Technical Refinement of the National Performance Indicators for Aboriginal and Torres Strait Islander Health

Report of a project by the Cooperative Research Centre for Aboriginal and Tropical Health for the Australian Institute of Health and Welfare

PO Box 41096
Casuarina, NT 0811

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TABLE OF CONTENTS

LIST OF FIGURES

EXECUTIVE SUMMARY

The task was to refine the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health in order to produce a set of well-defined indicators and detailed reporting procedures that would improve consistency, quality and ability to report. In addition, a set of indicators related to mental health and social and emotional wellbeing were to be proposed together with a method for trialing these.

A Reference Group, chaired by AIHW and consisting of representatives from OATSIH, HAHU, NHIMG and NACCHO was convened to advise the project team. The result of this brief is the current project report and an accompanying document containing the refined technical specifications for the existing and new indicators.

The project commenced in January 2000, with a paper-based review of the interim indicators. This was followed by a comprehensive national round of consultations to establish stakeholder views and to gather advice regarding refinement of the indicators. In this consultation, State and Territory health department staff, both technical and policy, were interviewed about the interim indicator set. The consultation also included meetings with peak State and Territory affiliate organisations of NACCHO, and other bodies such as the ABS and AIHW, and some regional areas of jurisdictional health departments, such as the Torres Strait District.

The refinement process was guided by recognition that the purpose of the indicators was to provide high-level information about changes pertinent to health. The indicators were not intended to provide a complete statistical description of health status. A particular focus during the refinement was to align, where appropriate, the definitions of the indicators with those of other indicator sets being used in Australia.

The indicator set has been conceived with a broad interpretation of the terms ‘performance’ and ‘indicator’. This broad interpretation has been derived through extensive consultation with Aboriginal and Torres Strait Islander communities, government agencies responsible for Aboriginal and Torres Strait Islander health, and agencies responsible for health information management.

In addition, a framework to help enhance understanding of the indicators was also drafted. The framework guides the user through the relatively large number of separate indicators and clarify the relevance of each indicator. It also identifies areas considered to be immediately modifiable such as resources through to the longer-term indicators such as health status.

The terms of reference called for the development of a set of indicators for mental health. Clear direction was received from almost all sources that the term “mental health” be replaced

by the broader term “social and emotional well being” in order to reflect more comprehensively the combination of the concepts of social justice and mental health. The Reference Group subsequently agreed that the mental health indicators should be renamed “indicators of social and emotional wellbeing”. A group of experts in the area was identified to advise on the development of these indicators. These indicators will be trialed over two periods of reporting.

The final Reference Group meeting was held on 8th September 2000. At this time the draft technical specifications and project report were approved, with minor emendations. The report was finalised on 15th September 2000 and handed to AIHW on that date in time for inclusion in the papers for the October 2000 meeting of AHMAC.

Reporting will now be shared across several jurisdictions and agencies. In particular, agencies who manage certain datasets have been ‘allocated’ indicators to calculate and distribute to the jurisdictions to use when preparing their annual reports. This will enhance the comparability of the data. As a result of this approach, the technical specifications document is arranged according to the agency that calculates the indicator. However, while this approach assists the preparation of the indicators it would not be a logical structure to use to present the indicators in the jurisdictional reports. Hence the indicators are numbered according to their relationship to the conceptual framework and we recommend that this ordering should be used in the jurisdictional reports.

Private health facilities and services and Aboriginal Community Controlled organisations are not required to report on indicators.

Reporting will be strengthened through ongoing improvements in the identification of Aboriginal and Torres Strait Islander people in various databases. However, in the interim, the variable and changing levels of identification mean that between-jurisdictional or across-time comparisons of the health status of Aboriginal and Torres Strait Islander people must be made with great caution. Some of the changes needed to make some indicators reportable have large cost and/or policy implications. Some indicators are only reportable if there is an ongoing commitment to national surveys of the Aboriginal and Torres Strait Islander people and if these survey continue to contain appropriate questions.

After this refinement, there are 56 separately defined indicators and this includes the proposed new indicators of social and emotional wellbeing. Some of the previous indicators are no longer necessary owing to other developments since the interim set were developed while others have been amalgamated. It is anticipated that ongoing developments in both the areas of Aboriginal and Torres Strait Islander health and the field of indicators would mean that further revisions will be necessary in the future. In particular, the social and emotional wellbeing indicators should be reviewed after two periods of reporting.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
AHMAC	Australian Health Ministers’ Advisory Council
AHMC	Australian Health Ministers’ Conference
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ATSI	Aboriginal and Torres Strait Islander
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIWHIU	Aboriginal and Torres Strait Islander World Health Indicator Unit
CRCATH	Cooperative Research Centre for Aboriginal and Tropical Health
CHINS	Community Housing and Infrastructure Needs Survey
DHAC	Department of Health and Aged Care
FTE	Full Time Equivalent
GP	General Practitioner
GSS	General Social Survey
HAHU	Heads of Aboriginal Health Units
ICD	International Classification of Disease
NACCHO	National Aboriginal Community Controlled Health Organisations
NATSIS	National Aboriginal and Torres Strait Islander Survey
NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NHPC	National Health Performance Committee
NHS	National Health Survey
NPHIWG	National Public Health Information Working Group
NPHP	National Public Health Partnership
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
Qld	Queensland
SA	South Australia
SMR	Standardised Mortality Ratio
Tas	Tasmania
Vic	Victoria
WA	Western Australia

1. INTRODUCTION

1.1 Background to the refinement process

In its February 1996 meeting, the Australian Health Ministers’ Advisory Council (AHMAC), (which consists of heads of Commonwealth, State and Territory health departments, and the Director of the Australian Institute of Health and Welfare) directed the Health Departments’ Heads of Aboriginal Health Units (HAHU) to develop a set of National Performance Indicators for Aboriginal and Torres Strait Islander Health. These indicators were intended for governments to use in monitoring and reporting on efforts towards improving Aboriginal and Torres Strait Islander health.

Draft indicators were developed by Aboriginal Health Units with advice from technical experts, following a series of meetings and discussions about the range of issues to be covered by the indicators. Many indicators were incomplete or imperfect because of uncertainties in definition or the lack of availability of adequate data for reporting. Further refinement of the indicators was undertaken in consultation with a wider group, including the National Health and Medical Research Council (NHMRC) and the National Aboriginal Community Controlled Health Organisation (NACCHO).

Goals and targets for some aspects of Aboriginal health had previously been drafted through an NHMRC sponsored process. Where possible, some of these (or similar targets) were attached to appropriate indicators. Subsequently the updated National Performance Indicators for Aboriginal and Torres Strait Islander Health (some of which were linked with targets) were distributed widely. The distribution list included the Aboriginal community controlled health sector and public health agencies. Each jurisdiction consulted with its own constituents as appropriate.

In February 1997, a two-day meeting was held in Perth to canvass the views of a broader range of stakeholders and experts. Participants in this meeting included Commonwealth, State and Territory health authorities, ATSIC, NACCHO, NHMRC, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs, ABS and the Australian Institute of Health and Welfare (AIHW).

Participants agreed that, despite the need for further refinement and consultation within jurisdictions and agencies, the indicators should be taken forward. Most recognised that the National Performance Indicators for Aboriginal and Torres Strait Islander Health could have a dual purpose: they would both enable a national picture of progress to be compiled, and allow each jurisdiction to assess its own performance. Information for reporting against National Performance Indicators for Aboriginal and Torres Strait Islander Health would come from Health Departments’ own data collections as well as national agencies such as ABS, AIHW and the Australian Childhood Immunisation Register (ACIR).

The National Performance Indicators for Aboriginal and Torres Strait Islander Health, with selected targets, were considered by the Australian Health Ministers' Council (AHMC). AHMC members agreed that jurisdictions should report annually against the indicators and targets to AHMC, and that where data were inadequate, jurisdictions should report on their progress in developing the capacity to report. They further agreed that additional refinement and consultation should be undertaken.

In 1997 Health Departments made their first attempt at reporting against the 58 indicators. The reporting process, while helpful to some jurisdictions, confirmed the need for further refinement. It also highlighted the almost complete absence of data for some indicators, and the variability in data availability and quality from jurisdiction to jurisdiction for other indicators.

In 1998, after some refinement of the indicators, jurisdictions were requested to provide their second annual reports, using a reporting template developed to improve data comparability among jurisdictions. Most jurisdictions used this template for their 1998 reports. Reporting improved, but the problems identified in preparing the 1997 reports persisted: uncertainty about indicator definitions, variable availability or lack of data, and lack of comparability of data among jurisdictions. At the time of commencement of this project, the 1999 reports had not been issued. However, it was not anticipated that reporting template will address the fundamental problems of inadequate indicator definitions and lack of information. The need for a further technical refinement was recognised by all parties.

In March 1998, AHMAC asked the Commonwealth to coordinate a further refinement of the indicators. The Office of Aboriginal and Torres Strait Islander Health (OATSIH) of DHAC requested AIHW to manage this refinement process. AIHW commissioned the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) to undertake the technical refinement project and report to AIHW by September 2000.

Mental health indicators were not included in the original interim set of National Performance Indicators for Aboriginal and Torres Strait Islander Health. The development of a set of mental health indicators was therefore included in the terms of reference of the technical refinement project. Subsequently (as described in section 2.2 below) it was determined that these indicators should reflect the broader concept of social and economic wellbeing, rather than the more circumscribed mental health focus which had traditionally been pursued in the development of national health priorities.

1.2 Aim of the Project

The purpose of this project was to refine an existing interim set of National Performance Indicators for Aboriginal and Torres Strait Islander Health, and to develop new indicators for mental health, for the year 2000 and beyond. The refinement process was intended to concentrate on technical aspects of the indicators.

1.3 Management of the Project

The AIHW sponsored the technical refinement project on behalf of OATSIH. The CRCATH was contracted by AIHW to undertake this project.

The contract was awarded in December 1999, with a specified completion date of September 2000. The timetable was devised to enable information to be presented for discussion at the October 2000 AHMAC meeting.

1.4 Terms of reference

The terms of reference for the project were as follows.

"To report to the Australian Institute of Health and Welfare (AIHW), with respect to the technical refinement of the interim set of National Performance Indicators for Aboriginal and Torres Strait Islander Health.

1. To undertake a technical refinement of the interim indicators taking into account their accuracy, validity, usefulness, timeliness, appropriateness and quality.
2. To develop a set of indicators for mental health and to propose a method of trialing these indicators.
3. To undertake a consultation program about the technical refinement work.
4. To identify additional issues or indicators identified by the project team in the process of the technical refinement of the indicators."

1.5 Reference Group

A reference group made up of nominees from relevant organisations was established by the AIHW to provide jurisdictional and technical expertise and direction to the CRCATH project team. The participants were:

Mr G Sims	(Chair) Australian Institute of Health and Welfare, (AIHW) (*until August 2000*)
Dr R Madden	(Chair) Australian Institute of Health and Welfare, (AIHW) (*from September 2000*)
Dr S Couzos	National Aboriginal Community Controlled Health Organisation, (NACCHO) (*until August 2000)*
Mr G Brice	National Aboriginal Community Controlled Health Organisations, (NACCHO) (*from August 2000)*
Dr J Daniels	National Aboriginal Community Controlled Health Organisation, (NACCHO)

Mr S Houston	Representing Heads of Aboriginal Health Units (HAHU) of jurisdictional Health Departments
Ms P Lowrey	Office of Aboriginal and Torres Strait Islander Health (OATSIH)
Prof I Ring	National Health Information Management Group (NHIMG)
Ms J Streatfield	Office of Aboriginal and Torres Strait Islander Health (OATSIH) - alternate for Ms P Lowrey

Ms T Burke from AIHW provided Secretariat support

The Reference Group met by teleconference four times during the project and also discussed various matters by e-mail. At the initial meeting (28th January 2000) the proposed work plan was discussed. Following this meeting, Reference Group approved by e-mail a proposed background briefing paper to be sent to consultees (Appendix 1).

At the second Reference Group meeting (2nd May), members discussed the results of the consultations, the paper that would be sent back to consultees about this (Appendix 2), and the approach to refining the existing indicators and developing the indicators of social and emotional wellbeing.

Between the second and third teleconferences, the project team and the Reference Group members had extensive e-mail interchange about the indicators. A preliminary set of refined indicators was compiled and discussed in the third teleconference held over two days on 28th June and 3rd July.

The draft technical specifications were sent out to the original consultation list for comment at the end of July 2000. The fourth teleconference was held on 8th September and which time both the technical specifications and project report were approved, subject to minor recommendations.

2. METHODS

There were a number of elements to this project that required a range of skills over the duration of the project. Professor Tony Barnes provided overall directions and Dr Dorothy Mackerras managed the project. People were recruited to the project with skills/expertise needed in each stage of the refinement process.

The project team consisted of:

Prof A Barnes	Director, CRCATH
Dr D Mackerras	Menzies School of Health Research
Ms L Clark	Consultant
A/Prof M Frommer	Deputy Director, Australian Centre for Effective Healthcare, University of Sydney
Ms P Gollow	Territory Health Services
Ms M Katona	Menzies School of Health Research
Ms D Morrison	Territory Health Services
Mr G Angeles	Menzies School of Health Research
Ms B Schmidt	Consultant
Mr R Chondur	seconded from DHAC
Ms T Dunbar	Business Manager, CRCATH.

Secretarial support was provided by Ms M Ahmat.

2.1 Review of indicator development and reporting

The first step in the refinement process was to review the original process used to develop the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health and the jurisdictional reports produced by the Commonwealth and States/Territory Health Departments. Variability in reporting between jurisdictions and difficulty in providing information to report were documented in detailed tables (sent out to consultees as part of the briefing papers, as described in Appendix 1). The review of reporting against the indicators by the States and Territories highlighted problems that required further investigations during the consultation and technical refinement stages.

Before the start of the national consultation, a meeting was held in Darwin with a broad cross-section of members of Territory Health Services, other participants in the CRCATH and ATSIWHIU to discuss the indicators and the project. This provided useful insights into the types of matters and questions that might arise during national consultations and also highlighted the need for the project team to consider the conceptual framework underpinning the indicator set.

2.2 Consultation process

In accordance with the terms of reference, a national consultation process was organised to gather information on refinement of existing indicators and related matters, and the development of mental health indicators. In December 1999, letters were sent to:

- the Chief Executive Officers of the Commonwealth, State and Territory Health Departments (copies were forwarded directly to the Heads of the Aboriginal Health Units and Epidemiology Units),
- all members of the NHIMG,
- NACCHO and each NACCHO affiliate,
- the Torres Strait and Northern Peninsula Area Health Council
- identified experts or organisations including ABS, AIHW, ATSIC, the Productivity Commission, and Dr R Murray, Medical Director of The Kimberley Aboriginal Medical Service.

Several others were added to this mailing list during the course of the project, including the WA Office of the Auditor General, the Combined Universities Centre for Rural Health in Geraldton, WA, and the Tropical Public Health Unit, Cairns, Qld.

The letters explained the project, and suggested a time for a consultation visit by the project team. Contact persons were nominated by each organisation, and an information package was sent to each consultation site prior to the visit. This package included a covering note describing the project, a suggested meeting outline, a brief history of the indicators, a summary of the problems identified in the 1997 and 1998 reports on the indicators from the jurisdictions, and questions about directions for refinement. A copy of this material is in Appendix 1.

The majority of the consultations took place in February and early March 2000. Appendix 3 contains a list of the people and organisations consulted. The team for the consultation visits consisted of two people: an experienced Aboriginal interviewer from the staff of the CRCATH or its core partners (Ms Katona, Ms Morrison, Mr Angeles, Ms Dunbar) and a person with a health statistics and epidemiology background (Dr Mackerras or Professor Barnes). The focus of discussions was on the reporting and use of the indicators and the difficulties encountered in the past. In general, stakeholders dealt with broad issues relating to the indicators, rather than detailed technical comment on each indicator.

A summary of the comments was compiled and sent back to consultees so that they had an additional opportunity to clarify comments (Appendix 2). A number of stakeholders were subsequently consulted again throughout the technical refinement.

2.3 Assessment and enhancement of indicator validity

The consultation visits provided very useful general comments about the National Performance Indicators for Aboriginal and Torres Strait Islander Health and helpful suggestions for overcoming reporting difficulties, but less information about the specific problems of individual indicators. The primary sources for identifying problems associated with reporting on the indicators were the jurisdictions' 1997 and 1998 reports. In addition, experts from amongst the CRCATH participants and other individuals in the field were consulted as required. A series of face-to-face meetings were held with local experts in Darwin to obtain specific comments about each indicator. For example, Danila Dilba Medical Service, the Top End Division of General Practice and the Flinders University Clinical School all provided perspectives on the concept of primary health care; paediatricians from the Territory Health Services (THS) were asked to comment on all the indicators relating to children; epidemiologists from THS and the ABS ATSIWHIU commented on various possible approaches to refining indicators related to routine statistics; and the heads of Staff Development, Health Promotion and other relevant units in the THS discussed indicators in their areas. This process helped to identify content-area experts and information sources that could contribute to the indicator refinement process. Contemporaneous projects which were being done under the auspices of AIHW and OATSIH, and which would impact or relate to the reporting on the National Performance Indicators for Aboriginal and Torres Strait Islander Health, were also identified.

A list of criteria was developed to guide the refinement process for each indicator (Appendix 4). These criteria were intended to ensure that the accuracy, validity, timeliness, usefulness, appropriateness and quality of data sources were considered as part of the refinement process. The criteria also helped to frame the strategic actions necessary to enable some indicators to be reported more completely or more easily, or in some cases, to be reported at all.

The advice of relevant experts was sought on individual indicators and groups as indicators as they were progressively refined. For example, the draft refined versions of the mortality and hospitalisation indicators were referred to the relevant sections of AIHW and the Epidemiology Branches of the State/Territory Health Departments, and the life expectancy indicator was referred to the Demography Section of the ABS in Canberra. This was done to ensure that the draft, refined set, which was sent out for comment by the jurisdictions and other stakeholders, would contain as few unexpected items as possible.

A draft of the refined indicators was circulated to the Reference Group in late June for discussion and comment. Based on the advice of the Reference Group, some further changes were made. A modified indicator set was then sent to Commonwealth, State and Territory Health Departments and organisations responsible for source information, such as AIHW and ABS, for a final technical check prior to wider circulation for comment

Where national data sets existed and were managed by national data-handling agencies (such as the AIHW, the ABS, and the ACIR), it was decided that indicator data should be compiled from the national data sets rather than from the jurisdictional data collections. The data compiled in this way would then be made available to States and Territories for reporting. Stakeholders agreed that this process, which was widely canvassed and supported, would enhance the efficiency, consistency and accuracy of reporting both by States and Territories and by the national data-handling agencies.

Late in July 2000, a paper describing the draft technical specifications of the indicator set was circulated widely among stakeholders and organisations that participated in the original consultations. Feedback was then incorporated into the indicator set where appropriate following discussions with the Reference Group.

2.4. The development of the indicators of social and emotional wellbeing

As described in sections 1.4 and 2.2 above, the terms of reference for the project called for the development of a set of mental health indicators. The mental health indicators were intended to generate and inform discourse, encourage a change in the thinking about mental health, reflect major strategies, and be linked with other information collections.

Stakeholders' perspectives and recommendations on indicators of mental health were initially gathered during the interviews conducted in each State and Territory, and were further sought during the consultation that was undertaken for the refinement project.

Clear direction was received from almost all sources that the term "mental health" be replaced by the broader term "social and emotional well being" in order to reflect more comprehensively the combination of the concepts of social justice and mental health the Reference Group subsequently agreed that the mental health indicators should be renamed "indicators of social and emotional wellbeing".

A comprehensive search was conducted of the Aboriginal mental health literature, and of current information and data collections that could guide the development of the indicators and serve as potential data sources for reporting on them. The following documents significantly influenced the development of the indicators: *Ways Forward*, commissioned by the AHMAC National Mental Health Working Group in 1995; the report of the National Indigenous Mental Health Data Workshop, held in 1996; and the Mental Health Promotion and Prevention National Action Plan 1999 (under the Second National Mental Health Plan: 1998-2003).

A framework that built on the literature and consultation was proposed. This aimed to incorporate aspects of social disadvantage, and articulate with the draft conceptual framework for the main indicator set (Figure 1). Indicators were initially designed to relate to the

National Health Priority Indicators for Mental Health, the objectives of the Mental Health Promotion and Prevention National Action Plan 1999 and the directions set out in *Ways Forward*.

Drafts of the framework and the technical specifications for the proposed indicators were distributed to the Reference Group, expert advisers in the Aboriginal and Torres Strait Islander mental health field, AIHW, ABS and NACCHO for comment. The responses reaffirmed the existence of a variety of perspectives, particularly in respect of the relationships between the domains of a broad social and emotional wellbeing framework. As with the consultations for the main set of indicators, few comments were received on the technical aspects of the indicators, such as methodological issues or recommended data sources. Respondents requested indicators on the following topics, among others: family violence, child welfare, community capacity, community grief, effective partnerships, targeted resources, suicide, and psychotic illness.

Following this consultation process, the re-shaping of the indicators continued. The recommended set is described in section 5.2.

During the development of the indicators, selected individuals from Commonwealth, State and Territory Governments, AIHW, ABS, NACCHO, and others with expertise in the fields of social and emotional wellbeing and mental health in Aboriginal and Torres Strait Islander peoples were regularly contacted. These individuals formed a “virtual” expert group. They people provided ideas and concepts for inclusion in the indicator set, and made recommendations on priorities for reporting. The “virtual” expert group communicated with the project team mainly via e-mail.

3. DEVELOPMENT OF CONCEPTUAL FRAMEWORK

The primary purpose of reporting on the indicators is to keep Australian governments and the community informed about progress towards improving key aspects of Aboriginal and Torres Strait Islander health.

Thus the indicators will stimulate evidence-based discussion and informed government decision-making, and encourage action to address this most important Australian social issue.

3.1 Specific Objectives

The overall purpose of the indicators, as understood by stakeholders, can be expressed as four specific objectives, which are broader than for most government service-delivery departments' performance indicator sets. In keeping with the requirement to refine rather than refocus the indicators, this project has accepted these objectives as given. They are as follows.

1. To inform discussion and decision-making within Australian governments and Health Departments
2. Through interstate comparisons, provide a bench marking process for encouraging improvement in government services and actions
3. To provide a catalyst for reframing and focusing discussion on the major causes of poor health status (and changes in the underlying causes) of Aboriginal and Torres Strait Islander people.
4. Through the ongoing reporting process, provide a lever to improve the quality of data about Aboriginal and Torres Strait Islander health.

3.2 The intent of the indicators

The indicators have been constructed or selected to provide specific information on such basic topics as:

1. How well Australian health care systems provide for the needs of Aboriginal and Torres Strait Islander people
2. How healthy are Australian Aboriginal and Torres Strait Islander populations.

Information provided in reports on the indicators should galvanise action by people in decision-making positions. The indicators must therefore be reportable and interpretable, and be readily understood by such people. Over time, indicator data should reflect the results of action taken.

3.3 Performance Measurement

During the last decade there has been a worldwide interest in the definition and use of indicators for monitoring and reporting on performance in health. The development of performance measurement in relation to Aboriginal and Torres Strait Islander health has been a specific area of interest in Australia. The National Aboriginal Health Strategy (NAHSWP, 1989), which recognised the need for effective monitoring and evaluation of Aboriginal health, was an important stimulus. Developmental work on national benchmarking and accountability for Aboriginal and Torres Strait Islander Australians commenced under the Council of Australian Governments (1992).

The WHO has made recommendations on the structure of national indicator sets. Its recommendations highlight resource allocation as the most meaningful measure of genuine policy commitment, and emphasise that national indicator sets must not merely restate data on the excess of death and disease without providing information on corrective action taken. These recommendations have important implications for the indicator refinement project.

A performance indicator may be defined as “a statistic or other unit of information which reflects, directly or indirectly, the extent to which an anticipated outcome is achieved, or the quality of processes leading to that outcome” (NHIMG).

A performance indicator may signal sentinel information, analogous to a warning light on the dashboard of a car, which draws attention to a potential problem needing investigation. The light does not supply all the information required to solve the problem - it simply flags the existence of the potential problem. With this analogy, it is clear that some of the items in the National Performance Indicators for Aboriginal and Torres Strait Islander Health are not ‘warning lights’, but rather provide quite detailed information. Some reflect process or aspects of health status that cannot be directly or indirectly attributed to health system or other aspects of jurisdictional government performance. The function of such indicators may evolve over time. Indeed it would be preferable to rename the indicator set as either “National Indicators” or “National Performance and Other Indicators”.

