Health

Part C: Health preface (HP)

The Health preface

Health care services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, detection and treatment of illness and injury, and the rehabilitation and palliative care of individuals who experience illness and injury. More broadly defined, the health system includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury (box HP.1).

Health care services in Australia are delivered by a variety of government and non-government providers in a range of service settings. The Report on Government Services primarily concentrates on the performance of public hospitals (chapter 9) and general practitioners (GPs) (chapter 10) because these services represent a significant component of government recurrent expenditure on health care. The Report also examines the interactions between different service mechanisms for dealing with two health management issues: mental health and breast cancer (chapter 11).

Estimates of government expenditure on health care provision commonly include (by definition) high level residential aged care services. These services are not covered in the health chapters but are reported separately in chapter 12 (Aged care services). Patient transport services are also included in estimates of government health expenditure. Ambulance services (defined as pre-hospital care, treatment and transport services) are reported in chapter 8 (Emergency management).

Other major areas of government involvement in health provision not covered in the health chapters, or elsewhere in the Report, include:

- government support for pharmaceuticals;
- community health services (although reporting on community health services for patients with mental disorders is increasing);
- public health programs, other than those for breast cancer and mental health; and

- funding for specialist medical practitioners.

A range of government services, such as education, public housing, sanitation and water supply also influence health outcomes. These are not formally part of Australia's health system and are not the subject of the health chapters. Education (chapters 3 and 4) and public housing (chapter 16) are, however, included in other chapters of the Report.

Box HP.1 **Some common health terms**

Community health services: health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.

General practitioners: medical practitioners who, for the purposes of Medicare, are vocationally registered under section 3F of the *Health Insurance Act 1973* (Cwlth), hold fellowship of the Royal Australian College of General Practitioners or equivalent, or hold a recognised training placement.

Medicare: Commonwealth Government funding of private medical and optometrical services (Medicare Benefits Schedule [MBS]). Some people use the term to include other forms of Commonwealth Government funding — for example, funding of selected pharmaceuticals (Pharmaceutical Benefits Scheme [PBS]) and public hospital funding (Australian Health Care Agreements [AHCA]) — which is aimed at providing public hospital services free of charge to public patients.

Public health: an organised social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing medical interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular 'at-risk' groups) and complements clinical provision of health care services.

Public hospital: a hospital that provides free treatment and accommodation to eligible admitted people who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. However, charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the AHCA (for example, charges for aids and appliances).

Source: AIHW (2000); DHAC (1999); Report on Government Services (ROGS) 2003, p. E.3.

Indigenous data in the Health preface

The health preface in the *Report on Government Services 2003* contains the following information on Indigenous people:

- Expenditure on health services for Aboriginal and Torres Strait Islander people 1998-99;

- Mortality rates for Indigenous Australians (including infants), 2000;
- Principal causes of death for Indigenous Australians, 2000;
- Life expectancy at birth for Indigenous people and median age at death, 1998-2000;
- Birthweight of babies, 1999; and
- Future directions for reporting on Indigenous health.

Supporting tables

Supporting tables for data within the health preface of the compendium are contained in the attachment to the compendium. Supporting tables are identified in references throughout this preface by the abbreviated preface name (for example, HP.A5 is table 5 in the health preface attachment to the compendium).

As the data are directly sourced from the *Report on Government Services 2003*, the compendium also notes where the original table, figure or text in the Report can be found. For example, where the compendium refers to ‘ROGS 2003, p. 6.15’ this is page 15 of chapter 6 of the Report and ‘ROGS 2003, 6A.2’ is attachment table 2 of attachment 6 of the Report.

Problems associated with Indigenous health data

The Steering Committee has allocated a high priority to reporting on Indigenous people. There are limited data available on Indigenous health and the data are of poor quality. Some of the problems associated with Indigenous health data are outlined in ABS/AIHW (2001) and Australian Indigenous Health Infonet (2002). In summary:

- estimating the Indigenous population is difficult because the propensity for people to identify as Indigenous varies;
- Indigenous people are not always accurately identified in administrative collections, such as hospital records and birth and death registrations, due to variations in definitions, different data collection methods and failure to record Indigenous status; and
- sampling for national household surveys is usually designed to provide aggregate information about the total Australian population, often does not include remote areas, and is usually insufficient to enable separate results to be published for Indigenous people.

