

# Health

Aboriginal and Torres Strait Islander peoples experience significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health.

## Overview

The Queensland Government is working with Aboriginal and Torres Strait Islander peoples, communities and organisations, health-service providers, and other levels of government to increase the life expectancy of Aboriginal and Torres Strait Islander peoples and address chronic disease and disability.

Below is an outline of Queensland's commitment under the COAG Indigenous reform agenda, as well as the measures which will be used to monitor progress, and the programs and services which have been delivered by the Queensland Government (in 2008/09) to address the health gap between Aboriginal and Torres Strait Islander and non-Indigenous peoples.

### Queensland's commitment under COAG

To address the COAG target of closing the life expectancy gap within a generation, the **Closing the Gap in Indigenous Health Outcomes National Partnership Agreement** identifies a number of evidence-based priority areas:

- tackling smoking
- healthy transition to adulthood
- making Indigenous health everyone's business
- primary health care services that can deliver
- fixing the gaps and improving the patient journey.

The **Closing the Gap in Indigenous Health Outcomes National Partnership Agreement** provides \$1.6 billion nationally over four years from 2009–2010 (combined contributions from the Australian and state governments). An implementation plan has been developed by the Queensland Government. Expected outcomes include a reduced smoking rate, reduced burden of disease, increased uptake of Medical Benefits Schedule funded primary health care services, improved care coordination and a reduction in the average length of hospital stay in readmissions.

To broadly tackle the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders, the Queensland Government has developed the **Making Tracks Indigenous Health Policy** (due for publication at the end of 2009). **Making Tracks** will provide a comprehensive and evidence-based policy framework for long-term effort required across the life-span and the health service continuum to achieve sustainable health gains for Aboriginal and Torres Strait Islander Queenslanders. It includes the following priority areas:

- providing Aboriginal and Torres Strait Islander children 0-8 years a healthy and safe start to life through effective women's health services, antenatal and infant health care, improved education outcomes and child protection services
- reaching out to 8-18 year olds to connect young Aboriginal and Torres Strait Islander peoples with health and education systems, and to establish positive and sustainable patterns of health behaviour that will impact greatly on adult physical and mental health outcomes
- reducing the modifiable risk factors that contribute to chronic disease through anti-smoking campaigns and initiatives, mechanisms to address harmful alcohol consumption, improve oral health and nutrition, and participation in physical activity, as well as access to reproductive and sexual health information and programs
- improving the living environments of Indigenous Australians through environmental health and housing initiatives, and efforts to enhance community and personal safety
- assisting Aboriginal and Torres Strait Islander Queenslanders with chronic disease through earlier diagnosis and appropriate treatment targeting, in particular, the most prevalent disease groups of cardiovascular disease, Type 2 diabetes and chronic respiratory diseases



- improving access to, and experience of, the health system by enhancing the cultural competence of the health workforce and participating in health service systems that encourage integration between programs and across all health service providers
- working more effectively with the Aboriginal and Torres Strait Islander community health sector to improve primary health care service coordination as well as to inform the design and delivery of funded programs and services for Indigenous Queenslanders across the state
- improving the quality and availability of research and data, accountability mechanisms and evaluation.

These priority areas are consistent with the **Indigenous Health Outcomes** and **Early Child Development** national partnership agreements.

The new **National Disability Agreement** came into effect in January 2009 and replaced the previous Commonwealth State/Territory Disability Agreement.

A priority under the **National Disability Agreement** is increased access to services for Indigenous Australians with disabilities which is being led by the Northern Territory. This priority will focus on the development of a National Indigenous Access framework which will ensure that Indigenous access issues are also addressed through a range of priority reform areas under the National Disability Agreement, including:

- population benchmarking framework
- quality improvement systems based on disability standards
- service planning and strategies to simplify access
- increased workforce capacity.

## The evidence

The onset of disease and infection can often be prevented or delayed through immunisation, good hygiene, healthy lifestyle, healthy environment and protection from parasites. However, prevention of disease may be affected by socio-

economic status, social marginalisation and lack of access to health and welfare services.<sup>32</sup>

The lower life expectancy of Aboriginal and Torres Strait Islander peoples, combined with a higher fertility rate, means that for Aboriginal and Torres Strait Islander peoples the proportion of the population which is young is higher than for non-Indigenous people (see Figure A9). In order to calibrate the two populations and give a truer estimate of rates, a technique known as 'age standardisation' has been applied where possible.

### Life expectancy

An Aboriginal and Torres Strait Islander baby boy born in Queensland in the period 2005–2007 can expect to live, on average, 10.4 years less than his non-Indigenous Australian peers. In comparison, the life expectancy gap between Aboriginal and Torres Strait Islander Queensland females and non-Indigenous Australian females born during 2005–2007 is 9.0 years (see Table 2).<sup>33</sup>

- Non-Indigenous life expectancy has been increasing on average at 0.24 years per year.
- If non-Indigenous life expectancy continues to increase at this rate to 2031 (one generation), the gaps between Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Australians will increase.
  - › Under this scenario, to close the gap between Aboriginal and Torres Strait Islander and non-Indigenous life expectancy by the year 2031, there will need to be a gain in Queensland Indigenous life expectancy of 16.4 years for males and 15.0 years for females over the 25 years from 2006. This is nearly three times the gains achieved by the overall Australian population in the last 25 years.<sup>34</sup>

32 Begg S., Vos T., Barker B., Stevenson C., Stanley L., and Lopez A.D., 2007, *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: AIHW.

33 Source: Australian Bureau of Statistics, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, 2005–2007*, cat. no. 3302.0.55.003.

34 Kennedy, B. and McGill, K. 2009, *Indigenous and non-Indigenous life expectancy at birth in Queensland and Australia*, <http://www.health.qld.gov.au/hic/statbite/statbite17.pdf>, accessed 9 October 2009.

**Table 2. Life expectancy in years, Queensland, 2005-2007.**

Population	Years
Aboriginal and Torres Strait Islander males - Queensland	68.3
Non-Indigenous males - Australia	78.7
Aboriginal and Torres Strait Islander females - Queensland	73.6
Non-Indigenous females - Australia	82.6

Source: Australian Bureau of Statistics, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, 2005-2007*, cat. no. 3302.0.55.003.

## Causes of death

### Mortality rate

In 2007, the mortality rate of Aboriginal and Torres Strait Islander peoples:<sup>35</sup>

- was much higher than the rate for non-Indigenous people (998.4 per 100,000 compared with 604.3 per 100,000 persons)
- increased with remoteness (from 683 per 100,000 persons in major cities to 1,246 per 100,000 persons in remote/very remote areas - see Figure 3).<sup>36</sup>

Over the five year period 2003-2007 the overall mortality rate of Aboriginal and Torres Strait Islander peoples varied little (see Figure A10).

