Aboriginal health in South Australia

2017 case study

Health Performance Council

Government of South Australia

Health Performance Council

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Artwork meaning: The Health Performance Council (shown as the largest main meeting place) watches over the health and care journey of people to make sure that they are getting the proper care in every way. The journey paths emanating to and from the meeting place indicate the distance, while the blue colour variations show the landscape types. Around the central meeting place are many communities. Yellow dots around these places keep the people safe through their journeys, ensuring proper care is achieved for everybody and that their needs are properly met.

Artist: Jordan Lovegrove, Ngarrindjeri, Dreamtime Public Relations, www.dreamtimepr.com.

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Acknowledgment

The Health Performance Council acknowledges the Aboriginal peoples of South Australia and their ongoing contributions to and participation in the life of South Australia. We acknowledge and respect their spiritual relationship with their respective countries.

We also acknowledge the diversity of Aboriginal people in South Australia. South Australia is estimated to be the area of 50 different language groups at the time of European colonisation and 36 continuing language groups (Reconciliation SA 2012). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

Executive summary

The health and wellbeing of Aboriginal and Torres Strait Islander Australians is a significant concern for all Australian governments (COAG 2008). We know from previous reviews and other research that Aboriginal people experience a range of disparities in health outcomes and do not benefit equitably from health services.

This case study forms part of the Health Performance Council's (HPC) 2015-18 four-yearly review program which reports to the South Australian Minister for Health on the performance of the South Australian health system, including how the system performs for specific and vulnerable population groups.

We launched this case study as a consultation draft on 31 May 2017 at the seventh Aboriginal Leaders' Forum. Valued feedback has been received from Aboriginal leaders, SA Health, expert independent bodies and other interested parties during subsequent consultations. Feedback and advice are incorporated into this final report.

This case study is not an exhaustive compendium of health statistics, but confirms that the overall outlook for the health of Aboriginal people in South Australia remains poor, despite positive movement in some areas and targetted initiatives by the South Australian Government. It is clear that piecemeal responses to Aboriginal health do not work.

It is time for a cohesive, comprehensive approach that is founded on careful and respectful listening to Aboriginal communities. This is the only way in which underlying issues can be identified and tackled. It is time to be innovative, considering options that fall outside 'western' health and medical models. It is time for a more holistic approach.

Aboriginal leaders are clear. If better health outcomes are to be realised across the board, there must be an integrated, cross-discipline, cross-portfolio, and Aboriginal-led approach. This approach must take account of social, cultural, spiritual, economic and environmental determinants such as education, employment, safe housing, and culturally appropriate health practices and health promotion.

This case study formulates advice for health system reform to address disparities in health outcomes of Aboriginal people. Four key areas for action emerged through consultation and research:

KEY AREAS FOR REFORM

1. **Increase the numbers of Aboriginal people trained for and placed in the health workforce, particularly in senior and health professional roles.**
2. **Expand culturally appropriate treatment to the entire health system, respecting Aboriginal people and drawing on their strength and endurance to support both individuals and communities to improve wellbeing.**
3. **Remove barriers to the reporting and recording of Aboriginal identification in the health system, both as staff and consumers.**
4. **Reduce and remove perceived and real institutional racism towards Aboriginal people within the health system through workplace audits, consumer feedback, safety and quality standards and personalised healthcare plans and by ensuring Aboriginal health consumers know their rights.**

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What is the Health Performance Council?

The Health Performance Council is the South Australian Government's statutory ministerial advisory body established under the *Health Care Act 2008* to provide advice to the Minister for Health on the performance of the health system, health outcomes for South Australians and specific population groups, and the effectiveness of community and individual engagement.

We publish four-yearly reviews of South Australian health system performance, case studies and other monitoring reports on our website: hpcsa.com.au.

Use of the term Aboriginal

The Health Performance Council respectfully uses the term 'Aboriginal' rather than 'Indigenous' to refer to people who identify as Aboriginal, Torres Strait Islander, or both. We recognise Aboriginal peoples and Torres Strait Islander peoples as two separate groups. However, this document refers to Aboriginal persons in recognition that Aboriginal people are the original and ongoing inhabitants of the state of South Australia. We recognise there are a number of people with Torres Strait Islander heritage living in South Australia. We acknowledge the complexity and diversity of the Aboriginal communities of South Australia, recognising each has its own beliefs and practice.

Data quality statement

The Health Performance Council developed this case study in consultation with Aboriginal leaders via the Aboriginal Leaders' Forums which are regularly co-hosted with the South Australian Health and Medical Research Institute's (SAHMRI) Wardliparingga Aboriginal Research Unit. These forums feature guest speakers, updates on issues that impact the health of Aboriginal people in the state, and advice and decision on future research. We publish output reports from these forums on our website: hpcsa.com.au/get_involved.

Data for this study has been sourced from organisations such as the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), and SA Health enterprise datasets. A complete list of sources and technical information has been provided in this report. We validate our monitoring with relevant experts to confirm robustness of method, accuracy of findings and clarity of presentation.

Data quality caveat

Despite the quality assurances of data providers and others, the Health Performance Council recognises that there is data missing from administrative data sets that can and do impact the analysis and reporting in this report.

The Health Performance Council can only report what we see in the data that is identified as belonging to Aboriginal people. We recognise that not all Aboriginal people are correctly identified in the data and not all Aboriginal people choose to identify themselves or their loved ones every time in administrative datasets, national censuses or other collections. For example, Aboriginal leaders told us that many Aboriginal health consumers do not identify as Aboriginal for fear of discrimination. Aboriginal leaders also told us that health service providers frequently fail to ask about the Aboriginal status of health consumers, even where collection of this status field is mandatory.

Further, due to the relatively small population size and small numbers of Aboriginal people within the state, reliable data and estimates cannot always be obtained. Some key data items presented in this report (such as life expectancy at birth) are missing at the state level. Where this is the case, national figures have been substituted.

Consultations for this report

The Health Performance Council launched this case study initially as consultation draft on 31 May 2017 at the seventh Aboriginal Leaders' Forum hosted at Tauondi College, Port Adelaide. Many of the topics discussed at this and previous forums are represented within this report.

What Aboriginal leaders told us at the consultation launch

Aboriginal leaders provided valuable feedback and new insights at the launch of the consultation draft of this report, summarised as follows:

Health and wellbeing

- More research into the health effects and impacts of removal from family and institutional care is needed.

Education and learning

- The TAFE and university sectors need to better inform Aboriginal students what scholarships are available. There is a need for partnerships between universities and TAFE.
- More information is needed on the numbers of mature-age Aboriginal students in tertiary education.

Employment

- More information is needed on Aboriginal under-employment.
- Safety in the workplace means that many Aboriginal people don't identify as Aboriginal. Aboriginal leaders spoke of incidents in which service providers put pressure on Aboriginal staff to identify as Aboriginal to 'reach quotas'.
- It is a difficult task to achieve the SA Health target of 2% Aboriginal employees, given the percentage of graduates and job opportunities. More resources must be allocated to opportunities in employment. The message is clear: 'Education is key'.

Racism and bias

- Many Aboriginal health consumers do not identify as Aboriginal for fear of discrimination. Aboriginal people need better explanation from health service providers about *why* this information is being collected, ie to promote better health outcomes. Aboriginal leaders expressed concern about misinformation in their communities regarding the perils of identifying Aboriginal status to health services.
- Health service providers are not consistently asking for Aboriginal status when consumers present for care. Aboriginal leaders told us that the Aboriginal status field needs to be mandatory, even if the answer is 'prefer not to say'.
- Aboriginal leaders told us that it's not enough to self-identify as Aboriginal and that Aboriginal identity 'goes well beyond what you look like'. Identity incorporates connection to community, connection to country, culture and language. Culturally competent health services must encompass all of these things.
- The lack of confidence in the health system on the part of Aboriginal consumers will remain until action is taken against institutional racism. Aboriginal leaders suggested addressing racism through workplace audits, consumer feedback, safety and quality standards, personalised healthcare plans and making Aboriginal health consumers aware of their rights. They told us that these mechanisms are easier to audit than complaints. Aboriginal leaders sought a way for people to 'scorecard' healthcare providers.

Other consultations

Following the launch of the consultation draft report on 31 May 2017, the Health Performance Council consulted with the Wardliparingga Aboriginal Research Unit (SAHMRI), the Aboriginal Health Directorate (Country Health SA LHN), the Aboriginal Health Strategy Branch (SA Health), Adelaide and Country Primary Health Networks (PHNs), health researchers and other stakeholders. Consultations were conducted via an online survey, written submissions and presentations.

What these consultations told us is that this case study is critically important and demonstrates the significant health gap that remains for Aboriginal people in South Australia. The consultation draft was well-received, with much of the feedback technical in nature, focussed around structure, presentation and interpretation of the information in the report. We also received suggestions for inclusion of additional data items and expert advice on the context and narrative behind the numbers.

Valued feedback received has been considered and incorporated into this final report.

An output report from the consultation phase will be produced separately to this report and made available on the Health Performance Council website.

We thank all participants who joined us in the consultation process for their important contributions and their ongoing support and interest in the work of the Health Performance Council.

Findings and advice

Summary

The Health Performance Council (HPC) is committed to supporting the South Australian Government to improve the health of Aboriginal people. We do this through a shared approach to policy development, planning and service across public services and respect for cultural diversity.

HPC reviews have identified exemplary practice in the South Australian health system. We have also identified areas for improvement, especially where variation in the system means not everybody benefits equitably from our health services.

The overall outlook for the health of Aboriginal people in South Australia remains poor, despite positive outcomes in some measures. This can be attributed in part to the performance of the health system, but not to this alone. What is needed to improve outcomes across the board is an integrated, cross-discipline, cross-portfolio, and Aboriginal-led approach that takes account of social, cultural, spiritual, economic and environmental determinants such as education, employment, safe housing, and culturally appropriate health practices and health promotion.

Findings

This case study identifies a number of areas in which health and wellbeing measures for Aboriginal people in South Australia are *above* those of the non-Aboriginal population.

Health determinant progress

- Strong cultural and community ties continue to support Aboriginal people in South Australia, including through cultural and sporting events. In times of crisis, the vast majority could access assistance from outside the household.
- Fewer Aboriginal people in South Australia are exceeding lifetime risk guidelines and single-occasion risk guidelines for alcohol consumption compared with Aboriginal people nationally and the overall South Australian population.
- A higher proportion of Aboriginal people is engaged in physical activity than non-Aboriginal people.
- More Aboriginal people in South Australia completed Year 12 or post-school qualifications and were enrolled in fulltime study than in previous years. The South Australian figures for all categories exceeded national statistics.

Health outcome progress

- The Aboriginal perinatal death rate is below the non-Aboriginal rate, although this rate is based on very small numbers and contrasts with higher infant and child mortality rates.
- Fewer Aboriginal people in South Australia report living with long-term health conditions than the overall state population. However, as long-term health conditions manifest with age, this result may be due to the higher mortality rate experienced by Aboriginal people.
- Fewer Aboriginal people report living with arthritis than the overall South Australian population. However, as this is an age-related disease, this outcome may be a result of the higher mortality rate experienced by Aboriginal people.

Interaction with health system progress

- Childhood immunisation for Aboriginal South Australian children aged five years is above the state average.
- A rise in early childhood health checks for Aboriginal South Australian children has brought the rate in line with the overall state figures.
- The rate of emergency readmission to hospital within 28 days is trending down for Aboriginal inpatients and is now slightly below the non-Aboriginal rate.
- The rate of Aboriginal persons hospitalised for potentially preventable conditions, as a share of all Aboriginal hospitalisations, is slightly below the equivalent share for non-Aboriginal people.

However, this case study identifies many more areas in which health and wellbeing measures for Aboriginal people fell *below* those of the non-Aboriginal population:

Health determinant challenges

- Fruit consumption remains low and vegetable consumption very low.
- Notification rates for sexually transmitted diseases are proportionally higher for the Aboriginal population.
- More than one in three Aboriginal persons are current daily smokers. Despite an overall downward trend, smoking rates during pregnancy remain very high.
- Illicit drug and other substance use by Aboriginal people in South Australia is ranked third highest of the states and territories (behind the Australian Capital Territory and Victoria).
- Around two-thirds of Aboriginal people in South Australia have a body mass index classified as overweight or obese.
- One in five Aboriginal people in South Australia reports doctor-diagnosed high blood pressure and/or were on medication for high blood pressure. The prevalence of high blood pressure amongst Aboriginal people in remote South Australia is more than double that of Aboriginal people living in the metropolitan area.
- Many Aboriginal people in South Australia and their relatives are living with the significant and ongoing lifetime impacts of removal from their birth family.
- There is an over-representation of Aboriginal children under the Guardianship of the Minister or subject to care and protection orders and also of admissions of children and young people to secure care.
- The experience of violence and the threat of violence for Aboriginal people in South Australia is high compared with the general population and has remained high since 2002.
- Aboriginal unemployment remains high at three times the state unemployment rate.
- Aboriginal people in South Australia experience high levels of homelessness and overcrowding.
- A high proportion of Aboriginal households in South Australia have experienced insufficient funds to meet basic expenses.

Health outcome challenges

- Life expectancy continues to be lower for Aboriginal people in Australia. South Australian-specific data is not available for this measure.
- Fewer Aboriginal people in South Australia report being in very good or excellent health compared with the general population.
- The leading causes of death for Aboriginal people in Australia – heart disease, diabetes, respiratory disease, cancer and self-harm – occur at many times the rates compared with the non-Aboriginal population. South Australian-specific data is not available for this measure.
- The Aboriginal infant and child mortality rate is double the non-Aboriginal rate.
- A higher proportion of babies born to Aboriginal women are low birthweight compared with babies born to all women.
- Rates of anxiety and depression among Aboriginal South Australians are more than double those for non-Aboriginal people in the state.
- Asthma rates are more than double compared with non-Aboriginal people in South Australia.
- Aboriginal people experience a higher incidence of cancers with low case survivals and, conversely, a lower incidence of cancers with high survivals. Aboriginal people generally have more advanced cancer stages at diagnosis.
- Aboriginal people in South Australia experience a high burden of cardiovascular risk and premature onset of cardiovascular disease. Aboriginal people in South Australia are

hospitalised with a principal diagnosis of cardiovascular disease at a higher rate than non-Aboriginal people.

- Diabetes prevalence is more than double compared with non-Aboriginal people in South Australia.
- The incidence of kidney disease is around seven times that of the non-Aboriginal population.

Training and education challenges

- The total number of Aboriginal students commencing health profession tertiary training in South Australia has increased, but as a proportion of all student commencements has remained low at around 1.3%.
- Completion rates for Aboriginal students remain lower than commencement rates and lower than for non-Aboriginal students. One-third of Aboriginal students in higher education courses do not complete their studies, compared with one-fifth of non-Aboriginal students.

Workforce participation challenges

- Aboriginal representation in health professions remains below the proportion of Aboriginal people in the general population, both nationally and in South Australia.
- Aboriginal persons make up 1.0% of SA Health employees, half of South Australia's Strategic Plan Progress Report 2012 target (T53) to 'increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications and agencies, to 2.0% by 2014 and maintain or better those levels through to 2020'.
- Aboriginal people employed in SA Health are under-represented in clinical roles and positions that have management responsibility or relative seniority.
- Aboriginal people are under-represented in applications received for vacant positions in SA Health.

Interaction with health system challenges

- Antenatal visits for Aboriginal women in the first 14 weeks of pregnancy continue at a much lower level than for non-Aboriginal women, although the trend is upward.
- The rate of Aboriginal persons leaving public hospital emergency departments (EDs) at their own risk after treatment had already commenced is higher than the equivalent share for non-Aboriginal people.
- The rate of Aboriginal inpatients self-discharging themselves from hospital against medical advice is higher than the equivalent share for non-Aboriginal people.
- Fewer older Aboriginal people are fully vaccinated against influenza and pneumococcal disease.

Advice

The 'whys' of Aboriginal poor health have been the subject of extensive research over decades, primarily led by non-Aboriginal people. But knowing the whys has to date been insufficient in addressing Aboriginal health needs. The failure to meet strategic plan targets has occurred despite ongoing effort and reform and a multiplicity of policy and programs over the last decade. Given ongoing poor health and wellbeing outcomes, it is time to identify where and how success has been achieved and to apply successful programs, pilot and otherwise, adapted to local conditions in the local context. It is also time to be innovative, considering options that fall outside 'western' health and medical approaches and take a more holistic approach to health.

Aboriginal engagement and leadership

The South Australian Aboriginal Health Research Accord (SAHMRI 2014) makes clear that the best health outcomes for Aboriginal people can only be achieved with Aboriginal people intimately engaged at every point, from discovery and research through design to on-the-ground delivery. Aboriginal health must be informed by the engagement of and at the direction of Aboriginal people. These guiding principles strengthen the validity of research and the appropriateness of responses and programs. Recognising the validity of Aboriginal experience and acknowledging Aboriginal intellectual property are keys to future success.

Priorities for the application of resources and for reform should be determined with input and leadership from the Aboriginal community and their representative organisations. Consideration can be given to a range of issues including population groups (such as children), disease prevalence, high-impact interventions, and foundational health issues. Important advances have been made, for example, in immunisation and health checks for Aboriginal children which will have long-term health benefits. This has come about due to community leadership and direction.

A holistic approach

Policies and programs that take an integrated approach across disciplines and portfolios are urgently needed. Where such integration already exists, it must be further enhanced. The founding principle for this approach is that Aboriginal health is not merely the absence of disease but is a complex health and wellbeing landscape informed by the interaction of social, cultural, economic, and environmental parameters. The 1989 National Aboriginal Health Strategy (NAHS) states that:

> *Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.*

Action within the health sector alone is therefore not enough. It must be integrated with policy changes across public sector portfolios and in association with the private and community sectors. This means that the health of Aboriginal people in South Australia is not merely the responsibility of SA Health and the private health sector, but of the whole South Australian Government and the community broadly.

