

# Government inputs

## **Indicator 1**

Efforts to improve identification of Aboriginal and Torres Strait Islander people in data collections.

## **Indicator 2**

Government expenditure on health services for Aboriginal and Torres Strait Islander people.

## **Indicator 4**

Government expenditure on, and description of, selected health promotion programs.

The following indicator currently cannot be reported on:

## **Indicator 3**

Government expenditure on health services for Aboriginal and Torres Strait Islander people living in small homeland communities and outstations.

## Introduction

The domain 'Government inputs' has four indicators – one on efforts to improve Indigenous identification in data collection and three on government expenditure on health services for Aboriginal and Torres Strait Islander people. These provide a broad indication of state and territory government inputs in relation to expenditure and data development in the Indigenous health area.

No data were provided for Indicator 3 – government expenditure on health services for Aboriginal and Torres Strait Islander people in small homeland communities and outstations. This was because states and territories do not record data in a way that isolates expenditure on small communities from other health expenditure. Nor is it possible to isolate expenditures incurred through some mainstream programs funded by the Australian Government, such as Medicare and the Pharmaceutical Benefits Scheme (PBS).

The states and territories provided the data for two of the indicators: Indicator 1 on the efforts to improve Indigenous identification and Indicator 4 on government expenditure on health promotion programs. For Indicator 1, only descriptive information is provided, but Indicator 4 includes both quantitative and descriptive data. There were problems associated with the data for Indicator 4 as it was difficult to apply a consistent definition of health promotion programs across states and territories and the Australian Government. It is recommended that the data for this indicator are aligned with data collected through the National Public Health Expenditure project as this would facilitate consistent reporting.

The data for Indicator 2 on government expenditure on health services came from a previous AIHW publication on expenditure on health services for Aboriginal and Torres Strait Islander people (AIHW 2005b). There are some issues with the data for this indicator including the under-identification of Indigenous people in health databases and the distinction between government funding and expenditure.

# **Indicator 1. Efforts to improve identification of Aboriginal and Torres Strait Islander people in data collections**

**Indicator:** A description of actions undertaken by the states and territories to improve the identification of Aboriginal and Torres Strait Islander people in the datasets used for reporting on the indicators.

## **Purpose**

The indicator provides information about the adequacy of recording Aboriginal and Torres Strait Islander health status in health-related datasets, identifies datasets that are considered reliable sources of information about Indigenous health and describes action taken to improve the identification of Indigenous peoples in health-related data.

## **Data**

The technical specifications for this indicator request that information be provided on progress towards Indigenous identification in eight administrative data sources – birth registrations, death registrations, hospital separation statistics, Pap smear registries (which is included under Indicator 25), Perinatal data collections, Equal Employment Opportunity (EEO) and other workplace surveys, notifiable disease registries, and pathology forms. Information for this indicator was provided by the states and territories and national data custodians. Information on the role of the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data and the role of the ABS in counting and estimating the Indigenous population in the Census is also provided below.

## **National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data**

The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) plays a very important role in improving the quality of Indigenous data. The group was established in October 2000 to provide broad strategic advice to the National Health Information Management Group (NHIMG) on the quality and availability of data and information on Aboriginal and Torres Strait Islander health and health service delivery. The advisory group was established to draw together the range of existing activities already underway into a coordinated and strategic process.

The advisory group is responsible for:

- advising the Aboriginal and Torres Strait Islander Health and Welfare Information Unit on priorities in its work plan
- providing advice to NHIMG and the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) on the national performance indicators and targets for Aboriginal and Torres Strait Islander health jurisdictional reporting and associated activities
- continuing the implementation of the National Indigenous Health Information Plan. This includes monitoring and improving Indigenous identification in a range of administrative datasets that include information on Indigenous health and service use.

In 2003, new governance arrangements for health information were set up and NAGATSIHID became a direct committee of the National Health Information Group. NHIMG became the Statistical Information Management Committee (SIMC).

The NAGATSIHID work program encompasses a broader range of datasets than those specified for this indicator, including population enumeration, national community mental health care, general practice, and alcohol and other drug treatment services. The datasets reported below are those specified by Indicator 1.

## **The Census of Population and Housing**

The Census of Population and Housing forms the centrepiece of ABS statistics on the characteristics of Aboriginal and Torres Strait Islander peoples. The Census also provides the basis for Indigenous population estimates. As in previous censuses, the ABS made considerable efforts to achieve an accurate count of Aboriginal and Torres Strait Islander peoples in 2001. The Census Indigenous Enumeration Strategy included collection procedures and awareness activities designed to address potential cultural barriers for Indigenous persons and to encourage their participation. It recognised the important role of consultation, liaison with Indigenous organisations and communities, and Indigenous involvement in all aspects of the collection process.

In 2001, 410,000 Aboriginal and Torres Strait Islander people were counted in the census. After adjusting for net undercount and Census records where Indigenous status was unknown, the estimated Indigenous population was estimated to be 458,000. Nationally, the total net undercount for the 2001 Census was 1.8%.

The undercount of Aboriginal and Torres Strait Islander peoples was estimated at 6.1%, compared with just over 7% in 1996.

Projections of the resident Indigenous population based on 1996 Census data were published in 1998. A high series and a low series were produced which were based on different assumptions about the level of unexplained growth in the Indigenous population. Estimates of the Indigenous population based on 2001 Census data show that the observed population growth for the intercensal period fell within the expected range.

Between 1996 and 2001, the Census count of Indigenous people increased by 16%, and about 12% of this growth can be explained by demographic factors (births and deaths). Overall growth in the Indigenous population in this period was lower than that observed between the 1991 and 1996 Censuses (33%), and the share of growth that could not be explained by demographic factors during this period also declined, from over half of the growth between 1991 and 1996 to one-quarter of growth from 1996 to 2001.

## **Birth registrations**

Birth registrations, from the Registrar of Births, Deaths and Marriages in each state and territory, provide information about both parents' Indigenous status. It is a legal requirement that all births are registered, but this does not always occur and in some cases the registration is incomplete, late or missing. Indigenous status may also be incorrectly recorded. Indigenous status is therefore underreported in birth registrations. The data on Indigenous births from all states and territories combined, however, are considered to be of sufficient coverage for statistical reporting.

## **National**

The ABS is responsible for coordinating efforts to improve the national data on births, deaths and marriages and continues to work with state and territory registrars to improve the quality of the data in all states and territories. Some jurisdictions have established data linkage projects between the Registry of Births, Deaths and Marriages and the perinatal data collection to resolve discrepancies between the two data sources.

## **New South Wales**

Indigenous identification in birth data is expected to improve with the electronic transfer of birth registration data from New South Wales public hospitals to the NSW Registry of Births Deaths and Marriages. The Registry will be able to follow up on unregistered births, a significant number of which are known to be Indigenous. The transfer of birth data was trialed during 2004 and from March 2005, the Registry commenced using the data to follow up unregistered births.

## **Victoria**

There are five datasets recording Aboriginal births in Victoria. No Victorian dataset currently records all Victorian births as Aboriginal. Two datasets record the Indigenous status of both parents: the Registrar of Births, Deaths and Marriages and Maternal and Child Health Service. The Perinatal Data Collection Unit records only the identification of the mother. The Victorian Admitted Episodes Dataset records the delivery to the mother. Some Victorian hospitals also ask about the father's or baby's identification, as well as the mother's. Koori Hospital Liaison Officers (KHLOs) record all births to Indigenous mothers or fathers in 16 hospitals and report directly to the Department of Human Services.

The Maternal and Child Health Service receives notifications from hospitals according to the mother's place of residence. All mothers are visited at home in the first week and information including Aboriginal status is collected at that time. Collecting information in this setting is believed to have contributed to the consistently high level of babies identified as Aboriginal.

Changes to the method of funding Aboriginal services in hospitals, commencing in July 2004, are expected to produce improvements in the identification of Aboriginal patients, including babies, in hospital admissions systems.

When comparing birth numbers with the number of children identified as Aboriginal in the first year of school (Prep) by the School Nursing Service (Department of Human Services) 6 years later, there is a substantial under-identification of Indigenous births. For example, in 2004, there were approximately 23% more children identified as Aboriginal by the School Nursing Service as by the Registry of Births Deaths and Marriages for 6 years earlier (1996).

Data in births datasets are compared annually to measure the level of under-identification. When possible, data are matched at unit level across datasets.

## **Queensland**

A variety of promotional and data quality exercises have been undertaken by Queensland Health in conjunction with the Registrar-General, Births, Deaths and Marriages. Further joint activities are planned with the Registrar-General's Office under the Queensland Government implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health.

## **Western Australia**

The ABS has continued to provide the WA Registrar of Births, Deaths and Marriages with promotional material, and has developed information and training sessions that can be conducted for both Registry staff and providers of information.

## **South Australia**

In the South Australian perinatal data collection notified by hospital and homebirth midwives to the Pregnancy Outcome Statistics Unit of the Department of Health, recording of Aboriginal and Torres Strait Islander status is undertaken in the manner recommended by the ABS. Guidelines are provided to midwives, also as recommended by the ABS. However, it is not known how this is implemented at the data collection point by individual hospitals and homebirth midwives. The South Australian perinatal data collection, as in all Australian states, only collects Aboriginal and Torres Strait Islander status for the mother, and reports on births to Aboriginal mothers. This differs from the data collection of birth registrations of the South Australian Births, Deaths and Marriages Registration Division, which is used by the ABS, in that Aboriginal and Torres Strait Islander births may be identified for both mother and father. While no efforts have been made recently to improve identification of Indigenous people in this data collection, the Pregnancy Outcome Statistics Unit is hoping to look at identification in conjunction with the Births, Deaths and Marriages to compare the two data collections with regards to Indigenous status of births in the near future.

## **Tasmania**

The ABS continues to work with the Registrar of Births and Deaths on improving the identification of Aboriginal and Torres Strait Islander peoples in birth registrations through quarterly meetings of the Aboriginal and Torres Strait Islander Data Working Group. The Department of Health and Human Services and Department of Education are also involved in these meetings.

## **Australian Capital Territory**

When compared with ABS experimental estimates (low series), only 62% of Aboriginal and Torres Strait Islander births are recorded as such on the ACT Register (average 65 per annum 1998–2003). ACT Health is considering the possibility of including the Aboriginal and Torres Strait Islander identifier as a mandatory field on birth notifications and registrations, via amendments to the Births, Deaths and Marriages Regulations. ACT Health will also monitor progress at the national level, on the proposal to record the Aboriginality of the father on the Maternal Perinatal Data Collection; this collection is considered to have a high level of reliability in the ACT and will provide a valuable source of cross-reference against birth registrations.

## **Northern Territory**

The Northern Territory uses a shared Client Master Index (CMI) to manage patient demographic data in almost all of the Department of Health and Community Services databases. CareSys, which is used in all five hospitals, acts as the master index and is linked to the Community Care Information System and Primary Care Information System. All three applications have the ability to register new clients as well as update existing registration details. This linking provides a very high level of data quality as the patient information is not just entered and updated by a single source and thus any incorrect recording of Indigenous status is greatly reduced.

## **Death registrations**

Like births, all deaths are required by law to be registered with the Registrar of Births, Deaths and Marriages. There is incomplete identification of Indigenous deaths in all states and territories; however, the data from Queensland, South Australia, Western Australia and the Northern Territory are currently considered to be of sufficient quality to enable statistics to be produced. For longer term analysis of Indigenous mortality, the data from South Australia, Western Australia and the Northern Territory are considered to be of sufficient quality for data analysis for the past 10 years.

## **National**

The ABS continues to work with state and territory Registrars of Births, Deaths and Marriages to improve the quality of the data in all states and territories. This includes ongoing publicity campaigns, which explain to the funeral industry the importance of accurate Indigenous identification. The various funeral directors' associations and individual members are also provided with literature promoting the ABS's standard Indigenous question and best practice in recording Indigenous status.