There are several different types of indicator sets in Australia at present. It is useful to consider how they should relate to each other. Some indicator sets reflect specific programs (e.g. breast screening), services (e.g. vaccination), or disease occurrence. Others, such as the National Performance Indicators for Aboriginal and Torres Strait Islander Health, try to summarise a number of content-specific sets to provide information at a more general level. Many of the indicators in the Aboriginal and Torres Strait Islander set provide information on progress in reducing inequalities in areas ranging from health status to health services. Adverse changes seen in indicators in summary sets draw attention to areas where more intense scrutiny is required. Such scrutiny relies on examining more detailed content-specific indicators and the use of other information.

The set of National Performance Indicators for Aboriginal and Torres Strait Islander Health includes:-

1. Measures of Health Department performance
2. Measures broader government service accountability
3. Measures the state of health of population groups, and
4. Measures of key health determinants, including risk factors.

In contrast, other indicator sets tend to contain fewer indicators, and are often more specific in their purpose (for example, they may be formulated specifically as indicators of discrete aspects of the performance of some clearly-defined entity such as a government department. They generally include only reportable indicators.

Thus, for instance, the indicators developed by the Productivity Commission include a comparatively small set of health indicators which have very clearly defined and articulated objectives (although in practice the data available for reporting may not always meet the objectives). The indicators are designed to provide information on Health Department performance only, and only reportable indicators are included. The Productivity Commission annual report is compiled by Commission staff from available data. It is not compiled from reports sent in by the jurisdictions.

There is debate on whether a set of National Performance Indicators for Aboriginal and Torres Strait Islander Health should include indicators that are not in the purview of health departments but reflect important determinants of health, such as indicators of poverty, education or housing. It remains unclear whether the indicators should indicate the performance of governments as a whole, or only the performance of the health departments. Many of the National Performance Indicators for Aboriginal and Torres Strait Islander Health reflect non-health sector initiatives and outcomes which are linked to health, but would not traditionally be included as health system indicators (again, poverty and housing are examples).

3.4 Coverage of the indicator set

These so-called ‘National Performance Indicators for Aboriginal and Torres Strait Islander Health’ comprise a heterogeneous set of variables which describe population and community health status, life expectancy and death rates, the incidence and prevalence of selected illnesses, social and economic well-being, factors pertaining to the organisation and delivery of health services, and social factors which affect the health of communities.

Collectively the ‘National Performance Indicators for Aboriginal and Torres Strait Islander Health’ provide a remarkable multi-dimensional overview of the health of Aboriginal and Torres Strait Islander peoples. Variously they provide statistical or narrative descriptions of health-related phenomena, or sentinel information.

They provide information about jurisdictional action on matters that are important for the health of Aboriginal and Torres Strait Islander peoples, and about the outcomes of that action. They also provide information (at jurisdictional level) on aspects of Aboriginal and Torres Strait Islander health that may not be clearly attributable to jurisdictions' work in developing, implementing and managing specific policies, programs and services.

Thus the indicator set has been conceived with a broad interpretation of the terms 'performance' and 'indicator'. This broad interpretation has been derived through extensive consultation with Aboriginal and Torres Strait Islander communities, government agencies responsible for Aboriginal and Torres Strait Islander health, and agencies responsible for health information management.

3.5 A Framework for Grouping And Selecting Indicators

3.5.1 The need for a performance indicator framework

Consultations with stakeholders indicated that many people had difficulty in coming to grips with the 58 National Performance Indicators for Aboriginal and Torres Strait Islander Health as they are grouped in the 1997 and 1998 reports. Stakeholders remarked on the apparent lack of an explicit conceptual framework underpinning the indicators. It was widely felt such a framework was necessary and could be readily produced.

3.5.2 Existing frameworks

Conceptual frameworks have been developed to assist in the reporting of progress in priority areas of health (National Health Priority Areas). and for monitoring and surveillance (AIHW & NPHIWG, 1999).

For example, the National Health Ministers Benchmarking Working Group (now re-established as the National Health Performance Committee) developed a framework to measure the performance of public acute care hospitals. This framework divided performance measurement into two broad areas: efficiency and effectiveness. Effectiveness is further divided into four dimensions; quality: appropriateness, accessibility and equity (KPMG, 2000). This framework has been adapted for mental health services..

Other frameworks have been developed for monitoring and surveillance. The National Health Information Management Group Working Party on Health Outcomes Activities and Priorities developed a framework with two dimensions: the nature of intervention (e.g. preventive interventions, or treatment interventions), and the phenomenon being measured (e.g. primary outcomes, or risk factors, or processes) This framework is primarily intended for use in connection with indicators relating to specific health conditions, such as the management of diabetes, rather than performance management.

More recently, attempts have been made to take a more holistic view of performance measurement in the health system by also focusing on public health activity. The paper, *National public health information development plan* (NPHP, 1999) provides a guide to the priority areas of public health at a National level and suggests a range of indicators for the surveillance and monitoring of public health. However, these indicators were not intended to be used for performance measurement or as performance benchmarks.

Subsequently, the National Public Health Partnership, in conjunction with the NHPC, AIHW and representatives from the various jurisdictions, began work on the development of a national health system framework that will include a population health perspective. A number of national and international frameworks were considered. The framework developed by the Canadian Institute of Health Information was favoured as the most suitable. It is a national indicator framework that covers four dimensions of health and health care: health status, determinants of health, health system performance and community and health system characteristics.

3.5.3 Scope and purpose of a framework for the National Performance Indicators for Aboriginal and Torres Strait Islander Health

A conceptual framework for the National Performance Indicators for Aboriginal and Torres Strait Islander Health should help in identifying the level of development of existing indicators, draw attention to areas where indicators are lacking, highlight gaps and deficiencies in the organisation and availability of relevant information, and show where improvements to information systems are needed.

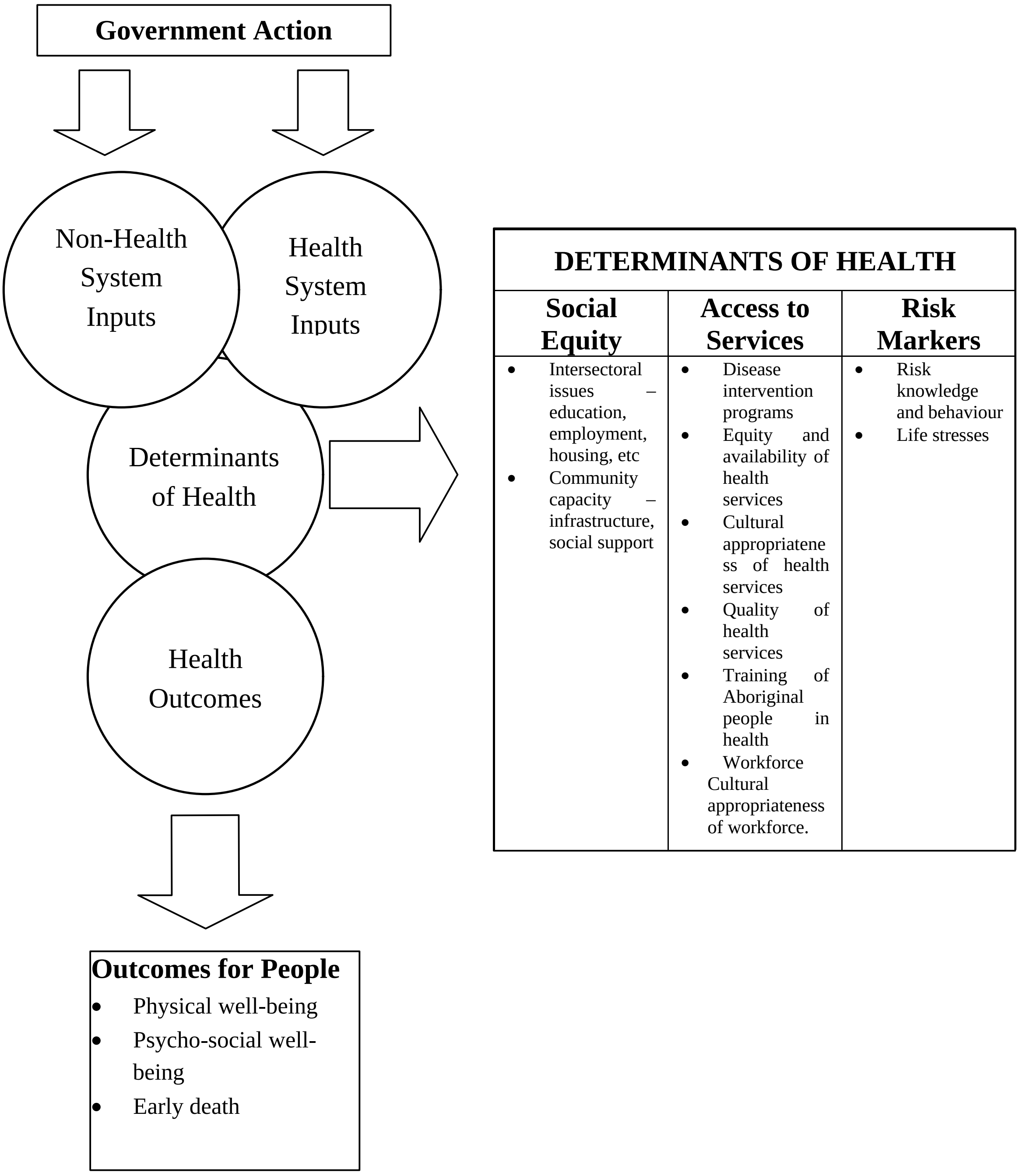
In most frameworks of performance for health systems, indicators of effectiveness and efficiency of health services are included in addition to indicators of population health status and determinant of health. In the case of Aboriginal and Torres Strait Islander health, the most important aspect of the effectiveness of health systems is concerned with the adequacy of access, in its many and varied forms, that Aboriginal and Torres Strait Islander people have to the health services they require. The underlying issues, if not the details, of cost-effectiveness or efficiency are broadly similar for service provision to Aboriginal and Torres Strait Islander peoples as they are for services to the whole population of states or territories, they have not been explicitly considered in this framework presented here.

A framework is provided to guide the user through the relatively large number of separate indicators and clarify the relevance of each indicator. It also identifies areas considered to be immediately modifiable such as resources through to the longer-term indicators such as health status.

3.5.4 Proposed framework

The proposed framework (Figure 1) for the National Performance Indicators for Aboriginal and Torres Strait Islander Health is a composite of several existing models. It was developed prior to that of the National Health Performance Committee but contains the same basic ideas with a slightly different emphasis. Figure 2 shows the link between the two frameworks.

Figure 1 - Conceptual Framework showing relationships between the domains



DETERMINANTS OF HEALTH		
Social Equity	**Access to Services**	**Risk Markers**
• Intersectoral issues – education, employment, housing, etc • Community capacity – infrastructure, social support	• Disease intervention programs • Equity and availability of health services • Cultural appropriateness of health services • Quality of health services • Training of Aboriginal people in health • Workforce Cultural appropriateness of workforce.	• Risk knowledge and behaviour • Life stresses

Outcomes for People

- Physical well-being
- Psycho-social well-being
- Early death

Figure 2 - The link between the conceptual framework developed for this project and the framework proposed by the National Health Performance Committee

Domains		NPIATSIH Number*	Australian Health Performance Framework Performance Tiers
Government inputs		1, 2, 3, 4, (20), (15),	Health System Performance
Determinants of health	Social Equity	5, 6, 7, 8, 9, 10, 11, 12, 13, 14, **(22), (23)**	
	Access to services	15, 16, 17, 18, 19, 20, 21, 22, 23, 24, **(13), (25)**	Determinants of health
	Risk markers	25, 26, 27, 28, 29, 30, 31, 32, 35, ***[27, 33, 34]***	
Outcomes for people		36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, **(5), (6),** ***[47]***	Health Outcomes

* these are the new indicator numbers

( ) – denotes indicators listed in a secondary domain. They have also been listed in what is considered to be the domain of their greatest contribution. They should be reported on under the domain of their greatest contribution ie not in parenthesis.

[ ] – denotes indicators that are currently not reportable.

4. CONSULTATION FINDINGS

4.1 Current National Performance Indicators for Aboriginal and Torres Strait Islander Health

The main messages that emerged during the consultation can be summarised as follows:

- The indicator set has no defined goal or clear set of objectives.
- There are too many indicators.
- The indicators do not reflect major strategies or intervention programs currently being implemented.
- Consistency is needed between this and other indicator sets.
- Clear and precise definitions of the indicators need to be developed.
- Data sources need to be identified.
- There is little good quality national data.
- A straightforward reporting procedure needs to be developed for use by all States and Territories.
- Frequency of reporting needs to be determined for each indicator.
- It is difficult to report consistently on an indicator when the data source is infrequent or irregular.
- Many indicators within other indicator sets could be suitable if indigenous identifiers were included.
- Several alternative indicators were suggested, along with specific improvements for individual indicators. These will be considered in the indicator catalogue.

See Appendix 2 for a full description of the findings. Suggested additional health issues warranting indicators included housing, environmental health, oral health, community capacity, poverty, infectious diseases, child growth monitoring and access to fresh fruit and vegetables (see section 7).

4.2 Indicators of Social and Emotional Wellbeing

Major themes that emerged from the consultation included the importance of:

- broadening the indicators to look at social justice issues as well as mental health.
- the relationship between social and emotional wellbeing, land rights and home ownership;
- the impact of grief resulting from the high death rates and extended family relationships;
- the impact of the stolen generation and quality of life; and
- the underpinning social determinants of health.

5. RECOMMENDED CHANGES TO THE INDICATORS

The majority of indicators required some refinement to reduce the variability in information reported or to make them more consistent with other national performance indicators already used in the health system. In most cases this involved providing a more comprehensive description of the indicator, including an expanded explanation of the information to be used in numerator(s) and denominator(s), the source data to be used, and the method of calculation for reporting on the indicator from the source data (where relevant). The refined technical specifications of the indicators are reported in an accompanying document, which is referred in this report as the “Instruction Manual”.

Refinement of several of the National Performance Indicators for Aboriginal and Torres Strait Islander Health has resulted in significant changes from the interim set, including changes in the information reported, methods of calculation, and the source of the information. In some cases these modifications have made the performance indicator redundant; such indicators have been recommended for deletion.

5.1 Key reasons for recommended changes to or deletion of indicators

The main reasons for recommended refinements to the National Performance Indicators for Aboriginal and Torres Strait Islander Health can be broadly grouped as follows:

5.1.1 Establishment of standards for reporting

The review of jurisdictional reports revealed significant variability among jurisdictions in the information presented and in reporting formats. To set a standard for reporting, a presentation format has been defined for each indicator. This should contribute significantly to reducing the variability in reporting, and should enhance comparability of data between jurisdictions.

5.1.2 Defining the scope of individual National Performance Indicators for Aboriginal and Torres Strait Islander Health

The consultations and the subsequent technical refinement process revealed there was often no consistent understanding of the purpose of individual indicators, what they measured, or to whom they applied.

An important starting point was to specify in the instructions for the National Performance Indicators for Aboriginal and Torres Strait Islander Health the agency with responsibility for reporting. Reporting is required from Health Departments at the State/Territory level for all indicators, and by the Commonwealth for selected indicators. However, some data will be derived from national compilations and provided to jurisdictions for inclusion in their reports. Private health facilities and services and Aboriginal Community Controlled organisations are not required to report on indicators.

In some cases reporting on indicators has been restricted to a sub-jurisdictional level. This is to ensure that information of importance is not obscured in general data collections. For example, information about geographic access to health services is restricted to remote areas and Aboriginal communities. Similarly, information on cross cultural awareness training is only required for areas where Aboriginal or Torres Strait Islander people make up a significant proportion of the population.

The refinement process was guided by recognition that the purpose of the indicators was to provide high-level information about changes pertinent to health. The indicators were not intended to provide a complete statistical description of health status. For example, the age range for reporting on all the hospitalisation and mortality indicators is limited to less than 75 years. This is because the high rates in the non-Indigenous elderly population will lead to an underestimate of the enormous disparity that exists between the two groups earlier in life. Only a small proportion of the Aboriginal and Torres Strait Islander population is aged 75 years or older (<1% for men <1.5% for women). It also resulted in the recommendation for deletion of the indicator on Primary Care Activity (numbered 4.8 in the interim set). There was no agreement at the jurisdictional level on what this indicator was trying to report on or its utility in providing information on Aboriginal and Torres Strait Islander health.

This view also influenced decisions about the scope of some indicators. For example, many diagnostic categories exist for pneumonia, but some (e.g. congenital pneumonia) are not important causes of morbidity or mortality in Aboriginal and Torres Strait Islander populations, and do not help to explain differences between Aboriginal and Torres Strait Islander morbidity or mortality and that of the total Australian population. Such diagnostic categories have been excluded from indicator definitions for reporting purposes. This helps to reduce the complexity of producing relevant data for comparative purposes.

5.1.3 Investment in research to support information collection about Aboriginal and Torres Strait islander Health

The consultation process identified a number of strategic initiatives that have occurred nationally since the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health were originally proposed, and some planned future initiatives. Knowledge of such initiatives has informed the refinement of many of the National Performance Indicators for Aboriginal and Torres Strait Islander Health. The initiatives included:

- the development of national public health indicators being undertaken under the auspices of the National Public Health Partnership
- the Commonwealth study to identify health expenditure on Aboriginal and Torres Strait Islander people
- the Commonwealth-sponsored study to define expenditure in health promotion

- the Commonwealth funded, NACCHO sponsored National Indigenous Health Workforce Study
- the establishment of the ACIR
- the establishment of a National Funding Program for Cervical screening and State cervical smear registers
- the establishment of Aboriginal And Torres Strait Islander health framework agreements in each State and Territory.

In many cases the research from these projects has produced nationally accepted definitions which could be used for the National Performance Indicators for Aboriginal and Torres Strait Islander Health, standard calculation methods, standard definitions for source data and agreed minimum data sets. An early copy of the audit of National Performance Indicators for Aboriginal and Torres Strait Islander Health produced as part of a discussion paper about national performance indicators (NHPC, 2000) was supplied to the team. This helped the ensure that, where possible, the refined National Performance Indicators for Aboriginal and Torres Strait Islander Health articulated with other national definitions.

Strategic research such as that underpinning the initiatives listed above has facilitated the establishment of national data collections. Where data are collected on a national basis, it has been recommended that the national organisation collecting the data should prepare information material to be reported by each State/Territory. State/Territory organisations should validate and comment on nationally- generated information before reporting it. This approach was recommended to improve the validity in reporting across jurisdictions, as it ensures consistency in calculations and data sources. It is also more effective by allowing jurisdictions to devote more effort to the indicators they must calculate.

5.1.4 Order of indicators in Instruction Manual

The changes in reporting tasks discussed above means that responsibility for producing the indicators will be shared across several jurisdictions and agencies. Hence in the Instruction Manual, the National Performance Indicators for Aboriginal and Torres Strait Islander Health have been ordered according to the agency responsible for calculating the Indicator to facilitate production of the data, however, they have been numbered according to the domains in the conceptual framework. A chart detailing how the indicators are mapped to the conceptual framework is shown in Figure 2 as well as in the Instruction Manual. When jurisdictions compile the indicators for their report, it would make more sense to order the indicators according to the framework under the main heading:-

- Government inputs
- Determinants of health
    - Social equity
    - Access to services

  - Risk markers
- Outcomes for people.

5.1.5 Using cost effective data collection methods

To date, the lack of relevant routine data collections has generally made it impossible for the States/Territories to report on the indicators of geographic access to health services, indicators covering risk factors which have an impact on health status e.g. smoking, obesity, alcohol, poverty and housing.

National surveys conducted by the ABS, such as the National Health Survey (NHS), the Community Housing and Infrastructure Needs Survey (CHINS) and the National Aboriginal and Torres Strait Islander Survey (NATSIS), collect information similar to that required for reporting on such indicators. They represent a cost-effective mechanism, for collecting information about access to services and risk factors. There is an ongoing commitment to the NHS, although it does not necessarily include a sufficiently large Aboriginal and Torres Strait Islander sample. The CHINS will be repeated at least once more and possible routinely every five years in the future. There are plans for an Indigenous General Social Survey (GSS) to replace NATSIS. However the areas of investigation in the Indigenous GSS have not been decided, so its potential utility as a source of data for the National Performance Indicators for Aboriginal and Torres Strait Islander Health is not yet known.

To facilitate reporting on these items, the definitions of indicators have been changed to be consistent with the questions in the national surveys. Conversely, in a few instances the project team has made a strong recommendation to modify the question used in the survey, or related definitions, to improve the utility of the survey data in reporting on the National Performance Indicators for Aboriginal and Torres Strait Islander Health.

5.1.6 Reporting time frames (timeliness)

When reviewing the time frames for reporting for each indicator, the benefits and costs of annual reporting were considered.

The indicators must be able to detect changes in the health-related phenomena that they reflect. Some of these phenomena may show significant variation over relatively short time periods as a result of action or inaction, and corrective steps may be necessary and feasible if adverse changes are detected. Annual reporting on such phenomena is important. Childhood immunisation is an example. At the opposite end of the reporting spectrum, indicators measuring population health status do not usually show significant changes on an annual basis, but information over several years is needed to interpret trends or variations in reported rates. Examples are risk factors such as obesity, alcohol consumption and smoking.

Indicators, which are to come from data collected in major national surveys (such as the NHS or CHINS), can be updated only after each survey or the Census of Population and Housing. The frequency and timing of these updates is not under the control of jurisdictions, although they can influence on the timing if not frequency.

The indicators derived from routinely collected data sources such as death registrations and hospital inpatient statistics collections can be reported on relatively inexpensively. However, trends in these indicators are likely to occur slowly. Annual reports on them are therefore likely to reflect random variations, as well as changes in individuals' propensity to identify as Aboriginal or as a Torres Strait Island person. In principle, therefore, occasional reporting (perhaps once every five years) would be suitable. In practice, however, annual reporting helps to keep the gaps in health between the Aboriginal and Torres Strait Islander and all-Australian groups on the agenda.

For some indicators, the cost of collecting high-quality data on a yearly basis is prohibitive, and jurisdictions do not necessarily have the capacity to report on these indicators annually. For example, reporting on the workforce indicators will require most jurisdictions to undertake an ad-hoc workforce survey, because relevant routine data collections do not exist. It is generally not feasible to undertake such surveys on an annual basis. After consideration of various factors that affect the frequency of reporting and discussion with the Reference Group, an appropriate interval for reporting was determined for each indicator.

5.1.7 Best practice statistical reporting

Expert opinions were canvassed to determine the appropriate statistical formulae for the calculation of morbidity and mortality indicators, including the definition of denominators. In summary the statistical methods to be applied to the revised indicators include the following.

- Indirect age adjustment will be used for indicators derived from hospitalisation and mortality data.
- Reported indicators for hospitalisation and mortality will be based on Aboriginal and Torres Strait Islander data in 3 years rolling averages.
- Some indicators have suggested reporting interval of every two years if data is unlikely to reflect any change in yearly reporting.

The project team and the Reference Group agreed that it was more important to show trends in health-related phenomena for Aboriginal and Torres Strait Islander populations than to show trends in the gaps between the Aboriginal and Torres Strait Islander and all-Australian populations. This is because trends in the gaps might be due solely to changes in the all-Australian rates. This decision had two important implications, as follows:

- the ‘standard’ population rates should be those for the all-Australian sex-specific populations
- ‘standard’ population rates should be held to a constant year, and not change annually.

As indirect adjustment is to be used, there is no need to continue to use 1991 as the reference year (as would be the case if direct adjustment had been specified). Hence the mortality rates for 1997 and hospital separation rates for 1997-8 have been specified as the ‘standard’ rates.

Discussions with the Reference Group led to the decision that the indicators of health status should reflect the health of populations resident in the jurisdiction, rather than health care delivered or events occurring within jurisdictions. Hence place of residence, not place of occurrence (of birth, death, or hospitalisation) has been specified for indicators derived from the mortality, hospitalisations and perinatal collections.

