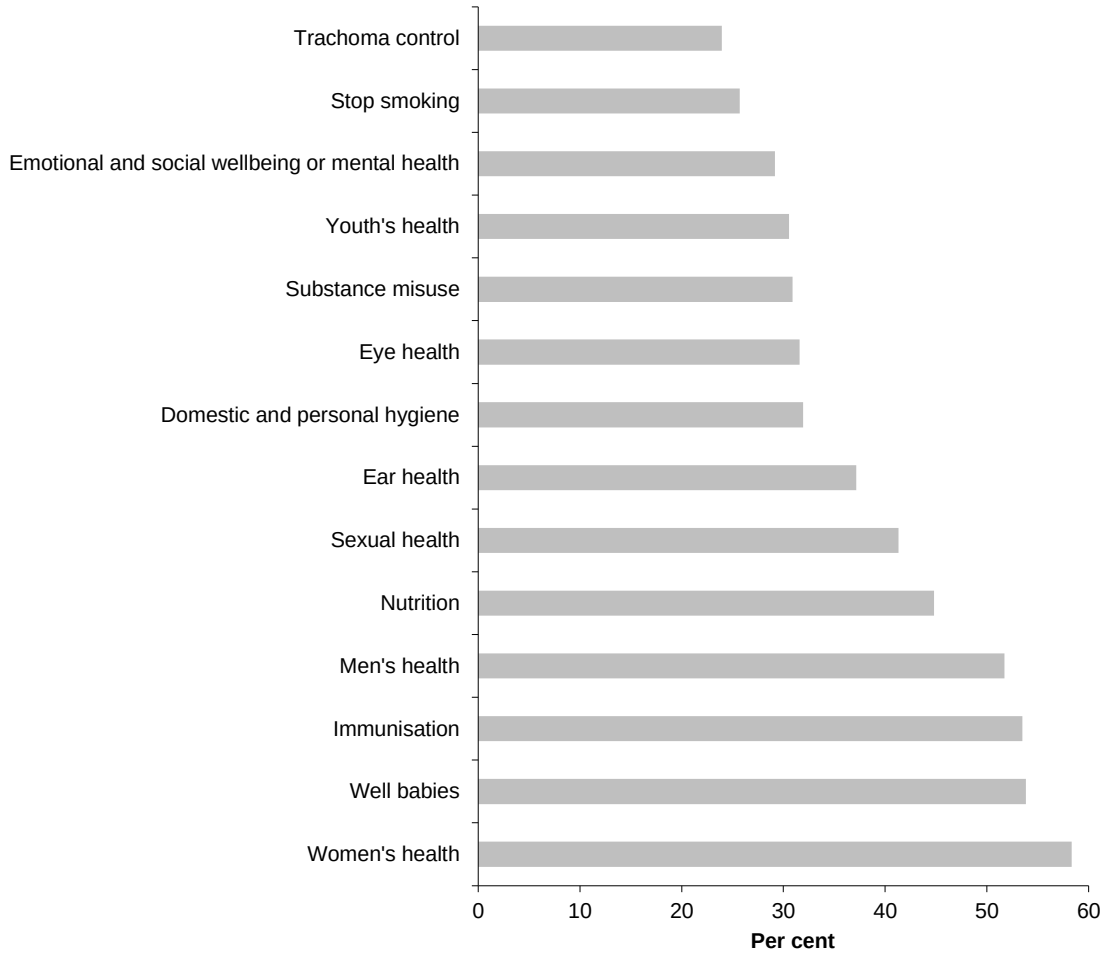
(a) With a population of 50 or more, or a reported usual population of fewer than 50 but which were not linked to a parent community or resource agency.

(b) Number of communities where at least one health promotion program was conducted.

(c) Number of communities where no health promotion programs were conducted.

(d) Excludes communities where distance to nearest hospital was not stated.

Source: AIHW analysis of 2006 CHINS.



Source: AIHW analysis of 2006 CHINS.

Figure 3.07.4: Proportion of discrete Indigenous communities located 10 kilometres or more with each type of health promotion program conducted, 2006.

Table 3.07.8: Discrete Indigenous communities[(a)] located 10 kilometres or more from a hospital: selected health promotion programs conducted in community, by state/territory, 2006

	NSW		Qld		WA		SA		NT		Australia[(b)]	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Well babies	10	33.3	19	70.4	29	40.8	14	42.4	80	64.5	155	53.8
Women's health	14	46.7	23	85.2	34	47.9	17	51.5	77	62.1	168	58.3
Men's health	10	33.3	17	63.0	28	39.4	16	48.5	75	60.5	149	51.7
Youth's health	9	30.0	10	37.0	19	26.8	9	27.3	39	31.5	88	30.6
Sexual health	10	33.3	19	70.4	27	38.0	4	12.1	57	46.0	119	41.3
Substance misuse	10	33.3	13	48.1	20	28.2	5	15.2	39	31.5	89	30.9
Immunisation	13	43.3	20	74.1	37	52.1	15	45.5	67	54.0	154	53.5
Trachoma control	2	6.7	4	14.8	25	35.2	1	3.0	36	29.0	69	24.0
Eye health	4	13.3	12	44.4	21	29.6	5	15.2	46	37.1	91	31.6
Ear health	9	30.0	12	44.4	31	43.7	4	12.1	48	38.7	107	37.2
Nutrition	10	33.3	14	51.9	28	39.4	4	12.1	70	56.5	129	44.8
Stop smoking	2	6.7	11	40.7	23	32.4	3	9.1	33	26.6	74	25.7
Domestic and personal hygiene	4	13.3	9	33.3	23	32.4	4	12.1	50	40.3	92	31.9
Emotional and social wellbeing or mental health	7	23.3	13	48.1	24	33.8	6	18.2	31	25.0	84	29.2
Total with at least one health promotion program	*15*	*50.0*	*24*	*88.9*	*43*	*60.6*	*18*	*54.5*	*91*	*73.4*	*194*	*67.4*
Total with no health promotion programs	*15*	*50.0*	*2*	*7.4*	*28*	*39.4*	*15*	*45.5*	*33*	*26.6*	*93*	*32.3*
Not stated	—	—	1	3.7	—	—	—	—	—	—	1	0.3
Total[(c)]	**30**	**100.0**	**27**	**100.0**	**71**	**100.0**	**33**	**100.0**	**124**	**100.0**	**288**	**100.0**

(a) With a population of 50 or more, or a reported usual population of fewer than 50 but which were not linked to a parent community or resource agency

(b) Victoria and Tasmania not included separately for confidentiality reasons, but in Australia total.

(c) Excludes communities where distance to nearest hospital was not stated.

Source: AIHW analysis of 2006 CHINS.