## **New South Wales**

In January 2002, the Department of Commerce's Office of Information Technology provided funding for the Birth and Death Information Transfer Project. This project delivers on-line medical certificate cause of death and medical certificate cause of perinatal death forms for use in public hospitals, as well as electronic notification of births that occur in public hospitals. The On-line Medical Certificate Cause of Death form (e-DC) continues to be trialed in two metropolitan public hospitals. State-wide release is expected in 2005. Under this project the medical practitioners in NSW public hospitals will enter data directly on to an electronic death certificate (e-DC) located on the NSW Health Intranet and this information will be sent regularly by secure on-line transfer to the Registrar of Births, Deaths and Marriages (RBDM).

It is anticipated that the introduction of the e-DC will contribute to improving the quality of Aboriginal and Torres Strait Islander origin information on death registrations. Demographic information, including Indigenous status, collected at hospital patient registration will be used to populate the form when completed by the doctor.

In 2002-03 communications with funeral directors were improved through forums held at the RBDM and birth registration forms were redesigned to include clearer instructions in relation to questions relating to the Indigenous origin of either parent.

## **Victoria**

Until 2003, deaths were recorded as Aboriginal according to the identification on the Notification of Death form provided to the Registrar of Births, Deaths and Marriages by the funeral director. Since 2004 Aboriginal status recorded on the Medical Certificate of Cause of Death can also be used for registration purposes. General practitioners and hospital doctors were targeted to improve completion of Aboriginal status on the death certificate.

Following a range of data quality audits at the Registrar of Births, Deaths and Marriages, the ABS has engaged in promotional activities aimed at improving the identification of Indigenous deaths. ABS has implemented an ongoing publicity campaign, which explains to the funeral industry the importance of accurate Indigenous identification. The various funeral directors' associations and individual members have received literature promoting the ABS standard Indigenous question and best practice in recording Indigenous status. The ABS has also spoken directly with a number of funeral directors in order to ascertain exactly why they are reluctant to ask the Indigenous status question.

Indigenous status is also recorded on the death certificate completed by a doctor but until 2003 this information was not used in the death registration. Efforts are being made to make greater use of this information. As such, doctors have been and will continue to be targeted regarding the need to complete the Indigenous status question on the death certificate.

## **Queensland**

A variety of promotional and data quality exercises have been undertaken by Queensland Health in conjunction with the Registrar-General, Births, Deaths and Marriages. Further joint activities are planned with the Registrar-General's Office under the Queensland Government implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health.

To formally register a death in Queensland, three different forms must be completed. Joint investigation with the Queensland Registrar-General of Births, Deaths and Marriages shows that many of the deaths that are incompletely registered are of Indigenous people. Queensland Health is currently working with the Registrar-General to investigate options to use these incomplete death registrations in reporting on deaths in the Indigenous population.

## **Western Australia**

See section on birth registrations.

## **Tasmania**

See section on birth registrations.

## **Australian Capital Territory**

The recorded rate of Aboriginal and Torres Strait Islander deaths in the Australian Capital Territory (an average of 1.5 per 1000) is less than half that of the non-Indigenous population, which indicates a very significant under-recording. ACT Health is investigating the possibility of including the Aboriginal and Torres Strait Islander identifier as a mandatory field on cause of death certification and death registration, via amendments to the Births, Deaths and Marriages Regulations.

## **Northern Territory**

In November 2003, the Department of Health and Community Services (DHCS) entered into an agreement with Births, Deaths and Marriages (BDM) to source the death data registered in the Northern Territory. At this time DHCS conducted an audit to update death data in the Client Master Index (CMI) back to 1980. The Royal Darwin Hospital Medical Records Manager is in charge of updating all death notifications from BDM. The other four hospitals within the Northern Territory have a daily report that provides the details of any patients in the CMI listed as deceased to ensure that the archiving of these records is up-to-date.

A Death Data Management Policy exists to govern the use of the death data received from BDM.

## **Hospital separation statistics**

### **National**

Data on hospitalisations are supplied to the AIHW by the state and territory health authorities. The collection of the data is undertaken by the AIHW under the auspices of the Australian Health Ministers' Advisory Council through the National Health Information

Agreement. The quality of the data on Indigenous status in hospital separation statistics has continued to improve due to the use of the *National Health Data Dictionary* definitions by all states and territories. However, further improvement is needed, with Indigenous data being considered of acceptable quality for only four states and territories in 2003–04 – South Australia, Western Australia, Queensland and the Northern Territory.

Recent work by the AIHW on the quality of Indigenous status data in hospital separations records has resulted in recommendations for appropriate analysis of Indigenous status data and for improving the quality of the data.

The analysis recommendations include that national analysis should be undertaken using data only from the Northern Territory, Western Australia, South Australia and Queensland. They also include that caveats should accompany the analyses noting that under-identification occurs and that the hospitalisation experience for Indigenous persons in those four jurisdictions may not necessarily reflect the hospitalisation experience of Indigenous persons from other jurisdictions. Also, that under-identification factors should not be applied to the data (except when required by the analytical purpose, such as estimation of the proportions of health expenditures that are on Indigenous and non-Indigenous persons), and that records for which Indigenous status is not reported should be regarded as being for non-Indigenous persons.

The recommendations for improving data quality include recommendations on data collection processes, on training of data collection staff, on organisational policies and practices and on ongoing data monitoring and audit activities. States and territories are already engaged in a range of similar initiatives aimed at improving the quality of Aboriginal and Torres Strait Islander origin information in hospital separations data.

## **New South Wales**

For 2002 to 2004, the New South Wales Health Department reported that its data were in need of improvement. To address this issue, the department continues to be active in the implementation of initiatives aimed at improving the quality of Indigenous origin information in hospital separations data. Departmental publications and circulars continue to be used to encourage a uniform approach to the identification of Indigenous patients in addition to providing a framework for continuous improvement in this data collection. To complement these strategies the Department has developed and implemented its Collecting Patient Registration Information Training Program. This training program raises awareness of data items, including Indigenous status, that may relate to sensitive issues and reviews strategies that may assist in the collection of complete and accurate patient registration information. This training program is being implemented in NSW Area Health Services.

Initially released in 2002, the training program is currently being reviewed to enable it to be used to improve quality of Indigenous data in other collections, for example, the state-wide Infant Screening for Hearing program.

## **Victoria**

The number of separations recorded as those of Aboriginal and Torres Strait Islander people has continued to increase each year, due both to natural increase and to the increased number of hospitals identifying Aboriginal patients correctly.

The Hospital Accreditation Project, which began in December 2001, aimed to develop a strategy for the accreditation of public hospitals in regard to the reporting of Aboriginal status and the provision of hospital services for Aboriginal and Torres Strait Islander patients. The project included a literature review, a report on the effectiveness of the existing Weighted Inlier Equivalent Separation (WIES) supplement (10%) for Aboriginal patients, the

development of appropriate quantitative and qualitative performance indicators, and the development of a methodology and implementation plan for hospital accreditation based on accurate recording of Indigenous status and the appropriateness of services provided.

The first part of the project was completed in December 2002 and recommended that:

- all acute care facilities be offered training related to the nature and applications of the quality framework
- appropriately skilled Aboriginal people should be in attendance at the training;
- a package of requirements be considered as the accreditation criteria for services to receive additional WIES payment, including reporting on Aboriginal service usage to Aboriginal community organisations
- all acute care services receiving WIES payment should have a continuous improvement process in place
- minimum acceptable standards be identified and accreditation would depend on meeting these standards.

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

- amalgamation of the formerly separate KHLO Program funding and the 10% Aboriginal WIES supplement into a single funding stream through WIES
- an increase in the Aboriginal WIES supplement to 30% for each Aboriginal patient
- a focus on cultural change in health services leading to improved identification and health care for Aboriginal patients.

It is expected that this will result in an increase in the number of patients identified as Aboriginal, which will be monitored by the Koori Human Services Unit.

## **Queensland**

Activities undertaken by Queensland Health to improve the quality of Indigenous identification on hospital separation records include: training hospital staff on the importance of identification; providing feedback to hospital staff with regard to performance in correctly recording patients' Indigenous status; and identifying a key contact within each health service district to take on the responsibility of promoting the need to accurately record Indigenous status.

Within the activities being implemented under the Indigenous Information Strategy Team, a program of hospital data quality audits will be carried out over the next few years to give a clear statewide picture of under-identification.

## **Western Australia**

A small internal working group has been established to review the progress of the implementation of the recommendations from the 'Assessing the quality of identification of Aboriginal and Torres Strait Islander people in Western Australian hospital data' report.

The ABS has given presentations and conducted sessions with relevant staff in country hospitals on the importance of Indigenous identification specific to regional hospitals.

## **South Australia**

In 2003-04, some South Australian hospitals considered strategies both for increasing self-identification of Aboriginal and Torres Strait Islander patients on admission, and sensitivity of

staff in undertaking admission procedures. These strategies included the review of admission forms, preparation of patient education brochures, and involvement of community representatives in redesign of patient care.

In 2002-03, the Department of Health provided training sessions to staff in metropolitan and country hospitals, based on a training package developed by the ABS. The sessions focussed on the importance of correct identification and the need to comply with the national standard for data capture. Further, the department's casemix payment system applies a 30% loading to Indigenous separations, which acts as an incentive for improved identification.

### **Tasmania**

In 2004, the Department of Health and Human Services through the Aboriginal Data Improvement Project conducted a series of training sessions on data collection throughout the agency aimed at improving the recording of Indigenous status in hospital records. These included the distribution of ABS posters and pamphlets on Indigenous identification.

### **Northern Territory**

The ABS continued to provide training sessions to hospital staff on how to ask the standard question on Indigenous status in an effort to improve the recording of Indigenous status in hospital records. The ABS has also prepared pamphlets for patients and staff on the 'why and how' of Indigenous status to increase staff awareness of the importance of recording Indigenous status correctly.

### **Australian Capital Territory**

Aboriginal and Torres Strait Islander hospital separations in the Australian Capital Territory are estimated to be approximately 45% under-identified. A project is being developed to identify and survey Aboriginal patients not identified on admission and determine the reasons for non-identification.

### **Perinatal collections**

Perinatal or midwives statistics include details of antenatal care, complications of pregnancy and labour, and neonatal health. The Indigenous status of the mother is identified in the National Perinatal Data Collection held at the AIHW, and in the perinatal collections in all states and territories. Most states and territories do not record any information about the father.

### **National**

The question of whether the Indigenous status of the father should be collected has been discussed by the National Perinatal Data Development Committee and was not supported. The committee considered it unlikely that reliable information on paternal Indigenous status could be captured through the state perinatal or midwives collections. Fathers may not be present at the birth and the data should therefore be collected from the mother (as the basis for collection of Indigenous status data is the mother identifying as Indigenous).

All jurisdictions are currently working towards improving the ascertainment of Indigenous status in their perinatal collections and this work needs to continue. It is recommended that 'Indigenous status' of the mother be reported in accordance with the *National Health Data Dictionary* data domains for all jurisdictions.

## **New South Wales**

Paternal Aboriginality is currently not included in the state perinatal data collection and there are currently no plans to do so. The National Perinatal Data Development Committee considers it unlikely that reliable information on paternal Indigenous status can be captured through the state perinatal/midwives collections. This is because the father may not be present at the birth and the data should not be collected from the mother (as the basis for collection is the individual identifying as Aboriginal). Also if a male person is present at the birth, that person may not be the baby's father.

However, NSW Health recognises that the Aboriginality of the baby depends on the Aboriginality of both mother and father. For this reason, NSW Health obtains information on paternal Aboriginality by linking perinatal data to the NSW Registry of Births, Deaths and Marriages birth registration data on an annual basis.

## **Victoria**

In Victoria, only 15% of babies registered as Indigenous have two Indigenous parents. Babies with Indigenous fathers and non-Indigenous mothers account for 40% of births registered as Indigenous. The inclusion of paternal identification in all birth datasets would increase the quantity and quality of data available on births.

Mercy Hospital for Women now asks about the Indigenous status of both parents on the pre-admission form. If the question is not answered on the form, the mother will be asked orally at the time of admission. The focus is on the identification of the baby rather than the father.

Although the perinatal collection does not record the father's identification, three other collections record the Aboriginal identification of both mother and father.

