NATIONAL SUMMARY

of the 1998 jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators

1998

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

National summary of the 1998
Jurisdictional reports against the
Aboriginal and Torres Strait Islander
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The National Health Information Management Group for Australian Health Ministers' Advisory Council, prepared and funded by the Commonwealth Office for Aboriginal and Torres Strait Islander Health

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Foreword

This first report against the interim set of national performance indicators for Aboriginal and Torres Strait Islander Health was commissioned by the Australian Health Ministers' Advisory Council (AHMAC). It has been compiled from separate reports for 1998 submitted by all jurisdictions and reflects a genuine national commitment to accountability by State, Territory and Commonwealth governments in the area of Aboriginal and Torres Strait Islander health.

A credible information base, developed over time, is crucial to our understanding of Aboriginal and Torres Strait Islander health status and the effectiveness of the strategies in place. This report provides a basis for that understanding and I am pleased to say that there is a commitment in all jurisdictions to further work to improve methodology, comparability and coverage of key data sets.

It is intended that this report will be produced on a regular basis. While there are acknowledged gaps and some deficiencies, the report is an important step in a process of ongoing improvement of the national information base about Aboriginal and Torres Strait Islander Health. Comparison and interpretation of the data provided are limited, however, by several factors:

- data quality problems affecting most jurisdictions (although to varying degrees);
- definitional problems associated with many of the performance indicators; and
- lack of available data or methods for collecting data for several of the indicators.

Most jurisdictions have reported implementing of a range of initiatives to improve data quality. Jurisdictions should be congratulated on their responsiveness and commitment to the task. Nonetheless, it must be acknowledged that these efforts will not yield accurate, high quality data across all jurisdictions in the short term. Future reports against the performance indicators will continue to be impacted by data quality problems and jurisdictions will be urged to remain committed to addressing these problems as a matter of priority.

The definitional problems inherent in many of the indicators have been well documented. Some indicators attempt to address complex concepts that are not yet adequately defined, and require further consultation and research. Many of the other indicators require technical refinement. In their present state, they allow inconsistencies in interpretation and reporting, preventing valid comparisons between States and Territories. Again, while these definitional problems exist, interpretation of reports against the performance indicators will be limited. In this regard, AHMAC has endorsed a refinement of the indicator set, and the Commonwealth has agreed to fund this work.

All jurisdictions are being encouraged to commit to progressive improvement in their reports. The new ABS Indigenous Statistics strategy should fill some of the data gaps, but significant new data from this source is unlikely until 2002. At present, the ABS Indigenous Statistics strategy and the broader Household Surveys strategy are still in draft, and AHMAC will be encouraging all parties to work with the ABS to give Aboriginal and Torres Strait Islander statistics the very high priority they need and deserve.

David Butt
Chair
Australian Health Ministers' Advisory Council

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Executive summary

This report represents progress towards improving our understanding of whether government policies and programs are making a significant difference in improving Aboriginal and Torres Strait Islander health; it is too soon, however, to expect that the results against these performance indicators will identify anything new about the state of health of the Aboriginal and Torres Strait Islander population.

This report reinforces what is already known: that heart disease and stroke, diabetes, respiratory diseases, cancer and injury are the most significant contributors to Aboriginal and Torres Strait Islander ill health and death. In many instances, these deaths and chronic illnesses are potentially preventable. This is clearly demonstrated when comparing the Aboriginal and Torres Strait Islander hospitalisation and death rates with those for the non-Aboriginal and Torres Strait Islander population. A number of jurisdictions have specific programs or projects underway to focus on prevention, early detection and treatment of preventable chronic diseases.

To ensure that reporting against these indicators is a meaningful exercise over time, it is necessary that jurisdictions have the data to report against the indicators. In many instances, some jurisdictions simply do not have the necessary processes in place to collect such data. The National Aboriginal and Torres Strait Islander Survey (NATSIS), which was conducted in 1994, is still the most recent source of national data for several of the indicators. Subsequent jurisdictional surveys have been undertaken to identify health needs. An example is the Western Australian Aboriginal Environmental Health Needs Survey 1997, which took a collaborative approach to data collection across local agencies. However, additional national data collections or surveys will need to be conducted if Australia-wide indicators of housing, infrastructure and risk factors are to be monitored over time.

Second, the quality of the data must be improved - in particular, the extent to which Aboriginal and Torres Strait Islander status is identified in health statistics. There is significant under-reporting of Aboriginal and Torres Strait Islander status in most health data collections and, until this is improved, the effective monitoring of efforts to improve Aboriginal and Torres Strait Islander health cannot occur. It is generally recognised that the most robust data, on life expectancy for example, can be derived from data collections from Western Australia, South Australia and Northern Territory (ABS & AIHW, 1997: 5). A number of agencies have been working over recent years to address this issue. The National Health Information Management Group (NHIMG) is now responsible for coordinating efforts to improve the identification of Aboriginal and Torres Strait Islander people in health data collections. The NHIMG is represented by Commonwealth, State and Territory agencies with a responsibility for health information.

The third issue is the quality of the indicators themselves. There are a number of indicators that need to be redefined to ensure that they are useful, reliable and valid. To assist in understanding the quality of the indicators in this report, their degree of reliability and validity has been assessed through a coding system, the details of which are outlined in the Introduction. A project to refine the indicators is being organised by the Commonwealth in conjunction with the States and Territories.

A fourth issue is that the current set of indicators does not address emotional and social well-being (including mental health) issues and that this needs to be taken up as part of the refinement of the National Performance Indicators and Targets.

Another issue relates to targets for some of the indicators. Ideally, a target – a specific and measurable outcome – should be established for each indicator. An example is 'a 20% reduction in age-standardised all-causes mortality rate ratios over ten years'. The setting of targets, and monitoring of progress towards them, requires adequate baseline data. As discussed above, there are major problems with the availability and quality of data for many of the areas in which indicators have been agreed. These problems, which prevented the setting of targets for some indicators, also precluded the meaningful reporting in this document of current levels against those targets which have been set. This issue also will be addressed in the project to refine the indicators.

Finally, as a first attempt this report enables jurisdictions to identify the type and quality of information reportable. While it has been useful to note the particular projects and programs being implemented, it is important now to take stock and collaboratively work out a more strategic approach to future reporting. Such an approach should enable stakeholders to form a national picture of the comprehensive and systematic approaches to health status improvement being undertaken across the country and where gaps in the overarching system exist so that resources can be targeted more effectively in the policy context.

RESULTS

These are a summary of the most significant results that were identified in the body of this report. These do not represent a complete picture of what each jurisdiction is doing. Please refer to the main sections of the report for a full description against each indicator. When the performance indicators were developed, they were grouped into categories such as mortality, morbidity, access, risk factors and workforce. For the purpose of reporting, the indicators have been analysed under the same general categories which follow below.

Categories one and two: Life expectancy and mortality

National statistics on life expectancy and mortality cannot be reported due to the under-reporting of Aboriginal and Torres Strait Islander status on death records in most jurisdictions. The Australian Bureau of Statistics (ABS) recommends that only mortality data from the Northern Territory, and to a lesser extent, Western Australia and South Australia can be used with confidence (ABS 1998: 85). Even for these jurisdictions, caution should be exercised, however, as identification levels may vary.

The data describing the main causes of ill health among Aboriginal and Torres Strait Islander people were not well reported. Also, as ABS and the Australian Institute of Health and Welfare (AIHW) have commented, ‘while hospitalisation statistics can provide an indicator of health, they are not a measure of prevalence of disease’ (ABS & AIHW, 1997:76). Care must also be taken in interpreting hospitalisation rates as ‘low rates may represent lower levels of need or they may mean existing needs are not being met. Conversely a rising rate of hospitalisation could mean either a worsening of health status or improvement in access’ (ABS & AIHW, 1997:76).

Efforts to improve the identification of Aboriginality in mortality and morbidity collections must be maintained to ensure that a truly national picture of Aboriginal and Torres Strait Islander ill health can occur over the next few years.

- In the mid 1990s, life expectancy was between 58 and 62 years for Aboriginal and Torres Strait Islander males in Western Australia and the Northern Territory, and between 64 and 67 years for Aboriginal and Torres Strait Islander females – around 14 to 17 years less than the life expectancy for other Australians.
- Death rates for Aboriginal and Torres Strait Islander people in Western Australia, South Australia and the Northern Territory were between one and a half and three times higher than those of non-Aboriginal and Torres Strait Islander people.

- Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander death rate ratios are highest among working-age people – ratios are more than 5 for people aged 25-44 years.
- Ischaemic heart disease is the main cause of death for both Aboriginal and Torres Strait Islander men and women.
- Some quite uncommon causes of death for non-Aboriginal and Torres Strait Islander people have a substantial impact among Aboriginal and Torres Strait Islander people. These include diabetes, pneumonia and rheumatic heart disease, and cervical cancer for Aboriginal and Torres Strait Islander females.
- Aboriginal and Torres Strait Islander people are two-three times more likely to be admitted to hospital than non-Aboriginal and Torres Strait Islander people.
- The proportions of low birthweight among babies born to Aboriginal and Torres Strait Islander women remain about twice the proportions among those born to non-Aboriginal and Torres Strait Islander women.

Category three: Access

It is difficult to monitor Aboriginal and Torres Strait Islander access to health services and most of the indicators in this category require further development to be able to capture meaningful data. Therefore, the focus should be on the efforts of jurisdictions to improve data so better reporting would be possible in the future.

The assessment of expenditure on health services for Aboriginal and Torres Strait Islander people was aided by an important recent national report (Deeble et al. 1998). This report provides for the first time a comprehensive national picture of what governments spend on Aboriginal and Torres Strait Islander health. In 1995-96, per capita health spending by State and Territory governments for Aboriginal and Torres Strait Islander people was more than twice the amount spent for non-Aboriginal and Torres Strait Islander people. Commonwealth health spending for Aboriginal and Torres Strait Islander people was slightly more than six-tenths the amount spent for non-Aboriginal and Torres Strait Islander people (because of much lower per person Medicare and Pharmaceutical Benefits Scheme expenditures).

Commonwealth

- Aboriginal and Torres Strait Islander people access the Medicare Benefits Scheme (MBS) at 25% and the Pharmaceutical Benefits Scheme (PBS) at 20% of the rate for non-Aboriginal and Torres Strait Islander people.
- 90% of Aboriginal and Torres Strait Islander health services funded by the Commonwealth through the Office for Aboriginal and Torres Strait Islander Health are community controlled.

States and Territories

- In some jurisdictions there are low levels of funding of community-controlled services.
- The greatest difference in spending is in community health which for some jurisdictions is three to four times higher for Aboriginal and Torres Strait Islander people than for non-Aboriginal and Torres Strait Islander people.
- The majority of State and Territory primary health care services for Aboriginal and Torres Strait Islander communities are government managed.

- New South Wales and the Northern Territory have high levels of Aboriginal and Torres Strait Islander representation on hospital and health boards.
- Access to health services, including that for remote communities, cannot be reported. Data on usual travel time to reach a health service are not available.

Category four: Health service impacts

The main issue for reporting against these indicators – which cover services such as immunisation, screening and other population health programs – is the lack of Aboriginal and Torres Strait Islander identified data. There is a need for improved national coordination of data collection to tackle Aboriginal and Torres Strait Islander identification on pathology and general practice disease notification records. Improving the recording of Aboriginal and Torres Strait Islander status on the National Childhood Immunisation Register is a priority.

Health promotion programs are very varied and most jurisdictions identified specific statewide or local programs that focus on education strategies and awareness raising of screening and immunisation programs.

- Population health programs focusing on immunisation, screening, early detection and treatment of disease among Aboriginal and Torres Strait Islander people are occurring in all jurisdictions.
- The development of protocols, early detection and management systems for renal disease, diabetes and cardiovascular disease are occurring in a number of jurisdictions, but there was little evidence of focus on respiratory diseases, including asthma.
- The extent of Aboriginal and Torres Strait Islander childhood and hepatitis B immunisation cannot be reported due to under-reporting of Aboriginal and Torres Strait Islander status on the relevant registers.
- It is not possible to report on the rate of pneumococcal vaccination among older Aboriginal and Torres Strait Islander people at this time.
- Poor identification of Aboriginal and Torres Strait Islander status in accident and emergency records means that there are no useful data on the utilisation of these services.
- Data on the utilisation by Aboriginal and Torres Strait Islander people of primary care services are not available, but some jurisdictions intend to collect some data in the future. In addition, the Commonwealth has provided funds to some community-controlled health services to install computerised patient information and recall systems.

Category five: Workforce development

The Commonwealth Department of Education, Training and Youth Affairs (DETYA) is able to provide global data on request relating to Aboriginal and Torres Strait Islander people participating in health-related training. Additional data collection processes that capture employment data will be needed in most jurisdictions to monitor the adequacy of the workforce in terms of meeting the health needs of Aboriginal and Torres Strait Islander people. Improved and readily accessible workforce and education/training data are also needed to increase our knowledge of the number of Aboriginal and Torres Strait Islander doctors and nurses.

- The enrolments for Aboriginal and Torres Strait Islander people in vocational training health courses have increased over the last couple of years while enrolments for university health courses have declined.
- Vacancies in health services are difficult to monitor.

- The number of identified positions cannot be reported across the country as some jurisdictions do not include this particular designation in their recruitment processes.

Category six: Risk factors

The indicators in this category are intended to monitor a number of significant health risk factors: smoking, obesity and over-weight and excess alcohol consumption. The most recent data available are from the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS) and the 1994 National Drug Survey (NDS). As a result, this report contains no new data.

It will not be possible to monitor the levels of these risk factors unless further surveys, such as the NATSIS, and the NDS, are undertaken and/or other data collection methodologies are developed.

Category seven: After-housing poverty and housing amenities

After-housing poverty refers to households whose after-tax income is below the poverty line once their rent or mortgage has been paid. It was not possible to report on after-housing poverty due to definitional problems and, more importantly, the lack of data.

As for risk factors, the most recent information about housing and other essential services came from the 1994 NATSIS; as such, this report contains no new data.

Category eight: Community involvement

These indicators aim to identify the extent of community involvement in health planning, policy development and program implementation.

Aboriginal and Torres Strait Islander Health Forums have now been established in each State and Territory and, as part of that, regional planning processes have been established in all jurisdictions.

The indicator aimed, however, at monitoring community participation in health planning and requires further development to properly capture such involvement.

Category nine: Quality of service provision

Complaints mechanisms for patients exist in most health services, but they are not believed to be well accessed by Aboriginal and Torres Strait Islander people. Most States and Territories are putting strategies in place to address this problem. No information was provided about the primary care sector.

Background

This report is the result of work on the development of national Aboriginal and Torres Strait Islander health performance indicators that has been occurring over the past five years. The Commonwealth, State and Territory health authorities have put considerable effort into producing their individual reports. This demonstrates their commitment to monitoring governments' efforts to address the poor state of Aboriginal and Torres Strait Islander health.

The set of interim performance indicators reported against in this report was agreed to by Health Ministers in 1997. All jurisdictions were to report against these indicators in October 1998 and 1999, and the indicators are to be further refined for reporting in October 2000 and beyond. The interim set evolved from an initial set of indicators that was agreed to by the Australian Health Ministers' Advisory Council (AHMAC) in 1998, and for which jurisdictions provided preliminary results.

The process of developing the indicators has been a cooperative effort, but nonetheless a difficult one. The National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) have worked with the Heads of Aboriginal Health Units (HAHU) from the Commonwealth, State and Territory health authorities to produce the interim set of national Aboriginal and Torres Strait Islander performance indicators.

However, when Health Ministers agreed to the interim set of performance indicators, it was also agreed that a project would be undertaken to further refine the performance indicators. A number of the indicator definitions are reasonably well defined but need further work to improve their usefulness, validity and reliability. Other indicator definitions are still under development. The appropriateness and potential availability of some indicators will need to be re-assessed. The refinement project is being organised by the Commonwealth in conjunction with the States and Territories.

The Aboriginal and Torres Strait Islander Health Information Plan (Aboriginal and Torres Strait Islander Health and Welfare Information Unit, 1998) will complement this work and will significantly enhance the governments' ability to report against these indicators in the future. An implementation working group of the NHIMG (initially chaired by David Filby of South Australia) has commenced overseeing the implementation of the recommendations from the Plan. Most importantly, they are focusing on improving the identification of Aboriginal and Torres Strait Islander people in routine data collections which is the single most significant quality issue detracting from meaningful reporting against the indicators.

