National summary of the 2003 and 2004 jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators

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Any enquiries about or comments on this publication should be directed to:

Dr Fadwa Al-Yaman
Aboriginal and Torres Strait Islander Health and Welfare Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Phone: (02) 6244 1146
E-mail: atsihwu@aihw.gov.au

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Foreword

This report is the second report against the refined set of indicators endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2000, and the fifth time that all jurisdictions have reported against a set of national performance indicators for Aboriginal and Torres Strait Islander health. AHMAC produces these reports in order to inform policy makers and senior government officials on aspects of, and trends in, Aboriginal and Torres Strait Islander health. The Australian Institute of Health and Welfare compiled this report for the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) on behalf of AHMAC.

The report demonstrates the need for ongoing, significant and concerted action on factors that contribute to the general health and wellbeing of Aboriginal and Torres Strait Islander peoples. It also shows that, while data quality has improved, further work remains to be done in this area, especially in the jurisdictions where the quality of Indigenous identification is not adequate for statistical reporting.

AHMAC, through SCATSIH and the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data, is actively supporting data development work to improve the quality of key health performance indicators. Work is also underway to improve the way we monitor health system performance for Aboriginal and Torres Strait Islander Australians. SCATSIH is advising AHMAC on the policy context and implications of this report.

I am pleased to present this report on behalf of SCATSIH, and would like to take this opportunity to commend the many people involved in preparing the information provided.

Robert Griew

Chair

Standing Committee on Aboriginal and Torres Strait Islander Health

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Acknowledgments

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Our thanks go to members of the following committees: the Standing Committee on Aboriginal and Torres Strait Islander Health, the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) and the Statistical Information Management Committee (SIMC).

Specific thanks are also extended to the following people who coordinated data collection within their jurisdiction or agency on these National Performance Indicators: Anne Leverton, Carey Smith, Debra Reid, Kirrily Harrison and Jilska Payoe (Office of Aboriginal and Torres Strait Islander Health, Australian Government Department of Health and Ageing), Ray Mahoney (New South Wales Health Department), Mary Sullivan (Victorian Department of Human Services), Don Lewis and Melissa Browning (Queensland Health), Daniel McAullay (Western Australian Department of Health), Leanne Ennis (South Australian Department of Health), Carol Owen and Jeanette James (Tasmanian Department of Health and Human Services), Kate Turner (Australian Capital Territory Department of Health and Community Care), Richard Inglis and Fred Stacey (Northern Territory Health Services), Sean Tarrant and Vicki Bennett (Health Insurance Commission), Dan Black and Rita Scholl (Australian Bureau of Statistics), and Lawrence Doherty and Jenny Morison (Department of Education, Science and Training).

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Executive summary

This is the second national summary report on the refined set of 56 health performance indicators for Aboriginal and Torres Strait Islander peoples. The indicators are designed to provide an assessment of whether the health of Indigenous people is improving and to highlight problem areas that Australia's health system should address as high priorities.

This report, like many previous reports, draws attention to the relatively poor quality of the data on the health of Aboriginal and Torres Strait Islander peoples. This means that comprehensive comparisons between states and territories are not yet possible. This executive summary is intended to highlight particular areas that warrant further attention.

General health

Life expectancy at birth is significantly lower for Aboriginal and Torres Strait Islander people than for all Australians (Indicator 5). Also, the probability of a 20-year-old person dying before his or her 55th birthday is 2 to 6 times higher for Indigenous Australians than for all Australians (Indicator 49). The proportion of births to Indigenous mothers that are low birthweight is twice the rate observed in non-Indigenous mothers (Indicator 28). The infant mortality rate in selected jurisdictions, despite showing declines over the last 10 years, continues to be 3 times that of the non-Indigenous population (Indicator 6).

Diseases and conditions

The major causes of early adult deaths in the Aboriginal and Torres Strait Islander population are chronic diseases such as diabetes, circulatory diseases (including rheumatic heart disease), cancer and respiratory system diseases. Death rates from diabetes are between 7 and 20 times as high as the rates in the non-Indigenous population (Indicator 55). Death rates from circulatory system diseases in the Indigenous population are 4 to 5 times the rate in the non-Indigenous population (Indicator 52). Death rates from respiratory diseases are between 5 and 6 times as high, and death rates from lung cancer are between 2 and 3 times as high (Indicator 54).

Rates of infection with chlamydia, gonococcus and syphilis are also high (Indicator 39). Sexually transmitted diseases are avoidable, and untreated sexually transmitted diseases can lead to serious complications and the continued spread of the diseases.

Social and emotional wellbeing is an important area for Aboriginal and Torres Strait Islander peoples. Mortality from self-harm is 2 to 4 times the rate in the non-Indigenous population, and morbidity is 2 to 3 times as high (Indicators 53 and 42). Hospitalisation rates for depressive and anxiety disorders are between 1 and 3 times the rates in the non-Indigenous population (Indicator 46).

Across the states and territories with the more complete coverage of hospitalisations and deaths data, Indigenous people are hospitalised for injury at between 3 and 4 times the rates of non-Indigenous people, and die from injury at between 2 and 4 times the rates of non-Indigenous people (Indicators 42 and 53). Prominent among injuries leading to hospitalisation or death is assault—hospitalisations for Indigenous people are between 12 and 27 times the rate for non-Indigenous people, while death rates for Indigenous people are between 5 and 12 times the rate for non-Indigenous people (Indicators 42 and 53). For injury resulting from assault, just over half of Indigenous hospitalisations are female, compared with less than one-quarter of non-Indigenous hospitalisations.

Health risk factors

A large proportion of Indigenous people are exposed to behaviours that place their health at risk in the short and long term. Approximately 48% of Indigenous adults are overweight or obese (Indicator 31), 53% are current smokers (Indicator 29), and 69% consume alcohol. Of those who consume alcohol, 50% consume it at risky or high-risk levels in the last 12 months (Indicator 30). The rate of hospitalisation for substance use disorders is 5 to 8 times higher in the Indigenous population (Indicator 46).

Education, employment and the health workforce

Indigenous Australians are much less likely to complete secondary school education (Indicator 8) than non-Indigenous Australians and are 3 times as likely to be unemployed (Indicator 9). Aboriginal and Torres Strait Islander people are underrepresented in the Australian professional health workforce, representing 1.3% of the health workforce (Indicator 20). Aboriginal and Torres Strait Islander people who are training or have qualified in key health professions are also underrepresented (Indicator 21).

Health system capacity

A number of the indicators provide measures of the current capacity of the Australian health system to provide health promotion and primary health care for Indigenous Australians (Indicators 2, 4 and 20).

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 per person spending on health services for Indigenous people is slightly higher than for 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 (Indicator 2).

In relation to expenditure on health promotion programs for Aboriginal and Torres Strait Islander people, there is considerable variation across states and territories. Expenditure in 2003–04 ranged from nil in Tasmania to $6 million in Victoria (Indicator 4). In relation to overall expenditure on health care, the ratios of expenditure on Indigenous to non-Indigenous Australians under the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme were just 0.40 and 0.32 respectively (Indicator 2). These programs are a principal route for the delivery of primary health care to both Indigenous and non-Indigenous Australians. The ratio of Indigenous to non-Indigenous expenditure for all programs funded and administered by the Australian Government was 0.86.

In 2001, only 0.3% of doctors and 0.5% of nurses were Indigenous (Indicator 20), although the numbers are increasing. Another way to improve access to services is to reduce the cultural barriers that confront Indigenous people seeking treatment in mainstream health services. A considerable amount of variation exists between states and territories in the cultural awareness training that is provided to professional staff (Indicator 24).

Data limitations

A common problem highlighted in the report is the poor quality of information, especially in the identification of Indigenous people, with Indigenous status being not recorded or wrongly recorded in some datasets. The identification of Indigenous people in birth and death registrations, primary health care service records and hospital records remains a significant data quality problem (Indicator 1). While progress is being made, continued effort is needed in states and territories to improve and maintain Indigenous identification in the different data collections.

Introduction

This is the second report against the refined set of health performance indicators endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2000. It covers activity in the 2003 and 2004 calendar years and the 2002–03 and 2003–04 financial years. This is the last report using this set of indicators as it is currently being replaced by the Aboriginal and Torres Strait Islander Health Performance Framework. Reporting on the latter will commence in 2006 on a biennial basis.

Background

In 1996 AHMAC directed state and federal health departments to develop a set of national performance indicators for Aboriginal and Torres Strait Islander health. In 1997 the Australian Health Ministers' Conference endorsed an interim set of 58 national performance indicators to be reported against annually by all states and territories. Annual reports against these interim indicators were prepared for 1998, 1999 and 2000 (published in 2003).

A number of problems existed with the interim set of performance indicators:

- some indicator definitions were difficult to interpret
- the data provided by states and territories were often of poor quality and for different time periods
- data were not provided at all by some states and territories for a number of important indicators
- no indicators addressed measures of social and emotional wellbeing
- no conceptual framework accompanied the indicator set.

In 1998 AHMAC requested that the national performance indicators be refined. The Co-operative Research Centre for Aboriginal and Tropical Health was engaged by the Australian Institute of Health and Welfare (AIHW) to conduct a technical refinement of the indicators. In October 2000 AHMAC endorsed the refined set of 56 indicators, which included a conceptual framework for the indicators, indicator definitions, potential data sources and reporting responsibilities.

This set of 56 national performance indicators for Aboriginal and Torres Strait Islander health is a heterogeneous set which describes population health status, the incidence and prevalence of selected conditions, death rates, social and economic wellbeing, and factors pertaining to the organisation and delivery of heath services. They include measures of health service delivery performance, broader government service accountability, state of health of the population, health outcomes and key health determinants including risk factors.

Rather than relying on states and territories to provide data for all indicators, the responsibility for reporting on the indicators is shared among the states and territories and a number of agencies. National data are used to report on the indicators whenever possible.

The conceptual framework

The refined set of 56 indicators is mapped within the conceptual framework that groups them according to three main domains:

- Government inputs
- Determinants of health
  - Social equity
  - Access to services
  - Risk markers
- Outcomes for people

The conceptual framework used for the national Aboriginal and Torres Strait Islander health indicators is a composite of several existing frameworks and contains the same basic ideas as the National Health Performance Framework.

Quality and limitations of the indicators

A number of limitations remain in the health performance indicators in the current report.

In November 2003, the AIHW held a workshop with representatives from the states and territories, the Australian Government's Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the Australian Bureau of Statistics (ABS). The indicators' definitions, interpretation, data availability and data quality were discussed, with a focus on indicators that had proved to be problematic. For some of these indicators—such as workforce availability, smoking prevalence, alcohol consumption, and overweight and obesity—it was agreed to use national data sources. For a number of other indicators, the workshop refined the definitions and reference periods for reporting.

Despite this work to refine and clarify indicators, some limitations in reporting remain. First, technical specifications for a number of indicators are quite restrictive and limit the ability to report according to the specification. For example, for a number of indicators (16, 17 and 18) which require the use of data from the Community Housing and Infrastructure Needs Survey (CHINS), the CHINS data specifications do not fully match the technical specifications of the indicator.

Second, definitions for some of the refined set of indicators were problematic. For example, the definition of a primary health care centre or an acute care hospital in the specifications is extremely restrictive, and few actual centres and hospitals meet them. In addition, conceptual difficulties were experienced when reporting some indicators. The concept of a catchment population for a health service is an example that proved problematic in application (Indicator 22).

Third, some indicators have little relevance for states and territories with a small population of Indigenous people. Therefore the capture of comparable data across states and territories might not be achievable.

Various data issues that were discussed at the AIHW workshop are presented in boxes throughout this report.

Future reports

This is the last report using this set of indicators and it will be replaced by the Aboriginal and Torres Strait Islander Health Performance Framework (HPF). The HPF is a policy based framework established under the auspices of the SCATSIH to support the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH). The Health Performance Framework will provide the basis for quantitative measurement of the impact of the NSFATSIH. The HPF consists of three tiers:

- Tier 1—Health, Status and Outcomes—has four domains: health conditions, human function, life expectancy and wellbeing, and deaths
- Tier 2—Determinants of Health—has five domains: environmental factors, socioeconomic factors, community capacity, health behaviours, and person–related factors
- Tier 3—Health System Performance—has nine domains: effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable.

Structure of the report

The report consists of five parts. Part 1 covers indicators 1–4, which form the first domain, 'Government inputs'. Part 2 covers indicators 5–14, which form the sub-domain 'Determinants of health—social equity'. Part 3 covers indicators 15–24, which form the sub-domain 'Determinants of health—access to services'. Part 4 covers indicators 25–35, which form the sub-domain 'Determinants of health—risk markers'. Part 5 reports indicators 36–56 under the domain 'Outcomes for people'. An executive summary is provided at the front of the report.

The layout for each indicator includes a definition according to the technical specifications, a statement of purpose that explains the importance of the indicator and what it is measuring or describing, and a data section. The data section includes information on the data sources and whether the data presented differ from those specified in the technical specifications. Recommendations from the November 2003 workshop for improvements to these indicators are outlined in a box under the relevant indicator.

The report concludes with an appendix that contains a summary table of the quantitative indicators and a mapping from the refined set of indicators to the interim set of indicators reported in previous reports (NHIMG 2000, 2001, 2003).

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 home-birth 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)		Indigenous share (%)	Expenditure per person ($)		Ratio
	Indigenous	Non-Indigenous		Indigenous	Non-Indigenous	
Expenditure by Australian Government						
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[(a)]	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
Total Australian Government expenditure	*407.3*	*19,479.2*	*2.0*	*888.39*	*1,027.67*	*0.86*
Expenditure by state/territory governments						
Hospitals	829.0	16,224.2	4.9	1,807.92	855.94	2.11
Admitted patient services[(b)]	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[(c)]	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*
Total state/territory government expenditure	*1,260.5*	*21,620.2*	*5.5*	*2,749.00*	*1,140.63*	*2.41*
Total government expenditure	***1,667.8***	***41,099.4***	***4.1***	***3,637.39***	***2,168.30***	***1.68***
Non-government expenditure	*120.8*	*21,609.5*	*0.6*	*263.44*	*1,140.66*	*0.23*
Total health expenditure[(d)]	**1,788.6**	**62,708.9**	**2.8**	**3,900.83**	**3,308.35**	**1.18**

(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[(a)]

	Expenditure ($m)			Expenditure per person ($)		
Area of expenditure	**Indigenous**	**Total**	**Indigenous share (%)**	**Indigenous**	**Non-Indigenous**	**Ratio**
New South Wales						
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
Total	**295.3**	**7,456.1**	**3.8**	**2,188.92**	**1,157.72**	**1.89**
Victoria						
Acute-care hospitals[(a)]	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[(b)]	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
Total	**66.8**	**5,291.2**	**1.2**	**2,398.19**	**1,107.68**	**2.17**
Queensland						
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[(c)]	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
Total	**302.3**	**3,806.3**	**7.4**	**2,400.84**	**1,086.57**	**2.21**

(continued)

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

Area of expenditure	Expenditure ($m) Indigenous	Expenditure ($m) Total	Indigenous share (%)	Expenditure per person ($) Indigenous	Expenditure per person ($) Non-Indigenous	Ratio
Western Australia						
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[(b)]	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
Total	**253.8**	**2,375.1**	**9.7**	**3,850.16**	**1,294.16**	**2.98**
South Australia						
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
Total	**61.0**	**1,399.0**	**4.2**	**2,388.43**	**941.33**	**2.54**
Tasmania						
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
Total	**14.2**	**671.8**	**2.1**	**815.49**	**1,478.31**	**0.55**

(continued)

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

	Expenditure ($m)			Expenditure per person ($)		
Area of expenditure	**Indigenous**	**Total**	**Indigenous share (%)**	**Indigenous**	**Non-Indigenous**	**Ratio**
Australian Capital Territory						
Acute-care hospitals[(d)]	7.0	323.3	2.1	1,778.69	1,024.99	1.74
Admitted patient services[(e)]	5.9	267.8	2.1	1,503.47	849.03	1.77
Non-admitted patient services[(f)]	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
Total	**9.9**	**449.8**	**2.2**	**2,538.46**	**1,426.13**	**1.78**
Northern Territory						
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
Total	**257.2**	**171.0**	**60.1**	**4,521.98**	**1,213.70**	**3.73**

(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(a)	Vic	Qld(b)	WA	SA(c)	Tas(d)	ACT	NT(e)	Aust Govt(f)
2002–03									
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
Total	**2,346.9**	**5,795.3**	**2,365.6**	**4,820.5**	**n.a**	**--**	**113.5**	**1,681.6**	**22,544.0**
2003–04									
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
Total	**1,105.4**	**6,029.9**	**2,913.6**	**4,629.7**	**n.a**	**--**	**69.6**	**1,678.9**	**24,420.6**

(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. he 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 though 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 Mannumurna 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.

Determinants of health—social equity

Indicator 5
Life expectancy at birth

Indicator 6
Infant mortality rate

Indicator 7
Income poverty

Indicator 8
Completed secondary school education

Indicator 9
Employment status

Indicator 10
Housing with utilities

Indicator 11
People in prison custody

Indicator 12
The development of governance capacity in health

Indicator 13
Aboriginal and Torres Strait Islander representation on health/hospital boards

Indicator 14
Reporting of complaints in hospitals

Introduction

The sub-domain ‘Determinants of health—social equity’ comprises 10 indicators. The first two indicators are accepted health measures of social equity—life expectancy and infant mortality. These are followed by indicators that measure different aspects of social equity and government inputs in these areas: income poverty, secondary school education completion, employment status, housing with utilities, and imprisonment rates. The final three indicators relate to governance and capacity building for Indigenous people—the development of governance capacity, Indigenous representation on hospital boards and reporting of complaints. These three indicators measure government efforts to enable Indigenous people to contribute to the management and development of the health system.

The AIHW provided data for infant mortality. Like the other mortality data included in this report, coverage of Indigenous deaths is only complete enough for statistical reporting in four states and territories—Queensland, Western Australia, South Australia and the Northern Territory. This is also the case for the data on life expectancy that were provided by the ABS.

The ABS also provided the data for five of the other indicators in this sub-domain: income, education and employment are from the 2002 National Aboriginal and Torres Strait Islander Social Survey. The tables provided here are based on actual counts from the 2001 Census of Population and Housing and as such are not adjusted for under-enumeration. The data on imprisonment rates comes from the ABS Prisoners Census. The data on housing utilities come from the 2001 ABS CHINS survey. This survey is limited in scope as it only captures data from discrete Indigenous communities and therefore does not include all Indigenous housing. The data for this survey are provided by key community informants and not by individual householders.

The data for the indicators on governance and capacity building were provided by the states and territories. The information provided for these three indicators is descriptive data only. There were no consistent quantitative data available on Indigenous representation on hospital boards or on the reporting of complaints in hospitals.

Indicator 5. Life expectancy at birth

Indicator: Life expectancy at birth for the Aboriginal and Torres Strait Islander population compared to the total Australian population, by sex.

Purpose

Life expectancy at birth is an internationally used summary measure of the health and wellbeing of populations. Life expectancy is determined by a range of different factors including socioeconomic status, biomedical risk factors, quality and access to the health system, and genetics.

Data

Information for this indicator was obtained from the ABS. Estimates are provided for all states and territories, however only Queensland, Western Australia, South Australia and the Northern Territory are considered to have complete enough coverage of Indigenous deaths for statistical reporting. Life expectancy estimates from the other states and territories should therefore be interpreted with caution.

Life expectancy at birth is the number of years a person born in the reference year can expect to live if they experience the current age-specific death rates. Given the problems experienced in accurately measuring the death rates for the Aboriginal and Torres Strait Islander population, life expectancy indicators are difficult to calculate, so care should be taken when interpreting these data. The latest available expectancies of life at birth for the Indigenous population are for the period 1996–2001. Estimates of life expectancy at birth for the total Australian population are presented for the period 1999–2001.

- Over the period 1996–2001, the life expectancy at birth for Indigenous people was estimated to be around 59 years for males and 65 years for females. This was some 17 years lower than life expectancy estimates for the total Australian population (77 years for males and 82 years for females). Of the four jurisdictions with the most complete coverage of Indigenous deaths, life expectancy was lowest for Indigenous males in the Northern Territory (58) and lowest in Queensland for Indigenous females (63) (Table 5.1).
- The life expectancy estimates reported in Table 5.1 are based on experimental population estimates based on the 2001 Census of Population and Housing. The Bhat method was used by the ABS to construct an experimental model life table for the Indigenous population which gives an estimation of life expectancy at birth. This method offers improvement over other indirect methods used earlier by the ABS to estimate life expectancy from incomplete data, such as the Preston and Hill (1980) method. While the Bhat method allows for an adjustment for changes in identification to be taken into account in the estimation of life expectancy, it remains experimental and therefore work needs to be done on such estimates as more robust methods become available.

- The estimated life expectancy of Aboriginal and Torres Strait Islander males and females was also much lower than that of Indigenous people in New Zealand and Canada. The life expectancy of Maoris for 2000–02 was 69.0 years for males and 73.2 years for females, while the life expectancy of Canadian First Nations people in 2000 was 68.9 years for males and 76.6 years for females (Statistics New Zealand 2005; Health Canada 2005). However, these data are not strictly comparable due to differences in methods used to estimate life expectancy. More–over, the populations covered by these estimates are variable across the three countries.

Table 5.1: Experimental estimates of life expectancy at birth (years), by Indigenous status, sex and state and territory

	Males	Females
	Indigenous (1996–2001)	
Queensland	58.9	62.6
South Australia/ Western Australia	58.5	67.2
Northern Territory	57.6	65.2
New South Wales/Victoria	60.0	65.1
Tasmania	60.0	65.1
Australian Capital Territory	60.0	65.1
Australia	**59.4**	**64.8**
	Total Australian (1999–2001)	
Queensland	76.9	82.3
Western Australia	77.3	82.8
South Australia	77.0	82.5
Northern Territory	70.8	76.5
New South Wales	76.9	82.4
Victoria	77.5	82.7
Tasmania	76.0	81.2
Australian Capital Territory	78.5	82.9
Australia	**77.0**	**82.4**

Notes

1. The experimental life tables used to estimate life expectancy at birth are based on the 2001 Census.
2. Jurisdictions which are shaded are considered to have less complete coverage of Indigenous deaths than other jurisdictions.

Source: ABS Data available on request.

Indicator 6. Infant mortality rate

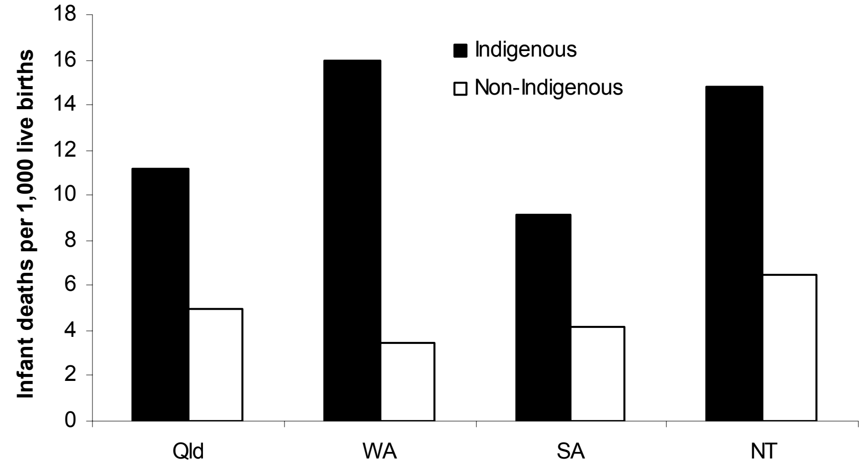
Indicator: The number of deaths of infants (children less than 1 year old) born to Aboriginal and Torres Strait Islander mothers, per 1,000 live births to Aboriginal and Torres Strait Islander mothers.

Purpose

This indicator is an internationally recognised measure of population health and is regarded as an important measure of general health and wellbeing. Infant mortality is an indicator of the quality of antenatal care, the effectiveness of obstetric services and the quality of infant care in the hospital and in the community. Infant mortality is also an indicator of maternal health, and a high infant mortality rate is associated with poor socioeconomic conditions.

Data

Information for this indicator was obtained from the AIHW National Mortality Database. The quality of the data on deaths of infants varies across states and territories and only data for Queensland, South Australia, Western Australia and the Northern Territory were considered to be sufficient to calculate rates. Three years of data (2001–03) were combined in order to smooth out yearly fluctuations in the number of infant deaths, which can cause variability in rates.



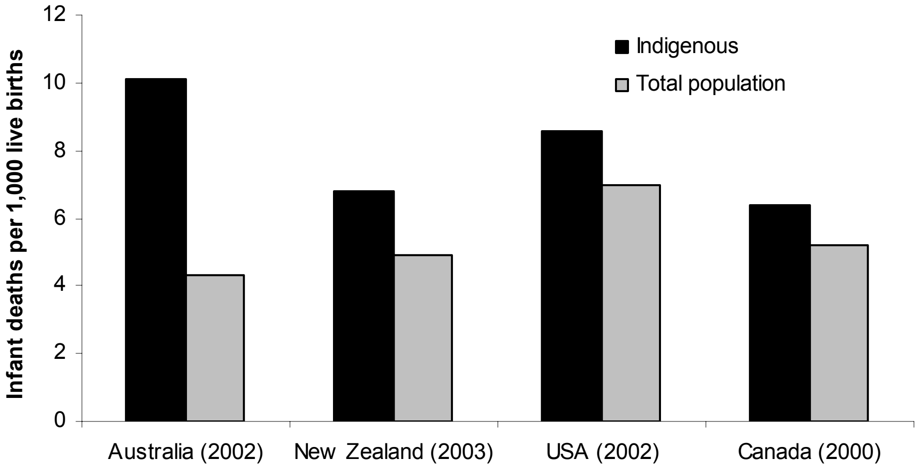
Source: AIHW National Mortality Database.

Figure 6.1: Infant mortality rates, by Indigenous status of the mother, selected states and territories, 2001–03

- In 2001–03, of the four states and territories with reliable data, the Indigenous infant mortality rate ranged from 9.1 per 1,000 live births in South Australia to 15.9 per 1,000 live births in Western Australia. In the Northern Territory the infant mortality rate was 14.8 per 1,000 births and in Queensland the rate was 11.2 per 1,000 births.

International comparisons

- The overall mortality rate for Aboriginal and Torres Strait Islander infants in Australia in 2002 was 11.4 per 1,000 (In the four states with reliable data, the rate was 14.0 per 1,000).
- In comparison, in 2003, the infant mortality rate was 6.8 per 1,000 live births for New Zealand Maoris; in 2002, 8.6 per 1,000 for American Indians and in 2000, 6.4 per 1,000 for First Nations people in Canada (Statistics New Zealand 2005; Health Canada 2005; US Department of Health and Human Services 2005).
- The difference in infant mortality rates between the Indigenous and total populations was much higher in Australia than in the other three countries, with Aboriginal and Torres Strait Islander infants dying at more than twice the rate of all Australian infants.



Notes

1. Indigeous populations are Aboriginal and Torres Strait Islander peoples, Maoris, American Indians and Canadian First Nations.
2. Total population rate for Canada is for 2001

Sources: AIHW National Mortality Database; Statistics New Zealand 2005; Health Canada 2005; US Department of Health and Human Services 2005.

Figure 6.2: Infant mortality rates in Australia, New Zealand, Canada and the United States, by Indigenous status, selected years

An analysis of trends in infant mortality among Indigenous Australians in Western Australia, South Australia and the Northern Territory over the period 1991–2002 was undertaken in the joint ABS/AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005* (ABS & AIHW 2005).

Indicator 7. Income poverty

Indicator:

(a) The proportion of Aboriginal and Torres Strait Islander households where household size-adjusted weekly income is less than the 20th percentile of all Australian household size-adjusted weekly income.

(b) The proportion of Aboriginal and Torres Strait Islander households where household size-adjusted weekly income is less than the 50th percentile of all Australian household size-adjusted weekly income.

Purpose

The measures provide an indication of the level of relative economic disadvantage of Aboriginal and Torres Strait islander people compared to two national income measures for all Australians. The expected proportions, if there is no relative economic disadvantage, are that 20% will fall below the 20th percentile and 50% will fall below the 50th percentile.

Data

Information for this indicator was obtained from the ABS National Aboriginal and Torres Strait Islander Social Survey.

Table 7.1: Proportion of households with household size-adjusted weekly incomes below the Australian 20th and 50th percentiles, by Indigenous status and state and territory, 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Less than 20th percentile									
Indigenous	45.4	40.6	43.1	46.1	46.6	39.2	23.1	49.0	44.2
Non-Indigenous	25.4	24.0	26.5	22.9	26.9	31.6	11.7	14.3	25.0
Less than 50th percentile									
Indigenous	74.4	74.7	76.2	78.8	77.6	76.1	47.2	82.9	76.0
Non-Indigenous	49.8	51.9	56.4	51.0	58.2	64.9	30.0	33.7	52.3

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

- In all states and territories a higher proportion of Indigenous households than non-Indigenous households had household size-adjusted weekly incomes less than the 20th percentile—44% of Indigenous households were below this point compared to 25% of non-Indigenous households.
- The extent of economic disadvantage varied by state and territory but was most marked in the Northern Territory where 49% of Indigenous households fell below the 20th percentile compared with 14% of non-Indigenous households. By contrast, in the Australian Capital Territory only 23% of Indigenous households fell below this mark, compared to 12% of non-Indigenous households.
- Australia-wide, 76% of Indigenous households had an adjusted weekly income below the 50th percentile, compared to 52% of non-Indigenous households.
- The proportion of Indigenous households with a size-adjusted weekly income below the 50th percentile was highest in the Northern Territory (83%), followed by Western

Australia (79%) and South Australia (78%). In the Australian Capital Territory, only 47% of Indigenous households fell below this mark compared with 30% of non-Indigenous households.

Indicator 8. Completed secondary school education

Indicator: The proportion of Aboriginal and Torres Strait Islander people aged 20–24 years who have completed secondary school (or equivalent level of education), by sex.

Purpose

Education is important for the overall wellbeing of people. The completion of secondary school education helps young people to obtain gainful employment. Education increases an understanding of the determinants of good health.

Data

Information for this indicator was obtained from the ABS National Aboriginal and Torres Strait Islander Social Survey.

Table 8.1: Number and proportion of people aged 20–24 years who completed Year 12 or equivalent, by sex, Indigenous status and state and territory, 2002

	Number[(a)]				Per cent (%)			
	Indigenous		Non-Indigenous		Indigenous		Non-Indigenous	
	Males	Females	Males	Females	Males	Females	Males	Females
NSW	1,300	1,500	120,300	145,400	27.5*	32.4*	59.9	71.4
Vic	300	400	110,100	114,900	25.0*	40.0*	65.5	74.6
Qld	1,900	1,600	88,700	90,500	39.1	31.3	72.8	76.3
WA	300	400	34,700	44,500	11.0*	15.3*	60.2	70.6
SA	400	300	24,300	27,800	42.2*	30.0*	56.2	72.3
Tas	100	300	9,000	9,000	20.3*	41.3	69.2	62.9
ACT	—	100	9,000	10,000	22.0**	62.2	80.9	80.6
NT	400	600	2,200	3,100	16.3*	21.8	41.2	63.2
Aust.	**4,700**	**5,200**	**398,100**	**445,300**	**27.1**	**29.0**	**64.1**	**73.1**

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

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

(a) Numbers are rounded to the nearest 100.

Sources: ABS National Aboriginal and Torres Strait Islander Social Survey 2002; ABS General Social Survey 2002.

- In 2002, the proportion of Indigenous males aged 20–24 years who had completed Year 12 or equivalent was less than half that for non-Indigenous males (27% compared with 64%).
- The secondary school completion rate for Indigenous males was highest in South Australia where 42% had completed Year 12, and was lowest in Western Australia where only 11% had completed Year 12.
- The difference in the proportion of Year 12 completions between Indigenous and non-Indigenous males was greatest in Western Australia and Tasmania.
- In 2002, the proportion of Indigenous females aged 20–24 years who had completed Year 12 or equivalent was less than half that for non-Indigenous females (29% compared with 73%).
- In 2002, The Year 12 completion rate for Indigenous females was highest in the Australian Capital Territory (62%) and lowest in Western Australia (15%).