<sup>35</sup> Source: Registered deaths - Australian Bureau of Statistics, 2009; Estimated resident populations - developed by Office of Economic and Statistical Research.

<sup>36</sup> This may be partially explained by the fact that mortality records in remote areas of Queensland more accurately identify Aboriginal and Torres Strait Islander peoples than mortality records in other parts of the state.

### Leading causes of death

In 2007:

- the leading cause of death for both Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders was circulatory disease (see Table 3)
- 15 per cent of Aboriginal and Torres Strait Islander deaths were due to accidents, poisoning and violence compared with six per cent of non-Indigenous deaths
- nine per cent of Aboriginal and Torres Strait Islander deaths were due to diabetes compared with only two per cent of non-Indigenous deaths.

Over the years 2003-2006 the proportional breakdown of causes of death changed little for Aboriginal and Torres Strait Islander Queenslanders.

### Leading causes of disease and injury

Aboriginal and Torres Strait Islander peoples made up 3.1 per cent of the Queensland population yet experienced 4.4 per cent of Queensland's disease and injury burden in 2006.<sup>37</sup> The causes of disease and injury that contributed most to this differential were cardiovascular diseases, diabetes and chronic respiratory disease. Cancer, injuries and mental health conditions were also significant contributors to the injury and disease burden borne by Queensland's Aboriginal and Torres Strait Islander peoples. Together these conditions explain 80 per cent of the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders.

This section compares hospitalisation rates for Indigenous and non-Indigenous Queenslanders but the data should be interpreted with caution. Hospitalisation data do not describe the prevalence of conditions included in this report - for example, it is not possible to determine the actual number of people with diabetes from counts of hospital admissions for diabetes.

<sup>37</sup> Begg S., Bright M., and Harper, C., 2006, *Queensland Burden of Disease and Injury*, Population Health Queensland, Division of Chief Health Officer, Queensland Health.



One person may have several admissions each year for the same condition. Admissions data are primarily collected to measure service need and use, and can only be indicative of the wellbeing or excess burden of ill health in the community. As such, increases in hospital admissions may reflect increased access and improved early detection and management of disease or, alternatively, increased burden of disease and poorer management of disease.

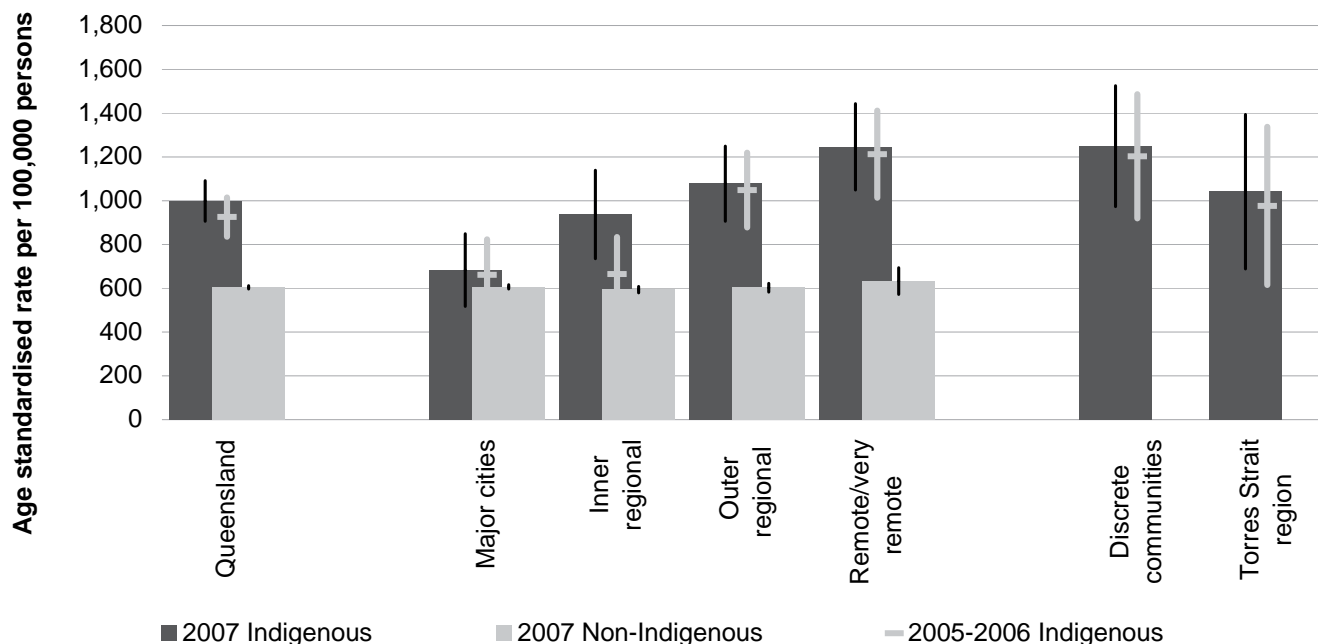
Differences in observed hospitalisation rates with remoteness are likely to be due in part to higher levels of under-identification of Aboriginal and Torres Strait Islander peoples in urban and regional areas. Hospitalisation rates in urban

areas in particular may be much higher than reported, hence differences across remoteness areas may not be as great as those reported.

### Circulatory disease (cardiovascular)

Circulatory system diseases include coronary heart disease, hypertension, stroke, vascular disease and heart failure. Rheumatic heart disease is also included in this category, and is caused by long-term damage done to heart muscle or valves as a result of acute rheumatic fever (ARF).<sup>38</sup> ARF and its long-term complications are preventable.<sup>39</sup>

**Figure 3. Mortality rate (age standardised), all causes of death, Queensland, 2005-2007.**



This graph compares the mortality rates of Queensland residents in two time periods for a range of geographic areas within Queensland. The earlier time period, the two years 2005-2006 is represented by a floating line for Aboriginal and Torres Strait Islander peoples and is compared with 2007, represented by a solid bar. Source: Registered deaths – Australian Bureau of Statistics, Vital Statistics, 2009; Estimated resident populations – developed by OESR. Notes: (1) Non-Indigenous rates include persons with unknown Indigenous status. (2) Data are presented by the year the deaths were registered, not year of actual death. (3) These data exclude the deaths of 283 Queensland residents whose deaths were registered interstate and were not available at the time of data processing. (4) The vertical lines on each bar in the graph represent 95 per cent confidence intervals – there is a 95 per cent chance that the true rate is within this range.

