

Determinants of health—risk markers

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Introduction

This subdomain includes 11 indicators, 8 of which are reported on.

Problem gambling and community grief cannot be reported on because there are no relevant data. It may be possible with future work using data on stressors from the National Aboriginal and Torres Strait Islander Social Survey, and data on social and emotional wellbeing from the 2004–05 National Aboriginal and Torres Strait Islander Health Survey, to construct a measure of community grief in the near future. This will be done as part of the development of the Aboriginal and Torres Strait Islander National Health Performance Framework.

The indicators in this subdomain cover the major risk factors for disease. They include low birthweight, immunisation rates, coverage of adult pneumococcal vaccine, Pap smear screening, smoking prevalence, alcohol consumption, injury, overweight and obesity, and child abuse and neglect.

The ABS provided data for three of these indicators. Data for the indicators on smoking prevalence and alcohol consumption were from the 2002 National Aboriginal and Torres Strait Islander Social Survey. Data for the indicator on overweight and obesity were from the 2001 National Health Survey and were provided at the national level due to the small number of Indigenous people in the sampled survey.

The AIHW provided data for two of the indicators. Data on low-birthweight infants came from the AIHW National Perinatal Statistics Unit. The AIHW also provided data on child protection substantiations, a broad measure of child abuse and neglect.

The data on childhood immunisation rates were provided by the Health Insurance Commission from the Australian Childhood Immunisation Register. Children must have at least one immunisation to be included on this register.

The states and territories provided the data for two of the indicators – Pap smear screening, and injuries presenting to hospital emergency facilities. No jurisdiction could provide quantitative data on the proportion of Indigenous women who have had a Pap smear, as Indigenous status is generally not recorded on pathology forms. Only six states and territories could provide quantitative data on the presentation of acute injuries at hospital accident and emergency facilities and the data are not strictly comparable because of differences in coding systems used.

Indicator 25. Pap smear screening

Indicator: The proportion of Aboriginal and Torres Strait Islander women within each eligible age group who have had a Pap smear within a 24-month period.

Purpose

Pap smear screening enables the early detection of cancer of the cervix, and most deaths due to cervical cancer are potentially avoidable. This indicator measures the success of government efforts to encourage Aboriginal and Torres Strait Islander women to have Pap smears, and their access to and utilisation of Pap smear services.

Data

No states and territories could provide quantitative data for this indicator, as Indigenous status is generally not recorded on pathology forms, and in some states and territories not recorded on Pap smear registers. Therefore only written responses were provided.

New South Wales

In 2002–03 the NSW Cervical Screening Program sponsored a range of activities to encourage the participation of Aboriginal and Torres Strait Islander women to participate in cervical screening, including:

- the continuation of the state-wide study into issues and strategies designed to improve cervical and breast screening for Aboriginal and Torres Strait Islander women.
- the provision of funding for development of partnerships with a number of Aboriginal Medical Services across the state to promote and support cervical screening initiatives for Aboriginal and Torres Strait Islander women, including in the Far West, Greater Murray, New England, Mid North Coast and Southern Area Health Services.
- the widespread distribution of materials developed in the previous reporting period – in particular, the prize-winning workshop resource, consisting of a booklet for participants and accompanying teaching materials including overhead transparencies for female Aboriginal Health Education Officers. The program also supported capacity building workshops for Aboriginal Health Workers to assist in the delivery of the resources.

A total of 4,543 resource items developed specifically for Aboriginal and Torres Strait Islander women were distributed across the state in this period. This equals 1.5% of total resources distributed.

In 2003–04 the NSW Cervical Screening Program:

- undertook the data analysis and produced the report on the study into issues and strategies designed to improve cervical and breast screening for Aboriginal and Torres Strait Islander women. The report and its recommendations are now being taken back to the contributing communities for consultation before its finalisation and release
- continued to provide funding to maintain partnerships with Aboriginal Medical Services to support cervical screening and provide workshops to Aboriginal Health Workers on cervical screening
- supported a number of special local projects aimed at recruiting Aboriginal women to cervical screening including: the use of art, graphics and story telling in association with the Mungabareena and Woomera Aboriginal Corporations, the development of a series of

posters by a women's craft group in the Greenhill community, and a 'pamper' day to raise awareness of cervical screening, in association with the Illawarra Aboriginal Medical Service

- continued to produce and circulate previously developed and tested materials specific to Aboriginal and Torres Strait Islander women, including 'A Message to Aboriginal Women', with an accompanying teaching kit, and the brochure and poster 'Well Women Strong Community'.

A total of 7,714 resource items specific to Aboriginal and Torres Strait Islander women were distributed in this period (2.7% of all resource items).

Victoria

PapScreen Victoria does not record Indigenous status. There is no Aboriginal identifier in either the Victorian Cervical Cytology Register or on pathology request forms, so that the participation of Aboriginal women in cervical cancer screening cannot be quantified. The Victorian Cervical Cytology Registry collects a patient's name, address, date of birth and Medicare number.

Indigenous status is a mandatory reporting item in the Victorian Cancer Registry (VCR), which is notified of every hospital attendance by patients with cancer. Collection of Aboriginal status by VCR depends on collection of this data by the hospitals. Notifications from sources other than hospitals are less likely to include Indigenous status.

A project to improve identification of Aboriginal patients in cancer-related datasets was developed in late 2004. The project recommended linkage of Victorian Admitted Episodes Data (VAED), which has the most reliable Aboriginal identification, with VCR. This project will continue in 2005.

The Victorian Aboriginal Health Service has cooperated with PapScreen and BreastScreen to increase screening of Aboriginal women through workshops for Koori women and health workers.

PapScreen Victoria is committed to working with the Koori community to develop culturally appropriate and community owned strategies to promote cervical screening. PapScreen funds a Koori health worker position based at the Victorian Aboriginal Health Service. This position provides state-wide education and support.

Queensland

Key initiatives undertaken by the Queensland Cervical Screening Program in 2003-04:

- The development and release of the 'Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women' which aim to remove barriers and increase access to the screening pathway for Indigenous women. These guidelines were developed with feedback and guidance from the Indigenous community and other key partners and were endorsed by members of the Indigenous community, the Commonwealth Department of Health and Ageing, Cancer Screening Services Unit (Public Health Services – Queensland Health) and program managers of national screening programs.
- Increased access to cervical screening services through enhanced service provision by female Pap Smear Providers to women in rural and remote settings. This includes the Rural and Remote Women's Health Program and Mobile Women's Health Service and involves collaboration with health care providers, local communities, Royal Flying Doctor Service – Queensland Division, Queensland Division of General Practice, Family Planning Queensland, Department of Health and Ageing, community workers, Local Divisions of

General Practice and individual GPs, Community Controlled Health Services and non-government organisations, and Queensland Health departments, for example, Queensland Pathology and Scientific services, BreastScreen Queensland and Zonal Public Health Units.