Health system reform

Within the health system itself, it is timely that the policy framework for Aboriginal health be examined. SA Health's Aboriginal Health Care Plan 2010-16 would benefit from an independent, comprehensive, outcomes-based evaluation led by the Aboriginal community. Similarly, and if not already undertaken, the SA Health Aboriginal Health Impact Statement Policy Directive should be reviewed for effectiveness and application across the department. Because there is no routinely collected data on the number of times this policy directive has been applied, it is not clear to what extent this directive has been applied, especially to major projects such as the new Royal Adelaide Hospital, the Enterprise Patient Administration System (EPAS) and Transforming Health.

SA Health is not meeting the state strategic plan target of 2.0% Aboriginal workforce participation. Increased effort in training and placement of Aboriginal people in health-related fields is needed as part of systemic reform. This study shows that, despite some progress, there continues to be a significant shortfall in Aboriginal people in health-related professions across all levels.

Prevention and primary care

Prevention is always better than interventions and treatment further down a disease pathway. This approach is not new. Some elements of health promotion, brief interventions and screening programs make a difference in areas such as childhood disease prevention (such as through immunisation), smoking quit rates and cancer survivability. These approaches need to be resourced and culturally relevant and take into account the broad distribution of Aboriginal people across metropolitan, country and remote South Australia and the diversity of need across the Aboriginal population.

The Aboriginal community has prioritised prevention in the areas of heart and stroke, cancer and diabetes. SA Health received completed chronic disease plans for identified community priority areas on 30 June 2016:

- SA Aboriginal Heart and Stroke Plan 2017-21
- SA Aboriginal Diabetes Strategy 2017-21
- SA Aboriginal Cancer Control Plan 2016-21.

These require prioritisation and support within the health system. To assist this, the SA Aboriginal Chronic Disease Consortium must receive sufficient support to successfully implement the priorities in the three plans.

Addressing Aboriginal disadvantage

Aboriginal disadvantage must be addressed. In nearly all health-risk, economic and social measures Aboriginal people in South Australia remain significantly disadvantaged compared with non-Aboriginal people in South Australia. Socioeconomic disadvantage is an ongoing concern for all South Australians and requires broad, pragmatic policy responses. That is not to say that nothing can change until socioeconomic disadvantage is addressed. Health measures must continue to be vigorously pursued.

Addressing the cultural competence of the health system

Cultural competence of the health system in delivering healthcare to Aboriginal people must be addressed with a focus on:

- the cultural competence of the whole health workforce in delivering appropriate healthcare to Aboriginal people
- barriers to reporting and recording Aboriginal identification (both staff and consumers)
- institutional racism and its effect on delivering safe healthcare to Aboriginal people
- the health effects and impacts of removal from family and of institutional care.

Future research considerations

It is not within the scope of this case study to review the reforms, policies and programs put in place to address the health of Aboriginal people in South Australia and Aboriginal representation in the health workforce. However, such a review is recommended, bringing together both internal and external evaluations of programs and exploring how these have succeeded or failed to meet their aims.

If not already undertaken, the SA Health Aboriginal Health Impact Statement Policy Directive should be reviewed for effectiveness and application across the department.

SA Health's Aboriginal Health Care Plan 2010-16, recently completed, would benefit from an independent review, guided by an advisory panel with Aboriginal leadership, through a comprehensive, outcomes-based evaluation.

Future monitoring could also include transparent reporting of funding allocated to Aboriginal health. This monitoring could look at Closing the Gap funding, what programs are being funded and why, and how much money is being directed to improving health outcomes for Aboriginal people.

Specific research into cultural competence, with a view to implementing change, is also recommended. Future case studies may consider the uptake and effectiveness of cultural safety training programs across the state.

Introduction

1.1. Background to this report

In October 2014 the Health Performance Council (HPC) published its first case study into Aboriginal health, *Aboriginal Health in South Australia 2011-14: A Case Study* (HPC 2014a).

This second case study forms part of the HPC's 2015-18 four-yearly review program which reports on the performance of the South Australian health system, including how the system performs for specific and vulnerable population groups.

Aboriginal health continues to be important. Many opportunities exist for improving the quality of care offered to Aboriginal people in South Australia, their experience of care and their health outcomes. The Aboriginal Leaders' Forum has steered the work in this second case study, as it did in the first.

This second case study is timely. Not only does it analyse changes in these areas since the release of the first case study, it also comes at the conclusion of the *SA Health's Aboriginal Health Care Plan 2010-16*. This plan's aims were to reduce Aboriginal ill-health, develop a culturally responsive health system, and promote Aboriginal community health and wellbeing. While this study does not directly address the health plan, it does shed some light on progress against its objectives.

1.2. Previous Health Performance Council studies

Our 2008-10 review of the health system, *Reflecting on Results*, assessed South Australia's public health system performance against the Aboriginal health objectives in South Australia's Strategic Plan. We found then that Aboriginal health outcomes remained unacceptable and access was limited to services which were deemed culturally appropriate by the community and relevant to the needs of Aboriginal people (HPC 2010). While there were encouraging instances of successful programs, we found no demonstration of overall improved health outcomes for Aboriginal people.

Our first case study into Aboriginal health, *Aboriginal Health in South Australia 2011-14: A Case Study* (HPC 2014a), made four significant findings:

1. Some health service areas are succeeding in reducing disparity between Aboriginal and non-Aboriginal people. More needs to be done to understand the challenges in reducing this gap.
2. Concerted system efforts are assisting many Aboriginal people to achieve health gains but significant numbers are still missing out. More needs to be done to understand why.
3. More Aboriginal people are accessing the right healthcare but the health system must do more to provide respectful, safe, relevant health services in accordance with community expectations and need.
4. Aboriginal people are under-represented in the health sector workforce and this needs to be addressed as a matter of urgency.

Despite various measures put in place by the state government to improve the health and wellbeing of Aboriginal people in South Australia, the absence of improvements in health outcomes for Aboriginal people, reported consistently by the HPC, demonstrates the need for ongoing and innovative improvements to services, Aboriginal people's experiences of healthcare, and health outcomes.

1.3. Scope of this case study

This case study provides a review of available data to analyse three key issues:

1. the health and wellbeing status of Aboriginal people in South Australia
2. the workforce participation of Aboriginal people in South Australia in the health sector
3. the effectiveness of the health system in providing services to Aboriginal people in South Australia.

Limited information on the private health sector is provided due to the limited availability of data as well as a major focus on the South Australian public sector body SA Health.

This case study is not intended to provide a comprehensive overview of the health of Aboriginal people in South Australia or of their interaction with the state's health system.

1.4. Study approach

The Aboriginal Leaders' Forum acted as the project advisory group for this study. The planning group, with assistance from forum meetings, helped determine the scope of this study and its priority topics, as well as providing quality assurance of drafts. HPC member Prof Lisa Jackson Pulver acted as project sponsor.

The HPC Secretariat undertook the data analysis using existing data available from external sources, such as the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and SA Health. A list of sources cited is available at the end of this document. HPC commissioned an external writer to assist with early preparation of a consultation draft.

1.5. Data quality notes

This case study relies on material from existing published data from external sources such as the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and SA Health enterprise datasets applying standardised business counting rules. These data sources rely on people choosing to nominate their Aboriginal status when interacting with government information collections, health systems and services. Levels of identification can vary and change depending on the individual and circumstances of the service interaction. HPC does not undertake any original data collection.

Where HPC sourced data from internal SA Health systems, such as hospital activity datasets, standard corporate business counting rules were applied for consistency and comparability with other reporting.

Many of the indicators presented in this report are based on population surveys, and as such are estimates within a sampling margin of error. HPC presents these indicators 'as is', acknowledging that differences between estimates may not be statistically significant (no statistical tests were done). We acknowledge that not reporting confidence intervals, or not reporting probabilities that differences may be due to chance alone, could detract from the reported results to technical audiences.

This case study presents a range of incidence and prevalence rates exactly 'as published' by various external data sources cited in this report. Sometimes these external data sources complement crude rate reporting with the production of age-standardised rates to allow for a more fair comparison between population groups. This case study preferences age-standardised rates over crude rates wherever this option is available. HPC does not do its own age-standardisation of crude rates reported by external sources.

2. Population and demography

2.1. Introduction

In 2015 the estimated resident Aboriginal population of South Australia was 40,646 people, representing around one in 42 (2.4%) of the state's population of 1.70 million (ABS 2017f).

This compares with 649,171 Aboriginal and Torres Strait Islander people in Australia as at the 2016 Census, accounting for 2.8% of the national population (ABS 2017h).

In 2015, 20,554 (50.6%) Aboriginal people in South Australia were female and 20,092 (49.4%) were male (ABS 2017f).

2.2. Population profile

In 2015, 33.1% of the state's Aboriginal population was aged under 15 years and 4.1% aged 65 years or more. This compares to the non-Aboriginal population rates of 17.2% aged under 15 years and 17.7% aged 65 years or more (ABS 2017f).

The estimated median age of Aboriginal persons in 2015 was 23 years, around half that of the general population (40 years). There is a relative over-representation of Aboriginal people in the 0 to 34 years' age cohorts and under-representation in the 35 years and over age groups (ABS 2017f).

The differences between age distributions can be explained by inequalities in life expectancy and the higher premature mortality rate experienced by Aboriginal people. It is also observed that the fertility rate of the Aboriginal population in South Australia is higher than the overall population, which may contribute to the differences in age distributions.

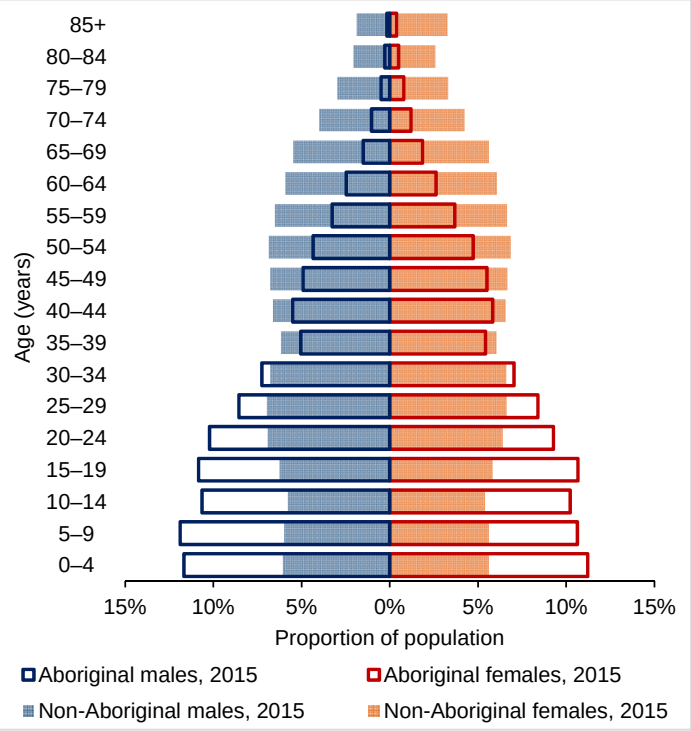


Figure 1: Population of South Australia by age and gender and Aboriginal status, 2015 (Source: ABS 2017f)

2.1. Population within SA Health local health networks

In 2011, Aboriginal people were distributed evenly between SA Health's metropolitan and country local health networks (LHNs), 48.9% and 51.1% respectively. The Northern Adelaide LHN was home to almost a quarter of Adelaide's Aboriginal population. Due to the geographic size of regional and remote South Australia, the table below summarises the population densities by ABS regions that make up the Country Health South Australia Local Health Network (SAHMRI 2016a).

Table 1: Aboriginal population distribution by SA Health LHNs, 2011

SA Health local health network (LHN)	Estimated resident population, 2011	
	No.	%
Northern Adelaide LHN	8,512	22.8%
Central Adelaide LHN	5,521	14.8%
Southern Adelaide LHN	4,264	11.4%
Metropolitan Adelaide sub-total	**18,297**	**48.9%**
Barossa Hills Fleurieu	2,271	6.1%
Eyre, Flinders and Far North East	4,768	12.7%
Eyre, Flinders and Far North West	5,808	15.5%
Riverland Mallee Coorong	2,928	7.8%
South East	1,331	3.6%
Yorke and Northern	2,005	5.4%
Country Health SA LHN sub-total	**19,111**	**51.1%**
South Australia total	**37,408**	**100.0%**

Source: SAHMRI 2016c

2.3. Fertility rate

In 2015, South Australia's Aboriginal total fertility rate (TFR) was 2.01 births per Aboriginal woman aged 15-49 years. This is below the national Aboriginal TFR of 2.27 births per Aboriginal woman. Between 2005 and 2008, the South Australian Aboriginal TFR increased but has since decreased (ABS 2017a).

South Australia's Aboriginal TFR of 2.01 births per woman is higher than the 1.76 recorded for all women in South Australia. The Aboriginal TFR in this state has been higher than the total population rate for the last decade (ABS 2017a).

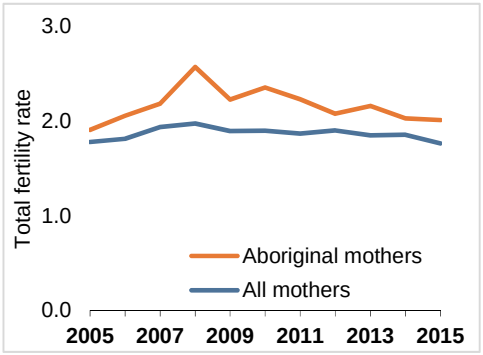


Figure 2: Fertility rates, South Australia (Source: ABS 2017a)

2.4. Death rate

In 2015, South Australia's Aboriginal age-specific death rate (ASDR) was 429.9 deaths per 100,000 Aboriginal population, slightly down from the rate of 434.9 recorded in 2005 (ABS 2017b).

Although the total Aboriginal ASDR is below the rate for the state's non-Aboriginal population (793.2 per 100,000 non-Aboriginal population), the 2015 ASDRs for Aboriginal people in South Australia was higher than the corresponding non-Aboriginal rates for all age cohorts except for ages 75 years and over (ABS 2017b).

Figure 3b breaks out the ASDRs by age cohort for the 0–54 years range to show detail. Note the change of scale between the two figures.

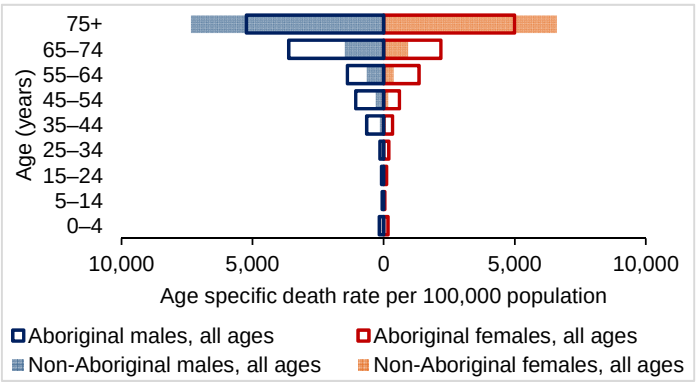


Figure 3a: Age-specific death rates, all age groups, South Australia, 2015 (Source: ABS 2017b)

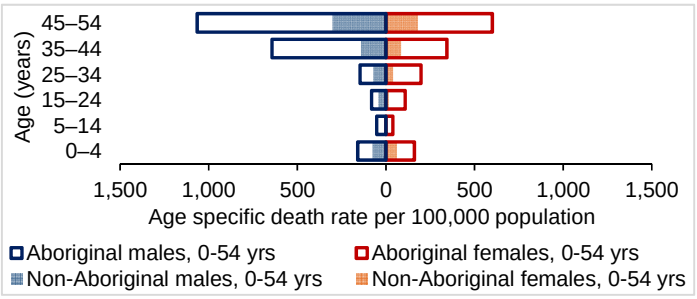


Figure 3b: Age-specific death rates, ages 0-54 years, South Australia, 2015 (Source: ABS 2017b)

2.5. Mortality profile

Aboriginal people in South Australia are dying at a younger age than their non-Aboriginal counterparts. In 2015, half of all deaths of Aboriginal persons in South Australia were in the age cohort of 55-59 years, compared with 80-84 years for the non-Aboriginal population (ABS 2017e).

The estimated median age of death for Aboriginal females in South Australia in 2015 was 62 years, and 55 years for Aboriginal males. This compares with the estimated median age of death for non-Aboriginal females in South Australia in 2015 of 86 years, and 80 years for non-Aboriginal males (ABS 2017e).

Aboriginal people were over-represented in the proportion of deaths compared with the non-Aboriginal population in all age cohorts up to 80 years and over (ABS 2017e).

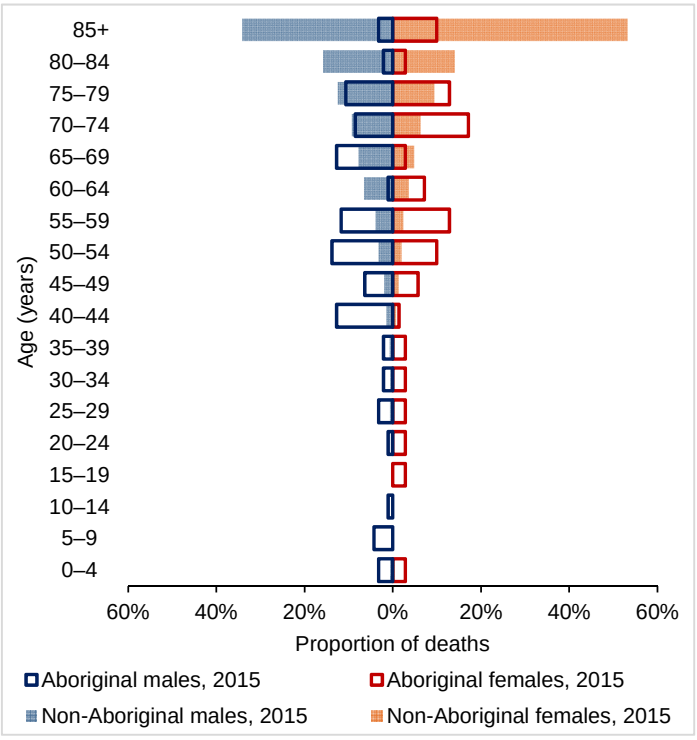


Figure 4: Deaths in South Australia by age, gender and Aboriginal status, 2015 (Source: ABS 2017e)

3. Determinants affecting health and wellbeing

3.1. Summary

There have been improvements for Aboriginal people in South Australia in relation to some determinants of health and wellbeing. However, in nearly all health-determinant measures Aboriginal people in South Australia are disadvantaged.