38 Australian Institute of Health and Welfare, Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008, The Aboriginal and Torres Strait Islander Health Series. AIHW Catalogue no IHW-21 AIHW, 2008.

39 [www.heartfoundation.org.au/document/NHF/ARF\\_RHD\\_PP-593\\_Mgmt\\_QuickRefGuide\\_0606.pdf](http://www.heartfoundation.org.au/document/NHF/ARF_RHD_PP-593_Mgmt_QuickRefGuide_0606.pdf) accessed 11/09/08.

**Table 3. Cause of death, proportion of all deaths, Queensland, 2007.**

Cause	Indigenous (%)	Non-Indigenous (%)
Circulatory disease	25	34
Cancer	19	28
Accidents/poisoning/violence	15	6
<i>Suicide and self harm</i>	5	1
Endocrine, metabolic and nutritional disorders	10	3
<i>Diabetes</i>	9	2
Other causes	9	9
Respiratory disease	8	10
Digestive disorders	5	3
Kidney disease	3	2
Conditions originating in the perinatal period	3	0
Nervous system disease	2	4
Infectious and other parasitic disease	2	1
<b>All</b>	<b>100 (588)</b>	<b>100 (24,930)</b>

Source: Registered deaths – Australian Bureau of Statistics, Vital Statistics, 2009. Notes: (1). Non-Indigenous rates include persons with unknown Indigenous status. (2) Data are presented by the year the deaths were registered, not year of actual death. (3) These data exclude the deaths of 283 Queensland residents whose deaths were registered interstate and were not available at the time of data processing. (4) Age standardised rates may show different ranking of cause of death, however, due to the data being incomplete at the time of processing, rates were not developed.

Over the two year period 2006/07–2007/08 Aboriginal and Torres Strait Islander peoples were hospitalised for circulatory disease:<sup>40</sup>

- at approximately 1.7 times the rate of non-Indigenous people (3,294 compared with 1,962 per 100,000 persons - see Figure A11)
- at a higher rate in regional (3,407 to 3,601 per 100,000 persons) and remote/very remote areas (3,783 per

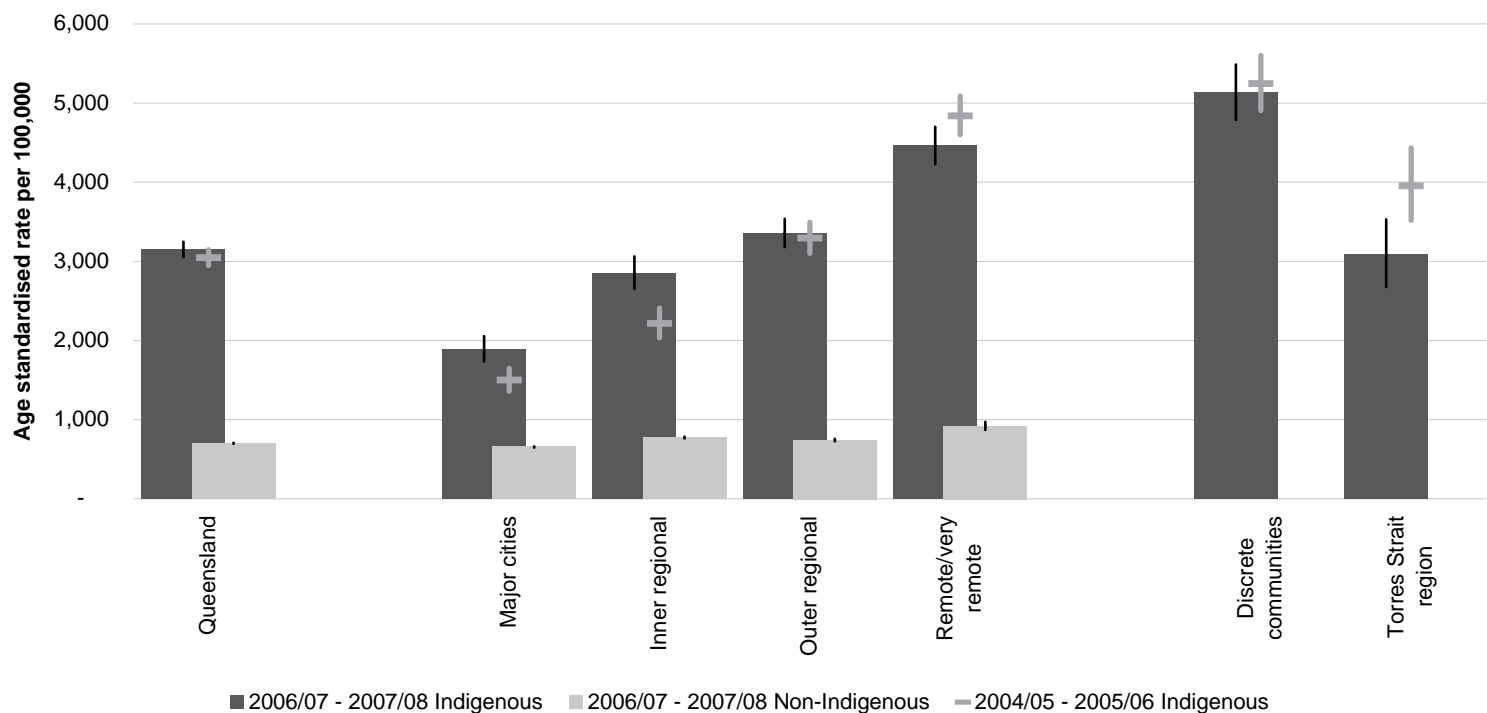
100,000 persons) than in major cities (2,379 per 100,000 persons).

Between 2004/05–2005/06 and 2006/07–2007/08 rates decreased significantly in remote/very remote regions (from 4,723 to 3,783 per 100,000 persons), the discrete communities (from 4,883 to 4,229 per 100,000 persons) and the Torres Strait region (from 3,097 to 2,242 per 100,000 persons).

<sup>40</sup> Source: Queensland Hospitals Admitted Patient Data Collection, Queensland Health. Note that these data exclude transfers and are thereby not directly comparable with the rates of hospitalisations by principal diagnosis presented in Table A8.



**Figure 4. Hospitalisation due to diabetes complications, age standardised rate, Queensland, 2006/07 - 2007/08 and 2004/05 - 2005/06.**



This graph compares the rate at which Queensland residents were hospitalised for complications of diabetes in two time periods for a range of geographic regions within Queensland. The earlier time period, the two years 2004/05-2005/06 is represented by a floating line for Aboriginal and Torres Strait Islander peoples and is compared with the two years 2006/07-2007/08, represented by a solid bar. Source: Queensland Hospitals Admitted Patient Data Collection, Queensland Health. Notes: (1) Data are aggregated by patient's place of usual residence. (2) Where possible, hospitalisations resulting from a patient transfer have been excluded to prevent double counting. (3) Patients whose Aboriginal and Torres Strait Islander status was unknown or not stated have been aggregated with non-Indigenous patients.

