CHAPTER 10

HEALTH SERVICES—PROVISION, ACCESS AND USE

INTRODUCTION

There is some evidence that Aboriginal and Torres Strait Islander people do not have the same level of access to many health services as other Australians and this can adversely impact on their health outcomes. The relatively poor health status and high mortality and morbidity rates among Indigenous Australians points to the need for more health services and a greater per capita investment of health resources for this population. Indigenous people face a number of barriers in accessing health care, including language and cultural barriers, distance to services, and the cost or services. Aboriginal and Torres Strait Islander people are under-represented in health-related occupations and in graduate courses in health. While Indigenous people were twice as likely as other Australians to be hospitalised, they were less likely to undergo a procedure once admitted to hospital.

Health services include primary health care services such as those provided by general medical practitioners (GPs), nurses and allied health professionals. They also include acute care provided in hospitals, and specialist services, such as those provided by obstetricians and eye specialists among others. These services are provided in a range of settings including community health centres, doctors' and specialists' rooms and hospitals. Aboriginal health services, which operate across Australia, are also important providers of comprehensive primary health services for Indigenous Australians, particularly in more remote areas. These services have funding provided by the Australian Government, the state and territory governments, or both.

This chapter presents analyses of various data collections in order to provide a comprehensive picture of Indigenous Australians' access to, and use of, health services. Health expenditure patterns show how health services are delivered and used. Some of the factors that impact on access to and use of health services are then examined, including cultural factors, such as language; availability of health professionals; the distances clients must travel to services and facilities; affordability of health services; and the participation of Indigenous people in the health and welfare workforce. The chapter also includes information on the use of health services, including Australian Government funded Aboriginal primary health care services, services provided by GPs, alcohol and other drug treatment services, mental health services and hospital services.

It is not always possible to accurately quantify the extent to which Aboriginal and Torres Strait Islander people access and use different health services. The administrative data on health services are collected by the various providers including Australian, state and territory governments, community organisations and private sector providers. There are, however, variations in the quality and coverage of these data, and in the accuracy with which Indigenous people are identified in various health service records.

PROVISION OF HEALTH SERVICES

Expenditure on health goods and services

Examining expenditure on health goods and services is one way of understanding the ways in which health resources are delivered and used. Expenditures reflect needs on which resources have been spent, rather than overall needs or needs that have not been met. Expenditures can also provide some broad insights into the use of health services. But any such interpretation must be undertaken with care, because the amount of expenditure incurred for a given level of use can also be affected by factors such as the demographic composition of the population and its geographic distribution. Thus, information about expenditure must be considered alongside the information about the numbers, types and locations of services that are presented in this and other chapters of this report.

In 2004–05, estimated expenditure on health goods and services for Indigenous Australians was $2,304 million or 2.8% of total health expenditure (table 10.1). More than two-thirds (67%) of the 2004–05 expenditure was on publicly provided health services such as public hospitals (46%) and community health services (22%).

10.1 EXPENDITURE ON HEALTH GOODS AND SERVICES, by area of expenditure, current prices—2004–05

	TOTAL EXPENDITURE ($M)		AVERAGE PER PERSON EXPENDITURE ($)		
Service	*Indigenous*	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*	*Ratio*(a)
Hospitals	1 080.7	27 337.6	2 213	1 386	1.6
Public hospital services(b)	1 048.6	21 042.7	2 147	1 067	2.0
Admitted patient services	799.4	16 226.8	1 637	823	2.0
Non-admitted patient services	249.2	4 815.8	510	244	2.1
Private hospitals	32.1	6 295.0	66	319	0.2
High-level residential care	41.7	6 283.4	85	319	0.3
Patient transport	103.5	1 369.9	212	69	3.1
Medical services	164.6	14 483.5	337	734	0.5
Community health services	497.8	3 052.7	1 019	155	6.6
Dental and other health practitioners	78.0	7 811.8	160	396	0.4
Medications	109.4	11 056.4	224	561	0.4
Aids and appliances	18.6	2 591.4	38	131	0.3
Public health	88.9	1 350.3	182	68	2.7
Research	46.0	1 669.0	94	85	1.1
Health administration n.e.c.	74.6	2 254.5	153	114	1.3
Total	**2 304.0**	**79 260.4**	**4 718**	**4 019**	**1.2**

(a) Average per person expenditure on Indigenous Australians divided by the average per person expenditure on other Australians.

(b) Excludes any dental services, community health services, patient transport services, public health and health research undertaken by the hospital.

Source: AIHW 2008a

On a per person basis, average expenditure on health goods and services for Aboriginal and Torres Strait Islander people was $4,718—some 17% higher than the expenditure for non-Indigenous people ($4,019). Considering the high level of morbidity among Indigenous Australians, and mortality rates that are more than twice those for other Australians, these figures suggest that expenditures for Aboriginal and Torres Strait Islander people were not sufficient to match needs (AHMAC 2006).

In 2004–05, average expenditure on services for Indigenous people was greater than that for non-Indigenous Australians in a number of program areas. These included community health services (where average expenditure on Indigenous people was 6.6 times higher than for non-Indigenous people), patient transport (over 3.1 times

Expenditure on health goods and services *continued*

higher) and public health, including prevention of hazardous and harmful drug use, cancer screening and environmental health (2.7 times higher) (table 10.1).

In contrast, average expenditure on some goods and services provided outside public hospitals was lower for Indigenous Australians than for non-Indigenous Australians. For example, average expenditures on high level residential care, medical services, medications, and dental and other health practitioners were less than half of that for non-Indigenous Australians.

Over the nine years to 2004–05, expenditure on health services on a per person basis for Aboriginal and Torres Strait Islander people has been between 14% and 20% higher than for other Australians (AIHW 2008a). A number of factors should be noted when reviewing changes over time, including that the methodology for developing estimates has changed. Thus, caution should be exercised when interpreting changes in expenditures over time.

ACCESS TO HEALTH SERVICES

Differences in the utilisation of health care services by Indigenous and other Australians may be related to differences in health care status, differing levels of service provision and/or barriers to accessing services. In some areas services may not be available, or where they are available, access for Indigenous people may be affected by distance to services, lack of transport, the cost of health care and/or language and cultural barriers. These factors may result in Indigenous Australians not accessing health care when needed.

Information on use of health care services when needed by Aboriginal and Torres Strait Islander people was collected in the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS); a survey of around 10,400 Indigenous Australians of all ages. In 2004–05, one in seven Indigenous Australians (15%) reported that they needed to go to a doctor in the previous 12 months, but had not gone; 8% needed to go to another type of health professional (e.g. nurse, Aboriginal health worker), but had not gone; 7% needed to go to a hospital, but had not gone; and 21% needed to go to a dentist, but had not gone (table 10.2).

Indigenous people in non-remote areas were more likely than those in remote areas to report that they had needed to go to a doctor, other health professional or dentist, but had not gone (AHMAC 2006). Indigenous females were more likely than Indigenous males to report that they had needed to go to a doctor or a dentist, but had not gone.

10.2 INDIGENOUS PERSONS WHO DID NOT ACCESS HEALTH SERVICES WHEN NEEDED(a), by remoteness and sex—2004–05

	REMOTENESS				SEX					
	Non-remote		*Remote*		*Male*		*Female*		*Total*	
	'000	%	'000	%	'000	%	'000	%	'000	%
Needed to go to a doctor but didn't	57.7	16.6	12.0	9.5	29.4	12.7	40.2	16.6	69.7	14.7
Needed to go to other health professional but didn't	29.7	8.5	6.0	4.7	16.0	6.9	19.7	8.1	35.7	7.5
Need to go to a hospital but didn't	23.0	6.6	8.8	7.0	15.4	6.6	16.4	6.8	31.8	6.7
Needed to go to a dentist but didn't(b)	74.1	22.4	18.9	15.6	40.5	18.2	52.4	22.8	92.9	20.5

(a) In the previous 12 months.
(b) Persons aged two years and over. Other categories include all Indigenous persons.

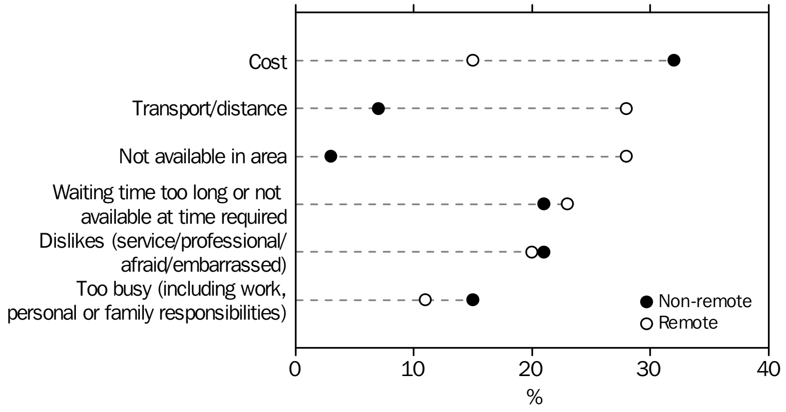
Source: ABS 2004–05 NATSIHS

ACCESS TO HEALTH SERVICES *continued*

The 2004–05 NATSIHS also collected information on the reasons that Indigenous people did not use health care services when needed, and on barriers to access. Factors such as transport and distance, long waiting times and cost were reported by a high proportion of those who had not seen a doctor when needed (AHMAC 2006).

While a higher proportion of Indigenous people in non-remote areas reported cost as a reason for not seeking health care when needed, transport/distance and the service not being available in the area were more commonly given as reasons by people in remote areas. For example, cost was reported as a reason for not seeing a dentist when needed by 32% of respondents in non-remote areas, compared with 15% of those in remote areas (graph 10.3). On the other hand, respondents in remote areas were much more likely than those in non-remote areas to report transport/distance (28% compared with 7%), or a service not being available in the area (28% compared with 3%) as reasons for not seeing a dentist when needed (AHMAC 2006).

10.3 REASONS FOR NOT VISITING A DENTIST WHEN NEEDED, Indigenous persons aged 2 years and over—2004–05



Source: ABS 2004–05 NATSIHS

Cultural and language barriers

A lack of understanding of Aboriginal and Torres Strait Islander culture, concepts of health and history, and Western-dominated models of care can result in Indigenous Australians feeling disempowered and less likely to use health services (Bailey 2005). According to Anderson et al (2004), Aboriginal and Torres Strait Islander peoples may need a different approach when consulting a GP, because of differences in how Indigenous people respond to illness and how they interact with health care providers.

COMMUNICATING WITH SERVICE PROVIDERS

The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) collected information on whether Indigenous Australians spoke a language other than English at home and whether they had difficulty communicating with service providers. About 14% of Indigenous people aged 15 years and over reported that they spoke a language other than English at home. Indigenous people living in remote areas were much more likely to report speaking an Aboriginal or Torres Strait Islander language at home (39%) than were those living in non-remote areas (2%) (ABS 2004d).

Difficulties in communicating with service providers may also affect treatment choices and treatment outcomes. Around 11% of Indigenous adults reported that they had difficulty understanding and/or being understood by service providers. Indigenous people living in remote areas were more likely than those in non-remote areas to report experiencing difficulty (19% compared with 8%) (ABS & AIHW 2005).

Condon et al (2006) examined the effect of speaking a language other than English on health outcomes in a study about cancer diagnosis and treatment in the Northern Territory. Among Indigenous people diagnosed with cancer, those with an Indigenous first language had a much higher risk of cancer death than English language speakers. Indigenous people were more likely to have a more advanced stage of cancer at diagnosis than non-Indigenous people, and for those whose first language was Indigenous, poorer treatment after diagnosis was also a contributing factor. The authors note that while Indigenous first language may point to possible communication difficulties, it is also 'a marker of social, cultural, economic, educational and geographic factors'.

TREATMENT WHEN SEEKING HEALTH CARE

The 2004–05 NATSIHS asked Indigenous Australians how they felt they were treated when they sought health care in the previous 12 months. The majority (77%) of Indigenous people reported that they felt they were treated the same as non-Indigenous people, 5% reported that they were treated better than non-Indigenous people and 4% reported that they were treated worse than non-Indigenous people (AIHW 2007a). A higher proportion of Indigenous people in remote areas reported that they were treated better than non-Indigenous people (11% compared with 3%). Approximately 16% of Aboriginal and Torres Strait Islander people felt that they were treated badly when they sought health care because they were Indigenous.

Availability of health professionals, services and facilities

Indigenous Australians are more likely to live outside urban areas than non-Indigenous Australians, and are therefore more likely to live further from mainstream health services and health professionals. Aboriginal health services, operating in many parts of the country, including remote areas, go some way towards addressing the differences in health service provision for a more geographically dispersed population. Indigenous people living in more remote areas, however, still do not have access to many of the services provided in urban areas.

LOCATION OF HEALTH PROFESSIONALS

The number of medical practitioners per head of population decreases with increasing geographic remoteness. This limits access to medical practitioners for people in rural and remote areas. As a higher proportion of Indigenous Australians live in rural and remote areas, they are more likely to have to move or travel substantial distances in order to get access to medical care. The supply rate of medical practitioners is measured by the full-time equivalent (FTE) rate per 100,000 population.

In 2005 there were more than twice as many medical practitioners per person in major cities (335 FTE per 100,000) as in remote/very remote areas (148 FTE per 100,000) (table 10.4). The number of medical specialists per person in major cities was eight times that in remote areas. The concentration of primary care practitioners, specialists and specialists in training in major cities and inner regional areas can be partially explained by the location of facilities for services provided by these types of professions.

Between 2002 and 2005, there was a slight increase in the supply of medical practitioners in Australia (from 271 FTE to 288 FTE per 100,000). The increase was spread across all remoteness areas.

Availability of health professionals, services and facilities *continued*

LOCATION OF HEALTH PROFESSIONALS *continued*

10.4 EMPLOYED MEDICAL PRACTITIONERS(a)(b), by remoteness area—2002 and 2005

	Major cities	*Inner regional*	*Outer regional*	*Remote/ Very remote*	*Australia*(c)
		2002			
Clinicians	288	169	138	131	252
Primary care	105	90	80	89	101
Hospital non-specialist	29	14	15	22	25
Specialist	114	55	35	16	95
Specialist in training	40	10	8	5	31
Non-clinicians	24	7	8	9	19
Total (2002)	**312**	**176**	**146**	**140**	**271**
		2005			
Clinicians	311	174	145	133	269
Primary care	100	88	84	92	98
Hospital non-specialist	40	18	13	22	33
Specialist	122	56	38	16	100
Specialist in training	49	12	10	4	37
Non-clinicians	24	7	8	14	19
Total (2005)	**335**	**181**	**153**	**148**	**288**

(a) Rate per 100,000 population; FTE rate: full time equivalent rate is based on a standard full-time working week of 45 hours.

(b) The FTE rates by Remoteness Areas are underestimates as they do not include medial practitioners who did not provide information on the location of their main job, whereas the Australian estimates are based on all employed medical practitioners. Care should be taken in interpreting the data by Remoteness Areas, particularly for the Remote/Very remote areas as there are large numbers of missing values.

(c) Includes medical practitioners who did not report the remoteness areas in which they worked.

Source: AIHW Medical Labour Force Survey 2002, 2005

The pattern across remoteness areas was different for nurses compared with medical practitioners. In 2005, the supply rate of nurses was highest in very remote areas (1,177 FTE per 100,000) and second highest in outer regional areas (1,139 FTE), while major cities had the lowest rate of nursing supply (1,074 FTE) (table 10.5). Between 2001 and 2005, the supply of nurses in Australia increased from 1,031 to 1,133 FTE per 100,000 population.

Availability of health professionals, services and facilities continued

LOCATION OF HEALTH PROFESSIONALS *continued*

10.5 EMPLOYED NURSES(a)(b)—2001 and 2005

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very Remote*	*Australia*(c)
Nurses (2001)	940	947	910	896	925	1 031
Nurses (2005)	1 074	1 107	1 139	1 081	1 177	1 133

(a) Rate per 100,000 population; FTE rate: full time equivalent rate is based on a standard full time working week of 35 hours.

(b) The FTE by Remoteness Areas are underestimates as they do not include nurses who did not provide information on the location of their main job, whereas the Australian estimates are based on all employed nurses.

(c) Includes nurses who did not report information on location of main job.

Source: AIHW 2001, 2005 Nursing Labour Force Survey

PEOPLE LIVING IN DISCRETE INDIGENOUS COMMUNITIES

Detailed information about the distance to, and the availability of, health facilities and health professionals for people living in discrete Indigenous communities is collected in the ABS Community Housing and Infrastructure Needs Survey (CHINS). The 2006 CHINS collected data from a total of 1,187 discrete Indigenous communities with a combined population of approximately 92,960 (ABS 2007d). Approximately 87% of the Indigenous people in these communities were living in remote and very remote parts of Australia. Nearly three-quarters (73%) of all communities included in the CHINS reported a usual population of less than 50.

Health facilities

The 2006 CHINS collected data on access by all communities to three types of health facilities—hospitals, Aboriginal Primary Health Care Centres and other (state funded) community health centres. These questions were asked separately for each community.

There were 10 discrete communities (with a usual population of 14,090) that had a hospital located within the community, and another 89 communities (with a usual population of 7,743) that had a hospital located within 10 kilometres of the community (table 10.6). Over half (56%) of the people living in discrete Indigenous communities (51,992 people in 755 communities) were located 100 kilometres or more from the nearest hospital.

There were 107 discrete communities (with a usual population of 41,450) that had an Aboriginal primary health care centre within the community, and 104 communities (with a usual population of 7,743) that were located within 10 kilometres of such a centre. Over one-quarter of those living in discrete Indigenous communities (27% or 25,486 people) were located 100 kilometres or more from the nearest Aboriginal primary health care centre (table 10.6).

Availability of health professionals, services and facilities continued

Health facilities continued

There were 104 discrete communities (with a usual population of 35,737) that had some other (generally state funded) community health centre located in the community and 113 communities (with a usual population of 8,101) that were located within 10 kilometres of such a centre. One-quarter of people living in discrete Indigenous communities were located 100 kilometres or more from the nearest other (state funded) community health centre (table 10.6).

10.6 ACCESS TO HEALTH FACILITIES, Discrete Indigenous communities—2006

	Communities		Usual population	
Type of facility and location	no.	%	no.	%
Hospital				
Located in community	10	0.8	14 090	15.2
Within 10km	89	7.5	7 743	8.3
10–99km	224	18.9	18 368	19.8
100km or more	755	63.6	51 992	55.9
Aboriginal Primary Health Care Centre				
Located in community	107	9.0	41 450	44.6
Within 10km	104	8.8	7 743	8.3
10–99km	426	35.9	13 438	14.5
100km or more	417	35.1	25 486	27.4
Other community health centre				
Located in community	104	8.8	35 737	38.4
Within 10km	113	9.5	8 101	8.7
10–99km	463	39.0	16 241	17.5
100km or more	372	31.3	23 308	25.1
Total(a)	**1 187**	**100.0**	**92 960**	**100.0**

(a) Includes those with access not stated.
Source: ABS 2006 CHINS

Of the 755 discrete Indigenous communities that were located 100 km or more from the nearest hospital, 268 (35%) reported having access to a medical emergency air service. The remaining 487 communities (with a usual population of 9,337), did not have access to a medical emergency air service.

Availability of health professionals

While location of health services provides one measure of access, people in communities may also have access to visiting health professionals or health workers. The CHINS collected information for all communities on the availability of services from four types of health professionals—doctors, registered nurses and female and male Indigenous health workers.

In 2006, there were 14 communities (with a usual population of 11,344) who had daily access to a doctor and another 162 (with a usual population of 37,447) with weekly to monthly access (table 10.7). Around four in ten people usually resident in these communities (39,759 people or 43%), did not have regular access to a doctor.

People living in discrete Indigenous communities had greater access to registered nurses than to doctors. There were 120 communities (with a usual population of 44,923) that had daily access to a nurse and another 81 communities (with a usual population of

Availability of health professionals, services and facilities continued

Availability of health professionals continued

9,717) with weekly or monthly access to a nurse. There were 37,237 people (40%) living in communities that did not have regular access to a registered nurse.

Some 15% of communities had access to a female health worker at least monthly and 11% had access to a male health worker at least monthly.

10.7 ACCESS TO SELECTED HEALTH PROFESSIONALS, Discrete Indigenous communities—2006

Type of professional and frequency of access	Communities		Usual population	
	no.	%	no.	%
Doctor				
Daily	14	1.2	11 344	12.2
Weekly to monthly	162	13.6	37 447	40.3
3 monthly or less	16	1.3	4 410	4.7
No access/not stated	995	83.8	39 759	42.8
Registered nurse				
Daily	120	10.1	44 923	48.3
Weekly to monthly	81	6.8	9 717	10.5
3 monthly or less	10	0.8	1 083	1.2
No access/not stated	976	82.2	37 237	40.1
Female Indigenous health worker				
Daily	121	10.2	45 587	49.0
Weekly to monthly	52	4.4	4 611	5.0
3 monthly or less	7	0.6	939	1.0
No access/not stated	1 007	84.8	41 823	45.0
Male Indigenous health worker				
Daily	75	6.3	34 300	36.9
Weekly to monthly	57	4.8	6 322	6.8
3 monthly or less	16	1.3	2 354	2.5
No access/not stated	1 039	87.5	49 984	53.8
Total(a)	**1 187**	**100.0**	**92 960**	**100.0**

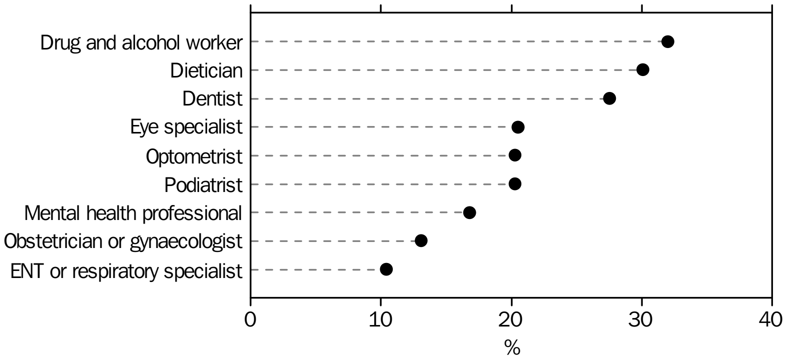
(a) Includes those with access not stated.
Source: ABS 2006 CHINS

Community access to other selected health professionals (such as dentists, obstetricians, optometrists) was collected from communities with a population of 50 or more and all communities with a population of 50 or less that were self-administered (375 communities in total). Access could be anything from daily to less than three-monthly visits, or visits as required. Around one-third (32%) of the communities surveyed reported having access to a drug and alcohol worker, 113 communities (30%) had access to a dietician and 103 communities (27%) had access to a dentist (graph 10.8). A much smaller proportion of communities reported having access to an obstetrician or gynaecologist (13%), and ear, nose and throat or respiratory specialist (10%).