Ninety-five percent confidence intervals were added to the specifications for most of the numerical data. This has advantages and disadvantages. On the one hand, it will become apparent that many of the mortality ratios are based on small numbers of events and so are not statistically significantly different between the jurisdictions. This will prevent inappropriate comparisons about performance. On the other hand confidence interval may imply that the underlying data are more consistent than is actually the case. For example, apparently-significant differences among ratios may in fact not be real differences, but may be due to varying degrees of completeness of Aboriginal and Torres Strait Islander identification in the datasets. This is likely to be the most serious problem. Differential completeness in identification by Aboriginal and Torres Strait Islander people in different parts of the country is probably the cause of the highly misleading and incorrect conclusion to be drawn from Shahidullah and Dunstan (2000) that life expectancy amongst Aboriginal and Torres Strait Islander Australians in eastern states is lower than in western states of Australia. This example highlights the extent to which the data are uncertain owing to problems with Aboriginal and Torres Strait Islander identification, and the level of caution that must be applied in interpreting changes over time for all of the indicators in this set.

5.1.8 Changes to the hospital coding system

The diagnostic codes to be used for the National Performance Indicators for Aboriginal and Torres Strait Islander Health were not previously specified, and this resulted in some reporting differences among the jurisdictions. The coding systems used in all jurisdictions’ mortality and hospital morbidity data collection systems were recently updated from International Classification of Diseases version 9 Clinical Modification (ICD 9 CM) to the International Classification of Diseases version 10 (ICD 10). Where National Performance Indicators for Aboriginal and Torres Strait Islander Health rely on mortality and hospital morbidity data collections, ICD 10 codes have been included in the updated indicator definitions.

5.1.9 *Service developments making indicators redundant*

Because of enhancements in service planning or programs, some indicators were no longer needed. These are listed in the following table, with explanations for each.

Previous Indicator No.	Indicator	Reason for deletion
4.5	Hepatitis B – Immunisation rates.	Now part of the routine ACIR reporting and as such no need for separate reporting.
5.5	Aboriginal identified positions	Most jurisdictions have workforce plans with a range of comprehensive strategies. The activity covered in this indicator is no longer used by most jurisdictions to increase Aboriginal employment.
8.1	Partnerships for Aboriginal health development.	The reporting requirement under the Framework Agreements for each state requires more comprehensive reporting on an annual basis, so reporting on this in the performance indicator set is redundant.
8.2	Regional and community planning for health	Reporting on community and regional planning is covered in more detail in the Aboriginal Health Framework Agreement reporting requirements for each State/Territory. Therefore these indicators have been superseded

5.1.10 *Other indicators amalgamated or deleted*

Several indicators were amalgamated. For example, the previously separate indicators for rates and ratios have been grouped together. Appendix 5 shows the former indicator numbers and titles, and relates these to the new indicator numbers and titles.

In addition, former "Case-fatality ratio of hospital separations to death for sentinel condition for Aboriginal and Torres Strait Islander people compared with non-Aboriginal and Torres Strait Islander people" (indicator number 3.4) has been deleted. This indicator had been derived from the 'index of access' of McDermott et al (1996), who defined the ratio of age-adjusted hospital separations in Aboriginal and Torres Strait Islanders to non-Indigenous people as an access ratio, and the ratio of age-adjusted mortality in these two groups as a need ratio. "This ratio of ratios accounts for the idea that groups of people with different levels of need require different levels of access. An index of access equal to 1 would mean that access (or, in this case utilisation) is the same in the two populations for a given level of need (in this case, death) after adjusting for difference in age distributions. An index of less than 1 would represent lower access among Indigenous people, and an index of greater than 1 would indicate higher access" (ABS, 1997). However, it was evident from calculation supplied by the Queensland Health Department for a number of diseases that this interpretation of ratios above or below 1 could not be applied consistently. Hence, as it would be unclear what the results meant, the indicator was deleted.

5.1.11 Indicator names

As shown in Appendix 5, the different naming styles were used in the interim performance indicator set. Some names were short, while others involved several lines of text, and could more accurately be described as definitions rather than names.

In the refinement process, all names were shortened as much as possible, so that indicators would be easy to find in the table of contents. As far as possible, indicator names were made to reflect the item being reported as precisely as possible. For example, the former indicator "Women at risk of cervical cancer" (former indicator number 4.2) provided information on the numbers of Pap smears done. This does not reflect the numbers of women at risk of cervical cancer, but does give information on Pap smear screening service delivery. This indicator has been re-named "Pap smear screening".

5.2 Indicators of social and emotional wellbeing

The social and emotional wellbeing set has twelve indicators: eight indicators describe social determinants of health, including social justice issues, access to services and risk markers. It also includes indicators of early death and psychosocial wellbeing. The alcohol and income poverty indicators, were previously, and remain, part of the refined indicator set. Expenditure on social and emotional wellbeing services are shown as a subsection of the government expenditure on health promotion programs indicator.

They are not intended to be a full statistical description of all social justice issues or all mental disorders or all health system responses. Instead, they can be thought of as a set of leading indicators that are likely to reflect changes in government policies.

The indicators of social and emotional wellbeing were selected from a number of possible indicators that were suggested and researched during the course of the project. They were strongly supported for inclusion because of the clarity with which they could be described, their likely validity, and their perceived utility. The indicators were designed to be technically consistent, were possible, with other indicators in the refined set of National Performance Indicators for Aboriginal and Torres Strait Islander Health.

Complex or compound indicators have not been included in the present indicator set as much more development will be needed to establish valid performance indicators in such fields as quality of life for Aboriginal and Torres Strait Islander communities. The most feasible approach at this point in time is to introduce indicators that will provide information on the social determinants of social and emotional wellbeing now, and over time, develop the more complex indicators that can cover other aspects of the field. It is clear that many of these factors can be impacting upon the social and emotional wellbeing of a person, family or community at one time.

The *Community Grief* indicator is likely to involve a combination of measures that can go beyond describing mental health status and encourage reporting on the impacts of social disadvantage and the contribution of high levels of stress, grief, anxiety and depression. These are factors that lead to a cycle of grief and are causal factors of suicide in Aboriginal and Torres Strait Islander communities. In the interim the refined early adult death indicator, which gives the probability of a person aged 20 dying before reaching the age of 55 years, could be used as a proxy measure of community grief.

There is a strong argument for inclusion of the intersectoral indicators of education, employment, income poverty and imprisonment within the set. Education has a protective function for mental health. Involuntary unemployment is a major mental health hazard. Unemployment increases social isolation and limits social networks. Socioeconomic and income factors are associated with social and emotional wellbeing and mental disorders, as is the ability to have control over life.

Access by Aboriginal and Torres Strait Islander people to services can be described by hospitalisations. However, hospitalisations can also reflect jurisdictional policy and diagnostic patterns. Community level service information will be available from mental health services at the end of 2002.

Alcohol and Gambling are factors which are closely associated. However, gambling is not always seen as a “Health Problem”,. The Productivity Commission report that the cost of problem gambling includes financial and emotional impacts on the gamblers and on others with on average at least five other people affected to vary degrees with one in ten reporting having contemplated suicide due to gambling. (Productivity Commission 1999, *Australia’s Gambling Industries* Report No. 10).

Death from suicide is of considerable importance to report on in the Aboriginal and Torres Strait Islander communities. Unreported suicides will lead to an underestimation of the problem. In addition, as many more attempt, than complete suicide, the statistics should be regarded as the tip of the iceberg.

The following table sets out the indicators of social and emotional wellbeing under the three components of the conceptual framework of the National Performance Indicators for Aboriginal and Torres Strait Islander Health. No single conceptual framework fitted the diverse views on the monitoring of social and emotional wellbeing. As all of these views warranted some accommodation, an eclectic approach was adopted. The indicators do not depend upon the framework for interpretation.

Figure 3 - Overview of indicators for Social and Emotional Well-being

GOVERNMENT INPUTS	DETERMINANTS OF HEALTH	OUTCOMES FOR PEOPLE
Non-Health System Inputs	**Social equity** Intersectoral issues – ▪ *Education,* ▪ *Employment,* ▪ *Income poverty*[a] ▪ *Imprisonment*	**Physical well-being and early death** ▪ *Suicide*[a]
Health System Inputs • *Government expenditure on, and the description of, selected health promotion programs - Social and emotional wellbeing*	**Access to services** ▪ *Hospitalisation for mental health conditions*	**Psycho social well-being** • *Prevalence of depression, anxiety and substance use*[b] • *Child abuse and neglect*
	Risk Markers ▪ *Alcohol*[a] ▪ *Problem gambling*[b] ▪ *Community grief*	

a= Shared with the National Aboriginal and Torres Strait Islander Health Performance Indicators Main Set
b=Require further development and/ or identification of data source

5.2.1 Trialing of the Social and Emotional Well-being set

Information is currently available to enable national reporting on nine of the indicators. Main information sources include the Census of Population and Housing, the National Minimum Data Set for Mental Health Care and the Prison Census. However to report upon the prevalence of depression, anxiety and substance use and problem gambling indicators surveys with a sufficient Aboriginal and Torres Strait Islander sample to report at jurisdictional level are required. Tested and reliable survey tools are available for inclusion within surveys for both of these indicators. Some forthcoming national surveys offer trialing opportunities to gather information[1].on these indicators. State-based surveys also offer opportunities to collect relevant information. It is specifically recommended that the usefulness of the proposed social and emotional well-being indicators should be considered after two periods of reporting.

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[1] Opportunities to gather information through National Surveys such as
  a) ABS General Social Survey and General Social Survey Indigenous as they include items on Self assessed health status, Mental health status, Disability status, Smoking, and Alcohol consumption.
  b) Population Health Survey – telephone survey include emotional and general well-being, information on prevalence of a variety of chronic diseases, protective and risk factors, and some economic measures.
  c) NSW Health Survey
  d) ABS National Health Survey 2001

6. STRATEGIC ACTIONS REQUIRED TO IMPROVE REPORTING OF INDICATORS

A number of strategic actions are required to remove the barriers to accurate reporting if there is to be real improvement in the quality of reporting for on the National Performance Indicators for Aboriginal and Torres Strait Islander Health. A summary of the key strategic actions required is outlined in the following discussion. The necessary actions are in two broad categories: (a) actions which depend upon AHMAC to initiate discussion and make decisions; and (b) actions which provide additional dimensions to work that is already in progress.

A detailed description of the strategic action required for each individual performance indicator is given in Appendix 5.

6.1 Strategic Actions Required By AHMAC

To facilitate improved reporting on Aboriginal and Torres Strait Islander Health in future, the Commonwealth and State/Territory Health Departments should consider the cost and policy implications of the issues outlined below to ensure robust data sources are available. If AHMAC determines not to take action on these issues, it may be necessary to defer reporting some of the National Performance Indicators for Aboriginal and Torres Strait Islander Health, as it will not be possible to report on them with a high level of validity (or, in some cases, it will not be possible to report on them at all).

6.1.1 Inclusion of indigenous reporting in national reporting and indicators research projects

Aboriginal and Torres Strait Islander identification should be in the terms of reference of any research project designed to improve national health reporting systems or provide information on health issues of national significance. This should help ensure that data describing differences between indigenous and non-indigenous categories can be reported. For example, a project to ascertain expenditure on health promotion activities in Australia is currently in progress. The inclusion of Aboriginal and Torres Strait Islander identification in the terms of reference of this project would have ensured that a routine data collection source was developed for the indicator covering expenditure on health promotion strategies specifically targeting Aboriginal or Torres Strait Islander peoples. This indicator is part of the set of National Indicators for Aboriginal and Torres Strait Islander Health.

6.1.2 Commitment to national surveys

National surveys have been recommended as data sources for some of the indicators, as such surveys would facilitate cost-effective reporting and ensure comparability across jurisdictions. The ABS plans to conduct a variety of national surveys over the next decade.

At this stage it is not clear what the sampling frame will be for these surveys, or whether the sampling in remote locations will be adequate to provide valid data for these indicators. If population health surveys are to provide valid indicator data, they must be nationally representation, with adequate sampling of Aboriginal and Torres Strait Islander peoples.
Specific surveys might include:

- questions about smoking and alcohol consumption,
- the measurement of heights and weights,
- the Kessler 10 scale of anxiety and depression, and, possibly,
- questions about adequacy of essential utilities in housing as the current data source, CHINS, only measures these items in discrete communities (and so the refined indicator has been restricted to discrete communties)

For consistency interpretation, national survey questions should be based on definitions that are widely used in the health industry. For example, in questions about service provided in a community, the term ‘primary health care services’ rather than ‘community health services’ should be used. In addition, the accepted definition of a primary health care service must be used.

Similarly, if it is intended that results from surveys done in the Aboriginal and Torres Strait Islander population be compared to the results from general population surveys, consistent survey questions should be be used. The current definitions for smoking and alcohol consumption in the National Health Survey are not based on the definitions in the National Health Data Dictionary because the NHS questions are not based on these definitions. The current definitions are based on the assumption that the questions asked in the 1995 NHS will be asked in surveys of Aboriginal and Torres Strait Islander people, such as the Indigenous GSS planned for 2002. The 1996 NHS questions will be used in the 2001 NHS and then will be re-developed for the 2004 NHS.

The various State and Commonwealth groups that currently conduct state-wide and nation-wide surveys (e.g. ABS, AIHW, National Drug and Alcohol Research Centre, Victorian Cancer Council) all use different sets of questions to enquire about smoking and alcohol consumption. A current project under the auspices of National Public Health Information Working Group is trying to harmonise the questions. The indicators on smoking and alcohol consumption in the set of National Performance Indicators for Aboriginal and Torres Strait Islander Health should be re-defined in the light of changes and developments in questionnaire modules.

6.1.3 Definition of a primary health care service

Aboriginal health policy emphasises the importance of enhancing access to and service delivery in primary health care as a strategy for achieving improvements in Aboriginal and Torres Strait Islander health. Several indicators in the National Performance Indicator for

Aboriginal and Torres Strait Islander health set refer to access to and workforce, expenditure and activities in the primary health care sector. However, there is no clear definition of what primary health care is in the Aboriginal health service context, and this has hindered attempts to improve the definitions of these indicators. Many different views exist on what primary health care is, who is involved in primary health care delivery, and the standard of service that should be available for a service to be "classified" as primary health care.

In the interim the CHINS could help to overcome some of the definitional problems because it allows reporting to be adjusted according to the location of the survey. However, the CHINS currently uses the term "community health services". This would have to be changed to "primary health care services" to reflect the terminology used in the National Performance Indicators for Aboriginal and Torres Strait Islander Health.

6.1.4 Classification of a hospital

Several of the National Performance Indicators for Aboriginal and Torres Strait Islander Health provide information on hospitals and hospital services. However, definitional difficulties can occur in relation to hospitals in remote areas. Some health care facilities in remote areas meet the National Health Data Dictionary definition of “hospital”, and are classified as hospitals under the Health Care Agreements, but are not staffed to provide 24-hour care and do not have medical officers on site. To differentiate acute care facilities that provide an extended range of inpatient and ambulatory care services from those that are staffed principally for ambulatory care services, either a new definition is needed for acute care hospitals, or the Health Care Agreements with the States and Territories will require revision as to the facilities which are included as hospitals.

6.1.5 Establishment of an adult immunisation schedule and immunisation register system

One of the National Performance Indicators for Aboriginal and Torres Strait Islander Health relates to pneumococcal vaccine coverage of adults. The Commonwealth makes the vaccine available free of charge to the States and Territories to promote universal access to immunisation for eligible individuals. It is recommended that all Aboriginal and Torres Strait Islander people over 50 years of age and Indigenous people with chronic disease should receive the vaccine. This program has not been supported by the development of an adult immunisation schedule or an immunisation register. Most States and Territories are not able to report on pneumococcal vaccine coverage rates by age group, or determine whether the vaccine was given according to the age and risk factor criteria. To facilitate reporting on the indicator of pneumococcal vaccine coverage, it will be necessary to establish an adult immunisation reporting system which includes mandatory reporting of Aboriginal and Torres Strait Islander status.

6.1.6 Activity reporting systems for ambulatory care

Over the last 15 years a significant effort has been invested in developing information systems to measure inpatient activity and outputs. There is similar interest in the outcomes of emergency department activity and primary health care, but preparatory research for the National Performance Indicators for Aboriginal and Torres Strait Islander Health relating to emergency departments found no consistent approach to emergency department data collection across jurisdictions.

To facilitate reporting on the performance indicator related to injury, which is one of the national priority areas and a major cause of morbidity and mortality for Aboriginal and Torres Strait Islander people, standard surveillance systems need to be developed and implemented into Emergency Departments. As with all new data collection systems developed, Aboriginal and Torres Strait identifiers need to be included as part of the minimum data requirements.

Theoretically, occasions of service funded by Medicare and PBS might be useful if Aboriginal and Torres Strait Islander identification was included in the data collection.

6.1.7 Definition of Poverty

In the interim set of National Performance Indicators for Aboriginal and Torres Strait Islander Health, the indicator of poverty was based on a comparison with the poverty line. However, there is no official poverty line in Australia. All the available measures of poverty comprise equivalence scales based on family or household income divided by an adjustment factor for family or household composition. Several elementary equivalence scales can be used. A new equivalence scale specified by the OECD gives the first adult in the family or household a weighting of 1.0, while subsequent persons over 14 receive a weighting of 0.5 and children under 14 receive a weighting of 0.3 (OECD, 1998). Other equivalence scales include the previous OECD scale (which gives weights of 1.0, 0.7, and 0.5 respectively), and the square root of the number of persons in the household; both of these result in apparently higher rates of child poverty, but similar patterns of change over time (B Hunter, personal communication). The Henderson index also has an adjustment for labour force status but is only calculable for families with less than 5 children.

'The ongoing controversy about the precise specification of equivalence scales revolves around the nature and extent of economies of scale in families and households. The smaller the proportion of expenditure on items which display economies of scale, the more justifiable it is simply to divide family/household income by the number of people it supports. When income levels are very low, a high proportion of expenditure is on food, basic clothing and cooking fuel. Given that each of these varies directly, and quite closely, with the number of people in the family and may make it appropriate to give each person a similar weight by focusing on per capita income. In contrast, where public goods are important more account needs to be taken of potential economies of scale implicit in the Henderson and other equivalence scales' (B Hunter, personal communication).

The newer OECD scale has been selected for the refined indicator set, and a comparison with the distribution for the entire Australian population. has been specified. Further, the indicator of poverty has been renamed 'income poverty' to highlight the fact that income is only one facet of poverty. This indicator does not, for example, provide an assessment of income in relation to the cost of living, which is higher in many remote areas than the urban areas.

6.1.8 Investment in priority health programs

Hearing loss is considered an important problem for Aboriginal and Torres Strait Islander health and a performance indicator relating to hearing assessment at the time of school entry was proposed in the interim set. It has not been possible to report on this indicator because there is no screening program for hearing at school entry in any jurisdiction, although such a program has recently been discussed at the national level. For this indicator to become reportable there would have to be a commitment to implement a school screening program, and an investment in a central data collation system.

6.1.9 Workforce reporting

Workforce data are recorded in different ways by different organisations. Measurements such as full-time equivalents that would have enabled comparisons across jurisdictions are no longer used by many Health Departments. The recommendations of the Workforce Modelling Project for Aboriginal and Torres Strait Islander People were not available to inform the refinement of indicators. To assist with defining these indicators further, and to facilitate meaningful comparisons among jurisdictions, a common standard for recording the workforce needs to be developed.

6.1.10 Legislative changes to facilitate recording of Aboriginal and Torres Strait Islander status on pathology forms.

Aboriginal and Torres Strait Islander identification is not a mandatory field on pathology request forms in all States and Territories. This creates problems for reporting on indicators such as Pap smear rates and communicable disease notifications, as the jurisdictional data collection systems rely on pathology notifications. Mandatory recording of Aboriginal and Torres Strait Islander identification on request forms would have significant policy and cost implications. However, without this, the indicators involved are unreportable in many jurisdictions. If the policy and/or cost issues are insurmountable, then the indicators of these important aspects of morbidity and service delivery should be deleted.

6.1.11 Aboriginal and Torres Strait Islander identification in the perinatal Collections

Current State and Territory (and hence national) perinatal data collections only record Aboriginal or Torres Strait Islander identification of the mother, and this is used to assign identification to the child. In previous reports, virtually all jurisdictions warned that identification was based on maternal status, not the status of the child. Two options can be considered for the future development of the National Performance Indicators for Aboriginal and Torres Strait Islander Health. The first is to accept the status quo, and take Aboriginal and Torres Strait Islander maternity as reflecting Aboriginal and Torres Strait Islander identification overall. This has obvious shortcomings, but is a pragmatic solution. The second option is for States and Territories to make paternal identification compulsory field in perinatal data collections. This would produce better information, but creates some practical difficulties of data collection. The refined indicators have adopted the former option, but this could be regarded as a short-term solution while the second option is examined.

6.1.12 Assessing trends in the refined indicators

Given the extensive development of the technical specifications, a decision is needed as to whether there should be some back-calculation of past years using the new specifications. This would be feasible, and not difficult, for the indicators derived from teh routine collections and the Census. We would suggest going back to about 1996. This would allow trends to be assessed more quickly than if there is no back-calculation.

6.2 Ongoing Strategic Action

6.2.1 Improved identification of indigenous status in data collection and reporting systems

An ongoing problem for all jurisdictions is the quality of identification of Aboriginal and Torres Strait Islander status on morbidity, mortality, birth registration and perinatal data collection systems. The template for reporting on the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health stipulated that this information should be provided for each indicator, creating some repetition in reports. Instead of this, the refined indicator set includes a ‘new’ performance indicator in which jurisdictions report on their progress in improving Aboriginal and Torres Strait Islander identification in data collection systems. While this should improve the efficiency of reporting, an effective national approach is required to address the systems issues that militate against accurate recording of Aboriginal and Torres Strait Islander identification. This matter is under development by the working group overseeing the implementation of the Aboriginal and Torres Strait Islander Health Information Plan.

National discussions involving the jurisdictions, NACCHO, and their affiliated organisations are needed to form agreements about the use and publication of information that contains Aboriginal and Torres Strait Islander identifiers. For example, the origin status of a child is routinely recorded on immunisation data provided to ACIR, but the lack of agreement about the release of information is an impediment to reporting on the performance indicator that covers childhood immunisation. A similar problem with the use of Pap smear information means that many Aboriginal Community Controlled Health Organisations are not actively promoting the opportunity to be part of a State or Territory Pap smear recall system.

The problem of Aboriginal and Torres Strait Islander identification is not confined to health information systems. Similar problems exist with human resource management systems in relation to workforce information. Very few jurisdictions routinely record Aboriginal and Torres Strait Islander identification. Consequently it is difficult to monitor the effects of workforce development strategies relevant to Aboriginal and Torres Strait Islander health. Jurisdictions need to continue their efforts in improving information collections. Recommendations from the National Indigenous Health Workforce Study will provide some direction for improved reporting on Aboriginal and Torres Strait Islander workforce issues in future.

6.3 Research to determine the extent of identification

One of the goals of the National Performance Indicators for Aboriginal and Torres Strait Islander Health is to improve the consistency of data reported by the jurisdictions. This could be achieved by imposing restrictions on reporting, such that only those jurisdictions with good quality identification of Aboriginal and Torres Strait Islander people report on respective indicators. Thus even where a national agency such as the AIHW or ABS can calculate indicator information, it is the jurisdiction's responsibility to decide whether it should be reported, or reported with qualifying comment. At present the only formal specification relates to mortality data. The ABS has itself nominated the jurisdictions which have good quality Aboriginal and Torres Strait Islander identification in death registrations (currently NT, WA, Qld and SA), however, the project team's enquiries revealed that this was not based on formal criteria. There may not be much difference between the quality of data in jurisdictions that are asked to report and those that are excluded from reporting. As shown in the following table, the coverage of deaths in Qld and SA, which are regarded as having acceptable coverage, is as close to the level in Vic (which is regarded as unacceptable) as it is to WA (which is regarded as acceptable).

Figure 4 - Estimated coverage (%) of Aboriginal and Torres Strait Islander deaths (ABS, 1999) based on the low series projections from the 1996 Census

Year	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust
1993	22	25		62	81	5	87	62	36
1994	23	24		67	78	3	87	61	36
1995	24	24		65	79	3	87	50	36
1996	19	23	29	63	75	-	73	28	39

1997	9	43	58	68	70	4	100	20	49
1998	47	56	63	64	74	10	88	14	61

Source: ABS. Deaths Australia 1998. Cat No 3302.0. ABS Canberra, 1999

The States and Territories have committed to studies of their hospital separations (Cunningham and Beneforti, 2000) collections to determine the completeness of identification of Aboriginal and Torres Strait Islander people. The results will be reported to AHMAC. This may allow a more formal way of specifying restrictions on reporting in the future. The same studies should be done so that formal comments can be made about the perinatal data collections.

