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Aboriginal and Torres Strait Islander
Health Performance Framework 2012 report

Australian Capital Territory

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Australian Institute of Health and Welfare

Authoritative information and statistics to promote better health and wellbeing

Aboriginal and Torres Strait Islander Health Performance Framework

2012 report

Australian Capital Territory

Australian Institute of Health and Welfare
Canberra
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Abbreviations

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
ACT	Australian Capital Territory
AGPAL	Australian General Practice Accreditation Limited
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
ANZDATA	Australian and New Zealand Dialysis and Transplant Registry
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
BMI	body mass index
CDEP	Community Development Employment Projects scheme
CIs	confidence intervals
COAG	Council of Australian Governments
COPD	chronic obstructive pulmonary disease
DASR	Drug and Alcohol Services Reporting
DEEWR	(Australian Government) Department of Education, Employment and Workplace Relations
DoHA	(Australian Government) Department of Health and Ageing
DSNMDS	Disability Services National Minimum Data Set
ERP	estimated resident population
ESRD	end stage renal disease
FTE	full-time equivalent
GP	general practitioner
GPA+	General Practice Accreditation Plus
GPMP	General Practice Management Plan
GSS	General Social Survey
HfL	Healthy for Life

HIV/AIDS	human immunodeficiency virus infection / acquired immunodeficiency syndrome
HPF	Aboriginal and Torres Strait Islander Health Performance Framework
ICD-10-AM	International statistical classification of disease and related health problems, 10th revision, Australian modification, 4th edition
IRSAD	Index of Relative Socio-Economic Advantage and Disadvantage
KPI	Key Performance Indicator
MBS	Medicare Benefits Schedule
MCEECDYA	Ministerial Council for Education, Early Childhood Development and Youth Affairs
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NAHA	National Affordable Housing Agreement
NAPEDCD	National Non-admitted Patient Emergency Department Care Database
NAPLAN	National Assessment Program—Literacy and Numeracy
NATSIHON	National Aboriginal and Torres Strait Islander Health Officials Network
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCMHCD	National Community Mental Health Care Database
NCVER	National Centre for Vocational Education Research
NDA	National Disability Agreement
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NIRA	National Indigenous Reform Agreement
NMDS	National Minimum Data Set
NNDSS	National Notifiable Diseases Surveillance System
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NPAH	National Partnership Agreement on Homelessness
NSSC	National Schools Statistics Collection
NSW	New South Wales
NT	Northern Territory

OATSIH	Office of Aboriginal and Torres Strait Islander Health
OSR	OATSIH Services Reporting
PES	Post-Enumeration Survey
PMRT	Performance Measurement and Reporting Taskforce
Qld	Queensland
SA	South Australia
SAAPNDC	Supported Accommodation Assistance Program National Data Collection
SAR	Service Activity Reporting
SEIFA	Socio-Economic Indexes For Areas
SHSC	Specialist Homelessness Services Collection
SIDS	sudden infant death syndrome
SIH	Survey of Income and Housing
STIs	sexually transmissible infections
TAFE	Technical and Further Education
Tas	Tasmania
TCA	Team Care Arrangement
VET	vocational education and training
Vic	Victoria
VII	Voluntary Indigenous Identification
WA	Western Australia
WHO	World Health Organisation

List of symbols used in tables

–	nil or rounded to zero
0	zero
. .	not applicable
n.a.	not available
n.e.c.	not elsewhere classified
n.f.d.	not further defined
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data

Executive summary

The *Aboriginal and Torres Strait Islander Health Performance Framework 2012* report for the Australian Capital Territory finds areas of improvement in the health of Aboriginal and Torres Strait Islander people living in the territory, including:

- a significant increase in health assessments for Aboriginal and Torres Strait Islander people aged 55 years and over recorded through Medicare since the introduction of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes in July 2009
- corresponding increases in allied health-care services claimed by Aboriginal and Torres Strait Islander people through Medicare since 1 July 2009. Aboriginal and Torres Strait Islander people have higher rates of general practitioner management plans and team care arrangements than non-Indigenous Australians
- immunisation coverage rates for Aboriginal and Torres Strait Islander children are close to those for other Australian children by age 5
- some improvements in literacy for Aboriginal and Torres Strait Islander students in Year 3 and 5 between 2009 and 2011
- apparent retention rates from Year 7 to Year 10 and from Year 11 to Year 12 are higher for Aboriginal and Torres Strait Islander people in the Australian Capital Territory than for Aboriginal and Torres Strait Islander people nationally.

Areas of concern include:

- high rates of smoking during pregnancy (51% total)
- around half of Aboriginal and Torres Strait Islander people aged 18 and over reported drinking alcohol at short-term risky/high-risk levels in the past 12 months, which was higher than the proportion for non-Indigenous people and for Indigenous people nationally
- almost two-thirds (63%) of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory have a disability or long-term health condition, which is higher than the proportion for Aboriginal and Torres Strait Islander people nationally (41%)
- breast cancer screening rates for Aboriginal and Torres Strait Islander women are lower than for other women.

Key findings

A summary of the key findings from this report for the Australian Capital Territory against the Aboriginal and Torres Strait Islander Health Performance Framework are outlined below. The main areas of improvement and areas of continuing concern are discussed for each tier of the framework (health status and outcomes, determinants of health, and health system performance). A table of key statistics from the report is presented in Table S1.

Health Status and Outcomes

Areas needing further work

Chronic disease

- Chronic diseases (for example, circulatory disease, cancer, diabetes, respiratory disease, kidney disease) were the cause of a large proportion of Indigenous hospitalisations in the Australian Capital Territory between 2008–09 and 2009–10. Aboriginal and Torres Strait Islander people were hospitalised at almost 4 times the rate of non-Indigenous Australians from diabetes, and almost twice the rate from circulatory diseases.

Disability

- In 2008, 63% of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory had a disability or long-term health condition. Of these, about 12% had a profound or severe core activity limitation.

Low birthweight

- Low birthweight is more than twice as common among babies of Aboriginal and Torres Strait Islander mothers as among babies of non-Indigenous mothers in the Australian Capital Territory (13% compared with 5%).

Determinants of Health

Areas of improvement

Education

- The proportions of Aboriginal and Torres Strait Islander students achieving literacy and numeracy benchmarks are generally higher in the Australian Capital Territory than the national average. Between 2009 and 2011 there has been a general increase in the proportion of Indigenous students at or above the national minimum standard for Year 3 spelling (from 78% to 88%) and grammar/punctuation (78% to 87%), and Year 5 reading (77% to 86%), spelling (73% to 84%) and grammar/punctuation (75% to 84%).
- Apparent retention rates from Year 11 to Year 12 are higher for Aboriginal and Torres Strait Islander people in the Australian Capital Territory (80% for males, 75% for females) than for Indigenous people nationally (66% for males, 69% females).

Areas needing further work

Smoking during pregnancy

- In 2009 in the Australian Capital Territory, 51% of Aboriginal and Torres Strait Islander mothers smoked during pregnancy, which after adjusting for differences in age structure, was 3 times the rate of non-Indigenous mothers.

Risky alcohol consumption

- In 2004–05, while only 11% of Aboriginal and Torres Strait Islander adults in the Australian Capital Territory reported drinking alcohol at long-term risky/high-risk levels in the past 12 months which was lower than for Indigenous persons nationally (16%), over half (51%) reported drinking alcohol at short-term risky/high-risk levels in the past 12 months which was higher than for non-Indigenous people in the Australian Capital Territory (40%) and for Indigenous people nationally (47%).

Overweight and obesity

- About 36% of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory were obese in 2004–05 compared with 19% of non-Indigenous people.

Education

- Despite some improvements in literacy and numeracy, the proportion of Aboriginal and Torres Strait Islander students in the Australian Capital Territory achieving the reading, writing and numeracy benchmarks in Years 3, 5, 7 and 9 remain below the corresponding proportions for all students.

Community safety

- Aboriginal and Torres Strait Islander people are more likely to experience exposure to violence, child abuse and neglect, and contact with the criminal justice system (including imprisonment) than other Australians in the Australian Capital Territory and across Australia.

Health System Performance

Areas of improvement

Chronic disease detection and management

- There has been a significant increase in health assessments provided to Aboriginal and Torres Strait Islander people aged 55 years and over in the Australian Capital Territory since the introduction of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes in July 2009.
- There has also been an increase in the total number of allied health-care services claimed through Medicare by Aboriginal and Torres Strait Islander people in the Australian Capital Territory between 2009–10 and 2010–11 from 784 to 1,349 services.
- Rates of general practitioner management plan claims (GPMPs) and team care arrangements (TCAs) were more than twice as high for Aboriginal and Torres Strait

Islander people compared with non-Indigenous Australians in the Australian Capital Territory in 2010–11.

Immunisation

- Immunisation coverage rates for Aboriginal and Torres Strait Islander children are lower than for other Australian children at age 1 and 2 (although these differences are not statistically significant), and are close to those for other children by age 5.

Areas needing further work

Access to health care

- In 2004–05, about one-third (35%) of Aboriginal and Torres Strait Islander people in the Australian Capital Territory reported they had accessed some type of health care in the last two weeks. This was lower than the proportion of Indigenous people across Australia who had accessed health care (42%) (Table 3.14.1).
- Aboriginal and Torres Strait Islander resident in the Australian Capital Territory were discharged from hospital against medical advice at 3 times the rate of non-Indigenous Australians between July 2008 and June 2010.

Screening

- Breast cancer screening rates in the Australian Capital Territory for Aboriginal and Torres Strait Islander women aged 40 and over are lower than for other women of this age (24% compared with 30% in 2008–09).

Health workforce

- In 2006, 2.1% of Aboriginal and Torres Strait Islander people aged 15 and over living in the Australian Capital Territory were employed in health-related occupations.
- Aboriginal and Torres Strait Islander people are under-represented in training for various health professions. In 2010, 0.7% of undergraduate students enrolled in health related courses in the Australian Capital Territory were Indigenous. There were no undergraduate health-related course completions by Indigenous people in the Australian Capital Territory in 2010.

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

		National	Australian Capital Territory					
		Current period	Current period			Trends		
Topic	Measure—Indigenous population	Indig	Indig	Non-Indig	Gap[(b)]	Indig	Non-Indig	Gap[(b)]
Health status and outcomes								
Low birthweight	Proportion of low-birthweight liveborn babies per 100 live births (2007–2009)	12.3	13.1*	5.2*	7.9	n.a.	n.a.	n.a.
Hospitalisations	Age-standardised hospitalisation rate for total hospitalisations (excluding dialysis) per 1,000 population (2008–09 to 2009–10)	408.5	227.0*	161.5*	65.5	n.a.	n.a.	n.a.
Disease incidence and prevalence	Age-standardised incidence rate of end-stage renal disease per 100,000 population (2008–2010) (NSW&ACT)	68.3	29.3*	9.7*	19.6	n.a.	n.a.	n.a.
Self-assessed health status	Age-standardised proportion of persons aged 15 and over reporting very good/excellent health (2007–08)	37.9	42.7*	56.1*	–13.4	n.a.	n.a.	n.a.
Community functioning	Recognises homeland (2008)	72	77	. .	. .	n.a.	. .	. .
	Speaks an Indigenous language (2008)	19	12	. .	. .	n.a.	. .	. .
	Lived in only 1 dwelling in past 12 months (2008)	78	82	. .	. .	n.a.	. .	. .
	Not a victim of physical or threatened violence in the last 12 months (2008)	75	69	. .	. .	n.a.	. .	. .
	Adult participated in sport/social/community activities in last 3 months (2008)	89	95	. .	. .	n.a.	. .	. .
Social & emotional wellbeing	Proportion of persons reporting high/very high levels of psychological distress (2008)	31.7	28.8	n.a.	n.a.	n.a.	n.a.	n.a.
Disability	Proportion of persons aged 18 and over with a profound or severe core activity limitation, non-remote (2008)	9.9	12.4	n.a.	n.a.	n.a.	n.a.	n.a.
Oral, ear and eye health	Proportion of children aged 4–14 with ear/hearing problems (2008)	10.1	14.6	n.a.	n.a.	n.a.	n.a.	n.a.
	Proportion of children aged 4–14 with teeth or gum problems (2008)	39.1	42.2	n.a.	n.a.	n.a.	n.a.	n.a.
	Proportion of children aged 4–14 with eye or sight problems (2008)	9.3	20.1	n.a.	n.a.	n.a.	n.a.	n.a.

(continued)

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

		National	Australian Capital Territory					
		Current period	Current period			Trends		
Topic	**Measure—Indigenous population**	**Indig**	**Indig**	**Non-Indig**	**Gap(b)**	**Indig**	**Non-Indig**	**Gap(b)**
Determinants of health								
Housing	Proportion of people aged 15 and over living in overcrowded households (2008)	25.1	6.3*	0.7*	5.6	n.a.	n.a.	n.a.
Environmental tobacco smoke	Proportion of children aged 0–14 living in households with daily smokers who smoke at home indoors (2008 and 2007–08)	21.6	13.4*	3.9*	9.5	n.a.	n.a.	n.a.
Education	Apparent retention rate for year 7/8 to Year 12—males (2011)	46.1	70.0*	87.2*	–17.2	n.a.	n.a.	n.a.
	Apparent retention rate for year 7/8 to Year 12—females (2011)	51.3	83.3*	92.0*	–8.7	n.a.	n.a.	n.a.
	Apparent retention rate for year 11 to Year 12—males (2011)	66.4	80.0*	87.7*	–7.7	n.a.	n.a.	n.a.
	Apparent retention rate for year 11 to Year 12—females (2011)	68.5	75.0*	87.4*	–12.4	n.a.	n.a.	n.a.
	Proportion of persons aged 25–64 who had a post-school qualification (2008)	40.2	63.3*	71.4*	–8.1	n.a.	n.a.	n.a.
Literacy & numeracy	Proportion of Year 3 students achieving reading benchmark(d) (2011)	76.3	86.8*	95.8*	–9.0	—	↑	—
	Proportion of Year 3 students achieving writing benchmark(d) (2011)	79.9	90.5*	96.3*	–5.8	. .	. .	. .
	Proportion of Year 3 students achieving numeracy benchmark(d) (2011)	83.6	88.9*	96.6*	–7.7	—	—	—
	Proportion of Year 3 students achieving spelling benchmark(d) (2011)	71.7	87.6*	94.9*	–7.3	↑	—	↓
	Proportion of Year 3 students achieving grammar/punctuation benchmark(d) (2011)	70.9	86.6*	95.3*	–8.7	↑	—	↓
Employment	Labour force participation rate (2008)	64.5	79.9	n.a.	n.a.	n.a.	n.a.	n.a.
	Unemployment rate (2008)	16.6	9.8	n.a.	n.a.	n.a.	n.a.	n.a.
Income	Proportion of persons aged 18 and over in the bottom 20% of equivalised gross weekly household income (2008)	49.2	21.3*	12.2*	9.1	n.a.	n.a.	n.a..
Transport	Proportion of households with at least one motor vehicle (2006)	71.9	82.9*	90.7*	–7.8	n.a.	n.a.	n.a..

(continued)

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

		National	Australian Capital Territory					
		Current period	Current period			Trends		
Topic	**Measure—Indigenous population**	**Indig**	**Indig**	**Non-Indig**	**Gap[b]**	**Indig**	**Non-Indig**	**Gap[b]**
Community safety and criminal justice	Proportion of persons aged 18 and over who reported they were a victim of physical or threatened violence in last 12 months (2008)	20.5	23.2*	9.4*	13.8	n.a.	n.a.	n.a.
	Age-standardised imprisonment rate per 100,000 adults (2011)	1,867.6	1,116.7*	87.5*	1,029.2	↑	↑	↑
	Rate of children aged 0–16 on child protection substantiations per 1,000 children (2010–11)	34.9	55.4*	4.4*	51.0	n.a.	n.a.	n.a.
Health behaviours	Proportion (age-standardised) of persons aged 15 and over who are current daily smokers (2008 and 2007–08)	44.6	35.9*	15.7*	20.2	n.a.	n.a.	n.a.
	Proportion (age-standardised) of persons aged 18 and over who drank at risky/high risk levels in last 12 months (2004–05)	47.0	51.0*	40.0*	11.0	n.a.	n.a.	n.a.
	Proportion (age-standardised) of persons aged 15 and over reporting sedentary levels of physical activity, non-remote areas (2004–05)	51	37*	24*	13	n.a.	n.a.	n.a.
	Age- standardised proportion of mothers who smoked during pregnancy (2009)	50.0	40.4*	11.7*	28.7	n.a.	n.a.	n.a.
	Proportion of infants (0–3) ever breastfed (2008)	75.5	73.0	n.a.	n.a.	n.a.	n.a.	n.a.
Overweight & obesity	Proportion (age-standardised) of persons aged 18 and over who are obese (2004–05)	33.6	36.4*	18.5*	17.9	n.a.	n.a.	n.a.
Health System Performance								
Early detection and prevention, health promotion	Proportion of 2 year olds fully vaccinated (2011)	92.3	85.7[c]	93.8[c]	–8.1	n.a.	n.a.	n.a.
	Age-standardised participation rates for women aged 40+ in BreastScreen Australia programs (2008–09)	24.5	23.7*[c]	29.9*[c]	–6.2	n.a.	n.a.	n.a.
	Rate per 1,000 of child 0–14 health checks (2010–11)	112.5	41.7	n.a.	n.a.	↑	n.a.	n.a.
	Rate per 1,000 of adult 15–54 health assessments (2010–11)	120.0	53.6	n.a.	n.a.	↑	n.a.	n.a.
	Rate per 1,000 of adult 55+ health assessments (2010–11)	209.3	111.4	n.a.	n.a.	↑	n.a.	n.a.

(continued)

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

		National	Australian Capital Territory					
		Current period	Current period			Trends		
Topic	**Measure—Indigenous population**	**Indig**	**Indig**	**Non-Indig**	**Gap(b)**	**Indig**	**Non-Indig**	**Gap(b)**
Chronic disease management/care planning	Age-standardised rate per 1,000 of General Practice Management Plans (GPMPs) (2010–11)	102	52*	24*	28	n.a.	n.a.	n.a.
	Age-standardised rate per 1,000 of Team Care Arrangements (TCAs) (2010–11)	83	43*	19*	24	n.a.	n.a.	n.a.
	Age-standardised rate per 1,000 of MBS allied health services provided (2010–11)	599	459*	285*	174	↑	n.a.	n.a.
Access to hospital procedures	Age-standardised proportions of hospitalisations with a procedure recorded (2008–09 to 2009–10)	60.0	72.5*	76.1*	–3.6	n.a.	n.a.	n.a.
Potentially preventable hospital admissions	Age-standardised hospitalisations rates for potentially preventable hospital admissions (2008–09 to 2009–10)	137.3	33.7*	17.4*	16.3	n.a.	n.a.	n.a.
Governance and cultural competency	Age-standardised per cent for discharge from hospital against medical advice (excluding mental and behavioural disorders) (2008–09 to 2009–10)	2.0	0.9*	0.3*	0.6	n.a.	n.a.	n.a.
	Proportion of Indigenous people experiencing discrimination (2008)	27.3	35.8	. .	. .	n.a.	. .	. .
	Proportion of Indigenous people aged 15 and over experiencing problems accessing health services (2008)	29.9	22.4	. .	. .	n.a.	. .	. .
Access to health services	Age-standardised rate per 1,000 population of MBS non-GP referred services claimed (2010–11)	6,376	6,595*	4,378*	2,217	n.a.	n.a.	n.a.
	Episodes of health care provided by Indigenous primary health care services – all clients (2010–11)	2,498,067	29,732	. .	. .	n.a.	. .	. .

(continued)

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

		National	Australian Capital Territory					
		Current period	Current period			Trends		
Topic	Measure—Indigenous population	Indig	Indig	Non-Indig	Gap(b)	Indig	Non-Indig	Gap(b)
Access to health services	Elective surgery waiting times in public hospitals– 50th percentile (days) (2010–11)	39	67	77	–10	n.a.	n.a.	n.a.
	Emergency department waiting times – proportion meeting national benchmark (2010–11)	66	56	58	–2	n.a.	n.a.	n.a.
	Age-standardised community mental health care service contacts per 1,000 population (2009–10)	841.8	1,767.0*	649.0*	1,118.0	n.a.	n.a.	n.a.
	Proportion of presentations to emergency departments which were after hours (2008–09 to 2009–10)	57.6	58.4	55.6	2.8	n.a.	n.a.	n.a.
	Whether usually goes to the same GP/health service (2004–05)	91.0	95.0	n.a.	n.a.	n.a.	n.a.	n.a.
Accreditation	Per cent of hospital admitted patient care episodes in accredited hospitals (2008–09 to 2009–10)	95.8	100.0	100.0	0.0	n.a.	n.a.	n.a.
	Proportion of general practices accredited	70.9	74.1	. .	. .	n.a.	. .	. .
Workforce, training and resources	Health workforce as a proportion of the Indigenous population aged 15 and over (2006)	2.0	2.1	. .	. .	n.a.	. .	. .
	Per cent of undergraduates enrolled in health related courses who were Indigenous (2010)	1.8	0.7	. .	. .	n.a.	. .	. .
	Per cent of VET students enrolled in health related courses who were Indigenous (2010)	4.7	1.2	. .	. .	n.a.	. .	. .

* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons at the $p < 0.05$ level.

(a) National data are the total jurisdictions combined for which data are available/reliable for reporting.

(b) Gap is the rate difference (Indigenous rate minus non-Indigenous rate).

(c) Comparison is Indigenous and Other Australians (where Other includes Indigenous status not stated).

(d) Benchmark applied to education data refers to proportion of students at or above national minimum standard.

↑ Statistically significant increase in long-term trends presented (see relevant measure in body of report and Appendix table for time period).

↓ Statistically significant decrease in long-term trends presented (see relevant measure in body of report and Appendix table for time period).

— No significant change in long-term trends presented (see relevant measure in body of report and Appendix table for time period).

n.a. Time trends data not available or not reported.

. . Not applicable.

Note: Figures reported in the current period column should not be compared as many of the measures are based on different denominators.

Introduction

This report provides information on a range of indicators on health status, determinants of health and 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 2012 report, detailed analysis*, the fourth in a series of reports against the Aboriginal and Torres Strait Islander Health Performance Framework (HPF). Analysis presented in this report includes both jurisdiction-specific measures and their comparison with national measures.

Detailed tables to support the analysis presented in this report can be found in Appendix 2 in the form of Excel tables.

The HPF comprises three tiers:

Tier 1—Health Status and Outcomes. This tier covers prevalence of health conditions (for example, circulatory disease, diabetes), human function (for example, disability), life expectancy and well-being 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 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 and dietary behaviours) and person-related factors (for example, prevalence of overweight and obesity). Such factors have been shown to have a strong association with both disease and ill-health.

Tier 3—Health Systems Performance. This 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, assess to secondary/tertiary care, the health workforce and expenditure.

The tiers and domains of the HPF and selected measures are shown in Figure 1. There are currently 68 indicators that can be reported against at national level but not all can be reported for the Australian Capital Territory 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 2012 policy report (AHMAC 2012). In addition, the Aboriginal and Torres Strait Islander population in the Australian Capital Territory is relatively small which poses a challenge for reporting data for many of the indicators included in this report. For example, for some indicators, data for the Australian Capital Territory is not able to be reported due to small numbers, and for other indicators several years of data is combined, or data for the Australian Capital Territory has been combined with data for New South Wales to allow large enough numbers to support analysis (see section on 'Data limitations' for more information).

Tier 1 - Health Status and Outcomes		
Health conditions 1.01 Low birthweight infants 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 C and sexually transmissible infections	**Human function** 1.13 Community functioning 1.14 Disability 1.15 Ear health 1.16 Eye health	**Deaths** 1.20 Infant and child mortality* 1.21 Perinatal mortality* 1.22 All causes age standardised deaths rates* 1.23 Leading causes of mortality* 1.24 Avoidable and preventable deaths*
	Life expectancy and wellbeing 1.17 Perceived health status 1.18 Social and emotional wellbeing 1.19 Life expectancy at birth*	
Tier 2 - Determinants of Health		
Environmental factors 2.01 Housing 2.02 Access to functional housing with utilities* 2.03 Environmental tobacco smoke	**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 behaviours* 2.20 Breastfeeding practices 2.25 Health behaviours during pregnancy
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 2.9 Index of disparity		**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 Selected potentially preventable hospital admissions 3.08 Cultural competency*	**Accessible** 3.14 Access to services compared with need 3.15 Access to prescription medicines* 3.16 Access to after-hours primary health care	**Capable** 3.19 Accreditation 3.20 Aboriginal and Torres Strait Islander people training for health related disciplines
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	**Continuous** 3.17 Regular GP or health service 3.18 Care planning for chronic diseases	**Sustainable** 3.21 Expenditure on Aboriginal and Torres Strait Islander health compared to need* 3.22 Recruitment and retention of staff

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

* Measures for which ACT data are unavailable, or data are not of sufficient quality for reporting.

Note: The Safe domain of Tier 3 is measured within the National Health Performance Framework.

Demographic information

The preliminary estimated resident Aboriginal and Torres Strait Islander population of the Australian Capital Territory as at 30 June 2011 was about 6,000 people (ABS 2012), accounting for 0.9% of Australia's Indigenous population. Indigenous people represent 1.7% of the Australian Capital Territory population, which is lower than the proportion of Indigenous people in the total Australian population (3.0%).

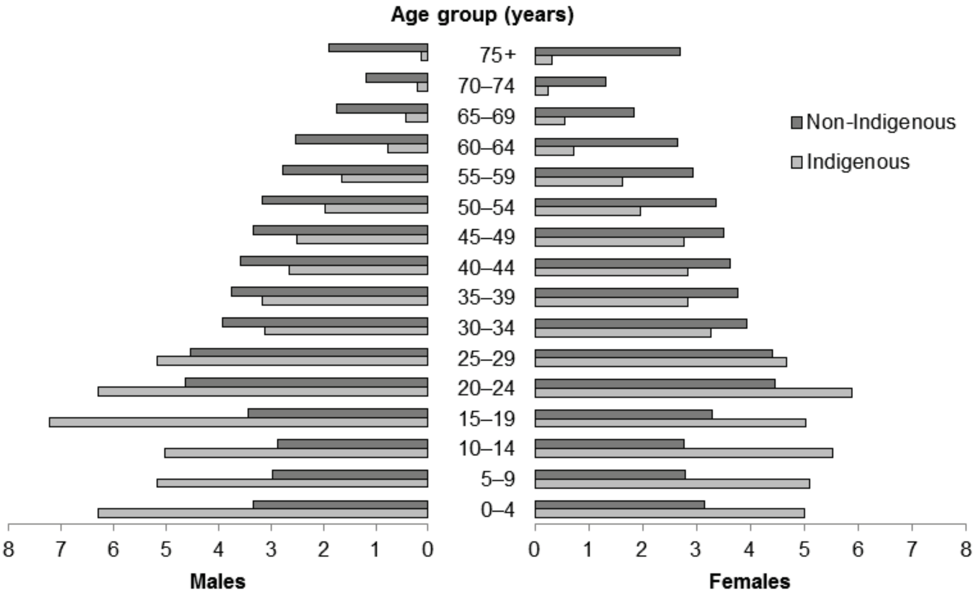
Table 1: Preliminary estimated resident population by Indigenous status, the Australian Capital Territory and Australia, 30 June 2011

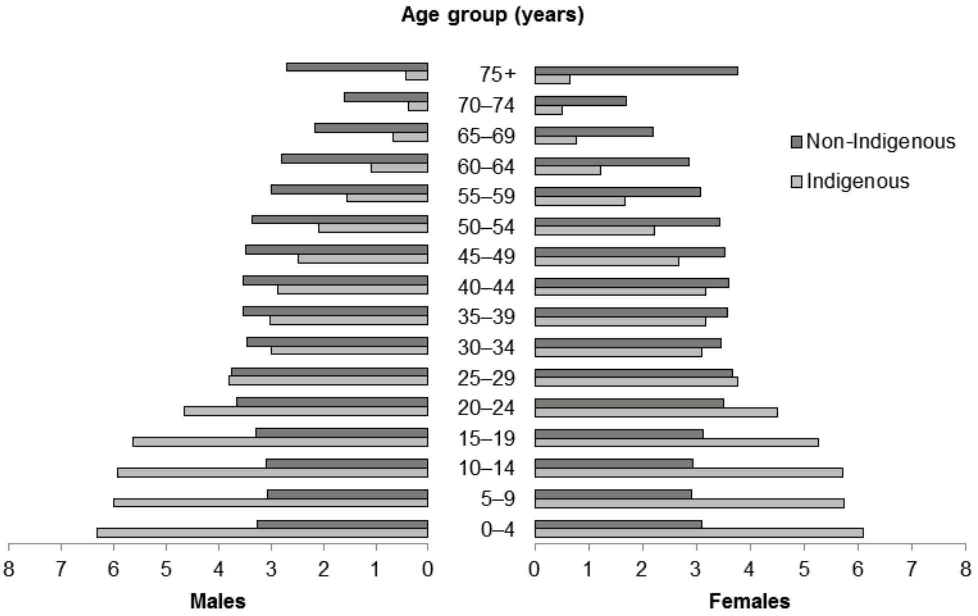
	Indigenous		Non-Indigenous		Total			
	Number	Per cent	Number	Per cent	Number	Per cent	Per cent Indig.	Per cent Non-Indig.
Australian Capital Territory	6,167	0.9	361,585	1.7	367,752	1.6	1.7	98.3
Australia[(a)]	**669,736**	**100.0**	**21,654,197**	**100.0**	**22,323,933**	**100.0**	**3.0**	**97.0**

(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 2011 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 about 18.1% of the total population in the Australian Capital Territory. Conversely, those aged 65 and over comprise only 1.9% of the Indigenous population, compared with 11% of the total Australian Capital Territory population (Figure 2).


Australian Capital Territory


Australia

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

Figure 2: Population profile, by Indigenous status, age and sex, the Australian Capital Territory and Australia, 2011

Structure of this report

Part 1 presents analyses for Tier 1—Health Status and Outcomes; Part 2 presents analyses for Tier 2—Determinants of Health, and Part 3 presents analyses for Tier 3—Health System Performance. For each indicator, jurisdiction-specific data are analysed in comparison with national data, or data from a group of jurisdictions with sufficient data quality. Where possible, analyses are presented by age, sex and Indigenous status. Time trends are also presented where data are available.

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).

Detailed tables for each indicator are presented in Appendix 2 in the form of Excel tables. These include all tables included in this report, the underlying data used in Figures presented in this report, and tables which support statements made in the text of this report for which a table or figure is not presented (these are dot points with a reference to Appendix 2 in brackets at the end).

Data sources and methodology

Data in this report come from around 30 data sources (26 administrative data sets and 3 surveys). A description of all sources is in Appendix 1.

Health-related administrative data sets include the Australian Institute of Health and Welfare's (AIHW) National Hospital Morbidity Database, the AIHW Community Mental Health Care Database, the AIHW National Perinatal Data Collection, the Australia and New Zealand Dialysis and Transplant Registry, the National Notifiable Diseases Surveillance System, and the Medicare database. Administrative data related to education include the Australian Bureau of Statistics (ABS) National Schools Statistics Collection, Department of Education, Employment and Workplace Relations (DEEWR) Higher Educations Statistics Collection and the National Centre for Vocational Education Research database. Community services related data include the AIHW National Child Protection Data collections.

Surveys that were used to obtain data include Indigenous specific surveys such as the National 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.

Age-standardised rates, rate differences and rate ratios have been used in many of the indicators to show how the Indigenous population fares relative to other Australians. All age-standardised rates and rate ratios have been calculated using the direct standardisation method and the 2001 Australian population as the standard population.

Time series analyses have used linear regression analysis to determine whether there have been significant increases or decreases in the observed rates. Many of the tables also include an asterisk (*) to indicate that rates for the Indigenous and non-Indigenous populations are statistically different from each other at the $p < 0.05$ level.

Data limitations

There are a number of limitations of data in this report that should be noted. The main issue in most administrative data collections is the under-identification of Aboriginal and Torres Strait Islander people. Under-identification is a major problem in mortality, hospital morbidity and communicable disease data, particularly in some states and territories. Data analysis has therefore been limited to jurisdictions with adequate identification of Aboriginal and Torres Strait Islander people. Appendix 1 presents a description of each data source and their main data limitations and data quality issues relating to Indigenous status.

Currently the Australian Capital Territory is not considered to have adequate mortality data for reporting, mainly because of the small Aboriginal and Torres Strait Islander population and therefore low number of Indigenous deaths in the Territory. Hospitalisation rates for the most recent reporting period have been presented in this report with caveats and should be interpreted with caution due to both small numbers and Indigenous under-identification in hospital separations data.

Data on communicable diseases from the National Notifiable Disease Surveillance System have been assessed and found to have varying levels of completeness across diseases and jurisdictions. The Australian Capital Territory had insufficient Indigenous identification for chlamydia and hepatitis C, but adequate identification for syphilis and gonorrhoea, hepatitis B and pneumonia.

The incompleteness of Indigenous identification means the number of hospital separations, deaths and disease notifications recorded as Indigenous result in underestimates of the true levels of hospitalisation and mortality.

Surveys are also subject to a number of data limitations due to sampling and non-sampling errors, such as bias in responses. In most tables in this report, estimates with large relative standard errors (between 25% and 50%), which is a measure of the sampling variability, have been footnoted to indicate that they should be used with caution or are considered too unreliable for general use. Data with estimated relative standard errors of larger than 50% are not published.

Small numbers, volatility and impact on Interpretation of changes over time

Due to the small size of the Aboriginal and Torres Strait Islander population in the Australian Capital Territory, many of the indicators included in this report are subject to small number issues. For some indicators, no data is reported as numbers are too small to publish. For other indicators, some data for the ACT has been combined with New South Wales because of its closeness in geographic proximity in order for numbers to be large enough to report. Some survey data reported involving small numbers have high relative standard errors and should be interpreted with caution.

Both small numbers and volatility in the data from year to year make it difficult to detect significant changes over time, and can greatly impact on any conclusions reached from a trend analysis. This is a particular problem when analysing trends for small populations such as the Aboriginal and Torres Strait Islander population in the smaller jurisdictions such as the Australian Capital Territory.

Statistical methods can be used to model trend data in various ways and to determine whether there is a statistically significant trend. Time series analyses presented throughout this report have used linear regression analysis to determine whether there have been significant increases or decreases in the observed rates over the period. Regression analysis has several advantages over other techniques for assessing trends. In general, regression modelling has the advantage of jointly considering the information contained in the series of rates (i.e. taking into account volatility from year to year), rather than considering each time point separately.

In this report, the average annual change in rates, rate ratios and rate differences are calculated using linear regression which uses the least squares method to calculate a straight line that best fits the data and returns an array that best describes the line. The simple linear regression line, $Y = a + bX$, or 'slope' estimate is used to determine the average annual change in the data over the period. The 95% confidence intervals (CIs) for the standard error of the slope estimate (average annual change) are used to determine whether the apparent increases or decreases in the data are statistically significant at the $p<0.05$ level.

