Australian Government
Australian Institute of Health and Welfare

access

INSIDE

Issue 20 September 2005

Special Edition

Simply and Plainly

A comprehensive picture of Indigenous health and welfare

'There's a concern out there that statistics fall on deaf ears.

'But it's very hard to convince policy makers about what we should be doing and where we should be spending the money—without good data.'

Such were the catchcries marking the release of the fifth biennial ABS–AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*—launched on 26 August 2005 by the Chief Executive, Department of Health in South Australia, Jim Birch, and Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma.

The launch, hosted by Australian Statistician Dennis Trewin and AIHW Director Richard Madden, was held at Tandanya, the National Aboriginal Cultural Institute, in Adelaide.

Jim Birch, who until recently chaired the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data, explained that while there were some improvements in Indigenous health, Australia 'could not afford to be complacent'.

'It clearly demonstrates that the health status of Australia's Aboriginal and Torres Strait Islanders is poor in comparison to the rest of the Australian population—but there are some improvements in education, employment, home ownership and health status.

'In education, for example, retention rates to Year 10 and beyond steadily increased in the last decade. This trend is particularly evident at the Year 11 level, where it rose from 47% in 1996 to 61% in 2004.

'Higher school retention rates are a particularly encouraging sign because better education is one of the most important factors in improving health.'

Other major health and welfare trends in the report outlined by Mr Birch included:

- Between 1994 and 2002, the proportion of Indigenous people aged 18–64 years in mainstream employment increased from 31% to 38%.

At the launch of the *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005* report. From left: Dennis Trewin, Richard Madden, Jim Birch, Tom Calma and Peter Collins

- The proportion of Indigenous households who owned their own home increased from 26% to 30% over the same period.
- Recorded Indigenous mortality rates declined in Western Australia between 1991 and 2002. Infant mortality rates in Western Australia, South Australia and the Northern Territory also fell over the same period.
- Indigenous people were at least twice as likely as non-Indigenous people to have a profound or severe disability.
- Between 1996 and 2001, the life expectancy of Indigenous Australians was around 17 years less than for other Australians.
- Aboriginal and Torres Strait Islander peoples are twice as likely to be hospitalised as other Australians.
- Despite major disparities in health status between Indigenous and non-Indigenous people in Australia, spending on health services per person is only slightly higher for Indigenous Australians—an estimated $3,901 per Indigenous person, compared to $3,308 per non-Indigenous person.

Mr Birch said that the greater per person amount spent on health services for Indigenous people was 'clearly not enough' given their vastly inferior health status.

In his response to the report, Tom Calma said the overall picture of the health and wellbeing of Australia's Indigenous people was a bleak one.

'How many more years will have to pass before the person launching this report can say that Indigenous Australians enjoy the same health as other Australians?' he asked.

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Contents

from the Director

You will notice as you read this edition of *AIHW Access* that there is a strong focus on statistics relating to Aboriginal and Torres Strait Islander people. The fifth AIHW–ABS biennial report: *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005* was launched on 26 August at the Tandanya National Aboriginal Cultural Institute in Adelaide. Mr Jim Birch (former Chair of the National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) and CEO of the South Australian Department of Health) and Mr Tom Calma (National Aboriginal and Torres Strait Islander Social Justice Commissioner) launched this important publication. It provides a comprehensive overview of the health and welfare of the Indigenous population. You can read about the launch in our lead article on page 1.

On 4–5 October 2005 a meeting to convene the Health Measurement Group in Vancouver will attract participants from Australia, New Zealand, USA and Canada. The meeting will address the measurement of health disparities for Indigenous populations and consider improvements in measurement methodologies. Key Aboriginal and Torres Strait Islander representatives will attend the meeting.

The Institute's Certified Agreement proposal was accepted by staff in July for the next three years. It establishes a good remuneration framework to enable the Institute to continue to recruit and retain valuable staff essential for providing quality statistics on health and welfare issues.

The traditional annual soccer match was contested in July and despite the less than optimal conditions (slight rain, cold and lots of mud) the players enjoyed a 2-all draw. I refereed the game and was lucky to stay on my feet throughout.

AIHW's 18th birthday party celebrations were in July this year to coincide with the Board meeting. A French theme was adopted due to it being Bastille Day and the festivities were enjoyed by all who attended.

The Board Chair welcomed Chrysanthe Psychogios to her first meeting as the staff-elected Board member. I would like to take this opportunity to acknowledge the contribution made by Justine Boland during her tenure as the staff-elected Board member.

Some readers may be aware that, after much consideration, I have decided not to seek a third term as Director of the Institute. I have been most fortunate to have spent almost 10 years at the Institute and have thoroughly enjoyed working with a remarkable team of great people, both here in Canberra and across our wide range of collaborating centres.

The Board Chair, Peter Collins, will be leading the search for a new Director. I am hoping that a new appointee will be in place by January so that there will be no break in continuity. In the meantime I look forward to my final months leading up to the festive season which will bring me to my last edition of Access.

Richard Madden, Director, AIHW.

Richard Madden's remarks, biennial report launch, 26 August 2005

'We are here today to launch the fifth edition of *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, a report produced jointly by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW).

The report contains around 300 pages of detailed information about Australia's Indigenous people, ranging from demographic characteristics, to details of housing, health service provision, community services, mothers and babies, health risk factors and mortality.

The first report in this series was launched in Darwin in April 1997, just over 8 years ago by the then Governor-General Sir William Deane along with the then Chair of ATSIC (who is sadly no longer with us). Launches of subsequent editions have involved Jan Reid (then AIHW chair), Sol Bellear, Mick Reid, Barbara Flick, Fiona Stanley and Ted Wilkes. I am delighted that Peter Collins, our current Chair, Tom Calma and Jim Birch are continuing the tradition of giving this report a high-profile launch. The contents of the report merit it.

The report reveals clearly and starkly the many dimensions of Aboriginal and Torres Strait Islander peoples' lives in the Australia of today. The fifth edition continues what I trust will be a long tradition of simply stating the facts. It does not preach, it does not blame, it does not apologise. It simply speaks, and I hope it speaks plainly.

Through most of the 20th century, statisticians have not had much to be proud of in describing Aboriginal and Torres Strait Islander peoples. The first years were promising, despite the constitutional ban on including full-blood Aboriginal people in the estimates of Australia's population. Coghlan had estimated an Aboriginal population of around 200,000 in 1900. Contrary to popular belief, the census continued to enumerate everyone possible, and reported on all of them. But only about 30,000 were enumerated in the 1911 census (Official Yearbook of the Commonwealth of Australia, No. 6, 1913, pp.108–09). Nevertheless, the 1913 Yearbook discusses the possible population of 'Aboriginal natives', with the general opinion of 150,000 reported. The race is said to be 'rapidly disappearing' (op cit, p.107), and two estimates around 100,000 are also mentioned. In retrospect, it is disappointing that there was not more analysis to back up this sweeping and important statement, but it fitted with the sentiment of the times (cf Daisy Bates, 1938, The Passing of the Aborigines).

The Bureau of Statistics continued to publish estimates of Aboriginal population up until the 1960s, calculated much as described following the 1911 census. For example, the 1967 Yearbook (p.206) estimates the Aboriginal population at 79, 253.

Given the example of Coghlan and the Commonwealth Statistician in 1913, it is a pity later statisticians did not attempt more thoughtful estimates of the Aboriginal population. One can only speculate on the policy consequences if the official estimates had been between 150,000 and 200,000 over the 50 years after the First World War (that is, more in line with Coghlan and Knibbs' estimates), rather than numbers one-third of this range.

Aboriginal people are largely invisible in successive Australian Yearbooks. The special article which appeared in 1930 (estimating the Aboriginal population at European settlement to be 250,000 to 300,000) was the last until 1998!

Real statistical effort got underway only in the 1980s. Indigenous identification was introduced in births and deaths registrations. The first Australia's Health (1988) included a full chapter on Aboriginal health.

In the 1990s, the ABS and AIHW agreed to work together, an advisory committee with an Indigenous majority was put in place, the present series of biennial reports began in 1997, and in the same year, a plan to improve Indigenous health statistics was approved by AHMAC. This was evocatively, and even provocatively titled *The Aboriginal and Torres Strait Islander Health Information Plan: This Time Let's Make it Happen*.