It is a priority of the Review to improve the reporting of data on delivery of health care services for Indigenous people and residents in nonmetropolitan regions of Australia.

Expenditures on health services for Indigenous people

Estimating health services expenditure for Indigenous people is difficult. Department of Veterans' Affairs' records do not identify Indigenous status. In other data sets, while Indigenous status is recorded, the identification of Indigenous people remains incomplete. Indigenous people have been able to voluntarily identify as Indigenous for the Medicare and PBS databases since late 2002.

Two sets of estimates of health services expenditure for Aboriginal and Torres Strait Islander people have now been released; the most recent for 1998-99 (AIHW 2001). Expenditure on primary care (including Medicare and the PBS) was approximated based on survey data, with identification of Indigenous status acknowledged as being incomplete. A full account of the most recent estimates was provided in the 2002 ROGS. The key issues are repeated here.

Total recurrent expenditure on health services for Indigenous people was around $1.2 billion in 1998-99.[1] This was equivalent to $3065 per Indigenous person compared with $2518 per non-Indigenous person; a ratio of 1.22:1 (table HP.1).[2]

The study (AIHW 2001) found that public expenditures on the health of Indigenous people appear to have been similar to those for non-Indigenous people in low income groups, when their relative income position was taken into account. Indigenous people were on average much higher users of publicly provided health services, but used fewer privately provided services (such as doctors in private practice). Governments funded 90.8 per cent of Indigenous recurrent health costs compared with 67.5 per cent of the recurrent health care costs of non-Indigenous Australians in 1998-99. For public funding, the ratio of Indigenous to non-Indigenous expenditures per person was 1.64:1, reflecting their relatively poor health and socioeconomic status (table HP.1).

The vast majority of Indigenous health expenditure was allocated through mainstream health programs — admitted and non-admitted patient services, community health services, medical and pharmaceutical health services and public

---

[1] The Report examines recurrent expenditure only. Capital costs are not included in expenditure estimates.

[2] If the higher costs of providing services in remote areas were factored in, the ratio of Indigenous to non-Indigenous health expenditure would be lower.

health services. A small proportion of health expenditure was allocated through programs directly targeting Indigenous people, the most significant being the Aboriginal Community Controlled Health Services (ACCHSs).

Table HP.1 **Estimated recurrent expenditure by source of funds and by Indigenous status, 1998-99 (per person)[a]**

Source of funds	*Indigenous*		*Non-Indigenous*		*Indigenous/ other*
	$/person	%	$/person	%	Ratio
State government funding of State government programs	*1 376*	*44.9*	*484*	*19.2*	*2.84*
Commonwealth Government funding	*1 393*	*45.5*	*1 206*	*47.9*	*1.15*
Indigenous-specific	298	9.7	1	–	..
Medicare/PBS	196	6.4	506	20.1	0.39
Other Commonwealth programs	163	5.3	366	14.5	0.45
Payments to States	735	24.0	334	13.2	2.20
Local government funding	*15*	*0.5*	*9*	*0.4*	*1.67*
Total government	**2 783**	**90.8**	**1 700**	**67.5**	**1.64**
Total private[b]	**281**	**9.2**	**819**	**32.5**	**0.34**
Total health expenditure	**3 065**	**100.0**	**2 518**	**100.0**	**1.22**

[a] Totals may not add as a result of rounding. [b] Private funding includes funding from out-of-pocket payments by patients, health insurance funding and other funding sources such as workers compensation. – Nil or rounded to zero. .. Not applicable.

Source: AIHW (2001); ROGS 2003, p. E.12.