Table 3.07.9: Discrete Indigenous communities with a population of 50 or more located 10 kilometres or more from a hospital: selected health promotion programs conducted in community, 2001 and 2006

	Health promotion program conducted		Health promotion program not conducted	
	2001	**2006**	**2001**	**2006**
	%	**%**	**%**	**%**
Well babies	66	61	33	39
Women's health	72	65	27	35
Men's health	62	58	36	42
Youth's health	52	34	47	66
Sexual health	65	46	33	54
Substance misuse	52	34	47	66
Immunisation	74	61	26	39
Eye health inc. trachoma[(a)]	60	44	39	37
Ear health	64	42	35	58
Nutrition[(b)]	n.a.	49	n.a.	51
Stop smoking[(b)]	n.a.	29	n.a.	71
Domestic and personal hygiene[(b)]	n.a.	35	n.a.	65
Emotional and social wellbeing or mental health	50	32	49	68
Sub-total	*82*[(c)]	*75*[(c)]	*17*[(d)]	*25*[(d)]
Not stated	1	—	1	—
Total no. communities[(e)]	**242**	**237**	**242**	**237**

(a) 2006 data is the sum of communities with health promotion programs for eye health and/or trachoma. In 2001, data were not collected separately for eye health and trachoma control programs.

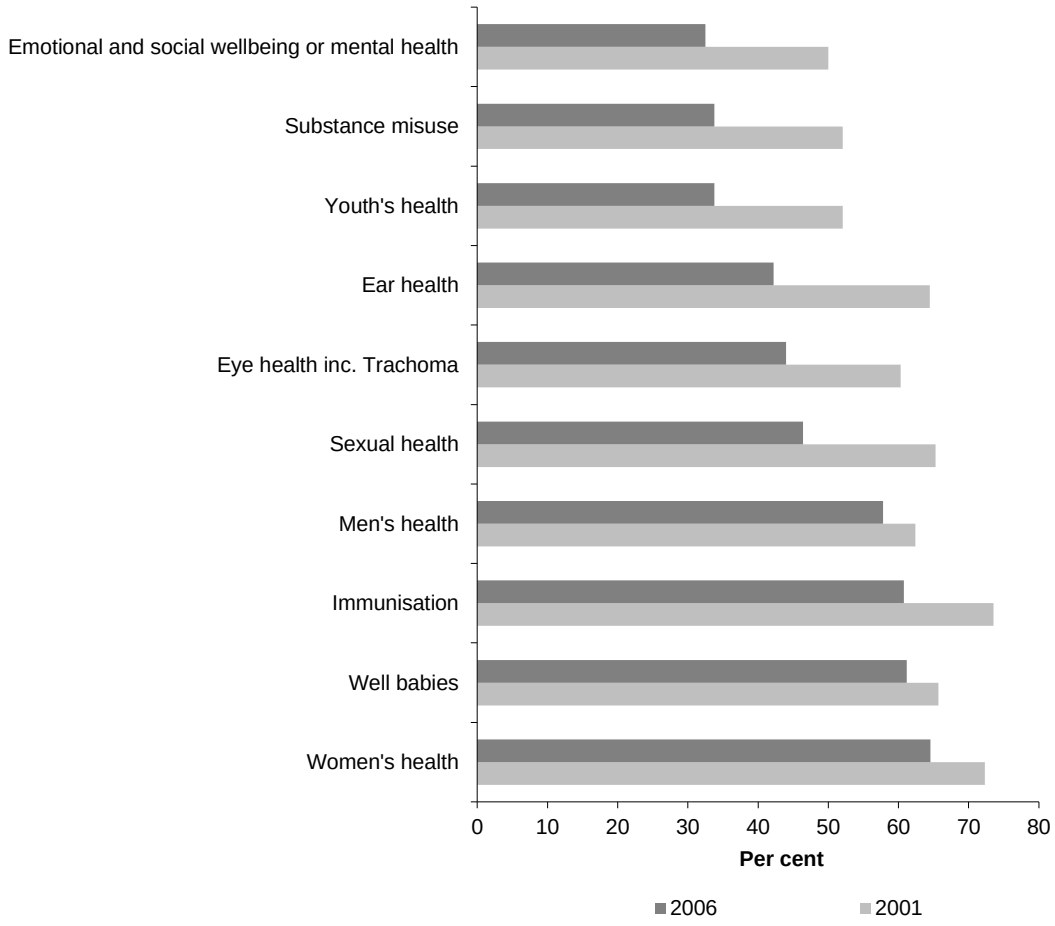
(b) Data on nutrition, stop smoking and domestic and personal hygiene programs were not collected in 2001.

(c) Number of communities where at least one health promotion program was conducted.

(d) Number of communities where no health promotion programs were conducted.

(e) Excludes communities where distance to nearest hospital was not stated.

Source: ABS 2002; AIHW analysis of 2006 CHINS.



Source: AIHW analysis of 2001 and 2006 CHINS.

Figure 3.07.5: Proportion of communities with each type of health promotion program conducted, 2001 and 2006.

Frequency of health promotion programs

- The frequency with which health promotion programs were conducted varied. The majority of programs were most likely to be conducted weekly or monthly, except for trachoma control and eye health, both of which were most likely to be conducted less than 3-monthly (Table 3.07.10).

Table 3.07.10: Discrete Indigenous communities[(a)] located 10 kilometres or more from a hospital: frequency of selected health promotion programs conducted in community, 2006

	Frequency of program						
Health promotion programs	Weekly	Fortnightly	Monthly	Three-monthly	Less than 3-monthly	Not conducted	All communities[(b)(c)]
	Number						
Well babies	66	7	39	28	15	132	288
Women's health	49	10	44	39	26	119	288
Men's health	42	5	35	34	33	138	288
Youth's health	32	1	23	13	19	199	288
Sexual health	36	6	26	16	35	168	288
Substance misuse	30	5	19	12	23	198	288
Immunisation	59	8	42	26	19	133	288
Trachoma control	11	4	8	8	38	218	288
Eye health	15	4	11	27	34	196	288
Ear health	32	6	24	15	30	180	288
Nutrition	36	11	27	27	28	158	288
Stop smoking	29	4	15	13	13	213	288
Domestic and personal hygiene	34	6	17	9	26	195	288
Emotional and social wellbeing or mental health	26	5	21	12	20	203	288

(a) With a population of 50 or more, or a reported usual population of fewer than 50 but which were not linked to a parent community or resource agency.

(b) Includes 'whether selected health promotion program conducted' not stated.

(c) Excludes communities where distance to nearest hospital not stated.

Source: AIHW analysis of 2006 CHINS.

