



# Cultural safety in health care for Indigenous Australians: monitoring framework

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Web report

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The *Cultural safety in health care for Indigenous Australians: monitoring framework* brings together available data to assess progress in achieving cultural safety in the health system for Indigenous Australians. The framework includes measures on culturally respectful health care services; Indigenous patient experience of health care; and access to health care services. The data are presented at the national, state and regional levels.

From 2013 to 2020 the number of Indigenous medical practitioners employed across Australia increased from 234 to 494

In 2018–19, 91% of Indigenous Australians in non-remote areas felt their doctor always/often respected what they said

In 2019–20, 50% of Indigenous patients waited 49 days to be admitted for elective surgery (38 days for non-Indigenous)

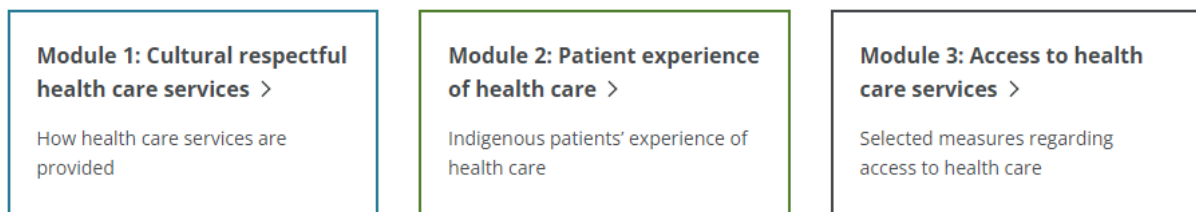
In 2018–19, among Indigenous Australians who did not access health services when needed 32% cited cultural reasons

# Summary and key findings

Improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. This means a health system that respects Indigenous cultural values, strengths and differences, and also addresses racism and inequity.

The *Cultural safety in health care for Indigenous Australians: monitoring framework* aims to measure progress in achieving cultural safety in the Australian health system. For this purpose, cultural safety is defined with reference to the experiences of Indigenous health care users, of the care they are given, their ability to access services and to raise concerns.

The cultural safety monitoring framework covers three modules:



Data are reported from a wide range of available national and state and territory level sources to provide a picture of cultural safety, though there are significant data gaps. Sources include both national administrative data collections and surveys of Indigenous health care users.

## Module 1: Culturally respectful health care services

Cultural respect is achieved when the health system is a safe environment for Indigenous Australians, and where cultural differences are respected. This module reports on how health care is provided, and whether cultural respect is reflected in structures, policies and programs.

Between 2013 to 2020:

- the rate of Indigenous medical practitioners employed in Australia increased from 234 to 494 (from 31 to 57 per 100,000)
- the number of Indigenous nurses and midwives employed in Australia increased from 2,434 to 4,610 (324 to 535 per 100,000).

Among Indigenous-specific primary health care organisations and maternal/child health services:

- 47% of full time equivalent health staff in 2020–21 were Indigenous—this proportion varied by type of health staff, with higher proportions for Aboriginal Health Practitioners/Aboriginal Health Workers (98%) and other health workers (55%) and lower proportions for GPs (5%) and nurses and midwives (15%).
- 40% provided interpreter services, while around one third offered culturally appropriate services such as bush tucker, bush medicine and traditional healing in 2017–18.

## Module 2: Patient experience of health care

The experiences of Aboriginal and Torres Strait Islander health care users, including having their cultural identity respected, is critical for assessing cultural safety. Aspects of cultural safety include good communication, respectful treatment, empowerment in decision making and the inclusion of family members.

- In 2018–19, 91% of Indigenous Australians aged 15 and over in non-remote areas reported that doctors always/often showed respect for what was said

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- In 2018–19, of the 243,663 Indigenous Australians who did not access health services when they needed to, 32% indicated this was due to cultural reasons, such as language problems, discrimination and cultural appropriateness.
- In 2020, 22% of Indigenous Australian adults or their families reported being racially discriminated against by doctors, nurses and/or medical staff in the last 12 months.

The differences in rates of Indigenous and non-Indigenous hospital patients who choose to leave prior to commencing or completing treatment are frequently used as indirect measures of cultural safety. In relation to admitted patient hospitalisations, Indigenous Australians were discharged against medical advice for 3.9% of hospitalisations in 2018–20. Based on age standardised rates, Indigenous patients were discharged against medical advice at over 5 times the rate of non-Indigenous Australians.

### **Module 3: Access to health care services**

Aboriginal and Torres Strait Islander people do not always have the same level of access to health services as non-Indigenous Australians. Disparities in use of health services may indicate problems with access to health services due to affordability, cultural safety, distance travelled especially in remote and very remote areas, and previous experiences of racism in health care environments for themselves, family or community members and fear of how they will be treated.

Selected measures of access to health care services for Indigenous and non-Indigenous Australians are used to monitor disparities in access.

- In the two-year period 2018–2019, 27% of Indigenous women aged 40 and over received a free mammogram through BreastScreen Australia. Based on age-standardised rates, 26% of Indigenous women aged 40 and above received a mammogram, compared with 34% of non-Indigenous women.
- Indigenous Australians waited longer to be admitted for elective surgery in 2019–20 than non-Indigenous Australians—50% of Indigenous patients were admitted for elective surgery within 49 days, compared with 38 days for non-Indigenous patients.
- In 2019, the potentially avoidable mortality rate for Indigenous Australians was 222 per 100,000. The Indigenous age-standardised rate was over 3 times that for non-Indigenous Australians (323 and 98 per 100,000 respectively).

### **Data gaps**

Monitoring cultural safety and cultural respect in the health system, and the impact it has on access to appropriate health care, are limited by a lack of national and state level data. This is particularly the case in relation to reporting on the policies and practices of mainstream health services, such as primary health care services and hospitals.

There is also limited data on the experiences of Indigenous health care users. Most jurisdictions undertake surveys about patients' experiences in public hospitals, but there is not a lot of available data on Indigenous patient experience. A high proportion of Indigenous Australians use mainstream health services, so further data developments in this area are required to allow for more comprehensive reporting across the health sector.

Additionally, the ABS Indigenous health and social surveys, for example, the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018–19 and the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) 2014–15, are national surveys to collect cultural safety information/patient experience. Both surveys contain questions relevant to patient

experience and cultural safety. However, the infrequent data collection (around 5–6 years or more) do not allow for timely update of data for the monitoring framework.

This report brings together data from a wide range of sources. All the data presented in this monitoring framework are available in Excel format under <Data>. The Excel tables also include all relevant footnotes, technical details and individual data sources.

## Impacts of COVID-19 on data

Since the beginning of the COVID-19 pandemic protecting the health, safety and wellbeing of Indigenous Australians has been a key national priority. However, there has been ongoing recognition that the changes to the health system and the restrictions and lockdowns necessary to prevent the spread of COVID-19 may have affected the need for, and use of, a broad range of health services by Indigenous Australians. This update presents data, where available, spanning the COVID-19 pandemic in Australia.

Specific impacts on the data are discussed in relation to relevant measures however, the full impact of COVID-19 may become apparent in the data for other measures in future years.

Impacts of COVID-19 on data used in this report are also explored in the AIHW reports:

- Indigenous specific health checks — [Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023](#)
- [Impact of COVID-19 on 2019–20 Elective surgery activity](#)
- [Impact of COVID-19 on 2019–20 Emergency department activity](#)
- Admitted patient care activity — forthcoming (July 2021)

For data and information that relate to COVID-19, please see the [AIHW's COVID-19 resources](#).

# Monitoring framework

The *Cultural safety in health care for Indigenous Australians: monitoring framework* is structured around three modules: Module 1 – Culturally respectful health care services; Module 2 – Patient experience of health care; and Module 3 – Access to health care services. Each of the three modules contains a number of domains, focus areas and measures, with the following structure:

**Module → domain → focus area → measure**

The three modules look at different dimensions of cultural safety—how health care is provided, experienced and accessed. The domains are topics within the modules; focus areas look at specific issues in the domains; and measures describe the data presented in the focus areas.

The modules and their domains are set out below.

## Module 1: Culturally respectful health care services >

- Organisational approach and commitment
- Communication and cultural services
- Workforce development and training
- Consumer engagement and stakeholder collaboration

## Module 2: Patient experience of health care >

- Communication
- Treated respectfully
- Unfair treatment and cultural barriers
- Empowerment
- Family inclusion
- Leave events

## Module 3: Access to health care services >

- Preventive health services
- Primary health care
- Hospital services
- Specialist services
- Overall health system

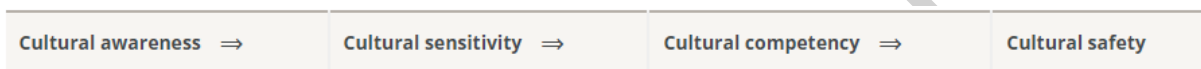
## Origin and policy context

The concept of cultural safety has been around for some time, with the notion originally defined and applied in the cultural context of New Zealand. It originated there in response to the harmful effects of colonisation and the ongoing legacy of colonisation on the health and healthcare of Maori people—in particular in mainstream health care services.

A commonly accepted definition of cultural safety from the Nursing Council of New Zealand (2005: 7) is the 'effective nursing practice of a person or family from another culture, and is determined by that person or family... Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.'

A distinctive feature of this definition of cultural safety is its emphasis on the provision of culturally safe health care services as defined by the end users of those services, notably, the Maori people of Aotearoa New Zealand, not by the (non-Maori) providers of care.

The National Collaboration Centre for Indigenous Health in Canada (2013) notes that culturally safe health care systems and environments are established by a continuum of building blocks:



The centre states that cultural safety '...requires practitioners to be aware of their own cultural values, beliefs, attitudes and outlooks that consciously or unconsciously affect their behaviours. Certain behaviours can intentionally or unintentionally cause clients to feel accepted and safe, or rejected and unsafe. Additionally cultural safety is a systemic outcome that requires organizations to review and reflect on their own policies, procedures, and practices in order to remove barriers to appropriate care.'

In Australia, there has been increasing recognition that improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. This means a health system where Indigenous cultural values, strengths and differences are respected; and racism and inequity is addressed.

There are difficulties in both defining and measuring generalised concepts such as cultural respect and cultural safety. They include lack of conceptual clarity and agreement on terms, the qualitative nature of the concepts, and the diversity of Indigenous Australians and their perceptions. The Australian literature uses various definitions of cultural safety, and related concepts such as cultural respect and cultural competency, and what these mean in relation to the provision of health care.

For the purpose of developing a monitoring framework, cultural safety is defined with reference to the experience of the Indigenous health care consumer, of the care they are given, their ability to access services and to raise concerns. Some of the essential features of cultural safety include an understanding of one's culture; an acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of this difference; and the ability to recognise, address and prevent racism. The presence or absence of cultural safety is determined by the experience of the recipient of care and is not defined by the caregiver (AHMAC 2016).

Two important aspects of culturally safe health care across the literature are, how it is *provided* and how it is *experienced*, and these form the basis for the monitoring framework (see AHMAC 2016; CATSINAM 2014; AIDA 2017; DHHS 2016; NACCHO 2011; Department of Health 2015).

#### **How health care is *provided***

- behaviour, attitude and culture of providers: respects and understands Indigenous culture and people
- defined with reference to the provision of care, including governance structures, policies and practices
- providers' ability to recognise, address and prevent racism at the individual and organisational levels.

#### **How health care is *experienced* by Indigenous people**

- feeling safe, connected to culture and cultural identity is respected
- can only be defined by those who receive health care.

The importance of cultural respect and cultural safety is outlined in Australian government documents such as the:

- [Cultural Respect Framework 2016–26 for Aboriginal and Torres Strait Islander Health](#)
- and the new [National Aboriginal and Torres Strait Islander Health Plan 2021–2031](#).

The new health plan was developed in genuine partnership with Aboriginal and Torres Strait Islander people and reflects their key priorities and recognises the influence of social factors and the strengths of culture as protective factors on physical, social and emotional wellbeing.

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) also included six Aboriginal and Torres Strait Islander specific actions in the [National Safety and Quality Health Service Standards](#) to improve care for Aboriginal and Torres Strait Islander people in mainstream health services.

## **Development of a monitoring framework**

The *Cultural safety in health care for Indigenous Australians: monitoring framework* aims to measure progress in achieving cultural safety in the Australian health system by bringing together data related to cultural safety. Specifically, to measure progress in achieving cultural safety in the health system under the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–23*. The framework can also assist in measuring progress in achieving cultural safety under the Cultural Respect Framework which commits the Commonwealth Government, and states and territories, to embed cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services.

The release of the 2020–2031 [National Agreement on Closing the Gap](#) necessitated revisions to the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, in order for the Health Plan to be aligned with the objectives and timeframes of the National Agreement. Following the release of the [National Aboriginal and Torres Strait Islander Health Plan 2021–2031](#) the Implementation Plan will be revised and a new accountability framework will be created.

In consultation with key stakeholders, including the former National Aboriginal and Torres Strait Islander Health Standing Committee and the Implementation Plan Advisory Group, this monitoring framework was developed through a review of relevant policy documents, academic literature, and potential national and state level data sources.

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The framework has 3 reporting modules which each include a range of measures focussing on culturally respectful health care services, patient experience of health care among Indigenous Australians, and access to health care as an indirect measure of cultural safety.



## Reporting against the framework

This monitoring framework brings together available national and state and territory level data to provide a picture of cultural safety in the health system. The scope of national and state and territory level data currently available are limited and further development is required to enable more comprehensive reporting. For more detail see information about data gaps in [Module 1: Culturally respectful health care services](#), [Module 2: Patient experience of health care](#), and [Module 3: Access to health care services](#).

Monitoring cultural safety and cultural respect in the health system, and the impact it has on access to appropriate health care, are limited by a lack of national and state level data. This is particularly the case in relation to reporting on the policies and practices of mainstream health services, such as primary health care services.

There are also limited data on the experiences of Indigenous health care users. Most jurisdictions undertake patient experience surveys in public hospitals, but there is little data on Indigenous Australians for reporting. A high proportion of Indigenous Australians use mainstream health services, so further data developments in this area are required to allow for more comprehensive reporting across the health sector.

As data developments occur and more comprehensive data become available, the cultural safety monitoring framework will be expanded and updated.

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## Relevant data developments

Data development for cultural safety measures are ongoing. There are also research and developments in measurement of areas related to cultural safety, such as wellbeing and quality of life.

One such project is the [What Matters 2 Adults study](#), which aims to develop a new instrument to measure and value wellbeing dimensions that are important to Indigenous Australians.

Another example is the [Mayi Kuwayu study](#), a national longitudinal survey of Indigenous Australians aged 16 years and above. It began in 2018, and could provide relevant data on cultural safety in the future. This survey, which was created by and for Indigenous people, focusses on the importance of culture and how it affects wellbeing, and includes a module on discrimination and racism in health care. Initial results from the study and the validity of the instrument used to measure discrimination in health care experienced by Indigenous Australians are discussed in the paper, [Developing and validating measures of self-reported everyday and healthcare discrimination for Aboriginal and Torres Strait Islander adults](#).

There have been a [number of publications released by the Mayi Kuwayu team](#), and they will be linked to in the relevant domains within the monitoring framework.

Indigenous patients' experiences of health care could be reported through Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) surveys. The collection of patient reported data through standardised PREMs and PROMs for Indigenous health care users' needs to consider the cultural adaptability of these tools and development work is underway to address this at hospital and primary health care service level.

## References

Australian Health Ministers' Advisory Council (AHMAC) 2016. [Cultural Respect Framework 2016–26 for Aboriginal and Torres Strait Islander Health: a national approach to building a culturally respectful health system](#). Canberra: AHMAC.

Australian Indigenous Doctors' Association (AIDA) 2017. [Position Paper: Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients](#). Canberra: AIDA.

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) 2014. [Towards a shared understanding of terms and concepts: Strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander peoples](#). Canberra: CATSINaM.

Department of Health 2013. [National Aboriginal and Torres Strait Islander Health Plan 2013–2023](#). Canberra: Department of Health.

Department of Health 2015. [Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023](#). Canberra: Department of Health.

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Howard K, Anderson A, Cunningham J, Cass A, Ratcliffe J, Whop LJ et al 2020. [What Matters 2 Adults: a study protocol to develop a new preference-based wellbeing measure with Aboriginal and Torres Strait Islander adults \(WM2Adults\)](#). BMC Public Health 20: 1739.

Johnstone M-J & Kanitsaki O 2007. [An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context](#). Journal of Transcultural Nursing, 18(3) 247–256. DOI: 10.1177/1043659607301304.

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National Aboriginal Community Controlled Health Organisation (NACCHO) 2011. [Creating the NACCHO Cultural Safety Training Standards and Assessment Process: A background paper](#). Canberra: NACCHO.

National Collaborating Centre for Indigenous Health (NCCIH) 2013. [Towards Cultural Safety for Métis: An Introduction for Health Care Providers](#). Canada: University of Northern British Columbia.

Nursing Council of New Zealand 2005. [Guidelines for cultural safety, the treaty of Waitangi, and Maori health in nursing and midwifery education and practice](#). Wellington: Nursing Council of New Zealand.

Thurber KA, Walker J, Batterham PJ, Gee GC, Chapman J, Priest N et al. [Developing and validating measures of self-reported everyday and healthcare discrimination for Aboriginal and Torres Strait Islander adults](#). *International Journal of Equity in Health* 10: 14.

Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute 2017. [National Safety and Quality Health Service Standards: user guide for Aboriginal and Torres Strait Islander health](#). Sydney: Australian Commission on Safety and Quality in Health Care.

## Module 1: Culturally respectful health care services

The structures, policies and processes across the health system all play a role in delivering culturally respectful health care. The provision of culturally safe health care for Aboriginal and Torres Strait Islander people reflects the extent to which health care systems and providers are aware of and responsive to Indigenous Australians' cultural needs and experiences. Cultural safety cannot be improved in isolation from the provision of health care.

### What data are available?

Reporting in this module is limited by a lack of national, state and territory, and small area level data. The main information source is the Online Services Report (OSR), a data collection from organisations funded by the Australian Government to deliver health services to Aboriginal and Torres Strait Islander people under the Indigenous Australians' Health Programme. The OSR includes organisations providing comprehensive primary care services and organisations providing maternal and child health programs and services. Mainstream services are not included in the OSR data.

National data are also reported on Indigenous Australians enrolled in health related training courses and those employed across the health system, including GPs, nurses and some specialist doctors. The Indigenous workforce is integral to ensuring that the health system addresses the health needs of Indigenous Australians in a culturally safe and sensitive way.

For further information on the data sources used in this module, see [Module 1 – Data sources and data gaps](#).

## Key findings

Among the Indigenous-specific primary health care organisations and maternal/child health services reporting to the OSR:

- 47% of full time equivalent health staff in 2020–21 were Indigenous—this proportion varied by type of health staff, with higher proportions for Aboriginal Health Practitioners/Aboriginal Health Workers (98%) and other health workers (55%) and lower proportions for GPs (5%) and nurses and midwives (15%).
- 40% provided interpreter services, while around one third offered culturally appropriate services such as bush tucker, bush medicine and traditional healing in 2017–18.

National health workforce data show that in Australia from 2013 to 2020, the number of Indigenous:

- medical practitioners employed increased from 234 to 494
- nurses and midwives employed increased from 2,434 to 4,610.

Higher education statistics from the Department of Education show that from 2001 to 2020, the rate of enrolment in health-related course for Indigenous students increased from 26.9 per 10,000 to 70.1 per 10,000.

See [Module 1 data tables](#) for all data presented in this module.

## Data gaps and limitations

Following the 2017–18 reporting period, the OSR collection was streamlined and specific data items on cultural safety are currently not collected.

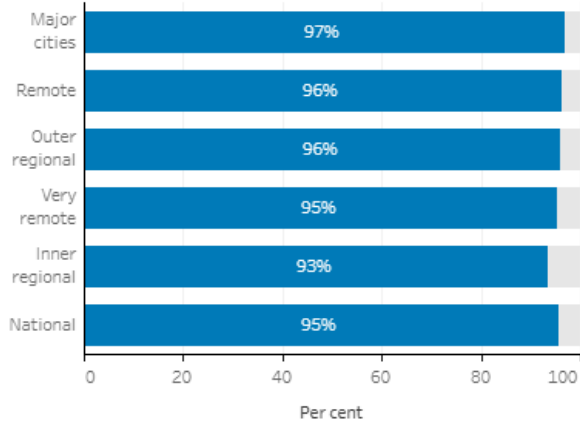
Data on cultural safety in mainstream health services, such as public hospitals and general practitioners, are a key data gap. Data on these services are required to provide a more comprehensive picture of culturally respectful health care for Indigenous Australians.

### 1.1 Organisational approach and commitment

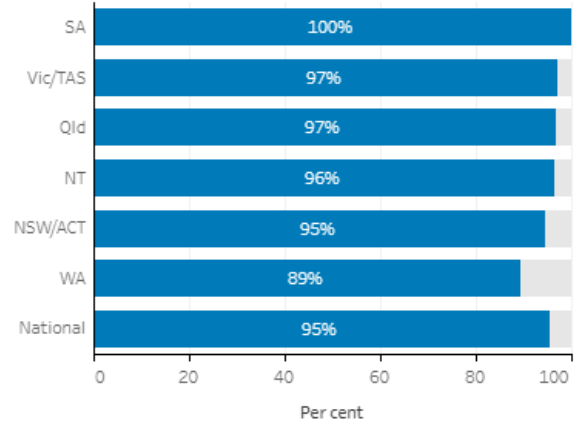
An organisational approach and commitment to providing culturally respectful and safe health care at the highest level is necessary but not sufficient to ensure care is culturally safe. Aboriginal and Torres Strait Islander leadership at the board or executive level is an indicator that services are culturally aware and respectful. Data on these measures are provided from organisations funded to deliver comprehensive primary health care and/or maternal and child health services to Indigenous Australians. Data on Indigenous leadership at the board/executive level are available for 2020–21, whilst the remainder of data on organisational approach and commitment available from the OSR collection are from 2017–18.

## Organisational commitment to culturally respectful and safe healthcare

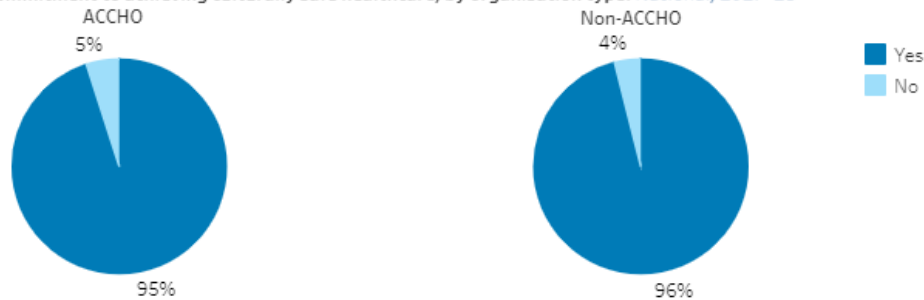
Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a formal organisational commitment to achieving culturally safe healthcare, by remoteness: National, 2017-18



Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a formal organisational commitment to achieving culturally safe healthcare, by state: National, 2017-18

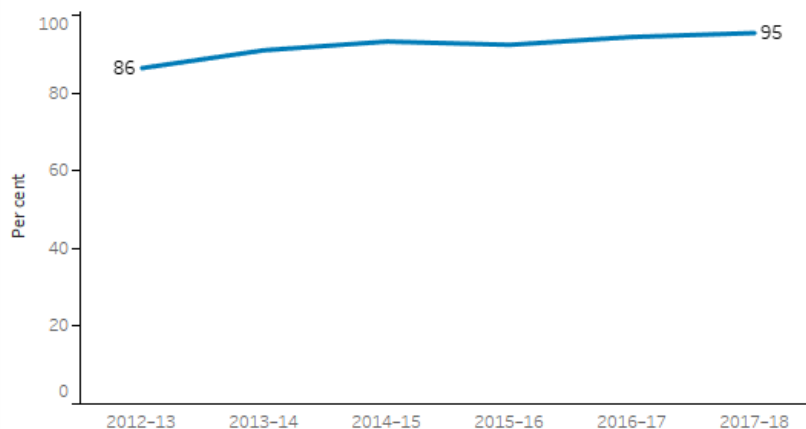


Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a formal organisational commitment to achieving culturally safe healthcare, by organisation type: National, 2017-18



Note: Aboriginal Community Controlled Health Organisations (ACCHOs) are primary 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. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.

Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a formal organisational commitment to achieving culturally safe healthcare: National, 2012-13 to 2017-18

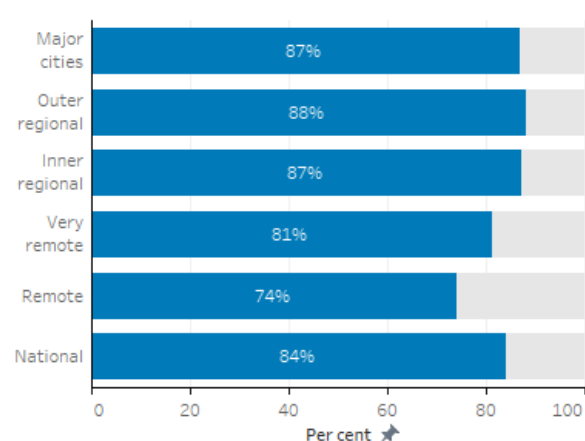


The proportion of organisations reporting to the OSR with a commitment to achieving culturally safe health care was **95% in 2017-18**, an increase from **86% in 2012-13**

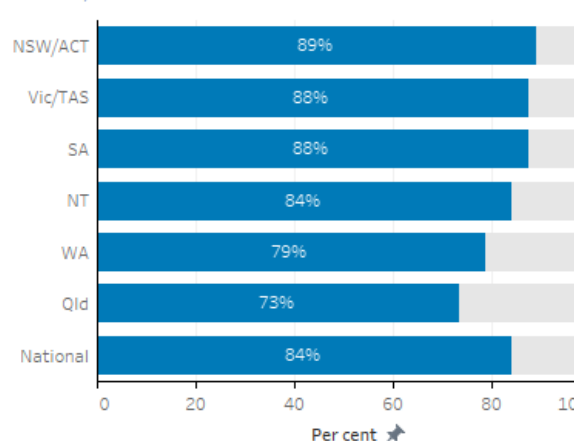
Source: Online Services Report, 2012-13 to 2017-18, unpublished (Table 1.1.1a).