A number of determinants showed positive outcomes:

- Strong cultural and community ties continue to support Aboriginal people in South Australia, including through cultural and sporting events. In times of crisis, the vast majority can access assistance from outside the household.
- Fewer Aboriginal people in South Australia are exceeding lifetime risk guidelines and single-occasion risk guidelines for alcohol consumption compared with Aboriginal people nationally as well as with the overall South Australian population.
- A higher proportion of Aboriginal people are engaged in physical activity than non-Aboriginal people.
- More Aboriginal people in South Australia completed Year 12 or post-school qualifications and were enrolled in fulltime study than in previous years. In these three areas outcomes were higher than for Aboriginal people nationally.

Other health and wellbeing determinants for Aboriginal people in South Australia remain of concern:

- Fruit consumption remains low and vegetable consumption very low.
- Notification rates for sexually transmitted diseases are proportionally higher for the Aboriginal population.
- More than one in three Aboriginal persons are current daily smokers. Despite an overall downward trend, smoking rates during pregnancy remain very high.
- Illicit drug and other substance use by Aboriginal people in South Australia is ranked third highest of the states and territories (behind the Australian Capital Territory and Victoria).
- Around two-thirds of Aboriginal people in South Australia have a body mass index classified as overweight or obese.
- One in five Aboriginal people in South Australia reports doctor-diagnosed high blood pressure and/or is on medication for high blood pressure. The prevalence of high blood pressure amongst Aboriginal people in remote South Australia is more than double that of Aboriginal people living in the metropolitan area.
- Many Aboriginal people in South Australia and their relatives are living with the significant and ongoing lifetime impacts of removal from their birth family.
- There is an over-representation of Aboriginal children under the Guardianship of the Minister, subject to care and protection orders, or admitted to secure care.
- The experience of violence and the threat of violence for Aboriginal people in South Australia is high compared with the general population and has remained high since 2002.
- Aboriginal unemployment remains high at three times the state unemployment rate.
- Aboriginal people in South Australia experience high levels of homelessness and overcrowding.
- A high proportion of Aboriginal households in South Australia has experienced insufficient funds to meet basic expenses.

3.2. Introduction

Health, according to the World Health Organisation (WHO), is 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 'Constitution'). WHO emphasises that the highest attainable standard of health is a fundamental right. It supports the participation of citizens in health service design and delivery and recognises the critical role governments have in providing health services (WHO 'Constitution').

Health can be measured in a variety of ways. In its first Aboriginal health case study, HPC drew upon data compiled in its report *State of Our Health: Aboriginal Population Compendium* to evaluate health system activity. The compendium presents trends and variations across indicators related to health status, healthcare outcomes, and health system performance for Aboriginal people in South Australia (HPC 2014b).

In this second case study we analyse a number of priority indicators identified by the project advisory group. These indicators are not comprehensive. Nevertheless, in combination they provide a significant and reliable overview of the current health status of Aboriginal people in South Australia, the factors affecting their health, the effectiveness of the health system in promoting their health and wellbeing, and their participation in the health workforce.

The health of individuals and communities is determined by a variety of factors, including the social and economic environment, the physical environment, and a person's individual characteristics and behaviours (WHO 'Determinants'). In this study, and in the context of Aboriginal health, we examine a selected group of demographic, health-protective factors and health risk factors.

3.3. Health in an Aboriginal context

Under the *Health Care Act 2008*, Aboriginal and Torres Strait Islander people are recognised as 'having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support values that respect their historical and contemporary cultures' (s 5(b)). The Act takes this concept of respect a step further by stating that 'some groups within the community should be able to access special or enhanced health services' (s 30).

As HPC outlined in its first case study, health in an Aboriginal context is a concept much larger than an individual's physical wellbeing. It includes an individual and collective sense of agency, as well as social, emotional, spiritual and environmental wellbeing (NAHSWP 1989). The health of Aboriginal people and communities is therefore impacted by the broader social, political and economic context. Health outcomes reflect not only the performance of the health system but also other social and economic institutions.

3.4. Lifestyle measures

The risk of developing chronic disease can be significantly increased through smoking, excessive alcohol consumption, poor nutrition and lack of exercise (AIHW 2012). Broad features of society such as culture, social cohesion and language can impact on health, as can economic determinants such as income, employment and education (AIHW 2012).

Alcohol consumption

Under current guidelines on alcohol consumption for healthy males and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury. Drinking no more than four standard drinks on a single occasion at least monthly reduces the risk of alcohol-related injury arising from that occasion (NHMRC 2014).

In 2014-15, Aboriginal people in South Australia reported exceeding lifetime risk guidelines for alcohol consumption at lower rates than for South Australia as a whole and for Aboriginal people nationally (all figures for people 15 years and over). Fewer than one in ten (9.6%) Aboriginal people in South

Australia reported exceeding this level compared with 14.7% for Aboriginal people nationally and 17.7% for the overall South Australian population (ABS 2016a; HPC 2017).

Around one in four (24.5%) Aboriginal people in South Australia aged 15 years and over reported exceeding single-risk guidelines for alcohol consumption, again below the national average for Aboriginal people (30.1%) and for South Australia in total (26.2%) (ABS 2016a; HPC 2017).

Table 2: Health risk factors: smoking and alcohol consumption

Health risk factors: alcohol consumption Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Alcohol consumption – Exceed lifetime risk*	17.7%	21.8%	**9.6%**	**14.7%**
Alcohol consumption – Exceed single-occasion risk*	36.5%	37.7%	**24.5%**	**30.1%**

**Alcohol consumption risk using 2009 NHMRC Guidelines*
Sources: ABS 2004; ABS 2009; ABS 2016a

Nutrition – fruit and vegetables

In 2014-15, 39.0% of Aboriginal people in South Australia aged 15 years and over reported eating the recommended two or more serves of fruit per day. This is below the 41.8% recorded for all South Australians aged 18 years or more in 2015 (ABS 2016a; HPC 2017).

In 2014-15, 5.2% of Aboriginal people in South Australia aged 15 years and over reported eating the recommended five or more serves of vegetables per day. This was less than half of the 10.7% rate recorded for all South Australians aged 18 years or more in 2015 (ABS 2016a; HPC 2017).

Table 3: Health risk factors: nutrition

Health risk factors: nutrition	Aboriginal persons aged 15 years and over, 2014-15		All South Australians aged 18 years and over, 2015
	South Australia	Australia	
Daily recommended consumption of fruit	**39.0%**	45.8%	41.8%
Daily recommended consumption of vegetables	**5.2%**	5.8%	10.7%

Sources: ABS 2016a; HPC 2017

Physical activity

A higher proportion of Aboriginal people was engaged in physical activity than non-Aboriginal people (52% and 39% respectively) (SAHMRI 2016a).

Aboriginal females achieved sufficient physical activity at a higher rate than non-Aboriginal females. However, Aboriginal males were 30% less likely to achieve this level of activity compared with non-Aboriginal males (SAHMRI 2016a).

Sexually transmitted diseases

Notification rates for sexually transmitted diseases are higher for the Aboriginal population in South Australia compared with the non-Aboriginal population.

In 2013-15, notification rates for the sexually transmitted infections of chlamydia (790.9 per 100,000 population, age-standardised), non-congenital syphilis (145.5), gonorrhoea (502.7), hepatitis C (180.3) and hepatitis B (54.7) amongst the Aboriginal population in South Australia were all higher than the non-Aboriginal notification rates (329.3, 7.6, 35.4, 27.7, and 19.7 respectively per 100,000 population) (AIHW 2017).

Notification rates for HIV in the Aboriginal population for South Australia were not published due to small numbers. However, nationally, the notification rate for 2013-15 was 5.5 per 100,000 population for Aboriginal people compared with 4.5 for non-Aboriginal (AIHW 2017).

Smoking prevalence

More than a third (35.4%) of Aboriginal people aged 15 years or older in South Australia reported smoking daily in 2014-15, below the national average for Aboriginal people of 38.9% (ABS 2016a). This is a decline on 2002 figures.

Although the figures are not directly comparable, due to differing sources and methodologies, this rate was more than twice the 15.7% of all South Australians aged 15 years or older who reported smoking daily, weekly or less often than weekly (HPC 2017).

Table 4: Health risk factors: smoking and alcohol consumption

Health risk factors: smoking Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Current daily smoker	43.9%	48.0%	**35.4%**	**38.9%**

Sources: ABS 2004; ABS 2009; ABS 2016a

Smoking during pregnancy

Improvements in smoking rates were recorded for the 2006 to 2014 period for pregnant women. This rate included women who reported smoking during pregnancy but had quit before their first antenatal visit.

In 2014, around one in two (49.9%) Aboriginal women who gave birth in South Australia reported being smokers at their first antenatal visit. This was down from the 60.8% recorded for 2006 (Pregnancy Outcome Unit 2016).

However, rates for non-Aboriginal women were much lower, at 11.7% for 2014 and 21.1% in 2006 (Pregnancy Outcome Unit 2016).

The period from 2006 to 2014 also saw gains in those Aboriginal women giving up smoking in the second half of their pregnancy, with smoking rates falling from 52.7% to 42.2%. In 2014, Aboriginal women who reported smoking in the second half of their pregnancy had dropped 7.7 percentage points compared with their first antenatal visit (Pregnancy Outcome Unit 2016).

By comparison, in 2014, 7.9% of non-Aboriginal women reported smoking in the second half of their pregnancy, suggesting a rate of one-fifth of Aboriginal women (Pregnancy Outcome Unit 2016).

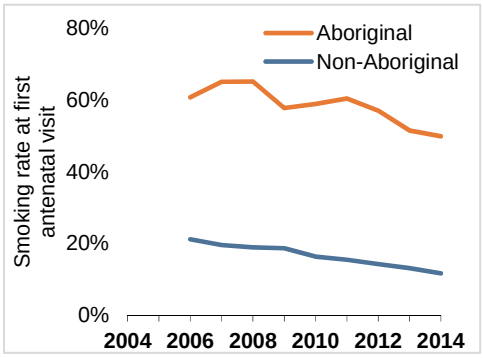


Figure 5a: Smoking rates at first antenatal visit, South Australia (Source: Pregnancy Outcome Unit 2016)

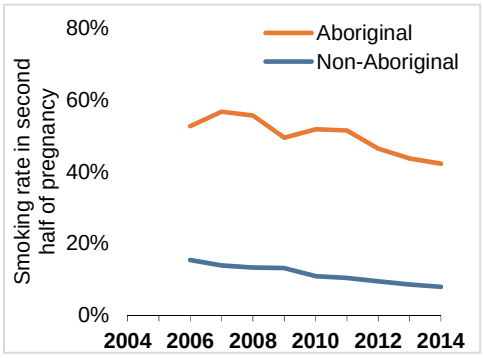


Figure 5b: Smoking rates in second half of pregnancy, South Australia (Source: Pregnancy Outcome Unit 2016)

Illicit drug and other substance use

In 2014-15, 37.3% of Aboriginal people (42.5% males and 30.8% females) in South Australia aged 15 years and over reported using illicit drugs or other substances in the previous 12 months. Illicit drugs and other substances include: marijuana, hashish or cannabis resin; amphetamines or speed; painkillers or analgesics for non-medical purposes; tranquillisers or sleeping pills for non-medical purposes; kava; petrol and other inhalants (AIHW 2017).

The South Australian rate of 37.3% ranked third highest of the states and territories and above the 30.6% national average for Aboriginal people in Australia aged 15 years and over (AIHW 2017).

3.5. Biomedical measures

Biomedical risk factors are physical or physiological states that pose health risks. They may be influenced by behavioural risk factors, genetic propensity, injury, socioeconomic conditions or other factors.

Overweight and obesity

Body mass index (BMI) is a measure of body fat based on the ratio of weight and height (bodyweight in kilograms divided by height in metres squared). The normal range of BMI for an adult is 18.5 to 24.9 kg/m^2. 'Overweight' is defined by the World Health Organisation as a BMI in the range of 25 to less than 30. 'Obesity' is a BMI of 30 or higher (WHO 2016). However, it should be noted that these WHO cut-off points are based on European populations and a BMI of less than 25 kg/m^2 may still be a risk factor for Aboriginal people in South Australia.

In 2012-13, 62.9% of Aboriginal people in South Australia aged 15 years and older had a BMI classified as overweight or obese (HPC 2017). Although not directly comparable, this is lower than the 64.5% overweight and obesity rate recorded for all South Australians aged 18 years or more in 2014-15 (HPC 2017).

Waist circumference is another measure of overweight and obesity which may more accurately reflect risk in the Aboriginal population. In 2012-13 national figures, 60.4% of Aboriginal males and 81.4% of Aboriginal females aged 18 years and over had a measured waist circumference that placed them at increased risk of developing chronic disease. The risk measurement is defined as a waist circumference of 94cm or more for adult males and 80cm or more for adult females (ABS 2014a).

High blood pressure

The Aboriginal population across Australia experiences high blood pressure (hypertension) at an earlier age than the non-Aboriginal population, with one in three Aboriginal people having hypertension in the 35 to 44 years age bracket (SAHMRI 2016a).

In 2012, one in five (20.0%) Aboriginal people aged 15 years and over in South Australia reported doctor-diagnosed high blood pressure and/or were on medication for high blood pressure (HPC 2017).

The prevalence of high blood pressure amongst Aboriginal people in remote South Australia (39.8%) was more than double that of Aboriginal people living in the metropolitan area (HPC 2017).

Table 5: High blood pressure and/or on medication for high blood pressure, Aboriginal people aged 15 years and over, March 2012

Region	%
Metropolitan Adelaide	**17.6%**
Rural SA	16.9%
Remote SA*	39.8%
Country SA total	**24.8%**
South Australia	**20.0%**

Source: HPC 2017.

** The Anangu Pitjantjatjara Yankunytjatjara (APY) Lands were excluded from the survey coverage.*

3.6. Social and economic measures

Social and economic measures, including experiences such as discrimination and limitations in opportunity, may pose direct risks to health. They may also contribute positively to wellbeing, including through measures such as community, family cohesion, and adequate household finance.

While culture, community and family provide health benefits for Aboriginal South Australians, other measures such as removal from family, discrimination, economic disadvantage (including in education and employment) and violence contribute to poor health and wellbeing outcomes.

Language and culture

According to the National Aboriginal and Torres Strait Islander Social Survey (NATSISS), in 2015 almost a quarter (23.9%) of Aboriginal people in South Australia aged 15 years and over spoke an Australian Indigenous language, with one in nine (11.1%) speaking an Indigenous language as their main language at home. Both of these rates were above the national totals of 18.3% and 10.5% respectively (ABS 2016a).

The percentage of those who speak an Indigenous language has fallen by 7.5 percentage points since 2002, down from 31.4% (ABS 2016a).

In 2014-15, around two-thirds (61.0%) of Aboriginal people in South Australia aged 15 years and over identified with a clan, tribal or language group. Over half (57.2%) were involved in selected cultural events, ceremonies or organisations, and 95.1% participated in selected sporting, social or community activities. Participation in cultural events and sporting and other community activities was only marginally lower than for the national figures of 62.6% and 96.9% respectively (ABS 2016a).

Between 2008 and 2014-15, there was a decline in those involved in selected cultural events, ceremonies or organisations over the previous 12 months (from 65.0% to 57.2%), while the numbers of those participating in sporting, social and community activities remained very high (rising from 94.0% to 95.1%) (ABS 2009; ABS 2016a).

Table 6: Language, culture and social networks: Aboriginal people aged 15 years and over

Language, culture, and social networks Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Main language spoken at home is an Australian Indigenous language	12.4%	9.2%	**11.1%**	**10.5%**
Speaks an Australian Indigenous language	31.4%	25.9%	**23.9%**	**18.3%**
Identifies with clan, tribal or language group	63.3%	72.7%	**61.0%**	**62.3%**
Involved in selected cultural events, ceremonies or organisations in last 12 months	n.a.	65.0%	**57.2%**	**62.6%**
Participated in selected sporting, social or community activities in last 12 months	n.a.	94.0%	**95.1%**	**96.9%**

Sources: ABS 2004; ABS 2009; ABS 2016a

Care and support

In 2014-15, more than one in four (27.3%) Aboriginal people in South Australia aged 15 years and over provided unpaid care for a person with a disability, long-term condition or old age. This was above the national figure of 25.5% (ABS 2016a).

Most of those surveyed (93.3%) were able to get support in a time of crisis, defined as support from outside the household which may be in the form of emotional, physical or financial help. This number showed an increase from 2002. The 2014-15 figure was marginally above the national result of 91.7% (ABS 2004; ABS 2016a).

Table 7: Caring and social support: Aboriginal people aged 15 years and over

Caring and social support Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Provided unpaid care for a person with disability, long-term condition or old age in last four weeks	n.a.	n.a.	**27.3%**	**25.5%**
Able to get support in time of crisis from outside household	90.4%	90.8%	**93.3%**	**91.7%**

Sources: ABS 2004; ABS 2009; ABS 2016a

Removal from birth family

In 1997, the Human Rights and Equal Opportunity Commission (HREOC) published *Bringing Them Home*, a report tracing the history of forcible removal of Aboriginal and Torres Strait Islander children from their families. The report documents the damaging effects forced separation and institutionalisation had, and continues to have, on the wellbeing of Aboriginal and Torres Strait Islander Australians (HREOC 1997).