Availability of health professionals, services and facilities *continued*

Availability of health professionals *continued*

10.8 ACCESS TO SELECTED HEALTH PROFESSIONALS, Discrete Indigenous communities(a)—2006



(a) Communities with a population of 50 or more and those with a population of less than 50 that were self-administered

Source: ABS 2006 CHINS

TRANSPORT

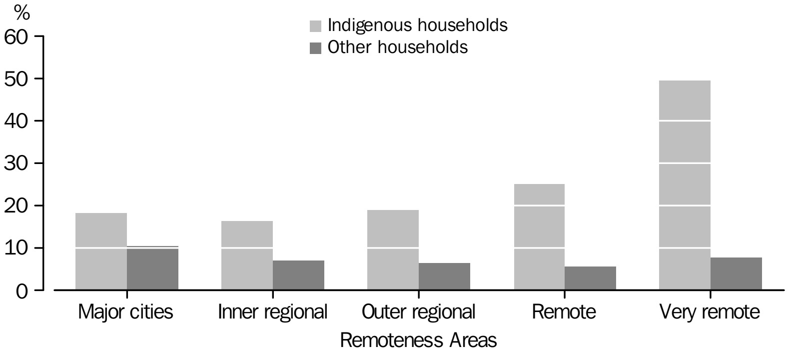
Distance to various health services provides one measure of access, but lack of transport may mean that comparatively short distances are an impediment to service use. Lack of transport can impact on people living in both remote and non-remote areas. Data are available from the 2006 Census (for all Indigenous households) on the number of motor vehicles owned or used by household members and garaged or parked at or near the dwelling on Census night.

The 2006 Census shows that Indigenous households were more likely than other households to be without access to a motor vehicle (graph 10.9). The proportion of Indigenous households that did not have a motor vehicle was 21%, compared with 9% for other households. These proportions were similar to those reported in the 2001 Census (23% and 9% respectively). Indigenous households in remote and very remote areas were less likely than those in non-remote areas to have ready access to a motor vehicle.

Availability of health professionals, services and facilities continued

TRANSPORT *continued*

10.9 HOUSEHOLDS WITHOUT A MOTOR VEHICLE(a), by Remoteness Areas—2006



(a) Owned or used by household members and garaged or parked at or near their dwelling on Census Night.

Source: ABS 2006 Census of Population and Housing

In the 2004–05 NATSIHS, difficulty with transport/distance was reported as the main reason that Indigenous Australians didn't visit the following services when needed in the previous 12 months—a hospital (19%), doctor (14%) and other health professional (8%). Around one in ten Indigenous people (11%) reported transport/distance as the main reason for not visiting a dentist when needed in the previous 12 months. A higher proportion of Indigenous people living in remote areas than in non-remote areas reported transport/distance as a reason for not accessing health services.

AFFORDABILITY

Many health services provided outside of public hospitals involve direct out-of-pocket payments by patients. This has a greater impact on access to health services for people with limited economic means and, given the generally poorer economic position of Aboriginal and Torres Strait Islander people (see Chapter 2), the effect is likely to be greater on Indigenous Australians than on other Australians.

Services which require out-of-pocket payments include those provided by dentists, physiotherapists, psychologists and other health professionals not covered by Medicare or not provided as part of a comprehensive primary health care service. It also includes pharmaceuticals not covered by the Pharmaceutical Benefits Scheme (PBS). In addition medical services subsidised under Medicare can attract co-payments if they are not bulk-billed. In the December quarter 2006, 72% of medical services were bulk-billed (DoHA 2007b). In 2005–06, GP bulk-billing rates were higher in capital cities than in rural or remote areas (SCRCSSP 2007b). Regardless of location, all Australian Government funded Aboriginal Community Controlled Health Services that have doctors or allied health workers can apply to be covered by Medicare and patients using these services are bulk-billed.

Availability of health professionals, services and facilities *continued*

AFFORDABILITY *continued*

The 2004–05 NATSIHS collected information on whether people in non-remote areas were required to make a co-payment for their last visit to a medical practitioner or other health professional. Around 15% of Indigenous people in non-remote areas were required to make a co-payment to the doctor, 37% were required to make a co-payment to a specialist and 17% were required make a co-payment to other health professionals (AIHW 2007a).

People who are prescribed drugs under the PBS are also required to make out-of-pocket co-payments. The amount that a patient pays is adjusted to some extent in accordance with the patient's ability to pay. Different co-payments apply to concession card holders, pensioners and general patients. The PBS also has safety net provisions that protect individuals and families from large overall expenses for PBS medicines.

PRIVATE HEALTH INSURANCE

Lack of health insurance is a barrier to accessing private hospitals and the services of those health professionals who work solely or primarily within the private health system. In the 2004–05 NATSIHS and 2004–05 NHS, a much higher proportion of Indigenous than non-Indigenous Australians in non-remote areas reported that they were not currently covered by private health insurance (83% compared with 49%) (AIHW 2007a).

The large gap in private health insurance coverage between Indigenous and other Australians is due, at least in part, to the relative economic disadvantage of Indigenous Australians. The most common reasons reported by Indigenous Australians for not getting private health insurance were that they could not afford it (65%), and that they felt that Medicare cover was sufficient (19%) (AIHW 2007a).

TELEPHONE

A working telephone in the home is often considered a necessity in cases of emergency so that health services such as hospitals, ambulances and doctors can be contacted quickly. People without a working telephone in the home are less equipped to seek medical help when required. Of those surveyed in the 2002 NATSISS, 71% of Indigenous Australians aged 15 years and over reported having a working telephone in their home. Indigenous people living in non-remote areas were almost twice as likely to have a working telephone (82%) as those living in remote areas (43%) (ABS 2004d).

CURRENT AND FUTURE INDIGENOUS HEALTH AND WELFARE/COMMUNITY SERVICES WORKFORCE

The availability of Aboriginal and Torres Strait Islander staff is an important factor in whether or not Indigenous people are able to effectively access health services (Kowanko et al 2003; Ivers et al 1997). One of the objectives of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (Australian Health Ministers' Advisory Council) is to increase the number of Aboriginal and Torres Strait Islander people working across all the health professions (SCATSIH 2002).

There are a number of sources of information about the participation of Indigenous Australians in the health workforce and in higher education courses in health and welfare-related fields. These include the ABS Census of Population and Housing, the Australian Government Department of Education, Employment and Workplace Relations (DEEWR) Higher Education Student Statistics Collection, the AIHW Medical and Nursing

CURRENT AND FUTURE INDIGENOUS HEALTH AND WELFARE/COMMUNITY SERVICES WORKFORCE *continued*

Labour Force Surveys, and DoHA's Service Activity Reporting (SAR). These data sources vary in coverage and not all of them have accurate and consistent recording of Indigenous status. For example, in the Medical Labour Force Survey, most jurisdictions use a simplified version of the standard ABS question on Indigenous status (yes/no response). Because of the issues around the quality of Indigenous identification, information from this survey has not been presented here. Data in this section therefore come from the 2006 Census of Population and Housing, the Nursing and Midwifery Labour Force Census, SAR and the Higher Education Student Statistics Collection.

The health workforce

Indigenous people represent 1.9% of the total population aged 15 years and over. In 2006, there were 4,891 Aboriginal and Torres Strait Islanders employed in selected health-related occupations, representing 1% of the health workforce (table 10.10). There were 100 Indigenous medical practitioners in Australia, including 40 who were medical specialists of some kind, representing only 0.2% of people employed in these occupations.

The health occupations with the largest number of Indigenous workers were registered nurse (1,107), Aboriginal and Torres Strait Islander health worker (965) and nursing support worker (442). The health occupations with the highest proportion of Indigenous workers were Aboriginal and Torres Strait Islander health worker (96%), health promotion officer (11%) and environmental health worker (3%). Aboriginal and Torres Strait Islander health workers may be employed as specialists in such areas as alcohol and drug treatment, mental health, diabetes, eye and ear health, and sexual health, or they may work as generalist members of primary care teams, or as hospital liaison officers.

The health workforce continued

10.10 EMPLOYMENT IN SELECTED HEALTH-RELATED OCCUPATIONS, Indigenous persons aged 15 years and over—2006

	Indigenous		*All persons*
Occupation	%	no.	no.
Medical practitioners			
General medical practitioner	0.2	60	29 920
Other -specialist, psychiatrist or surgeon	0.2	40	25 155
Midwifery and nursing professionals			
Midwife	0.4	53	13 164
Nurse educator or researcher	0.5	17	3 762
Nurse manager	0.4	46	10 899
Registered nurse	0.6	1 107	172 575
Health therapy professionals			
Dental practitioner	0.2	16	9 065
Dental hygienist, technician or therapist	0.4	22	5 169
Dental assistant	1.1	171	15 378
Physiotherapist	0.4	54	12 286
Psychologist	0.3	39	13 437
Health and welfare service managers	1.3	141	10 807
Health diagnostic and promotion professionals			
Medical imaging professional	0.2	18	10 147
Environmental health officer	2.5	98	3 907
Occupational health and safety adviser	0.7	50	6 840
Health promotion officer	11.2	437	3 898
Health and welfare support workers			
Aboriginal and Torres Strait Islander health worker	95.5	965	1 010
Ambulance officer or paramedic	1.7	153	9 098
Diversional therapist	1.0	41	4 078
Enrolled or mothercraft nurse	1.1	215	19 397
Massage therapist	0.7	54	8 200
Hospital orderly	1.7	165	9 939
Nursing support worker	2.0	442	22 380
Personal care assistant	1.5	339	21 956
Other nursing support or personal care worker	1.0	39	3 899
Total	**1.0**	**4 891**	**492 342**

Source: ABS 2006 Census of Population and Housing

While the ABS Census provides self-reported information on the number of people employed in health-related occupations, the Nursing and Midwifery Labour Force Census provides information about nurses who have renewed their registration/enrolment with a state or territory nursing and midwifery registration board at the time the Nursing and Midwifery Labour Force Census is conducted. In 2005, the proportions of enrolled and registered nurses who identified as Indigenous were 0.9% and 0.3% respectively (table 10.11).

The health workforce continued

10.11 EMPLOYED REGISTERED AND ENROLLED NURSES, by Indigenous status—2005

	Indigenous		*All persons*(a)
	%	no.	no.
Employed registered nurses	0.3	644	198 315
Employed enrolled nurses	0.9	419	46 044
Total	**0.4**	**1 063**	**244 360**

(a) Includes not stated responses.
Source: AIHW 2008b

The welfare and community services workforce

People employed in welfare and community service-related occupations such as counselling, disability and social work often support the work of other health professionals, and may also be working within the health industry (AIHW 2003b). In 2006, Indigenous people were more likely to report being employed in selected welfare and community service-related occupations than in health-related occupations.

There were 12,411 Indigenous people employed in selected welfare-related occupations in 2006, representing 3.6% of those employed in these occupations. The largest numbers of Indigenous people employed in this sector were teachers' aides (2,011), carers for the aged or people with disability (1,735), child care workers (1,424) and Aboriginal and Torres Strait Islander education workers (1,379) (table 10.12).

Aboriginal and Torres Strait Islander people were well represented among family support workers (16%), youth workers (9%), special care workers (8%) and community workers (7%). Indigenous people also made up 2% of child carers.

The welfare and community services workforce continued

10.12 EMPLOYMENT IN SELECTED WELFARE AND COMMUNITY SERVICE-RELATED OCCUPATIONS, Indigenous persons aged 15 years and over—2006

	Indigenous		All persons
Occupation	%	no.	no.
Welfare workers			
Community worker	7.1	1 270	17 874
Family support worker	15.9	309	1 946
Youth worker	8.6	687	8 024
Other welfare support workers	1.8	228	12 450
Child carers			
Child care worker	2.4	1 424	59 473
Other child carers	2.2	562	25 783
Child care centre and welfare centre managers	1.9	178	9 479
Education aides			
Aboriginal and Torres Strait Islander education worker	91.3	1 379	1 510
Teachers' aide	5.9	2 011	34 316
Other education aides	1.4	303	20 937
Aged or disabled carer	2.2	1 735	77 413
Special care workers	7.8	184	2 354
Other health and welfare support workers	4.4	324	7 432
Welfare, recreation and community arts workers			
Welfare worker	5.7	643	11 270
Other welfare, recreational, community arts workers	5.5	147	2 664
Counsellors	2.6	386	14 646
Minister of religion	0.6	88	14 784
Social professionals	3.4	237	6 908
Social workers	2.2	269	12 441
Social and welfare professionals nfd	5.5	47	849
Total	**3.6**	**12 411**	**342 553**

Source: ABS 2006 Census of Population and Housing

Undergraduate studies in health, welfare and community service-related courses

The future involvement of Indigenous Australians in health and welfare services will be influenced by their current participation in health and welfare-related education. Overall in 2005, 166 Indigenous students completed health-related undergraduate courses, and 83 completed welfare-related courses, representing 1% of all students completing undergraduate courses in these two fields (table 10.13). In the health-related field, the largest proportions of course completions by Indigenous students were in public health (e.g. Environmental Health and Indigenous Health) (47%) and Nursing (29%). In 2005, Indigenous students accounted for 11% of all graduates in the field of public health and less than 1% of nursing graduates. The welfare-related courses most commonly completed by Indigenous students were early childhood education (33%), Behavioural science, which includes psychology (23%) and social work (18%). Indigenous students accounted for around 1% of all early childhood education and social work graduates and less than 1% of behavioural science graduates in 2005.

In 2005, 13 Indigenous students completed a degree in Medical Studies, 48 in Nursing and 78 in Public Health. The number of Indigenous students who completed health-related courses was similar in 2003 and 2005 (168 and 166 respectively). The number of Indigenous students who completed welfare-related courses declined from 124 in 2003 to 83 in 2005.

Undergraduate studies in health, welfare and community service-related courses continued

10.13 INDIGENOUS STUDENTS WHO COMPLETED HEALTH AND WELFARE-RELATED UNDERGRADUATE COURSES(a)—2003 and 2005

	2003			2005		
	Indigenous		*All persons*	*Indigenous*		*All persons*
	%	no.	no.	%	no.	no.
Health						
Medical Studies	0.6	10	1 735	0.8	13	1 697
Nursing	0.8	61	7 497	0.6	48	7 565
Pharmacy	0.1	1	769	0.2	2	1 037
Dental Studies	0.7	2	306	0.6	2	343
Optical Science	1.7	2	121	1.1	1	92
Public Health(b)	6.0	40	672	10.6	78	736
Radiography	—	—	468	0.4	3	688
Rehabilitation Therapies	0.5	12	2 193	0.2	6	2 451
Complementary Therapies(c)	—	—	408	1.0	3	315
Other health(d)	1.9	40	2 100	0.4	10	2 471
Total(e)	**1.0**	**168**	**16 269**	**1.0**	**166**	**17 395**
Welfare						
Early childhood education	2.3	45	1 971	1.4	27	1 949
Special education	1.2	3	253	1.1	2	186
Human Welfare Studies and Services	4.6	16	347	3.0	9	296
Social work	1.6	19	1 224	1.1	15	1 367
Counselling	2.7	4	146	3.5	8	228
Behavioural science(f)	0.8	27	3 317	0.5	19	3 561
Other welfare(g)	2.2	10	456	0.6	3	485
Total(e)	**1.6**	**124**	**7 714**	**1.0**	**83**	**8 072**

— nil or rounded to zero (including null cells)

(a) Based on ABS narrow field of education. Health course codes in order of appearance: 060100–060199; 060300–060399; 060500–060501; 060700–060799; 060900–060999; 061300–061399; 061500–061501; 061900–061999; 069900–069999. Welfare course codes in order of appearance: 70101; 70113; 90500; 90501; 90513; 090700–090799; 90503, 90505, 90507, 90509, 90511, 90515, 90599.

(b) Includes occupational health and safety, environmental health, Indigenous health, health promotion, community health, epidemiology and public health n.e.c.

(c) Includes naturopathy, acupuncture, traditional Chinese medicine, complementary therapies n.e.c.

(d) Includes nutrition and dietetics, human movement, paramedical studies, first aid and health n.e.c.

(e) The data take into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all fields of education.

(f) Includes psychology and behavioural science n.e.c.

(g) Includes children's services, youth work, care for the aged, care for the disabled, residential client care, welfare studies and human welfare studies and services n.e.c.

Source: AIHW analysis of Department of Education, Employment and Workplace Relations (DEEWR), Higher Education Student Statistics Collection

According to the 2004 VET Provider Collection, 111 vocational and training sector (VET) students had completed a course aimed at Aboriginal and Torres Strait Islander Health Worker occupations in Australia (table 10.14). The majority of these course completions were at the Certificate III or IV level (89%). Of all the VET sector students who had completed a course aimed at Aboriginal and Torres Strait Islander Health Worker occupations in 2004, 71% were female (79 course completions) and 28% were male (31 course completions).

Undergraduate studies in health, welfare and community service-related courses continued

10.14 ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKERS(a)(b), course completions by level of qualification—2004

	Males	*Females*	*Persons*(c)
	no.	no.	no.
Certificate I	—	—	—
Certificate II	—	—	—
Certificate III	16	32	49
Certificate IV	13	37	50
Diploma or higher	2	10	12
Total	**31**	**79**	**111**

— nil or rounded to zero (including null cells)

(a) ASCO (Occupation) classification - 3493 Aboriginal and Torres Strait Islander Health Workers.

(b) An ASCO code assigned to the courses indicates the most likely occupation associated with this course. Students may enrol in more than one course.

(c) Includes one student for whom sex was not stated.

Source: NCVER 2004 VET Provider Collection, AHMAC 2006

USE OF HEALTH SERVICES

Information on the use of health services by Aboriginal and Torres Strait Islander people is available from a range of sources. This section draws on survey data from the 2004–05 NATSIHS and the survey of general practice activity, as well as administrative data from services such as alcohol and other drug treatment services, mental health services and hospitals.

The 2004–05 NATSIHS and 2004–05 NHS asked respondents about health-related actions they may have taken in the previous two weeks, and about hospital admissions in the previous 12 months. Approximately 20% of Indigenous Australians reported they had visited a doctor or specialist in the last 2 weeks, 17% had consulted with other health professionals in the last 2 weeks, while 16% had been admitted to hospital in the last 12 months (ABS 2006c).

After adjusting for differences in the age structures of the Indigenous and non-Indigenous populations, a higher proportion of Indigenous people than non-Indigenous people had taken at least one health-related action. The differences were most marked in relation to visits to casualty (rate ratio of 2.3) and other health professionals (rate ratio of 1.5). On the other hand, Indigenous Australians visited a dentist at 0.6 times the rate for non-Indigenous Australians (ABS 2006c).

Community controlled primary health services

Health services that are initiated, controlled and operated by the Indigenous community have the potential to increase the level of access to health services for Aboriginal and Torres Strait Islander people by providing holistic and culturally appropriate care. A review of the Australian Government's Aboriginal and Torres Strait Islander primary health care program (the Primary Health Care Review), completed in 2003–04, found that access to comprehensive primary health care was an essential component of action to improve health status (Dwyer et al 2004).

Aboriginal and Torres Strait Islander primary health care services offer clinical care, screening programs, and a wide range of preventative health care activities, as well as

Community controlled primary health services continued

health-related and community support services. In addition, other services offered include social and emotional wellbeing support, provided by counsellors and social workers; substance use treatment and health-related community support roles, such as men's and women's support groups; transport to medical appointments; and school-based activities. The Australian Government provides funding to some 140 community controlled Aboriginal and Torres Strait Islander primary health care services. State and territory governments also provide a number of community-based Indigenous primary health care services.

A recent initiative by the Australian Government aims to improve primary health care for Aboriginal and Torres Strait Islander people that is delivered through both community controlled and other health services (box 10.15)

10.15 HEALTHY FOR LIFE

Healthy for Life is an Australian Government program that aims to improve the capacity and performance of primary health care services to deliver high quality maternal and children's health services, and chronic disease care to Aboriginal and Torres Strait Islander people. The program uses population health approaches and is guided by best practice and quality improvement principles. It is funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) of the Australian Government Department of Health and Ageing. At the end of 2007 there were 73 services participating in the program.

The collection of good quality data by Healthy for Life services is important for improving local service delivery, as well as for monitoring of national expected outcomes for the Healthy for Life program. OATSIH has developed a set of 11 essential indicators, with additional qualitative indicators, for which services are required to provide data. A web-based information system is used by services to report indicator and related data and generate reports back to services. The AIHW is responsible for storage, collation and analysis of data collected from the Healthy for Life services.

General practice

Information about the extent to which GPs are used by both Indigenous and other Australians is available from a survey of general practice activity in Australia known as the Bettering the Evaluation and Care of Health (BEACH) survey. See Chapter 7 for more information on the BEACH methodology and for data on consultations between Indigenous people and GPs for the period 2001–02 to 2005–06 (table 7.6).

Over the five-year period 2001–02 to 2005–06, only 1.5% of total consultations were with Aboriginal and Torres Strait Islander patients. This rate of consultation is low, relative to the proportion of Indigenous people in the total population (2.5% at 30 June 2006). These lower figures may be the result of the geographic distribution of GPs not reflecting that of the Indigenous population; lower use of private GP services by Indigenous people where other services such as Aboriginal primary health care services exist; Indigenous people using other services such as hospital emergency departments or pharmacists; failure by GPs to record the Indigenous status of patients; or Indigenous patients not identifying as Indigenous. Supplementary surveys in recent years (Supplementary

General practice *continued*

Analysis of Nominated Data (SAND)) together with investigations of means for better ascertaining the Indigenous status of patients in the BEACH survey, have suggested ways for improving such data in the future.

