Determinants of health—access to services

Indicator 15
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Indicator 23
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Cross-cultural training for hospital staff

Introduction

There are 10 indicators in this sub-domain. The first five indicators relate to Indigenous access to health services—Aboriginal and Torres Strait Islander community-controlled health services, community health centres, hospitals, health services for small homeland communities, and services for key health conditions. These indicators provide a measure of the extent to which Aboriginal and Torres Strait Islander people have access to the range of different health services that most non-Indigenous people can access.

The next four indicators relate to health services workforce availability and training. Indicators on the number of Indigenous people in the health workforce and the numbers of Indigenous people with higher education and training in key health professions are being developed to assess the extent of the capacity of Indigenous people to deliver health services to Indigenous people. There are two indicators on workforce availability in services providing health care to a significant proportion of Indigenous people—one for primary health care services and one for hospitals. These provide measures of these services to provide care for a large population of Indigenous people. The last indicator in this sub-domain is the extent to which hospital staff are trained to provide culturally appropriate services to Indigenous people.

Indicator 15. Aboriginal and Torres Strait Islander community-controlled health services

Indicator:

(a) The number of primary health care services that are community-controlled

(b) The per person funding for primary health care services provided by government to Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).

Purpose

This indicator is intended to measure the extent to which primary health care for Aboriginal and Torres Strait Islander people is community-controlled, and the capacity of such services to provide comprehensive primary health care. The Australian Government has joint responsibility with state and territory governments for funding and/or direct provision of Aboriginal and Torres Strait Islander primary health care services. The indicator allows monitoring of state, territory and Australian Government allocation to these services.

Data

Data are provided on the funding for Aboriginal and Torres Strait Islander primary health care services (ATSIPHCS). This includes ACCHOs, as well as other Indigenous primary health care services. Most of the data relates to community-controlled services but it was not possible to provide data only on these services.

The table includes Australian Government expenditure from OATSIH and state government expenditure on Aboriginal and Torres Strait Islander primary health care services. Australian Government data are from the SAR annual data collection project. State government numbers and expenditure data were provided separately by each jurisdiction.

- The number of ATSIPHCS in Australia increased from 137 in 2002–03 to 140 in 2003–04.
- The Northern Territory (29 in 2002–03 and 27 in 2003–04) and Queensland (26 in 2002–03 and 27 in 2003–04) had the largest number of ATSIPHCS.
- Most expenditure on ATSIPHCS services came from the Australian Government: in 2002–03, 78% of total expenditure, and in 2001–02, 76% of expenditure.
- Australian Government expenditure across Australia decreased by $10 million between 2002–03 and 2003–04. Expenditure by state governments increased by approximately $1 million over the same period.
- In 2002–03, the highest per capita expenditure on ATSIPHCS was in Victoria ($772) and the Northern Territory ($637), and in 2003–04 the highest per capita expenditure was in Victoria ($821) and South Australia ($763). The lowest per capita expenditure was in Tasmania, where there was no expenditure by the state government on these organisations ($180 in 2002–03 and $200 in 2003–04).

Table 15.1: Number of and expenditure on Aboriginal and Torres Strait Islander primary health care services, 2002–03 and 2003–04

	NSW & ACT[a]	Vic[b]	Qld	WA	SA	Tas	NT	Australia
				2002–03				
No. of ATSIPHCS[c]	28	20	26	21	8	5	29	137
Expenditure ($'000)								
Australian Govt[d]	26,407.5	12,620.1	23,727.3	29,068.5	15,520.7	3,207.6	33,305.4	143,857.1
State/territory	5,852.3	9,817.2	4,159.9	13,049.1	3,361.0	—	4,026.8	40,266.2
Total	*32,259.8*	*22,437.3*	*27,887.2*	*42,117.6*	*18,881.7*	*3,207.6*	*3,7332.2*	*184,123.3*
Estimated population[e]	142,228	28,743	129,954	67,783	26,299	17,731	58,196	470,933
Per person expenditure ($)	226.7	772.4	212.4	615.7	711.1	179.7	636.7	390.8
				2003–04				
No. of ATSIPHCS[c]	29	21	27	21	10	5	27	140
Expenditure ($'000)								
Australian Govt[d]	29,888.6	13,353.8	27,499.5	32,949.7	17,271.2	3,590.7	39,275.6	133,940.5
State/territory	5,758.0	10,768.5	4,333.5	12,346.1	3,182.0	—	4,877.5	41,266.0
Total	*35,646.6*	*24,122.3*	*31,833.1*	*45,296.2*	*20,453.2*	*3,590.7*	*44,153.1*	*175,206.5*
Estimated population[e]	144,562	29,367	132,658	69,034	26,806	17,968	59,071	479,464
Per person expenditure ($)	246.6	821.4	240.0	656.1	763.0	199.8	747.5	365.2

ATSIPHCS—Aboriginal and Torres Strait Islander primary health care services.

(a) New South Wales and Australian Capital Territory data have been combined to avoid the identification of a single service's data.

(b) Victoria expenditure includes expenditure on health programs for all agencies. Excludes expenditure on admitted patients (approximately $18,000,000 for 2002–03 and $20,000,000 for 2003–04) and welfare programs (approximately 12,000,000 for 2002–03 and 13,000,000 for 2003–04).

(c) The number of reported ATSIPHCS which were funded through the Australian Government differed from the number funded through the states and territories. Numbers presented are ATSIPHCS funded by the Australian Government.

(d) Australian Government data includes all Aboriginal and Torres Strait Islander primary health care services, not just those that were community-controlled, as it is not possible to obtain data specific to community-controlled organisations only. Data have been categorised according to the state or territory that administers the service. This is not always the same as the location State/Territory of the Service.

(e) The average of the 2002 and 2003, and 2003 and 2004, ABS Indigenous population projections have been used for both financial years to calculate per capita expenditure. These estimates are based on the final results of the 2001 Census.

Sources: Australian Government data provided by Office of Aboriginal and Torres Strait Islander Health. State data provided by each jurisdiction.

Box 15.1: Data issues

The data provided included all Aboriginal and Torres Strait primary health care services, not just those that were community-controlled, as it was not possible to obtain data only for community-controlled organisations. It is suggested that the indicator specifications be changed to include all Indigenous primary health care services.

Indicator 16. Distance to a primary health care centre

Indicator: The proportion of Aboriginal and Torres Strait Islander communities that are more than 25 kilometres from a primary health care centre.

Purpose

This indicator reveals geographic access to primary health care services. A primary health care centre is the first point of contact with a health service for most Aboriginal and Torres Strait Islander people living in discrete Indigenous communities. Distance to a primary health care centre is an important determinant of whether people are able to seek treatment. Delayed diagnosis and treatment can lead to poor health outcomes.

Data

The data for this indicator come from the ABS 2001 CHINS which information on a total of 1,216 discrete Indigenous communities. A complete description of the collection method is available in the principal publication outlining the 2001 CHINS—*Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001* (ABS 2002).

The survey collected information on discrete Indigenous communities (not all communities as specified in the indicator) 25 kilometres or more from a community health clinic. This information was only collected for those communities that were 10 kilometres or more from the nearest hospital.

The CHINS definition of a community health clinic differs somewhat from a primary health care centre, which is the specified facility identified for this indicator. A community health clinic is defined as a facility which provides a range of health services, such as nursing, medical, dental and nutritional services. In remote areas not all of these services may be available; however, generally the centre would have nurses, health workers and/or doctors in regular attendance (ABS 2002).

Table 16.1: Discrete Indigenous communities[(a)] by distance to nearest community health clinic, for selected states and territories, 2001

Distance to nearest community health clinic	NSW	Qld	WA	SA	NT	Australia[(b)]
			Number			
Less than 25 km	17	48	117	43	254	481
25 km or more	10	72	139	42	342	606
Total[(c)]	**60**	**142**	**283**	**96**	**632**	**1,216**
			Per cent			
Proportion of communities 25 km or more from the nearest community centre and 10 km or more from the nearest hospital	**17**	**51**	**49**	**44**	**54**	**50**

(a) Data applicable to communities that were 10 kilometres or more from the nearest hospital.

(b) The Australian Capital Territory has no discrete Indigenous communities; Tasmania and Victoria are included in the Australian total.

(c) Includes communities located within 10 kilometres of a hospital.

Source: ABS Community Housing and Infrastructure Needs Survey, 2001.

- In 2001, approximately half (606 or 50%) of all discrete Indigenous communities were located 10 kilometres or more from the nearest hospital and 25 kilometres or more from the nearest community health clinic.
- States and territories with the highest proportion of Indigenous communities located 25 kilometres or more from the nearest community health clinic were the Northern Territory (342 or 54%), Queensland (72 or 51%) and Western Australia (139 or 49%). These communities were also located 10 kilometres or more from the nearest hospital.

Indicator 17. Distance to a hospital

Indicator: The proportion of Aboriginal and Torres Strait Islander communities which are more than 50 kilometres from the nearest acute hospital.

Purpose

Indigenous people have more chronic illness, including diabetes, kidney disease and coronary heart disease, than the overall population. People with these conditions need to travel frequently to the nearest hospital. People who live at a distance from a hospital often need to move residence in order to receive regular treatment, or must find alternative means of care in their current residence, or must travel large distances to receive treatment. Improving the access of Aboriginal and Torres Strait Islander communities to acute hospital care is a goal for all states and territories.

Data

The data for this indicator come from the ABS 2001 CHINS which collected information on a total of 1,216 discrete communities. A complete description of the collection method is available in the principal publication outlining the 2001 CHINS—*Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001* (ABS 2002).

This survey collected information on discrete Indigenous communities (not all communities as specified in the indicator specification) 50 kilometres or more from the nearest hospital.

Table 17.1: Discrete Indigenous communities by distance to the nearest acute hospital, for selected states and territories, 2001

Distance to nearest hospital	NSW	Qld	WA	SA	NT	Australia[a]
			Number			
Less than 50 km	52	46	73	24	74	271
50 km or more	8	96	210	72	556	943
Total[b]	**60**	**142**	**283**	**96**	**632**	**1,216**
			Per cent			
Proportion of communities 50 km or more from the nearest hospital	**13**	**68**	**74**	**75**	**88**	**78**

a) The Australian Capital Territory had no discrete Indigenous communities. Tasmania and Victoria are included in the Australian total.

b) Includes 'Distance to nearest hospital' not stated.

Source: ABS Community Housing and Infrastructure Needs Survey, 2001.

- In 2001, 943 or 78% of discrete Indigenous communities were located 50 kilometres or more from the nearest hospital.
- The Northern Territory (88%), South Australia (75%), Western Australia (74%) and Queensland (68%) had the highest proportions of communities located 50 kilometres or more from the nearest hospital.

Indicator 18. Access to primary health care services—small homeland communities and outstations

Indicator: The proportion of Aboriginal and Torres Strait Islander homeland communities/outstations, with a usual population of less than 50 people and that are more than 50 kilometres from a primary health care service, that have access to various types of health services on a regular basis.

Purpose

Small and isolated communities create special health service delivery challenges. Improving the access of Aboriginal and Torres Strait Islander communities to primary health services in general is a goal for all states and territories. The indicators examined here combine isolation and size of communities.