- The difference in the proportion of Year 12 completions between Indigenous and non-Indigenous females was lowest in Tasmania and the Australian Capital Territory.

Indicator 9. Employment status

Indicator: The proportions of Aboriginal and Torres Strait Islander people aged 20–64 years who are employed, unemployed or not in the labour force, by full-time and part-time status.

Purpose

The proportion of people of working age who are not in employment is an indicator of socioeconomic disadvantage for a population. Poor health is strongly associated with low socioeconomic status.

Data

Information for this indicator was obtained from the ABS National Aboriginal and Torres Strait Islander Social Survey.

Table 9.1: Labour force status of Indigenous and non-Indigenous persons aged 20–64 years, by state and territory, 2002 (per cent)

Labour force status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust[(a)]
					Indigenous (%)				
Employed[(a)]	49.8	51.8	51.8	54.4	51.8	54.6	70.9	51.5	51.8
Full-time	30.7	36.0	29.2	26.2	26.9	34.4	53.1	18.6	28.6
Part-time	19.1	15.8	22.5	27.9	24.8	20.3	17.8	32.8	23.2
Unemployed	14.7	8.8	13.9	11.7	11.3	10.0	2.8*	6.5	12.1
Total in the labour force	*64.5*	*60.6*	*65.6*	*66.1*	*63.1*	*64.6*	*73.7*	*58.1*	*64.0*
Not in the labour force	35.5	39.4	34.4	33.9	36.9	35.4	26.3	41.9	36.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
					Non-Indigenous (%)				
Employed[(a)]	75.2	75.0	73.8	74.6	73.5	68.9	82.1	84.5	74.7
Full-time	53.6	55.6	54.4	55.5	52.6	46.7	62.6	68.0	54.5
Part-time	21.6	19.4	19.4	19.1	20.9	22.2	19.5	16.5	20.3
Unemployed	3.6	3.8	4.7	4.6	3.5	4.3	1.5	3.6	3.9
Total in the labour force	*78.8*	*78.8*	*78.5*	*79.2*	*77.0*	*73.2*	*83.5*	*88.1*	*78.7*
Not in the labour force	21.2	21.2	21.5	20.8	23.0	26.8	16.5	11.9	21.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(a) Total employed includes persons who did not state whether their employment status was full-time or part-time.

Sources: ABS National Aboriginal and Torres Strait Islander Social Survey; ABS General Social Survey 2002.

- In 2002, 52% of Indigenous people aged 20-64 years were employed in part-time or full-time work, 12% were unemployed and 36% were not in the labour force. The comparison figures for the non-Indigenous population were 75%, 4% and 21% respectively.
- The proportion of Indigenous people who were employed in 2002 ranged from 50% in New South Wales to 71% in the Australian Capital Territory.
- The majority of Indigenous people who were employed were working full-time in all states and territories except in Western Australia and South Australia, where there was a similar proportion of people in part-time and full-time employment (28% compared to

26% and 27% compared to 25%); and in the Northern Territory where there was a larger proportion of people in part-time than full-time employment (19% compared to 33%). This probably reflects high rates of participation in the Community Development Employment Projects scheme that operates in regional and remote areas where there is a limited labour market.

- The proportion of Indigenous people who were unemployed in 2002 ranged from 2.8% in the Australian Capital Territory to 14.7% in New South Wales.
- The Northern Territory (42%) followed by Victoria (39%) had the highest proportions of Indigenous people not in the labour force.

Indicator 10. Housing with utilities

Indicator: The proportion of permanent dwellings in discrete Aboriginal and Torres Strait Islander communities with a sewerage system, water, electricity or gas supply.

Purpose

Inadequate housing and water, electricity and sewerage provision are associated with poor health and higher rates of infectious and parasitic diseases, respiratory diseases, diarrhoeal diseases and rheumatic fever.

Data

Information for this indicator was obtained from the ABS 2001 Community Housing and Infrastructure Needs Survey (CHINS). The survey collected information on connection to water and electricity supply but did not collect information on gas supply and therefore this is not reported.

The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) collected information on the functionality of household facilities. It reported that 99% of Indigenous households surveyed had a working toilet. While the CHINS does not examine functionality of utilities, this proportion appears to be high when compared to data on housing utilities presented below.

Table 10.1: Number and proportion of permanent dwellings in discrete Indigenous communities by whether connected to water and electricity supply and sewerage systems, by state and territory, 2001

	NSW	Vic	Qld	WA	SA	Tas	NT	Aust[(a)]
Sewerage								
Connected	1,325	42	4,021	2,947	1,071	30	6,912	16,348
Not connected	—	—	9	31	—	—	261	301
% connected	*100.0*	*100.0*	*99.8*	*98.9*	*100.0*	*100.0*	*96.4*	*98.2*
Water								
Connected	1,325	42	4,011	2,958	1,064	30	7,014	16,444
Not connected	—	—	18	11	7	—	98	134
No supply	—	—	—	9	—	—	4	13
% connected	*100.0*	*100.0*	*99.5*	*99.3*	*99.3*	*100.0*	*97.8*	*98.8*
Electricity								
Connected	1,325	42	4,019	2,948	1,049	30	6,910	16,323
Not connected	—	—	7	27	18	—	125	177
No supply	—	—	3	3	4	—	70	80
% connected	*100.0*	*100.0*	*99.7*	*99.0*	*97.9*	*100.0*	*96.3*	*98.0*
Total[(b)]	**1,325**	**42**	**4,030**	**2,978**	**1,071**	**30**	**7,173**	**16,649**

(a) Includes the Australian Capital Territory (no Indigenous communities recorded).

(b) Includes not stated responses for 'Whether connected to community water supply' and 'Whether connected to community electricity supply'.

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

- In 2001, 16,348 or 98% of permanent dwellings in discrete Indigenous communities were connected to a sewerage system. There were 301 permanent dwellings which had no organised sewerage system.

- The majority of permanent dwellings in discrete Indigenous communities were connected to a community water supply (16,444 or 99%) and/or to a community electricity supply (16,323 or 98%).
- In communities where a water supply was available, 134 dwellings were not connected. Thirteen permanent dwellings were in places where no organised water supply existed.
- In communities where an electricity supply was available, 177 dwellings were not connected. Eighty permanent dwellings were in places where no organised electricity supply existed.
- In New South Wales, Victoria and Tasmania all permanent dwellings had sewerage, water or electricity supply.

Indicator 11. People in prison custody

Indicator: The imprisonment rate of Aboriginal and Torres Strait Islander adults aged 17 years and older.

Purpose

Imprisonment has a significant impact on the social and emotional wellbeing of individuals, their families and their communities. Indigenous people—males in particular—are overrepresented in the prison system. This impacts adversely on their health and wellbeing.

Data

Information for this indicator was obtained from the ABS.

Table 11.1: Rate of Indigenous imprisonment per 100,000, by state and territory, 30 June 2004

	Number		Crude rate[(a)]		Age-standardised rate[(a)]		
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Rate ratio[(b)]
NSW[(c)]	1,576	7,629	2,012.2	149.1	1,561.9	153.6	10.2
Vic.	186	3,438	1,068.8	89.2	810.5	90.7	8.9
Qld	1,195	3,989	1,572.2	138.3	1,203.5	140.9	8.5
WA	1,217	1,952	3,114.4	134.5	2,358.7	136.6	17.3
SA	249	1,069	1,623.7	91.4	1,218.5	100.1	12.2
Tas.	59	388	597.2	109.4	467.2	121.3	3.9
ACT[(d)]	26	252	1,094.7	103.0	867.8	88.9	9.8
NT	556	161	1,589.4	153.5	1,218.7	141.0	8.6
Australia	**5,048**	**18,776**	**1,851.9**	**124.3**	**1,413.9**	**126.7**	**11.2**

(a) Rate per 100,000 adult population.

(b) The ratio of Indigenous to non-Indigenous imprisonment is calculated by dividing the Indigenous rate by the non-Indigenous rate.

(c) Rates for NSW exclude ACT prisoners held in NSW prisons.

(d) Rates for the ACT include ACT prisoners held in NSW as well as ACT prisoners held in the ACT.

Note: Numbers do not include persons in juvenile institutions, psychiatric custody or police custody.

Source: ABS 2004b.

- At 30 June 2004 there were 5,048 Aboriginal and Torres Strait Islander people aged 17 years and over in prison. Indigenous prisoners represented 27% of the total prison population.
- The overall imprisonment rate for Aboriginal and Torres Strait Islanders in 2002 was 1,852 per 100,000. Western Australia had the highest imprisonment rate (3,114 per 100,000), followed by New South Wales (2,012), South Australia (1,624), the Northern Territory (1,589) and Queensland (1,572).
- Indigenous Australians were imprisoned at 11 times the rate of non-Indigenous Australians. The difference between the rates was greatest in the Northern Territory where Indigenous people were imprisoned at 17 times the rate of non-Indigenous people.

Indicator 12. The development of governance capacity in health

Indicator: The strategies used by the Australian Government and state and territory governments to develop community capacity in health planning, management and evaluation, including forms of governance for primary health care services that involve Aboriginal and Torres Strait Islander people, and the proportion of funding allocated to these.

Purpose

The indicator demonstrates the commitment by governments to invest resources and time to ensure that Aboriginal and Torres Strait Islander people are supported to develop governance skills in health and facilitate communities to take greater control over their health.

Data

Information for this indicator was obtained from the states, territories and the Australian Government. Limited quantitative data are provided for this indicator as jurisdictions had difficulties identifying expenditure on governance.

Australian Government

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) sees governance and management as a key issue in the effective delivery of high-quality health care for Aboriginal and Torres Strait Islander Australians. The Management Support and Development Program targets resources at OATSIH funded services to improve their governance and management structures. For a number of years an allocation for the Management Support and Development Program has been made to assist organisations in difficulty. The Program consists of two elements. One element, known as the Management Development element, provides funds for proactive purposes, aimed at assisting organisations before they get into difficulty. The second element, the Management Support element, provides funds for reactive purposes, aimed at assisting organisations that are in serious difficulty and in danger of ceasing to provide the services for which they have been funded by OATSIH.

The main areas of support include the following:

- governance training for boards
- management and financial training for both boards and senior management;
- conducting reviews/audits of operations to establish the extent of any financial operational or managerial difficulty
- the appointment of Funds Administrators to assist with managing OATSIH funds
- as a last resort, assistance with the re-auspicing of a service from one provider to another.

In 2002–03, the Australian Government provided annual funding of $934,697 through the Management Support and Development Program to assist OATSIH—funded Aboriginal and Torres Strait Islander health and substance use organisations in building governance, operational and management capacity and developing management workforce skills. This was increased to $1.113 million in 2003–04.

OATSIH also provides funds for an Aboriginal Health Management Training Program. Each course involves an intake of around 10 students and leads to a certificate of management from the Australian College of Health Service Executives and/or a graduate diploma from the University of New England. In 2002–03 and 2003–04, $237,545 and $174,413, respectively, were spent on this Program.

New South Wales

In 2001, the NSW Premier announced the development of a plan to manage Aboriginal affairs in New South Wales; Two Ways Together. The plan has two objectives: to achieve improved outcomes for Aboriginal people across a range of indicators, and to develop committed partnerships between Aboriginal people and government.

Two Ways Together is the NSW Government's 10-year plan to improve outcomes for Aboriginal people and communities. It made up of two core elements: Making Services Work, and New Ways of Doing Business. Through Making Services Work, cluster groups of government agencies and Aboriginal community organisations are working to address Aboriginal disadvantage in the areas identified by the Productivity Commission's report *Overcoming Indigenous Disadvantage – Key Indicators 2003 (*SCRGSP 2003*)*. The health cluster (part of Two Ways Together) has recently been amalgamated with three other government agencies: Department of Education and Training, Department of Housing and Department of Community Services. The new cluster forms the Families and Communities Cluster.

New Ways of Doing Business, the second element of Two Ways Together, applies to all government agencies and it aims to improve the ways they work with Aboriginal communities. It has five goals: improving the capacity of agencies to work with Aboriginal people; enhancing the capacity of Aboriginal communities; planning and decision making at the local, regional and state level; improving accountability; and Enhancing the whole-of-government approach to Aboriginal Affairs.

The NSW Aboriginal Health Partnership Agreement, between the Aboriginal Health and Medical Research Council of NSW and the NSW Minister for Health, underpins all state-wide and local policy development, and implementation, for Aboriginal health. The Agreement forms the cornerstone for collaboration between the Public Health System and Aboriginal Community Controlled Health Services at the local level. The original NSW Aboriginal Health Partnership Agreement was signed in 1995. A review of the Partnership was undertaken and resulted in the Agreement being re-signed in May 2001 and is still current. The Partnership aims to ensure that the expertise of Aboriginal communities is brought to the health care process.

The NSW Aboriginal Health Partnership has been replicated in a number of Area Health Services throughout the state with the establishment of Local/Area Aboriginal Health Partnerships. These play a vital role in the organisation and co-ordination of resources to address Aboriginal health issues identified in the Local Aboriginal Health Plans and the Area Health Service Aboriginal Health Strategic Plans. While the Local/Area Partnerships are between the Area Health Services and the local Aboriginal Community Controlled Health Services, the involvement of other service providers (e.g. GPs and other relevant organisations) through working groups will enhance the effective coordination and delivery of health services.

Victoria

The 3-year Aboriginal Services Plan (effective from December 2002) was developed in consultation with Aboriginal people, representatives of Aboriginal communities, peak Aboriginal organisations and ATSIC commissioners.

Through the Plan the department is committed to:

- incorporating Aboriginal needs, issues and positives outcomes in all planning through consultation with key stakeholders and Aboriginal communities
- empowering Aboriginal communities to collaborate as partners
- providing support to build the capacity of Aboriginal managed community and health services across Victoria
- increasing the number of Aboriginal people employed within the portfolio
- increasing the number of Aboriginal people in decision-making positions.

Regions have developed action plans and strong links with local Aboriginal communities. Many program areas have developed strategies and programs to address Aboriginal issues.

The goals of the Plan are:

- to develop structures for ongoing consultation with Aboriginal organisations
- to establish planning, monitoring and evaluation arrangements within the department and between the department, communities and mainstream agencies
- to ensure that community aspirations, needs and priorities are reflected in all regional and Divisional Plans and that these Plans have clear outcomes, performance indicators and timelines
- to establish broad parameters and protocols to guide the relationships that the Department and funded agencies establish with communities, peak bodies and statewide agencies, both regionally and centrally
- to build capacity in Aboriginal organisations to develop quality services and partnerships to meet community needs
- to recognise and maintain existing plans, agreements and protocols as a central framework
- to strengthen working links between the department and other government departments, local government and the Commonwealth Government to support an integrated approach to Aboriginal policy and program development.

Primary Care Partnerships (PCP) Strategy

The 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
- reducing the preventable 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 department is committed to using the PCP Strategy and Community Health Plans to encourage the development of services in partnership with Aboriginal communities and agencies, and attention to the health needs of Aboriginal people.

A number of PCPs include capacity building for Aboriginal community organisations in their community health plans.

In 2003–04, the Rural Health Branch extended Board of Management training for rural hospitals to include the Aboriginal Community Controlled Organisations. This program will continue to March 2006.

Queensland

Queensland Health informs and negotiates with three major Indigenous forums: the Queensland Aboriginal and Torres Strait Islander Health Partnership, the Torres Strait Health Partnership and the Queensland Aboriginal and Torres Strait Islander Health Alliance. All three forums include representatives of peak Aboriginal and Torres Strait Islander bodies and organisations.

In addition to these, there is engagement at a more local level in each of the three zones in the state. The Northern Zone developed the Northern Zone Aboriginal and Torres Strait Islander Health Plan (2002–05). The plan outlines the establishment of regional and local forums as the mechanisms for community engagement. In areas where there is an Aboriginal Community Controlled Health Organisation (ACCHO), they will be the community focal point.

The Central Zone developed the Aboriginal and Torres Strait Islander Services Development Framework 2001–03. This document provides strategic direction and support in the planning, development and provision of appropriate and effective health services for Indigenous peoples.

The Southern Zone maintains ongoing consultation with Aboriginal and Torres Strait Islander Health Reference Groups. These consultations provide the opportunity for representatives to contribute to the development of policies that address Indigenous health. The Health Reference Groups will oversee the implementation of the Southern Zone Aboriginal and Torres Strait Islander Health Services Plan. Underpinning this plan are the principles of the Aboriginal and Torres Strait Islander Health Policy 1994.

Western Australia

The Office of Aboriginal Health continues to support the regional Aboriginal health planning forums throughout the state. In 2004 the office held a workshop aimed at implementing the Best Practice Model to all funded Aboriginal Community Controlled Health Services (ACCHSs) in Western Australia. The office also convened an internal working group aimed at developing the capacity of ACCHS governing boards.

South Australia

The South Australian Aboriginal Health Partnership, established in 1996, is a high-level coordination mechanism for supporting reforms in health care and community service provision in public, private and community-controlled health and community sectors. The South Australian Aboriginal Health Partnership through its structure (executive committee, management committee and secretariat team) approves the major commitments contained within the current framework agreement. These commitments are to undertake joint regional planning, increase resourcing to match need, increase access to public sector and community-controlled health and community services, and improve data collection, evaluation and accountability.

As an outcome of the Generational Health Review, and other processes, the South Australian Government released the First Steps Forward agenda for Health Reform in June 2003. Commitments included providing services closer to home, strengthening primary health care services through strategies such as primary health care networks, improving health services for vulnerable populations (including Aboriginal people), developing an appropriately skilled and supported workforce, changing governance structures, broadening practitioner involvement in health planning and policy development, and sustaining the current health system.

Three new health entities were established including two metropolitan regional health services and a new organisation for women, children and youth. Each of these new entities incorporates hospital services and is required to provide culturally appropriate services to Aboriginal and Torres Strait Islander people. A State Clinical Senate was also established, and hospital avoidance programs were further developed.

Tasmania

The partners in the Aboriginal Health Forum (state government, OATSIH and the NACCHO affiliate) have completed the Northern regional plan. This plan will be used to inform priority areas in Aboriginal health in northern Tasmania. In 2004 the Forum accessed Primary Health Care Access Program (PHCAP) funding to help address identified areas of need within the community. This will be an ongoing process with the regional plans for the north-west and southern Tasmania underway. Tasmania does not fund Aboriginal organisations.

Australian Capital Territory

In 2003 and 2004, ACT Health supported the development of governance capacity at the Community Controlled Health Service, Winnunga Nimmityjah, through the provision of assistance and advice with regard to performance reporting on ACT Health funded services/programs. Funding was also provided for business and policy support to enable the Chief Executive Officer of Winnunga to participate in the review and development of programs for Aboriginal and Torres Strait Islander people in the Australian Capital Territory, and to enable the continuance of the Quality Medical Services accreditation process.

Northern Territory

The Northern Territory Aboriginal Health Forum is a state-level organisation formed to address Aboriginal and Torres Strait Islander health issues. It aims to facilitate improved community capacity in health planning and Indigenous involvement in health management and evaluation. The Forum aims to improve health outcomes for Aboriginal and Torres Strait Islander people through improving access to health and health-related programs and increased health service resources that reflect the higher level of need for services. Joint planning processes allow for Indigenous participation in health decision–making and priority setting, improved cooperation and coordination of service delivery, increased clarity with respect to roles and responsibilities, and enhanced service effectiveness and efficiency. The Forum operates by a formal agreement and brings together representatives from a number of agencies including DoHA, ATSIC (whilst it remained in existence), the Northern Territory Department of Health and Community Services (DHCS), and the Aboriginal Medical Services Alliance of the Northern Territory.

In the Northern Territory, Aboriginal and Torres Strait Islander residents access primary care services through a variety of service delivery models. The DHCS funds primary health care through 100 health clinics. This can be further sub-divided into the following four categories:

1. Community Controlled Aboriginal Health Services in the five main population centres of Darwin, Alice Springs, Katherine, Tennant Creek and Grove, and three remote communities (total 8).
2. Community health centres in the five main population centres and 61 remote Aboriginal communities funded, staffed and managed by the Northern Territory (total 66).

3. Community health services in 10 mainly remote Aboriginal communities managed by local non-Government organisations with funding provided by the Northern Territory (total 10).
4. Primary health services in three health zones: Tiwi Islands Health Service, Katherine West Health Service Aboriginal Corporation and Sunrise Health Service Aboriginal Corporation (Katherine East). These services are managed by elected health boards and receive funding from the Commonwealth and Northern Territory. There are three primary health service outlets on Tiwi, eight in Katherine West and nine in Sunrise or Katherine East (total 20).

Aboriginal Community Controlled Health Services (ACCHSs) are a culturally valid and unique process for delivering Aboriginal and Torres Strait Islander specific health services and form an important part of the overall health system. They are incorporated organisations under relevant federal or Northern Territory legislation with governance arrangements vested in boards of elected local Aboriginal people.

The auspicing of primary health and related services in Aboriginal communities makes a significant and positive contribution for utilisation of (the other aspects of) human capital and also for bolstering the local economy.

Program initiatives by the Australian Government to improve Indigenous access to the Medicare Benefits Schedule and PBS have allowed the development of jointly funded arrangements which also promote increased Indigenous control over primary health care services. Coordinated Care Trials were initially trialled at two Northern Territory sites (Tiwi Islands and Katherine West). Following the trial period the Tiwi Health Board became operational in December 1997 taking over the operational responsibility for the Community Health Centres on the Tiwi Islands. In addition to the primary health care service provided through the health centres, the Tiwi Health Board also provided a community-based aged care service, a mental health service and an environmental health service. Following a period of financial difficulties Tiwi Health Board went into voluntary administration in 2003. In late 2003 management of the primary health care, mental health and environmental health functions was transferred to DHCS. The joint funding of the service by the Australian Government of Health and Ageing and DHCS has been renegotiated to reflect management of the service by DHCS. An eventual goal of the current management of Tiwi Health Service is to return health service to community management.

Joint Australian Government–Northern Territory funding initiatives are being extended under both the Coordinated Care Trials initiative (in Katherine East) and the new Primary Health Care Access Program (PHCAP). Under PHCAP, plans are advancing to develop services in five Central Australian health zones and two Top End health zones and they are progressing to the local health committees to link into the zone committees.

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) is the peak body representing Aboriginal community-controlled health services in the Northern Territory. Under the Northern Territory Framework Agreement on Aboriginal and Torres Strait Islander Health, DHCS is responsible for funding AMSANT. In 2004, AMSANT received base funding totalling approximately $270,000. In addition, three one-off payments were made to AMSANT: $40,000 to support reform initiatives, plus an additional $40,000 to support leasing of vehicles and $100,000 to hold a health summit.

In its 10th year of operation AMSANT hosted its fourth Health Summit from 29 November to 2 December 2004 at Ross River Station (about 80 km by bitumen road from Alice Springs). The summit theme of 'Reaffirming Our Rights: Community Control, Primary Health Care and Health Financing' provided an opportunity for Aboriginal health professionals and community representatives to present a united voice to governments on key issues and strategies for improving the health status of Aboriginal people.

Box 12.1: Data issues

It was agreed that no quantitative data be reported for this indicator as it was not clear what resources should be included under governance. States and territories and the Australian Government also found it difficult to separate out expenditure for governance from broader expenditure provided to Aboriginal and Torres Strait Islander people.

The definition of what is required for this indicator and the specifications need to be clarified.

Indicator 13. Aboriginal and Torres Strait Islander representation on health/hospital boards

Indicator:

(a) The number of health/hospital boards that have Aboriginal and Torres Strait Islander representation.

(b) The proportion of boards that have Aboriginal and Torres Strait Islander representation mandated by terms of reference or legislation.

Purpose

This indicator reflects commitment to mechanisms for Aboriginal and Torres Strait Islander representation in health system management at regional and/or institutional levels. The poor health status of Aboriginal and Torres Strait Islander people is reflected in a high level of need for mainstream hospital and health services. Accordingly, representation on hospital boards is needed to ensure Indigenous participation in decision-making processes and the determination of priorities.

Data

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

New South Wales

In New South Wales, health service boards have the overall responsibility for the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The boards guide and direct, establish policies, chart the course of their respective organisations and act as advocates for their organisations in the local communities. The boards are subject to the direction and control of the Minister except in relation to the context of a report or recommendation.

In 2002–03, 17 out of the 80 Health Service Boards in New South Wales had at least one Aboriginal and Torres Strait Islander member. In 2003–04, this fell to 6 out of 62. There were fewer boards/committees in 2003–04 due to the dissolution of 18 Area Health Service Boards in August 2004.

The *Health Services Act 1997* and the *Ambulance Service Act 1990* do not make provision for the makeup of membership on Health Service Boards, so Aboriginal and Torres Strait Islander membership is not mandated. However, it should be noted that the constitution of the soon to be appointed Area Health Service Councils, which will replace the 18 dissolved Area Health Service Boards, states that 'at least one <member> must be a person who has expertise, knowledge or experience in relation to Aboriginal health'.

Victoria

The functions of the board of a public hospital, denominational hospital or multi-purpose service are to oversee and manage the hospital and to ensure that the services provided by the hospital comply with the requirements of the *Health Services Act 1988* and the objectives of the hospital. Public hospitals must have a board of management of between 6 and 12 persons, whose names are submitted by the board and appointed by the Minister.

Metropolitan health services must have a Board of Management of between 6 and 9 persons appointed by the Governor in Council on the recommendation of the Minister. The Minister must ensure that the Board includes at least one person who is able to reflect the perspectives of users of health services and that women and men are adequately represented. Members of the Boards of denominational public hospitals are not appointed by the Minister.

Information on the structure of health/hospital boards is not routinely collected by the Department of Human Services in Victoria and there is no requirement for the hospital and community health centres to record the Indigenous status of board members. Available data show that 6 of the 84 health boards in Victoria reported Aboriginal and Torres Strait Islander representation in 2002–02 and 2003–04.

Individual boards no longer exist in the Melbourne metropolitan regions. In no case is Indigenous membership mandatory, though some hospitals seek a representative from the local Aboriginal cooperative/community organisation and encourage members of minority groups when advertising opportunities for board appointments.

Opportunities also exist for community members to participate in hospital advisory committees. Information on the membership of these committees is not collected by the Department of Human Services.

Queensland

Queensland Health is divided into three zones containing 38 Health Service Districts. Each District has a District Health Service Council. The role of the District Health Service Council is to work in cooperation with the relevant Health Service District to ensure that the needs of the community are represented and reflected in the health services provided and to monitor the performance of the District against a service agreement. The Council should act as a direct link between the public and Queensland Health.

District Health Service Councils are to facilitate community input into the planning, delivery, monitoring, and evaluation of hospital and community-based health services. The Councils are established in legislation, with a direct reporting relationship to the Minister and consist of up to 10 members with equitable community representation. Members are not elected, but are appointed by the Governor-in-Council. A term as member is for a period of three to four years. All District Health Service Councillors are ministerial appointments. There is no requirement mandated by the terms of reference for Indigenous representation, nor is there a requirement for appointees to record Indigenous status. However, currently there are 26 Indigenous members serving on 11 of the District Health Service Councils.

Western Australia

Health service boards are established under the *Hospital and Health Services Act 1927* and derive their functions and responsibilities from the Act. The boards are responsible for the control, management and maintenance of the hospital and for providing health services as approved by the Minister under an Australian Government–state agreement.

In 2002–03 all existing hospital boards were disbanded. In 2003–04, 17 new District Health Advisory Councils (DHACs) were established, 15 of which had Aboriginal and Torres Strait Islander people as members. The 17 DHACs have been established to achieve diverse representation from the community and have input into service planning, plus propose creative and community-based ideas for improving service access and quality.

South Australia

There were 73 incorporated hospitals and health centres under the South Australian Health Commission, at 30 June 2003. Information is available on 38 boards that have provision within the hospital's constitution for a ministerial nomination. In the 2002–03 and 2003–04 financial years, 13 health/hospital boards in the Hills Mallee Southern, Eyre, Northern and Far Western, Riverland and Mid-North regions of South Australia reported Aboriginal and Torres Strait Islander membership.

Tasmania

Tasmania does not have regional health or hospital boards. Services are administered by the Department of Health and Human Services.

Australian Capital Territory

All board/committee members are asked if they wish to identify their Aboriginal or Torres Strait Islander status at the time of initial appointment. However, some members may choose not to do so. The representation may, therefore, be higher than recorded. In 2002–03, four members of the 10 health boards and committees identified as Aboriginals and/or Torres Strait Islanders. In 2003–04, five members of the 14 boards and committees identified as Indigenous Australians.

In February 2002, the ACT Government announced a review of the structural and governance arrangements for the health and community care system. As a result of the review, the ACT Health and Community Care Board was abolished, and legislation to formally repeal the purchaser/provider arrangements in health was passed by the ACT Legislative Assembly in December 2002. The health portfolio has been restructured into a simplified model, and the ACT Health Council established to provide a consultative mechanism involving health consumers and professionals in ACT Health policy and planning processes. There was Aboriginal and Torres Strait Islander representation on the Council in both 2002–03 and 2003–04.

Northern Territory

Under the Hospital Management Boards Act, each public hospital in the Northern Territory is to have a board of eight members, five of whom are to be appointed by the Minister. Although the Act does not require hospitals to have Indigenous people on the boards, all Northern Territory hospitals make every effort to include Aboriginal members.

The Northern Territory has a wide array of representative health groups, many of which include Aboriginal representation and some of which require a majority of Aboriginal members. Examples of this latter group are the Northern Territory Aboriginal Ear Health Committee and the Northern Territory Aboriginal Eye Health Committee.

Box 13.1: Data issues

Responses to this indicator revealed different interpretations of 'hospital/health' boards. It was therefore agreed to only report descriptive data for this indicator.

Most states and territories indicated that there was no legislation governing appointments to hospital boards, and as a consequence the Indigenous status of members was not routinely collected. A number of states and territories stated that the composition of boards was intended to represent the users of the health service. Accordingly, the makeup of boards of hospitals with a high proportion of Aboriginal and Torres Strait Islander separations was recognised as particularly important to the provision of culturally appropriate services.

Indicator 14. Reporting of complaints in hospitals

Indicator:

(a) The ratio of complaints to hospital separations in the Aboriginal and Torres Strait Islander population compared to the Australian population.

(b) The structures and mechanisms available to assist Aboriginal and Torres Strait Islander people who want to make a complaint.

Purpose

Indigenous Australians may have undesired experiences in hospital and may also experience difficulties in making complaints or formal notifications. Because Aboriginal and Torres Strait Islander people have a high use of hospitals, it is important to assess their access to complaint mechanisms.

Data

Information for this indicator was obtained from the states and territories; however, many states and territories could not provide quantitative data.

New South Wales

Complaints are managed by the Health Care Complaints Commission. The Commission employs Conciliation and Resolution Officers (known during the reporting period as Patient Support Officers) who assist parties with the complaints process and with achieving suitable resolution. A position for a designated Aboriginal and Torres Strait Islander officer also exists in the Commission who can assist individual Indigenous complainants and also provide education about the Commission to Indigenous communities. An Aboriginal person is also represented on the Commission's Consumer Consultative Committee which advises the Commission on matters that impact on a range of health consumers and which assists the Commission in reaching as many people as possible who may have a complaint against a health care provider.

Each complainant to the Commission is sent a survey form seeking their demographic information. Information about individuals is provided voluntarily and remains confidential. Not all questions to the survey are answered by every survey respondent. For 2002–03, 1,681 complainants returned the survey. Of these, 522 provided responses to the question on the survey regarding the ethnic profile of the complainants. Of these complainants, 18 reported that they were of Aboriginal or Torres Strait Islander origin. For 2003–04, 2,311 returned the survey. Of these, 388 provided responses to the query about ethnic profile and 17 of these identified as Aboriginal or Torres Strait Islander origin.

In July 2004 the Australian Council for Safety and Quality in Health Care released the Better Practice Guidelines on Complaints Management for Health Care Services. These guidelines were developed following the Council-funded work of the Turning Wrongs into Rights: Learning from Consumer Reported Incidents project. NSW Health Care Complaints Commission undertook this project on behalf of the Australasian Complaints Commissioners, working with the Royal Australasian College of Physicians and the Health Issues Centre.

