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Aboriginal and Torres Strait Islander health organisations

Online Services Report—key results 2016–17

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Aboriginal and Torres Strait Islander
health services report no. 9.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
ARIA	Accessibility/Remoteness Index of Australia
BP	Best Practice
BSTL	Better Start to Life
CDMP	chronic disease management plan
CEO	Chief Executive Officer
CIS	Clinical information system
COAG	Council of Australian Governments
CSHISC	Community Services and Health Industry Skills Council
DoH	Department of Health
DQS	Data Quality Statement
ENT	ear, nose and throat
FTE	full-time equivalent
GIRS	Geographically-adjusted Index of Relative Supply
HDP	Health Data Portal
IAS	Indigenous Advancement Strategy
IAHP	Indigenous Australians' Health Programme
MBS	Medicare Benefits Schedule
MD	Medical Director
nKPI	national Key Performance Indicator
NSW	New South Wales
NT	Northern Territory
NTG	Northern Territory Government
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OSR	Online Services Report
PM&C	Department of the Prime Minister and Cabinet
Qld	Queensland
RACGP	Royal Australian College of General Practitioners
SA	South Australia
SEWB	social and emotional wellbeing
Tas	Tasmania
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

Symbols

—	nil or rounded to zero
. .	not applicable
<	less than
>	greater than

Summary

This ninth national report provides information on 266 organisations funded by the Australian Government to deliver health services to Aboriginal and Torres Strait Islander people. These organisations contributed to the 2016–17 Online Services Report. Information is presented on the characteristics of these organisations; the services they provide; client numbers, contacts and episodes of care; staffing levels; and service gaps and challenges.

Some changes were made to the 2016–17 data collection, aimed at ensuring consistency in episode of care reporting between the different data collection systems. This resulted in a decrease in primary health episode of care counts in 2016–17. These are not comparable with previous collections, so comparisons are not presented in this report. See Chapter 2 for more information about the data collection, data quality and the impacts of these changes.

Key messages

1. A range of services are provided to Aboriginal and Torres Strait Islander people

Of the 266 organisations in 2016–17:

- 196 (74%) provided a range of primary health-care services to around 444,700 clients through 3.2 million episodes of care. Just over two-thirds of these organisations (136) were Aboriginal Community Controlled Health Organisations. Services provided include: health promotion; clinical care; substance-use treatment and prevention; and social and emotional wellbeing support. These organisations also provided access to specialist, allied health and dental services, either on site or by facilitating off-site access. For example, most provided access to cardiologists (90%); renal specialists (87%); ophthalmologists (86%); paediatricians (90%); psychiatrists (87%); diabetes specialists (90%); and ear, nose and throat (ENT) specialists (88%). They also provided access to dental services (94%) and to allied health services such as physiotherapists (89%); psychologists (93%); dieticians (95%); podiatrists (96%); optometrists (94%); and audiologists (91%).
- Around 7,600 full-time equivalent (FTE) staff were employed by organisations providing primary health-care services and just over half of all staff (53%) were Aboriginal and/or Torres Strait Islander (see Chapter 3).
- 213 (80%) provided maternal and/or child health services through their primary health and/or New Directions funding. Around 8,400 Indigenous women were seen through 42,200 antenatal visits—an average of 5 visits per client (see Chapter 4).
- 88 (33%) provided social and emotional wellbeing services. The 189 counsellors in these organisations saw around 16,300 clients, through 77,100 client contacts—an average of 5 contacts per client (see Chapter 5).
- 80 (30%) provided substance-use services to around 39,400 clients through 197,700 episodes of care. Most episodes of care (88%) were for non-residential or after-care services (see Chapter 6).

2. Many funded organisations provide services in *Remote* and *Very remote* areas

Nearly half (46%) of the organisations funded to provide primary health-care services to Aboriginal and Torres Strait Islander people did so in *Remote* or *Very remote* areas and they saw around 168,100 (38%) clients. Around 44% of employed staff (3,347 FTE) worked in *Remote* or *Very remote* areas, including a higher proportion of employed nurses and midwives (59% or 664 FTE) and a lower proportion of employed dental care staff (21% or 38 FTE). There were more FTE nurses and midwives per 1,000 clients in *Remote* (3.5) and *Very remote* areas (4.4), compared with 2.6 per 1,000 clients overall. There were fewer doctors in *Very remote* areas (0.9 FTE doctors per 1,000 clients compared with 1.3 overall), perhaps reflecting a greater reliance on nurse-led clinics in these areas. Contacts by nurses and midwives represented half (51%) of all contacts in *Very remote* areas compared with 29% overall.

Over 800,000 episodes of care (25%) were provided to clients in *Very remote* areas. However, organisations in *Very remote* areas were still more likely to report staffing vacancies. Nearly one-third (31%) of reported health-staff vacancies were in organisations in *Very remote* areas. They also had more health-staff vacancies per 1,000 clients (1.0 compared with 0.7 overall). Organisations in *Very remote* areas were also more likely to report the recruitment, training and support of staff as one of the challenges they faced in providing quality care to clients (75% compared with 67% overall) as well as staff retention and turnover (75% compared with 57% overall).

3. Various group activities are run to promote health and wellbeing

Organisations delivered a range of group activities in 2016–17 to improve the health of the community:

- Those funded to provide primary health-care services ran around 8,400 physical activity/healthy weight sessions; 4,300 chronic disease client support sessions; and 3,300 tobacco-use treatment and prevention sessions. Other common health promotion activities included campaigns to encourage immunisation services (in 81% of organisations), healthy lifestyle programs (75%) and sexual health/education (71%).
- With respect to maternal and child health services, around 20,300 home visits; 3,100 maternal and baby/child health group sessions; 2,100 parenting group sessions and 1,000 antenatal group sessions were provided.
- In those funded to provide substance-use services, most (93%) provided community education, while 60% did school visits. Around 4 in 5 (80%) ran physical activity or healthy weight programs and around three-quarters ran tobacco-use treatment and prevention groups (76%), alcohol-misuse treatment and prevention groups (74%), living skills groups (75%), men's groups (75%) and women's groups (74%).

Things to note

- Most (94%) organisations funded to provide primary health care also provided social and emotional wellbeing or mental health or counselling services, and over half (57%) had mental health promotion activities in 2016–17; however, nearly two-thirds of organisations still reported mental health and social and emotional wellbeing services as a service gap (63%). This was even higher (78%) in organisations funded to provide substance-use services, but not primary health care.
- Some organisations indicated that clients with high needs had to wait too long for some services, in particular to access dental services and mental health professionals. For example, 50 (27%) organisations providing on-site or off-site access to dental services still felt clients with high needs often had to wait a clinically unacceptable time for dental services. This was higher in organisations in *Remote* (44%) and *Very remote* (34%) areas.

1 Introduction

This ninth national report provides an overview of 266 organisations funded by the Australian Government Department of Health (DoH) and/or the Department of the Prime Minister and Cabinet (PM&C) to provide health services to Aboriginal and Torres Strait Islander people. These organisations contributed to the 2016–17 Online Services Report (OSR) data collection (see Box 1.1). This report presents the main findings from 2016–17 and includes information on: the characteristics of these organisations; health services provided; client numbers, contacts and episodes of care; staffing levels; and service gaps and challenges.

Box 1.1: About the OSR data collection

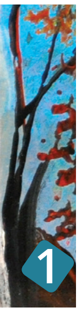
The Australian Institute of Health and Welfare (AIHW) annually collects data from organisations funded by the Australian Government to provide one or more of the following services to Aboriginal and Torres Strait Islander people: primary health care; maternal and child health care; social and emotional wellbeing services; and substance-use services.

Data collected includes staffing (both employed and visiting), the types of health services provided, the total number of individual clients seen (both Indigenous and non-Indigenous clients) and client contacts and episodes of care. The OSR also collects a range of contextual information about the organisation, for example, on governance, accreditation, information systems, advocacy, knowledge and research activities, policy and planning processes, and service gaps and challenges.

In 2016–17, 266 out of 275 in-scope organisations (97%) provided data for the OSR. Of these, 196 (74%) reported on their primary health-care services, 213 (80%) on maternal and child health services, 88 (33%) on social and emotional wellbeing services and 80 (30%) on substance-use services. Complete data were obtained from most (94%) organisations, while 6% (16 organisations) had some of their data excluded from the national analyses presented in this report.

The following should be kept in mind when using OSR data:

- The organisations in scope for reporting in the collection may change over time and the definition of an organisation in this report may differ slightly from the one used by the DoH and PM&C for funding purposes.
- The organisations submitting valid data for a data item may change over time.
- In some organisations, data on the number of clients and episodes of care are based on estimates.
- Analyses for each year are based on the organisations providing valid data in that year.
- There were some changes in the 2016–17 collection in how some data were generated and extracted. These were made to improve consistency in episodes of care reporting between different data collection systems and to allow some OSR data to be automatically extracted from an organisation's clinical information system (CIS). These changes affected primary health episodes of care counts in particular, and these counts are not comparable with previous collections and represent a break in series. See Chapter 2 for more information about the data collection, data quality and the impacts of these changes.



1.1 Policy context

The health of Indigenous Australians

In June 2016, around 798,400 people were estimated as being Aboriginal and/or Torres Strait Islander, representing 3.3% of the Australian population (ABS 2017a). Around 9% of the Indigenous population identified as being of Torres Strait Islander origin, and almost two-thirds (64%) of Torres Strait Islanders lived in Queensland. The Indigenous population has a younger age structure than the non-Indigenous population. In 2016, the median age of the Indigenous population (the age at which half the population is older and half is younger) was 23, compared with 38 for the non-Indigenous population (ABS 2017c). The birth rate for Indigenous women is also higher; in 2016 the total fertility rate for Aboriginal and Torres Strait Islander women was 2.12 compared with 1.79 for all women (ABS 2017b). While most Indigenous Australians live in non-remote areas (79% in 2011), a higher proportion (21%) live in remote areas compared with just 2% of non-Indigenous Australians (AIHW 2015d).

The gap in health outcomes between Indigenous and non-Indigenous Australians is well documented, especially in life expectancy, infant mortality, child mortality, chronic disease prevalence, potentially preventable hospitalisations and the burden of disease (AIHW 2015a). For example, a recent study found that Indigenous Australians experienced a burden of disease 2.3 times the rate of non-Indigenous Australians, with diabetes being 6 times as high. Chronic diseases were responsible for more than two-thirds (70%) of the total health gap in 2011 and for 64% of the total disease burden among Indigenous Australians. The 5 disease groups that caused the most burden were mental and substance use disorders (19% of total disease burden), injuries (which includes suicide) (15%), cardiovascular diseases (12%), cancer (9%) and respiratory diseases (8%). This study also shows that over one-third (37%) of the burden of disease in Indigenous Australians could be prevented by reducing exposure to modifiable risk factors. The risk factors contributing most to the overall disease burden were tobacco and alcohol use, high body mass, physical inactivity, high blood pressure and dietary factors (AIHW 2016a).

While there have been some improvements in the health and wellbeing outcomes of Indigenous Australians—for example, between 1998 and 2016 the Indigenous child (0–4) mortality rate declined by 35%—Indigenous Australians remain disadvantaged compared with non-Indigenous Australians (PM&C 2018a). A number of factors contribute to this disadvantage, including the social determinants of health such as housing, education, employment and income; behavioural risk factors such as smoking, poor nutrition, and physical inactivity; and access to health services (AIHW 2015a). In addition, a broader range of social and emotional wellbeing issues result from colonisation and its intergenerational legacies: loss and trauma; removal from family and cultural dislocation; racism; and discrimination (DoH 2013).

Policy responses

In 2008 a framework was developed to tackle Aboriginal and Torres Strait Islander disadvantage, with 6 targets established to close the gap between Indigenous and non-Indigenous people with respect to child mortality, early childhood education, reading and numeracy, year 12 attainment, employment and life expectancy. These targets were agreed with all states and territories through the Council of Australian Governments (COAG). A seventh target to close the gap in school attendance was added in 2014. While progress has been made across the target areas, latest data indicate that 3 of the 7 targets are on track to be met and 4 of the existing targets expire in 2018 (PM&C 2018a). As the 10th anniversary of Closing the Gap approaches, the Australian Government and state and territory governments have agreed to work together with Aboriginal and Torres Strait Islander leaders, organisations, communities and families to refresh the Closing the Gap agenda and to renew targets. A part of this refresh is looking at how governments can improve program implementation. Six principles have been developed to guide the new agenda including:

- funding prioritised to meet targets
- evidence-based programs and policies

- genuine collaboration between governments and communities
- programs and services tailored for communities
- shared decision-making
- clear roles, responsibilities and accountability (PM&C 2018b).

As part of this, in 2018 Aboriginal and Torres Strait Islander people are being consulted on the best way to refresh the Closing the Gap agenda (PM&C 2018c). To provide context for policy debate and discussion around the Closing the Gap refresh, the AIHW released the report *Closing the Gap targets: 2017 analysis of progress and key drivers of change*. This provides information and analyses on the Closing the Gap targets, including key drivers of change—that is, factors associated with outcomes, based on data modelling and evidence from the literature (AIHW 2018a).

National Aboriginal and Torres Strait Islander Health Plan

Following on from the initial COAG targets, the Australian Government worked with Aboriginal and Torres Strait Islander people to produce the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. This sets out the direction of Indigenous health policy and provides a long-term, evidence-based framework to close the gap in Indigenous disadvantage. The vision outlined in the Health Plan for health system effectiveness is that it deliver primary health care that is evidenced-based, culturally safe, high quality, responsive, and accessible to all Aboriginal and Torres Strait Islander people (DoH 2013).

An Implementation Plan sits alongside the Health Plan, detailing the actions to be taken by the Australian Government and other key stakeholders to implement the Health Plan (DoH 2015a). It identifies 20 goals to support the achievement of the COAG targets relating to the effectiveness of the health system and priorities across the life course, from maternal health and parenting, childhood health and development, adolescent and youth health to healthy adults and healthy ageing. A technical companion document to the Implementation Plan outlines these goals and how progress will be measured (AIHW 2015b).

The second version of the Implementation Plan will be released in 2018 and will further develop actions and goals in the domain of social and cultural determinants of health and health system effectiveness. This will be informed by the consultation process (My Life My Lead), led by the DoH and the Implementation Plan Advisory Group across Australia, between March and May 2017. These consultations provided an opportunity for Aboriginal and Torres Strait Islander communities and leaders, government and the non-government and private sectors to help shape the Implementation Plan (DoH 2017).

Progress towards the Implementation Plan goals will be reported every 2 years in line with the release of the *Aboriginal and Torres Strait Islander Health Performance Framework*. The findings will also be incorporated into the DoH's annual report and will inform the annual *Closing the Gap Prime Minister's report*. Progress reports monitoring the Implementation Plan goals are on the AIHW website. The most recent report, *Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023*, is now available (AIHW 2018b).

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

A renewed *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* was released in October 2017. Developed under the auspices of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, the Framework sets out a comprehensive and culturally appropriate stepped care model that will help guide and support Indigenous mental health policy and practice over the next 5 years. It is designed to complement the *Fifth National Mental Health and Suicide Prevention Plan* and contribute to the vision of the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The Framework is a key component of ongoing reform to the mental health system to close the gap between Indigenous and non-Indigenous people (PM&C 2017).

Indigenous Advancement Strategy (IAS)

The IAS is the overall strategy by which the Australian Government funds and delivers programs for Indigenous Australians, including social and emotional wellbeing and alcohol and other drug (AOD) services. The IAS consolidates many different Australian Government Indigenous policies and programs in the following areas:

- Jobs, Land and Economy
- Children and Schooling
- Safety and Wellbeing
- Culture and Capability
- Remote Australia Strategies
- Evaluation and Research.

The services provided under the IAS are designed to improve 3 priority areas:

- The positive impact that education has on the future success of individuals, families and communities is clear. Children who go to school have better life outcomes.
- Employment, economic development and social participation improve the lives of families and communities. The right conditions and incentives need to be in place for Indigenous Australians to participate in the economy and broader society.
- Growing up in a healthy and safe home and community is essential for families to thrive and reach their full potential. In particular, the violence that too many women and children face must be addressed.

The IAS has the flexibility to ensure that Indigenous Australians are actively involved in the development and delivery of local solutions. It is administered mainly through PM&C's Regional Network. The network has regional offices across Australia that help Indigenous Australians and other stakeholders develop appropriate, community-led solutions tailored to local circumstances to achieve enduring outcomes consistent with Australian Government priorities (PM&C 2015).

More information on the IAS is available at <https://www.pmc.gov.au/indigenous-affairs/indigenous-advancement-strategy>.

Primary health-care services for Indigenous Australians

Primary health-care services play a critical role in helping to improve health outcomes for Indigenous Australians. Indigenous Australians may access either mainstream or Indigenous primary health-care services, which offer prevention, diagnosis and treatment in a range of settings. Indigenous primary health-care services are funded by the Australian and state and territory governments, and are available through hospitals, community clinics, Aboriginal Community Controlled Health Services (ACCHS) and other health-care facilities (AIHW 2016b).

The primary health-care services funded under the Indigenous Australians' Health Programme (IAHP) play a critical role in seeking to close the gap in life expectancy within a generation (2031) and to halving the gap in mortality rates for Aboriginal and Torres Strait Islander children under 5 within a decade (2018). Funding of $489.3 million in 2016–17 was allocated to over 200 service providers, including ACCHS, to deliver comprehensive primary health care (DoH 2018).

This funding is for primary health-care services tailored to the needs of the Aboriginal and Torres Strait Islander community including clinical services, population health services and activities that support essential clinical services. These include:

- improving access to antenatal care and child, maternal and family health services by Aboriginal and Torres Strait Islander children, their mothers and families
- the prevention, detection and management of chronic diseases
- further investment in priority health areas in regions of high health need or population growth
- building the capacity of multidisciplinary teams to deliver effective health services to manage chronic disease among Aboriginal and Torres Strait Islander people
- improving the clinical effectiveness of the health system and supporting sustainable, long-term service reform and improvement through continuous quality improvement.

The AIHW has found that Australian Government-funded Indigenous primary health-care services were well positioned relative to the geographic distribution of Indigenous Australians and to the distribution of other general practitioner (GP) services. However, there were still some areas where Indigenous people with high need for health care had limited access to both Indigenous services and GP services in general (AIHW 2015c).

Another report using a new measure developed by the AIHW—the Geographically-adjusted Index of Relative Supply (GIRS), looked at the supply of the clinical health workforce in 7 professions: GPs, nurses, midwives, pharmacists, dentists, psychologists and optometrists. GIRS scores of 0 or 1 (most likely to face supply challenges) occurred most often for midwives, optometrists and psychologists, and least often for nurses. For each of the 7 professions, a higher proportion of Indigenous than non-Indigenous people live in areas with lower GIRS scores (AIHW 2016c).

The AIHW has also analysed the distribution of maternal and child health services in relation to the geographic distribution of Indigenous women of child-bearing age. This found that while 97% of Indigenous women of child-bearing age had access to at least 1 of the following maternal health services within a 1-hour drive: hospitals with public birthing units; Indigenous primary health-care services; Royal Flying Doctor Service clinics; or GPs, around one-fifth (25,600 Indigenous women) lived outside a 1-hour drive from the nearest hospital with a birthing unit. Women in *Remote* and *Very remote* areas had fewer types of services available to them within a 1-hour drive and the lowest levels of access (84% and 93%, respectively had access to at least 1 type of service). Associations between geographic accessibility to services, maternal behaviours, and birth outcomes were also examined and this suggested that poorer access to any of the 4 maternal health services was associated with higher smoking rates and higher rates of pre-term deliveries and low birthweight (AIHW 2017c).

1.2 OSR organisations

In 2016–17, the Australian Government funded organisations across Australia to deliver one or more of the following services to Aboriginal and Torres Strait Islander people:

- **Primary health-care services**—funded by the DoH to provide access to doctors, nurses, allied health professionals and medical specialists outside hospital. These services provide clinical services and access to the broader health system, and play a key role in maintaining and improving population health through health promotion, disease prevention, advice and referral. They also provide maternal and child health services (DoH 2018).
- **New Directions: Mothers and Babies Services**—funded by the DoH to increase access to, and use of, child and maternal health services for Aboriginal and Torres Strait Islander families. The program funds organisations to provide: antenatal and postnatal care; information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring of developmental milestones, immunisation status and infections; and health checks for Aboriginal and Torres Strait Islander children before starting school (DoH 2016).
- **Social and emotional wellbeing services**—funded by PM&C to improve the health, wellbeing and resilience of Aboriginal and Torres Strait Islander individuals, families and communities. This includes social and emotional wellbeing counselling and support services, as well as Link Up services that assist those affected by past practices of the forced removal of children from Aboriginal and Torres Strait Islander families, through counselling, family tracing and reunion support.
- **Substance-use services**—funded primarily by PM&C to provide treatment, support and rehabilitation services to prevent harmful substance use among Aboriginal and Torres Strait Islander people. These services include residential and non-residential treatment and rehabilitation services, sobering-up shelters and transitional after-care resources.

In 2016–17, 266 organisations providing one or more of these services contributed to the OSR. For the purposes of this report 'organisations' are a count of the entities that provide these types of services (see Table 1.1). It should be noted, however, that the definition of an organisation in the OSR collection may differ slightly from that used by the DoH and PM&C for the purposes of funding. Given this, the number of organisations reported in the OSR may differ from the number of funded organisations reported by the DoH and PM&C elsewhere. It should also be noted that the Australian Government may not be the sole source of funding for these organisations. For example, if an organisation is in the OSR because it was funded by the Australian Government to provide Indigenous primary health-care services, it may also have received funding from other sources, such as state or territory governments. Organisations with multiple funding sources report on all their primary health activity in the OSR.

Table 1.1: Organisations in the OSR, by type of Australian Government funding, 2016–17

Indigenous health services	Organisations funded for primary health care	Organisations with other funding(a)	Total organisations
Primary health care (Chapter 3)	196	—	196
Maternal and child health (Chapter 4)	196(b)	17(c)	213
Social and emotional wellbeing (Chapter 5)	72	16(d)	88
Substance use (Chapter 6)	39	41(d)	80
Total organisations(e)	**196**	**70**	**266**

(a) Includes organisations not funded for primary health, but funded for New Directions and/or social and emotional wellbeing services and/or substance-use services.

(b) Includes 81 organisations funded for primary health and New Directions, and 115 funded for primary health but not New Directions.

(c) Organisations funded for New Directions only.

(d) Includes 3 organisations funded to deliver social and emotional wellbeing services and substance-use services.

(e) Totals do not add, because organisations may be funded to provide more than one service.

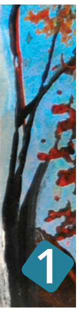
1.3 Data collection

Data from organisations providing health services to Aboriginal and Torres Strait Islander people have been collected annually since 2008–09. The number of organisations contributing to the OSR changes slightly from year to year. This may be due to administrative changes to funding arrangements, changes to the organisations funded, or changes in auspicing and reporting arrangements at the local level. For example, the overall number of organisations submitting OSR data in 2016–17 (266) was 11 fewer than in 2015–16 (277 organisations). There were 3 new organisations in scope for reporting that did not report in 2015–16. Two of these organisations submitted data in 2016–17. Thirteen of the organisations reporting in 2015–16 did not report in 2016–17 (5 of these were no longer in scope and 8 did not submit data by the cut-off date).

There have also been developments and changes to the collection, as outlined below. More information about these changes and how they may affect data quality and comparability can be found in Chapter 2 (Data quality).

- From 2008–09 to 2010–11, the collection used a paper-based questionnaire and was known as the Office for Aboriginal and Torres Strait Islander Health (OATSIH) Services Reporting data collection. It became an online form in 2011–12 with data collected through OCHREStreams, a web portal built and maintained by the Improvement Foundation for the DoH. The collection itself was renamed the OSR.
- Revisions were made to the online form for the 2012–13 collection (see Appendix A). Other changes to this collection meant some data (including counts of clients, client contacts and episodes of care) could now be extracted and loaded from an organisation's CIS directly onto OCHREStreams, using the PenCAT data extraction tool. A number of organisations used PenCAT to do this. These changes were designed to improve the ease of reporting and to reduce respondent burden. It should be noted however that organisations could still overwrite this function and make changes to their data before it was submitted, and not all organisations used this tool, so many still submitted all of their data manually onto the web portal.
- The PenCAT tool was available for use until 30 June 2015. Given this, the 2014–15 collection reporting period was 1 June 2014 to 31 May 2015, rather than the financial year (1 July to 30 June) used in other years. The Census date was brought forward by 1 month to 31 May 2015 to allow organisations to use the PenCAT tool for this collection.
- As the PenCAT tool was not available to extract data onto OCHREStreams from 1 July 2015, for the 2015–16 collection organisations relied on their own data extraction processes and manually entered this onto OCHREStreams.
- How pre-populated data was extracted onto OCHREStreams changed again for the 2016–17 collection. The DoH worked directly with CIS vendors to introduce direct load to again allow some data to be extracted directly from an organisation's CIS onto OCHREStreams. As in previous collections, however, some organisations still submitted all of their OSR data manually and all organisations were able to overwrite and make changes to their data before it was submitted.

The scope of the collection has also changed. Organisations providing New Directions services were in scope for the OSR for the first time in 2013–14, although most already contributed to the collection because they were also funded to provide Indigenous primary health-care services. In 2016–17, 17 organisations in the collection reported on their New Directions services only.



Aims of the collection

The OSR provides a basic measure of activity, volume and coverage of a range of health services delivered to Aboriginal and Torres Strait Islander people. This information supports:

- evidence-based policy development and planning
- improved understanding of health service needs
- accountability for policy implementation of service delivery
- the assessment of access and levels of activity over time
- quality improvement, at the service level and nationally.

For individual organisations, OSR data support:

- evidence-based practice
- continuous quality improvement of service delivery
- benchmarking against national data
- an opportunity to provide feedback on key service gaps and health-service delivery challenges to policy makers/funders.

The OSR complements other work being done by the AIHW to measure and report on health outcomes. While the OSR collects information on the types of health services provided to Aboriginal and Torres Strait Islander people and the number of clients getting these services, it does not collect data on health outcomes. This type of information is presented in another DoH-funded AIHW report, *National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care* (AIHW 2017b), and in the *Aboriginal and Torres Strait Islander Health Performance Framework* (AIHW 2017a).

Like the OSR, national Key Performance Indicator (nKPI) data is provided to the AIHW from organisations funded by the Australian Government to provide primary health-care services to Aboriginal and Torres Strait Islander people. Many of the organisations contributing to the OSR in 2016–17 (196) also contributed to the nKPI data collection (see Table 1.2). OSR data are also used in other reports including the Aboriginal and Torres Strait Islander Health Performance Framework, the annual Report on Government Services and in spatial analysis work. Together these data provide information to help monitor progress against the COAG commitment to closing the gap in health outcomes between Indigenous and non-Indigenous Australians. They also support the vision of the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*.

Table 1.2: Organisations in the OSR and nKPI collections, 2016–17

Organisations	Number
Total OSR organisations reporting on primary health and/or maternal and child health(a)	213
Total nKPI organisations(b)	228
Total organisations reporting in both collections(c)	196

(a) Includes organisations funded by the Australian Government for primary health care and/or New Directions (see Table 1.1).

(b) Includes organisations funded by the Australian Government for primary health care and organisations funded solely by the Northern Territory Government.

(c) Includes organisations reporting in both collections.

1.4 Structure of the report

After this introduction, **Chapter 2** looks at data quality to add context to the information presented in the rest of the report. **Chapters 3 to 6** are then structured according to the different services OSR organisations are funded to provide to Aboriginal and Torres Strait Islander people.

Chapter 3 presents information on primary health-care services funded by the DoH.

Chapter 4 presents information on maternal and child health services funded by the DoH.

Chapter 5 presents information on social and emotional wellbeing services funded by PM&C.

Chapter 6 presents information on substance-use services funded by PM&C.

Appendix A presents the main changes to the OSR form for the 2012–13 collection.

Appendix B presents information on current DoH projects to improve data quality in both the OSR and nKPI data collections.

Appendix C presents a list of positions included as ‘health’ and ‘other’ staff.

Appendix D presents additional maps on service locations for the states and territories.

Appendix E presents a list of organisations contributing to the 2016–17 OSR.

See Box 1.2 for some general notes about this report.

Box 1.2: Notes about this report

The term ‘Aboriginal and Torres Strait Islander people’ is preferred in AIHW publications, however, the term ‘Indigenous’ is used interchangeably with ‘Aboriginal and Torres Strait Islander’ to assist readability.

Figures, tables and text contain numbers that have been rounded. In some cases, owing to this rounding, the components may not add to the total or to 100%.

Throughout this report, all references to tables that include an ‘S’ in the table number (for example, S3.1) are to **supplementary tables**. These tables are available on the AIHW website <https://www.aihw.gov.au/reports/indigenous-health-welfare-services/health-organisations-osr-key-results-2016-17>.

A copy of the OSR questionnaire also can be found on the AIHW website.

2 Data quality

Data quality for any collection is about ensuring the data collected is fit for its intended use. The AIHW ensures the OSR data collected are of good quality by (i) working with data providers to maximise the currency and quality of the data they provide, (ii) providing advice and assistance to users of data, and (iii) reporting on data quality. At the end of the data collection period, a data quality statement (DQS) is produced for each collection describing various aspects of the collection, including what it is about, the institutional environment, timeliness, accessibility, interpretability, relevance, accuracy and coherence. This information helps users to understand any limitations of the data and to make informed judgments about their use of the data.

2.1 Assessment of the 2016–17 collection

As with previous collections, the AIHW used a set of validation rules to check each data submission. If validation issues were identified, a data quality email outlining the data queries to be followed up was sent to the organisation. Organisations were asked to confirm data were correct or to revise and resubmit data on OCHREStreams. The OSR validation rules can be broadly grouped into 2 types of queries:

TYPE 1—these are raised because they fail logical tests according to OSR definitions, for example having more clients than episodes of care for a population group. These usually require a resubmission to correct and may result in a partial acceptance of data if not fixed.

TYPE 2—these are raised where there are inconsistencies between outputs or where data have changed significantly since the previous collection. Organisations are asked to confirm data are correct or to resubmit data where they are incorrect. These queries will not usually lead to a partial acceptance of data, unless it is felt that data are an overestimate and the organisation has not confirmed the data to be correct.

The number of queries raised in 2016–17 was similar to the number in 2015–16 (an average of 7 compared with 6.8 in 2016), but higher than in 2014–15 (5.8). With the exception of Northern Territory Government (NTG) clinics, for which fewer queries were raised, there were small increases in the average number of queries raised per organisation across the different types of CIS (see Table 2.1).

Table 2.1: Queries raised, by type of CIS

Type of CIS in 2016–17	Number of organisations[a]	Number of queries in 2016–17	Rate per organisation	Number of queries in 2015–16	Rate per organisation	Number of queries in 2014–15	Rate per organisation
Best Practice	9	77	8.6	64	7.1	60	6.7
Communicare	60	498	8.3	462	7.7	391	6.5
Medical Director	25	225	9.0	216	8.6	149	6.0
MMEX	10	96	9.6	81	8.1	70	7.0
NTG	31	30	1.0	117	3.8	142	4.6
Other[b]	50	371	7.4	309	6.2	252	5.0
Total	**185**	**1,297**	**7.0**	**1,249**	**6.8**	**1,064**	**5.8**

(a) Based on organisations that submitted primary health data in all 3 years.
(b) Organisations that submitted all their OSR data manually.

Changes to the data collection

Three changes were made to the 2016–17 OSR collection that could affect the comparability with previous collections (see Box 2.1).

Box 2.1: Changes to the 2016–17 OSR collection

1. The Communicare CIS did not always adhere to the episode of care definition of 1 episode of care per day per client, regardless of the number of contacts a client had. Therefore, the DoH requested changes to how this CIS captured primary health 'episodes of care' for the OSR to make it consistent with the definition.
2. As the definition of a primary health episode of care did not prescribe what types of contacts are counted, this resulted in some inconsistencies in the types of contacts being included in episodes of care counts between the different systems. Accordingly, the DoH advised that:
    - Telephone contacts (health care delivered over the phone) should not be counted as a valid contact type for episode of care counts. They were excluded from Communicare software counts as were 'administration–client contacts', 'hospital contacts' (GP, emergency and all types) and 'other' contacts.
    - Hospital contacts should also be removed from episode of care counts in Medical Director (MD) and Best Practice (BP) software.

    This meant that some contact types previously included in the primary health episode of care count in some organisations were now excluded from the count.
3. Changes to how some data were loaded into OCHREStreams.

    The DoH introduced a new direct load process where some data items could be directly extracted from an organisation's CIS into OCHREStreams. Data that could be extracted automatically included client numbers, episodes of care, client contacts, adult and child health checks, chronic disease management plans (CDMPs), and antenatal clients and visits. This aimed to reduce the reporting burden on individual organisations.

    Direct load involved upgrades to the software being used by some organisations and potential mapping changes to some data items. As in previous collections, however, organisations could still submit all their data manually (27% of organisations providing primary health-care services and 46% of organisations overall submitted manually in 2016–17) and all organisations could overwrite and make changes to their data before it was submitted to the AIHW.

Impacts of changes on data

As in previous collections, most data were entered manually. This has remained unchanged since 2012–13. Of the approximately 130 questions in the OSR, only 5 to 9 questions (depending on the type of CIS used) could be pre-populated (electronically extracted directly from an organisation's CIS into OCHREStreams). The remaining questions were tick-box questions (for example, the types of programs/activities an organisation provides), open-text/comments, or numeric questions that could not be pre-populated (for example, workforce numbers). Given this, most of the OSR data should be comparable with previous years and can be reported on nationally.

The data items pre-populated in previous collections were extracted using a single data extraction tool, while in 2016–17, with the introduction of direct load, data were extracted directly from an organisation's CIS into OCHREStreams. To look at the impact of these changes, in addition to running validation checks on each submission, the AIHW analysed time trend data for 8 primary health data items that could potentially be pre-populated into OCHREStreams, by the type of CIS used in 2016–17. These included Communicare, BP, MD and MMEx. Trends for the NTG clinics as a whole and for 'other' organisations (manual submitters) were also examined as they were also expected to exclude telephone and hospital contacts from their episode of care counts. The time trend analyses considered short-term changes compared with 2015–16 and longer-term trends since 2014–15, to look at the impact of different extraction methods. A single extraction tool was used in the 2014–15 collection, no extraction tool was used in the 2015–16 collection (organisations submitted data manually), and direct load was introduced in 2016–17. To look at the impact of these changes, only a subset of organisations contributing valid data across all years since 2013–14 was included in the analysis, so not all organisations in the 2016–17 collection were included. The AIHW also looked at how many organisations reported big changes in data compared with previous years, and other indicators of data quality including levels of non-response, whether data were fully or partially accepted, and the number of validation queries raised.

These analyses suggest that for some organisations there were changes in the episodes of care counts and the relationship between these and client contact counts. There were also changes in counts of health checks and CDMPs, possibly resulting from the direct-load process introduced in 2016–17.

Episodes of care

For organisations contributing valid data since 2013–14, the number of episodes of care decreased by 9% in 2016–17, compared with increases of 9% and 6% in 2014–15 and 2015–16 (see Table 2.2). This decrease varied by type of CIS, ranging from a 28% decrease for MD users to a 3% increase for BP users. Given the changes noted above, a decrease in episodes of care was expected, mainly for organisations using Communicare software, but an unexpected decrease was seen in organisations using MD software. This is related to a recording/extract issue identified by some organisations where 'Practice Admin' visit type was set as the default visit type for existing and new users (other than for doctors and nurse practitioners who had their default visit type as 'surgery consultation'). This meant for some organisations using MD some clinical contacts were recorded as 'Practice admin' and were not counted in their episodes of care data as they should have been.

Given the changes to the collection in 2016–17, the episodes of care data are not comparable with previous years.

Table 2.2: Episodes of care, by type of CIS, 2014–15 to 2016–17

Type of CIS in 2016–17	Number of organisations[a]	2014–15 Number	2014–15 Change (%)[b]	2015–16 Number	2015–16 Change (%)[b]	2016–17 Number	2016–17 Change (%)[b]
Communicare	55	1,196,615	3.4	1,203,490	0.6	1,038,222	-13.7
Best Practice	9	72,573	5.3	88,137	21.4	90,813	3.0
Medical Director	22	412,018	16.2	416,332	1.0	301,362	-27.6
MMEX	10	405,296	26.4	471,578	16.4	515,633	9.3
Other[c]	41	775,270	10.5	892,074	15.1	807,757	-9.5
NTG	30	265,714	1.4	263,490	-0.8	266,601	1.2
Total	**167**	**3,127,486**	**9.2**	**3,335,101**	**6.6**	**3,020,388**	**-9.4**

(a) Based on organisations that submitted valid data in each year from 2013–14.

(b) Compared with the previous year.

(b) Organisations that submitted all their OSR data manually.

Client contacts

Overall, for organisations contributing valid data since 2013–14, there was an increase in contacts (excluding transport contacts) of 10% (see Table 2.3). While this was consistent with overall increases in the two previous collections (both 6%), the pattern of change was not consistent across the different types of CIS and was not consistent with changes in the episode of care count in 2016–17. For example, organisations using Communicare had a 3% increase in client contacts in 2014–15, a decrease of nearly 2% in 2015–16, but an increase of 15% in 2016–17. This large increase was despite a decrease in episodes of care being reported. Episodes of care decreased by 28% in organisations using MD, but client contacts increased by 1.2% in 2016–17. These patterns raise some questions about the mapping/extraction of this data in 2016–17. While changes were applied to the episodes data with respect to what was counted, these were not applied to the contacts data. This means there may be some inconsistencies between the contact types contributing to the episodes and contacts counts in some organisations and the relationship between the two is not as close as in previous collections. The counting rules and mapping of these items need further checking.

Table 2.3: Client contacts, by type of CIS, 2014–15 to 2016–17

Type of CIS in 2016–17	Number of organisations[a]	2014–15 Number	2014–15 Change (%)[b]	2015–16 Number	2015–16 Change (%)[b]	2016–17 Number	2016–17 Change (%)[b]
Communicare	59	1,532,966	3.1	1,504,342	-1.9	1,734,542	15.3
Best Practice	9	106,135	16.2	122,027	15.0	135,748	11.2
Medical Director	24	582,974	-1.7	579,171	-0.7	585,900	1.2
MMEX	10	501,550	27.2	630,816	25.8	722,117	14.5
Other[c]	44	1,069,354	7.8	1,218,717	14.0	1,297,419	6.5
NTG	30	322,680	2.3	320,096	-0.8	326,088	1.9
Total	**176**	**4,115,659**	**6.3**	**4,375,169**	**6.3**	**4,801,814**	**9.8**

(a) Based on organisations that submitted valid data in each year from 2013–14. Excludes transport contacts.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

Client numbers

The overall increase in clients in 2016–17 (3%) was similar to that in the previous two collections (5% and 4%, respectively). The overall increase masks some variation by type of CIS—in particular, changes for BP ranged from +62% to -19%, and for MMEX changes ranged from 4% to 25% (see Table 2.4).

Table 2.4: Client numbers, by type of CIS, 2014–15 to 2016–17

		2014–15		2015–16		2016–17	
Type of CIS in 2016–17	Number of organisations[a]	Number	Change (%)[b]	Number	Change (%)[b]	Number	Change (%)[b]
Communicare	59	131,509	-1.5	137,487	4.5	146,718	6.7
Best Practice	9	16,733	62.2	13,539	-19.1	14,474	6.9
Medical Director	24	50,432	-7.0	56,068	11.2	52,745	-5.9
MMEX	10	48,066	24.7	53,015	10.3	55,219	4.2
Other[c]	45	110,409	5.6	117,740	6.6	121,901	3.5
NTG	30	30,528	-1.2	30,525	0.0	30,525	0.0
Total	**177**	**387,677**	**4.2**	**408,374**	**5.3**	**421,582**	**3.2**

(a) Based on organisations that submitted valid data in each year from 2013–14.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

Health checks and CDMPs

These items have shown variability since they were added to the OSR in 2012–13, and questions over data quality have meant that only child health check data has been reported on in OSR national reports. Compared with 2015–16, for organisations contributing valid data since 2013–14, there were increases in adult health checks (MBS Item 715) for those 25 years and over (35%), child health checks (MBS Item 715) for those 0–4 years (26%) and CDMPs (32%). These increases mask variation by type of CIS (see tables 2.5, 2.6 and 2.7). Compared with 2015–16, there were large increases in organisations using Communicare and MD. These increases raise some questions about data quality and comparability and further investigation is needed to determine whether data have been mapped correctly for each CIS and whether they are being collected consistently across the different systems. The DoH has commissioned mapping documentation from software vendors for these and other direct-load data.