Interim national performance indicators

Category one: Life expectancy and mortality

Indicator 1.1	Life expectancy at birth by sex.
Indicator 1.2a	Age-standardised all-causes mortality rates by sex.
Indicator 1.2b	Age-specific all-causes mortality rates by sex.
Indicator 1.3a	Age-standardised all-causes mortality rate ratio by sex.
Indicator 1.3b	All-causes age-specific rate by ratio by sex.
Indicator 1.4	Chance of dying between 20 and 54 years by sex.
Indicator 1.5	Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1,000 total births to Aboriginal and Torres Strait Islander mothers.
Indicator 1.6	Death rate of Aboriginal and Torres Strait Islanders from birth to one year of age.
Indicator 1.7a	Age-standardised mortality rates for ischaemic heart disease and rheumatic heart disease. Disease by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7b	Age-standardised mortality rates of injury and poisoning by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7c	Age-standardised mortality for pneumonia by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7d	Age-standardised mortality rates from diabetes by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7e	Age-standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non-Aboriginal and Torres Strait Islander women.

Category two: Morbidity

Indicator 2.1a	Notification rates for selected vaccine-preventable diseases: pertussis, measles, hepatitis B.
Indicator 2.1b	Notification rates for meningococcal infection.
Indicator 2.2	Crude notification rates for gonorrhoea and syphilis by sex.
Indicator 2.3	Percentage of Aboriginal and Torres Strait Islander children at school entry having >25dB hearing loss averaged over three frequencies.
Indicator 2.4	Proportion of Aboriginal and Torres Strait Islander newborns with birth weight <2,500 g, per 1,000 live births.
Indicator 2.5	Age-standardised all-causes hospital separation rate ratio by sex.
Indicator 2.6a	Age-standardised hospitalisation rate and ratio by sex for acute myocardial infarction.
Indicator 2.6b	Age-standardised hospitalisation rate ratio by sex for injury and poisoning.

Indicator 2.6c	Age-standardised hospitalisation rate ratio by sex for respiratory diseases.
Indicator 2.6d	Age-standardised hospitalisation rate ratio by sex for diabetes.
Indicator 2.6e	Age-standardised hospitalisation rate ratio by sex for tympanoplasty.

Category three: Access

Indicator 3.1	Proportion of Aboriginal and Torres Strait Islander people whose ordinary residence is <30 minutes routine travel time from a full-time permanent primary care service by usual means of transport.
Indicator 3.2	Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is <one hour travel time from a hospital that provides acute inpatient care with the continuous availability of medical supervision.
Indicator 3.3	Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population.
Indicator 3.4	Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non-Aboriginal and Torres Strait Islander people.
Indicator 3.5	Proportion of primary care services, and the resources allocated to these services.
Indicator 3.6	Extent of community participation in health services.
Indicator 3.7	(a) What number of local or regional health/hospital boards have Aboriginal and Torres Strait Islander members?; and (b) Is this membership mandated by terms of reference?
Indicator 3.8	Proportion of communities with usual populations of <100, within one hour usual travel time to primary health care services.
Indicator 3.9	Per capita recurrent expenditure by governments on health care services to communities with populations <100, as compared with expenditure for the general population.

Category four: Health service impacts

Indicator 4.1	Expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander people.
Indicator 4.2	Number of Pap smears among Aboriginal and Torres Strait Islander females aged 18-70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group.
Indicator 4.3	Proportion of Aboriginal and Torres Strait Islander children aged two years and six years old that are fully immunised as recorded in the Australian Childhood Immunisation Register (ACIR).
Indicator 4.4	Proportion of Aboriginal and Torres Strait Islander people aged >50 years who have received pneumococcal vaccine in the last six years.
Indicator 4.5	Proportion of children aged between two and six years who are fully immunised against Hepatitis B as recorded in the National Childhood Immunisation Register.
Indicator 4.6	Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension.

Indicator 4.7	Age-standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders.
Indicator 4.8	Proportion of total consultations by condition and care provider.

Category five: Workforce development

Indicator 5.1	Number of Aboriginal and Torres Strait Islander people who have: (a) graduated in the previous year; and (b) training in key health-related fields.
Indicator 5.2	Number and proportion of Aboriginal Health Workers who graduated in the previous year or are participating in accredited training programs.
Indicator 5.3	Proportion of vacant funded full-time equivalent (FTE) positions for doctors, nurses and Aboriginal Health Workers in: (a) Aboriginal health services; and (b) other organisations providing primary care for Aboriginal and Torres Strait Islander peoples on a given date.
Indicator 5.4	Number of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in hospitals where >25% of separations are Aboriginal and Torres Strait Islander people on a given date.
Indicator 5.5	Number of Aboriginal and Torres Strait Islander identified positions in the health sector.
Indicator 5.6	Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander.
Indicator 5.7	Proportion of accredited hospitals for which the accreditation process required Aboriginal and Torres Strait Islander cross-cultural awareness programs for staff to be in place.

Category six: Risk factors

Indicator 6.1	Proportion of Aboriginal and Torres Strait Islander people aged >13 years who currently smoke by age and sex.
Indicator 6.2	Proportion of Aboriginal and Torres Strait Islander people with a body mass index (BMI) >25, by sex and age.
Indicator 6.3	Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming >4 drinks on the occasions when they drank alcohol in the last two weeks, relative to the total numbers who reported on consumption.

Category seven: Intersectoral issues

Indicator 7.1	Proportion of households where the after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the poverty line.
Indicator 7.2	Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last four weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives.

Category eight: Community involvement

Indicator 8.1	Establishment of a forum representing the Aboriginal health sector, Aboriginal and Torres Strait Islander Commission (ATSIC) and State jurisdiction in each State and Territory.
Indicator 8.2	Cooperative community planning with the implementation of the regional planning processes.

Category nine: Quality of service provision

Indicator 9.1	Critical incidence reporting and complaints mechanisms at all levels of health services.

Introduction

AIM

The aim of this report is to provide a summary of the State, Territory and Commonwealth reports received in late 1998 against the National Aboriginal and Torres Strait Islander Health Performance Indicators, focusing in particular on:

- presentation of comparative results for the indicators where the data quality is sufficient;
- discussion of data quality issues related to the indicators; and
- discussion of the national policy and priority areas.

This report should provide a baseline from which future comparisons can be made.

SCOPE OF THE REPORT

- This report focuses on indicators that were agreed to by Health Ministers, and is not a complete picture of the state of Aboriginal and Torres Strait Islander health. There is a range of documents, particularly the statistical reports published by the ABS and AIHW, that provide a more complete picture on the state of Aboriginal and Torres Strait Islander health.
- The report is limited by the availability of such data in State, Territory and Commonwealth collections.

PREPARATION OF THE REPORT

- The data provided in the State, Territory and Commonwealth reports allow for broad reporting at a national level and for comparisons between jurisdictions. However, there are problems with data quality for some items. These have been noted as appropriate in the report.
- Efforts were made to represent most data provided by jurisdictions, regardless of their quality, to demonstrate that the data are at least available, even though they cannot all be analysed at this stage. Data have not been presented without the agreement of jurisdictions.
- Each jurisdiction provided their 1998 report against the indicators and the results were firstly compiled and then the commentary added. This was a considerable task as each jurisdictional report was presented differently though a proforma had been developed to encourage a common reporting format.
- Some jurisdictions presented more information than was required against particular indicators and this was not included, as it could not be presented in a national context.
- The following issues were considered in examining the data:
    - jurisdictional efforts to improve data quality and availability; and
- problems identified by jurisdictions with the indicator definitions (a separate report will be provided to the Commonwealth on the definitional issues to feed into the project aimed at refining the indicators).

QUALITY AND LIMITATIONS OF THE INDICATORS

When the indicators were developed and agreed to for reporting, it was also acknowledged that a number of the indicator definitions required further refinement. Each indicator in the interim set was assigned a value of 1-5, in terms of current usefulness, clarity of definition, validity and reliability:

1. Indicators that are well defined, commonly used and are straightforward to report against.
2. Indicators that are reasonably well defined but which need further work regarding either their usefulness, interpretation, reliability or validity.

3. Indicators that may be reportable but require substantial additional work regarding usefulness, interpretation, reliability and/or validity.
4. Indicators that are not likely to be reportable in their current form and which may require major developmental work.
5. Indicators that are unlikely to be useable or reportable in the foreseeable future. This is not to suggest that what the indicator is trying to monitor is unimportant but that another indicator may be better.

To assist in the interpretation of information provided against the indicators in this report, the assigned usefulness is shown along with the definition of each indicator. For simplicity of presentation, usefulness is indicated with the abbreviation CU and its assigned numerical value.

As noted above, the process of reporting against the indicators has uncovered a number of limitations. First, some of the indicators are not applicable to all jurisdictions. For example, Indicator 5.4 requires reporting of the 'number of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in hospitals where greater than 25% of separations are Aboriginal and Torres Strait Islander people on a given date'. As Victoria has pointed out, there are no hospitals in that State for which Aboriginal and Torres Strait Islander people comprise more than 25% of separations. Similarly, the 'proportion of communities, with usual populations of less than 100, within one hour usual travel time to primary health care services' (Indicator 3.8) is probably only applicable to Aboriginal and Torres Strait Islander people living in relatively remote parts of the country.

A second type of limitation relates to the appropriate assessment of indicators measuring mortality or morbidity, particularly when the number of cases involved is quite small. Estimation of the Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander ratios for these indicators requires the use of indirect standardisation, rather than the more commonly used direct standardisation procedure. A related aspect is the confidence that can be placed on estimates derived from small numbers. Both of these aspects will be examined in the project aimed at refining the indicators.

EXPLANATORY NOTES

- The indicator definitions did not specify the year for the data sources and consequently, there are differing data sources across jurisdictions for a number of the indicators. It is very difficult to compare data across different years and this needs to be taken into consideration when examining the results.
- Where jurisdictions provided results for more than one year or period, the most recent data have been included. It was not possible in this first report to present national trends over time.
- All age-adjusted rates in the report had been directly standardised by the States and Territories to the Australian total population from the 1991 Census.
- The reliability of the population estimates for Aboriginal and Torres Strait Islander people poses an additional problem for a number of indicators, such as those for mortality and morbidity. The increase in the number of Aboriginal and Torres Strait Islander people between 1991 and 1996, as enumerated by the Censuses, was much greater than could be explained by natural increase. The ABS has accounted for some of this increase, but there is still some uncertainty about the population estimates, particularly within some jurisdictions.
- For presentational purposes, most data have been reported without decimal places. However, for numbers less than ten, most have been reported to one decimal place to enable better comparisons to be made.
- Table numbering corresponds to the indicator numbers. It was not possible and/or appropriate to present tables for each indicator, so there are gaps in the numerical sequence of tables.

Category one: Life expectancy and mortality

National statistics on Aboriginal and Torres Strait Islander life expectancy and mortality cannot be reported. This is because of the limited extent to which Aboriginal and Torres Strait Islander people are identified correctly in the death registration systems in most jurisdictions.

Based on a recent assessment, the ABS recommends that only mortality data from the Northern Territory, and to a lesser extent, Western Australia and South Australia can be used with confidence (ABS 1998: 85). Also, as noted above, reliable estimates of the numbers of Aboriginal and Torres Strait Islander people in individual jurisdictions are crucial in preparing mortality indicators.

The need for the correct identification of Aboriginal and Torres Strait Islander people in death registration systems (and in other health-related data collections) cannot be overemphasised. For example, if only 70% of the Aboriginal and Torres Strait Islander people dying from heart disease are correctly identified, then the estimated death rate from heart disease is only 70% of the real rate. The difference in rates between Aboriginal and Torres Strait Islander people and other Australians is underestimated by a similar amount. Further, variations between years, and between jurisdictions, in the level of correct identification of Aboriginal and Torres Strait Islander people present great challenges in interpretation of changes over time, and of differences between jurisdictions.

Therefore, the following data should be interpreted cautiously. All States and Territories are working hard currently towards improving the quality of their data, which should be available for analysis in the next couple of years. In the meantime, it is important not to draw unwarranted conclusions from possibly unreliable data sources.

Indicator 1.1 Life expectancy at birth by sex (current usefulness (CU)[1]: 1)

There is some evidence that the life expectancy at birth of Aboriginal and Torres Strait Islander people in Western Australia and the Northern Territory has improved over recent years. In Western Australia, Aboriginal and Torres Strait Islander males at birth could expect to live 62 years in 1996, compared with 57.3 in earlier years (refer to Table.1.1; see also Box 1 for notes, and information about symbols used in the tables). Life expectancy at birth of Aboriginal and Torres Strait Islander females in the Northern Territory increased by just over two years between earlier years and 1995-97 (refer to Chart 1).

In the absence of reliable death data for all jurisdictions, national estimates of expectation of life at birth for Aboriginal and Torres Strait Islander people have been made by indirect methods using census data. The 1991-96 estimates for Aboriginal and Torres Strait Islander people were 56.9 years for males and 61.7 years for females, in each case almost 20 years less than levels for the total Australian population – 75.2 years for males and 81.1 years for females (AIHW, 1998). For Aboriginal and Torres Strait Islander people, expectation of life at birth was slightly better in 'eastern Australia' (New South Wales, Victoria, Queensland, Tasmania and the Australian Capital Territory) – 59.2 years for males and 63.6 years for females - than in 'western Australia' (Western Australia, South Australia and the Northern Territory) – 53.7 years for males and 58.9 years for females. (Being indirect estimates, they are much less reliable than those derived from death registration information.)

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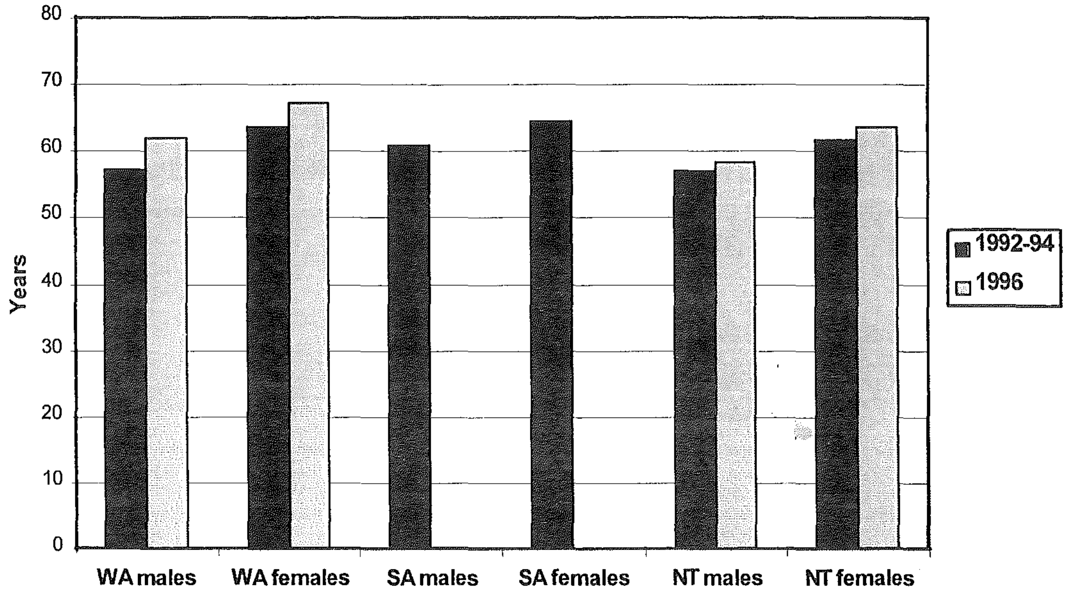
[1] See 'Quality and limitations of indicators' in *Introduction* for details of the current usefulness (CU) of this and other indicators.

Table 1.1: Life expectancy at birth by sex and State/Territory

Sex	Jurisdiction							
	NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	NP✚	59-67	NP✚	62.0	NP	NP✚	☆	58.3
Female	NP✚	63-72	NP✚	67.3	NP	NP✚	☆	63.8

Note: See Box 1 for notes and information about symbols used in this table.
Sources: Vic 1992-96; WA 1996; NT 1995-97.

Chart 1: Indigenous life expectancy at birth, Western Australia, South Australia and the Northern Territory, 1992-1994 and 1996



Notes: 1. NT estimates are for 1995-1997, but, for presentation, have been reported as 1996.
2. SA data were not available for 1996.
Sources: Anderson et al.,1996; WA 1996; NT 1995-97.