Data

The data for this indicator come from the ABS 2001 CHINS which collected information on discrete Indigenous communities with less than 50 people (not small homeland communities/outstations) which were more than 50 kilometres from a community health clinic. The survey collected data on access to health professionals from only 14 of these 374 communities and thus the following data should be interpreted with extreme caution due to the small number of communities from which the data were sourced. No information was collected on access to health services as specified in the indicator.

The defined health professionals for this indicator were an Indigenous health worker working in the community every day, a nurse visiting at least every fortnight and a doctor visiting at least every month. There were, however, no data available on the number of health professionals visiting these communities more frequently than at least once a month.

- There were a total of 374 communities in Australia with less than 50 people that were more than 50 kilometres from a community health clinic.
- One–half of the 14 communities for which information on access to health professionals was collected did not have any health professionals visiting or working within the community.
- The most common health professional visiting these communities was a registered nurse (36%), followed by both an Indigenous health worker and a doctor (21%).

Table 18.1: Number and proportion of communities with less than 50 people and more than 50 km from a community health clinic[a], by access to selected health professionals, 2001

Visit or work within community	Number	Proportion of communities for which information was collected	Reported usual population of community
Indigenous health worker	3	21.0	102
Registered nurse	5	36.0	142
Doctor	3	21.0	92
Other	2	14.0	62
By any selected health professionals[b]	*7*	*50.0*	*398*
Not visited by selected health professionals	7	50.0	184
Information not collected	362	n.a.	5,084
Total	**376**	**100.0**	**5,482**

(a) Excludes communities within 10 km of a hospital.

(b) Sum of components may not add to total as communities may have access to more than one type of health professional.

Source: ABS Community Housing and Infrastructure Needs Survey, 2001.

Indicator 19. Management of key conditions

Indicator: The extent to which there is systematic support for:

- the development and implementation of evidence-based treatment protocols
- the presence of early detection programs
- chronic disease management systems in Aboriginal and Torres Strait Islander people, using recommendations specifically developed for them (where appropriate).

Purpose

Early detection and management of chronic conditions are recognised components of health care systems. This indicator is designed to reflect jurisdictional commitment to the dissemination and implementation of best practice recommendations for conditions that cause high levels of morbidity and mortality in Aboriginal and Torres Strait Islander populations.

Data

Data for this indicator were provided by state and territory governments and the Australian Government.

Australian Government

Patient Information and Recall System

The Patient Information and Recall (PIR) System program administered by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) is intended to support the delivery of best practice and holistic primary health care to Aboriginal and Torres Strait Islander communities throughout Australia. Custom-designed software is employed in the program and is built on the evidence-based concept of health care delivery. The funding provided under the program is non-recurrent and is designed to enable Australian Government-funded Aboriginal and Torres Strait Islander primary health care organisations to acquire and implement computer-based PIR systems.

PIR systems software includes a patient recall capacity that is designed to assist services in the implementation and maintenance of whole-of-life care plans. Initiatives that are enabled by this functionality include immunisation, communicable disease and chronic disease screening and management. PIR systems include the means of recording clinical summaries necessary for the effective tracking and control of chronic disease states.

Funding provided to organisations in 2002–03 amounted to $1.38 million and, in 2003–04, $1.28 million. The funding provided covers the costs of hardware, software, staff training and data management.

The Northern Territory HealthConnect Trial

This trial tests the concept of HealthConnect within a rural and remote region of Australia. The trial is being conducted in the Katherine region where a number of public and private health service providers deliver health care to over 3,000 people; 1,300 people are currently enrolled in the trial.

HealthConnect is Australia's system of electronic health records. With the consent of individual consumers, HealthConnect enables summary health information to be safely collected, stored and exchanged so that it is always available at the point of care, thereby improving the quality and safety of health care.

The current HealthConnect trial in Katherine is a collaborative project involving Katherine West Health Board, Wurli Wurlinjang Health Service, Sunrise Health Service, Katherine Hospital, Binjari Health Service, the Territory and the Commonwealth.

The Northern Territory HealthConnect repository holds medical summaries, including information on medications, allergies, active alerts and doctors' notes, as well as hospital discharge summaries and pathology results. The client has the right to view the information held at any time. It is anticipated that HealthConnect information will particularly contribute to the management of chronic diseases which are prevalent in the population of this region.

Funding provided to the Northern Territory Trial for 2002–03 was $830,000 and $1.38 million for 2003–04.

Otitis media

$41,933 was expended in 2002–03 and $91,795 in 2003–04 on reprinting and disseminating the *Recommendations for Clinical Care Guidelines on the Management of Otitis Media (Middle Ear Infection) in Aboriginal and Torres Strait Islander Populations, 2001* package. The package includes:

- the Guidelines
- the *Systematic Review of Existing Evidence and Primary Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations*
- a *Plain Language Summary of the Systematic Review*
- a middle ear infection checklist poster highlighting key messages for primary health care providers.

Rheumatic heart disease register program in the Top End of the Northern Territory and Central Australia

In 2002–03, the Australian Government provided further funding to continue supporting the rheumatic heart disease register program in the Top End of the Northern Territory and to extend the program to Central Australia. This funding amounted to $255,000.

Aboriginal and Torres Strait Islander peoples have one of the highest rates of rheumatic heart disease in the world. The program operates using a register-based approach as recommended by the World Health Organisation as a means of coordinating individual patient management and improving adherence to drug treatment to prevent rheumatic fever and the associated cumulative valve damage. It identifies those affected by rheumatic fever and rheumatic heart disease, providing a reminder system for monthly prophylactic penicillin injections and other clinical follow-up in Aboriginal communities.

These registers have led to improvements in the rates of notification of patients with rheumatic fever and rheumatic heart disease, and in adherence to secondary prevention with penicillin.

During 2003–04, the Australian Government funded a defined project in the Northern Territory to identify community-based models of prevention and management of rheumatic heart disease in remote communities across Australia. This funding amounted to $123,000.

Continuous improvement projects for the early detection and management of chronic disease for Aboriginal and Torres Strait Islander people.

The continuous improvement projects in the early detection and management of chronic diseases for Aboriginal and Torres Strait Islander people (CIPs) builds on current Australian and international research on systematic approaches to chronic disease in the primary health care context.

Through the CIPs the Office for Aboriginal and Torres Strait Islander Health is working with Aboriginal community-controlled health services who had expressed an interest in refining their approach to chronic disease in order to:

- identify, in partnership with services, the essential elements of a sustainable comprehensive systems approach to the early detection and management of chronic diseases in the community-controlled health care setting;
- foster a continuous improvement approach to chronic disease early detection and management;
- enhance the sharing of information arising from the projects between the community-controlled health care services; and
- inform the development of policy.

The CIPs are 2–year projects that commenced in 2003 with a staged approach to implementation. Two successful CIPs workshops were held in 2003–04 for Aboriginal and Torres Strait Islander Community Controlled Health Services participating in the initiative. These workshops facilitated the sharing of information and learning from other's experiences in relation to continuous quality improvement and chronic disease in primary health care settings.

Funding provided to Aboriginal community-controlled health services in 2002–03 was $41,942 and $612,532 in 2003–04.

Addressing safer alcohol consumption

In 2002–03 and 2003–04, two publications aimed at encouraging safer alcohol consumption by Aboriginal and Torres Strait Islander peoples were reprinted by OATSIH.

Two thousand copies of the flipchart—*Talking about Alcohol with Aboriginal and Torres Strait Islander Patients: A Brief Intervention Tool for Health Professionals* by Maggie Brady and Ernest Hunter (2003)—were reprinted at a cost of $14,958. This flipchart is designed as a brief intervention tool to help health professionals motivate individuals to change their drinking behaviour, either by cutting down on their alcohol intake, or by cutting it out altogether.

Two thousand copies of the book—*Giving Away the Grog: A Collection of Aboriginal Accounts of Drinking and Not Drinking*, by Maggie Brady (1995)—were reprinted at a cost of $17,105. This collection of personal accounts of living with and without alcohol, taken from interviews with Aboriginal people in the Northern Territory and South Australia, was recorded by Maggie Brady between 1992 and 1994. The book can be used by health professionals as a brief intervention tool to initiate discussions on alcohol consumption and covers issues such as: how did people learn to drink; what kind of troubles do drinkers have; what happened to make people drink; reasons for giving up the grog; and how did people have the willpower to stop.

Sharing Health Care Initiative

Through structured self-management education and support, patients with chronic conditions learn to:

- better manage and monitor their symptoms
- better maintain a healthier lifestyle
- better manage impacts of their illness and their treatment regimes
- communicate more effectively with their family, carer and health provider
- more effectively use health and community services.

Evidence in Australia arising from the Australian Government's Sharing Health Care Initiative (SHCI) and other Australian and overseas research shows that patients suffering from chronic conditions, and who are involved in self-management education, have improved health outcomes and live a better quality of life.

Five of the 12 SCHI demonstration projects involve Aboriginal health services. These projects are located at the Katherine West and Danila Dilba Aboriginal Medical Services in the Northern Territory, the Pika Wiya, Port Lincoln and Ceduna/Koonibba Aboriginal Health Service in South Australia, and the Goondir Aboriginal and Torres Strait Islanders Corporation for health services in Queensland.

Expenditure for this program was $1,165,254 for 2002–03 and $688,276 for 2003–04 (GST exclusive).

Initial data from the draft National Evaluation of the SHCI (still to be finalised) shows improved general health status and increased symptom control, decreased psychological distress and improved health behaviours, and slightly decreased length of hospital and GP visits.

A range of chronic condition self-management education and training resources for Aboriginal Health Workers and Community Support Workers has also been developed and tested within the demonstration projects. These resources are based on the Stanford (Lorig) education course (developed by Professor Kate Lorig in the US) and the Flinders University education and training courses, with each Aboriginal Medical Service adapting the programs for their particular community needs.

Details of the SHCI and related publications can be obtained on the chronic condition self-management website at <www.chronicdisease.health.gov.au>.

Coordinated Care Trials

The second round of Coordinated Care Trials are time-limited research projects exploring models of health care that test new ways of organising, delivering and funding health services for people with complex care needs and/or poor health. Three of these Trials focus on a total of approximately 14,000 Aboriginal and Torres Strait Islander people in three specific rural areas of Australia and they commenced at various times in 2003. The Australian Government provided substantial funding to the three Trials in 2003–04. This funding was used by the Trial sponsors for a variety of purposes including the early detection, and use of evidence–based protocols in the management, of a range of chronic diseases such as diabetes, asthma and cardiovascular disease. It is impossible to identify which proportion of the total Australian Government funding for the Indigenous Coordinated Care Trials relates to management of key conditions (especially noting that the Trials also receive funding from other sources such as state/territory governments.)

Medicare Benefits Schedule item for a 2-yearly Aboriginal and Torres Strait Islander adult health check

Since 1 May 2004, a 2-yearly adult health check item has been available on the Medicare Benefits Schedule for self-identifying Aboriginal and Torres Strait Islander people between the ages of 15 and 54 (inclusive).