NSW Health is currently working to develop key performance indicators which will assist the implementation of these guidelines in the Area Health Services. However, until the implementation of the Better Practice Guidelines on Complaints Management for Health Care

Services the deliverables of the Statewide Complaints Handling Data Project (1998) remain current. These included: data model; process model for complaints handling; data dictionary with agreed data definitions; code set listings for specified data elements; minimum data set for Frontline Complaints Handling Systems; and state level minimum dataset.

NSW Health collects information about resolved complaints managed by the Area Health Services. The collection commenced in April 1999 and contains approximately 12,000 complaints per year.

Within the current minimum data set for the Statewide Complaints Data Collection, demographic data allowing the identification of complaints made by Aboriginal and Torres Strait Islander people are not collected. In the past this has been because of a lack of a comprehensive complaints management system to manage this data collection. In November 2004 NSW Health launched an Incident Information Management System (IIMS), which facilitates notification, and management of all incidents including complaints.

It is acknowledged that originally expectations were that Aboriginal and Torres Strait Islander demographic data would be captured within these minimum data sets. However, due to the statistically small number of incidents involving this demographic it was advised privacy principles might be breached in the publication and use of this data. Further solutions have been sought and to this end due to the volume of demographic data captured on patient admission details and other such documents, data from IIMS will be migrated into the Health Information Exchange and at this point should be able to be linked and therefore provide relevant information regarding the undesired experiences in hospitals of Indigenous Australians.

At this time, only the total number of complaints can be provided: during 2002–03 there were 9,910 and during 2003–04 there were 9,107.

Victoria

Many complaints about hospitals and health services are dealt with satisfactorily by those services and are not taken further. Complaints frequently relate to the referral process between services, as well as relating to problems within specific services.

The Office of the Health Services Commissioner is an independent, statutory authority set up under the *Health Services (Conciliation and Review) Act 1988*, to deal with disputes that arise between users and providers of health services in Victoria. The Office has an Aboriginal Liaison Officer (ALO) who is employed to create awareness within Indigenous communities of its services and to deal with complaints and enquiries that it receives from Aboriginal people. Enquiries are complaints that are made verbally, either in person or on the telephone, that are not confirmed in writing. Formal complaints are therefore matters that have been confirmed in writing.

In 2002–03, 13 complaints by Aboriginal and Torres Strait Islander people (2% of all complaints made in writing) were made in hospitals and a further 45 were made in other health services (6.6% of all complaints managed by the Office of the Health Services Commissioner). In the same period 70 enquiries were made by Aboriginal and Torres Strait Islander people, representing 0.8% of all enquiries received in 2002–03. The Office managed fewer complaints by Aboriginal and Torres Strait Islander people during 2003–04: 8 or 1% of complaints were made by Indigenous Australians in hospitals and a further 47 complaints (8.5%) were made in other health services. Indigenous enquiries to the Office represented 0.5% of all enquiries in 2003–04. The ratio of complaints to separations for 2003–04 for Aboriginal and Torres Strait Islander people was 0.67 compared to 0.07 for other Australians.

Mechanisms to assist Indigenous people

An ALO is always available to assist an Aboriginal person to formalise a complaint in writing where assistance is needed. The complaints that have been confirmed in writing have tended to relate to issues of a serious nature that have required a certain amount of investigation in the form of obtaining medical records, medical reports and opinions and ongoing negotiations between the parties.

Complaints of a less serious nature can generally be dealt with informally on the basis of a person just making an enquiry without having to confirm the matter in writing. The ALO is able to follow the matter up on the same day and, if possible, try to obtain a resolution informally within a couple of days at most.

It has been the experience of the ALO that Aboriginal people find confirming complaints in writing, even with assistance, to be a very difficult and bureaucratic process and much prefer to deal with complaints as informally as possible. This has therefore dictated changes to the Office's standard procedures in dealing with complaints to be more culturally appropriate to the needs of Aboriginal people.

Queensland

The Queensland Health Quality Improvement and Enhancement Program has developed a Queensland Health Complaints Management Policy that provides a complaint handling model; performance standards and criteria; and responsibility and specific accountability. This policy was effective from August 2002. Each Health Service District is responsible in setting up a complaints system in their area. While some Health Service Districts have the capacity for recording Indigenous status on their complaints system, the majority do not collect this information.

Individuals have the right to independently complain to external agencies at any time. Relevant statutory agencies include, but are not limited to, the Official Visitors, the Health Rights Commission, Police, Ombudsman, Crime and Misconduct Commission and Professional Registration Boards.

Mechanisms to assist Indigenous people

Queensland Health Hospital Liaison Officers provide advice and support to Aboriginal and Torres Strait Islander clients and their families in negotiations with medical staff in hospital and clinical settings. The Hospital Liaison Officers also have access to skilled interpreters through networks within the community. It is the responsibility of all Queensland Health employees to assist any client with documenting a complaint.

Western Australia

In Western Australia, the complaints procedure varies from hospital to hospital. Many hospitals accept verbal complaints and have ALOs or social workers to assist Aboriginal and Torres Strait Islander people if they wish to make a complaint. Complaint data recorded at the hospital level do not identify if complainants are Indigenous Australians. Anecdotal information suggests that very few Aboriginal people make complaints.

The Office of Health Review is a state government body that provides a means of having complaints about health and disability services reviewed, conciliated and dealt with. It provides a free service to all users of health and disability services in Western Australia. However, it encourages complainants to make a direct approach to the service provider first and therefore represents only those complaints that were not resolved through the hospital complaints system.

Complaints must be lodged in writing to the office, although staff can assist consumers to submit a complaint, and there are also interpreters available if needed. The complaint form includes a question regarding Indigenous identification which is phrased 'Do you wish to be identified as a person of Aboriginal or Torres Strait Islander descent?' As such, the number of people who are of Aboriginal or Torres Strait Islander origin are likely to be under-represented. In 2002–03, there were 1,652 complaints about public hospitals and 2 were recorded as being from Aboriginal people. In 2003–04, there were 1,775 complaints about public hospitals and 7 were from Aboriginal people. Indigenous Australians were less likely to make complaints about public hospitals than other Australians (ratios of complaints to hospital separations for Indigenous people compared to other Australians were 0.02 in 2002–03 and 0.05 in 2003–04).

South Australia

The South Australian *Health and Community Services Complaints Act 2004* is likely to be proclaimed in June 2005. The Act will provide for the making and resolution of complaints against health or community service providers; to make provision in respect of the rights and responsibilities of health and community service users and providers; and for other purposes. The Act outlines that the Commissioner will provide information and advice, and in the assessment and consideration of any complaint, take into account the position of persons within special needs groups. The Commissioner is appointed on conditions determined by the Governor and for a term not exceeding 7 years.

The Aboriginal Health Division, Department of Health, has commenced in its infancy some consultation with the health and community sectors regarding their opinion and advice on the need for an Aboriginal Health Complaints mechanism.

Tasmania

Indigenous status is not collected when patients make a complaint. Structures and mechanisms to support all patients making complaints have been developed, but none of these are specific to people of Indigenous or non-Indigenous backgrounds. Two of the three major public hospitals in Tasmania employ ALOs to assist in promoting cultural awareness, and to facilitate any complaints.

Australian Capital Territory

Data cannot be provided for this indicator as acute hospital facilities in the Australian Capital Territory do not include an Aboriginal and Torres Strait Islander identifier on their databases. Resources are currently focused on improving the identification of Indigenous patients within the Emergency and In-Patients databases. ALOs are located in public hospitals, and are able to address patient issues and assist in making a formal complaint if required.

Northern Territory

Public hospitals have established formal processes for complaint handling. These processes are monitored within the Northern Territory by the Complaints Handling Group and are a requirement for national hospital accreditation. Information on complaints is available for all public hospitals and in all cases the rate of complaints per hospital separation is much higher for Indigenous patients than for non-Indigenous patients. In 2003–04, in the Royal Darwin and Alice Springs Hospitals, there were 493 complaints, 50 of which were from Aboriginal people. Indigenous Australians were less likely to make complaints about these hospitals than other

Australians (ratios of complaints to hospital separations for Indigenous people compared to other Australians were 0.07 in 2002–03 and 0.06 in 2003–04).

A range of hospital initiatives is helping to improve communication with Aboriginal clients. These include ALOs, hospital-based Aboriginal Health Workers, the Aboriginal Interpreter Service and cross-cultural training for hospital staff. While Aboriginal staff help communication with Aboriginal clients in matters such as informed consent and improved treatment, they also resolve difficulties that arise outside the formal complaints system.

Box 14.1: Data issues

Most states and territories could not provide quantitative data for this indicator and it was agreed to report descriptive and quantitative information. There were no consistent processes for managing and recording Aboriginal and Torres Strait Islander complaints about hospital services across states and territories. A number of states and territories reported progress towards developing systems for reporting and managing complaints. These systems may relate solely to hospitals, or the broader health services sector. Most states and territories reported the employment of Aboriginal Liaison Officers to help Indigenous people who wanted to make a complaint.

Determinants of health—access to services

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

Indicator 16
Distance to a primary health care centre

Indicator 17
Distance to a hospital

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

Indicator 19
Management of key conditions

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

Indicator 21
Higher education and training in key health professions

Indicator 22
Workforce availability in primary health care services

Indicator 23
Workforce availability in hospitals

Indicator 24
Cross-cultural training for hospital staff

Introduction

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

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

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

Indicator:

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

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

Purpose

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

Data

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

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

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

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

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

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

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

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

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

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

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

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

Box 15.1: Data issues

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

Indicator 16. Distance to a primary health care centre

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

Purpose

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

Data

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

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

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

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

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

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

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

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

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

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

Indicator 17. Distance to a hospital

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

Purpose

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

Data

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

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

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

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

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

b) Includes ‘Distance to nearest hospital’ not stated.

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

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

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

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

Purpose

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

Data

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

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

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

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

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

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

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

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

Indicator 19. Management of key conditions

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

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

Purpose

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

Data

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

Australian Government

Patient Information and Recall System

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

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

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

The Northern Territory HealthConnect Trial

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

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

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

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

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

Otitis media

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

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

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

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

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

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

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

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

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

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

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

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

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

Addressing safer alcohol consumption

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

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

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

Sharing Health Care Initiative

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

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

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

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

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

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

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

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

Coordinated Care Trials

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

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

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

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

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

New South Wales

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

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

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

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

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

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

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

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

The Standards were published in 2004–05.

Victoria

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

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

Management strategies

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

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

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

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

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

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

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

Strategies for specific conditions

Asthma

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

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

Renal failure

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

Diabetes

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

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

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

Tertiary intervention covers: acute services and inpatients and outpatients.

Queensland

Health Outcomes Plans

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

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

Enhanced Model of Primary Health Care (EMPHC)

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

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

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

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

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

Queensland Health HIV /AIDS Strategy

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

Renal Service Plans

Each of the three Queensland Health Zones have developed Renal Service Plans that recognise Aboriginal and Torres Strait Islander peoples as a priority population. The Renal Service Plans include specific strategies to address renal disease in Aboriginal and Torres Strait Islander peoples including health promotion, early detection, clinic management, renal replacement services, workforce management and information support actions. Queensland Health recognises that many rural/remote areas of the state do not have ready access to a hospital renal unit or satellite unit and is working towards ensuring that high-quality home dialysis is available. Examples include strategies established in the Toowoomba Renal Service for the provision of a multi-user self-care dialysis and the opening in March 2004 of the Mt Isa satellite service which is providing haemodialysis closer to home for patients who previously received this service out of Townsville.

Western Australia

Chronic disease prevention

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

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

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

South Australia

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

Chronic disease

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

Diabetes

Evidence-based treatment protocols

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

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

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

Early detection systems

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

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

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

Management systems

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

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

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

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

Tasmania

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

Australian Capital Territory

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

Diabetes

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

Northern Territory

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

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

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

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

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

Purpose

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

Data

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

Data from the Census

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

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

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

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

(continued)

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

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

(continued)

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

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

(continued)

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

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

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

(b) Includes registered and enrolled nurses.

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

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

Source: ABS Census of Population and Housing 2001.

Data from state/territory workplace surveys

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

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

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

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

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

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

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

(continued)

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

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

(a) Includes registered and enrolled nurses.

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

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

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

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

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

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

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

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

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

Box 20.1: Data issues

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

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

Indicator 21. Higher education and training in key health professions

Indicator:

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

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

Purpose

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

Data

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

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

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

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

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

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

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

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

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

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

Source: National Centre for Vocational Educational Research Ltd.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: National Centre for Vocational Educational Research Ltd.

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

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

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

(b) Aboriginal Health Worker.

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

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

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

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

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

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

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

Quality of the data

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

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

Australian Government programs

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

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

Indigenous Education Strategic Initiatives Programme (IESIP)

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

The Objects of the Act include;

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

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

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

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

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

'Mixed-mode' AFB

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

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

ABSTUDY Away-from-base (AFB)

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

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

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

Indigenous education direct assistance

Indigenous Tutorial Assistance Scheme

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

The Vocational Education Guidance for Aboriginals Scheme

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

Vocational education

Nursing Initiative for Indigenous Students project (Queensland)

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

Group Training New Apprenticeship Targeted Initiative Program (TIP)

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

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

Career education products.

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

Indicator 22. Workforce availability in primary health care services

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

Purpose

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

Data

Information for this indicator was obtained from OATSIH.

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

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

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

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

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

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

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

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

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

Box 22.1: Data issues

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

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

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

Indicator 23. Workforce availability in hospitals

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

Purpose

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

Data

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

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

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

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

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

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

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

Source: Data provided by the states and territories.

Box 23.1: Data issues

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

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

Indicator 24. Cross-cultural training for hospital staff

Indicator:

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

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

Purpose

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

Data

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

New South Wales

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

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

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

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

Victoria

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

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

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

Queensland

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

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

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

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

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

Western Australia

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

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

South Australia

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

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

Tasmania

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

Australian Capital Territory

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

Northern Territory

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

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

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

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

Box 24.2: Data issues

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

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

Determinants of health—risk markers

Indicator 25

Pap smear screening

Indicator 26

Childhood immunisation rates

Indicator 27

Coverage of adult pneumococcal vaccine

Indicator 28

Low-birthweight infants

Indicator 29

Smoking prevalence

Indicator 30

Alcohol consumption

Indicator 31

Overweight and obesity

Indicator 32

Child abuse and neglect

Indicator 35

Injuries presenting to hospital accident and emergency facilities

Indicators that currently cannot be reported on:

Indicator 33

Problem gambling

Indicator 34

Community grief

Introduction

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

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

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

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

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

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

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

Indicator 25. Pap smear screening

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

Purpose

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

Data

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

New South Wales

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

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

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

In 2003–04 the NSW Cervical Screening Program:

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

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

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

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

Victoria

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

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

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

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

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

Queensland

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

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

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

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

Western Australia

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

South Australia

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

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

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

Tasmania

Data are not currently collected in Tasmania.

Australian Capital Territory

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

Northern Territory

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

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

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

Indicator 26. Childhood immunisation rates

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

Purpose

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

Data

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

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

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

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

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

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

Source: Health Insurance Commission Australian Childhood Immunisation Register.

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

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

Indicator 27. Coverage of adult pneumococcal vaccine

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

Purpose

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

Data

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

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

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

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

(a) Vaccinated in the last 12 months.

(b) Vaccinated in last 5 years.

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

Indicator 28. Low-birthweight infants

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

Purpose

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

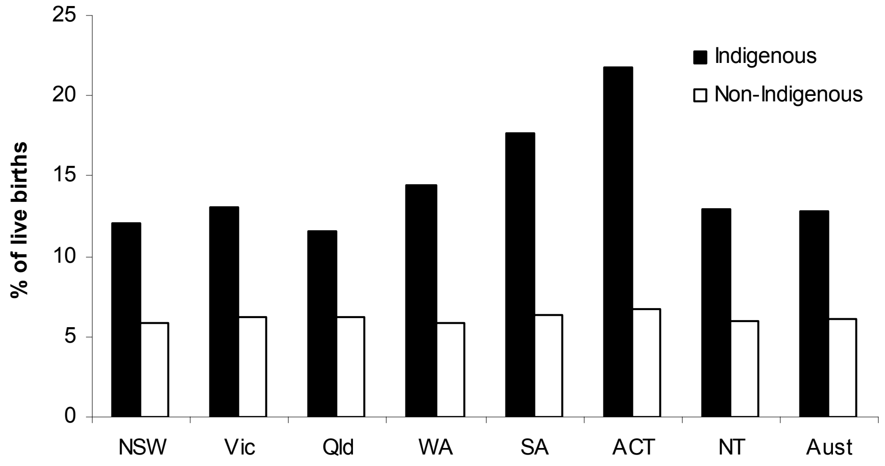
Babies born with a birthweight of less than 2,500 grams are classified as being of 'low birthweight'. Low birthweight may be a result of pre-term birth, foetal growth retardation, or a combination of the two (Alberman 1994). There are a range of factors that can affect a baby's birthweight, including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

Data

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

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

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



Notes

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

Source: AIHW National Perinatal Statistics Unit.

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

Indicator 29. Smoking prevalence

Indicator:

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

(b) The proportion of Aboriginal and Torres Strait Islander adults who formerly smoked regularly (ex-smokers), by age and sex.

Purpose

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

Data

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

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

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

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

(continued)

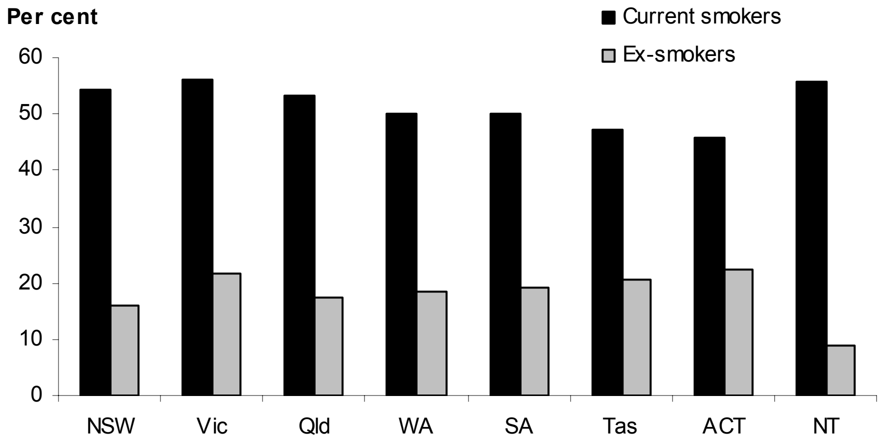
Table 29.1 (continued): Smoking status of Indigenous adults aged 18 years and over, by age, sex and state and territory, 2002

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

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

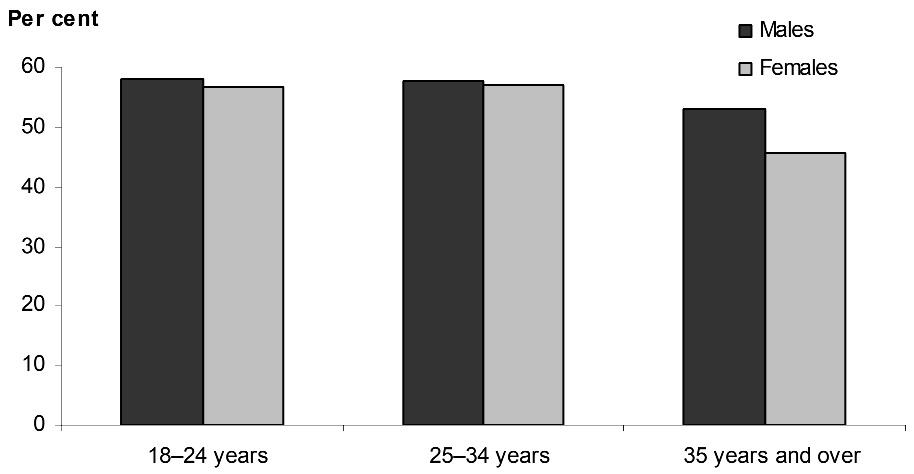
** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

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



Source: 2002 National Aboriginal and Torres Strait Islander Survey.

Figure 29.1: Current and ex-smokers, by state and territory, Indigenous Australians aged 18 years and over, 2002



Source: 2002 National Aboriginal and Torres Strait Islander Survey.

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

Indicator 30. Alcohol consumption

Indicator:

(a) The proportion of Aboriginal and Torres Strait Islander people aged 18 years and over who consumed alcohol in the week before the survey, by age and sex.

(b) The proportion of Aboriginal and Torres Strait Islander drinkers aged 18 years and over who reported drinking at levels of medium or high risk in the week before the survey.

Purpose

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

Data

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

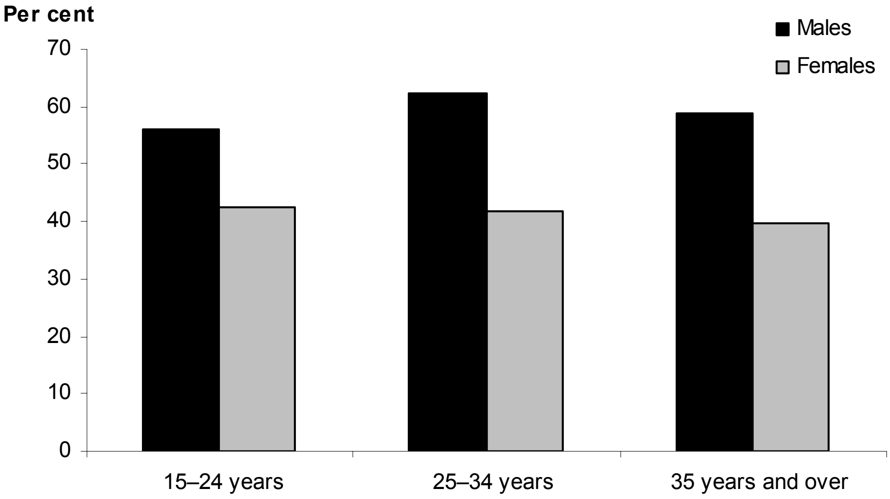
Due to small numbers of Indigenous people surveyed in some states and territories, estimates should be interpreted with caution.

Proportion who consumed alcohol

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

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

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



Source: 2002 NATSISS.

Figure 30.1: Proportion of drinkers who consumed alcohol at risky/high-risk levels in the 2 weeks prior to survey, by sex and age, Indigenous Australians, 2002

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

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

(Continued)

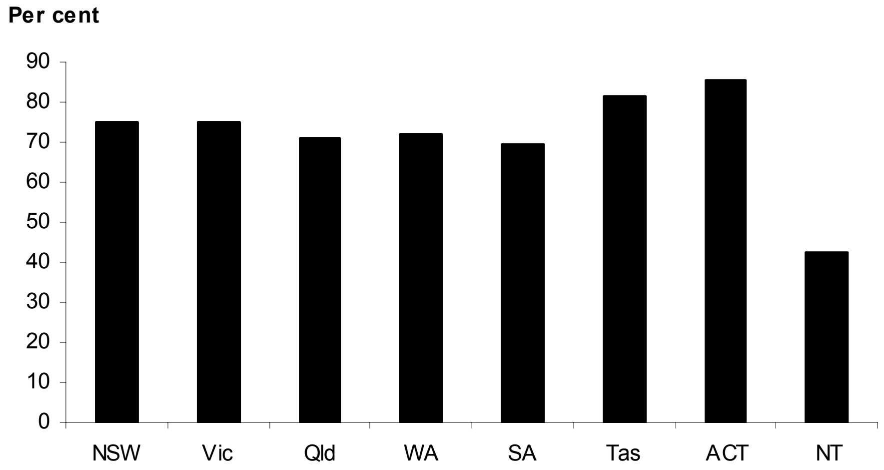
Table 30.1 (continued): Indigenous persons aged 15 years and over: by whether consumed alcohol and drank at risky/high risk levels, by age and sex, 2002

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

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

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

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



Source: 2002 NATSISS.

Figure 30.2: Proportion who consumed alcohol in last 12 months, by state and territory, Indigenous Australians aged 15 years and over, 2002

Indicator 31. Overweight and obesity

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

Purpose

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

Data

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

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

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

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

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

(b) Overweight and obesity are measured by the body mass index (BMI), a measure of the person's weight relative to their height (weight in kilograms divided by height in meters squared: kg/m^2). A BMI of between ≥ 25 and < 30 defines overweight while a BMI of ≥ 30 defines obesity.

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

Source: ABS National Health Survey 2001.

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

Indicator 32. Child abuse and neglect

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

Purpose

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

Data

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

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

Data for 2003–04 are presented for this indicator.

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

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

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

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

Notes

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

Source: AIHW 2005a.

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

Box 32.1: Data issues

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

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

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

Indicator 35. Injuries presenting to hospital accident and emergency facilities

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

Purpose

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

Data

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

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

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

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

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

(a) Injury and poisoning-related emergency department visits were selected using the principal provisional diagnosis assigned to the visit (ICD-9-AM codes 800–999). Aboriginal people may be under-identified in this data collection. Diagnoses are not coded by trained coders and should therefore be considered indicative only. Information on cause of injury are therefore not available.

(b) Data collected through the Victorian Emergency Minimum Dataset is coded by a composite of Injury Cause and Human Intent data fields,

(c) Data from the Queensland Injury Surveillance. Data are from 14 hospitals which comprise three sample regions: metropolitan (South Brisbane); regional (Mackay and Moranbah Health Districts) and remote (Mt Isa).

(d) Western Australia was not able to provide data by cause of injury.

(e) Causes of injuries are not recorded. ICD-9 Codes 800–960 and ICD-10 Codes S00–T14 were used to identify primary diagnosis of 'injury'.

(f) Injury presentations are classified on the basis of ‘body part’ and not by cause of the injury. Specific ICD injury codes are not captured in enough detail to split the total figure into the categories required for this report. Injury presentations have been captured using the Presenting Problem as entered at the time of triage.

Source: Data provided by the jurisdictions.

Box 35.1: Data issues

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

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

Outcomes for people

Indicator 37

Notification rates for selected vaccine-preventable diseases

Indicator 38

Notification rates for meningococcal disease

Indicator 39

Notification rates for sexually transmissible diseases

Indicator 40

Ratios for all hospitalisations

Indicator 41

Hospitalisation ratios for circulatory diseases

Indicator 42

Hospitalisation ratios for injury and poisoning

Indicator 43

Hospitalisation ratios for respiratory diseases and lung cancer

Indicator 44

Hospitalisation ratios for diabetes

Indicator 45

Hospitalisation ratios for tympanoplasty associated with otitis media

Indicator 46

Hospitalisation ratios for mental health conditions

Indicator 47

Children's hearing loss

Indicator 48

Still-births to Aboriginal and Torres Strait Islander mothers

Indicator 49

Early adult death

Indicator 50

Age- and sex-specific all cause death rates and ratios

Indicator 51

Standardised mortality ratios for all causes

Indicator 52

Standardised mortality ratios for circulatory diseases

Indicator 53

Standardised mortality ratios for injury and poisoning

Indicator 54

Standardised mortality ratios for respiratory diseases and lung cancer

Indicator 55

Standardised mortality ratios for diabetes

Indicator 56

Standardised mortality ratios for cervical cancer

The following indicator could not be reported on:

Indicator 36

Prevalence of anxiety and depression

Introduction

The domain 'Outcomes for people' has 21 indicators and data were provided for 20 of these indicators. The indicators measure a range of different health outcomes for Indigenous people. There are three indicators on notifications for communicable diseases, seven indicators on hospitalisations, one indicator on hearing loss and nine indicators on mortality. Many of the hospitalisations and mortality indicators include a number of sub-indicators.

Indicator 36—prevalence of anxiety and depression—was not reported on as at present there are no national data sources that provide information about the incidence or prevalence of mental disorders among Aboriginal and Torres Strait Islander people. The forthcoming 2004–05 National Aboriginal and Torres Strait Islander Health Survey will, for the first time, include a module to assess various aspects of social and emotional wellbeing of Aboriginal and Torres Strait Islander people. At present, data on hospitalisation and mortality due to mental disorders and illnesses are the main sources of information that provide an indication of the burden of mental health conditions in the Indigenous population.

Information on the quality of data for notifiable diseases, hospitalisations and mortality, and on efforts to improve the Indigenous identification in these datasets, was provided by the states and territories and national data custodians and is described under Indicator 1 in the domain 'Government inputs'.

Data for the three indicators on communicable disease notifications—for selected vaccine preventable diseases, meningococcal disease and sexually transmissible diseases—were provided by the Department of Health and Ageing—National Notifiable Disease Surveillance System. The coverage of Indigenous people in the notifiable disease registers is incomplete in most jurisdictions. Data from Western Australia, South Australia and the Northern Territory are considered to be sufficient to calculate rates.

The hospitalisation data were extracted from the AIHW National Hospital Morbidity Database. The under identification of Indigenous people in all states and territories affects the counts and the calculations of rates of hospitalisations for Indigenous people. The data from Queensland, Western Australia, South Australia and the Northern Territory were considered—as assessed by the relevant jurisdiction—to be sufficient to calculate rates (AIHW 2005c). Therefore data from only these four states and territories were used to describe details of hospitalisations. It should be noted that data from these jurisdictions may not be representative of Australia as a whole.

For each indicator, data are presented on the number of hospitalisations for each condition (for the years 2002–03 and 2003–04 combined), the average age-standardised rates for 2002–03 to 2003–04 and the average standardised hospital separation ratios for 2002–03 to 2003–04. The indirect standardisation method was used for all hospitalisation data.

The mortality data for six of the indicators were extracted from the AIHW's National Mortality Database. The under-identification of Indigenous people in all states and territories affects the counts and the calculations of death rates for Indigenous people. Data on numbers of deaths were extracted for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Queensland, Western Australia, South Australia and the Northern Territory have more complete coverage of Indigenous deaths than the other states and territories. New South Wales has the largest Indigenous population in Australia—29% of Aboriginal and Torres Strait Islander people live in New South Wales. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales. Rates were calculated for four states and territories—

Queensland, Western Australia, South Australia and the Northern Territory. Even within the coverage of Indigenous deaths from Queensland, the Northern Territory, South Australia and Western Australia, the data varies in its completeness from jurisdiction to jurisdiction. For this reason, no attempt has been made to establish the statistical significance of the differences between death rates of Indigenous populations in these states and territories and with the non-Indigenous population. Care should be taken with the interpretation of these data.

For each indicator, data are presented on the total number of deaths from each condition (for 2002, 2003 and 2004 combined), age-standardised rates and standardised mortality ratios. The indirect standardisation method was used to standardise all mortality data. As the standardised mortality ratio reflects health status and the standardised hospital separation ratio can reflect both health status and health service utilisation, comparing these two provides an indication of the access to service, relative to need.

Indicator 37. Notification rates for selected vaccine-preventable diseases

Indicator: The notification rate for Aboriginal and Torres Strait Islander people per 100,000 population for pertussis, measles and Hib.

Purpose

The indicator provides information on the incidence of pertussis, measles and *Haemophilus influenzae* type b (Hib disease). This reflects uptake of and access to immunisations to prevent these conditions.

Data

Data on notifications were provided by the Department of Health and Ageing—National Notifiable Disease Surveillance System (NNDSS). Queensland noted that currently Indigenous status is not supplied in notifications from private laboratories, nor generally in notifications from Queensland Health laboratories where the source of sample is a private provider. Indigenous status is generally well recorded for those conditions where individual cases are followed up by Public Health staff with enhanced surveillance.

There were very few cases of pertussis, measles or Hib in Queensland in 2003 or 2004. Pertussis notifications are not followed up routinely, except for (i) children less than 5 years old and (ii) all cases in the Northern zone. It is hence Queensland Health's view that the Indigenous identification is not of adequate completeness and Indigenous pertussis data should not be reported for Queensland. Measles and Hib disease are generally followed up for all cases; however, given the very low number of notifications, it is not useful to attempt to calculate rates for these conditions.

Three states and territories—Western Australia, South Australia and the Northern Territory—have been assessed by the NNDSS to have adequate coverage of Indigenous notifications and therefore considered to be sufficient to calculate rates. Data from other jurisdictions are likely to be an under-estimate of the true number of notifications in the Indigenous population and therefore should be interpreted with caution.

