



Australian Government

Australian Institute of
Health and Welfare

Aboriginal and Torres Strait Islander
Health Performance Framework
2017 report

Australian Capital Territory





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Health and Welfare**

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACT	Australian Capital Territory
AGPAL	Australian General Practice Accreditation Limited
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
ESKD	end-stage kidney disease
FTE	full-time equivalent
GP	general practitioner
GPA+	General Practice Accreditation Plus
GPMP	General Practice Management Plan
HbA1C	glycated haemoglobin (A1c)
HIB	Haemophilus influenzae type B
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
ISHP	Indigenous-specific health service
ISPHS	Indigenous-specific primary health service
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NAPLAN	National Assessment Program—Literacy and Numeracy
NDA	National Disability Agreement
NMDS	national minimum data set
NSSC	National Schools Statistics Collection
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
Qld	Queensland
RPBS	Repatriation Schedule of Pharmaceutical Benefits
RHD	rheumatic heart disease
SA	South Australia
SEIFA	Socio-Economic Indexes for Areas

SIDS	sudden infant death syndrome
SUDI	sudden unexpected death in infancy
STIs	sexually transmissible infections
Tas	Tasmania
TCA	Team Care Arrangement
VET	Vocational education and training
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

Symbols

..	not applicable
<	less than
e.g.	for example
n.a.	not available
n.e.c.	not elsewhere classified
n.p.	not published because of small numbers, confidentiality, or other concerns about the quality of the data

Summary

The *Aboriginal and Torres Strait Islander Health Performance Framework 2017* report for the Australian Capital Territory finds areas of improvement and areas of concern in the health of Aboriginal and Torres Strait Islander people living in the Australian Capital Territory.

Areas of improvement for the Australian Capital Territory include:

- A significant increase in Indigenous-specific health assessments, from 34 per 1,000 in 2006–07 to 221 per 1,000 in 2015–16 (Table 3.04.3).
- The immunisation coverage rate was slightly higher for Indigenous children than for other children by age 5, 94.1% compared with 93.4% as at 31 December 2015 (Table 3.02.4).
- The gap in literacy and numeracy attainment between Indigenous and non-Indigenous Year 9 students in the Australian Capital Territory was smaller than at the national level in 2016 (tables 2.04.1, 2.04.3, 2.04.5, 2.04.7, 2.04.9).
- The proportion of Indigenous children aged 4–14 undertaking at least 60 minutes of physical activity increased from 59% in 2008 to 65% in 2014–15 (Table 2.18.3).

Areas of concern for the Australian Capital Territory include:

- Indigenous Australians had a higher age-standardised rate of hospitalisation for injury and poisoning compared with non-Indigenous Australians (29 compared with 22 per 1,000) in July 2013 to June 2015 (Table 1.03.3).
- The age-standardised rate of hospitalisation for a principal diagnosis related to alcohol use for Indigenous Australians was 3.5 times the rate for non-Indigenous Australians (7.1 compared with 2.0 per 1,000, in July 2013 to June 2015) (Table 2.16.15).
- Indigenous Australians had a lower age-standardised rate of hospitalisation where procedures were recorded, compared with non-Indigenous Australians (68% compared with 78%) in July 2013 to June 2015 (Table 3.06.1).
- The proportion of Indigenous households living in dwellings of an unacceptable standard increased over time, from 8.4% in 2008 to 17% in 2014–15 (Table 2.02.6).
- The employment rates for people aged 15–64 continued to be lower for Indigenous Australians than for non-Indigenous Australians in 2014–15 (63% compared with 77%) (Table 2.07.5).
- A higher proportion of Indigenous Australians aged 15 and over reported being a victim of physical or threatened violence (20%) compared with non-Indigenous Australians (8%) in 2014–15 (Table 2.10.25).
- The rate of Indigenous Australians aged 18 and over reporting high levels of psychological stress increased over time, from 21% in 2004–05 to 32% in 2014–15 (Table 1.18.36).
- The age-standardised rate of disability or restrictive long-term health condition was almost twice as high for Indigenous Australians as for non-Indigenous Australians, 48% compared with 26% in 2014–15 (Table 1.14.1).
- For Indigenous females, the age-standardised hospitalisation rate for self-harm was 2.6 times the rate for non-Indigenous females, 4.0 per 1,000 compared with 1.5 per 1,000 in July 2013 to June 2015 (Table 1.18.28).

Table S1: Key measures of Aboriginal and Torres Strait Islander health, national and the Australian Capital Territory

Topic	Measure	National		Australian Capital Territory	
		Indigenous ^(a)	Age-standardised gap ^(b)	Indigenous ^(a)	Age-standardised gap ^(b)
Health status and outcomes					
Low birthweight	Low birthweight live born babies per 100 live births (2014)	11.8	5.6*	n.p.	n.p.
Hospitalisations	Total hospitalisations (excluding dialysis) per 1,000 population (July 2013–June 2015)	320.9	82.9 ^(c)	232.2	62.5 ^(c)
Disease incidence and prevalence	Percentage of persons reporting circulatory disease as a long-term condition (2012–13)	12.7	3.7 ^(c)	8.8	–1.9 ^(c)
	Age-standardised percentage of persons with diabetes (2012–13)	17.9	12.8 ^(c)	n.p.	n.p.
	Age-standardised incidence of cancer per 100,000 population (2008–12)	483.9 ^(d)	44.8 ^{(c)(d)}	n.p.	n.p.
	Age-standardised rate of treated end-stage kidney disease per 100,000 population (2012–14)	58.8	52.1*	33.7 ^(e)	24.2 ^{(e)*}
Social and emotional wellbeing	Percentage of adults reporting high/very high levels of psychological distress (2012–13)	30.2	18.6 ^(c)	30.3	21.9 ^(c)
Disability	Percentage of persons with a disability or restrictive long-term health condition (2014–15)	45.1	20.1*	44.5	21.9*
Mortality	Life expectancy at birth, males (2010–12)	67.4 ^(f)	–12.4 ^{(c)(f)}	n.p.	n.p.
	Life expectancy at birth, females (2010–12)	72.3 ^(f)	–10.9 ^{(c)(f)}	n.p.	n.p.
	Age-standardised mortality per 100,000 population (2011–15)	991.7	411.7*	n.p.	n.p.
	Age-standardised mortality for avoidable and preventable deaths (0–74) per 100,000 population (2011–15)	345.2	239.8*	n.p.	n.p.
	Age-standardised mortality for circulatory diseases per 100,000 population (2011–15)	271.4	98.1 ^(c)	n.p.	n.p.
	Child 0–4 mortality per 100,000 population (2011–15)	164.9	84.8*	n.p.	n.p.
	Infant mortality per 1,000 live born infants (2011–15)	6.1	2.8*	n.p.	n.p.

(continued)

Table S1 (continued): Key measures of Aboriginal and Torres Strait Islander health, national and the Australian Capital Territory

Topic	Measure	National		Australian Capital Territory	
		Indigenous ^(a)	Age-standardised gap ^(b)	Indigenous ^(a)	Age-standardised gap ^(b)
Determinants of health					
Housing	Percentage of persons living in overcrowded households (2014–15)	20.7	15.2 ^(c)	5.2	0.5 ^(c)
Environmental tobacco smoke	Percentage of children aged 0–14 living in households with daily smokers who smoke at home indoors (2014–15)	13.3	n.a. ^(c)	7.1	n.a.
Education	Percentage of Year 7 students achieving reading benchmark (2016)	77.4	–18.2 ^(c)	90.0	–6.4 ^(c)
	Percentage of Year 7 students achieving writing benchmark (2016)	63.5	–27.8 ^(c)	71.9	–20.2 ^(c)
	Percentage of Year 7 students achieving numeracy benchmark (2016)	79.4	–17.1 ^(c)	87.3	–9.6 ^(c)
	Apparent retention rate Year 7/8 to Year 12 (2015)	59.4	–25.8 ^(c)	88.2	–8.6 ^(c)
Employment	Labour force participation rate, persons aged 15–64 (2014–15)	61.1	–16.0 ^(c)	69.2	–10.8*
	Employment rate (percentage of population employed), persons aged 15–64 (2014–15)	48.4	–24.2 ^(c)	62.9	–13.7*
	Unemployment rate, persons aged 15–64 (2014–15)	20.8	15.0 ^(c)	8.4	3.9 ^(c)
Income	Percentage of persons aged 18 and over in the bottom 20% of equivalised gross weekly household income (2014–15)	36.5	19.9 ^(c)	20.6	13.9*
Transport	Percentage of persons aged 15 and over with access to a motor vehicle (2014–15)	75.4	–9.7 ^(c)	83.8	–4.7 ^(c)
Community safety	Imprisonment per 100,000 adults (2016)	2,345.9	1,875.8 ^(c)	2,266.4	1,796.8 ^(c)
	Age-standardised hospitalisation for assault per 1,000 population (July 2013 to June 2015)	8.9	8.3 ^(c)	2.3	1.9 ^(c)

(continued)

Table S1 (continued): Key measures of Aboriginal and Torres Strait Islander health, national and the Australian Capital Territory

Topic	Measure	National		Australian Capital Territory	
		Indigenous ^(a)	Age-standardised gap ^(b)	Indigenous ^(a)	Age-standardised gap ^(b)
Health behaviours	Percentage aged 15 and over who are current smokers (2014–15)	41.9	26.5 ^(c)	39.3	25.1 ^(c)
	Percentage that reported short-term/single occasion alcohol risk, aged 18 and over (2014–15)	57.1	6.6 ^(c)	69.4	12.9 ^(c)
	Percentage of mothers who smoked during pregnancy (2014)	46.0	33.1*	n.p.	n.p.
Overweight and obesity	Percentage of persons aged 15 and over who are obese (2012–13)	37.4	14.8*	36.7	n.p.
Health system performance					
Early detection and prevention, health promotion	Percentage of mothers who attended an antenatal care session during the first trimester of pregnancy (2014)	53.9	–7.0*	n.p.	n.p.
	Percentage of 5 year olds fully vaccinated (31 December 2015)	95.1	2.0	94.1	0.7
	Age-standardised percentage of women aged 50–69 who participated in BreastScreen Australia programs (2013–14)	36.5	–17.3 ^(c)	n.p.	n.p.
	Child 0–14 health checks, per 1,000 population (2015–16)	256.1	..	186.0	..
	Adult 15–54 health assessments, per 1,000 population (2015–16)	251.9	..	224.9	..
	Adult 55+ health assessments, per 1,000 population (2015–16)	383.1	..	318.3	..
Chronic disease management/care planning	General Practice Management Plans (GPMPs), per 100 type 2 diabetes patients (May 2015)	51.2	..	52.1	..
	Team Care Arrangements (TCAs), per 100 type 2 diabetes patients (May 2015)	48.3	..	50.0	..
	MBS allied health services provided, age-standardised per 1,000 population (2015–16)	412.9	–33.8*	360.4	101.4*
Access to hospital procedures	Age-standardised percentage of hospitalisations (excluding dialysis) with a procedure recorded (July 2013 to June 2015)	61.9	–19.0 ^(c)	68.1	–10.2 ^(c)

(continued)

Table S1 (continued): Key measures of Aboriginal and Torres Strait Islander health, national and the Australian Capital Territory

Topic	Measure	National		Australian Capital Territory	
		Indigenous ^(a)	Age-standardised gap ^(b)	Indigenous ^(a)	Age-standardised gap ^(b)
Access to health services	MBS non-referred GP services claimed, age-standardised per 1,000 population (2015–16)	6,622.5	782.6	6,222.5	1,566.4*
	Age-standardised community mental health-care service contacts, per 1,000 population (2014–15)	1,155.4	829.1 ^(c)	2,603.7	1,870.9 ^(c)
	Percentage of presentations to emergency departments which were after hours (2014–15 to 2015–16)	58.7	2.7 ^(c)	n.a.	n.a.
Workforce, training and resources	People in the health workforce (per 100,000 population) (2014)	613.3	–1,567.3 ^(c)	970.7	–1,354.4 ^(c)
	Percentage of undergraduates enrolled in health-related courses who were Indigenous (2015)	1.9	..	1.9	..
	Percentage of VET students enrolled in health-related courses who were Indigenous (2015)	4.7	..	2.8	..
Expenditure	State and territory government health expenditure per person (2013–14) ^(g)	4,889.5	2,464.9 ^(c)

* Represents statistically significant differences between Indigenous and non-Indigenous data at the p<0.05 level (see Glossary).

(a) Indigenous crude rates are presented unless otherwise indicated in the measure description.

(b) Age-standardised gap is the Indigenous age-standardised rate minus the non-Indigenous age-standardised rate. Age-standardised comparisons take into account the differences in the age structure between the Indigenous and non-Indigenous populations. The age-standardised gap cannot be used to calculate the non-Indigenous rate. Age-standardisation is not appropriate for the following measures, and gaps calculated on crude rates have been presented for: low birthweight, life expectancy, housing, employment, education, motor vehicles, income, children in households with daily smokers, child health checks, emergency department presentations, health workforce, expenditure, and higher education data. The age-standardised gap is positive (+) when the Indigenous rate is higher than the non-Indigenous rate, and negative (–) when the Indigenous rate is lower than the non-Indigenous rate.

(c) The differences between Indigenous and non-Indigenous Australians were not tested for statistical significance.

(d) Data are reported for New South Wales, Victoria, Queensland, Western Australia and the Northern Territory only.

(e) Data for New South Wales also include data for the Australian Capital Territory.

(f) National life expectancy estimates presented in this table enable effective comparison with state and territory estimates. However, estimates in measure 1.19 have been calculated using a different method and enable comparison across 2 time points.

(g) 2013–14 data from the health expenditure database are not calculated for the Australian Capital Territory because estimates for the Australian Capital Territory include substantial expenditures for New South Wales residents.

Introduction

This report provides information on a range of measures of health status, determinants of health and the health system performance relating to Aboriginal and Torres Strait Islander people in the Australian Capital Territory. The report is based on the *Aboriginal and Torres Strait Islander Health Performance Framework 2017 report, detailed analyses*, the sixth in a series of reports against the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) which are published every 2 years. Analysis presented in this report includes jurisdiction-specific measures and how they compare with national measures. Detailed tables to support the analysis can be found on the AIHW website in the form of Excel tables. See <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

The HPF comprises 3 tiers:

Tier 1—Health status and outcomes. This tier covers the prevalence of health conditions (for example, circulatory disease, diabetes), human function (for example, disability), life expectancy, wellbeing and deaths. It aims to provide an overall indication of current health status and recent trends on a range of issues, including child and maternal health, chronic diseases, injury, communicable diseases, and social and emotional wellbeing.

Tier 2—Determinants of health. This tier covers determinants of health that focus on factors outside the health system that affect the health of Aboriginal and Torres Strait Islander people. This includes socioeconomic status (for example, income and education), environmental factors (for example, overcrowding), community capacity (for example, child protection), health behaviours (for example, risky alcohol consumption or dietary behaviour) and person-related factors (for example, prevalence of overweight and obesity). Such factors have been shown to have a strong association with disease and ill health.

Tier 3—Health system performance. This tier covers the performance of the health system, including population health, primary health care and secondary/tertiary care services. Six domains are covered: effectiveness of health services, responsiveness of health services to Aboriginal and Torres Strait Islander communities and individuals, accessibility of services, continuity, capability and sustainability. This tier includes measures that deal with a range of programs and service types, including child and maternal health, early detection and chronic disease management, continuous care, access to secondary/tertiary care, and the health workforce and expenditure. The safety and quality of health care is measured through the Australian Safety and Quality Framework for Health Care <<http://www.safetyandquality.gov.au>>.

The tiers and domains of the HPF and selected measures are shown in Figure 1. There are currently 68 measures that can be reported at the national level but not all can be reported for individual jurisdictions due to data availability and quality issues. Information on why these indicators were selected is in the Aboriginal and Torres Strait Islander Health Performance Framework 2017 policy report (AHMAC 2017).

Tier 1—Health status and outcomes		
Health conditions 1.01 Low birthweight 1.02 Top reasons for hospitalisation 1.03 Injury and poisoning 1.04 Respiratory disease 1.05 Circulatory disease 1.06 Acute rheumatic fever & rheumatic heart disease 1.07 High blood pressure 1.08 Cancer 1.09 Diabetes 1.10 Kidney disease 1.11 Oral health 1.12 HIV/AIDS, hepatitis and sexually transmissible infections	Human function 1.13 Community functioning 1.14 Disability 1.15 Ear health 1.16 Eye health Life expectancy and wellbeing 1.17 Perceived health status 1.18 Social and emotional wellbeing 1.19 Life expectancy at birth	Deaths 1.20 Infant and child mortality 1.21 Perinatal mortality 1.22 All causes age-standardised death rates 1.23 Leading causes of mortality 1.24 Avoidable and preventable deaths
Tier 2—Determinants of health		
Environmental factors 2.01 Housing 2.02 Access to functional housing with utilities 2.03 Environmental tobacco smoke Socioeconomic factors 2.04 Literacy and numeracy 2.05 Education outcomes for young people 2.06 Educational participation and attainment of adults 2.07 Employment 2.08 Income 2.09 Index of disadvantage	Community capacity 2.10 Community safety 2.11 Contact with the criminal justice system 2.12 Child protection 2.13 Transport 2.14 Indigenous people with access to their traditional lands	Health behaviours 2.15 Tobacco use 2.16 Risky alcohol consumption 2.17 Drug and other substance use including inhalants 2.18 Physical activity 2.19 Dietary behaviour 2.20 Breastfeeding practices 2.21 Health behaviours during pregnancy Person-related factors 2.22 Overweight and obesity
Tier 3—Health system performance		
Effective/appropriate/efficient 3.01 Antenatal care 3.02 Immunisation 3.03 Health promotion 3.04 Early detection and early treatment 3.05 Chronic disease management 3.06 Access to hospital procedures 3.07 Potentially preventable hospital admissions 3.08 Cultural competency Responsive 3.09 Discharge against medical advice 3.10 Access to mental health services 3.11 Access to alcohol and drug services 3.12 Aboriginal and Torres Strait Islander Australians in the health workforce 3.13 Competent governance	Accessible 3.14 Access to services compared with need 3.15 Access to prescription medicines 3.16 Access to after-hours primary health care Continuous 3.17 Regular GP or health service 3.18 Care planning for chronic diseases	Capable 3.19 Accreditation 3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines Sustainable 3.21 Expenditure on Aboriginal and Torres Strait Islander health compared with need 3.22 Recruitment and retention of staff

Figure 1: Aboriginal and Torres Strait Islander Health Performance Framework Measures

Demographic information

The preliminary estimated resident Aboriginal and Torres Strait Islander population in the Australian Capital Territory as at 30 June 2016 was about 7,500 people (ABS 2017), accounting for 0.9% of Australia's Indigenous population. Indigenous people represent 1.9% of the Australian Capital Territory population, which is lower than the proportion of Indigenous people in the total Australian population (3.3%) (Table 1 ACT).

Table 1 ACT: Preliminary estimated resident population by Indigenous status, Australian Capital Territory and Australia, 30 June 2016

	Indigenous		Non-Indigenous		Total			
	Number	%	Number	%	Number	%	% Indigenous	% Non-Indigenous
Australian Capital Territory	7,524	0.9	395,944	1.7	403,468	1.7	1.9	98.1
Australia^(a)	798,381	100.0	23,412,428	100.0	24,210,809	100.0	3.3	96.7

(a) Includes territories other than New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, the Northern Territory and the Australian Capital Territory.

Source: AIHW analysis of ABS preliminary population estimates based on 2016 Census.

The Aboriginal and Torres Strait Islander population has an age structure that is significantly younger than that of other Australians. For example, in the Australian Capital Territory, Aboriginal and Torres Strait Islander people aged under 15 constitute 32% of the Indigenous population, whereas this age group represents 19% of the non-Indigenous population. Conversely, people aged 65 and over comprised only 2.9% of the Indigenous population in the Australian Capital Territory, compared with 12% of the non-Indigenous population (Figure 2).

The 2016 Estimated resident population by remoteness categories was not available at the time of publication of this report. In 2011 in the Australian Capital Territory, all residents lived in *Major cities* (100%).

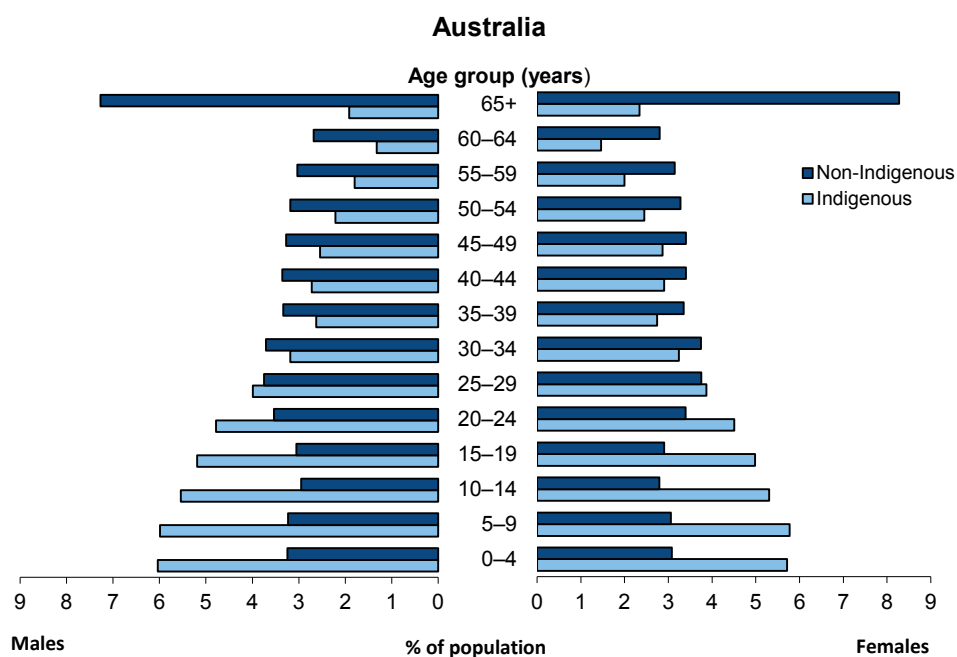
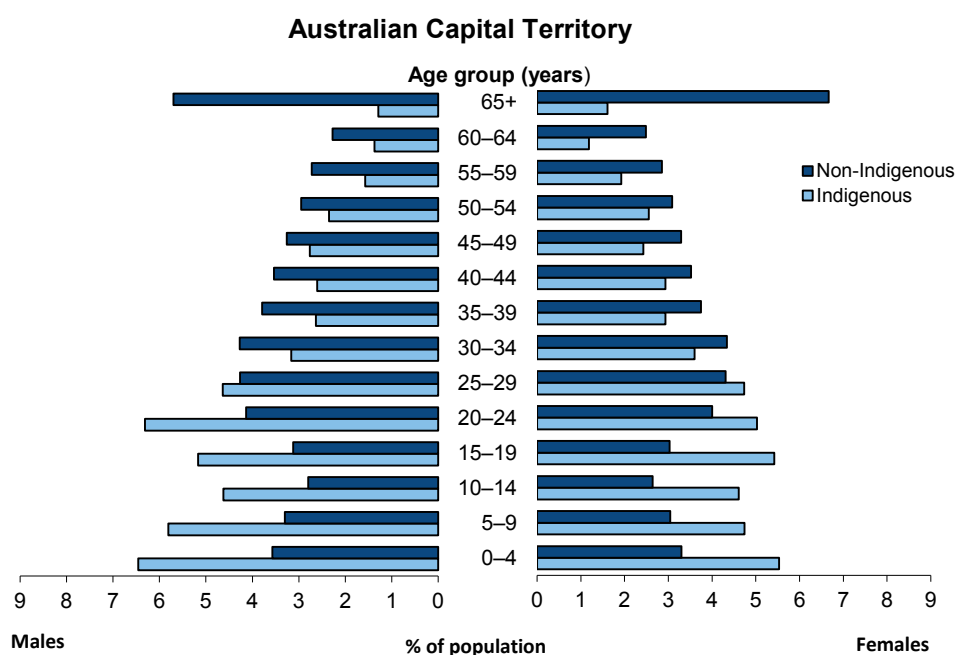
Nationally, more than three-quarters of the total Indigenous population in Australia lived in *Major cities* (34.8%), *Inner regional* (22.0%) and *Outer regional* areas (21.8%), with under one-quarter in *Remote* (7.7%) and *Very remote* (13.7%) areas (Table 2 ACT).

Table 2 ACT: Estimated resident population by remoteness area and Indigenous status, the Australian Capital Territory and Australia, 30 June 2011

	Indigenous		Non-Indigenous		Total			
	Number	%	Number	%	Number	%	% Indigenous	% Non-Indigenous
Australian Capital Territory								
Australian Capital Territory	6,160	100.0	361,825	100.0	367,985	100.0	1.7	98.3
Australia								
Major cities	233,146	34.8	15,451,394	71.3	15,684,540	70.2	1.5	98.5
Inner regional	147,683	22.0	3,963,346	18.3	4,111,029	18.4	3.6	96.4
Outer regional	146,129	21.8	1,880,300	8.7	2,026,429	9.1	7.2	92.8
Remote	51,275	7.7	263,401	1.2	314,676	1.4	16.3	83.7
Very remote	91,648	13.7	111,702	0.5	203,350	0.9	45.1	54.9
Australia	669,881	100.0	21,670,143	100.0	22,340,024	100.0	3.0	97.0

Note: All areas in the Australian Capital Territory are classified as Major city.

Source: AIHW analysis of ABS population estimates based on 2011 Census.



Note: Proportions are calculated separately for Indigenous and non-Indigenous populations. For example, males aged 0–4 years represent 6% of the Indigenous population of Australia, and just over 3% of the non-Indigenous population.

Source: AIHW analysis of ABS preliminary population estimates based on 2016 Census, Table 3 ACT.

Figure 2: Population profile, by Indigenous status, age and sex, Australian Capital Territory and Australia, 30 June 2016

Structure of this report

This report presents the most recent data available at the time of writing, which varies by data source (see Table S1 for the most recent year/period for which key statistics are reported). Analyses for each measure are presented in order of Tier 1—Health status and outcomes, Tier 2—Determinants of health, and Tier 3—Health system performance.

Detailed Excel tables to support the analyses presented in this report can be found at www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents.

Interpreting the data in this report

Data sources and limitations

Data in this report come from various administrative data sets and surveys, all of which have limitations that should be considered when interpreting the results. A brief description of the major data sources used in this report is at Appendix 1, while a more detailed description of all data sources and comments on data quality can be found at www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents. The data in this report was progressively collected and different data sources have different date ranges. The most recent data in this report is 2016.

Administrative data sources

Health-related administrative data sets used for this report include the AIHW's National Hospital Morbidity Database, the National Mortality Database, the Community Mental Health Care Database, the National Perinatal Data Collection, the Australia and New Zealand Dialysis and Transplant Registry, the National Notifiable Diseases Surveillance System, the Online Services Report data collection, and Medicare databases. Administrative data related to education include the Australian Bureau of Statistics' National Schools Statistics Collection, Department of Education and Training Higher Education Student Statistics Collection, and the National Vocational Education and Training database. Community services related data include the National Child Protection Data collections.

The main limitation in most of these administrative data collections is the under-identification of Aboriginal and Torres Strait Islander people. Under-identification is a problem in mortality, hospital morbidity, and communicable disease data, particularly in some states and territories. As a result, data analysis using these sources has been limited to jurisdictions with adequate identification of Indigenous Australians, and this has been noted in relevant measures. Time-series analyses might also be affected by changes in the quality of Indigenous identification over time.

For current hospitalisation results (July 2013 – June 2015), all states and territories are considered as having data of sufficient quality to be included in the analyses. For short-term trends (2004–05 to 2014–15), data from New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory are used.

Admission practices can differ across jurisdictions, which might affect comparisons between state and territories. Time series analyses for emergency department data might also be affected by changes in admission practices.

For both current and long-term mortality data (from 1998 onwards), New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory are considered as having adequate levels of Indigenous identification to be included in the analyses.

Data on communicable diseases from the National Notifiable Disease Surveillance System have been found to have varying levels of completeness across diseases and jurisdictions. Results for each disease include only data from those jurisdictions considered to have adequate levels of Indigenous identification for that disease. Footnotes in tables and figures specify which jurisdictions have been included in each case.

The incompleteness of Indigenous identification in many administrative data sources results in an underestimate of the true rates for Indigenous Australians.

Surveys and other non-administrative data sources

Surveys that were used to obtain data for this report include Indigenous-specific surveys, such as the Australian Aboriginal and Torres Strait Islander Health Survey, and the National Aboriginal and Torres Strait Islander Social Survey. Data from the Census of Population and Housing have also been used.

Surveys are also subject to various data limitations, due to sampling and non-sampling errors, such as bias in responses. In many tables that are referred to in this report, estimates with large relative standard errors (which is a measure of the sampling variability) contain footnotes to indicate that they should be used with caution, or are considered too unreliable for general use.

For convenience, text and tables including data from the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey and the 2011–12 Australian Health Survey (which provides a non-Indigenous comparison) are referred to as being 2012–13 data.

Methods used for analysis

Comparison population

This report focuses on the health of Aboriginal and Torres Strait Islander people and how they are faring relative to other Australians. Wherever possible, results for Indigenous Australians are compared with those for non-Indigenous Australians—that is, people who identified as not being of Aboriginal or Torres Strait Islander origin.

This is not always possible, as some data sources do not allow for the separate identification of people who identified as not being of Aboriginal and/or Torres Strait Islander origin, and people for whom no Indigenous status information was available.

For other data sources, investigation has shown that the characteristics of records with unknown Indigenous status are more similar to those specified as not Indigenous than to those specified as Indigenous. So these may be grouped with the ‘not Indigenous’ records. In these cases, results for Indigenous Australians are compared with those for ‘other Australians’, where the ‘other Australians’ group comprises non-Indigenous Australians and those of unknown Indigenous status. Text, tables and figures in this report clearly note whether ‘non-Indigenous Australians’ or ‘other Australians’ are the comparison population.

Population data

Population data are required when computing rates. The 2016 preliminary estimated resident population (ERP) is the latest available data that gives an estimate of the number of Aboriginal and Torres Strait Islander people in the population (ABS 2017). Because the 2016

ERP was released shortly before publication of this report, it was not available for use with the data. Therefore, unless otherwise noted, denominators used to calculate Indigenous Australian rates in this report are based on the ABS backcast Indigenous population estimates, and projections from the 2011 Census (ABS 2014a). Estimates of the non-Indigenous population for each year have been calculated by subtracting the Indigenous population estimates from the total Australian estimated resident population. These estimates have been used as denominators for both the 'non-Indigenous' and 'other Australian' rates.

The Census enumerated the Indigenous population from responses to a question on a person's Indigenous status. The Indigenous estimated resident population for 2011 is computed using this enumerated figure, and adjusted for under-count based on results from the Post-Enumeration Survey, as well as for non-response to the Indigenous status question (ABS 2013a).

Estimates of the Indigenous estimated resident population at June 2011, based on the 2011 Census, are about 30 per cent as high as estimates of the 2006 Indigenous estimated resident population, based on the 2006 Census. This increase involved a 21% rise in the Census count (mostly at age groups under 19 years), and an increase in the measured under-count (influenced by improved Post-Enumeration Survey questions on Indigenous status). As a result, historical rates presented in this report will be different to those presented in previous Health Performance Framework reports.

Calculating rates

This report presents both crude and age-standardised rates.

A crude rate provides information on the number of events (for example, deaths of Indigenous Australians) relative to the population 'at risk' (for example, all Indigenous Australians). No age adjustments are made when calculating such a rate.

Crude rates might not always be suitable when making comparisons across time or between groups when differences by age structure exist (for example, the Indigenous population has a much younger age structure than the non-Indigenous population). In such situations, more meaningful comparisons can be made by using age-standardised rates, which take into account differences in age structures of the populations.

For this report, the Australian estimated resident population at 30 June 2001 (based on the 2001 Census) has been used as the standard population when deriving age-standardised rates. The same population was used for males and females to enable valid comparison of age-standardised rates between the sexes.

Two methods of age-standardisation can be used: direct and indirect. Unless otherwise noted (specifically, for hospital procedures and some perinatal data), direct age-standardisation has been used in this report.

Effects of rounding

Entries in columns and rows of tables might not add to the totals shown because of rounding. Derived values (such as proportions, rates, rate ratios and rate differences) are calculated using unrounded numbers. As a result, percentages cited in the text might not add to 100, due to rounding.

Comparing rates at a point in time

Comparison of rates for Indigenous and non-Indigenous (or other) Australians has been done by calculating rate differences and rate ratios.

A 'rate difference' measures the literal, or absolute, gap between 2 population rates; in this report, it is calculated as the rate for Indigenous Australians minus the rate for non-Indigenous Australians.

A 'rate ratio' measures the relative difference between populations by taking scale into account; in this report, it is calculated as the rate for Indigenous Australians divided by the rate for non-Indigenous Australians, and is interpreted as follows:

- A rate ratio of 1 indicates there is no difference between the rates.
- A rate ratio of less than 1 indicates the rate is lower in the Indigenous population.
- A rate ratio greater than 1 indicates the rate is higher in the Indigenous population.

A large rate ratio does not necessarily imply that an event has a large absolute impact. Events that are rare in the comparative population (the non-Indigenous population in this report) can produce large rate ratios, even if the prevalence of that event in the population of interest (the Indigenous population) is relatively low.

To determine whether the Indigenous and non-Indigenous rates are significantly different from each other, 95% confidence intervals are given around the rate difference or rate ratio. If these show that the rate difference is statistically significantly different from 0, or the rate ratio is significantly different from 1, then the rates are considered to be significantly different from each other at the $p < 0.05$ level (see Glossary).

A similar method has been used in tables that present data for subgroups of the Indigenous population (for example, smokers and non-smokers) to determine whether the results for those groups are significantly different from each other.

In tables, proportions, rates, rate ratios and rate differences that are statistically different from each other at the $p < 0.05$ level are marked with an asterisk (*). Footnotes in each table specify which results are being compared. Where results of significance testing differ between rate ratios and rate differences, results should be interpreted with caution.

Comparing rates over time

In cases where at least 4 data points are available, linear regression analysis has been used to calculate annual change and overall percentage change over the period, to determine whether there have been significant changes in the observed rates. Such analysis produces more powerful results, because the regression modelling has the advantage of jointly considering the information contained in the series of rates, rather than considering each time point separately.

Analysing the series of rates as a unit imposes stability and, consequently, the confidence band around the set of predicted values is narrower than when calculated around the rates separately. Footnotes in the tables indicate when linear regression analysis was used.

Linear regression uses the least squares method to calculate a straight line that best fits the data. The 'slope' of the line is an estimate of the average annual change in the data over the period—if the slope is statistically significantly greater than 0 then the data are said to have significantly risen over the period; if less than 0, then data have significantly fallen. The annual change estimates presented in this report represent the change each year in the units presented in the table (for example, number of deaths, or rate per 1,000), rather than the average annual percentage change often presented in other publications.

In contrast to Health Performance Framework publications before the 2014 edition, the overall percentage change estimates presented in this report are calculated using the start and end points of the fitted regression line, rather than the actual start and end data points. This overcomes the problem of variation from 1 data point to the next leading to highly variable percentage and annual change estimates. As a result, the time-trend results in this report should not be compared with Health Performance Framework publications prior to 2014.

Because percentage change is the change from the starting point (of the trend line), and the values of the starting points are generally different, the estimates presented for Indigenous and non-Indigenous Australians should not be compared with each other. In contrast, annual change estimates presented for Indigenous and non-Indigenous Australians can be compared.

Both small numbers and variability in the data from year to year can make it difficult to detect significant changes over time, and can have an impact on any conclusions reached from a trend analysis. This is a particular problem when analysing trends for small populations, such as the Indigenous population in the smaller jurisdictions. Care should be taken when assessing apparent changes over time, particularly those involving small numbers and a small number of data points.

Time-series analysis of rate ratios has not been done in the 2017 Health Performance Framework, as the accuracy of this testing might be low. As rate ratios often do not rise or fall in a linear manner, applying linear regression to rate ratios might not accurately reflect the change over time.

Significance testing

Annual change and per cent change were only calculated for a series of 4 or more data points. The 95% confidence intervals (CIs) for the standard error of the slope estimate (annual change) based on linear regression are used to determine whether the apparent increases or decreases in the data are statistically significant at the $p < 0.05$ level. The formula used to calculate the CIs for the standard error of the slope estimate is:
 $95\% \text{ CI } (x) = x \pm t^*_{(n-2)} \times SE(x)$ where x is the annual change (slope estimate), $t^*_{(n-2)}$ is the 97.5th quintile of the t_{n-2} distribution. If the upper and lower 95% confidence intervals do not include zero, then it can be concluded that there is statistical evidence of an increasing or decreasing trend in the data over the study period. Significant changes are denoted with a * against the annual change statistics included in relevant tables.

Testing rate differences and rate ratios

If the 95% CIs of the difference in rates do not include zero, then it can be concluded that there is statistical evidence of a difference in rates. If the 95% CIs of the rate ratio do not include 1, then it can be concluded that there is statistical evidence of a difference in the rates contributing to the rate ratio. Tables include a * next to the rate ratio and rate difference to indicate that rates for the Indigenous and non-Indigenous populations are statistically different from each other at the $p < 0.05$ level (based on 95% CIs). Where results of significance testing differed between rate ratios and rate differences, caution should be exercised in the interpretation of the tests.

Remoteness areas

Remoteness is an important factor in understanding the health of Indigenous Australians. Remoteness areas in this report are classified using the Australian Statistical Geography Standard Remoteness Structure, based on the Accessibility/Remoteness Index of Australia,

which measures the remoteness of a point based on the physical road distance to the nearest urban centre (ABS 2013b).

The ABS classifications for remoteness have recently been subject to revision. Rates for 2011 remoteness areas are calculated using 2011 Census estimated resident populations, so should not be compared with rates calculated using estimated resident populations based on previous censuses.

Measuring the gap

Throughout this report, the term 'the gap' is used to refer to the rate difference. For trend analyses, references to the widening or narrowing of the gap refer to changes in the rate difference over time.

Reading about diagnoses and causes of death

This report presents information on hospitalisations and deaths from specific diseases and injuries. This information usually refers to hospitalisations with a principal diagnosis of a particular disease or injury, or deaths with an underlying cause of the disease or external cause of injury (see Glossary).

For ease of reading, in this report, the phrases 'hospitalisations for' or 'hospitalised due to' mean 'hospitalisations with a principal diagnosis of'. Similarly, the phrase 'deaths due to' means 'deaths with an underlying cause of'.

In death records, coding rules indicate that the event causing the injury or poisoning leading to death should be recorded as the underlying cause of death. These are referred to as 'external causes'.

For ease of reading, the phrase 'deaths due to injury and poisoning' is used in this report, to mean 'deaths with an underlying cause of an external cause of injury or poisoning'.

Data improvement activities

Jurisdictions, in liaison with the AIHW and the ABS have been actively engaged and committed to a range of activities to improve the quality of Aboriginal and Torres Strait Islander data in health data collections. These activities were funded by the Council of Australian Governments (COAG) and the Australian Government with a total budget of \$46.4 million over 4 years to June 2013 under the National Indigenous Reform Agreement. The activities cover the key data sets required for Indigenous reporting under the National Indigenous Reform Agreement, including mortality data, morbidity data, perinatal data, and population estimates.

Major data development activities done or in progress by the AIHW are described in this section. Those achieved by the ABS include:

- improvements to the Census Indigenous enumeration procedures and expansion of the Census Post-Enumeration Survey
- timing of the National Aboriginal and Torres Strait Islander Social Survey and Australian Aboriginal and Torres Strait Islander Health Survey scheduled at 6-yearly cycles to provide 3-yearly estimates for key statistics collected in both surveys
- 2011 Census records linked with death registration records to assess the level of Indigenous identification.

A variety of data improvement activities have also been done or are in progress throughout the states and territories. Further detail on these activities is available in the Health Performance Framework policy report technical appendix (AHMAC 2017).

Perinatal National Minimum Data Set

AIHW is working with the states and territories to develop an improved Perinatal National Minimum Data Set (NMDS), with improvements including the following:

- Nationally consistent data items on smoking during the first 20 weeks and after the first 20 weeks of pregnancy until the birth, were included in the Perinatal NMDS from 1 July 2010.
- A data item for the Indigenous status of the baby was added to the Perinatal NMDS from 1 July 2012.
- A data item on the estimated duration of pregnancy at the first visit for antenatal care was added to the Perinatal NMDS from 1 July 2010.
- A data item on the number of antenatal visits was included in the Perinatal NMDS from 1 July 2013.
- New voluntary data items have been added to the Perinatal Data Set Specifications (birth year), including:
 - reasons for caesarean section (2014–15)
 - maternal height and weight (2014–15)
 - diabetes, diabetes mellitus during pregnancy, and type of diabetes (2014–15)
 - hypertensive disorder during pregnancy (2014–15)
 - primary postpartum haemorrhage, blood transfusion for postpartum haemorrhage, and estimated postpartum haemorrhage blood loss (2014–15)
 - indication for induction of labour (2015–16)
 - baby head circumference (2016–17).

- The AIHW is currently consulting jurisdictions about including and developing psychosocial data items for screening during antenatal visits, which might include information about alcohol use during pregnancy, antenatal anxiety and depression, and illicit substance use in pregnancy.
- The Maternity Model of Care Data Set Specification was approved by National Health Information Standards and Statistics Committee, and added to the National Health Data Dictionary in May 2015. The AIHW has started collecting maternity models of care data from 91 registered users from participating maternity services in Australia.

Improving Indigenous identification in data sets

The AIHW released national best-practice guidelines for collecting Indigenous status in health data sets in April 2010. The AIHW provides continuing support for better Indigenous identification through its National Indigenous Data Improvement Support Centre's helpdesk, which gives advice and assistance to health providers on issues relating to collecting and recording Indigenous status. The centre also supports better Indigenous data collection, by providing resources and training materials.

The ABS continues to conduct various engagement and education activities, liaise with government departments about best practice in Indigenous data collections, and conduct data linkage programs to assess and improve Indigenous identification status.

The ABS also has in place an Indigenous Community Engagement Strategy to improve the collection and dissemination of statistics, in partnership with Aboriginal and Torres Strait Islander communities. Through the use of Indigenous Engagement Managers in ABS offices across Australia, the ABS is building relationships with communities to improve the quality and relevance of Aboriginal and Torres Strait Islander statistics.

More information on ABS key directions in Aboriginal and Torres Strait Islander statistics can be obtained in the ABS's 2012–13 annual report (ABS 2013c).

National best practice guidelines for data linkage activities relating to Aboriginal and Torres Strait Islander people

The AIHW and ABS in partnership with jurisdictions, developed national best-practice guidelines for linking data relating to Indigenous people. The guidelines for linking Indigenous data covered linkage methods and protocols, privacy protocols, quality standards, and procedures. *The National Best Practice Guidelines for Data Linkage Activities Relating to Aboriginal and Torres Strait Islander People* were released on 9 July 2012, with 2 attachments released on 14 June 2013. The attachments review the current and recent body of data linkage activities relating to Aboriginal and Torres Strait Islander people, along with a thematic listing of these activities. In describing and comparing data linkage practices to date, these documents provide an evidence base for the national data linkage guidelines.

Improving estimates of Indigenous under-identification in key data sets

The AIHW has published reports on the assessment of the quality of Indigenous identification in labour force data collections, community services data collections, the National Cancer Registry, the National Diabetes Register, the national Key Performance Indicator data collection and in hospital separations data.

Improving estimates of Indigenous mortality

The AIHW's Enhanced Mortality Database project aimed to improve information on Indigenous status on the registered deaths data set, by linking it to several additional data sources that contain information on deaths and Indigenous identification—namely admitted hospital records, perinatal records, and residential aged care data. This enables more accurate estimates of Aboriginal and Torres Strait Islander mortality and life expectancy.

The AIHW published a final report on the results of the project, *Trends in Indigenous mortality and life expectancy: evidence from the Enhanced Mortality Database, 2001–2013*, in December 2016. A permanent and ongoing AIHW data collection, the Enhanced Indigenous Mortality Data Collection, is now being established based on the Enhanced Mortality Database project method, to extend and continue this work.

Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan

Following on from the 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 a 10-year plan for the direction of Indigenous health policy and provides a long-term, evidence-based policy framework to close the gap in Indigenous disadvantage. The vision outlined in the Health Plan around health system effectiveness is that the Australian health system delivers primary health care that is evidence-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 2015). It identifies 20 goals to support the achievement of the COAG targets around 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, healthy adults and healthy ageing. A technical companion document to the Implementation Plan outlines these goals and how they will be measured (AIHW 2015a).

The second stage 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. It will also seek to increase engagement between Australian Government agencies, state, territory and local governments, the Aboriginal community-controlled health sector, the non-government sector and the corporate/private sector (DoH 2017).

Progress on achieving the Implementation Plan goals will be reported every two years in line with the release of the Aboriginal and Torres Strait Islander Health Performance Framework. The findings will be incorporated into the Department of Health's Annual Report and will inform the Prime Minister's annual Closing the Gap report. Progress on the goals will also be publicly reported on the DoH and AIHW websites from mid-2017 (DoH 2015).

Enhanced Perinatal National Minimum Data Set

The AIHW Linked Perinatal, Births, Deaths Data set Project aims to create a national, ongoing, linked perinatal, birth and death data set to obtain more accurate estimates of Indigenous infant and child mortality, and to analyse the factors affecting infant and child health outcomes in Australia. Infant and child death rates are important markers of population health.

At the national level, combined data show significant differences in infant and child death rates within Australia by factors such as Indigenous status, sociodemographics, and maternal health status. But these factors are not able to be analysed simultaneously, as they are dispersed across various data sources.

An initial data set is being created by linking unit record level data across jurisdictions from perinatal data collections, birth records, and death records. It covers all births from 2003 to 2010, and deaths within this birth cohort that occurred up to age 5.

National linkage, including all relevant births and all deaths occurring up to mid-2016 was completed in late 2016, and the resulting data are now being analysed. The first report from the project, which uses unlinked perinatal data to look at factors associated with poor birth outcomes, will be published by the AIHW in 2017.

Including Indigenous status in pathology data

The AIHW's 2013 report *The inclusion of Indigenous status on pathology request forms* (AIHW 2013) outlines work towards including Indigenous status on pathology request forms to improve Indigenous identification in national cancer, communicable disease and cervical screening registries.

Other relevant activities

Closing the Gap Clearinghouse

The AIHW in collaboration with the Australian Institute of Family Studies delivered the Closing the Gap Clearinghouse. The Clearinghouse is an online collection of research and evaluation evidence on what works to overcome Indigenous disadvantage. It focuses on 7 subject areas: early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership.

The Clearinghouse supports policymakers and service providers involved in overcoming Indigenous disadvantage, by providing access to and synthesising the evidence on particular topics. As the contract for the Clearinghouse ended in June 2014, no new material is being added, though all resources and publications already published continue to be available.

National Prisoner Health Data Collection

The National Prisoner Health Data Collection was first conducted in 2009, based on a set of indicators aligned to the National Health Performance Framework, and designed to monitor the health of prisoners. Subsequent data collections were held in 2010, 2012 and 2015.

The collection provides information on the health of people entering prison (prison entrants), health conditions managed at prison clinics, medications administered at the clinics, the health of people about to be released from prison (prison dischargees), and operations of the clinics. Major reports relating to each data collection have been released by the AIHW, supplemented by smaller bulletins focused on topics such as mental health. All of these reports include analysis of the health of Aboriginal and Torres Strait Islander prisoners.

Mapping of health services and need

The AIHW has completed a series of projects looking at the geographic distribution of health services, and mapping against potential need for these services among Aboriginal and Torres Strait Islander people.

The first project involved developing an area-based index that measures access to general practitioners (GPs), relative to the need for primary health care for both the Indigenous and non-Indigenous populations. *Access to primary health care relative to need for Indigenous Australians* (AIHW 2014a) shows that, on average, for both population groups, access to GPs and access to GPs relative to need reduces with increasing remoteness, but that the effect appears to be greater for the Indigenous population.

The 2nd project, reported in *Spatial variation in Aboriginal and Torres Strait Islander people's access to primary health care* (AIHW 2015b), aimed to identify areas with critical service gaps for the Indigenous population in relation to their access to primary health care. Areas with potential service gaps were defined as Statistical Areas Level 2 with no Indigenous-specific primary health-care service located within 1 hour's drive, and with poor access to GP services in general.

The 3rd report, *Spatial distribution of the supply of the clinical health workforce 2014: relationship to the distribution of the Indigenous population* (AIHW 2016a), uses a new measure developed by the AIHW—the Geographically-adjusted Index of Relative Supply—to look at the geographic supply of the clinical health workforce in 7 key professions with particular relevance to Indigenous Australians.

These professions were general practitioners, nurses, midwives, pharmacists, dentists, psychologists, and optometrists. Areas with lower scores under the index are more likely to face workforce supply challenges than those with higher scores.

The Geographically-adjusted Index of Relative Supply is an important resource for policy discussions on improving the supply of health services.

The 4th project is looking at the distribution of maternal and child health services in relation to the geographic distribution of Indigenous women of childbearing age and Indigenous children. The aim of this work is to find gaps and look at whether the supply of these services is associated with relevant health outcomes (for example, low birthweight, smoking during pregnancy, antenatal care use) at low geographic levels. This project is expected to be published in 2017.

Closing the Gap initiatives

With the 10th anniversary of Closing the Gap approaching in 2018, the COAG has agreed to work together, and with Indigenous Australians, to refresh the Closing the Gap agenda.

The AIHW has contributed to this work, and investigated when the Closing the Gap health initiatives are likely to have an impact on the Indigenous child mortality target. This work involved looking at the main drivers affecting the child mortality target, interventions that have been shown to be effective in reducing risk factors and child mortality, and time lags between program implementation, expected reductions in child mortality, and the availability of data to measure the outcomes that have been achieved.

The report, *Timing impact assessment for COAG Closing the Gap targets: child mortality* (AIHW 2014b), suggests that the full effect of the COAG maternal and child health initiatives might not be evident for many years.

Indigenous burden of disease

The AIHW received funding from the Department of Health and the previous Australian National Preventive Health Agency to revise and update Australia's burden of disease estimates for the total Australian population and the Aboriginal and Torres Strait Islander population.

This work, which was last updated in 2007 using 2003 data, builds on the AIHW's previous burden of disease studies and existing disease monitoring work. It aims to identify the extent and distribution of health problems in Australia, and quantify the contribution of key health risks.

Estimates of the fatal and non-fatal burden of disease for Indigenous Australians are presented in *Australian Burden of Disease Study: fatal burden of disease in Aboriginal and Torres Strait Islander people 2011* (AIHW 2016b). That report also includes estimates of the gap in disease burden between Indigenous and non-Indigenous Australians. The disease groups causing the most burden among Indigenous Australians in 2011 were mental and substance use disorders, injuries, cardiovascular diseases, cancer and respiratory diseases. Indigenous Australians experienced a burden of disease that was 2.3 times the rate of non-Indigenous Australians. More than one-third of the overall disease burden experienced by Indigenous Australians could be prevented by removing exposure to risk factors such as tobacco and alcohol use, high body mass, physical inactivity and high blood pressure.

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Tier 1—Health status and outcomes

1.01 Low birthweight

Why it is important

This measure reports on low birthweight among live born babies of Indigenous mothers. Low birthweight (newborns weighing <2,500 grams) is associated with being born early (pre-term) or being small for gestational age, which indicates possible growth restriction within the uterus. Low birthweight infants are at a greater risk of dying during their first year of life, and are prone to ill-health in childhood and the development of chronic diseases as adults, including cardiovascular disease, high blood pressure, kidney disease and type 2 diabetes (Arnold et al. 2015; Hoy & Nicol 2010; Luyckx et al. 2013; OECD 2011; Scott 2014; White et al. 2010; Zhang et al. 2013).

Key findings

In accordance with AIHW policy, proportions are not calculated when the denominator is less than 100.

Overall: Nationally, low birthweight was almost twice as common among all live born babies born to Indigenous mothers compared with those born to non-Indigenous mothers (11.8% compared with 6.2%). After excluding multiple births, the proportions were 10.5% and 4.7%, respectively (Table 1.01.1).

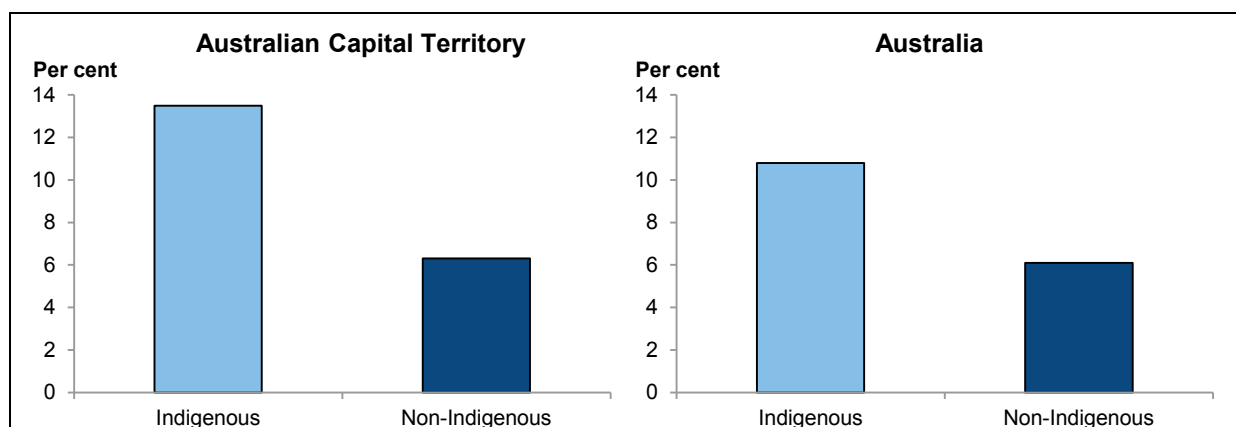
Baby's Indigenous status: In 2014 in the Australian Capital Territory, considering live born babies only, the overall low birthweight rate for Indigenous babies was 2.1 times the rate for non-Indigenous babies (13.5% compared with 6.3%). After excluding multiple births, the low birthweight rate for Indigenous singleton birth babies was 2.3 times the rate for non-Indigenous babies (10.7% compared with 4.8%).

Nationally in 2014, the overall low birthweight rate for Indigenous babies was 1.8 times the rate for non-Indigenous babies (10.8% compared with 6.1%). After excluding multiple births, the low birthweight rate for Indigenous singleton birth babies was 2.1 times the rate for non-Indigenous babies (9.6% compared with 4.6%) (Table 1.01.12, Figure 1.01.1).

Trend over time: The numbers of multiple births have increased (although rates have decreased) from 2004 to 2014. This is due to factors such as increased use of fertility treatments and delays in child bearing that result in higher proportions of older mothers (AIHW 2015c). Because of this, multiple births are often excluded from statistics that present trends in birthweight. Trend data are not available for the Australian Capital Territory due to small numbers that result in volatile results.

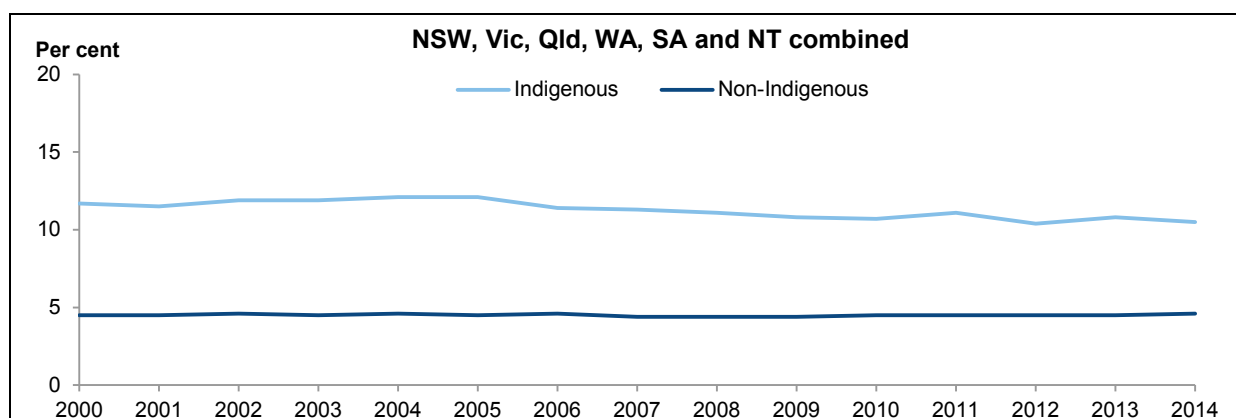
There were 6 jurisdictions that had adequate data quality to report long-term trends. In NSW, Vic, Qld, WA, SA and the NT combined, the proportion of low birthweight singleton babies born to Indigenous mothers declined by 12.6% between 2000 and 2014, from 11.7% to 10.5% (Table 1.01.3, Figure 1.01.2).

Age of Indigenous mothers: Nationally in 2014, the proportion of low birthweight singleton births was highest for Indigenous mothers in the 35 and over age group (12.5%). For non-Indigenous mothers it was highest in the under 20 age group (7.6%) (Table 1.01.7, Figure 1.01.3).



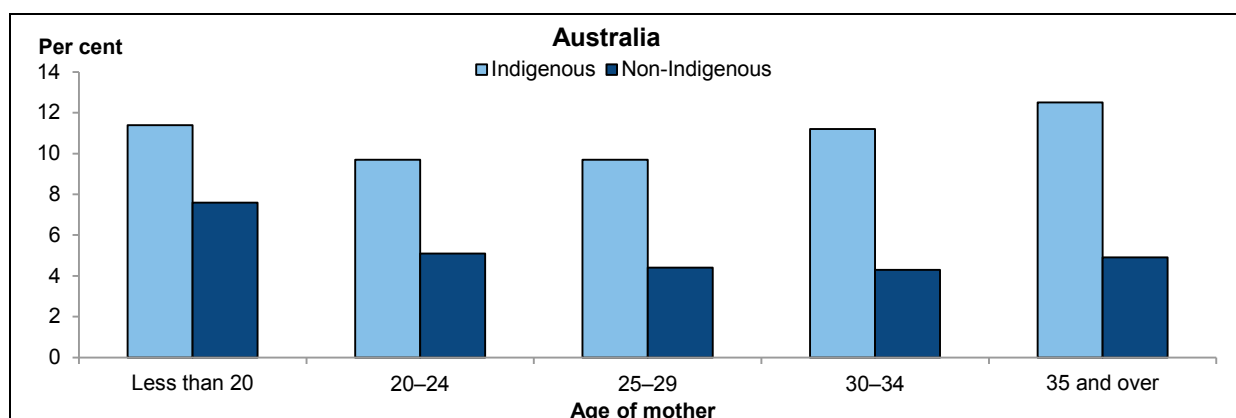
Source: Table 1.01.12.

Figure 1.01.1: Proportion of low birthweight babies, by Indigenous status of the baby, Australian Capital Territory and Australia, 2014



Source: Table 1.01.3.

Figure 1.01.2: Proportion of low birthweight babies, by Indigenous status of mother (per 100 singleton live births), NSW, Vic, Qld, WA, SA and NT combined, 2000–2014



Source: Table 1.01.7.

Figure 1.01.3: Proportion of low birthweight live born singleton babies, age of mother by Indigenous status of the mother, Australia, 2014

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.02 Top reasons for hospitalisation

Why it is important

This measure reports on the leading causes of hospitalisation. Rates indicate the occurrence in a population of serious illnesses and conditions that require hospitalisation, and use of hospitals by people with such conditions. Rates are based on the number of hospital episodes rather than the number of individual people who are hospitalised. Rates do not necessarily reflect the level of occurrence of an illness in the population (AHMAC 2017).

Key findings

Overall: The age-standardised hospitalisation rate (excluding dialysis) for Indigenous Australians in the Australian Capital Territory from July 2013 to June 2015 was 326 per 1,000. This was 1.3 times the rate for non-Indigenous Australians.

Nationally from July 2013 to June 2015, the age-standardised hospitalisation rate (excluding dialysis) for Indigenous Australians was 417 per 1,000. This was 1.2 times the rate for non-Indigenous Australians. After adjusting for Indigenous under-identification, the hospitalisation rate for Indigenous Australians was 1.3 times the rate for non-Indigenous Australians (Table 1.02.1).

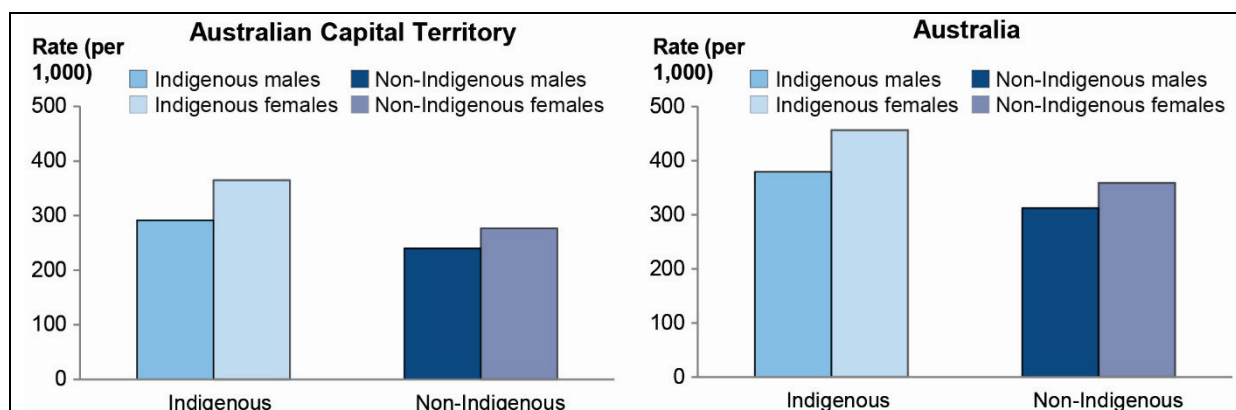
Sex: From July 2013 to June 2015, for both Indigenous and non-Indigenous Australians, the age-standardised hospitalisation rate in the Australian Capital Territory was higher for females than for males. The rate for Indigenous Australians was 365 per 1,000 for females compared with 292 per 1,000 for males. For non-Indigenous Australians the rate was 277 per 1,000 for females compared with 240 per 1,000 for males.

From July 2013 to June 2015 nationally, for both Indigenous and non-Indigenous Australians, the age-standardised hospitalisation rate was also higher for females than for males. The rate for Indigenous Australians was 457 per 1,000 for females compared with 379 per 1,000 for males. For non-Indigenous Australians the rate was 359 per 1,000 for females compared with 312 per 1,000 for males (Table 1.02.1, Figure 1.02.1).

Age group: Nationally, from July 2013 to June 2015, for all age groups under 65, the hospitalisation rate was higher for Indigenous Australians than for non-Indigenous Australians. The largest difference was for those aged 45–54, where the rate for Indigenous Australians was 1.6 times the rate for non-Indigenous Australians (Table 1.02.2).

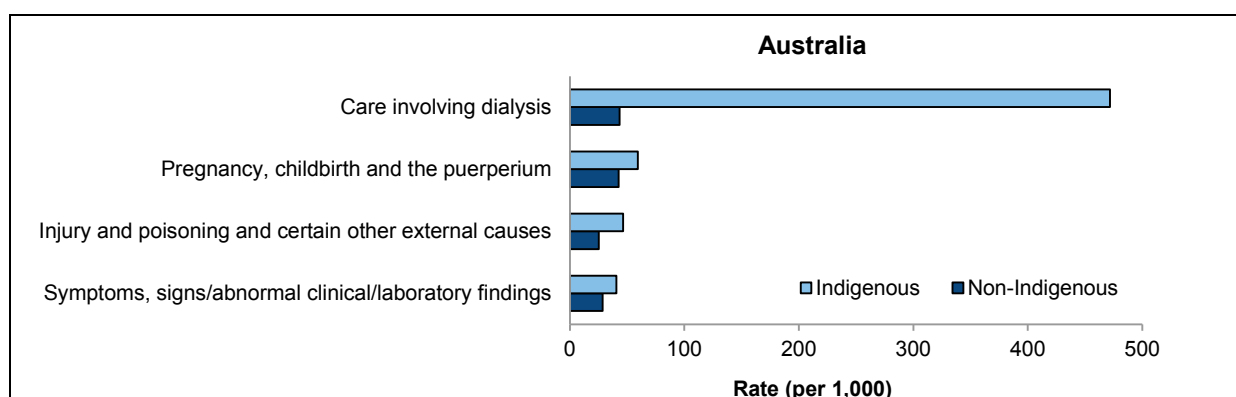
Top reasons for hospitalisation: Nationally, the age-standardised rate for care involving dialysis was the most common reason for hospitalisation for Indigenous Australians (472 per 1,000), followed by pregnancy and childbirth (59 per 1,000) and injury and poisoning (47 per 1,000) (Table 1.02.5, Figure 1.02.2).

Trend over time: For NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised rate increased from 2004–05 to 2014–15 by 37% for Indigenous Australians (from 317 to 433 per 1,000). The rate for non-Indigenous Australians increased by 14% over this time (from 294 to 339 per 1,000) (Table 1.02.4, Figure 1.02.3).



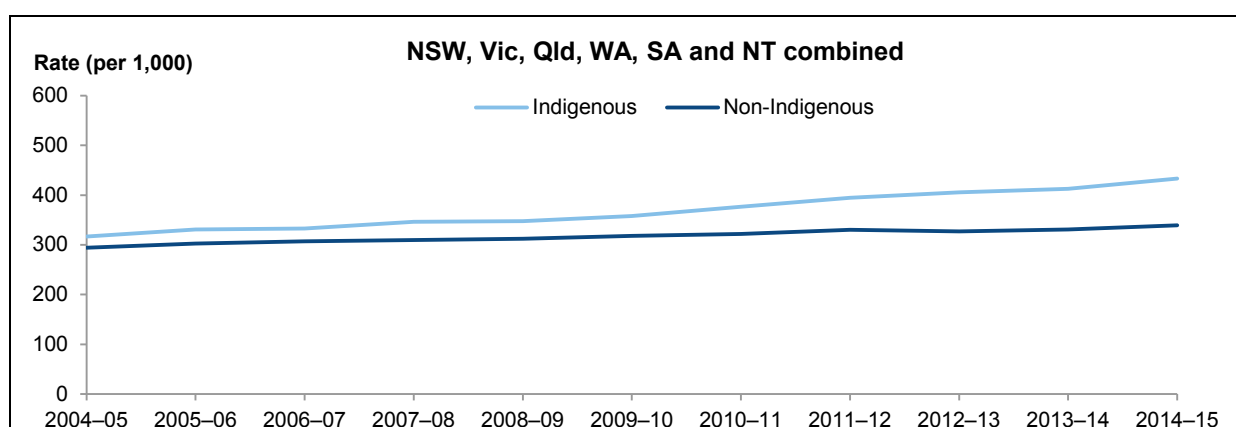
Source: Table 1.02.1.

Figure 1.02.1: Age-standardised hospitalisation rate, by sex and Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.02.5.

Figure 1.02.2: Age-standardised hospitalisation rate, by diagnosis and Indigenous status, Australia, July 2013 to June 2015



Source: Table 1.02.4.

Figure 1.02.3: Age-standardised hospitalisation rate (excluding dialysis), NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.03 Injury and poisoning

Why it is important

This measure reports on injury and poisoning. Injury and poisoning can cause long-term disability and disadvantage, including reduced opportunities for education and employment, communication impairment and burden on caregivers (Stephens et al. 2014).

Key findings

Hospitalisation: In the Australian Capital Territory between July 2013 and June 2015, the age-standardised hospitalisation rate for injury and poisoning was 29 per 1,000 for Indigenous Australians. This was 1.3 times the rate for non-Indigenous Australians (22 per 1,000).

Nationally between July 2013 and June 2015, the age-standardised hospitalisation rate for injury and poisoning was 47 per 1,000 for Indigenous Australians. This was 1.8 times the rate for non-Indigenous Australians (25 per 1,000) (Table 1.03.3, Figure 1.03.1).

Sex: In the Australian Capital Territory between July 2013 and June 2015, the age-standardised hospitalisation rate for injury and poisoning was lower for Indigenous males compared with Indigenous females (24 per 1,000 compared with 33 per 1,000). For non-Indigenous Australians, the rate for males was higher than the rate for females (24 compared with 20 per 1,000).

Nationally, for both Indigenous and non-Indigenous Australians, the hospitalisation rate for injury and poisoning was higher for males than females; 50 compared with 43 per 1,000 for Indigenous Australians and 28 compared with 22 per 1,000 for non-Indigenous Australians (Table 1.03.3).

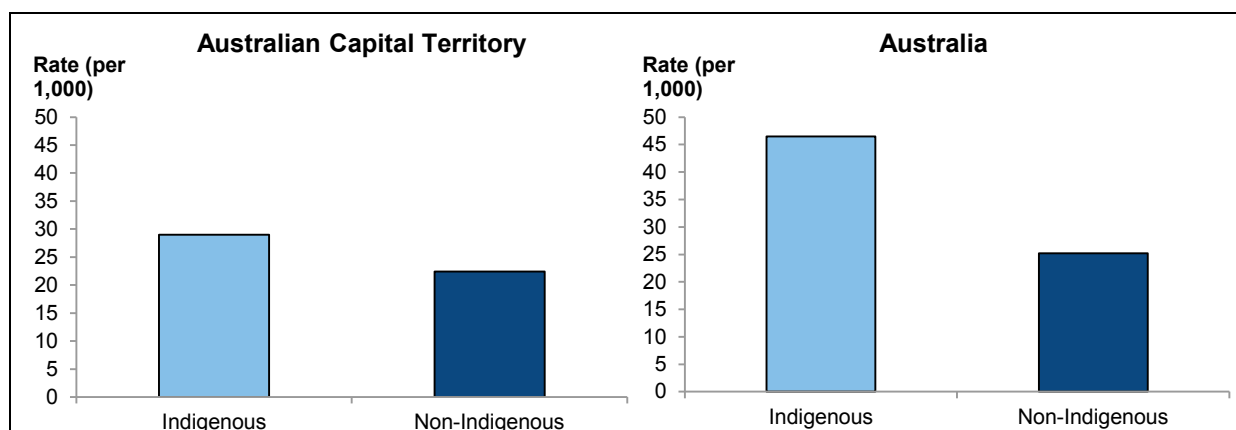
Age group: Nationally between July 2013 and June 2015, the rate of hospitalisation for injury and poisoning was highest for Indigenous Australians aged 35–44 (60 per 1,000). The highest rate for non-Indigenous Australians was for those aged 65 and over (58 per 1,000) (Table 1.03.2).

Leading cause of injury: Nationally, assault was the highest cause of injury and poisoning requiring hospitalisation for Indigenous Australians (20.1%), followed by falls (19.7%) (Table 1.03.7).

Injury in the last 4 weeks: In 2012–13 in the Australian Capital Territory, the rate for Indigenous Australians reporting an injury in the last 4 weeks was 25 per 100.

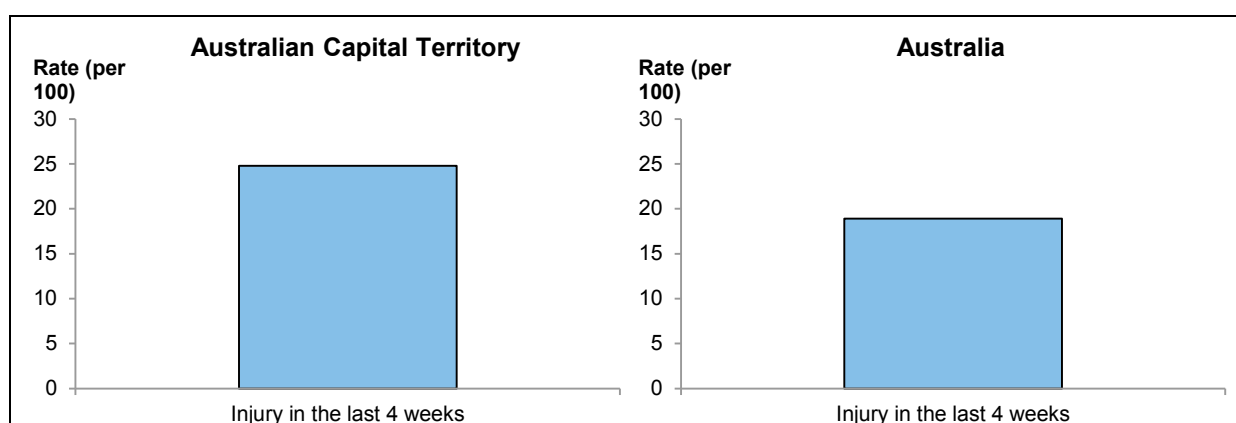
In 2012–13 nationally, the rate for Indigenous Australians reporting an injury in the last 4 weeks was 19 per 100 (Figure 1.03.2). The proportion was higher in *Non-remote* areas (20%) than in *Remote* areas (14%) (Table 1.03.10).

Trend over time: In NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised hospitalisation rate for Indigenous Australians increased by 38% (from 36 per 1,000 in 2004–05 to 48 per 1,000 in 2014–15). The gap between Indigenous and non-Indigenous Australians increased by 79% (from 14 per 1,000 in 2004–05 to 23 per 1,000 in 2014–15), a rate increase of 1.0 per 1,000 per year (Table 1.03.5, Figure 1.03.3).



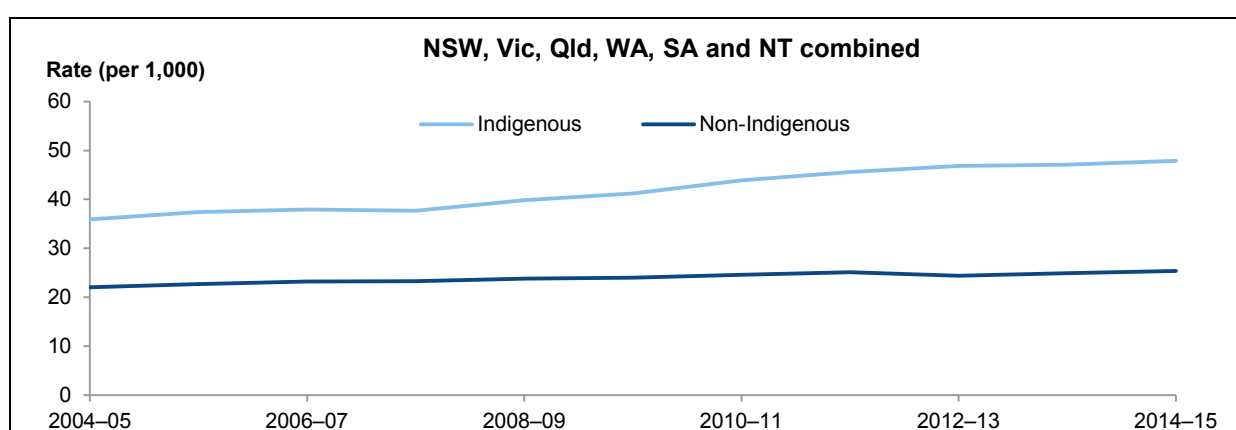
Source: Table 1.03.3.

Figure 1.03.1: Age-standardised hospitalisation rate for injury and poisoning, by Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.03.10.

Figure 1.03.2: Indigenous persons reporting an injury in the last 4 weeks, Australian Capital Territory and Australia, 2012–13



Source: Table 1.03.5.

Figure 1.03.3: Age-standardised hospitalisation rate for injury and poisoning, by Indigenous status, NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.04 Respiratory diseases

Why it is important

This measure reports on deaths, hospitalisation and prevalence of respiratory diseases. Indigenous people experience higher mortality and morbidity from respiratory diseases such as asthma, chronic obstructive pulmonary disease (COPD) (including bronchitis and emphysema), pneumonia and invasive pneumococcal disease than other Australians (AHMAC 2017).

Key findings

Overall prevalence: In 2012–13, 44% of Indigenous Australians in the Australian Capital Territory reported having a respiratory disease which had lasted or was likely to last for 6 months or more (Table 1.04.2). The age-standardised rate for Indigenous Australians was 1.5 times the rate for non-Indigenous Australians (49% compared with 32%) (Table 1.04.3, Figure 1.04.1).

Nationally in 2012–13, 31% of Indigenous Australians reported having respiratory diseases which had lasted or was likely to last 6 months or more. Higher proportions of Indigenous Australians living in *Non-remote* areas reported having respiratory diseases (35%) than those living in *Remote* areas (18%) (Table 1.04.2). The age-standardised rate for Indigenous Australians was 1.2 times the rate for non-Indigenous Australians (35% compared with 29%) (Table 1.04.3, Figure 1.04.1).

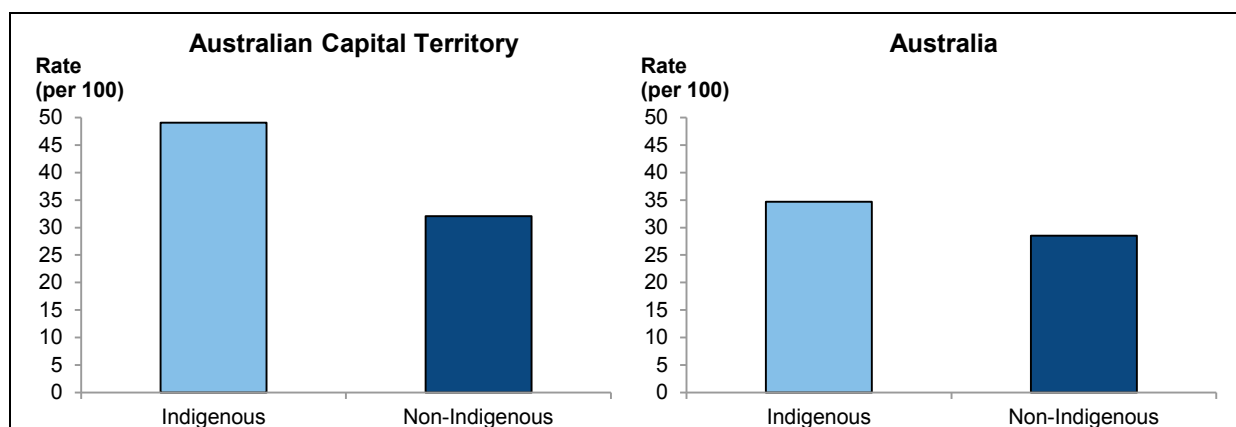
Hospitalisation: The age-standardised hospitalisation rate for Indigenous Australians for respiratory diseases between July 2013 and June 2015 in the Australian Capital Territory was 26 per 1,000. This was 1.8 times the rate for non-Indigenous Australians (14 per 1,000).