The per cent change estimates presented in this report use the slope estimate to derive an end point in the time series, rather than the actual end point. This overcomes the problem of being reliant on the end data point to determine the significance of the trend. However the first data point in the time series is still used in the per cent change calculation and therefore care must be taken in selecting a sensible starting point.

Great care should be taken when assessing apparent changes over time, particularly those involving small numbers and a small number of data points.

Data improvement activities

All jurisdictions are working towards improving the quality of Indigenous status in health data collections.

States and territories have agreed to improve Aboriginal and Torres Strait Islander data collection procedures in key data collections including implementation of the *National best practice guidelines for the collection of Indigenous status in health data sets* published by the AIHW in 2008.

The AIHW is working with the states and territories in the development of an enhanced Perinatal National Minimum Data Set (NMDS) to include nationally consistent data items on antenatal care, smoking and alcohol use during pregnancy, and Indigenous status of the baby. Nationally consistent data items on smoking during pregnancy, gestational age at first antenatal visit, and Indigenous status of the baby have been added to the Perinatal NMDS (from 1 July 2009, 1 July 2010, and 1 July 2012 respectively). A data item on number of antenatal visits will be included in the Perinatal NMDS from 1 July 2013. Work is underway to progress data elements related to alcohol use in pregnancy.

The ABS and the AIHW work in partnership with jurisdictions to lead analysis of the level of Indigenous identification in key data sets. As part of this work, the AIHW conducted a study in 2011–12 to assess the level of under-identification in public hospitals data, which was a repeat of a study conducted in 2007. All states and territories have participated in the study to assess improvements in data quality. A report on the findings is expected to be published in April 2013, which will include new correction factors for the level of Indigenous under-identification in hospital separations data at the national, state/territory and remoteness levels.

As part of the data development work funded under the National Indigenous Reform Agreement (NIRA), the ABS will link Census records with death registration records to assess the level of identification in relation to the 2011 Census (this was undertaken for data from the 2006 Census and will be repeated).

The AIHW is also undertaking a project to develop an Enhanced Mortality Database by linking death registration records to several additional data sources that contain information on Aboriginal and Torres Strait Islander deaths (hospital, perinatal and residential aged care data). The enhanced data are expected to enable more accurate estimates of Aboriginal and Torres Strait Islander mortality, including life expectancy, to be made. Results from phase 1 of the project, which linked data for 2001 to 2006, produced national estimates of Aboriginal and Torres Strait Islander life expectancy at birth of 66.6 years for males and 72.7 for females, which was similar to the estimates produced by the ABS (AIHW 2012c).

Population data

Aboriginal and Torres Strait Islander population data are required when computing rates from administrative data collections. While the 2011 preliminary estimated resident population is the latest available data that gives an estimate of the number of Aboriginal and Torres Strait Islander people in the population, estimates are not yet available from the 2011 Census for years pre or post 2011. Denominators used to calculate proportions and rates in this report are therefore based on Aboriginal and Torres Strait Islander population estimates and projections from the 2006 Census (ABS 2009).

The Census enumerated the Aboriginal and Torres Strait Islander population from responses to a question on a person's Indigenous status. The Indigenous ERP for 2006 is computed using this enumerated figure, and adjusted for undercount based on results from the Post-Enumeration Survey (PES) as well as for non-response to the Indigenous status question (ABS 2009). Population numbers for other years are projected based on assumed future levels of fertility, mortality and migration (ABS 2009).

Statistical definitions

A number of statistic terms are used in this report. The definitions are:

Incidence is the number of new cases (of an illness or event, and so on) occurring during a given period.

Prevalence is the number or proportion (of cases, instances, and so forth) in a population at a given time.

Crude rate in this report refers to the number or proportion (of cases, instances, and so forth) in a population at a given time, unadjusted for age differences across the Indigenous and non-Indigenous populations

Age-standardised rate in this report refers to a directly age-standardised rate in which the age-specific rates are multiplied by a constant population. This effectively removes the influence of the age structure on the summary rate to enable comparisons to be made between populations that have different age structures such as the Indigenous and non-Indigenous populations.

Rate ratio is calculated by dividing the rate for Aboriginal and Torres Strait Islander people with a particular characteristic by the rate for non-Indigenous Australians with the same characteristic.

Rate difference is calculated by subtracting the rate for Aboriginal and Torres Strait Islander people from the rate for non-Indigenous Australians for the characteristic of interest.

Statistically significant difference, for example between Indigenous and non-Indigenous or over time, is denoted as 'significant' in the text and denoted with a * against relevant statistics in tables. The word 'significant' is not used outside its statistical context.

Average annual change is used for rates, rate ratios and rate differences to reflect the average annual change in these statistics over the specified period.

Percentage change is used for rates, rate ratios and rate differences and is the difference between the first year and the last year of the specified period based on the average annual change over the period.

Other definitions

The term 'Indigenous Australians' has been used interchangeably with 'Aboriginal and Torres Strait Islander people' throughout this report to refer to persons who have identified as being of Aboriginal and/or Torres Strait Islander origin.

Part 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 and 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*

Health outcomes

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 *

* Data is not available for the Australian Capital Territory for these indicators.

The first part of this report, Health Status and Outcomes, presents Tier 1 measures of the Aboriginal and Torres Strait Islander Health Performance Framework. It provides measures of the health status of Aboriginal and Torres Strait Islander people on a range of health issues. Data are presented on the health conditions that cause the highest morbidity and mortality among the Indigenous population. Comparisons with the non-Indigenous population and changes over time are examined to assess whether the gap is narrowing or widening. Tier 1 comprises four sections: Health conditions, Human function, Life expectancy and wellbeing, and Health outcomes.

Health conditions

This section presents data for 12 measures that cover the leading causes of morbidity and mortality in the Aboriginal and Torres Strait Islander population (such as injury, respiratory diseases, circulatory diseases, cancer, diabetes, kidney disease, oral health and sexually transmitted infections, or STIs), as well as low birthweight.

Data on incidence and prevalence of acute rheumatic fever or rheumatic heart disease is collected by the Northern Territory Rheumatic Heart Disease Program located in the Northern Territory. It is not currently collected in other jurisdictions. Therefore this data is not available for the Australian Capital Territory.

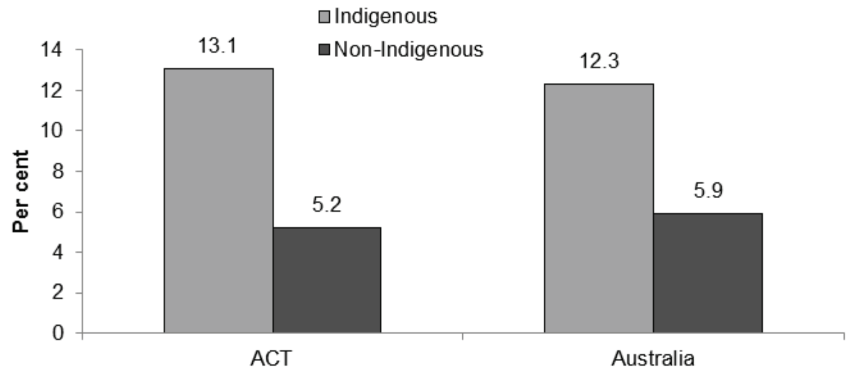
1.01 Low birthweight

Birthweight is a key indicator of infant health and a principal determinant of a baby's chance of survival and good health. For newborns, low birthweight (defined as less than 2,500 grams) poses a greater risk of lengthy hospitalisation after birth, the need for resuscitation, and death. Low birthweight is a risk factor for neurological and physical disabilities and for ill health in childhood, with the risk of adverse outcomes increasing with decreasing birthweight (Ford et al. 2003).

Data are presented on the proportion of low birthweight babies born to Aboriginal and Torres Strait Islander mothers using data from the National Perinatal Data Collection.

Key findings

- Over the three year period from 2007 to 2009 in the Australian Capital Territory, liveborn babies born to Aboriginal and Torres Strait Islander mothers were more than twice as likely to be of low birthweight as live-born babies born to non-Indigenous mothers (13% compared with 5%) (Figure 1.01.1).
- These figures were slightly lower for Australia; however, babies born to Aboriginal and Torres Strait Islander mothers were still about twice as likely to be of low birthweight as babies born to non-Indigenous mothers (12% compared with 6%) (Figure 1.01.1).



Source: AIHW (unpublished) National Perinatal Data Collection.

Figure 1.01.1: Proportion of low birthweight liveborn babies, by Indigenous status of mother, the Australian Capital Territory and Australia, 2007–2009

1.02 Top reasons for hospitalisation

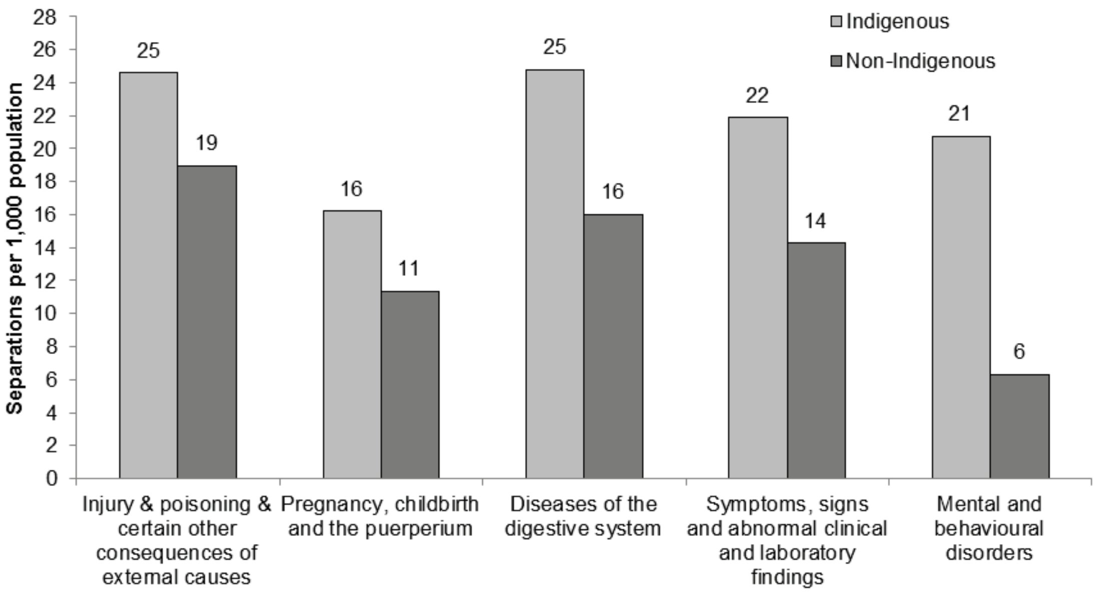
Hospitalisation rates can be an indicator of the health of a population, although they only represent the most serious cases of ill health requiring inpatient hospital treatment (SCRGSP 2009). Rates of hospitalisation also indicate access to and use of hospital treatment, which is also affected by the availability of primary care and other services.

National comparisons for hospital data are presented for New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined. AIHW has assessed these six jurisdictions as having adequate identification of Indigenous hospitalisations in 2008–10. Hospital data for the Australian Capital Territory should be considered with caution due to the small number of hospitalisations.

Data are presented on the leading causes of hospitalisation (at the International Classification of Diseases and Related Health Problems 10th Revision, Australian Modification (ICD–10 AM) Chapter level of diseases) among the Indigenous population compared with the non-Indigenous population.

Key findings

- Between July 2008 and June 2010, there were 1,688 hospitalisations of Aboriginal and Torres Strait Islander people in the Australian Capital Territory (excluding dialysis) (Table 1.02.1, Appendix 2).
- Aboriginal and Torres Strait Islander people in the Australian Capital Territory were hospitalised at 1.4 times the rate of non-Indigenous people, which is similar to the rate ratio in the six jurisdictions combined (New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory) (ratio of 1.3).
- The most common principal diagnosis for hospitalisations among Aboriginal and Torres Strait Islander people in the Australian Capital Territory, excluding health conditions involving dialysis, was injury and poisoning (representing 9% of Indigenous hospitalisations), followed by pregnancy and childbirth (6.5%), and diseases of the digestive system (5.7%). For non-Indigenous persons in the Australian Capital Territory, the most common principal diagnoses for hospitalisations excluding dialysis was injury and poisoning (9%), followed by diseases of the digestive system (7.6%), and symptoms, signs and abnormal clinical and laboratory findings (6.6%).
- After adjusting for differences in age-structure, Aboriginal and Torres Strait Islander persons in the Australian Capital Territory were hospitalised for injury and poisoning at 1.3 times the rate; and for diseases of the digestive system at 1.5 times the rate, of non-Indigenous persons. The largest difference was observed for mental and behavioural disorders, for which Indigenous persons in the Australian Capital Territory were hospitalised at 3.3 times the rate of non-Indigenous persons (rate difference of 14.4 per 1,000) (Figure 1.02.1).



Source: AIHW analyses of National Hospital Morbidity Database.

Figure 1.02.1: Hospitalisation rates (age-standardised) per 1,000 by principal diagnosis and Indigenous status, the Australian Capital Territory, July 2008 to June 2010

1.03 Injury and poisoning

Injury and poisoning are large contributors to Indigenous ill health, especially for younger people, and comprised 15% of the health gap between Indigenous and non-Indigenous Australians in 2003 (Vos et al. 2007). Various factors can affect a person's risk of injury, including age, gender, and socioeconomic status. The incidence of intentional injury is much more common among Aboriginal and Torres Strait Islander people than other Australians, reflecting issues including disadvantage, grief and discrimination (AHMAC 2006).

Injury data can be viewed in terms of the damage sustained to the body (for example, broken bones, head injuries), or by the external cause of the injury (for example, falls, poisoning and drowning), both of which are recorded by hospitals on admission.

Data are presented on hospitalisations with a principal diagnosis of injury and poisoning for Aboriginal and Torres Strait Islander Australians compared with non-Indigenous Australians.

Key findings

- Between July 2008 and June 2010, there were 257 hospitalisations of Aboriginal and Torres Strait Islander people with a principal diagnosis of injury and poisoning in the Australian Capital Territory (Table 1.03.1, Appendix 2).
- After adjusting for differences in age structure, Aboriginal and Torres Strait Islander people were hospitalised for injury and poisoning at 1.3 times the rate of non-Indigenous people in the Australian Capital Territory (24.6 compared with 18.9 per 1,000 population) (Table 1.03.1, Appendix 2).

1.04 Respiratory diseases

Respiratory diseases are leading causes of illness, disability and mortality around the world. Common among them are asthma, chronic obstructive pulmonary disease, influenza and pneumonia. While all respiratory diseases result in high use of health services, pneumonia and chronic obstructive pulmonary disease, in particular, are leading underlying causes of death. Aboriginal and Torres Strait Islander Australians experience considerably greater mortality and morbidity from respiratory diseases than other Australians.

Data are presented on hospitalisations with a principal diagnosis of respiratory disease for Aboriginal and Torres Strait Islander Australians compared with non-Indigenous Australians.

Key findings

- Between July 2008 and June 2010 in the Australian Capital Territory, there were 100 hospitalisations of Aboriginal and Torres Strait Islander people with a principal diagnosis of respiratory diseases (rate of 12.8 per 1,000 population) (Table 1.04.1).
- After adjusting for differences in age structure, Aboriginal and Torres Strait Islander people in the Australian Capital Territory were hospitalised for respiratory diseases at about the same rate of non-Indigenous people. In New South Wales, Victoria, Queensland, South Australia, Western Australia and the Northern Territory combined, Indigenous people were hospitalised for respiratory diseases at almost 3 times the rate of non-Indigenous people (Table 1.04.1).
- Between July 2008 and June 2010, in the Australian Capital Territory, Indigenous people were hospitalised for respiratory diseases at 12.8 per 1,000 population which was lower than for Indigenous people in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (43.2 per 1,000) (Table 1.04.1).

Table 1.04.1: Hospitalisations for all respiratory diseases for Aboriginal and Torres Strait Islander people, by sex, the Australian Capital Territory and NSW, Vic, Qld, WA, SA & NT combined, July 2008 to June 2010

	Australian Capital Territory				NSW, Vic, Qld, WA, SA & NT			
	Number	Number per 1,000	Rate ratio	Rate difference	Number	Number per 1,000	Rate ratio	Rate difference
Males	55	9.3	0.9	–1.4	17,475	43.3	2.5*	25.8*
Females	45	16.2	1.8*	7.1*	17,868	43.5	3.0*	28.8*
Persons	100	12.8	1.3	3.0	35,343	43.2	2.7*	27.3*

* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons at the $p < 0.05$ level.

Source: AIHW analyses of National Hospital Morbidity Database.

1.05 Circulatory disease

Cardiovascular diseases include coronary heart disease, stroke, peripheral vascular disease, heart failure and rheumatic heart disease. Collectively, these diseases are the largest cause of death in Australia, and account for the largest health-care expenditure of any disease group (AIHW 2011a). Circulatory disease accounted for 17% of the burden of disease in Aboriginal and Torres Strait Islander people in 2003 (Vos et al. 2007) and 26% of mortality in 2006–10 (see indicator 1.23).

Data are presented on prevalence of heart and circulatory problems from the 2004-05 NATSIHS, and hospitalisations with a principal diagnosis of circulatory disease for Aboriginal and Torres Strait Islander people.

Key findings

- In 2004-05, approximately 10% of Aboriginal and Torres Strait Islander persons in the Australian Capital Territory reported heart/circulatory problems. This compared to 12% of Indigenous persons nationally (ABS 2006).
- Between July 2008 and June 2010 in the Australian Capital Territory, Indigenous people were hospitalised for circulatory disease at a higher rate (22.3) than non-Indigenous people (14.0) (Table 1.05.1, Appendix 2).
- In the Australian Capital Territory, after adjusting for differences in age structure, Aboriginal and Torres Strait Islander people were hospitalised for circulatory diseases at 1.6 times the rate of non-Indigenous people, which is similar to the rate ratio in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (1.7 times).

1.07 High blood pressure

High blood pressure, also referred to as hypertension, is a major risk factor for a number of diseases, including stroke, coronary heart disease, kidney disease, and peripheral vascular disease. High blood pressure is more common among Aboriginal and Torres Strait Islander people than other Australians and is a major contributor to the increased risk of heart attack, stroke and other circulatory diseases among Aboriginal and Torres Strait Islander people (AIHW 2002).

Data are presented on high blood pressure during pregnancy from the 2008 NATSISS.

Key findings

- In 2008, the proportion of Aboriginal and Torres Strait Islander children aged 0–3 whose mother had high blood pressure during pregnancy was higher in the Australian Capital Territory than in Australia (21% compared with 14.3%) (Table 1.07.1). However this data should be treated with caution due to high relative standard errors (between 25% and 50%) (Table 1.07.1).
- During the period July 2008 to June 2010, there was only one hospitalisation recorded for Aboriginal and Torres Strait Islander persons with a principal diagnosis of hypertensive disease in the Australian Capital Territory.

Table 1.07.1: Number and proportion of Indigenous children aged 0–3 whose mother had high blood pressure during pregnancy, the Australian Capital Territory and Australia, 2008

	Number	Per cent
ACT	88*	21.0*
Australia	7,295	14.3

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

Note: Proportions exclude not known and not collected responses.

Source: 2008 NATSISS.

1.08 Cancer

Cancer was identified as a leading cause of morbidity and mortality in Australia in 2010, accounting for 19% of the total burden of disease (AIHW & AACR 2010). Recent research shows that the cancer survival rate is lower for Indigenous people who are diagnosed with cancer than non-Indigenous people (Cramb et al. 2012).

Data are presented on hospitalisations for a principal diagnosis of cancer for Indigenous and non-Indigenous Australians. Cancer incidence data is not considered of sufficient quality to report for Aboriginal and Torres Strait Islander people in the Australian Capital Territory because Indigenous status was not always recorded for these data.

Key findings

- Between July 2008 and June 2010 in the Australian Capital Territory, there were 18 hospitalisations for cancer of Indigenous people and 4,701 hospitalisations of non-Indigenous people (Table 1.08.1, Appendix 2).

1.09 Diabetes

Diabetes is a long-term (chronic) condition that can damage various parts of the body due to high glucose levels. Diabetes comprised 12% of the health gap between Indigenous and non-Aboriginal and Torres Strait Islander people in 2003 (Vos et al. 2007). Diabetes prevalence is higher for Aboriginal and Torres Strait Islander people than non-Indigenous Australians. Prevention, early detection and better management of diabetes will be important in closing the gap in life expectancy.

Data are presented from the 2004–05 NATSIHS on Indigenous persons with diabetes or high sugar levels; the 2008 NATSISS on mothers of Indigenous children who had diabetes or sugar problems during pregnancy; and hospitalisation rates for persons diagnosed with diabetes. NATSISS data on smoking during pregnancy for the Australian Capital Territory has been combined with New South Wales due to small numbers.

Key findings

- In 2004–05, approximately 4% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory reported diabetes or high sugar levels as a long-term health condition. This compared to 6% of Aboriginal and Torres Strait Islander people nationally (ABS 2006). The proportion for the Australian Capital Territory should be interpreted with caution due to a high relative standard error (between 25% and 50%).
- In 2008, 8.5%of Indigenous children aged 0–3 had mothers who had diabetes or sugar problems during pregnancy. This proportion was similar in New South Wales/Australian Capital Territory with 8.3% of children aged 0–3 having mothers who had diabetes or sugar problems during pregnancy. This estimate, however, should be interpreted with caution due to a high relative standard error (between 25% and 50%) (Table 1.09.1).
- Between July 2008 and June 2010, there were 34 hospitalisations of Indigenous people resident in the Australian Capital Territory with a principal diagnosis of diabetes mellitus. Indigenous people were hospitalised with a principal diagnosis of diabetes at a rate of 8.4 per 1,000 population. This was lower than the rate for New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (14.1 per 1,000 population) (Table 1.09.2, Appendix 2).

- After adjusting for differences in age structure, Indigenous people in the Australian Capital Territory were hospitalised for diabetes at 3.6 times the rate of non-Indigenous people. This data, however, should be interpreted with caution due to a small number of Indigenous hospitalisations (34) in comparison with non-Indigenous hospitalisations (1,476) (Table 1.09.2, Appendix 2).

Table 1.09.1: Number and proportion of Indigenous children aged 0–3 years whose mother had diabetes or sugar problems during pregnancy, New South Wales/Australian Capital Territory and Australia, 2008

	Number	Proportion
NSW/ACT	1,328*	8.3*
Australia	4,361	8.5

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

Note: Proportions exclude not known and not collected responses.

Source: 2008 NATSISS.

1.10 Kidney disease

The kidneys can be damaged by various acute illnesses (for example, severe infections) or by progressive damage from chronic conditions such as elevated blood pressure (untreated hypertension) and long-standing high blood sugar levels (untreated diabetes). If the kidneys cease functioning entirely (known as end-stage renal disease or kidney failure), it is necessary to have renal dialysis several times per week or undergo a kidney transplant (AIHW 2011a).

Kidney disease, in particular end-stage renal disease (ESRD), contributes substantially to the high burden of ill health experienced by Aboriginal and Torres Strait Islander people. Renal failure was estimated to contribute 5% of the burden of disease for Aboriginal and Torres Strait Islander people in 2003 (Vos et al. 2007). Aboriginal and Torres Strait Islander people have very high levels of ESRD due to a range of risk factors.

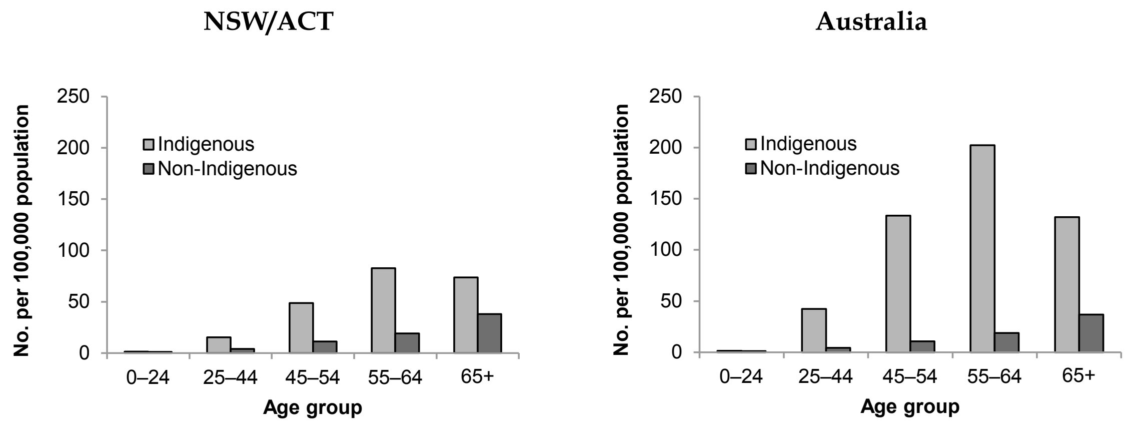
Data are presented on the incidence of ESRD among Aboriginal and Torres Strait Islander people using data from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA), as well as hospitalisation rates with a principal diagnosis of chronic kidney disease. ANZDATA for the Australian Capital Territory has been combined with New South Wales due to small numbers.

Key findings

- Between 2008 and 2010 in New South Wales/Australian Capital Territory, there were 82 cases of end-stage renal disease registered to ANZDATA for Aboriginal and Torres Strait Islander people. After adjusting for differences in age structure, the incidence rate of ESRD for Indigenous Australians was 3 times as high as non-Indigenous Australians (29 compared with 10 per 100, 000). Incidence rates for Aboriginal and Torres Strait Islander people were lower for New South Wales/Australian Capital Territory than nationally (29 and 68 respectively) (Table 1.10.1, Appendix 2).
- The incidence rate of ESRD for Aboriginal and Torres Strait Islander people was higher than for non-Indigenous Australians across all age groups. The greatest difference in incidence rates occurred in the 55–64 age group, where the incidence rate for Aboriginal

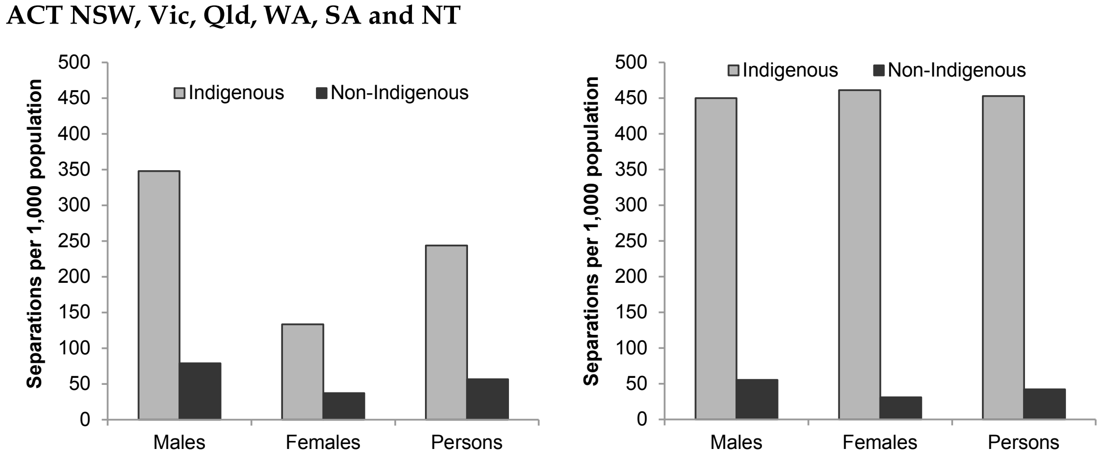
and Torres Strait Islander people was 4.3 times the rate for non-Indigenous Australians (Figure 1.10.1).

- Between July 2008 and June 2010, the age-standardised hospitalisation rate of dialysis and chronic kidney disease for Indigenous people was lower in the Australian Capital Territory than in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (244 compared with 453 per 1,000 population). Both Indigenous males and females were hospitalised for chronic kidney disease at around 4 times the rate of non-Indigenous Australians in the Australian Capital Territory (Figure 1.10.2).



Source: AIHW analyses of Australian and New Zealand Dialysis and Transplant Registry.

Figure 1.10.1: Age specific incidence rates of treated end-stage renal disease by Indigenous status and age group, New South Wales/Australian Capital Territory and Australia, 2008–2010



Source: AIHW analysis of National Hospital Morbidity Database.

Figure 1.10.2: Hospitalisations rate per 1,000 for dialysis and chronic kidney disease by Indigenous status and sex, the Australian Capital Territory and NSW, Vic, Qld, WA, SA and NT combined, July 2008 to June 2010

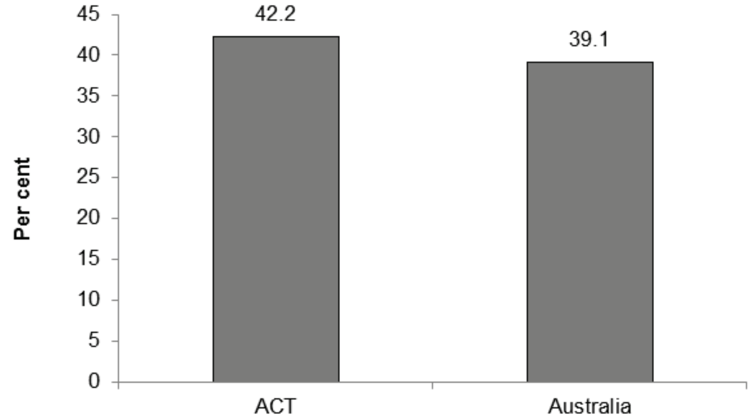
1.11 Oral health

Aboriginal and Torres Strait Islander people are more likely than other Australians to have a range of oral health problems such as having lost all their teeth and gum disease. They are more likely to have untreated teeth and gum disease and less likely to have received preventive dental care (Jamieson et al. 2010). Periodontal disease (that is, of the gums) is associated with poor oral hygiene, infrequent dental visits, smoking, low education and income levels, and certain medical conditions such as diabetes. Research has also found an association between periodontal disease and pre-term, low birthweight babies, rheumatoid arthritis and cardiovascular disease (NATSIHC & SCoATSIH 2003; Thompson et al. 2004) and with inhalant use (Jamieson et al. 2010).

Data are presented on the prevalence of teeth or gum problems for Aboriginal and Torres Strait Islander children using data from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and hospitalisation numbers for dental conditions for Indigenous Australians compared with non-Indigenous Australians.

Key findings

- In 2008 in the Australian Capital Territory, about 42% of Indigenous children aged 4–14 reported teeth or gum problems. This was higher than the proportion nationally (39%) (Figure 1.11.1).
- Between July 2008 and June 2010, there were 16 hospitalisations of Indigenous people in the Australian Capital Territory for dental problems and 276 hospitalisations for non-Indigenous people (Table 1.11.1, Appendix 2).



Source: AIHW analysis of 2008 NATSISS.

Figure 1.11.1: Number and proportion of Indigenous children aged 4–14 with reported teeth or gum problems, Australian Capital Territory and Australia, 2008

1.12 HIV/AIDS, hepatitis and sexually transmissible infections

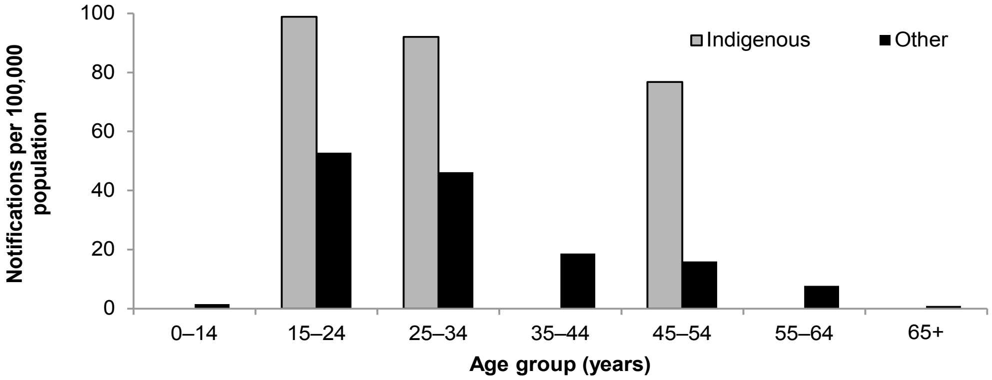
Bacterial STIs (including syphilis, chlamydia and gonorrhoea) can have serious long-term effects if not diagnosed or treated, such as infertility in women after gonorrhoea and chlamydia, and heart and brain damage caused by syphilis (Bowden et al. 2002; Couzos & Murray 2003). Hepatitis and Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) are viral infections that can both be fatal. Several STIs (chlamydia, gonorrhoea, syphilis and donovanosis) are much more common for Aboriginal and Torres Strait Islander people than for other Australians.

Data are presented on the rates of notified sexually transmissible infections for hepatitis B, gonorrhoea and syphilis, for Aboriginal and Torres Strait Islander people compared with other Australians using data from the National Notifiable Disease Surveillance System. Data for other STIs that are notifiable (donovanosis, chlamydia and hepatitis C) are not presented because the Indigenous status completeness for notifications of these diseases in the Australian Capital Territory is less than 50%, which is not considered sufficient for reporting.

No data is included for the Australian Capital Territory on HIV/AIDS notification rates due to the small number of cases.

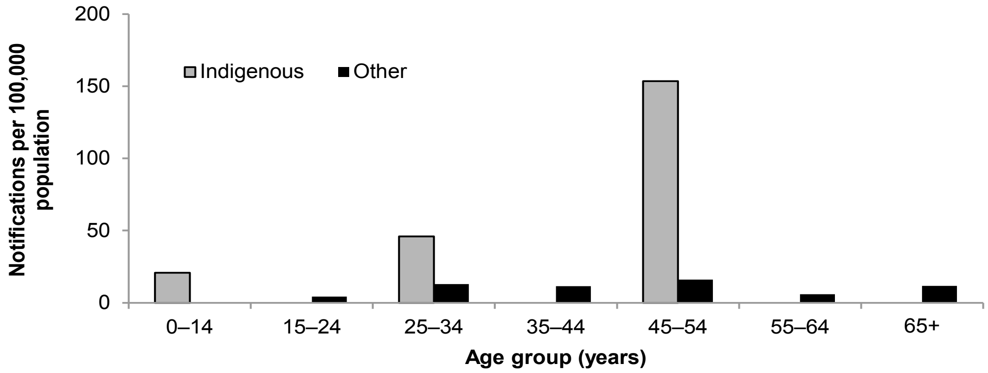
Key findings

- Between 2009 and 2011, there were 296 notifications of hepatitis B, 95 notifications of syphilis and 239 notifications of gonorrhoea in the Australian Capital Territory, of which 2%, 4% and 3% were for Aboriginal and Torres Strait Islander people, respectively.
- In the Australian Capital Territory, notification rates for gonorrhoea and hepatitis B were highest among Indigenous people aged 15–24 and notification rates for syphilis were highest among Indigenous people aged 45–54 (Figures 1.12.1, 1.12.2, 1.12.3).
- Notification rates in the Australian Capital Territory for gonorrhoea were higher among Indigenous people than other people for the 15–24, 25–34 and 45–54 year age groups. Notification rates for syphilis were higher among Indigenous than other people for the 0–14, 25–34 and 45–54 year age groups. Notification rates for hepatitis B were higher among Indigenous than other people for the 15–24 and 35–44 year age groups (Figures 1.12.1, 1.12.2, 1.12.3).
- Notification rates in the Australian Capital Territory for hepatitis B, syphilis and gonorrhoea were lower among Indigenous people in the Australian Capital Territory than in the jurisdictions combined with adequate coverage of Indigenous notifications (Figure 1.12.4).
- After adjusting for differences in age structure, notification rates for syphilis among Indigenous people in the Australian Capital Territory were 4 times as high as for other people, and notification rates for gonorrhoea were twice as high (Figure 1.12.4).