Alcohol and other drug treatment services

Information on the use of alcohol and other drug treatment services by Aboriginal and Torres Strait Islander people is available from a number of sources, including the Drug and Alcohol Service Report (DASR), the Service Activity Reporting (SAR) data, and the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). It should be noted that the DASR, SAR and AODTS-NMDS have different collection purposes, scope and counting rules, therefore the resulting data are not comparable.

The DASR collects information from all Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services. In 2004–05, of the estimated 27,600 clients seen by these services, 78% (21,600) identified as being of Aboriginal and/or Torres Strait Islander origin (AIHW 2006a). Common substances/drugs for which services provided treatment or assistance included alcohol use (100% of services), cannabis (95%), multiple drug use (78%), amphetamines and tobacco/nicotine (61% each).

The SAR collects information from all Australian Government-funded Aboriginal and Torres Strait Islander primary health care services. Around half of these services had treated clients for multiple drug use (53%), benzodiazepines (52%), solvents and inhalants (49%) and petrol (47%). Most services covered issues relating to alcohol use (89%), tobacco/nicotine (84%) and/or cannabis (82%) (AIHW 2006a).

The AODTS-NMDS is a nationally agreed set of common data items collected by in-scope government-funded service providers of clients of alcohol and other drug treatment services (AIHW 2006a). Reported numbers in the 2004–05 annual report on the AODTS-NMDS do not include the majority of services covered by the DASR and SAR collections, as these services are not included in the specific program under which the Australian Government currently reports AODTS-NMDS data. Data for 2004–05, the fifth year of collection, are presented here.

In 2004–05, there were 13,666 closed treatment episodes (10%) involving clients who identified as being of Aboriginal and/or Torres Strait Islander origin (table 10.16) (AIHW 2006a). A closed treatment episode refers to a period of contact between a client and a treatment agency, with defined start and end dates.

Alcohol and other drug treatment services continued

10.16 CLOSED TREATMENT EPISODES, by Indigenous status and age—2004–05

Age group (years)	Indigenous no.	Indigenous %	Other(a) no.	Other(a) %	Total no.	Total %
10–19	2 786	2.0	14 620	10.3	17 406	12.2
20–29	4 387	3.1	41 857	29.4	46 244	32.5
30–39	3 935	2.8	36 188	25.5	40 123	28.2
40–49	1 672	1.2	22 284	15.7	23 956	16.9
50–59	395	0.3	9 198	6.5	9 593	6.7
60 and over	80	0.1	3 248	2.3	3 328	2.3
Not stated	411	0.3	1 083	0.8	1 494	1.1
Total	**13 666**	**9.6**	**128 478**	**90.4**	**142 144**	**100.0**

(a) Includes closed treatment episodes for clients for whom Indigenous status was not stated (5% of episodes).

Source: AIHW 2006a

Overall, closed treatment episodes involving Aboriginal and Torres Strait Islander clients were most likely to involve alcohol (43%), cannabis (23%), heroin (12%) or amphetamines (11%)—that is, the same four principal drugs of concern as for non-Indigenous Australians—but with alcohol more likely to be nominated (43% compared with 37%) and heroin less so (12% compared with 18%).

Community mental health services

Mental health care is provided by a broad range of services and agencies including care provided by general practitioners, psychologists and medical specialists, as well as through community mental health services. Information on the use of community mental health services by Aboriginal and Torres Strait Islander people is available from the AIHW National Community Mental Health Care Database (NCMHCD). Community mental health care is defined as care which is provided by specialised public mental health services dedicated to the assessment, treatment, rehabilitation and care of non-admitted clients. This excludes specialised mental health care for admitted patients (covered in Chapter 7), support that is not provided by specialised mental health care services, care provided by non-government organisations, and residential care.

Data on the use of community mental health services by Indigenous clients in 2004–05 are presented here. There is likely to be an under-estimation of the actual number of service contacts for Indigenous clients in these data due to data quality issues. In some instances, Indigenous clients may have been reported as non-Indigenous, or they may have been represented within the service contacts with a 'not stated' Indigenous status (AIHW 2007j).

In 2004–05, around 4% of service contacts (224,213) were for clients who identified themselves as Indigenous (table 10.17). After adjusting for differences in the age structures of the Indigenous and non-Indigenous populations, the rate at which community mental health services were accessed by Aboriginal and Torres Strait Islander peoples was 507 service contacts per 1,000 population compared with 220 service contacts per 1,000 population for other Australians—a rate ratio of 2.3. The rate ratio of service contacts for Indigenous Australians and other Australians has increased from 1.4 in 2002–03 and 1.7 in 2003–04, however, this may be due to increased coverage of services and/or improved identification of Aboriginal and Torres Strait Islander clients,

Community mental health services *continued*

rather than an actual increase in the proportion of Indigenous people accessing community mental health services.

Consistent with differences in the age structures of the two populations, Indigenous Australians were more likely than other Australians to have service contacts in the younger age groups and correspondingly lower representation in the older age groups. For example, 24% of service contacts for Indigenous males were for clients aged 15–24 years compared with 17% of service contacts for other Australian males. There were more service contacts for Aboriginal and Torres Strait Islander males than for females (1.6 times) whereas the rates for other Australian males and females were similar.

10.17 COMMUNITY MENTAL HEALTH SERVICE CONTACTS, by Indigenous status, sex and age—2004–05(a)

Sex and age group (years)	Indigenous		Other(b)		Total	
	no.	%	no.	%	no.	%
Males						
Less than 15	12 158	8.7	223 624	8.9	235 782	8.9
15–24	32 650	23.5	416 807	16.6	449 457	17.0
25–34	53 098	38.2	661 254	26.3	714 352	26.9
35–44	27 891	20.1	517 875	20.6	545 766	20.6
45–54	8 927	6.4	327 865	13.0	336 792	12.7
55–64	3 319	2.4	165 311	6.6	168 630	6.4
65 and over	929	0.7	191 163	7.6	192 092	7.2
Total(c)	139 037	100.0	2 512 477	100.0	2 651 514	100.0
Females						
Less than 15	6 284	7.4	143 567	6.5	149 851	6.5
15–24	18 963	22.3	388 419	17.5	407 382	17.7
25–34	24 910	29.3	400 826	18.0	425 736	18.5
35–44	19 460	22.9	410 706	18.5	430 166	18.7
45–54	10 446	12.3	330 475	14.9	340 921	14.8
55–64	2 169	2.6	198 289	8.9	200 458	8.7
65 and over	2 709	3.2	341 794	15.4	344 503	14.9
Total(c)	84 985	100.0	2 221 516	100.0	2 306 501	100.0
Total(c)	**224 213**	. .	**4 884 311**	. .	**5 108 524**	. .

. . not applicable
(a) These data should be interpreted with caution due to likely under-identification of Indigenous persons.
(b) Includes service contacts for clients for whom Indigenous status was not stated.
(c) Includes service contacts for clients for whom age or sex was not stated.
Source: AIHW 2007j

Hospital services

Hospital services are a major component of expenditure on health services for Aboriginal and Torres Strait Islander people. Although the reasons for which people are hospitalised and the procedures they may undergo in hospital are not necessarily indicative of the health of the total population, information on hospitalisations can provide some insights into the health of the population.

Hospitalisation statistics are limited to information about the conditions for which people are admitted to hospital, thereby excluding service use information regarding those who visited the emergency department but were not admitted, or had hospital outpatient clinic visits, or who made use of other health services, such as GPs and community health clinics. The number and pattern of hospital admissions can also be affected by the variation between hospitals in decisions about whether to admit patients

Hospital services continued

or to treat them as non-admitted patients. Information concerning non-admitted patients is only reported in selected public hospitals and is not always available at the episode-level. Other factors, such as the availability of, and access to, other medical services, may influence hospital utilisation. For example, a rising rate of hospitalisation could mean that health status has deteriorated, or that access to hospitals has improved, or that access to GPs has decreased, or all of these.

Indigenous Australians are less likely than other Australians to undergo a procedure once admitted to hospital. It is not known which factors cause this disparity. Presentation late in the course of the illness, the presence of co-morbidities and communication difficulties are some of the suggested factors that may be involved (AHMAC 2006). Along with data on hospitalisations, this section provides information on hospital procedures recorded for Indigenous and other Australians.

HOSPITALISATIONS

Hospitalisation rates for Indigenous people are influenced by their relatively poor health status, as well as their access to hospital and other health services (AIHW 2007b). Reported hospitalisation rates in the Indigenous population are also influenced by the quality of Indigenous identification in hospital records, which varies among the states and territories (see Chapter 7, box 7.9 for more detail).

The information presented in this section is for the six jurisdictions which have been assessed as having adequate identification of Indigenous people in hospitalisations data in 2004–05—New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory. These six jurisdictions represent approximately 96% of the Indigenous population of Australia, however, the information presented here is not necessarily representative of the other two jurisdictions (Tasmania and the Australian Capital Territory).

In Australia, during 2005–06, there were 7.3 million hospitalisations recorded across all jurisdictions (AIHW 2007b). In the same period, around 7.0 million hospitalisations were recorded in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined. Of these, 243,106 or 3.5% were hospitalisations of Indigenous people. The same patient may have been hospitalised more than once during this period. After adjusting for differences in the age structures of the Indigenous and non-Indigenous populations, Indigenous males and females were more than twice as likely to be hospitalised as other Australian males and females.

In 2005–06, in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, about 94% of hospitalisations involving Indigenous patients were recorded in public hospitals, compared with 60% of hospitalisations of other Australians. While Indigenous patients are not identified well in private hospitals compared with public hospitals, the much lower proportions of hospitalisations of Indigenous patients in private hospitals probably reflects lower attendance at private hospitals by Indigenous patients.

The most common diagnosis for both Indigenous males and females in hospitalisations data in 2005–06 was 'care involving dialysis', which is used in the treatment of chronic kidney disease. In New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, hospitalisation rates for a diagnosis of

Hospital services continued

HOSPITALISATIONS *continued*

care involving dialysis accounted for 41% of all hospitalisations involving Indigenous patients, and 11% of hospitalisations for other patients; rates were around 14 times as high for Indigenous Australians compared with other Australians.

POTENTIALLY PREVENTABLE HOSPITALISATIONS

Potentially preventable hospitalisations provide an indication of the scope for health gain through preventative care and early disease management. These are also referred to as ambulatory care-sensitive conditions and are admissions to hospital that potentially could have been prevented through the provision of appropriate non-inpatient health services. Potentially preventable hospitalisations will never be entirely eliminated, but the variation in rates between Indigenous and non-Indigenous Australians demonstrates considerable potential for strengthening the impact of non-hospital care.

Ambulatory care-sensitive conditions can be broken down into three categories:

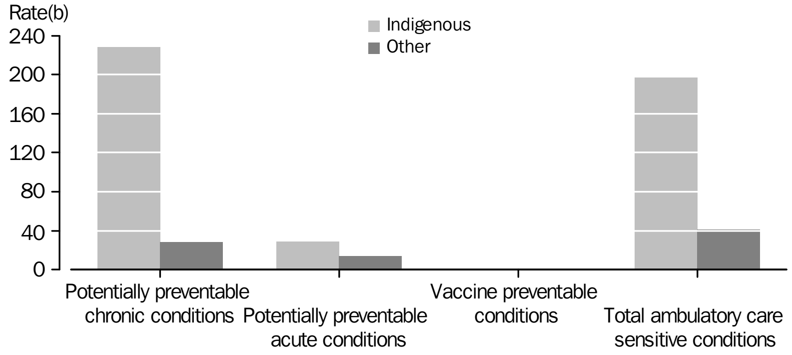
- vaccine-preventable conditions, including influenza, tetanus, measles, mumps, rubella, diphtheria, pertussis and polio;
- potentially preventable acute conditions, including dehydration, gastroenteritis, kidney infection, perforated ulcer, cellulitis, pelvic inflammatory disease, ear, nose and throat infections, and dental conditions; and
- potentially preventable chronic conditions, including diabetes, asthma, angina, hypertension, congestive heart failure and chronic obstructive pulmonary disease.

In 2005–06, in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, the rate of hospitalisations due to ambulatory care-sensitive conditions for Indigenous Australians was five times the rate for other Australians. Indigenous Australians were hospitalised for potentially preventable chronic conditions at eight times the rate of other Australians, for potentially preventable acute conditions at twice the rate, and for vaccine preventable conditions at three times the rate of other Australians (graph 10.18). Of the potentially preventable chronic conditions, diabetes complications had the highest hospitalisation rate, with the rate for Indigenous Australians being twelve times the rate for other Australians.

Hospital services continued

POTENTIALLY PREVENTABLE HOSPITALISATIONS *continued*

10.18 HOSPITALISATION RATES FOR AMBULATORY CARE SENSITIVE CONDITIONS, by Indigenous status(a)—2005–06

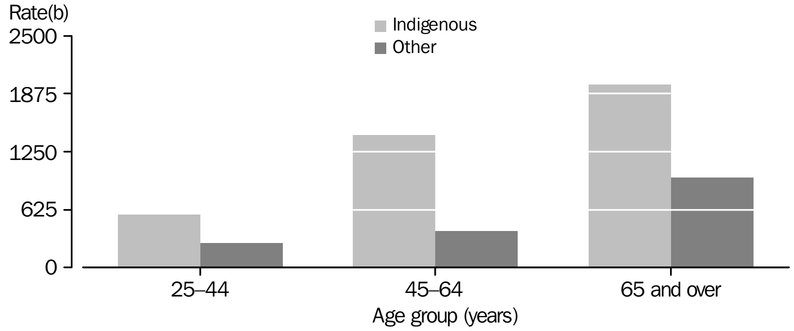


(a) Data are for NSW, Vic., Qld, WA, SA and NT combined.
(b) Rate per 1,000 population

Source: AIHW National Hospital Morbidity Database

Age-specific hospitalisation rates by Indigenous status are shown for three different scenarios (graphs 10.19, 10.20 and 10.21). The first scenario which includes all hospitalisations (including dialysis) shows rates of hospitalisations for Indigenous patients and for other patients in all age groups from 25 years onwards. When dialysis was excluded in the second scenario, the difference in hospitalisation rates between Indigenous and non-Indigenous Australians was much smaller. When hospitalisations from both dialysis and ambulatory care sensitive conditions were excluded in the third scenario, much of the difference in hospitalisation rates between Indigenous and other Australians from 25 years onwards was removed. Dialysis and ambulatory care sensitive conditions accounted for 80% of all hospitalisations of Indigenous people aged 45 years or over, compared with 28% for other Australians in this age group.

10.19 RATES FOR HOSPITALISATIONS INCLUDING DIALYSIS, by Indigenous status and age(a)—2005–06



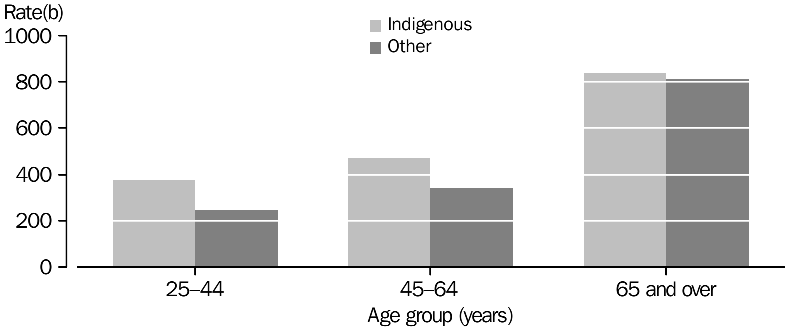
(a) Data are for NSW, Vic., Qld, WA, SA and NT combined.
(b) Rate per 1,000 population.

Source: AIHW National Hospital Morbidity Database

Hospital services continued

POTENTIALLY PREVENTABLE HOSPITALISATIONS *continued*

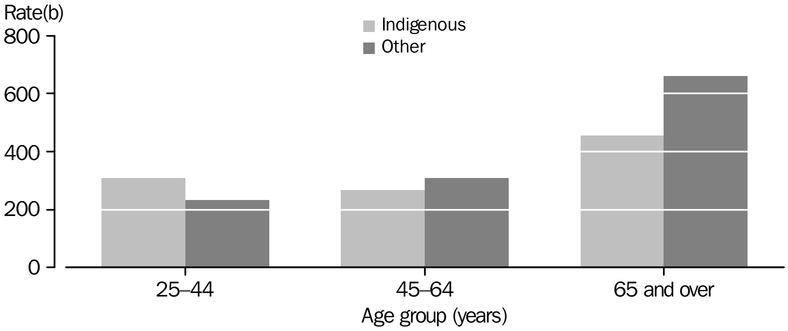
10.20 RATES FOR HOSPITALISATIONS EXCLUDING DIALYSIS, by Indigenous status and age(a)—2005–06



(a) Data are for NSW, Vic., Qld, WA, SA and NT combined.
(b) Rate per 1,000 population.

Source: AIHW National Hospital Morbifity Database

10.21 HOSPITALISATIONS EXCLUDING DIALYSIS AND AMBULATORY CARE SENSITIVE CONDITIONS, by Indigenous status and age(a)—2005–06



(a) Data are for NSW, Vic., Qld, WA, SA and NT combined.
(b) Rate per 1,000 population.

Source: AIHW National Hospital Morbidity Database

Hospitalisations and procedures

Procedures are clinical interventions (surgical interventions and interventions that require specialised training or special facilities or equipment) such as X-rays and chemotherapy. One or more procedures can be reported for each hospitalisation, but many hospital admissions will not involve procedures.

Around half (48%) of all hospitalisations of Indigenous Australians (excluding dialysis hospitalisations) did not have a procedure reported. Around 16% of Indigenous hospitalisations had one procedure reported, 16% had two procedures reported, 8% had three procedures reported and 11% had four or more procedures reported (table 10.22).

While Indigenous Australians were more likely to be hospitalised than other Australians, they were less likely to undergo a procedure once admitted to hospital. Indigenous Australians were twice as likely as other Australians to have no procedures recorded and

Hospitalisations and procedures continued

less likely than other Australians to have 1 to 9 procedures recorded. They were, however, more likely to have 10 or more procedures recorded, probably reflecting higher rates of co-morbidities and case complexity.

10.22 HOSPITALISATIONS (EXCLUDING DIAGNOSES FOR CARE INVOLVING DIALYSIS), by number of procedures—2005–06

	NUMBER		CRUDE PROPORTION	AGE STANDARDISED PROPORTION(a)		
Number of procedures	*Indigenous*	*Other*	*Indigenous*	*Indigenous*	*Other*	*Ratio*(b)
0	70 474	1 276 264	48.3	38.6	20.4	1.9
1	23 940	1 282 689	16.4	18.8	20.5	0.9
2	23 762	1 764 594	16.3	16.5	28.3	0.6
3	12 352	950 506	8.5	9.2	15.2	0.6
4	6 095	410 862	4.2	4.5	6.6	0.7
5–9	7 717	516 492	5.3	5.7	8.3	0.7
10 or more	2 338	75 648	1.6	1.6	1.2	1.3
Total hospitalisations	**145 875**	**6 244 283**	**100.0**	. .	. .	. .
Total hospitalisations with procedure	**76 204**	**5 000 791**	**52.2**	**55.8**	**80.1**	**0.7**

. . not applicable

(a) Proportions are indirectly age standardised using the age-specific proportions of other Australians as the standard.

(b) Ratio is observed hospitalisations divided by the expected number of hospitalisations based on the age and sex-specific proportions for other Australians.

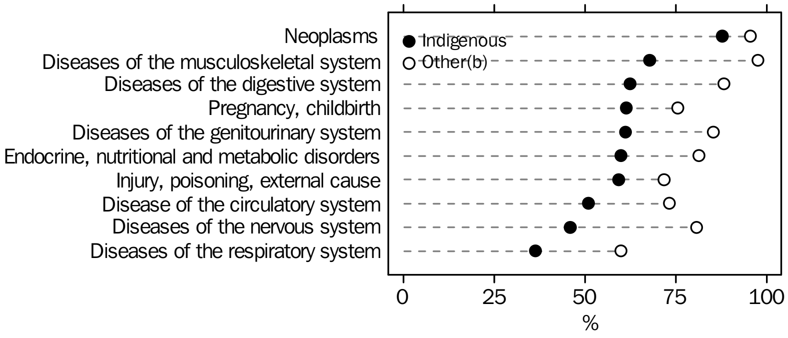
Source: AIHW National Hospital Morbidity Database

For almost all principal diagnoses, Indigenous patients were less likely than other patients to have a procedure recorded (graph 10.23). The greatest disparities between Indigenous and other Australians in the proportion of hospitalisations with a procedure reported were seen in hospitalisations for diseases of the nervous system, diseases of the respiratory system, and symptoms, signs and abnormal findings (e.g. breathing abnormalities, nausea and vomiting, fever of unknown origin).

Indigenous Australians are less likely to undergo a procedure once admitted to hospital than other Australians but it is not known which factors cause this disparity. This can include institutionalised racism (AMA 2007) which has been defined as 'systemic practices not ill-intentioned, but still discriminatory, and almost invisible to the patient provider encounter' (AHMAC 2006). Presentation late in the course of the illness, the presence of co-morbidities and communication difficulties are some of the other suggested factors that may be involved (AHMAC 2006).

Hospitalisations and procedures *continued*

10.23 HOSPITALISATIONS WITH A PROCEDURE RECORDED, by principal diagnosis and Indigenous status(a)—2005–06



(a) Excludes care involving dialysis.
(b) Includes hospitalisations of non-Indigenous Australians and those for whom Indigenous status was not stated.

Source: AIHW National Hospital Morbidity Database

CORONARY PROCEDURES

A study by Coory and Walsh (2005), which followed patients admitted to Queensland hospitals for acute myocardial infarction (AMI) between 1998 and 2002, found that rates of coronary procedures among Indigenous patients were significantly lower (by 22%) than among other patients with AMI.