Why all this activity to collect information on Aboriginal and Torres Strait Islander people? Firstly, Australia's Indigenous people are not just any sub-group within the Australian population. They are the descendants of people who have been occupying Australia for many thousands of years and who have had to bear a grossly

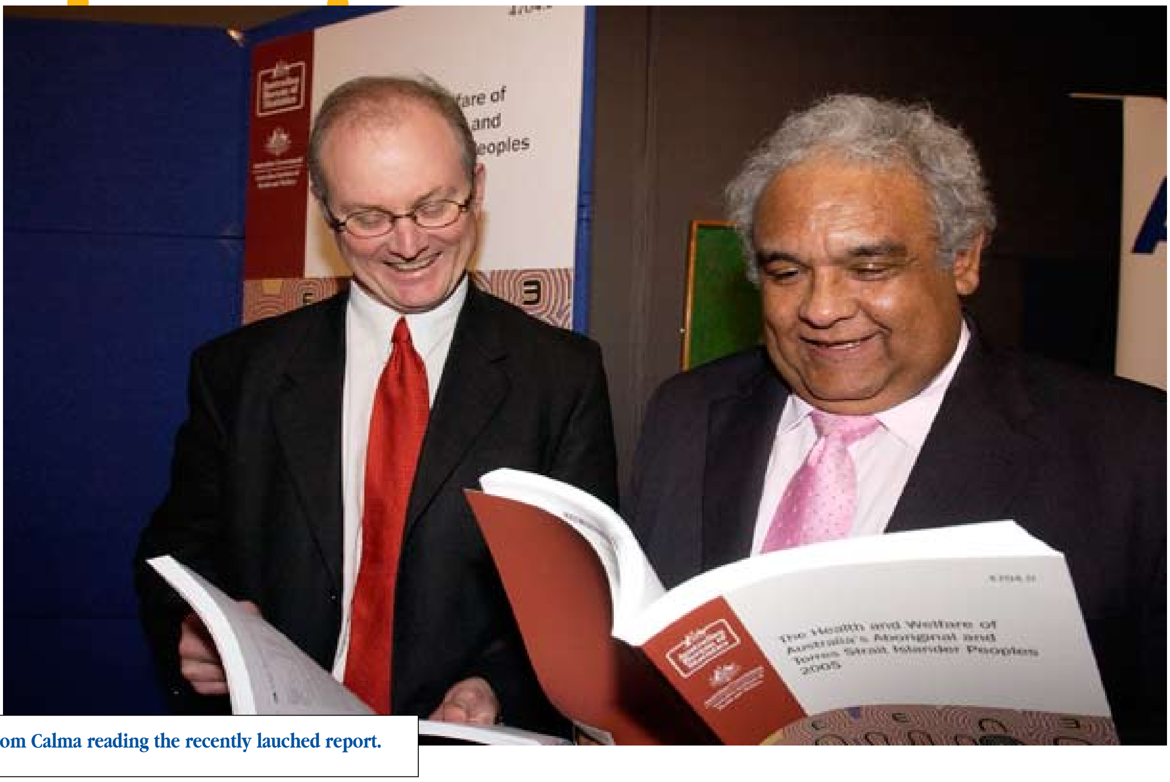
disproportionate impact of the arrival of all of the rest of us on these shores. I do not have time today to list out the great many disadvantages this has caused them. They are well recorded and available for anyone who wants to hear.

One of the most severe inheritances of this colonisation on Indigenous people has been very poor health status. This report describes the health status of Australia's Indigenous people in some detail, and for the first time includes disability status.

It is important that everyone in Australia recognises these facts and works towards fixing the situation. It is statisticians' particular responsibility to work with Indigenous people to describe and analyse the reality, so we can know where to place our major efforts. This two-yearly snapshot is meant to inform debate and guide policy. As Ted Wilkes said at the launch of the 2003 report, 'If you are going to convince anyone of the seriousness of Indigenous health status in Australia, you have to have the information to convince them'.

Collecting, analysing and reporting on the health and welfare of Australia's Indigenous peoples are hard tasks. The AIHW and ABS have worked closely with a wide range of groups to improve quality. But we have not allowed the excellent to be the enemy of the good. Usable data in this difficult field has been the goal, with continuous improvement always on the agenda.

This report sets out what we know now, and it is a credit to all concerned. Since it began in 1987, the AIHW has been and continues to be deeply committed to Indigenous statistics. Our joint unit with the ABS in Darwin until 2002, and now the unit at AIHW headed by Dr Fadwa Al-Yaman, have 'made it happen'! I am proud of everyone involved. Long may it continue'.



Jim Birch and Tom Calma reading the recently lauched report.

project reports

Third Report on Health Expenditure for Aboriginal and Torres Strait Islanders

Project 1

The third report on health expenditure for Aboriginal and Torres Strait Islander people for the 2001–02 financial year was released on 20 July 2005.

In 2001, Indigenous people comprised 2.4% of the total Australian population. Just over $1,788 million was estimated to have been spent on Indigenous health in 2001–02, an increase of $432 million from 1998–99. This was 2.8% of total national health expenditure in 2001–02. Average expenditure was $3,901 per Indigenous person compared to $3,308 per person spent on all other Australians—a ratio of $1.18 for every $1 spent on other Australians.

While the total amount spent on health services to Indigenous people increased between 1998–99 and 2000–01, from $1.4 billion to $1.8 billion, the ratio of estimated per person health expenditure between Indigenous and other Australians has changed little. The ratio reflects considerable differences in the mix and relative costs of health care for the two populations. There has been particularly rapid growth in expenditure on some health services that are used less by Indigenous Australians.

The overall spending ratio does not necessarily indicate that Indigenous people use more health services. Many services to Indigenous people are more costly to deliver, both because of geography and because many health services have to be provided in different ways from the mainstream so that Indigenous people will use them.

A greater proportion of the Indigenous population lives in remote and very remote regions (26% compared with 2%). The costs involved in just getting services to such areas are much higher than for more settled regions. But, even in urban areas, many Indigenous people are relatively low users of mainstream services. The report shows that Indigenous Australians use Medicare and the Pharmaceutical Benefits Scheme, at 39% and 33% respectively of average use by other Australians. This has not changed much since 1998–99. This is offset to some extent by increased access to specific programs such as Aboriginal Community Controlled Health Services, and other community health services targeted to Indigenous people.

Almost two-thirds of the expenditure on health services to Indigenous people (72%) occurred in the provision of hospital services (48%) and in community health services and public health activities, including Aboriginal Community Controlled Health Services (25%). The remainder (28%) included mainly expenditure on medical services, dental services, pharmaceuticals and residential aged care services. In contrast, hospital services accounted for 34% of health expenditure on all other Australians, and community health services comprised only 5% of expenditure on all other Australians. Almost one-third of expenditure on other Australians was for Medicare and the Pharmaceutical Benefits Scheme (32%). Indigenous Australians used services provided through Medicare and the Pharmaceutical Benefits Scheme at only 39% and 33% the levels of use by other Australians. They also used private dental and other professional health services significantly less than other Australians. This is probably because only 15–20% of Indigenous Australians have private health insurance, which commonly pays for these services.

The Australian government was the source of 43% of Indigenous health expenditure. State and territory governments provided 50%, and 7% came from private services including medical insurance. For all other Australians, the Australian Government provided 49%, state and territory governments 20% and 33% came from private services. However, 71% of the money was spent in programs managed by state and territory governments, 23% through Australian Government programs and 6% by non-government organisations.

For the first time, the report includes estimates of welfare expenditure on Indigenous Australians, in particular expenditure on welfare services for the aged and people with disabilities. This expenditure is not included as health expenditure, but at $152 million, it was equivalent to 9% of the total expended on the health of Indigenous people.

While the per person spending on health services for Indigenous people is slightly higher than other Australians, any analysis of per person spending on health services for Indigenous people should take into account the comparatively poor health of Indigenous people. Mortality rates for Indigenous Australians are three times the rate of other Australians, and Indigenous people die on average 17 years younger than the average for all Australians.

Fadwa Al-Yaman
Unit Head
Aboriginal and Torres Strait Islander Health and Welfare Unit
July 2005

Redeveloped National Data Collection for the Homeless Implemented

Project 2

On 1 July 2001 a 'core data set' was implemented for the SAAP National Data Collection (NDC), which describes the major program response to people experiencing, or at risk of, homelessness in Australia. The release of the core data set was the culmination of a number of years of consultation between the AIHW and the Supported Accommodation Assistance Program (SAAP) service providers, the SAAP state, territory and Australian government administrators and the SAAP peak organisations. The consultations attempted to balance the reporting load of providers, the data needs of administrators, program advocates and the service providers themselves and the extent to which the data were practical to collect.

There were three important elements of the SAAP NDC redevelopment:

- New paper and electronic collection tools were introduced which pared the core data set back from 29 questions to 23.
- Important data definitions were aligned with national standards, redefined to assure better quality data and more clearly articulated to ensure consistency of interpretation.
- The SAAP NDC adopted a linkage key common to other community services and aged care data collections that will allow for longitudinal analyses of service usage within SAAP and between SAAP and other community services and (possibly) health programs.

The three above-mentioned elements of the SAAP NDC were tested with more than 200 service providers over 18 months. The design and testing of both the paper and the electronic collection tools were undertaken by Supported Accommodation and Crisis Services (SACS) Unit staff and the implementation of the redeveloped data collection was accompanied by over 50 information sessions for service providers in all states and territories, including rural and remote centres such as Kunnunurra, Mt Isa and Burnie.