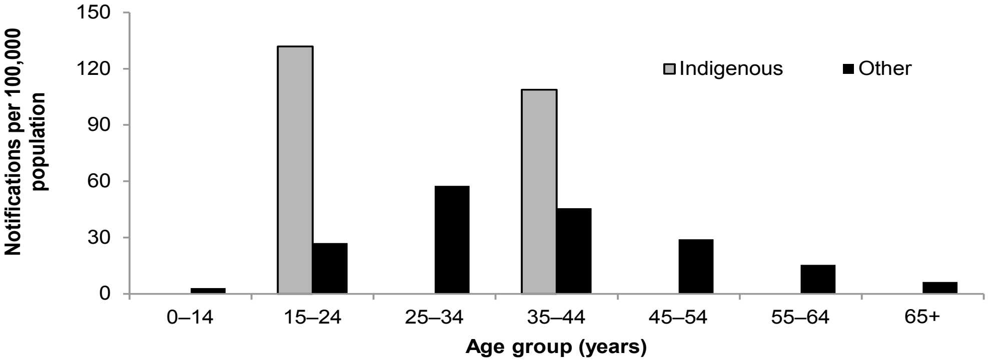
Source: AIHW analyses of NNDSS.

Figure 1.12.1: Age-specific notification rates for gonorrhoea, by Indigenous status, the Australian Capital Territory, 2009–2011



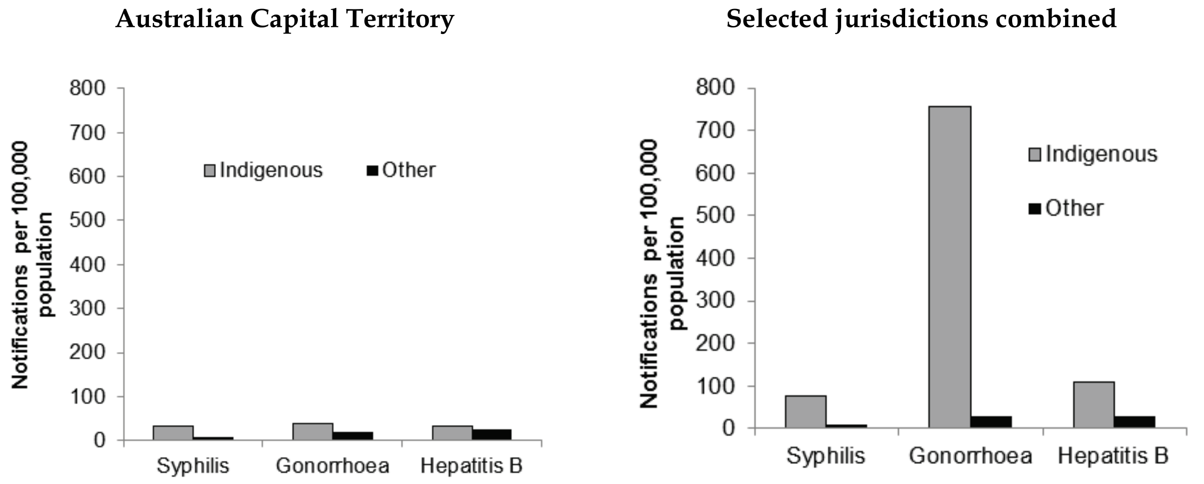
Source: AIHW analyses of NNDSS.

Figure 1.12.2: Age-specific notification rates for syphilis, by Indigenous status, the Australian Capital Territory, 2009–2011



Source: AIHW analyses of NNDSS.

Figure 1.12.3: Age-specific notification rates for hepatitis B, by Indigenous status, the Australian Capital Territory, 2009–2011



Source: AIHW analyses of NNDSS data.

Figure 1.12.4: Age-standardised notification rates for syphilis, gonorrhoea and hepatitis B, the Australian Capital Territory and selected jurisdictions combined, 2009–2011

Human function

A basic aspect of health and wellbeing is how well people function from day to day. The Aboriginal and Torres Strait Islander view of health recognises that achieving optimal conditions for health and wellbeing requires a holistic and whole-of-life view that encompasses the social, emotional and cultural wellbeing of the whole community (AIHW 2011a). This section presents information on 4 measures of human function: community functioning, disability, ear health and eye health.

1.13 Community functioning

Aboriginal and Torres Strait Islander people have long sought health outcomes encompassing the physical, social, cultural and emotional elements of life. This includes the ability to live proudly and freely as Aboriginal and Torres Strait Islander people. Functioning is about the things people achieve or experience, consistent with their account of wellbeing. The conversion of capabilities into functioning is influenced by the values and personal features of individuals, families and communities and by the environment in which they live. Hence it is likely that different cultures will give greater or lesser priority to different aspects of functioning (Office of Aboriginal Health et al. 2004).

Data are presented on selected measures of aspects of community functioning for Aboriginal and Torres Strait Islander people using data from the 2008 NATSISS.

Key findings

Connectedness to country, land and history; culture and identity

Of Aboriginal and Torres Strait Islander people in the Australian Capital Territory aged 15 and over:

- 77% reported recognition of their homeland, 12% spoke an Aboriginal or Torres Strait Islander language, 72% had attended an Aboriginal and Torres Strait Islander cultural event in the last 12 months and 71% identified with a clan or language group.
- 95% felt able to have a say with family and friends some, most, or all of the time, 97% had contact with family or friends from outside their household at least once a week and 83% had friends to confide in (Table 1.13.1, Appendix 2).

Resilience

Of Aboriginal and Torres Strait Islander people in the Australian Capital Territory aged 15 and over:

- 59% did not avoid situations due to past discrimination, 83% agreed that their doctor could be trusted and 65% agreed that the local school could be trusted.
- 28% of employed people said work allowed them to fulfil cultural responsibilities, 61% knew someone in an organisation they would feel comfortable contacting and 95% had participated in sport, social or community activities in the three months before the survey (Table 1.13.1, Appendix 2).

Having a role, structure and routine

Of Aboriginal and Torres Strait Islander people in the Australian Capital Territory aged 15 and over, 82% had lived in only one dwelling in the last 12 months (Table 1.13.1, Appendix 2).

Feeling safe

In the Australian Capital Territory, of Aboriginal and Torres Strait Islander people aged 15 and over, 82% felt safe at home alone after dark and 69% had not experienced physical and/or threatened violence in the last 12 months.

Vitality

Of Aboriginal and Torres Strait Islander people in the Australian Capital Territory aged 15 and over:

- 44% had no disability or long-term health condition and 71% had experienced low/moderate levels of psychological distress in the 4 weeks before the survey.
- 81% said they could easily get to places as needed (Table 1.13.1, Appendix 2).

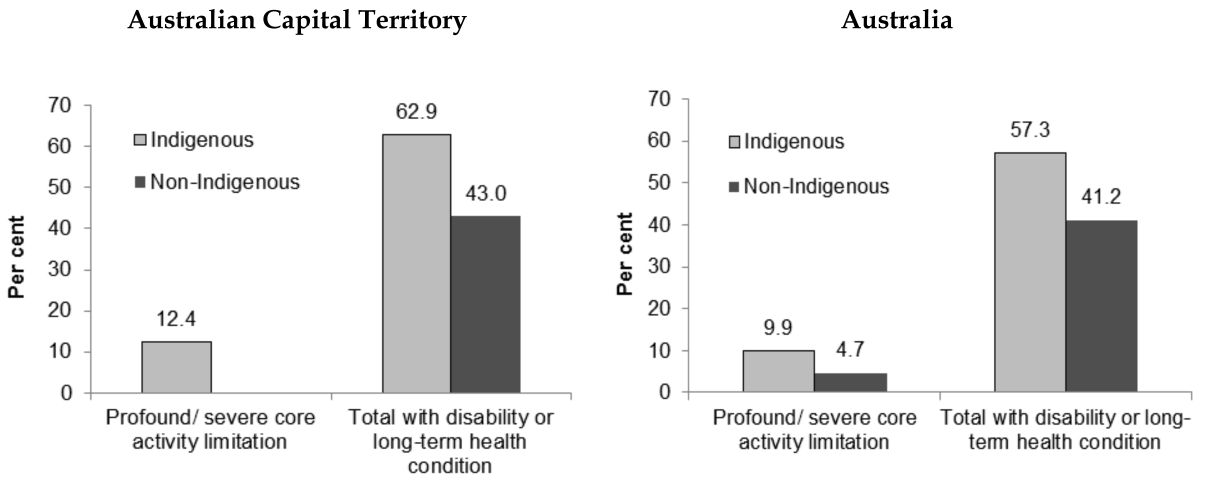
1.14 Disability

A disability may be an impairment of body structure or function, a limitation in activities, and/or a restriction in participation of a person in specific activities. Aboriginal and Torres Strait Islander people are at greater risk of disability in part because they may be more frequently subject to factors including low birthweight, chronic disease and infectious diseases (for example, otitis media, especially among young children). In addition, there may be increased risk of acquiring disability through accidents, injury and substance abuse.

Data are presented on the self-reported prevalence of disability among Aboriginal and Torres Strait Islander people using data from the 2008 NATSISS and the 2006 Census; and on the use of disability support services using data from the 2009–10 Disability Services National Minimum Data Set.

Key findings

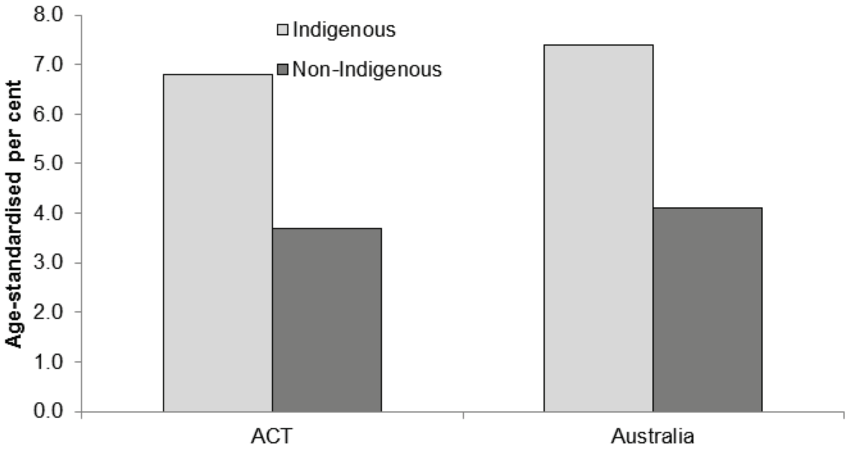
- According to the 2008 NATSISS, about 63% of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory had a disability or long-term health condition. Approximately 12% had a profound or severe core activity limitation meaning that they always or sometimes needed assistance with at least one activity of everyday living (self-care, mobility or communication) (Figure 1.14.1).These proportions were higher than those reported nationally for Indigenous Australians in non-remote areas of Australia (Figure 1.14.1).
- Indigenous Australians aged 18 and over were 1.5 times as likely as non-Indigenous Australians to have a disability or a long-term health condition in the Australian Capital Territory in 2008 (Figure 1.14.1).
- According to the 2006 Census, the proportion of Indigenous people who needed assistance with one or more core activities in the areas of self-care, mobility and communication, was around 4% in both the Australian Capital Territory and Australia.
- After adjusting for differences in age structure, Aboriginal and Torres Strait Islander people in the Australian Capital Territory were nearly twice as likely to have a core activity need for assistance than non-Indigenous people in 2006 (Figure 1.14.2).
- In 2009–10, Indigenous people in the Australian Capital Territory aged under 65 used disability support services at a much lower rate than non-Indigenous people (2 compared with 35 per 1,000 population). However, Indigenous people at the national level used disability services at a much higher rate than non-Indigenous people (28 compared with 13 per 1,000) (Table 1.14.1).



Note: Profound/ severe core activity limitation for non-Indigenous people in the Australian Capital Territory is not provided due to data quality.

Source: NATSISS 2008 and NHS 07-08.

Figure 1.14.1: Disability status by Indigenous status, persons aged 18 and over, age-standardised rates, the Australian Capital Territory and Australia non-remote, 2008



Source: ABS and AIHW analysis of 2006 Census.

Figure 1.14.2: Age-standardised proportion of people with a core activity need for assistance, by Indigenous status, the Australian Capital Territory and Australia, 2006

Table 1.14.1: Users of disability support services, persons aged under 65, by Indigenous status and sex, the Australian Capital Territory and Australia, 2009–10

	Indigenous			Non-Indigenous				
	Number	Crude no. per 1,000	Age std. no. per 1,000	Number	Crude no. per 1,000	Age std. no. per 1,000	Rate ratio	Rate difference
ACT								
Males	114	3.5	2.9	3,119	39.5	43.4	0.1	–40.5
Females	49	1.5	1.3	1,758	24.8	25.6	0.0	–24.3
Persons	163	2.5	2.1	4,877	32.6	34.7	0.1	–32.7
Australia								
Males	8,472	31.4	33.2	150,896	16.0	16.1	2.1	17.1
Females	5,398	20.1	22.0	98,614	10.7	10.6	2.1	11.4
Persons	13,873	25.8	27.6	249,594	13.4	13.4	2.1	14.2

Source: Unpublished data from the 2009–10 Disability Services National Minimum Data Set.

1.15 Ear Health

Hearing loss, especially in childhood, can lead to social and learning difficulties and behavioural problems in school, which may have a negative effect on educational outcomes. Hearing loss among Aboriginal and Torres Strait Islander people is widespread and much more common than in the broader Australian population.

Data are presented on prevalence of ear/hearing problems from the 2004-05 NATSIHS; children's ear health using self-reported prevalence data from the 2008 NATSISS and hospitalisation numbers for diseases of the ear and mastoid process.

Key findings

- According to the 2004-05 NATSIHS, approximately 14% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory reported ear or hearing problems. This compared to 12% of Indigenous persons nationally (ABS 2006).
- According to the 2008 NATSISS, about 15% of Indigenous children aged 4–14 in the Australian Capital Territory had ear or hearing problems. This compares with 10% of Indigenous children nationally (Table 1.15.1, Appendix 2). The proportion for the Australian Capital Territory should be used with caution due to a high relative standard error (between 25% and 50%).
- Between July 2008 and June 2010, in the Australian Capital Territory, there were 18 hospitalisations of Indigenous people and 673 of non-Indigenous people for diseases of the ear and mastoid process (Table 1.15.2, Appendix 2).

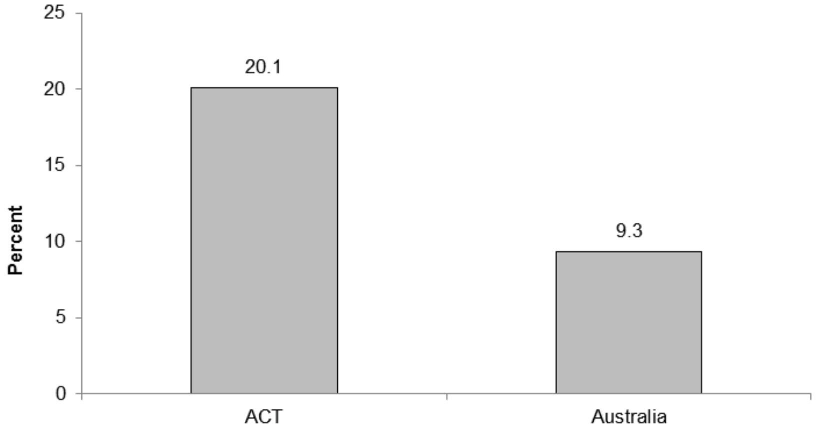
1.16 Eye Health

The World Health Organization (WHO) and the Australian Government have identified eye health as an important health area. Although often being unnoticed, eye illnesses affect a large proportion of Australians of all ages. Indigenous Australian are reported to be at higher risk of vision loss than the general population, with blindness rates among the Indigenous population 6 times those among non-Indigenous Australians (Taylor et al. 2011).

Data are presented on self-reported eye and sight problems among Aboriginal and Torres Strait Islander Australians using data from the 2008 National Indigenous Eye Health Survey; the 2008 NATSISS; and hospitalisation rates for diseases of the eye and adnexa.

Key findings

- According to the 2008 NATSISS, about 20% of Indigenous children aged 4–14 in the Australian Capital Territory were reported to experience eye or sight problems. This proportion was higher than for Indigenous persons nationally (9%) (Figure 1.16.1).



Note: Includes not known responses.

Source: ABS 2008 NATSISS.

Figure 1.16.1: Proportion of Indigenous children aged 4–14 reporting eye or sight problems, Australian Capital Territory and Australia, 2008

Life expectancy and wellbeing

Research shows that persons in better health in general have a longer life expectancy than those in poorer health (Lubitz et al. 2003).

In the previous section, measures on specific health conditions have been analysed. In this section, data on perceived health status and social emotional wellbeing is presented. Life expectancy for Aboriginal and Torres Strait Islander people in the Australian Capital Territory is unable to be calculated due to the small population size, and therefore small number of deaths of Indigenous persons in the Australian Capital Territory.

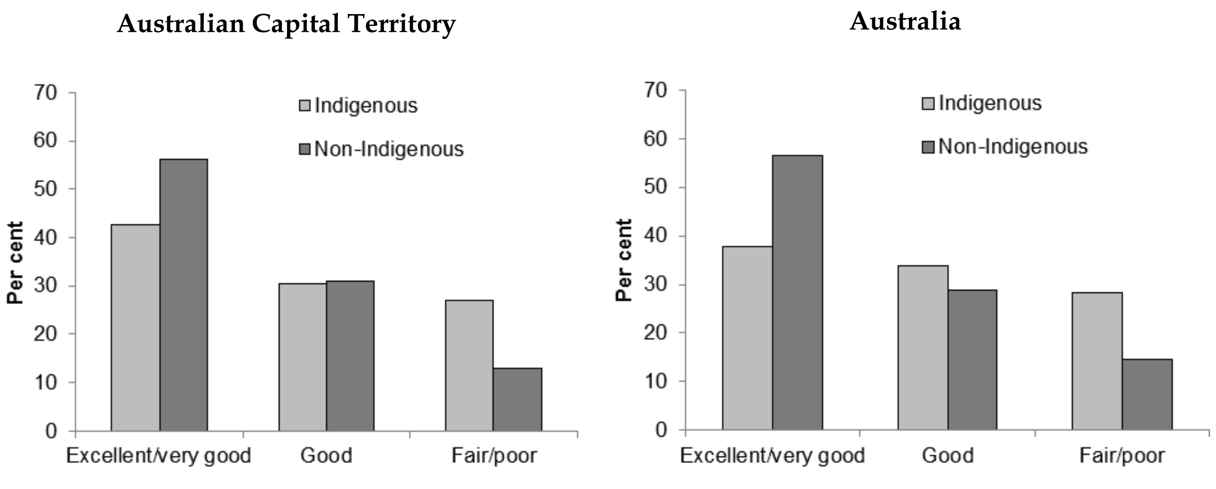
1.17 Perceived health status

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.

Data are presented on the self-assessed health status of Aboriginal and Torres Strait Islander Australians compared with non-Indigenous Australians using data from the 2008 NATSISS and 2007–08 NHS.

Key findings

- In 2008, after adjusting for differences in age structure between the Indigenous and non-Indigenous populations, Indigenous people in the Australian Capital Territory were approximately twice as likely as non-Indigenous people to report their health as fair or poor (note this estimate has a high relative standard error of between 25% and 50%), and less likely to report their health as excellent or very good. The same pattern was evident for Australia (Figure 1.17.1).



Note: ACT estimates for fair/poor health status have a relative standard error between 25% and 50% and should be used with caution.

Source: ABS and AIHW analysis of NATSISS 2008 and NHS 2007–08.

Figure 1.17.1: Self-assessed health status (age-adjusted), people aged 15 and over, by Indigenous status, the Australian Capital Territory and Australia, 2008

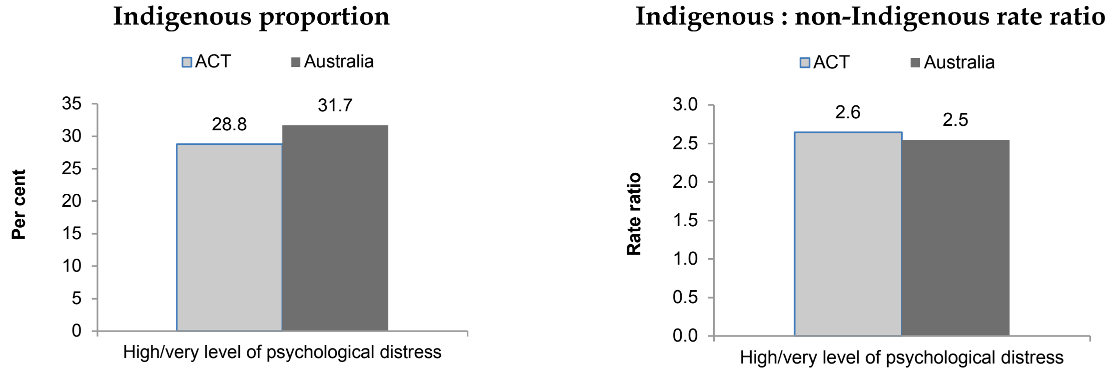
1.18 Social and emotional wellbeing

Social and emotional wellbeing is a holistic concept related to individual, family and community experience. For Aboriginal and Torres Strait Islander people, health is not just the physical wellbeing of the individual but the 'social, emotional and cultural wellbeing of the whole community' (Social Health Reference Group 2004).

Data are presented on levels of psychological distress among Indigenous adults from the 2008 NATSISS. Hospitalisation rates for mental health-related conditions and deaths from suicide are also presented.

Key findings

- According to the 2008 NATSISS, 29% of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory reported high/very high levels of psychological distress. This was similar to the proportion reported for Indigenous people nationally (32%) (Figure 1.18.1).
- After adjusting for differences in age structure, Indigenous adults in the Australian Capital Territory were 2.6 times as likely to report high/very high levels of psychological distress as non-Indigenous adults in 2008.
- In 2008, about 87% of Indigenous people aged 18 and over in the Australian Capital Territory reported feeling calm and peaceful all/most/some of the time; about 93% reported feeling happy all/most/some of the time; 83% reported full of life all/most/some of the time and 77% reported having lots of energy all/most/some of the time (Table 1.18.1. Appendix 2).
- Hospitalisation rates for mental health-related conditions for Aboriginal and Torres Strait Islander people in the Australian Capital Territory were lower than for Indigenous people in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (20.9 and 26.7 per 1,000 population) (Table 1.18.2, Appendix 2).
- After adjusting for difference in age structure, Indigenous males were 3.6 times as likely as non-Indigenous males, and Indigenous females were 2.8 times as likely as non-Indigenous females, to be hospitalised for mental health-related conditions (Table 1.18.2, Appendix 2).



Source: AIHW analyses of NATSISS 2008.

Figure 1.18.1: Proportion of Indigenous people aged 18 and over who reported high/very high levels of psychological distress, the Australian Capital Territory and Australia, 2008

Part 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

2.13 Transport

Community capacity

2.10 Community safety

2.11 Contact with the criminal justice system

2.12 Child protection

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 practice

2.21 Health behaviours during pregnancy including antenatal care

2.22 Overweight and obesity

* Measures for which data for the Australian Capital Territory is not available

The second part of this report, Determinants of Health, presents Tier 2 measures of the Aboriginal and Torres Strait Islander Health Performance Framework. It covers measures that affect health outcomes such as housing, education, employment and health risk factors including smoking and alcohol use. Data are presented on the key determinants of health in the Aboriginal and Torres Strait Islander population, with comparisons to the non-Indigenous population where data are available. Tier 2 comprises four sections: Environmental factors, Socioeconomic factors, Community capacity and Health behaviours.

Environmental factors

This section focuses on environmental factors that affect health outcomes, such as conditions of housing, access to functional housing with utilities and environmental tobacco smoke.

2.01 Housing

Factors related to housing, such as overcrowding in housing and housing tenure type, have potentially significant impacts on health. Living in overcrowded households may increase the risk of infectious diseases, such as meningitis, acute rheumatic fever, tuberculosis, and skin and respiratory infections (AIHW 2005). Overcrowding has also been associated with poorer self-reported physical and mental health, and higher rates of smoking and hazardous drinking (Shaw 2004). People who own their own home typically experience better health than those who rent (Hulse et al. 2010). Indigenous home ownership rates are relatively low compared with non-Indigenous households. This partly reflects the lower socioeconomic status of many Indigenous households, as well as cultural differences regarding the value of home ownership (AIHW 2011a).

Data are presented on rates of overcrowding and housing tenure for Indigenous and non-Indigenous people and households using data from the 2006 Census and 2008 NATSISS. Data on clients of specialist homelessness services from the Supported Accommodation Assistance Program data collection is also presented. Data from the 2006 Census on overcrowding by tenure type for the Australian Capital Territory has been combined with New South Wales (jurisdiction with the closest geographical proximity) due to small numbers.

Canadian National Occupancy Standard for overcrowding

Data presented on overcrowding are based on the Canadian National Occupancy Standard of housing overcrowding, the measure most widely used in Australia. This standard specifies the number of bedrooms required in a dwelling based on the numbers, age, sex and relationships of household members. Households that require one more bedroom to meet the standard are considered to experience overcrowding (AIHW 2005).

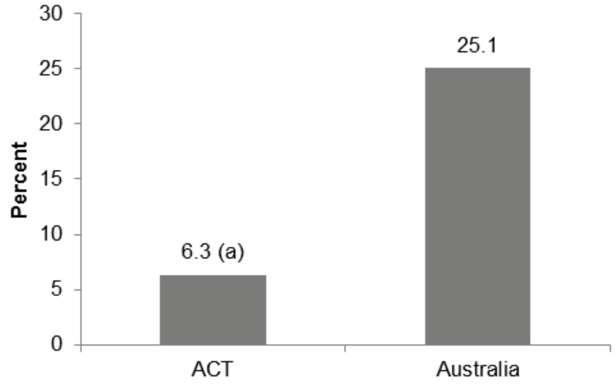
Key findings

- According to the 2008 NATSISS, an estimated 177 Indigenous households were overcrowded in the Australian Capital Territory. About 6% of Indigenous people aged 15 and over were living in overcrowded households, which was lower than that reported nationally (25%) (Figure 2.01.1). Caution must be exercised in interpreting these data because the proportion for the Australian Capital Territory has a high relative standard errors (between 25% and 50%).
- 2006 Census data shows that, for the Australian Capital Territory and New South Wales combined, overcrowding varied by tenure type with 18% of Indigenous households in housing co-operative, community or church group housing overcrowded, and 11% of Indigenous households in state or territory housing authority housing overcrowded. This compared with 11% of private and other renters and 7% of home owners or buyers (Table 2.01.1, Appendix 2).
- In 2008 in the Australian Capital Territory, about 48% of Indigenous households owned or were buying their own home, 33% were private and other renters, and 19% were

renters of some form of social housing (state or territory housing authority/housing cooperative or church group/Indigenous housing organisation or community housing). This compared with 66% of non-Indigenous households who owned or were buying their home, 23% who were private and other renters, and 7% who were renters of some form of social housing (Table 2.01.2, Appendix 2).

- A much higher proportion of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory were home owners or buyers than Indigenous people nationally (53% compared with 29%) and a lower proportion were renters (47% for the Australian Capital Territory and 69% nationally) (Figure 2.01.2).

In 2009–10, there were 318 support periods for clients of specialist homeless services in the Australian Capital Territory who identified as Aboriginal or Torres Strait Islander. This represented 12% of all support periods for clients of these services in the Australian Capital Territory (Table 2.01.3, Appendix 2).



(a) Estimate has a relative standard error between 25% and 50% and should be used with caution.

Source: AIHW analyses of NATSISS 2008.

Figure 2.01.1: Proportion of Aboriginal and Torres Strait Islander people aged 15 and over living in overcrowded housing, based on the Canadian Occupancy Standard, the Australian Capital Territory and Australia, 2008

Source: AIHW analyses of NATSISS 2008.

Figure 2.01.2: Proportion of people aged 18 and over, by tenure type and Indigenous status, the Australian Capital Territory and Australia, 2008

2.03 Environmental tobacco smoke

Environmental tobacco smoke, or passive smoking, is a significant cause of morbidity and mortality. There is strong and consistent evidence that passive smoking increases a non-smoker's risk of lung cancer and ischaemic heart disease. Passive smoking is also associated with increased risk of respiratory conditions and otitis media in children (Thomson et al. 2012; Jacoby et al. 2008) and of respiratory disease in adults (NHMRC 1997).

Data are presented on the proportion of Aboriginal and Torres Strait Islander children aged 0–14 years who live in households with regular smokers using data from the 2008 NATSISS.

Key findings

- In 2008 in the Australian Capital Territory, about 53% of Indigenous children aged 0–14 lived in households with a daily smoker, compared with 28% of non-Indigenous children the same age (Table 2.03.1). In the same period nationally, around 65% of Indigenous children aged 0–14 lived in households with a daily smoker, compared with 32% of non-Indigenous children.
- About 13% of Indigenous children aged 0–14 in the Australian Capital Territory were living in households with a daily smoker who smoked at home indoors compared with 4% of non-Indigenous children of the same age. The proportions nationally were 22% for Indigenous children and 7% for non-Indigenous children of the same age.

Table 2.03.1: Children aged 0–14 living in households with smokers, by Indigenous status of children, the Australian Capital Territory and Australia, 2008 and 2007–08

			ACT	Australia
Proportion of children living with daily smoker(s)[(a)]	Indigenous	%	52.9	65.1
	Non-Indigenous	%	28.4	32.2
	Rate ratio		1.9*	2.0*
Proportion of children with daily smoker who smokes at home indoors in household[(a)]	Indigenous	%	13.4	21.6
	Non-Indigenous	%	3.9	6.6
	Rate ratio		3.4*	3.3*
Total number of children aged 0–14 years[(b)]	Indigenous	No.	1,567	193,249
	Non-Indigenous	No.	62,751	3,907,621

* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons.

(a) Proportions exclude not stated responses.

(b) Includes households in which the smoking status of members was not stated.

Source: ABS and AIHW analysis of NATSISS 2008 and NHS 2007–08.

Socioeconomic factors

Socioeconomic factors of a population refer to characteristics such as education, employment and income. Their influence on health is both complex and profound. Socioeconomically disadvantaged people (such as those with low income or poor education) tend to live shorter and less healthy lives. Having a low income and/or lower levels of education limits choices and opportunities for improving health outcomes, and may influence other health-related factors, such as diet and access to health care.

This section focuses on socioeconomic factors that affect the health of Aboriginal and Torres Strait Islander people, such as literacy and numeracy, education outcomes for young people, educational participation and attainment of adults, employment, income and transport.

2.04 Literacy and numeracy

Poor literacy and numeracy skills can severely compromise children's ability to engage in school learning, to undertake future learning, to be successfully employed and to positively participate in society (Cope & Kalantzis 2000). Students who do not attain minimum standards for literacy and numeracy in the early years of schooling may have difficulty progressing further, and are less likely to enter higher education.

One of the six Council of Australian Governments (COAG) targets is to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade (by 2018).

Data are presented on the proportion of Year 3, 5, 7 and 9 students achieving national benchmarks for literacy and numeracy using data from the National Assessment Program — Literacy and Numeracy (NAPLAN). "Benchmark" here refers to proportion of students at or above national minimum standard. Comparisons are presented for Australia as a whole, and for all metropolitan areas in Australia, due to the Australian Capital Territory being largely metropolitan.

Key findings

Reading

- In the Australian Capital Territory in 2011, 87% of Year 3 Aboriginal and Torres Strait Islander students achieved the reading benchmark, compared with 96% of non-Indigenous students; 86% of Year 5 Indigenous students achieved the reading benchmark, compared with 95% of non-Indigenous students; 86% of Year 7 Indigenous students achieved the reading benchmark, compared with 97% of non-Indigenous students; and 89% of Year 9 Indigenous students achieved the reading benchmark, compared with 95% of non-Indigenous students. The proportions of Indigenous students having achieved reading benchmarks were higher in the Australian Capital Territory than nationally and for all metropolitan areas in Australia for all of the four year levels (Table 2.04.1).

Writing

- A new Persuasive Writing scale has been introduced in 2011 to replace the Narrative Writing scale used in 2008. As persuasive writing is a separate scale to narrative writing, there was a break in the time series and the persuasive writing results for 2011 should not be directly compared to the narrative writing results from earlier years.
- In the Australian Capital Territory in 2011, 91% of Year 3 Aboriginal and Torres Strait Islander students achieved the persuasive writing benchmark, compared with 96% of non-Indigenous students; 87% of Year 5 Indigenous students achieved the persuasive writing benchmark, compared with 94% of non-Indigenous students; 69% of Year 7 Indigenous students achieved the persuasive writing benchmark, compared with 92% of non-Indigenous students; and 63% of Year 9 Indigenous students achieved the persuasive writing benchmark, compared with 86% of non-Indigenous students. The proportions of Indigenous students having achieved persuasive writing benchmarks were higher in the Australian Capital Territory than nationally for all of the four year levels; and were higher than or similar to metropolitan areas in Australia for all four year levels (Table 2.04.1).

Spelling

- In the Australian Capital Territory in 2011, 88% of Year 3 Aboriginal and Torres Strait Islander students achieved the spelling benchmark, compared with 95% of non-Indigenous students; 84% of Year 5 Indigenous students achieved the spelling benchmark, compared with 93% of non-Indigenous students; 81% of Indigenous Year 7 students achieved the spelling benchmark, compared with 95% of non-Indigenous students; and 82% of Year 9 Indigenous students achieved the spelling benchmark, compared with 92% of non-Indigenous students. The proportions of Indigenous students having achieved spelling benchmarks were higher in the Australian Capital Territory than nationally for all of the four year levels; and were higher than or similar to metropolitan areas in Australia for all four year levels (Table 2.04.1).