- Ongoing implementation of the Queensland Indigenous Women's Cervical Screening Strategy 2000–2004. This strategy is currently being reviewed. Key action areas that are being progressed are: workforce development (education and training of Indigenous health personnel, and cross-cultural awareness training); and screening and follow-up services (increasing access to culturally safe screening services).

Western Australia

The Western Australian Cervical Cytology Registry has the capacity to collect Indigenous status; however, as demographic data received from laboratories are limited to the information provided on the pathology form (which does not include Indigenous status), Indigenous status cannot be recorded currently. The WA Cervical Cancer Prevention Program is committed to working with other states and territories and the Australian Government in being able to collect data on Indigenous status. The program is also committed to improving participation of Aboriginal and Torres Strait Islander women in cervical screening. An Indigenous Women's Reference Group was established in early 2003 which includes representatives from all Aboriginal communities throughout the state. This group aims to evaluate and develop culturally appropriate strategies and resources for educating Indigenous women about both breast and cervical screening. A community education resource kit has also been developed (currently in draft form) to assist Aboriginal Health Workers promote cervical cancer prevention to Indigenous women.

South Australia

The Aboriginal Well Women's Screening Programme is a cervical screening programme for which funding has been provided to both Aboriginal and non Aboriginal Health Services (where there is an Aboriginal Health unit) to undertake various health promotion and education activities within the 2003–2004 financial year.

Some of these health services have a clinical component to their service, and health promotion and education is provided throughout the year by the staff or visiting staff. Other health services which do not have a clinical component provide health promotion and education in a different way; for example, Well Women's Health Camps, which are held over two to three days and Health Promotion and Education Days. Information is gathered in an informal way on what other women's health topics they would like to learn about so that they can make informed decisions about their own health. Women are encouraged to utilise their local medical service, or if visiting a larger town, they are encouraged to attend the clinic there, if they feel more comfortable. Evaluations are also carried out on these activities.

Support is given to the organisations, Aboriginal Health Workers, non-Aboriginal health workers and the community women by the Senior Project Officer of the Aboriginal Well Women's Screening Programme. The number of health promotion and education sessions held during the year depends on the workload of Aboriginal and Torres Strait Islander Health Workers, and also what is happening in the community.

Tasmania

Data are not currently collected in Tasmania.

Australian Capital Territory

Due to restrictions arising from the Public Health Regulations and the absence of the identifier on pathology request forms, the Aboriginality of women on the ACT Cervical Cytology Register is currently not recorded. Following detailed investigation and consultations with pathology laboratories and other stakeholders on the impact of legislating for the inclusion of the identifier on pathology request forms, the ACT has concluded that due to the cross-border nature of pathology operations, any such initiative would have to be implemented at a national level. The issue has been referred to the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID).

Northern Territory

The Cervical Cytology Regulations allow for the collection of Indigenous status but as the data source, the laboratory form completed by the smear taker, does not, the Northern Territory Pap Smear Register records only the result of all participating women (regardless of status) across the Territory. The Registry has access to CareSys, which is an index linked to the Community Care Information System and Primary Care Information System. This enables the Registry to accurately identify the Indigenous status for any clients whose forms have inadequate information in areas or health services where there is a high proportion of Aboriginal and Torres Strait Islander women.

In 2003-04, 63.4% of women aged 20 to 69 years had a registered Pap smear within the Northern Territory in the previous 24 months. There has been a nationwide decline in screening rates similar to that experienced in the Northern Territory. Estimates of rates of Pap smear screening for those areas with a high proportion of Aboriginal women are generally consistent with rates over the Northern Territory.

Regional Women's Health Educators have been active in training remote area nurses and Aboriginal Health Workers to take pap smears and also in providing information to Aboriginal women in remote areas about the need for regular Pap smear screening. Community-based Women's Health Days are often conducted in remote areas and are designed to encourage women to access basic health screening. Resources such as videos, flipcharts and pamphlets are made available and are specific to Indigenous women.

Indicator 26. Childhood immunisation rates

Indicator: The proportion of Aboriginal and Torres Strait Islander children who are fully immunised against vaccine-preventable diseases, according to the National Health and Medical Research Council's (NHMRC) recommendations at 12 months, 2 years and 6 years of age.

Purpose

Immunisation against childhood diseases that are preventable by vaccination is important to ensure the health and wellbeing of Indigenous children. The indicator provides a measure of access to and utilisation of immunisation services.

Data

Information for this indicator was obtained from the Australian Childhood Immunisation Register, which is managed by the Health Insurance Commission. 'Fully immunised' means a child has received all age-appropriate vaccines on the Australian Childhood Immunisation Schedule.

Children are added to the Australian Childhood Immunisation Register at their first immunisation. The rates reported here are the number immunised as a proportion of children on the register, not as a proportion of children in that age group as specified in the indicator.

Data were not provided for Queensland, Tasmania and the Australian Capital Territory because the coverage of Indigenous children on the register in these states and territories was not sufficient to calculate rates.

Table 26.1: The proportion of Indigenous children who were fully immunised at 1, 2 and 6 years of age, for selected states and territories, 30 June 2003 and 30 June 2004 (per cent)

Age	NSW	Vic	WA	SA	NT
2003					
1 year	84	87	78	85	89
2 years	86	91	86	88	84
6 years	80	83	77	76	64
2004					
1 year	85	88	78	83	84
2 years	87	86	87	94	94
6 years	85	84	78	82	89

Note: Data were not provided for Queensland, Tasmania, and the Australian Capital Territory because the coverage of Indigenous children was not complete enough to calculate rates.

Source: Health Insurance Commission Australian Childhood Immunisation Register.

- In 2003, the proportion of Indigenous children on the register who were fully immunised at 1 year ranged from 78% in Western Australia to 89% in the Northern Territory. In 2004, the proportion of Indigenous children on the register who were fully immunised at 1 year of age ranged from 78% in Western Australia to 88% in Victoria.

- In 2003, the proportion of Indigenous children on the register who were fully immunised at 2 years of age ranged from 84% in the Northern Territory to 91% in Victoria. In 2004, the proportion of Indigenous children on the register who were fully immunised at 2 years of age ranged from 86% in Victoria to 94% in South Australia and the Northern Territory.
- In 2003, the proportion of Indigenous children on the register who were fully immunised at 6 years of age was highest in Victoria (83%) and lowest in the Northern Territory (64%). In 2004, the proportion of Indigenous children on the register who were fully immunised at 6 years of age ranged from 78% in Western Australia to 89% in the Northern Territory.