The AIHW report *Aboriginal and Torres Strait Islander people with coronary heart disease: further perspectives on health status and treatment*, outlines the disparities between Aboriginal and Torres Strait Islander people and other Australians in the health status and treatment of coronary heart disease (CHD), including the use of coronary procedures in hospital (AIHW 2006b). Among those Australians hospitalised with CHD in 2002–03, Indigenous Australians were less likely than other Australians to receive key coronary investigations and procedures, such as coronary angiography and revascularisation. This was evident across all age groups.

In 2002–03, there were 4,126 hospitalisations of Indigenous Australians with CHD as the principal diagnosis, compared with 113,109 hospitalisations of other Australians. After adjusting for differences in the age structures of the Indigenous and non-Indigenous populations, the angiography and revascularisation rates for Aboriginal and Torres Strait Islanders were 40% lower than the rate for other Australians (rate ratios of 0.6 for both). Revascularisation procedures include percutaneous coronary intervention (PCI) and coronary artery bypass grafts (CABG). Similar results were observed when PCI and CABG were analysed separately, with Indigenous Australians generally less likely to receive these procedures than other Australians across all age groups for those hospitalised for CHD. The age-adjusted procedure rate for PCI is around 40% lower than other Australians, while the age-adjusted rate for CABG is 20% lower (age standardised rate ratio of 0.6 and 0.8 respectively).

Indigenous Australians with CHD tended to be more complex cases (as measured by the number of co-morbidities). However, the complexity of cases did not explain the lower procedure rate in Indigenous Australians compared with other Australians. In 2002–03, Aboriginal and Torres Strait Islander people with CHD were less likely to undergo a coronary procedure across all levels of complexity. The largest difference in procedure

Hospitalisations and procedures *continued*

CORONARY PROCEDURES *continued*

rates between Indigenous Australians and other Australians occurred in the least complex groups (no or 1–2 co-morbidities present). In these groups, Indigenous Australians were just over half as likely to have had a coronary procedure.

TREATMENT FOR CANCER

A study of 815 Indigenous and 810 non-Indigenous patients diagnosed with cancer in Queensland between 1997 and 2002 found that after adjustment for stage at diagnosis, treatment and co-morbidities, non-Indigenous Australians had better survival rates than Indigenous patients. Indigenous patients were less likely to have had treatment for cancer (e.g. surgery, chemotherapy, radiotherapy) and were more likely to have waited longer for surgery than non-Indigenous patients (Valery et al 2006).

A study in Western Australia of patients who had a cancer registration in the state between 1982 and 2001 found that Indigenous women were as likely as non-Indigenous women to undergo breast-conserving surgery for breast cancer, but Indigenous men were less likely than non-Indigenous men to receive radical prostatectomy for prostate cancer. Indigenous people were also less likely than non-Indigenous people to receive surgery for lung cancer (Hall et al 2004).

SUMMARY

In 2004–05, $1.17 was spent on Aboriginal and Torres Strait Islander health for every $1.00 spent on the health of non-Indigenous Australians. The relatively high levels of morbidity and mortality among Indigenous Australians, however, suggest that current expenditures for Aboriginal and Torres Strait Islander people may not be sufficient to address their health needs.

The access of Aboriginal and Torres Strait Islander people to health services may be hindered by a number of barriers, sometimes resulting in them not accessing care when needed. In the 2004–05 NATSIHS, for example, 21% of Indigenous Australians reported they had needed to go to a dentist in the last 12 months, but had not gone, and 15% had needed to go to a doctor, but had not gone. Reasons reported for not accessing care include lack of availability of services, transport and distance to services, cost, and language and cultural barriers. A higher proportion of Indigenous people in non-remote areas reported cost as a reason for not seeking health care, while for those in remote areas, transport/distance and the service not being available in the area were more commonly reported.

Indigenous participation in the delivery of services is considered an important factor for improving access to services. In 2006 Indigenous Australians were under-represented in almost all health-related occupations and comprised 1% of the health workforce. Indigenous students were also under-represented among those completing graduate courses in health. Aboriginal and Torres Strait Islander people, however, were better represented in selected welfare and community service occupations, comprising 3.6% of people employed in this sector.

After adjusting for differences in the age structures of the Indigenous and non-Indigenous populations, Indigenous Australians were more likely to have taken at least one health-related action in 2004–05, such as visiting a doctor or being admitted to hospital, than non-Indigenous Australians. The differences were most marked in relation

SUMMARY *continued*

to visits to casualty and other health professionals where the rates for Indigenous Australians were twice the rates for non-Indigenous Australians. On the other hand, the rate of Indigenous Australians who visited a dentist was 0.6 times the rate for non-Indigenous Australians.

In 2005–06, Indigenous males and females were more than twice as likely as other males and females to have been hospitalised, with the greatest differences in hospitalisation rates for people aged 25 years and over. Most of the difference in hospitalisation rates was due to high rates of care involving dialysis, and potentially preventable hospitalisations. Indigenous Australians were hospitalised for care involving dialysis at 14 times the rate of other Australians and for potentially preventable hospitalisations at five times the rate of other Australians.

While Indigenous Australians were more likely to be hospitalised than other Australians, they were less likely to undergo a procedure once admitted to hospital. It is not clear why Indigenous patients are less likely to undergo a procedure, but some possible factors include communication difficulties, institutionalised racism, the presence of co-morbidities, and presentation late in the course of illness.

CHAPTER 11 COMMUNITY SERVICES

INTRODUCTION

This chapter presents information about the use of community services by Aboriginal and Torres Strait Islander clients in the areas of child care, child protection, adoptions, juvenile justice, disability services and aged care. Aboriginal and Torres Strait Islander children and young people are over-represented in both the child protection and juvenile justice systems. Only 3% of disability service users were Indigenous, even though their rates of disability are almost twice the rate of non-Indigenous Australians (see Chapter 5). Indigenous people were more likely to utilise both disability and aged care services at younger ages, reflecting their poorer health status and lower life expectancy.

Community services are provided by Australian, state, territory and local government agencies, as well as by non-government not-for-profit and for-profit organisations. Most of the data in this chapter come from national data collections compiled by the Australian Institute of Health and Welfare (AIHW) from the administrative databases of community service providers. While these data provide useful information, there are some limitations on data quality. The Indigenous status of clients is not always disclosed by the clients or recorded by the service provider. In addition, in some cases where Indigenous status is recorded, inconsistencies in recording methods result in data that are not comparable between jurisdictions (see box 11.21).

CHILD CARE

Child care services provide care and development activities for children generally aged 12 years and younger. These services enable parents to participate in employment, education and training, community activities and personal activities. They may also be used for family support reasons. As a condition of government funding and regulation, child care services must promote and enhance children's emotional, intellectual, social and physical development. Dedicated preschool services offer educational and developmental programs for children in the year or two before full-time school.

In early 2008 the Australian Government Department of Education, Employment and Workplace Relations (DEEWR) gained responsibility for child care (prior to this, child care was the responsibility of the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)). DEEWR funds most child care services through the Australian Government Child Care Support Program. DEEWR also provides supplementary funding for Indigenous children enrolled in government and non-government preschools under the *Indigenous Education (Targeted Assistance) Act 2000* in order to accelerate improvements to the educational outcomes of Indigenous Australians. During 2005–2008, over $500 million in Supplementary Recurrent Assistance (SRA) will be allocated to schools, including preschools (DEST 2004).

All state and territory governments fund dedicated preschool services. They also provide some funding for other child care services, either solely or in conjunction with the Australian Government.

CHILD CARE *continued*

The Australian Government supports mainstream child care services such as long day care centres, family day care services and outside hours care services, as well as culturally specific services for Aboriginal and Torres Strait Islander children. These include:

- Multifunctional Aboriginal Children's Services (MACS), which provide flexible services to meet Aboriginal and Torres Strait Islander children's social and developmental needs. MACS offer care for children under school age and for school age children, including long day care, playgroups, before and after school care and school holiday care, and cultural programs.
- Aboriginal Playgroups and Enrichment Programs. Aboriginal playgroups provide opportunities for children under school age and their parents to socialise and interact with one another. Enrichment programs provide supervised care, organised activities, homework centres and nutrition services for school age children.

Although not specifically for Indigenous children, the Australian Government also funds mobile children's services which visit remote areas and provide occasional care, school holiday care, playgroups, story telling, games and toy library services for children and information and support for parents.

Nationally, comprehensive and comparable data on children using child care and preschool services are not available. The development phase of a Children's Services National Minimum Data Set (CSNMDS) has been completed. The final report on the development of the CSNMDS was released in February 2007 and work is currently underway to develop options for its implementation. Since most child care services are supported by the Australian Government, the Census of Child Care Services (previously administered by FaHCSIA) is currently the most comprehensive source of data on Indigenous children attending child care services in Australia. Results from the 2006 Child Care Census are not yet available for reporting. Data from the 2004 Child Care Census are therefore provided.

In 2004, there were 651,044 children using Australian Government supported child care services, of whom 11,971 (1.8%) were Indigenous. Not surprisingly, Indigenous-specific services such as Aboriginal Playgroups and Enrichment Services and Multifunctional Aboriginal Children's Services had the highest proportions of Indigenous children (88% and 79% respectively). Among mainstream services in 2004, around 10% of children using Mobile and Toy Library Services were Indigenous and 6% of children using Multifunctional Children's Services were Indigenous. Indigenous children represented less than 2% of all children using the remaining service types.

CHILD CARE *continued*

11.1 CHILDREN IN AUSTRALIAN GOVERNMENT SUPPORTED CHILD CARE, by Indigenous status and service type—May 2004

		Indigenous children	*Other children*(a)
Long day care centres	%	50.7	59.0
Family day care	%	8.9	13.8
Occasional care	%	1.1	1.2
Multifunctional Aboriginal Children's Services	%	11.7	—
Multifunctional Children's Services	%	0.5	0.2
Before/after school care (Outside of School Hours Care) services	%	15.5	24.9
Vacation care	%	—	—
Mobile and Toy Library Services	%	2.5	0.4
Aboriginal Playgroups and Enrichment Services	%	8.9	—
In-home Care Services	%	0.2	0.5
Total	%	**100.0**	**100.0**
	no.	**11 971**	**639 073**

— nil or rounded to zero (including null cells)

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

Source: 2004 FaCS Australian Government Census of Child Care Services

Of all Indigenous children in Australian Government supported child care services, 51% were in long day care centres, 16% were in before/after school care and 9% were in family day care (table 11.1). The corresponding proportions for other Australian children were 59%, 25% and 14% respectively.

Some data are also available on the number of Indigenous children enrolled in state and territory funded and non-government funded preschool services from the annual census conducted by DEEWR. In 2006, there were 4,931 Aboriginal and Torres Strait Islander children enrolled in state/territory funded preschools in all jurisdictions, excluding Queensland and Victoria (children attending state and territory funded preschools in Queensland and Victoria were excluded from the data collection in 2006), and there were a further 4,344 Indigenous children enrolled in non-government funded preschools in all states and territories.

CHILD PROTECTION

Each state and territory has a department which is responsible for child protection services. Children who come into contact with these departments for protective reasons include those:

- who have been abused, neglected or otherwise harmed
- whose parents cannot provide adequate care or protection.

Children who are seen to be in need of protection can come to the attention of child protection authorities through a report by an individual or organisation, or by the children themselves. Reports of suspected abuse or neglect can lead to the matter being dealt with as a family support issue (whereupon services will be provided) or as a child protection notification. Departments then determine if a notification requires an investigation or is better dealt with by other means, such as referral to other organisations or family support services. If an investigation is carried out, the outcome can be a substantiation, meaning that the investigating authority concludes that the child has been, is being, or is likely to be, abused, neglected or otherwise harmed. A range of services may then be provided to the child and the child's family.

CHILD PROTECTION *continued*

The departments provide assistance to these children through the provision of, or referral to, a wide range of services. Non-government agencies are often contracted by the departments to provide these services which range from family support to the placement of children in out-of-home care.

In more serious cases, the department may also apply to the relevant court to place a child under a care and protection order. Care and protection orders vary between jurisdictions but can provide for a supervisory role for the department or transfer of legal guardianship to the department. The issuing of a care and protection order is often a legal requirement if a child is to be placed in out-of-home care. This option can be used to protect the child from further harm, where there is family conflict and 'time out' is needed, or where parents are ill or unable to care for the child.

The three areas of child protection services for which national data are collected are:

- child protection notifications, investigations and substantiations
- children on care and protection orders
- children in out-of-home care.

Each state and territory has its own legislation, policies and practices in relation to child protection, so the data provided by jurisdictions are not strictly comparable, and national data are limited. This is particularly the case with the data on notifications, investigations and substantiations, where jurisdictions use different definitions and processes (AIHW 2007d). It is also worth noting that the quality of Indigenous data varies across jurisdictions due to differences in the practices used to identify and record the Indigenous status of children and young people in the child protection system.

Substantiations

In 2005–06, the rates of Aboriginal and Torres Strait Islander children who were the subject of a child protection substantiation were substantially higher than the rates for other children in all jurisdictions except Tasmania (table 11.2). Data for Tasmania, however, should be interpreted with caution due to the low incidence of child protection workers recording Indigenous status at the time of the substantiation.

Substantiations continued

11.2 CHILDREN WHO WERE THE SUBJECT OF A CHILD PROTECTION SUBSTANTIATION(a), by Indigenous status—2005–06

	NUMBER OF CHILDREN			RATE PER 1,000 CHILDREN(b)			
	Indigenous	*Other*(d)	*Total*	*Indigenous*	*Other*(d)	*Total*	*Rate ratio*(c)
State/territory	no.	no.	no.	rate	rate	rate	ratio
New South Wales	2 696	9 931	12 627	44.2	6.9	8.4	6.4
Victoria	834	6 453	7 287	67.7	6.0	6.7	11.3
Queensland	1 340	8 737	10 077	23.0	10.1	10.9	2.3
Western Australia	316	603	919	10.9	1.4	2.0	7.8
South Australia	360	1 101	1 461	32.3	3.5	4.5	9.2
Tasmania(e)	34	635	669	4.4	6.2	6.1	0.7
Australian Capital Territory	99	754	853	56.8	10.9	12.0	5.2
Northern Territory	354	108	462	15.2	3.2	8.1	4.8

(a) Aged 0–16 years.
(b) Based on ABS 'low series' population projections.
(c) The rate for Indigenous children divided by the rate for other children.
(d) Includes children for whom Indigenous status was not stated.
(e) Data should be interpreted with caution due to the high proportion of investigations not finalised by 31 August 2006 (the cut-off date for the processing of investigations for inclusion in the data for that year).
Source: AIHW 2007d

Substantiations are classified into one of the following four categories depending on the main type of abuse or neglect that has occurred: physical abuse, sexual abuse, emotional abuse, or neglect. While more than one type of abuse or neglect may be recorded, only the most serious type of abuse or neglect for the first substantiation of the year for each child is reported. Thus, it is difficult to measure the real patterns of abuse or neglect that each child may experience. The precise definition of type of abuse or neglect, as well as the types of incidences that may be substantiated, vary according to the policies and practices of the different jurisdictions.

The pattern of substantiated abuse and neglect for Aboriginal and Torres Strait Islander children differs somewhat from the pattern for other children. Indigenous children were more likely to be the subject of a substantiation of neglect than other children. For example, in Western Australia 40% of Indigenous children in substantiations were the subject of a substantiation of neglect, compared with 30% of other children (table 11.3). However, other Australian children were more likely than Indigenous children to have substantiations where the main type of abuse was sexual. For example, in New South Wales, 17% of other Australian children had substantiations where the main type of abuse was sexual abuse, compared with 9% of Indigenous children. Victoria and the Australian Capital Territory had a relatively high proportion of substantiations that were classified as 'emotional abuse' for both Indigenous and other children.

Substantiations continued

11.3 CHILDREN WHO WERE THE SUBJECT OF A CHILD PROTECTION SUBSTANTIATION(a), by type of abuse or neglect and Indigenous status—2005–06

Type of abuse or neglect	NSW	Vic.	Qld	WA	SA	Tas.(b)	ACT(b)	NT
INDIGENOUS CHILDREN								
Physical abuse	17.5	20.7	20.7	27.4	14.7	26.5	7.1	33.1
Sexual abuse	9.2	5.6	4.2	16.4	5.8	2.9	—	4.2
Emotional abuse	37.0	49.3	36.2	16.1	36.1	23.5	69.7	28.4
Neglect	36.3	24.3	38.9	40.1	43.3	47.1	23.2	34.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
OTHER CHILDREN								
Physical abuse	21.5	25.1	22.1	28.6	25.9	22.2	9.0	31.5
Sexual abuse	16.7	9.4	6.6	23.6	9.7	12.5	3.3	9.3
Emotional abuse	38.1	43.1	42.4	17.9	32.1	26.9	71.8	37.0
Neglect	23.6	22.5	28.8	29.9	32.3	38.5	15.9	22.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

— nil or rounded to zero (including null cells)

(a) Children aged 0–17 years.

(b) The proportion of Indigenous children who were the subject of a substantiation in Tasmania and the Australian Capital Territory should be interpreted with caution due to small numbers in these jurisdictions.

Source: AIHW 2007d

Care and protection orders and out-of-home care

The rate of Aboriginal and Torres Strait Islander children being placed on care and protection orders and in out-of-home care was around seven times the rate for other Australian children (table 11.4). The rate ratios varied considerably by jurisdiction and were highest in Victoria (12.3 for children on care and protection orders and 11.4 for children in out-of-home care) and lowest in Tasmania (2.3 for children on care and protection orders and 2.2 for children in out-of-home care). Again, however, it should be noted that data from Tasmania should be interpreted with caution due to the low incidence of child protection workers recording Indigenous status at the time of the substantiation.

Care and protection orders and out-of-home care continued

11.4 CHILDREN ON CARE AND PROTECTION ORDERS AND IN OUT-OF-HOME CARE(a), by Indigenous status—30 June 2006

	CARE AND PROTECTION ORDERS			OUT-OF-HOME CARE		
State/Territory	*Indigenous*	*Other*(b)	*Rate ratio*(c)	*Indigenous*	*Other*(b)	*Rate ratio*(c)
New South Wales	37.2	4.5	8.3	44.7	4.6	9.7
Victoria	56.4	4.6	12.3	42.1	3.7	11.4
Queensland	26.7	5.2	5.1	24.0	4.7	5.1
Western Australia	31.8	3.9	8.2	30.2	3.4	8.9
South Australia	25.8	2.7	9.6	24.8	2.6	9.5
Tasmania(d)	15.2	6.5	2.3	11.9	5.4	2.2
Australian Capital Territory	12.2	3.8	3.2	10.0	3.0	3.3
Northern Territory	53.3	6.2	8.6	43.7	4.1	10.7
Australia	**29.9**	**4.5**	**6.6**	**29.8**	**4.1**	**7.3**

(a) Rates per 1,000 children aged 0–17 years, based on 'low series' ABS population projections from the 2001 Census of Population and Housing.
(b) Includes children for whom Indigenous status was not stated.
(c) Rate ratio is equal to the rate for Indigenous children divided by the rate for other children.
(d) Data for Tasmania should be interpreted with caution due to the low incidence of child protection workers recording Indigenous status.
Source: AIHW 2007d

One of the most significant changes in child welfare policy in relation to Indigenous children was the introduction of the Aboriginal Child Placement Principle (box 11.5). The Principle outlines a preference for placing Aboriginal and Torres Strait Islander children with relatives/kin or other Indigenous carers. All jurisdictions have adopted the Aboriginal Child Placement Principle in legislation and policy.

11.5 THE ABORIGINAL CHILD PLACEMENT PRINCIPLE

The Aboriginal Child Placement Principle expresses a preference for the placement of Aboriginal and Torres Strait Islander children with other Aboriginal and Torres Strait Islander people when they are placed outside their family (Lock 1997). The Principle has the following order of preference for the placement of Aboriginal and Torres Strait Islander children:

- with the child's extended family
- within the child's Indigenous community
- with other Indigenous people.

The Principle covers the placement of Indigenous children in out-of-home care as well as the adoption of Indigenous children.

The impact of the Aboriginal Child Placement Principle is reflected in the relatively high proportion of Indigenous children who are placed with Indigenous caregivers or with relatives, though this proportion varies by state and territory. At 30 June 2006, the proportion of Indigenous children in out-of-home care placed with relatives/kin, other Indigenous caregivers or in Indigenous residential care was at least 62% in all jurisdictions, except Tasmania (table 11.6). These data do not necessarily reflect the effort made to place a child in accordance with the Principle, however, as the availability

Care and protection orders and out-of-home care *continued*

of Indigenous caregivers and other considerations in relation to the suitability of the placement can impact on the placement outcomes.

11.6 INDIGENOUS CHILDREN IN OUT-OF-HOME CARE(a), by relationship to, and Indigenous status of carer—30 June 2006

Relationship/Indigenous status of carer	*NSW*	*Vic.*	*Qld*	*WA*	*SA*	*Tas.*	*ACT*	*NT*
NUMBER								
Indigenous relative/kin	1 669	152	379	394	109	10	28	90
Other Indigenous caregiver	512	102	400	143	138	13	17	67
Other relative/kin	282	80	142	64	28	8	11	(b)na
Indigenous residential care	9	21	9	18	—	—	1	—
Total with relative/kin, other Indigenous caregivers, Indigenous residential care	***2 472***	***355***	***930***	***619***	***275***	***31***	***57***	***157***
Other caregiver	374	166	538	92	62	55	18	87
Other residential care	43	27	28	45	22	7	6	—
Total other caregivers, other residential care	***417***	***193***	***566***	***137***	***84***	***62***	***24***	***87***
Total	**2 889**	**548**	**1 496**	**756**	**359**	**93**	**81**	**244**
PERCENT								
Indigenous relative/kin	57.8	27.7	25.3	52.1	30.4	10.8	34.6	36.9
Other Indigenous caregiver	17.7	18.6	26.7	18.9	38.4	14.0	21.0	27.5
Other relative/kin	9.8	14.6	9.5	8.5	7.8	8.6	13.6	na
Indigenous residential care	0.3	3.8	0.6	2.4	—	—	1.2	—
Total with relative/kin, other Indigenous caregivers, Indigenous residential care	***85.6***	***64.8***	***62.2***	***81.9***	***76.6***	***33.3***	***70.4***	***64.3***
Other caregiver	12.9	30.3	36.0	12.2	17.3	59.1	22.2	35.7
Other residential care	1.5	4.9	1.9	6.0	6.1	7.5	7.4	—
Total other caregivers, other residential care	***14.4***	***35.2***	***37.8***	***18.1***	***23.4***	***66.7***	***29.6***	***35.7***
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

— nil or rounded to zero (including null cells)
na not available
(a) This table does not include Indigenous children who were living independently or whose living arrangements were unknown.
(b) In the Northern Territory, children placed with family members have all been included in the 'Indigenous relative/kin' category.