During 2003 there were 4 notifications of measles and 7 notifications of Hib in the Australian Indigenous population. In 2004 there were 8 notifications of measles and 3 notifications of Hib among Indigenous Australians.

The numbers and rates of notifications for pertussis are shown in Table 37.1. Rates were not provided by sex because the numbers of notifications were too low to produce useful rates.

Table 37.1: Number and rate per 100,000 of notifications for pertussis among Indigenous Australians, by state and territory, 2003 and 2004

	2003		2004	
	No.	**Rate**	**No.**	**Rate**
Western Australia	10	14.6	44	63.2
South Australia	n.p.	n.p.	6	22.2
Northern Territory	n.p.	n.p.	n.p.	n.p.
New South Wales	65	46.7	46	32.5
Victoria	5	17.2	n.p.	n.p.
Queensland	22	16.8	20	14.9
Tasmania	n.p	n.p.	0	0.0
Australian Capital Territory	n.p.	n.p.	0	0.0
Australia	**110**	**23.1**	**120**	**24.8**

n.p. Not published where numbers were less than 5.

Note: Shading indicates that the Indigenous identification for these data is in need of improvement.

Source: Data provided by the Department of Health and Ageing—NNDSS.

- There were a total of 110 notifications for pertussis among Aboriginal and Torres Strait Islander Australians in 2003 and 120 notifications in 2004.
- In 2003, pertussis was notified among Indigenous Australians at a rate of 14.6 per 100,000 population in Western Australia.
- In 2004, pertussis was notified at a rate of 22.2 per 100,000 in South Australia and 63.2 per 100,000 in Western Australia.

Indicator 38. Notification rates for meningococcal disease

Indicator: Notification rates per 100,000 for meningococcal disease in Aboriginal and Torres Strait Islander people.

Purpose

The indicator provides information on the incidence of meningococcal disease. This can reflect crowded housing conditions that facilitate person-to-person spread of the infection and access to vaccination.

Data

Data for this indicator were provided by the Department of Health and Ageing, National Notifiable Disease Surveillance System (NNDSS). Four states and territories—Queensland, Western Australia, South Australia and the Northern Territory—are considered to have adequate coverage of Indigenous notifications for meningococcal disease and were considered to be sufficient to calculate rates. Queensland Health advised that Indigenous status is generally well recorded for invasive meningococcal disease due to follow-up of all cases by Public Health Unit staff.

Numbers and rates from other jurisdictions should therefore be interpreted with caution.

Table 38.1: Number and rate per 100,000 of notifications for meningococcal disease among Indigenous Australians, by state and territory, 2003 and 2004

	2003		2004	
	No.	**Rate**	**No.**	**Rate**
Western Australia	7	10.2	6	8.6
South Australia	n.p.	n.p.	n.p.	n.p.
Northern Territory	11	18.8	8	13.4
Queensland	n.p.	n.p.	11	8.2
New South Wales	9	6.5	11	7.8
Victoria	n.p.	n.p.	0	0.0
Tasmania	n.p.	n.p.	n.p.	n.p.
Australian Capital Territory	0	0.0	n.p.	n.p.
Australia	**35**	**7.4**	**39**	**8.1**

n.p. Not published where numbers were less than 5.

Notes

1. Shading indicates that the Indigenous identification for these data is in need of improvement.
2. ABS 2003 and 2004 Indigenous population projections based on the 2001 Census were used in the calculation of crude rates.

Source: Data provided by the Department of Health and Ageing —NNDSS.

- In 2003 and 2004, there were 35 and 39 respective notifications of meningococcal disease among Aboriginal and Torres Strait Islander people in Australia.

- In 2003, the notification rate for meningococcal disease for Indigenous people in Western Australia was 10.2 per 100,000 and in the Northern Territory the rate was 18.8 per 100,000.
- In 2004, the notification rate for meningococcal disease for Indigenous people in Western Australia was 8.6 per 100,000. In the Northern Territory, the notification rate was 13.4 per 100,000 and in Queensland, the rate was 8.2 per 100,000.

Indicator 39. Notification rates for sexually transmissible diseases

Indicator: The notification rate for Aboriginal and Torres Strait Islander people per 100,000 population for gonorrhoea, syphilis and chlamydia, by sex.

Purpose

The indicator provides information on the incidence of gonorrhoea, syphilis and chlamydia, the most common notifiable sexually transmissible diseases. It reflects community knowledge of and practices in relation to safe sex.

Data

Data for this indicator were provided by the Department of Health and Ageing, National Notifiable Disease Surveillance System (NNDSS). The numbers provided are likely to represent only a proportion of all infections with the organisms that cause these diseases, as asymptomatic and milder cases are less likely to be diagnosed and/or notified. Queensland Health advised that neither chlamydia nor gonorrhoea notifications are generally followed up through enhanced surveillance. Syphilis notifications are routinely followed up in Queensland through a state-wide process where staging is determined and treatment information provided.

Three states and territories—Western Australia, South Australia and the Northern Territory—are considered to have adequate coverage of Indigenous notifications and were considered to be sufficient to calculate rates. Numbers and rates from other jurisdictions should therefore be interpreted with caution. Numbers and rates are provided for those aged 15 to 54 years as the numbers in other age groups were too low to produce useful or accurate rates.

- In 2004, there were 1,128 notifications of gonorrhoea, 1,064 notifications of chlamydia and 52 notifications of syphilis among Indigenous males aged 15–54 years (Table 39.1).
- In the same period there were 1,792 notifications of chlamydia, 1,186 notifications of gonorrhoea, and 52 notifications of syphilis among Indigenous females aged 15–54 years.

Table 39.1: Number of sexually transmissible diseases among Aboriginal and Torres Strait Islander people aged 15–54 years, by sex, for selected states and territories, 2003 and 2004

	WA	SA	NT	NSW	Vic	Qld	Aust(a)
Males				**2003**			
Gonorrhoea	429	47	486	23	n.p.	123	1,111
Syphilis	30	0	127	0	0	0	158
Chlamydia	307	47	354	59	11	309	1,087
Females							
Gonorrhoea	405	48	614	19	n.p.	139	1,227
Syphilis	32	0	133	0	0	0	165
Chlamydia	490	111	633	99	25	620	1,978
Males				**2004**			
Gonorrhoea	394	72	511	10	n.p.	147	1,128
Syphilis	0	0	52	0	0	0	52
Chlamydia	272	74	323	54	14	327	1,064
Females							
Gonorrhoea	353	84	618	11	n.p.	175	1,186
Syphilis	0	0	52	0	0	0	52
Chlamydia	444	115	549	76	36	570	1,792

n.p. Not published where numbers were less than 5.

(a) Includes Tasmania and the Australian Capital Territory for which numbers were too small to present separately.

Notes

1. Shading indicates that the Indigenous identification for these data is in need of improvement.
2. ABS 2003 and 2004 Indigenous population projections based on the 2001 Census were used in the calculation of rates.

Source: Data provided by the Department of Health and Ageing—NNDSS.

- Of the three sexually transmitted diseases for which data were provided, notification rates in 2004 for Aboriginal and Torres Strait Islander males aged 15 to 54 years were highest for gonorrhoea in Western Australia (2,062 per 100,000) and the Northern Territory (2,969 per 100,000), and highest for chlamydia in South Australia (991 per 100,000) (Table 39.2).
- For Aboriginal and Torres Strait Islander females aged 15 to 54 years, notification rates in 2004 were highest for chlamydia in Western Australia (2,235 per 100,000) and South Australia (1,485 per 100,000), and highest for gonorrhoea in the Northern Territory (3,529 per 100,000).
- Notification rates for chlamydia were significantly higher among Indigenous females than among Indigenous males for both years.
- In 2003 and 2004, the Northern Territory had the highest rate of notifications for all three conditions among both Indigenous males and females.

Table 39.2: Rate per 100,000 of sexually transmissible diseases among Aboriginal and Torres Strait Islander people aged 15–54 years, by sex, for selected states and territories, 2003 and 2004

	WA	SA	NT	NSW	Vic	Qld	Aust[(a)]
Males				**2003**			
Gonorrhoea	2,303.2	644.4	2,881.2	62.5	n.p.	361.5	870.5
Syphilis	161.1	0.0	752.9	0.0	0.0	0.0	123.8
Chlamydia	1,648.2	644.4	2,098.6	160.4	137.9	908.2	851.7
Females							
Gonorrhoea	2,095.2	636.4	3,571.0	49.9	n.p.	375.5	918.9
Syphilis	165.5	0.0	366.9	0.0	0.0	0.0	123.6
Chlamydia	2,534.9	1,1471.6	3,681.5	260.2	307.7	1,674.7	1,481.4
Males				**2004**			
Gonorrhoea	2062.2	964.4	2,968.9	26.6	n.p.	419.4	861.7
Syphilis	0.0	0.0	302.1	0.0	0.0	0.0	39.7
Chlamydia	1423.6	991.2	1,876.6	143.5	170.0	932.8	812.8
Females							
Gonorrhoea	1,776.7	1,084.4	3,528.8	28.2	n.p.	461.0	866.7
Syphilis	0.0	0.0	296.9	0.0	0.0	0.0	38.0
Chlamydia	2,234.7	1,484.6	3,134.8	195.1	427.9	1,501.6	1,309.6

n.p. Not published where numbers were less than 5.

(a) Includes Tasmania and the Australian Capital Territory.

Notes:

1. Shading indicates that the Indigenous identification for these data is in need of improvement.
2. ABS 2003 and 2004 Indigenous population projections based on the 2001 Census were used in the calculation of rates.

Source: Data provided by the Department of Health and Ageing—NNDSS.

Indicator 40. Ratios for all hospitalisations

Indicator: Standardised hospital separation ratios for all hospitalisations in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

Hospitalisation rates are a widely used surrogate measure of morbidity. All-cause hospitalisation rates and rate ratios also provide a measure of the extent of the relative magnitude of heath problems in the Indigenous population compared with the non-Indigenous population.

Data

Data for this indicator come from the AIHW's National Hospital Morbidity Database. Because hospitalisation data do not distinguish between people being hospitalised once and the same person being hospitalised a number of times, hospitalisations are not a direct measure of the incidence or prevalence of a disease.

Data in four states and territories—Queensland, Western Australia, South Australia and the Northern Territory—have been assessed by the AIHW as having the more complete coverage of Indigenous hospitalisations (AIHW 2005c). This quality assessment is based on the state or territory of the hospital. Hospitalisation data in this report are based on the state or territory of usual residence of the patient hospitalised, rather than the state or territory of the hospital. Given that there are cross-border flows between most states and territories, it is reasonable to use the assessments in an approximate way. Data from only Queensland, Western Australia, South Australia and the Northern Territory were therefore used to describe details of hospitalisations. Data from these states and territories are not necessarily representative of the other states and territories.

Hospitalisations for which Indigenous status was 'not stated' have not been included in the calculation of rates in this report. This is to be consistent with previous reports in this series. It should be noted however, that the current recommendation is to combine hospitalisations for which Indigenous status was not reported with hospitalisation data for non-Indigenous people. This is to enable consistency across jurisdictions as Western Australia and Victoria do not have a category for the reporting of 'not stated' Indigenous status. In these states, separations with unidentified Indigenous status become grouped with separations of non-Indigenous people.

The incompleteness of Indigenous identification means the number of hospital separations recorded as Indigenous is an underestimate of Aboriginal and Torres Strait Islander hospitalisations.

Table 40.1: Hospitalisations for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[a]	Total[b]	NSW	Vic	Tas[a]	ACT[a]	Aust[c]
Indigenous										
Males	47,727	34,053	13,119	33,553	128,452	37,512	6,729	1,301	902	175,040
Females	60,467	51,358	16,151	48,454	176,430	44,037	9,080	2,255	1,136	233,251
Persons	108,194	85,411	29,270	82,007	304,882	81,549	15,809	3,556	2,038	408,291
Non-Indigenous										
Males	830,677	469,154	401,868	24,327	1,726,026	1,494,976	1,332,015	60,046	41,883	4,690,002
Females	953,574	530,914	457,232	24,319	1,966,039	1,693,385	1,575,627	62,409	42,725	5,390,475
Persons	1,784,251	1,000,068	859,100	48,646	3,692,065	3,188,361	2,907,642	122,455	84,608	10,080,477
Subtotal	***1,892,445***	***1,085,479***	***888,370***	***130,653***	**3,996,947**	***3,269,910***	***2,923,451***	***126,011***	***86,646***	***10,488,768***
Not stated	257,421	332	22,606	279	280,638	21,569	1,136	8,425	2,674	394,949
Total	**2,149,866**	**1,085,811**	**910,976**	**130,932**	**4,277,585**	**3,291,479**	**2,924,587**	**134,436**	**89,320**	**10,883,717**
Proportion not stated (%)	12.0	—	2.5	0.2	6.6	0.7	0.0	6.3	3.0	3.6

(a) Excludes data for private hospitals.

(b) Queensland, Western Australia, South Australia and Northern Territory combined.

(c) Does not include ‘Other Territories’.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, there were 10,883,717 hospitalisations in Australia among persons aged less than 75 years. Of these, 408,291 hospitalisations (3.8%) were Indigenous people and for 3.6% of hospitalisations, Indigenous status was ‘not stated’.
- Females made up 57% of hospitalisations among Indigenous people compared with 53% of hospitalisations among non-Indigenous people.
- In Queensland, Western Australia, South Australia and the Northern Territory, where the recording of Indigenous status in hospitalisation data is more complete, there were 4,277,585 hospitalisations among persons aged less than 75 years. Of these, 304,882, or 7.1%, were Indigenous people and for 6.6% of hospitalisations, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 40.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04.

	Qld	WA	SA	NT(a)	Total(b)	NSW	Vic	Tas(a)	ACT(a)	Aust(c)
					Rate per 1,000					
Indigenous males	516.2	694.9	694.3	795.5	633.5	366.1	319.3	98.4	313.6	513.5
Non-Indigenous males	235.6	261.0	277.0	179.4	249.8	239.2	289.2	132.7	146.2	254.2
Indigenous females	579.8	948.4	761.7	1,027.1	664.5	406.5	395.7	164.9	361.0	624.4
Non-Indigenous females	277.7	302.8	322.8	204.8	250.1	275.7	339.9	142.8	142.4	296.3
Indigenous persons	551.1	826.1	726.9	913.8	653.8	387.2	358.1	132.8	337.1	571.3
Non-Indigenous persons	256.7	281.5	299.2	191.2	249.9	257.3	314.5	137.9	144.0	275.1
					Standardised hospital separation ratio(d)					
Males	1.9	2.6	2.6	3.0	2.4	1.4	1.2	0.4	1.2	1.9
Females	1.9	3.1	2.5	3.3	2.5	1.3	1.3	0.5	1.2	2.0
Persons	1.9	2.9	2.5	3.2	2.5	1.3	1.2	0.5	1.2	2.0

(a) Excludes data for private hospitals.

(b) Queensland, Western Australia, South Australia and Northern Territory combined.

(c) Does not include ‘Other Territories’.

(d) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised at between 2 and 3 times the rate of non-Indigenous people.
- The standardised hospital separation ratios for males and females were similar in most states and territories.

Indicator 41. Hospitalisation ratios for circulatory diseases

Indicator:

(a) Standardised hospital separation ratios for circulatory diseases as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared with the non-Indigenous Australian population, by sex, for ages 0–74 years.

(b) Standardised hospital separation ratios for coronary heart disease as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared with the non-Indigenous Australian population, by sex, for ages 0–74 years.

(c) Standardised hospital separation ratios for rheumatic fever and rheumatic heart disease as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared with the non-Indigenous Australian population, by sex, for ages 0–74 years.

Purpose

A significant proportion of Aboriginal and Torres Strait Islander people suffer from diseases of the circulatory system. The indicator provides a broad measure of the occurrence of all circulatory diseases and access to hospital admitted patient services for Aboriginal and Torres Strait Islander people, relative to the non-Indigenous population.

Data

The data provided are for hospitalisations for all circulatory diseases, as well as for the two subgroups of coronary heart disease and rheumatic heart disease. 'Principal diagnosis' refers to 'the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in a hospital'.

Circulatory diseases

Table 41.1: Hospitalisations for circulatory disease[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	2,025	1,312	513	1,060	4,910	1,809	268	71	30	7,100
Females	1,843	1,138	431	869	4,281	1,454	261	48	15	6,065
Persons	3,868	2,450	944	1,929	9,191	3,263	529	119	45	13,165
Non-Indigenous										
Males	55,938	28,861	27,507	1,635	113,941	118,237	88,196	4,906	2,892	330,645
Females	34,321	16,842	16,844	692	68,699	70,943	55,609	2,705	1,490	201,221
Persons	90,259	45,703	44,351	2,327	182,640	189,180	143,805	7,611	4,382	531,866
Subtotal	***94,127***	***48,153***	***45,295***	***4,256***	**191,831**	***192,443***	***144,334***	***7,730***	***4,427***	***545,031***
Not stated	14,887	33	927	35	15,882	1,249	146	541	97	22,022
Total	**109,014**	**48,186**	**46,222**	**4,291**	**207,713**	**193,692**	**144,480**	**8,271**	**4,524**	**567,053**
Proportion not stated (%)	13.7	0.1	2.0	0.8	7.6	0.6	0.1	6.5	2.1	3.9

(a) ICD-10-AM codes I00–I99.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include ‘Other Territories’.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, there were 567,053 hospitalisations due to circulatory diseases in Australia among people aged 0–74 years. Of these, 13,165 hospitalisations or 2.3% were of Indigenous people and for 3.9% of hospitalisations, Indigenous status was not stated.
- Males made up 62% of the non-Indigenous hospitalisations for circulatory diseases, compared with only 54% of the Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, where the recording of Indigenous status in hospitalisation data is most complete, there were 207,713 hospitalisations for circulatory diseases. Of these, 9,191, or 4.4%, were Indigenous people and for 7.6% of hospitalisations, Indigenous status was ‘not stated.’

Age-standardised rates and standardised hospital separation ratios

Table 41.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for circulatory disease[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	37.2	44.6	44.7	42.2	40.8	28.3	20.3	8.4	19.0	34.3
Non-Indigenous males	15.8	16.1	18.3	13.3	16.4	18.7	19.1	10.3	10.7	17.8
Indigenous females	28.8	33.1	31.6	29.6	49.0	20.8	17.9	5.6	8.8	25.8
Non-Indigenous females	10.1	9.7	11.2	7.3	16.5	11.4	11.9	5.8	5.4	11.0
Indigenous persons	32.9	38.6	37.8	35.6	43.6	24.5	19.1	7.0	13.9	30.0
Non-Indigenous persons	13.0	13.0	14.7	10.8	16.4	15.1	15.5	8.1	8.0	14.4
					Standardised hospital separation ratio[(e)]					
Males	2.0	2.4	2.4	2.3	2.2	1.5	1.1	0.5	1.0	1.8
Females	2.5	2.9	2.8	2.6	2.7	1.8	1.6	0.5	0.8	2.2
Persons	2.2	2.6	2.5	2.4	2.4	1.6	1.3	0.5	0.9	2.0

(a) ICD-10-AM codes I00–I99.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for circulatory disease at between 2 and 3 times the rate for non-Indigenous people.
- In these four states and territories, hospitalisation rates for circulatory disease for Indigenous females were around 3 times those for non-Indigenous females. Rates for Indigenous males were around twice those for non-Indigenous males.

Coronary heart disease

Table 41.3: Hospitalisations for coronary heart disease[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	1,048	576	241	462	2,327	894	145	35	21	3,425
Females	803	451	173	303	1,730	687	119	24	6	2,567
Persons	1,851	1,027	414	765	4,057	1,581	264	59	27	5,992
Non-Indigenous										
Males	25,411	11,857	11,562	721	49,551	53,588	38,258	2,177	1,290	145,846
Females	10,587	4,256	4,520	233	19,596	21,003	14,666	926	398	56,929
Persons	35,998	16,113	16,082	954	69,147	74,591	52,924	3,103	1,688	202,775
Subtotal	***37,849***	***17,140***	***16,496***	***1,719***	***73,204***	***76,172***	***53,188***	***3,162***	***1,715***	***208,767***
Not stated	6,295	22	359	29	6,705	513	88	306	7	9,135
Total	**44,144**	**17,162**	**16,855**	**1,748**	**79,909**	**76,685**	**53,276**	**3,468**	**1,722**	**217,902**
Proportion not stated (%)	14.3	0.1	2.1	1.7	8.4	0.7	0.2	8.8	0.4	4.2

(a) ICD-10-AM codes I20–I25.
(b) Excludes data for private hospitals.
(c) Queensland, Western Australia, South Australia and Northern Territory combined.
(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04 there were 217,902 hospitalisations for coronary heart disease in Australia among people aged less than 75 years. Of these, 5,992 hospitalisations (2.7%) were of Indigenous people and for 4.2% of hospitalisations, Indigenous status was not stated.
- Males made up 57% of the Indigenous hospitalisations for coronary heart disease compared with 72% of the non-Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 79,909 hospitalisations for coronary heart disease. Of these, 4,057, or 5.0%, were of Indigenous people and for 8.4%of hospitalisations, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 41.4: Age-standardised hospitalisation rates and standardised hospital separation ratios for coronary heart disease[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	22.1	22.5	24.1	21.4	22.3	15.6	12.4	4.6	16.1	18.9
Non-Indigenous males	7.1	6.6	7.6	6.0	7.1	8.5	8.3	4.5	4.8	7.8
Indigenous females	16.3	16.6	15.9	13.2	38.9	12.2	10.3	3.5	5.3	13.9
Non-Indigenous females	3.1	2.5	2.9	2.9	7.2	3.3	3.1	1.9	1.5	3.1
Indigenous persons	18.8	19.2	19.5	16.9	26.4	13.7	11.2	4.0	10.8	16.1
Non-Indigenous persons	5.2	4.6	5.3	4.7	7.2	5.9	5.7	3.2	3.2	5.5
					Standardised hospital separation ratio[(e)]					
Males	2.7	2.7	2.9	2.6	2.7	1.9	1.5	0.6	2.0	2.3
Females	4.9	5.0	4.8	4.0	4.8	3.7	3.1	1.1	1.6	4.2
Persons	3.3	3.3	3.4	2.9	3.2	2.4	1.9	0.7	1.9	2.8

(a) ICD-10-AM codes I20–I25.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for coronary heart disease at around 3 times the rate for non-Indigenous people.
- The differences in rates are particularly marked in females, with Indigenous females hospitalised at between 4 and 5 times the rates for non-Indigenous females. Indigenous males were hospitalised at around 3 times the rate for non-Indigenous males.

Rheumatic heart disease

Table 41.5: Hospitalisations for rheumatic fever and heart disease[(a)] for persons aged 0–74 years by Indigenous status and by sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Aust[(d)]
Indigenous								
Males	47	39	n.p.	115	203	14	n.p.	219
Females	98	73	n.p.	179	363	26	n.p.	394
Persons	145	112	15	294	566	40	7	613
Non-Indigenous								
Males	201	115	57	16	389	360	266	1,040
Females	287	166	89	10	552	556	374	1,537
Persons	488	281	146	26	941	916	640	2,577
Subtotal	***633***	***393***	***161***	***320***	***1,507***	***956***	***647***	***3,190***
Not stated	194	0	6	2	202	2	0	241
Total	**827**	**393**	**167**	**322**	**1,709**	**958**	**647**	**3,431**
Proportion not stated (%)	23.5	0.0	3.6	0.6	11.8	0.2	0.0	7.0

n.p. Not published where numbers were less than 5.

(a) ICD-10-AM codes I00–I09.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Due to low numbers for rheumatic heart disease in the Australian Capital Territory and Tasmania, data from these states and territories were not included in the table separately but are included in the Australian total. Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, there were 3,431 hospitalisations for rheumatic heart disease in Australia among those aged 0–74 years. Of these, 613 hospitalisations or 18% were of Indigenous people and for 7.0%, Indigenous status was not stated.
- Males made up 36% of the hospitalisations for rheumatic heart disease among Indigenous people, and 40% of the hospitalisations among non-Indigenous people.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 1,709 hospitalisations for rheumatic heart disease. Of these, 566 or 33% were Indigenous people and for 11.8% Indigenous status was not stated.

• Age-standardised rates and standardised hospital separation ratios

Table 41.6: Age-standardised hospitalisation rates and standardised hospital separation ratios for rheumatic fever and heart disease[(a)] for persons aged 0–74 years, by Indigenous status, sex and state and territory, 2002–03 to 2003–04.

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Aust[(d)]
				Rate per 1,000				
Indigenous males	0.6	1.0	n.p.	3.3	1.2	0.2	n.p.	0.8
Non-Indigenous males	0.1	0.1	n.p.	0.1	0.1	0.1	n.p.	0.1
Indigenous females	1.2	1.7	0.8	4.9	1.4	0.3	0.3	1.3
Non-Indigenous females	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Indigenous persons	0.9	1.3	0.5	4.1	1.3	0.2	0.2	1.1
Non-Indigenous persons	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1
				Standardised hospital separation ratio[(e)]				
Males	8.5	13.2	n.p.	46.1	16.7	2.2	n.p.	10.4
Females	11.1	15.7	n.p.	45.3	18.8	2.7	n.p.	12.1
Persons	10.2	14.8	5.1	45.9	18.1	2.5	2.1	11.5

n.p. Not published where numbers were less than 5.

(a) ICD-10-AM codes I00–I09.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Due to low numbers for rheumatic heart disease in the Australian Capital Territory and Tasmania, data for these states and territories were not included separately in the table but are included in the Australian total. Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- The low numbers of cases of rheumatic heart disease in both populations make the age-standardised rates less stable than they are for the other heart diseases. Nevertheless, it is clear that there was a significantly higher rate of hospitalisation for Indigenous people with rheumatic heart disease than for non-Indigenous people.
- In 2002–03 to 2003–04 in the Northern Territory, Indigenous people were hospitalised at 46 times the rate of non-Indigenous people, and in Western Australia Indigenous people were hospitalised at 15 times the rate of non-Indigenous people. These large differences are to some extent determined by very low rates of hospitalisations in the non-Indigenous population.
- The high rates of rheumatic heart disease hospitalisations in the Indigenous population are closely related to high rates of infection with rheumatic fever. This in turn reflects high levels of exposure to group A streptococci (the cause of rheumatic fever) from skin sores and throat infections. These conditions are related to overcrowding and poor living conditions.

Indicator 42. Hospitalisation ratios for injury and poisoning

Indicator:

(a) Standardised hospital separation ratio for injury and poisoning as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for ages 0–74 years.

(b) Standardised hospital separation ratio for transport accidents as an external cause of hospitalisation in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for ages 0–74 years.

(c) Standardised hospital separation ratio for other accidents as an external cause of hospitalisation in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for ages 0–74 years.

(d) Standardised hospital separation ratio for self-harm as an external cause of hospitalisation in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for ages 0–74 years.

(e) Standardised hospital separation ratio for assault as an external cause of hospitalisation in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for ages 0–74 years.

Purpose

Injury is a leading cause of hospitalisation for Aboriginal and Torres Strait Islander people. The indicators provide a broad measure of the incidence of injuries resulting in hospitalisation, as well as the major causes of injury and access to hospital admitted patient services for Aboriginal and Torres Strait Islander people compared to non-Indigenous people.

Data

The specifications for this indicator state that data on injury and poisoning as the principal diagnosis be provided, but the ICD codes provided for the indicator relate to external causes of morbidity and mortality. Thus data presented here are for hospitalisations with a principal diagnosis of injury and poisoning, and for external causes of hospitalisation including transport accidents, other accidents, self-harm and assault which are not restricted to having a principal diagnosis of injury and poisoning.

Injury and poisoning

This category includes all injury and poisoning.

Table 42.1: Hospitalisations for injury and poisoning[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	5,252	4,264	1,182	2,980	13,678	4,391	755	160	56	19,048
Females	3,719	3,874	1,073	2,616	11,282	2,835	507	118	49	14,798
Persons	8,971	8,138	2,255	5,596	24,960	7,226	1,262	278	105	33,846
Non-Indigenous										
Males	83,400	39,547	31,712	3,494	158,153	143,688	105,080	6,752	4,093	419,621
Females	46,986	23,433	20,402	1,404	92,225	84,043	67,775	3,967	2,439	251,806
Persons	130,386	62,980	52,114	4,898	250,378	227,731	172,855	10,719	6,532	671,427
Subtotal	***139,357***	***71,118***	***54,369***	***10,494***	***275,338***	***234,957***	***174,117***	***10,997***	***6,637***	***705,273***
Not stated	10,001	25	1,470	28	11,524	2,135	165	812	80	18,245
Total	**149,358**	**71,143**	**55,839**	**10,522**	**286,862**	**237,092**	**174,282**	**11,809**	**6,717**	**723,518**
Proportion not stated (%)	6.7	0.0	2.6	0.3	4.0	0.9	0.1	6.9	1.2	2.5

(a) ICD-10-AM codes S00–T98.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04 there were 723,518 hospitalisations among people aged 0–74 years due to injury and poisoning. Of these 33,846 hospitalisations (4.7%) were of Indigenous people and for 2.5%, Indigenous status was not stated.
- Males made up 56% of the Indigenous hospitalisations from injury and poisoning, compared with 62% of the non-Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 286,862 hospitalisations for injury and poisoning. Of these, 24,960 or 8.7% were of Indigenous people and for 4.0% of hospitalisations Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 42.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for injury and poisoning(a) for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT(b)	Total(c)	NSW	Vic	Tas(b)	ACT(b)	Aust(d)
					Rate per 1,000					
Indigenous males	40.3	61.7	44.3	49.4	47.8	31.4	25.7	8.8	13.4	40.0
Non-Indigenous males	23.8	21.9	22.7	23.8	23.0	23.3	22.9	15.9	13.3	22.9
Indigenous females	29.9	60.4	42.7	48.0	68.4	21.9	18.6	7.1	12.9	33.4
Non-Indigenous females	13.7	13.3	14.6	11.6	22.3	13.8	14.7	9.1	8.1	13.9
Indigenous persons	34.8	60.4	43.1	48.2	55.0	26.5	22.1	7.9	12.9	36.4
Non-Indigenous persons	18.7	17.6	18.7	18.2	22.8	18.6	18.8	12.5	10.7	18.4
					Standardised hospital separation ratio(e)					
Males	1.7	2.6	1.9	2.1	2.0	1.3	1.1	0.4	0.6	1.7
Females	2.0	4.1	2.9	3.3	2.9	1.5	1.3	0.5	0.9	2.3
Persons	1.8	3.1	2.2	2.5	2.3	1.4	1.1	0.4	0.7	1.9

(a) ICD-10-AM codes S00–T98.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for injury and poisoning at 2 to 3 times the rate of non-Indigenous people.
- In these four states and territories, the hospitalisation rates of Indigenous females for injury and poisoning were approximately 2 to 4 times those of non-Indigenous females.

Transport accidents

This category includes injuries caused by accidents involving cars, buses, trucks, motorcycles, bicycles and pedestrians. It excludes other land transport accidents, water transport accidents, air and space transport accidents and other and unspecified transport accidents.

Table 42.3: Hospitalisations for transport accidents[(a)] for persons aged 0–74 years by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	554	513	117	330	1,514	533	85	30	n.p.	2,172
Females	252	279	75	149	755	232	44	13	n.p.	1,047
Persons	806	792	192	479	2,269	765	129	43	13	3,219
Non-Indigenous										
Males	13,070	6,080	4,817	601	24,568	21,352	15,910	988	728	63,656
Females	4,770	2,177	2,072	209	9,228	9,281	7,555	422	288	26,831
Persons	17,840	8,257	6,889	810	33,796	30,633	23,465	1,410	1,016	90,487
Subtotal	***18,646***	***9,049***	***7,081***	***1,289***	***36,065***	***31,398***	***23,594***	***1,453***	***1,029***	***93,706***
Not stated	835	6	305	4	1,150	434	53	190	16	2,085
Total	**19,481**	**9,055**	**7,386**	**1,293**	**37,215**	**31,832**	**23,647**	**1,643**	**1,045**	**95,791**
Proportion not stated (%)	4.3	0.1	4.1	0.3	3.1	1.4	0.2	11.6	1.5	2.2

n.p. Not publishable where numbers were less than 5.