Indicator 27. Coverage of adult pneumococcal vaccine

Indicator: The proportion of Aboriginal and Torres Strait Islander people aged 50 years and over who have received pneumococcal vaccine in the last 5 years.

Purpose

Immunisation against illnesses that are preventable by vaccination is important to ensure the health and wellbeing of Indigenous people, in particular the elderly. The indicator provides a measure of access to and utilisation of immunisation services.

Data

Data on coverage of adult pneumococcal vaccine are only available at the national level from the 2001 National Health Survey, and are presented in the 2004 report *Vaccine Preventable Diseases and Vaccination Coverage in Aboriginal and Torres Strait Islander People, Australia, 1999 to 2002* (Menzies et al. 2004) by the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases. Data from this report were used for this indicator and are outlined below:

- In 2001, 25% of Indigenous persons aged 50 years and over had been vaccinated for pneumococcal disease in the last 5 years compared with 14% of non-Indigenous Australians aged 50 years and over.
- Just over half (51%) of Indigenous persons aged 50 years and over had been vaccinated for influenza over the last 12 months compared to 47% of non-Indigenous people of the same age.

Table 27.1: Vaccination coverage estimates for influenza and pneumococcal disease for Indigenous and non-Indigenous adults, 2001 (percent)

Vaccine	Indigenous status	50–64 years	65+ years	50 years and over
Influenza ^(a)	Indigenous	47	71	51
	Non-Indigenous	26	75	47
Pneumococcal ^(b)	Indigenous	20	47	25
	Non-Indigenous	3	28	14

(a) Vaccinated in the last 12 months.

(b) Vaccinated in last 5 years.

Sources: Unpublished data from 2001 National Health Survey; Menzies et al. 2004.

Indicator 28. Low-birthweight infants

Indicator: The prevalence of low birthweight in live-born babies of Aboriginal and Torres Strait Islander women.

Purpose

The indicator reflects the health of Aboriginal and Torres Strait Islander women, their access to and utilisation of antenatal care, and the quality of antenatal care. It also indicates the health and development of Aboriginal and Torres Strait Islander babies, as low-birthweight babies are more prone to ill health during childhood, and may be more vulnerable to illness in adulthood (Alberman 1994; Barker & Clark 1997).

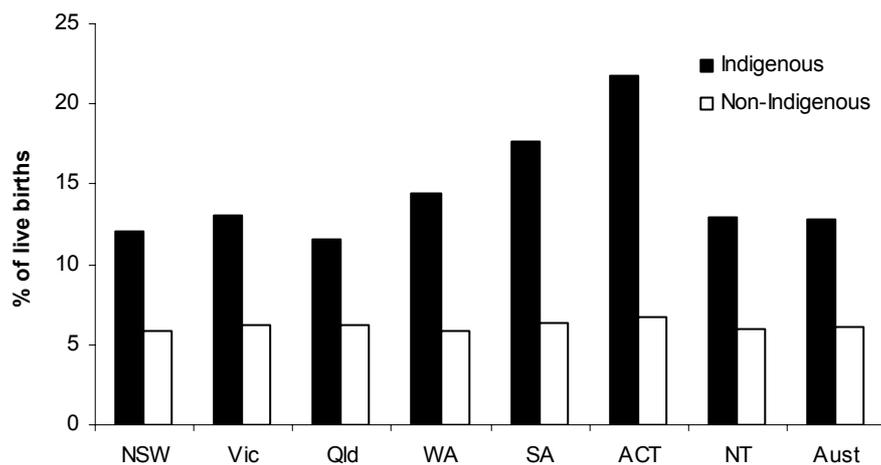
Babies born with a birthweight of less than 2,500 grams are classified as being of 'low birthweight'. Low birthweight may be a result of pre-term birth, foetal growth retardation, or a combination of the two (Alberman 1994). There are a range of factors that can affect a baby's birthweight, including socioeconomic disadvantage, the size and age of the mother, the number of babies previously born to the mother, the mother's nutritional status, smoking and other risk behaviours, illness during pregnancy, presence of a multiple birth and the duration of pregnancy.

Data

The data on the birthweight of babies are collected by the AIHW National Perinatal Statistics Unit. The data are likely to underestimate the number of births to Indigenous mothers, because Indigenous status is not always recorded in these data collections.

Three years of data were combined in order to smooth out yearly fluctuations in the number of births to Indigenous mothers, which can cause volatility in rates. Data on low-birth weight babies were not available from Tasmania and care should be taken in interpreting data from the Australia Capital Territory due to small numbers.

- In the period 2000–02, the proportion of low-birthweight babies born to Indigenous mothers in Australia was more than twice as high as the proportion born to other Australian mothers (12.9% compared to 6.1%).
- The proportion of low-birthweight Indigenous babies ranged from 11.6% in Queensland and 12.0% in New South Wales to 17.7% in South Australia and 21.8% in the Australian Capital Territory.



Notes

1. ACT data includes ACT and non-ACT residents that gave birth in the ACT. Among live-born babies of ACT resident Indigenous mothers who gave birth in the ACT, 10.9% weighed less than 2,500 grams and 89.1% weighed 2,500 grams or more.
2. Australia data excludes Tasmania as data were not available from this jurisdiction.

Source: AIHW National Perinatal Statistics Unit.

Figure 28.1: Proportion of low-birthweight babies, by mother's Indigenous status and state and territory, 2000-02

Indicator 29. Smoking prevalence

Indicator:

- (a) The proportion of Aboriginal and Torres Strait Islander adults aged 18 years and over who reported they were current smokers, by age and sex.
- (b) The proportion of Aboriginal and Torres Strait Islander adults who formerly smoked regularly (ex-smokers), by age and sex.

Purpose

Tobacco smoking increases the risk of coronary heart disease, stroke and peripheral vascular disease. It also increases the risk of a range of cancers including lung, oesophagus, kidney, pancreas and the cervix. Tobacco smoking during pregnancy can lead to spontaneous abortion, low birthweight and sudden infant death syndrome. Exposure to tobacco smoke (passive smoking) can also lead to serious health conditions such as heart diseases in adults and respiratory diseases in children.

Data

Data for this indicator came from the 2002 National Aboriginal and Torres Strait Islander Social Survey. Due to small numbers of Indigenous people surveyed in some states and territories, estimates should be interpreted with caution.