Since implementation on 1 July, the SAAP National Data Collection Agency Hotline at the AIHW has been kept very busy responding to core data set enquiries from the 1300 NGOs funded to provide services about their homeless clients. Fortunately most of the calls are relatively routine, such as requesting assistance with installing their upgraded or new electronic data collection tool or asking for more paper forms. Reaction to the redeveloped forms, revised data definitions and new linkage key has been overwhelmingly positive. This strong endorsement of the changes to the SAAP NDC augers well for the future quality of data produced about the SAAP. The collection will continue to be supported by a training program conducted by the SACS Unit staff across Australia.

While the SAAP core data set implementation is a major achievement, work will now be required to ensure that the products of the collection produce and report relevant, consistent and accurate data about the SAAP. The data collection tool development work will also not cease. The next version of the SAAP electronic collection instrument (SMART version 6.0) will be developed to facilitate information management by service providers, assist and promote the collection of national data according to national standards and provide the potential to collect data once about a person for multiple program data collection requirements.

Therapy and Equipment Needs Study (TEN)

Project 3

In early 2005 the AIHW and CP Australia commenced the Therapy and Equipment Needs Study (TEN)—the first project of its nature in Australia. TEN intends to contribute meaningful and objective information on the need for therapy and equipment among people with cerebral palsy and related conditions. The project is being supported by funding from Telstra, CP Australia member organisations and contributions from CP Australia and AIHW.

TEN is a collaborative effort between experienced state and territory representatives of CP Australia and a multidisciplinary AIHW project team from the Functioning and Disability Unit. These teams will be operating under the leadership of CP Australia project leaders, Paula Dyke and Anita Ghose (Cerebral Palsy Association of Western Australia) and Ros Madden (Head of the Functioning and Disability Unit of the AIHW) respectively. Input from clients, families, therapists and other experts throughout the project and formally, via an Advisory Committee, will play a crucial role in guiding the direction and content of TEN.

Primary objectives of the project are to:

1. Review and summarise the key findings of national and international literature about the definitions, costs and benefits of therapy, and whether therapy 'makes a difference' for people with disabilities related to, or similar to those related to, cerebral palsy—that is, its relationship to improvements in and maintenance of levels of functioning.
2. Identify the nature and quantify the extent of met, partially met and unmet need for therapies and equipment among people, of different ages, with cerebral palsy and similar disabilities.
3. Estimate the effects of the provision of therapy and equipment in terms of improved or maintained individual functioning and participation, at different ages, and in terms of reduced social costs of disability.

The project methodology involves several components to be interwoven in the analysis in the final report:

- literature review
- analysis of CP Australia client records
- focus groups involving therapists, clients and families
- developing and costing 'archetypal cases' and total needs and
- national data analysis.

A final report is scheduled for release in mid-2006.

For further information please contact Ros Madden (ros.madden@aihw.gov.au) or Paula Dyke (paula.dyke@cpawa.com.au).

project reports

from the Inside

The Aboriginal and Torres Strait Islander Health and Welfare Unit

The Aboriginal and Torres Strait Islander Health and Welfare Unit was established at the Institute in its current form in May 2003. Over the last two years, the unit has made a significant contribution to improving the understanding of Indigenous health, welfare and housing in Australia.

One of the major areas of work for the unit has been on trends in Indigenous mortality—a difficult and contentious area, with issues of data quality, policy implications of findings and numerous interested parties. National and state and territory policy makers including Health Ministers want to know whether the services and programs delivered to Indigenous people are making a difference. It is also important for Indigenous people to know whether health outcomes have improved.

The Unit's work on trends in Indigenous mortality were presented in the 2005 ABS—AIHW biennial report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. This report was launched by Jim Birch and Tom Calma in August 2005. The Unit wrote a number of chapters for this report, including the chapters on housing circumstances, mothers and children, health status and health services and mortality, as well as coordinating major aspects of the production of the whole report.

In the area of housing, the Unit has completed a draft report on the assessment of the extent of Indigenous housing needs, using a multi-measure needs model. The report is currently being used by the Standing Committee on Indigenous Housing to respond to the Housing Ministers' resolution to review housing programs, in order to achieve greater equity in the distribution of housing resources. In addition, the Unit has initiated the collection of data from the Indigenous Community Housing sector and has prepared a national Indigenous housing indicators report.

The Unit is also pioneering work in areas of public health importance where there are currently no national data collections. This includes the collection of data on the health of prisoners and on family violence. Indigenous Australians are affected by both disproportionately to other Australians. The work on the health of prisoners is supported by the Standing Committee on Aboriginal and Torres Strait Islander Health and involves collaboration between the AIHW and the Centre for Health Research in Criminal Justice. A National Minimum Data set has been agreed by the Prisoners Health Information Group.

The Unit is also involved in an international initiative to improve an understanding of Indigenous health and welfare. The Unit Head presented a paper, *The Health of Indigenous Australians: Is It Improving?*, at the *Australia's Health: Vital Statistics*, Vital Signs conference and another paper entitled *Issues and Challenges in Measuring the Health of Australia's Aboriginal and Torres Strait Islander Peoples* at the International Association of Official Statistics Satellite Meeting in Wellington, New Zealand in April 2005. Over the last year the Unit has supported the AIHW Director in collaborative efforts between Australia, the United States, New Zealand and Canada to improve the measurement of health disparities and trends over time for Indigenous populations in these countries. The Unit Head will attend the first meeting in Canada in October 2005.

The Unit is well placed to influence change and participate in the national efforts to improve data through its representation on a number of Groups and Committees. They include: the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID); the Standing Committee of Aboriginal and Torres Strait Islander Health (SCATSIH); the National Indigenous Housing Information Implementation Committee (NIHIIC) for which the unit provides secretariat support; the Standing Committee on Indigenous Housing (SCIH); the Aboriginal and Torres Strait Islander Services Working Group (ATSISWG); the Prisoners Health Information Group; the Indigenous Working Group for the Report on Overcoming Indigenous Disadvantage; the Report on Government Services Health subgroup; the Indigenous Health Survey Reference Group; and the Steering Committee for the Burden of Disease and Injury Study in Indigenous Australians.

'The Aboriginal and Torres Strait Islander Health and Welfare Unit (left to right): Michelle Wallis, Helen Johnstone, Mieke van Doeland, Fadwa Al-Yaman and Michelle Gourley (not pictured: Gabrielle Hodgson, Joanne Maples and Raymond Lovett).

Staff

Fadwa Al-Yaman has been head of the Unit since it was established in 2003. Over the last two years, one of Fadwa's objectives has been to enhance the expertise of the Unit and to build upon the Institute's reputation for providing high quality information on Indigenous health, housing and welfare. Before the establishment of the Unit, Fadwa worked in the Children, Youth and Families Unit where she completed two major reports—*Australia's Young People 2003: Their Health and Wellbeing* and *Australia's Children 2002: Their Health and Wellbeing.*

Prior to joining the Institute, Fadwa had an established career in immunology and spent four years in Papua New Guinea working on a malaria vaccine trial for children. Fadwa has a PhD in immunology from the John Curtin School of Medical Research at the Australian National University (ANU) and a Masters of Population Studies from the ANU. Fadwa enjoys reading, walking and watching movies.

Helen Johnstone has worked at the Institute for seven years and has been with the Unit for two years. Helen is responsible for the national Indigenous housing data collection, in particular, Indigenous Community Housing. For her first five years at the Institute Helen worked in the Children, Youth and Families Unit where she was responsible for the national child protection data collection. Helen has a keen interest in social policy. She completed a Graduate Diploma in Epidemiology and Population Health at the National Centre for Population Health at ANU in 2004. In her spare time Helen enjoys reading, walking, cooking and going to the cinema.

Gabrielle Hodgson joined the Institute in 2000, but had a two-year sojourn in Paris in 2002 when she worked at the OECD. She is a statistician and has worked in the Unit for the past year, mainly on trends in Indigenous mortality. Gabrielle has completed an honours degree in Statistics as well as a Bachelor of Mathematics and Bachelor of Science at the University of Newcastle. Prior to joining the Institute, Gabrielle was with the Australian Bureau of Statistics and the Health Insurance Commission. Gabrielle enjoys card making, belly dancing, reading and travelling.

Michelle Gourley joined the Unit in January 2004 through the Graduate Program after completing an honours degree in sociology at the ANU. Michelle worked on the biennial publication, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005* and is currently working on the latest jurisdictional reports against Aboriginal and Torres Strait Islander health performance indicators. Prior to joining the Institute, Michelle worked as an accounts clerk and spent several months travelling around Europe and the United Kingdom. Michelle enjoys gymnastics, aerobics and travelling.