Table 2.5: Number of adult health checks, by type of CIS, 2014–15 to 2016–17

		2014–15		2015–16		2016–17	
Type of CIS in 2016–17	Number of organisations[a]	Number	Change (%)[b]	Number	Change (%)[b]	Number	Change (%)[b]
Communicare	54	17,329	-53.1	18,317	5.7	27,518	50.2
Best Practice	9	1,798	95.2	1,815	0.9	2,188	20.6
Medical Director	22	5,449	0.4	7,288	33.7	13,580	86.3
MMEX	10	8,072	41.8	9,376	16.2	10,688	14.0
Other[c]	32	15,541	-42.5	14,847	-4.5	17,231	16.1
NTG	30	2,755	16.0	3,534	28.3	3,211	-9.1
Total	**157**	**50,944**	**-35.0**	**55,177**	**8.3**	**74,416**	**34.9**

(a) Based on organisations that submitted valid data in each year from 2013–14.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

Table 2.6: Number of child health checks, by type of CIS, 2014–15 to 2016–17

		2014–15		2015–16		2016–17	
Type of CIS in 2016–17	Number of organisations[a]	Number	Change (%)[b]	Number	Change (%)[b]	Number	Change (%)[b]
Communicare	51	3,942	-55.0	4,545	15.3	6,741	48.3
Best Practice	8	251	32.1	505	101.2	548	8.5
Medical Director	21	1,809	38.0	1,651	-8.7	1,986	20.3
MMEX	10	2,109	45.2	2,455	16.4	2,950	20.2
Other[c]	25	3,243	-39.4	2,985	-8.0	3,628	21.5
NTG	29	1,344	-66.2	1,240	-7.7	1,045	-15.7
Total	**144**	**12,698**	**-39.7**	**13,381**	**5.4**	**16,898**	**26.3**

(a) Based on organisations that submitted valid data in each year from 2013–14.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

Table 2.7: Number of CDMPs, by type of CIS, 2014–15 to 2016–17

		2014–15		2015–16		2016–17	
Type of CIS in 2016–17	Number of organisations[a]	Number	Change (%)[b]	Number	Change (%)[b]	Number	Change (%)[b]
Communicare	52	7,475	-57.7	8,486	13.5	12,908	52.1
Best Practice	9	492	35.2	769	56.3	910	18.3
Medical Director	22	2,708	-4.5	2,947	8.8	3,976	34.9
MMEX	10	4,918	55.4	4,512	-8.3	5,912	31.0
Other[c]	27	6,767	-19.9	6,169	-8.8	7,345	19.1
NTG	30	2,188	9.3	2,579	17.9	2,453	-4.9
Total	**150**	**24,548**	**-28.8**	**25,462**	**3.7**	**33,504**	**31.6**

(a) Based on organisations that submitted valid data in each year from 2013–14.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

Antenatal clients and visits

Overall, for organisations contributing valid data since 2013–14, there were small increases in the number of Indigenous clients attending antenatal care (2%) and the number of visits reported (8%) (see tables 2.8 and 2.9).

Table 2.8: Number of Indigenous antenatal clients, by type of CIS, 2014–15 to 2016–17

		2014–15		2015–16		2016–17	
Type of CIS in 2016–17	Number of organisations[a]	Number	Change (%)[b]	Number	Change (%)[b]	Number	Change (%)[b]
Communicare	49	1,966	0.3	2,109	7.3	2,198	4.2
Best Practice	6	96	4.3	117	21.9	140	19.7
Medical Director	19	683	-0.6	755	10.5	695	-7.9
MMEX	9	729	6.9	918	25.9	907	-1.2
Other[c]	31	2,069	2.8	2,380	15.0	2,519	5.8
NTG	3	97	10.2	155	59.8	130	-16.1
Total	**117**	**5,640**	**2.2**	**6,434**	**14.1**	**6,589**	**2.4**

(a) Based on organisations that submitted valid data in each year from 2013–14. Data from 3 NTG clinics are available.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

Table 2.9: Number of Indigenous antenatal visits, by type of CIS, 2014–15 to 2016–17

		2014–15		2015–16		2016–17	
Type of CIS in 2016–17	Number of organisations[a]	Number	Change (%)[b]	Number	Change (%)[b]	Number	Change (%)[b]
Communicare	49	8,779	-3.8	10,135	15.4	12,655	24.9
Best Practice	6	507	21.9	535	5.5	754	40.9
Medical Director	19	2,716	-37.5	2,779	2.3	2,847	2.4
MMEX	9	3,544	11.3	4,211	18.8	3,692	-12.3
Other(c)	31	9,581	8.5	13,330	39.1	13,580	1.9
NTG	3	654	11.4	755	15.4	629	-16.7
Total	**117**	**25,781**	**-2.7**	**31,745**	**23.1**	**34,157**	**7.6**

(a) Based on organisations that submitted valid data in each year from 2013–14. Data from 3 NTG clinics are available.

(b) Compared with the previous year.

(c) Organisations that submitted all their OSR data manually.

What are the implications for national reporting?

While most of the OSR data should be comparable with previous years' and can be reported on nationally, it is difficult to assess the impact of the changes introduced in 2016–17. This is because organisations could still override their direct-load data before their first submission to the AIHW if they felt the data to be incomplete or incorrect. The AIHW does not know what changes, if any were made to direct-load data, other than as a result of AIHW data queries. In 2016–17, changes to what was considered a valid clinical contact for the episodes of care count as well as the move to direct load made it more difficult than usual to determine whether changes in data were due to 'real world' changes or to changed processes. The AIHW data quality assessment of the 2016–17 collection raised some questions that need further investigation and this work is currently being undertaken. The changes discussed above have had an impact on national reporting as outlined below.

Break in time series for episodes of care data

A decrease in episodes of care was expected for some organisations. However, some organisations also had recording/extract issues in the 2016–17 collection that could not be resolved by the end of the collection period. This meant that in addition to the other changes for episodes of care, these data were underestimated in some organisations. The overall number of episodes of care reported in 2016–17 was 16% lower than the number reported in 2015–16, and this represents a break in series compared with previous collections. Episodes of care time series are therefore not presented in this report.

Changes in the relationship between episodes of care and client contact counts

Compared with 2015–16, there was a decrease in episodes of care counts but an increase in client contacts (excluding transport contacts). In previous collections there was a closer relationship between the type of contacts that would count as an episode of care or a client contact (excluding transport), with the main difference being that only 1 episode of care per client could be counted on 1 calendar day, while 1 episode could result in more than 1 client contact. The ratio of contacts to episodes increased from 1.3 in 2015–16 to 1.6 in 2016–17, the biggest increase being in organisations using Communicare (from 1.2 to 1.6). The relationship between these counts may not be as close as in previous collections.

Potential mapping/extraction issues relating to specific data items

Large increases in health checks and CDMPs were reported in some organisations. Further investigation of how the mapping was done for these items is being done to assess whether they are comparable with previous collections and if they are being collected consistently across the different systems. While adult health check and CDMP data have not been included in the OSR national report before, child health check data have also been excluded from national reporting in 2016–17.

2.2 Other factors that affect OSR data

In addition to the 2016–17 collection-specific issues discussed above, there are a number of other factors to keep in mind when using OSR data, as they may affect interpretability and comparability.

1. The organisations submitting data may change over time

The OSR collects aggregated organisation-level data. The total number of organisations submitting data changes each year. Although for the most part the same organisations contribute to the collection, the number of organisations may change due to changes in funding, auspicing or reporting arrangements at the local level. For example, in 2016–17 the total number of organisations in scope for the collection was 275, a decrease of 2 from 2015–16 (277 organisations). Of these, 266 organisations submitted data compared with 277 in 2015–16. Thirteen organisations that reported in 2015–16 did not report in 2016–17 (5 were no longer in scope and 8 were non-response), while 2 organisations not reporting in 2015–16 were in scope for reporting in 2016–17.

2. The organisations submitting valid data for a particular item may change over time

Each year some organisations have data that is partially accepted, rather than fully accepted. This is because the AIHW analyses the data submitted by each organisation and does internal consistency checks and comparisons with previous submissions. Queries about the data are sent to each organisation and they are requested to clarify matters or to provide additional or corrected data. Data with remaining quality issues may be excluded from national analyses. In 2016–17, queries were raised for 258 (97%) organisations and around three-quarters of organisations (74%) resubmitted some data. Common data queries related to incomplete or inaccurate data, data discrepancies between 2 or more questions and large changes compared with previous submissions. Of the 266 organisations that submitted data by the cut-off date, most (94%) had data that could be included in national analyses. The remaining 6% (16 organisations) had in total 32 data items excluded from national analyses (see Table 2.10).

Table 2.10: Data exclusions, 2016–17

Data item	Number of issues	Number of organisations with data excluded	Total organisations	Proportion of organisations
Primary health episodes of care	2	2	196	1.0
Primary health client contacts	2	2	196	1.0
Adult health checks and CDMPs	1	1	196	0.5
Antenatal care clients and visits	2	2	185	1.1
Social and emotional wellbeing clients	3	3	80	3.8
Social and emotional wellbeing contacts	3	3	80	3.8
Social and emotional wellbeing funded counsellors	2	2	80	2.5
Substance-use total clients	5	5	80	6.3
Residential clients/episodes of care	3	1	80	1.3
Sobering-up clients/episodes of care	3	2	80	2.5
Non-residential clients/episodes of care	6	3	80	3.8
Total	**32**	**16**	**266**	**6.0**

It should also be noted that while 97% of organisations in scope for the 2016–17 collection submitted data, the level of non-response was higher than the previous year, with 9 organisations unable to submit data by the cut-off date (compared with 0 in 2015–16). Time series analyses are based on the organisations that provide valid data in each year, and not on a subset of organisations with valid data over all years.

3. Organisations may estimate some of their data

Some organisations providing primary health-care services are unable to give exact data and may provide estimates of their client numbers and episodes of care. This may be because some staff (for example visiting staff), could not record their data or provide complete data, or because multiple systems are used and data needs to be estimated from these. Also, some organisations may be able to generate total numbers from their CIS but need to estimate Indigenous or gender breakdowns. In 2016–17, 20 organisations (10%) estimated their primary health episodes of care and 31 (16%) estimated their primary health client numbers. This data was accepted based on comparisons with previous reporting periods, unless the AIHW assessed that data were likely to overestimate actual numbers.

4. Reporting period changes

The reporting period for the collection is the financial year from 1 July to 30 June. In 2014–15, however, the census date for the collection was brought forward by 1 month to 31 May 2015, rather than 30 June. This was to allow organisations to continue to use the PenCAT extraction tool, which would not be available for OSR reporting after 30 June 2015. Organisations were still asked to provide data for a 12-month period (1 June 2014 to 31 May 2015) to enable time series analyses, but this meant that data for June 2014 might have been reported in both the 2013–14 and 2014–15 collections for clients, contacts and episodes of care. Comparing 2013–14, 2014–15 and 2015–16 data did not show any obvious underreporting for any data items at the national level.

5. Substance-use validation

In 2014–15, the AIHW added some more validation checks to the collection. One check suggested that some substance-use counts (mainly non-residential) were being extracted incorrectly from the CIS of a few organisations. This was largely a concern with non-residential substance-use client and episode of care counts. Where substance-use data for these organisations could not be corrected, they were excluded from national analyses. To enable time series analyses, the substance-use data extracted by these organisations in previous years were also investigated, which resulted in a revision of substance-use client and episodes data for 2012–13 and 2013–14. These revisions have been applied to any time series data presented since 2014–15, including in this report.

6. Changes to the collection

Other changes to the collection are worth noting:

- Before 2011–12, only stand-alone substance-use services that were not funded to provide Indigenous primary health-care services were required to report on their substance-use clients and episodes of care. This meant the collection did not capture all of the substance-use work being done. In 2011–12, the scope for reporting on substance-use services changed. Organisations funded by the Australian Government to provide both primary health care and substance-use services could now report on both types of services, whereas previously they could report only on their primary health-care services. Therefore, the number of organisations reporting substance-use data increased substantially between 2010–11 and 2011–12 and has further increased since then, on the basis that all funded client-based residential and non-residential substance-use services should be reporting.
- In 2012–13, following a review of the OSR collection, a revised collection instrument was introduced that subdivided the questionnaire into modules for ease of completion. The wording and response categories of some existing questions also changed, which resulted in a break in time series data for some questions (see Appendix A for a list of major changes to the questionnaire).

- From 2012–13, the collection was assisted by the introduction of the PenCAT audit tool and the OCHREStreams online reporting portal. These enhancements meant some data (including counts of clients, client contacts and episodes of care) could be extracted and loaded from an organisation's CIS into OCHREStreams. These changes were designed to improve the accuracy of the data and reporting response times and to reduce respondent burden; however, they might have led to some differences in the data reported for some organisations. While many organisations used the PenCAT tool to extract data from their CIS and load it into OCHREStreams, they could still overwrite this data before it was sent to the AIHW. Not all organisations used this facility; they still submitted all of their data manually onto the web portal.
- The PenCAT tool was not available from 1 July 2015, so was not used for the 2015–16 collection. For 2015–16, organisations relied on their own data extraction processes and manually entered data into OCHREStreams.
- The way in which some data were extracted into OCHREStreams changed again for the 2016–17 collection. Direct load was developed by the DoH working directly with CIS vendors to extract some data (including counts of clients, client contacts and episodes of care) directly from an organisation's CIS into OCHREStreams. As in previous collections, however, some organisations still submitted their OSR data manually and all organisations were able to overwrite and make changes to their data before it was submitted to the AIHW.
- From 2012–13, some information was collected at the site level, rather than at just the organisation level. This included the address of each service delivery site (where an organisation had more than one delivery site) and the range of services provided from each site. Using this information meant a change in remoteness category for a few organisations in 2015–16, to better reflect their service delivery, rather than an administrative address.

7. Other issues

The quality of OSR data also depends on whether organisations are recording information correctly, have sufficient management resources to support the data collection and can use their CIS, reporting tools and the OCHREStreams online portal effectively.

It should also be noted that individual organisations contributing to the collection and those supporting them have worked over many years to improve data quality at the service level, including working with CIS providers to fix problems as they are identified. The DoH has also funded a number of projects to improve OSR and nKPI data quality. Details about these can be found in Appendix B.

Further information on the collection and data quality can be found in the OSR DQS on the AIHW website <http://meteor.aihw.gov.au/content/index.phtml/itemId/688427>.

3 Primary health care

This chapter reports on Indigenous primary health-care services funded by the DoH (see Box 3.1). The vision outlined in the Health Plan is that the health system delivers primary health care that is evidenced-based, culturally safe, high quality, responsive and accessible (DoH 2013).

In 2016–17, 196 (98%) organisations in scope for reporting on their primary health-care services submitted data. This was 8 fewer than in 2015–16 (204 organisations). Compared with 2015–16, 1 new organisation was in scope for reporting, 4 organisations were no longer in scope, and 5 organisations were unable to submit data by the cut-off date, so were non-response. This chapter includes a profile of these 196 organisations and information on the types of services they provide, client numbers, client contacts and episodes of care, staffing levels and service gaps and challenges.

Box 3.1: Overview of primary health-care services

Of the 196 organisations providing Indigenous primary health-care services:

- One-third (33%) provided services in *Very remote* areas, 22% in *Outer regional* areas, 21% in *Inner regional* areas, 13% in *Remote* areas and 11% in *Major cities*.
- The Northern Territory and New South Wales and the Australian Capital Territory combined had the most organisations (56 and 43, respectively).
- Just over two-thirds (136) were Aboriginal Community Controlled Health Organisations (ACCHOs) and they saw around 371,600 (84%) clients. The rest included 50 state and territory government-run organisations and 10 other non-government-run organisations and they saw around 73,100 (16%) clients.
- Over three-quarters (154) had a governing committee or board and 72% of these (111) had 100% Indigenous board membership.
- Most (85%) provided access to a doctor, and over half (53%) provided all of the following: diagnosis and treatment of illness/disease; antenatal care; maternal and child health care; social and emotional wellbeing services; substance-use programs, as well as on-site or off-site access to specialist, allied health and dental services.
- A range of group activities were provided, for example, around 8,400 physical activity/healthy weight sessions, 4,300 chronic disease client support sessions, and 3,300 tobacco-use treatment and prevention sessions.

These organisations employed 7,600 FTE staff, and 53% were Indigenous. Health staff represented 58% of all employed staff (4,439 FTE) and other staff (including managers and supervisors, administrative and support staff, and drivers and field officers) 42% (3,161 FTE). Nurses and midwives were the most common type of health worker (1,124 FTE or 15% of employed staff), followed by Aboriginal and Torres Strait Islander health workers and practitioners (13%) and doctors (7%).

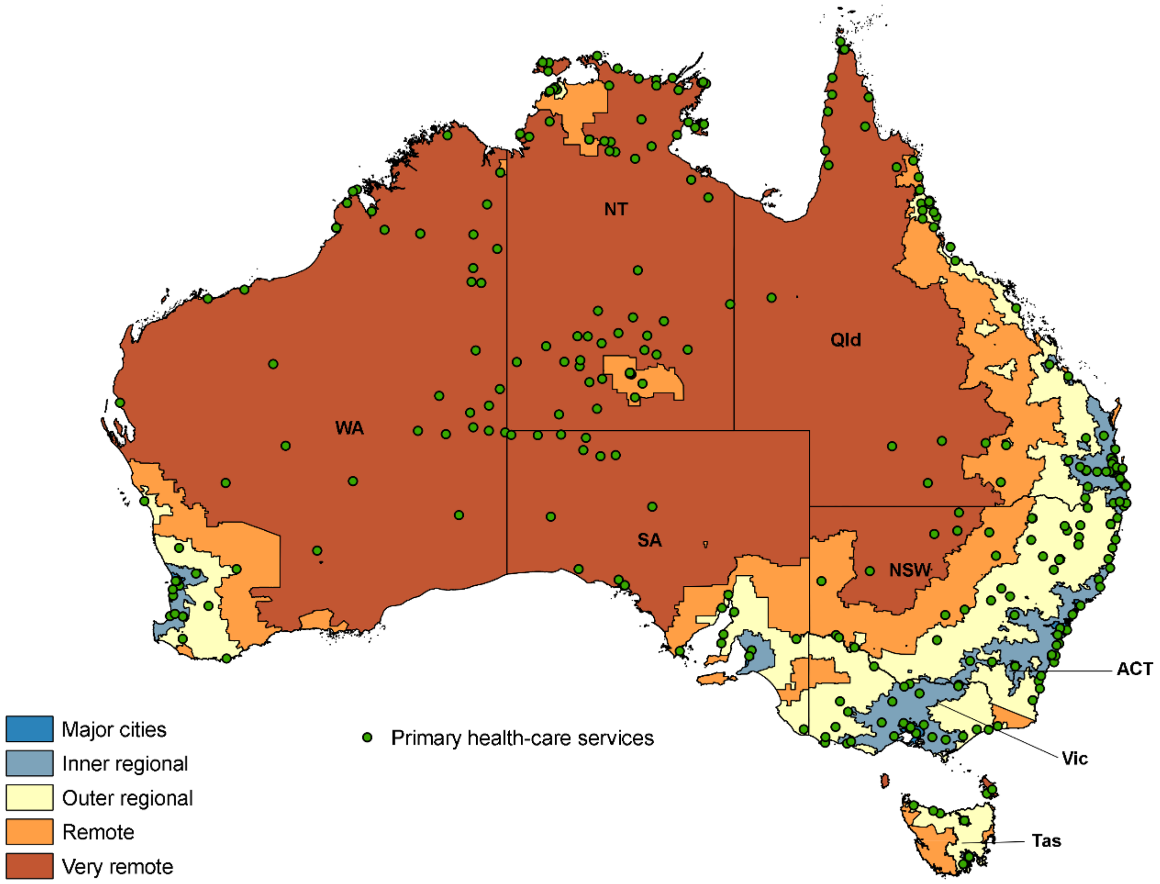
Around 5.5 million contacts were reported with 444,700 clients, and 58% of these were made by Nurses (including midwives) and doctors. Contacts by nurses represented half (51%) of all contacts in *Very remote* areas, compared with 29% overall.

Around 3.2 million episodes of care were provided to clients; more than 800,000 (25%) of these were in *Very remote* areas.

3.1 Organisation profile

Location

The 196 organisations providing Indigenous primary health-care services were spread across all states and territories and remoteness areas (see Figure 3.1).



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 3.1: Australian Government-funded organisations providing primary health-care services to Aboriginal and Torres Strait Islander people, by remoteness area, 2016–17

- One-third (33%) were in *Very remote* areas, 22% in *Outer regional* areas and 21% in *Inner regional* areas (see Table S3.2). Smaller proportions were in *Remote* areas (13%) and *Major cities* (11%).
- The Northern Territory had the most organisations (56), followed by New South Wales and the Australian Capital Territory combined (43) (see Figure 3.2). It should be noted that 36 (64%) organisations in the Northern Territory were small Northern Territory Government-run clinics that were counted in the OSR as separate organisations. Tasmania had the smallest number of organisations reporting (7).
- Over three-quarters (79%) of organisations in the Northern Territory were in *Very remote* areas, as were 38% of those in Western Australia.
- Most organisations in Victoria were in either *Inner regional* (42%) or *Outer regional* (42%) areas, as were most organisations in New South Wales and the Australian Capital Territory combined (44% and 26%, respectively).

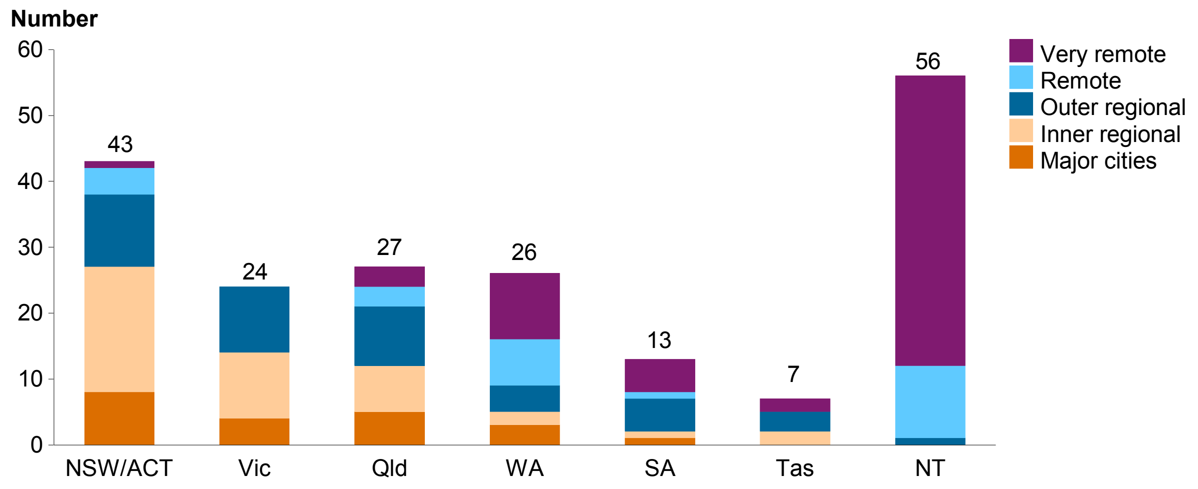
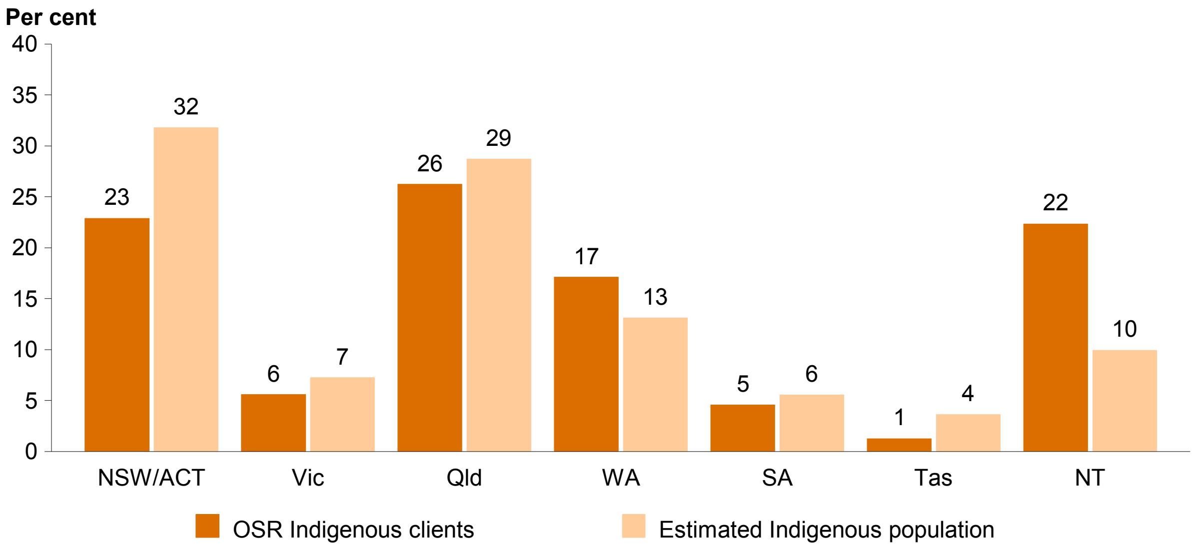


Figure 3.2: Number of primary health-care organisations, by state and territory and remoteness area, 2016–17

Compared with the distribution of the Indigenous population nationally, Indigenous clients from OSR organisations were over-represented in Western Australia and the Northern Territory (see Figure 3.3). The organisations in the Northern Territory and Western Australia saw a higher proportion of all OSR Indigenous clients compared with the distribution of the estimated Indigenous population as a whole. In contrast, although one-third of the estimated Indigenous population lived in New South Wales and the Australian Capital Territory combined (32%), a smaller proportion of OSR Indigenous clients were seen there (23%).



Note: In some cases OSR clients may be counted at more than one organisation. Estimated Indigenous population is the ABS projected Indigenous population in June 2017 (projection series B).

Figure 3.3: Proportion of OSR Indigenous clients and the estimated Indigenous population, by state and territory, 2016–17

Compared with the distribution of the Indigenous population nationally, Indigenous clients from OSR organisations were over-represented in *Remote* and *Very remote* areas and under-represented in *Major cities* (see Figure 3.4). Organisations in *Remote* and *Very remote* areas saw a higher proportion of all OSR Indigenous clients compared with the distribution of the estimated Indigenous population as a whole. Although around one-third of the estimated Indigenous population lived in *Major cities* (35%), a smaller proportion of OSR clients were seen there (21%).

Figure 3.4: Proportion of OSR Indigenous clients and the estimated Indigenous population, by remoteness area, 2016–17

Key characteristics

Of the 196 organisations providing Indigenous primary health-care services:

- 70% (138) delivered services from 1 site, while 12% (23) had 2 sites and 18% (35) had 3 or more sites
- 69% (136) were ACCHOs
- 79% (154) had a governing committee or board and of these 72% (111) had 100% Indigenous membership
- 79% (155) were accredited against the Royal Australian College of General Practitioners (RACGP) and/or organisational standards
- 27% (53) had more than 3,000 clients (see Table S3.1).

Type of organisation

These organisations can be broadly grouped into 3 types: ACCHOs, government-run organisations and other non-government-run organisations. ACCHOs are non-government organisations operated by local Aboriginal and Torres Strait Islander communities to deliver health care to the communities that control them, through an elected board of management (NACCHO 2015).

There were more ACCHOs than other types of organisations in all remoteness areas, except in *Very remote* areas, and in all states and territories except the Northern Territory. This was due to the high number of small Northern Territory Government-run organisations in *Very remote* areas in the Northern Territory (see tables S3.3 and S3.4). In 2016–17:

- 69% (136 organisations) were ACCHOs. New South Wales and the Australian Capital Territory combined had the most ACCHOs with 38, followed by Queensland with 24 (see Figure 3.5).
- 26% (50 organisations) were government-run. Thirty-six of these (72%) were small Northern Territory Government-run clinics counted as separate organisations in the OSR. These 36 organisations represented 64% of organisations in the Northern Territory.
- 5% (10 organisations) were other non-government organisations, with 5 (50%) of these being in Western Australia.

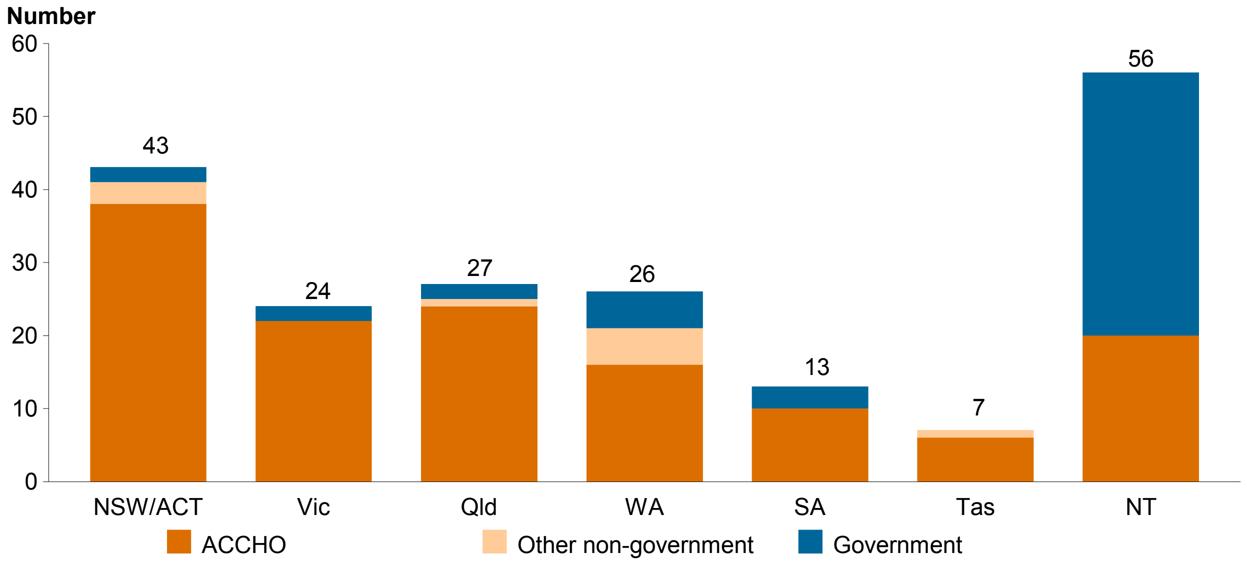


Figure 3.5: Number of primary health-care organisations, by type of organisation and state and territory, 2016–17

Governance

Over three-quarters of organisations (79%) had a governing committee or board. This was higher in ACCHOs (99%) than in other organisations (33%). Most ACCHOs with a governing committee or board had all Indigenous board members (83%). In other organisations with a governing committee or board, 35% had no Indigenous board members (see Table S3.5).

Accreditation

Organisations achieving accreditation or certification have been assessed as having reached defined standards of excellence in safety and quality in primary health care. In 2016–17, most (79%) organisations providing Indigenous primary health-care services were accredited by Australian General Practice Accreditation Limited, against the RACGP standards for general practice and/or organisational standards such as the Quality Improvement Council, the International Organization for Standardization or the Australian Council on Healthcare Standards. This was similar to the proportion in 2015–16 (79%). An organisation may have both types of accreditation (clinical and organisational).

The proportion accredited varied by state and territory. In Queensland, Western Australia and South Australia, all organisations were accredited with the RACGP and/or against organisational standards, while in the Northern Territory and Tasmania this was 41% and 29% of organisations, respectively (see Table S3.6). This may be related to the size of these organisations. In the Northern Territory, the smaller government-run clinics were less likely to be accredited (8%) than were ACCHOs (100%).

The proportion accredited was higher in organisations with a doctor (GP) (83%) compared with those without a doctor (55%). It was also higher in ACCHOs (97%) compared with other organisations (38%). A lower proportion of organisations in *Very remote* areas were accredited (52%), compared with other remoteness areas (see tables S3.7, S3.8 and S3.9).

Service size

Half (50%) of the organisations providing primary health-care services had 1,500 or fewer clients and 23% had between 1,501 and 3,000 clients. Just over one-quarter (27%) were larger organisations with more than 3,000 clients and 28% of these were in Queensland (see Figure 3.6 and Table S3.10). Nearly three-quarters (73%) of organisations in the Northern Territory had 1,500 clients or fewer while in Tasmania, 71% were smaller with 500 or fewer clients.

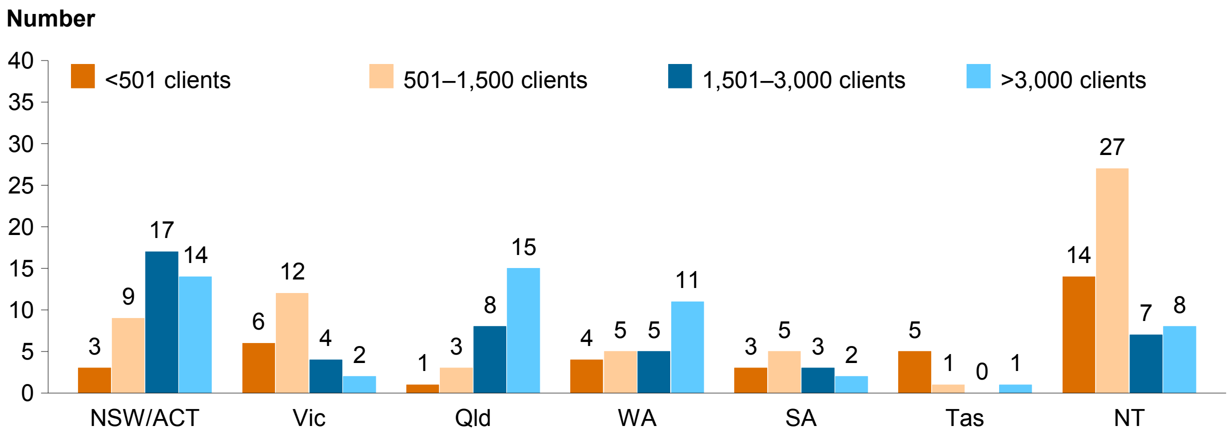
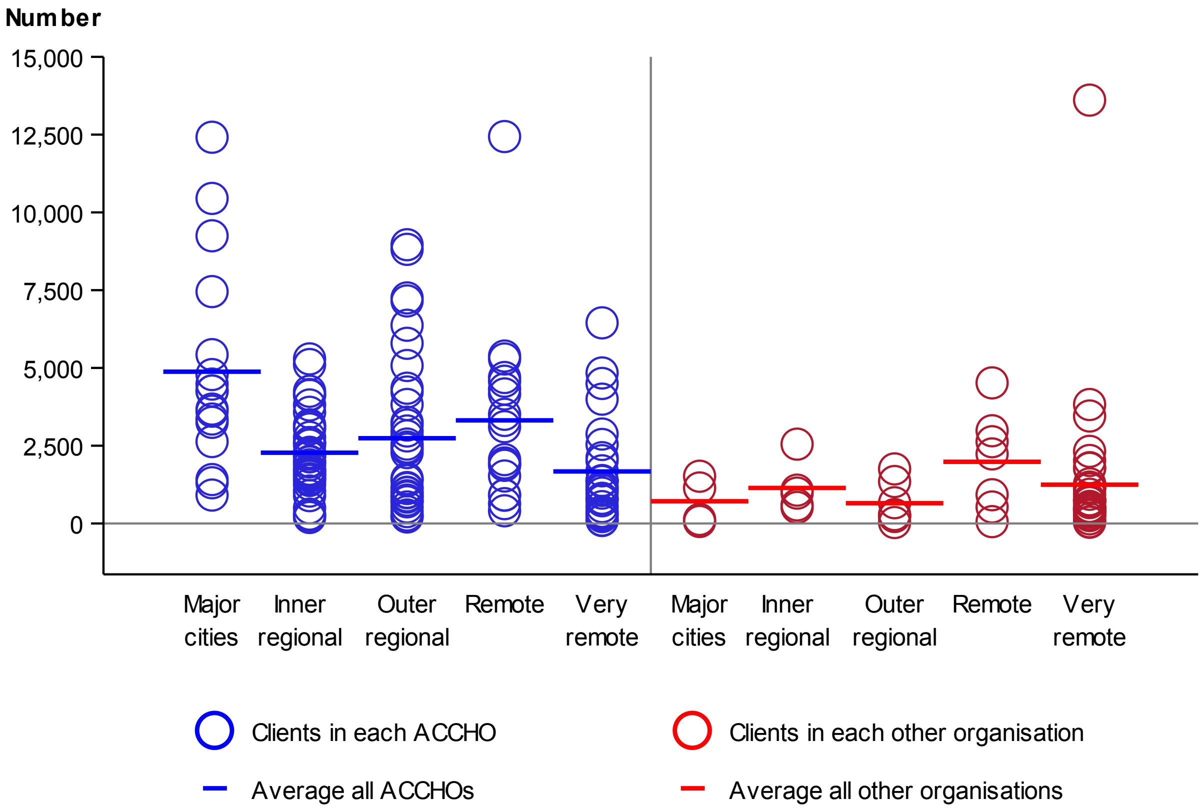


Figure 3.6: Number of primary health-care organisations, by size (number of clients) and state and territory, 2016–17

The proportion of organisations accredited with the RACGP or against organisational standards increased with service size. Forty-seven per cent of organisations with 500 or fewer clients had neither form of accreditation, compared with 2% of those with more than 3,000 clients. The proportion with a governing committee or board also increased with service size. Although 61% of organisations with 500 or fewer clients had a board, this increased to 98% in those with more than 3,000 clients (see Table S3.11).

ACCHOs were generally larger than other organisations (see Figure 3.7 and Table S3.12). A higher proportion of ACCHOs had more than 3,000 clients (36% compared with 7% of other organisations), and a lower proportion had 1,500 or fewer clients (39% compared with 77% of other organisations).



Note: 'Other' organisations include both government-run organisations and non-government organisations (excluding ACCHOs).

Figure 3.7: Primary health-care organisations, by size (number of clients), type of organisation and remoteness area, 2016–17

3.2 Services provided

Organisations providing Indigenous primary health-care services generally provide access to doctors, nurses, allied health professionals, social and emotional wellbeing staff and medical specialists. Many provide a variety of services including health promotion, clinical care, substance-use treatment and prevention, and social and emotional wellbeing support. Some focus on specific activities such as health promotion.

At a glance

In 2016–17, Indigenous primary-health care services were delivered by 196 organisations from 366 sites (see Table 3.1). Most sites (89%) operated 5 days or more per week, and 25% offered 24-hour emergency care—similar to services in 2015–16 (89% and 26%, respectively). Most sites provided clinical services, such as the diagnosis and treatment of chronic illnesses (88%), antenatal care (77%), maternal and child health care (85%), and mental health and counselling services (88%). Many also offered tobacco programs (68%) and substance-use programs (65%).

Most organisations (85%) provided access to a doctor, while just over half (53%) delivered a wide range of services, including all of the following during usual opening hours: diagnosis and treatment of illness and disease; antenatal care; maternal and child health care; social and emotional wellbeing/counselling services; and substance-use programs, as well as on-site or off-site access to specialist, allied health and dental care services.

Compared with 2015–16, client numbers decreased by 4% and FTE staff employed by 2%, but the average number of contacts (12) per client was similar.

Table 3.1: Indigenous primary health-care services, 2015–16 and 2016–17

	2015–16		2016–17	
	Number	%	Number	%
Total organisations providing services	**204**	**100.0**	**196**	**100.0**
Organisations providing a wide range of services[(a)]	101	49.5	103	52.6
Organisations with a doctor (employed/visiting)	160	78.4	167	85.2
Sites and services during usual opening hours				
Diagnosis and treatment of chronic illness/diseases	311	84.5	321	87.7
Diagnosis and treatment of infectious illness/diseases	286	77.7	300	82.0
Treatment of injury	283	76.9	296	80.9
Antenatal care	274	74.5	283	77.3
Maternal and child health care	293	79.6	310	84.7
Social and emotional wellbeing/mental health/counselling	310	84.2	322	88.0
Substance use/drug and alcohol programs	220	59.8	237	64.8
Tobacco programs	223	60.6	250	68.3
Transport	304	82.6	311	85.0
Total sites	**368**	**100.0**	**366**	**100.0**
Clients				
Indigenous clients	364,389	79.0	364,087	81.9
Total clients	**461,483**	**100.0**	**444,721**	**100.0**
Client contacts				
Client contacts	5,380,653	100.0	5,499,991	100.0
Average contacts per client	12	. .	12	. .
Employed staff (FTE)				
Health	4,457	57.4	4,439	58.4
Other	3,309	42.6	3,161	41.6
Total	**7,766**	**100.0**	**7,600**	**100.0**

(a) Includes all of the following services during usual opening hours: diagnosis and treatment of illness and disease; antenatal care; maternal and child health care; social and emotional wellbeing/counselling services; and substance use programs, as well as on-site or off-site access to a range of specialist, allied health and dental care services.

