Health

Part C: Health preface

Health care services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, the 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 primarily concentrates on the performance of public hospitals (see chapter 9), and primary and community health services (including general practice) (see 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 (see 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 in this Report, but are reported separately in chapter 12 (on 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 (on 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
- public health programs, other than those for breast cancer and mental health
- 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 (see chapters 3 and 4) and public housing (see chapter 16), however, are included in other chapters of the Report.

Indigenous people and people in rural and remote areas often have different health care needs and may experience poorer health outcomes than those of the community at large. It is a priority of the Review to improve reporting on the performance of government provided health care services for Indigenous people and residents in non-metropolitan regions of Australia.

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

Primary health care: Services that:

- provide the first point of contact with the health system
- have a particular focus on prevention of illness or early intervention
- are intended to maintain people’s independence and maximise their quality of life through care and support at home or in local community settings.

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 AHCAs (for example, charges for aids and appliances).

Source: ROGS 2004, p. E.3.

Indigenous data in the Health preface

The health preface in the *Report on Government Services 2004* contains the following information on Indigenous people:

- An overview of Indigenous health, including information on government policy and programs, expenditure and data quality
- Expenditure on health services for Indigenous people, 1998-99
- Mortality rates (including infants), 1999–2001
- Principal causes of death, 2001
- Life expectancy at birth and median age at death, 1999-2001
- Birthweight of babies, 2000

Supporting tables

Supporting tables for data within the health preface of the compendium are contained in the attachment to the compendium. These tables are identified in references throughout this chapter by a 'HPA' suffix (for example, table HPA.3 is table 3 in the health preface attachment to the compendium). As the data are directly sourced from the Report on Government Services 2004, the compendium also notes where the original table, figure or text in the Report on Government Services 2004 can be found. For example, where the compendium refers to 'ROGS 2004, p. 9.15' this is page 15 of chapter 9 and 'ROGS 2004, 9A.2' is attachment table 2 of attachment 9 of the Report on Government Services 2004.

Overview of Indigenous health

The Steering Committee has placed a high priority on reporting on services to Indigenous people. Accordingly, data on health outcomes and the provision of health services for Indigenous people are included where possible in this Report. This overview is designed to assist in the interpretation of these data and provide a broader understanding of Indigenous health.

Indigenous people are more likely to experience disability and reduced quality of life due to ill health, and to die at younger ages than other Australians do (NHIMG 2003). These patterns are reflected in the data on mortality, life expectancy and low birthweight babies (later in this preface); hospitalisation for diabetes, assault and infectious pneumonia (see chapter 9); and suicide (see chapter 11). Other publications, such as *The Health and*

Welfare of Australia's Aboriginal and Torres Strait Islander Peoples (ABS/AIHW 2003), include more comprehensive data on the health status of Indigenous people.

Mortality rates for Indigenous Australians are also higher than those for Indigenous people in New Zealand and the United States (Ring and Firman 2000). In recent decades the mortality rates for Indigenous populations in these countries have declined to levels well below the rates for Indigenous Australians.

Many interrelated factors contribute to the health status of Indigenous people being generally poorer than other Australians, including:

- relatively low education, employment and income levels
- relatively high rates for risk factors such as obesity, smoking, harmful alcohol use and violence
- geographic, language, cultural and financial barriers to accessing health services, particularly primary health services
- inadequate housing, water supply, sewerage and other health related infrastructure.

The determinants of health for Indigenous people also vary across regions and between urban, rural and remote areas (ABS/AIHW 2003). The extent to which differences between jurisdictions in reported health outcomes can be attributed to the performance of government provided health services alone is limited due to the complexity of determinants of health and the data quality problems discussed below. The Steering Committee publication *Overcoming Indigenous Disadvantage: Key Indicators 2003* (SCRGSP 2003), shows some of the multiple contributors (and their complex cross-links) to outcomes for Indigenous people.

Government policy and programs

The majority of government expenditure on Indigenous health is through mainstream health programs (AIHW 2001). In addition, the Australian, State and Territory governments fund Indigenous specific health programs and undertake coordination and research activities. Following the transfer of responsibility from the Aboriginal and Torres Strait Islander Commission (ATSIC) in 1995, the Australian Government Department of Health and Ageing has adopted a leadership role in Indigenous health. Most Australian Government expenditure on Indigenous specific health programs is directed to ACCHSs. State and Territory governments fund a range of community and public health programs that specifically target Indigenous people. More information on these services is included in chapter 10 (on primary and community health).

Agreements on Aboriginal and Torres Strait Islander Health (framework agreements) have been established in each State and Territory to promote a partnership approach. Partners to these agreements are the Australian, State and Territory governments, ATSIC and the community sector. The agreements commit signatories to work together to:

- increase the level of resources allocated to reflect the level of need
- plan jointly
- improve access to both mainstream and Indigenous specific health and health related services
- improve data collection and evaluation.

At the national level, under the framework agreements, the National Aboriginal and Torres Strait Islander Health Council was established to provide policy advice to the Australian Government Minister for Health on Indigenous health issues. The Council has overseen the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, which all health ministers endorsed at the July 2003 Australian Health Ministers Conference.

This new framework builds on the 1989 National Aboriginal Health Strategy and outlines agreed principles and the following nine key result areas that all jurisdictions and the community controlled sector are committed to achieving cooperatively over the next 10 years:

- *community controlled primary health care*: building community capacity so individuals and communities can better address their own health needs
- *health system delivery framework*: focusing on improving the responsiveness of mainstream services to Indigenous health needs, and forging stronger partnerships between mainstream and Indigenous specific services
- *a competent health workforce*: aiming to improve the training, recruitment and retention of appropriately skilled health professionals in both mainstream and Indigenous specific services
- *emotional and social wellbeing*: focusing on mental health, suicide, family violence, substance misuse and male health
- *environmental health*: delivering safe housing, water, sewerage and waste disposal
- *wider strategies that impact on health*: requiring the involvement of portfolios outside the health sector, such as action in the areas of education, employment and transport
- *data, research and evidence*: improving information on health service effectiveness in meeting the needs of Indigenous Australians
- *resources and finance*: providing resources for Indigenous health commensurate with need, the cost of delivering services and community capacity to deliver health outcomes
- *accountability*: being accountable to communities and governments for the delivery and effectiveness of health services.

Expenditure

The most recent estimates of health services expenditure for Indigenous people are for 1998-99 (AIHW 2001). Expenditure on primary care (including Medicare and the PBS) included in these estimates was based on survey data, with identification of Indigenous status acknowledged as being incomplete. The 2002 and 2003 Reports covered these estimates, so only key points are repeated here.

- Total recurrent expenditure on health services for Indigenous people was around $1.2 billion in 1998-99.[1] This total was equivalent to $3065 per Indigenous person, compared with $2518 per non-Indigenous person — a ratio of 1.22:1 (table E.1). This ratio is low, considering the much lower health status of Indigenous Australians and the higher costs of service delivery in remote areas.
- Expenditure per person on Medicare and the PBS in 1998-99 was much lower for Indigenous people — around 39 per cent of that for non-Indigenous people (AIHW 2001) (table HP.1).
- Indigenous Australians are using secondary/tertiary care at a higher rate than they are using primary health care.
- Public expenditure on the health of Indigenous people in 1998-99 appears to have been similar to that on the health of non-Indigenous people in low income groups (when their relative income position is taken into account) (AIHW 2001). Indigenous people, however, have generally lower health status than that of non-Indigenous people in low income groups.
- Indigenous people were much higher users of publicly provided health services in 1998-99, on average 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 (table HP.1).
- Expenditure on Indigenous people in public hospitals in 1998-99 was twice as much per person as expenditure for non-Indigenous people. In community and public health services it was more than five times as much per person, (table HP.2).

In light of the key role that preventative and primary health services play in maintaining health, the apparent low rate of expenditure on these services for Indigenous people is perhaps the most important message from the expenditure data.

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

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

Source of funds	*Indigenous*		*Non-Indigenous*		*Indigenous/ non-Indigenous*
	$/person	%	$/person	%	ratio
State government funding of State government programs	*1 376*	*44.9*	*484*	*19.2*	*2.84*
Australian 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 Australian Government 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 2004, p. E.14.

Data quality

Good quality data are needed to assess the effectiveness of programs and to evaluate policies designed to improve health services and outcomes for Indigenous people. Despite some recent improvements, however, limited data are available on Indigenous health and there are significant quality issues with most of the data that are available.

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

	Indigenous $/person	*Non-Indigenous $/person*	*Indigenous/ non-Indigenous ratio*
Expenditure through Australian, 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 through the Department of Veterans' Affairs. [c] Includes PBS payments through patient co-payments and through the Department of Veterans' Affairs.

Source: AIHW (2001); ROGS 2004, p. E.15.

Some of the following problems are associated with Indigenous health data (ABS/AIHW 2003):

- Estimates of the Indigenous population are affected by variations in the propensity of people to identify as Indigenous and by incomplete identification of Indigenous status in the births and deaths data used in estimating population changes between Census years.
- Indigenous people are not always accurately or consistently 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.

- Various health related surveys include an Indigenous identifier but do not necessarily provide reliable data on Indigenous people due to their sample size or survey design (although considerable improvement has been made in this area in recent years).

In some cases, agencies such as the Australian Bureau of Statistics (ABS) or the AIHW have identified jurisdictions with acceptable data quality for particular collections. These judgments have informed the presentation of Indigenous health data in this Report.

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 non-health 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 self-assessed health status, mortality rates (for infants and all people), leading causes of death, life expectancy 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 non-health related factors.

Mortality rates

Most components of the health system can influence mortality rates, although there may be a lag of decades between the action and the effect. A public health campaign to reduce smoking by young people, for example, may reduce premature deaths due to smoking related conditions some decades in the future. Factors external to the health system also influence 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 across States and Territories. The term ‘coverage’ refers to the number of Indigenous deaths registered as a percentage of the number of deaths expected based on Census 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 2001, the estimated coverage ranged from 85 per cent in the NT to 22 per cent in Tasmania, with 55 per cent coverage Australia-wide (based on 1996 low series population projections).

Limitations to identification in the Census and births data also affect the reliability of Indigenous mortality data. The number of Indigenous deaths (or births) can be underestimated; by extension, the mortality (or birth) rate of Indigenous people can also be underestimated (ABS 2002b). The ABS now makes available Indigenous mortality data for all jurisdictions except Tasmania and the ACT. Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data in table E.4 are presented for a three year period. To improve comparability, indirect age standardisation methods have been used for both the Indigenous and total population rates. With above caveats concerning coverage in mind, the mortality rate for Indigenous people in 1999–2001 was more than twice that for all people in all jurisdictions for which data are available (table HP.3).

Table HP.3 **Mortality per 1000 people, age standardised for all causes, 1999–2001[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]
Total population	6.8	6.7	6.9	6.6	6.8	na	na	11.9	6.8
Indigenous[c, d, e]	14.4	14.9	17.2	21.6	19.5	na	na	27.4	18.5

a Calculated using indirect methods of age standardisation. **b** Based on NSW, Victoria, Queensland, WA, SA and the NT. **c** Uses age specific death rates for the total population as the standard and the low series of the projected Indigenous populations. **d** Based on registered deaths with no adjustment for undercoverage of Indigenous death registrations. **e** The accuracy of Indigenous mortality data is variable. ABS assessments indicate that the coverage of death registrations for Indigenous people in Queensland, WA, SA and the NT is higher than that for other jurisdictions. Estimated coverage of Indigenous deaths based on the ABS 1996 Census (per cent): NSW 45, Victoria 41, Queensland 56, WA 62, SA 59, Tasmania 22 and the NT 85. **na** Not available.

Source: ABS (unpublished); ROGS 2004, p. E.21.

The infant mortality rates shown in figure HP.1 have been averaged over three years to reduce the volatility inherent in the annual rates. Infant mortality rates[2] in Australia declined from 6.3 per 1000 live births in 1992–94 to 5.4 per 1000 live births in 1999–2001, although the rate has been relatively static in recent years (table EA.6). Infant mortality rates in 1999–2001 were highest in the NT (11.4 per 1000 live births) and lowest in the ACT (4.3 per 1000 live births) (figure HP.1).

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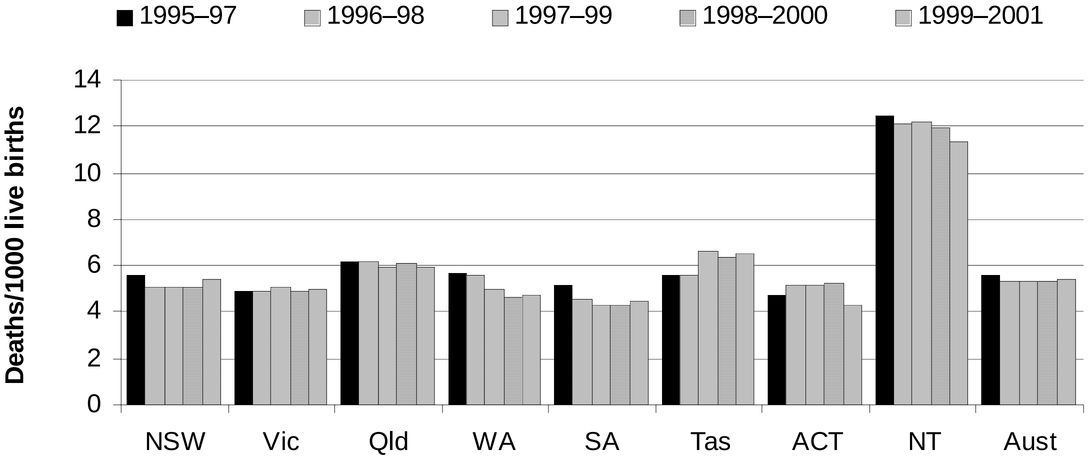
[2] The number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year.

Figure HP.1 **Infant mortality rate, three year average**



Source: ABS (2002b); ROGS 2003, p. E.21; Table HPA.1.

Three year average 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 to changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data. In all jurisdictions for which data are reported, the Indigenous infant mortality rate was more than twice as high as the national average for all Australians in 1999–2001 (table HPA.1).

Principal causes of death

The leading causes of death for Indigenous people in 2001 are presented in table HP.4. (The equivalent results for all Australians are in attachment table HPA.2.) External causes[3] of death made up a higher proportion of deaths for Indigenous people (20.0 per cent for males and 11.7 per cent for females) than for all Australians (8.1 per cent for males and 3.9 per cent for females). Similarly, diabetes mellitus contributed to 5.3 per cent (males) and 9.9 per cent (females) of Indigenous deaths compared to 2.5 per cent (males) and 2.3 per cent (females) of total deaths (table HP.4). Malignant neoplasms (cancers) accounted for a smaller proportion of Indigenous deaths (13.4 per cent for males and 19.6 per cent for females) than for all Australians (31.1 per cent for males and 25.9 per cent for females) (tables HPA.2 and HPA.3 of the 2004 Report on Government Services). Some of the difference in the proportions of deaths for particular causes is due to differences in the age profiles of the Indigenous and total Australian populations.

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[3] 'External causes' includes transport accidents, suicide, assault and all other external causes of mortality.

Table HP.4 **Principal causes of deaths for Indigenous people, 2001 (per cent)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Male									
External causes[c]	15.9	24.1	20.2	20.5	31.1	na	na	20.1	20.0
Suicide	4.7	na	10.4	na	6.8	na	na	na	6.8
Transport accidents	3.6	na	na	6.2	na	na	na	5.4	4.8
Assault	1.8	na	na	na	na	na	na	2.7	2.1
Heart disease[d]	26.8	24.1	20.9	14.3	13.5	na	na	13.9	19.5
Diabetes mellitus	3.3	na	5.5	7.1	6.8	na	na	5.4	5.3
Female									
External causes[c]	10.2	12.8	9.6	11.9	9.9	na	na	15.3	11.7
Suicide	2.4	na	3.3	na	3.7	na	na	na	2.6
Transport accidents	2.0	na	na	4.8	na	na	na	5.9	2.7
Assault	1.5	na	na	na	na	na	na	5.9	2.5
Heart disease[d]	21.5	15.4	14.6	8.7	9.9	na	na	10.0	14.7
Diabetes mellitus	4.4	na	9.6	16.7	6.2	na	na	14.1	9.9

[a] The accuracy of Indigenous mortality data is variable. ABS assessments indicate that the coverage of death registrations for Indigenous people in Queensland, WA, SA and the NT is higher than that for other jurisdictions. Estimated coverage of Indigenous deaths based on the 1996 Census (per cent): NSW 45, Victoria 41, Queensland 56, WA 62, SA 59, Tasmania 22 and the NT 85. [b] Numbers of Indigenous deaths from some causes in some jurisdictions are very small and a small change in the number of deaths for one cause may result in a large change in percentage terms. [c] Includes transport accidents, intentional self-harm, assault and all other external causes of mortality. [d] Ischaemic heart disease. **na** Not available.

Source: ABS (2002c); ROG 2004, p. E.24; Table HPA.3.

Life expectancy

The life expectancy of Australians has improved dramatically since Federation. The average life expectancy at birth in the period 1901–10 was 55.2 years for males and 58.8 years for females. It then rose steadily until it reached 77.0 years for males and 82.4 for females in 1999–2001 (table HPA.4).

Indigenous Australians had considerably lower life expectancies than those of non-Indigenous Australians for all years reported. The ABS has published experimental estimates of life expectancy for Indigenous Australians for a number of years. Based on estimates for 1999–2001, the life expectancies at birth of Indigenous Australians were 56.3 years for males and 62.8 years for females. Indigenous life expectancies are 20.7 years less for males and 19.6 years less for females than the average life expectancies for all Australians (table HPA.4). Care needs to be taken when interpreting these figures because they are only estimates and are affected by underreporting of Indigenous deaths.

The method of calculating Indigenous life expectancy estimates has been updated; new estimates are available from the ABS but were not released in time for inclusion in this Report. In updating the estimates of both Indigenous life expectancy and the coverage of Indigenous deaths registrations, the ABS has accounted for the 2001 Census based population estimates and registered deaths since 1996.

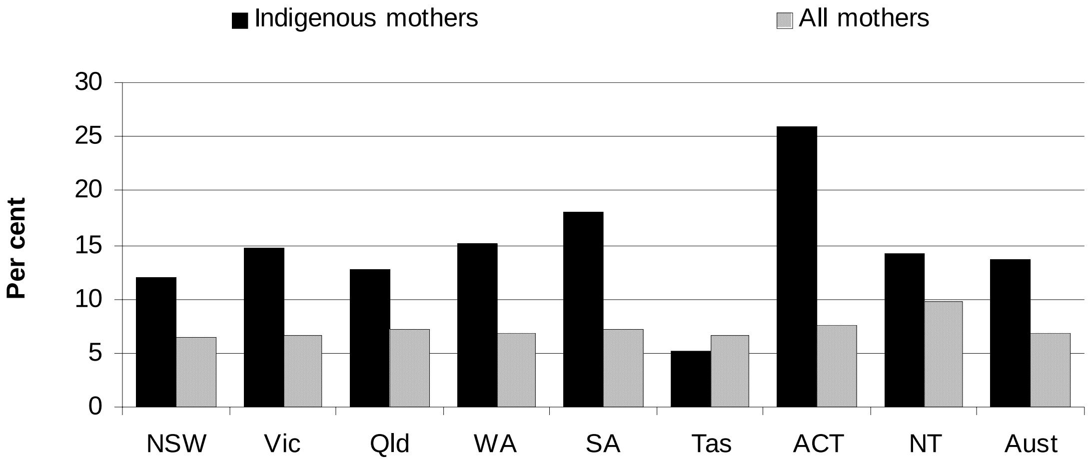
The median age at death is an alternative measure of longevity. This measure is less affected by underreporting of Indigenous deaths, although comparisons of the median age at death for Indigenous and non-Indigenous people are affected by the different age structures of these populations. In 2001, the median age at death was 75.5 years for males and 81.8 years for females for all Australians, and 52.0 years for males and 57.6 years for females for Indigenous Australians (table HPA.5). The median age at death for male Indigenous Australians was highest in NSW (56.3 years) and lowest in the NT (45.1 years). For female Indigenous Australians it was highest in Victoria (63.8 years) and lowest in the NT (52.8 years) (table HPA.5).

Birthweight of babies

The birthweights of babies born to all mothers and to Indigenous mothers are included as part of the Steering Committee’s focus on improving reporting on the Indigenous population. It is an important indicator 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 most recent data available for birthweights of babies are for 2000 (AIHW NPSU 2003). The mean birthweight of babies born to Indigenous mothers nationally was 3166 grams in 2000 (table HPA.6), compared with 3364 grams for babies born to all mothers (table HPA.7). The percentage of babies weighing less than 2500 grams born to Indigenous mothers nationally was 13.6 per cent in 2000, compared with 6.8 per cent for babies born to all mothers. For babies born to Indigenous mothers, the percentage ranged from 25.9 per cent in the ACT to 5.2 per cent in Tasmania; for babies born to all mothers, it ranged from 9.8 per cent in the NT to 6.4 per cent in NSW (figure HP.2). The data are only for babies born to Indigenous mothers and do not include babies with Indigenous fathers and non-Indigenous mothers.

Figure HP.2 **Proportion of babies with birthweights under 2500 grams, 2000[a, b]**



[a] Data are for babies born to Indigenous mothers only. Babies with Indigenous fathers and non-Indigenous mothers are not included. [b] The ACT data for births to Indigenous mothers may vary from year to year due to small numbers. In 2000, most of the low birth weight babies born to Indigenous mothers in the ACT were to women from NSW, so the proportion of such births does not reflect the health status of resident Indigenous mothers and their babies.

Source: AIHW NPSU (2003); tables HPA.6 and HPA.7.

Future directions

Improving reporting on Indigenous health is a common priority across all of the health chapters. Performance indicators for use of health services by Indigenous Australians were first published in the 2000 Report. Improvements have since been made where possible. During 2003, the Steering Committee developed a strategy for reporting on Indigenous health. Some elements of the strategy have been incorporated in the 2004 Report, such as the Indigenous health overview included in this preface. Other elements of the strategy that will be developed for future reports include:

- focussing on priority areas such as primary and community health, diabetes, substance use and mental health
- developing time series reporting
- investigating reporting on environmental health across the Review, with a view to addressing gaps in reporting within the health chapters
- considering the outcomes of the Australian Health Ministers' Advisory Council Standing Committee on Aboriginal and Torres Strait Islander Health review of national performance indicators for Aboriginal and Torres Strait Islander health, with a view to adopting new indicators for this Report

- continuing to report on expenditure on health services for Indigenous people, if possible by including AIHW data for 2001-02 in the 2005 Report.

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