Nationally between July 2013 and June 2015, the age-standardised hospitalisation rate for Indigenous Australians for respiratory diseases was 39 per 1,000. This was 2.4 times the rate for non-Indigenous Australians, which was 17 per 1,000 (Table 1.04.7, Figure 1.04.2).

Hospitalisation by sex: Between July 2013 and June 2015 in the Australian Capital Territory, the age-standardised hospitalisation rate for respiratory diseases for Indigenous males was similar to the rate for Indigenous females (25 compared with 26 per 1,000). For non-Indigenous Australians, the rate for males was slightly higher than the rate for females (15 per 1,000 compared with 14 per 1,000).

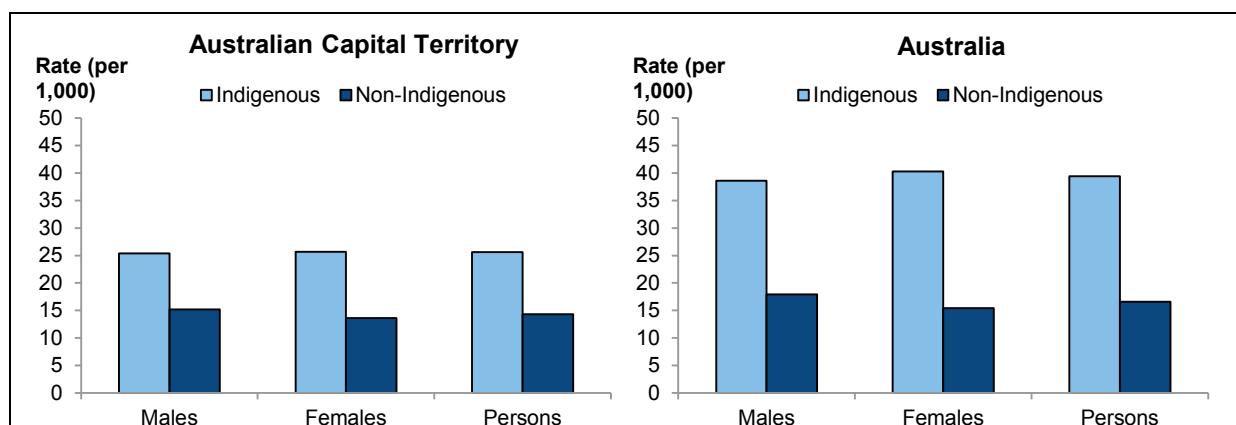
Between July 2013 and June 2015 nationally, the age-standardised hospitalisation rate for respiratory diseases for Indigenous males was lower than for Indigenous females (39 compared with 40 per 1,000). The rate for non-Indigenous males was higher than for non-Indigenous females (18 compared with 15 per 1,000) (Table 1.04.7, Figure 1.04.2).

Trend over time: In NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised hospitalisation rate for respiratory diseases for Indigenous Australians increased by 18% (from 36 per 1,000 in 2004–05 to 42 per 1,000 in 2014–15). The rate for non-Indigenous Australians increased by 8% (from 16 per 1,000 to 17 per 1,000) over the same period. The rate difference between Indigenous and non-Indigenous Australians varied between 19 per 1,000 and 25 per 1,000 during the period (Table 1.04.11, Figure 1.04.3).



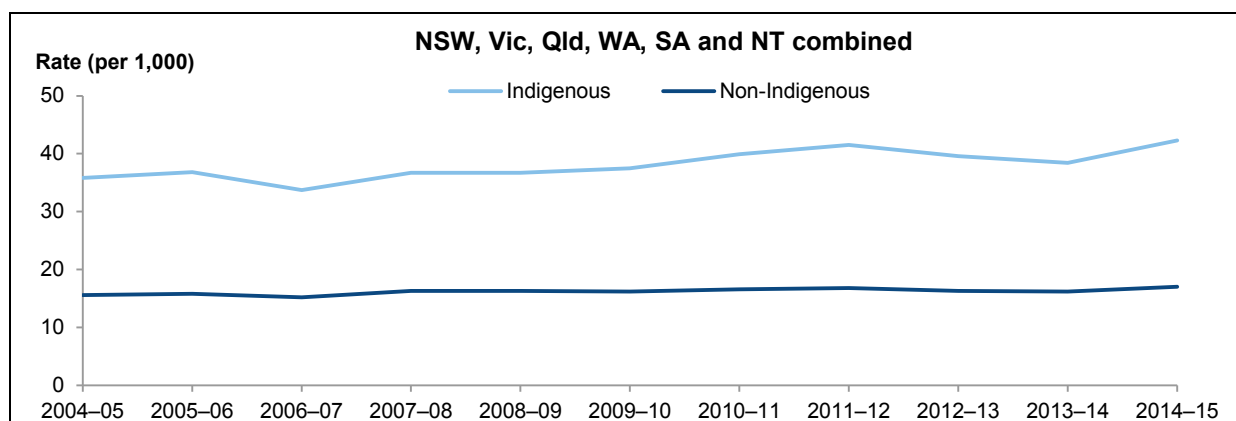
Source: Table 1.04.3.

Figure 1.04.1: Age-standardised rates for persons reporting respiratory diseases, by Indigenous status, Australian Capital Territory and Australia, 2012–13



Source: Table 1.04.7.

Figure 1.04.2: Age-standardised hospitalisation rate for respiratory diseases, by Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.04.11.

Figure 1.04.3: Age-standardised hospitalisation rate for respiratory diseases, by Indigenous status, NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.05 Circulatory diseases

Why it is important

This measure reports on prevalence, incidence, deaths and hospitalisations caused by circulatory diseases. Circulatory diseases are a major cause of morbidity and mortality for Indigenous Australians. They are more common among Indigenous than non-Indigenous Australians and tend to occur at younger ages (AIHW 2015d; Bradshaw et al. 2011; Brown 2012; Katzenellenbogen et al. 2014).

Key findings

Overall: Based on self-reported data in 2012–13 in the Australian Capital Territory, 9% of Indigenous Australians aged 2 and over had a heart or circulatory condition (Table 1.05.1). The age-standardised rate for Indigenous Australians with heart or circulatory conditions was lower than the rate for non-Indigenous Australians (16.5% compared with 18.4%) (Table 1.05.2, Figure 1.05.1).

Nationally in 2012–13, 13% of Indigenous Australians aged 2 and over had a heart or circulatory condition. The rate was significantly higher in *Remote* than *Non-remote* areas (18% compared with 11%) (Table 1.05.1). The age-standardised rate for Indigenous Australians was higher than for non-Indigenous Australians (20% compared with 16%) (Table 1.05.2, Figure 1.05.1).

Hospitalisation: In July 2013 to June 2015 in the Australian Capital Territory, the age-standardised hospitalisation rate for circulatory diseases was 2 times the rate for non-Indigenous Australians (32 per 1,000 compared with 16 per 1,000).

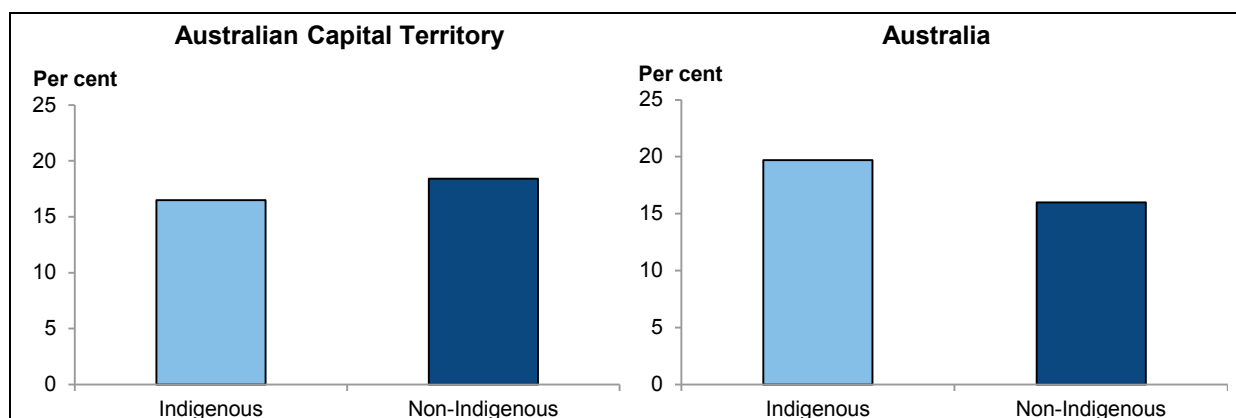
Nationally in July 2013 to June 2015, the age-standardised rate of hospitalisation for circulatory diseases for Indigenous Australians was 1.8 times the rate for non-Indigenous Australians (32 per 1,000 compared with 18 per 1,000) (Table 1.05.7, Figure 1.05.2).

Hospitalisation by sex: In July 2013 to June 2015 in the Australian Capital Territory, the age-standardised hospitalisation rate for circulatory diseases was higher for Indigenous males than for Indigenous females (34 compared with 30 per 1,000). The non-Indigenous rate was also higher for males than for females (21 compared with 13 per 1,000).

Nationally in July 2013 to June 2015, the age-standardised hospitalisation rate for circulatory diseases for Indigenous and non-Indigenous males was higher than for Indigenous and non-Indigenous females. For Indigenous Australians the rate was 35 compared with 29 per 1,000. For non-Indigenous Australians the rate was 22 compared with 14 per 1,000 (Table 1.05.7, Figure 1.05.2).

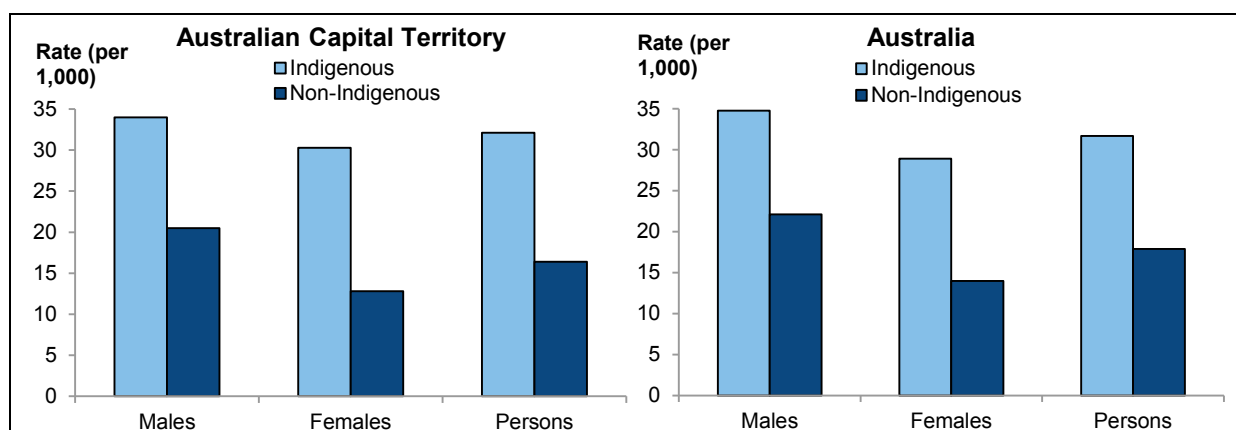
Mortality: In NSW, Qld, WA, SA and the NT combined, circulatory diseases were the leading cause of mortality. The age-standardised mortality rate was higher for Indigenous Australians than non-Indigenous Australians (271 compared with 173 per 100,000) (Table 1.23.2).

Trend over time: In NSW, Vic, Qld, WA, SA and the NT combined, there was a 17% increase in the age-standardised hospitalisation rate for Indigenous Australians for circulatory diseases (from 28 per 1,000 in 2004–05 to 33 per 1,000 in 2014–15). For non-Indigenous Australians there was a 12% decline (from 21 to 18 per 1,000) over the same time period (Table 1.05.11, Figure 1.05.3).



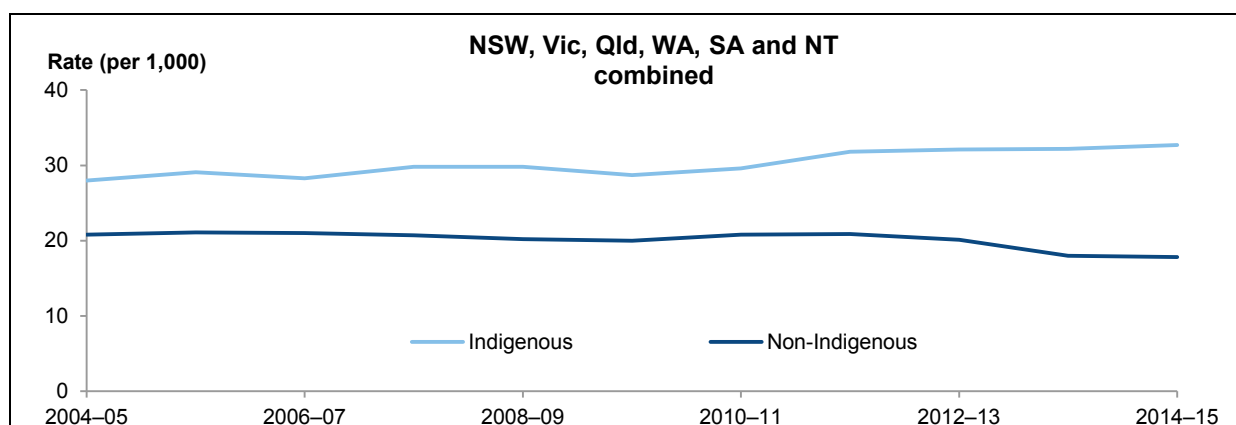
Source: Table 1.05.2.

Figure 1.05.1: Age-standardised rate (aged 2 and over) reporting heart or circulatory conditions, by Indigenous status, Australian Capital Territory and Australia, 2012–13



Source: Table 1.05.7.

Figure 1.05.2: Age-standardised hospitalisation rate for circulatory diseases, by sex and Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.05.11.

Figure 1.05.3: Age-standardised hospitalisation rate for circulatory diseases, by Indigenous status, NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.06 Acute rheumatic fever and rheumatic heart disease

Why it is important

This measure reports on the incidence and prevalence of acute rheumatic fever (ARF) and rheumatic heart disease (RHD). ARF is a disease caused by an autoimmune reaction to an infection with the bacterium group A streptococcus. ARF is a short illness, but can result in permanent damage to the heart (RHD). ARF and RHD are associated with environmental factors such as poverty and poor living conditions. ARF and RHD are now rare diseases in populations with good living conditions and easy access to quality medical care (He et al. 2016). Indigenous Australians remain at risk of ARF/RHD because of socioeconomic disadvantage and barriers to accessing health care (AHMAC 2017).

Key findings

Hospitalisation: Numbers and rates of hospitalisation from July 2013 to June 2015 for ARF or RHD are not reported for Indigenous Australians in the Australian Capital Territory due to confidentiality reasons, as the numbers are small. For non-Indigenous Australians in the Australian Capital Territory, the hospitalisation rate for ARF or RHD was 0.1 per 1,000 population.

Nationally from July 2013 to June 2015, the age-standardised hospitalisation rate for Indigenous Australians for ARF or RHD was 7 times the rate for non-Indigenous Australians, 0.7 and 0.1 per 1,000, respectively (Table 1.06.17, Figure 1.06.1).

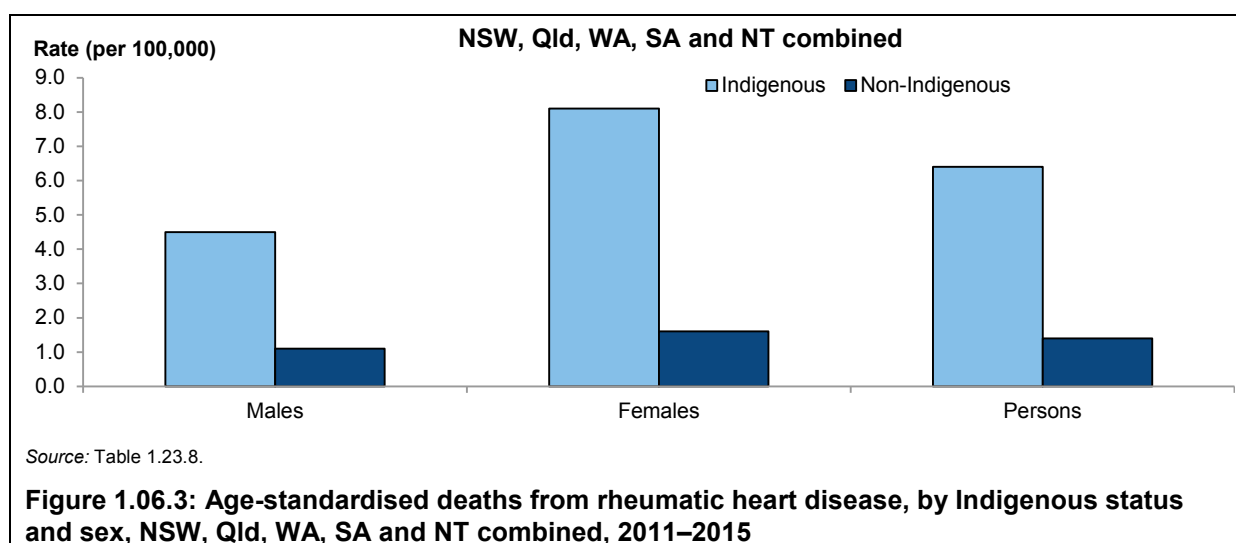
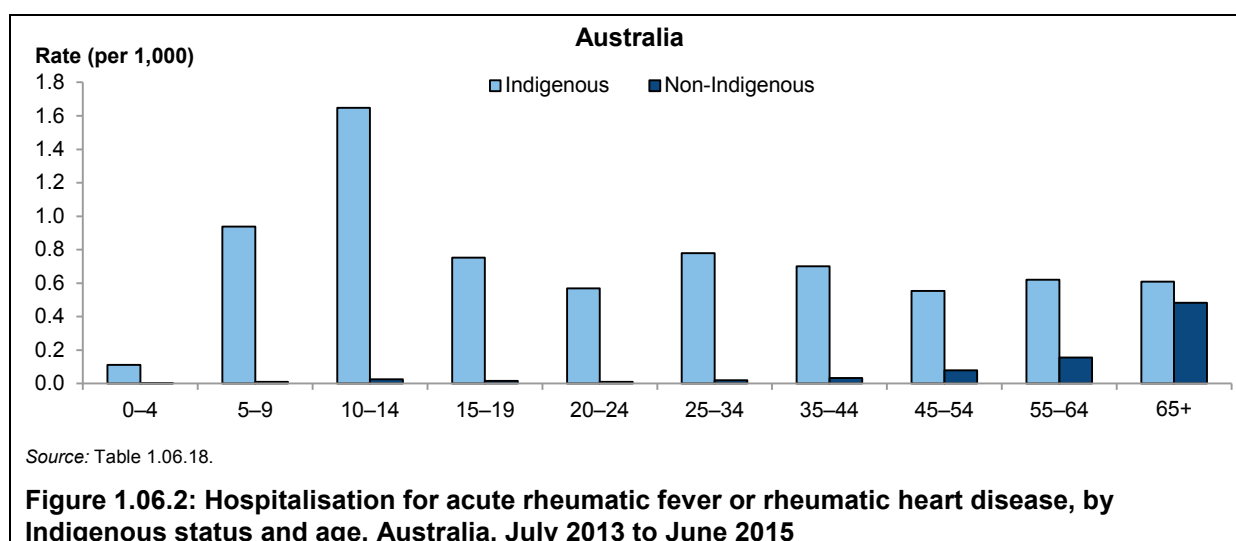
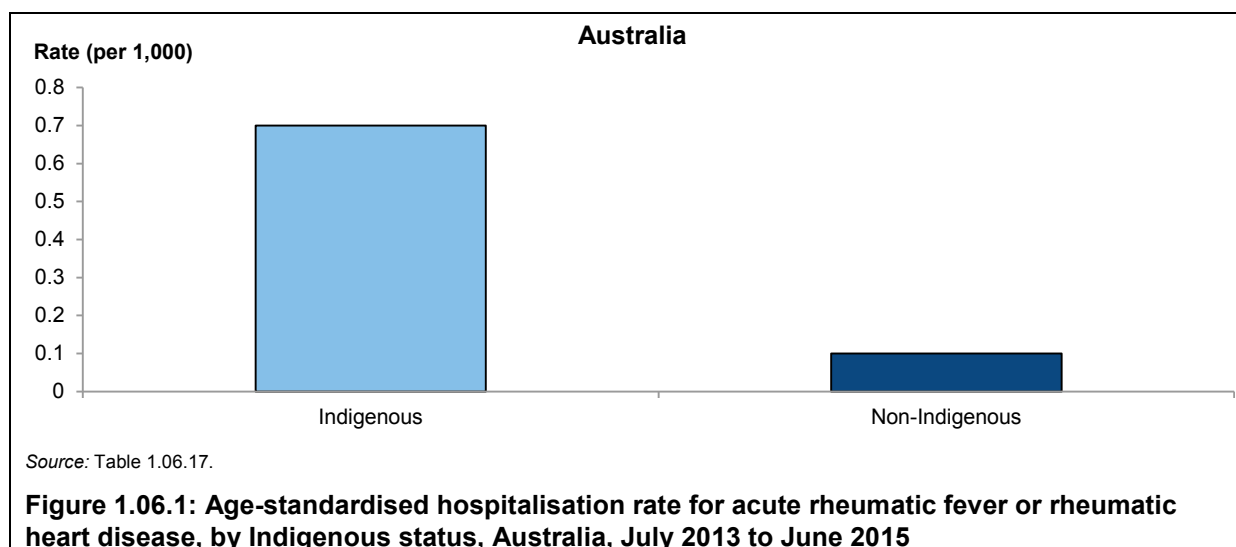
Hospitalisation by age: Numbers and rates of hospitalisation are not published by jurisdiction and age due to the small numbers involved.

Nationally, in July 2013 to June 2015, the highest proportion of hospitalisation for Indigenous Australians for ARF or RHD was for those aged 10–14, at 1.6 per 1,000. This differed for non-Indigenous Australians, where the highest hospitalisation rate was for those aged 65 and over, at 0.5 per 1,000 (Table 1.06.18, Figure 1.06.2).

Mortality: Numbers and rates of deaths due to RHD are not published for the Australian Capital Territory.

In 2011–15 in NSW, Qld, WA, SA and the NT combined, there were 108 deaths of Indigenous Australians due to RHD, which accounted for 3.4% of deaths due to circulatory diseases (Table 1.23.8). This was an age-standardised rate of 6.4 per 100,000, which was 4.7 times the rate for non-Indigenous Australians (1.4 per 100,000). The mortality rate for Indigenous males was lower than the rate for Indigenous females (4.5 per 100,000 compared with 8.1 per 100,000) (Table 1.23.8, Figure 1.06.3).

The number of deaths of Indigenous Australians due to RHD increased with age, and the majority occurred in those aged 35 and older (81%) (Table 1.23.9).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.07 High blood pressure

Why it is important

This measure reports on the prevalence (self-reported and measured) of high blood pressure (also referred to as hypertension). High blood pressure is a major risk factor for stroke, coronary heart disease, heart failure, kidney disease, deteriorating vision and peripheral vascular disease (which leads to leg ulcers and gangrene). Reducing the prevalence of high blood pressure is one of the most important means of reducing serious circulatory diseases, which are the leading cause of death among Indigenous Australians (AHMAC 2017).

Key findings

Overall: In 2012–13 in the Australian Capital Territory, based on measured and self-reported survey data, 23% of Indigenous adults had high blood pressure (Table 1.07.4). The age-standardised proportion of Indigenous adults with high blood pressure was higher than for non-Indigenous adults (34% compared with 30%) (Table 1.07.7, Figure 1.07.1).

Nationally in 2012–13, based on a combination of self-reported and measured high blood pressure, 27% of Indigenous adults had high blood pressure (Table 1.07.4). The age-standardised proportion of Indigenous Australians with high blood pressure was higher than for non-Indigenous Australians (33% compared with 29%) (Figure 1.07.1). Rates were also higher in *Remote* areas (40%) than *Non-remote* areas (31%) (Table 1.07.7).

Hospitalisation overall: In July 2013 to June 2015, Indigenous Australians in the Australian Capital Territory were hospitalised for high blood pressure at a rate 0.1 per 1,000. Due to small numbers, the age-standardised rate was not calculated for Indigenous Australians. Non-Indigenous Australians were hospitalised for high blood pressure at a rate 0.2 per 1,000.

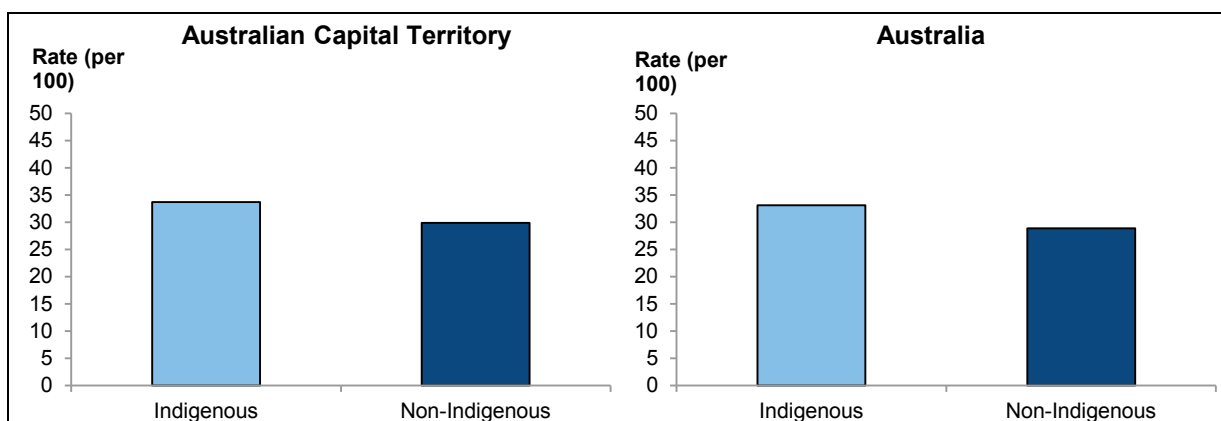
In July 2013 to June 2015 nationally, the hospitalisation rate for Indigenous Australians for high blood pressure was higher than the rate for non-Indigenous Australians (0.5 per 1,000 compared with 0.4 per 1,000) (Table 1.07.10).

Hospitalisation by sex: In the period July 2013 to June 2015 in the Australian Capital Territory, the hospitalisation rate for high blood pressure was less than 1% for both Indigenous males and females. For non-Indigenous Australians, the hospitalisation rate for high blood pressure was similar for males and females (0.2 compared with 0.3 per 1,000, respectively).

In July 2013 to June 2015 nationally, the hospitalisation rate for high blood pressure for Indigenous females was higher than the rate for Indigenous males (0.6 per 1,000 compared with 0.4 per 1,000) (Table 1.07.10, Figure 1.07.2).

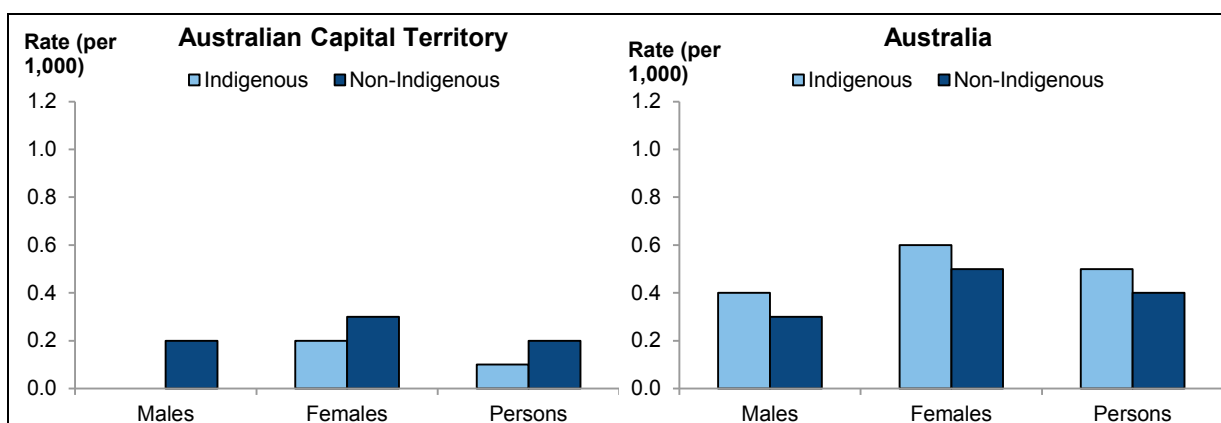
Hospitalisation by age: The hospitalisation rates for high blood pressure are not available by age group for the period July 2013 to June 2015 for the Australian Capital Territory.

For the period July 2013 to June 2015 nationally, the largest difference between Indigenous and non-Indigenous Australians hospitalised for high blood pressure was for those aged 45–54. The rate for Indigenous Australians for this age group was 4.5 times the rate for non-Indigenous Australians (1.4 per 1,000 compared with 0.3 per 1,000) (Table 1.07.9, Figure 1.07.3).



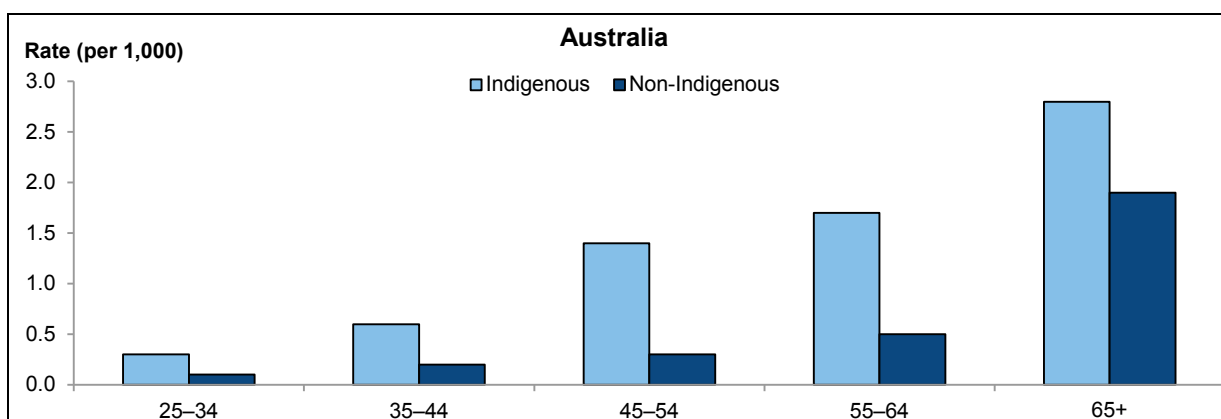
Source: Table 1.07.7.

Figure 1.07.1: Age-standardised rate for high blood pressure, aged 18 and over, by Indigenous status, Australian Capital Territory and Australia, 2012–13



Source: Table 1.07.10.

Figure 1.07.2: Hospitalisation rate for high blood pressure, by Indigenous status and sex, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.07.9.

Figure 1.07.3: Age-specific hospitalisation rate for high blood pressure, by Indigenous status, Australia, July 2013 to June 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.08 Cancer

Why it is important

This measure reports on the incidence, mortality and hospitalisations for selected cancers and all cancers combined. Indigenous Australians have higher rates of death due to cancer, and higher incidence of certain screen-detectable and many preventable cancers. They are also diagnosed at more advanced stages, and often with more complex comorbidities (Cunningham et al. 2008).

Key findings

Cancer incidence: Data on cancer incidence by Indigenous status are not available for the Australian Capital Territory for the period 2008–2012.

Over the period 2008–2012 in NSW, Vic, Qld, WA and the NT combined, the age-standardised incidence rate of cancer (based on registrations of newly diagnosed cancers) was higher for Indigenous Australians (484 per 100,000) than for non-Indigenous Australians (439 per 100,000) (Table 1.08.3).

Hospitalisation: From July 2013 to June 2015 in the Australian Capital Territory, the age-standardised hospitalisation rate for cancer was lower for Indigenous Australians than for non-Indigenous Australians (9.2 per 1,000 compared with 10 per 1,000).

From July 2013 to June 2015 nationally, the age-standardised hospitalisation rate for cancer was lower for Indigenous Australians than non-Indigenous Australians (12 per 1,000, compared with 16 per 1,000) (Table 1.08.12, Figure 1.08.1).

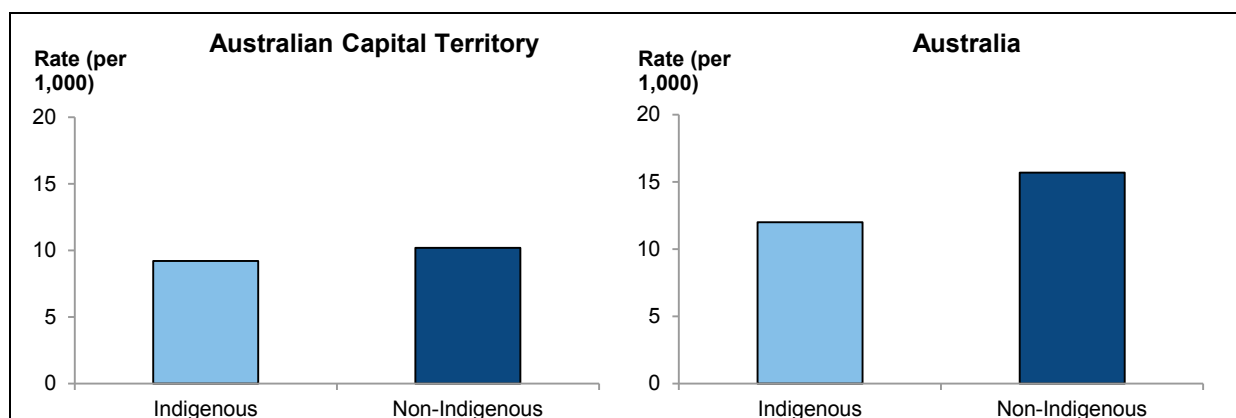
Overall: Data on cancer from Australian Aboriginal and Torres Strait Islander Health Survey 2012–13 for the Australian Capital Territory are not available for publication due to the small numbers involved.

Nationally, 0.9% of Indigenous Australians in 2012–13 reported ever being told by a doctor or nurse they have cancer, including currently having cancer and cancer in remission. The proportion in *Non-remote* areas (1%) was twice the proportion in *Remote* areas (0.5%) (Table 1.08.4).

Mortality: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised mortality rate for all cancers combined was 232 per 100,000 for Indigenous Australians, compared with 172 per 100,000 for non-Indigenous Australians (Table 1.23.2, Figure 1.08.2).

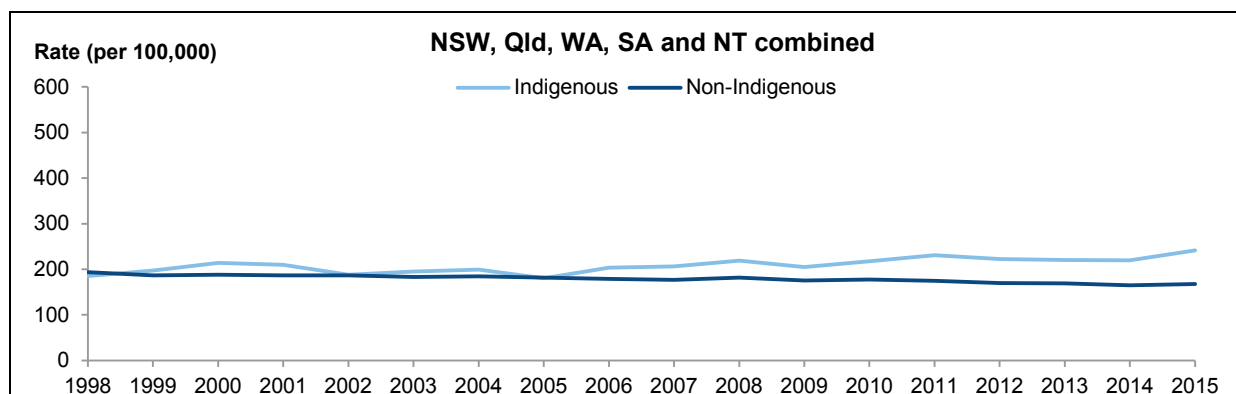
Trend over time: Trend data are not available for the Australian Capital Territory.

In NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised hospitalisation rate for cancer increased for Indigenous Australians, from 8.0 per 1,000 in 2004–05 to 13 per 1,000 in 2014–15. For non-Indigenous Australians, the rate increased from 16 per 1,000 in 2004–05 to 17 per 1,000 in 2009–10, and then decreased to 16 per 1,000 in 2014–15 (Table 1.08.15, Figure 1.08.3).



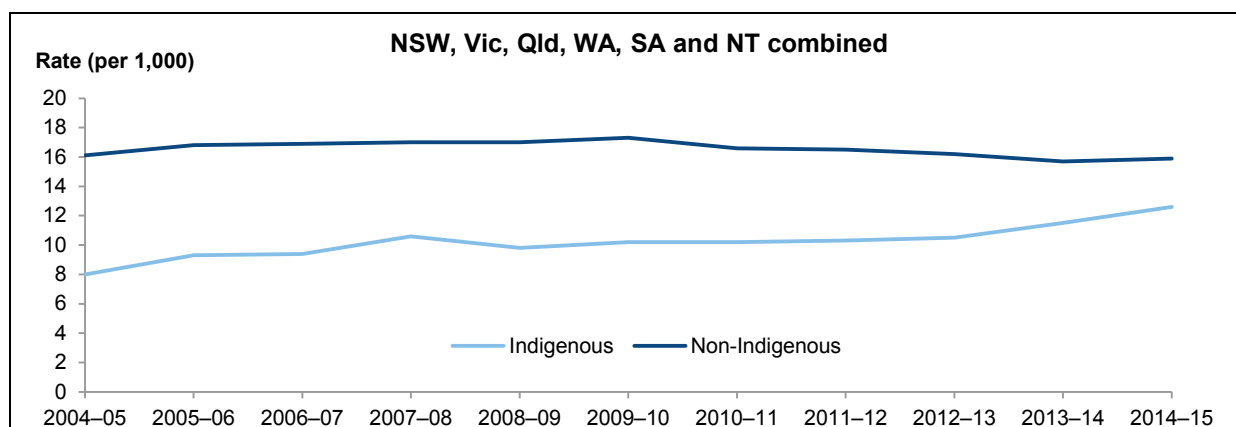
Source: Table 1.08.12.

Figure 1.08.1: Age-standardised hospitalisation rate for cancer, by Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.23.29.

Figure 1.08.2: Age-standardised mortality rate for all cancers combined, by Indigenous status, NSW, Qld, WA, SA and NT combined, 1998–2015



Source: Table 1.08.15.

Figure 1.08.3: Age-standardised hospitalisation rates for cancer by Indigenous status, NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.09 Diabetes

Why it is important

This measure reports on the prevalence of diabetes for Indigenous Australians. Diabetes is a long-term chronic condition where blood glucose levels become too high. Over time, high blood glucose levels can damage various parts of the body, especially the heart and blood vessels, eyes, kidneys and nerves. It can result in permanent disability, mental health problems, reduced quality of life and premature death (AIHW 2015d; Burrow & Ride 2016). High blood glucose levels cause complications for both the mother and baby during pregnancy. Type 2 diabetes is a significant contributor to morbidity and mortality for Indigenous Australians (AIHW 2015d).

Key findings

Overall: Data from the Australian Aboriginal and Torres Strait Islander Health Survey 2012–13 and Australian Health Survey 2011–12 are not available for the Australian Capital Territory due to the small numbers involved.

Nationally in 2012–13, the age-standardised rate for Indigenous Australians aged 18 and over who had diabetes was 18%. The prevalence of diabetes was based on biomedical results and self-reported survey information. This was 3.5 times as high as the rate for non-Indigenous Australians, which was 5.1% (Table 1.09.2).

Hospitalisation (overall): In July 2013 to June 2015 in the Australian Capital Territory, Indigenous Australians were hospitalised for diabetes at a rate of 2.2 per 1,000. Due to the small numbers involved, an age-standardised rate was not calculated for Indigenous Australians. Non-Indigenous Australians were hospitalised for diabetes at a rate of 1.1 per 1,000.

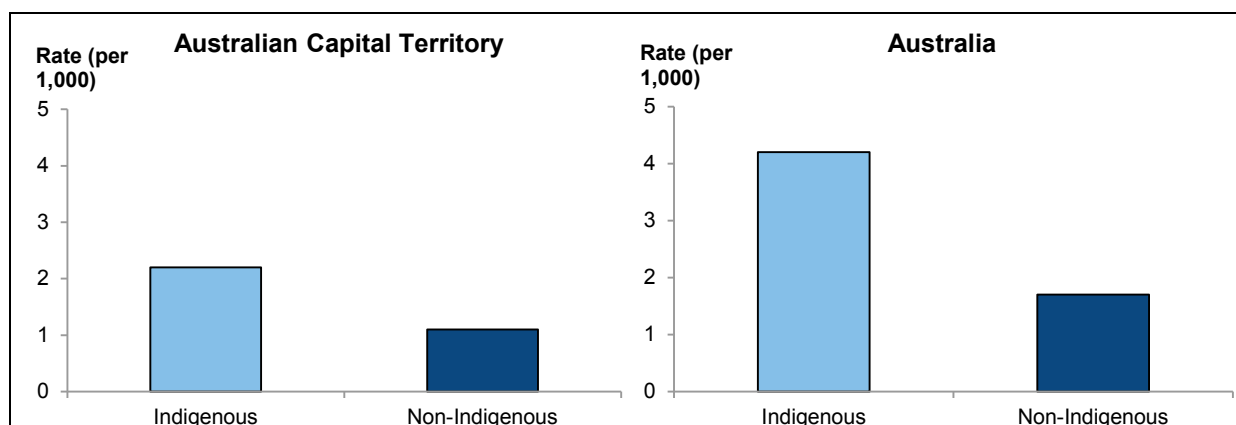
In July 2013 to June 2015 nationally, the hospitalisation rate for Indigenous Australians for diabetes was 4.2 per 1,000 compared with 1.7 per 1,000 for non-Indigenous Australians (Table 1.09.8, Figure 1.09.1).

Hospitalisation by sex: In July 2013 to June 2015 in the Australian Capital Territory, the hospitalisation rate for diabetes for Indigenous males was lower than for Indigenous females (1.4 per 1,000 compared with 3.1 per 1,000). The hospitalisation rate for non-Indigenous males was higher than for non-Indigenous females (1.3 per 1,000 compared with 0.9 per 1,000).

In July 2013 to June 2015 nationally, the hospitalisation rate for diabetes was higher for Indigenous males than for Indigenous females (4.3 per 1,000 compared with 4.1 per 1,000). The hospitalisation rate was higher for non-Indigenous males than for non-Indigenous females (2.0 compared with 1.4 per 1,000) (Table 1.09.8, Figure 1.09.2).

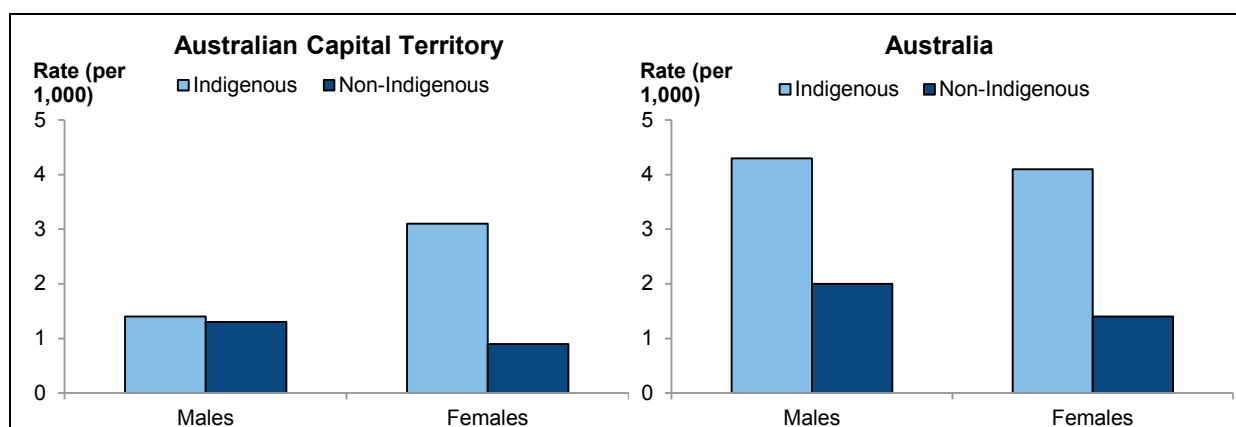
Hospitalisation by age: Due to the small numbers involved, the hospitalisation rates for diabetes by age group are not reported for the Australian Capital Territory.

Nationally in July 2013 to June 2015, the hospitalisation rate for total Indigenous Australians increased with age (from 0.2 per 1,000 in those aged 0–4 to 18 per 1,000 in those aged 65 and over). The hospitalisation rate also increased with age for non-Indigenous Australians (from 0.3 per 1,000 in those aged 0–4 to 5 per 1,000 for those aged 65 and over) (Table 1.09.7, Figure 1.09.3).



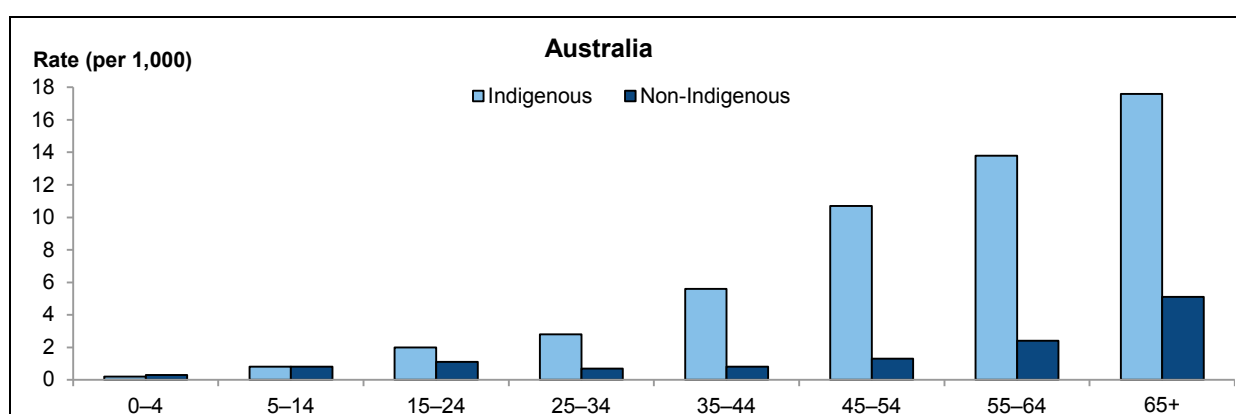
Source: Table 1.09.8.

Figure 1.09.1: Hospitalisation for diabetes, by Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.09.8.

Figure 1.09.2: Hospitalisation for diabetes, by Indigenous status and sex, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.09.7.

Figure 1.09.3: Age-specific hospitalisation for diabetes, by Indigenous status and age group, Australia, July 2013 to June 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.10 Kidney disease

Why it is important

This measure reports on prevalence, deaths and hospitalisation for chronic kidney disease, and incidence of treated end-stage kidney disease. Kidney disease can be a disease in its own right, or can be caused by the kidneys being permanently damaged by various acute illnesses or by progressive damage from other chronic conditions (AIHW 2011). If the kidneys cease functioning, this can cause death unless the person has regular dialysis or a new kidney is provided by transplant (AHMAC 2017).

Key findings

Overall: Nationally in 2011–13, the age-standardised rate of Indigenous Australians aged 18 and over with chronic kidney disease was 22%, based on biomedical results. This was twice the proportion for non-Indigenous Australians (10%) (Table 1.10.1, Figure 1.10.1).

Hospitalisation: In July 2013 to June 2015 in the Australian Capital Territory, the hospitalisation rate for Indigenous Australians for chronic kidney disease (excluding dialysis) was 1.0 per 1,000. Due to the small numbers involved, the age-standardised rate was not calculated for Indigenous Australians. The rate for non-Indigenous Australians with chronic kidney disease was 0.9 per 1,000.

Nationally in July 2013 to June 2015, the hospitalisation rate for Indigenous Australians for chronic kidney disease (excluding dialysis) was 4.1 per 1,000 compared with 1.7 per 1,000 for non-Indigenous Australians (Table 1.10.7, Figure 1.10.2).

Hospitalisation by sex: In July 2013 to June 2015 in the Australian Capital Territory, the hospitalisation rate for chronic kidney disease (excluding dialysis) for Indigenous males was higher than for Indigenous females (1.2 per 1,000 compared with 0.9 per 1,000). The hospitalisation rate was lower for non-Indigenous males than females (0.8 per 1,000 compared with 1.0 per 1,000).

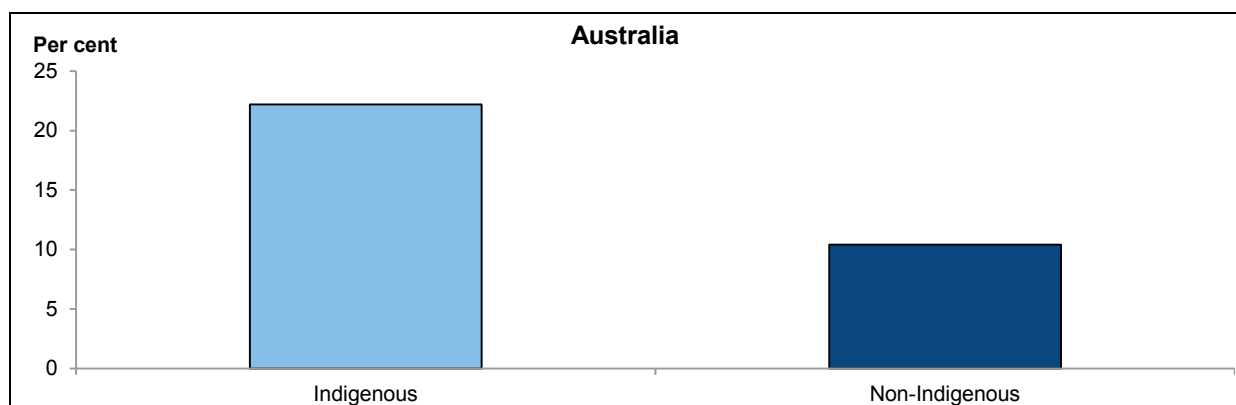
Nationally in July 2013 to June 2015, the hospitalisation rate for chronic kidney disease was lower for Indigenous males than for Indigenous females (2.8 per 1,000 compared with 5.3 per 1,000). The rate was similar for non-Indigenous males and females (1.7 per 1,000 compared with 1.6 per 1,000) (Table 1.10.7, Figure 1.10.2).

End-stage kidney disease: The incidence of end-stage kidney disease in 2012–2014 is not available for the Australian Capital Territory as an individual jurisdiction, but are combined with New South Wales data.

Nationally, in 2012–2014, the age-standardised incidence rate of treated ESKD for Indigenous Australians was 8.7 times the rate for non-Indigenous Australians (59 compared with 6.8 per 100,000). The rate for Indigenous females was 13 times higher than for non-Indigenous females (64 compared with 5 per 100,000). The rate for Indigenous males was 6.3 times the rate for non-Indigenous males (53 compared with 8.4 per 100,000) (Table 1.10.11).

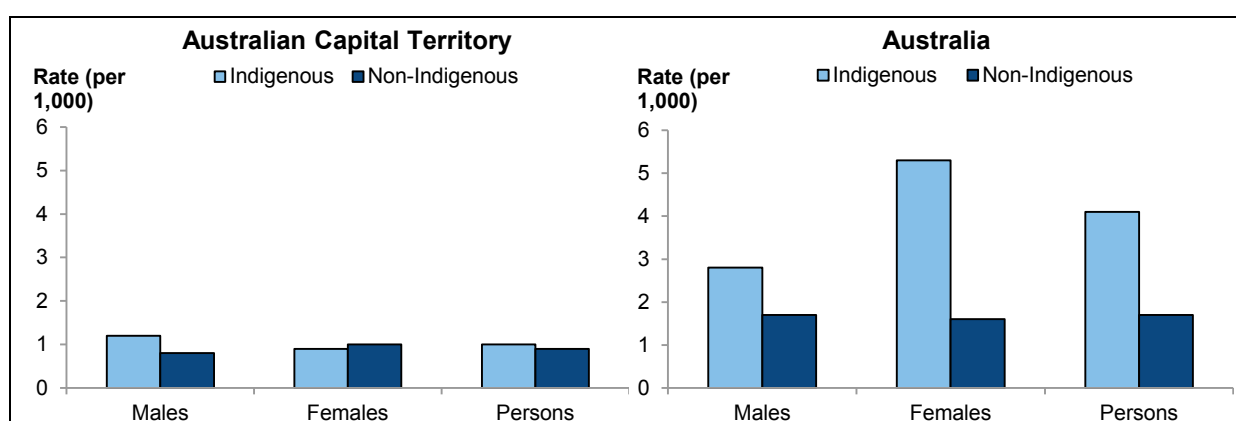
Trend over time: Trend data on ESKD are not available for the Australian Capital Territory due to the small numbers involved.

Nationally, the incidence rate of treated ESKD for Indigenous Australians increased by 39% between 1996 and 2014, from 22 per 100,000 to 36 per 100,000 (Table 1.10.15, Figure 1.10.3).



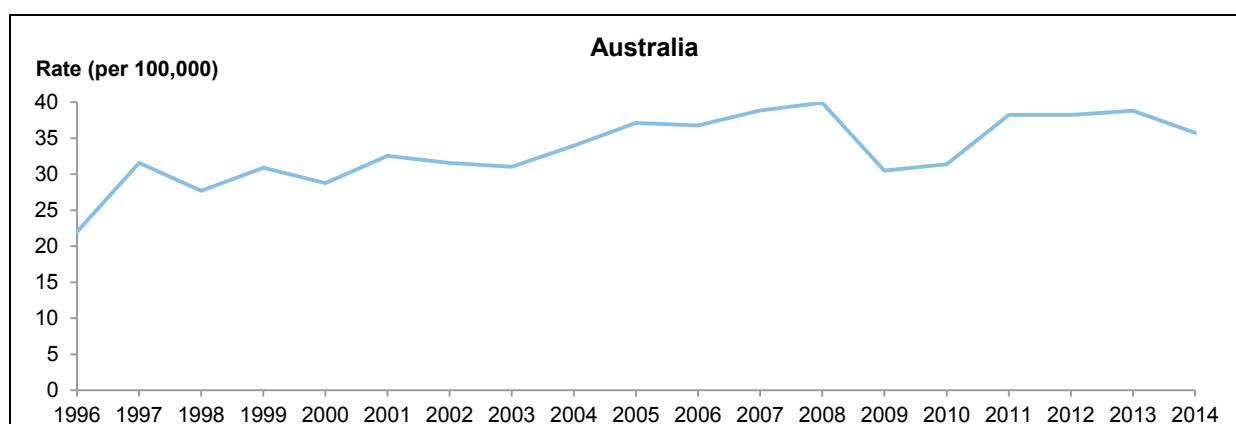
Source: Table 1.10.1.

Figure 1.10.1: Age-standardised rate (18 years and over) with chronic kidney disease, by Indigenous status, Australia, 2011–13



Source: Table 1.10.7.

Figure 1.10.2: Hospitalisation rate for chronic kidney disease (excluding dialysis), by sex and Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.10.15.

Figure 1.10.3: Incidence (crude rate) of end-stage kidney disease for Indigenous Australians, Australia, 1996–2014

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.11 Oral health

Why it is important

This measure reports on teeth and gum problems, and hospitalisations for dental problems. The 2 most common oral diseases are tooth decay and gum disease. If left untreated, these can cause discomfort and tooth loss, affecting a person's ability to eat, speak and socialise (Williams et al. 2011). Oral diseases can exacerbate other chronic diseases (Jamieson et al. 2010) and are associated with cardiovascular diseases, diabetes, stroke and pre-term low birthweight (Roberts-Thomson et al. 2008; Williams et al. 2011).

Key findings

Overall: Due to small numbers, data for children with teeth or gum problems in the Australian Capital Territory were combined with data for children in Tasmania. Of those children surveyed in 2014–15, 35% reported teeth or gum problems. Compared with 2008, there has been a decrease in teeth or gum problems (from 37%).

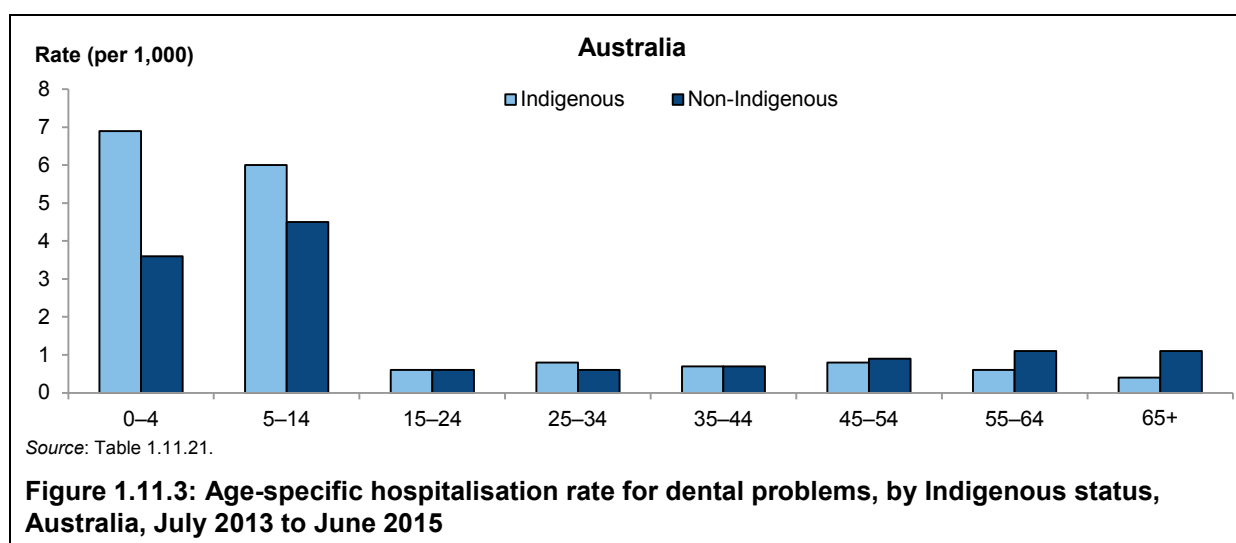
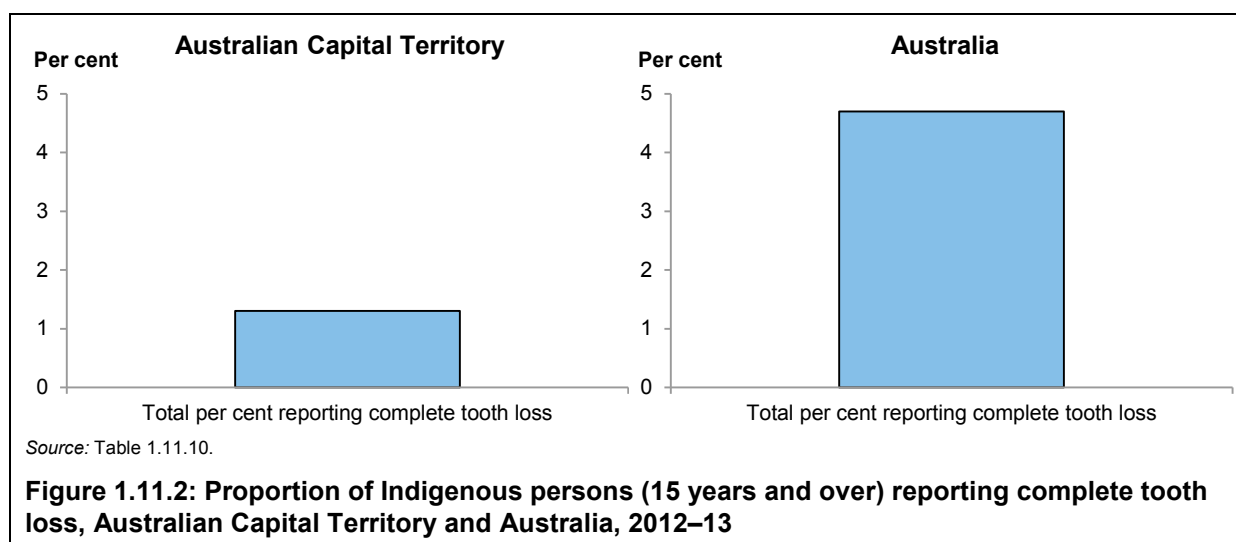
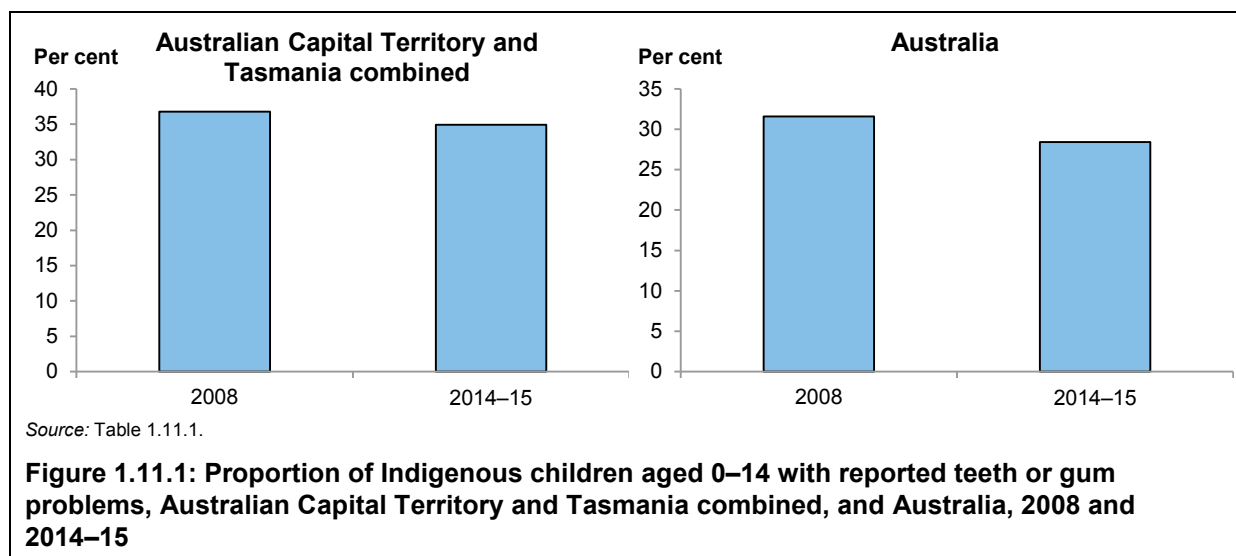
Nationally, 28% of Indigenous children aged 0–14 who were surveyed in 2014–15 reported teeth or gum problems. Compared with 2008, there has been a decrease in teeth or gum problems (from 32%) (Table 1.11.1, Figure 1.11.1). The proportions who had teeth or gum problems increased with age (from 11% for ages 0–4 to 39% for ages 10–14) (Table 1.11.4).

Tooth loss: In 2012–13 in the Australian Capital Territory, an estimated 1.3% of Indigenous Australians aged 15 and over reported having complete tooth loss (note that wisdom teeth are excluded from this category). However, this estimate was subject to a high relative standard error and should be used with caution.

Nationally in 2012–13, 4.7% of Indigenous Australians aged 15 and over reported having complete tooth loss (note that wisdom teeth are excluded from this category). The proportion was higher in *Non-remote* areas (5.1%) than in *Remote* areas (3.3%) (Table 1.11.10, Figure 1.11.2).

Hospitalisation (overall): Nationally, in July 2013 to June 2015, the age-standardised hospitalisation rate for dental problems for Indigenous Australians was 1.2 times the rate for non-Indigenous Australians (1.8 per 1,000 compared with 1.5 per 1,000) (Table 1.11.21).

Hospitalisation by age: Nationally, in July 2013 to June 2015, the age-standardised hospitalisation rate for dental problems for Indigenous Australians was highest for those aged 0–4 (6.9 per 1,000). This was almost double the rate for non-Indigenous children of the same age (3.6 per 1,000). From age 5, the hospitalisation rate was slightly higher or similar for Indigenous Australians than for non-Indigenous Australians until the 45–54 age group. From then non-Indigenous rate became higher (Table 1.11.21, Figure 1.11.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.12 HIV/AIDS, hepatitis and sexually transmissible infections

Why it is important

This measure reports on the rates of hepatitis B and C, HIV and some bacterial sexually transmissible infections. The bacterial sexually transmissible infections included are notified cases of chlamydia, gonorrhoea and non-congenital syphilis. These infections can have potentially serious consequences if left untreated. Hepatitis causes serious illness and can also progress to cirrhosis of the liver, cancer and premature death (ASHA 2016). Sexually transmissible infections can have serious long-term consequences (Bowden et al. 2002). Several of these infections can cause miscarriage (Campbell et al. 2011).

Key findings

Non-congenital syphilis: In 2013–2015 in the Australian Capital Territory, the number and rate of notifications for non-congenital syphilis are not reported for Indigenous Australians due to the small numbers involved. There were 80 notifications of non-congenital syphilis for other Australians, a rate of 7 per 100,000 (Table 1.12.1).

In 2013–2015 nationally, the age-standardised notification rate for non-congenital syphilis for Indigenous Australians was 4.6 times the rate for other Australians (72 compared with 15 per 100,000). The notification rate for non-congenital syphilis for Indigenous females was 16 times the rate for other females. The notification rate for non-congenital syphilis for Indigenous males was 2.9 times the rate for other males (Table 1.12.1, Figure 1.12.1).

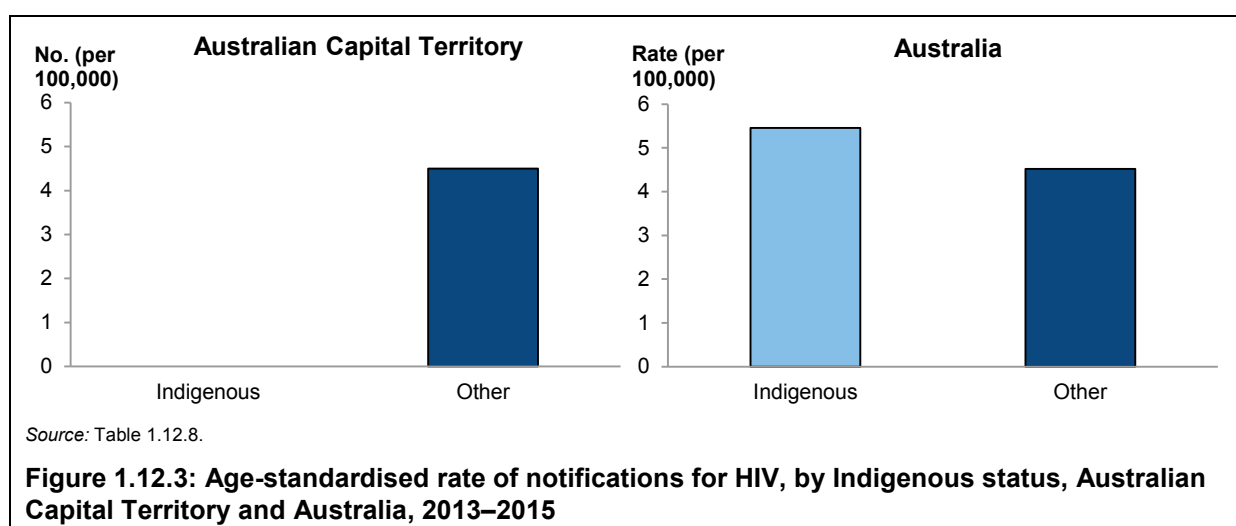
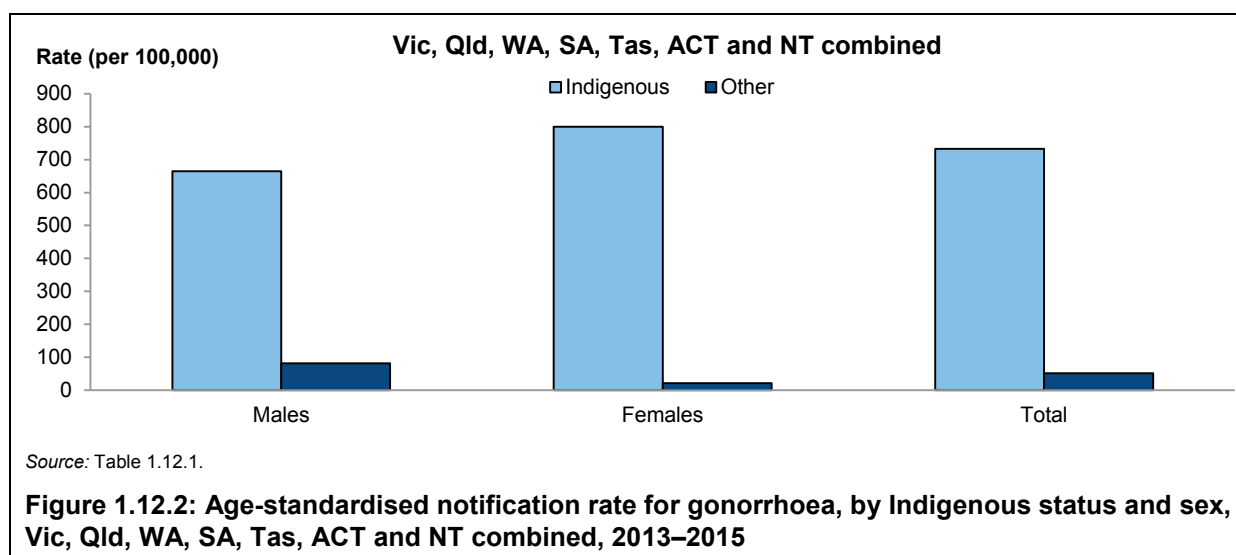
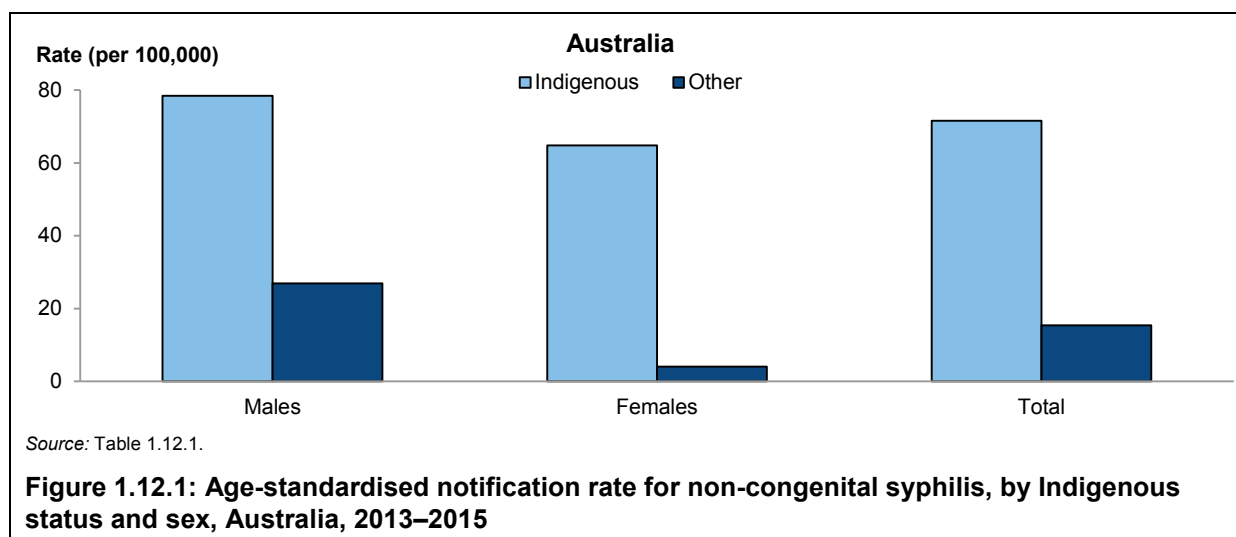
Gonorrhoea: In 2013–2015 in the Australian Capital Territory, the number and rate of notifications for gonorrhoea are not reported for Indigenous Australians due to the small numbers involved. There were 370 notifications of gonorrhoea for other Australians, an age-standardised rate of 30 per 100,000 (Table 1.12.1).

In 2013–2015 in Vic, Qld, WA, SA, Tas, ACT and the NT combined, the age-standardised notification rate for gonorrhoea for Indigenous Australians was 14 times the rate for other Australians (732 compared with 51 per 100,000). The notification rate for gonorrhoea for Indigenous females was 37 times higher than for other females. The notification rate for Indigenous males was 8.2 times higher than for other males (Table 1.12.1, Figure 1.12.2).

HIV: In 2013–2015, there were 53 HIV notifications in the Australian Capital Territory. None of the notifications were identified as Indigenous Australians. The age-standardised rate for other Australians was 4.5 per 100,000.

Nationally in 2013–2015, there were 3,137 notifications of HIV during this time, an age-standardised rate of 5.5 per 100,000 for Indigenous Australians, compared with 4.5 per 100,000 for other Australians (Table 1.12.8, Figure 1.12.3).

Trend over time: Trend data are not available for the Australian Capital Territory for this measure.



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.13 Community functioning

Why it is important

This measure reports on factors used to describe community functioning for Indigenous Australians. This is the ability and freedom of community members and communities to determine the context of their lives and translate capability into action (AHMAC 2017).

Key findings

Connectedness to Country, land and history, culture and identity: In 2014–15 in the Australian Capital Territory, 78% of Indigenous Australians aged 15 and over reported that they recognised their homelands; 68% had attended an Indigenous cultural event in the last 12 months; and 64% identified with a clan or language group.

Nationally in 2014–15, 74% of Indigenous Australians aged 15 and over reported that they recognised their homelands; 63% had attended an Indigenous cultural event in the last 12 months; and 62% identified with a clan or language group (Table 1.13.12, Figure 1.13.1).

Resilience: In 2014–15 in the Australian Capital Territory, 82% of Indigenous Australians aged 15 and over reported that they did not avoid situations due to past discrimination; 81% agreed that their doctor could be trusted and 70% agreed that the local school could be trusted; 47% of employed people said work allowed them to fulfil cultural responsibilities.

In 2014–15 nationally, 86% of Indigenous Australians aged 15 and over reported that they did not avoid situations due to past discrimination; 81% agreed that their doctor could be trusted and 70% agreed that the local school could be trusted; and 41% of employed people said work allowed them to fulfil cultural responsibilities (Table 1.13.12, Figure 1.13.2).

Having a role, structure, routine: In 2014–15 in the Australian Capital Territory, 27% of Indigenous Australians 15 and over reported living in 1 dwelling in the last 12 months.

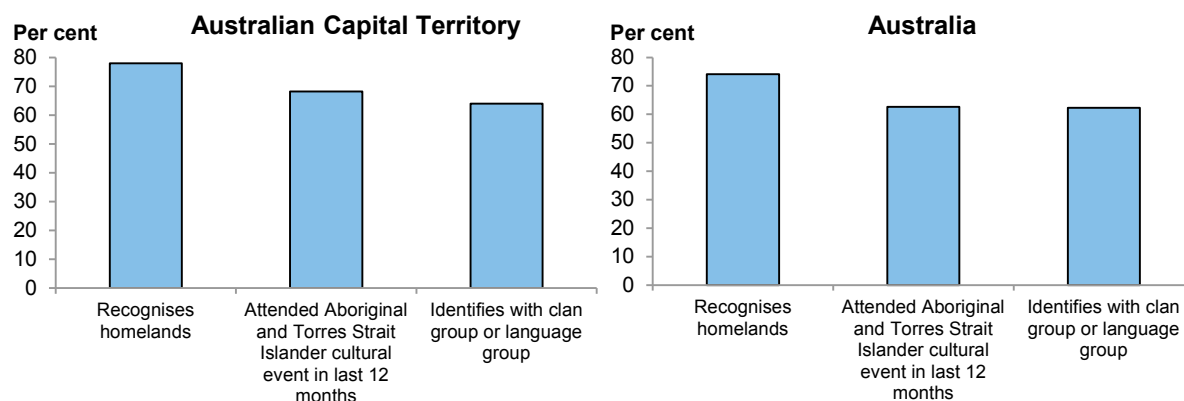
Nationally in 2014–15, 32% of Indigenous Australians 15 and over reported that they had lived in 1 dwelling in the last 12 months (Table 1.13.12).

Feeling safe: In 2014–15 in the Australian Capital Territory, 78% of Indigenous Australians 15 and over reported that they had not experienced physical or threatened violence in the last 12 months; 88% felt safe at home alone after dark; and 68% felt safe walking alone in the local area after dark.

Nationally in 2014–15, 78% of Indigenous Australians 15 and over reported that they had not experienced physical or threatened violence in the last 12 months; 87% felt safe at home alone after dark; and 68% felt safe walking alone in the local area after dark (Table 1.13.12, Figure 1.13.3).