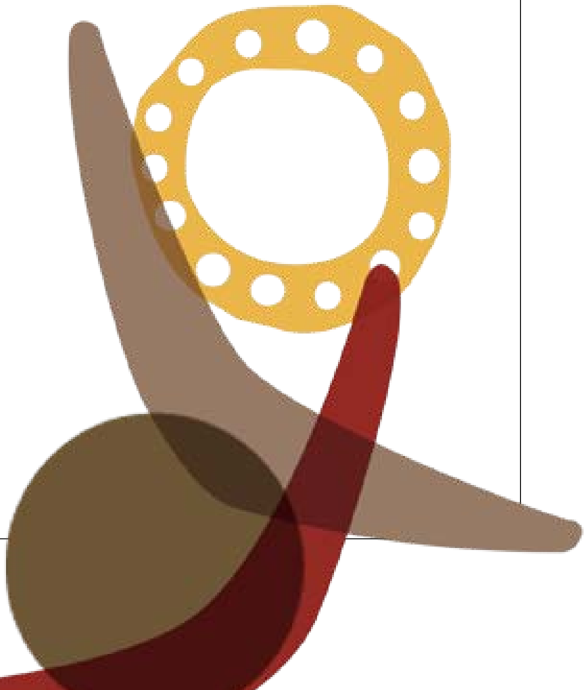
Michelle Wallis joined the Unit recently through the 2005 Graduate Program. Her main focus has been the Indigenous housing reports, as well as helping out with a number of other projects. Prior to joining the Institute, she completed a PhD in Biochemistry and spent two years in the United States performing research into type II diabetes. Michelle enjoys travelling, bushwalking, art, reading and watching movies.

Joanne Maples is a long-standing staff member of the Institute, having commenced in 1988 working on the Institute's first externally-funded project. She coordinates work in two areas of the Institute—in the Welfare Division she brings together contributions to *Australia's Welfare 2005* and in the Aboriginal and Torres Strait Islander Health and Welfare Unit on *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005*. Outside work Joanne enjoys looking after her three school-aged children with their many activities—though she doesn't enjoy dealing with their homework—and doing volunteer work at their schools. She also enjoys playing in masters volleyball tournaments, visiting friends and gardening.

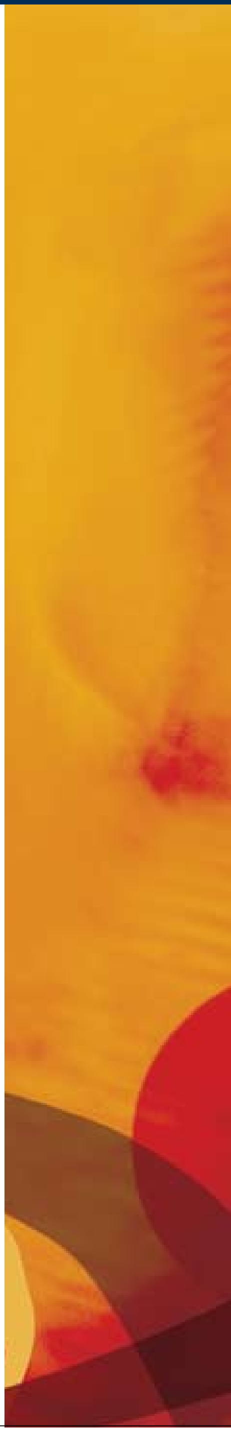
Raymond Lovett moved to Canberra in 2004 to undertake the Masters of Applied Epidemiology at the ANU, from where he has a placement in the Unit. He has written a paper on hospitalisation from diabetes in Indigenous Australians and evaluated the health information system for Canberra's local Aboriginal Medical Service, Winnunga. Ray is a descendant of the Wongaibon people of western New South Wales. He has completed a Bachelor of Nursing and a Bachelor of Health Science and has worked as both a nurse and Aboriginal health educator. Prior to moving to Canberra he worked at NSW Health managing a project aimed at increasing the number of Aboriginal nurses in the New South Wales public health system. Raymond enjoys reading and fishing.

Mieke van Doeland has recently joined the unit. When she first started working at the Institute in July 1998, she was studying for a Graduate Diploma in Epidemiology and Population Health at the National Centre for Population Health at the ANU, and since then has been involved in a variety of projects. While in the Health Registers & Cancer Monitoring Unit, she worked on the Vietnam Veterans Validation Study and on BreastScreen monitoring reports. In more recent years Mieke has focussed on data development work in the areas of aged and community care and palliative care as part of the National Data Development and Standards Unit. Before joining the Institute, she worked in a range of jobs as a physiotherapist and community counsellor.

Mieke's favourite activities include singing, swimming, visiting family and friends in Holland and walking her dog Benny.



National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID)



The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) was established following a decision taken at the Australian Health Ministers' Advisory Council (AHMAC) meeting in October 2000. NAGATSIHID is a standing committee of, and provides broad strategic advice to, the National Health Information Group (NHIG) on the improvement of the quality and availability of data and information on Aboriginal and Torres Strait Islander health and health service delivery.

This group supersedes the National Indigenous Health Information Plan Implementation Working Group (NIHIP IWG) and the Aboriginal and Torres Strait Islander Health and Welfare Information Unit Advisory Committee (ATSIHWIU AC), which had previously advised the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW) on their joint work program on Indigenous statistics. Development of the 2005 Biennial Report, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, featured in this publication, has been guided by NAGATSIHID.

As well as continuing the role of advising the AIHW and the ABS on their joint work program on Indigenous statistics, NAGATSIHID advises NHIG and the Steering Committee for Aboriginal and Torres Strait Islander Health on the National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health jurisdictional reporting and associated activities.

When the Group was established, a major responsibility was to continue the implementation of the National Indigenous Health Information Plan—This time, let's make it happen. Most items included in the original Plan have been completed. NAGATSIHID members have been investing considerable time and intellectual effort to developing a new Plan which will guide its future work program.

A vital element of NAGATSIHID's operations is inclusion of a majority of Aboriginal and Torres Strait Islander members. Aboriginal and Torres Strait Islander Advisors are also called upon to represent NAGATSIHID on various project-specific steering groups and advisory committees. When the current National Health Information governance was established in 2003, the NHIG approved NAGATSIHID having a membership comprising:

(a) a single representative from the following organisations:
  - ABS
  - AIHW
  - Department of Health and Ageing (DoHA)
  - Aboriginal and Torres Strait Islander Services (ATSIS)
  - Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)
  - Torres Strait Regional Authority
  - Statistical Information Management Committee (SIMC)

(b) two representatives from SCATSIH

(c) two representatives from the National Aboriginal Community Controlled Health Organisation (NACCHO)

(d) three Indigenous Advisors on Aboriginal and Torres Strait Islander health and welfare

(e) an epidemiologist with expertise in Indigenous health issues.

The importance of NAGATSIHID is reflected in AHMAC's appointment of one of its members to chair the Group. Mr Robert Griew, CEO of the Northern Territory Department of Health and Community Services, took over leadership at the August 2005 meeting from Mr Jim Birch, CEO of the South Australian Department of Health. The Group was previously chaired by Ms Patricia Faulkner, Secretary, Department of Human Services, Victoria. Mr Mick Reid, then Chief Executive of the New South Wales Department of Health was NAGATSIHID's inaugural Chair.

soap
box

Reflections from the shores of Lake Geneva

In September 1997 I became the head of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Australian Department of Health and Ageing. The health portfolio had taken over responsibility for Indigenous health from the Aboriginal and Torres Strait Islander Commission (ATSIC) only two years before and a strategic plan for the Office was still in its infancy. However several significant reports and processes related to data and performance measurement were in place, and the report This Time Let's Make It Happen, endorsed by The Australian Health Ministers' Council (AHMC), had just been released. AHMC had also agreed, for the first time, to report biennially on a set of 56 national performance indicators in Aboriginal and Torres Strait Islander Health and work was nearly completed on the first report on total health expenditure on Indigenous health. The significance of this report was that it would give the first benchmarking of Indigenous health expenditure against whole-of-health sector and national per capita health expenditure. The Ministerial Advisory Council on Aboriginal and Torres Strait Islander Health had also just endorsed pro formas for service activity reporting information on OATSIH-funded Aboriginal Community Controlled Health Services (ACCHS). All that sounded like a very promising foundation for strengthening the data which were needed to give a sound evidence base for performance measurement, policy development and resource allocation.

Oh, that it had turned out to be that easy! Aboriginal and Torres Strait Islander people constitute only 2.4% of the Australian population. Many of the health and welfare administrative databases from which the information would have to come did not have Indigenous identifiers, and those that did were of variable reliability and validity. Moreover, a history of unilateral use and misuse of data by non-Indigenous Australians, often to the disadvantage and bewilderment of Aboriginal and Torres Strait Islander Australians, meant that Indigenous leaders operated in a climate of significant mistrust and many were disinclined to help resolve data issues. Understandably, it was very hard for them to see what positive benefits for their people might come from cooperating to strengthen data. In relation particularly to service information, this mistrust was compounded by a strongly held view that funding for Aboriginal community controlled health services was an entitlement, part of the self-determination agenda. From that point of view what went on in those services was none of the government funders' business. As well, the Australian Bureau of Statistics (ABS) in these years was unwilling to devote any resources to Aboriginal and Torres Strait Islander surveys, such topics not being seen as core information needs.