OATSIH Services Reporting (OSR) data

Programs/activities provided

All Indigenous primary health-care services undertake a number of extended care roles to support their communities. The data in this section refer to the proportion of Indigenous primary health-care services included in the OSR data collection that undertake these roles through the provision of programs and activities, but not the extent to which they are undertaken or the amount of resources used to carry out these activities.

In 2008–09, there were 211 Indigenous primary health-care services included in the OSR of which 205 (97%) responded to the OSR questionnaire. Figure 3.07.6a shows the proportion of Indigenous primary health-care services that offered selected preventative health-care programs in 2008–09. Figure 3.07.6b shows the proportion of Indigenous primary health-care services that offered selected health care and screening activities (health related and community services) in 2008-09. Figure 3.07.6c shows the proportion of Indigenous primary health-care services that offered selected preventative health care and screening activities (screening programs) in 2008–09. Figure 3.07.6d shows the proportion of Indigenous primary health-care services that offered selected preventative health care and screening activities (traditional health care) in 2008–09.

Preventative health care and screening

- In 2008–09, a majority of Indigenous primary health-care services undertook each of the preventative care and screening programs: 94% offered health promotion/education programs, 82% routinely organised influenza immunisation, 81% offered child immunisation and 77% offered women's health programs. Ten programs were offered by fewer than half of Indigenous primary health-care services (Figure 3.07.6a).

Health related and community services

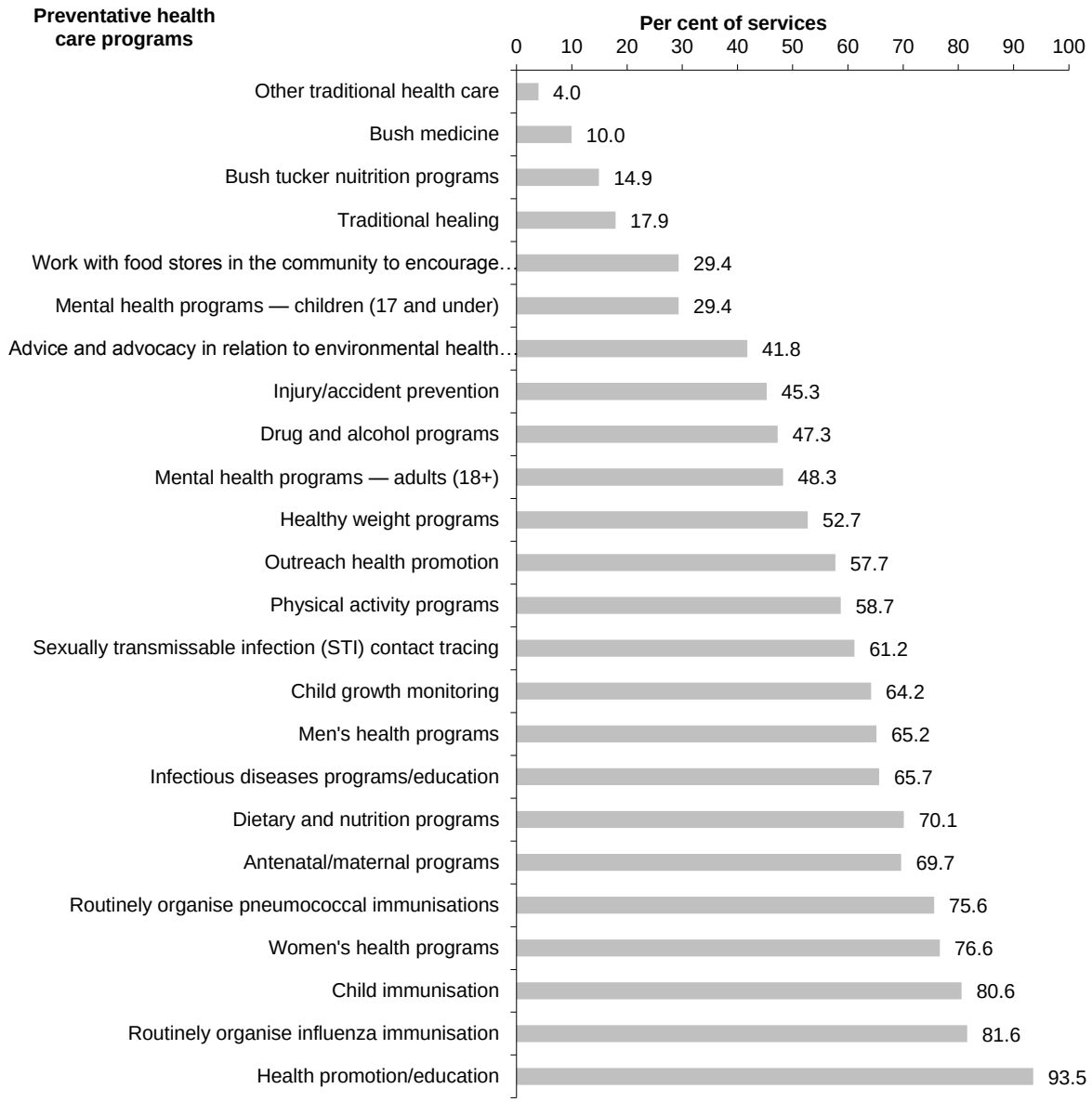
- In 2008–09, a majority of Indigenous primary health-care services undertook each of the preventative care programs: 86% offered transport, 77% were involved with committees on health and 69% offered to attend medical appointments with patients to provide support (Figure 3.07.6b). Ten programs were offered by less than half of Indigenous primary health-care services.

Screening programs

- In 2008–09, a majority of Indigenous primary health-care services undertook each of the screening programs; 80% offered PAP smears/cervical screening, but only 54% offered renal disease screening (Figure 3.07.6c).

Traditional health care

- In 2008–09, traditional health care was offered by a minority of Indigenous primary health-care services; 18% of Indigenous primary health-care services offered traditional healing, and 10% offered bush medicine activities (Figure 3.07.6d).