7. ADDITIONAL ISSUES OR INDICATORS IDENTIFIED

The brief for this project was the refinement of existing indicators. The interim National Performance Indicators for Aboriginal and Torres Strait Islander Health were structured in such a way as to provide little flexibility for drawing attention to successful strategies that have lead to improvements in Aboriginal health at the regional or individual community level. To overcome this problem, it is recommended that future iterations of the National Performance Indicators for Aboriginal and Torres Strait Islander Health include an indicator that prompts jurisdictions to highlight significant improvements or successful strategies that are not already highlighted by the existing indicators.

Furthermore, the reporting process does not require any action by the jurisdiction beyond the responsibility for providing information in response to each indicator. It may useful to include a requirement for the Commonwealth and State and Territory Health Departments to outline action they have taken in the last 12 months to address the problems identified in the previous year's report on the National Performance Indicators for Aboriginal and Torres Strait Islander Health.

7.1 Suggested additional indicators

Consultees suggested that the set of National Performance Indicators for Aboriginal and Torres Strait Islander Health should ultimately include indicators in additional areas, as follows.

- Prevalence of trachoma
- Prevalence of asthma
- The proportion of certain amputations associated with diabetes
- Incidence of renal disease and access to dialysis services
- Information on different categories of health workers e.g environmental health workers, nutrition workers, health promotion officers
- Environmental health workforce
- Expenditure on people, training, and housing
- Information on quality of care in some of the areas covered by the National Performance Indicators for Aboriginal and Torres Strait Islander Health
- Information on the success of programs, whether people were receptive to them, and whether they changed people's attitudes
- Prevalence of high birthweight
- Child growth
- Perinatal mortality
- Provision of housing for health service staff - Aboriginal and Torres Strait Islander and non-Indigenous
- Oral health

- Access to fresh fruit and vegetables
- Breast screening
- Access to hospital indicator does not specify that there must be a doctor in the hospital
- Access problems for those in urban areas
- Quality included in service indicators
- Motor vehicle accident rates
- Mortality related to illegal and legal drugs
- Number of deaths per month by community
- Physician activities (e.g. proportion of adults who have 30 minutes of activities per day)
- Mental illness/hospital discharge
- Smoke free policy
- Progress with land rights as a marker for social and emotional wellbeing
- Employment in real jobs
- Crowding in housing
- Regular maintenance of nurses' accommodation
- Number of Aboriginal and Torres Strait Islander staff living locally who have accommodation provided (as it is provided for non-Indigenous staff)
- Number of doctors for population
- Patient satisfaction would be better than complaints
- Proportion of rheumatic heart disease that is secondary disease
- Price of food
- The number (or proportion) of towns with a population between (say) 1,000 and 50,000 that have neither an AMS nor a GP who bulk bills
- Access to essential medication (section 100)
- Equipment maintenance and replacement.
- Policy implementation relating to hospital accreditation and the inclusion of cross-cultural training as part of health professional accreditation

It is impossible to develop indicators for some of these topics at present. For example, it is impossible to collect information on perinatal mortality because of difference with Aboriginal and Torres Strait Islander identification in the potential source data. The stillbirths data comes from the Perinatal Collection where maternal identification is used while the neonatal mortality component is derived from death registrations where both maternal and paternal identification is recorded. While the growth of children under five years of age is internationally recognised as an indicator of health, it is not available in either the general Australian population or the Aboriginal and Torres Strait Islander population. Others of these indicators would not be appropriate in a summary set such as this. For example, the average price of food in a state would be fairly meaningless - it is the variation in price around the jurisdiction that is important. This belongs in a content set of indicators, not a summary set.

7.2 Variation in socio-economic status in Aboriginal and Torres Strait Islander people

Consultees pointed out that, because of limitations of data quality and the focus on jurisdictional boundaries, very little is known about the health of Aboriginal and Torres Strait Islanders living in the eastern states, or about those living in capital cities and other urban areas. In the general population, determinants of health (including the distribution of socio-economic status, housing, and the availability of services) vary between urban and rural areas. Reporting at whole-of-State or whole-of-Territory level may obscure or distort important similarities or differences that would show up in comparisons of parts of States or Territories. Thus there is an argument for part-of-State/Territory comparisons, such as comparing health among remote areas of States/Territories versus the capital cities. It has been suggested that the Commonwealth report on the National Performance Indicators for Aboriginal and Torres Strait Islander Health should contain part-of-state breakdowns for indicators of morbidity and mortality, while the State/Territory reports could concentrate on indicators that refer to the State/Territory geographical boundaries.

7.3 Policy implications of the indicators

The suggested framework is one way of grouping the indicators. Another way would be to look at them from the policy perspective. See Appendix 6 for an alternative grouping system.

8. APPROACHES FOR FUTURE REPORTING

8.1 Targets

Refining targets and setting new targets were outside the Terms of Reference of the current project. Targets were previously specified for some of the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health. The following table links the original targets to the indicators as re-named in the refined set which is the subject of this report.

Indicator	**Target**
• Life expectancy at birth • Age-specific all cause death rates and ratios • Standardised mortality ratio for all causes • Early adult death	Consistent with a 20% reduction in age standardised all causes mortality rate ratios over ten years
• Stillbirths to Aboriginal and Torres Strait Islander mothers • Infant mortality rate	Reduce by 50% within 10 years
Standardised mortality ratios for circulatory diseases	Reduce mortality due to ischaemic heart disease and rheumatic heart disease by 50% within 10 years
Standardised mortality ratios for injury and poisoning, including suicide	Reduce mortality from injury and poisoning by 50% within 10 years
Standardised mortality ratios for respiratory disease and lung cancer	Reduce mortality from pneumonia by 50% within 10 years
Standardised mortality ratios for diabetes	Reduce mortality from diabetes by 20% within 10 years
Standardised mortality ratio for cervical cancer	Reduce mortality from cervical cancer by 50% within 10 years
Pap smear screening	Equivalent to the level in the non-Aboriginal and Torres Strait Islander community in 3 years
Child immunisation rates	At least 85% coverage within 3 years
Coverage of adult pneumoccal vaccine	At least 85% coverage of the target population in 3 years
Hepatitis B (now deleted)	95% coverage of the at risk population in two years

Smoking prevalence	25% reduction in the prevalence of smoking in 10 years
Overweight and obesity	15% reduction in the prevalence of overweight and (obesity) in people aged 25-64 years in 10 years
Alcohol consumption	20% reduction of the proportion of the population who drink hazardous and harmful levels in 10 years

These targets are not included in the technical specifications of the refined indicators.

8.2 Trends

For the indicators reported annually, it is unlikely that there will be statistically significant movements from year to year. The use of three-year moving averages for the mortality data means that the data points are not independent of each other and so cannot be readily tested for difference. Use of single-year data for reporting would not clarify trends, because it would increase the width of confidence intervals.

The assessment of trends is complicated by the difficulty of determining whether apparent trends in data represent real changes in health, or are a result of changes in the propensity to identify as an Aboriginal or Torres Strait Islander person.

Hence an annual assessment of trends for all indicators is not recommended.. A systematic assessment of trends should be made approximately once every 3 to 5 years. Apparent trends should be interpreted in the light of known changes in identification. An assessment of the direction and magnitude of trends should be made for the indicators that are derived from national (or State/Territory) surveys with the same frequency as the surveys themselves are conducted.

8.3 Best practice reporting format

Some indicators can be readily updated on an annual basis. For others, new data are not available annually; indeed, some indicators depend upon data derived from the quinquennial Census. A few indicators depend upon data to be collected from national surveys. The timing of these surveys has not been set for the long-term future, although it seems likely that they will be conducted at approximately 3-6 year intervals. For other indicators, including those based on death registrations and hospital inpatient statistics, data can be compiled anew each year. However, as explained in section 5.1.6 above, annual changes in the indicators may not be readily interpretable. Updates on yet other indicators might be available on a biennial basis. Finally, some indicators might not yet be reportable, at least by all jurisdictions.

Thus the frequencies with which individual indicators can be freshly reported are very variable. Annual reporting is recommended for relatively few of the indicators. The current practice of preparing annual paper-based reports by jurisdiction unavoidably leads to a substantial amount of non-reporting or repetition of data from previous reports. Nevertheless, complete annual reporting of the whole indicator set has the distinct merit of requiring jurisdictions to focus on Aboriginal and Torres Strait Islander health information, and is likely to encourage improvements in data collections. However, if a large number of indicators cannot be reported, or if a substantial proportion of the data are repeated from year to year, the reporting process may cease to be a priority for the agencies responsible for preparing the reports, and the National Performance Indicators for Aboriginal and Torres Strait Islander Health may be overlooked by those for whom the indicator information is intended.

8.4 Electronic reporting for the future?

The advantages of well-designed electronic reporting are numerous. They include the following.

- Indicators could easily be updated at whatever frequency fresh data become available.

- Electronic reporting would facilitate interaction between national agencies which compile data on some of the indicators, and jurisdictions which scrutinise, check and comment on the data before preparing their own reports.

- Electronic reporting is rapidly becoming the norm for government and other agencies.

- Electronic reporting can enable flexible presentation of the material in the indicator reports, which can thus be tailored for specific purposes and specific users, and made available in many different formats.

- Reporting through common electronic templates would reduce the risk of jurisdictions inadvertently introducing inconsistent procedures.

8.5 Collation of jurisdictional reports

Reporting on an indicator depends upon a sufficient level of Aboriginal and Torres Strait Islander identification in the source data collection. Data on specific indicators should not be reported in jurisdictions that cannot provide reliable identification. Indicator values can, of course, be calculated from poor-quality source data, but such values should not be reported.

The order of the indicators in the Instruction Manual has been done according to the agency that produces the data, however, to assist with the reporting process the numbering of the indicators is according to the conceptual framework.

For the annual jurisdictional reports, the indicators should be presented according to the domains to which they relate. A suggested order is included in the technical instructions. The instruction document also contains a suggested table for each of the numerical indicators, or a note that text is required for the non-numerical indicators.

8.6 Impact of the 2001 Census

There was a very large increase in the population identifying as Aboriginal or Torres Strait Islander between the 1991 and 1996 censuses. Much of this increase was due to people's preparedness to identify themselves as Aboriginal or Torres Strait Islander, and to improved enumeration in the Census process, rather than natural increase. However, there are some suggestions that the Aboriginal and Torres Strait Islander population was still undercounted in the 1996 census; for example, local community records yield much higher counts than the Census for a number of communities. The ABS is working on improvements in counting for the 2001 census. Consequently there may be a big difference between the actual 2001 count and the projections based on expected Aboriginal and Torres Strait Islander birth and death rates estimated from the 1996 census. This may create a need to re- calculating data from some of the earlier reports so that a trend can be assessed.

8.7 Other matters raised

Consultees raised many matters that did not relate to the refinement of the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health or the development of indicators of social and emotional well-being. These included:

- the question of how to interpret the indicators given the lack of a framework
- the question of how to use the indicators for policy action
- the question of how to report on the indicators in a format that would be useful for jurisdictions
- the cost of reporting, recognising that there are several similar indicators, and that some jurisdictions were charged by the Commonwealth Department of Education, Training and Youth Affairs for the information they needed to compile indicators
- the lack of a link between the interim National Performance Indicators for Aboriginal and Torres Strait Islander Health and any programs being implemented
- additional indicators were mentioned
- possible alternative ways of calculating some indicator values, or defining the indicators (for example, median age at death or hospital separation could be used rather than mean, or age-specific rates) - this has the advantage that jurisdictions with good Aboriginal and

Torres Strait Islander identification in the death registrations or hospital separations data but uncertain identification in the Census could report, but has the disadvantage that the resulting statistic is not corrected for age

The project team became aware of some national projects to develop indicators for which Aboriginal and Torres Strait Islander identification was not stipulated. The indicator development work done in such projects could contribute to the National Performance Indicators for Aboriginal and Torres Strait Islander health. An example is the project looking at health promotion funded by AIHW.

It would also be desirable to link the National Performance Indicators for Aboriginal and Torres Strait Islander Health to national health strategies which target Aboriginal and Torres Strait Islander peoples (as most do). This would provide a context for the indicators and promote use of the indicators in policy development.

9. RECOMMENDATIONS FOR FUTURE REVISIONS

During the current set of refinements it was noted that developments had made some indicators as they were being reported on to AHMAC elsewhere. Developments in some areas mean that indicators could be amalgamated. It is likely that this would continue to happen in the future and lead to further refinements being appropriate. Although it is recognised that the goal is to report on health and performance, rather than to engage in endless technical refinement, there are some comments the team for this project would make.

- Some indicators have been set at a very low level in recognition that this is the current state of play. For example, Indicator 24 describes the existence of cross-cultural training program hospitals. As most jurisdictions start to meet this level, it would be appropriate to raise the level to include some aspect of program content, acquisition of staff knowledge etc.
- Some mortality indicators may be based on very low numbers of events. To date the jurisdictions have only reported the rates, as was previously specified. There was no agreement as to whether a minimum number of events should be set as part of a reporting criterion. Hence, the number of events has been specified for reporting to aid future decisions about whether other avenues of reporting should be sought for certain conditions (e.g. perhaps rheumatic heart disease).
- Examine the usefulness of urgency of admission (Indicator 40.1) to determine whether this is useful, and whether it would be applied to all indicators based on hospital separations.
- A description of the combination of hospital separations codes that best capture the burden of renal disease may become available.
- It would be useful to explore how often pneumonia is coded in the principal diagnosis field versus any other diagnosis field to determine whether using the principal diagnosis is adequate. This would need to include a consideration of the reasons why pneumonia might be coded second and what the coding rules are.
- Examine the outcomes of projects funded to develop indicators about, for example, health promotion, workforce description and housing, to determine if definitions should be adopted.
- Examine whether indicators about smoking, alcohol consumption or other items derived from surveys need to be adopted to account for changes in standard question modules.
- The year used for the ‘standard population rates’ for the indirect adjusted mortality and hospital separations ratios should be updated every 5-10 years.
- The difference between the projections from the 1996 Census and the observed Aboriginal and Torres Strait Islander population estimated in the 2001 Census will need to be evaluated and recommendations made about what population projections to use for calculating the indicators.

- Future revisions should consider other indicators in use in Australia and ensure articulation and/or alignment whenever possible.

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APPENDIX 1 - Background briefing material for consultations

Dear Colleague,

Thank you for being part of the consultation to assist with refining Performance Indicators and Targets for the Aboriginal and Torres Strait Islander Health. As you are aware, these have been agreed to by the Australian Health Ministers Advisory Council (AHMAC) and the Australian Health Ministers Conference (AHMC) for annual reporting by State, Territory and Commonwealth governments to record efforts in improving Indigenous health at a jurisdictional level and also to draw together a national picture of progress.

In our consultations on the technical refinement of this set of indicators, we anticipate that meetings are likely to fall into two parts.

During the first part, which would involve everybody, we would like to discuss general issues surrounding the Indicators including

- any issues nominated by the group
- suggestions for making the reporting process easier and more useful
- possible frameworks for Indigenous health which may assist report users in understanding the thrust of the Indicators
- indicators which are most/least useful for your jurisdiction

Attachment 1 describes the background to the Performance Indicators and Terms of Reference for the project and is useful background for the first part of the consultation. Attachment 2 is a list of the indicators.

In the second part we will focus on technical refinement issues and this may not interest all participants. Relevant background material and an outline of the information we wish to gather are attached:

- Attachment 3: our summary of issues raised in the 1998 Performance Indicators' reports from the states and territories
- Attachment 4: guidelines for discussion about specific indicators with technical experts e.g. those who compiled the report
- Excel spreadsheet: detailed analysis of the issues summarised in Attachment 2

At the end of the consultation round, we would like to have ascertained:

- views about what larger themes/issues in Indigenous health the indicators reflect
- suggestions about the refinement of particular indicators to clarify their definitions, reliability, usefulness and reportability and reflection the larger themes/issues
- suggestions about how to make the process of reporting easier and more useful

- other comments relevant for the ongoing process of refining the indicators

For details about the venue of the consultation or any queries about the consultation process, please refer to your local contact person or the project manager Dorothy Mackerras (dorothy@menzies.edu.au) or Pam Gollow (pam.gollow@nt.gov.au).

Looking forward to meeting you,

Yours sincerely,
Tony Barnes

Attachment 1:

Background to Aboriginal Health Performance Indicators.

In its February 1996 meeting, the Australian Health Minister Advisory Council (AHMAC), (which consists of heads of Commonwealth, State and Territory health departments) directed their Heads of Aboriginal Health Units (HAHU) to develop a set of performance indicators that governments could use to monitor and report on efforts and progress towards improving Aboriginal and Torres Strait Islander health.

Most parties recognise that the performance indicators can have a dual purpose. Reporting assists with working towards compiling a national picture of progress and also allows each jurisdiction to assess its own performance against its own criteria. Data come partly from health departments own collections but also depend heavily on data from national agencies such as ABS. Data sources or some indicators are uncertain.

Draft indicators were developed by Aboriginal health units with advice from technical experts following a series of meetings and discussions about the range of issues to be covered by the indicators. Many indicators were incomplete or imperfect because of uncertainties in definition or availability of adequate data for reporting. Further refinement of the indicators was undertaken in consultations with a wider group, including National Health and Medical Research Council (NHMRC) and National Aboriginal and Community Controlled Health Organisation (NACCHO).

Goals and targets for some aspects of Aboriginal health had previously been drafted through an NHMRC sponsored process. Where possible some of these or similar targets were attached to appropriate indicators. The updated performance indicators, with some targets, were subsequently distributed widely, including to the Aboriginal community health sector and public health agencies. Each jurisdiction consulted with its own constituents as appropriate.

In February 1997 a two-day meeting was held in Perth to garner the views of a broader range of players. Participants in this meeting included state, Territory, and Commonwealth health authorities, ATSIC, NACCHO, NHMRC, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs, ABS and the Australian Institute of Health and Welfare (AIHW).

This meeting agreed that, despite the need for further refinement and consultation within jurisdictions and agencies, the indicators should be taken forward.

The performance indicators, with selected targets, were considered by the Australian Health Minister Conference (AHMC) which agreed that jurisdictions should report annually against the indicators and targets to AHMC. Where data is inadequate, jurisdictions should report on their progress in developing the capacity to report. They further agreed that additional refinement and consultation should be undertaken.

In 1997 health departments made the first preliminary reporting attempts using the latest available data against the endorsed indicators. An analysis of these reports lead to the production of a template for reporting. The reporting process, while helpful to some jurisdictions, confirmed the need for further refinement and highlighted the almost complete absence of data for some indicators and the variability in data availability and quality from jurisdiction to jurisdiction for other indicators.

In 1998, after minor refinement of the indicators, a further round of annual reporting (for pre-1997 data) was undertaken. While reporting improved for most jurisdictions, the same problems identified in the preliminary reports - uncertainty in definition, data availability and lack of comparability from jurisdiction to jurisdiction - were still present. In an attempt to assist comparability across jurisdictions in future reports a simple reporting template had been constructed in 1998. Some jurisdictions used this template for their 1998 reports. The 1999 reports are not yet available. However it is not anticipated that reporting through the template will address any of the problems of uncertainty in definitions or data availability. All parties recognise that a further technical refinement process is essential.

Currently the 58 indicators in the performance indicator set are arranged in 9 categories (or chapters) which partially reflects the technical production of the report and partially the larger theme/issues underpinning Indigenous health. To date, the state and territory reports list the information on the 58 separate indicators.

In March, 1998, AHMAC asked the Commonwealth to coordinate the refinement process. The Office of Aboriginal Torres Strait Islander Health (OATSIH) of Department of Health and Aged Care (DHAC) has requested AIHW to manage this refinement process. AIHW have commissioned the Cooperative Research Centre for Aboriginal and Tropical Health (CRC-ATH) to undertake the technical refinement and report to AIHW by September 2000.

The terms of Reference provided by the AIHW for this task are:

To report to the Australian Institute of Health and Welfare (AIHW), with respect to the technical refinement of the interim set of national performance indicators for Aboriginal and Torres Strait Islander Health.

1. To undertake a technical refinement of the interim indicators taking into account their accuracy, validity, usefulness, timeliness, appropriateness and quality.

2. To develop a set of indicators for mental illness and for self-reporting of health status, suitable targets for these indicators and to propose a method of trialing these indicators.
3. To undertake a consultation program about the technical refinement work.
4. To identify additional issues or indicators identified by the project team in the process of the technical refinement of the indicators.

Attachment 2:

Interim national performance indicators

Category one: Life expectancy and mortality

Indicator 1.1:	Life expectancy at birth by sex.
Indicator 1.2a	Age-standardised all-causes mortality rates by sex.
Indicator 1.2b	Age-specific all-causes mortality rates by sex.
Indicator 1.3a	Age-standardised all-causes mortality rate ratio by sex.
Indicator 1.3b	All causes age-specific rate by ratio by sex.
Indicator 1.4	Chance of dying between 20 and 54 years by sex.
Indicator 1.5	Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1000 total births to Aboriginal and Torres Strait Islander mothers.
Indicator 1.6	Death rate of Aboriginal and Torres Strait Islanders from birth to one year old.
Indicator 1.7a	Age-standardised mortality rates for ischaemic heart disease and rheumatic heart. Disease by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islanders.
Indicator1.7b	Age-standardised mortality rates of injury and poisoning by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7c	Age-standardised mortality for pneumonia by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7d	Age-standardised mortality rates from diabetes by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7e	Age-standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non-Aboriginal and Torres Strait Islander women.

Category two: Morbidity

Indicator 2.1	Notification rates for selected vaccine preventable diseases: pertussis, measles, hepatitis B.
Indicator 2.1b	Notification rate for meningococcal infection.
Indicator 2.2	Crude notification rates for gonorrhoea and syphilis by sex.
Indicator 2.3	Percentage of Aboriginal and Torres Strait Islander children at school entry having >25dB hearing loss averaged over three frequencies.

Indicator 2.4	Proportion of Aboriginal and Torres Strait Islander newborns with birth weight <2500g, per 1000 live births.
Indicator 2.5	Age-standardised all-causes hospital separation rate ratio by sex.
Indicator 2.6a	Age-standardised hospitalisation rate and ratio by sex for acute myocardial infarction.
Indicator 2.6b	Age-standardised hospitalisation rate ratio by sex for injury and poisoning.
Indicator 2.6c	Age-standardised hospitalisation rate ratio by sex for respiratory diseases.
Indicator 2.6d	Age-standardised hospitalisation rate ratio by sex for diabetes.
Indicator 2.6e	Age-standardised hospitalisation rate ratio by sex for tympanoplasty.

Category three: Access

Indicator 3.1	Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is <30minutes routine travel time from a full-time permanent primary care service by usual means of transport.
Indicator 3.2	Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is <one hour's travel time from a hospital that provides acute inpatient care with the continuous availability of medical supervision.
Indicator 3.3	Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander peoples compared with expenditure for the total population.
Indicator 3.4	Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander peoples compared with non-Aboriginal and Torres Strait Islander people.
Indicator 3.5	Proportion of primary care services, and the resources allocated to these services.
Indicator 3.6	Extent of community participation in health services
Indicator 3.7	a) What number of local or regional health/hospital boards have Aboriginal and Torres Strait Islander members? b) Is this membership mandated by terms of reference?
Indicator 3.8	Proportion of communities with usual populations of <100, within one hour's usual travel time to primary health care services
Indicator 3.9	Per capita recurrent expenditure by government on health care services to communities with populations <100, as compared with expenditure for the general population.

Category four: Health service impacts

Indicator 4.1	Expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander peoples.
Indicator 4.2	Number of Pap smears among Aboriginal and Torres Strait Islander females aged 18-70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group.
Indicator 4.3	Proportion of Aboriginal and Torres Strait Islander children aged two years and six years old that are fully immunised as recorded in the Australian Childhood Immunisation Register (ACIR).
Indicator 4.4	Proportion of Aboriginal and Torres Strait Islander peoples aged >50 years who have received pneumococcal vaccine in the last 6 years compared with the Aboriginal and Torres Strait Islander population in that age group.
Indicator 4.5	Proportion of children aged two and six years who are fully immunised against Hepatitis B as recorded in the National Childhood Immunisation Register.
Indicator 4.6	Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension.
Indicator 4.7	Age-standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders.
Indicator 4.8	Proportion of total consultations by condition and care provider.

Category five: Workforce development

Indicator 5.1	Number of Aboriginal and Torres Strait Islander peoples who have: a graduated in the previous year; and b training in key health related fields.
Indicator 5.2	Number and proportion of Aboriginal Health Workers who graduated in the previous year or are participating in accredited training.
Indicator 5.3	Proportion of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in: a Aboriginal health services; and b Other organisations providing primary care for Aboriginal and Torres Strait Islander peoples on a given date.
Indicator 5.4	Number of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in hospitals where >25% of separations are Aboriginal and Torres Strait Islander peoples on a given date.