- In 2002, 53% of Indigenous persons aged 18 years and over reported they were current smokers, and a further 17% were ex-smokers (Table 29.1).
- The proportion of current smokers was higher for Indigenous males than for Indigenous females (55% compared with 51%).
- In 2002, the Northern Territory and Victoria had the highest proportion of current smokers (56%). The Australian Capital Territory and Victoria had the highest proportion of ex-smokers (22%) (Figure 29.1).
- Among males and females, the highest proportions of current smokers were among those aged 18–24 years and 25–34 years (around 58% and 57% among males and females respectively for both these age groups compared with 53% and 46% among males and females aged 35 years and over) (Figure 29.2).
- The highest proportions of ex-smokers were among those aged 35 years and over for both Indigenous males and females (23% and 21% respectively).
- In the Northern Territory, the proportion of Indigenous males who were current smokers was substantially higher than the proportion of Indigenous females who were current smokers (64% compared to 48% respectively).

Table 29.1: Smoking status of Indigenous adults aged 18 years and over, by age, sex and state and territory, 2002

	Current smokers			Ex-smokers		
	Males	Females	Persons	Males	Females	Persons
18–24 years	53.9	62.9	58.3	8.7 *	11.2 *	9.9 *
25–34 years	50.2	59.0	54.9	11.5 *	10.1 *	10.7
35 years and over	53.5	51.6	52.5	19.1	22.5	20.9
Total	52.8	55.7	54.3	15.0	16.9	16.0
Victoria						
18–24 years	54.5	66.8	60.6	7.8 *	14.1 *	10.9 *
25–34 years	52.7	56.3	54.6	26.0 *	12.5 *	18.9 *
35 years and over	51.4	58.1	54.9	32.0	23.6	27.6
Total	52.4	59.3	56.0	25.0	18.5	21.6
Queensland						
18–24 years	64.8	60.5	62.6	2.6 **	10.3 *	6.5 *
25–34 years	63.0	58.4	60.6	6.1 *	15.1 *	10.9
35 years and over	51.4	39.6	45.1	26.8	24.5	25.6
Total	57.6	49.3	53.2	15.7	18.9	17.4
Western Australia						
18–24 years	58.0	57.4	57.7	8.3 *	10.0 *	9.2
25–34 years	56.4	53.1	54.7	23.0 *	13.6 *	18.0
35 years and over	49.5	39.7	44.2	23.2	21.5	22.3
Total	53.2	47.2	50.0	20.2	16.8	18.4
South Australia						
18–24 years	49.8	47.9	48.9	4.1 **	7.2 **	5.7 *
25–34 years	57.5	53.1	55.2	12.6 *	15.8 *	14.3
35 years and over	49.9	46.3	48.0	34.7	20.5	27.1
Total	52.0	48.5	50.2	21.9	16.5	19.0
Tasmania						
18–24 years	54.5	33.6	43.2	11.7 **	13.1 *	12.5 *
25–34 years	58.3	46.7	52.1	7.5 *	19.5 *	13.9
35 years and over	47.1	45.9	46.5	33.9	20.3	27.0
Total	51.3	43.4	47.2	23.1	18.5	20.7
Australian Capital Territory						
18–24 years	64.1	64.1	64.1	21.0 **	12.7 **	16.4 *
25–34 years	34.2	57.2	45.6	16.0 *	11.9 *	14.0 *
35 years and over	39.4	37.5	38.5	30.8	29.4	30.1
Total	42.0	49.4	45.7	24.2	20.3	22.3
Northern Territory						
18–24 years	59.3	41.1	50.0	9.6 *	5.1	7.3 *
25–34 years	67.2	57.3	62.2	8.5 *	5.8	7.1 *
35 years and over	65.2	45.5	54.7	12.6	8.3	10.3
Total	64.4	48.0	55.9	10.7	6.9	8.7

(continued)

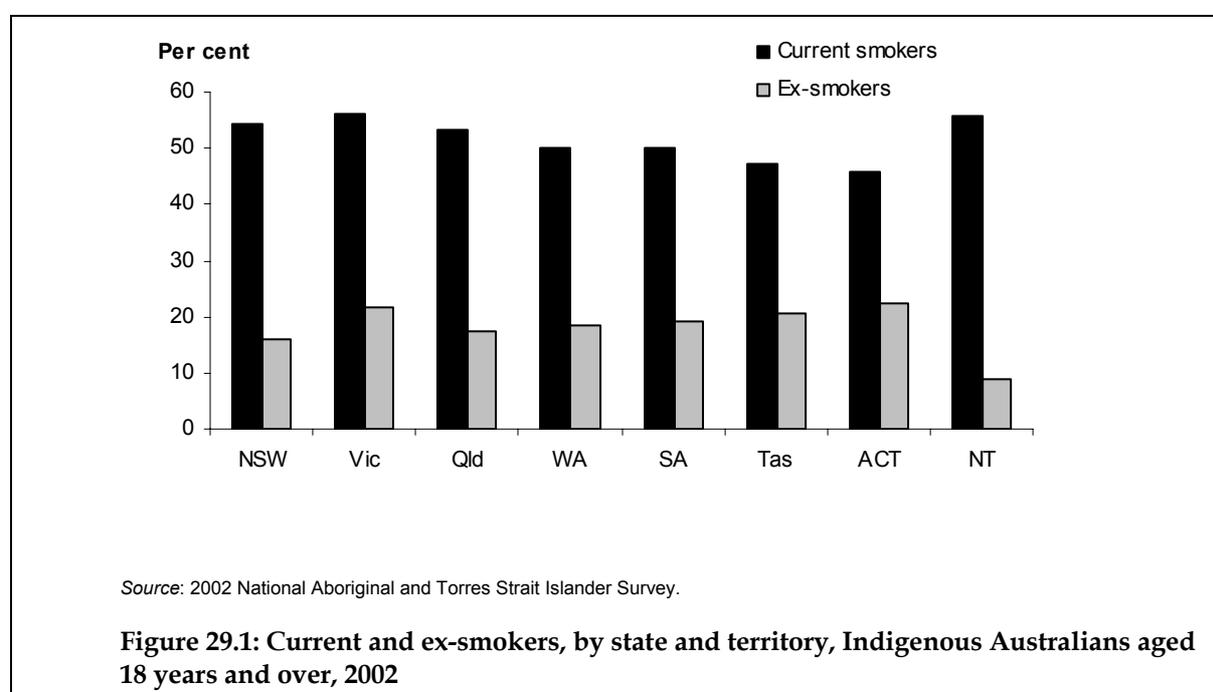
Table 29.1 (continued): Smoking status of Indigenous adults aged 18 years and over, by age, sex and state and territory, 2002