### Diabetes and renal disease

Kidney disease has a variety of causes. Pyelonephritis is an infection of the kidneys or the ureters and may be an acute or chronic condition. Chronic pyelonephritis is persistent kidney inflammation that can scar the kidneys and lead to chronic renal failure. End stage renal disease results when the kidneys cease functioning almost entirely, leading to a build up of waste products and excess water in the body

causing progressively worse illness.<sup>41</sup> This is the last and most debilitating stage of chronic kidney disease.

In 2007:

- Aboriginal and Torres Strait Islander peoples in Queensland were 8.7 times more likely than non-Indigenous people in Queensland to have commenced treatment for kidney disease

<sup>41</sup> Australian Institute of Health and Welfare, 2007, Aboriginal and Torres Strait Islander Health Performance Framework, 2006 report: detailed analyses. AIHW cat. no. IHW 20. Canberra: AIHW.

- the median age of commencing treatment for renal failure (for example dialysis) for Indigenous Queenslanders was 49.8 years, compared with 65.6 years for non-Indigenous people<sup>42</sup>
- diabetes Type 2 was by far the most common primary cause of renal failure in Aboriginal and Torres Strait Islander renal patients in Queensland, accounting for 62 per cent of renal failure in new patients.

Over the two year period 2006/07–2007/08 Aboriginal and Torres Strait Islander peoples were:

- hospitalised for diabetes complications at approximately four times the rate of non-Indigenous people (3,150 compared with 702 per 100,000 persons - see Figure 4)
- hospitalised for diabetes complications at a greater rate in remote (4,459 per 100,000 persons) and regional areas (2,852 to 3,357 per 100,000 persons) than in major cities (1,891 per 100,000 persons)
- hospitalised for pyelonephritis at approximately three times the rate of non-Indigenous people (684 compared with 217 per 100,000 persons)<sup>43</sup>
- 10 times more likely to be hospitalised due to dialysis than non-Indigenous people (36,383 compared with 3,537 per 100,000 persons - see Figure A12)<sup>44</sup>
- between 2004/05–2005/06 and 2006/07–2007/08 rates of hospitalisation for dialysis decreased in the Torres Strait region (from 11,740 to 4,593 per 100,000 persons) and major cities (from 23,347 to 17,583 per 100,000 persons), and increased in the discrete communities (from 20,061 to 27,275 per 100,000 persons - see Figure A12).

42 Australia and New Zealand Dialysis and Transplant Registry (ANZDATA), Annual Report, 2008.

43 Numbers of admissions for this condition were too small to make comparisons between remoteness areas.

44 Each episode of dialysis is classed as an admission to hospital, so differences may be due to differences in the proportion of the population being on dialysis and/or differences in the frequency of treatment required by individual patients.

## Diseases of the respiratory system

Over the two year period 2006/07–2007/08, Aboriginal and Torres Strait Islander peoples were hospitalised for diseases of the respiratory system:<sup>45</sup>

- at over twice the rate of non-Indigenous people (3,622 per 100,000 compared with 1,506 per 100,000 persons - see Figure 5 and Table A8)
- at a significantly higher rate in remote/very remote areas (5,712 per 100,000 persons) than in other geographical areas.

Between 2004/05–2005/06 and 2006/07–2007/08, this rate significantly increased in inner regional areas (from 2,518 to 3,155 per 100,000 persons) and significantly decreased in remote/very remote areas (from 6,387 to 5,712 per 100,000 persons) and outer regional areas (from 4,025 to 3,687 per 100,000 persons).

## Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a long-term lung disease characterised by shortness of breath that becomes progressively worse over time. COPD is a major cause of mortality, illness and disability among Aboriginal and Torres Strait Islander Queenslanders and there is no known cure. The Australian Institute of Health and Welfare notes that tobacco smoking is by far the strongest risk factor for COPD.<sup>46</sup>

Over the two year period 2006/07–2007/08, Aboriginal and Torres Strait Islander peoples were hospitalised for COPD:<sup>47</sup>

- at a rate four times greater than for non-Indigenous people (1,103 compared with 271 per 100,000 persons - see Figure A13 and Table A8)
- at a slight increasing trend with increasing remoteness (from 759 per 100,000 persons in major cities to 1,551 per 100,000 persons in remote/very remote regions).

45 Source: Queensland Hospitals Admitted Patient Data Collection.

46 Cited in Australian Institute of Health and Welfare 2005, *Chronic respiratory diseases in Australia: their prevalence, consequences and prevention*. AIHW Cat. No. PHE 63. Canberra: AIHW.

47 Source: Queensland Hospitals Admitted Patient Data Collection.



Between 2004/05–2005/06 and 2006/07–2007/08, this rate significantly increased in inner regional areas (from 553 to 951 per 100,000 persons), and significantly decreased in remote/very remote regions (from 1,952 to 1,551 per 100,000 persons).

### Cancer

Over the two year period 2006/07–2007/08, Aboriginal and Torres Strait Islander peoples were hospitalised for cancer related conditions:<sup>48</sup>

- at a significantly lower rate than non-Indigenous people (1,950 per 100,000 compared with 2,895 per 100,000 persons - see Figure A14 and Table A8)