Box 1: Notes about (1) symbols used in tables; and (2) mortality indicators

Footnote symbols

NA	Data not available.
NA ●	Jurisdiction is making efforts to collect data in the future.
NP	Data not provided because of poor data quality.
NP✚	Jurisdiction is seeking to improve data quality.
☆	Numbers were too small to be able to be reported.
▲	The ABS regards the mortality and hospitalisation data from these jurisdictions to be under-reported for Aboriginal and Torres Strait Islander people, and unable to be meaningfully interpreted at this time.

Notes

1. Age-standardised and age-specific rates are presented as rates per 100,000 person-years (population).
2. Rates were directly standardised to the 1991 Australian population.
3. Indicators were assigned a value of 1-5, indicating current usefulness (CU) in terms of definition, reliability and validity, starting from 1 as most useful. See the Introduction for a description of each value.
4. Death rates for Queensland relate only to the Aboriginal Deed of Grant in Trust (DOGIT) communities. Queensland also provided data about deaths in the Torres Statistical Local Area (SLA) as a proxy measure for Torres Strait Islander mortality. However, the level of under-reporting is even greater for the Torres SLA than for the DOGIT communities, so they have not been included here.
5. The indicators refer to 'mortality' rates, but they have been reported as death rates in this report. This is the correct term, and is used by the ABS and the AIHW.
6. Caution should be exercised in the interpretation of the rates and rate ratios included in tables and charts, as some are based on small numbers.

Indicator 1.2a Age-standardised all-causes mortality rates by sex (CU 1)
Indicator 1.2b Age-specific all-causes mortality rates by sex (CU 1)
Indicator 1.3a Age-standardised all-causes mortality rate ratio by sex (CU 1)
Indicator 1.3b All-causes age-specific rate ratio by sex (CU 1)
Indicator 1.4 The chance of dying between 20 and 54 years by sex (CU 1)

In all States and Territories where data were reported, Aboriginal and Torres Strait Islander people had much higher death rates than other Australians – overall and across all age groups (refer to Tables 1.2a-1.4 and Box 1). This is consistent with their lower life expectancy, reported above. After adjusting for differences in the age structures of the two populations, death rates for Aboriginal and Torres Strait Islander people were between two and three times those of non-Aboriginal and Torres Strait Islander people in Western Australia and the Northern Territory. The ratios in South Australia were similar.

Western Australia has advised that comparisons within that State between 1985-89 and 1990-95 show that while mortality rates for Aboriginal and Torres Strait Islander people are improving, they are not improving at the same rate as for non-Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander death rate ratios are highest among working-age people, and are between five and eight for those aged 25-44 years (refer to Tables 1.2b and 1.3b and Box 1).

Table 1.2a: All-cause age-standardised death rates by sex and State/Territory

Sex	Jurisdiction							
	NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	NP✚	NP✚	1,840	1,675	1,980	NP✚	☆	2,140
Female	NP✚	NP✚	1,687	1,141	936	NP✚	☆	1,630

Note: 1. See Box 1 for notes and information about symbols used in this table.
2. Caution should be exercised in the interpretation of the rates and rate ratios included in tables and charts, as some are based on small numbers.
Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995-96.

Table 1.2b: All-cause age-specific death rates by sex and State/Territory

Sex/age group (years)		Jurisdiction							
		NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	0-4	NP✚	NP✚	513	550	355	NP✚	☆	480
	5-24	NP✚	NP✚	399	97	133	NP✚	☆	190
	25-44	NP✚	NP✚	837	704	970	NP✚	☆	800
	45-64	NP✚	NP✚	3,489	1,885	2,287	NP✚	☆	3,310
	65+	NP✚	NP✚	6,579	8,011	10,300	NP✚	☆	8,570
Female	0-4	NP✚	NP✚	463	305	143	NP✚	☆	460
	5-24	NP✚	NP✚	186	33	22	NP✚	☆	40
	25-44	NP✚	NP✚	508	253	292	NP✚	☆	440
	45-64	NP✚	NP✚	2,511	1,653	1,123	NP✚	☆	2,000
	65+	NP✚	NP✚	6,916	5,478	4,823	NP✚	☆	8,360

Note: See Box 1 for notes and information about symbols used in this table.
Sources: Qld 1992-96; WA 1996; SA 1997; NT 1995-96.

Table 1.3a: All-cause age-standardised death rate ratios by sex and State/Territory

Sex	Jurisdiction							
	NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	NP✚	NP✚	3.6	2.2	2.9	NP✚	☆	2.7
Female	NP✚	NP✚	4.2	2.3	1.6	NP✚	☆	3.1

Note: 1. See Box 1 for notes and information about symbols used in this table.
2. Caution should be exercised in the interpretation of the rates and rate ratios included in tables and charts, as some are based on small numbers.
Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995-96.

Table 1.3b: All-cause age-specific death rate ratios by sex and State/Territory

Sex/age group (years)		Jurisdiction							
		NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	0-4	NP✚	NP✚	2.7	3.8	2.7	NP✚	☆	3.1
	5-24	NP✚	NP✚	5.9	1.6	2.9	NP✚	☆	3.0
	25-44	NP✚	NP✚	5.4	5.6	7.8	NP✚	☆	5.2
	45-64	NP✚	NP✚	5.3	3.6	4.1	NP✚	☆	5.4
	65+	NP✚	NP✚	1.3	1.6	2.0	NP✚	☆	1.7
Female	0-4	NP✚	NP✚	3.1	3.9	1.6	NP✚	☆	3.7
	5-24	NP✚	NP✚	6.2	1.6	1.0	NP✚	☆	1.5
	25-44	NP✚	NP✚	7.0	3.8	4.3	NP✚	☆	6.5
	45-64	NP✚	NP✚	6.7	5.8	3.8	NP✚	☆	5.6
	65+	NP✚	NP✚	1.8	1.4	1.2	NP✚	☆	2.1

Note: See Box 1 for notes and information about symbols used in this table.
Sources: Qld 1992-95; WA 1996; SA 1997; NT 1996.

Table 1.4: Chance of dying between 20 and 54 years of age by sex and State/Territory

Sex	Jurisdiction							
	NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	NP✚	NP✚	NP✚	NP	NP	NP✚	☆	27%
Female	NP✚	NP✚	NP✚	NP	NP	NP✚	☆	16%

Note: See Box 1 for notes and information about symbols used in this table.
Sources: WA 1996; NT 1995-97.

Indicator 1.5 Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1,000 total births to Aboriginal and Torres Strait Islander mothers (CU 2)

Stillbirth rates for births to Aboriginal and Torres Strait Islander women ranged from 8.9 stillbirths per 1,000 total births in Western Australia to 25.1 per 1,000 in South Australia. In view of the small numbers involved, these rates fluctuate somewhat from year to year (refer to Table 1.5).

Table 1.5: Stillbirth rate (per 1,000 total births) to Aboriginal and Torres Strait Islander mothers by State/Territory

Jurisdiction								
NSW▲	Vic▲	Qld▲ Aboriginal	Qld▲ Torres Strait Islander	WA	SA	Tas▲	ACT▲	NT
12.9	10.4	15.0	15.0	8.9	25.1	NP✚	☆	13.0

Note: See Box 1 for notes and information about symbols used in this table.
Sources: NSW 1997: Vic 1992-96; Qld 1992-95; WA 1995; SA 1997; NT 1996.

The Northern Territory noted that the 1996 stillbirth rate of 13 per 1,000 total births to Aboriginal and Torres Strait Islander women had declined from the 1995 rate of 16.8 per 1,000 and was part of a steady decrease over recent years in the Territory.

It is important to compare these rates with those for births to non-Aboriginal and Torres Strait Islander mothers, even though this information was not requested as part of the indicator definition. In New South Wales in 1996, the stillbirth rate for Aboriginal and Torres Strait Islander mothers (11.6 per 1,000 total births) was nearly twice the rate for non-Aboriginal and Torres Strait Islander mothers (6.2 per 1,000 total births). In the Northern Territory for the same year, the rate for Aboriginal and Torres Strait Islander mothers was 13 per 1,000 total births, 2.7 times the rate for non-Aboriginal and Torres Strait Islander mothers (4.9 per 1,000 total births). In the period 1993-1996, the Aboriginal and Torres Strait Islander stillbirth rate in Queensland (15 per 1,000 total births) was also more than twice the rate for non-Aboriginal and Torres Strait Islander mothers (6 per 1,000 total births).

Indicator 1.6 Death rate of Aboriginal and Torres Strait Islanders from birth to one year of age (CU 1)

The Aboriginal and Torres Strait Islander infant mortality rate was 21.4 infant deaths per 1,000 live births for Western Australia in 1995 and 22.3 per 1,000 for the Northern Territory in 1996 (refer to Table 1.6). The latter was much higher than the rate for other infants in the Territory - 9.9 per 1,000. The rate for Aboriginal and Torres Strait Islander infants in the Territory had increased from 18.5 per 1,000 in 1995, while the rate for other infants decreased from 10.4 per 1,000.

Table 1.6: Death rate of Aboriginal and Torres Strait Islanders from birth to one year of age by State/Territory

Jurisdiction							
NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
NP✚	NP✚	NP✚	21.4	17.9	NP✚	☆	22.3

Note: See Box 1 for notes and information about symbols used in this table.
Sources: WA 1995; SA 1997; NT 1996.

Indicator 1.7a-d Age-standardised mortality rates for ischaemic heart disease and rheumatic heart disease (7a: CU 2), injury and poisoning (7b: CU 1), pneumonia (7c: CU 2) and diabetes (7d: CU 3), by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders (CU 1)

Indicator 1.7e Age-standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non-Aboriginal and Torres Strait Islander women (CU 2)

Ischaemic heart disease was the main cause of death among Aboriginal and Torres Strait Islander males and females in Western Australia, South Australia and the Northern Territory in recent years (see Tables 1.7a, 1.7b and Box 1). Injury and poisoning was also a major cause of death for Aboriginal and Torres Strait Islander males. Even though it was a much more frequent cause of death among Aboriginal and Torres Strait Islander than non-Aboriginal and Torres Strait Islander females, injury and poisoning was a much less important cause of death than diabetes for Aboriginal and Torres Strait Islander females (see Tables 1.7b, 1.7d and Box 1).

Some quite uncommon causes of death for non-Aboriginal and Torres Strait Islander people have a substantial impact among Aboriginal and Torres Strait Islander people. These include diabetes (refer to Table 1.7d), pneumonia (refer to Table 1.7c) and rheumatic heart disease (refer to Table 1.7a), and cervical cancer for Aboriginal and Torres Strait Islander females (refer to Table 1.7e).

Table 1.7a: Age-standardised death rates for ischaemic heart disease and rheumatic heart disease[a] by sex, Aboriginal and Torres Strait Islander status and State/Territory

Cause of death/sex/Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Ischaemic heart disease									
Male	Aboriginal and Torres Strait Islander	NP✚	NP✚	432	284	245	NP✚	☆	174
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	217	178	161	NP✚	☆	199
Female	Aboriginal and Torres Strait Islander	NP✚	NP✚	297	173	209	NP✚	☆	142
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	123	105	127	NP✚	☆	117
Rheumatic heart disease (a)									
Male	Aboriginal and Torres Strait Islander	NP✚	NP✚	0	0	0	NP✚	☆	19
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	1.4	0.9	1.7	NP✚	☆	2.0
Female	Aboriginal and Torres Strait Islander	NP✚	NP✚	51	30	16.8	NP✚	☆	32
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	1.7	1.6	1.7	NP✚	☆	2.0

(a) The numbers of deaths from rheumatic heart disease are small, so in some years no deaths may occur.

Notes: 1. See Box 1 for notes and information about symbols used in this table.

2. Caution should be exercised in the interpretation of the rates and rate ratios included in tables and charts, as some are based on small numbers.

Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995

Table 1.7b: Age-standardised death rates for injury and poisoning by sex, Aboriginal and Torres Strait Islander status and State/Territory

Sex/Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	Aboriginal and Torres Strait Islander	NP✚	NP✚	279	207	217	NP✚	☆	172
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	69	57	51	NP✚	☆	58
Female	Aboriginal and Torres Strait Islander	NP✚	NP✚	78	47	56	NP✚	☆	88
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	25	23	21	NP✚	☆	23

Note: See Box 1 for notes and information about symbols used in this table.

Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995.

Table 1.7c: Age-standardised death rates for pneumonia by sex, Aboriginal and Torres Strait Islander status and State/Territory

Sex/Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	Aboriginal and Torres Strait Islander	NP✚	NP✚	99	154	165	NP✚	☆	85
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	12	12	25	NP✚	☆	10
Female	Aboriginal and Torres Strait Islander	NP✚	NP✚	46	38	13	NP✚	☆	112
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	8.0	8.8	33	NP✚	☆	8.0

Note: 1. See Box 1 for notes and information about symbols used in this table.

2. Caution should be exercised in the interpretation of the rates and rate ratios included in tables and charts, as some are based on small numbers.

Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995

Table 1.7d: Age-standardised death rates from diabetes by sex, Aboriginal and Torres Strait Islander status and State/Territory

Sex/Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Male	Aboriginal and Torres Strait Islander	NP✚	NP✚	71	104	92	NP✚	☆	119
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	14	18	25	NP✚	☆	16
Female	Aboriginal and Torres Strait Islander	NP✚	NP✚	178	198	121	NP✚	☆	137
	Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	11	11	13	NP✚	☆	12

Note: See Box 1 for notes and information about symbols used in this table.

Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995.

Table 1.7e: Age-standardised death rates from cancer of the cervix, by Aboriginal and Torres Strait Islander status and State/Territory

Aboriginal and Torres Strait Islander status	Jurisdiction							
	NSW▲	Vic▲	Qld▲	WA	SA	Tas▲	ACT▲	NT
Aboriginal and Torres Strait Islander	NP✚	NP✚	20	9.6	0	NP✚	☆	21
Non-Aboriginal and Torres Strait Islander	NP✚	NP✚	3.4	2.8	1.8	NP✚	☆	3.0

Notes: 1. See Box 1 for notes and information about symbols used in this table.

2. Caution should be exercised in the interpretation of the rates and rate ratios included in tables and charts, as some are based on small numbers.

Sources: Qld 1992-95; WA 1996; SA 1997; NT 1995.

The indicators describing causes of death are not meant to provide a comprehensive picture of Aboriginal and Torres Strait Islander mortality but rather a snapshot of the main conditions responsible for a large proportion of Aboriginal and Torres Strait Islander deaths. The ABS noted that during 1992-94, diseases of the circulatory system (represented here by ischaemic heart disease (IHD) and rheumatic heart disease), respiratory diseases (represented here by pneumonia), neoplasms (represented here by cervical cancer), and diabetes were responsible for three out of every four deaths (ABS & AIHW 1997:86). Injury and poisoning has also been included as another significant cause of high rates of death.