Indicator 5.5	Number of Aboriginal identified positions in the health sector.
Indicator 5.6	Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander.
Indicator 5.7	Proportion of accredited hospitals for which the accreditation process required Aboriginal cross-cultural awareness programs for staff to be in place.

Category six: Risk factors

Indicator 6.1	Proportion of Aboriginal and Torres Strait Islander peoples aged >13 years who currently smoke by age and sex.
Indicator 6.2	Proportion of Aboriginal and Torres Strait Islander peoples with a Body Mass Index >25, by sex and age.
Indicator 6.3	Proportion of Aboriginal and Torres Strait Islander peoples who reported usually consuming >4 drinks on the occasions when they drank alcohol in the last two weeks relative to the total numbers who reported on consumption.

Category seven: Intersectoral issues

Indicator 7.1	Proportion of households where the after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the poverty line.
Indicator 7.2	Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives.

Category eight: Community involvement

Indicator 8.1	Establishment of a forum representing the Aboriginal health sector, ATSIC and state jurisdiction in each State and Territory.
Indicator 8.2	Cooperative community planning with the implementation of the regional planning processes.

Category nine: Quality of service provision

Indicator 9.1	Critical incidence reporting and complaints mechanisms at all levels of health services.

Attachment 3:

Summary of issues raised in the 1998 state/territory PI reports

This summary is based on the analysis in the accompanying Excel workbook

Summary of data quality issues raised as a result of the analysis of the 1998 jurisdictional reports. These are mainly related to the accuracy, validity and quality of the interim indicators

Under-reporting of Indigenous status
Indigenous status not recorded at all in some datasets
Sensitive information ie. Women's business
Small numbers – change difficult to interpret, data may lack anonymity
Infants with Indigenous fathers but non-Indigenous mothers not identified as Indigenous
Standardisation methods and age groups need to be consistent across jurisdictions and for Indigenous and non-Indigenous
Data not routinely collected
Inadequate and unclear definitions for indicators
Should the years for reporting be specified
Should year of death registration or occurrence be reported

Issues concerned with usefulness and appropriateness of the interim indicators identified by analysis of the 1998 jurisdictional reports and preliminary interviews

Do the indicators measure what they are intended to measure
Are there any gaps or overlap in the indicators
Is the balance of indicators appropriate
Does each indicator need to be reported on annually or should we only report when the data can be updated
Should some of the indicators be reported on less frequently
Should agencies such as ABS have a responsibility to provide information to all jurisdictions in a common format
Critical issues in accessing data e.g. ownership, obscure sources, cost
Should AHMAC have a responsibility to organise the provision of information to jurisdictions from national sources
Should there be a limited set of indicators used for the purpose of comparison that must meet certain minimum criteria in terms of comparability
Are there other data that actually provide better information than what has been asked for.

Further issues identified by analysis of the 1998 jurisdictional reports and preliminary interviews

Are the indicators appropriate to evaluate changes in the health of Indigenous people
Are the categories for the indicators appropriate
Are the issues raised by the indicators relevant/important to Indigenous people
What is the primary underlying purpose of the indicators

1. to provide information for the jurisdictions themselves
2. to compile a national picture within technical limitations

Attachment 4:

Guidelines for discussions with Technical Experts

This attachment is an outline of the discussion that we would like to have with technical experts who are able and interested to give advice and feedback on technical refinement details. This outline has been developed with experts at the state/territory level in mind and slight variations would be needed for experts from other organisations. Interviewees will be offered the opportunity to submit additional written responses.

Each expert will be asked to consider these questions in relation to every indicator defined in the document, “National performance indicators and targets for 1998-2000: to monitor governments’ efforts to improve Aboriginal and Torres Strait Islander health, February 1998” that they feel competent to comment on. If you do not have access to this document an electronic copy can be sent to you upon request (dorothy@menzies.edu.au).

1. Can your jurisdiction report on the indicator as defined?
    a) If not, what would your jurisdiction need to do (e.g. data improvements) to allow it to report on the indicator?
    b) Could the indicator be modified to become one that could be reported on by your jurisdiction either now or in the near future?
3. Do you think that the comments under the heading “what the indicator tells us” are correct for this indicator? If not, please indicate why and explain how the definition or indicator could be modified to remove inconsistencies.
4. Do you see any definitional issues” additional to those stated in the document?
5. Do you think that the stated “data source” is the most appropriate? Are these adequately specified?
6. Although setting targets is beyond the scope of this technical refinement process, do you have any comments you wish to make regarding targets?
7. Do you agree that the proposed “frequency of reporting” is
    a) feasible using available data (ie. new data is available at that frequency);
    b) sensible (ie. a change of a useful magnitude could be meaningfully detected in the time period proposed)?
8. Bearing in mind the desirability of consistent reporting across jurisdictions (ie. common time periods) and the constraints placed on reporting because of lack of available data, what is the most appropriate time period to report on this indicator? For example, for a report constructed in the year 2000 the time period might be defined as calendar year 1999, financial year 1998/99 or the year might be left undefined as the ‘latest reportable year’.

9. Does your jurisdiction report, either internally or for any national purpose, on a similar but not identical indicator? If so please give details.

10. Other than your responses to the above questions are there other refinement suggestions that you would like to make?

Key: CU1 - Indicators that are well defined, commonly used and are straight forward to report against.

CU2 - Indicators that are reasonably well defined but which need further work regarding either their usefulness, interpretation, reliability or validity

CU3 - Indicators that may be reportable but require substantial additional work regarding usefulness, interpretation, reliability and/or validity

CU4 - Indicators that are not likely to be reportable in their current form and which may require major developmental work

CU5 - Indicators that are unlikely to be useable or reportable in the foreseeable future. This is not to suggest that what the indicator is trying to monitor is unimportant but that another indicator may be better.

1. Life expectancy & mortality		**Indicator validity**	**Frequency of reporting**	**Misc comment**
1.1	Life expectancy at birth by sex	CU1	annual	NSW shows that how you handle open-ended upper age gp gives v different results. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions
1.2a	Age-standardised all-cause Aboriginal and Torres Strait Islander mortality Rates by sex	CU1	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
1.2b	Age-specific all-cause mortality rates by sex	CU1	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
1.3a	Age-standardised all-cause mortality Rate ratio by sex	CU1	annual	? - age-gps for stdisation use open range of 65+ - was this used for both Indigenous and nonIndigenous populations. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population
1.3b	All-cause age-specific rate ratio by sex	CU1	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
1.4	Chance of dying between 20 and 54 years by sex	CU1	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
1.5	No. stillbirths to Aboriginal and Torres Strait Islander mothers per 1000 total births to Aboriginal and Torres Strait Islander mothers	CU2	annual	?Indigenous status of father ie. Indigenous mums not Indigenous babies. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
1.6	Death rate of Aboriginal and Torres Strait Islander Infants from birth to one year of age	CU1	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
1.7a	Age-standardised Mortality rates for rheumatic heart disease and ischaemic heart disease by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	CU2	annual	? - age-gps for stdisation use open range of 65+ - was this used for both Indigenous and nonIndigenous populations. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population

1.7b	Age-standardised Mortality rates for injury and poisoning by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	CU1	annual	? - age-gps for stdisation use open range of 65+ - was this used for both Indigenous and nonIndigenous populations. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population
1.7c	Age-standardised Mortality rates for pneumonia by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	CU2	annual	? - age-gps for stdisation use open range of 65+ - was this used for both Indigenous and nonIndigenous populations. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population
1.7d	Age-standardised Mortality rates for diabetes by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	CU3	annual	? - age-gps for stdisation use open range of 65+ - was this used for both Indigenous and nonIndigenous populations. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population
1.7e	Age-standardised Mortality rates for cervical cancer for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander women	CU2	annual	? - age-gps for stdisation use open range of 65+ - was this used for both Indigenous and nonIndigenous populations. Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population

2. Morbidity

2.1a	Notification rates of selected vaccine preventable diseases: pertussis, measles, hepatitis B.	CU3	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
2.1b	Notification rates of meningococcal infection	CU3	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.
2.2	Crude notification rates of gonorrhoea and syphilis by sex	CU3	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions. Uncertainty of coverage of screening programs.
2.3	Percentage of Aboriginal and Torres Strait Islander children at school entry having >25dB hearing loss averaged over 3 frequencies	CU4		No jurisdiction able to report on indicator - and none have plans to screen children in this way in the near future.
2.4	Proportion of Aboriginal and Torres Strait Islander newborns with birthweight <2500g, per 100 livebirths	CU1	annual	Has similar proble as 1.5 regarding lack of identification as Indigenous when Indigenous father but non-Indigenous mother
2.5	Age standardised all-cause hospital separation rat ratio by sex	CU2	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions. Use of indirect standardisation methods by some jurisdictions makes comparison with other sta
2.6a	Age-standardised hospitalisation rate and ratio by sex for acute MI	CU2	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions.Use of indirect standardisation methods by some jurisdictions makes comparison with other stat
2.6b	Age-standardised hospitalisation rate and ratio by sex for injury and poisoning	CU2	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions. Use of indirect standardisation methods by some jurisdictions makes comparison with other sta
2.6c	Age-standardised hospitalisation rate and ratio by sex for respiratory diseases	CU2	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions. Use of indirect standardisation methods by some jurisdictions makes comparison with other sta

2.6d	Age-standardised hospitalisation rate and ratio by sex for diabetes	CU4	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions. Use of indirect standardisation methods by some jurisdictions makes comparison with other sta
2.6e	Age-standardised hospitalisation rate and ratio by sex for tympanoplasty	CU2	annual	Major difficulty in reporting is due to under-reporting of indigenous status in death registration systems and small Indigenous population in some jurisdictions. Use of indirect standardisation methods by some jurisdictions makes comparison with other sta

3. Access

3.1	Proportion of Aboriginal and Torres Strait Islander people whose ordingary residence is <30 minutes routine travel time from a full-time permanent primary care service by usual means of transport	CU3	Data dependent on ad-hoc surveys - ie. NATSIS	Only information available is self reported from NATSIS 1994 survey/ ?? Plans to repeat survey
3.2	Proportion of Aboriginal and Torres Strait Islander people whose ordingary residence is <1 hours travel time from a hospital that provides acute inpatient care with the continuous availabiltiy of medical supervision	CU3	Data dependent on ad-hoc surveys - ie. NATSIS	Only information available is self reported from NATSIS 1994 survey/ ?? Plans to repeat survey
3.3	Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population	CU4	annual but data not avail in specified categories	Need clear definitions for primary, secondard, tertiary health care services to ensure comparability of data between jurisdictions
3.4	Case fatality ratio of hospital separation to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with nonAboriginal and Torres Strait Islander people	CU3	annual	Indicator calculated differently by different jurisdictions. Need to specify "sentinel conditions" / ICD codes etc
3.5	Proportion of Primary Care Health Services, and the resources allocated to these services. Health services should be classified into those services managed by a. incorporated Aboriginal health organisations, b. community councils, c. state/territory go	CU5	data not generally available	Jurisdictions want clear definition of primary care service. Some could not categorise services by the definitions of management of the indicator or report resource allocation to these services.
3.6	Extent of community participation in health services	CU5	? not reportable	What is meant by community participation. Need clarification to ensure comparability of data
3.7	a. What no. of local or regional health/hospital boards have Aboriginal and Torres Strait Islander members? b. Is this membership mandated by terms of reference?	CU1	annually but not centrally collated	Not routinely collected but most jurisdictions provided some information. Mostly hospital boards/ health boards also need to be included
3.8	Proportion of communities with usual populations of <100, within one hour's usual travel time to primary health care services.	CU3	Data dependent on ad-hoc surveys - ie. NATSIS	Does this included outstations?? What is meant by usual - In remote areas air is routine methods of travel during wet season? Ask WA about their GPS thing. NATSIS could provide some data if repeated
3.9	Per capita recurrent expenditure by government on health care services to communities with populations <100, as compared with expenditure for general population	CU4	not reportable	does pop<100 include outstations of larger cties? If they only live there in the dry? Who came up with this and what did they mean?

4. Health service impacts

4.1	Expenditure on, and description of, health promotion programs specifically targeting A&TSI people	CU2	Annually	Different interpretation of health promotion program - indicator needs clarification
4.2	No. of Pap smears among Aboriginal and Torres Strait Islander females aged 18-70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group.	CU2	not reportable	indig status currently not on path form (with the probable exception of public hosp path labs)/ reporting would also require co-operation of private GP to complete indigenous status on forms
4.3	Proportion of Aboriginal and Torres Strait Islander children aged 2 & 6 years who are fully immunised as recorded in the Australian Childhood Immunisation Register (ACIR)	CU3	Annually	do CCHO report into ACIR? Indigenous not a compulsory field in ACIR!! What is Indigenous identification in ACIR like? C/wealth is liaising with HIC on ways to improve identification of Indigenous children
4.4	Proportion of Aboriginal and Torres Strait Islander peoples aged >50 years who have received pneumococcal vaccine in the last 6 years compared with the Aboriginal and Torres Strait Islander population in the age group.	CU4	Annually when all databases established	vaccine last 5 years- the method of calculating the coverage needs to be clear to allow comparison between jurisdictions
4.5	Proportion of children aged 2 & 6 years who are fully immunised against Hepatitis B as recorded in the Australian Childhood Immunisation Register (ACIR)	CU4	Annually	Indicator does not specify Indigenous children?? Indigenous not a compulsory field in ACIR!! What is Indigenous identification in ACIR like? C/wealth is liaising with HIC on ways to improve identification of Indigenous children
4.6	Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic repiratory conditions and hypertension.	CU1	Annual (Descriptive)	Descriptive responses which varied in comprehensiveness b/t jurisdictions. Need a structured framework to ensure a similar level of information is provided
4.7	Age-standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders. Ideally this	CU4	Annually when all databases established	ICD-CM and E codes probably needed; differential if hospital in location too. What about remote communities where most A&E services provided by community health centre nurse/AHW.
4.8	Proportion of total consultation by condition and by care provider	CU4	not currently reportable	Should this indicator should include all Medicare consults too? - and allied health professionals in private practice etc.? What if client sees more than one or all health professional, ie referred from AHW to nurse to doc? Various states trying to do t

5. Workforce Development - training

5.1	No. Aboriginal and Torres Strait Islander people who have a. graduated in the previous year; and b. training in key health related fields	CU1	annually through DEETYA / Otherwise centrally collated	DEETYA provided some jurisdictions with data. Needs clarification as to what should be included as tertiary training - AHW training conducted in tertiary institutions / does this refer to certificate, diploma and degree courses/ what about post graduate

5.2	No. and proportion of AHWs who graduated in the previous year or are participating in accredited training	CU2	annually - not centrally collated by all jurisdictions	AHW training available at many levels - cert, diploma, degree, post graduate etc
5.3	Proportion of vacant funded FTE positions for doctors, nursesAHWs in: a. Aboriginal health services; b. Other organisations providing primary care for Aboriginal and Torres Strait Islander people on a given date	CU3	data not available - not centrally collated	Before or after the Budget? Over Xmas? Need to pick a day but this does not show up seasonal turnover
5.4	No. of FTE positions for doctors, nurses and AHWs in hospitals where >25% of separations are Aboriginal and Torres Strait Islander people on a given date	CU1	data not available - not centrally collated	CU2 maybe - give us the date!! But also ACT reported for this when surely no hospital there meets the definition!!
5.5	No. of Aboriginal identified positions in the health sector	CU1	data not available	Unclear definition - TAS quoted positions that provided services to Indigenous people rather than posiitions occupied by Indigenous people
5.6	Proportion of doctors and nurses who identify as Aboriginal and/or TSI	CU2	data not available	No data source with indigenous status
5.7	Proportion of accredited hospitals for which the accreditation process required Aboriginal cross-cultural awareness programs for staff to be in place	CU3	not reportable	Not a requirement for accreditation/ an issue for ACHS rather than individual jurisdictions

6. Risk factors

6.1	Proportion of Aboriginal and Torres Strait Islander people aged >13 yrs who currently smoke x age & sex	CU2	Data dependent on ad-hoc surveys - ie. NATSIS	Only information available is from NATSIS 1994 survey/ ?? Plans to repeat survey
6.2	Proportion of Aboriginal and Torres Strait Islander with BMI >25 x age & sex	CU2	Data dependent on ad-hoc surveys - ie. NATSIS	reported from NATSIS which did 13 years and older/ currently no other source of data/ ?? Plans to repeat survey
6.3	Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming > 4 drinks on the occasions when they drank alcohol in the last two weeks relative to the total number who reported on consumption	CU4	Data dependent on ad-hoc surveys - ie. NATSIS	No current data source/ hazardous levels of EtOH consumption is different for M cf F

7. Intersectoral issues

7.1	Proportion of households where the after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the proverty line	CU3	Data dependent on ad-hoc surveys - ie. NATSIS	Need an agreed poverty line - none stated/ ??routine data source identifying indigenous status
7.2	Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives	CU2	Data dependent on ad-hoc surveys - ie. NATSIS	Only information available is from NATSIS 1994 survey/ ??plans to repeat survey/ no clear definition of "reliable" or "adequate"

8. Community involvement

8.1	Establishment of a forum representing the Aboriginal health sector, ATSIC and state jurisdiction in each state and territory. Do forums exist? If yes, what is its membership? Frequency and method of operation of meetings? Brief description of the effe	CU1	annual (descriptive)	Forums established in all jurisdictions - need to expand indicator to include outcomes
8.2	Cooperative community planning with the implementation of the regional planning processes	CU4	annual (descriptive)	Indicator does not monitor whether community participation is actually part of community health planning processes

9. Quality of service provision

9.1	Critical incidence reporting and complaints mechanism at all levels of health service	CU4	annual (descriptive)	Most jurisdictions unable to report on activities outside hospital sector/ indigenous status often not recorded/ most complaints mechanisms not very accessible to Indigenous people

Key: ✪ = jurisdiction considers data to be available & of acceptable quality

= data require improving

= data collection under development

-- = no data available

				NSW	QLD	VIC	NT	SA	WA	TAS	ACT	National collation
1. Life expectancy & mortality		**Able to provide reliable data**	**Not able to provide reliable, updated data**					NA				
1.1	Life expectancy at birth by sex	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			Data not considered valid should not be included in the National report
1.2a	Age-standardised all-cause Aboriginal and Torres Strait Islander mortality Rates by sex	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			
1.2b	Age-specific all-cause mortality rates by sex	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			
1.3a	Age-standardised all-cause mortality Rate ratio by sex	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			
1.3b	All-cause age-specific rate ratio by sex	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT		--		✪		✪			
1.4	Chance of dying between 20 and 54 years by sex	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT		--		✪		✪			
1.5	No. stillbirths to Aboriginal and Torres Strait Islander mothers per 1000 total births to Aboriginal and Torres Strait Islander mothers	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			
1.6	Death rate of Aboriginal and Torres Strait Islander Infants from birth to one year of age	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT		--		✪		✪			
1.7a	Age-standardised Mortality rates for rheumatic heart disease and ischaemic heart disease by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			
1.7b	Age-standardised Mortality rates for injury and poisoning by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			
1.7c	Age-standardised Mortality rates for pneumonia by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	NT, WA, (SA),	NSW, QLD, VIC,TAS, ACT				✪		✪			

1.7d	Age-standardised Mortality rates for diabetes by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,				✪		✪		
1.7e	Age-standardised Mortality rates for cervical cancer for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander women	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,				✪		✪		

2. Morbidity

2.1a	Notification rates of selected vaccine preventable diseases: pertussis, measles, hepatitis B.	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,			--	✪		✪		
2.1b	Notification rates of meningococcal infection	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,			--	✪		✪	--	--
2.2	Crude notification rates of gonorrhoea and syphilis by sex	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,			--	✪		✪	--	--
2.3	Percentage of Aboriginal and Torres Strait Islander children at school entry having >25dB hearing loss averaged over 3 frequencies		all jurisdiction		--	--	--	--		--	--	--
2.4	Proportion of Aboriginal and Torres Strait Islander newborns with birthweight <2500g, per 100 livebirths	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,				✪		✪		
2.5	Age standardised all-cause hospital separation rat ratio by sex	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,				✪		✪		
2.6a	Age-standardised hospitalisation rate and ratio by sex for acute MI	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,			--	✪		✪		
2.6b	Age-standardised hospitalisation rate and ratio by sex for injury and poisoning	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,				✪		✪		
2.6c	Age-standardised hospitalisation rate and ratio by sex for respiratory diseases	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,				✪		✪		
2.6d	Age-standardised hospitalisation rate and ratio by sex for diabetes	NT, WA, (SA),	NSW, VIC,TAS, ACT	QLD,			--	✪		✪		
2.6e	Age-standardised hospitalisation rate and ratio by sex for tympanoplasty	NT, (SA),	NSW, QLD, VIC,TAS, ACT, WA				--	✪		?		

3. Access

3.1	Proportion of Aboriginal and Torres Strait Islander people whose ordingary residence is <30 minutes routine travel time from a full-time permanent primary care service by usual means of transport		all jurisdiction									--
3.2	Proportion of Aboriginal and Torres Strait Islander people whose ordingary residence is <1 hours travel time from a hospital that provides acute inpatient care with the continuous availabiltiy of medical supervision		all jurisdiction									--

3.3	Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population	All (see national report)								--	--
3.4	Case fatality ratio of hospital separation to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non-Aboriginal and Torres Strait Islander people	NT, WA	NSW, QLD, VIC,TAS, ACT, SA				✪		✪		
3.5	Proportion of Primary Care Health Services, and the resources allocated to these services. Health services should be classified into those services managed by a. incorporated Aboriginal health organisations, b. community councils, c. state/territory go		all jurisdiction	--						--	
3.6	Extent of community participation in health services		all jurisdiction	--					--		
3.7	a. What no. of local or regional health/hospital boards have Aboriginal and Torres Strait Islander members? b. Is this membership mandated by terms of reference?	all jurisdiction		✪	✪	✪	✪		✪	✪	✪
3.8	Proportion of communities with usual populations of <100, within one hour's usual travel time to primary health care services.		all jurisdiction	--		?			--	--	--
3.9	Per capita recurrent expenditure by government on health care services to communities with populations <100, as compared with expenditure for general population		all jurisdiction	--	--	--	--		--	--	--

4. Health service impacts

4.1	Expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander people		all jurisdiction		--						
4.2	No. of Pap smears among Aboriginal and Torres Strait Islander females aged 18-70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group.		all jurisdiction	--	--	--	--		--	--	--
4.3	Proportion of Indigenous children aged 2 & 6 years who are fully immunised as recorded in the Australian Childhood Immunisation Register (ACIR)		all jurisdiction	--		--			--	--	
4.4	Proportion of Aboriginal and Torres Strait Islander peoples aged >50 years who have received pneumococcal vaccine in the last 6 years compared with the Aboriginal and Torres Strait Islander population in the age group.	NT	NSW, QLD, VIC,TAS, ACT, SA, WA			--	✪		--		
4.5	Proportion of children aged 2 & 6 years who are fully immunised against Hepatitis B as recorded in the Australian Childhood Immunisation Register (ACIR)		all jurisdiction	--		--			--	--	
4.6	Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic repiratory		all jurisdiction	?		--					--

	conditions and hypertension.										
4.7	Age-standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders. Ideally this		all jurisdiction		--	--			--		--
4.8	Proportion of total consultation by condition and by care provider		all jurisdiction	--		--			--	--	--
5. Workforce Development - training											
5.1	No. Aboriginal and Torres Strait Islander people who have a. graduated in the previous year; and b. training in key health related fields	NSW, VIC, NT, WA	ACT. QLD. TAS	✪	--	✪	✪		✪	--	
5.2	No. and proportion of AHWs who graduated in the previous year or are participating in accredited training	NSW, VIC, NT, WA	ACT. QLD. TAS	✪	--		✪		✪	--	--
5.3	Proportion of vacant funded FTE positions for doctors, nursesAHWs in: a. Aboriginal health services; b. Other organisations providing primary care for ATSI people on a given date	NT	NSW, QLD, VIC,TAS, ACT. WA			--	✪		--		
5.4	No. of FTE positions for doctors, nurses and AHWs in hospitals where >25% of separations are ATSI people on a given date	NT	NSW, QLD, VIC,TAS, ACT. WA				✪		--	--	
5.5	No. of Aboriginal identified positions in the health sector	ACT,	NSW, QLD, VIC,TAS, NT. WA	--		--			--		✪
5.6	Proportion of doctors and nurses who identify as Aboriginal and/or TSI	ACT, NT	NSW, QLD, VIC,TAS, WA			--			✪		--
5.7	Proportion of accredited hospitals for which the accreditation process required Aboriginal cross-cultural awareness programs for staff to be in place		all jurisdiction - unclear indicator								--
6. Risk factors											
6.1	Proportion of Aboriginal and Torres Strait Islander people aged >13 yrs who currently smoke x age & sex		all jurisdiction								
6.2	Proportion of Aboriginal and Torres Strait Islander with BMI >25 x age & sex		all jurisdiction								
6.3	Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming > 4 drinks on the occasions when they drank alcohol in the last two weeks relative to the total number who reported on consumption		all jurisdiction		--	--	--		--		--

7. Intersectoral issues										
7.1	Proportion of households where the after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the proverty line	all jurisdiction		--	--	--		--	--	--
7.2	Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives	all jurisdiction		--				--		--
8. Community involvement										
8.1	Establishment of a forum representing the Aboriginal health sector, ATSIC and state jurisdiction in each state and territory. Do forums exist? If yes, what is its membership? Frequency and method of operation of meetings? Brief description of the effe	all jurisdiction	✪	✪	✪	✪		✪	✪	✪
8.2	Cooperative community planning with the implementation of the regional planning processes	Unclear indicator								
9. Quality of service provision										
9.1	Critical incidence reporting and complaints mechanism at all levels of health service	Limited ability by all jurisdictions				--		--	--	--

A conceptual framework (handed out during consultations)

A Conceptual Framework for the National Aboriginal and Torres Strait Islander Health Performance Indicators (NATSIHPI)

Conceptual frameworks have been developed in a number of health areas to assist in the reporting of progress in priority areas of health (National Health Priority Areas) and for monitoring and surveillance (AIHW & NPHIWG, 1999). They are effective tools for decision-makers, planners and practitioners in the development of policies and strategies. Frameworks can be used at many levels. Although the primary audience for the National Aboriginal and Torres Strait Islander Health Performance Indicators (NATSIHPI) is the national body other major audiences are the state or territory health department, program areas and non-Government agencies. The frameworks need to have a high degree of generality to be relevant to the different audiences and provide the basis for decision-making and resource allocation. They should also be flexible enough to accommodate change. The common themes of these frameworks are that they reflect the current policy and guide the establishment of a set of indicators in each of the relevant key health domains.