## **South Australia**

See section on birth registrations.

## **Tasmania**

At present, data on Indigenous status is not compliant with the specifications outlined in the *National Health Data Dictionary*. This is because the 'Not stated' category for Indigenous status is not able to be distinguished from the category of mothers who were neither Aboriginal or Torres Strait Islander. The Department of Health and Human Services in Tasmania is actively pursuing improvements in the collection and provision of Indigenous status data.

## **Australian Capital Territory**

The ACT is monitoring national moves to include paternal Indigenous identification in the Maternal Perinatal Data Collection.

## **Northern Territory**

The Indigenous status of mothers is identified in the perinatal data collection; however, no information is recorded about the father.

## **Notifiable disease registries**

Communicable diseases of particular public health importance are, under legislation, notifiable to state and territory health authorities. Notifications are received from hospitals, general practitioners (GPs) and diagnostic laboratories. The proportions of notifications, however, vary.

## **National**

The National Notifiable Disease Surveillance System (NNDSS) is maintained by the Australian Government. It receives notifications of communicable diseases from all Australian states and territories which collect data under public health legislation. The NNDSS includes an Indigenous identifier but it is not consistent across all states and territories.

In 2004, the completeness of Indigenous identification in notifications to the NNDSS was assessed by analysing the proportion of notifications lacking identification of Indigenous status by state and territory and disease. Adequate levels of completeness (defined as at least 60% for a substantial majority of the diseases analysed) was achieved in the Northern Territory (91.9%), South Australia (89%) and Western Australia (64%). However the completeness of Indigenous data in other states and territories was poor – Australian Capital Territory (3%), New South Wales (21%), Queensland (33%), Tasmania (5%).

In 2002–03 expenditure on the NNDSS was \$318,000 and in 2003–04 expenditure was approximately \$337,000.

The project – *Improving Indigenous identification in communicable diseases reporting systems: Stage 1, Initial Report* – was funded by the Australian Government and auspiced by the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data and the National Public Health Information Working Group. A steering committee was established which comprised peak Indigenous health organisations and Indigenous health experts to improve the quality of the Indigenous data in notifiable disease registries. Under the guidance of the steering committee, the project developed a draft discussion paper containing recommended strategies and options to improve Indigenous identification in communicable disease reporting. The paper recommends actions to improve Indigenous identification reporting in all communicable disease data collections in all jurisdictions through developing policy, creating incentives, improving reporting, introducing workplace reforms, enhancing information systems and exploring initiatives for targeted change.

For 2002–03, rounded expenditure was \$26,000 and in 2003–04 it was \$32,000.

## **Victoria**

The Health (Infectious Diseases) Regulations were revised to include Indigenous status and became effective in May 2001. Prior to that there was no provision for recording Indigenous status on notifications or laboratory report forms. Measles and acute hepatitis B notifications were followed up by Department of Human Services staff who checked the patient's Indigenous status with the doctor or patient.

Very few Aboriginal patients have been identified through the Notifiable Diseases Information system, often fewer than identified by hospitals as inpatients. Pathology forms do not record Aboriginal status, apart from those required under the Health (Infectious Diseases) Regulations.

Efforts have been made to encourage GPs to identify patients on infectious diseases notifications.

## **Queensland**

Data for notification rates are dependent on an Indigenous status field being recorded on pathology request forms. Routinely, GPs and private pathology laboratories do not record this information. While Queensland Health facilities are improving their recording, only a third or less of disease notifications are received from these facilities. In general the completeness of identification is not sufficient to provide reliable rates for notifiable diseases amongst Indigenous people.

An exception is when 'enhanced surveillance' is performed. Enhanced surveillance occurs when public health unit staff follow up individually on notifiable cases and collect more information than is obtained through the normal notification process. For these cases, the recording of Indigenous status information is significantly improved.

### **Western Australia**

Notification forms request data on Aboriginal identification but in many cases Indigenous status is not recorded. The Western Australian Indigenous Sexual Health Advisory Committee has placed on its workplan ways to improve Indigenous identification on notification forms. A small internal working group has been established to look at issues around identification of Aboriginal and Torres Strait Islander people on Pap smear registries.

### **South Australia**

The Communicable Disease Control Branch maintains a notifiable diseases database that records Indigenous status. In South Australia, laboratories do not routinely collect information on Indigenous status. However, medical practitioners are requested to identify Indigenous status on a Report of Notifiable Disease or Related Death form.

In 2004, there were 9,840 notifications of infectious disease in South Australia. Of these, medical practitioners identified 580 (7%) as Indigenous persons, 6,872 (78%) non-Indigenous persons, and for 1388 (16%) the status was unknown or not recorded. Since 1996, local attempts to improve Indigenous/non-Indigenous reporting have only resulted in modest improvements in the completeness of this field.

In South Australia, the quality of medical practitioner reporting has not been evaluated. Based on the draft report 'Improving Indigenous Identification in Communicable Disease Systems', it is reasonable to assume that Indigenous status is under-reported by medical practitioners and therefore Indigenous people are under-represented in the South Australian dataset.

In 2005 and following circulation of the above draft report, a committee was formed to address the issues raised. This committee has specifically been asked by Communicable Diseases Network Australia to address issues related to the feasibility of general practitioner reporting (i.e. patient privacy considerations and funding issues; Public Health Outcome Funding Agreements).

The committee consists of representatives from public health units in various states and territories. One option under consideration is reporting Indigenous status on laboratory forms. This option would allow South Australia to cross-reference information received by medical practitioners and laboratories, thereby improving the completeness of the dataset.

### **Tasmania**

Indigenous status is able to be collected through a questionnaire sent to general practitioners by the Public and Environmental Health Service. Correct data rely on GPs being aware of their patients' Indigenous status.

### **Australian Capital Territory**

The ACT Notifiable Diseases Registry is able to record the Aboriginal identifier; however, all entries are set to 'Unknown' due to a lack of information from GPs and pathology laboratories. ACT Health has investigated the possibility of including the Aboriginal and Torres Strait Islander identifier as a mandatory field in the Registry, through amendments to the Public Health Regulations, and determined that a national approach is required.

Three Registries (Pap Smear, Cancer and Notifiable Diseases) are reliant on pathology request forms to obtain the Indigenous identifier. Following detailed investigations and discussions with the pathology laboratories providing services in the Australian Capital Territory, it has become apparent that due to the cross-jurisdictional nature of pathology operations, only a consistent national approach will be feasible. Patient information systems used by GPs, pathology databases, data transfer mechanisms and operational processes would all be impacted by changes to the request form, and cannot feasibly be tailored for individual jurisdictions. The issue has been referred to NAGATSIHID.

### **Northern Territory**

As part of the revision of the schedules pertaining to the Notifiable Diseases Act, the Department of Health and Community Services (DHCS) has ensured that reporting of Indigenous status is a mandatory requirement with the reporting of notifiable conditions by doctors and laboratories. Through the Northern Territory Public Health and Pathology Network DHCS has encouraged laboratories to record Indigenous status on pathology reports. DHCS has developed plans to review the accuracy of Indigenous status on the current hospital information system (this is being done elsewhere and may have been reported elsewhere). In the new Northern Territory Notifiable Diseases System, the national classification system for Indigenous status has been adopted.

Pathology referral forms include a field for Indigenous status; however, the field is inconsistently completed by medical practitioners.

### **Pap smear registries**

See Indicator 25.

### **Workforce surveys**

At present, there is no regular national survey which captures numbers of Aboriginal and Torres Strait Islander people in the health workforce. All states and territories administer an Equal Employment Opportunity questionnaire to new employees which includes an Indigenous identifier; however, identification is voluntary. In addition to this, some states and territories, such as New South Wales and Victoria, conduct annual surveys of the health labour force which also include a question on Indigenous status.

### **New South Wales**

The Premiers Workforce Profile Collection Data is a primary source of workforce statistical data for all NSW Government agencies on matters relating to equity and diversity. Although the profile captures information on whether the employee is of Aboriginal or Torres Strait Islander descent, there is concern about the response rate and the ability to accurately reflect actual numbers of Aboriginal and Torres Strait Islander people in the workforce.

Currently the Workforce Profile does not discriminate by 'job category', as defined by the AIHW. However, proposed changes to the Workforce Profile collection in 2005 will give the NSW Health Department the ability to report by a departmental 'treasury code' which classifies employees by the following groupings:

- Medical
- Nursing
- Hospital Administration and Clerical Support Service
- Allied Health Professionals

- Hospital Employees
- Hotel Services
- Maintenance and Trades
- Ambulance Uniform Staff
- Others.

The NSW Health Department conducts seven annual labour force surveys of all NSW Health professionals, both public and private. The surveys are conducted as part of the annual registration process with their respective registration boards. Currently the Medical and Nursing labour force surveys collect information on the Aboriginality of its registered members. The department is currently updating all seven labour force surveys during 2005 to collect information as to the Aboriginal status of each professional group surveyed. The NSW Health professionals groups, which are surveyed annually, are listed below:

- Medical Practitioners
- Registered and Enrolled Nurses
- Dentists
- Psychologists
- Podiatrists
- Pharmacists
- Physiotherapists.

## **Victoria**

The Indigenous status of health service delivery staff is only known for a small number of job categories. With the exception of nurses, all of these positions are Indigenous-specific. The Nurses Board of Victoria included Indigenous status in its annual survey for the first time in 2002. There is no record of the number of Aboriginal Health Workers employed in Victoria.

In 2003-04, there were 17 Koori Health Liaison Officers (KHLOs) funded by the Department of Human Services and employed in Victorian hospitals and 10 Koori Mental Health Liaison Officers. The Koori Mental Health Liaison Officers are funded by the Department of Human Services to improve access to, and effectiveness of, mental health services for Aboriginal communities. These positions are generally located in the Area Mental Health Service.

The health labour force is surveyed by the Department of Health Services. Surveys will be conducted annually from 2005. Surveys are being amended to include Aboriginal status. Registration of health professionals now includes Aboriginal status.

Registration Boards which will be surveyed include: Chinese Medicine Registration Board, Chiropractors Registration Board, Dental Practice Registration Board, Medical Practitioners Registration Board, Medical radiation technologists, Occupational therapists, Osteopaths Registration Board, Optometrists Registration Board, Pathology Services Accreditation Board, Pharmacy Board, Physiotherapists Registration Board, Podiatrists, Psychologists Registration Board, Speech Pathologists.

## **Queensland**

Queensland Health conducts statistical surveys for most health professions in which practitioners are required to be registered. Indigenous status is one of the data elements collected within the surveys.

Employees of Queensland Health voluntarily complete an EEO questionnaire when they commence employment. Indigenous status is one of the data elements collected. Data are collected and collated centrally and then sent to the Office of the Public Sector Merit and Equity.

### **Western Australia**

The Western Australian Department of Health, along with other Western Australian Government departments, are required to record Aboriginal and Torres Strait Islander status of all employees according to the Human Resource Minimum Obligatory Information Requirements 2004.

### **South Australia**

The collection of information for all new employees includes an Indigenous identifier. Discussions are ongoing within the Department of Human Services about how to get similar information for existing employees. There is an Aboriginal Recruitment and Retention Committee that is currently working on the issue of uniformity of employee Indigenous identification.

### **Tasmania**

EEO forms are completed by all new employees. Aboriginal or Torres Strait Islander identification is voluntary.

### **Australian Capital Territory**

Employees of ACT Health complete an EEO questionnaire upon commencement. However, it is voluntary for new employees to identify if they are Aboriginal or Torres Strait Islander.

### **Northern Territory**

Employees of the Department of Health and Community Services (DHCS) are required to complete an EEO questionnaire when they commence work. This self-completed questionnaire has an optional part which identifies Indigenous status. DHCS also undertakes an annual census day, which is designed to encourage staff to update their EEO data on the Personnel and Integrated Payroll System, especially if they have failed to complete this data when they commenced employment.

## **Indicator 2. Government expenditure on health services for Aboriginal and Torres Strait Islander people**

**Indicator:** Overall per capita annual expenditure by governments on primary and secondary/tertiary care for Aboriginal and Torres Strait Islander health compared to the total population.