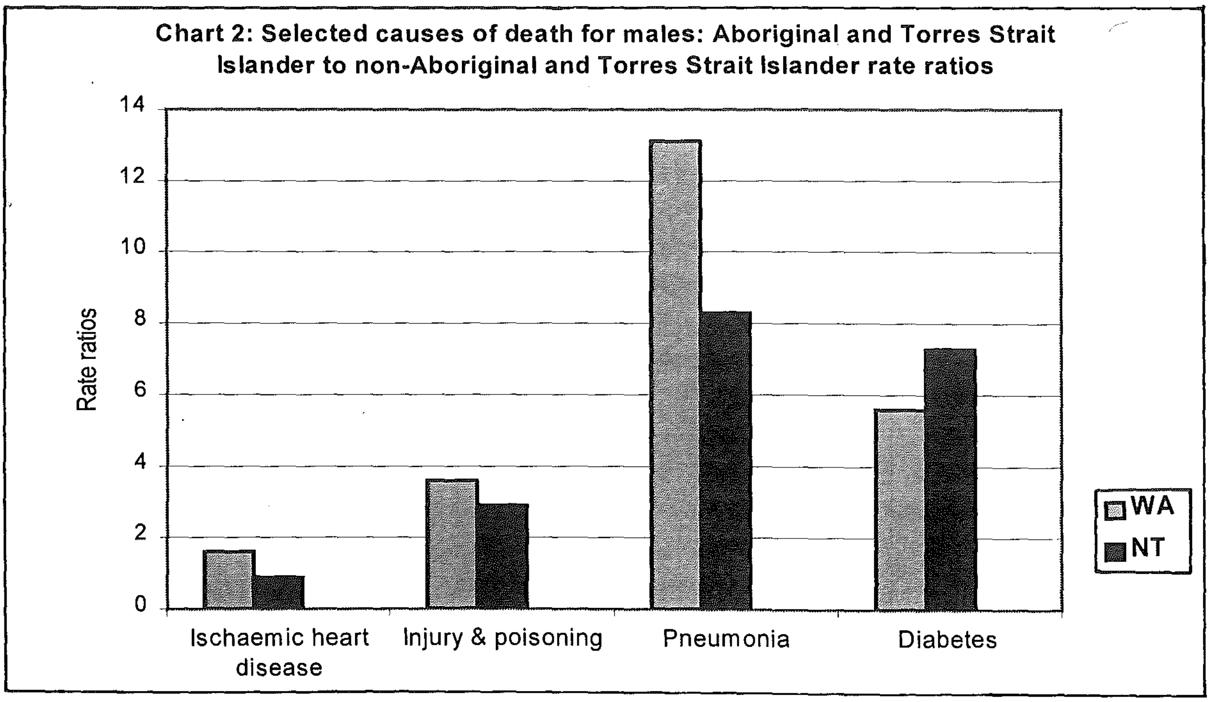
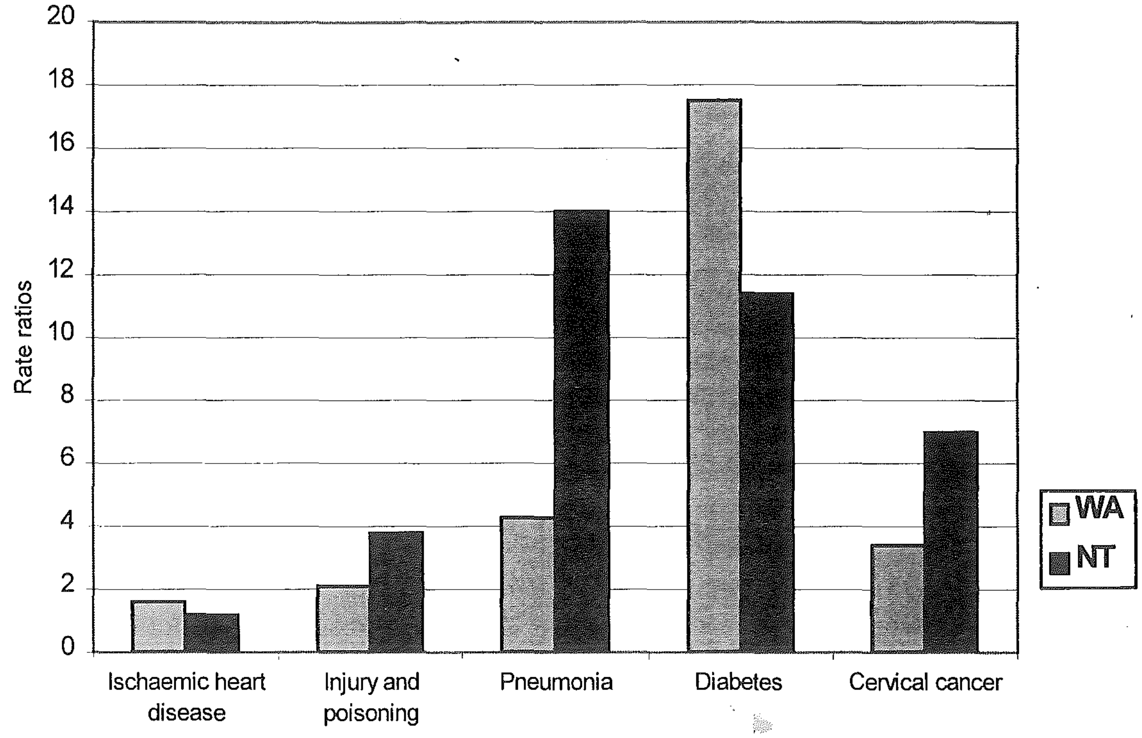


Chart 2: Selected causes of death for males: Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander rate ratios

Sources: WA 1996; NT 1995.

Chart 3: Selected causes of death for females: Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander rate ratios



Sources: WA 1996; NT 1995.

EFFORTS TO IMPROVE MORTALITY DATA

Tasmania and the Australian Capital Territory noted under-reporting of Aboriginal and Torres Strait Islander people in their mortality data collections. However, these jurisdictions have relatively small Aboriginal and Torres Strait Islander populations which will result in only small numbers of deaths expected. There may be confidentiality concerns if the numbers are small enough to possibly identify people, and it is also difficult to draw any conclusions from such small numbers.

Victoria, New South Wales and Queensland reported significant under-reporting as the most serious deficiency with their data collections. While Victoria and New South Wales cited this as the main reason for their inability to provide their data for reporting, Queensland did provide some results, but only those for Aboriginal people living in the Deed of Grant in Trust (DOGIT) communities were included in this report. New South Wales hopes to report reliable mortality data by 2000. They are working with the ABS to improve the identification of Aboriginal and Torres Strait Islander people by the Registry of Births, Deaths and Marriages. The Registry is also exploring the possibility of including an Aboriginal and Torres Strait Islander status question on medical death certificates to provide an additional source for this information (the provision exists already for this question on the Form of Notification of Death). Victoria is putting in place a process to improve data but no timeframe was provided. Queensland has developed a method to obtain death rates for discrete Aboriginal and Torres Strait Islander communities and is working to improve the identification of Aboriginal and Torres Strait Islander status on death records. However, Queensland only started identifying Aboriginal and Torres Strait Islander status on death records in 1996, so it is likely to be a few years before reliable data are collected.

The NHIMG is working with the ABS, Commonwealth, States and Territories and other relevant stakeholders to improve the identification of Aboriginal and Torres Strait Islander people in routine health data collections. The implementation of the Aboriginal and Torres Strait Islander Health Information Plan (Aboriginal and Torres Strait Islander Health and Welfare Information Unit 1998) is being undertaken by a NHIMG working group.

CONCLUSIONS

- Efforts to improve the identification of Aboriginal and Torres Strait Islander status in mortality collections must continue. This will ensure that a truly national picture of Aboriginal and Torres Strait Islander mortality can occur in the next few years.
- While the State and Territory reports do not provide new information on the main causes of premature death among Aboriginal and Torres Strait Islander Australians, they reinforce the need to focus efforts on the five main diseases responsible for such a large proportion of Aboriginal and Torres Strait Islander mortality: cardiovascular disease (including heart disease), respiratory diseases, neoplasms, injury and poisoning, and diabetes.

Category two: Morbidity

The data describing the main causes of ill health among Aboriginal and Torres Strait Islander people were not well reported other than hospitalisation rates. However, 'while hospitalisation statistics can provide an indicator of health, they are not a measure of prevalence of disease' (ABS & AIHW1997:66). Care must also be taken in interpreting hospitalisation rates as 'low rates may represent lower levels of need or they may mean existing needs are not being met. Conversely a rising rate of hospitalisation could mean either a worsening of health status or an improvement in access' (ABS & AIHW1997:66). Please refer to the ABS and AIHW report on Aboriginal and Torres Strait Islander health for a more complete discussion of this issue (ABS & AIHW1997:66).

The uncertainty of the population estimates for Aboriginal and Torres Strait Islander people, as noted under 'Explanatory notes' in the introduction, also affects the hospital separation statistics. Without reliable population figures, hospital separation rates and rate ratios cannot be calculated accurately. This problem adds to the already significant issue of under-reporting of Aboriginal and Torres Strait Islander status in hospital separation data collections.

Notifiable communicable diseases and vaccine-preventable diseases are the other areas reported in this category. Unfortunately, only Western Australia and the Northern Territory were able to report against all of these indicators. South Australia reported notification rates for hepatitis B.

Indicator 2.1a Notification rates for selected vaccine preventable diseases: pertussis, measles, hepatitis B (CU 3)

As noted above, notification rates for pertussis, measles, hepatitis B and meningococcal infection were reported by Western Australia and the Northern Territory, but it is not possible to clearly compare results as the two jurisdictions reported differently according to age and gender. However, some broad conclusions can be drawn.

New South Wales provided counts, not rates over time, but the high level of under-reporting of Aboriginal and Torres Strait Islander status means that it is not possible to reliably analyse the results at this time. Victoria, Queensland and South Australia all reported that they were investigating ways to improve the identification of Aboriginal and Torres Strait Islander status in the notification of infectious diseases.

Pertussis (whooping cough) was reported more frequently among the non-Aboriginal and Torres Strait Islander population than the Aboriginal and Torres Strait Islander population in the Northern Territory, but the reverse was true for Western Australia (refer to Tables 2.1a1 and 2.1a2). This may reflect data quality rather than real differences.

Measles was reported twice as frequently among Aboriginal and Torres Strait Islander people than non-Aboriginal and Torres Strait Islander people in Western Australia. The number of cases reported in the Northern Territory was very small making it difficult to draw any conclusions. It is believed that not all cases of measles are notified and, further, Aboriginal and Torres Strait Islander status is not recorded on many pathology forms, so under-reporting is likely to be a significant problem.

The notification rates for hepatitis B were significantly higher for Aboriginal and Torres Strait Islander people compared with other Australians in both Western Australia and the Northern Territory. Compared with Western Australia, notification rates were low for South Australia – for Aboriginal and Torres Strait Islander people and for non-Aboriginal and Torres Strait Islander people. In Western Australia, the notification rate for Aboriginal and Torres Strait Islander people was around 12-19 times that of non-Aboriginal and Torres Strait Islander people.

In the Northern Territory, there were only four notifications for non-Aboriginal and Torres Strait Islander people compared with 15 for Aboriginal and Torres Strait Islander people.

Table 2.1a1 Crude notification rates (per 100,000) for selected vaccine-preventable diseases, by sex, Aboriginal and Torres Strait Islander status and State/Territory

Disease/sex/Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW	Vic	Qld	WA	SA	Tas	ACT	NT(a)
Pertussis									
Male	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	45	NA ●	NP✚	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	23	NA ●	NP✚	☆	NA
Female	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	41	NA ●	NP✚	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	29	NA ●	NP✚	☆	NA
Measles									
Male	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	7.4	NA ●	NP✚	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	3.5	NA ●	NP✚	☆	NA
Female	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	7.4	NA ●	NP✚	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	4.1	NA ●	NP✚	☆	NA
Hepatitis B									
Male	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	432	0	NP✚	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	35	1.4	NP✚	☆	NA
Female	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	427	0	NP✚	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	23	0.6	NP✚	☆	NA

(a) See Table 2.1a2 for notification rates for the Northern Territory, which were provided in a different format to this table.

Notes: 1. See Box 1 for notes and information about symbols used in this table.

2. Great caution should be exercised in the comparison of notification rates, as substantial variations in levels of notification may exist between jurisdictions.

Source: WA 1995-96; SA 1997-98.

Table 2.1a2: Notification rates (per 100,000) for selected vaccine-preventable disease, by age group and Aboriginal and Torres Strait Islander status, Northern Territory, 1997

Disease/ Aboriginal and Torres Strait Islander status	Age group (years)			
	0-4	5-9	10-14	15+
Pertussis				
Aboriginal and Torres Strait Islander	15	16	17	0
Non-Aboriginal and Torres Strait Islander	54	38	44	5.6
Measles				
Aboriginal and Torres Strait Islander	15	0	0	3.3
Non-Aboriginal and Torres Strait Islander	45	9.6	0	2.8
Hepatitis B				
Aboriginal and Torres Strait Islander	30	31	0	36
Non-Aboriginal and Torres Strait Islander	0	0	0	3.8

Note: Great caution should be exercised in the comparison of notification rates, as substantial variations in levels of notification may exist between jurisdictions.

Indicator 2.1b Notification rate for meningococcal infection (CU 3)

The notification rates for meningococcal infection were 6-8 times higher for Aboriginal and Torres Strait Islander people than non-Aboriginal and Torres Strait Islander people in Western Australia and the Northern Territory (Table 2.1b, including footnote).

Table 2.1b: Crude notification rate (per 100,000) for meningococcal, by sex, Aboriginal and Torres Strait Islander status and State/Territory

Sex/ Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW	Vic	Qld	WA	SA	Tas	ACT	NT[a]
Male	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	19	NP	NP	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	3.0	NP	NP	☆	NA
Female	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	22	NP	NP	☆	NA
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	3.0	NP	NP	☆	NA

(a) The Northern Territory reported for 1997 an overall Aboriginal and Torres Strait Islander: non-Aboriginal and Torres Strait Islander rate ratio of 8.0 for notifications of meningococcal disease.

Note: 1. See Box 1 for notes and information about symbols used in this table.

Source: WA 1995-96.

Indicator 2.2 Crude notification rates for gonorrhoea and syphilis by sex (CU 3)

Great caution must be exercised in the interpretation of notification rates for sexually transmitted diseases, as, at least for gonorrhoea, there are likely to be systematic differences in reporting. Bearing this in mind, notification rates for gonorrhoea and syphilis were all very much higher for Aboriginal and Torres Strait Islander males and females than non-Aboriginal and Torres Strait Islander males and females in Western Australia, South Australia and the Northern Territory (Table 2.2).

One noteworthy feature of the notification rates for Aboriginal and Torres Strait Islander people was the difference between Western and South Australian and the Northern Territory in the relative importance of gonorrhoea and syphilis. Gonorrhoea was much more commonly notified among Aboriginal and Torres Strait Islander people in Western Australia and South Australia than the Northern Territory, but the reverse was true for syphilis. For both gonorrhoea and syphilis, notification rates were lower in South Australia than in the other jurisdictions.

The other jurisdictions did provide data on gonorrhoea and syphilis, but they described efforts to improve the collection of information. For example, the proposed screening program for North Queensland (jointly funded by the Commonwealth and Queensland governments) should provide excellent data regarding sexually transmitted diseases among Aboriginal and Torres Strait Islander people living in remote and rural areas of the State. New South Wales and Victoria are attempting to improve the identification of Aboriginal and Torres Strait Islander status on notification records.

Table 2.2: Crude notification rates (per 100,000) for selected sexually transmitted diseases, by sex, Aboriginal and Torres Strait Islander status and State/Territory

Disease/ sex/ Aboriginal and Torres Strait Islander status		Jurisdiction							
		NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Gonorrhoea									
Male	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	3665	916	NP	☆	1192
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	21	9.3	NP	☆	81
Female	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	2340	684	NP	☆	1876
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	6.9	1.5	NP	☆	57
Syphilis									
Male	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	223	120	NP	☆	494
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	4.5	0.3	NP	☆	14
Female	Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	269	71	NP	☆	496
	Non-Aboriginal and Torres Strait Islander	NP✚	NA ●	NA ●	1.4	0	NP	☆	9.4

Notes: 1. See Box 1 for notes and explanation of symbols used in this table.
Source: WA 1995-96; SA 1997-98; NT 1997.

Indicator 2.3 Percentage of Aboriginal and Torres Strait Islander children at school entry having greater than 25dB hearing loss averaged over three frequencies (CU 4)

Jurisdictions were not able to report on this indicator at this time. The indicator is still under development, as reporting is dependent upon the establishment of a program to screen all Aboriginal and Torres Strait Islander children on school entry. However, no State or Territory plans to screen children in this way in the near future.

This indicator will be further developed under the project currently being undertaken to refine definitions.

Indicator 2.4 Proportion of Aboriginal and Torres Strait Islander newborns with birth weight less than 2,500 grams (CU 1)

For babies born to Aboriginal and Torres Strait Islander mothers, South Australia had the highest proportion of low birth weight – 16% (Table 2.4). New South Wales had the lowest proportion – 10.5%. (It should be noted that the indicator is for Aboriginal and Torres Strait Islander newborns. The data available relate to the Aboriginal and Torres Strait Islander status of the mother, regardless of the father's status. As a result, the data reported here do not include information about babies born to non-Aboriginal and Torres Strait Islander mothers and Aboriginal and Torres Strait Islander fathers.)

Data on births to non-Aboriginal and Torres Strait Islander women were not requested under this indicator, but some jurisdictions did provide comparative information. In New South Wales, Queensland, South Australia and the Northern Territory, babies born to Aboriginal and Torres Strait Islander women were approximately twice as likely to be of low birth weight compared with those born to non-Aboriginal and Torres Strait Islander women.

This indicator is a significant predictor of poor child survival, and low birth weight is now believed also to be correlated with some chronic diseases (particularly renal disease) in later life. Further work is needed to strengthen capacity to report against this key indicator.

Table 2.4 Proportions (%) of low birth weight for live babies born to Aboriginal and Torres Strait Islander mothers by State/Territory

Jurisdiction								
NSW	Vic	Qld Aboriginal	Qld Torres Strait Islander	WA	SA	Tas	ACT	NT
10.5	11.1	12.3	8.2	11.7	16.0	NP✚	13.6	14.9

Notes: 1. Low birth weight is defined as a birth weight of less than 2,500 grams.
2. See Box 1 for notes and information about symbols used in this table.