(a) ICD-10-AM codes V01–V79.
(b) Excludes data for private hospitals.
(c) Queensland, Western Australia, South Australia and Northern Territory combined.
(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 there were 95,791 hospitalisations among people aged 0–74 years due to transport accidents. Of these 3,219 hospitalisations (3.4%) were of Indigenous people, and for 2.2%, Indigenous status was not stated.
- Females made up 33% of hospitalisations among Indigenous people as a result of motor vehicle accidents, compared with 30% of hospitalisations among non-Indigenous people.
- In the four states and territories where the recording of Indigenous status in hospitalisation data is considered most complete, 2.0% of hospitalisations for transport accidents were of Indigenous people, and for 3.1%, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 42.4: Age-standardised hospitalisation rates and standardised hospital separation ratios for transport accidents[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	4.0	6.9	4.0	5.0	4.9	3.6	2.7	1.5	n.p.	4.2
Non-Indigenous males	3.7	3.3	3.5	4.0	3.6	3.5	3.5	2.4	2.3	3.5
Indigenous females	1.9	4.0	2.8	2.5	6.0	1.7	1.5	0.7	n.p.	2.2
Non-Indigenous females	1.4	1.2	1.5	1.7	3.2	1.5	1.6	1.0	0.9	1.5
Indigenous persons	2.9	5.4	3.4	3.8	5.2	2.6	2.1	1.1	1.5	3.2
Non-Indigenous persons	2.6	2.3	2.5	2.9	3.5	2.5	2.6	1.7	1.6	2.5
					Standardised hospital separation ratio[(e)]					
Males	1.1	1.9	1.1	1.4	1.4	1.0	0.8	0.4	n.p.	1.2
Females	1.2	2.6	1.8	1.6	1.7	1.1	1.0	0.5	n.p.	1.4
Persons	1.1	2.1	1.3	1.5	1.5	1.0	0.8	0.4	0.6	1.2

n.p. Not publishable where numbers were less than 5.

(a) ICD-10-AM codes V01–V79.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include ‘Other Territories’.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Western Australia and the Northern Territory, Indigenous people were hospitalised for transport accidents at up to twice the rate of non-Indigenous people.
- In Queensland and South Australia, the hospitalisation rates for transport accidents were similar for Indigenous and non-Indigenous people.
- The standardised hospital separation ratios were higher for females than males in all four jurisdictions with the most complete coverage of Indigenous hospitalisations.

Other accidents

This category includes other land transport accidents, water transport accidents, falls, drowning and poisoning.

Table 42.5: Hospitalisations for other accidents[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 and 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	3,504	2,585	732	1,820	8,641	2,893	515	97	31	12,195
Females	1,991	1,720	492	1,120	5,323	1,617	305	73	23	7,350
Persons	5,495	4,305	1,224	2,940	13,964	4,510	820	170	54	19,545
Non-Indigenous										
Males	63,006	28,283	22,202	2,412	115,903	103,586	73,674	4,377	2,830	301,707
Females	34,496	15,364	13,355	954	64,169	59,475	44,019	2,420	1,682	172,544
Persons	97,502	43,647	35,557	3,366	180,072	163,061	117,693	6,797	4,512	474,251
Subtotal	***102,997***	***47,952***	***36,781***	***6,306***	***194,036***	***167,571***	***118,513***	***6,967***	***4,566***	***493,796***
Not stated	7,114	19	926	18	8,077	1,276	114	502	46	12,525
Total	**110,111**	**47,971**	**37,707**	**6,324**	**202,113**	**168,847**	**118,627**	**7,469**	**4,612**	**506,321**
Proportion not stated (%)	6.5	0.0	2.5	0.3	4.0	0.8	0.1	6.7	1.0	2.5

(a) ICD-10-AM codes V80–X59.
(b) Excludes data for private hospitals.
(c) Queensland, Western Australia, South Australia and Northern Territory combined.
(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, there were 506,321 hospitalisations among people aged 0–74 years due to other accidents. Of these 19,545 hospitalisations (3.9%) were for people identified as Indigenous and for 2.5% of hospitalisations, Indigenous status was not stated.
- Females made up 38% of the Indigenous hospitalisations as a result of other accidents, compared with 36% of the non-Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 202,113 hospitalisations for other accidents. Of these, 13,964 or 6.9% were Indigenous people and for 4.0% Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 42.6: Age-standardised hospitalisation rates and standardised hospital separation ratios for other accidents[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	26.4	36.9	27.1	30.0	29.8	20.3	17.4	5.3	7.3	25.2
Non-Indigenous males	17.9	15.7	15.9	16.5	16.9	16.8	16.1	10.2	9.2	16.5
Indigenous females	15.7	26.5	19.4	20.5	33.8	12.3	11.0	4.4	6.0	16.3
Non-Indigenous females	10.1	8.8	9.5	8.1	16.5	9.7	9.6	5.5	5.7	9.5
Indigenous persons	20.9	31.5	23.1	25.2	31.0	16.2	14.1	4.8	6.6	20.7
Non-Indigenous persons	14.0	12.3	12.7	12.7	16.8	13.3	12.8	7.9	7.5	13.0
					Standardised hospital separation ratio[(e)]					
Males	1.6	2.2	1.6	1.8	1.8	1.2	1.0	0.3	0.4	1.5
Females	1.6	2.7	2.0	2.1	2.0	1.2	1.1	0.4	0.6	1.6
Persons	1.6	2.3	1.7	1.9	1.8	1.2	1.1	0.4	0.5	1.5

(a) ICD-10-AM codes V80–X59.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, South Australia, Western Australia and the Northern Territory, Indigenous persons were hospitalised for other accidents at around twice the rate for non-Indigenous persons.
- The standardised hospital separation ratios were slightly higher for females than for males in most jurisdictions.

Self-harm

Table 42.7: Hospitalisations for self-harm[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	271	308	109	149	837	341	65	13	n.p.	1,261
Females	366	320	162	135	983	513	102	32	n.p.	1,644
Persons	637	628	271	284	1,820	854	167	45	17	2,905
Non-Indigenous										
Males	4,112	2,255	1,802	138	8,307	7,166	4,583	584	187	20,866
Females	6,345	3,478	2,895	136	12,854	10,904	7,906	842	430	33,041
Persons	10,457	5,733	4,697	274	21,161	18,070	12,489	1,426	617	53,907
Subtotal	***11,094***	***6,361***	***4,968***	***558***	***22,981***	***18,924***	***12,656***	***1,471***	***634***	***56,812***
Not stated	329	0	170	1	500	199	7	142	5	926
Total	**11,423**	**6,361**	**5,138**	**559**	**23,481**	**19,123**	**12,663**	**1,613**	**639**	**57,738**
Proportion not stated (%)	2.9	0.0	3.3	0.2	2.1	1.0	0.1	8.8	0.8	1.6

N.p. Not published where numbers were less than 5.

(a) ICD-10-AM codes X60–X84.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 there were 57,738 hospitalisations for which self harm was reported as a cause of injury among people aged 0–74. Of these 2,905 hospitalisations (5.0%) were for people identified as Indigenous, and for 1.6% of hospitalisations, Indigenous status was not stated.
- Females made up 57% of hospitalisations among Indigenous people as a result of self-harm, and 61% of hospitalisations among non-Indigenous females.
- In Queensland, Western Australia, South Australia and the Northern Territory, where recording of Indigenous status in hospitalisation data is more complete, there were 23,481 hospitalisations for which self harm was reported as a cause of injury. Of these, 1,820 or 7.8% were of Indigenous people and for 2.1% Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 42.8: Age-standardised hospitalisation rates and standardised hospital separation ratios for self-harm[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
					Rate per 1,000					
Indigenous males	2.4	5.0	4.5	2.7	3.3	2.8	2.5	0.8	n.p.	3.0
Non-Indigenous males	1.2	1.2	1.3	0.9	1.2	1.2	1.0	1.4	0.6	1.1
Indigenous females	2.8	4.7	6.1	2.3	2.2	3.8	3.6	1.8	n.p.	3.5
Non-Indigenous females	1.8	1.9	2.1	1.0	1.2	1.8	1.7	2.0	1.3	1.8
Indigenous persons	2.6	4.8	5.3	2.4	2.6	3.3	3.0	1.3	2.1	3.2
Non-Indigenous persons	1.5	1.6	1.7	0.9	1.2	1.5	1.4	1.7	1.0	1.5
					Standardised hospital separation ratio[e]					
Males	2.0	4.2	3.8	2.2	2.8	2.4	2.1	0.7	n.p.	2.5
Females	1.5	2.5	3.2	1.2	1.8	2.0	1.9	1.0	n.p.	1.9
Persons	1.7	3.1	3.4	1.6	2.2	2.2	2.0	0.9	1.4	2.1

(a) ICD-10-AM codes X60–X84.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for self-harm as a cause of injury at 2 to 3 times the rate for non-Indigenous persons.
- Standardised hospital separation ratios were higher for males than females in the four jurisdictions with the most complete coverage of Indigenous hospitalisations.

Assault

Table 42.9: Hospitalisations for assault[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	1,047	1,403	310	944	3,704	671	118	26	6	4,525
Females	925	1,847	400	1,337	4,509	587	71	15	6	5,188
Persons	1,972	3,250	710	2,281	8,213	1,258	189	41	12	9,713
Non-Indigenous										
Males	4,739	2,269	1,648	375	9,031	8,176	5,374	519	223	23,359
Females	1,256	743	535	78	2,612	2,313	1,563	126	42	6,663
Persons	5,995	3,012	2,183	453	11,643	10,489	6,937	645	265	30,022
Subtotal	***7,967***	***6,262***	***2,893***	***2,734***	***19,856***	***11,747***	***7,126***	***686***	***277***	***39,735***
Not stated	251	2	103	5	361	183	4	54	3	659
Total	**8,218**	**6,264**	**2,996**	**2,739**	**20,217**	**11,930**	**7,130**	**740**	**280**	**40,394**
Proportion not stated (%)	3.1	0.0	3.4	0.2	1.8	1.5	0.1	7.3	1.1	1.6

(a) ICD-10-AM codes X85–Y09.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for these data is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04 there were 40,394 hospitalisations in Australia among people aged 0–74 years for which assault was a cause of injury. Of these 9,713 hospitalisations (24%) were of Indigenous people, and for 1.6% of hospitalisations, Indigenous status was not stated.
- Females made up 53% of the Indigenous hospitalisations due to assault, compared to only 22% of the non-Indigenous hospitalisations.
- In the four states and territories where the recording of Indigenous status in hospitalisation records is most complete, there were 8,213 hospitalisations of Indigenous people for which assault was reported as a cause of injury, which represented 41% of total hospitalisations related to assault in these states and territories.

Age-standardised rates and standardised hospital separation ratios

Table 42.10: Age-standardised hospitalisation rates and standardised hospital separation ratios for assault[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	8.1	20.1	11.4	14.8	12.8	4.9	4.0	1.5	1.4	9.5
Non-Indigenous males	1.4	1.2	1.2	2.4	1.3	1.3	1.2	1.3	0.7	1.3
Indigenous females	6.7	25.9	14.4	21.1	35.1	4.2	2.4	0.8	1.4	10.6
Non-Indigenous females	0.4	0.4	0.4	0.6	0.9	0.4	0.3	0.3	0.1	0.4
Indigenous persons	7.4	23.0	12.9	17.9	19.4	4.6	3.2	1.1	1.4	10.0
Non-Indigenous persons	0.9	0.8	0.8	1.5	1.2	0.9	0.8	0.8	0.4	0.8
					Standardised hospital separation ratio[(e)]					
Males	5.4	13.3	7.5	9.8	8.5	3.3	2.6	1.0	0.9	6.3
Females	10.4	40.2	22.4	32.8	23.3	6.5	3.7	1.3	2.1	16.4
Persons	6.9	21.3	11.9	16.6	12.9	4.2	2.9	1.1	1.3	9.3

(a) ICD-10-AM codes X85–Y09.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for assault at between 7 and 21 times the rate for non-Indigenous people.
- Indigenous females had substantially higher rates of hospitalisations from assaults compared to non-Indigenous females in Queensland, Western Australia, South Australia and the Northern Territory (ratios of 10, 40, 22 and 33 respectively).

Indicator 43. Hospitalisation ratios for respiratory diseases and lung cancer

Indicator:

(a) Standardised hospital separation ratio for all respiratory diseases as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised hospital separation ratio for pneumonia as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised hospital separation ratio for lung cancer as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

The indicator provides a measure of the occurrence of respiratory disease and lung cancer and use of admitted patient services for Aboriginal and Torres Strait Islander people compared to non-Indigenous people. A considerable proportion of respiratory diseases and lung cancers may be preventable if risk behaviours such as smoking are avoided.

Data

Data are provided for all respiratory diseases, and separately for pneumonia and for lung cancer.

Respiratory diseases

Table 43.1: Hospitalisations for respiratory diseases[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	3,721	3,315	946	2,938	10,920	3,384	540	90	32	14,977
Females	3,369	3,571	1,084	2,813	10,837	3,379	511	125	33	14,891
Persons	7,090	6,886	2,030	5,751	21,757	6,763	1,051	215	65	29,868
Non-Indigenous										
Males	42,748	24,425	23,943	1,635	92,751	89,652	62,963	3,141	1,913	252,020
Females	36,257	20,791	21,023	1,034	79,105	73,415	55,914	2,906	1,823	214,616
Persons	79,005	45,216	44,966	2,669	171,856	163,067	118,877	6,047	3,736	466,636
Subtotal	***86,095***	***52,102***	***46,996***	***8,420***	***193,613***	***169,830***	***119,928***	***6,262***	***3,801***	***496,504***
Not stated	10,021	21	888	13	10,943	884	58	468	54	14,642
Total	**96,116**	**52,123**	**47,884**	**8,433**	**204,556**	**170,714**	**119,986**	**6,730**	**3,855**	**511,146**
Proportion not stated (%)	10.4	0.0	1.9	0.2	5.3	0.5	0.0	7.0	1.4	2.9

(a) ICD-10-AM codes J00–J99.
(b) Excludes data for private hospitals.
(c) Queensland, Western Australia, South Australia and Northern Territory combined.
(d) Does not include ‘Other Territories’.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- From 2002–03 to 2003–04, there were 511,146 hospitalisations for respiratory diseases in Australia where Indigenous status was recorded (Table 43.1). Of these, 29,868 hospitalisations (5.8%) were of Indigenous people and for 2.9% of hospitalisations, Indigenous status was not stated.
- An equal proportion of all Indigenous hospitalisations were of males (50%) and females (50%), compared with the non-Indigenous population where 54% of hospitalisations were of males and only 46% were of females.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 204,556 hospitalisations for respiratory diseases, 21,757 or 10.6% of which were of Indigenous people. For 5.3% of hospitalisations in these states and territories, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 43.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for respiratory diseases(a) for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT(b)	Total(c)	NSW	Vic	Tas(b)	ACT(b)	Aust(d)
					Rate per 1,000					
Indigenous males	25.4	43.9	33.1	46.5	34.8	21.4	17.3	4.5	7.1	28.5
Non-Indigenous males	12.2	13.8	17.2	11.8	13.6	14.5	13.8	7.1	6.6	13.8
Indigenous females	23.5	48.6	37.9	46.0	40.6	22.6	16.5	6.6	7.6	29.2
Non-Indigenous females	10.6	11.9	15.1	8.6	13.6	12.0	12.2	6.7	6.2	11.9
Indigenous persons	24.4	46.1	35.4	46.2	37.4	21.9	16.8	5.5	7.3	28.8
Non-Indigenous persons	11.4	12.9	16.1	10.3	13.6	13.3	13.0	6.9	6.4	12.8
					Standardised hospital separation ratio(e)					
Males	1.8	3.0	2.3	3.2	2.4	1.5	1.2	0.3	0.5	1.9
Females	1.9	3.9	3.0	3.7	2.8	1.8	1.3	0.5	0.6	2.3
Persons	1.8	3.4	2.6	3.4	2.6	1.6	1.2	0.4	0.5	2.1

(a) ICD-10-AM codes J00–J99.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- The largest differences in age-standardised hospitalisation rates for respiratory diseases were in the Northern Territory and Western Australia, where rates for Indigenous males were 3 times those for non-Indigenous males, and rates for Indigenous females were up to 4 times those for non-Indigenous females.

Pneumonia

Table 43.3: Hospitalisations for a principal diagnosis of pneumonia[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	951	1,046	273	1,311	3,581	688	88	10	9	4,377
Females	837	972	302	1,157	3,268	630	99	15	7	4,019
Persons	1,788	2,018	575	2,468	6,849	1,318	187	25	16	8,396
Non-Indigenous										
Males	7,444	3,523	3,378	301	14,646	14,822	10,904	633	494	41,638
Females	6,546	2,973	2,830	213	12,562	12,102	9,049	531	460	34,845
Persons	13,990	6,496	6,208	514	27,208	26,924	19,953	1,164	954	76,483
Subtotal	***15,778***	***8,514***	***6,783***	***2,982***	***34,057***	***28,242***	***20,140***	***1,189***	***970***	***84,879***
Not stated	1,085	1	120	3	1,209	156	13	85	4	1,764
Total	**16,863**	**8,515**	**6,903**	**2,985**	**35,266**	**28,398**	**20,153**	**1,274**	**974**	**86,643**
Proportion not stated (%)	6.4	—	1.7	0.1	3.4	0.5	0.1	6.7	0.4	2.0

(a) ICD-10-AM codes J10–J18.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 there were 86,643 hospitalisations due to pneumonia in Australia among people aged less than 75 years. Of these, 8,396 hospitalisations (9.7%) were of Indigenous people and for 2.0% of hospitalisations Indigenous status was not stated.
- Males made up 52% of the Indigenous hospitalisations for pneumonia, and 54% of the non-Indigenous hospitalisations.
- In the four states and territories with the more complete coverage of Indigenous hospitalisations, there were 35,266 hospitalisations for respiratory diseases, 19.4% of which were of Indigenous people. For 3.4% of hospitalisations, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 43.4: Age-standardised hospital separation rates and standardised hospital separation ratios for a principal diagnosis of pneumonia[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	7.7	16.3	11.2	24.3	13.4	5.1	3.3	0.6	2.4	9.8
Non-Indigenous males	2.1	2.0	2.4	2.2	2.1	2.4	2.4	1.4	1.8	2.3
Indigenous females	6.5	14.7	11.7	21.0	13.8	4.7	3.5	0.9	1.8	8.8
Non-Indigenous females	1.9	1.7	2.0	1.8	2.2	2.0	2.0	1.2	1.6	1.9
Indigenous persons	7.1	15.5	11.5	22.6	13.6	4.9	3.4	0.7	2.1	9.3
Non-Indigenous persons	2.0	1.9	2.2	2.0	2.2	2.2	2.2	1.3	1.7	2.1
					Standardised hospital separation ratio[(d)]					
Males	3.1	6.6	4.5	9.8	5.4	2.1	1.3	0.2	1.0	3.9
Females	3.1	6.9	5.5	9.9	5.6	2.2	1.7	0.4	0.9	4.1
Persons	3.1	6.7	5.0	9.8	5.5	2.1	1.5	0.3	0.9	4.0

(a) ICD-10-AM codes J10–J18.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for pneumonia at between 3 and 10 times the rate of non-Indigenous people.
- Standardised hospital separation ratios for pneumonia were around 7 for males and females in Western Australia and around 10 for males and females in the Northern Territory.

Lung cancer

Table 43.5: Hospitalisations for lung cancer[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Aust[d]
Indigenous								
Males	42	33	14	33	122	51	6	180
Females	44	31	13	26	114	43	11	175
Persons	86	64	27	59	236	94	17	355
Non-Indigenous								
Males	2,747	1,385	1,444	67	5,643	4,424	3,631	14,121
Females	1,532	838	833	11	3,214	2,524	2,112	8,128
Persons	4,279	2,223	2,277	78	8,857	6,948	5,743	22,249
Subtotal	***4,365***	***2,287***	***2,304***	***137***	***9,093***	***7,042***	***5,760***	***22,604***
Not stated	592	0	48	0	640	49	2	868
Total	**4,957**	**2,287**	**2,352**	**137**	**9,733**	**7,091**	**5,762**	**23,472**
Proportion not stated (%)	11.9	0.0	2.0	0.0	6.6	0.7	0.0	3.7

(a) ICD-10-AM codes C33–C34.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Due to low numbers for rheumatic heart disease in the Australian Capital Territory and Tasmania, these states and territories were not included in the table but were included in the Australian total. Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, in Australia, 23,472 hospitalisations were recorded for lung cancer among people aged less than 75 years. Of these, 355 hospitalisations (1.5%) were of Indigenous people. However, it is likely that this disease is under-diagnosed in people living in remote areas.
- Males made up 61% of the Indigenous hospitalisations from lung cancer, compared with 63% of the non-Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 9,733 hospitalisations due to lung cancer, of which 2.4% were of Indigenous people. For 6.6% of hospitalisations in these states and territories, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 43.6: Age-standardised hospital separation rates and standardised hospital separation ratios for lung cancer[(a)] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Aust[(d)]
				Rate per 1,000				
Indigenous males	1.0	1.5	1.6	1.8	1.3	1.0	0.6	1.1
Non-Indigenous males	0.8	0.8	0.9	0.6	0.8	0.7	0.8	0.8
Indigenous females	0.9	1.1	1.2	1.1	1.7	0.8	0.9	0.9
Non-Indigenous females	0.4	0.5	0.5	0.1	0.8	0.4	0.5	0.4
Indigenous persons	1.0	1.3	1.4	1.4	1.5	0.9	0.8	1.0
Non-Indigenous persons	0.6	0.6	0.7	0.4	0.8	0.5	0.6	0.6
				Standardised hospital separation ratio[(e)]				
Males	1.3	1.9	2.1	2.3	1.7	1.3	0.8	1.4
Females	1.9	2.5	2.6	2.4	2.2	1.7	2.1	2.0
Persons	1.5	2.1	2.2	2.3	1.9	1.4	1.3	1.7

(a) ICD-10-AM codes C33–C34.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Due to low numbers for lung cancer in the Australian Capital Territory and Tasmania, data for these states and territories were not included in the table separately but are included in the Australian total. Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, Indigenous people in Queensland, Western Australia, South Australia and the Northern Territory were hospitalised for lung cancer at around twice the rate for non-Indigenous people in these states and territories.
- Standardised hospital separation ratios were higher for females than for males in these four jurisdictions.

Indicator 44. Hospitalisation ratios for diabetes

Indicator:

(a) Standardised hospital separation ratio for diabetes as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised hospital separation ratio for diabetes as an associated diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised hospital separation ratio for diabetes as a principal or an associated diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

Diabetes is a significant contributor to morbidity and mortality in the Aboriginal and Torres Strait Islander population. The indicator provides a broad measure of the occurrence of diabetes and access to hospital admitted patient services for Aboriginal and Torres Strait Islander people compared to non-Indigenous people.

Diabetes is often reported as an associated diagnosis, in particular in association with principal diagnoses of coronary heart disease, stroke and kidney disease. To assess the impact of diabetes on the Indigenous population, diabetes as both a principal and an associated diagnosis needs to be considered.

Data

Data were provided for hospitalisations where diabetes was the principal diagnosis, and where diabetes was an associated diagnosis, and the total of these two categories. 'Associated diagnosis' refers to 'a condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility'.

Diabetes as the principal diagnosis

Table 44.1: Hospitalisations for diabetes[(a)] as the principal diagnosis for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04.

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	785	503	243	564	2,095	476	91	39	5	2,706
Females	1,281	860	351	743	3,235	630	150	13	7	4,035
Persons	2,066	1,363	594	1,307	5,330	1,106	241	52	12	6,741
Non-Indigenous										
Males	6,859	3,829	4,670	808	16,166	11,195	11,624	708	240	40,169
Females	6,858	3,591	5,246	236	15,931	12,565	12,559	789	314	42,457
Persons	13,717	7,420	9,916	1,044	32,097	23,760	24,183	1,497	554	82,626
Subtotal	***15,783***	***8,783***	***10,510***	***2,351***	***37,427***	***24,866***	***24,424***	***1,549***	***566***	***89,367***
Not stated	1,003	1	220	2	1,226	96	4	235	53	2,205
Total	**16,786**	**8,784**	**10,730**	**2,353**	**38,653**	**24,962**	**24,428**	**1,784**	**619**	**91,572**
Proportion not stated (%)	6.0	—	2.1	0.1	3.2	0.4	—	13.2	8.6	2.4

(a) ICD-10-AM codes E10–E14, O24.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04 there were 91,572 hospitalisations among people aged 0–74 years with a principal diagnosis of diabetes. Of these 6,741 hospitalisations (7.4%) were for people identified as Indigenous and 2.4% of hospitalisations had a 'not stated' Indigenous status.
- Females made up 60% of the hospitalisations from diabetes among Indigenous people, compared to only 49% of hospitalisations among non-Indigenous people.
- In Queensland, Western Australia, South Australia and the Northern Territory, where the recording of Indigenous status in hospital records is most complete, 13.8% of hospitalisations for diabetes were among Indigenous people. For 3.2% of hospitalisations in these jurisdictions Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 44.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for diabetes[(a)] as the principal diagnosis for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	11.6	13.8	17.2	18.2	14.0	6.2	5.7	3.8	2.5	10.7
Non-Indigenous males	1.9	2.1	3.1	6.6	2.3	1.8	2.5	1.5	0.9	2.2
Indigenous females	13.3	17.2	17.9	16.9	14.0	6.3	7.0	1.0	2.5	11.7
Non-Indigenous females	2.0	2.1	3.7	2.1	2.2	2.0	2.7	1.8	1.1	2.3
Indigenous persons	12.6	15.7	17.4	17.2	14.1	6.2	6.4	2.3	2.5	11.2
Non-Indigenous persons	2.0	2.1	3.4	4.5	2.2	1.9	2.6	1.7	1.0	2.2
					Standardised hospital separation ratio[(e)]					
Males	5.0	6.0	7.5	7.9	6.1	2.7	2.5	1.7	1.1	4.6
Females	5.3	6.8	7.0	6.7	6.1	2.5	2.8	0.4	1.0	4.6
Persons	5.2	6.5	7.2	7.1	6.1	2.6	2.7	1.0	1.0	4.6

(a) ICD-10-AM codes E10–E14, O24.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous persons were hospitalised for diabetes as a principal diagnosis at between 5 and 7 times the rate for non-Indigenous persons.

Diabetes as an associated diagnosis

Table 44.3: Hospitalisations for diabetes(a) as an associated diagnosis for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT(b)	Total(c)	NSW	Vic	Tas(b)	ACT(b)	Aust(d)
Indigenous										
Males	3,140	3,030	1,111	2,132	9,413	2,270	480	69	40	12,282
Females	4,445	4,118	1,549	3,475	13,587	2,767	536	88	37	17,027
Persons	7,585	7,148	2,660	5,607	23,000	5,037	1,016	157	77	29,309
Non-Indigenous										
Males	41,130	17,345	21,423	1,379	81,277	82,933	66,942	3,341	1,703	237,724
Females	31,922	14,624	18,429	748	65,723	63,055	54,092	2,729	1,331	188,239
Persons	73,052	31,969	39,852	2,127	147,000	145,988	121,034	6,070	3,034	425,963
Subtotal	***80,637***	***39,117***	***42,512***	***7,734***	***170,000***	***151,025***	***122,050***	***6,227***	***3,111***	***455,272***
Not stated	8,875	10	619	16	9,520	685	54	329	108	13,647
Total	**89,512**	**39,127**	**43,131**	**7,750**	**179,520**	**151,710**	**122,104**	**6,556**	**3,219**	**468,919**
Proportion not stated (%)	9.9	0.0	1.4	0.2	5.3	0.5	0.0	5.0	3.4	2.9

(a) ICD-10-AM codes E10–E14, O24. Excludes separations where principal diagnosis was routine dialysis (Z49.1 and Z49.2).

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 there were 468,919 hospitalisations in Australia where diabetes was recorded as an associated diagnosis among people aged 0–74 years. Of these 29,309 hospitalisations (6.3%) were for people identified as Indigenous.
- Females made up 58% of the Indigenous hospitalisations from diabetes as an associated cause, compared to only 44% of the non-Indigenous hospitalisations.
- In the four states and territories with the most complete coverage of Indigenous hospitalisations, there were 23,000 hospitalisations of Indigenous people where diabetes was recorded as an associated diagnosis. For 5.3% of hospitalisations, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 44.4: Age-standardised hospitalisation rates and standardised hospital separation ratios for diabetes(a) as an associated diagnosis for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT(b)	Total(c)	NSW	Vic	Tas(b)	ACT(b)	Aust(d)
					Rate per 1,000					
Indigenous males	64.5	115.2	108.4	95.5	87.5	39.1	40.5	9.0	29.9	66.2
Non-Indigenous males	11.6	9.7	14.1	11.9	11.7	13.1	14.4	6.9	6.5	12.8
Indigenous females	71.4	122.9	116.6	120.6	118.8	40.6	37.7	10.5	22.8	74.3
Non-Indigenous females	9.4	8.5	12.2	8.2	11.8	10.1	11.6	5.8	4.9	10.3
Indigenous persons	69.0	120.0	113.5	110.1	103.0	40.2	39.2	9.9	26.3	71.1
Non-Indigenous persons	10.5	9.1	13.1	10.3	11.7	11.6	13.0	6.4	5.7	11.5
					Standardised hospital separation ratio(e)					
Males	4.8	8.5	8.0	7.1	6.5	2.9	3.0	0.7	2.2	4.8
Females	6.4	10.9	10.4	10.7	8.8	3.6	3.4	0.9	2.0	6.5
Persons	5.6	9.7	9.2	8.9	7.6	3.2	3.2	0.8	2.1	5.7

(a) ICD-10-AM codes E10–E14, O24. Excludes separations where principal diagnosis was routine dialysis (Z49.1 and Z49.2).

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include ‘Other Territories’.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised for diabetes as an associated diagnosis at between 6 and 10 times the rate for non-Indigenous people.
- Indigenous females were hospitalised at up to 11 times the rate of non-Indigenous females in Western Australia and the Northern Territory.

Diabetes as a principal or an associated diagnosis

Table 44.5: Hospitalisations for diabetes[a] as a principal or an associated diagnosis for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 and 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	3,617	3,299	1,272	2,477	10,665	2,622	530	102	41	13,970
Females	5,220	4,569	1,762	3,857	15,408	3,197	651	94	42	19,404
Persons	8,837	7,868	3,034	6,334	26,073	5,819	1,181	196	83	33,374
Non-Indigenous										
Males	46,171	20,264	24,873	2,097	93,405	91,579	74,879	3,761	1,877	267,226
Females	36,582	17,263	21,852	920	76,617	71,977	62,667	3,160	1,554	217,498
Persons	82,753	37,527	46,725	3,017	170,022	163,556	137,546	6,921	3,431	484,724
Subtotal	***91,590***	***45,395***	***49,759***	***9,351***	***196,095***	***169,375***	***138,727***	***7,117***	***3,514***	***518,098***
Not stated	9,542	11	785	18	10,356	766	57	444	155	15,174
Total	**101,132**	**45,406**	**50,544**	**9,369**	**206,451**	**170,141**	**138,784**	**7,561**	**3,669**	**533,272**
Proportion not stated (%)	9.4	—	1.6	0.2	5.0	0.5	—	5.9	4.2	2.8

(a) ICD-10-AM codes E10–E14, O24. Excludes separations where principal diagnosis was routine dialysis (Z49.1 and Z49.2).
(b) Excludes data for private hospitals.
(c) Queensland, Western Australia, South Australia and Northern Territory combined.
(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04, there were 533,272 hospitalisations in Australia where diabetes was recorded as a principal or an associated diagnosis mong those aged 0–74 years. Of these, 33,374 hospitalisations (6.3%) were for people identified as Indigenous. For 2.8% of hospitalisations Indigenous status was not stated.
- Females made up 58% of the Indigenous hospitalisations with diabetes as a principal or associated diagnosis, compared to only 45% of the non-Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 26,073 hospitalisations among Indigenous people where diabetes was recorded as a principal of associated diagnosis. This represented 12.6% of hospitalisations in these 4 states and territories. For 5.0% of hospitalisations, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 44.6: Age-standardised hospitalisation rates and standardised hospital separation ratios for diabetes[(a)] as a principal or associated cause for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	70.6	119.4	118.3	105.6	94.3	43.3	42.7	12.7	28.9	71.8
Non-Indigenous males	13.0	11.4	16.4	18.0	13.4	14.5	16.2	7.8	7.1	14.4
Indigenous females	78.5	128.4	125.1	125.9	123.2	44.3	43.1	10.6	23.7	79.6
Non-Indigenous females	10.7	10.0	14.6	9.8	13.4	11.5	13.4	6.8	5.7	11.9
Indigenous persons	75.8	125.0	122.6	117.5	109.0	44.1	43.2	11.7	26.3	76.7
Non-Indigenous persons	11.9	10.7	15.5	14.5	13.4	13.0	14.8	7.3	6.4	13.1
					Standardised hospital separation ratio[(e)]					
Males	4.6	7.8	7.8	6.9	6.2	2.8	2.8	0.8	1.9	4.7
Females	6.1	9.9	9.7	9.7	8.1	3.4	3.3	0.8	1.8	6.1
Persons	5.4	8.9	8.7	8.3	7.2	3.1	3.1	0.8	1.9	5.4

(a) ICD-10-AM codes E10–E14, O24. Excludes separations where primary diagnosis was routine dialysis (Z49.1 and Z49.2).