While we still only have robust mortality data for 60% of the Aboriginal and Torres Strait Islander population, looking back, nearly eight years later, I am pleased to say that there has been significant progress. Perhaps the major reason for this fact is that we now have a small, but growing, number of articulate and respected Aboriginal and Torres Strait Islander professionals who understand the important role data and evidence can play in improving the health and wellbeing of their people. They are also acutely aware of the misuse to which data can and have been put and are vocal in their informed criticism when this occurs. The contribution of Aboriginal Australians like Prof. Ian Anderson, Dr Sandra Eades, Dr Shane Houston and Ms Debra Reid, among others, to achieving this shift from hostility and mistrust to informed debate, cannot be underestimated. The leadership role taken, collaboratively, by Aboriginal and Torres Strait Islander health services providers, policy makers and funders in the Northern Territory to develop an agreed set of core performance indicators for primary health services (both government and non-government) in the Northern Territory is another example of the shift to a shared view that to make progress it is essential to measure and assess what is being achieved. The AIHW's decision, several years ago, to establish a unit dedicated to building a solid evidence base in Aboriginal and Torres Strait Islander health, ABS's now strong commitment to a sophisticated Indigenous survey cycle and the biennial report produced jointly by those two organisations, have also contributed to building a solider evidence base. The same applies to the development of a comprehensive national Aboriginal and Torres Strait Islander Health Performance Framework and a Service Development and Reporting Framework by experienced and infinitely patient Indigenous and non-Indigenous staff in OATSIH. Even today there are fresh challenges in the form of the requirement by some

colleagues in another portfolio that resources for Indigenous health services require a higher evidence benchmark than do resources for mainstream service providers.

Three months ago I moved to The Global Fund to Fight Aids, Tuberculosis and Malaria based in Geneva. The Fund is a multi-billion dollar financing body which, only four years since its inception, already provides large grants into 130 of the world's poorest countries. The Fund adopted as one of its founding principles performance-based funding. While the scale of the Fund is global, many of the issues it is grappling with have much in common with the challenges facing Aboriginal and Torres Strait Islander health—communities with major multiple health problems, fragile health systems, multiple funders, shortages in skilled professionals, limited expertise in governance and management, and last but not least, limited core data. Funding based on measurable performance in this environment has many challenges and is not without its critics. However, the Global Fund has started with a business model which is, in many ways, at a point we are just moving to in Australia after having painstakingly laid the foundations to enable this to happen.

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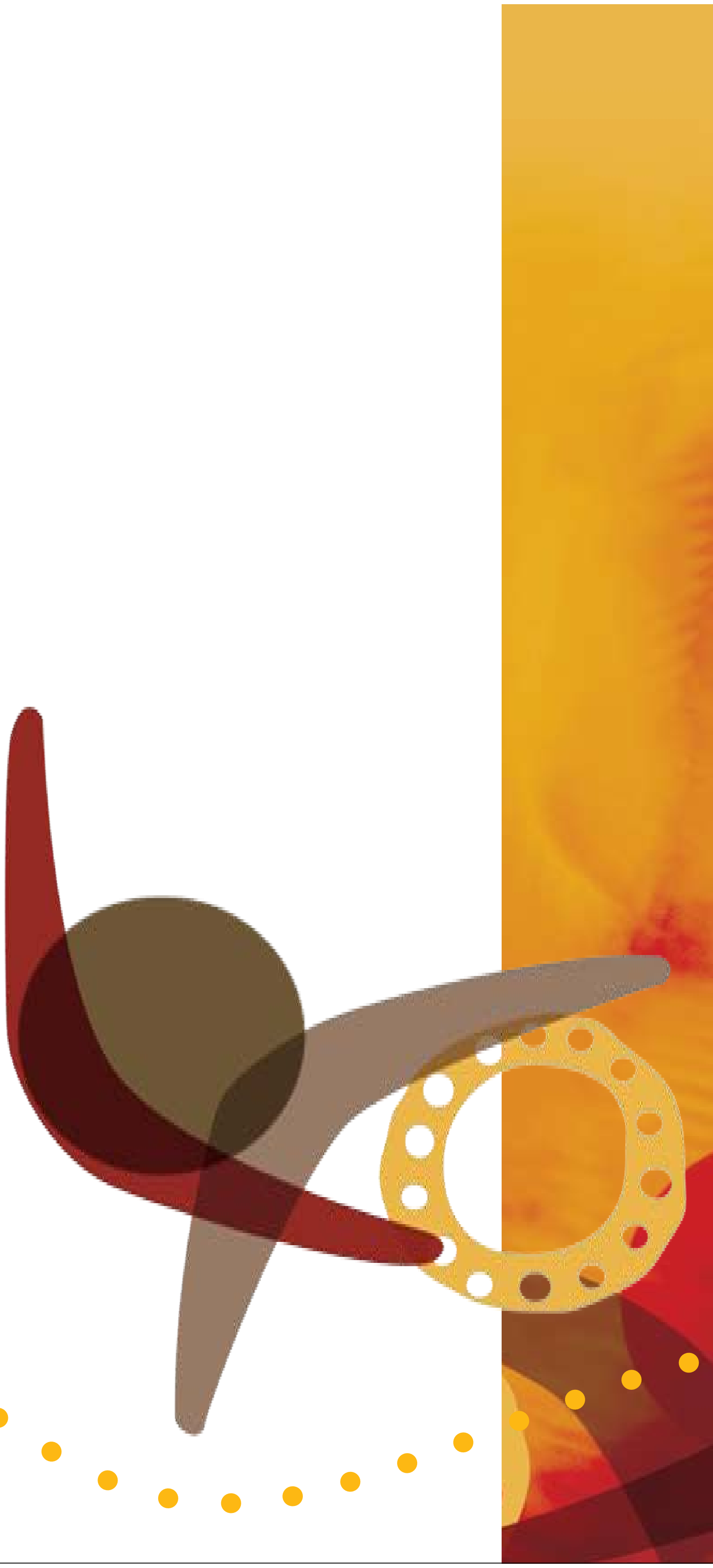

data speak

Aboriginal and Torres Strait Islander peoples

Complete and consistent Indigenous identification in censuses, surveys and administrative data collections is fundamental to developing high quality information about Aboriginal and Torres Strait Islander peoples. This requires substantial effort on the part of government and non-government organisations to establish the broad acceptance of a standard question on Indigenous origin in all key data collections and to set up structures that help with its implementation.

The collection of information on Indigenous Australians in the health, welfare and housing areas is managed and progressed through a number of national committees that provide advice on national priorities, develop work programs and monitor progress. These priorities are articulated into national information plans.

Several years ago, in recognition of the slow pace of progress in collecting information on Indigenous Australians, specific information plans in the health and housing areas were developed and committees were set up to progress their implementation. The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) has overseen the implementation of the National Indigenous Health Information Plan (NIHIP), and the National Indigenous Housing Information Implementation Committee (NIHIIC) oversees the implementation of the Agreement on National Indigenous Housing Information (ANIHI). In the community services area, however, there are no Indigenous-specific information plans, and information and data issues relating to Indigenous Australians are articulated in the National Community Services Information Agreement which is progressed through the National Community Services Information Management Group.

While both the housing and the community services information groups consist mainly of representatives from state and territory governments, the Australian Government, the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS), the structure of the health advisory group, NAGATSIHID, is different in one important respect. It has a majority of Indigenous Australians as members. These come from a variety of backgrounds and expertise including research and academic and health service delivery.

The AIHW and ABS have initiated, and continue to drive, programs in partnership with state and territory authorities, to improve the completeness with which Aboriginal and Torres Strait Islander peoples are recorded in a wide range of administrative data sets. These include birth and death registration, the perinatal data collection, hospitalisation data, cancer registers, community mental health services, alcohol and other drug treatment services, juvenile justice, children's services, and disability services.

Another area where considerable effort has been expended to improve Indigenous identification is communicable diseases. The National Notifiable Disease Surveillance System—managed by the Australian Government Department of Health and Ageing—is a register of 56 nationally notifiable communicable diseases including vaccine preventable diseases, viral infections such as Ross River virus, Human Immunodeficiency virus (HIV), hepatitis A, B and C and some sexually transmitted diseases.

In addition to administrative data, dedicated Indigenous surveys have been implemented by the ABS. The main catalyst for one of the key surveys was the release, in 1989, of the findings of the Royal Commission into Aboriginal Deaths in Custody, which resulted in considerable concern and action. One of the report recommendations dealt with the paucity of statistical information about the Aboriginal and Torres Strait Islander populations. It stated: 'That proposals for a special national survey, covering a range of social, demographic, health and economic characteristics of the Aboriginal population with full Aboriginal participation, at all levels be supported.'