In 2008, one in eight (11.9%) Aboriginal people in South Australia aged 15 years and over had been removed from their birth families, removed by welfare or the government or who were taken away to a mission. This was higher than the 8.2% reported nationally. A larger proportion (41.8%) had relatives removed from their birth families. Again, this was higher than the Australian proportion of 38.4% (ABS 2009).

Removal from birth family has had significant life-time impact on loss of language, country and culture, cultural identity, discrimination, social and community isolation and, for some, the grief of trauma of never being reunited with their families. It is associated with higher rates of emotional distress, and depression, poorer physical health, higher rates of smoking and greater use of illicit substances. It has also been associated with lower educational and employment outcomes. These consequences of separation not only affect those who personally experience removal but are trans-generational, impacting on children, families and communities (ABS 2010b).

Children under the Guardianship of the Minister and in secure care

Under the *Children's Protection Act 1993*, the Guardian for Children and Young People (GCYP) monitors the circumstances of children and young people in out-of-home care and releases annual monitoring reports for children and young people in residential care, under Guardianship of the Minister or in secure care.

Between June 2015 and June 2016, the number of South Australian children up to the age of 18 years under the Guardianship of the Minister or subject to care and protection orders increased from 2,690 to 3,014, of which Aboriginal children accounted for 29.4% rising to 32.8% over the period. Between June 2015 and June 2016 admissions of children and young people to secure care increased from 827 to 865, of which Aboriginal representation increased from 44.3% to 47.9% respectively (GCYP 2016a; GCYP 2016b).

Violence

More than one in four Aboriginal people in South Australia aged 15 years and over (25.9%) experienced physical or threatened physical violence in the 12 months previous to 2014-15. This was a decline compared with the 29.6% recorded in 2002, but still higher than for Aboriginal people nationally (22.3%) (ABS 2004; ABS 2016a).

In 2012, 5.5% of all females and 7.0% of all males in the general South Australian population reported experiencing violence in the previous 12 months (ABS 2014b). This suggests Aboriginal people experience violence or the threat of violence at a rate of around four times that for all South Australians.

Table 8: Experience of violence: Aboriginal people aged 15 years and over

Security: Experience of violence or threat of violence Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Experienced physical or threatened physical violence in last 12 months	29.6%	n.a.	**25.9%**	**22.3%**

Sources: ABS 2004; ABS 2009; ABS 2016a

Education

The period 2002 to 2014-15 saw improvements in education outcomes for Aboriginal people aged 15 years and over in South Australia.

Over a quarter (26.8%) of Aboriginal people aged 15 years and over in 2014-15 had completed school Year 12 or equivalent compared with 49.2% of the South Australian population in 2016. Around half (48.8%) of Aboriginal people in South Australia achieved a non-school qualification (vocational education and training or tertiary education) compared with 43.9% of the state population aged 15 years and over in 2011 (ABS 2016a; ABS 2017g; ABS 2013a).

More than one in five (23.0%) Aboriginal people aged 15 years and over were enrolled in formal study in 2014-15, fewer than the 28.9% of persons of all ages in South Australia in 2016 (ABS 2016a; ABS 2017g).

All figures represented modest to significant improvements for Aboriginal people on the years 2002 and 2008 and were marginally higher than the national results for Aboriginal and Torres Strait Islander people (ABS 2004; ABS 2009; ABS 2016a)

It is acknowledged that education measures presented here refer to persons aged 15 years and over. Future reports will endeavour to report educational attainment for 20-24 year olds as a more contemporary measure of improvement in education.

Table 9: Education: Aboriginal people aged 15 years and over

Education: Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Highest year of school completed is Year 12 or equivalent	n.a.	18.8%	**26.8%**	**25.7%**
Has a non-school qualification	33.2%	36.5%	**48.8%**	**46.5%**
Currently enrolled in formal study	n.a.	19.5%	**23.0%**	**21.5%**

Sources: ABS 2004; ABS 2009; ABS 2016a

Employment

Between 2002 to 2014-15, the unemployment rate for Aboriginal persons aged 15 years and over in South Australia increased (ABS 2004; ABS 2009; ABS 2016a)

Unemployment in this period rose from 20.4% to 22.0%. National unemployment in 2014-15 for Aboriginal people was recorded at 20.6% (ABS 2004; ABS 2009; ABS 2016a).

The 2014-15 unemployment rate was around three times higher than the overall state unemployment rate recorded for June 2015 (7.7%) (ABS 2017c).

Table 10: Employment: Aboriginal people aged 15 years and over

Employment: Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Unemployment rate	20.4%	18.3%	**22.0%**	**20.6%**

Sources: ABS 2004; ABS 2009; ABS 2016a

At the 2011 Census, the Aboriginal unemployment rate in South Australia was 18.1% (17.9% in metropolitan Adelaide and 18.3% in Country SA). This compared to an unemployment rate of 5.6% for the non-Aboriginal population (5.7% in metropolitan Adelaide and 5.1% in Country SA). By geography, across the state Aboriginal unemployment was highest in Adelaide's north (20.2%) and lowest in the central and hills area of Adelaide (13.1%) (ABS 2017d).

Homelessness

In 2014-15, around one in three Aboriginal people in South Australia aged 15 years and over (30.2%) had experienced homelessness. This number was more than double the overall state rate of 12.7% in 2014 (ABS 2016a; ABS 2015a).

Overcrowding is defined by the Canadian National Occupancy Standard for Housing Appropriateness as households requiring at least one additional bedroom. In 2014-15, 13.1% of Aboriginal people in South Australia of all ages were living in overcrowded households (6.7% in non-remote areas and 42.8% in remote areas). This was three times higher than the 4.3% of non-Aboriginal people in South Australia living in overcrowded households (AIHW 2017).

Financial stress

In 2014-15, around one in three Aboriginal people in South Australia aged 15 years and over (29.1%) experienced household members running out of money for basic living expenses in the previous 12 months. These rates were higher for Aboriginal people in South Australia than for Aboriginal people on average across Australia (ABS 2016a).

Table 11: Homelessness and insufficient funds for household needs: Aboriginal people aged 15 years and over

Housing and financial disadvantage: Aboriginal persons aged 15 years and over	South Australia			AUST 2014-15
	2002	2008	2014-15	
Has experienced homelessness	n.a.	n.a.	**30.2%**	**29.1%**
Household members ran out of money for basic living expenses in last 12 months	n.a.	31.4%	**29.1%**	**27.5%**

Sources: ABS 2004; ABS 2009; ABS 2016a

4. Health and wellbeing outcomes

4.1. Summary

In some areas, the health outcomes for Aboriginal people in South Australia are above those for non-Aboriginal people. These relatively positive outcomes must be interpreted with caution. Some age-related outcomes, for example, may be related to Aboriginal people experiencing earlier mortality and a higher disease burden at earlier ages compared with their non-Aboriginal counterparts. Small datasets may also make population comparisons difficult.

- The Aboriginal perinatal death rate is below the non-Aboriginal rate, although this rate is based on very small numbers and contrasts with higher infant and child mortality rates.
- Fewer Aboriginal people in South Australia report living with long-term health conditions than the overall state population. However, as long-term health conditions manifest with age, this result may be due to the higher mortality rate experienced by Aboriginal people.
- Fewer Aboriginal people report living with arthritis than the overall South Australian population. However, as this is an age-related disease, this outcome may be a result of the higher mortality rate experienced by Aboriginal people.

Health outcomes for Aboriginal people are below those for non-Aboriginal people in the following areas:

- Life expectancy continues to be lower for Aboriginal people in Australia. South Australian specific data is not available for this measure.
- The Aboriginal infant and child mortality rate is double the non-Aboriginal rate.
- A higher proportion of babies born to Aboriginal women are low birthweight compared with babies born to all women.
- Fewer Aboriginal people in South Australia report being in very good or excellent health.
- The leading causes of death for Aboriginal people in Australia – heart disease, diabetes, respiratory disease, cancer and self-harm – occur at many times the rates compared to the non-Aboriginal population.
- Rates of anxiety and depression are more than double than those for non-Aboriginal people in South Australia.
- Asthma rates are more than double compared with non-Aboriginal people in South Australia.
- Aboriginal people experience a higher incidence of cancers with low case survivals, and, conversely a lower incidence of cancers with high survivals. Aboriginal patients generally have more advanced cancer stages at diagnosis.
- Aboriginal people in South Australia experience a high burden of cardiovascular risk that contributes to a premature onset of cardiovascular disease. Aboriginal people in South Australia are hospitalised with a principal diagnosis of cardiovascular disease at a higher rate than non-Aboriginal people.
- Diabetes prevalence is more than double compared with non-Aboriginal people in South Australia.
- The incidence of kidney disease is around seven times that of the non-Aboriginal population.

4.2. Introduction

Health and wellbeing status may be measured under four main categories (AIHW 2014):

- health conditions – prevalence of disease, disorder injury or trauma, or other health-related states
- human function – alternations to body structure or function (impairment), activity limitations and restrictions in participation
- wellbeing – measures of physical, mental and social wellbeing in individuals
- deaths – mortality rates and measures of life expectancy.

Given the scope of this study, it concentrates on biomedical risk factors, some measurements of mortality and life expectancy, and chronic and long-term illness.

HPC acknowledges the gap in health measures in this report between the life stages of early childhood to adult and ageing. Given that a third of the Aboriginal population in South Australia is aged under 15 years, future reports will endeavour to give more consideration to adolescent health.

4.3. Life expectancy

Australia-wide, the total life expectancy of Aboriginal males (69.1 years) and females (73.7 years) born in the years 2010-12 is more than a decade lower than for all persons (79.9 and 84.3 years for all males and females respectively) born in the same years (ABS 2013b).

There are no life expectancy figures for Aboriginal people born in South Australia specifically, as the number of deaths of Aboriginal persons in this state is too small to reliably derive the estimates.

4.4. Health status

In 2014-15, two in five (40.3%) of Aboriginal people in South Australia aged 15 years and over self-assessed their health status as being excellent or very good. However, this was down from the nearly one in two (48.2%) recorded in 2002 (ABS 2016a; ABS 2004).

Although not directly comparable, the percentage of Aboriginal people who regarded themselves as being in excellent or very good health in 2014-15 was below the rate of the general South Australian population aged 18 years and over (56.0%) who self-assessed their health status as excellent or very good in the same period (ABS 2015b).

4.5. Cause of death, including intentional self-harm (suicide)

Leading causes of death

The ABS does not publish leading cause of death information for Aboriginal people specifically for South Australia, however data is available for New South Wales, Queensland, South Australia, Western Australia and the Northern Territory combined (ABS 2016b).

In 2015, the top five underlying causes of death (standardised death rates) for Aboriginal people across the five states and territories of New South Wales, Queensland, South Australia, Western Australia and the Northern Territory combined were (ABS 2016b):

- ischaemic heart diseases (143.1 deaths per 100,000 Aboriginal population compared with 71.9 for the non-Aboriginal population – twice the rate for non-Aboriginal people)
- diabetes (76.9 deaths per 100,000 Aboriginal population compared with 16.3 for the non-Aboriginal population – almost five times the non-Aboriginal rate)
- chronic lower respiratory diseases (72.1 deaths per 100,000 Aboriginal population compared with 28.2 for the non-Aboriginal population – 2.6 times the non-Aboriginal rate)

- malignant neoplasm (cancer) of the trachea, bronchus and lung (56.0 deaths per 100,000 Aboriginal population compared with 30.5 for the non-Aboriginal population – nearly twice that of the non-Aboriginal rate)
- intentional self-harm (suicide) (25.5 deaths per 100,000 Aboriginal population compared with 12.5 for the non-Aboriginal population – twice that of the non-Aboriginal rate).

All figures suggest significant to very significant death rates for Aboriginal people compared with the non-Aboriginal population.

Suicide

Between 2001 and 2010 the ABS recorded a total of 77 deaths by suicide of Aboriginal persons in South Australia (35 in metropolitan Adelaide and 42 in Country SA). This represented an age-standardised rate of 26.7 deaths per 100,000 Aboriginal population and was 2.4 times the corresponding rate of 11.2 deaths per 100,000 population for non-Aboriginal people in South Australia (ABS 2012b).

SA Health is currently developing a suicide registry, in collaboration with the Office of the Chief Psychiatrist and the Coroner's Court, which will assist in better informing this measure in the future.

4.6. Child health

Perinatal mortality

Perinatal deaths are defined as all foetal deaths (at least 20 weeks' gestation or at least 400 grams birth weight) plus all neonatal deaths (HPC 2017).

From 2011-15, there was an average of 4.5 Aboriginal perinatal deaths in South Australia for every 1,000 births, up from a rate of 3.9 recorded over the 2010-14 period, but below the 6.2 recorded for non-Aboriginal perinatal deaths (ABS 2016b).

Over the period 2006-15 the Aboriginal perinatal death rate was below the non-Aboriginal rate (ABS 2016b).

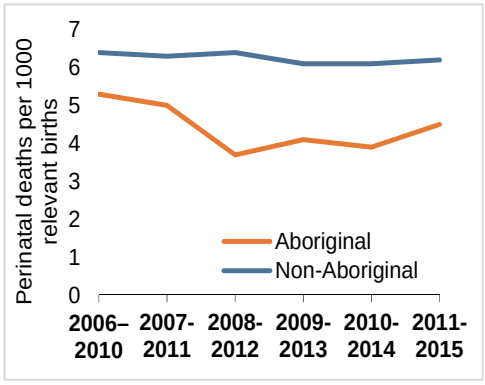


Figure 6: Rates of perinatal death, South Australia (Source: ABS 2016b)

Caution is recommended in interpreting trends due to the very small numbers behind the calculation of Aboriginal perinatal mortality rates. The South Australian trend of a lower perinatal mortality rate for the Aboriginal population compared with the non-Aboriginal population is in contrast to the national trend, which shows Aboriginal perinatal mortality rates as higher than non-Aboriginal rates. It should also be noted that mortality rates are higher for Aboriginal infants and children.

Infant and child mortality

In 2015, the age-specific death rate (ASDR) for Aboriginal infants and children aged 0 to 4 years in South Australia was 175.2 deaths per 100,000 Aboriginal population. This was 2.5 times that of the corresponding ASDR for non-Aboriginal infants and children (68.5 per 100,000 non-Aboriginal population) (ABS 2017b).

The 2015 ASDR rate for Aboriginal children was higher than for 2005 (156.0 deaths per 100,000), despite the trend in ASDR for non-Aboriginal infants and children declining in the last decade (ABS 2017b).

Caution is recommended in interpreting trends due to the very small numbers behind the calculation of Aboriginal infant and child ASDR which varies from year to year.

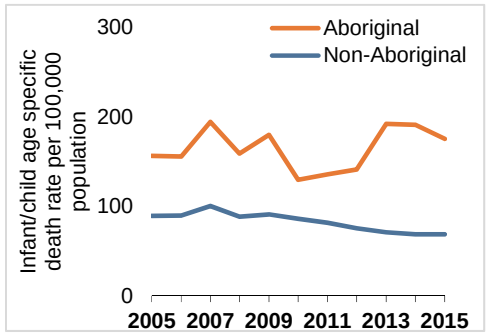


Figure 7: Infant and child death rates, South Australia (Source: ABS 2017b)

Birth weight

A baby's birthweight is a key indicator of health status and babies are defined as low birthweight if their weight at birth is less than 2,500 grams (HPC 2017).

In 2014, the average birthweight of liveborn babies to Aboriginal women in South Australia was 3,140 grams, less than the national average for babies born to Aboriginal women (3,215 grams) and less than the South Australian average for babies to all women (3,335 grams) (AIHW 2016).

Around one in seven (14.8%) liveborn babies to Aboriginal women in South Australia during 2014 were low birthweight, a higher rate than the 11.8% recorded nationally for liveborn babies to Aboriginal women and more than double the rate recorded for babies to all women in South Australia (6.6%) (AIHW 2016).

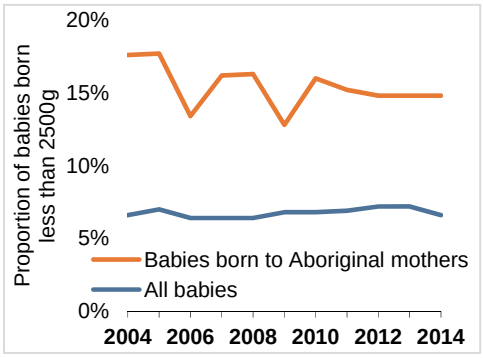


Figure 8: Percentage of low birthweight babies born, South Australia (Source: AIHW 2016)

The trend in percentage of low birthweight liveborn babies to Aboriginal women in South Australia has been declining over the last decade, down from 17.6% in 2004 (AIHW 2016).

Ear and hearing problems in children

In 2008, 7.8% of Aboriginal children in South Australia reported ear and hearing problems, including total or partial hearing loss and otitis media (a group of inflammatory diseases of the middle ear, including 'runny ear' and 'glue ear'). This rate was lower than the 8.6% national average percentage for Aboriginal children (AIHW 2017).

Between July 2013 and June 2015, 191 Aboriginal children aged 0-14 years were hospitalised in South Australia for diseases of the ear and mastoid process, representing an age-standardised rate of 7.0 per 1,000 population. This is lower than the hospitalisation rate of 11.1 per 1,000 population for non-Aboriginal children aged 0-14 years in South Australia, and lower than the average national rate of 7.5 per 1,000 population recorded for Aboriginal children across Australia (AIHW 2017).

Eye problems in children

In 2012, the National Trachoma Surveillance and Reporting Unit reported 933 Aboriginal children aged 5-9 years in South Australia had been screened for trachoma, a bacterial infection affecting the inner surface of the eyelids that can cause blindness if left untreated. Of the 933 children screened, 13 (1.4%) were found to have active trachoma (AIHW 2017).

The unit estimates trachoma prevalence amongst Aboriginal children aged 1-9 years in South Australia at 1.0%, below the 4.0% estimated for the combined states and territories of Northern Territory, South Australia, Western Australia and Queensland (AIHW 2017).