### **Purpose**

This indicator is designed to reflect resource allocation by governments on Aboriginal and Torres Strait Islander people relative to the total population.

### **Data**

Information for this indicator was prepared by the AIHW.

Data for 2001–02 published by the AIHW were used for this indicator (AIHW 2005b). Estimates of expenditure on health goods and services for Aboriginal and Torres Strait Islander people are produced triennially. Whilst comparisons with the total population have been specified for this indicator, data presented here compare expenditure for Indigenous and non-Indigenous Australians.

There are a number of difficulties in reporting on this indicator, including the issue of under-identification of Indigenous Australians in health databases (such as for hospital separations). In some areas, such as expenditure on medical and pharmaceutical services, surveys have been used to estimate service use by Aboriginal and Torres Strait Islander people, and this, in turn, is used in the estimates of expenditure. Consequently, the reliability of the expenditure estimates is affected by sampling error. The surveys used in producing these estimates are also affected by under-identification.

It should also be noted that it is not always possible to make accurate estimations of health expenditure for Aboriginal and Torres Strait Islander peoples and their corresponding service use due to some services not collecting accurate information on the Indigenous status of service users. There may also be some limitations associated with the scope and definition of health expenditures and there may be inconsistencies in reporting and categorisation of expenditure on health goods and services across data providers.

Estimates of average expenditures per person also need to be interpreted with care. They are an indication of the average health expenditure per head of the reference population and do not reflect the average expenditure incurred by each person accessing the goods and services being discussed.

This indicator reports government health expenditure on the basis of where the responsibility for incurring the expenditure lies. It does not necessarily reflect the ultimate source of the funds that are used to pay for that expenditure. To this extent it does not necessarily give an accurate reflection of the level of responsiveness of a particular level of government to specific health needs of a population. For example, Australian Government transfers to the states and territories for health purposes are not recorded as Australian Government expenditure but are subsumed into the estimates of state and territory expenditure since it is the states and territories that have actually incurred the related expenditure.

In 2001–02, the Australian Government provided 43.1% of the total financing of health for Indigenous Australians. State and territory governments provided 49.5% and the remainder (7.3%) came from non-government funding sources (AIHW 2005b).

Estimated total expenditure on health services for Aboriginal and Torres Strait Islander peoples in 2001–02 was \$1,788.6 million which was 2.8% of national health expenditure. The average total expenditure per person was \$3,901 per Indigenous person, compared with \$3,308 per person for other Australians, giving a ratio (Indigenous Australians to non-Indigenous Australians) of 1.18:1. This includes government and private expenditure.

A breakdown of Australian Government and state and territory government expenditure on health services for Indigenous Australians is presented in Table 2.1.

- The majority of expenditure on Indigenous health was related to state and territory government administered programs. Of the estimated \$1,788.6 million expenditure on health for Aboriginal and Torres Strait Islander people in 2001–02, \$1,260.5 million (or 70.5%) related to programs that were primarily responsibilities of state and territory governments.
- On a per person basis, total government expenditure on Aboriginal and Torres Strait Islander people was estimated at \$3,637 per person, compared with \$2,168 per person for non-Indigenous Australians.
- State and territory governments spent an estimated \$2,749 per Aboriginal and Torres Strait Islander person, compared with \$1,141 for non-Indigenous people, giving a ratio (Indigenous to non-Indigenous) of 2.41:1.
- The Australian Government spent an estimated \$888 per Aboriginal and Torres Strait Islander person compared with \$1,028 per person for non-Indigenous Australians, giving a ratio (Indigenous to non-Indigenous) of 0.86:1.

**Table 2.1: Annual expenditure and expenditure per person by the Australian Government and state/territory governments, by source of funds and Indigenous status, Australia, 2001–02**

Source of funds	Expenditure (\$ million)			Expenditure per person (\$)		Ratio
	Indigenous	Non-Indigenous	Indigenous share (%)	Indigenous	Non-Indigenous	
<b>Expenditure by Australian Government</b>						
Public (psychiatric) hospitals	9.1	175.6	4.9	19.74	9.26	2.13
Private hospitals	—	7.7	0.5	0.08	0.40	0.19
Services for older people	30.5	3,379.2	0.9	66.57	178.28	0.37
Medical services	93.7	8,700.4	1.0	182.58	459.01	0.40
Pharmaceuticals <sup>(a)</sup>	35.9	4,671.4	0.8	78.3	246.45	0.32
Community health services	166.8	30.7	84.5	363.81	1.62	224.55
Patient transport	12.4	65.3	15.9	26.95	3.44	7.82
Dental services	0.2	70.8	0.3	0.48	3.73	0.13
Other professional services	6.0	433.0	1.4	13.18	22.84	0.58
Aids and appliances	1.0	102.5	0.9	2.12	5.41	0.39
Public health	16.3	317.4	4.9	35.49	16.74	2.12
Other health services (nec)	19.5	692.3	2.7	42.53	36.52	1.16
Health administration	25.9	832.9	3.0	56.54	43.94	1.29
<i>Total Australian Government expenditure</i>	<i>407.3</i>	<i>19,479.2</i>	<i>2.0</i>	<i>888.39</i>	<i>1,027.67</i>	<i>0.86</i>
<b>Expenditure by state/territory governments</b>						
Hospitals	829.0	16,224.2	4.9	1,807.92	855.94	2.11
Admitted patient services <sup>(b)</sup>	661.9	12,694.7	5.0	1,443.55	669.74	2.16
Non-admitted patient services	142.4	3,116.5	4.4	310.56	164.42	1.89
Public (psychiatric) hospitals	24.7	413.0	5.6	53.80	21.79	2.47
Services for older people	11.7	420.0	2.7	25.51	22.16	1.15
Patient transport	50.2	771.6	6.1	109.45	40.71	2.69
Public health activities <sup>(c)</sup>	56.2	712.5	7.3	122.65	37.59	3.26
Community health service	272.8	2,772.1	9.0	594.93	146.25	4.07
Health research	10.5	215.6	4.6	22.84	11.38	2.01
Health administration	13.5	250.5	5.1	29.39	13.22	2.22
Other health services	16.6	253.7	6.2	36.31	13.38	2.71
<i>Total state/territory government expenditure</i>	<i>1,260.5</i>	<i>21,620.2</i>	<i>5.5</i>	<i>2,749.00</i>	<i>1,140.63</i>	<i>2.41</i>
<b>Total government expenditure</b>	<b>1,667.8</b>	<b>41,099.4</b>	<b>4.1</b>	<b>3,637.39</b>	<b>2,168.30</b>	<b>1.68</b>
<i>Non-government expenditure</i>	<i>120.8</i>	<i>21,609.5</i>	<i>0.6</i>	<i>263.44</i>	<i>1,140.66</i>	<i>0.23</i>
<b>Total health expenditure<sup>(d)</sup></b>	<b>1,788.6</b>	<b>62,708.9</b>	<b>2.8</b>	<b>3,900.83</b>	<b>3,308.35</b>	<b>1.18</b>

(a) Includes estimated benefits through the PBS and RPBS. PBS benefits include those via special supply arrangements as well as mainstream PBS and enhanced rural and remote pharmacy package.

(b) All admitted patients in public (non-psychiatric) hospitals plus public patients in private hospitals.

(c) Expenditure estimates for public health activities were sourced from NPHEP and GPC reporting mechanisms.

(d) Total health expenditure includes funding by non-government sources.

Source: AIHW 2005b.

A jurisdictional split of estimates of expenditure on health services for Indigenous and non-Indigenous people are shown in Table 2.2. These expenditures are partly funded by the Australian Government.

- The Northern Territory and Western Australia had the highest average expenditure per person (\$4,522 and \$3,850 respectively). This is, at least in part, explained by the large proportions of their Indigenous population living in remote areas. Tasmania, which had the lowest expenditure per person (\$815), was the only jurisdiction where the estimated expenditure per person for Indigenous Australians was lower than that for non-Indigenous people (\$1,478).

**Table 2.2: Estimated annual and per person state/territory expenditure on health services, by program, 2001–02<sup>(a)</sup>**

Area of expenditure	Expenditure (\$m)		Indigenous share (%)	Expenditure per person (\$)		Ratio
	Indigenous	Total		Indigenous	Non-Indigenous	
<b>New South Wales</b>						
Acute-care hospitals	177.8	5,743.4	3.0	1,317.78	891.78	1.48
Admitted patient services	131.9	4,513.8	2.8	978.01	700.87	1.40
Non-admitted patient services	45.8	1,229.5	3.6	339.77	190.91	1.78
Public (psychiatric) hospitals	7.3	152.2	4.6	54.41	23.63	2.30
Services for older people	0.3	43.5	0.6	2.01	6.76	0.30
Patient transport	9.7	302.6	3.1	71.71	46.99	1.53
Public health activities	9.0	217.4	4.0	67.01	33.75	1.99
Community health services	88.9	878.5	9.2	659.09	136.41	4.83
Health research	1.8	93.9	1.9	13.49	14.59	0.92
Other health services (nec)	0.5	24.6	1.8	3.41	3.82	0.89
<b>Total</b>	<b>295.3</b>	<b>7,456.1</b>	<b>3.8</b>	<b>2,188.92</b>	<b>1,157.72</b>	<b>1.89</b>
<b>Victoria</b>						
Acute-care hospitals <sup>(a)</sup>	37.3	4,147.1	0.9	1,338.43	868.17	1.54
Admitted patient services	27.0	3,463.8	0.8	968.8	725.11	1.34
Non-admitted patient services	10.3	683.4	1.5	369.63	143.06	2.58
Services for older people	0.4	98.7	0.4	14.40	20.66	0.70
Patient transport	1.3	170.1	0.7	45.38	35.60	1.27
Public health activities <sup>(b)</sup>	7.8	194.9	3.9	281.66	40.79	6.90
Community health services	19.4	640.9	2.9	697.83	134.17	5.20
Health research	0.1	17.8	0.6	3.73	3.73	1.00
Other health services (nec)	0.5	21.8	2.1	16.77	4.55	3.68
<b>Total</b>	<b>66.8</b>	<b>5,291.2</b>	<b>1.2</b>	<b>2,398.19</b>	<b>1,107.68</b>	<b>2.17</b>
<b>Queensland</b>						
Acute-care hospitals	198.1	2,449.0	7.5	1,573.16	699.11	2.25
Admitted patient services	153.4	1,920.8	7.4	1,218.67	548.33	2.22
Non-admitted patient services	44.6	528.2	7.8	354.49	150.78	2.35
Public (psychiatric) hospitals	7.9	121.4	6.1	62.83	34.64	1.81
Services for older people	2.1	114.9	1.8	16.52	32.81	0.50
Patient transport	19.4	214.4	8.3	154.14	61.21	2.52
Public health activities <sup>(c)</sup>	7.8	119.1	6.1	61.78	33.99	1.82
Community health services	62.7	690.1	8.3	497.68	196.99	2.53
Health research	1.3	35.6	3.5	10.15	10.16	1.00
Health administration (nec)	2.8	57.0	4.7	22.43	16.28	1.38
Other health services (nec)	0.3	4.8	5.3	2.15	1.37	1.57
<b>Total</b>	<b>302.3</b>	<b>3,806.3</b>	<b>7.4</b>	<b>2,400.84</b>	<b>1,086.57</b>	<b>2.21</b>

(continued)

**Table 2.2 (continued): Estimated annual and per person state/territory expenditure on health services, by program, 2001–02<sup>(a)</sup>**