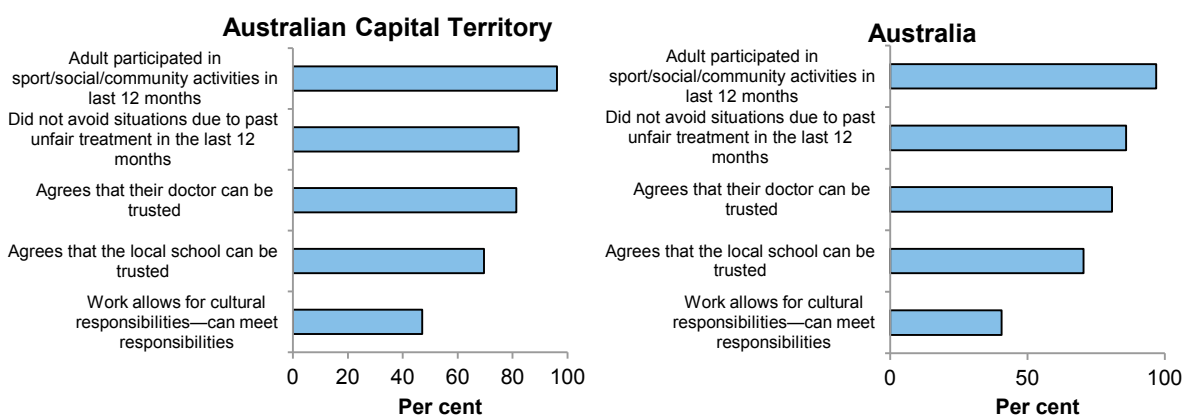
Vitality: In 2014–15 in the Australian Capital Territory, 40% of Indigenous Australians aged 15 and over self-assessed their health status as excellent or very good; 68% had experienced low/moderate levels of psychological distress in the 4 weeks before the survey; and 80% could easily get to places as needed.

Nationally in 2014–15, 40% of Indigenous Australians self-assessed their health status as excellent or very good; 67% had experienced low/moderate levels of psychological distress in the 4 weeks before the survey; and 75% could easily get to places as needed (Table 1.13.12).



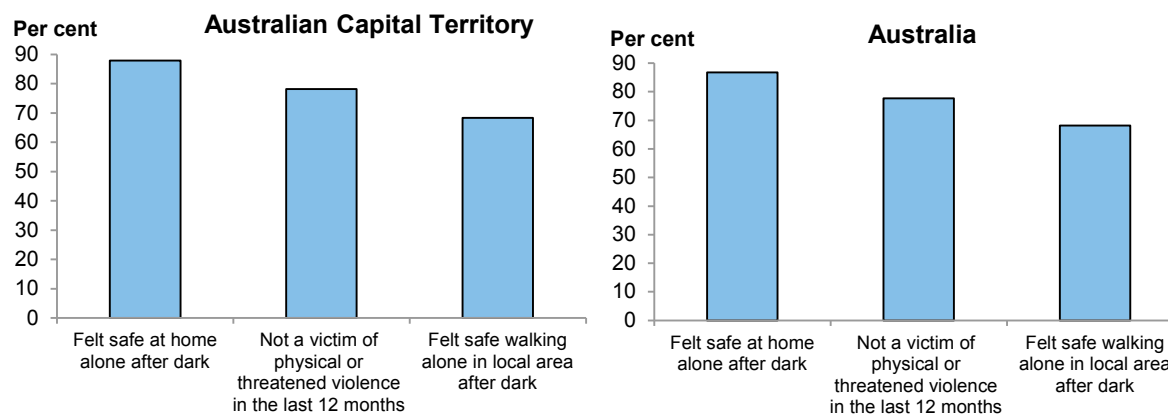
Source: Table 1.13.12.

Figure 1.13.1: Proportion of Indigenous Australians aged 15 and over: connectedness to Country, land and history, culture and identity, Australian Capital Territory and Australia, 2014–15



Source: Table 1.13.12.

Figure 1.13.2: Proportion of Indigenous Australians aged 15 and over: resilience, Australian Capital Territory and Australia, 2014–15



Source: Table 1.13.12.

Figure 1.13.3: Proportion of Indigenous Australians aged 15 and over: feeling safe, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.14 Disability

Why it is important

This measure reports on the prevalence of disability for Indigenous Australians, including children with special needs and users of disability support services. Disability may be an impairment of body structure or function, a limitation in activities or a restriction in a person's participation in specific activities. A person's functioning involves an interaction between health conditions and environmental and personal factors. Indigenous Australians are at greater risk of disability due to increased exposure to factors such as low birthweight, chronic disease, infectious diseases, injury and substance use (AHMAC 2017).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 45% of Indigenous Australians aged 15 and over reported having a disability or restrictive long-term health condition (Table 1.14.2). The age-standardised rate for Indigenous Australians reporting a disability or restrictive long-term health condition was 1.8 times the rate for non-Indigenous Australians (48% compared with 26%) (Table 1.14.1, Figure 1.14.1).

Nationally in 2014–15, 45% of Indigenous Australians aged 15 and over reported having a disability or restrictive long-term health condition (Table 1.14.2). The age-standardised rate for Indigenous Australians reporting a disability or restrictive long-term health condition was 1.7 times higher than the rate for non-Indigenous Australians (50% compared with 30%) (Table 1.14.1, Figure 1.14.1).

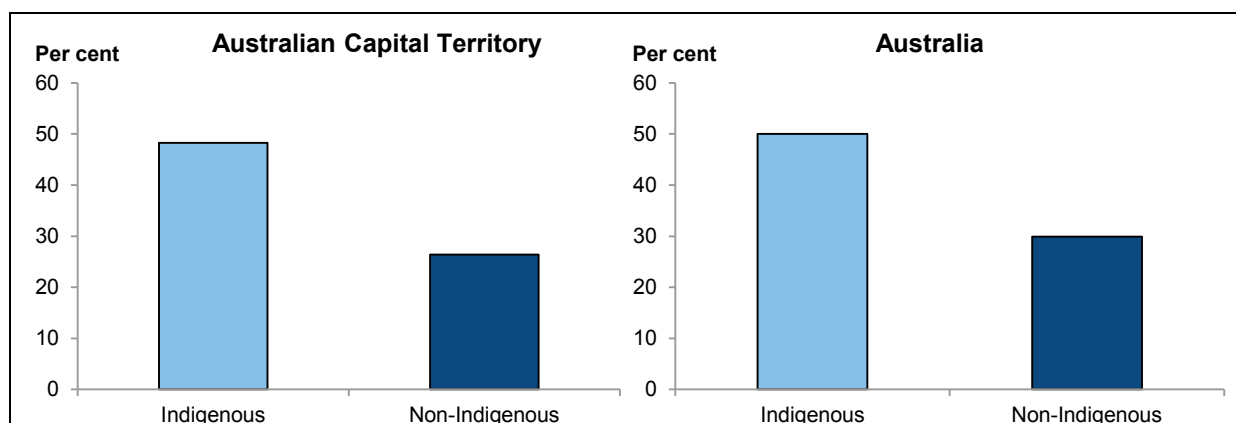
Assistance with core activities: In 2011 in the Australian Capital Territory, Census data showed that 5.1% of Indigenous Australians needed assistance with a core activity (self-care, mobility or communication) some or all of the time. The age-standardised rate for Indigenous Australians who needed assistance with core activities was 2.5 times the rate for non-Indigenous Australians (9.5% compared with 3.8%).

Nationally in 2011, 5.7% of Indigenous Australians needed assistance with a core activity. The age-standardised rate for Indigenous Australians was 2 times the rate for non-Indigenous Australians (9.2% compared with 4.5%) (Table 1.14.12, Figure 1.14.2).

Users of disability support services: In 2014–15 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians aged under 65 who had used disability support services was 38 per 1,000. This was 2.4 times the rate for non-Indigenous Australians (16 per 1,000). The rate was higher for Indigenous males than for Indigenous females (44 and 30 per 1,000). The rate was also higher for non-Indigenous males than for non-Indigenous females (20 per 1,000, compared with 12 per 1,000).

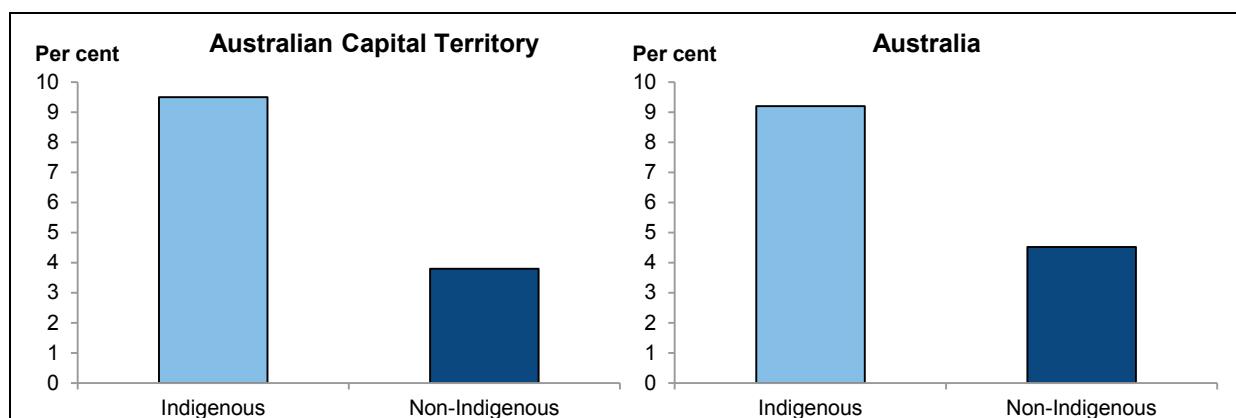
Nationally in 2014–15, the age-standardised rate for Indigenous Australians aged under 65 who had used disability support services was 28 per 1,000. This was 1.9 times the rate for non-Indigenous Australians (15 per 1,000). The rate was higher for Indigenous males than for Indigenous females (33 and 23 per 1,000), and for non-Indigenous males compared with non-Indigenous females (17 and 12 per 1,000) (Table 1.14.16, Figure 1.14.3).

Trend over time: Comparable trend data are not available for individual jurisdictions.



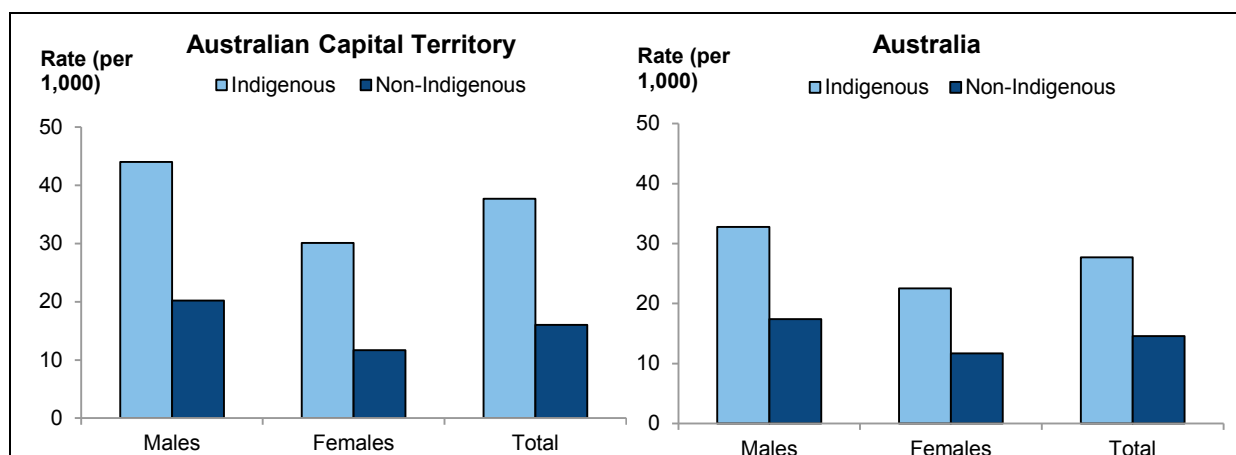
Source: Table 1.14.1.

Figure 1.14.1: Age-standardised rate reporting disability or a restrictive long-term health condition, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 1.14.12.

Figure 1.14.2: Age-standardised rate that need assistance with core activities, by Indigenous status, Australian Capital Territory and Australia, 2011



Source: Table 1.14.16.

Figure 1.14.3: Age-standardised rate (aged under 65) using disability support services, by sex and Indigenous status, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.15 Ear health

Why it is important

This measure reports on hearing health in children and adults, including prevalence rates for ear and hearing problems, hospitalisation rates for disease of the ear and mastoid process, and rates of ear and hearing problems managed at consultations with GPs. Hearing loss, especially in childhood, may reduce educational achievements and have lifelong consequences (Williams & Jacobs 2009).

Key findings

Overall: In 2012–13, 12% Indigenous Australians living in the Australian Capital Territory reported having an ear or hearing problem (Table 1.15.4). The age-standardised rate for Indigenous Australians who reported an ear or hearing problem was 1.3 times the rate for non-Indigenous Australians (15% compared with 12%) (Table 1.15.5, Figure 1.15.1).

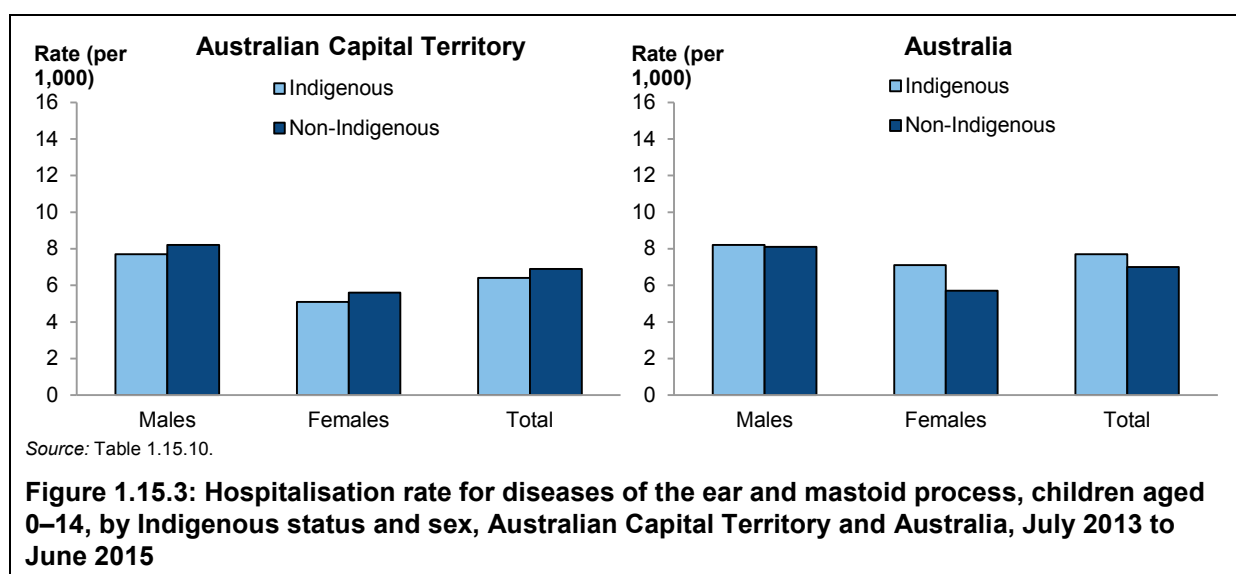
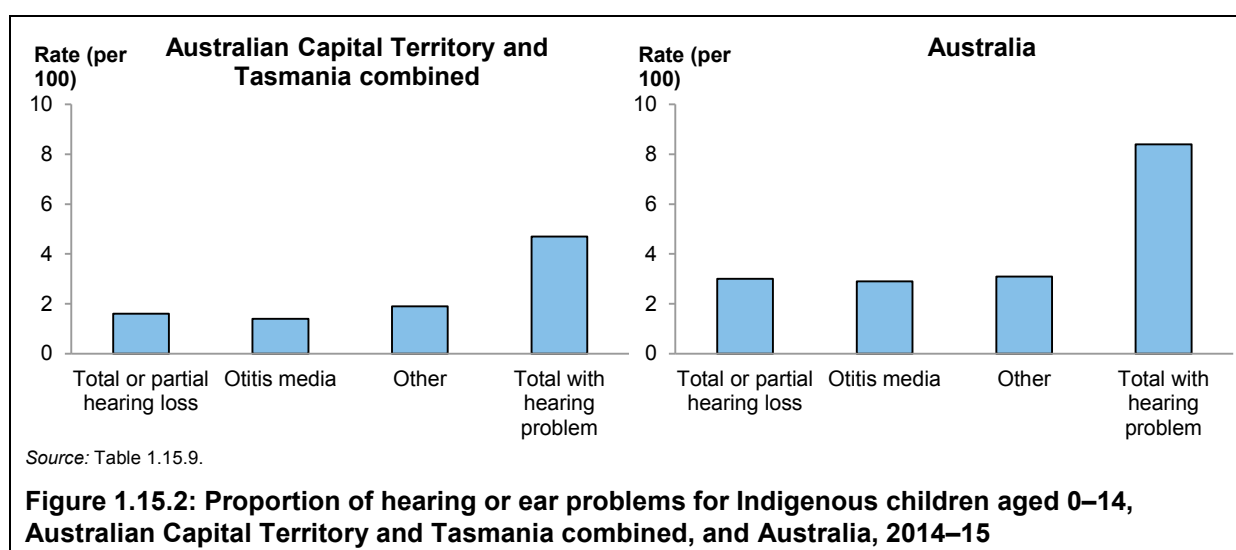
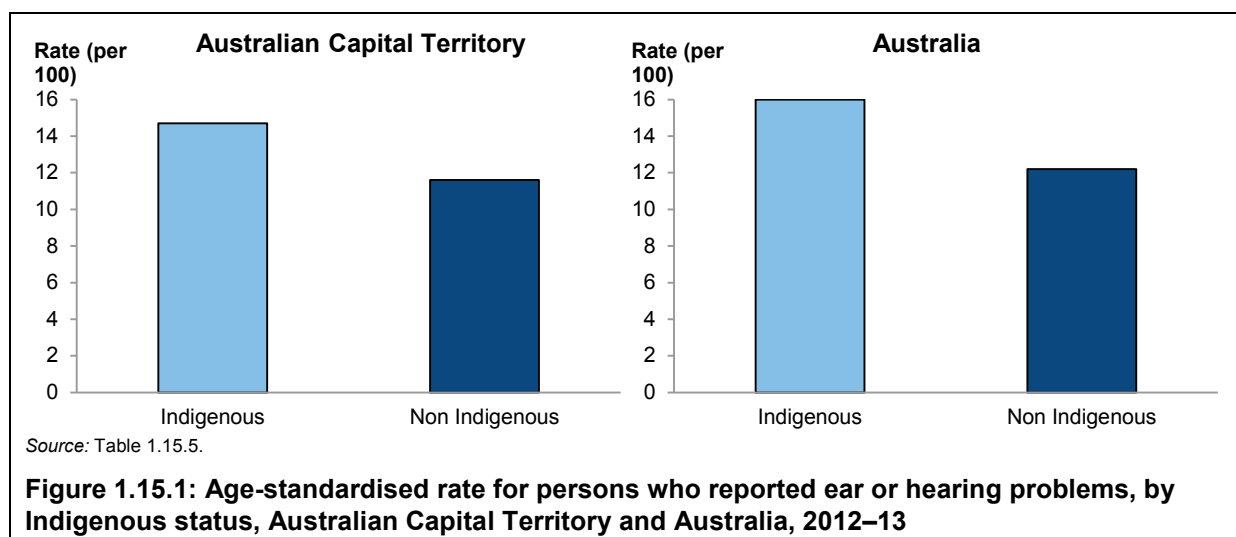
In 2012–13 nationally, there were 62,694 Indigenous Australians who reported an ear or hearing problem, a rate of 12.3 per 100. The rate in *Non-remote* areas was similar to the rate in *Remote* areas (13% and 12%, respectively) (Table 1.15.4). Nationally, the age-standardised rate for Indigenous Australians who reported an ear or hearing problem was 1.3 times the rate for non-Indigenous Australians (16% compared with 12%) (Table 1.15.5, Figure 1.15.1).

Children aged 0–14: In 2014–15, based on reported information for the Australian Capital Territory and Tasmania combined, 4.7% of Indigenous children aged 14 or below had an ear or hearing problem; 1.6% had hearing loss (total or partial); 1.4% had otitis media; and 1.9% had other ear or hearing problems.

Nationally in 2014–15, 8.4% of Indigenous children were reported to have had an ear or hearing problem; 3.0% had hearing loss (total or partial); 2.9% had otitis media; and 3.1% had other ear or hearing problems (Table 1.15.9, Figure 1.15.2).

Hospitalisation: In July 2013 to June 2015 in the Australian Capital Territory, the hospitalisation rate for diseases of the ear and mastoid process for Indigenous children aged 14 or below was similar to the rate for non-Indigenous children (6.4 per 1,000 compared with 6.9 per 1,000). Age-standardised rates were not calculated due to the small numbers involved. The hospitalisation rate for Indigenous males was higher than the rate for Indigenous females (7.7 compared with 5.1 per 1,000).

In July 2013 to June 2015 nationally, the hospitalisation rate for diseases of the ear and mastoid process for Indigenous children aged 14 or below was 7.7 per 1,000 compared with 7.0 per 1,000 for non-Indigenous children. The hospitalisation rate for Indigenous males was higher than the rate for Indigenous females (8.2 compared with 7.1 per 1,000) (Table 1.15.10, Figure 1.15.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.16 Eye health

Why it is important

This measure reports on prevalence of eye health problems, including low vision, blindness, refractive error, cataract, diabetic retinopathy and trachoma for Indigenous Australians. The partial or full loss of vision affects all dimensions of life. Vision loss and eye disease can lead to linguistic, social and learning difficulties and behavioural problems during schooling years, which can then lead to poor education outcomes and employment prospects. Indigenous Australians experience higher rates of cataract, diabetic retinopathy and trachoma compared with non-Indigenous Australians (AHMAC 2017).

Key findings

Overall: In 2014–15, in the Australian Capital Territory, 17% of Indigenous Australians aged 15 and over reported having eye or sight problems.

Nationally in 2014–15, 19% of Indigenous Australians reported having eye or sight problems (Table 1.16.5, Figure 1.16.1).

Reported eye and sight problems: In 2012–13 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians reporting having eye or sight problems was similar to the rate for non-Indigenous Australians (57% compared with 55%).

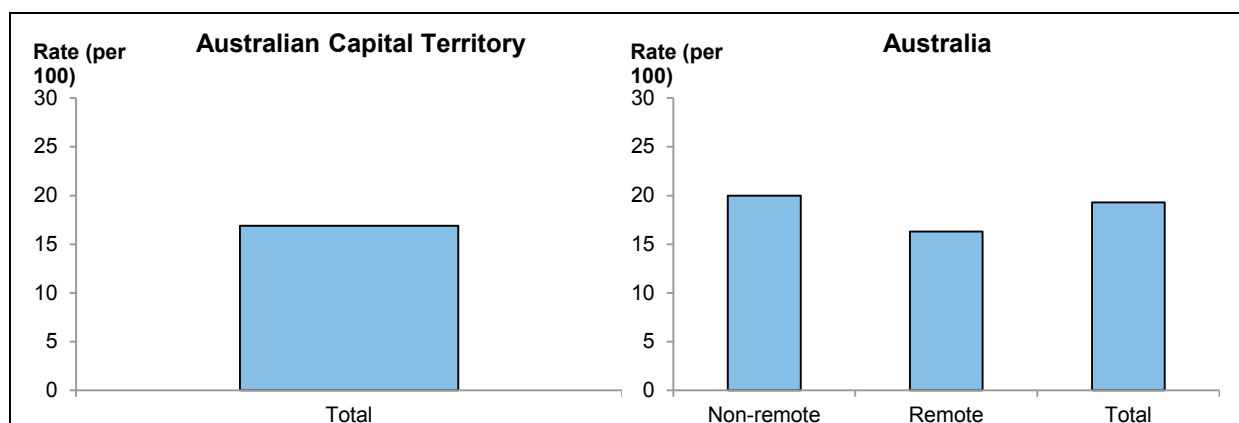
In 2012–13 nationally, the age-standardised rate for Indigenous Australians reporting having eye or sight problems was 0.9 times the rate for non-Indigenous Australians (48% compared with 52%) (Table 1.16.6, Figure 1.16.2).

Hospitalisation: In July 2013 to June 2015 in the Australian Capital Territory, the hospitalisation rate for Indigenous Australians for diseases of the eye and adnexa was 2.0 per 1,000. The age-standardised rate was not calculated due to the small numbers involved. The hospitalisation rate for non-Indigenous Australians for diseases of the eye and adnexa was 6.2 per 1,000 (Table 1.16.14).

Nationally in July 2013 to June 2015, the hospitalisation rate for Indigenous Australians for diseases of the eye and adnexa was 4.6 per 1,000, compared with 15 per 1,000 for non-Indigenous Australians (Table 1.16.14). The hospitalisation rate increased with age for Indigenous Australians from 1.5 per 1,000 for those aged 0–4 to 51 per 1,000 for those aged 65 and over (Table 1.16.12).

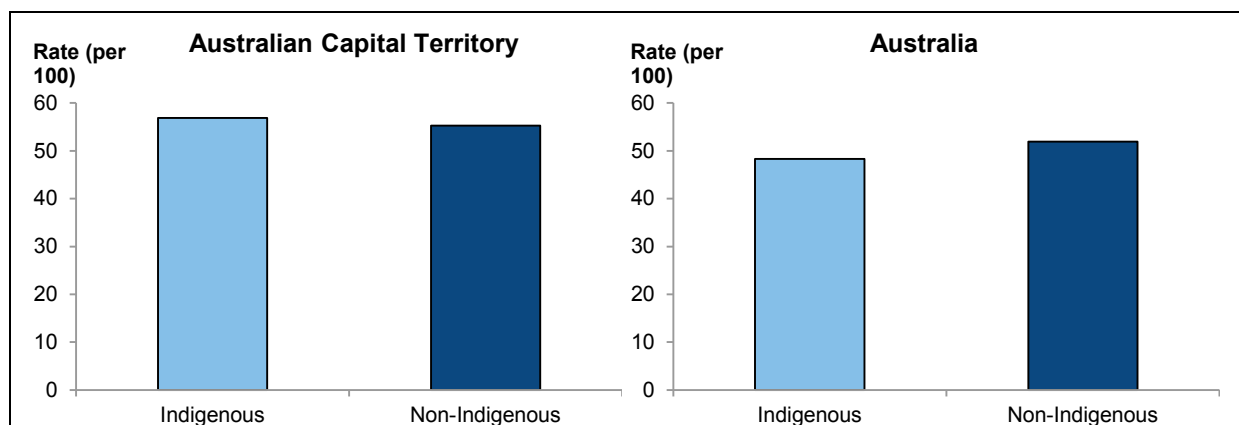
Trend over time: Trend data for the Australian Capital Territory for hospitalisation for diseases of the eye and adnexa are not available for publication.

In NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised hospitalisation rate for Indigenous Australians for diseases of the eye and adnexa increased from 5.4 per 1,000 in 2004–05 to 11 per 1,000 in 2014–15. The rate of diseases of the eye and adnexa for non-Indigenous Australians increased from 9.5 per 1,000 in 2004–05 to 14 per 1,000 in 2014–15 (Table 1.16.18, Figure 1.16.3).



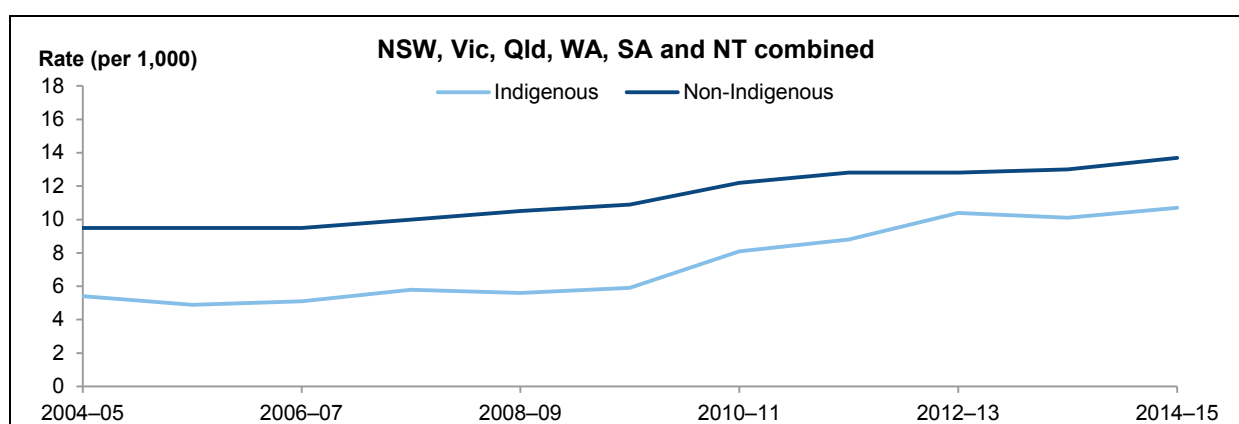
Source: Table 1.16.5.

Figure 1.16.1: Indigenous Australians aged 15 and over reporting eye or sight problems, Australian Capital Territory and Australia, 2014–15



Source: Table 1.16.6.

Figure 1.16.2: Age-standardised proportion reporting eye or sight problems, by Indigenous status, Australian Capital Territory and Australia, 2012–13



Source: Table 1.16.18.

Figure 1.16.3: Age-standardised hospitalisation rate for diseases of the eye and adnexa, by Indigenous status, NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.17 Perceived health status

Why it is important

This measure reports on self-assessed health status of Indigenous Australians. Self-assessed health status provides a measure of the overall level of a population's health based on individuals' personal perceptions of their own health. Self-assessed health status is dependent on an individual's awareness and expectations about their health. It is influenced by various factors, including access to health services and information, the extent to which health conditions have been diagnosed and level of education (Delpierre et al. 2009).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 40% of Indigenous Australians aged 15 and over self-assessed their health as excellent/very good, 33% as good and 26% as fair/poor.

Nationally in 2014–15, of Indigenous Australians aged 15 and over, 40% self-assessed their health as excellent/very good, 35% as good and 26% as fair/poor (Table 1.17.8, Figure 1.17.1).

Excellent/very good health: In 2014–15 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians who self-assessed their health as excellent/very good was 0.6 times the rate for non-Indigenous Australians (36% compared with 57%).

Nationally in 2014–15, the age-standardised rate for Indigenous Australians who self-assessed their health as excellent/very good was 0.6 times the rate for non-Indigenous Australians (35% compared with 57%) (Table 1.17.9, Figure 1.17.2).

Good health: In the Australian Capital Territory in 2014–15, the age-standardised rate for Indigenous Australians who self-assessed their health as good was 1.2 times the rate for non-Indigenous Australians (33% compared with 31%).

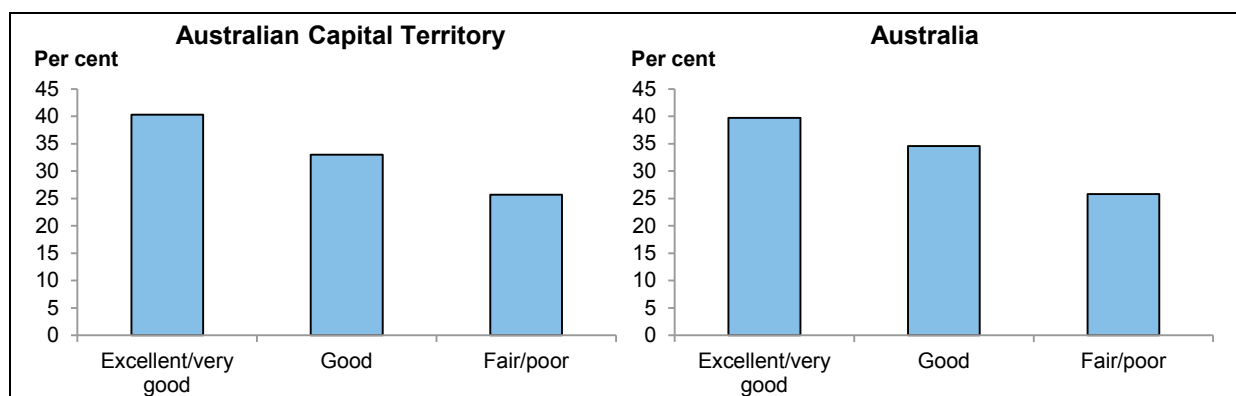
Nationally in 2014–15, the age-standardised rate for Indigenous Australians who self-assessed their health as good was 1.2 times the rate for non-Indigenous Australians (35% compared with 29%) (Table 1.17.9, Figure 1.17.2).

Fair/poor health: In the Australian Capital Territory in 2014–15, the age-standardised rate for Indigenous Australians who self-assessed their health as fair/poor was 30%, 2.5 times the rate for non-Indigenous Australians (12%).

Nationally in 2014–15, the age-standardised rate for Indigenous Australians who self-assessed their health as fair/poor was 31%, 2.2 times the rate for non-Indigenous Australians (14%) (Table 1.17.9, Figure 1.17.2).

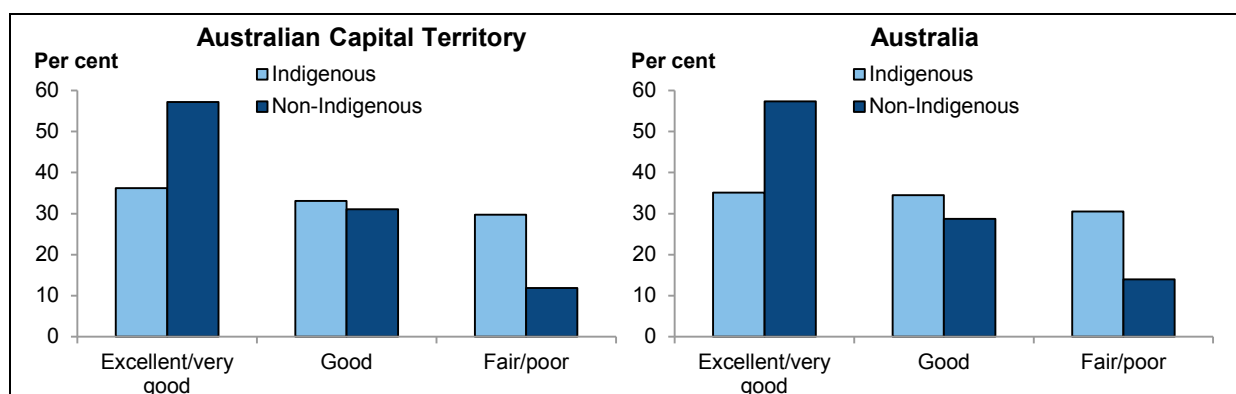
Trend over time: The proportion of Indigenous Australians in the Australian Capital Territory aged 15 and over who self-assessed their health as excellent/very good decreased from 47% in 2002 to 40% in 2014–15 (Table 1.17.8).

Nationally, the proportion of Indigenous Australians who self-assessed their health as excellent/very good decreased slightly by 4 percentage points between 2002 and 2014–15, from 44% to 40% (Table 1.17.8, Figure 1.17.3).



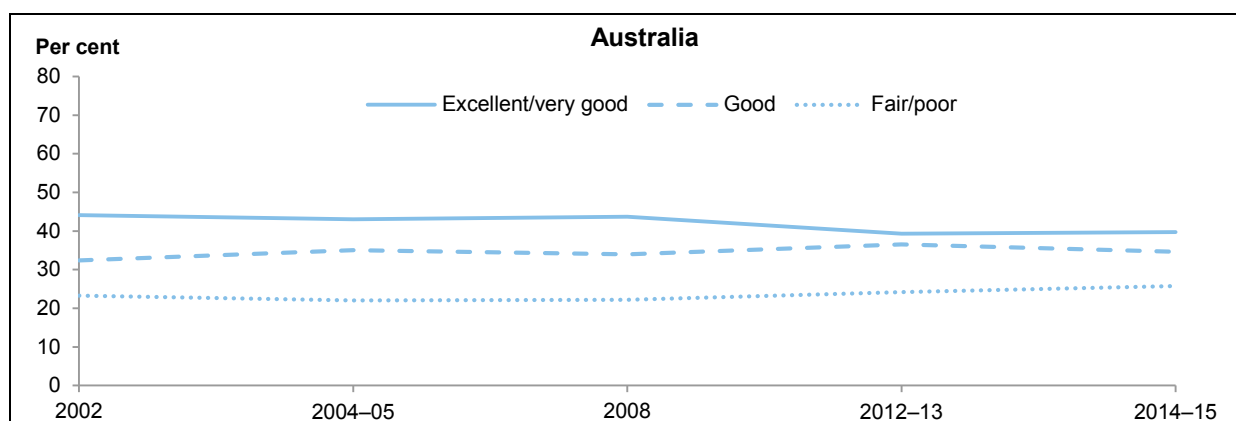
Source: Table 1.17.8.

Figure 1.17.1: Self-assessed health status, Indigenous Australians aged 15 and over, Australian Capital Territory and Australia, 2014–15



Source: Table 1.17.9.

Figure 1.17.2: Age-standardised self-assessed health status, aged 15 and over, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 1.17.8.

Figure 1.17.3: Self-assessed health status of Indigenous Australians aged 15 and over, Australia, 2002 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.18 Social and emotional wellbeing

Why it is important

This measure reports on the social and emotional wellbeing of Indigenous Australians. This is a holistic concept for Indigenous Australians, health is not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community (Dudgeon et al. 2014; Gee et al. 2014; SHRG 2004).

Key findings

Overall: In 2012–13 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians aged 18 and over who reported high or very high levels of psychological distress was 31%, compared with 9% for non-Indigenous Australians.

Nationally, the age-standardised rate for Indigenous Australians aged 18 and over who reported high or very high levels of psychological distress in 2012–13 was 30%, compared with 11% for non-Indigenous Australians (Table 1.18.3).

Hospitalisation for mental health-related conditions: In July 2013 to June 2015, the age-standardised hospitalisation rate for Indigenous Australians in the Australian Capital Territory for mental health-related conditions was 16 per 1,000. This is 1.9 times the rate for non-Indigenous Australians (8.8 per 1,000).

In July 2013 to June 2015 nationally, the age-standardised hospitalisation rate for Indigenous Australians for mental health-related conditions was 29 per 1,000, 1.8 times the rate for non-Indigenous Australians (16 per 1,000) (Table 1.18.15, Figure 1.18.1).

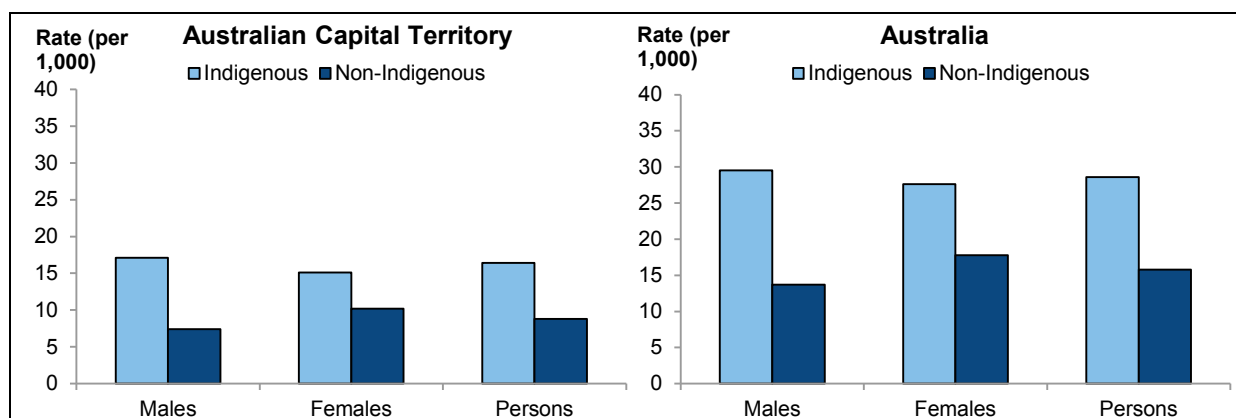
Hospitalisation for self-harm: In July 2013 to June 2015, the age-standardised hospitalisation rate for Indigenous Australians in the Australian Capital Territory for injury and poisoning and a first reported external cause of self-harm was 2.4 per 1,000. This is 2.2 times the rate for non-Indigenous Australians (1.1 per 1,000). For Indigenous females, the age-standardised hospitalisation rate for self-harm was 2.6 times the rate for non-Indigenous females in July 2013 to June 2015 (Table 1.18.28)

Nationally in July 2013 to June 2015, the age-standardised hospitalisation rate for Indigenous Australians for injury and poisoning and a first reported external cause of self-harm was 3.2 per 1,000, 2.7 times the rate for non-Indigenous Australians (1.2 per 1,000) (Table 1.18.28, Figure 1.18.2).

Deaths: Data for mortality caused by self-harm in the period 2011–2015 are not available for the Australian Capital Territory, as the jurisdiction is not considered to have an adequate level of Indigenous identification in mortality data.

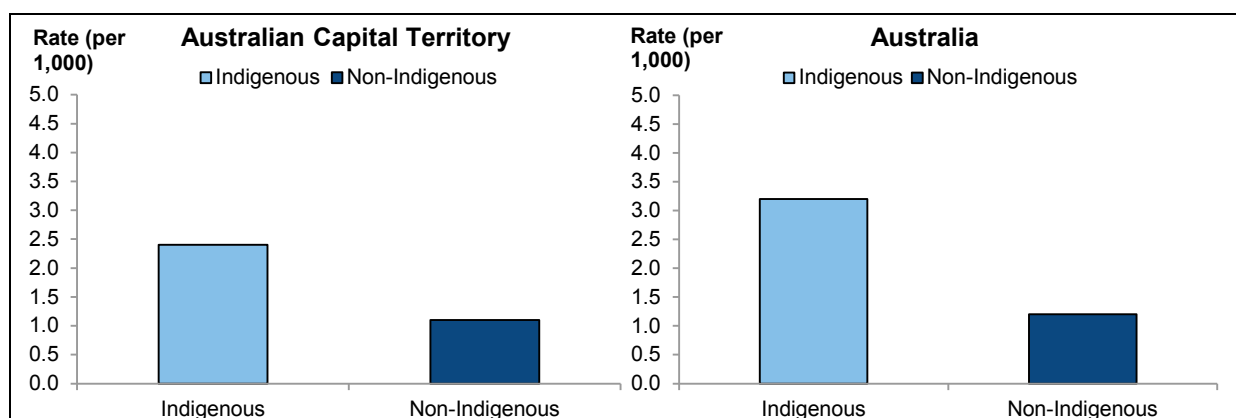
For NSW, Qld, WA, SA and the NT combined in 2011–2015, the age-standardised death rate for Indigenous Australians for intentional self-harm was 23 deaths per 100,000. This was 2.1 times the rate for non-Indigenous Australians, at 11 deaths per 100,000 (Table 1.18.30).

Trend over time: For NSW, Qld, WA, SA and the NT combined, the age-standardised death rate for intentional self-harm for Indigenous Australians from 1998 to 2015 increased by 32%, and varied from 13 per 100,000 in 1999 to 26 per 100,000 in 2015. The rate for non-Indigenous Australians varied between 9.7 per 100,000 in 2004 and 14.5 per 100,000 in 1998, but generally decreased by 13% (Table 1.18.26, Figure 1.18.3).



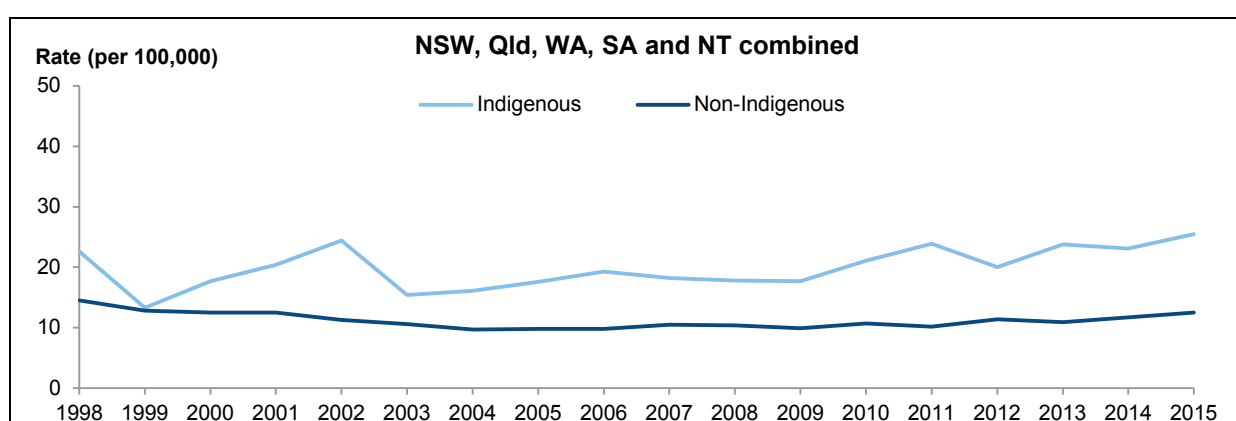
Source: Table 1.18.15.

Figure 1.18.1: Age-standardised hospitalisation rate for mental health-related conditions, by sex and Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.18.28.

Figure 1.18.2: Age-standardised hospitalisation rate for injury and poisoning and a first reported external cause of self-harm, by sex and Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 1.18.26.

Figure 1.18.3: Intentional self-harm mortality rates by Indigenous status, NSW, Qld, WA, SA and NT combined, 1998–2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.19 Life expectancy at birth

Why it is important

This measure reports on life expectancy at birth. Life expectancy refers to the average number of years a person of a given age and sex can expect to live, if current age and sex-specific death rates continue to apply throughout his or her lifetime. Life expectancy at birth is widely used internationally as a measure of the general health of populations. There is currently a large gap in life expectancy between Indigenous and non-Indigenous Australians. Social and economic factors such as poverty, racism, stressors, educational exposure and employment status affect the individual's likelihood to engage in health risk behaviours as well as their access to the health system. These factors combined lead to increased risk of circulatory disease (Dong et al. 2004) and cancer (Kelly-Irving et al. 2013) the leading causes of death.

Key findings

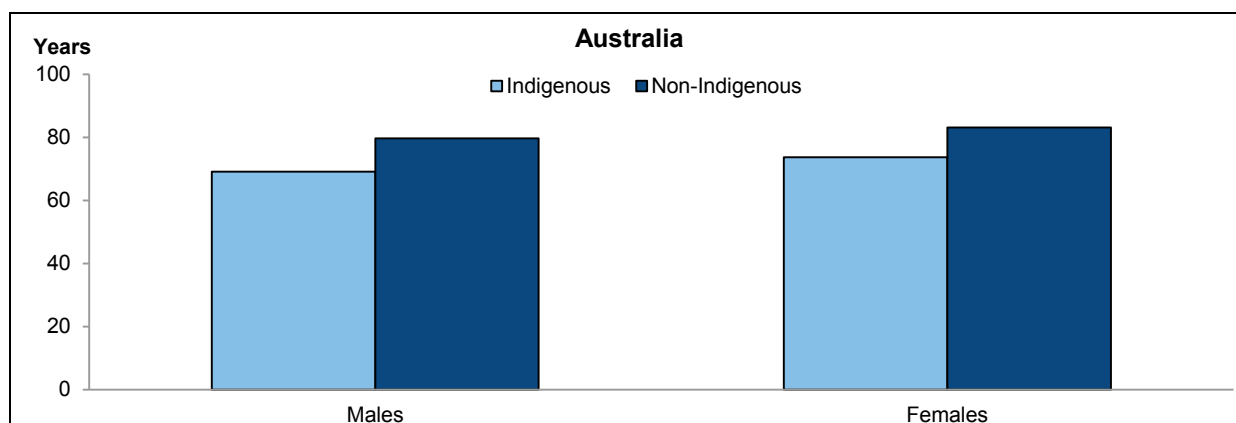
Life expectancy at birth data by Indigenous status are not available for the Australian Capital Territory. Due to the small number of Indigenous deaths in the Australian Capital Territory, it is not possible to construct life tables for the jurisdiction (ABS 2009).

Overall: Nationally in 2010–2012, life expectancy at birth for Indigenous Australians was estimated to be 69.1 years for males and 73.7 years for females. In comparison, life expectancy at birth for non-Indigenous Australians was 79.7 years for males and 83.1 years for females. This represents a gap of 10.6 years for males and 9.5 years for females (Table 1.19.1, Figure 1.19.1).

Remoteness: Life expectancy estimates that are disaggregated by remoteness categories are not available for individual jurisdictions.

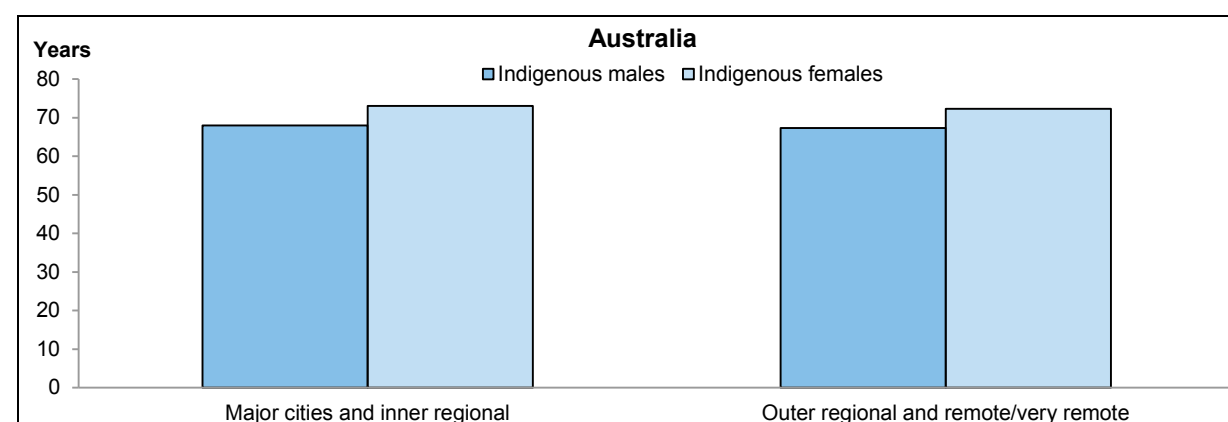
Nationally in 2010–2012, life expectancy for Indigenous males living in the combined areas of *Outer regional*, *Remote* and *Very remote* was estimated to be 0.7 years lower than for Indigenous males living the combined areas of *Major cities* and *Inner regional* (67.3 compared with 68.0 years). For Indigenous females living in the combined areas of *Outer regional*, *Remote* and *Very remote*, life expectancy was 0.8 years lower than for Indigenous females living in *Major cities* and *Inner regional* areas combined (72.3 years compared with 73.1 years) (AHMAC 2017) (Figure 1.19.2).

Over time: Nationally, life expectancy between 2005–2007 and 2010–2012 increased for both Indigenous males and females, by 1.6 and 0.6 years, respectively. The gap between Indigenous Australians and non-Indigenous Australians decreased from 11.4 to 10.6 years for Indigenous males, and from 9.6 to 9.5 years for Indigenous females (Table 1.19.1, Figure 1.19.3). National life expectancy estimates presented in this measure were calculated using a different method to the estimates in Table S1. The estimates in this measure are comparable across 2 time points. The estimates in Table S1 enable comparison between the national and jurisdiction estimates (ABS 2013a).



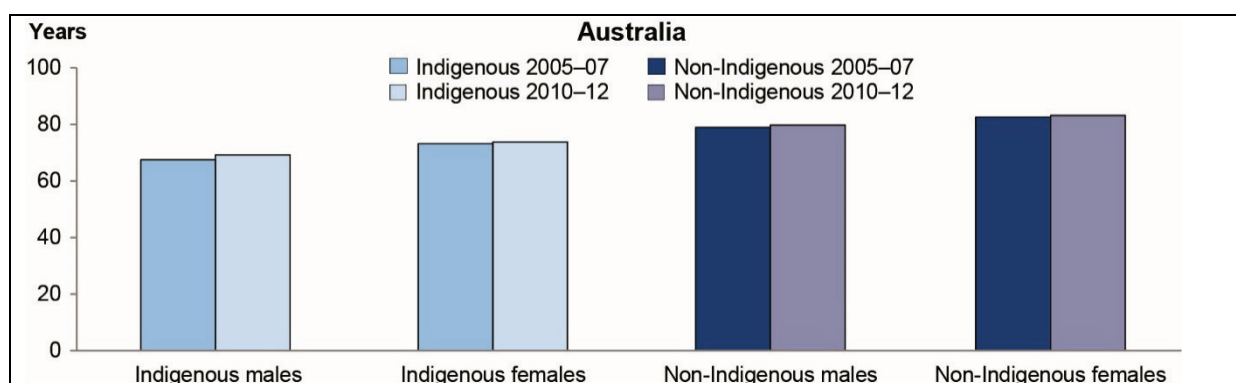
Source: Table 1.19.1.

Figure 1.19.1: Life expectancy at birth, by Indigenous status and sex, Australia, 2010–2012



Source: AHMAC 2017.

Figure 1.19.2: Life expectancy at birth, Indigenous Australians, by remoteness and sex, Australia, 2010–2012



Source: Table 1.19.1.

Figure 1.19.3: Life expectancy at birth, by Indigenous status and sex, Australia, 2005–2007 (revised) and 2010–2012 (life expectancy in years)

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.20 Infant and child mortality

Why it is important

This measure reports on the death rates of Indigenous infants and children aged 0–4 years, by cause of death. Infant mortality is a long established measure of child health, as well as the overall health of the population, and its physical and social environment (AHMAC 2017).

Key findings

Data are not available for the Australian Capital Territory, as the jurisdiction is not considered to have an adequate level of Indigenous identification in mortality data.

Overall: In 2011–2015 for NSW, Qld, WA, SA and the NT combined, the mortality rate for Indigenous children aged 0–4 was 2.1 times the rate for non-Indigenous children (165 compared with 80 per 100,000) (Table 1.20.1, Figure 1.20.1).

Cause of death: The most common cause of death for Indigenous children aged 1–4 in 2011–2015 (for NSW, Qld, WA, SA and the NT combined) was injury and poisoning, which accounted for 54% of deaths in this age group. This was 3.9 times the rate for non-Indigenous children (20.1 per 1,000 compared with 5.1 per 1,000) (Table 1.20.14).

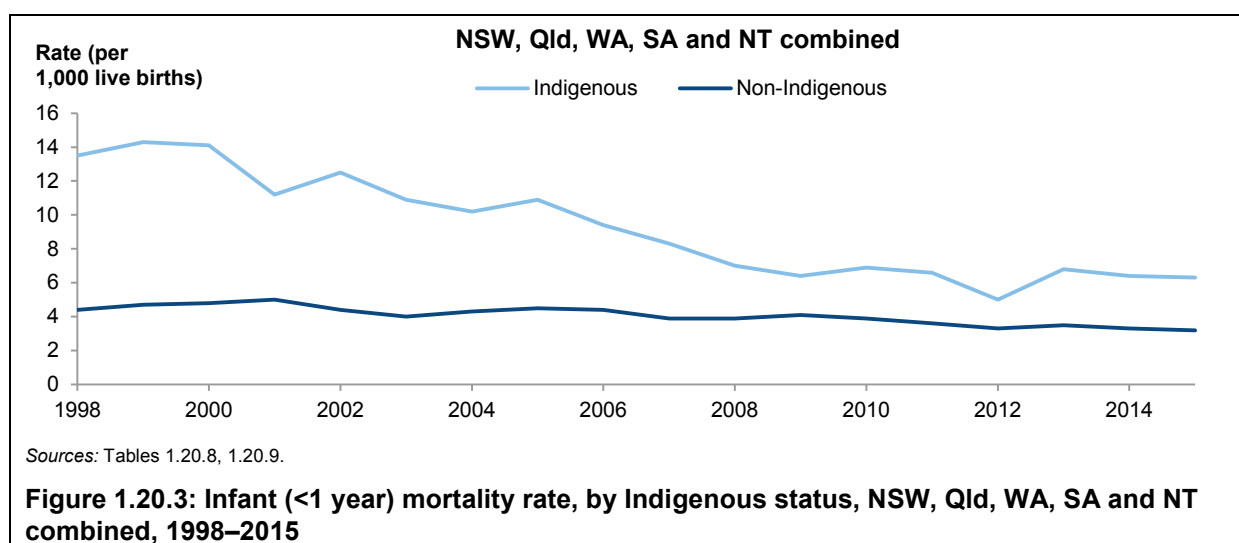
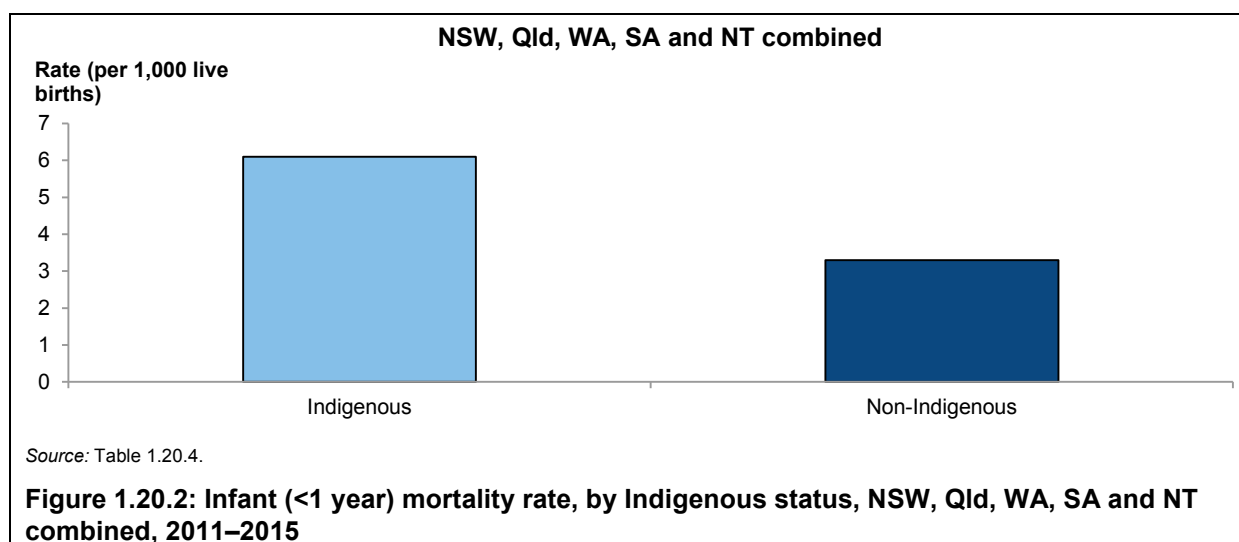
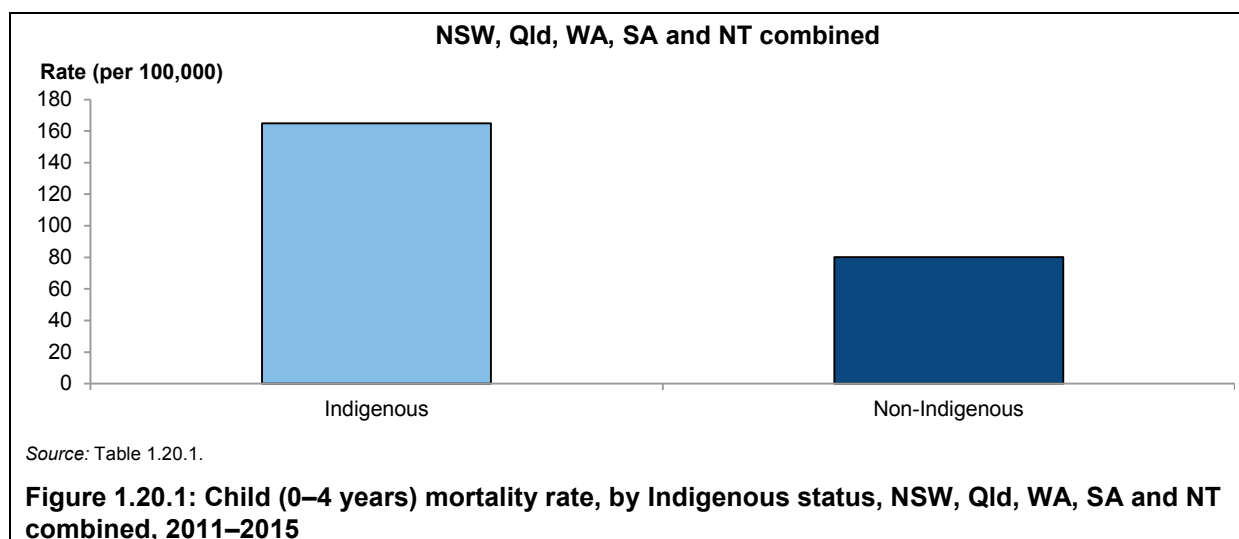
Infant mortality: In 2011–2015 for NSW, Qld, WA, SA and the NT combined, the mortality rate for Indigenous infants was 1.9 times the rate for non-Indigenous infants (6.1 compared with 3.3 per 1,000 live births) (Table 1.20.4, Figure 1.20.2).

Causes of infant mortality: In 2011–2015 for NSW, Qld, WA, SA and the NT combined, the most common underlying cause of death for Indigenous infants was conditions originating in the perinatal period, which accounted for just over half (51%) of Indigenous infant deaths. This was 1.8 times the rate for non-Indigenous infants (3.1 per 1,000 compared with 1.7 per 1,000) (Table 1.20.13).

SIDS and SUDI mortality: In 2011–2015 for NSW, Qld, WA, SA and the NT combined, the sudden infant death syndrome (SIDS) mortality rate for Indigenous infants was 3.1 times the rate for non-Indigenous infants (0.5 per 1,000 live births compared with 0.2 per 1,000 live births). The sudden unexpected death in infancy (SUDI) mortality rate for Indigenous infants in 2011–2015 was 4.1 times the rate for non-Indigenous infants (0.8 per live 1,000 live births and 0.2 per 1,000 live births) (Table 1.20.6).

Trend over time: For NSW, Qld, WA, SA and the NT combined, the mortality rate for Indigenous infants between 1998 and 2015 decreased from 13.5 per 1,000 in 1998 to 6.3 per 1,000 in 2015 (deaths are presented in 3-year groupings because of small numbers in each year). The gap decreased significantly (from 9.1 in 1998 to 3.0 per 1,000 in 2015) (Table 1.20.8, Figure 1.20.3).

For NSW, Qld, WA, SA and the NT combined, there was a 35% significant decrease in the mortality rate for Indigenous children aged 0–4 (from 202 per 100,000 in 1998 to 156 per 100,000 in 2015). For non-Indigenous children, there was a 37% significant decrease (from 104 to 70 per 100,000) (Table 1.20.17).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.21 Perinatal mortality

Why it is important

This measure reports on the number of Indigenous babies who die in the perinatal period. The perinatal death rate includes fetal deaths (stillbirths) and deaths of live born babies within the first 28 days after birth. Perinatal mortality reflects the health status and health care of the general population, access to and quality of preconception, reproductive, antenatal and obstetric services for women, and health care in the neonatal period. Broader social factors such as maternal education, nutrition, smoking, alcohol use in pregnancy and socioeconomic disadvantage are also significant (AHMAC 2017).

Key findings

Mortality data are not available for the Australian Capital Territory for this measure. Data for NSW, Qld, WA, SA and the NT combined are used, as those jurisdictions are considered to have an adequate level of Indigenous identification in mortality data.

Overall: In NSW, Qld, WA, SA and the NT combined, in 2011–2015, the perinatal mortality rate for Indigenous babies was 1.2 times the rate for non-Indigenous babies (9.2 per 1,000 births compared with 7.7 per 1,000 births) (Table 1.21.4, Figure 1.21.1).

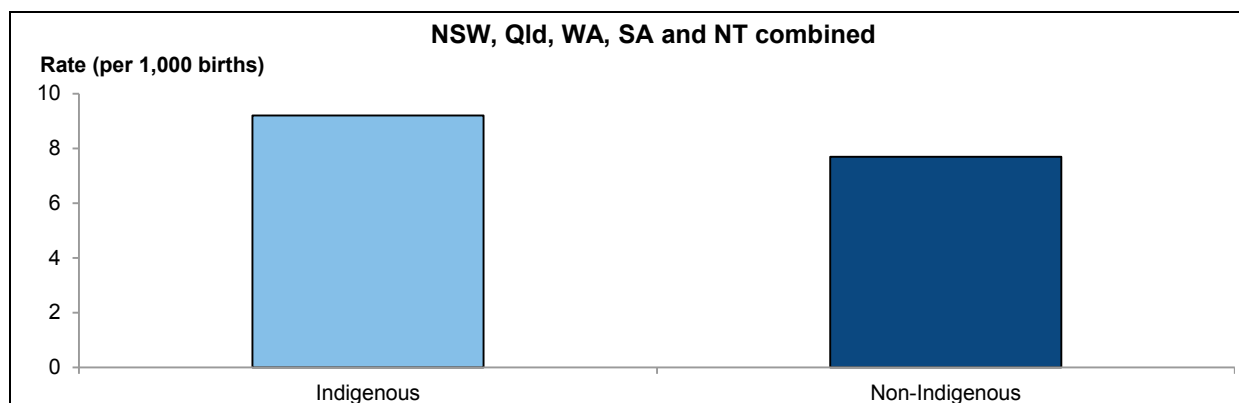
The main conditions contributing to perinatal mortality for Indigenous babies were other conditions originating in the perinatal period (44%) and disorders related to the length of gestation and fetal growth (30%) (Table 1.21.5).

Fetal deaths: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, fetal deaths (stillbirths) accounted for 59% of perinatal deaths for Indigenous babies and 70% for non-Indigenous babies (Table 1.21.4, Figure 1.21.2).

Neonatal deaths: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the rate of neonatal deaths for Indigenous babies was 1.6 times the rate for non-Indigenous babies (3.8 per 1,000 compared with 2.3 per 1,000) (Table 1.21.4, Figure 1.21.2).

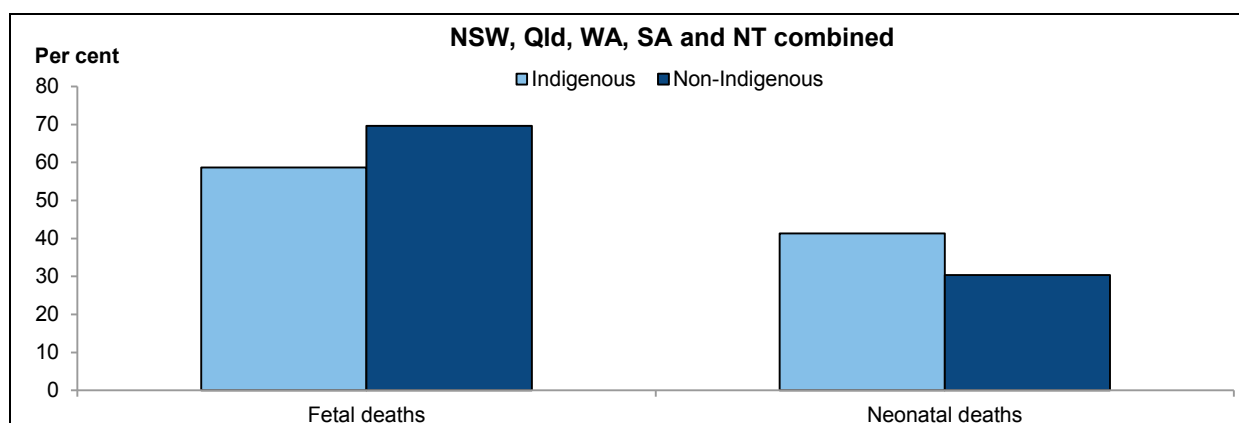
Trend over time: In NSW, Qld, WA, SA and the NT combined, the perinatal mortality rate for Indigenous babies in 2011–2015 was significantly lower than the rate in 2006–2010 (9.2 compared with 11.3 per 1,000 births). For non-Indigenous babies, the perinatal mortality rate in 2011–15 was similar to the rate in 2006–2010 (7.7 compared with 7.9 per 1,000 births) (Table 1.21.4).

Over the longer term, in NSW, Qld, WA, SA and the NT combined, the fetal mortality rate for Indigenous babies decreased from 10.4 per 1,000 in 1998 to 6.0 per 1,000 in 2015, a reduction of 53%. The neonatal mortality rate for Indigenous babies also decreased over this time (by 60%), from 7.7 per 1,000 in 1998 to 3.9 per 1,000 in 2015 (Table 1.21.3, Figure 1.21.3).



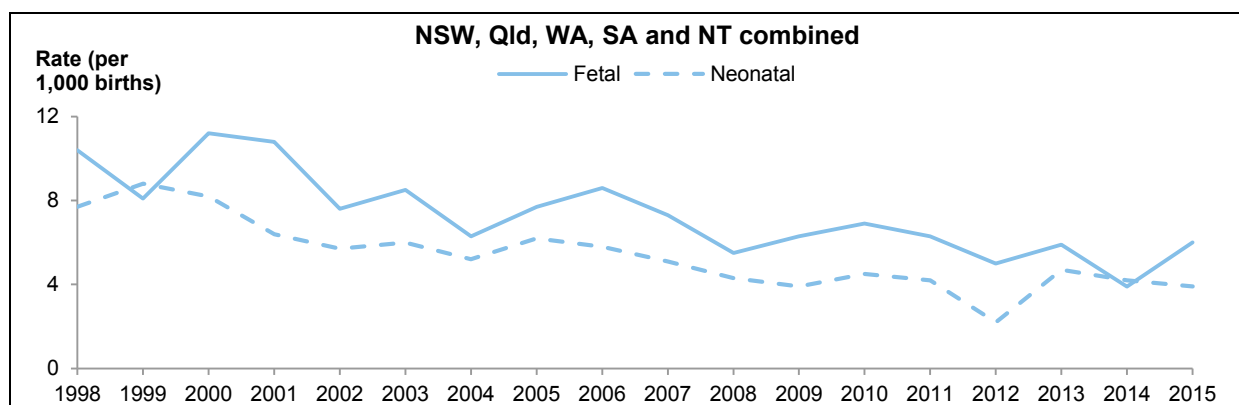
Source: Table 1.21.4.

Figure 1.21.1: Perinatal mortality per 1,000 births, by Indigenous status, NSW, Qld, WA, SA and NT combined, 2011–2015



Source: Table 1.21.4.

Figure 1.21.2: Fetal and neonatal mortality (per cent of perinatal deaths), by Indigenous status, NSW, Qld, WA, SA and NT combined, 2011–2015



Source: Table 1.21.3.

Figure 1.21.3: Indigenous fetal and neonatal mortality per 1,000 births, NSW, Qld, WA, SA and NT combined, 1998–2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.22 All causes age-standardised death rates

Why it is important

This measure reports on the death rate from all causes. The death rate of a population provides a summary measure of the overall health status of that population. Death rates are a useful measure with which to compare the overall health status of different populations and to monitor changes in overall health status of populations over time. The rate for Indigenous Australians is 1.7 times that for non-Indigenous Australians, indicating that the overall health status is worse for Indigenous Australians. Mortality rates are also used as an annual progress measure for the COAG target to close the gap in life expectancy by 2031, as life expectancy estimates are only available every 5 years (AHMAC 2017).

Key findings

Data are not available for the Australian Capital Territory, as the jurisdiction is not considered to have an adequate level of Indigenous identification in mortality data. Data from NSW, Qld, WA, SA and the NT combined are used as those jurisdictions are considered to have an adequate level of Indigenous identification in mortality data.

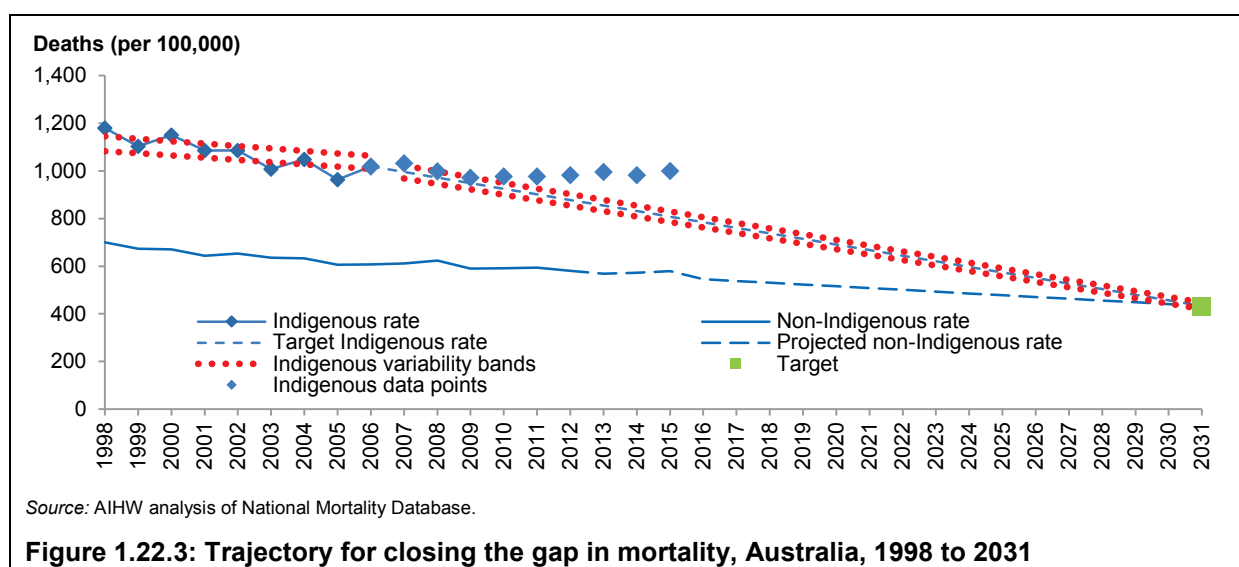
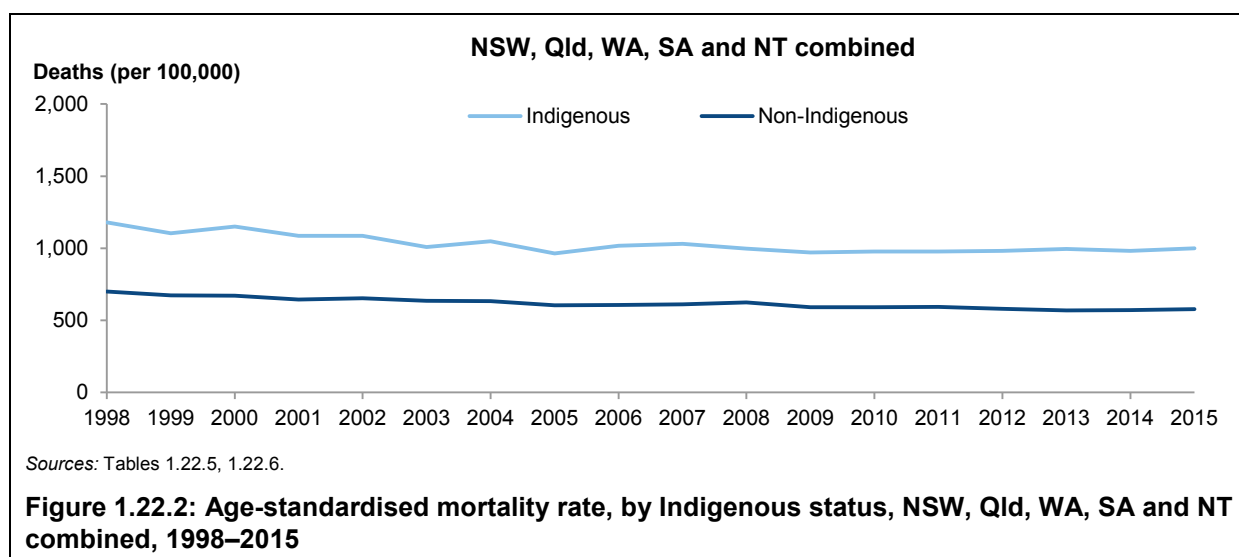
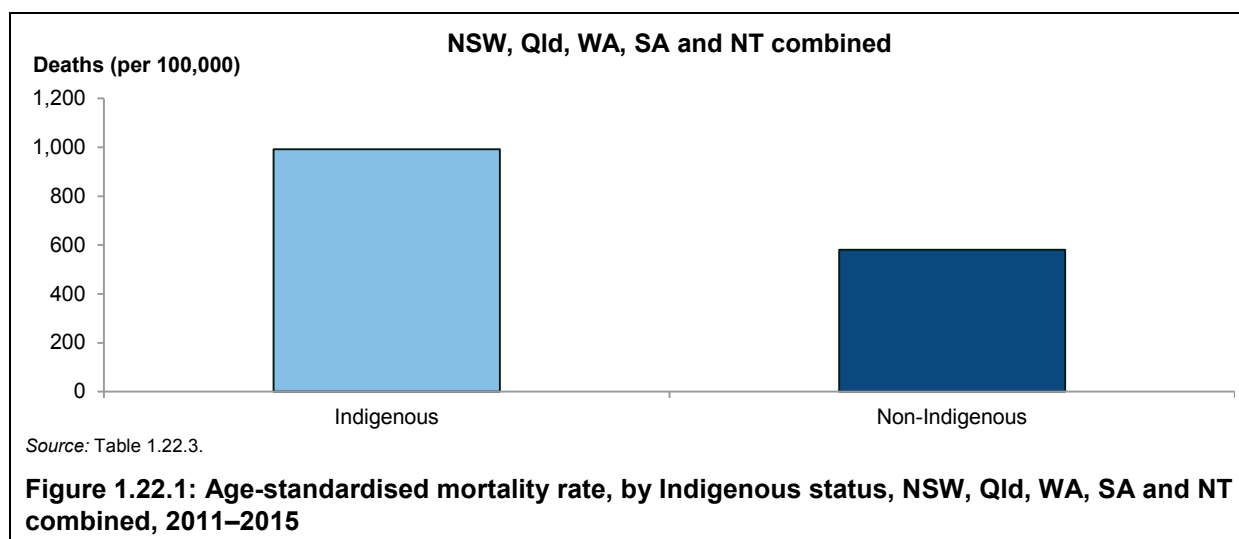
Overall: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised mortality rate for Indigenous Australians was 1.7 times the rate for non-Indigenous Australians (992 compared with 580 per 100,000) (Table 1.22.3, Figure 1.22.1).

Gap between Indigenous and non-Indigenous Australians: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the gap in the age-standardised death rate between Indigenous and non-Indigenous Australians was 412 per 100,000 (Table 1.22.3).