Note: In 2016–17, 5 organisations out of 201 in scope for reporting did not provide data.

Health promotion

Health promotion is the process of enabling people to increase control over and improve their health (WHO 2016). It may include, for example, policy interventions, information to support healthy lifestyles, marketing and media campaigns and activities to empower individuals and strengthen communities (AHMAC 2015).

In 2016–17, organisations providing Indigenous primary health-care services ran a range of health promotion programs and activities (see Figure 3.8 and Table S3.13). Three-quarters (75%) had healthy lifestyle programs, ranging from 59% in *Very remote* areas to 85% in *Inner regional* areas. Most also promoted immunisation services to children (81%) and adults (81%), and provided sexual health/education activities (71%). Generally, the proportions providing various health promotion activities were similar to those in 2015–16; however, there was an increase in the proportion promoting immunisation services to adults (81% compared with 69% in 2015–16) and a decrease in the proportion providing healthy lifestyle programs (75% compared with 85%).

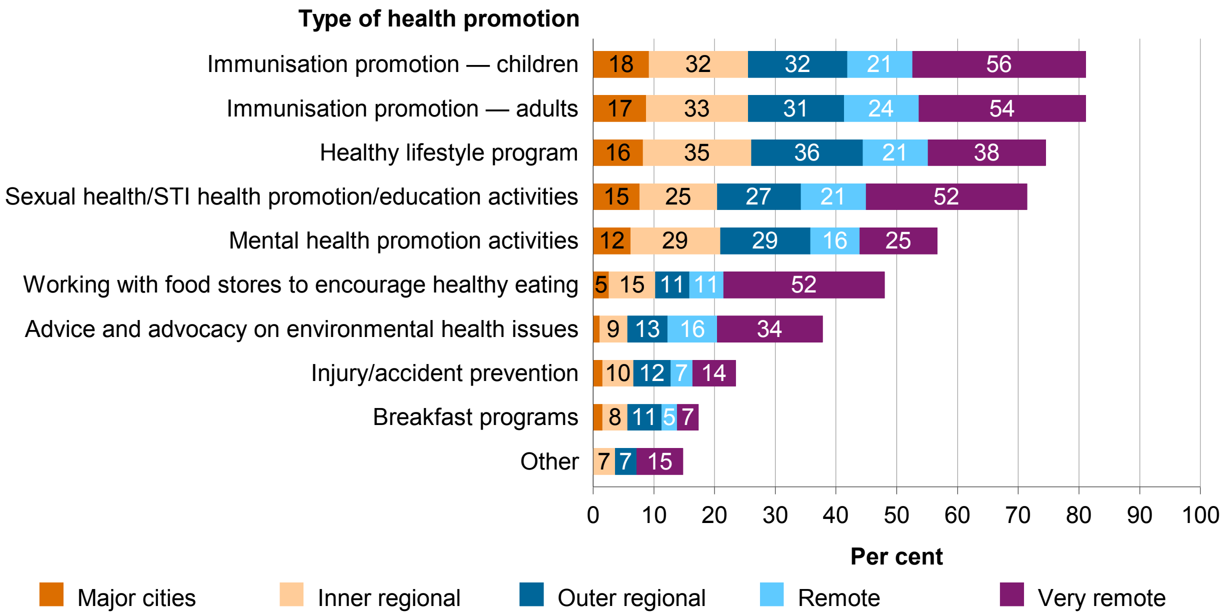
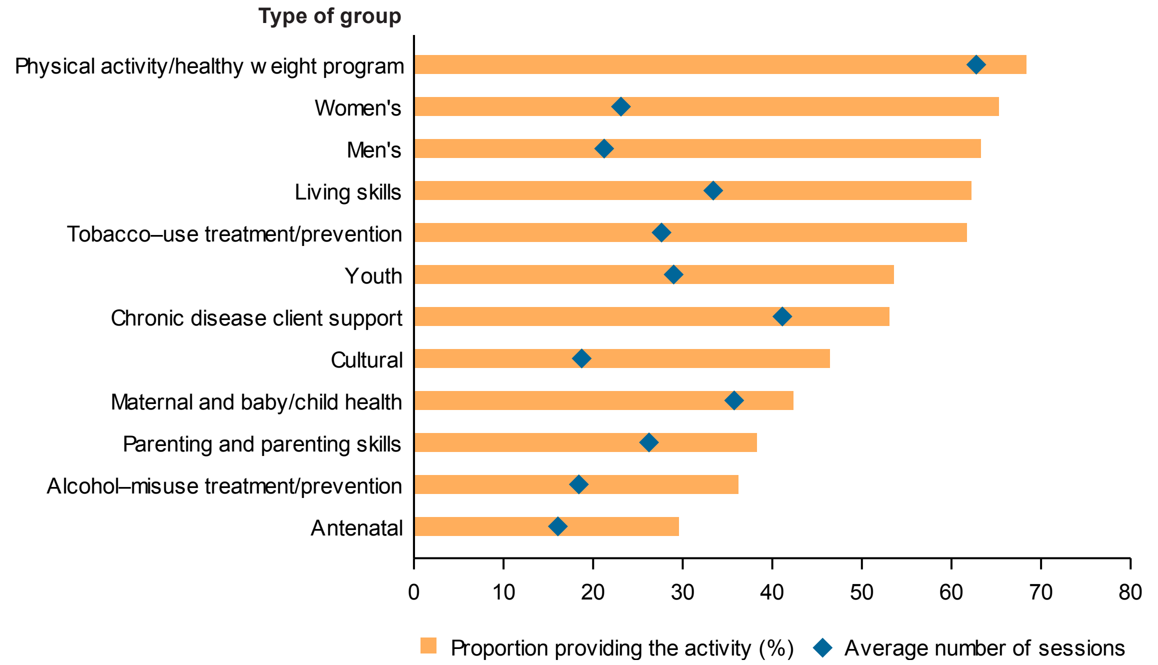


Figure 3.8: Number (as labelled) and proportion (in scale) of primary health-care organisations, by type of health promotion and remoteness area, 2016–17

Group activities

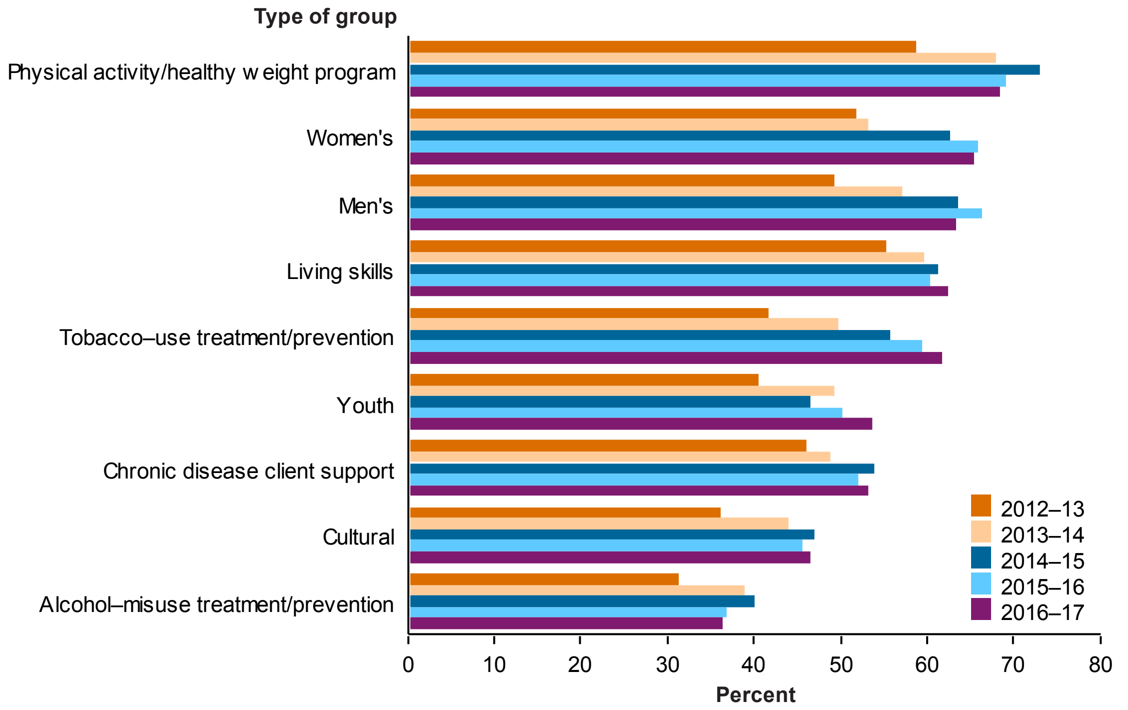
Most organisations (184 or 94%) provided at least one type of group activity as part of their health promotion and prevention work. For example, around 8,400 physical activity/healthy weight sessions; 4,100 living skills sessions; 4,300 chronic disease client support sessions and 3,300 tobacco-use treatment and prevention sessions were conducted (see Table S3.14). Around two-thirds (68%) of organisations ran physical activity and healthy weight programs, while just under two-thirds ran men's and women's groups (63% and 65%, respectively), living skills groups (62%) and tobacco-use treatment and prevention groups (62%). Around half ran youth groups (54%), chronic disease client support groups (53%), and cultural groups (46%) and just over one-third (36%) ran alcohol-misuse treatment and prevention groups (see Figure 3.9). With respect to maternal and child health care, 83 (42%) organisations ran maternal and baby/child health groups, 75 (38%) ran parenting groups and 82 (42%) did home visits.



Note: Averages are based on the number of organisations providing each type of group activity. Organisations not providing an activity were excluded from average calculations.

Figure 3.9: Proportion of primary health-care organisations providing selected group activities and the average number of sessions conducted, by type of group activity, 2016–17

The proportion of organisations providing various group activities has increased since 2012–13 (see Table S3.15). For example, the proportion providing chronic disease support groups increased from 46% in 2012–13 to 53% in 2016–17, and tobacco-use treatment/prevention groups from 42% of organisations to 62% (see Figure 3.10).



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 3.10: Proportion of primary health-care organisations providing selected group activities, by type of group activity, 2012–13 to 2016–17

Clinical or health-related services

Organisations provided various clinical and health-related services. As in 2015–16, most organisations kept track of clients who needed follow-up (99%) and provided child immunisation (88%) services, free medical supplies and pharmaceuticals (83%), and routine screening for sexually transmitted infections (85%) to the local community (see Figure 3.11). Over half (54%) provided aged-care services, palliative care (60%) and services for people with a disability (62%). Organisations in *Remote* and *Very remote* areas were more likely to provide free medical supplies/pharmaceuticals (96% and 89%, respectively) and palliative care (65% and 79%, respectively) than organisations in other areas. Organisations in *Very remote* areas were also more likely to provide aged-care services (63%) and medical evacuation services (77%) compared with other areas (see Table S3.16).

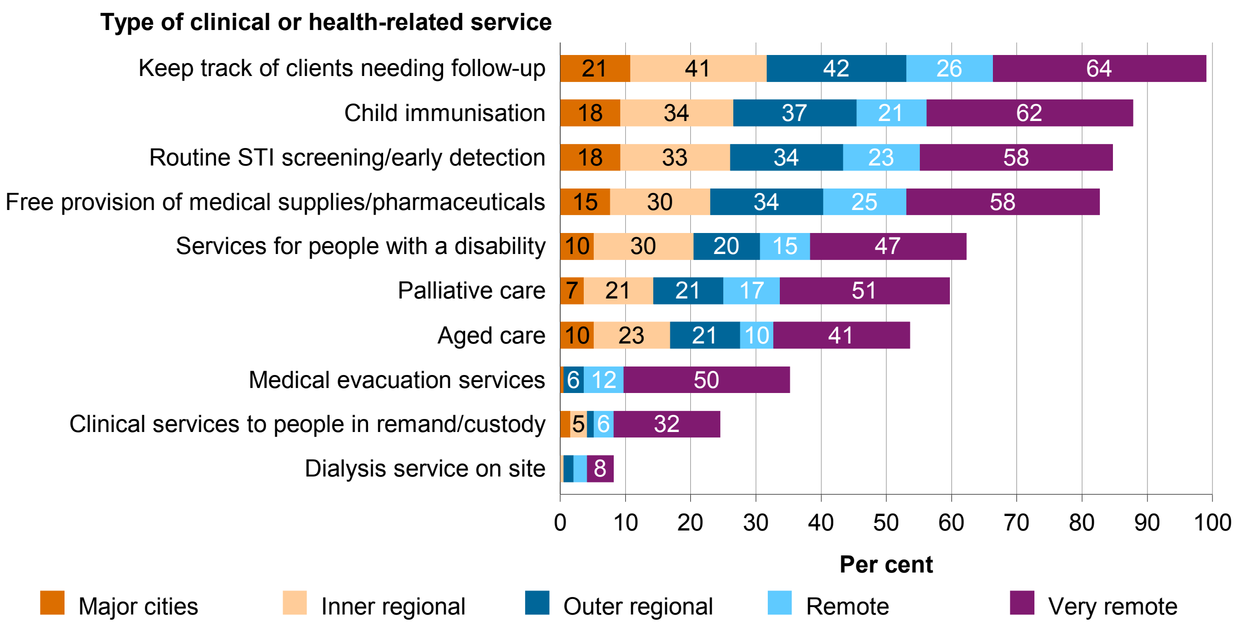


Figure 3.11: Number (as labelled) and proportion (in scale) of primary health-care organisations providing selected clinical or health-related services, by remoteness area, 2016–17

With respect to continuity of care for clients, most organisations (82%) had established relationships with Aboriginal liaison officers at local hospitals and 71% had shared care arrangements for chronic disease management with local hospitals (see Figure 3.12). Around 6 in 10 reported that discharge planning was well-coordinated (61%), staff regularly attended hospital/specialist appointments with clients (63%), and staff regularly visited clients in hospital (57%). Organisations in *Major cities*, *Inner regional* and *Outer regional* areas were more likely to have staff who regularly attended hospital or specialist appointments with clients, or visited clients in hospital, compared with those in *Remote* and *Very remote* areas where access to hospitals would be more limited (see Table S3.17). Half of organisations (50%) reported the coordination of clinical care with other providers, such as hospitals, as one of their challenges in delivering quality health services (see Section 3.7).

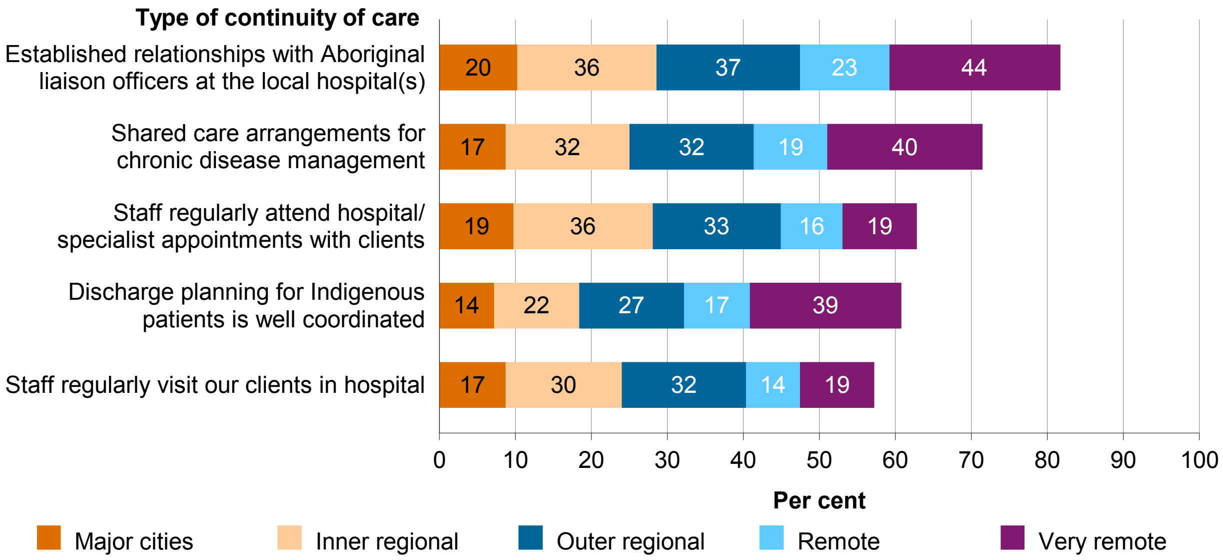


Figure 3.12: Number (as labelled) and proportion (in scale) of primary health-care organisations providing continuity of care with local hospitals, by remoteness area, 2016–17

Access to specialist, allied health and dental services

Organisations providing Indigenous primary health-care services also offered access to a range of specialist services (for example, paediatric, cardiology, renal, ophthalmologic, psychiatric, diabetes and ENT); allied health services (for example, physiotherapy, podiatry, optometry and audiology); and dental services. These were provided on site and/or through facilitating access to off-site services. A small proportion of organisations did not provide any access to these services (see Figure 3.13 and Table S3.18). In 2016–17:

- paediatrician services were available at 90% of organisations (32% on-site only, 33% off-site only and 25% both on-site and off-site)
- diabetes specialist services were available at 90% of organisations (36% on-site only, 41% off-site only and 13% both on-site and off-site)
- podiatrist services were available at 96% of organisations (67% on-site only, 15% off-site only and 15% both on-site and off-site)
- dental services were available at 94% of organisations (33% on-site only, 48% off-site only and 14% both on-site and off-site)
- ACCHOs were more likely than other organisations to provide on-site access to a diabetes specialist (52% compared with 42%), psychologist (59% compared with 37%), optometrist (75% compared with 63%) and dental services (49% compared with 40%), while other organisations were more likely to provide off-site access to most services (see Table S3.19).

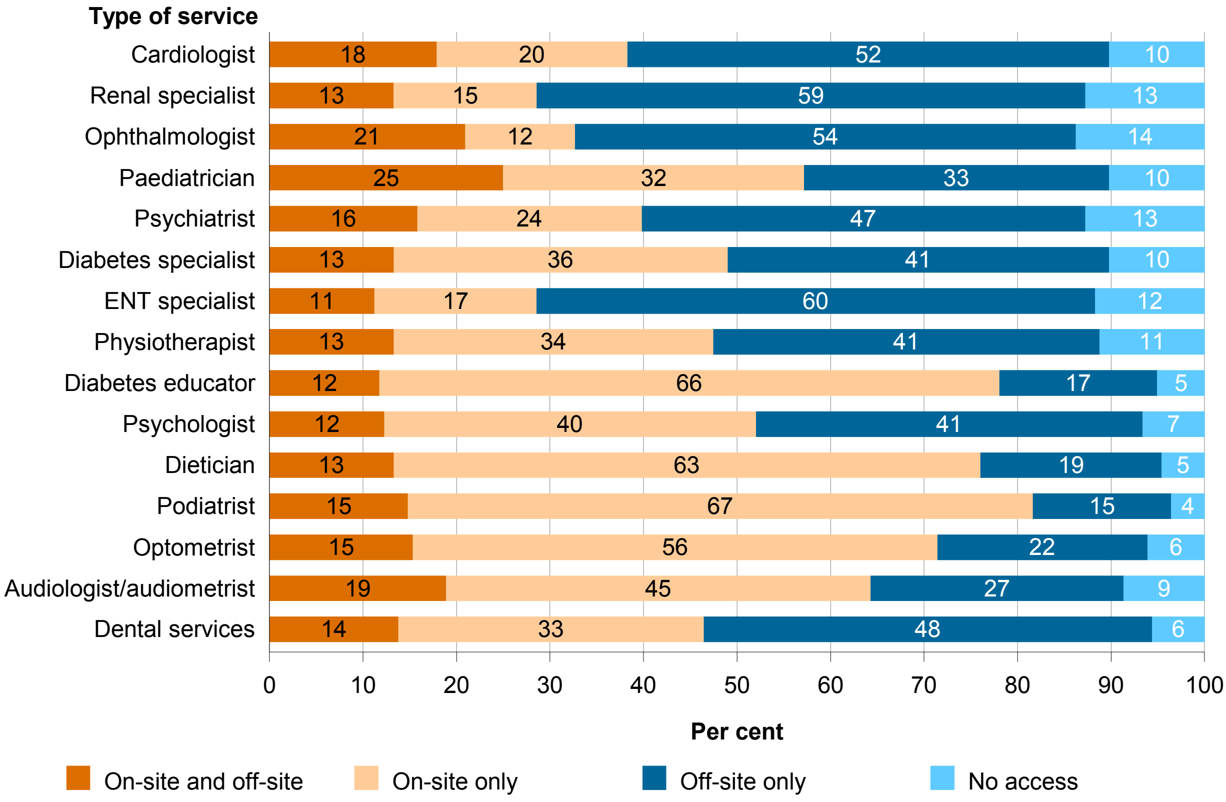
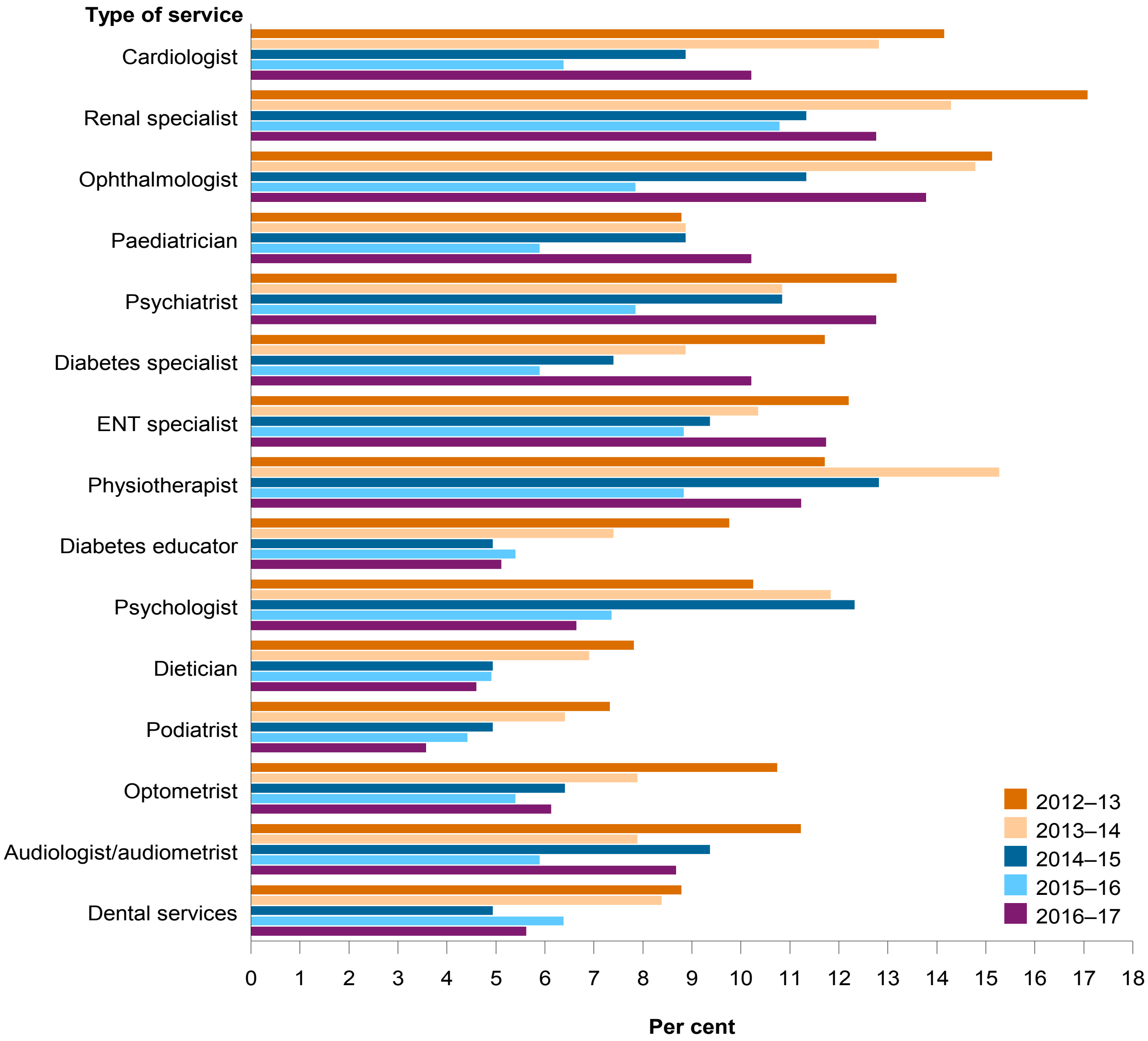


Figure 3.13: Proportion of primary health-care organisations, by type of access to specialist, allied health and dental services, by type of service, 2016–17

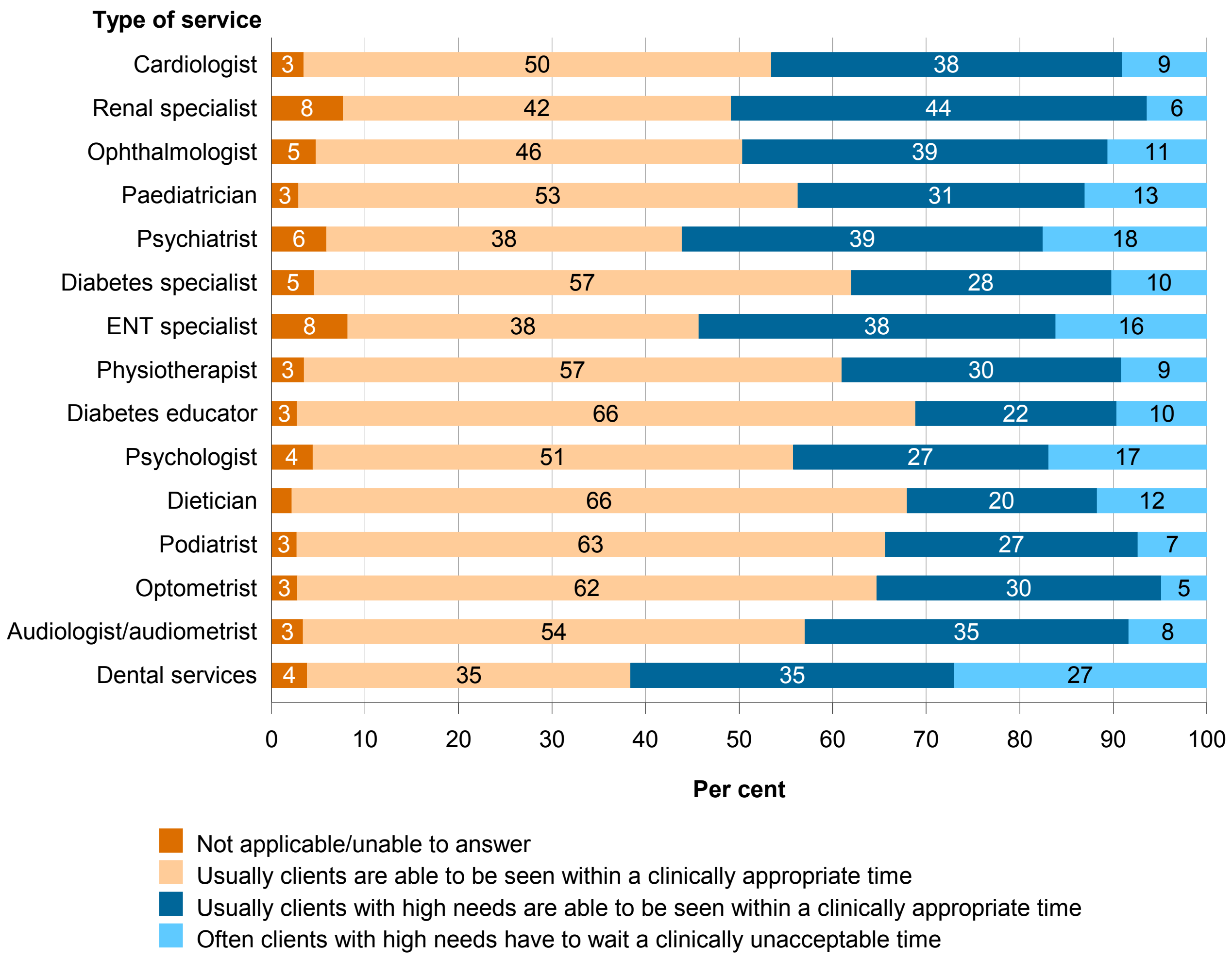
The proportion of organisations providing on-site or off-site access to various specialist and allied health services was similar to 2015–16 for many types of services; however, there were some small increases in the proportion of organisations reporting no access to some services. For example, the proportion reporting no access to an ophthalmologist increased from 8% to 14% while the proportion reporting no access to a cardiologist increased from 6% of organisations to 10% (see Figure 3.14 and Table S3.20).



Note: Is the proportion of organisations with no on-site or off-site access to each type of service, in each year.

Figure 3.14: Proportion of primary health-care organisations offering no access to specialist, allied health and dental services, by type of service, 2012–13 to 2016–17

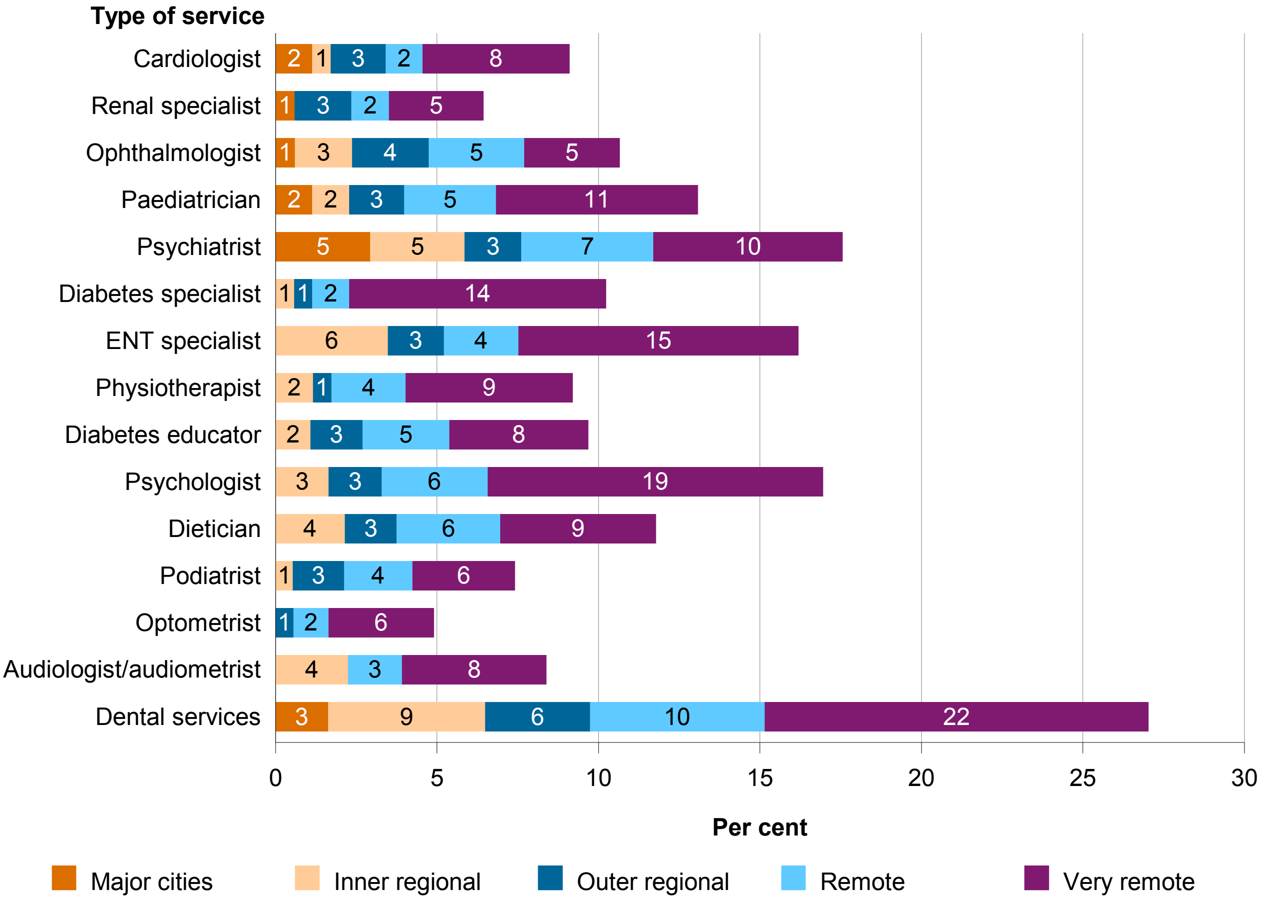
Organisations providing on-site or off-site access to specialist, allied health and dental services were asked to rate the level of access for their clients to these services, between 1 (usually clients were able to be seen within a clinically appropriate time) and 3 (clients with high-priority needs often had to wait a clinically unacceptable time). In 2016–17, the proportion of organisations providing services that indicated all clients or high-priority needs clients were usually able to see specialist or allied health professionals within a clinically appropriate time ranged from 69% for dental services to 92% for optometrists (see Figure 3.15 and Table S3.21).



Note: Proportions are based on the number of organisations providing on-site or off-site access to that service only.

Figure 3.15: Proportion of primary health-care organisations offering access to specialist, allied health and dental services, by level of client access and type of service, 2016–17

The proportion of organisations providing access to specialist, allied health and dental services that indicated clients with high-priority needs often had to wait a clinically unacceptable time was higher for dental services (27% or 50 organisations). This was followed by services provided by psychiatrists (18%) psychologists (17%) and ENT specialists (16%). For many services, organisations in *Remote* and *Very remote* areas were more likely to say that clients with high-priority needs had to wait a clinically unacceptable time (see Figure 3.16 and Table S3.22). For example, the proportion of organisations in *Very remote* areas that indicated clients with high needs had to wait too long was higher for ENT specialists (24% compared with 16% in all organisations), psychologists (31% compared with 17% in all organisations), and diabetes specialists (22% compared with 10% in all organisations). For dental services, the proportion of organisations that indicated clients with high-priority needs had to wait a clinically unacceptable time ranged from 14% (6 organisations) in *Outer regional* areas to 44% (10 organisations) in *Remote* areas.



Note: Proportions are based on the number of organisations that provided on-site or off-site access to that service. Organisations not providing access to that service were excluded from the calculations.

Figure 3.16: Number (as labelled) and proportion (in scale) of primary health-care organisations that felt clients with high-priority needs had to wait too long for services, by type of service and remoteness area, 2016–17

Social and emotional wellbeing services

Many organisations provide social and emotional wellbeing support to clients as part of their primary health-care delivery. In 2016–17, most (94%) organisations providing Indigenous primary health-care services provided social and emotional wellbeing or mental health or counselling services during usual opening hours, and 24% provided services outside usual hours. Around three-quarters (74%) reported providing services to members of the Stolen Generations.

Organisations were asked about their 5 most important social and emotional wellbeing issues in terms of staff time and organisational resources (see Table S3.23). The issues they provided the most assistance for were depression (77%), anxiety and stress (76%), grief and loss (64%), family/community violence (60%) and family/relationship issues (57%). These were similar to the issues reported in 2015–16, although the proportion reporting family/community violence issues increased from 51% of organisations in 2015–16 to 60% in 2016–17.

Organisations provided a range of social and emotional wellbeing support and mental health services to clients. For example, most (89%) provided short-term counselling; 63%, long-term or ongoing counselling; 62%, group activities; 54%, self-harm and suicide prevention; and 48% provided outreach services (see Table S3.24).

It should be noted that 72 (37%) organisations providing primary health-care services were also funded by PM&C specifically to deliver social and emotional wellbeing services. More information on all organisations funded to provide these services is provided in Chapter 5.

Substance-use services

Many organisations provide substance-use services as part of their primary health-care delivery. Over two-thirds of organisations providing Indigenous primary health-care services provided substance-use/drug and alcohol programs (70%) and tobacco programs (70%) during usual opening hours. Organisations were asked about their 5 most important substance-use issues in terms of staff time and organisational resources (see Table S3.25). The most common substance-use issues they provided services for were alcohol (96%), tobacco/nicotine (89%), cannabis/marijuana (86%), amphetamines (57%) and multiple drug use (47%). These were similar to those reported in 2015–16. Organisations provided a range of substance-use services (see Table S3.26). Most provided individual counselling (83%), community education (73%), and crisis intervention (64%) and over half (56%), school education and visits. Around one-third provided support groups (36%), group counselling (35%), youth programs (31%) and a Tackling Smoking and Healthy Lifestyle team (35%).

It should be noted that 39 (20%) organisations providing primary health-care services were also funded specifically by PM&C to provide substance-use services. More information on all organisations funded to provide these services is provided in Chapter 6.

3.3 Clients

In 2016–17, 195 (99%) organisations reported primary health client numbers, compared with 204 organisations in 2015–16. These 195 organisations saw around 444,700 clients. This was 4% lower than the number of clients reported in 2015–16 (around 461,500). Queensland had the highest number of clients (around 118,800), followed by New South Wales and the Australian Capital Territory combined (around 105,900). Tasmania had the lowest number, with around 5,500 clients (see Table S3.27). Just under half (44%) of all clients were seen in either *Outer regional* (103,200 clients) or *Very remote* areas (91,300 clients).

It should be noted that 31 organisations (16%) estimated their client numbers. In some cases, individuals may be clients at more than one organisation and therefore counted twice, so the total client count is likely to overestimate the total number of individual clients seen. Some clients may also be clients of other mainstream primary health-care providers.

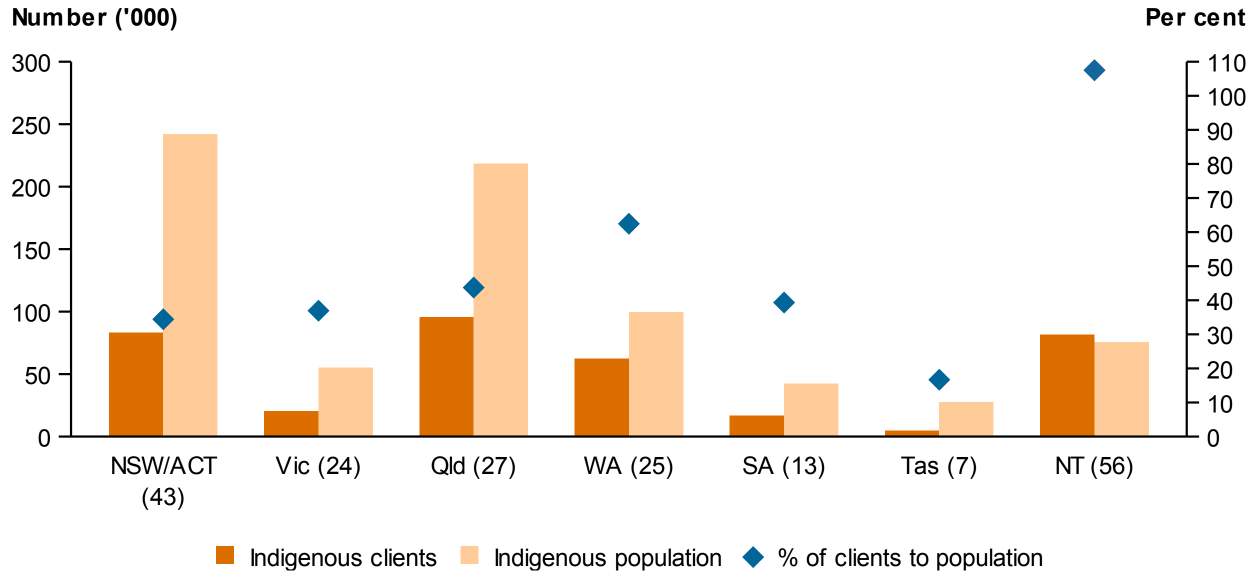
Indigenous status

Eighty-two per cent of clients (around 364,100) were Indigenous, 16% were non-Indigenous and 2% had no Indigenous status recorded. Across the states and territories:

- Queensland had 14% of organisations and 26% of all Indigenous clients.
- New South Wales and the Australian Capital Territory combined had 22% of organisations and a similar proportion (23%) of all Indigenous clients.
- The Northern Territory had 29% of organisations and 22% of all Indigenous clients.
- Western Australia had 13% of organisations and 17% of all Indigenous clients.