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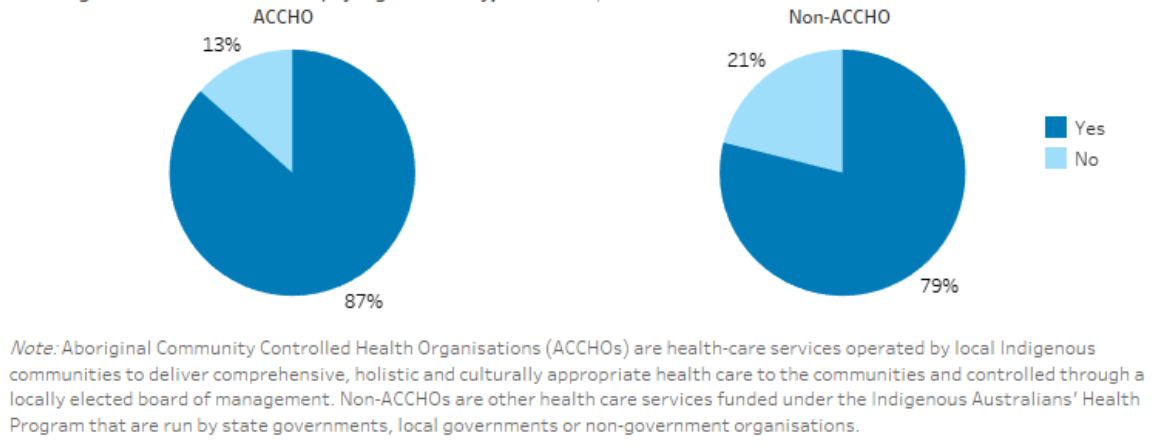
Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a mechanism for obtaining advice on cultural matters, by remoteness: National, 2017-18



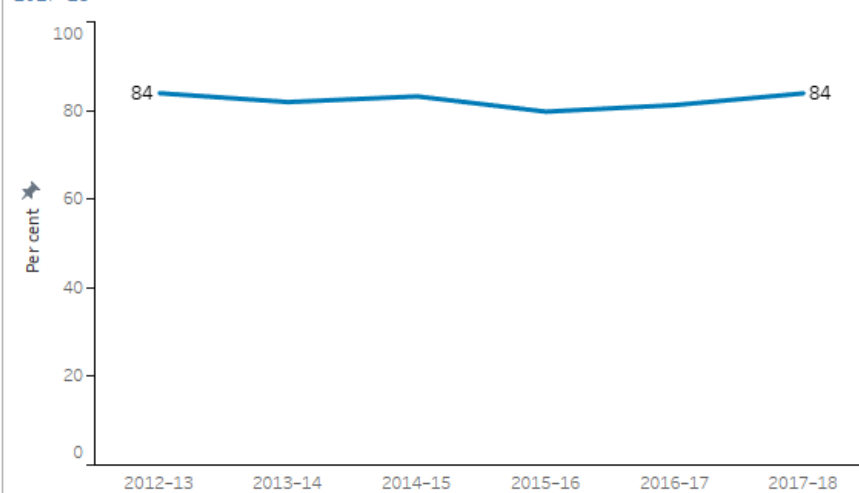
Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a mechanism for obtaining advice on cultural matters, by state and territory: National, 2017-18



Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a mechanism for obtaining advice on cultural matters, by organisation type: National, 2017-18



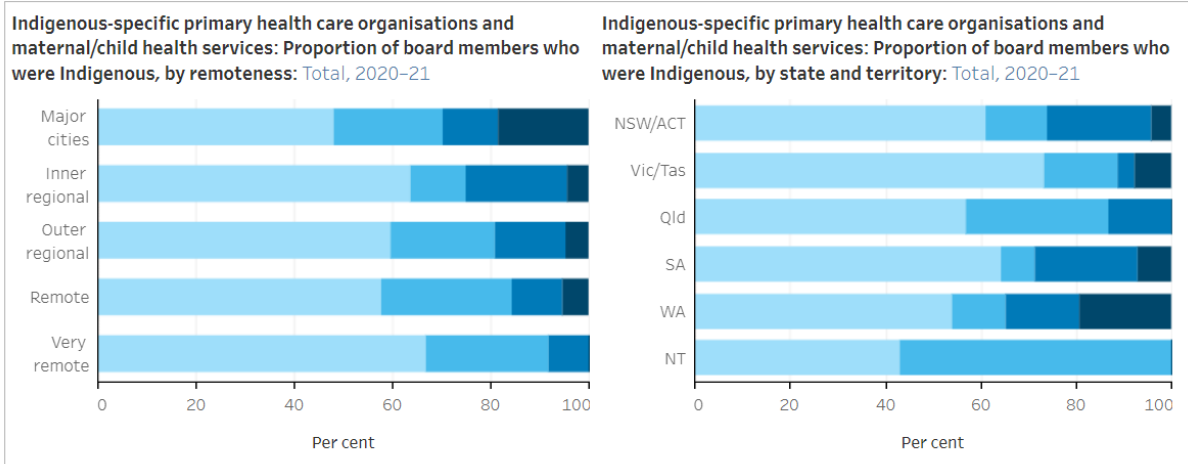
Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had a mechanism for obtaining advice on cultural matters: National, 2012-13 to 2017-18



**8 out of 10** organisations reporting to the OSR had mechanisms for obtaining advice on cultural matters

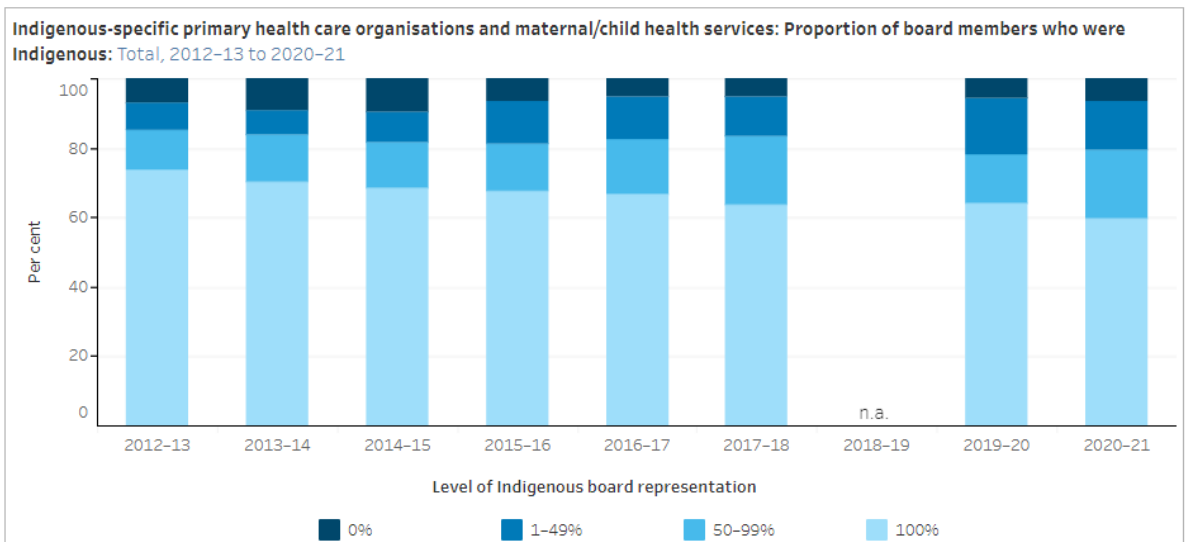
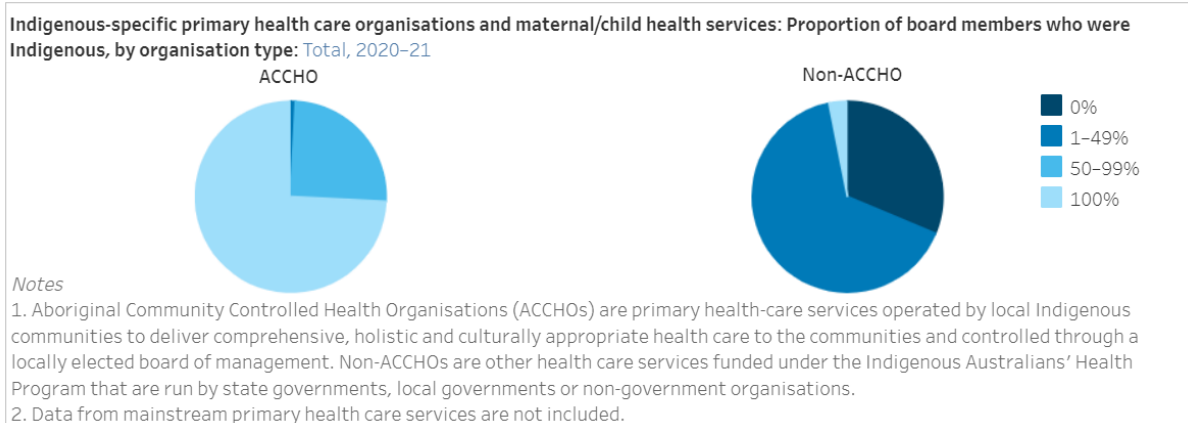
Source: Online Services Report, 2012-13 to 2017-18, previously unpublished (Table 1.1.1b).

## Aboriginal and Torres Strait Islander leadership at Board/Executive level



Level of Indigenous board representation: 100% (light blue), 50-99% (medium blue), 1-49% (dark blue), 0% (black)

Note: Data from mainstream primary health care services are not included.



n.a. = data not available for this year.

Note: Data from mainstream primary health care services are not included.

Source: Online Services Report, 2012-13 to 2020-21, previously unpublished (see data tables for Module 1 – Table 1.1.2).

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## 1.2 Communication and cultural services

Health service environments that value Aboriginal and Torres Strait Islander culture by displaying Indigenous artwork and providing culturally appropriate resources, communications and other services can help to make Indigenous people feel culturally safe.

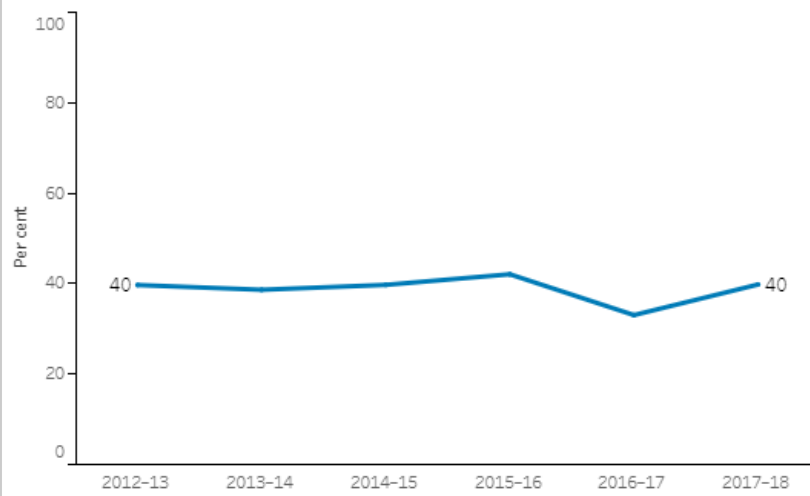
There are some data on communication and cultural services from organisations funded to provide comprehensive primary health care and maternal and/or child health services to Indigenous Australians. The latest data available from the OSR collection on communication and cultural services are from 2017–18.

### Culturally appropriate communication resources





Indigenous-specific primary health care organisations and maternal/child health services: Proportion that provided interpreter services: National, 2012-13 to 2017-18



**Half or more** organisations reporting to the OSR provided interpreters in **Western Australia** and the **Northern Territory**

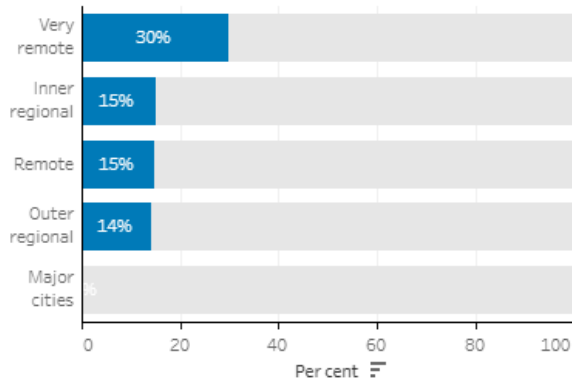
Source: Online Services Report, 2012-13 to 2017-18, previously unpublished (Table 1.2.1).

## Offers culturally appropriate services

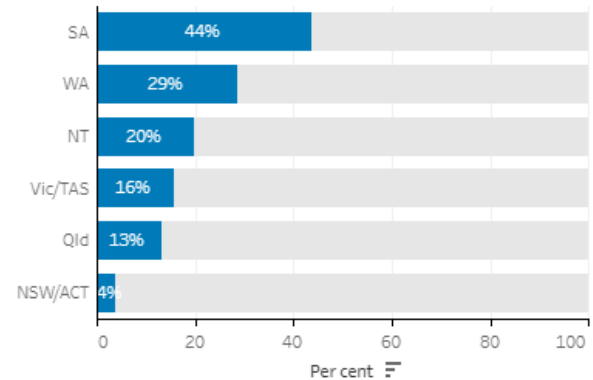
Choose service type:

Bush medicine

Indigenous-specific primary health care organisations and maternal/child health services: Proportion offering bush medicine programs, by remoteness: National, 2017-18



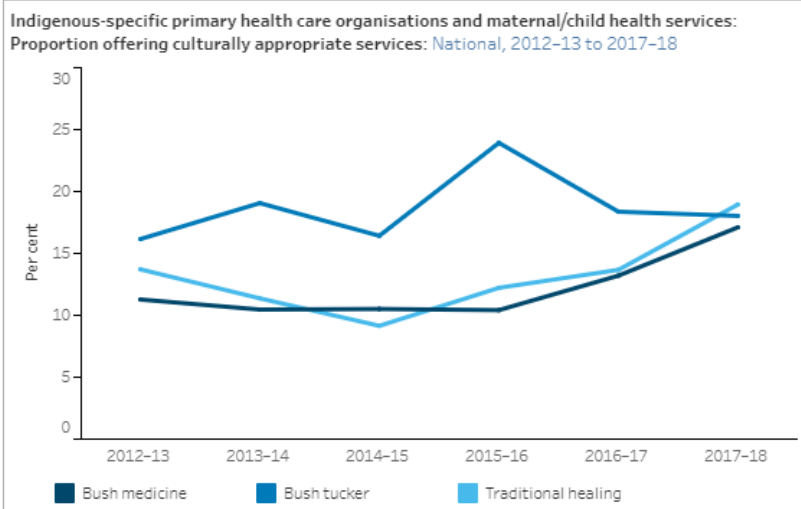
Indigenous-specific primary health care organisations and maternal/child health services: Proportion offering bush medicine programs, by state or territory: National, 2017-18



Indigenous-specific primary health care organisations and maternal/child health services: Proportion offering bush medicine programs, by service type: National, 2017-18



Note: Aboriginal Community Controlled Health Organisations (ACCHOs) are primary 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. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.



More than **one quarter** of organisations reporting to the OSR in **very remote** areas provided **bush tucker programs**

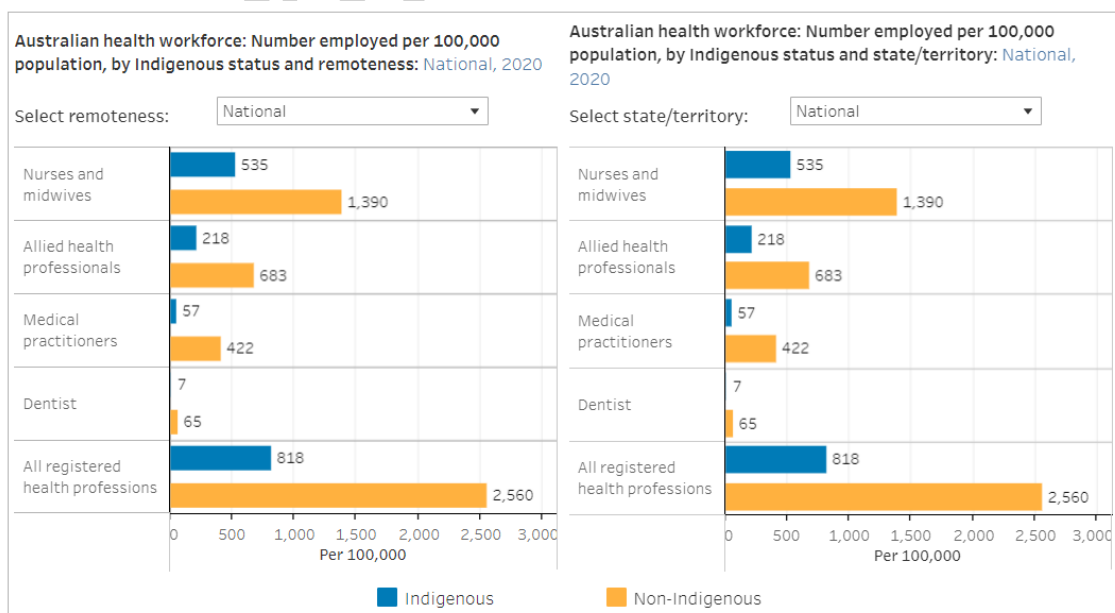
Source: Online Services Report, 2012-13 to 2017-18, previously unpublished (Table 1.2.2).

The Mayi Kuwayu team published a paper showing that a culturally modified measure of psychological distress (created in partnership with Indigenous focus groups) can decrease misunderstanding and be more culturally appropriate, and in this way, more accurately identify Indigenous people who need clinical support.

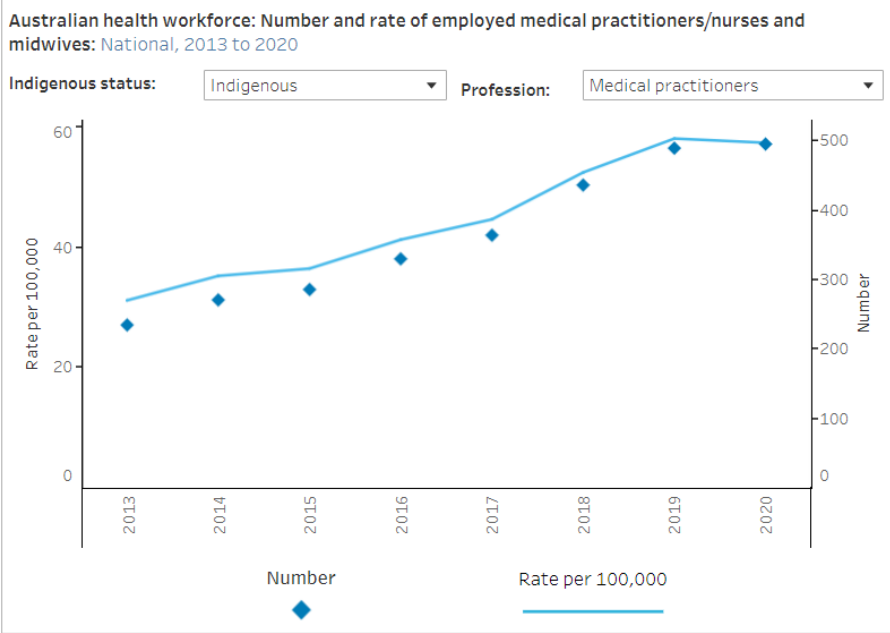
### 1.3 Workforce development and training

Aboriginal and Torres Strait Islander employees in the health workforce can increase the cultural safety of Indigenous patients because they understand the needs and priorities of Indigenous patients. National data are available on Indigenous enrolments in health related courses and Indigenous participation in the health workforce for 2020. Data on the health workforce and on cultural safety training among non-Indigenous staff are also available from organisations funded to provide comprehensive primary health care and/or maternal and child health services to Indigenous Australians with the latest data available from the OSR collection from 2017-18.

### Aboriginal and Torres Strait Islander participation in the workforce

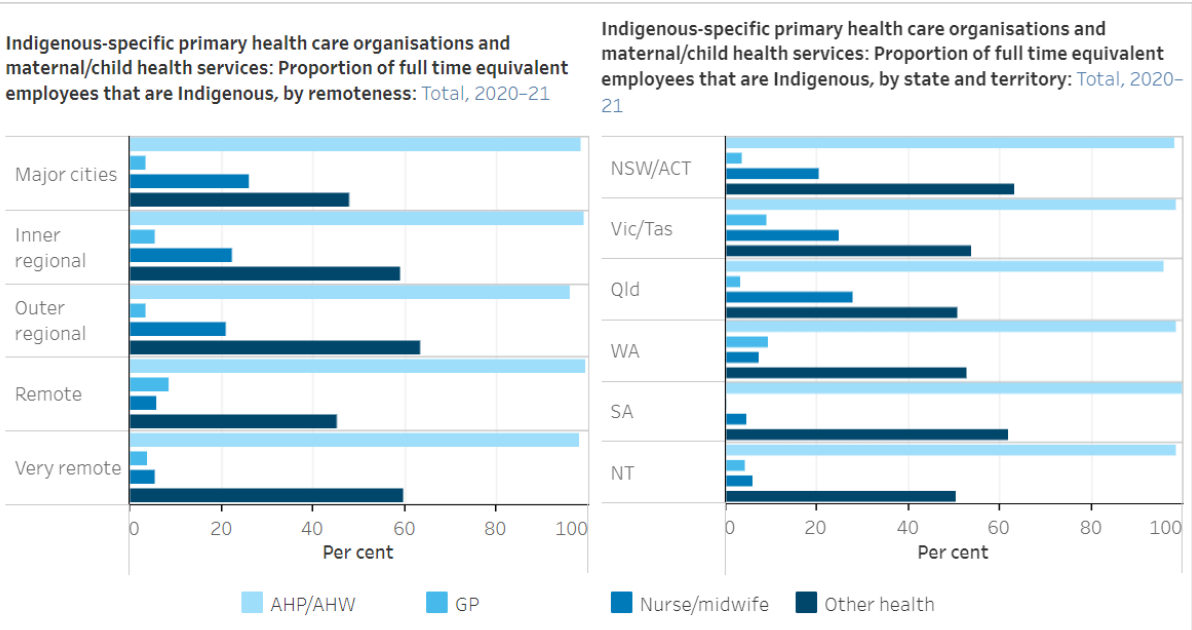


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From 2013 to 2020 the number of Indigenous Australian medical practitioners increased from **234 to 494**

Source: AIHW analysis of National Health Workforce Data Set, as published in Health 2021 (see data tables for Module 1 – Table 1.3.1a).

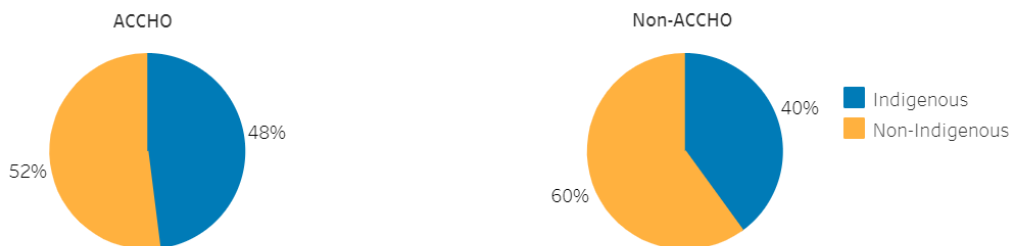


Note: Data from mainstream primary health care services are not included.

**Indigenous-specific primary health care organisations and maternal/child health services: Proportion of full time equivalent employees that are Indigenous, by organisation type: Total, 2020-21**

Select profession:

All health



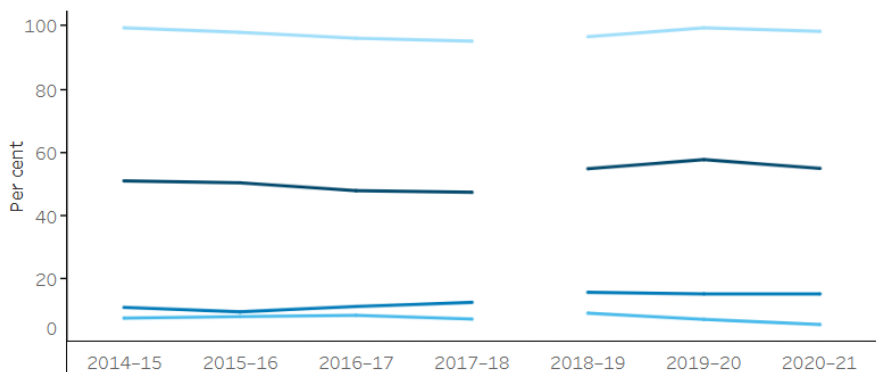
**Notes**

1. Aboriginal Community Controlled Health Organisations (ACCHOs) are primary 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. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.
2. Data from mainstream primary health care services are not included.

**Indigenous-specific primary health care organisations and maternal/child health services: Proportion of the workforce that is Indigenous: Total, 2014-15 to 2020-21**

View data by:

By type of health staff



**Notes**

1. Break in series for 2018-19 data, which no longer include visiting health professionals (due to changes in Online Services Report data collection).
2. Data from mainstream primary health care services are not included.



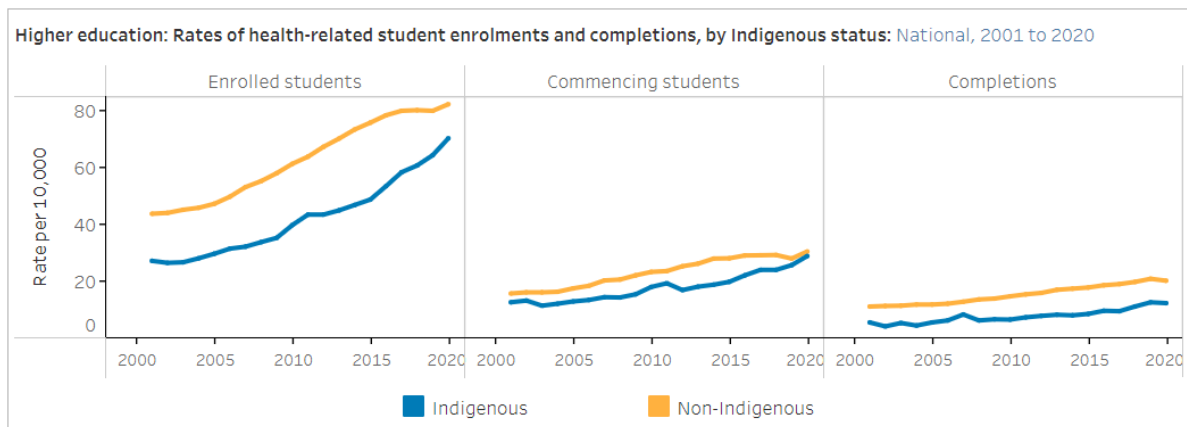
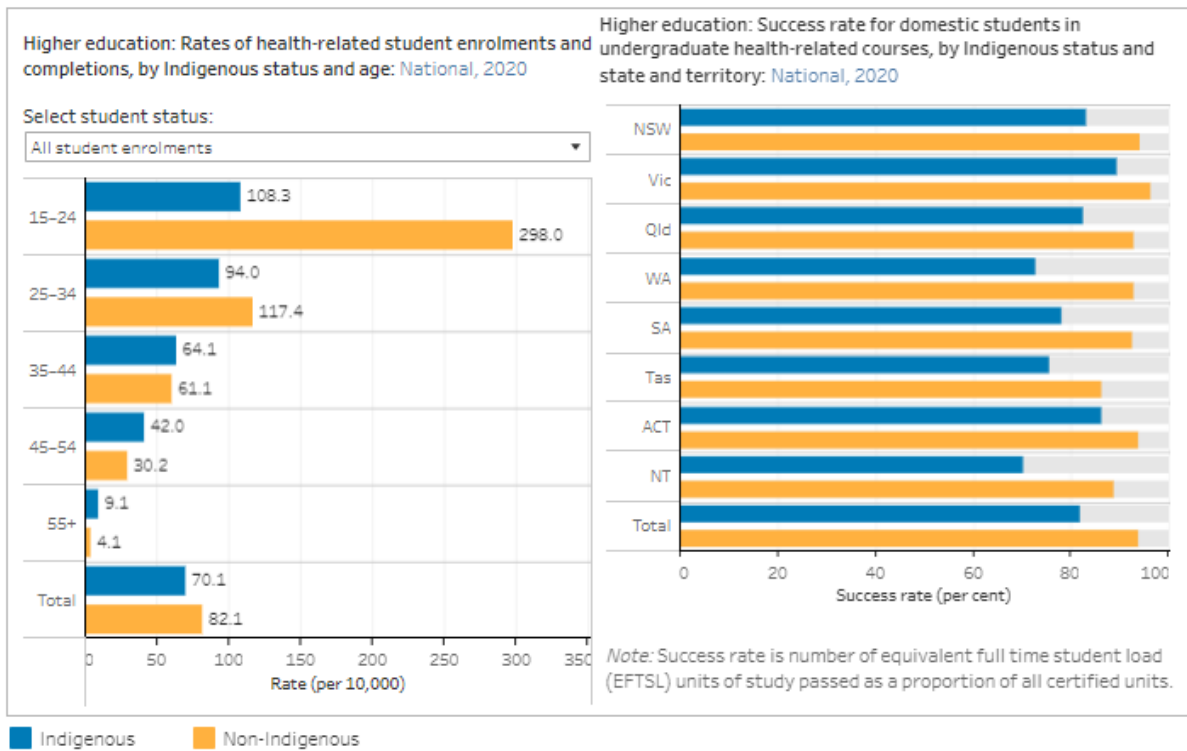
AHP/AHW = Aboriginal and Torres Strait Islander health workers and practitioners.

Source: Online Services Report, 2012-13 to 2020-21, previously unpublished (see data tables for Module 1 – Table 1.3.1b, 1.3.1c).

In 2020-21 **almost half** of full time equivalent employees in organisations reporting to the OSR were Indigenous

The Mayi Kuwayu team published a paper further describing trends in the Indigenous health workforce using ABS Census data from 2006, 2011 and 2016. For more information on, see [A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006-2016](#).

## Aboriginal and Torres Strait Islander workforce development



Source: Department of Education Higher Education Statistics (see data tables for Module 1 – Tables 1.3.2a, 1.3.2b).