While the Commonwealth was the major *source* of funding in 1998-99 (table HP.1), the majority of health services provided to Indigenous people were *administered* by State and Territory governments (around 72.0 per cent). State and Territory government services may be funded by the States and Territories, by the Commonwealth or from private sources. Programs delivered directly by the Commonwealth Government accounted for 22.5 per cent of total health expenditure per Indigenous person — a significant proportion through grants to ACCHSs (AIHW 2001). Commonwealth Government programs may be funded by the Commonwealth or from private sources.

Indigenous Australians are currently using secondary/tertiary care at a higher rate than primary health care. Patterns of government expenditure per person in 1998-99 for Indigenous people reflected their relatively higher use of hospital services (both admitted and non-admitted) compared with non-Indigenous Australians. Expenditure on Indigenous people in public hospitals was twice as much per person, and in community and public health services more than five times as much per person, as expenditure for non-Indigenous people (see table HP.2). On the other hand, expenditure per person on Medicare and the PBS was much lower for Indigenous people — around 39 per cent of that for non-Indigenous people (AIHW 2001) (table HP.1). Indigenous per person expenditure on private sector services was only 23 per cent of non-Indigenous expenditure per person (table HP.2).

Table HP.2 **Estimated recurrent expenditure by program and by Indigenous status, 1998-99[a]**

	Indigenous $/person	*non-Indigenous $/person*	*Ratio Indigenous/ non-Indigenous*
Expenditure through Commonwealth, State and Territory government programs			
Acute care institutions			
Admitted patient services	1 125	558	2.02
Non-admitted patient services	307	139	2.21
Mental health institutions	64	25	2.53
Public hospitals	*1 496*	*722*	*2.07*
High care residential aged care	99	209	0.47
Community and public health	874	170	5.14
Patient transport	106	31	3.39
Medicare and other medical[b]	179	468	0.38
PBS medicines[c]	61	195	0.31
Administration and research	101	72	1.40
Total government program expenditure	**2 917**	**1 868**	**1.56**
Expenditures on private sector services			
Private hospitals	25	222	0.11
Dental and other professional	42	213	0.20
Non-PBS medicines and appliances	66	144	0.46
Medical (compensable etc)	11	37	0.30
Administration	5	34	0.14
Total private sector services expenditure	**148**	**650**	**0.23**
Total health expenditure	**3 065**	**2 518**	**1.22**

[a] Totals may not add as a result of rounding. [b] Includes Medicare optometrical and dental as well as medical services, and includes MBS payments through patient co-payments, and MBS payments through the Department of Veterans' Affairs. [c] Includes PBS payments through patient co-payments and PBS payments through the Department of Veterans' Affairs.

Source: AIHW (2001); ROGS 2003, p. E.13.

International experience has shown that a comprehensive approach to primary health care can contribute to significant improvements in health in developing countries and among Indigenous populations in developed countries comparable to Australia (DHA 2001).

In its 1999-2000 budget, the Commonwealth Government announced the Primary Health Care Access Program, a local health services development program to increase the availability of appropriate primary health care services for Indigenous

Australians where services are inadequate. The program will establish a framework for the expansion of comprehensive primary health care services, including clinical care, illness prevention and early intervention activities and management and support system, in a planned and coordinated manner in line with regional planning.

Selected indicators of health outcomes

It is difficult to isolate the effect of health care services on the general health of the population. Socioeconomic factors (such as ethnicity, residential location, income levels and employment rates) and the provision of nonhealth care government services (such as clean water, sewerage, nutrition, education and public housing) each contribute to overall health outcomes. Data on health outcomes presented in this Report include life expectancy, mortality rates (for infants and all people), leading causes of death, and the birthweight of babies.

As discussed elsewhere, reporting data for Indigenous people is a priority for the Review. Where possible, data are presented for Indigenous people as well as the Australian population as a whole.

The efforts of governments to address health care needs are influenced by factors external to their control, including geographic dispersion, age profiles, racial characteristics and socioeconomic status. It is important to remember the limits of the data presented, due to the effects of other nonhealth related factors.