Proportion of the estimated Indigenous population

The Indigenous clients of these organisations represented nearly half (48%) the total Indigenous population of Australia, estimated by the Australian Bureau of Statistics (ABS) to be around 761,000 in June 2017 (ABS 2014). Coverage of the Indigenous population varied by state and territory and ranged from an estimated 17% of the total Indigenous population in Tasmania to all of the Indigenous population in the Northern Territory (see Figure 3.17). It should be noted that clients may have attended more than one organisation and so the proportion of the total Indigenous population that were clients of these organisations is likely to be overestimated. This is most obvious in the Northern Territory where OSR Indigenous clients were more than the estimated Indigenous population of the Northern Territory. The Northern Territory had a relatively large number of organisations (56) contributing to the collection and some clients may have been counted at both an ACCHO and one of the Northern Territory Government-run clinics.



Note: In some cases, clients may be counted at more than one organisation. The proportion of clients to population may therefore be overestimated. Indigenous population is based on the ABS projected Indigenous population in June 2017 (projection series B). The number of organisations in each state and territory is in brackets.

Figure 3.17: Indigenous clients, population and proportion of clients to population, by state and territory, 2016–17

Type of organisation

ACCHOs represented 69% of all organisations and saw around 371,600 (84%) clients, while other organisations saw around 73,100 (16%) clients (see Table S3.28). Indigenous clients represented 82% of ACCHOs' clients and 81% of other organisations' clients (see Table S3.29). ACCHOs had more Indigenous clients than other organisations in all states and territories and therefore saw a higher proportion of the total estimated Indigenous population (40%), compared with other organisations (8%).

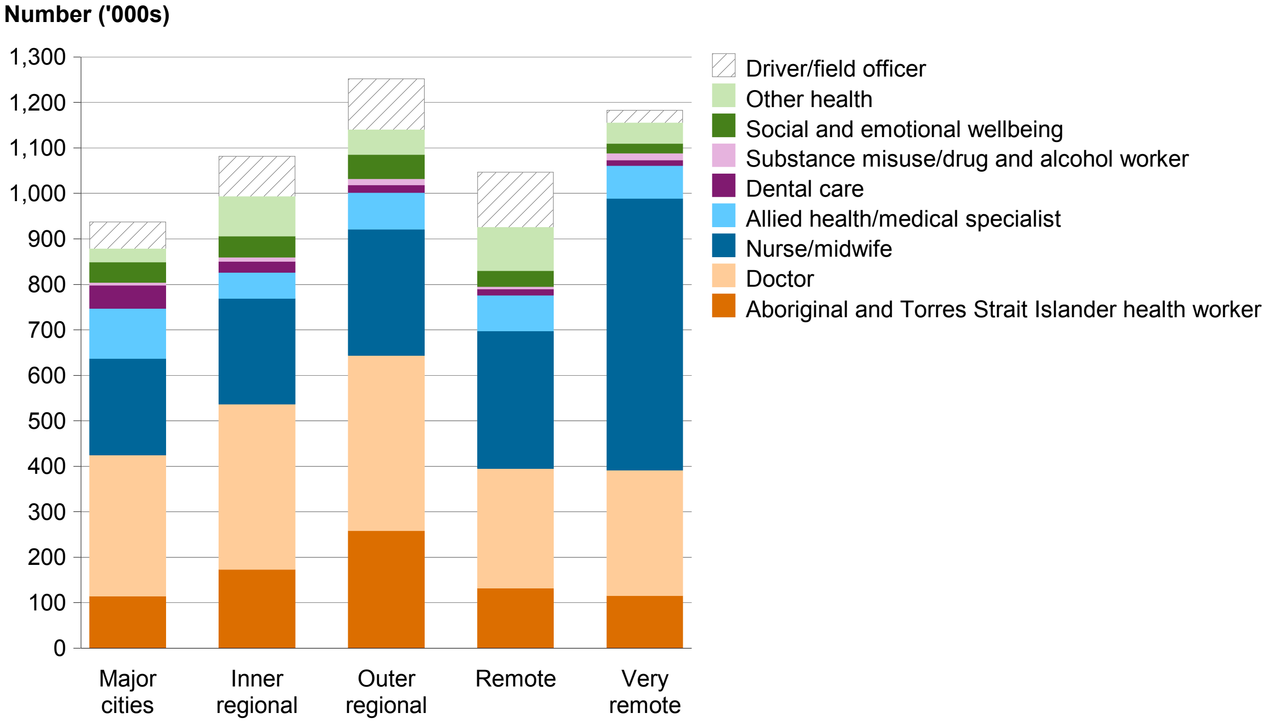
3.4 Client contacts

Organisations providing Indigenous primary health-care services report on both their client contacts and episodes of care in the OSR. An episode of care is a contact between an individual client and one or more health workers within a calendar day. All contacts with the same client on the same day are counted as 1 episode of care only. Client contacts, however, are the number of individual contacts made with each client by each health worker and include contacts by employed and visiting health staff and those providing transport services. If more than one worker sees a client in the same visit (for example, a nurse and a driver) then an episode of care will result in more than one client contact.

In 2016–17, organisations providing Indigenous primary health-care services made around 5.5 million client contacts—an average of 12.4 contacts per client (see Table S3.30). The average number of contacts per client ranged from 11.4 in New South Wales and the Australian Capital Territory combined to 18.4 in South Australia (see Table S3.31). A higher proportion of all contacts were made in *Outer regional* areas (23%), and *Very remote* areas (22%), and a smaller proportion (17%) in *Major cities*, reflecting the distribution of clients in these areas (see Figure 3.18). Nearly 6 in 10 (59%) contacts were with nurses/midwives or doctors:

- Nurses and midwives (14% of the total FTE workforce reported by organisations providing Indigenous primary health-care services) made around 1.6 million contacts (29% of all contacts). Of these, 37% were in *Very remote* areas and 19% in *Remote* areas. Contacts by nurses represented half (51%) of all contacts in *Very remote* areas and 29% of contacts in *Remote* areas—a higher proportion than in other areas.

- Doctors (7% of the total FTE workforce reported) made around 1.6 million contacts (29% of all contacts). Of these, 24% were in *Outer regional* areas (385,000). Contacts by doctors represented around one-third of all contacts in *Major cities* (33%), *Inner regional* areas (34%) and *Outer regional* areas (31%), and around one-quarter of contacts in *Remote* (25%) and *Very remote* (23%) areas.
- Aboriginal and Torres Strait Islander health workers and practitioners (13% of the total FTE workforce reported) made around 791,000 contacts (14% of all contacts). One-third of these (258,000) were in *Outer regional* areas.
- Allied health professionals (3% of the total FTE workforce reported) made around 334,000 contacts (6% of all contacts).
- Social and emotional wellbeing staff (6% of the total FTE workforce reported) made around 202,000 contacts (4% of all contacts). Contacts by social and emotional wellbeing staff represented 2% of all contacts in *Very remote* areas—a lower proportion than in other areas.
- Drivers and field officers (5% of the total FTE workforce reported) made around 410,000 contacts (7% of all contacts).



Notes

1. Aboriginal and Torres Strait Islander health practitioner positions are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
2. ‘Other health’ positions included sexual health workers, traditional healers and ‘other’ health staff not recorded elsewhere.

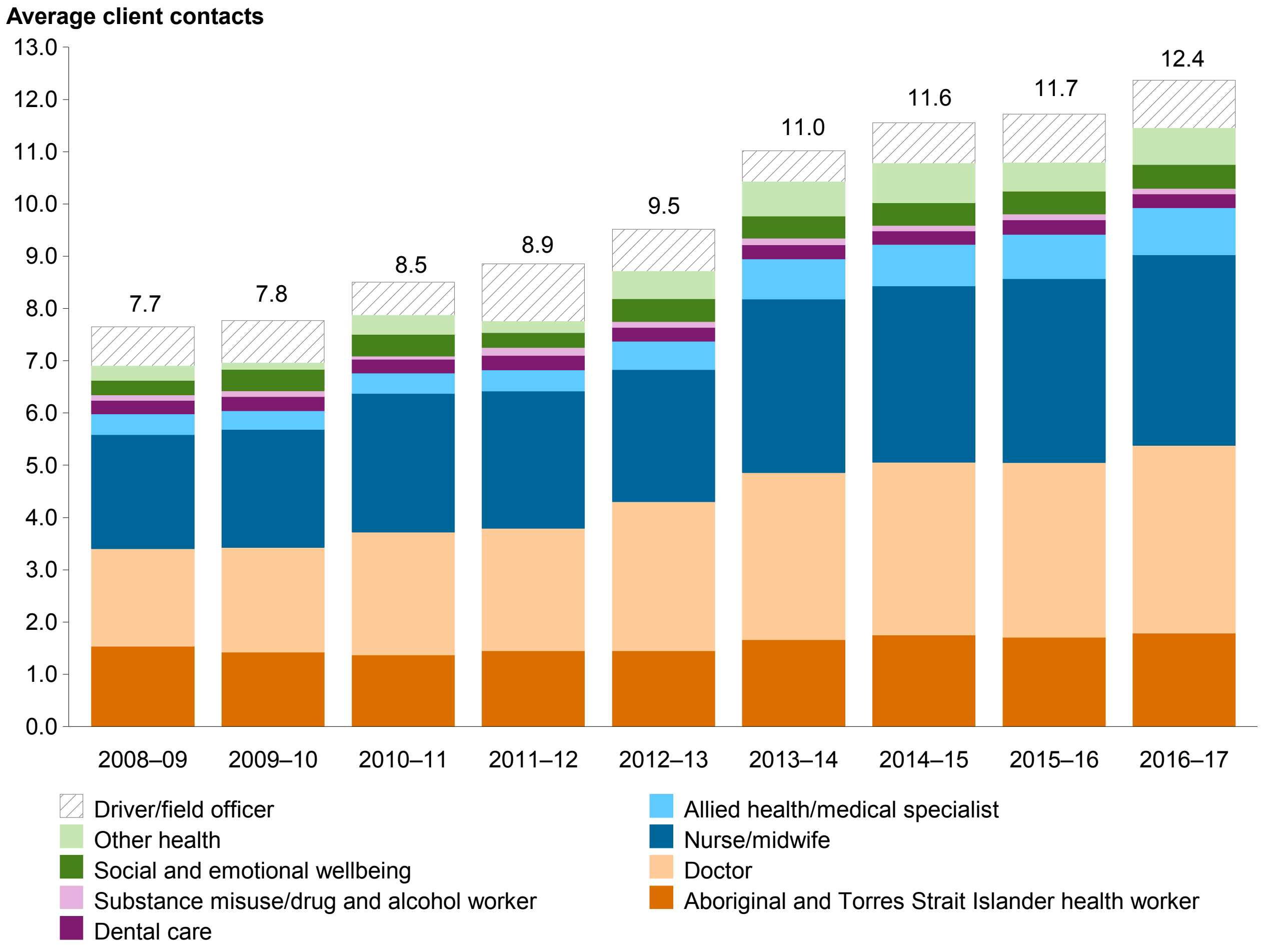
Figure 3.18: Number of client contacts, by position type and remoteness area, 2016–17

Time series

In 2016–17, 194 organisations reported client contact numbers compared with 203 in 2015–16. The total number of client contacts reported in 2016–17 (5.5 million) was 2% higher than in 2015–16 (5.4 million).

Average number of contacts

The average number of contacts per client (12.4) was higher than in 2015–16 (11.7). The average number of contacts per client has steadily increased over the past 8 years, from 7.7 in 2008–09 to 12.4 in 2016–17 (see Figure 3.19 and Table S3.31). Since 2008–09, there has been an increase in the average number of contacts per client with doctors (from 1.9 in 2008–09 to 3.6 in 2016–17) and nurses and midwives (from 2.2 in 2008–09 to 3.6 in 2016–17).



Notes

1. In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.
2. Aboriginal and Torres Strait Islander health practitioner positions were new in 2012–13 and are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
3. ‘Other health’ positions included sexual health workers, traditional healers and ‘other’ health staff not recorded elsewhere.

Figure 3.19: Average number of contacts per client, by position type, 2008–09 to 2016–17

3.5 Episodes of care

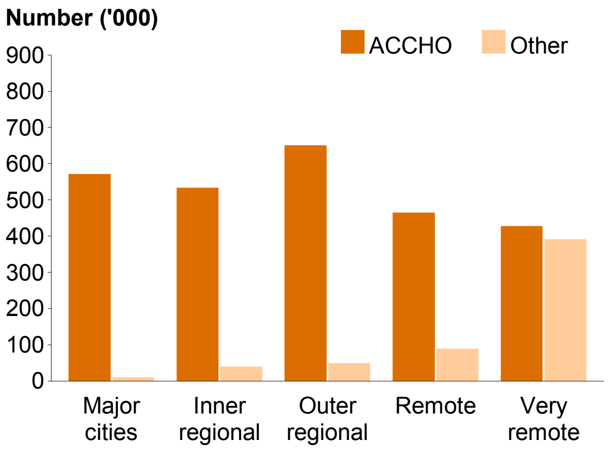
An episode of care is a contact between an individual client and one or more health workers within a calendar day. All contacts with the same client on the same day are counted as 1 episode of care. If more than one health worker sees a client on the same day, then an episode of care will result in more than one client contact. An episode of care may include health care provided on site or off site. It does not, however, include residential care, group activities, administrative contacts (for example, a receptionist making an appointment) or transport-only contacts.

In 2016–17, there was a push to enforce the OSR definition of counting only one episode of care per client per day and for greater consistency in the types of contacts included in the episode of care count between the different types of CIS (see Chapter 2). Some contacts (for example, hospital visits and health care delivered over the telephone) previously included in the episode of care count in some organisations were now excluded from the count. This meant episode of care counts were lower in some organisations, especially in those using Communicare. Episodes of care were also under-reported in some organisations using MD due to changes in how data were recorded. This meant contacts for some health workers were not always included in the OSR episode of care count as they should have been. The impact of these changes is that episodes of care counts are lower in 2016–17 and are not comparable with previous OSR collections.

In 2016–17, 193 (98%) organisations reported valid episodes of care counts, compared with 202 (99%) in 2015–16, and 20 of these organisations (10%) estimated their episodes of care. Around 3.2 million episodes of care were reported by these 193 organisations and one-quarter (817,000) were in *Very remote* areas (see Table S3.32). Queensland had the most episodes of care (26%), followed by the Northern Territory (25%) and New South Wales and the Australian Capital Territory combined (21%), reflecting the higher number of organisations and clients in these areas (see Table S3.33).

Type of organisation

ACCHOs provided around 2.6 million (82%) episodes of care and other organisations around 575,000 (18%). For ACCHOs, the number of episodes of care was higher in *Outer regional* areas (25%) and *Major cities* (22%). For other organisations, the number of episodes of care was higher in *Very remote* (68%) and *Remote* (15%) areas, reflecting the increasing number of other organisations by remoteness, in particular the Northern Territory Government-run clinics (see Figure 3.20 and Table S3.34).

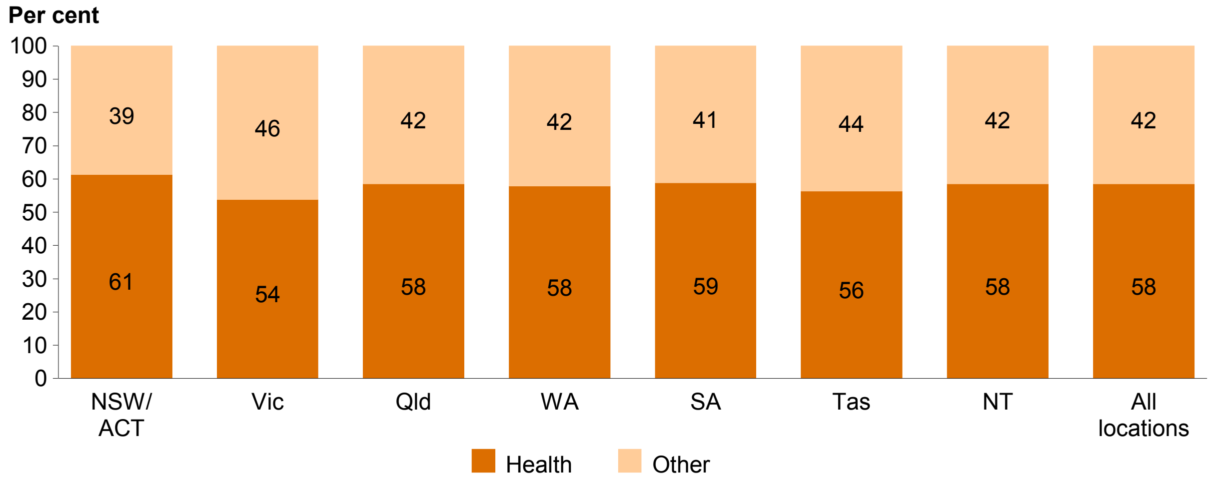


Note: 'Other' organisations include both government-run organisations and non-government organisations (excluding ACCHOs).

Figure 3.20: Number of primary health-care episodes of care, by type of organisation and remoteness area, 2016–17

3.6 Staffing

Organisations providing Indigenous primary health-care services employed 7,600 FTE staff at 30 June 2017. Of these, 58% (4,439 FTE) were health staff and 42% (3,161 FTE) were other staff (including managers and supervisors, administrative and support staff, and drivers and field officers). The proportion of health staff was similar to 30 June 2016 (57%). The proportion of health staff ranged from 55% in *Inner regional* areas to 61% in *Outer regional* areas and *Major cities*. There was also some variation by state and territory. The proportion of health staff ranged from 54% in Victoria to 61% in New South Wales and the Australian Capital Territory combined (see Figure 3.21). Victoria and Tasmania had a higher proportion of managerial, administrative and other staff (46% and 44% of all staff, respectively).



Note: Excludes visiting staff. See Appendix C for a list of positions included as 'health' and 'other' positions.

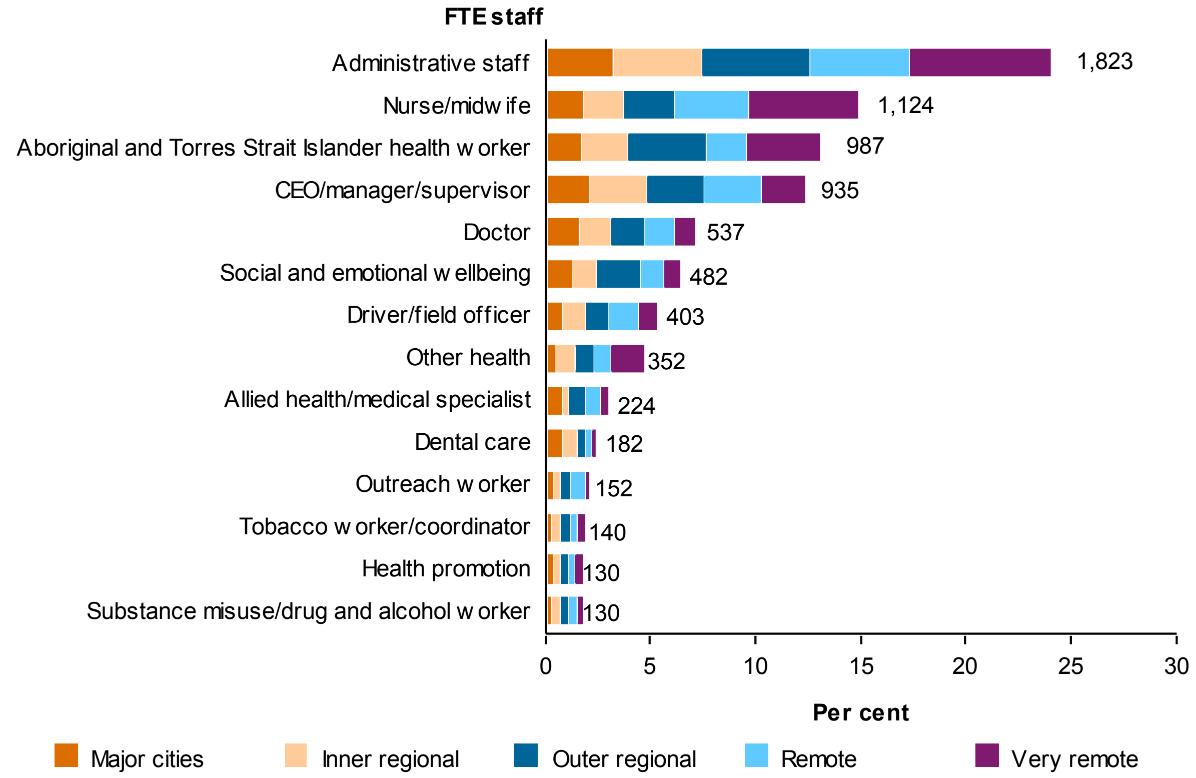
Figure 3.21: Proportion of FTE staff employed by primary health-care organisations, by position type and state and territory, at 30 June 2017

Just over half (53%) of FTE staff employed were Indigenous, similar to the proportion in 2015–16 (53%). Although smaller proportions of doctors and nurses were Indigenous (7% and 14%, respectively), nearly all Aboriginal and Torres Strait Islander health workers and health practitioners were Indigenous (96%), as were most drivers and field officers (84%) and outreach workers (86%). A high proportion of tobacco workers (83%), substance misuse workers (76%) and health promotion workers (69%) were also Indigenous (see Table S3.35).

These organisations were assisted by an additional 269 FTE visiting staff not paid for by the organisations themselves, making a total workforce of 7,869 FTE staff (see Table S3.36). This equates to an average of 17.6 FTE staff per 1,000 clients in these organisations.

Type of positions

Health staff represented 58% of employed staff (4,439 FTE) and nurses and midwives were the most common type of health worker (1,124 FTE or 15% of employed FTE staff). Aboriginal and Torres Strait Islander health workers and health practitioners represented 13% of employed FTE staff and doctors 7% (see Figure 3.22). Administrative staff (including administrative and clerical, finance and accounting, information technology and data management, and support staff) made up one-quarter (24%) of employed positions (1,823 FTE).



Notes

1. Health practitioners are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
2. Administrative staff include administrative and clerical staff, finance and accounting staff, information technology and data management staff, and support staff.
3. 'Other health' positions include sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health staff not recorded elsewhere.
4. Excludes visiting staff.

Figure 3.22: Number (as labelled) and proportion (in scale) of FTE staff employed by primary health-care organisations, by position type and remoteness area, at 30 June 2017

Aboriginal and Torres Strait Islander health workers

Aboriginal and Torres Strait Islander health workers have an important role in improving the health of Aboriginal and Torres Strait Islander people. In 2013, the Community Services and Health Industry Skills Council (CSHISC) released new health training packages that contained a suite of updated qualifications, skill sets and units of competency in first aid, workplace health and safety and telehealth (CSHISC 2014). At 30 June 2017, 357 Aboriginal and Torres Strait Islander health workers held a Certificate IV practice stream qualification, 141 held a Certificate IV community stream qualification and 273 a Certificate III qualification (see Table S3.42).

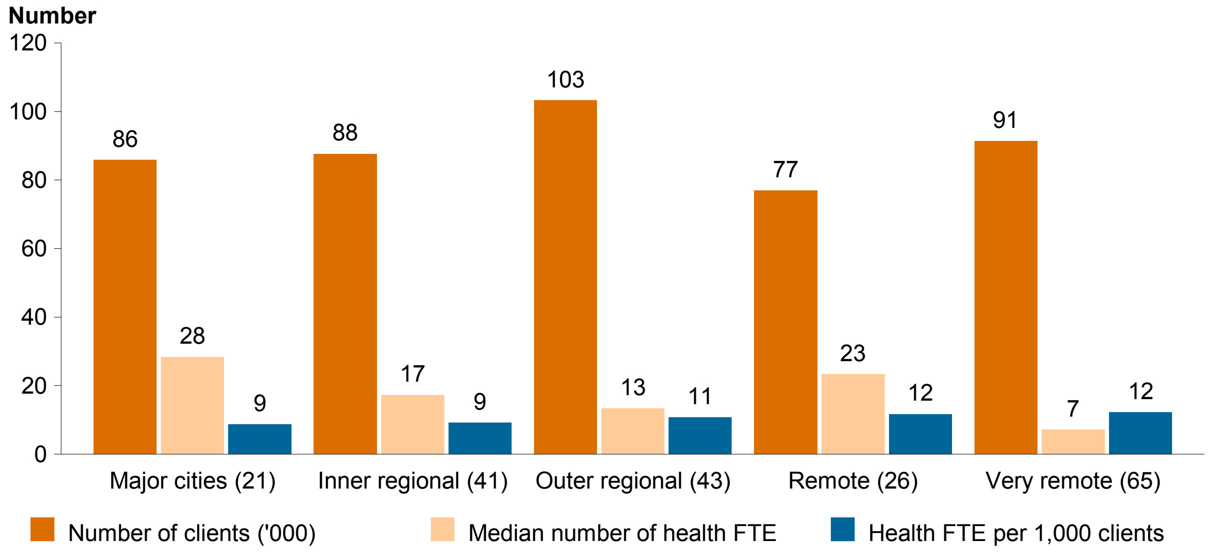
Remoteness area

The distribution of employed staff varied by remoteness area with around one-quarter (24%) employed in *Very remote* areas, followed by *Outer regional* areas with 23% and *Remote* areas (20%). *Major cities* had a smaller proportion of FTE staff (15%). There were also differences in the types of positions by remoteness area. *Major cities* and *Inner regional* areas had a higher proportion of all dental care staff employed, with 33% and 26%, respectively (see Table S3.38). *Outer regional* areas had a higher proportion of Aboriginal and Torres Strait Islander health workers and practitioners (29%), and social and emotional wellbeing staff (34%) than other areas. *Remote* and *Very remote* areas had higher proportions of nurses and midwives (24% and 35%, respectively).

At 30 June 2017:

- Aboriginal and Torres Strait Islander health workers and practitioners represented 13% of employed FTE positions. Of the 987 FTE health worker and practitioners employed, 29% (282 FTE) were in *Outer regional* areas and 27% (268 FTE) in *Very remote* areas
- nurses and midwives represented 15% of employed FTE positions. Of the 1,124 FTE nurses and midwives employed, 35% (398 FTE) were in *Very remote* areas and 24% (267 FTE) in *Remote* areas
- doctors represented 7% of employed FTE positions. The 537 FTE doctors were evenly spread across all remoteness areas except *Very remote* areas, which had a lower proportion (14%) compared with other areas
- social and emotional wellbeing staff represented 6% of employed FTE positions. Of the 482 FTE staff employed, 34% (166 FTE) were in *Outer regional* areas
- allied health professionals represented 3% of employed FTE positions. Of the 194 FTE allied health professionals employed, 29% (57 FTE) were in *Outer regional* areas.

Health FTE staff per 1,000 clients (including both employed and visiting staff) was higher in organisations in *Remote* and *Very remote* areas (both 12 per 1,000 clients). The median number of health FTE staff per organisation was higher in *Major cities* (28) and *Remote* areas (23) and lower in *Very remote* areas (see Figure 3.23).

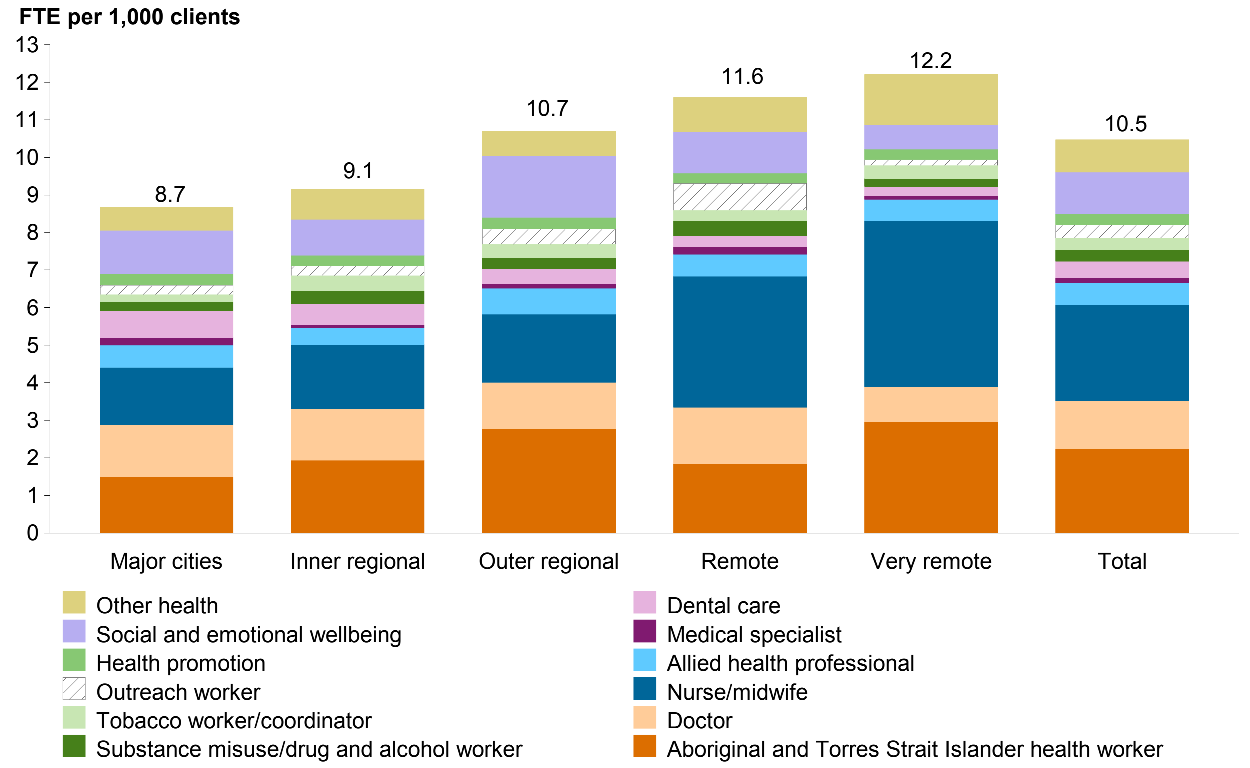


Note: The number of primary health-care organisations in each remoteness area is in brackets.

Figure 3.23: Number of clients, median number of health FTE staff and health FTE staff per 1,000 clients, by remoteness area, 2016–17

The ratio of staff to clients also varied by position type (see Figure 3.24 and Table S3.36):

- There were 4.4 FTE nurses and midwives per 1,000 clients in *Very remote* areas and 3.5 per 1,000 clients in *Remote* areas, which was higher than the average for all organisations (2.6), while the rate for doctors in *Very remote* areas was lower (0.9 compared with 1.3 for all organisations).
- There were 0.7 FTE dental care staff per 1,000 clients in *Major cities* and 0.6 in *Inner regional* areas, which was higher than the average for all organisations (0.4).
- There were fewer FTE social and emotional wellbeing staff per 1,000 clients in *Very remote* areas (0.7), compared with the average for all organisations (1.1).



Notes

1. Aboriginal and Torres Strait Islander health practitioner positions are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
2. In 2016–17, 'Other health' positions included sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health staff not recorded elsewhere.
3. Includes visiting staff not paid for by the organisations themselves.

Figure 3.24: Number of health FTE staff per 1,000 clients, by position type and remoteness area, 2016–17

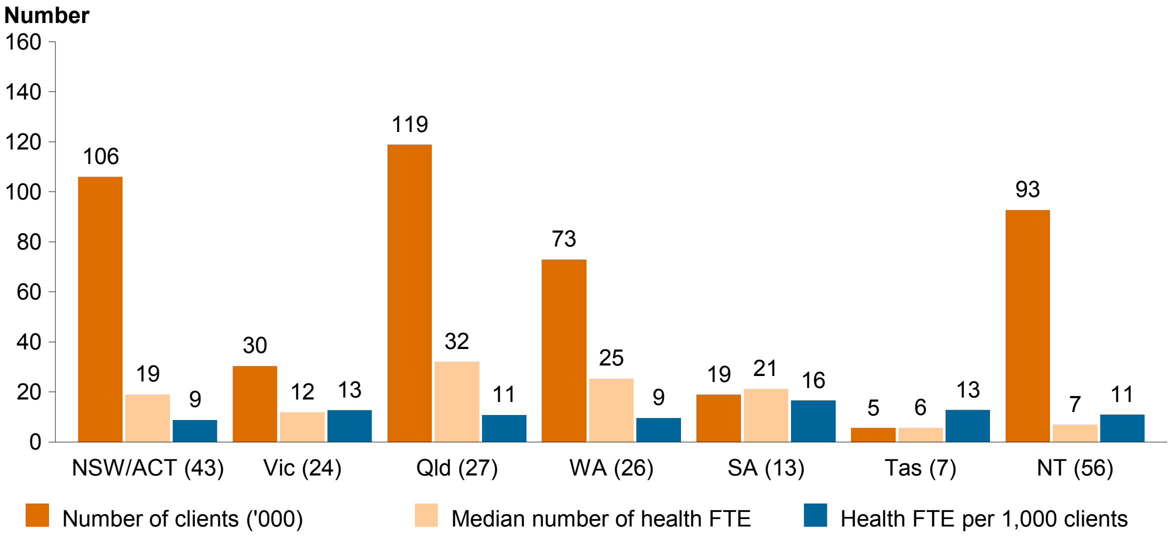
State and territory

The distribution of employed staff varied by state and territory, with Queensland having 28% of FTE staff, followed by the Northern Territory (21%) and New South Wales and the Australian Capital Territory combined (19%) (see Table S3.39). New South Wales and the Australian Capital Territory combined had higher proportions of dental care staff (40%) and the Northern Territory higher proportions of Aboriginal and Torres Strait Islander health practitioners (36%). Queensland had higher proportions of social and emotional wellbeing staff (36%), doctors (34%), nurses and midwives (30%), Aboriginal and Torres Strait Islander health workers (31%) and drivers and field officers (27%).

At 30 June 2017:

- the 29% of organisations in the Northern Territory had 21% of employed FTE staff. A relatively high proportion of Aboriginal and Torres Strait Islander health practitioners (36%) and nurses (27%) were employed there. Nurses represented 19% of employed FTE staff in the Northern Territory, compared with 15% for all organisations. The higher number of nurses may be related to the fact that many Northern Territory organisations (79%) were located in *Very remote* areas where there may be more nurse-led clinics
- the 22% of organisations in New South Wales and the Australian Capital Territory combined had 19% of employed staff. Around 24% of doctors and 40% of dental care staff were employed there
- the 14% of organisations in Queensland had 28% of employed staff. Just over one-third of allied health professionals (36%) and social and emotional wellbeing staff (36%), and around one-third of doctors (34%), Aboriginal and Torres Strait Islander health workers (31%) and nurses and midwives (30%) were employed there.

Health FTE staff per 1,000 clients (including both employed and visiting staff) ranged from 9 in organisations in Western Australia and in New South Wales and the Australian Capital Territory combined, to 16 in South Australia (see Figure 3.25). The median number of health FTE staff ranged from 6 for organisations in Tasmania to 32 for those in Queensland and reflects the size and number of organisations in these states.



Note: The number of primary health-care organisations in each state and territory is in brackets.

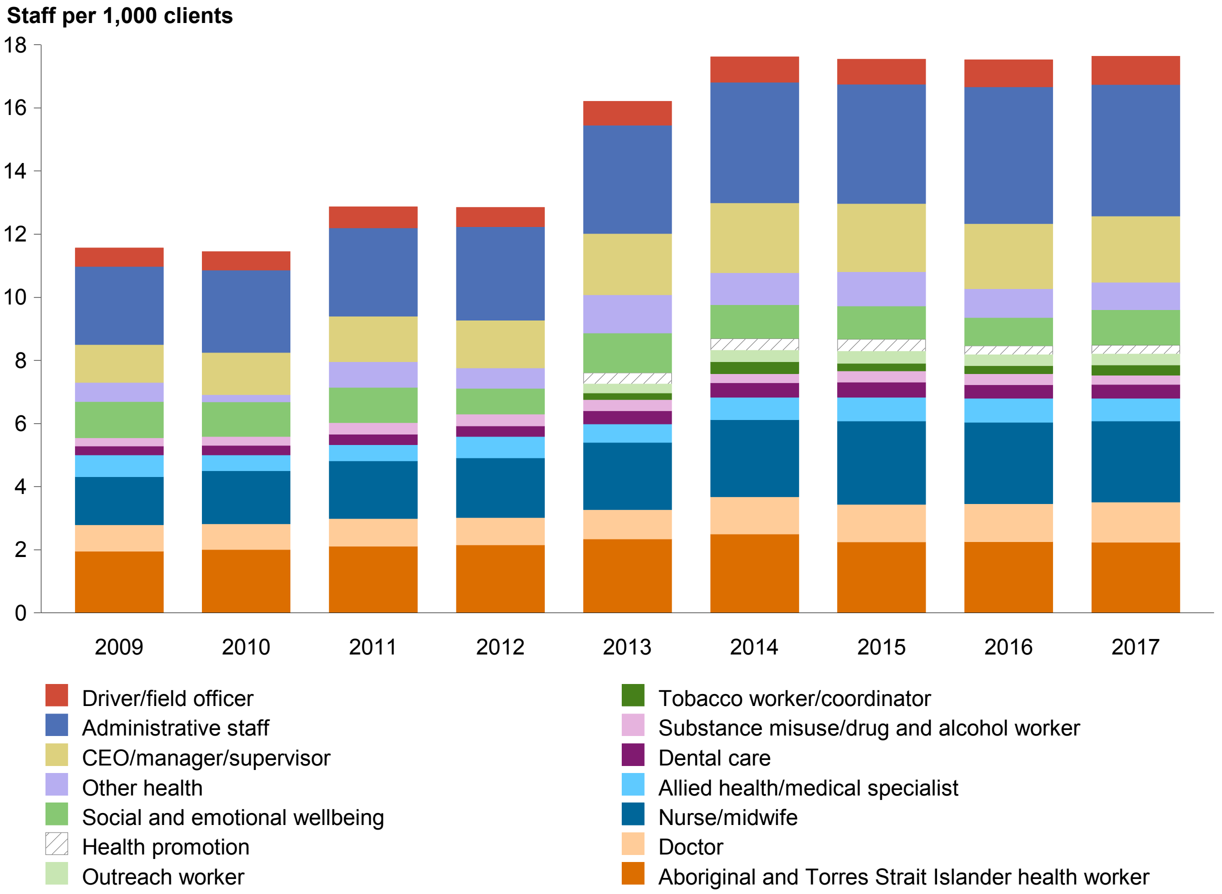
Figure 3.25: Number of clients, median number of health FTE staff and health FTE staff per 1,000 clients, by state and territory, 2016–17

The ratio of staff to clients also varied by position type (see Table S3.37):

- There were 3.6 FTE nurses and midwives per 1,000 clients in South Australia and 3.3 per 1,000 clients in the Northern Territory—higher than the average for all organisations (2.6).
- There were more FTE dental care staff per 1,000 clients in Victoria (0.9) and in New South Wales and the Australian Capital Territory combined (0.7), compared with the average for all organisations (0.4).
- There were more FTE social and emotional wellbeing staff per 1,000 clients in South Australia (1.9) and Victoria (1.8), compared with the average for all organisations (1.1).
- There were more FTE drivers and field officers per 1,000 clients in Tasmania (1.9), compared with the average for all organisations (0.9).

Time series

In 2016–17, 196 organisations reported workforce data compared with 204 in 2015–16. The number of employed FTE staff at 30 June 2017 (7,600 FTE) was 2% lower than at 30 June 2016 (7,766 FTE) (see Table S3.40). If visiting staff are included, the total number of FTE staff decreased by 214 (3%) compared with 2015–16; however, the total FTE staff per 1,000 clients was similar (17.6 compared with 17.5 per 1,000 clients in 2015–16) and was similar for most position types (see Figure 3.26). Since 2008–09, the total FTE staff per 1,000 clients reported increased from 11.6 to 17.6, while health FTE staff per 1,000 clients reported increased from 7.3 to 10.5 (see Table S3.41).



Notes

1. In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.
2. Aboriginal and Torres Strait Islander health practitioner positions were new in 2012–13 and are included with Aboriginal and Torres Strait Islander health workers. See the Glossary for a definition of these positions.
3. From 2012–13 'Other health' positions included sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health staff not recorded elsewhere. Before 2012–13, 'Other health' positions included all of these positions, but may also have included tobacco worker/coordinators, outreach workers and health promotion workers because these were not collected separately before 2012–13.
4. Includes visiting staff not paid for by the organisations themselves.