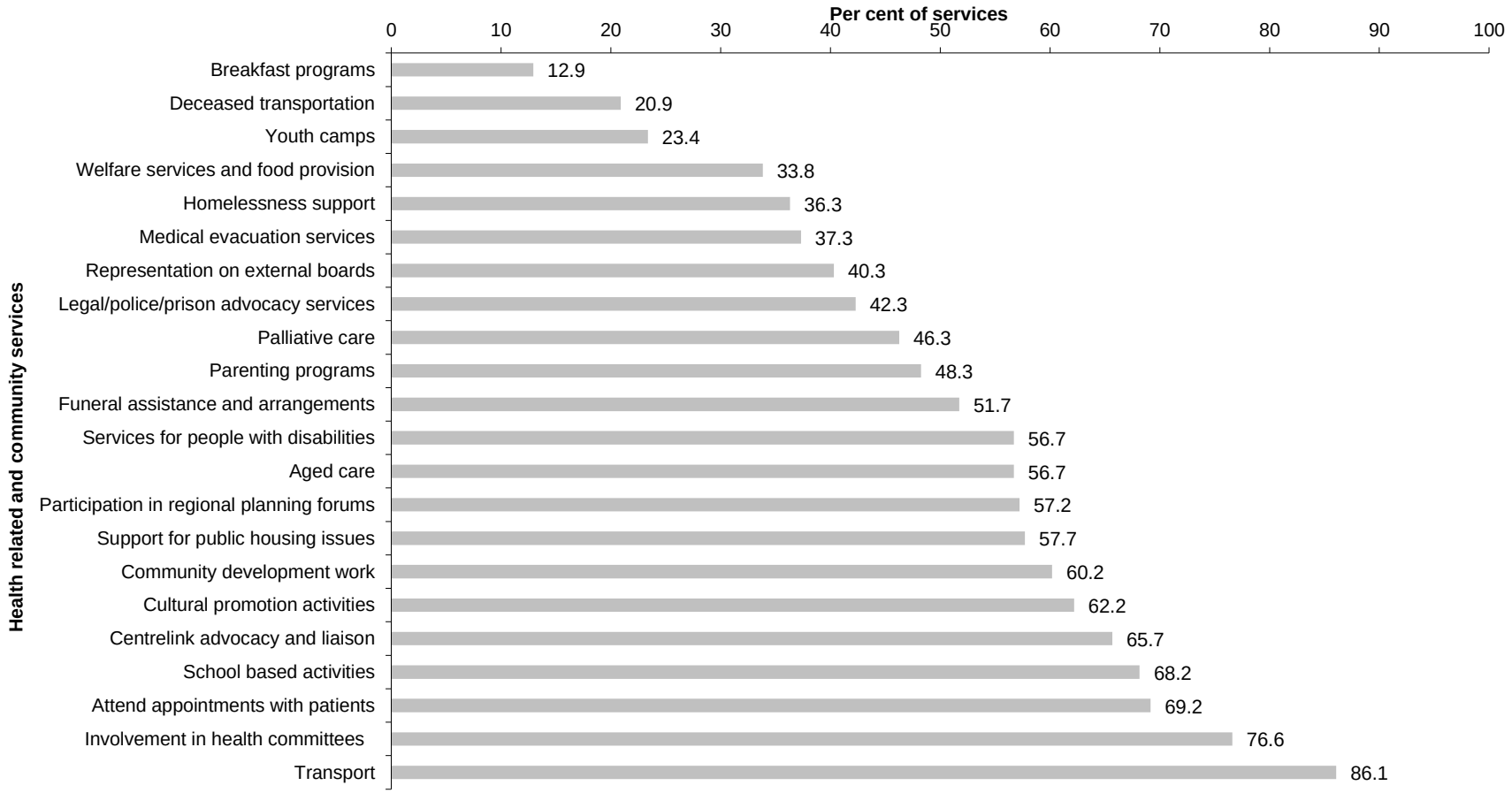


(a) Two hundred and one of the 205 respondent Aboriginal and Torres Strait Islander primary health-care services provided valid data about health-related activities provided by the service. The percentages in the table above are calculated as a proportion of these 201 services.

Note: 'Preventative health care programs' changed to 'Population health programs' in 2008–09 OSR.

Source: AIHW OSR data collection.

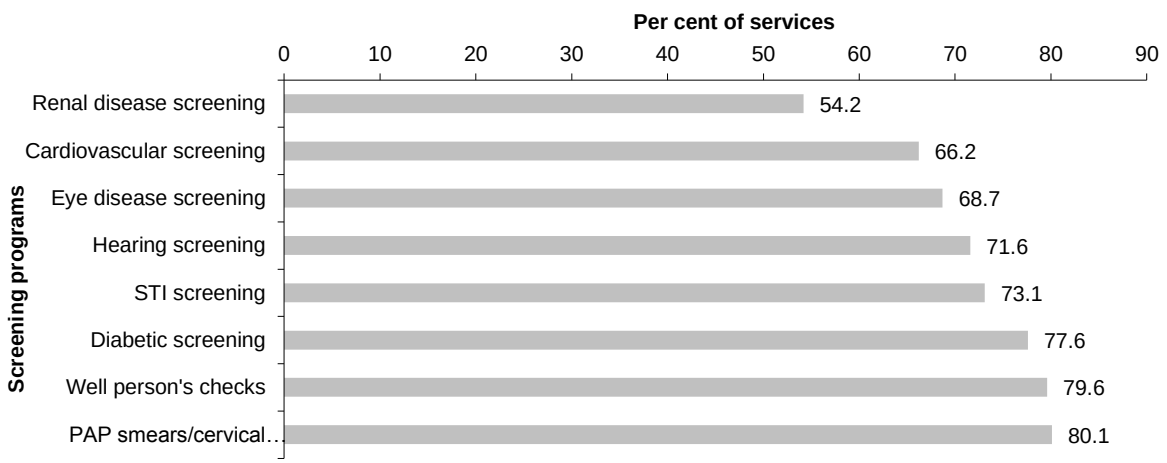
Figure 3.07.6a: Proportion[(a)] of Aboriginal and Torres Strait Islander primary health-care services that undertake selected preventative health care and screening activities, (preventative health care programs), 2008–09



Note: Two hundred and one of the 205 respondent Aboriginal and Torres Strait Islander primary health-care services provided valid data about health related activities provided by the service. The percentages in the table above are calculated as a proportion of these 201 services

Source: AIHW OSR data collection.