Trend over time—age-standardised death rate: From 1998 to 2015 in NSW, Qld, WA, SA and the NT combined, there was a 15% significant decrease in the age-standardised mortality rate for Indigenous Australians (from 1,180 to 1,000 per 100,000). For non-Indigenous Australians there was a 17% significant decrease (from 700 per 100,000 to 579 per 100,000) (Table 1.22.5, Figure 1.22.2).

Trend over time—gap between Indigenous and non-Indigenous Australians: From 1998 to 2015 in NSW, Qld, WA, SA and the NT combined, there was no significant change in the gap in the age-standardised death rate between Indigenous and non-Indigenous Australians (479 per 100,000 in 1998 and 421 per 100,000 in 2015) (Table 1.22.5).

Trajectory for closing the gap in mortality: Mortality rates relate to the Council of Australian Governments' target to close the gap in life expectancy within a generation. Figure 1.22.3 shows no improvement in mortality rates for Indigenous Australians nationally over the long term, and a considerable decrease required to reach the target in 2031.



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.23 Leading causes of mortality

Why it is important

This measure reports on the main causes of death. Death rates are a useful measure of the overall health status of a population, or to measure improvements over time. The gap between the Indigenous and non-Indigenous populations for particular causes of death provides an indication of the prevention, prevalence and management of particular diseases, helping to determine the diseases that most affect Indigenous Australians (AHMAC 2017).

Key findings

Mortality data are not available for the Australian Capital Territory for this measure. Data from NSW, Qld, WA, SA and the NT combined are used as those jurisdictions are considered to have an adequate level of Indigenous identification in mortality data.

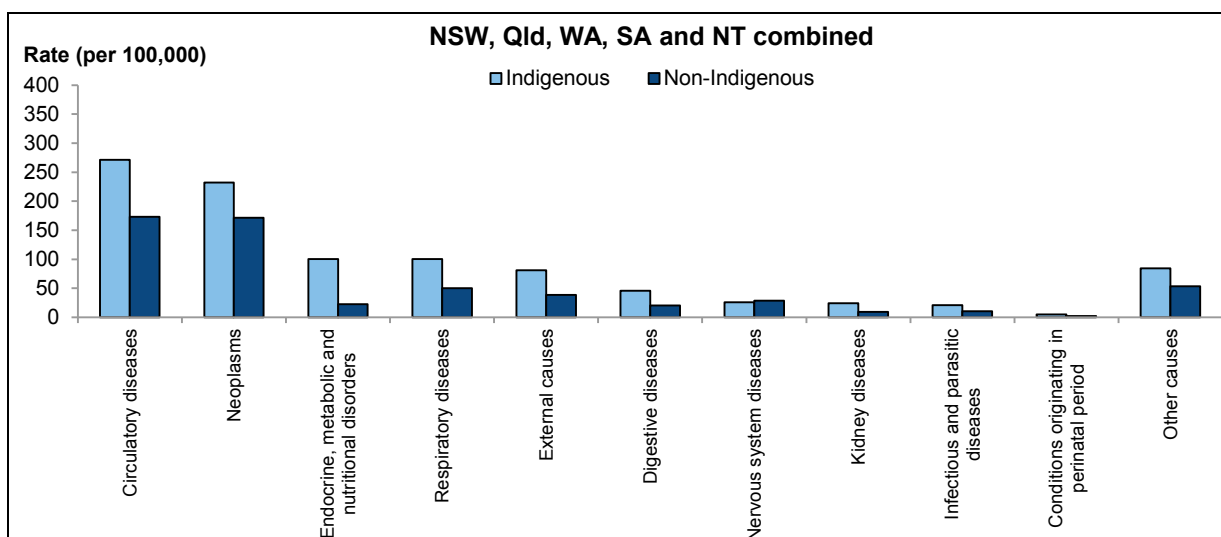
Overall: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised rates for the most common causes of death for Indigenous and non-Indigenous Australians were: circulatory diseases (271 compared with 173 per 100,000); followed by neoplasms (232 compared with 172 per 100,000); endocrine, metabolic and nutritional disorders (101 compared with 23 per 100,000); respiratory diseases (101 compared with 50 per 100,000); and external causes (81 compared with 38 per 100,000) (Table 1.23.2, Figure 1.23.1).

Chronic disease mortality: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised mortality rate for chronic diseases for Indigenous Australians aged 0–74 was 2.8 times the rate for non-Indigenous Australians (447 compared with 159 per 100,000).

The mortality rate for chronic diseases differed by age group. The age group with the highest mortality rate for chronic disease was 65–74 years for both Indigenous and non-Indigenous Australians (2,466 compared with 1,087 per 100,000). However, the age group with the biggest gap was 35–44 years. The age-standardised mortality rate for chronic diseases for Indigenous Australians aged 35–44 years was 5 times the rate for non-Indigenous Australians (245 compared with 49 per 100,000) (Table 1.23.5).

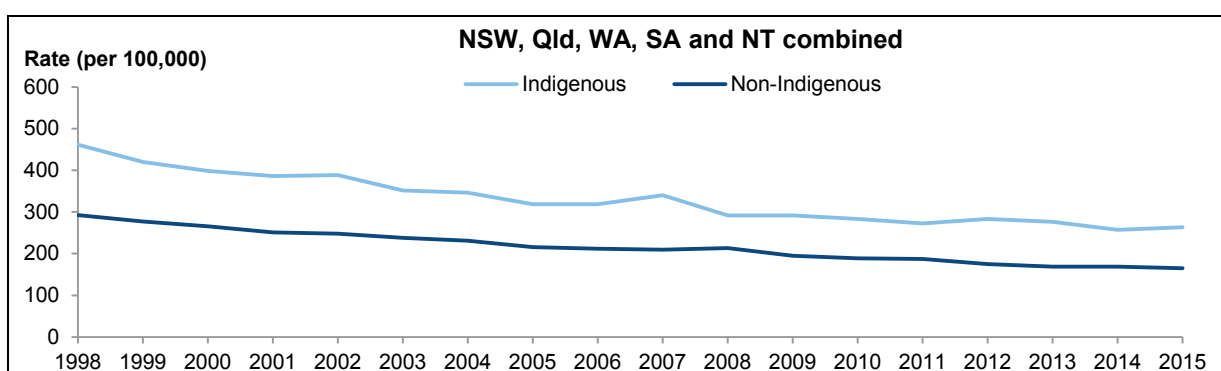
Trend over time—circulatory disease: From 1998 to 2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised mortality rate for Indigenous Australians for circulatory diseases decreased by 43% (from 462 to 263 per 100,000). The gap decreased by 42% (from 169 to 98 per 100,000) (Table 1.23.18, Figure 1.23.2).

Trend over time—cancer: From 1998 to 2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised mortality rate for Indigenous Australians for cancer increased by 21% (from 185 to 241 per 100,000). The rate for non-Indigenous Australians decreased by 13% (from 194 to 168 per 100,000) over the same time period (Table 1.23.20, Figure 1.23.3).



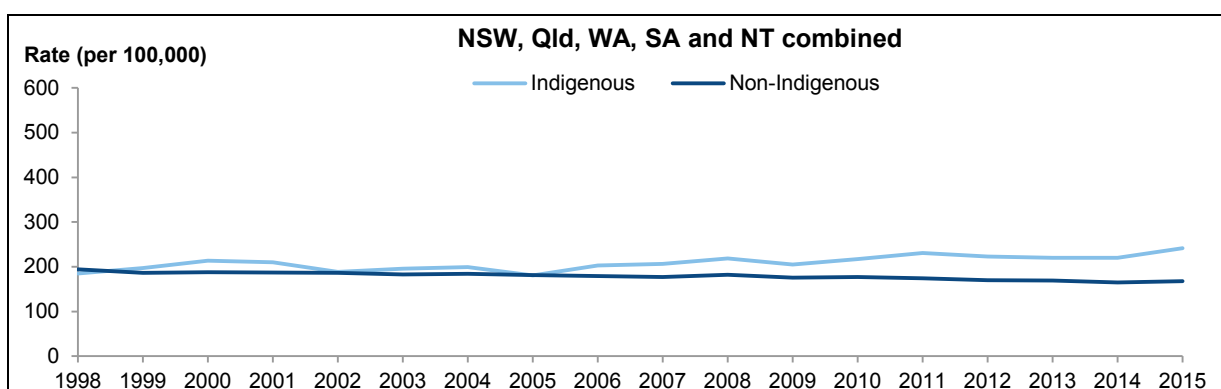
Source: Table 1.23.2.

Figure 1.23.1: Age-standardised mortality rate, by cause and Indigenous status, NSW, Qld, WA, SA and NT combined, 2011–2015



Source: Table 1.23.28.

Figure 1.23.2: Age-standardised mortality rate for circulatory diseases, by Indigenous status, NSW, Qld, WA, SA and NT combined, 1998–2015



Source: Table 1.23.29.

Figure 1.23.3: Age-standardised mortality rate for cancer, by Indigenous status, NSW, Qld, WA, SA and NT combined, 1998–2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

1.24 Avoidable and preventable deaths

Why it is important

This measure reports on potentially avoidable deaths of Indigenous Australians aged 0–74. Avoidable death refers to deaths from conditions that are considered avoidable, given timely and effective health care (including disease prevention and population health initiatives) (AIHW 2010b; Page et al. 2006). Avoidable deaths have been used in various studies to measure the quality, effectiveness and accessibility of the health system. Deaths from most conditions are influenced by various factors in addition to health system performance, including the underlying prevalence of conditions in the community, environmental and social factors and health behaviours (AHMAC 2017).

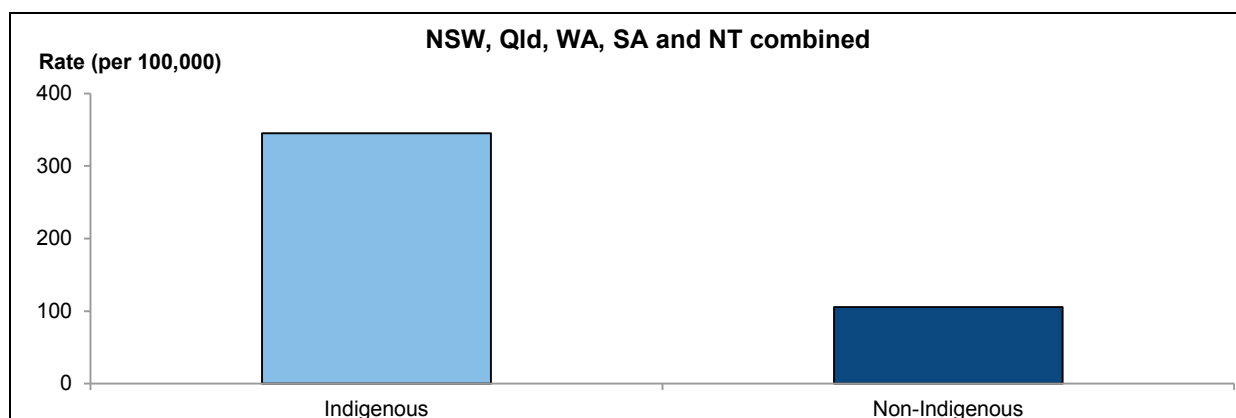
Key findings

Mortality data are not available for the Australian Capital Territory for this measure. Data from NSW, Qld, WA, SA and the NT combined are used as those jurisdictions are considered to have an adequate level of Indigenous identification in mortality data.

Overall: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the age-standardised avoidable death rate for Indigenous Australians aged 0–74 was 3.3 times the rate for non-Indigenous Australians (345 compared with 105 per 100,000) (Table 1.24.4, Figure 1.24.1).

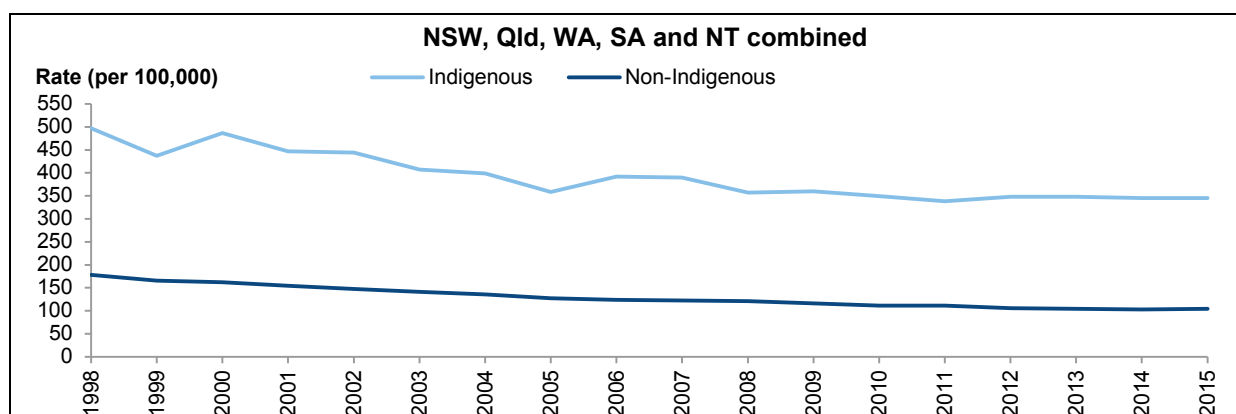
Gap between Indigenous and non-Indigenous Australians: In 2011–2015 in NSW, Qld, WA, SA and the NT combined, the gap in the age-standardised death rate between Indigenous and non-Indigenous Australians for avoidable causes was 240 per 100,000 (Table 1.24.4).

Trend over time: For NSW, Qld, WA, SA and the NT combined, the age-standardised avoidable mortality rate for Indigenous Australians aged 0–74 decreased from 497 per 100,000 in 1998 to 345 per 100,000 in 2015. The age-standardised, avoidable mortality rate for non-Indigenous Australians decreased from 178 per 100,000 in 1998 to 104 per 100,000 in 2015 (Table 1.24.2, Figure 1.24.2).



Source: Table 1.24.4.

Figure 1.24.1: Age-standardised avoidable death rate (aged 0–74), by Indigenous status, NSW, Qld, WA, SA and NT combined, 2011–2015



Source: Table 1.24.2.

Figure 1.24.2: Age-standardised avoidable death rate (aged 0–74), by Indigenous status, NSW, Qld, WA, SA and NT combined, 1998–2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

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Tier 2—Determinants of health

2.01 Housing

Why it is important

This measure reports on the housing circumstances of Indigenous Australians, including overcrowding (based on the Canadian National Occupancy Standard for Housing Appropriateness), tenure type and homelessness. Housing circumstances affect health and wellbeing (Andersen et al. 2016). There are complex relationships between housing circumstances, health and socioeconomic factors such as education, income and employment (Thomson et al. 2013).

Key findings

Home owners: In 2014–15 in the Australian Capital Territory, 44% of Indigenous Australians aged 18 and over reported owning their own homes, compared with 69% of non-Indigenous Australians.

Nationally in 2014–15, 29% of Indigenous Australians owned their own homes, compared with 69% of non-Indigenous Australians (Table 2.01.17, Figure 2.01.1).

Renters: In 2014–15 in the Australian Capital Territory, 56% of Indigenous Australians reported that they rented, compared with 30% of non-Indigenous Australians. A higher proportion of Indigenous Australians (26%) than non-Indigenous Australians (4%) rented through territory housing authorities (organisations subsidised by public funds). For other organisations (such as housing cooperatives, church groups and Indigenous housing organisations) the proportions for Indigenous and non-Indigenous Australians were 2.2% and 0.4%, respectively.

Nationally in 2014–15, 70% of Indigenous Australians rented, compared with 29% of non-Indigenous Australians. A higher proportion of Indigenous Australians rented through state or territory housing authorities (23%) compared with non-Indigenous Australians (3%) (Table 2.01.17, Figure 2.01.1).

Overcrowding: In 2014–15 in the Australian Capital Territory, 5.2% of Indigenous Australians reported living in overcrowded households, compared with 4.7% of non-Indigenous Australians.

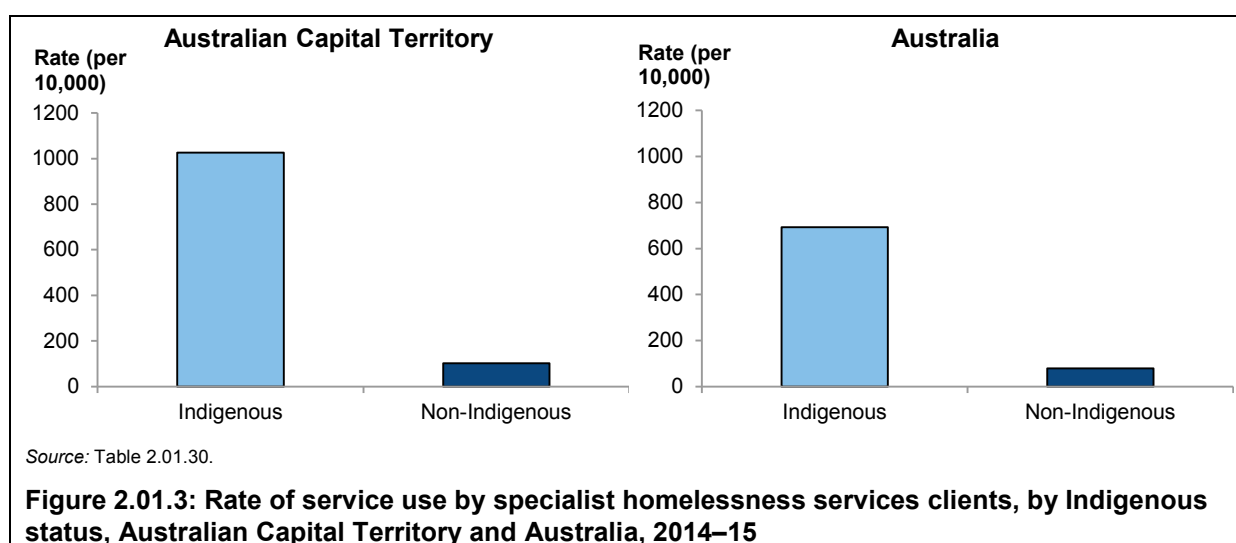
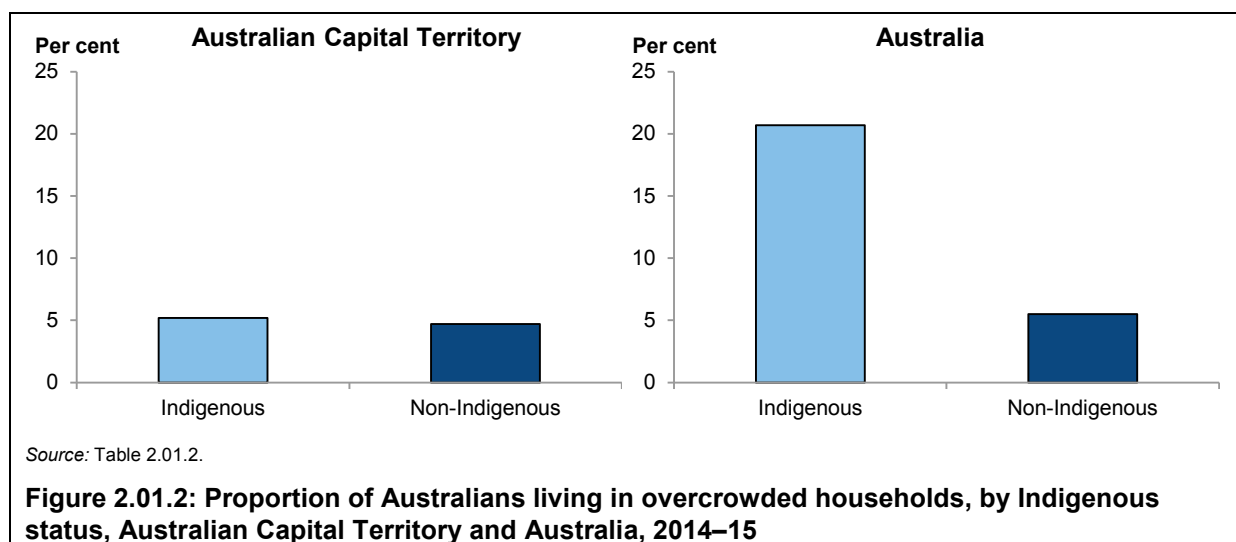
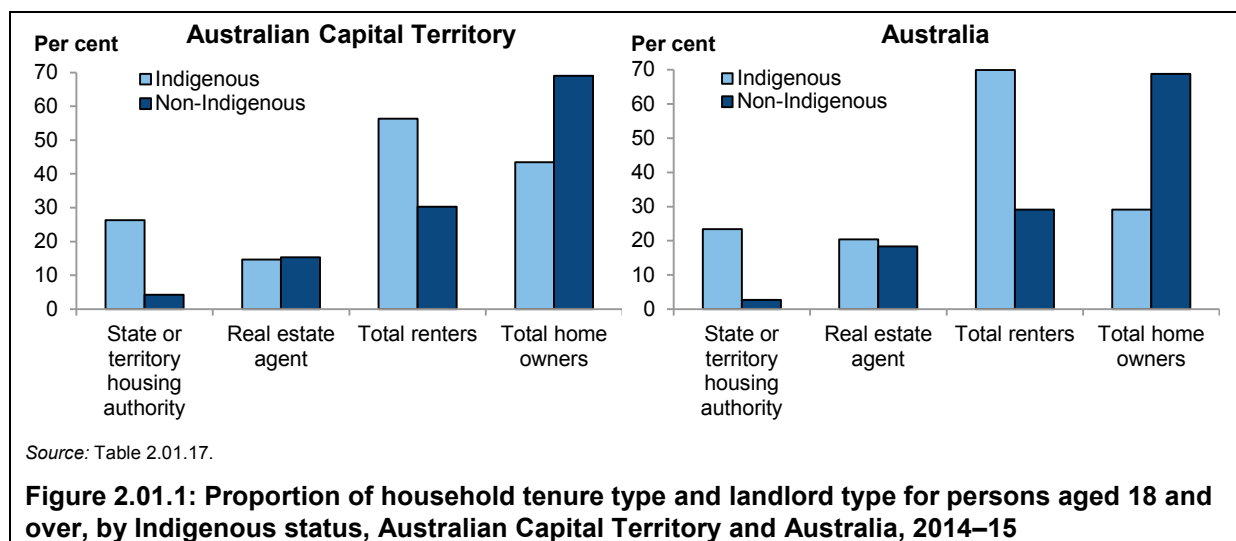
Nationally in 2014–15, 21% of Indigenous Australians lived in overcrowded households, compared with 5.5% of non-Indigenous Australians (Table 2.01.2, Figure 2.01.2).

Specialist homelessness services: In 2014–15 in the Australian Capital Territory, the rate of specialist homelessness services use by Indigenous Australians (all ages) was 10 times the rate for non-Indigenous Australians (1,027 per 10,000 compared with 103 per 10,000).

Nationally in 2014–15, the rate of specialist homelessness services use by Indigenous Australians (all ages) was 8.7 times the rate for non-Indigenous Australians (693 per 10,000 compared with 80 per 10,000) (Table 2.01.30, Figure 2.01.3).

Trend over time: Between 2004–05 and 2014–15 in the Australian Capital Territory, the proportion of Indigenous Australians who reported they live in overcrowded households decreased from 11% to 5%.

Nationally between 2004–05 and 2014–15, the proportion of Indigenous Australians living in overcrowded households decreased from 27% to 21% (Table 2.01.24).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.02 Access to functional housing with utilities

Why it is important

This measure reports on connection to water, sewerage and electricity, and the overall functionality of Indigenous housing facilities needed for healthy living. Housing is important for health and wellbeing. Functional housing encompasses basic services and facilities, infrastructure and habitability. These factors combined enable households to carry out healthy living practices including: waste removal; maintaining cleanliness through washing people, clothing and bedding; managing environmental risk factors such as electrical safety and temperature in the living environment; controlling air pollution for allergens; and preparing food safely (Bailie & Wayte 2006; DFCS 2003; Nganampa Health Council et al. 1987).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 17% of Indigenous Australians reported living in dwellings of an unacceptable standard.

Nationally, 18% of Indigenous Australians reported living in dwellings of an unacceptable standard (Table 2.02.6).

Major structural problems: In 2014–15 in the Australian Capital Territory, 23% of Indigenous Australians reported living in dwellings with major structural problems, compared with 13% of non-Indigenous Australians. The most common structural problems for both Indigenous and non-Indigenous Australians were major cracks in walls and floors (10% and 5%, respectively).

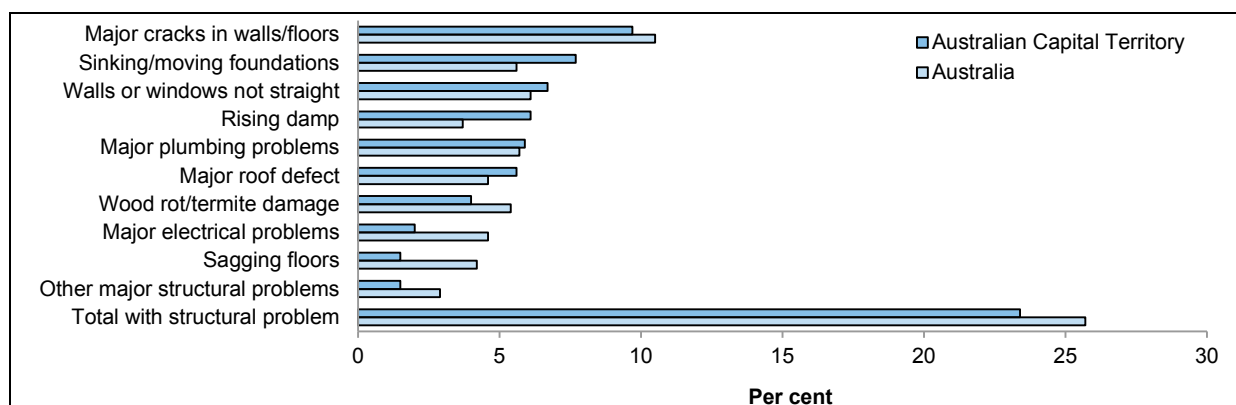
Nationally in 2014–15, 26% of Indigenous Australians reported living in dwellings with major structural problems, compared with 14% of non-Indigenous Australians. The most common structural problems for both Indigenous and non-Indigenous Australians were major cracks in walls or floors (11% and 6%, respectively) (Table 2.02.1, Figure 2.02.1).

Access to household facilities: In 2014–15 in the Australian Capital Territory, 4.7% of Indigenous Australians reported they did not have access to facilities for washing people; 7.5% did not have access to facilities for washing clothes and bedding; 7.2% did not have access to facilities for preparing food; and 7.6% did not have access to working sewerage facilities.

Nationally in 2014–15, 3.3% of Indigenous Australians did not have access to facilities for washing people; 8.7% did not have access to facilities for washing clothes and bedding; 8.0% did not have access to facilities for preparing food; and 3.5% did not have working sewerage facilities (Table 2.02.3, Figure 2.02.2).

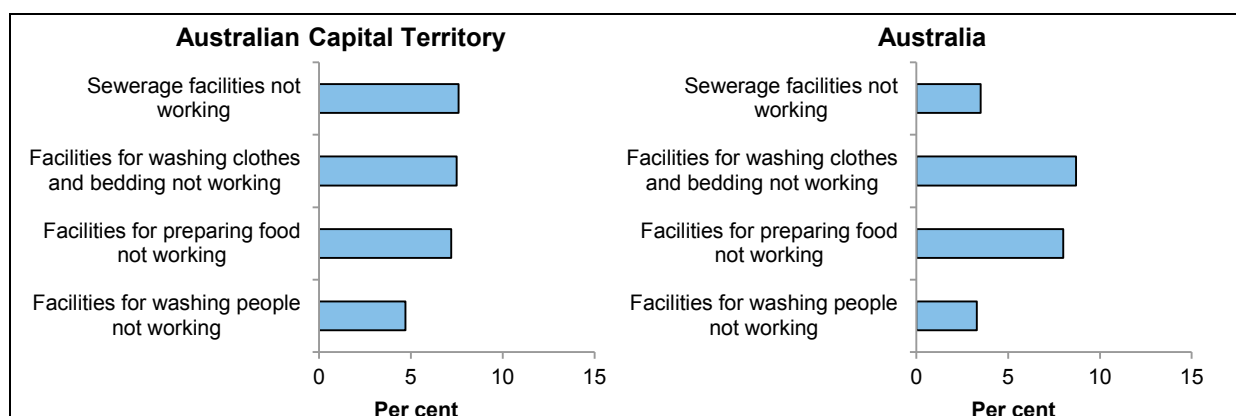
Trend over time: Between 2008 and 2014–15 in the Australian Capital Territory, the proportion of Indigenous Australians reporting they were living in dwellings of an unacceptable standard varied between 19% and 8.4%.

Nationally, between 2008 and 2014–15, the proportion of Indigenous Australians who reported living in dwellings of an unacceptable standard varied between 22% and 17% (Table 2.02.6, Figure 2.02.3).



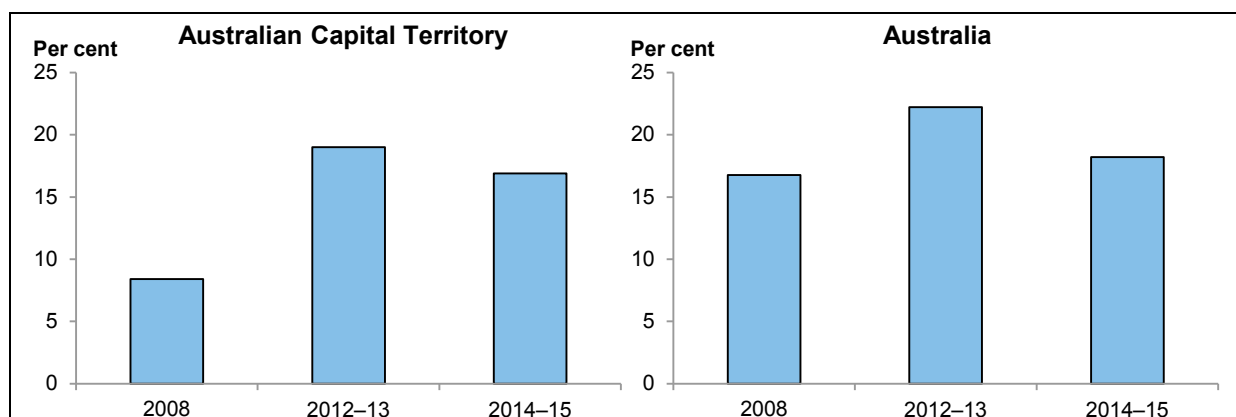
Source: Table 2.02.1.

Figure 2.02.1: Indigenous households with major structural problems, Australian Capital Territory and Australia, 2014–15



Source: Table 2.02.3.

Figure 2.02.2: Proportion of Indigenous households without working facilities to support healthy living, Australian Capital Territory and Australia, 2014–15



Source: Table 2.02.6.

Figure 2.02.3: Proportion of Indigenous households living in houses of an unacceptable standard, Australian Capital Territory and Australia, 2008, 2012–13 and 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.03 Environmental tobacco smoke

Why it is important

This measure reports Indigenous children aged 0–14 who live in households with daily smokers and daily indoor smokers. Environmental tobacco smoke (also known as second-hand smoke) is a significant cause of morbidity and mortality. There is strong and consistent evidence that second-hand smoke causes lung cancer and ischaemic heart disease, and is associated with an increased risk of respiratory disease in adults. It increases the risk of sudden infant death syndrome and exacerbates asthma and ear infections such as otitis media in children (Thomas & Stevens 2014). Exposure to second hand smoke during pregnancy is associated with an increased risk in neural tube defects (Wang et al. 2014a).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 56% of Indigenous children aged 0–14 were reported to live in households with daily smokers, compared with 15% of non-Indigenous children (Table 2.03.3, Figure 2.03.1). For 7% of Indigenous children, smoking occurred indoors (Table 2.03.4, Figure 2.03.2).

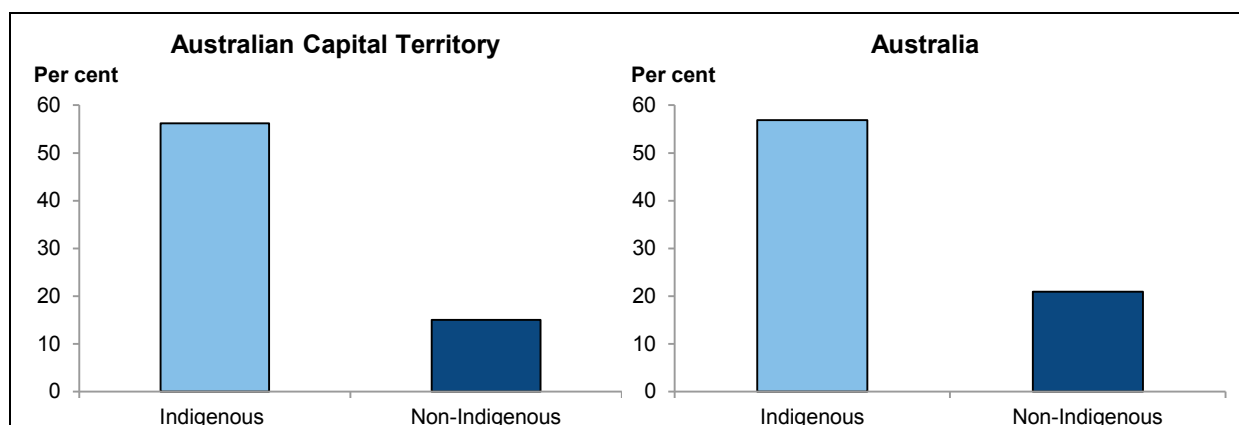
Nationally in 2014–15, 57% of Indigenous children aged 0–14 were reported to live in households with daily smokers, compared with 21% of non-Indigenous children (Table 2.03.3, Figure 2.03.1). Nationally, 13% of Indigenous children lived in households where smoking occurred indoors (Table 2.03.4, Figure 2.03.2).

Remoteness: Nationally, in 2014–15, the proportion of Indigenous children living in households with a daily smoker was reported to be highest for those in *Very remote* areas and lowest for those in *Major cities* (76% and 49%). For non-Indigenous children, the proportion was highest in *Outer regional* areas and lowest in *Major cities* (32% and 18%) (Table 2.03.5). Data are not available for non-Indigenous children for *Very remote* areas.

Nationally, smoking was reported to occur indoors at a higher rate for Indigenous children living in *Very remote* and *Inner regional* areas (20% and 14%) and was lowest among those living in *Major cities* (11%) (Table 2.03.6).

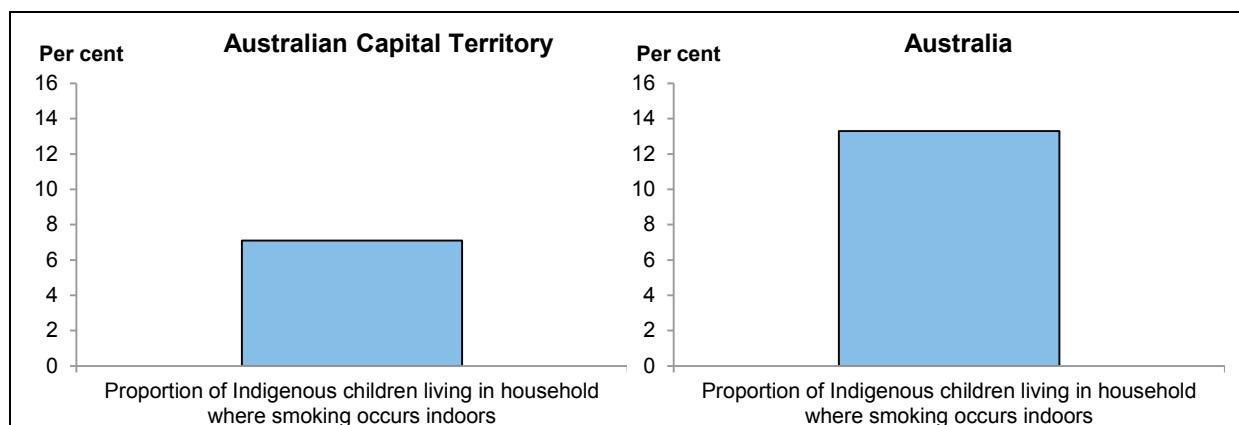
Socioeconomic characteristics: Nationally, in 2014–15, 49% of Indigenous children living with regular daily smokers were reported to be from households with an income in the lowest quintile. The proportion of Indigenous children who were living in the lowest income quintile households were exposed to smoking indoors at 6.6 times the proportion for those living in the highest 2 income quintiles (19% compared with 3%). Of Indigenous children living with regular daily smokers, 82% lived in a rented household and 29% experienced overcrowding (Table 2.03.8).

Trend over time: Nationally, the proportion of Indigenous children who were reported to live in a household with a daily smoker decreased from 68% in 2004–05 to 57% in 2014–15. For non-Indigenous children the proportion decreased from 35% in 2004–05 to 21% in 2014–15 (Table 2.03.7, Figure 2.03.3).



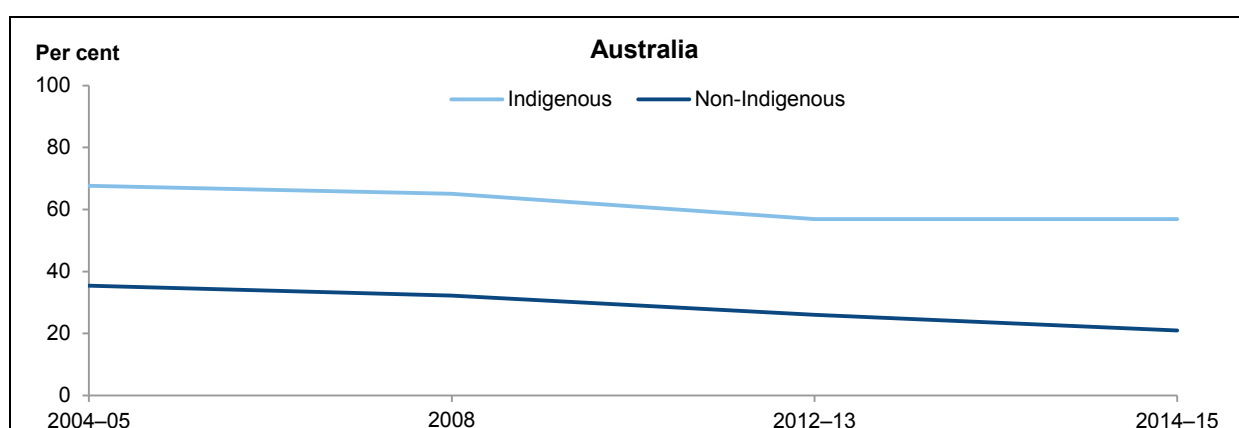
Source: Table 2.03.3.

Figure 2.03.1: Children aged 0–14 living in households with daily smokers, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 2.03.4.

Figure 2.03.2: Indigenous children aged 0–14 living in households where smoking occurs indoors, Australian Capital Territory and Australia, 2014–15



Source: Table 2.03.7.

Figure 2.03.3: Children aged 0–14 living in households with daily smokers, by Indigenous status, Australia, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.04 Literacy and numeracy

Why it is important

This measure reports on Year 3, 5, 7 and 9 students achieving national benchmarks.

Key findings

Reading: In 2016 in the Australian Capital Territory, 84% of Indigenous students met or exceeded the Year 3 national minimum standard in reading, 83% in Year 5, 90% in Year 7 and 81% in Year 9. For non-Indigenous students, the proportions were 97% for Year 3, 96% for Year 5, 96% for Year 7 and 96% for Year 9.

Nationally in 2016, 81% of Indigenous students met or exceeded the Year 3 national minimum standard in reading, 71% in Year 5, 77% in Year 7 and 74% in Year 9. For non-Indigenous students, the proportions were 96% for Year 3, 94% for Year 5, 96% for Year 7 and 94% for Year 9 (Table 2.04.1, Figure 2.04.1).

Writing: In 2016 in the Australian Capital Territory, 89% of Indigenous students met or exceeded the Year 3 national minimum standard for writing, 81% in Year 5, 72% in Year 7 and 66% in Year 9. For non-Indigenous students, the proportions were 97% for Year 3, 95% for Year 5, 92% for Year 7 and 86% for Year 9.

Nationally in 2016, 85% of Indigenous students met or exceeded the national minimum standard for writing in Year 3, 74% in Year 5, 64% in Year 7 and 53% in Year 9. For non-Indigenous students, the proportions were 97% for Year 3, 94% for Year 5, 91% for Year 7 and 85% for Year 9 (Table 2.04.3, Figure 2.04.1).

Spelling: In 2016 in the Australian Capital Territory, 80% of Indigenous students met or exceeded the Year 3 national minimum standard for spelling, 78% in Year 5, 79% in Year 7 and 77% in Year 9. For non-Indigenous students, the proportions were 95% for Year 3, 94% for Year 5, 95% for Year 7 and 93% for Year 9.

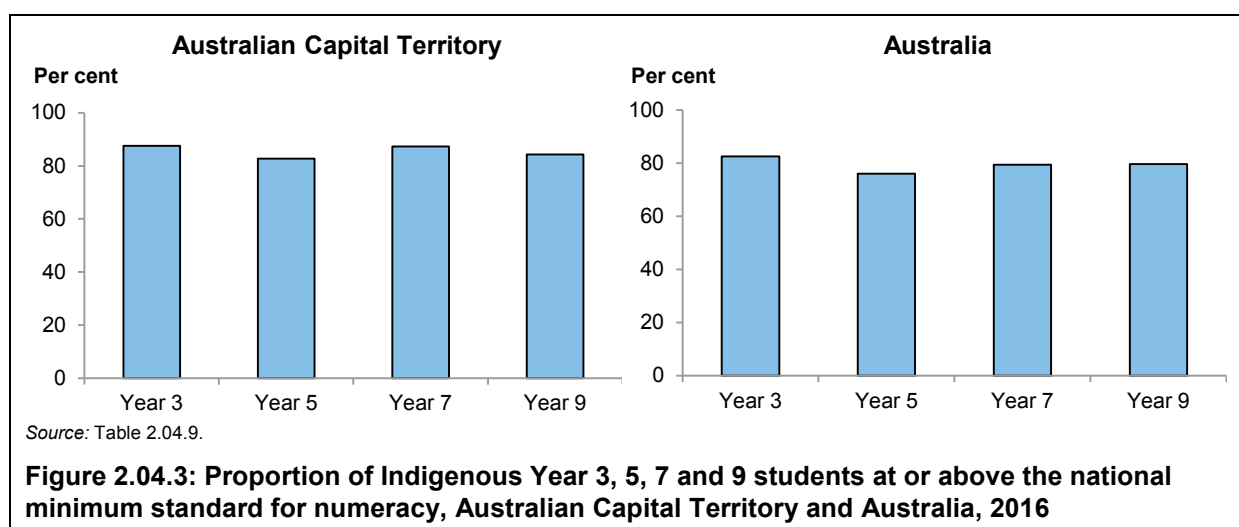
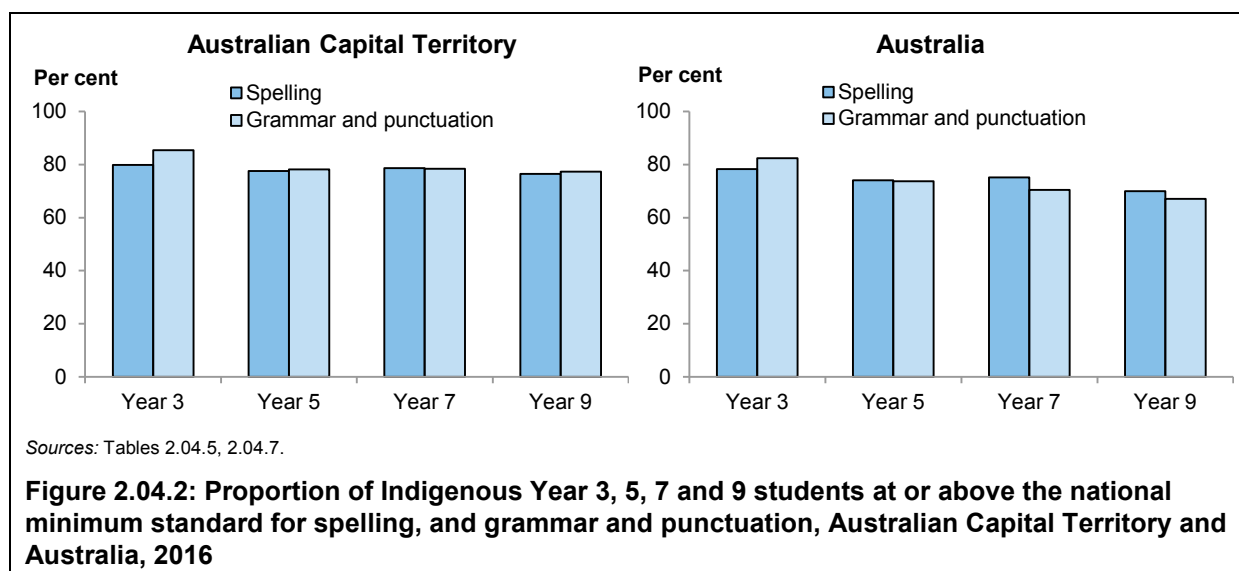
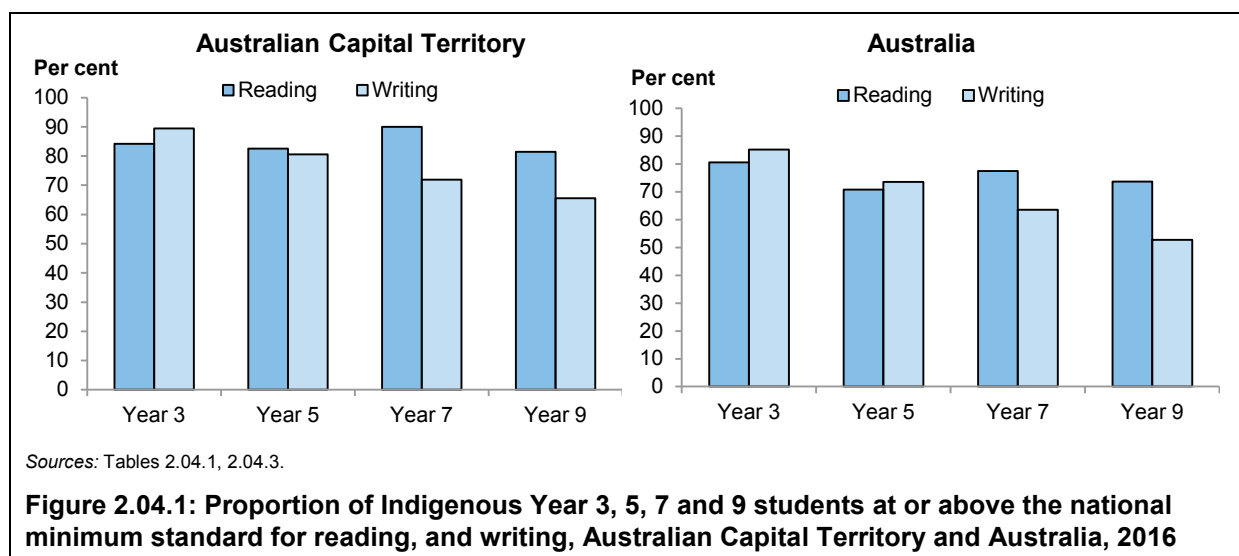
Nationally in 2016, 78% of Indigenous students met or exceeded the national minimum standard for spelling in Year 3, 74% in Year 5, 75% in Year 7 and 70% in Year 9. For non-Indigenous students, the proportions were 95% for Year 3, 94% for Year 5, 94% for Year 7 and 92% for Year 9 (Table 2.04.5, Figure 2.04.2).

Grammar and punctuation: In 2016 in the Australian Capital Territory, 85% of Indigenous students met or exceeded the Year 3 national minimum standard for grammar and punctuation, 78% in Year 5, 78% in Year 7 and 77% in Year 9. For non-Indigenous students, the proportions were 97% for Year 3, 96% for Year 5, 95% for Year 7 and 94% for Year 9.

Nationally in 2016, 82% of Indigenous students met or exceeded the standard in Year 3, 74% in Year 5, 70% in Year 7 and 67% in Year 9. For non-Indigenous students, the proportions were 96% for Year 3, 95% for Year 5, 94% for Year 7 and 92% for Year 9 (Table 2.04.7, Figure 2.04.2).

Numeracy: In 2016 in the Australian Capital Territory, 88% of Indigenous students met or exceeded the Year 3 national minimum standard for numeracy, 83% in Year 5, 87% in Year 7 and 84% in Year 9. For non-Indigenous students, the proportions were 97% for all years.

Nationally in 2016, 83% of Indigenous students met or exceeded the standard for numeracy in Year 3, 76% in Year 5, 79% in Year 7 and 80% in Year 9. For non-Indigenous students, the proportions were around 96% for Year 3, 5 and 9 and 97% for Year 7 (Table 2.04.9, Figure 2.04.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.05 Education outcomes for young people

Why it is important

This measure reports on the rates of Indigenous students who stay in education through Year 10 and Year 12, as well as Indigenous students Year 12 attainment rates. Higher levels of education are associated with better health outcomes through greater health literacy as well as better prospects for socioeconomic status (including income and employment), which supports better access to safe and healthy housing, as well as healthy lifestyle choices such as regularly eating fruit and vegetables, and not smoking (Clark & Utz 2014).

Research in the US found that mortality declined at a faster pace for those with more education, with a 7-year increase in life expectancy for college-educated students (Wong et al. 2002). International literature also documents that increased levels of maternal education leads to lower child mortality, due to various factors, including a better understanding of health services and a greater willingness to access them.

Key findings

Apparent retention: In 2015 in the Australian Capital Territory, the apparent retention rate from Year 7/8 to Year 12 was 88% for Indigenous students and 97% for other students. The apparent retention rate from Year 10 to Year 12 was 87% for Indigenous students and 95% for other students.

Nationally in 2015, the apparent retention rate from Year 7/8 to Year 12 was 59% for Indigenous students and 85% for other students. The apparent retention rate from Year 10 to Year 12 was 61% for Indigenous students and 84% for other students (Table 2.05.2, Figure 2.05.1).

School attendance: In 2014–15 in the Australian Capital Territory, 97% of Indigenous children aged 4–14 were reported to usually attend school (Table 2.05.10, Figure 2.05.2), and 37% of Indigenous children missed days at school, preschool or kindergarten in the week prior to the survey (Table 2.05.10).

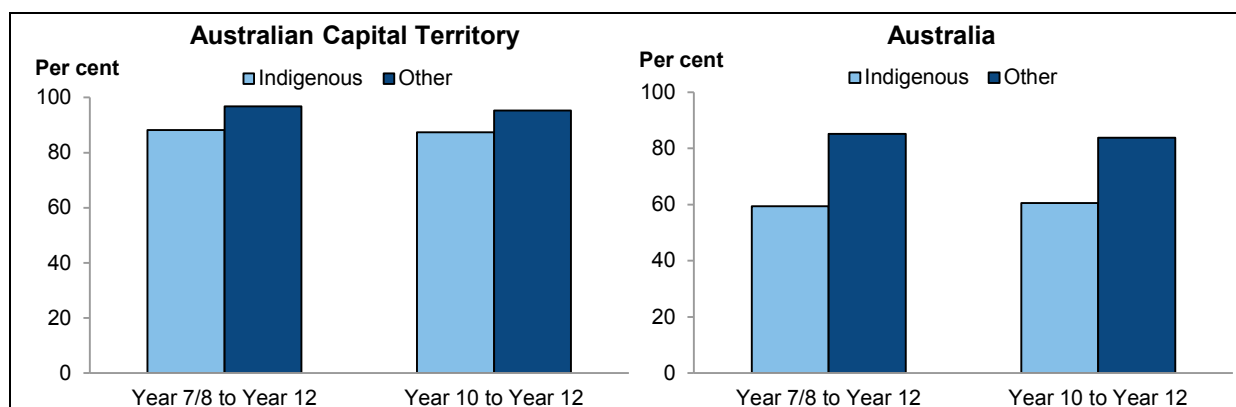
In 2014–15 nationally, 96% of Indigenous children aged 4–14 were reported to usually attend school (Table 2.05.10, Figure 2.05.2), and 28% of Indigenous children missed days at school, preschool or kindergarten in the week prior to the survey (Table 2.05.10).

Unfairness: In 2014–15 in the Australian Capital Territory, 14.6% of Indigenous children aged 2–14 were reported to have been treated unfairly at school. This included the current or previous schools the child had attended.

Nationally in 2014–15, 8.7% of Indigenous children aged 2–14 were reported to have been treated unfairly at school (Table 2.05.13).

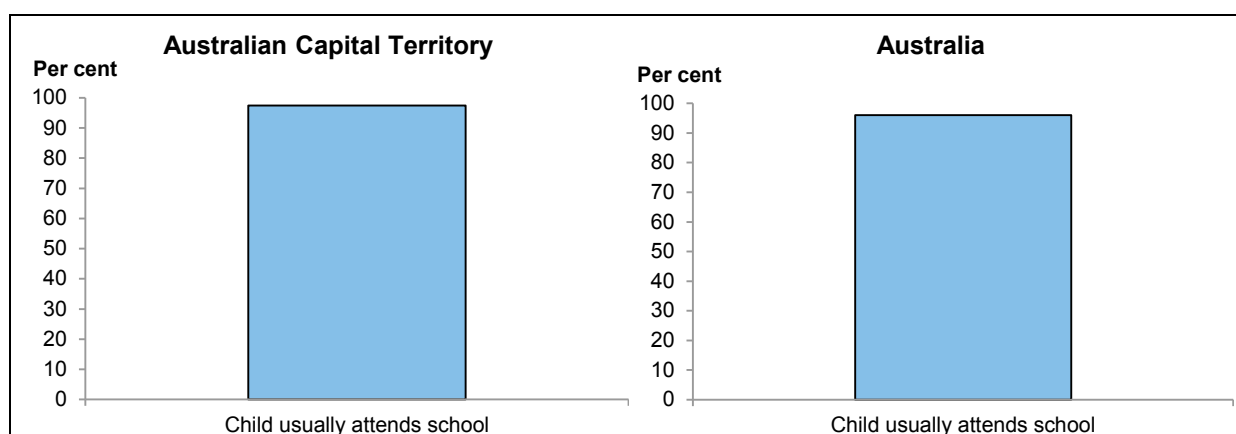
Year 12 or equivalent: In 2014–15 in the Australian Capital Territory, 83% of Indigenous Australians aged 20–24 reported they had attained Year 12 or equivalent or Certificate II or above, and 80% had attained Year 12 or equivalent or Certificate III or above. For non-Indigenous Australians, the proportion was 93% for both categories.

In 2014–15 nationally, 62% of Indigenous Australians aged 20–24 reported they had attained Year 12 or equivalent or Certificate II or above, and 54% had attained Year 12 or equivalent or Certificate III or above. The proportions for non-Indigenous Australians were 86% and 85%, respectively (Table 2.05.14, Figure 2.05.3).



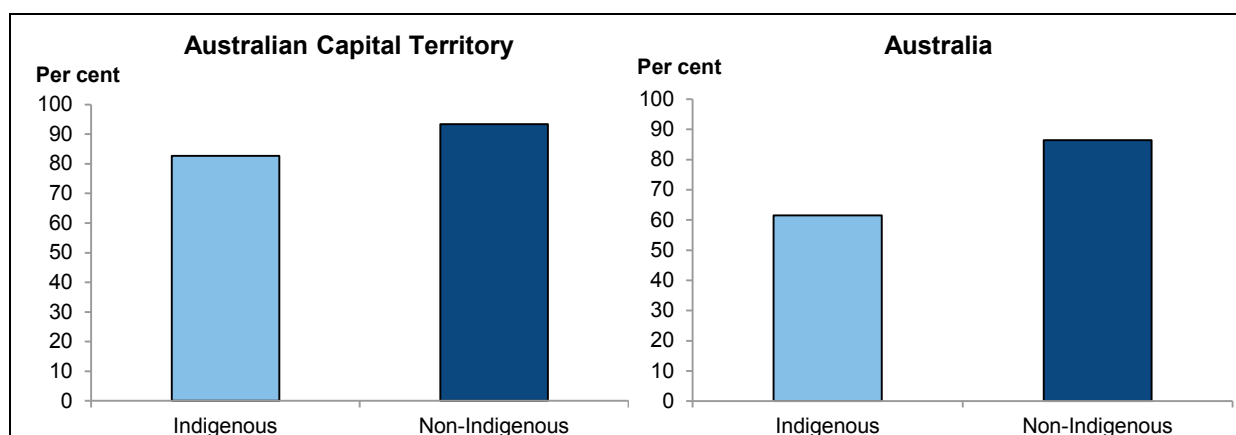
Source: Table 2.05.2.

Figure 2.05.1: Apparent retention rates, by Indigenous status, Australian Capital Territory and Australia, 2015



Source: Table 2.05.10.

Figure 2.05.2: School attendance for Aboriginal and Torres Strait Islander children aged 4–14, Australian Capital Territory and Australia, 2014–15



Source: Table 2.05.14.

Figure 2.05.3: Proportion of 20–24 year olds having attained at least Year 12 or equivalent or Certificate II or above, by Indigenous status, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.06 Educational participation and attainment of adults

Why it is important

This measure reports on educational participation by adults (undertaking formal education or training) and educational attainment (completion of a particular level of school education or non-school qualification). Adult learning is a powerful tool in achieving better health, education and economic outcomes (Chandola & Jenkins 2014). The employment gap between Indigenous and non-Indigenous Australians declines as the level of education attainment increases. The transition from education to work is usually smoother for vocational education and training (VET) and university graduates, and salaries are higher than for those who enter the workforce directly from school (Lamb & McKenzie 2001).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 34% of Indigenous Australians aged 15 and over reported that they were currently studying at an educational institution, compared with 21% of non-Indigenous Australians. Of those who were studying, the largest proportions of Indigenous and non-Indigenous students were at a university or other higher education institution (31% and 50%, respectively).

In 2014–15 nationally, 22% of Indigenous Australians aged 15 and over reported that they were currently studying at an educational institution, compared with 18% of non-Indigenous Australians. Of those who were studying, the largest proportion of Indigenous students (36%) were at secondary school; however, most non-Indigenous students were studying at a university or other higher education institution (39%) (Table 2.06.3, Figure 2.06.1).

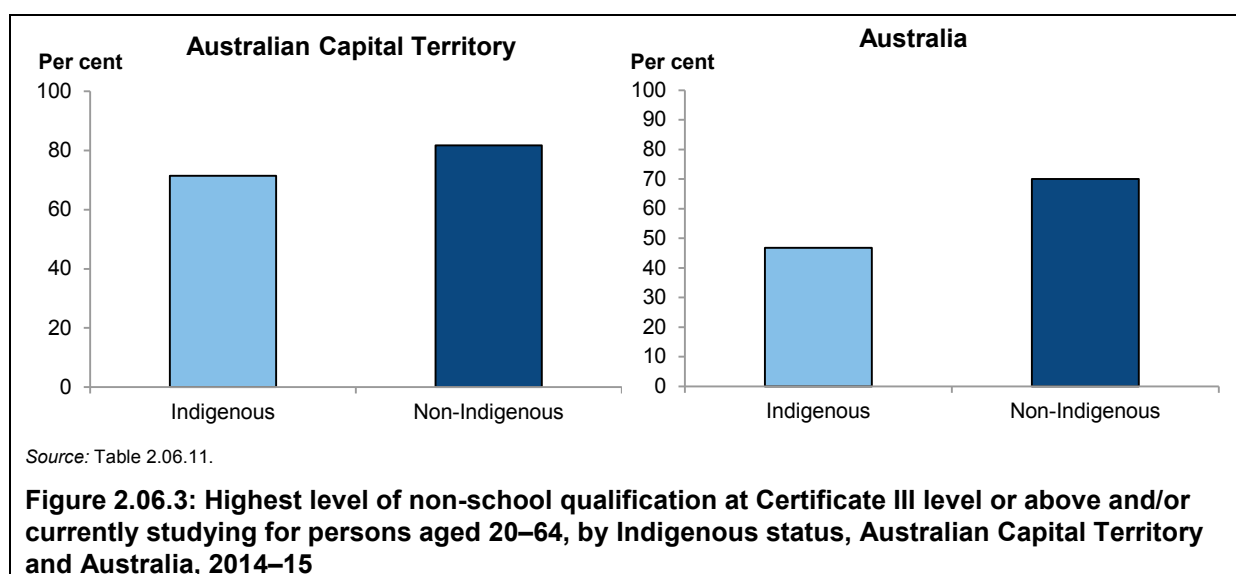
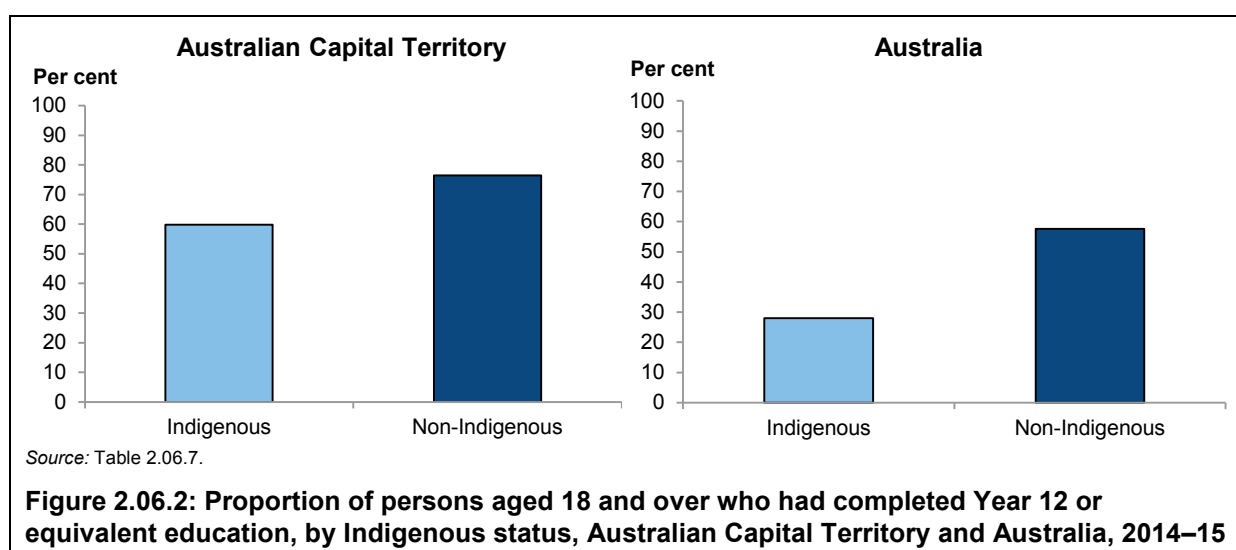
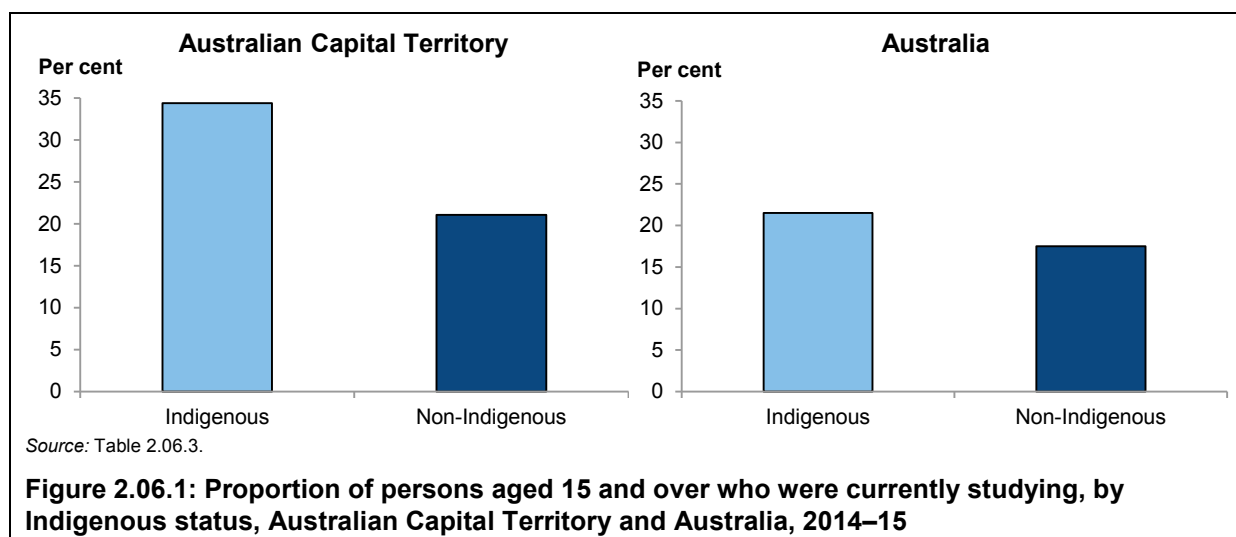
Highest level of school completed: In 2014–15 in the Australian Capital Territory, 60% of Indigenous adults reported that Year 12 or equivalent was the highest level of school completed, compared with 77% of non-Indigenous adults.

Nationally in 2014–15, 28% of Indigenous adults reported that Year 12 or equivalent was the highest level of school completed, compared with 58% of non-Indigenous adults (Table 2.06.7, Figure 2.06.2).

Non-school qualification: In 2014–15 in the Australian Capital Territory, 72% of Indigenous Australians aged 20–64 reported they either had a Certificate III or above or were studying at any level, compared with 82% of non-Indigenous Australians.

Nationally in 2014–15, 47% of Indigenous Australians aged 20–64 years reported they either had a Certificate III or above or were studying at any level, compared with 70% of non-Indigenous Australians (Table 2.06.11, Figure 2.06.3).

Trend over time: Nationally, the proportion of Indigenous Australians aged 15 and over who reported that they were currently studying has increased over time, from 18% in 2002 to 22% in 2014–15. This included studying at secondary schools; institutions for technical and further education; and universities or other higher education institutions (Table 2.06.20).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.07 Employment

Why it is important

This measure reports on the employment status of Indigenous Australians aged 15–64. Participation in employment has important consequences for health, social and emotional wellbeing and living standards for individuals, families and communities (Bambra 2011; Gray et al. 2014). Conversely, being sick or disabled, or looking after someone in poor health acts as a barrier to labour force participation (Belachew & Kumar 2014). Health risks from being unemployed include mental health and stress related health impacts such as heart disease (Wilkinson & Pickett 2009), being unable to afford necessities such as food, security, safe neighbourhoods and adequate housing (Bambra 2011), and the effects from adopting unhealthy coping behaviours (Dooley et al. 1996). Experiencing extended and repeated periods of unemployment compound these effects (Taulbut et al. 2013).

Key findings

Labour force participation: In 2014–15 in the Australian Capital Territory, 69% of Indigenous Australians of working age (15–64 years) were in the labour force, compared with 80% of non-Indigenous Australians (from the 2014 Survey of Education and Work).

In 2014–15 nationally, 61% of Indigenous Australians of working age (15–64) reported they were in the labour force, compared with 77% of non-Indigenous Australians (Table 2.07.5, Figure 2.07.1). The largest difference between Indigenous and non-Indigenous Australians in the labour force was for those aged 45–54, where the proportions were 59% compared with 84% (Table 2.07.3).

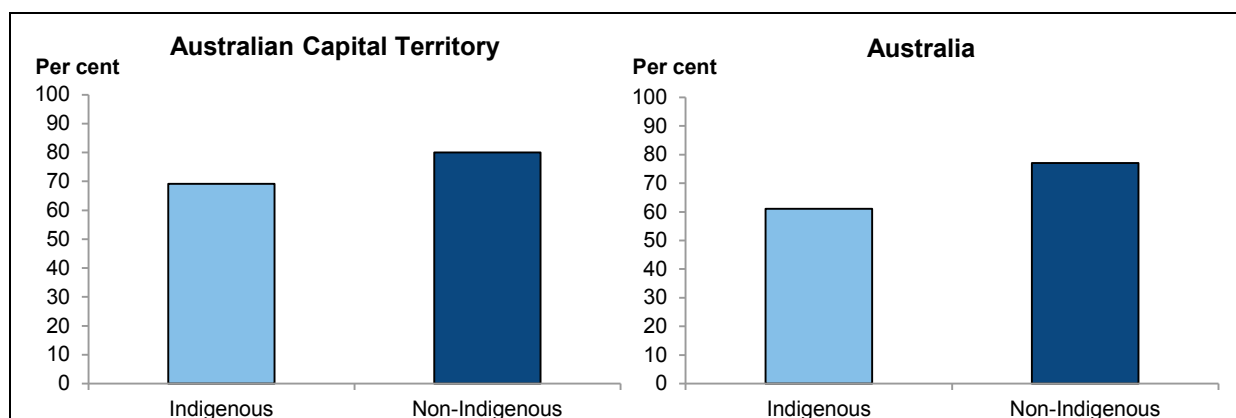
Employment: In 2014–15 in the Australian Capital Territory, 63% of Indigenous Australians of working age reported that they were employed; 45% were working full time and 19% were working part time. For non-Indigenous Australians (in 2014), 77% of the working age population were employed; 57% were working full time and 19% were working part time.

Nationally in 2014–15, 48% of Indigenous Australians of working age were employed; 29% were working full time and 19% were working part time. For non-Indigenous Australians (in 2014), 73% of the working age population were employed; 51% were working full time and 21% were working part time (Table 2.07.5, Figure 2.07.2).

Unemployment: In 2014–15 in the Australian Capital Territory, the reported unemployment rate for Indigenous Australians aged 15–64 was 8.4%, compared with 4.5% for non-Indigenous Australians (in 2014).

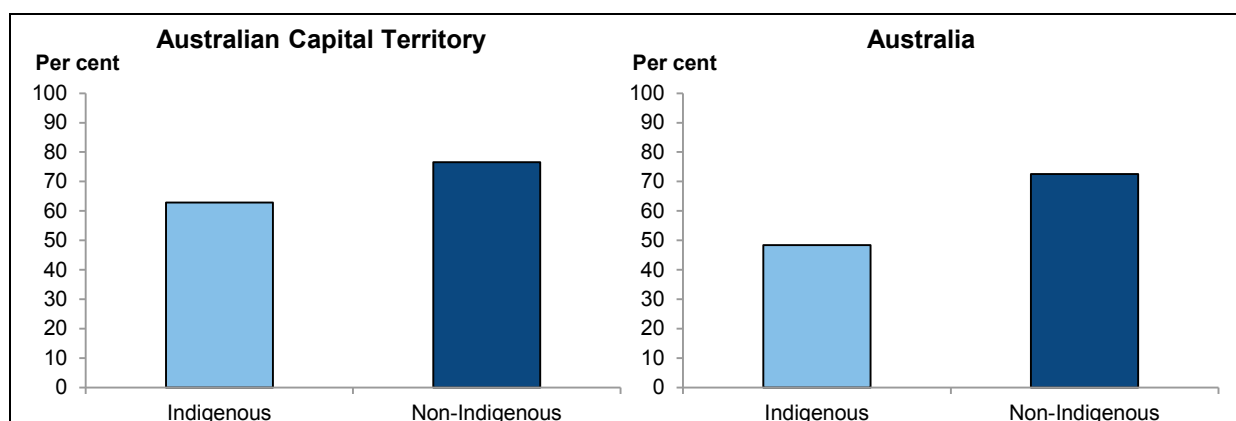
Nationally in 2014–15, the unemployment rate for Indigenous Australians was 21%, compared with 5.8% for non-Indigenous Australians (in 2014) (Table 2.07.5, Figure 2.07.3).

Difficulty in finding work: Nationally in 2014–15, 92% of Indigenous Australians who were unemployed reported difficulties in finding work. The most common reasons provided were that there were no jobs in the local area or line of work (41%) and transport problems or distance (32%) (Table 2.07.10).



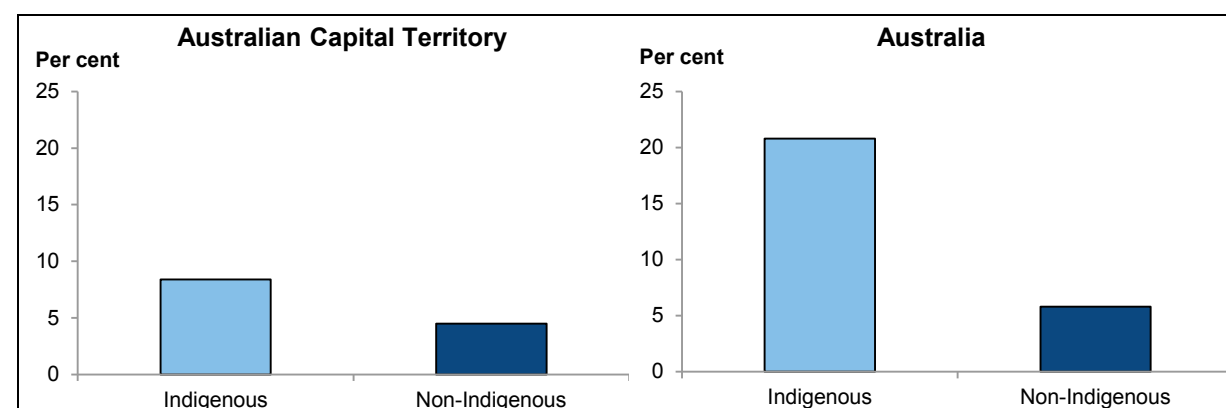
Source: Table 2.07.5.

Figure 2.07.1: Labour force participation rate, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 2.07.5.

Figure 2.07.2: Employment rate, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 2.07.5.

Figure 2.07.3: Unemployment rate, by Indigenous status, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.08 Income

Why it is important

This measure reports on equivalised gross household and individual income. Studies across different countries have found a gradient in health outcomes associated with income (Marmott 2002). Income itself is highly correlated with educational attainment, employment and various social indicators (Deaton 2003). The relationship between income and health is complex, and is linked to other factors such as the capacity to live a healthy life, including being able to afford nutritious food and quality housing (AHMAC 2017).

Key findings

Equivalised gross weekly household income: In 2014–15 in the Australian Capital Territory, 21% of Indigenous adults reported they were living in households in the lowest equivalised weekly household income quintile. This was 3 times the proportion of non-Indigenous adults (6.7%). Almost a quarter (23%) of Indigenous adults lived in households with a weekly household income in the highest quintile, compared with 39% of non-Indigenous Australians.

In 2014–15 nationally, more than one-third (37%) of Indigenous adults reported they were living in households in the lowest equivalised weekly household income quintile. This was more than twice the proportion of non-Indigenous adults (17%). In 2014–15 nationally, 6.2% of Indigenous adults lived in households with a weekly household income in the highest quintile, compared with 22% of non-Indigenous Australians (Table 2.08.1, Figure 2.08.1).

Median equivalised gross weekly household income: In 2014–15 in the Australian Capital Territory, the reported median equivalised gross weekly household income for Indigenous adults was \$805 compared with \$1,279 for non-Indigenous adults.

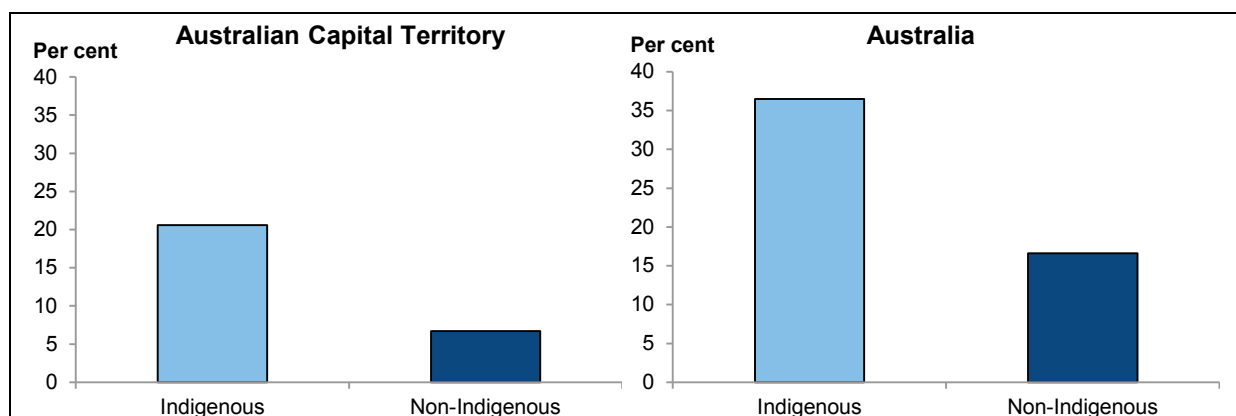
Nationally in 2014–15, the reported median equivalised gross weekly household income for Indigenous adults was \$542 compared with \$852 for non-Indigenous adults (Table 2.08.3).

Ability to raise \$2,000 in a week: In 2014–15 in the Australian Capital Territory, 35% of Indigenous Australians reported they were living in households that could not raise \$2,000 within a week in an emergency (indicating financial stress).

Nationally in 2014–15, 50% of Indigenous Australians reported they were living in households that could not raise \$2,000 within a week in an emergency. The rate was higher in *Remote* areas (64%) than *Non-remote* areas (46%) (Table 2.08.6, Figure 2.08.2).