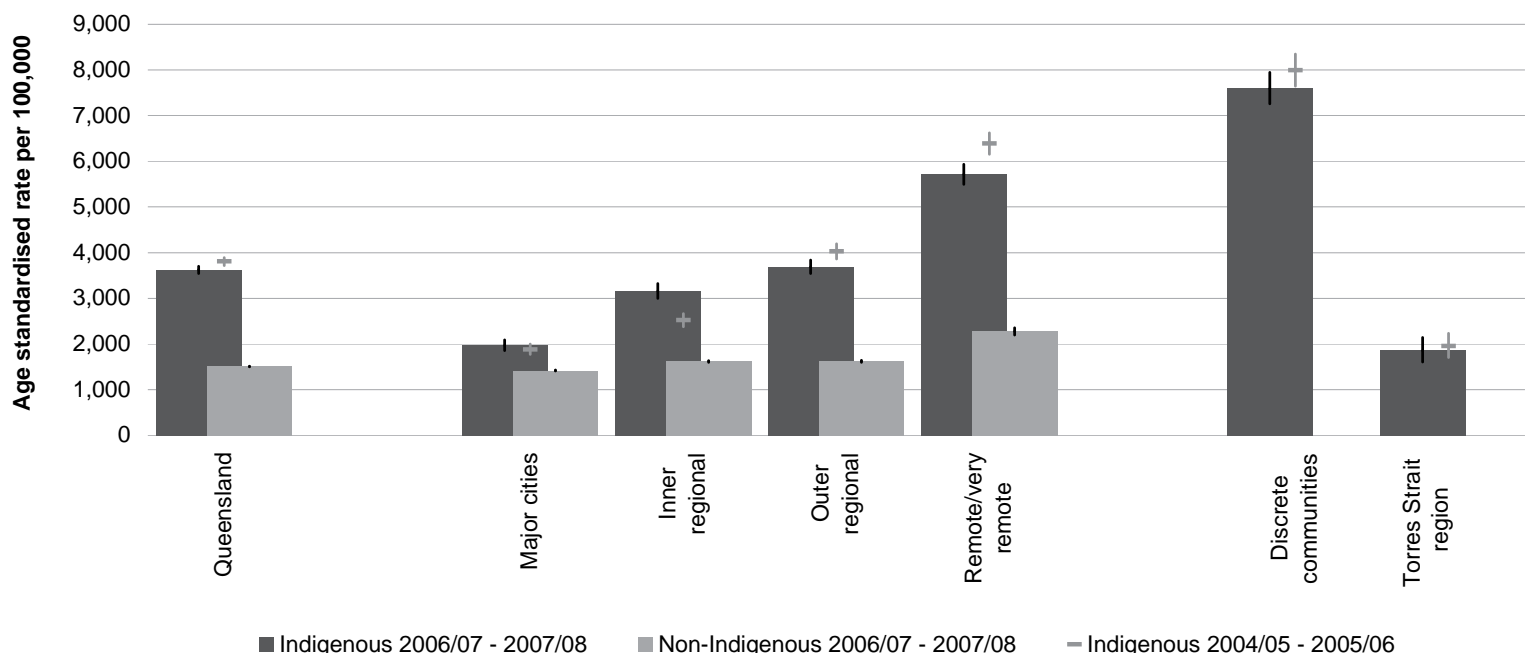
- in major cities (2,311 per 100,000 persons) and inner regional areas (2,260 per 100,000 persons) at a significantly higher rate than in other areas.

Between 2004/05–2005/06 and 2006/07–2007/08, rates increased significantly in all areas except outer regional areas and the Torres Strait region.

### Injury, poisoning and certain other consequences of external causes

Over the two year period 2006/07–2007/08, Aboriginal and Torres Strait Islander peoples were hospitalised for injury, poisoning and certain other consequences of external causes:<sup>49</sup>

**Figure 5. Hospitalisations for diseases of the respiratory system for all patients, age standardised rate, Queensland, 2004/05 - 2005/06 and 2006/07 - 2007/08.**



This graph compares the rate at which Queensland residents were hospitalised for diseases of the respiratory system in two time periods for a range of geographic regions within Queensland. The earlier time period, the two years 2004/05-2005/06 is represented by a floating line for Aboriginal and Torres Strait Islander peoples and is compared with the two years 2006/07-2007/08, represented by a solid bar. Source: Queensland Hospitals Admitted Patient Data Collection Notes: (1) Data are presented in two-year groupings because of small numbers each year. These groupings represent two financial years. (2) Non-Indigenous data include separations where the Indigenous status is not stated. (3) These data exclude unqualified newborns, boarders, organ procurements, dialysis patients and patients admitted to dedicated psychiatric hospitals. 4 Confidence limits are used to aid analysis in this graph. Please refer to Appendix 1 for further information on how to read these graphs.

48 Source: Queensland Hospitals Admitted Patient Data Collection.

49 Source: Queensland Hospitals Admitted Patient Data Collection.

- at a significantly higher rate than non-Indigenous people (3,797 per 100,000 compared with 2,442 per 100,000 persons - see Table A8)
- at a significantly higher rate in remote/very remote areas (6,093 per 100,000 persons) than in other geographical areas.

Between 2004/05–2005/06 and 2006/07–2007/08, rates did not change significantly.

### Mental and behavioural disorders

These data include mental health patients admitted to acute treatment facilities only. Patients admitted to dedicated public tertiary mental health facilities (i.e. Baillie Henderson

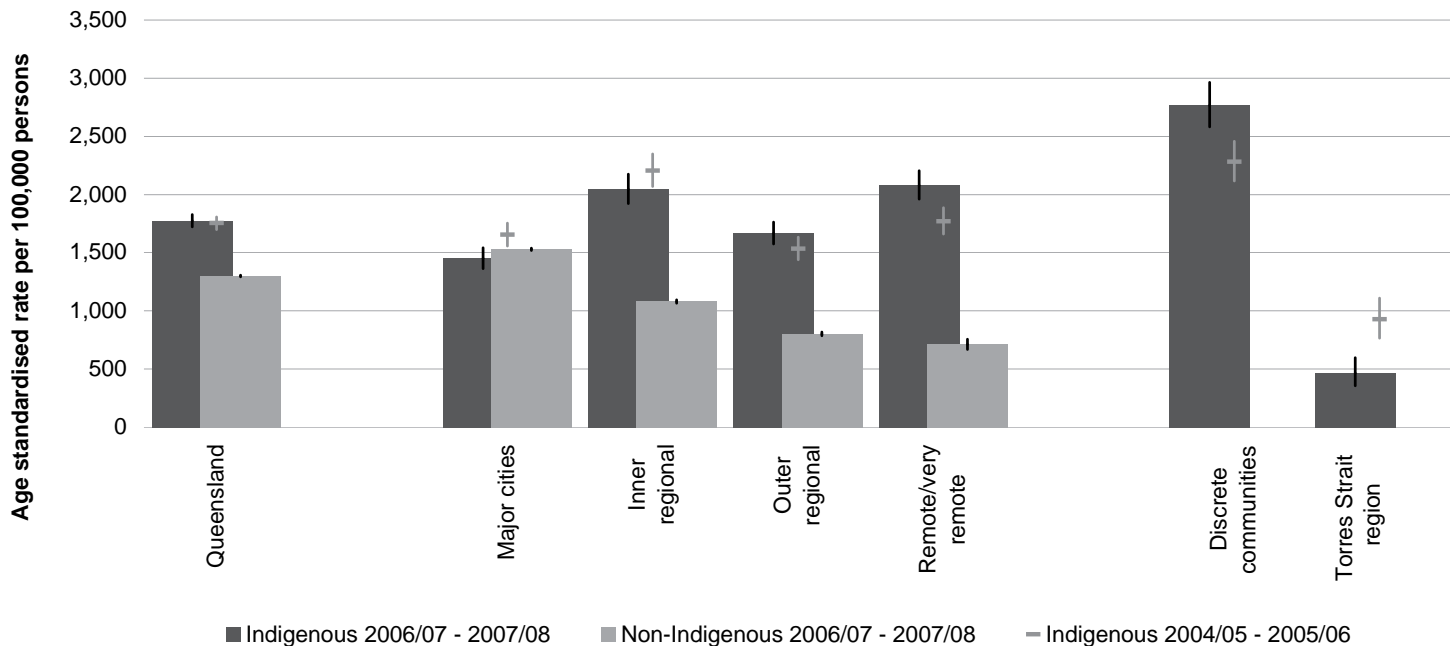
Hospital, The Park, Mosman Hall Hospital) are excluded from these data.