The purpose of the adult health check is to ensure early detection, diagnosis and intervention for common and treatable conditions that cause considerable illness and early mortality, such as diabetes or cardiovascular disease. It covers the patient's medical history, a physical examination, required investigations, an assessment of the patient's health, any necessary interventions and referrals, and documenting a straightforward strategy for the good health of the patient. It includes 'mandatory' and 'as indicated' components to be covered at each step. It can be provided by Aboriginal and Torres Strait Islander Community Controlled Health Services that access Medicare and by general practitioners in the broader community.

Funding for provision of the item by GPs in the 2 months of 2003–04 in which the item was available was $279,000.

New South Wales

In 2002–03, the NSW Aboriginal Vascular Health Program was expanded to an additional six sites, two metropolitan and four rural, and to three additional correctional facilities within the Corrections Health Service.

Projects with designated Aboriginal Health Workers in both Area Health Services and Aboriginal Community Controlled Health Services have developed culturally and community specific models of chronic health care service delivery with the aim of improving the prevention, early detection and self-management of vascular diseases including diabetes, cardiovascular disease, hypertension, renal disease, stroke and diseases of the circulatory system for Aboriginal communities in New South Wales.

An external evaluation of the NSW Aboriginal Vascular Health Program conducted in 2003 to assess its overall effectiveness, indicated the sound strategic direction of the program, with all sites making progress towards specific aims and objectives and many building their projects to have sustainability into the future.

There have been a number of important indications of impact such as new services to, and targeted resources for, Aboriginal communities; Aboriginal Health Workers enhancing their skill base with clinical roles related to screening and health education programs; collaboration with tertiary services and the Aboriginal community controlled health sector; and most importantly, increased numbers of mainstream service workers being more aware of the health needs of Aboriginal people and communities in their service area.

In 2003–04, the state-wide components of the NSW Aboriginal Vascular Health Program were maintained and strengthened with project sites further expanding within Northern Rivers and Western Sydney Area Health Services and newly situated in Central Sydney Area Health Service. The Department of Health's commitment to improving the vascular health of Aboriginal people and communities is now long term, demonstrated through $2 million in recurrent funding from the Centre for Aboriginal Health, NSW Health.

Project workers are being moved to implement evidence-based strategies with monitoring and project evaluation, to enable better decision-making, quality assessment of risk and measurement of success for individual sites. The Aboriginal Vascular Health Network, open to health professionals and people interested or involved with Aboriginal vascular health, has more than 300 members, with interest extending beyond New South Wales.

The Aboriginal Chronic Conditions Area Health Service Standards are in the process of being developed to address chronic health conditions relating to cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer for the Aboriginal people and communities. Developed in collaboration with the Aboriginal Health & Medical Research Council of NSW, the Standards aim to enhance the provision of holistic, culturally respectful health care services for Aboriginal people within NSW Area Health Services. The four Standards have been designed to assist and direct Area Health Services to newly develop, enhance or change health approaches and practices when working with Aboriginal people and communities with chronic health conditions and include:

1. A coordinated local approach to prevention and management of chronic conditions within the Aboriginal population
2. Targeted Aboriginal chronic conditions health promotion initiatives across the life-course and chronic conditions continuum
3. Effective systems for the diagnosis and care of Aboriginal people with, or at risk of, chronic conditions
4. Enhanced capacity of the Aboriginal health workforce to address prevention and management of chronic conditions

The Standards were published in 2004–05.

Victoria

Chronic conditions such as asthma, diabetes, coronary heart disease, chronic renal disease, chronic respiratory conditions and hypertension in Victoria are managed both through condition-specific strategies and through broader strategies for the health system.

The Victorian Aboriginal Community Controlled Health Organisation is developing Memoranda of Understanding with key health bodies (e.g. Heart Foundation, Diabetes Australia, Cancer Council) to address Indigenous issues.

Management strategies

The Hospital Demand Management Strategy was established in October 2000 in response to increases in demand for, and deterioration in access to, acute public hospital services. As part of this, the Hospital Admissions Risk Program (HARP) aims to reduce the avoidable use of hospitals by:

- developing preventive models of care that involve both the hospital and the community
- focusing on people who have a manifest health need, often where their disease or condition is chronic or complex
- giving priority to high volume and/or frequent users of the acute public hospital system.

HARP is implemented through projects, none of which has been targeted at Aboriginal people. However, many have been applicable to Aboriginal people.

In 2002–03, 42 projects commenced covering chronic disease management, respiratory disease, paediatric asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease, diabetes, mental health and falls. In 2003–04, 29 new projects were funded, making a total of 100 projects. The 2003–04 projects included chronic heart failure, complex psychosocial needs, COPD, asthma, diabetes and wound management.

Ongoing HARP evaluation began on November 2002 with the aim of identifying interventions and models of care that are effective in improving clinical outcomes and reducing the preventable use of health services.

There are working parties on chronic heart failure disease management and COPD. They aim to:

- promote evidence-based practice
- span the continuum of care
- promote service coordination and efficiency in service delivery
- be patient centred
- demonstrate improvement in patient outcome and quality of life
- minimise exacerbations of the condition and reduce emergency department presentations.

Strategies for specific conditions

Asthma

Review of public health interventions for asthma: Aboriginal people are more at risk of admission for respiratory diseases including asthma. There are no asthma care projects directed specifically at Aboriginal people.

The development of National Service Improvement Frameworks was agreed to by AHMAC in October 2002. The Draft National Service Improvement Framework for asthma has been developed to the point where stakeholder consultation is now taking place. The Framework focuses on the needs of disadvantaged groups, including Aboriginal and Torres Strait Islander people, and recognises risk factors particularly relevant to Aboriginal people.

Renal failure

In 2003–04, 29% of all hospital admissions of Aboriginal people were for renal dialysis. The rate of renal dialysis is 6–8 times that of the non-Aboriginal population. A review of the current service model for renal dialysis was undertaken in October 2004. Victoria has also had input into the development of the Improving Indigenous Health: Remote Area Renal Services Project.

Diabetes

Diabetes initiatives occur at three levels—primary, secondary and tertiary. These are provided by different divisions/ branches of the Department of Human Services.

Primary Intervention covers: public health, pre-diabetes intervention program, risk factor assessment tool, diet, obesity prevention and physical activity initiatives, including for special groups, health promotion and physical activity initiatives through PCP and Diabetes Australia, primary and community health, integrated health promotion, and podiatry, nursing and dietetics.

Secondary intervention covers: disability services, practice guidelines for diabetes management, hospital demand management/HARP, disease management HARP, aged care, and home and community care dietetic services.

Tertiary intervention covers: acute services and inpatients and outpatients.

Queensland

Health Outcomes Plans

Health Outcomes Plans developed across the National Health Priority Areas continue to be implemented. In addition, Queensland Health in partnership with the Australian Government Department of Health and Ageing, Divisions of General Practice and other key external stakeholders, commenced the development of the Statewide Chronic Disease Implementation Initiative. The scope of this initiative includes the risk factors of smoking, nutrition, alcohol and physical activity and cardiovascular diseases, renal disease, chronic respiratory disease and diabetes.

This process has included particular consultation with Indigenous groups. Chronic disease strategies are being implemented in three place-based initiatives, including Innisfail which has a high Indigenous population and an Aboriginal Medical Service.

Enhanced Model of Primary Health Care (EMPHC)

The EMPHC is an initiative to introduce a systems-based approach to the delivery of primary health care services in the remote areas of Queensland Health's Northern Zone. Key components of this model are partnerships, planning, evidence–based care, support structures and workforce development. It utilises a collaborative practice model of service delivery.

Within the evidence–based care component there are two key strategies:

- **Chronic Disease Strategy** which emphasises the prevention, early detection and management of chronic illness through the utilisation of standard treatment protocols and care plans specifically tailored to Indigenous populations
- **Primary Clinical Care Manual** which provides Health Management Protocols for both acute and chronic conditions.

The early detection component of the chronic disease strategy utilises standard annual screening protocols and brief interventions to detect and increase community awareness of clinical and behavioural risk factors. The Adult Health Check for those aged 15 years and over is currently in use. Health checks for those aged 0–4 years, 5–14 years and 55 years and over are being developed to provide a life continuum approach.

The EMPHC utilises the patient information recall system *Ferret* to provide systematic recall of clients for routine surveillance, follow-up and chronic disease management. The data collected also provides information on community health status which can be used to facilitate planning and relayed back to the community to allow joint priority setting.

Queensland Health HIV /AIDS Strategy

This strategy aims to provide an integrated approach to the delivery of sexual health care services to Aboriginal and Torres Strait Islander peoples. Ongoing support through the Queensland and Torres Strait Health Partnership Forums under the Framework Agreements, and collaboration with the Community Controlled Health Services has ensured the effective implementation of the strategy. Successful implementation of this program is further assured by the establishment of Zonal Indigenous Health Coordinator positions.

Renal Service Plans

Each of the three Queensland Health Zones have developed Renal Service Plans that recognise Aboriginal and Torres Strait Islander peoples as a priority population. The Renal Service Plans include specific strategies to address renal disease in Aboriginal and Torres Strait Islander peoples including health promotion, early detection, clinic management, renal replacement

services, workforce management and information support actions. Queensland Health recognises that many rural/remote areas of the state do not have ready access to a hospital renal unit or satellite unit and is working towards ensuring that high-quality home dialysis is available. Examples include strategies established in the Toowoomba Renal Service for the provision of a multi-user self-care dialysis and the opening in March 2004 of the Mt Isa satellite service which is providing haemodialysis closer to home for patients who previously received this service out of Townsville.

Western Australia

Chronic disease prevention

The Department of Health has conducted a workshop with the aim of progressing the development of a Chronic Conditions Strategy. The strategy will:

- enhance primary prevention initiatives to reduce the incidence of the development of chronic conditions
- improve the quality of life of people with chronic conditions
- improve the quality of life of their carers and families
- reduce the number of unnecessary and inappropriate hospital admissions and readmissions
- be aligned with the national chronic disease strategy.

The issues specific to Aboriginal people will be included within and addressed throughout the strategy. The department has also commenced developing a range of quality improvement initiatives such as primary care collaboratives and the Audit and Best Practice for Chronic Disease Extension program in partnership with the Cooperative Research Centre for Aboriginal Health.

South Australia

South Australia has been actively involved in developing and implementing evidence-based treatment protocols for chronic disease as well as early detection programs for risk factors. A key factor in this work has been the facilitation of cultural awareness programs for medical practitioners involved in the diagnosis and treatment of chronic disease, and the active participation in ensuring that services and policy responses are inclusive of Aboriginal and Torres Strait Islander peoples.

Chronic disease

The Nganampa Health Council maintains a chronic disease register. This shows that on the Anangu Pitjantjatjara Lands in November 2002, approximately 48% of adults over the age of 15 years had a chronic illness. The registrar improves the management of clients with chronic illness and is also used in implementing health interventions.

Diabetes

Evidence-based treatment protocols

In the Hills Mallee Southern region, an Aboriginal-specific regional Health Living Coordinator is employed to work with and develop strategic strategies with the Chronic Disease Regional Program Officer. Outreach programs, including physiotherapy, podiatry and diabetes clinics, are currently provided through Aboriginal controlled organisations.