Grammar and punctuation

- In the Australian Capital Territory in 2011, 87% of Year 3 Aboriginal and Torres Strait Islander students achieved the grammar and punctuation benchmark, compared with 95% of non-Indigenous students; 84% of Year 5 Indigenous students achieved the grammar and punctuation benchmark, compared with 95% of non-Indigenous students; 78% of Year 7 Indigenous students achieved the grammar and punctuation benchmark, compared with 96% of non-Indigenous students; and 76% of Year 9 Indigenous students achieved the grammar and punctuation benchmark, compared with 93% of non-Indigenous students. The proportions of Indigenous students having achieved grammar and punctuation benchmarks were higher in the Australian Capital Territory than nationally and for all metropolitan areas in Australia for all of the four year levels (Table 2.04.1).

Numeracy

- In the Australian Capital Territory in 2011, 89% of Year 3 Aboriginal and Torres Strait Islander students achieved the numeracy benchmark, compared with 97% of non-Indigenous students; 86% of Year 5 Indigenous students achieved the numeracy benchmark, compared with 96% of non-Indigenous students; 80% of Year 7 Indigenous students achieved the numeracy benchmark, compared with 96% of non-Indigenous students; and 83% of Year 9 Indigenous students achieved the numeracy benchmark, compared with 95% of non-Indigenous students. The proportions of Indigenous students having achieved numeracy benchmarks were higher in the Australian Capital Territory than nationally for all of the four year levels; and were higher than or similar to metropolitan areas in Australia for all four year levels (Table 2.04.1).

Trends over time

- In the Australian Capital Territory, there has been a general increase in the proportion of Aboriginal and Torres Strait Islander students achieving the Year 3 benchmarks for spelling and grammar/punctuation, and the Year 5 benchmarks for reading, writing, spelling, and grammar/punctuation between 2009 and 2011. The proportion of Indigenous Year 3 students achieving the spelling benchmark increased from 78% in 2009 to 88% in 2011, and the proportion of Year 5 students achieving the reading benchmark increased from 77% to 86% (Table 2.04.1, Appendix 2).

Table 2.04.1: Proportion of Year 3, 5, 7 and 9 students at or above the national minimum standard for reading, writing, spelling, grammar & punctuation, and numeracy, by Indigenous status, the Australian Capital Territory, Australia and metropolitan areas, 2011

	Indigenous					Non-Indigenous				
	Reading	Writing	Spelling	Grammar & punctuation	Numeracy	Reading	Writing	Spelling	Grammar & punctuation	Numeracy
Australian Capital Territory										
Year 3	86.8	90.5	87.6	86.6	88.9	95.8	96.3	94.9	95.3	96.6
Year 5	86.0	87.0	83.6	84.0	86.0	94.7	93.9	92.9	94.9	95.6
Year 7	86.1	69.3	80.7	78.1	79.6	97.1	92.4	94.8	96.3	96.1
Year 9	89.0	62.7	82.3	76.4	83.0	94.6	86.1	92.1	93.1	94.9
Australia										
Year 3	76.3	79.9	71.7	70.9	83.6	94.9	96.2	94.1	94.4	96.4
Year 5	66.4	68.9	68.8	64.8	75.2	92.9	93.9	92.6	93.6	95.5
Year 7	77.1	66.9	73.8	67.0	76.5	95.7	92.6	93.5	94.3	95.5
Year 9	71.9	55.0	72.2	61.2	72.0	93.5	86.4	91.6	91.5	94.1
Metropolitan areas Australia										
Year 3	84.2	88.1	81.4	80.5	89.0	95.2	96.4	94.7	94.9	96.5
Year 5	76.7	79.8	79.0	75.9	84.0	93.4	94.6	93.6	94.2	95.7
Year 7	85.0	77.2	81.9	77.2	85.0	95.9	93.5	94.3	94.7	95.7
Year 9	78.4	63.4	79.3	69.5	78.0	93.7	88.0	92.6	92.1	94.4

Note:

(i) NAPLAN tests are equated so that the 2011 results can be compared with those for previous years. Equating enables the results from NAPLAN tests in different years to be reported on the same achievement scale.

(ii) Equating one test with another is a complex technical procedure and involves some degree of statistical error. For this reason, there may be minor fluctuations in the average NAPLAN test results from year to year when, in reality, the level of student achievement has remained essentially the same.

(iii) With the change in the Writing genre in 2011, a new Persuasive Writing scale was introduced. As this is a separate scale to Narrative Writing, there is a break in the time series. The Persuasive Writing results for 2011 should not be directly compared to the Narrative Writing results from earlier years.

Source: Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA) 2008; Australian Assessment, Reporting and Assessment Authority (2009, 2010, 2011)

2.05 Education and outcomes for young people

Access to education by young people is an important determinant of health and wellbeing. Successful completion of Year 12 is critical to improving socioeconomic status. Higher levels of education improve employment prospects, future income, standard of housing and access to health care (ABS 2002; SCRGSP 2007; ABS & AIHW 2008). Higher levels of education have also been associated with reduced propensity to engage in risky health behaviours. COAG has committed to halve the gap in Indigenous Year 12 or equivalent attainment by 2020.

Data are presented on Year 10 and 12 retention rates and Year 12 completion rates for Aboriginal and Torres Strait Islander people using data from the National Schools Statistics Collection.

Apparent retention and completion rates

Apparent retention rates are the percentage of full-time students of a given cohort group who continue from the beginning of secondary schooling to a specified year level. The term apparent is used as the retention rate does not account for students repeating a year of school or migrating in or out of the Australian school student population or between states/territories.

Completion rates are the proportion of Year 11 students who went on to achieve a Year 12 certificate.

Key findings

- In 2011 in the Australian Capital Territory, the apparent retention rate from Year 7–8 to Year 10 for full-time Indigenous students was over 100% for males and females. Apparent retention rates for non-Indigenous students were also over 100%. Rates can be above 100% due to inter-state movements of students between Years 7-8 and Year 10.
- The apparent retention rate from Year 7–8 to Year 11 was 73% for Indigenous males and 128% for Indigenous females, compared with 101% and 107% for non-Indigenous males and females, respectively.
- The apparent retention rate from Year 7–8 to Year 12 for Indigenous students was lower than for non-Indigenous students—70% for Indigenous males and 83% for Indigenous females, compared with 87% for non-Indigenous males and 92% for non-Indigenous females.
- The apparent retention rate from Year 10 to Year 12 was also lower for Indigenous students (70% for males and 88% for females, compared with 88% and 93% for non-Indigenous males and females).
- In 2011, 80% of Indigenous male Year 11 students and 75% of Indigenous female Year 11 students went on to achieve a Year 12 certificate in the Australian Capital Territory. This compared with 88% and 87% of non-Indigenous male and female Year 11 students.
- Apparent retention and completion rates for Indigenous students in the Australian Capital Territory were higher than the national rates for Indigenous students across all levels (Table 2.05.1).

Table 2.05.1: Apparent retention and completion rates, by Indigenous status and sex, the Australian Capital Territory and Australia, 2011[(a)(b)(c)]

	Australian Capital Territory		Australia	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Year 7–8 to Year 10[(a)]	Per cent		Per cent	
Males	107.8	101.0	98.4	100.7
Females	105.3	101.4	99.0	101.8
Year 7–8 to Year 11[(a)]				
Males	73.4	100.7	71.4	91.1
Females	127.7	106.8	75.2	96.5
Year 7–8 to Year 12[(a)]				
Males	70.0	87.2	46.1	75.9
Females	83.3	92.0	51.3	85.8
Year 10 to Year 12[(b)]				
Males	70.0	87.8	51.5	76.4
Females	88.2	92.5	55.6	84.9
Year 11 to Year 12[(c)]				
Males	80.0	87.7	66.4	84.2
Females	75.0	87.4	68.5	89.1

(a) Retention rate = Year 10, 11 or 12 students as a proportion of the corresponding cohort from the first year of secondary schooling (Year 7–8).

(b) Retention rate = Year 12 students as a proportion of the corresponding cohort from Year 10.

(c) Retention rate = Year 12 students as a proportion of the corresponding cohort from Year 11.

Source: ABS 2010; ABS and AIHW analysis of National Schools Statistics Collection (NSSC).

2.06 Educational participation and attainment of adults

People who go on to higher education (universities and other tertiary institutions) and graduate with a degree or diploma are more likely to obtain full-time work and earn higher incomes than those who do not. Likewise people who complete a vocational education and training (VET) course are more likely to be employed after the completion of their course than they were before (SCRGSP 2007).

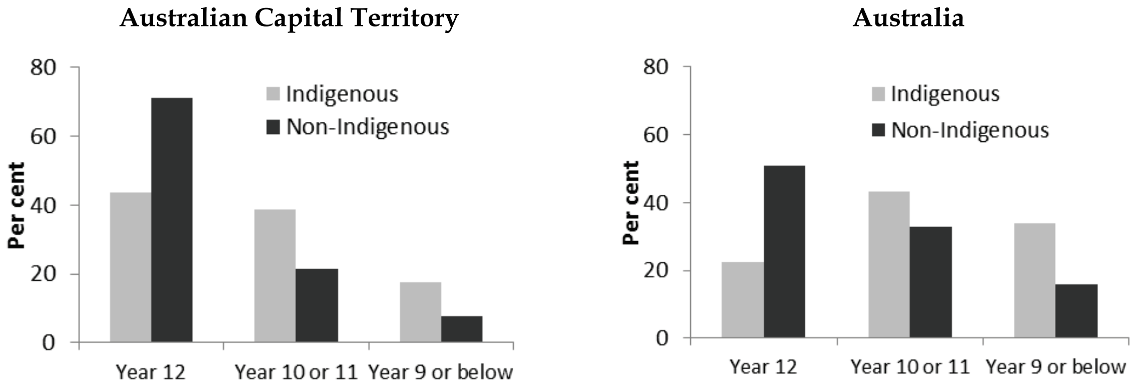
Data are presented on educational participation (people undertaking formal education or training) and educational attainment (people who have completed a particular level of school education or post-school qualification) of Aboriginal and Torres Strait Islander adults compared with non-Indigenous adults using data from the 2008 NATSISS.

Key findings

- In 2008 in the Australian Capital Territory, the proportion of Aboriginal and Torres Strait Islander people aged 15 and over who were studying was higher than that for non-Indigenous Australians (27% compared with 22%). A similar pattern can be observed nationally (Table 2.06.1).
- A higher proportion of Aboriginal and Torres Strait Islander people from the Australian Capital Territory attended secondary school or a technical institution in 2008 than non-Indigenous people, but the proportion of Indigenous people who attended a university or other higher education was less than that of non-Indigenous people (Table 2.06.1).

These estimates, however, have high relative standard errors (between 25% and 50%) and should be used with caution.

- Non-Indigenous people aged 18 and over were more likely than Indigenous people to have completed Year 12 (71% compared with 44%) in the Australian Capital Territory. A higher proportion of Indigenous adults than non-Indigenous adults reported that the highest year of school completed was Year 9 or below (18% compared with 8%). The proportion of Indigenous people who completed Year 12 was higher in the Australian Capital Territory than nationally (44% compared with 23%) (Figure 2.06.1).
- In the Australian Capital Territory about 63% of Indigenous people aged 25–64 had a post-school qualification compared with 71% of non-Indigenous people (note this is not a statistically significantly difference). The most commonly held qualification was for a certificate course for Indigenous and bachelor degree or above for non-Indigenous people in the Australian Capital Territory (Table 2.06.2).



Note: Year 9 or below includes people who never attended school.

Source: ABS and AIHW analysis of NATSISS 2008.

Figure 2.06.1: Highest level of school completed, by Indigenous status, people aged 18 and over, the Australian Capital Territory and Australia, 2008

Table 2.06.1: Educational institution currently attended, by Indigenous status, people aged 15 and over, the Australian Capital Territory and Australia, 2008

	Educational participation		Secondary school	TAFE/technical college/ business college/ industry skills centre	University/other higher education	Total currently studying[(a)]	Not studying	Total[(a)]	Total number
ACT	Indigenous	%	7.6[(b)]	10.0[(b)]	7.7[(b)]	26.6	73.4	100	2,810
	Non-Indigenous	%	5.2	4.6	10.8	21.9	78.1	100	268,844
	Rate ratio		1.5	2.2	0.7	1.2	0.9	. .	. .
Australia	Indigenous	%	8.4*	6.0*	2.7*	19.0*	81.0*	100	327,101
	Non-Indigenous	%	4.2*	4.6*	5.6*	15.6*	84.4*	100	16,374,202
	Rate ratio		2.0	1.3	0.5	1.2	1.0	. .	. .

* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons.

(a) Includes other educational institutions not further defined.

(b) Estimate has a relative standard error of between 25% and 50% and should be used with caution.

Source: ABS and AIHW analysis of NATSISS 2008.

Table 2.06.2: Whether has a post-school qualification, by Indigenous status, people aged 25–64, the Australian Capital Territory and Australia, 2008

	Highest post-school qualification		Bachelor degree or above[(a)]	Advanced diploma/ diploma	Certificate	Total with post-school qualification	Does not have a post-school qualification	Total	Total number of people
ACT	Indigenous	%	20.8*	9.9[(b)]	30.4*	63.3	36.7	100	1,798
	Non-Indigenous	%	41.6*	11.2	17.6*	71.4	28.6	100	187,298
	Rate ratio		0.5	0.9	1.7	0.9	1.3	. .	. .
Australia	Indigenous	%	6.5*	5.6*	24.7	40.2*	59.9*	100	207,342
	Non-Indigenous	%	24.9*	9.8*	24.9	61.4*	38.6*	100	10,997,331
	Rate ratio		0.3	0.6	1.0	0.7	1.6	. .	. .

* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons.

(a) Includes bachelor degree, doctorate, masters, graduate diploma and graduate certificate.

(b) Estimate has a relative standard error of between 25% and 50% and should be used with caution.

Source: NATSISS 2008 and NHS 2007–08.

2.07 Employment

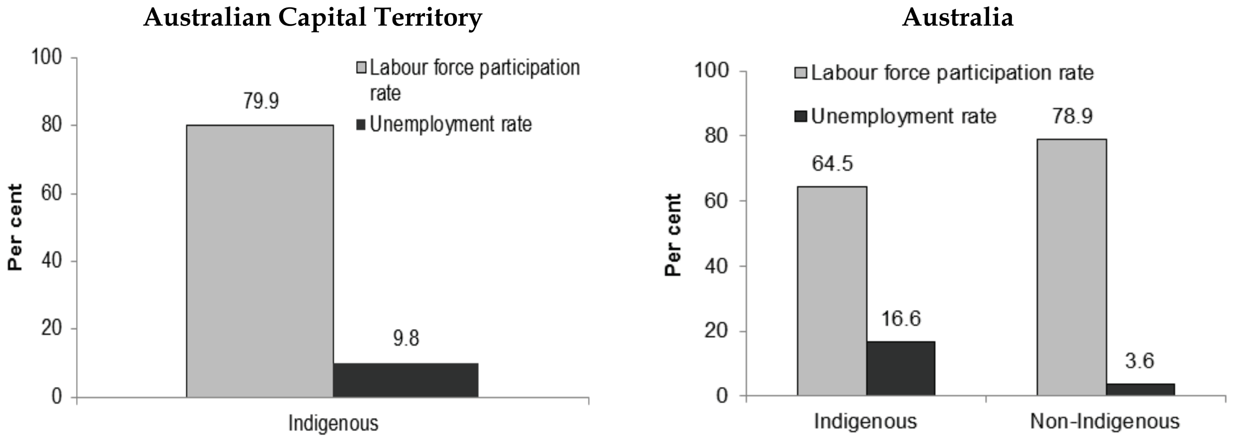
Participation in employment has important consequences for living standards and social and emotional wellbeing, including self-esteem, opportunities for self-development and participation in the community. Long periods out of the workforce can have negative effects on an individual's health (both physical and psychological) (McLure 2000).

Aboriginal and Torres Strait Islander people have relatively low levels of employment, due to several factors (AIHW 2011a).

Data are presented on the employment status of Aboriginal and Torres Strait Islander people aged 15–64 using data from the 2008 NATSISS and 2007–08 NHS.

Key findings

- In 2008 in the Australian Capital Territory, the labour force participation rate for Aboriginal and Torres Strait Islander people aged 15–64 was estimated to be 80%, with 10% of those in the labour force unemployed and looking for full-time or part-time work. There was no available data about the labour force participation rate for non-Indigenous people (Figure 2.07.1).
- The labour force participation rate for Aboriginal and Torres Strait Islander people aged 15–64 was higher in the Australian Capital Territory than nationally (80% compared with 65%), and the unemployment rates was lower (10% in the Australian Capital Territory compared with 17% nationally).
- An estimated 72% of Aboriginal and Torres Strait Islander people aged 15–64 were employed in the Australian Capital Territory in 2008. Of the non-Indigenous population, 84% were employed (Table 2.07.1).



Note: Labour force participation and unemployment rates for non-Indigenous persons in the ACT are not published from the NATSISS.

Source: NATSISS 2008 and NHS 2007–08.

Figure 2.07.1: Unemployment and labour force participation rates, people aged 15–64, by Indigenous status, the Australian Capital Territory and Australia, 2008

Table 2.07.1: Labour force status of people aged 15–64, by Indigenous status, the Australian Capital Territory and Australia, 2008

	Australian Capital Territory		Australia	
	Indigenous	**Non-Indigenous**	**Indigenous**	**Non-Indigenous**
		Per cent		
In the labour force				
Employed CDEP	n.p.	. .	5.6	. .
Employed non-CDEP	n.p.	. .	48.2	. .
Total employed	**72.1**	**83.7**	**53.8**	**76.0**
Unemployed	7.8	n.p.	10.7	2.9
Not in the labour force	20.1	n.p.	35.5	21.1
Total	**100.0**	**100.0**	**100.0**	**100.0**

Source: NATSISS 2008 and NHS 2007–08.

2.08 Income

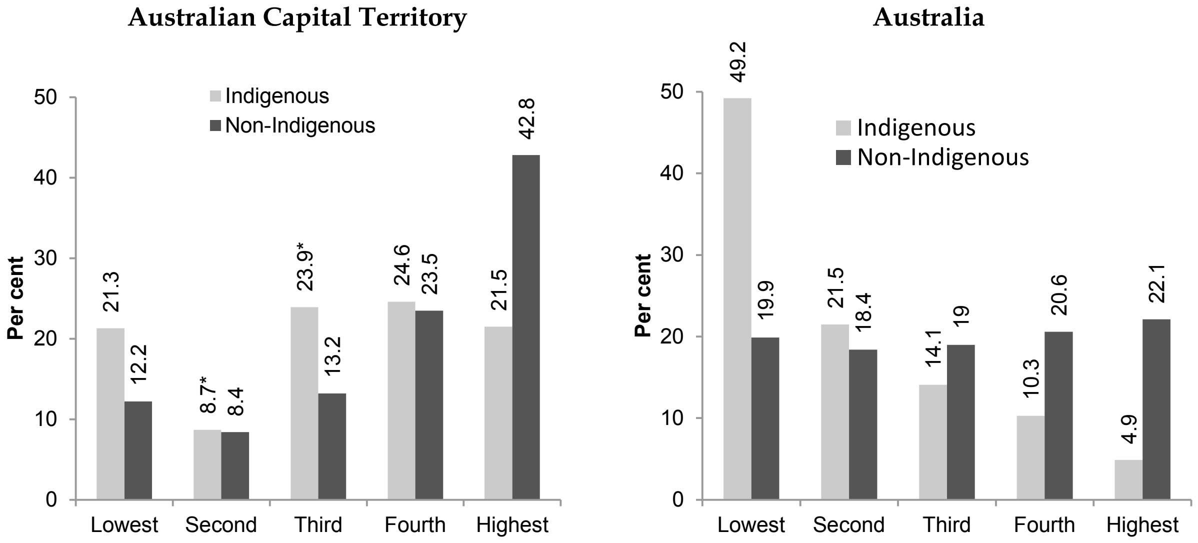
Low income is associated with a wide range of disadvantages, including shorter life expectancy, low levels of education, substance abuse, reduced social participation, and contact with the criminal justice system. People with lower socioeconomic status, including many Aboriginal and Torres Strait Islander people, also have poorer health status and a significantly higher burden of disease (Begg et al. 2007).

Data are presented on equivalised gross household and individual income of Aboriginal and Torres Strait Islander people using data from the 2008 NATSISS and 2007–08 Survey of Income and Housing.

Equivalised gross household income refers to the amount of income per household after adjusting for household size and for age of children (if any).

Key findings

- According to the NATSISS, in 2008, 21% of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory were in the lowest quintile (most disadvantaged) of equivalised gross weekly household income and 22% were in the highest (least disadvantaged). This compares with 12% of non-Indigenous people in the lowest quintile and 42% in the highest. (Figure 2.08.1). The pattern was different nationally, with nearly 50% of Indigenous people aged 18 and over in the lowest quintile and 5% in the highest. Twenty per cent of non-Indigenous people were in the lowest quintile and 22% in the highest.
- In 2008 in the Australian Capital Territory, the mean equivalised gross weekly household income for Aboriginal and Torres Strait Islander people aged 18 and over was $990 per week, compared with $1,268 per week for non-Indigenous people. Nationally, the mean equivalised gross weekly household income for Indigenous people aged 18 and over was $580, compared with $983 for non-Indigenous people (Figure 2.08.2).



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

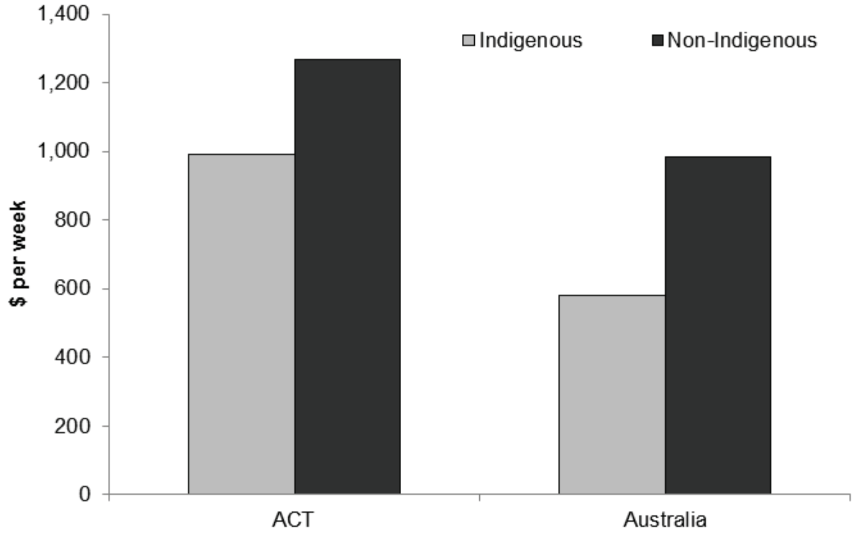
(a) Equivalised gross household income quintile boundaries for Indigenous Australians are: first (0 to $435); second ($436 to $686); third ($687 to $952); fourth ($953 to $1,380); and fifth ($1,381 or more).

(b) Equivalised gross household income quintile boundaries for non-Indigenous Australians are: first (0 to $423); second ($424 to $666); third ($667 to $925); fourth ($926 to $1,341); and fifth ($1,342 or more).

(c) Proportions excluding people whose gross household income is not stated.

Source: NATSISS 2008 and SIH 2007–08.

Figure 2.08.1: Proportion of people aged 18 and over in each equivalised gross weekly household income quintile[(a)(b)(c)], by Indigenous status, the Australian Capital Territory and Australia, 2008



Source: NATSISS 2008 and SIH 2007–08.

Figure 2.08.2: Mean equivalised gross household income ($ per week), by Indigenous status, people aged 18 and over, the Australian Capital Territory and Australia, 2008

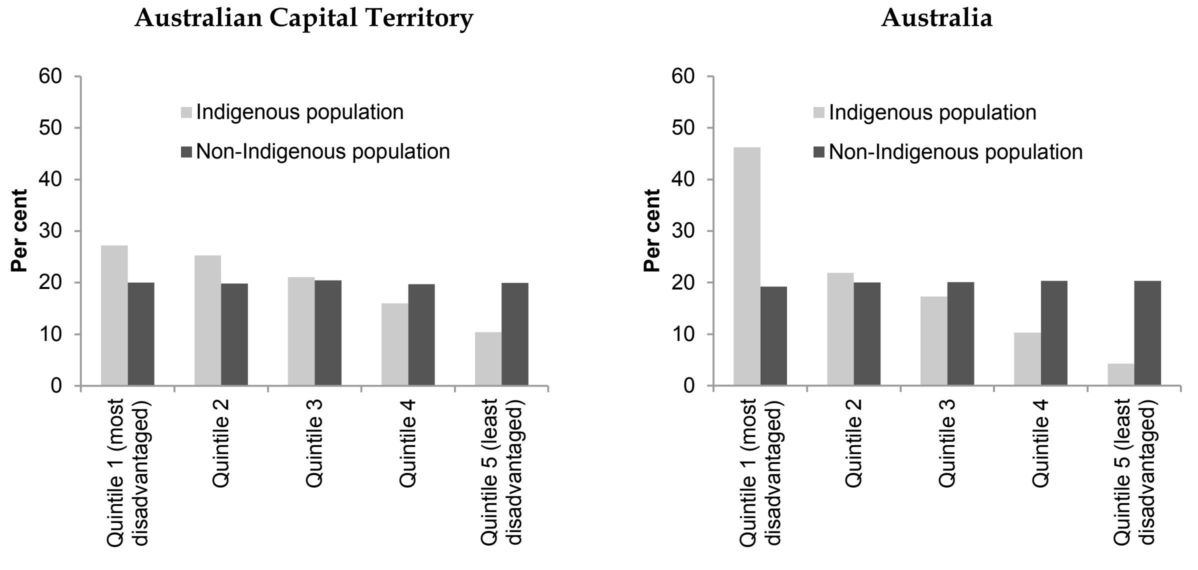
2.09 Index of disadvantage

The links between different forms of disadvantage, such as poverty, unemployment, low levels of education, racism and consequent social dysfunction, stress, social exclusion and poor health, are well documented (Wilkinson and Marmot 2003; Marmot 2005; Paradies 2006; Saunders and Davidson 2007; Sassi 2009).

Data are presented on the relative disadvantage within the Aboriginal and Torres Strait Islander population compared with the non-Indigenous population using an index developed by the ABS to allow measurement of relative socioeconomic status at a small area level known as Socio-Economic Indexes for Areas (SEIFA). SEIFA analysis presented below uses the Index of Relative Socio-Economic Advantage and Disadvantage and is based on data from the 2006 Census at the geographical level.

Key findings

- In 2006 in the Australian Capital Territory, a greater proportion of the Aboriginal and Torres Strait Islander population was in the most disadvantaged quintile of socioeconomic status than the non-Indigenous population (27% compared with 20%) (Figure 2.09.1). About 10% of the Indigenous population was in the least disadvantaged quintile, compared with 20% of the non-Indigenous population.
- Compared with the Indigenous population nationally, the Australian Capital Territory had lower proportion of Indigenous people in the most disadvantaged quintile of socioeconomic status (27% compared with 46%) and a higher proportion of Indigenous people in the least disadvantaged quintile (10% compared with 4%).



Source: AIHW analyses of 2006 Census data.

Figure 2.09.1: Population distribution by SEIFA advantage/disadvantage quintiles, by Indigenous status, the Australian Capital Territory and Australia, 2006

Community capacity

Community capacity refers to the capacity of a population to deliver a sustainable environment for health and wellbeing to its members. It includes providing resources (human or other), leadership and a feeling of community cohesion. Strong communities support stable family structures, inter-generational care and social networks, which in turn lead to improved health outcomes (AIHW 2011a).

A variety of indicators can be used to profile the capacity of a community in relation to health and wellbeing. This section presents data on child protection, community safety, and contact with the criminal justice system.

2.10 Community safety

Community safety refers to the notion of being and feeling protected from harm. It is an important aspect of physical and mental wellbeing. Stressors experienced by individuals, as well as their family members and/or close friends, also influence the sense of community safety.

Community safety here includes three parameters, namely experience of personal injury or death as a result of violence; experience of threatened violence or a social setting in which violence is common; and experience of a social setting where there is a lack of security and a perception of danger, for example, where crimes against property or disorderly behaviour are common.

Data are presented on experience of physical or threatened violence, stressors experienced in the last 12 months, and reported community/neighbourhood problems for the Australian Capital Territory, using data from the 2008 NATSISS. Hospitalisations from assault are also reported.

Key findings

- According to the 2008 NATSISS, about 23% of Aboriginal and Torres Strait Islander people aged 18 and over in the Australian Capital Territory reported being a victim of physical or threatened violence in the last 12 months compared to 9% of non-Indigenous people of the same age. Nationally, the proportions were 21% and 11% for Indigenous and non-Indigenous Australians respectively (Table 2.10.1).
- In 2008 in the Australian Capital Territory, about 81% of Aboriginal and Torres Strait Islander people aged 18 and over or their family members and close friends, experienced at least one stressor in the previous 12 months, compared with 52% of non-Indigenous people. The most common stressors for Indigenous people were death of a family member or close friend (46%), mental illness and alcohol- or drug-related problems (both at 31%) (Table 2.10.1). These proportions were higher than those reported nationally.
- Between July 2008 and June 2010, there were 35 hospitalisations of Aboriginal and Torres Strait Islander people in the Australian Capital Territory with a principal diagnosis of assault. Indigenous people in the Australian Capital Territory were hospitalised for assault at 4.6 times the rate of non-Indigenous Australians. In New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, Indigenous people were hospitalised at 12 times the rate of non-Indigenous people (Table 2.10.2, Appendix 2).

Table 2.10.1: Issues of community safety, people aged 18 and over, by Indigenous status, the Australian Capital Territory and Australia, 2008

	Australian Capital Territory		Australia	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
	Per cent		Per cent	
Victim of physical or threatened violence in last 12 months[(a)]	23.2*	9.4*	20.5*	10.8*
Stressors experienced by individual, family members and/or close friends in last 12 months[(b)]				
Mental illness	31.4*	10.4*	17.1*	8.8*
Death of family member or close friend	46.2*	18.4*	40.4*	19.4*
Alcohol or drug-related problems	30.9*	7.3*	24.2*	5.7*
Abuse or violent crime	11.2*	2.9*	7.6*	2.4*
Witness to violence	12.0*	2.2*	9.0*	2.2*
Trouble with the police	18.0*	3.4*	14.7*	2.6*
One or more of the above stressors	*66.4**	*32.8**	*59.1**	*30.2**
You, a family member or friend spent time in gaol	16.8	. .	12.8	. .
Overcrowding at home	17.1[(c)]	. .	12.7	. .
Treated badly / discrimination	18.6	. .	10.2	. .
Total experienced stressors[(c)(d)]	*80.8**	*52.0**	*79.0**	*49.1**
No stressors reported	19.2*	48.0*	21.0*	50.9*
Total	**100.0**	**100.0**	**100.0**	**100.**

* Represents statistically significant differences in the Indigenous/non-Indigenous comparisons.

(a) For this variable only, non-Indigenous comparison has been sourced from General Social Survey (GSS) 2006.

(b) In the 2008 NATSISS, Indigenous Australians were asked about 24 separate stressors, and in the 2007–08 NHS, non-Indigenous Australians were asked about 14 separate stressors.

(c) Sum of components may exceed total, as people may have reported more than one type of stressor.

(d) Includes all other types of stressors not listed here.

Note: Excludes stressors not stated.

Source: NATSISS 2008 and NHS 2007–08.

2.11 Contact with the criminal justice system

The rate of incarceration is relatively high among Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians. This not only affects the health and wellbeing of those imprisoned, but also of their families and children (Levy 2005).

Data are presented on Aboriginal and Torres Strait Islander people in prison custody and deaths in custody (police and prison).

Key findings

- As at 30 June 2011, there were 42 Indigenous and 253 non-Indigenous people in prison custody in the Australian Capital Territory. Nationally, there were 7,656 Indigenous and 21,426 non-Indigenous people in prison custody (Table 2.11.1). The age-standardised rate of imprisonment for Indigenous people in the Australian Capital Territory was 1,117 per 100,000, which was almost 13 times the rate for non-Indigenous people (88 per 100,000).

Imprisonment rates were lower in the Australian Capital Territory than the national rates for both Indigenous and non-Indigenous Australians.

- In the Australian Capital Territory, the age-standardised imprisonment rate for Aboriginal and Torres Strait Islander people significantly increased by 54% between 2001 and 2011. The imprisonment rate for non-Indigenous people increased by 7%. Nationally, the age-standardised imprisonment rate for Indigenous people increased by 58% over this period (Figure 2.11.1).
- There were no deaths of Indigenous people in custody (police and prison) in the Australian Capital Territory in 2010–11. Nationally, Indigenous people represented one-quarter (25%) of deaths in custody (Table 2.11.2, Appendix 2).

Table 2.11.1: People in prison custody, by Indigenous status, the Australian Capital Territory and Australia, 30 June 2011

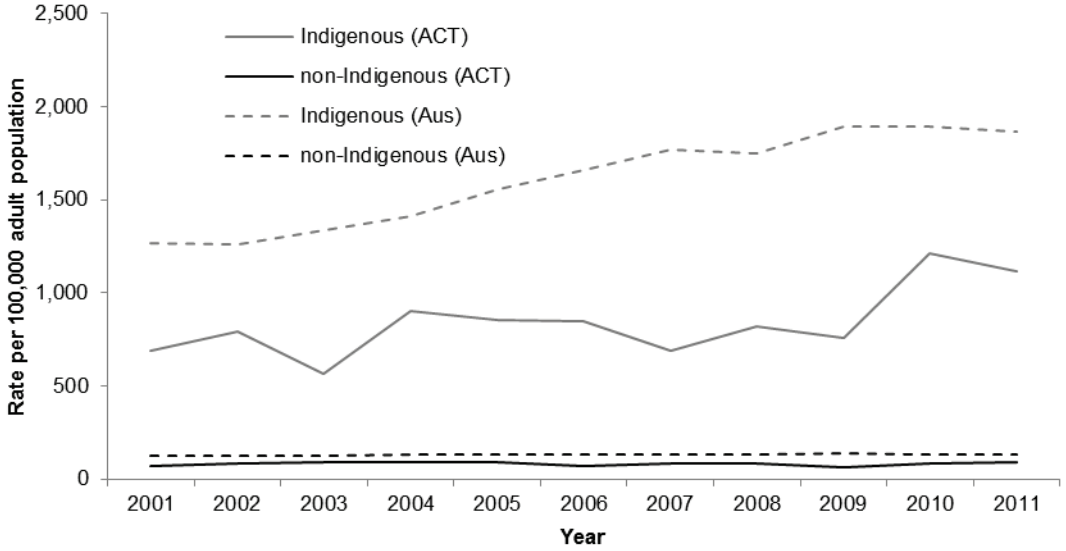
	Indigenous			Non-Indigenous			
	Number	Crude rate[(a)]	Age standardised rate[(b)]	Number	Crude rate[(a)]	Age standardised rate[(b)]	Age standardised rate ratio[(c)]
ACT	42	1,455.8	1,116.7	253	90.2	87.5	12.8
Australia	**7,656**	**2,247.5**	**1,867.6**	**21,426**	**125**	**130.2**	**14.3**

(a) Number per 100,000 adult population.