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, Western Australia, South Australia and the Northern Territory, Indigenous people were hospitalised with diabetes as a principal or an associated diagnosis at between 5 and 9 times the rate for non-Indigenous people.
- Indigenous females were hospitalised at around 10 times the rate of non-Indigenous females in Western Australia, South Australia and the Northern Territory. Indigenous males were hospitalised at round 8 times the rate of other males in Western Australia and South Australia.

Indicator 45. Hospitalisation ratios for tympanoplasty associated with otitis media

Indicator: The standardised hospital separation ratios for tympanoplasty for otitis media as a procedure in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–14 years.

Purpose

Tympanoplasty is a surgical procedure to repair the tympany, or eardrum, perforated as a result of chronic otitis media (infections of the middle ear). The procedure restores the hearing of children affected by a perforated eardrum. The indicator therefore provides a measure of the occurrence of chronic ear infection and perforations of the eardrum, as well as access to hospital treatment, in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population.

Data

While the indicator specifies separations for tympanoplasty for otitis media, the codes specified were for tympanoplasty and otitis media.

Table 45.1: Hospitalisations for tympanoplasty and otitis media[(a)] for children aged 0–14 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Aust[(d)]
Indigenous							
Males	30	94	7	43	174	15	194
Females	25	109	5	44	183	17	204
Persons	55	203	12	87	357	32	398
Non-Indigenous							
Males	155	216	124	5	500	315	1,032
Females	123	137	119	2	381	244	787
Persons	278	353	243	7	881	559	1,819
Subtotal	333	556	255	94	1,238	591	***2,217***
Not stated	107	0	3	0	110	2	127
Total	440	556	258	94	1,348	593	**2,344**
Proportion not stated (%)	24.3	0.0	1.2	0.0	8.2	0.3	5.4

(a) ICD-10-AM codes H65, H66, H72, [313] 41635–01, 41527–00, 41530–00, 41533–01, [315] 41542–00, 41638–01, [316] 90114–00, [325] 41551–00, 41560–00, 41560–01,41554–00, 41563–00, 41563–01.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Due to low numbers for tympanoplasty in Victoria, the Australian Capital Territory and Tasmania, data for these states and territories were not included separately in the table but are included in the Australian total. Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, there were 2,344 hospitalisations in Australia of children aged 0–14 years with otitis media and tympanoplasty. Of these hospitalisations, 398 or 17.0% were identified as being Indigenous children and for 5.4% of hospitalisations Indigenous status was not stated.
- Males made up 49% of the Indigenous hospitalisations for tympanoplasty, compared to 57% of the non-Indigenous hospitalisations.
- In the four states and territories with the most complete coverage of Indigenous hospitalisations, there were 357 hospitalisations among Indigenous children aged 0–14 years, which represented 26% of hospitalisations for tympanoplasty in these jurisdictions.

Age-standardised rates and standardised hospital separation ratios

Table 45.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for tympanoplasty and otitis media[a], for children aged 0–14 years, by Indigenous status and sex, by state and territory, 2002–03 and 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Aust[d]
				Rate per 1,000			
Indigenous males	0.1	0.8	0.2	0.4	0.3	0.1	0.2
Non-Indigenous males	0.0	0.1	0.1	0.0	0.1	0.1	0.1
Indigenous females	0.1	0.9	0.1	0.5	0.5	0.1	0.2
Non-Indigenous females	0.0	0.1	0.1	0.0	0.1	0.0	0.0
Indigenous person	0.1	0.9	0.1	0.5	0.4	0.1	0.2
Non-Indigenous person	0.0	0.1	0.1	0.0	0.1	0.0	0.1
				Standardised hospital separation ratio[e]			
Males	1.8	11.5	2.3	6.6	5.1	0.9	3.3
Females	1.9	17.0	2.0	8.7	6.7	1.2	4.4
Persons	1.9	13.9	2.1	7.5	5.8	1.0	3.8

(a) ICD-10-AM codes H65, H66, H72, [313] 41635–01, 41527–00, 41530–00, 41533–01, [315] 41542–00, 41638–01, [316] 90114–00, [325] 41551–00, 41560–00, 41560–01,41554–00, 41563–00, 41563–01.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Due to low numbers for tympanoplasty in Victoria, the Australian Capital Territory and Tasmania, data for these states and territories were not included in the table separately but are included in the Australian total. Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Western Australia and the Northern Territory, Indigenous children were hospitalised for tympanoplasty and otitis media at 14 and 8 times the rate for non-Indigenous children respectively. This indicates a much higher rate of chronic ear infections and perforations of the eardrum among Indigenous children.

Indicator 46. Hospitalisation ratios for mental health conditions

Indicator:

(a) Standardised hospital separation ratio for depressive disorders as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised hospital separation ratio for anxiety disorders as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised hospital separation ratio for substance use disorders as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

There are limited data available on the mental health of Aboriginal and Torres Strait Islander people compared to the non-Indigenous population. A number of studies have shown an association between poor socio-economic status and living conditions and mental health problems (Turrell et al. 1999). This indicator only picks up a proportion of the mental health conditions that require hospitalisation. The indicator reflects access to hospital admitted patient services for mental health conditions for Aboriginal and Torres Strait Islander people compared to the non-Indigenous population.

Data

Data were provided for three major mental health conditions—depressive disorders, anxiety disorders and substance use disorders. The technical specifications only included selected codes for these conditions, while the data provided include a broader range of codes for the different mental health conditions. For example, the codes specified for substance use disorders did not include codes for use of alcohol or volatile substances, but data are provided for these. Data for psychotic disorders, as included in the technical specifications, were not provided due to small numbers of hospitalisations.

Depressive disorders

Table 46.1: Hospitalisations for depressive disorders[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 and 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	166	151	100	40	457	299	49	n.p.	n.p.	811
Females	334	345	274	57	1,010	572	115	n.p.	n.p.	1,797
Persons	500	496	374	97	1,467	871	164	40	13	2,608
Non-Indigenous										
Males	8,857	4,414	2,794	135	16,200	12,095	12,990	551	170	42,634
Females	17,154	9,172	5,416	96	31,838	19,894	36,348	978	247	91,329
Persons	26,011	13,586	8,210	231	48,038	31,989	49,338	1,529	417	133,963
Subtotal	***26,511***	***14,082***	***8,584***	***328***	***49,505***	***32,860***	***49,502***	***1,569***	***430***	***136,571***
Not stated	1,256	1	162	2	1,421	262	3	90	21	2,144
Total	**27,767**	**14,083**	**8,746**	**330**	**50,926**	**33,122**	**49,505**	**1,659**	**451**	**138,715**
Proportion not stated (%)	4.5	—	1.9	0.6	2.8	0.8	—	5.4	4.7	1.5

n.p. Not published where numbers were less than 5.

(a) ICD-10-AM codes F32–F33.
(b) Excludes data for private hospitals.
(c) Queensland, Western Australia, South Australia and Northern Territory combined.
(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 there were 138,715 hospitalisations in Australia among people aged 0–74 years for which depressive disorders were the principal diagnosis. Of these, 2,608 hospitalisations (1.9%) were of Indigenous people.
- Females made up 69% of the Indigenous hospitalisations for depressive disorders and 68% of the non-Indigenous hospitalisations.
- In Queensland, Western Australia, South Australia and the Northern Territory, where the recording of Indigenous status in hospital records is considered most complete, there were 50,926 hospitalisations due to depressive disorders, 2.9% of which were of Indigenous people. For 2.8% of hospitalisations, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 46.2: Age-standardised hospitalisation rates and standardised hospital separation ratios for depressive disorders[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
					Rate per 1,000					
Indigenous males	1.9	3.2	5.4	1.0	2.4	3.1	2.4	n.p.	n.p.	2.5
Non-Indigenous males	2.5	2.4	1.9	0.9	2.3	1.9	2.8	1.3	0.6	2.3
Indigenous females	3.4	6.6	13.4	1.3	2.2	5.5	5.2	n.p.	n.p.	5.0
Non-Indigenous females	5.0	5.2	3.8	0.8	2.2	3.3	7.8	2.2	0.8	5.0
Indigenous persons	2.7	5.0	9.5	1.1	2.3	4.3	3.8	1.5	2.2	3.8
Non-Indigenous persons	3.7	3.8	2.9	0.8	2.2	2.6	5.3	1.8	0.7	3.7
					Standardised hospital separation ratio[e]					
Males	0.8	1.4	2.3	0.4	1.0	1.4	1.0	n.p.	n.p.	1.1
Females	0.7	1.3	2.7	0.3	0.9	1.1	1.1	n.p.	n.p.	1.0
Persons	0.7	1.4	2.6	0.3	1.0	1.2	1.1	0.4	0.6	1.0

n.p. Not published where numbers were less than 5.

(a) ICD-10-AM codes F32–F33.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in South Australia, Indigenous people were hospitalised for depressive disorders at higher rates than non-Indigenous people. In Queensland, and Western Australia, Indigenous people were hospitalised at similar rates to non-Indigenous people and in the Northern Territory, non-Indigenous people were hospitalised at higher rates than Indigenous people.

Anxiety disorders

Table 46.3: Hospitalisations for anxiety disorders[a] for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[b]	Total[c]	NSW	Vic	Tas[b]	ACT[b]	Aust[d]
Indigenous										
Males	212	146	88	34	480	257	50	23	n.p.	814
Females	284	369	223	49	925	386	69	34	n.p.	1,432
Persons	496	515	311	83	1,405	643	119	57	10	2,246
Non-Indigenous										
Males	9,462	3,609	2,437	126	15,634	12,252	8,495	543	111	37,763
Females	9,679	6,668	3,069	81	19,497	10,083	13,065	661	164	45,014
Persons	19,141	10,277	5,506	207	35,131	22,335	21,560	1,204	275	82,777
Subtotal	***19,637***	***10,792***	***5,817***	***290***	***36,536***	***22,978***	***21,679***	***1,261***	***285***	***85,023***
Not stated	719	1	162	2	884	361	2	85	4	1,740
Total	**20,356**	**10,793**	**5,979**	**292**	**37,420**	**23,339**	**21,681**	**1,346**	**289**	**86,763**
Proportion not stated (%)	3.5	—	2.7	0.7	2.4	1.5	—	6.3	1.4	2.0

n.p. Not published where numbers were less than 5 and calculable.

(a) ICD-10-AM codes F40–F43.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the two years 2002–03 to 2003–04 there were 86,763 hospitalisations in Australia where anxiety disorders were recorded as the principal diagnosis among people aged 0–74 years. Of these, 2,246 hospitalisations (2.6%) were of Indigenous people.
- Females made up 64% of hospitalisations among Indigenous people for anxiety disorders, compared with only 54% of hospitalisations among non-Indigenous people.
- In Queensland, Western Australia, South Australia and the Northern Territory, there were 37,420 hospitalisations due to depressive disorders. Of these, 3.7% were of Indigenous people and for 2.4%, Indigenous status was not stated.

Age-standardised rates and standardised hospital separation ratios

Table 46.4: Age-standardised hospitalisation rates and standardised hospital separation ratios for anxiety disorders(a) for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04.

	Qld	WA	SA	NT(b)	Total(c)	NSW	Vic	Tas(b)	ACT(b)	Aust(d)
					Rate per 1,000					
Indigenous males	2.3	3.0	4.6	0.8	2.4	2.6	2.3	1.8	n.p.	2.4
Non-Indigenous males	2.7	2.0	1.7	0.8	2.2	2.0	1.8	1.2	0.4	2.0
Indigenous females	2.5	6.2	9.6	0.9	3.1	3.3	2.7	2.3	n.p.	3.7
Non-Indigenous females	2.8	3.8	2.2	0.6	2.4	1.7	2.8	1.6	0.5	2.5
Indigenous persons	2.4	4.7	7.3	0.9	2.8	3.0	2.5	2.0	1.5	3.1
Non-Indigenous persons	2.7	2.9	2.0	0.7	2.3	1.8	2.3	1.4	0.4	2.3
					Standardised hospital separation ratio(e)					
Males	1.1	1.5	2.2	0.4	1.2	1.3	1.1	0.9	n.p.	1.1
Females	1.0	2.5	3.9	0.4	1.5	1.3	1.1	0.9	n.p.	1.4
Persons	1.1	2.1	3.2	0.4	1.4	1.3	1.1	0.9	0.7	1.3

n.p. Not published where numbers were less than 5.

(a) ICD-10-AM codes F40–F43.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include ‘Other Territories’.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Western Australia and South Australia, Indigenous people were hospitalised for anxiety disorders at around 2–3 times the rate of non-Indigenous people.
- In Queensland, hospitalisation rates were similar for Indigenous and non-Indigenous people.

Substance use disorders

Table 46.5: Hospitalisations for substance use disorders[(a)] for persons aged 0–74 years, by Indigenous status, sex and state and territory, 2002–03 to 2003–04.

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
Indigenous										
Males	916	907	318	166	2,307	1,664	219	34	11	4,369
Females	474	564	194	82	1,314	836	96	20	8	2,319
Persons	1,390	1,471	512	248	3,621	2,500	315	54	19	6,688
Non-Indigenous										
Males	8,892	4,040	2,702	159	15,793	20,464	10,493	723	132	48,263
Females	5,547	2,347	1,350	65	9,309	12,135	8,035	507	142	30,336
Persons	14,439	6,387	4,052	224	25,102	32,599	18,528	1,230	274	78,599
Subtotal	***15,829***	***7,858***	***4,564***	***472***	***28,723***	***35,099***	***18,843***	***1,284***	***293***	***85,287***
Not stated	2,427	1	174	5	2,607	393	12	114	3	3,318
Total	**18,256**	**7,859**	**4,738**	**477**	**31,330**	**35,492**	**18,855**	**1,398**	**296**	**88,605**
Proportion not stated (%)	13.3	—	3.7	1.0	8.3	1.1	0.1	8.2	1.0	3.7

(a) ICD-10-AM codes F10–F19.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In the period 2002–03 to 2003–04, there were 88,605 hospitalisations in Australia due to substance use disorders among people aged less than 75 years. Of these, 6,688 hospitalisations (7.5%) were of Indigenous people and for 3.7% of hospitalisations, Indigenous status was not stated.
- Females made up 35% of the Indigenous hospitalisations from substance use disorders, compared with 39% of the non-Indigenous hospitalisations.
- In the four states and territories with the most complete coverage of Indigenous hospitalisations, there were 3,621 hospitalisations among Indigenous people where substance use disorders was recorded as the principal diagnosis. This represented 11.6% of hospitalisations for substance use disorders in these jurisdictions.
- In Queensland, Western Australia, South Australia and the Northern Territory, the majority of Indigenous hospitalisations for substance use disorders were for, or related to, alcohol use (75%) followed by cannabis use (8%) and multiple drug use (7%).

Age-standardised rates and standardised hospital separation ratios

Table 46.6: Age-standardised hospitalisation rates and standardised hospital separation ratios for substance use disorders for persons aged 0–74 years, by Indigenous status and sex, by state and territory, 2002–03 to 2003–04

	Qld	WA	SA	NT[(b)]	Total[(c)]	NSW	Vic	Tas[(b)]	ACT[(b)]	Aust[(d)]
					Rate per 1,000					
Indigenous males	9.3	16.9	15.1	3.4	10.4	15.5	9.4	2.5	3.3	11.9
Non-Indigenous males	2.5	2.2	1.9	1.0	2.3	3.3	2.3	1.7	0.4	2.6
Indigenous females	4.4	9.9	8.7	1.6	8.6	7.4	4.0	1.4	2.3	5.9
Non-Indigenous females	1.6	1.3	1.0	0.5	2.2	2.0	1.7	1.2	0.4	1.7
Indigenous persons	6.7	13.3	11.8	2.5	9.6	11.4	6.7	1.9	2.8	8.8
Non-Indigenous persons	2.1	1.8	1.4	0.8	2.2	2.7	2.0	1.4	0.4	2.1
					Standardised hospital separation ratio[(e)]					
Males	3.3	5.9	5.3	1.2	3.6	5.4	3.3	0.9	1.1	4.1
Females	2.4	5.5	4.8	0.9	3.0	4.1	2.2	0.8	1.3	3.2
Persons	2.9	5.7	5.1	1.1	3.4	4.9	2.8	0.8	1.2	3.7

(a) ICD-10-AM codes F10–F19.

(b) Excludes data for private hospitals.

(c) Queensland, Western Australia, South Australia and Northern Territory combined.

(d) Does not include 'Other Territories'.

(e) Observed number of hospitalisations for Indigenous people divided by the expected number of hospitalisations based on the age-specific rates for the total Australian population.

Notes

1. Shading indicates that the Indigenous identification for hospital data in these jurisdictions is in need of improvement. This is based on an analysis of Indigenous identification in hospital records by the AIHW (AIHW 2005c).
2. Hospitalisations for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence.

Source: AIHW National Hospital Morbidity Database.

- In 2002–03 to 2003–04 in Queensland, Western Australia and South Australia, Indigenous people were hospitalised for substance use disorders at between 3 and 6 times the rate for non-Indigenous people.
- In the Northern Territory, Indigenous people were hospitalised for substance use disorders at similar rates of non-Indigenous people.

Indicator 47. Children's hearing loss

Indicator: The proportion of Aboriginal and Torres Strait Islanders at school entry having >25 db hearing loss at either 1 or 4 KHz in either ear.

Purpose

The indicator gives information on the prevalence of hearing deficit in children at school entry. It predicts the occurrence of learning difficulties and behavioural problems in children and young people.

Data

Hearing loss among Aboriginal and Torres Strait Islander children is widespread. It can be the result of repeated bouts of otitis media, and is thought to be more severe among Indigenous children due to crowded housing conditions and lack of access to primary health care. Hearing loss often leads to increased learning difficulties and behavioural problems in school, adding to existing social disadvantage experienced by Indigenous people.

New South Wales

NSW Health has commenced a $2.49 million state-wide otitis media screening initiative for 0–6 year old Aboriginal children over a 4 year term. Over 9,000 children were tested for otitis media in the first year of operation (2004–05) and this is expected to increase to over 19,000 children being checked annually by 2007–08.

Victoria

Victoria reported that children are screened for hearing through School Nursing Services which aim to screen all children in the first year of school (Prep); however screening is not compulsory. A form is sent to the parents of all Prep children and Aboriginal identification is asked but is not mandatory. Each child is screened once during the year.

In 2004, 58,793 Prep children were screened, of whom 724 were recorded as Aboriginal and/or Torres Strait Islander. Of the Aboriginal children screened, 598 were recorded with hearing within normal limits and 141 were referred for further action.

Further work is being carried out by a PhD student at the University of Melbourne who is working on a project about the prevention of hearing loss in Aboriginal children. The aim of the project is to gather evidence about risk factors and social determinants for otitis media, in order to develop a community-based intervention strategy aimed at the prevention of otitis media in the Indigenous population.

Queensland

Queensland currently does not routinely collect data regarding hearing loss detected in preschool and school age children. However, child health nurses and health workers screen children opportunistically and in cases where they have had children with suspected hearing loss referred to them.

Universal Newborn Hearing Screening is being progressively introduced across Queensland Health hospitals to detect permanent childhood hearing impairment. Referral to paediatric audiology services takes place for further diagnostic testing where screening detects a problem. An information system to gather data, including the Indigenous status of the baby, is nearing completion.

Western Australia

No comprehensive data on children's hearing loss were available for this indicator.

South Australia

The excessive burden of ear disease in Aboriginal populations has long been recognised. The average time of ear infection is 32 months for the Aboriginal community compared to 3 months for the general community. An estimated 46% of Aboriginal people admitted to a South Australian hospital with otitis media from 1 July 1999 to 30 June 2003 were aged 0–4 and 30% were aged 5–9 years (South Australia Department of Health—hospital separations data). A Ministerial Advisory Committee on students with disabilities found that otitis media with subsequent hearing loss is a likely contributor to the high percentage of Aboriginal children with a communication and language disability (11.1% compared to 4.7%) (Ministerial Advisory Committee: Students with Disabilities, Sept 2003). Recent testing of Aboriginal children in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands has revealed disturbingly high and untreated levels of otitis media.

Tasmania

Family and child Health Services collects information on hearing loss from children entering private and government schools using a self identifying method. Enrolment cards are completed by either parents or nurses and asking Indigenous status is mandatory, but responding is voluntary. If children's hearing loss is already detected and they attend the Australian Hearing Service, their Indigenous status is collected, however with unsure reliability. Some work is being conducted to promote the identification of Aboriginal children entering the school system and improvements in data collection will improve reporting ability.

Australian Capital Territory

Data on the extent of children's hearing loss is currently not available for the ACT. The Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah, has received recurrent funding from ACT Health to implement an otitis media program for infants and children. The program will provide a comprehensive screening service, appropriate education and treatment, and children will be referred for surgical intervention where necessary. The extent of hearing loss will be recorded on Winnunga's recently installed patient information system.

Northern Territory

Aboriginal children are known to have high rates of acute and chronic ear infections, resulting in permanent ear damage, hearing loss and educational disadvantage. In the Northern Territory, remote nurses from the Maternal and Child Health team perform hearing screening. Hearing screening is performed at 25dBHL at 1KHz and 4KHz at school entry. Children who fail the hearing screening are then referred to the hearing services within the Department of Health and Community Services for follow-up diagnostic assessments.

In 2004, 62% of school-aged children (aged 4–16 years) tested in remote communities in the Northern Territory were identified with varying degrees of hearing loss in one or both ears. The tests were performed by audiologists and nurse audiometrists who travelled to remote communities. The numbers tested included mostly children who failed hearing screening at school entry (aged 4–5 years) and children with hearing concerns but also older children who have had existing hearing loss and were being monitored.

Indicator 48. Stillbirths to Aboriginal and Torres Strait Islander mothers

Indicator: The proportion of all births to Aboriginal and Torres Strait Islander women that are stillborn.

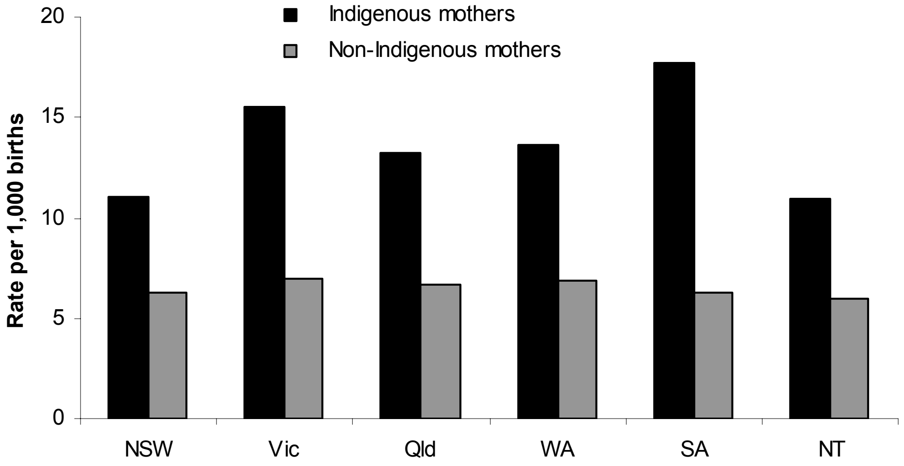
Purpose

The indicator reflects the health of pregnant Aboriginal and Torres Strait Islander women, their access to and utilisation of antenatal care, and the quality of antenatal care.

Data

The data on stillbirths come from the AIHW National Perinatal Statistics Unit (Midwives' Collection). While the data are likely to capture most stillbirths, the number of stillbirths to Indigenous mothers is likely to be underestimated because Indigenous status is not always recorded. In addition, the Indigenous status of the father is not recorded in the Midwives' data collection and therefore it is not possible to report information on stillbirths of babies born to Indigenous fathers and non-Indigenous mothers.

Three years of data were combined in Figure 48.1 in order to smooth out yearly fluctuations in the number of stillbirths to Indigenous mothers, which can cause volatility in rates.



Note: Data for the Australian Capital Territory are not presented due to small numbers. Data for Tasmania were not available because the 'Not stated' category for Indigenous status was not able to be distinguished from the category of mothers who were neither Aboriginal or Torres Strait Islander.

Source: AIHW National Perinatal Statistics Unit.

Figure 48.1: Rates of stillbirths, by mother's Indigenous status, by state and territory, 2000–02

- The rate of stillbirths to Aboriginal and Torres Strait Islander mothers was around twice the rate for non-Indigenous mothers in all jurisdictions except for South Australia, where the rate was around three times as high.
- The rate of stillbirths to Indigenous mothers ranged from 11.0 per 1,000 in New South Wales and the Northern Territory to 17.7 per 1,000 in South Australia.

Indicator 49. Early adult death

Indicator: The probability of a person aged 20–24 years dying before reaching the age of 55 years in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, by sex.

Purpose

This indicator is designed to capture early adult mortality. If linked to adult mortality data it can be used to identify the causes of death that should be a priority area for prevention.

Data

Data for this indicator were provided by the ABS. Data are presented for all states and territories, but only in Queensland, Western Australia, South Australia and the Northern Territory is the coverage of deaths is considered more complete. Given the problems experienced in accurately measuring life expectancy and the death rates for the Aboriginal and Torres Strait Islander population, early adult mortality indicators are difficult to calculate and should be interpreted with care.

Table 49.1: Experimental estimates of the probability of a person aged 20 years dying before age 55 years, for the Indigenous and total Australian populations, by sex

	Males	Females
	Indigenous (1996–2001)	
Queensland	0.34	0.26
South Australia// Western Australia	0.35	0.18
Northern Territory	0.37	0.21
New South Wales/Victoria	0.30	0.20
Tasmania	0.30	0.20
Australian Capital Territory	0.30	0.20
Australia	**0.33**	**0.22**
	Total Australian (1999–2001)	
Queensland	0.07	0.04
Western Australia	0.07	0.04
South Australia	0.07	0.04
Northern Territory	0.14	0.09
New South Wales	0.07	0.04
Victoria	0.06	0.04
Tasmania	0.07	0.04
Australian Capital Territory	0.05	0.03
Australia	**0.07**	**0.04**

Note: States and territories with less complete coverage of Indigenous deaths have been shaded.

Source: Abridged experimental Indigenous life tables 1996–2001; Australian and state life tables 1999–2001; ABS 2004a.

- Based on estimates over the period 1996–2001, in the four jurisdictions with the most complete coverage of Indigenous deaths, an Indigenous male had between 34% and 37% chance of dying before the age of 55. The comparable percentages for all-Australian males for the period 1999–2001 were between 7% and 14%.
- The early adult mortality estimates reported in Table 49.1 are based on experimental population estimates based on the 2001 Census of Population and Housing. The Bhat method was used by the ABS to construct an experimental model life table for the Indigenous population which gives an estimation of the probability of a person aged 20 years dying before aged 55 years.
- In Queensland, Western Australia, South Australia and the Northern Territory, Indigenous females had an 18%—26% chance of dying before the age of 55 years. The comparable percentages for all-Australian females were between 4% and 9%.
- The probability of a person aged 20 dying before age 55 was highest in the Northern Territory for Indigenous males, all-Australian males and all-Australian females. For Indigenous females, the probability of dying before age 55 years at aged 20 was highest in Queensland.

Indicator 50. Age- and sex-specific all-cause death rates and ratios

Indicator: Age- and sex-specific death rates from all causes for Aboriginal and Torres Strait Islander people and Indigenous to non-Indigenous rate ratios.

Purpose

The indicator provides a measure of mortality for different age and sex groups for the Indigenous and non-Indigenous populations. Groups where there are major differences in death rates between the Indigenous and non-Indigenous populations can be identified.

Data

The data provided come from the AIHW National Mortality Database. Number of deaths is presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were only calculated for Queensland, Western Australia, South Australia and the Northern Territory as these states and territories have been assessed as having more complete coverage of Indigenous deaths. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

Number of deaths

- Over the 3-year period 2001–03, the number of deaths among people who identified as Indigenous was 1,482 in New South Wales, 1,724 in Queensland, 798 in Western Australia, 369 in South Australia and 1,325 in the Northern Territory. In New South Wales, the highest proportion of deaths was among those aged 65 years and over and for all other states and territories the highest proportion of deaths was among those aged 45–64 years (Table 50.1).
- Over the 3-year period 1999–01, the number of deaths for which Indigenous status was not recorded was 4,065 in New South Wales, 997 in Queensland, 537 in Western Australia, 818 in South Australia and 17 in the Northern Territory. The proportion of deaths for which Indigenous status was not stated was 2.8 in New South Wales, 2.3 in South Australia, 1.6 in Western Australia, 1.4 in Queensland and 0.6 in the Northern Territory.

Age- and sex-specific rates and rate ratios

- In all four states and territories, the death rates for Indigenous males and females were considerably higher than for non-Indigenous Australian males and females for all age groups (Table 50.2).
- In the four states and territories, the highest death rates among Indigenous and non-Indigenous Australians were among those aged 65 years and over. Indigenous Australians died at much higher rates than non-Indigenous Australians at ages 25–44 and 45–64 years.