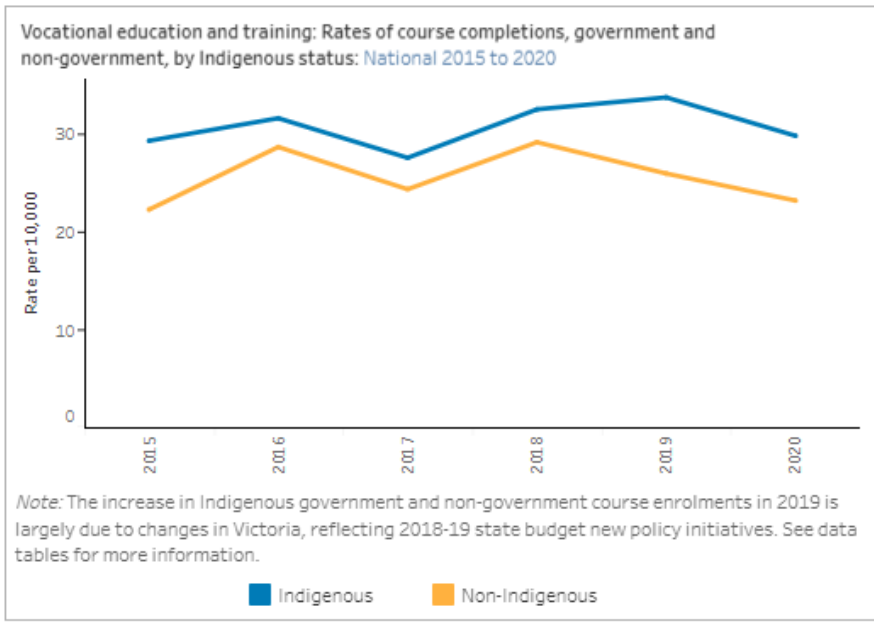
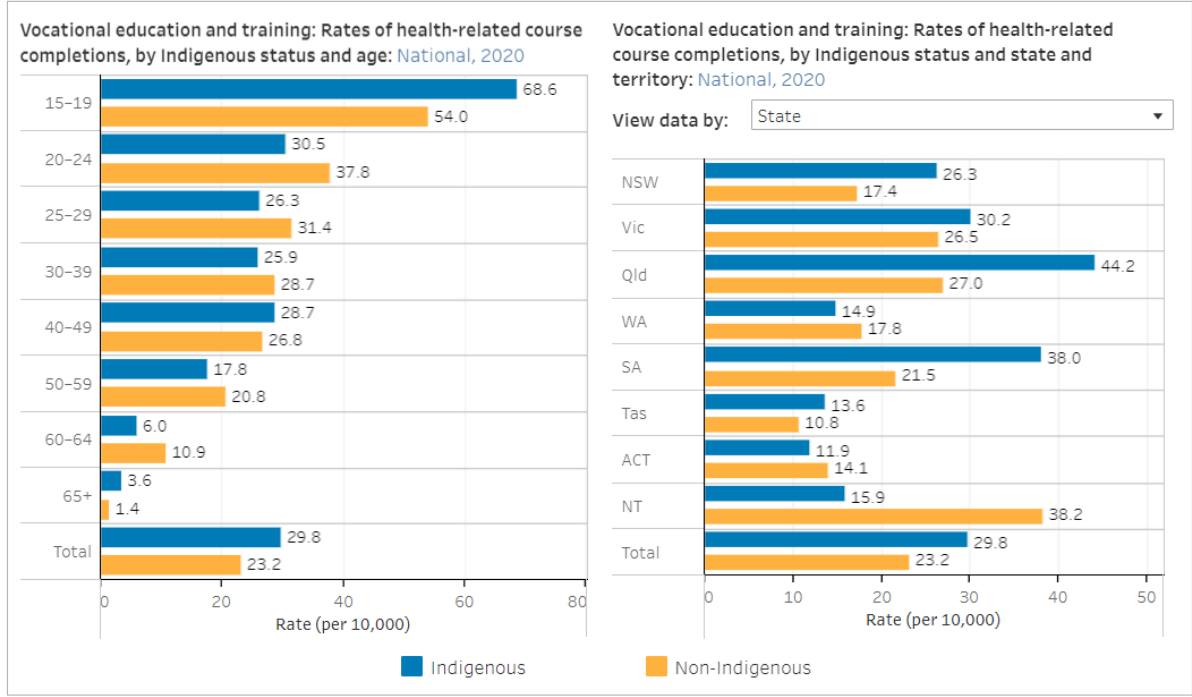
AI

Choose student status:

Course completions

Choose type of training:

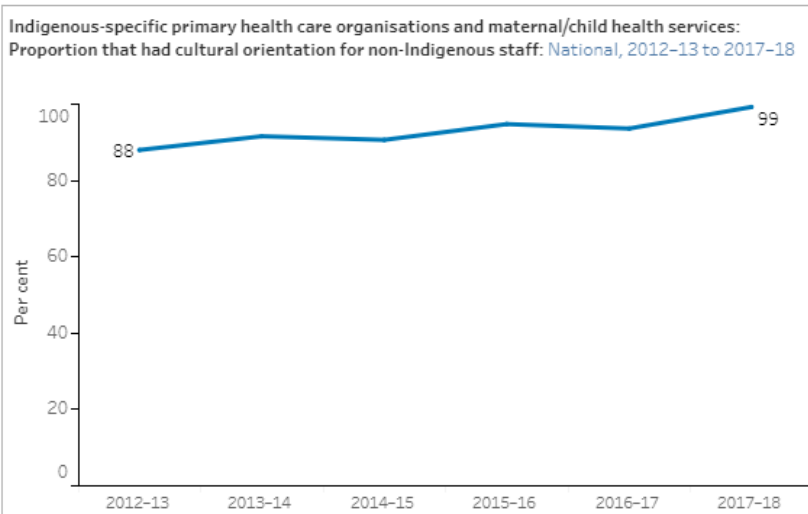
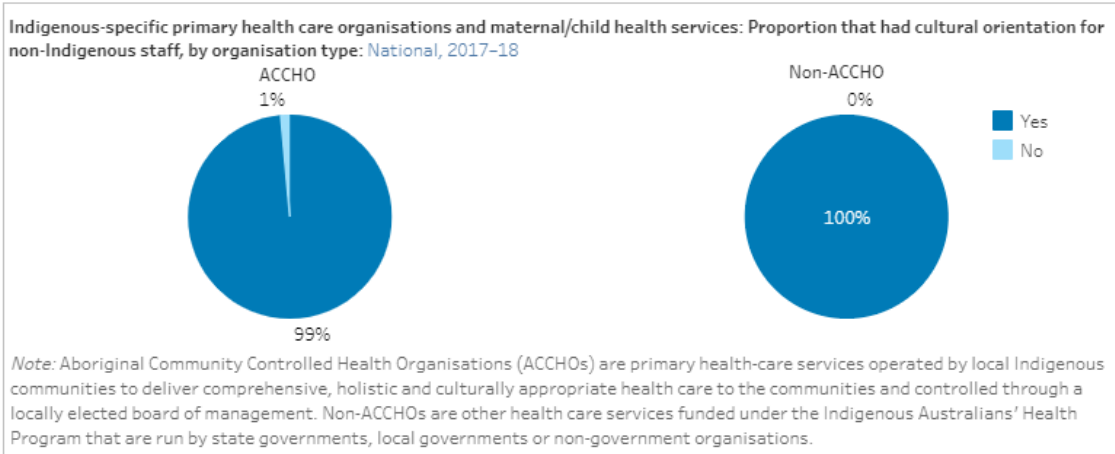
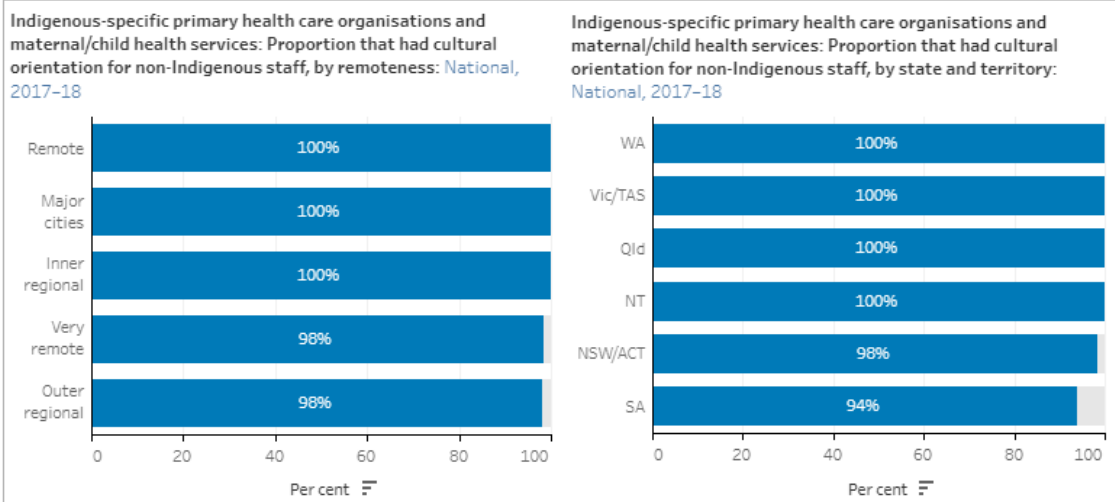
Government and non-government



**Indigenous Australians were more than twice as likely to be enrolled in health-related vocational education and training than non-Indigenous Australians**

Source: AIHW analysis of National Vocational Education and Training Provider Collection, as published in NCVER 2021 (see data tables for Module 1 - Tables 1.3.2c, 1.3.2d).

## Cultural safety and responsiveness training for staff



In 2017-18 **almost all** organisations reporting to the OSR provided **cultural orientation** for non-Indigenous staff

Source: Online Services Report, 2012-13 to 2017-18, previously unpublished (Table 1.3.3).

## References

- Department of Health (Health) 2021. [Health Workforce Data](#). Viewed 2 December 2021.
- National Centre for Vocational Education Research (NCVER) 2021. VOCSTATS. Adelaide: NCVR.

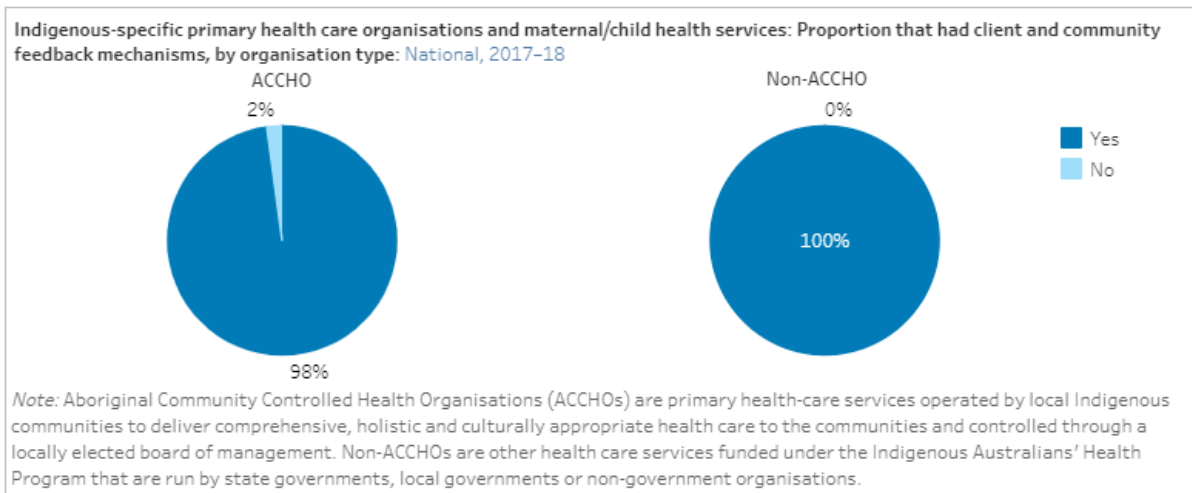
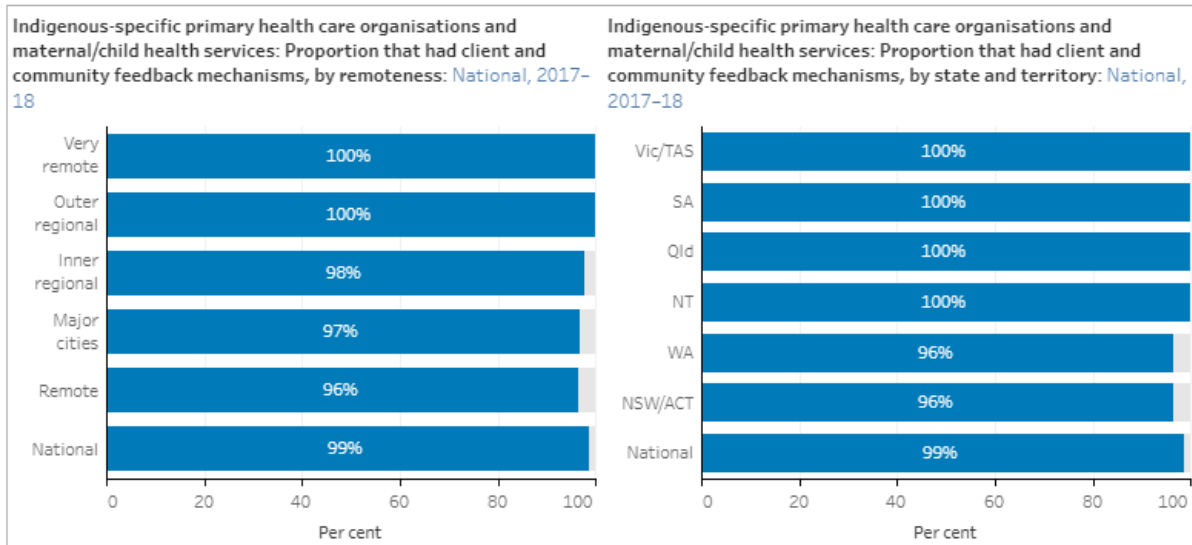
Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



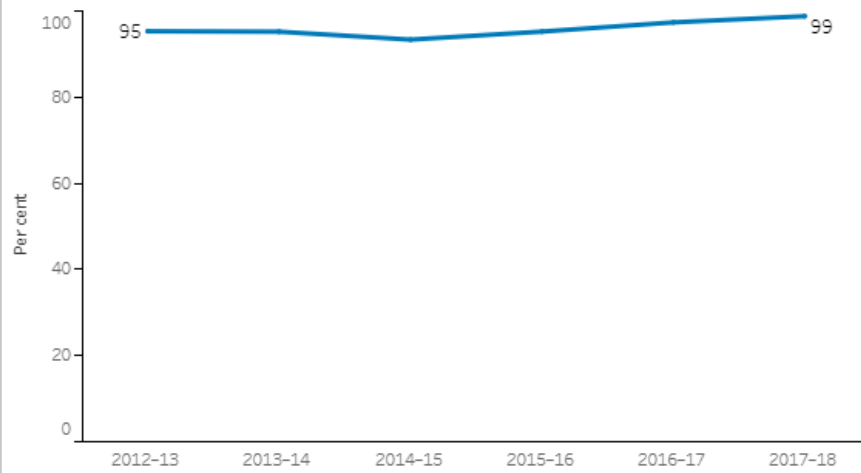
## 1.4 Consumer engagement and stakeholder collaboration

Client and community feedback is important for health services to ensure that their policies and programs are meeting the needs of Aboriginal and Torres Strait Islander communities. Collaboration with Indigenous organisations is also important for ensuring services are culturally respectful. Data on these measures are provided from organisations funded to provide comprehensive primary health care and/or maternal and child health services to Indigenous Australians. The latest data available from the OSR collection on consumer engagement and stakeholder collaboration are from 2017–18.

### Client and community feedback mechanisms



Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had client and community feedback mechanisms: National, 2012-13 to 2017-18

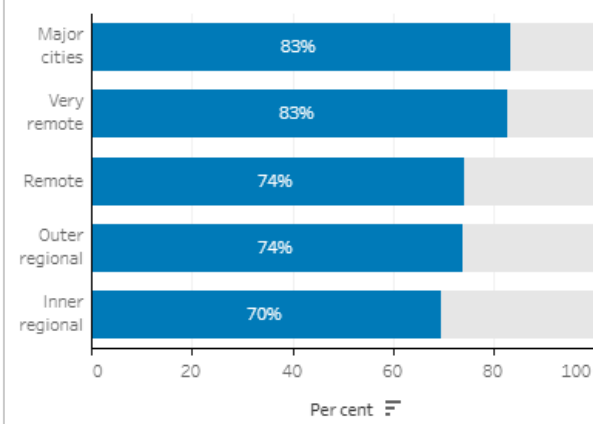


**Almost all** organisations reporting to the OSR had client and community **feedback mechanisms**

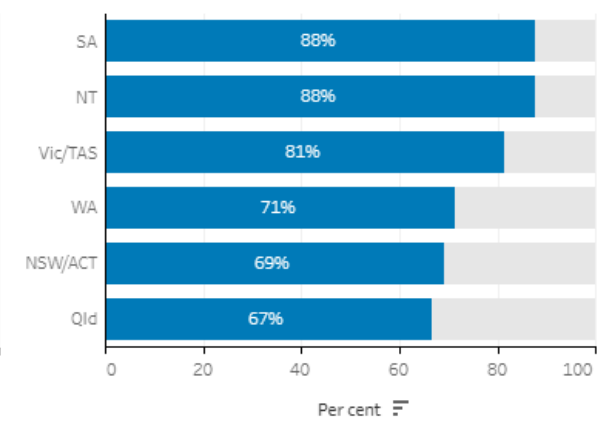
Source: Online Services Report, 2012-13 to 2017-18, previously unpublished (Table 1.4.1).

## Consultation with Aboriginal and Torres Strait Islander communities

Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had formal cultural safety policies, by remoteness: National, 2017-18



Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had formal cultural safety policies, by state and territory: National, 2017-18

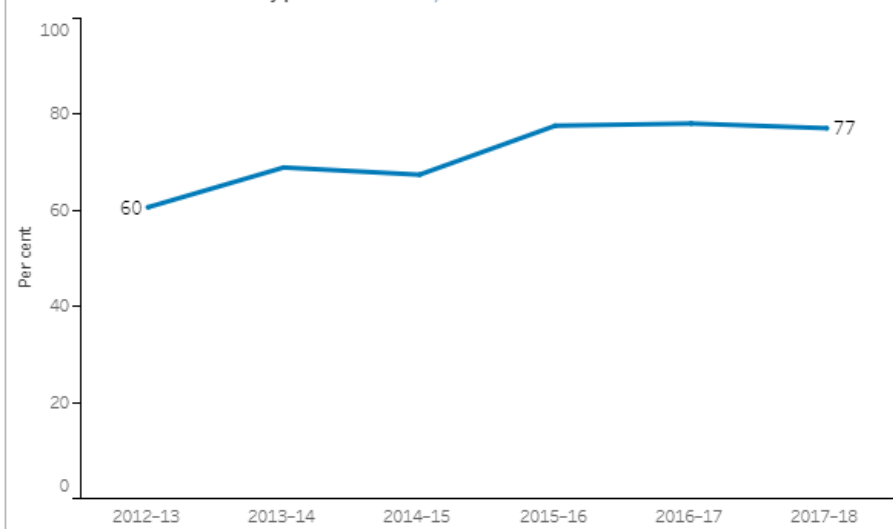


Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had formal cultural safety policies, by organisation type: National, 2017-18



Note: Aboriginal Community Controlled Health Organisations (ACCHOs) are primary 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. Non-ACCHOs are other health care services funded under the Indigenous Australians' Health Program that are run by state governments, local governments or non-government organisations.

Indigenous-specific primary health care organisations and maternal/child health services: Proportion that had formal cultural safety policies: National, 2012-13 to 2017-18



In **2017-18**, more than **three quarters** of organisations reporting to the OSR had **cultural safety policies** in place

Source: Online Services Report, 2012-13 to 2017-18, previously unpublished (Table 1.4.2).

## Data sources and data gaps

The following sources were included for this module:

- [Online Services Report](#) (OSR)—for data on Indigenous-specific primary health care organisations and maternal/child health services funded through the Indigenous Australians' Health Programme
- [Higher Education Statistics](#) and [National Vocational Education and Training](#) data—for data on enrolments in health-related courses
- [National Health Workforce Dataset](#)—for information on the characteristics of the health workforce.

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Culturally respectful health care services – measures and data sources

| Domains and measures  | NHWD | HES/VET | OSR |
|---|------|---------|-----|
| <b>1.1. Organisational approach and commitment</b>                        |      |         |     |
| Organisational commitment to culturally respectful and safe healthcare    |      |         | ✓   |
| Aboriginal and Torres Strait Islander leadership at Board/Executive level |      |         | ✓   |
| <b>1.2. Communication and cultural services</b>                           |      |         |     |
| Culturally appropriate communication resources (brochures, interpreters)  |      |         | ✓   |
| Offers culturally appropriate services                                    |      |         | ✓   |
| <b>1.3. Workforce development and training</b>                            |      |         |     |
| Aboriginal and Torres Strait Islander participation in the workforce      | ✓    |         | ✓   |
| Aboriginal and Torres Strait Islander workforce development               |      | ✓       |     |
| Cultural safety and responsiveness training for staff                     |      |         | ✓   |
| <b>1.4 Consumer engagement and stakeholder collaboration</b>              |      |         |     |
| Client and community feedback mechanism                                   |      |         | ✓   |
| Consultation with Aboriginal and Torres Strait Islander communities       |      |         | ✓   |

Note: OSR – Online Services Report; HES – Higher Education Statistics; VET – Vocational Education and Training statistics; NHWD National Health Workforce Dataset; NHMD – National Hospital Morbidity Database.

### Notes

Most of the available data for this module comes from the AIHW Online Services Report (OSR) data collection and relates to Indigenous-specific primary health care and maternal and child health services. These services include Aboriginal Community Controlled Health Organisations (ACCHOs), government and non-government organisations funded under the Indigenous Australians' Health Programme (IAHP).

For 2019–20 and 2020–21, reporting to the OSR collection was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19, therefore data should be interpreted with caution. For more information see [Impact of COVID-19](#).

## Number of organisations reporting to OSR collection

| Collection year | Number of primary care organisations | Number of organisations funded for maternal and child health services only |
|-----------------|--------------------------------------|--|
| 2017–18         | 198                                  | 19   |
| 2018–19         | 210                                  | 22   |
| 2019–20         | 196                                  | 19   |
| 2020–21         | 191                                  | 20   |

For further information see [OSR – summary over time](#).

The OSR has a module-based structure, with individual items that are a mix of counts of activities/services provided (such as number of clients seen), workforce information, questions with tick box answers, and some text responses. The OSR collection includes data on staffing levels, client numbers, client contacts, episodes of care and services provided.

Contextual information about each organisation is also collected. The OSR data presented in this monitoring framework are drawn from the:

- Community engagement, control and cultural safety module, which consists of mostly tick box answers about activities undertaken by organisations to deliver culturally safe services to Indigenous clients.
- Corporate services/infrastructure module, workforce submodule, which consists mostly of counts of FTE staff by Indigenous status and various role/function categories.

See [<Supplementary material: Cultural safety-related questions from the OSR data collection>](#) for more information.

OSR data presented in the monitoring framework are also disaggregated by type of organisation—that is, by whether it is an ACCHO or other organisation receiving funding under the IAHP.

The OSR collection is being redeveloped and as a result some items have not had updated data since the 2017–18 reporting period. For more information about OSR see:

- [Aboriginal and Torres Strait Islander-specific primary health care: results from the OSR and nKPI collections – Interpreting OSR data](#)
- [Online Services Report data collection](#).

The National Health Workforce Dataset provides national data on the Indigenous status of the health workforce for a wide range of professions, including GPs, nurses, and medical specialists. The Higher Education and Vocational Education and Training data provide information on the Indigenous status of student enrolments and completions for health related courses such as health workers, nursing, medical studies, pharmacy and radiography. These data are important for monitoring programs that aim to build an Indigenous health workforce to help improve the cultural safety of health services.

**Note:** This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Data gaps

There are major data gaps for reporting on culturally respectful services, with most of the data reported relating to Indigenous specific primary health care services. There is little national, state and territory, and smaller area level data found to report on the measures in relation to mainstream health services, for example primary health care and hospitals, though a high proportion of Indigenous Australians use these services.

The Australian Commission on Safety and Quality in Health Care has included [six Aboriginal and Torres Strait Islander specific actions](#) in the [National Safety and Quality Health Service Standards](#). The aims of the Standards are to protect the public from harm and to improve the quality of health service provision.

Archived content

## Module 2: Patient experience of health care

Cultural safety is defined with reference to the experience of Aboriginal and Torres Strait Islander people who access and use health care services, including their treatment by health care professionals and their feelings of cultural safety. It also includes some indirect measures of cultural safety where clients take their own leave from hospitals. These measures suggest that there are situations where Indigenous patients do not find the hospital environment to be culturally safe.

### What data are available?

The data sources include the ABS national Aboriginal and Torres Strait Islander health and social surveys, surveys of public hospital patients in New South Wales and Queensland and Reconciliation Australia's Australian Reconciliation Barometer survey. There are also data from the national hospital data collections on indirect measures of cultural safety.

For further information on the data sources used in this module, see [Module 2 – Data sources and data gaps](#).

#### Key findings

The National Aboriginal and Torres Strait Islander Health Survey shows that in 2018–19:

- 88% of Indigenous Australians aged 15 and over in non-remote areas reported that doctors always/often explained things in a way that could be understood
- 91% of Indigenous Australians aged 15 and over in non-remote areas reported that doctors always/often showed respect for what was said
- 32% of Indigenous Australians who did not access health services when they needed to, indicated this was due to cultural reasons, such as language problems, discrimination and cultural appropriateness.

Data from the 2020 Australian Reconciliation Barometer indicate that 22% of Indigenous Australians or their families were racially discriminated against by doctors, nurses and/or medical staff in the last 12 months.

The differences in rates of Indigenous and non-Indigenous hospital patients who choose to leave prior to commencing or completing treatment are frequently used as indirect measures of cultural safety.

- In relation to admitted patient hospitalisations, Indigenous Australians were discharged against medical advice for 3.9% of hospitalisations in 2018–20. Based on age standardised rates, Indigenous patients were discharged against medical advice at over 5 times the rate of non-Indigenous Australians.
- In relation to emergency department care, based on age standardised rates, Indigenous patients left at own risk or did not wait at 1.5 times the rate of non-Indigenous patients.

See [Module 2 data tables](#) for all data presented in this module.

### Data gaps and limitations

Data from Indigenous health care users about the health care that they receive are limited. Data from surveys of hospital patients in all states and territories are required, as well as additional national data on patient satisfaction with different types of health care services. However, data from these surveys are not always available by Indigenous status and may not include questions that relate to cultural safety for Indigenous Australians.

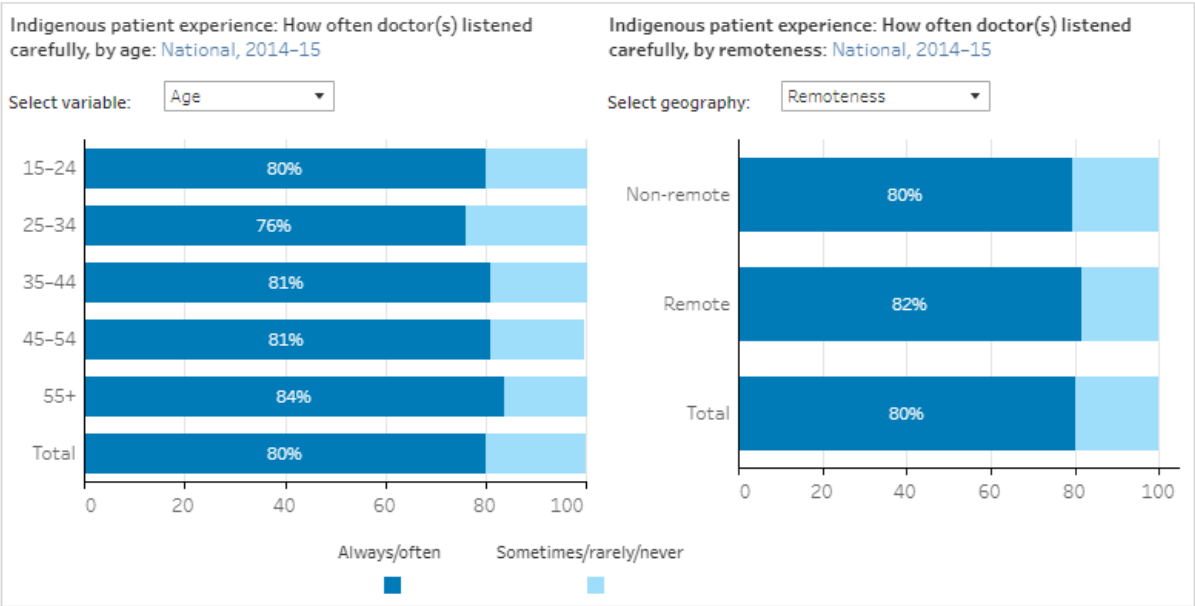
**Note:** This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



## 2.1 Communication

The quality of communication between health care providers and Aboriginal and Torres Strait Islander patients, including an awareness and interest in Indigenous culture, is important for ensuring patients feel culturally safe. Respectful communication makes it more likely that Indigenous Australians will access health care, and that the care they receive will be more effective. The data reported on Indigenous patient experiences of communication with health care providers come from national surveys, and public hospital patient surveys in some states.