Source: AIHW 2007d

ADOPTION

The formal adoption of Aboriginal and Torres Strait Islander children has not been a common practice in recent years. In many cases where Aboriginal or Torres Strait Islander children cannot live with their birth parents, informal arrangements are made for them to live with a relative or other member of the community (HREOC 1997). Arrangements of this type are generally preferred and adoption orders are only made when informal alternatives are judged not to be in the best interests of the child.

Between 2001–02 and 2005–06, there were only 18 adoptions of Aboriginal and Torres Strait Islander children in Australia. Eight of these were 'known' child adoptions where the adoptive parents had a pre-existing relationship with the child (e.g. relatives/kin or carers), and 10 were 'local' adoptions where there was no pre-existing relationship between the adoptive parents and the child.

Although the Aboriginal Child Placement Principle (box 11.5) also covers the adoption of Indigenous children, of the 10 'local' adoptions of Indigenous children between 2001–02 and 2005–06, three were adoptions by Indigenous parents and seven were adoptions by non-Indigenous parents.

JUVENILE JUSTICE

The juvenile justice system is responsible for dealing with young people who have committed or allegedly committed an offence while a 'juvenile'. In Queensland, juvenile justice legislation applies to those people who were aged 10–16 years of age at the time of the offence. In most other jurisdictions, however, those who were aged 10–17 years of age are included as juveniles. Victoria also has a sentencing option for adult courts which allows for some 18–20 year-olds to be sentenced to detention in juvenile justice facilities.

Juvenile justice is a state and territory responsibility and each jurisdiction has its own legislation that dictates policies and practices in this area. While there are differences in detail, the intent of the legislation is very similar across Australia. For example, key elements of juvenile justice in all jurisdictions include:

- diversion of young people from court where appropriate;
- incarceration as a last resort;
- victim's rights;
- the acceptance of responsibility by the offender for his or her behaviour; and
- community safety.

The juvenile justice system in each state and territory comprises several organisations, each having a different primary role and responsibility in dealing with young offenders:

- the Police, who are usually the young person's first point of contact with the justice system. Where considered appropriate, the Police may administer warnings, cautions and in some jurisdictions use conferencing to divert the juvenile from proceeding to court;
- the courts (usually a special children's or youth court), where matters regarding the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options if the young person admits guilt or is found guilty by the court;
- the juvenile justice departments, which are responsible for the supervision of juveniles on a range of community-based orders and supervised bail and which are also responsible for the administration of juvenile detention centres.

The AIHW and the Australasian Juvenile Justice Administrators (AJJA) have developed a national data collection with information about young people who are on supervised community-based orders or in detention centres. The latest report from this new Juvenile Justice National Minimum Data Set was released in August 2007 and presents data from 2005–06, with trends from 2000–01—the first year of data collected (AIHW 2007i). The quality of information collected on the Indigenous status of juvenile justice clients varies according to differing collection and recording practices in the states and territories. Since the first report of the NMDS was released in February 2006, the quality has improved and it is expected that further improvements will be made over the next couple of years as standardised methods are implemented.

Few young people have contact with the juvenile justice system and many who do are diverted from the court when the offences committed are relatively minor and/or are a first offence. Of those young people who do go to court, most receive either non-supervised orders or community-based orders, with only a small proportion of young people placed in juvenile detention centres. Community-based supervision includes supervised bail, probation, community service orders and parole. Detention supervision includes both custodial remand prior to the case being finalised in court and

JUVENILE JUSTICE *continued*

sentenced detention. Juvenile justice supervision includes those under community-based supervision and those in detention.

The rates of juvenile justice supervision for all young people aged 10–17 years show high levels of over-representation of Indigenous youth during the period 2003–04 to 2005–06, relative to the proportion of Indigenous youth in state and territory populations (table 11.7). In 2005–06, Aboriginal and Torres Strait Islander young people were under juvenile justice supervision at a rate of 44 per 1,000, compared with a rate of 3 per 1,000 for non-Indigenous young people.

Rates of juvenile justice supervision for both Indigenous and non-Indigenous young people decreased in most states and territories during the period 2003–04 to 2005–06.

11.7 RATES OF YOUNG PEOPLE AGED 10–17 YEARS UNDER JUVENILE JUSTICE SUPERVISION(a)(b), by Indigenous status—2003–04 to 2005–06

	NSW	*Vic.*	*Qld*	*WA*	*SA*	*Tas.*(c)	*ACT*	*NT*	*Australia*
					2003–04				
Indigenous	35.8	26.5	41.6	99.6	63.0	11.9	56.7	21.6	45.1
Non-Indigenous	2.5	2.6	3.6	3.8	4.5	3.8	6.7	3.9	3.1
Total	**4.1**	**2.8**	**5.8**	**10.1**	**6.7**	**6.3**	**7.9**	**11.3**	**5.1**
					2004–05				
Indigenous	33.8	23.9	39.7	103.4	58.0	14.4	59.3	23.0	44.3
Non-Indigenous	2.5	2.2	3.1	3.8	4.0	4.1	5.8	3.3	2.9
Total	**4.0**	**2.5**	**5.3**	**10.2**	**6.1**	**6.3**	**7.1**	**11.6**	**4.9**
					2005–06				
Indigenous	34.7	23.8	39.8	106.6	51.4	17.7	44.2	21.2	44.4
Non-Indigenous	2.6	2.0	3.0	4.2	3.9	4.9	5.1	3.5	2.9
Total	**4.3**	**2.6**	**5.3**	**10.8**	**5.8**	**6.9**	**6.2**	**11.2**	**5.0**

(a) Age is calculated as at date of first juvenile justice supervision during the relevant year.

(b) Rates per 1,000 young people. Calculation of rates excludes records for young people whose Indigenous status was not stated. The rates are based on ABS high series 2001 Estimated Resident Indigenous population projections.

(c) Indigenous data for Tasmania may not be reliable due to limitations in the reporting capabilities of the information system.

Source: AIHW 2007i

Community-based supervision

In the period 2000–01 to 2005–06, the average daily number of Indigenous young people in community-based supervision increased by 24% (from 1,579 to 1,961). In comparison, there was a 4% decrease (from 2,980 to 2,853) for non-Indigenous young people over the same period. Part of the increase in Aboriginal and Torres Strait Islander numbers is likely to be due to a decrease in the number of young people whose Indigenous status was unknown, from 613 to 266 over this period (table 11.8).

Community-based supervision continued

11.8 YOUNG PEOPLE, average daily number in community supervision by Indigenous status(a)(b)—2000–01 to 2005–06

Year	*Indigenous*	*Non-Indigenous*	*Unknown*	*Total*(c)
2000–01	1 579	2 980	613	5 172
2001–02	1 543	3 026	448	5 017
2002–03	1 674	3 026	407	5 107
2003–04	1 757	2 969	344	5 070
2004–05	1 814	2 833	258	4 905
2005–06	1 961	2 853	266	5 081

(a) Averages are calculated by summing the community supervision days throughout the year and then dividing by 365.25 to get an average daily number. A community supervision day is one day of community-based supervision for one person.
(b) Australian Capital Territory is excluded as data for 2000–01, 2001–02 and 2002–03 were unavailable.
(c) Components may not add to total due to rounding.
Source: AIHW 2007h, 2007i

Detention supervision

In the period 2000–01 to 2005–06, the average daily number of Indigenous young people in detention supervision increased by 11%, from 321 in 2000–01 to 357 in 2005–06 (excluding the Australian Capital Territory for which data from 2000–01 to 2002–03 were unavailable). In comparison, there was a 15% decrease (from 501 to 425) for non-Indigenous young people over this period. The higher number of Indigenous young people in detention supervision may be due, or partly due, to improvements in Indigenous identification, with the average daily number of young people in detention whose Indigenous status was unknown decreasing from 59 to 15 over this period (table 11.9).

11.9 YOUNG PEOPLE, average daily number in detention by Indigenous status(a)(b)—2000–01 to 2005–06

Year	*Indigenous*	*Non-Indigenous*	*Unknown*	*Total*(c)
2000–01	321	501	59	881
2001–02	340	501	44	886
2002–03	333	465	35	833
2003–04	346	438	29	814
2004–05	341	406	19	766
2005–06	357	425	15	798

(a) Averages are calculated by summing the detention supervision days throughout the year and then dividing by 365.25 to get an average daily number. A detention supervision day is one day of detention supervision for one person.
(b) Australian Capital Territory is excluded as data for 2000–01, 2001–02 and 2002–03 were unavailable.
(c) Components may not add to total due to rounding.
Source: AIHW 2007h, 2007i

Juvenile justice supervision

Most young people under juvenile justice supervision are in community-based supervision rather than detention (tables 11.8 and 11.9). However, on an average day in 2005–06, Indigenous young people comprised a larger share of those in detention (45%) than those under community-based supervision (38%).

Juvenile justice supervision continued

Young Indigenous males under juvenile justice supervision outnumbered Indigenous females by a ratio of four to one. However, Indigenous females comprised a larger share of all females under supervision (45%) than did Indigenous males as a proportion of all males under supervision (37%) (table 11.10).

11.10 YOUNG PEOPLE UNDER JUVENILE JUSTICE SUPERVISION, by Indigenous status and sex—2005–06

Indigenous status	*Males*	*Females*	*Total*
NUMBER			
Indigenous	4 044	1 009	5 054
Non-Indigenous	6 385	1 084	7 470
Unknown/not recorded	602	127	730
Total	**11 031**	**2 220**	**13 254**
PERCENT			
Indigenous	36.7	45.5	38.1
Non-Indigenous	57.9	48.8	56.4
Unknown/not recorded	5.5	5.7	5.5
Total	**100.0**	**100.0**	**100.0**

Source: AIHW 2007i

Most young people under juvenile justice supervision during 2005–06 were aged 16 years or over (64%). However, 14% of Indigenous young people under supervision were aged 13 years or less, compared with only 6% of non-Indigenous young people (table 11.11).

11.11 YOUNG PEOPLE UNDER JUVENILE JUSTICE SUPERVISION, by Indigenous status and age—2005–06

	AGE (YEARS)									
Indigenous status	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18 and over*	*Total*
NUMBER										
Indigenous	20	65	170	430	736	948	1 129	1 094	462	5 054
Non-Indigenous	8	31	64	280	675	1 207	1 835	2 026	1 344	7 470
Unknown/not recorded	—	5	2	19	45	113	175	188	183	730
Total	**28**	**101**	**236**	**729**	**1 456**	**2 268**	**3 139**	**3 308**	**1 989**	**13 254**
PERCENT										
Indigenous	0.4	1.3	3.4	8.5	14.6	18.8	22.4	21.5	9.2	100.0
Non-Indigenous	0.1	0.4	0.9	3.7	9.0	16.2	24.6	27.1	18.0	100.0
Unknown/not recorded	—	0.7	0.3	2.6	6.2	15.5	24.0	25.8	25.1	100.0
Total	**0.2**	**0.8**	**1.8**	**5.5**	**11.0**	**17.1**	**23.7**	**25.0**	**15.0**	**100.0**

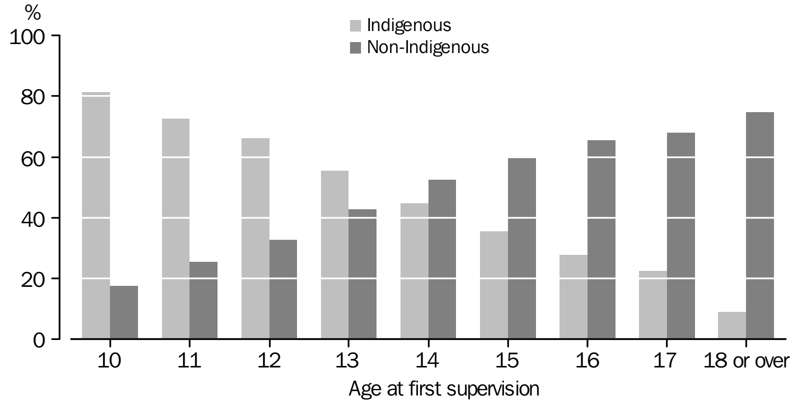
— nil or rounded to zero (including null cells)

Source: AIHW 2007i

Juvenile justice supervision continued

There are also differences in the age at which young people were first placed under juvenile justice supervision. Of those under juvenile justice supervision in 2005–06, Aboriginal and Torres Strait Islander young people were younger, on average, at the time of first ever supervision than non-Indigenous young people (graph 11.12). Just over half (56%) of Indigenous young people were aged 14 years or less during their initial supervision, compared with 30% of non-Indigenous young people.

11.12 YOUNG PEOPLE UNDER JUVENILE JUSTICE SUPERVISION, by Indigenous status and age at first supervision—2005–06



Source: AIHW 2007i

The over-representation of Indigenous people in the justice system is not confined to young people. While Aboriginal and Torres Strait Islander people comprise around 2% of the adult population, they constituted 24% of the average daily number of prisoners in full-time custody and 18% of adults on community corrections orders in the March 2007 quarter (ABS 2007b).

DISABILITY SERVICES

Services funded under the Commonwealth State-Territory Disability Agreement (CSTDA) are designed for people who need ongoing support with everyday life activities. Under this agreement the Australian Government has responsibility for planning, policy setting and management of employment services, while the states and territories have responsibilities for all other disability services. These include:

- accommodation support—services that provide accommodation to people with disability and services that provide the support needed to enable a person with disability to remain in his or her existing accommodation or move to more suitable or appropriate accommodation
- community support—services that provide the support needed for a person to live in a non-institutional setting, including therapy, early childhood intervention, counselling and case management
- community access—services that provide opportunities for people with disability to gain and use their abilities to enjoy their full potential for social independence, including day programs (alternatives to employment) and recreation/holiday programs
- respite—services that provide a short-term break for families and other voluntary caregivers of people with disability, while providing a positive experience for the person with disability.

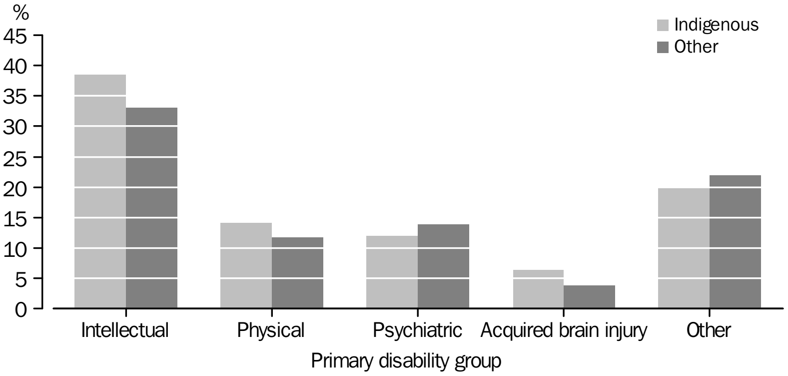
DISABILITY SERVICES *continued*

Advocacy, print disability and information services are considered shared responsibilities of the Australian state and territory governments.

National data on services are collected through the CSTDA National Minimum Data Set (NMDS), which includes information relating to CSTDA services and the people who use these services throughout the financial year. Data are collected by each state and territory and the Australian Government and forwarded to the AIHW for collation and analysis.

Data presented here are from the 2005–06 data collection, the third full year of the CSTDA NMDS. In 2005–06 there were 7,182 Indigenous CSTDA-funded service users, representing 3% of all users. The Indigenous status of 23,156 service users (11%) was unknown. The proportion of service users who were Indigenous has changed little over the three collection years (AIHW 2007f).

11.13 USERS OF CSTDA-FUNDED SERVICES, by Indigenous status and primary disability group (a)—2005–06



(a) Excludes 33,350 service users with primary disability group not stated.

Source: AIHW 2007f

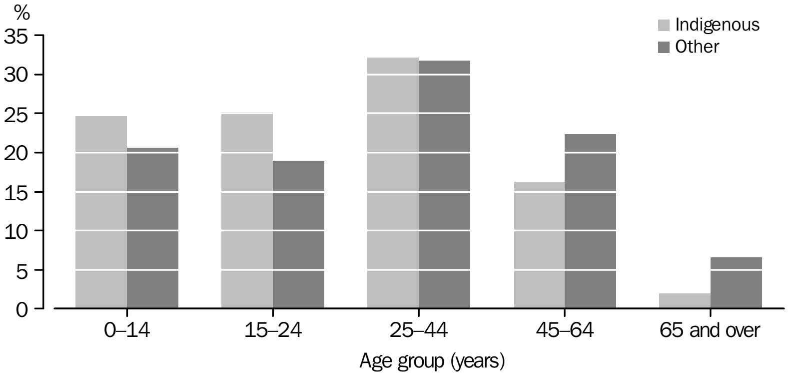
The most commonly reported primary disabilities for Indigenous service users were intellectual (39%), followed by physical (14%) and psychiatric (12%) (graph 11.13). Among non-Indigenous service users the most commonly reported primary disabilities were also intellectual (36%), but these were followed by people with psychiatric (15%) and then physical (11%) disabilities (AIHW 2007f).

Service users who were Indigenous more often reported multiple disabilities. Nearly half of all Indigenous service users (46%) reported a primary disability and at least one other significant disability, compared with 34% of non-Indigenous users (AIHW 2007f).

Indigenous service users of CSTDA services were younger, on average, than other service users (graph 11.14). The median age for Indigenous service users was 25 years, compared with a median age of 32 years for other service users (AIHW 2007f). This is consistent with the earlier onset of many chronic health conditions and shorter life expectancy in the Indigenous population (see Chapter 7).

DISABILITY SERVICES
continued

11.14 USERS OF CSTDA-FUNDED SERVICES, by Indigenous status and age(a)—2005–06



(a) Excludes 167 service users whose age was not stated.
Source: AIHW 2007f

Patterns of service use were similar for Indigenous and non-Indigenous service users (table 11.15). Similar to non-Indigenous users, Indigenous service users most commonly accessed community support services, followed by employment, accommodation, community access, and respite services. Indigenous service users were more likely than non-Indigenous users to access community support services (53% compared with 42%) respite services (20% compared with 13%), and accommodation services (20% compared with 18%). A lower proportion of Indigenous users accessed employment services (24% compared with 38%) and community access services (20% compared with 23%).

Differences in the types of services accessed may reflect different availability of services in regional/remote areas rather than differing needs of Indigenous and non-Indigenous service users. Some 12% of Indigenous users lived in remote and very remote areas, compared with 1% of other users, while 37% of Indigenous users were located in major cities compared with 64% of other users (AIHW 2007f).

11.15 USERS OF CSTDA-FUNDED SERVICES(a), by Indigenous status and service group —2005–06

	Indigenous		*Non-Indigenous*		*Unknown*		*Total*(b)	
Service group	no.	%	no.	%	no.	%	no.	%
Accommodation support	1 443	20.1	32 909	17.6	1 214	5.2	35 566	16.4
Community support	3 819	53.2	77 831	41.7	15 014	64.8	96 664	44.5
Community access	1 402	19.5	42 063	22.5	4 273	18.5	47 738	22.0
Respite	1 404	19.5	23 971	12.8	1 944	8.4	27 319	12.6
Employment	1 748	24.3	70 121	37.5	1 288	5.6	73 157	33.7
All service groups	**7 182**	**100.0**	**186 805**	**100.0**	**23 156**	**100.0**	**217 143**	**100.0**

(a) Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the twelve months from 1 July 2005 to 30 June 2006.
(b) Column totals may not be the sum of the components since individuals may have accessed services in more than one service group during the twelve month period.
Source: AIHW 2007f

AGED CARE

This section provides information on government services that give care and support to frail older people who are living in the community or who are in a residential aged care facility. Entry to many of the programs requires assessment and approval by an Aged Care Assessment Team (ACAT), but ACATs also refer clients to other services which do not require formal approval. The Home and Community Care Program (HACC) is one such program and is the largest community care program, both in terms of expenditure and numbers of clients receiving care in any given year.

HACC is jointly funded by the Australian and state and territory governments. It provides community-based support services, such as home nursing, personal care, respite, domestic help, meals, and transport to people who can be appropriately cared for in the community and can therefore live at home.

ACAT approval is required to access Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages, EACH Dementia packages and residential aged care (including residential respite care), all of which are subsidised by the Australian Government. In addition, ACAT assessment is required for entry to the Transition Care Program, and may be required by some states and territories for entry to the Multi-purpose Service program, both of which are funded jointly with the states and territories.

CACPs provide support and care to people who prefer to remain at home rather than enter low level residential aged care for which they are also eligible. EACH is a relatively new program which provides home care for people who are otherwise eligible for high level residential aged care. A recent innovation in provision of high care packages has seen the introduction of the EACH Dementia program with packages that are specifically targeted at people with dementia and associated behaviour and psychological symptoms (EACH Dementia). Use of the EACH and EACH Dementia programs by Indigenous people has been relatively low.

Residential aged care is subsidised by the Australian Government and provides accommodation and other support services such as personal care, help with performing daily tasks, and nursing care.

Although these services are mainly used by older people, a proportion of younger people utilise such services. This occurs relatively more often among Indigenous Australians because of the higher prevalence of chronic diseases among young people. For example, Type 2 diabetes, cardiovascular diseases and kidney disease typically occur at younger ages among Indigenous people and can result in a need for care at younger ages.