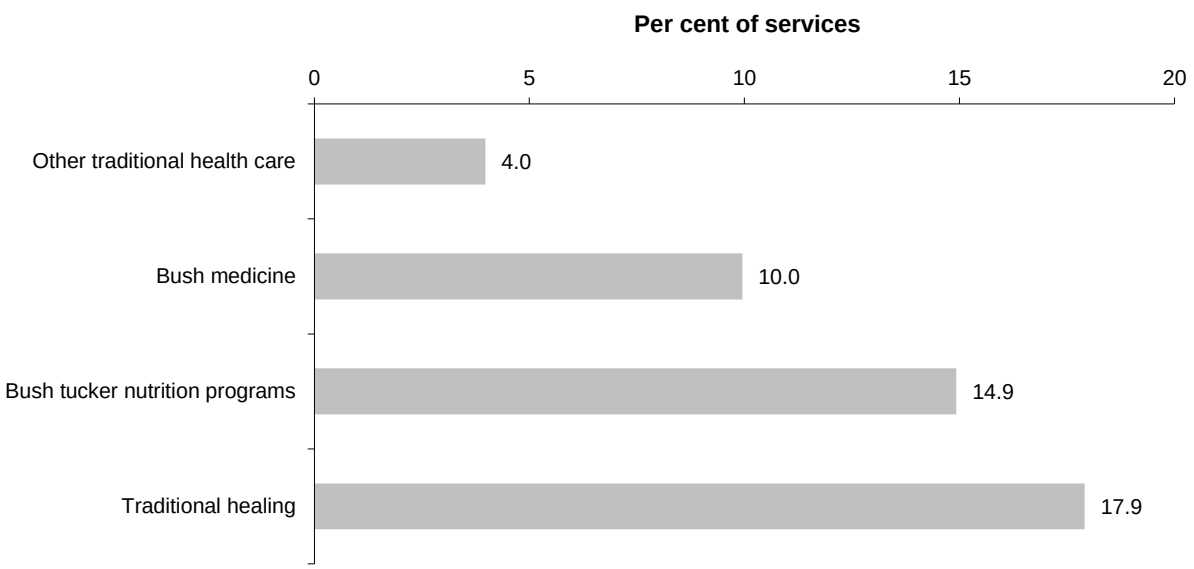
Figure 3.07.6b: Proportion of Aboriginal and Torres Strait Islander primary health-care services that undertake selected health care and screening activities (health related and community services), 2008–09



Note: Two hundred and one of the 205 respondent Aboriginal and Torres Strait Islander primary health-care services provided valid data about health-related activities provided by the service. The percentages in the table above are calculated as a proportion of these 201 services

Source: AIHW OSR data collection.

Figure 3.07.6c: Proportion of Aboriginal and Torres Strait Islander primary health-care services that undertake selected preventative health care and screening activities (screening programs), 2008–09



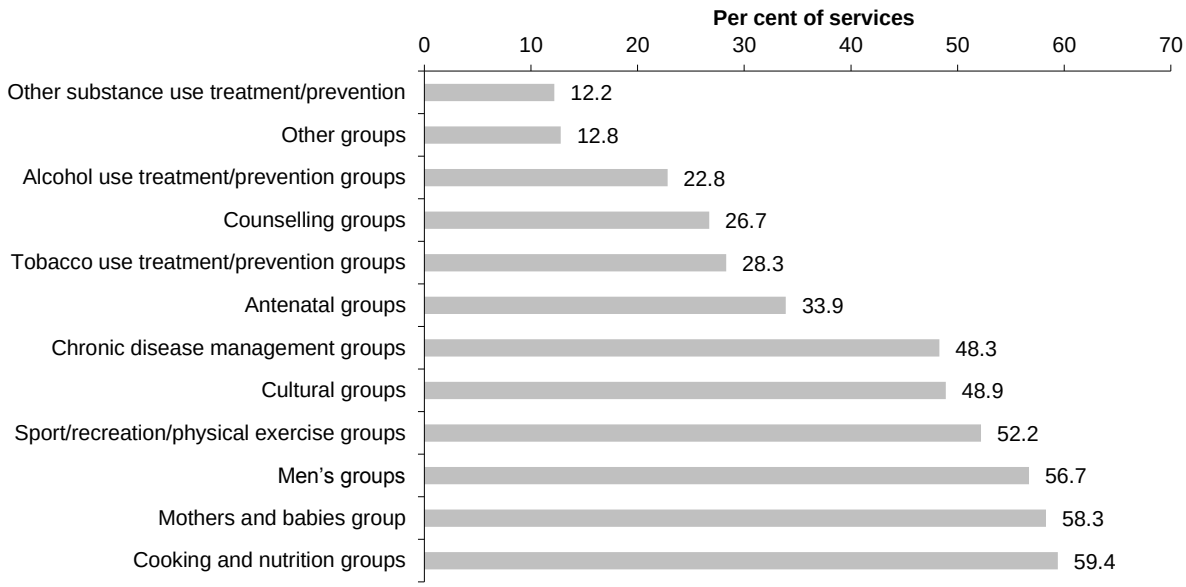
(a) Two hundred and one of the 205 respondent Aboriginal and Torres Strait Islander primary health-care services provided valid data about health-related activities provided by the service. The percentages in the table above are calculated as a proportion of these 201 services.

Source: AIHW OSR data collection.

Figure 3.07.6d: Proportion[(a)] of Aboriginal and Torres Strait Islander primary health-care services that undertake selected preventative health care and screening activities (traditional health care), 2008–09

Health promotion/prevention group activities

- In 2008–09, the most common health promotion/prevention group activity run by Aboriginal and Torres Strait Islander primary health-care services was cooking and nutrition groups (59%), followed by mothers and babies groups (58%) and men's groups (57%) (Figure 3.07.7).
- The least common health promotion/previous group activity was other substance use treatment/prevention (12%), followed by other groups (13%) and alcohol use treatment/prevention groups (23%).



(a) One hundred and eighty of the 205 respondent Aboriginal and Torres Strait Islander primary health-care services provided information on group activities offered by the service. The percentages in the table above are calculated as a proportion of these 180 services.

Source: AIHW OSR data collection.

Figure 3.07.7: Proportion[(a)] of Aboriginal and Torres Strait Islander primary health-care services that ran health promotion/prevention group activities during 2008-09