A domain is defined as “an area of policy focus and … health activity in the heath sector that enables a clustering of meaningful analysis, actions and discussion under its heading. A domain may be focused on either a determinant of health or a priority health outcome." (NPHP, 1999).

A conceptual framework for the NATSIHPIs will facilitates a process for the prioritisation of issues affecting health by focussing attention on each domain or priority area. In this way it will guides the systematic identification of appropriate indicators within each of these domains. In most cases these indicators have already been defined but in their current format they fail to adequately inform policy-makers because it is not clear what the indicators are actually measuring and how they relate to policy.

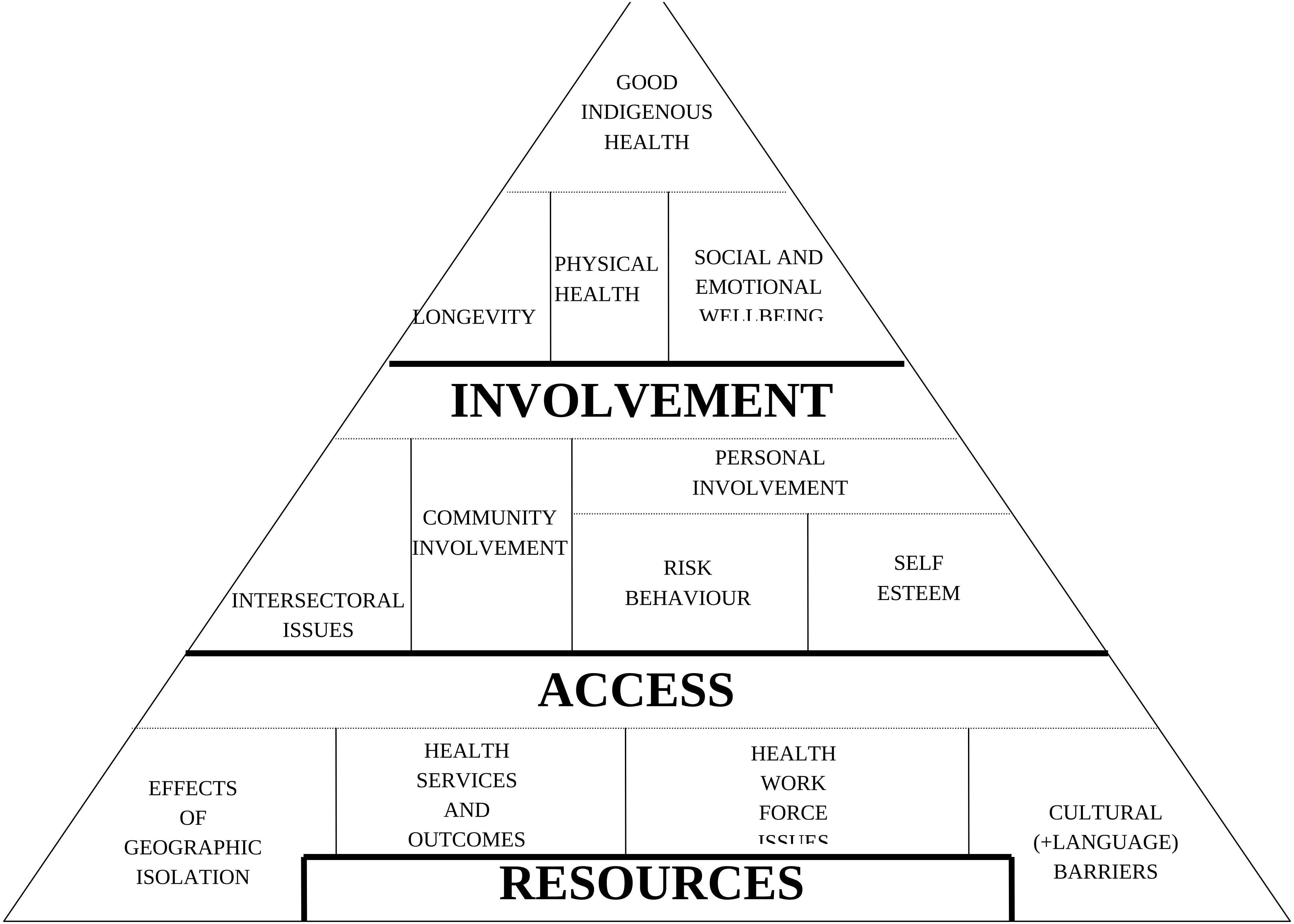
The ability to report on a population’s health is dependent on the availability of health information. However, the conceptual framework is not limited by this availability. In some domains there are well-developed information systems and agreed indicators that are clearly defined and readily reported on. Alternatively, some areas have inadequate information systems, poorly defined indicators and limited ability to report change or progress. The framework will assist in identification of the level of development of existing indicators and focus attention on areas where indicators are lacking. It will also highlight gaps and deficiencies in the organisation and availability of relevant information and indicate where improved information systems are required.

A framework will also assist with the reporting process. Each domain will ideally include quantitative indicators that are comparable across jurisdictions. The collated outcomes from the indicators in each domain will provide summary information on performance within each domain that will readily translate into decision-making in policy areas. A framework will therefore, reflect the current relevant policy, monitor its performance as well as providing a focus for the development of future policy directions.

A framework is proposed below for Aboriginal and Torres Strait Islander health performance indicators. This framework has been developed specifically for use with indicators for Aboriginal and Torres Strait Islander health by considering many proposed indicator frameworks and marrying together salient features of a number of different models.

In most frameworks of performance for health systems, indicators of effectiveness and efficiency of health services are included in addition to indicators of population health status and determinant of health. In the case of Aboriginal health the most important aspect of the effectiveness of health systems is concerned with the adequacy of access Aboriginal and Torres Strait Islander people have to the health services they require. The underlying issues of cost-effectiveness or efficiency are broadly similar for service provision to Aboriginal and Torres Strait Islander peoples as they are for services to the whole population of states or territories, they have not been considered in this framework presented here.

A framework is provided to guide the user through the relatively large number of separate indicators and clarify the relevance of each indicator. It also identifies areas considered to be immediately modifiable such as resources through to the longer term indicators such as health status.


GOOD INDIGENOUS HEALTH
LONGEVITY
PHYSICAL HEALTH
SOCIAL AND EMOTIONAL WELLBEING
INVOLVEMENT
INTERSECTORAL ISSUES
COMMUNITY INVOLVEMENT
PERSONAL INVOLVEMENT
RISK BEHAVIOUR
SELF ESTEEM
ACCESS
EFFECTS OF GEOGRAPHIC ISOLATION
HEALTH SERVICES AND OUTCOMES
HEALTH WORK FORCE ISSUES
CULTURAL (+LANGUAGE) BARRIERS
RESOURCES

APPENDIX 2 - Summary of consultations (sent out to consultees)

Findings from the consultations about the National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health

In August 1997 every Health Minister in Australia signed off on a set of performance indicators to report on the health of Aboriginal and Torres Strait Islanders. They were designed as a way to monitor and report regularly on activity and progress towards improving Aboriginal health.

The National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health set is composed of 58 indicators that report on health status, determinants of health and health service outcomes. The complexity of measures ranges from simple numerical information to composite indicators such as life expectancy. Each state and territory government has reported against them in 1997, 1998 and 1999.

At the onset of the process it was acknowledged that the Performance Indicator set would require further work to refine and develop better and more useful indicators. This process is being funded by the Commonwealth through the Australian Institute of Health and Welfare and is being undertaken by the Cooperative Research Centre for Aboriginal and Tropical Health. A report will be prepared for consideration by the Australian Health Ministers Advisory Council when it meets in September.

The first phase of the refinement has included an extensive consultation involving people from all jurisdictional health departments, Aboriginal community controlled peak bodies in each state and territory and key health information agencies in order to gather information from diverse perspectives. Key themes emerging from the consultation are presented in this paper, followed by a discussion of actions required to bring about a more useful indicator set.

This paper has four purposes: to reflect the main themes emerging from the consultation phase; to describe the classification system developed by the project team; to outline the next steps in the refinement process and to stimulate further comment. It also provides an opportunity to thank the organisations and individuals who have participated in the consultation and willingly provided relevant documents.

The nature of the indicator process

There has been a worldwide trend toward reporting Performance Indicators as a way of measuring performance. The following reports and events significantly influenced the path taken in the development of the National Aboriginal Health Performance indicator set:

- The 1989 *National Aboriginal Health Strategy* where one of the key elements was the need for effective monitoring and evaluation of Aboriginal health.

- The national benchmarking and accountability work for Indigenous Australians that commenced under the Council of Australian Governments' 1992 *National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders.*

- The Royal Commission's report into Aboriginal Deaths in Custody.

- National Health and Medical Research Council Standing Committee on Aboriginal and Torres Strait Islander Health on goals and targets.

- 1994 National Aboriginal and Torres Strait Islander Survey.

- The National Indigenous Health Information Plan: '*this time lets make it happen.*

- The Framework Agreements on Aboriginal and Torres Strait Islander health that requires Aboriginal health to be monitored and reported.

Key events in the development of the Indicator set:

- In February, 1996 the Australian Health Ministers Advisory Council instructed the Heads of Aboriginal Health Units from government health authorities to develop broad performance indicators to monitor the key factors influencing Aboriginal and Torres Strait Islander people's health.

- October 1996 the Heads of Aboriginal Health Units presented a set of draft indicators to the Australian Health Ministers Advisory Council advising the involvement of the Aboriginal community controlled health services.

- February 1997 a 'consensus' meeting with representatives from government health departments, ATSIC, NACCHO, NHMRC, MCATSIA, ABS and AIHW where an agreement was reached to proceed to further develop a set of indicators.

- August 1997 Health Ministers endorsed Indicators set and agreed that all jurisdictions would report annually

- October 1997 the first reports by each jurisdiction prepared for the Australian Health Ministers Advisory Council by state and territory health departments.

- Indicators were refined and termed "Interim Set" for reporting in 1998 and 1999. AHMAC gave the Commonwealth the responsibility for overseeing the further technical refinement of the Indicators.
- December 1998 a second report prepared for the Australian Health Ministers Advisory Council by state and territory health departments.

- The Commonwealth Office of Aboriginal Torres Strait Islander Health given the task of coordination and commissioned a National Summary report prepared for AHMAC from the 1998 state and territory information.

- 1998 AIHW was requested by the Commonwealth to manage the refinement process .

- AIHW commissioned the Cooperative Research Centre for Aboriginal and Tropical Health to undertake the technical refinement and report to AIHW by September 2000.

- January 2000 all jurisdictions reported on the Interim Indicators for the third time to the National Health Information Management Group, a sub-committee of AHMAC. A 1999 data National Summary report is being prepared by the AIHW to be presented to AHMAC in October 2000.

Terms of Reference of the Refinement Project

The refinement process of the National Aboriginal Health Performance Indicator set is being done so that the indicators are better able to monitor and record the progress made towards improving Aboriginal health.

The terms of reference guiding the work of the Cooperative Research Centre are:

1. To undertake a technical refinement of the interim indicators taking into account their accuracy, validity, usefulness, timeliness, appropriateness and quality.

2. To develop a set of mental health indicators, suitable targets for these indicators and to propose a method of trialing these indicators

3. To undertake a consultation program about the technical refinement work

4. To identify additional issues or indicators identified by the project team in the process of the technical refinement of the indicators

This paper addresses the third and fourth terms of reference and will set out the processes for the first and second.

The Consultation

Most of the consultation component took place during February and March 2000. State and territory health departments, Aboriginal community controlled peak bodies and key organisations and individuals involved in collation of Aboriginal and health information were invited to participate in the consultation.

A number of face-to-face meetings were held in each state and territory. The discussion was structured to cover both general issues about health indicators; how to make the reporting process easier and more useful; a possible framework for Indigenous health to link the indicators and where possible to gather suggestions on the technical refinement of specific indicators.

Participants were provided with a brief background paper to the indicators, a summary of issues raised in the *National Summary of the 1998 jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators* prior to the meeting.

Members of the project team travelled to all capital cities, North Queensland and the Torres Strait, Western NSW and the Kimberley and Geraldton regions of WA. The number of participants and structure of the consultation meeting varied from site to site. The people interviewed represented many perspectives; health service delivery, health policy and health information. The depth to which issues were explored during the meetings depended upon the participants prior exposure and experience in collecting and using the indicator set.

The consultations provided an opportunity to gather both verbal comments and relevant documents, including those prepared by state and territory health departments as part of the 1999 report on the National Performance Indicators (or NPIs) for the Australian Health Ministers Advisory Council.

Phase 1 Findings

It was evident from the consultation that only a few select people in policy and technical areas had had the opportunity to be familiar with the NAHPI reports from their own state.

Key information gathered during this consultation has been summarised under the following points:

The indicator set has no defined goal or clear set of objectives. The range of purposes suggested by consultees included: 1. The NHAPI could improve reporting to generate a wider public discourse on Indigenous health by focussing on specific areas and trying to measure what is happening in those areas. 2. Indicators could be used for interstate comparisons but the main users of reports will inevitably be within a state or territory. 3. The ability to benchmark may improve government services. 4. To reframe and focus discussion on the major causes of morbidity and mortality of Aboriginal and Torres Strait Islanders. 5.To inform discussions and decisions within organisations. 6. As a lever to change the way of thinking about Aboriginal health. However, people thought that the NAHPI set had not generally achieved these purposes. In addition there were a number of comments that

a) the indicators do not appear to be based on any overall policy objective in improving Aboriginal health. They are also not linked to known determinantsof disease. The indicators need to move beyond merely restating the burden of disease.

b) A common statement was that there are too many indicators. No one suggested which ones should be removed. The 58 indicators are currently in categories but without a guide of how to interpret or link to policy. The need for *a loose framework was suggested. The conceptual framework* that was presented during the consultations was generally accepted as having merit. A community capacity domain was added to the initial framework.

c) *The indicators do not reflect major strategies or intervention programs currently being implemented.*

d) Consistency between indicator sets was uniformly requested. To reduce duplication of *work, the indicators need to be mapped to other major indicator sets and where there is overlap a uniform definition adopted.* The number of national health indicator sets have been developed in recent years that each state and territory government is required to report on. PIs have been developed for the National Health Priority Areas of injury, diabetes, cardiovascular disease, cancer and PHOFA indicators. All have relevance to the further development and refinement of the NAHPIs.

e) *Clear and precise definitions of the indicators need to be developed.* This is the most commonly cited problem of the indicators. Imprecise definitions or a lack of clarity weaken the overall value of the indicator. Consistency of definition with national data dictionaries unless there is a good reason as to offer an alternative definition to the commonly used is suggested. New definitions could be added to the data dictionaries. Population denominators should be standardised. It was suggested that they should be based on a linear interpolation between censuses.

f) Data sources need to be identified. It was suggested that a common single source of data be used whenever possible across the different states and territories. Where possible data sources should be prescribed. Data collated centrally could also be produced by the central source for reporting against the indicators. Data used for the indicators should not be regarded as confidential by the collector.

g) Little good quality national data. Few of the indicators could be reported against in all states. The most significant reason is the extent to which Aboriginal or Torres Strait Islander status is not identified in health statistics.

h) A straightforward reporting procedure needs to be developed for use by all states and territories. Electronic reporting using a proforma was discussed and acknowledged during the consultations as a sensible alternative to the current system.

i) Frequency of reporting needs to be determined for each indicator. It was noted that the data for which it is easiest to produce annual statistics are the items which will change most slowly and so annual updates have little meaning (i.e. the mortality data). The indicators of access, service etc which might change annually are poorly reported and difficult to report on.

j) Difficulty of reporting consistently on an indicator when the data source is infrequent or irregular. A number of indicators cannot be reported on unless another survey like the 1994 NATSIS is done.

k) A number of alternative indicators were suggested. Alternative indicators were frequently suggested to monitor access, the Aboriginal workforce development and primary health care capacity. For example, indicator 3.1 measures a person's ordinary residence within 30 minutes of a primary health care facility which has limited value. One suggestion is 'the number of % of towns within a given population range that do not have an Aboriginal Medical Service or a General Practitioner that bulk bills'. Many suggestions were received about monitoring aspects of health service delivery such as access to housing by Aboriginal employees, equipment maintenance and replacement and employment of environmental health workers.

l) A number of specific improvements were suggested for individual indicators which will be considered in the indicator catalogue. E.g. age ranges, listing ICD codes, matching the alcohol categories to the NHMRC definitions etc

m) Many indicators within other indicator sets could be suitable if indigenous identifiers were included.

n) Additional health issues suggested included, housing, environmental health (both of which could be indicators of a policy objective to address the socio-economic determinants of disease), oral health, community capacity, poverty, infectious diseases, child growth monitoring and access to fresh fruit and vegetables.

Many excellent ideas that fall outside the terms of reference for this project were suggested to the project team. Interesting suggestions include the possibility of international benchmarking and the varied frameworks for performance indicators that are being used by First Nations in Canada.

Development of Mental health indicators.

Many consultees commented that mental health was the wrong title for this set as it gave the appearance of measuring mental illness. Renaming this section to Social and Emotional Wellbeing and including indicators of the wellbeing aspects were desired. There have been a small number of surveys that have included questions trying to address this angle and which might be able to be developed further.

By contrast, the readily available data tends to relate to mental illness and adverse outcomes. States and territories will provide community-level information to the Commonwealth under the Health Care Funding Agreement from 1 July 2000. Both inpatient and community level information will be reported. Other available data includes:

- Suicide - can be linked to existing programs.
- Mental illness – Depression, grief, loss - hospitalisation and community data
- Alcohol and other drug use – comorbidities.
- Injury – self inflicted and that inflicted by others
- Motor vehicle crash data

Classification scheme for assessing the indicators

The project team developed a classification set for assessing the current 58 indicators (Appendix 1). The criteria are derived from similar sets developed by AIHW and in the US and Canada. We thought the criteria fell into 3 types – assessing the extent to which the indicators reflected important items for Indigenous people, the extent to which the indicators were congruent with other indicators reflecting the same item and the ability to report on the indicator in a nationally uniform manner.

Where to from here

The suggested ways to refine the indicators that arise from the consultations can be summarised as:

- Reduce the overall number of different performance indicators
- Produce a simple concise method for national reporting
- Provide indicators that are possible to link to policy
- Improve public access to information

The steps for the next phase of the project are

- Assess the current 58 against the classification scheme (Appendix 1)
- For indicators which pass Part 1
- Refine the definition (when possible) using data dictionaries and other sources
- For indicators which do not pass Part 1
- Suggest alternative definitions
- Simultaneously with the above process, a set of indicators of social and emotional wellbeing will be constructed and assessed against the classification scheme
- The method of collecting, analysing and presenting the data will be described
- The refined indicators will be sent to the organisations consulted in the first round for comment
- As part of the final document, one or more possible frameworks for linking the indicators will be suggested
- The final document will also contain a list of new indicators suggested by respondents, together with any currently existing indicators from other indicator sets. This document will also include other comments about the indicator set, or future refinement work that were made during the consultations.

Conclusion

The development of a national Aboriginal health indicator set is at a critical stage. The challenge is to recognise the imperfections, working on data improvement, develop new systems, and to design indicators to make the best possible use of existing information.

Clearly all the issues identified above cannot be resolved during this refinement process. However, with refinement the indicators could contribute to a national picture, focus attention to the determinants of health, foster information development and broaden community knowledge.