Source: NSW 1997; Vic 1996; Qld 1993-96; WA 1995; SA 1996-97; ACT 1996; NT 1996.

Indicator 2.5 Age-standardised all-causes hospital separation rate ratio by sex (CU 2)

The problem of under-reporting of Aboriginal and Torres Strait Islander status is an issue for hospital separation statistics in all jurisdictions. However, the very high level of under-reporting in some jurisdictions means that their data are unreliable. The ABS recommends that only hospital separation data from Western Australia, South Australia and the Northern Territory can be used reliably.

Aboriginal and Torres Strait Islander people were around two to three times more likely to be hospitalised than other people in Western Australia, South Australia and the Northern Territory (Table 2.5). Compared with other Queenslanders, Aboriginal people living in the Deed of Grant in Trust (DOGIT) communities were around three times more likely to be hospitalised.

Table 2.5: All-cause age-standardised hospital separation ratios(a) by sex and State/Territory

Sex	Jurisdiction								
	NSW▲	Vic▲	Qld▲ Aboriginal	Qld▲ Torres Strait Islander	WA	SA	Tas▲	ACT▲	NT
Male	2.2	1.7	3.1	1.1	2.5	1.9	NP✚	0.8	2.1
Female	2.0	2.0	3.1	1.3	2.9	2.7	NP✚	0.8	2.2

(a) The ratios of Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander hospital separations.

Notes: 1. Ratios for NSW, Vic, WA, SA and the NT were based on direct standardisation and those for Qld and the ACT on indirect standardisation.
2. Queensland Aboriginal ratios were calculated using just the data from Deed of Grant in Trust (DOGIT) communities. The Torres Strait Islander ratios were calculated using the Torres Statistical Local Area data (20% of the population are not Aboriginal and Torres Strait Islander).
3. See Box 1 for notes and information about symbols used in this table.

Source: NSW 1996-97 (public hospitals only); Vic 1997-98 (public hospitals only); Qld 1995-96 & 1996-97; WA 1996-97; SA 1997-98 (public and private hospitals); ACT 1996-97; NT 1997 (not known if these data are for public and private hospitals or public hospitals only).

Indicator 2.6a-e Age-standardised hospital separation rate ratio for acute myocardial infarction (6a: CU 2), injury and poisoning (6b: CU 2), respiratory diseases (6c: CU 2), diabetes (6d: CU 4) and tympanoplasty (6e: CU 2), by sex

Of the specific diseases considered as hospitalisation indicators, the most striking differences between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people were separations for diabetes (Table 2.6). In Western Australia, South Australia and the Northern Territory, Aboriginal and Torres Strait Islander women were between 10 and 18 times more likely to have been hospitalised for diabetes than other women in those jurisdictions, and Aboriginal and Torres Strait Islander men between three and 13 times more likely than other men. Aboriginal people living in the Queensland Deed of Grant in Trust (DOGIT) communities were between 13 and 18 times more likely to be hospitalised for diabetes than other Queenslanders, and people living in the Torres Statistical Local Area were six to 11 times more likely (these estimates are based on quite small numbers, so should be interpreted with caution).

The very high ratios for Aboriginal and Torres Strait Islander women are reflected in their very high death rates (see Table 1.7d).

It is believed that these ratios under-represent the true situation with diabetes, as they relate only to admissions for which diabetes was the primary diagnosis, and do not include some admissions relating to the complications of diabetes.

Compared with non-Aboriginal and Torres Strait Islander people, Aboriginal and Torres Strait Islanders were admitted to hospital around one-and-a-half to three-and-a-half times more frequently for acute myocardial infarction, between one-and-a-half to six-and-a-half times for injury and poisoning (except for the ACT), and between two and six times for respiratory diseases.

Hospital separation ratios for tympanoplasty were very high for the Northern Territory (10.8 for males and 15.6 for females), and quite high for South Australia (3.7 for males and 3.8 for females).

Table 2.6: Age-standardised hospital separation ratios(a) for selected causes by sex and State/Territory

Disease/sex	Jurisdiction								
	NSW▲	Vic▲	Qld▲ Aboriginal	Qld▲ Torres Strait Islander	WA	SA	Tas▲	ACT▲	NT
Acute myocardial infarction									
Males	1.6	NA	3.2	1.4	2.2	2.0	NP✚	☆	1.8
Females	2.2	NA	3.9	2.3	2.6	3.6	NP✚	☆	1.3
Injury and poisoning									
Males	1.4	1.8	4.3	1.3	3.4	2.5	NP✚	1.0	2.3
Females	1.5	2.1	6.7	1.5	4.3	3.1	NP✚	1.2	2.9
Respiratory diseases									
Males	2.4	2.1	5.7	1.4	4.7	2.8	NP✚	☆	3.5
Females	2.8	2.8	6.1	1.3	5.4	2.6	NP✚	☆	5.5
Diabetes									
Males	4.2	NA	13.2	5.6	12.6	7.3	NP✚	6.6	3.2
Females	6.9	NA	18.2	10.5	10.4	10.6	NP✚	2.6	17.5
Tympanoplasty									
Males	0.7	NA	1.1	0.5	NP	3.7	NP✚	0	10.8
Females	2.1	NA	1.5	0	NP	3.8	NP✚	0	15.6

(a) The ratios of Aboriginal and Torres Strait Islander to non-Aboriginal and Torres Strait Islander hospital separations.

Notes: 1. Ratios for NSW, Vic, WA, SA and the NT were based on direct standardisation and those for Qld and the ACT on indirect standardisation.

2. Queensland Aboriginal ratios were calculated using just the data from Deed of Grant in Trust (DOGIT) communities. The Torres Strait Islander ratios were calculated using the Torres Statistical Local Area data (20% of the population are not Aboriginal and Torres Strait Islander).

3. See Box 1 for details notes and information about symbols used in this table.

Source NSW 1996-97 (public and private hospitals); Vic 1997-98 (public hospitals only); Qld 1995-96 & 1996-97; WA 1996-97; SA 1997-98 (public and private hospitals); ACT 1996-97; NT 1997 (not known if these data are for public and private hospitals or public hospitals only).

EFFORTS TO IMPROVE MORBIDITY DATA

- As mentioned in the previous category on mortality, the NHIMG is working cooperatively with the States and Territories to improve the identification of Aboriginal and Torres Strait Islander people in hospital separation collections. All States and Territories stated that they were intending to address the issue of under-reporting. The ABS/AIHW recently completed a report assessing the quality of Aboriginal and Torres Strait Islander identification in Australian hospitals. The Aboriginal and Torres Strait Islander Health Information Plan (Aboriginal and Torres Strait Islander Health and Welfare Information Unit, 1998) recommended that all States and Territories work towards deriving an estimate of the extent of under-reporting by the end of 1999. The results of the ABS/AIHW report should assist jurisdictions to this end.
- Most jurisdictions need to make progress on improving the identification of Aboriginal and Torres Strait Islander people in notifiable disease collections before any national picture of the prevalence of these diseases emerges and the effectiveness of vaccination programs can be fully assessed.
- The quality and coverage of data related to sexually transmitted diseases is poor in most States and Territories and it is vital that these data improve to enable effective monitoring of access to treatment and follow-up services.

CONCLUSIONS

- The very high notification rates for hepatitis B and meningococcal infection in the Northern Territory and Western Australia confirm a high incidence of these vaccine-preventable diseases among Aboriginal and Torres Strait Islander people, and may indicate that efforts to identify the prevalence of these conditions among Aboriginal and Torres Strait Islander people are proving successful. There is not enough information, however, to draw any conclusions about the levels of access to immunisation programs.
- Hearing loss among Aboriginal and Torres Strait Islander children has major implications for later educational and psychological development. It is an issue highlighted in earlier reports including the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody. Strategies to assess and address hearing loss in children should be evaluated and strengthened.
- The proportions of low birth weight among babies born to Aboriginal and Torres Strait Islander women do not appear to have decreased over time. Strategies to address this problem should be evaluated and strengthened.
- Indicator 2.4 should include reporting on comparative data on low birth weight among babies born to non-Aboriginal and Torres Strait Islander women.

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CONCLUSIONS

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- Indicator 2.4 should include reporting on comparative data on low birth weight among babies born to non-Aboriginal and Torres Strait Islander women.

Category three: Access

Indicator 3.3 Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population (CU 4)

Jurisdictions were not able to report spending on health services for Aboriginal and Torres Strait Islander people according to primary, secondary and tertiary categories but provided information by types of services (see Table 3.3). (These figures were extracted from Deeble et al. 1998. This report represents the first comprehensive effort at producing a national picture of what governments spend on Aboriginal and Torres Strait Islander health. Commonwealth, State and Territory governments cooperated with the development of the report and contributed their expenditure data. Prior to the publication of this report, there was speculation that Aboriginal and Torres Strait Islander people consumed a much larger proportion of the health budget than has now been demonstrated.)

Total recurrent health expenditure for Aboriginal and Torres Strait Islander people in 1995-96 was estimated at $853 million, of which government programs contributed $822 million (Deeble et al. 1998). Total spending for and by Aboriginal and Torres Strait Islander people was $2,320 per person, about 8% higher than for and by other Australians. Reflecting the much greater utilisation of public than private health care services by Aboriginal and Torres Strait Islander people, per capita spending by governments was 44% higher for Aboriginal and Torres Strait Islander people than for other Australians. For government-subsidised programs, State, Territory and local governments spent $649 million (79% of total government expenditure) and the Commonwealth $173 million (21%).

State and Territory government spending on health services for Aboriginal and Torres Strait Islander people was much higher than spending for non-Aboriginal and Torres Strait Islander people in all jurisdictions except the ACT. It was highest in the Northern Territory and Western Australia, for which jurisdictions the ratios of Aboriginal and Torres Strait Islander: non-Aboriginal and Torres Strait Islander spending were 3.3 and 2.7 respectively. On average, the ratio of spending in the States and Territories was 2.2:1. In contrast, the ratio of Aboriginal and Torres Strait Islander: non-Aboriginal and Torres Strait Islander spending by the Commonwealth was 0.63:1 – mainly because of much lower per-person Medicare and Pharmaceutical Benefits Scheme expenditures.

The Australian Capital Territory (ACT) reported spending the least amount on health services for Aboriginal and Torres Strait Islander people, but it appears that the $659 per capita may have been an underestimate of expenditure due to the significant under-identification of Aboriginal and Torres Strait Islanders in the ACT hospital system. The ACT expenditure figures are also likely to be proportionally lower than for other jurisdictions, given the nature of the local Aboriginal and Torres Strait Islander population. For instance, the relatively high income levels and better health status of the ACT Aboriginal and Torres Strait Islander population is likely to lead to a smaller proportion of this population accessing public hospital and community health services, compared to Aboriginal and Torres Strait Islander people in other jurisdictions. Similarly, the ACT has much lower patient transport costs than the States or the Northern Territory.

Table 3.3. Per capita annual expenditure ($) by governments on health care services for Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people, by type of health care and State/Territory

Aboriginal and Torres Strait Islander status/type of health care	Jurisdiction							
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Aboriginal and Torres Strait Islander people								
Acute care	1,042	1,095	1,120	1,487	964	868	492	1,607
Mental health	20	NA(b)	29	60	55	59	NA	NA
Nursing homes	16	69	41	58	NA	98	NA	4
Community health services	174	31	243	431	301	96	76	669
All types(a)	1,334	1,326	1,518	2,152	1,500	1,227	659	3,221
Non-Aboriginal and Torres Strait Islander people								
Acute care	637	574	543	599	581	505	724	528
Mental health	25	NA	25	45	55	69	NA	NA
Nursing homes	14	43	25	36	NA	81	NA	2
Community health services	88	44	75	78	115	42	41	148
All types(a)	825	747	716	807	827	788	869	963
Ratio	1.62	1.78	2.12	2.67	1.81	1.56	0.76	3.34

(a) The amount for 'All types' is greater than the sum of the four categories, as it includes other aspects, such as patient transport and administration.

(b) NA: not available

Source: Deeble et al. 1998.

Given the disparity in health status between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people, however, a higher per capita expenditure for Aboriginal and Torres Strait Islander people does not necessarily indicate a disproportionate health expenditure. Further, overall spending levels for Aboriginal and Torres Strait Islander people are similar to other Australians in the same income category, even though their health status is worse (Australian National Audit Office1998: 20).

The greatest apparent difference in spending between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people was in the area of community health. In Queensland, for example, overall spending was 2.12 times greater for Aboriginal and Torres Strait Islander than non-Aboriginal and Torres Strait Islander people, but spending on community health was 3.24 times greater. In the Northern Territory, more than three times as much was spent on overall health services for Aboriginal and Torres Strait Islander people, compared with those for the non-Aboriginal and Torres Strait Islander population. In the area of community health services, it was over four times as much. Caution needs to be exercised, however, in interpreting these figures as the cost of remoteness could 'largely explain the spending differences...(although)... not entirely' (Deeble et al. 1998:16).

More was spent on nursing home services in all jurisdictions for Aboriginal and Torres Strait Islander people than for non-Aboriginal and Torres Strait Islander people, with four jurisdictions spending more than one and a half times as much. Relative spending on Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people was closer for mental health. Expenditure in Western Australia on mental health was one and a half times as much on Aboriginal and Torres Strait Islander people as non-Aboriginal and Torres Strait Islander people. Tasmania spent 85% as much on mental health for Aboriginal and Torres Strait Islander people as it did for non-Aboriginal and Torres Strait Islander people.

The Commonwealth reported spending nationally $883 per capita on primary health care for Aboriginal and Torres Strait Islander people compared with $513 for non-Aboriginal and Torres Strait Islander people (a ratio of 1.73).

Indicator 3.4 Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non-Aboriginal and Torres Strait Islander people (CU 3)

New South Wales, Western Australia and the Northern Territory reported against this indicator, but there appear to be differences in the ways the individual measures were calculated. As a result, the figures have not been included in this report. This is another indicator which needs further development.

Indicator 3.5 Proportion of primary care services, and the resources allocated to these services (CU 5)

Only Western Australia and the Northern Territory were able to report against this indicator. These reports showed that the majority of primary care services that received funding specifically for Aboriginal and Torres Strait Islander peoples were managed by the government. In Western Australia the proportion government controlled was 79% and in the Northern Territory it was 66% (see Table 3.5). To some extent this reflects the fact that resources flow to the high use of hospital-level outpatient care by Aboriginal and Torres Strait Islander people.

Table 3.5: Proportion of primary care services by type of management and jurisdiction

Type of management	Jurisdiction								
	C/wealth	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Incorporated Aboriginal and Torres Strait Islander health organisations	NA	NA	NP	NP	21	NP	NA	NA	17
Aboriginal and Torres Strait Islander community councils	NA	NA	NP	NP	0	NP	NA	NA	17
State/Territory governments	NA	NA	NP	NP	79	NP	NA	NA	64
Other	NA	NA	NP	NP	0	NP	NA	NA	0

At Commonwealth level, 1998 data was not available at the time of reporting on direct Commonwealth expenditure on primary health care by type of management. The Commonwealth did report that in 1998 about 90% of primary health services funded by the Office for Aboriginal and Torres Strait Islander Health were managed by incorporated Aboriginal and Torres Strait Islander health organisations. This also represented around 90% of the Office's funding allocation for Aboriginal and Torres Strait Islander health services.

Victoria was the only other jurisdiction that provided any funding information but it did not provide details of allocations to primary care services according to the indicator definition. New South Wales and Victoria commented that they did not believe there was a uniformly accepted definition of primary health care to allow reporting at present.

Indicator 3.6 Extent of community participation in health services (CU 5)

This indicator requires further redefining to clarify what is meant by community participation, but most jurisdictions reported on what they were doing to involve Aboriginal and Torres Strait Islander people in health service delivery and planning.

In the Northern Territory, for example, community store committees enable people to be involved in the planning of food and nutrition policies and programs. A few hospitals in Victoria, such as The Royal Children's Hospital and the Eye and Ear Hospital, have Koori representatives on Aboriginal and Torres Strait Islander Health Advisory Committees. Local Aboriginal communities in Victoria are also entering into health outcome agreements with regional offices and mainstream service providers as part of the Koori Health Reform Strategy. Queensland and New South Wales have sought to involve local Aboriginal and Torres Strait Islander representatives in a range of regional health planning forums.