Figure 3.26: Number of FTE staff per 1,000 clients, by position type, 2008–09 to 2016–17

Vacancies

Organisations providing Indigenous primary health-care services reported 384 vacant FTE positions at 30 June 2017. This included 310 health and 74 other (administrative, managerial and support) positions (see Table S3.43). Nearly one-quarter (23%) of vacancies were for Aboriginal and Torres Strait Islander health workers and practitioners (see Table S3.44). This was followed closely by vacancies for nurses and midwives (22%).

A large number of health vacancies (130 FTE) were in the Northern Territory (42%), followed by Western Australia (14%) and New South Wales and the Australian Capital Territory combined (13%). The Northern Territory also had a higher proportion of its health positions vacant (12% compared with 7% overall), while New South Wales and the Australian Capital Territory combined had a lower proportion (4%) (see Table S3.47).

The number of health vacancies increased with remoteness, reflecting perhaps the difficulties in getting trained staff out to more remote areas. Nearly one-third of health vacancies were reported from organisations in *Very remote* areas (31%), while those in *Major cities* and *Inner regional* areas had just 10% and 13% of vacancies, respectively. *Very remote* areas also had a higher proportion of health positions vacant (8%, compared with 4% in *Major cities* and 5% in *Inner regional* areas) and more health vacancies per 1,000 clients—1.0 compared with 0.7 per 1,000 clients overall (see tables S3.43 and S3.45).

Just over half of all health vacancies (54%) were vacant for 13 weeks or less, and this proportion was higher in *Major cities* and *Inner regional* areas (66% and 61%, respectively). Around 1 in 5 health vacancies (21%) were vacant for more than 40 weeks (see Table S3.46). This was higher in *Very remote* areas (30%) (see Figure 3.27).

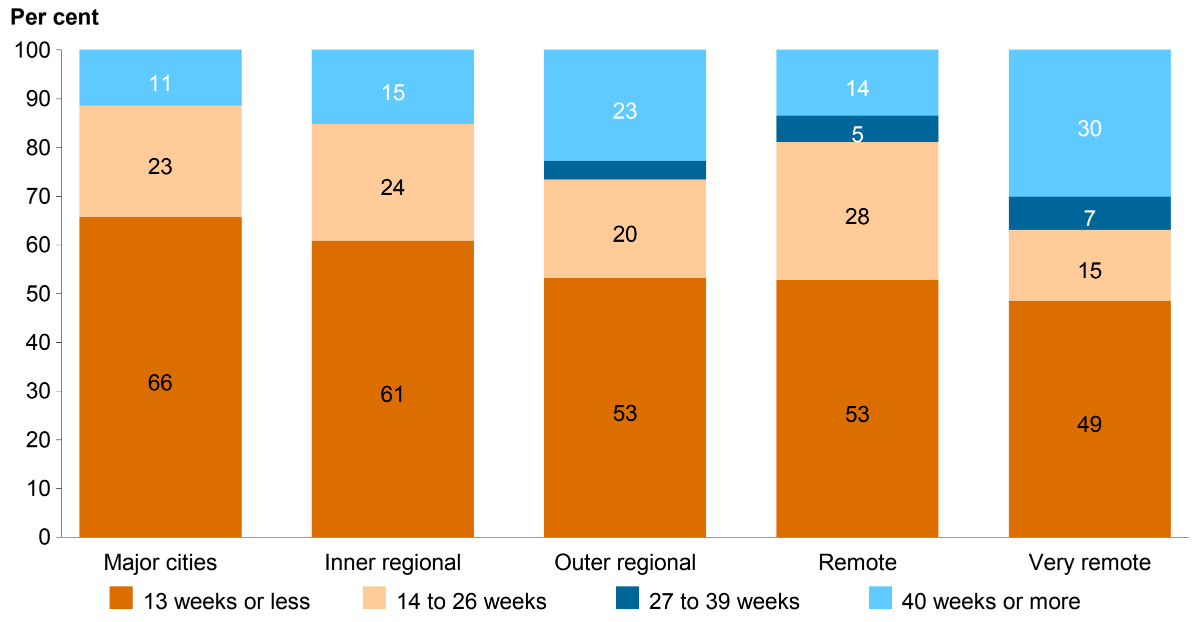
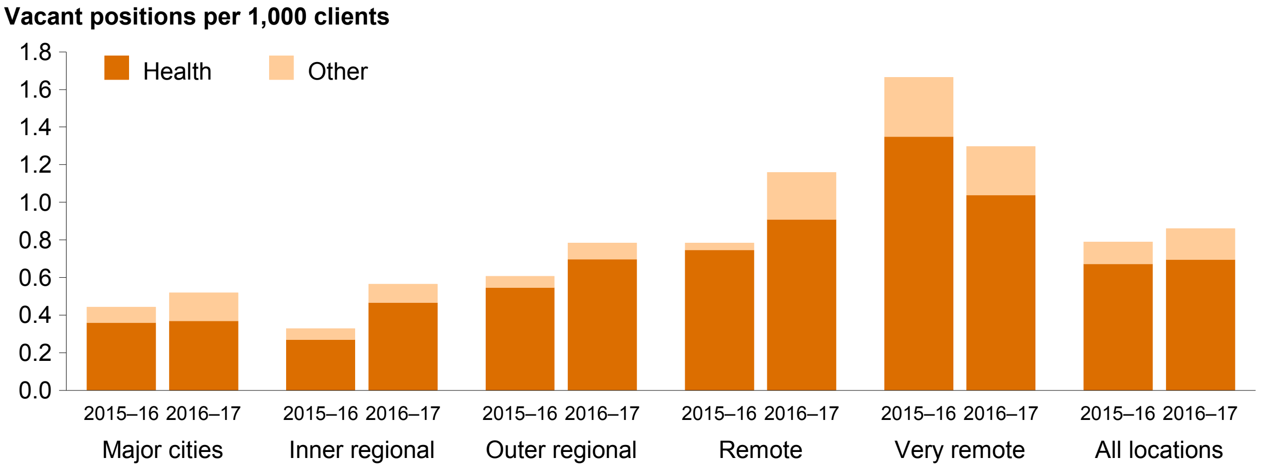


Figure 3.27: Proportion of vacant positions, by length of vacancy and remoteness area, at 30 June 2017

Time series

The number of vacancies reported (384) was higher than in 2015–16 (364), but the number of vacant positions per 1,000 clients was similar (0.9 compared with 0.8 in 2015–16), as was the proportion of health-related vacancies (7% in both years). *Very remote* areas had the most vacant positions per 1,000 clients in both years, although the rate decreased from 1.7 per 1,000 clients in 2015–16 to 1.3 in 2016–17 (see Figure 3.28).



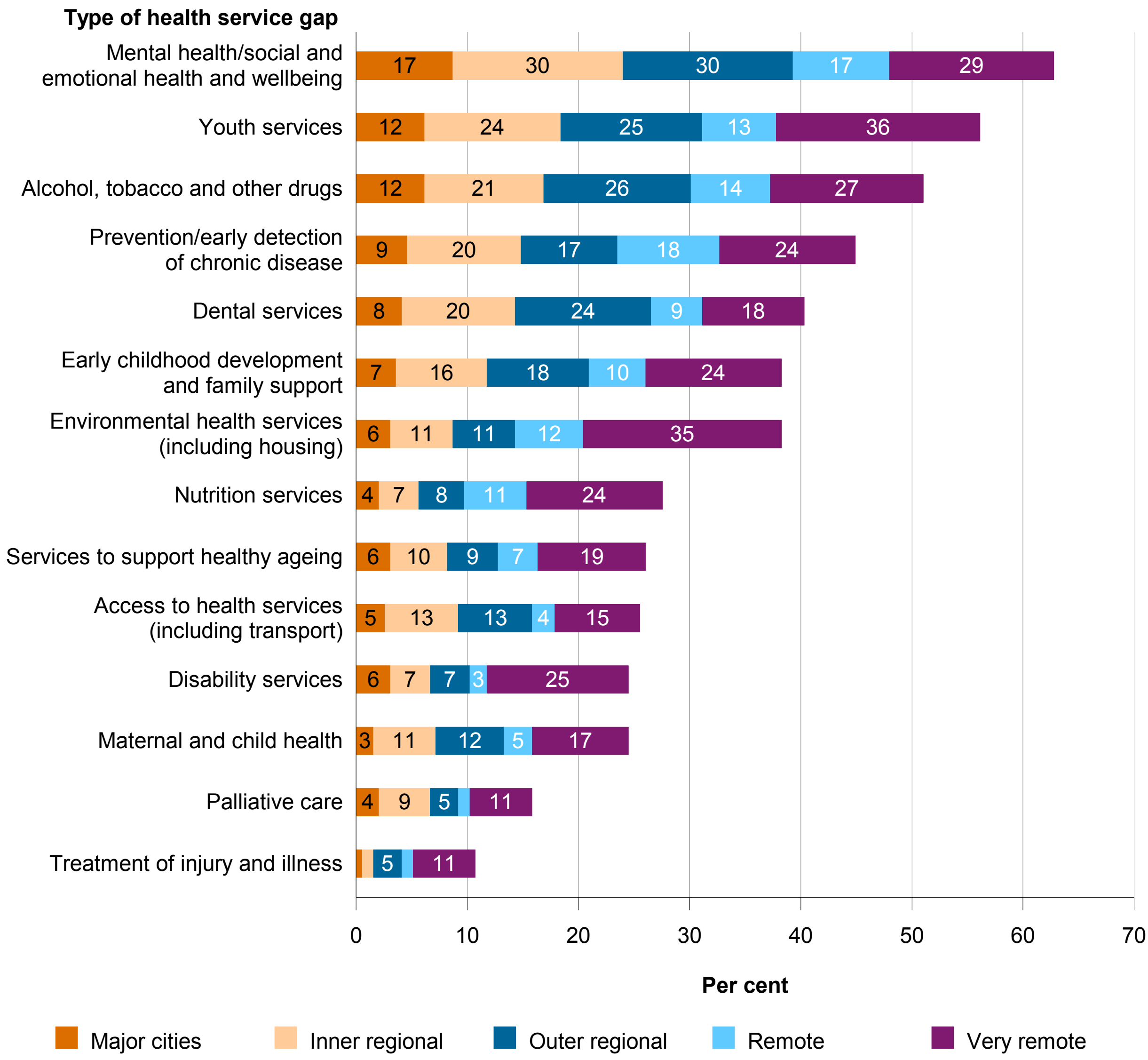
Note: See Appendix C for a list of positions included as 'health' and 'other' positions.

Figure 3.28: Number of FTE vacant positions per 1,000 clients, by position type and remoteness area, at 30 June 2016 and 2017

3.7 Service gaps and challenges

Organisations were asked to report on service gaps and could list up to 5 gaps from a predefined list. Since this question was introduced in 2012–13, the most commonly reported gap each year was a lack of mental health/social and emotional health and wellbeing services. In 2016–17, this was reported as a top 5 gap by 63% of organisations providing Indigenous primary health-care services. Over half reported youth services (56%) and alcohol, tobacco and other drug services (51%) as gaps, while under half reported the prevention and early detection of chronic disease (45%) and dental services (40%) as service gaps (see Figure 3.29).

Service gaps commonly reported varied by remoteness area (see Table S3.48). The proportion of organisations reporting mental health and social and emotional wellbeing services as a gap was higher in *Major cities* (81%), *Inner regional* areas (73%), and *Outer regional* areas (70%), compared with *Remote* (65%) and *Very remote* (45%) areas. In *Remote* and *Very remote* areas, environmental health services were more likely to be reported as a gap (46% and 54%, respectively, compared with 38% for all organisations). In *Remote* areas the prevention and early detection of chronic disease was more likely to be reported as a gap (69% compared with 45% for all organisations), while disability services were more likely to be reported as a gap in *Very remote* areas (39% compared with 25% for all organisations).



Note: Organisations were asked to select up to 5 health service gaps faced by the community they served.

Figure 3.29: Number (as labelled) and proportion (in scale) of primary health-care organisations, by type of health service gap and remoteness area, 2016–17

Organisations were also asked to select up to 5 challenges they faced in providing quality care to clients from a predefined list of challenges. Issues concerning staffing, rather than access to services or organisation administration, were most commonly reported. Two-thirds reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff and staffing levels as challenges and over half (57%) reported staff retention and turnover as a challenge. These were similar to the challenges reported in 2015–16. Other common challenges were appropriate health-service infrastructure (52%) and the coordination of clinical care with other providers such as hospitals (50%).

Service challenges commonly reported varied by remoteness area (see Table S3.49). Organisations providing primary health-care services in *Very remote* areas were more likely to report recruitment, training and support of Aboriginal and Torres Strait Islander staff as a challenge (75% compared with 67% overall). Organisations in *Remote* and *Very remote* areas were more likely to report staff retention/turnover (69% and 75%, respectively, compared with 57% overall) and staff housing as challenges (42% and 55%, respectively, compared with 30% for organisations overall).

4 Maternal and child health

Maternal and child health is a core component of primary health care. Access to high-quality antenatal care and maternal and child health services can reduce the risk of poor health outcomes for mothers and babies (AIHW 2012). These services also have a key role to play in realising the COAG target of halving the Indigenous child mortality gap within a decade.

The vision outlined in the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* is that Aboriginal and Torres Strait Islander mothers and fathers get the best possible support to promote safe pregnancies and a good start to life for their newborns, and that Aboriginal and Torres Strait Islander children are in good health and meet key developmental milestones, laying the foundation for long and healthy lives (DoH 2013).

Maternal and child health has been a focus of funding from the Australian Government, with the announcement of $94 million in the 2014–15 Budget to implement the Better Start to Life (BSTL) approach. The aim of BSTL is to increase access to Aboriginal and Torres Strait Islander antenatal and postnatal care by increasing the availability of child and maternal health services. This includes increasing the number of sites providing New Directions: Mothers and Babies Services to increase foundational child and maternal health services, and expanding the Australian Nurse Family Partnership Program to provide intensive support for high-need families (DoH 2016).

This chapter reports on 213 organisations funded by the DoH to provide maternal and/or child health services to Aboriginal and Torres Strait Islander people (see Box 4.1). This includes the 196 organisations providing primary health-care services from Chapter 3, plus 17 organisations funded for New Directions: Mothers and Babies Services only. The total number of organisations in scope for reporting on their maternal and child health services (213) is 9 less than in 2015–16 (222). In 2016–17, there was 1 new organisation in scope for reporting, while 10 organisations reporting in 2015–16 did not report (5 were no longer in scope and 5 were in scope but did not submit data, so were non-response). This chapter includes a profile of these organisations and information on the maternal and child health services they provide. Child health check data have not been included in this report, due to potential data quality issues that need further investigation (see Chapter 2).

Box 4.1: Overview of maternal and child health services

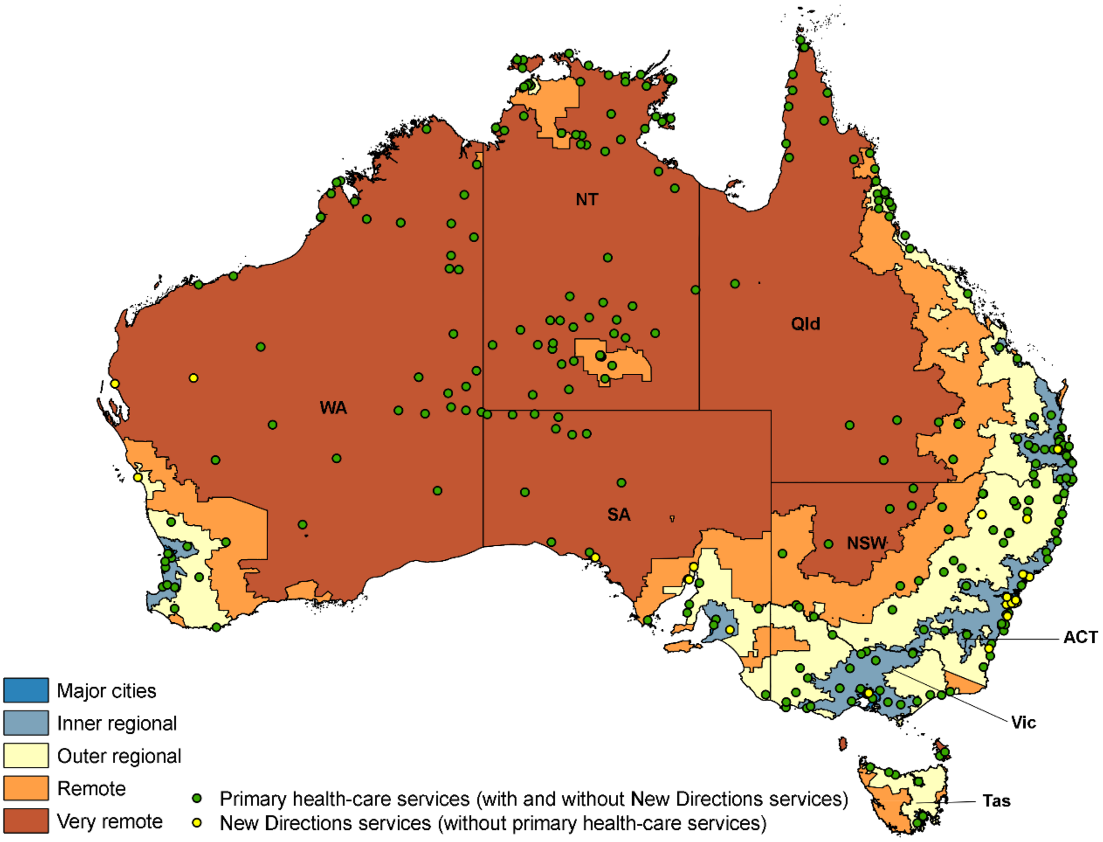
There were 213 organisations providing maternal and/or child health services. Just over half (54%) had DoH primary health funding, 81 (38%) had both primary health and New Directions funding and 17 (8%) had New Directions funding only. Key objectives of New Directions are: increased access to antenatal and postnatal care; standard information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring of developmental milestones, immunisation status and infections; and health checks and referrals for Indigenous children before starting school (DoH 2016). In these organisations:

- around 8,400 Indigenous women had in total 42,200 antenatal visits—an average of 5 visits per antenatal client
- a range of services and group activities were provided including around 20,300 home visits; 3,100 maternal and baby/child health group sessions; 2,100 parenting group sessions and 1,000 antenatal group sessions.

4.1 Organisation profile

Location

The 213 organisations providing maternal and/or child health services were spread across all states and territories and remoteness areas (see Figure 4.1 and Table S4.1).



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 4.1: Australian Government-funded organisations providing maternal and child health services to Aboriginal and Torres Strait Islander people, by remoteness area, 2016–17

At a glance

Over half (54%) of these organisations (115) had DoH funding for primary health care only, 38% (81 organisations) were funded for both primary health care and New Directions, and 8% (17 organisations) were funded for New Directions only. In 2016–17, around 8,400 Indigenous clients had at least 1 antenatal visit and had on average 5 antenatal visits (see Table 4.1).

Table 4.1: Indigenous maternal and child health services, 2015–16 and 2016–17

	2015–16		2016–17	
	Number	%	Number	%
Total organisations providing services	**222**	**100.0**	**213**	**100.0**
New Directions funding	18	8.1	17	8.0
New Directions and primary health funding	81	36.5	81	38.0
Primary health funding	123	55.1	115	54.0
Antenatal clients/visits				
Indigenous clients	8,471	88.5	8,376	82.8
Total clients	**9,568**	**100.0**	**10,113**	**100.0**
Indigenous antenatal visits	41,963	89.0	42,198	80.1
Total antenatal visits	**47,157**	**100.0**	**52,654**	**100.0**
Average visits per Indigenous client	5.0	. .	5.0	. .
Average visits per client	**4.9**	**. .**	**5.2**	**. .**
Group activities (average number)				
Antenatal groups	17	. .	16	. .
Maternal and baby/child health groups	36	. .	35	. .
Parenting and parenting skills groups	37	. .	25	. .
Home visits	142	. .	220	. .

Notes

1. The definition of an 'organisation' in the OSR collection is different from that used by the DoH for the purposes of funding. As a result, the number of organisations reporting in the OSR may differ from the number of funded organisations reported by the DoH.
2. Group activity averages are based on the number of organisations providing each type of activity. Organisations not providing an activity were excluded from the calculations.

4.2 Services and clients

Antenatal care

Antenatal care includes providing advice and guidance on pregnancy and delivery, education on self-care during pregnancy, screening tests and referral if necessary. Attending antenatal visits at least 4 times during pregnancy, as recommended by the World Health Organization (WHO), can improve health outcomes for mothers and babies (WHO 2011). The Implementation Plan acknowledges this recommendation by including the goal of increasing the rate of Aboriginal and Torres Strait Islander women attending at least 5 antenatal care visits from 84% to 90% by 2023 (DoH 2015a).

In 2016–17, 183 (86%) organisations providing maternal and/or child health services provided antenatal care. They saw around 10,100 women, most of whom (8,400 or 83%) were Indigenous. Just over one-quarter (27%) of these Indigenous women were in *Outer regional* areas (2,200) and 20% (1,700) were in *Very remote* areas (see Table S4.2).

One-quarter (25%) of Indigenous women with an antenatal visit were in Queensland (2,100). This was followed by 23% in both the Northern Territory and in New South Wales and the Australian Capital Territory combined (around 2,000 and 1,900 Indigenous women, respectively), and 18% (1,500 Indigenous women) in Western Australia (see Table S4.3).

Around 52,700 routine antenatal visits were reported, and most of these (80% or 42,200) were with Indigenous women (see Table S4.5). Half (52%) of all visits by Indigenous women were in either *Outer regional* areas (12,000 visits) or *Very remote* areas (9,800 visits). This was followed by *Inner regional* areas (7,800 visits) and *Remote* areas (7,600 visits) (see Table S4.6). The Northern Territory reported 27% of all visits by Indigenous women (11,200 visits) followed by New South Wales and the Australian Capital Territory combined with 22% (9,300 visits) and Western Australia with 19% (8,100 visits) (see Table S4.9).

Indigenous antenatal clients had on average 5 antenatal visits. This varied by remoteness area and state and territory (see tables S4.7, S4.8 and S4.10). The average number of visits for Indigenous women increased with remoteness from 3.6 in *Major cities* to 5.8 in *Very remote* areas (see Figure 4.2).

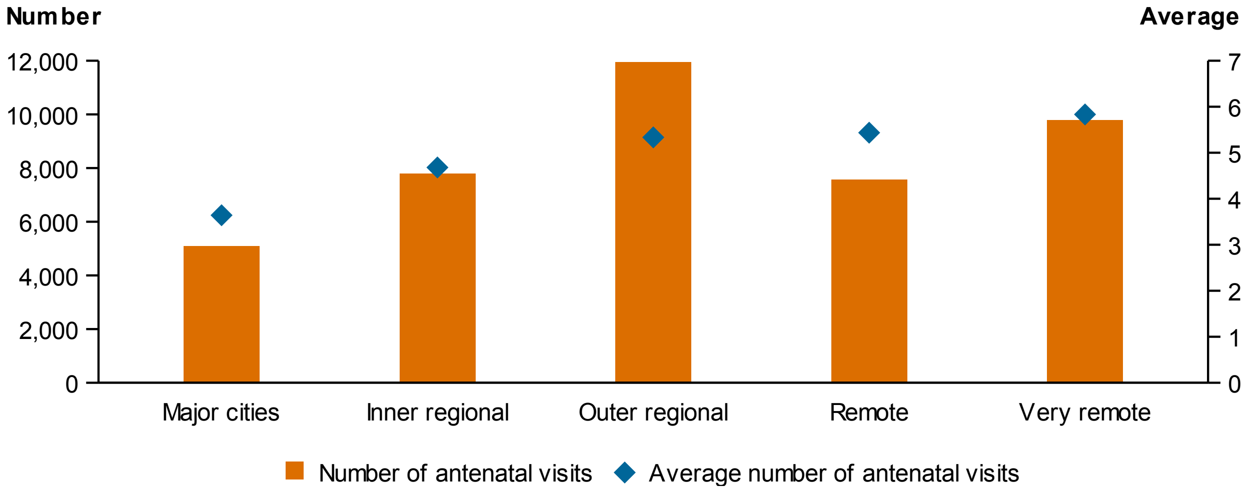


Figure 4.2: Number of antenatal visits by Indigenous clients and average antenatal visits per Indigenous client, by remoteness area, 2016–17

It was also higher in South Australia (8.1) and the Northern Territory (5.7) and lower in Tasmania (3.9) and Queensland (3.6) (see Figure 4.3).

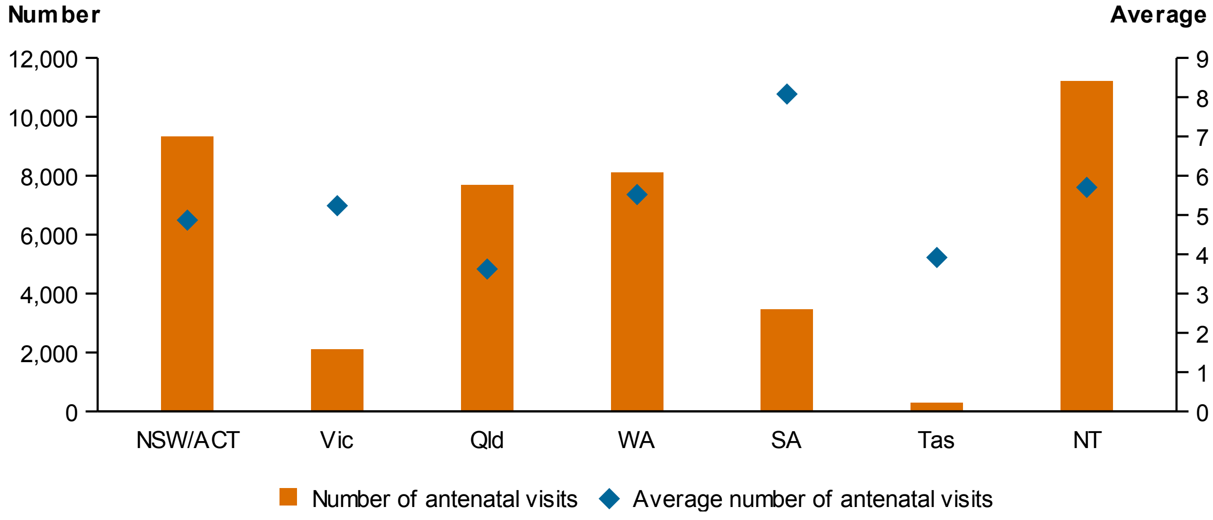
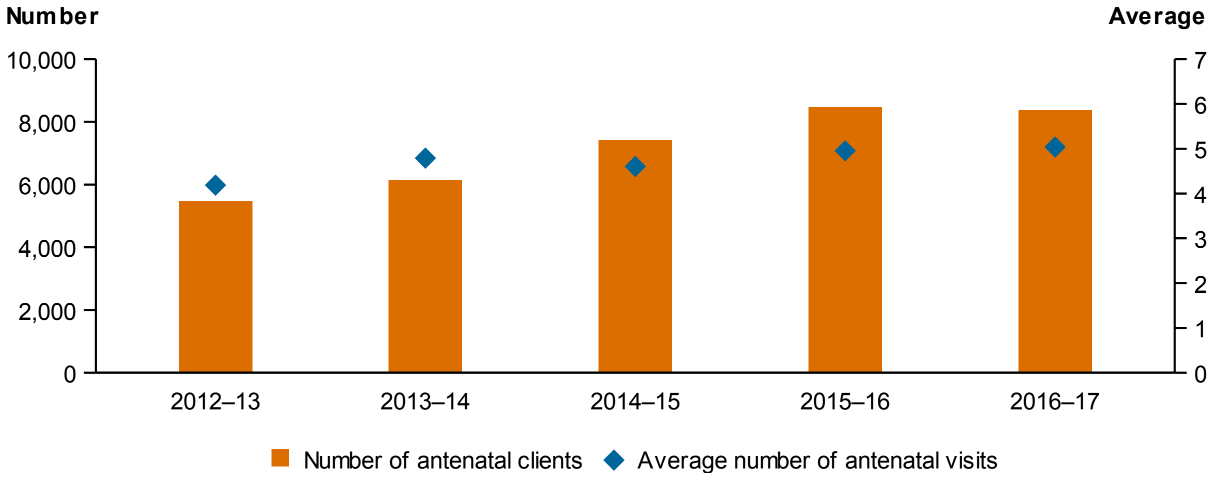


Figure 4.3: Number of antenatal visits by Indigenous clients and average antenatal visits per Indigenous client, by state and territory, 2016–17

Time series

In 2016–17, the total number of Indigenous antenatal clients (around 8,400) was similar to 2015–16 (around 8,500), as was the average number of antenatal visits per Indigenous client (see Figure 4.4 and Table S4.11).



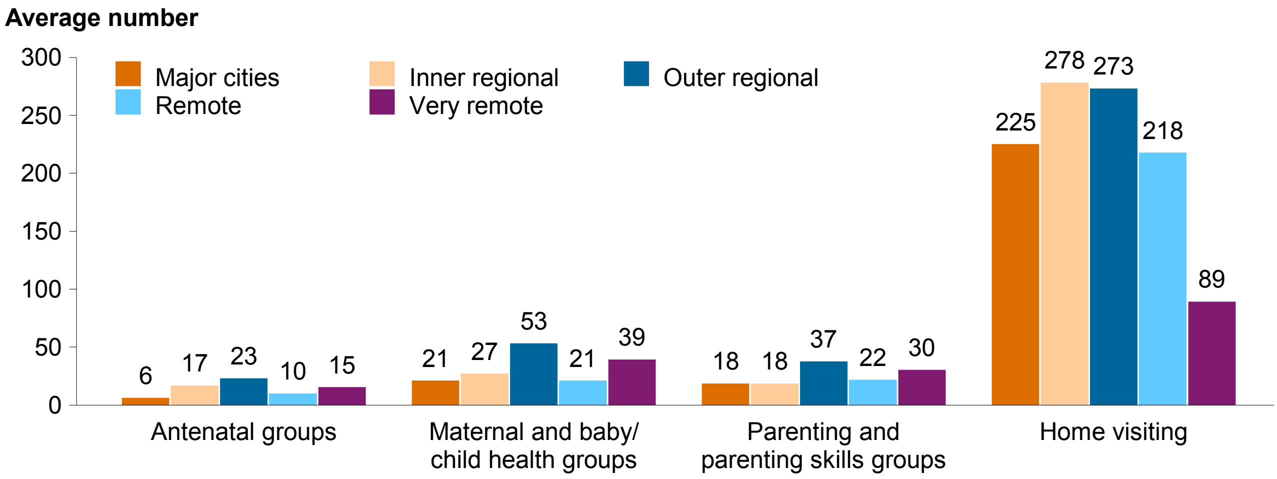
Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 4.4: Number of Indigenous antenatal clients and average antenatal visits per Indigenous client, 2012–13 to 2016–17

Group activities

In 2016–17, 129 (61%) organisations providing maternal and/or child health services ran at least one type of antenatal or maternal group activity, such as antenatal groups, parenting groups, maternal and baby/child health groups or home visiting services. Around 20,300 home visits were reported by 92 (43%) organisations; 3,100 maternal and baby/child health sessions by 89 (42%) organisations; 2,100 parenting skills sessions by 81 (38%) organisations; and 1,000 antenatal sessions by 61 (29%) organisations. The organisations providing these types of group activities made on average 220 home visits, conducted 16 antenatal group sessions, 35 maternal and baby/child health group sessions and 25 parenting skills group sessions (see Table S4.12). The number of home visits reported (20,300) was higher than in 2015–16 (12,900), as was the average number of home visits per organisation (220, compared with 142). While some of this increase (around one-third) came from increases in organisations reporting in both years, most of the increase was in a few organisations reporting home visits in 2016–17, but not in 2015–16.

For those running these groups, organisations in *Outer regional* areas had a higher average number of antenatal group sessions (23 compared with 16 overall), maternal and baby/child health group sessions (53 compared with 35 overall) and parenting and parenting skills group sessions (37 compared with 25 overall). Organisations in *Major cities* had a lower average number of sessions for these groups (see Figure 4.5 and Table S4.13).



Note: Averages are based on the number of organisations providing each type of activity. Organisations not providing an activity were excluded from the calculations.

Figure 4.5: Average number of antenatal and maternal group activity sessions, by type of activity and remoteness area, 2016–17

5 Social and emotional wellbeing

This chapter reports on social and emotional wellbeing services funded by PM&C (see Box 5.1). Social and emotional wellbeing is a holistic concept that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual (PM&C 2017). The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* and the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* stress that social and emotional wellbeing is the foundation for Aboriginal and Torres Strait Islander physical and mental health. As such, there is a need to continue support for counselling, health promotion and early intervention services to promote social and emotional wellbeing among Indigenous people, including members of the Stolen Generations (DoH 2013).

In 2016–17, 88 (99%) organisations in scope for reporting on their social and emotional wellbeing services submitted data. This was 5 fewer than the number reporting in 2015–16 (93). Compared with 2015–16, 1 new organisation was in scope for reporting on its social and emotional wellbeing services, 5 organisations were no longer in scope for reporting and 1 organisation was unable to submit data by the cut-off date, so was non-response.

This chapter includes a profile of the 88 organisations providing social and emotional wellbeing services, and information on the types of services provided, client numbers and contacts, counsellors employed and service gaps and challenges. Most of these organisations (80) provided social and emotional wellbeing support services with a focus on counselling, casework and other wellbeing activities. Collectively in this chapter, these 80 organisations are referred to as SEWB support services. The other 8 organisations provided Link Up services, which assist clients with family tracing and provide reunion support. Collectively, these 8 organisations are referred to as Link Up services.

Box 5.1: Overview of social and emotional wellbeing services

There were 88 organisations providing social and emotional wellbeing services. Of these:

- 72 (82%) were also funded by the DoH to provide primary health-care services
- 80 (91%) provided SEWB support services and 8 (9%), Link Up services.

In 2016–17, 189 counsellors in these organisations provided social and emotional wellbeing services, 61% of whom were Indigenous. Around two-thirds of counsellors were female (65%) and one-third were male (35%).

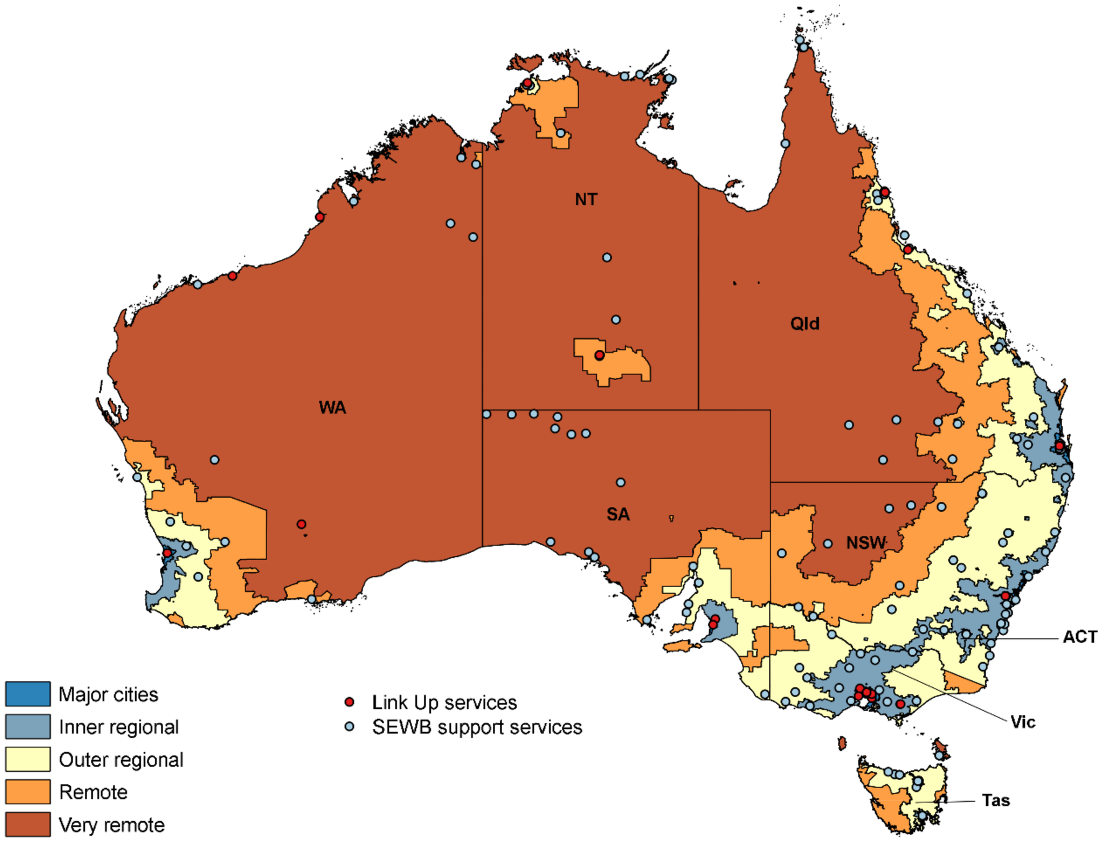
These counsellors saw around 16,300 clients and of these 14,400 (89%) were SEWB support clients and 1,900 (11%) were Link Up clients.

Around 77,100 client contacts were made—an average of 5 contacts per client. The average number of contacts per client was similar to 2015–16.

5.1 Organisation profile

Location

The 88 organisations providing social and emotional wellbeing services were spread across all states and territories. Of the 80 organisations providing SEWB support services, 22 (28%) were in New South Wales and the Australian Capital Territory combined, 15 (19%) were in Queensland and in Victoria and 11 (14%) were in Western Australia (see Table S5.1). Smaller numbers were in South Australia (9), the Northern Territory (6) and Tasmania (2). There was a Link Up service in all states and territories, except Tasmania and the Australian Capital Territory (see Figure 5.1).



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 5.1: Australian Government-funded organisations providing social and emotional wellbeing services to Aboriginal and Torres Strait Islander people, by remoteness area and type of service, 2016–17

Organisations providing social and emotional wellbeing services were spread across all remoteness areas (see Figure 5.2 and Table S5.2). Twenty-three organisations (26%) were in *Outer regional* areas, 21 (24%) were in *Inner regional* areas and 18 (21%) were in *Major cities*. Fewer were in *Very remote* and *Remote* areas (15 and 11 organisations, respectively).

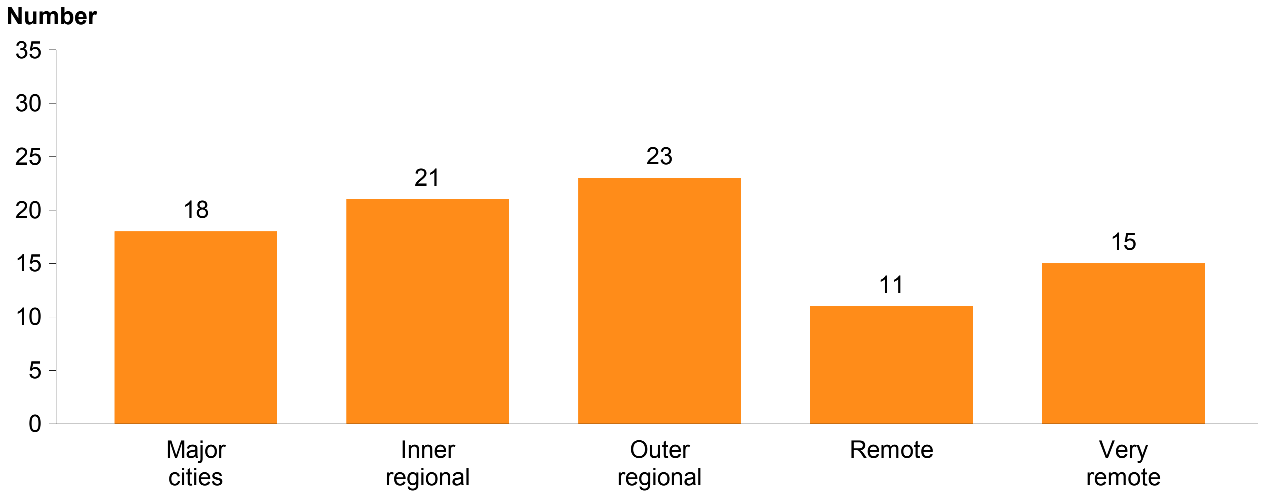


Figure 5.2: Number of organisations providing social and emotional wellbeing services, by remoteness area, 2016–17

Key characteristics

Of the 88 organisations:

- 72 (82%) were also funded by the DoH to provide Indigenous primary health-care services and 16 did not receive primary health care funding
- 77 (88%) were ACCHOs
- 87 (99%) had a governing committee or board, and 68 (77%) had all Indigenous board members
- all of those also funded for primary health care were accredited with the RACGP and/or against organisational standards, and 69% of other organisations providing social and emotional wellbeing services had organisational accreditation only
- 51 (58%) provided services from 1 site, 17 (19%) had 2 sites and 20 (23%) had 3 or more sites (see Table S5.3).