Area of expenditure	Expenditure (\$m)		Indigenous share (%)	Expenditure per person (\$)		Ratio
	Indigenous	Total		Indigenous	Non-Indigenous	
<b>Western Australia</b>						
Acute-care hospitals	181.2	1,693.8	9.7	2,748.22	922.95	2.98
Admitted patient services	157.4	1,398.2	10.1	2,387.24	761.88	3.13
Non-admitted patient services	23.8	295.6	7.5	360.98	161.07	2.24
Public (psychiatric) hospitals	4.2	54.8	7.1	63.55	29.87	2.13
Services for older people	8.8	122.8	6.7	133.78	66.90	2.00
Patient transport	1.7	7.8	17.9	25.78	4.25	6.07
Public health activities <sup>(b)</sup>	4.5	60.0	6.9	67.65	32.72	2.07
Community health services	32.7	127.8	20.4	495.97	69.64	7.12
Health research	1.7	41.4	4.0	25.78	22.40	1.15
Health administration (nec)	5.8	80.7	6.7	87.69	43.98	1.99
Other health services (nec)	13.3	186.2	6.7	201.73	101.46	1.99
<b>Total</b>	<b>253.8</b>	<b>2,375.1</b>	<b>9.7</b>	<b>3,850.16</b>	<b>1,294.16</b>	<b>2.98</b>
<b>South Australia</b>						
Acute-care hospitals	36.5	966.8	3.6	1429.21	650.52	2.20
Admitted patient services	30.0	761.7	3.8	1,174.54	512.51	2.29
Non-admitted patient services	6.5	205.1	3.1	254.66	138.00	1.85
Public (psychiatric) hospitals	5.0	78.3	6.0	194.03	52.68	3.68
Services for older people	0.1	40.0	0.3	4.82	26.92	0.18
Patient transport	1.9	34.3	5.1	72.45	23.06	3.14
Public health activities	2.0	64.8	3.0	78.31	43.61	1.80
Community health services	9.0	128.6	6.6	353.75	86.53	4.09
Health research	2.5	20.0	11.1	97.87	13.46	7.27
Health administration (nec)	4.0	66.2	5.7	158.00	44.56	3.55
<b>Total</b>	<b>61.0</b>	<b>1,399.0</b>	<b>4.2</b>	<b>2,388.43</b>	<b>941.33</b>	<b>2.54</b>
<b>Tasmania</b>						
Acute-care hospitals	8.0	375.6	2.1	458.48	826.46	0.55
Admitted patient services	4.0	266.2	1.5	230.55	585.87	0.39
Non-admitted patient services	4.0	109.3	3.5	227.93	240.59	0.95
Public (psychiatric) hospitals	0.3	6.4	4.1	15.65	14.01	1.12
Patient transport	0.5	26.0	1.7	26.25	57.18	0.46
Public health activities	0.7	19.9	3.4	39.79	43.70	0.91
Community health services	3.5	191.3	1.8	201.55	420.91	0.48
Health administration (nec)	0.8	46.6	1.8	47.94	102.52	0.47
Other health services (nec)	0.4	6.2	6.8	25.85	13.54	1.91
<b>Total</b>	<b>14.2</b>	<b>671.8</b>	<b>2.1</b>	<b>815.49</b>	<b>1,478.31</b>	<b>0.55</b>

(continued)

**Table 2.2 (continued): Estimated annual and per person state/territory expenditure on health services, by program, 2001–02<sup>(a)</sup>**

Area of expenditure	Expenditure (\$m)		Indigenous share (%)	Expenditure per person (\$)		Ratio
	Indigenous	Total		Indigenous	Non-Indigenous	
<b>Australian Capital Territory</b>						
Acute-care hospitals <sup>(d)</sup>	7.0	323.3	2.1	1,778.69	1,024.99	1.74
Admitted patient services <sup>(e)</sup>	5.9	267.8	2.1	1,503.47	849.03	1.77
Non-admitted patient services <sup>(f)</sup>	1.1	55.5	1.9	275.22	175.95	1.56
Public health activities	0.3	22.4	1.2	67.26	71.00	0.95
Community health services	2.2	78.8	2.7	570.7	249.94	2.28
Health research	0.1	6.7	1.2	21.05	21.12	1.81
Other health services (nec)	0.2	9.5	2.2	54.72	30.19	1.81
<b>Total</b>	<b>9.9</b>	<b>449.8</b>	<b>2.2</b>	<b>2,538.46</b>	<b>1,426.13</b>	<b>1.78</b>
<b>Northern Territory</b>						
Acute-care hospitals	158.6	112.2	58.6	2,788.15	796.61	3.50
Admitted patient services	152.3	102.3	59.8	2,677.39	726.21	3.69
Non-admitted patient services	6.3	9.9	38.8	110.76	70.40	1.57
Patient transport	15.6	7.4	68.0	275.16	52.27	5.26
Public health activities	24.2	14.1	63.1	424.86	100.17	4.24
Community health services	54.3	36.1	60.1	955.13	256.20	3.73
Health research	3.0	0.5	85.0	52.57	3.74	14.04
Other health services (nec)	1.5	0.7	69.1	26.11	4.71	5.55
<b>Total</b>	<b>257.2</b>	<b>171.0</b>	<b>60.1</b>	<b>4,521.98</b>	<b>1,213.70</b>	<b>3.73</b>

(a) Expenditure on public (psychiatric) hospitals is included in admitted patient services.

(b) Reported expenditure for public health activities does not necessarily concur with NPHEP activity reporting.

(c) Public health activities expenditure is reported using the NPHEP activity classifications.

(d) An estimated 22% of separations in the ACT are non-ACT residents; the expenditure per person rates have been adjusted to account for this.

(e) An estimated 22% of separations in the ACT are non-ACT residents; the expenditure per person rates have not been adjusted to account for this.

(f) No split of expenditure on non-admitted patient services into expenditure on emergency departments and other non-admitted patient services is available for the ACT. It is estimated that 12% of emergency department presentations in the ACT are of non-ACT residents; the expenditure per person estimates have not been adjusted to account for this.

*Notes:*

1. Excludes state funding of private hospitals.

2. For New South Wales, Victoria, Australian Capital Territory and the Northern Territory, all health administration expenditure has been apportioned across the expenditure categories.

Source: AIHW 2005b.

### **Box 2.1: Data issues**

*It is not always possible to make accurate estimations of health expenditure for Aboriginal and Torres Strait Islander peoples and their corresponding service use due to some services not collecting accurate information on the Indigenous status of service users. Consequently, the estimates published here may somewhat overstate or understate actual expenditure.*

*There may be some limitations associated with the scope and definition of health expenditures included in this indicator and there may be inconsistencies in reporting and categorisation of expenditure on health goods and services across data providers. These may result from limitations of financial reporting systems, and/or different reporting mechanisms. Reporting of health administration (nec) is one such example. In some cases, all the associated administration costs have been included in the estimates of expenditure on a particular health service category (for example acute-care services), whereas in other cases, they have been separately reported.*

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

*Variations in the adjustment were also applied at a very broad level to two regional classifications – a 38% under-identification adjustment was applied to data from hospitals in metropolitan areas and a 21% adjustment to all other hospitals. It should be noted that some of the expenditure patterns suggested are influenced by these likely variations in identification and that the application of very broad under-identification adjustments may mask some differences that may exist between states and territories and between regional types.*

*Estimates of average expenditures per person need to be interpreted with care. They are an indication of the average health expenditure per head of the reference population(s) – in this case, the whole of the Indigenous and non-Indigenous populations drawn from ABS Census estimates for 2001 – and do not reflect the average expenditure incurred by each person accessing the goods and services being discussed.*

*Furthermore, readers should bear in mind that the average cost of providing health services is likely to vary quite considerably from one jurisdiction to the next for a variety of demographic, economic, geographic and other reasons such as differences in the health status of the population.*

## **Indicator 4. Government expenditure on, and description of, selected health promotion programs**

### **Indicator:**

- (a) A brief description of health promotion programs targeting social and emotional wellbeing and mental health for Aboriginal and Torres Strait Islander people and an estimate of total expenditure on them.
- (b) A brief description of health promotion programs targeting risk factors except social and emotional wellbeing and mental health for Aboriginal and Torres Strait Islander people and estimate of total expenditure on them.

### **Purpose**

Information for this indicator was provided by the states and territories and the Australian Government.

This indicator describes the commitment to health promotion programs for Aboriginal and Torres Strait Islander people by the state and territory governments and the Australian Government. Expenditure on health promotion programs targeting social and emotional wellbeing and mental health for Aboriginal and Torres Strait Islander people are separately identified from all other expenditures on health promotion.

### **Data**

- The Australian Government spent \$16.7 million in 2002–03 and \$17.8 million in 2003–04 on programs to promote social and emotional wellbeing and mental health, and \$5.9 million in 2002–03 and \$6.6 million in 2003–04 on other health promotion programs.
- Among the states and territories which were able to provide data, expenditure on health programs for social and emotional wellbeing was highest in Western Australia (\$1.9 million in 2003–04) and Victoria (\$1.4 million in 2003–04).
- Expenditure on other health promotion programs was highest in Victoria in both years (\$4.8 million in 2002–03 and \$4.7 million in 2003–04).

**Table 4.1: Expenditure on health promotion programs targeting Aboriginal and Torres Strait Islander people, 2002–03 and 2003–04 (\$'000)**

	NSW <sup>(a)</sup>	Vic	Qld <sup>(b)</sup>	WA	SA <sup>(c)</sup>	Tas <sup>(d)</sup>	ACT	NT <sup>(e)</sup>	Aust Govt <sup>(f)</sup>
<b>2002–03</b>									
Social /emotional wellbeing	n.a	1,027.1	219.6	1,653.8	n.a	—	50.5	n.a	16,683.1
Other health promotion	2,346.9	4,768.2	2,146.0	3,167.7	n.a	—	63.0	n.a	5,860.9
<b>Total</b>	<b>2,346.9</b>	<b>5,795.3</b>	<b>2,365.6</b>	<b>4,820.5</b>	<b>n.a</b>	<b>—</b>	<b>113.5</b>	<b>1,681.6</b>	<b>22,544.0</b>
<b>2003–04</b>									
Social /emotional wellbeing	n.a	1,357.1	67.8	1,859.7	n.a	—	28.1	n.a	17,820.0
Other health promotion	1,105.4	4,672.8	2,845.8	2,770.0	n.a	—	41.5	n.a	6,600.7
<b>Total</b>	<b>1,105.4</b>	<b>6,029.9</b>	<b>2,913.6</b>	<b>4,629.7</b>	<b>n.a</b>	<b>—</b>	<b>69.6</b>	<b>1,678.9</b>	<b>24,420.6</b>

(a) Accurate data on social and emotional wellbeing health promotion expenditure in NSW were not available for these periods and thus were not presented.

(b) Queensland expenditure estimates relates only to expenditure by Queensland Health Public Health Services. Individual Health Service Districts also expend money on targeted health promotion activities. It should be noted that a significant component of Public Health Services' mainstream work incorporates strategies for the Aboriginal and Torres Strait Islander population. As these were not considered to 'specifically target' the Indigenous population, they have been excluded from the information provided. Other health promotion activities are funded through population health and area health services however this is unable to be quantified.

(c) South Australia was unable to provide data for this indicator.

(d) Tasmania did not provide health promotion programs specific to Aboriginal and Torres Strait Islander people in these years.

(e) Provision of expenditure information in relation to mental health (social/emotional) activities has some inherent difficulties as it is almost impossible to accurately isolate funding that relates specifically to Indigenous mental health promotion.

(f) The 2003–04 aggregated expenditure total includes general expenditure of \$300,000 on 2nd round coordinated care trials. This is an over-estimate, as it is impossible to separate health promotion activities from other trial activities.

*Source:* Data provided by states and territories, the Office of Aboriginal and Torres Strait Islander Health and the Australian Government Department of Health and Ageing.

The differences in data provided by the states and territories suggest that 'health promotion activities' may have been interpreted differently in different states and territories. For example, some jurisdictions may have included all Indigenous health promotions funding in 'other health promotion', as the distinction between social/emotional wellbeing and other health is difficult to make. Also, expenditure details for programs that have been identified as 'health promotion' are likely to have included some components for the treatment of pre-existing illnesses. Furthermore, other programs that are mainly service delivery oriented (and therefore have been excluded from the current expenditure estimate) may also have a 'health promotion' component. As a result, the actual expenditure on 'health promotion' may be misrepresented.