Mortality rates

Data on Indigenous mortality are collected through State and Territory death registrations. Although these data collections have good data for the total Australian population, the accuracy of the identification of Indigenous Australians varies significantly between States and Territories. The term ‘coverage’ refers to the number of Indigenous deaths registered, expressed as a percentage of the number of deaths expected based on Census-based population data. The NT, SA, WA and, more recently, Queensland are generally considered to have the best coverage of death registrations for Indigenous people. In 2000, the estimated coverage ranged from 92 per cent in the NT to six per cent in Tasmania, with 59 per cent coverage Australia-wide (based on 1996 low series population projections). There are also limitations to identification in the Census and births data which affect the reliability of Indigenous mortality data. There can be underestimation of the number of Indigenous deaths (or births) and, by extension, an underestimation of the mortality (or birth) rate of Indigenous people (ABS 2001a). The ABS now publishes the Indigenous mortality data for all jurisdictions except Tasmania and the ACT. Changes are being made that will improve the coverage of Indigenous death registrations in these jurisdictions (ABS 2000c). With these caveats in mind the Indigenous mortality rate in 2000 in the NT, SA and WA combined was 21 deaths per 1000, a rate over three times the national rate for all people (six per 1000) (ABS 2001a). Of these three jurisdictions, the Indigenous mortality rate in 2000 was highest in the NT (24.0 per 1000) and lowest in SA (18.1 per 1000) (table HP.3).

Table HP.3 **Mortality rates, age standardised for all causes, 2000 (per 1000 people)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[a]
All Australians	5.8	5.5	5.7	5.4	5.8	6.2	5.1	8.9	5.7
Indigenous[b]	12.0	12.1	14.0	19.8	18.1	**na**	**na**	24.0	15.2

[a] Figures for Australia include 'Other Territories'. [b] Indigenous death rates for 2000 are based on indirect age standardisation according to the ABS *Experimental Projections for the Indigenous Population: 1996 to 2006.* **na** Not available.

Source: ABS (2001a); ROGS 2003, p. E.19; table HP.A1.

Infant mortality rates[3] for all Australians were 5.2 in 2000 (table HP.A2). Across jurisdictions, infant mortality rates in 2000 were highest in the NT (11.7 per 1000 live births) and lowest in the ACT (4.2 per 1000 live births).

Infant mortality rates for Indigenous Australians are reported for NSW, Queensland, WA and the NT in this year's Report. The accuracy of Indigenous mortality data is variable due to varying rates of coverage across jurisdictions and over time, and changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data. The Indigenous infant mortality rate was between 22.9 per 1000 live births in the NT and 10.7 per 1000 live births in Queensland (between 4.4 times (NT) and 2.1 times (Queensland) the national average for all Australians in 2000) (table HP.4).

Table HP.4 **Infant mortality rates, 2000 (per 1000 live births)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[a]
All Australians	5.2	4.5	6.2	4.3	4.6	5.8	4.2	11.7	5.2
Indigenous[b]	12.4	**na**	10.7	16.9	**na**	**na**	**na**	22.9	13.6

[a] Figures for Australia include 'Other Territories'. [b] Indigenous data is subject to uncertainty as a result of the underreporting of both births and deaths. The accuracy of Indigenous mortality data is variable due to varying rates of coverage across jurisdictions and over time, and changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data. **na** Not available.

Source: ABS (2001a); table HP.A2.

---

[3] The number of deaths of children under one year of age in a calendar year per 1000 live births in the same calendar year.

Principal causes of death

The main causes of death among Australians in 2000, when measured in terms of broad categories of disease and injury, were diseases of the circulatory system (heart diseases, heart attacks and strokes), neoplasms (tumours and malignant cancers), diseases of the respiratory system (such as chronic obstructive pulmonary disease) and external causes (including accidents and suicide). These accounted for 83.5 per cent of all deaths among males and 80.2 per cent of all deaths among females (table HP.A3).

Table HP.5 summarises the most significant individual causes of mortality among Australian males and females. Ischaemic heart disease, acute myocardial infarction and stroke are the most common causes for both men and women.