5.2 Services provided

At a glance

In 2016–17, social and emotional wellbeing services were provided through 172 sites (see Table 5.1). Given that most organisations providing these services were also funded to deliver primary health-care services (82%), many services were delivered within a primary health-care setting. A total of 189 counsellors provided services to around 16,300 clients. Clients had on average 4.7 contacts per client, which was similar to 2015–16 (4.7).

Table 5.1: Indigenous social and emotional wellbeing services, 2015–16 and 2016–17

	2015–16		2016–17	
	Number	%	Number	%
Total organisations providing services	**93**	**100.0**	**88**	**100.0**
Organisations also funded for primary health care	76	81.7	72	81.8
Other organisations	17	18.3	16	18.2
Total number of sites providing services during usual hours	**164**	. .	**172**	. .
Clients				
Indigenous clients	16,812	88.9	15,141	92.8
Total clients[(a)]	**18,914**	**100.0**	**16,324**	**100.0**
Contacts				
Indigenous contacts	81,934	92.2	71,076	91.3
Total contacts[(a)]	**88,875**	**100.0**	**77,846**	**100.0**
Average contacts per client	4.7	. .	4.7	. .
Reunions				
Organisations with counsellors involved in reunions	35	37.6	33	37.5
Total reunions	**200**	. .	**295**	. .
Staffing				
Counsellors	216	. .	189	. .
Vacant counsellor positions	32	12.9	29	13.3

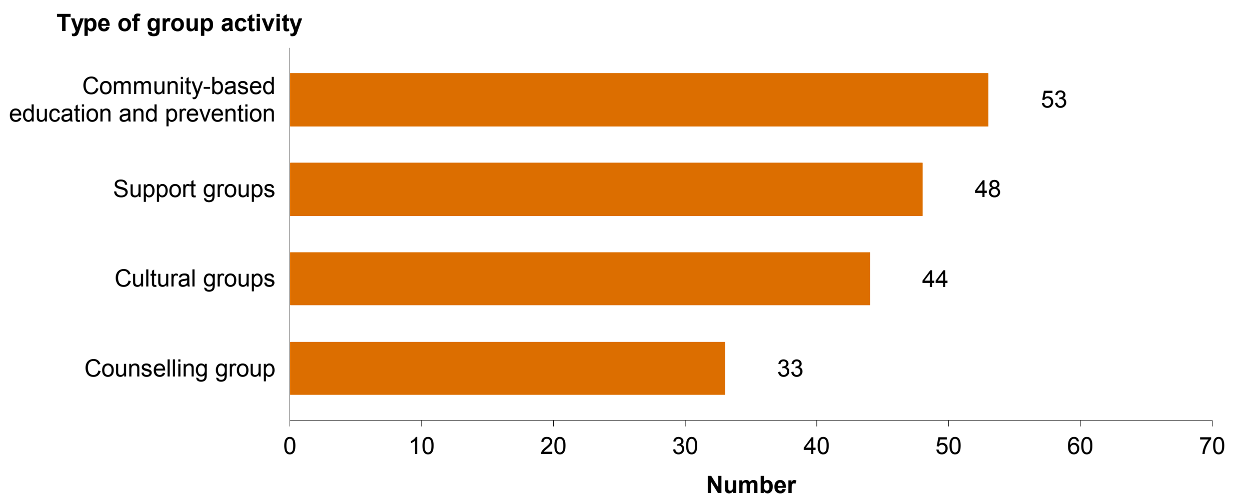
(a) Includes those who were identified as being Indigenous or non-Indigenous as well as those whose Indigenous status was unknown.

SEWB support counsellors spent just over half their time on average (54%) working directly with individual clients providing counselling, support and advocacy. Other time was spent on administration (12%), working with groups, for example support groups or specific therapy groups (12%), and on outreach or travel (11%).

Link Up counsellors spent on average 23% of their time on reunion-related activities, 21% of their time researching family history and 21% working directly with individual clients providing counselling, support and advocacy. This was followed by time spent on administration (14%), and outreach or travel (13%) (see Table S5.4).

Group activities

Organisations providing SEWB support services were asked about the group activities they offered. In 2016–17, 66 (83%) of these organisations ran group activities. Of these, 53 (80%) ran community-based education and prevention groups, 48 (73%) ran support groups, 44 (67%) ran cultural groups, and 33 (50%), counselling groups (see Figure 5.3 and Table S5.5).



Note: Only organisations providing SEWB support services were asked to report on these group activities, not those providing Link Up services.

Figure 5.3: Number of organisations providing social and emotional wellbeing support services, by type of group activity, 2016–17

5.3 Clients

In 2016–17, 85 (97%) organisations providing social and emotional wellbeing services reported valid client and contacts data. Around 16,300 clients received social and emotional wellbeing services from these organisations. Most of these (14,400 or 89%) were SEWB support clients and 1,900 (11%) were Link Up clients. Over one-third (37%) of social and emotional wellbeing clients were in *Major cities*, followed by similar proportions (19%) in both *Outer regional* and *Inner regional* areas (see Table S5.6). Over half (58%) of clients were female and 41% were male (see Table S5.7).

Around 4,800 clients (29%) were members of the first, second or third Stolen Generations (see Figure 5.4). This proportion was higher for clients of Link Up services (95%) as these services target members of the Stolen Generations. First Generation clients are those who were removed from their families and communities, second Stolen Generation clients are those whose parents were first Stolen Generation members and third Stolen Generation clients are those whose grandparents were first Stolen Generation members or who are descended from people removed from their families.

A further 10,300 clients (63%) were 'other' Indigenous clients. This proportion was higher for clients of SEWB support services (71%) compared with Link Up services (4%). It should be noted that this group may include clients who were Stolen Generation members, but this information was not collected by the organisation and could not be reported on. There were also around 900 non-Indigenous clients (6%) and a small number of clients whose Indigenous status was not recorded (2%).

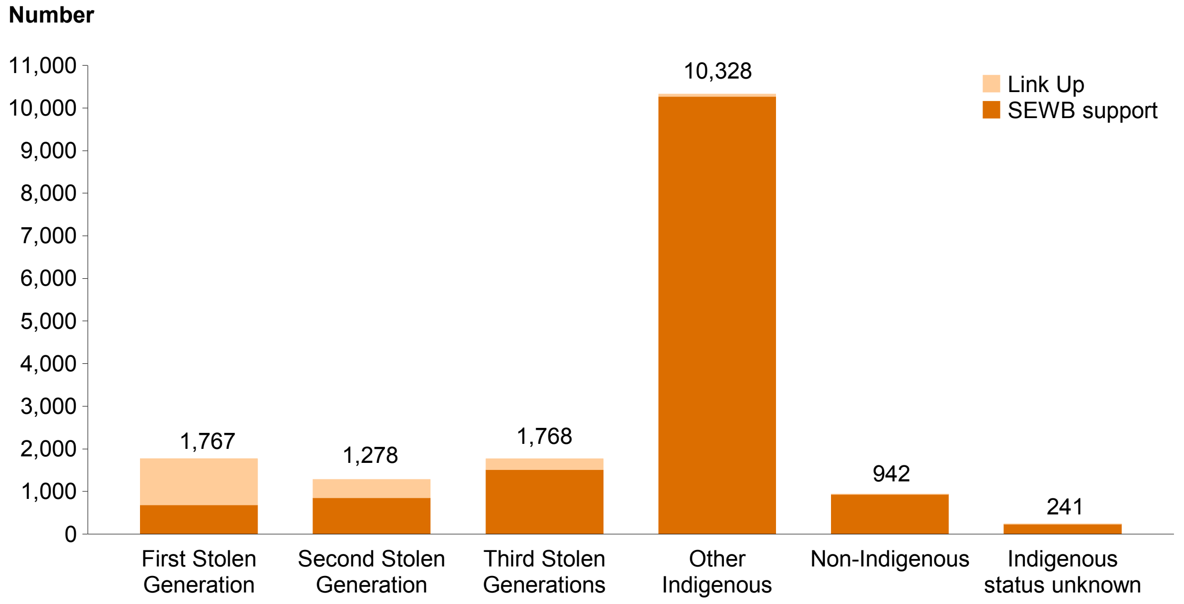


Figure 5.4: Number of clients of social and emotional wellbeing services, by Indigenous status and type of service, 2016–17

Time series

The number of clients of social and emotional wellbeing services (around 16,300), was 14% lower compared with 2015–16 (around 18,900). This decrease was largely due to several organisations reporting lower client numbers, and fewer organisations submitting client data in 2016–17 (85 compared with 92).

The total number of social and emotional wellbeing clients reported has ranged from 8,400 clients in 2008–09 to 21,100 in 2014–15. It should be noted that the number of organisations contributing to these counts also fluctuates each year and has ranged from 81 in 2008–09 to 96 in 2012–13 (see Table S5.8). The most significant increase in client numbers was between the 2011–12 and 2012–13 collection periods, and is probably due to changes in how data were collected and extracted, and an increase in the number of organisations in scope for the collection.

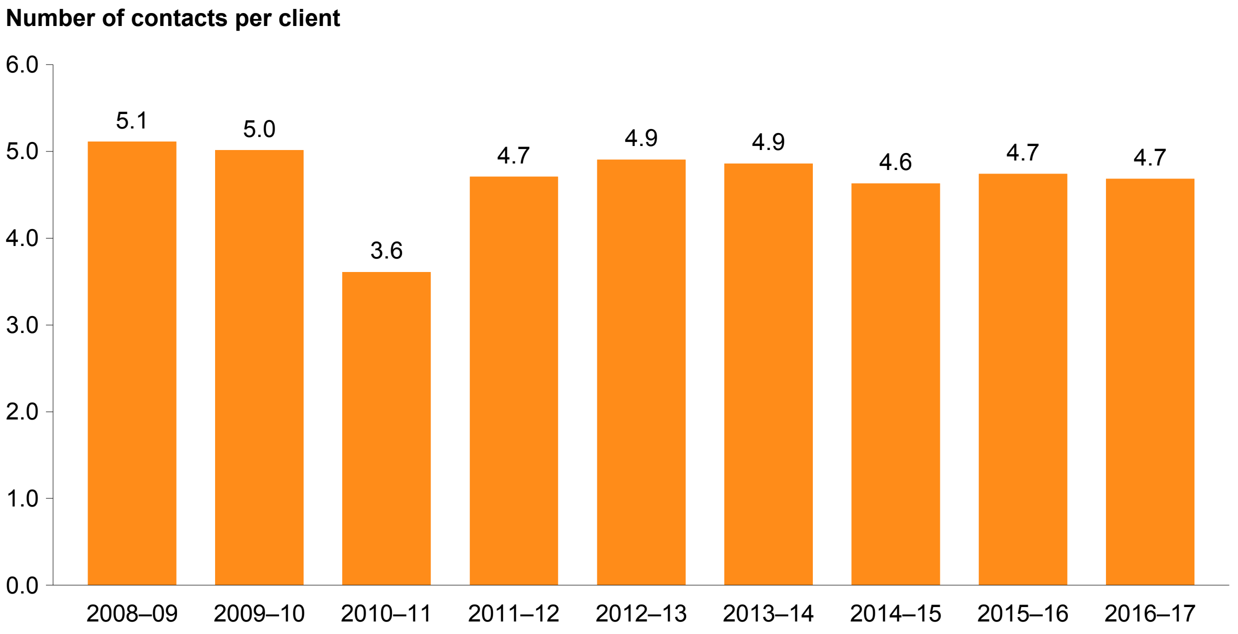
5.4 Client contacts

Counsellors providing social and emotional wellbeing services made around 77,100 contacts with clients in 2016–17, an average of 5 contacts per client. Most of these contacts (93%) were made by SEWB support services (71,700 contacts), and 7% (5,400 contacts) were made by Link Up services (see Table S5.9). Organisations in *Major cities* reported just over one-third of all client contacts (35%), followed by organisations in *Inner regional* (23%) and *Outer regional* areas (22%), which reflects the number of clients reported in these areas (see Table S5.10).

Time series

The number of social and emotional wellbeing client contacts in 2016–17 (around 77,100) decreased by 13% compared with 2015–16 (around 88,900). This decrease was related to the smaller number of organisations reporting data in 2016–17 (85 compared with 92 in 2015–16) and to several organisations reporting lower client contact numbers.

Although the overall number of client contacts decreased, the average number of contacts per client (4.7) was similar to that in 2015–16 (4.7). Since 2008–09, the average number of contacts per client has generally been around 5, and has ranged from 3.6 in 2010–11 to 5.1 in 2008–09 (see Figure 5.5 and Table S5.11).



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 5.5: Average social and emotional wellbeing contacts per client, 2008–09 to 2016–17

5.5 Counsellors

Organisations funded by PM&C to provide social and emotional wellbeing services were asked about the counsellors they employed through this funding to deliver these services. At 30 June 2017, nearly half (46%) had 1 counsellor position, around one-quarter (24%) had 2 positions, and one-quarter (25%) had 3 or more positions (see Table S5.12). A small number of organisations (6%) had no counsellor positions, due to counsellor vacancies. A total of 189 counsellors provided social and emotional wellbeing services at 30 June 2017, with 173 (92%) of these in SEWB support services and 16 (8%) in Link Up services.

New South Wales and the Australian Capital Territory combined had the highest number of counsellors with 56 (30%), followed by 42 (22%) in Queensland and 28 (15%) in Western Australia (see Table S5.13). Smaller numbers were in the Northern Territory (24), Victoria (21), South Australia (12) and Tasmania (6). With respect to remoteness, organisations in *Major cities* had the most counsellors with 51 (27%) followed by *Outer regional* areas with 44 (23%) and *Inner regional* areas with 38 (20%). *Very remote* and *Remote* areas had smaller numbers with 30 and 26 counsellors, respectively (see Table S5.14). There were more Indigenous counsellors than non-Indigenous counsellors in all remoteness areas except *Remote* areas, where nearly three-quarters (73%) were non-Indigenous.

Of the 173 SEWB support counsellors, 101 (58%) were Indigenous and 72 (42%) were non-Indigenous, while 114 (66%) were female and 59 (34%) were male. Of the 16 counsellors in Link Up services, 14 (88%) were Indigenous and 2 (12%) were non-Indigenous, while 9 (56%) were female and 7 (44%) were male.

Overall, there were more female counsellors than male counsellors (65% compared with 35%), and more Indigenous counsellors than non-Indigenous counsellors (61% compared with 39%). Over one-third of counsellors were Indigenous women (38%) and 23% were Indigenous men (see Figure 5.6 and Table S5.15).

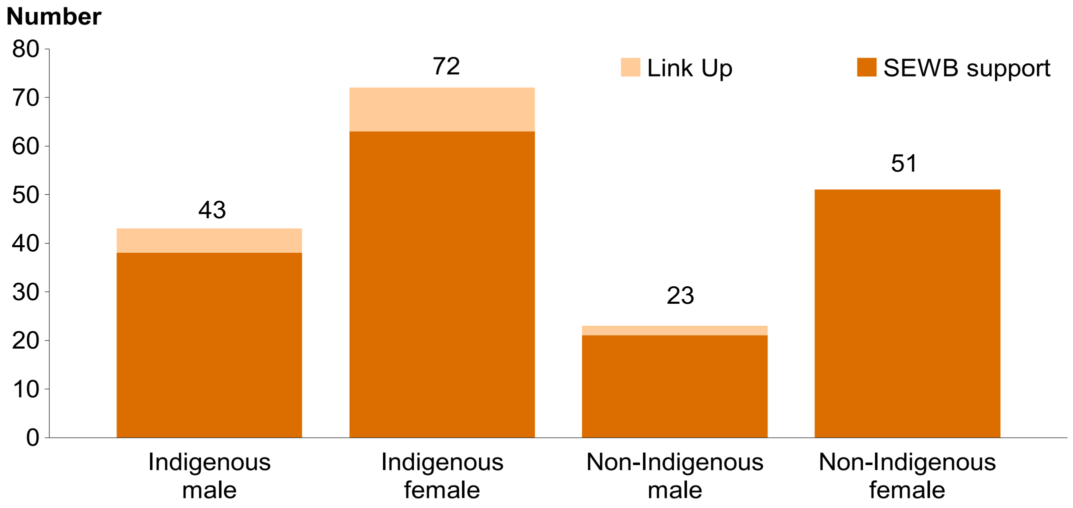


Figure 5.6: Number of counsellors in social and emotional wellbeing services, by Indigenous status, gender and type of service, at 30 June 2017

Qualifications and training

Most counsellors (92%) had a certificate-level qualification or higher and 42% had a bachelor's degree or higher qualification (see Table S5.16). Around 8% had no qualification or were in the process of attaining a qualification. This was higher in *Outer regional* areas (16%). Nearly all counsellors in *Very remote* areas (97%) had a certificate-level qualification or higher. Over half (57%) of organisations providing social and emotional wellbeing services had counsellors who undertook formal training courses in 2016–17, with a total of 154 training courses undertaken (see Table S5.17).

Supervision

Many organisations (81%) providing social and emotional wellbeing services provided professional supervision to counsellors (see Table S5.18). In 58% of these organisations, supervision was for less than half an hour per week (see tables S5.19 and S5.20).

Organisations providing social and emotional support services provided various types of support to counsellors. The most common types included peer support (through work colleagues), case counselling, debriefing, cultural mentoring and telephone support (see Table S5.21).

In organisations providing Link Up services the most common types of support provided to staff included debriefing, casework assistance, telephone support, peer support (through work colleagues) and cultural mentoring (see Table S5.22).

Vacancies

Organisations reported 29 vacant counsellor positions at 30 June 2017 (see Table S5.23). Overall, 13% of counsellor positions were vacant, a similar proportion to that recorded at 30 June 2016 (13%). *Major cities* and *Inner regional* areas had a higher proportion of counsellor positions vacant (20% and 17%, respectively) than other areas (see Figure 5.7).

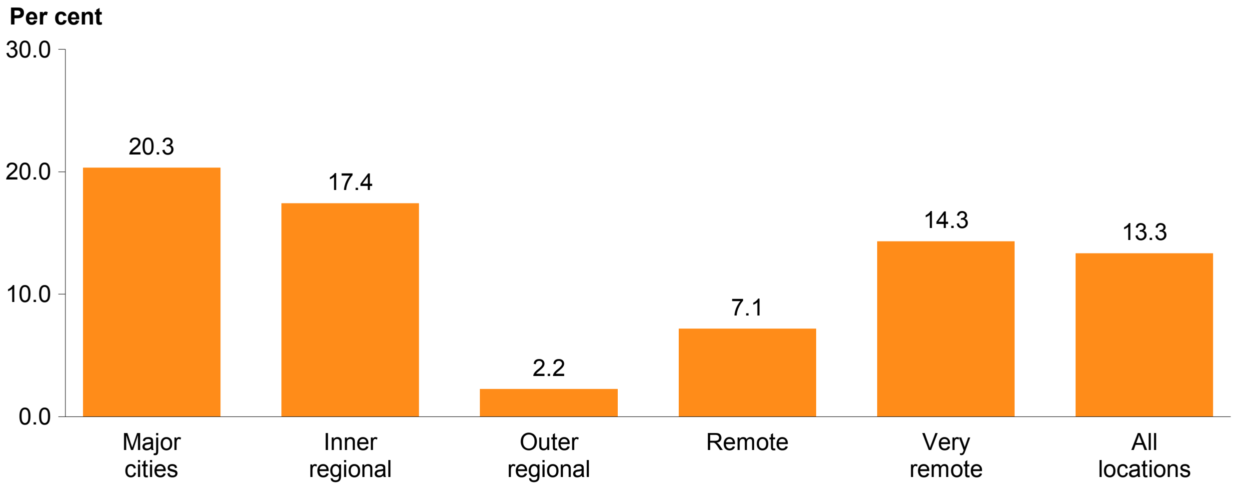
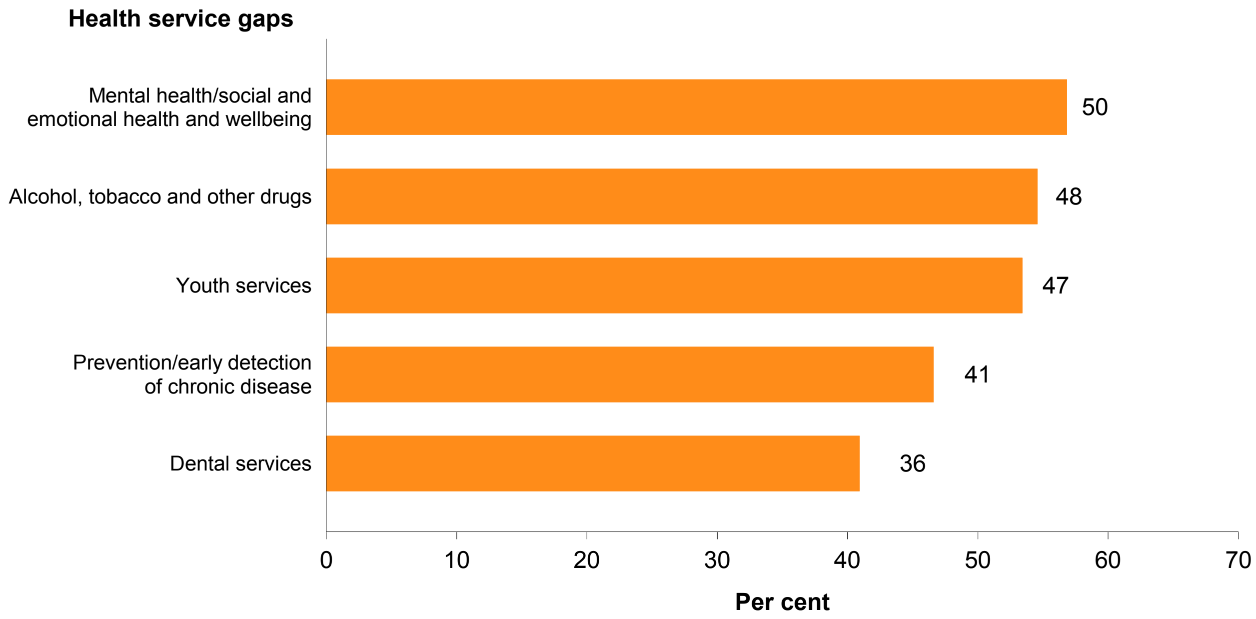


Figure 5.7: Proportion of counsellor positions vacant, by remoteness area, at 30 June 2017

5.6 Service gaps and challenges

Over half the organisations providing social and emotional wellbeing services (57%) reported services for mental health and social and emotional wellbeing in their top 5 service gaps (see Table S5.24). This was followed by alcohol, tobacco and other drugs (55%) and youth services (53%). Nearly half (47%) reported the prevention and early detection of chronic disease among their top 5 service gaps and 41% reported dental services (see Figure 5.8).



Note: Organisations were asked to select up to 5 health service gaps faced by the community they served.

Figure 5.8: Number (as labelled) and proportion (in scale) of organisations funded for social and emotional wellbeing services, by type of health service gap, 2016–17

With respect to challenges faced in delivering quality health services, around two-thirds of organisations reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff (68%) and staffing levels (66%) in their top 5 service challenges. Staff retention and turnover was seen as a challenge by 59% of organisations, while around half reported the coordination of clinical care with other providers (52%) and appropriate health service infrastructure (50%) as a challenge (see Table S5.25). A higher proportion of organisations also funded for primary health care reported appropriate health service infrastructure as a challenge (58% compared with 13% in organisations not funded for primary health care), as well as the coordination of clinical care with other providers (58% compared with 25%).

6 Substance use

This chapter reports on substance-use services funded by PM&C under the IAS (see Box 6.1). The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* suggests that promoting links across AOD and mental health services is an important strategy for improving Aboriginal and Torres Strait Islander health and wellbeing. Continuing to increase community awareness and education about the options for dealing with the use of drugs, alcohol and tobacco is also vital (DoH 2013). Many projects funded by the Australian Government are designed to reduce substance abuse through the provision of culturally appropriate AOD prevention, education, counselling, treatment, rehabilitation and after-care services for Aboriginal and Torres Strait Islander people.

In 2016–17, 80 (96%) organisations in scope for reporting on their substance-use services submitted data. This was similar to the number of organisations reporting in 2015–16 (80). Compared with 2015–16, 5 new organisations were in scope for substance-use reporting, 2 organisations were no longer in scope for reporting and 3 were unable to submit data by the cut-off date, so were non-response. This chapter includes a profile of these 80 organisations and information on the types of services they provide, client numbers and episodes of care, and service gaps and challenges.

Box 6.1: Overview of substance-use services

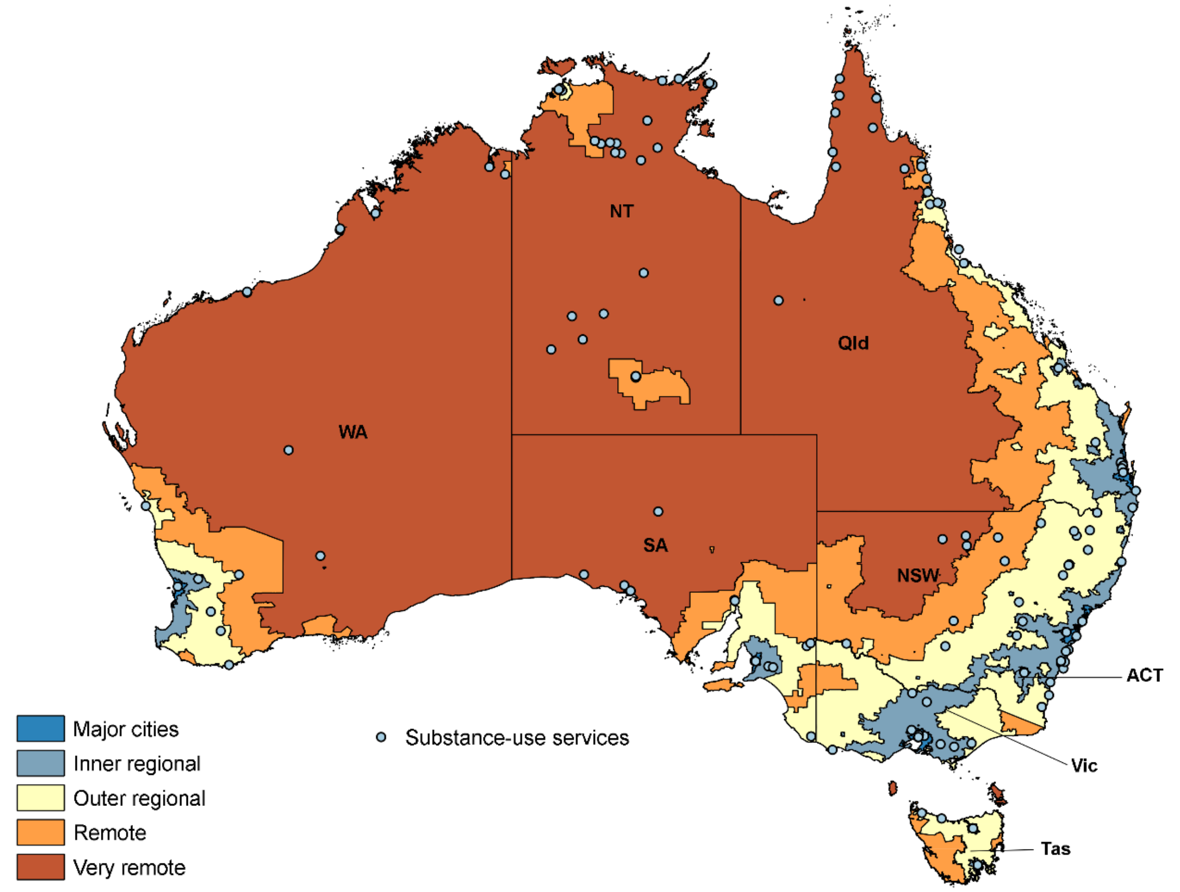
There were 80 organisations providing substance-use services, and 39 (49%) were also funded by the DoH to provide primary health-care services. In these 80 organisations:

- around 39,400 clients received at least one type of substance-use service. Most clients (around 36,100) received non-residential services, while 10,400 received sobering-up, residential respite or short-term care services and 3,000 residential care services
- around 197,700 episodes of care were provided, with 88% of these for non-residential services, 10% for sobering-up, residential respite or short-term care, and 2% for residential care services
- clients of non-residential services had on average 4.8 episodes of care, while those receiving sobering-up, residential respite or short-term care had on average 1.9 episodes of care
- episodes of care for non-residential and sobering-up, residential respite or short-term care were evenly split between male and female clients. However, around two-thirds of residential episodes of care were with male clients.

6.1 Organisation profile

Location

The 80 organisations reporting on substance-use services were spread across all states and territories (see Figure 6.1 and Table S6.1). There were 24 (30%) in New South Wales and the Australian Capital Territory combined, 14 (18%) in Queensland and in the Northern Territory and 13 (16%) in Western Australia. Smaller numbers were in South Australia (7), Victoria (5) and Tasmania (3).



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure 6.1: Australian Government-funded organisations providing substance-use services to Aboriginal and Torres Strait Islander people, by remoteness area, 2016–17

Organisations were spread across all remoteness areas, with 21 (26%) in *Outer regional* areas, 19 (24%) in *Remote* areas, 16 (20%) in *Major cities* and 12 (15%) in both *Very remote* areas and *Inner regional* areas (see Figure 6.2 and Table S6.2).

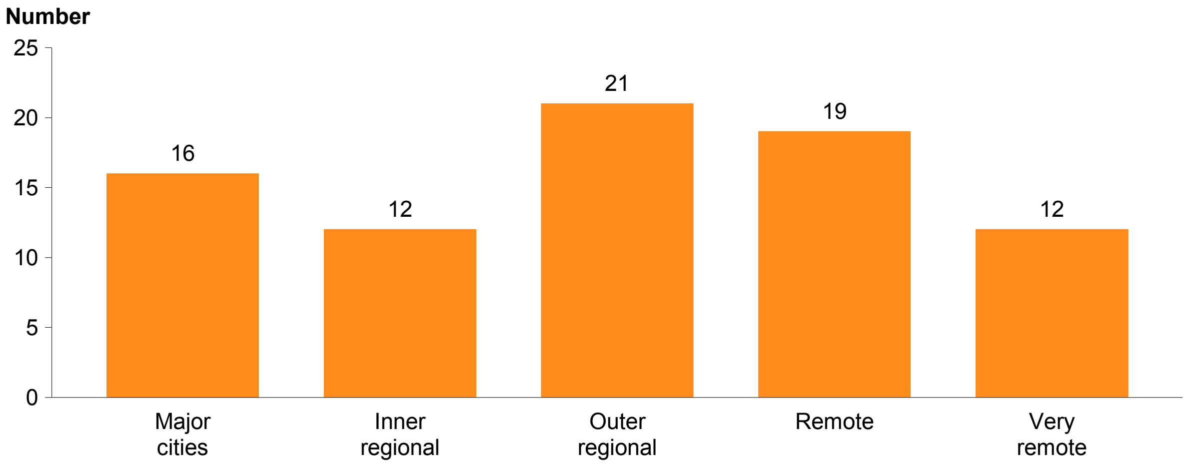


Figure 6.2: Number of substance-use organisations, by remoteness area, 2016–17

Key characteristics

Of the 80 organisations:

- 39 (49%) were also funded by the DoH to provide Indigenous primary health-care services and 41 (51%) were not funded by the DoH for primary health-care services
- 56 (70%) were ACCHOs, 22 (28%) were other non-government-run organisations and 2 (2%) were government-run
- 78 (98%) had a governing committee or board, and of these, 47 (60%) had all Indigenous board members
- most organisations (85%) were accredited with the RACGP and/or against organisational standards. This was higher in organisations also funded for Indigenous primary health care (95%) than in other substance-use organisations (76%). Just over two-thirds of organisations also funded for Indigenous primary health care were accredited with both the RACGP and against organisational standards (69%), while other substance-use organisations that were accredited were accredited against organisational standards only
- 54 (68%) had 500 or fewer clients
- 50 (62%) provided services from 1 site and 38% had more than 1 site (see Table S6.3).

6.2 Services provided

At a glance

In 2016–17, most substance-use organisations (95%) provided non-residential services, 40% ran residential care services and 14% sobering-up, residential respite or short-term care services (see Table 6.1). Services were delivered from 171 sites. Nearly three-quarters of these sites provided non-residential counselling services and group work (73%) and 29%, residential counselling. Around 39,400 clients were seen through 197,700 episodes of care. Client numbers increased by 20% and episodes of care by 16% compared with 2015–16.

Table 6.1: Indigenous substance-use services, 2015–16 and 2016–17

	2015–16		2016–17	
	Number	%	Number	%
Total organisations providing substance-use services	**80**	**100.0**	**80**	**100.0**
Organisation also funded for primary health care	38	47.5	39	48.8
Other organisation	42	52.5	41	51.3
Type of service[(a)]				
Residential	32	40.0	32	40.0
Sobering-up/respite care	12	15.0	11	13.8
Non-residential	77	96.3	76	95.0
Sites providing services during usual opening hours				
Receive referrals	152	95.6	163	95.3
Residential counselling	56	35.2	49	28.7
Non-residential counselling	109	68.6	125	73.1
Residential group work	56	35.2	52	30.4
Mobile assistance patrol/night patrol	10	6.3	10	5.8
Group work with clients not in residential care	97	61.0	124	72.5
Total sites[(b)]	**159**	**100.0**	**171**	**100.0**
Clients[(c)]				
Residential	2,844	8.7	2,962	7.5
Non-residential	26,467	80.8	36,137	91.6
Sobering-up/respite care	8,080	24.7	10,404	26.4
Total clients	**32,740**	**100.0**	**39,448**	**100.0**
Episodes of care				
Residential	3,173	1.9	3,339	1.7
Non-residential	148,842	87.4	174,942	88.5
Sobering-up/respite care	18,355	10.8	19,390	9.8
Total episodes of care	**170,370**	**100.0**	**197,671**	**100.0**

(a) Organisations may provide more than one type of service, so categories will not add to the total number of organisations.

(b) Includes all sites whether services were provided during normal hours or not.

(c) Clients may receive more than one type of service, so categories will not add to the total number of clients.

Types of services

The 5 most common substance-use issues reported, in terms of staff time and organisational resources, were alcohol, cannabis or marijuana, amphetamines, tobacco or nicotine and multiple drug use (see Table S6.4). These were similar to those reported in 2015–16. All organisations reported alcohol as one of their most common substance-use issues, followed by cannabis/ marijuana (95%) and amphetamines (80%). Tobacco was reported as a common substance-use issue by two-thirds of organisations and multiple drug use by 60% (see Table S6.5).

Substance-use services are provided through a range of settings and types of treatment and may be broadly grouped into 3 types depending on the service setting: residential care; sobering-up, residential respite and short-term care; and non-residential care (see Box 6.2).

Box 6.2: Types of substance-use services

Residential care: includes culturally appropriate temporary live-in accommodation for clients requiring formal substance-use treatment and rehabilitation.

Sobering-up, residential respite or short-term care: includes overnight and short-term (1–7 days) care in residential settings. It includes mobile assistance patrols, night patrols and 'walk-in' services for clients who stay overnight. These clients do not receive formal rehabilitation.

Non-residential care: includes culturally appropriate treatment, rehabilitation and education without the option of residing in-house. This includes counselling, assessment, treatment, education, support, referral to other services and home visits. It also includes follow-up care from residential services after discharge. Follow-up care may include one-on-one support or case management for up to a year after exiting the rehabilitation program.

It should be noted that clients may receive more than one type of AOD service and may move between services. For example, residential clients may receive non-residential follow-up care after discharge, while sobering-up, residential respite or short-term care clients may receive services that include brief interventions and other non-residential services.

In 2016–17, 48 (60%) organisations provided one type of service, mainly non-residential care, while 32 (40%) provided a combination of services (see Table 6.2). Seventy-six organisations (95%) provided non-residential services; 32, residential services (40%); and 11 (14%), sobering-up, residential respite or short-term care services (see tables S6.6 and S6.7).

Table 6.2: Organisations providing substance-use services, by type of service, 2016–17

Substance-use services	Number	%
One type of service		
Residential care only	3	3.8
Sobering-up, residential respite or short-term care only	1	1.3
Non-residential care only	44	55.0
More than one type of service		
Residential and non-residential care	22	27.5
Sobering-up, residential respite and non-residential care	3	3.8
All three types of care	7	8.8
Total	**80**	**100.0**

Source: AIHW analyses of OSR data collection, 2016–17.

Type of treatment

Various primary treatment methods were used by AOD counsellors (see Table S6.8). The main ones were harm reduction (36%), controlled or minimised substance misuse (20%) and abstinence (19%). The types of treatments used by most organisations included information and education (99%), counselling services (90%) and support and case management (88%), while nearly half (48%) provided rehabilitation services (see Table S6.9).

However, a wide range of AOD programs and activities was provided. The most common included community education (93%), crisis intervention (74%), group counselling (70%), cultural groups (70%) and support groups (64%). School education and visits were done by 60% of organisations, and tobacco control programs provided by 53% of organisations (see Figure 6.3 and Table S6.10).

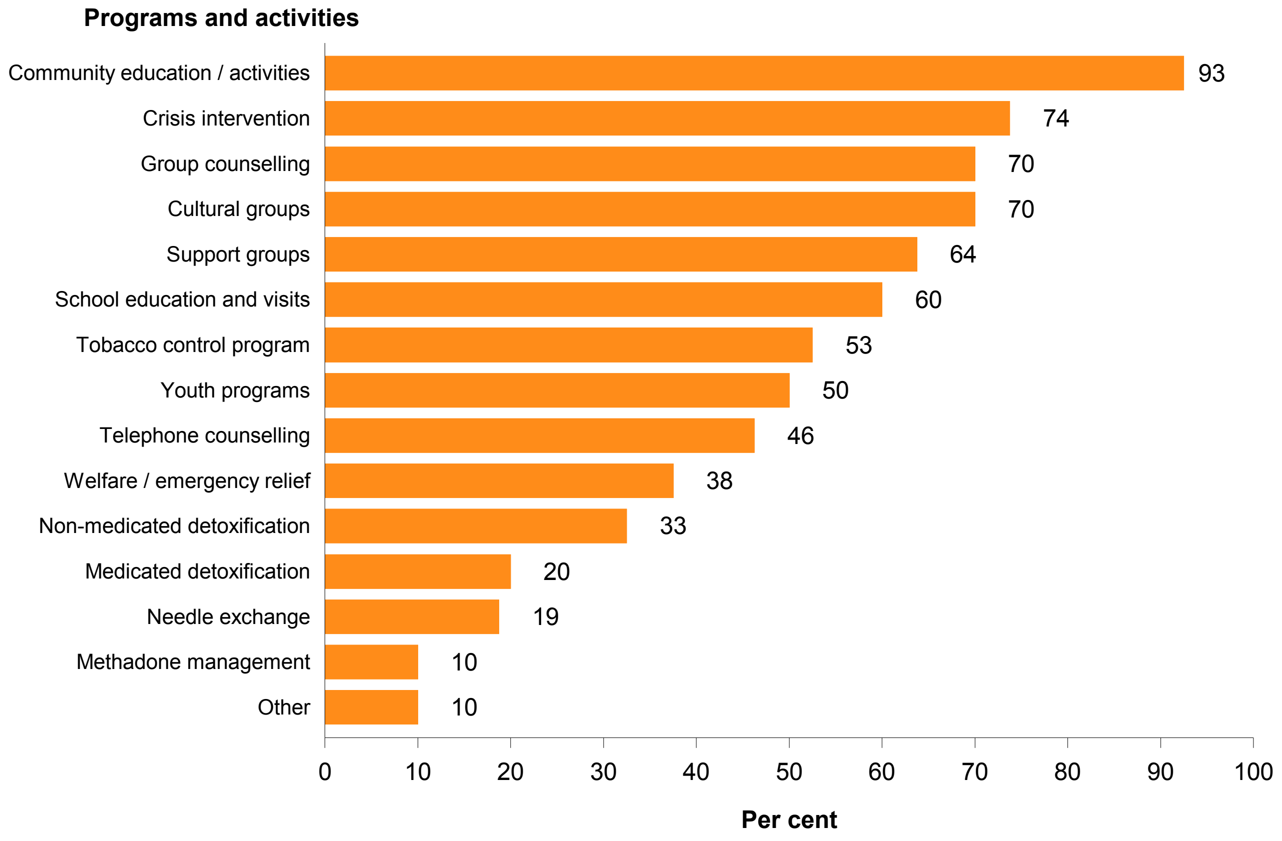


Figure 6.3: Proportion of substance-use organisations, by type of programs and activities provided, 2016–17

Health promotion

In 2016–17, organisations providing substance-use services ran a range of health promotion group activities (see Figure 6.4 and Table S6.11). Many ran physical activity or healthy weight programs (80%) and around three-quarters ran tobacco-use treatment/prevention groups (76%), alcohol-misuse treatment and prevention groups (74%), living skills groups (75%), women's groups (74%) and men's groups (75%). A higher proportion of organisations funded for substance-use only ran alcohol-misuse treatment and prevention groups (90%) compared with organisations funded for both substance-use and primary health care (56%). Organisations funded for both substance-use and primary health care were more likely to provide physical activity/healthy weight programs (87% compared with 73%), chronic disease client support groups (72% compared with 49%) and youth groups (74% compared with 34%).