Over the two year period 2006/07–2007/08, Aboriginal and Torres Strait Islander peoples were hospitalised for mental and behavioural disorders:<sup>50</sup>

- at a significantly higher rate than non-Indigenous people (1,774 per 100,000 compared with 1,300 per 100,000 persons - see Figure 6 and Table A8)
- at a significantly higher rate in remote/very remote areas (2,079 per 100,000 persons) than in major cities.<sup>51</sup>

Between 2004/05–2005/06 and 2006/07–2007/08, rates decreased significantly in major cities (from 1,654 to 1,451

**Figure 6. Hospitalisations for mental and behavioural disorders for all patients, age standardised rate, Queensland, 2004/05 - 2005/06 and 2006/07 - 2007/08.**



This graph compares the rate at which Queensland residents were hospitalised for mental and behavioural disorders in two time periods for a range of geographic regions within Queensland. The earlier time period, the two years 2004/05-2005/06 is represented by a floating line for Aboriginal and Torres Strait Islander peoples and is compared with the two years 2006/07-2007/08, represented by a solid bar. Source: Queensland Hospitals Admitted Patient Data Collection. Notes: (1) Data are presented in two-year groupings because of small numbers each year. These groupings represent two financial years. (2) Non-Indigenous data include separations where the Indigenous status is not stated. (3) These data exclude unqualified newborns, boarders, organ procurements, dialysis patients and patients admitted to dedicated psychiatric hospitals. (4) Confidence limits are used to aid analysis in this graph. Please refer to Appendix 1 for further information on how to read these graphs.

50 Source: Queensland Hospitals Admitted Patient Data Collection.

51 Rates reflect patients' places of residence, not the location of the health care facility.



per 100,000 persons) and the Torres Strait region (from 926 to 465 per 100,000 persons) and increased significantly in remote/very remote areas (from 1,770 to 2,079 per 100,000 persons) and the discrete communities (from 2,283 to 2,768 per 100,000 persons).

See Table A8 for hospitalisation rates by principal diagnosis for all persons (Indigenous and other) in Queensland over the period 2006/07–2007/08.

## Access to health care

### Participation in voluntary annual health checks

Voluntary health assessments and checks are Medicare Benefit Schedule (MBS) items that allow General Practitioners to undertake comprehensive examinations of patient health, including physical, psychological and social functioning. They are available for older Australians as well as for Aboriginal and Torres Strait Islander peoples of all ages, as the prevalence of preventable and/or treatable conditions is high in both population groups.<sup>52</sup>

- The estimated proportion of Aboriginal and Torres Strait Islander persons aged 55 years or over receiving an annual health check more than doubled over the four years 2003/04–2007/08 (from 4.4 per cent in 2003/04 to 12.3 per cent in 2007/08), suggesting that access to early detection and treatment services for Aboriginal and Torres Strait Islander peoples is improving.
- In 2007/08, Aboriginal and Torres Strait Islander older persons were half as likely to have received an annual health check as older non-Indigenous persons (12.3 per cent compared with 24.4 per cent). This suggests that access to early detection and early treatment services may not be equitable for this group.

<sup>52</sup> Steering Committee for the Review of Government Service Provision (SCRGSP), 2009. *Report on Government Services 2009, Indigenous Compendium*, Productivity Commission, Canberra.

Health check items were introduced to MBS for Aboriginal and Torres Strait Islander peoples aged 15-54 years in May 2004, and Aboriginal and Torres Strait Islander children aged 0-14 years in May 2006. Health checks are available annually for children aged 0-14 years and biennially for 15-54 year olds.

- In 2007/08, only 6.3 per cent of Aboriginal and Torres Strait Islander children aged 0-14 years received an annual health assessment with 3,341 assessments undertaken. In contrast, for 15-54 year olds, there were 8,569 annual assessments undertaken in 2007/08 (10.8 per cent).<sup>53</sup>

### Participation rates in breast screening by BreastScreen Australia

Aboriginal and Torres Strait Islander women aged 40 years and over participated in breast screening at slightly lower rates than all Queensland women. Between 36.4 per cent and 39.8 per cent of Aboriginal and Torres Strait Islander women accessed the service over the years 2002–2007, compared with 41.6 to 42.4 per cent of all Queensland women.<sup>54</sup>

### Proportion of persons accessing health care by type of service

The National Aboriginal and Torres Strait Islander Health Survey<sup>55</sup> shows that in 2004/05:

- Aboriginal and Torres Strait Islander Queenslanders aged 15 years and over were more likely to report that they had been admitted to hospital in the last 12 months (20 per cent) than non-Indigenous Queenslanders of the same age (16 per cent)
- a higher proportion of Aboriginal and Torres Strait Islander Queenslanders reported visiting other health professionals (21 per cent) compared with non-Indigenous

<sup>53</sup> This may in part reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items.

<sup>54</sup> Please note that these rates have been age standardised.

<sup>55</sup> Australian Bureau of Statistics, 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004–05*, cat. no. 4715.3.55.005, ABS, Canberra.

Queenslanders (15 per cent) over the two week period prior to the survey<sup>56</sup>

- General Practitioners and/or specialist doctors were the most consulted medical professional by both Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders (25 per cent and 24 per cent respectively)
- there was little difference in the proportion of Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders who consulted with dentists (around five per cent for both).<sup>57</sup>

## Proportion of persons who needed to but did not access health care

The National Aboriginal and Torres Strait Islander Health Survey<sup>58</sup> shows that, in 2004/05, the proportion of Aboriginal and Torres Strait Islander Queenslanders surveyed who did not seek medical treatment when it was needed were as follows:

- 20 per cent required dental treatment but did not visit a dentist
- 15 per cent did not consult a doctor when required
- nine per cent needed to go to other health professionals but did not
- seven per cent needed to go to the hospital but did not.

Some of the most common reasons that Aboriginal and Torres Strait Islander Queenslanders cited for not seeking medical treatment were too busy, the cost, the waiting time was too long or the medical professional was not available at the time required.