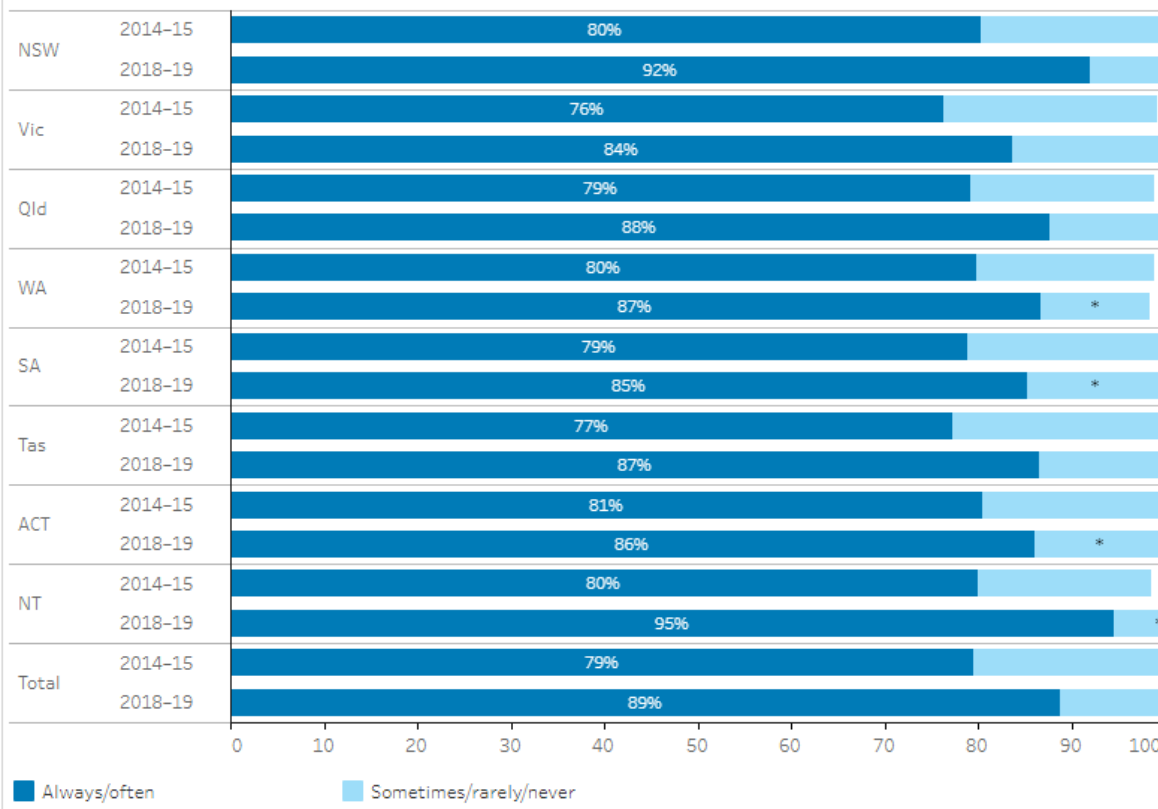
### Interaction with health professionals



Source: AIHW analysis of National Aboriginal and Torres Strait Islander Social Survey 2014-15, as published in AIHW & NIAA 2020 (Table 2.1.1a).

**Indigenous patient experience: How often doctor(s) listened carefully, by age, sex and jurisdiction: Non-remote only, 2014-15 and 2018-19**

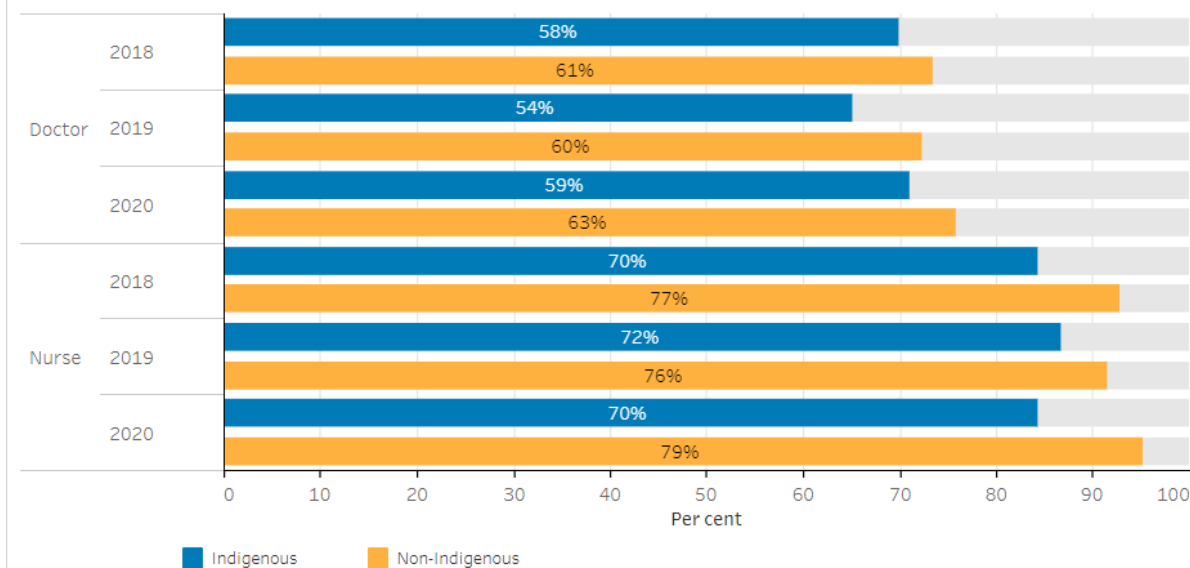
Select variable:



\* Estimate has RSE of 25% to 50% and should be used with caution.

Source: AIHW analysis of National Aboriginal and Torres Strait Islander Social Survey 2014-15, National Aboriginal and Torres Strait Islander Health Survey 2018-19, from ABS 2016 and ABS 2019 (Table 2.1.1b).

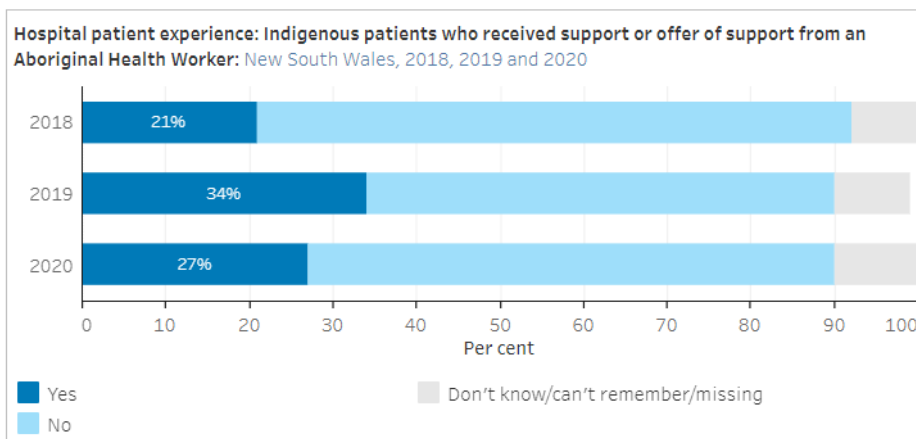
**Hospital patient experience: Always have the opportunity to talk to a doctor or nurse, by Indigenous status: New South Wales, 2018, 2019 and 2020**



**Notes**

1. Based on responding 'Yes,always' to the question 'If you needed to talk to a doctor/nurse, did you get the opportunity to do so'.
2. Data are based on weighted percentages and therefore different to previously published percentages.

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



In 2018, **21%** of Indigenous hospital patients in NSW received support or the offer of support from an Aboriginal Health Worker, compared with **27%** in 2020

*Note:* Data are based on weighted percentages and therefore different to previously published percentages.

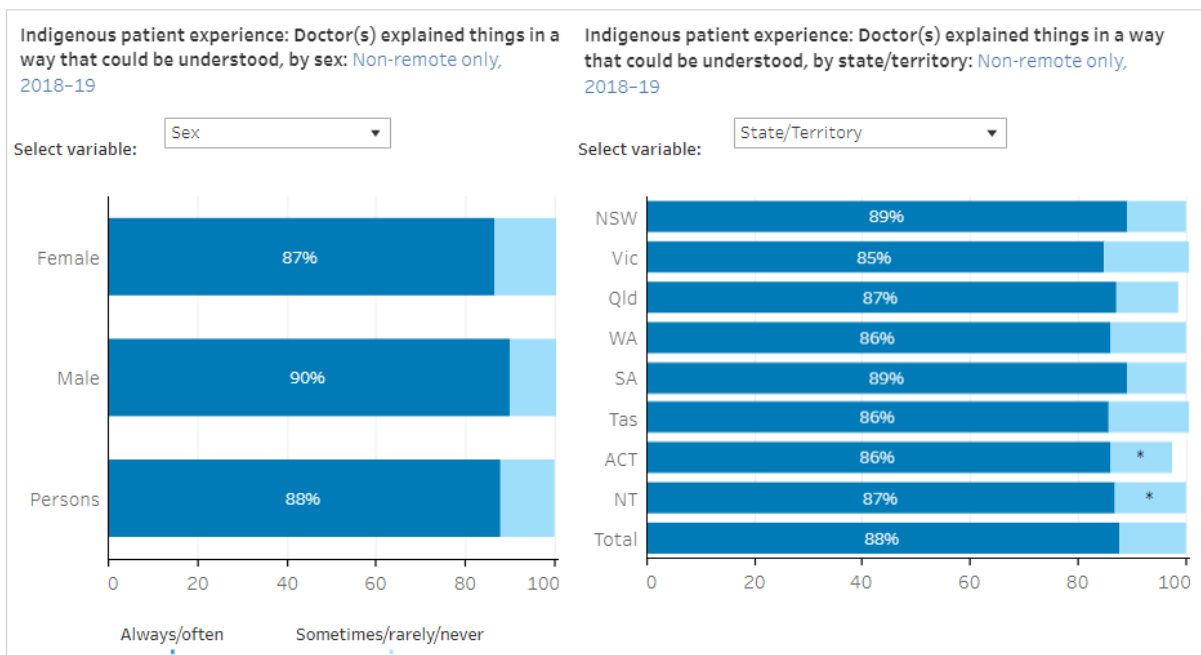
*Source:* NSW Adult Admitted Patient Survey 2018, 2019 and 2020, as published in BHI 2022 (see data tables for Module 2 – Tables 2.1.1.c, 2.1.1.d).

Results from the NSW 2019 Adult Admitted Patient Survey (AAPS) showed that the majority of Aboriginal and Torres Strait Islander patients said health professionals ‘always’ explained things in an understandable way (73%), although this result was lower than for non-Indigenous patients (81%) (BHI 2021).

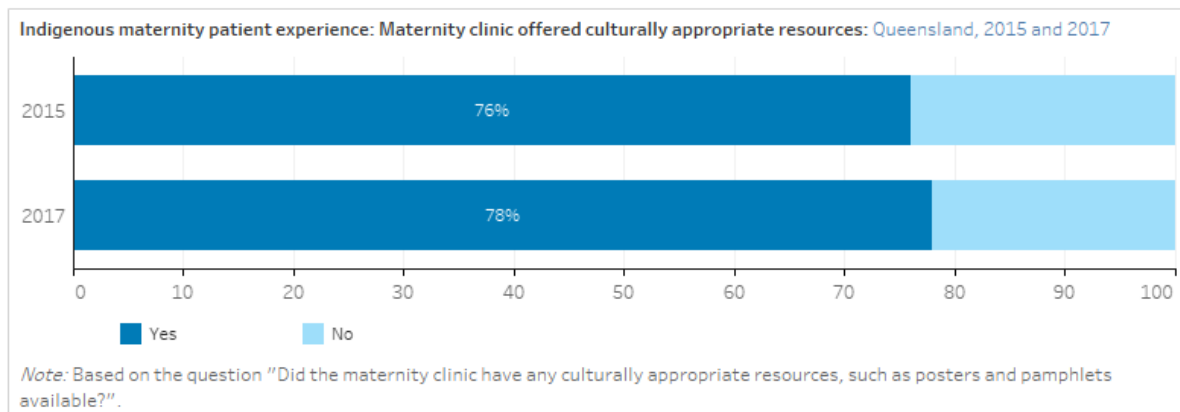
The NSW 2019 AAPS also described aspects of care that were most strongly associated with Aboriginal and Torres Strait Islander people reporting that the overall care they received in hospital was ‘very good’. These factors included that their care was ‘very well’ organised and that they were treated fairly based their Aboriginality or other reasons (BHI 2021).

Results from the NSW 2019 Maternity Care Survey showed that 79% of Aboriginal and Torres Strait Islander women who had the support of an Aboriginal Health Worker rated their overall care during labour and birth as ‘very good’, significantly higher than those who were not supported by an Aboriginal Health Worker, 58%, after adjusting for age (BHI 2021).

## Information provided in a way that could be understood

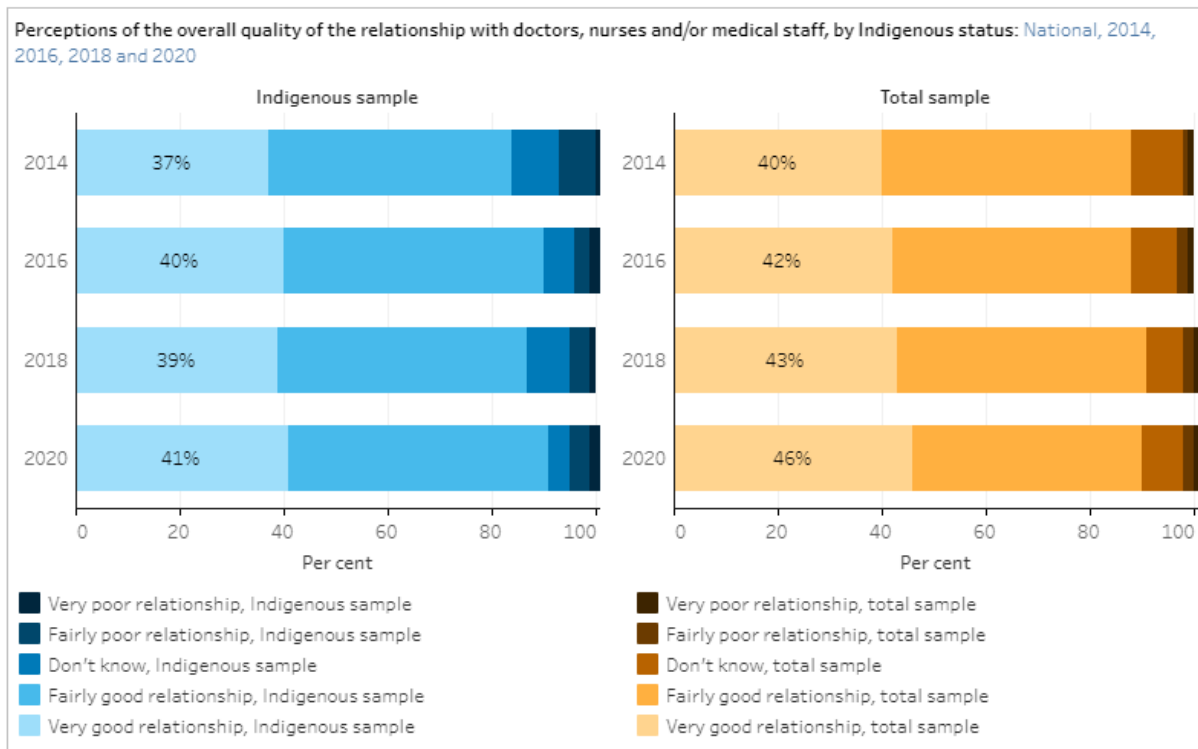


Source: National Aboriginal and Torres Strait Islander Health Survey 2018-19, ABS 2019 (see data tables for Module 2 - Table 2.1.2a).



Source: Qld Maternity Outpatient Clinic Patient Experience Survey, 2015 and 2017, as published in Queensland Government 2017 and Queensland Government 2019 (see data tables for Module 2 - Table 2.1.2b).

## Quality of relationship



### Notes

- Between 2014 and 2020 the Indigenous sample is between 495 and 502. The total sample ranges from 1,100 in 2014 to 2,277 in 2016.
- Both the total sample and Indigenous sample are weighted to be representative in terms of age group, gender and location (state and territory populations), as per Australian Bureau of Statistics 2016 Census data.

Source: Australian Reconciliation Barometer survey as published in Reconciliation Australia 2015, 2017, 2019 and 2020 (Table 2.1.3).

## References

- Australian Bureau of Statistics (ABS) 2016. [National Aboriginal and Torres Strait Islander Social Survey](#). [TableBuilder]. Retrieved 9 November, 2020.
- ABS 2019. [National Aboriginal and Torres Strait Islander Health Survey 2018–19](#). [TableBuilder]. Retrieved 9 November, 2020.
- Australian Institute of Health and Welfare (AIHW) & National Indigenous Australians Agency (NIAA) 2020. [Aboriginal and Torres Strait Islander Health Performance Framework \(HPF\) report 2017 \[archived\]](#). Canberra: AIHW.
- Bureau of Health Information (BHI) 2021. [The Insights Series-Aboriginal people's experiences of hospital care](#). July 2021. Sydney (NSW): BHI.
- BHI 2022. [Healthcare Observer](#). Sydney (NSW): BHI. Retrieved 4 March, 2022.
- Queensland Government 2017. [2015 Maternity Outpatient Clinic Patient Experience Statewide Report](#). Queensland: Queensland Health.
- Queensland Government 2019. [2017 Maternity Outpatient Clinic Patient Experience Survey Report](#). Queensland: Queensland Health.
- Reconciliation Australia 2015. [2014 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

Reconciliation Australia 2017. [2016 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Reconciliation Australia 2019. [2018 Australian Reconciliation Barometer](#). Polity Research & Consulting.

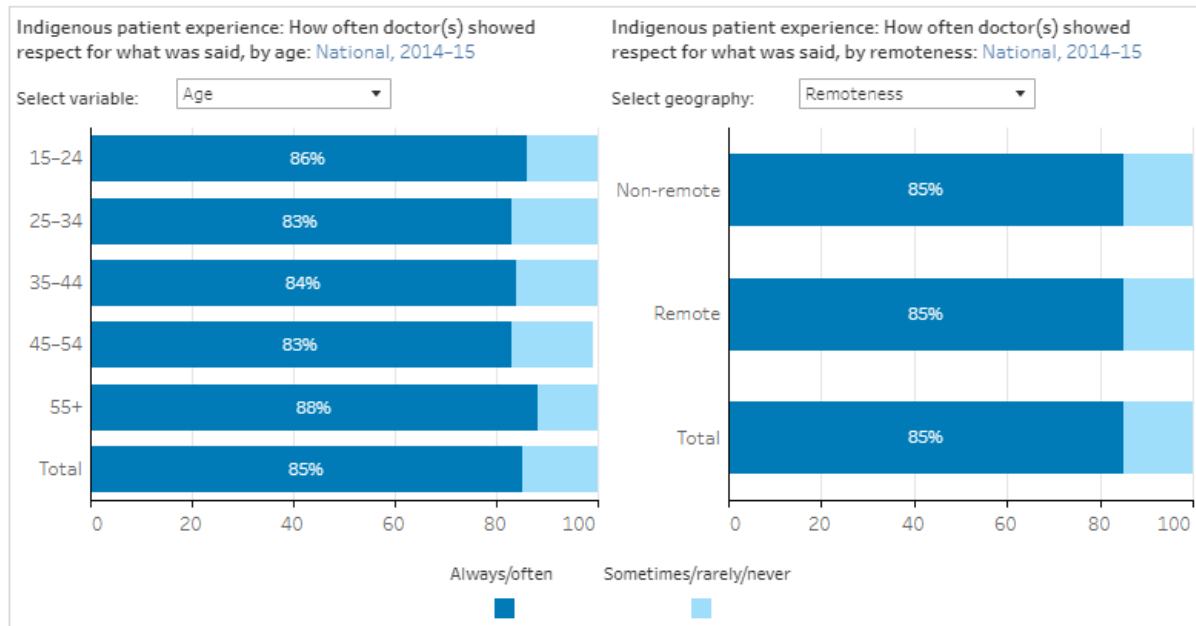
Reconciliation Australia 2020. [2020 Australian Reconciliation Barometer](#). Polity Research & Consulting.

## 2.2 Treated respectfully

Aboriginal and Torres Strait Islander people are more likely to feel culturally safe when they are treated with understanding, respect and empathy by health care providers. This leads to more trust and confidence in the health care they receive. The data reported on Indigenous patient experiences of interpersonal treatment come from national surveys, and public hospital patient surveys in some states.

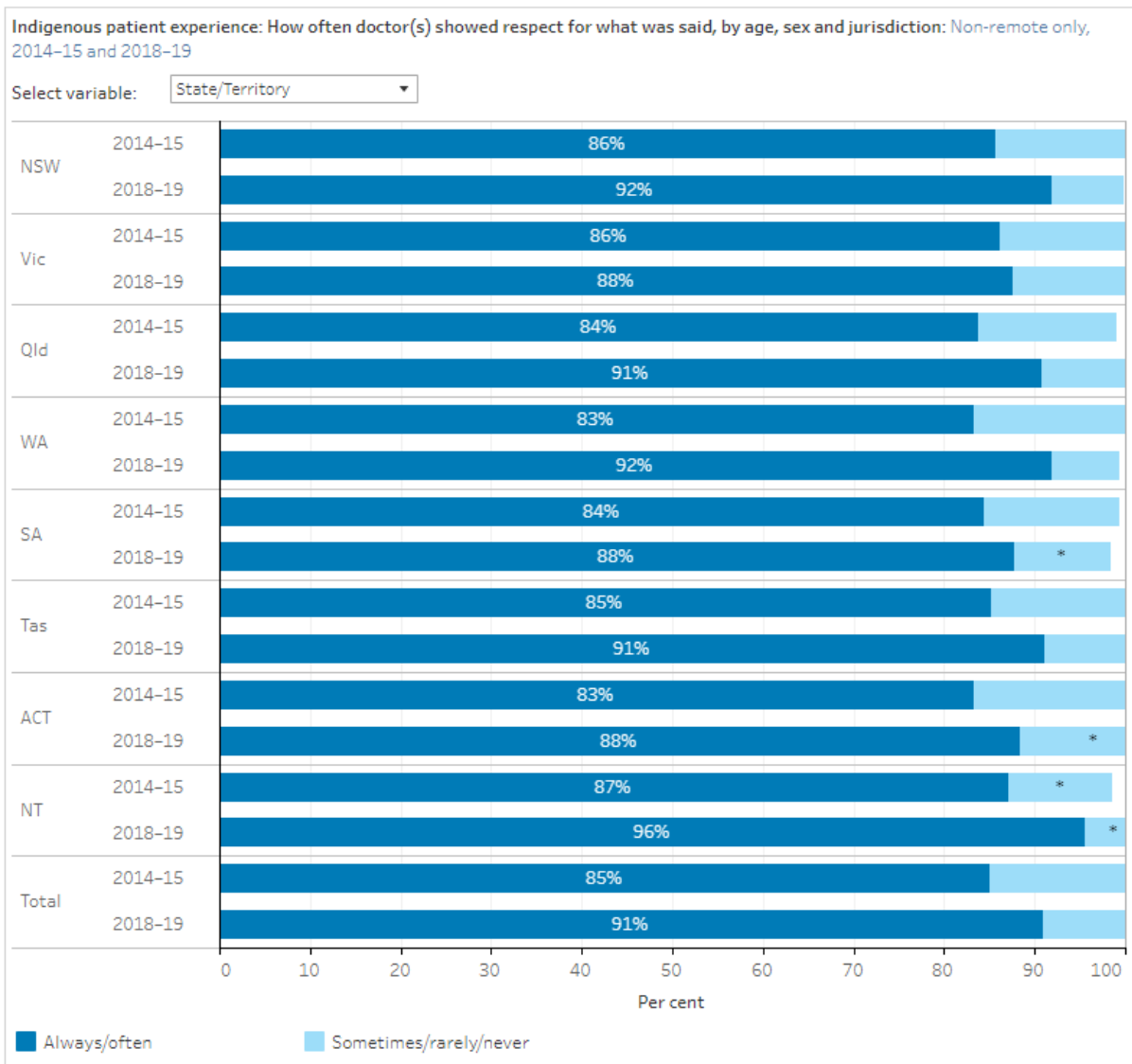
### Respect

Hover over any element of the chart to see number of responses in each category.



Source: AIHW analysis of National Aboriginal and Torres Strait Islander Social Survey 2014-15, as published in AIHW & NIAA 2020 (Table 2.2.1a).

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



\* Estimate has RSE of 25% to 50% and should be used with caution.

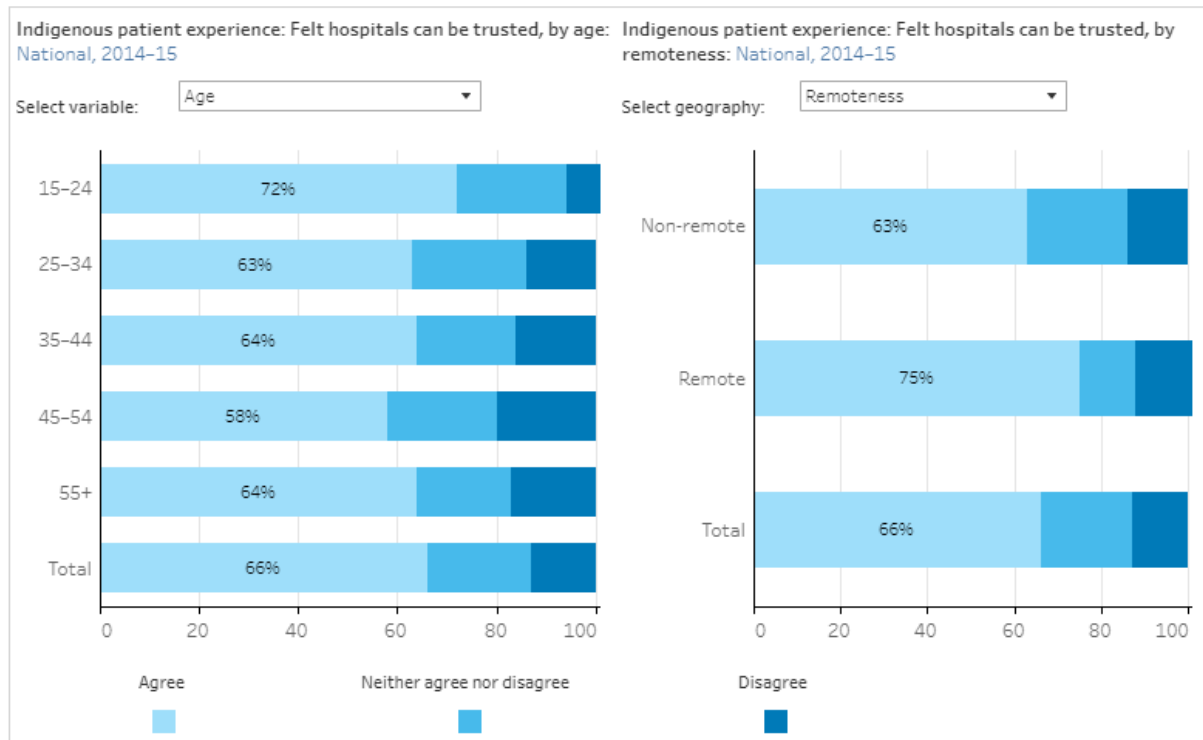
Source: AIHW analysis of National Aboriginal and Torres Strait Islander Social Survey 2014-15, National Aboriginal and Torres Strait Islander Health Survey 2018-19, from ABS 2016 and ABS 2019 (Table 2.2.1b).

Results from the NSW 2019 Adult Admitted Patient Survey showed that around 78% of Aboriginal and Torres Strait Islander patients said they were treated with respect and dignity. However, this was significantly lower than the percentage of non-Indigenous patients who reported this in answer to the same questions (86%) (BHI 2021).

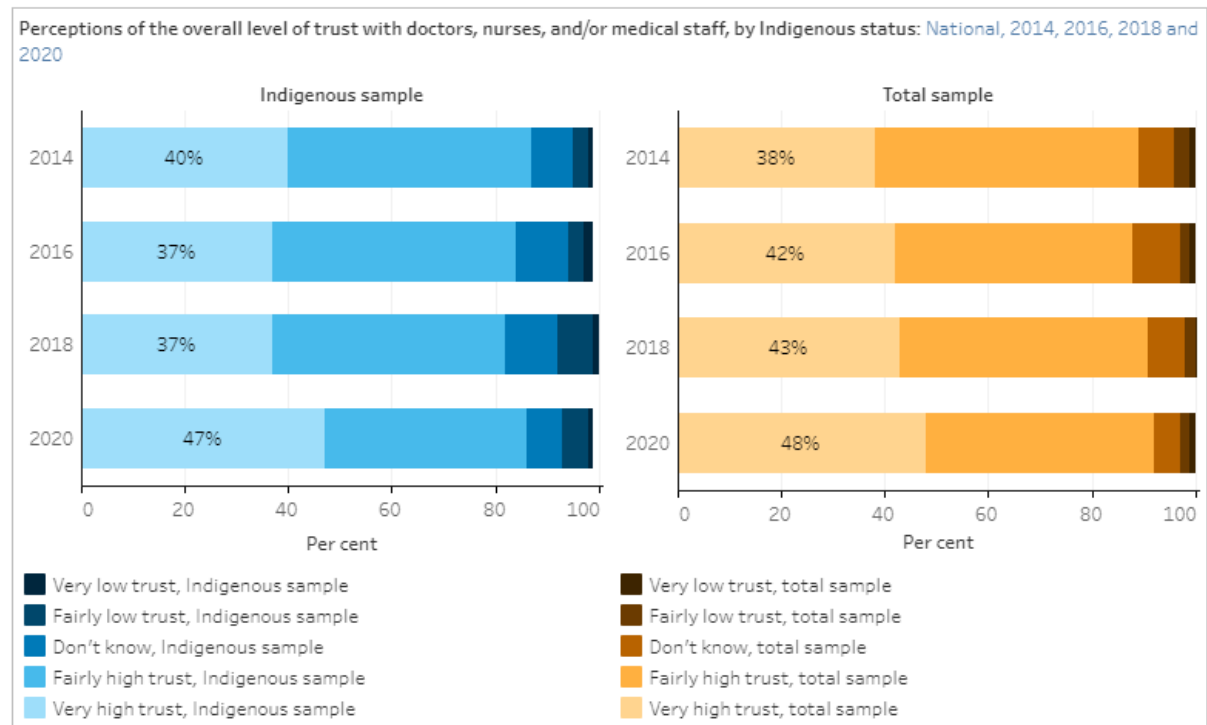
Note: This is not the most recent version of this report. Please visit the [AIHW website](https://www.aihw.gov.au) for updates.