In Ceduna and Port Lincoln, diabetes clinics are held in conjunction with Diabetes Health workers and general practitioners. All diabetes clients are checked for micro-albuminuria every 3 to 12 months. Blood pressure is checked and treatment initiated and followed up by health workers where possible. All clients who attend clinics are assessed for BMI and encouraged to participate in at least 30 minutes of exercise daily. Aboriginal Health Workers are trained in Diabetic foot assessments and provide foot care education. Healthy Eating education is provided to clients, carers and existing community groups.

In the Northern and Far West Regional Health Service, the Diabetes Management in General Practice Guidelines are used by all health professionals, in collaboration with the GPs, diabetes educators, dieticians, podiatrists and all other specialists. This involves a clinical assessment and formulating a diabetes care plan for each client, that includes regular clinical reviews (either 3, 6 or 12 monthly). The service action plan of the Aboriginal Health Team, Riverland Regional Health Service is linked to national and South Australian Aboriginal Health Partnership priorities.

Early detection systems

Health checks and screening programs operate within most Aboriginal community settings. A team comprising Aboriginal Health Workers, GPs and allied health personnel provide this service. The Point-Of-Care (POC) into Aboriginal Hands system for early detection of diabetes is used within the Riverland Aboriginal and Torres Strait Islander community to conduct health screening checks, as well as monitor diabetes management.

A suitably qualified Aboriginal Health Worker provides a well developed screening system within the Mallee Coorong Health area. General screening is undertaken at all 13 health units within the region but is generally dependent upon GP referral.

For Ceduna and remote centres, targeted screening for adults during adult immunisation and health education programs are available. All diabetes clients on care plans are given an annual ECG check to establish a baseline and detect any early heart changes.

Management systems

A joint management partnership exits between the Murray Mallee Community Health Service and the Commonwealth-funded Aboriginal Primary Health Care Program to establish programs and mutual support systems through the region for Aboriginal specific service development.

The Diabetes Management in General Practice guidelines (NHRMC 2001) are followed for best practice as far as practicable for location and client base.

In local Aboriginal community settings in Wakefield, Aboriginal Health Workers provide education, monitoring and support to clients. Aboriginal Health Workers conference with GPs and other health workers to ensure effective management systems are in place.

Other areas are working with the Commonwealth in regards to data management and recall and the potential to use a Medical Director for GP clinics run across the region.

Tasmania

Separate protocols on the management of key conditions are not developed for Aboriginal or Torres Strait Islander patients.

Australian Capital Territory

Due to the geographic size of the Australian Capital Territory, and relatively small Aboriginal population, it is reasonable to assume that the majority of Aboriginal people in the Australian Capital Territory have access to the community-controlled Aboriginal Health Service, facilitating early detection of chronic disease.

Diabetes

The ACT Health Diabetes Service holds a monthly multidisciplinary clinic for clients with or at risk of developing diabetes at the Australian Capital Territory's Community Controlled Health Organisation, Winnunga Nimmityjah. These sessions include basic clinical assessment for complications such as blood pressure, urinary micro-albumin, HbA1c, foot screening and periodic eye screening with a non-mydriatric camera. In addition, a comprehensive review including self-management skills and knowledge, nutritional assessment and counselling and podiatry foot treatment was offered. Between five and 20 individuals attend this clinic each month. Health promotion and prevention strategies have included group sessions such as cooking/nutrition and podiatry demonstrations and education, talks at the women's camp, carers groups and with the elders at the request of Winnunga Nimmityjah. The Diabetes Service also worked with Winnunga Nimmityjah in planning and conducting a Wellness Day and wellness check.

Northern Territory

The Northern Territory has a well-established and comprehensive process of developing and implementing evidence-based treatment protocols, which are used by all Aboriginal health services. The fourth edition of the *Central Australian Rural Practitioners Association Standard Treatment Manual* was in development during this period. The new edition incorporates detailed chronic disease guidelines that were developed for the two Northern Territory Coordinated Care Trial sites. Implementation of the Standard Treatment Manual includes policy support by health services, introduction to the manual at the start of employment, inclusion of the manual in training, and provision of copies to all clinical staff.

All primary health care services have programs for 'Well persons' screening. These are holistic programs that aim to detect risk factors, chronic diseases, sexually transmitted infections and women's cancers. The extent of coverage and effective program delivery across the Northern Territory is currently not known, although individual services have some data. The program is provided both opportunistically by primary health care staff, and as part of organised screening weeks supported by visiting public health staff. Health assessments for Aboriginal people aged 50 years and older are encouraged through use of the enhanced primary care items, and by the use of a standard screening form.

All Northern Territory primary health care services have management systems including chronic disease registers and recall systems, either paper or computerised care plans, training programs and regular specialist visits to both remote and urban services. In 2005, a recall system project was undertaken and the final report includes recommendations for a standardised information technology based recall system. The Audit and Best Practice for Chronic Disease project is a four and a half-year project between the Cooperative Research Centre for Aboriginal and Tropical Health, Menzies School of Health Research, the Department of Health and Community Services, and several Aboriginal Medical Services across the Northern Territory, and is aimed at supporting health services to improve the effectiveness of their chronic disease service delivery. The project uses a participatory research approach to introduce a cycle of continuous quality improvement. Information from clinical

audits and organisational assessments is being fed back to Health Centre staff and key stakeholders to guide organisational improvements.

Indicator 20. Aboriginal and Torres Strait Islander people in the health workforce

Indicator: The proportion of the health workforce employed by states and territories that identify as Aboriginal or Torres Strait Islander.

Purpose

This indicator monitors the proportion of Indigenous people employed as professional health care workers in order to assess the extent to which the capacity of Indigenous people to deliver health services to Indigenous people is being developed.

Data

States and territories reported difficulties obtaining information on the proportion of doctors and nurses who were Indigenous, because ethnic identification was not required by the relevant registration boards and because identification may be understated. For several states and territories it was possible to gain some idea of these proportions from various staff surveys. However, in many cases the completion of such surveys is voluntary, as is the collection of Indigenous status information within these surveys.

Data from the Census

Data from the ABS 2001 Census of Population and Housing are thought to be most reliable and were used for this indicator. These data are not restricted to the public sector employed health workforce, as stipulated in the definitions for this indicator.

- Aboriginal and Torres Strait Islander people are under-represented in the Australian professional health workforce, representing 1.3% of that workforce.
- The states with the greatest proportion of Indigenous Australians in their professional health workforce were the Northern Territory (9.0%) and Queensland (2.2%).
- Nursing was the most common profession for Aboriginal and Torres Strait Islander people working in the health services delivery sector.
- Queensland and the Northern Territory had the largest numbers of Indigenous health workers.
- In the category of management and support staff, most Aboriginal and Torres Strait Islander people were employed as policy officers, project officers or administrative workers.

Table 20.1: Aboriginal and Torres Strait Islander employment in the health workforce[a], by state and territory, 2001

	No. of Indigenous people employed	Total no. of people employed	Proportion of Indigenous people employed (%)
New South Wales and Australian Capital Territory			
Health services delivery staff			
Medical staff	19	5,335	0.4
Nursing staff[b]	205	33,579	0.6
Aboriginal and Torres Strait Islander health worker	42	42	100.0
Welfare and community workers	149	1,837	8.1
Allied health	108	8,636	1.3
Dental practitioners	3	202	1.5
Pharmacists	0	457	0.0
Other	94	4,810	2.0
Management and support staff			
Program/service/unit managers	56	4,922	1.1
Policy/project officers and administrative workers[c]	455	23,296	2.0
Operational staff[d]	114	5,195	2.2
Total	**1,245**	**88,311**	**1.4**
Victoria			
Health services delivery staff			
Medical staff	6	3,771	0.2
Nursing staff[b]	57	24,557	0.2
Aboriginal and Torres Strait Islander health worker	11	14	78.6
Welfare and community workers	25	1,805	1.4
Allied health	20	6,048	0.3
Dental practitioners	0	173	0.0
Pharmacists	0	395	0.0
Other	9	2,979	0.3
Management and support staff			
Program/service/unit managers	10	3,197	0.3
Policy/project officers and administrative workers[c]	66	18,095	0.4
Operational staff[d]	19	3,322	0.6
Total	**223**	**64,356**	**0.3**

(continued)

Table 20.1 (continued): Aboriginal and Torres Strait Islander employment in the health workforce[a], by state and territory, 2001

	No. of Indigenous people employed	Total no. of people employed	Proportion of Indigenous people employed (%)
Queensland			
Health services delivery staff			
Medical staff	15	2,670	0.6
Nursing staff[b]	129	17,298	0.7
Aboriginal and Torres Strait Islander health worker	109	117	93.2
Welfare and community workers	74	764	9.7
Allied health	72	4,053	1.8
Dental practitioners	0	241	0.0
Pharmacists	0	202	0.0
Other	58	3,269	1.8
Management and support staff			
Program/service/unit managers	92	3,235	2.8
Policy/project officers and administrative workers[c]	351	11,075	3.2
Operational staff[d]	91	2,247	4.0
Total	**991**	**45,171**	**2.2**
Western Australia			
Health services delivery staff			
Medical staff	3	1,346	0.2
Nursing staff[b]	28	7,242	0.4
Aboriginal and Torres Strait Islander health worker	31	31	100.0
Welfare and community workers	29	393	7.4
Allied health	15	2,318	0.6
Dental practitioners	0	28	0.0
Pharmacists	0	117	0.0
Other	16	821	1.9
Management and support staff			
Program/service/unit managers	24	943	2.5
Policy/project officers and administrative workers[c]	94	5,834	1.6
Operational staff[d]	31	893	3.5
Total	**271**	**19,966**	**1.4**

(continued)

Table 20.1 (continued): Aboriginal and Torres Strait Islander employment in the health workforce[a], by state and territory, 2001

	No. of Indigenous people employed	Total no. of people employed	Proportion of Indigenous people employed (%)
South Australia			
Health services delivery staff			
Medical staff	0	1,326	0.0
Nursing staff[b]	24	8,206	0.3
Aboriginal and Torres Strait Islander health worker	43	49	87.8
Welfare and community workers	22	386	5.7
Allied health	3	1,736	0.2
Dental practitioners	0	87	0.0
Pharmacists	0	101	0.0
Other	9	1,307	0.7
Management and support staff			
Program/service/unit managers	18	1,289	1.4
Policy/project officers and administrative workers[c]	63	5,421	1.2
Operational staff[d]	17	1,124	1.5
Total	**199**	**21,032**	**0.9**
Tasmania			
Health services delivery staff			
Medical staff	3	317	0.9
Nursing staff[b]	20	2,198	0.9
Aboriginal and Torres Strait Islander health worker	3	3	100.0
Welfare and community workers	6	83	7.2
Allied health	9	485	1.9
Dental practitioners	0	11	0.0
Pharmacists	0	43	0.0
Other	3	237	1.3
Management and support staff			
Program/service/unit managers	12	253	4.7
Policy/project officers and administrative workers[c]	44	1,374	3.2
Operational staff[d]	6	369	1.6
Total	**106**	**5,373**	**2.0**

(continued)

Table 20.1 (continued): Aboriginal and Torres Strait Islander employment in the health workforce[a], by state and territory, 2001

	No. of Indigenous people employed	Total no. of people employed	Proportion of Indigenous people employed (%)
Northern Territory			
Health services delivery staff			
Medical staff	3	235	1.3
Nursing staff[b]	24	1,284	1.9
Aboriginal and Torres Strait Islander health worker	73	73	100.0
Welfare and community workers	21	91	23.1
Allied health	16	234	6.8
Dental practitioners	0	13	0.0
Pharmacists	0	8	0.0
Other	22	157	14.0
Management and support staff			
Program/service/unit managers	25	260	9.6
Policy/project officers and administrative workers[c]	88	789	11.2
Operational staff[d]	23	142	16.2
Total	**295**	**3,286**	**9.0**

(a) Includes health, community services, and health and community services undefined.