Between July 2013 and June 2015, the hospitalisation rate for Aboriginal children in South Australia aged 0-4 years admitted for a principal diagnosis of diseases of the eye and adnexa (eyelids and tear ducts) was 1.8 per 1,000 population, below the 2.8 per 1,000 population recorded for non-Aboriginal children in South Australia aged 0-4 years (AIHW 2017).

4.7. Chronic and long-term illness

Long-term health conditions

More than two in three (68.3%) Aboriginal people in South Australia aged 15 years and over reported at least one long-term health condition in 2014-15. A long-term health condition is a diagnosed medical condition which lasted, or is expected to last, for six months or more (ABS 2016a).

This is below the 78.4% of all South Australians aged 15 years and over who reported living with at least one long-term health condition in 2014-15 (ABS 2015b). However, as long-term health conditions manifest with age, this result may be due to the higher mortality rate experienced by Aboriginal people.

Disability (profound or severe core-activity limitation)

Profound or severe core-activity limitation is defined as always or sometimes needing help with core activities of self-care, mobility and/or communication (ABS 2016a).

Around one in ten (9.6%) Aboriginal people in South Australia aged 15 years and over recorded a profound or severe core-activity limitation in 2014-15. This was above the national average for Aboriginal people (7.7%) (ABS 2016a).

Anxiety and depression

A third (33.4%) of Aboriginal people in South Australia aged 15 years and over experienced high or very high levels of anxiety and depression in 2014-15. Psychological distress, as defined for Aboriginal people in the NATSISS, used the Kessler 5 Item (K5) Psychological Distress Questionnaire, a subset of five questions from the Kessler 10 Item (K10) scale. This checklist measures whether a person may have been affected by anxiety and depression during the past four weeks (ABS 2016a).

Although not directly comparable, this is more than double the 13.6% of the general South Australian population aged 18 years and over who registered high or very high levels of anxiety and depression in 2015 (assessed using the full K10 scale) (ABS 2015b).

Arthritis

In 2012-13, around one in nine (11.2%) Aboriginal people aged 15 years or more in South Australia reported living with arthritis. This rate was above the national average for Aboriginal people of 9.5% and below the 15.2% for all persons in South Australia recorded in 2014-15 (ABS 2014a; ABS 2015b). However, as this is an age-related disease, this outcome may be a result of the higher mortality rate experienced by Aboriginal people.

Asthma

In 2012-13, the nearly one in five (19.7%) Aboriginal people in South Australia aged 15 years or more who reported living with asthma was slightly above the national average for Aboriginal people (17.5%). The rate for Aboriginal people in South Australia during 2012-13 was around double the 10.6% for all persons in the state recorded in 2014-15 (ABS 2014a; ABS 2015b).

Cancer

Limited cancer data is available for the South Australian Aboriginal population, reflecting the small population in proportional terms and the under-reporting of Aboriginal identity in cancer records (SA Health 2015). However, the 2015 South Australian Aboriginal cancer incidence rate for all cancers combined was estimated at 267.4 cases per 100,000 population, compared with a rate of 280.1 per 100,000 for the non-Aboriginal population (SA Health 2015).

In 2015, Aboriginal people experienced a higher incidence of cancers with low case survivals, such as cancers of the lung, liver, pancreas, and digestive organs. Conversely, they experienced a lower incidence of cancers with high survival rates, such as cancers of the breast, skin, prostate and bowel. Higher rates of some cancers of the reproductive organs were experienced by Aboriginal women (SA Health 2015).

Aboriginal people generally presented with more advanced cancer stages at diagnosis, reflecting delayed diagnoses influenced by poorer access to services (SA Health 2015).

Cardiovascular disease

Aboriginal people in South Australia experience a high burden of cardiovascular risk through factors such as high smoking rates, high levels of stress and worry, obesity, and high blood pressure. This high burden of risk, particularly at young ages, contributes to a premature onset of cardiovascular disease (SAHMRI 2016a).

Cardiovascular diseases (heart diseases, stroke and heart failure) are the leading cause of mortality for Aboriginal people and the age at which Aboriginal people die from cardiovascular disease is dramatically earlier than for the non-Aboriginal population, peaking between 45 and 59 years of age for Aboriginal people compared with 70 years and over for non-Aboriginal people (SAHMRI 2016a).

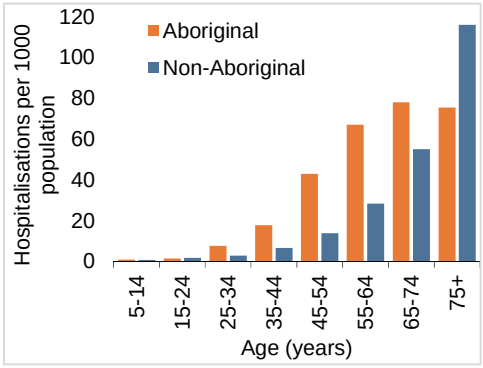


Figure 9: Age-specific hospitalisation rate per 1,000 population for a principal diagnosis of cardiovascular disease, 1 July 2010 - 30 June 2015 (Source: SAHMRI 2016a)

Between July 2010 and June 2015, 26 per 1,000 Aboriginal people in South Australia were hospitalised with a principal diagnosis of cardiovascular disease, compared to 17 per 1,000 non-Aboriginal people. Aboriginal people experience substantially higher age-specific hospitalisation rates between the ages of 25 and 74, compared to non-Aboriginal people (SAHMRI 2016a).

Diabetes

In 2012-13, the prevalence of type 2 diabetes mellitus (T2DM) among Aboriginal people aged 18 year and over in South Australia was 12.8%, compared with 5.1% among the non-Aboriginal population. The T2DM rate among Aboriginal females was higher than for Aboriginal males (15.0% and 9.1% respectively), compared with 4.2% and 5.9% respectively among non-Aboriginal people (SAHMRI 2016b).

The total diabetes rates (types 1, 2 and gestational) for South Australia were 20.0% among Aboriginal people and 6.2% for non-Aboriginal people (SAHMRI 2016b).

Kidney disease

In 2012-2014, the incidence of end-stage kidney disease for Aboriginal people in South Australia was 57.8 per 100,000 population, varying from 39.9 per 100,000 for Aboriginal males to 72.6 for Aboriginal females. The state incidence for Aboriginal people of 57.8 per 100,000 population was around seven times the rate of 8.5 per 100,000 recorded for non-Aboriginal people in South Australia (AIHW 2017).

HEALTH WORKFORCE PARTICIPATION OF ABORIGINAL PEOPLE IN SOUTH AUSTRALIA

5. Training and education in the health professions

5.1. Summary

The total number of Aboriginal students commencing health profession tertiary training in South Australia has increased, but as a proportion of all student commencements has remained low at around 1.3%.

Completion rates for Aboriginal students are lower than for non-Aboriginal students with one-third of Aboriginal students in higher education courses failing to complete their studies, compared with one-fifth of non-Aboriginal students.

5.2. Introduction

Increasing the size of the Aboriginal health workforce is fundamental to closing the gap in Aboriginal life expectancy. Training and placement of more Aboriginal clinicians is seen as crucial because Aboriginal people with clinical training are considered more likely to practise in Aboriginal communities and to provide culturally appropriate care (ATSIHWWG 2016).

5.3. Commencements in health-related training

Between 2010 and 2014 the number of Aboriginal students commencing in tertiary health-related courses in South Australia increased from 103 commencements to 131. As a proportion of all domestic health student commencements the rate has remained relatively steady (1.2% in 2010 compared with 1.3% in 2014) (ATSIHWWG 2016).

Commencements in each year were below those for Aboriginal people nationally, with national commencements ranging between a minimum of 1.8% (2012) and a maximum of 2.1% (2011) over the five-year period (ATSIHWWG 2016).

Table 12: Aboriginal health student commencements as a proportion of all domestic health student commencements, 2010-14

Year of commencement	South Australia no. & %	Australia no. & %
2010	103 (1.2%)	1,678 (1.9%)
2011	138 (1.6%)	1,924 (2.1%)
2012	125 (1.3%)	1,838 (1.8%)
2013	125 (1.2%)	2,007 (1.9%)
2014	131 (1.3%)	2,148 (1.9%)

Source: ATSIHWWG 2016

In 2010, around a quarter of those Aboriginal students in the state commencing a health-related course enrolled in a nursing qualification (24 or 23.3% of Aboriginal students). By 2014 this had fallen to 16.8%, suggesting enrolment in a broader range of health courses (ATSIHWWG 2016).

5.4. Completions of health-related training

Completion rates for Aboriginal students remain lower than for non-Aboriginal students. One-third of Aboriginal students in higher education courses do not complete their studies, compared with one-fifth of non-Aboriginal students (ATSIHWWG 2016).

In 2014, 53 Aboriginal students in South Australia completed their health profession course, representing only 0.8% of all domestic health student completions. To reach a target of 2.0% in 2014, an additional 73 Aboriginal student completions would be required (ATSIHWWG 2016).

National completions by Aboriginal students were 50% higher, with 1.2% completing their health-related studies in 2014 (ATSIHWWG 2016).

Table 13: Aboriginal health student completions as a proportion of all domestic health student completions, 2010-14

Year of completion	South Australia no. & %	Australia no. & %
2010	43 (0.8%)	485 (1.0%)
2011	45 (0.9%)	606 (1.2%)
2012	42 (0.8%)	614 (1.1%)
2013	38 (0.6%)	689 (1.2%)
2014	53 (0.8%)	731 (1.2%)

Source: ATSIWHHG 2016

5.5. Student support

Dedicated support for Aboriginal students has been put in place at the state's three universities and TAFESA to improve completion rates as well as academic and non-academic support for Aboriginal students:

- Flinders University – Yunggorendi First Nations Centre for Higher Education and Research
- TAFESA – Aboriginal Access Centre
- University of Adelaide – Wirltu Yarlu Aboriginal Education
- University of South Australia – Wirringka Student Services.

Other programs also available to support Aboriginal students in their tertiary studies include:

- Away from Base (AFB) – This covers travel costs for higher education and vocational education and training (VET) students studying an approved mixed-mode course. A mixed-mode course is a nationally accredited course that is delivered through a combination of distance education and face-to-face teaching for students who are based in their home communities and undertake occasional intensive study periods on campus (DET 2012).
- Indigenous Student Success Programme (ISSP) – This provides supplementary funding to universities to help students take on the demands of university and succeed. Universities can offer scholarships, tutorial assistance, mentoring and other personal support. The ISSP combines the Indigenous Support Programme, Commonwealth Scholarships Programme and tutorial assistance offered under the Indigenous Advancement Strategy (PMC 2017).
- The Indigenous Tutorial Assistance Scheme – Tertiary Tuition (ITAS-TT) – This provides funding for supplementary tuition to Aboriginal and Torres Strait Islander students studying university award-level courses and some specified Australian Qualifications Framework-accredited VET courses at ITAS-funded institutions. Tuition is managed by education providers and is available only for subjects in a student's formal education program (DET 2012).

Evaluation of these programs, including levels of utilisation and success in assisting Aboriginal students to complete their studies, is beyond the scope of this case study.

6. Health workforce participation

6.1. Summary

Aboriginal representation in health professions remains below the proportion of Aboriginal people in the general population, both nationally and in South Australia.

Aboriginal persons make up 1.0% of SA Health employees, half of the *South Australia's Strategic Plan Progress Report 2012* target (T53) to 'increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications and agencies, to 2% by 2014 and maintain or better those levels through to 2020'.

Aboriginal people employed in SA Health are under-represented in clinical roles and positions that have management responsibility or relative seniority.

Aboriginal people are under-represented in applications received for vacant positions in SA Health.

6.2. Introduction

Aboriginal employment in the health sector is a key enabler in improving Aboriginal population health, yet Aboriginal people remain under-represented.

In addition to the important contribution Aboriginal professionals and support staff make to Aboriginal health outcomes, employment of Aboriginal people contributes to better economic and subsequent health outcomes for those employed, their families and their communities.

There continues to be a significant shortfall of Aboriginal people working in health-related professions across all levels.

6.3. Health professionals

In the 2011 Census, 35,692 people identified themselves as public and private sector health professionals in the South Australian workforce. These were professionals who diagnosed and treated physical and mental illnesses and conditions and recommended, administered, dispensed and developed medications and treatment to promote or restore good health (ABS 2016c).

Of South Australia's total health professional workforce, 190 identified as Aboriginal. This number included 100 nurses and midwives (including nurse managers) and 14 medical practitioners. It represented only 0.5% of health professionals in the state and was less than a quarter of the percentage of Aboriginal people in the South Australian population (2.4%) (ABS 2016c).

6.4. Clinical and allied health profession registrations

In 2015, a total of 312 Aboriginal people in South Australia were registered across the 14 health professions overseen by the Australian Health Practitioner Regulation Agency (AHPRA). This was a growth on the two previous years, in which 253 and 261 Aboriginal professionals were registered (2013 and 2014 respectively) (HWA 2017).

The 2015 total included 37 Aboriginal and Torres Strait Islander (ATSI) health practitioners. ATSI health practitioners are a distinct class of registered health professionals, providing clinical and primary care for Aboriginal people, their families and community groups. The SA Health Aboriginal Health Practitioners project currently in progress aims to increase the number of ATSI health practitioners employed across SA Health services. Further structural reform and support is being considered to improve the utilisation of ATSI health practitioners in the SA Health workforce (ATSIHWWG 2016).

The overall percentage of registered Aboriginal clinical and allied health professionals (0.7% for all professions in 2015) was proportionally lower than the South Australian Aboriginal population (2.4%) (HWA 2017).

For a target of 2.0% Aboriginal clinical and allied health professionals registered across the 14 health professions overseen by AHPRA to be met, an additional 586 would be required.

Table 14: Number of Aboriginal practitioners employed in South Australia working in a registered profession, 2013-15

AHPRA health profession	2013		2014		2015	
	no.	%	no.	%	no.	%
ATSI health practitioners	6	100.0%	11	100.0%	37	100.0%
Chiropractors	0	0.0%	3	0.9%	0	0.0%
Chinese medicine practitioners	0	0.0%	0	0.0%	0	0.0%
Dental practitioners	6	0.4%	8	0.5%	10	0.6%
Medical practitioners	22	0.3%	25	0.4%	28	0.4%
Medical radiation practitioners	0	0.0%	0	0.0%	0	0.0%
Nurses and midwives	197	0.7%	196	0.7%	211	0.8%
Occupational therapists	0	0.0%	3	0.3%	3	0.3%
Optometrists	3	1.2%	0	0.0%	0	0.0%
Osteopaths	0	0.0%	0	0.0%	0	0.0%
Pharmacists	6	0.4%	5	0.3%	6	0.3%
Physiotherapists	6	0.3%	4	0.2%	7	0.3%
Podiatrists	0	0.0%	3	0.8%	3	0.8%
Psychologists	8	0.7%	3	0.2%	8	0.6%
Total	**253**	**0.6%**	**261**	**0.6%**	**312**	**0.7%**

Source: HWA 2017. Sum of rows may not tally exactly with totals due to confidentialising of small cells

6.5. SA Health workforce

Aboriginal employment in SA Health has decreased since 2011. SA Health has failed and continues to fail to meet its state strategic plan target of 2.0% of Aboriginal employees (DPC 2012).

Overall employment

As at 30 June 2016, SA Health had a total workforce of 42,701 people (30,354.2 fulltime-equivalent staff or FTEs) including clinical, support and administration staff across central office, all local health networks, and the SA Ambulance Service (SA Health 2017a).

SA Health records the self-identified Aboriginal status of its employees, although the level of reporting varies. As at 30 June 2016, two-thirds (66.6%) of employees identified as Aboriginal or non-Aboriginal, up from 37.9% in 2006. HPC has previously recommended that SA Health work to increase the rate of Aboriginal identification to 80% (SA Health 2017a).

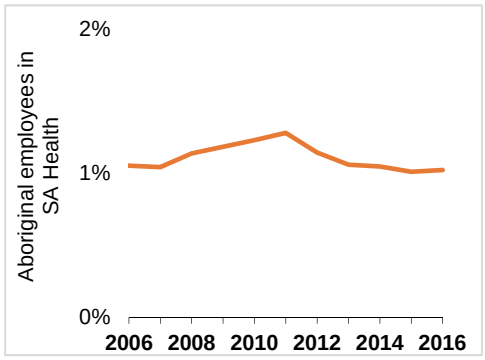


Figure 10: Percentage of Aboriginal employees in SA Health, 2006-16 (Source: SA Health 2017a)

At 30 June 2016, 406 SA Health staff members (310.1 FTEs) identified as Aboriginal, representing 1.0% of the FTE workforce, down from 1.3% in 2011. For SA Health to reach South Australia's Strategic Plan target of 2.0% Aboriginal employees, an additional 297.0 Aboriginal FTEs would have been required in 2016 (SA Health 2017a).

Additional time series detail of Aboriginal workforce participation by SA Health business units is available in Appendix A.

Local health networks

SA Health's organisation structure comprises central office, five local health networks (LHNs), and the SA Ambulance Service. At 30 June 2016, Aboriginal representation varied across the organisation. The highest level of employment was in the Country Health SA LHN and the Women's and Children's Health Network (HN) (2.0% FTEs each). The lowest employment was in the Northern Adelaide LHN (0.4% of FTEs). The largest number of employees was in the Country Health SA LHN, with 103.3 employees (SA Health 2017a).

Table 15: Aboriginal FTEs in SA Health by business unit, 2014-16

SA Health business unit	30 June 2014		30 June 2015		30 June 2016	
	No. FTEs	% FTEs	No. FTEs	% FTEs	No. FTEs	% FTEs
Central Office	16.2	0.7%	16.0	0.7%	12.6	0.6%
Northern Adelaide LHN	5.3	0.2%	5.7	0.2%	8.7	0.4%
Central Adelaide LHN	84.4	0.7%	80.4	0.7%	79.1	0.7%
Southern Adelaide LHN	51.1	0.9%	45.1	0.8%	45.3	0.8%
Country Health SA LHN	118.3	1.9%	104.3	1.9%	103.3	2.0%
Women's & Children's HN	51.6	1.9%	53.2	2.0%	52.9	2.0%
SA Ambulance Service	12.2	0.9%	8.8	0.7%	8.1	0.6%
SA Health total	**339.0**	**1.0%**	**313.5**	**1.0%**	**310.1**	**1.0%**

Source: SA Health 2017a

Additional time series detail of Aboriginal workforce participation by SA Health business unit is available in Appendix A.