56 Other health professionals includes Aboriginal Health Worker, Nurse, Chemist and Allied Health professionals.

57 Note: These rates have been age standardised.

58 Australian Bureau of Statistics, 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, cat. no. 4715.3.55.005, ABS, Canberra.

## Discharge against medical advice

Patients who discharge against medical advice (self-discharge) are at greater risk of increased patient morbidity and readmission to hospital.<sup>59</sup>

Over the period 2003/04–2007/08:<sup>60</sup>

- Aboriginal and Torres Strait Islander patients were around three times more likely to self-discharge than non-Indigenous patients (see Table A9)
- males were more likely to self-discharge than females, and both Aboriginal and Torres Strait Islander and non-Indigenous patients with a psychiatric principal diagnosis were approximately three times more likely to self-discharge than patients with other conditions.<sup>61</sup>

## Risk factors

### Smoking - persons aged 18 years and over smoking daily

Tobacco use is a major cause of premature mortality and morbidity within the Australian population. Smoking substantially increases the risk of cardiovascular disease, stroke, respiratory disease and lung cancer.<sup>62</sup> Tobacco use is the leading risk factor contributing to disease and death among the Aboriginal and Torres Strait Islander population.<sup>63</sup>

According to the National Aboriginal and Torres Strait Islander Health Survey, in 2004/05:

- approximately 50 per cent of the Aboriginal and Torres Strait Islander population surveyed in Queensland were current daily smokers, that is, people who smoked one or more cigarettes per day on average

59 Franks, P., Meldrum, S. and Fiscella, K., 2006, Discharge against medical advice: Are race/ethnicity predictors? *Journal of General Internal Medicine*, vol. 29, no. 9. pp. 955-960.

60 Source: Queensland Hospital Admitted Patient Data Collection.

61 These data were sourced from the Queensland Health publication *Are Indigenous admitted patients more likely to discharge against medical advice than non-Indigenous patients?* McGill, K. and Kennedy, B. February 2009, <http://www.health.qld.gov.au/hic/statbite/statbite11.pdf>, accessed on 8 October 2009.

62 Baade, P., 2000. *Smoking prevalence and the contribution of cigarette smoking to mortality and morbidity in Queensland*, Queensland Health.

63 Vos, T., Barker, B., Stanley, L. and Lopez, A.D., 2007, *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003*, School of Population Health, the University of Queensland, Brisbane.



- Aboriginal and Torres Strait Islander Queenslanders were around twice as likely to be current daily smokers compared with non-Indigenous Queenslanders
- the age group that reported the highest prevalence of current daily smokers was the 35-44 years age bracket for Aboriginal and Torres Strait Islander Queenslanders (59 per cent) and 25-34 years for non-Indigenous Queenslanders (32 per cent)
- Aboriginal and Torres Strait Islander Queenslanders living in remote areas were also more likely to be current daily smokers than non-Indigenous Queenslanders living in non-remote areas (56 per cent for males and 57 per cent for females, compared with 51 per cent for males and 46 per cent for females).

The National Aboriginal and Torres Strait Islander Social Survey<sup>64</sup> shows that between 2002 and 2008 the age standardised rate of Aboriginal and Torres Strait Islander peoples who were current smokers (aged 15 years and over) decreased slightly from 46.0 per cent to 42.3 per cent. The rate for non-Indigenous people decreased as well from 23.7 per cent to 22.4 per cent.

According to the *Overcoming Indigenous Disadvantage: Key Indicators 2009* report, in 2006/07, the hospitalisation rate of Aboriginal and Torres Strait Islander Queenslanders for illnesses related to tobacco use (1.6 hospitalisations per 1,000 persons) was over three times that of non-Indigenous Queenslanders (0.5 hospitalisations per 1,000 persons).<sup>65</sup>

#### **Alcohol - proportion of persons aged 18 years and over drinking at risky or high risk levels**

Alcohol misuse is a key public health and social concern across Queensland. Alcohol is responsible for a considerable burden of death, disease and injury in Australia. Alcohol-related harm to health is not limited to drinkers but also affects families and the broader community.

64 Australian Bureau of Statistics, 2009, *National Aboriginal and Torres Strait Islander Social Survey, 2008*, cat no. 4714.0, ABS, Canberra.

65 Steering Committee for the Review of Government Service Provision (SCRGSP), 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra.

The National Aboriginal and Torres Strait Islander Health Survey<sup>66</sup> reports that, in 2004/05:

- approximately 51 per cent of Aboriginal and Torres Strait Islander Queenslanders surveyed drank at short-term risky/high risk levels in the 12 months prior to the survey, and 16 per cent reported drinking at these levels at least once a week. Comparatively, 42 per cent of non-Indigenous Queenslanders drank at short-term risky/high risk levels in the 12 months prior to the survey, with nine per cent reporting drinking at this level at least once a week
- long-term risky/high risk drinking was reported by 18 per cent of Aboriginal and Torres Strait Islander Queenslanders compared with 14 per cent of non-Indigenous Queenslanders
- Aboriginal and Torres Strait Islander Queenslanders were also reported as more likely to have abstained from alcohol consumption over the last 12 months (28 per cent) compared with non-Indigenous Queenslanders (13 per cent).

According to the *Overcoming Indigenous Disadvantage: Key Indicators 2009* report, between 2003 and 2007, Aboriginal and Torres Strait Islander deaths related to alcohol were six times higher (30.5 deaths per 100,000) than non-Indigenous alcohol-related deaths (4.7 deaths per 100,000).<sup>67</sup>

#### **Obesity - proportion of persons aged 15 years and over considered overweight or obese**

When an individual exceeds their recommended healthy weight range (calculated using the Body Mass Index) there is an increased risk of chronic disease. For adults, the health problems and consequences of being overweight or obese include musculo-skeletal problems, cardiovascular disease, some cancers, sleep apnoea, Type 2 diabetes and hypertension.<sup>68</sup> Many of these health problems are preventable through a healthy and active lifestyle.

66 Australian Bureau of Statistics, 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, cat. no. 4715.3.55.005, ABS, Canberra.

67 Steering Committee for the Review of Government Service Provision (SCRGSP), 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra.

68 Department of Health and Ageing, 2009, Factsheet: *Chronic disease and its impact on Australia*. [www.health.gov.au](http://www.health.gov.au).