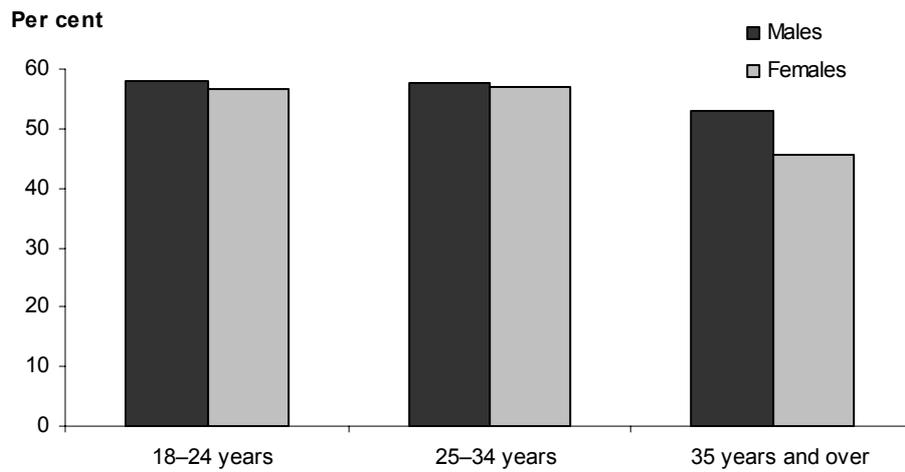
	Current smokers			Ex-smokers		
	Males	Females	Persons	Males	Females	Persons
Australia						
18–24 years	58.0	56.5	57.2	7.0	9.9	8.5
25–34 years	57.7	56.9	57.3	12.1	12.2	12.2
35 years and over	53.1	45.7	49.2	23.3	21.1	22.2
Total	55.4	51.1	53.1	16.7	16.3	16.5

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: ABS National Aboriginal and Torres Strait Islander Social Survey 2002.





Source: 2002 National Aboriginal and Torres Strait Islander Survey.

Figure 29.2: Current smokers, by age and sex, Indigenous Australians aged 18 years and over, 2002

Indicator 30. Alcohol consumption

Indicator:

- (a) The proportion of Aboriginal and Torres Strait Islander people aged 18 years and over who consumed alcohol in the week before the survey, by age and sex.
- (b) The proportion of Aboriginal and Torres Strait Islander drinkers aged 18 years and over who reported drinking at levels of medium or high risk in the week before the survey.

Purpose

While low levels of alcohol consumption appear to protect against some illness in adulthood, including coronary heart disease, stroke and hypertension, excessive use can lead to harm both in the short and long term. Binge drinking can increase the risk of injury due to falls, assault, road accidents, fights and violence. Long-term excessive alcohol use can lead to alcohol addiction, poor diet, and stomach and liver problems as well as emotional and financial problems.

Data

States and territories were originally asked to provide data for this indicator but there were no consistent data available, and data from the ABS were therefore used. These data come from the 2002 National Aboriginal and Torres Strait Islander Social Survey and are not comparable with data on alcohol consumption from the 2001 National Health Survey published in the previous edition of this report. While the National Health Survey collected information on average daily consumption of alcohol in the week prior to interview, the NATSISS data are for usual consumption on a drinking day in the 12 months before interview, and the largest quantity of alcohol consumed in a single day in the 2 weeks before interview.

Due to small numbers of Indigenous people surveyed in some states and territories, estimates should be interpreted with caution.

Proportion who consumed alcohol

- In 2002, 69% of Indigenous persons aged 15 years and over reported having consumed alcohol in the 12 months prior to survey (Table 30.1).
- Among Indigenous people, 76% of males compared to 64% of females consumed alcohol in the last 12 months.
- The highest proportion of drinkers was among those aged 25–34 years (82% of males and 70% of females in this age group consumed alcohol in the last 12 months).
- The Australian Capital Territory had the highest proportion of Indigenous persons who reported they consumed alcohol in the 12 months prior to survey (85%), followed by Tasmania (81%). The Northern Territory had the lowest proportion of Indigenous persons who consumed alcohol (43%) (Figure 30.2). This jurisdictional variation could partially be explained by the high proportion of Indigenous people living in rural and remote areas of Australia within the Northern Territory compared to the small, mainly urban Indigenous populations living in the Australian Capital Territory and Tasmania.

Proportion of drinkers who consumed alcohol at risky/high-risk levels

- In 2002, of all people surveyed (drinkers and non-drinkers) approximately 35% of Indigenous people consumed alcohol at risky/high-risk levels in the 2 weeks prior to survey and 15% consumed alcohol at risky/high-risk levels in the 12 months prior to survey.
- Of the Indigenous people who consumed alcohol, 59% of males and 41% of females did so at a risky/high-risk level in the 2 weeks prior to survey (Table 30.1). In Western Australia, South Australia and the Northern Territory, 53% of Indigenous people who consumed alcohol in the 12 months prior to survey reported they had done so at a risky/high-risk level in the last 2 weeks.
- Of those who consumed alcohol, males were more likely to drink at risky/high-risk levels than females across all age groups (Figure 30.1).

