

# Determinants of health—social equity

## **Indicator 5**

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## 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
<b>Indigenous (1996–2001)</b>		
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
<b>Australia</b>	<b>59.4</b>	<b>64.8</b>
<b>Total Australian (1999–2001)</b>		
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
<b>Australia</b>	<b>77.0</b>	<b>82.4</b>

*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

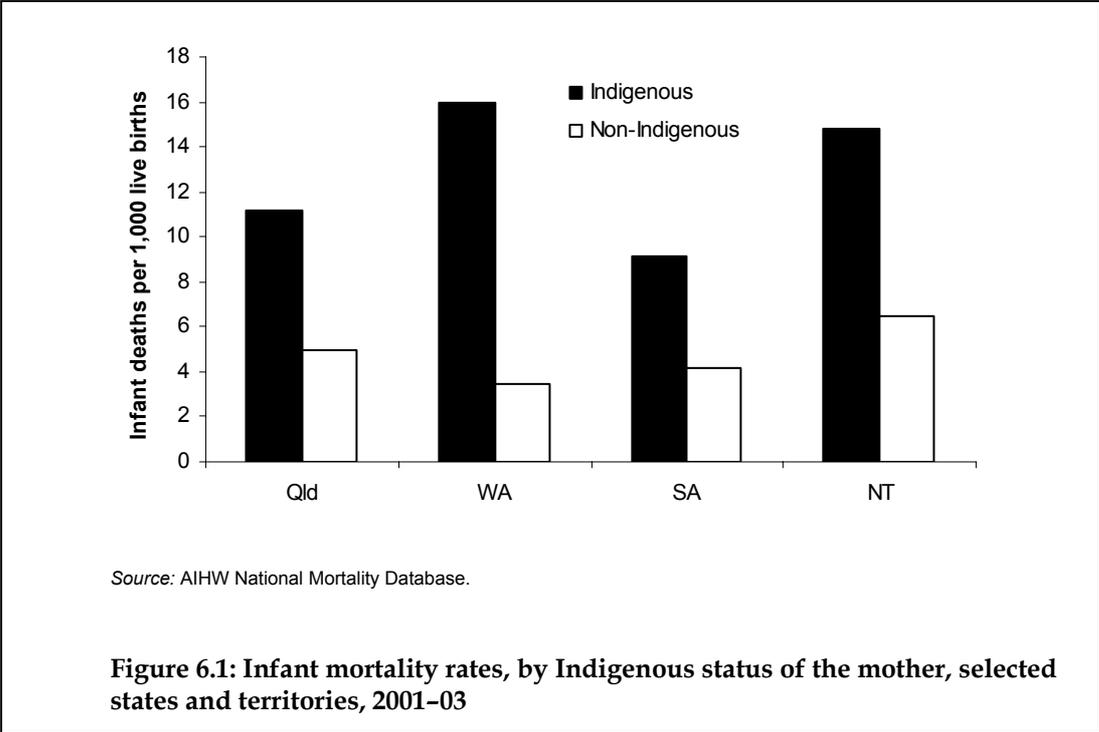
**Indicator:** The number of deaths of infants (children less than 1 year old) born to Aboriginal and Torres Strait Islander mothers, per 1,000 live births to Aboriginal and Torres Strait Islander mothers.