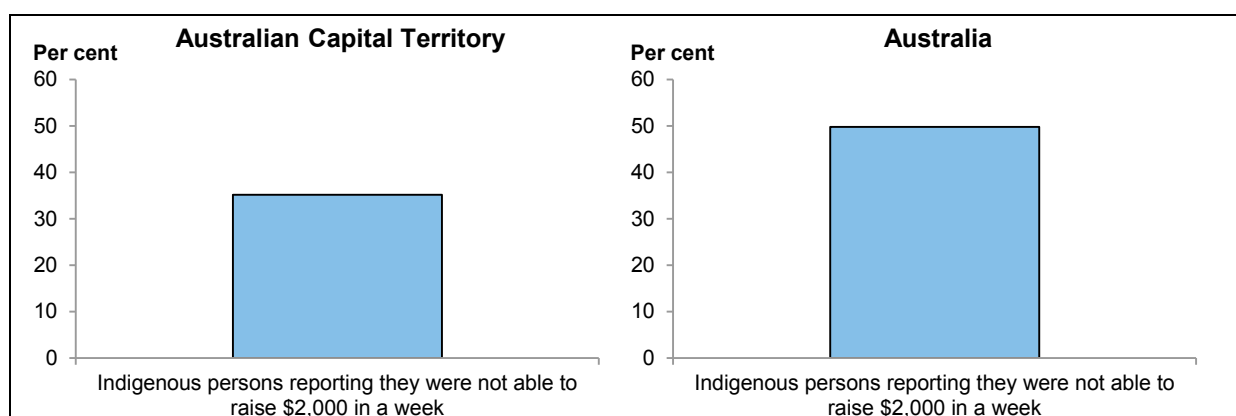
Trend over time: In the Australian Capital Territory, the reported median equivalised gross weekly household income for Indigenous Australians aged 18 and over (in 2014–15 dollars) increased from \$756 in 2002 to \$864 in 2012–13, then declined to \$805 in 2014–15. For non-Indigenous Australians, it increased from \$1,084 in 2002 to \$1,355 in 2012–13, and then decreased to \$1,279 in 2014–15.

Nationally, the reported median equivalised gross weekly household income for adults significantly increased from \$402 in 2002 to \$542 in 2014–15 for Indigenous Australians. For non-Indigenous Australians, it increased from \$751 in 2002 to \$907 in 2012–13, and then declined to \$852 in 2014–15 (Table 2.08.3, Figure 2.08.3).



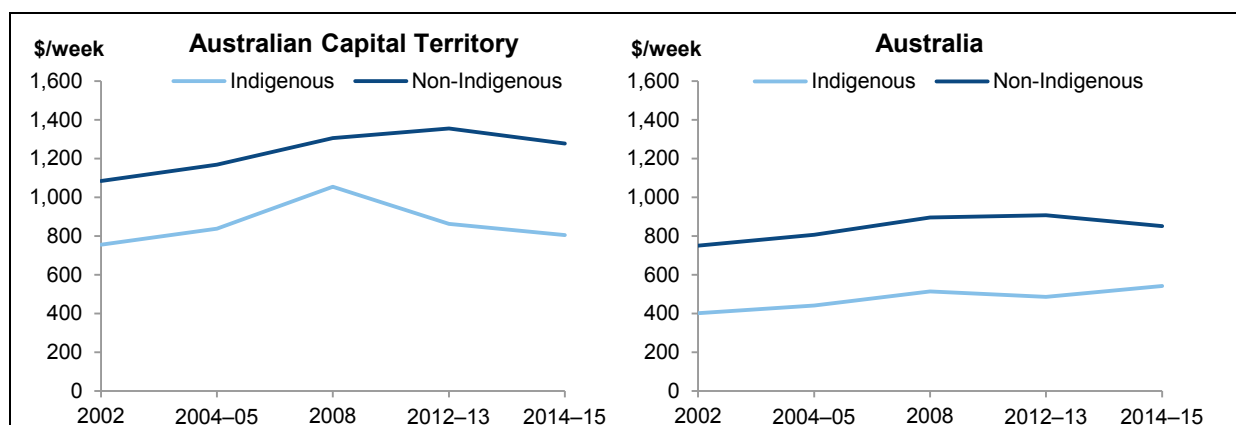
Source: Table 2.08.1.

Figure 2.08.1: Proportion of adults with equivalised gross weekly household income in the lowest quintile, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 2.08.6.

Figure 2.08.2: Indigenous persons in households reporting they were not able to raise \$2,000 in a week, Australian Capital Territory and Australia, 2014–15



Source: Table 2.08.3.

Figure 2.08.3: Median equivalised gross weekly household income, people aged 18 and over, by Indigenous status, Australian Capital Territory and Australia, 2002 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.09 Index of disadvantage

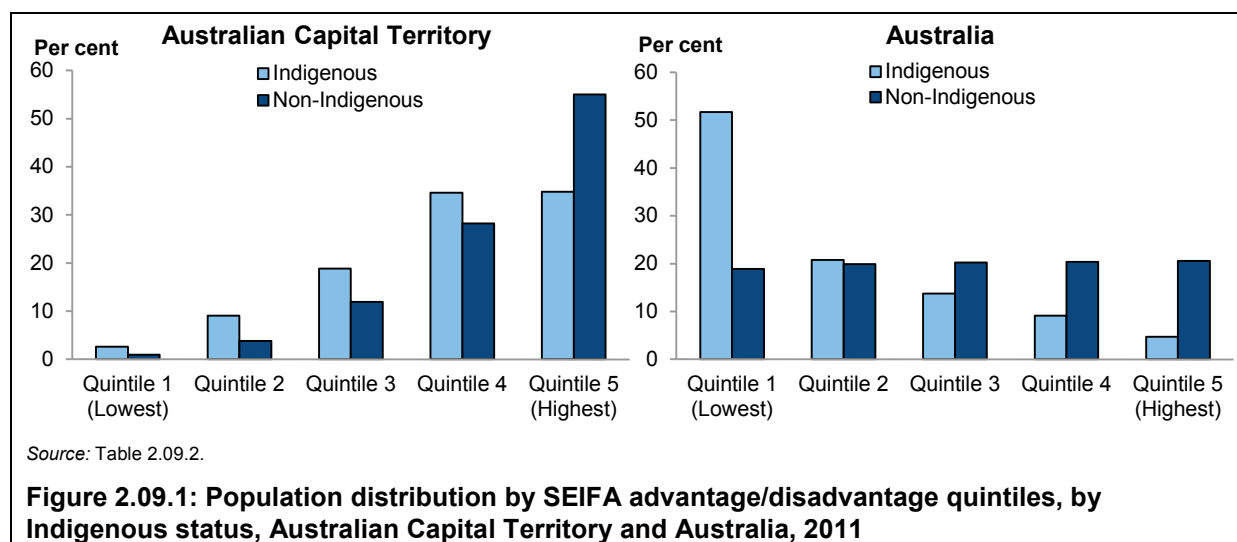
Why it is important

This measure reports on the relative disadvantage for Indigenous Australians compared with non-Indigenous Australians. It is based on the Index of Relative Socio-Economic Advantage and Disadvantage (SEIFA), and shows the distribution of the Indigenous population across areas of advantage and disadvantage. The areas are grouped into quintiles (5 categories of advantage or disadvantage, with 1 being the lowest socioeconomic status (SES) and 5 being the highest SES) under the Socio-Economic Indexes for Areas (SEIFA). Results from the 2011 Census showed that Indigenous Australians had higher levels of socioeconomic disadvantage than non-Indigenous Australians across all remoteness areas. In Australia, there were no areas where the Indigenous population had greater or equal economic outcomes compared with the non-Indigenous population (Biddle 2013).

Key findings

Overall: In 2011 in the Australian Capital Territory, 2.6% of the Indigenous population lived in the most disadvantaged areas (quintile 1) and 35% of Indigenous Australians lived in areas of most advantage (quintile 5). For non-Indigenous Australians, 0.9% lived in areas of most disadvantage (quintile 1) and 55% lived in areas of most advantage (quintile 5).

Nationally in 2011, 52% of Indigenous Australians lived in areas of most disadvantage (quintile 1), which is higher than the 2.6% in the Australian Capital Territory. The proportion living in areas of most advantage (quintile 5) was lower nationally (4.7%) than in the Australian Capital Territory (35%). For non-Indigenous Australians the proportions ranged from 19% in quintile 1 to 21% in quintile 5 (Table 2.09.2, Figure 2.09.1).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

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2.10 Community safety

Why it is important

This measure reports on experience of personal injury or death as a result of violence, threatened violence or a social setting in which violence is common, and social settings where there is a lack of security and a perception of danger (AHMAC 2015). The level of violence experienced by Indigenous Australians is also experienced in a context of discrimination and markers of disadvantage such as low income, unemployment and substance abuse (Day et al. 2013).

Key findings

Feelings of safety: In 2014–15 in the Australian Capital Territory, 68% of Indigenous Australians aged 15 and over reported they felt safe or very safe when they walked alone in the local area after dark, and 15% felt unsafe or very unsafe. Most (88%) felt safe or very safe at home alone after dark; 6.0% felt unsafe or very unsafe.

Nationally in 2014–15, 68% of Indigenous Australians aged 15 and over reported they felt safe or very safe when they walked alone in the local area after dark, and 20% felt unsafe or very unsafe. Most (87%) felt safe or very safe at home alone after dark; 8.4% felt unsafe or very unsafe (Table 2.10.2, Figure 2.10.1).

Neighbourhood or community problems: In 2014–15 in the Australian Capital Territory, 58% of Indigenous Australians aged 15 and over reported that they were aware of neighbourhood or community problems: 40% were aware of dangerous or noisy driving; 34% were aware of theft, including burglaries, theft from homes, motor vehicle theft and other theft; 22% were aware of vandalism or graffiti or damage to property; 20% were aware of alcohol and 16% were aware of illegal drugs.

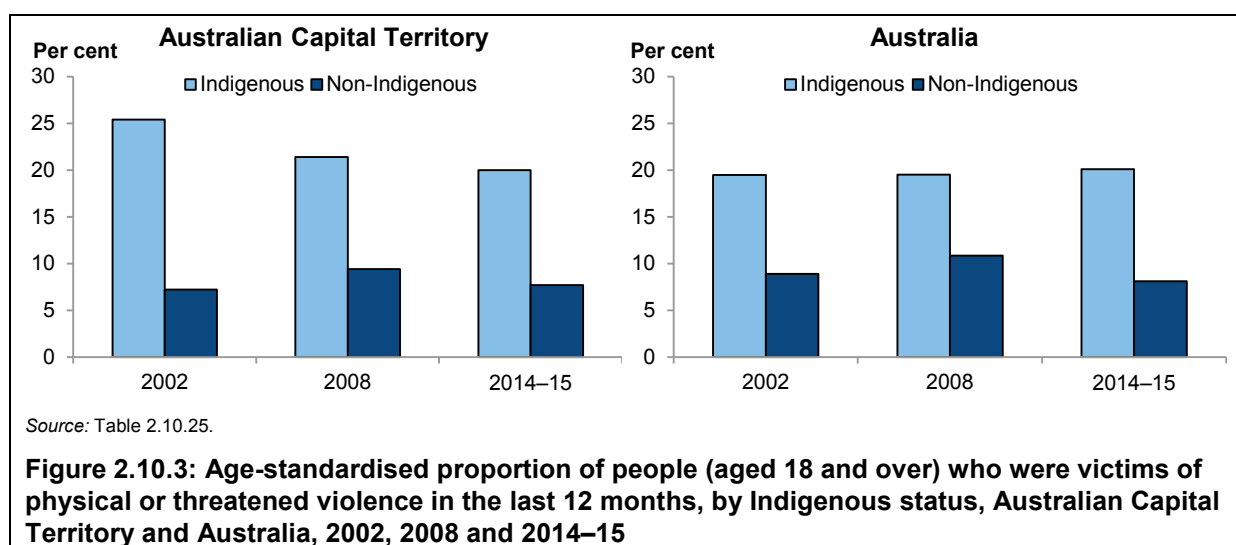
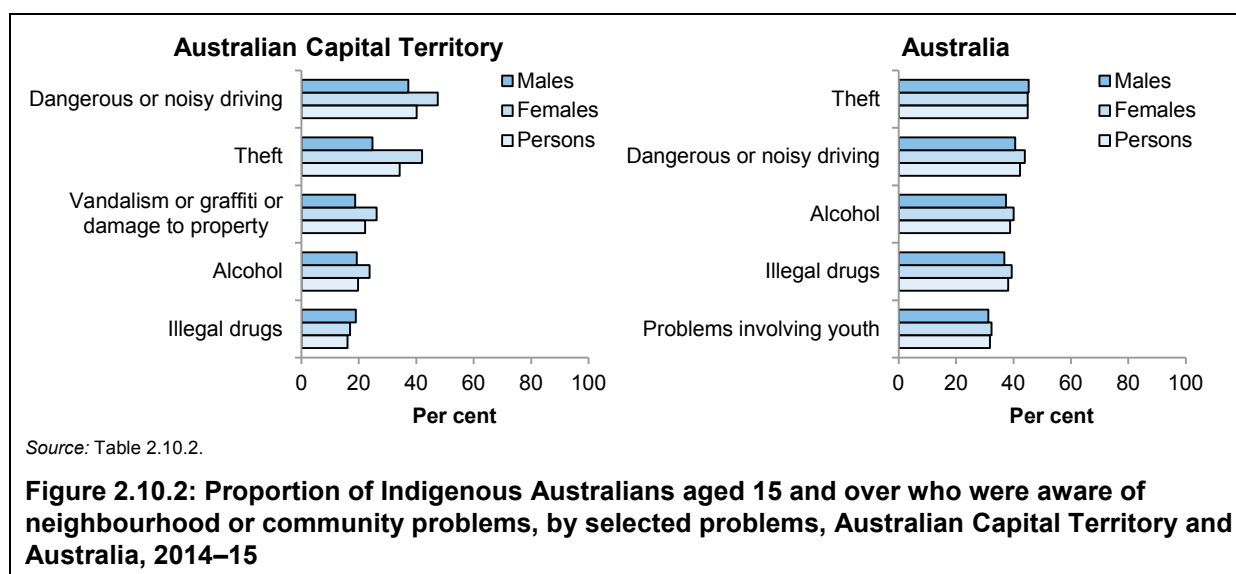
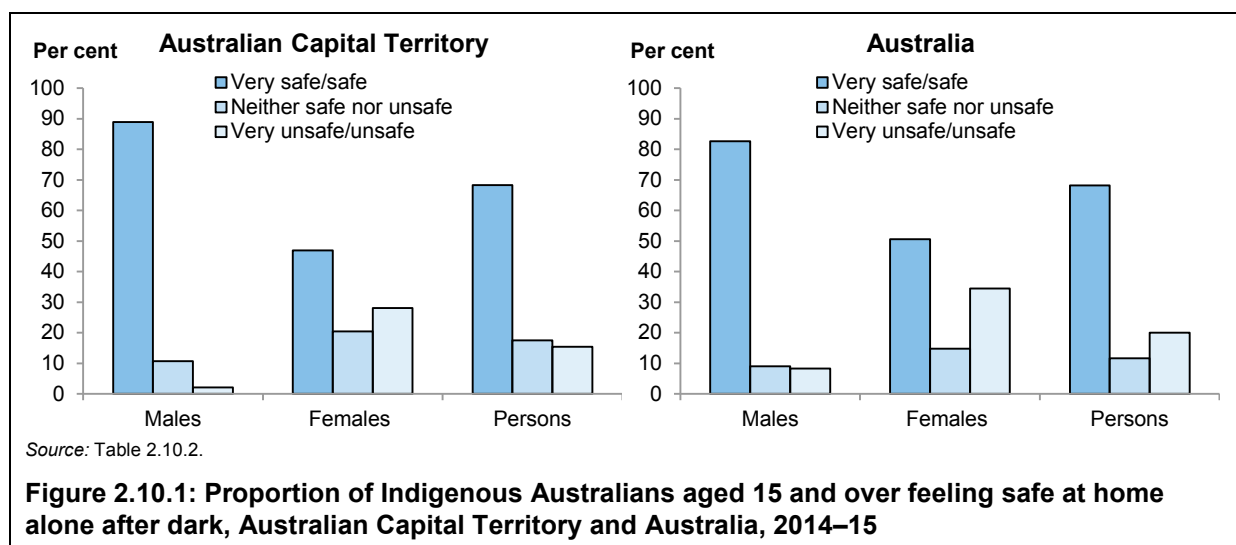
Nationally in 2014–15, 71% of Indigenous Australians aged 15 and over reported that they were aware of neighbourhood or community problems; 45% were aware of theft; 42% were aware of dangerous or noisy driving; 39% were aware of alcohol; 38% were aware of illegal drugs; and 32% were aware of problems involving youths (Table 2.10.2, Figure 2.10.2).

Victims of violence: In 2014–15 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians aged 18 and over reporting that they were a victim of physical or threatened violence in the last 12 months was 20%, 2.6 times the rate for non-Indigenous Australians in 2014–15(7.7%).

Nationally in 2014–15, the age-standardised rate for Indigenous Australians aged 18 and over reporting they were a victim of physical or threatened violence in the last 12 months was 20%, which was 2.5 times the rate for non-Indigenous Australians (8.1%) (Table 2.10.25).

Time trend: In the Australian Capital Territory, the age-standardised rate for Indigenous Australians aged 18 and over reporting they were a victim of physical or threatened violence in the last 12 months decreased from 25% in 2002 to 20% in 2014–15. For non-Indigenous Australians the rate increased from 7.2% in 2002 to 9.4% in 2008 then dropped to 7.7% in 2014–15.

Nationally, the age-standardised rate for Indigenous Australians aged 18 and over who reported they were a victim of physical or threatened violence in the last 12 months was the same across time: 20% for 2002, 2008 and 2014–15. For non-Indigenous Australians the rate was 8.9% in 2002, 10.8% in 2008 and 8.1% in 2014–15 (Table 2.10.25, Figure 2.10.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.11 Contact with the criminal justice system

Why it is important

This measure reports on the prevalence of Indigenous Australians in prison custody, and those who have other contact with the criminal justice system, including police custody and juvenile justice. It also reports on relationships with health and social factors. Indigenous Australians experience higher rates of arrest and incarceration than non-Indigenous Australians. Imprisonment also affects family, children and the broader community. It increases stress, affects relationships and has adverse employment and financial consequences (AHMAC 2017).

Key findings

Youth justice supervision: In the Australian Capital Territory, on an average day in 2014–15, 213 per 10,000 Indigenous Australians aged 10–17 were under youth justice supervision, compared with 16 per 10,000 for non-Indigenous Australians.

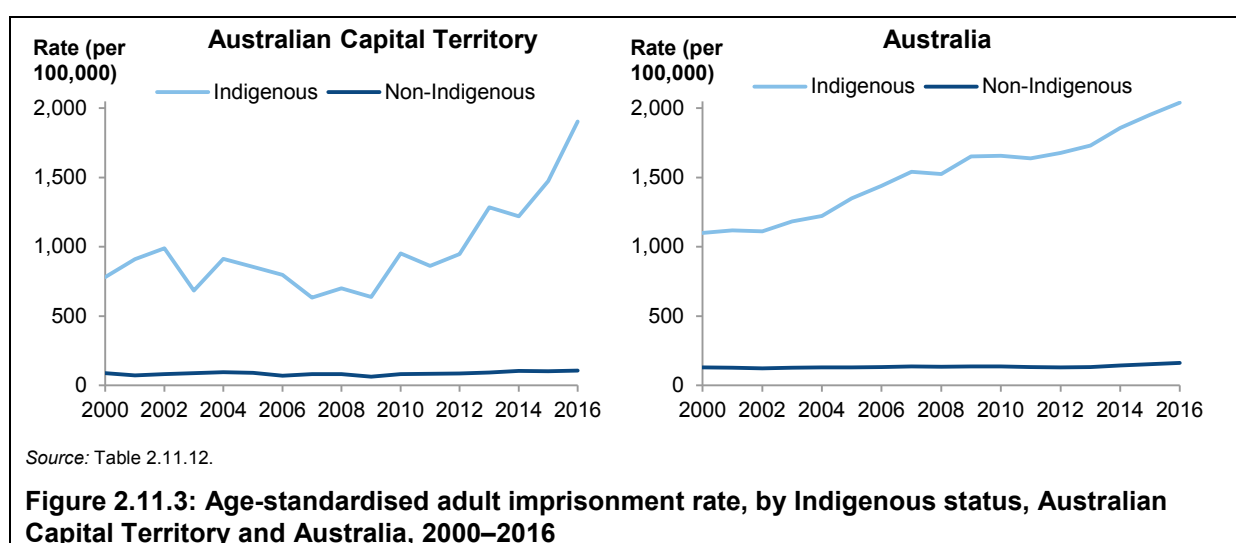
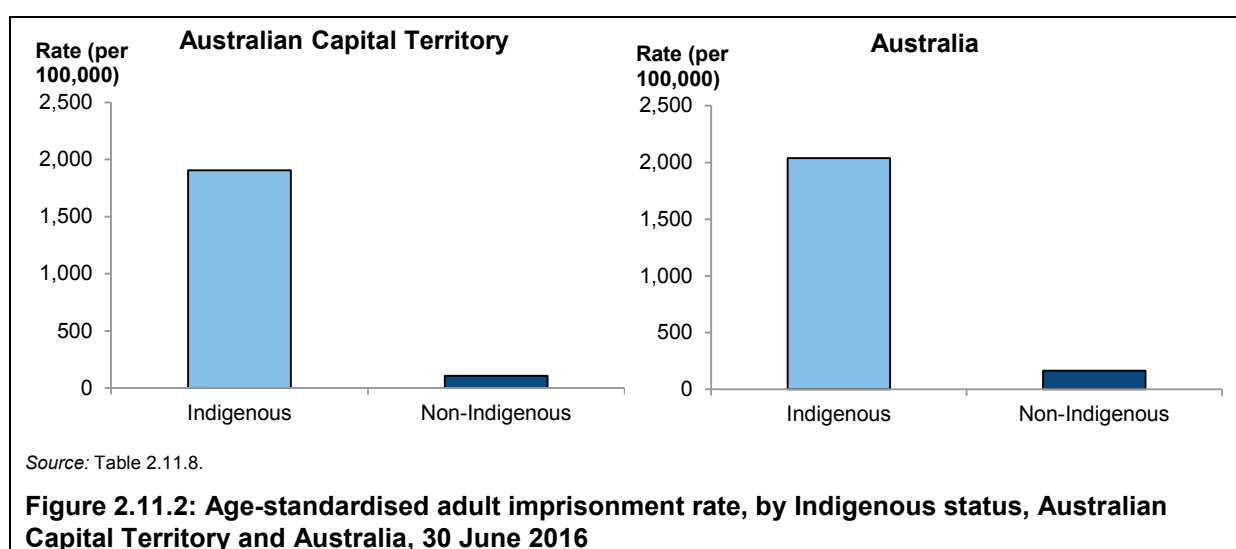
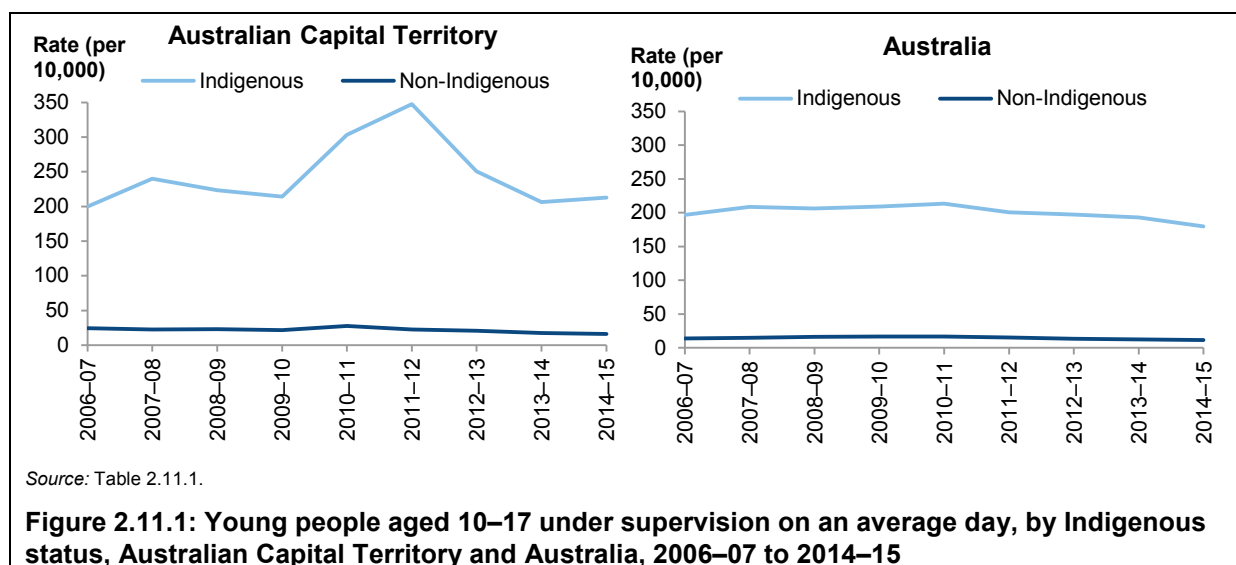
On an average day in 2014–15 nationally, 180 per 10,000 Indigenous Australians aged 10–17 were under youth justice supervision, compared with 12 per 10,000 for non-Indigenous Australians (Table 2.11.1, Figure 2.11.1).

Prison custody: On 30 June 2016 in the Australian Capital Territory, 24% of people in prison custody were Indigenous. The age-standardised rate of Indigenous adults in prison custody was 18 times the rate for non-Indigenous Australians (1,904 per 100,000 compared with 108 per 100,000) (Table 2.11.8, Figure 2.11.2). For Indigenous Australians, the number of males in prison custody was higher than the number of females (94 compared with 7). For non-Indigenous Australians, the number of males in prison custody was also higher than the number of females (311 compared with 20) (Table 2.11.8).

On 30 June 2016 nationally, 27% of people in prison custody were Indigenous. The age-standardised rate of adults in prison custody for Indigenous Australians was 13 times the rate for non-Indigenous Australians (2,039 per 100,000 compared with 163 per 100,000) (Table 2.11.8, Figure 2.11.2). For Indigenous Australians, the number of males in prison custody was 9 times the number of females (9,534 compared with 1,062). For non-Indigenous Australians, the number of males in prison custody was 13 times the number of females (26,190 compared with 2,033) (Table 2.11.8).

Trend over time: From 2003–04 to 2014–15 in the Australian Capital Territory, the rate of Indigenous Australians aged 10–17 who were under youth justice supervision on an average day varied between 200 and 348 per 10,000. For non-Indigenous Australians, the rate decreased from 36 per 10,000 in 2003–04 to 16 per 10,000 in 2014–15 (note that for comparability, only rates for 2006–07 are shown in Figure 2.11.1). The age-standardised imprisonment rate increased by 112% for Indigenous adults (from 782 per 100,000 in 2000 to 1,904 per 100,000 in 2016). The rate increased for non-Indigenous adults (from 89 per 100,000 in 2000 to 193 per 100,000 in 2016); however, this was not statistically significant.

Nationally, the rate of Indigenous young people aged 10–17 who were under youth justice supervision on an average day decreased from 197 per 10,000 in 2006–07 to 180 per 10,000 in 2014–15. The rate decreased by 18% for non-Indigenous Australians (from 14 to 12 per 10,000) (Table 2.11.1, Figure 2.11.1). From 2000 to 2016, the age-standardised imprisonment rate for Indigenous adults increased (from 1,100 to 2,039 per 100,000). For non-Indigenous adults the rate of increase was lower (from 129 to 163 per 100,000) (Table 2.11.12, Figure 2.11.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.12 Child protection

Why it is important

This measure reports on the number and rate for children who were the subject of substantiated child protection notifications, on care and protection orders, and in out-of-home care. Maltreatment (physical, emotional and psychological abuse, neglect, sexual abuse and witnessing family violence) during childhood has serious and long-term effects on social and emotional wellbeing and health (Emerson et al. 2015).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, the rate for Indigenous children (aged 0–17) who were the subject of substantiated child protection notification was 40 per 1,000. This was 12 times the rate for non-Indigenous children (3.3 per 1,000).

Nationally in 2014–15, the rate for Indigenous children who were the subject of substantiated child protection notification was 40 per 1,000. This was 6.7 times the rate for non-Indigenous children (5.9 per 1,000) (Table 2.12.3, Figure 2.12.1).

Trend over time: In the Australian Capital Territory, rates for Indigenous children who were the subject of a substantiated child protection notification fluctuated from a high of 48 per 1,000 in 2009–10 to a low of 27 per 1,000 in 2013–14.

Nationally, rates for Indigenous children increased from 29 per 1,000 in 2008–09 to 40 per 1,000 in 2014–15 (Table 2.12.5, Figure 2.12.2).

Care and protection orders: At 30 June 2015 in the Australian Capital Territory, the rate for Indigenous children (aged 0–17) on care and protection orders was 83 per 1,000. This rate was 13 times the rate for non-Indigenous children on care and protection orders (6.4 per 1,000).

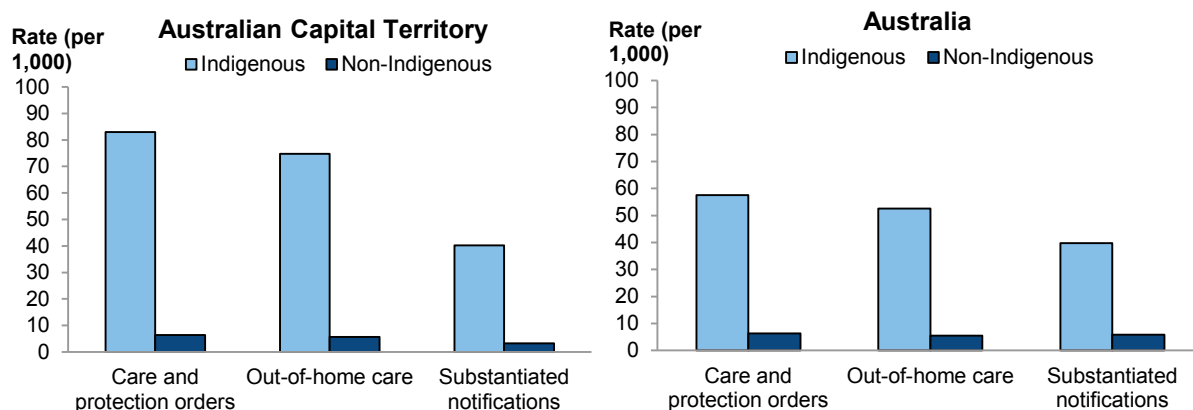
Nationally at 30 June 2015, the rate for Indigenous children on care and protection orders was 58 per 1,000. This was 9 times the rate for non-Indigenous children (6.3 per 1,000) (Table 2.12.7, Figure 2.12.1).

Trend over time: In the Australian Capital Territory, the rate for Indigenous children who were on care and protection orders increased from 53 per 1,000 at 30 June 2009 to 83 per 1,000 at 30 June 2015. For non-Indigenous children, the rate fluctuated between 5.9 and 6.9 per 1,000 over this time.

Nationally, the rate increased from 37 per 1,000 at 30 June 2009 to 58 per 1,000 at 30 June 2015. The rate for non-Indigenous children increased from 5.3 per 1,000 at 30 June 2009 to 6.3 per 1,000 at 30 June 2015 (Table 2.12.11, Figure 2.12.3).

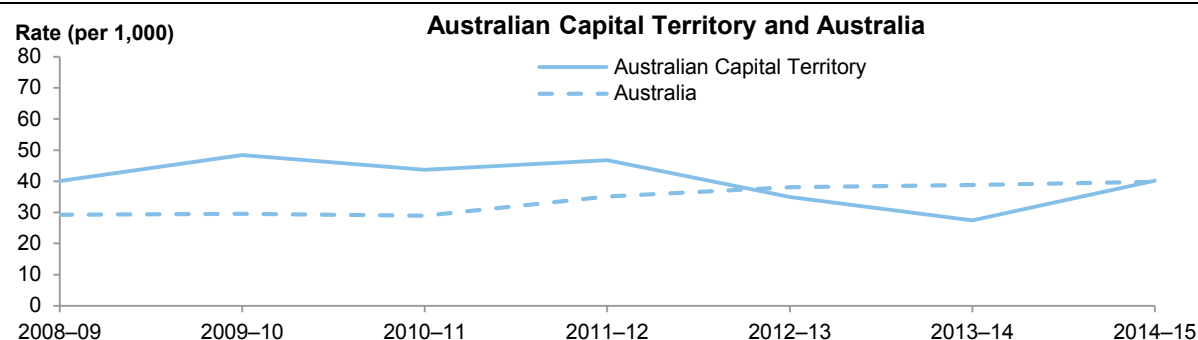
Out-of-home care: At 30 June 2015 in the Australian Capital Territory, the rate for Indigenous children in out-of-home care was 75 per 1,000. This was 13 times the rate for non-Indigenous children (5.7 per 1,000) (Table 2.12.12, Figure 2.12.1).

At 30 June 2015 nationally, the rate for Indigenous children in out-of-home care was 53 per 1,000. This was 10 times the rate for non-Indigenous children (5.5 per 1,000) (Table 2.12.12, Figure 2.12.1).



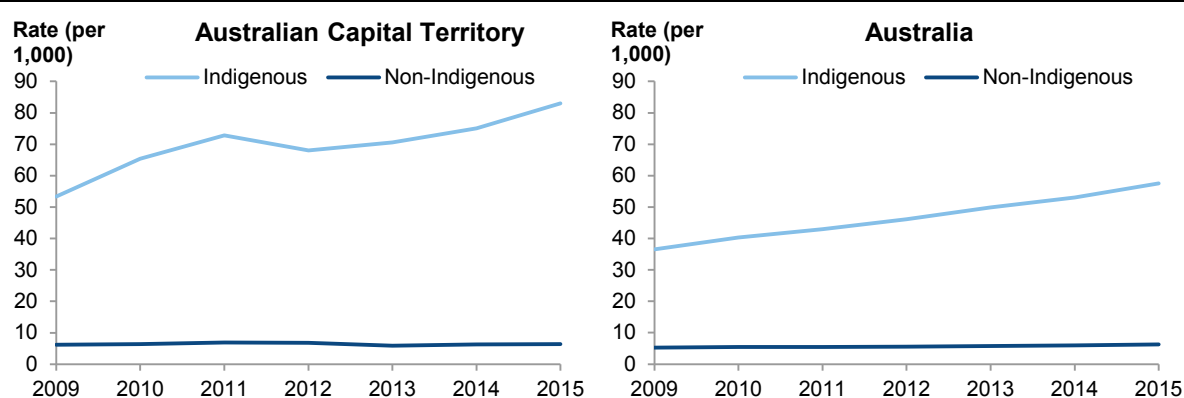
Sources: Tables 2.12.3, 2.12.7, 2.12.12.

Figure 2.12.1: Children aged 0–17 on care and protection orders, 30 June 2015, in out-of-home care, 30 June 2015 and subjects of substantiated notifications, 2014–15, by Indigenous status, Australian Capital Territory and Australia



Source: Table 2.12.5.

Figure 2.12.2: Indigenous children aged 0–17 who were the subject of substantiated notifications, Australian Capital Territory and Australia, 2008–09 to 2014–15



Source: Table 2.12.11.

Figure 2.12.3: Children aged 0–17 on care and protection orders, by Indigenous status, Australian Capital Territory and Australia, 30 June 2009 to 30 June 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.13 Transport

Why it is important

This measure reports on the use of transport, including walking, access to motor vehicles and perceived difficulty with transport for Indigenous Australians. Transport is key to enabling access to health care, goods and services, and supports Indigenous people to achieve education and employment outcomes and maintain cultural obligations to travel to family commitments (Helps et al. 2010; Ivers et al. 2016). Indigenous Australians face various barriers to accessing appropriate health care, including logistics, cost and reliability of transport options (Lee et al. 2014). Having limited or no public transport options significantly affects the capacity to access health care, particularly for patients with chronic health conditions (Teng et al. 2014) those needing birthing services (Parker et al. 2014), and those in rural and remote areas (Kelly et al. 2014).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 80% of Indigenous Australians aged 15 and over reported they can easily get to places needed; the proportion was 89% for non-Indigenous Australians. An estimated 1.6% of Indigenous Australians reported that they were unable to get to places needed, never went out or were housebound, compared with 0.4% of non-Indigenous Australians.

Nationally in 2014–15, 75% of Indigenous Australians aged 15 and over reported they can easily get to places needed; the proportion was 84% for non-Indigenous Australians. An estimated 8.2% of Indigenous Australians reported that they were unable to get to places needed, never went out or were housebound, compared with 0.9% of non-Indigenous Australians (Table 2.13.4, Figure 2.13.1).

Access to a motor vehicle: In 2014–15 in the Australian Capital Territory, 84% of Indigenous Australians aged 15 and over reported that they had access to a motor vehicle. This was 0.9 times the proportion for non-Indigenous Australians (89%).

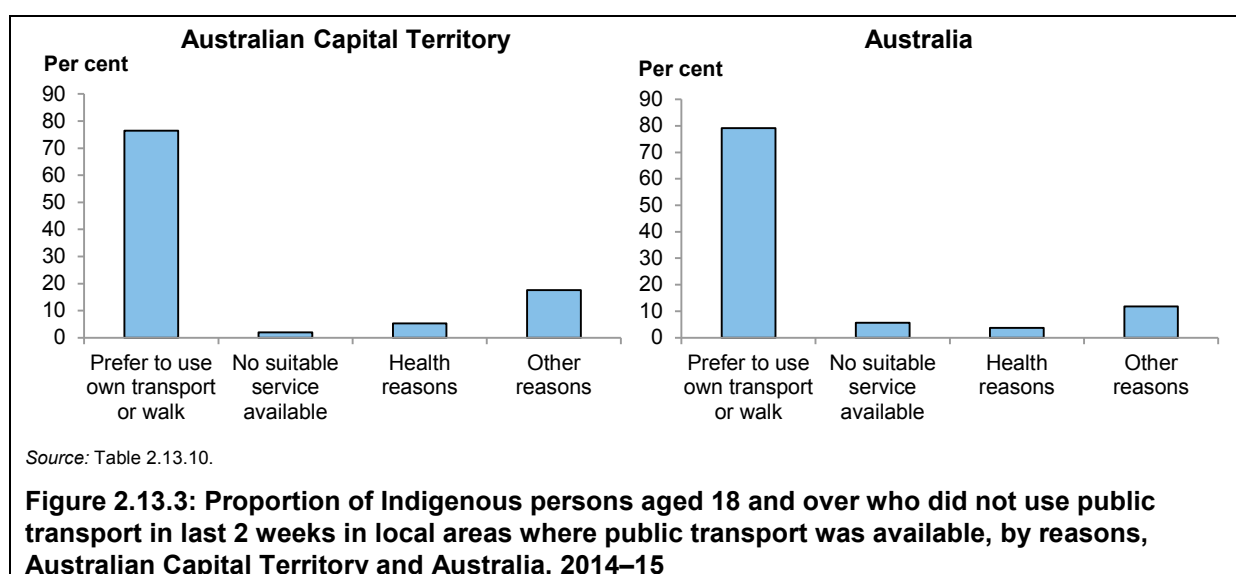
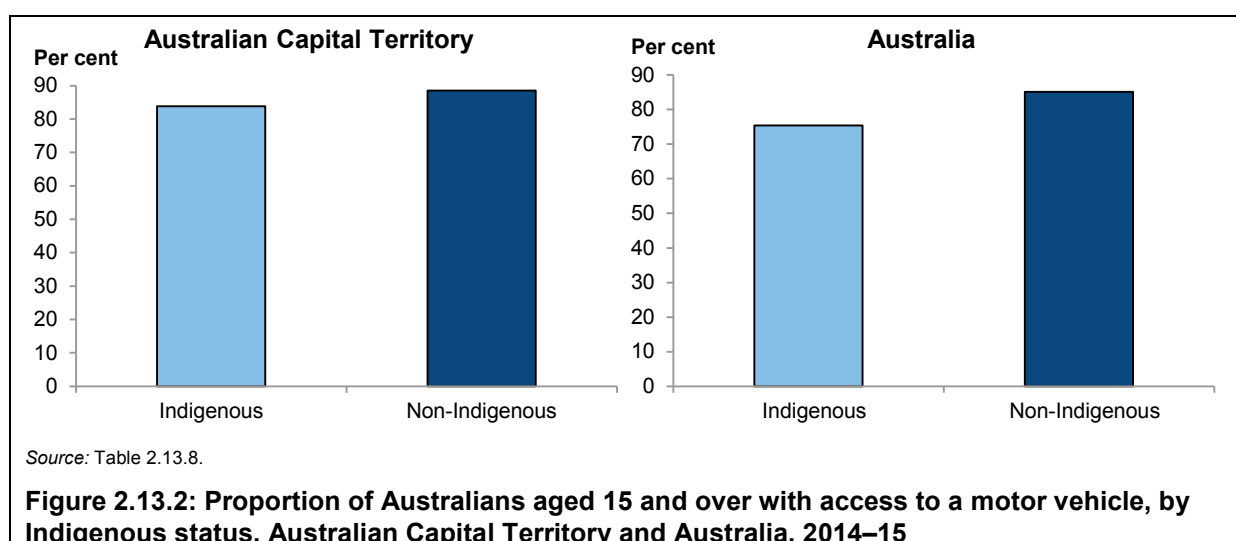
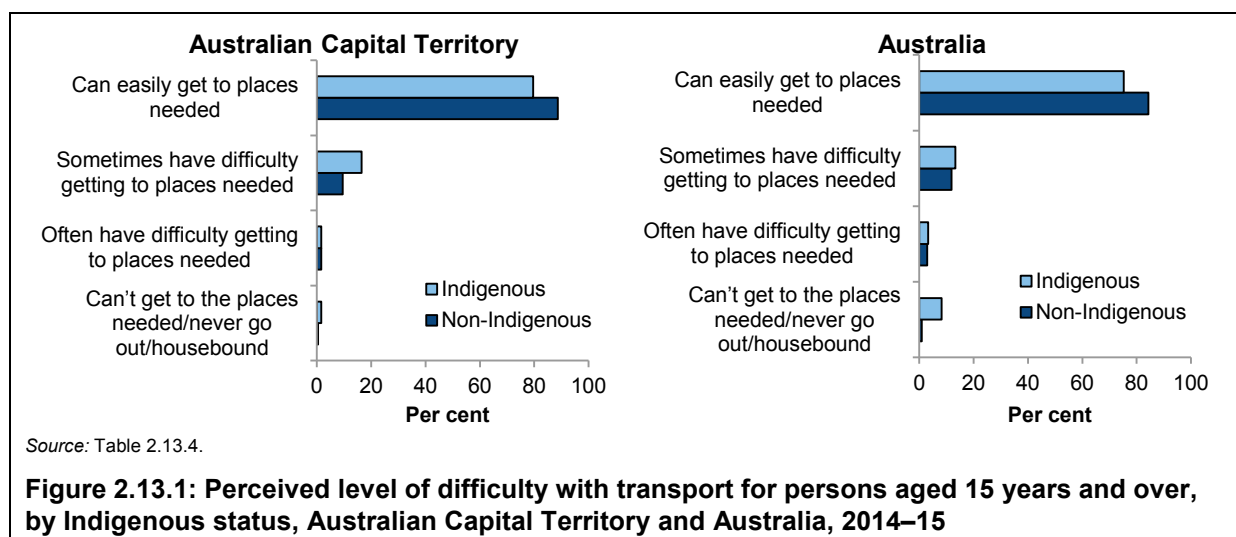
In 2014–15 nationally, 75% of Indigenous Australians aged 15 and over reported that they had access to a motor vehicle, and this also was 0.9 times the proportion for non-Indigenous Australians (85%) (Table 2.13.8, Figure 2.13.2).

Use of public transport: In 2014–15 in the Australian Capital Territory, 36% of Indigenous Australians aged 15 and over (who were not housebound) reported they had used public transport in the last 2 weeks.

Nationally in 2014–15, 29% of Indigenous Australians (who were not housebound) reported they had used public transport in the last 2 weeks (Table 2.13.9).

Access to public transport: In 2014–15 in the Australian Capital Territory, 98% of Indigenous Australians aged 15 and over reported that public transport was available in the local area. Of those who could access it, 77% reported they preferred to use their own transport or walk.

Nationally in 2014–15, public transport was available to 75% of Indigenous Australians aged 15 and over. Of those who could access it, 79% reported they preferred to use their own transport or walk (Table 2.13.10, Figure 2.13.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.14 Indigenous people with access to their traditional lands

Why it is important

This measure reports on the proportion of Indigenous Australians living on or visiting traditional areas of land with which they have ancestral or cultural links. Connection to family and community, land and sea, and cultural identity are integral to health from an Aboriginal perspective (NAHSWP 1989). Ongoing access to traditional lands also offers socio-political, economic and environmental benefits (Weir et al. 2011). Access to traditional lands is a determinant of health in remote contexts where Indigenous Australians are more likely to have ownership and control over their Country; it is also a determinant of health for those living in non-remote and urban areas. Research in Victoria has found the role of Country helps strengthen self-esteem, self-worth, pride, cultural and spiritual connection, and positive states of wellbeing (Kingsley et al. 2013).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 78% of Indigenous Australians aged 15 and over reported that they recognised homelands or traditional Country.

Nationally in 2014–15, 74% of Indigenous Australians aged 15 and over reported that they recognised homelands or traditional Country (Table 2.14.6). The proportion of Indigenous Australians was higher in *Remote* than *Non-remote* areas of Australia (89% compared with 70%) (Table 2.14.1, Figure 2.14.1).

Living on homelands/traditional Country: In 2014–15 in the Australian Capital Territory, 10% of Indigenous Australians aged 15 and over reported that they lived on their homelands or traditional Country.

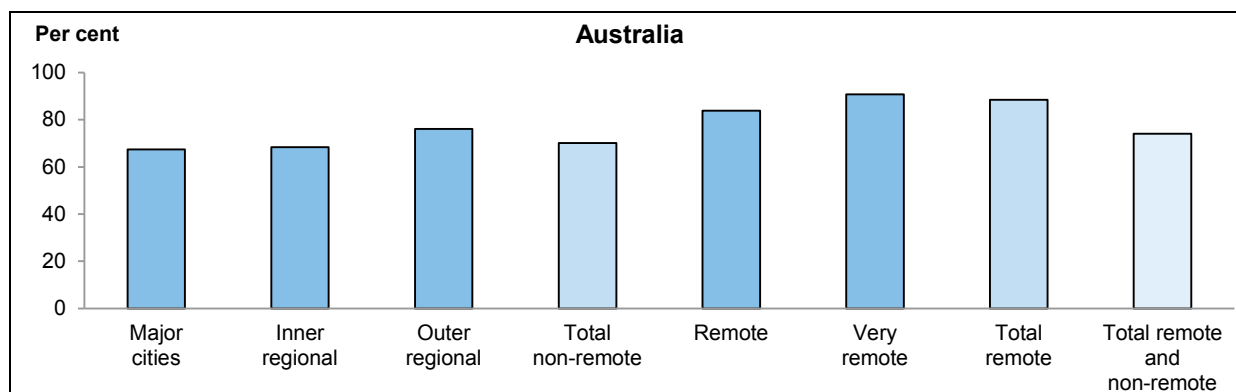
Nationally in 2014–15, 23% of Indigenous Australians aged 15 and over reported that they lived on their homelands or traditional Country (Table 2.14.6, Figure 2.14.2).

Visiting homelands/traditional Country: In 2014–15 in the Australian Capital Territory, 68% of Indigenous Australians aged 15 and over reported that they were allowed to visit their homelands or traditional Country.

Nationally in 2014–15, 50% of Indigenous Australians were allowed to visit their homelands or traditional Country and 1.0% reported not being allowed to visit (Table 2.14.6, Figure 2.14.2).

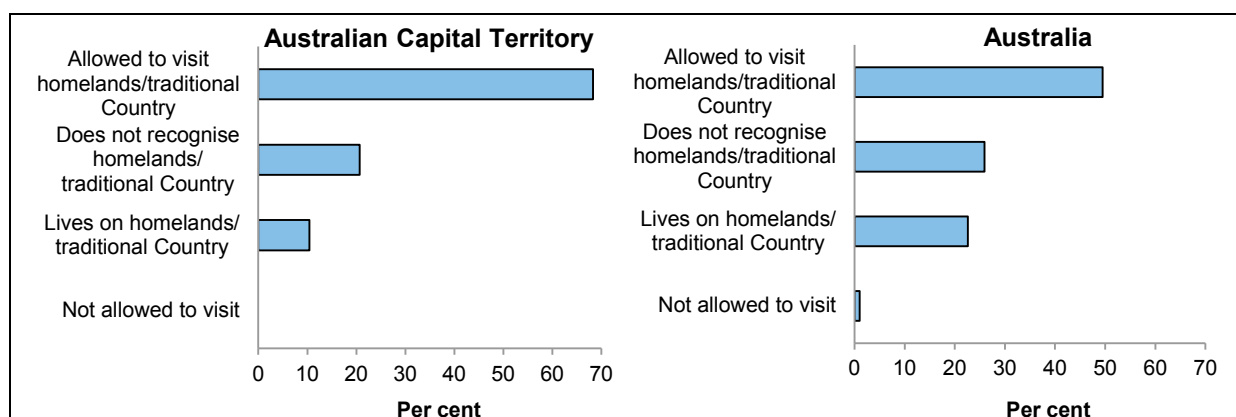
Identifying with clan, tribal or language group: In 2014–15 in the Australian Capital Territory, 64% of Indigenous Australians aged 15 and over reported that they identified with a clan, tribal or language group, and 35% did not.

Nationally in 2014–15, the proportion of Indigenous Australians aged 15 and over who reported that they identified with a clan, tribal or language group was 62%, and the proportion who did not was 38% (Table 2.14.6, Figure 2.14.3).



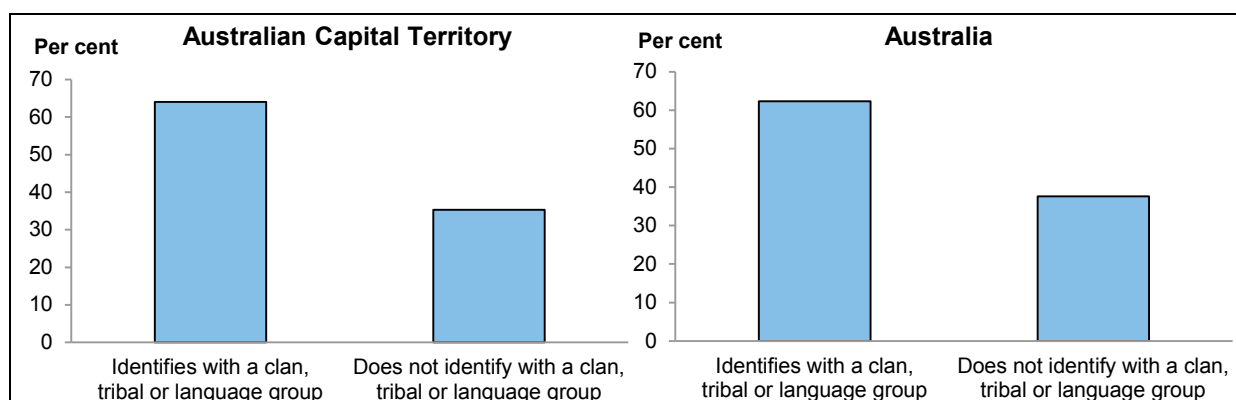
Source: Table 2.14.1.

Figure 2.14.1: Recognition of homelands/traditional Country, by remoteness, Indigenous Australians aged 15 and over, Australia, 2014–15



Source: Table 2.14.6.

Figure 2.14.2: Access to homelands/traditional Country, Indigenous Australians aged 15 and over, Australian Capital Territory and Australia, 2014–15



Source: Table 2.14.6.

Figure 2.14.3: Cultural identification with a clan, tribal or language group, Indigenous Australians aged 15 and over, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.15 Tobacco use

Why it is important

This measure reports on the proportion of Indigenous Australians who smoke daily, at least once a week and less than weekly. The health impact of smoking is evident in the high rates of hospitalisation and deaths from tobacco-related conditions (for example, chronic lung disease, cardiovascular disease and many forms of cancer) (Marley et al. 2014; Pircher et al. 2012). Maternal smoking during pregnancy increases the risk of poor outcomes for babies and children. Second-hand smoke also has adverse health effects for those exposed to it (AHMAC 2017).

Key findings

Overall: In 2014–15 in the Australian Capital Territory, 39% of Indigenous Australians reported they were current smokers (Table 2.15.1). The age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was 37%; 24% were ex-smokers; and 40% had never smoked (Table 2.15.7, Figure 2.15.1).

Nationally in 2014–15, 42% of Indigenous Australians reported they were current smokers (Table 2.15.1). The age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was 42%; 26% were ex-smokers; and 32% had never smoked (Table 2.15.7, Figure 2.15.1).

Remoteness: Nationally in 2014–15, the age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was higher in *Remote* areas than in *Non-remote* areas by 11 percentage points (51% compared with 40%). The rate for non-Indigenous Australians who were a current smoker was also higher in *Remote* areas than in *Non-remote* areas (19% compared with 15%, a 4-percentage-point difference) (Table 2.15.8).

Current smokers: In 2014–15 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was 3.1 times the rate for non-Indigenous current smokers (37% compared with 12%).

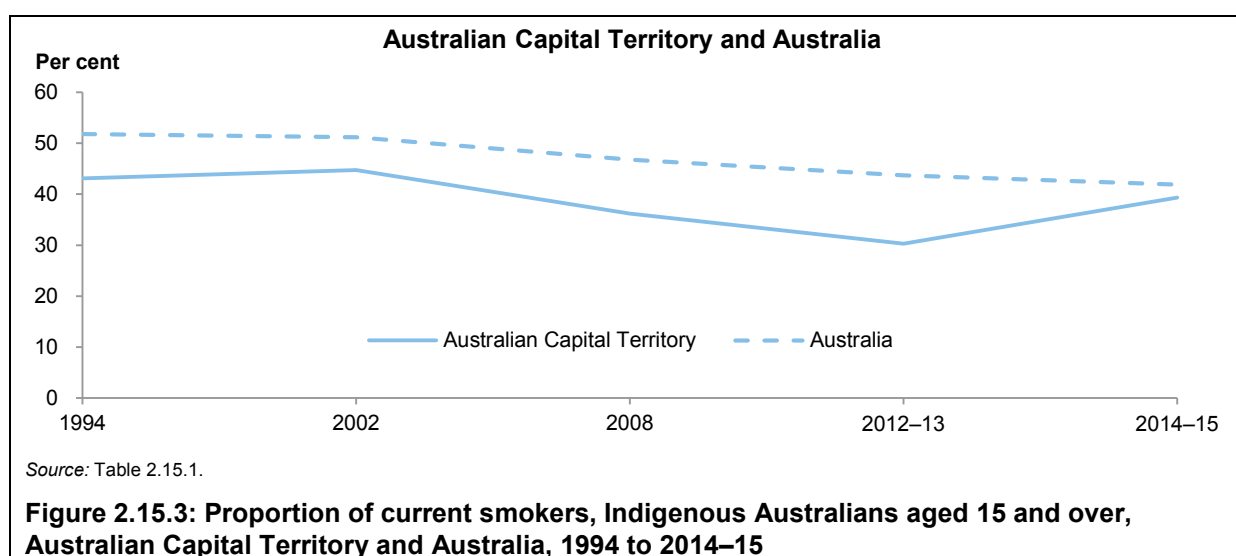
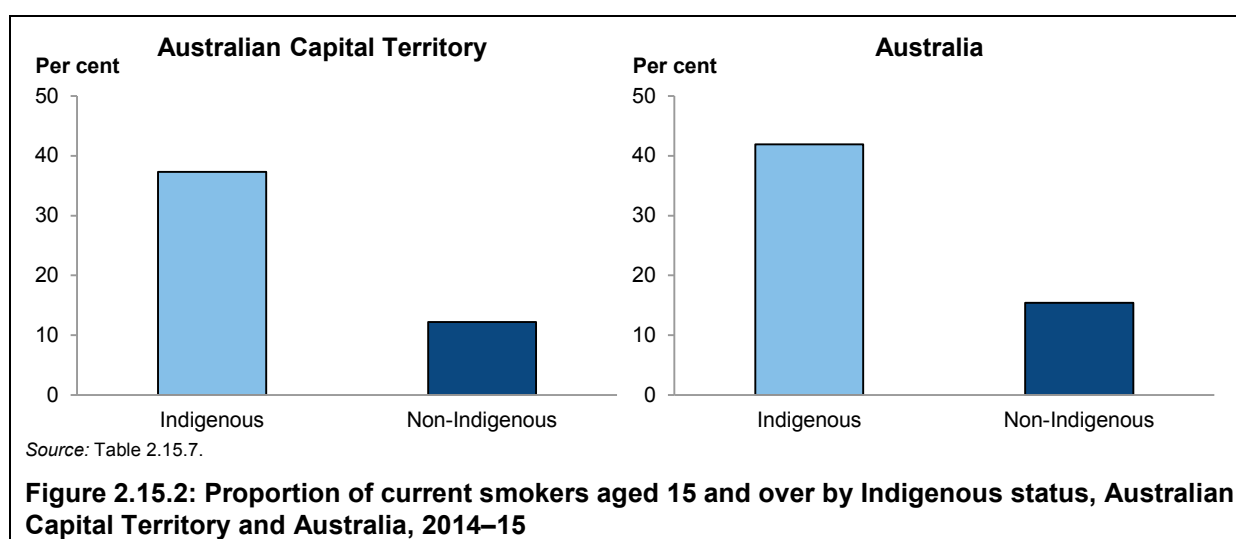
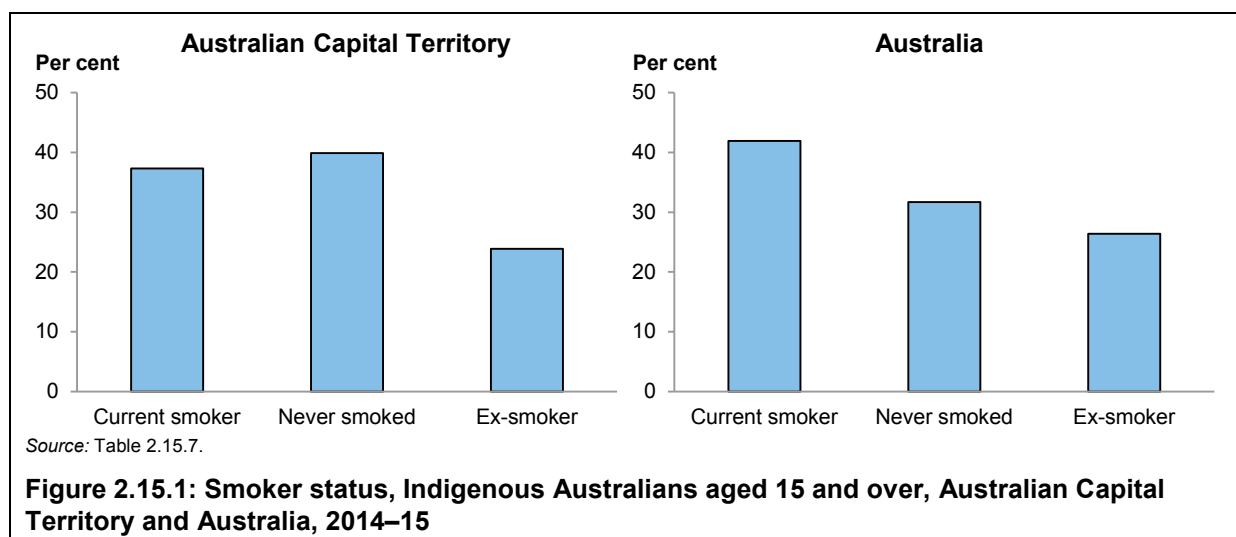
Nationally in 2014–15, the age-standardised rate for Indigenous Australians aged 15 and over reporting to be a current smoker was 2.7 times the rate for non-Indigenous Australians (42% compared with 15%) (Table 2.15.7, Figure 2.15.2).

Quitting status: In 2014–15 in the Australian Capital Territory, 69% of Indigenous Australians who reported being a current smoker reported they had tried to quit or reduce smoking.

Nationally in 2014–15, the proportion was the same, 69% of Indigenous Australians who reported being a current smoker had tried to quit or reduce smoking (Table 2.15.10).

Over time: The rate for Indigenous Australians aged 15 and over in the Australian Capital Territory who reported being a current smoker fluctuated between 1994 and 2014–15. The lowest rate was 30% in 2012–13 and the highest was 45% in 2002, but in general a decrease in rates was evident.

Nationally, the rate for Indigenous Australians declined, from 52% in 1994 to 42% in 2014–15 (Table 2.15.1, Figure 2.15.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.16 Risky alcohol consumption

Why it is important

This measure reports on the consumption of alcohol at risky or high-risk levels. Excessive consumption is associated with health and social problems in most populations. Long-term excessive consumption is a major risk factor for conditions such as liver disease, pancreatitis, heart disease, stroke, diabetes, obesity and cancer. Binge drinking contributes to injuries, suicide, transport accidents, violence, burns and falls (AHMAC 2017).

Key findings

Non-Indigenous comparisons for single occasion and lifetime risk are not available for 2014–15 as the data were not collected as part of the ABS General Social Survey 2014.

Single occasion risk: In 2014–15 in the Australian Capital Territory, an estimated 36% of Indigenous Australians aged 15 and over reported exceeding the single occasion alcohol risk guideline in the last 12 months.

Nationally in 2014–15, an estimated 31% of Indigenous Australians aged 15 and over reported exceeding the single occasion alcohol risk guideline in the last 12 months (Table 2.16.19, Figure 2.16.1).

Lifetime risk: In 2014–15 in the Australian Capital Territory, an estimated 13% of Indigenous Australians aged 15 and over reported exceeding the lifetime risk alcohol guidelines.

Nationally in 2014–15, an estimated 15% of Indigenous Australians aged 15 and over reported exceeding the lifetime risk alcohol guideline (Table 2.16.20, Figure 2.16.1).

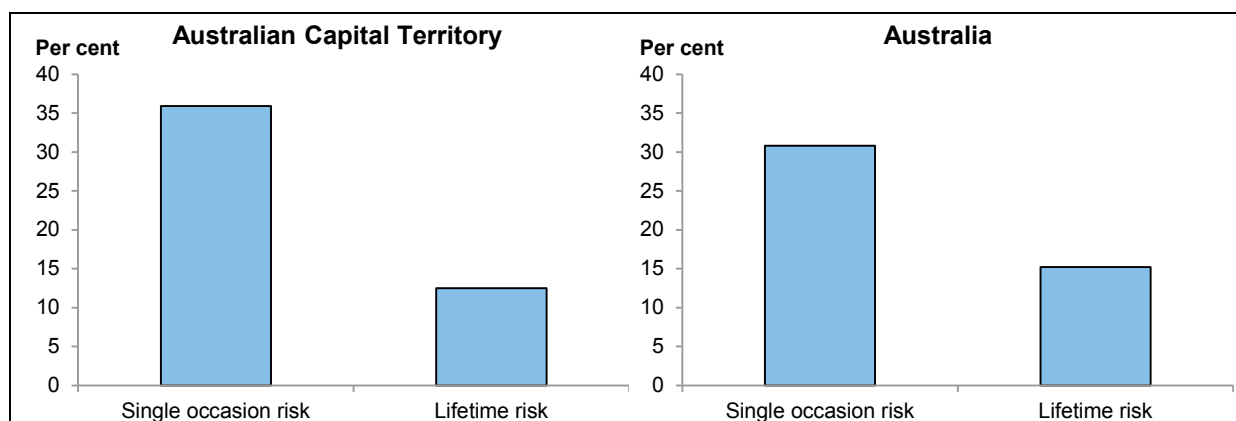
Remoteness: Nationally in 2012–13, the age-standardised rate of Indigenous Australians aged 18 and over who reported that they had engaged in short-term or single occasion risky drinking was 53% in *Non-remote* areas, compared with 45% of non-Indigenous Australians. In *Remote* areas the rate was lower for Indigenous Australians and higher for non-Indigenous Australians (47% and 55%, respectively) (Table 2.16.2, Figure 2.16.2).

Hospitalisation: From July 2013 to June 2015 in the Australian Capital Territory, the age-standardised rate of hospitalisation related to alcohol use for Indigenous Australians was 7.1 per 1,000. This was 3.5 times the rate for non-Indigenous Australians (2.0 per 1,000).

From July 2013 to June 2015 nationally, the age-standardised rate of hospitalisation related to alcohol use for Indigenous Australians was 3.9 times the rate for non-Indigenous Australians (9.0 per 1,000 compared with 2.3 per 1,000) (Table 2.16.15).

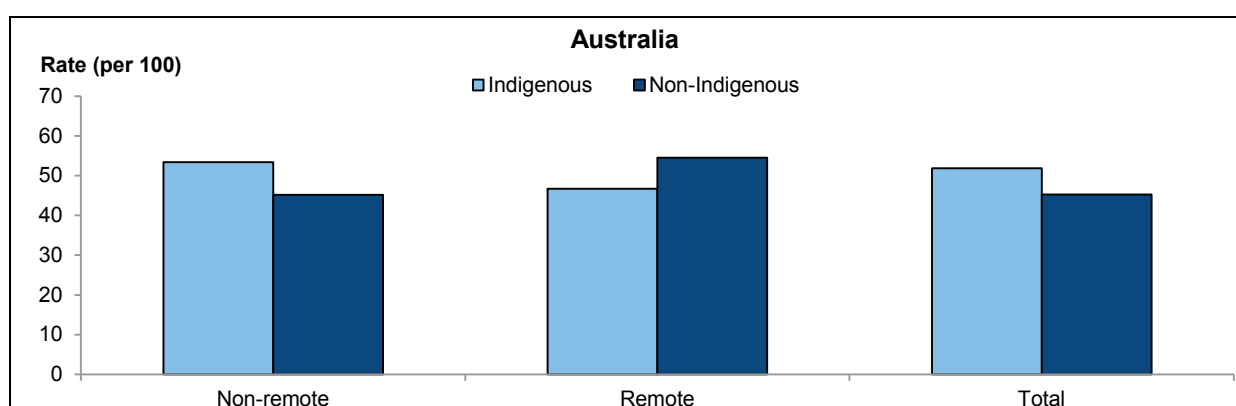
Over time: In the Australian Capital Territory, the rate for Indigenous Australians aged 18 and over who engaged in short-term risky or high risk drinking was 59% in 2004–05 and 66% in 2012–13.

Nationally, the rate was 55% in 2004–05 and 53% in 2012–13 (Table 2.16.7, Figure 2.16.3).



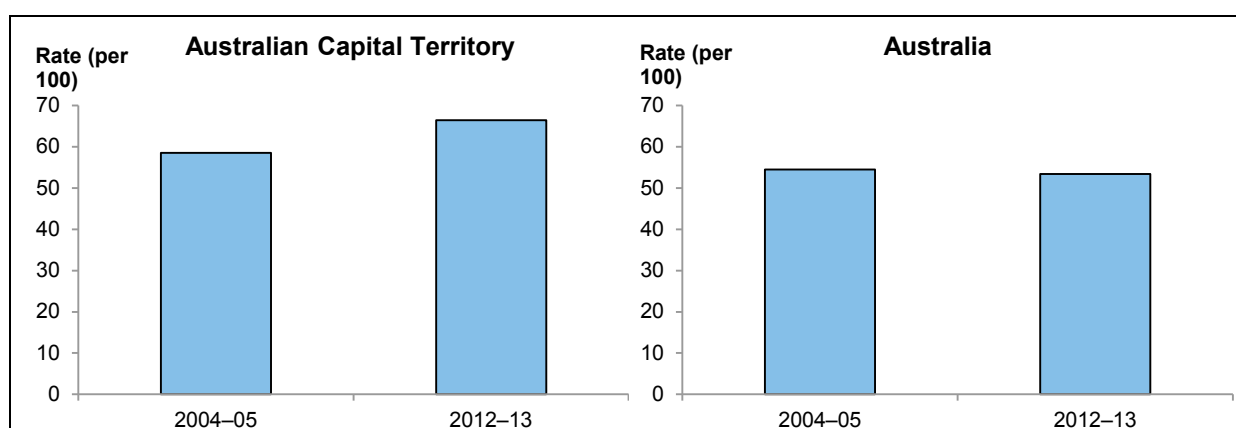
Sources: Table 2.16.19 and Table 2.16.20.

Figure 2.16.1: Indigenous persons who exceeded single occasion alcohol risk guideline, and who exceeded lifetime risk alcohol guideline, aged 15 and over, Australian Capital Territory and Australia, 2014-15



Source: Table 2.16.2.

Figure 2.16.2: Age-standardised rate, persons aged 18 and over reporting short-term/single occasion alcohol risk, by Indigenous status and remoteness, Australia, 2012-13



Source: Table 2.16.7.

Figure 2.16.3: Short-term risky/high risk alcohol consumption for Indigenous persons 18 years and over, Australian Capital Territory and Australia, 2004-05 and 2012-13

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.17 Drug and other substance use including inhalants

Why it is important

This measure reports on the use of drugs and other substances, including inhalants. Drug and other substance use is a contributing factor to illness and disease, accident and injury, violence and crime, family and social disruption and workplace problems (SCRGSP 2014). Substance use is often associated with mental health problems (Catto & Thomson 2008) and has been found to be a factor in suicides (Robinson et al. 2011). For communities, there is increased potential for social disruption, such as domestic violence, crime and assaults (Franks 2006). Alcohol and substance use has been found to be a factor in assault (Mitchell, 2011; Mouzos & Makkai 2004). Risky sexual behaviour is also associated with alcohol and illicit drug use, leading to increased sexually transmitted infections among younger people (Wand et al. 2016). Drugs and other substance use play a significant role in Indigenous people's involvement in the criminal justice system (AHMAC 2017).

Key findings

Non-Indigenous comparisons for substance use are not available for 2014–15 as the data were not collected as part of the ABS General Social Survey 2014.

Overall: In 2014–15 in the Australian Capital Territory, an estimated 40% of Indigenous Australians aged 15 and over reported using substances in the last 12 months.

Nationally in 2014–15, an estimated 31% of Indigenous Australians aged 15 and over reported using substances in the last 12 months (Table 2.17.3, Figure 2.17.1).

Sex: In the Australian Capital Territory in 2014–15, the reported rate of substance use for Indigenous males aged 15 and over was 1.2 times the rate for Indigenous females (46% compared with 39%).

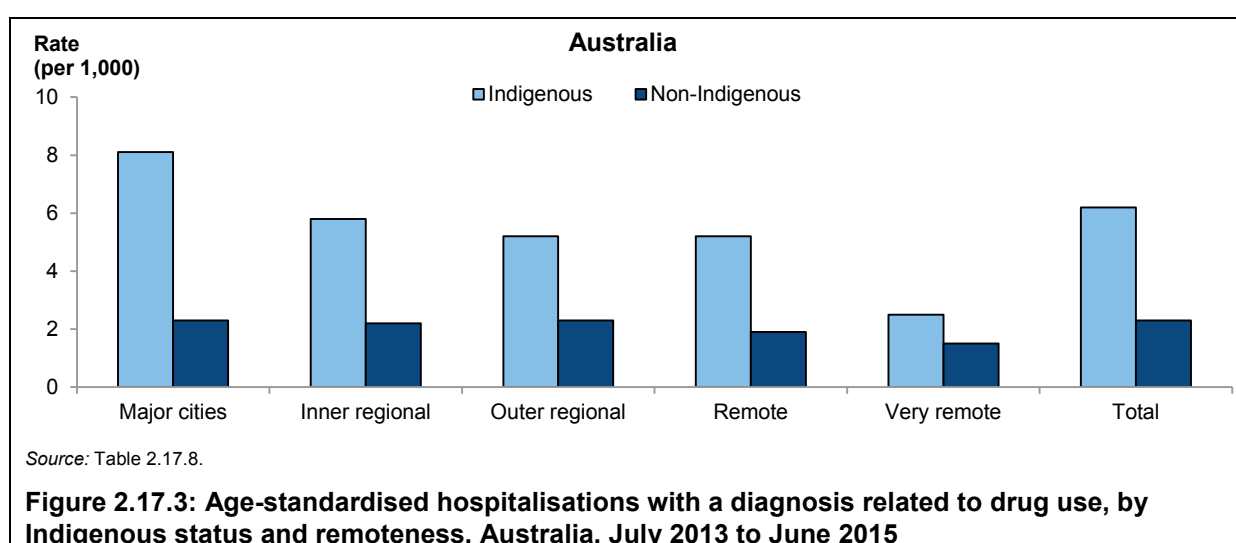
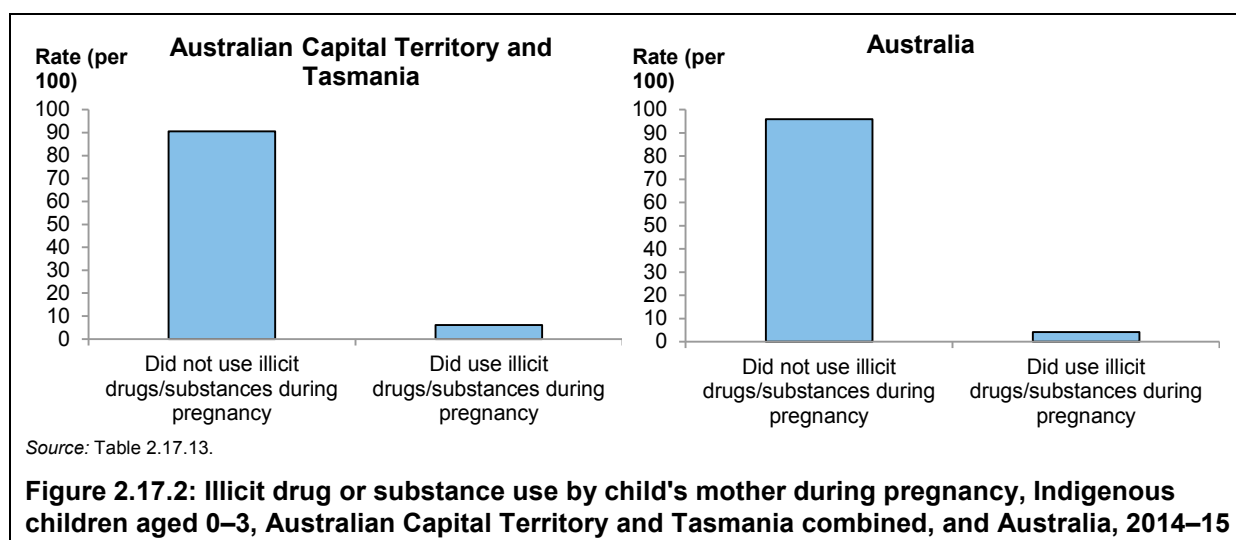
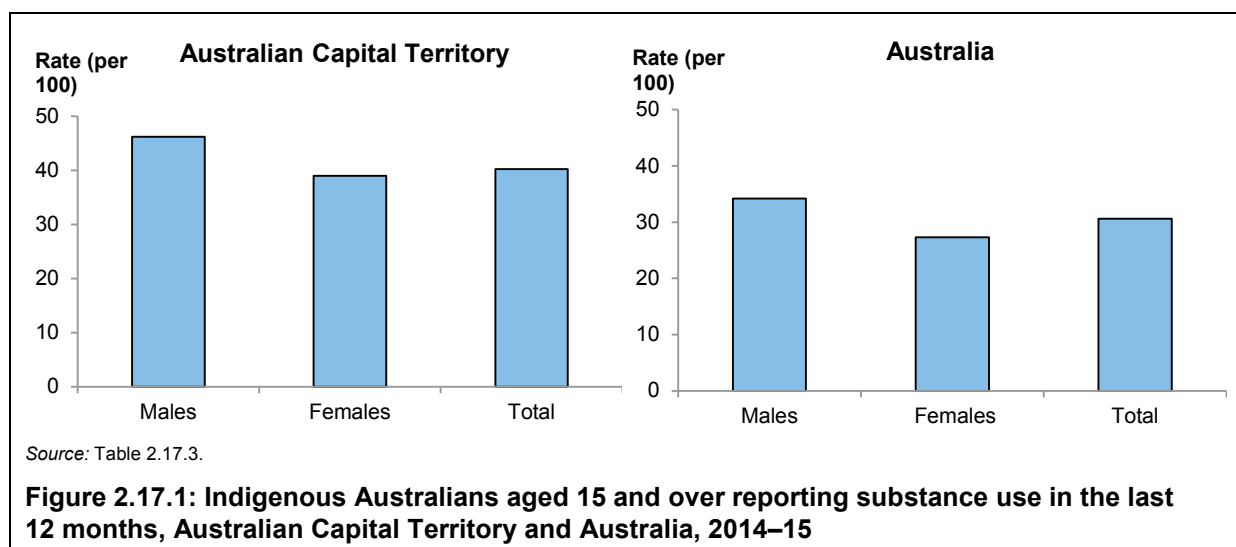
Nationally in 2014–15, 34% of Indigenous males aged 15 and over reported that they used substances, compared with 27% of Indigenous females (Table 2.17.3, Figure 2.17.1).

Age: Nationally in 2014–15, the highest rate for Indigenous Australians reporting substance use in the last 12 months was for males aged 18–34, and for females aged 25–34 (40 and 35 per 100, respectively) (Table 2.17.3).

Use during pregnancy: The 2014–15 National Aboriginal and Torres Strait Islander Social Survey combined estimates for the Australian Capital Territory and Tasmania. Based on reported information, an estimated 6.1% of mothers of Indigenous children aged 0–3 used illicit drugs or substances during their pregnancy.

Nationally in 2014–15, 4.1% of mothers of Indigenous children aged 0–3 reported that they had used illicit drugs or substances during pregnancy (Table 2.17.13, Figure 2.17.2).

Hospitalisations: Nationally in July 2013 to June 2015, the age-standardised hospitalisation rate related to drug use was higher for Indigenous Australians who lived in *Major cities* (8.1 per 1,000) than in other areas of Australia. The rate was 3.6 times the rate for non-Indigenous Australians in *Major cities* (2.3 per 1,000) (Table 2.17.8, Figure 2.17.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.18 Physical activity

Why it is important

This measure reports on the levels of physical activity among Indigenous Australians (low, moderate or high). Physical activity can be defined as a bodily movement produced by the muscles resulting in energy expenditure, and can include organised or incidental activity (AIHW 2010a). Physical inactivity is an important modifiable risk factor associated with several potentially preventable chronic diseases that are prevalent among Indigenous Australians. These diseases include cardiovascular disease, cancer, stroke, hypertension, and diabetes (AIHW 2012; Gray et al. 2013; Wilmot et al. 2012). Physical inactivity is also related to being overweight and obese, another important risk factor for multiple preventable diseases (AHMAC 2017).