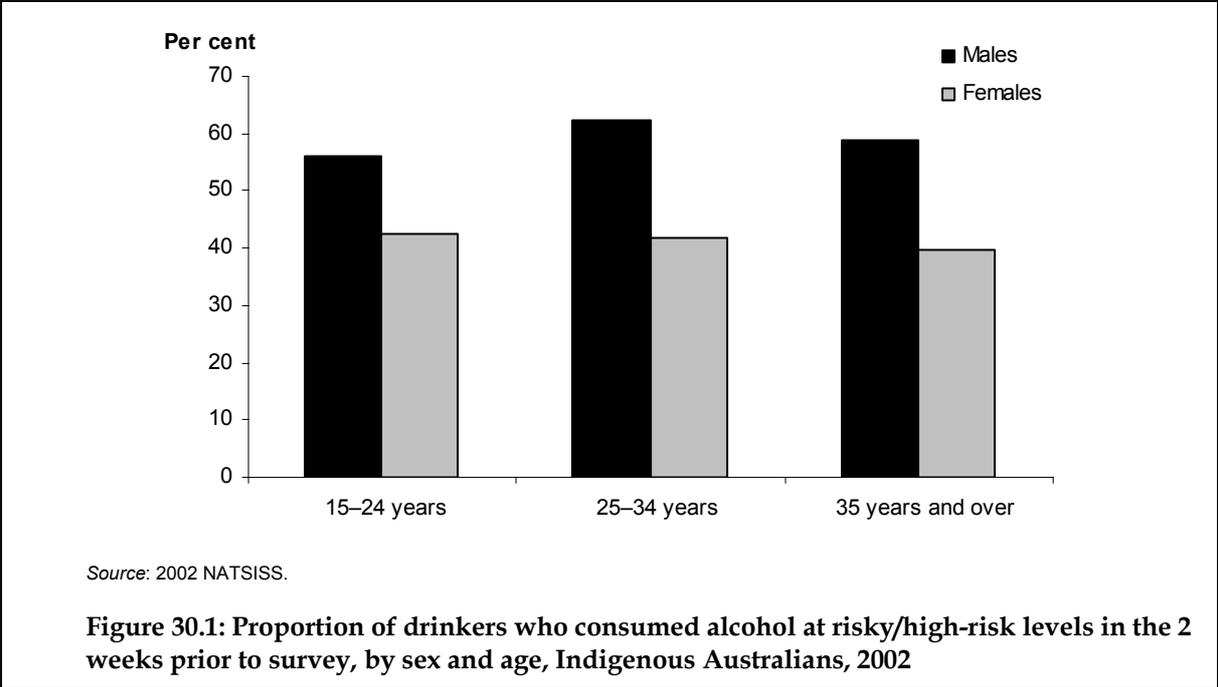


Table 30.1: Indigenous persons aged 15 years and over: by whether consumed alcohol and drank at risky/high-risk levels, by age and sex, 2002

	% of population who drank in 12 months prior to survey ^(a)			% of those who drank at risky/ high-risk levels in 2 wks prior to survey as a % of total population who drank in 12 mths prior to survey ^(b)		
	Males	Females	Persons	Males	Females	Persons
	Proportion (%)					
New South Wales						
15–24 years	78.2	75.2	76.7	54.6	44.3	49.7
25–34 years	84.0	74.7	79.0	57.1	45.6	51.2
35 years and over	76.6	66.8	71.5	57.3	41.8	49.8
Total	78.8	71.0	74.8	56.5	43.5	50.1
Victoria						
15–24 years	82.1	79.2	80.7	51.9	36.3	44.3
25–34 years	87.9	76.5	81.9	53.1	44.9	49.1
35 years and over	76.3	60.2	67.8	46.9	37.6	42.6
Total	81.0	69.7	75.2	50.1	39.3	44.9
Queensland						
15–24 years	74.6	67.2	70.9	59.7	40.7	50.5
25–34 years	86.9	75.9	81.0	72.2	36.1	54.1
35 years and over	75.5	57.1	65.7	60.8	37.7	50.0
Total	78.2	65.0	71.2	63.7	38.1	51.4
Western Australia						
15–24 years	77.5	69.9	73.6	55.9	47.6	51.9
25–34 years	78.6	77.3	77.9	66.1	42.1	53.5
35 years and over	77.0	58.8	67.3	63.9	39.6	52.5
Total	77.6	66.7	71.8	62.0	42.7	52.6
South Australia						
15–24 years	74.0	69.5	71.7	61.3	43.6	52.8
25–34 years	84.1	72.4	77.9	61.9	46.5	54.3
35 years and over	73.5	55.6	63.9	58.3	45.9	52.5
Total	76.3	63.7	69.7	60.2	45.3	53.1
Tasmania						
15–24 years	79.1	79.7	79.4	50.6	38.5	44.4
25–34 years	90.5	84.2	87.1	62.1	22.9	41.9
35 years and over	84.1	76.2	80.1	46.5	27.3	37.3
Total	83.8	79.1	81.4	51.2	29.8	40.5
Australian Capital Territory						
15–24 years	81.4	91.7	86.6	55.0	47.8	51.2
25–34 years	86.8	91.6	89.2	41.6	39.6	40.6
35 years and over	81.5	82.1	81.8	52.6	37.7	45.3
Total	83.0	87.6	85.3	50.0	41.4	45.6

(Continued)

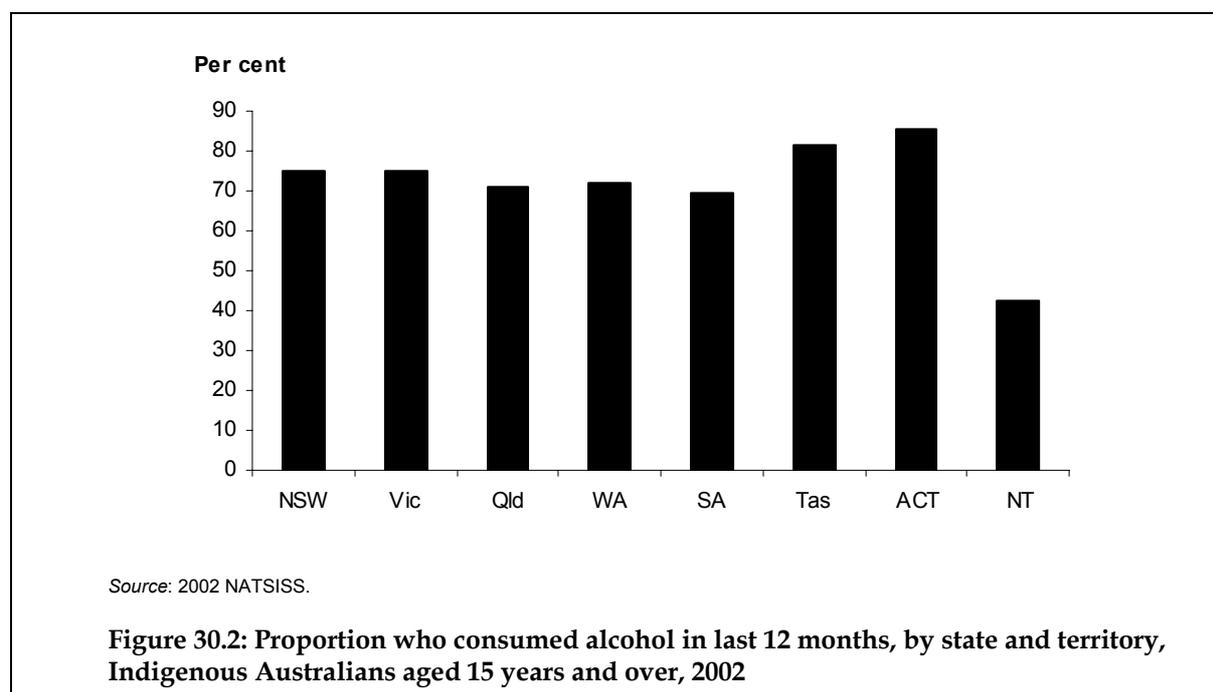
Table 30.1 (continued): Indigenous persons aged 15 years and over: by whether consumed alcohol and drank at risky/high risk levels, by age and sex, 2002