When planning service places and packages for older people, the Australian Government uses population estimates for the general population aged 70 years and over. However, in the allocation of places and packages across the country the Government also takes into account the number of Indigenous Australians who are 50 years and over (as a proxy for old age) (DHAC 2001). A research project, funded under the National Health and Medical Research Council/Australian Research Council *Ageing Well, Ageing Productively* program is underway in the School for Social and Policy Research at Charles Darwin University to examine the robustness of this planning assumption.

In developing programs to meet the care needs of older people, particular consideration is given to issues of access and equity for groups with special needs—such as Indigenous

AGED CARE *continued*

Australians. The Aboriginal and Torres Strait Islander Aged Care Strategy was developed in 1994 after consultation with Indigenous communities and organisations involved in the provision of aged care services. This Strategy tackles issues of access to services, including those related to the rural and remote location of many Indigenous communities. The Strategy established Aboriginal and Torres Strait Islander Flexible Services, which provide aged care services with a mix of residential and community care places that can change as community needs vary. Many of these services have been established in remote areas where no aged care services were previously available. The flexible services developed as part of the Strategy are now funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

In rural and remote locations that are too small to support the standard systems of aged care provision, Multi-purpose Services provide a more workable care and treatment model by bringing together a range of local health and aged care services, often including residential aged care, under one management structure. Multi-purpose Services provide flexible care places.

Home and Community Care Program

Data about client characteristics and services provided through the HACC program are collected on a quarterly basis and records are linked across quarters to form the annual HACC Minimum Data Set (MDS). Although a set of demographic, circumstance and assistance totals is held in the data repository for each agency reporting a client's data, only one set of demographic data is included in the combined linked data set. These demographic data are not a compilation from multiple data records but rather a selection of the demographic data record with the most recent assessment date. Consequently, not all valid demographic values may be captured and some invalid or missing values may be included. This may have an impact on the consistency of reporting of Indigenous status over time within the linked data. In 2005–06, Indigenous status was not recorded or not known for nearly 16% of HACC clients, compared with 11% of clients in 2004–05.

During 2005–06 approximately 3,200 organisations (around 82% of HACC-funded organisations) submitted data on the services they provided to clients across Australia. Among participating agencies, HACC services were provided to about 777,500 clients of all ages. Of these, just over 2.5% (about 19,100 after pro-rating of clients with missing Indigenous status) were reported to be Indigenous clients, ranging from 45% in the Northern Territory to 1% in Victoria and the Australian Capital Territory (DoHA 2007a).

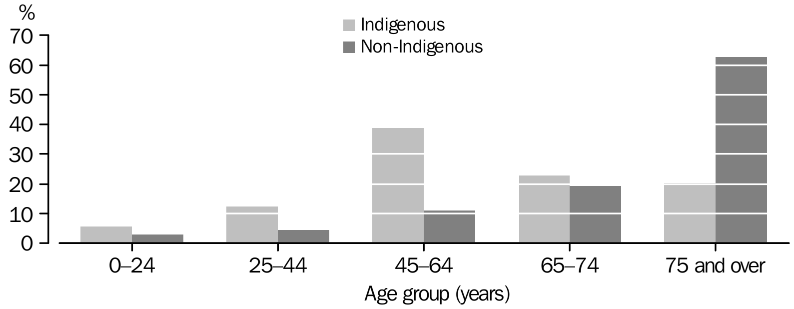
AGE PROFILE

Analysis of HACC MDS data shows that Indigenous HACC clients had a younger age profile than other clients (graph 11.16). About 57% of Indigenous clients were aged less than 65 years, compared with 18% of non-Indigenous clients. About 20% of Indigenous clients were aged 75 years or over, compared with 63% of non-Indigenous clients. The proportion of both Indigenous and non-Indigenous clients who were aged 75 years or over has increased slightly for both groups since 2003–04 (18% and 57% respectively), reflecting the ageing of the Australian population overall (DOHA 2007a).

Home and Community Care Program continued

AGE PROFILE *continued*

11.16 HOME AND COMMUNITY CARE CLIENTS, by Indigenous status and age(a)—2005–06



(a) Excludes 152,349 clients whose Indigenous status was not stated. Within age groups, these clients have been distributed between 'Indigenous' and 'Non-Indigenous' categories in accordance with the proportions that occurred for clients with known Indigenous status.

Source: AIHW analysis of the DoHA Aged and Community Care Management Information System Database

USAGE RATES

An examination of age-specific usage rates for Indigenous HACC clients in 2005–06 suggests the existence of some data quality problems. For some groups (e.g. Indigenous women aged 75 years and over) and for some states, the number of HACC clients identified as Indigenous were close to or greater than the ABS estimates of the corresponding Indigenous population. There may be a number of factors contributing to this. Repeat HACC clients may provide different name or birth date information to different HACC agencies, resulting in them being counted more than once. Over-estimation of the clients' ages could also result in higher age-specific usage rates for older clients. The usage rate might also be inflated if people were more inclined to identify themselves as Indigenous in the HACC collection than in the 2001 Census.

Because of these concerns about Indigenous identification in the HACC MDS, further information by Indigenous status is not presented for the Home and Community Care Program.

The Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) is jointly funded by the Australian Government and the states

and territories to support the network of multidisciplinary Aged Care Assessment Teams (ACATs) which operate in each state and territory within Australia. The primary purpose of ACATs is to comprehensively assess the care needs of frail older people and assist them to gain access to the types of available services most appropriate to meet their care needs. The assessment of care needs takes into account a person's physical, medical, psychological and social needs and assists them in gaining access to appropriate care services.

Aged Care Assessment Teams (ACATs) may be hospital or community-based. The main professional groups represented in teams are doctors, nurses, social workers, physiotherapists and occupational therapists. The target populations for assessment by

The Aged Care Assessment Program continued

an ACAT are non-Indigenous people aged 70 years or over and Indigenous people aged 50 years or over. Data about ACAT clients and services are recorded at a national level in the ACAP MDS. Indigenous status was not known or not recorded for 3.4% of completed assessments in 2004–05 (ACAP NDR 2006).

In 2004–05, there were 2,075 referrals to ACAP for Indigenous clients. Nationwide, 5% of the Indigenous population aged 50 years and over were referred to the ACAP and 1,862 received a complete assessment (ACAP NDR 2006). Nationally, the proportion of referrals to the ACAP for Indigenous clients was only 46% of the expected number, given the proportion of people in the target population (ACAP NDR 2006).

Both waiting times for assessment and the duration of the assessment process were generally shorter for Indigenous than non-Indigenous clients. The report from the ACAP National Data Repository notes that 'ACATs seem to have made an effort to complete assessments for Indigenous clients quickly, even though Indigenous clients often live in isolated communities and their assessments may require assistance from an interpreter or culturally appropriate assessor'.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

At 30 June 2006, there were around 30 services delivering 580 flexible places for Indigenous clients under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded to deliver culturally appropriate aged care, close to home and country, mainly in rural and remote areas.

As part of the 1994 National Strategy, services were established to provide aged care using a flexible model. Communities are encouraged to participate in every aspect of service provision, from the very early planning stages right through to the operation of the services. These services are now funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

The funding is 'cashed-out' and can be used flexibly so that a mix of residential and community aged care services can be provided. The mix of services may change as aged care needs vary. Funding is based on an agreed allocation of places, and not on the occupancy of those places. This provides a constant income stream so that service providers have both stability of income from the funding and flexibility to manage the delivery of aged care services. No demographic data are available for clients of these services.

Community Aged Care Packages

Out of a total of 31,803 people receiving Community Aged Care Packages (CACP) at 30 June 2006, 1,204 (4%) identified as being of Aboriginal or Torres Strait Islander origin. Indigenous status was not known for 0.4% of care recipients.

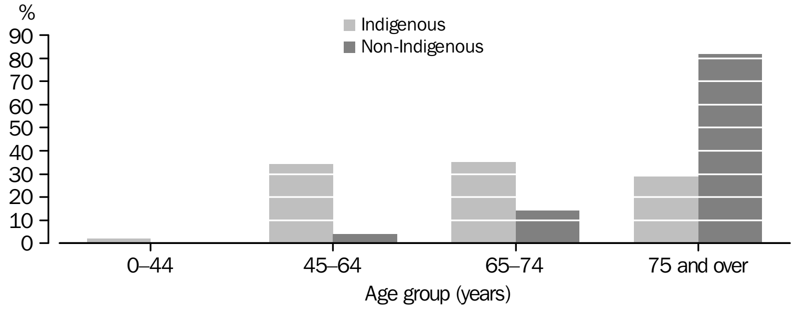
AGE PROFILE

Of people receiving assistance, proportionately more Indigenous recipients were in younger age groups (graph 11.17). About 36% of Indigenous CACP recipients were aged less than 65 years of age, compared with fewer than 4% of other CACP recipients. About 29% of Indigenous care recipients were aged 75 years and over, compared with 82% of other care recipients.

Community Aged Care Packages *continued*

AGE PROFILE *continued*

11.17 COMMUNITY AGED CARE PACKAGE RECIPIENTS, by Indigenous status and age(a)—30 June 2006



(a) Includes 134 clients whose Indigenous status was not stated. Within age groups, these clients have been distributed between the 'Indigenous' and 'Non-Indigenous' categories in accordance with the proportions that occurred for clients with a known Indigenous status.

Source: AIHW analysis of the DoHA Aged and Community Care Management Information System Database.

USAGE RATES

Use of Community Aged Care Packages is higher for Indigenous Australians compared with other Australians in all age groups examined. At 30 June 2006, there were 16 per 1,000 Indigenous clients aged 50–74 years, compared with 1 per 1,000 other Australian clients in the same age group (table 11.18). There were 85 per 1,000 Indigenous Australians aged 75 years and over using Community Aged Care Packages, compared with 20 per 1,000 other Australians in this age group.

11.18 COMMUNITY AGED CARE PACKAGE RECIPIENTS(a), by Indigenous status and age(b)—30 June 2006

	RECIPIENTS			USAGE RATE PER 1,000(c)		
Age group (years)	*Indigenous*	*Other*	*Total*	*Indigenous*	*Other*	*Total*
Less than 50	58	128	186	0.1	—	—
50–74	806	5 431	6 237	15.7	1.1	1.2
75 and over	345	25 035	25 380	84.8	19.6	19.8
Total	1 209	30 594	31 803	0.2	1.5	1.5

— nil or rounded to zero (including null cells)

(a) Recipients of packages provided by multi-purpose services and services receiving flexible funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program are not included, as age-specific figures are not available for these programs.

(b) There were 134 recipients whose Indigenous status was not stated. Within age groups, these recipients have been distributed between the 'Indigenous' and 'Other' categories in accordance with the proportion that occurred for recipients with a known Indigenous status.

(c) Rates per 1,000 are based on the 'low series' ABS population projections based on the 2001 Census.

Source: AIHW analysis of the DoHA Aged and Community Care Management Information System Database

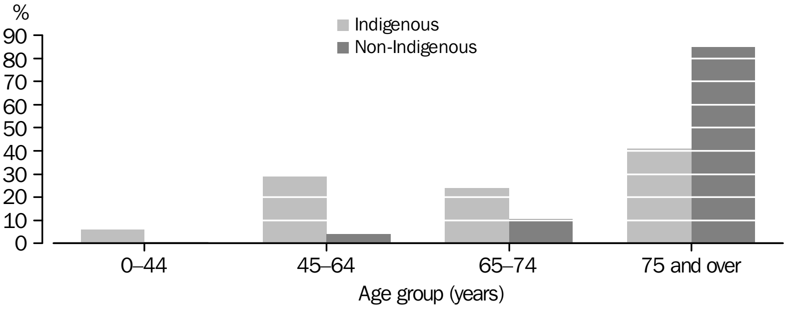
Residential aged care services

There were 154,872 people using residential aged care services at 30 June 2006. Of these, 872 permanent residents (0.6% of all permanent residents) and 35 people in respite care (1.1% of all people in respite care) identified as being of Aboriginal or Torres Strait Islander origin. Indigenous status was not recorded or not known for 10,967 residents (5%) (AIHW 2007m).

AGE PROFILE

Of those who were admitted to permanent or respite care during 2005–06, proportionately more Indigenous people were in younger age groups (graph 11.19). Almost 35% of Indigenous Australians were less than 65 years of age on admission to residential aged care, compared with 4% of other Australians. In contrast, about 41% of Indigenous Australians were aged 75 years or over on admission, compared with 85% of other Australians.

11.19 RESIDENTIAL AGED CARE ADMISSIONS, by Indigenous status and age(a)—2005–06



(a) Includes 612 clients whose Indigenous status was not stated. Within age groups, these clients have been distributed between the 'Indigenous' and 'Non-Indigenous' categories in accordance with the proportions that occurred for clients with a known Indigenous status.

Source: AIHW analysis of the DoHA Aged and Community Care Management Information System Database.

USAGE RATES

Age-specific usage rates show that Indigenous Australians make higher use of residential aged care services than other Australians at all ages (table 11.20). At 30 June 2006, 8 per 1,000 Indigenous people aged 50–74 years were residents in residential aged care, compared with 4 per 1,000 other Australians. At ages 75 years and over, 109 per 1,000 Indigenous people were in residential care, and 105 per 1,000 other Australians were in residential care. However, total usage rates for Indigenous Australians are lower than for non-Indigenous Australians due to the small proportion of the Indigenous population aged 75 years and over, the age group in which usage rates are highest.

Residential aged care services continued

USAGE RATES *continued*

11.20 RESIDENTS OF RESIDENTIAL AGED CARE SERVICES AND SERVICE USAGE RATES(a), by resident's Indigenous status and age—30 June 2006

	RESIDENTS			USAGE RATE PER 1,000(c)		
Age range (years) (b)	*Indigenous*	*Other*	*Total*	*Indigenous*	*Other*	*Total*
Under 50	85	963	1 048	0.2	0.1	0.1
50–74	428	18 677	19 105	8.3	3.8	3.8
75 and over	444	134 275	134 719	109.0	105.3	105.3
Total	957	153 915	154 872	1.9	7.6	7.5

(a) Places provided by multi-purpose services and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy are not included, as age-specific figures are not available for these programs.

(b) There were 6,799 residents whose Indigenous status was not stated. Within age groups, these residents have been distributed between the 'Indigenous' and 'Other' categories in accordance with the proportion that occurred for residents with a known Indigenous status.

(c) Rates per 1,000 are based on the 'low series' ABS population projections based on the 2001 Census.

Source: AIHW analysis of the DoHA Aged and Community Care Management Information System Database

DEPENDENCY LEVELS

The care needs of residents (dependency levels) are indicated by scores on the Resident Classification Scale (RCS). The RCS has eight categories which represent eight levels of care need in descending order from 1 to 8, with categories 1–4 representing high-care status and categories 5–8 representing low-care status.

Overall, 72% of Indigenous residents were classified as high-care at 30 June 2006, compared with 68% of other residents.

Residential respite care

Respite care supports community living for people who receive assistance from informal providers (family carers), by giving carers a break from providing assistance to see to their own affairs, to visit family and friends, to take a holiday or in instances where carers themselves encounter health, personal or family problems.

Residential respite care is recognised as an important component of the carer support system and provides short-term accommodation and care in residential aged care homes on a planned or emergency basis. Apart from emergencies, ACAT approval is required to access residential respite care and an approval remains valid for 12 months. A person with a valid ACAT approval for residential respite care may use up to 63 days of respite care in a financial year, which can be taken in 'blocks', for example, one or two weeks at a time. An extra 21 days may be available if deemed necessary by an ACAT.

There were 49,727 admissions for residential respite care between 1 July 2005 and 30 June 2006, 490 of which (1%) were for people who identified as Indigenous. Admission rates for Indigenous people in younger age groups were higher than non-Indigenous people, however, over two-thirds (68%) of admissions of Indigenous

Residential respite care *continued*

people were for those aged 65 years and over. At 30 June 2006, there were 3,135 respite residents, 35 (or 1%) of whom were Indigenous.

11.21 INDIGENOUS IDENTIFICATION IN COMMUNITY SERVICES COLLECTIONS

Indigenous identification in community services collections

Since the 2005 edition of this report, the quality of identification of Aboriginal and Torres Strait Islander clients in eight community services data collections has been examined, by analysing the extent to which Indigenous status is missing or not stated in each of the data collections (AIHW 2007l). The rates of missing/not stated were compared with those reported earlier, and a survey of activities at the national and the jurisdictional level to improve the quality of Indigenous identification in these data collections was also carried out.

The eight data collections examined were:

- Commonwealth-State Disability Agreement Minimum Data Set
- Residential Aged Care Services Data Collection
- Home and Community Care Minimum Data Set
- Community Aged Care Packages Data Collection
- Supported Accommodation Assistance Program National Data Collection
- Juvenile Justice National Minimum Data Set
- Alcohol and Other Drug Treatment Services National Minimum Data Set
- National Child Protection data collection, incorporating three data collections:
    - Children who are the subject of notifications, investigations and substantiations;
    - Children on care and protection orders; and
    - Children in out of home care.

Five out of the eight data collections reported decreases in the national missing/not stated Indigenous status rates, while the other three collections recorded an increase. It should be noted that these increases are not necessarily indicative of a decline in the quality of the data collected—the implementation of methods to promote longer term improvements may also contribute to a short-term increase in the rate of missing/not stated Indigenous status.

The extent to which the Indigenous identifier was missing or not stated varied greatly between the datasets. However, any analysis of Indigenous identification data in the community services sector must take into consideration that the preparedness of clients to identify may be influenced by a number of factors related to the nature of the service provided, including the purpose of the service and the voluntary nature of the clients' access to the service.

Activities aimed at improving the identification of Aboriginal and Torres Strait Islander clients that have been implemented at the national level include the development of improved data collection forms and software; implementation of the standard Indigenous status question; consultation with jurisdictions and agencies on the use of their data, including the return of data; and edit checks of national and jurisdictional data. Activities implemented in various data collections at the jurisdictional level have

Residential respite care continued

included supplying feedback to participating agencies by following up on data quality issues as they arise and providing support to participating agencies through training and data guides, help-desks and data collection software packages.

SUMMARY

In 2004, the proportion of Aboriginal and Torres Strait Islander children using Australian Government supported child care services was 1.8%. Of all Indigenous children in Australian Government supported child care services, 51% were in long day care centres, 16% were in before/after school care and 9% were in family day care. The corresponding proportions for other Australian children were 59%, 25% and 14% respectively.

Aboriginal and Torres Strait Islander children were over-represented in the child protection systems across most of Australia, with rates of Indigenous children in substantiations 11 times the rate for other children in Victoria and 9 times the rate in Western Australia. Across Australia, the rate of Indigenous children being placed under care and protection orders and in out-of-home care was seven times the rate for other children. Around two-thirds of children in out-of-home care were placed with Indigenous relatives/kin (37%) or with other Indigenous caregivers (27%). These are the preferred placements under the Aboriginal Child Placement Principle that has been adopted by all jurisdictions.

The rates of juvenile justice supervision for young people aged 10–17 years show high levels of over-representation of Indigenous youth. In 2005–06 there were 44 Indigenous youth per 1,000 under juvenile justice supervision compared with 3 per 1,000 for non-Indigenous youth. Most young people under juvenile justice supervision were in community-based supervision rather than detention. Indigenous youth comprised a larger share of those in detention (45%) than those under community supervision (38%). Aboriginal and Torres Strait Islander young people were younger, on average, than non-Indigenous young people when first placed under juvenile justice supervision.

In 2005–06, 7,182 people, or 3% of those receiving Commonwealth/State/Territory Disability Agreement funded services were Indigenous. The proportion of Indigenous people who use disability services is relatively low given that the rate of disability in the Indigenous population is almost twice the rate of disability in the non-Indigenous population. Indigenous service users were more likely than non-Indigenous users to report a physical disability as their primary disability, acquired brain injury or developmental delay. Disability service users who were Indigenous were younger than other service users, with a median age of 25 years compared with a median age of 32 years for non-Indigenous users.

Aboriginal and Torres Strait Islander people were also more likely than other Australians to utilise aged care services at younger ages, consistent with the poorer health status and lower life expectancy for this population. Of those admitted to permanent or respite residential care during 2005–06, almost 35% were less than 65 years of age, compared with fewer than 4% of other Australians. Of all Indigenous Australians receiving Community Aged Care Packages at 30 June 2006, 36% were less than 65 years of age and 20% were aged 75 years or over. The corresponding rates for other HACC clients were 4% and 63% respectively.

CHAPTER 12 TORRES STRAIT ISLANDER PEOPLES

INTRODUCTION

Torres Strait Islander people are a significant cultural group representing one-tenth of the Australian Indigenous population. While they share many of the characteristics of other Indigenous Australians, some health and welfare characteristics are different from those of Aboriginal peoples.

Since 1971, Torres Strait Islander people have been recognised as a separate group from Aboriginal people according to the Australian Bureau of Statistics (ABS) standard. From the 1996 Census of Population and Housing onwards, Indigenous people have also been able to indicate if they are of both Torres Strait Islander and Aboriginal origin. Torres Strait Islander people are defined in this chapter as those who identified as being of Torres Strait Islander origin only, or of both Torres Strait Islander and Aboriginal origin.

The information in this chapter is drawn from the Censuses of Population and Housing for 2006, 2001 and 1996, the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), the 2006 Community Housing and Infrastructure Needs Survey (CHINS), the ABS Birth Registrations Collection, the Australian Institute of Health and Welfare (AIHW) National Hospital Morbidity Database (NHMD), the AIHW National Mortality Database and the AIHW National Perinatal Data Collection.

National data on Torres Strait Islander health and welfare continue to be improved through better design of the Indigenous sample in ABS collections, and through enhanced Indigenous identification within administrative health data sets.

This chapter compares Torres Strait Islander people with the overall Indigenous population, which comprises people of Torres Strait Islander origin and people of Aboriginal origin. Contrasts are also provided with the non-Indigenous people of Australia, and between Torres Strait Islander people living in the Torres Strait Indigenous Region and those living in other areas.