Table 50.1: Number of deaths, by age and sex, for selected states and territories, 2001–03

	Males		Females		Total(a)				
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Not stated	Total deaths	Not stated (%)
New South Wales									
0–4 yrs	56	716	39	580	95	1,296	111	1,502	7.4
5–24	33	1,106	33	418	66	1,524	72	1,662	4.3
25–44	192	10,064	93	1,593	285	11,657	200	12,142	1.6
45–64	287	11,298	184	6,706	471	18,004	628	19,103	3.3
65+	297	51,288	268	54,387	565	105,675	3,054	109,294	2.8
Total	**865**	**74,472**	**617**	**63,684**	**1,482**	**138,156**	**4,065**	**143,703**	**2.8**
Queensland									
0–4 yrs	82	468	51	340	133	808	15	956	1.6
5–24	69	776	45	291	114	1,067	16	1,197	1.3
25–44	224	2,048	117	987	341	3,035	37	3,413	1.1
45–64	337	6,514	237	3,670	574	10,184	134	10,892	1.2
65+	274	26,086	288	26,423	562	52,509	795	53,866	1.5
Total	**986**	**35,892**	**738**	**31,711**	**1,724**	**67,603**	**997**	**70,324**	**1.4**
Western Australia									
0–4 yrs	43	180	44	131	87	311	19	417	4.6
5–24	53	371	22	150	75	521	28	624	4.5
25–44	132	974	88	494	220	1,468	59	1,747	3.4
45–64	189	2,847	138	1,698	227	4,545	110	4,882	2.3
65+	162	12,162	142	12,791	189	24,953	321	25,463	1.3
Total	**579**	**16,534**	**434**	**15,264**	**798**	**31,798**	**537**	**33,133**	**1.6**
South Australia									
0–4 yrs	7	128	12	129	19	257	10	286	3.5
5–24	17	260	5	107	22	367	21	410	5.1
25–44	58	839	33	445	91	1,284	66	1,441	4.6
45–64	89	2,682	54	1,652	143	4,334	114	4,591	2.5
65+	47	13,850	47	14,784	94	28,634	607	29,335	2.1
Total	**218**	**17,759**	**151**	**17,117**	**369**	**34,876**	**818**	**36,063**	**2.3**
Northern Territory									
0–4 yrs	52	37	42	16	94	53	2	149	1.3
5–24	68	33	33	23	101	56	1	158	0.6
25–44	256	115	137	34	393	149	2	544	0.4
45–64	240	272	164	108	404	380	7	791	0.9
65+	166	404	167	268	333	672	5	1,010	0.5
Total	**782**	**861**	**543**	**449**	**1,325**	**1,310**	**17**	**2,652**	**0.6**

Notes

1. Table includes deaths data from New South Wales, which has the largest Indigenous population, and from the four states and territories where coverage of Indigenous status is more complete.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

Table 50.2: Age- and sex-specific death rates per 1,000 and rate ratios for all causes, for selected states and territories, 2001–03

	Males			Females		
	Indigenous	Non-Indig.	Rate ratio	Indigenous	Non-Indig.	Rate ratio
Queensland						
0–4 yrs	3.2	1.3	2.4	2.0	1.0	2.0
5–24	0.8	0.5	1.6	0.5	0.2	2.6
25–44	4.5	1.3	3.4	2.0	0.6	3.3
45–64	16.2	5.0	3.2	10.1	2.9	3.5
65+	59.0	44.0	1.3	49.5	37.4	1.3
Western Australia						
0–4 yrs	3.3	1.0	3.3	3.5	0.8	4.6
5–24	1.2	0.5	2.5	0.5	0.2	2.6
25–44	4.8	1.2	4.1	3.0	0.6	5.1
45–64	16.7	4.2	4.0	11.1	2.6	4.3
65+	60.8	42.2	1.4	41.2	36.2	1.1
South Australia						
0–4 yrs	1.5	1.0	1.5	2.5	1.0	2.4
5–24	1.0	0.4	2.2	0.3	0.2	1.6
25–44	5.4	1.3	4.1	2.9	0.7	4.1
45–64	19.8	4.9	4.0	11.0	3.0	3.7
65+	51.5	47.4	1.1	36.8	39.2	0.9
Northern Territory						
0–4 yrs	4.9	2.2	2.2	4.1	1.0	4.0
5–24	1.7	0.5	3.2	0.9	0.4	2.2
25–44	10.0	1.4	7.2	5.2	0.5	11.2
45–64	25.0	4.9	5.1	15.5	2.5	6.3
65+	82.3	38.6	2.1	58.4	32.5	1.8

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Rate ratio is the mortality rate for Indigenous people divided by the mortality rate for non-Indigenous people.
3. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
4. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

Indicator 51. Standardised mortality ratios for all causes

Indicator: Standardised mortality ratio for deaths from all causes in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population.

Purpose

The indicator provides a comparative measure of overall mortality rates for Aboriginal and Torres Strait Islander males and females with rates for other Australians, taking into account differences in the age structure of the populations. It provides a summary measure of the differences between the two populations.

Data

The data provided come from the AIHW National Mortality Database. Data on numbers of deaths are presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were calculated for Queensland, Western Australia, South Australia and the Northern Territory as these states and territories have been assessed as having more complete coverage of Indigenous deaths. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

Table 51.1: Number of deaths among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	741	866	506	204	714	3,031
Females	457	597	361	126	465	2,006
Persons	1,198	1,463	867	330	1,179	5,037
Non-Indigenous						
Males	31,194	17,286	7,892	7,482	636	64,490
Females	18,155	9,661	4,546	4,498	246	37,106
Persons	49,349	26,947	12,438	11,980	882	101,596
Subtotal	***50,547***	***28,410***	***13,305***	***12,310***	***2,061***	***106,633***
Not stated	1,764	355	299	306	14	2,738
Total	**52,311**	**28,765**	**13,604**	**12,616**	**2,075**	**109,371**
Proportion not stated (%)	3.4	1.2	2.2	2.4	0.7	2.5

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03, in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there was a total of 109,371 deaths among people aged 0–74 years. Of these deaths, 5,037 (4.6%) were of Indigenous people.
- For 2,738 deaths (2.5%), Indigenous status was not stated. This ranged from 0.7% in the Northern Territory to 3.4% in New South Wales.
- Of all Indigenous deaths, 60% were males compared with 63% male deaths among non-Indigenous people.

Age-standardised rates and standardised mortality ratios

Table 51.2: Age-standardised mortality rates and standardised mortality ratios, by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
	Rate per 100,000			
Indigenous males	1,006.8	1,089.5	1,135.1	1,796.0
Non-Indigenous males	338.0	304.3	331.9	375.9
Indigenous females	643.1	730.3	643.8	1,100.6
Non-Indigenous females	196.0	180.9	197.6	196.4
Indigenous persons	814.2	900.9	876.0	1,430.9
Non-Indigenous persons	268.3	243.5	264.6	299.6
	Standardised mortality ratio[(a)]			
Males	2.9	3.2	3.3	5.2
Females	3.2	3.6	3.2	5.4
Persons	3.0	3.3	3.2	5.2

(a) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

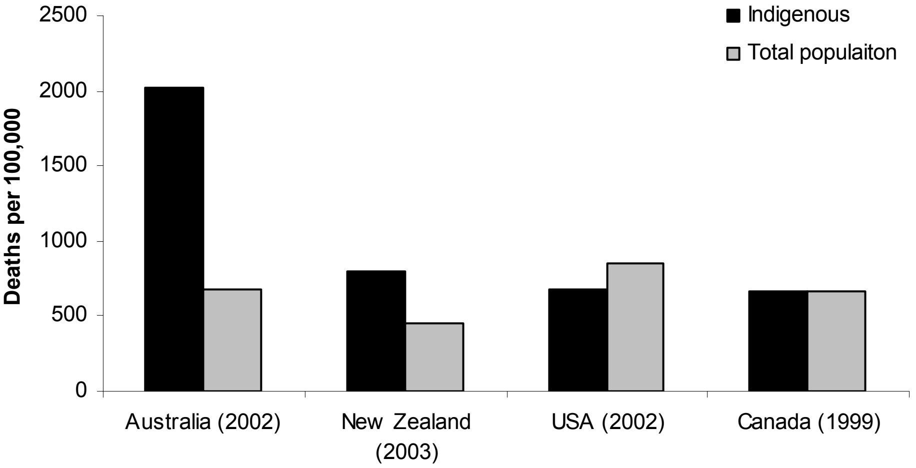
Source: AIHW National Mortality Database.

- In 2001–03 in Queensland, Western Australia, South Australia and the Northern Territory, death rates for Indigenous persons ranged from 814 per 100,000 in Queensland to 1,431 per 100,000 in the Northern Territory.
- Indigenous Australians in Queensland, South Australia and Western Australia died at around 3 times the rate of non-Indigenous Australians. In the Northern Territory, Indigenous people died at more than 5 times the rate of non-Indigenous people.

An analysis of trends in all-cause mortality among Indigenous Australians in Western Australia, South Australia and the Northern territory over the period 1991–2002 was undertaken in the joint ABS/AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005* (ABS & AIHW 2005).

International comparisons

- Death rates among Indigenous Australians were higher than death rates among New Zealand Maori, American Indians and Canadian First Nations.
- The overall Australian age-standardised death rate in 2002 for Aboriginal and Torres Strait Islander people was 2,026 per 100,000.
- In 2003 the age-standardised death rate was 796 per 100,000 for New Zealand Maoris, in 2002, 677 per 100,000 for American Indians and in 1999, 662 per 100,000 for First Nations in Canada (Statistics New Zealand 2005; Government of Canada 2003; US Department of Health and Human Services 2004).
- The difference in mortality rates between the Indigenous and total populations was higher in Australia than in the other three countries, with Aboriginal and Torres Strait Islander peoples dying at three times the rate of all Australians.
- Although some methodological differences—such as variation in the method used for standardisation and the age structure or death rates of the population used for standardisation in the different countries—have probably influenced the observed death rates, these are unlikely to account for the large difference observed in the death rates between Indigenous Australians and the Indigenous groups in the other countries.



Note: Indigenous includes Aboriginal and Torres Strait Islander Peoples, Maoris, American Indians and Canadian First Nations.

Sources: AIHW National Mortality Database; Statistics New Zealand 2005; Government of Canada 2003; US Department of Health and Human Services 2004.

Figure 51.1: Age-standardised mortality rates of people in Australia, New Zealand, the United States and Canada, by Indigenous status

Indicator 52. Standardised mortality ratios for circulatory diseases

Indicator:

(a) Standardised mortality ratio for deaths from circulatory diseases as the underlying cause of death in the Aboriginal and Torres Strait Islander population, compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised mortality ratio for deaths from coronary heart disease as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised mortality ratio for deaths from rheumatic heart disease as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

Circulatory diseases are a significant leading cause of death in the Aboriginal and Torres Strait Islander population. Many deaths from circulatory disease are preventable. It is therefore important to monitor changes in the rates of death from circulatory diseases in the Indigenous population compared with those in the non-Indigenous population.

Data

The data provided come from the AIHW National Mortality Database. Number of deaths are presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were only calculated for Queensland, Western Australia, South Australia and the Northern Territory. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

The data provided are for deaths from all circulatory diseases, as well as for the subgroups of circulatory diseases—coronary heart disease, and rheumatic fever and rheumatic heart disease.

Circulatory diseases

Table 52.1: Number of deaths from circulatory disease[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	238	239	132	47	170	826
Females	126	156	63	40	106	491
Persons	364	395	195	87	276	1,317
Non-Indigenous						
Males	8,640	4,453	1,850	2,124	161	17,228
Females	4,003	1,920	801	949	44	7,717
Persons	12,643	6,373	2,651	3,073	205	24,945
Subtotal	***13,007***	***6,768***	***2,846***	***3,160***	***481***	***26,262***
Not stated	447	94	55	70	4	670
Total	**13,454**	**6,862**	**2,901**	**3,230**	**485**	**26,932**
Proportion not stated (%)	3.3	1.4	1.9	2.2	0.8	2.5

(a) ICD-10 codes I00–I99.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.

2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 26,932 deaths among people aged 0–74 years due to circulatory disease. Of these, 1,317 or 4,9% were deaths of Indigenous people.
- For 670 deaths (2.5%), Indigenous status was not recorded. The proportion of 'not stated' varied by jurisdiction and ranged from 0.8% of all deaths in the Northern Territory to 3.3% of all deaths in New South Wales.
- Males made up 63% of the Indigenous deaths from circulatory disease, compared with 69% of the non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 52.2: Age-standardised mortality rates and standardised mortality ratios for death from circulatory diseases[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	372.3	377.9	346.4	580.5
Non-Indigenous males	87.1	71.8	92.5	103.8
Indigenous females	227.7	167.6	267.3	330.8
Non-Indigenous females	39.4	32.4	40.6	43.4
Indigenous persons	293.9	266.1	301.8	445.0
Non-Indigenous persons	63.8	52.5	66.4	79.2
		Standardised mortality ratio[(b)]		
Males	4.1	4.2	3.8	6.4
Females	5.4	4.0	6.4	7.9
Persons	4.4	4.0	4.5	6.7

(a) ICD-10 codes I00–I99.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was more complete than in other states and territories, death rates for the Indigenous population ranged from 266 per 100,000 in Queensland to 445 per 100,000 in the Northern Territory.
- The age-standardised mortality rates for deaths caused by circulatory diseases were between 4 and 7 times higher in the Indigenous population than in the non-Indigenous population in Queensland, Western Australia, South Australia and the Northern Territory.

Coronary heart disease

Table 52.3: Number of deaths from coronary heart disease[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	163	170	74	34	107	548
Females	70	84	33	22	49	258
Persons	233	254	107	56	156	806
Non-Indigenous						
Males	5,542	3,039	1,250	1,360	111	11,302
Females	1,891	985	426	465	23	3,790
Persons	7,433	4,024	1,676	1,825	134	15,092
Subtotal	***7,666***	***4,278***	***1,783***	***1,881***	***290***	***15,898***
Not stated	263	51	43	33	2	392
Total	**7,929**	**4,329**	**1,826**	**1,914**	**292**	**16,290**
Proportion not stated (%)	3.3	1.2	2.4	1.7	0.7	2.4

(a) ICD-10 codes I20–I25.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 16,290 deaths from coronary heart disease. Of these deaths, 806 or 4.9% were of Indigenous people.
- For 392 deaths (2.4%), Indigenous status was not stated. The proportion of 'not stated' varied by jurisdiction and ranged from 0.7% all deaths in the Northern Territory to 3.3% of all deaths in New South Wales.
- Females made up 32% of Indigenous deaths from coronary heart disease and 33% of non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 52.4: Age-standardised mortality rates and standardised mortality ratios for death from coronary heart disease[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	272.7	218.1	257.5	376.8
Non-Indigenous males	59.4	48.5	59.2	71.3
Indigenous females	133.7	94.9	158.7	165.6
Non-Indigenous females	20.3	17.3	19.8	24.1
Indigenous persons	196.6	151.7	201.5	261.5
Non-Indigenous persons	40.2	33.1	39.4	52.0
		Standardised mortality ratio[(b)]		
Males	4.6	3.7	4.3	6.4
Females	6.5	4.6	7.7	8.1
Persons	4.9	3.8	5.0	6.5

(a) ICD-10 codes I20–I25.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in the four states and territories where the Indigenous identification was more complete than in other states and territories, death rates for the Indigenous population ranged from 152 per 100,000 in Western Australia to 262 per 100,000 in the Northern Territory.
- Age-standardised mortality rates for deaths caused by coronary heart disease in Queensland and South Australia were around 5 times higher in the Indigenous population than in the non-Indigenous population. In Western Australia and the Northern Territory, Indigenous people were hospitalised at 4 and 7 times the rate of non-Indigenous people respectively.
- The standardised mortality ratios were higher for females than for males in all states and territories.

Rheumatic heart disease

Table 52.5: Number of deaths from rheumatic heart disease[(a)] among those aged less than 75 years, by Indigenous status, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous persons	9	19	8	n.p.	29	n.p.
Non-Indigenous persons	90	57	21	n.p.	3	n.p.
Subtotal	***99***	***76***	***29***	***30***	***32***	***266***
Not stated	2	1	0	0	0	3
Total	**101**	**77**	**29**	**30**	**32**	**269**
Proportion not stated (%)	2.0	1.3	0.0	0.0	0.0	1.1

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes I00–I09.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Numbers for males and females were not published because of low numbers.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 269 deaths recorded among people aged 0–74 years as being caused by rheumatic heart disease. Of these, 26% were deaths of Indigenous people.

Age-standardised rates and standardised mortality ratios

Table 52.6: Age-standardised mortality rates and standardised mortality ratios for death from rheumatic heart disease[(a)], by Indigenous status, and selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous persons	11.2	8.7	n.p.	36.6
Non-Indigenous persons	0.6	0.4	n.p.	1.0
		Standardised mortality ratio[(b)]		
Persons	17.1	13.3	n.p.	55.9

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes I00–I09.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Standardised mortality ratio is the standardised mortality rate for Indigenous people divided by the standardised mortality rate for non-Indigenous people.
4. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- Death rates from rheumatic heart disease should be interpreted with care because of the low numbers of deaths.
- The standardised mortality ratio was 17 in Queensland, 13 in Western Australia and 56 in the Northern Territory.

An analysis of trends in mortality from cardiovascular diseases among Indigenous Australians in Western Australia, South Australia and the Northern Territory over the periods 1991–96 and 1997–2002 was undertaken in the joint ABS/AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005* (ABS & AIHW 2005).

Indicator 53. Standardised mortality ratios for injury and poisoning

Indicator:

(a) Standardised mortality ratio for deaths from injury and poisoning as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised mortality ratio for deaths from road vehicle-related injury as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised mortality ratio for deaths from other accidents as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(d) Standardised mortality ratio for deaths from suicide as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 15–24 years.

(e) Standardised mortality ratio for deaths from assault as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

Injury is a significant cause of death among Aboriginal and Torres Strait Islander people. The indicators provide a measure of the rate of deaths for all injuries, as well as the main causes of injury for Aboriginal and Torres Strait Islander people compared to non-Indigenous people.

Data

The data provided come from the AIHW National Mortality Database. Number of deaths are presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were only calculated for Queensland, Western Australia, South Australia and the Northern Territory. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

The data provided were for the category 'all injuries and poisoning', as well as for the four major injury subgroups—road vehicle accidents, other accidents, self-harm and assault.

Injury and poisoning

Table 53.1: Number of deaths from injury and poisoning[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	132	182	101	54	161	630
Females	53	72	46	17	71	259
Persons	185	254	147	71	232	889
Non-Indigenous						
Males	3,916	2,643	1,176	930	161	8,826
Females	1,195	781	406	283	43	2,708
Persons	5,111	3,424	1,582	1,213	204	11,534
Subtotal	***5,296***	***3,678***	***1,729***	***1,284***	***436***	***12,423***
Not stated	189	38	74	90	1	392
Total	**5,485**	**3,716**	**1,803**	**1,374**	**437**	**12,815**
Proportion not stated (%)	3.4	1.0	4.1	6.6	0.2	3.1

(a) ICD-10 codes V01–Y98.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001 to 2003 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 12,815 deaths due to all types of injury and poisoning among people aged 0–74 years. Of these, 889 or 6.9% were Indigenous people.
- Indigenous status was not stated for 392 deaths (3.1%). This ranged from 0.2% of all deaths in the Northern Territory to 6.6% of all deaths in South Australia.
- Males made up 71% of the Indigenous deaths from injury and poisoning, compared with 77% of the non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 53.2: Age-standardised mortality rates and standardised mortality ratios for death from injury and poisoning[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	118.3	120.6	165.3	211.8
Non-Indigenous males	51.7	43.8	44.2	70.2
Indigenous females	43.6	53.8	50.8	94.7
Non-Indigenous females	15.5	15.6	13.5	22.9
Indigenous persons	79.1	86.5	107.0	152.3
Non-Indigenous persons	33.8	29.9	29.0	48.4
		Standardised mortality ratio[(b)]		
Males	2.5	2.6	3.5	4.5
Females	2.8	3.5	3.3	6.1
Persons	2.5	2.8	3.4	4.9

(a) ICD-10 codes V01–Y98.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was more complete, death rates for the Indigenous population ranged from 79 per 100,000 in Queensland to 152 per 100,000 in the Northern Territory.
- Indigenous people died from injury and poisoning at between 3 and 5 times the rate of non-Indigenous people.
- The standardised mortality ratio of Indigenous to non-Indigenous deaths from injury and poisoning was highest in the Northern Territory (4.9).

Transport accidents

This category includes injuries caused by accidents involving cars, buses, trucks, motorcycles, bicycles and pedestrians. It excludes other land transport accidents, water transport accidents, air and space transport accidents and other and unspecified transport accidents.

Table 53.3: Number of deaths from transport accidents[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	30	30	29	21	50	160
Females	10	14	17	9	30	80
Persons	40	44	46	30	80	240
Non-Indigenous						
Males	931	669	315	280	50	2,245
Females	302	219	107	91	21	740
Persons	1,233	888	422	371	71	2,985
Subtotal	***1,273***	***932***	***468***	***401***	***151***	***3,225***
Not stated	52	10	23	25	0	110
Total	**1,325**	**942**	**491**	**426**	**151**	**3,335**
Proportion not stated (%)	3.9	1.1	4.7	5.9	0.0	3.3

(a) ICD-10 codes V01–V79.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 3,335 deaths due to transport accidents (mostly road-vehicle related). Of these, 240 or 7.2% were Indigenous people.
- For 110 deaths (3.3%), Indigenous status was not stated. This ranged from none in the Northern Territory to 5.9% of all deaths in South Australia.
- Males made up two-thirds (67%) of the Indigenous deaths from motor vehicle accidents, and three-quarters (75%) of the non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 53.4: Age-standardised mortality rates and standardised mortality ratios for death from transport accidents[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	17.2	30.6	56.9	58.0
Non-Indigenous males	13.1	11.7	13.4	22.0
Indigenous females	7.9	18.5	25.0	37.2
Non-Indigenous females	4.3	4.1	4.4	11.4
Indigenous persons	12.3	24.3	40.6	47.1
Non-Indigenous persons	8.7	8.0	8.9	17.0
		Standardised mortality ratio[(b)]		
Males	1.4	2.5	4.7	4.7
Females	1.9	4.5	6.0	9.0
Persons	1.5	3.0	5.0	5.7

(a) ICD-10 codes V01–V79.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in the four states and territories where the Indigenous identification was acceptable, death rates for the Indigenous population ranged from 12 per 100,000 in Queensland to 47 per 100,000 in the Northern Territory.
- Indigenous people died from transport accidents at around 3 times the rate of non-Indigenous people in Western Australia, at 6 times the rate of non-Indigenous people in South Australia, and at 6 times the rate of non-Indigenous people in the Northern Territory.

Other accidents

This category includes other land transport accidents, water transport accidents, falls, drowning, poisoning, etc.

Table 53.5: Number of deaths from other accidents[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	43	56	39	9	26	173
Females	25	19	18	4	10	76
Persons	68	75	57	13	36	249
Non-Indigenous						
Males	1,338	822	339	226	43	2,768
Females	440	269	135	85	10	939
Persons	1,778	1,091	474	311	53	3,707
Subtotal	***1,846***	***1,166***	***531***	***324***	***89***	***3,956***
Not stated	55	17	15	24	1	112
Total	**1,901**	**1,183**	**546**	**348**	**90**	**4,068**
Proportion not stated (%)	2.9	1.4	2.7	6.9	1.1	2.8

(a) ICD-10 codes V80–X59.

Notes:

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 4,068 deaths caused by other accidents. Of these, 249 or 6.1% were Indigenous people.
- Indigenous status was not stated for 112 deaths (2.8%). This ranged from 1.1% of all deaths in the Northern Territory to 6.9% of all deaths in South Australia.
- Males made up 69% of the Indigenous deaths from other accidents, compared to 75% of the non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 53.6: Age-standardised mortality rates and standardised mortality ratios for death from other accidents[a], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	37.8	48.7	28.9	36.2
Non-Indigenous males	16.1	12.7	10.7	19.1
Indigenous females	11.8	21.6	12.2	13.8
Non-Indigenous females	5.4	5.2	4.0	5.6
Indigenous persons	24.2	34.9	20.4	24.9
Non-Indigenous persons	10.8	9.0	7.4	13.0
		Standardised mortality ratio[b]		
Males	2.6	3.4	2.0	2.5
Females	2.3	4.1	2.3	2.7
Persons	2.5	3.5	2.1	2.5

(a) ICD-10 codes V80–X59.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was more complete, death rates for the Indigenous population ranged from 20 per 100,000 in South Australia to 35 per 100,000 in Western Australia.
- Indigenous people died from other accidents at between 2 and 4 times the rate at which non-Indigenous people died.
- The standardised mortality ratios were higher for females than males in Western Australia, South Australia and the Northern Territory, largely reflecting the very low death rates from other accidents among non-Indigenous women.

Self-harm

Table 53.7: Number of deaths from self-harm[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	46	80	20	16	64	226
Females	13	28	4	4	8	57
Persons	59	108	24	20	72	283
Non-Indigenous						
Males	1,463	1,056	492	398	60	3,469
Females	378	247	145	86	9	865
Persons	1,841	1,303	637	484	69	4,334
Subtotal	***1,900***	***1,411***	***661***	***504***	***141***	***4,617***
Not stated	67	10	32	33	0	142
Total	**1,967**	**1,421**	**693**	**537**	**141**	**4,759**
Proportion not stated (%)	3.4	0.7	4.6	6.1	0.0	3.0

(a) ICD-10 codes X60–X84.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001 to 2003 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 4,759 deaths caused by self-harm among those aged less than 75 years. Of these, 283 or 5.9% were Indigenous people.
- For 142 deaths (3.0%), Indigenous status was not stated. The proportions not stated varied by jurisdiction and ranged from none in the Northern Territory to 6.1% of all deaths in South Australia.

Age-standardised rates and standardised mortality ratios

Table 53.8: Age-standardised mortality rates and standardised mortality ratios for death from self-harm[a], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	55.7	25.4	51.9	88.9
Non-Indigenous males	20.7	18.3	18.9	25.7
Indigenous females	18.4	5.1	12.9	11.4
Non-Indigenous females	4.9	5.5	4.1	4.6
Indigenous persons	36.0	15.0	32.0	49.9
Non-Indigenous persons	12.9	12.0	11.6	16.0
		Standardised mortality ratio[b]		
Males	3.0	1.4	2.8	4.8
Females	3.6	1.0	2.5	2.2
Persons	3.0	1.3	2.7	4.2

(a) ICD-10 codes X60–X84.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was more complete, death rates for the Indigenous population ranged from 15 per 100,000 in Western Australia to 49.9 per 100,000 in the Northern Territory.
- In Queensland, and South Australia and the Northern Territory, Indigenous people died from self-harm at between 3 and 4 times the rate at which non-Indigenous people died in these jurisdictions.
- In Western Australia, Indigenous people died from self-harm at similar rates to non-Indigenous people.

Assault

Table 53.9: Number of deaths from assault[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	13	16	13	8	21	71
Females	5	11	7	0	23	46
Persons	18	27	20	8	44	117
Non-Indigenous						
Males	184	96	30	26	n.p.	n.p.
Females	75	46	19	21	n.p.	n.p.
Persons	259	142	49	47	11	508
Subtotal	***277***	***169***	***69***	***55***	***55***	***625***
Not stated	15	1	4	8	0	28
Total	**292**	**170**	**73**	**63**	**55**	**653**
Proportion not stated (%)	5.1	0.6	5.5	12.7	0.0	4.3

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes X85–Y09.

Notes:

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 653 deaths caused by assault. Of these, 117 or 18% were Indigenous people.
- For 28 deaths (4.3%), Indigenous status was not stated. This ranged from none in the Northern Territory to 12.7% of all deaths in South Australia.
- Females made up 39% of the Indigenous deaths from assault, compared with only 32% of non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 53.10: Age-standardised mortality rates and standardised mortality ratios for death from assault[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	9.6	14.5	22.9	25.9
Non-Indigenous males	1.9	1.1	1.2	n.p.
Indigenous females	5.6	7.0	0.0	26.0
Non-Indigenous females	0.9	0.7	1.0	n.p.
Indigenous persons	7.6	10.7	11.0	26.2
Non-Indigenous persons	1.4	0.9	1.1	2.5
		Standardised mortality ratio[(b)]		
Males	4.8	7.1	11.3	n.p.
Females	5.5	6.8	0.0	n.p.
Persons	5.0	7.0	7.2	17.2

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes X85–Y09.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was more complete, death rates for the Indigenous population ranged from 8 per 100,000 in Queensland to 26 per 100,000 in the Northern Territory.
- The standardised mortality ratios show that Indigenous people died from assault between 5 and 17 times the rate at which non-Indigenous people died.

An analysis of trends in mortality from injury and poisoning among Indigenous Australians in Western Australia, South Australia and the Northern Territory over the periods 1991–96 and 1997–2002 was undertaken in the joint ABS/AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005* (ABS & AIHW 2005).

Indicator 54. Standardised mortality ratios for respiratory diseases and lung cancer

Indicator:

(a) Standardised mortality ratio for deaths from respiratory diseases as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised mortality ratio for deaths from pneumonia as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised mortality ratio for deaths from cancer of the lung, trachea and bronchus as the underlying cause in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

The indicators provide a measure of the rate of deaths from respiratory disease and lung cancer for Aboriginal and Torres Strait Islander people compared to non-Indigenous people.

Data

The data provided come from the AIHW National Mortality Database. Number of deaths are presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were only calculated for Queensland, Western Australia, South Australia and the Northern Territory. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

Data are presented for the category of 'all respiratory diseases' as well as two of the sub groups—pneumonia and lung cancer.

Respiratory diseases

Table 54.1: Number of deaths from respiratory disease[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	63	76	39	16	63	257
Females	42	48	30	16	42	178
Persons	105	124	69	32	105	435
Non-Indigenous						
Males	1,876	948	447	484	38	3,793
Females	1,287	653	269	306	8	2,523
Persons	3,163	1,601	716	790	46	6,316
Subtotal	***3,268***	***1,725***	***785***	***822***	***151***	***6,751***
Not stated	124	29	21	25	1	200
Total	**3,392**	**1,754**	**806**	**847**	**152**	**6,951**
Proportion not stated (%)	3.7	1.7	2.6	3.0	0.7	2.9

(a) ICD-10 codes J00–J99.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 6,951 deaths caused by respiratory diseases among people aged less than 75 years. Of these, 435 or 6.2% were Indigenous people.
- There was a total of 200 deaths (2.9%) for which Indigenous status was not stated. This ranged from 0.7% in the Northern Territory to 3.7% in New South Wales.
- Males made up 59% of the Indigenous deaths from respiratory disease, and 60% of the non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 54.2: Age-standardised mortality rates and standardised mortality ratios for death from respiratory diseases[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	121.6	115.0	122.8	224.1
Non-Indigenous males	18.7	17.6	20.9	27.3
Indigenous females	67.0	76.9	103.1	126.2
Non-Indigenous females	13.4	10.9	13.1	7.9
Indigenous persons	92.7	94.7	112.2	171.1
Non-Indigenous persons	16.1	14.3	17.0	19.2
		Standardised mortality ratio[(b)]		
Males	6.0	5.7	6.1	11.1
Females	4.8	5.5	7.3	9.0
Persons	5.4	5.5	6.6	10.0

(a) ICD-10 codes J00–J99.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was acceptable, death rates for the Indigenous population ranged from 93 per 100,000 in Queensland to 171 per 100,000 in the Northern Territory.
- The standardised mortality ratios indicate that Indigenous people die from respiratory diseases at between 5 and 10 times the rate at which non-Indigenous people die.

Pneumonia

Table 54.3: Number of deaths from pneumonia[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	10	21	19	n.p.	17	n.p.
Females	7	14	16	n.p.	7	n.p.
Persons	17	35	35	9	24	120
Non-Indigenous						
Males	277	148	69	88	n.p.	n.p.
Females	202	86	48	52	n.p.	n.p.
Persons	479	234	117	140	12	982
Subtotal	***496***	***269***	***152***	***149***	***36***	***1,102***
Not stated	30	3	6	9	1	49
Total	**526**	**272**	**158**	**158**	**37**	**1,151**
Proportion not stated (%)	5.7	1.1	3.8	5.7	2.7	4.3

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes J10–J18.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 1,151 deaths caused by pneumonia among people aged 0–74 years. Of these, 120 or 10.4% were Indigenous people.
- For 49 deaths due to pneumonia, Indigenous status was not stated (4.3%). This ranged from 1.1% in Queensland to 5.7% in New South Wales and South Australia.
- Males made up 59% of deaths from pneumonia among Indigenous people, and 60% of deaths among non-Indigenous people.

Age-standardised rates and standardised mortality ratios

Table 54.4: Age-standardised mortality rates and standardised mortality ratios for death from pneumonia[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	26.3	44.2	n.p.	47.4
Non-Indigenous males	2.9	2.7	3.8	n.p.
Indigenous females	15.4	33.2	n.p.	17.1
Non-Indigenous females	1.8	1.9	2.3	n.p.
Indigenous persons	20.6	38.5	25.3	31.3
Non-Indigenous persons	2.3	2.3	3.1	4.4
		Standardised mortality ratio[(b)]		
Males	8.4	14.0	n.p.	n.p.
Females	7.5	16.1	n.p.	n.p.
.Persons	7.9	14.7	9.7	12.0

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes J10–J18.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was acceptable, death rates for the Indigenous population ranged from 21 per 100,000 in Queensland to 39 per 100,000 in Western Australia.
- The standardised mortality ratios for pneumonia indicate that Indigenous people die from pneumonia at between 8 and 15 times the rate at which non-Indigenous people die.
- Standardised mortality ratios were highest in Western Australia (14.7) followed by the Northern Territory (12.0).