## Australian Government

### Emotional and social wellbeing health promotion programs

#### *Emotional and Social Wellbeing Program*

Through the Office for Aboriginal and Torres Strait Islander Health, the Australian Government funds the Emotional and Social Wellbeing Program targeting Aboriginal and Torres Strait Islander peoples with an expenditure of \$5.976 million in 2002–03 and \$5.624 million in 2003–04. With these funds, the Australian Government continued funding

19 emotional and social wellbeing services, and a range of related projects around Australia, including the ongoing development and expansion of 13 regional centres that provide training and workforce support.

The regional centres help build effective infrastructure for the delivery of emotional and social wellbeing programs through developing curricula, supporting training, and providing professional support to Aboriginal and Torres Strait Islander mental health and counselling staff and programs. Increased funding enabled the number of regional centres to be expanded from 13 in 2002–03 to 15 in 2004–05 and allowed a number of education and training initiatives to be instigated.

A second and third round of Innovative Grants in 2002–03 and 2003–04 provided funding for innovative, culturally appropriate approaches to healing. Examples of projects supported under this initiative included community healing workshops, traditional healing, return to country, return to institutions, arts and oral history healing projects. Continued funding was provided for the Marumali Program, a training program aimed at improving the quality of support available to individuals and communities affected by the past removal of children.

In addition to the funding outlined above, expenditure on the Bringing Them Home Program rose from \$9.037 million in 2002–03, to \$9.221 million in 2003–04. As part of the response to the Bringing Them Home report (HREOC 1997), the Australian Government has continued to provide funding for Bringing Them Home counselling positions around Australia to provide personal support for individuals, families and communities affected by past policies of the forced removal of children. In 2002–03, there were 104 counselling positions under this program rising to 105 in 2003–04.

#### *MindMatters*

The MindMatters program was launched in March 2000. It is an Australia-wide program conducted by the Australian Principals Associations Professional Development Council and the Curriculum Corporation with funding from the Australian Government. The initiative has several components including resources for schools, a national professional development and training strategy, and a dedicated website. Aboriginal and Torres Strait Islander issues are woven throughout the MindMatters program.

Funding has been made available to enable the employment of an Indigenous person to work across the suite of MindMatters packages to ensure the cultural appropriateness and inclusiveness of the entire initiative over the period 2003–2005. Expenditure on this initiative was \$15,000 in 2002–03 and \$90,000 in 2003–04.

#### *National suicide prevention strategy*

A number of Indigenous Australians with expertise in writing and drawing have been engaged to reproduce information about suicide prevention in a culturally appropriate way. This will enable Aboriginal and Torres Strait Islander peoples to have access to important information about a range of issues along with information on the experiences of a number of Indigenous communities relating to suicide and suicide prevention. Expenditure on this strategy was \$500,000 in 2003–04.

#### *The development and implementation of the National Aboriginal and Torres Strait Islander Safety Promotion Strategy*

The National Aboriginal and Torres Strait Islander Safety Promotion Strategy outlines specific strategic requirements for improving safety and reducing the incidence of and harm from injury to Aboriginal and Torres Strait Islander peoples. The Strategy builds on and is

integrated with the National Injury Prevention and Safety Promotion Plan – 2004–2014, and together they represent a comprehensive approach to safety promotion and injury prevention for all Australians. The vision for the Strategy is for Aboriginal and Torres Strait Islander peoples to live in safe environments free from the effects of injury. Underlying the Strategy is the right for people to be safe, and their responsibility to promote and maintain the safety of others. The Strategy's goals include improving the safety of environments and increasing community capacity to promote wellbeing, supporting communities to prioritise and address safety and injury issues, and mobilising actors and resources that encourage Aboriginal and Torres Strait Islander communities, government, and non-government sectors to work together to promote safety and prevent injury.

In 2002–03 a workshop was held as part of the National Injury Prevention Conference in Perth for the initial development of the Strategy. In 2003–04, a workshop was held to further develop the Strategy based on the Injury Prevention Activity Among Aboriginal and Torres Strait Islander People's Project. The objective of this project was to examine and report on the current state of injury prevention activity for Aboriginal and Torres Strait Islander people throughout Australia. The first draft was published and disseminated for public consultation in August 2004. The final version of the Strategy is expected to be submitted to AHMAC for endorsement in April 2005. Expenditure on the Strategy was \$95,123 in 2002–03 and \$24,953 in 2003–04.

### *Croc Festivals*

Croc Festivals give students living in remote and rural Australia the chance to create their own production from a conceptual stage through to a final live performance in front of an audience of their peers, families and community members. The Festivals were developed to encourage young Indigenous students to attend school more regularly and to lead healthy, positive lifestyles without misusing alcohol or consuming tobacco, illicit drugs or other volatile substances.

- In 2003, seven Croc Festivals were held – Thursday Island (Qld), Tennant Creek (NT), Derby (WA), Kalgoorlie (WA), Port Augusta (SA), Swan Hill (Vic) and Moree (NSW). The 2003 Festivals involved 12,708 students from 267 schools. The total Australian Government expenditure for the 2002–03 events was \$1.56 million.
- In 2004, Croc Festivals were held in eight locations – Weipa (Qld), Katherine (NT), Derby (WA), Geraldton (WA), Port Augusta (SA), Swan Hill (Vic), Moree (NSW) and Alice Springs (NT). The 2004 Festivals involved more than 14,000 students from 270 schools. The total Australian Government expenditure for the 2003–04 events was \$2.36 million.

## **Other health promotion programs**

### *Nutrition Education Project*

The Australian Government provides funding of \$120,000 per year to the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council for the purpose of facilitating a nutrition education project for mothers, babies and other carers throughout the Ngaanyatjarra Pitjantjatjara Yankunytjatjara region of Central Australia.

### *National Child Nutrition Program*

The National Child Nutrition Program, announced as part of the 1999–2000 Federal Budget, provided \$13.6 million for community grants of up to 3 years duration, targeting the nutrition and long-term eating patterns of children aged 0–12 years and pregnant women. A high

priority was given to projects in rural and remote communities, Aboriginal and Torres Strait Islander communities and lower socioeconomic communities.

Over \$3.9 million (representing 31% of total funding) was provided to projects on child nutrition specifically targeting Aboriginal and Torres Strait Islander communities in the period prior to 2002–03. There were two funding rounds of the National Child Nutrition Program, one of which funded only Indigenous-specific projects (Round 2). Twenty-three projects, focusing on high-need Indigenous communities, were funded in this round. Projects were funded within a range of settings including antenatal and postnatal services, childcare services, outside school hour care and primary school settings.

In 2002–03 expenditure on Indigenous projects funded under Round 2 of the National Child Nutrition Program was \$616,040, representing 18% of general Program expenditure. Similarly in 2003–04, expenditure on Indigenous projects funded under Round 2 of the National Child Nutrition Program was \$471,919, representing 22% of general program expenditure.

#### *Aboriginal and Torres Strait Islander Women's Forum*

The Aboriginal and Torres Strait Islander Women's Forum was established in 2000 by the previous National Advisory Committee to the National Cervical Screening Program (replaced by the Australian Screening Advisory Committee in 2004). The National Advisory Committee recognised cancer of the cervix as a major issue for Indigenous women. The death rate from cervical cancer among Indigenous women is much higher than in the non-Indigenous population. The Forum meets twice a year and comprises Aboriginal and Torres Strait Islander women from around Australia, with the Australian Government providing an adviser and the secretariat. The Forum's terms of reference are both advisory and project-based. The Australian Government provides approximately \$35,000 annually to support these meetings.

#### *Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women*

A document entitled *Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women* was completed in February 2004. This publication was designed to better inform health professionals on how to provide cervical screening services to Indigenous women. Queensland Health through its Women's Cervical Screening Service managed the development of the document which produced through the Aboriginal and Torres Strait Islander Women's Forum and involved a national consultation process. Distribution is ongoing throughout Australia in urban, regional and remote areas. The Forum also produced an accompanying postcard to alert Indigenous women to the document's existence. The Australian Government provided \$153,000 for the development and printing of the document. Further funds were also provided for distribution (approximately \$4,000). The majority of this was expended prior to 2002. Funding was \$2,500 in 2002–03 and \$29,000 in 2003–04.

#### *Indigenous Tobacco Control Program*

A \$1 million package for an Indigenous tobacco control program was awarded to the VicHealth Koori Health Research and Community Development Unit and began operation on 16 September 2003. The program will be for a 3-year period and consists of the following three elements:

- development of an Indigenous tobacco control clearinghouse or centre of excellence;
- work around smoking and Indigenous health workers

- development of a culturally appropriate Indigenous tobacco control resource.

Funded under Outcome 1 Population Health, \$340,000 was expended on the program in 2003–04.

### *National Illicit Drug Strategy*

Under the National Illicit Drug Strategy, funding of more than \$2.2 million was allocated for programs targeting Aboriginal and Torres Strait Islander peoples in 2002–03. In 2003–04 this figure exceeded \$2.3 million. The two components of this Strategy are described below.

The Non-Government Organisation Treatment Grants Program aims to provide funding to non-government organisations to establish and operate new treatment services as well as to expand or enhance existing services for treating illicit drug problems. Particular emphasis is placed on filling the geographical and target group gaps in the coverage of existing treatment services (including Aboriginal and Torres Strait Islander peoples, youth and women with children). Expenditure on programs targeting Aboriginal and Torres Strait Islander peoples in 2002–03 was \$2,076,570 and \$1,814,431 in 2003–04.

The Community Partnerships Initiative is a community grants program that aims to encourage community action to prevent illicit drug use and to build on existing activity occurring across Australia. Expenditure on programs targeting Aboriginal and Torres Strait Islander peoples in 2002–03 was \$166,007 and \$513,491 in 2003–04.

### *Coordinated Care Trials of health promotion programs*

The second round of Coordinated Care Trials are time-limited research projects exploring models of health care that test new ways of organising, delivering and funding health services for people with complex care needs and/or poor health. Three of these Trials focus on a total of approximately 14,000 Aboriginal and Torres Strait Islander people in three specific rural areas of Australia and they commenced at various times in 2003. The Australian Government provided approximately \$300,000 in 2003–04 to the Trials for health promotion programs addressing issues such as increasing physical activity levels, improving nutrition, dealing with drugs of dependence and domestic violence. It is not possible to determine the exact expenditure dedicated to health promotion as these Trials include other activities.

### *Rural Chronic Disease Initiative*

The Rural Chronic Disease Initiative funded nine projects targeting Aboriginal and Torres Strait Islander communities. These projects enabled communities to develop and implement local solutions to prevent and better manage chronic disease within their own communities. Projects focused on reducing multiple chronic disease risk factors. These included encouraging good nutrition, increasing physical activity, reducing smoking and the moderate consumption of alcohol. Funding was \$300,785 in 2002–03 and \$307,813 in 2003–04.

For information on action specifically targeted to Aboriginal and Torres Strait Islander peoples, see report under Indicator 1.

## **New South Wales**

During 2002–03, the Centre for Chronic Disease Prevention and Health Advancement (CCDPHA) provided funds for the establishment of the NSW Collaborative Centre for Aboriginal Health Promotion (\$120 000) located at the Aboriginal Health and Medical Research Council in Redfern. The Collaborative Centre distributed \$98,000 in grants to Aboriginal Community Controlled Medical Services for prevention programs in risk factors consistent with the NSW Aboriginal Health Strategic Plan and Directions Paper. Also funded

this year was an Aboriginal and Torres Strait Islander Forum by the Tobacco and Health Branch in the CCDPHA. Total funds distributed for health promotion in 2002–03 were \$233,000.

During 2003–04, the CCDPHA provided \$49,678 to the Well Persons Health Check program in Far West Area Health Service (\$79,000 for the Aboriginal Safety Promotion Program and \$100,000 for the Aboriginal and Torres Strait Islander Brief Intervention Tobacco Program). Total funds distributed for health promotion in 2003–04 were \$228,768.

The Centre for Aboriginal Health allocation for health promotion in 2002–03 was \$2,341,770 with \$2,113,922 expended during this period. In 2003–04 the allocation was \$1,713,544; however, only \$876,629 was expended.