(b) Number per 100,000 adult population directly age standardised to 2001 Australian standard population.

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

Source: ABS 2011.



Source: ABS 2011.

Figure 2.11.1 Age-standardised imprisonment rates, by Indigenous status, the Australian Capital Territory and Australia, 2001–2010

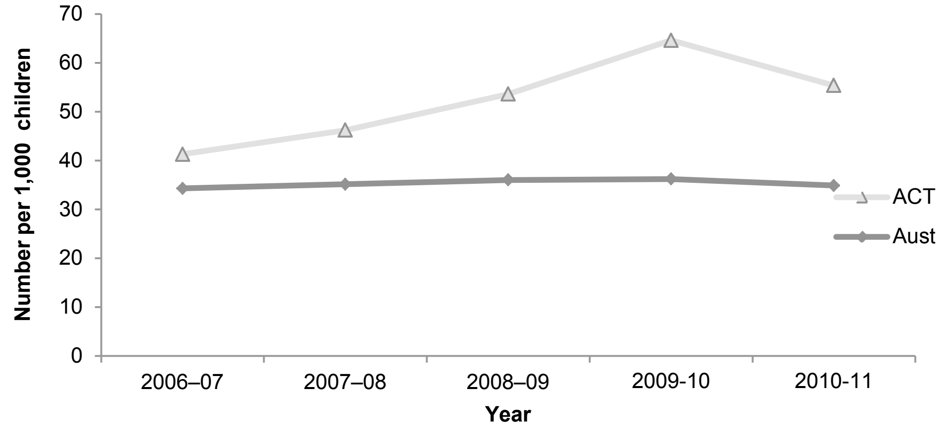
2.12 Child protection

Child protection services 'receive and assess allegations of child abuse and neglect, and/or harm to children and young people; provide and refer clients to family support and other relevant services; and intervene to protect children' (AIHW 2012a; SCRGSP 2005). Aboriginal and Torres Strait Islander children are over-represented in the child protection system. The reasons for this are complex, and include the intergenerational effects of separation from family and culture, perceptions arising from cultural differences in child-rearing practices, and the relative socioeconomic disadvantage of Indigenous Australians (HREOC 1997; Stanley et al. 2003).

Data are presented on Aboriginal and Torres Strait Islander children who were the subject of a substantiation, on care and protection orders and in out-of-home care. Substantiations refer to child protection notifications made to relevant authorities that were investigated and it was concluded that there was reasonable cause to believe that the child had been, was being or was likely to be abused or neglected or otherwise harmed.

Key findings

- In 2010–11, there were 101 Indigenous children aged 0–16 who were the subject of a substantiation in the Australian Capital Territory. Indigenous children aged 0–16 were more likely to be the subject of substantiation than non-Indigenous children aged 0–16 (55 per 1,000 compared with 4 per 1,000). Substantiation rates for Indigenous children were higher in the Australian Capital Territory than across Australia (Table 2.12.2, Appendix 2).
- The rate of Aboriginal and Torres Strait Islander children in the Australian Capital Territory who were the subject of substantiations showed an apparent increase between 2006–07 and 2009–10, and then decreased in 2010–11. Substantiation rates for Indigenous children nationally remained relatively stable over the period (Figure 2.12.1).
- As at 30 June 2011, there were 176 Indigenous children aged 0–17 who were on care and protection orders in the Australian Capital Territory. Indigenous children were over 13 times more likely to be on care and protection orders than non-Indigenous children (91 per 1,000 compared with 7 per 1,000) (Table 2.12.3, Appendix 2).
- As at 30 June 2011, there were 119 Indigenous children aged 0–17 who were in out-of-home care in the Australian Capital Territory. Indigenous children were nearly 12 times more likely to be in out-of-home care than non-Indigenous children (61 per 1,000 compared with 5 per 1,000). The rate of Indigenous children on care and protection orders was higher in the Australian Capital Territory than nationally (61 compared with 52 per 1,000) (Table 2.12.4, Appendix 2).
- About 64% of Aboriginal and Torres Strait Islander children in out-of-home care in the Australian Capital Territory were placed with relative/kin, other Indigenous caregivers or Indigenous residential care. This compared with 69% nationally (Table 2.12.1).



Note: Rates for the ACT should be interpreted with care due to small numbers. Any fluctuation in the numbers of children has a large impact on the rates.

Source: AIHW analysis of National Child Protection Data Collection 2011.

Figure 2.12.1: Rates (No. per 1,000 children) of Aboriginal and Torres Strait Islander and other children aged 0–16 who were the subject of substantiation, the Australian Capital Territory and Australia, 2006–07 to 2010–11

Table 2.12.1: Aboriginal and Torres Strait Islander children in out-of-home care: Indigenous status and relationship of carer, the Australian Capital Territory and Australia, at 30 June 2011

Relationship	ACT	Australia
	Number	
Indigenous relative/kin	54	4,803
Other Indigenous caregiver	13	2,055
Other relative/kin	9	1,657
Total placed with relatives/kin, other Indigenous caregivers or in Indigenous residential care	*76*	*8,515*
Other caregiver	43	3,788
Total not placed with relatives/kin, other Indigenous caregivers or in Indigenous residential care	*43*	*3,788*
Total	**119**	**12,303**
	Per cent	
Indigenous relative/kin	45.4	39.0
Other Indigenous caregiver	10.9	16.7
Other relative/kin	7.6	13.5
Total placed with relatives/kin, other Indigenous caregivers or in Indigenous residential care	*63.9*	*69.2*
Other caregiver	36.1	30.8
Total not placed with relatives/kin, other Indigenous caregivers or in Indigenous residential care	*36.1*	*30.8*
Total	**100.0**	**100.0**

Notes

1. This table does not include Aboriginal and Torres Strait Islander children who were living independently or whose living arrangements were unknown.
2. Percentages in the table may not add to 100 due to rounding.
3. Family group homes and residential care are reported under other caregiver.

Source: AIHW Child Protection Collections 2011.

2.13 Transport

Transport can be an important resource, providing communities with greater opportunity to pursue employment, educational, social and health outcomes.

Data are presented on the use of transport by Aboriginal and Torres Strait Islander people, including access to motor vehicles and perceived difficulty with transport, using data from the 2006 Census and the 2008 NATSISS.

Key findings

- According to the 2006 Census, 83% of Indigenous households and 91% of other households in the Australian Capital Territory had at least one vehicle, compared with 72% of Indigenous households and 87% of other households nationally (Table 2.13.1).
- The ratio of people to vehicles was slightly higher for Indigenous households with 1.19 people per vehicle in the Australian Capital Territory, compared with 1.16 people per vehicle for other households. Nationally, the ratio was 1.59 for Indigenous households and 1.19 for others.
- According to the 2008 NATSISS, Indigenous people in the Australian Capital Territory and nationally were more likely than non-Indigenous people to have difficulty getting to the places they needed to. In 2008, 17% of Indigenous people living in the Australian Capital Territory reported that they sometimes or often had difficulty, or could not get to places, compared with 10% of non-Indigenous people. A similar pattern was observed nationally (25% for Indigenous and 16% for non-Indigenous) (Figure 2.13.1).

Table 2.13.1: Households with at least one registered vehicle, by Indigenous status, the Australian Capital Territory and Australia, 2006

	Ratio of people aged 17 and over in occupied private dwellings to vehicle[(a)]			Proportion of households[(b)] with at least one vehicle		
	Indigenous[(c)]	Other[(d)]	Total	Indigenous[(c)]	Other[(d)]	Total
State/territory						
ACT	1.19	1.16	1.16	82.9	90.7	90.6
Australia[(e)]	1.59	1.19	1.19	71.9	87.2	86.9

(a) Excludes motorbikes.

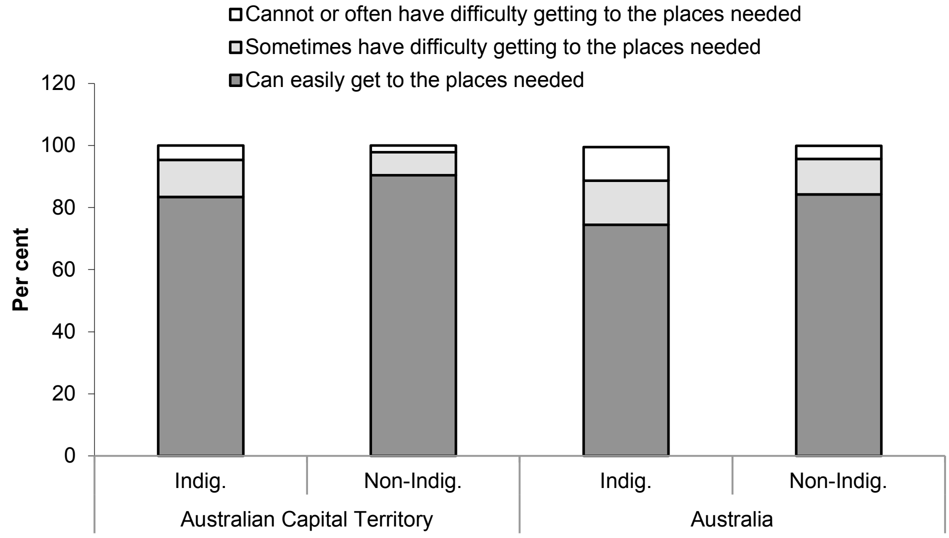
(b) Defined as all households (excluding visitor households), in an occupied private dwelling, being Australian usual residents.

(c) An Indigenous household is defined where a family within the household contains one or more people of Aboriginal or Torres Strait Islander origin or where a lone person is of Aboriginal or Torres Strait Islander origin.

(d) Includes households where Indigenous status was 'not stated'.

(e) Includes Territories of Christmas Island and Cocos Islands.

Source: ABS and AIHW analysis of 2006 Census data.



Source: ABS and AIHW analyses of NATSISS 2008 and General Social Survey (GSS) 2006.

Figure 2.13.1: Difficulty with transport, by Indigenous status, the Australian Capital Territory and Australia, people aged 18 and over, 2008

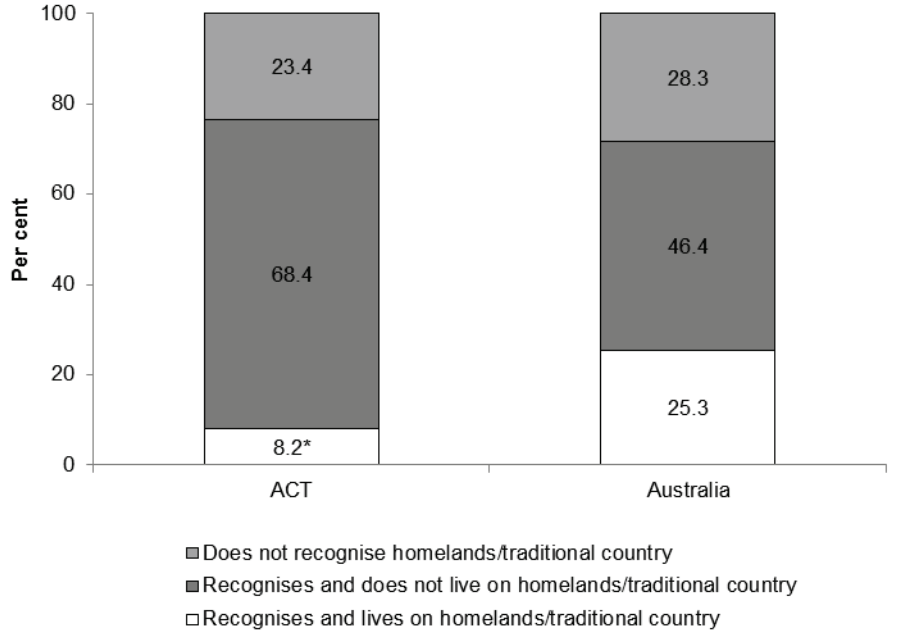
2.14 Indigenous people with access to their traditional lands

Loss of traditional lands has been associated with trauma, illness and poor social outcomes experienced by Aboriginal and Torres Strait Islander people today (Northern Land Council & Central Land Council 1994; Royal Commission into Aboriginal Deaths in Custody 1991). Ongoing access to traditional lands has been found to have a positive association with health among Aboriginal and Torres Strait Islander people (McDermott et al. 1998).

Data are presented on the proportion of Aboriginal and Torres Strait Islander people who identify with their clan or tribal group; and the proportion living on or visiting traditional areas of land with which they have ancestral and/or cultural links using data from the 2008 NATSISS.

Key findings

- According to the NATSISS, in 2008 in the Australian Capital Territory, approximately 71% of Aboriginal and Torres Strait Islander people aged 15 and over identified with their clan or tribal group. This was higher than the proportion for Indigenous people nationally (62%) (Table 2.14.1, Appendix 2).
- About 8% of Indigenous people in the Australian Capital Territory and 25% of Aboriginal and Torres Strait Islander people nationally, lived on their homelands in 2008. The proportion for the Australian Capital Territory should be interpreted with caution due to high relative standard errors (between 25% and 50%) (Figure 2.14.1).
- Around 23% of Indigenous people in the Australian Capital Territory reported they did not recognise their homelands in 2008. This compared with 28% for Aboriginal and Torres Strait Islander people nationally (Figure 2.14.1).



* Estimate has a relative standard error of between 15% and 50% and should be used with caution.

Source: AIHW analyses of NATSISS 2008.

Figure 2.14.1: Access to homelands/traditional country, Indigenous Australians aged 15 and over, the Australian Capital Territory and Australia, 2008

Health behaviours

In addition to various socioeconomic and community factors, individual behaviours play a key role in health and wellbeing outcomes. These include adverse health behaviours, such as tobacco smoking, physical inactivity, poor nutrition, alcohol consumption and illicit drug use. Many of these behaviours are more prevalent in populations with lower socioeconomic status, but this relationship is complex.

This section presents data on tobacco use, alcohol consumption, substance use, breastfeeding practices, physical activity level and dietary behaviour using data from the 2008 NATSISS and 2004–05 NATSIHS.

2.15 Tobacco use

Tobacco is one of the most widely used legal drugs in Australia, but its use is more prevalent in the Indigenous population than in the non-Indigenous population. Tobacco use plays a significant role in the gap between Indigenous and non-Indigenous Australians in life expectancy and health (Catto & Thomson 2008). Under the COAG Closing the Gap National Health Partnership, the Australian and state/territory governments are making significant investments in programs to tackle the high rates of smoking among Indigenous Australians.

Data are presented on the smoking status of Indigenous Australians using data from the 2008 NATSISS, with non-Indigenous comparisons from the 2007–08 NHS.

Key findings

- According to the NATSISS, in the Australian Capital Territory in 2008, about 36% of Aboriginal and Torres Strait Islander people aged 15 and over were current daily smokers, 1% were smokers who smoked weekly or less than weekly, 26% were ex-smokers and 38% had never smoked (Table 2.15.1).
- A lower proportion of Aboriginal and Torres Strait Islander people aged 15 and over in the Australian Capital Territory were current daily smokers than Aboriginal and Torres Strait Islander people of the same age nationally (36% compared with 45%).
- Aboriginal and Torres Strait Islander people in the Australian Capital Territory were more than twice as likely to be daily smokers as non-Indigenous people.

Table 2.15.1 Current daily smokers by Indigenous status, persons aged 15 and over, the Australian Capital Territory and Australia, 2008

	Australian Capital Territory			Australia		
Smoker status (%)	**Indigenous**	**Non-Indigenous**	**Rate ratio**	**Indigenous**	**Non-Indigenous**	**Rate ratio**
Current daily smoker	35.9	15.7	2.3	44.6	18.0	2.5
Current smoker other[a]	1.3	2.8	0.5	2.2	1.8	1.2
Ex-smoker	26.2	28.3	0.9	19.7	28.6	0.7
Never smoked	37.7	53.2	0.7	33.5	51.6	0.6
All persons	**100.0**	**100.0**	. .	**100.0**	**100.0**	..
Total number of persons	**2,810**	**268,844**	. .	**327,101**	**16,374,202**	. .

(a) Includes current smoker weekly and current smoker less than weekly.

Source: AIHW analyses of NATSISS 2008 and National Health Survey 2007–08.

2.16 Risky and high-risk alcohol consumption

Excessive consumption of alcohol is a major risk factor for conditions such as liver disease, pancreatitis, diabetes and some types of cancer. Alcohol is also a frequent contributor to motor vehicle accidents, injuries and suicide. It can also lead to anti-social behaviour, domestic violence and family breakdown. Current levels of risky alcohol consumption (both chronic and binge) are a concern for Indigenous and non-Indigenous Australians alike, and are major risk factors for morbidity and mortality in both populations (AIHW 2006).

Data are presented on self-reported alcohol consumption at risky/high-risk levels by Aboriginal and Torres Strait Islander people compared with the non-Indigenous population using data from the 2004–05 NATSIHS.

Risky/high risk alcohol consumption

The consumption of alcohol at risky and high-risk levels was defined as alcohol consumption that exceeded the National Health and Medical Research Council (NHMRC) guidelines for low risk drinking in the short or long term. These guidelines are outlined below:

Short-term risky drinking is consumption of more than 6 but fewer than 11 standard drinks on any one day for males, and more than 4 but fewer than 7 standard drinks for females.

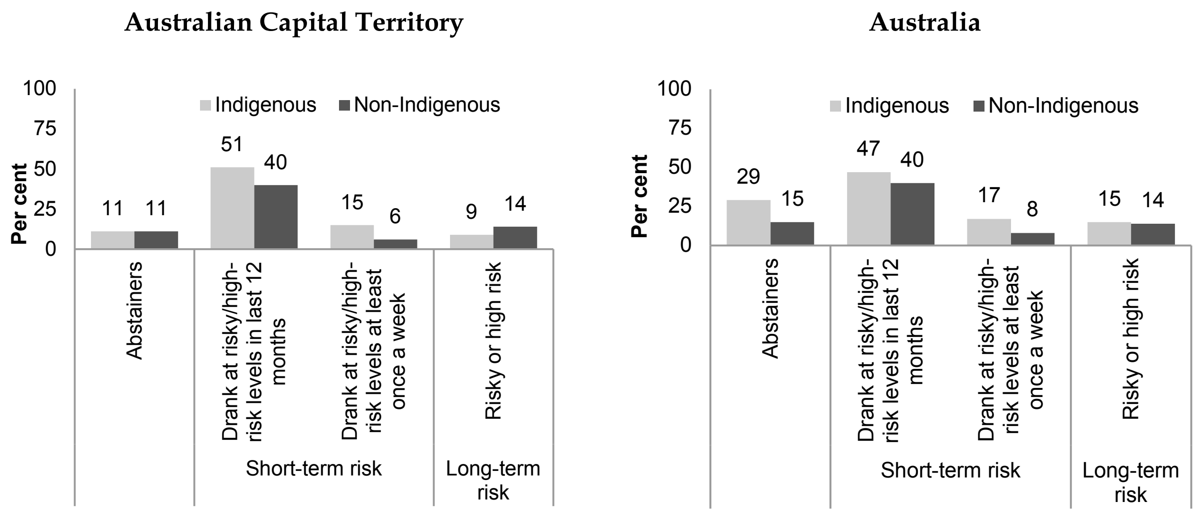
Short-term high-risk drinking is consumption of 11 or more standard drinks on any one day for males, and more than 7 standard drinks for females.

Long-term risky drinking is average consumption of more than 4 but fewer than 6 standard drinks per day (amounting to 29 but fewer than 42 per week) for males, and more than 2 but fewer than 5 standard drinks per day (amounting to 15 but fewer than 28 per week) for females.

Long-term high-risk drinking is average consumption of more than 6 standard drinks per day (amounting to 43 or more per week) for males, and more than 4 standard drinks per day (amounting to 29 or more per week) for females.

Key findings

- In 2004–05 in the Australian Capital Territory, a similar proportion of Indigenous and non-Indigenous adults reported having abstained from alcohol consumption in the last 12 months (both at 11%) (Figure 2.16.1). At the national level, 29% of Indigenous and 15% of non-Indigenous adults were abstainers.
- In the Australian Capital Territory, about 51% of Indigenous adults drank at short-term risky/high-risk levels in the last 12 months, and 15% reported drinking at short-term risky/high-risk levels at least once a week. This compares with 40% and 6% respectively for non-Indigenous adults. Similar patterns can be observed nationally.
- About 11% of Indigenous adults in the Australian Capital Territory drank at long-term risky/high-risk levels in the last 12 months (Table 2.16.1, Appendix 2).
- After adjusting for differences in age-structure, Indigenous adults in the Australian Capital Territory were less likely to drink at long-term risky/high-risk levels in the last 12 months (9% compared with 14%). The proportions nationally were 15% and 14% for Indigenous and non-Indigenous adults respectively.



Notes

1. Risk level based on Australian Alcohol Guidelines 2000.
2. Based on responses to questions in 2004–05 National Health Survey/NATSIHS about frequency of consumption of specified number of drinks in previous year. The number of drinks was based on the NHMRC guidelines for risky and high-risk short-term alcohol consumption for males and females.
3. Long term risk level based on consumption in week prior to interview.

Source: ABS and AIHW analyses of NATSIHS 2004–05 and NHS 2004–05.

Figure 2.16.1: Alcohol risk levels by Indigenous status, people aged 18 and over, age standardised, the Australian Capital Territory and Australia, 2004–05

2.18 Physical activity

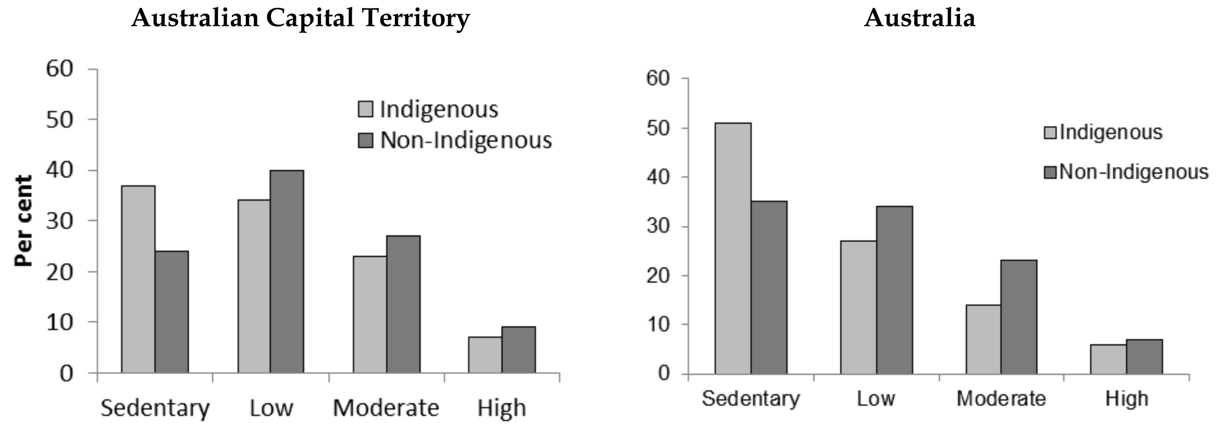
Physical inactivity is associated with several preventable chronic diseases, including cardiovascular disease, hypertension and diabetes, all of which are highly prevalent in the Indigenous population. It is also related to overweight and obesity, important risk factors for multiple diseases.

Data are presented on self-reported physical activity levels of Aboriginal and Torres Strait Islander and non-Indigenous adults using data from the 2004–05 NATSIHS. Data are reported for the Australian Capital Territory and non-remote areas of Australia, as information on physical activity were not collected for remote areas of Australia in the NATSIHS.

Key findings

- In 2004–05, in the Australian Capital Territory, 37% of Aboriginal and Torres Strait Islander people aged 15 and over reported their exercise level as sedentary in the 2 weeks before the survey, 34% reported it as low, 23% as moderate and 7% as high (Figure 2.18.1).
- Compared with Indigenous people nationally (in non-remote areas), a lower proportion of Indigenous people in the Australian Capital Territory reported their exercise level as sedentary and a higher proportion reported their exercise level as moderate or high (Figure 2.18.1).

- After adjusting for differences in age structure between the Indigenous and non-Indigenous populations, a higher proportion of Indigenous than non-Indigenous people in the Australian Capital Territory reported their exercise level as sedentary, and a slightly lower proportion reported their exercise levels as moderate or high (Figure 2.18.1).



Source: ABS and AIHW analyses of NATSIHS 2004–05 and NHS 2004–05.

Figure 2.18.1: People aged 15 and over, level of physical activity, by Indigenous status, the Australian Capital Territory and Australia (non-remote areas), 2004–05

2.20 Breastfeeding practices

Breastfeeding provides many benefits to young children including to reduce children's risk of sudden infant death syndrome (SIDS) and many types of infections and allergies. Breast milk may also help protect young children from some health problems, such as eczema, obesity, asthma, and diabetes (Lawrence & Lawrence 2009; Public Health Agency of Canada, et al. 2011).

Data are presented on the he breastfeeding status of Aboriginal and Torres Strait Islander infants using data from the 2008 NATSISS and 2004–05 NATSIHS.

Key findings

- According to the NATSIHS, in 2004-05 in the Australian Capital Territory, approximately 92% of Indigenous infants aged 0-3 years had ever been breastfed, which was similar to the proportion for non-Indigenous infants (96%). These proportions were higher than for Indigenous and non-Indigenous infants in non-remote areas of Australia (Table 2.20.1).
- Among children aged 0 to less than 6 months, approximately 41% of Indigenous infants had been breastfed compared to 29% of non-Indigenous infants. Nationally 33% of Indigenous infants and 36% of non-Indigenous infants of this age had been breastfed.
- According to the NATSISS, in 2008 in the Australian Capital Territory, about 73% of Indigenous infants aged 0–3 years had ever been breastfed, compared with 76% of Indigenous infants of the same age nationally (Table 2.20.2, Appendix 2).

Table 2.20.1: Breastfeeding status, by Indigenous status, infants aged 0–3 years, 2004–05

	ACT		Australia[a]	
Breastfeeding measure	**Indig.**	**Non-Indig.**	**Indig.**	**Non-Indig.**
Child has been breastfed		Per cent		
0 to less than 6 months	41	29	33	36
For 6 to 12 months	16[b]	24	19	22
12 months or more	17[b]	23[b]	13	14
Currently breastfeeding	17[b]	21[b]	13	16
Ever breastfed	***92***	***96***	***79***	***88***
Never breastfed	n.p(c)	4[b]	21	12
Total	**100**	**100**	**100**	**100**
Total no. of infants	433	16,702	34,964	933,013

(a) Data are for non-remote areas only.

(b) Estimate has a relative standard error of between 25% and 50% and should be used with caution.

(c) Data is not provided due to an estimated relative standard error of greater than 50% and is considered too unreliable for general use.

(d) Indicates that the maximum length of time breastfed in weeks is greater than this value, but for confidentiality reasons the maximum length of time cannot be released.

Source: AIHW and ABS analysis of 2004-05 NATSIHS.

2.21 Health behaviours during pregnancy

Health behaviours during pregnancy can have major impacts on the health outcomes of mothers and their children. Smoking during pregnancy can result in health problems for the newborn, including low birthweight, intrauterine growth restriction, prematurity, placental complications, birth defects, lung function abnormalities and respiratory symptoms and perinatal mortality (Jauniaux & Burton 2007; Julvez et al. 2007). Drinking alcohol while pregnant may result in a range of impairments in cognitive, social and emotional functioning over the child's lifetime (France et al. 2010). Nutrition before and during pregnancy is also critical to fetal development (McDermott et al. 2009).

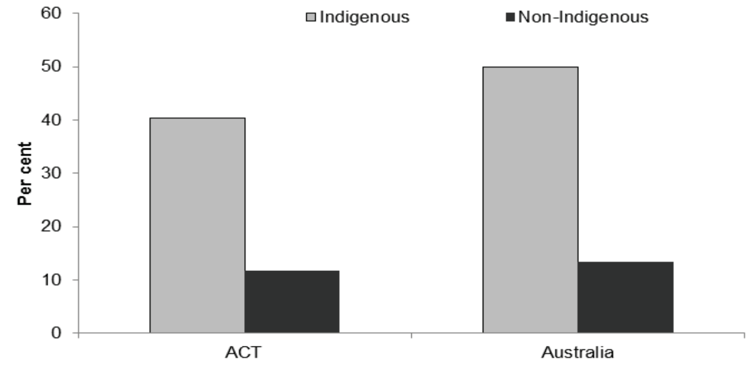
Data are presented on smoking during pregnancy from the National Perinatal Data Collection, health issues of mothers from the NATSISS, and risk factors of mothers reported during antenatal care from the Healthy for Life (HfL) data collection. HFL data for the Australian Capital Territory has been combined with New South Wales due to small numbers.

Key findings

- According to the National Perinatal Data Collection in the Australian Capital Territory in 2009, about 51% of Aboriginal and Torres Strait Islander mothers smoked during pregnancy (Table 2.21.1, Appendix 2).
- After adjusting for differences in age structure, Aboriginal and Torres Strait Islander mothers in the Australian Capital Territory were 3.4 times as likely as non-Indigenous mothers to report smoking during pregnancy (40% compared with 12%). These were lower than the proportions nationally (40% compared with 50%) (Figure 2.21.1).
- According to the 2008 NATSISS, in the Australian Capital Territory, about 30% of Indigenous mothers of children aged 0–3 reported that they smoked/chewed tobacco during pregnancy, 38% reported that they sought advice about pregnancy and child

birth, 35% took medications or supplements during pregnancy, 58% took folate before/or during pregnancy, and 21% had high blood pressure (Figure 2.21.2). Some of these estimates, however, must be used with caution due to high relative standard errors (between 25% and 50%).

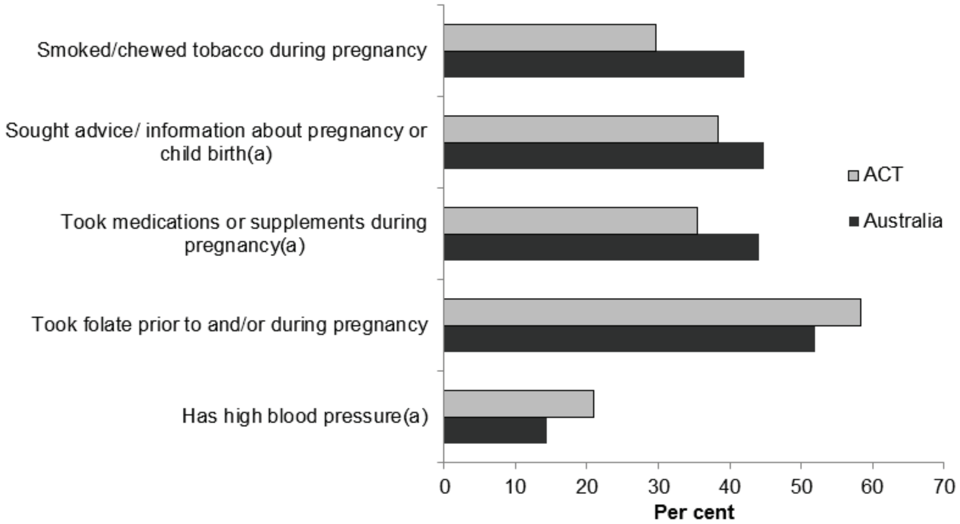
- Of mothers in the Australian Capital Territory and New South Wales combined who were regular clients of a Healthy for Life Indigenous primary health-care service and attended antenatal care in the first trimester, 49% reported smoking, 22% reported low/high-risk alcohol consumption and 18% reported using illicit drugs in 2009–10 (Table 2.21.2, Appendix 2).



Note: Proportions are age-standardised. Excludes mothers for whom smoking status was not stated.

Source: National Perinatal Data Collection.

Figure 2.21.1: Proportion of mothers who smoked during pregnancy, by Indigenous status, the Australian Capital Territory and Australia, 2009



(a) Estimate for ACT has a relative standard error between 25% and 50% and should be used with caution.

Source: 2008 NATSISS.

Figure 2.21.2: Selected health issues of Indigenous mothers, children aged 0–3, the Australian Capital Territory and Australia 2008

Person-related factors

This section is on one measure — overweight and obesity.

2.22 Overweight and obesity

Overweight and obesity is a major current health problem for Australia, with more than 60% of Australian adults overweight or obese in 2007–08 (AIHW 2011b). The consequences of being overweight or obese are many and varied, including the risk of suffering coronary heart disease, Type 2 diabetes, some cancers, knee and hip problems, and sleep apnoea. Obesity is closely associated with risk factors for some of the major causes of morbidity and mortality amongst Aboriginal and Torres Strait Islander people, such as diabetes (NHMRC 2000). Obesity was estimated to contribute 16% of the health gap between Aboriginal and Torres Strait Islander people and the total Australian population in 2003 (Vos et al. 2007).

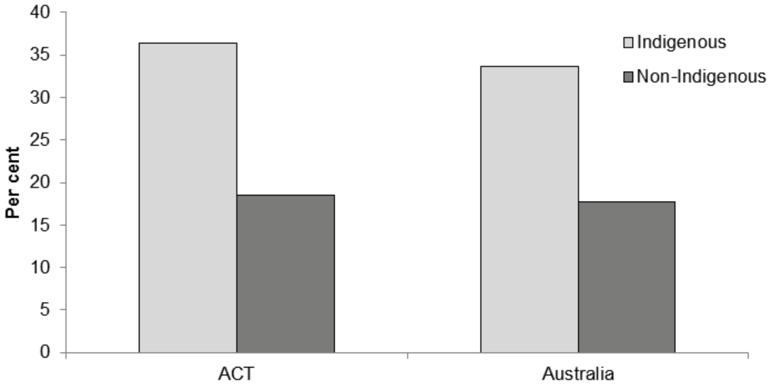
Data are presented on the prevalence of overweight and obesity among Aboriginal and Torres Strait Islander adults based on body mass index using data from the 2004–05 NATSIHS.

Body mass index

Body mass index (BMI), is calculated by dividing weight in kilograms by height in metres squared. The normal range of BMI is between 18.5 and 25. A person is underweight if his/her BMI is less than 18.5, or overweight if the BMI is equal to or more than 25. A person is obese if the BMI is equal to or more than 30.

Key findings

- In 2004–05, about 58% of Aboriginal and Torres Strait Islander people aged 15 and over in the Australian Capital Territory were overweight or obese. This was similar to the proportion of Indigenous people nationally (57%) (Table 2.22.1, Appendix 2).
- About 31% of Indigenous adults in the Australian Capital Territory were obese (BMI greater than 30). After adjusting for differences in age structure, Indigenous adults were twice as likely to be obese as non-Indigenous adults (Figure 2.22.1). The same pattern was observed nationally.



Source: 2004–05 NATSIHS, 2004–05 NHS.