Table HP.5 **Principal causes of deaths, 2000 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Male									
Heart disease[a]	21.5	20.2	21.6	19.8	22.2	20.4	19.2	15.8	21.0
Acute myocardial infarction[c]	11.2	11.0	11.7	11.2	12.9	11.4	9.7	7.2	11.4
Stroke[b]	8.1	6.8	7.2	6.6	7.0	8.0	6.5	3.5	7.4
Lung cancer[d]	6.7	6.7	7.3	7.3	7.1	7.0	5.0	6.0	6.9
Prostate cancer	3.8	4.2	4.3	3.7	4.1	4.4	3.7	1.1	4.0
Suicide	2.5	2.3	3.5	3.6	2.6	2.1	3.9	6.5	2.8
Diabetes mellitus	1.9	3.0	2.6	2.5	2.1	2.1	1.6	3.2	2.4
Female									
Heart disease[a]	20.5	18.7	23.2	20.8	18.6	19.2	9.8	20.2	20.3
Stroke[b]	12.8	11.1	12.4	12.0	11.0	11.3	5.6	12.9	12.0
Acute myocardial infarction[c]	10.8	11.0	13.4	13.0	10.4	10.5	4.4	11.9	11.4
Breast cancer	3.8	4.5	3.8	3.9	4.1	4.4	4.4	6.7	4.1
Lung cancer[d]	3.6	3.8	3.5	3.4	4.7	4.2	3.8	4.7	3.7
Suicide	0.6	0.8	1.2	0.7	1.1	0.6	1.5	0.6	0.8
Diabetes mellitus	1.8	2.8	2.4	2.7	2.5	1.3	5.0	1.7	2.3

a Ischaemic heart disease. **b** Cerebrovascular disease. **c** Heart attack. **d** Cancer of the trachea, bronchus and lung.

Source: ABS (2001a); ROGS 2003, p. E.21; table HP.A3.

The leading causes of death for Indigenous people in 2000 are presented in table HP.6. External causes[4] of death made up a higher proportion of deaths for Indigenous people (19.2 per cent for males and 10.3 per cent for females) than for all Australians (8.3 per cent for males and 4.2 per cent for females). Similarly, diabetes mellitus contributed to 5.6 per cent (males) and 11.3 per cent (females) of Indigenous deaths compared to 2.3 per cent (females) and 2.4 per cent (males) of total deaths (table HP.6). Malignant neoplasms (cancers) accounted for a smaller proportion of Indigenous deaths (15.7 per cent for males and 15.8 per cent for females) than for all Australians (30.2 per cent for males and 25.2 per cent for females) (tables HP.A3 and HP.A4).

Table HP.6 **Principal causes of deaths for Indigenous people, 2000 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Male									
External causes[b]	15.4	15.8	19.2	24.5	17.7	**na**	**na**	19.1	19.2
Suicide	4.2	5.3	6.9	8.4	3.8	**na**	**na**	5.3	6.0
Transport accidents	4.2	1.8	3.8	5.1	5.1	**na**	**na**	6.1	4.6
Assault	2.7	–	1.7	2.1	1.3	**na**	**na**	4.1	2.4
Heart disease[c]	24.7	22.8	18.2	13.1	15.2	**na**	**na**	15.9	18.1
Diabetes mellitus	4.2	3.5	7.2	6.3	6.3	**na**	**na**	4.9	5.6
Female									
External causes[b]	9.8	11.8	8.6	15.3	15.4	**na**	**na**	6.9	10.3
Suicide	1.9	3.9	1.6	1.8	3.1	**na**	**na**	0.5	1.7
Transport accidents	3.3	3.9	2.0	2.9	4.6	**na**	**na**	2.0	2.7
Assault	2.3	–	2.0	4.1	–	**na**	**na**	2.5	2.3
Heart disease[c]	18.7	5.9	17.6	17.1	18.5	**na**	**na**	9.8	15.4
Diabetes mellitus	6.1	11.8	16.0	14.1	20.0	**na**	**na**	6.4	11.3

[a] The NT, SA, WA and, more recently, Queensland are generally considered to have the best coverage of death registrations for Aboriginal and Torres Strait Islander Australians. Numbers of Indigenous deaths for some causes in some jurisdictions are very small and a small change in the number of deaths for one of those causes may result in a large change in percentage terms. [b] Includes transport accidents, intentional self harm, assault and all other external causes of mortality. [c] Ischaemic heart disease. **na** Not available.