Indicator 3.7 Representation of Aboriginal and Torres Strait Islander people on health/hospital boards, and whether membership is mandated by terms of reference (CU 1)

New South Wales and the Northern Territory reported high proportions of Aboriginal and Torres Strait Islander representation on relevant health/hospital boards (Table 3.7). New South Wales reported that all 20 Health Service Boards had at least one Aboriginal and Torres Strait Islander representative. In the Northern Territory, there were Aboriginal and Torres Strait Islander representatives on five out of the six health and hospital boards. Victoria identified Aboriginal and Torres Strait Islander representation on three health boards. Queensland and South Australia were unable to identify the numbers of Aboriginal and Torres Strait Islander representatives on relevant boards.

Table 3.7: Extent and nature of Aboriginal and Torres Strait Islander representation on health/hospital boards by State/Territory, 1998

	Jurisdiction							
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Number of boards with Aboriginal and Torres Strait Islander representation[1]	20 (20)	3 (213)	NP	5 (48)	NA	0 (1)	0 (1)	4 (6)
Membership mandated by terms of reference	NP	NP	NP	NP	NA	NP	No	NP

Notes: 1. The numbers of relevant boards on which Aboriginal and Torres Strait people could be represented in each jurisdiction are shown in parentheses.

2. See Box 1 for notes and information about symbols used in this table.

Indicator 3.8 Proportion of communities with usual populations of less than 100 people within one hour usual travel time to primary health care services (CU 3)

This indicator could not be reported on because jurisdictions do not have any processes to collect such data. It was felt that a national process, such as the NATSIS, would be the best way to collect such information, although States and Territories may choose to carry out a separate collection for this indicator as Western Australia is endeavouring to do at present. Western Australia is examining the use of the Global Positioning System to generate information to be used in reporting against this and other indicators which relate to travel time to a health facility. It must be noted that NATSIS asked questions related to health services access in terms of *distance* travelled rather than the *time* required when it was conducted in 1994.

Indicator 3.9 Per capita recurrent expenditure by governments on health care services to communities with populations of less than 100 people, as compared with expenditure for the general population (CU 4)

This indicator could not be reported on at this stage because the definition is still under development and there are no processes to collect these data by jurisdictions.

EFFORTS TO IMPROVE ACCESS DATA

- The indicator definitions for monitoring the distance travelled to a health service are reasonably valid and reliable, but there are no processes to collect the data against these indicators.
- The national Community Health Infrastructure Needs Survey (1999) will collect data from remote communities on distance to health services rather than travel time.
- In order for Indicators 3.1, 3.2 and 3.8 to be reported on in the future, a national survey, such as the NATSIS, needs to be ongoing and include questions related to time required to travel to health services rather than just in terms of distance away from health services (as was the case in the 1994 NATSIS). Otherwise, there will continue to be a significant gap in the understanding of patterns of access and locational disadvantage.
- The Commonwealth, in conjunction with the Aboriginal and Torres Strait Islander community-controlled health sector, is pursuing the issue of voluntary Aboriginal and Torres Strait Islander identification in the Medicare Benefits Scheme (MBS) database. This is a sensitive issue and NACCHO has agreed to consult broadly with its membership as a contribution to taking this matter forward. The critical issues of privacy and safeguards on use of identified data will be addressed. Currently, the Commonwealth's focus is on the MBS database.

CONCLUSIONS

- Indicator 3.5 needs to be developed further as there is no agreed definition of a primary health care service, and what constitutes a community-controlled service. This indicator was intended to flag the extent of jurisdictional support for community control but it does not elicit this information in its current form. It is very important that the indicator definition is clear, so that it can be properly assessed whether Aboriginal and Torres Strait Islander communities are participating in the provision and management of primary health care services. The definition should also make it clear that it is referring to primary services specifically for Aboriginal and Torres Strait Islander people.
- The purpose of Indicator 3.6 needs to be reconsidered, given that most jurisdictions reported against it in a similar fashion to Indicator 8.2 (which addresses Aboriginal and Torres Strait Islander involvement in regional planning processes).
- Aboriginal and Torres Strait Islander people are not yet widely represented on health and hospital boards across most jurisdictions and thus are less able to influence policy and planning decisions that may affect Aboriginal and Torres Strait Islander patients and communities.

- From the reporting of Indicator 3.7, it is not evident that any jurisdiction has mandated Aboriginal and Torres Strait Islander representation on health and hospital boards. This may explain the poor levels of representation across most jurisdictions. The term 'health or hospital board' also has different meanings across jurisdictions. This affects the usefulness of the indicator, as differing responsibilities of a health or hospital board will mean differing levels of involvement on the part of the Aboriginal and Torres Strait Islander representative.
- Agreed definitions of primary, secondary and tertiary care are needed if meaningful information on Indicator 3.3 is to be reported in the future. New South Wales suggests that the discussion in the Deeble report (Deeble et al. 1998:59-61) provides one way for categorising levels of care. Reliable data on type of care will assist in making decisions regarding where expenditures should be targeted, with the aim of focusing more on primary and secondary care, and on early intervention and prevention. Even though there is a high level of hospitalisation among the Aboriginal and Torres Strait Islander community (Deeble et al. 1998:61), there are also higher levels of expenditure on primary care for Aboriginal and Torres Strait Islander people than for other people. There is a great need for both primary and secondary care. All jurisdictions need to increase their efforts to improve access to primary care while continuing with efforts to improve access to hospital care.

Category four: Health service impacts

Indicator 4.1 The expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander people (CU 2)

Reporting against this indicator varied widely between jurisdictions – some simply provided their overall funding allocation for Aboriginal and Torres Strait Islander health promotion programs, and others provided details of specific programs. Some of the programs or projects are health promotion and education, while others are more to do with screening and early intervention activities.

Most jurisdictions are funding a range of health promotion programs specifically targeting Aboriginal and Torres Strait Islander communities and focusing on the key contributors of ill-health and the common causes of death. For example, programs targeting diabetes, risk factors (such as smoking, poor nutrition and alcohol use), and child and maternal health are occurring across a number of jurisdictions. More details are provided below on some of these programs.

In New South Wales, $1.658 million was allocated to the Aboriginal Health Promotion program during 1997-98. This was partially expended on statewide initiatives and partially allocated to nine Area Health Services for local initiatives. Details on the content and effectiveness of the health promotion programs are not currently available but should be in the future.

Western Australia allocated $864,180 in 1997-98 specifically on health promotion programs, including the prevention of alcohol-related disease, heart health, the prevention and treatment of diabetes, improving nutrition, reducing smoking and first aid training. This was additional to health promotion expenditure that cannot be separately identified, as it was part of spending on related primary health care initiatives.

Queensland could not provide any details on its Aboriginal and Torres Strait Islander health promotion programs.

The Commonwealth expended $26 million on Aboriginal and Torres Strait Islander public health during 1995-96. It was not possible to extract from this expenditure the specific amounts spent on health promotion for Aboriginal and Torres Strait Islander people. Further, the funding provided by the Commonwealth for community-controlled health services was for the delivery of comprehensive primary health care, which encompasses health promotion and education activities as well as population health activities and clinical care.

Diabetes

- Victoria allocated $454,286 over three years for diabetes education and the development of a resource kit for people with diabetes and their families.
- South Australia has established a Diabetes Forum with a focus on health promotion.

Drugs and alcohol

- The Australian Capital Territory allocated $16,700 for drug and alcohol education programs.
- Koori Community Drug and Alcohol workers in Victoria are based in local Aboriginal organisations working according to a harm minimisation model. During 1997-98, $657,892 was expended on this program.
- The 'Aboriginal Living with Alcohol Program' in the Northern Territory had $2.36 million allocated over three years. There are also projects in Alice Springs and Katherine focusing on petrol sniffing.

Cervical cancer screening

- In Victoria, $40,000 was spent in 1997-98 on strategies to support rural Koori women's access to both Aboriginal and mainstream cervical cancer screening programs.
- The Commonwealth is encouraging States/Territories to improve participation rates for cervical cancer screening as part of the national cervical cancer screening program.

Nutrition

- In the Northern Territory, $2.9 million is being spent over three years on appointing community nutrition workers and improving the provision of nutritious food in remote community stores.
- Two projects are being funded in Victoria. One aims at incorporating traditional foods into urban Aboriginal and Torres Strait Islander diets ($4,800), and the other is promoting healthy eating in the Shepparton Koori community (Rumbalara Football and Netball Club) ($21,415).
- An Aboriginal nutrition network is being established in South Australia to assist practitioners in the field to communicate and share information.
- Western Australia and Queensland have published nutrition policies and are currently implementing these.
- A focus on Aboriginal and Torres Strait Islander nutrition, including access to good food for remote communities, will be part of the national public health nutrition strategy which is expected to be completed in 1999.

Child and maternal health

- The Commonwealth has allocated $277,850 for breastfeeding and infant nutrition promotional literature to be developed. Family planning workshops have been held for Aboriginal and Torres Strait Islander health workers.
- The 'Strong women, Strong babies, Strong culture' program in the Northern Territory has been allocated approximately $1.7 million over three years.
- Funds have been provided in Victoria for projects promoting a healthier lifestyle for Koori women in Gippsland ($5,000) and Shepparton ($5,000).

Smoking

- The Aboriginal Smoking Strategy in the Northern Territory, which provides education and funding for community-based initiatives, has been allocated $548,120 over three years.
- The Koori 'Quit' strategy in Victoria was provided with $66,500, and an additional $93,640 for addressing smoking in the Shepparton region.
- A stop smoking campaign is being run for Aboriginal Health Workers in South Australia, and will be broadened to apply to the general Aboriginal community in that State.

Sexual health

- The HIV/STDs program in Victoria was allocated $90,000.
- Through funding to States and Territories for the implementation of the National Indigenous Australians' Sexual Health Strategy (NIASHS), the Commonwealth has supported a range of STD/HIV education programs. An amount of $150,000 over two years was set aside under the strategy to support the development and implementation of regionally and locally based education initiatives. In addition, funding was provided to the Australian Federation of AIDS Organisations for the establishment of an Aboriginal and Torres Strait Islander gay and transgender research and education project.

CONCLUSIONS FOR INDICATOR 4.1

- Jurisdictions have started focusing promotional work on the inter-relatedness of good life skills and practices and long-term health in the areas of child and maternal health, childhood development, and in relation to the risk factors which underpin the development of chronic conditions.
- This first report indicates that most of the information available currently is descriptive information about individual projects or programs. To enable meaningful future reports against Indicator 4.1 it is important that:
    1. jurisdictions cooperatively develop data sources which enable stakeholders to identify what is being undertaken across States/Territories to promote Aboriginal and Torres Strait Islander health;
    2. jurisdictions need to agree on a structured framework for reporting to ensure that similar levels of information are provided. This issue will be addressed in the future refinement of this indicator; and
    3. jurisdictions will need to improve their ability to clearly identify expenditures for Aboriginal and Torres Strait Islander-specific health promotion programs if reliable information is to be provided in the future. The funding for some Aboriginal and Torres Strait Islander health promotion programs will be difficult to identify, as they are administered under a mainstream allocation.
- There are projects in individual jurisdictions tackling the same health promotion issues, but it is not clear how, or if, they are being coordinated between governments. It is important that any areas of potential duplication across jurisdictions identified in this report are addressed. For example, are child and maternal health programs coordinated between governments to ensure that the allocations are used most effectively?

Indicator 4.2 Number of Pap smears among Aboriginal and Torres Strait Islander females aged 18-70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group (CU 2)

No jurisdiction is able, at present, to report on the number of Pap smears among Aboriginal and Torres Strait Islander women. This is because Aboriginal and Torres Strait Islander status is not identified on State and Territory Pap smear registers or pathology forms. It is acknowledged that this is a very sensitive issue and will need to be approached with care.

It is important to recognise the value of Pap smears, given that cervical screening is one of the most effective ways to detect the early signs and some of the risk factors of cancer of the cervix. As reported for Indicator 1.7, Aboriginal and Torres Strait Islander women in the Northern Territory were seven times more likely to die from cervical cancer than other women, and those in Western Australia three times more likely (see Table 1.7e).

Queensland and the Australian Capital Territory reported that they were investigating ways to improve their collections by adding an Aboriginal and Torres Strait Islander identifier on Pap smear records.

The Commonwealth does not collect national data on number of Pap smears even though it is funding the National Cervical Screening Program. However, some sample data will be collected as part of the national Bettering the Evaluation and Care of Health (BEACH) survey. This survey will provide identified information, including genital screening data, for a sample of about 110,000 people of whom approximately 1,400 are Aboriginal and Torres Strait Islander.

CONCLUSIONS FOR INDICATOR 4.2

- It will not be possible to monitor, at a national level, whether Aboriginal and Torres Strait Islander women are receiving access to cervical cancer screening unless efforts are made to place an Aboriginal and Torres Strait Islander identifier on the pathology forms and the Pap smear and cytology registers.
- The issues surrounding how general practitioners ask about Aboriginal and Torres Strait Islander status and include this information on pathology forms should be investigated.
- It is important that the Commonwealth reports on the results of the BEACH survey and ensures that reliable national data are collected and reported upon.

Indicator 4.3 Proportion of Aboriginal and Torres Strait Islander children aged two years and six years old that are fully immunised as recorded in the Australian Childhood Immunisation Register (ACIR) (CU 3)

No jurisdiction is able to report against this indicator as Aboriginal and Torres Strait Islander status is not a compulsory field on the Australian Childhood Immunisation Register (ACIR). The register can only identify an immunised child as Aboriginal and/or Torres Strait Islander if this information is on the forms provided by the immunisation providers. Unfortunately, immunisation providers do not consistently either collect or provide this information. In some jurisdictions, the immunisation forms do not allow for the recording of Aboriginal and Torres Strait Islander status. New South Wales noted that they could not report ACIR data because the ACIR ethics committee would not release the data.

The Northern Territory believes the rate of immunisation for Aboriginal and Torres Strait Islander children aged 12-14 months is approximately 85%, but this is inferred from regional immunisation rates for all children.

All jurisdictions are trying to improve the collection of Aboriginal and Torres Strait Islander identified data and the Commonwealth is liaising with the Health Insurance Commission on ways to improve the identification of Aboriginal and Torres Strait Islander children on immunisation forms and the reporting of this information to the ACIR. As well, more work needs to be done with Aboriginal-controlled health services and Aboriginal and Torres Strait Islander communities to find an appropriate way to obtain data on childhood Aboriginal and Torres Strait Islander immunisation rates.

Indicator 4.4 Proportion of Aboriginal and Torres Strait Islander people aged older than 50 years who have received pneumococcal vaccine in the last six years (CU 4)

Aboriginal and Torres Strait Islander people are much more likely than other people to die from pneumonia in the Northern Territory and Western Australia (see Table 1.7c), but there is no national information available on about how many of those most at risk are vaccinated against pneumococcal disease.

The Commonwealth pneumococcal and influenza program was implemented recently but coverage data are not yet available. Information following an evaluation of the program is expected in late 1999 or early 2000.

However, a couple of jurisdictions did provide some results as they have had vaccination programs in place for some time. The Northern Territory has regional pneumococcal databases and it is estimated that 78% of Aboriginal and Torres Strait Islander people aged over 50 years have been immunised. However, under-reporting means that this result may not be accurate. In Queensland, 85% of Aboriginal and Torres Strait Islander people aged over 50 years living in the north and north-west of the State are estimated to have received pneumococcal vaccine in the last six years. Statewide data are expected in 1999. Victoria conducted a telephone survey about pneumococcal vaccination, but the Koori sample was too small for any valid results to be reported. The Australian Capital Territory is developing a form to collect data on the number of Aboriginal and Torres Strait Islander people who are immunised against pneumococcal disease.

Indicator 4.5 ***Proportion of children aged between two and six years who are fully immunised against hepatitis B, as recorded in the Australian Childhood Immunisation Register (ACIR) (CU 4)***

See comments above about the identification of Aboriginal and Torres Strait Islander children in the ACIR.

The Northern Territory was the only jurisdiction able to report on this indicator. Hepatitis B immunisation of children aged 12-14 months was reported at 73%, but the overall level for children is believed to be higher, at around 92%.

CONCLUSIONS FOR INDICATORS 4.3–4.5

- To enable the effective monitoring of government programs to immunise Aboriginal and Torres Strait Islander children, efforts must be made by States and Territories to improve the collection and provision of Aboriginal and Torres Strait Islander identified data in the ACIR. If possible, Aboriginal and Torres Strait Islander status should be made a compulsory field in the ACIR.
- Further work needs to be undertaken with Aboriginal-controlled health services and other immunisation providers to find appropriate ways to address the privacy and confidentiality issues surrounding identified immunisation information.
- It is important that the Commonwealth efforts, particularly those by the Health Insurance Commission, to improve the identification of Aboriginal and Torres Strait Islander status on immunisation forms and in the ACIR are reported upon in the future.
- Jurisdictions will need to improve the collection of Aboriginal and Torres Strait Islander identified hepatitis B data to enable its monitoring over time. However, this is not to say that there should be duplicate registries or databases set up in each State or Territory. The ACIR should be responsible for improving national compliance and the provision of data.