## Had trust and confidence

Hover over any element of the chart to see number of responses in each category.



Source: ABS analysis of National Aboriginal and Torres Strait Islander Survey 2008, AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Social Survey 2014-15, as published in AIHW & NIAA 2020 (Table 2.2.2a).



### Notes

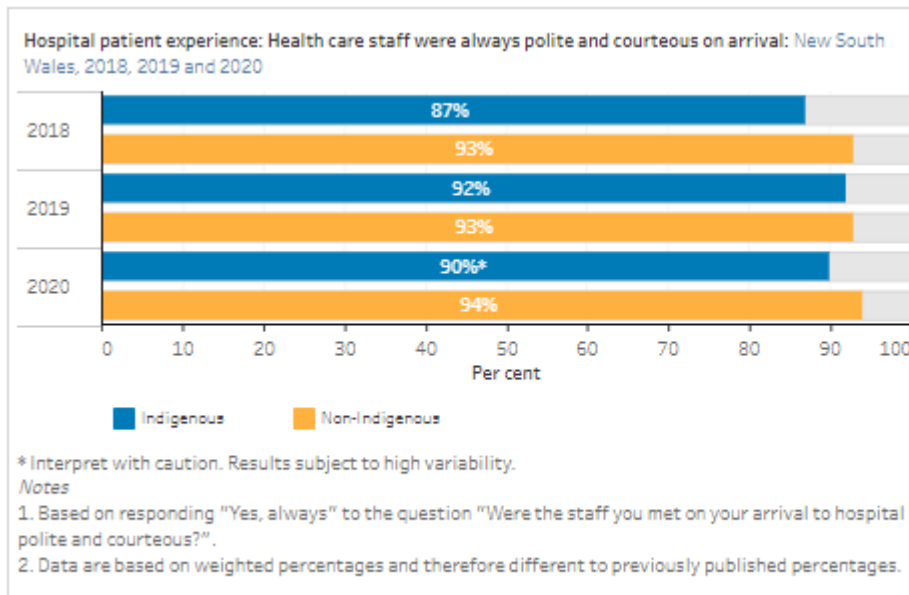
- Between 2014 and 2020 the Indigenous sample is between 495 and 502. The total sample ranges from 1,100 in 2014 to 2,277 in 2016.
- Both the total sample and Indigenous sample are weighted to be representative in terms of age group, gender and location (state and territory populations), as per Australian Bureau of Statistics 2016 Census data.

Source: Australian Reconciliation Barometer survey as published in Reconciliation Australia 2015, 2017, 2019 and 2020 (Table 2.2.2b).

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



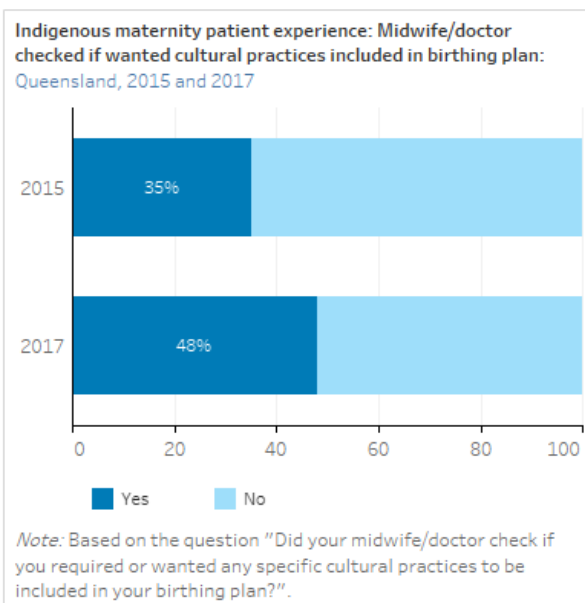
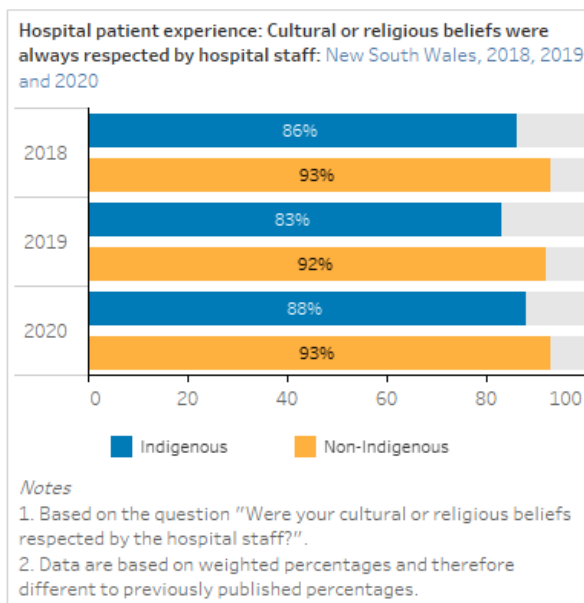
## Staff were polite and courteous

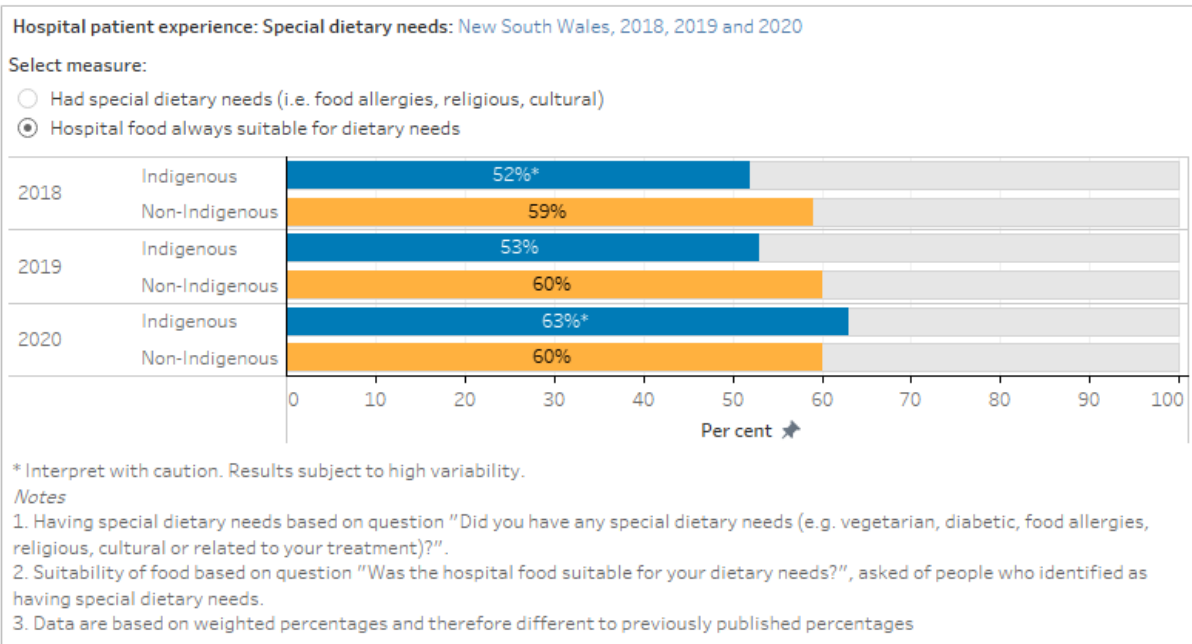


**9 out of 10** Indigenous public hospital patients in NSW reported that the arrival staff were **polite and courteous**

Source: NSW Adult Admitted Patient Survey, 2018, 2019 and 2020, as published in BHI 2022 (see data tables for Module 2 - Table 2.2.3).

## Respect for cultural or religious beliefs





Source: NSW Adult Admitted Patient Survey 2018, 2019 and 2020, as published in BHI 2022; Qld Maternity Outpatient Clinic Patient Experience Survey, 2015 and 2017, as published in Queensland Government 2017 and Queensland Government 2019 (see data tables for Module 2 – Tables 2.2.4a, 2.2.4b, 2.2.4c).

## References

Australian Bureau of Statistics (ABS) 2016. [National Aboriginal and Torres Strait Islander Social Survey](#). [TableBuilder]. Retrieved 11 November, 2020.

ABS 2019. [National Aboriginal and Torres Strait Islander Health Survey 2018–19](#). [TableBuilder]. Retrieved 11 November, 2020.

Australian Institute of Health and Welfare (AIHW) & National Indigenous Australians Agency (NIAA) 2020. [Aboriginal and Torres Strait Islander Health Performance Framework \(HPF\) report 2017 \[archived\]](#). Canberra: AIHW.

Bureau of Health Information (BHI) 2021. [The Insights Series-Aboriginal people's experiences of hospital care](#). July 2021. Sydney (NSW): BHI.

BHI 2022. [Healthcare Observer](#). Sydney (NSW): BHI. Retrieved 4 March, 2022.

Queensland Government 2017. [2015 Maternity Outpatient Clinic Patient Experience Statewide Report](#). Queensland: Queensland Health.

Queensland Government 2019. [2017 Maternity Outpatient Clinic Patient Experience Survey Report](#). Queensland: Queensland Health.

Reconciliation Australia 2015. [2014 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Reconciliation Australia 2017. [2016 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Reconciliation Australia 2019. [2018 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Reconciliation Australia 2020. [2020 Australian Reconciliation Barometer](#). Polity Research & Consulting.

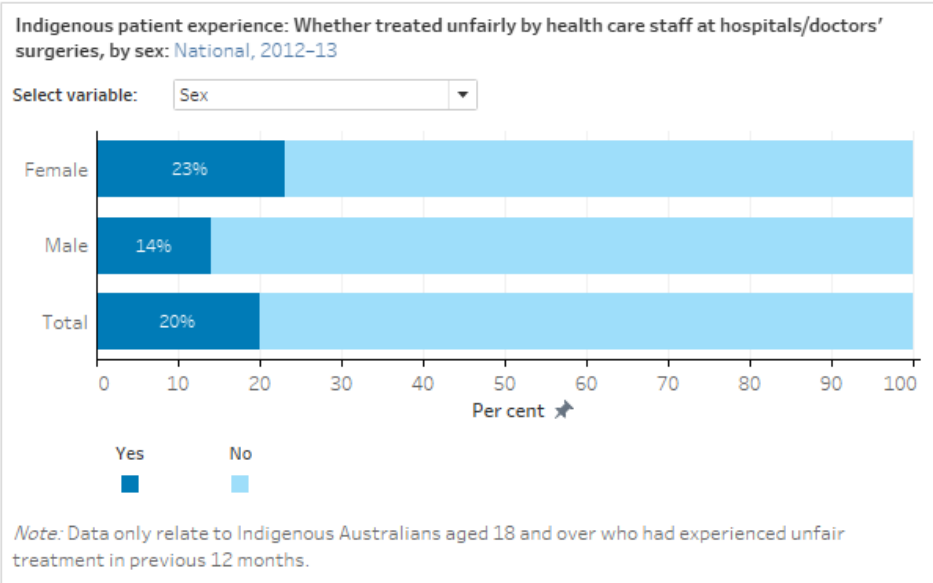
Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

### 2.3 Unfair treatment and cultural barriers

Where Aboriginal and Torres Strait Islander peoples are treated badly, unfairly or unequally because of their race, culture or language they may be less likely to access health care, or to feel comfortable and culturally safe when receiving care. The data reported on Indigenous patient experiences of interpersonal treatment come from national surveys.

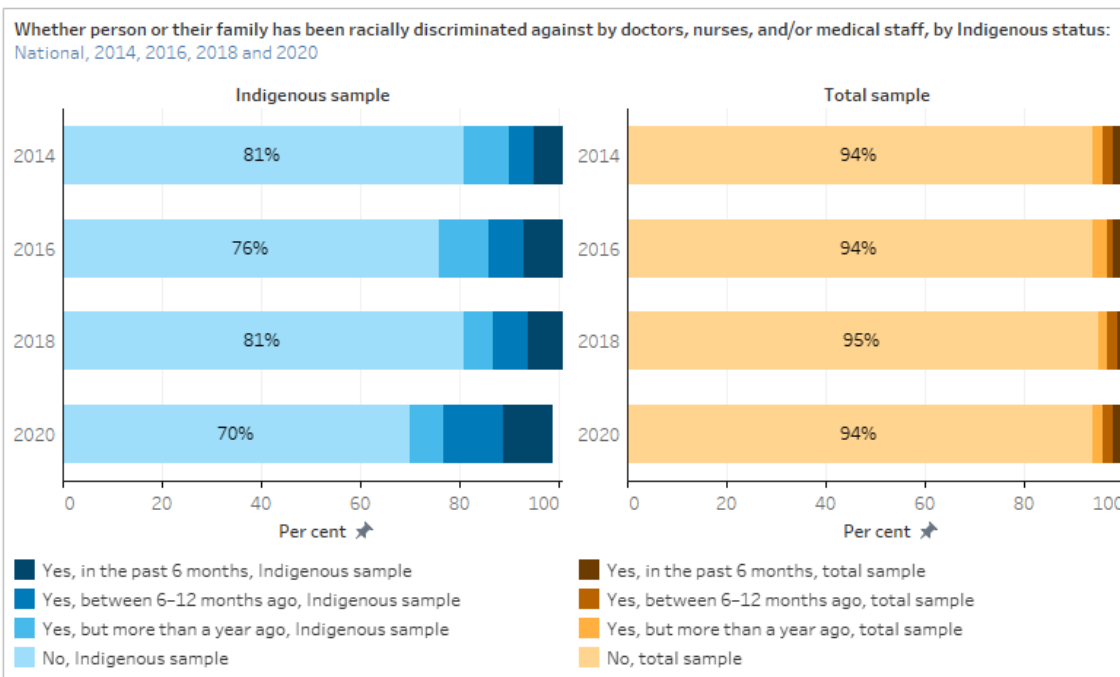
Analysis using data from the Mayi Kuwayu longitudinal study described the effects of discrimination towards Aboriginal and Torres Strait Islander people, across demographic characteristics, and how discrimination related to health and social and emotional wellbeing outcomes. For more information see [Prevalence of Everyday Discrimination and Relation with Wellbeing among Aboriginal and Torres Strait Islander Adults in Australia](#).

#### Unfair treatment and discrimination



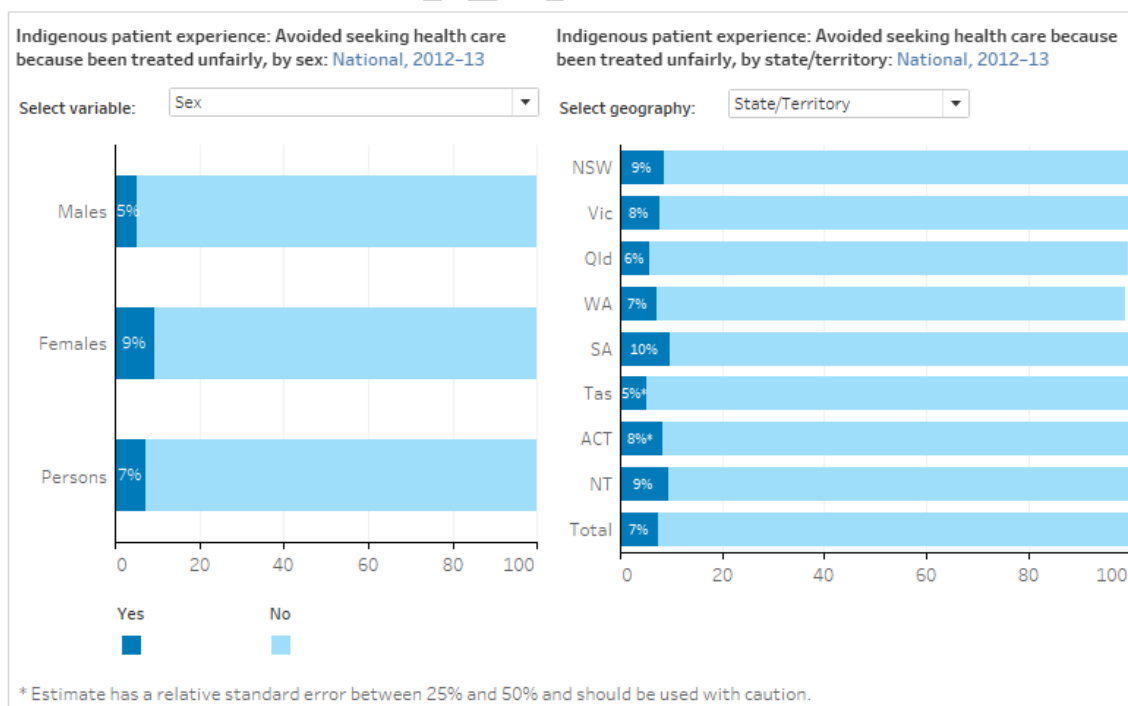
Of Indigenous Australians who reported being treated unfairly in 2012-13, **20%** were treated unfairly in a health setting

Source: AIHW analysis of Australian Aboriginal and Torres Strait Islander Health Survey 2012-13, as published in AIHW & NIAA 2020a (Table 2.3.1a).



Results from the NSW 2019 Adult Admitted Patient Survey showed that most Aboriginal and Torres Strait Islander patients reported they were not treated unfairly (89%) however, this was significantly lower than the percentage of non-Indigenous patients (95%) (BHI 2021).

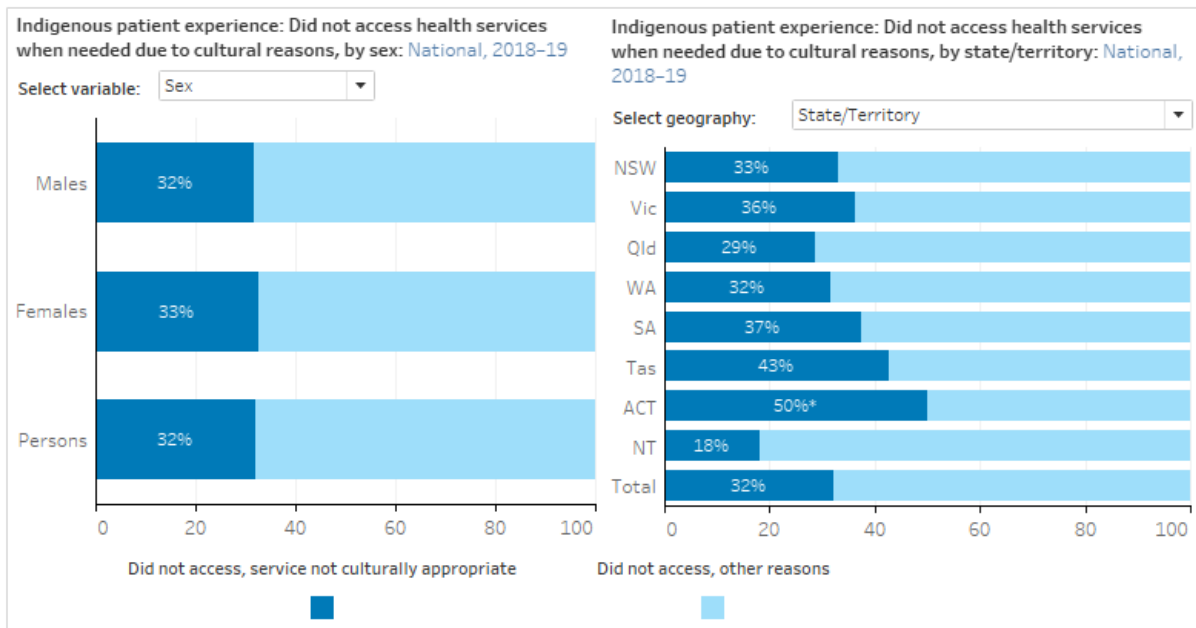
### Avoided health care due to poor treatment



Source: AIHW analysis of Australian Aboriginal and Torres Strait Islander Health Survey 2012-13, as published in AIHW & NIAA 2020a (Table 2.3.2).

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Did not access health care due to cultural reasons



\* Estimate has RSE of 25% to 50% and should be used with caution.

Note: Data only include those who did not access health services when needed.

Source: AIHW analysis of National Aboriginal and Torres Strait Islander Health Survey 2018-19, as published in AIHW & NIAA 2020b (Table 2.3.3).

## References

Australian Institute of Health and Welfare (AIHW) & National Indigenous Australians Agency (NIAA) 2020a. [Aboriginal and Torres Strait Islander Health Performance Framework \(HPF\) report 2017 \[archived\]](#). Canberra: AIHW.

AIHW & NIAA 2020b. [Aboriginal and Torres Strait Islander Health Performance Framework](#). Canberra: AIHW.

Bureau of Health Information (BHI) 2021. [The Insights Series-Aboriginal people's experiences of hospital care](#). July 2021, Sydney (NSW): BHI.

Reconciliation Australia 2015. [2014 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Reconciliation Australia 2017. [2016 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Reconciliation Australia 2019. [2018 Australian Reconciliation Barometer](#). Polity Research & Consulting.

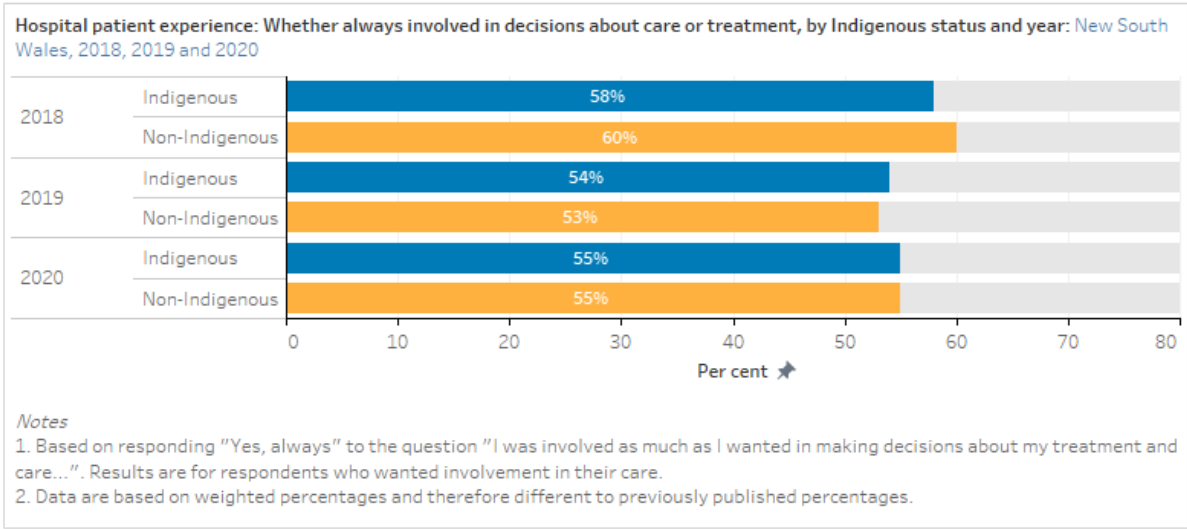
Reconciliation Australia 2020. [2020 Australian Reconciliation Barometer](#). Polity Research & Consulting.

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## 2.4 Empowerment

Empowerment is related to the extent to which people feel included in decisions about their health care, and that they have some control over the care that they receive. Being provided with information about your rights as health care consumers also empowers patients. The data reported on empowerment come from New South Wales public hospital patient experience surveys.

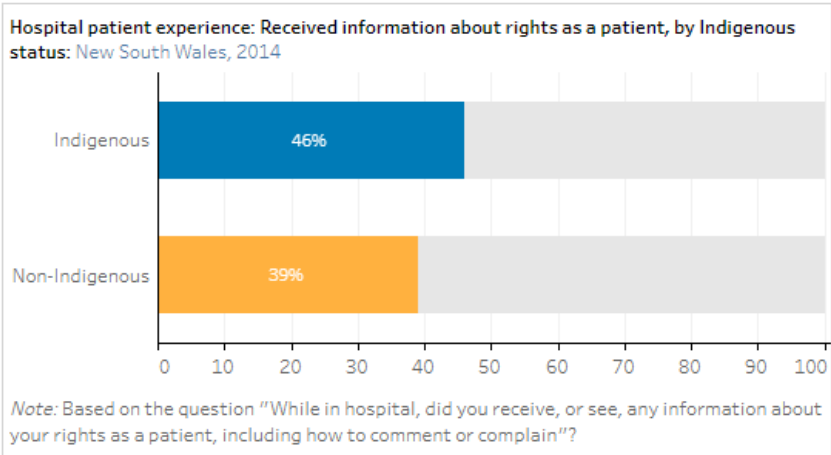
### Involved in health care decisions



Source: NSW Adult Admitted Patient Survey 2018, 2019 and 2020, as published in BHI 2022 (see data tables for Module 2 – Table 2.4.1).

Results from the NSW 2019 Maternity Care Survey showed that 73% of Aboriginal and Torres Strait Islander women said their decisions about how they wanted to feed their baby were 'always' respected by health professionals. In contrast, when asked the same question, 82% of non-Indigenous women gave this response (BHI 2021).

### Provided with information about patient rights



A higher proportion of Indigenous patients in NSW hospitals received information about their rights as a patient than non-Indigenous patients (46% compared with 39%)

Source: NSW Adult Admitted Patient Survey 2014, as published in BHI 2020.

[Source data tables and footnotes](#)

## References

Bureau of Health Information (BHI) 2016. [Patient Perspectives: Hospital care for Aboriginal people](#). 10 August 2016. Sydney: BHI.

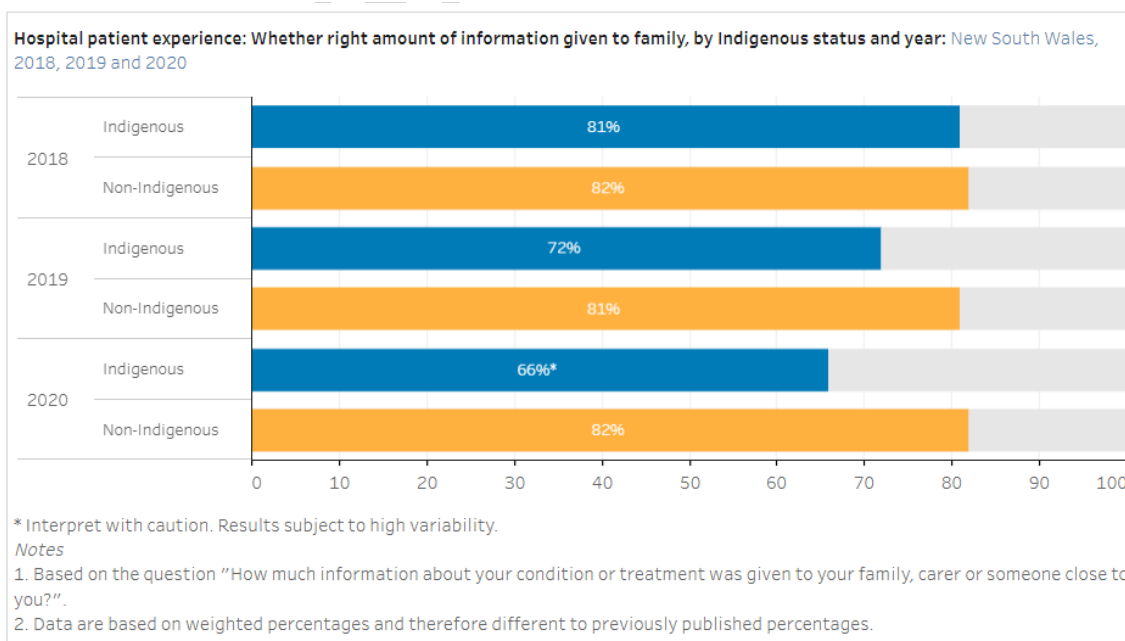
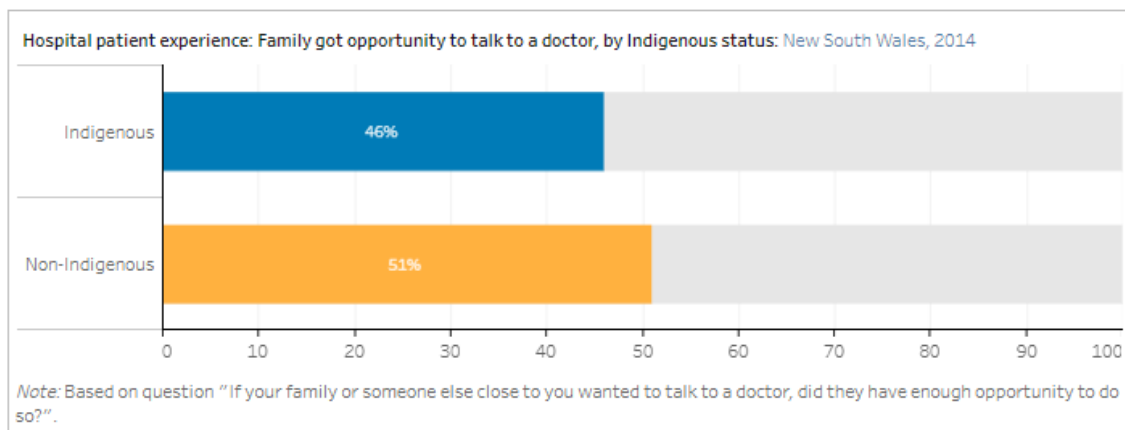
BHI 2021. [The Insights Series-Aboriginal people's experiences of hospital care](#). July 2021. Sydney (NSW): BHI.