Source: ABS (2001b); ROGS 2003, p. E.22; table HP.A4.

---

[4] ‘External causes’ includes transport accidents, suicide, assault and all other external causes of mortality.

Life expectancy

Attachment table HP.A5 shows the average life expectancy at birth for all Australians (broken down by male and female) and Indigenous persons (broken down by male and female).

Life expectancy at birth varies across jurisdictions. Average life expectancy for males at birth was 78.3 years in the ACT in 2000, compared with 70.3 years in the NT. The average for females in WA was 82.6 years, which was more than seven years longer than that for females in the NT (75.2 years). These differences reflect the large Indigenous proportion of the NT population (compared with other jurisdictions) and the shorter life expectancy of Indigenous people generally (HP.A5).

Indigenous Australians had considerably lower life expectancies than non-Indigenous Australians for all years reported. The ABS has published experimental estimates of life expectancy for Indigenous Australians for 1998–2000. Based on these estimates, the life expectancies at birth of Indigenous Australians were 56.0 for males and 62.7 for females. Indigenous life expectancies are 19.3 years less for females and 20.6 years less for males than the average life expectancies for all Australians (table HP.A5). Care needs to be taken when interpreting these figures as they are estimates only.

Concerns with the under reporting of Indigenous deaths also affect estimates of life expectancies (ABS 2001a). An alternative measure of longevity is the median age at death, although this does not indicate the current health status of living people. In 2000, the median age at death for all Australians was 75.3 years for males and 81.7 years for females. In contrast, the median age at death for Indigenous Australians was 50.8 years for males and 57.4 years for females (table HP.A6).

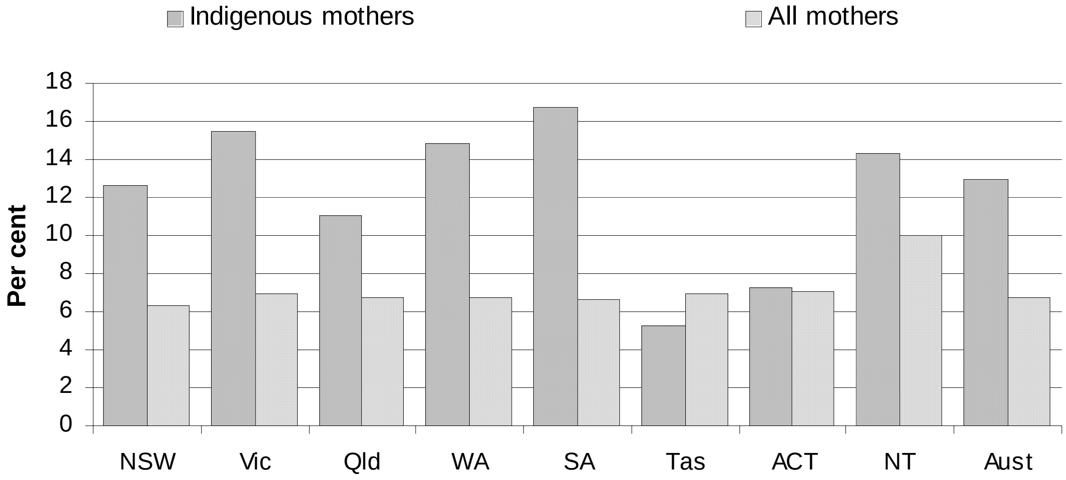
The median age at death for Indigenous Australians was highest among females in Queensland (61.3 years) and lowest among males in the NT (46.2 years). For all Australians, the highest median age at death was for females in SA (82.2 years) and the lowest was for males in the NT (55.7 years) (table HP.A6).

Birthweight of babies

For the first time this year, the Report contains information on the birthweights of babies born to all mothers and to Indigenous mothers. It is reported as part of the Steering Committee’s focus on improving reporting on the Indigenous population, and this indicator is a key signal of the health and life expectancy of Indigenous people compared with the population generally.