Indicator 4.6 ***Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension (CU 1)***

Most jurisdictions are actively supporting the development and implementation of protocols and management systems for those chronic conditions that are responsible for a large proportion of Aboriginal and Torres Strait Islander ill health and death.

However, reporting against this indicator varied from a general description of a jurisdiction's overall response, to details on initiatives for each condition (these are provided later in the section).

Overall efforts to address chronic conditions

The Northern Territory has a chronic disease strategy aimed at the five conditions responsible for a high proportion of Aboriginal and Torres Strait Islander mortality and morbidity. It is focused on prevention, early detection and best practice management.

Under the Coordinated Care Trials in Western Australia, care plans have been developed for a range of conditions including chronic renal failure, hypertension and diabetes.

In the Australian Capital Territory, the Winnunga Nimmityjah Aboriginal Medical Service is working with mainstream health organisations, the Aboriginal and Torres Strait Islander Health Forum and ACT Health to address the priorities identified in the Aboriginal and Torres Strait Islander health strategic plan – in particular, diabetes, circulatory disease and asthma.

The Victorian Advisory Council on Koori Health is still to consider the development of protocols and disease management systems for specific conditions.

The Commonwealth has supported the development of a small number of pilot projects of an integrated approach to prevention, early detection, treatment and management of chronic disease. These pilot projects involve screening, early detection and treatment of chronic disease together with health promotion activities aimed at the factors which will help prevent chronic diseases.

Diabetes

- The Commonwealth funded the development of two reports on the prevention and treatment of diabetes. Under the National Diabetes Strategy, it also supported two community projects in 1998 aimed at encouraging lifestyle changes to reduce the incidence and impact of diabetes on the Aboriginal and Torres Strait Islander community, and a project to identify best practice in testing and illness management for diabetes.
- To improve data on diabetes, the AIHW is developing a diabetes register for insulin-treated diabetes. The register, operational from January 1999, includes the standard Aboriginal and Torres Strait Islander identifier.
- An action plan to address diabetes has been developed in Queensland, and an information system is to be trialed in the Torres Strait.
- New South Wales has developed guidelines for the management of diabetes in adults, children and adolescents, as well as foot care guidelines, nutrition guidelines and a guide for diabetes education. It is also developing guidelines for primary care strategies for the early detection and management of vascular disease and type 2 diabetes in Aboriginal communities. Strategies for improving primary health care in diabetes have been included also in the draft Aboriginal Health Strategic Plan.
- South Australia is developing an Aboriginal diabetes strategy which includes protocols for prevention, detection and management.
- Tasmania has appointed a diabetes project officer.

Chronic renal disease

- As noted above, the Commonwealth is supporting a small number of pilot projects for the screening of renal disease and other chronic diseases. Projects focusing on identifying best practice for early intervention and the management of renal disease are being undertaken in Coober Pedy and Tiwi.
- Strategies are being developed in Western Australia, the Northern Territory and Queensland to address end-stage renal disease in Aboriginal and Torres Strait Islander communities.

Cardiovascular disease

- New South Wales has developed a guide for the management of unstable angina, guidelines and standards of care for cardiac rehabilitation, and a consumer guide to cardiac rehabilitation. It has developed also a guide for acute stroke care and early rehabilitation, a guide for stroke prevention in clinical settings and an information resource for community information. Strategies for improving primary care for diseases of the circulatory system have been included in the draft Aboriginal Health Strategic Plan.
- Queensland is developing a strategy for the development of protocols for the management of cardiovascular disease.

Asthma and other respiratory disease

- New South Wales has developed a statement of priorities for improving asthma management, and is conducting an evidence-based review of the existing national asthma management plan.
- Queensland is developing a strategy for the development of protocols in relation to respiratory disease.

CONCLUSIONS FOR INDICATOR 4.6

- It will be important to ensure that there is coordination of the development of protocols and disease management strategies across jurisdictions to avoid duplication and to encourage the sharing of information and experience.
- To enable meaningful future analysis against this indicator, jurisdictions need to agree to develop data sources that reveal a systematic approach to screening and interventions to minimise the need for more acute care, as well as a structured framework for reporting (to ensure that a similar level of information is provided). These issues should be addressed in the future refinement of this indicator.
- There are a number of chronic diseases, such as asthma, for which only a few jurisdictions reported working on the development of protocols for detection and management.

Indicator 4.7 Age-standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders (CU 4)

The purpose of this indicator is to flag whether Aboriginal and Torres Strait Islander people are treated for the type of conditions that may be a consequence of health or social problems, such as substance misuse, violence and accidental injury. Presentation to emergency departments for respiratory infections, skin infections and nutritional disorders may also be a consequence of poor housing, infrastructure or access to primary health care.

Unfortunately, no jurisdiction was able to report against this indicator, as emergency data are not widely collected. New South Wales and Victoria identify Aboriginal and/or Torres Strait Islander status on their emergency department databases, but the quality of the data are very poor due to under-reporting of Aboriginal and/or Torres Strait Islander status.

Western Australia is implementing an information system in tertiary hospitals during 1999 which should result in the collection of emergency department data. The Northern Territory is establishing an emergency department information system and expects to be able to report against this indicator next year.

New South Wales also noted a problem with the indicator definition because emergency treatment is available outside hospitals but the indicator does not include a reference to other providers of emergency treatment such as general practitioners.

Indicator 4.8 Proportion of total consultations by condition and by care provider (CU 4)

No jurisdiction was able to report against this indicator, as data from primary care health providers identifying Aboriginal and/or Torres Strait Islander status on consultations are not available. Aboriginal-controlled health services collect this information for their own purposes, but it is not collected generally in private general practices. This indicator will be further developed under the indicator refinement project.

EFFORTS TO IMPROVE DATA FOR INDICATOR 4.8

There are a number of initiatives under way that may provide the data necessary to report against this indicator in the future:

- The Community Health Information Management Enterprise (CHIME), a consortium made up of New South Wales, Queensland and South Australia, is working to develop an information management system for community health. The system will identify Aboriginal and Torres Strait Islander clients but will not cover data from general practices.
- The Commonwealth service reporting requirements for Aboriginal-controlled health services will provide total episodes of care but not by condition. The Commonwealth has provided funding to community-controlled health services to install computerised patient information and recall systems that will help improve clinical management of complex conditions, as well as assist services to measure service throughput and activities.
- The national Bettering the Evaluation and Care of Health (BEACH) project is undertaking sample collections of consultation information from general practitioners nationally and will include provision for the identification of Aboriginal and/or Torres Strait Islander people and the reason for consultation.
- There is a project in the Torres Strait on establishing remote health information systems that will record the type of community health provider and primary diagnoses. This should enable reporting against this indicator for the Torres Strait.
- Victoria is considering recommendations to improve health information systems for Aboriginal Medical Services and is commencing a project in 1999 aimed at improving the recording of Aboriginality in mainstream community health services.

Category five: Workforce development

Indicator 5.1 Number of Aboriginal and Torres Strait Islander people who have: a) graduated in the previous year; and b) are in training in key health-related fields (CU 1)

Key health-related fields are defined as those included in the tertiary training database maintained by the Commonwealth Department of Training and Youth Affairs (DETYA). Statistics obtained from DETYA by the Commonwealth reveal that in 1997 there were 784 Aboriginal and Torres Strait Islander people enrolled in these fields nationally, a small decline from the 840 enrolments in 1996. In 1997, 158 Aboriginal and Torres Strait Islander people graduated from health-related tertiary courses in Australia. The courses included dental health, nursing, pharmacy, podiatry, optometry, medicine, physiotherapy, medical science, pathology and rehabilitation.

Some jurisdictions obtained information about tertiary enrolments and graduations directly from DETYA, and others sought information from their tertiary institutions directly. As a result, the jurisdictional breakdown is incomplete (see Table 5.1).

In contrast to the decline between 1996 and 1997 in tertiary enrolments, participation by Aboriginal and Torres Strait Islander people in vocational training (such as through TAFEs) increased. Recent data, obtained by the Commonwealth, reveals that 4,332 Aboriginal and Torres Strait Islander people were studying vocational health courses in 1997, an increase of 726 over the previous year. In 1997, a total of 810 Aboriginal and Torres Strait Islander people in Australia completed vocational training courses, in areas such as health science, dental science, rehabilitation and community care.

Table 5.1 Training of Aboriginal and Torres Strait Islander people in key health-related fields[a], by jurisdiction

Stage of training	Jurisdiction							
	NSW[a]	Vic[a]	Qld	WA[b]	SA	Tas	ACT[c]	NT[d]
Number who graduated in previous year	46	12	NA	NA	NA ●	NP	0	36
In training in health-related fields	309	58	NA	NA	NA ●	NP	1	136

(a) 'Key health-related fields' are those included in the DETYA tertiary training database. Data for NSW and Vic were obtained from DETYA

(b) WA reported that in 1998 there had been 10 Aboriginal and Torres Strait Islander graduates from one of the State's four universities offering health-related courses. Information from three universities revealed a total of 18 enrolled, but data were not available from the university offering most health-related courses.

(c) ACT reported also that eight Aboriginal and Torres Strait Islander people from around Australia were enrolled in the Master of Applied Epidemiology course at the Australian National University.

(d) Includes Bachelor College enrolments and graduates.

Notes:1. See Box 1 for notes and information about symbols used in this table.

Sources: NSW 1996; Vic 1996-97; ACT 1998; NT 1997-98.

Indicator 5.2 Number and proportion of Aboriginal Health Workers who graduated in the previous year or are participating in accredited training programs (CU 2)

Information about Aboriginal (and Torres Strait Islander) Health Worker (AHW) training comes from a variety of sources. First, the Commonwealth Department of Training and Youth Affairs (DETYA) collates data nationally. Second, the State and Territory health authorities collect some data. Third, the National Centre for Vocational Education Research (NCVER) began collecting in 1997 statistics about Aboriginal and Torres Strait Islander people enrolled in accredited VET sector AHW courses. With three separate sources of data, there are likely to be inconsistencies in the numbers reported (and this is borne out in the following tables).

DETYA figures, reported by the Commonwealth, reveal that 145 people graduated nationally as Aboriginal Health Workers in 1997, and 679 people participated in AHW training. These Australia-wide figures were calculated from publicly funded institutions only. The numbers are less than the sum of those reported separately by some States and the Northern Territory (see Table 5.2a), and it is possible that the latter figures may include data from privately funded training bodies. The Commonwealth will liaise with DETYA to resolve the issues of terminology that are affecting the reliability of this indicator.

NCVER figures reveal that there were 856 Aboriginal and Torres Strait Islander people (358 males and 498 females) enrolled in accredited VET sector AHW courses in that year (Table 5.2b). Statistics for Western Australia and Tasmania were not collected by NCVER because of variances in the ways those States currently collect enrolment statistics in the VET sector. A true reflection of AHW training nationally is therefore currently not available.

Table 5.2a: Training of Aboriginal and Torres Strait Islander Health Workers, by jurisdiction

Stage of training	Jurisdiction							
	NSW [a]	Vic [b]	Qld	WA	SA	Tas	ACT [b]	NT
Number who graduated in previous year	79	NA	NA	37	NA ●	NP	NA	126
In training in health-related fields	285	NA	119	74	NA ●	NP	NA	477

(a) Figures for NSW include up to 14 graduates and up to 48 enrolments who were non-Aboriginal and/or Torres Strait Islander or unknown. Similar information was not provided by the other jurisdictions.

(b) Neither Victoria nor the ACT has an accredited training program for AHWs.

Notes: 1. See Box 1 for notes and information about symbols used in this table

Sources: NSW 1997; Qld 1998; WA 1998; NT 1997-98.

Table 5.2b Aboriginal Health Worker enrolments by sex and jurisdiction, 1997

Sex	Jurisdiction							
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Male	130	32	119	NA	30	NA	NA	47
Female	155	17	208	NA	62	NA	NA	56

Note: 1. See Box 1 for notes and information about symbols used in this table.

Source: National Centre for Vocational Education Research, September 1998.

CONCLUSIONS FOR INDICATORS 5.1-5.2

- There is some disparity between the figures reported at a national level and those at the State and Territory level and the results should be interpreted cautiously. Some jurisdictions reported enrolments for 1998, while the national figures were for 1997. There were also differences in the way that tertiary training was interpreted. Some jurisdictions included vocational training as part of tertiary training whereas others did not.
- Both Queensland and South Australia are examining ways to improve the collection of training data and hope to be able to report more fully against these indicators in future years.

Indicator 5.3 The proportion of vacant funded full-time equivalent (FTE) positions for doctors, nurses and Aboriginal Health Workers in: a) Aboriginal health services; and b) other organisations providing primary care for Aboriginal and Torres Strait Islander people on a given date (CU 3)

Results can only be reported from the Northern Territory, as there was no centrally collected, comprehensive vacancy data available from any other jurisdiction. In the Northern Territory in 1998, there were vacancies for five doctors and 14 for remote nurses. There were also 37 vacancies for Aboriginal Health Workers, about half the number for the previous year.

Victoria, Queensland and South Australia reported efforts to improve the reliability of data through the development of databases to capture vacancy information.

Indicator 5.4 Number of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in hospitals where greater than 25% of separations are Aboriginal and Torres Strait Islander people on a given date (CU 1)

Only the Northern Territory and the Australian Capital Territory reported against this indicator, and they had no vacancies.

Indicator 5.5 Number of Aboriginal and Torres Strait Islander identified positions in the health sector (CU 1)

The number of Aboriginal and Torres Strait Islander identified positions in the health sector is difficult to analyse, as some jurisdictions do not, by law, allow for strictly identified positions. The Northern Territory observes an affirmative action policy as defined in the Anti-Discrimination Act, which states that if two applicants are of equal merit, then the Aboriginal and Torres Strait Islander person should be employed. Queensland uses a similar process to encourage Aboriginal and Torres Strait Islander people to be employed in positions where it is believed they are the best people for the job (for example, as Aboriginal and Torres Strait Islander health and liaison officers).

Table 5.5: Identified Aboriginal and Torres Strait Islander positions in the health sector, by jurisdiction

	Jurisdiction								
	C/wealth(a)	NSW	Vic	Qld(b)	WA	SA	Tas	ACT	NT(c)
Number of positions	15	NA ●	47	330	NA ●	NP	5	16	312

(a) These positions were in the Department of Health and Aged Care.
(b) Not strictly identified.
(c) Affirmative action positions.
Notes: 1. See Box 1 for notes and information about symbols used in this Table.
Sources: C/wealth 1997; Vic 1996; Qld 1998; Tas 1998; ACT 1998; NT 1998.

CONCLUSIONS FOR INDICATORS 5.3-5.5

- Additional data collection processes will be needed in most jurisdictions to capture employment data to enable the monitoring of an adequate workforce to meet the health needs of Aboriginal and Torres Strait Islander people.
- The meaning of 'identified positions' and their relationship with the different terms employed by the Northern Territory and Queensland, and possibly other jurisdictions, needs to be resolved to obtain comparable data.

Indicator 5.6 Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander (CU 2)

It is not possible at this time to report on the proportion of doctors and nurses that identified as Aboriginal and Torres Strait Islander people, due to poor data across most jurisdictions. Professional registration boards for doctors and nurses do not record Aboriginal and Torres Strait Islander status, so most data is either anecdotal or obtained through one-off or annual equal employment opportunity (EEO) surveys.

Some jurisdictions reported numbers of Aboriginal and Torres Strait Islander doctors and nurses, others proportions of their medical and nursing workforces identifying as Aboriginal and/or Torres Strait Islander, and others could not report.

New South Wales reported that, based on 1994 registrations, 0.28% of Registered Nurses and 1.01% of State Enrolled Nurses identified as Aboriginal and/or Torres Strait Islander. 0.2% of their medical workforce was identified from the EEO Survey Data of Health Services as being

Aboriginal or Torres Strait Islander. Queensland reported that 0.3% of their medical workforce and 1% of their nursing workforce identified as Aboriginal and/or Torres Strait Islander. Western Australia reported that three doctors identified as Aboriginal and/or Torres Strait Islander, and the Northern Territory that one did so. The Territory reported also that one nurse identified as Aboriginal and/or Torres Strait Islander. Six nurses (0.09% of the nursing workforce) were reported by South Australia as identifying as Aboriginal and/or Torres Strait Islander.