Figure 2.22.1: Proportion of adults who are obese (BMI greater than 30), by Indigenous status, the Australian Capital Territory and Australia, 2004–05

Part 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 procedure

3.07 Selected potentially preventable hospital admissions

3.08 Cultural competency

Accessible

3.14 Access to services by types of services compared to 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 disease

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 Australian in the health workforce

3.13 Competent governance

Capable

3.19 Accreditation

3.20 Aboriginal and Torres Strait Islander peoples training for health related disciplines

Sustainable

3.21 Expenditure on Aboriginal and Torres Strait Islander health compared to need*

3.22 Recruitment and retention of staff

* Indicators for which data for the Australian Capital Territory is unavailable and/or not considered adequate for reporting

The third part of this report, Health System Performance, presents Tier 3 measures of the Aboriginal and Torres Strait Islander Health Performance Framework. Tier 3 aims to cover the entire health system including Indigenous specific services and programs, and mainstream services. The measures examine a number of different factors, including child and maternal health, health promotion, access to care, early detection and chronic disease management, the health workforce and adequacy of resources.

Tier 3 is structured around addressing five key questions:

- Is the health system effective/appropriate/efficient?
- Is the health system responsive to needs of Indigenous people?
- Is health care accessible?

- Is there continuity in quality health care?
- Is the health system capable and sustainable?

Is the health system effective/appropriate/efficient?

This section includes measures on effectiveness, appropriateness and efficiency of the health system in the following areas: immunisation, early detection and early treatment, chronic disease management, access to hospital procedures, potentially preventable hospital admissions and cultural competency.

3.02 Immunisation

Immunisation is an effective way of protecting people against harmful diseases before they come into contact with them in the community. Immunisation therefore not only protects individuals, but also others in the community, by reducing the spread of disease. The Immunise Australia Program aims to reduce morbidity and mortality associated with several vaccine-preventable diseases by funding a series of age-specific vaccinations as outlined in the National Immunisation Program Schedule (DoHA 2010). Increasing the proportion of Indigenous children who are fully vaccinated is one of the agreed outcomes of the Indigenous Early Childhood Development National Partnership (COAG 2009).

Data are presented on vaccination coverage rates among Indigenous Australian children using data from the Australian Childhood Immunisation Register, and immunisation of influenza and pneumonia by Indigenous adults using data from the 2004–05 NATSIHS. NATSIHS data for the Australian Capital Territory has been combined with New South Wales due to small numbers.

Key findings

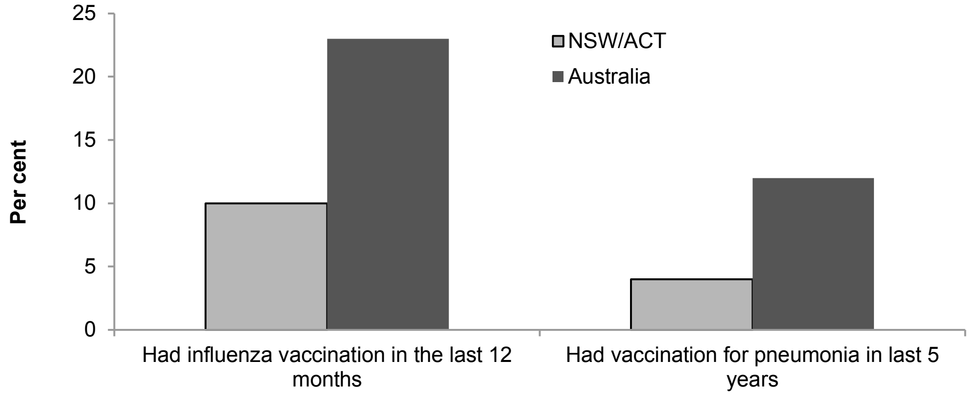
- Data as at December 2011, collected for children born between 1 July and 30 September 2010 in the Australian Capital Territory, about 85% of Indigenous children aged 1 year were fully vaccinated, compared with 94% of other children. A similar pattern can be observed for Indigenous and other children aged 2 in the Australian Capital Territory (86% and 94%), however, by age 5 rates are similar (89% and 93%, respectively) (Table 3.02.1).
- Vaccination coverage rates for Indigenous children in the Australian Capital Territory were the same as for Indigenous children reported nationally for 1 year old, were lower for 2 year olds, and were slightly higher for 5 year olds.
- Vaccination coverage rates for Indigenous children in the Australian Capital Territory were similar for all types of vaccines in the national schedule (Table 3.01, Appendix 1).
- In 2004–05, about 10% of Indigenous Australians aged 18–49 in New South Wales/Australian Capital Territory had influenza vaccination in the last 12 months and about 4% had vaccination for pneumonia in the last 5 years. These proportions were lower than those reported nationally (Figure 3.02.1).

Table 3.02.1: Vaccination coverage estimates for selected diseases for children 'fully vaccinated' at 1, 2 and 5 years of age, by Indigenous status, Australian Capital Territory and Australia, as at 31 December 2011

	Australian Capital Territory	Australia
	Per cent	
1 year of age		
Indigenous	85.2	85.2
Other	93.5	93.5
Ratio	0.9	0.9
Rate difference	–8.3	–8.3*
2 year of age		
Indigenous	85.7	92.3
Other	93.8	92.6
Ratio	0.9	1.0
Rate difference	–8.1	–0.3
5 year of age		
Indigenous	88.9	86.5
Other	92.6	90.1
Ratio	1.0	1.0
Rate difference	–3.7	–3.6*

* Represents results with statistically significant differences in the Indigenous/other comparisons.

Source: AIHW analysis of ACIR Medicare Australia data.



Source: ABS and AIHW analyses of NATSIHS 2004–05 and NHS 2004–05.

Figure 3.02.1: Indigenous adults aged 18 to 49: immunisation status, New South Wales/Australian Capital Territory and Australia, 2004–05

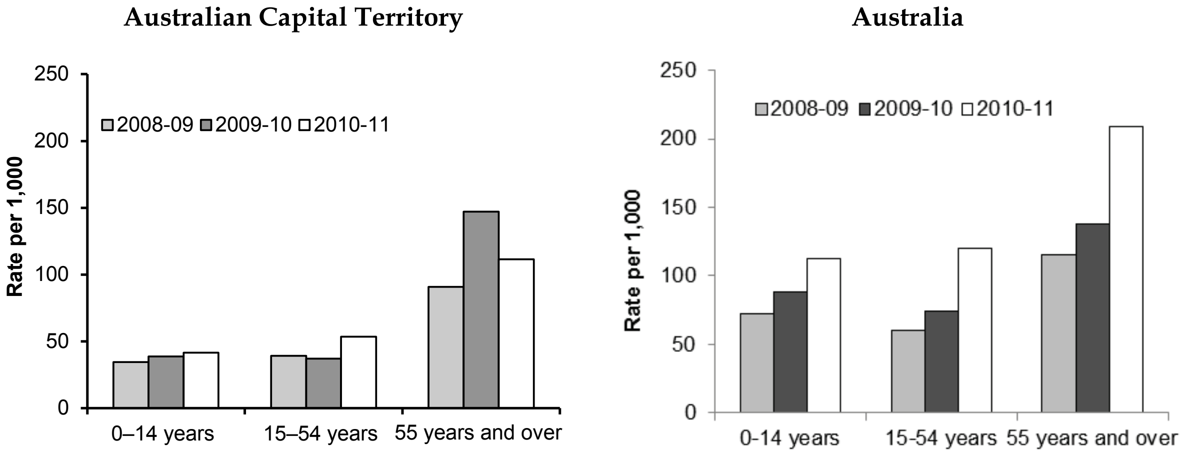
3.04 Early detection and early treatment of disease

Early detection is the discovery of a disease or condition at an early stage of its onset or development. Disease screening and regular health checks help prevent or delay the onset of a variety of conditions. Population-based screening activities, such as breast, bowel and cervical cancer screening programs, focus on detecting diseases in their early or pre-disease stages or to prevent occurrence of disease in the first place (cervical screening) to reduce morbidity and mortality. National programs for breast and cervical cancer screening were implemented in Australia in the early 1990s, and the national program for bowel cancer screening was implemented in 2006. Several item numbers are available under the Medicare Benefits Schedule (MBS) to encourage primary care providers to carry out regular health assessments, including some specific items for Aboriginal and Torres Strait Islander patients.

Data are presented on the health assessment and disease screening of Aboriginal and Torres Strait Islander people using MBS data, and data from BreastScreen Australia.

Key findings

- In the Australian Capital Territory from July 2010 to June 2011:
  - 42 per 1,000 Indigenous children aged 0–14 had an annual child health check
  - 54 per 1,000 Indigenous people aged 15–54 had a two-yearly health check
  - 111 per 1,000 Indigenous people aged 55 and over had an annual health assessment (Figure 3.04.1).
- The rate of Aboriginal and Torres Strait Islander people in the Australian Capital Territory undertaking health checks and health assessments at age 0–14, 15–54, and 55 and over was lower than for Indigenous people nationally (Figure 3.04.1).
- The introduction of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes occurred in July 2008. There has been an increase in the rate of health assessments provided to Aboriginal and Torres Strait Islander people aged 55 years and over between 2008-09 and 2009-10 (Figure 3.04.1).
- The BreastScreen Australia program focuses on women aged 50–69, although women aged 40 and over may also receive free screening. In 2008–09 in the Australian Capital Territory, the number of Indigenous women aged 50–69 participating in the BreastScreen Australia program was too low for age-standardised rates to be calculated. For women aged 40 and over, about 24% of Indigenous women in the Australian Capital Territory participated in the Breast Screen Australia program compared with 30% of other women (Table 3.04.1).
- BreastScreen participation rates were higher for Aboriginal and Torres Strait Islander women in the Australian Capital Territory than for Aboriginal and Torres Strait Islander people women nationally for age groups 60–64 and 65 and over (Table 3.04.1).



Source: AIHW analyses of Medicare data.

Figure 3.04.1: Medicare Benefits Schedule Health Assessments and Health Checks for Indigenous people, the Australian Capital Territory and Australia, 2008-09, 2009-10 and 2010-11

Table 3.04.1: Age-specific participation rates[(a)] in BreastScreen Australia programs, Indigenous and other women, the Australian Capital Territory and Australia, 2008–2009

	Australian Capital Territory		Australia	
Age group (years)	Indigenous	Other	Indigenous	Other
		Per cent		
40–49	6.8	8.7	12.4	14.8
50–59	25.3	50.3	34.4	53.4
60–64	46.4	61.0	39.2	59.7
65+	34.1	25.3	24.3	24.5
40+ (age-standardised rate)[(b)]	**23.7**	**29.9**	**24.5**	**32.5**
50–69 (age-standardised rate)[(b)(c)]	**n.p.**	**n.p.**	**36.5**	**55.5**
		Rate ratio[(c)]		
40+	**0.8**	. .	**0.8***	. .
50–69	**n.p.**	. .	**0.7***	. .
		Rate difference[(d)]		
40+	**–6.2**	. .	**–7.9***	. .
50–69	**n.p.**	. .	**–19.0***	. .

* Represents results with statistically significant differences in the Indigenous/other women comparisons.

(a) Rates are the number of women screened as a percentage of the eligible female population calculated as the average of the 2008 and 2009 ABS estimated resident population.

(b) Rates are directly age-standardised to the Australian 2001 standard population.

(c) Rate ratio Indigenous: other women.

(d) Rate difference Indigenous: other women.

Source: AIHW analysis of BreastScreen Australia data.

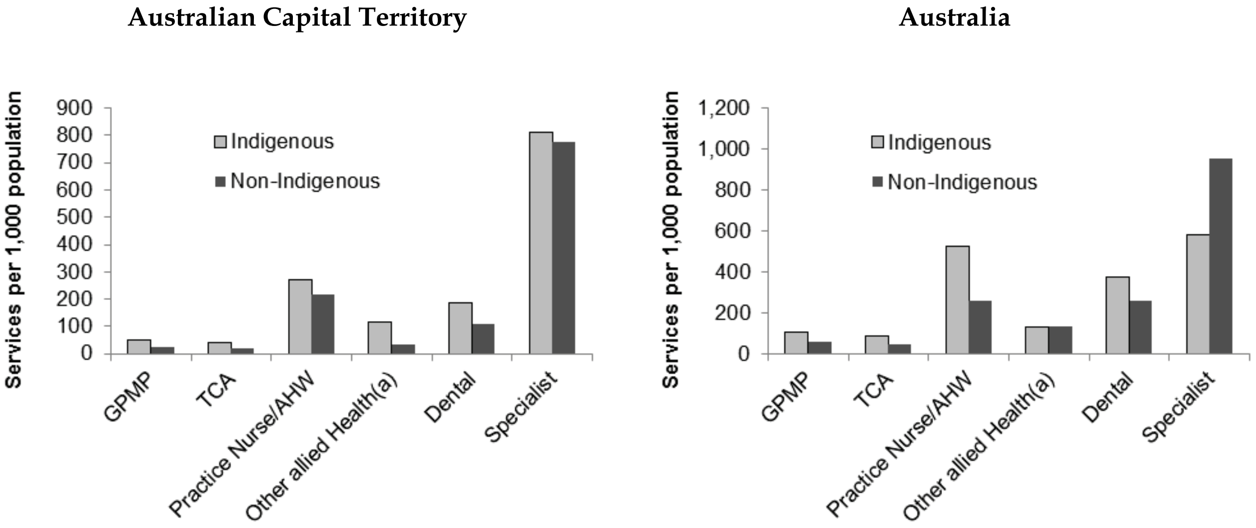
3.05 Chronic disease management

Chronic diseases are accountable for a large part of the disease burden in Australia, and many of these diseases are avoidable if the known risk factors are managed (AIHW 2012b). Better management of these conditions is an important factor in meeting the target of closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. Effective management of chronic disease can delay the progression of disease, improve quality of life, increase life expectancy, and decrease the need for high-cost interventions.

Data are presented on the management of chronic disease by Indigenous primary health care services using Medicare data, and data from the HfL data collection.

Key findings

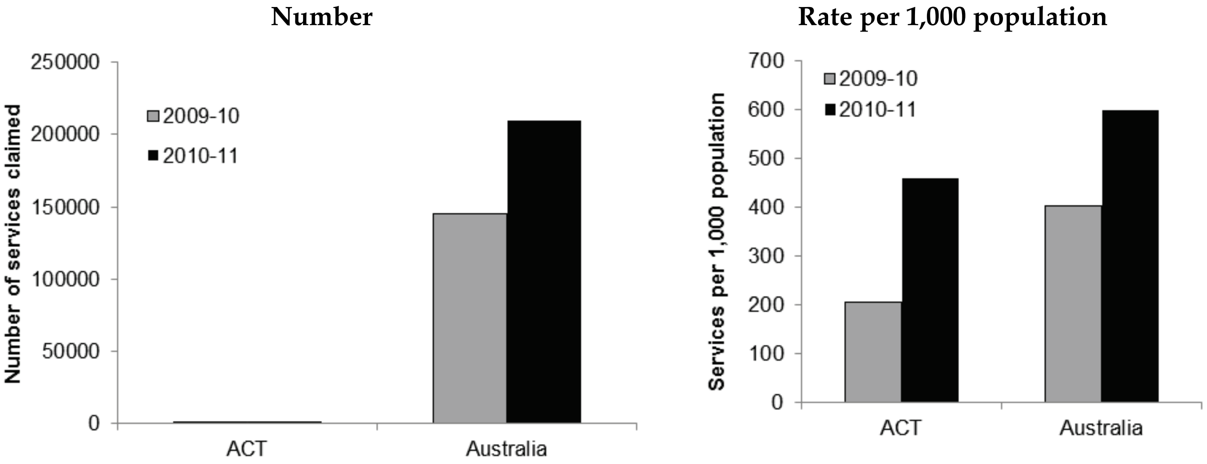
- Medicare claims data show that in 2010–11, there were 151 general practitioner management plan claims (GPMPs) and 114 team care arrangements (TCAs) for Indigenous Australians in the Australian Capital Territory. Rates were twice as high for these services for Indigenous Australians compared with non-Indigenous Australians (Figure 3.05.1).
- Indigenous Australians in the Australian Capital Territory also had higher rates of nurse/Aboriginal Health Worker consultations and dental consultations claimed than non-Indigenous Australians.
- Rates of MBS services claimed by Indigenous Australians in the Australian Capital Territory were lower than those claimed nationally, except for specialist services (811 per 1,000 population for the Australian Capital Territory compared with 580 per 1,000 nationally) (Figure 3.05.1).
- There has been an increase in the total number of allied health care services claimed through Medicare by Indigenous Australians in the Australian Capital Territory between 2009–10 and 2010–11 from 784 to 1,349 services. The rate of allied health services claimed has also increased for Indigenous people in the Australian Capital Territory from 207 to 459 per 1,000 population, which was a larger increase than that observed nationally (Figure 3.05.2).
- Data on GPMPs and TCAs is not available by state/territory for 2009–10; however, national data suggests there has also been an increase in these services claimed by Indigenous Australians through Medicare since 1 July 2009.
- Between January and June 2010, of the Indigenous regular clients of services in New South Wales and the Australian Capital Territory combined, that were part of the Healthy for Life program that had Type 2 diabetes, 67% had a blood pressure test in the last 6 months, which was higher than that reported nationally (62%); and 50% had a HbA1C test in the last 6 months, which was slightly lower than that reported nationally (52%) (Table 3.05.1).
- Over the same period, of the Indigenous regular clients with coronary heart disease, 68% had a blood pressure test in the last 6 months, which was almost the same as the proportion nationally (69%).



(a) Includes Aboriginal Health Workers (AHW).

Source: AIHW analyses of Medicare data.

Figure 3.05.1: Age-standardised-rate of selected MBS services claimed per 1,000 population, Indigenous and non-Indigenous Australians, the Australian Capital Territory and Australia, 2010–11



Source: AIHW analyses of Medicare data.

Figure 3.05.2: Number and age-standardised rate per 1,000 population of MBS total allied health services claimed, Indigenous Australians, the Australian Capital Territory and Australia, 2009–10 and 2010–11

Table 3.05.1: Proportion and number of Indigenous regular clients[(a)] with Type 2 diabetes or coronary heart disease who had a blood pressure test in last 6 months, and HbA1C test in the last 6 months (diabetes only), New South Wales and the Australian Capital Territory and Australia, 1 January–30 June 2010

	NSW/ACT		Australia	
	No	Per cent	No	Per cent
Clients with Type 2 diabetes who had blood pressure test in last 6 months	995	66.6	8,253	62.2
Clients with coronary heart disease who had blood pressure test in last 6 months	430	68.4	2,748	69.4
Clients with Type 2 diabetes who had HbA1C test in last 6 months	741	49.6	6,874	51.8

(a) Indigenous regular clients aged 15 years and over.

Source: AIHW HfL data collection.

3.06 Access to hospital procedures

Studies have shown that while Aboriginal and Torres Strait Islander people are more likely to be hospitalised than other people, they are less likely to receive a medical or surgical procedure while in hospital (ABS & AIHW 2008).

Data are presented on the key hospital procedure differentials between Aboriginal and Torres Strait Islander people and non-Indigenous Australians using data from the National Hospital Morbidity Database.

Key findings

- Between July 2008 and June 2010 in the Australian Capital Territory, 73% of hospitalisations of Aboriginal and Torres Strait Islander people had a procedure reported, compared with 76% of hospitalisations of non-Indigenous people. Nationally, these proportions were 60% and 81% respectively (Table 3.06.1).
- Indigenous people hospitalised with a principal diagnosis of diseases of the eye and adnexa were most likely to have a procedure reported (101%) followed by congenital malfunctions (97%). Non-Indigenous people hospitalised with a principal diagnosis of diseases of the eye and adnexa were most likely to have a procedure reported (98%), followed by congenital malfunctions and neoplasms (both 96%) (Figure 3.06.1).
- The proportion of hospitalisations with a procedure reported was lower for Indigenous patients than for non-Indigenous patients for almost all of the diagnosis chapters. The largest differences were for persons hospitalised for diseases of the respiratory system and diseases of the blood (Figure 3.06.1).

Table 3.06.1: Number and proportion of hospitalisations with a procedure recorded[(a)], by Indigenous status, the Australian Capital Territory and Australia, July 2008 to June 2010

	Indigenous		Non-Indigenous			
	No.	Per cent	No.	Per cent	Ratio[(b)]	Difference[(c)]
ACT	1,159	72.5	82,217	76.1	1.0	–3.7
Australia	**191,222**	**60.0**	**11,065,696**	**81.4**	**0.74***	**–21.4***

* Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons at the $p < 0.05$ level.

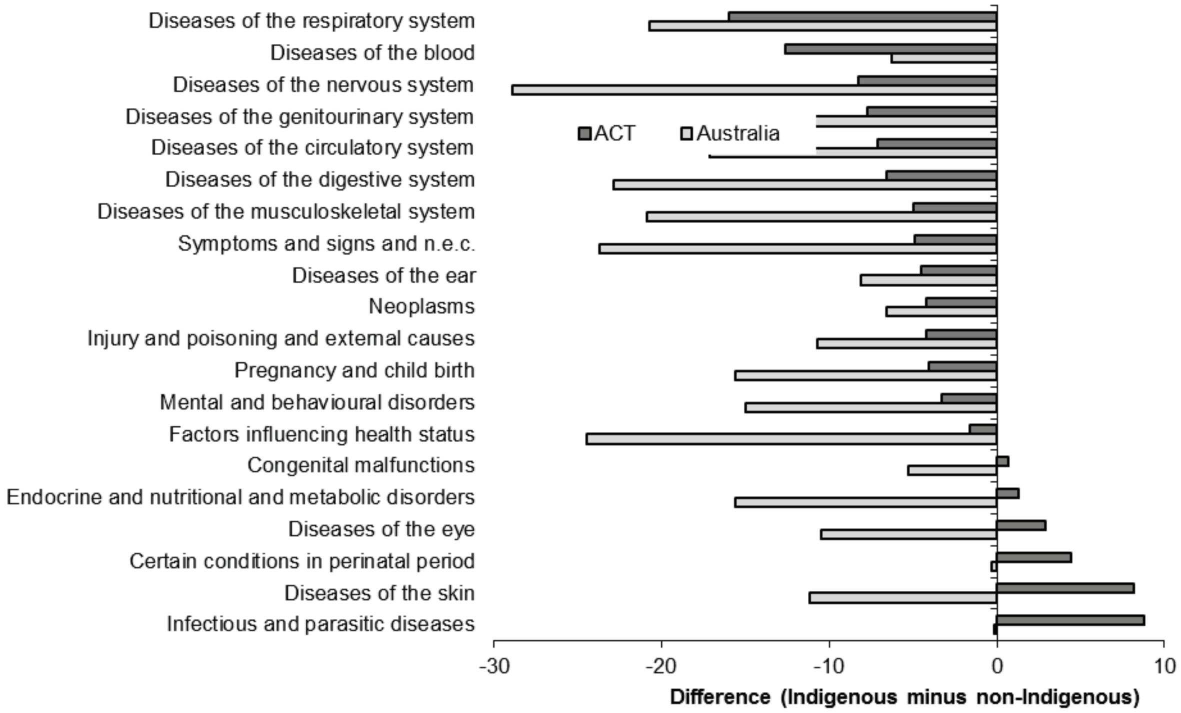
(a) Hospitalisations with a principal diagnosis of care involving dialysis (Z49) have been excluded.

(b) Ratio—Indigenous divided by non-Indigenous.

(c) Difference—Indigenous minus non-Indigenous.

Note: Proportions are age-standardised using the age-specific rates of non-Indigenous Australians.

Source: AIHW analysis of National Hospital Morbidity Database.



Source: AIHW analysis of National Hospital Morbidity Database.

Figure 3.06.1: Per cent (age standardised) differences between Indigenous and non-Indigenous hospital episodes with a procedure reported, selected principal diagnoses, Australian Capital Territory and Australia, 2008–09 to 2009–10

3.07 Selected potentially preventable hospital admissions

An indirect measure of access to primary care is the rate of potentially preventable hospitalisations. These are hospitalisations that could potentially have been prevented through the timely and appropriate provision of primary care or other non-hospital services. A high rate may indicate an inadequacy in non-hospital care; however, it may also reflect hospitals responding appropriately to a high prevalence of certain conditions which could have been prevented in other ways.

Data are presented on rates of potentially preventable hospital admissions for Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians.

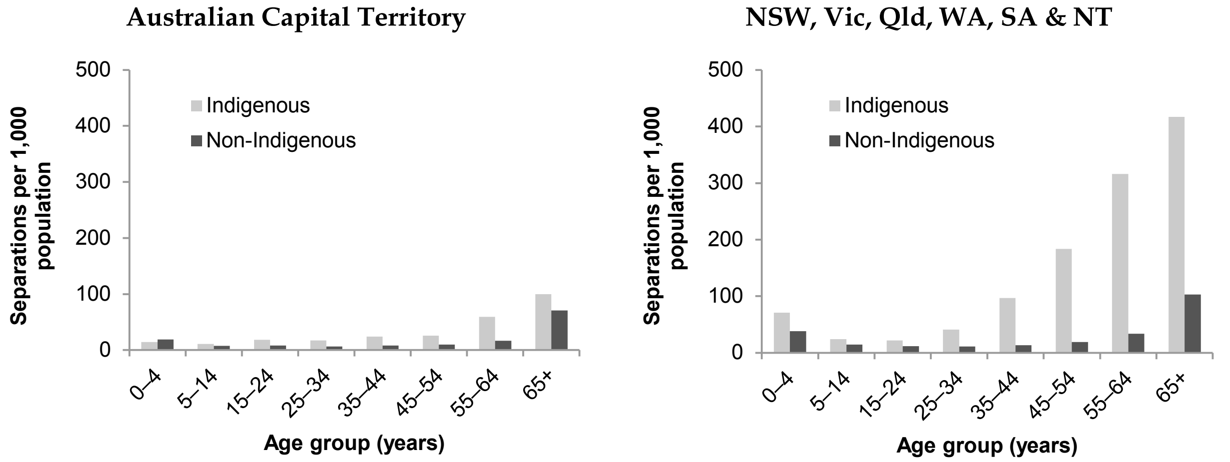
Potentially preventable conditions

Potentially preventable conditions can be divided into three categories:

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

Key findings

- Between July 2008 and June 2010 in the Australian Capital Territory, Aboriginal and Torres Strait Islander people were hospitalised for potentially preventable conditions at a rate of 34 per 1,000 population, which was 1.9 times the rate of non-Indigenous people in the Australian Capital Territory. This was much lower than the rate and rate ratio for New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (137 per 1,000; rate ratio of 4.8) (Table 3.07.1, Appendix 2).
- Indigenous people had higher hospitalisation rates than non-Indigenous people for potentially preventable conditions across all age groups, except age group 0–4. Differences were particularly marked in the 55–64 year age group, where Indigenous people were hospitalised at 3.6 times of the rate of non-Indigenous people (Figure 3.07.1).
- In the Australian Capital Territory, Indigenous people were hospitalised for chronic conditions at 2.2 times the rate of non-Indigenous Australians, for acute conditions at 1.7 times the rate and for vaccine preventable conditions at 1.6 times the rate of non-Indigenous Australians (Figure 3.07.2).
- Hospitalisation rates for Aboriginal and Torres Strait Islander people for chronic conditions, acute conditions and vaccine preventable conditions were lower in the Australian Capital Territory than in the six jurisdictions combined.
- Diabetes complications were the most common type of potentially preventable condition for which Indigenous people in the Australian Capital Territory were hospitalised (11 per 1,000 population); followed by dehydration and gastroenteritis disease (4 per 1,000) and ear, nose and throat infections (3 per 1,000). Indigenous people were hospitalised at 3 times the rate of non-Indigenous people for diabetes complications, at 2 times the rate for dehydration and gastroenteritis disease and 1.7 times the rate for ear, nose and throat infections (Table 3.07.1, Appendix 2).

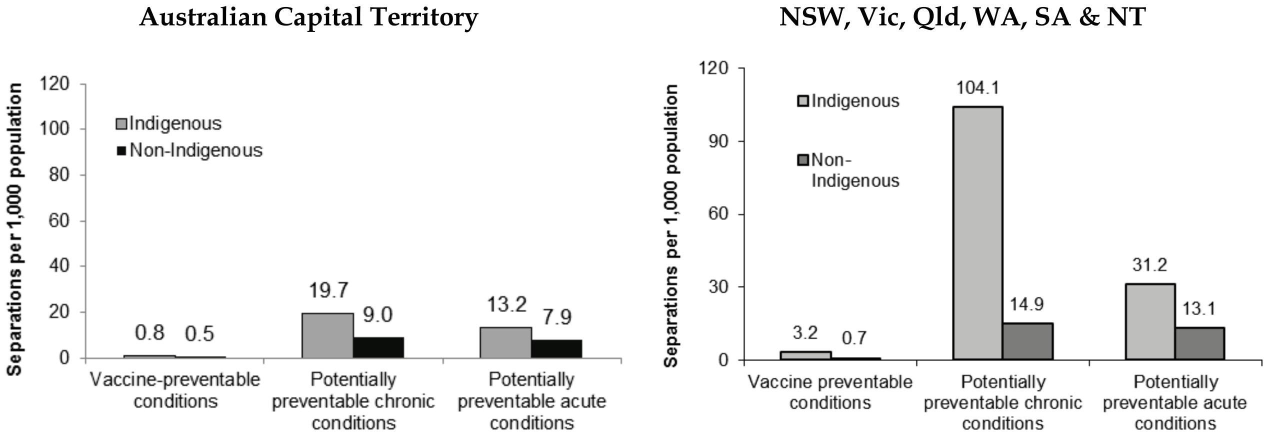


Australian Capital Territory

NSW, Vic, Qld, WA, SA & NT

Source: AIHW analysis of National Hospital Morbidity Database.

Figure 3.07.1: Age-specific hospitalisation rates for potentially preventable hospital admissions, by Indigenous status, the Australian Capital Territory and NSW, Vic, Qld, WA, SA & NT combined, July 2008 to June 2010



Australian Capital Territory

NSW, Vic, Qld, WA, SA & NT

Source: AIHW analysis of National Hospital Morbidity Database.

Figure 3.07.2: Age-standardised hospitalisation rates for potentially preventable hospital admissions, by Indigenous status, the Australian Capital Territory and NSW, Vic, Qld, WA, SA & NT combined, July 2008 to June 2010

3.08 Cultural competency

Ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander people are respected has been identified as an important principle in the delivery of culturally appropriate health services (AHMAC 2003). The National Aboriginal Health Strategy describes a broad Aboriginal view of health as 'not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community'. The Northern Territory Department of Health, in collaboration with the

National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) and the National Aboriginal and Torres Strait Islander Health Standing (NATSIHSC) previously known as National Aboriginal and Torres Strait Islander Health Officials Network (NATSIHON), have recently developed a cultural competence framework.

Data are presented below on aspects of cultural competency that can be analysed from data available in the Health Performance Framework report, including data on discharge from hospital against medical advice and Indigenous people studying for and employed in health-related occupations.

Key findings

- Between July 2008 and June 2010, there were 30 hospitalisations where Aboriginal and Torres Strait Islander people in the Australian Capital Territory left hospital against medical advice or were discharged at their own risk. This represented about 0.9% of all hospitalisations for Indigenous people, which compares with 0.3% for non-Indigenous people (Table 3.09.1, Appendix 2). See section '3.09 Discharge against medical advice' for more information.
- According to the 2011 Census, there were 107 Indigenous people employed in health-related occupations in the Australian Capital Territory. This represented 1.2% of the Territory's total Indigenous population aged 15 and over, and 0.8% of the Territory's total health workforce (Figure 3.12.1, Appendix 2). See section '3.12 Aboriginal and Torres Strait Islander people in the health workforce' for more information.
- In 2010, it was estimated that there were 10 enrolments of Indigenous undergraduate students in health-related courses, making up 0.7% of the total students in these courses in the Australian Capital Territory (Table 3.20.1, Appendix 2). See section '3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines' for more information.

Is the health system responsive to needs of Indigenous people?

This section includes measures on the responsiveness of the health system in the following areas: discharge against medical advice, access to mental health services, access to alcohol and other drug treatment services, Aboriginal and Torres Strait Islander people in the health workforce, and competent governance.

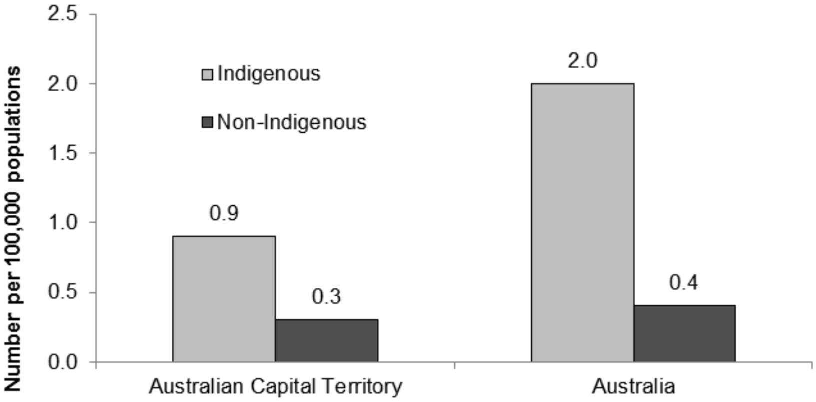
3.09 Discharge against medical advice

Discharge against medical advice provides indirect evidence of the extent to which hospital services are responsive to Indigenous Australian patients' needs, and the level of patient satisfaction with hospital services. Feedback on patient experiences, and community views of health-care services and providers are important for shaping health services and policy (AHMAC 2012).

Data are presented on rates at which Aboriginal and Torres Strait Islander people leave hospital against medical advice or are discharged at their own risk. Data for this measure come from the AIHW's National Hospital Morbidity Database. Hospitalisations for mental and behavioural disorders are excluded.

Key findings

- Between July 2008 and June 2010, about 1.1% of hospitalisations of Aboriginal and Torres Strait Islander people in the Australian Capital Territory ended with discharge against medical advice. This proportion was lower than that for Indigenous people nationally (2.4%) (Table 3.09.1, Appendix 2).
- After adjusting for differences in age structure, Aboriginal and Torres Strait Islander people in the Australian Capital Territory were more than 3 times as likely as non-Indigenous people to discharge against medical advice. Nationally, the rate ratio was 5.1. These data were computed based on a small number of hospitalisations (30 for Indigenous and 375 for non-Indigenous) therefore should be used with caution (Table 3.09.1, Appendix 2; Figure 3.09.1).



Source: AIHW analysis of National Hospital Morbidity Database.

Figure 3.09.1: Discharges from hospital against medical advice (excluding mental and behavioural disorders), by Indigenous status, the Australian Capital Territory & Australia, July 2008 to June 2010

3.10 Access to mental health services

Most mental health services address mental health conditions once they have emerged rather than the underlying causes of that distress. Nevertheless, early access to effective services can help reduce the consequences of mental health problems and help restore a person's sense of emotional and social wellbeing. Therefore, the accessibility of mental health services for Aboriginal and Torres Strait Islander people is important (AHMAC 2012).