BHI 2022. [Healthcare Observer](#). Sydney (NSW): BHI. Retrieved 4 March, 2022.

## 2.5 Family inclusion

Aboriginal and Torres Strait Islander patients are more likely to feel culturally safe when family members, or other people important to them, are included in the health care process and decisions about their care. This can help improve the quality of health care and ensure that it is more effective. The data reported on family inclusion come from New South Wales public hospital patient experience surveys.

### Family members were informed and included



Source: NSW Adult Admitted Patient Survey 2014, 2018, 2019 and 2020, as published in BHI 2016 and BHI 2021 (see data tables for Module 2 – Tables 2.5.1, 2.5.2).

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Results from the NSW 2019 Adult Admitted Patient Survey showed Aboriginal and Torres Strait Islander patients in rural hospitals were significantly more positive when asked how much information about their condition or treatment was given to their family or someone close to them (78% in rural hospitals said the 'right amount', compared with 69% in urban hospitals) (BHI 2021).

## References

- Bureau of Health Information (BHI) 2016. [Patient Perspectives: Hospital care for Aboriginal people](#). 10 August 2016. Sydney: BHI.
- BHI 2021. [The Insights Series-Aboriginal people's experiences of hospital care](#). July 2021. Sydney (NSW): BHI.
- BHI 2022. [Healthcare Observer](#). Sydney (NSW): BHI. Retrieved 4 March, 2022.

## 2.6 Leave events

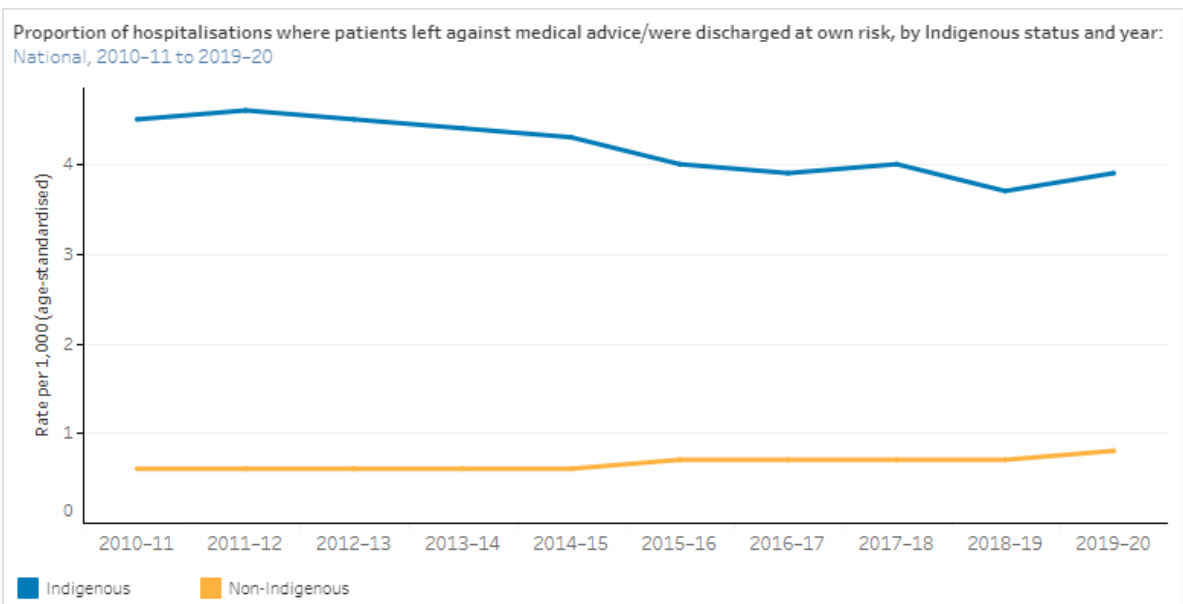
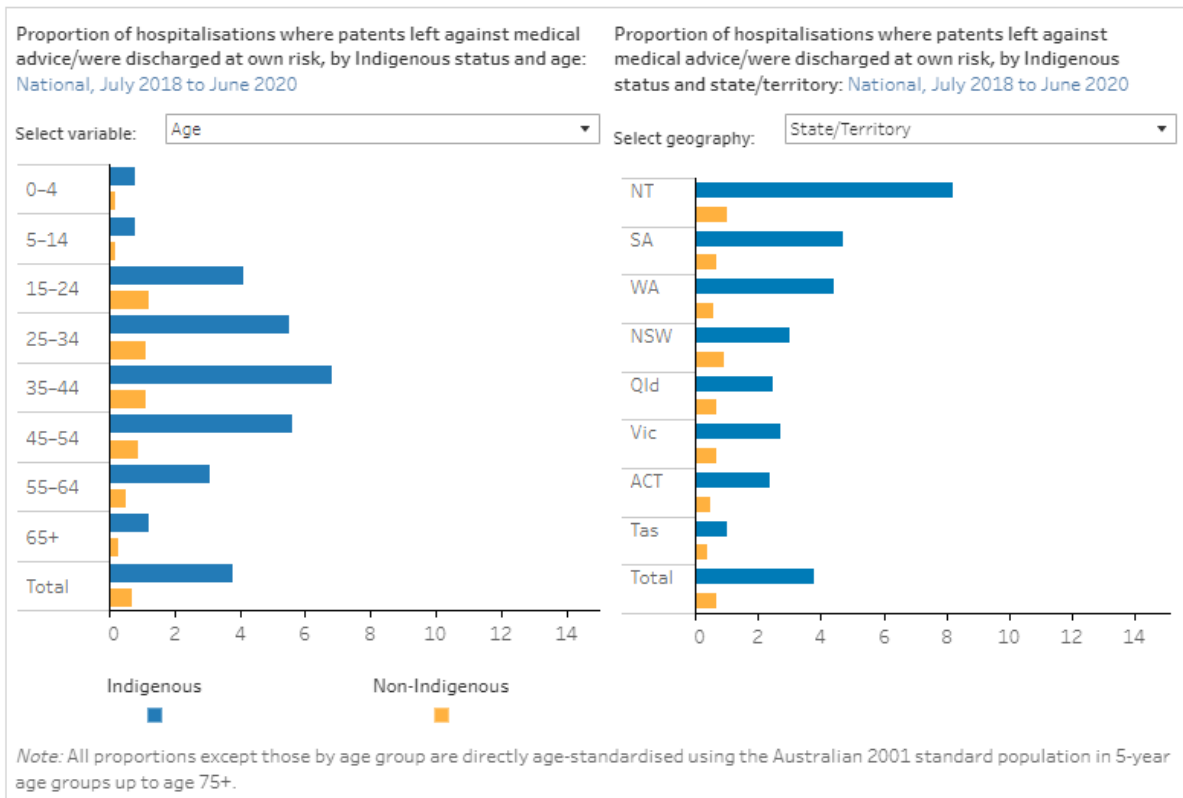
Leave events refers to situations where hospital patients choose to leave prior to commencing or completing their treatment. Patient experiences of health care services affect health-related behaviours and health outcomes. Leave event patients are more likely to re-present to emergency departments and have higher mortality rates (Shaw 2016). There have been a limited number of studies on Aboriginal and Torres Strait Islander peoples' reasons for leave events from hospital. However, common factors include institutionalised racism; a lack of cultural safety; a distrust of the health system; miscommunication; family and social obligations; isolation and loneliness; a lack of understanding of the treatment they were receiving and the feeling that the treatment had finished; and communication and language barriers between staff and the patient (Shaw 2016). For more information on leave events or [discharge against medical advice](#), see the [Aboriginal and Torres Strait Islander Health Performance Framework](#).

This domain includes two leave events measures: incomplete emergency attendances and discharge from hospital against medical advice. Leave events are more likely for Indigenous Australians — which may be due to feeling culturally unsafe — and this is therefore viewed as an indirect measure of cultural safety, or the extent to which hospitals are responsive to Indigenous Australians patient needs.

The data reported for these two measures come from hospitals administrative data.



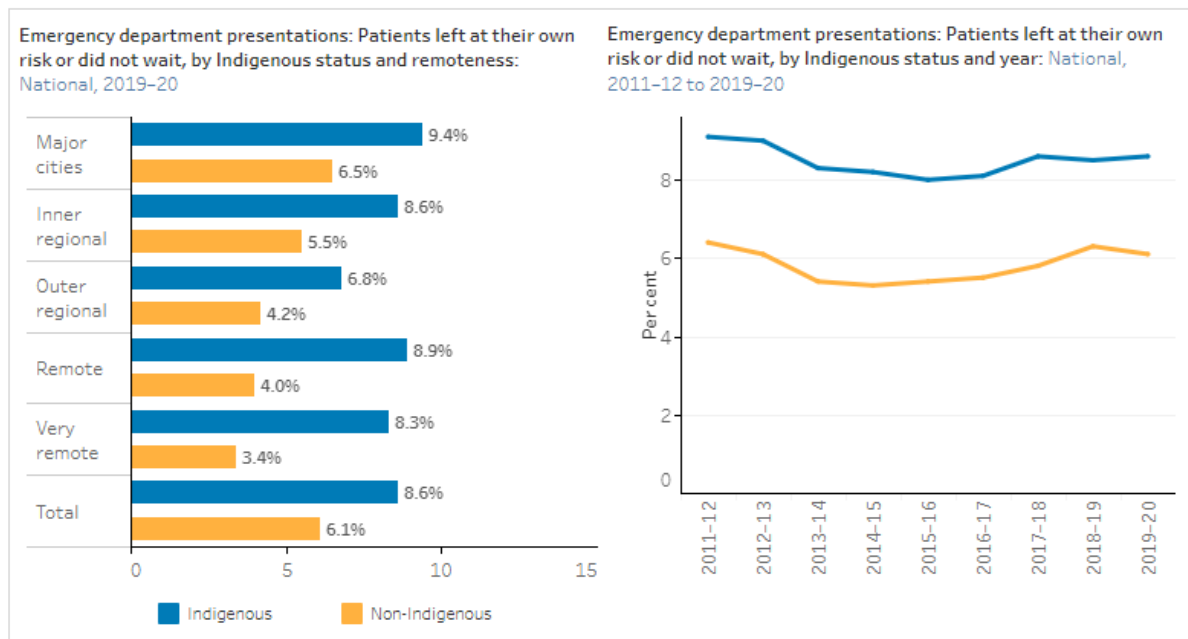
## Admitted patient leave events



Source: AIHW analysis of National Hospital Morbidity Database, previously unpublished (see data tables for Module 2 - Tables 2.6.1a, 2.6.1b).

Note: This is not the most recent version of this report. Please visit the [AIHW website](https://www.aihw.gov.au) for updates.

## Emergency department leave events



Note: Based on age-standardised data.

Source: AIHW analysis of National Non-admitted Patient Emergency Department Care Database, unpublished (see data tables for Module 2 – Table 2.6.2).

## References

Shaw C 2016. [An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients](#). Deakin, ACT: AHHA.

## Data sources and data gaps

The data sources with relevant data items on patient experiences and with data available on Indigenous Australians were:

- [ABS National Aboriginal and Torres Strait Islander Health Survey, 2018-19](#)
- [ABS National Aboriginal and Torres Strait Islander Social Survey, 2014-15](#)
- [ABS Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13](#)
- [Australian Reconciliation Barometer 2020, 2018, 2016, 2014](#)
- [National Hospitals Data Collection](#)
  - National Hospital Morbidity Database, 2019-20
  - National Non-Admitted Patients Emergency Department Care Database, 2019-20
- [New South Wales Adult Admitted Patient Survey, 2014, 2018, 2019 and 2020](#)
- [Queensland Maternity Outpatient Clinic Patient Experience Survey 2015 and 2017](#).

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Patient experience of health care – measures and data sources

| Domains and measures                                   | AATSIHS/<br>NATSIHS<br>/NATSISS | NHMD<br>/NNAPEDCD | Australian<br>Reconciliation<br>Barometer | NSW<br>AAPS | Qld<br>MOCES |
|--|---------------------------------|-------------------|---|-------------|--------------|
| <b>2.1 Communication</b>                               |                                 |                   |   |             |              |
| Interaction with health professionals                  | ✓                               |                   |   |             |              |
| Information provided in a way that could be understood | ✓                               |                   |   |             | ✓            |
| Quality of relationship                                |                                 |                   | ✓   |             |              |
| <b>2.2 Treated respectfully</b>                        |                                 |                   |   |             |              |
| Respect  | ✓                               |                   |   |             |              |
| Had trust and confidence                               | ✓                               |                   | ✓   |             |              |
| Staff were polite and courteous                        |                                 |                   |   | ✓           |              |
| Respect for cultural or religious beliefs              |                                 |                   |   | ✓           | ✓            |
| <b>2.3 Unfair treatment and cultural barriers</b>      |                                 |                   |   |             |              |
| Unfair treatment and discrimination                    | ✓                               |                   | ✓   |             |              |
| Avoided health care due to poor treatment              | ✓                               |                   |   |             |              |
| Did not access health care due to cultural reasons     | ✓                               |                   |   |             |              |
| <b>2.4 Empowerment</b>                                 |                                 |                   |   |             |              |
| Involved in health care decisions                      |                                 |                   |   | ✓           |              |
| Provided with information about patient rights         |                                 |                   |   | ✓           |              |
| <b>2.5 Inclusion</b>                                   |                                 |                   |   |             |              |
| Family members were informed and included              |                                 |                   |   | ✓           |              |
| <b>2.6 Leave events</b>                                |                                 |                   |   |             |              |
| Admitted patient leave events                          |                                 | ✓                 |   |             |              |
| Emergency department leave events                      |                                 | ✓                 |   |             |              |

Note: AATSIHS – Australian Aboriginal and Torres Strait Islander Health Survey; NATSIHS – National Aboriginal and Torres Strait Islander Health Survey; NATSISS – National Aboriginal and Torres Strait Islander Social Survey; NHMD – National Hospital Morbidity Database; NNAPEDCD – National Non-admitted Emergency Department Care Database; NSW Adult Admitted Patient Survey (AAPS); Queensland Maternity Outpatient Clinic Experience Survey (MOCES).

### Notes

The ABS national survey data sources were the Aboriginal and Torres Strait Islander Health Surveys (AATSIHS in 2012–13 and NATSIHS 2018–19) and the National Aboriginal and Torres Strait Islander Social Survey, 2014–15. These surveys include data that relate to the communication, treated respectfully and treated unfairly domains. The national ABS Patient Experience Survey

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(PES), which includes data related to communication and respectful treatment by general practitioners, is not available by Indigenous status. More information on ABS social and health surveys of Indigenous Australians is found in the [Data sources and quality page](#) of the Aboriginal and Torres Strait Islander Health Performance Framework.

Most jurisdictions undertake surveys about patients' experiences in public hospitals, but there is not a lot of publicly released data on Indigenous patients and their experiences.

The NSW Bureau of Health Information (BHI) collects and publishes data about the experiences of people admitted to NSW public hospitals. Data are reported for New South Wales from the Adult Admitted Patient Survey, a survey of patients who have recently been admitted to a NSW public hospital.

### **Number of Aboriginal and/or Torres Strait Islander respondents to the NSW Adult Admitted Patient Survey**

| Year | Aboriginal and/or Torres Strait Islander respondents |
|------|--|
| 2014 | 2,682  |
| 2018 | 443  |
| 2019 | 3,454  |
| 2020 | 364  |

Note: Aboriginal and/or Torres Strait Islander respondents oversampled in 2014 and 2019 surveys.

This report used data from the 2014, 2018, 2019 and 2020 surveys downloaded from the BHI's interactive data portal: [Healthcare Observer](#). The NSW BHI also released a detailed report in 2021, [Aboriginal people's experiences of hospital care](#), focussing on Aboriginal and Torres Strait Islander patient experiences using data from various BHI surveys in 2019. Some highlights from this report are also presented in this report.

The Queensland Maternity Outpatient Clinic Patient Experience Survey includes Aboriginal and Torres Strait Islander specific questions. Data on Aboriginal and Torres Strait Islander women are available from the 2015 (350 women) and 2017 (390 women) surveys. For more information see the [2017 Maternity Outpatient Clinic Patient Experience Survey Report](#). This survey has been discontinued.

Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) surveys could provide another opportunity to collect data on Indigenous patients' experiences of health care. The collection of patient reported data through standardised PREMs and PROMs for Indigenous health care users needs to consider cultural adaptability of these tools and development work is underway to address this at hospital and primary health care service level for accountability and continued quality improvement.

Reconciliation Australia's Australian Reconciliation Barometer (ARB) was developed as a tool to measure the progress of reconciliation between Indigenous and non-Indigenous Australians. The first study was completed in 2008, with biennial reports since then. The results of surveys prior to 2014 are no longer included in the ARB, so that applicable tracking results are more directly comparable. For the 2014, 2016, 2018 and 2020 surveys, the Indigenous community sample ranged between 495 and 502, and the general community sample between 1,100 and 2,277. The general sample also includes Australians who are Indigenous or have Aboriginal and/or Torres Strait Islander heritage. Both the general and Indigenous samples are weighted to be

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representative in terms of age group, gender and location (state and territory populations), as per ABS 2016 Census data. Data from the [2020 report](#) covers the period to July 2020 and therefore some responses to the survey questions may be in reference to approximately the first six months of the COVID-19 pandemic in Australia.

The two final measures in this module for leave events used data from the national hospitals and national emergency care data collections. See the Data sources and data gaps section in [Module 3](#) for more information on hospitals data collections.

### **Data gaps**

Major data gaps in this module are the lack of hospital patient experience data from most jurisdictions, as well as data on patients of non-hospital health care services such as primary health care and specialist services. Regular, national data collections of Indigenous patient experiences are needed to enable monitoring of the impact of government initiatives and measuring of progress in achieving cultural safety. Such data collections should allow for reporting across small areas and in different health sectors.

Archived content

## Module 3: Access to health care services

Overall, Aboriginal and Torres Strait Islander people experience poorer health than non-Indigenous Australians, but they do not always have the same level of access to health services. This module includes some selected measures of access to health care services that cover the different levels of the health system. The measures compare use of various services for Indigenous and non-Indigenous Australians as a way of broadly monitoring disparities in access. Disparities in access and use of health services may indicate problems with the cultural safety of services, but there may be many other factors, such as remoteness, affordability, previous experiences of racism in health care environments for themselves, family or community members and fear of how they will be treated.

For example, potentially preventable hospitalisations (hospitalisations for conditions that can be effectively treated in a non-hospital setting) can serve as a proxy measure of access to timely, effective and appropriate primary and community-based care. Systematic differences in hospitalisation rates for Indigenous Australians and non-Indigenous Australians can indicate gaps in the provision of population health interventions, primary care services, and continuing care support. The rate of potentially preventable hospitalisations is affected by the interaction of a broad range of factors; however, culturally safe primary health care could help better detect and manage health risk factors and conditions and thereby reduce rates of potentially preventable hospitalisations.

### What data are available?

The measures in this module are based on national administrative data collections covering immunisation, Medicare Benefits Schedule (MBS), hospitals, mortality, perinatal and elective surgery waiting times.

For further information on the data sources used in this module, see [Module 3 – Data sources and data gaps](#).

#### Key findings

Selected measures of access to health care services for Indigenous and non-Indigenous Australians are used to monitor disparities in access as they may indicate problems with the cultural safety of services, though many other factors can also impact on access to and use of services (for example, remoteness, affordability, previous experiences of racism, presence of co-morbidities).

- In the two-year period 2018–2019, 27% of Indigenous women aged 40 and over received a free mammogram through BreastScreen Australia. Based on age-standardised rates, 26% of Indigenous women aged 40 and above received a mammogram, compared with 34% of non-Indigenous women.
- Indigenous Australians waited longer to be admitted for elective surgery in 2019–20 than non-Indigenous Australians—50% of Indigenous patients were admitted for elective surgery within 49 days, compared with 38 days for non-Indigenous patients.
- In 2019, the avoidable mortality rate for Indigenous Australians was 222 per 100,000. The Indigenous age-standardised rate was over 3 times that for non-Indigenous Australians (323 and 98 per 100,000 respectively).
- In 2019–20, the rate of potentially preventable hospitalisations for Indigenous Australians was around 3 times the rate for non-Indigenous Australians (68.4 compared with 23.3 per 1,000, based on age-standardised rates).
- In 2019, of 5,311 registered cases of rheumatic heart disease, 82% were Indigenous Australians compared with 18% non-Indigenous Australians.

See [Module 3 data tables](#) for all data presented in this module.

**Note:** This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Data gaps and limitations

Disparities in access may be due to a range of factors other than a lack of cultural safety. The data provide overall measures of access, but do not include information on all the factors that can impact on access, such as affordability, previous experiences of racism, the presence of co-morbidities or patient choice.

### 3.1 Preventive health services

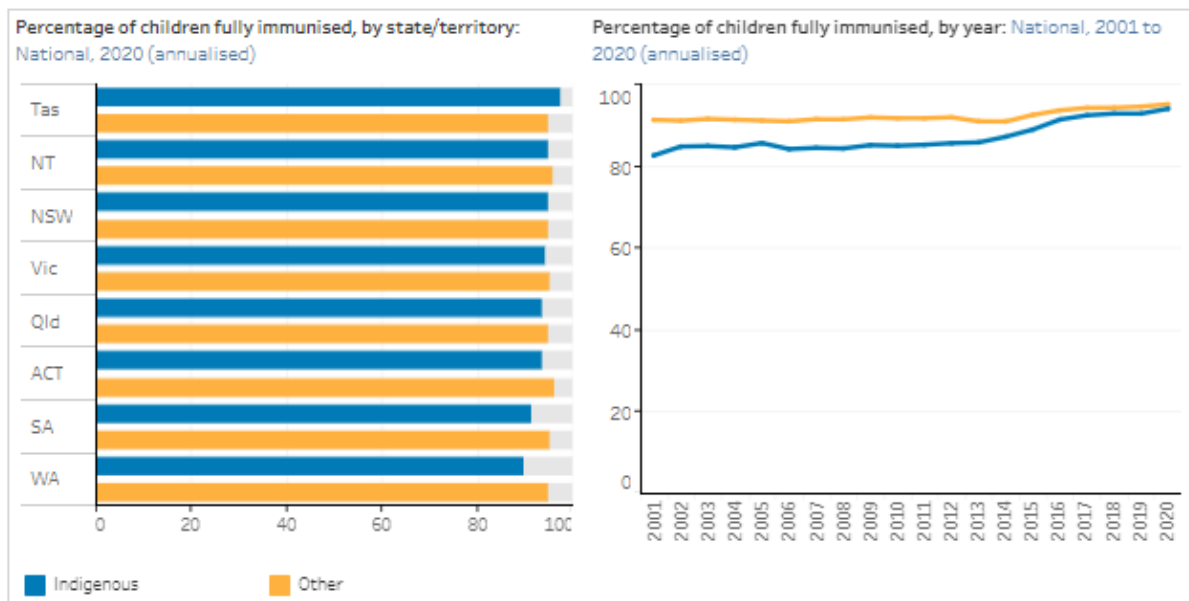
Preventive health services, such as immunisation, can protect children and adults from harmful infectious diseases and prevent the spread of diseases amongst the community. Health screening services, such as breast screening, can help detect serious conditions and reduce mortality.

The data reported for these two measures come from the Australian Immunisation Register and BreastScreen Australia.

#### Rates of immunisation

Select age group:

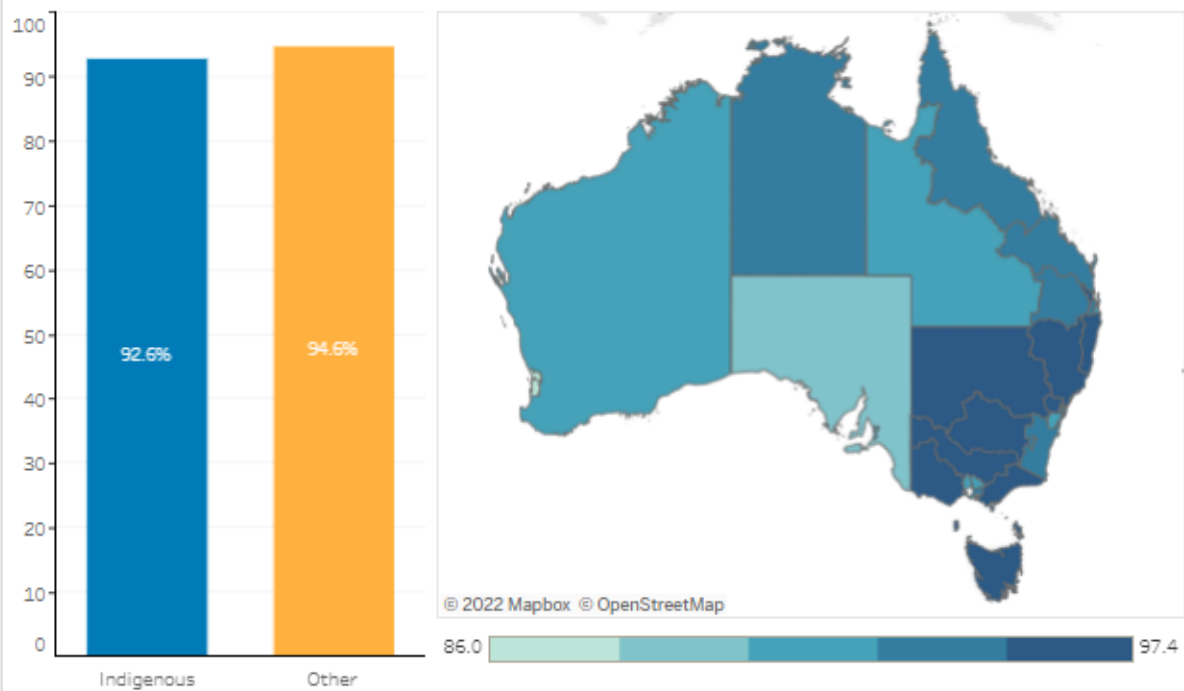
1 year



Percentage of children fully immunised, by Primary Health Network, as at 31 December 2020

Hover over a section of the map to see detailed comparisons by Primary Health Network.

Children aged 1 year, Country WA



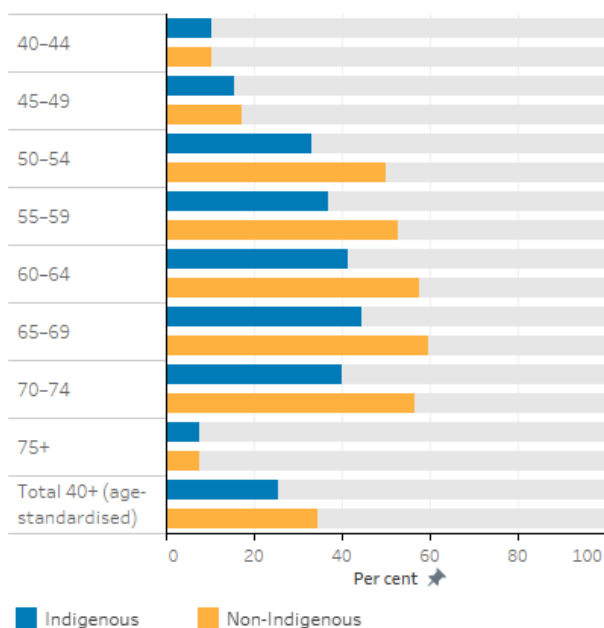
Notes

1. Suppression has been applied to data by PHN to protect the privacy.
2. In map by PHN,  $\geq 95.0\%$  and  $\geq 99.0\%$  values are treated as 95.0% and 99.0% respectively.