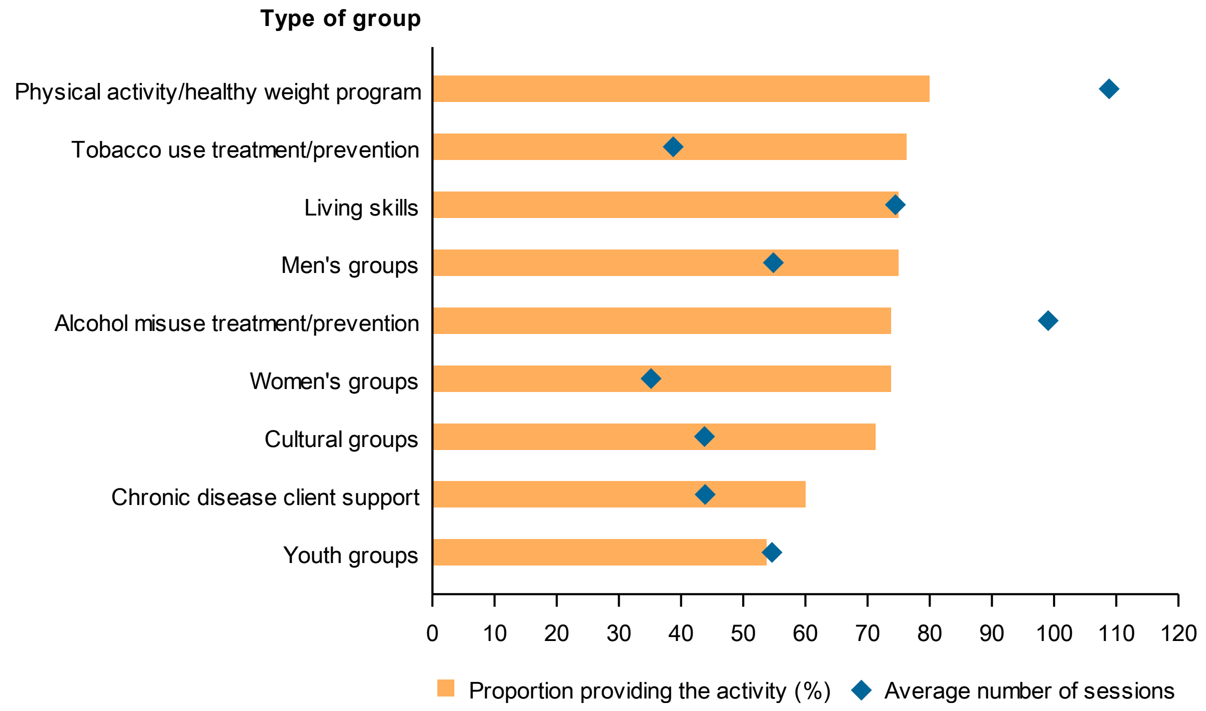
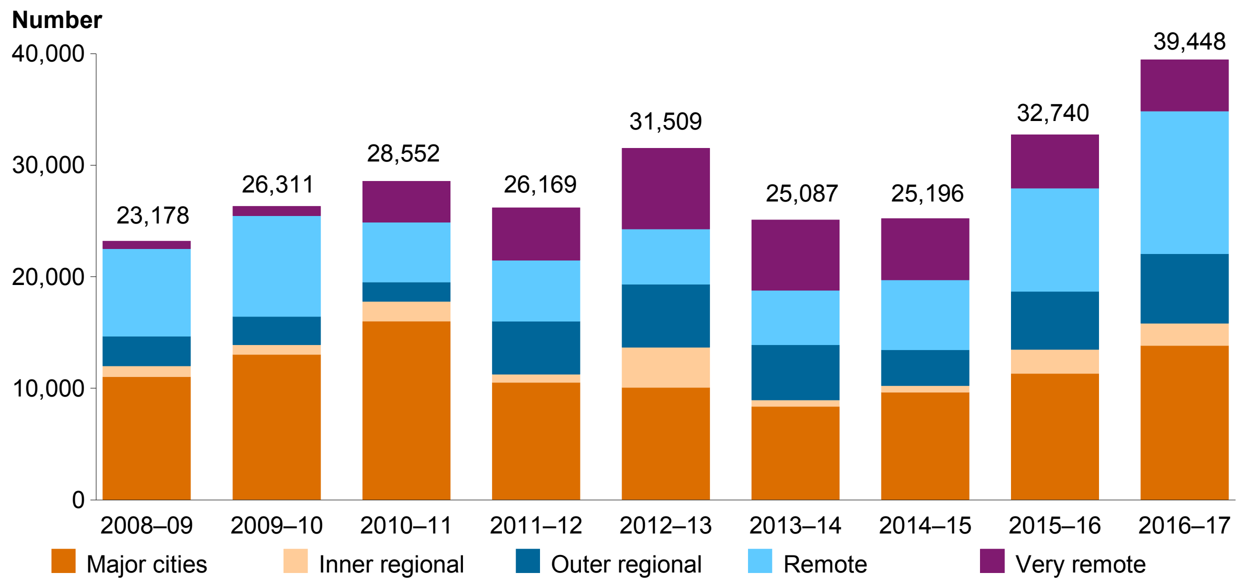


Figure 6.4: Proportion of substance-use organisations providing selected group activities and the average number of sessions conducted, by type of group activity, 2016–17

6.3 Clients

In 2016–17, valid client numbers were provided by 76 (95%) organisations. They reported around 39,400 clients across all locations and types of services (see Figure 6.5). This was 20% more than the number of clients reported in 2015–16 (32,700 clients) and was due to 43 existing organisations reporting more clients in 2016–17. Organisations in *Major cities* had around 13,800 (35%) clients, those in *Remote* areas around 12,800 (33%) clients and those in *Outer regional* areas around 6,200 (16%) clients (see Table S6.12).



Note: In 2014–15, the reporting period was 1 June 2014 to 31 May 2015. In other years, it was the financial year from 1 July to 30 June.

Figure 6.5: Number of substance-use clients, by remoteness area, 2008–09 to 2016–17

Residential clients

In 2016–17, the 32 organisations providing residential care reported around 3,000 clients (see Table S6.13). This was 4% higher than the number of clients reported in 2015–16 (2,800 clients). Most residential care clients (85%) were Indigenous and just over two-thirds of these Indigenous clients (69%) were male (see Table 6.3). Nearly half (47%) of Indigenous clients were aged between 19 and 35, 39% were aged 36 and over and 14% were aged 18 and under (see Table S6.14). Just over two-thirds (69%) of these organisations had a waiting list for services and 362 people were reported to be waiting for services at 30 June 2017 (see Table S6.15). This was fewer than the number reported in 2015–16 (445).

Table 6.3: Estimated clients of residential treatment services, by Indigenous status and gender, 2016–17

				Total	
Indigenous status	Male	Female	Gender not recorded	Number	%
Indigenous	1,750	775	5	2,530	85.4
Non-Indigenous	336	90	0	426	14.4
Indigenous status not recorded	4	2	0	6	0.2
Total	**2,090**	**867**	**5**	**2,962**	**100.0**

Source: AIHW analyses of OSR data collection, 2016–17.

Around one-third (35%) of clients in residential care had a length of stay of 2–8 weeks, while another third (33%) had a length of stay of 9–16 weeks. Very short or long stays were less common, with fewer clients staying less than 2 weeks (19%) or 17 weeks or more (13%). This was similar to 2015–16 (see Table S6.16).

Sobering-up, residential respite and short-term care clients

In 2016–17, the 11 organisations providing sobering-up, residential respite and short-term care reported around 10,400 clients, an increase of 29% compared with 2015–16 (around 8,100 clients). This increase was due to 1 organisation reporting more clients in 2016–17. Over three-quarters of clients were Indigenous (78%) and just over half (53%) of these Indigenous clients were male (see Table 6.4). Sixty per cent of Indigenous clients were aged 36 and over (see Table S6.17).

Table 6.4: Estimated clients of sobering-up, residential respite and short-term care services, by Indigenous status and gender, 2016–17

Indigenous status	Male	Female	Gender not recorded	Total Number	Total %
Indigenous	4,280	3,852	0	8,132	78.2
Non-Indigenous	192	216	0	408	3.9
Indigenous status not recorded	832	1,032	0	1,864	17.9
Total	**5,304**	**5,100**	**0**	**10,404**	**100.0**

Source: AIHW analyses of OSR data collection, 2016–17.

Non-residential and after-care clients

In 2016–17, 71 (93%) organisations providing non-residential and after-care services reported valid client numbers, 3 had their client data excluded due to data quality issues and 2 reported on non-residential group activities only. Around 36,100 clients were reported from these 71 organisations, an increase of 37% compared with 2015–2016 (around 26,500 clients). Around 60% of this increase was from 3 organisations reporting more clients in 2016–17. The rest of this increase was from other organisations reporting more clients and because more organisations reported client data (71 compared with 65 in 2015–16).

Over three-quarters of non-residential care clients were Indigenous (81%) and just over half of these (56%) were male and 43% were female (see Table 6.5). Forty-five per cent of all Indigenous clients were aged 19 to 35 and 43% were aged 36 and over. Clients aged 18 and under made up a smaller proportion (11%) of all Indigenous clients (see Table S6.18).

Table 6.5: Estimated clients of non-residential and after-care services, by Indigenous status and gender, 2016–17

Indigenous status	Male	Female	Gender not recorded	Total Number	Total %
Indigenous	16,410	12,498	377	29,285	81.0
Non-Indigenous	2,888	1,852	12	4,752	13.1
Indigenous status not recorded	977	1,122	1	2,100	5.8
Total	**20,275**	**15,472**	**390**	**36,137**	**100.0**

Source: AIHW analyses of OSR data collection, 2016–17.

Referrals

Substance-use clients are referred from different sources. In 2016–17, most organisations had clients who walked in or referred themselves (96%), and clients referred by a family member, elder or friend (95%). Most also had clients referred by mental health services (86%), Aboriginal medical services (87%), and community health services (79%). Around three-quarters had clients referred from hospitals (77%), mainstream AOD services (76%), and the justice system (73%) (see Table S6.19).

6.4 Episodes of care

In 2016–17, around 197,700 substance-use episodes of care were reported (see tables S6.20 and S6.21). This was an increase of 16% compared with 2015–16 (around 170,400 episodes) and was mainly due to increases in episode counts in organisations reporting in both years (81%). Some of the increase in episodes (19%) was from more organisations reporting in 2016–17 (77 compared with 72 in 2015–16).

Residential episodes of care

A residential episode of care refers to a treatment period, from the time of admission into treatment through to discharge. If a client receives treatment on separate occasions, then each of these is counted as a separate episode of care.

In 2016–17, the 32 organisations providing residential care reported around 3,300 episodes of care (see Table S6.22). This was an increase of 5% compared with 2014–15 (3,200 episodes). Indigenous clients received 86% of all residential episodes of care and over two-thirds of these (68%) were with Indigenous males and 32% with Indigenous females (see Table 6.6).

Table 6.6: Estimated residential episodes of care by residential substance-use services, by Indigenous status and gender, 2016–17

Indigenous status	Male	Female	Gender not recorded	Total	
				Number	%
Indigenous	1,949	904	5	2,858	85.6
Non-Indigenous	363	106	0	469	14.0
Indigenous status not recorded	4	8	0	12	0.4
Total	**2,316**	**1,018**	**5**	**3,339**	**100.0**

Source: AIHW analyses of OSR data collection, 2016–17.

Sobering-up, residential respite and short-term care episodes of care

A sobering-up, residential respite or short-term care episode of care starts at admission into a program and ends at discharge. Each time a client comes to stay is counted as a separate episode of care.

In 2016–17, the 11 organisations providing this type of service reported around 19,400 episodes of care. This was an increase of 6% compared with the number reported in 2015–16 (around 18,400 episodes). This increase was mainly due to 1 organisation reporting more episodes of care in 2016–17.

Indigenous clients received 87% of all sobering-up, residential respite or short-term care episodes of care, and just over half (53%) of these were with male clients (see Table 6.7). Over two-thirds of episodes of care with Indigenous clients (71%) were with clients aged 36 and over (see Table S6.23). Each sobering-up, residential respite or short-term care client had on average 1.9 episodes of care.

Table 6.7: Estimated episodes of care by sobering-up, residential respite and short-term care services, by Indigenous status and gender, 2016–17

Indigenous status	Male	Female	Gender not recorded	Total	
				Number	%
Indigenous	9,010	7,943	0	16,953	87.4
Non-Indigenous	346	220	0	566	2.9
Indigenous status not recorded	837	1,034	0	1,871	9.6
Total	**10,193**	**9,197**	**0**	**19,390**	**100.0**

Source: AIHW analyses of OSR data collection, 2016–17.

Non-residential and after-care episodes of care

A non-residential or after-care episode of care is each occasion a client accesses services such as substance-use counselling, assessment, treatment, education, and support or follow-up from residential services (after discharge). In 2016–17, 71 (93%) organisations providing non-residential services reported valid episodes of care data. These organisations reported around 174,900 episodes of care, an increase of 18% compared with 2016–17 (around 148,800 episodes). This increase was largely due to increases in organisations reporting in both years (76%). Some of the increase (24%) was due to more organisations reporting data in 2016–17 (71 compared with 65 organisations in 2015–16).

Indigenous clients received 84% of all non-residential episodes of care and non-Indigenous clients 15% (see Table 6.8). Just over half of non-residential episodes of care with Indigenous clients were with male clients (53%). Over half (52%) of non-residential episodes of care with Indigenous clients were with clients aged 36 and over, while 39% were with clients aged 19–35. Around 9% of episodes of care with Indigenous clients were with clients aged 18 and under (see Table S6.24). Non-residential and after-care clients had on average 4.8 episodes of care.

Table 6.8: Estimated episodes of care by non-residential services, by Indigenous status and gender, 2016–17

Indigenous status	Male	Female	Gender not recorded	Total	
				Number	%
Indigenous	77,490	65,449	3,203	146,142	83.5
Non-Indigenous	17,147	9,070	232	26,449	15.1
Indigenous status not recorded	1,189	1,161	1	2,351	1.3
Total	**95,826**	**75,680**	**3,436**	**174,942**	**100.0**

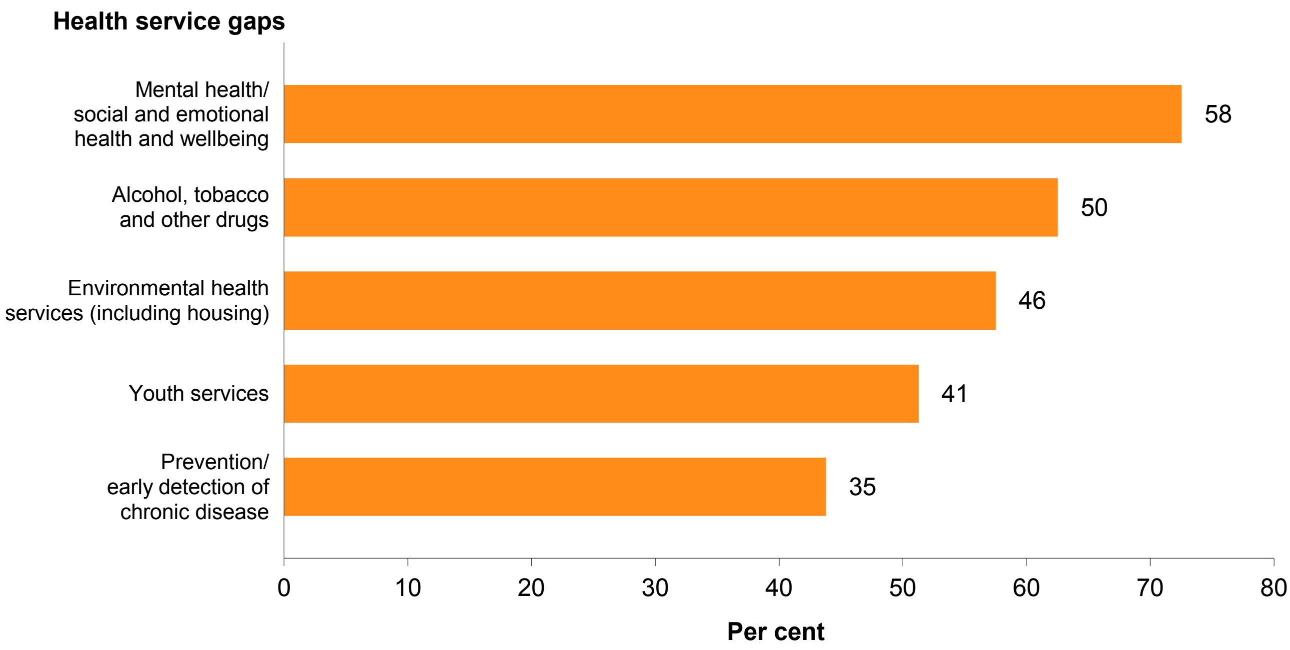
Source: AIHW analyses of OSR data collection, 2016–17.

6.5 Service gaps and challenges

Services for mental health and social and emotional wellbeing were among the top 5 service gaps reported for 73% of organisations funded to provide substance-use services (see Figure 6.6 and Table S6.25). This was followed by services for alcohol, tobacco and other drugs (63%), environmental health services (58%), and youth services (51%).

The 41 organisations not funded by the DoH for primary health care were more likely to report services for mental health and social and emotional wellbeing as a gap than those also funded for primary health care (78% compared with 67%). They were also more likely to report services for alcohol, tobacco and other drugs as a gap (73% compared with 51%), access to health services (46% compared with 28%) and environmental health services (66% compared with 49%) than those also funded for primary health care.

The 39 organisations also funded for primary health care were more likely to report dental services as a gap than those not funded for primary health care (54% compared with 22%, respectively). They were also more likely to report nutrition services (including lack of access to affordable healthy food) as a gap (28% compared with 17%).



Note: Organisations were asked to select up to 5 health service gaps faced by the community they served.

Figure 6.6: Number (as labelled) and proportion (in scale) of organisations funded for substance-use services, by type of health service gap, 2016–17

Just over two-thirds (69%) of organisations reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff among their top 5 service challenges and 60% reported staffing levels as challenges (see Table S6.26). Just under half reported the coordination of clinical care with other providers (49%), staff retention and turnover (48%), and appropriate health service infrastructure (45%) as challenges.

Appendix A: Changes to the OSR form

Table A1 summarises the key changes to the online OSR form for the 2012–13 collection.

Table A1: Changes to the OSR questionnaire in 2012–13

Items	Details	Notes
Accreditation	The category of 'not accredited' was no longer collected.	The 2012–13 questionnaire asked whether health organisations were accredited with RACGP and/or organisational standards. It did not ask whether an organisation was accredited with other standards or did not have accreditation.
Clinical health activities	A few types of activities were no longer collected, such as: • outreach clinic services • interpreting services • immunisation and vaccination registers • maintains health registers.	
Population health programs	A few types of programs were no longer collected, such as: • regularly organise pneumococcal immunisations • routinely organise influenza immunisations • dietary and nutrition programs • child growth monitoring.	The 2012–13 questionnaire collected data on population health programs at the organisational level; previously they were collected only for primary health-care organisations.
Screening programs	Most programs were no longer collected, such as eye screening and renal screening.	
Community services	A few types of services were no longer collected, such as: • school-based activities • medical evacuation services • youth camps.	The 2012–13 questionnaire collected data on advocacy, planning and policy, research and cultural promotion activities at the organisation level; previously they were collected only for primary health-care organisations.

Appendix B: Data improvement projects

(This section on the work being done to improve data quality was written by the Department of Health).

Background

In 2011 the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* was developed, and the Australian Health Ministers' Advisory Council approved a set of 24 national Key Performance Indicators (nKPIs) to track and evaluate the Closing the Gap health outcomes of Aboriginal and Torres Strait Islander people. The nKPIs have been collected bi-annually from around 230 organisations since June 2012 and the AIHW has produced national reports on the data set since May 2014. The nKPIs are a mix of process of care and outcome indicators. They focus on chronic disease prevention and management and maternal and child health, which are two key areas for achieving the objective of Closing the Gap in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

The OSR collects information on clients, client contacts, episodes of care and workforce FTE by type of workforce, in an aggregate form at the service level. The OSR data provide information on services delivered and activities provided by funded organisations as well as feedback on the key service gaps and challenges, and assist with:

- identifying key issues affecting Aboriginal and Torres Strait Islander services
- identifying gaps in Aboriginal and Torres Strait Islander services provided
- identifying the services delivered by the Aboriginal Community Controlled Health Service (ACCHS) sector in comparison with mainstream services
- informing the continuous quality improvement process of services.

A governance framework covering the collection, storage, ownership, access to and usage of collected nKPI and OSR data was developed in 2012 and updated in 2015.

During the initial years of nKPI and OSR reporting, data were extracted from health services' CIS and values calculated from that data by third-party software products. This data was then stored in OCHREStreams, a data portal developed and managed by an external provider. While this resulted in a stable collection process and consistency in the data flowing through to the AIHW during the period 2012–2015, the data transformations coded by the extraction products were never externally checked, nor was an objective validation undertaken to confirm that the results were comparable or accurate.

During this period the data were collected and transformed from 5 different CISs (Communicare, Medical Director, Best Practice, MMEx and PCIS) used by health services, each with a different data structure and in most cases using a different clinical coding system. The third-party data extraction and transformation process imposed a level of consistency across the CISs, however some health services in the ACCHS sector felt that these calculated values did not reflect their underlying data and some CIS vendors observed that the process of making data from different systems consistent resulted in a loss of data fidelity.

A decision was made in 2017 to remove the need for extraction tools entirely by working with CIS vendors to develop 'direct load': the capability in each CIS to extract, transform, encrypt and send nKPI and OSR data directly to the data portal. In parallel, DoH decided to replace the OCHREStreams data portal from 2018 by enhancing its existing enterprise Health Data Portal (HDP) and Enterprise Data Warehouse to add functionality for Indigenous data collection. As well as further reducing reliance on external providers, the HDP will provide a simple, reliable and up-to-date mechanism, supporting modern data analytics capability and aligning with the relevant Australian Government Digital Transformation standards.

Current and planned data quality improvement initiatives

In June 2017 the mechanism for direct load from CIS to OCHREStreams was used for the first time. In parallel, a project to objectively validate the nKPI values calculated through direct load by 3 of the major CISs was implemented, and a validation process for OSR values scheduled for completion during 2018. The focus now is to maintain and progressively improve the direct-load collection mechanism and the quality of the data collected, across all parts of the collection chain.

The projects to implement direct load and to add Indigenous reporting capability to the HDP are key enablers for a range of data quality improvement projects currently underway or planned. Each project falls into one of the following categories:

- Data quality—storage and access (improvements in the way in which submitted data is received, stored and made accessible)
- Data quality—generation and transmission (improvements to the accuracy of the direct-load data from each CIS and the consistency of data calculations between CISs)
- Data quality—content and currency (improvements to data practices and processes within health services, along with activities to keep collections up to date).

Data quality—storage and access

The key project in this category is the DoH HDP. The new portal will replace the current OCHREStreams portal from December 2018. The expected benefits from this project include:

- higher levels of sector acceptance and take-up resulting from the HDP co-design process (involving a program of consultation workshops around Australia throughout the design and development phases, along with continuous sector feedback on prototypes of key features) used to plan and implement the HDP
- faster turnaround, more engaged health services and streamlining of work because automated validation on submission and revision of data will empower health services to fix identified problems and respond with comments to identified potential problems before data submissions reach the AIHW for national reporting purposes
- providing each health service with a data dashboard showing its own data and comparison data will further engage and empower many health services, giving them timely and early insight into how their results compare to, for example, national averages and nKPI trajectories relevant to the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan. For many health services, this facility will directly support local efforts to improve data quality between collections.

Data quality—generation and transmission

Following on from the initial validation of nKPI and OSR data during 2017, the Data Validation (Stage 3) project will deliver a repeatable nKPI/OSR data validation process using a specially developed Control Data Set of a minimum of 700 dummy patient records designed to test each vendor's process for producing nKPI and OSR data values. This will allow DoH (or other parties) to re-validate test data in any clinical system when CIS vendors issue software updates or when indicators are changed. This validation process, to be in place in 2018, will provide assurance to the sector that changes to their clinical software by CIS vendors will not degrade their data quality.

During the first half of 2018, the nKPI/OSR Specification Harmonisation project will see the removal of any differences between the master nKPI definition in METeOR, the AIHW User Guide and Improvement Foundation documents which provide additional information for CIS vendors. This will ensure we eliminate misunderstandings and help to reduce the impact on data quality of vendor interpretation of the specifications.

During 2018 Best Practice Software will develop a direct-load capability, bringing it into line with Communicare, Medical Director and MMEx. This will allow Best Practice health services to report directly from its system, saving time for health services as well as producing better-quality data.

The Department's newly-formed Clinical Coding Working Group will provide assistance in mapping relevant chronic disease codes across Communicare (ICPC2), MMEx (SNOMED), Medical Director (DOCLE) and ICD-10. This will result in greater data consistency across the major CISs.

Data quality—content and currency

The Data Quality Assessment and Support Project will focus on reviewing and making recommendations for improving data within health services, as well as sharing examples of good practice within the sector. This project will involve multi-skilled teams visiting reporting health services to review and assess aspects of their data practices and processes, especially those relevant to the proposed IAHP Funding Model (scheduled for implementation from July 2019). This will deliver immediate benefits to health services in the form of an individual report with recommendations, as well as providing DoH with assessed baseline data for each health service along with a set of themes for future development of national education and support resources relating to data quality improvement. Stage 1 of this project will see visits to up to 50 health services by 30 June 2018. Depending on the results of Stage 1, remaining reporting health services may be visited during the 2018–19 financial year, with rollout of resulting education and support during the same period.

By documenting for all CIS products the linkages between each calculated nKPI and OSR value and the underlying clinical data fields, the nKPI/OSR Mapping Project will ensure that health services gain better insight into data gaps or under-reporting caused by entering data into non-standard fields. This will allow health services to review their data entry practices and achieve more comprehensive data capture. Mapping for Communicare, Medical Director, MMEx and Best Practice will be in place by 30 June 2018.

Reviews will be conducted of both the nKPI and OSR collections during 2018. These comprehensive reviews will ensure that both collections remain aligned to current objectives, including Closing the Gap, the indicator set/modules balance the need for data against the need to minimise reporting burden, the individual indicators/questions are both relevant and collectable from existing data, and the indicator specifications are correct and give practical guidance to CIS vendors.

To enable many of the above activities, the Department is actively building direct relationships with CIS vendors (rather than working through third parties). This will result in improved communication, better CIS vendor support for health services and more efficient specification, scheduling and rollout of software upgrades relevant to nKPI and OSR reporting.

Working more closely and effectively with vendors will also allow for the continuous improvement of all CIS direct-load mechanisms over time. Direct load has been used for one collection (June 2017) by three CIS vendors, with the fourth major CIS vendor (Best Practice) intending to develop this facility during 2018. Over time it will be possible to make corrections and improvements to the direct-load feed supplied by each CIS vendor, and a number of the projects listed above will provide improvement opportunities. This will improve the stability and accuracy of direct load.

For further information, please contact <hs.data.advisory.group@health.gov.au>.

Appendix C: Workforce

The following is a list of staff included as 'health' and 'other' positions in this report.

Health staff

Aboriginal and Torres Strait Islander health worker

Aboriginal and Torres Strait Islander health practitioner

Doctor or general practitioner (GP)

Nurse or midwife

Substance misuse or drug and alcohol worker

Tobacco worker or coordinator

Dentists or dental therapists

Dental support (for example, dental assistant, dental technician)

Sexual health worker

Outreach worker

Traditional healer

Environmental health worker or officer

Medical specialist (for example, paediatrician, endocrinologist, ophthalmologist, obstetrician or gynaecologist, ENT specialist, cardiologist, renal medicine specialist, psychiatrist, dermatologist, surgeon)

Social and emotional wellbeing staff or counsellor (for example, psychologist, counsellor, social worker, welfare worker, Link Up caseworker)

Allied health professional (for example, audiologist or audiometrist, diabetes educator, dietician, optometrist, pharmacist, physiotherapist, podiatrist, speech pathologist)

Health promotion or prevention worker

Training or trainee position

Other (general) staff

Chief Executive Officer (CEO)

Manager or supervisor

Driver or field officer

Finance and accounting staff

Administrative and clerical staff

Information technology and data management staff

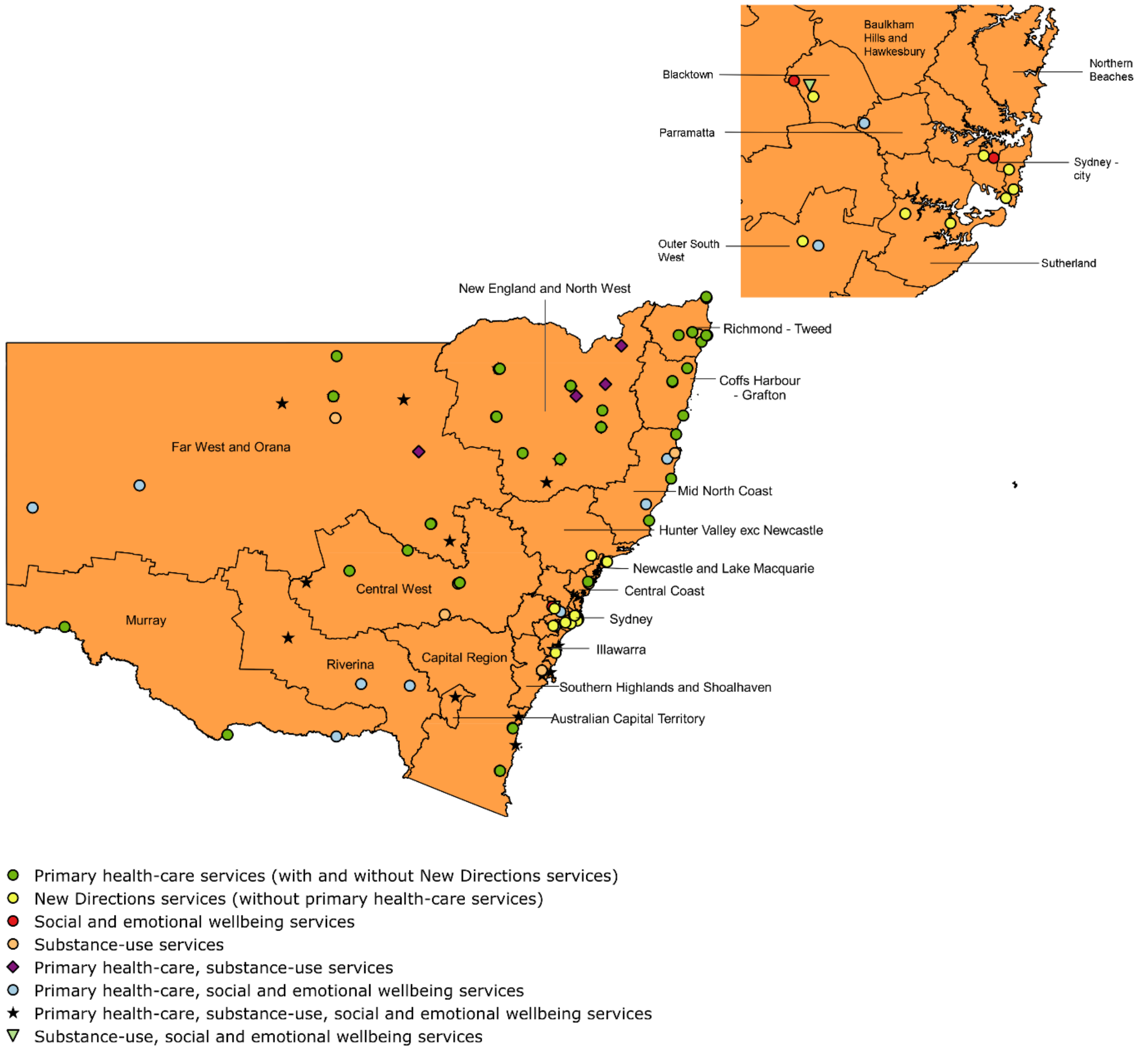
Cleaner, security or other support staff

Administrative or support trainees

Appendix D: Maps of organisations for states and territories

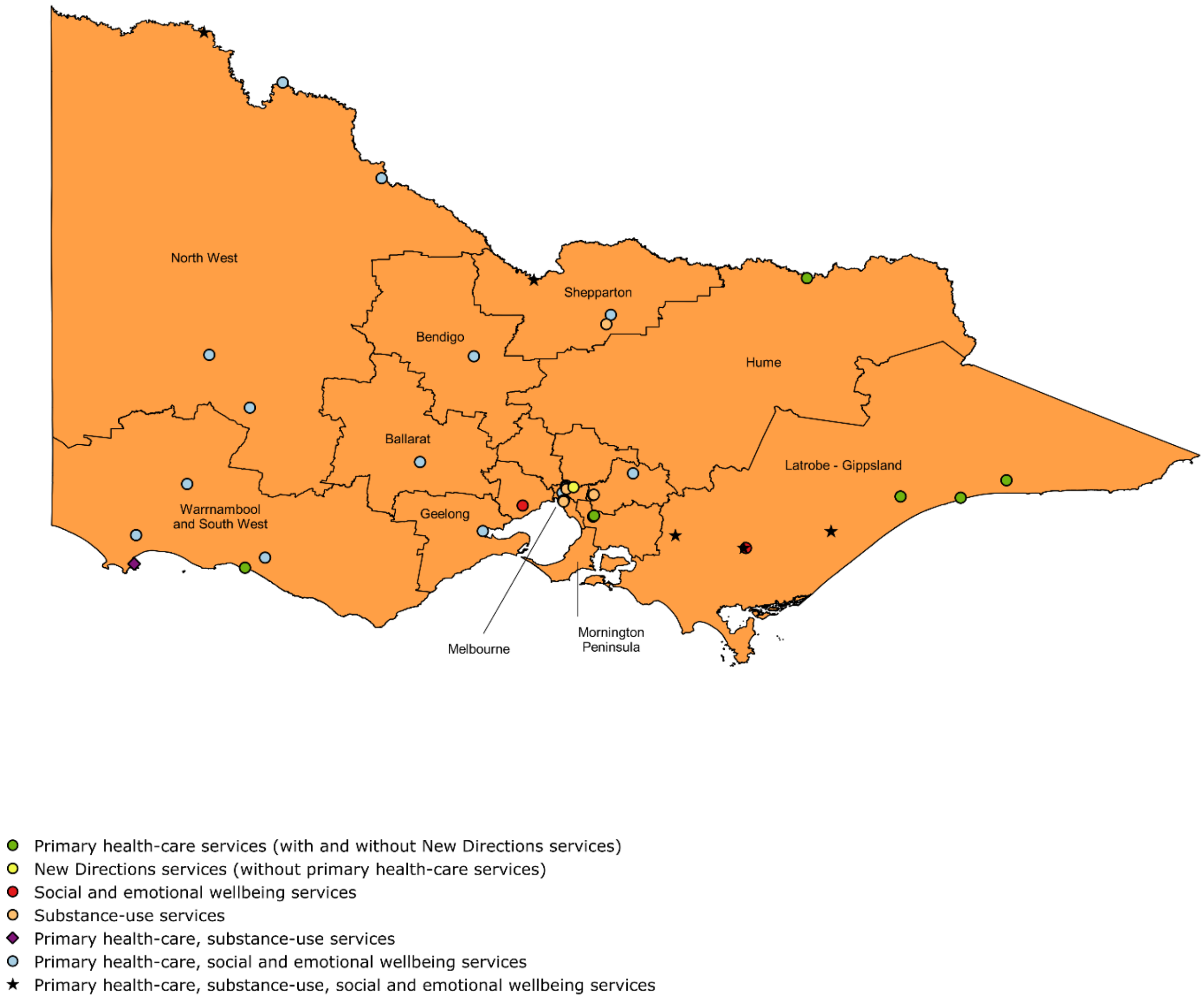
The following state and territory maps show the locations of organisations in the 2016–17 OSR collection. Each organisation is represented by a symbol which describes the combination of services provided by that organisation.

OSR organisations were funded by the Australian Government to provide one or more of the following services to Aboriginal and Torres Strait Islander people: primary health care; New Directions: Mothers and Babies Services; social and emotional wellbeing services; and substance-use services. Some organisations provided only one of these services, while others provided multiple services. For example, the green circles indicate organisations which were funded to provide primary health-care services (with or without New Directions funding), while the purple diamonds indicate organisations which were funded to provide both primary health-care services and substance-use services.