The government agreed to the Royal Commission's recommendation. The ABS was specially funded to conduct this survey, the National Aboriginal and Torres Strait Islander Survey 1994 (NATSIS). The survey covered the full range of social and economic issues and, significantly, explored more sensitive issues around attachment to land and removal from family. Its release focused national attention on the disadvantages of Aboriginal and Torres Strait Islander peoples.

For several years, no resources were identified for a second survey. In 2000, following a review of its household survey program, the ABS announced plans for a 3-yearly Indigenous household survey with alternating focus on health and social issues. The latter has now been recognised as the successor to the NATSIS, with many topics in common. These surveys continue to address gaps in information about Indigenous Australians. For example, the latest National Aboriginal and Torres Strait Islander Social Survey, which was conducted in 2002, collected for the first time information on disability among Indigenous people and therefore estimates of the extent of disability among Indigenous Australians are now possible. Likewise, the 2004-05 National Aboriginal and Torres Strait Islander Health Survey contains for the first time a module that allows an assessment of the extent of social and emotional wellbeing among Indigenous people.

Statistics on Indigenous housing have also improved. The ABS, supported by the Aboriginal and Torres Strait Islander Commission (ATSIC), conducted the Community Housing and Infrastructure Needs Surveys (CHINS) in 1999 and 2001. The 2001 CHINS was conducted in conjunction with the 2001 Census, and updates the 1999 CHINS by maintaining comparability with that collection. CHINS data include details of the current housing stock, and management practices and financial arrangements of Indigenous housing organisations. Details of housing and related infrastructure, such as water, power and sewerage systems, as well as other facilities, such as education and health services available in discrete Aboriginal and Torres Strait Islander communities, are also collected. The 2006 CHINS will provide continuity with previous surveys and enhance the quality of some of the data collected in the earlier surveys. The AIHW has been working with states and territories under the National Indigenous Housing Information Agreement to collect data on Indigenous residents of public housing and of Indigenous-specific housing including those managed by the states as well as those managed by the Indigenous community housing organisations.

The difficulty of estimating the size of the Indigenous population in the face of the uncertainties over the level of identification is a problem that remains today. Much effort is dedicated by the ABS—with advice from other groups including the AIHW and NAGATSIHID—to improving census enumeration of Indigenous people.

In summary, the picture of Indigenous statistics in 2005 is as follows:

- a recognition that enumerating Indigenous people is a complex task, and that estimating Indigenous population is a matter needing sophisticated techniques as well as judgment
- Indigenous births and deaths statistics for all jurisdictions; but the quality is variable and inconsistent
- an array of administrative by-product data exist showing service use by Indigenous people
- regular Aboriginal and Torres Strait Islander health and social surveys are in place
- improved methods to assess trends in infant and adult mortality adult over the last decade among Aboriginal and Torres Strait Islanders in selected jurisdictions—Western Australia, South Australia and the Northern Territory.

Although the years since 1990 have been very different from earlier years for Aboriginal and Torres Strait Islander statistics, progress in collecting and publishing Indigenous statistics still poses a range of old and new analytical and conceptual issues.

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Unit Head
Aboriginal and Torres Strait Islander Health and
Welfare Unit

Sections of this article are based on a paper by Richard Madden and Fadwa Al-Yaman entitled 'How Statisticians Describe Aboriginal and Torres Strait Islander Peoples' which was presented by Richard Madden at the Australian Institute of Aboriginal and Torres Strait Islander Studies, July 2003.

trustme

Sizing up sin and other things — the population attributable fraction: Part 1

‘Over 80% of lung cancer deaths are due to cigarette smoking.’

‘We could cut heart attack deaths in Australia by an estimated 30% if we all took up regular exercise.’

‘440 road deaths in 1998 can be attributed to alcohol use.’

Gee they’re clever, these scientific authorities. Do you ever wonder how they come up with figures like this? I mean, do they just make them up? Or does someone actually go out and count the bodies around the country and arrive at a percentage? And do the poor victims die with flags on them saying things like ‘sunk by the smokes’ or ‘slain by sloth’?

Don’t be silly, of course not. But the estimates we make can be almost as good as if this really were the case. They’re a routine and vital way of assessing the overall population impact of various problems—risk factors like smoking, obesity, not wearing seat belts, and any number of others.

And luckily, you don’t need to be clever to make them. What you do need is to draw carefully on a raft of research about the factor concerned and a particular disease or injury. You then combine the level of disease in those ‘exposed’ to the problem, the level in those not exposed and the proportion exposed.

The result is commonly known as the population attributable fraction, the fraction of all the deaths or cases of a disease or injury in a population that can be attributed to the risk factor—statistics like those at the top, for example. Or the measure may alternatively be known as the aetiological fraction, which just means the causal fraction—but why use a simpler word when there’s a complex one to hand?

So in this first of two parts in *Access* I’ll aim to introduce the population attributable fraction and how we work it out. It’s a concept that the AIHW has made excellent and influential use of in some of its publications, notably on the burden of disease and on drug-caused death and ill health. [1, 2] (Oh, and sorry, this article isn’t really about sin, in case you hoped it was. Unless you think that things like smoking, sloth and gluttony are sins and not just the simple joys of life …)

But so far things may have been a bit technical and vague and we’re probably getting ahead of ourselves. How do we arrive at a population attributable fraction? Let’s walk through the process.

The steps involved

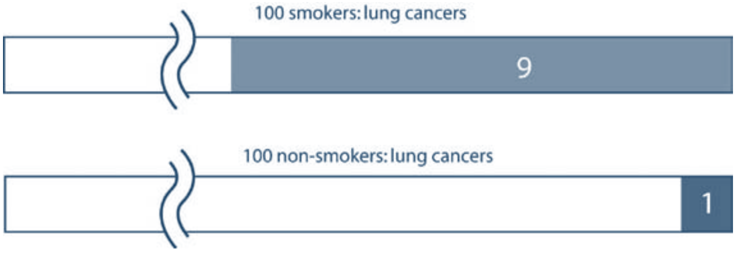
First and foremost, it must have been firmly established that the factor plays a causal role in the disease or injury. This always means drawing on studies of huge numbers of people and on many different numbers and types of studies, including laboratory, clinical and population research (where they often *do* have to count bodies)—many lines of evidence that point to the same conclusion. In fact, I wrote about causation in an early issue of *Access*.

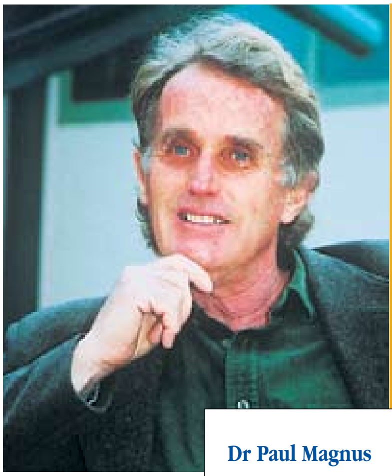
The next step is to work out the extra risk for individuals who have the factor compared with those who don’t. Taking a particular disease or injury, if a factor carries five times the risk, all else being equal, it is said to have a relative risk of five.

Finally, there is a formula to combine this relative risk with knowledge about the factor’s frequency, namely how common it is in the population. This produces the population attributable fraction.

Two examples

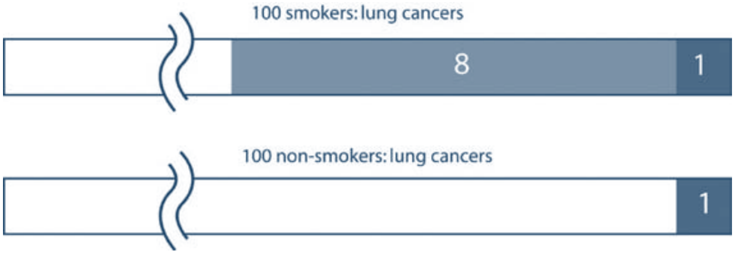
But this is probably still a bit too abstract. Without going into the formula yet, let's see if an example from lung cancer can help us understand this intuitively. Say we have followed the same number of long-term smokers and lifelong non-smokers, with the two groups being equally exposed to anything else that may conceivably cause lung cancer.For the best science, the numbers in the two groups should be quite large, but for simplicity we'll choose only 100 smokers and 100 non-smokers. After a long period of observation, one lung cancer death occurs among the non-smokers and nine among the smokers, making 10 cases in all. This is shown in the diagram below:





Dr Paul Magnus
AIHW Medical Advisor

We can see that our individual smokers here have nine times the risk of the non-smoker—a relative risk of nine.* How many cases among the 200 people can be attributed to smoking in this example? We can expect that one case would have arisen among the smokers for reasons other than their smoking, because that's the number that occurred in the non-smokers. This is shown in the next diagram.