Substance use services

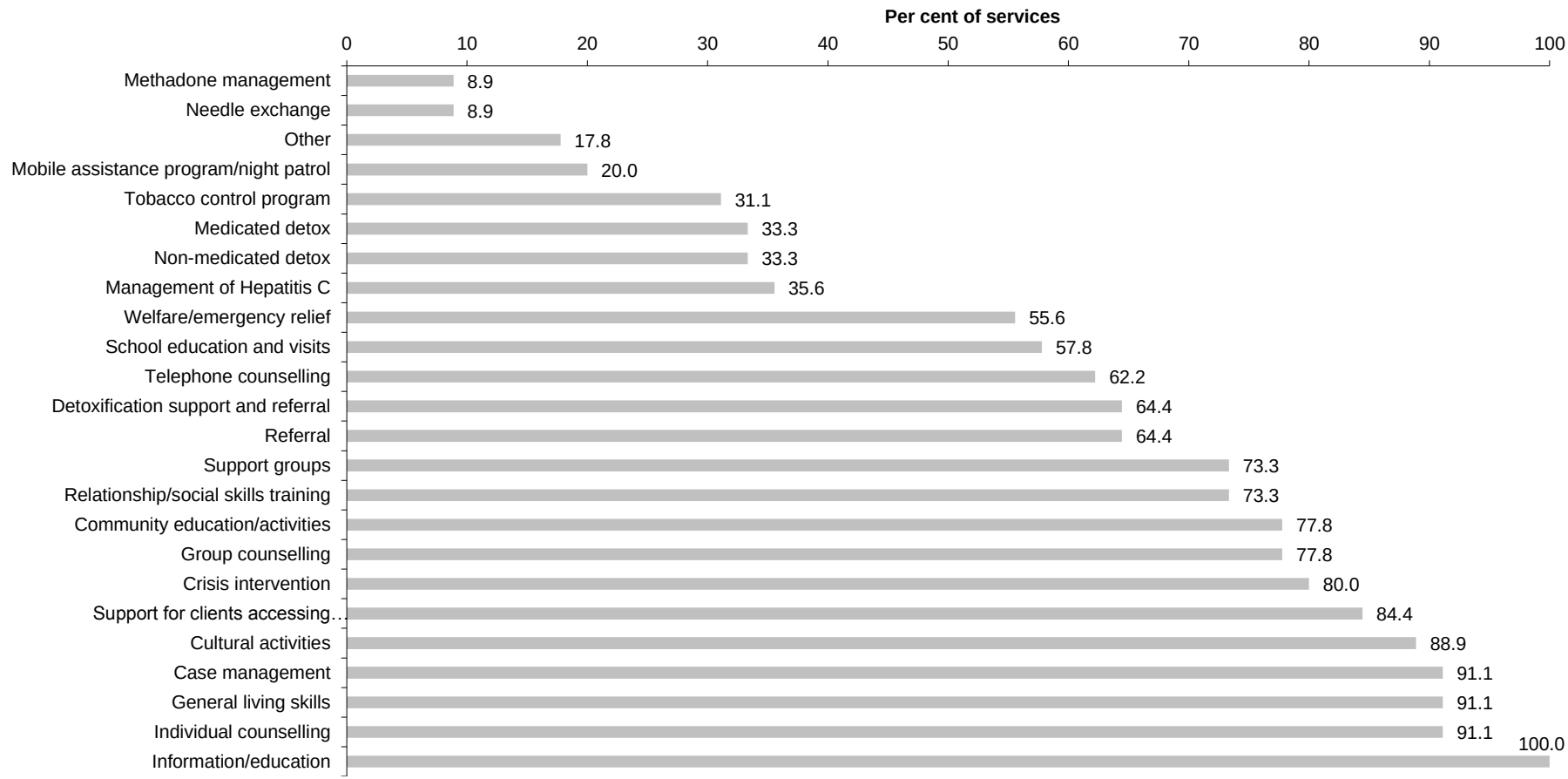
In 2008–09, there were 50 stand-alone Indigenous-specific substance use services that received OATSIH funding, of which 45 (90%) responded to the OSR questionnaire.

Counselling approaches and cultural activities

- In 2008-09, information/education programs were the most common program offered by substance use services (100%), followed by individual counselling, general living skills and case management programs (all 91%) (Figure 3.07.8; Table 3.07.11).
- Methadone management (8.9%) and needle exchange programs (8.9%) were the least offered programs in 2008–09.

Other selected groups

- In 2008–09, the most commonly run programs by substance use services were cultural groups (91%), community-based education and prevention groups (84%) and alcohol use treatment/prevention groups (82%) (Figure 3.07.9; Table 3.07.12).
- Less than half of substance use services ran youth groups (32%) or tobacco use treatment/prevention groups (46%).



(a) All of the 45 respondent Aboriginal and Torres Strait Islander substance use services provided valid data about activities the service provided to tackle substance use.

Source: AIHW OSR data collection.

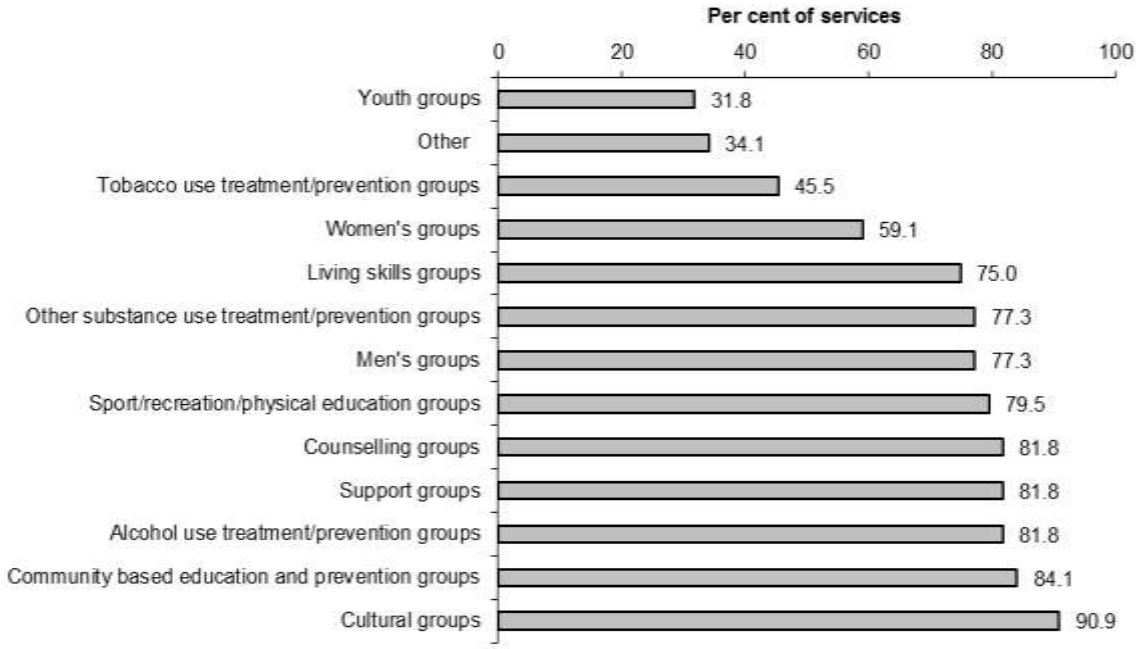
Figure 3.07.8: Proportion[(a)] of services conducting selected drug and alcohol service counselling approaches and cultural activities, 2008-09

Table 3.07.11: Proportion[(a)] of services conducting selected drug and alcohol service counselling approaches and cultural activities, 2008–09

Service	Percentage
Information/education	100.0
Case management	91.1
Individual counselling	91.1
General living skills	91.1
Cultural activities	88.9
Support for clients accessing mainstream services	84.4
Crisis intervention	80.0
Community education/activities	77.8
Group counselling	77.8
Support groups	73.3
Relationship/social skills training	73.3
Detoxification support & referral	64.4
Referral	64.4
Telephone conselling	62.2
School education & visits	57.8
Welfare/emergency relief	55.6
Management of Hepatitis C	35.6
Medication detox	33.3
non-medicated detox	33.3
Tobacco control program	31.1
Mobile assistance program/night patrol	20.0
Needle exchange	8.9
Methadone management	8.9
Other	17.8

(a) All of the 45 respondent Aboriginal and Torres Strait Islander substance use services provided valid data about activities the service provided to address substance use.