Results for adults are presented by whether a person (aged 18–64) had met the recommended guidelines for sufficient physical activity to gain a health benefit (150–300 minutes of moderate activity per week, or 75–150 minutes of vigorous activity per week) (ABS 2016). For children, results are presented in terms of time taken for physical activity and the number of days children were active.

Key findings

Adult physical activity: In 2012–13 in the Australian Capital Territory, 55% of Indigenous adults reported they had undertaken a sufficient level of physical activity for health in the last week. The age-standardised rate for Indigenous adults who met sufficient activity levels in the last week was similar to the rate for non-Indigenous adults (48% compared with 49%) (ABS 2014b, Figure 2.18.1).

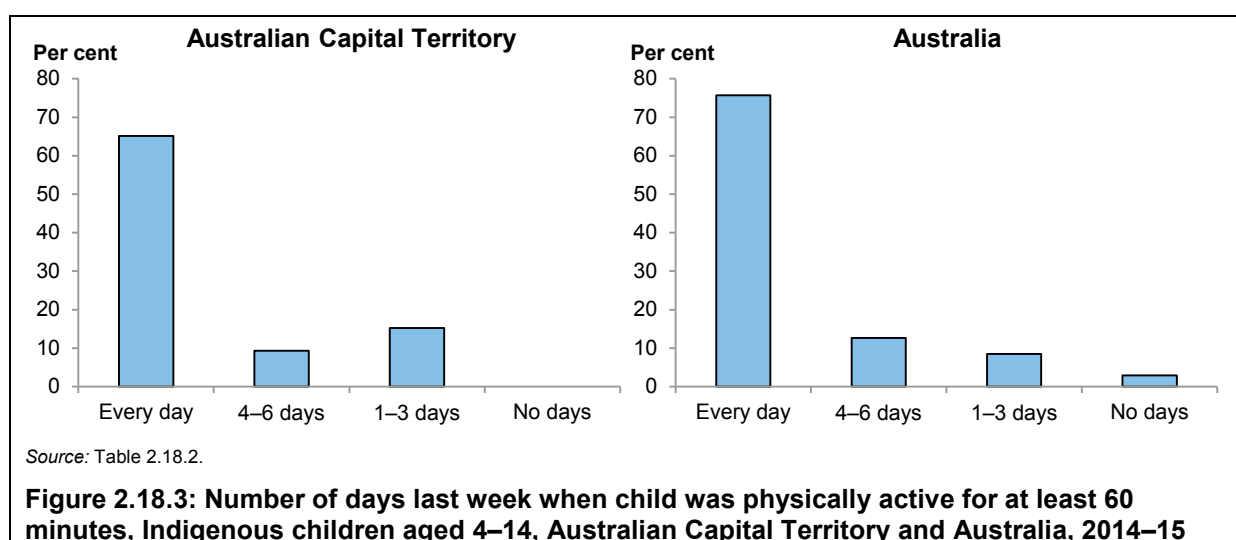
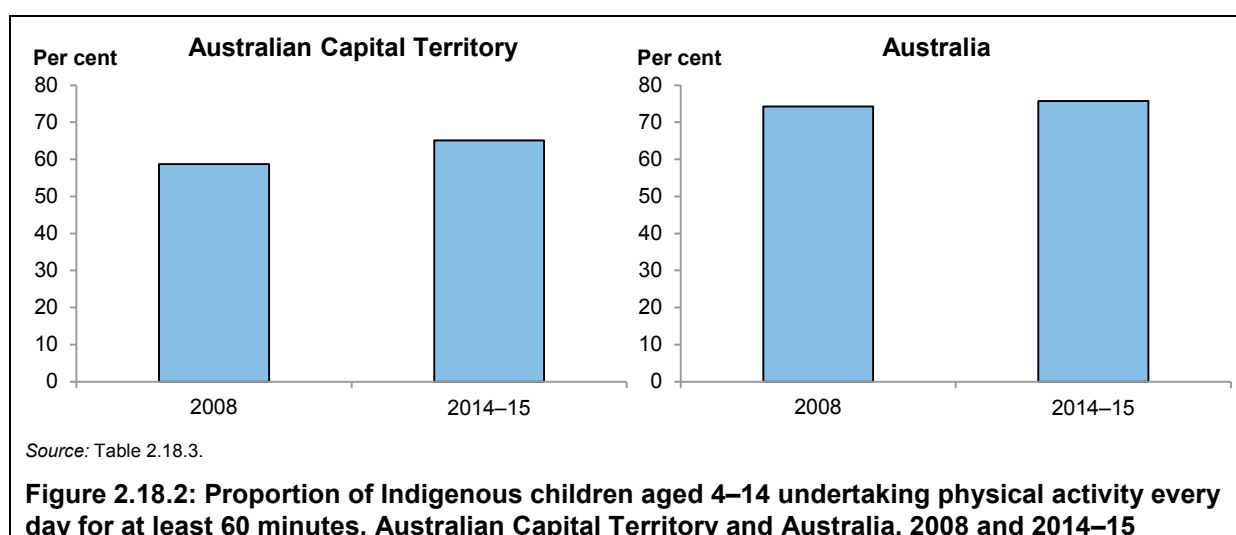
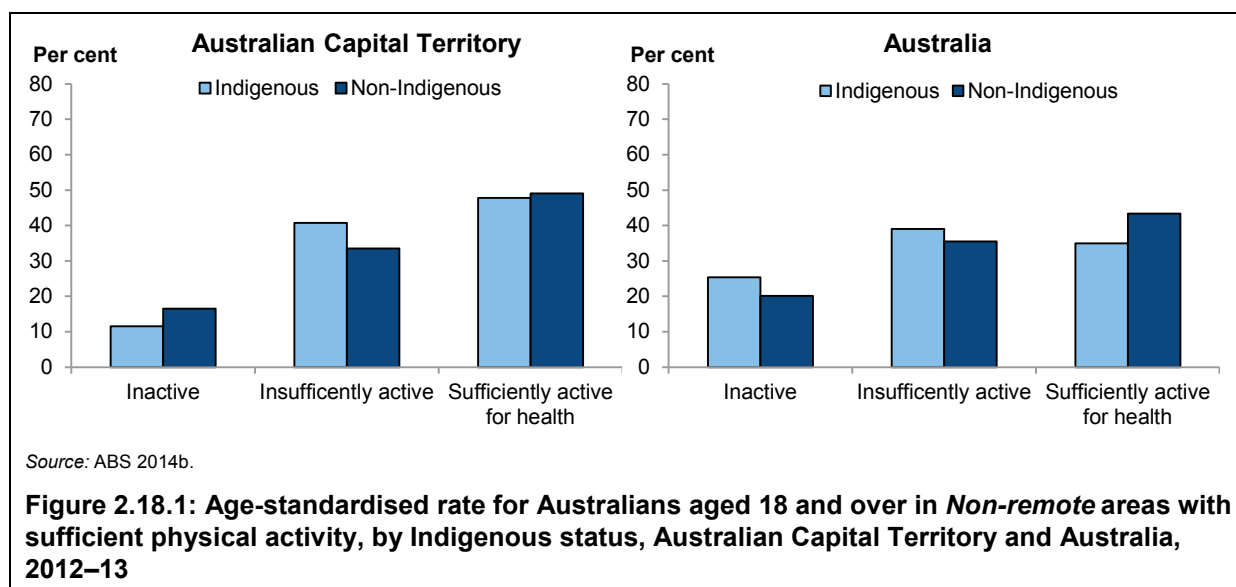
Nationally in 2012–13, in *Non-remote* areas, 38% of Indigenous adults reported they had undertaken a sufficient level of physical activity for health in the last week. The age-standardised rate for Indigenous adults who met sufficient activity levels in the last week was 0.8 times the rate for non-Indigenous adults (35% compared with 43%) (ABS 2014b, Figure 2.18.1).

Children's daily activity: In 2014–15 in the Australian Capital Territory, 65% of Indigenous children aged 4–14 were reported to undertake at least 60 minutes of physical activity every day. In 2008, the estimate was 59%.

Nationally in 2014–15, 76% of Indigenous children aged 4–14 were reported to undertake at least 60 minutes of physical activity every day. In 2008, this estimate was 74% (Table 2.18.3, Figure 2.18.2).

Days of physical activity for children: In 2014–15 in the Australian Capital Territory, of Indigenous children aged 4–14 surveyed, 65% were reported to be physically active every day in the previous week, and a further 9% were active on 4–6 days. No children had no days of physical activity in the previous week reported for them.

In 2014–15 nationally, 76% of Indigenous children aged 4–14 were reported to be physically active every day of the previous week, and 13% were active on 4–6 days. Almost 3% had days where they were not physically active in the last week (Table 2.18.2, Figure 2.18.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.19 Dietary behaviour

Why it is important

This measure reports on dietary behaviour, including fruit and vegetable consumption. Many of the principal causes of ill-health among Indigenous Australians are nutrition-related diseases, such as heart disease, type 2 diabetes and renal disease. While a diet high in saturated fats and refined carbohydrates increases the likelihood of developing these diseases, regular exercise and intake of fibre-rich foods, such as fruit and vegetables, can have a protective effect against disease (Wang et al. 2014b).

Key findings

Consumption of fruit: In 2014–15 in the Australian Capital Territory, 22% of Indigenous Australians (aged 12 and over) reported eating less than 1 serve of fruit a day.

Nationally in 2014–15, 25% of Indigenous Australians aged 12 and over reported eating less than 1 serve of fruit a day (Table 2.19.2, Figure 2.19.1). The rate for Indigenous Australians who live in *Non-remote* areas was similar to the rate for those who live in *Remote* areas (25% and 24%, respectively) (Table 2.19.2).

Consumption of vegetables: In 2014–15 in the Australian Capital Territory, 14% of Indigenous Australians (aged 12 and over) reported eating less than 1 serve of vegetables a day.

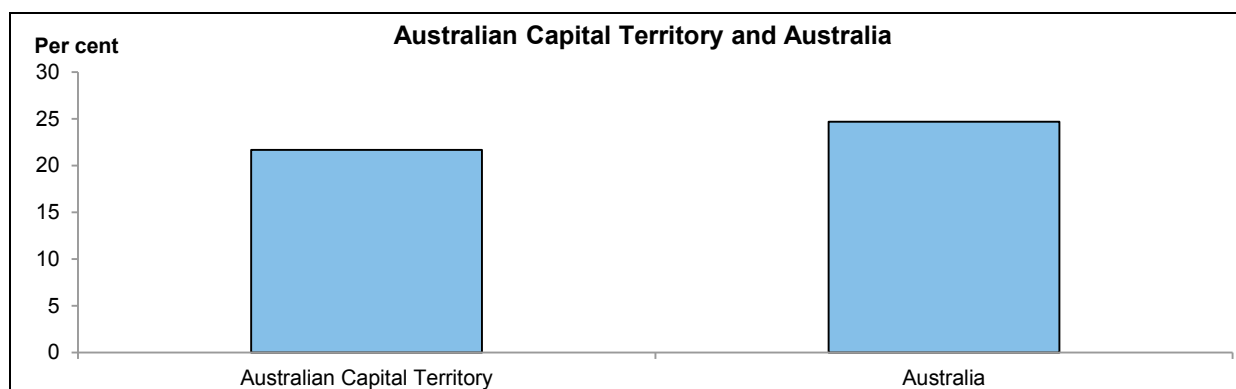
Nationally in 2014–15, 12% of Indigenous Australians aged 12 and over reported eating less than 1 serve of vegetables per day (Table 2.19.3, Figure 2.19.2). The proportion of Indigenous Australians who ate less than 1 serve of vegetables per day was lower in *Non-remote* than in *Remote* areas (11% compared with 15%) (Table 2.19.3).

Children's consumption of fruit: In 2014–15 in the Australian Capital Territory, 29% of Indigenous children aged 2–14 were reported to eat 1 or less than 1 serve of fruit a day.

Nationally in 2014–15, one-third (33%) of Indigenous children aged 2–14 were reported to eat 1 or less than 1 serve of fruit a day (Table 2.19.9, Figure 2.19.3).

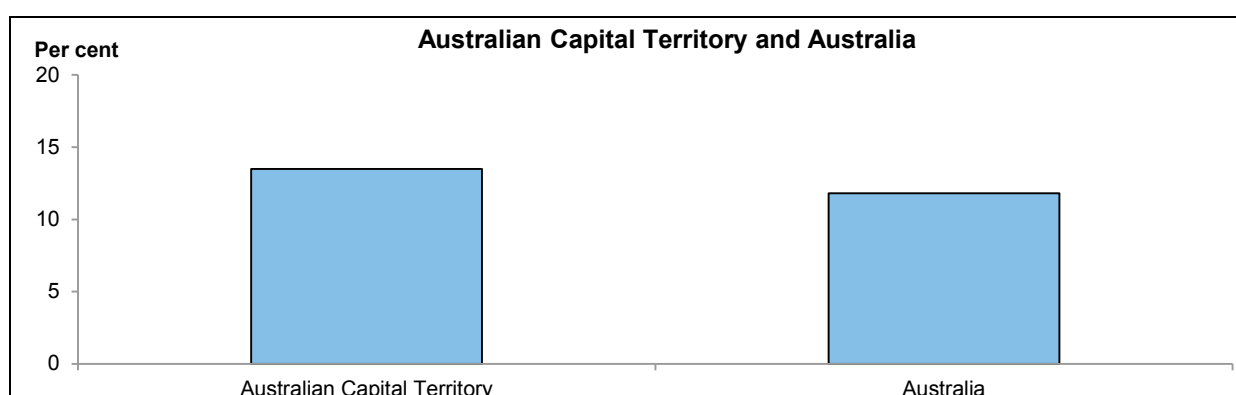
Children's consumption of vegetables: In 2014–15 in the Australian Capital Territory, 44% of Indigenous children aged 2–14 were reported to eat 1 or less than 1 serve of vegetables a day; 28% ate 2 serves; and 19% ate 3 or more serves. Almost 6% reported not usually eating vegetables.

Nationally in 2014–15, 39% of Indigenous children aged 2–14 were reported to eat 1 or less than 1 serve of vegetables a day; 30% ate 2 serves; and 28% ate 3 or more. An estimated 3% were reported to not usually eat vegetables (Table 2.19.9, Figure 2.19.3).



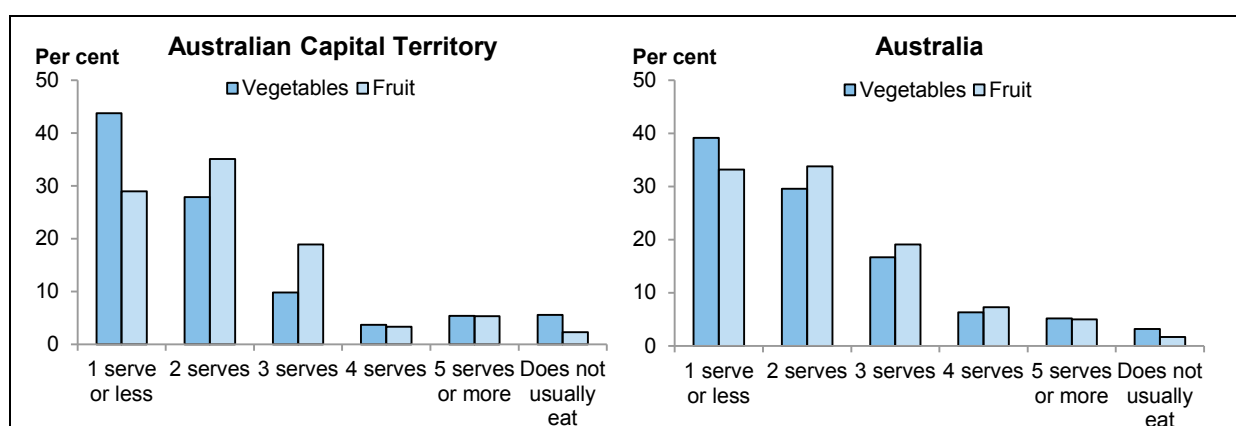
Source: Table 2.19.2.

Figure 2.19.1: Indigenous Australians (12 years and over) reported to eat less than 1 serve of fruit per day, Australian Capital Territory and Australia, 2014–15



Source: Table 2.19.3.

Figure 2.19.2: Indigenous Australians (12 years and over) reported to eat less than 1 serve of vegetables per day, Australian Capital Territory and Australia, 2014–15



Source: Table 2.19.9.

Figure 2.19.3: Indigenous children (aged 2–14), number of serves of fruit and vegetables consumed daily, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.20 Breastfeeding practices

Why it is important

This measure reports on the breastfeeding status of infants, including: breastfeeding duration, breastfeeding and other sources of food, and the reasons mothers stopped breastfeeding. Breastfeeding is one of the most important human behaviours for the survival, growth, development and health of infants and young children. Early initiation (within the first hour after birth) and exclusive breastfeeding during the first month is associated with a reduced risk of neonatal morbidity and mortality (Khan et al. 2014). Breastfeeding also offers protection against many conditions, including sudden infant death syndrome, diarrhoea, respiratory infections, middle ear infections and the development of diabetes in later life (Annamalay et al. 2012; Horta et al. 2015).

Key findings

All comparisons between Indigenous and non-Indigenous infants are for ages 0–2 years due to the scope of the ABS National Health Survey 2014–15.

Children aged 0–3 years: In 2014–15 in the Australian Capital Territory, 83% of Indigenous children aged 0–3 had been or were currently breastfed; and 13% were never breastfed; however, this includes where breastfeeding status was not known.

Nationally in 2014–15, 80% of Indigenous children aged 0–3 were reported to have been or were currently breastfed; and 20% had never been breastfed or breastfeeding status was not known (Table 2.20.2, Figure 2.20.1).

Children aged 0–2 years: In 2014–15 in the Australian Capital Territory, 87% of Indigenous children aged 0–2 were reported to have been breastfed, compared with 93% for non-Indigenous children.

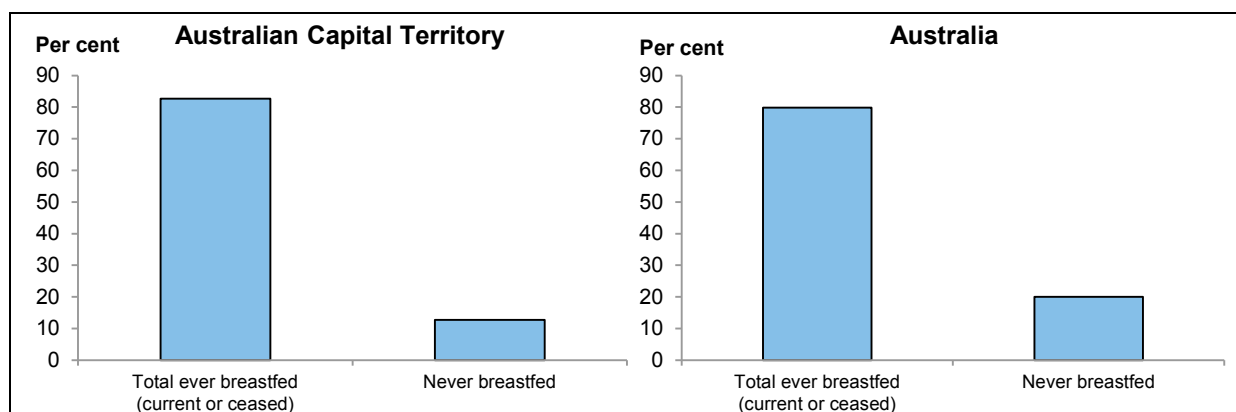
Nationally in 2014–15, a smaller proportion of Indigenous than non-Indigenous children were reported to have been breastfed (82% and 86%, respectively) (Table 2.20.6).

Time breastfed (children aged 0–2 years): In 2014–15 in the Australian Capital Territory, of Indigenous children who had been breastfed, the most common duration of feeding was 1 month to less than 6 months (39%), compared with 24% for non-Indigenous children.

Nationally in 2014–15, of Indigenous children who had been breastfed, the most common duration of feeding was 1 month to less than 6 months (24%). The proportion was similar for non-Indigenous children (26%) (Table 2.20.6, Figure 2.20.2).

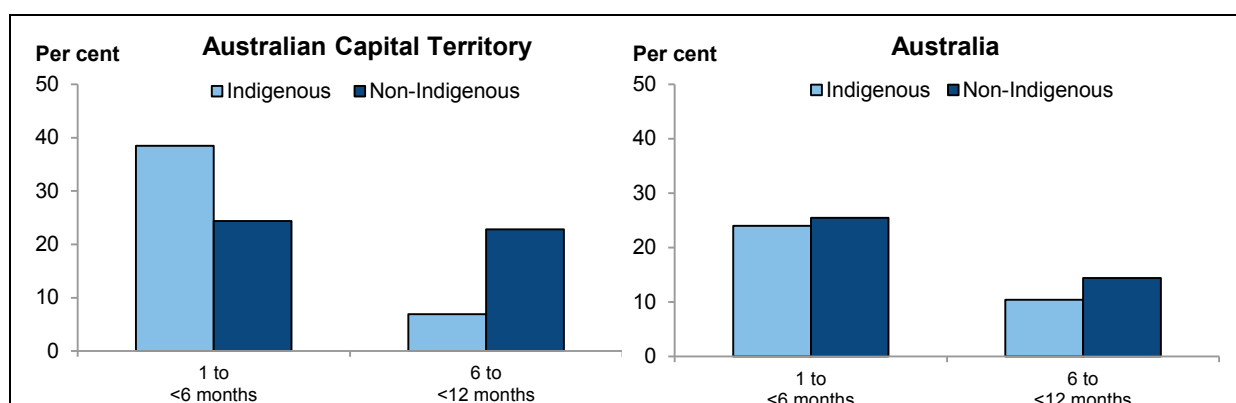
Remoteness (children aged 0–2 years): Nationally, in 2014–15, the proportion of Indigenous children aged 0–2 who were reported to be currently or previously breastfed was highest in *Very remote* areas (91%) and lowest in *Major cities* (73%). For non-Indigenous children, the highest proportion was in *Outer regional* areas (91%) and the lowest was in *Inner regional* areas (80%) (Table 2.20.5).

Trend over time (children aged 0–3 years): Nationally, the rate of breastfeeding of Indigenous infants varied from 2004–05 to 2014–15, and no clear trend is discernible. Higher rates of breastfeeding were consistently reported in *Remote* areas (85% in 2004–05 and 87% in 2014–15) than in *Non-remote* areas (79% in 2004–05 and 2014–15) (Table 2.20.4, Figure 2.20.3).



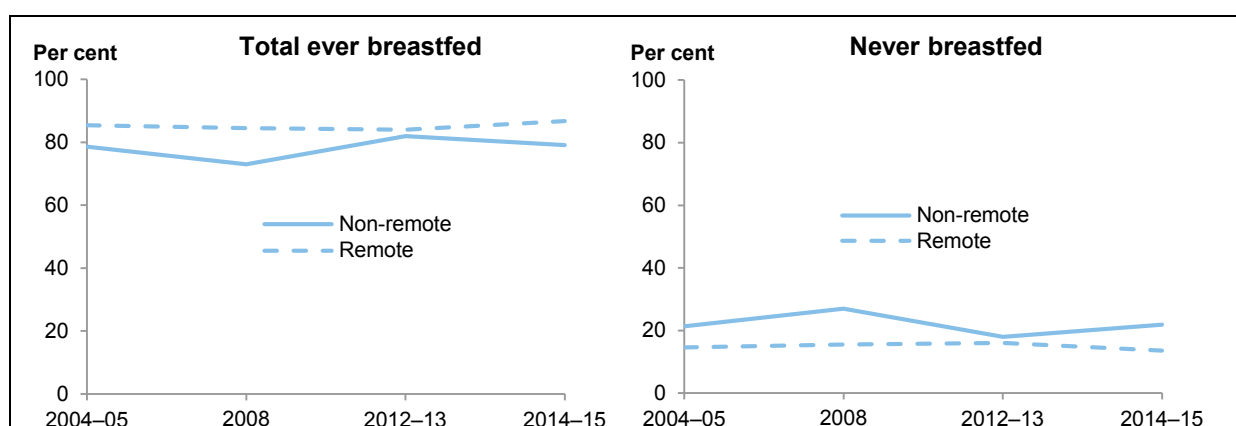
Source: Table 2.20.2.

Figure 2.20.1: Breastfeeding status, Indigenous Australian infants aged 0–3 years, Australian Capital Territory and Australia, 2014–2015



Source: Table 2.20.6.

Figure 2.20.2: Time breastfed, infants aged 0–2 years, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 2.20.4.

Figure 2.20.3: Breastfeeding status of Indigenous Australian infants aged 0–3 years, by remoteness, Australia, 2004–05, 2008, 2012–13, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.21 Health behaviours during pregnancy

Why it is important

This measure reports on the use of tobacco, alcohol, illicit substances and other health-related behaviours during pregnancy. Many lifestyle factors contribute to, and can have adverse effects on, the health and wellbeing of a woman and her baby during pregnancy and birth, as well as for children later in life (AHMAC 2017). Smoking tobacco, drinking alcohol and using illicit drugs while pregnant increases the risk of complications and poor perinatal outcomes (England et al. 2004; Hodyl et al. 2014; Laws et al. 2005; Pringle et al. 2015; Wills & Coory 2008). Nutrition before and during pregnancy is critical to fetal development (McDermott et al. 2009; Wen et al. 2010). Drinking alcohol while pregnant has been shown to result in potentially lifelong physical, mental, behavioural and learning issues, collectively referred to as fetal alcohol spectrum disorders (France et al. 2010; Mutch et al. 2015; Sriartika & O’Leary 2015).

Key findings

Smoking: In 2014–15 in the Australian Capital Territory, 56% of mothers of Indigenous children aged 0–3 reported that they did not use tobacco during pregnancy.

Nationally in 2014–15, 61% of mothers of Indigenous children aged 0–3 years reported that they did not use tobacco during pregnancy (Table 2.21.6, Figure 2.21.1).

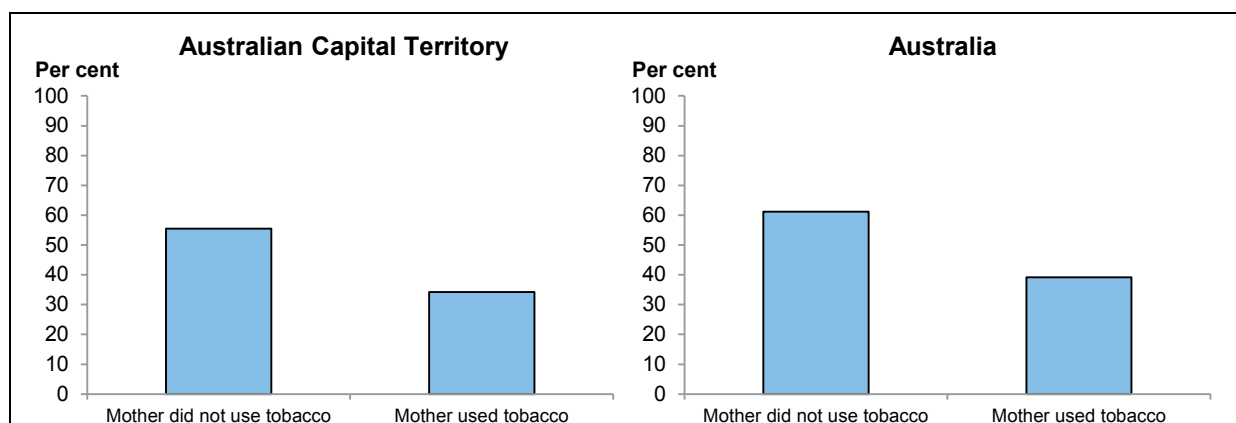
Alcohol consumption: In 2014–15 in the Australian Capital Territory, 91% of Indigenous mothers of children aged 0–3 years reported that they did not consume alcohol during pregnancy.

Nationally in 2014–15, 91% of Indigenous mothers of children aged 0–3 years reported that they did not consume alcohol during pregnancy (Table 2.21.6, Figure 2.21.2).

Illicit drug or substance use: In 2014–15 in the Australian Capital Territory, 86% of Indigenous mothers of children aged 0–3 years, who provided information about illicit drug or substance use, reported that they did not use illicit drugs or substances during pregnancy.

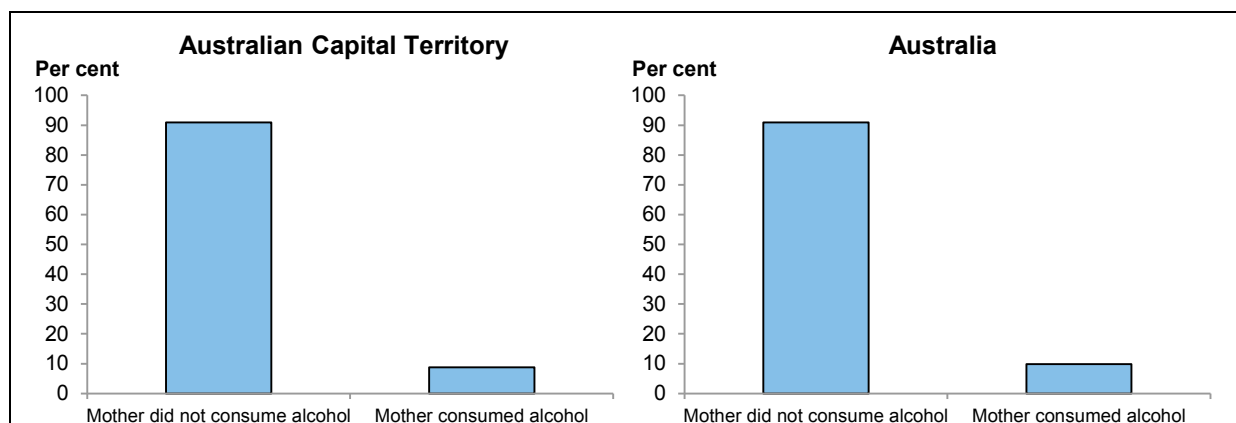
Nationally in 2014–15, 96% of Indigenous mothers of children aged 0–3 years, who provided information about illicit drug or substance use, reported they did not use illicit drugs or substances during pregnancy (Table 2.21.6, Figure 2.21.3).

Remoteness: Nationally, in 2014–15, mothers of Indigenous children aged 0–3 years who lived in *Remote* areas reported a higher proportion of alcohol consumption during their pregnancy than mothers who lived in *Non-remote* areas (13% compared with 9%). They also reported a higher proportion of tobacco use during pregnancy (42% compared with 38%) and a lower proportion of use of illicit drugs during pregnancy (2.4% compared with 4.8%) (Table 2.21.7).



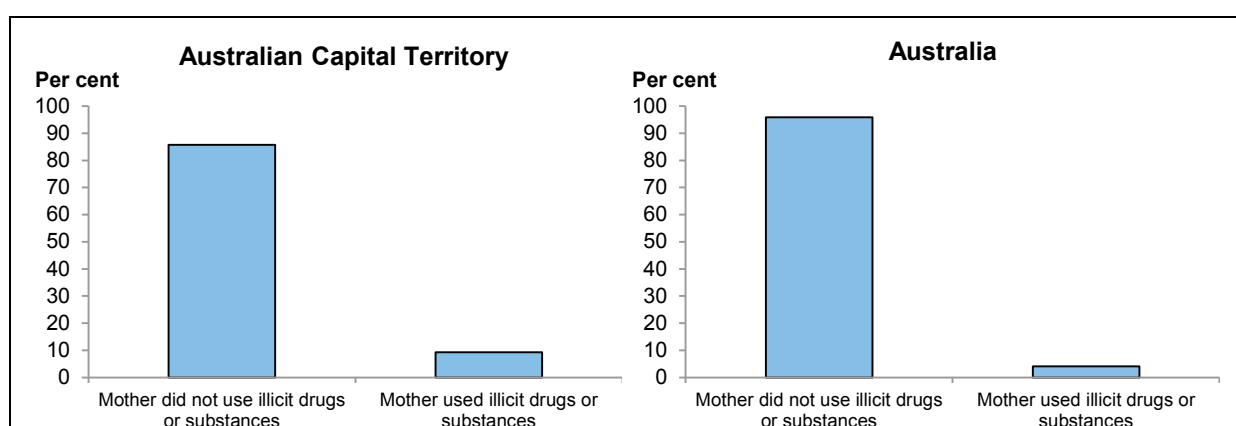
Source: Table 2.21.6.

Figure 2.21.1: Tobacco use during pregnancy, mothers of Indigenous children aged 0–3, Australian Capital Territory and Australia, 2014–15



Source: Table 2.21.6.

Figure 2.21.2: Alcohol consumption by women during pregnancy, mothers of Indigenous children aged 0–3, Australian Capital Territory and Australia, 2014–15



Source: Table 2.21.6.

Figure 2.21.3: Illicit drug or substance use by women during pregnancy, mothers of Indigenous children aged 0–3, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

2.22 Overweight and obesity

Why it is important

This measure reports on the prevalence of overweight and obesity among Indigenous Australians. Overweight and obesity is a global health problem (OECD 2014). Being overweight or obese increases the risk of various health conditions, including coronary heart disease, type 2 diabetes, some cancers, respiratory problems, joint problems, sleep disorders, and social problems. The excess burden of obesity in the Indigenous population is estimated to explain 1 to 3 years (9% to 17%) of the life expectancy gap between Indigenous and non-Indigenous Australians in the Northern Territory (Zhao et al. 2013).

Key findings

Overall: In 2012–13 in the Australian Capital Territory, based on measurements taken at interview, 60% of Indigenous Australians aged 15 and over were overweight or obese (23% overweight and 37% obese).

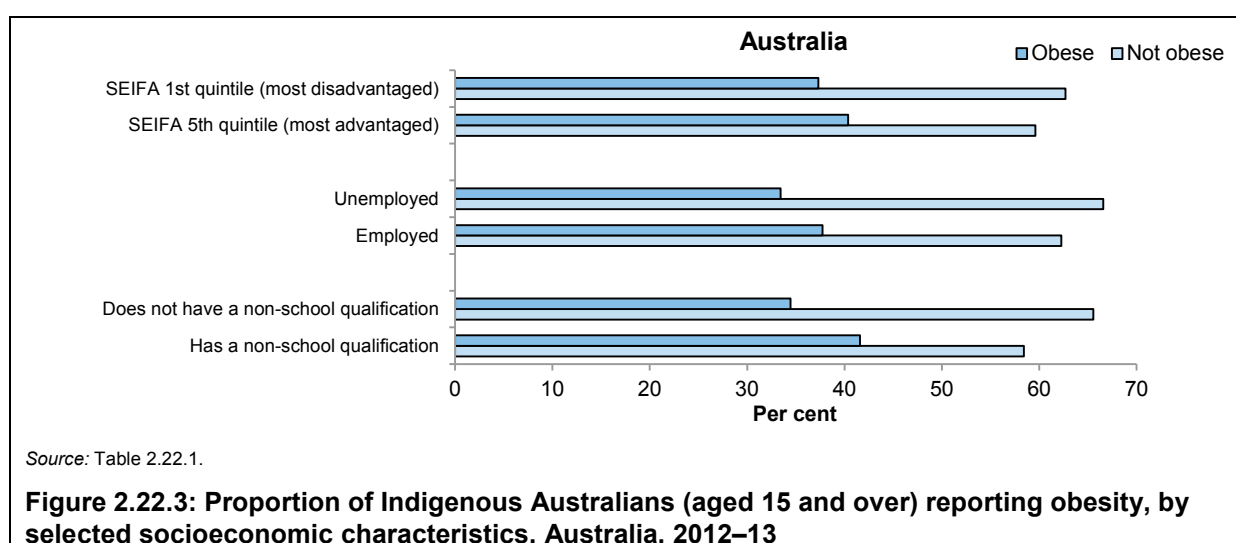
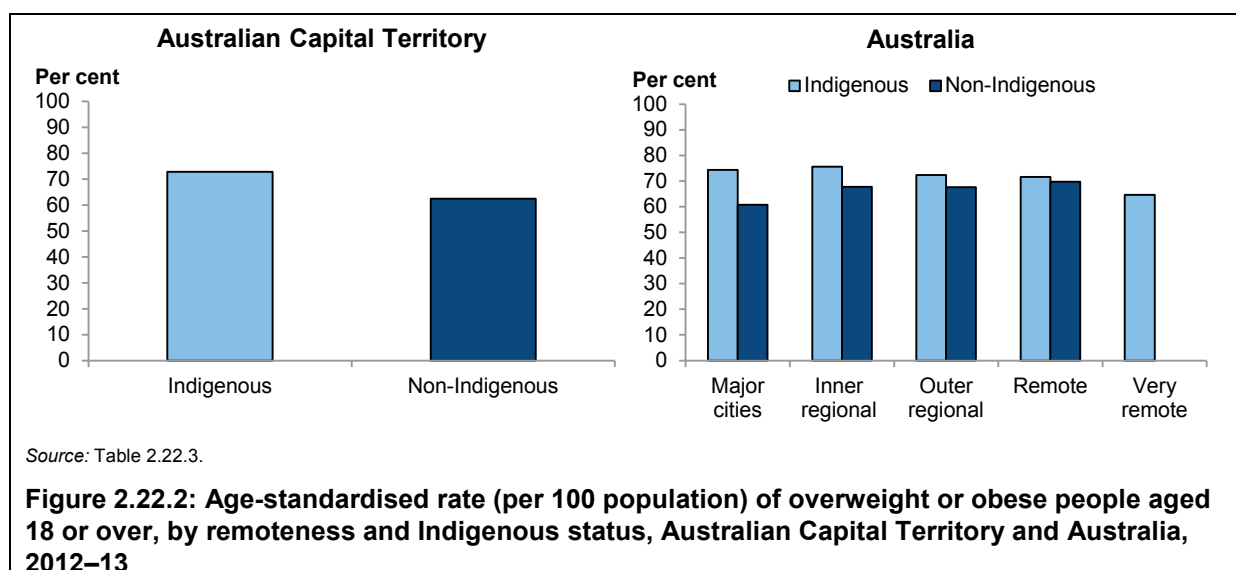
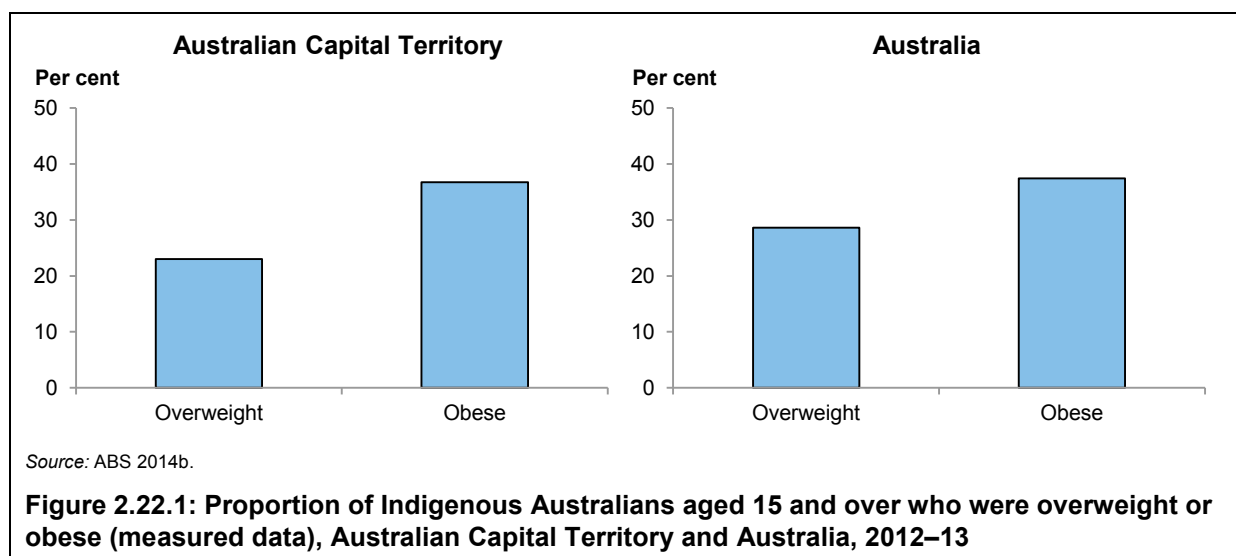
Nationally in 2012–13, based on measurements taken at interview, 66% of Indigenous Australians aged 15 and over were overweight or obese (29% overweight and 37% obese) (ABS 2014b, Figure 2.22.1).

Remoteness: In 2012–13 in the Australian Capital Territory, the age-standardised rate for Indigenous Australians aged 18 and over who were overweight or obese was 73%, compared with 63% for non-Indigenous Australians.

Nationally in 2012–13, based on measurements taken at interview, the age-standardised rate of Indigenous Australians aged 18 or over who were overweight or obese was lower in *Remote* than *Non-remote* areas. The rates were 74% in *Major cities*; 76% in *Inner regional* areas; 72% in *Outer regional* areas; 72% in *Remote* areas; and 65% in *Very remote* areas (Table 2.22.3, Figure 2.22.2).

Selected socioeconomic characteristics: Nationally in 2012–13, based on measured data, the rate of obesity for Indigenous Australians aged 15 and over who were living in the most advantaged areas (SEIFA 5th quintile) was 40%. This was higher than the rate for those living in the most disadvantaged areas (SEIFA 1st quintile), which was 37%. The rate of obesity was higher for people who are employed than those who are unemployed (38% compared with 33%). The rate was higher for those with a non-school qualification than for those without (42% compared with 34%) (Table 2.22.1, Figure 2.22.3).

Physical activity: Nationally in 2012–13, based on self-reported data, Indigenous Australians aged 18 and over who did not meet the physical activity guidelines had a higher rate of obesity than those who met the physical activity guidelines (44% compared with 36%); and those who experienced one or more stressors had a higher rate of obesity than those who had no stressors (40% compared with 38%) (Table 2.22.2).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

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Tier 3—Health system performance

3.01 Antenatal care

Why it is important

This measure reports the total number of antenatal visits, duration of pregnancy at first antenatal visit and types of antenatal services used. Antenatal care is especially important for Indigenous women because they are at higher risk of giving birth to pre-term and low birthweight babies and have greater exposure to other risk factors and complications such as anaemia, poor nutritional status, chronic illness, hypertension, diabetes, genital and urinary tract infections, smoking and high levels of psychosocial stressors (AHMAC 2017; de Costa & Wenitong 2009). The World Health Organization recommends receiving antenatal care at least 4 times during pregnancy. The Australian Antenatal Guidelines (AHMAC 2012) recommend that the first antenatal visit occur within the first 10 weeks of pregnancy and that first-time mothers with an uncomplicated pregnancy attend 10 visits (7 visits for subsequent uncomplicated pregnancies).

Key findings

In line with AIHW policy, rates are not calculated where the denominator is less than 100.

Overall: In 2014 in the Australian Capital Territory, 98% of Indigenous mothers accessed antenatal care services at least once during their pregnancy. For non-Indigenous mothers, 99.9% accessed antenatal care services at least once during their pregnancy (Table 3.01.20).

Nationally in 2014, 99% of Indigenous mothers accessed antenatal care services at least once during their pregnancy. The age-standardised proportions were similar for Indigenous and non-Indigenous mothers (98.8% and 99.9%, respectively) (Table 3.01.20, Figure 3.01.1).

Number of antenatal visits: In the Australian Capital Territory in 2014, 69 of the 92 Indigenous mothers who gave birth at 32 weeks' gestation or more had attended 5 or more antenatal visits during their pregnancy. For non-Indigenous mothers, 79% had attended 5 or more antenatal visits during their pregnancy (Table 3.01.1).

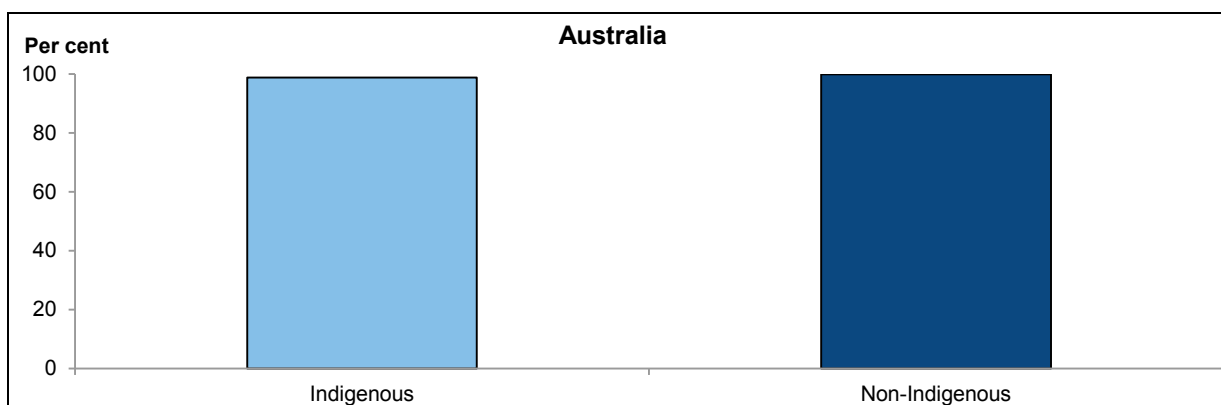
Nationally in 2014, 86% of Indigenous mothers had attended 5 or more antenatal visits during their pregnancy. The age-standardised rate for Indigenous mothers was 0.9 times the rate for non-Indigenous mothers (86% compared with 95%) (Table 3.01.1, Figure 3.01.2).

First antenatal visit: In the Australian Capital Territory in 2014, 44 of the 98 Indigenous mothers had their first antenatal visit in the first trimester of pregnancy. For non-Indigenous mothers, 45% had their first antenatal visit in the first trimester of pregnancy.

Nationally in 2014, 54% of Indigenous mothers had their first antenatal visit in the first trimester of pregnancy. The age-standardised rate for Indigenous mothers who had their first antenatal visit in the first trimester was 0.9 times the rate for non-Indigenous mothers (53% compared with 60%) (Table 3.01.10).

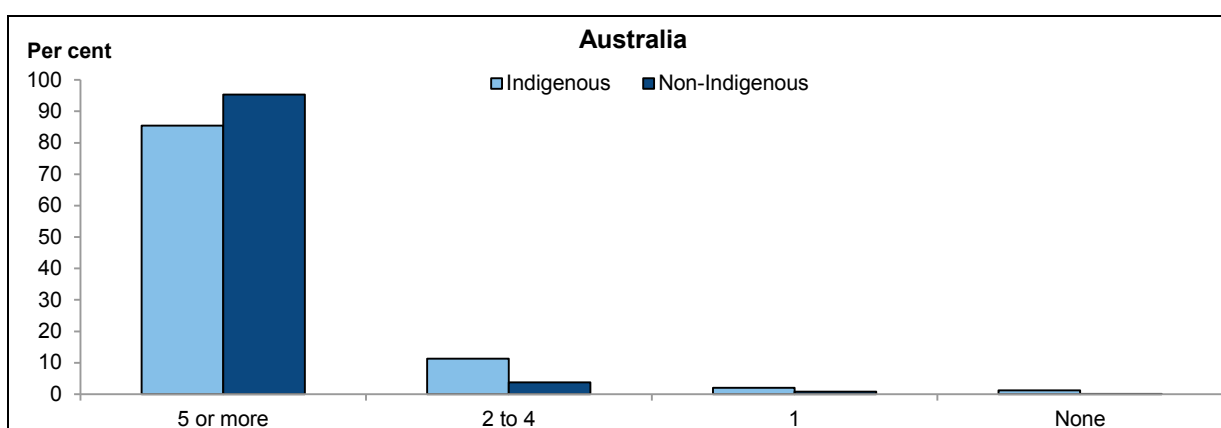
Regular care: In 2014–15 in the Australian Capital Territory, 96% of mothers of Indigenous children aged 0–3 reported they had regular pregnancy check-ups.

In 2014–15 nationally, 94% of mothers of Indigenous children aged 0–3 reported they had regular pregnancy check-ups (Table 3.01.18, Figure 3.01.3).



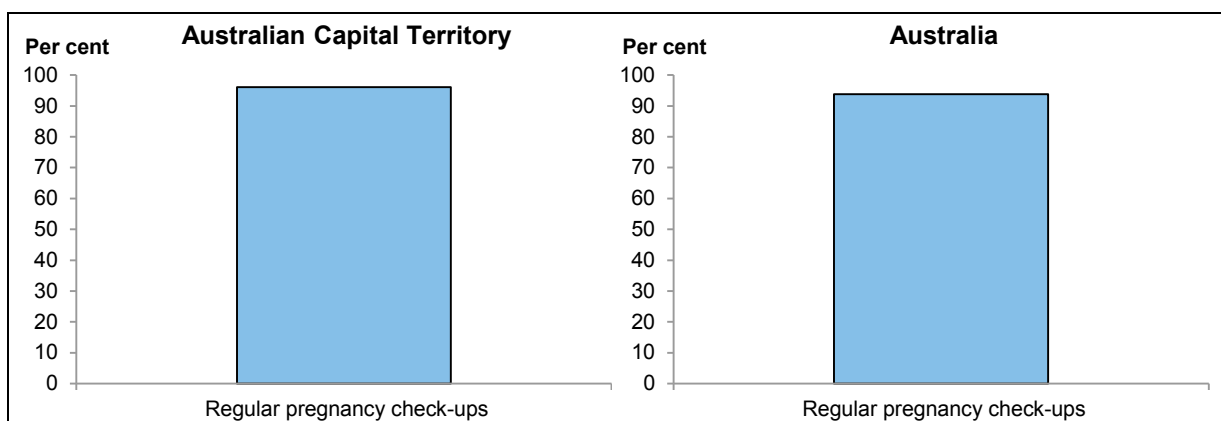
Source: Table 3.01.20.

Figure 3.01.1: Age-standardised rate of mothers attending at least 1 antenatal visit, by Indigenous status, Australia, 2014



Source: Table 3.01.1.

Figure 3.01.2: Age-standardised rate of women who gave birth at 32 weeks' gestation or more, by number of antenatal visits, by Indigenous status, Australia, 2014



Source: Table 3.01.18.

Figure 3.01.3: Proportion of mothers of Indigenous children aged 0–3, who had regular pregnancy check-ups, Australian Capital Territory and Australia, 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.02 Immunisation

Why it is important

This measure reports on vaccination coverage rates for children aged 1, 2 and 5 years. Vaccination is highly effective in reducing morbidity and mortality caused by vaccine-preventable diseases. Vaccinations have been effective in reducing the disease disparities between Indigenous and non-Indigenous Australians (Menzies & Singleton 2009).

Key findings

Overall: At 31 December 2015 in the Australian Capital Territory, 98% of Indigenous children aged 1 were fully immunised, compared with 95% for other Australian children (Table 3.02.2, Figure 3.02.1). At age 2, 83% of Indigenous children were fully immunised compared with 92% for other Australian children (Table 3.02.3, Figure 3.02.2). By age 5, the rates were similar (94% compared with 93%) (Table 3.02.4, Figure 3.02.3).

At 31 December 2015 nationally, vaccination coverage for Indigenous children aged 1 was 90% compared with 93% for other Australian children (90% compared with 93%) (Table 3.02.2, Figure 3.02.1). At age 2, 87% of Indigenous children were fully immunised compared with 90% of other Australian children (Table 3.02.3, Figure 3.02.2). By age 5, the rate for Indigenous children was higher than for other Australian children (95% compared with 93%) (Table 3.02.4, Figure 3.02.3).

At age 1: In the Australian Capital Territory at 31 December 2015, for children aged 1, the vaccination rates for hepatitis B, DTP, polio, HIB and pneumococcal were higher for Indigenous children (98% for all vaccinations) than for other children (96% for hepatitis B, DTP and polio; 95% for HIB and pneumococcal).

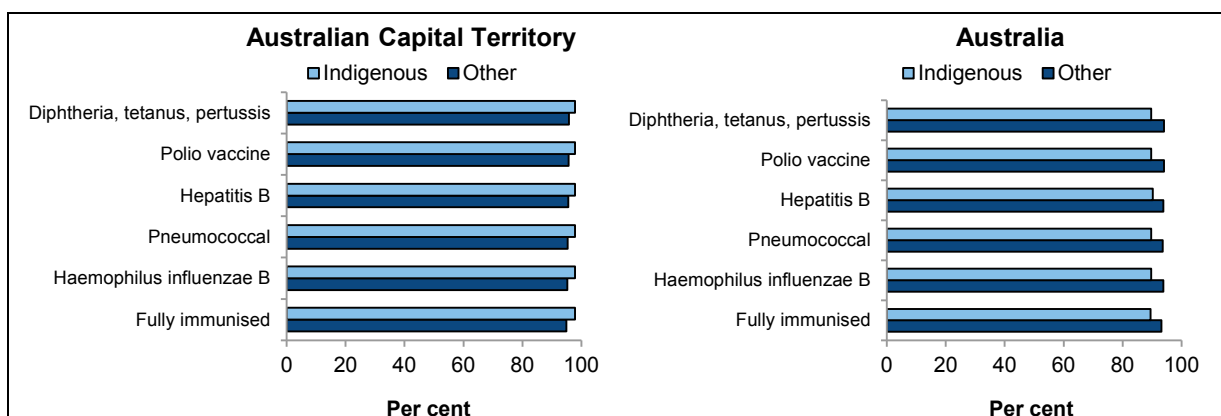
Nationally at 31 December 2015, vaccination rates for Indigenous children aged 1 were lower for Indigenous children than for other children (90% for all compared with 94% for all) (Table 3.02.2, Figure 3.02.1).

At age 2: In the Australian Capital Territory at 31 December 2015, for children aged 2, the vaccination rates for hepatitis B, DTP, polio and HIB were lower for Indigenous children (94% for all) than for other children (97% for all, except HIB, 96%). The vaccination rates for MMR and varicella were lower for Indigenous children (89% and 86%) than for other children (93% and 94%).

Nationally at 31 December 2015, the vaccination rates for hepatitis B and polio vaccine were higher for Indigenous children than for other children (96% compared with 95%). For DTP the rate for both Indigenous children and other children was 96% and for HIB the rate was 95% for both. The rates for MMR and varicella were lower for Indigenous children (89% for both) than for other children (92% for both) (Table 3.02.3, Figure 3.02.2).

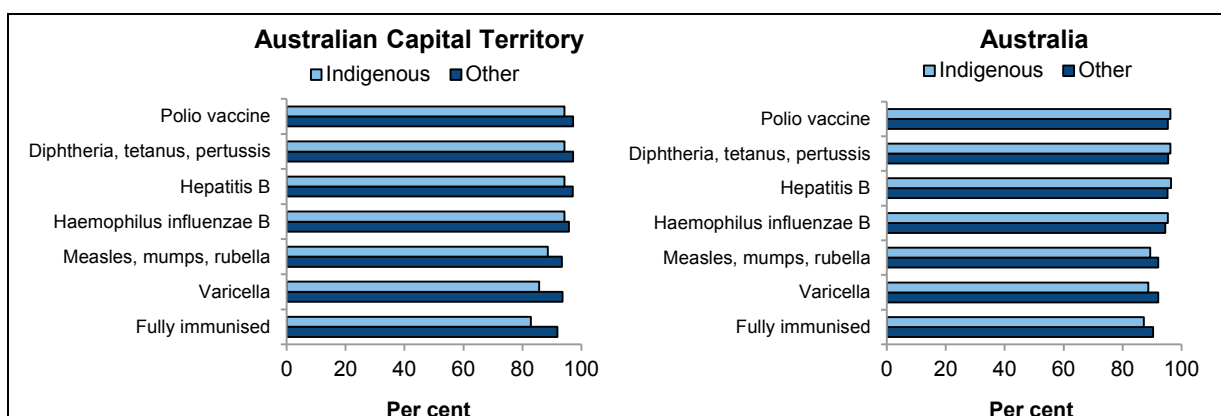
At age 5: In the Australian Capital Territory at 31 December 2015, for children aged 5, the vaccination rates for DTP, polio and MMR for Indigenous children were the same as for other children (94%).

Nationally at 31 December 2015, the vaccination rates for Indigenous children for DTP and polio were both 95%, which was higher than the rate for other children (94% for both). The vaccination rate for MMR was higher for Indigenous children than other children (96% compared with 94%) (Table 3.02.4, Figure 3.02.3).



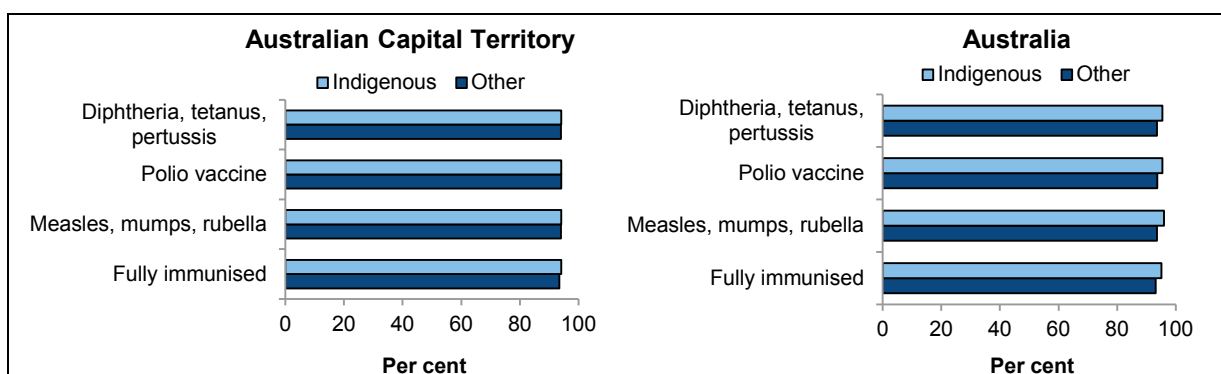
Source: Table 3.02.2.

Figure 3.02.1: Vaccination coverage estimates for selected diseases for children immunised at age 1, by Indigenous status, Australian Capital Territory and Australia, at 31 December 2015



Source: Table 3.02.3.

Figure 3.02.2: Vaccination coverage estimates for selected diseases for children immunised at age 2, by Indigenous status, Australian Capital Territory and Australia, at 31 December 2015



Source: Table 3.02.4.

Figure 3.02.3: Vaccination coverage estimates for selected diseases for children immunised at age 5, by Indigenous status, Australian Capital Territory and Australia, at 31 December 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.03 Health promotion

Why it is important

This measure reports on interventions provided by clinicians and health promotion initiatives funded by governments and provided by a range of health professionals. Indigenous Australians experience higher levels of morbidity and mortality from potentially avoidable conditions than other Australians (AHMAC 2017). Health promotion is the process of enabling people to increase control over their health and its determinants, and improve their health as a result (WHO 2005). Health promotion includes: public policy interventions (for example, packaging of cigarettes, seat belt laws); information to support healthy lifestyles (for example, smoking, alcohol and drug use, physical activity and diet); social marketing (for example, sunscreen use); and mass media campaigns (for example, drink-driving, road safety) (AHMAC 2015).

Key findings

Overall: In the Australian Capital Territory in 2012–13, 88% of Indigenous Australians aged 15 and over reported they had consulted a doctor in the last 12 months. Of those who had consulted a doctor, 45% reported they had discussed lifestyle issues with a GP or health professional.

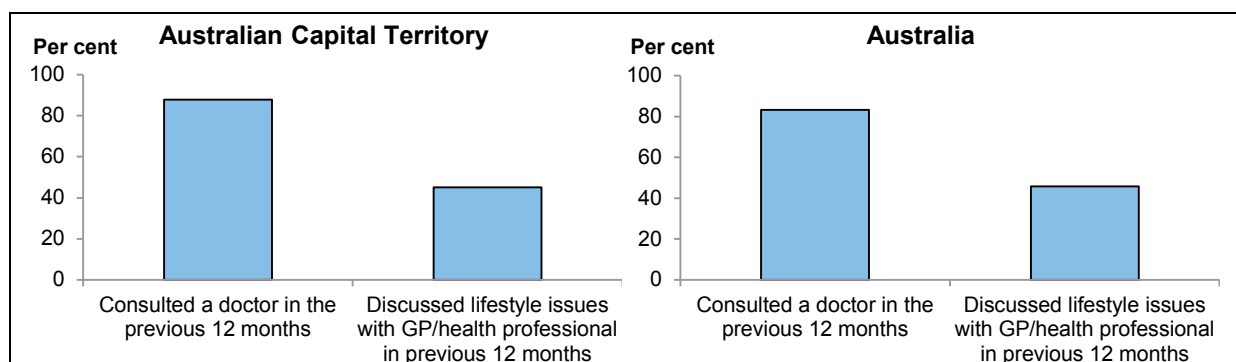
Nationally in 2012–13, 83% of Indigenous Australians aged 15 and over reported they had consulted a doctor in the last 12 months. Of those who had consulted a doctor, 46% reported they had discussed lifestyle issues with a GP or health professional (Table 3.03.4, Figure 3.03.1).

Lifestyle information: In the Australian Capital Territory in 2012–13, Indigenous Australians reported that the most common lifestyle issues discussed with a GP or health professional were reaching a healthy weight (50%), eating healthy food or improving their diet (48%), increasing physical activity (41%) and reducing or quitting smoking (28%).

Nationally in 2012–13, Indigenous Australians aged 15 and over reported that the most common lifestyle issues discussed with a GP or health professional by Indigenous Australians were reaching a healthy weight (50%), eating healthy food or improving their diet (44%), reducing or quitting smoking (43%) and increasing physical activity (30%) (Table 3.03.4, Figure 3.03.2).

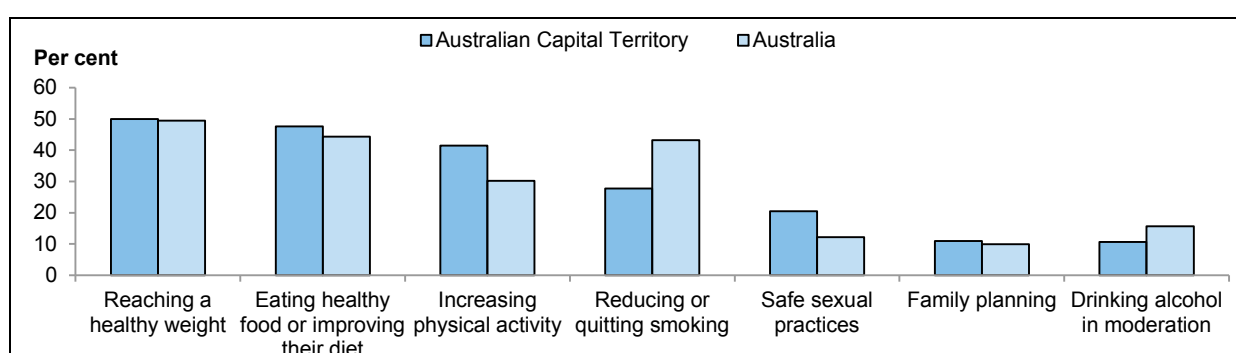
Programs and activities: In the Australian Capital Territory and New South Wales combined, from 1 June 2014 to 31 May 2015, when data were combined from all Indigenous-specific health-care services, the most common type of health promotion activities and programs provided by Aboriginal and Torres Strait Islander primary health-care organisations were physical activity or healthy weight programs and activities (86%), men's groups (61%), chronic disease client support groups (61%) and living skills groups such as cooking or nutrition groups (59%).

Nationally, from 1 June 2014 to 31 May 2015, the most common type of health promotion activities and programs provided by Aboriginal and Torres Strait Islander primary health-care organisations were physical activity or healthy weight programs and activities (73%), men's groups (64%), women's groups (63%) and living skills groups, such as cooking or nutrition groups (61%) (Table 3.03.10, Figure 3.03.3).



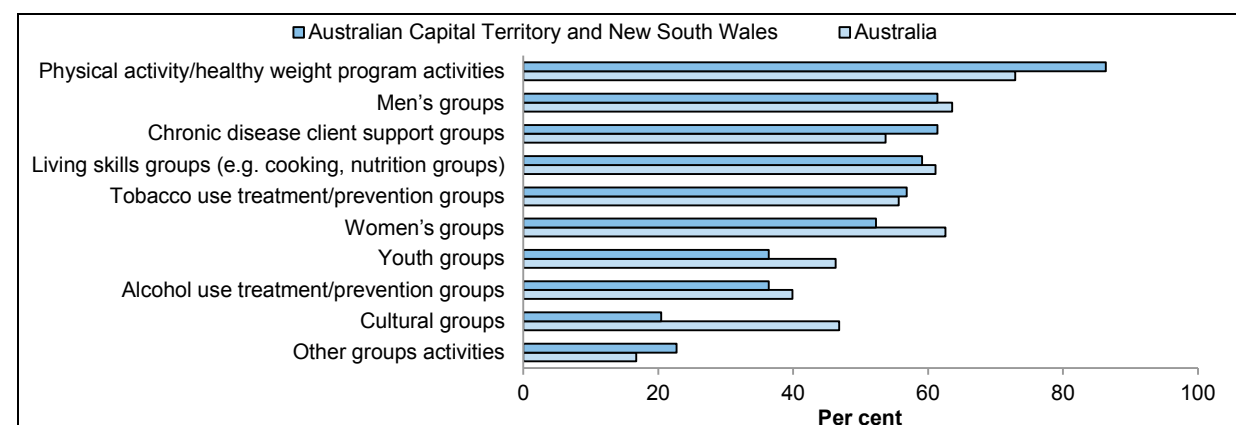
Source: Table 3.03.4.

Figure 3.03.1: Proportion of Indigenous Australians aged 15 and over who discussed lifestyle with a GP or health professional, Australian Capital Territory and Australia, 2012–13



Source: Table 3.03.4.

Figure 3.03.2: Type of lifestyle issues discussed with a GP or health professional in the last 12 months (multiple responses allowed), by Indigenous Australians aged 15 and over, Australian Capital Territory and Australia, 2012–13



Note: the Australian Capital Territory and New South Wales data are shown together.

Source: Table 3.03.10.

Figure 3.03.3: Proportion of Aboriginal and Torres Strait Islander primary health-care organisations providing health promotion, by type of program or activity (multiple responses allowed), Australian Capital Territory and New South Wales combined, and Australia, 1 June 2014 to 31 May 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.04 Early detection and early treatment

Why it is important

This measure reports on the early detection and early treatment of disease. Early detection is the discovery of a disease or condition at an early stage, usually before symptoms occur. This means the disease can be treated much earlier, which results in better health outcomes for patients. Medicare Benefits Schedule (MBS) health assessment items for Indigenous Australians encourage early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality. Screening programs are designed to detect cancer early (breast and bowel) or prevent its occurrence in the first place by detecting pre-cancerous changes (bowel and cervical) (AHMAC 2017; AIHW 2016d).

Key findings

Medicare health assessments: In 2015–16 in the Australian Capital Territory, the rate of Indigenous-specific health checks claimed (MBS item 715) was 221 per 1,000. Rates across all age groups were lower than the equivalent national rates described below. By age group, the rates were 186 per 1,000 for ages 0–14; 225 per 1,000 for ages 15–54; and 318 per 1,000 for ages 55 and older.

Nationally in 2015–16, the rate of Indigenous-specific health checks claimed (MBS item 715) was 267 per 1,000. By age group, the rates were 256 per 1,000 for ages 0–14, 252 per 1,000 for ages 15–54 and 383 per 1,000 for ages 55 and older (Table 3.04.1, Figure 3.04.1).

Breast cancer screening: In 2013–2014 in the Australian Capital Territory, 27% of Indigenous women aged 40 and over had been screened, compared with 33% for non-Indigenous women.

In 2013–2014 nationally, 26% of Indigenous women aged 40 and over had been screened, compared with 34% for non-Indigenous women (Table 3.04.9, Figure 3.04.2).

Pap smear test: In 2012–13 in the Australian Capital Territory, 73% of Indigenous women aged 20–69 reported they had regular pap smear tests.

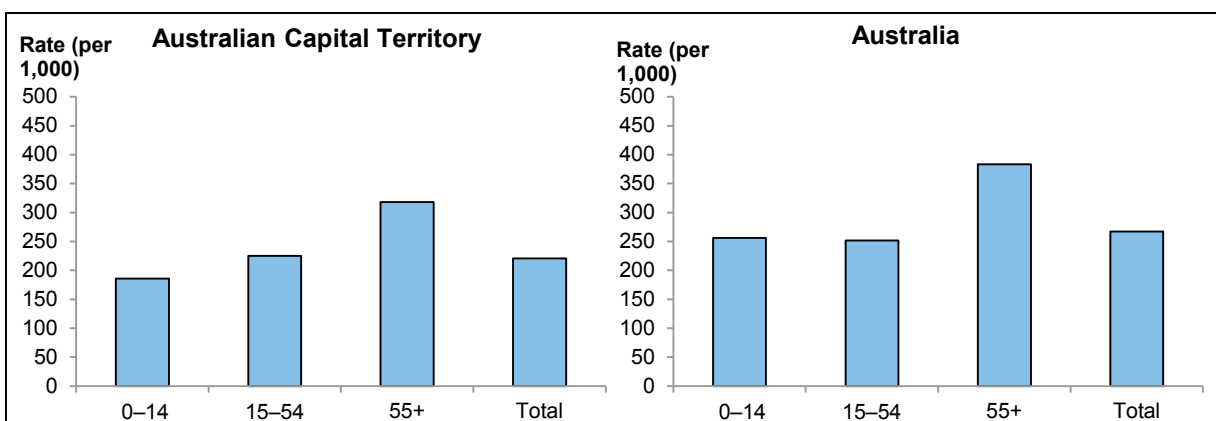
Nationally in 2012–13, 70% of Indigenous women aged 20–69 reported they had regular pap smear tests (Table 3.04.13).

Bowel cancer screening: In 2012–13 in the Australian Capital Territory, 22% of Indigenous males and females aged 50–74 reported they had participated in bowel cancer screening tests.

Nationally in 2012–13, 18% of Indigenous males and 11% of Indigenous females aged 50–74 reported they had participated in bowel cancer screening tests (Table 3.04.17).

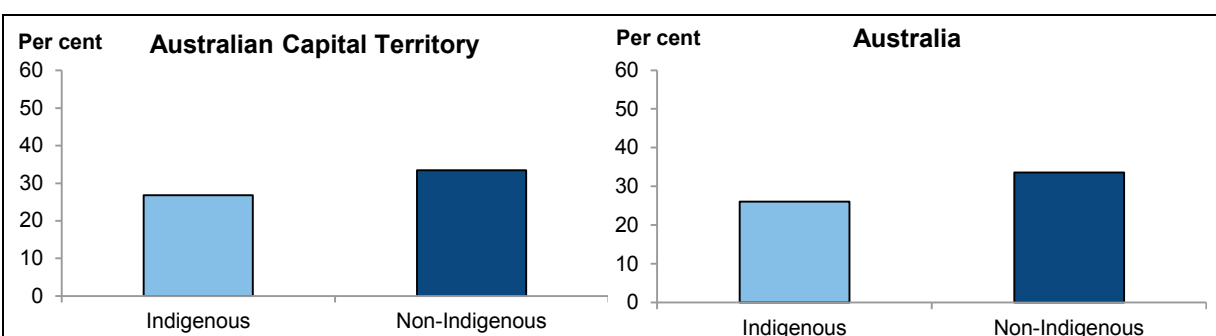
Trend over time: In the Australian Capital Territory, the rate of Indigenous-specific health checks claimed (MBS item 715) increased from 34 per 1,000 in 2006–07 to 221 per 1,000 in 2015–16. Increases were evident for all age groups; the largest increase was observed in those aged 55 and over.

Nationally, the rate of Indigenous-specific health checks claimed (MBS item 715) increased from 37 per 1,000 in 2006–07 to 267 per 1,000 in 2015–16. Increases were evident in all age groups; the largest increase was observed in those aged 55 and over (Table 3.04.3, Figure 3.04.3).



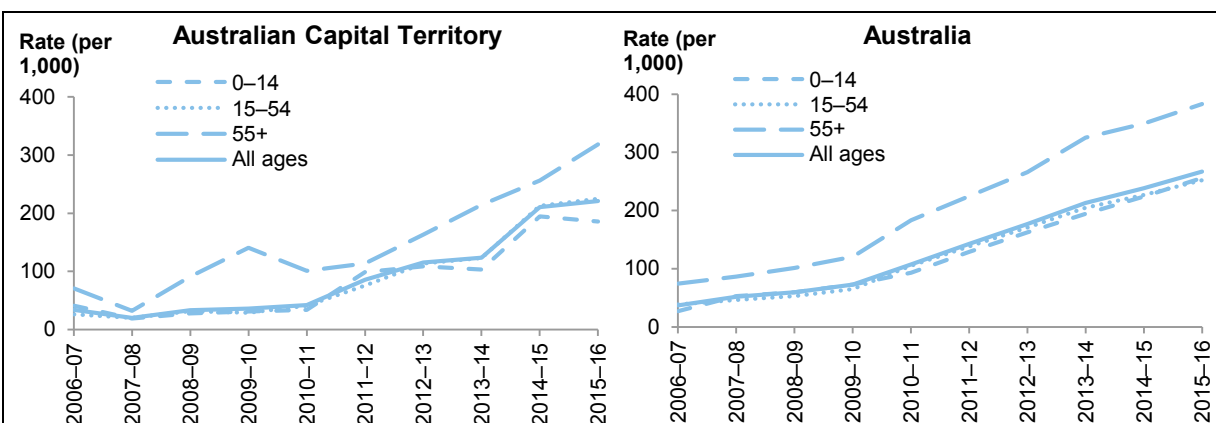
Source: Table 3.04.1.

Figure 3.04.1: Rate of Indigenous-specific health checks claimed (MBS item 715), Indigenous Australians aged 0–14, 15–54 and 55 and over, Australian Capital Territory and Australia, 2015–16



Source: Table 3.04.9.

Figure 3.04.2: Age-standardised participation rates in BreastScreen Australia programs for women aged 40 and over, by Indigenous status, Australian Capital Territory and Australia, 2013–2014



Sources: Tables 3.04.3, 3.04.5, 3.04.6 and 3.04.7.

Figure 3.04.3: Rate of Indigenous-specific health checks claimed (MBS item 715), Indigenous Australians, by age group, Australian Capital Territory and Australia, 2006–07 to 2015–16

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.05 Chronic diseases management

Why it is important

This measure reports on the management of chronic diseases. Chronic diseases are the leading causes of illness, disability and death among Indigenous Australians and are estimated to be responsible for 70% of the health gap between Indigenous and non-Indigenous Australians (AIHW 2016b). Effective management of chronic diseases is key in meeting the target of closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. Effective management of chronic diseases can delay the progression of the disease, improve quality of life, increase life expectancy and decrease the need for high cost interventions leading to net savings (Thomas et al. 2014; Zhao et al. 2014).

Key findings

Blood tests and foot checks: In 2012–13 in the Australian Capital Territory, of Indigenous Australians with current and long-term diabetes or high sugar levels, 82% reported having undergone HbA1C testing in the last 12 months compared with 68% of non-Indigenous Australians (Table 3.05.13, Figure 3.05.1). Blood glucose levels were checked for 100% of Indigenous Australians compared with 93% of non-Indigenous Australians. Feet were checked for 73% of Indigenous Australians compared with 72% of non-Indigenous Australians (Table 3.05.13).

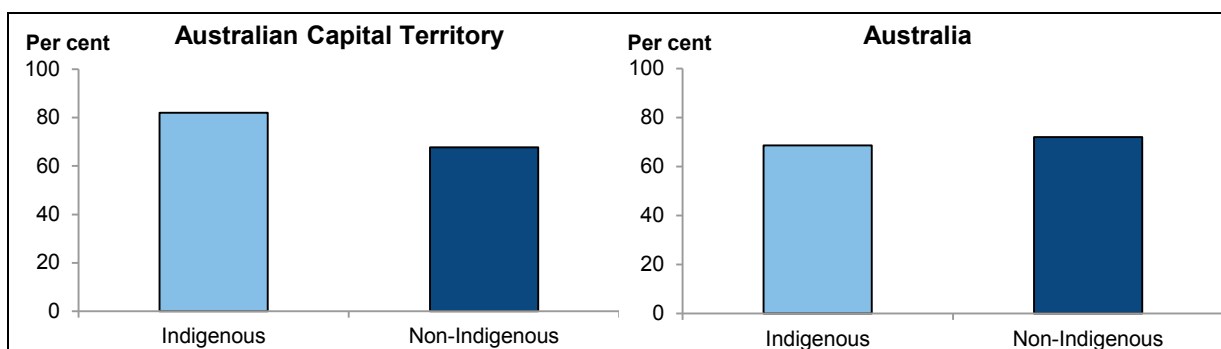
Nationally in 2012–13, of Indigenous Australians with current and long-term diabetes or high sugar levels, 69% reported having undergone HbA1C testing in the last 12 months compared with 72% of non-Indigenous Australians (Table 3.05.13, Figure 3.05.1). Blood glucose levels were checked for 95% of Indigenous Australians compared with 97% of non-Indigenous Australians. Feet were checked for 68% of Indigenous Australians compared with 74% of non-Indigenous Australians (Table 3.05.13).

Actions taken: In the Australian Capital Territory in 2012–13, Indigenous Australians reported that actions taken to manage current and long-term diabetes or high sugar levels included: lifestyle actions such as diet, weight loss or exercise (90%); taking medicine or tablets (49%); and using insulin (11%).

Nationally in 2012–13, Indigenous Australians reported that actions they had taken to manage current and long-term diabetes or high sugar levels included: a lifestyle action such as diet, weight loss or exercise (80%); taking medicine or tablets (64%); and using insulin (30%) (Table 3.05.13, Figure 3.05.2).