(b) Includes registered and enrolled nurses.

(c) Includes business and information professionals; accountants, auditors and corporate treasurers; sales, marketing and advertising professionals; computing professionals; miscellaneous business and information professionals; advanced clerical and service workers; intermediate clerical, sales and service workers; intermediate production and transport workers; and elementary clerical, sales and service workers.

(d) Includes labourers and related workers; cleaners; other labourers and related workers; and food tradespersons (includes cooks).

Source: ABS Census of Population and Housing 2001.

Data from state/territory workplace surveys

Data on Indigenous employment in the health workforce were provided by New South Wales, Queensland, Western Australia, South Australia, Tasmania, the Australian Capital Territory, and the Northern Territory health departments from information collected from workforce surveys. Victoria could not provide data for this reporting round; however, from 2005, annual surveys of the health workforce in Victoria will be conducted and will include an Indigenous identifier.

In many of the surveys from which data were collected, Indigenous identification was voluntary and different classifications of health professionals were used. Surveys also varied in scope—South Australia, for example, could only provide data on new employees. Also, not all jurisdictions could provide data for all categories of employment in the health workforce. The data presented below are therefore not strictly comparable between jurisdictions or with data from the Census:

- Information on the medical workforce in New South Wales is reported annually by the New South Wales Department of Health and includes a breakdown of the Indigenous workforce across some job categories. Data for the 2003–04 financial year indicate that there were 313 Indigenous medical staff and 366 Indigenous nurses working in New South Wales, representing 2.1% and 0.7% of total people employed in these professions.

Data is currently unavailable on the number of Indigenous health workers, Aboriginal Liaison Officers, and Aboriginal people employed as allied health workers, dentists, pharmacists and other health services delivery staff.

- In Queensland in 2003–04, there were 1,125 Indigenous people employed in the health services, representing 2.1% of total people employed in the health industry. Of these, 236 were Aboriginal and Torres Strait Islander health workers and 198 were nursing staff. In the category of management and support staff, most Indigenous people were employed as administrative workers or operational staff.
- In Western Australia, approximately 1.6% (243) of persons employed in health services in 2003–04 were of Aboriginal or Torres Strait Islander origin. Nursing was the most common profession for Indigenous people working in the health services delivery sector, followed by Aboriginal and Torres Strait Islander health workers and allied health workers.
- There were 168 Aboriginal and Torres Strait Islander peoples working in the health workforce in the Northern Territory in 2003–04. This represented 4.1% of total people employed in the health workforce during this period. There were 53 Aboriginal and Torres Strait Islander health workers and 8 nursing staff.
- According to the Australian Capital Territory internal survey on the induction of staff, in 2003–04 there were 16 Indigenous people working in the health workforce, most of whom (9) were in administration.
- Tasmania reported that, in 2003–04, there were 5 Indigenous people employed in the Department of Health and Human Services in specified positions requiring Indigenous status. Of these, 3 were operational staff, 1 was a policy/project officer and 1 was an Aboriginal Liaison Officer. The number of Indigenous people in non-specified positions cannot be reported due to a change in data collection methods. Tasmania no longer requires new staff to indicate their Indigenous status nor does it routinely collect employees' Indigenous status information. Consequently, accurate data for the total proportion of the health workforce employed by the Tasmanian Government who identify as Aboriginal or Torres Strait Islander cannot be reported due to data collection limitations.
- South Australia also provided data for this indicator and reported that, in 2003–04, 168 Indigenous people were employed in the health services. Of these, 22 were nursing staff and 24 were welfare and community workers. These figures are under-estimates of the total number of Indigenous people employed in the health workforce as they are sourced from information on new employees only and not from information on the entire health workforce.

Table 20.2: Aboriginal and Torres Strait Islander employment in the health workforce, by state and territory, 2003–04

	No. of Indigenous people employed	Total no. of people employed	Proportion of Indigenous people employed (%)
New South Wales			
Health services delivery staff			
Medical staff	313	14,692	2.1
Nursing staff[(a)]	366	54,587	0.7
Total	**679**	**69,279**	**1.0**
Queensland			
Health services delivery staff			
Medical staff	21	4,062	0.5
Nursing staff[(a)]	198	20,192	1
Aboriginal and Torres Strait Islander health workers	236	396	59.6
Welfare and community workers	16	25	64
Allied health	34	2,635	1.3
Dental practitioners	1	367	0.3
Pharmacists	0	291	0
Other[(b)]	143	6,058	2.4
Management and support staff			
Program/service/unit managers	38	1,949	1.9
Policy/project officers and administrative workers[(c)]	75	4,887	1.5
Administration	195	8,116	2.4
Operational staff[(d)]	168	4,932	3.4
Total	**1,125**	**53,910**	**2.1**
Western Australia			
Health services delivery staff			
Medical staff	7	1,865	0.4
Nursing staff[(a)]	81	12,016	0.7
Aboriginal and Torres Strait Islander health worker	69	69	100
Allied health	69	3,535	2
Dental practitioners	—	107	—
Pharmacists	1	163	0.6
Other	16	306	5.2
Management and support staff			
Program/service/unit managers	9	415	2.2
Policy/project officers and administrative workers[(c)]	15	378	4
Administration	44	3,289	1.3
Operational staff[(d)]	112	4,260	2.6
Total	**423**	**26,403**	**1.6**

(continued)

Table 20.2 (continued): Aboriginal and Torres Strait Islander employment in the health workforce, by state and territory, 2003–04

	No. of Indigenous people employed	Total no. of people employed	Proportion of Indigenous people employed (%)
Australian Capital Territory[h]			
Health services delivery staff			
Medical staff	1	442	0.2
Nursing staff	4	2,223	0.2
Aboriginal liaison officer	2	2	100
Management and support staff			
Administration[i]	9	1,255	0.7
Total	**16**	**3,922**	**0.4**
Northern Territory[e]			
Health services delivery staff			
Medical staff	1	324	0.3
Nursing staff	8	1,431	0.6
Aboriginal and Torres Strait Islander health worker	53	118	44.6
Other[f]	13	622	2.1
Management and support staff[g]			
Administration	72	1,072	6.7
Operational staff[d]	21	559	3.8
Total	**168**	**4,125**	**4.1**

(a) Includes registered and enrolled nurses.

(b) Many jobs which were considered professional/semi-professional that were not easily categorised under any of the existing categories have been allocated to this category.

(c) Includes business and information professionals; accountants, auditors and corporate treasurers; sales, marketing and advertising professionals; computing professionals; miscellaneous business and information professionals; advanced clerical and service workers; intermediate clerical, sales and service workers; intermediate production and transport workers; and elementary clerical, sales and service workers.

(d) Includes labourers and related workers; cleaners; other labourers and related workers; and food tradespersons (includes cooks).

(e) Numbers provided are for Paid Full Time Equivalent staff. Data supplied are as at Pay 26 2004-05.

(f) DHCS systems do not readily identify AIHW classifications of Allied Health, Dentists or Pharmacy; these categories have been included under 'Other'.

(g) Program/Service/Unit Managers are not readily identified; these staff are included in other classifications as appropriate.

(h) Aboriginality is unknown for approximately 30% of staff, either because they were employed prior to this question being asked on the survey, or they have not completed the question.

(i) All Management and Support staff have been categorised under 'Administration' as we are unable to report on the total number of senior officers who are also managers. One Aboriginal Unit Manager was employed in 2003–04.

Sources: State and territory health departments (Profile of the Medical Workforce in NSW, 2003; Qld Health Human Resource Decision Support System; ACT internal survey on induction of staff; NT Government Personnel System).

Box 20.1: Data issues

Specifications for this indicator stipulate EEO, affirmative action or workforce surveys conducted by state and territory health departments as the sources of data for this indicator. Most states and territories were able to provide data but had varied information available to report against this indicator as surveys were often limited to the government-employed workforce, varied in scope and did not necessarily cover all professions listed above.

Census data covering the health and community services sectors were therefore also used for this indicator. The distinction between the health and community services sectors in these data was not clear enough to allow for health services reporting only. Professional categories stipulated for reporting against this indicator were not neatly identifiable within Census data. Furthermore, the employment categories to be reported under 'management and support staff' were not defined in the technical specifications for this report.

Indicator 21. Higher education and training in key health professions

Indicator:

(a) The number of Aboriginal and Torres Strait Islander people who gained a health qualification in the previous academic year.

(b) The number of Aboriginal and Torres Strait Islander people who are training in key health-related fields in the vocational education sector or the higher education sector.

Purpose

This indicator measures vocational education and training, and entry into the health professional workforce. The numbers of Indigenous people training in key health professions, or who have recently qualified, are important measures of the participation of Indigenous people in delivering health services. These measures assist in assessing the extent to which the capacity of Indigenous people to deliver health services to Indigenous people is being developed.

Data

Data for this indicator were obtained from the Department of Education, Science and Training's Higher Education Student Collection, which is responsible for the collection of statistics relating to the provision of higher education in all Australian universities; and the National Centre for Vocational Educational Research, which collects information on the vocational education and training (VET) sector. The data are likely to understate the number of Aboriginal and Torres Strait Islander people enrolled and qualified. Data are presented for the 2003 calendar year only.

It should be noted that the numbers of Aboriginal Health Workers and nurses presented here are significantly lower than those presented in the previous report due to differences in occupational codes used. For this reporting period, Higher Education data and VET data are presented separately (they were combined in the last report). Therefore data for this indicator should not be compared across the two reports.

- Of all Aboriginal and Torres Strait Islander students enrolled and qualified in vocational education courses in 2003, Certificate III and Certificate IV courses were the most popular.
- Of the professions presented, Aboriginal health work attracted the highest number of Indigenous students in the vocational education sector. The majority of Indigenous students who qualified as Aboriginal Health Workers completed the Certificate III course.
- For higher education courses, enrolments in allied health attracted the highest numbers of Indigenous students in 2003 (756). University nursing studies and Aboriginal health work also attracted larger numbers of students.
- The majority of Aboriginal and Torres Strait Islander people who held a health qualification (124) were allied health workers. Allied health includes professions such as social work, behavioural science, environmental health, optical science, radiography, rehabilitation therapies and complementary therapies.
- Queensland had the highest number of Aboriginal Health Workers in the vocational education sector (29 qualified and 216 enrolled), and New South Wales had the highest number in higher education (20 qualified and 115 enrolled).