APPENDIX 3 - List of people and organisations consulted

Pre-consultation planning and consultation meeting, Darwin, 27/1/00

Pam Gollow	THS
Terry Dunbar	Business Manager, CRC
Joan Cunningham	Director of Research, ABS NCATSIS
Joe Martin-Jard	THS
Tony Barnes	Director, CRC
Edouard d’Espaignet	Head, Epidemiology Branch, THS
Sally Cairnduff	THS
Trish Jones	HAHU, THS
Jenny Cleary	A/Asst. Sec Aboriginal and Community Services, THS
Dot Morrison	Public Health Strategy Unit, THS
Dorothy Mackerras	MSHR
Rob Currie	Staff Development, THS
John Condon	formerly Head, Epidemiology Branch THS

Victorian Health Dept 9/2/00

Rick Marshall,	Epidemiology
Ron James	HAHU

Productivity Commission, Melbourne 9/2/00

Simon Corden.	
Robyn Sheen	
Ilias Mastoris	
Diana Edwards.	
David Adams	(Victorian Premier’s Dept)

NSW Health 10/2/00

Dr Tim Smythe	Deputy Director-General of Policy
Jim Pearce	

NSW AH&MRC, Sydney 10/2/00

Sandra Bailey & John Williams

Bila Muuji meeting, Wellington NSW 11/2/00

Joyce Williams	Chair, Wellington Aboriginal Health Group
Christine Thorne	Walget AMS - CEO
Jody Himt	Walget AMS - Eye Health Coordinator
Cameron Daley	Thubbo AMS - Dubbo - Youth Worker
Raquel Clark	Thubbo AMS - Dubbo Tenants Advice Worker
Cheryl Ah Chee	Thubbo AMS - Health Worker

NSW Health - 14/4/00

Tim Churchs	Epidemiology
Amanda Lees	Policy Branch,
Angela Todd	
Lynne Madden	

NACCHO Board Meeting Canberra 15/2/00
List of attendees not available - all affiliates represented

Robert Griew, Sydney - 16/2/00

Tasmania Dept of Health, Hobart 17/2/00
Anna Williams
Jeanette Lewis
Mercia Bresnehan
Shane Nichols

AMSANT - Darwin 17/2/00
List of attendees not available - approximately 20 people

Commonwealth Health and Aged Care 28/2/00

Phillipa Lowrey	Research and data
Simon Doyle	Research and data (NPI)
Jan Streatfield	Research and data
Kirrily Harrison	Research and data (SAR Surveys)
Ellen Seymour	Research and data (NPI)
Helen Monten	Social Health
Jodie Lewfatt	Social Health
Gabriela Samcewicz	Health Issues
Fran Emerson	Health workforce
Helen McFarlae	Sexual Health and Immunisation
David Ashbridge	OATSIH

Second DHAC consultation 29/12/2000

Pillipa Lowrey	OATSIH
Gina Callan	HSD
Jonette McDonnell	National Health
Alan Browne	Rural Health Broome
Gemma Duffy	HSD – Rural Health Branch
Simon Doyle	Research and Data OATSIH
Jodie Lewfatt	OATSIH

Maurice Walker	Social Health OATSIH
Tony Moore	HSD – Mental Health Branch
Frances Byers	Eval & Research Pop Health Div
Katie Birch	Eval & Research Pop Health Div
Brendan Gibson	Eval & Research Pop Health Div
Maria Jolly	Policy & Planning Pop Health

ATSIC - Housing Infrastructure, Health and Heritage Branch

Geoff Dane	ATSIC
Kate Ross	ABS Outpost Officer
Noel Baxendell	ATSIC

ACT Health

Ian King	Indigenous Policy Officer
Carol Kee	Population Health Information Unit
Josie Barac	Population Health Info Unit
Margaret Summers	Consumer and Community Priorities
Vicki Crispe	Officer of the Chief Health Officer
Gary Kennedy	Information Management Unit (could not attend)

AIHW, Canberra, 2/3/00

Lynelle Moon
David Bradock

ABS meeting, 2/3/00

John Paice	Demography
Saul Jain	Demography
Norma Briscoe	Health
Kathyrn Hughes	Indigenous and General Surveys
Ian Brodie-Reed	Indigenous and General Surveys
Janis Shaw	ATSIS

VACCHO Members meeting, Healesville Vic, 3/3/00

Need to get list

Aboriginal Health Council of South Australia, Adelaide, 4/3/00

Peter Miller	Executive Chairperson
Graham Brice	Senior Research/Policy Officer

SA Health Commission, Dept of Human Services 4/3/00

Darrien Bromley	Aboriginal Services
Paul Basso	Information Management Services

Stuart Speigt	
Sally Castill Mcgregor	Aboriginal Services
Catherine Morgan	Aboriginal Services Division
Anne Taylor	Epidemiology Branch
Annabelle Chan	Pregnancy Outcome Unit, Epidemiology Branch

QAIHF Meeting, Brisbane 6/3/00

List of attendees not obtained, about 20 representatives from member organisations

Queensland Health, Brisbane, 7/3/00

Dr Ian Ring	Health Information Centre
Dr Christine McClintock	Health Information Centre
David Firman	Health Information Centre
Brian Kennedy	Health Information Centre
Terry Coyne	Health Information Centre
Bill Fox	Public Health Services - ATOD’s
Coralie Ober	Public Health Services - ATOD’s
Paul Woods	Public Health Services - Oral Health
Mark Counter	Public Health Services
Magnolia Cardona	Public Health Services
Odette Pagan	Zonal Health Units
Catherine Luck	Organisational Development Branch
Madonna Cuthbert	Mental Health Unit
Glenys Powell	Mental Health Unit
Marj Droste	Mental Health Unit
Robert Barton	Child Health
Jennifer Muller	Cancer Prevention Program
Marie Skinner	Aboriginal & Torres Strait Islander Health Unit
Indrani Ganguly	Aboriginal & Torres Strait Islander Health Unit
Michael Tilse	Health Promotion

Primary health – Thursday Island, 9/3/00

Beris Joyner	Medical Superintendent, Primary Health Care
Wendy McKay	Director Nursing, Primary Health care
Cathy Cook	Child Health Nurse
Millie Gaffney	Acting Health Centre Manager
Yoko Nakada	Men’s and Women’s Health
Gary Tierney	Mental Health Nurse
Yancy Laifoo	Program Coordinator, Maternal and Child Health
Maria McGowan	Dentist
Lynette Puiton	Public health nurse

Peter Holt	Medical Superintendent, Thursday Island Hospital
Aletia Twist	Nutritionist

Torres Strait Region, 9/3/00

Grace Fisher,	Chair, Health Council
Phillip Mills,	District Manager
Meiko Stephen,	Policy Coordinator, TS Framework Agreement

Tropical Public Health Unit, Cairns, 10/3/00

Ross Spark	Manager
Robyn McDermott	
Dympna Leonard	Nutritionist

WA Health, Perth - 13/3/00

Alan Bansemer,	Commissioner of Health
Shane Houston,	General Manager, Office of Aboriginal Health
Stuart Garrow,	Director, Kimberley Public Health Unit
Merryn Smith,	General Manager, Health Information Centre
Jim Codde,	Director, Health Information Centre
Peter Somerford,	Senior Research Officer, Health Information Centre

WA Health - 14/3/00

Brett Wakefield,	Project Officer, Health Workforce & Reform
Peta Williams,	A/Senior Policy Officer, Office of Aboriginal Health
Trevor Jewell,	Senior Policy Officer, Office of Aboriginal Health
Dick Hallson,	Manager, Office of Aboriginal Health
John Kirwan,	Executive General Manager, Public Health & Purchasing
Jennifer Medcalfe-Moore,	Manager, Aged and Continuing Care
Barbara Campbell,	Senior Project Officer, General Health Purchasing
Elizabeth Rohwedder,	Director, Government Health Purchasing
Gordon Stacey,	Director, Health System Performance
Moira McKinnon,	Director, Public Health

WAACCHO, Perth

Di Potter	CEO

WA – Auditor Generals Dept

Peter Williams
Gordon Roberts
Rod Berg

Clearinghouse
Neil Thompson

Combined Universities Centre for Rural Health, Geraldton, WA

Institute for Child Health Research, Perth WA

Anne Read	Epidemiology – Aboriginal health
Suzanne Peel	Midwife/Coordinator Bibbulung Gmarmee
Daniel McAullay	Coordinator Indigenous Child Health Research Network
Jane Freemantle	PhD Student
Deborah Lehmann	Senior Researcher Fellow Epidemiology

Kimberley Aboriginal Medical Service, Broome, 16/3/00

Richard Murray	Medical Director

NACCHO, Broome, 16/4/00

Sophia Couzos	Public Health Officer

NCATSIS, Darwin, 27/3/00

Janis Shaw	Director

Territory Health Services, Darwin, 28/4/00

Peter Plummer	Secretary

Territory Health Services, Darwin 2/5/00

Jenny Cleary	Assistant Secretary
Noelene Swanson	
Trish Jones	HAHU

APPENDIX 4 - Criteria for the inclusion of performance indicators

Part 1. Social and political value and valency of performance indicators

Does the indicator measure things that Aboriginal and Torres Strait Islander people care about?

Does the indicator influence accountability by Govts (ie does it reflect an area of Government responsibility?

Does the indicator have potential social and political impact?

Does the indicator make sense to people?

Does the indicator reflect aspects of policy, programs and services that are amenable to action?

Is the use of the indicator consistent with ethical requirements of the Australian community at large, and Aboriginal and Torres Strait Islander peoples in particular?

Part 2. Definition, validity and reliability of performance indicators

Is the indicator valid, i.e. does it reflect the phenomenon or activity which it purports to reflect?

Are alternative indicators available? If so, why is the recommended indicator preferred?

Is the indicator clearly defined, with reference to numerator and denominator?

Is the definition standardised for national consistency?

Is the definition consistent with national data dictionaries and national information models?

Is the indicator reliable, i.e. is it repeatable if there is no change in the phenomenon or activity being measured?

Part 3. Reportability

Are recent data available from all jurisdictions to report on the indicator?

If not, are all jurisdictions moving towards a capacity to report on the indicator?

Are indigenous people adequately identified in the source data?

If not, are all jurisdictions moving towards a capacity for improving the identification of indigenous people to an adequate level?

Can the indicator data be updated with sufficient frequency?

Are data collections from jurisdictions nationally consistent?

APPENDIX 5 - Changes to name and number of indicators and strategic action required for the future

Changes made to all indicators:	**Improved definition of elements of the indicator** **Presentation format provided** **Method of calculation of indicator described** **Data sources identified** **Frequency of reporting has been specified** **Agency to produce the data for the jurisdictions has been specified**

OLD INDICATOR NO.	OLD INDICATOR NAME	NEW INDICATOR NO.	NEW INDICATOR NAME	CHANGES MADE	STRATEGIC ACTIONS REQUIRED FOR THE FUTURE
1.1	Average Length of Life	5	Life expectancy at birth	ABS procedures for calculation specified	Improved Aboriginal and Torres Strait Islander identification on death certificates Improved counts and estimates of the Aboriginal and Torres Strait Islander population in the Census
1.2a	All-Causes Aboriginal and Torres Strait Islander Death Rates	51	Standardised mortality ratio for all causes	Calculations described	ditto
1.2b	All-Causes Aboriginal and Torres Strait Islander Death Rates by Age	50	Age specific all cause death rates and ratio	Calculations described Age groups specified	ditto
1.3a	All-Causes Aboriginal and Torres Strait Islander Death Rates Relative to non-Aboriginal and Torres Strait Islander Death Rates		amalgamated into: Standardised mortality ratio for all causes	Calculations described	ditto

1.3b	Aboriginal and Torres Strait Islander Death Rates Relative to non-Aboriginal and Torres Strait Islander Death Rates		amalgamated into: Age specific all cause death rates and ratio	Calculations described Age groups specified	ditto
1.4	Early Adult Death for Aboriginal and Torres Strait Islander Peoples	49	Early Adult Death	Calculations described	ditto
1.5	Stillbirths Among Aboriginal and Torres Strait Islander Mothers	48	Stillbirths to Aboriginal and Torres Strait Islander mothers	Nil	Paternal identification included in the Midwives/Perinatal Collections
1.6	Death Rates for Infants	6	Infant mortality rate	Nil	Improved Aboriginal and Torres Strait Islander identification on death certificates Improved counts and estimates of the Aboriginal and Torres Strait Islander population in the Census
1.7a	Aboriginal and Torres Strait Islander Death Rates Circulatory Diseases	52	Standardised mortality ratio for Circulatory Diseases	Sub-categories specified ICD codes specified 95% confidence intervals have been added	ditto
1.7b	Aboriginal and Torres Strait Islander Death Rates Injury and Poisoning	53	Standardised mortality ratio for Injury and Poisoning (including suicide)	Sub-categories specified ICD codes specified consistent with National Health Priority Area 95% confidence intervals have been added	ditto
1.7c	Aboriginal and Torres Strait Islander Death Rates Respiratory Diseases	54	Standardised mortality ratio from Respiratory Diseases and lung cancer	Sub-categories specified Lung cancer included ICD codes specified 95% confidence intervals have been added	ditto

1.7d	Aboriginal and Torres Strait Islander Death Rates diabetes	55	Standardised mortality ratio for diabetes	Underlying and multiple causes specified ICD codes specified 95% confidence intervals have been added	ditto
1.7e	Aboriginal and Torres Strait Islander Death Rates Cervical Cancer	56	Standardised mortality ratio for cervical cancer	ICD codes specified 95% confidence intervals have been added	ditto
2.1a	Notification Rates of infectious disease – Vaccine preventable	37	Notification rates - selected vaccine preventable disease	Hepatitis B has been removed and Hib added. Age groups for reporting have been included.	Improved Aboriginal and Torres Strait Islander identification on pathology reporting forms
2.1b	Notification Rates of Notifiable Diseases Meningococcal Disease	38	Notification Rates - Meningoccocal Disease	Age groups for reporting have been included.	ditto
2.2	Sexual Health	39	Notification Rates - Sexually Transmitted diseases	Chlamydia has been added, new cases only of syphilis Age groups for reporting have been included	Improved Aboriginal and Torres Strait Islander identification on pathology reporting forms
2.3	Children's Hearing Loss	47	Children's Hearing Loss		Collection and collation of relevant data
2.4	Low Birthweight Infants	28	Low Birthweight Infants	95% confidence intervals have been added	Paternal identification included in the Midwives/Perinatal Collections
2.5	Aboriginal and Torres Strait Islander Hospitalisation Rates Relative to non-Aboriginal and Torres Strait Islander Hospitalisation Rates	40	Ratios for all hospitalisations	Neonates with unqualified days excluded 95% confidence intervals have been added	Improved Aboriginal and Torres Strait Islander identification on hospital forms Improved counts and estimates of the Aboriginal and Torres Strait Islander population in the Census

2.6a	Aboriginal and Torres Strait Islander Hospitalisation Rates Relative to non-Aboriginal and Torres Strait Islander Hospitalisation Rates acute Myocardial infarction	41	Hospitalisation ratio for circulatory disease	All circulatory disease and sub-categories specified ICD codes specified 95% confidence intervals have been added	ditto
2.6b	Aboriginal and Torres Strait Islander Hospitalisation Rates Relative to non-Aboriginal and Torres Strait Islander Hospitalisation Rates Injury and Poisoning	42	Hospitalisation ratio for injury and poisoning	Sub-categories specified ICD codes specified consistent with National Health Priority Area 95% confidence intervals have been added	ditto
2.6c	Aboriginal and Torres Strait Islander Hospitalisation Rates Relative to non-Aboriginal and Torres Strait Islander Hospitalisation Rates Respiratory Disease	43	Hospitalisation ratio for respiratory disease and lung cancer	Sub-categories specified Lung cancer included ICD codes specified 95% confidence intervals have been added	ditto

2.6d	Aboriginal and Torres Strait Islander Hospitalisation Rates Relative to non-Aboriginal and Torres Strait Islander Hospitalisation Rates Diabetes	44	Hospitalisation ratio for Diabetes	Principal and other diagnoses specified ICD codes specified 95% confidence intervals have been added	ditto
2.6e	Aboriginal and Torres Strait Islander Hospitalisation Rates Relative to non-Aboriginal and Torres Strait Islander Hospitalisation Rates Tympanoplasty	45	Hospitalisation ratio for Tympanoplasty associated with otitis media	Age range specified ICD codes specified 95% confidence intervals have been added	ditto
3.1	Distance to a Primary Health Care Service	16	Distance to a Primary Health Care Centre	The time criterion for access has been replaced with a distance criterion	On going commitment to CHINS survey as the collection tool for the information Change the term "Community health centre in the CHINS survey to "Primary health care centre"
3.2	Distance to a Hospital that Provides Inpatient Care	17	Distance to a Hospital	The time criterion for access has been replaced with a distance criterion	On going commitment to CHINS survey as the collection tool for the information. Review of facilities in remote areas that are classified as hospitals but are in fact primary health care facilities.
3.3	Expenditure on Health Services for Aboriginal and Torres Strait Islander People	2	Government expenditure on health services for Aboriginal and Torres Strait Islander people,	The categories used in the Deeble study have been used to specify categories for reporting information.	

3.4	Access to Hospital Care		Recommended for deletion		
3.5	Proportion of Primary Care Health Services that are Community Controlled	15	Aboriginal & Torres Strait Islander community controlled health services	The expenditure element to the question has been requested as a per capita expenditure to facilitate better comparison The NACCHO definition of community controlled has been adopted	
3.6	The Development of Community Capacity	12	The development of governance capacity in health	More information has been requested on strategies adopted to improve the communities capacity to be involved in health	
3.7	Aboriginal and Torres Strait Islander Representation on Health/Hospital Boards	13	Aboriginal and Torres Strait Islander Representation on Health/Hospital Boards	Nil	
3.8	Time Required to Reach Primary Health Care Services	18	Access to primary health care services - small homeland communities and outstations	The time criterion for access has been replaced with a distance criterion	
3.9	Expenditure on Aboriginal and Torres Strait Islander People Living in Small Communities and Outstations	3	Government expenditure on health services for Aboriginal and Torres Strait Islander people living in small homeland communities and outstations	The expenditure element to the question has been requested as a per capita expenditure to facilitate better comparison	

4.1	Expenditure on and description of specifically targeted health promotion programs	4	Government expenditure on and the description of selected health promotion programs	The heading of the indicator has been changed to reflect that the indicator does not include all health promotion activities, but only selected health promotion programs. The definitions developed as part of the National Public Health Expenditure project have been used to define expenditure areas. A sub-category of social and emotional wellbeing and mental health specified	Aboriginal and Torres Strait Islander identifiers on expenditure programs
4.2	Women at Risk of Cervical Cancer	25	Pap smear screening	The name of the indicator has been changed to reflect that the indicator is measuring coverage for people who have had pap smears. Age grouping for reporting has been included consistent with the National Cervical Screening program reporting. 95% confidence intervals have been added.	Need to include Aboriginal and Torres Strait Islander identifier on pathology forms and pap smear register data bases in each State/Territory Need to resolve with some Community Controlled Health Services concerns they have with confidentiality of information on the pap smear register so all women are included

4.3	Child Immunisation Rates	26	Childhood Immunisation Rates	It is recommended this be changed to include reporting at 12 months as well as 2 year and 6 year age reporting. This makes reporting consistent with the ACIR routine reports of age cohorts against coverage of immunisation schedules. 95% confidence intervals have been added	Need to negotiate with NACCHO state affiliates to get agreement to release indigenous identified data.
4.4	Coverage of Pneumococcal Vaccine	27	Coverage of adult pneumoccocal Vaccine	Nil but no states were able to report this information accurately	Establishment of an adult vaccination schedule. Establishment of an adult vaccine immunisation register
4.5	Hepatitis B		Recommended for deletion	Hepatitis B is given as a combination vaccine an no longer needs be reported separately to the Childhood immunisation rates	
4.6	Management of Key Conditions Responsible for Aboriginal and Torres Strait Islander Ill-health and Death	19	Management of Key Conditions	The indicator has been clarified to define that jurisdictions should report on systematic approaches to implementing evidenced based programs and chronic disease management systems	

4.7	Hospital Outpatient Activity	35	Injuries presenting to hospital Accident and Emergency facilities	The indicator provides a broad indication of the use of Emergency departments for injury related conditions. ICD codes specified The way the indicator was previously written it was unclear as to the point of the indicator.	The development of standard data collection sets for Emergency departments.
4.8	Primary Care Activity		Recommended for deletion	The indicator is actually an analysis question that does not offer any meaningful information at the jurisdictional level.	What is primary health care and a primary health care service needs to be developed.
5.1	Tertiary Training in Health Sector for Aboriginal and Torres Strait Islander Peoples	21	Higher education and training in key health professions	This indicator has combined the two indicators relating to Aboriginal training into one indicator. The reason for this is that there is now no clear distinction between the levels of training delivered in the VET sector and the higher education sector . Health worker training is no longer the sole domain of the VET sector and Health worker training courses are being delivered from higher education facilities.	Improved Aboriginal and Torres Strait Islander identification in the DETYA databases

5.2	Non-Tertiary Training for Aboriginal Health Workers		Amalgamated with: Higher education and training in key health professions		
5.3	Workforce Availability Aboriginal and Torres Strait Islander Primary Care	22	Workforce Availability in Primary Health services that provide care to Aboriginal and Torres Strait Islander population.	The indicator has been changed to report on positions rather than vacant positions. The staff categories to be reported on have been defined	
5.4	Workforce Availability Aboriginal and Torres Strait Islander Hospital services	23	Workforce Availability in Hospitals that provide services to Aboriginal and Torres Strait Islander population.	The categories of staff to be reported on has been expanded	
5.5	Aboriginal identified positions		Recommended for deletion	Health Department do not use Aboriginal identified positions as a strategy to improve indigenous employment..	
5.6	Aboriginal and Torres Strait Islander Workforce	20	Aboriginal and Torres Strait Islander people in the Health workforce	There has been improved definition and a listing of the professions of interest for this indicator to report on. Policy positions included A comparison with non-Indigenous staff has been included.	Improved HRM data collection systems and Aboriginal and Torres Strait identification.

5.7	Knowledge of Cross-Cultural Issues	24	Cross-cultural training for hospital staff	The indicator has removed references to the accreditation process as this was not relevant. The indicator has been refocused to look at the number of facilities with cross cultural programs and numbers of staff completing this training.	
6.1	Smoking Prevalence	29	Smoking Prevalence	The definition has been changed to be consistent with the NHS.	Ongoing commitment to population health surveys by ABS which includes the right questions Adaptation of the indicator if the question used on future national surveys changes
6.2	Prevalence of Overweight and Obesity	31	Overweight and Obesity	Measured heights and weights specified	Ongoing commitment to population health surveys by ABS that includes anthropometric measurement
6.3	Harmful Alcohol Consumption	30	Alcohol Consumption	The definition has been changed to be consistent with the NHS.	Ongoing commitment to population health surveys by ABS which includes the right questions Adaptation of the indicator if the question used on future national surveys changes
7.1	After Housing Poverty	7	Income poverty	The definition of poverty has been included based on the national distribution of income	

7.2	Housing Amenity	10	Housing with utilities	‘Reliable’ services defined	Ongoing commitment to CHINS surveys by ABS A means of collecting the same information outside the discrete communities
8.1	Functioning Partnerships		Recommended for deletion	The reporting requirements under the Framework agreements have superseded these indicators and as such they indicators have been made redundant.	
8.2	Cooperative Community Planning		Recommended for deletion		
9.1	Service Deficiencies and Racism in Health Services	14	Reporting of complaints in hospital	Critical incidents deleted for the present	Recording of Aboriginal or Torres Strait Islander status on complaints and patient master indexes Critical incidents need further defining
	New indicator	1	Efforts to improve identification	Included to streamline reporting for a number of the ongoing strategic initiatives that will make the indicator set more useful	
	New indicator	8	Education	Age range restricted to that where improved school retention would be most obvious	Inclusion of relevant question on the Census
	New indicator	9	Employment		
	New indicator	11	Imprisonment		
	New indicator		Substantiated notifications of child abuse and neglect		

	New indicator	46	Hospitalisations for mental health conditions	ICD codes specified	
	New indicator	36	Prevalence of depression		Ongoing commitment to population health surveys by ABS which includes the right questions (i.e. the Kessler 10) Adaptation of the indicator if the question used on future national surveys changes
	New indicator	33	Problem gambling		Needs extensive development
	New indicator	34	Community grief		Needs extensive development

APPENDIX 6 - Policy implications of the indicators: an additional grouping system

The refined set of National Performance Indicators of Aboriginal and Torres Strait Islander heath will present the user with a large body of statistical and qualitative information which will be difficult to assimilate. The sheer volume of information may dilute the potential of the indicators to stimulate government policy development and action.

The National Health Information Management Group has therefore raised the possibility of identifying a subset of the indicators which could be highlighted for the attention of AHMAC. This possibility has the obvious advantages of concentrating AHMAC members' attention on a smaller number of health issues which can be monitored using the indicators, and which warrant government action in the short to medium term.

However, the selection of this subset of indicators is fraught with difficulty, because the selection criteria can be set from several different perspectives, of which the following are examples.

- The value of indicators to Aboriginal and Torres Strait Islander peoples
- The value of indicators to jurisdictions
- The potential of indicators to motivate improvements in Aboriginal and Torres Strait Islander health
- The need for indicators which reflect major programmatic initiatives and/or are responsive to jurisdictional action
- The need for indicators which can track trends in major causes of morbidity and/or mortality
- The importance of keeping watch on indicators which are widely recognised as fundamental population indicators of health and well-being (and which may be required under Australia's international health and human rights obligations)
- The value of keeping watch on indicators which provide sentinel information on the occurrence of important health problems
- Pragmatic considerations which give priority to indicators that can be reported now, or soon.

Therefore the selection of a subset of indicators should not be undertaken without wide consultation. Such a selection process is beyond the brief of the technical refinement project which is the subject of this report.

However, it may be helpful to view the indicator set from the perspective of a policy maker responsible for government action on Aboriginal and Torres Strait Islander health. Such a policy maker may find the indicator set easier to use if the indicators were placed in groups which could be linked to policy considerations. The following list of groups illustrates this approach. The individual indicators have been allocated to the groups (it is possible that individual indicators should fall into more than one group; the allocation given below does not cover this possibility).

- <u>Indicators of health status</u>
  1.1, 1.2, 1.3, 1.5, 1.6

- <u>Cardinal indicators of adversity in Aboriginal and Torres Strait Islander populations*</u>
  1.4

- <u>Indicators of morbidity or mortality which are likely to be affected by jurisdictional health service action</u>
  1.7a, 1.7c-e, 2.4

- <u>Indicators of access which are likely to be affected by jurisdictional health service action</u>
  3.4, 3.7

- <u>Indicators of jurisdictional commitment to health improvement</u>
  3.3, 3.9, 4.1, 4.6, 5.7, 8.1, 8.2, 9.1

- <u>Indicators of the effectiveness of jurisdictional preventive programs</u>
  2.1, 2.3, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2,

- <u>Indicators of the effectiveness of jurisdictional workforce development programs</u>
  5.1/5.2, 5.3, 5.4, 5.5, 5.6

- <u>Indicators which may be affected by many factors in addition to, or other than, the effectiveness of jurisdictional action</u>
  1.7b, 2.1b, 2.2, 2.3, 2.5, 2.6a-e, 4.7, 6.3, 7.1, 7.2

*This indicator is listed separately because it highlights a phenomenon which particularly characterises the predicament of Aboriginal and Torres Strait Islander populations, namely the grossly premature death of adults.