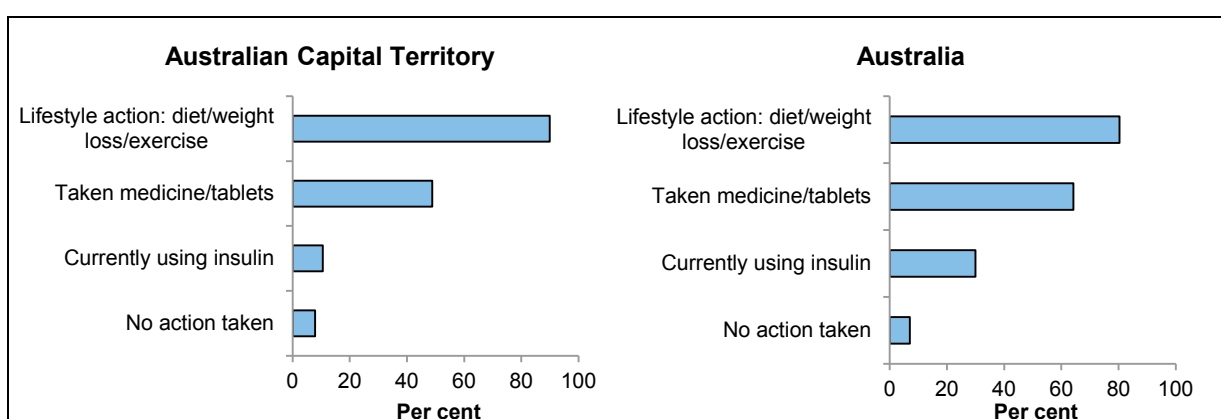
Trend over time: In the Australian Capital Territory and New South Wales combined, the proportion of Indigenous clients of Indigenous Specific Primary Health Services (ISPHS) with type 2 diabetes who had a GP Management Plan (GPMP) within the past 2 years increased steadily from 46% in 2012 to 53% in 2014, then decreased slightly to 52% in 2015. A similar pattern was seen for ISPHS clients with a Team Care Arrangement (TCA); there was an increase from 44% in 2012 to 52% in 2014, followed by a decrease to 50% in 2015.

Nationally, the proportion of all ISPHS clients in Australia with type 2 diabetes who had a GPMP within the past 2 years increased from 41% in 2012 to 51% in 2015. The proportion of ISPHS clients with a TCA also increased, from 36% in 2012 to 48% in 2015 (Table 3.18.1, Figure 3.05.3).



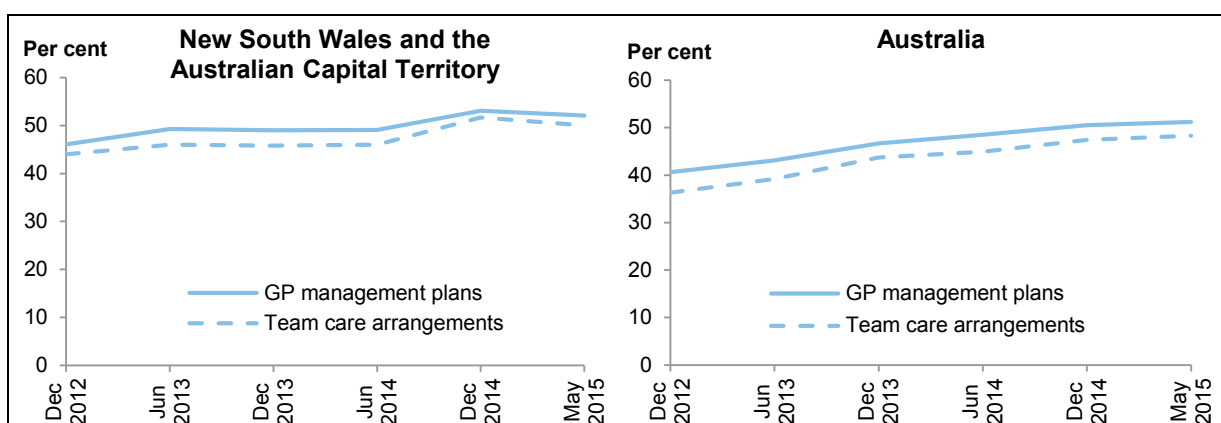
Source: Table 3.05.13.

Figure 3.05.1: People with diagnosed, current and long-term diabetes or high sugar levels who had an HbA1C test in the last 12 months, by Indigenous status, Australian Capital Territory and Australia, 2012–13



Source: Table 3.05.13.

Figure 3.05.2: Actions taken to manage diabetes or high sugar levels by Indigenous Australians, Australian Capital Territory and Australia, 2012–13



Source: Table 3.18.1.

Figure 3.05.3: Proportion of Indigenous, regular clients with type 2 diabetes who had a GPMP or TCA in the last 2 years, Indigenous primary health-care services, NSW and ACT combined, and Australia, December 2012 to May 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.06 Access to hospital procedures

Why it is important

This measure reports on the key hospital procedure differences between Indigenous and non-Indigenous Australians for hospitalisation with the same principal diagnosis. Studies have shown that, although Indigenous Australians are more likely to be hospitalised than non-Indigenous Australians, they are less likely to receive a medical or surgical procedure while in hospital (ABS & AIHW 2008; Cunningham 2002). Research has shown that the most significant factors were: whether the hospital was public or private, the number of principal and additional diagnoses, state/territory of usual residence, Indigenous status, age group, remoteness of usual residence, and sex (AHMAC 2017).

Key findings

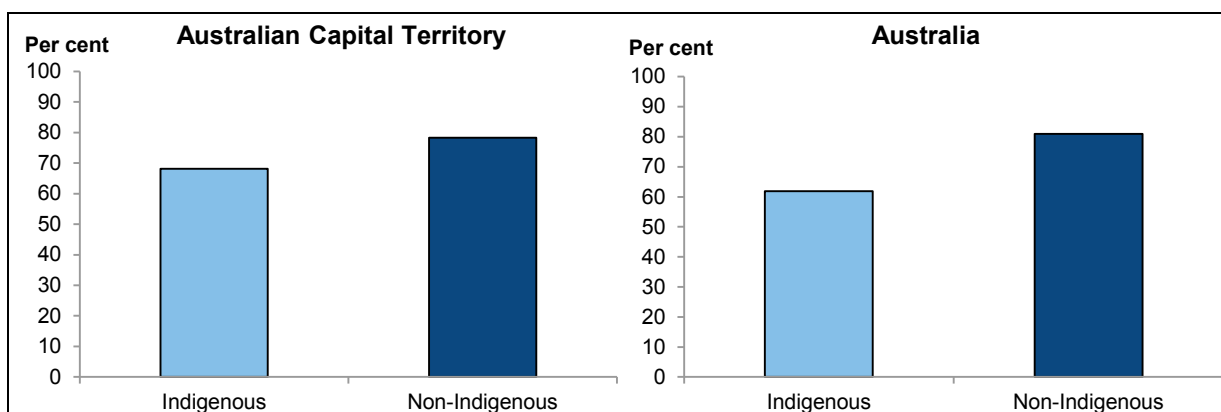
Overall: In July 2013 to June 2015 in the Australian Capital Territory, the age-standardised rate of hospitalisations where a procedure was recorded was 68% for Indigenous Australians, compared with 78% for non-Indigenous Australians. This was a rate difference of 10 percentage points.

In July 2013 to June 2015 nationally, an age-standardised rate of 62% of hospitalisations for Indigenous Australians had a procedure recorded compared with 81% for non-Indigenous Australians. The rate difference between Indigenous and non-Indigenous hospitalisations where a procedure was recorded was 19 percentage points (Table 3.06.1, Figure 3.06.1).

Procedures by age: In July 2013 to June 2015 nationally, the proportion of hospitalisations for Indigenous Australians where a procedure was reported increased with age, from 47% for ages 0–4 to 70% for ages 65 and over. For non-Indigenous Australians, proportions were higher at every age group; for example, 54% for ages 0–4 and 86% for ages 65 and over (Table 3.06.4).

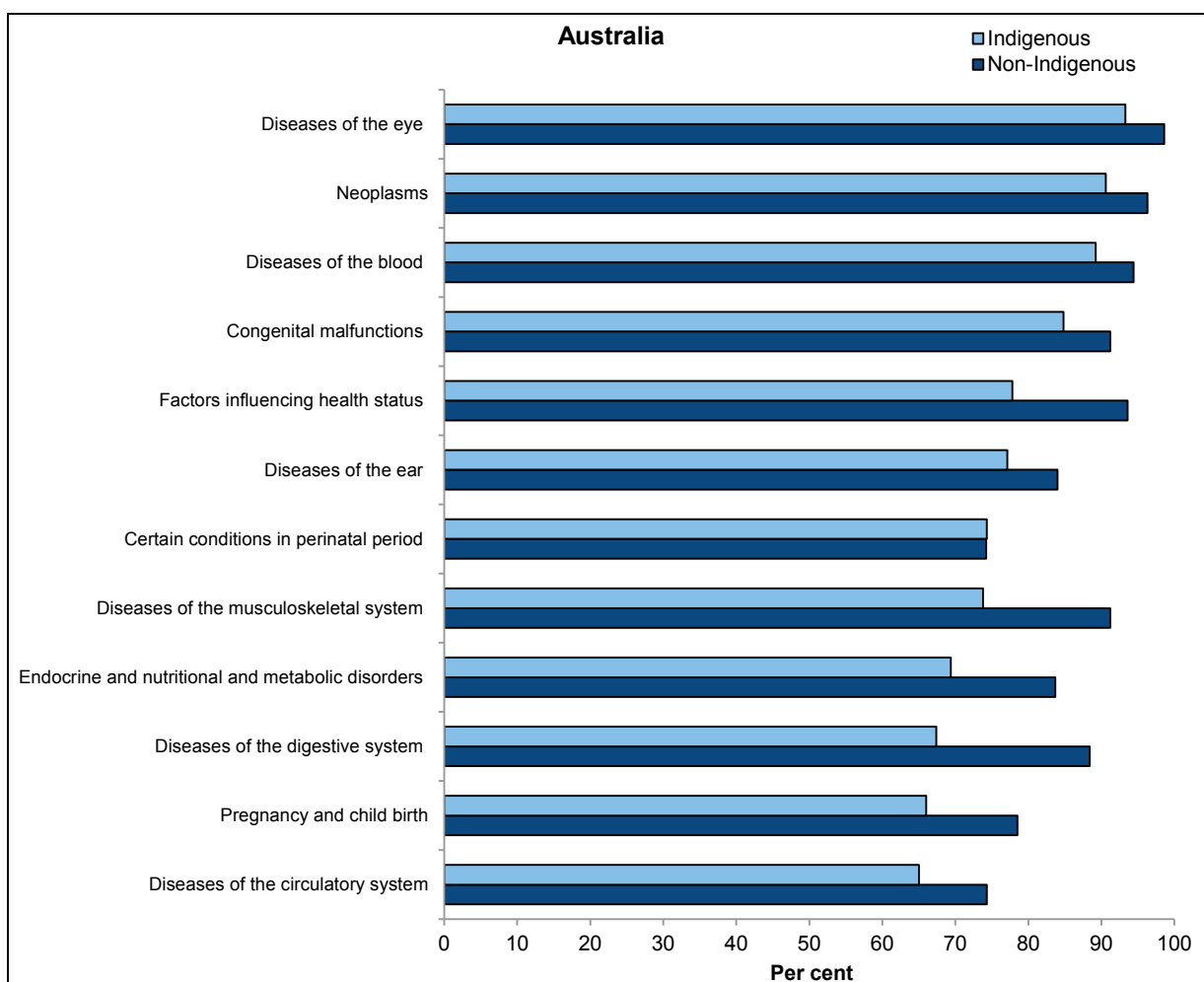
Main diagnosis: Nationally in July 2013 to June 2015, the age-standardised rate for hospitalisation where a procedure was recorded was highest for diseases of the eye for both Indigenous and non-Indigenous Australians (93% and 99%, respectively). These were followed by hospitalisations for cancers (neoplasms) (91% and 96%, respectively) and diseases of the blood (89% and 94%, respectively) (Table 3.06.2, Figure 3.06.2).

Trend over time: Nationally, the age-standardised rate of hospitalisations for Indigenous Australians where a procedure was reported increased by 13%, from 53% in 2004–05 to 63% in 2014–15. The difference between Indigenous and non-Indigenous Australians decreased by 29%, from 26% in 2004–05 to 17% in 2014–15 (Table 3.06.11).



Source: Table 3.06.1.

Figure 3.06.1: Age-standardised rate of hospitalisations with a procedure recorded, by Indigenous status, Australian Capital Territory and Australia, July 2013 to June 2015



Source: Table 3.06.2.

Figure 3.06.2: Age-standardised rate of hospitalisation with a procedure recorded, by diagnosis and Indigenous status, Australia, July 2013 to June 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.07 Selected potentially preventable hospital admissions

Why it is important

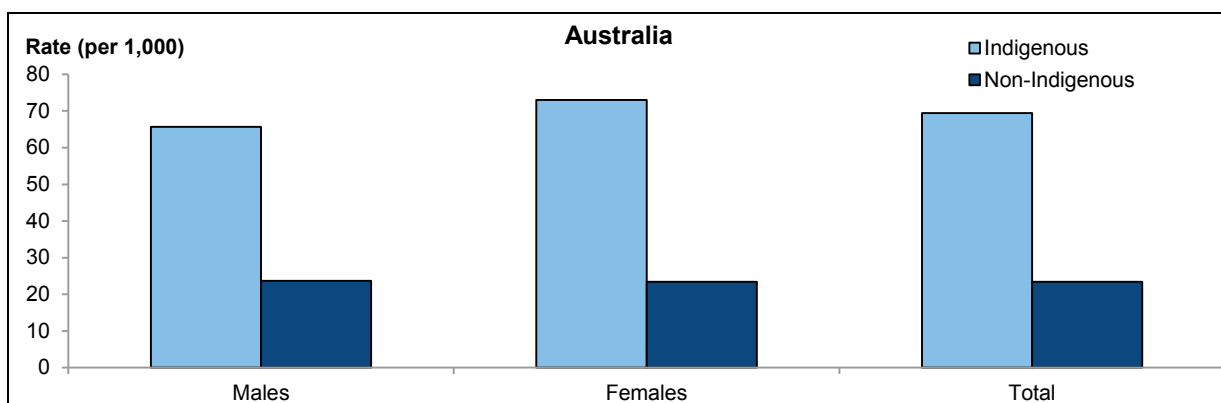
This measure reports on the number of hospitalisations for potentially preventable conditions. Systematic differences in hospitalisation rates for Indigenous and non-Indigenous Australians could indicate gaps in the provision of population health interventions (such as vaccination), primary care services (for example, early interventions to detect and treat chronic disease) and continuing care support (for example, care planning for people with chronic illnesses, such as congestive heart failure) (AHMAC 2017).

Key findings

Overall: Nationally in July 2013 to June 2015, the age-standardised rate for potentially preventable hospitalisations for Indigenous Australians was 3 times the rate for non-Indigenous Australians (69 per 1,000 compared with 23 per 1,000). The rate for Indigenous males was 66 per 1,000, which was lower than the rate for Indigenous females (73 per 1,000). For non-Indigenous Australians the rates for males and females were similar (24 and 23 per 1,000) (Table 3.07.1, Figure 3.07.1).

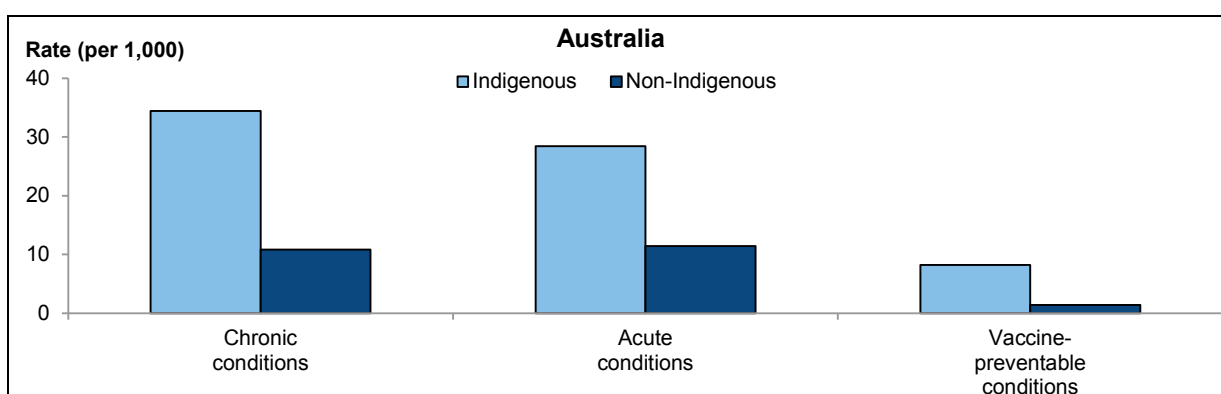
Reason for hospitalisation: Nationally in July 2013 to June 2015, age-standardised rates for potentially preventable hospitalisations for Indigenous Australians were 34 per 1,000 for chronic conditions; 28 per 1,000 for acute conditions; and 8 per 1,000 for vaccine-preventable conditions. For non-Indigenous Australians, the rates were 11 per 1,000 for both chronic and acute conditions, and 1.4 per 1,000 for vaccine-preventable conditions (Table 3.07.4, Figure 3.07.2).

Age group: Nationally in July 2013 to June 2015, the rate of potentially preventable hospitalisations for Indigenous Australians was highest for those aged 65 and over (171 per 1,000). For non-Indigenous Australians, the rate was also highest for the 65 and over age group (78 per 1,000) (Table 3.07.1, Figure 3.07.3).



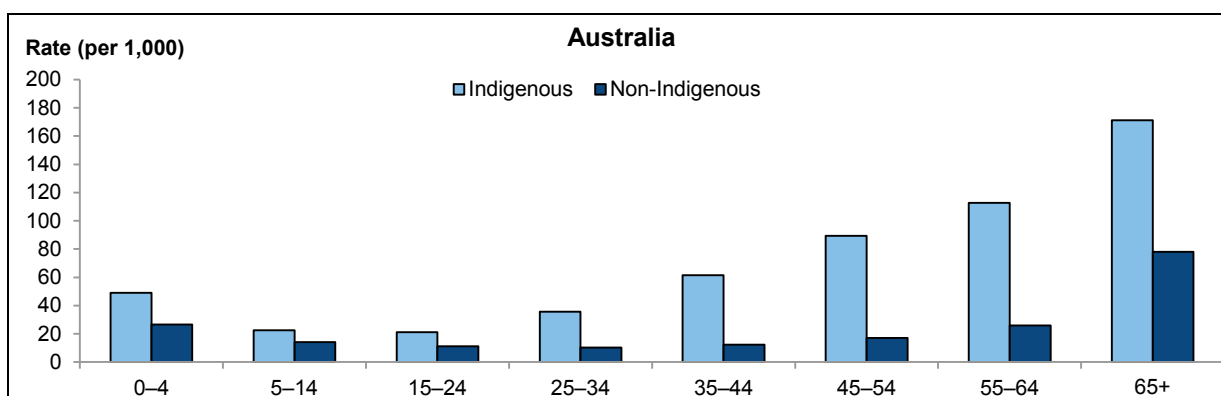
Source: Table 3.07.1.

Figure 3.07.1: Age-standardised hospitalisation rate for potentially preventable hospitalisations, by sex and Indigenous status, Australia, July 2013 to June 2015



Source: Table 3.07.4.

Figure 3.07.2: Age-standardised hospitalisation rate for potentially preventable hospitalisations, by Indigenous status, Australia, July 2013 to June 2015



Source: Table 3.07.1.

Figure 3.07.3: Age-specific hospitalisation rate for potentially preventable hospitalisations, by Indigenous status, Australia, July 2013 to June 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.08 Cultural competency

Why it is important

This measure reports on aspects of cultural competency, including discrimination and barriers to accessing services for Indigenous Australians. Improving the cultural competency of health-care services can increase Indigenous Australians' access to health care, increase the effectiveness of care that is received, and improve the disparities in health outcomes (Freeman et al. 2014). Cultural competency can be measured directly (self-reporting on patient experience) or indirectly (for example, discharge against medical advice—see Measure 3.09—and employment of Indigenous health workers) (AHMAC 2017). However, there is limited data available on the cultural competence of health services (Paradies et al. 2014) or on effectiveness of interventions to address cultural competency in health care for Indigenous people (Clifford et al. 2015; Truong et al. 2014).

Key findings

Overall: In 2012–13 in the Australian Capital Territory, 38% of Indigenous Australians aged 2 and over were reported to have not seen a health provider in the last 12 months when it was necessary. The dentist was the most common service not accessed when needed (25%), with cost the most common reason (48%). For Indigenous Australians of all ages, other services that were not accessed when needed included doctors (21%); other health professionals (13%); and hospitals (7%). For those aged 18 and over, 18% did not access counsellors.

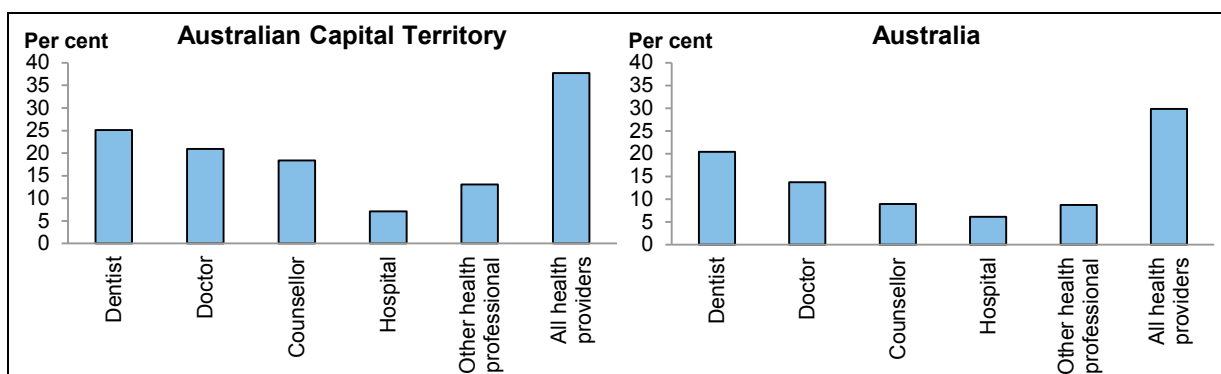
Nationally in 2012–13, 30% of Indigenous Australians aged 2 and over were reported to have not seen a health provider in the last 12 months when it was necessary. The dentist was the most common service not accessed when needed (20%), with cost the most common reason (43%). For Indigenous Australians of all ages, other services not accessed when needed included doctors (14%); other health professionals (8.7%); and hospitals (6.1%). For those aged 18 and over, 8.9% did not access counsellors (Table 3.08.4, Figure 3.08.1).

Barriers: In 2012–13, 42% of all Indigenous Australians in the Australian Capital Territory reported that they did not have access to a health provider for reasons relating to the cultural appropriateness of the service (discrimination or language problems; dislike service or professional; was embarrassed or afraid; felt the service would be inadequate or did not trust the service). Further, 42% of Indigenous Australians did not access a health service due to logistical reasons (including waiting time was too long or not available at the time required; transport or distance; service not available in area).

Nationally in 2012–13, 40% of all Indigenous Australians reported that they did not have access to a health service due to logistical reasons, and 32% for reasons relating to the cultural appropriateness of the service (Table 3.08.4, Figure 3.08.2).

Patient experience: In 2012–13 in *Non-remote* areas in the Australian Capital Territory, Indigenous Australians aged 15 and over responded with always/usually when asked how often doctors: spent enough time with the patient (83%); explained things in a way that could be understood (89%); listened (89%); and showed respect for what was said (92%).

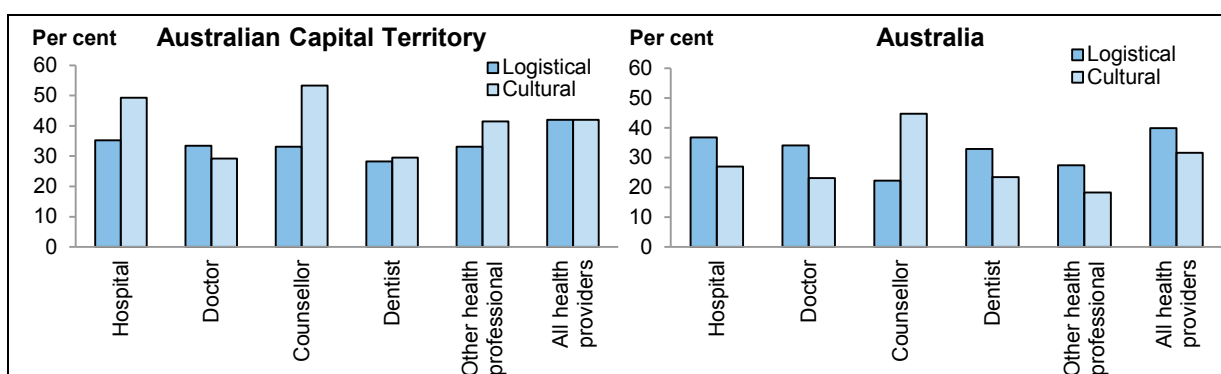
Nationally in 2012–13 in *Non-remote* areas, Indigenous Australians aged 15 and over responded with always/usually to how often doctors: spent enough time with the patient (85%); explained things in a way that could be understood (87%); listened (89%); and showed respect for what was said (89%) (Table 3.08.7, Figure 3.08.3).



Note: Data for dentist is for persons aged 2 and over. Data for counsellor is for persons aged 18 and over.

Source: Table 3.08.4.

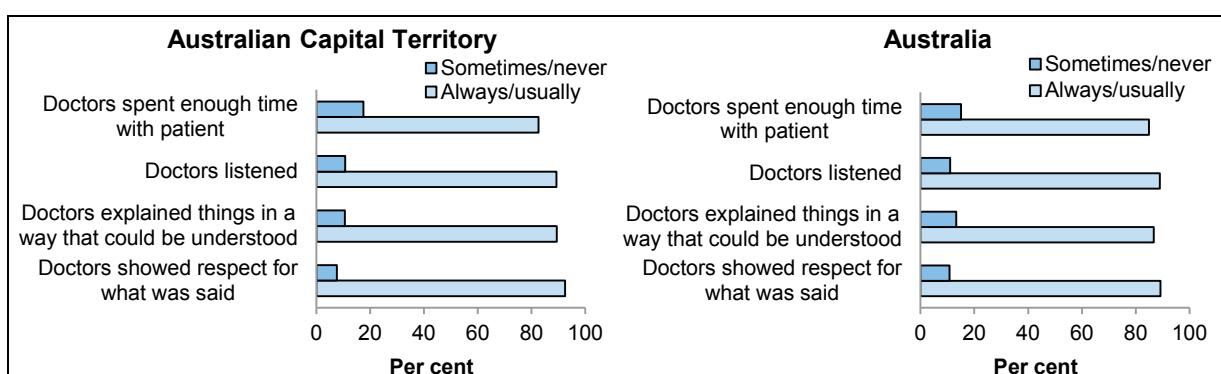
Figure 3.08.1: Proportion of Indigenous Australians who did not access a health provider when needed, by health provider type, Australian Capital Territory and Australia, 2012–13



Note: Data for dentist are for persons aged 2 and over. Data for counsellor are for persons aged 18 and over.

Source: Table 3.08.4.

Figure 3.08.2: Proportion of Indigenous Australians who did not access a health provider when needed who reported this was due to logistical reasons or cultural appropriateness of service, by health provider type, Australian Capital Territory and Australia, 2012–13



Source: Table 3.08.7.

Figure 3.08.3: Patient experience, Indigenous persons aged 15 and over (Non-remote), Australian Capital Territory and Australia, 2012–13

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.09 Discharge against medical advice

Why it is important

This measure reports on the rate at which Indigenous Australians leave hospital against medical advice or are discharged at their own risk. People who take their own leave from hospital are more likely to present again at emergency departments, and have higher death rates. The reasons for which Indigenous Australians take their own leave from hospital include: institutionalised racism, a lack of cultural safety, a distrust of the health system, family and social obligations, isolation and loneliness, a lack of understanding of the treatment they were receiving and feeling that the treatment had finished, and communication and language barriers between staff and patient (AHMAC 2017; Shaw 2016).

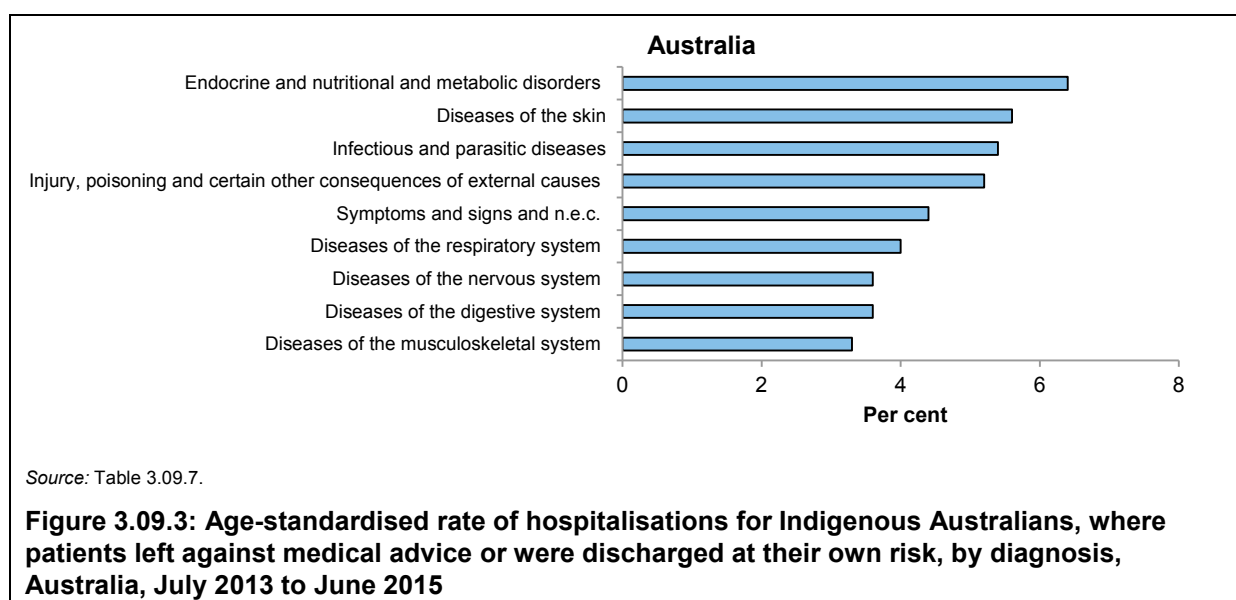
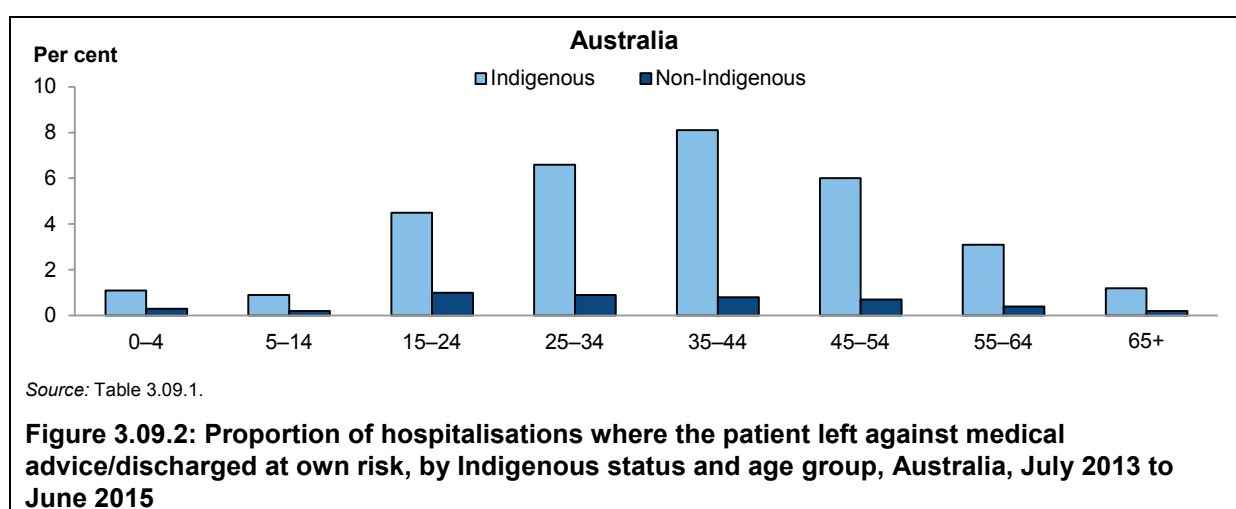
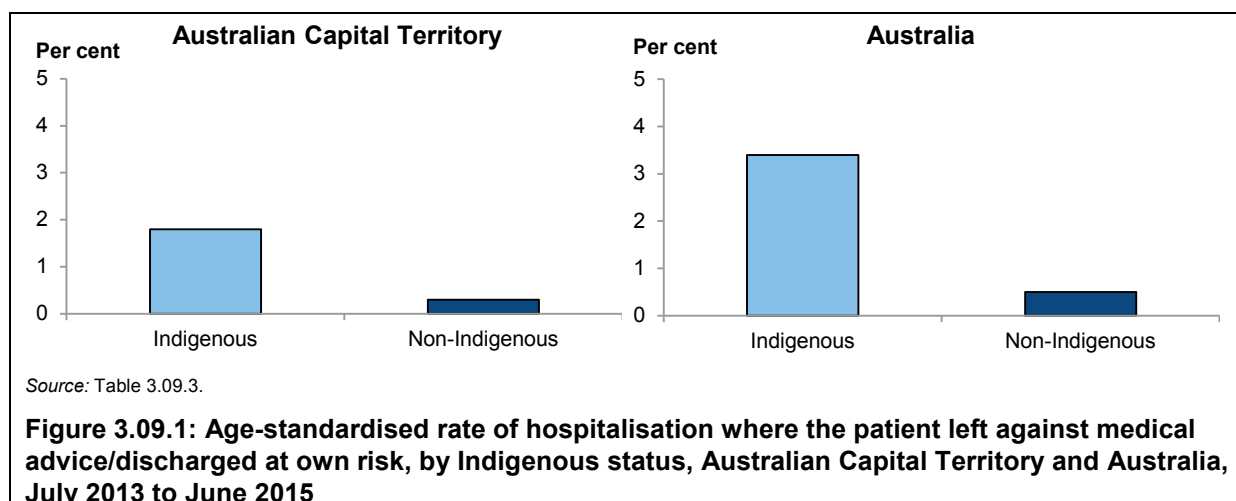
Key findings

Overall: In July 2013 to June 2015 in the Australian Capital Territory, the proportion of hospitalisations of Indigenous Australians where patients left against medical advice or were discharged at their own risk was 2.2%. The age-standardised rate where Indigenous patients left against medical advice, or were discharged at their own risk, was 5.2 times the rate for non-Indigenous patients (1.8% compared with 0.3%).

In July 2013 to June 2015 nationally, the proportion of hospitalisations of Indigenous Australians where patients left against medical advice or were discharged at their own risk was 4.3%. The age-standardised rate where Indigenous patients left against medical advice, or were discharged at their own risk, was 7.1 times the rate for non-Indigenous patients (3.4% compared with 0.5%) (Table 3.09.3, Figure 3.09.1).

Age groups: Nationally in July 2013 to June 2015, higher proportions of Indigenous Australians than non-Indigenous Australians (in all age groups) left hospital against medical advice or were discharged at their own risk. Indigenous Australians aged 35–44 had the highest proportion of hospitalisations where patients left hospital against medical advice or were discharged at their own risk (8.1%). The lowest proportion was for patients aged 5–14 (0.9%) (Table 3.09.1, Figure 3.09.2).

Principal diagnosis: Nationally in July 2013 to June 2015, the 2 highest age-standardised rates of hospitalisation where Indigenous patients left hospital against medical advice or were discharged at their own risk were for endocrine, nutritional and metabolic disorders (for example, type 2 diabetes) (6.4%) and diseases of the skin (for example, sunburn) (5.6%) (Table 3.09.7, Figure 3.09.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.10 Access to mental health services

Why it is important

This measure reports on access to mental health-care services such as hospitals, community mental health care, doctors and Aboriginal and Torres Strait Islander primary health-care services. Indigenous Australians experience higher rates of mental health issues than other Australians, with deaths from suicide twice as high, hospitalisation rates for intentional self-harm 2.7 times as high, and rates of high/very high psychological distress 2.6 times as high as for other Australians (AHMAC 2017). Mental health care may be provided by specialised mental health-care services (for example, private psychiatrists, and specialised hospital, residential or community services), or by general health-care services that supply mental health-related care (for example, GPs and Indigenous primary health-care organisations) (AHMAC 2017).

Key findings

Community service contacts: In 2014–15 in the Australian Capital Territory, the age-standardised rate for Indigenous clients who had service contacts with community mental health was 3.6 times the rate for non-Indigenous clients (2,604 per 1,000 compared with 733 per 1,000).

Nationally in 2014–15, the age-standardised rate for community mental health service contacts for Indigenous clients was 1,155 per 1,000, which was 3.5 times the rate for non-Indigenous clients (326 per 1,000) (Table 3.10.4, Figure 3.10.1).

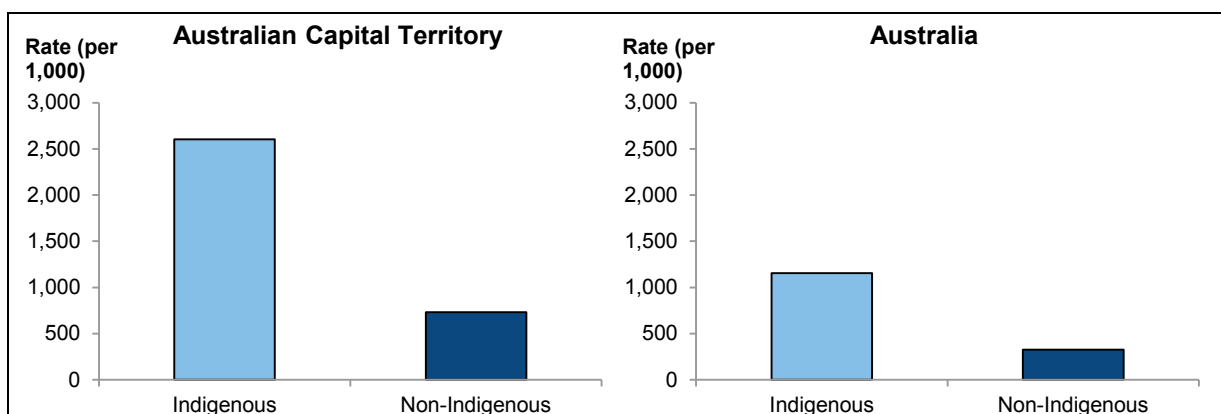
Residential mental health-care episodes: In 2014–15 in the Australian Capital Territory, of the 53 residential mental health-care episodes, 3 were for Indigenous clients, 48 were for non-Indigenous clients, and there were 2 episodes where Indigenous status was not stated. The rates for Indigenous clients were not calculated because of the small number of episodes involved. For non-Indigenous clients, the rate was 1.3 per 10,000.

Nationally in 2014–15, the age-standardised rates for residential mental health-care episodes for Indigenous Australians was 6.2 per 10,000. For non-Indigenous Australians the rate was 3.2 per 10,000 (Table 3.10.5).

Psychiatric hospital beds: In 2013–14 in the Australian Capital Territory, there were no public psychiatric hospitals. There were 2 public acute hospitals with specialised mental health units; these had 70 available psychiatric beds. This accounted to a rate of 18 available psychiatric beds per 100,000 population.

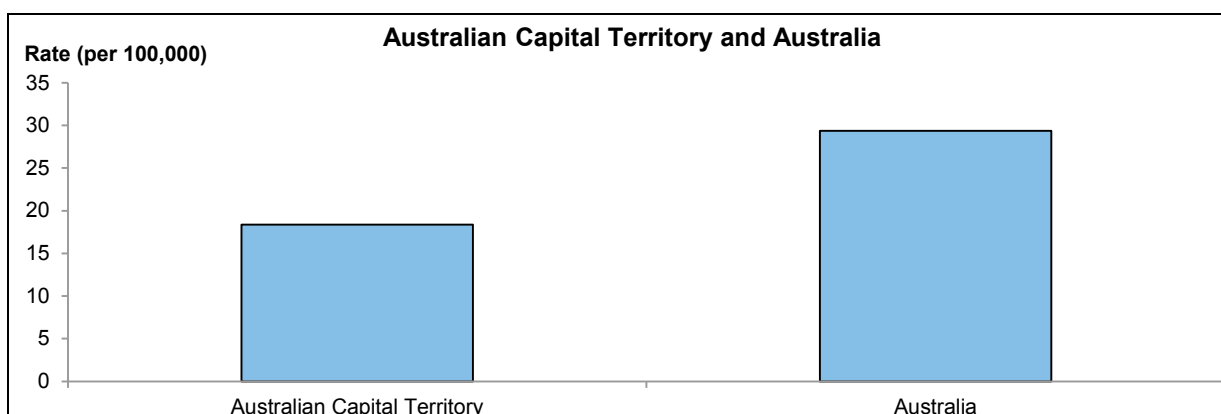
In 2013–14 nationally, there were 17 public psychiatric hospitals and 142 public acute hospitals with specialised mental health units – a total of 6,791 available psychiatric beds. This accounted to a rate of 29 available psychiatric beds per 100,000 population (Table 3.10.10, Figure 3.10.2).

Trend over time: For NSW, Vic, Qld, WA, SA and the NT combined, the age-standardised hospitalisation rate for mental health-related conditions increased by 46% for Indigenous Australians, from 21 per 1,000 in 2004–05 to 29 per 1,000 in 2014–15. The rate for non-Indigenous Australians increased by 6%, from 15 per 1,000 in 2004–05 to 16 per 1,000 in 2014–15 (Table 3.10.9, Figure 3.10.3).



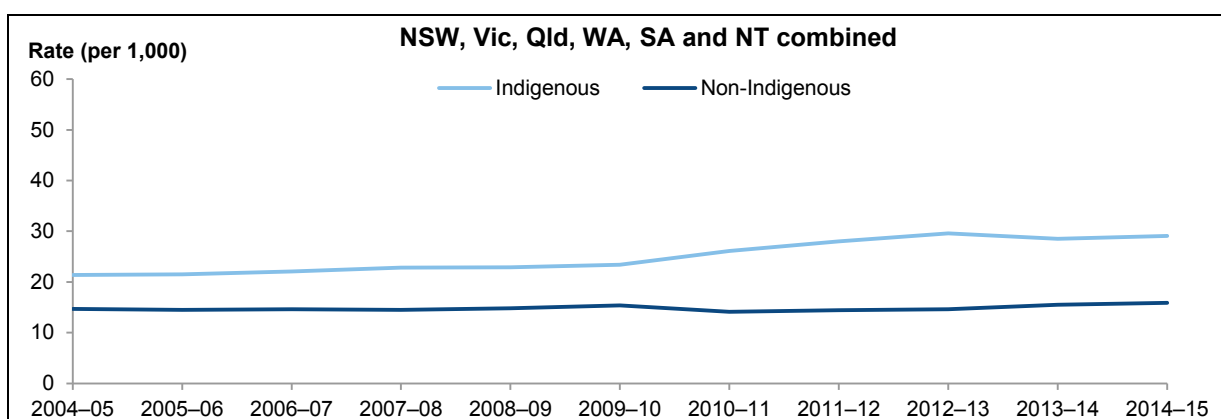
Source: Table 3.10.4.

Figure 3.10.1: Age-standardised rate of community mental health service contacts, by Indigenous status, Australian Capital Territory and Australia, 2014–15



Source: Table 3.10.10.

Figure 3.10.2: Rate of available psychiatric beds, Australian Capital Territory and Australia, 2013–14



Source: Table 3.10.9.

Figure 3.10.3: Age-standardised hospitalisation rate, mental health-related conditions, NSW, Vic, Qld, WA, SA and NT combined, 2004–05 to 2014–15

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.11 Access to alcohol and drug services

Why it is important

This measure reports on access to alcohol and drug services. Alcohol and substance misuse causes a wide range of harms including: mental health issues, chronic disease (for example, liver disease), bloodborne virus spread, injuries from motor vehicle accidents and assaults, incarceration, and social disruptions including family breakdown. Alcohol and substance-use services provide various interventions and support that seek to tackle harmful alcohol and other drug use, and restore the physical, social and emotional wellbeing of clients and families (NIDAC 2014).

Key findings

Self-report substance use: In 2014–15 in the Australian Capital Territory, 40% of Indigenous Australians aged 15 and over reported using substances in the last 12 months.

Nationally in 2014–15, 31% of Indigenous Australians aged 15 and over reported using substances in the last 12 months (Table 2.17.3).

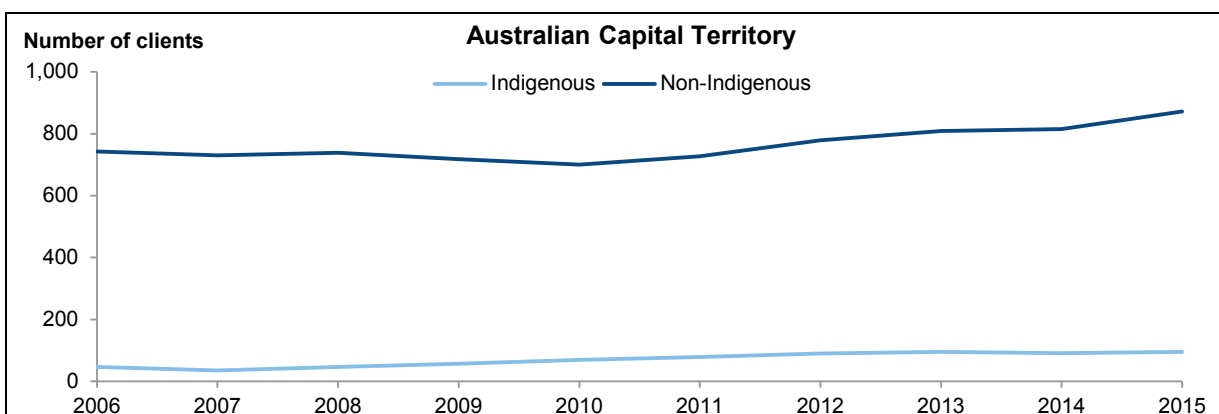
Pharmacotherapy: In the Australian Capital Territory, on a 'snapshot' day in 2015, there were 95 Indigenous Australians receiving pharmacotherapy (including methadone, buprenorphine, and buprenorphine/naloxone), an increase from 47 clients in 2006. There was also an increase for non-Indigenous Australians receiving pharmacotherapy, from 743 in 2006 to 872 in 2015 (Table 3.11.4, Figure 3.11.1).

In NSW, Qld, SA and the ACT combined, 3,129 Indigenous Australians were receiving pharmacotherapy in 2015, an increase from 1,662 in 2006. There was also an increase for non-Indigenous Australians, from 16,354 in 2006 to 24,190 in 2015 (Table 3.11.4). Note that for 2006, Indigenous data were not available for South Australia and, for 2016, data had not yet been published for the ACT.

Primary health-care services: Between 1 June 2014 and 31 May 2015 in the Australian Capital Territory and New South Wales combined, 57% of Aboriginal and Torres Strait Islander primary health-care organisations provided tobacco use treatment or prevention groups and 36% provided alcohol use treatment or prevention groups.

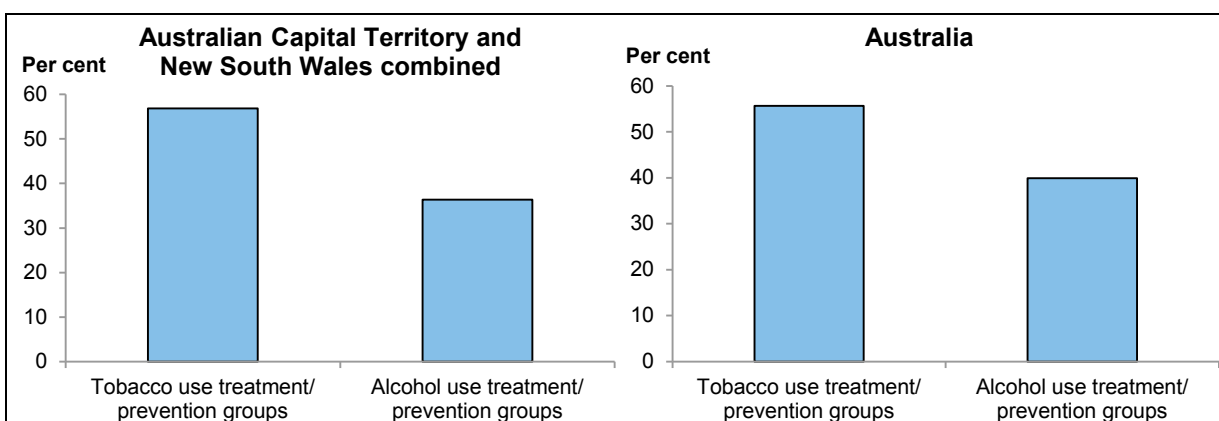
Between 1 June 2014 and 31 May 2015 nationally, 56% of Aboriginal and Torres Strait Islander primary health-care organisations provided tobacco use treatment or prevention groups and 40% provided alcohol use treatment or prevention groups (Table 3.03.10, Figure 3.11.2).

Episodes of care provided by substance use services: Nationally, between 1 June 2014 and 31 May 2015, there were 150,581 services provided by Australian Government funded organisations that provided substance-use services for Indigenous Australians. Indigenous clients accounted for 88% of these episodes. Of these, 116,190 services were for non-residential/follow-up/aftercare episodes of care, 13,941 were for sobering-up/residential respite episodes of care and 2,440 were for residential treatment/rehabilitation episodes of care (Table 3.11.2, Figure 3.11.3).



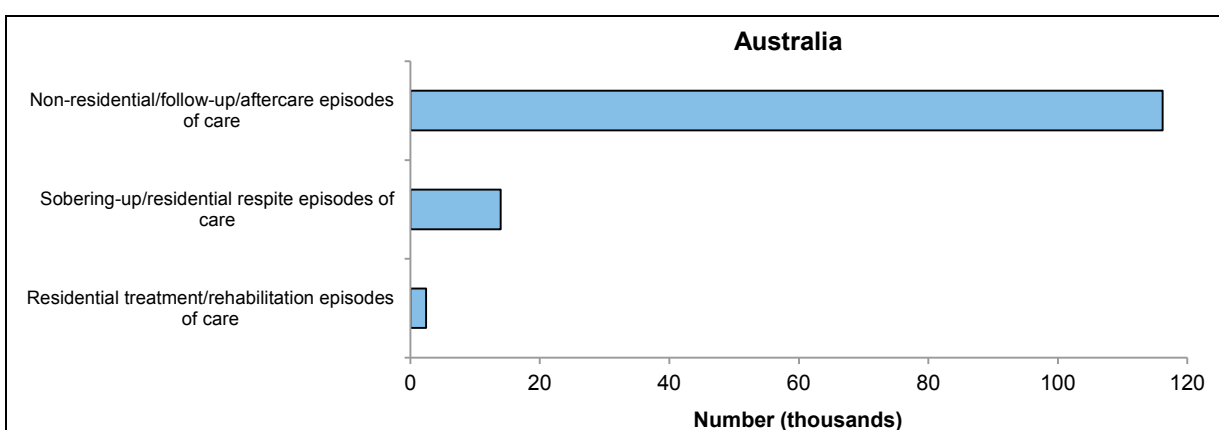
Source: Table 3.11.4.

Figure 3.11.1: Number of pharmacotherapy clients on a 'snapshot' day, by Indigenous status, Australian Capital Territory, 2006–2015



Source: Table 3.03.10.

Figure 3.11.2: Proportion of Aboriginal and Torres Strait Islander primary health-care organisations providing health promotion, by type of program/activity, Australian Capital Territory and New South Wales combined, and Australia, 1 June 2014 to 31 May 2015



Source: Table 3.11.2.

Figure 3.11.3: Episodes of care provided at Australian Government funded Aboriginal and Torres Strait Islander substance use services by type, Australia, 1 June 2014 – 31 May 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.12 Aboriginal and Torres Strait Islander people in the health workforce

Why it is important

This measure reports on Indigenous Australians employed in the health workforce. Indigenous Australians are significantly under-represented in the health workforce, which potentially contributes to reduced access to health services for the broader Indigenous Australian population. The Indigenous workforce is integral to ensuring that the health system can address the needs of Indigenous Australians. Indigenous health professionals can align their unique technical and sociocultural skills to improve patient care, improve access to services and ensure culturally appropriate care in the services that they and their non-Indigenous colleagues deliver (Anderson et al. 2009; West et al. 2010).

Key findings

Overall: Based on data from 2014 and 2015, in the Australian Capital Territory, there were 67 Indigenous Australians employed in registered health professions, compared with 8,925 non-Indigenous Australians. The rate of Indigenous Australians employed in registered health professions was 971 per 100,000, compared with 2,325 per 100,000 for non-Indigenous Australians.

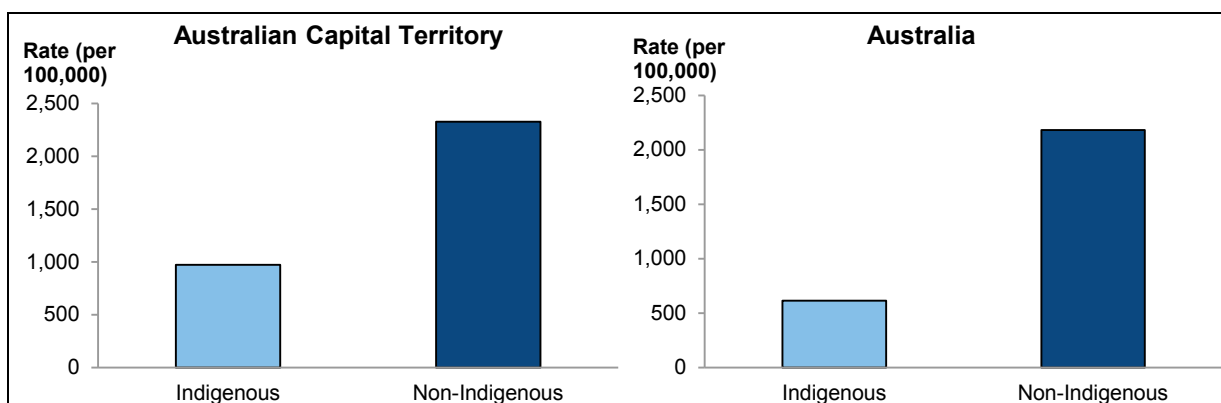
Nationally, based on data from 2014 and 2015, of those who identified as being Indigenous, there were 4,471 Indigenous Australians employed in registered health professions, compared with 502,667 non-Indigenous Australians. The rate for Indigenous Australians was 613 per 100,000, compared with 2,181 per 100,000 for non-Indigenous Australians (Table 3.12.4, Figure 3.12.1).

Medical practitioners: In the Australian Capital Territory in 2015, there were 8 Indigenous Australians employed as medical practitioners, which is 0.5% of employed medical practitioners in the Australian Capital Territory (Table 3.12.6). The rates for Indigenous and non-Indigenous Australians employed as medical practitioners were 116 and 406 per 100,000, respectively, a difference of 290 per 100,000 (Table 3.12.4, Figure 3.12.2).

Nationally in 2015, there were 409 Indigenous Australians employed as medical practitioners, which is 0.5% of employed medical practitioners (Table 3.12.6). The rates for Indigenous and non-Indigenous Australians employed as medical practitioners were 56 and 353 per 100,000, respectively, a difference of 297 per 100,000 (Table 3.12.4, Figure 3.12.2).

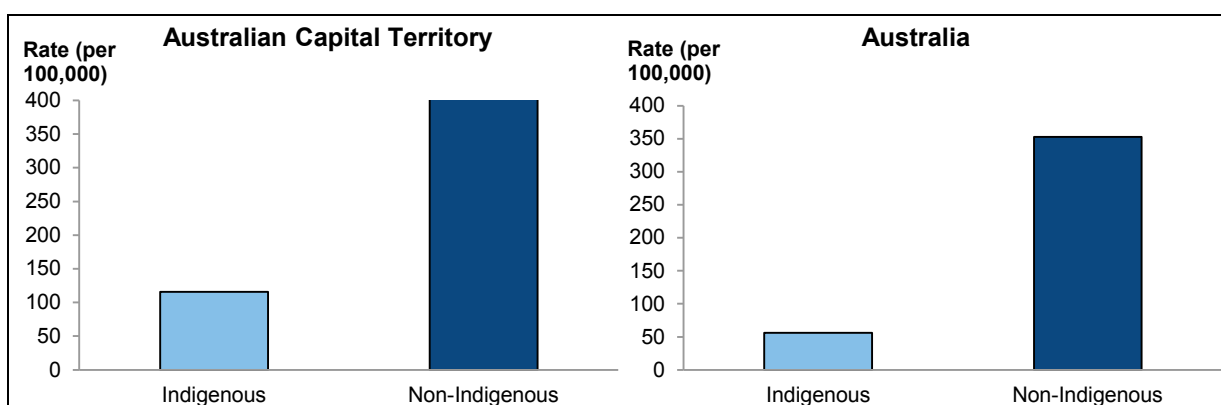
Nurses and midwives: In 2015 in the Australian Capital Territory, 48 Indigenous Australians were employed as nurses and midwives, which is 1% of employed nurses and midwives in the Australian Capital Territory (Table 3.12.9). The rate difference between Indigenous and non-Indigenous Australians employed as nurses and midwives was 584 per 100,000 (696 per 100,000 for Indigenous Australians and 1,280 per 100,000 for non-Indigenous Australians) (Table 3.12.4, Figure 3.12.3).

Nationally in 2015, 3,187 Indigenous Australians were employed as nurses and midwives, which is 1.1% of employed nurses and midwives in Australia (Table 3.12.9). The rate difference between Indigenous and non-Indigenous Australians employed as nurses and midwives was 858 per 100,000 (437 per 100,000 for Indigenous Australians and 1,295 per 100,000 for non-Indigenous Australians) (Table 3.12.4, Figure 3.12.3).



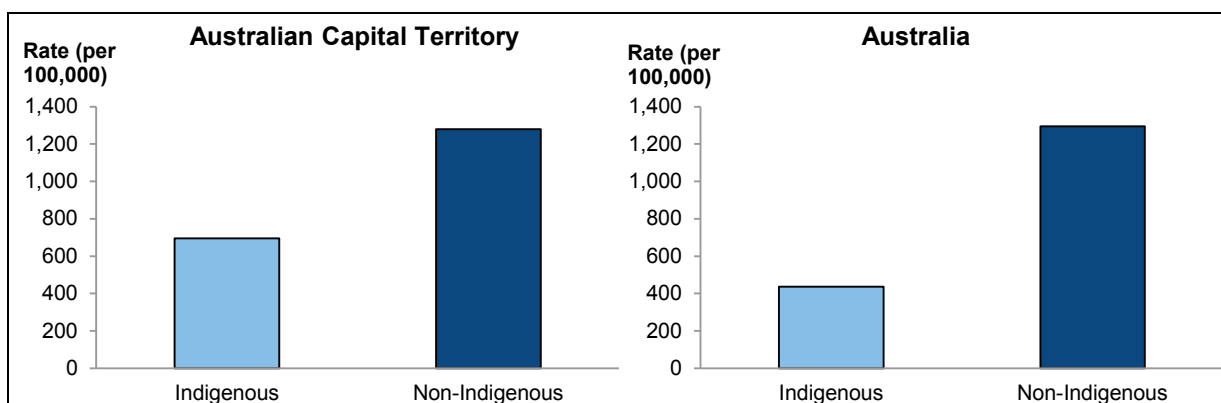
Source: Table 3.12.4.

Figure 3.12.1: Rate of employed health professionals, by Indigenous status, Australian Capital Territory and Australia, 2014 and 2015



Source: Table 3.12.4.

Figure 3.12.2: Rate of employed medical practitioners, by Indigenous status, Australian Capital Territory and Australia, 2015



Source: Table 3.12.4.

Figure 3.12.3: Rate of employed nurses and midwives, by Indigenous status, Australian Capital Territory and Australia, 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.13 Competent governance

Why it is important

This measure reports on governance in Indigenous-specific and mainstream health services. Governance refers to the evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve things that matter to them (Hunt et al. 2008). The way governance functions are done has a direct impact on the wellbeing of individuals and communities (AHMAC 2017).

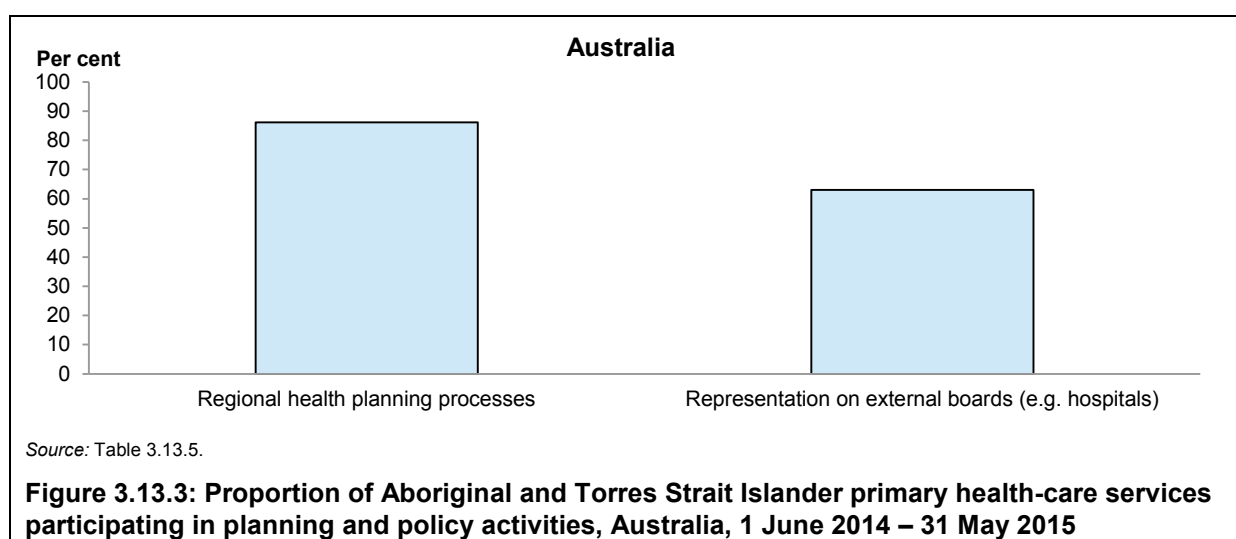
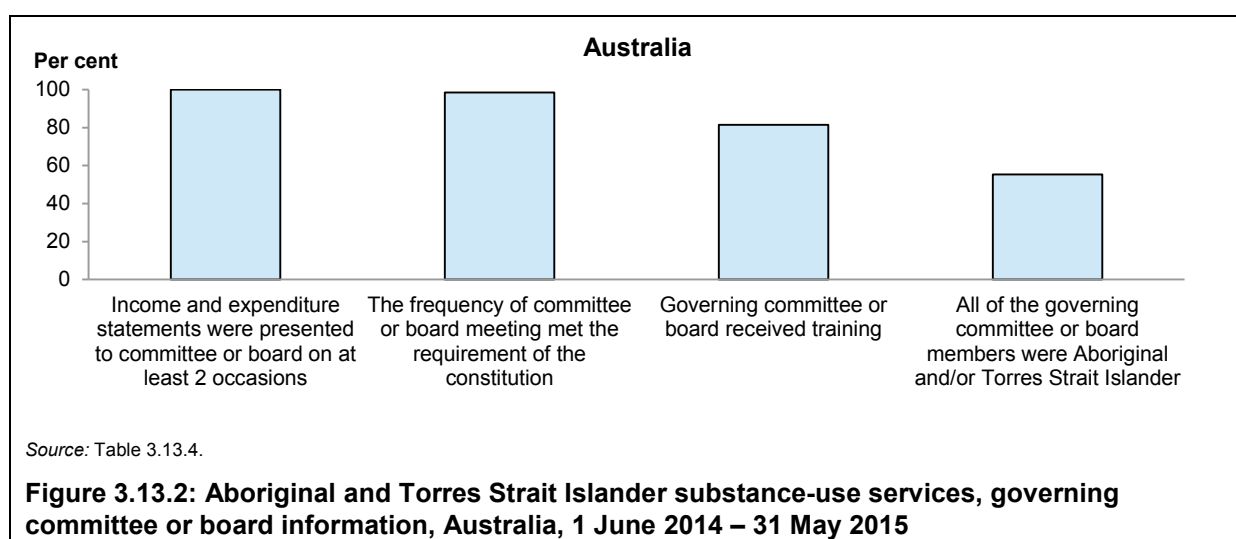
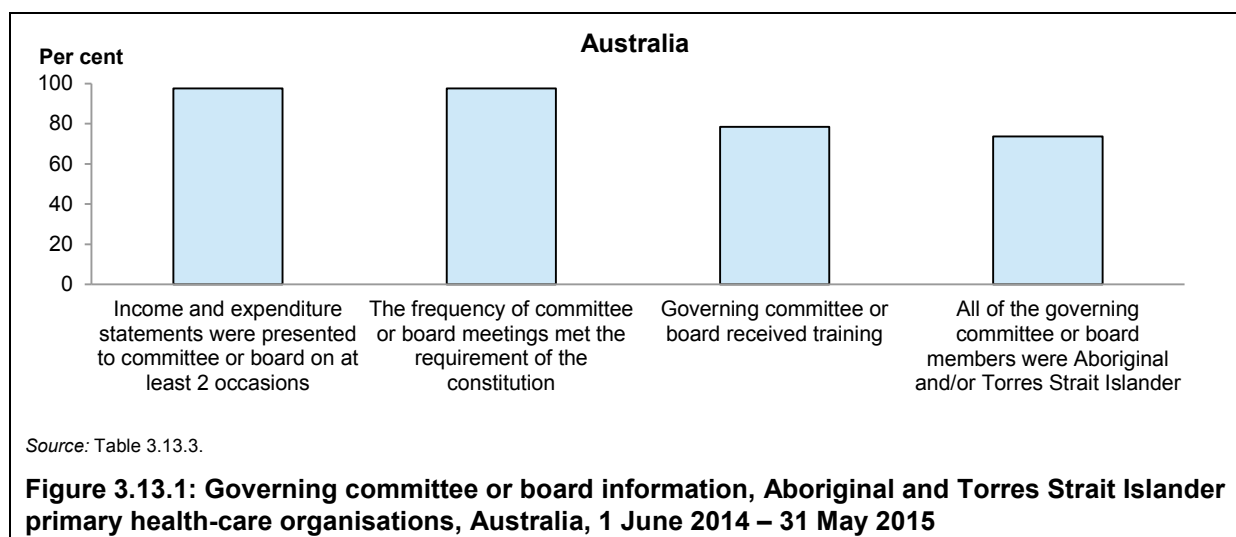
Key findings

Indigenous primary health-care organisations: Nationally, in the period from 1 June 2014 to 31 May 2015, of the 203 Indigenous primary health-care organisations, 163 (80%) reported having a governing committee or board. Of these, 159 (98%) had met the requirement of the constitution for the frequency of meetings, and 159 (98%) had income and expenditure statements presented on at least 2 occasions. Almost three-quarters (120 or 74%) of the committees were entirely comprised of Indigenous members and 128 (79%) received training on governing committee or board functions (Table 3.13.3, Figure 3.13.1).

Indigenous substance-use services: Nationally, in the period from 1 June 2014 to 31 May 2015, of 67 Indigenous substance-use services, 65 reported have a governing committee or board. Of these, 64 (98%) had met the requirement of the constitution for the frequency of meetings, and all had income and expenditure statements presented on at least 2 occasions. Over half (36 or 55%) of the committees or boards were entirely comprised of Indigenous Australian members and 53 (82%) received training on governing committee or board functions (Table 3.13.4, Figure 3.13.2).

Mainstream processes participation: Nationally, in the period from 1 June 2014 to 31 May 2015, of the 203 Indigenous health services, 128 (63%) had representatives on external boards (for example, hospitals); 175 (86%) participated in regional health planning processes; and 96 (47%) participated in jurisdiction or national policy development processes (Table 3.13.5, Figure 3.13.3).

Compliance: From 2000–01 to 2014–15, the number of corporations that were incorporated under the *Aboriginal Councils and Associations Act 1976* (ACA) or the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act) (ACA was replaced by CATSI Act in 2006) increased from 77 to 85. The legislation sets out governance standards, with special measures to suit the needs of Indigenous Australians (AHMAC 2017). Over this time, the proportion of health corporations that were compliant increased from 96% to 100% (Table 3.13.2).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.14 Access to services compared with need

Why it is important

This measure reports on the use of various types of health services (for example, primary care, hospital, dental and allied health and post-acute care and palliative care) and potential barriers to accessing these services. Indigenous Australians have significantly poorer health status than non-Indigenous Australians. Inequalities in health care access and use may further exacerbate inequalities in health status (OECD 2009). As a result, access to health care when needed is essential to closing the gap in life expectancy.

Key findings

Self-reported use of services: In 2012–13 in the Australian Capital Territory, 47% of Indigenous Australians were reported to have accessed health care in the previous 2 weeks. In this period, 26% had consulted a doctor or specialist; 23% had consulted other health professionals; 4.0% (of those aged over 2) had seen a dentist and 3.6% had visited casualty or outpatient services. In the previous 12 months, 18% had been admitted to hospital.

Nationally in 2012–13, 44% of Indigenous Australians were reported to have accessed health care in the previous 2 weeks. In this period, 22% had consulted a doctor or specialist; 19% had consulted other health professionals; 4.8% had visited casualty or outpatient services; and 4.5% (of those aged over 2) had seen a dentist. In the previous 12 months, 18% had been admitted to hospital (Table 3.14.3, Figure 3.14.1).

Services claimed through Medicare: In 2015–16 in the Australian Capital Territory, the rate of MBS services claimed for Indigenous Australians was 11,651 per 1,000 (Table 3.14.30). The age-standardised rate for Indigenous Australians was 1.2 times the rate for non-Indigenous Australians (14,691 per 1,000 compared with 12,750 per 1,000) (Table 3.14.31, Figure 3.14.2).

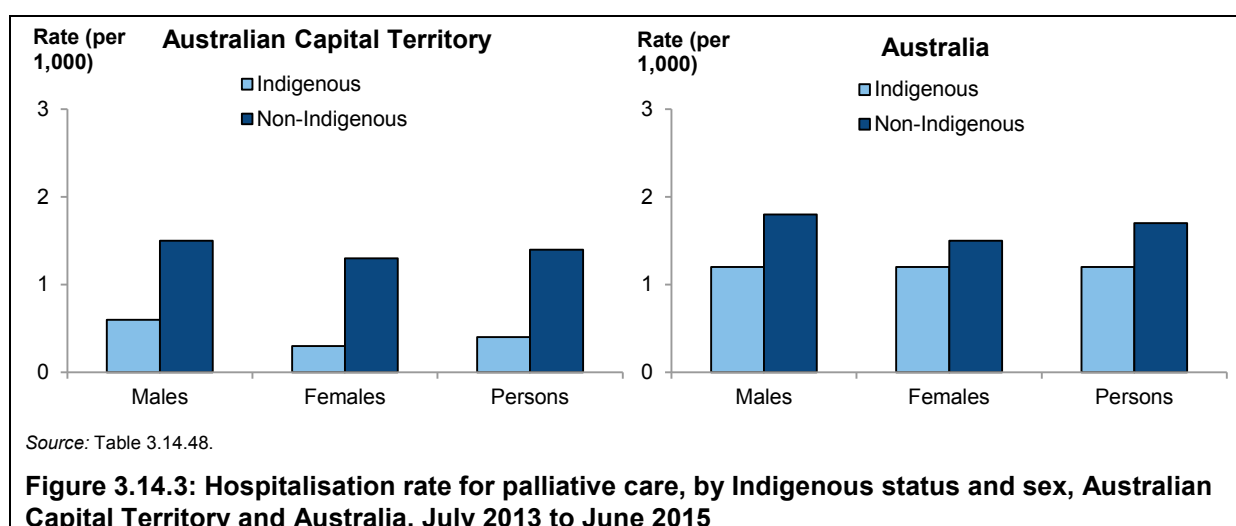
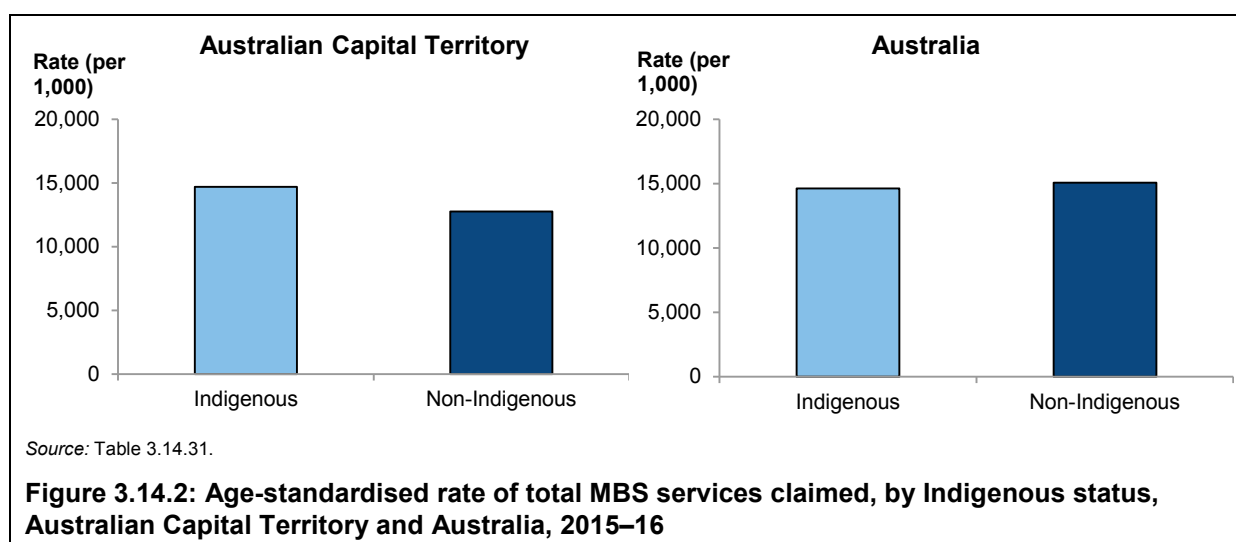
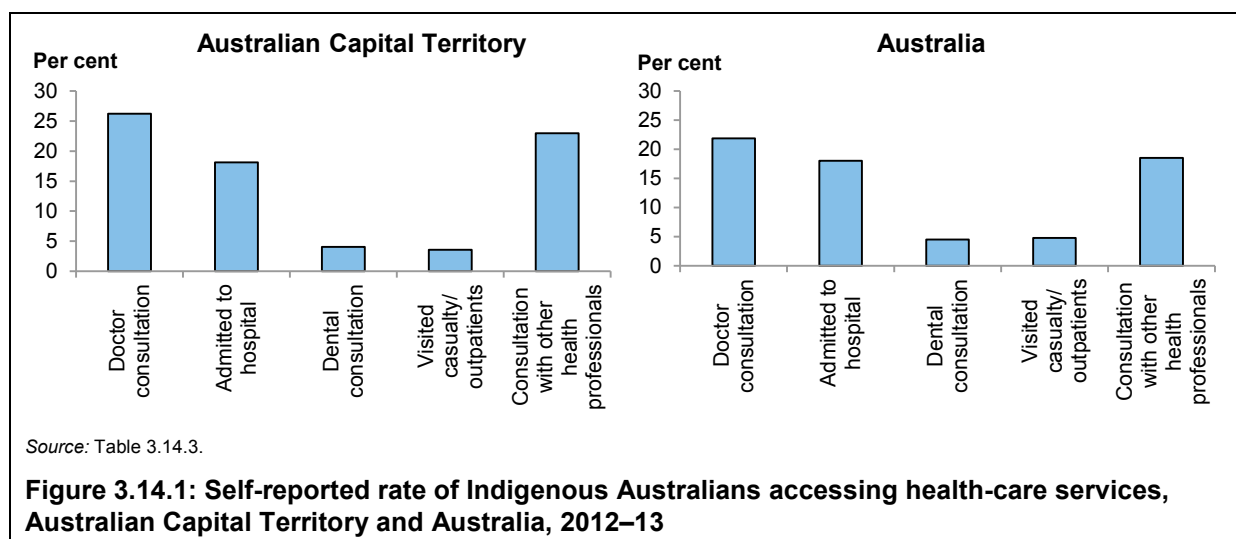
Nationally in 2015–16, the rate of MBS services claimed for Indigenous Australians was 11,787 per 1,000 (Table 3.14.30). The age-standardised rates of claim were 14,622 per 1,000 for Indigenous Australians and 15,063 per 1,000 for non-Indigenous Australians (Table 3.14.31, Figure 3.14.2).

Hospitalisations: In July 2013 to June 2015 in the Australian Capital Territory, the rate of hospitalisation (excluding dialysis) for Indigenous Australians was 232 per 1,000. The age-standardised rate for hospitalisation for Indigenous Australians was 1.4 times the rate for non-Indigenous Australians (222 per 1,000 compared with 159 per 1,000).

Nationally in July 2013 to June 2015, the rate of hospitalisation (excluding dialysis) for Indigenous Australians was 350 per 1,000 population. The age-standardised rate for Indigenous Australians hospitalised was 1.3 times the rate for non-Indigenous Australians (417 compared with 335 per 1,000) (Table 1.02.1).

Hospitalisation for palliative care: In July 2013 to June 2015 in the Australian Capital Territory, the rate of hospitalisation for palliative care was 0.4 per 1,000 for Indigenous Australians and 1.4 per 1,000 for non-Indigenous Australians. The rate for Indigenous males was 0.6 per 1,000 and the rate for Indigenous females was 0.3 per 1,000.

In July 2013 to June 2015 nationally, the rate of hospitalisation (excluding dialysis) for Indigenous Australians was 1.2 per 1,000 compared with 1.7 per 1,000 for non-Indigenous Australians. The rate for both Indigenous males and females was 1.2 per 1,000 (Table 3.14.48, Figure 3.14.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.15 Access to prescription medicines

Why it is important

This measure reports on expenditure on pharmaceuticals, the Pharmaceutical Benefits Scheme (PBS) and reasons Indigenous Australians might not access prescription medicines. Essential medicines save lives and improve health when they are available, affordable and quality-assured, and properly used. Affordable access to medicines is important for many acute and chronic illnesses. For chronic illnesses, such as diabetes, hypertension, heart disease and renal failure, multiple medications might be required for many years to avoid complications (WHO 2004). It is important to ensure that Indigenous Australians, who experience high rates of acute and chronic illnesses, are able to access appropriate prescription medications when required (AHMAC 2017).