Lung cancer

Table 54.5: Number of deaths from lung cancer[(a)] among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	38	37	12	n.p.	25	n.p.
Females	26	32	12	n.p.	13	n.p.
Persons	64	69	24	8	38	203
Non-Indigenous						
Males	2,737	1,597	767	602	41	5,744
Females	1,360	784	351	309	20	2,824
Persons	4,097	2,381	1,118	911	61	8,568
Subtotal	***4,161***	***2,450***	***1,142***	***919***	***99***	***8,771***
Not stated	115	30	19	16	2	182
Total	**4,276**	**2,480**	**1,161**	**935**	**101**	**8,953**
Proportion not stated (%)	2.7	1.2	1.6	1.7	2.0	2.0

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes C33–C34.9.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 8,953 deaths caused by lung cancer among people aged less than 75 years. Of these, 203 or 2.3% were Indigenous people.
- There were a total of 184 deaths for which Indigenous status was not stated (2.0%). This ranged from 1.2% in Queensland to 2.7% in New South Wales.
- Females made up 42% of the Indigenous deaths from lung cancer, compared with 33% of the non-Indigenous deaths.

Age-standardised rate and standardised mortality ratios

Table 54.6: Age-standardised mortality rates and standardised mortality ratios for death from lung cancer[(a)], by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	64.5	38.5	n.p.	96.1
Non-Indigenous males	31.2	29.9	26.1	27.8
Indigenous females	46.4	31.9	n.p.	40.4
Non-Indigenous females	15.9	14.0	13.3	18.0
Indigenous persons	55.1	35.2	29.7	65.7
Non-Indigenous persons	23.7	22.1	19.7	23.9
		Standardised mortality ratio[(b)]		
Males	2.2	1.3	n.p.	3.2
Females	3.0	2.1	n.p.	2.6
Persons	2.4	1.6	1.3	2.9

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 codes C33–C34.9.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was acceptable, death rates for the Indigenous population ranged from 30 per 100,000 in South Australia to 66 per 100,000 in the Northern Territory.
- The standardised mortality ratios for lung cancer indicate that Indigenous people die from lung cancer at between 1 and 3 times the rate at which non-Indigenous people die.

An analysis of trends in mortality from respiratory diseases among Indigenous Australians in Western Australia, South Australia and the Northern Territory over the periods 1991–96 and 1997–2002 was undertaken in the joint ABS/AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005* (ABS & AIHW 2005).

Indicator 55. Standardised mortality ratios for diabetes

Indicator:

(a) Standardised mortality ratio for diabetes as the underlying cause of death in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(b) Standardised mortality ratio for diabetes as an associated but not underlying cause of death in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

(c) Standardised mortality ratio for diabetes as the underlying or as an associated cause of death in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population, by sex, for those aged 0–74 years.

Purpose

Diabetes is a significant contributor to morbidity and mortality among Aboriginal and Torres Strait Islander people. The indicator provides a measure of the rate of death from diabetes in the Indigenous population compared to the non-Indigenous population.

Diabetes is often reported as a multiple cause of death, in particular in association with death with a primary cause of coronary heart disease, stroke and kidney disease. To assess the impact of diabetes on the Indigenous population, diabetes as both an underlying and an associated cause needs to be considered.

Data

The data provided come from the AIHW National Mortality Database. Number of deaths are presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were only calculated for Queensland, Western Australia, South Australia and the Northern Territory. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

Data were presented for deaths where diabetes was an underlying cause, where diabetes was a multiple cause and the total of these two categories, where diabetes was either an underlying or a multiple cause of death.

Diabetes as an underlying cause

Table 55.1: Number of deaths from diabetes[(a)] as an underlying cause among those aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	27	57	32	15	43	174
Females	22	63	47	14	45	191
Persons	49	120	79	29	88	365
Non-Indigenous						
Males	630	346	184	172	12	1,344
Females	294	203	98	89	7	691
Persons	924	549	282	261	19	2,035
Subtotal	***973***	***669***	***361***	***290***	***107***	***2,400***
Not stated	30	8	5	2	0	45
Total	**1,003**	**677**	**366**	**292**	**107**	**2,445**
Proportion not stated (%)	3.0	1.2	1.4	0.7	0.0	1.8

(a) ICD-10 codes E10–E14.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period from 2001 to 2003 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 2,445 deaths caused by diabetes. Of these, 365 or 14.9% were Indigenous people.
- There were 45 deaths for which Indigenous status was not stated (1.8%). This ranged from none in the Northern Territory to 3.0% in New South Wales.
- Females made up 52% of deaths from diabetes as an underlying cause among Indigenous people, compared with only 34% of deaths among non-Indigenous people.

Age-standardised rates and standardised mortality ratios

Table 55.2: Age-standardised mortality rates and standardised mortality ratios for death from diabetes[(a)] as an underlying cause, by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	93.4	96.4	116.3	154.4
Non-Indigenous males	6.8	7.2	7.5	7.9
Indigenous females	91.8	124.9	93.4	139.6
Non-Indigenous females	4.2	4.0	3.8	6.8
Indigenous persons	92.3	111.3	103.8	146.1
Non-Indigenous persons	5.5	5.6	5.6	7.5
		Standardised mortality ratio[(b)]		
Males	10.9	11.3	13.6	18.1
Females	19.4	26.3	19.7	29.4
Persons	13.9	16.7	15.6	22.0

(a) ICD-10 codes E10–E14.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was more complete, death rates for the Indigenous population ranged from 92 per 100,000 in Queensland to 140 per 100,000 in the Northern Territory.
- The standardised mortality ratio for diabetes as an underlying cause indicates that Indigenous people die from diabetes at between 14 and 22 times the rate at which non-Indigenous people die.
- The standardised mortality ratio for Indigenous females compared with non-Indigenous females was higher than for Indigenous males compared with non-Indigenous males in all four states and territories.

Diabetes as an associated cause

Table 55.3: The number of deaths from diabetes[(a)] as an associated cause for people aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	73	87	49	22	51	282
Females	37	91	45	16	44	233
Persons	110	178	94	38	95	515
Non-Indigenous						
Males	2,008	847	388	522	42	3,807
Females	1,120	452	216	305	9	2,102
Persons	3,128	1,299	604	827	51	5,909
Subtotal	***3,238***	***1,477***	***698***	***865***	***146***	***6,424***
Not stated	87	22	21	8	2	140
Total	**3,325**	**1,499**	**719**	**873**	**148**	**6,564**
Proportion not stated (%)	2.6	1.5	2.9	0.9	1.4	2.1

(a) ICD-10 codes E10–E14.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001–03 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 6,564 deaths caused by diabetes as an associated cause among people aged 0–74 years. Of these, 515 or 7.8% were Indigenous people.
- Indigenous status was not stated for 140 deaths (2.1%) caused by diabetes. This ranged from 0.9% in the Northern Territory to 2.6% in New South Wales.
- Females made up 49% of the Indigenous deaths from diabetes as an associated cause, compared with only 34% of the non-Indigenous deaths.

Age-standardised rates and standardised mortality ratios

Table 55.4: Age-standardised mortality rates and standardised mortality ratios for diabetes[(a)] as an associated cause, by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	152.0	157.1	182.2	196.8
Non-Indigenous males	16.6	15.2	22.5	29.2
Indigenous females	143.5	128.4	114.5	147.1
Non-Indigenous females	9.3	8.8	13.0	9.4
Indigenous persons	146.8	141.3	145.2	169.4
Non-Indigenous persons	13.0	12.0	17.7	21.2
		Standardised mortality ratio[(b)]		
Males	7.6	7.8	9.1	9.8
Females	12.5	11.2	10.0	12.8
Persons	9.3	9.0	9.2	10.7

(a) ICD-10 codes E10–E14.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was acceptable, death rates for diabetes as an associated cause for the Indigenous population ranged from 141 per 100,000 in Western Australia to 169 per 100,000 in the Northern Territory.
- The standardised mortality ratios for diabetes as an associated cause indicate that Indigenous people die from diabetes at between 9 and 11 times the rate at which non-Indigenous people die.
- Indigenous females died from diabetes as an associated cause at up to 13 times the rate of non-Indigenous females in Queensland and the Northern Territory.

Diabetes as an underlying or as an associated cause

Table 55.5: The number of deaths from diabetes[(a)] as an underlying or an associated cause for people aged less than 75 years, by Indigenous status and sex, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous						
Males	100	144	81	37	94	456
Females	59	154	92	30	89	424
Persons	159	298	173	67	183	880
Non-Indigenous						
Males	2,638	1,193	572	694	54	5,151
Females	1,414	655	314	394	16	2,793
Persons	4,052	1,848	886	1,088	70	7,944
Subtotal	***4,211***	***2,146***	***1,059***	***1,155***	***253***	***8,824***
Not stated	117	30	26	10	2	185
Total	**4,328**	**2,176**	**1,085**	**1,165**	**255**	**9,009**
Proportion not stated (%)	2.7	1.4	2.4	0.9	0.8	2.1

(a) ICD-10 codes E10–E14.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period 2001 to 2003 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 9,009 deaths caused by diabetes as an underlying or associated cause among people aged less than 75 years. Of these, 880 or 9.7% were Indigenous people.
- For 185 deaths (2.1%), Indigenous status was not stated. This ranged from 0.8% in the Northern Territory to 2.7% in New South Wales.
- Females made up 48% of deaths from diabetes as an underlying or associated cause among Indigenous people, compared with only 35% of deaths among non-Indigenous people.

Age-standardised rates and standardised mortality ratios

Table 55.6: Age-standardised mortality rates and standardised mortality ratios for diabetes[(a)] as an underlying or an associated cause, by Indigenous status and sex, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous males	246.7	254.8	300.3	354.8
Non-Indigenous males	23.4	22.4	30.0	37.0
Indigenous females	237.1	257.0	210.2	290.9
Non-Indigenous females	13.4	12.7	16.8	16.3
Indigenous persons	240.6	255.1	251.0	319.3
Non-Indigenous persons	18.5	17.6	23.4	28.7
		Standardised mortality ratio(b)		
Males	8.6	8.9	10.5	12.4
Females	14.6	15.8	13.0	17.9
Persons	10.7	11.4	11.2	14.2

(a) ICD-10 codes E10–E14.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state and territory of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In 2001–03 in the four states and territories where the Indigenous identification was acceptable, death rates for the Indigenous population ranged from 241 per 100,000 in New South Wales to 319 per 100,000 in the Northern Territory.
- The standardised mortality ratios indicate that Indigenous people die from diabetes at between 11 and 14 times the rate at which non-Indigenous people die.
- The standardised mortality ratios for females were higher than for males in all four states and territories.

Indicator 56. Standardised mortality ratios for cervical cancer

Indicator: The standardised mortality ratios for deaths from cervical cancer among Aboriginal and Torres Strait Islander women and non-Indigenous women, for those aged 0–74 years.

Purpose

Death from cervical cancer can be prevented through Pap-smear screening. The indicator provides a measure of the death rates of Aboriginal and Torres Strait Islander women from cervical cancer compared to the death rates for non-Indigenous women.

Data

The data provided come from the AIHW National Mortality Database. Number of deaths are presented for five states and territories—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Rates were only calculated for Queensland, Western Australia, South Australia and the Northern Territory. Given the recent efforts by New South Wales to improve coverage of Indigenous deaths, it was important to present the number of deaths in this jurisdiction despite the fact that they are still considered incomplete. Consequently, rates have not been calculated for New South Wales.

Table 56.1: Number of deaths from cervical cancer[(a)] among females aged less than 75 years, by Indigenous status, for selected states and territories, 2001–03

	NSW	Qld	WA	SA	NT	Total
Indigenous females	10	13	n.p.	n.p.	n.p.	29
Non-Indigenous females	154	78	53	45	n.p.	n.p.
Subtotal	***164***	***91***	***55***	***46***	***7***	***363***
Not stated	5	1	1	1	0	8
Total	**169**	**92**	**56**	**47**	**7**	**371**
Proportion not stated (%)	3.0	1.1	1.8	2.1	0.0	2.2

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 code C53.

Notes

1. Table includes mortality data from New South Wales, having the largest Indigenous population, and from the four states and territories with the most complete coverage of Indigenous deaths.
2. Data are for state of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- In the period from 2001 to 2003 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory, there were 371 deaths caused by cervical cancer where Indigenous status was recorded. Of these, 29 or 7.8% were Indigenous females.
- There were 8 deaths for which Indigenous status was not stated (2.2%). Most of these occurred in New South Wales.

Age-standardised rates and standardised mortality ratios

Table 56.2: Age-standardised mortality rates and rate ratios for death from cervical cancer[(a)], by Indigenous status, for selected states and territories, 2001–03

	Qld	WA	SA	NT
		Rate per 100,000		
Indigenous females	13.2	n.p.	n.p.	n.p.
Non-Indigenous females	1.6	2.1	2.0	n.p.
		Standardised mortality ratio[(b)]		
Females	7.4	n.p.	n.p.	n.p.

n.p. Not publishable where numbers were less than 5.

(a) ICD-10 code C53.

(b) Standardised mortality ratio is the number of observed deaths in the Indigenous population divided by the number of expected deaths, based on the age-specific rates of the total Australian population.

Notes

1. In New South Wales, Victoria, the Australian Capital Territory and Tasmania, the coverage of Indigenous deaths is not sufficient to calculate rates.
2. Deaths for which Indigenous status was not stated were excluded from the calculation of rates.
3. Data are for state of usual residence and year of registration of death.

Source: AIHW National Mortality Database.

- The standardised mortality ratios for cervical cancer were only provided for Queensland as there were fewer than five Indigenous deaths from cervical cancer in the three other states and territories.
- In Queensland there were 7 times as many deaths from cervical cancer among Indigenous females as among non-Indigenous females.

Appendix 1

Table A.1 summarises data for the quantitative indicators in this report. This table should be read in conjunction with each relevant indicator in order to get a better understanding of issues surrounding the data.

Table A.1: Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	Government inputs												
2	Per person state/territory government expenditure on health services for Indigenous people ($)	20	AIHW	01–02	2,189	2,398	2,401	3,850	2,383	815	2,538	4,522	2,749
4	Total government expenditure on selected health promotion programs ($'000)	29	states	03–04	1,105	6,030	2,914	4,630	n.a.	—	70	1,679	24,421
	Determinants of health—social equity												
5	Life expectancy at birth (years)	44	ABS	96–01									
	Males				60	60	59	59	59	60	60	58	59
	Females				65	65	63	67	67	65	65	65	65
6	Infant mortality rate per 1,000 live births	46	AIHW	01–03	n.p.	n.p.	11.2	15.9	9.1	n.p.	n.p.	14.8	n.p.
7	Income poverty—proportion of persons with incomes:	48	ABS	2002									
	Less than Australian 20th percentile				45	41	43	46	47	39	23	49	44
	Less than Australian 50th percentile				74	75	76	79	78	76	47	83	76
8	Proportion of 20–24 year olds who completed secondary school education	50	ABS	2002									
	Males				27.5	25.0	39.1	11.0	42.2	20.3	22.0	16.3	27.1
	Females				32.4	40.0	31.3	15.3	30.0	41.3	62.2	21.8	29.0
9	Employment status—proportion aged 20–64 who were:	52	ABS	2002									
	Employed				49.8	51.8	51.8	54.4	51.8	54.6	70.9	51.5	51.8
	Unemployed				14.7	8.8	13.9	11.7	11.3	10.0	2.8	6.5	12.1
	Not in the labour force				35.5	39.4	34.4	33.9	36.9	35.4	26.3	41.9	36.0
10	Housing utilities—proportion of dwellings in communities connected to:	45	ABS	2001									
	Sewerage system				100.0	100.0	99.8	98.9	100.0	100.0	n.a.	96.4	98.2
	Water supply				100.0	100.0	99.5	99.3	99.3	100.0	n.a.	97.8	98.8
	Electricity supply				100.0	100.0	99.7	99.0	97.9	100.0	n.a.	96.3	98.0
11	Imprisonment rate per 100,000	57	ABS	2004	2,012	1,069	1,572	3,114	1,624	597	1,095	1,589	1,852

(continued)

Table A.1 (continued): Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	Determinants of health—access to services												
15	Aboriginal and Torres Strait Islander community controlled health services:	76	OATSIH / states	03–04									
	Number				29[(a)]	21	27	21	10	5	n.a.	27	140
	Per person expenditure				247[(a)]	821	240	656	763	200	n.a.	747	365
16	Proportion of communities 25 km or more to a community health clinic and 10km or more from nearest hospital	64	ABS	2001	17	n.a.	51	49	44	n.a.	n.a.	54	50
17	Proportion of communities 50 km or more to an acute care hospital	66	ABS	2001	13	n.a.	68	74	75	n.a.	n.a.	88	78
18	Proportion of communities of less than 50 people and more than 50 km from a community health clinic not visited by health professionals at least once a month	67	ABS	2001	n.p.	n.p.	97.4	75.9	100	n.p.	n.p.	72.8	76.7
20	The proportion of Aboriginal and Torres Strait Islander people in the health workforce	95	ABS	2002	n.a.	0.3	2.1	1.6	0.9	2.0	0.4	4.1	n.a.
21	Higher education—the number of Aboriginal and Torres Strait Islander people who:	103	DEST	2003									
	(a) had gained a health qualification (VET & HEdn data)				158	58	112	84	37	9	3	40	507
	(b) were enrolled to gain a health qualification (VET & HEdn data)				733	246	889	404	375	33	14	419	3,138
22	Number of health professionals working in primary health care centres for Indigenous people	111	OATSIH	June 03	521(a)	235	441	599	375	40	n.a.	491	2,606
23	Workforce availability in hospitals that provide services to Aboriginal and Torres Strait Islander people	114	states		n.a.	n.a.	1,481	772	n.a.	n.a.	n.a.	1,310	n.a.

(continued)

Table A.1 (continued): Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	Determinants of health—risk markers												
26	Childhood immunisation rates—proportion of children fully immunised at:	127	HIC	June 04									
	1 year				85	88	n.p.	78	83	n.p.	n.p.	84	n.p.
	2 years				87	86	n.p.	87	94	n.p.	n.p.	94	n.p.
	6 years				85	84	n.p.	78	82	n.p.	n.p.	89	n.p.
28	Proportion of low-birthweight infants	129	AIHW	00–02	12.0	13.1	11.6	14.5	17.6	n.a.	21.8	13.0	12.9
29	Smoking prevalence—proportion of adults who were:	131	ABS	2002									
	Current smokers				54.3	56.0	53.2	50.0	50.2	47.2	45.7	55.9	53.1
	Ex-smokers				16.0	21.6	17.4	18.4	19.0	20.7	22.3	8.7	16.5
30	Alcohol consumption—proportion of adults who:	134	ABS	2002									
	Consumed alcohol in 12 mths prior to survey				74.8	75.2	71.2	71.8	69.7	81.4	85.3	42.5	69.4
	Of those who consumed alcohol in 12 mths prior to survey, drank at risky/high- risk levels in 2 wks prior to survey				50.1	44.9	51.4	52.6	53.1	40.5	45.6	52.7	50.4
31	Overweight and obesity—proportion of adults who were:	107	ABS	2001									
	Overweight				n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	26
	Obese				n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	22
32	Child protection substantiations rate per 1,000	138	AIHW	03–04	n.a.	57.7	20.8	11.2	39.9	1.6	25.3	16.2	n.a.
35	Number of injuries presenting to hospital accident and emergency facilities	110	states	03–04	8,211	2,508	2,625	3,411	n.a.	n.a.	304	6,211	n.a.
	Outcomes for people												
37	Notification rates per 100,000 for vaccine preventable diseases:	146	DoHA—NNDSS	2004									
	Pertussis				37.5	n.p.	114.9	63.2	22.2	0.0	0.0	n.p.	24.8
38	Notification rates per 100,000 for meningococcal disease	148	DoHA—NNDSS	2004	7.8	0.0	8.2	8.6	n.p.	n.p.	n.p.	3.4	8.1

(continued)

Table A.1 (continued): Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
39	Notification rates per 100,000 for sexually transmitted diseases:	149	DoHA—NNDSS	2004									
	Males												
	Gonorrhoea				26.6	n.p.	419.4	2,062.2	964.4	n.p.	n.p.	2,968.9	870.5
	Syphilis				0.0	0.0	0.0	0.0	0.0	n.p.	n.p.	302.1	123.6
	Chlamydia				260.2	307.7	1,674.7	1,423.6	991.2	n.p.	n.p.	1,876.6	1,481.4
	Females												
	Gonorrhoea				28.2	n.p.	461.0	1,776.7	1,084.4	n.p.	n.p.	3,528.8	866.7
	Syphilis				0.0	0.0	0.0	0.0	0.0	n.p.	n.p.	296.9	
	Chlamydia				195.1	427.9	1,501.6	2,234.7	1,484.6	n.p.	n.p.	3,134.8	1309.6
40	Standardised hospital separation ratios for all hospitalisations by sex:	151	AIHW	03–04									
	Males				1.4	1.2	1.9	2.6	2.6	0.4	1.2	3.0	1.9
	Females				1.3	1.3	1.9	3.1	2.5	0.5	1.2	3.3	2.0
41	Standardised hospital separations ratios for:	154	AIHW	03–04									
	Circulatory diseases				1.6	1.3	2.2	2.6	2.5	0.5	0.9	2.4	2.0
	Coronary heart disease				2.4	1.9	3.3	3.3	3.4	0.7	1.9	2.9	2.8
	Rheumatic fever and rheumatic heart disease				2.5	2.1	10.2	14.8	5.1	n.p.	n.p.	45.9	11.5
42	Standardised hospital separations ratios for:	161	AIHW	03–04									
	Injury and poisoning				1.4	1.1	1.8	3.4	2.2	0.4	0.7	2.5	1.9
	Transport accidents				1.0	0.8	1.1	2.1	1.3	0.4	0.6	1.5	1.2
	Other accidents				1.2	1.1	1.6	2.3	1.7	0.4	0.5	1.8	1.5
	Self-harm				2.2	2.0	1.7	3.1	3.4	0.9	1.4	2.2	2.1
	Assault				4.2	2.9	6.9	21.3	11.9	1.1	1.3	16.6	9.3

(continued)

Table A.1 continued: Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
43	Standardised hospital separations ratios for:	172	AIHW	03–04									
	Respiratory disease				1.6	1.2	1.8	3.4	2.6	0.4	0.5	3.4	2.1
	Pneumonia				2.1	1.5	3.1	6.7	5.0	0.3	0.9	9.8	4.0
	Lung cancer				1.4	1.3	1.5	2.1	2.2	n.p.	n.p.	2.3	1.7
44	Standardised hospital separations ratios for:	179	AIHW	03–04									
	Diabetes as a principal diagnosis				2.6	2.7	5.2	6.5	7.1	1.0	1.0	7.1	4.6
	Diabetes as an associated diagnosis				3.2	3.2	5.6	9.7	9.2	0.8	2.1	7.6	5.7
	Diabetes as a principal or an associated diagnosis				3.1	3.1	5.4	8.9	8.7	0.8	1.9	7.2	5.4
45	Standardised hospital separation ratios for tympanoplasty for otitis media	186	AIHW	03–04	1.0	n.p.	1.9	13.9	2.1	n.p.	n.p.	7.5	3.8
46	Standardised hospital separations ratios for:	188	AIHW	03–04									
	Depressive disorders				1.2	1.1	0.7	1.4	2.6	0.4	0.6	1.0	1.0
	Anxiety disorders				1.3	1.1	1.1	2.1	3.7	0.9	0.7	0.4	1.3
	Substance use disorders				4.9	2.8	2.9	5.7	5.1	0.8	12	1.1	3.7
	Psychotic disorders				n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
48	Stillbirths to Aboriginal and Torres Strait Islander mothers per 1,000 births	197	AIHW	00–02	11.0	15.5	12.3	12.9	18.0	n.p.	n.p.	13.3	n.p.
49	Probability of dying before age 55 years:	198	ABS	96–01									
	Males				0.30	0.30	0.34	0.35	0.35	0.30	0.30	0.37	0.33
	Females				0.20	0.20.	0.26	0.18	0.18	0.20	0.20.	0.21	0.22

(continued)

Table A.1 (continued): Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
50	Age-specific all cause death rates per 1,000:	200	AIHW	01–03									
	Males												
	0–4 years				n.p.	n.p.	3.2	3.3	1.5	n.p.	n.p.	4.9	n.p.
	5–24 years				n.p.	n.p.	0.8	1.2	1.0	n.p.	n.p.	1.7	n.p.
	25–44 years				n.p.	n.p.	4.5	4.8	5.4	n.p.	n.p.	10.0	n.p.
	45–64 years				n.p.	n.p.	16.2	16.7	19.8	n.p.	n.p.	25.0	n.p.
	65 years and over				n.p.	n.p.	59.0	60.8	51.5	n.p.	n.p.	82.3	n.p.
	Females												
	0–4 years				n.p.	n.p.	2.0	3.5	2.5	n.p.	n.p.	4.1	n.p.
	5–24 years				n.p.	n.p.	0.5	0.5	0.3	n.p.	n.p.	0.9	n.p.
	25–44 years				n.p.	n.p.	2.0	3.0	2.9	n.p.	n.p.	5.2	n.p.
	45–64 years				n.p.	n.p.	10.1	11.1	11.0	n.p.	n.p.	15.5	n.p.
	65 years and over				n.p.	n.p.	49.5	41.2	36.8	n.p.	n.p.	58.4	n.p.
51	Standardised mortality ratios for all causes by sex:	203	AIHW	01–03									
	Males				n.p.	n.p.	2.9	3.2	3.3	n.p.	n.p.	5.2	n.p.
	Females				n.p.	n.p.	3.2	3.6	3.2	n.p.	n.p.	5.4	n.p.
52	Standardised mortality ratios for:	206	AIHW	01–03									
	(a) Circulatory diseases				n.p.	n.p.	4.4	4.0	4.5	n.p.	n.p.	6.7	n.p.
	(b) Coronary heart disease				n.p.	n.p.	4.9	3.8	5.0	n.p.	n.p.	6.5	n.p.
	(c) Rheumatic fever and rheumatic heart disease				n.p.	n.p.	17.1	13.3	n.p.	n.p.	n.p.	55.9	n.p.

(continued)

Table A.1 (continued): Summary of quantitative indicators

No.	Performance indicator	Page	Source	Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
53	Standardised mortality ratios for:	213	AIHW	01–03									
	Injury and poisoning				n.p.	n.p.	2.5	2.8	3.4	n.p.	n.p.	4.9	n.p.
	Transport accidents				n.p.	n.p.	1.5	3.0	5.0	n.p.	n.p.	5.7	n.p.
	Other accidents				n.p.	n.p.	2.5	3.5	2.1	n.p.	n.p.	2.5	n.p.
	Self-harm				n.p.	n.p.	3.0	1.3	2.7	n.p.	n.p.	4.2	n.p.
	Assault				n.p.	n.p.	5.0	7.0	7.2	n.p.	n.p.	17.2	n.p.
54	Standardised mortality ratios for:	224	AIHW	01–03									
	Respiratory disease				n.p.	n.p.	5.4	5.5	6.6	n.p.	n.p.	10.0	n.p.
	Pneumonia				n.p.	n.p.	7.9	14.7	9.7	n.p.	n.p.	12.0	n.p.
	Cancer of the lung, trachea and bronchus				n.p.	n.p.	2.4	1.6	1.3	n.p.	n.p.	2.9	n.p.
55	Standardised mortality ratios for:	231	AIHW	01–03									
	Diabetes as the underlying cause				n.p.	n.p.	13.9	16.7	15.6	n.p.	n.p.	22.0	n.p.
	Diabetes as an associated cause				n.p.	n.p.	9.3	9.0	9.2	n.p.	n.p.	10.7	n.p.
	Diabetes as an underlying or associated cause				n.p.	n.p.	10.7	11.4	11.2	n.p.	n.p.	14.2	n.p.
56	Standardised mortality ratios for cervical cancer	238	AIHW	01–03	n.p.	n.p.	7.4	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.

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

Notes

1. There were no data or information included in the report for indicator numbers 3, 27, 33, 34 and 36.
2. There were no data included in this table for indicator numbers 1, 12, 13, 14, 19, 24 and 25 as the data provided in the report were mainly qualitative.

Symbols used in the table:

n.p.(shaded)	Not published because of data quality issues
—	Rounded to zero
0	Zero
. .	Not applicable
n.a.	Not available

Abbreviations

ABS	Australian Bureau of Statistics
ABSTUDY	Aboriginal and Torres Strait Islander Study Assistance Scheme
ACAP	Aboriginal Cultural Awareness Program
ACCHO	Aboriginal Community Controlled Health Organisations
ACCHS	Aboriginal Community Controlled Health Services
AEP	National Aboriginal and Torres Strait Islander Education Policy
AFB	Away-from-base
AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
AIMHI	Australian Integrated Mental Health Initiative
ALO	Aboriginal Liaison Officer
AMSANT	Aboriginal Medical Services Alliance Northern Territory
APHCAP	Aboriginal Primary Health Care Access Program
APY	Anangu Pitjantjatjara Yankunytjatjara
ATSI	Aboriginal and Torres Strait Islanders
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIPHCS	Aboriginal and Torres Strait Islander Primary Health Care Services
BDM	Births, Deaths and Marriages
BMI	Body mass index
CACP	Community Aged Care Package
CARPA	Central Australia Rural Practitioners Association
CAP	Cultural Awareness Program
CAT	Cultural Awareness Training
CCDPHA	Centre for Chronic Disease Prevention and Health Advancement
CEO	Chief executive officer
CHINS	Community Housing Infrastructure Needs Survey
CIP	Continuous Improvement Projects for the early detection and management of chronic diseases for Aboriginal and Torres Strait Islander people
CMI	Client Master Index
COOL	Cultural Orientation Online Learning
COPD	Chronic Obstructive Pulmonary Disease
DAARE	Department of Aboriginal Affairs and Reconciliation
DEST	Department of Education, Science and Training
DHAC	District Health Advisory Council

DHCS	Department of Health and Community Services
DoHA	Australian Government Department of Health and Ageing
e-DC	Electronic Death Certificate
EEO	Equal Employment Opportunity
EMPHC	Enhanced Model of Primary Health Care
FTE	Full-Time Equivalent
GP	General Practitioner
GPC	Government Purpose Classification
HARP	Hospital Admissions Risk Program
Hib	*Haemophilus influenzae* type b
HIC	Health Insurance Commission
HPF	Health Performance Framework
ICD	International Classification of Diseases
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IESIP	Indigenous Education Strategic Initiatives Programme
IIMS	Incident Information Management System
IT	Information Technology
KHLO	Koori Hospital Liaison Officer
NACCHO	National Aboriginal Community Controlled Health Organisations
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NFWRHS	North and Far Western Regional Health Service
NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NNDSS	National Notifiable Disease Surveillance System
NPHEP	National Public Health Expenditure Project
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
OATSIH	Office for Aboriginal and Torres Strait Islander Health
Pap	Papanicolaou (cervical test)
PBS	Pharmaceutical Benefits Scheme
PCP	Primary Care Partnership
PHCAP	Primary Health Care Access Program
PIR	Patient Information and Recall (System)
RBDM	Registrar of Births, Deaths and Marriages
RSE	Relative Standard Error
SAAHP	South Australian Aboriginal Health Partnership

SAR	Service Activity Reporting
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
SHCI	Sharing Health Care Initiative
SIMC	Statistical Information Management Committee
STI	Sexually Transmissible infection
SWSBSC	Strong Women, Strong Babies, Strong Culture
TIP	Targeted Initiative Program
VAED	Victorian Admitted Episodes Data
VCR	Victorian Cancer Registry
VET	Vocational education and training
VicHealth	Victorian Health Promotion Foundation
WIES	Weighted Inlier Equivalent Separation

Symbols

$	Australian dollars, unless otherwise specified
$m	million dollars
dB	decibel
kg	kilogram
Hz	hertz
kHz	kilohertz
km	kilometre
n.a.	not available
n.p.	not published due to data quality issues
. .	not applicable
—	nil or rounded to zero

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