The birthweight of a baby is an important indicator of its health status and future wellbeing. The mean birthweight of babies born to Indigenous mothers nationally was 3149 grams in 1999, compared to 3360 grams for babies born to all mothers (tables HP.A7 and HP.A8). The percentage of babies weighing less than 2500 grams born to Indigenous mothers nationally was 13.0 per cent in 1999, compared with 6.7 per cent for babies born to all mothers. The percentage of babies weighing less than 2500 grams born to Indigenous mothers ranged from 16.7 per cent in SA to 5.3 per cent in Tasmania. The percentage of babies weighing less than 2500 grams born to all mothers ranged from 10.0 per cent in the NT to 6.3 per cent in NSW (figure HP.1). The data are only for babies born to Indigenous mothers and do not include babies with Indigenous fathers and non-Indigenous mothers.

Figure HP.1 **Proportion of babies with birthweights under 2500 grams, 1999[a, b]**



[a] Data are for babies born to Indigenous mothers only. Babies with Indigenous fathers and non-Indigenous mothers are not included. [b] Data for 1999 for Tasmania unavailable. Data for 1998 used as estimates.

Source: AIHW (2001c); ROGS 2003, p. E.26; tables HP.A7 and HP.A8.

Future directions in Indigenous health reporting

Performance indicators for use of health services by Indigenous Australians were first published in the 2000 Report. Since then improvements have been made where possible. The 2003 Report's Health preface includes data on expenditure on health services to Indigenous people and Indigenous mortality, causes of death and life expectancy. The Public hospitals chapter (chapter 9) in the 2003 Report includes several indicators for use of public hospital services by Indigenous people.

During 2002, the Review considered how best to expand its reporting of Indigenous health. The Review has considered the work done by other bodies in identifying priorities, for example, the Commonwealth Grants Commission (CGC) (box HP.2), the National Aboriginal and Torres Strait Islander Health Council, and the Australian Health Ministers Advisory Council (AHMAC) (box HP.3). Governments have tested health reforms to improve Indigenous health through the Aboriginal and Torres Strait Islander Coordinated Care Trials (box HP.4).

Box HP.2 **Commonwealth Grants Commission *Report on Indigenous Funding 2001***

The CGC *Report on Indigenous Funding 2001* suggested the following priorities for Indigenous health:

- Increased resources allocated to Indigenous health — particularly in rural and remote areas — justified by the poor health status of Indigenous people and their reliance on the public health system. (The Commonwealth Government in its response to the CGC report said that data limitations mean it is difficult to draw conclusions about whether Indigenous people in remote areas have poorer health than those in urban areas [Commonwealth Government 2002]);
- Equitable access to mainstream services: access to renal dialysis and 'improved support services such as patient transport and liaison officers' in acute care settings, and increasing Indigenous people's access to Medicare and the PBS;
- Improving the effectiveness of primary care services and increasing their use through:
  - partnership arrangements/community control;
  - improving access to mainstream services;
  - expansion of community controlled health services in accordance with regional health plans;
  - focusing on environmental issues; and
  - focusing on workforce issues;
- Emphasising community-based care to assist elders to remain in communities.

Source: CGC (2001); ROGS 2003, p. E.27.

Box HP.3 **National performance indicators for Aboriginal and Torres Strait Islander health**

For several years there has been a collaborative effort between statistical agencies, health departments and Indigenous organisations to improve the quality of data and reporting on Indigenous health status and health services. A key initiative has been the development of an indicator set for annual reporting by all jurisdictions. An interim set of national health performance indicators was endorsed by AHMAC in 1997, and a refined set was endorsed in 2000.

The interim set covered performance within a framework of health status, risk factors and service delivery and has been reported against by jurisdictions for 1998 and 1999. For many jurisdictions, the data required to report on the indicators were unavailable, of poor quality, or in need of substantial development in order to be reported (NHIMG 2001).