The responsibility for Aboriginal mental health falls to the Area Health Services. It is unclear what proportion of Centre for Mental Health funding provided to the Area Health Services may be allocated to Aboriginal social and emotional wellbeing health promotion. The Centre for Mental Health does not receive reports of Area Health Services on Aboriginal social and emotional wellbeing health promotion.

## **Victoria**

Health promotion to the Victorian Aboriginal community is delivered through a number of vehicles. The Department of Human Services funds health services to provide specific Indigenous health promotion programs.

**Regional Health Promotion Officers** are members of the regional public health teams, which also include a Regional Public Health Manager and a Regional Environmental Health Officer. The core values of the Regional Health Promotion Officer Network are:

- addressing the broader determinants of health
- basing activities on the best available data and evidence
- acting to reduce social inequities and injustice
- emphasising active consumer and community participation
- empowering individuals
- explicitly considering differences in gender and culture
- Facilitating intersectoral cooperation.

Integrated health promotion priorities for 2004–06 are nutrition, physical activity, mental wellbeing and social connectedness, and tobacco, alcohol and other drugs.

**Regional Mental Health Promotion Officers** work within their regions under the auspices of the Child and Adolescent Mental Health Service to facilitate and resource a systemic approach to promoting the mental health of young people. Activities include networking, consultation, education and training.

**The Primary Care Partnership (PCP)** strategy aims to improve the overall health and wellbeing of Victorians by:

- improving the experience and outcomes for people who use primary care services; and
- reducing the use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

The Primary Care Partnership in Bendigo – Loddon supports the Indigenous Youth Program 'Being proud' which supports young Aboriginal people. The budget includes \$32,000 for

capacity building including Aboriginal organisations and \$113,600 for youth activities including those with Aboriginal youth (2003–04 \$145,000).

The Campaspe PCP continues to link and support Campaspe Aboriginal communities with the work of the PCP. It aims to implement service coordination within the broader program areas of Njernda Aboriginal Corporation, to foster and strengthen relations between mainstream services and Aboriginal communities and to strengthen agency responsiveness to the needs of the Aboriginal communities.

The Koori Health Promotion project works across three local Koori communities and aims to increase the capacity of Indigenous communities to identify priority health and wellbeing issues and develop strategies to address them. An additional aim is to build the capacity of local mainstream services to work effectively with the local Koori communities in addressing these priority needs. In 2003–04, \$87,428 was spent on Koori population health.

The goal of the Goulburn Valley PCP is to work with Rumbalara Aboriginal Cooperative to develop a population health profile of the local Aboriginal community in order to inform evidence-based approaches to integrated service planning and health promotion interventions to reduce health inequality for Aboriginal people.

The health promotion strategy in the North Central Metropolitan PCP targets those with the poorest access to health promoting experiences, including Aboriginal people. There is particular emphasis on reducing the impact of chronic diseases and improving mental health.

In Southern Grampians – Glenelg the priorities for the Aboriginal community are: improved access to mainstream allied health, mental health and specialist services; increased awareness of cultural and gender specific issues; additional services to address substance misuse and associated family violence.

The Southern Mallee PCP aims to improve the parenting skills of young Aboriginal parents through implementation of the Indigenous Parenting Program.

Under the Upper Hume PCP, priorities which are targeted at Aboriginal people include: community and neighbourhood supports, alcohol abuse, parenting, cultural sensitivity, domestic violence, mental health and preventative health. The Aboriginal community is included in the strategic objectives.

**The Public Health Branch of Rural and Regional Health and Aged Care Division** funds a number of health promotion activities.

Koori Community Alcohol and Drug Resource Services (Sobering-up Centres) and Koori Community Alcohol and Drug Workers are located in Aboriginal cooperatives. The Koori Community Alcohol and Drug Workers program includes a specific health promotion role. These workers undertake a number of activities based on a harm minimisation approach including health promotion, information provision, education activities, development and maintenance of community linkages, referrals, counselling interventions, the provision of advice to generalist services, liaising with relevant programs and fulfilling an advocacy role on behalf of the service user. Services are provided for both adults and young people.

Public Health provides approximately \$100,000 annual recurrent funding to the Victorian Aboriginal Health Service for education programs on blood-borne viruses and STIs. The training is directed both at workforce development and persons at risk. There are no data available on throughput.

Health promotion initiatives are also delivered through the **Victorian Health Promotion Foundation (VicHealth)**. The mission of VicHealth is to build the capabilities of organisations, communities and individuals in ways that:

- change social, economic and physical environments so that they improve health for all Victorians
- strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain good health.

Projects are delivered by both Indigenous and mainstream agencies and funded under the following categories: physical activity and healthy eating, and mental health and wellbeing (research workforce and tobacco control, substance misuse, sun protection, multiple focus and other health issues). Twenty-three Indigenous projects were funded in 2002–03 (\$927,831) and 30 in 2003–04 (\$1,677,116).

VicHealth supports Indigenous tobacco control efforts through Quit Victoria and the VicHealth Koori Health Research and Community Development Unit, consortium partners in the National Centre for Excellence in Indigenous Tobacco Control.

## Queensland

Queensland Health has spent nearly \$5.2 million on Indigenous health promotion during the period 2002–03 to 2003–04. Positions have been established in each health zone to address major public health concerns such as environmental issues, communicable diseases, injury, nutrition and mental health. Specific programs include: injury prevention projects focused on domestic violence and football-related violence; programs on nutrition and obesity; personal hygiene training in childcare settings; suicide prevention, and an Indigenous smoking cessation program.

A significant component of Public Health Services' mainstream work incorporates strategies for the Aboriginal and Torres Strait Islander population. Public Health Services also develop, fund and deliver many health promotion programs for the general population that have significant and direct benefit for all subgroups of the general population, including Indigenous people. For these health promotion programs, it is extremely difficult to quantify the proportion of expenditure that can be considered 'Indigenous specific'.

## Western Australia

**Social and emotional wellbeing programs** continue to include the Building Solid Families program. This program provides a comprehensive information and support service for Aboriginal and Torres Strait Islander individuals, families and communities, particularly those affected by family separation, trauma, grief and loss, mental health problems and are at risk of self-harm.

**Health promotion programs** continue to target priority health problems to improve the health of Aboriginal people in Western Australia. Diseases that affect Aboriginal and Torres Strait Islander people are caused by poor nutrition, alcohol and substance abuse, low levels of physical activity, substandard living conditions, high levels of psychosocial stress, violence and under-utilisation and/or inappropriate use of health services. A number of health promotion programs are delivered across the state, including:

- men's health and youth health
- maternal, foetal and child health
- diabetes and renal disease
- heart disease
- injury and violence
- drug, tobacco and alcohol abuse.

The major initiative of 2004 has been the completion of a draft health promotion strategy focusing on smoking, nutrition and physical activity.

Healthway continues to fund a range of health promotion activities targeting the health and wellbeing of the Aboriginal and Torres Strait Islander peoples of Western Australia.

Activities addressing Indigenous health and involving Aboriginal and Torres Strait Islander people are funded through the health promotion projects and research areas as well as sports and arts sponsorships, which promote a range of health messages including the 'Respect Yourself, Respect Your Culture' message. Healthway's commitment to this important target group is supported by initiatives such as specific research and health promotion scholarships for Indigenous people, special weighting when assessing relevant research grants and specific funding programs which are designed to increase access by Indigenous groups.

In 2002–03 Healthway funded 54 projects for \$1,133,957 and in 2003–04, 40 projects for \$1,225,327.

## **South Australia**

South Australia has been active in developing and delivering health promotion programs across the state to address the health disparity of Aboriginal peoples. The following programs are examples of the diverse range of interventions at both the regional and state level.

### **State-level programs**

#### *Police Drug Diversion Initiative*

Funding from the Police Drug Diversion Initiative, a joint initiative of Commonwealth and state governments, has been provided to the Nganampa Health Council to run Young Fellas and Women Choosing Wisely workshops in collaboration with Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council and Anangu Schools.

#### *Healthy Ways Program*

In response to the need to address the poor health of pregnant women, mums, babies and children in remote Aboriginal communities, in 2001 a partnership was formed between the Department of Health and the now Department of Education and Children's Services. The joint approach looked at improving health and learning outcomes through community initiated responses that aimed to enhance mothers' confidence in child rearing as well as focusing education around nutrition and tobacco use. The approach took account of the experience of aid agencies in the developing world in focusing on the education of young women as a key strategy to achieving sustainable health and wellbeing benefits for families and communities. The four objectives of the Healthy Ways Program are:

- MUMS TO BE – Understanding Pregnancy and looking after yourself and Infant Health
- GROWING LITTLE KIDS UP – Increasing women's confidence in supporting their infant's and children's growth and development
- KIDS AND MUMS LEARNING – Safe space and private time for kids and mums learning together
- THE SCHOOL BUILDING BRIDGES – Peer education and support in and out of school around Healthy Ways objectives.

The Healthy Ways Project is predicated on established community development theory and principles – i.e. a process that leads to individuals and communities having the confidence to determine their own directions and futures. All Healthy Ways funded community programs

are in response to community identified priorities and are driven by senior women within the community.

The communities participating in the Healthy Ways Project are Coober Pedy, Marree, Oodnadatta, Whyalla, Yalata, Oak Valley, and APY Lands. Outcomes achieved include workforce capacity – Aboriginal women have undergone, are undergoing or will commence health-related training (ie: childcare, nursing, midwifery, aged care, community/family service) in Whyalla, Marree, Coober Pedy, the APY Lands communities.

A Training and Employment Action Plan has been developed for the Marree community, building on the Healthy Ways health/education Aboriginal maternal and child health community development initiative. The plan is based on community consultation that identified the skills and training required to improve health, life expectancy and employment. The Plan includes:

- an Aboriginal health worker position for Maree
- vocational Education and Training in schools. One student is undertaking a pathway to nursing placement with support through the Port Augusta Hospital
- first Aid Training through Futures Connect
- nutrition training through the Children, Youth and Women's Health Service and the Northern and Far Western Regional Health Service, which commenced in February 2005.

#### *The South Australian Aboriginal Health Partnership*

The South Australian Aboriginal Health Partnership (SAAHP) 'Aboriginal Health – Everything Business' Regional Resource Package 2005–10 is a cross-sector strategic Planning resource for use by state, organisations and community stakeholders. Its purpose is to provide a holistic approach to improving health and wellbeing service provision outcomes for, and with, Aboriginal communities, families and individuals on community identified priorities (SAAHP, First Step Regional Plans, 1997). The resource contains cross-sector strategic directions and desired outcomes for:

- diabetes
- social and emotional wellbeing
- substance misuse
- health data and information collection (organisational enablers)
- health workforce development (organisational enablers).

#### *Community constables*

Community constables have joined the Drug Action Teams in Adelaide and the Far North (based in Port Augusta to work on greater links and partnerships between local police and Aboriginal communities. Through community constables' work, Aboriginal communities are being encouraged to develop and participate in alcohol and drug-related crime reduction strategies for their communities.

#### *Workforce initiatives*

The Department of Health and the Adelaide University have jointly funded the development of a promotional tool to attract Aboriginal students to health-related courses.

The department jointly funded the Croc Festival in Port Augusta in September 2004. The Aboriginal Health Division of the department attended the festival and delivered health promotional material.

### *National Palliative Care Program*

Under the National Palliative Care Program, South Australia received funding to undertake activities to improve access to palliative care services for Aboriginal and Torres Strait Islander people. Work commenced to adapt the national Aboriginal palliative care resource kit. A South Australian Aboriginal Palliative Care resource kit is being developed to assist mainstream palliative care workers to provide culturally safe palliative care throughout the state.

In 2005 additional funding was provided to develop a companion resource to the resource kit, which is to include locally relevant cultural information. Funding was also provided to undertake initiatives such as community awareness programs on palliative care for Aboriginal and Torres Strait Islander people and a series of palliative care workshops for Aboriginal health service workers.