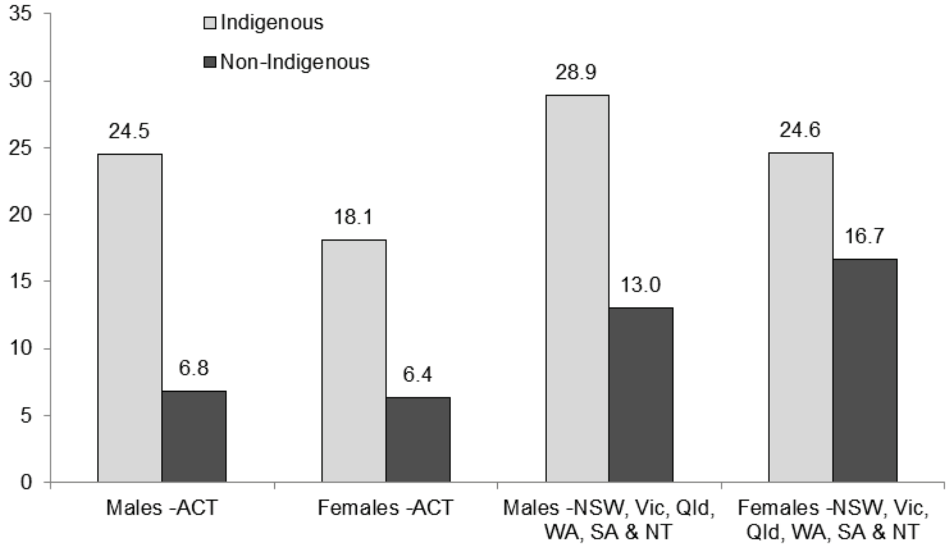
Mental health services

Mental health services include non-specialist services such as community-based health services, Aboriginal and Torres Strait Islander primary health-care services and general practitioner (GP) visits; and specialist services such as private psychiatrists, state mental health teams, and designated psychiatric services both in general hospitals and in specialist facilities.

Data are presented on access to mental health services as measured by hospitalisations for mental health-related conditions using data from the National Hospital Morbidity Database, and rates of contact with community mental health services using data from the National Community Mental Health Care Database.

Key findings

- Between July 2008 and June 2010 in the Australian Capital Territory, there were 142 hospitalisations of Aboriginal and Torres Strait Islander people with a principal diagnosis of mental health-related conditions (Figure 3.10.1, Appendix 2).
- Indigenous males were hospitalised at 3.6 times the rate of non-Indigenous males, and Indigenous females were hospitalised at 2.8 times the rate of non-Indigenous females in Australian Capital Territory.
- Indigenous males and females in the Australian Capital Territory were hospitalised for mental health-related conditions at lower rates (25 and 18 per 1,000) than Indigenous males and females in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined (29 and 25 per 1,000) (Figure 3.10.1).
- In 2009–10 in the Australian Capital Territory, there were 7,804 client contacts with community mental health-care services for people who identified as Aboriginal or Torres Strait Islander (3% of total service contacts in the Australian Capital Territory).
- Aboriginal and Torres Strait Islander people in the Australian Capital Territory were 2.7 times as likely as non-Indigenous people to be clients of a community mental health service (1,767 compared with 649 per 1,000 population) (Table 3.10.1).
- The rate of contact with community mental health services was higher in the Australian Capital Territory than nationally for both Indigenous (1,767 compared with 842 per 1,000 population) and non-Indigenous people (649 compared with 262 per 1,000 population).



Source: AIHW analysis of National Hospital Morbidity Database.

Figure 3.10.1: Age-standardised hospitalisation rates for principal diagnosis of mental health-related conditions by Indigenous status and sex, Australian Capital Territory and NSW, Vic, Qld, WA, SA & NT combined, July 2008 to June 2010

Table 3.10.1: Community mental health care service contacts per 1,000 population, by Indigenous status, Australian Capital Territory and Australia, 2009–10

	ACT	Australia
	Number	
Indigenous	7,804	430,894
Non-Indigenous	226,842	5,583,400
Not stated	22,851	579,770
Total	**257,497**	**6,594,064**
	Number per 1,000 population[(a)]	
Indigenous	1,767.0	841.8
Non-Indigenous	649.0	262.2
Total	**728.4**	**302.5**
	Rate ratio & Rate difference	
Ratio[(b)]	2.7	3.2
Rate Difference[(c)]	1118.0	579.8

(a) Rates were directly age-standardised using the Australian 2001 Standard population.

(b) Rate ratio Indigenous: non-Indigenous.

(c) Rate ratio difference is equal to Indigenous rate minus non-Indigenous.

Note: Shading indicates that the Indigenous identification in the National Community Mental Health Care Database (NCMHCD) in these jurisdictions is in need of improvement. This is based on information provided by state and territory health authorities on the quality of their data in the NCMHCD. Data from these states and territories should be interpreted with caution due to likely under identification of Indigenous Australians.

Source: AIHW National Community Mental Health Care Database (NCMHCD).

3.11 Access to alcohol and drug services

Alcohol and other drug services cover a variety of treatment interventions for alcohol and other drug use. Treatment services which reduce harm from alcohol and other drugs can significantly reduce the occurrence of injuries such as from motor vehicles accidents and assaults, reduce the level of diseases such as liver disease, and reduce the number of social disruptions (AIHW 2006). Reducing drug and alcohol related harm can improve health, social and economic outcomes at both individual and community levels (Steering Committee for the Review of Government Service Provision 2011).

Data are presented on treatment episodes provided to clients accessing alcohol and other drug treatment services using data from the Alcohol and Other Drug Treatment NMDS, and on clients of pharmacotherapy services using data from the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection.

Key findings

- In 2009–10, there were 343 treatment episodes of clients of alcohol and other drug treatment services who identified as Aboriginal or Torres Strait Islander in in the Australian Capital Territory. This represented 10% of the total treatments episodes in the Australian Capital Territory, slightly lower than that nationally (13%) (Table 3.11.2, Appendix 2).
- On a snapshot day in 2010, there were 69 Indigenous clients receiving pharmacotherapy for opioid dependence in the Australian Capital Territory. Aboriginal and Torres Strait Islander clients represented 9% of all clients in the Australian Capital Territory and 9% of

all clients in the four jurisdictions combined for which data were available (New South Wales, Queensland, South Australia and the Australian Capital Territory) (Table 3.11.1).

- The number of Aboriginal and Torres Strait Islander clients receiving pharmacotherapy for opioid dependence in the Australian Capital Territory, on a snapshot day each year, has fluctuated between 2006 and 2010 (from 35 in 2007 to 69 in 2010). This may partly reflect small numbers and changing identification over this period (Table 3.11.1).

Table 3.11.1: Number of pharmacotherapy clients[(a)] on a 'snapshot/specified' day by Indigenous status and jurisdiction, the Australian Capital Territory and NSW, Qld, SA, ACT combined, 2006–2010

	2006	2007	2008	2009	2010
Australian Capital Territory					
Indigenous	47	35	47	57	69
Non-Indigenous	743	730	739	718	700
Not stated	—	—	—	17	42
NSW, Qld, SA & ACT					
Indigenous	1,662	1,768	2,086	2,252	2,591
Non-Indigenous	16,354	17,203	20,273	21,406	23,316
Not stated	3,766	5,285	3,546	3,269	2,916

Source: National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) statistical report 2006 to 2010; Tables 2.4, 5.3, 8 and 10.

3.12 Aboriginal and Torres Strait Islander people in the health workforce

Aboriginal and Torres Strait Islander people are significantly under-represented in the health workforce, which may potentially contribute to reduced access to health services. An Indigenous health workforce is critical to ensuring that the health system has the capacity to address the needs of Aboriginal and Torres Strait Islander people. Indigenous health professionals may be able to better ensure culturally appropriate care in the services they deliver and improve the patient care of Indigenous Australians (Anderson et al. 2009). Data are presented on the number and proportion of Aboriginal and Torres Strait Islander Australians in the health workforce using data from the 2011 Census.

Key findings

- In 2011, there were 107 people aged 15 and over in the Australian Capital Territory who identified as Aboriginal or Torres Strait Islander who were employed in the health workforce (3.1% of Indigenous people aged 15 and over) (Figure 3.12.1). They accounted for 0.8% of the total health workforce, which was lower than the proportion of the Australian Capital Territory population aged 15 and over that is Indigenous (1.5%) (Table 3.12.1,Appendix 1).
- Nationally, 3.8% of Aboriginal and Torres Strait Islander people aged 15 and over were employed in the health workforce. This accounted for 1.5% of the total health workforce, which is lower than the proportion of the total Australian population aged 15 and over that is Indigenous (2%) (Figure 3.12.1).

Source: AIHW analyses of 2011 Census of Population and Housing.

Figure 3.12.1: Aboriginal and Torres Strait Islander health workforce as a proportion of the Indigenous population aged 15 years and over, the Australian Capital Territory and Australia, 2011

3.13 Competent governance

Governance involves having the processes and institutional capacity to be able to exercise control through sound decision-making. Competent governance requires the means to establish good governance arrangements with the ultimate aim of achieving the social, cultural, and economic developments sought by citizens (Dodson & Smith 2003).

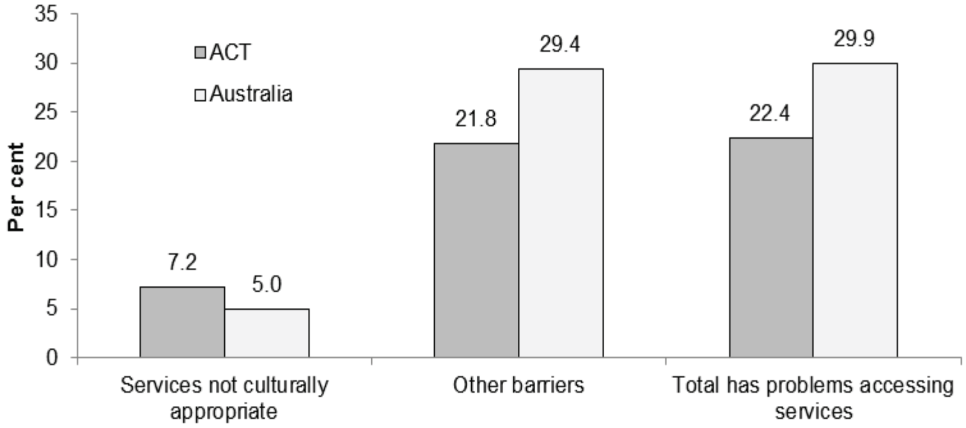
Competent governance in the context of Indigenous health includes the involvement of Aboriginal Community Controlled Health Services which can offer comprehensive primary health care appropriate to Aboriginal and Torres Strait Islander people (AHMAC 2012; Larkins et al. 2006). It must also address the cultural responsiveness of mainstream service delivery for Indigenous clients and effective participation of Indigenous people on management committees, decision-making boards, and other relevant bodies (AHMAC 2012).

Data are presented on one measure of competent governance: barriers to accessing health services using data from the 2008 NATSISS.

Key findings

- According to the 2008 NATSISS, 22% of Indigenous people aged 15 and over in the Australian Capital Territory reported problems accessing health services. This was lower than the proportion nationally (30%).
- About 7% of Indigenous people aged 15 and over in the Australian Capital Territory reported having problems accessing health services due to the services not being culturally appropriate. This was higher than the proportion nationally (5.0%) (Figure 3.13.1).

- About 36% of Indigenous people aged 15 and over in the Australian Capital Territory reported that they felt discriminated against, compared with 27% of Indigenous people nationally (Table 3.13.1, Appendix 2).



Source: ABS analysis of 2008 NATSISS.

Figure 3.13.1: Barriers to access health-service providers, Indigenous persons aged 15 years and over who had problems accessing services, the Australian Capital Territory and Australia, 2008

Is health care accessible?

This section includes measures on accessibility of the health system, such as access to services compared with need, and access to after-hours primary health care.

3.14 Access to services compared with need

Improving access to health-care services is an important component of ameliorating the demonstrated health inequalities between Indigenous and non-Indigenous Australians (Griew 2008; NACCHO 2009). Monitoring the extent to which health service availability and accessibility meets need is a critical component of policy development. Access to health care when needed is essential to closing the gap in life expectancy.

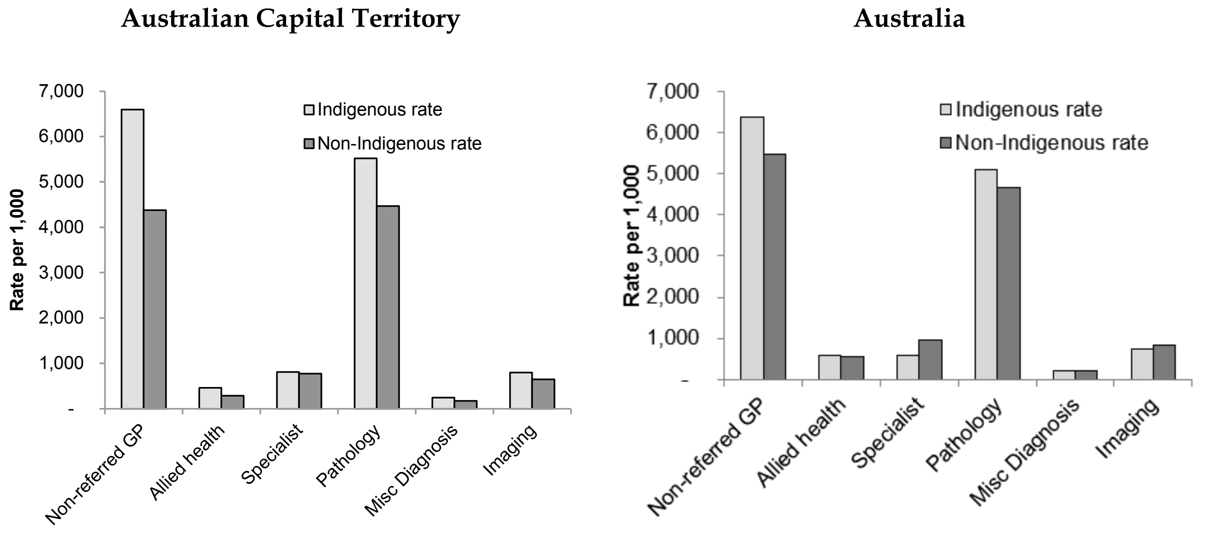
Data on MBS services claimed and services provided are from the Medicare database. Self-reported data on access to health services and barriers to accessing health services are from 2004–05 NATSIHS. Hospitalisation rates and waiting times are from the AIHW National Hospital Morbidity Database, and episodes of health care provided by Indigenous primary health care services data are from the OSR data collection.

Key findings

- In 2010–11 in the Australian Capital Territory, Aboriginal and Torres Strait Islander people had 49,771 Medicare claims, of which 24,584 were for non-referred GP consultations. Indigenous Australians were more likely than non-Indigenous Australians to have received services for non-referred GP consultations, allied health, private specialists, pathology, miscellaneous diagnosis and imaging. Service claims for other MBS services were lower for Indigenous Australians (Figure 3.14.1).
- In 2004–05, about 35% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory reported they had accessed some type of health care in the last two

weeks. The proportion of Indigenous people across Australia who had accessed health care was 42% (Table 3.14.1).

- In 2004–05, about 13% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory reported they had visited a doctor or specialist in the last two weeks, 14% had been admitted to hospital in the last 12 months and 16% had consulted with other health professionals in the last 2 weeks (Table 3.14.1).
- Between July 2008 and June 2010, Aboriginal and Torres Strait Islander people in the Australian Capital Territory were hospitalised (excluding dialysis), at 1.4 times the rate of non-Indigenous Australians. Similarly, Indigenous Australians in the six jurisdictions (NSW, Vic, Qld, WA, SA & NT combined) were hospitalised at 1.3 times the rate of non-Indigenous Australians (Table 3.14.2, Appendix 2).
- In 2010–11, there were 25,832 episodes of health care provided to Aboriginal and Torres Strait Islander people by Indigenous primary health-care services reporting under the OSR in the Australian Capital Territory (Table 3.14.3, Appendix 2).
- In 2010–11, waiting times for elective surgery in public hospitals in the Australian Capital Territory at the 50th percentile (representing number of days within which 50% of people were admitted) was 67 days for Indigenous Australians compared with 77 days for non-Indigenous Australians. Nationally, waiting times at the 50th percentile were 39 days for Indigenous Australians compared with 36 days for non-Indigenous Australians (Table 3.14. 4, Appendix 2).
- About 56% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory were treated within national benchmarks for emergency department waiting times in 2010–11 compared with 58% of other Australians in the Australian Capital Territory. Nationally these proportions were 66% and 69% respectively (Table 3.14.5, Appendix 2).



Source: Medicare Financing & Analysis Branch, Department of Health & Ageing.

Figure 3.14.1: Age-standardised-rate per 1,000 population of selected MBS services, Australian Capital Territory and Australia, 2010–11

Table 3.14.1: Indigenous Australians accessing health care, the Australian Capital Territory and Australia, 2004–05

Accessing health care[a]	ACT	Australia
	Per cent	
Admitted to hospital	13.5	16.4
Visited casualty/ outpatients	2.3[b]	4.8
Doctor consultation (GP and/or specialist)	13.1	20.1
Dental consultation[c]	4.6	3.8
Consultation with other health professional	16.0	17.3
Total accessing health care[d]	**34.7**	**41.9**
Total not accessing health care	**65.3**	**58.1**
Total number	**4,162**	**474,310**

(a) Total who took at least one health-related action—those who were admitted to hospital in last 12 months, dental consultation in last two weeks, doctor consultation in last two weeks, visited casualty/outpatient in last two weeks or consulted with other health professional in last two weeks.

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

(c) Persons aged two years and over.

(d) Components may not add to total because persons may have reported more than one type of action.

Source: ABS and AIHW analysis of 2004–05 NATSIHS.

3.16 Access to after-hours primary care

An important component of comprehensive primary 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 may delay seeking care.

After-hours care

After hours medical care is usually medical care provided at any time outside 8am to 6pm on weekdays (that are not public holidays) or 8am to 12pm on a Saturday (AHMAC 2012)

Data are presented on presentations to emergency departments after hours using data from the National Non-admitted Patient Emergency Department Care Database. There are many reasons why people present at after-hours emergency departments, including difficulties accessing primary care during school and work hours.

Key findings

- From July 2008 to June 2010 in the Australian Capital Territory, there were 116,052 episodes of care provided after hours in emergency departments, 2,465 (2.1%) of which were for patients identified as Aboriginal or Torres Strait Islander. Just over half of all presentations to emergency departments were for after-hours care (58% for Indigenous and 56% for non-Indigenous patients) (Table 3.16.1).
- There were 67,743 episodes of after-hours care provided by emergency departments for triage categories 4 (semi-urgent) and 5 (non-urgent) in the Australian Capital Territory, 1,528 (2.3%) of which were for patients identified as Aboriginal and Torres Strait Islander. For Indigenous people, about 58% of episodes to emergency departments for triage categories semi-urgent and non-urgent were after hours, which was slightly higher to the proportion for non-Indigenous people (55%).

Table 3.16.1: Presentations to emergency departments after hours by Indigenous status of the patient, the Australian Capital Territory and Australia, July 2008 to June 2010

	Semi-urgent and non-urgent		Total presentations	
	ACT	Australia	ACT	Australia
After hours presentations				
Indigenous	1,528	185,864	2,465	307,001
Non-Indigenous	65,268	3,324,238	111,865	5,899,612
Not stated	947	189,794	1,722	337,933
Total	**67,743**	**3,699,896**	**116,052**	**6,544,546**
Total emergency department presentations				
Indigenous	2,634	335,796	4,222	533,170
Non-Indigenous	119,482	6,150,031	201,324	10,573,478
Not stated	1,776	332,699	3,166	581,074
Total	**123,892**	**6,818,526**	**208,712**	**11,687,722**
Proportion of after-hours presentations out of all presentations to emergency department				
Indigenous	58.0	55.4	58.4	57.6
Non-Indigenous	54.6	54.1	55.6	55.8
Not stated	53.3	57.0	54.4	58.2
Total	**54.7**	**54.3**	**55.6**	**56.0**

Source: AIHW analysis of National Non-admitted Patient Emergency Department Care Database.

Is there continuity in health care?

This section includes measures on continuity of health care, such as having a regular GP or health service, and care planning for chronic disease.

3.17 Regular GP or health service

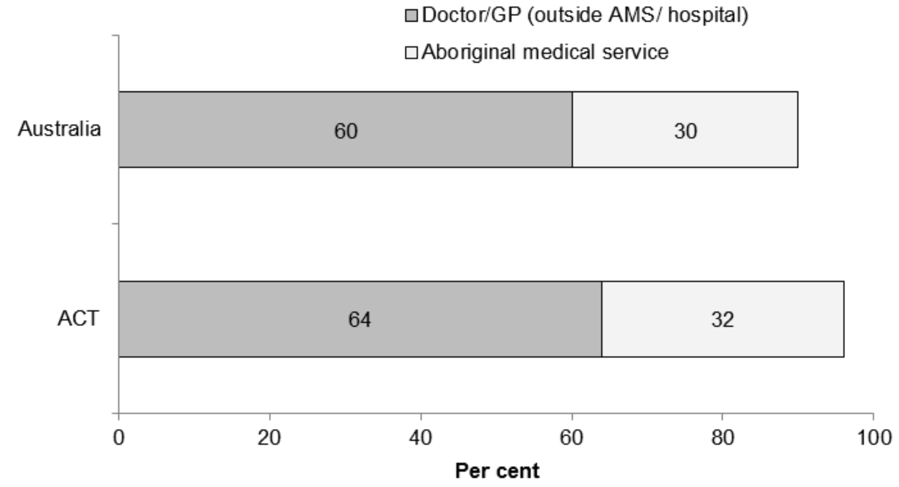
Having a usual primary care provider is associated with good communication between the patient and provider, greater trust in the provider, improved preventive care and better health outcomes (Mainous et al. 2001; Starfield 1998; Starfield & Shi 2004). Effective communication between the patient and provider is particularly relevant to the health of Indigenous Australians where communication issues can lead to health-care problems such as misdiagnosis or incorrect treatment, and lack of trust in the provider (AHMAC 2012).

Data are presented on the proportion of Aboriginal and Torres Strait Islander people who have a regular GP or Aboriginal medical service, using data from the 2004–05 NATSIHS.

Key findings

- According to the 2004–05 NATSIHS, 64% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory used a doctor (outside of Aboriginal medical services and hospitals) for their regular health care, compared with 60% national (Figure 3.17.1).
- The proportion of Aboriginal and Torres Strait Islander people in the Australian Capital Territory using an Aboriginal medical service for regular health care was slightly higher than for Australia (32% compared with 30%).

- 95% of Aboriginal and Torres Strait Islander people in the Australian Capital Territory reported they usually go to the same GP/Medical service, compared with 91% of Indigenous people across Australia (Figure 3.17.1).



Source: ABS and AIHW analyses of NATSIHS 2004–05.

Figure 3.17.1: Where usually go if problem with health, Aboriginal and Torres Strait Islander people, Australian Capital Territory and Australia, 2004–05

3.18 Care planning for clients with chronic diseases

Effective management of chronic disease can delay the progression of disease, decrease the need for high-cost interventions, improve quality of life, and increase life expectancy (AHMAC 2012). The development of care plans is one way in which the client and primary health-care provider can ensure appropriate care is arranged and coordinated. A care plan is a written action plan containing strategies for delivering care that address an individual's specific needs, particularly patients with chronic conditions and/or complex care needs. It can be used to encourage collaboration with other service providers to achieve management goals for the patient, as well as to help encourage the patient to take informed responsibility for their care.

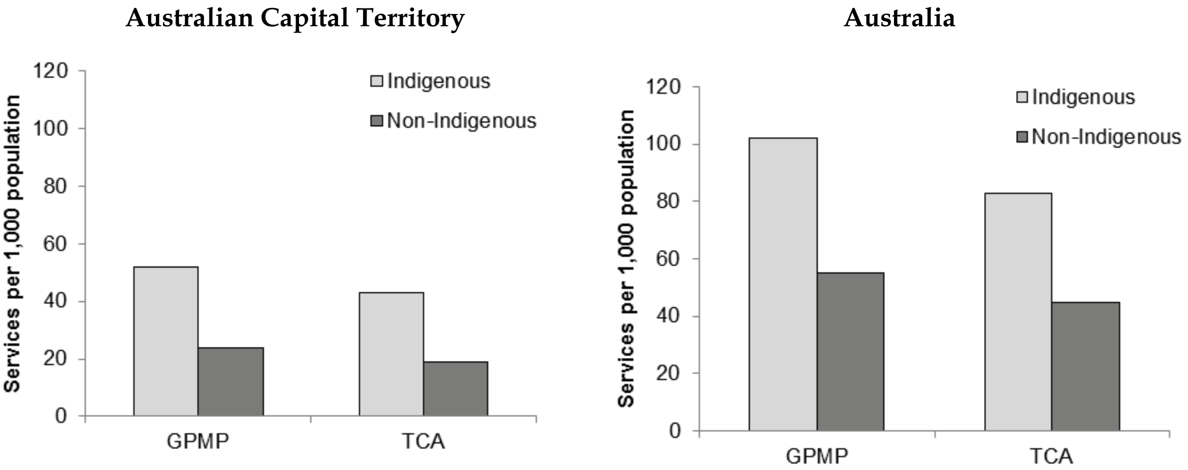
Data are presented on chronic disease management plans using MBS claims data and data from services funded under the Healthy for Life (HfL) program. HFL data for the Australian Capital Territory has been combined with New South Wales (jurisdiction with the closest geographical proximity) due to small numbers.

Key findings

- Medicare claims data show that there was 151 GP management plan services and 114 team care arrangements claimed by Aboriginal and Torres Strait Islander people in the Australian Capital Territory in 2010–11. Rates of GPMPs and TCAs claimed by Indigenous people in the Australian Capital Territory were about half that for Indigenous people nationally (Figure 3.18.1).
- After adjusting for differences in age structures of the two populations, Indigenous Australians in the Australian Capital Territory received more claimed GPMPs than non-

Indigenous Australians (52 per 1,000 compared with 24 per 1,000) and also had a higher rate of TCAs claimed (43 per 1,000 compared with 19 per 1,000) (Figure 3.18.1).

- In the 6 month from January to June 2010 in New South Wales and the Australian Capital Territory combined, of the Indigenous regular clients of HfL services with Type 2 diabetes, 30% had a current GPMP and 26% had a TCA. This was higher than the proportions nationally (26 and 23% respectively) (Table 3.18.1).
- Over the same period, of the Indigenous regular clients of HfL services with coronary heart disease, 25% had a current GPMP and 20% had a TCA. This was lower than the proportions nationally (28 and 23% respectively).



Australian Capital Territory

Australia

Source: Medicare Financing & Analysis Branch, Department of Health & Ageing.

Figure 3.18.1: Rate of GPMPs and TCAs claimed through Medicare, Indigenous and non-Indigenous Australians, the Australian Capital Territory and Australia, 2010–11

Table 3.18.1: Proportion and number of Indigenous regular clients[(a)] with Type 2 diabetes or coronary heart disease with current chronic disease management plans (GPMP or TCA), New South Wales and the Australian Capital Territory combined and Australia, 1 January–30 June 2010

	NSW/ACT		Australia	
	Number	Per cent	Number	Per cent
Clients with Type 2 diabetes who had a current GPMP	410	29.6	3,112	26.1
Clients with coronary heart disease who had a current GPMP	148	25.0	1,030	28.1
Clients with Type 2 diabetes who had a current TCA	318	26.0	2,566	22.8
Clients with Coronary heart disease who had a current TCA	101	20.3	792	22.6

(a) Indigenous regular clients aged 15 and over.

Source: AIHW HfL data collection.

Is the health system capable and sustainable?

This section includes measures on the capability and sustainability of the health system such as accreditation, Aboriginal and Torres Strait Islander people training for health-related disciplines, and recruitment and retention of staff.

3.19 Accreditation

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. Accreditation status provides one measure of the capability of services, based on their skills and knowledge, to provide quality health services to Aboriginal and Torres Strait Islander people (AHMAC 2012).

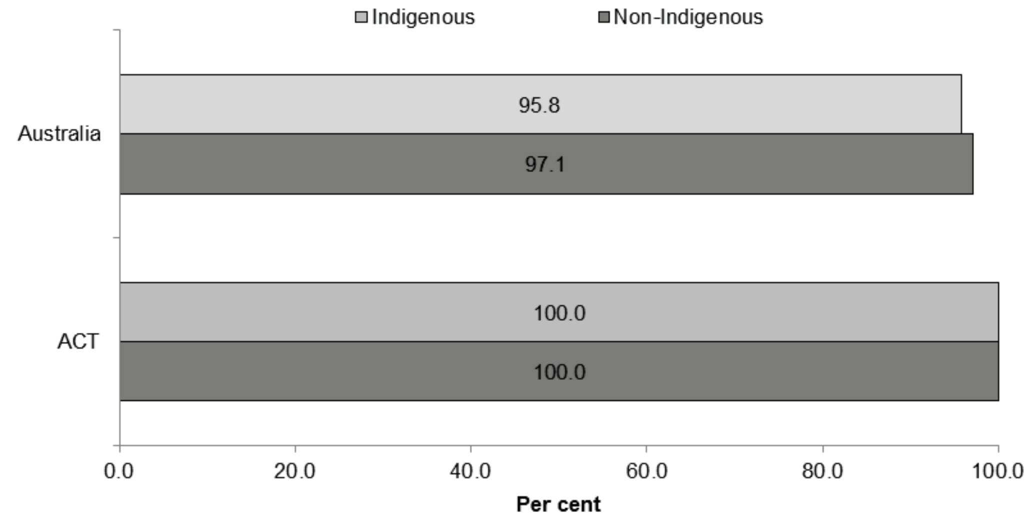
Accreditation for hospitals and general practice in Australia

In Australia, there are accreditation systems for hospitals and general practice. Most hospitals are accredited by the Australian Council of Healthcare Standards Evaluation and Quality Improvement Program. Accreditation in general practice involves assessment against standards set by the Royal Australian College of General Practitioners and is undertaken through two registered providers of general practice accreditation in Australia; Australian General Practice Accreditation Limited (AGPAL) and General Practices Australia (GPA+).

Data are presented on the proportion of Aboriginal and Torres Strait Islander hospital separations that occurred in accredited hospitals using data from the National Public Hospitals Establishments Database. Data are also presented on the accreditation of general practices using data from AGPAL and GPA+.

Key findings

- Between July 2008 and June 2010 in the Australian Capital Territory, 100% of hospital admitted episodes for Aboriginal and Torres Strait Islander people and 100% of episodes for non-Indigenous people occurred in accredited hospitals. In Australia, 96% of hospital admitted episodes for Indigenous people occurred in accredited hospitals, compared with 97% of episodes for non-Indigenous people (Figure 3.19.1)
- In 2010–11 in the Australian Capital Territory, 20 general practices were accredited and 7 practices were registered but not yet accredited. The proportion of general practices that were accredited was 74%, which was higher than the proportion nationally (71%) (Table 3.19.1, Appendix 2).
- All of the general practices in the Australian Capital Territory that are accredited, are located in areas where 1–2% of the population is Aboriginal and Torres Strait Islander.



Source: AIHW analysis of National Hospital Morbidity Database and National Public Hospitals Establishment Database.

Figure 3.19.1: Percentage of hospital admitted patent episodes in accredited hospitals, by Indigenous status, the Australian Capital Territory and Australia combined, July 2008 to June 2010

3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines

Aboriginal and Torres Strait Islander people are significantly under-represented in the health workforce. Improving the participation of Aboriginal and Torres Strait Islander people in tertiary education for health-related disciplines is critical to increasing Aboriginal and Torres Strait Islander participation in the health workforce, and creating a workforce better capable of working with Indigenous Australians to improve health.

Data are presented on the proportion of Aboriginal and Torres Strait Islander Australians in tertiary education for health-related disciplines using data from the DEEWR Higher Education Statistics Collection and the National Centre for Vocational Education Research (NCVER) National VET Provider Collection.

Key findings

- In 2010 in the Australian Capital Territory there were 10 enrolments in health-related courses by Aboriginal and Torres Strait Islander undergraduate domestic students, which was 0.7% of total undergraduate enrolments. In the same year, no completion in health-related courses was recorded for Indigenous undergraduate students (Table 3.20.1). This was lower than the proportions nationally (1.8% of enrolments and 1.1% of completions) (Table 3.20.1, Appendix 2).
- In the Australian Capital Territory, all the Aboriginal and Torres Strait Islander undergraduate students who were enrolled in health-related courses in 2010 were enrolled in nursing and medical studies.
- In 2010 in the Australian Capital Territory, there were 13 Aboriginal and Torres Strait Islander students enrolled in health-related courses in the VET sector (1.2% of all enrolments), and no Indigenous completions. In comparison, the national proportion of

Indigenous enrolments was 4.7% and the national proportion of Indigenous completions was 3.5% (Table 3.20.2, Appendix 2).

- In the Australian Capital Territory, the most common type of health-related course in which Aboriginal and Torres Strait Islander VET students were enrolled was complementary therapies (8 enrolled).

Table 3.20.1: Number of undergraduate domestic students[(a)] enrolled and completed[(a)] health-related courses[(b)] in the Tertiary Education sector, by qualification type, the Australian Capital Territory, 2010

	Enrolled			Completed		
	Aboriginal & Torres Strait Islander	Total	Per cent Aboriginal & Torres Strait Islander	Aboriginal & Torres Strait Islander	Total	Per cent Aboriginal & Torres Strait Islander
Medical studies	<10	336	. .	0	82	. .
Nursing	<10	522	. .	0	80	. .
Pharmacy	0	0	n.a.	0	0	n.a.
Dental studies	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Optical science	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public health	0	0	n.a.	0	0	n.a.
Radiography	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Rehabilitation therapies	0	0	n.a.	0	0	n.a.
Total	**10**	**1,406**	**0.7**	**0**	**162**	**. .**

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

(b) Medical studies, nursing, pharmacy, dental studies, optical science, public health, radiography, rehabilitation therapies.

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

Table 3.20.2: Vocational education and training (VET) sector students enrolled and completed[(a)] health-related courses, Australian Capital Territory, 2010

	Enrolled			Completed[(b)]		
	Aboriginal & Torres Strait Islander	Total[(c)]	Per cent Aboriginal & Torres Strait Islander	Aboriginal & Torres Strait Islander	Total	Per cent Aboriginal & Torres Strait Islander
Medical studies	0	0	n.a.	0	0	n.a.
Nursing	1	261	0.4	0	53	0.0
Pharmacy	0	0	n.a.	0	0	n.a.
Dental studies	2	107	1.9	0	14	0.0
Optical science	0	0	n.a.	0	0	n.a.
Public health	1	132	0.8	0	22	0.0
Rehabilitation therapies	0	158	0.0	0	16	0.0
Complementary therapies	8	342	2.3	0	11	0.0
Other health	1	129	0.8	0	27	0.0
Total	**13**	**1,129**	**1.2**	**0**	**143**	**0.0**

(a) Represents number of enrolments and completions, students may be enrolled and complete more than one course.