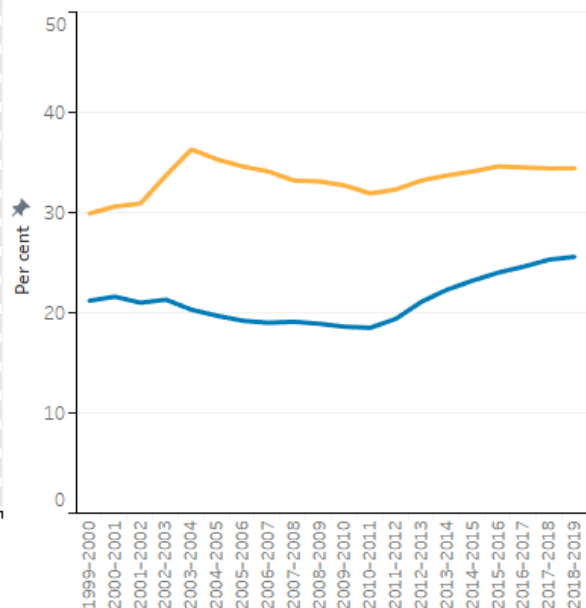
Source: Australian Immunisation Register (AIR) (see data tables for Module 3 – Tables 3.1.1a, 3.1.1b, 3.1.1c).

## Participation rates for breast screening

BreastScreen participation rates by age group: National, 2018–2019



BreastScreen participation rates by year: National, 1999–2000 to 2018–2019



Source: AIHW analysis of BreastScreen Australia data, as published in AIHW 2021 (see data tables for Module 3 – Tables 3.1.2a, 3.1.2b).

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



## References

Australian Institute of Health and Welfare (AIHW) 2020. [Aboriginal and Torres Strait Islander Health Performance Framework 2020](#). Canberra: AIHW.

AIHW 2021. [BreastScreen Australia monitoring report 2021](#). Cat. no. CAN 135. Canberra: AIHW. Viewed 13 December 2021.

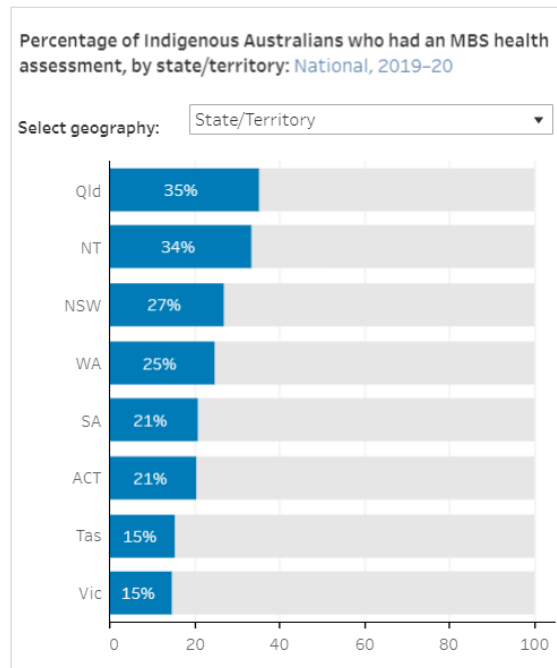
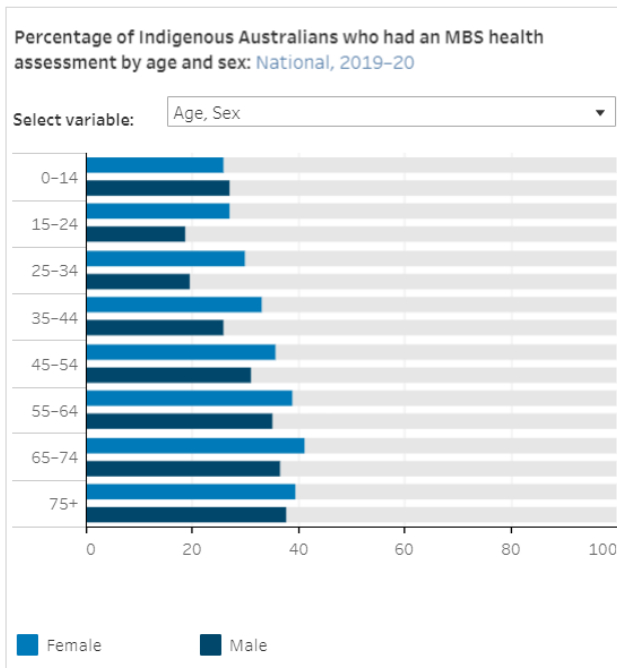
## 3.2 Primary health care

Primary health care services can help to keep people well and out of hospital by supporting them to manage their health issues in the community and at home, potentially avoiding health issues from becoming more serious. These services can reduce the need for specialist services and visits to emergency departments.

This domain has data on:

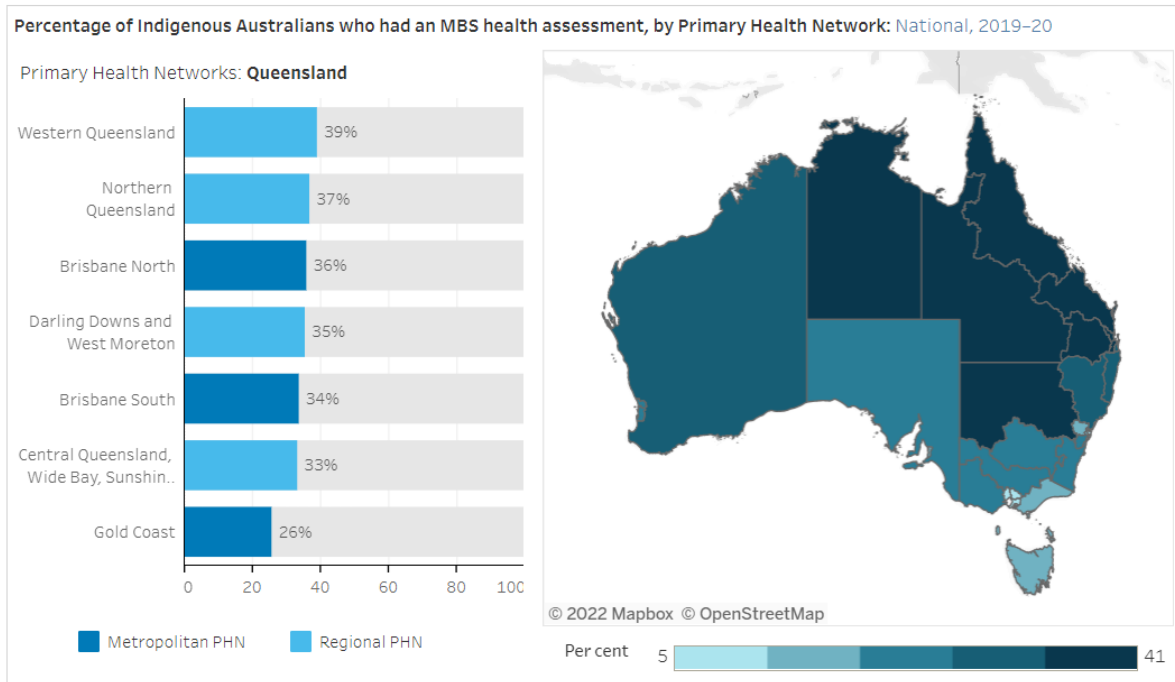
- Indigenous health checks, including, MBS items 715 and 228 and temporary telehealth items 92004, 92011, 92016, 92023 made available from March 2020 (through to March 2021) in response to the COVID-19 pandemic
- antenatal care
- potentially preventable hospitalisations.

### Indigenous health checks



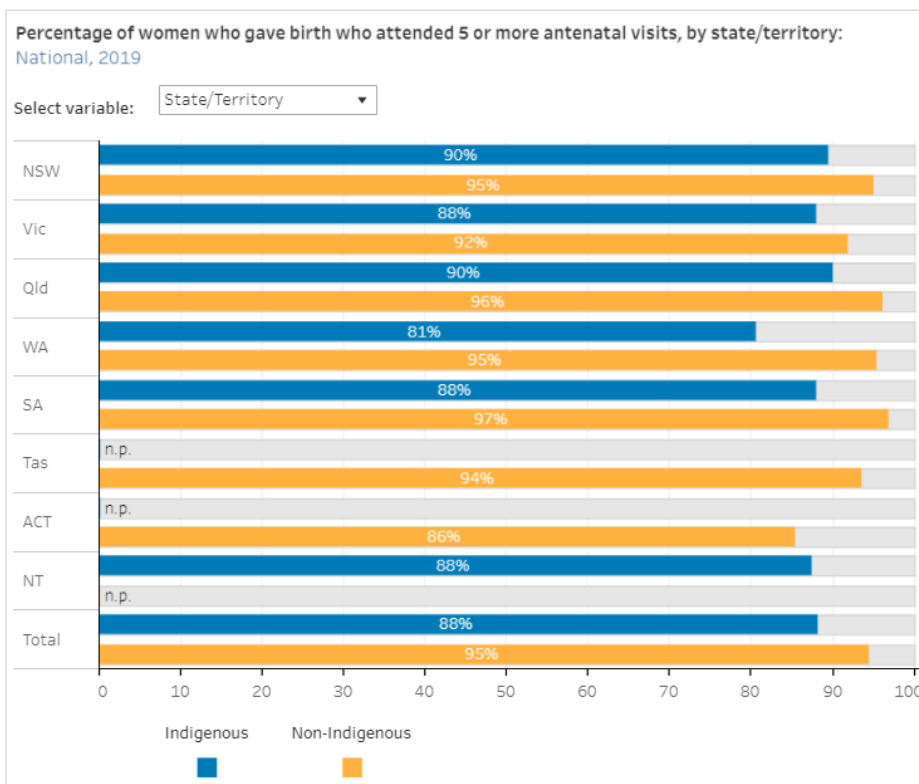
Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

Hover over a section of the map to see comparisons by state/territory.



Source: AIHW analysis of Medicare Benefits Schedule data, unpublished (see data tables for Module 3 – Tables 3.2.1a, 3.2.1b, 3.2.1c, 3.2.1d).

## Access to antenatal care



The rate of Indigenous women who attended 5 or more antenatal visits was **lower than** the rate for non-Indigenous women across remoteness areas

n.p. = not publishable

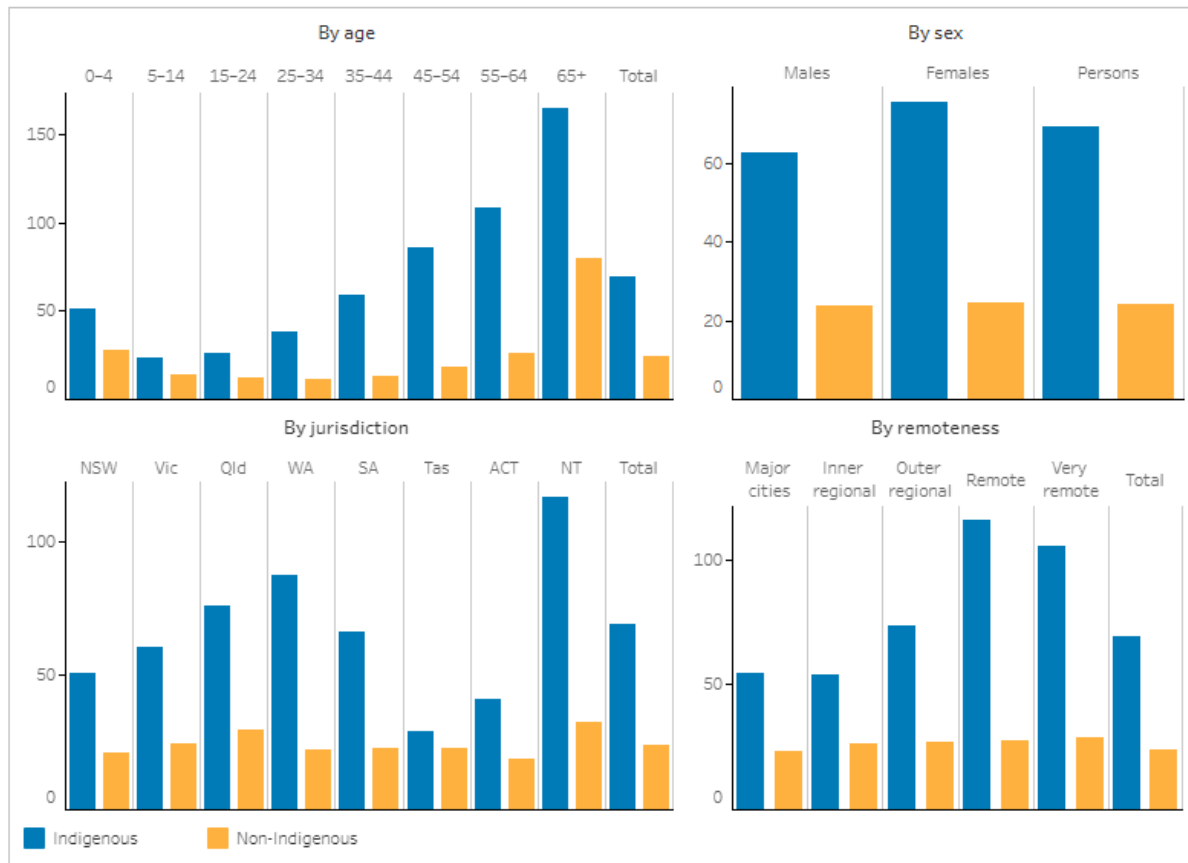
Source: AIHW analysis of the National Perinatal Data Collection, as published in AIHW 2021 (see data tables for Module 3 – Tables 3.2.2a, 3.2.2b).

Note: This is not the most recent version of this report. Please visit the [AIHW website](https://www.aihw.gov.au) for updates.

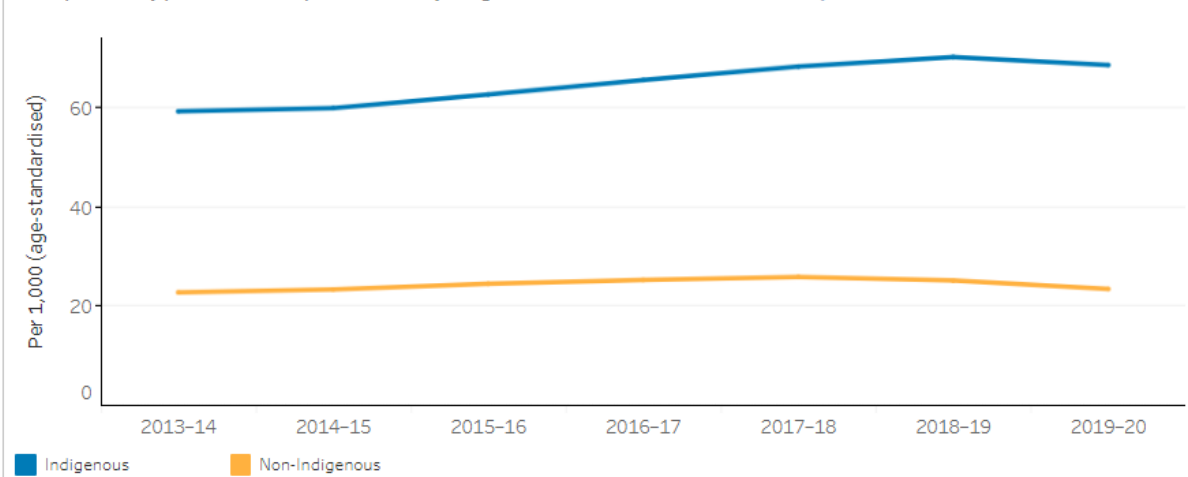
## Potentially preventable hospitalisations

Potentially preventable hospitalisations are hospitalisations for conditions that can be effectively treated in a non-hospital system. These hospitalisations serve as a proxy measure for access to timely, effective and appropriate primary and community-based care. For more information on PPH, see the [Aboriginal and Torres Strait Islander Health Performance Framework](#).

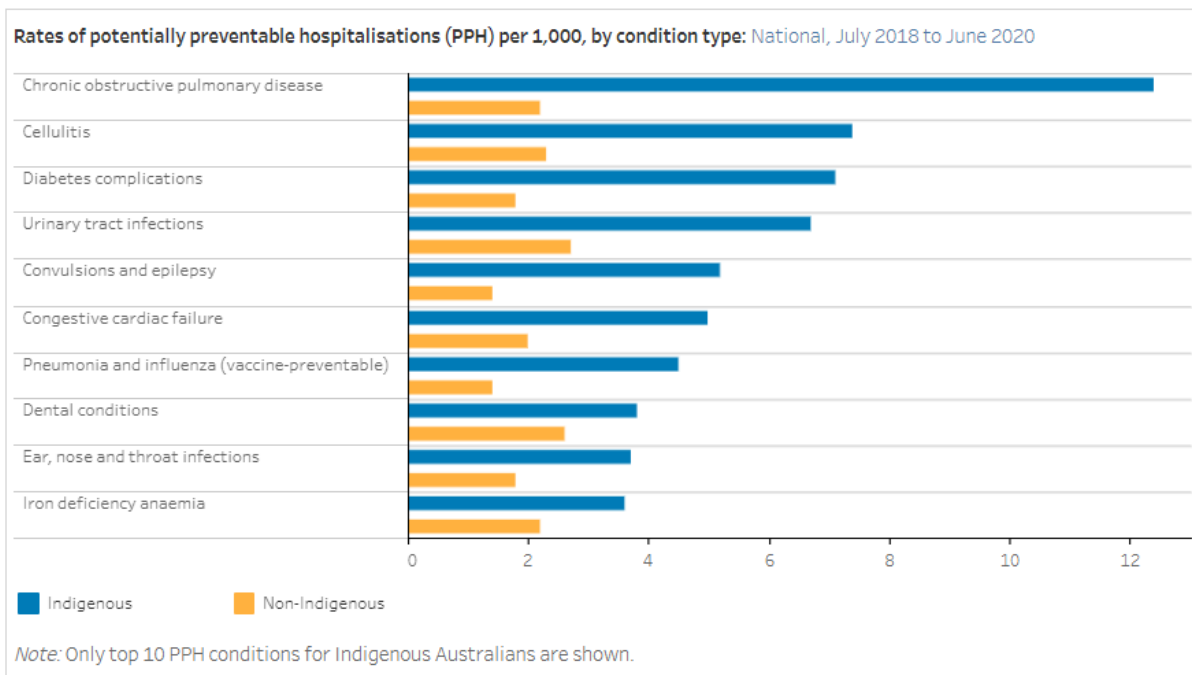
Total potentially preventable hospitalisations per 1,000, by age, sex, jurisdiction and remoteness: National, July 2018 to June 2020



Total potentially preventable hospitalisations, by Indigenous status, timetrend: National, July 2013 to June 2020



Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



Source: AIHW analysis of National Hospital Morbidity Database (see data tables for Module 3 – Table 3.2.3a, 3.2.3b, 3.2.3c, 3.2.3d).

## References

Australian Institute of Health and Welfare (AIHW) 2021. [Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023](#). Cat. No. IHW 201. Canberra: AIHW. Accessed 1 January 2022.

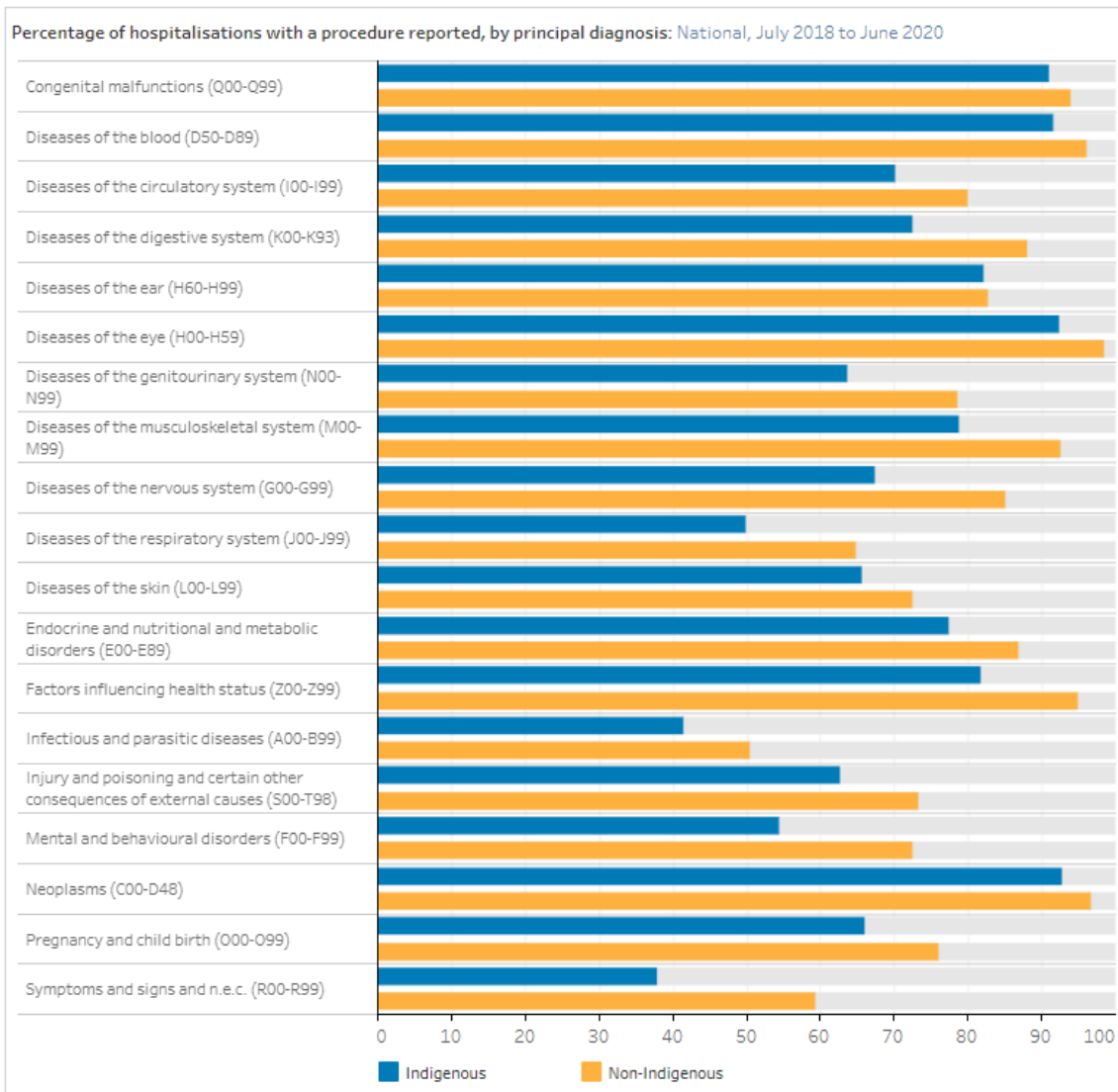
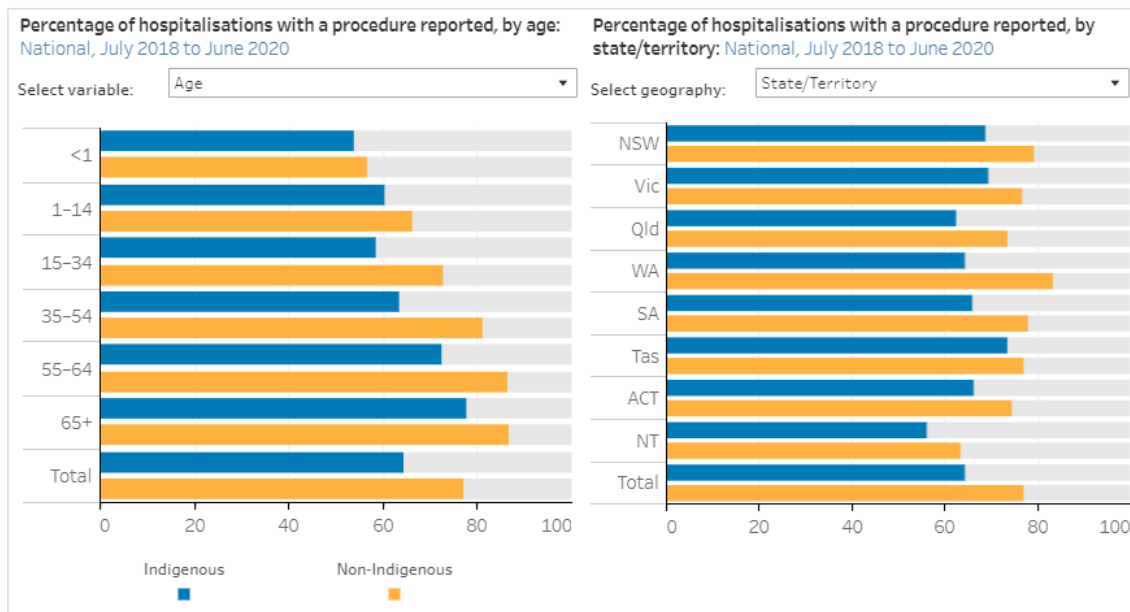
## 3.3 Hospital services

There are various measures that can be used to assess access to hospital services. Emergency department waiting times are one indicator of accessibility of hospital services as they reflect how long patients have to wait for urgent medical attention, or to receive care as an admitted hospital patient. Access to medical procedures while in hospital are another indicator as studies have shown that while Aboriginal and Torres Strait Islander people are more likely to be hospitalised than other Australians, they are less likely to receive certain medical or surgical procedures. The data on waiting times for elective surgery also show that Indigenous Australians often wait longer to receive surgery.

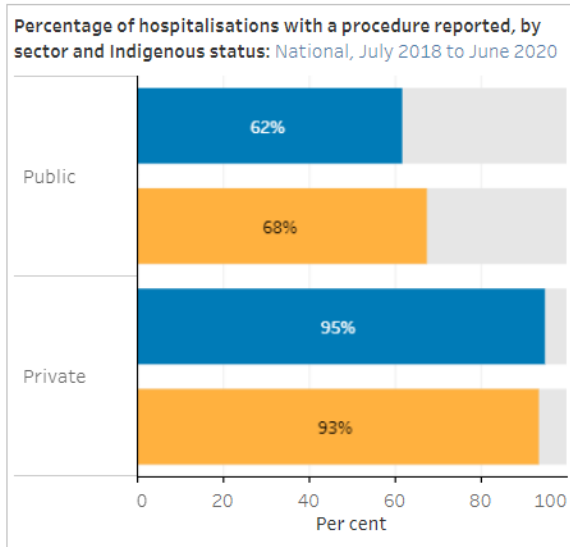
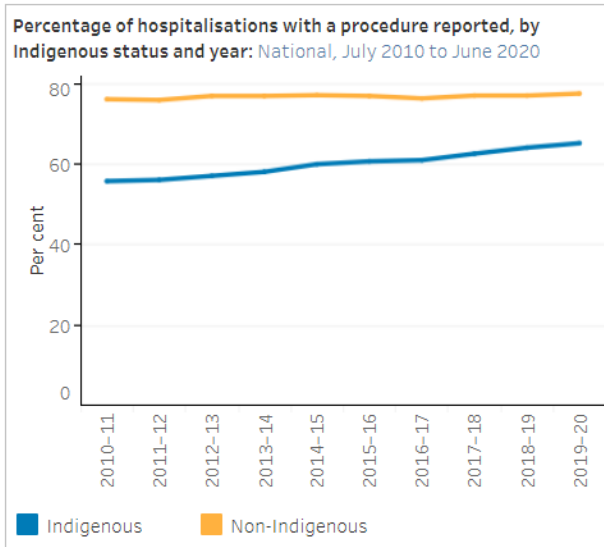
Following a decision by National Cabinet, in the context of ensuring the health system maintained adequate capacity to deal with the COVID-19 pandemic, restrictions were applied to selected elective surgeries from early 2020. These restrictions contributed to an overall decrease in admissions from elective surgery waiting lists of 9.2% between 2018–19 and 2019–20 and impacted waiting times for elective surgery.

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Access to hospital procedures



Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

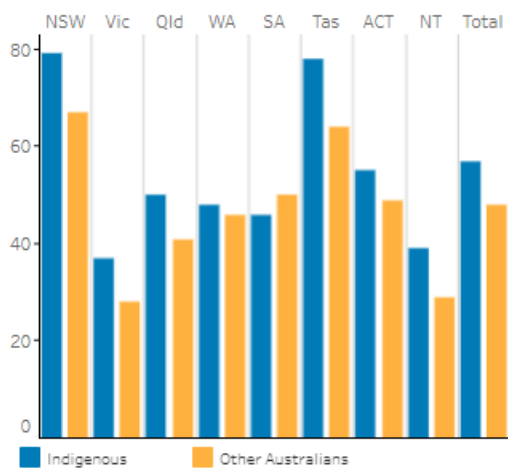


Source: AIHW analysis of National Hospital Morbidity Database (see data tables for Module 3 – Tables 3.3.1a, 3.3.1b and 3.3.1c).