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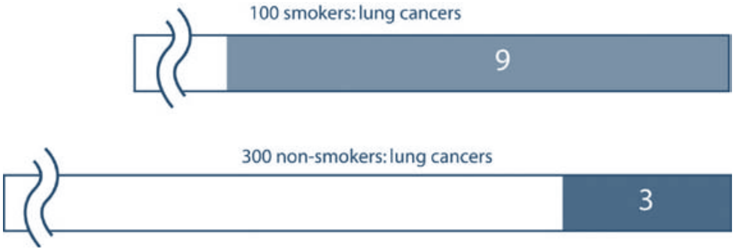
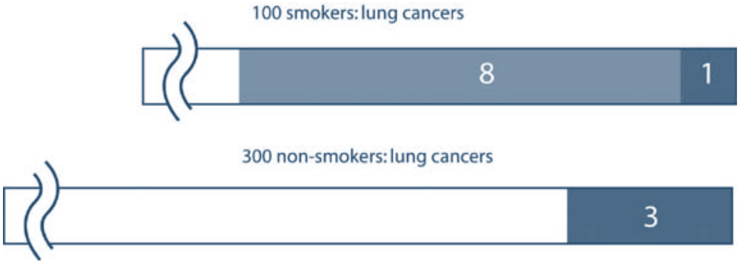
* Remember that this is only a convenient example. A realistic relative risk for smokers is more like 12 for the typical smoker, higher still for the heavy smoker.

This leaves us with eight cases—10 minus two—that can be attributed to smoking, 80% of the total. The formula for population attributable fraction would give the same result. Based on this and everything else we know about tobacco, we conclude that in this example 80% of the lung cancer deaths wouldn't have occurred if no one had smoked.

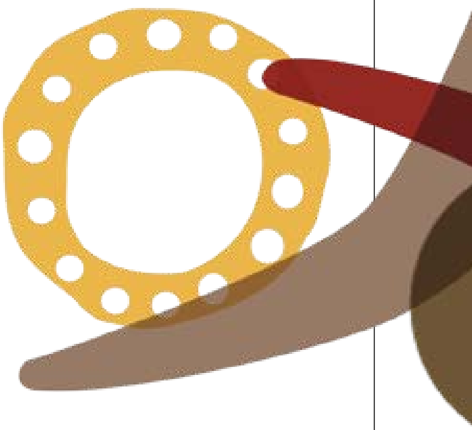


Now what if we didn't have the convenient 5050 smoker: non-smoker situation? We can apply the same reasoning to any frequency of exposure. Say we now had 100 smokers and 300 non-smokers, as in the next diagram. This population frequency of 25% smokers is closer to the current Australian levels, though still higher.



In this case we still have nine lung cancer cases among the smokers but three times as many as before, three, among the non-smokers because their number is now three times as great. From the final diagram we can apply the same reasoning as before about how many lung cancers are due to smoking and how many are not (next diagram).

We can see that we'd expect a total of four cases of lung cancer altogether that cannot be attributed to smoking—three among the 300 non-smokers and a corresponding rate of one among the 100 smokers. So smoking would now be held responsible for two-thirds—eight out of the total 12—of the lung cancer cases in this particular population. (Of course, this is much lower than the *present* lung cancer toll of smoking, which reflects smoking prevalence of some decades back.)



The formula

Thanks to a simple formula, though, we don't have to think each case through like we have above. The population attributable fraction can be expressed as:

$$\frac{\text{fraction exposed (relative risk} - 1)}{1 + \text{fraction exposed (relative risk} - 1)}$$

Applying this to our second example, we get:

$$\frac{.25\,(9 - 1)}{1 + .25\,(9 - 1)}$$

which equals 2/3 or 67%.

And in practice the beauty is that we don't have to resort to all-in-one situations like those presented in the examples. We can get our information from several easily available and authoritative sources. The 'fraction exposed', like the proportion of smokers in this case, can come from nationally representative and up-to-date prevalence surveys. Our relative risk estimates can be obtained from the general literature drawing on many follow-up (prospective) studies. And our mortality numbers—if that's what we're interested in—can come from the ABS's annual updates.

Putting a number to the fraction

Also, when we know the actual number of people getting a particular problem or dying from it, we can apply the relevant population attributable fraction to estimate an attributable number.

For example, with 27,825 deaths from heart attack ('ischaemic heart disease') in 1998 and a population attributable fraction for smoking of 14.5%, about 4,000 such deaths can be attributed to smoking that year.[2] Likewise, with 1,731 road deaths that year and a population attributable fraction of 25.4% for alcohol, 440 of those deaths can be put down to alcohol.[2]

Looking to Part 2

This article has introduced the population attributable fraction, a highly useful way of estimating the population impact of various risk factors, and so just how preventable some diseases like lung cancer are.

Of course, as usual there are details and some strong provisos with this statistic that I haven't gone into here. The aim has just been to convey the essence.

It's also worth mentioning that this approach can be applied beyond health issues. In principle it can be used for any situation, 'good' or 'bad'. All we need—which may be much easier said than done—is to be able to measure the situation, identify its causes or risk factors confidently, and measure their frequency and relative risk.

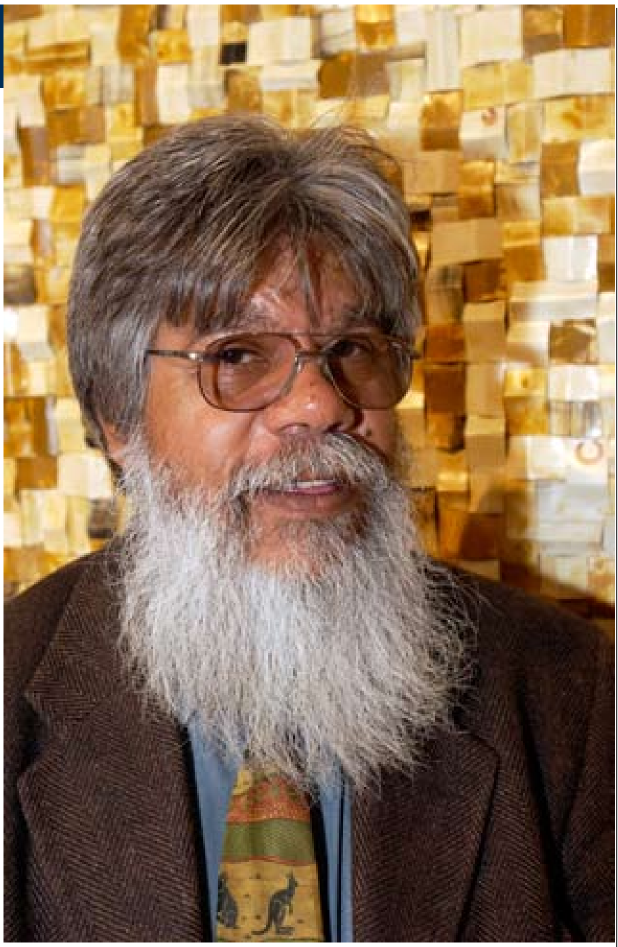
In the next issue of *Access* I'll say more about the uses and features of the population attributable fraction, and some pitfalls.

1. Mathers C, and Vos T. Stevenson C 1999. The burden of disease and injury in Australia. AIHW cat. no. PHE 17. Canberra: AIHW.

2. Ridolfo B and Stevenson C 2001. The quantification of drug-caused mortality and morbidity in Australia, 1998. AIHW cat. no. PHE 29. Canberra: AIHW.

spotlight

on Ted Wilkes



The lives of many Indigenous Australians have, historically, been full of hardship. As an 'agent of change', Nyungar man and Professorial Fellow at the Centre for Developmental Health, Curtin University, Ted Wilkes, is one of those making a difference—by using his knowledge of Australia's health system to improve the circumstances and lives of Australia's Aboriginal and Torres Strait Islander peoples.

'The history of this country is the reason why my childhood and upbringing and my life have been hard. I would think that's the case for most Aboriginal and Torres Strait Islander people', Ted said.

'Aboriginal people who've moved into activism—or into a change agent role like I have—have probably experienced a different kind of hardship as they try to change the mindset and the systems that are at play.

'But you get to a point where hardship doesn't necessarily deter you because you recognise that as a change agent you don't have to get upset when people attack and abuse you.

'On the way through life, there are always lessons to draw from conflict with other people.'

Ted has seen his fair share of resistance to improving the health and wellbeing of Australia's Indigenous people. But it has only made him more resilient and determined than ever to improve the quality of life for Indigenous communities. He believes that by improving the quality of life for Indigenous people, he is improving the quality of life for all Australians.

As an Aboriginal leader, Ted strives to achieve positive health and social outcomes for the Aboriginal community. Over his working life, he has served on a wide range of state, national and international committees, which work towards improving the lives of Indigenous Australians.