(b) Total includes people whose Indigenous status is unknown.

(c) The number of qualifications completed in 2010 are based on preliminary data and will be revised upwards in the next collection.

Source: AIHW analyses of National Centre for Vocational Education Research (NCVER), National VET Provider Collection 2010.

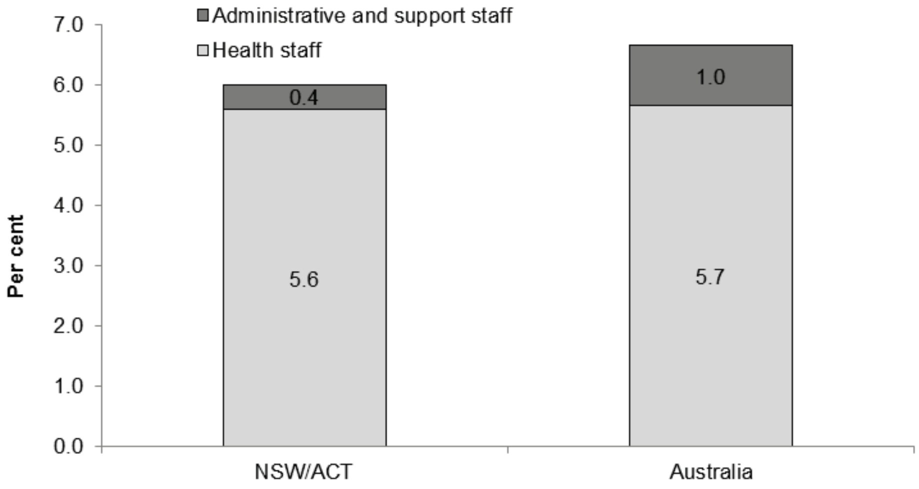
3.22 Recruitment and retention of staff

The capacity to recruit and retain appropriate staff is extremely important to the quality, continuity and sustainability of health-care services, including Aboriginal and Torres Strait Islander primary health-care services.

Data are presented on the number of positions that are currently vacant in Indigenous primary health-care services using data from the OSR collection. OSR data for the Australian Capital Territory has been combined with New South Wales (jurisdiction with the closest geographical proximity) due to small numbers.

Key findings

- For 2010–11 in New South Wales and the Australian Capital Territory combined, 5.6% of full-time equivalent (FTE) health staff positions and 0.4% of administrative and support staff positions in Aboriginal and Torres Strait Islander primary health-care organisations were vacant (Figure 3.22.1). This was similar to the proportions of staff vacancies nationally (5.7% of the FTE health staff positions and 1.0% of administrative and support staff positions).



Source: AIHW OSR data collection.

Figure 3.22.1: Vacancies as a percentage of total positions (FTE) in Aboriginal and Torres Strait Islander primary health care organisations, the Australian Capital Territory/New South Wales and Australia, at 2010–11

Appendix 1 Data sources and quality

Alcohol and Other Drug Treatment Services National Minimum Data Set

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) is a collection of data from all publicly funded (at state, territory and/or Australian Government level) government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services. The NMDS counts treatment episodes completed during the collection period.

There is a diverse range of alcohol and other drug treatment services in Australia and not all of these are in the scope of the AODTS–NMDS. Clients receiving services that are funded solely by the Office for Aboriginal and Torres Strait Islander Health as Indigenous substance use services, Aboriginal primary health-care services, Aboriginal medical services and community controlled health services are not currently included in the scope of the AODTS–NMDS.

In indicator:

- 3.11 Access to alcohol and drug services

Quality statement: http://meteor.aihw.gov.au/content/index.phtml/itemId/498552

Australia and New Zealand Dialysis and Transplant Registry

In Australia, persons who develop end-stage renal disease (ESRD) and undertake dialysis or kidney transplantation are registered with the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA). The registry is the most comprehensive and reliable source of information on persons treated for ESRD. It compiles data on incidence and prevalence, renal complications, comorbidities and patient deaths. The current registry began in 1977 and is coordinated by the Queen Elizabeth Hospital in Adelaide. All relevant hospitals and related satellite units in Australia and New Zealand participate.

Indigenous identification is based on self-identification and discussion with the treating nurse or physician, and is often based on identification in hospital records. However, because of the heightened awareness of the extent of renal disease in Indigenous Australians and the prolonged and repeated contact with renal units in hospitals, it is believed that Indigenous identification in the registry is more complete than in general hospital data (Cass et al. 2001).

In indicator:

- 1.10 Kidney disease

Australian Childhood Immunisation Register

The Australian Childhood Immunisation Register (ACIR) is a national register that records details of vaccinations given to children aged under 7 who live in Australia. Immunisation coverage is produced at the national, state/territory and local level on a quarterly basis using the data recorded on the ACIR.

Coverage estimates for Aboriginal and Torres Strait Islander children include only those who identify as such and are registered on the ACIR. Children identified as Indigenous on the ACIR may not be representative of all Aboriginal and Torres Strait Islander children, and thus coverage estimates should be interpreted with caution.

Vaccination coverage is a measure of the proportion of people in a target population who have received the recommended course of vaccinations at a particular age.

In this report, children for whom Indigenous status was not stated are included with 'non-Indigenous' under the 'other' category.

In indicator:

- 3.02 Immunisation

BreastScreen Australia

BreastScreen Australia is a comprehensive population-based screening program for breast cancer. It consists of a network of dedicated screening and assessment services throughout urban, rural and remote areas of all states and territories. The program provides free biennial mammographic screening and follow-up of any suspicious lesions identified at screening to the point of diagnosis. It is aimed specifically at asymptomatic women aged 50–69, with a participation target of 70%. However, women aged 40–49, and 70 and older are able to attend for screening (AIHW 2011c).

The national program was established in 1991. It is a joint program of the Australian Government and state and territory governments. BreastScreen Australia is monitored annually and reported at the national level by the AIHW in the BreastScreen Australia monitoring report.

The standard ABS question is used to record Indigenous status in this database. While self-reported data are generally a robust source of data on Aboriginal and Torres Strait Islander status (AIHW 2011c), a significant cause of concern with the accuracy of these data is that some jurisdictions do not allow for the 'not stated' category. Further, some Aboriginal and Torres Strait Islander women may choose not to identify as such when presenting to a BreastScreen Australia service. The participation rate for Indigenous women in breast screening should be treated with caution as it is not known how many women do not report their Indigenous status (AIHW 2011c).

In indicator:

- 3.04 Early detection and early treatment

Quality statement: <http://meteor.aihw.gov.au/content/index.phtml/itemId/491846>.

Census of Population and Housing

The Census of Population and Housing is conducted by the ABS every 5 years, and is designed to include all Australian households. The Census uses the ABS standard Indigenous status question for each household member.

Although the Census data are adjusted for undercount at the person level to arrive at the estimated resident population, no such adjustment is done at the household level. This affects the accuracy of the person counts at the household level to provide adjusted household estimates.

The 2011 Census is the most recent, however, data for the Indigenous population was not yet released at the time of writing this report. Therefore, data in this report come from the 2006 Census. In 2006, the ABS enhanced the sample for the Post-Enumeration Survey to include remote areas. The measured undercount for Indigenous Australians was 11.5%.

In indicators:

- 1.14 Disability
- 2.01 Housing
- 2.09 Index of disadvantage
- 2.13 Transport
- 3.12 Aboriginal and Torres Strait Islander people in the health workforce

Community Mental Health Care Database

Information on the use of community mental health services by Indigenous people is available from the AIHW National Community Mental Health Care Database (NCMHCD). The NCMHCD is a collation of data on specialised mental health services provided to non-admitted patients, in both government-operated community and hospital-based ambulatory care services, for example, community mental health services, outpatient clinics and day clinics.

The quality of the Indigenous identification in this database varies by jurisdiction and should be interpreted with caution. All state and territory health authorities provided information on the quality of the data for the NCMHCD 2009–10. New South Wales, Victoria, Western Australia, Tasmania, and the Australian Capital Territory considered the quality of Indigenous status data to be acceptable. Queensland reported that the quality of Indigenous status data was acceptable at the broad level, however, there are quality issues regarding the coding of more specific details (that is, Aboriginal, Torres Strait Islander, or Both Aboriginal and Torres Strait Islander). Northern Territory considered the quality to be below the previous year's standard as a result of lack of compliance with non-mandated data collection items by new external (non-mental health) health service provider data entry. South Australia indicated that the quality of these data is uncertain at this stage.

In indicator:

- 3.10 Access to mental health services

Deaths in Custody Australia

As a requirement of the Deaths in Custody Royal Commission, the Australian Institute of Criminology collects data on deaths in custody each year for all jurisdictions. Data collected include custodial authority (police, prison, juvenile justice/welfare), legal status (sentenced or unsentenced), cause of death, manner of death, location of death and most serious offence.

Indigenous status is determined by previous self-identification to prison authorities.

In indicator:

- 2.11 Contact with criminal justice system

Department of Education, Employment and Workplace Relations Higher Education Statistics Collection

The Australian Government Department of Education, Employment and Workplace Relations (DEEWR) is the responsible agency for the Higher Education Statistics Collection, which includes information from higher education institutions, such as universities and vocational education and training colleges. This data collection contains statistics relating to students enrolled in higher education courses between 1 January and 31 December of each year in each Australian higher education provider.

Although universities design and produce their own enrolment forms, DEEWR has provided institutions with suggested wording for questions relating to Indigenous status (ABS 2003). About 3% of students in this data collection have a 'not stated' Indigenous status. At the moment these are recorded as non-Indigenous, although plans are under way to record the 'not stated' responses separately.

In indicators:

- 3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines

Disability Services National Minimum Data Set

The purpose of the Disability Services National Minimum Data Set (DS NMDS) collection is to facilitate the annual collation of nationally comparable data about disability services, and to obtain reliable, consistent data with minimal load on the disability services field. Under the National Disability Agreement (NDA), the Disability Administrators in all Australian jurisdictions are responsible for ensuring that DS NMDS information will be comparable across all jurisdictions and years.

Services within the scope of the collection are those for which funding has been provided, during the specified period, by a government organisation operating under the NDA. Therefore, if a service type outlet did not receive NDA funding for the 2009–10 collection (i.e. its NDA funding dollars for the financial year are zero), then details of this outlet should not be included in the data collection.

A funded agency may receive funding from multiple sources. Where a funded agency is unable to differentiate service users and/or staff according to funding source (i.e. NDA or other), they are asked to provide details of all service users and staff (for each service type).

Most agencies funded under the NDA are asked to provide information about:

- each of the service types they are funded to provide (i.e. service type outlets they operate);
- all service users who received support over a specified reporting period; and
- the DS NMDS service type(s) the service user received.

The level of information a funded agency is asked to provide varies according to the particular service type (i.e. for each service type outlet).

In indicator:

- 1.14 Disability

Healthy for Life

The Healthy for Life (HfL) program is an ongoing program funded by the Office for Aboriginal and Torres Strait Islander Health of the Australian Government Department of Health and Ageing (DoHA). The program aims to improve the capacity and performance of primary health-care services to deliver high-quality maternal, children's and chronic disease care to Aboriginal and Torres Strait Islander people. This is carried out through population health approaches using best-practice and quality improvement principles.

Services participating in the HfL program are required to submit de-identified, aggregate service data for 11 essential indicators. These indicators cover maternal health, child health and chronic disease care on a regular basis (6 and 12 months), as well as information about the characteristics of their service and organisational infrastructure.

The Australian Government and the AIHW are working with the states and territories to develop a national key performance indicator (KPI) framework for Indigenous primary health-care services. The new national KPIs will replace the Healthy for Life program essential indicators and cover maternal and child health and chronic disease management. The AIHW is leading the development and refinement of the indicators, data standards and analyses and reporting back to services. The national KPI data collection will be implemented in three stages, with roll-out in 2012 and 2013.

In indicators:

- 3.05 Chronic disease management
- 3.18 Care planning for clients with chronic diseases

Medicare Database

Medicare enrolment application forms are lodged by persons wishing to enrol with Medicare at Medicare offices in each state/territory or by mail. Information from these forms is entered directly into the Medicare database, which is held by DoHA.

In November 2002, the ABS standard question on Indigenous identification was included on this form. The question is asked in relation to the cardholder and any other family member named on the card. Responding to the question is voluntary and there is an explanation of the reasons for the question and the use of the data included on the form. This is referred to as the Voluntary Indigenous Identifier (VII).

Because the VII was only introduced recently, the coverage of Aboriginal and Torres Strait Islander Australians in this database is not complete.

As at 1 February 2011, 297,000 Indigenous Australians were enrolled on the VII database. This represents 52.7% of the estimated total Indigenous population (DoHA 2012, unpublished).

Medicare data presented in this report have been adjusted for under-identification. There are a number of caveats to the VII adjustment methodology, including that as the VII sample is generated voluntarily, it is not truly random and cannot be perfectly representative of the Indigenous population until full coverage is achieved. There could therefore be biases in the data that are not addressed by the adjustment methodology.

In indicator:

- 3.04 Early detection and early treatment

National Aboriginal and Torres Strait Islander Health Survey

The 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected information from 10,439 Indigenous Australians of all ages. This sample was considerably larger than the supplementary Indigenous samples in the 1995 and 2001 National Health Surveys. The survey was conducted in remote and non-remote areas of Australia and collected a range of information from Indigenous Australians. This included information on health-related actions, health risk factors, health status, socioeconomic circumstances and women's health. The survey provides comparisons over time in the health of Indigenous Australians. Selected non-Indigenous comparisons are available through the 2004–05 National Health Survey (NHS).

It is planned to repeat the NATSIHS every 6 years, with the next one to be conducted during 2012–13 as part of the Australian Health Survey (will be called the Australian Aboriginal and Torres Strait Islander Health Survey, or ATSIHS).

In indicators:

- 1.05 Circulatory disease
- 1.09 Diabetes
- 1.15 Ear health
- 2.16 Risky and high-risk alcohol consumption
- 2.18 Level of physical activity
- 2.19 Dietary behaviour
- 2.20 Breastfeeding practices
- 2.22 Overweight and obesity
- 3.02 Immunisation
- 3.14 Access to services compared with need
- 3.17 Regular GP or health service
- 3.18 Care planning for clients with chronic diseases

National Aboriginal and Torres Strait Islander Social Survey

The ABS conducted the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) between August 2002 and April 2003. The 2008 NATSISS was conducted between August 2008 and April 2009. The survey provides information about the Aboriginal and Torres Strait Islander populations of Australia for a wide range of areas of social concern including health, education, culture and labour force participation. For the first time, the 2008 NATSISS included children aged under 15. The NATSISS will be conducted every 6 years, with the next one planned for 2014.

The 2008 NATSISS collected information by personal interview from 13,300 Indigenous Australians across all states and territories of Australia, including those living in remote areas. The sample covered persons aged 15 and over who are usual residents in selected private dwellings. It collected information on a wide range of subjects, including family and culture, health, education, employment, income, financial stress, housing, and law and justice.

The 2008 NATSISS has a relatively large level of under-coverage when compared with other ABS surveys. There was also an increase in under-coverage compared with previous ABS Indigenous surveys. For example, the estimated under-coverage in the 2004–05 NATSIHS was 42%. The overall under-coverage rate for the 2008 NATSISS is about 53% of the in-scope population at the national level. This rate varies across the states and territories (ABS 2010).

Time series comparisons for the 2008 survey are available through the 1994 National Aboriginal and Torres Strait Islander Social Survey and the 2002 NATSISS. However, not all data elements align across the three (1994, 2002 and 2008) NATSISS surveys, hence care is required when reviewing results across the three surveys. There are no strictly comparable non-Indigenous results available for the 2008 NATSISS because the latest General Social Survey (which has been used in the past to compare with Indigenous results from the NATSISS) was run in 2006, with the next being run in 2010. Data from other ABS surveys run in 2008 may, however, be used to obtain rough non-Indigenous comparisons for some data items. Where possible, the ABS has provided recommendations for non-Indigenous data comparisons these have been adopted in this report.

In indicators:

- 1.11 Oral health
- 1.15 Ear health
- 1.14 Disability
- 1.13 Community functioning
- 1.17 Perceived health status
- 1.18 Social and emotional wellbeing
- 2.01 Housing
- 2.03 Environmental tobacco smoke
- 2.06 Educational participation and attainment of adults
- 2.08 Income
- 2.10 Community safety
- 2.13 Transport
- 2.14 Indigenous people with access to their traditional lands
- 2.15 Tobacco use
- 2.17 Drug and other substance use including inhalants
- 3.14 Access to services compared with need

National Assessment Program—Literacy and Numeracy

The first National Assessment Program—Literacy and Numeracy (NAPLAN) tests were conducted in May 2008 for all Years 3, 5, 7 and 9 students in government and non-government schools. For the first time, all students in the same year level were assessed on the same test items in the domains of reading, writing, language conventions (spelling, grammar and punctuation) and numeracy. Before 2008, students had undertaken different tests in each state and territory. NAPLAN results are reported using five national achievement scales, one for each of the assessed aspects of literacy—reading, writing, spelling, grammar and punctuation—and one for numeracy. These reporting scales are constructed so that any given scaled score represents the same level of achievement over time (2008 NAPLAN annual report).

Student achievements for literacy and numeracy are reported on five national achievement scales. The scales consist of 10 bands to cover the full range of student achievement across Year 3 to Year 9. School participation data is collected and reported on the My School website. However, this data is not available for this report.

The non-response for Aboriginal and Torres Strait Islander status is about 3% nationally. This information is captured from captured from administrative data collected on enrolment. The students' Aboriginal and Torres Strait Islander status is updated upon request by parent or carer.

In indicator:

- 2.04 Literacy and numeracy

National Child Protection Australia

There are three national child protection data collections:

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

These data are collected each year by the AIHW from the relevant departments in each state and territory. Each state and territory has its own legislation, policies and practices in relation to child protection, which accounts for some of the differences between jurisdictions in the data provided. Australian totals have not been provided for those data that are not comparable across the states and territories.

The practices used to identify and record the Indigenous status of children vary across states and territories, with some jurisdictions recording large numbers of unknowns. No state or territory can validate the data on Aboriginal and Torres Strait Islander children by other means and the quality of the data is therefore unknown.

In this collection, children are counted as Indigenous if they are identified as such in the state and territory collections. Children whose Indigenous status is recorded as 'unknown' are excluded, where possible, from calculations of rates and proportions. The counts for Aboriginal and Torres Strait Islander children are therefore likely to be an underestimates of the actual number of Aboriginal and Torres Strait Islander children in the child protection system.

Note that Tasmania and the Australian Capital Territory have very small numbers, and statistics from these jurisdictions are susceptible to random fluctuations.

Reported rates for Aboriginal and Torres Strait Islander children in the child protection system for 2008–09 and later cannot be compared directly with those from previous years in earlier AIHW *Child protection Australia* publications. In previous years, rates were calculated using ABS Indigenous population data from the 1996 and 2001 Census; the latter projections are based on the data from the 2006 Census. For time series analyses presented in this measure, rates have been reported as they were in the corresponding referenced publications.

In indicator:

- 2.12 Child protection

National Hospital Morbidity Database

The National Hospital Morbidity Database is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals in each state and territory. Information on the characteristics, diagnoses and care of admitted patients in public and private hospitals is provided annually to the AIHW by state and territory health departments.

Hospitalisation data are presented for the 2 years from July 2008 to June 2010. An aggregate of 2 years of data has been used, because the number of hospitalisations for some conditions is likely to be small for a single year.

Hospital records are for 'separations' and not individuals, and as there can be multiple admissions for the same individual, hospital separation rates do not usually reflect the incidence or prevalence of the disease or condition in question. For example, it is not possible to identify whether one patient was admitted 5 times or five patients were admitted once. People who receive treatment at hospital but are not admitted are not counted in hospital records. Hospital separation data are also affected by variations in admission practices, and the availability of and access to hospital and non-hospital services.

Care types 7.3, 9 and 10 (Newborn—unqualified days only; organ procurement; hospital border) have been excluded from analysis.

Data are presented for the six jurisdictions that the AIHW has assessed as having adequate identification of Indigenous hospitalisations in 2006–08—New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory (public hospitals only). These six jurisdictions represent about 96% of the Indigenous population of Australia. National totals include separations for people resident in these six jurisdictions only and are not necessarily representative of the jurisdictions not included. Indigenous status data are reported for Tasmania and the Australian Capital Territory (public hospitals only) with caveats until further audits of the quality of data in these jurisdictions are completed.

Data are presented by state/territory of usual residence of the patient.

The following caveats have been recommended for analysis of hospitalisation data from selected jurisdictions (AIHW 2010):

- Interpretation of results should take into account the relative quality of the data from the jurisdictions included (currently a small degree of Indigenous under-identification in data from New South Wales and South Australia, and relatively marked Indigenous under-identification in data from Queensland and Victoria).
- Interpretation of time series analysis should take into account the possible contribution of changes over time in ascertainment of Indigenous status. This will be reflected in Indigenous patient changes in hospitalisation rates for Indigenous people.

In indicators:

- 1.02 Top reasons for hospitalisation
- 1.03 Injury and poisoning
- 1.04 Respiratory disease
- 1.05 Circulatory disease
- 1.07 High blood pressure
- 1.09 Diabetes
- 1.10 Kidney disease
- 1.11 Oral health
- 1.15 Ear health
- 1.18 Social and emotional wellbeing
- 2.10 Community safety
- 3.06 Access to hospital procedures
- 3.07 Selected potentially preventable hospitalisations
- 3.08 Cultural competency
- 3.09 Discharge against medical advice
- 3.14 Access to services compared with need

Quality statement: <http://meteor.aihw.gov.au/content/index.phtml/itemId/511338>.

National Non-admitted Patient Emergency Department Care Database

The National Non-admitted Patient Emergency Department Care Database (NAPEDCD) is a national collection of de-identified data on emergency department episodes held at the AIHW. The database includes episode-level data on non-admitted patients treated in the emergency departments of public hospitals. These hospitals are classified in the public hospital peer groups of principal referral and specialist women's and children's hospitals and large hospitals. Data excludes patients who were admitted or arrived at the hospital by ambulance.

The NAPEDCD includes data on the type and length of emergency department visit, triage category, waiting times, patient demographics, arrival mode and departure status.

This data set includes the standard Indigenous status question. The identification of Indigenous patients is not considered complete and varies among jurisdictions.

It is recommended that these data only be reported as numbers and proportions and not rates, because the denominator would include Indigenous Australians not covered in this collection. The quality of the data reported for Indigenous status in emergency departments has not been formally assessed; most states and territories advised that the Indigenous status data collected in an emergency department setting could be less accurate than the data collected for admitted patients (AIHW 2012d).

In indicator:

- 3.16 Access to After-hours primary health care

Quality statement: <http://meteor.aihw.gov.au/content/index.phtml/itemId/497269>.

National Notifiable Diseases Surveillance System

A set of 65 diseases and conditions are notifiable nationally to the National Notifiable Diseases Surveillance System (NNDSS), which is managed by DoHA.

Identification of Indigenous notifications in all states and territories is incomplete, with the level of completeness varying across diseases as well as jurisdictions. The NNDSS provided the AIHW with data on Indigenous status completeness by disease and jurisdiction. Using a cut-off of 50% completeness of Indigenous status for 2009–2011, Western Australia, South Australia, Tasmania and the Northern Territory were assessed to have adequate identification for chlamydia, syphilis, gonorrhoea, hepatitis B and hepatitis C. Of the remaining states/territories, Queensland and Victoria had adequate identification for syphilis, gonorrhoea and chlamydia; the Australian Capital Territory had adequate identification for syphilis, gonorrhoea and hepatitis B; and New South Wales had adequate identification for syphilis only.

Although data on hepatitis C is included in this indicator, sexual transmission is not considered the main route of transmission, hepatitis C primarily occurs among those with a history of injecting drug use. Data for hepatitis C included in this indicator are for newly acquired notifications only (excluding Queensland, as hepatitis C data are reported in a separate category).

All categories of syphilis (including infectious, latent and unknown duration) have been included in the analysis of data in this report, with the exception on New South Wales for which the category of greater than 2 years duration or unknown status have been excluded due to low completeness of Indigenous status for these data.

Three years have been combined for reporting due to the small number of Indigenous and non-Indigenous notifications for some STIs each year.

Other Australians includes notifications for non-Indigenous Australians and those for whom Indigenous status is not stated.

In indicator:

- 1.12 HIV/AIDS, hepatitis C and sexually transmissible infections

National Opioid Pharmacotherapy Statistics Annual Data collection

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection is an administrative by-product collection (that is, secondary use). Data are collated in each jurisdiction from information already collected for the purposes of administering or providing a service (that is, primary use).

The main purpose of the current NOPSAD collection is to report jurisdictional data on the number of clients accessing pharmacotherapy for the treatment of opioid dependence, the number of prescribers participating in the delivery of pharmacotherapy treatment, and quantitative information about the prescribing sector. From the collection, national information on pharmacotherapy can be reported.

In 2005, the AIHW took on the responsibility for managing, analysing and reporting on the NOPSAD collection.

The collection includes information on client's Indigenous status. Currently, Victoria and Western Australia are unable to provide data on the Indigenous status of clients receiving pharmacotherapy services.

In indicator:

- 3.11 Access to alcohol and drug services

Quality statement: <http://meteor.aihw.gov.au/content/index.phtml/itemId/487002 >.

National Perinatal Data Collection

Perinatal data included in this report come from the AIHW National Perinatal Epidemiology and Statistics Unit National Perinatal Data Collection.

Each state and territory has a perinatal collection based on birth notifications completed by midwives and other staff, using information obtained from mothers and from hospital and other records. Perinatal notification forms are completed in Australia for all births of 20 weeks or more gestation, or a birthweight of 400 grams or more.

The Perinatal National Minimum Data Set includes all births in Australia in hospitals, birth centres and the community. State-level data are based on place of mother's usual residence rather than place where birth occurred. A standard data item for Indigenous status is specified in the Perinatal National Minimum Data Set. However, at this stage not all states and territories use this standard wording for the Indigenous status question on their forms. Data on Indigenous status are not reported for Tasmania before 2005 as the not stated category for Indigenous status was included with the non-Indigenous category. Data for Tasmania and the Australian Capital Territory are not deemed of sufficient stability to support trends analysis (AIHW: Leeds KL et al. 2007).

Data on mothers for whom Indigenous status was 'not stated' have been excluded from analysis.

All jurisdictions collect Indigenous status of the mother for each baby. A data item on Indigenous status of the baby was added to the Perinatal NMDS from July 2012. Currently, data on antenatal care is not available from all jurisdictions. A nationally consistent data item on gestational age at first antenatal visit was added to the Perinatal NMDS from July 2010 and a data item on number of antenatal visits will be included in the Perinatal NMDS from 1 July 2013. Work is under way to progress data elements related to alcohol use in pregnancy.

In indicators:

- 1.01 Low birthweight infants
- 2.21 Health behaviours during pregnancy

National Prisoner Census

The ABS collects data from administrative records on persons in prison custody on 30 June each year in all jurisdictions. This Census includes all prisoners in adult corrective services, but not persons in juvenile institutions, psychiatric care or police custody. The Census collects information on the number of people in custody, legal status (sentenced or unsentenced), prior imprisonment, the most serious offence committed and length of sentence.

Most jurisdictions collect Indigenous status from individual prisoners. It is uncommon for corrective services agencies to collect Indigenous status from anyone other than the prisoners themselves. However, the accuracy of these data has not been assessed.

In indicator:

- 2.11 Contact with criminal justice system

National Public Hospitals Establishment Database

The AIHW National Public Hospitals Establishment Database holds establishment-level data for public hospitals within the jurisdiction of the state and territory health authorities. Private hospitals and public hospitals not administered by the state and territory health authorities are not included. Information is provided annually to the AIHW by state and territory health departments.

Data are presented for the six jurisdictions that have been assessed by the AIHW as having adequate identification of Indigenous hospitalisations in 2006–08—New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory (AIHW 2010). These six jurisdictions represent approximately 96% of the Indigenous population of Australia. Data are presented by state/territory of usual residence of the patient.

In indicator:

- 3.19 Accreditation

National Schools Statistics Collections

The National Schools Statistics Collection (NSSC) is a collaborative arrangement between state, territory and Australian Government education departments. It is managed by the Ministerial Council on Education, Early Childhood Development and Youth Affairs (MCEECDYA) Performance Measurement and Reporting Taskforce (PMRT). Information is provided on the number and characteristics of schools, students and staff. These data are derived from the annual Schools Census enumerated each August by the responsible authorities.

Care should be exercised in the interpretation of apparent retention rates, because the method of calculation does not take into account a range of factors. At the Australia level, these include students repeating a year of education, migration and other net changes to the school population. At lower levels of disaggregation, additional factors affecting the data, such as enrolment policies (which contribute to different age/grade structures between states and territories), inter-sector transfers and interstate movements of students, have not been taken into account. These and other factors affecting the interpretation of apparent retention rates are being looked at, where possible, in the ABS's review of apparent retention rates.

In indicator:

- 2.05 Years 10 and 12 retention and attainment

National Vocational Education and Training Provider Collection

The National Centre for Vocational Education Research is Australia's main provider of vocational education and training (VET) sector research and statistics. VET is a national system designed to give workers the skills for particular occupations and industries. The VET sector includes providers that receive public VET funding, such as technical and further education organisations, higher education institutions, other government providers (for example, agricultural colleges), community education providers, government-funded private registered training organisations, schools funded through government allocations for VET, and all other Australian Government and state recurrent and specific-purpose funded VET, regardless of the location of the training organisation.

Non-identification rates for Indigenous students in these data are high. Care also needs to be taken when comparing data across jurisdictions for load pass rates, as average module durations vary across jurisdictions.

In indicators:

- 3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines

Office for Aboriginal and Torres Strait Islander Health Services Reporting data collection

The AIHW has collected data from Aboriginal and Torres Strait Islander primary health-care services, stand-alone substance use services, and Bringing Them Home and Link Up counselling services that received funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) for 2008–09 onwards.

OATSIH-funded services include both Indigenous community controlled health organisations and non-community controlled health organisations. Note that the OATSIH Services Reporting (OSR) only includes Aboriginal and Torres Strait Islander health organisations that receive at least some Australian Government funding to facilitate access to primary health care.

This collection, referred to as the OSR data collection replaces the Service Activity Reporting (SAR), Drug and Alcohol Services Reporting (DASR), and Bringing Them Home and Link Up counselling data collections previously collected by the OATSIH.

The counting rules used in OSR data analyses treats each auspice service as a single service and this yields a larger numerator and denominator when calculating rates whereas in earlier collections (SAR and DSAR) only the higher level service was counted. For example, a higher level service could have five auspice services under it and in OSR these will be counted as five individual services, whereas in SAR and DSAR it was counted as a single service. While this change only marginally affects the aggregate rates, caution should be exercised when comparing rates with earlier data collection periods.

The OSR data collection included 300 Australian Government-funded Aboriginal and Torres Strait Islander primary health-care services in 2010–11.

In indicators:

- 3.04 Early detection and early treatment
- 3.05 Chronic disease management
- 3.14 Access to services by types of service compared with need
- 3.22 Recruitment and retention of clinical management staff (including GPs)

Quality statement: <http://meteor.aihw.gov.au/content/index.phtml/itemId/495823>.

Socio-Economic Indexes for Areas

The ABS has developed four indexes to allow measurement of relative socioeconomic status at a small area level. These indexes summarise a range of socioeconomic variables associated with disadvantage. Each index summarises a different aspect of the socio-economic conditions of people living in an area. They each summarise a different set of social and economic information. The indexes take into account a range of factors in determining socio-economic conditions.

The indexes are:

- Index of Relative Socio-Economic Disadvantage
- Index of Relative Socio-Economic Advantage and Disadvantage
- Index of Economic Resources
- Index of Education and Occupation.

SEIFA uses a broad definition of relative socio-economic disadvantage in terms of people's access to material and social resources, and their ability to participate in society.
While SEIFA represents an average of all people living in an area, it does not represent the individual situation of each person. Larger areas are more likely to have greater diversity of people and households.

This report uses the Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) in all presentation of data by SEIFA. This index is a continuum of advantage to disadvantage and is available for both urban and rural areas. Low values indicate areas of disadvantage, and high values indicate areas of advantage. It takes into account variables such as the proportion of families with high incomes, people with a tertiary education, and employment in skilled occupations (ABS 2003).

The Census does not collect all of the variables identified as being related to socioeconomic status. Some of the variables may be context-specific and some are associated with age (e.g. income), yet the methodology does not allow for age-standardisation. This is particularly relevant in the context of this performance measure where we are comparing two populations that have different age structures.

Analysis of SEIFA results at small area levels has found that within any area there will be individuals and subpopulations with very different characteristics from the overall population of the area. When judgments are made about the individual or subpopulation based on the characteristics of the area, there is considerable potential for error (Baker & Adhikari 2007). This issue is particularly relevant for the Indigenous.

In indicator:

- 2.09 Index of disadvantage

Supported Accommodation Assistance Program National Data Collection

The Supported Accommodation Assistance Program National Data Collection (SAAP NDC) was collected from 1996 to June 2011. It was designed to capture data on government response to homelessness, and focuses on services provided by agencies funded under the Supported Accommodation Assistance Program which specifically target and provide services to people who are homeless or at risk of homelessness. Therefore, service providers who do not receive government funding and general service providers (that is, which are not 'specialist homelessness agencies') are not included in this data collection.

From July 2011, the SAAP NDC was replaced by the Specialist Homelessness Services Collection (SHSC). The SHSC was developed by the AIHW in collaboration with the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs and relevant departments of all state and territory governments. Key differences between the SAAP NDC and SHSC include the expanded scope of agencies included in the SHSC, to agencies funded under the National Affordable Housing Agreement (NAHA) and National Partnership Agreement on Homelessness (NPAH); the inclusion of children as clients in their own right in SHSC (whereas accompanying children were recorded on their parent's form in SAAP NDC); and the monthly collection of client information and services provided for the SHSC (whereas SAAP NDC information was only collected at the end of a support period).

In indicator:

- 2.01 Housing

Survey of Income and Housing

The Survey of Income and Housing is conducted by the ABS every 2 years, with the first survey beginning in 1994–95. The survey was developed to provide broad aggregates for households within Australia. The current survey was conducted during August 2007 and June 2008 and 9,345 households participated through a personal interview at their usual place of residence. The dwellings were selected through a stratified, multistage cluster design and the survey was conducted over 12 months to be representative of a yearly pattern. Participants were asked information regarding their household, including characteristics, costs, assets and liabilities and individual personal characteristics for residents over 15 years.

Very remote areas were not covered by the survey.

In indicator:

- 2.08 Income

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This report provides the latest information on how Aboriginal and Torres Strait Islander people in the Australian Capital Territory are faring according to a range of indicators on health status, 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. For example, while health assessments have increased significantly and there have been some improvements in literacy for Indigenous students in Year 3 and 5, about half of Aboriginal and Torres Strait Islander mothers smoke during pregnancy and breast cancer screening rates for Indigenous women are lower than for other women.