Gender

At 30 June 2016, 234.0 (75.5%) of the 310.1 total Aboriginal FTEs in SA Health were female and 76.1 (24.5%) were male (SA Health 2017a).

This is in keeping with the highly gendered nature of the health workforce and is consistent with the 74.7% female and 25.3% male distribution of the non-Aboriginal SA Health workforce (SA Health 2017a).

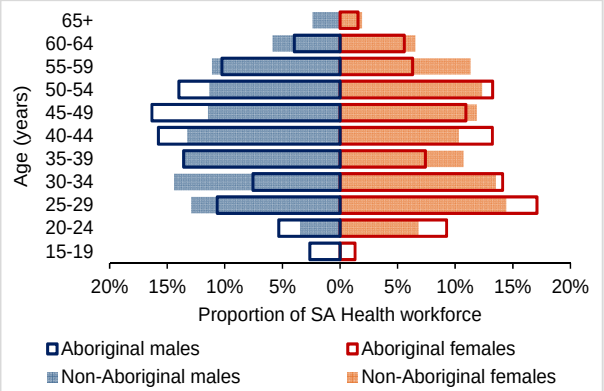


Figure 11: Employment in SA Health by gender and age, 30 June 2016 (Source: SA Health 2017a)

Roles and status

The majority of Aboriginal employees in SA Health at 30 June 2016 were in administrative or non-client contact roles, followed by nurses and other client contact roles. There were 4.0 FTE doctors in SA Health as at 30 June 2016 who identified as Aboriginal employees, representing 0.1% of doctors employed by SA Health (SA Health 2017a).

Table 16: Aboriginal workforce in SA Health by role and status, 30 June 2016

Job type	Aboriginal males	Aboriginal females	Aboriginal persons
Administrative/non-client contact	52.9 (2.0%)	146.0 (2.5%)	198.9 (2.4%)
Allied health	1.0 (0.2%)	8.0 (0.3%)	9.0 (0.3%)
Doctor	3.0 (0.2%)	1.0 (0.1%)	4.0 (0.1%)
Nurse	4.1 (0.3%)	49.4 (0.5%)	53.5 (0.4%)
Other client contact role	15.1 (1.9%)	29.6 (1.1%)	44.7 (1.3%)
Unknown	0.0 (–)	0.0 (–)	0.0 (–)
SA Health total	**76.1 (1.0%)**	**234.0 (1.0%)**	**310.1 (1.0%)**

Source: SA Health 2017a

At 30 June 2016, Aboriginal persons were under-represented compared to the non-Aboriginal SA Health workforce across the clinical roles of nurses, doctors and allied health. These roles made up a combined 57.6% of the non-Aboriginal workforce but 21.5% of the Aboriginal workforce (SA Health 2017a).

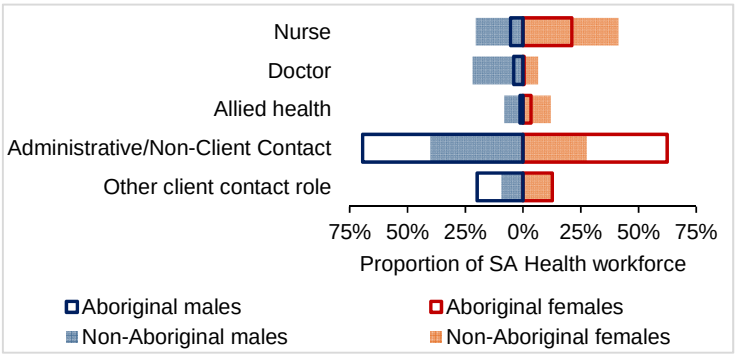


Figure 12: Roles in SA Health by Aboriginal status and gender, 30 June 2016 (Source: SA Health 2017a)

There is a range of different employment classification types across SA Health. To allow for simplified comparison of relative seniority across the organisation, the table below organises salary amounts into five cohorts corresponding to administrative services officer (ASO) classifications in the SA public service. The annual ASO salary-equivalent pay rates (fulltime and gross) that applied as at 30 June 2016 were:

ASO1–ASO2 ..... up to $53,661

ASO3–ASO4 ..... $53,662 to $69,036

ASO5–ASO6 ..... $69,037 to $90,481

ASO7–ASO8 ..... $90,482 to $110,257

MAS1 or over ..... $110,258 and over.

At June 30 2016, Aboriginal people were under-represented in roles at the ASO 5-equivalent level and higher. Fewer than 10 out of the 310.1 Aboriginal FTE staff within SA Health were at the MAS1-equivalent level or higher (SA Health 2017a).

Table 17: Aboriginal workforce in SA Health by ASO salary equivalent, 30 June 2016

Equivalent salary range	Aboriginal males	Aboriginal females	Aboriginal persons
ASO1-ASO2 salary range	17.9 (1.7%)	56.1 (1.1%)	74.0 (1.2%)
ASO3-ASO4 salary range	27.3 (2.4%)	97.3 (2.0%)	124.6 (2.0%)
ASO5-ASO6 salary range	20.9 (0.8%)	60.4 (0.7%)	81.2 (0.7%)
ASO7-ASO8 salary range	**	12.2 (0.5%)	17.2 (0.5%)
MAS1 or over salary range	**	**	**
Unknown	**	**	**
SA Health total	**76.1 (1.0%)**	**234.0 (1.0%)**	**310.1 (1.0%)**

Source: SA Health 2017a

*** Small cells (counts of greater than zero but less than ten) have been suppressed to protect privacy*

At 30 June 2016, Aboriginal persons were under-represented in senior roles (ASO5-equivalent and higher). These roles accounted for 57.0% of the non-Aboriginal workforce but only 34.7% of the Aboriginal workforce (SA Health 2017a).

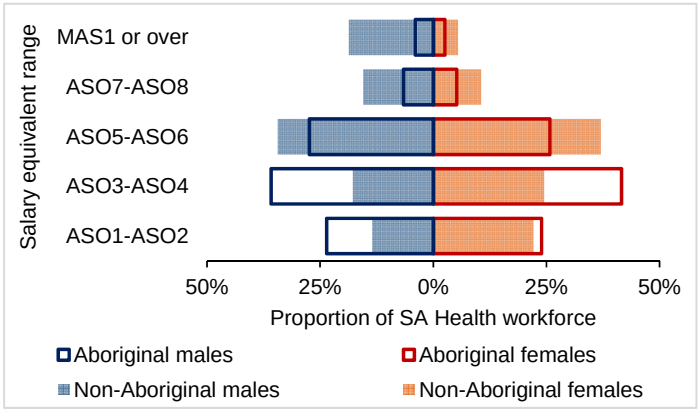


Figure 13: South Australian public sector salary-equivalent ranges, 30 June 2016 (Source: SA Health 2017a)

Applications for SA Health positions

Applicants for positions in SA Health are given the opportunity to identify as Indigenous. In 2016, a total of 87,594 applications were received for positions across SA Health and 91.6% of applicants declared whether they were Aboriginal or non-Aboriginal (SA Health 2017b).

Of the 87,594 total applications received in 2016, 1,417 applications (1.6%) were received by people who identified as Aboriginal (compared with the statewide Aboriginal population of (2.4%)). Aboriginal-identified applications were concentrated in the areas of administrative and executive roles (2.4% or total applications for these roles) and weekly paid positions (3.3% of all applications received for these roles). Only 35 (0.4%) of the applications received from Aboriginal people were for medical professional positions (SA Health 2017b).

Over the period 2014 to 2016, the number of those applying for allied health professional roles more than doubled from 22 to 53 and weekly paid also more than doubled from 152 to 382. Aboriginal people applying for medical professional jobs in SA Health more than tripled over the same period from 10 in 2014 to 35 in 2016 (SA Health 2017b).

For SA Health to reach 2.0% of Aboriginal persons applying for positions across the organisation, an additional 335 applications from Aboriginal people would have been required (SA Health 2017b).

Table 18: Applications for SA Health positions received by Aboriginal persons

Stream	2014		2015		2016	
	No.	%	No.	%	No.	%
Administrative/executive	603	2.5%	558	2.7%	566	2.4%
Allied health professionals	22	0.4%	40	0.6%	53	0.8%
Medical professionals	10	0.3%	41	0.6%	35	0.4%
Nurses/midwives	197	0.9%	167	0.8%	222	0.9%
Professional officers	**	**	**	**	**	**
SA Ambulance	**	**	**	**	25	1.3%
Scientific/technical	16	0.6%	15	0.6%	**	**
Weekly paid	152	2.0%	211	3.3%	382	3.3%
Other	105	2.3%	173	3.3%	124	2.2%
TOTAL	**1,116**	**1.5%**	**1,214**	**1.6%**	**1,417**	**1.6%**

Source: SA Health 2017b

*** Small cells (counts of greater than zero but less than ten) have been suppressed to protect privacy*

7. Interactions with the SA health system

7.1. Summary

Outcomes for Aboriginal people in South Australia in their interaction with health system services has improved in some areas:

- Childhood immunisation for Aboriginal South Australian children aged five years is above the state average.
- A rise in early childhood health checks for Aboriginal South Australian children has brought the rate in line with the overall state figures.
- The rate of emergency readmission to hospital within 28 days is trending down for Aboriginal inpatients and is now slightly below the non-Aboriginal rate.
- The rate of Aboriginal persons hospitalised for potentially preventable conditions, as a share of all Aboriginal hospitalisations, is slightly below the equivalent share for non-Aboriginal people.

However, access and ongoing interaction with the health system in other critical areas are below those for the non-Aboriginal population:

- Antenatal visits for Aboriginal women in the first 14 weeks of pregnancy continue at a much lower level than for non-Aboriginal women, although the trend is upward.
- The rate of Aboriginal persons leaving public hospital emergency departments (EDs) at their own risk after treatment has commenced is higher than the equivalent share for non-Aboriginal people.
- The rate of Aboriginal inpatients self-discharging themselves from hospital against medical advice is higher than the equivalent share for non-Aboriginal people.
- Fewer older Aboriginal people are fully vaccinated against influenza and pneumococcal disease.

7.2. Introduction

The performance of the health system may be analysed using a number of measurements: effectiveness, continuity of care, safety, accessibility, responsiveness, and efficiency and sustainability (AIHW 2014). Consumer engagement is also a key indicator of system performance. Together these allow review of the quality of care.

In addressing the question of how well the health system is working for Aboriginal people in South Australia, this case study concentrates on elements of accessibility (measured here in the narrowest sense of interactions with the health system).

An important issue is the cultural appropriateness of healthcare. There exists a positive association between patient experience, patient safety and clinical effectiveness (Doyle 2013). For Aboriginal people cultural appropriateness is critical to best health outcomes.

7.3. Maternal health – antenatal visits

Over half (54.7%) of Aboriginal women who gave birth in South Australia in 2014 had their first antenatal visit within the first 14 weeks of pregnancy. By comparison, 79.7% of non-Aboriginal women had their first visit within this timeframe (Pregnancy Outcome Unit 2016).

The overall trend for both Aboriginal and non-Aboriginal women has been trending up since 2007, although the rate for Aboriginal women remains significantly below the non-Aboriginal rate (Pregnancy Outcome Unit 2016).

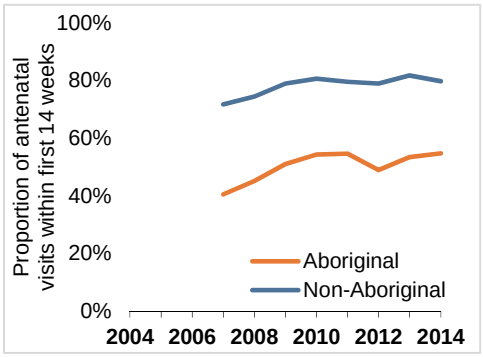


Figure 14: Antenatal visits in first 14 weeks of pregnancy in South Australia (Source: Pregnancy Outcome Unit 2016)

7.4. Child health interactions

Childhood immunisation

Childhood immunisation for Aboriginal South Australian children is above the state average.

As at December 2016, 94.3% of Aboriginal children aged five years in South Australia were fully immunised. This included vaccination against hepatitis B, diphtheria, tetanus, pertussis, haemophilus influenza B, polio, measles, mumps and rubella, pneumococcal, varicella and meningococcal C (DOH 2017).

The trend in percentage of Aboriginal children fully immunised by age five years in this state has increased over the last decade (up from 70.4% in 2007). South Australia's proportion of Aboriginal children aged five years fully immunised is above the state's overall figure of 93.1% (DOH 2017).

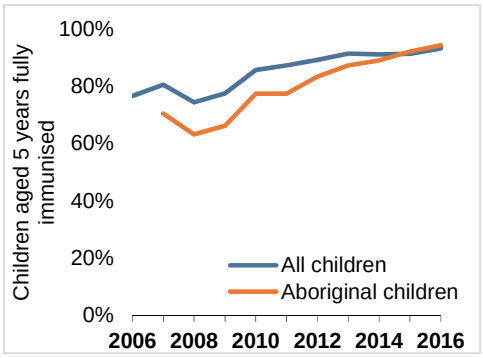


Figure 15: Childhood immunisation in South Australia (Source: DOH 2017)

Early childhood health checks

A rise in early childhood health checks for Aboriginal South Australian children has brought these in line with the overall state figures.

In 2014-15, over half (55.9%) of Aboriginal children in South Australia in the target cohort had received a fourth-year developmental health check known as the Aboriginal and Torres Strait Islander Child Health Check (SCRGSP 2017).

Over the last four years of comparable data, South Australia's rate of early childhood health checks for Aboriginal children has been increasing and is now effectively the same as for all children in South Australia in the target cohort receiving a Healthy Kids Check (57.8%) (SCRGSP 2017).

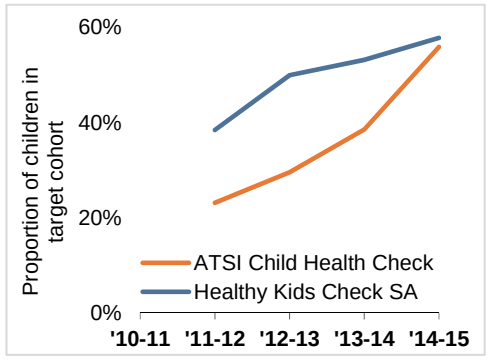


Figure 16: Early childhood health checks in South Australia (Source: SCRGSP 2017)

7.5. Adverse and avoidable hospital activity

Leaving hospital emergency department at own risk

In 2015-16 across South Australia's seven major metropolitan Adelaide[1] and seven major country public hospitals[2], 3,865 of the total 481,908 presentations to emergency departments (EDs) resulted in the person leaving prematurely at their own risk after treatment had commenced (SA Health 2017c).

Aboriginal persons represented a disproportionate share of this activity, comprising 432 of the 3,865 ED presentations who left at their own risk after treatment had started, five times the expected rate based on population (SA Health 2017c).

As a share of overall ED activity, Aboriginal persons leaving EDs at their own risk after treatment started represented a rate of 19.2 per 1,000 total ED presentations in 2015-16, more than double the 7.4 per 1,000 for the non-Aboriginal population (SA Health 2017c).

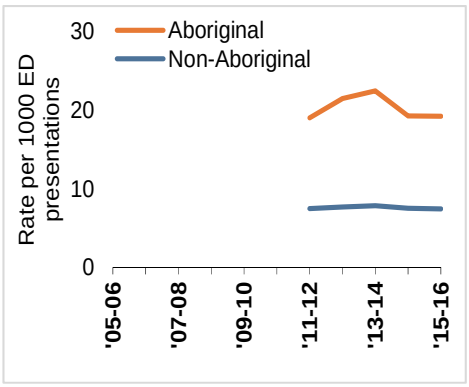


Figure 17: Rate of presentations to SA public hospital EDs that leave at their own risk after treatment started (Source: SA Health 2017c)

Note that the data reviewed relates to the seven major hospitals in order to conform to SA Health standard business counting rules. Reporting for these hospitals' ED data commenced in 2011-12.

Additional detail by SA Health local health network is available in Appendix B.

Inpatient discharge against medical advice from hospital

In 2015-16, there were 437,921 hospitalisations (inpatient separations) at public hospitals across South Australia, of which 3,659 resulted in the inpatient self-discharging against medical advice (SA Health 2017d).

Aboriginal inpatients represented a disproportionately large share of this activity. Of the 3,659 self-discharges against medical advice, 668 were Aboriginal inpatients, nine times the expected rate based on population (SA Health 2017d).

As a share of overall hospital activity, Aboriginal inpatients who self-discharged from a public hospital against medical advice represented a rate of 28.1 per 1,000 hospitalisations, compared with 7.3 per 1,000 for non-Aboriginal inpatients in 2015-16 (SA Health 2017d).

The trend has been downward since 2005-06.

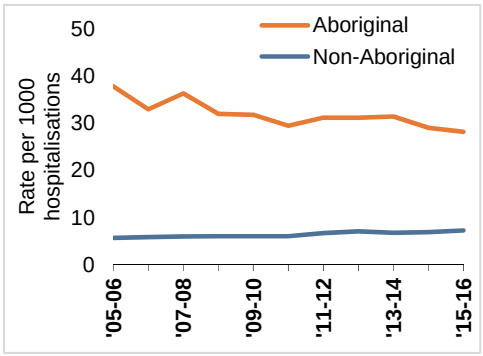


Figure 18: Rate of inpatient self-discharge against medical advice from SA public hospitals (Source: SA Health 2017d)

Additional detail by SA Health local health network is available in Appendix B.

[1] (1) Flinders Medical Centre, (2) Lyell McEwin Hospital, (3) Modbury Hospital, (4) Noarlunga Health Service, (5) Royal Adelaide Hospital, (6) The Queen Elizabeth Hospital, (7) Women's and Children's Hospital.