	% of population who drank in 12 months prior to survey ^(a)			% of those who drank at risky/ high risk levels in 2 wks prior to survey as a % of total population who drank in 12 mths prior to survey ^(b)		
	Males	Females	Persons	Males	Females	Persons
Northern Territory						
15–24 years	49.5	25.1	37.4	51.8	37.1	46.9
25–34 years	68.5	31.8	49.8	53.5	56.4	54.4
35 years and over	50.0	34.0	41.5	65.7	41.6	55.2
Total	55.0	30.8	42.5	57.6	44.6	52.7
Australia						
15–24 years	73.4	65.9	69.6	56.0	42.6	49.6
25–34 years	82.3	70.2	75.9	62.3	41.8	52.3
35 years and over	73.4	58.6	65.6	58.7	39.6	49.7
Total	75.6	63.6	69.4	58.8	41.1	50.4

(a) Based on a person's reported usual daily consumption of alcohol and the frequency of consumption in the 12 months prior to survey

(b) Based on the greatest number of drinks consumed in a single day in the 2 weeks before interview.

Source: ABS National Aboriginal and Torres Strait Islander Social Survey 2002.



Indicator 31. Overweight and obesity

Indicator: The proportion of Aboriginal and Torres Strait Islander adults aged 18 years and over with a body mass index (BMI) in the overweight and obese category, by sex.

Purpose

Being overweight or obese is a risk for a number of chronic diseases including Type 2 diabetes, coronary heart disease, high blood pressure, stroke and certain types of cancer. Obesity can lead to premature deaths from certain chronic conditions.

Data

States and territories were originally asked to provide data for this indicator but there were no consistent data available, and data from the ABS were therefore used. These data come from the 2001 National Health Survey. Due to small numbers of Indigenous people in the survey only national totals can be provided.

BMI is weight (kg)/height (metres) squared. Overweight is a BMI of 25 to less than 30, and obese is a BMI of 30 and over.

Table 31.1: Weight status^(a): Indigenous adults aged 18 years and over based on body mass index^(b), Australia, 2001

Weight status	Males		Females		Total	
	%	RSE (%)	%	RSE (%)	%	RSE (%)
Normal range or less	35	7	31	7	33	5
Overweight	30	9	22	9	26	7
Obese	22	10	22	7	22	6
Unknown	13	..	25	..	19	..
Total	100	2	100	1	100	1

(a) These data are based on self-reported height and weight.

(b) Overweight and obesity are measured by the body mass index (BMI), a measure of the person's weight relative to their height (weight in kilograms divided by height in meters squared: kg/m²). A BMI of between ≥ 25 and < 30 defines overweight while a BMI of ≥ 30 defines obesity.

Note: RSE refers to the relative standard error of the estimates.

Source: ABS National Health Survey 2001.

- Almost one in two Indigenous people (48%) aged 18 years and over were reported to be overweight or obese.
- A higher proportion of Indigenous adult males than females was reported to be overweight or obese (52% compared with 44%).

Indicator 32. Child abuse and neglect

Indicator: The number and rate of Aboriginal and Torres Strait Islander children aged 0–16 years who are subject to a substantiation of child abuse or neglect, compared to non-Indigenous children.

Purpose

This indicator provides a broad measure of the rates of Indigenous children who were abused, neglected or otherwise harmed, relative to the non-Indigenous population. This is a risk factor for poor health and wellbeing.

Data

A 'substantiation' is a report of child abuse or neglect or harm to a child that is investigated and formally confirmed by a legally recognised child protection agency.

Major differences exist in child protection policies and practices across states and territories and these are reflected in the child protection data. The data from the states and territories are therefore not strictly comparable and should not be used to compare jurisdictions. In addition, the practices used to identify and record the Indigenous status of children varies across states and territories, with some states and territories recording a large number of unknowns. The quality of the data on Indigenous status has, however, improved over the last few years (see Box 32.1).

Data for 2003–04 are presented for this indicator.

Table 32.1: Children in child protection substantiations: number and rates per 1,000 children, by Indigenous status, by state and territory, 2003–04

State/territory	Number of children			Rate per 1,000 children			Rate ratio ^(b)
	Indigenous	Other ^(a)	Total	Indigenous	Other ^(a)	Total	
NSW	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Vic	700	6,323	7,023	57.7	5.9	6.4	9.8
Qld	1,192	11,481	12,673	20.8	13.6	14.0	1.5
WA	322	599	921	11.2	1.4	2.0	8.0
SA	441	1,499	1,940	39.9	4.7	5.9	8.4
Tas	12	317	329	1.6	3.1	3.0	0.5
ACT	44	441	485	25.3	6.2	6.7	4.1
NT	375	116	491	16.2	3.5	8.7	4.7

(a) Includes children for whom Indigenous status was not stated.

(b) Rate ratio is equal to the rate for Indigenous children divided by the rate for other children.

Notes

1. Children aged 0–16 years. Due to the small numbers involved, children aged 17 years were not included in this table.
2. Data from Tasmania should be interpreted carefully due to the low incidence of workers recording Indigenous status at the time of the substantiation.
3. NSW was unable to provide these data due to the ongoing implementation of the data system.
4. Rates per 1,000 are calculated using the 'low series' ABS population projections based on the 2001 Census.

Source: AIHW 2005a.

- Aboriginal and Torres Strait Islander children were much more likely to be the subject of child protection substantiations than other Australian children.
- In 2003–04, in all states and territories except New South Wales, for which data could not be provided, and Tasmania, the substantiation rate for Indigenous children was higher than the rate for other children.
- In Victoria, the rate of Indigenous children in substantiations was nearly 10 times higher than the rate for other children, while in Western Australia and South Australia it was around 8 times higher. These higher rates may in part be related to the quality of the data on Indigenous status (see Box 32.1).
- In the Northern Territory the rate for Indigenous children was 4.7 times higher than the rate for other Australian children and in the Australian Capital Territory it was 4.1 times higher.

Box 32.1: Data issues

The variation in the rate ratios across states and territories may in part reflect differences in the quality of the data on Indigenous status due to differences in practices adopted to identify and record Indigenous status. Some states and territories are using the standard ABS question (for example, Queensland has just introduced this as a requirement for all child protection workers) but in others the information appears to be acquired in a more ad hoc way. Although the Indigenous status field is mandatory in all states and territories, there is a 'not known' option when entering the information onto the data system in all jurisdictions except Victoria. The proportion of 'unknowns' varies considerably across states and territories.