Key findings

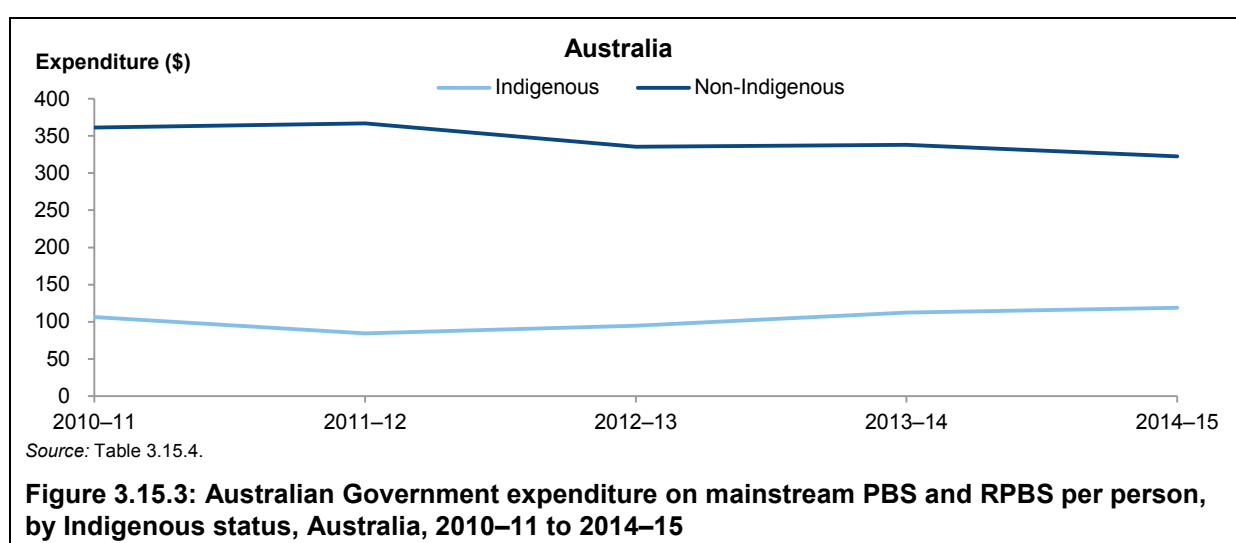
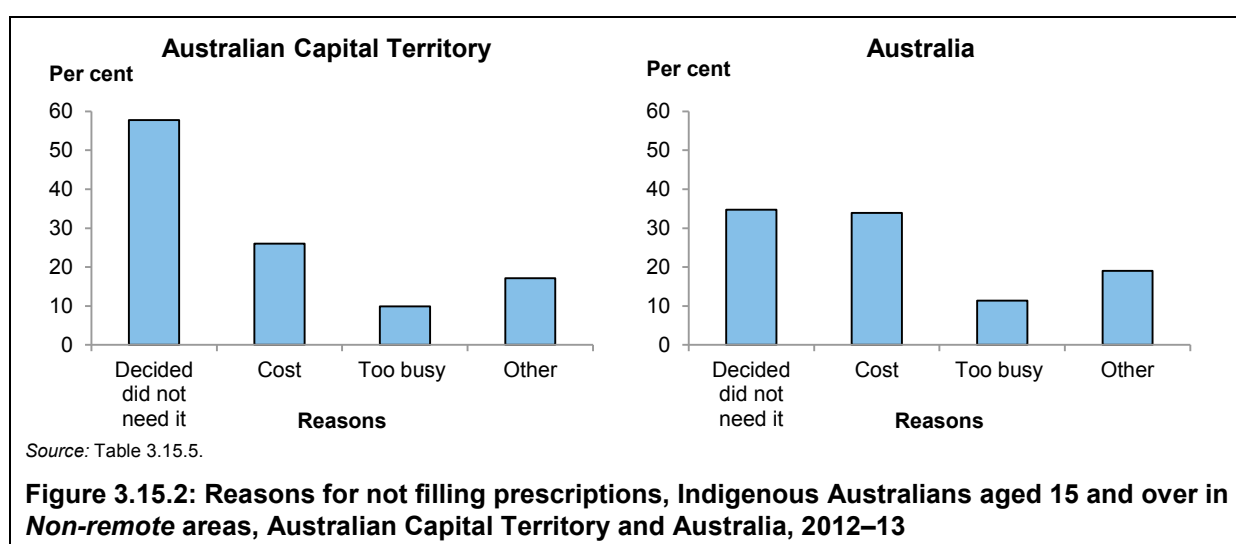
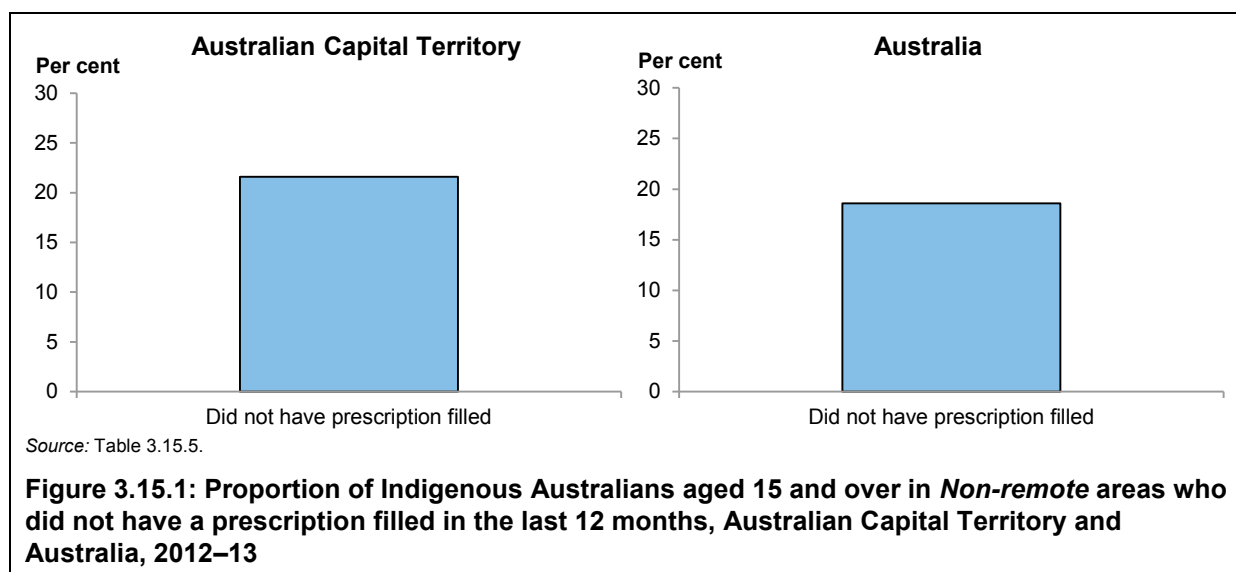
Expenditure per person: Nationally in 2013–14, total expenditure (government and non-government) on pharmaceuticals per person for Indigenous Australians was around two-thirds of the amount spent per person for non-Indigenous Australians (\$579 compared with \$857) (Table 3.15.1).

Pharmaceutical Benefits Scheme: Nationally in 2013–14, expenditure by the Australian Department of Health through the PBS was \$195 per person for Indigenous Australians. This was less than the PBS expenditure per person for non-Indigenous Australians (\$374). Drugs supplied under Section 100 arrangements (this allows for PBS medicines to be provided to remote area Aboriginal and Torres Strait Islander primary healthcare services) accounted for \$48 per person of the total PBS expenditure (Table 3.15.2).

Access to prescription medicines: In 2012–13, in the Australian Capital Territory, 22% of Indigenous Australians aged 15 and over reported they had a prescription that did not get filled in the last 12 months (Table 3.15.5, Figure 3.15.1). The most common reasons reported by Indigenous Australians for not having a prescription filled were: they decided they did not need it (58%); cost (26%); transport issues, lost the prescription or other (17%); and too busy (10%) (Table 3.15.5, Figure 3.15.2).

Nationally in 2012–13, 19% of Indigenous Australians aged 15 and over in *Non-remote* areas reported they had a prescription that did not get filled in the last 12 months (Table 3.15.5, Figure 3.15.1). The most common reasons reported by Indigenous Australians for not having a prescription filled were: they decided they did not need it (35%); cost (34%); transport issues, lost the prescription or other (19%); did not want to (14%); and too busy (11%) (Table 3.15.5, Figure 3.15.2).

Trend over time: Nationally, from 2010–11 to 2014–15, Australian Government expenditure on mainstream PBS and Repatriation Schedule of Pharmaceutical Benefits (RPBS) for Indigenous Australians increased by 11.7%, from \$106 to \$119 per person. For non-Indigenous Australians, expenditure decreased by 10.8% from \$362 to \$323 per person (Table 3.15.4, Figure 3.15.3). Note: state and territory governments do not provide funds for the PBS or RPBS.



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.16 Access to after-hours primary health care

Why it is important

This measure reports on access to after-hours primary health care. 'After hours' refers to services provided on Sundays, before 8 am and/or after 12 pm on a Saturday, or at any time other than 8 am to 6 pm on weekdays. An important component of comprehensive primary health-care services is the capacity for patients to access services after hours. In the absence of after-hours primary health care, patients with more urgent needs might delay seeking care (AHMAC 2017).

Key findings

Urgent medical care: In 2012–13 in the Australian Capital Territory, 10% of Indigenous Australians reported that they visited a doctor for urgent medical care in the previous 12 months.

In 2012–13 nationally, 11% of Indigenous Australians living in *Non-remote* areas reported they had visited a doctor for urgent medical care in the previous 12 months (Table 3.16.1, Figure 3.16.1).

Waiting time: Nationally in 2012–13, of Indigenous Australians in *Non-remote* areas who had urgent medical care in the previous 12 months, 9% reported that the waiting time was more than 24 hours, and 91% reported that the waiting time was within 24 hours (Table 3.16.1).

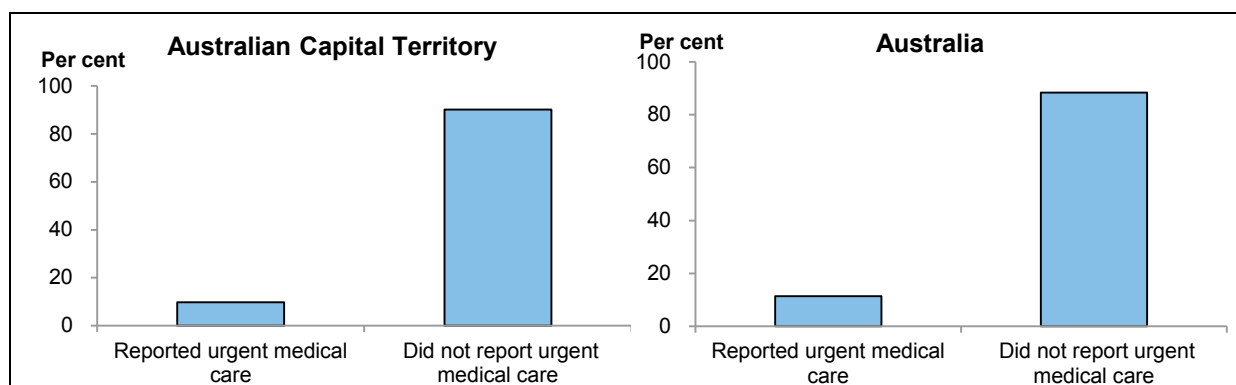
Access to doctor or GP after hours: In 2012–13 in the Australian Capital Territory, 10% of Indigenous Australians reported that they visited a doctor outside normal business hours in the previous 12 months.

Nationally in 2012–13, 8.8% of Indigenous Australians living in *Non-remote* areas reported they had visited a doctor outside normal business hours for urgent medical care in the previous 12 months (Table 3.16.1, Figure 3.16.2).

Medicare: In 2015–16 in the Australian Capital Territory, the age-standardised rate for MBS services claimed for after-hours care for Indigenous Australians was 1.1 times the rate for non-Indigenous Australians (350 compared with 330 per 1,000).

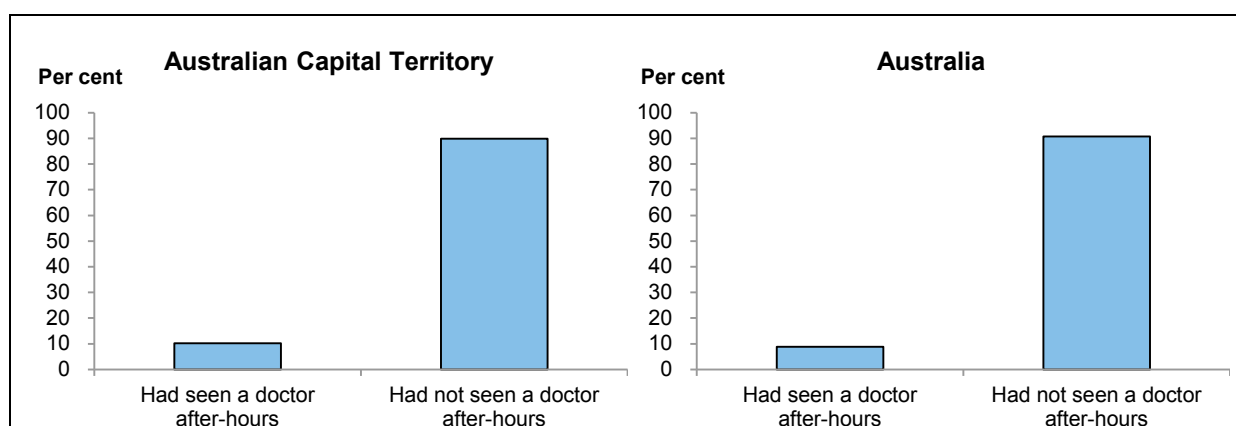
Nationally in 2015–16, the rate for MBS services claimed by Indigenous Australians for after-hours care items was 400 per 1,000. The age-standardised rate for Indigenous Australians was 0.8 times the rate for non-Indigenous Australians (390 compared with 474 per 1,000) (Table 3.16.3, Figure 3.16.3).

Emergency department presentations: Nationally in 2014–15 to 2015–16, and excluding the Australian Capital Territory, 59% of emergency department presentations for Indigenous patients occurred after hours. This proportion was similar for non-Indigenous patients (56%) (Table 3.16.10).



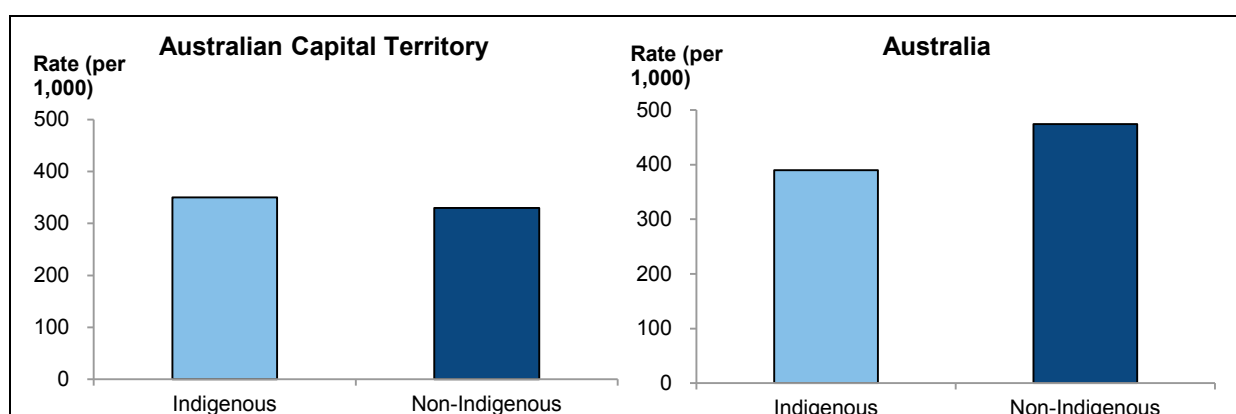
Source: Table 3.16.1.

Figure 3.16.1: Proportion of Indigenous Australians reporting urgent medical care, Australian Capital Territory and Australia (Non-remote areas), 2012–13



Source: Table 3.16.1.

Figure 3.16.2: Proportion of Indigenous Australians reporting access to a doctor or GP after hours, Australian Capital Territory and Australia (Non-remote areas), 2012–13



Source: Table 3.16.3.

Figure 3.16.3: Age-standardised rate of MBS services claims for after-hours care, by Indigenous status, Australian Capital Territory and Australia, 2015–16

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.17 Regular GP or health service

Why it is important

This measure reports on people who have a regular GP or health service. Having a usual primary health-care provider is associated with good communication between the patient and provider, greater levels of trust and satisfaction with providers (Mainous et al. 2001; Schers et al. 2005) and better health outcomes for patients (Starfield 1998; Starfield & Shi 2004). Those with a usual primary care provider are more likely to receive care based on guidelines, preventive care and better coordination of care with other providers to meet patient need (Atlas et al. 2009; Forrest & Starfield 1996). Other benefits of having a continuous doctor–patient relationship include improved diagnoses, better medication management, avoidance of repeat tests or other interventions, and fewer hospitalisations, particularly for people with complex health-care needs (Hollander et al. 2009).

Key findings

Overall: In the Australian Capital Territory, in 2012–13, 86% of Indigenous Australians (all ages) reported that they had a usual place to go for health problems and advice.

Nationally in 2012–13, 87% of Indigenous Australians had a usual place to go for health problems and advice (Table 3.17.1, Figure 3.17.1).

Usual place to go: In 2012–13 in the Australian Capital Territory, Indigenous Australians reported they usually went to a doctor or GP if they had a problem with their health (77%), followed by an Aboriginal Medical Service (AMS) (19%) and a community clinic (3.7%).

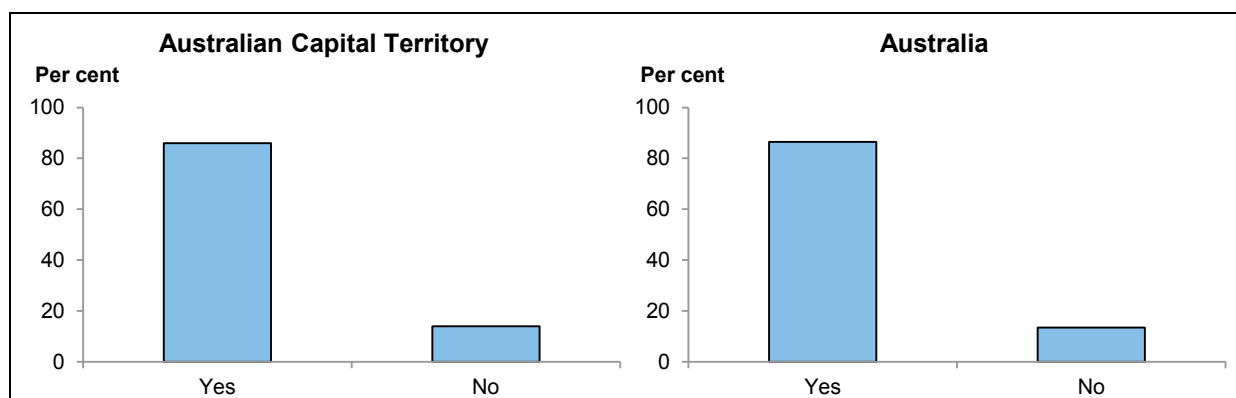
Nationally in 2012–13, 62% of Indigenous Australians reported that they usually went to a doctor or GP, 20% went to an AMS, 11% went to community clinics and 6.3% went to a hospital (Table 3.17.1, Figure 3.17.2).

Health care available in local area: In 2012–13 in the Australian Capital Territory, 93% of Indigenous Australians reported that a doctor or GP was locally available, 84% had a hospital available, and for 42% an AMS was available.

In 2012–13 nationally, 83% of Indigenous Australians reported that a doctor or GP was locally available, 71% had a hospital available, and for 48% an AMS was available (Table 3.17.1, Figure 3.17.3).

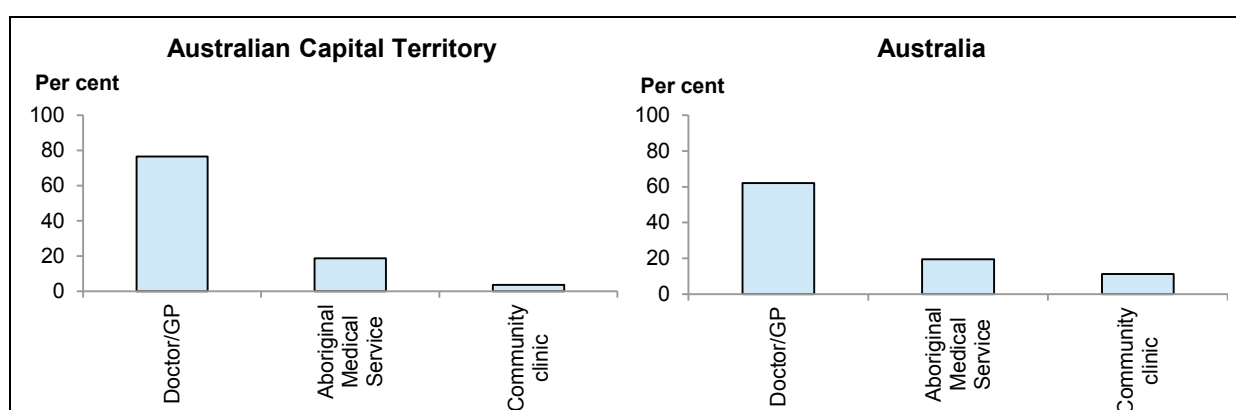
Preferred health care: In 2012–13 in the Australian Capital Territory, 63% of Indigenous Australians reported that they preferred to go to a doctor or GP for health problems or advice, followed by an AMS (28%) and a hospital (4%).

Nationally in 2012–13, 53% of Indigenous Australians preferred to go to a doctor or GP for health problems or advice, followed by an AMS (26%) and a hospital (9.6%) (Table 3.17.1).



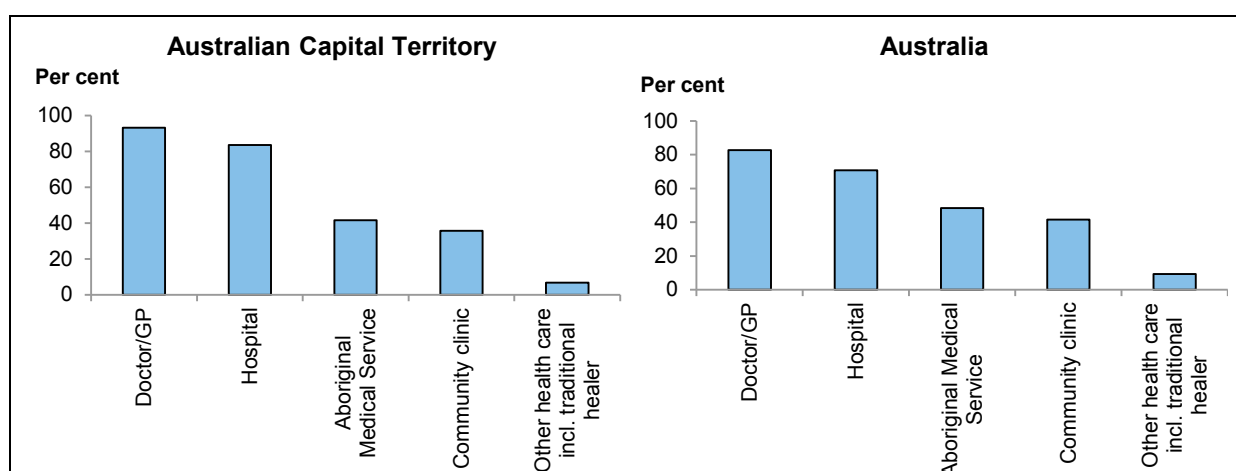
Source: Table 3.17.1.

Figure 3.17.1: Proportion of Indigenous Australians having a usual place to go for health problems or advice, Australian Capital Territory and Australia, 2012–13



Source: Table 3.17.1.

Figure 3.17.2: Types of health care preferred by Indigenous Australians, Australian Capital Territory and Australia, 2012–13



Source: Table 3.17.1.

Figure 3.17.3: Health services availability in local area, Australian Capital Territory and Australia, 2012–13

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.18 Care planning for chronic diseases

Why it is important

This measure reports on care planning for the management of chronic disease. Chronic diseases are major causes of illness, disability and death among Indigenous Australians. An estimated 70% of the health gap between Indigenous and non-Indigenous Australians is attributed to chronic diseases (AIHW 2016b). Effective management of chronic diseases can delay the progression of disease, reduce the need for high-cost interventions, improve quality of life and increase life expectancy. Good quality care for people with chronic diseases generally involves multiple health-care providers across multiple settings. As a result, care plans are one way the client and primary health-care provider can ensure appropriate care is arranged and coordinated. GPs are encouraged to develop care plans through several items under the Medicare Benefits Schedule, including a GP Management Plan (GPMP) and a Team Care Arrangement (TCA) (AHMAC 2017).

Key findings

GP Management Plan: In May 2015 in the Australian Capital Territory and New South Wales combined, 52% of Indigenous clients of Indigenous primary health-care services with type 2 diabetes had a GP Management Plan (GPMP) in the last 2 years.

In May 2015 nationally, 51% of Indigenous clients of Indigenous primary health-care services with type 2 diabetes claimed a GPMP in the last 2 years (Table 3.18.1, Figure 3.18.1).

Team Care Arrangement: In May 2015 in the Australian Capital Territory and New South Wales combined, 50% of Indigenous clients of Indigenous primary health-care services with type 2 diabetes claimed a TCA in the last 2 years.

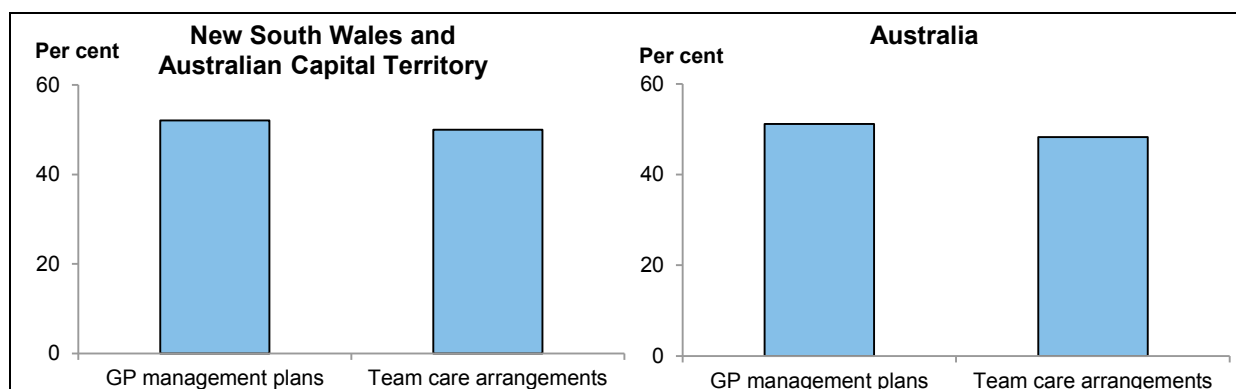
Nationally in May 2015, 48% of Indigenous clients of Indigenous primary health-care services with type 2 diabetes claimed a TCA in the last 2 years (Table 3.18.1, Figure 3.18.1).

Trend over time (GPMP): In the Australian Capital Territory and New South Wales combined, the proportion of Indigenous clients of Indigenous primary health-care services with type 2 diabetes who claimed a GPMP increased from 46% in December 2012 to 52% in May 2015.

Nationally, the proportion of Indigenous clients of Indigenous primary health-care services with type 2 diabetes who claimed a GPMP increased from 41% in December 2012 to 51% in May 2015 (Table 3.18.1, Figure 3.18.2).

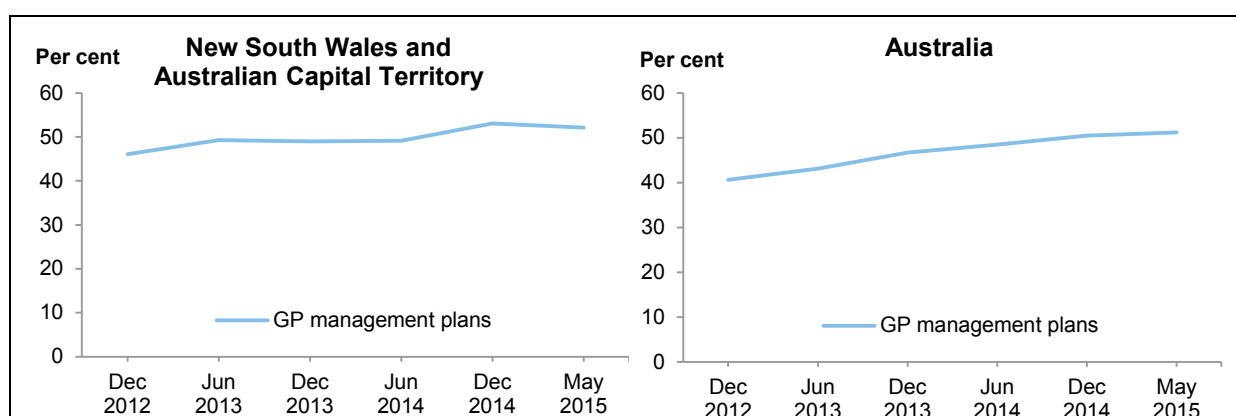
Trend over time (TCA): In the Australian Capital Territory and New South Wales combined, the proportion of Indigenous clients of Indigenous primary health-care services with type 2 diabetes who had a TCA increased from 44% in December 2012 to 50% in May 2015.

Nationally, the proportion of Indigenous clients of Indigenous primary health-care services with type 2 diabetes who had a TCA increased from 36% in December 2012 to 48% in May 2015 (Table 3.18.1, Figure 3.18.3).



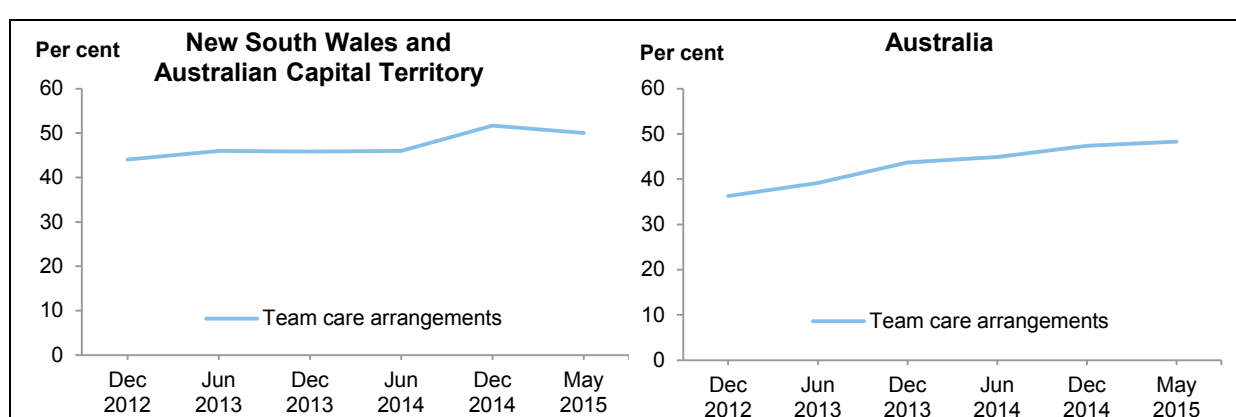
Source: Table 3.18.1.

Figure 3.18.1: Proportion of Indigenous, regular clients with type 2 diabetes who had a GPMP or TCA in the last 2 years, Indigenous primary health-care services, NSW and ACT combined, and Australia, May 2015



Source: Table 3.18.1.

Figure 3.18.2: Proportion of Indigenous, regular clients with type 2 diabetes who had a GPMP in the last 2 years, Indigenous primary health-care services, NSW and ACT combined, and Australia, December 2012 to May 2015



Source: Table 3.18.1.

Figure 3.18.3: Proportion of Indigenous, regular clients with type 2 diabetes who had a TCA in the last 2 years, Indigenous primary health-care services, NSW and ACT combined, and Australia, December 2012 to May 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.19 Accreditation

Why it is important

This measure reports on the proportion of accredited public hospitals and accredited general medical practices. Accreditation is a process (usually voluntary) through which a recognised external body assesses the extent to which a health-care organisation meets applicable quality standards. Quality standards typically consider issues such as: governance of the organisation, management of safety issues such as infection control, handling of care processes such as discharge planning, general management issues such as human resource management, quality of the physical infrastructure, and issues such as handling of patient complaints (AHMAC 2017). Public and private hospitals are accredited against the National Safety and Quality Health Service Standards. Accreditation in general practice involves assessment against standards set by the Royal Australian College of General Practitioners. There are 2 registered general practice accreditation providers: Australian General Practice Accreditation Limited (AGPAL) and General Practice Accreditation Plus (GPA+) (AHMAC 2017).

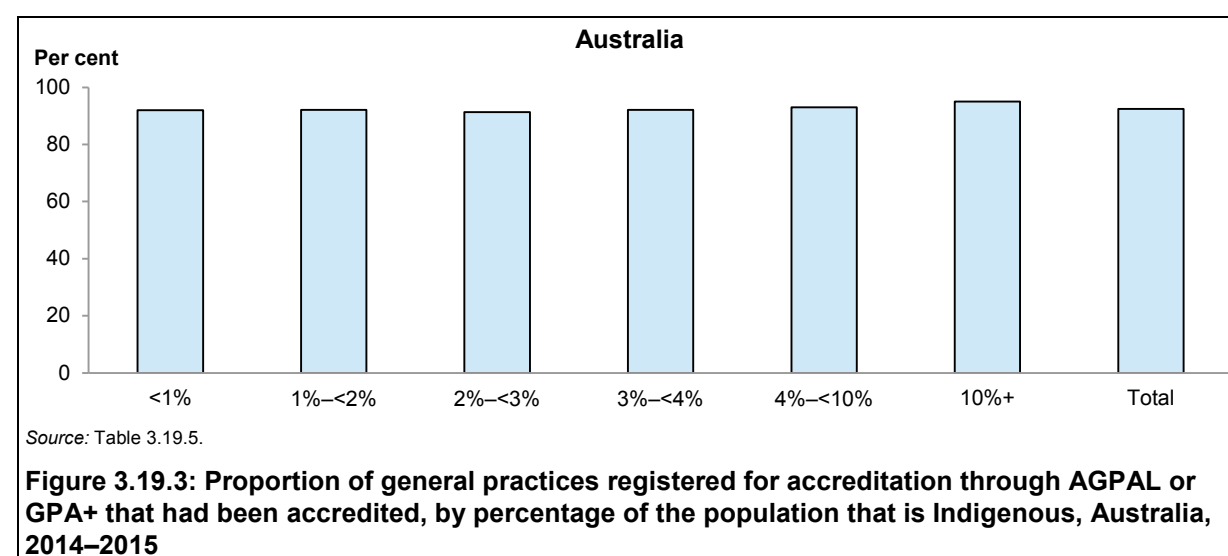
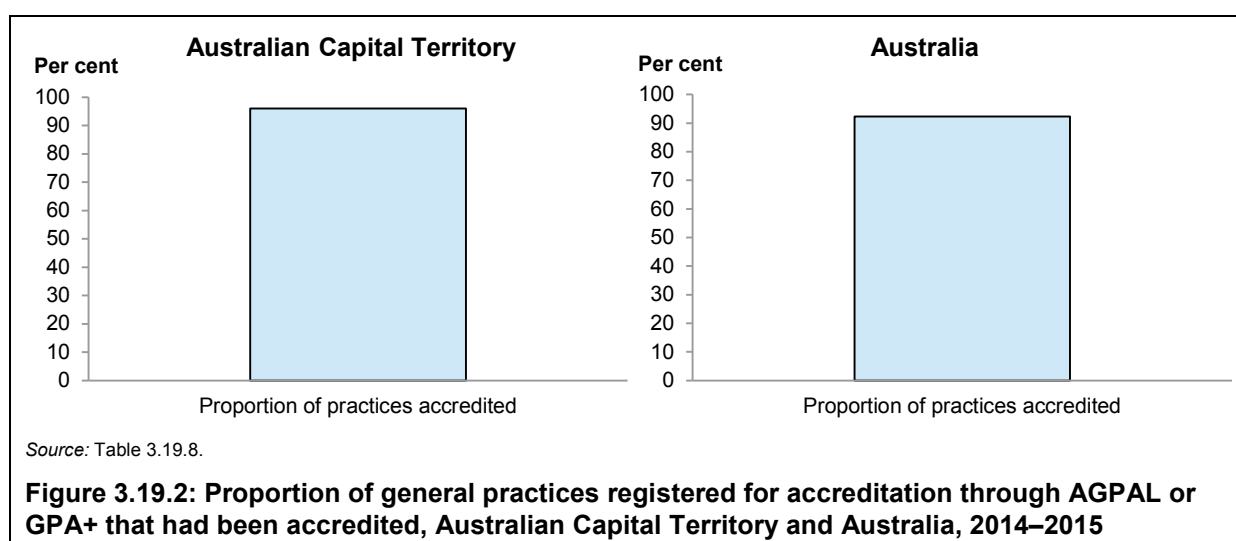
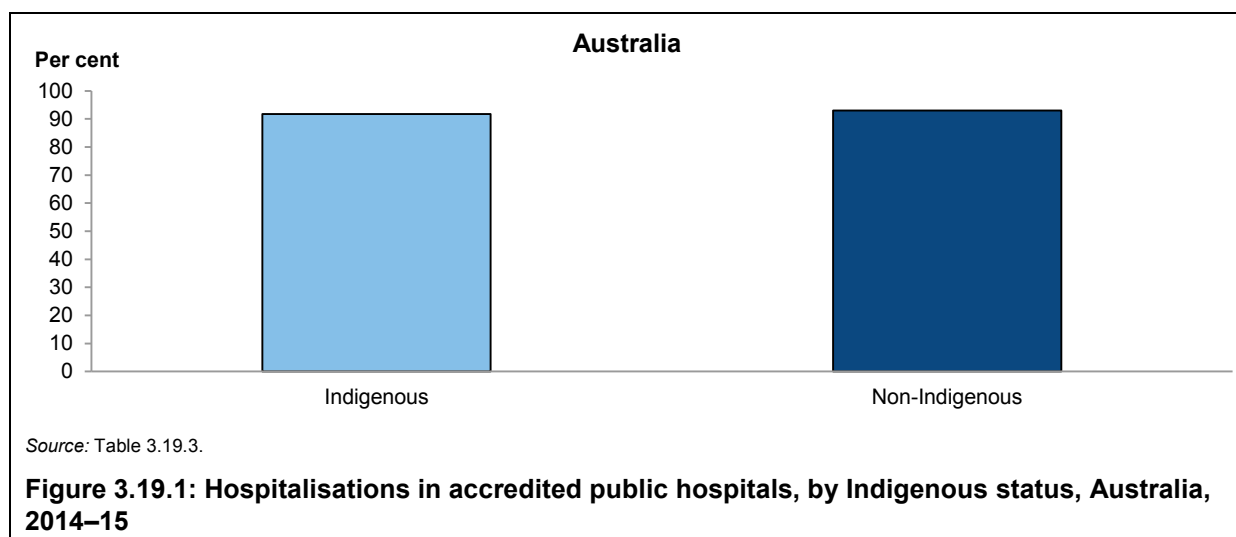
Key findings

Hospitals overall: Nationally in 2014–15, there were 400,068 hospitalisations in public hospitals for Indigenous Australians. Of these, 92% occurred in the 647 accredited hospitals. For non-Indigenous Australians there were 5,528,913 hospitalisations and 93% occurred in accredited hospitals (tables 3.19.3, 3.19.7, Figure 3.19.1).

Hospitals by remoteness: Nationally in 2014–15, the proportion of hospitalisations that occurred in accredited hospitals varied with remoteness. The lowest proportions occurred in *Outer regional* areas for both Indigenous and non-Indigenous Australians (81% and 85%, respectively). The highest proportion occurred in *Remote* areas (100% for Indigenous Australians and 99.8% for non-Indigenous Australians) (Table 3.19.3).

General practices: In 2014–15 in the Australian Capital Territory, of the 75 general practices registered with GPA+ or AGPAL, 72 (96%) were fully accredited by the respective organisation and 3 were undergoing accreditation (Table 3.19.8, Figure 3.19.2).

Nationally in 2014–15, 92% of general practices registered with GPA+ or AGPAL were fully accredited by the respective organisation (Table 3.19.8, Figure 3.19.2) The proportion of practices that were accredited ranged from 91% for practices in areas where Indigenous Australians make up between 2% less than 3% of the population, to 95% in areas where 10% or more of the population is Indigenous (Table 3.19.5, Figure 3.19.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.20 Aboriginal and Torres Strait Islander peoples training for health-related disciplines

Why it is important

This measure reports on the proportion of Indigenous Australians in tertiary education for health-related disciplines. Indigenous Australians are significantly under-represented in the health workforce. Improving and supporting the participation of Indigenous Australians in tertiary education for health-related disciplines is vital to increasing Indigenous Australians participation in the health workforce (AHMAC 2017).

Key findings

Tertiary education enrolment: In 2015 in the Australian Capital Territory, there were 24 undergraduate domestic health-related course enrolments for Indigenous students aged 15 and over. This represents a rate of 50 per 10,000 for Indigenous Australians, 1.3 times the rate for non-Indigenous Australians (39 per 10,000).

Nationally in 2015, there were 2,001 undergraduate domestic health-related course enrolments for Indigenous students. This represents a rate of 42 per 10,000 for Indigenous Australians aged 15 and over, 0.8 times the rate for non-Indigenous Australians (55 per 10,000) (Table 3.20.27, Figure 3.20.1).

Tertiary education completion: In 2015 in the Australian Capital Territory, there were less than 5 undergraduate domestic health-related course completions for Indigenous students. The rate was not calculated due to the small number of students involved.

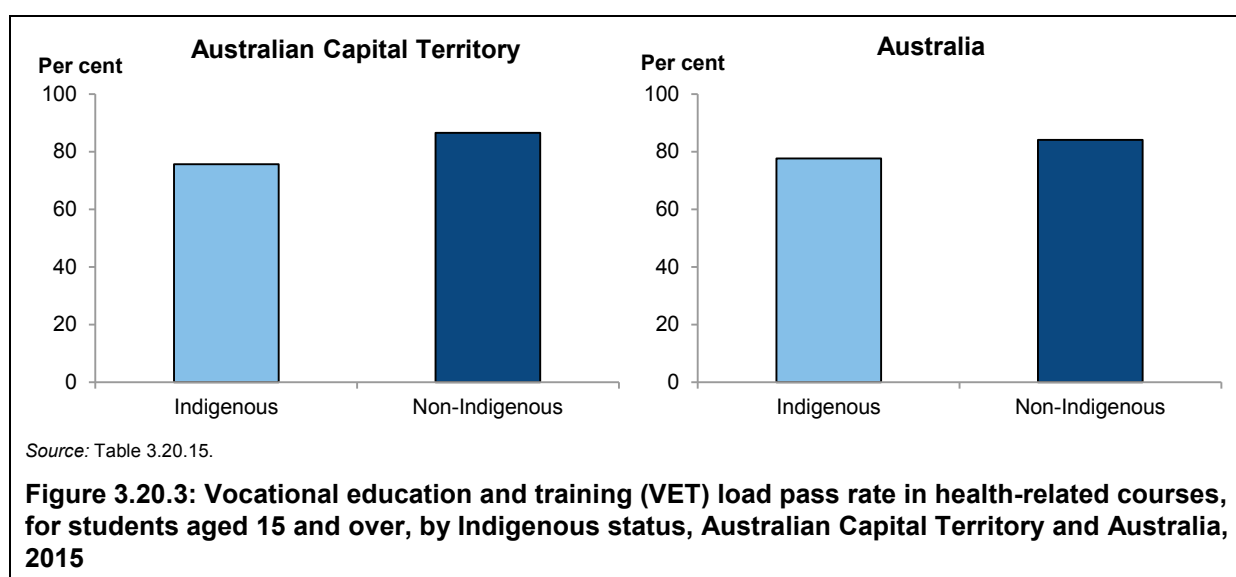
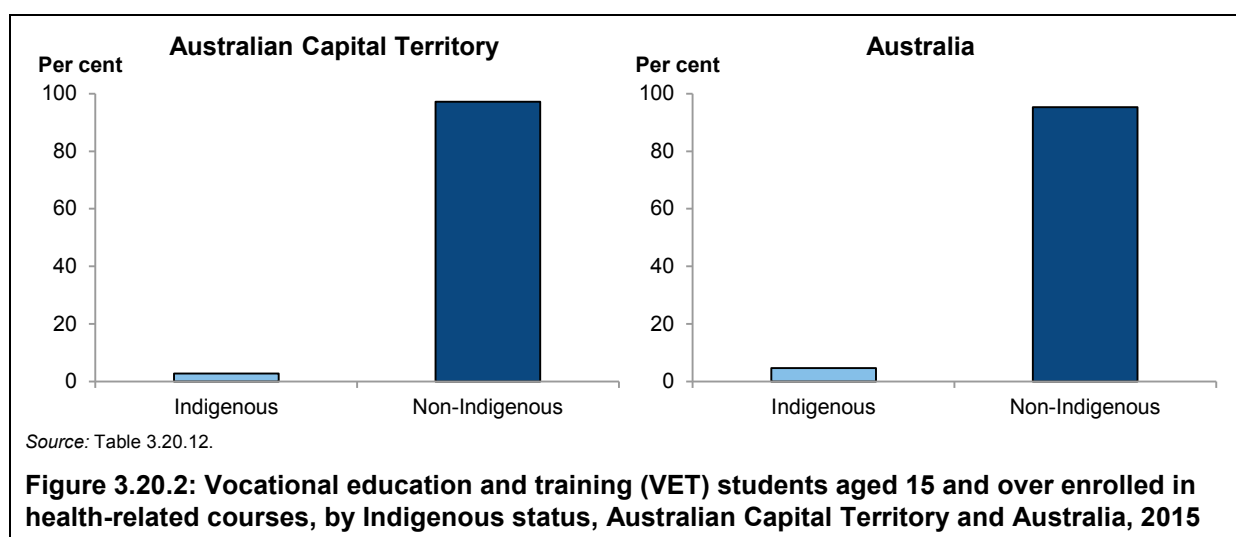
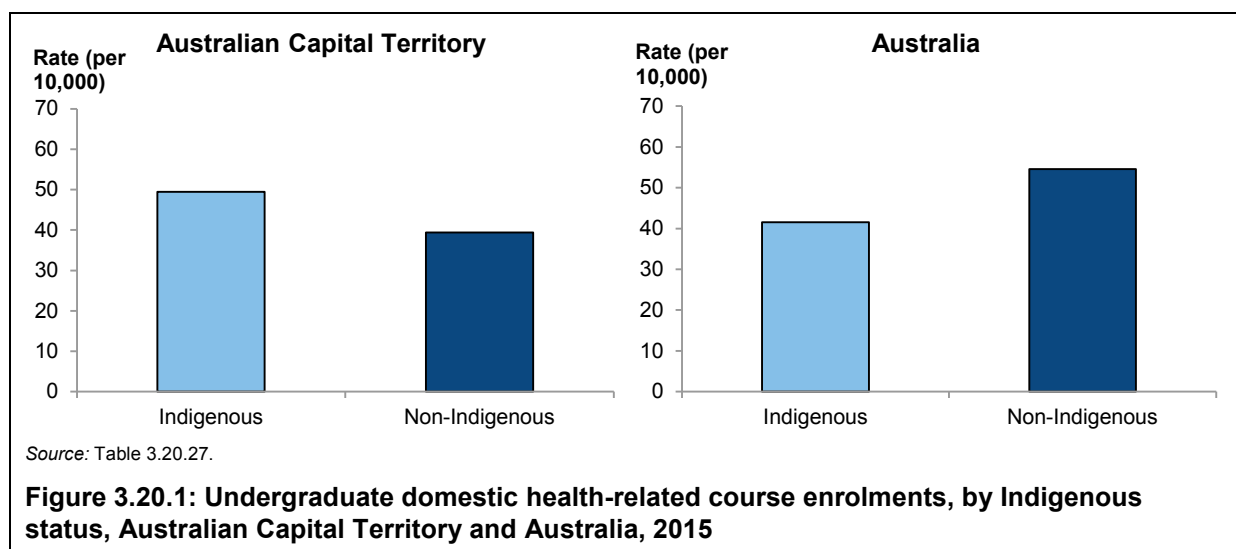
Nationally in 2015, there were 270 undergraduate domestic health-related course completions for Indigenous students. This represents a rate of 5.6 per 10,000 for Indigenous Australians aged 15 and over, 0.5 times the rate for non-Indigenous Australians (10.5 per 10,000) (Table 3.20.27).

Vocational education and training (VET) enrolment: In 2015 in the Australian Capital Territory, 15 VET students aged 15 and over enrolled in health-related courses were Indigenous. This represents 2.8% of total VET students aged 15 and over enrolled in health-related courses, and 0.3% of the Indigenous population that are aged 15–64.

Nationally in 2015, 3,021 VET students aged 15 and over enrolled in health-related courses were Indigenous. This represents 4.7% of total VET students aged 15 and over enrolled in health-related courses, and 0.6% of the Indigenous population that are aged 15–64 (Table 3.20.12, Figure 3.20.2).

Vocational education and training load pass rate: In 2015 in the Australian Capital Territory, for VET students aged 15 and over in health-related courses, the load pass rate was 76% for Indigenous students and 87% for non-Indigenous students.

Nationally in 2015, the load pass rate for VET students aged 15 and over in health-related courses was 78% for Indigenous students and 84% for non-Indigenous students (Table 3.20.36, Figure 3.20.3).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.21 Expenditure on Aboriginal and Torres Strait Islander health compared to need

Why it is important

This measure reports on health-related expenditure. A basic principle of equity is that health expenditure should reflect the relative needs for health services (Braveman & Gruskin 2003; Whitehead 1992). Health expenditure for population groups with higher levels of need should be proportionately higher. A broad assessment of how well this principle is implemented is provided by comparing differentials in health status with differences in per capita health expenditure (AHMAC 2017).

Key findings

Because estimates for the Australian Capital Territory include substantial expenditures for New South Wales residents, 2013–14 data from the health expenditure database are not calculated for the Australian Capital Territory. As a result, the ACT population is not an appropriate denominator. Below are summaries of state and territory government health expenditure data for all of Australia.

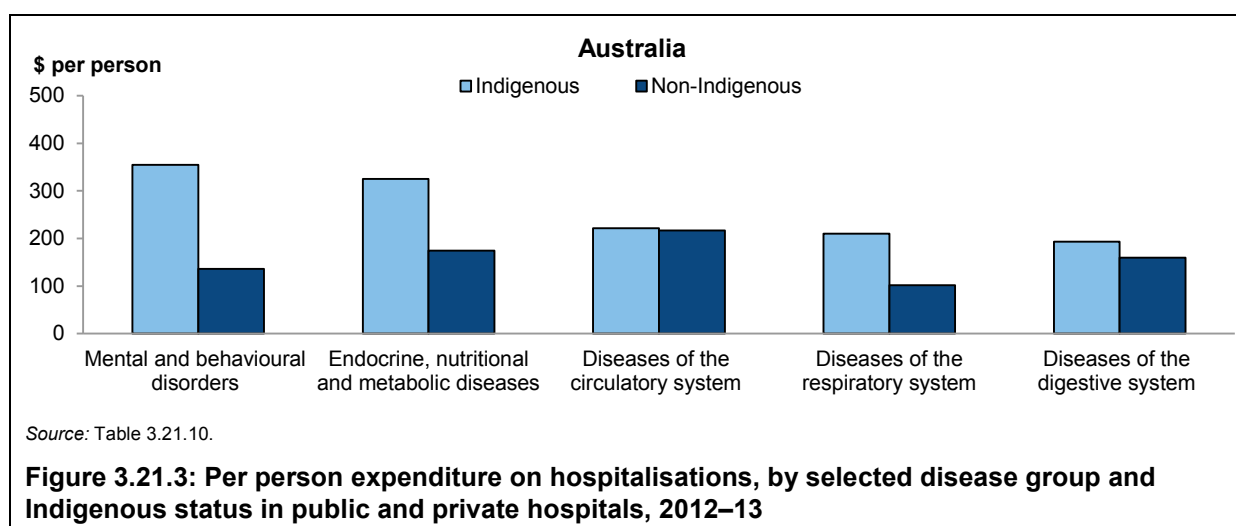
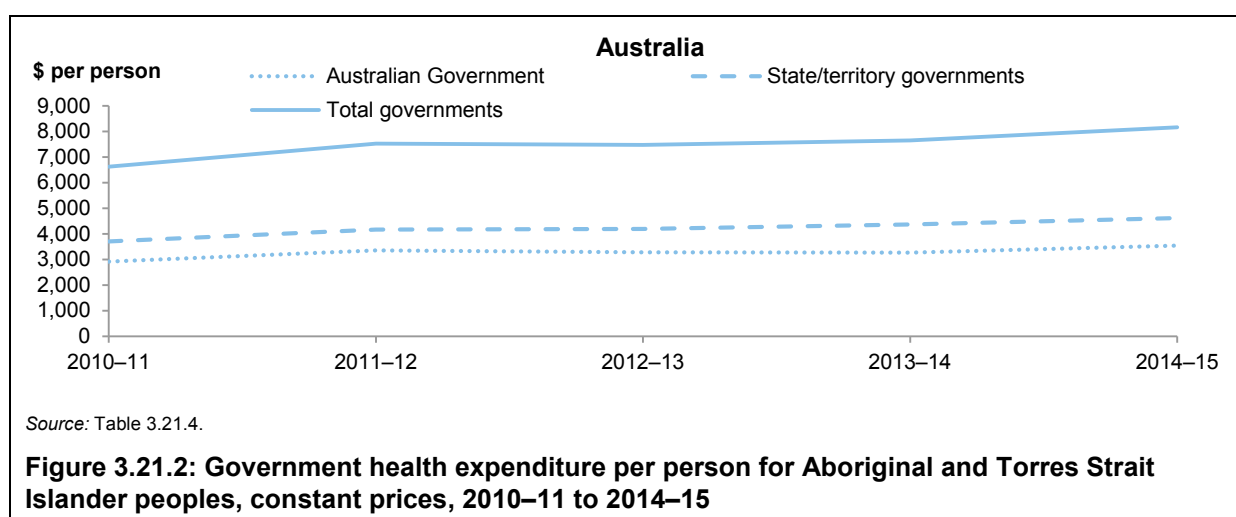
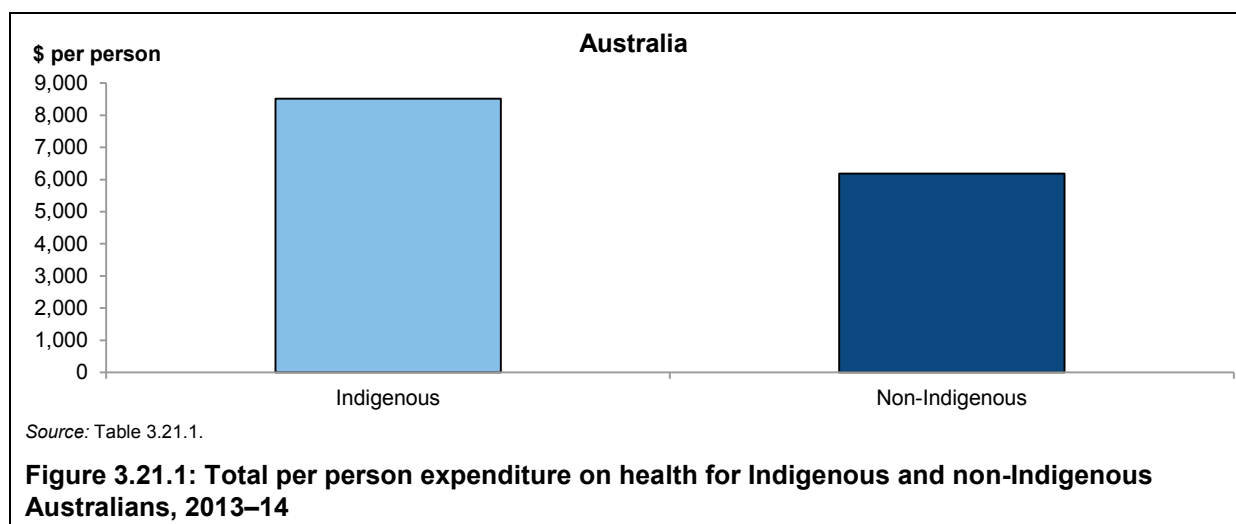
Overall: Nationally in 2013–14, the total health expenditure was \$145.6 million. On a per person basis, average health expenditure for Indigenous Australians was \$8,515, compared with \$6,180 for non-Indigenous Australians. This indicates that for every \$1.00 spent per person for non-Indigenous Australians, \$1.38 was spent per person for Indigenous Australians (Table 3.21.1, Figure 3.21.1).

Government health expenditure: In 2014–15, in 2013–14 prices, per person expenditure for Indigenous Australians was \$3,546 by the Australian Government and \$4,619 by state or territory governments (Table 3.21.4, Figure 3.21.2).

Government health expenditure over time: From 2010–11 to 2014–15, in 2013–14 prices, the total government health expenditure per person increased by 23%, from \$6,626 to \$8,164. Health expenditure per person by the Australian Government increased by 21%, from \$2,924 to \$3,546; and health expenditure per person by state and territory governments increased by 25%, from \$3,702 to \$4,619 (Table 3.21.4, Figure 3.21.2).

Hospitalisations: In 2012–13, the total expenditure per person on hospitalisations was \$3,006 for Indigenous Australians, 1.6 times the expenditure per person for non-Indigenous Australians (\$1,927). The highest expenditure per person for Indigenous Australians was for mental and behavioural disorders (\$355), followed by endocrine, nutritional and metabolic diseases (\$325) (Table 3.21.10, Figure 3.21.3). For non-Indigenous Australians, the highest expenditure per person for Indigenous Australians was for diseases of the circulatory system (\$217), followed by endocrine, nutritional and metabolic diseases (\$174) and injury, poisoning (\$173).

Potentially preventable hospitalisations: In 2012–13, the total expenditure on potentially preventable hospitalisations was \$406 per person for Indigenous Australians, and \$159 per person for non-Indigenous Australians. For the following potentially preventable conditions, the expenditure was: chronic conditions, \$187 per person for Indigenous Australians and \$82 per person for non-Indigenous Australians; acute conditions, \$172 per person for Indigenous Australians and \$63 per person for non-Indigenous Australians; vaccine-preventable conditions, \$47 per person for Indigenous Australians and \$14 per person for non-Indigenous Australians (Table 3.21.11).



Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

3.22 Recruitment and retention of staff

Why it is important

This measure reports on the recruitment and retention of qualified clinical and management staff to provide effective health care. The capacity to recruit and retain appropriate staff is critical to the appropriateness, continuity and sustainability of health services including Aboriginal and Torres Strait Islander primary health-care services. Staff recruitment and retention is particularly important in regional, rural and remote areas because 65% of Indigenous Australians live outside the major cities (AHMAC 2017). Aboriginal Community Controlled Health Organisations (ACCHO) are non-government organisations operated by local Aboriginal and Torres Strait Islander communities to deliver health care to communities that control them (NACCHO 2015). There are more ACCHOs than any other type of health service organisations in all remoteness areas, making them an ideal indicator for the scope of health-care services for Indigenous Australians (AIHW 2016e).

Key findings

Medical practitioners: In 2015 in the Australian Capital Territory, there were 1,775 medical practitioners (which includes general practitioners, specialists, hospital non-specialists, specialists in training, and non-clinicians). Of these, 93% were employed in medicine.

Nationally in 2015, there were 97,466 medical practitioners registered. Of these, 90% were employed in medicine (Table 3.22.1, Figure 3.22.1).

Nurses and midwives: In 2015 in the Australian Capital Territory, there were 5,812 nurses and midwives. Of these, 93% were employed in nursing or midwifery.

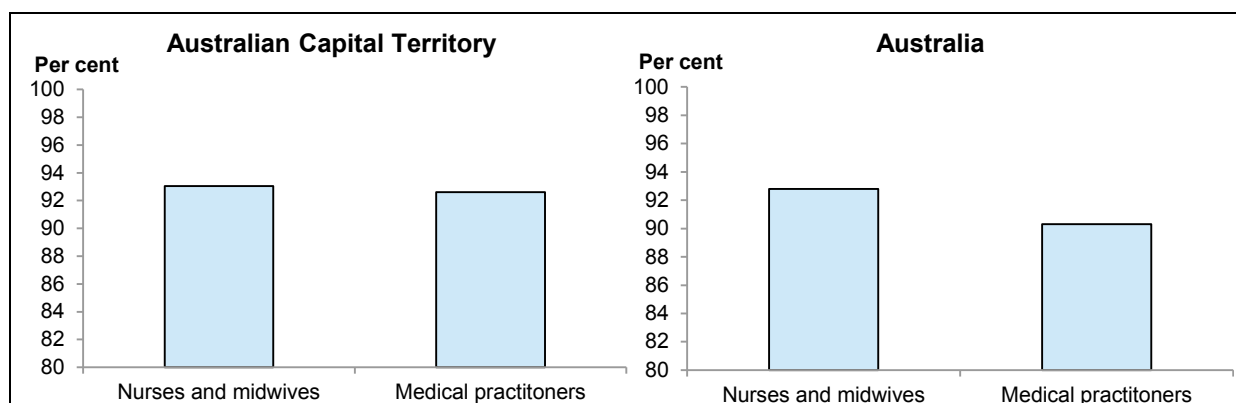
Nationally in 2015, there were 360,008 nurses or midwives. Of these, 93% were employed in nursing or midwifery (Table 3.22.10, Figure 3.22.1).

General practitioners employed in Indigenous specific health services (ISHP): In New South Wales and the Australian Capital Territory combined, between June 2014 and May 2015, there were 1.2 full-time equivalent (FTE) general practitioners per 1,000 clients in the ACCHOs. For other ISHPs, there were 0.3 FTE general practitioners per 1,000 clients.

Nationally between June 2014 and May 2015, there were 1.3 FTE general practitioners per 1,000 clients in the ACCHOs. For other ISHPs, there were 0.8 FTE general practitioners per 1,000 clients (AIHW 2016e, Figure 3.22.2).

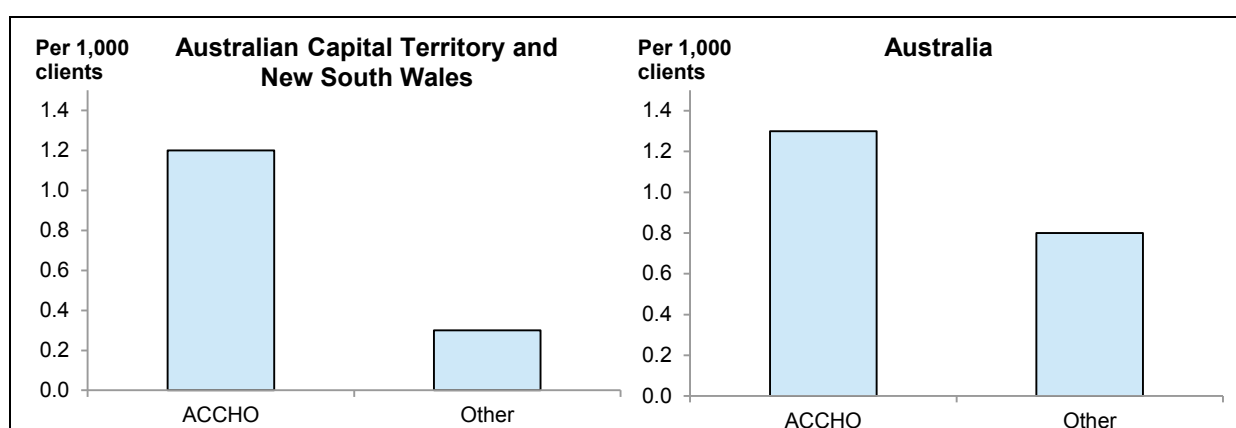
Vacant full-time medical positions in ISHPs: In New South Wales and the Australian Capital Territory combined, between June 2014 and May 2015 there were 0.3 vacant full-time equivalent (FTE) positions per 1,000 clients in the ACCHOs. For other ISHPs, there were 0.4 vacant full-time positions per 1,000 clients.

Nationally, between June 2014 and May 2015, there were 0.6 vacant full-time positions (including visiting staff) per 1,000 clients in the ACCHOs. For other ISHPs, there were 0.9 vacant full-time positions per 1,000 clients (AIHW 2016e, Figure 3.22.3).



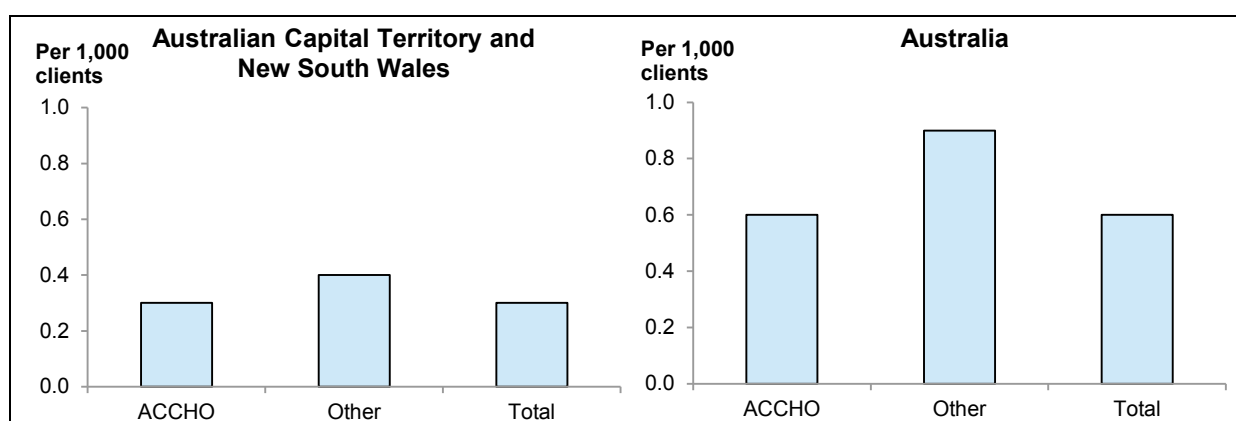
Sources: Tables 3.22.1, 3.22.10.

Figure 3.22.1: Proportion of nurses and midwives and medical practitioners employed in their field, Australian Capital Territory and Australia, 2015



Source: AIHW 2016e.

Figure 3.22.2: Number of FTE general practitioners per 1,000 clients, by organisation, Australian Capital Territory and New South Wales combined, and Australia, June 2014 to May 2015



Source: AIHW 2016e.

Figure 3.22.3: Number of FTE vacant positions within health organisations per 1,000 clients, by organisation, Australian Capital Territory and New South Wales combined, and Australia, June 2014 to May 2015

Tables referenced, and data sources and quality: see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

Appendix A: Data sources

The data in this report are drawn from the national data collections and surveys. Table A1 shows all data sources and the Aboriginal and Torres Strait Islander Health Performance Framework measures that they relate to.

For a description of the data sources used in this report and links to data quality statements see <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents>.

Table A1: Data sources and the Aboriginal and Torres Strait Islander Health Performance Framework measures they relate to

Data source	Relevant measures
Alcohol and Other Drug Treatment Services National Minimum Data Set	3.11
Australia and New Zealand Dialysis and Transplant Registry	1.10
Australian Aboriginal and Torres Strait Islander Health Survey	1.03, 1.04, 1.05, 1.07, 1.08, 1.09, 1.10, 1.11, 1.14, 1.15, 1.16, 1.17, 1.18, 2.01, 2.02, 2.03, 2.06, 2.07, 2.08, 2.15, 2.16, 2.17, 2.19, 2.22, 3.02, 3.03, 3.04, 3.05, 3.08, 3.10, 3.14, 3.15, 3.16, 3.17
Australian Cancer Database	1.08
Australian Immunisation Register	3.02
Australian General Practice Accreditation Limited	3.19
Australian Government Department of Health data	1.16, 3.21
Australian Health Survey	1.05, 1.07, 1.08, 1.09, 1.10, 1.15, 1.16, 1.17, 1.18, 2.01, 2.03, 2.06, 2.07, 2.08, 2.16, 2.19, 2.22, 3.05
BreastScreen Australia	3.04
Causes of Death, Australia	1.20
Census of Population and Housing	1.14, 2.01, 2.09
Child Dental Health Survey	1.11
Child Health Check Initiative Dental data	1.11, 1.15
Child Protection Collection	2.12
Deadly Ears Program	1.15
Disability Services National Minimum Data Set	1.14
Drug Use Monitoring in Australia Survey	2.17
Family Medicine Research Centre, University of Sydney, Bettering the Evaluation and Care of Health data	1.03, 1.05, 1.07, 1.08, 1.09, 1.15, 1.16, 1.18, 3.03, 3.16
General Practice Accreditation Plus	3.19
General Practice Statistics	3.22
General Social Survey	1.14, 1.18, 2.01, 2.06, 2.07, 2.08, 2.10, 2.13
Health Expenditure Database	3.03, 3.15, 3.21
Healthy for Life data collection	3.05
Higher Education Statistics Collection	2.06
Indigenous Primary Health-care National Key Performance Indicators data collection	1.01, 2.15, 2.21, 2.22, 3.01, 3.02, 3.04, 3.05, 3.18
Juvenile Justice National Minimum Dataset	2.11
Life tables, states, territories and Australia	1.19
Medical Labour Force Survey	3.12
Medicare data	3.02, 3.04, 3.05, 3.10, 3.14, 3.16

(continued)

Table A1 (continued): Data sources and the Aboriginal and Torres Strait Islander Health Performance Framework measures they relate to

Data source	Relevant measures
National Aboriginal and Torres Strait Islander Health Survey	1.16, 1.17, 1.18, 2.01, 2.03, 2.06, 2.07, 2.08, 2.15, 2.16, 2.17, 2.19, 3.02, 3.14
National Aboriginal and Torres Strait Islander Social Survey	1.11, 1.13, 1.14, 1.15, 1.16, 1.17, 1.18, 2.01, 2.02, 2.03, 2.04, 2.05, 2.06, 2.07, 2.08, 2.10, 2.11, 2.12, 2.13, 2.14, 2.15, 2.16, 2.17, 2.18, 2.19, 2.20, 2.21, 3.01, 3.08
National Aboriginal and Torres Strait Islander Survey	2.07, 2.15
National Assessment Program—Literacy and Numeracy tests	2.04
National Community Mental Health Care Database	3.10
National Deaths in Custody Program	2.11
National Elective Surgery Waiting Times Data Collection	3.14
National Health Survey	1.15, 1.16, 1.17, 1.18, 2.01, 2.03, 2.06, 2.07, 2.08, 2.13, 2.15, 2.20, 3.02, 3.14
National Health Workforce Dataset	3.10, 3.12, 3.22
National HIV Registry	1.12
National Homicide Monitoring Program	2.10
National Hospital Morbidity Database	1.02, 1.03, 1.04, 1.05, 1.06, 1.07, 1.08, 1.09, 1.10, 1.11, 1.15, 1.16, 1.18, 2.10, 2.16, 2.17, 3.06, 3.07, 3.09, 3.10, 3.14, 3.19
National Indigenous Eye Health Survey	1.16
National Mental Health Establishments Database	3.10
National Mortality Database	1.03, 1.04, 1.08, 1.10, 1.18, 1.20, 1.21, 1.22, 1.23, 1.24, 2.10, 2.16
National Non-admitted Patient Emergency Department Care Database	3.09, 3.14, 3.16
National Notifiable Diseases Surveillance System	1.04, 1.12
National Opioid Pharmacotherapy Statistics Annual Data collection	3.11
National Perinatal Data Collection	1.01, 1.20, 1.22, 2.21, 3.01
National Prisoner Census	2.11
National Public Hospitals Establishment Database	3.19
National Schools Statistics Collection	2.05
National Vocational Education Training in Schools Collection	3.20
National Vocational Education Training Provider Collection	2.06, 3.20
New Zealand Ministry of Health	1.01, 1.20, 1.22
Northern Territory Rheumatic Heart Disease Program data	1.06
Office of the Registrar of Indigenous Corporations	3.13
Online Services Report data collection	3.03, 3.08, 3.11, 3.13, 3.14, 3.16, 3.18, 3.19, 3.22
Queensland Rheumatic Heart Disease Register	1.06
Rural Workforce Agencies National Minimum Data Set	3.22
Selected Higher Education Statistics	3.20
Service Activity Reporting	3.14, 3.22
South Australian Rheumatic Heart Disease Register	1.06
Specialist Homelessness Services Collection	2.01
Statistics Canada: Vital statistics—Birth Database	1.01
Stronger Futures in the Northern Territory data	1.11, 1.15
Survey of Education and Work	2.05, 2.07
Trachoma surveillance report	1.16
United States Centres for Disease Control and Prevention, National Centre for Health Statistics	1.01, 1.20
Western Australian Rheumatic Heart Disease Register	1.06

Glossary

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

additional diagnosis: A condition or complaint that either coexists with the principal diagnosis or arises during an episode of admitted patient care. An additional diagnosis is reported if the condition affects patient management. Compare with **principal diagnosis**.

age-specific rate: An estimate of the proportion of people experiencing a particular event in a specified age group relative to the total number of people 'at risk' of that event in that age group. See also **crude rate**.

age-standardised rates: Rates adjusted for age to take into account differences in age structures when comparing different populations or across time.

associated cause(s) of death: All causes listed on the death certificate, other than the underlying cause of death. They include the immediate cause, any intervening causes, and conditions which contributed to the death but were not related to the disease or condition causing the death. See also **cause of death**.

cause of death: All diseases, morbid conditions or injuries that either resulted in or contributed to death, and the circumstances of the accident or violence that produced any such injuries, as entered on the Medical Certificate of Cause of Death. Causes of death are commonly reported using the underlying cause of death. See also **associated cause(s) of death**.

crude rate: An estimate of the proportion of a population that experiences an outcome during a specified period. It is calculated by dividing the number of people with the outcome in a specified period by the number of people in the population during that period.

determinant: A factor that can increase the chances of ill health (risk factor) or good health (protective factor) in a population or individual. By convention, services or other programs that aim to improve health are usually not included.

dialysis: A process used to treat kidney failure. A machine is connected to the patient's bloodstream to filter the blood externally to the body, removing water, excess substances and waste from the blood, as well as regulating the levels of circulating chemicals. In doing this, the machine takes on the role normally played by the kidneys.

external cause: The term used in disease classification to refer to an event or circumstance in a person's external environment that is regarded as a cause of injury or poisoning.

gap: In this report, 'the gap' refers to the rate difference.

hospitalisation (or separation): An episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

household: A group of 2 or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living, or an individual living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.

incidence: The number of new cases (of an illness or event, and so on) occurring during a given period. Compare with **prevalence**.

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

non-Indigenous: People who have indicated they are not of **Aboriginal or Torres Strait Islander** descent. Compare with **other Australians**.

other Australians: Includes people who do not identify as being of Aboriginal or Torres Strait Islander origin, and people for whom information on their Indigenous status was not available. Compare with **non-Indigenous**.

prevalence: The number or proportion (of cases, instances, and so forth) in a population at a given time. Compare with **incidence**.

principal diagnosis: The diagnosis established after study to be chiefly responsible for occasioning a patient's episode of admitted patient care. Compare with **additional diagnosis**.

remoteness areas: A classification of the remoteness of a location using the Australian Statistical Geography Standard Remoteness Structure, based on the Accessibility/Remoteness Index of Australia which measures the remoteness of a point based on the physical road distance to the nearest urban centre (ABS 2013b).

statistical significance: An indication from a statistical test that an observed difference or association may be significant or 'real' because it is unlikely to be due just to chance. In this report, references to 'significant' or 'statistically significant' differences refer to differences at the $p < 0.05$ level—that is, there is less than a 1 in 20 chance that the result occurred by chance. The words 'significant' and 'significantly' are not used in this report other than in their statistical context.

underlying cause of death: The disease or injury that initiated the sequence of events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury. See also **cause of death** and **associated cause(s) of death**.

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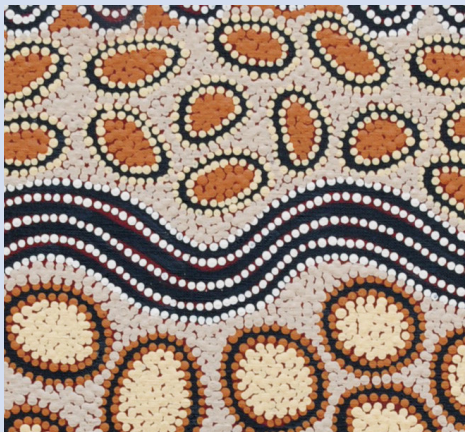
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The earlier editions are:

- AIHW 2007. Aboriginal and Torres Strait Islander Health Performance Framework 2006 report: detailed analyses. Cat. no. IHW 20. Canberra: AIHW.
- AIHW 2009. Aboriginal and Torres Strait Islander Health Performance Framework 2008 report: detailed analyses. Cat. no. IHW 22. Canberra: AIHW.
- AIHW 2011. Aboriginal and Torres Strait Islander Health Performance Framework 2010: detailed analyses. Cat. no. IHW 53. Canberra: AIHW.
- AIHW 2013. Aboriginal and Torres Strait Islander Health Performance Framework 2012: detailed analyses. Cat. no. IHW 94. Canberra: AIHW.
- AIHW 2015. Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: detailed analyses. Cat. no. IHW 167. Canberra: AIHW.



This report gives the latest information on how Aboriginal and Torres Strait Islander people in the Australian Capital Territory are faring according to various measures of health status and outcomes, determinants of health, and health system performance. Indicators are based on the Aboriginal and Torres Strait Islander Health Performance Framework. The report highlights the main areas of improvement, and continuing concern.