- There were 44 Aboriginal and Torres Strait Islander people who qualified as nurses through vocational education courses in 2002 (3 of whom were registered nurses) and a further 86 qualified through higher education courses (58 of whom were registered nurses).
- Only 11 Aboriginal and Torres Strait Islander people were qualified as medical practitioners in 2003 and a further 102 were in training.
- One Aboriginal and Torres Strait Islander person was qualified as a dentist and 4 were in training.

Table 21.1: Number of Aboriginal and Torres Strait Islander people qualifying[(a)] or currently enrolled in vocational education, 2003

Profession	Cert. II	Cert. III	Cert. IV	Diploma	Adv. diploma /assoc. degree	Total
Aboriginal Health Worker						
Qualified	—	53	36	7	—	96
Enrolled	—	481	233	64	20	798
Nursing[(b)]						
Qualified	6	4	31	—	—	41
Enrolled	11	42	109	44	—	206
Nursing (registration)[(c)]						
Qualified	—	2	1	—	—	3
Enrolled	2	20	6	—	—	28
Allied Health						
Qualified	—	22	11	30	—	63
Enrolled	8	81	79	257	—	425
Health Management						
Qualified	2	—	5	—	—	7
Enrolled	33	20	25	6	—	84
Total						
Qualified	**8**	**81**	**84**	**37**	**—**	**210**
Enrolled	**54**	**644**	**452**	**371**	**20**	**1,541**

(a) 'Qualifying' students are those who completed studies in 2003.

(b) Includes enrolled nurses, nursing assistants and dental nurses.

(c) Includes students completing a general nursing course required for initial registration.

Note: Occupational codes used are as follows: Aboriginal Health worker: 3493; Nursing: 3411, 6391, 6314-13; Nursing (registration): 2323; Allied Health: 2385, 2393, 2388, 2383, 2384, 2511, 2514, 2512-11; Health Management: 2299-11, 2543, 1292.

Source: National Centre for Vocational Educational Research Ltd.

Table 21.2: Number of Aboriginal and Torres Strait Islander people qualifying[a] or currently enrolled in higher education, 2003

Profession	Other award courses[f]	Diploma	Adv. diploma/ assoc. Degree	Bachelor	Masters	Postgrad.[g]	Total
Aboriginal Health Worker							
Qualified	1	1	—	19	1	8	30
Enrolled	—	27	2	69	29	19	146
Nursing[b]							
Qualified	—	—	1	3	4	20	28
Enrolled	1	—	—	8	10	41	60
Nursing (university)[c]							
Qualified	—	—	—	58	—	—	58
Enrolled	—	—	—	324	—	—	324
Medicine (registration)[d]							
Qualified	—	—	—	11	—	—	11
Enrolled	—	—	—	102	—	—	102
Medical studies[e]							
Qualified	—	—	—	6	1	—	7
Enrolled	—	—	—	28	4	11	43
Allied health							
Qualified	—	13	7	86	9	9	124
Enrolled	11	112	38	521	33	41	756
Health management							
Qualified	—	—	—	1	3	7	11
Enrolled	—	—	—	6	6	20	32
Pharmacy							
Qualified	—	—	—	1	—	1	2
Enrolled	—	—	—	7	—	1	8
Dental							
Qualified	—	—	—	1	—	—	1
Enrolled	—	—	—	4	—	—	4
Public health							
Qualified	—	—	14	3	2	3	22
Enrolled	—	—	68	21	21	12	122
Total							
Qualified	**1**	**14**	**22**	**189**	**20**	**48**	**294**
Enrolled	**12**	**139**	**108**	**1,090**	**103**	**145**	**1,597**

(a) 'Qualifying' students are those who completed studies in 2003.

(b) Includes enrolled nurses, nursing assistants and dental nurses.

(c) Includes students completing a general nursing course required for initial registration.

(d) Includes courses leading to provisional registration as a medical practitioner.

(e) Includes general medicine, surgery, obstetrics and gynaecology, paediatrics, anaesthesiology, pathology, radiology, internal medicine, general practice, medical studies n.e.c, medical science.

(f) Includes any other undergraduate award course not mentioned in the other categories.

(g) Includes Doctorate (by research or coursework), Postgraduate Qualifying/Preliminary, Graduate/Postgraduate Diploma or Certificate.

Note: Field of education codes used: Aboriginal Health Worker= 061305,061307,061309, Nursing= 060300-060399, Nursing (registration)=Special Course Indicator=21, Medicine (Registration)=Special Course Indicator=23, Medicinal Studies= 060100-060104, 060106-060199, 019901 (excluding students under Medicine (Registration), Allied Health= 060000, 060105, 060705, 060799, 060900-060999, 061303, 061500-069999, 090501, 090515, 090700-090799, Health Management= 061301, 080313, Pharmacy= 060500-060501, 019907, Dental= 060701, Public Health= 061300, 061311-061399.

Source: Department of Education, Science and Training Higher Education Student Collection.

Table 21.3: Number of Aboriginal and Torres Strait Islanders qualifying[a] or currently in vocational education, by state and territory, 2003

	Aboriginal Health Worker	Nursing[b]	Nursing (registration)[b][c]	Allied health	Health management	Total
NSW						
Qualified	2	14	—	45	4	65
Enrolled	21	61	—	203	15	300
Vic						
Qualified	1	19	—	—	—	20
Enrolled	9	30	—	—	1	40
Qld						
Qualified	29	6	—	18	—	53
Enrolled	216	66	—	211	1	494
WA						
Qualified	43	1	3	—	—	47
Enrolled	185	5	26	8	—	224
SA						
Qualified	17	1	—	—	—	18
Enrolled	221	39	2	3	3	268
Tas						
Qualified	—	—	—	—	—	—
Enrolled	—	2	—	—	3	5
ACT						
Qualified	—	—	—	—	—	—
Enrolled	—	—	—	—	—	—
NT						
Qualified	7	—	—	—	3	10
Enrolled	146	3	—	—	61	210
Australia						
Qualified	**99**	**41**	**3**	**63**	**7**	**213**
Enrolled	**798**	**206**	**28**	**425**	**84**	**1,541**

(a) 'Qualifying' students are those who completed studies in 2003.

(b) These nursing students include enrolled nurses, nursing assistants and dental nurses.

(c) Includes students completing a general nursing course required for initial registration.

Note: Occupational codes used are as follows: Aboriginal Health worker: 3493; Nursing: 3411, 6391, 6314–13; Nursing (registration): 2323; Allied Health: 2385, 2393, 2388, 2383, 2384, 2511, 2514, 2512–11; Health Management: 2299–11, 2543, 1292.

Source: National Centre for Vocational Educational Research Ltd.

Table 21.4: Number of Aboriginal and Torres Strait Islander people qualifying[a] or currently in higher education, by state and territory, 2003

	AHW[b]	Nurs.[c]	Nurs. (uni)[d]	Medi-cine[e]	Med. Studies[f]	Allied health	Health manage -ment.	Pharm-acy	Dental	Public health	Total
NSW											
Qualified	20	5	16	7	2	35	7	—	—	1	93
Enrolled	115	10	94	43	7	146	12	—	—	6	433
Vic											
Qualified	2	9	5	2	1	17	—	1	—	1	38
Enrolled	18	19	30	5	8	108	2	5	—	11	206
Qld											
Qualified	1	6	11	1	4	35	—	—	1	—	59
Enrolled	1	14	100	22	21	208	12	2	3	12	395
WA											
Qualified	5	—	8	—	—	6	—	—	—	18	37
Enrolled	2	2	19	17	3	51	—	—	1	85	180
SA											
Qualified	—	5	6	1	—	2	3	—	—	2	19
Enrolled	—	9	35	14	1	36	4	—	—	8	107
Tas											
Qualified	—	—	5	—	—	3	—	1	—	—	9
Enrolled	—	2	12	1	3	9	—	1	—	—	28
ACT											
Qualified	1	—	—	—	—	2	—	—	—	—	3
Enrolled	3	—	1	—	—	8	2	—	—	—	14
NT											
Qualified	1	3	4	—	—	21	1	—	—	—	30
Enrolled	7	4	21	—	—	177	—	—	—	—	209
Aust.[g]											
Qualified	**30**	**28**	**58**	**11**	**7**	**124**	**11**	**2**	**1**	**22**	**294**
Enrolled	**146**	**60**	**324**	**102**	**43**	**756**	**32**	**8**	**4**	**122**	**1,597**

(a) 'Qualified' students are those who completed studies in 2003.

(b) Aboriginal Health Worker.

(c) These nursing students include enrolled nurses, nursing assistants and dental nurses.

(d) Includes students completing a general nursing course required for initial registration.

(e) Includes courses leading to provisional registration as a medical practitioner.

(f) Includes general medicine, surgery, obstetrics and gynaecology, paediatrics, anaesthesiology, pathology, radiology, internal medicine, general practice, medical studies n.e.c, medical science.

(g) Includes students qualified and enrolled in courses in multiple states.

Note: Field of education codes used: Aboriginal Health Worker= 061305, 061307, 061309, Nursing= 060300-060399, 060703, Nursing (registration)=Special Course Indicator=21, Medicine (Registration)=Special Course Indicator=23, Medicinal Studies= 060100-060104, 060106-060199, 019901, Allied Health= 060000, 060105, 060705, 060799, 060900-060999, 061303, 061500-069999, 090501, 090515, 090700-090799, Health Management=061301, 080313, Pharmacy= 060500-060501, 019907, Dental= 060701, Public Health= 061300, 061311-061399.

Source: Department of Education, Science and Training Higher Education Student Collection.

Quality of the data

Higher education institutions are autonomous, and the Australian Government exercises no control over their activities. However, institutions that receive funding from the Australian Government are responsible under the *Higher Education Funding Act 1988* for ensuring equity of access. The Australian Government monitors the achievement of equity objectives through the annual educational profiles process, for which institutions are required to provide an Indigenous education strategy. These strategies detail the approach adopted by institutions to increase participation of Aboriginal and Torres Strait Islander students and to advance the goals of the National Aboriginal and Torres Strait Islander Education Policy.

Base operating grants to higher education institutions include allocations from the Indigenous Support Funding Program to meet the specific needs of Indigenous students. The program supports activities such as the establishment of Indigenous education and/or support units, assistance with study skills, counselling and cultural awareness activities. The allocation of funding is calculated on the basis of participation (Equivalent Full Time Student Units), student progress and completion of award courses. While encouraging Indigenous students to identify as such is the responsibility of individual higher education institutions, the Australian Government provides directions and incentives to the institutions to do so.

Australian Government programs

The Australian Government has encouraged increased participation of Indigenous Australians in higher education particularly through:

- the Indigenous Support Programme which assists institutions to meet the specific needs of Indigenous students and advance the goals of the National Aboriginal and Torres Strait Islander Education Policy (AEP)
- the requirement for reporting Indigenous education strategies for the annual Institution Assessment Framework.

Indigenous Education Strategic Initiatives Programme (IESIP)

IESIP is a programme aimed at achieving educational outcomes for Indigenous people that will match those of other Australians. *The Indigenous Education (Targeted Assistance) Act 2000* appropriates funding for IESIP for the purposes of advancing the Objects of the Act which embody the goals of the AEP.