Source: AIHW OSR data collection.



(a) Forty-four of the 45 respondent Aboriginal and Torres Strait Islander substance use services provided information on group activities. The percentages in the table above are calculated as a proportion of these 44 services.

Source: AIHW OSR data collection.

Figure 3.07.9: Proportion[(a)] of Aboriginal and Torres Strait Islander substance-use-specific services that ran selected groups during 2008–09

Table 3.07.12: Proportion[(a)] of Aboriginal and Torres Strait Islander substance-use-specific services that ran selected groups during 2008-09

Group	Percentage
Counselling groups	81.8
Support groups	81.8
Community based education and prevention groups	84.1
Cultural groups	90.9
Sport/recreation/physical education groups	79.5
Living skills groups	75.0
Alcohol use treatment/prevention groups	81.8
Tobacco use treatment/prevention groups	45.5
Other substance use treatment/prevention groups	77.3
Men's groups	77.3
Women's groups	59.1
Youth groups	31.8
Other	34.1

(a) Forty-four of the 45 respondent Aboriginal and Torres Strait Islander substance use services provided information on group activities. The percentages in the table above are calculated as a proportion of these 44 services.

Source: AIHW OSR data collection.

Additional information

Information on services funded through the HFL program that had health promotion programs for behavioural risk reduction is available from the AIHW Healthy For Life data collection.

- In 2007, 2008 and 2009, of the services that were included in the HFL program that had community health promotion/development activities, those engaging with preschools and/or schools were 88%, 84% and 82%, respectively. Those engaging with child care centres and/or play groups were 63%, 67% and 65%, respectively (Table 3.07.13a).
- In 2007, 2008 and 2009, of the services that were included in the HFL program and provided strategies for chronic disease preventative care, those providing brief intervention programs for smoking were 73%, 91% and 85%, respectively. Those providing other advice on smoking were 72%, 90% and 85%, respectively (Table 3.07.13b).
- About 75% of HFL Services provided programs for nutrition and physical activity in 2007, about 93% for both in 2008 and 87% for nutrition and 85% for physical activity in 2009. Similar results were seen for the provision of emotional wellbeing advice and brief intervention (Table 3.07.13b).
- Services funded through the Healthy For Life program also provided strategies for chronic disease management in 2007, 2008 and 2009. Behavioural risk reduction for smoking was provided through brief intervention in 76%, 88%, 85% of services respectively. While behavioural risk reduction for alcohol consumption was provided through brief intervention in 75%, 90%, 85% of services respectively (Table 3.07.13c).

Table 3.07.13a: Proportion of services funded through the Healthy For Life program that had community health promotion/development activities[(a)] , reporting periods ending 30 June 2007 to 2009

	Jun-07			Jun-08			Jun-09		
	Yes	No	No response	Yes	No	No response	Yes	No	No response
	Per cent								
Engagement with child care centres and/or play groups	62.7	32.2	1.7	67.2	25.4	6.0	65.3	23.6	11.1
Engagement with preschools and/or schools	88.1	8.5	1.7	83.6	10.4	6.0	82.2	6.8	11.0
Engagement with community groups									
Community council	72.9	11.9	10.2	64.2	23.9	7.5	69.0	14.1	16.9
Women's group(s)	69.5	18.6	10.2	82.1	10.4	6.0	75.0	6.9	18.1
Men's group(s)	69.5	18.6	10.2	70.1	22.4	6.0	66.2	10.8	23.0
Youth group(s)	64.4	23.7	10.2	59.7	28.4	9.0	51.4	23.6	25.0
Sports club(s)	45.8	39.0	15.3	52.2	28.4	13.4	46.5	33.8	19.7
Art/cultural centre(s)	39.0	39.0	16.9	37.3	44.8	9.0	26.8	50.7	22.5
Other	28.8	15.3	54.2	24.2	28.8	40.9	16.4	34.2	49.3
Other community engagement	44.1	10.2	45.8	46.3	11.9	35.8	42.3	19.7	38.0

(a) Relating to maternal and child health and chronic disease prevention and care, including risk reduction for smoking, nutrition, alcohol, physical activity and emotional wellbeing.

Source: AIHW, Healthy for Life data collection.

Table 3.07.13b: Proportion of services funded through the Healthy For Life program that had strategies for chronic disease preventative care for their service population, reporting periods ending 30 June 2007 to 2009

	Jun-07			Jun-08			Jun-09		
	Yes	No	No response	Yes	No	No response	Yes	No	No response
	Per cent								
Behavioural risk reduction									
Smoking									
Brief intervention	72.9	8.5	18.6	91.0	1.5	7.5	85.1	2.7	12.2
Other advice	71.2	10.2	18.6	89.6	1.5	9.0	85.1	2.7	12.2
Nutrition	74.6	6.8	18.6	92.5	. .	7.5	86.5	1.4	12.2
Alcohol									
Brief intervention	74.6	6.8	18.6	89.6	3.0	7.5	85.1	2.7	12.2
Other advice	67.8	11.9	20.3	77.6	13.4	9.0	81.1	6.8	12.2
Physical activity	74.6	6.8	18.6	92.5	. .	7.5	85.1	2.7	12.2
Emotional wellbeing	71.2	8.5	20.3	91.0	. .	9.0	86.5	. .	13.5
Other	33.9	18.6	47.5	14.9	40.3	44.8	13.5	36.5	50.0

Source: AIHW, Healthy for Life data collection.

Table 3.07.13c: Proportion of services funded through the Healthy For Life program that had strategies for chronic disease management[(a)] for their clients with chronic disease, reporting periods ending 30 June 2007 to 2009

	Jun-07			Jun-08			Jun-09		
	Yes	No	No response	Yes	No	No response	Yes	No	No response
					Per cent				
Behavioural risk reduction									
Smoking									
Brief intervention	76.3	6.8	16.9	88.1	3.0	9.0	85.1	4.1	10.8
Other advice	69.5	11.9	18.6	86.6	6.0	7.5	83.8	5.4	10.8
Nutrition	74.6	6.8	18.6	91.0	1.5	7.5	83.8	4.1	12.2
Alcohol									
Brief intervention	74.6	8.5	16.9	88.1	4.5	7.5	85.1	4.1	10.8
Other advice	66.1	13.6	20.3	83.6	9.0	7.5	81.1	8.1	10.8
Physical activity	74.6	8.5	16.9	91.0	1.5	7.5	87.8	1.4	10.8
Emotional wellbeing	69.5	11.9	18.6	91.0	1.5	7.5	89.2	0.0	10.8
Other	28.8	30.5	40.7	14.9	46.3	38.8	21.6	44.6	33.8

(a) 'Management' includes health promotion, prevention of complications, clinical care and advocacy.