DEMOGRAPHIC CHARACTERISTICS

Estimated resident Indigenous population

The census count of Torres Strait Islander people, based on their place of usual residence, is used to generate a more reliable estimate of the size of this population by adjusting for net undercount and for instances in which Indigenous status is unknown. Births, deaths and migration are taken into account in calculating the Estimated Resident Population (ERP) which provides an estimate of the size of the Torres Strait Islander population, and the Aboriginal population, as well as the total Indigenous population.

The ERP for all people of Torres Strait Islander origin at 30 June 2006 was 53,300 (table 12.1). Torres Strait Islander people comprised around 10% of all Indigenous Australians, 23% of Indigenous people in Queensland and 0.3% of the total Australian population. Across Australia, 20,200 people were estimated to be of both Aboriginal and Torres Strait Islander origin (38% of all Torres Strait Islander people).

Estimated resident Indigenous population continued

In 2006, 62% of Torres Strait Islander people lived in Queensland (including 15% in the Torres Strait Indigenous Region) and a further 15% lived in New South Wales. There were an estimated 7,800 Torres Strait Islander people living in the Torres Strait Indigenous Region. This was 23% of all Torres Strait Islander people who usually live in Queensland, and 15% of all Torres Strait Islander people in Australia.

12.1 ESTIMATED RESIDENT INDIGENOUS POPULATION, by state/territory of usual residence—2006 (preliminary)

State/territory		Torres Strait Islander(a)	Aboriginal only	Total Indigenous
New South Wales	%	15.4	30.2	28.7
Victoria	%	5.8	6.0	6.0
Queensland	%	62.2	24.4	28.3
South Australia	%	2.8	5.3	5.0
Western Australia	%	5.1	16.2	15.1
Tasmania	%	3.6	3.2	3.3
Northern Territory	%	4.7	13.8	12.9
Australian Capital Territory	%	0.5	0.8	0.8
Australia(b)	%	100.0	100.0	100.0
Population estimate(b)	no.	**53 300**	**463 900**	**517 200**

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.
(b) Includes Other Territories, comprising Jervis Bay Territory, Christmas Island and Cocos (Keeling) Islands.
Source: ABS 2007f

The age distribution of Torres Strait Islander people was similar to that of the overall Indigenous population. In 2006, 71% of Torres Strait Islander people and the same proportion of the overall Indigenous population were less than 35 years of age. This compared with 47% of the non-Indigenous population who were in this younger age group. Only 10% of Torres Strait Islander people were aged 55 years or over compared with 8% of all Indigenous people and 24% of non-Indigenous people (table 12.2).

12.2 ESTIMATED RESIDENT POPULATION, by Indigenous status and age—2006 (preliminary)

		TORRES STRAIT ISLANDER(a)					
Age group (years)		Torres Strait Indigenous Region	Balance of Australia	Total	Aboriginal only	Total Indigenous	Non-Indigenous
0–14	%	38.9	38.1	38.3	37.3	37.4	19.1
15–34	%	32.3	32.5	32.4	33.5	33.4	27.8
35–54	%	19.5	19.3	19.3	21.6	21.4	28.8
55 and over	%	9.2	10.1	10.0	7.6	7.8	24.3
Total	%	100.0	100.0	100.0	100.0	100.0	100.0
Population estimate	no.	**7 800**	**45 500**	**53 300**	**463 900**	**517 200**	**20 184 300**

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.
Source: ABS Unpublished data, available on request

Births

A Torres Strait Islander birth is registered as such when at least one parent identifies as being of Torres Strait Islander origin or of both Torres Strait Islander and Aboriginal origin. Indigenous births data are subject to under-identification and registrations do not always distinguish between Aboriginal and Torres Strait Islander births. Identification of Indigenous births for the period 2002–2006 is estimated to be 95% for Australia and 98% for Queensland (ABS 2007a). Separate estimates of the level of identification of Torres Strait Islander births are not available.

Over the period 2004–2006, Torres Strait Islander births comprised 11% of all registered Indigenous births. In 2006, one-quarter (25%) of Indigenous births in Queensland were registered as being Torres Strait Islander births (table 12.3).

12.3 TORRES STRAIT ISLANDER REGISTERED BIRTHS—2004–2006

	Torres Strait Islander births(a)	*Total Indigenous births*	*Torres Strait Islander births as a proportion of all Indigenous births*
	no.	no.	%
2004	1 296	12 006	10.8
2005	1 374	12 078	11.4
2006	1 378	12 496	11.0
2006			
Queensland	864	3 463	24.9
Balance of Australia	514	9 033	5.7
Males	709	6 288	11.3
Females	669	6 208	10.8

(a) Includes births where mother or father was of both Torres Strait Islander and Aboriginal origin.

Source: ABS Birth Registrations Collection

There were 4,048 births registered as Torres Strait Islander in the period 2004–2006, of which two-thirds (2,582) were to Torres Strait Islander mothers. The median age of Torres Strait Islander mothers was 25 years which was the same as for all Indigenous mothers (table 12.4). This was younger than the median age of non-Indigenous mothers (31 years).

Births continued

12.4 AGE OF PARENTS, Torres Strait Islander registered births—2004–2006

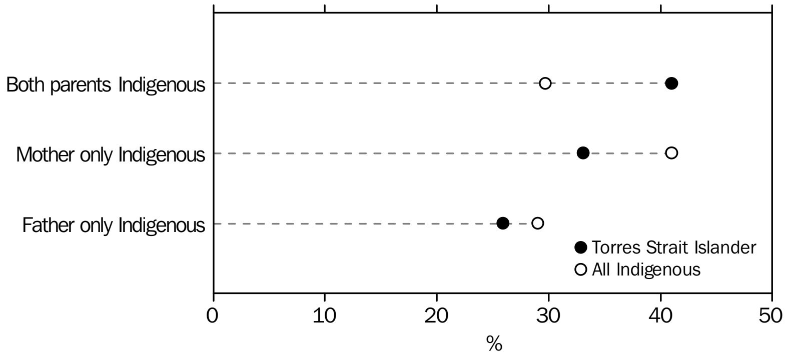
Age of mother (years)		*Torres Strait Islander mothers*(a)	*Total Indigenous mothers*	*Non-Indigenous mothers*
Less than 20	%	17.0	21.1	3.4
20–24	%	31.1	31.1	13.4
25–29	%	23.7	23.3	26.9
30–34	%	18.9	16.2	34.9
35–39	%	7.7	7.0	17.8
40 and over	%	1.5	1.3	3.5
Total	%	100.0	100.0	100.0
Median age of mother	years	25.3	24.6	30.9
Median age of father	years	28.2	27.7	33.1
All registered births	no.	**2 582**	**25 989**	**743 943**

(a) Includes mothers who were of both Torres Strait Islander and Aboriginal origin.

Source: ABS Birth Registrations Collection

Forty-one percent of babies registered as being of Torres Strait Islander origin in 2004–2006 had two Indigenous parents, compared with 30% of Indigenous babies overall (graph 12.5).

12.5 INDIGENOUS STATUS OF PARENTS, Torres Strait Islander(a) and all Indigenous births—2004–2006



(a) Includes births where the mother or father was of both Torres Strait Islander and Aboriginal origin.

Source: ABS Birth Registrations Collection

Babies

The AIHW National Perinatal Statistics Unit (NPSU) collects birth data from midwives and other health professionals who attend births. As birth registrations are based on information provided by parents to state and territory Registrars of Births, Deaths and Marriages, different sources mean that statistics obtained vary. Only the Indigenous status of the mother is collected by the NPSU, while birth registrations collect the Indigenous status of both mother and father.

The AIHW National Perinatal Data Collection recorded an average of 1,041 liveborn babies with a Torres Strait Islander mother each year in the period 2003–2005. Of these babies, 96 each year, on average, were low birthweight babies (less than 2,500 grams at birth) including an average of 20 very low birthweight babies (less than 1,500 grams at birth) per year. With around one in ten liveborn babies (9%) recording a low birthweight, Babies *continued*

Torres Strait Islander mothers were less likely than Indigenous mothers overall (13%) but more likely than non-Indigenous mothers (6%) to have low birthweight babies.

Over the same period, the perinatal death rate was 17 per 1,000 births to Torres Strait Islander mothers. This was similar to the perinatal death rate for births to Indigenous mothers overall (18 per 1,000 births) but 70% higher than the perinatal death rate for births to non-Indigenous mothers (10 per 1,000 births).

Deaths

Undercounting of Indigenous deaths is likely to result from some Torres Strait Islander people not being identified as such when their death is registered. Although identification of Indigenous deaths is incomplete in all state and territory registration systems, the ABS has determined that data for Queensland, Western Australia, South Australia and the Northern Territory have sufficient coverage to enable the production of mortality statistics for Aboriginal and Torres Strait Islander peoples. In 2001–2005, the rate of coverage of Indigenous deaths was over 50% for each of these states and 92% in the Northern Territory. Deaths data presented in this chapter have been combined from these four jurisdictions and should be regarded as indicative only.

During 2001–2005, the median age at death was 55 years for Torres Strait Islander males and 62 years for Torres Strait Islander females (table 12.6).

12.6 INDIGENOUS DEATHS, by sex and median age at death(a)—2001–2005

		Torres Strait Islander(b)	*Total Indigenous*	*Non-Indigenous*
Deaths				
Males	no.	375	4 329	119 211
Females	no.	263	3 215	108 185
Persons	no.	638	7 544	227 396
Median age at death				
Males	years	55	49	76
Females	years	62	55	82
Persons	years	58	51	79

(a) Data are for Qld, WA, SA and NT combined, based on state/territory of usual residence. Deaths are based on year of registration of death for 2001–2005.

(b) Includes deaths where person was of both Torres Strait Islander and Aboriginal origin.

Source: AIHW National Mortality Database

Cause of death

The most commonly recorded cause of death among Torres Strait Islander people in the period 2001–2005, accounting for 30% of registered deaths, were diseases of the circulatory system (e.g. heart diseases). Circulatory diseases were also the most common cause of death in the Indigenous population (accounting for 27% of registered deaths). Torres Strait Islander people were more likely than Indigenous people overall to die from cancer (malignant neoplasms) (21% compared with 15%), and were less likely to die as a result of external causes (including injury) (10% compared with 16%) (table 12.7).

Cause of death continued

12.7 UNDERLYING CAUSE OF DEATH(a), by Indigenous status—2001–2006

	TORRES STRAIT ISLANDER(b)		TOTAL INDIGENOUS	
	no.	*%*	*no.*	*%*
Malignant neoplasms (C00–C96)	132	20.7	1 113	14.8
Endocrine, nutritional and metabolic diseases (E00–E90)	73	11.4	682	9.0
Diabetes (E10–E14)	63	9.9	600	8.0
Diseases of the circulatory system (I00–I99)	190	29.8	2 006	26.6
Diseases of the respiratory system (J00–J99)	40	6.3	659	8.7
Diseases of the digestive system (K00–K93)	25	3.9	433	5.7
External causes of morbidity and mortality (V01–Y98)	66	10.3	1 220	16.2
Other causes	112	17.6	1 431	19.0
All causes	**638**	**100.0**	**7 544**	**100.0**

(a) Data are for Qld, WA, SA and NT combined, based on state/territory of usual residence. Deaths are based on year of registration of death for 2001–2005.

(b) Includes deaths where person was of both Torres Strait Islander and Aboriginal origin.

Source: AIHW National Mortality Database

SOCIOECONOMIC CHARACTERISTICS

The economic and social circumstances of Torres Strait Islander people differ substantially depending on whether they live in the Torres Strait Indigenous Region, or in other parts of Australia. While Torres Strait Islander people living outside of the Torres Strait Indigenous Region display characteristics which are generally similar to the overall Indigenous population, those living in the Torres Strait Indigenous Region tend to share the socioeconomic outcomes of Indigenous people living in very remote parts of Australia. Over a range of indicators, Torres Strait Islander people generally experience greater socioeconomic disadvantage than do non-Indigenous Australians.

Language spoken at home

The preservation of language, as a key element in the maintenance of cultural identity, contributes significantly to overall well-being and health outcomes in Indigenous communities.

According to the 2006 Census, 75% of Torres Strait Islander people in the Torres Strait Indigenous Region reported speaking an Australian Indigenous language at home. Of these, 72% spoke Torres Strait Island Creole and 17% spoke Kalaw Kawaw Ya/Kalaw Lagaw Ya.

The majority of Torres Strait Islander people living outside of the Torres Strait Indigenous Region (80%) spoke only English at home and 7% spoke an Indigenous language. Similarly, 82% of the overall Indigenous population spoke only English at home, and 11% spoke an Indigenous language.

Around four out of five Torres Strait Islander people (81%) who spoke an Indigenous language at home reported being able to speak English well or very well, which was comparable with the level of English proficiency of all Indigenous people who spoke an Indigenous language at home (79%).

In the Torres Strait Indigenous Region, 19% of Torres Strait Islander people who spoke an Indigenous language at home did not speak English well, or did not speak it at all. This was the same proportion reported for all Indigenous people. However, only 13% of

Language spoken at home continued

Torres Strait Islander people living outside the Torres Strait Indigenous Region who spoke an Indigenous language at home did not speak English well, or at all (table 12.8).

12.8 LANGUAGE SPOKEN AT HOME AND PROFICIENCY IN ENGLISH—2006

	TORRES STRAIT ISLANDER(a)			
	Torres Strait Indigenous Region	*Balance of Australia*	*Total*	*Total Indigenous*
	%	%	%	%
Language spoken at home				
English only	12.5	80.3	70.3	81.8
Australian Indigenous language	**75.2**	**6.8**	**16.9**	**11.4**
Other language	8.1	6.1	6.4	1.6
Total(b)	100.0	100.0	100.0	100.0
Proficiency in English				
Spoke English well or very well	80.2	83.8	81.4	78.6
Did not speak English well, or at all	18.6	13.2	16.7	19.0
Total persons who spoke an Australian Indigenous language at home(c)	100.0	100.0	100.0	100.0

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.
(b) Includes language spoken at home not stated.
(c) Includes proficiency in English not stated.
Source: ABS 2006 Census of Population and Housing

Highest year of school completed

The relationship between higher levels of educational attainment and improved overall health status in the Indigenous population has been discussed in Chapter 3 of this report.

In 2006, 32% of Torres Strait Islander people aged 15 years or over (excluding those still at school) had completed Year 12; an increase from 27% in 2001. While the Year 12 completion rate for all Indigenous Australians increased from 20% to 23% over the five year period, it remained lower than for Torres Strait Islander people.

Year 12 completion by Torres Strait Islander people was higher among those living in the Torres Strait Indigenous Region (39%) than for those in other parts of Australia (31%). However, levels of secondary school completion were still lower than those for the non-Indigenous population (49%) in 2006 (table 12.9).

12.9 HIGHEST YEAR OF SCHOOL COMPLETED—2006

		TORRES STRAIT ISLANDER(a)				
		Torres Strait Indigenous Region	Balance of Australia	Total	Total Indigenous	Non-Indigenous
Year 12	%	38.5	31.0	32.2	23.0	49.1
Year 10 or 11	%	35.7	42.9	41.7	43.2	35.2
Year 9 or below(b)	%	25.8	26.1	26.1	33.9	15.8
Total	%	100.0	100.0	100.0	100.0	100.0
Persons aged 15 years and over(c)	no.	**3 880**	**19 664**	**23 544**	**232 870**	**13 346 618**
Highest year of school completed not stated	no.	132	3 709	3 841	32 951	730 000

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.

(b) Includes persons who never attended school.

(c) Excludes persons whose highest year of school completed was not stated.

Source: ABS 2006 Census of Population and Housing

Highest non-school qualification

In 2006, there were around 5,000 Torres Strait Islander people aged 25–64 years with a non-school qualification (32% of the Torres Strait Islander population). The following analysis focuses on non-school qualifications of Certificate III or higher. For further explanation of the differences between certificate levels, see Chapter 3.

Just over one-quarter (27%) of Torres Strait Islander people aged 25–64 years had attained a Certificate III or higher qualification in 2006, similar to the rate in the overall Indigenous population (25%). These rates were both significantly lower than those for non-Indigenous people (50%). In 2001, 20% of Torres Strait Islander people aged 25–64 years had a Certificate III or higher qualification.

Torres Strait Islander people living in the Torres Strait Indigenous Region in 2006 were as likely as those living in other parts of Australia to have completed a non-school qualification of Certificate III or higher (28% and 27% respectively) (table 12.10).

12.10 HIGHEST NON-SCHOOL QUALIFICATION—2006

		TORRES STRAIT ISLANDER(a)				
		Torres Strait Indigenous Region	Balance of Australia	Total	Total Indigenous	Non-Indigenous
Bachelor degree or above	%	4.0	6.0	5.6	6.1	22.6
Certificate or Diploma, Certificate III or above(b)	%	23.9	21.0	21.5	18.8	27.5
Total with a non-school qualification, Certificate III or above	%	27.8	27.0	27.1	24.9	50.1
Certificate I/II(c)	%	9.1	4.4	5.2	4.1	3.4
No non-school qualification	%	61.2	67.0	66.0	69.6	44.7
Total	%	100.0	100.0	100.0	100.0	100.0
Persons aged 25–64 years(d)	no.	**2 452**	**12 925**	**15 377**	**156 391**	**9 324 895**
Highest non-school qualification not stated	no.	273	2 675	2 948	26 399	493 215

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.

(b) Includes persons with a Diploma or Advanced Diploma.

(c) Includes persons with a Certificate n.f.d.

(d) Includes persons with level of education inadequately described. Excludes persons with level of education not stated.

Source: ABS 2006 Census of Population and Housing

Labour force status

Labour force data from the 2006 Census have been used in this report. For further information on the main differences between labour force data from the Census and Indigenous-specific surveys, refer to Chapter 2.

Labour force participation by Torres Strait Islander people aged 15–64 years was 59% in 2006, having changed little since 1996 when the rate was 57%. Their participation was greater than the overall Indigenous rate (54%) but lower than the participation rate for non-Indigenous people (75%). Among Torres Strait Islander people aged 15–64 years, the male labour force participation rate was 65% and the female rate was 53% (table 12.11).

Torres Strait Islander people aged 15–64 years had a lower unemployment rate (12%) than did all Indigenous people in this age group (16%) in 2006. The corresponding unemployment rate for non-Indigenous Australians was 5%. The Torres Strait Islander unemployment rate of 12% had decreased from 19% in 1996, consistent with the general decline in unemployment Australia-wide.

The unemployment rate was 5% for Torres Strait Islander people living in the Torres Strait Indigenous Region in 2006, compared with 14% for those living in other areas. While full-time employment was reported at similar rates for all Torres Strait Islander people aged 15–64 years, part-time employment was almost twice as common for those living in the Torres Strait Indigenous Region than in other parts of Australia (29% compared with 15%).

12.11 LABOUR FORCE CHARACTERISTICS—2006

		TORRES STRAIT ISLANDER(a)				
		Torres Strait Indigenous Region	*Balance of Australia*	*Total*	*Total Indigenous*	*Non-Indigenous*
Labour force status						
Employed						
Full-time	%	31.5	28.5	28.9	24.1	45.9
Part-time	%	28.5	15.1	17.1	16.6	20.5
Total(b)	%	66.5	49.1	51.6	45.2	70.8
Unemployed	%	3.3	7.9	7.2	8.4	3.8
Not in the labour force	%	26.7	36.2	34.8	40.7	24.2
Total(c)	%	100.0	100.0	100.0	100.0	100.0
Labour force participation rate						
Males	%	78.6	62.4	64.7	59.1	81.0
Females	%	61.7	51.3	52.9	48.4	68.5
Persons	%	69.9	57.0	58.9	53.6	74.7
Unemployment rate						
Males	%	4.1	13.4	11.8	15.8	5.1
Females	%	5.4	14.5	12.8	15.4	5.2
Persons	%	4.7	13.9	12.3	15.6	5.1
Total persons aged 15–64 years	no.	**3 934**	**22 921**	**26 855**	**268 807**	**12 276 785**

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.
(b) Includes persons who were away from work.
(c) Includes persons whose labour force status was not stated.
Source: ABS 2006 Census of Population and Housing

Labour force status continued

The comparatively low unemployment rate and greater share of part-time work among Torres Strait Islander people in the Torres Strait Indigenous Region is largely the result of higher participation in the Community Development Employment Projects (CDEP) programme. Results from the 2004–05 NATSIHS show that CDEP work comprised 56% of all employment for Torres Strait Islander people aged 15–64 years in the Torres Strait Indigenous Region, whereas 91% of employed Torres Strait Islander people living in other parts of Australia were in mainstream jobs. For further information on the CDEP programme, refer to the Glossary.

Income

In comparing the relative economic wellbeing of households of different size and composition, the actual incomes of households are adjusted using an equivalence scale to produce the equivalised gross weekly income of each person in that household. For further explanation of equivalised gross household income, see the Glossary.

In 2006, the median equivalised gross household income for Torres Strait Islander people was $388 per week. This was higher than that for all Indigenous people ($362 per week), and was equal to 60% of the median equivalised household income for non-Indigenous people ($642 per week).

Torres Strait Islander people who lived in the Torres Strait Indigenous Region had a lower median equivalised household income than those in other parts of Australia ($354 compared with $400). Torres Strait Islander median equivalised incomes were lower for women than for men ($379 compared with $399), and this was also reflected in both the Indigenous and non-Indigenous populations.

LOW RESOURCE HOUSEHOLDS

People with equivalised gross weekly household incomes in the lowest quintile (i.e. less than $315 per week) who were living in a dwelling that was not owned (with or without a mortgage) by a household member, and in which no household member was the owner/manager of an unincorporated business, were considered to be living in low resource households. For further information on income quintiles and low resource households, refer to the Glossary.

In 2006, 32% of Torres Strait Islander people, 39% of Indigenous people overall, and 8% of non-Indigenous people were living in low resource households. Torres Strait Islander people in the Torres Strait Indigenous Region were more likely to be living in low resource households (39%) than those living in other parts of Australia (31%) (table 12.12).