[2] (1) Gawler Health Service, (2) Mount Gambier and Districts Health Service, (3) Port Augusta Hospital and Regional Health Service, (4) Port Lincoln Health Service, (5) Port Pirie Regional Health Service, (6) Riverland General Hospital, (7) Whyalla Hospital and Health Service

Inpatient emergency readmission to hospital within 28 days

In 2015-16, there were 28,823 hospitalisations (inpatient separations) at public hospitals in South Australia where the admission was an emergency readmission back to the same hospital within 28 days. Emergency readmissions do not include administrative or obstetrics-related readmissions (SA Health 2017d).

Aboriginal inpatients represented a disproportionate share of this activity in 2015-16. Of the 28,823 emergency readmissions to public hospitals, 1,444 were Aboriginal inpatients, more than twice the expected rate based on population (SA Health 2017d).

However, as a share of overall hospital activity, Aboriginal emergency readmissions in 2015-16 represented 6.5% of all Aboriginal inpatient admissions, lower than the 7.4% recorded for non-Aboriginal inpatients (SA Health 2017d).

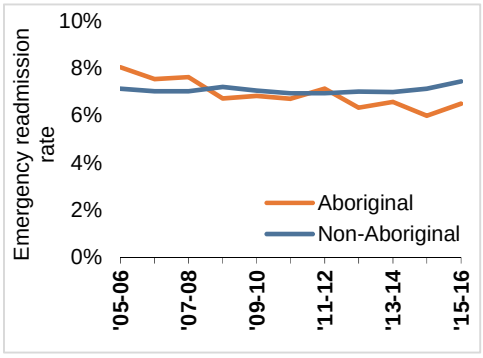


Figure 19: Rate of inpatient emergency readmissions to SA public hospitals (Source: SA Health 2017d)

The trend in Aboriginal inpatient public hospital emergency readmissions has been downward since 2005-06, while the non-Aboriginal trend has been steady.

Additional detail by SA Health local health network is available in Appendix B.

Potentially preventable hospital admission

In 2015-16, there were 39,775 hospitalisations (inpatient separations) defined as potentially preventable. Potentially preventable admissions are hospitalisations for conditions that can be effectively treated in a non-hospital setting, including vaccine-preventable diseases such as influenza, potentially preventable acute conditions such as gastroenteritis, and potentially manageable chronic conditions such as asthma (SA Health 2017d).

Aboriginal inpatients represented a disproportionately high share of this activity in 2015-16. Of the 39,775 potentially preventable admissions to public hospitals, 2,052 were Aboriginal inpatients, more than twice the expected rate based on population (SA Health 2017d).

However, as a share of overall hospital activity, Aboriginal potentially preventable admissions to hospital in 2015-16 represented a rate of 86.4 per 1,000 hospitalisations, slightly lower than the 91.5 recorded for non-Aboriginal inpatients (SA Health 2017d).

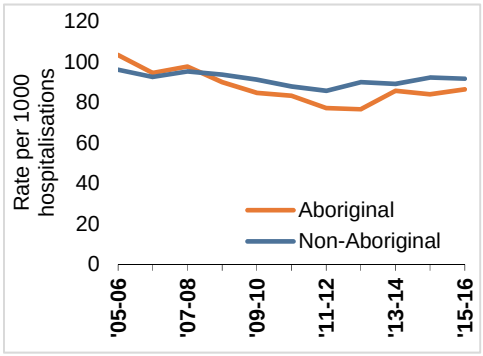


Figure 20: Rate of potentially preventable admissions to SA public hospitals (Source: SA Health 2017d)

The trend in Aboriginal potentially preventable admissions declined between 2005-06 and 2012-13 but has increased slightly since. The Aboriginal rate has been below the non-Aboriginal rate since 2008-09 (SA Health 2017d).

Additional detail by SA Health local health network is available in Appendix B.

7.6. Older people vaccinated

In 2012-13, over a quarter (25.7%) of Aboriginal people aged 50 years or over were fully vaccinated against influenza and pneumococcal disease, down from the 35.9% recorded in 2004-05. This compared to the 2012-13 and 2004-05 Australian averages for Aboriginal people aged 50 years or over of 25.3% and 31.1% respectively (SCRGSP 2017).

8. Addressing Aboriginal health in South Australia

8.1. Summary

SA Health has not achieved *South Australia's Strategic Plan Progress Report 2012* target to 'increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications and agencies, to 2% by 2014 and maintain or better those levels through to 2020'. In fact, the overall trend has been down since 2011. The target has been reached in only two business units, the Country Health SA LHN and the Women's and Children's HN, with the other business units significantly lagging behind.

For Aboriginal people living in South Australia there have been some improvements in a limited number of strategic plan measurements such as antenatal visits, birthweight, child immunisation and smoking, although disparities in many of these measures still remain unacceptably high.

The failure to meet state strategic plan targets has occurred despite ongoing effort and reform and a multiplicity of policy and programs over the last decade. At least in the case of Aboriginal healthy life expectancy, HPC has heard during consultations for this report that the target was put in place without reasoning or community consultation.

8.2. Introduction

It is beyond the scope of this case study to review the success or otherwise of all policies and programs dedicated to Aboriginal health in South Australia. Rather, the approach is to briefly appraise selected targets, progress against those targets, and selected policies.

8.3. Targets and outcomes

In 2012, *South Australia's Strategic Plan Progress Report 2012* produced by the Department of Premier and Cabinet identified eleven targets relating to Aboriginal people (DPC 2012).

Progress ratings and achievability ratings from that report are summarised in the table below.

Table 19: South Australia's Strategic Plan Progress Report 2012: targets for Aboriginal people

2012 Target	Description	Progress rating	Achievability rating
T6 Aboriginal wellbeing	Improve the overall wellbeing of Aboriginal South Australians.	Positive movement	Within reach
T9 Aboriginal housing	Reduce overcrowding in Aboriginal households by 10% by 2014.	Positive movement	On track
T15 Aboriginal education – early years	Increase yearly the proportion of Aboriginal children reading at age-appropriate levels at the end of Year 1.	Positive movement	Within reach
T26 Early childhood – birthweight	Halve the proportion of Aboriginal low-weight babies by 2020.	Positive movement	Within reach
T27 Understanding of Aboriginal culture	Aboriginal cultural studies is included in school curriculum by 2016 with involvement of Aboriginal people in design and delivery.	Steady or no movement	Within reach
T28 Aboriginal leadership	Increase the number of Aboriginal South Australians participating in community leadership and in community leadership development programs.	Negative movement	Unlikely
T44 Aboriginal lands – Native Title	Resolve 80% of Native Title claims by 2020.	Positive movement	Within reach
T51 Aboriginal unemployment	Halve the gap between Aboriginal and non-Aboriginal unemployment rates by 2018.	Positive movement	Within reach
T53 Aboriginal employees	Increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications and agencies, to 2% by 2014 and maintain or better those levels through to 2020.	Positive movement	Within reach
T79 Aboriginal healthy life expectancy*	Increase the average healthy life expectancy of Aboriginal males to 67.5 years (22%) and Aboriginal females to 72.3 years (19%) by 2020.	Unclear	Unclear
T80 Smoking	Halve the smoking rate of Aboriginal South Australians by 2018.	Baseline established	Baseline established

Source: DPC 2012
** Updated in 2013-14.*

Change of Aboriginal healthy life expectancy target in SA's Strategic Plan

Following the release of *South Australia's Strategic Plan Progress Report 2012*, the Aboriginal healthy life expectancy target (T79) has been updated with a simplified target of *Aboriginal life expectancy: Increase the average life expectancy of Aboriginal South Australians*. That is, the indicator no longer focusses on *healthy* life expectancy, has dropped specific age targets and omits a timeframe for achievement (DPC 2017).

During the consultation phase of this project stakeholders expressed concern that this change was made with inadequate reasoning and community consultation. Stakeholders believe that the update was unnecessary and ill-advised and that, with adequate resourcing, it is feasible to continue to monitor the original indicator.

8.4. Policies, programs and the health sector

The failure to meet strategic plan targets for Aboriginal health and employment has occurred despite ongoing effort and reform and a multiplicity of policy and programs over the last decade.

SA Health policies

SA Health Aboriginal Cultural Respect Framework

The Aboriginal Cultural Respect Framework targets achievable goals and sets out a methodology that focuses on strategic partnerships. The framework integrates the SA Aboriginal Health Policy, the SA Health Statement of Reconciliation, the Aboriginal Health Impact Statement Policy Directive, services reform through cultural partnerships, education, review and practice development, Aboriginal workforce development and monitoring and evaluation to maintain a high level of commitment to closing the gap in health outcomes. Compliance is mandatory (SA Health 2007a).

SA Health Aboriginal Employment Policy

The Aboriginal Employment Policy outlines SA Health's policy commitment to increasing the employment of Aboriginal people at all levels across the portfolio and the retention and development of current and future Aboriginal employees. Compliance is mandatory (SA Health 2008).

SA Health Aboriginal Health Policy

The Aboriginal Health Policy outlines SA Health's commitment to improving the health of Aboriginal and Torres Strait Islander people through shared approaches to policy development, planning and service across the health system and respect for cultural diversity. Compliance is mandatory (SA Health 2007b).

SA Health Aboriginal Health Impact Statement Policy Directive

The Aboriginal Health Impact Statement Policy Directive aims to ensure that Aboriginal stakeholders have been engaged in the decisions that affect their health and wellbeing. Culturally respectful engagement aims to ensure that proposals address Aboriginal health disparities. The directive contains three questions to be included in briefing templates for SA Health executive groups:

- Is the proposal linked with any Aboriginal-specific initiatives?
- Will the proposal have an Aboriginal impact?
- Have Aboriginal stakeholders been engaged and will they continue to be?

Staff are required to complete the three questions for proposals to SA Health executive groups (SA Health 2014a). Compliance is mandatory (SA Health 2014a).

It is not clear whether this directive has been internally or independently reviewed. It is not clear to what extent this directive has been applied, especially to major projects such as the new Royal Adelaide Hospital, the Enterprise Patient Administration System (EPAS) or Transforming Health.

SA Health Reconciliation Action Plan

The plan outlines SA Health's commitment to ensuring health equity for Aboriginal South Australians through strong respectful relationships, culturally appropriate engagement, and increased education and economic participation opportunities. The plan emphasises that Aboriginal health and perspectives must be incorporated in to all SA Health policies and strategic directions (SA Health 2017e).The framework focuses on four areas:

- relationships
- respect
- opportunities
- governance, tracking and reporting.

SA Health's Aboriginal Health Care Plan 2010-16

Recently concluded, this plan sought to deliver (SA Health 2010):

- support for good health
- stronger primary healthcare
- better care for those with high needs
- an integrated and collaborative approach to the planning and delivery of services and programs
- a focus on priorities, including the identified major health issues of child health, youth health and safety, chronic diseases, oral, ear and eye health, social and emotional health and mental illness, and preventable injuries
- enablers for action including leadership, workforce, safety and quality, research, evaluation and monitoring, and health information and management systems.

Other policies

A further number of policies and programs have been targeted at the health and health outcomes of Aboriginal people in South Australia, many in association with national (and in particular Council of Australian Government) initiatives on Aboriginal health, research and disease-specific bodies. It is outside the scope of this paper to list all of these.

8.5. Training, employment and cultural programs

In the area of workforce, employment and training, policies and programs within SA Health and the South Australian government more broadly include, but are not limited to:

- Aboriginal Employment Career Pathways (OPS)
- Aboriginal Nursing and Midwifery Cadetship Program (coordinated by the Northern Adelaide LHN) (ATSIHWWG 2016)
- Learning Set for Aboriginal Managers (SA Health) (Dwyer and O'Donnell 2013)
- SA Health Aboriginal Health Practitioners project and the Aboriginal Maternal Infant Care initiative (ATSIHWWG 2016).
- SA Health Aboriginal Health Scholarship Program (ATSIHWWG 2016)
- SA Health Aboriginal Workforce Reform Strategy (SA Health 2009).

In addition to workforce, employment and training programs, the South Australian Government has put in place a range of cultural awareness and cultural respect programs, including in public hospitals and health services. These include programs provided as part of induction process for new staff, as well as programs for existing staff. Specific programs include, but are not limited to:

- Office of the Public Sector's 90-day project Safe to be You: Cultural Safety (OPS)
- SA Health Aboriginal Cultural Respect Framework (SA Health 2007a).

Future case studies can consider the uptake and effectiveness of cultural safety training programs across the state.

Appendix A: Workforce charts: SA Health business units

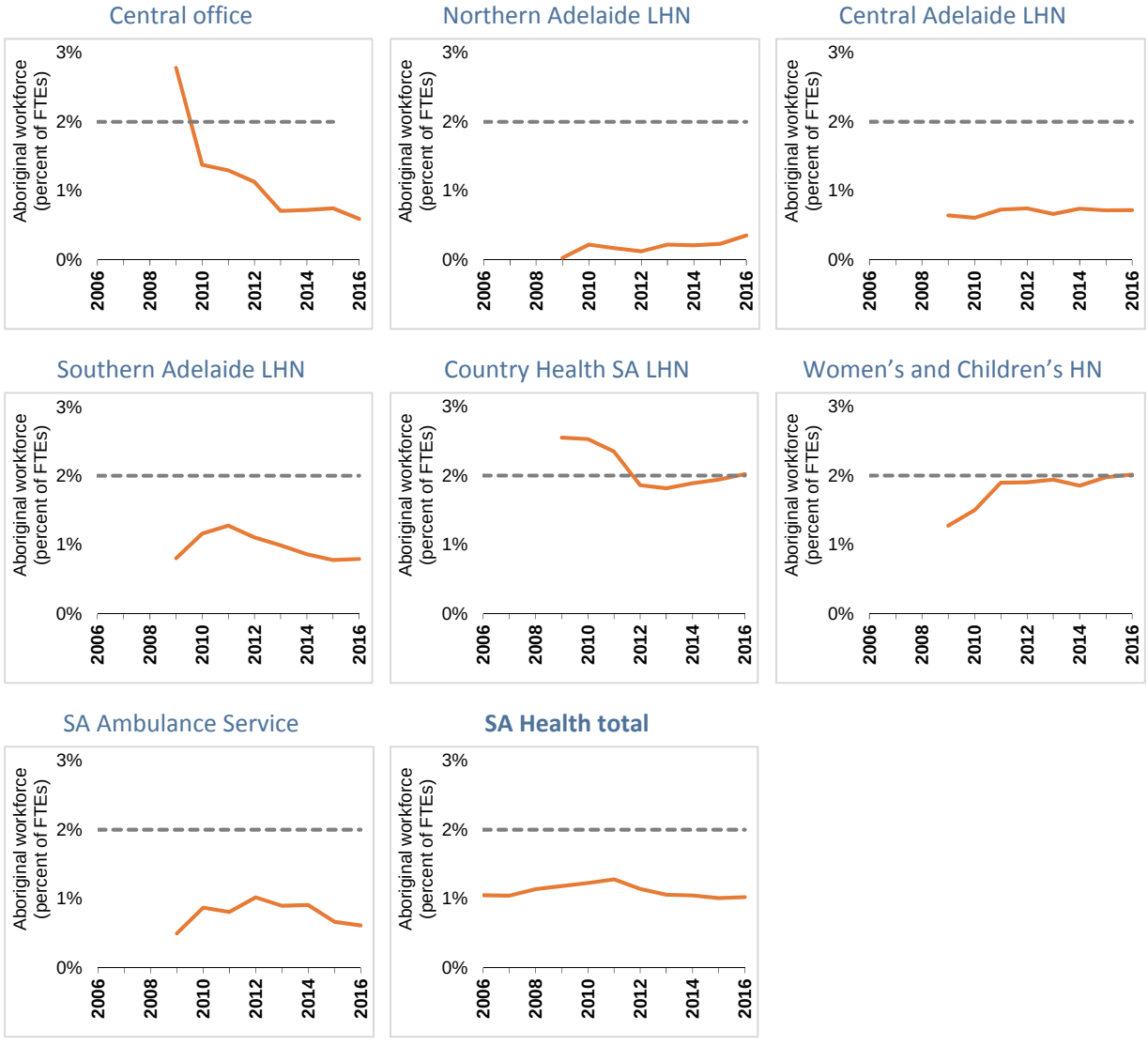
Aboriginal workforce participation in SA Health

The eight charts below show trends in levels of Aboriginal workforce participation across the business units of SA Health. Charted is the number of fulltime-equivalent (FTE) staff who have self-identified on the SA Health payroll system as Aboriginal, as a percentage of total FTEs, as at 30 June each year.

SA's Strategic Plan target calls for 2.0% of the public sector workforce to be Aboriginal persons.

Local health networks (LHNs) were established under the *Health Care Act 2008*, so these charts commenced from 30 June 2009. The SA Health total chart spans the whole time series.

Aboriginal workforce participation by SA Health business unit



Source: SA Health 2017a

Appendix B: Adverse and avoidable hospital activity charts: SA Health local health networks

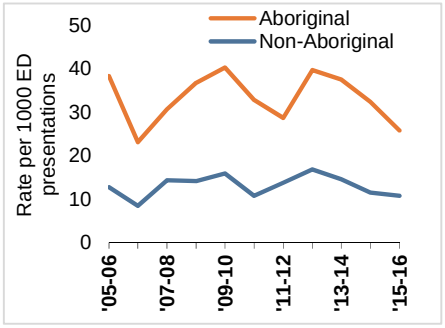
Leaving hospital emergency department at own risk

The six charts below show trends in rates of persons who prematurely leave public hospital emergency departments (EDs) at their own risk after treatment has already commenced. Trends are expressed as a hospital activity outcome measure, not a population measure – outcomes per 1,000 ED presentations by SA Health local health network (LHN) of the public hospital (not the resident).