The quality of the child protection data on Indigenous status has improved in recent years as states and territories have introduced measures to improve the identification of Indigenous children in the child protection system. For example, in New South Wales in 1998–99 and in Western Australia in 2001–02 practices were introduced to improve the identification of Indigenous children and this resulted in an increase in the number of children who were identified as Indigenous in both states.

A number of states and territories are currently undertaking work to improve the quality of the Indigenous child protection data such as through the adoption of the standard ABS question to identify Indigenous status.

Indicator 35. Injuries presenting to hospital accident and emergency facilities

Indicator: The proportion of consultations at accident and emergency facilities by Aboriginal and Torres Strait Islander people that are for acute injury conditions.

Purpose

The indicator provides an estimate of the frequency of injury of sufficient severity to seek hospital care and reflects access of Aboriginal and Torres Strait Islander peoples to hospital.

Data

Information for this indicator was obtained from the states and territories. While only four states and territories could provide data for this indicator in the last reporting round, six jurisdictions provided data for the current reporting period which suggests improved ability to distinguish injury from non-injury presentations in emergency department data in recent years. However, there are still problems with the quality of the data provided by some jurisdictions. For example, data from Queensland are from only 14 hospitals, and Western Australia, the Australian Capital Territory and the Northern Territory were only able to report total injury attendances and not the cause of the injury. In addition, the data provided are not comparable across states and territories because of differences in the coding systems for cause of injury that were used.

- In New South Wales, Victoria, Western Australia and the Australian Capital Territory, around one-fifth to one-quarter of presentations at hospital and emergency facilities by Aboriginal and Torres Strait Islander people were due to acute injuries – in New South Wales they represented 21% of presentations in 2002–03 and 20% of presentations in 2003–04; in Victoria they represented 23% of presentations for the 2 years; in Western Australia they represented 22% in 2002–03 and 24% in 2003–04 and in the Australian Capital Territory they represented 21% of presentations for the 2 years (Table 35.1).
- In these states, almost three-quarters of Indigenous presentations to hospital emergency and accident facilities were therefore not due to injury. This is consistent with other findings that suggest that Indigenous people frequently use accident and emergency facilities as an initial point of contact for their health concerns, rather than GPs, or that they suffer more acute episodes of other conditions.
- In the Northern Territory, around 6% of presentations at hospital and emergency facilities by Indigenous people were due to injuries.
- In Victoria, most injury presentations by Indigenous people were for ‘other accidents’, which are accidents not attributable to transport accidents (82% in 2002–03, 79% in 2003–04), followed by assault (9.1% in 2002–03 and 10.7% in 2003–04).
- In Queensland, one-quarter (25%) and one-fifth (20%) of injury presentations were for assault in 2002–03 and 2003–04 respectively.
- The variation between states and territories in the cause of injury presentations may reflect differences in methods used for the coding of injuries.
- New South Wales Health collects data from over 50 emergency departments across the state. While this represents just over one-third of all emergency departments, it covers around two-thirds of total presentations. Rural emergency departments are

under-represented in the collection. This incomplete and unequal coverage invalidates reporting on this indicator at a state level. In addition, a number of studies have shown that Aboriginal people are under-identified in emergency department injury data (eg AIHW 2005b).

Table 35.1: Aboriginal and Torres Strait Islander presentations at hospital accident and emergency facilities, for selected states and territories, by cause of injury, 2002–03 and 2003–04

	NSW ^(a)		Vic ^(b)		Qld ^(c)		WA ^(d)		ACT ^(e)		NT ^(f)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
2002–03												
Road vehicle-related injury	n.a.	n.a.	128	5.7	129	4.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Other accidents	n.a.	n.a.	1,861	82.3	1,876	67.8	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Self-harm	n.a.	n.a.	66	2.9	74	2.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Assault	n.a.	n.a.	205	9.1	687	24.8	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total injury presentations	7,762	100	2,260	100	2,766	100	2,918	100.0	295	100	6,349	100
All accident and emergency presentations	37,194	20.9	9,789	23.1	n.a.	n.a.	13,399	21.8	1,426	20.7	100,754	6.3
2003–04												
Road vehicle-related injury	n.a.	n.a.	158	6.3	166	6.3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Other accident	n.a.	n.a.	1,979	78.9	1,856	70.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Self-harm	n.a.	n.a.	102	4.1	67	2.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Assault	n.a.	n.a.	269	10.7	536	20.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total injury presentations	8,211	100	2,508	100	2,625	100	3,411	100	304	100	6,211	100
All accident and emergency presentations	40,970	20.0	11,106	22.6	n.a.	n.a.	14,459	23.6	1,440	21.1	102,495	6.1

- (a) Injury and poisoning-related emergency department visits were selected using the principal provisional diagnosis assigned to the visit (ICD-9-AM codes 800–999). Aboriginal people may be under-identified in this data collection. Diagnoses are not coded by trained coders and should therefore be considered indicative only. Information on cause of injury are therefore not available.
- (b) Data collected through the Victorian Emergency Minimum Dataset is coded by a composite of Injury Cause and Human Intent data fields.
- (c) Data from the Queensland Injury Surveillance. Data are from 14 hospitals which comprise three sample regions: metropolitan (South Brisbane); regional (Mackay and Moranbah Health Districts) and remote (Mt Isa).
- (d) Western Australia was not able to provide data by cause of injury.
- (e) Causes of injuries are not recorded. ICD-9 Codes 800–960 and ICD-10 Codes S00–T14 were used to identify primary diagnosis of 'injury'.
- (f) Injury presentations are classified on the basis of 'body part' and not by cause of the injury. Specific ICD injury codes are not captured in enough detail to split the total figure into the categories required for this report. Injury presentations have been captured using the Presenting Problem as entered at the time of triage.

Source: Data provided by the jurisdictions.

Box 35.1: Data issues

The data provided by some of the states and territories were not comparable as different classification systems were used and coverage of Indigenous hospitalisations in emergency departments is not complete in all reporting states and territories and thus Indigenous people are likely to be under-enumerated. Some states and territories could not provide quantitative data for this indicator.

The purpose of this indicator is to measure frequency of injury and access of Indigenous people to hospitals, but there is no comparison group specified for the indicator. A more useful measure would be injury presentations in hospital emergency sections per 100,000 populations for Indigenous Australians and other Australians, classed by severity.