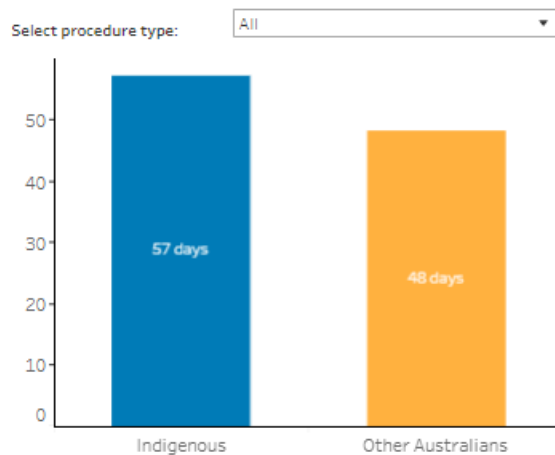
## Waiting times for elective surgery

Select measure:

Admissions and waiting times for admissions from elective surgery waiting lists, public hospitals, by state/territory: National, 2020-21



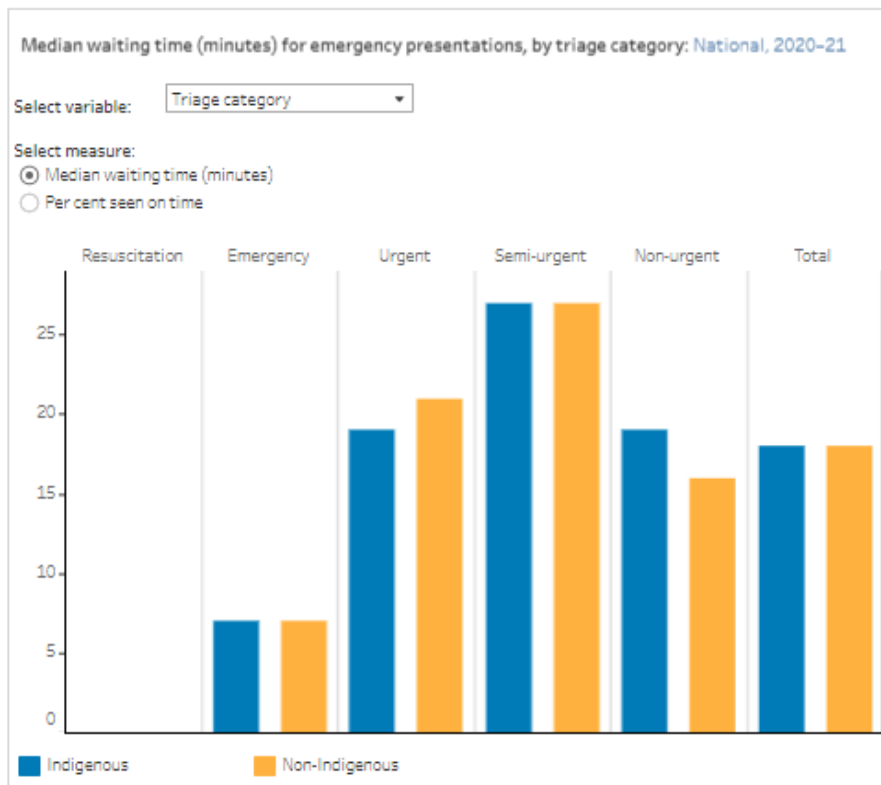
Admissions and waiting times for admissions from elective surgery waiting lists, public hospitals, by procedure: National, 2020-21



Note: 'Other Australians' includes patients for whom Indigenous status was 'Not reported'.

Source: AIHW analysis of National Elective Surgery Waiting Times Data Collection, as published in AIHW 2022 (see data tables for Module 3 – Tables 3.3.2a, 3.3.2b).

## Emergency department waiting times



The median waiting time for emergency presentations was **equal** for **Indigenous Australians** and **other Australians** (both **18 minutes**)

### Notes

1. 'Other Australians' includes patients for whom Indigenous status was 'Not reported'.

2. Waiting time is defined by the elapsed time from presentation to commencement of clinical care.

Source: AIHW analysis of the National Non-Admitted Patient Emergency Department Care Database, as published in AIHW 2021 (see data tables for Module 3 – Tables 3.3.3a, 3.3.3b).

## References

Australian Institute of Health and Welfare (AIHW) 2021. [Emergency department care](#). MyHospitals. Canberra: AIHW. Viewed 17 December 2021.

AIHW 2022. [Elective surgery](#). MyHospitals. Canberra: AIHW. Viewed 27 January 2022.

## 3.4 Specialist services

The Australian health system provides specialist treatment services to help people with a range of health concerns. Data are reported on specialist services claimed through the Medical Benefits Schedule (MBS), and on treatment of kidney failure, rheumatic heart disease and cataract surgery.

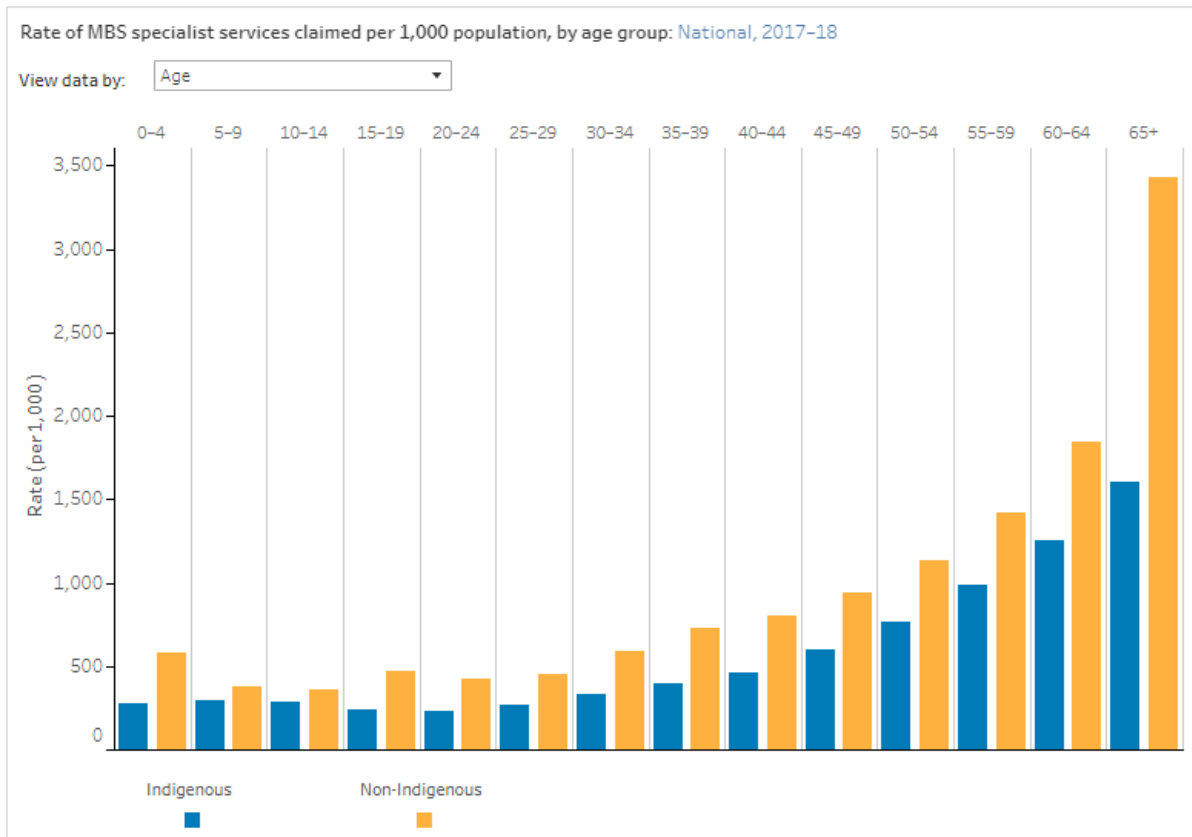
Cataract surgery procedure rates over 2019–20 were significantly affected by COVID-19 related restrictions on elective surgery in 2020. In 2019–20,

- 31 procedures for Aboriginal and Torres Strait Islander peoples took place in April, down from 289 in April 2018–19, a drop of 89 percentage points.
- 140 procedures were performed in May, down from 363 in May 2018–19, a drop of 61 percentage points.
- 305 cataract surgery procedures were performed in June back to a similar amount of 329 procedures performed in June 2018–19.

**Note:** This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

Indigenous status in the MBS data is based on the Voluntary Indigenous Identifier (VII) For more information, see [Indigenous eye health measures 2020](#). MBS specialist services are not updating for this release as the current Indigenous identifier is not available for 2019–20 as it is under development by the Commonwealth Department of Health.

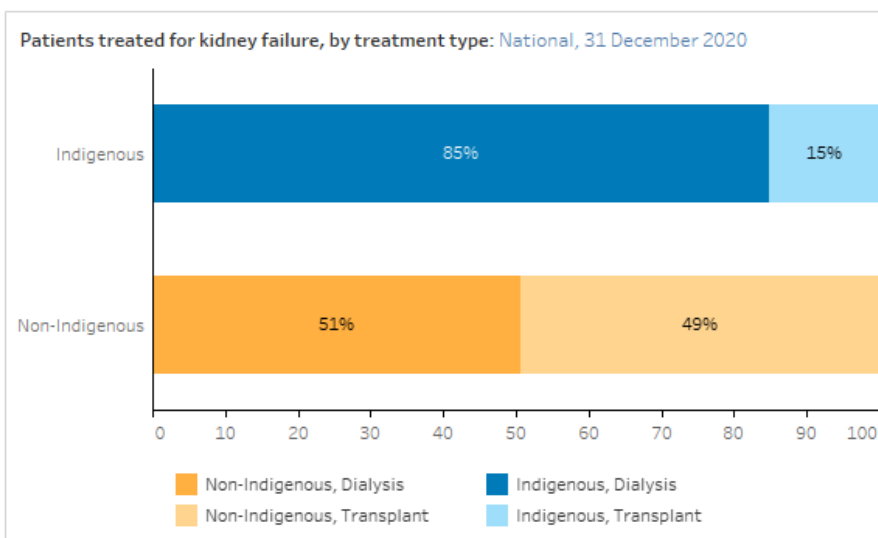
## MBS specialist services



Source: AIHW analysis of Medicare data.

[Source data tables and footnotes](#)

## Treatment of kidney failure



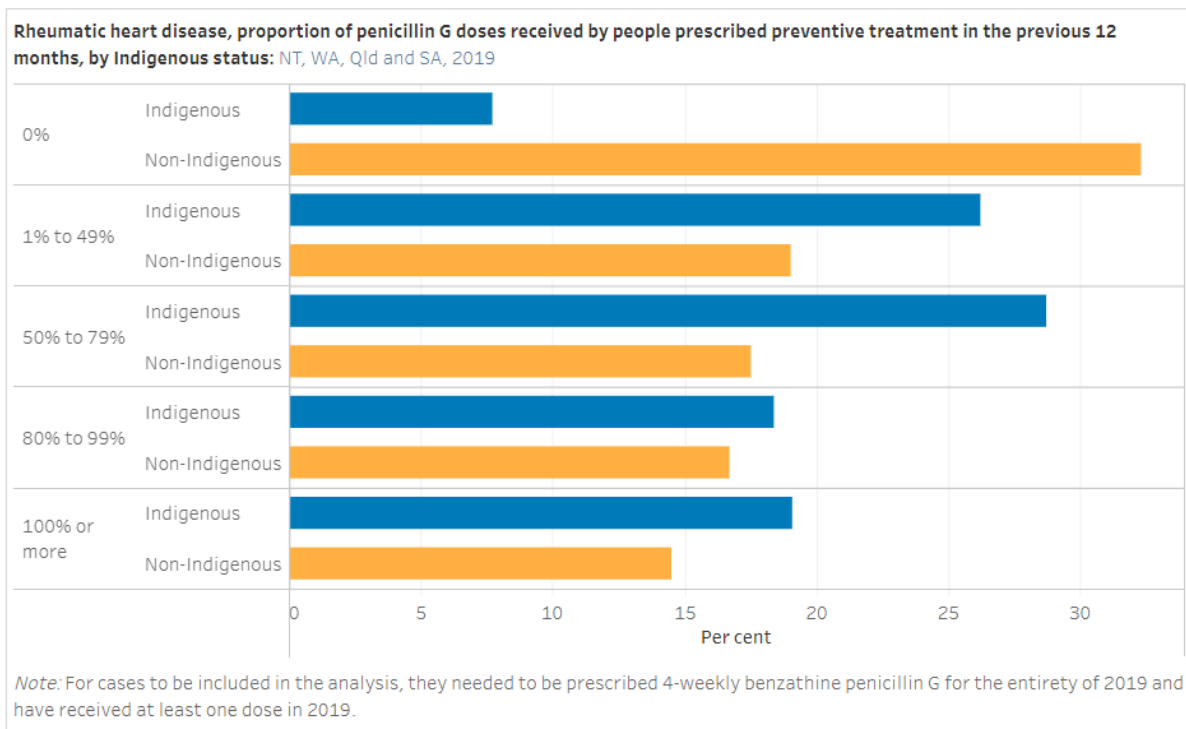
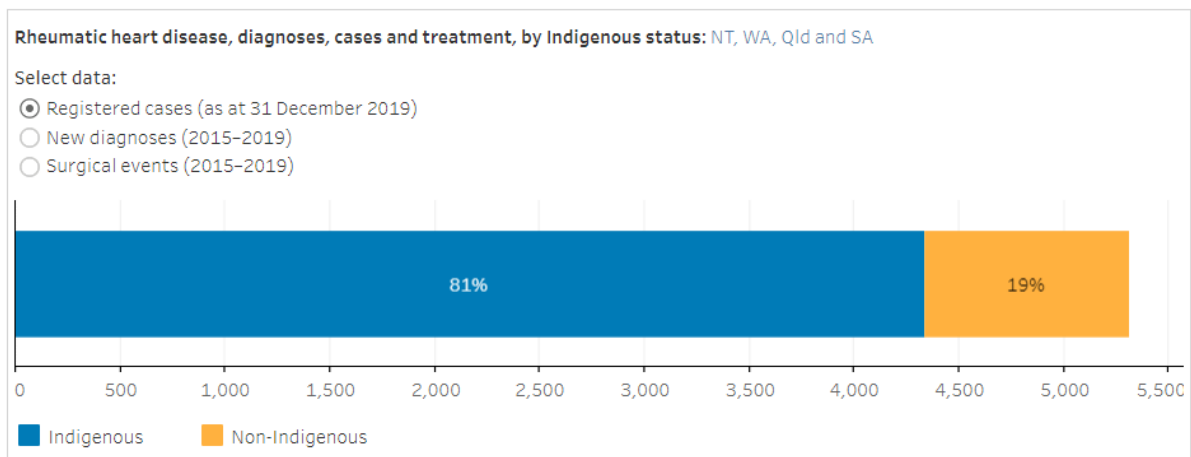
In 2020, among patients treated for kidney failure, a **lower** proportion of **Indigenous Australians** received transplants (**15%**) than **non-Indigenous Australians (49%)**

Source: AIHW analysis of ANZDATA data (see data tables for Module 3 – Table 3.4.2).

Note: This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.



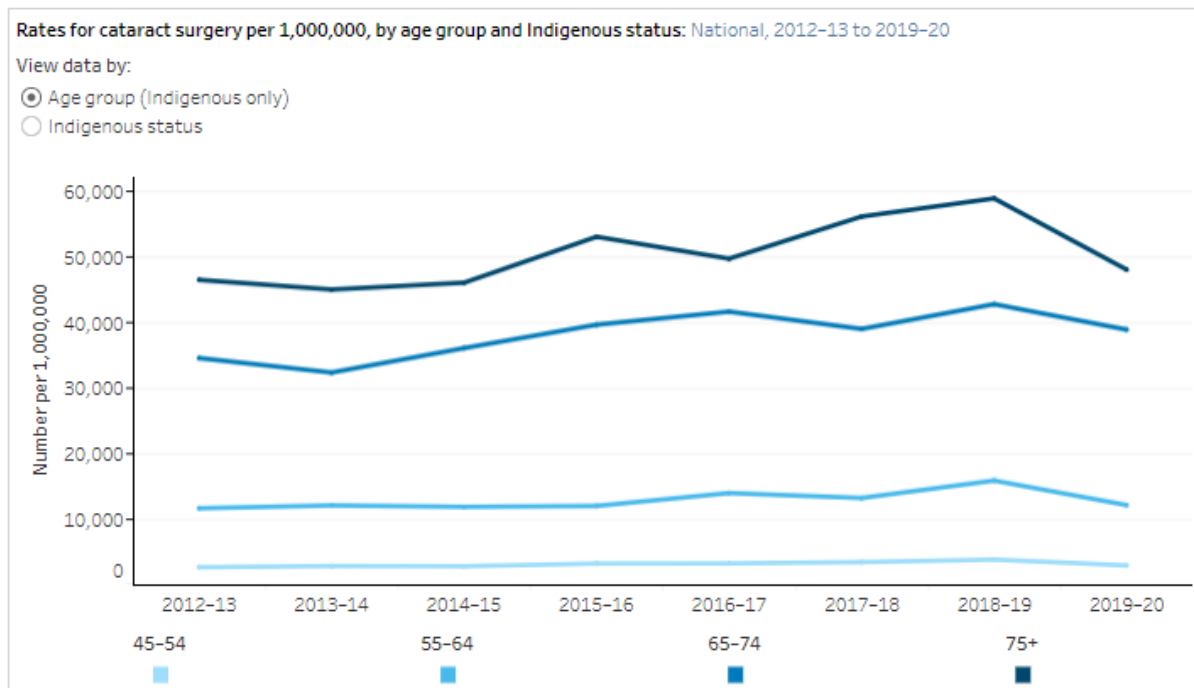
## Rheumatic heart disease



*Source:* AIHW analysis of National Rheumatic Heart Disease data collection, as published in AIHW 2021a and AIHW 2021b (see data tables for Module 3 – Tables 3.4.3a, 3.4.3b).

For more information on rheumatic heart disease, see [Better Cardiac Care measures for Aboriginal and Torres Strait Islander people: six national report 2021](#).

## Cataract surgery



Source: AIHW National Hospital Morbidity Database.

## References

Australian Institute of Health and Welfare (AIHW) 2021a. [Acute rheumatic fever and rheumatic heart disease in Australia, 2015–2019](#). Cat. no. CVD 90. Canberra: AIHW. Viewed 17 December, 2021.

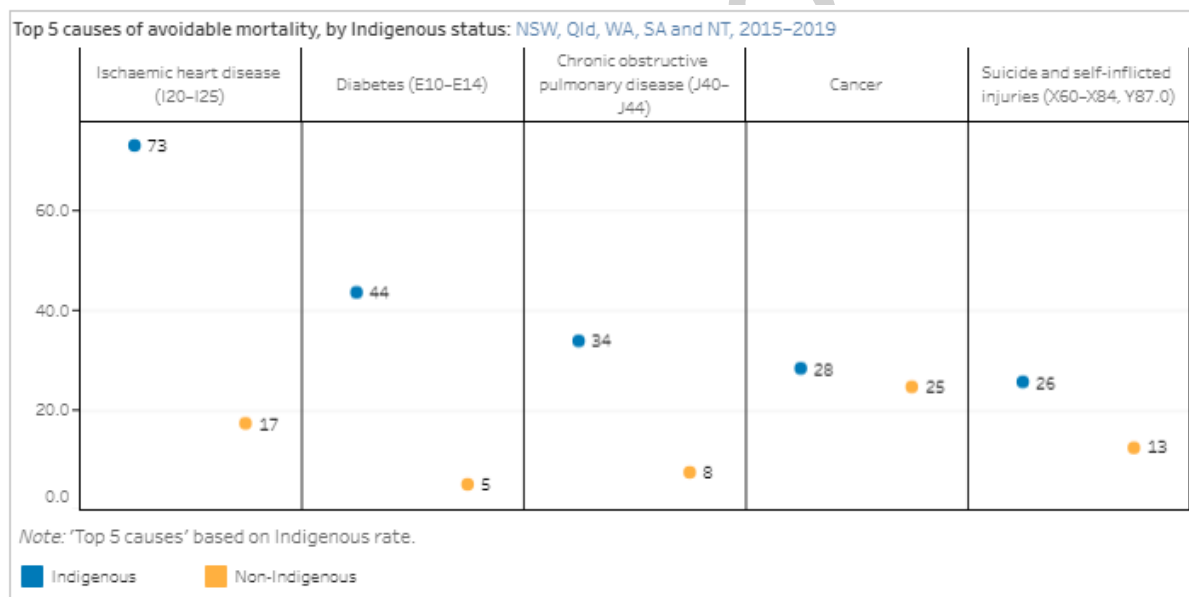
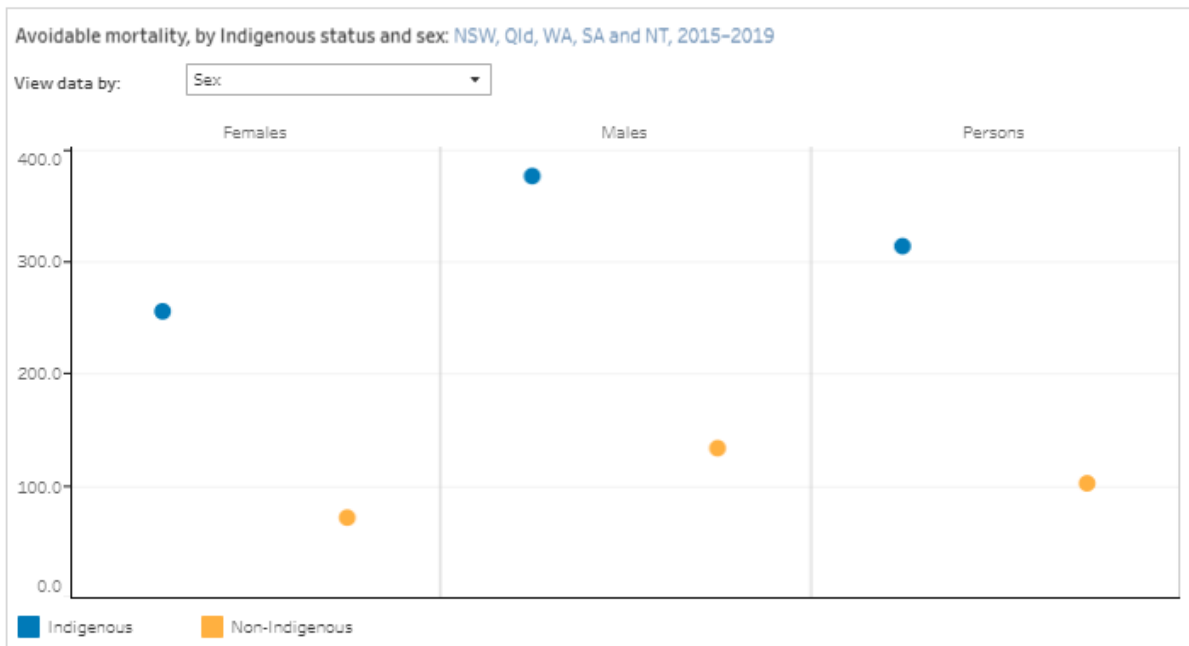
AIHW 2021b. [Better Cardiac Care measures for Aboriginal and Torres Strait Islander people: sixth national report 2021](#). Cat. no. IHW 263. Canberra: AIHW. Viewed 17 December, 2021.

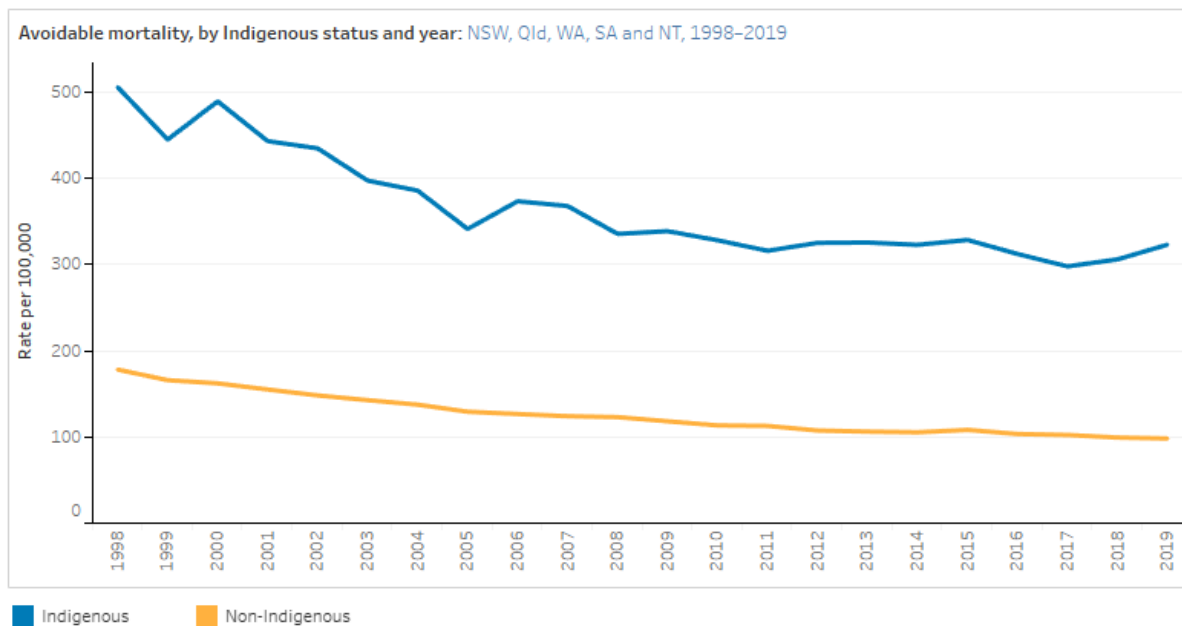
## 3.5 Overall health system

Avoidable mortality refers to deaths from conditions that are considered avoidable, given timely and effective health care, including disease prevention and population health initiatives.

Avoidable mortality is one measure of the quality, effectiveness and accessibility of the health system. It should be noted, however, that deaths from most conditions are also influenced by factors other than access to health system services, including the underlying prevalence of conditions in the community, environmental and social factors, and health risk factors.

## Avoidable mortality





Source: AIHW and ABS analysis of National Mortality Database, previously unpublished (see data tables for Module 3 – Tables 3.5.1a, 3.5.1b, 3.5.1c, 3.5.1d).

For more information on potentially [avoidable deaths](#), see the [Aboriginal and Torres Strait Islander Health Performance Framework](#).

## Reference

Australian Institute of Health and Welfare (AIHW) & National Indigenous Australians Agency (AIHW) 2022. [Aboriginal and Torres Strait Islander Health Performance Framework: Measure 1.24 Avoidable and preventable deaths](#). Canberra: AIHW. Viewed 1 June 2022.

## Data sources and data gaps

The main data sources for the access to services measures were national data collections, mainly administrative data:

- [Australian and New Zealand Dialysis and Transplant Registry](#)
- [Australian Immunisation Register](#)
- [BreastScreen Australia data](#)
- [Medicare Benefits Schedule data](#)
- [National Hospitals Data Collection](#)
  - National Elective Surgery Waiting Times Data Collection
  - National Hospital Morbidity Database
  - National Non-admitted Patient Emergency Department Care Database
- [National Mortality Database](#)
- [National Perinatal Data Collection](#)
- [National Rheumatic Heart Disease data collection](#).

There were data available for reporting on all measures in this module as they were based on existing national indicators or data collections.

**Note:** This is not the most recent version of this report. Please visit the [AIHW website](#) for updates.

## Access to health care services: measures and data sources

| Domains and measures                     | Data sources   |
|--|--|
| <b>3.1 Preventive health services</b>    |  |
| Rates of immunisation                    | Australian Immunisation Register                                 |
| Participation rates for breast screening | BreastScreen Australia data                                      |
| <b>3.2 Primary health care</b>           |  |
| Indigenous health checks                 | Medicare Benefits Schedule data                                  |
| Access to antenatal care                 | National Perinatal Data Collection                               |
| Potentially preventable hospitalisations | National Hospital Morbidity Database                             |
| <b>3.3 Hospital services</b>             |  |
| Access to hospital procedures            | National Hospital Morbidity Database                             |
| Waiting times for elective surgery       | National Elective Surgery Waiting Times Database                 |
| Emergency department waiting times       | National Non-Admitted Patient Emergency Department Care Database |
| <b>3.4 Specialist services</b>           |  |
| Specialist services claimed              | Medicare Benefits Schedule data                                  |
| Treatment of kidney failure              | Australian and New Zealand Dialysis and Transplant Registry      |
| Rheumatic heart disease                  | Rheumatic Heart Disease data collection                          |
| Cataract surgery                         | National Hospital Morbidity Database                             |
| <b>3.5 Overall health system</b>         |  |
| AVodiable mortality                      | National Mortality Database                                      |

### Notes

The National Hospitals Data Collection includes the major national hospitals databases held by the AIHW. This report includes data from the following hospital data collections:

- The National Hospital Morbidity Database (NHMD), a compilation of episode-level records from admitted patient morbidity data collection systems in Australian public and private hospitals.
- The National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), a compilation of episode-level records (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals.
- The National Elective Surgery Waiting Times Data Collection (NESWTDC), which holds episode-level information on patients added to or removed from elective surgery waiting lists managed by public hospitals.

For more information about these hospitals collections and the data quality statements see [National Hospitals Data Collection](#) and [MyHospitals 'About the Data'](#).

See the Aboriginal and Torres Strait Islander Health Performance Framework 'Data sources and quality' page for more information on [AIHW data collections](#) and [other data collections](#) presented in this module.

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