## 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

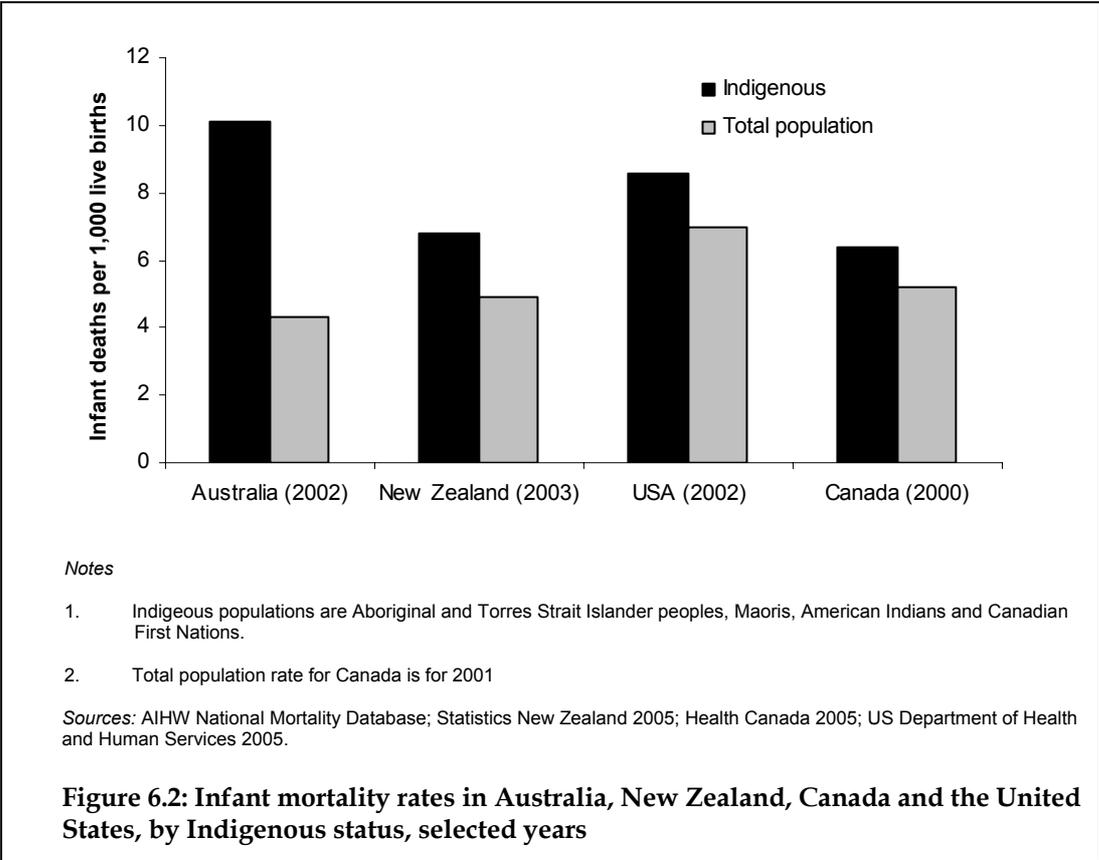
Information for this indicator was obtained from the AIHW National Mortality Database. The quality of the data on deaths of infants varies across states and territories and only data for Queensland, South Australia, Western Australia and the Northern Territory were considered to be sufficient to calculate 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.



- 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.



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
<b>Less than 20th percentile</b>									
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
<b>Less than 50th percentile</b>									
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 <sup>(a)</sup>				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
<b>Aust.</b>	<b>4,700</b>	<b>5,200</b>	<b>398,100</b>	<b>445,300</b>	<b>27.1</b>	<b>29.0</b>	<b>64.1</b>	<b>73.1</b>

\* 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 <sup>(a)</sup>
<b>Indigenous (%)</b>									
Employed <sup>(a)</sup>	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
<i>Total in the labour force</i>	<i>64.5</i>	<i>60.6</i>	<i>65.6</i>	<i>66.1</i>	<i>63.1</i>	<i>64.6</i>	<i>73.7</i>	<i>58.1</i>	<i>64.0</i>
Not in the labour force	35.5	39.4	34.4	33.9	36.9	35.4	26.3	41.9	36.0
<b>Total</b>	<b>100.0</b>								
<b>Non-Indigenous (%)</b>									
Employed <sup>(a)</sup>	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
<i>Total in the labour force</i>	<i>78.8</i>	<i>78.8</i>	<i>78.5</i>	<i>79.2</i>	<i>77.0</i>	<i>73.2</i>	<i>83.5</i>	<i>88.1</i>	<i>78.7</i>
Not in the labour force	21.2	21.2	21.5	20.8	23.0	26.8	16.5	11.9	21.3
<b>Total</b>	<b>100.0</b>								

\* 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 <sup>(a)</sup>
<b>Sewerage</b>								
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
<b>Water</b>								
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
<b>Electricity</b>								
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
<b>Total<sup>(b)</sup></b>	<b>1,325</b>	<b>42</b>	<b>4,030</b>	<b>2,978</b>	<b>1,071</b>	<b>30</b>	<b>7,173</b>	<b>16,649</b>

(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 <sup>(a)</sup>		Age-standardised rate <sup>(a)</sup>		Rate ratio <sup>(b)</sup>
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	
NSW <sup>(c)</sup>	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 <sup>(d)</sup>	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
<b>Australia</b>	<b>5,048</b>	<b>18,776</b>	<b>1,851.9</b>	<b>124.3</b>	<b>1,413.9</b>	<b>126.7</b>	<b>11.2</b>

(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-auspicings 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.*