The National Aboriginal and Torres Strait Islander Health Survey<sup>69</sup> found that, in 2004/05:

- after adjusting for difference in population age structure, a similar proportion of Aboriginal and Torres Strait Islander Queenslanders surveyed (31 per cent) were overweight compared with the non-Indigenous Queensland population (34 per cent). However, almost double the proportion of Aboriginal and Torres Strait Islander persons were reported as obese (34 per cent) compared with the non-Indigenous Queensland population (18 per cent)
- the age group that was most likely to be overweight or obese was the 55 years and over age bracket for Aboriginal and Torres Strait Islander Queenslanders (76 per cent) and 45-54 years for non-Indigenous Queenslanders (60 per cent).

Additionally, Queensland Health research shows that in 2008, Aboriginal and Torres Strait Islander women who gave birth were more likely to be obese (45.8 per cent) than non-Indigenous women (36 per cent).<sup>70</sup>

### **Exercise - proportion of persons aged 15 years and over with sedentary/low level exercise**

A lack of regular exercise has been shown to increase the risk of developing health conditions such as obesity, diabetes and heart disease.<sup>71</sup>

The National Aboriginal and Torres Strait Islander Health Survey<sup>72</sup> found that, in 2004/05:

- approximately 51 per cent of Aboriginal and Torres Strait Islander Queenslanders surveyed aged 15 years and over in non-remote areas reported their exercise level as sedentary in the two weeks prior to the survey, and 27 per cent reported their level of exercise as low. In comparison, 35 per cent of non-Indigenous Queenslanders reported their exercise level as sedentary, with a further 34 per cent reporting it as low

69 Australian Bureau of Statistics, 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, cat. no. 4715.3.55.005, ABS, Canberra.

70 Watson, M., & Howell, S., 2008. *Characteristics of overweight and obese mothers in Queensland, 2008*, Health Statistics Centre, Queensland Health.

71 Department of Health and Ageing, 2009, *Factsheet: Chronic disease and its impact on Australia*, www.health.gov.au.

72 Australian Bureau of Statistics, 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, cat. no. 4715.3.55.005, ABS, Canberra.

- both Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders were generally more likely to report their exercise level as sedentary with increasing age.

## Key Queensland Government actions to close the gap

### **Initiatives to tackle existing illness**

The Queensland Government has delivered a range of programs and services to enhance the treatment and management of the disease groups that most contribute to the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders. These include:

- the enhancement of **renal services**, including training for Indigenous Health Workers and nurses to upskill or specialise in chronic kidney disease
- the provision of **Indigenous cardiac outreach services** across 16 sites in Central and Western Queensland
- funding a range of mental health and suicide prevention programs such as:
  - › the **Creative Arts Recovery Project**, which is a community-based arts initiative for people with mental health problems living in remote Cape York communities
  - › **Resilience Plus** (Department of Psychiatry, the University of Queensland), which is a resilience-building school-based program delivered in Mount Isa and Brisbane
  - › **Gallang Place**, which conducts activities to reduce the incidence of suicide and self-harm by Aboriginal and Torres Strait Islander young people in Brisbane



- › the **Trainee Community Counsellors Project** (Royal Flying Doctor Service), which trains young people in remote Cape York communities to develop youth suicide prevention strategies
  - › **Indigenous Communities Suicide Prevention Project**, under which ‘community suicide prevention response plans’ are being developed for Aurukun, Mornington Island, Doomadgee, Mount Isa, St George and Cunnamulla
  - › the **Life Promotion Program** in the Indigenous communities of Hope Vale, Wujal Wujal and Yarrabah
  - › the **Transition from Correctional Facilities** program, which provides non-clinical support to people with a mental illness transitioning from correctional facilities into the community.
- \$18 million over four years in **child and maternal health services** in Cape York, including the popular Baby Basket initiative
  - enhancement of the **sexual health** workforce to fill service gaps, sexual health education and Polymerase Chain Reaction (PCR) testing (a test for sexually transmitted infections)
  - the **SmokeCheck Program** which provides specialist training and brief intervention resources to health workers with Aboriginal and Torres Strait Islander clients. In 2008/09, 205 health workers were trained to undertake the SmokeCheck Program
  - the **Events Support Program** which provides small grants for initiatives that will raise awareness of the health effects of smoking

### Initiatives to target risk factors

The Queensland Government has funded in 2008/09 several Indigenous-specific health initiatives to target the leading risk factors that contribute to the health gap. These include:

- \$36 million over a four year period to provide more alcohol treatment and counselling services in or near 21 Indigenous communities. Services will be provided by up to 63 extra staff including nurses, allied health staff and local Indigenous Community Support Workers to provide an integrated clinical and therapeutic pathway from hospital back to the community. Local services will be further supported by 10 alcohol withdrawal services (detox units) in the following locations: Cherbourg, Woorabinda, Townsville, Mornington Island, Doomadgee, Normanton, Mossman, Weipa, Cooktown and Bamaga
  - the **Queensland Indigenous Alcohol Diversion Program** under which 153 Aboriginal and Torres Strait Islander Queenslanders were formally accepted into treatment in 2008/09, with 70 people successfully completing the program
- › a range of **sport and recreation programs** such as:
    - › the **Community Activities Program through Education** (operated by the Police Citizen’s Youth Club) provides sport and recreation services to promote healthier lifestyles and reduce the incidence of anti-social behaviour in several remote Indigenous communities. In 2008/09, there were 12 sport and recreation officers employed to run programs in Aurukun, the Northern Peninsula Area and Woorabinda
    - › \$2.12 million per annum over three years (from 1 January 2009) to employ 34.5 **Indigenous Community Sport and Recreation Officers** in remote, rural and urban Indigenous communities (there are currently 30.5 officers employed)
    - › over \$420,000, under the **Local Sport and Recreation Program**, to enhance sporting opportunities in Doomadgee, Kowanyama, Palm Island and Yarrabah.

## Health-related support services

The Queensland Government has funded initiatives to assist Aboriginal and Torres Strait Islander peoples to access health-related support services. These include:

- providing \$6.1 million in 2008/09 for the **Local Area Coordinators program** to enable 1,180 people to access support and 760 people to access information and referral services. Approximately 23 per cent of people registered with the program identified themselves as Aboriginal and/or Torres Strait Islander
- the **Evolve Interagency Service** which provides intensive behaviour support intervention for children and young people with a disability and challenging behaviours who are in the care of Child Safety. In 2008/09, 56 children and young people who received an Evolve Behaviour Support Service were from Aboriginal and/or Torres Strait Islander backgrounds
- the delivery of targeted **Home and Community Care (HACC) services** to Aboriginal and Torres Strait Islander peoples across Queensland. During 2008/09, 4,020 Aboriginal and Torres Strait Islander clients accessed HACC services
- providing over \$2.5 million to operate **ambulance stations** servicing Indigenous communities, as well as to operate field offices and support first responder groups.