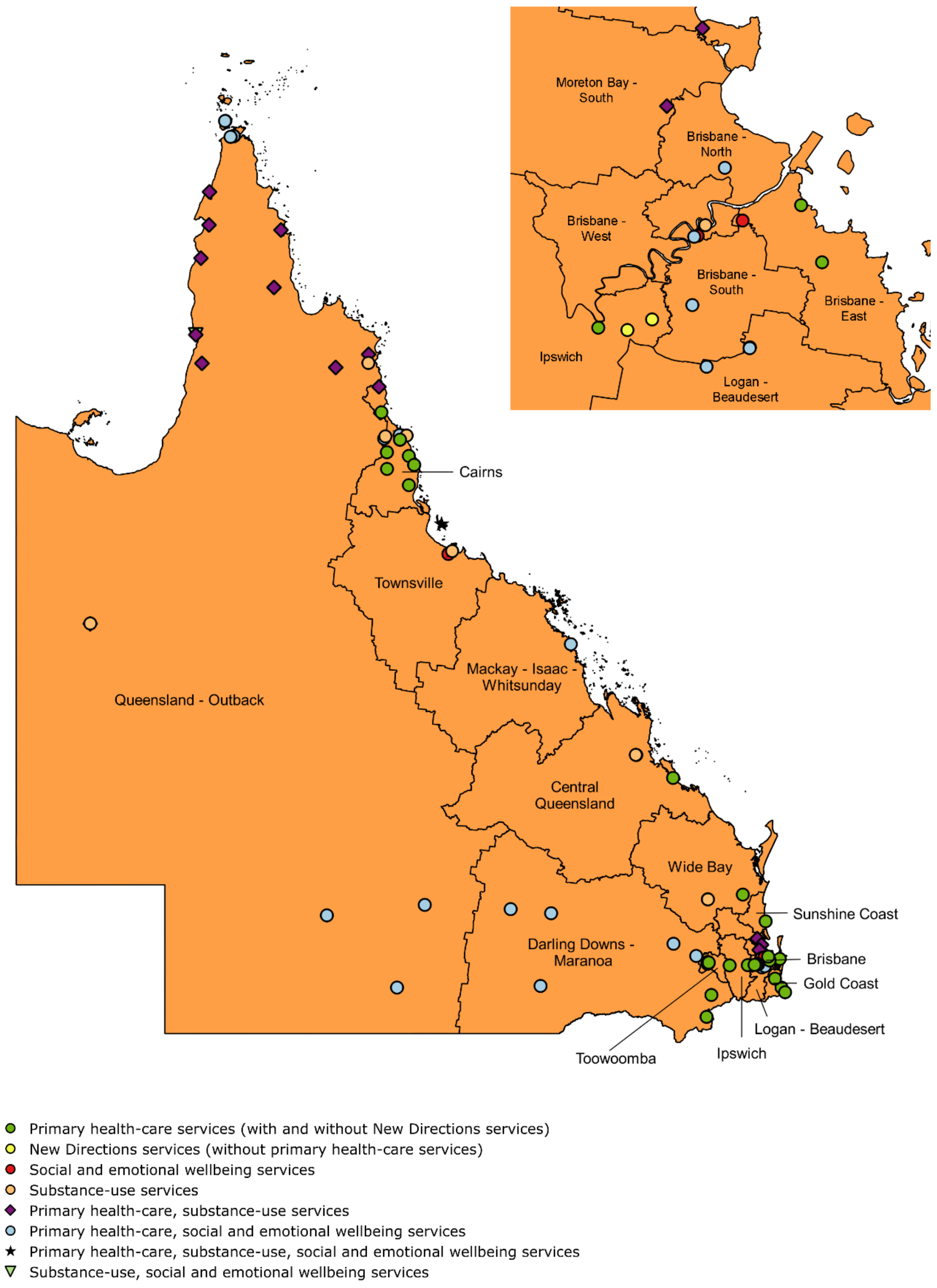
Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D1: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, New South Wales and the Australian Capital Territory, 2016–17



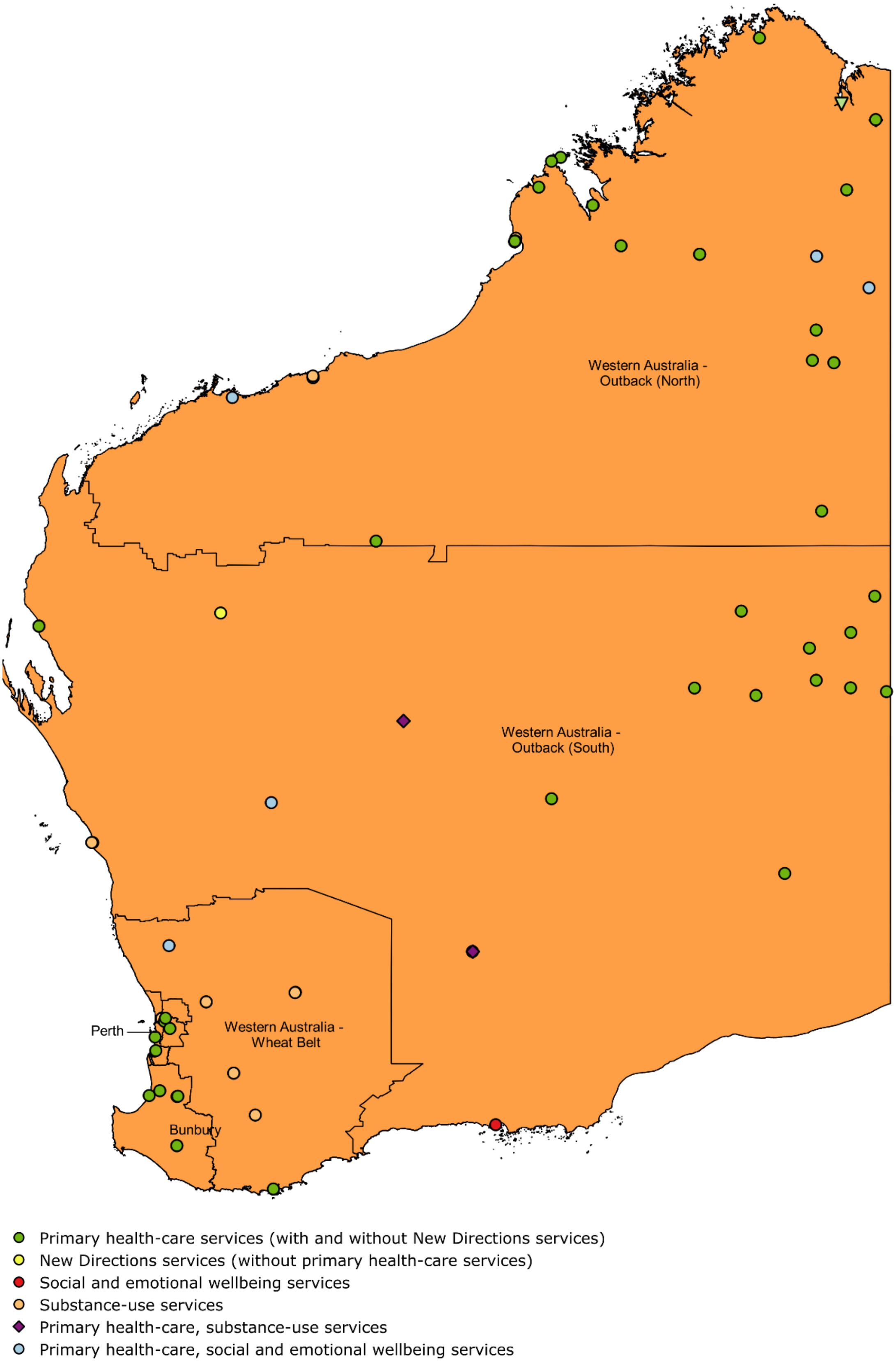
Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D2: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Victoria, 2016–17



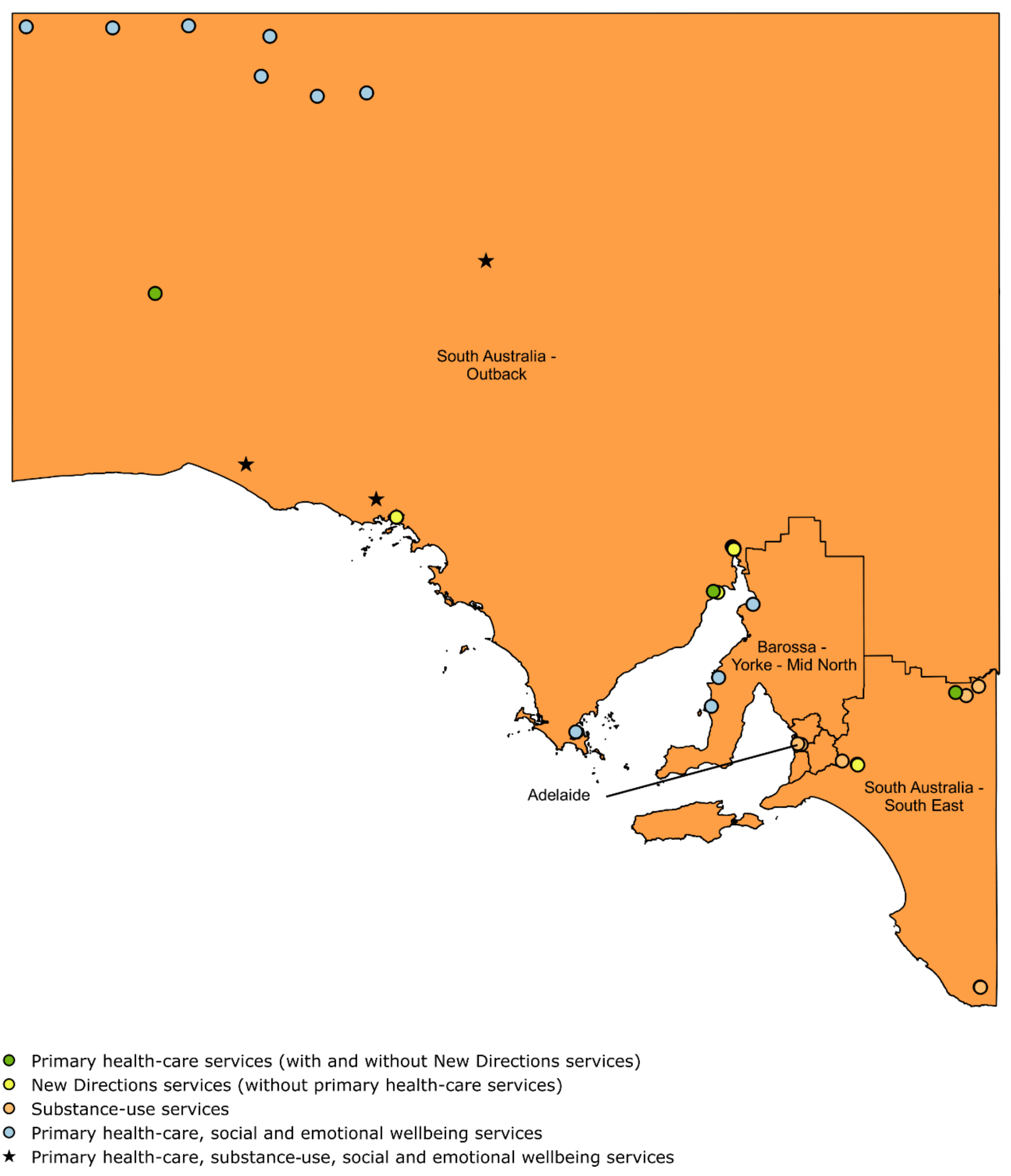
Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D3: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Queensland, 2016–17



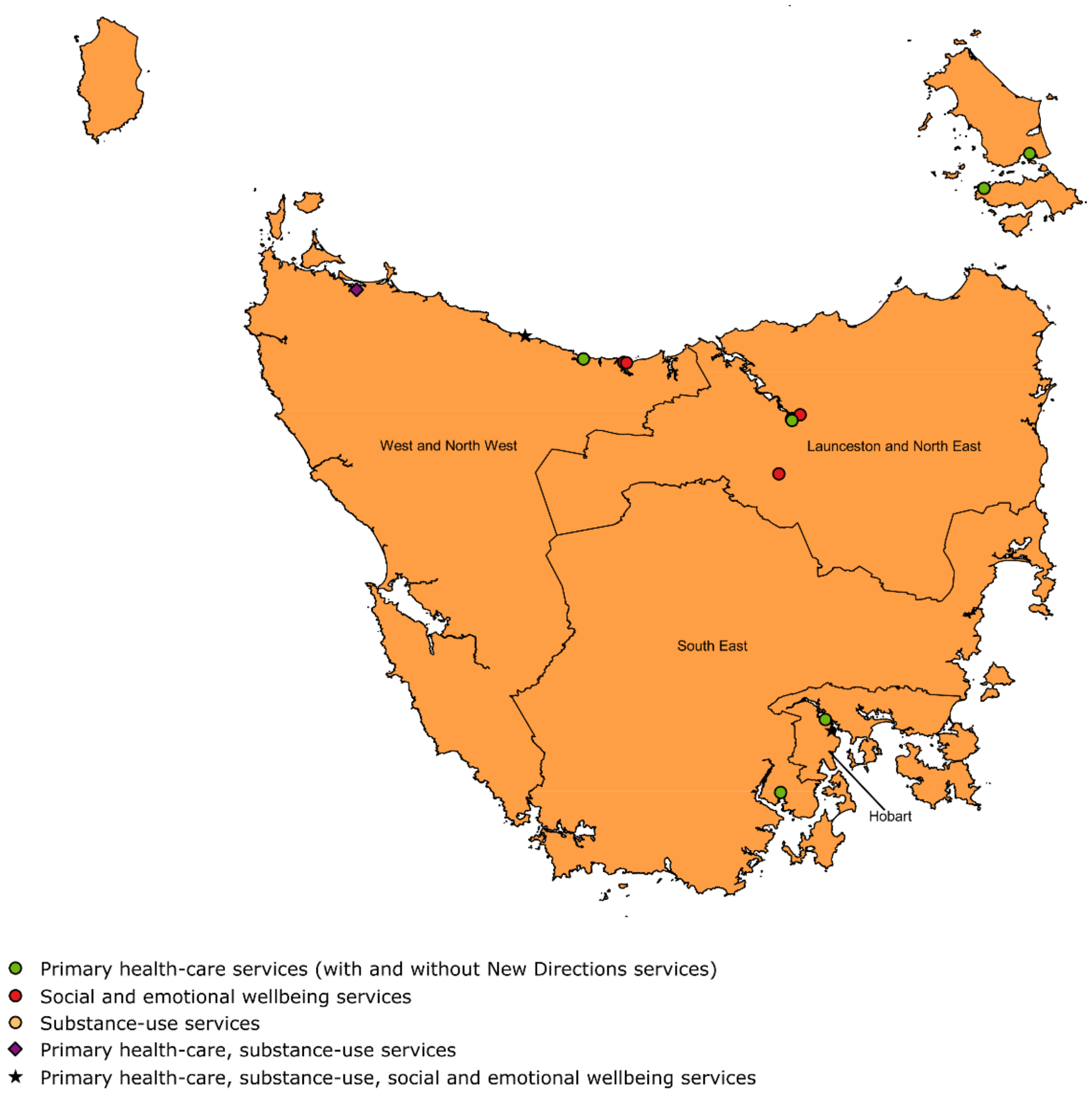
Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D4: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Western Australia, 2016–17



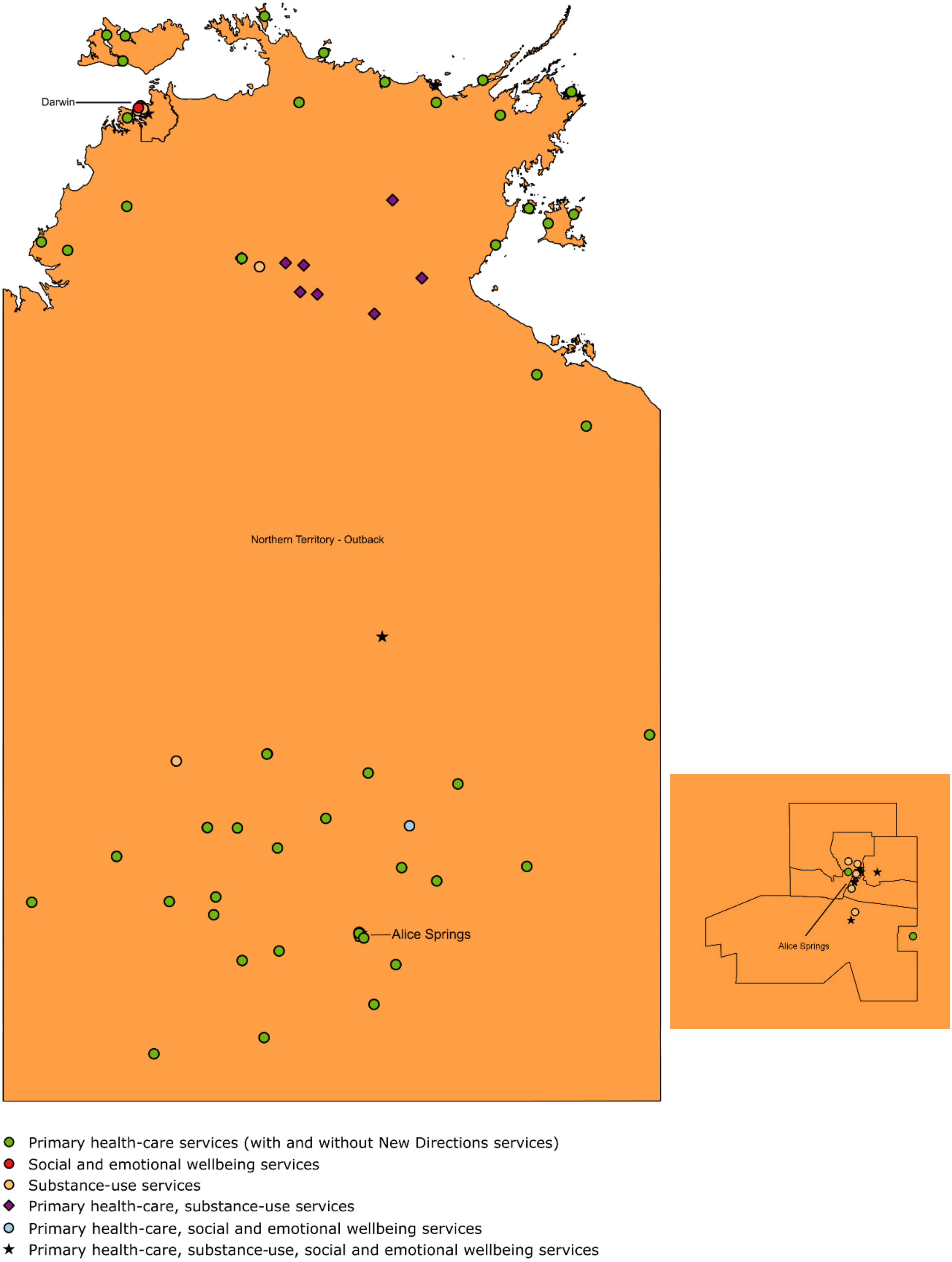
Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D5: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, South Australia, 2016–17



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D6: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Tasmania, 2016–17



Note: Multiple service delivery sites for an organisation may be shown. Also, multiple organisations may be located within a small geographical area, so not all organisations will be visible on the map.

Figure D7: Australian Government-funded organisations providing health services to Aboriginal and Torres Strait Islander people, by type of funding, Northern Territory, 2016–17

Appendix E: List of organisations

Table E1 lists the 266 organisations that contributed to the 2016–17 OSR collection.

Table E1: OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited	Qld
Aboriginal Alcohol and Drug Service (AADS) Incorporated	WA
Aboriginal Drug and Alcohol Council SA Incorporated	SA
Aboriginal Medical Service Cooperative Limited	NSW
Aboriginal Sobriety Group Incorporated	SA
Aboriginal and Torres Strait Islanders Community Health Service Limited (Mackay)	Qld
Albury Wodonga Aboriginal Health Service Incorporated	NSW
Amoonguna Community Health Service	NT
Ampilatwatja Health Centre Aboriginal Corporation	NT
Anglicare WA Incorporated	WA
Anyinginyi Health Aboriginal Corporation	NT
Apunipima Cape York Health Council Aboriginal Corporation	Qld
Arche Health Limited	WA
Armajun Aboriginal Health Service	NSW
Armidale Child and Family Team, Armidale Community Health Service (HNELHD)	NSW
Awabakal Limited	NSW
Ballarat and District Aboriginal Cooperative	Vic
Balunu Foundation Limited	NT
Bega Garnbirringu Health Service Aboriginal Corporation	WA
Bendigo and District Aboriginal Cooperative	Vic
Benelong's Haven Limited	NSW
Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region	Qld
Binjari Community Health Service	NT
Biripi Aboriginal Corporation Medical Centre	NSW
Birra-Li Aboriginal Maternal, Infant and Child Health Service (HNELHD)	NSW
Bloodwood Tree Association	WA
Boab Health Services	WA
Bourke Aboriginal Health Service	NSW
Brewarrina Aboriginal Health Service	NSW
Broome Regional Aboriginal Medical Service	WA
Budja Budja Aboriginal Cooperative	Vic
Bulgarr Ngaru Medical Aboriginal Corporation	NSW
Bulgarr Ngaru Medical Aboriginal Corporation—Richmond Valley	NSW

(Continued)

Table E1 (continued): OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
Bullinah Aboriginal Health Service	NSW
Bushmob Incorporated	NT
Cairns and Hinterland Hospital and Health Service	Qld
Cape Barren Island Aboriginal Association Incorporated	Tas
Carbal Aboriginal and Torres Strait Islander Health Services Limited	Qld
Carnarvon Medical Service Aboriginal Corporation	WA
Ceduna/Koonibba Aboriginal Health Service (Aboriginal Corporation)	SA
Central Australian Aboriginal Alcohol Programmes Unit	NT
Central Australian Aboriginal Congress Aboriginal Corporation	NT
Centrecare Incorporated	WA
Cessnock/Kurri Kurri Community Health Service (HNELHD)	NSW
Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health Limited	Qld
Cherbourg Regional Aboriginal and Islander Community Controlled Health Services Limited	Qld
Circular Head Aboriginal Corporation	Tas
City of Greater Dandenong	Vic
Condobolin Aboriginal Health Service Incorporated	NSW
Coomealla Health Aboriginal Corporation	NSW
Coonamble Aboriginal Health Service Incorporated	NSW
Cornerstone Youth Services	Tas
Council for Aboriginal Alcohol Program Services Incorporated	NT
Cummeragunja Housing and Development Aboriginal Corporation	Vic
Cunnamulla Aboriginal Corporation for Health	Qld
Dandenong and District Aborigines Cooperative Limited—Bunurong Health Service	Vic
Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation	NT
Darrimba Maarra	NSW
Derbarl Yerrigan Health Service Incorporated	WA
Derby Aboriginal Health Service	WA
Dhauwurd-Wurrung Elderly and Community Health Service Incorporated	Vic
Drug and Alcohol Services Association Alice Springs Incorporated	NT
Dubbo Regional Aboriginal Medical Service	NSW
Durri Aboriginal Corporation Medical Services	NSW
Eyre Region (CHSALHN)	SA
Flinders Island Aboriginal Association Incorporated	Tas
Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties Corporation	NT
GP Down South General Practice Network	WA
Galambila Aboriginal Health Service Incorporated	NSW
Gallang Place Aboriginal and Torres Strait Islander Corporation	Qld

(Continued)

Table E1 (continued): OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
Garl Garl Walbu Alcohol Association Aboriginal Corporation	WA
Geraldton Regional Aboriginal Medical Service	WA
Gindaja Treatment and Healing Indigenous Corporation	Qld
Gippsland and East Gippsland Aboriginal Cooperative Limited	Vic
Goolburri Aboriginal Health Advancement Company Limited	Qld
Goolum Goolum Aboriginal Cooperative	Vic
Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services	Qld
Grand Pacific Health	NSW
Griffith Aboriginal Medical Service Aboriginal Corporation	NSW
Gunditjmara Aboriginal Cooperative	Vic
HealthWISE New England North West	NSW
Healthy North Coast Limited (North Coast Primary Health Network)—Bugalwena General Practice	NSW
Holyoake Australian Institute for Alcohol and Drug Addiction Resolutions Incorporated	WA
Illawarra Aboriginal Medical Service Aboriginal Corporation	NSW
Illawarra Shoalhaven Local Health District	NSW
Inala Indigenous Health Service	Qld
Institute for Urban Indigenous Health Limited	Qld
Jullums Lismore Aboriginal Medical Service	NSW
Kalano Community Association Incorporated	NT
Kalwun Health Service	Qld
Kambu Aboriginal and Torres Strait Islander Corporation for Health	Qld
Karadi Aboriginal Corporation	Tas
Katherine West Health Board Aboriginal Corporation	NT
Katungul Aboriginal Corporation Community and Medical Services	NSW
Kimberley Aboriginal Medical Service Incorporated	WA
Kimberley Stolen Generation Aboriginal Corporation	WA
Kinchela Boys Home Aboriginal Corporation	NSW
Kirrae Health Service Incorporated	Vic
Lake Tyers Health and Children Services Association Incorporated	Vic
Laynhapuy Homelands Aboriginal Corporation	NT
Link-Up (NSW) Aboriginal Corporation	NSW
Link-Up (Queensland) Aboriginal Corporation	Qld
Lives Lived Well—Brighter Futures (in Cherbourg)	Qld
Lives Lived Well—Shanty Creek (in Mareeba)	Qld
Maari Ma Health Aboriginal Corporation—Broken Hill and Wilcannia	NSW
Mallee District Aboriginal Services	Vic
Mamu Health Service Limited Innisfail	Qld

(Continued)

Table E1 (continued): OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
Marrin Weejali Aboriginal Corporation	NSW
Marthakal Homeland and Resource Centre Association	NT
Mawarnkarra Health Service	WA
Mercy Public Hospitals Incorporated	Vic
Mid North—Port Pirie (CHSALHN)	SA
Milliya Rumurra Aboriginal Corporation	WA
Miwatj Health Aboriginal Corporation	NT
Moogji Aboriginal Council East Gippsland Incorporated	Vic
Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation	Qld
Mount Isa Aboriginal Community Controlled Health Services Limited	Qld
Mpwelarre Health Aboriginal Corporation	NT
Mulungu Aboriginal Corporation Medical Service	Qld
Mungabareena Aboriginal Corporation	Vic
Murdi Paaki Drug and Alcohol Network (The Lyndon Community)	NSW
Murray Valley Aboriginal Cooperative (Robinvale)	Vic
Mutijulu Community Health Service	NT
NPA Family and Community Services Aboriginal and Torres Strait Islander Corporation	Qld
NT Department of Health—Alpurrurulam Community Health Centre	NT
NT Department of Health—Amunturrngu Community Health Centre	NT
NT Department of Health—Angurugu Community Health Centre	NT
NT Department of Health—Aputula Community Health Centre	NT
NT Department of Health—Atitjere Community Health Centre	NT
NT Department of Health—Belyuen Community Health Centre	NT
NT Department of Health—Bonya Community Health Centre	NT
NT Department of Health—Borroloola Community Health Centre	NT
NT Department of Health—Engawala Community Health Centre	NT
NT Department of Health—Gapuwiyak Community Health Centre	NT
NT Department of Health—Gunbalanya Community Health Centre	NT
NT Department of Health—Ikuntji Community Health Centre	NT
NT Department of Health—Imanpa Community Health Centre	NT
NT Department of Health—Julanimawu (Nguiu) Community Health Centre	NT
NT Department of Health—Laramba Community Health Centre	NT
NT Department of Health—Maningrida Community Health Centre	NT
NT Department of Health—Milikapiti Community Health Centre	NT
NT Department of Health—Milyakburra Community Health Centre	NT
NT Department of Health—Minjilang Community Health Centre	NT
NT Department of Health—Nauiyu (Daly River) Community Health Centre	NT

(Continued)

Table E1 (continued): OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
NT Department of Health—Numbulwar Community Health Centre	NT
NT Department of Health—Nyirripi Community Health Centre	NT
NT Department of Health—Palumpa Community Health Centre	NT
NT Department of Health—Papunya Community Health Centre	NT
NT Department of Health—Pirlangimpi Community Health Centre	NT
NT Department of Health—Ramingining Community Health Centre	NT
NT Department of Health—Robinson River Community Health Centre	NT
NT Department of Health—Tara Community Health Centre	NT
NT Department of Health—Ti Tree Community Health Centre	NT
NT Department of Health—Titjikala Community Health Centre	NT
NT Department of Health—Umbakumba Community Health Centre	NT
NT Department of Health—Wadeye Community Health Centre	NT
NT Department of Health—Warruwi Community Health Centre	NT
NT Department of Health—Willowra Community Health Centre	NT
NT Department of Health—Yuelamu Community Health Centre	NT
NT Department of Health—Yuendumu Community Health Centre	NT
NT Stolen Generations Aboriginal Corporation	NT
Namatjira Haven Limited	NSW
Narrabri Community Health Service (HNELHD)	NSW
Ngaanyatjarra Health Service	NT
Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation	NT
Ngaimpe Aboriginal Corporation (The Glen)	NSW
Nganampa Health Council Incorporated	SA
Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	WA
Ngnowar-Aerwah Aboriginal Corporation	WA
Ngwala Willumbong Cooperative Limited	Vic
Nhulundu Wooribah Indigenous Health Organisation Incorporated	Qld
Nindilingarri Cultural Health Services	WA
Njernda Aboriginal Corporation	Vic
North Coast Aboriginal Corporation for Community Health	Qld
Northern NSW Local Health District	NSW
Nunkuwarrin Yunti Incorporated	SA
Nunyara Aboriginal Health Service Incorporated	SA
Oak Valley (Maralinga) Incorporated	SA
On Track Community Programs Limited	NSW
Orana Haven Aboriginal Corporation	NSW
Orange Aboriginal Medical Service	NSW

(Continued)

Table E1 (continued): OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
Ord Valley Aboriginal Health Service Aboriginal Corporation	WA
Palmerston Association Incorporated	WA
Pangula Mannamurna Incorporated	SA
Paupiyala Tjarutja Aboriginal Corporation	WA
Peak Hill Aboriginal Medical Service Incorporated	NSW
Pika Wiya Health Service Aboriginal Corporation	SA
Pintupi Homelands Health Service	NT
PiusX Aboriginal Corporation	NSW
Pormpur Paanth Aboriginal Corporation	Qld
Port Augusta Substance Misuse Service—Mobile Assistance Patrol Service	SA
Port Lincoln Aboriginal Health Service Incorporated	SA
Puntukurnu Aboriginal Medical Service Aboriginal Corporation	WA
Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services	Qld
Ramahyuck and District Aboriginal Corporation	Vic
Rekindling The Spirit Limited	NSW
Relationships Australia Tasmania	Tas
Riverina Medical and Dental Aboriginal Corporation	NSW
Riverland Region (CHSALHN)	SA
Royal Flying Doctor Service of Australia (Queensland Section)	Qld
Royal Hospital for Women (Malabar Community midwifery Link Service)	NSW
Rumbalara Aboriginal Cooperative	Vic
Rural Health Tasmania	Tas
South Coast Medical Service Aboriginal Corporation	NSW
South Coast Women’s Health and Welfare Aboriginal Corporation (Waminda)	NSW
South Coastal Women’s Health Services Association Incorporated	WA
South East Tasmanian Aboriginal Corporation	Tas
South West Aboriginal Medical Service Aboriginal Corporation	WA
South Western Sydney Local Health District	NSW
Southern NSW Local Health District	NSW
St George/Sutherland (Narrangy-Booris Menai Service)	NSW
Sunrise Health Service Aboriginal Corporation	NT
Swan Hill Aboriginal Health Service	Vic
Sydney Local Health District	NSW
Tamworth Aboriginal Medical Service	NSW
Tasmanian Aboriginal Centre Incorporated	Tas
Tharawal Aboriginal Corporation	NSW
The Gumbi-Gumbi Aboriginal and Torres Strait Islanders Corp	Qld

(Continued)

Table E1 (continued): OSR organisations[(a)], by state and territory, 2016–17

Organisation name	State/territory
The Oolong Aboriginal Corporation	NSW
The Salvation Army (Queensland) Property Trust	Qld
The Uniting Church In Australia Property Trust (QUEENSLAND)—Cape York Family Centre	Qld
The Uniting Church In Australia Property Trust (QUEENSLAND)—Stagpole Street Drug and Alcohol Rehabilitation Unit	Qld
Tobwabba Aboriginal Medical Service Incorporated	NSW
Torres and Cape Hospital Health Service—Torres Strait and Northern Peninsula	Qld
Townsville Aboriginal and Torres Strait Islanders Health Services Limited	Qld
Tullawon Health Service Incorporated	SA
Umoona Tjutagku Health Service Aboriginal Corporation	SA
Uniting Care Children Young People and Families	NSW
Uniting Care Wesley Adelaide	SA
Urapuntja Health Service Aboriginal Corporation	NT
Utju Medical Service	NT
Victorian Aboriginal Child Care Agency Cooperative Limited (Link-Up Victoria)	Vic
Victorian Aboriginal Health Service Cooperative Limited	Vic
WA Country Health Service—Great Southern Aboriginal Health Service	WA
WA Country Health Service—Kimberley Region (West Kimberley): Sexual Health	WA
WA Country Health Service—Kimberley Region: Primary Health Care	WA
WA Country Health Service—Midwest Region (Carnarvon): New Directions	WA
WA Country Health Service—Midwest Region (Gascoyne): Geraldton Sexual Health	WA
WA Country Health Service—Midwest Region (Geraldton): New Directions	WA
WA Country Health Service—Pilbara	WA
WA Country Health Service—Wheatbelt Aboriginal Health Service	WA
Walgett Aboriginal Medical Services	NSW
Walhallow Aboriginal Corporation	NSW
Wandarma Aboriginal Drug and Alcohol Service—Bega and Region (The Lyndon Community)	NSW
Warlpiri Youth Development Aboriginal Corporation	NT
Wathaurong Aboriginal Cooperative	Vic
Weigelli Centre Aboriginal Corporation	NSW
Wellington Aboriginal Corporation Health Service	NSW
Werin Medical Centre (Port Macquarie)	NSW
Western Aranda Health Aboriginal Corporation (WAHAC)	NT
Western NSW Local Health District	NSW
Western Sydney Local Health District	NSW
Whyalla Flinders and Far North (CHSALHN)	SA
Winda Mara Aboriginal Corporation	Vic
Winnunga Nimmityjah Aboriginal Health Clinic/Health Service Incorporated (ACT)	ACT

(Continued)

Table E1 (continued): OSR organisations[a], by state and territory, 2016–17

Organisation name	State/territory
Wirraka Maya Health Services Aboriginal Corporation	WA
Wuchopperen Health Service (Midin Clinic)	Qld
Wuchopperen Health Service (Reef House)	Qld
Wurli Wurlinjang Aboriginal Corporation	NT
Yaandina Family Centre Incorporated	WA
Yarra Valley Community Health Service (Eastern Health)	Vic
Yerin Aboriginal Health Services Incorporated	NSW
Yorgum Aboriginal Corporation	WA
Yorke Peninsula Health Service (CHSALHN)	SA
Yulu-Burri-Ba Aboriginal Corporation for Community Health	Qld
Yura Yungi Medical Service Aboriginal Corporation	WA

(a) As advised by the DoH. This does not include every organisation that received Australian Government funding, because not all organisations were part of the OSR collection.

Glossary

Aboriginal Community Controlled Health Organisations (ACCHOs): Health-care services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to the communities and controlled through a locally elected board of management. They range from large services with several medical practitioners who provide a range of services, to small services that rely on nurses and/or Aboriginal health workers to provide most services. For more information see <www.naccho.org.au>**.**

Aboriginal and Torres Strait Islander health worker: An Aboriginal and/or Torres Strait Islander person with a minimum qualification in the field of primary health-care work or clinical practice. This includes Aboriginal and Torres Strait Islander health practitioners who are one speciality stream of health worker. Health workers liaise with patients, clients and visitors to hospitals and health clinics, and work as a team member to arrange, coordinate and provide health-care delivery in community health clinics.

Aboriginal and Torres Strait Islander health practitioner: A person who has completed Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. The practitioner may undertake higher levels of clinical assessment and care within their agreed scope of practice. This role became nationally registered from 1 July 2013 under the National Registration and Accreditation Scheme for health professions.

Accessibility/Remoteness Index of Australia (ARIA): ARIA measures the remoteness of a point based on the physical road distances to the nearest urban centre in each of 5 size classes. Therefore, not all remoteness areas are represented in each state or territory.

There are 6 remoteness areas in this structure:

- *Major cities*—collection districts (CDs) with an average ARIA index value between 0 and less than or equal to 0.2
- *Inner regional* areas—CDs with an average ARIA index value greater than 0.2 and less than or equal to 2.4
- *Outer regional* areas—CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92
- *Remote* areas—CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53
- *Very remote* areas—CDs with an average ARIA index value greater than 10.53
- *Migratory*—composed of offshore, shipping and migratory CDs.

For more information, see ABS (2006).

aged care: This is defined in the OSR as the organisation routinely provides clinical and support services to older people, including any of the following: coordination of care; assessment, case management, therapy and review; routine management of acute and chronic medical conditions; referral and support to access aged care services; specific group activities for older people; and visiting services to older people at home or in residential aged care facilities.

allied health professionals: Professionals working in audiology, dietetics and nutrition, hospital pharmacy, occupational therapy, orthoptics, orthotics and prosthetics.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

client: An individual receiving heath care by an organisation during the collection period. Each individual is counted as a client once only, regardless of how many times they are seen. Visitors and transient clients are included in client counts, but any clients attending group activities only (who do not receive individual care) are excluded.

client contacts: A summation of the individual client contacts that were made by each type of worker involved in the provision of health care by the service.

episode of health care: Contact between an individual client and a service by one or more staff members to provide health care.

first Stolen Generation clients: Clients who were removed from their families and communities.

full-time equivalent (FTE): A standard measure of the size of a workforce that takes into account both the number of workers and the hours that each works. For example, if a workforce comprises 2 people working full time 35 hours a week and 2 working half time, this is the same as 3 working full time—an FTE of 3.

Indigenous: A person of Australian Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander.

medical specialists: Medical practitioners who are registered as specialists under a law of state or territory or recognised as specialists or consultant physicians by a specialist recognition advisory committee, such as paediatricians, ophthalmologists, cardiologists, ear, nose and throat specialists, obstetricians and surgeons.

non-Indigenous: A person who has declared they are not of Aboriginal and/or Torres Strait Islander descent.

non-residential service: Substance-use services that offer substance-use treatment, rehabilitation and/or education for clients predominantly without the option of residing in-house.

non-residential, follow-up or after-care episode of care: Care provided to a client not in residential care, such as substance-use counselling, assessment, treatment, education, support or follow-up from residential services.

palliative care: This is defined in the OSR as: the organisation provides clinical management and care coordination, including assessment, triage and referral using a palliative approach for patients with uncomplicated needs associated with a life-limiting illness or end of life care. The organisation also has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary.

program: A planned, regular activity organised by a service.

remoteness areas: The remoteness areas divide Australia into broad geographic regions that share common characteristics of remoteness for statistical purposes. Each state and territory is divided into several regions based on their relative accessibility to goods and services (such as GPs, hospitals and specialist care) as measured by road distance. These regions are based on the ARIA. Individual states and territories may not contain areas of every class: for example, the Northern Territory does not contain a *Major city* or an *Inner regional* classification.

remoteness structure: One of 7 geographical structures listed in the Australian Standard Geographic Classification. Its purpose is to classify collection districts that share characteristics of remoteness into broad geographical regions called remoteness areas.

residential service: Drug and alcohol services that offer temporary, live-in accommodation for clients requiring substance-use treatment and rehabilitation.

residential treatment or rehabilitation episode of care: Commences at admission into residential treatment or rehabilitation and ends at discharge.

second Stolen Generation clients: Those clients whose parent(s) are first Stolen Generation members.

shared care: Where care is shared between practitioners and/or services, in a formalised arrangement, with an agreed plan to manage the patient. Details surrounding this arrangement depend on the practitioner involved, patient needs and the health-care context.

Sobering-up or residential respite clients: Clients who are in residential care overnight to sober up, or those who stay in residential care for 1 to 7 days for respite, and who do not receive formal rehabilitation.

Sobering-up, residential respite or short-term episode of care: Commences at admission into a sobering-up, residential respite or short-term care program and ends at discharge. One episode of care can last 1–7 days.

social and emotional wellbeing and Link Up counsellors: Counsellors who provide a support service to Aboriginal and Torres Strait Islander communities, prioritising members of the Stolen Generations who have been directly or indirectly affected by the removal and separation of children from their families, and those going through the process of being reunited. Counsellors must possess at commencement of employment, or within 12 months of commencing employment, formal tertiary or vocational qualifications to a minimum of a Certificate IV qualification from a nationally recognised course of study in counselling, social work, mental health or a related area.

social and emotional wellbeing (SEWB) staff: These include (but are not limited to) psychologists, counsellors, mental health workers, social workers and welfare workers.

Tackling Indigenous Smoking and Healthy Lifestyle Program: A program funded by the Australian Government focusing on health promotion around smoking and healthy lifestyles to help close the gap between the health of Indigenous Australians and non-Indigenous Australians, and to reduce chronic disease in Aboriginal people. The team is made up of regional tobacco action workers and healthy lifestyle workers, and all are trained outreach Aboriginal health workers.

Tackling Indigenous Smoking Program: Funded by the Australian Government, this targeted activity aims to prevent the uptake of smoking and supports smoking cessation among Aboriginal and Torres Strait Islander people. It is a multi-component program that focuses on evidence-based activities and tobacco reduction outcomes. It uses proven approaches to change smoking behaviours, with activities delivered at multiple levels, including health service funding, workforce training and organisational support, and support for smokers through Quitline funding. The Tackling Indigenous Smoking Program replaces the previous Tackling Indigenous Smoking and Healthy Lifestyle Program.

third and subsequent Stolen Generation clients: Those clients whose grandparent(s) are first Stolen Generation members or who are directly descended from people who were removed from their families and communities in subsequent Stolen Generations.

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Related publications

This report is part of an annual series. Earlier editions can be downloaded free from the AIHW website <https://www.aihw.gov.au/>.

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AIHW 2017. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2015–16. Aboriginal and Torres Strait Islander health services report no. 8. Cat. no. IHW 180. Canberra: AIHW.

This is the ninth national report on organisations funded by the Australian Government to provide health services to Aboriginal and Torres Strait Islander people. In 2016–17:

- 196 organisations provided primary health-care services to around 444,700 clients through 5.5 million client contacts and 3.2 million episodes of care
- 189 counsellors from 88 organisations provided social and emotional wellbeing services to around 16,300 clients through 77,100 client contacts
- 80 organisations provided substance-use services to around 39,400 clients through 197,700 episodes of care.

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