Source: AIHW, Healthy for Life data collection.

Data quality issues

Health Expenditure Data

Health expenditure data is affected by most of the reservations about data relating to Aboriginal and Torres Strait Islander peoples. The issue of poor Indigenous identification means that the attribution of expenditure to Indigenous people either on a population or per capita basis must be treated with caution. This single factor is arguably the major important data quality issue, affecting as it does nearly all health and population based measures. Reliable Indigenous status data is a major requirement to produce reliable, consistent and valid information on most aspects of Indigenous health. The "completeness of identification of Indigenous Australians varies significantly across states and territories" and in administrative health data collections (SCRGSP 2006).

Quality of data on Indigenous service use

For many publicly funded health services, there is incomplete information available about service users and, in particular, about their Indigenous status. For privately funded services, this information is frequently unavailable. For those services that do collect this information, recording Indigenous status accurately for all people does not always occur. The result is that there is some margin of error in the estimations of health expenditure for Indigenous people and their corresponding service use.

Expenditure estimates

There may be some limitations associated with the scope and definition of health expenditures included in this measure. Other (non-health) agency contributions to health expenditure, such as 'health' expenditures incurred within education departments and prisons, are not included.

In some areas of expenditure, surveys have been used to estimate service use by Indigenous people, which, in turn, have been used in the estimates of expenditure. Consequently, the reliability of the expenditure estimates is affected by sampling error.

Furthermore, although every effort has been made to ensure consistent reporting and categorisation of expenditure on health goods and services, in some cases there may be inconsistencies across data providers. These may result from limitations of financial reporting systems, and/or different reporting mechanisms (AIHW 2009).

Under-identification

Estimates of the level of Indigenous under-identification were used to adjust some reported expenditure. In some states and territories, a single state wide average under-identification adjustment factor was applied. In others, differential under-identification factors were used, depending on the region in which the particular service(s) were located. In some jurisdictions, no Indigenous under-identification adjustment was considered necessary.

Comparison with estimates for 2004–05

This indicator provides separate estimates of expenditure for health, and for health and high care residential aged care services.

This allows comparison with estimates with health and high care residential aged care expenditure in the 2004–05 report as well as presentation of estimates that relate more directly to estimates in the AIHW's Health expenditure Australia 2007–08 (AIHW 2009). There has also been a change in the method for estimating MBS and PBS expenditure.

Comparison with estimates for 2004–05 (continued)

The method involves the use of Medicare Voluntary Indigenous Identifier (VII) data to estimate expenditure on medical services. Services include general practitioner (GP), specialist, pathologist and imaging services, and prescription pharmaceuticals provided to Aboriginal and Torres Strait Islander people (see Appendix B, AIHW 2009).

This change may have contributed to the increase in estimated MBS and PBS expenditure reported in 2006–07 compared with 2004–05.This change may have contributed to the increase in estimated MBS and PBS expenditure reported in 2006–07 compared with 2004–05.

Divisions of GP Survey

The data in the Survey are self-reported by Divisions and represent estimates and answers to questions about Division activities, staffing and other matters. Validity checks are implemented as part of the data collection and cleaning processes. However, the accuracy and quality is ultimately determined by Division data collection methods and influenced by Division staff turnover and skills (Howard et al. 2009).

The administration and structure of the ASD have changed considerably since the first survey in 1993–94. Two major milestones in this process were in 2005–06, with the implementation of the National Quality & Performance System (NQPS), aligning ASD questions with the national priority areas, and the conversion of the survey from a word document to a web-based survey with online submission. Some of the advantages of the ASD are that it has been an annual, standardised, comprehensive survey with a 100% response rate.

In 2007–08, around two-thirds of questions were removed, with some new questions introduced. This resulted in a significant reduction in the ASD content and reporting requirements.

The information provided in the 2007–08 ASD report is gathered directly from Divisions. Therefore, it is important to recognise that the accuracy and quality of the self-reported data provided is largely dependent on the nature of Division administration and information systems, as well as factors such as staff turnover. However, every effort is made to enhance the quality of the data by conducting a range of data checks.

General Practitioner Data (BEACH)

Information about general practitioner encounters is available from the Bettering the Evaluation and Care of Health (BEACH) survey. The BEACH data on Indigenous Australians should be treated with care. First, the sample frame has not been designed to produce statistically significant results for population subgroups such as Indigenous Australians. Second, the identification of Indigenous Australians is not complete. In the BEACH survey, 'not stated' responses to the Indigenous identification question are often higher than the 'yes' responses. It can be assumed, therefore, that the survey consistently undercounts the number of Indigenous Australians visiting general practitioners, but the extent of this undercount is not measurable.

Community Housing and Infrastructure Needs Survey (CHINS)

The 2006 CHINS collected information on a variety of topics from discrete Aboriginal and Torres Strait Islander communities throughout Australia and on Indigenous organisations that provide rental housing to Indigenous people. In 2006, CHINS information was collected on 496 Indigenous organisations, which managed a total of 21,854 permanent dwellings. The majority of those dwellings were located in the Northern Territory (6,448), Queensland (6,230), New South Wales (4,176) and Western Australia (3,462) (ABS 2007).

The CHINS survey covers only discrete Indigenous communities. In 2006, the CHINS collected information from 1,187 discrete indigenous communities. This included approximately 92,960 Aboriginal and Torres Strait Islanders or 18% of the total Indigenous population. CHINS data is collected every 5 years. The data are collected from key personnel in Indigenous communities and housing organisations that are knowledgeable about housing and infrastructure issues.

The estimates are not subject to sampling error because the CHINS was designed as a complete enumeration of discrete Indigenous communities. However, data could not be obtained from a small number of communities. In addition, the community population was often estimated by community representatives without reference to records. Therefore, the data is subject non-sampling error.

Further information on the CHINS can be found in the publication Housing and infrastructure in Aboriginal and Torres Strait Islander communities (ABS 2007).

OATSIH Services Reporting (OSR) data collection

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

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

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

The AIHW identified three major problems with the data quality: missing data, inappropriate data provided for the question, and divergence of data from two or more questions. The majority of 2008–09 OSR questionnaires received had one or more of these data quality issues.

Further information can be found in the data quality statement in the Aboriginal and Torres Strait Islander Health Services Report, 2008–09 (AIHW 2010).

List of symbols used in tables

n.a. not available

— rounded to zero (including null cells)

0 zero

. . not applicable

n.e.c. not elsewhere classified

n.f.d. not further defined

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

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List of tables

List of figures