### **Regions**

#### *Pangula Mannamurna – South Eastern Aboriginal Social and Emotional Wellbeing Centre*

The Centre received funding for a 12-seater vehicle to provide transport for members of the South East Aboriginal and Torres Strait Islander community. This will result in increased member participation in health and social welfare programs operating from Pangula Mannamurna and increased access to services in Mt Gambier and surrounding districts to improve Aboriginal wellbeing.

#### *Hills Mallee Southern Region*

The Lower Murray Nungas Club has provided a partnership model to facilitate services for the Aboriginal community. Services provided under the model include the following fortnightly services: general practitioner, podiatry clinic, physiotherapy and diabetes education.

Women's health camps, youth camps and elders camps and programs addressing health and wellbeing have been delivered in the region.

The Lower Murray Nungas Club has been identified as the most desirable place to provide culturally appropriate programs to Aboriginal people. Extensive plans have been developed with the Department of Health and OATSIH regarding development of this site.

The Eyre Health Service Community Aged Care Package Program has continued to provide flexible community services for older people. During the reporting period some services have been expanded to focus on services being delivered in the community.

Clinical support for rotation of staff from Aboriginal Community Controlled agencies with local Health Service Partnership between local Health Service and Social and Emotional Wellbeing Team in Ceduna and Port Lincoln to provide mentoring, training and collaborative programs, shared care protocols and clinical pathways.

An Aboriginal Families Forum has been developed in partnership with the Early Childhood Advisory Committee and the Aboriginal Primary Health Care Access Program (APHCAP).

#### *Northern and Far Western*

An Aboriginal Health Profile for the region has been implemented to ensure responses to health and wellbeing needs are appropriate.

The region worked in collaboration with the Umoona Community Council to sustain the Mothers and Babies Group in Coober Pedy. This group promotes healthy choices, hygiene,

play and attachment between parent/child and self-esteem for parents. Funding has been provided for the next 4 years.

A consortium selected the North and Far Western Regional Health Service (NFWRHS) as the lead partner to reduce middle ear disease in Aboriginal children aged 0–8 years. The Otitis Media Clinical Support Systems Project is a collaborative project between the department, OATSIH, Royal Australian College of Physicians, NFWRHS, Eyre Regional Health Service and all Aboriginal Community Controlled Health Services in the region.

The Regional Aboriginal Integrated Social and Emotional Well-Being (RAISE Well-Being) Project has been operating through-out the reporting period. The goal is to improve the mental health and wellbeing of Aboriginal people within the Region.

The Aboriginal Mental Health Promotion and Arts Project provides sustainable prevention, promotion and early intervention in mental health, by culturally appropriate community development with an arts focus in Oodnadatta.

During March 2005 the Regional Health Board undertook a mid-year review on additional funds and supported an allocation of \$23,000 towards an Aboriginal Community Controlled Project. The APHCAP plan was implemented with additional Aboriginal resources employed in regional Aboriginal communities and mentor supports from local health units.

### *Riverland*

The Aboriginal Men's Group and Women's Group have been growing significantly in the last few months and are steadily improving access to health services. Men's Group guests have included a physiotherapist, Director of Community and Allied Health Services, mental health worker and dietitian.

The Australian Government and the Department of Aboriginal Affairs and Reconciliation (DAARE) have funded a major community development project to address Indigenous family violence. The Aboriginal Health Division, Families and Communities and DAARE are agency partners for this project, which will be auspiced by Riverland Regional Health Service.

Aboriginal community aged care services have been expanded in recent years through submissions for specific funding through Home and Community Care and Community Aged Care Packages (CACPs) and a submission for further CACPs is being developed for the 2005–06 funding round.

A six-month Aboriginal early childhood development needs assessment and service development project funded by APHCAP commenced in January 2005 and the report is being finalised.

The 'Opening Doors' Demonstration Project commenced taking clients in January 2005 and provides supported accommodation and mental health intervention to young Aboriginal people with complex needs. This interagency service model is underpinned by a Memorandum of Understanding between the non-government sector, the SA Housing Trust and the health services.

The Regional Health Authorities draft Business Plan identifies mental health as a key element of the Aboriginal Health Plan to be developed.

### *Wakefield*

Health screenings have been undertaken for Aboriginal children at the local school in partnership with Narangaa Youth.

During the reporting period there have been regular mental health nurse visits to the Point Pearce community.

### *Children, Youth and Women's Health Service*

The Children, Youth and Women's Health Service Aboriginal Health Strategy 2005–10 identifies strategies to improve access to mainstream services and the expansion or development of specific services for Aboriginal and Torres Strait Islander people with an emphasis on prevention and early intervention.

### *Southern Adelaide Health Service*

Aboriginal Primary Health Care Action Plan funding from both the Commonwealth and the state has been provided and is currently being held by Nunkkuwarrin Yunti. Planning Officers will be employed to establish a service model that will integrate existing GP services to provide culturally appropriate healthcare services to the Aboriginal and Torres Strait Islander community.

An Aboriginal mental health liaison service and primary health care for Aboriginal people in the western metropolitan area has been established at the Noarlunga Health Service.

## **Tasmania**

Tasmania reported that no specific health promotion programs for Aboriginal and Torres Strait Islander people were funded in 2002–03 or 2003–04.

## **Australian Capital Territory**

In 2002–03 and 2003–04, ACT Health funded a range of targeted health promotion initiatives through the Healthpact community funding program, including programs for Aboriginal youth, sporting activities, quit smoking, epilepsy awareness, sexual health, and a cultural camp for Ngunnawal Elders. Projects funded and delivered by ACT Health's Health Promotion Unit included a Vitality Promotion at the National Aboriginal and Islander Day Observance Committee Week Family Picnic Day, and a 3-month nutritional program for young Aboriginal mothers.

## **Northern Territory**

The Department of Health and Community Services funds a variety of health promotion initiatives targeting priority health issues for Aboriginal people. In addition to these initiatives, the department employs Aboriginal Health Promotion Officers to work with rural and remote Aboriginal communities in the development and implementation of health promotion initiatives. Health promotion training and support is also provided for health and community services staff to work in health-promoting ways, including the use of *The Public Health Bush Book: A resource for working in community settings in the Northern Territory*.

## **Life promotion**

### *Suicide prevention*

On 15 October 2003, the Northern Territory Strategic Framework for Suicide Prevention was launched by the Minister for Health and Community Services. This framework acknowledges and builds on existing suicide prevention initiatives and confirms key directions and pathways for future activities. The framework provides a platform to guide future planning and development of programs with a focus on life promotion and prevention. Suicide prevention activities are embedded across a range of government sectors and include the Life Promotion Program.

### *Life Promotion Program*

This program uses a promotion prevention and early intervention approach in the coordination of health promotion strategies through culturally relevant initiatives. It uses a partnership model and aims to support community development, education and training and the management and treatment of suicidal behaviour. The Life Promotion Program is provided by Top End Mental Health Services in Darwin. In Alice Springs, the Mental Health Association of Central Australia is funded to deliver this service.

### **Mental Health Program**

Mental health is a key priority area for the Northern Territory Government. The allocation of an additional \$12.7 million from 2003–04 to 2005–06, and a further \$5.5 million from 2005–06 to 2007–08, to achieve this goal underlines this commitment. The budget in 2005–06 is \$24.4 million, of which \$2.4 million will be spent in funding to non-government organisations service providers. This funding will purchase services which target individuals at high or increased risk and will help broaden the spectrum of care and support to prevent and intervene early with mental health problems, increase access to specialist mental health assessment, treatment and sub-acute care, as well as assist individuals' recovery and rehabilitation.

The Mental Health Program has also supported the establishment of the first non-government peak body for mental health in the Northern Territory. The Northern Territory Mental Health Coalition has been provided with funding to undertake mental health promotional activities. The program is also part of a Health Promotion Evidence in Policy and Practice Project, which is aiming to review the status of health promotion activity across the four priority program areas of mental health, alcohol and other drugs, child and maternal health, and preventable chronic disease. The information will be used to help determine best practice health promotion interventions in the Northern Territory.

Mental Health service provision data collected since 2000 indicates that:

- 38% of all consumers assisted by the community based (non-inpatient) mental health services are Aboriginal (10% above population proportion of 28%)
- 42% of admissions to mental health inpatient facilities are Aboriginal (14% above population proportion of 28%).

### *Aboriginal Mental Health Workers*

Aboriginal Mental Health Workers play an instrumental role in overcoming challenges at the individual and community level by contributing to the delivery of well-informed information and interventions to Aboriginal people. They work hand in hand with mainstream mental health professionals to provide services and act as cultural brokers and mediators, as well as providing mental health assessments, management, and education at an individual, family and community level.

### *The Australian Integrated Mental Health Initiative*

This initiative (AIMHI) is a national 5-year research project for consumers suffering chronic mental illness. AIMHI has sites in New South Wales, Victoria, Queensland and the Northern Territory. Its Northern Territory site, the remote Top End, is one of only two Indigenous sites in Australia.

The AIMHI in the Northern Territory is targeting remote Top End people with a chronic mental illness and aims to improve community-based interventions and the links between remote community services and urban services. It is also developing strategies for mental

health promotion in remote communities which include developing culturally appropriate resources, links with other programs such as Alcohol and Other Drugs, and strategies to improve mental health literacy within remote communities.

### **Growth Assessment and Action Program**

This program aims to improve the growth of Aboriginal children aged 0–5 years through regular monitoring and early intervention if growth falters. The three components are: growth monitoring, growth promotion or growth-promoting action, and growth surveillance at 6-monthly intervals.

### **Community Nutrition Worker Program**

The Department of Health and Community Services funds a variety of nutrition promotion initiatives targeting priority nutrition issues for Aboriginal people of the Northern Territory. In addition to these initiatives, the department funds communities to employ Aboriginal nutrition workers to develop and implement nutrition programs in their communities. Training and support for nutrition workers are provided by visiting public health nutritionists

### **Strong Women, Strong Babies, Strong Culture Program**

SWSBSC is a community-based program run by Aboriginal women and based on Grandmothers law. The program provides bicultural health promotion, education and support to teenage girls and women. SWSBSC coordinators are based in Alice Springs and Darwin and provide support to community-based Strong Women Workers. In 2003–04 there were 14 communities with the SWSBSC Program. Activities during this time included supporting cultural ceremonies and traditions for women, education to post-primary school girls and young women on healthy lifestyles and nutrition, supporting women during pregnancy and helping mothers care for young children, including involvement with the Growth Assessment and Action Program. A training workshop for all the Strong Women Workers was held in 2003.

### **Alcohol and Other Drugs Program**

The Alcohol and Other Drugs Program maintained Community Education and Research officers in each Northern Territory region during 2003–04 to provide drug and alcohol expertise and to support community action to respond to substance misuse issues. These officers undertook a range of activities including the provision and administration of health promotion grants, development, coordination and delivery of public education campaigns and of resources, and provision of information, education and support to communities in relation to drug and alcohol issues. The range of substances covered includes alcohol, tobacco, inhalants, cannabis and other illicit drugs. The *Tobacco Control Act 2002* was introduced in 2002–03. The object of the Act is to reduce the harm to people's health from the consumption of tobacco products by discouraging people from smoking, by reducing people's exposure to environmental tobacco smoke, and by supporting people to stop smoking. Community educators and policy officers arranged public education campaigns, public information forums and site visits to communicate the new legislation requirements. 'No Smoking' signage and other health message signage was provided and distributed by the Department of Health and Community Services. All tobacco retailers became licensed and new point of sale restrictions came into force with high penalties for failure to comply.

**Box 4.1: Data issues**

*In supplying the data for this indicator, some states and territories had difficulties in identifying some expenditure on health promotion programs and in isolating expenditure on social and emotional wellbeing and mental health. This was particularly the case where programs were funded holistically. As there was no detailed definition of 'health promotion' and 'mental health and social and emotional wellbeing', states and territories are likely to have interpreted these concepts in different ways, affecting the comparability of expenditure estimates provided. Queensland also noted that it was extremely difficult to quantify the proportion of expenditure that can be considered 'Indigenous specific' as many mainstream health promotion programs have significant and direct benefit for all subgroups of the population, including Indigenous people.*