12.12 EQUIVALISED GROSS WEEKLY HOUSEHOLD INCOME(a)—2006

		TORRES STRAIT ISLANDER(b)				
		Torres Strait Indigenous Region	*Balance of Australia*	*Total*	*Total Indigenous*	*Non-Indigenous*
Lowest income quintile (Less than $315)						
Low resource households(c)	%	38.7	31.1	32.4	38.7	8.0
Remainder of households	%	2.8	7.8	6.9	6.5	11.6
Second and third income quintiles	%	52.0	42.9	44.4	39.0	39.5
Fourth and fifth income quintiles	%	6.5	18.2	16.2	15.8	40.8
Total	%	100.0	100.0	100.0	100.0	100.0
	no.	**5 899**	**28 804**	**34 703**	**337 503**	**15 288 123**
Income not stated(d)	no.	442	7 342	7 784	73 054	1 893 333

(a) Derived from gross weekly household income in occupied private dwellings, where all incomes were reported.

(b) Includes persons who were of both Torres Strait Islander and Aboriginal origin.

(c) Excludes persons in dwellings that were partially or fully owned by a household member and persons in households where a household member was an owner manager of an unincorporated enterprise.

(d) Comprises Nil income, Negative income, Partial incomes stated, All incomes not stated and Not applicable.

Source: ABS 2006 Census of Population and Housing

Housing

Torres Strait Islander people were more likely to be living in a rented dwelling in 2006 than in a dwelling that was owned (with or without a mortgage) by a household member (65% compared with 28%). While the same proportion of Indigenous people overall (65%) were renting, around one-quarter of non-Indigenous people (24%) were living in rented housing.

In 2006, one in ten Torres Strait Islander people (10%) lived in a dwelling that was fully owned, and almost one in five (18%) lived in a dwelling that was being purchased. Similarly, 8% of Indigenous people lived in fully owned dwellings and 20% lived in dwellings that were being purchased. Around one-third of non-Indigenous people (30%) were living in fully owned dwellings and 42% were in dwellings that were being purchased (table 12.13).

There was no significant change in the proportion of Torres Strait Islander people living in homes which were owned (with or without a mortgage) between 1996 (29%) and 2006 (28%). Rates of housing rental among Torres Strait Islander people also changed little (from 60% to 65%) over this period.

In the Torres Strait Indigenous Region in 2006, 88% of Torres Strait Islander people were living in rented housing compared with 61% of Torres Strait Islander people living in other parts of the country. A much smaller proportion of Torres Strait Islander people in the Torres Strait Indigenous Region (7%) were living in a dwelling that was owned (with or without a mortgage), compared with 31% of Torres Strait Islander people living in other areas. Housing tenure among Torres Strait Islander people in the Torres Strait Indigenous Region mirrored that of Indigenous people in other very remote parts of Australia, where 84% lived in rented dwellings and 4% lived in a home that was owned (with or without a mortgage).

In the Torres Strait Indigenous Region, 40% of Torres Strait Islander people were living in housing provided by Indigenous Housing Organisations (IHOs), other housing

Housing continued

co-operatives, or church or community groups, compared with 8% of Torres Strait Islander people living elsewhere in Australia.

12.13 HOUSING TENURE(a)—2006

		Torres Strait Islander(b): Torres Strait Indigenous Region	Torres Strait Islander(b): Balance of Australia	Torres Strait Islander(b): Total	Total Indigenous	Non-Indigenous
Homeowner						
Fully owned	%	5.6	10.4	9.7	7.8	30.2
Being purchased	%	1.2	20.8	17.8	20.5	41.6
Total owners/purchasers	%	6.8	31.1	27.5	28.3	71.8
Renter						
State or territory housing authority	%	37.7	21.5	23.9	22.5	3.2
Indigenous housing organisation/community housing	%	39.7	7.6	12.4	16.9	0.4
Private and other renter(c)	%	11.0	31.5	28.5	25.3	20.8
Total renters	%	88.4	60.6	64.8	64.6	24.4
Other tenure type(c)	%	2.6	2.4	2.4	2.8	1.8
Tenure type not stated	%	2.2	5.8	5.3	4.3	2.0
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
	no.	**6 341**	**36 146**	**42 487**	**410 557**	**17 181 456**

(a) Data are for persons living in occupied private dwellings. Excludes visitors, Other not classifiable and Not Applicable.

(b) Includes persons who were of both Torres Strait Islander and Aboriginal origin.

(c) Includes landlord type not stated.

Source: ABS 2006 Census of Population and Housing

The 2006 Community Housing and Infrastructure Needs Survey collected information about the state of repair of dwellings owned or managed by IHOs. While dwellings in the Torres Strait Indigenous Region were less likely than other IHO dwellings to require major repairs (14% compared with 26%), they were equally likely to require replacement (9%).

12.14 DWELLING CONDITION, permanent dwellings owned or managed by Indigenous Housing Organisations—2006

	Dwellings in Torres Strait Indigenous Region		Dwellings in balance of Australia		Total Australia	
	no.	%	no.	%	no.	%
Minor or no repair required	911	77.7	9 382	64.9	10 293	65.7
Major repair required	160	13.7	3 750	25.9	3 910	25.0
Replacement required	101	8.6	1 323	9.2	1 424	9.1
Total IHO owned or managed permanent dwellings	**1 172**	**100.0**	**14 455**	**100.0**	**15 627**	**100.0**

Source: ABS 2006 CHINS

Internet access

In 2006, 35% of Torres Strait Islander people had access to an Internet connection in their home. Internet access was significantly lower in the Torres Strait Indigenous Region, where 84% of people of Torres Strait Islander origin did not have Internet access at home, compared with 54% of those living in other parts of Australia. The situation in the Torres Strait Indigenous Region was similar to very remote areas overall, in which

Internet access continued

86% of Indigenous people did not have Internet access at home. More than half (58%) of Indigenous people and 27% of non-Indigenous people were without Internet access at home (table 12.15).

12.15 INTERNET ACCESS(a)—2006

		TORRES STRAIT ISLANDER(b)				
		Torres Strait Indigenous Region	*Balance of Australia*	*Total*	*Total Indigenous*	*Non-Indigenous*
Type of Internet connection at home						
Broadband	%	6.3	23.5	21.0	22.1	47.0
Dial-up	%	6.2	13.6	12.5	13.1	23.1
Total(c)	%	13.3	38.3	34.6	36.2	70.7
No internet connection at home	%	84.1	54.0	58.5	57.9	27.0
Total(d)	%	100.0	100.0	100.0	100.0	100.0
	no.	**6 341**	**36 146**	**42 487**	**410 557**	**17 181 456**

(a) Information collected for occupied private dwellings.
(b) Includes persons who were of both Torres Strait Islander and Aboriginal origin.
(c) Includes other types of Internet connection.
(d) Includes type of Internet connection not stated.
Source: ABS 2006 Census of Population and Housing

Social and cultural participation

The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) collected information on participation in social activities and Aboriginal and Torres Strait Islander cultural activities. According to the survey, 44% of Torres Strait Islander people aged 15 years or over identified with a clan, tribal group or language group. While the proportion was higher for all Indigenous people in this age group (54%), similar proportions of Torres Strait Islander and Indigenous people overall recognised homelands or traditional country (67% and 70%) (ABS & AIHW 2005).

In 2002, almost all Torres Strait Islander people aged 15 years or over in the Torres Strait Indigenous Region (99%) had attended some kind of cultural event in the previous 12 months. In comparison, 67% of Torres Strait Islander people living in other parts of Australia reported having attended a cultural event in this period. The majority of Torres Strait Islander people aged 15 years or over (90%) had been involved in social activities in the previous three months, equal to the level of social participation reported by Indigenous people overall. Torres Strait Islander people were more likely than Indigenous people overall to have been involved in church or religious activities in the last three months (30% compared with 24%).

In the 12 months preceding the 2006 Census, 17% of Torres Strait Islander females aged 15 years or over and 14% of Torres Strait Islander males in this age group had undertaken voluntary work. The rates for Indigenous people overall were similar (15% for females and 12% for males). In the non-Indigenous population, corresponding rates were 21% for females and 17% for males.

Stressful life circumstances

In 2004–05, 73% of Torres Strait Islander people aged 18 years or over reported that a stressful life event or circumstance had been a problem for them or someone close to them over the previous 12 months. For further information on the stressors included in the 2004–05 NATSIHS, refer to the Glossary of National Aboriginal and Torres Strait Islander Health Survey 2004–05 (ABS 2006c).

Most commonly reported stressors among Torres Strait Islander people aged 18 years or over in 2004–05 were the death of a family member or friend (40%), household financial stress (39%), overcrowding at home (16%) and inability to find a job (14%). Indigenous adults had similar experiences of life stressors, however Torres Strait Islander people were less likely than Indigenous people overall to report financial stress (39% compared with 51%) and alcohol-related problems (11% compared with 20%).

Neighbourhood problems

In the 2002 NATSISS, 73% of Torres Strait Islander people aged 15 years or over reported the presence of at least one serious problem in their neighbourhood or community. This was comparable to the overall proportion of Indigenous people reporting neighbourhood problems (74%) (ABS & AIHW 2005).

The types of problems most commonly reported by Torres Strait Islander people related to theft (42%), alcohol (36%), illegal drugs (35%), vandalism and other damage to property (33%), youth-related problems (32%), and family violence (26%) (ABS & AIHW 2005).

HEALTH INDICATORS

Self-assessed health and long-term health conditions

In the 2004–05 NATSIHS, 44% of Torres Strait Islander people aged 15 years or over reported that their health was excellent or very good while 23% said they had fair or poor health. These were similar to the rates reported by all Indigenous people (43% and 22% respectively).

Almost three-quarters (73%) of Torres Strait Islander people aged 15 years or over had a long-term health condition in 2004–05, similar to the proportion of all Indigenous people of the same age (77%) (table 12.16). Reporting of long-term conditions by Torres Strait Islander people living in the Torres Strait Indigenous Region was comparable to those living in other areas (70% and 73% respectively).

The most commonly reported long-term conditions among Torres Strait Islander people aged 15 years or over were eye/sight problems (38%) and back pain/problems (18%). While the prevalence of most long-term conditions were similar in the Torres Strait Islander and total Indigenous populations, Torres Strait Islander people were less likely to report heart disease and/or circulatory problems (13% compared with 18%).

Self-assessed health and long-term health conditions continued

12.16 HEALTH STATUS AND SELECTED LONG-TERM CONDITIONS, by Indigenous status—2004–05

		Torres Strait Islander(a)	*Total Indigenous*
Self-assessed health			
Excellent/very good	%	44.5	43.2
Good	%	32.6	34.9
Fair/poor	%	22.9	21.9
Eye/sight problems	%	38.4	43.6
Back pain/symptoms	%	18.3	20.9
Heart and circulatory problems/diseases	%	(b) 13.2	(b) 18.1
Asthma	%	12.7	15.8
Ear/hearing problems	%	12.1	13.9
Arthritis	%	11.6	14.6
Diabetes/high sugar levels	%	8.8	9.8
Has a long-term condition	%	72.9	77.3
No long-term condition	%	27.1	22.7
Total persons aged 15 years and over	'000	**30.7**	**29.4**

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.

(b) Difference between Torres Strait Islander and Indigenous data is statistically significant.

Source: ABS 2004–05 NATSIHS

12.17 IMPROVED INFRASTRUCTURE CREATES POSITIVE HEALTH OUTCOMES FOR TORRES STRAIT COMMUNITIES

The incidence of water and hygiene-associated communicable diseases in the Torres Strait region decreased in the period 1996 to 2006. This has been attributed to improvements in the region’s environmental health infrastructure as part of the Torres Strait’s Major Infrastructure Program (MIP). The facilities delivered through MIP in a partnership between the Torres Strait Regional Authority and the Queensland Department of Local Government, Planning, Sport and Recreation, are producing positive health outcomes in the 15 outer Torres Strait Island communities and the two Northern Peninsula communities of Bamaga and Seisia.

In the Torres Strait region, notifications of environmental health-related diseases such as Shigellosis, Salmonella, and Hepatitis A halved between 1996 and 2006, according to data from the Queensland Notifiable Conditions Database (NOCS). Close to 40 cases were reported in the region in 1996 and under 20 cases were reported in 2006. According to the World Health Organization (WHO), in 2006, 88% of global environmental infectious diseases such as diarrhoea were attributable to poor water, sanitation and hygiene.

Since 1998, developments in the Torres Strait region have included increased access to clean and safe drinking water, flushing toilets, serviced housing lots, sealed roads and drainage systems. Island Councils are better able to manage community waste through the installation of sewerage treatment plants and improved refuse control techniques. Projects commenced in 2007 continued to improve infrastructure standards in the region, including further installation of portable desalination units for the use of island communities affected by drought conditions in recent years.

Source: TSRA media release, MIP Continues To Deliver, 20/02/2007.

Risk factors

In 2004–05, around half (49%) of Torres Strait Islander people aged 18 years or over were current daily smokers. This is similar to the rate reported by the overall Indigenous population (50%). Torres Strait Islander people living in the Torres Strait Indigenous Region reported lower rates of regular smoking than did those in other parts of Australia (38% compared with 51%).

The 2004–05 NATSIHS collected two measures of alcohol consumption using National Health and Medical Research Council (NHMRC) guidelines—one on long-term use and the other on short-term, heavy use (binge drinking). For further information, see the Glossary and Chapter 8 of this publication.

In 2004–05, 13% of Torres Strait Islander people aged 18 years or over reported long-term risky or high risk alcohol consumption and 16% reported risky or high risk short-term alcohol consumption. These rates of alcohol consumption were not significantly different from those reported by Indigenous people overall (table 12.18).

A sedentary lifestyle, defined by very low levels of exercise or no exercise at all, was reported by 36% of the 22,700 Torres Strait Islander people aged 15 years or over in non-remote parts of Australia. Indigenous people overall were more likely to be sedentary, with 47% of those aged 15 years or over in non-remote areas reporting that they do very little or no exercise. Despite their greater engagement in physical exercise, Torres Strait Islander people aged 15 years or over in non-remote areas were just as likely as Indigenous people overall to be overweight or obese (57% and 56% respectively).

In non-remote areas in 2004–05, 45% of Torres Strait Islander people aged 15 years or over who agreed to answer questions regarding substance use reported that they had used illicit substances, and 31% had used illicit substances in the past 12 months. These rates of illicit substance use were not significantly different from those of the overall Indigenous population.

Risk factors continued

12.18 SELECTED HEALTH RISK FACTORS—2004–05

		Torres Strait Islander(a)	*Total Indigenous*
Current daily smoker	%	49.4	50.0
Risky/high risk alcohol consumption			
long-term	%	13.0	16.5
short-term	%	16.0	19.3
Total persons aged 18 years and over	%	100.0	100.0
	no.	**26 600**	**258 300**
Overweight	%	29.1	27.5
Obese	%	27.9	28.7
Total overweight and obese	%	57.0	56.2
Total persons aged 15 years and over in non-remote areas who reported a BMI(b)	%	100.0	100.0
	no.	**19 900**	**177 500**
Persons aged 15 years and over in non-remote areas who did not report a BMI(b)	no.	2 800	35 900
Has used illicit substances			
during lifetime	%	44.9	49.1
in last 12 months	%	30.7	28.2
Has never used illicit substances	%	53.9	49.1
Total persons aged 15 years and over in non-remote areas who answered substance use form(c)	%	100.0	100.0
	no.	**17 600**	**165 600**
Persons aged 15 years and over in non-remote areas who did not answer substance use form	no.	5 100	47 900

(a) Includes persons who were of both Torres Strait Islander and Aboriginal origin.
(b) For an explanation of Body Mass Index, refer to Glossary.
(c) Includes persons who did not state whether they had ever used illicit substances.
Source: ABS 2004–05 NATSIHS

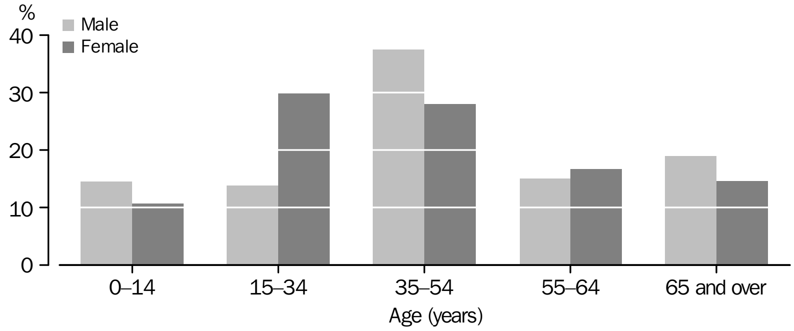
Hospitalisations

A hospital separation (hospitalisation) refers to an admitted patient completing an episode of care in hospital, by being discharged, transferring to another hospital or care facility, or dying. It is therefore possible for the same patient to be counted more than once if they are hospitalised on multiple occasions. For further information on hospital separations, refer to the 2005 edition of this report (ABS & AIHW 2005). While Indigenous identification in hospital separations data are incomplete nationally, coverage in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory is sufficient to support statistics on hospitalisations of Torres Strait Islander people. In 2005–06, these jurisdictions recorded 15,216 hospitalisations involving Torres Strait Islander people, accounting for 8% of all hospitalisations of Indigenous people. More than half (56%) of all hospitalisations involving Torres Strait Islander people were for females, similar to the pattern for Indigenous people overall (57%).

Hospitalisations of Torres Strait Islander females were most common for those of child-bearing age (15–34 years) (29%), and for those aged 35–54 years (26%). The hospitalisation rate for Torres Strait Islander males aged 35–54 years (40%) was significantly higher than for males in other age groups (graph 12.19).

Hospitalisations continued

12.19 HOSPITALISATIONS(a), Torres Strait Islander persons(b)—2005–06



(a) Data are for NSW, Vic., Qld, WA, SA and NT based on state/territory of usual residence. Excludes private hospitals in the NT.
(b) Includes patients who were of both Torres Strait Islander and Aboriginal origin.

Source: AIHW National Hospital Morbidity Databse

During 2005–06, kidney disease involving dialysis was the most commonly recorded principal diagnosis, accounting for 39% of hospitalisations of Torres Strait Islander people, similar to the hospitalisation rate for dialysis for Indigenous people overall (41%) (table 12.20). Over half (53%) of hospitalisations for dialysis treatment of Torres Strait Islander males involved those aged less than 55 years. The corresponding proportion of hospitalisations involving Torres Strait Islander females less than 55 years was 45%.

12.20 HOSPITALISATIONS BY PRINCIPAL DIAGNOSIS(a), for Indigenous persons—2005–06

	Torres Strait Islander(b)		*Total Indigenous*	
	no.	%	no.	%
Certain infectious and parasitic diseases (A00–B99)	285	1.5	5 249	2.2
Neoplasms (C00–D48)	435	2.3	3 532	1.5
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50–D89)	124	0.7	1 161	0.5
Endocrine, nutritional and metabolic diseases (E00–E90)	400	2.1	4 797	2.0
Mental and behavioural disorders (F00–F99)	726	3.8	10 083	4.1
Diseases of the nervous system (G00–G99)	192	1.0	3 347	1.4
Diseases of the eye and adnexa (H00–H59)	158	0.8	1 170	0.5
Diseases of the ear and mastoid process (H60–H95)	104	0.6	1 714	0.7
Diseases of the circulatory system (I00–I99)	644	3.4	7 859	3.2
Diseases of the respiratory system (J00–J99)	921	4.9	15 722	6.5
Diseases of the digestive system (K00–K93)	1 119	5.9	12 906	5.3
Diseases of the skin and subcutaneous tissue (L00–L99)	386	2.0	5 599	2.3
Diseases of the musculoskeletal system and connective tissue (M00–M99)	416	2.2	4 205	1.7
Diseases of the genitourinary system (N00–N99)	556	2.9	6 220	2.6
Pregnancy, childbirth and the puerperium (O00–O99)	1 807	9.6	18 012	7.4
Certain conditions originating in the perinatal period (P00–P96)	241	1.3	2 601	1.1
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	109	0.6	879	0.4
Symptoms, signs and abnormal clinical and laboratory findings, n.e.c. (R00–R99)	642	3.4	10 461	4.3
Injury, poisoning and certain other consequences of external causes (S00–T98)	1 261	6.7	18 843	7.8
Factors influencing health status and contact with health services (Z00–Z99 excluding Z49)	1 001	5.3	8 529	3.5
Total excluding care involving dialysis	11 529	61.0	142 953	58.8
Care involving dialysis (Z49)	7 367	39.0	100 153	41.2
Total(c)	**18 896**	**100.0**	**243 106**	**100.0**

(a) Data are for NSW, Vic., Qld, WA, SA and NT combined, based on state/territory of usual residence. Excludes private hospitals in the NT.

(b) Includes patients who were of both Torres Strait Islander and Aboriginal origin.

(c) Includes hospitalisations for which no principal diagnosis was reported.

Source: AIHW National Hospital Morbidity Database

SUMMARY

Torres Strait Islander people have more favourable outcomes than other Indigenous people for several social and economic indicators. They have higher rates of secondary school completion, higher equivalised incomes, and lower unemployment rates than Indigenous people overall. Like the Indigenous population as a whole, however, Torres Strait Islander people experience higher levels of disadvantage than do non-Indigenous Australians across most indicators of health and welfare..

The data suggest that the health and welfare of the Torres Strait Islander population is improving. Between 2001 and 2006, educational attainment improved in terms of Year 12 completion and non-school qualifications. In addition, labour force participation increased and the unemployment rate decreased for Torres Strait Islander people over this five-year period.

When compared with Torres Strait Islander people in other parts of Australia, those living in the Torres Strait Indigenous Region had significantly different outcomes for certain socioeconomic indicators. Torres Strait Islander people in the Torres Strait Indigenous Region had higher rates of secondary school completion and cultural participation, and lower unemployment than those living elsewhere. They also had comparatively low equivalised household incomes, lower rates of home ownership and limited Internet access, reflecting the general disparity in opportunities and services that exist between people living in urban and very remote parts of Australia.