The Objects of the Act include;

- **equitable and appropriate educational outcomes—** providing arrangements enabling Indigenous students participating in post-secondary education to attain the same graduation rates as those attained by other students
- **equal access to education—** that Indigenous people have equitable access to other secondary and post-compulsory education
- **equity of participation—** that the participation rate of Indigenous people in other secondary and post-secondary education is equivalent to that of other Australians
- **increasing the involvement of Indigenous people in education—** the establishment of effective arrangements for the participation of Indigenous students and other Indigenous people in decisions concerning the planning, delivery and evaluation of post-compulsory education to Indigenous people; and an increase in the number of Indigenous people who are employed or otherwise involved in education:
    - as administrators, teachers, teaching assistants, researchers, student services officers

- as special teachers of the culture, history, contemporary society and languages of Indigenous people

- **developing culturally appropriate education services—**the development of teaching methods and techniques that are suited to the learning styles of Indigenous students.

IESIP provides funding under four discrete elements: Supplementary Recurrent Assistance; English as a Second Language—Indigenous Language Speaking Students; Indigenous Education Projects—Capital and Non-Capital (Projects); and 'Mixed-mode' Away from Base Assistance (AFB).

There are two broad categories of AFB assistance, which is available to the VET and Higher Education sectors: IEP or 'mixed-mode'AFB; and ABSTUDY AFB, which is administered by Centrelink.

'Mixed-mode' AFB

'Mixed-Mode' study is a form of tertiary education where students undertake accredited courses of study through a combination of distance education and 'residential' periods of intensive face-to-face teaching. This mode of study allows students to complete courses in their home communities with occasional time on-campus, and is well-suited for some Indigenous students.

'Mixed-mode' AFB provides funding to cover travel costs, including fares, meals and accommodation costs for students studying approved mixed-mode courses.

ABSTUDY Away-from-base (AFB)

In addition, the Australian Government provides financial assistance to Indigenous students in the form of ABSTUDY to target benefits to those students most in need of assistance. ABSTUDY represents a major component of the government's commitment to Indigenous education to:

- ensure Aboriginal and Torres Strait Islander involvement in educational decision making
- provide equality of access for Aboriginal and Torres Strait Islander peoples to education services
- raise the rates of Indigenous participation in education to those for all Australians
- achieve equitable and appropriate educational outcomes for Aboriginal and Torres Strait Islander people.

ABSTUDY AFB covers actual travel, meals and accommodation costs for students attending testing and assessment programs, short courses, field trips, occasional residential schools or practical placements.

Indigenous education direct assistance

Indigenous Tutorial Assistance Scheme

The Indigenous Tutorial Assistance Scheme is targeted at students requiring supplementary tutorial assistance. Under the scheme, 36 universities are funded to provide additional tutorial assistance to help students stay at university and complete award courses. Indigenous students who are assessed as requiring additional help with their studies may receive assistance from a tutor, either individually or in a small group.

The Vocational Education Guidance for Aboriginals Scheme

VEGAS provides grants to sponsoring organisations to conduct projects for Indigenous students to foster positive attitudes towards participation in education and provide information to help them to consider their options for further study and career. This program has become inactive since 1 January 2005.

Vocational education

Nursing Initiative for Indigenous Students project (Queensland)

The Australian Government project The Nursing Initiative for Indigenous Students (Queensland) included a focus on the provision of vocational learning opportunities in schools in Brisbane, Townsville and Cairns and the development of pathways for Indigenous students into nursing and the allied health industries through VET in Schools and School-based New Apprenticeships programs. The initiative was completed in November 2004. The key project outcomes included the development and establishment of models in nursing and related health industries for articulated vocational education and VET in Schools programs for Indigenous school students.

Group Training New Apprenticeship Targeted Initiative Program (TIP)

The objective of the TIP is to enable Group Training Organisations to generate quality new apprenticeship opportunities in priority areas, including health that would not otherwise happen. In general, priority areas are those considered critical, challenging or under serviced. TIP funding rounds are usually targeted to specific funding priorities that have emerged within these areas. In 2004-05, TIP priorities include projects that target participation by Indigenous people, particularly those that increase completion rates for Indigenous people undertaking VET qualifications and those that target higher VET Certificate levels.

A current project under TIP focuses on the creation and establishment of sustainable New Apprenticeship opportunities in Certificate III Community Services, and implements an articulation pathway from Certificate III Community Services to Certificate IV Nursing in New South Wales, the Australian Capital Territory, Victoria, South Australia, Tasmania and Queensland. New Apprenticeship recruitment under the project is expected to target and secure commencements among Indigenous people. The project commenced in June 2003 and will conclude in April 2006.

Career education products.

In 2002 DEST launched the publication *No Shame Job – Careers in Health*. Some 5,500 copies were ordered by schools, DEST program providers, TAFE and community health organisations during 2003 and 2004. In 2003, 7,000 copies were provided to Centrelink for distribution.

Indicator 22. Workforce availability in primary health care services

Indicator: The number of health professionals working in primary health care centres that provide care in populations where more than 60% of the catchment population are Aboriginal and Torres Strait Islander people.

Purpose

Providing adequate care to meet the needs of Aboriginal and Torres Strait Islander people is an important goal for all states and territories. This indicator measures the number and professional expertise of health workers employed in primary health care services that serve a majority of Aboriginal and Torres Strait Islander people.

Data

Information for this indicator was obtained from OATSIH.

The concept of a 'catchment population', defined as the number of people resident within the catchment area of a service, was difficult to apply. A number of states and territories reported an inability to determine the catchment populations of primary health care services. 'Catchment population' should probably be redefined as 'service population', that is, the number of Aboriginal and Torres Strait Islander people attending a primary care service.

Therefore, instead of using data from the states and territories, data from the Australian Government's SAR annual data collection are used for this indicator. The SAR collects data on full-time equivalent positions in Australian Government-funded Aboriginal and Torres Strait Islander primary health care services. It also measures the number of people using these services. SAR does not record catchment proportions, nor is this able to be derived from the data. However, many of these services are in areas with a high proportion of Indigenous people.

- At 30 June 2003, 2,606 full-time equivalent positions were reported to exist in Australian Government-funded Aboriginal and Torres Strait Islander primary health care services.
- Western Australia reported the highest number of full-time equivalent positions (599), followed by the Northern Territory (521).
- Aboriginal Health Workers comprised 24% of this workforce, while Indigenous nursing staff and GPs represented 9.9% and 7.2% of the full-time equivalent positions in these services.

Table 22.1: Full-time equivalent positions employed by Australian Government-funded Aboriginal and Torres Strait Islander primary health care services[a], 30 June 2003

	NSW & ACT	Vic	Qld	WA	SA	Tas	NT	Australia
Aboriginal Health Workers	119	57	86	154	82	10	105	614
Medical staff								
GPs	48	9	39	44	12	2	32	187
Specialists	3	0	—	—	0	0	2	5
Nursing staff	51	14	27	74	34	4	56	259
Allied health[b]	5	3	8	10	3	—	6	35
Dental								
Dentists	20	5	7	3	2	—	3	39
Dental assistants	18	8	11	2	3	—	4	47
Orthodontists	—	—	—	—	—	—	—	—
Pharmacy	—	—	—	—	—	—	—	—
Other health								
Traditional healers	0	1	—	—	2	0	6	9
Substance misuse workers	22	21	11	9	8	0	11	81
Environmental health workers	2	0	0	21	4	0	3	30
Other Emotional and Social Well Being staff	27	19	31	27	19	3	34	160
Drivers/field officers	25	11	27	26	11	1	16	118
Other health staff	12	5	15	12	6	2	13	64
Management/administrative staff								
CEOs/administrators/managers	49	27	42	62	23	4	58	264
Secretaries/receptionists	57	20	56	60	31	6	57	287
Accountants/bookkeepers	25	15	25	28	16	2	15	126
Information systems/data staff	4	2	9	13	5	1	7	40
Trainers/educators	1	1	8	12	5	0	30	56
Cleaners/cooks/gardeners	23	8	16	23	7	4	21	103
Other	10.	10	23	19	8	2	11	81
Total	**521**	**235**	**441**	**599**	**280**	**40**	**491**	**2,606**

(a) Includes psychiatrist, pediatrician, physician, gynecologist.

(b) Includes social worker, psychologist, audiologist, chiropractor, dietitian, naturopath, physiotherapist, podiatrist, remedial therapist and speech therapist.

Note: Visiting staff and staff who worked at the service and were not paid by the service are not included in the table.

Source: Department of Health and Ageing Service Activity Reporting 2002–03.

Box 22.1: Data issues

The concept of a catchment area where more than 60% of the population are Aboriginal and Torres Strait Islander people was difficult for states and territories to measure. It was agreed to use Australian Government SAR data on Aboriginal and Torres Strait Islander community-controlled health services. These organisations provide services mainly to the Indigenous population, yet some of these services may be located in areas where Indigenous people make up only a small proportion of the total population.

The provision of culturally appropriate health services and the employment of Indigenous staff in these services may affect the access of Aboriginal and Torres Strait Islander people. Therefore, it is important to report information on the proportion of this workforce who are Indigenous.

The definition of a 'primary health care service' in the indicator specifications says that these services must include all of the following: 24 hour service, treatment, access to registered health worker, access to a doctor, immunisation services, antenatal care, screening and early interventions services, women's and men's health programs, and sexually transmitted infection and communicable disease control. If applied strictly, this definition would have seriously limited the number of services for which data were reported.

Indicator 23. Workforce availability in hospitals

Indicator: The number of positions for medical officers, nurses, Aboriginal Health Workers and Aboriginal Liaison Officers in acute care hospitals where more than 25% of the separations are for Aboriginal and Torres Strait Islander people.

Purpose

Providing adequate care for Aboriginal and Torres Strait Islander people in hospitals dealing with a high proportion of Indigenous people is important in addressing their needs for health care. This indicator describes the medical and nursing capacity and the availability of special support services in hospitals that provide care for Aboriginal and Torres Strait Islander peoples.

Data

Data were provided by the states and territories. Victoria, Tasmania and the Australian Capital Territory do not have any acute care hospitals that reported more than 25% of separations for Aboriginal and Torres Strait Islander people.

- In 2003–04, 75 hospitals in Australia reported that more than one-quarter of their separations were for Aboriginal and Torres Strait Islander people.
- Queensland had 32 hospitals with more than 25% Indigenous separations with 608 full-time and 544 part-time nurses; 158 full-time and 36 part-time medical staff, 116 full-time and 12 part-time Aboriginal Health Workers and 7 full-time Aboriginal Liaison Officers.
- In Western Australia there were 18 hospitals with more than 25% Indigenous separations. These employed 501 full-time and 189 part-time nursing staff, 45 full-time and 1 part-time medical staff, 23 full-time and 1 part-time Aboriginal Health Workers, and 7 full-time and 5 part-time Aboriginal Liaison Officers.
- In the Northern Territory there were 5 such hospitals, with 723 full-time and 297 part-time nursing staff, 246 full-time and 27 part-time medical staff, and 16 full-time and 1 part-time Aboriginal Health Workers.
- In New South Wales there were 13 hospitals reporting more than 25% Indigenous separations. While data were provided for some of these hospitals in the last reporting period, none were available for the current reporting period. This was because some hospitals did not meet the definition of an 'acute care hospital' and some hospitals/area health services did not respond to requests for information on workforce availability.
- In South Australia there were 7 hospitals reporting more than 25% Indigenous separations, but no data on the workforce were available.