As program leader for the Rio Tinto Child Health Partnership, for example, he works collaboratively across organisations, governments and communities to translate beneficial research into sustainable health policy and practice. In this partnership, corporate giant Rio Tinto has joined with the Telethon Institute for Child Health Research in Perth, the Australian Alcohol and Research Foundation, and the Western Australian, Queensland and Northern Territory governments to foster improvements in maternal and child health in Aboriginal communities—and build a better health workforce.

'We're saying to mining companies and the corporate sector that if you're going to mine on Aboriginal land you've got to put more back into community.

'Hopefully we can zero in on the impact of alcohol and tobacco on mothers and fathers and on unborn babies and build better programs and services for them.'

Ted is also a team investigator with the Capacity Building Grant Researchers at the Telethon Institute for Child Health Research. Together with working towards a PhD degree, he has recently accepted a part-time position as Special Indigenous Advisor to the Health Reform Implementation Taskforce with the Western Australian Department of Health.

Ted's early working life was spent with the Western Australian Museum as an Aboriginal site recorder in 1974.

Following this, he started a full-time undergraduate degree (Bachelor of Arts in Social Science). While studying, Ted took on a position as the coordinator of the Aboriginal Studies Unit at Curtin University. This unit was later developed into a Centre for Aboriginal Studies, with Ted acting as its Inaugural Head. Upon completion of his degree, Ted enjoyed 16 years as the Director of the Derbarl Yerrigan Aboriginal Health Service in Perth.

'Working there was interesting because we worked to a holistic model and I guess I took that holistic model to extremes. I realised that health—physical health—wasn't going to improve unless you started to challenge or address a few underlying issues.'

Ted describes himself as a 'social health person' who is focused on 'the structural determinants of health and the systems that are at play' and how they might create better pathways for Aboriginal people.

'I guess I'm involved in many issues, and in so doing I've tried to change the quality of life—I prefer to talk about change of quality of life than health because it's more than about doctors, and having access to needles and pills.'

Over the years, Ted has used his knowledge of Australia's health systems to help improve the lives of Indigenous Australian communities.

In 2000, he completed the Australian and New Zealand Health Leaders Program, which included visits to New Zealand, most states of Australia and the ACT to learn about health systems. Ted was one of three Indigenous Australians to complete the program.

'It's only in the recent part of my life I've become more of an agent of change working within those systems as a special advisor—prior to that I've worked outside of those systems.'

Ted said that in his view the standardised mortality ratio was just one measure of how Aboriginal and Torres Strait Islander health was progressing. Currently he feels it is 'unacceptable that death rates are three times that of non-Indigenous Australians'.

'Other indicators that measure improvements are our school system and living conditions—I'd like to see accommodation for all Indigenous Australians so that they don't have to go without heating or cooling. These are basic human needs.'

So what 'drives' Ted Wilkes' professional and personal life? According to Ted, it's all about the children and the kind of legacy we leave for future generations. Ted, is one of nine children. He now has eight children and 16 grandchildren aged from 2 months to 16 years.

'The major drivers for me are issues associated with mental health and children.

'Children are themselves little drivers of change. I make sure that I have a relationship with every one of my children and grandchildren because they are shaped and influenced by their environment. It's all about preparing the next generation to fight for equality.'

Music also plays a big role in Ted's family and social life.

'We have a very musical family. I like to play all musical instruments but I play guitar and keyboard mostly.'

And when he's not playing music, he's 'probably gone fishing'.

Looking back over his professional life so far, Ted believes that often the most rewarding experiences have been the unexpected and personal ones.

'They are those when one of your own people, say an older Aboriginal man or woman, comes up and says "hey fella, you're doing a good job". Those sorts of pats on the back mean more than people could ever imagine.

'Professionally, I'm doing what I want to do to be involved in issues that will impact on improving the quality of life for everyone.'

Simply and Plainly

Continued from page 1

'The fact that three-quarters of Indigenous Australians die before age 75 years is just not acceptable in a developed country like Australia.

'It's also really important for more Indigenous people to be engaged and actively involved in the process of changing health and wellbeing, because otherwise I don't believe we'll see further improvements.'

Mr Calma said the fact that a higher proportion of Indigenous Australians lived in more overcrowded conditions than other Australians was another indicator that there was still much more work to be done to improve the health and wellbeing of Indigenous communities.

'A poor state of housing and housing-related infrastructure hinders health', he said.

'We also know that too many Indigenous people still drink and smoke—and continue to do so during pregnancy.

'And why is it that so many Indigenous Australians start drinking and smoking at a young age and are not able to stop? It's because so many suffer from life stresses—for example, they lose a close family member, or their job. The stresses suffered in past generations have carried over.

'It's not an acceptable state of affairs in this day and age and a lot more effort needs to be put in. And what we also need to do is really focus on some of the other activities that contribute to health.

'The harsh facts are that good health is holistic: it's not just about good science or effective medicine.'

Outlining the issues in the collection of data on Indigenous communities, Richard Madden said the report revealed 'clearly and starkly the many dimensions of Aboriginal and Torres Strait Islander peoples' lives in the Australia of today'.

'It does not preach, it does not blame, it does not apologise. It simply speaks, and I hope it speaks plainly.'

Dr Madden spoke about the history of collecting Aboriginal and Torres Strait Islander statistics in Australia.

'Why all this activity to collect information on Aboriginal and Torres Strait Islander people? Australia's Indigenous people are the descendants of those who have been occupying Australia for many thousands of years and who have had to bear a grossly disproportionate impact of the arrival of the rest of us on these shores.

'One of the most severe inheritances of this colonisation on Indigenous people has been very poor health status.

'It is statisticians' particular responsibility to work with Indigenous people to describe and analyse the reality, so we can know where to place our major efforts.'

This year, the Australian Bureau of Statistics celebrates 100 years of statistics, and it continues to introduce initiatives to improve the quality and availability of data on the Aboriginal and Torres Strait Islander population.

Dennis Trewin acknowledged that Australia still has a 'long way to go' to improve the collection of information on Indigenous communities, but the ABS would continue to work with the states and territories towards this goal.

Mr Trewin described the strengths of the ABS Indigenous Household Survey program in providing ongoing Indigenous health and welfare data. He made special mention of the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the role it played in improving the 'quality of health and welfare information' over the last decade.

'The population census is not just about counting people, it collects a range of socioeconomic data', he said.

'For instance, for the first time, the 2005 report includes information on disability in the Indigenous population.

'The 2006 census data, along with other data sets, will include more information about the social wellbeing of Indigenous Australians, on their health risk factors, disabilities, and a range of sporting and social activities.'

Both Jim Birch and Richard Madden acknowledged calls from both Indigenous and non-Indigenous Australians for action rather than statistical facts.

'But as Ted Wilkes said at the launch of the 2003 report, "If you are going to convince anyone of the seriousness of Indigenous health in Australia, you have to have the information to convince them"', Dr Madden said.

The 2005 report provides a comprehensive picture of the health and welfare of Australia's Indigenous population. It covers a range of topics—and includes new information on the links between health and education, housing and homelessness, and disability and ageing.

Printed copies of the 300-page report (ABS Catalogue no. 4704.0, AIHW Catalogue no. IHW 14) are available from either the ABS or the AIHW (price $65), or the report can be accessed free of charge on the AIHW web site (www.aihw.gov.au).

Recent releases

June

Access Issue 19 May 2005. (AIHW Access No. 19).	Cat. No. HWI 81	FREE
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Injury Deaths, Australia, 1999. (Injury Research and Statistics Series No. 24).	Cat. No. INJCAT 67	FREE (Internet only)
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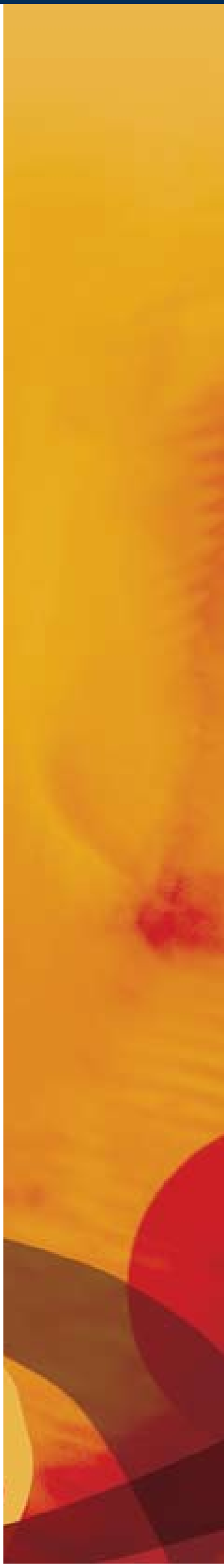

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For contributions contact:
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Publishing Manager
Ph: (02) 6244 1028

Graphic design
Levitate Graphic Design

Printed by
Union Offset Printers

Catalogue No. HWI 82
ISSN 1442-4908
Print post approved PP 255003/04169