At present, the refined set includes over 50 indicators covering mortality, morbidity, access to health services, health services impacts, workforce developments, risk factors, intersectoral issues, community development and quality of service provision. The technical specifications for the refined set include recommendations for improved definitions and methods of collection for many of the indicators. In August 2002, the AHMAC Standing Committee on Aboriginal and Torres Strait Islander Health established a sub-committee to prioritise a subset of core indicators for jurisdictions to develop and improve data. The sub-committee will choose the indicators for their usefulness rather than the ability of jurisdictions to report on them. As the quality of reporting improves for the core indicators, the sub-committee will choose another group of the refined indicators for developing data with the eventual aim of improving data quality for all of the indicators.

Source: ROGS 2003, p. E.28.

Box HP.4 **The Aboriginal and Torres Strait Islander Coordinated Care Trials**

A first round of Aboriginal and Torres Strait Islander Coordinated Care Trials, comprising four trials in the NT, NSW and WA, ran from 1997 to 1999. They were evaluated in 2000. The Aboriginal and Torres Strait Islander trials ran concurrently with a first round of general trials. The trials were implemented by Aboriginal community health organisations with pooling of Commonwealth, State and Territory funds for health services in the participating communities. Their overall objective was to improve the health status of targeted Indigenous communities through a more coordinated approach to delivery of health care. The approach was to improve accessibility and appropriateness of health care services and establish or improve local organisational capacity and make financial and administrative arrangements more flexible. The

(Continued on next page)

Box HP.4 **(Continued)**

process was to be driven by clients and their communities to create empowerment.

The evaluation found that the trials made considerable progress in all aspects of the intended program of reforms. The reported outcomes included significantly improved access to services, health care planning, population health programs targeting priority needs at the community level, and building the skills and resources of local communities and organisations so that improvements could be made and sustained into the future.

Financial reform and enhanced community capacity — that is, the combination of funds pooling and its administration by community-based organisations — were the key factors in improving the capacity of the health care system to achieve enhanced health outcomes for Indigenous people.

A second round of Coordinated Care Trials includes three trials specifically targeting Aboriginal and Torres Strait Islander people. The second round of Aboriginal and Torres Strait Islander Coordinated Care Trials will run for three years and include a focus on reforming local health care systems, building the capacity of communities, organisations and services to identify and address local health care needs, and ways to enhance access to medical services for Indigenous people.

Source: DHAC (2001); ROGS 2003, p. E.28.

Future priorities for Indigenous health reporting by the Review are likely to include:

- social equity/access/disadvantage;
- mental health;
- substance abuse;
- primary and community health;
- funding for Indigenous health; and
- information on Indigenous health trends over time.

These issues have been selected as priorities because they have been identified by governments as key policy and program priorities in Indigenous health or because they represent areas where there is currently a dearth of information or where the availability of reliable and comparable data is limited but where the Review can potentially be a positive influence in improving data sets.

The availability of data is gradually improving. During 2001-02, key statistics on the services provided by Commonwealth funded Aboriginal primary health care services were collected and are being used for policy development and planning by the services, the sector, the National Aboriginal Community Controlled Health Organisation (NACCHO) and government. These statistics are collected through the annual Service Activity Reporting Questionnaire, a joint Office of Aboriginal and Torres Strait Islander Health and NACCHO initiative. The questionnaire collects service level data on health care and health-related activities over a 12-month period from over 100 Commonwealth funded Aboriginal primary health care services.

Comprehensive data have been published for the first time on the activities of Commonwealth funded stand-alone Aboriginal and Torres Strait Islander substance use services. The annual Drug and Alcohol Service Report questionnaire collects detailed service level information about episodes of care provided, staffing profiles, and the broad range of activities undertaken to prevent and treat substance use. This important information can be used by the government and the sector in formulating policy, in planning, and to profile the work of substance use services for Indigenous people.

Data development in the area of primary health care has been recognised as a priority by the National Advisory Group Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID). A NAGATSIHID working group is being formed to consider issues such as the development of a minimum data set to standardise primary health care information across the health sector with an emphasis on improving service delivery.