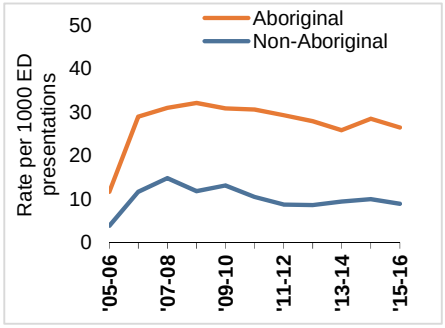
The charts cover South Australia's seven major metropolitan Adelaide ED public hospitals[3] and, effective from 2011-12 when data collection for these sites commenced, seven major country ED public hospitals.[4] The chart for the total state begins at 2011-12 to ensure a consistent time series.

Left emergency department at own risk by LHN of hospital

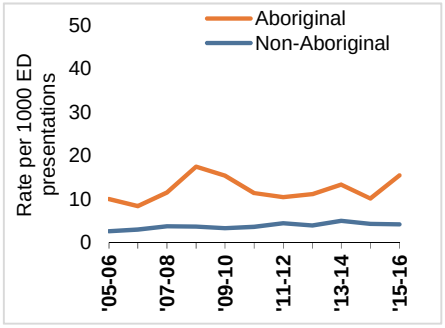
Northern Adelaide LHN



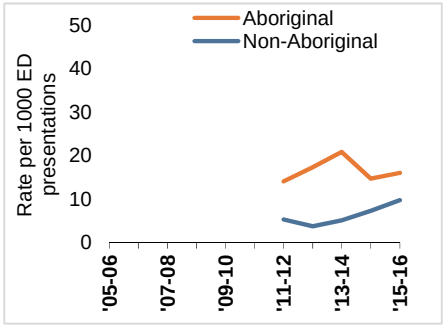
Central Adelaide LHN



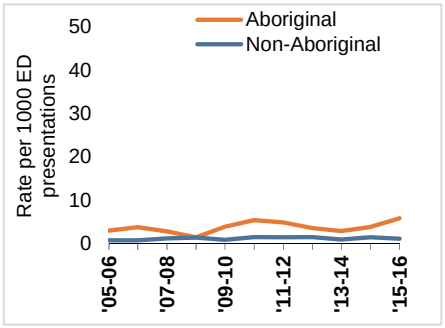
Southern Adelaide LHN



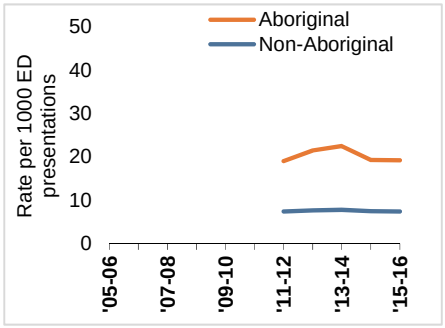
Country Health SA LHN



Women's and Children's HN



South Australian total



Source: SA Health 2017c

[3] Flinders Medical Centre, Lyell McEwin Hospital, Modbury Hospital, Noarlunga Health Service, Royal Adelaide Hospital, Queen Elizabeth Hospital, Women's and Children's Hospital.
[4] Gawler Health Service, Mt Gambier & Districts Health Service, Pt Augusta Hospital & Regional Health Service, Pt Lincoln Health Service, Pt Pirie Regional Health Service, Riverland General Hospital, Whyalla Hospital and Health Service.

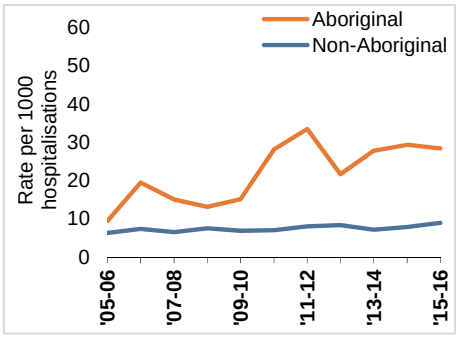
Inpatient discharge against medical advice from hospital

The six charts below show trends in rates of public hospital-admitted inpatients who discharge themselves early against medical advice.

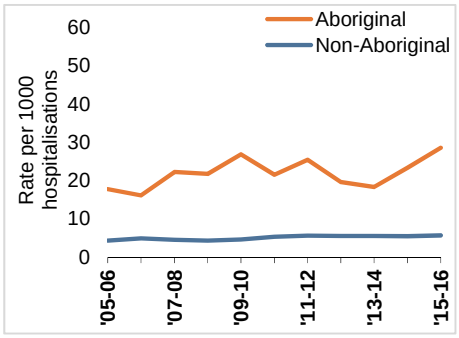
Trends are expressed as a hospital activity outcome measure, not a population measure – outcomes per 1,000 total hospitalisations (inpatient separations) by SA Health local health network (LHN) of the public hospital (not the resident).

Discharge against medical advice by LHN of hospital

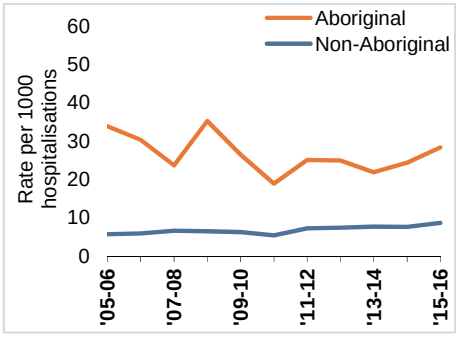
Northern Adelaide LHN



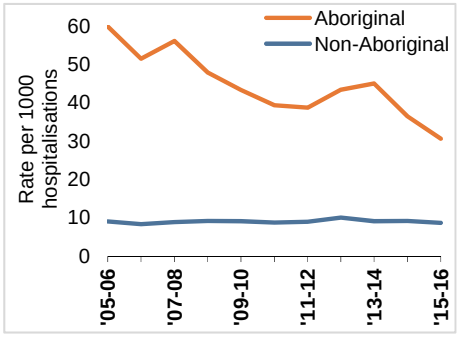
Central Adelaide LHN



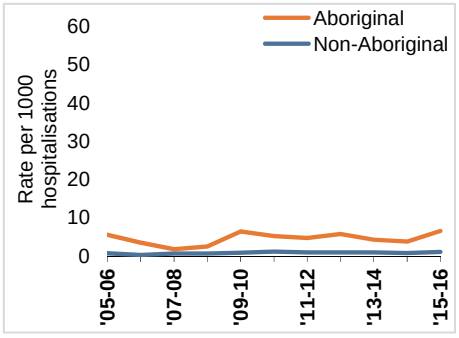
Southern Adelaide LHN



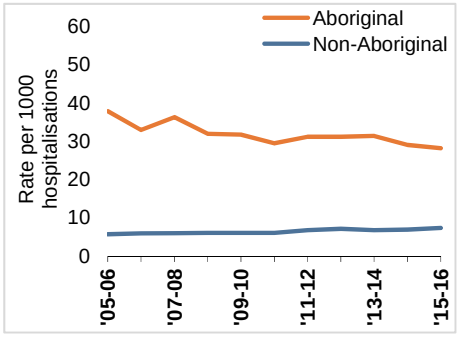
Country Health SA LHN



Women's and Children's HN



South Australian total



Source: SA Health 2017d

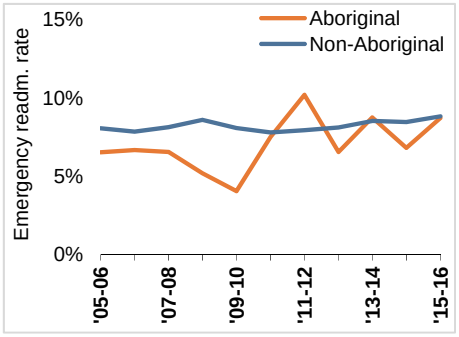
Inpatient emergency readmissions to hospital within 28 days

The six charts below show trends in rates of public hospital-admitted inpatients who have been emergency-readmitted back to the same hospital within 28 days of their previous discharge.

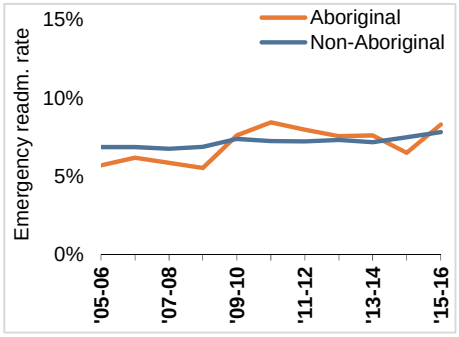
Trends are expressed as hospital activity outcome measure, not a population measure – outcomes as a percentage of total hospitalisations (inpatient separations) by SA Health local health network (LHN) of the public hospital (not the resident).

Emergency readmissions within 28 days by LHN of hospital

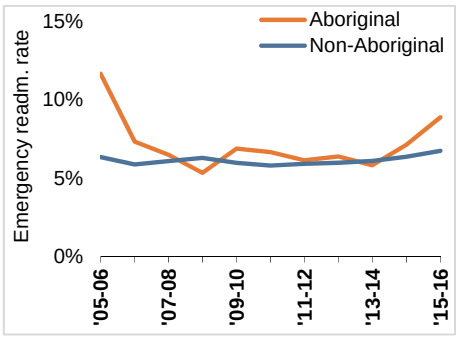
Northern Adelaide LHN



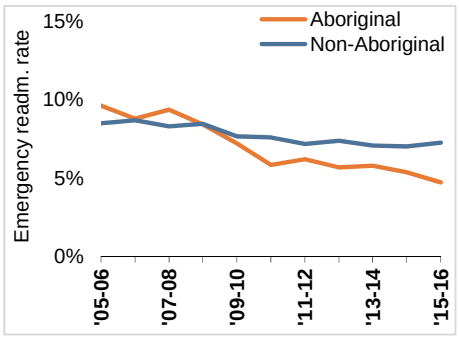
Central Adelaide LHN



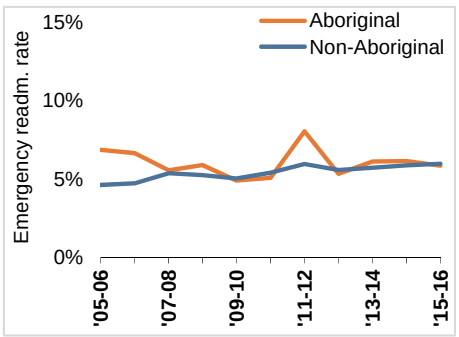
Southern Adelaide LHN



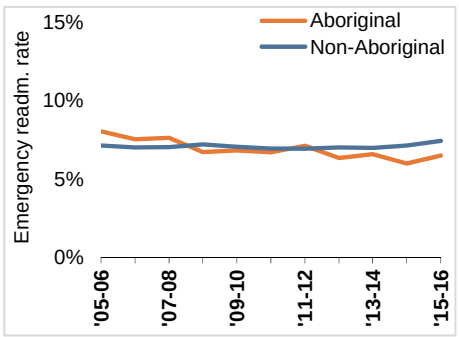
Country Health SA LHN



Women's and Children's HN



South Australian total



Source: SA Health 2017d

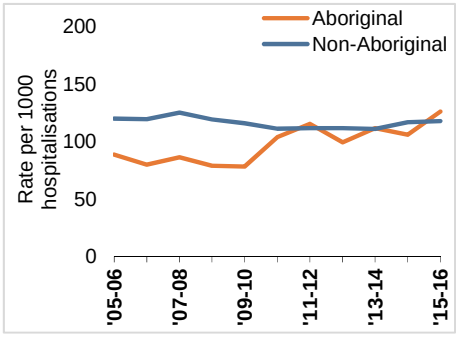
Potentially preventable hospital admissions

The six charts below show trends in rates of public hospitalisations (inpatient separations) for potentially preventable conditions. Potentially preventable admissions are hospitalisations for conditions that can be effectively treated in a non-hospital setting, including vaccine-preventable diseases such as influenza, potentially preventable acute conditions such as gastroenteritis, and potentially manageable chronic conditions such as asthma.

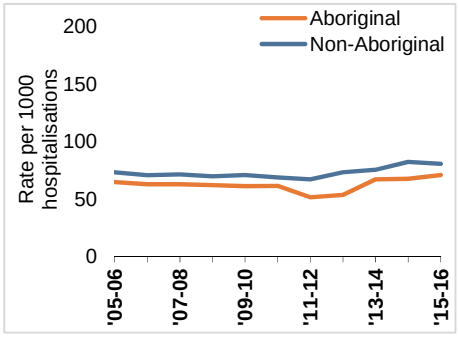
Trends are expressed as a hospital activity outcome measure, not a population measure – outcomes per 1,000 total hospitalisations (inpatient separations) by SA Health local health network (LHN) of the public hospital (not the resident).

Potentially preventable hospital admissions by LHN of hospital

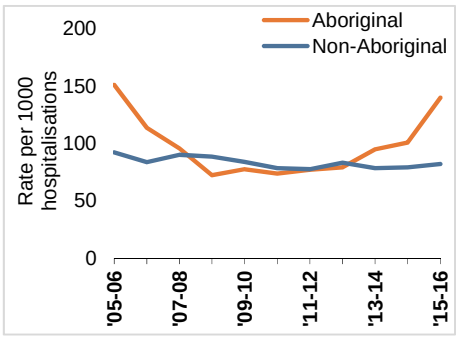
Northern Adelaide LHN



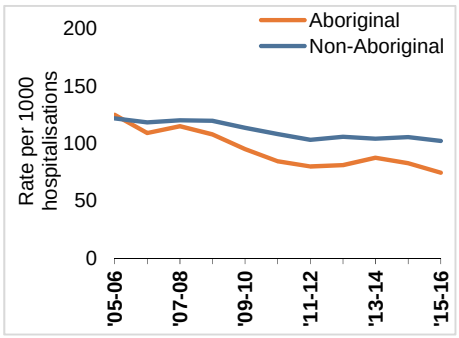
Central Adelaide LHN



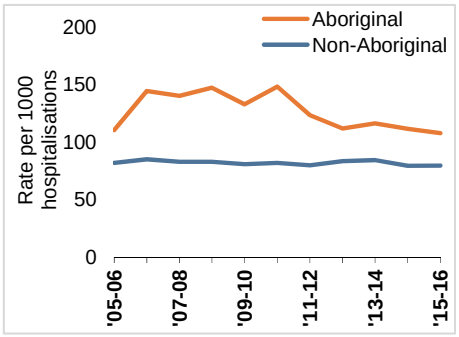
Southern Adelaide LHN



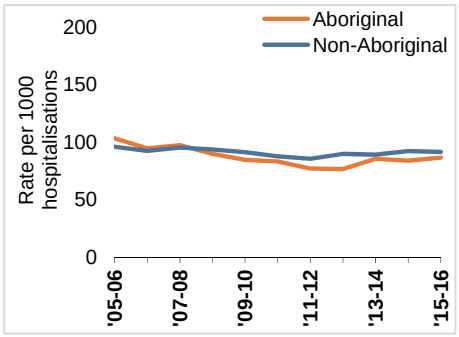
Country Health SA LHN



Women's and Children's HN



South Australian total



Source: SA Health 2017d

Appendix C: Additional Aboriginal and Torres Strait Islander health data resources

It is beyond the scope of this case study to provide an exhaustive overview of the health and wellbeing of Aboriginal and Torres Strait peoples in South Australia and Australia. Links to additional statistical resources are provided below.

ABS *Indigenous Health*

www.abs.gov.au/ausstats/abs@.nsf/ViewContent?readform&view=productsbytopic&Action=Expand&Num=5.7.10

AIHW *Aboriginal and Torres Strait Islander Health Performance Framework*

www.aihw.gov.au/indigenous-data/health-performance-framework

AIHW *Closing the Gap Clearinghouse*

www.aihw.gov.au/closingthegap

AIHW *Indigenous Observatory*

www.aihw.gov.au/indigenous-observatory

Australian Indigenous Health*InfoNet*

www.healthinfonet.ecu.edu.au

Glossary

ABS	Australian Bureau of Statistics
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
ASDR	Age-specific death rate. The total number of deaths per 100,000 population within an age group and geographic area
ASO	Administrative Services Officer in the South Australian public sector workforce
ATSIHWWG	Aboriginal and Torres Strait Islander Health Workforce Working Group
Average	A central value of a set of numbers, calculated by adding the numbers together and dividing by how many numbers there are
BMI	Body mass index, a measure of body fat based on the ratio of weight and height
CHRIS	Complete Human Resources Information System
ED	Hospital emergency department
FTE	Fulltime-equivalent (hours worked by one employee on a full-time basis)
GCYP	Guardian for Children and Young People
Hospitalisation	A hospital inpatient 'separation' referred to in this case study report is a completed episode of care of an admitted patient, generally concluding with their discharge from hospital (mostly to home), transfer to another healthcare facility or in-hospital death. It can also include other types of separation, such as 'administrative separation' applied for hospital activity payment purposes
HPC	Health Performance Council
HWA	Health Workforce Australia
Influenza	Influenza (the 'flu') is a highly contagious disease that infects the upper airways and lungs caused by infection from three types (types A, B and, rarely, C) of influenza virus. The flu is not the same as a common cold and can be a serious illness, especially for people with underlying medical conditions
LHN	Local health network. Local health networks manage the delivery of public hospital services and other community-based health services as determined by the state government
Mean	Another term for average (see above)
Median	The middlemost point in a sorted set of data. In a sequence of numbers arranged from lowest to highest, half the numbers will be below the median and half above
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NHMRC	National Health and Medical Research Council
Pneumococcal	Pneumococcal disease is a range of illnesses from mild to life-threatening infection affecting various parts of the body. It is caused by infection with the bacterium *Streptococcus pneumoniae* or pneumococcus.
SA	South Australia
SAHMRI	South Australian Health and Medical Research Institute
SCRGSP	Steering Committee for the Review of Government Service Provision
Total fertility rate	The sum of age-specific fertility rates (live births at each age of woman per female population of that age) divided by 1,000. It represents the number of children a woman would bear during her lifetime if she experienced current age-specific fertility rates at each age of her reproductive life (ages 15–49 years).

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