Table 23.1: Medical workforce numbers in acute care hospitals where more than 25% of separations are for Aboriginal and Torres Strait Islander people[a], selected states and territories, 2003–04

	Qld[b]	WA	NT[c]
Aboriginal Liaison Officers			
Full-time	7	7	—
Part-time	—	5	—
Aboriginal Health Workers			
Full-time	116	23	16
Part-time	12	1	1
Medical staff			
Full-time	158	45	246
Part-time	36	1	27
Nursing staff			
Full-time	608	501	723
Part-time	544	189	297
Total	**1,481**	**772**	**1,310**
Total number of hospitals	***32***	***18***	***5***

(a) Victoria, Tasmania and the Australian Capital Territory do not have any acute care hospitals that report more than 25% of separations for Aboriginal and Torres Strait Islander people. South Australia has 7 hospitals and New South Wales has 13 hospitals that reported more than 25% of separations for Aboriginal and Torres Strait Islander people, but no data were available. This was because some hospitals did not meet the definition of an 'acute care hospital' and some hospitals/area health services did not respond to requests for information on workforce availability.

(b) The data provided for Queensland are from the Queensland Health Human Resource Decision Report System. The number of casual positions within these hospitals was also provided; however, for consistency, these have not been reported. Australian Standard Classification of Occupations (ASCO) codes were used for medical and nursing staff. Aboriginal Liaison Officers and Aboriginal Health Workers categories were determined by manual review.

(c) Numbers provided are for paid full-time equivalent staff, not a basic head count, to more accurately represent DHCS.

Source: Data provided by the states and territories.

Box 23.1: Data issues

The definition of 'Acute care hospital' included in the specifications for this indicator was problematic. 'Acute care hospital services' are defined as having a 24-hour staffed emergency department, 24-hour medical supervision or on-call roster, round-the-clock comprehensive nursing and other necessary professional services, and a referral network to specialist services to promote continuity of care. It is recommended that the National Health Data Dictionary *definition of an 'acute care episode for admitted patients' be used for this indicator. Throughout this report the definition of a hospital in the* National Health Data Dictionary *was used.*

The specifications called for workforce data in even-numbered calendar years. Information on workforce provided generally related to a point in time, usually 30 June 2004. As separations data are normally calculated on a financial year basis, the data were requested for hospitals reporting more than 25% Indigenous separations in 2003–04.

Indicator 24. Cross-cultural training for hospital staff

Indicator:

(a) The proportion of acute care hospitals where staff receive information about Aboriginal and Torres Strait Islander values and cross-cultural issues, as part of orientation.

(b) The proportion of new staff in acute care hospitals who have completed appropriate orientation training in the past year.

Purpose

This indicator provides a measure of the commitment of acute care hospitals to provide staff with cross-cultural training and orientation for working with Aboriginal and Torres Strait Islander people. Such training will assist in improving Indigenous access to services, through the delivery of culturally sensitive services.

Data

Information for this indicator was obtained from the states and territories. States and territories could not provide quantitative data for this indicator and only written responses are provided.

New South Wales

A review was held in NSW Health in 1999 to examine 'The effectiveness of Cultural Awareness Training in the NSW Public Health System'. It found these programs did not always consider skills and knowledge needed for staff to become culturally competent. Recommendations from this review are being implemented through the NSW Health Aboriginal Cultural Respect and Communication Project, which commenced in May 2003.

In consideration of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009, developed by the Standing Committee on Aboriginal and Torres Strait Islander Health, and the Department of Aboriginal Affairs New Ways of Doing Business, NSW Health undertook a survey in late 2003 across all health services to determine numbers of staff who have attended courses and the duration, content and assumed effectiveness of cultural awareness programs.

This survey highlighted that cultural awareness was available to staff in many differing modes and length of delivery and in some Area Health Services orientation is limited to between 5 and 15 minutes for Aboriginal health; however, some orientation programs have no Aboriginal health content. Specific cultural issues are seldom addressed in this short time. NSW Health and many health services do not have a policy of mandatory or compulsory training for additional cultural awareness.

The NSW Health Department has identified the need for a shift in emphasis from shaping attitudes to changing behaviour in order to deliver effective services. The current Aboriginal Cultural Respect and Communication Project will develop a Framework of Principles and Protocols—'Work in a cross cultural setting with Aboriginal and Torres Strait Islander people and organisations'—and later be linked into the Australian National Training Authority Competency Standards Health Unit.

Victoria

Hospitals with large local Aboriginal populations are more likely to provide cross cultural training and orientation. In smaller hospitals this is provided as required by numbers of new staff members. As the definition of cross-cultural training varies between hospitals, and the amount of training is not standard, it is not possible to quantify the number of hospitals providing a set level of cross-cultural training. From July 2004 there will be increased emphasis on cross-cultural training. This will be facilitated by the changed funding arrangements.

From July 2004 the Koori Health Liaison Officer (KHLO) program ceased as a separate funding item. A new program, Improving Care for Aboriginal and Torres Strait Islander Patients, will operate. The program will involve:

- Amalgamation of the formerly separate KHLO program funding and the 10% Aboriginal Weighted Inlier Equivalent Separation (WIES) supplement into a single funding stream through WIES
- An increase in the Aboriginal WIES supplement to 30% for each Aboriginal patient
- A focus on cultural change in health services leading to improved identification and health care for Aboriginal patients.

Queensland

Cultural Awareness Program – while individual hospitals are not required to have such programs in place, under the Queensland Health Aboriginal and Torres Strait Islander Cultural Awareness Program Revised Minimum Standards for Queensland Health encourages and recommends all Queensland Health staff participate in the Queensland Health Aboriginal and Torres Strait Islander Cultural Awareness Program (CAP). The Rural Health Training Units in each of Queensland Health's three zones facilitate CAP. To date, over 10,000 staff have completed the CAP across all Health Service Districts and Corporate Offices.

Cultural Orientation Online (Aboriginal and Torres Strait Islander Communities) – COOL Program: this new initiative was introduced in July 2004 and aims to increase appropriateness of health services for Aboriginal and Torres Strait Islander peoples. COOL is a flexible, online workshop which is designed to complement the Aboriginal and Torres Strait Islander Cultural Awareness Program by providing an introduction to the local community. COOL has not yet been launched but has been piloted throughout the districts since July 2004. Approximately 165 staff members have accessed the online workshop from 32 Districts and/or state-wide units within Queensland Health during this time.

Reconciliation Learning Circles – the Queensland Health Reconciliation Learning Circles Program continues to be delivered throughout the districts. The program is not compulsory for employees, but there continues to be a slow increase in the overall number of those who have participated. The number of facilitators has decreased over the last year, and this issue will be addressed in 2005 by workshops focused on training new facilitators and improving facilitator skills.

'One Talk': Queensland Health's Aboriginal and Torres Strait Islander Consumer and Community Participation Toolkit aims to enhance engagement between Queensland Health staff and Aboriginal and Torres Strait Islander peoples and communities, and improve consumer awareness of Queensland Health services. It will be available in early 2005.

The AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004—2009 is currently being distributed. Queensland Health is in the process of developing the Implementation Plan for the Framework. Implementation will ensure that Queensland Health staff and services are able to provide culturally sensitive health care.

Western Australia

There continues to be inconsistency between cross-cultural awareness training programs through-out the state. The programs appear to be more comprehensive and appropriate in the rural and remote area hospitals than those in the metropolitan area. For example, one of the regional areas reported that Aboriginal cultural awareness is a component of a standardised framework developed and delivered by Aboriginal Health Workers and covers: an introduction to Aboriginal history; Aboriginal spirituality and relationship to the land; government policies and their impact; do's and don'ts of caring for Aboriginal people; and beliefs around death and dying.

In contrast, a metropolitan health service reported that Aboriginal and Torres Strait Islander values and cross-cultural issues were addressed in the language services component of a generic orientation program. For example, this covered aspects of dealing with issues that may arise when dealing with patients from differing cultural backgrounds and how to access interpreter services.

South Australia

Cross-cultural awareness training continues to be undertaken in South Australia by hospitals and health services on an ad hoc basis. During the reporting periods there was no uniform cultural-awareness training strategy. However, the following activities have been undertaken across the state during the reporting period to increase cultural awareness for hospital and health service staff:

- The Lyell McEwin Hospital has provided training to reception staff around identifying Aboriginal consumers and cultural awareness training and development for non-Aboriginal workers has been implemented
- The Hills Mallee Southern Regional Health Service has rolled out a Winmill Yuntawarrin (Working Together) project across the region to ensure staff are culturally competent in working with the Indigenous community
- The Rural and Remote Divisions of GP are funded to provide a range of support services to all GPs in their area including cultural awareness training for overseas trained doctors including Indigenous health and rural medical family support
- Cultural awareness training within the Wakefield and Point Pearce regional area for senior staff was a major focus during the reporting period. Cultural awareness and promotional initiatives have been a focus within the region. The painting of murals in Unit foyers and displaying Aboriginal and Torres Strait Islander flags in all areas of the Health Service are examples of this activity
- Cultural awareness training is provided to staff at Port Pirie, Peterborough hospitals
- The purchase of IT equipment (lap-top and LCD projector) will provide for a better delivery of the cultural awareness educational information to health personnel in Northern and Far Western health services.

Tasmania

There is no formal cross-cultural training provided to new hospital staff. Through the Aboriginal Data Improvement Project cultural awareness training will be available to hospital staff.

Australian Capital Territory

The Australian Capital Territory's two acute care facilities include workplace diversity training in their orientation programs, but have not provided specific modules for Aboriginal and Torres Strait Islander values and culture. Culturally specific training and awareness for ACT Health staff is a priority action area under the Aboriginal and Torres Strait Islander Cultural Respect Implementation Plan. Research into suitable models for the design and delivery of cultural awareness training across ACT Health is underway.

Northern Territory

Cross–cultural awareness training is available in all five public hospitals in the Northern Territory. There are two facilitation teams, one in Alice Springs and the other in Darwin. These teams facilitate training for staff in all five major town regions throughout the Territory.

The Central and Top End offer different programs. The Top End program was developed in consultation with the School of Australian Indigenous Knowledge Systems through Charles Darwin University. This program encompasses three full-day modules:

- Module A (Culture, Indigenous Timeline, Kinship, Language, Aboriginal Well Being)
- Module B (Culture Shock, Communication, Racism, Cultural Safety)
- Module C (Primary Health Care, Indigenous Governance, Partnerships in Health, Structural Violence).

The Australian College of Ambulance Professionals team also facilitates a 2 hour Departmental Orientation that is compulsory for all new staff.

Box 24.2: Data issues

States and territories generally did not collect quantitative data for this indicator and it was agreed to report descriptive data.

A variety of interpretations of 'cross-cultural training' resulted in inconsistencies in reporting both across and within states and territories. For example, some hospitals may report training that includes a brief mention of cross-cultural issues, whereas other hospitals report half-day workshops about Aboriginal cultural issues. There were also difficulties about whether to include agency staff or short-term staff when reporting on cross-cultural training.