APPENDIX 7 - Template used when refining the indicators

Indicator name
(indicator names should be consistent e.g. all death rates are called death rates or mortality rates, not a mixture of both name types)

Definition :	**Verbal description**
Specification of the numerator	E.g. data source, deaths by year of registration or occurrence; ICD code, etc
Specification of the denominator	Mid-year pop of which year; censal or mid-censal estimates; 1991 counted or recalculated estimates etc; what age-group breakdowns
Specification of strata	E.g. AREA codes; are outstations communities etc Breakdowns if different for Commonwealth - e.g. ABS part-of-state
Method of calculation of indicator from basic information	E.g. direct or indirect standardisation; calculation of 3 year moving averages only etc. Present per 100,000; per 1000 whatever
Comment about comparison population	Use all-Australian, all-state, non-indigenous etc. Annual trends if we use 3 year averages????
Other definitional comments:	
Production of the data for the indicator	Who does this - DHAC? State health? ABS etc
Frequency of reporting	
What alternatives are allowed?	E.g. for things currently only available in NATSIS, should we encourage e.g. the NT to report the smoking from Midwives Collection? If so, I think we should specify that the source covers a large or important geographic area and is done regularly; or is a regular sentinel site type survey - the possibility of ongoing annual/biannual reporting and ability to describe who the data apply to would seem the main criteria for allowing a state to report its own thing
Domain 1:	Domain name
What the indicator tells us about Domain 1:	
Validity for Domain 1	An indicator could have different degrees of validity for different domains
Domain 2:	Domain name
What the indicator tells us about Domain 2	
Validity for Domain 2	
Target/benchmark	Put in benchmarks as well as targets? E.g. N HW per pop, N docs per pop etc - Machlin papers. But add in comment for part-of-state breakdown to allow for loss of time due to travel?
Similar indicators in other PI reporting	And reason for differences
Future development needed:	
Jurisdictions reporting in 1999 with good quality data	Surely saying “all are able to report but data quality is an issue” is pointless - we should provide an overview of current status
Current usefulness	This is a summary of the previous 2 lines - do we need it? Could also classify as - can report on now - fixable in next 5-10 years - wishlist

APPENDIX 8 - List of indicators from other sets that are similar to the NPIATSIH

Previous NPIATSIH Indicator Definition	▪ **Comments from consultations**	**Other close Indicators**
1.1 Life Expectancy at birth by sex	▪ Prefer to report by year of death not year of registration Difficult to report Aboriginal and TI separately ▪ Discrepancy between reported population size and census ▪ Small numbers of deaths for some diseases ▪ Does not take into account remoteness or socio-economic status therefore masking differences between remote and more urbanised communities ▪ Some data should be aggregated over 5 years ▪ Early release of death data before end of next year could happen	Life Expectancy at Birth, 1960 and 1993 (NHMBG) Gains in life expectancy at birth, 1960 to 1993 (NHMBG) Canadian: Life expectancy at birth and at 65 years old
1.2 a Age-standardised all-causes mortality rates by sex		Canadian: Age standardised rate of deaths from all causes.
1.2b Age-specific mortality by Sex		

1.3a Age-standardised all-causes mortality rate ratio by sex	▪ Need to define population for All Australian rate ratio	
1.3b Age-specific all-causes mortality rate ratio by sex	▪	
1.4 The chance of dying between 20 and 54 years by sex	▪ Life expectancy tables not available in all jurisdictions	
1.5 Number of still births to Aboriginal and Torres Strait Islander mothers per 1000 total births to Aboriginal and Torres Strait Islander mothers	▪ Small numbers ▪ Based on ethnic origin of mother only	Canadian: Annual number of stillbirths (28 or more weeks) and early neonatal deaths (deaths in the first week of life) per 1000 total births.
1.6 Death rate of Aboriginal and Torres Strait Islander from birth to one year of age	▪ Small numbers	Maternity Services 1.15 – Foetal, neonatal and perinatal death rates by indigenous status. Canadian: Number of infants who die in the first year of life, expressed as a rate per 1000 live births.
1.7a Age-standardised mortality rates for ischaemic heart disease and rheumatic heart disease by sex	▪ Qld used ICD coded 3930-3989 and for ischaemic heart disease 4100-4149	NHPA 2.2.10 Death rate for coronary heart disease ages 0-79 NHPA 2.2.11 Death rate for coronary heart disease among rural and remote area residents, ages 0-79 NHS (UK) Deaths in hospital within 30 days of emergency admission with a hear attack for patients aged 50 and over NHS (UK) Death rates for all circulatory diseases Canadian: Age standardised rate of deaths per 100,000 population from ischaemic heart disease (ICD code of 410-

		414) stroke (ICD code of 430-438) and all circulatory deaths (ICD code of 390-459).
1.7b Age-standardised mortality rates for injury and poisoning by sex	▪ Qld used ICD 8000-9999	NHPA Injury 1.1 Death rate for injury and poisoning in the total population NHPA Injury 2.1 Death rate ratio comparing the injury status of Indigenous and non-Indigenous populations NHPA Injury 2.2 Death rate ratio comparing the injury status of males and females NHPA Injury 2.3 Rate ratio comparing the injury status among males aged 25-45 years from low socio-economic groups with males of high socio-economic groups NHPA Injury 2.4 Death rate ratio comparing the injury status among people living in rural and remote areas and the general population
1.7c Age-standardised mortality rates for pneumonia by sex	▪ Qld used ICD 4660-4661, 4800-4869, 7700-7701	NHPA 3.1.1; Incidence of cancer of lung, trachea and bronchus NHPA 3.1.2 Death rate for cancer of lung, trachea and bronchus Indian Health Services: Lung cancer mortality rate

		Canadian: Age standardised rate of deaths from respiratory disease per 100,000 population (ICD code of 460-519).
1.7d Age-standardised mortality rates for diabetes by sex	▪ Qld used ICD 2500-2509 ▪ Need to be specific with ICD codes as can be a primary or secondary diagnosis	NHPA Diabetes 5.1 Death rates for diabetes in the general population, Indigenous population, and among people from culturally and linguistically diverse backgrounds NHPA Diabetes 5.2 Death rate for coronary heart disease and stroke among persons with diabetes in: (a) general population;(b) Indigenous population; and (c) among people from culturally and linguistically diverse background
1.7e Age-standardised mortality rates for cancer of the cervix	▪ Qld used ICD 1800-1809 ▪ WA suggest using 5yr aggregate data ▪ Cancer screening not identified	PHOA Mortality due to cervical cancer per 100,000 estimated resident female population for the target age group (20-69 years) and all women NHPA 3.1.7 Incidence of cancer of the cervix (females aged (20-74) NHPA 3.1.8 Death rate for cancer of the cervix (females aged 20-74) NHPA 3.2.1 Proportion of females aged 50-69 years screened for breast cancer NHPA Five-year survival rate for cancer of the cervix Canadian: Age standardised rate of deaths per 100,000 population for specific sites -lung (ICD code of 410-414), breast (females, ICD code of 174), prostate (males, ICD

		code of 185), and all cancers (ICD code of 140-208).
2.1a Notification rates for selected vaccine preventable diseases: pertussis measles hepatitis B	▪ Laboratories do not record indigenous status	PHOA 1.4 Number of childhood vaccine preventable diseases notified through notifiable diseases surveillance systems Notifications for the 0 – 4 year age group for: Haemophilus influenzae type b infection; measles, mumps, rubella, diphtheria, tetanus, pertussis; polio; hepatitis B. Canadian: Number of cases of pertussis reported in a given year. Number of cases of measles reported in a given year. Number of new cases of tuberculosis reported in a given time period.
2.1b Notification rates for meningococcal infection	▪ Small numbers	
2.2 Crude notification rates for gonorrhoea and syphilis by sex	▪ Laboratories do not record indigenous status ▪ *Note indicator recorded as amended to Age standardised rate of sexually transmitted diseases a) number of gonorrhoea notification b)number of syphilis notification by sex in September 1997 – Commonwealth document*	
2.3 Percentage of Aboriginal and Torres Strait Islander children at school entry having	▪ Info not currently available. WA ▪ Info not available in Qld and no plans to collect	

>25dB hearing loss averaged over three frequencies		
2.4 Proportion of Aboriginal and Torres Strait Islander newborns with birth weight <2500g per 1000 live births	▪ Aboriginality by status of mother only ▪ Some suggested to measure high birth weight infants	Maternity Services 1.9 – Percentage of low birth-weight infants; <1000g, 1000-1499g, 1500-1999g, 2000-2499g by Indigenous status Canadian: Low birth weight – Proportion of live births with a birth weight less than2500g per 1000 live births (excluding births with unknown birth weight).
2.5 Age-standardised all causes hospital separation rate ratio by sex	▪ Unknown validity of hospital identification rates ▪ Some states using data for all hospitals others just public hospitals ▪ Qld using a proxy method for calculating indigenous hospital separation rates	
2.6a Age-standardised all-causes hospital separation rate ratio by sex for myocardial infarction	▪ QLD using ICD codes 410-41099	NHPA 2.2.1 Incidence rate for myocardial infarction ages 30-79 NHPA 2.2.4 Hospital separation rates for principal diagnosis of unstable angina pectoris, ages 0-79 NHPA 2.2.5 Hospital separation rates for principal diagnosis of congestive heart failure, ages 0-79
2.6b Age- standardised all causes hospital separation rate ratio by sex for injury and poisoning	▪ Qld using ICD codes 800-9999	NHPA Injury 1.2 Hospital separation rate for injury and poisoning in the total population NHPA Injury 2.1 Death rate ration comparing the injury status of Indigenous and non-Indigenous populations

		NHPA Injury 2.5 Hospital separation rate ratio comparing the injury status among the indigenous and non indigenous populations NHPA Injury 2.6 Hospital separation rate ratio comparing the injury status among males aged 25-54 years from low socio-economic groups with males from high socio-economic groups
2.6c Age-standardised all causes hospital separation rate ratio by sex for respiratory diseases	▪ Qld using ICD codes 460-51999	Age standardised rate of acute care inpatient hospitalisation for pneumonia and influenza (primary ICD-9 or ICD-9-CM diagnosis code of 250, 291-292, 300, 303-305, 311, 401-405 or 493). Canadian: Proportion of the population age 12 and older who report that they have been diagnosed by a health professional as having asthma.
2.6d Age-standardised all cause hospital separation rate ratio by sex for diabetes	▪ Qld using ICAD codes 250-25099	NHPA 2.4.1 Hospital separation rate for major amputation for peripheral vascular disease, 0-79 NHPA diabetes 1.1 Prevalence rates for Type 1 and Type 2 diabetes in the general population, in the Indigenous population, and among people from culturally and linguistically diverse background (National Health Survey data for 1995) NHPA 1.2 Incidence rate for Type 1 and Type 2 diabetes in the general population, in the Indigenous population, and among people from culturally and linguistically diverse background (no data)

		NHPA Diabetes 1.3 – Gestational diabetes among women aged 20-44 years, by parity NHPA diabetes 4.1 Hospital Separations for end-stage renal disease with diabetic nephropathy as a causal factor NHPA Diabetes 4.2 Hospital separations for coronary heart disease or stroke where diabetes is an additional diagnosis NHPA Diabetes 4.3 – Hospital separation rate for conditions other than end-stage renal disease and coronary heart disease/stroke among: (a) persons for whom diabetes was reported as the principal diagnosis or an additional diagnosis; and (b) persons without diabetes as a reported diagnosis. Canadian: Proportion of the population age 12 and older who report that they have been diagnosed by a health professional as having diabetes.
2.6e Age standardised all causes hospital separation rate ratio by sex for tympanoplasty	▪ Qld using ICD codes 194-19699 ▪ Small numbers ▪ Suggest use of procedure rates as an indicator can be improved by using as the denominator incidence of conditions potentially treated by the procedure rather than the overall population	

3.1 Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is <30 minutes routine travel time from a full-time permanent primary care service by usual means of transport	▪ No information Nat's reports distance. ▪ More relevance on a district and regional basis than by state ▪ CHINS will provide data on a communities distance to nearest hospital, or community health centre. ▪ Redefine indicator as most measures of access are by distance ▪ Need definition of Primary Health Care ▪ More meaningful if a comparison was made with non indigenous people ▪ *Note indicator recorded as amended to Proportion whose ordinary residence is 50km form a full time permanent PHC …. to primary health care service in September 1997 – Commonwealth document*	AHCA 03.05 Access to primary care • Access rates for GP services • Access rates for Pathology and radiology services ordered by GPs • Access rates for PBS prescribed by GPs • Access rates for Medical services provided by community health services • Access rates for Aboriginal medical services • Access rates for Accident and Emergency Departments • Access rates for other post-acute services Commonwealth Budget Papers 1998-99 1.1 Percentage of MBS services that are bulk billed 1.2 Number of full-time equivalent medical practitioners assessing Medicare 1.3 Number of GP and specialist attendances per head of population in rural and remote compared to other areas
3.2 Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is<one hours routine travel time from a hospital that	▪ No information Nat's reports distance. ▪ More relevance on a district and regional basis than by state ▪ *Note indicator recorded as*	WA performance indicators for hospitals are working on access indicators in Derby region

provides acute inpatient care with the continuous availability of medical supervision	*amended distance to a hospital that provides inpatient care in September 1997 – Commonwealth document*	
3.3 Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander peoples compared with expenditure for the total population	▪ Data quality inconsistent both between and within states ▪ Expenditure report (Deeble) will be reproduced every 2 years need to align definition with Deeble methodology	NHMBG 1.04 - Health expenditure as a percentage of Gross Domestic Product (GDP) NHMBG 1.05 -Total health services expenditure, current and constant (1989-90) prices and annual growth rates, 1984-5 to 1996-97 NHMBG 1.06 - Government and non-government expenditures (current prices) as a percentage of total health services expenditure, 1984-85 to 1996-97 NHMBG 1.08 - Percentage of recurrent health services expenditure (current prices), by area of expenditure, 1989-90 to 1995-96 NHMBG 1.09 - Recurrent health services expenditure, by area of expenditure Canadian: Health expenditures in current dollars (1997, 1998 and 1999); expenditures per capita (1997, 1998 and 1999); percent of Gross Domestic Product (1997), public sector expenditures as a percent of total spending (1997);

		expenditures by use of funds (1997).
3.4 Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non-Aboriginal and Torres Strait Islander people (Acute Myocardial Infarction and Pneumonia)	▪ *Note indicator recorded as amended to public hospitals in September 1997 – Commonwealth document*	
3.5 Proportion of primary care services and the resources allocated to these services	▪ Clearer definitions of PHC and Community Control and Resources required ▪ Data sources are ad hoc reports	USA: Percentage of population with an ongoing source of primary care
3.6 The extent of community participation in health services	▪ Only descriptive Info available ▪ Request for definition of capacity	
3.7 The number of local or regional health/hospital boards that have Aboriginal and Torres Strait Islander members		
3.8 Proportion of communities with usual populations of <100 within one hours usual travel time to primary health care services	▪ No Info No accurate national database currently exists to provide information on this indicator	
3.9 Per capita recurrent expenditure by governments on	▪ No info	

health care services to communities with populations <100 as compared with expenditure on the general population		
4.1 The expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander peoples	▪ Boundary between health promotion and screening not clearly defined	
4.2 Number of Pap smears among ATSI females aged 18-70 years as a proportion of the female ATSI population in that age group	▪	PHOA 3.0 Cervical Cancer screening 3.1 Interval cancer rate for squamous malignancy among screened women aged 20-69 years 3.2 Percentage of women screened in a 24 month period by 5 year age groups (20-69 years) 3.3 Incidence rate of (a) micro-invasive cervical cancer and (b) non-invasive cervical cancer, and (c) total cervical cancers by 10 year age groups Canadian: Proportion of women age 18-69 who report having had a Pap test within the last three years
4.3 Proportion of Aboriginal and Torres Strait Islander children aged two years and six	▪ Non mandatory identification on ACIR ▪ Identification on GP but not	NHS (UK) % of target population vaccinated PHOA

years old that are fully immunised as recorded on the ACIR	laboratory reporting ▪ Need to specify whether require Aboriginal rates only, or non-Aboriginal rates also. ▪ Need to specify whether age standardised crude or age-specific rates are required ▪ Need to know completeness of reporting of Aboriginality on ACIR database- has NACCHO agreed that ACIR data by Aboriginality can be released?	i. Proportion of children fully immunised at 12 months (for milestone 1, that is completed all immunisations up to 6 months). ii. Proportion of children fully immunised at 2 years (for milestone 2, that is completed all immunisations up to 12 months, and for Milestone 3, that is completed all immunisations up to 18 months). iii. Proportion of children fully immunised at 6 years (first reported for the 2002-2003)
4.4 The proportion of Aboriginal and Torres Strait Islander people aged >50 years who have received pneumococcal vaccine in the last 6 years compared with the non Aboriginal and Torres Strait Island population in that age group	▪ Each state and territory record this data differently commonwealth is evaluating national program and will recommend minimum data sets. ▪ WA believes this PI will not be achievable until such time as an ACIR type registrar is established	Canadian: Influenza immunisation, Age 65 and older – Proportion of the population age 65 and older who report that they received a dose of influenza vaccine in the past year. PHOA I
4.5 Proportion of Aboriginal and Torres Strait Islander children aged 2 years and 6 years old that are fully immunised against Hepatitis B	▪ Non mandatory identification on ACIR ▪ Problem with age	

on the ACIR		
4.6 Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension	▪	
4.7 Age standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders	▪ No data base and no uniform coding system across states	
4.8 Proportion of total consultations by condition and by care provider	▪ Data not available suggest introducing an identifier to the Medicate data set	Possible indicator under the Bettering the Evaluation and Care of Health (BEACH) project which collects detailed info on consultations with GPs think with AIHW
5.1 Number of Aboriginal and Torres Strait Islander peoples who have a) graduated in the previous year and b) are in	▪ Data not centrally located ▪ Data not collected in QLD ▪ Comm data for higher education from Higher Education Collection	USA: % of population GES 18 TO 24 who have completed high school

training in key health related fields	and for VET in the National Centre for Vocational Education Research ▪ Suggest wording changed to Number of Aboriginal and Torres Strait Islander peoples who have a) gained qualifications in the previous year to reflect the AQF for VET	
5.2 Number and proportion of Aboriginal Health Workers who graduated in the previous year or are participating in accredited training	▪ Data not centrally located ▪ National Centre for Vocational Education Research data available for publicly funded VET however indigenous status unknown for many ▪ Suggest wording changed to Number of Aboriginal and Torres Strait Islander peoples who have a) gained qualifications in the previous year to reflect the AQF for VET ▪ Suggest number and % of year 12 completions	
5.3 The proportion of vacant funded FTE positions for doctors, nurses and AHWs in a) Aboriginal health services and	▪ Requires special survey ▪ Data not collected in Qld	WA % of graduates who were employed or proceeded to further study; extent to which targets were achieved

b) other organisations providing primary care for Aboriginal and Torres Strait Islander people on a given date		
5.4 Number of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers where>25% of separations are Aboriginal and Torres Strait Islander people on a given date	▪ Requires special survey ▪ Data not collected in Qld	
5.5 Number of Aboriginal identified position in the health sector	▪ ‘Aboriginal Identified’ not used	
5.6 Proportion of doctors and nursed who identify as Aboriginal and or Torres Strait Islander		Indian Health Service: Patient encounters by provider, discipline, per year
5.7 The proportion of accredited hospitals for which the accreditation process required Aboriginal cross-cultural awareness programs for staff to be in place	▪ Not currently required for hospital accreditation under EQUIP ▪ Check Australian Council of Healthcare Standards (ACHS) the other accrediting authority	WA hospitals use equity of access indicators such as 1. frequency of interpreter service use 2. mix of Aboriginality and non Aboriginality Indian Health Service: Routine availability of translator for locally spoken language
6.1 The proportion of Aboriginal and Torres Strait Islander people aged >13 years	▪ Requires special survey ▪ Used in NATSIS 1994 ▪ This indicator has been included	NHPA 2.1.1 Proportion of adults who smoke regularly ages 18 or more

who currently smoke by age and sex	in 2001 National Health Survey but has not been broken down into age categories	NHPA 2.1.2 Proportion of secondary school students who smoke, age 15 USA: Percentage of households in which one or more members use any tobacco product Canadian: Proportion of the population age 12 and older who are current smokers. Current smokers are those who smoke on either a daily or an occasional basis.
6.2 The proportion of Aboriginal and Torres Strait Islander people aged >13 years with a Body Mass Index >25, by sex and age	▪ NATSIS source ▪ Future National Health Surveys are expected to collect data on body mass index – ? same indicator	NHPA 2.1.4 Proportion of adults who are overweight ages 18 or more NHPA Diabetes 2.1 – Prevalence rates for obesity and being overweight (as measured by BMI) in: (a) general population; and (b) among persons with Type 2 diabetes Canadian: Proportion of the population age 20 to 64 who are overweight to the point of probable health risk (a BMI of 27.0 or greater; also, BMI 30 or greater)
6.3 The proportion of Aboriginal and Torres Strait Islander people who reported usually consuming >4 drinks on the occasions wen they drank alcohol in the last two weeks relative to the total numbers who reported on	▪ No available data ▪ National Drug Strategy household Survey Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994 and National Health Survey 1995 – Urban areas only	Canada: Prevalence of alcohol and drug dependence of adults, youth, and pregnant women Family violence Injuries Canadian: Proportion of current alcohol drinkers age 12 and older who report having had five or more drinks on one occasion, 12 or more time in the previous year.

consumption		
7.1 The proportion of households where after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the poverty line	▪ Definition for ‘poverty line’ ▪ NATSIS source No current plans to conduct another NATSIS ▪ Poverty indicator could use indigenous cost of living as a PI	Measures of affordability of Indigenous housing Hawaii’s: per capita income Percentage of population below 100% of poverty Civilian unemployment rate = no of persons unemployed divided by total civilian labour force multiplied by 100 Percentage of households on public assistance = no of persons receiving financial aid under government programs Canadian: • Proportion of households spending more than 30 per cent of total household income on shelter costs for renter households, home owners, and total. • Proportion of persons in economic families and unattached individuals with incomes below the Statistics Canada low-income cut-off (LICO) point. The cut-offs represent levels of income where people spend disproportionate amounts of money for food, shelter, and clothing. LICOs are set at income levels differentiated by family size and degree of urbanisation; cut-offs are updated to compensate for changes in the consumer price index.
7.2 The proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last four weeks had	▪ Requires special survey – 1999 CHINS to be repeated in 2001 and then possibly every 5 years ▪ A suggested alternative is the overcrowding and homelessness	Measures of the adequacy of Indigenous housing 1. Homelessness 2. Overcrowding 3. Services Work by Roger Jones

reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives	data derived from the census ▪ AIHW have developed a draft set of Indigenous Housing Indicators	
8.1 Establishment of a forum representing the Aboriginal health sector, ATSIC and state jurisdiction in each state and territory	▪	
8.2 Co-operative community planning with the implementation of the regional planning processes	▪	
9.1 Critical incident reporting and complaints mechanisms at all levels of health services	▪	Patient satisfaction survey Forum for customer input and feedback AHCA 03.06 Quality of care 06.1 Patient satisfaction 06.2 Patient complaints 06.3 Services accreditation 06.4 Patient safety
Original performance indicators identified to be refined at a later date in September 1997	▪ Included Suicide rates ▪ Homicide rates ▪ Psychotic illness ▪ Access to counselling	NHPA Mental Health (depression) 5.1.2 Prevalence rates for depressive disorders 5.1.2 Prevalence rates for anxiety disorders 5.2.1 Hospital separations for suicide and self inflicted injury among young adults aged 15-24 years and older people aged 65 years and over

		5.2.2 Death rates for suicide among young adults (15-24) and older people (65 years and over) NHS (UK) Death rates form suicide and undetermined injury Community Grief
	▪ Oral indicator	NHS (UK) Decayed, missing and filled teeth in five year olds, average number
		Canada: Collaboration or incorporation of traditional healing at facility with respect for traditional beliefs
	▪ Disability	Percentage of population with limitations of activity due to physical, mental or developmental conditions