Queensland reported that it will be improving the collection of its data through an improved annual EEO survey, and Western Australia is also considering a survey of Aboriginal and Torres Strait Islander health employment. Implementation of the New South Wales Aboriginal Employment Strategy should also improve its data in the future.

Indicator 5.7 Proportion of accredited hospitals for which the accreditation process required Aboriginal and Torres Strait Islander cross-cultural awareness programs for staff to be in place (CU 3)

Most jurisdictions have Aboriginal and Torres Strait Islander cross-cultural programs to educate hospital personnel, but these programs are not linked to accreditation. This is really an issue for the accrediting organisation - the Australian Council on Healthcare Standards - rather than individual States and Territories. However, in New South Wales the establishment of Aboriginal and Torres Strait Islander cross-cultural awareness programs is part of agreements with its Health Services. Fifteen Health Services out of 20 have implemented cultural awareness programs for their staff.

CONCLUSIONS FOR INDICATORS 5.6-5.7

- The Northern Territory suggested that the inclusion of an Aboriginal and Torres Strait Islander identifier on health professional board databases would be the most efficient way to improve our knowledge of the number of Aboriginal and Torres Strait Islander nurses and doctors. These data could be analysed by the AIHW as part of its regular reports on professional registration board data.
- The Australian Council on Healthcare Standards decides on rules for accreditation and should be consulted on ways of including Aboriginal and Torres Strait Islander cross-cultural awareness as a condition of hospital accreditation.
- Jurisdictions could consider incorporating the establishment of Aboriginal and Torres Strait Islander cross-cultural awareness training as part of their outcome agreements with hospitals or regional health authorities.
- Under the Aboriginal and Torres Strait Islander Health Plan (Aboriginal and Torres Strait Islander Health and Welfare Information Unit 1998), recommendation 12 notes that States and Territories have the responsibility to ensure the recruitment of Aboriginal health liaison officers in hospitals with a sizeable number of Aboriginal and Torres Strait Islander clients.

EFFORTS TO IMPROVE DATA FOR INDICATORS 5.1–5.7

Workforce modelling

In recognition of the need for accurate health workforce data, and in order to consider fundamental health workforce requirements in all health professional categories, the Commonwealth has commissioned a national workforce modelling project. The project will examine both the current mix and number of health professionals, and develop models that will identify the appropriate mix and skill requirements for health professionals providing services to Aboriginal and Torres Strait Islander people in the future. It is anticipated that significant workforce data focusing on all health professional categories will arise from the project. It is anticipated that these data will be available in December 1999.

Category six: Risk factors

Indicator 6.1 *Proportion of Aboriginal and Torres Strait Islander people aged greater than 13 years who currently smoke by age and sex (CU 2)*

Victoria and the Northern Territory derived, from the NATSIS results, smoking prevalence data for Aboriginal and Torres Strait Islander people by sex and age groups. In these jurisdictions, the highest proportions of smokers were in the 25-44 years age group. In Victoria, 75% of women aged 25-44 years smoked as did 74% of men in the Northern Territory in this age group.

Further analysis of the NATSIS results shows that approximately 50% of Aboriginal and Torres Strait Islander people over the age of 13 years reported smoking (ABS 1996). Those aged 25-44 across Australia were more likely to smoke than other age groups (85%), but smoking was still very prevalent among young people with over one-third reporting that they smoked (34%).

Table 6.1: Proportions of Aboriginal and Torres Strait Islander smokers by sex, age group and State/Territory

Sex/age group (years)		Jurisdiction							
		NSW[(a)]	Vic[(b)]	Qld[(c)]	WA	SA	Tas	ACT	NT[(b)]
Male	13-24	NA	46	NA	NA	NA	NA	NA	44
	25-44	NA	66	NA	NA	NA	NA	NA	74
	45+	NA	39	NA	NA	NA	NA	NA	61
Female	13-24	NA	57	NA	NA	NA	NA	NA	28
	25-44	NA	75	NA	NA	NA	NA	NA	47
	45+	NA	46	NA	NA	NA	NA	NA	28

(a) NSW did not provide an age breakdown of smoking proportions, but reported that 52% of Aboriginal and Torres Strait Islander males aged 13 years and older smoked, as did 50% of Aboriginal and Torres Strait Islander females aged 13 years and older.

(b) For Victoria and the Northern Territory the proportions shown in the 45+ age group relate only to people aged 45-64 years. The figures for Aboriginal and Torres Strait Islander people aged 65 years and older were: Vic: males 9%, females 19%; NT males 43%, females 13%.

(c) Queensland did not provide an age breakdown of smoking proportions, but reported that 53% of Aboriginal and Torres Strait Islander males aged 13 years and older smoked, as did 44% of Aboriginal and Torres Strait Islander females aged 13 years and older.

Source: Derived from NATSIS (ABS) 1994

Indicator 6.2 *Proportion of Aboriginal and Torres Strait Islander people with a body mass index (BMI) greater than 25, by sex and age (CU 2)*

High proportions of Aboriginal and Torres Strait Islander adults reported to the NATSIS that they were overweight or obese (Table 6.2). Overall for Aboriginal and Torres Strait Islander people, 28% of males and 19% of females reported being overweight, and 20% of males and females reported being obese. Aboriginal and Torres Strait Islander people in the Northern Territory were less likely to be overweight or obese than other Aboriginal and Torres Strait Islander people.

Table 6.2: Proportion of overweight and obese Aboriginal and Torres Strait Islander people by sex and State/Territory

Sex/weight status		Jurisdiction							
		NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Male	Overweight (BMI > 25 and < 30)	28	36	32	24	27	36	NA	18
	Obese (BMI ≥30)	21	21	22	18	22	14	NA	10
Female	Overweight (BMI > 25 and < 30)	24	23	21	19	20	29	NA	15
	Obese (BMI ≥ 30)	20	20	25	22	19	19	NA	11

Notes: 1. BMI, body mass index, is defined as the weight (in kilograms) divided by the height (in metres) squared.
2. See Box 1 for notes ane information about symbols used in this table.
Source: Derived from NATSIS (ABS) 1994.

Indicator 6.3 *Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming more than four drinks on the occasions when they drank alcohol in the last two weeks, relative to the total numbers who reported on consumption (CU 4)*

This indicator was not reported on by jurisdictions as there were no data available on the number of alcoholic drinks consumed. Results from the National Aboriginal and Torres Strait Islander Drug Survey provide some insights for Aboriginal and Torres Strait Islander people living in urban areas. The survey reported that 74% of Aboriginal and Torres Strait Islander men and women consumed alcohol and, of these, 56% of males and 73% of females did so at hazardous or harmful levels (Commonwealth Department of Human Services and Health 1994). This indicates that fewer Aboriginal and Torres Strait Islander people consume alcohol than non-Aboriginal and Torres Strait Islander people, but those people who do are more likely to consume at harmful levels.

The 1994 NATSIS requested information about the time since alcohol was last consumed, but not about the amount consumed. This indicator has already been identified as one that will be further developed and refined under the indicator development project.

CONCLUSIONS FOR INDICATORS ON RISK FACTORS

- Good data on risk factors are critical given the strong relationship between risk factors and the development of chronic disease and other poor health outcomes, and the need to determine where to target resources and interventions to minimise risk.
- The most recent data available are from the 1994 NATSIS and the National Aboriginal and Torres Strait Islander Drug Survey. There is a need for further data collections to monitor whether progress towards meeting the goals of reducing the prevalence of smoking, overweight and obesity, and harmful alcohol consumption are indeed being achieved.
- The 1995 National Health Survey did provide identified data on Aboriginal and Torres Strait Islander health, but the quality of the data from remote areas was problematic. The next National Health Survey will need to collect more reliable data on Aboriginal and Torres Strait Islander health.
- New South Wales may be able to report more fully on these items in the future based on combined data from the 1997 and 1998 New South Wales Health Survey.

Category seven: Intersectoral issues

Indicator 7.1 *Proportion of households where the after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the poverty line (CU 3)*

There are a number of recognised measures of poverty. However, most jurisdictions did not report against this indicator because there is no broad agreement on which definition of 'poverty line' was to be used. New South Wales reported against the indicator using the Henderson poverty line but acknowledged that it is not widely accepted as the best measure of poverty. From an analysis of 1991 Census data against the Henderson poverty line, 50% of Australian Aboriginal and Torres Strait Islander families with children were classified as 'very poor' compared with 21% of other Australian households (Ross & Mikalauskas 1996).

There is also a problem with obtaining household after-tax income. The Census and NATSIS data include details on gross income, but not net income which is required to report against this indicator. An appropriate source should be identified as part of the refinement process for the National Performance Indicators and Targets.

Indicator 7.2 *Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last four weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives (CU 2)*

From the 1994 NATSIS, just over 9% of households reported having a breakdown in services (such as running water, power, gas or sewerage) in the previous four weeks. However, the Northern Territory noted that the national picture does not represent the deficient state of housing infrastructure in the Territory, where 13% of Aboriginal and Torres Strait Islander households reported lacking one or more of these basic amenities.

Some recent data on dwellings in discrete Aboriginal communities (excluding towns) in Western Australia is available through the 1997 Western Australia Environmental Needs Survey. The data was not provided, as it is not in the form prescribed by National Performance Indicators and Targets.

CONCLUSIONS FOR INDICATORS ON INTERSECTORAL ISSUES

- A decision is needed on the definition of 'poverty line' to be used before jurisdictions can report against Indicator 7.1. (New South Wales suggests Altman & Hunter 1997 may be helpful.)
- A source for data on after-tax income is also required to report against Indicator 7.1.
- An additional national data source is needed for jurisdictions to continue to be able to report against Indicator 7.2. The planned 1999 Community Health Infrastructure Needs Survey may provide the opportunity to collect some useful data.

Category eight: Community involvement

Indicator 8.1 *Establishment of a forum representing the Aboriginal health sector, Aboriginal and Torres Strait Islander Commission (ATSIC) and the State jurisdiction in each State and Territory (CU 1)*

Forums with representatives from all agencies have been established in all States and Territories, except for Tasmania which did not report having an Aboriginal health sector representative.

Each jurisdiction has a regular program of meetings with forums, focusing on community and regional planning. In the Northern Territory, for example, the Top End Regional Study will be the first major achievement of the forum. The South Australian forum is examining whether health planning can be managed by regional committees.

All forums have met at least twice and most jurisdictions report that meetings have progressed successfully. All States and Territories, except Queensland and Tasmania, have established funding of the community-controlled health sector affiliates. In Tasmania, however, only one health service is involved and the Commonwealth has agreed to provide funds for the affiliate in that State. Queensland Health has not yet reached agreement on funding an independent community-controlled body.

Indicator 8.2 *Cooperative community planning with the implementation of the regional planning processes (CU 4)*

All States and Territories have commenced the development of regional health plans and representatives from the Aboriginal community health sector are included in the process. South Australia, the central Northern Territory, and Queensland have completed their plans and have started to implement the priorities identified in the plans. Western Australia is close to finalising six regional plans covering the State.

In New South Wales, Aboriginal community organisations and representatives have been involved in a number of planning processes. Aboriginal Health Strategic Plans have been developed for Health Services with the participation of local Aboriginal community organisations. A formal partnership agreement has been in place between the State and the Aboriginal Health and Medical Research Council (AH&MRC) since 1995. Formal partnerships have also been established at the local level between 18 Health Services and representatives from the AH&MRC (the AH&MRC represents the Aboriginal community-controlled health services in New South Wales).

Three Victorian regions (Loddon-Mallee, Hume and Northern Metropolitan) are pilot sites for the development of Health Outcome Agreements between local Koori communities and regional offices as part of the Koori Health Reform Strategy. These agreements will facilitate community involvement in health planning. Victoria also provided examples of Aboriginal and Torres Strait Islander community involvement in community health planning in a number of regional centres. For example, the Yarra Valley Community Health Service has an Aboriginal and Torres Strait Islander health steering committee that advises on Aboriginal and Torres Strait Islander planning, policy and delivery issues. The Barwon South Western and Grampian Regions have a Koori Aged and Disabled Networks Committee that includes representatives from each of the Koori cooperatives that have Home and Community Care services.

The South Australia Regional Health Boards each have an Aboriginal and Torres Strait Islander representative to advocate on behalf of the local Aboriginal and Torres Strait Islander community and advise on Aboriginal and Torres Strait Islander health issues.

The coordinated care trials in the Northern Territory have involved regional health authorities working with representatives from Aboriginal and Torres Strait Islander communities on the provision of local health services.

The Australian Capital Territory provided details of community consultations that have taken place, and reported that Aboriginal and Torres Strait Islander community participation has improved since some internal community differences had been resolved.

CONCLUSIONS FOR INDICATORS ON COMMUNITY INVOLVEMENT

- Now that all forums have been established and membership agreed, Indicator 8.1 may need to be expanded to include some specific outcomes or issues that forums are expected to address. An example is the development and implementation of regional plans.
- Reporting against this indicator may duplicate current reporting requirements under the Framework Agreements.
- Indicator 8.2 has already been identified as one that requires further development, as it does not adequately monitor whether community participation is actually part of community health planning processes. Queensland suggested that the definition could be modified to refer to the number of regions or districts with Aboriginal and Torres Strait Islander health plans that were developed by and with the local Aboriginal and Torres Strait Islander communities.
- Further development and implementation of State and Territory Aboriginal and Torres Strait Islander health plans will improve reporting against this indicator.

Category nine: Quality of service provision

Indicator 9.1 *Critical incidence reporting and complaints mechanisms at all levels of health services (CU 4)*

All jurisdictions have formal complaints mechanisms in place for hospitals, but these are not well accessed by Aboriginal and Torres Strait Islander people. Queensland notes that Aboriginal and Torres Strait Islander complaints are more likely to be received second-hand through Aboriginal and Torres Strait Islander liaison or patient officers.

States and Territories acknowledge this problem and most jurisdictions describe projects aimed at improving the monitoring of service deficiencies and racism in the hospital system. For example, New South Wales has developed guidelines to improve complaints reporting and handling. These are being implemented currently across all health services. They are also identifying ways to make complaints processes more accessible to Aboriginal and Torres Strait Islander people in the State. Jurisdictional reports, other than the New South Wales report, only mentioned hospital services, however, and did not discuss critical incident reporting in other types of health services.

In some jurisdictions, Aboriginal and/or Torres Strait Islander status is not identified on complaints data, which means that it is impossible to monitor the reporting of complaints by Aboriginal and Torres Strait Islander people.

CONCLUSIONS FOR INDICATORS ON QUALITY OF SERVICE PROVISION

- There is a need for Aboriginal and Torres Strait Islander people to be made aware of their rights to quality health care and the avenues open to them to raise concerns if they have a complaint or have been affected by racism.
- Aboriginal and/or Torres Strait Islander status must be identified in complaints data if quality of service provision for Aboriginal and Torres Strait Islander clients is to be monitored. It is recognised, however, that the small numbers of Aboriginal and Torres Strait Islander people likely to be involved means that individual privacy may be difficult to protect. This issue is being addressed under the ABS/AIHW, Department of Health and Aged Care and State/Territory joint efforts to improve the identification of Aboriginal and Torres Strait Islander status across a range of health data collections.

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Abbreviations

ABS	Australian Bureau of Statistics
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AH&MRC	Aboriginal Health and Medical Research Council
AHW	Aboriginal Health Worker
AIDS	acquired immuno-deficiency syndrome
AIHW	Australian Institute of Health and Welfare
ATSIC	Aboriginal and Torres Strait Islander Commission
BEACH	Bettering the Evaluation and Care of Health
BMI	body mass index
CHIME	Community Health Information Management Enterprise
CU	current usefulness
DETYA	(Commonwealth) Department of Education, Training and Youth Affairs
DHAC	(Commonwealth) Department of Health and Aged Care
DOGIT	Deed of Grant in Trust
EEO	equal employment opportunity
FTE	full-time equivalent
HIV	Human immunodeficiency virus
MBS	Medicare Benefits Scheme
NA	not available
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIS	National Aboriginal and Torres Strait Islander Survey
NCVER	National Centre for Vocational Education Research
NDS	National Drug Survey
NHIMG	National Health Information Management Group
NIASHS	National Indigenous Australians' Sexual Health Strategy
NP	not provided
PBS	Pharmaceutical Benefits Scheme
SLA	Statistical Local Area
STD	sexually transmitted disease
TAFE	(College of) Technical and Further Education
VET	vocational educational training

Places

ACT	Australian Capital Territory
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia