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Number 12

**The health of
Aboriginal and Torres
Strait Islander people
in the ACT**

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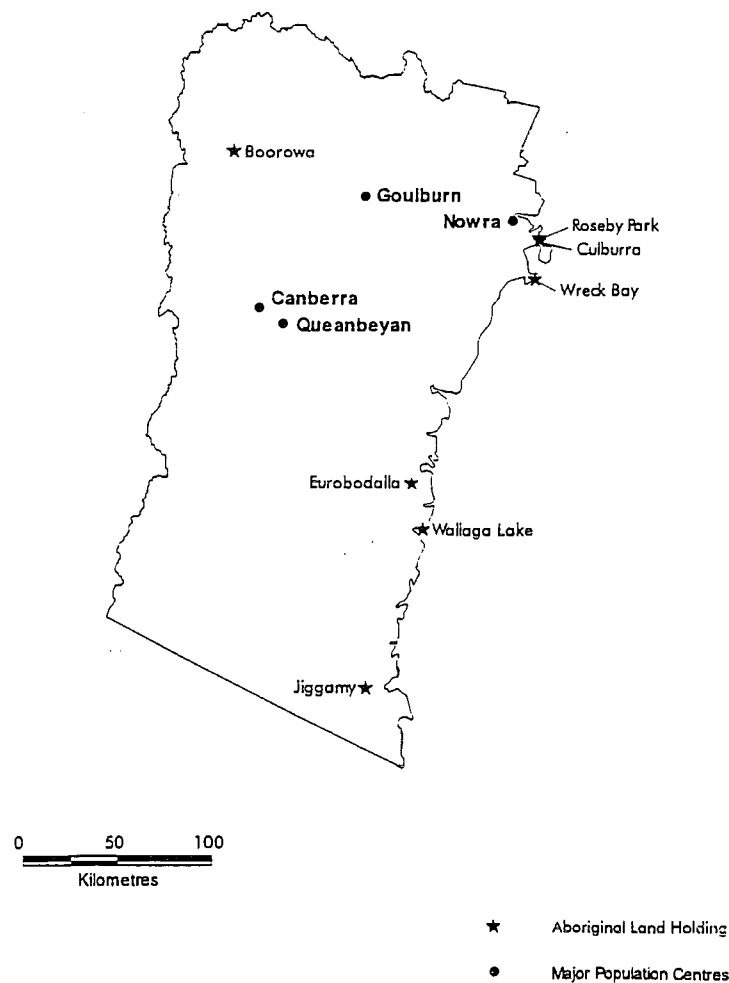
How Aboriginal and Torres Strait Islander people are identified

The ACT Department of Health and Community Care considers that identifying Aboriginal and Torres Strait Islander peoples within the health system is crucial for monitoring health status and service utilisation. It has adopted the 1993 National Health Data dictionary (Shadbolt: 1995; 57) definition of an Aboriginal or Torres Strait Islander person:

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated.'

In this report, the term Aborigines or Aboriginal should be taken to refer to both Aboriginal and Torres Strait Islander people of Australia.

Aboriginal and Torres Strait Islander Land Queanbeyan Region 1992



Source: Land Tenure Map, 1992. AUSLIG
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1. Introduction

The health of Aboriginal and Torres Strait Islander peoples is a major concern for all levels of government. The ACT Department of Health and Community Care recognises the fact that Aboriginal and Torres Strait Islander people have the worst health of all Australians and has responded by progressively implementing the recommendations of the Royal Commission into Aboriginal Deaths in Custody regarding data collection. During the 1996/97 financial year the Department will implement the framework Agreement on Aboriginal and Torres Strait Islander Health between the Australian Capital Territory and the Commonwealth Department of Health and Family Services, and the Aboriginal and Torres Strait Islander Commission. The agreement aims to improve the coordination and delivery of programs and services at all levels of ACT government, and to facilitate better health outcomes for Aboriginal and Torres Strait Islander peoples.

One of the objectives of the agreement is to increase the level of resources allocated to Aboriginal and Torres Strait Islander services, including those located within mainstream services, and to facilitate regular reporting of all services and programs. The Department is currently implementing the Agreement through the development of a 5-year strategic plan on Aboriginal and Torres Strait Islander health and the appointment of an Aboriginal health policy officer within the Department's Health Outcomes Policy and Planning Branch. Under the Agreement, the Commonwealth and Australian Capital Territory agree to develop in partnership with ATSIC Aboriginal and Torres Strait Islander community services contracts which are outcome oriented which include the evaluation of services to be implemented, including mechanisms to simplify reporting processes.

The Department has agreed that in partnership with the Commonwealth and the Winnunga Nimmityjah Health Service it will establish culturally sensitive and ethical privacy and confidentiality protocols in line with the Privacy Act, for the routine collection of standardised data on Aboriginal and Torres Strait Islander health. These protocols will recognise Aboriginal and Torres Strait Islander ownership regarding the use of the data. Of particular relevance is the understanding that the Commonwealth and the Australian Capital Territory in partnership with ATSIC, National Aboriginal Community Controlled Health Organisation and the Winnunga Nimmityjah Health Service will work towards improving the quality of relevant data available. The participating bodies have agreed to develop appropriate health outcome indicators and to report regularly on a six monthly basis.

The purpose of this publication is to draw together available data to give as detailed an analysis as possible on the profile of Aboriginal and Torres Strait Islander people in the Australian Capital Territory and its surrounding region. This will provide planners and interested bodies with information on which to base priorities for interventions to improve both current and future services.

2. Data issues

The following summary of Aboriginal vital statistics data collected in the Australian Capital Territory was presented to a recent workshop convened to improve Indigenous identification in administrative data collections. The workshop was organised by the National Centre for Aboriginal and Torres Strait Islander Statistics of the Australian Bureau of Statistics, and was held in the Queensland office of the ABS during November 1996. The initiative was part of the ongoing work plan of the Aboriginal and Torres Strait Islander Health and Welfare Information Unit - a joint project between the Australian Bureau of Statistics and the Australian Institute of Health and Welfare (ABS/AIHW: 1996; v).

Hospital admission data

There is a question on the admission forms of the major hospitals in the ACT asking whether a person is of Aboriginal or Torres Strait Islander descent or not. Admission forms are normally sent to the patient at home for completion, thus allowing the patient to identify as an Aboriginal or Torres Strait Islander person if they wish to. However, problems seem to arise when patients are admitted through the Emergency Department - although there is provision for identification of Aboriginal and Torres Strait Islander persons hospital personnel tend not to ask the question because in the past some people have found the question offensive. If not answered the system defaults to no. However, this problem is not unique to Aboriginal data collections. The Australian Bureau of Statistics encounter these sorts of problems all the time with their surveys, and they do have mechanisms for getting around the problems of asking sensitive questions. Indirect methods can be used such as showing the respondent a card with the question on rather than directly asking the question. These sorts of techniques now need to be incorporated into Aboriginal data collection methodology to improve the quality of the data.

In an attempt to validate the Aboriginal field within the ACT morbidity file a cross tabulation was computed. We selected Aboriginal patients who had inpatient episodes during two consecutive years, and although the numbers were small the results were interesting. In 1993/94 260 persons identified as Aboriginal and in 1994/95 313 persons identified. A subset of those persons who had episodes in both years were selected, and the results showed that of the 52 persons from the first year who identified as Aboriginal persons only 39 identified in the second year, and 10 out of the 49 persons in the second year had not identified in the previous year. This small exercise highlights the problem of self identification which is likely to be an ongoing problem in data collection.

Aboriginality is also included in mental health data collections on The Canberra Hospital admission forms and on immunisation forms. Mental health services record the occasions of service of Aboriginal people using mental health services.

Birth and death registrations

Aboriginal persons are identified on both birth and death registration forms in the Australian Capital Territory. The racial origin of the mother and father is asked of the person filling in birth registration, and the family of the deceased are asked the racial origin of the deceased. Births, Deaths and Marriages spokesperson commented that this field often was not completed, and as in most other systems if the field is not completed the system defaults to no.

Perinatal and maternal collections

There is a field on the midwives collection form for the self-identification of the mother as being of Aboriginal or non-Aboriginal descent.

Cancer notification

At present there is a question on the notification form which asks if the patient is Aborigine/TSI with a tick box for yes/no. The ACT cancer notifications are processed by the NSW Cancer Council and the data manager there maintains that the quality of the data is very poor. This is mainly because the information on these forms is derived from the hospital admission forms, and if the information is not actively collected at admission then the information does not flow on. Because the quality of the data is known to be poor this has a flow on effect that the update of this field is not actively pursued, thus compounding the problem. The NSW Cancer Council are currently designing a new form which will incorporate the directive from the NSW Department of Health that from the 1 July 1996 forms should have the following on their notification forms 1. Aborigine; 2. Torres Strait Islander; 3. Both; 4. Neither Aboriginal or Torres Strait Islander. This will be incorporated on ACT notifications on the next print run. Women attending the ACT Breast Screening clinic are asked whether they are Aboriginal or Torres Strait Islander.

Recommendations for improving data collection

The ACT Department of Health and Community Care's obligations

- The Department has agreed to work toward culturally sensitive and ethical privacy and confidentiality protocols in the routine collection of standardised data on Aboriginal and Torres Strait Islander health. This is being undertaken in partnership with the Commonwealth Department of Health and Family Services and Winnunga Nimmityjah Aboriginal Medical Service.
- The Department along with the Commonwealth is working towards improving the quality of relevant data available in partnership with the Aboriginal and Torres Strait Islander Commission, National Aboriginal Community Controlled Health Organisation and Winnunga Nimmityjah Aboriginal Medical Service.

- The Department is committed to progressively implementing the recommendations of the Royal Commission into Aboriginal Deaths in Custody regarding data collection.

What to aim toward

- The Australian Bureau of Statistics considers that data is only useful when information is 90 per cent complete. In relation to statistics identifying Aboriginal and Torres Strait Islander origin, it would seem reasonable for the Department to have in place mechanisms that enable a 90 per cent completion rate of all Aboriginal identifiers to be in place.

Areas currently looking at data collection

- A new data collection form is being developed by the NSW Cancer Council which will be designed to improve the identification of Aboriginality. This form will be incorporated on the ACT notifications on the next print run.
- The National Centre for Aboriginal and Torres Strait Islander Statistics within the Australian Bureau of Statistics is currently examining the question of Aboriginal identifiers in data collections.

Specific recommendations for improving data collection within the ACT Department of Health and Community Care

1. Specific target areas within the Department include:
 - Accident and Emergency
 - Communicable Diseases (eg Pathology)
 - Immunisation Records
 - Mental Health Services
 - Perinatal.
2. Implement more sensitive data collection practices within all data collection areas of the Department. This may involve employing methods such as showing the respondent a card with the question on rather than directly asking the question.
3. Encourage employees in the Department to update data collections if Aboriginality becomes known after initial data collection has been taken.
4. Make provisions for identifying the status of Aboriginal fathers for perinatal data.
5. Make resources available to monitor quantifying the percentage of completion of the Aboriginality identifier. This should be undertaken for all data collections so that progress toward the goal of 90 per cent completion of this identifier is readily known.
6. Actively seek updated information from other data collection areas such as the Australian Bureau of Statistics on the best practice for identifying the Aboriginality of people in statistical data collections.

Major data sources used in this report

The National Aboriginal and Torres Strait Islander Survey 1994

The National Aboriginal and Torres Strait Islander Survey was conducted in 1994 as part of the Government's response to the Royal Commission into Aboriginal Deaths in custody. The Royal Commission was concerned at the lack of statistical information about the Aboriginal and Torres Strait Islander populations, and in its response recommended that a survey be conducted to provide better information. In April 1992 the development of the survey commenced with stakeholders advice sought on the information to be collected and how it should be collected. To ensure the survey's success approximately 90 Aboriginal and Torres Strait Islander people were recruited to interview more than 15,700 Aboriginal and Torres Strait Islander people selected throughout Australia. The Survey was designed to ensure the sample was nationally representative of Aboriginal and Torres Strait Islander people living in different circumstances. This also included a prison sample that enabled prisoners to be included in statistics for ATSIC regions (ABS: 1995c; 4190.0). An Australian Summary and Regional Overview was produced for each of the 35 ATSIC Regions and the Torres Strait areas. This publication draws heavily on the Queanbeyan ATSIC region data, as well as the national findings for statistical information (ABS: 1995c; 4190.0). The ACT is part of the Queanbeyan ATSIC region which covers 57,600 square kilometres around South-Eastern NSW, bounded by the Sydney region to the North, Wagga Wagga to the West and Wangaratta to the South.

Census of Population and Housing

National data collected by the Australian Bureau of Statistics in the Census of Population and Housing are the major source of estimates of the Aboriginal population over time. The twelfth national Census of Population and Housing was taken on 6 August 1991 and provides detailed information about the population for small geographic areas and small population groups such as Aboriginal and Torres Strait Islander persons. Although Aboriginal people have been counted in each census since 1911, it was not until the first census following the 1967 referendum (which repealed section 127 of the Constitution) that they were included in official publications relating to the Australian population (ABS: 1993c; 2740.0; 10). First counts from the 1996 Census of Population and Housing are expected to be released by the Bureau of Statistics from July of this year onwards.

National Health Survey

The 1995 National Health Survey (NHS) is the second in a series of 5-yearly surveys conducted by the Australian Bureau of Statistics which collects information on the health of Australians. The aim of the survey is 'to obtain information about the health status of Australians, their use of health services and facilities and about health related aspects of their lifestyle such as smoking, alcohol consumption and exercise' (ABS: 1995d; 4363.0; 17). The survey was conducted by the Australian Bureau of Statistics between January 1995 and January 1996.

3. Performance indicators

A national set of Performance Indicators and Targets for Aboriginal Health has been developed in conjunction with State and Territory governments, the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Commonwealth Government. These indicators were agreed to by the Australian Health Ministers Advisory Council (AHMAC) in February 1997, and a small technical group has been convened to refine the indicators in time for reporting for the next AHMAC meeting later in 1997.

The National Health Priority Areas for the general population are cancer, injury, cardiovascular disease, mental health, and diabetes. Additional priorities have been identified for Aboriginal persons and include: otitis media (hearing); sexual health; mental health including substance misuse; and respiratory diseases.

To facilitate service delivery the indicators have been arranged in the following categories: health outcomes, access to health services, service outputs, workforce issues, risk factors and intersectoral issues. The following is a brief explanation of these categories:

Health outcomes

Health status performance indicators include self identification, hospitalisation, morbidity and mortality, longevity, infants and children, chronic and communicable disease and well-being (which includes mental health and notifiable diseases such as HIV).

Access to primary health care service

The indicators in this section cover a number of the factors which contribute to (or inhibit) access. They include the travel time required to reach health services, the extent of community control and involvement, and governments' per capita expenditure on health services.

Health service impacts

These indicators relate to immunisation and screening rates, health promotion activities and hospital activity. There are also indicators for the small number of conditions that show consistently high mortality and morbidity rates, which include cardiovascular diseases, diabetes, respiratory diseases and cervical cancer.

Workforce and education development

These indicators flag access to training for Aboriginal people and the existence of employment and education initiatives across the full range of health related occupations

and professions. In addition, there are indicators to monitor cultural awareness training, the existence of identified positions and the availability of staff to work in Aboriginal primary health care.

Risk factors

The indicators in this section relate to the prevalence of smoking, obesity, sunscreen protection and dangerous alcohol and other substance misuse.

Intersectoral issues

These indicators include housing poverty and the level of functional housing. Hospital morbidity data is used to flag inadequacies at a whole of system level - including health services and environmental health infrastructure.

Community involvement

This indicator flags community involvement by indicating the establishment of forums that represent the Aboriginal community health sector and ATSIC in each state and territory and the implementation of regional planning strategies.

Quality of service provision

This indicator flags the implementation of mechanisms for critical incidence reporting and complaints reporting in all levels of health services.

4. Winnunga Nimmityjah Aboriginal Health Clinic

Winnunga Nimmityjah Aboriginal Health Clinic is located in the ACT. The idea for its establishment was conceived by Aborigines during the opening of the new Parliament House in May 1988. For the first two years the Clinic operated part-time out of temporary accommodation. The present premises for the Health Centre are at the Griffin Centre, and were officially opened on 1 November 1990. The administration is housed separately, and the management board draws its members from the local Aboriginal community. The Service is funded by the ACT Government to provide primary health care, including access to pharmaceutical and specialist services, community liaison, and access to mental health, and alcohol and drug services. Winnunga Nimmityjah is more than a medical service. People are encouraged to use the centre for related health issues, such as personal hygiene, and to exchange ideas on community issues of concern.

5. Demographics

The Aboriginal population in the ACT increased substantially from 824 persons in 1976 to 1,590 in 1991 (Figure 5.1). This increase occurred mainly in the 0-14 and 15-59 age groups for both males and females (Figures 5.2 and 5.3). The rise in the working age population can in part be attributed to the establishment of the Office of Aboriginal Affairs in the late 1960s, the Department of Aboriginal Affairs in the 1970s and more recently the Aboriginal and Torres Strait Islander Commission in the early 1990s, resulting in 43 per cent of Aboriginal persons in the ACT employed in Public administration and defence industries (ABS: 1996a; 2722.8). The number of males and females in the older age groups remained low throughout the period.

The overall increase in the Aboriginal population of the ACT, however, is not solely due to natural increase or interstate immigration. As in the rest of Australia there has been a greater inclination in recent years for persons of Aboriginal or Torres Strait Islander descent to identify as such. In addition, there have been general improvements in census counting procedures and enumeration, including an awareness campaign directed towards Aboriginal persons in 1991 and special field enumeration practices.

At the 1991 census there were 289,038 persons in the ACT, of these 1,590 (0.6 per cent) persons were of Aboriginal or Torres Strait Islander origin. The age structure of these two populations is quite different (Figure 5.4). The Aboriginal population has a relatively young profile, for example, more than 38 per cent of Aboriginal persons were aged less than 15 years compared to 23 per cent of the total ACT population. This pattern was evident for all age groups under 30 years of age. Equally noteworthy is the paucity of Aboriginal persons in the older age groups. For example, there were less than three per cent of Aboriginal persons aged older than 55 years compared to more than 12 per cent in the total ACT population.

The National Aboriginal and Torres Strait Islander Survey (NATSIS) conducted in 1994 estimated the total Australian Aboriginal population to be 303,260, and of these 5,770 lived in the Queanbeyan region. Although the NATSI Survey covers a greater geographical area than the ACT the findings have been included to expand on the relatively few sources of information available about Aboriginal persons in the ACT and its regions. In addition, the NATSI survey is in part comparable with the National Health Survey, thus allowing comparisons to be made between the health of Aboriginal and non-Aboriginal persons. Figure 5.5 compares the Aboriginal population of the ACT with the total Aboriginal population of Australia. Both populations reflect a young age structure and are similar in composition.

Figure 5.1: Aborigines in the ACT by sex, 1976 to 1991

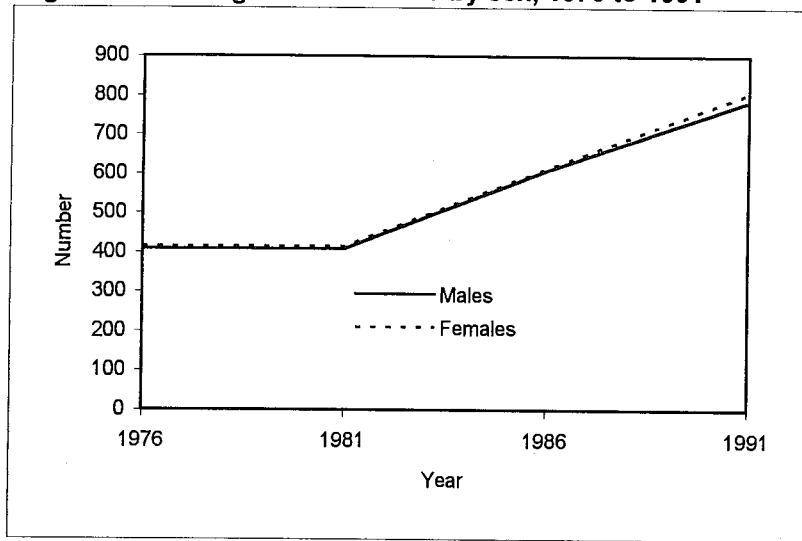


Figure 5.2: Aboriginal males in the ACT, 1976 to 1991

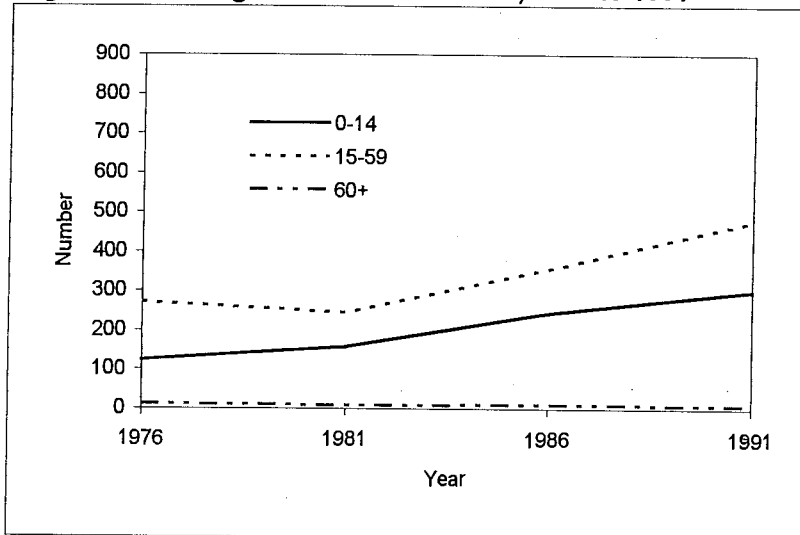
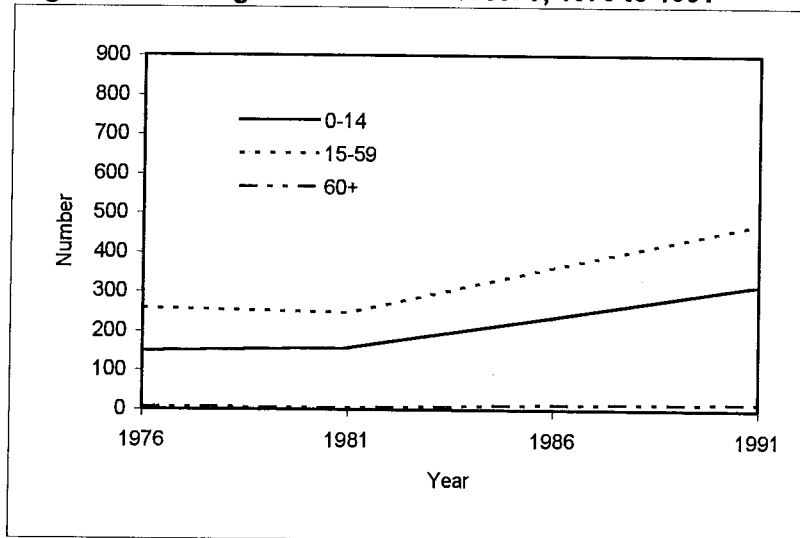
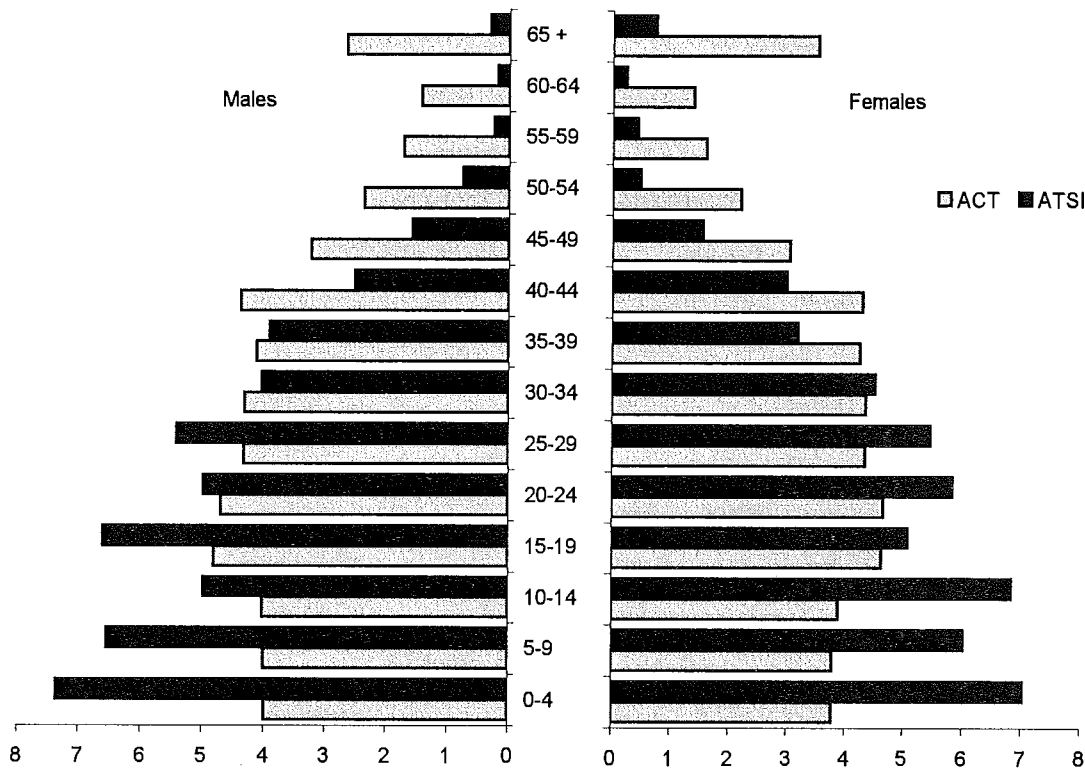


Figure 5.3: Aboriginal females in the ACT, 1976 to 1991



Source: Census of Population and Housing 1976, 1981, 1986 and 1991

Figure 5.4: Estimated age distribution of the ACT Aboriginal and total ACT populations, 1991



Percentage of population

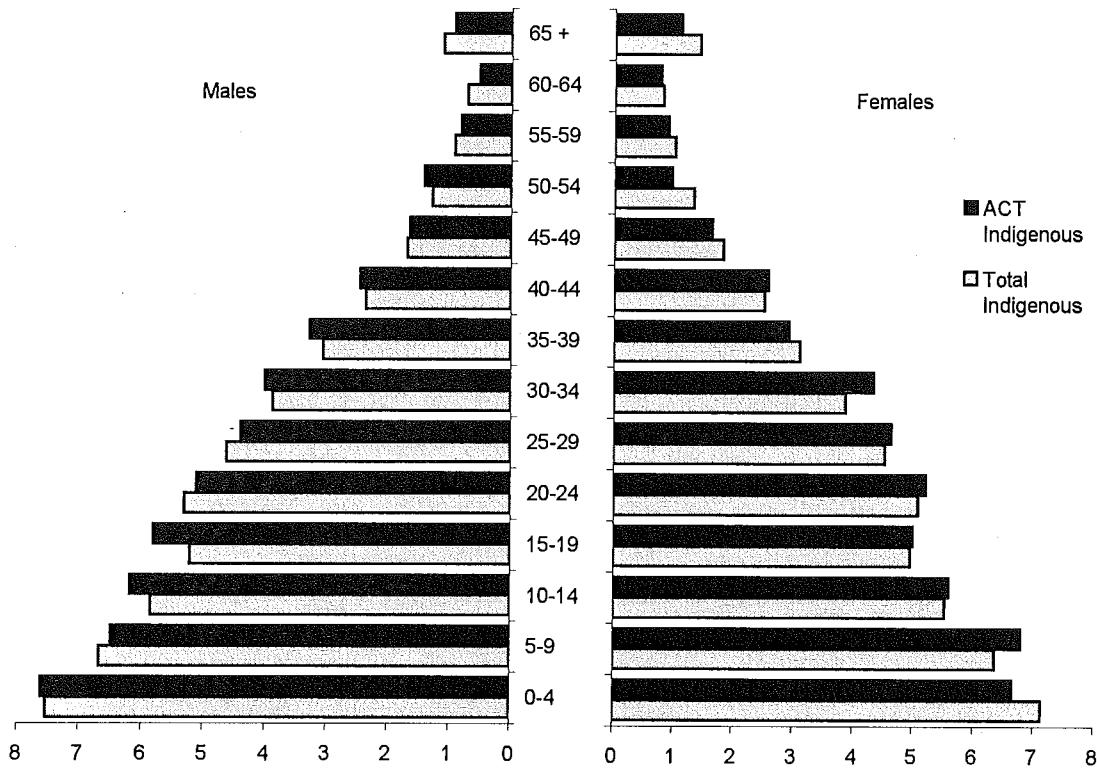
Source: ABS, 1991 Demography Australian Capital Territory, Cat No.3311.8

ABS, 1991 Census of Population and Housing, Aboriginal Community Profile, Cat No. 2722.8

Table 5.1: Aboriginal and ACT populations, 1991

	Males		Females		Males		Females	
	Total %	Indigenous %	Total %	Indigenous %	Total pop	Indigenous pop	Total pop	Indigenous pop
0-4	4	7	4	7	11502	117	10977	112
5-9	4	7	4	6	11557	104	10997	96
10-14	4	5	4	7	11614	79	11270	109
15-19	5	7	5	5	13885	105	13414	81
20-24	5	5	5	6	13566	79	13507	93
25-29	4	5	4	5	12485	86	12598	87
30-34	4	4	4	5	12440	64	12635	72
35-39	4	4	4	3	11883	62	12349	51
40-44	4	3	4	3	12636	40	12483	48
45-49	3	2	3	2	9327	25	8878	25
50-54	2	1	2	1	6848	12	6415	8
55-59	2	0	2	0	4974	4	4688	7
60-64	1	0	1	0	4138	3	4062	4
65 +	3	0	4	1	7680	5	10230	12
Total	50	49	50	51	144535	785	144503	805

Figure 5.5: Estimated age distribution of total Aboriginal population and the Queanbeyan Indigenous population, 1994



Percentage of population

Source: ABS, National Aboriginal and Torres Strait Islander Survey 1994, Cat No.4190.0

ABS, 1991 Census of Population and Housing, Aboriginal Community Profile, Cat No. 2722.8

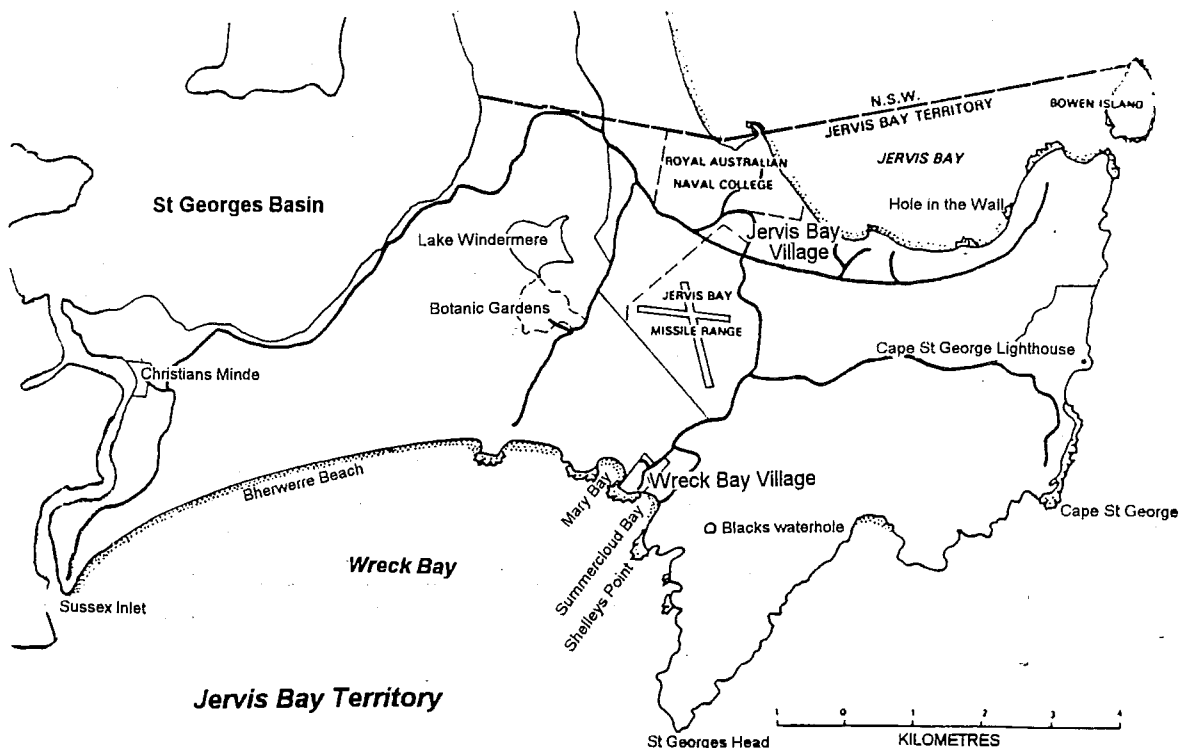
Table 5.2: Queanbeyan ATSI region and total Aboriginal Australia, 1994

	Males		Females		Males		Females	
	Queanbeyan %	Total %	Queanbeyan %	Total %	Queanbeyan pop	Total pop	Queanbeyan pop	Total pop
0-4	8	8	7	7	22844	439	21680	385
5-9	7	6	6	7	20229	374	19317	393
10-14	6	6	6	6	17755	357	16796	323
15-19	5	6	5	5	15826	335	15078	289
20-24	5	5	5	5	16103	295	15448	301
25-29	5	4	5	5	14038	254	13793	268
30-34	4	4	4	4	11777	231	11805	251
35-39	3	3	3	3	9268	189	9472	170
40-44	2	2	3	3	7171	142	7683	150
45-49	2	2	2	2	5135	95	5604	96
50-54	1	1	1	1	3900	82	4113	57
55-59	1	1	1	1	2797	47	3132	53
60-64	1	1	1	1	2185	30	2545	46
65 +	1	1	1	1	3378	53	4388	65
Total	50	51	50	49	152406	2923	150854	2847

Jervis Bay

The 1991 Census of Population and Housing enumerated a total of 753 people living at Jervis Bay, and a little over a quarter (179 people) of these people were Aboriginal (ABS: 1997b; 2722.8). However, the Community Housing Infrastructure Needs Survey estimated that there were 240 Aboriginal people living at Wreck Bay (ABS: 1997a; 4196.0.001). Persons at Jervis Bay accounted for about 14 per cent of the total Aboriginal population of the ACT (Hugo: 1991; 30). Data shows that although the numbers of Aboriginal people are increasing overall, the percentage of Aboriginal people who live in Wreck Bay are decreasing relative to those who live in the urban area of the ACT (Hugo: 1991; 30). In this report the residents of Jervis Bay are included in ACT data. The ACT Government funds a community nurse who services the Jervis Bay area. The community nurse is based at the Child Health Clinic which is funded by the Commonwealth Government and administered by NSW Health. In addition, the ACT Department of Health and Community Care provide a range of environmental and health surveillance services to the Jervis Bay community.

Most of the Aboriginal people in Jervis Bay live in the Aboriginal community at Wreck Bay, and access general community generic health services provided by the NSW Department of Health. Facilities include a childcare centre which is managed by Aboriginal people and accepts both Aboriginal and non-Aboriginal children. Aboriginal people at Wreck Bay largely live off their fishing businesses as well as employment by the local council and community organisations. In 1994, the Wreck Bay Aboriginal Community became legal owners of the Jervis Bay National Park and subsequently leased the land back to the Federal Government to be used as a National Park. The Federal Government pays a lease to the community and also a commission on park entry fees. The land owned by the community is 6,300 ha in area (SMH: 29/10/94; 13).



6. Social indicators

Education

The link between educational achievements, employment and income are well documented. Existing data shows that the higher a person's educational achievement, the more likely they are to be in employment and the more highly paid that job is likely to be (Miller: 1989, Daly: 1992). In addition, studies have shown that improving educational status improves health status independently of income (Macklin: 1992; 1; 14). Other consequences of lower educational participation rates have been documented in the Royal Commission into Aboriginal Deaths in Custody which states that:

'Low self esteem, diminished educational opportunities, and a consequential lack of employment prospects, are significant factors in the disproportionately high rate of Aboriginal imprisonment' (Johnston: 1991; Vol 2; 369).

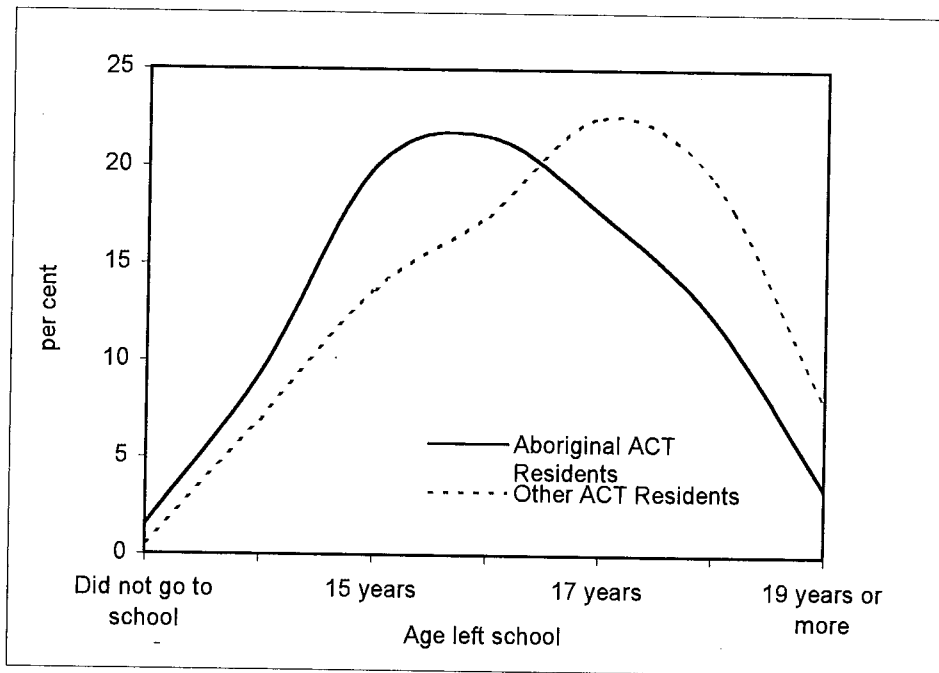
The Aboriginal people in the ACT have the highest education rates of all Aboriginal people in Australia, but still have less formal education and tend to leave school at a younger age than their non-Aboriginal ACT counterparts (see Figure 6.1). However, Aboriginal people in the ACT tend to stay on at school longer than do the total population of Australia. For instance, 9 per cent of Aboriginal people in the ACT stated that they left school before the age of 15 (ABS: 1996a; 2722.8; 2) compared to 7 per cent of all ACT residents (ABS: 1993b; 2722.8; 6) and 15 per cent of all Australian residents (see Figure 6.2) (ABS; 1993c; 2740.0; 12).

Aboriginal people in the ACT are also more likely to have never gone to school (1.5 per cent of people 15 years and over) compared with other ACT residents (0.5 per cent) and all Australian residents (0.9 per cent) (ABS; 1993c; 2740.0; 12, ABS: 1993b; 2722.8; 6, ABS: 1996a; 2722.8). For Aboriginal people across Australia, the percentage who have never attended school is decreasing while the percentage of non-Aboriginal people never having attended school remains largely the same (Daly: 1993; 22). This indicates that the gap between the rate of Aboriginal people and non-Aboriginal people never attending school is closing.

In general, Aboriginal students have lower literacy and numeracy rates and higher truancy rates than other students (Daly: 1993; 4). Apart from the higher truancy rates being a causal factor in lower literacy and numeracy rates among Aboriginal students, some other reasons could be lack of a quiet study area due to overcrowding in the family home and a higher rate of hearing problems among Aboriginal students (National Board of Employment, Education and Training: 1995; 57-9).

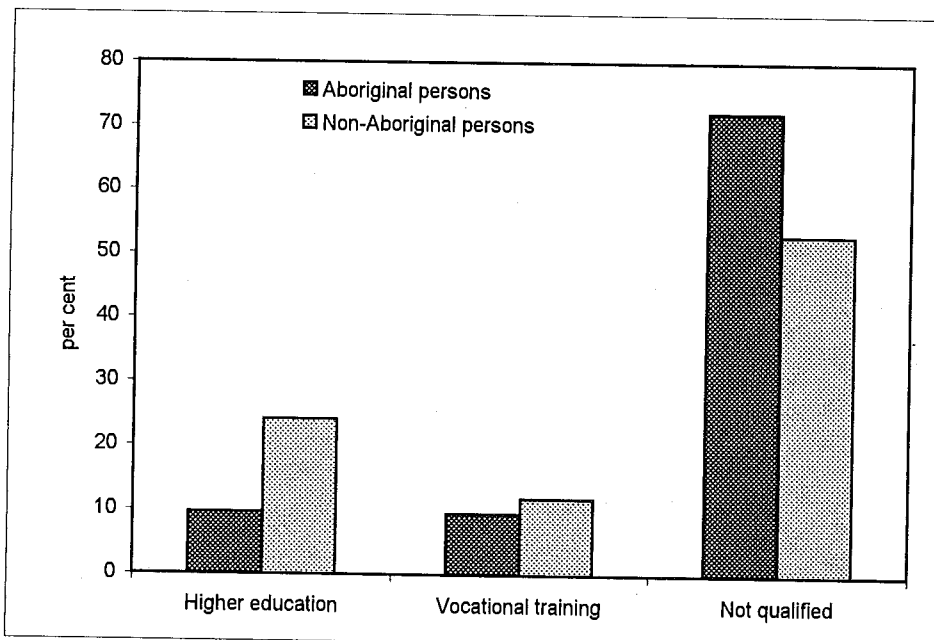
The National Aboriginal and Torres Strait Islander Survey showed that for Aboriginal people in the Queanbeyan ATSIC region aged 15 years and over who had left school, only 8 per cent were undertaking study for a qualification. Of those who were not

Figure 6.1: Age left school of ACT Aboriginal and non-Aboriginal persons



Source: 1991 Census of Population and Housing, Cat. No. 2722.8

Figure 6.2: Highest qualification attained by ACT Aboriginal and non-Aboriginal persons



Source: 1991 Census of Population and Housing, Cat. No. 2722.8

studying, 84 per cent felt they would have difficulty undertaking further study. The main barriers cited were financial, transport or travel, childcare and lack of prerequisites (ABS: 1996c; 4196.0.00.001; 40).

Over recent years, there has been a general trend of increasing participation of Aboriginal people (especially young people) in educational institutions. The bulk of this increase occurred in universities. It is interesting to note that among the 20-24 year olds, the growth in Aboriginal men's attendance at educational institutions occurred mainly in TAFE colleges whereas Aboriginal women attended universities in larger numbers than the men (Daly: 1993; 24). Although there was an increase in participation for Aboriginal people, there was an even greater growth for non-Aboriginal people (Daly: 1993; 22), resulting in a widening gap between highest educational achievement of Aboriginal people and non-Aboriginal people.

Employment status

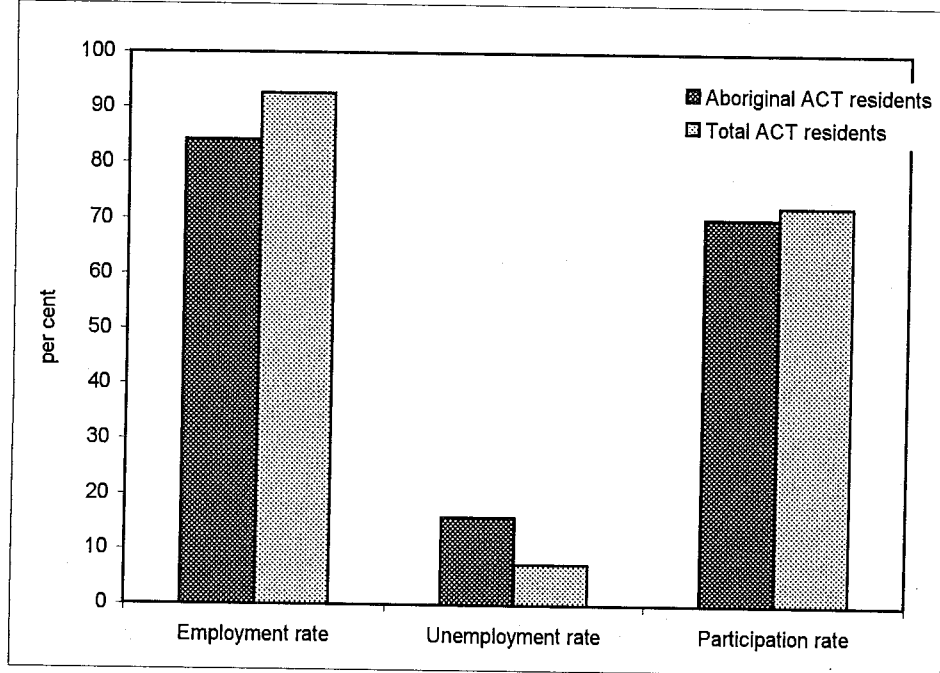
Studies have shown that there is an association between unemployment and health, people who are unemployed or who are poorly paid are at a greater risk of sickness, mental illness and premature death and are more frequent users of medical services (Abraham et al: 1995; 70). The higher frequency of use of health services by low income earners can be explained by the fact that they are sicker than higher income earners (Macklin: 1992; 1; 12-3).

Much of the poor health of Aboriginal people in Australia can be explained by their low income status. Aboriginal people compared to other Australians are disproportionately unemployed and are over-represented in more unskilled and low paying jobs (Taylor: 1992; 1). In 1991, 16 per cent of the Aboriginal workforce in the ACT was unemployed compared with 7 per cent of other ACT residents (see Figure 6.3). It is interesting to note however, that non-Aboriginal people are employed part-time (17 per cent) at a higher rate than Aboriginal people (12 per cent). Aboriginal people in the ACT have very similar participation rates in the work force (70 per cent) when compared to other people in the ACT (72 per cent).

When comparing Aboriginal people in the ACT to other Australians (see Figure 6.3) it can be seen that although Aboriginal people in the ACT have higher unemployment rates than non-Aboriginal Australians (11 per cent), they also have a higher participation rate in the labour force. (Participation rate for all Australians is 63 per cent and for Aboriginal people in the ACT it is 70 per cent.) Aboriginal Australians also have much lower participation rates in the work force at 54 per cent when compared to Aboriginal people in the ACT. Aboriginal people in the ACT have lower unemployment rates than other Aboriginal people for whom unemployment was 31 per cent in 1991.

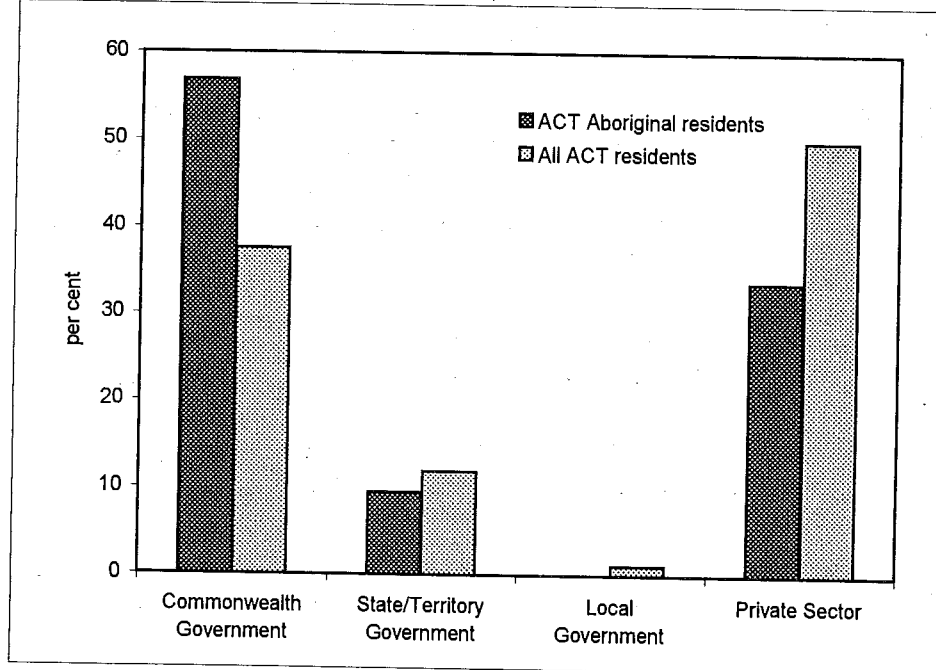
In the general population, young people are disproportionately represented in the unemployment category and this is even more evident among Aboriginal youth whose unemployment rate is even higher than for other young people (Miller: 1989). However, between 1986 and 1991, the unemployment rate of Aboriginal young people decreased while it increased for other youth (Daly: 1993; 25).

Figure 6.3: A comparison of labour force status of ACT Aboriginal and non-Aboriginal persons, 1991



Source: 1991 Census of Population and Housing, Cat. No. 2722.8

Figure 6.4: Type of employer of ACT Aboriginal and non-Aboriginal persons, 1991



Source: 1991 Census of Population and Housing, Cat. No. 2722.8

Aboriginal workers in the ACT are more likely to be unemployed and employed in lower paid work than other ACT workers which is similar to the national pattern. Twenty eight percent of the Aboriginal workforce in the ACT are employed as clerks. By contrast, the largest proportion of the total ACT workforce are employed as professionals. This pattern is different for Aboriginal people nationally, for example, in 1986, labourers and other related workers was the major employment category for Aboriginal people followed by clerks while other Australians were mainly employed as tradespersons followed by clerks (Taylor: 1992; 5). This reflects the impact of the public sector on the ACT.

There may be a number of factors other than Aboriginality that would determine the lower level at which Aboriginal people are employed. These factors include educational achievement, age, marital status, gender and number of children. However, a study comparing Aborigines and other Australians (Daly: 1991) shows that even taking these factors into consideration, Aboriginal people are still employed less and are in lower paid work than other Australians (Daly: 1991; 16).

State and Commonwealth Governments across Australia are relatively high employers of Aboriginal people compared with the private sector. For example, 66 per cent of employed Aboriginal people in the ACT have jobs in either State or Commonwealth government compared to 51 per cent of all people in the ACT. For the whole of Australia, 38 per cent of employed Aboriginal people are employed by a Government compared to 24 per cent of all employed Australians (see Figure 6.4).

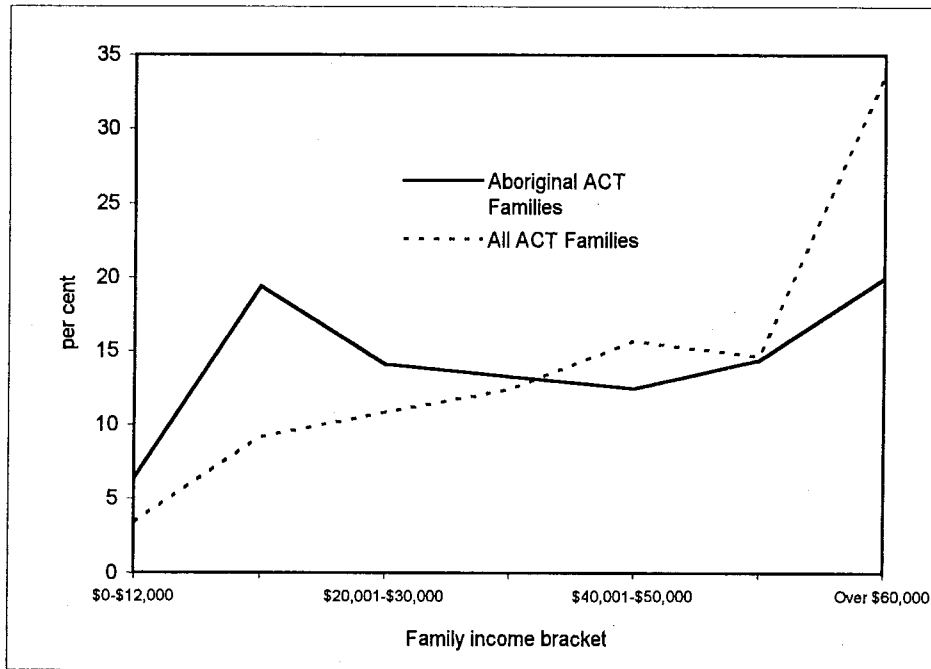
The fact that the ACT has a higher percentage of public sector jobs may account for the relatively high employment rate of Aboriginal people in the ACT when compared to other Aboriginal people. The location of the central office of the Aboriginal and Torres Strait Islander Commission (ATSIC) in Canberra accounts for a high proportion of Aboriginal employment in the public sector.

Economic status

As discussed above, people of low socioeconomic status are high users of primary and secondary health services such as hospitals, doctors and outpatient clinics but are low utilisers of preventative health services (Macklin: 1992; 1; 80-2). There is also a higher prevalence of risk factors such as obesity, inactivity, smoking, and excessive alcohol consumption among people of low socioeconomic status (Macklin: 1992; 81). Mortality rates for low income earners are higher for nearly every cause of death than for high income earners (Macklin: 1992; 80-4). The difference in economic status of Aboriginal people and non-Aboriginal people can largely be explained by the higher unemployment rates of the former and their representation in low skilled employment. The higher rates of single parent families may also contribute to the lower income status of Aboriginal people.

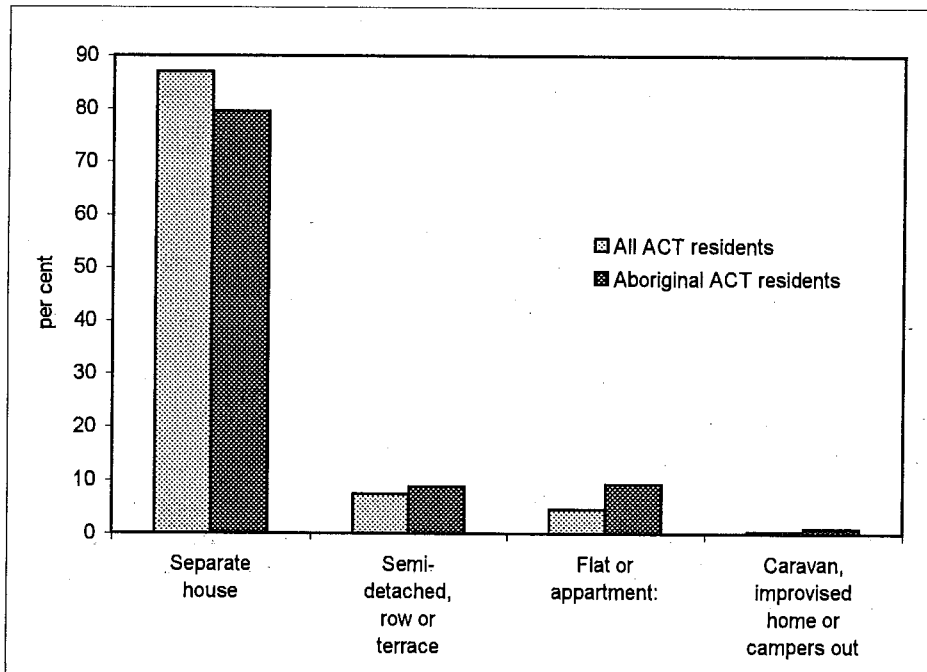
Aboriginal people in the ACT are disproportionately represented as lower income earners when compared to other ACT families. Approximately 26 per cent of Aboriginal families in the ACT earn less than \$20,000 compared to 13 per cent of other ACT families (see Figure 6.5). This rate is similar to that of all Australian families at 26 per cent, however it must be noted, that Aboriginal families in the ACT

Figure 6.5: Annual family income of ACT Aboriginal and non-Aboriginal persons, 1991



Source: 1991 Census of Population and Housing, Cat. No.2722.8

Figure 6.6: Persons in occupied private dwellings by structure of dwelling, by ACT Aboriginal and non-Aboriginal persons



Source: 1991 Census of Population and Housing, Cat. No.2722.8

are larger than the Australian average and hence their family income must provide for more people (Daly & Hawke: 1992; 1). In comparison, Aboriginal families nationally have the largest proportion of families earning \$20,000 or less (37 per cent).

Closer examination of census data shows some interesting gender differences. Daly and Hawke (1992; 1) showed that between 1976 and 1991, while the median annual income for Aboriginal women was rising both in real terms and in comparison to their non-Aboriginal counterparts, Aboriginal men's real median income was falling and was also falling in comparison to all men in Australia (Daly & Hawke: 1992; 1). In 1986, employed Aboriginal males had an average income that was 71 per cent of that of employed non-Aboriginal men and employed Aboriginal women's income was 89 per cent of the income of their non-Aboriginal counterparts (Daly: 1992; 1).

The 1991 Census shows that single parent families have a lower income than two parent families. Aboriginal families have a higher proportion of single parent families than non-Aboriginal families. Approximately 8 per cent of families in Australia are headed by one parent (usually a female). By contrast, for Aboriginal families Australia wide, approximately 23 per cent are headed by a single parent. In the ACT, figures are similar with around 11 per cent of families being single parent families and about 21 per cent of Aboriginal families being headed by single parents in the ACT (ABS & AIHW: 1997; 4704.0; 9).

In conclusion, Aboriginal families in the ACT have a lower income than all ACT families and a higher income status than Aboriginal families Australia wide. It is interesting to note that while Aboriginal women's median income is rising, Aboriginal men's income is declining. However, the median incomes of both Aboriginal men and women are still below that of other Australian men and women. Some of the reasons why Aboriginal incomes are below that of other Australians is their higher unemployment rate and their greater employment in low-skill jobs, and families are also more likely to be headed by single parents than other Australian families.

Housing

The standard of a person's dwelling is often a direct result of their economic status. However, there is no agreed definition of what constitutes appropriate housing as this often depends upon cultural differences and family circumstances. As well as the actual dwelling a person lives in, there are other factors that determine the quality of the housing. These include adequate insulation, ventilation and heating, water and sewerage, and food preparation and storage facilities.

The standard of a person's housing and their health status are linked. An absence of adequate housing and facilities may be associated with a number of infectious and parasitic diseases and other illnesses. Such disorders can become long term more serious problems such as rheumatic heart disease, hearing loss and liver cancer. Overcrowded conditions can promote cross-infection (ABS & AIHW: 1997; 4704.0; 11-13). A study of Aboriginal children's hospital admission rates showed those areas with better housing conditions had lower admission rates (Munoz et al: 1992).

Although Aboriginal people living in the ACT have a smaller average household size than the total Aboriginal population, the size is larger than for all Australian households and ACT households. The average Aboriginal household size in the ACT is 4 people compared with 3 people for the total ACT population (ABS: 1993c; 2740.0; 8). The average national Aboriginal household size is 5 people and for all Australian households it is 3 people. Jones (1994), using his criteria for housing need, estimated that between 29 and 87 extra bedrooms per 1,000 were needed in Aboriginal households in the Queanbeyan ATSI region in order to fulfil housing need. The national average of Aboriginal housing need was 133 bedrooms per 1,000 (ABS & AIHW: 1997; 4704.0; 15-17).

In addition to the larger household sizes, Aboriginal people in the ACT in general tend to live in smaller homes. Eighty seven percent of non-Aboriginal residents (ABS: 1993b; 2722.8; 19) are living in a separate house compared with 80 per cent of Aboriginal people (ABS: 1996a; 2722.8; 10). By contrast 10 per cent of Aboriginal people in the ACT are living in flats, apartments or caravans (ABS: 1996a; 2722.8; 10) whereas 5 per cent of other ACT residents are living in such dwellings (ABS: 1993b; 2722.8; 19).

The nature of occupancy of dwellings is also very different for Aboriginal ACT residents than for other ACT residents (see Figure 6.6). Approximately 63 per cent of non-Aboriginal homes are owned or being bought (ABS: 1993b; 2722.8; 19) compared to only 35 per cent of Aboriginal homes (ABS: 1996a; 2722.8; 10). An almost reciprocal arrangement exists with rented homes where 64 per cent of Aboriginal homes are rented (ABS: 1996a; 2722.8; 10) compared to only 33 per cent of other ACT residential homes (ABS: 1993b; 2722.8; 19).

The 1994 National Aboriginal and Torres Strait Islander Survey of the Queanbeyan ATSI Region¹ reported that the 12 per cent of respondents who were dissatisfied with their dwelling stated that the main problems with the dwelling were not enough bedrooms, in need of repair, not enough living area, needs better insulation/ventilation, and inadequate bathing facilities.

¹ This region covers an area of South Eastern NSW which includes part of NSW. This survey cannot be used to show definite trends in the ACT but is meant as a general guide to the sorts of problems incurred.

7. Maternal and perinatal health

Data sources

The National Perinatal Statistics Unit perinatal collection is collated from notification forms completed by midwives in each State and Territory. Information is collected about the characteristics of the mother; previous pregnancies; the current pregnancy; labour, delivery and the puerperium; and the infant's birth status (live birth or stillborn) sex, birth weight, Apgar scores and outcome (Plunkett et al: 1996; 2). The major deficiency in the perinatal data collection is that the Aboriginal status of fathers is not recorded, that is information on infants born to Aboriginal fathers and non-Aboriginal mothers cannot be obtained from this source. The proportion of all Aboriginal births in which the father was Aboriginal and the mother non-Aboriginal varies from state to state. The ABS has estimated this to be from a high of 20 per cent in South Australia to a low of six per cent in the Northern Territory. It can be assumed that, like in other states, there is an under enumeration of Aboriginal births in the ACT (Plunkett et al: 1996; 3).

Fertility

In the early 1980s Gray undertook the first comprehensive research on Aboriginal fertility, and found the total fertility rate peaked in the period from 1956-61 at 5.9 children per woman. This rate declined steeply in the 1970s to reach a low of 3.1 by the mid 1980s. These findings were supported by Jain who applied indirect methods of fertility estimation to 1986 census information. There have, however, been conflicting reports as to whether these fertility trends continued throughout the 1980s, and there were even some suggestions of a small rise in fertility. But Tesfaghiorghis argues that these results could have been influenced to some extent by the increasing likelihood of persons of mixed descent to identify as Aborigines (Tefaghiorghis: 1996; 155). In spite of this, the fertility of Aboriginal women remains much higher than that of non-Aboriginal women. The 1991 census estimates indicate that the total fertility rate of Aboriginal women was approximately 3.1 children, compared with 1.9 children for non-Aboriginal Australian women. The striking difference between the two populations is largely due to the greater proportion of births to young Aboriginal women - more than 25 per cent of Aboriginal births were to women aged less than 20 compared to less than five per cent of non-Aboriginal births (Plunkett et al: 1996; 6, 37).

In the ACT during the period 1991 to 1993 there were 79 confinements resulting in 81 live births to Aboriginal women. There were no recorded infant deaths. It is likely that the major influences on low Aboriginal mortality in the ACT in the period 1991-93 were the inter-related factors of mother's age and number of children. Tesfaghiorghis's study showed that most of the moderately high Aboriginal fertility was due to the very high fertility of teenagers and young women (1996: 13; 165). The mean age of Aboriginal mothers in the ACT was 25.8 years - the second highest in Australia following Tasmania - compared to 23.7 years for total Aboriginal Australia

Figure 7.1: Aboriginal maternal age at confinement, 1991-1993

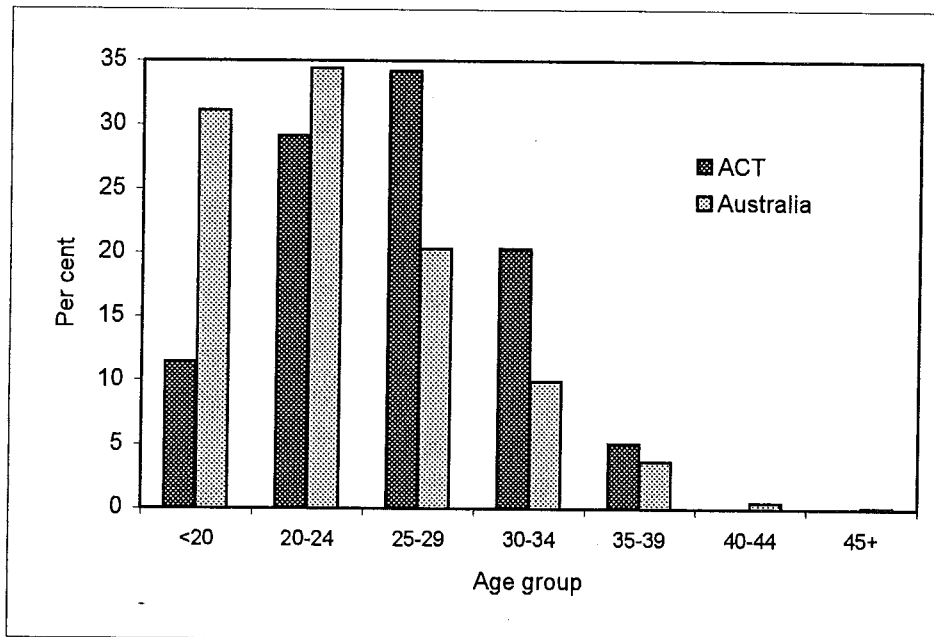
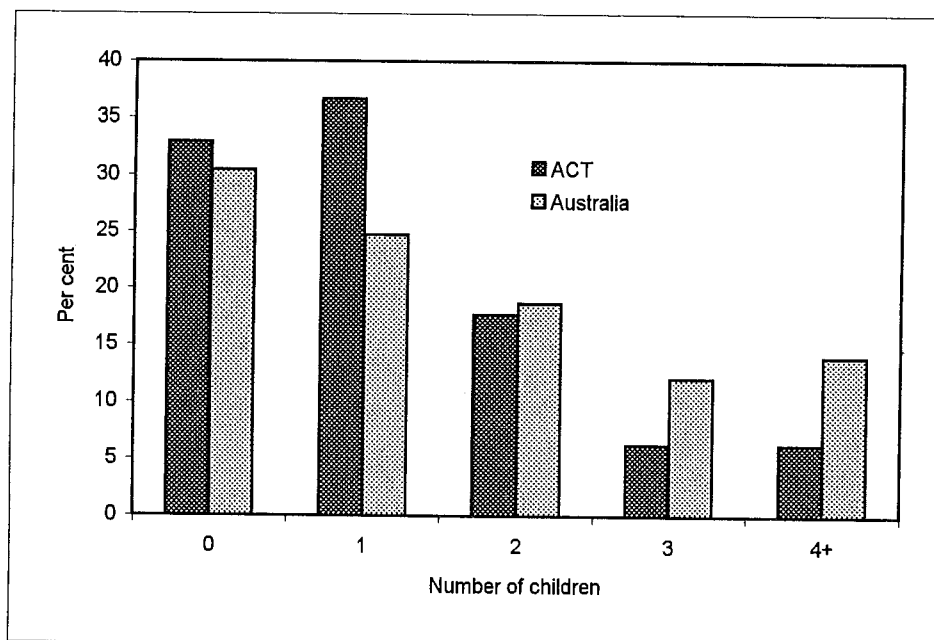


Figure 7.2: Aboriginal mother's parity, 1991-1993



Source: Plunkett A (1996)

(see Figure 7.1). In addition, approximately 87 per cent of Aboriginal mothers in the ACT had two or less children compared to 73 per cent of all Aboriginal mothers (see Figure 7.2).

In the ACT from 1991-1993, 64 (81 per cent) of Aboriginal births were in public hospitals and 15 (19 per cent) in private hospitals, and the mean length of antenatal stay in hospital was 0.5 days which was somewhat lower than the total Aboriginal Australian stay of 1.8 days (Plunkett et al: 1996; 38-41). Low birth weight continues to be a problem for babies of Aboriginal mothers, and on average their babies are 150 to 350 grams lighter than non-Aboriginal babies at birth (Macklin: 1992; 86). During the period 1991-1993 13 per cent of babies born to all Aboriginal mothers had birthweights less than 2500 grams, compared to six per cent of non-Aboriginal babies. The proportion of babies of low birthweight born to Aboriginal mothers in the ACT was slightly less at 11 per cent, but again still much higher than for the Territory's non-Aboriginal population - less than two per cent (Lancaster: 1996; 75) (Plunkett et al: 1996; 55).

Table 7.1: Aboriginal confinements, births and deaths, 1991-1993.

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Confinements	4,269	1,260	6,698	4,320	1,228	12	79	3,673	21,539
Fetal deaths	73	17	93	64	27	-	-	71	345
Live births	4,240	1,250	6,676	4,300	1,213	12	81	3,633	21,405
All births	4,313	1,267	6,769	4,364	1,240	12	81	3,704	21,750
% of all births	1.6	0.6	4.9	5.8	2.1	0.1	0.6	34.8	2.9

Source: Plunkett A, Indigenous Mothers and their Babies Australia 1991-1993, ABS:1994;3301.0

8. Mortality

Data sources

Paradoxically the health of a population is often measured by the mortality or death statistics of that group. One of the reasons mortality data are used is that deaths and causes of death are a reliable source of information collected by all State and Territory Registrars of Births, Deaths and Marriages. However, the provision for the identification of Aboriginal deaths on death registration forms has existed for different lengths of time in the various States and Territories, resulting in the quality of the data varying between regions. In 1994 the Australian Bureau of Statistics considered data from Western Australia, South Australia, the Northern Territory and the Australian Capital Territory only to be of publishable standard when it estimated coverage to be more than 90 per cent complete in these regions (ABS: 1994; 3301.0; 5).

Mortality

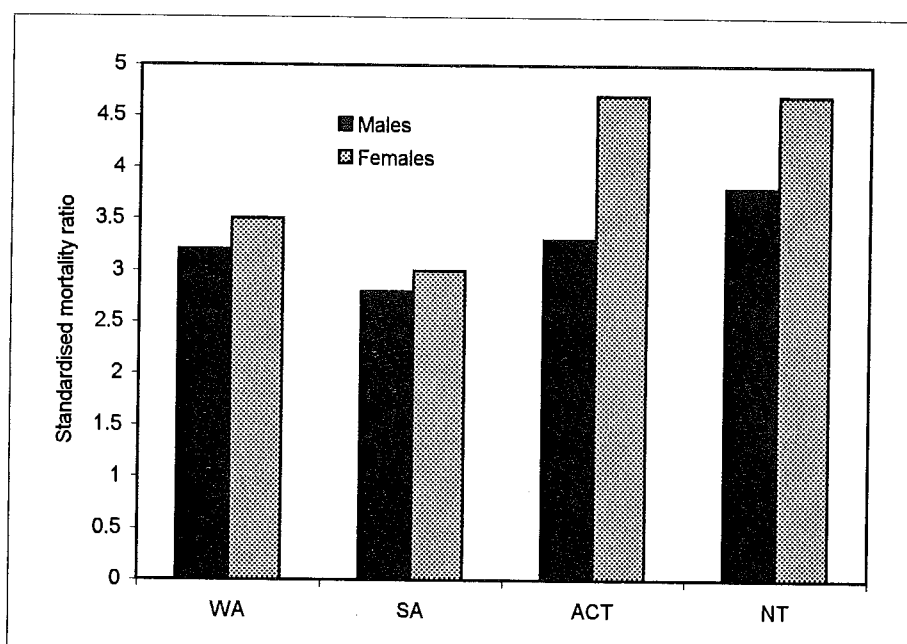
The level of excess mortality experienced by Aboriginal persons has long been recognised as a measure of their health disadvantage (Thomson: 1991; 235). Although there is considerable fluctuation in the number of Aboriginal deaths in the ACT, the excess mortality rate does give some indication of the extent of this disadvantage. In the two year period between 1993 and 1994 there were nine male and ten female Aboriginal deaths in the ACT, resulting in an age-standardised death rate of 1,719 and 4,362 per 100,000 persons respectively. These mortality rates are considerably higher than for all non-Aboriginal Australians which were 839 and 542 per 100,000 respectively (ABS, AIHW: 1994; 3315.0; 13). Thomson maintains that in general Aboriginal death rates are between two and four times those of the non-Aboriginal population after standardisation (1991; 235).

Expectation of life

Life expectancy is a demographic indicator used to estimate the expected number of years a person of a given age and sex might live if they experience the current age-specific death rates (ABS: 1995b; 3302.0; 43). It is well documented (Thomson: 1991, Khalidi: 1989) that the life expectancy of Aboriginal Australians is considerably less than that of the non-Aboriginal population. In 1992-94 the life expectancy of a non-Aboriginal Australian male was 74.9 years, and 80.6 years for a non-Aboriginal Australian female. Because the quality of identification of Aboriginal deaths is not considered sufficient in all States it is not possible to calculate a total Aboriginal life expectancy. However, it is possible to estimate life expectancy for Aboriginal persons in Western Australia, South Australia and the Northern Territory with some measure of confidence.

Life expectancy for the ACT has not been included because the number of deaths is too small to produce a valid estimation. But given the pattern of lower life expectancy in Western and South Australia, and the Northern Territory it can probably be assumed that these estimates are indicative of Aboriginal life expectancy in other regions. It can be seen from Table 8.1 that even the highest Aboriginal life expectancy for males is

Figure 8.1: Aboriginal standardised mortality ratios, 1992-94



Source: ABS, Occasional paper: mortality of Indigenous Australians. Cat.No. 3315.0

Note: Figures for the Australian Capital Territory are for 1993 and 1994. Age-standardised to the total 1991 Australian population.

Table 8.1: Measures of mortality for identified Aboriginal deaths, 1992-94

Males	Deaths	CDR	ASDR	SMR	Life exp
Australian Capital Territory	9	520	1719	3.3	(a)
Western Australia	627	896	2062	3.2	57.3
South Australia	189	695	1704	2.8	61.0
Northern Territory	624	920	2334	3.8	56.7

Females	Deaths	CDR	ASDR	SMR	Life exp
Australian Capital Territory	10	517	4362	4.7	(a)
Western Australia	468	681	1693	3.5	63.7
South Australia	151	557	1203	3.0	64.6
Northern Territory	499	742	1891	4.7	61.1

Source: ABS, Occasional paper: mortality of Indigenous Australians. Cat.No. 3315.0

Note: Figures for the Australian Capital Territory are for 1993 and 1994. Age-standardised to the total 1991 Australian population. (a) The number of deaths is too small to calculate life expectancy.

nearly 14 years less than for their non-Aboriginal counterpart. The disparity is even more evident for females - while a newborn non-Aboriginal female can expect to live to 80 plus years her Aboriginal equal life expectancy is less than 65 years.

Age-specific mortality and causes of death

Thomson argues that the lower expectation of life at birth for Aboriginal people largely reflects the much higher mortality experienced by young adults (1991:236), and that the ratio of age-specific Aboriginal to non-Aboriginal death rates is much higher in young and middle-aged adults. This pattern of Aboriginal mortality is apparent in the ACT - although the numbers are small, in 1995 there were nine reported Aboriginal deaths, of these more than 55 per cent were aged 40 years or less compared to less than 11 per cent in the total ACT population. These premature deaths were mainly attributed to injury and poisoning causes (ABS: 1995a; 3303.0).

The leading causes of death for Aboriginal persons in Western Australia, South Australia and Northern Territory in the period 1992 to 1994 were diseases of the circulatory system, respiratory diseases, neoplasms and injury and poisoning. Although these data do not relate directly to the Australian Capital Territory because there are not enough cases to disaggregate further, they do give some indication of the leading causes of death for Aboriginal persons throughout Australia. Of particular concern is that injury and poisoning was the second and third most common cause of death for males and females respectively, and the leading cause in the 1-34 years of age group (ABS, AIHW: 1994; 3315.0; 15).

The pattern of female specific mortality is also quite different among Aboriginal women. The age-standardised death rate for cervical cancer was twice that of breast cancer for Aboriginal women, while for non-Aboriginal Australian women breast cancer was responsible for eight times as many deaths as cervical cancer. Also of particular concern are the rates of maternal mortality in the Aboriginal population in other States and Territories (there were no maternal deaths in the ACT). There has been little improvement in the incidence of Aboriginal deaths resulting from complications of pregnancy and childbirth since the early 1970s, while at the same time the maternal mortality rate for non-Aboriginal women has halved. In the late 1980s Aboriginal women were eight times as likely to die from pregnancy related complications than non-Aboriginal women. Although Aboriginal women comprise only about two per cent of the population of pregnant women they account for nearly 15 per cent of all maternal deaths (Bastian: 1993; 159; 571).

High infant mortality rates continue to be a problem in the wider Aboriginal community. In the period from 1991 to 1993, the fetal death rate among births to Aboriginal mothers (15.9 per 1,000 live births) was more than double that for non-Aboriginal births (6.7 per 1,000 live births) (Plunkett: 1996; 67). Deaths due to sudden infant death syndrome occur about six times more often than expected for both Aboriginal male and female infants (ABS, AIHW: 1994; 3315.0; 15).

9. Morbidity

Data sources

Together with mortality patterns, morbidity (illness) patterns provide an insight into the health profile of Aboriginal Australians in the ACT and the ATSIQ Queanbeyan region.

In this study a number of sources are used to provide morbidity data including the ACT hospitals morbidity collection, the National Aboriginal and Torres Strait Islander Survey and the National Health Survey.

ACT hospitals morbidity data collection

The majority of hospital services in the ACT are provided by The Canberra Hospital (TCH) and Calvary Public Hospitals. In addition, there are two private hospitals - Calvary Private Hospital and John James Memorial Hospital. The morbidity data collected from these hospitals provides information on Aboriginality, sex, age, usual place of residence, medical conditions/procedures and length of stay in hospital. Hospital morbidity data are generally expressed in terms of hospital separations, that is, those who have left the hospital in the given time period.

As hospital separation data primarily describe treatment of those with acute or chronic disease they do not fully describe the pattern of disease within the community. It has been recognised that caution needs to be applied when using hospital service utilisation as a proxy to plan resource allocation without examining the appropriateness of services for the conditions being studied (Payne et al: 1994; 74-78). Additionally, ACT hospital separation data are unique in that approximately 20 per cent of all hospital separations relate to non-ACT residents (Gilbert et al: 1995; 22). The majority of interstate patients come from large NSW towns in close proximity to the ACT.

Data limitations

There are a number of data limitations that need to be taken into account when analysing the ACT hospital morbidity collection, and in particular, issues relating to the ACT's Aboriginal population. These limitations include the likely under-enumeration of Aboriginal persons as described more fully in the section on data quality at the beginning of this report (page 2). The Aboriginal population in the ACT is small and therefore, any further disaggregation at the specific disease level results in very small cells and makes any analysis less reliable. To increase reliability, hospital data from 1991/92 through to 1994/95 have been combined.

In addition, hospital morbidity data only records acute and/or chronic illness episodes that require hospitalisation. In effect, this means that individuals who were ill but did not require a hospital bed or were outpatients, saw a GP or a specialist outside the hospital, or who consulted a pharmacist or alternative practitioners are not recorded.

A further limitation of hospital morbidity data is that it does not measure the severity of the illness (Gilbert et al: 1995; 100). For example, within an ICD9 code for a particular condition there is the potential for a wide range of variation with regards to

severity and impact on lifestyle. The length of stay in hospital may give some indication, but with the trend towards home care and shorter hospital stays it may not be an accurate reflection of severity.

Data from both the National Aboriginal and Torres Strait Islander Survey and the National Health Survey are self-reported, and are therefore subject to a number of limitations. These include the possibility that an individual's response may reflect momentary or short-term, rather than usual, feelings or circumstances, and that responses may have been influenced by such factors as the presence of another family member (ABS: 1996d; 4363.0; 33). In addition, National Health Survey data used in this publication are only preliminary data, and it is possible that some numbers could change when reviewed.

To expand on the paucity of data available at the State level on Aboriginal persons the authors have used data from the National Aboriginal and Torres Strait Islander Survey which are comparable with the National Health Survey. However, there are problems inherent in doing this, first, the surveys were conducted during different years - the National Aboriginal and Torres Strait Islander Survey in 1994 and the National Health Survey in 1995. Second, different populations were targeted - the National Health Survey selected a sample from the entire Australian population, including the Aboriginal population, while the National Aboriginal and Torres Strait Islander Survey was specifically tailored to assess the needs of Australia's Aboriginal population.

Results

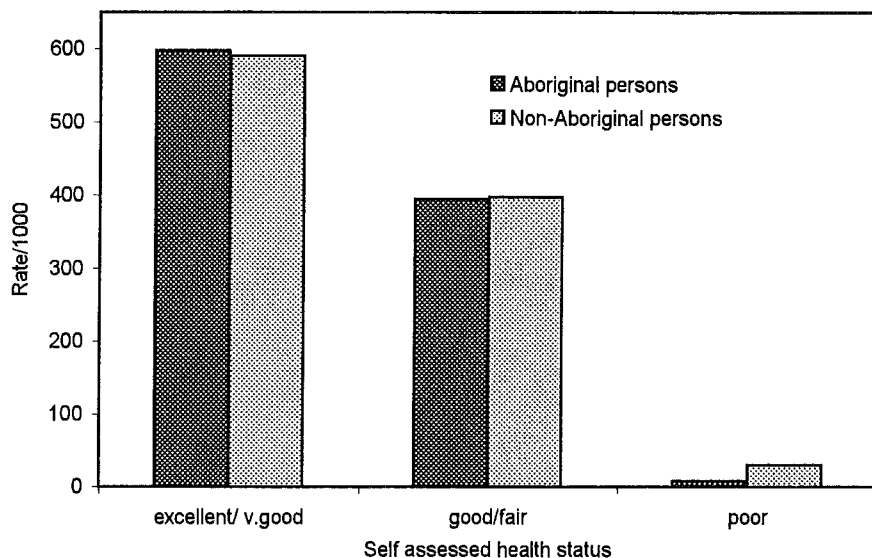
Self assessed health status

Both the 1994 National Aboriginal and Torres Strait Islander Survey and the 1995 National Health Survey included self assessment questions on the health status of participants. The National Aboriginal and Torres Strait Islander Survey states that 597 per 1000 Aboriginal persons in the Queanbeyan ATSIC region reported their health as being excellent or very good. This compares favourably with the National Health survey results of 590 per 1000 ACT residents reporting their health as being excellent or very good. The rates were again much the same for persons reporting their health as being good or fair, 395 and 398 per 1000 persons respectively. Of particular interest is the fact that only 8 per 1000 Queanbeyan ATSIC region population felt their health was poor compared with 29 per 1000 ACT population. However, as Mathers argues 'as reported' implies by its very nature subjectivity in the way conditions are identified and described (1995: 9). Figure 9.1 graphically compares the results of these questions.

Long term illness conditions

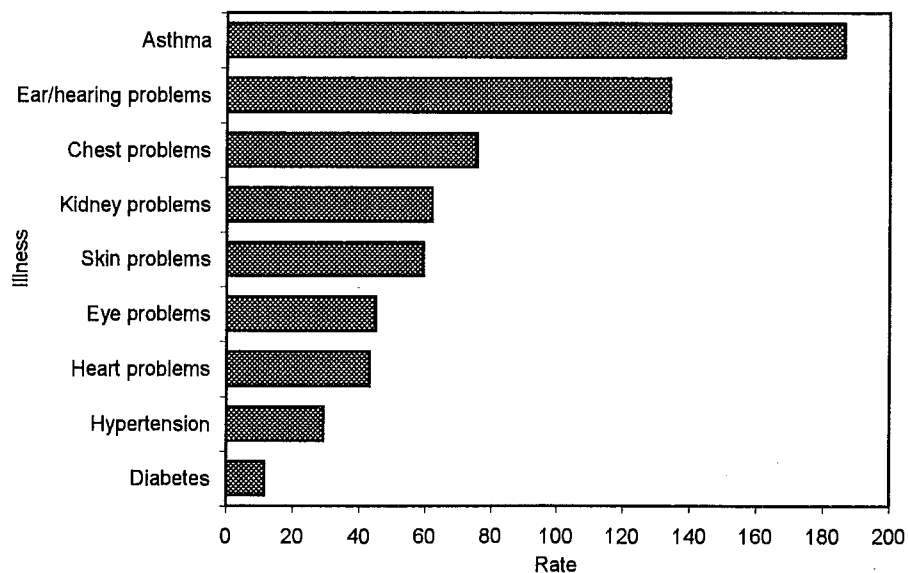
The National Health Survey (ABS: 1995c; 4363.0) and the National Aboriginal and Torres Strait Islander Survey (ABS: 1995c; 4190.0) both asked respondents to report any long-term illnesses. Long-term conditions are those which have lasted at least six months, or which the respondent expects to last for six months or more (ABS: 1995c; 4363.0; 30).

Figure 9.1: Self assessed health status of Aboriginal and non-Aboriginal respondents



Source: National Health Survey, Australian Capital Territory (first results) 1995
National Aboriginal and Torres Strait Islander Survey, Queanbeyan results

Figure 9.2: Leading selected long-term illness/conditions of Aboriginal persons, 1994



Source: National Aboriginal and Torres Strait Islander Survey, 1994, Queanbeyan region
Note: Does not include problems that can be corrected by glasses. Deafness includes partial and complete.

In 1994 the most commonly reported long term condition for Aboriginal persons in the Queanbeyan ATSI region was asthma (186.6 per 1000). Followed by ear/hearing problems (134 per 1000), chest problems (75.6 per 1000), kidney problems (62 per 1000) and eye problems (59.5 per 1000) (Figure 9.2).

Hospital separations 1991/92 to 1994/95.

As a percentage of all separations the number of Aboriginal persons treated in ACT hospitals is relatively small, therefore all Aboriginal persons are included (not just ACT residents) in this analyses. Rates are calculated using the hospital population for the period as the denominator.

Usual area of residence

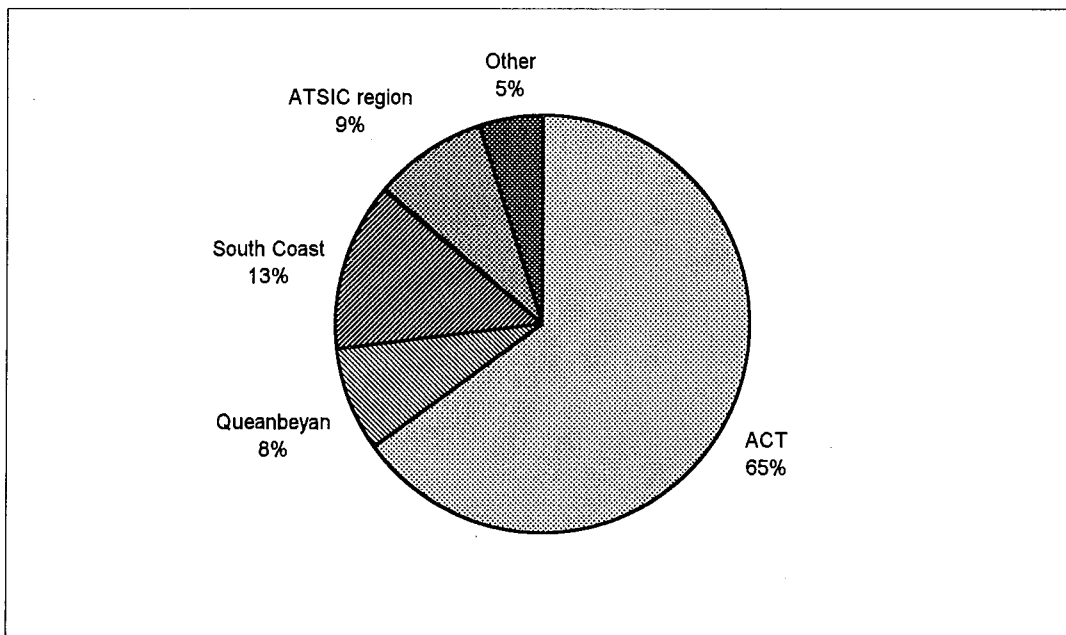
As noted earlier, 20 per cent of patients admitted to hospitals in the ACT are from interstate. This phenomenon appears to be even more pronounced within the Aboriginal population, resulting in more than 35 per cent of hospital separations relating to persons from outside the ACT. Of the 1,253 Aboriginal persons treated in ACT hospitals during the period 1991/92 - 1994/95, 814 named the ACT as their usual place of residence. One hundred named their usual place of residence as nearby Queanbeyan, and 163 usually resided on the NSW South Coast. Of the remaining, 113 lived in other areas that were within the Queanbeyan ATSI region, and 63 named places of residence that were outside the boundaries of the Queanbeyan ATSI region. The 5 per cent of 'Other' separations are interesting in that most of these persons are from Queensland.

Service utilisation

The National Health Strategy 1992 maintains that Aboriginal persons are 2.5 to three times more likely to be admitted to hospital than non-Aboriginal persons, and when admitted tend to stay longer for virtually every cause, and for every age group (Macklin: 1992; 86). Figure 9.4 shows the hospital separation rates for selected main diagnostic groups for Aboriginal persons treated in ACT hospitals between 1991/92 and 1994/95. Aboriginal separation rates were higher than non-Aboriginal rates for pregnancy, injury, respiratory, circulatory and mental conditions. Macklin argues that many of these diseases are directly related to lifestyle differentials such as nutrition and housing. Evidence for these findings came directly from a cohort study by Munoz who examined the quality of housing, including the number of shared resources, and found a direct correlation between these factors and hospital admission rates (Macklin: 1992; 90).

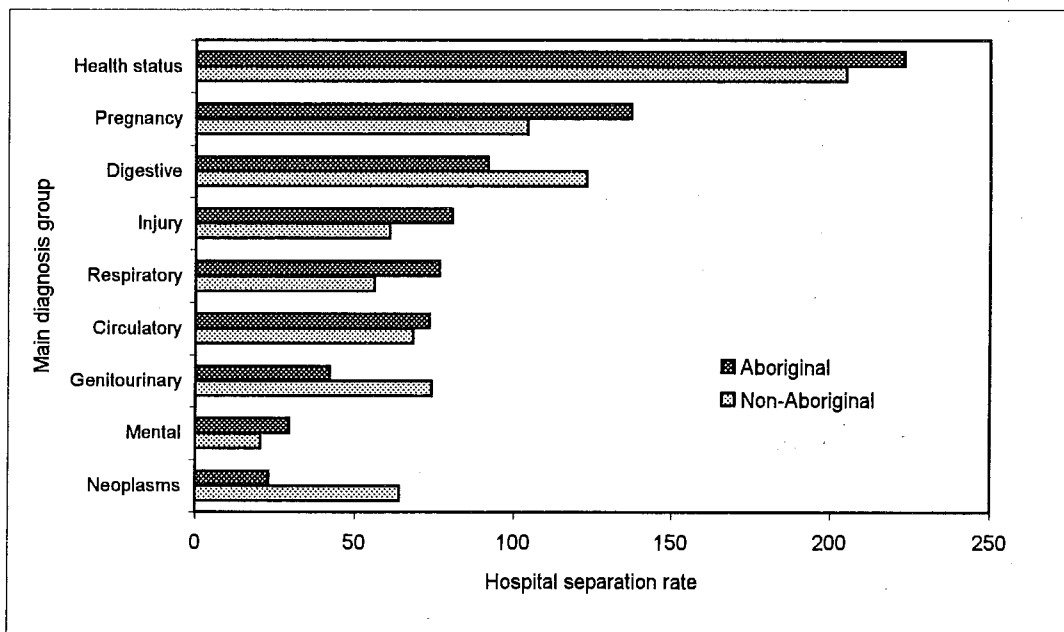
Aboriginal males had higher separation rates for health status, injury/poisoning, perinatal conditions, and mental conditions (Figure 9.5). The health status ICD classification is provided for use when a person with a known disease or injury, whether current or not, encounters the health care system for specific treatment of that disease, for example, dialysis for renal disease, or chemotherapy treatment (WHO: 1993; 700). Within this classification more than 17 per cent of the treatments for males were for renal dialysis. More than 80 per cent of the male separations attributed to injury/poisoning were for injuries, whereas for females the proportion of injuries was

Figure 9.3: Usual place of residence for Aboriginal persons in ACT hospitals from 1991/92 to 1994/95



Source: Source: ACT Hospitals morbidity data collection (1991/92 - 1994/95)

Figure 9.4: Hospital separation rates(a) for Aboriginal and non-Aboriginal persons by selected main diagnosis group, 1991/92 - 1994/95.



Source: Source: ACT Hospitals morbidity data collection (1991/92 - 1994/95)

Figure 9.5: Hospital separation rates for selected diagnosis groups, males 1991/92 - 1994/95

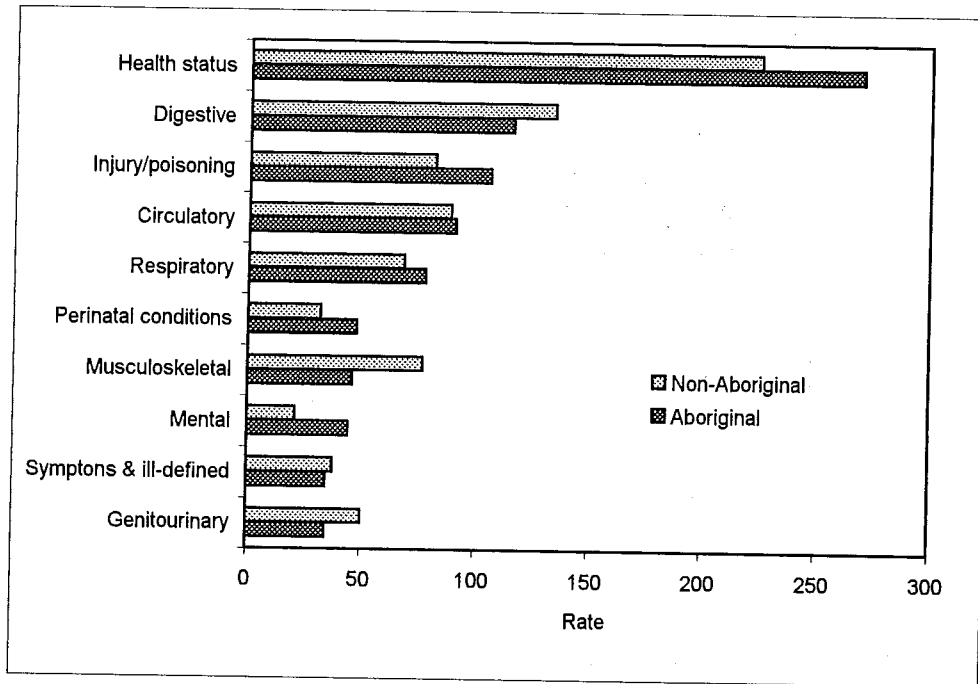
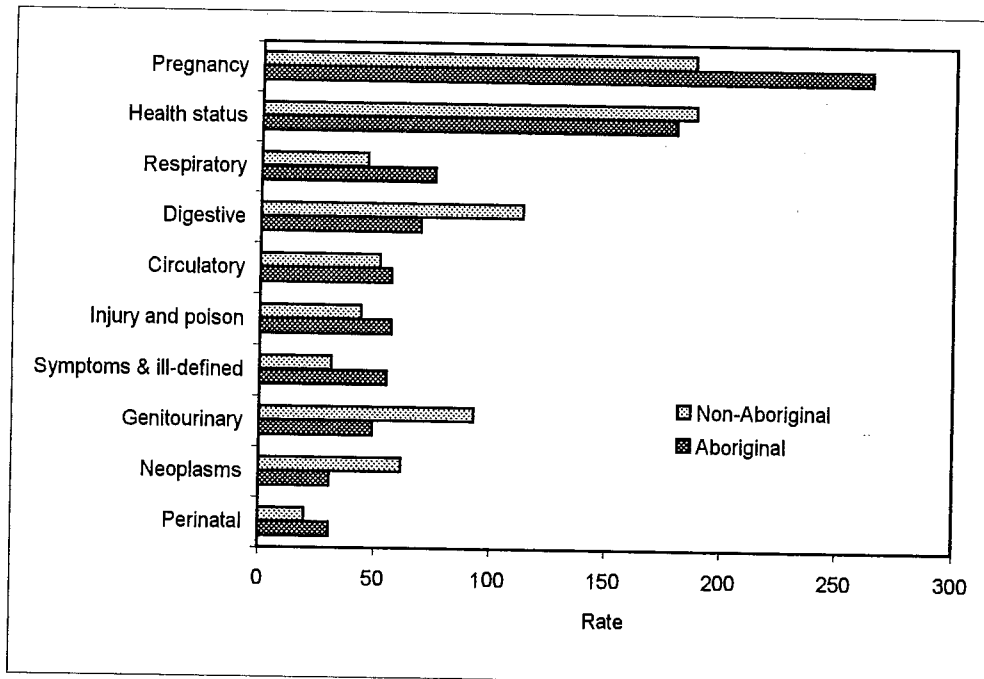


Figure 9.6: Hospital separation rates for selected diagnosis groups, females 1991/92 - 1994/95



Source: ACT Hospitals morbidity data collection (1991/92 - 1994/95)

lower. Aboriginal males had a slightly higher rate of separations than non-Aboriginal males attributed to psychoses, 70 per cent compared to 62 per cent respectively.

Aboriginal females had higher separation rates for pregnancy, respiratory, circulatory, injury and poisoning, symptoms and ill-defined conditions, and perinatal. A recent study into Aboriginal perinatal and maternal morbidity found that in general Aboriginal women were more likely to be younger, have a higher parity than non-Aboriginal women and booked their confinement later in pregnancy. As a result of these added risk factors Aboriginal mothers suffered more from pregnancy-induced hypertension, urinary tract infection and their babies were more likely to be born preterm and be of lower birthweight. Of particular significance is the fact that these findings applied to both urban and rural Aboriginal mothers (de Costa et al: 1996; 523).

ACT Health Goals and Targets Priority Areas

National health goals and targets were developed and endorsed by State, Territory and Commonwealth health ministers in 1994. The ACT has, alongside the national targets, developed its own Health Goals and Targets for the year 2000 (ACT Dept of Health: 1994). The priority areas selected for the ACT are asthma, cancer, cardiovascular disease, communicable disease, diabetes mellitus, injury and mental health, and form the basis for the following analysis of the ACT hospital morbidity data.

Asthma

The National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party: 1989) identified asthma as a health issue for Australia's Aboriginal population's health. It has been suggested that while the prevalence of asthma is not associated with specific socio-economic groups, therapy and management of the condition is better in those groups with higher socio-economic standing (Nutbeam et al: 1993; 77). Asthma is a condition distinguished by severe attacks of laboured breathing, wheezing, feelings of constriction in the chest and coughing (Gilbert: 1996). Asthma was the most common long term illness or condition reported by Aboriginal persons in the National Aboriginal and Torres Strait Islander Survey (Queanbeyan) region. The rate of self reported asthma was 186.6 per 1000 population, compared to 114.6 per 1000 for the ACT population as reported in the first results from the National Health Survey, which is itself high compared to the rest of Australia.

In the period 1991/92 - 1994/95 there were 4581 hospital separations with a primary or secondary diagnosis of asthma, of these 36 were Aboriginal separations. These cases represent nearly one per cent of all those with a primary or secondary diagnosis of asthma. There was a significantly higher proportion of asthma separations for Aboriginal persons ($\chi^2 = 10.13$, $df = 1$, $p < 0.01$) as opposed to non-Aboriginal persons. The Aboriginal rate of asthma separations was 28.7 per 1000 hospital population, compared to the non-Aboriginal rate of 17 per 1000 hospital separations.

The pattern of hospital separations was different for males and females. The rate per 1000 hospital population of a primary or secondary diagnosis of asthma was 20 for Aboriginal females and 15.5 for non-Aboriginal females. And for males the rates were 38.2 and 18.9 per 1000 respectively. There was a significantly higher proportion of asthma hospital separations for Aboriginal males ($\chi^2 = 11.89$, $df = 1$, $p < 0.01$).

Figure 9.7: Hospital separation rates for asthma by sex, ACT, 1991/1992 - 1994/1995.

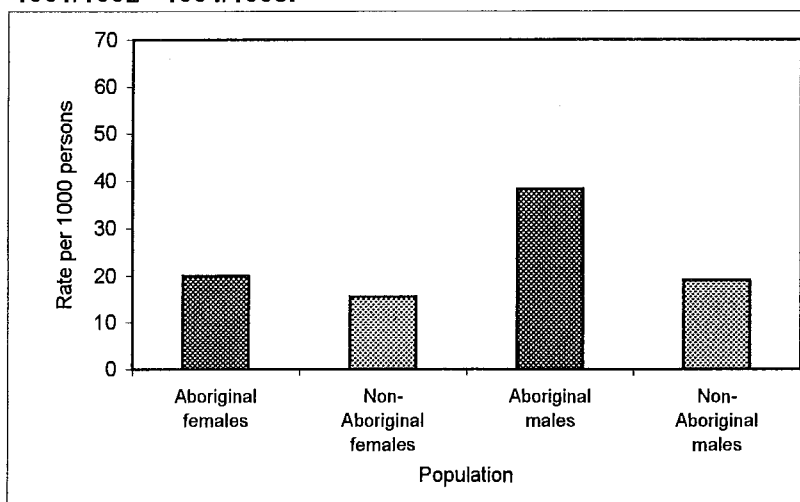


Figure 9.8: Hospital separation rates for cancer by sex, ACT, 1991/1992 - 1994/1995.

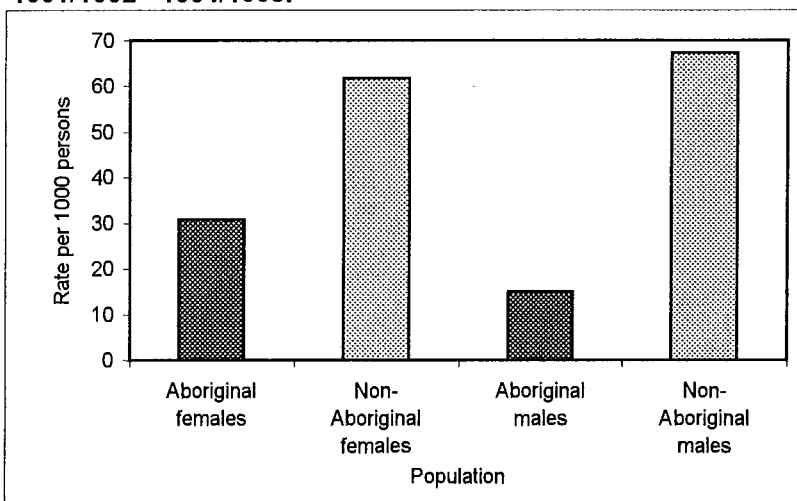
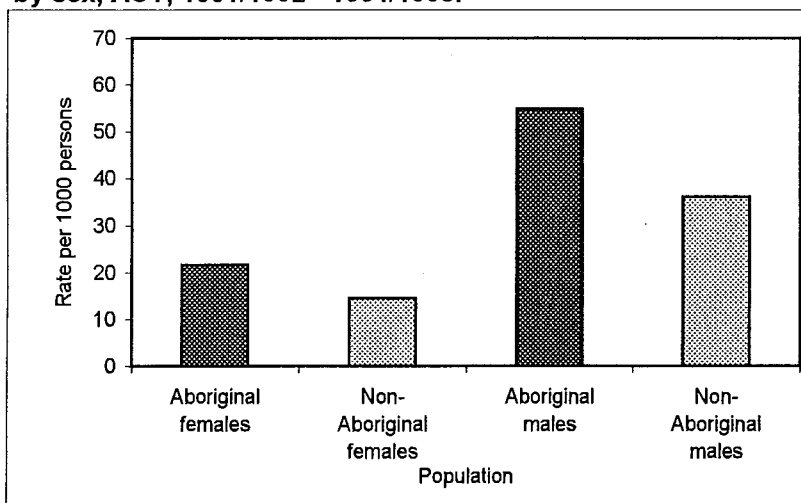


Figure 9.9: Hospital separation rates for coronary heart disease by sex, ACT, 1991/1992 - 1994/1995.



Source: ACT Hospitals Morbidity data collection (1991/92 - 1994/1995)
 Note: Hospital separations were the denominator in the calculation of rates

Neoplasms

Neoplasms can be defined as 'one of a number of diseases which result when the process of cell division, by which tissues grow and renew themselves, becomes uncontrolled and leads to the development of malignant cells' (DHS: 1995; xiv). Cancer was not reported as a leading long term illness in the National Aboriginal and Torres Strait Islander Survey or the National Health Survey.

Apart from lung cancer, cancers were not mentioned in the National Aboriginal Health Strategy. This probably reflects the fact that while cancer can and does occur at all ages, it is predominantly a disease of the elderly (DHS: 1995; 13) and it is well documented that the Aboriginal community has a relatively young age structure (see Demography section of this report, page 10) and hence less likely to exhibit diseases associated with old age. In addition, research suggests that Aboriginal patients may also report their cancers at a later stage of development. However, cancers such as those of the lung, liver, pancreas and cervix are of particular concern in the Aboriginal community because of their association with known risk factors such as smoking, hepatitis and alcohol consumption (DHS: 1995; 13). In addition, a recent study found that poor early detection rates in cancer of the cervix resulted in an age-standardised mortality rate of 51.9 per 100,000 among Aboriginal women compared to 10.8 for non-Aboriginal women.

Hospital morbidity data are not a good measure of the prevalence of cancer in the community because they do not record day patients who have chemotherapy, and not all cancer patients are hospitalised. The state and territory cancer registries collect data on the incidence of cancer in the community, but the quality of the Aboriginal identifier is poor.

In the period from 1991/92 to 1994/95 there were 17,232 hospital separations with a primary diagnosis of neoplasms, of these 29 were for Aboriginal persons. The neoplasm separation rate among Aboriginal Australians was 23 per 1000 hospital population, compared to the much higher rate of 64.2 per 1000 hospital populations for non-Aboriginal Australians. The Aboriginal neoplasm rate of hospital separations was significantly lower than that of non-Aboriginal persons ($\chi^2 = 35.08$, $df = 1$, $p < 0.01$).

Aboriginal males had a hospital separation rate for a primary diagnosis of neoplasm of 15 per 1000 population for a primary diagnosis of neoplasm compared with 67.3 for non-Aboriginal males (Figure 9.8). There was a significantly lower number of hospital separations for neoplasms for Aboriginal males ($\chi^2 = 26.2$, $df = 1$, $p < 0.01$) when compared with non-Aboriginal males. The neoplasm separation rate per 1000 hospital population was 30.8 for Aboriginal females and 61.7 for non-Aboriginal females. These results were significantly different ($\chi^2 = 10.7$, $df = 1$, $p < 0.01$).

Diseases of the cardiovascular system

Cardiovascular means pertaining to the heart and blood vessels (O'Toole: 1992, 254). Cardiovascular disease includes: cerebrovascular disease (stroke), hypertension, coronary heart disease (ischaemic heart disease), peripheral vascular disease and other diseases of arteries and veins and other circulatory conditions.

Cardiovascular diseases are considered part of the degenerative process of ageing, and are believed to be linked to lifestyle or environmental factors and prevailing social and economic conditions as well as a person's genetic make-up (d'Espaignet: 1993; 7). Of particular importance to Aboriginal persons is coronary heart disease (Gilbert et al: 1997). Coronary heart disease occurs when arteriosclerosis (thickening of the walls, loss of elasticity) causes blockage to one or more coronary arteries which supply the heart with blood (Gilbert et al: 1997; 9). The major risk factors for coronary heart disease are smoking, excessive alcohol consumption, high fat intake, lack of exercise, high cholesterol and high blood pressure (d'Espaignet: 1993; 29).

The National Aboriginal and Torres Strait Islander Survey reported both chest problems and heart problems in the top five most common self reported long term illnesses and conditions. However, the results from the two surveys were not directly comparable because the questions had differing formats.

In the period from 1991/92 to 1994/95 there were 18,450 hospital separations with a primary diagnosis of cardiovascular disease. Of these, 92 were for Aboriginal persons, representing a hospital separation rate of 73.4 per 1000 persons for cardiovascular diseases. This compares to 68.5 per 1000 persons for non-Aboriginal persons.

Overall there was no significant difference in the number of hospital separations due to cardiovascular disease for Aboriginal and non Aboriginal ACT residents ($\chi^2 = .472$, $df = 1$, $p < 0.5$). However, this was not the case when cardiovascular disease was disaggregated to its various components. The results of a chi square test were significant for coronary heart disease for Aboriginal persons ($\chi^2 = 9.59$, $df = 1$, $p < 0.01$).

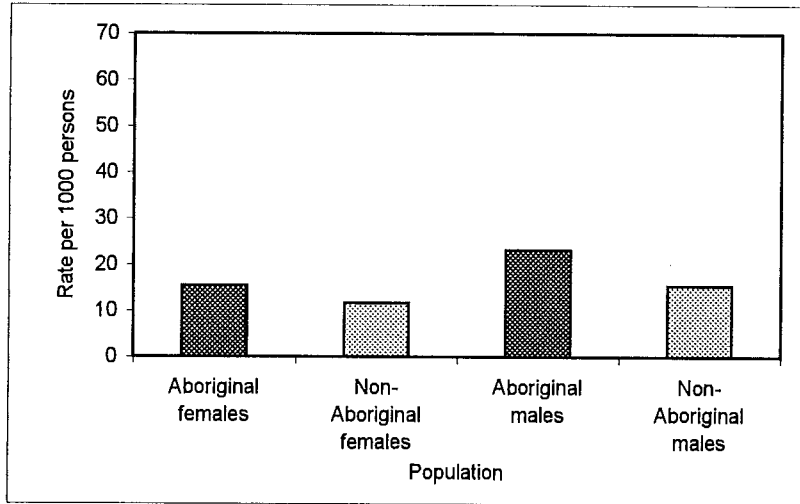
The rate per 1000 hospital population for a primary diagnosis of coronary heart disease was slightly higher for Aboriginal than non-Aboriginal females, 21.5 and 14.4 per 1000 females respectively. However, there was a significant difference between Aboriginal and non-Aboriginal males for coronary heart disease, 54.8 and 36.1 respectively, representing a chi square of ($\chi^2 = 6.03$, $df = 1$, $p < 0.05$).

Communicable diseases

Communicable diseases are defined as the causative agents which may pass or be carried from one person to another directly or indirectly (O'Toole: 1992; 338). There were 24 Aboriginal hospital separations for communicable diseases in the period from 1991/92 to 1994/95, representing a separation rate of 19.2 and 13.4 per 1000 for Aboriginal and non-Aboriginal persons respectively. There was no significant difference in the rate of communicable disease hospital separations for Aboriginal persons ($\chi^2 = 3.18$, $df = 1$, $p < 0.05$) as opposed to non-Aboriginal persons.

The infectious disease rate for Aboriginal females was 15.4 per 1000 females compared to the non-Aboriginal rate of 11.7, and for males 23.3 and 15.5 per 1000 males respectively. These differences were not significant.

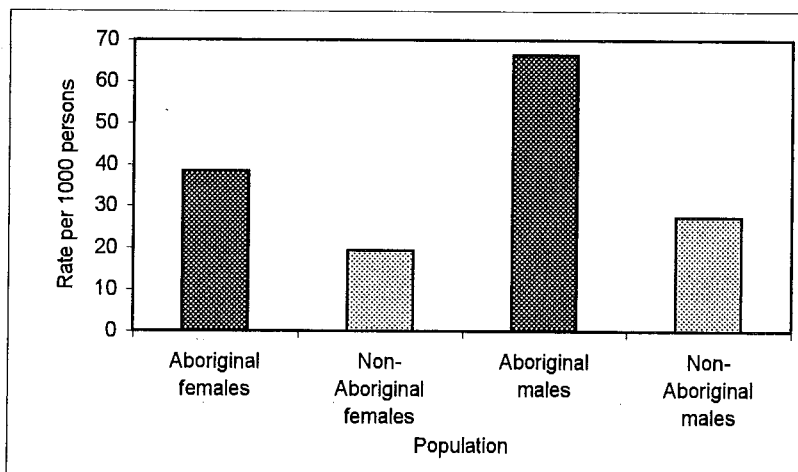
Figure 9.10: Hospital separation rates for communicable diseases by sex, ACT, 1991/1992 - 1994/1995.



Source: ACT Hospitals Morbidity data collection (1991/92 - 1994/1995)

Note: Hospital separations were the denominator in the calculation of rates

Figure 9.11: Hospital separation rates for diabetes by sex, ACT, 1991/1992 - 1994/1995.



Source: ACT Hospitals Morbidity data collection (1991/92 - 1994/1995)

Note: Hospital separations were the denominator in the calculation of rates

Diabetes mellitus

Diabetes mellitus is a broadly applied term that is used to denote a complex group of syndromes that all have in common a disturbance in the oxidation and utilisation of glucose (O'Toole: 1992; 412). It occurs when the pancreas is unable to produce sufficient insulin, or the insulin produced is unable to work effectively. Insulin is required to make glucose available for basic cell and organ function (Gilbert: 1996; 5).

The most common types of diabetes mellitus are juvenile insulin dependent diabetes, and mature-age onset non-insulin dependent diabetes. Serious clinical complications can be caused by diabetes such as adult blindness (leading cause), chronic kidney failure (major cause), coronary heart disease, stroke, peripheral vascular disease, amputations (leading cause) and impotence. The literature suggests that some people are predisposed genetically to mature-age onset diabetes. However, known modifiable risk factors including poor eating patterns (particularly the consumption of refined fats, sugar and alcohol) and obesity contribute to the number of excess Aboriginal cases (O'Dea: 1991; 135).

Results from the 1995 National Health Survey indicate that 15.1 per 1000 Aboriginal persons suffer from diabetes mellitus in the ACT. These results are higher than the results from the National Aboriginal and Torres Strait Islander Survey findings of 11.7 per 1000 persons in the Queanbeyan region. 12 per cent of those surveyed reported that they believed diabetes mellitus to be a problem in the local area. The survey did not distinguish between non-insulin and insulin dependent persons.

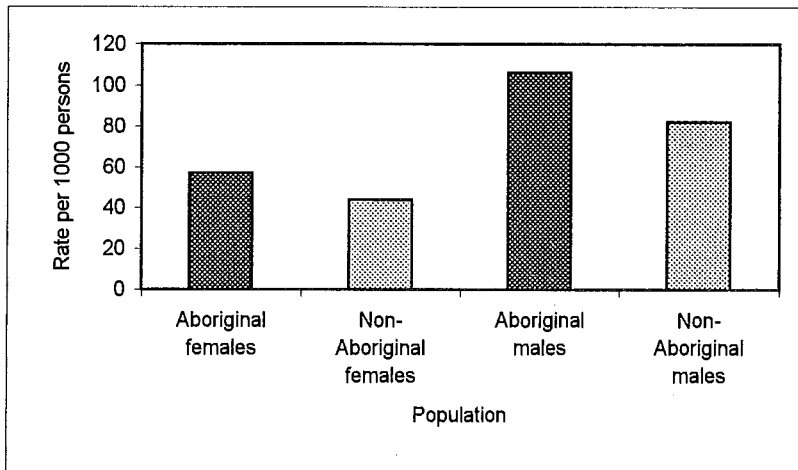
There were 65 hospital separation rates for Aboriginal persons suffering from diabetes mellitus in the period from 1991/92 to 1994/95, representing a hospital separation rate of 51.9 per 1000. There were a significantly higher proportion of diabetes mellitus hospital separations for Aboriginal persons ($\chi^2 = 46.0$, $df = 1$, $p < 0.01$) as opposed to non-Aboriginal persons.

Aboriginal males in particular were over represented in the hospital population with a diabetes separation rate of 66.4 compared to the non-Aboriginal male rate of 27.5 per 1000. Although Aboriginal female diabetes rates were much lower at 38.5 per 1000, they were still twice that of the non-Aboriginal female hospital separations (19.4).

Injury

Injury can be defined as 'harm or hurt; a wound or maim; usually applied to damage inflicted on the body by an external force' (O'Toole: 1992; 773). A recent working paper produced by the National Injury Surveillance Unit examined injury hospitalisation data for Aboriginal persons. Although it was noted that difficulties with data quality meant that findings need to be treated cautiously it showed that there is a

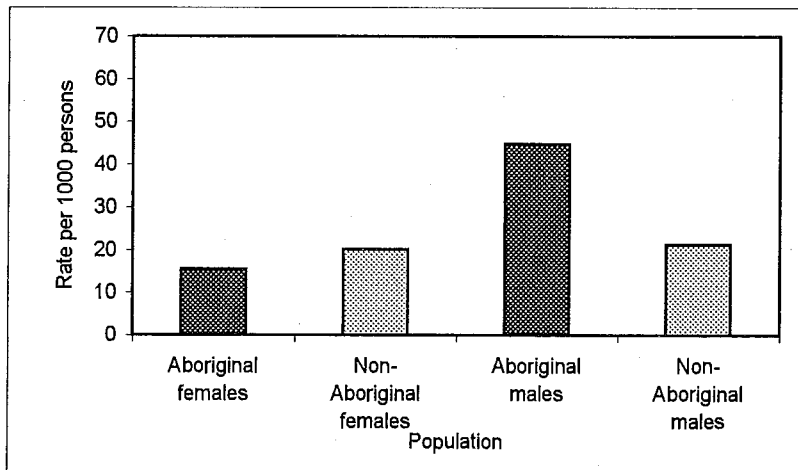
Figure 9.12: Hospital separation rates for injury by sex, ACT, 1991/1992 - 1994/1995.



Source: ACT Hospitals Morbidity data collection (1991/92 - 1994/1995)

Note: Hospital separations were the denominator in the calculation of rates

Figure 9.13: Hospital separation rates for mental health by sex, ACT, 1991/1992 - 1994/1995.



Source: ACT Hospitals Morbidity data collection (1991/92 - 1994/1995)

Note: Hospital separations were the denominator in the calculation of rates

higher rate of injury hospitalisation among Aboriginal peoples across a wide range of causes (Moller: 1996; 1). The National Aboriginal and Torres Strait Islander Survey found that 340 or 5 per cent of respondents in the Queanbeyan ATSI region reported being physically attacked or verbally threatened in the last twelve months (ABS: 1996c; 4196.0 ;55).

For Aboriginal persons in the ACT there were 101 hospital separations attributed to injury, representing a rate of 80.6 per 1000 separations. The non-Aboriginal hospital separation rate was 60.9 per 1000 separations.

The rate of injury is quite different for that of males and females. What is interesting is that the rate of injury for males is twice that of females in both the Aboriginal and non-Aboriginal populations. For Aboriginal males the hospital separation rate is 106.3 per 1000 persons, and for non-Aboriginal males 82.2. For females the rate is 56.9 and 43.9 respectively. There was a significant difference between the injury separation rates for Aboriginal and non-Aboriginal males ($\chi^2 = 4.6$, $df = 1$, $p < 0.03$).

Mental and emotional health

The nature and sensitivity surrounding mental health has meant that there is little consensus regarding a definition. However, the National Mental Health Policy has adopted the following definition:

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) , the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.'

They further define a mental health problem as one which disrupts the interactions between the individual and the environment producing a diminished state of mental health (Swan et al: 1995; 15).

A recently released report '*The Mental Health Needs of Aboriginals and Torres Strait Islanders Living in the ACT*' states that from the available data (which is extremely limited) in 1995, 8.5 per cent of the local Aboriginal community accessed the ACT Mental Health Services compared to 1.5 per cent of the general community (O'Neil: 1996; 2). The major mental health problems experienced by Aboriginal people who accessed the services were depression, anxiety, stress and adjustment problems followed by parent-child issues and family disturbances (O'Neil: 1996; 24). The Mental Health Services recorded 27 attempted suicides by Aboriginal people in the ACT between 1994 and 1995 (O'Neil: 1996; 16). By contrast, during the year 1994-95, ACT hospital separations data recorded no Aboriginal people being admitted due to attempted suicide or self-inflicted injury (White et al: 1997; 20). This disparity between data could be due to all suicide attempts being made in the first half of 1994 and the second half of 1995, or Aboriginal people who attempted suicide may not have been admitted to hospital, or the hospital data under enumerates Aboriginality on admission forms.

Recorded deaths of Aboriginal people due to suicide were too small for comparison with the wider ACT population. However, a comparison of mortality rates from suicide of Aboriginal and non-Aboriginal people in Western Australia, South Australia, and the Northern Territory for the period 1992 to 1994 shows that the death rate of Aboriginal males was approximately twice as high as non-Aboriginal males. Suicide rates for both Aboriginal and non-Aboriginal females were approximately the same (ABS, AIHW: 1994; 3315.0; 14).

The report made 28 recommendations for improving mental health services through access and quality of care for Aboriginal and Torres Strait Islander people living in the ACT (O'Neil: 1996; 35-7). Among the recommendations were that cross-cultural training on Aboriginal and Torres Strait Islander cultures be undertaken by all ACT Mental Health Staff, and as a priority, a team of Aboriginal volunteers be set up to work with the ACT Mental Health Crisis Team (O'Neil: 1996; 35). The report also recommends that data collection within the mental health areas be improved to better reflect the numbers of Aboriginal people currently accessing mental health services to enable better quality research to be conducted (O'Neil: 1996; 35-6).

Aboriginal persons accounted for 37 hospital separations in the period 1991/92 to 1994/95, representing a separation rate of 29.5 per 1000 compared to 20.6 for non-Aboriginal separations. There was a significant difference in the rate of mental illness for Aboriginal persons and non-Aboriginal persons ($\chi^2 = 4.91$, $df = 1$, $p < 0.02$). However, a quite different picture is presented when the data are disaggregated by sex. While Aboriginal females had a lower rate of separations than non-Aboriginal females, 15.3 and 20.1 respectively, Aboriginal males had twice the number of separations, 44.8 compared to 21.3 per 1000.

10. Communicable diseases

The Department of Health and Family Services has recently produced a report called '*The national Indigenous Australians' sexual health strategy 1996-97 to 1998-99*'. The working party conducted a comprehensive examination of the sexual health of Aboriginal and Torres Strait Islander people, and developed strategies which address the specific clinical care and cultural needs of Aboriginal people. The report also includes an extensive review of literature, and the latest data available. Reliable data collection mechanisms for sexually transmitted diseases are only available from the Northern Territory and Western Australia, and this remains one of the most controversial aspects of sexual health policy. The National Centre for Aboriginal and Torres Strait Islander Statistics within the Australian Bureau of Statistics is currently examining the question of Aboriginal identifiers in data collections.

The ACT has a paucity of information on communicable diseases in the Aboriginal community. For this reason much of the discussion below is based on more generic data from other States and Territories throughout Australia.

Sexually transmitted diseases

Data on the prevalence rates of sexually transmitted diseases are not available for ACT, Victorian or Tasmanian Aboriginal communities. From data available in other states the infection rates for Aboriginal people with gonorrhoea are increasing, for chlamydia are stable, and infectious rates of syphilis are decreasing. By comparison, rates among the non-Aboriginal population are stable for gonorrhoea, decreasing for syphilis and declining for chlamydia. Donovanosis which causes severe ulcerative disease occurs almost exclusively among Aboriginal people, and available data show that Aboriginal people have higher rates of bacterial sexually transmitted diseases than do non-Aboriginal people. For example, in South Australia, Western Australia and the Northern Territory Aboriginal people have infection rates of chlamydia at between two and eight times higher than the general population. The Northern Territory and Western Australia are the only areas in Australia which reliably report new cases of this condition (ANCARD: 1997; 26-9). In addition, there appears to be a different demographic pattern of sexually transmitted diseases in the Aboriginal population: Aboriginal persons are likely to be younger, and a higher proportion are more likely to be female.

HIV/AIDS

The Human Immuno-deficiency Virus (HIV) leads to Acquired Immune Deficiency Syndrome (AIDS) and is transferred through contact with infected blood, semen or vaginal fluid (Moloney et al: 1993; 329). The main modes of transmission of HIV in Australia include unprotected sexual intercourse with an HIV positive person and sharing contaminated injecting equipment, or perinatal, fetal or natal infection (Abraham et al: 1995; 47).

The World Health Organisation recognises the main modes of transmission of HIV/AIDS are through unprotected male homosexual sex and the sharing of needles of intravenous drug users (Pattern 1). This pattern of transmission occurs mainly in

industrialised countries such as Australia, New Zealand, the UK, etc. In Pattern 1, transmission through unprotected male to male sex is the major mode of transmission, followed by unsafe injecting practices and then unprotected heterosexual sex. Although the numbers are low, Aboriginal people are more likely to report heterosexual sex as the mode of transmission of HIV (27 per cent) than non-Aboriginal people (8 per cent) (ANCARD: 1997; 24). The overall rate of notification of HIV is similar for Aboriginal and non-Aboriginal people.

However, while the number of non-Aboriginal people with HIV/AIDS decreased, the number of Aboriginal notifications increased between 1992 and 1996. Until 1996 there were 128 notifications of HIV, 50 AIDS diagnoses and 34 subsequent deaths among Aboriginal adults in Queensland, South Australia and Western Australia. These data are likely to be under enumerations, particularly in Queensland where the non-reporting of Aboriginal status was high. Of the 128 HIV notifications 54 per cent were homosexual or bisexual, 27 per cent were heterosexual, five per cent intravenous drug users and four per cent of persons were unknown (ANCARD: 1997; 26).

There are limited data available in regards to HIV/AIDS infection for Aboriginal people. In addition, there are inconsistencies in the way each state and territory collects information on Aboriginal status when notifying new cases of HIV infection. These disparities make interpretation of the data very difficult. Further, data on HIV infection rates among Aboriginal people are not available for the ACT, Victoria or Tasmania, and is limited for Queensland and NSW (ANCARD: 1997; 24-26).

Hepatitis B and C

Hepatitis is a viral infection which affects the liver. Hepatitis B and C are transferred in much the same way: through blood, seminal and vaginal fluid. Risks for spreading the virus include sharing any injecting equipment, unprotected sex, sharing toothbrushes and razors. Although data are very limited, the prevalence of Hepatitis C in the Aboriginal population is believed to be less than among non-Aboriginal people (ANCARD: 1997; 30). Hepatitis B on the other hand is believed to be more prevalent among Aboriginal people and incidence rates as high as four to 26 times have been measured in Aboriginal populations (ANCARD: 1997; 31).

Other communicable diseases

There are no reliable data for tuberculosis rates among Aboriginal people in the ACT. However, in areas where such data are obtainable (NSW, NT, QLD, SA, WA), Aboriginal people showed higher rates of infection than for the total Australian population. It has been reported that rates of tuberculosis as high as 12.5 per 100,000 exist in Aboriginal communities compared to 5.7 per 100,000 for total Australia (ABS, AIHW: 1997; 78).

Although no specific data are available for rates of infection of Aboriginal people in the ACT, evidence suggests a considerable disparity in the rate of infection between Aboriginal and non-Aboriginal people in other parts of Australia. For example,

meningococcal infection in NSW, SA and WA, salmonellosis and shigellosis in WA, SA and NT. Rates of salmonellosis infection among Aboriginal people are two to five times higher than that of other Australians. Of particular concern for Aboriginal people are the rates for shigellosis - rates as high as 199 per 100,000 have been recorded, while for non-Aboriginal people the rate is 6.1 per 100,000. In addition, rates for meningococcal infection are 13 per 100,000 Aboriginal people compared with 2.2 per 100,000 non-Aboriginal people (ABS, AIHW: 1997; 78).

11. GLOSSARY

Aboriginal and Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated.

Age-specific birth rate is the number of births to women of a given age group per 1,000 women in that age group. (2)

Age-specific death rate is the number of deaths per 100,000 population for age groups other than under one year.

Apgar score is a quantitative estimate of the condition of an infant one to five minutes after birth, derived by assigning points to the quality of heart rate, respiratory effort, colour, muscle tone and response to stimulation; expressed as the sum of these points, the maximum or best score being ten. (9)

Communicable diseases are those diseases which are spread by direct contact with infectious agents. These infectious agents include droplets in the air (eg measles, rubella), body fluids (eg hepatitis B and C, HIV), spores (eg tetanus), food and water (eg cholera, salmonella) and insects (eg malaria). (6)

Demography is the study of the changes in populations, or peoples as they relate to births, deaths and migration (10).

Fertility rate refers to the number of children one woman would expect to bear if the age-specific rates of the year shown continued during her child-bearing lifetime. (2)

Health, as defined by the World Health Organisation is "a state of complete physical, medical and social wellbeing, and not merely the absence of disease or infirmity". This definition has been adopted by ACT Department of Health and Community Care.

Health risk factors are factors which increase the risk of ill-health in a person. For example, the presence of a health risk factor in a person may increase the chance that individual has of developing a particular illness or injury. (1)

Hospital separation rate is the number of separations per 1,000 persons of a particular age and sex group, including inpatients who were discharged more than once during the year. (1)

Immunisation status is defined as the degree to which the recommended course of vaccinations for a particular disease has been received (as appropriate to the age of the child).

Incidence refers to the number of instances of illness commencing, or of persons falling ill, during a given period in a specified population (ie the number of new cases which develop during a specified period in time). (7)

Indigenous is used in this report interchangeably with the term Aboriginal and Torres Strait Islander to refer to persons of Aboriginal and Torres Strait Islander descent.

Life expectancy refers to the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his or her lifetime. (2) The most commonly used life expectancy statistic is life expectancy at birth. (10)

Maternal means pertaining to a mother.

Mortality rate is the relative number of deaths, or death rate, as in a district or community. (4)

Morbidity rate is the proportion of sickness in a population. (4)

Performance indicators are methods for measuring the outputs and key processes of health service delivery in order to quantify the achievement or non-achievement of a health goal. (3)

Perinatal death is a stillborn or neonatal death.

Perinatal mortality rate is the number of perinatal deaths in a year per 1,000 total births in the same year.

Pertussis is a childhood communicable disease commonly known as whooping cough. (6)

Prevalence is the number of instances of a given disorder or other condition in a given population at a designated time. (7)

Puerperium is the period following the expulsion of the afterbirth, lasting until the pelvic organs have returned to normal size. This period usually lasts 3-6 weeks. (1)

Social indicator is a factor which indicates a person's social status. For example, a person's standard of housing, education, employment or income all relate to their social status. (10)

Standardised death rate is the overall death rate that would have prevailed in a standard population, if it had experienced at each stage the death rates of the population being studied. (2)

Statistically significant infers that it can be concluded on the basis of statistical analysis that it is highly probable. (6)

Total fertility rate is the number of children 1,000 women would bear during their lifetimes if they conformed to the current age-specific fertility rates. (1)

Winnunga Nimmitjiah is the Aboriginal and Torres Strait Islander medical service for the ACT.

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Abbreviations

ANCARD - Australian National Council on AIDS and Related Diseases

ATSIC - Aboriginal and Torres Strait Islander Commission

ICD9 - International Classification of Diseases 9th Edition. These codes are used to assign all possible diseases with a number. This makes statistical and other collections easier.

NACCHO - National Aboriginal Community Controlled Health Organisation

NATISIS - National Aboriginal and Torres Strait Islander Survey 1994

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13. Health Series Publications

The Epidemiology Unit of the Department of Health and Community Care has developed an on-going health series of publications to inform health professionals, policy developers and the community on health status in the Territory.

- Number 1: *ACT's Health: A report on the health status of ACT residents*
Carol Gilbert, Ursula White, October 1995
- Number 2: *The Epidemiology of Injury in the ACT*
Carol Gilbert, Chris Gordon, February 1996
- Number 3: *Cancer in the Australian Capital Territory 1983-1992*
Norma Briscoe, April 1996
- Number 4: *The Epidemiology of Asthma in the ACT*
Carol Gilbert, April 1996
- Number 5: *The Epidemiology of Diabetes Mellitus in the ACT*
Carol Gilbert, Chris Gordon, July 1996
- Number 6: *Developing a Strategic Plan for Cancer Services in the ACT*
Kate Burns, June 1996
- Number 7: *The First Year of The Care Continuum and Health Outcomes Project*
Bruce Shadbolt, June 1996
- Number 8: *The Epidemiology of Cardiovascular Disease in the ACT*
Carol Gilbert, Ursula White, January 1997
- Number 9: *Health Related Quality of Life in the ACT: 1994-95*
Darren Gannon, Chris Gordon, Brian Egloff, Bruce Shadbolt, February 1997
- Number 10: *Disability and Ageing in the ACT: An Epidemiological Review*
Carol Gilbert, April 1997
- Number 11: *Mental Health in the ACT*
Ursula White, Carol Gilbert, George Johansen, May 1997
- Number 12: *The health of Aboriginal and Torres Strait Islander people in the ACT*
Norma Briscoe, Josie McConnell, Michelle Petersen, June 1997

