

Linking acute care to a strategy for improving Aboriginal health

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Abstract

In this paper we consider the extent to which strategies to improve access to acute care services have been integrated with national strategies to improve Aboriginal health outcomes. To do this we review the primary and secondary sources and provide an overview of current national strategy in Aboriginal health and identify where policy and strategic issues relevant to acute care have been developed. In particular we consider the extent to which national policy processes have focussed on the interface between the primary and acute sectors. It is our contention that nationally integrated strategies to improve access to the acute care sector require the development of an Aboriginal health focus in hospital based quality assurance processes and a comprehensive engagement with Aboriginal issues across the acute care sector.

Over the last couple of decades, increasing attention has been paid to the needs of Aboriginal Australians in the hospital setting. A number of distinct and innovative strategies have been developed in order to achieve this. Such reforms have usually been the consequence of strategies developed at the jurisdictional level – or a result of leadership within local and regional hospitals. At a local level hospitals have generally developed approaches to improving Aboriginal access to hospital services through the employment of Aboriginal advocates, interpreters or liaison officers within the local hospital. Nowadays, Aboriginal hospital liaison workers undertake a range of general and specialist roles in some hospitals. Commonly, Aboriginal liaison workers advocate for Aboriginal patients, providing them with social and related support services and assist patients and their treatment staff in the clinical decision making process. Aboriginal hospital liaison officers often provide the critical service link within the ongoing processes of care both within and outside the hospital (see for example, Clarke et al undated). In addition, a number of hospitals have developed mechanisms and processes that build collaboration between the hospital and Aboriginal community structures.

In this paper our particular interest is the extent to which strategies to improve access to acute care and related hospital services have been integrated with the current national strategy in Aboriginal health. Although the focus of this paper is acute care, hospitals provide a range of non-acute services (such as hospital outpatients, ambulatory care etc), which provide potential points of integration with primary care services. For this reason we will refer to non-acute hospital services at various points in this paper, particularly with respect to the discussion on health strategy

First, we will intend to provide an overview of current national strategy in Aboriginal health and identify those aspects of the national agenda that intersect with strategies to improve access to hospital and related services. We will argue that while a number of national policy processes have engaged acute care issues; there has been insufficient focus on the interface between the primary and acute sectors. Further, if strategies to improve access to the acute care sector are to integrate with national strategies in Aboriginal health, implementation mechanisms are required that integrate hospital based quality assurance processes with existing reform initiatives and which provide for a comprehensive engagement with Aboriginal issues across the acute care sector.

The national policy context

In 1995 the Commonwealth health portfolio assumed responsibility for the administration of the national Aboriginal health program. In the period since, health sector reform has been a key priority in national Aboriginal health policy. In parallel, strategies continue to be developed which address the determinants of health that lie outside the health sector (for example: the health portfolio has collaborated with the ATSIC on implementing environmental health programs, Anderson, 2002). The Agreements on *Aboriginal and Torres Strait Islander Health* (Framework Agreements) were one of the key mechanisms developed to deliver this health reformed focussed agenda. As multi-lateral agreements, Commonwealth and State/Territory health ministers signed the Framework Agreements in addition to representatives of the Aboriginal and Torres Strait Islander Commission (ATSIC) and State/Territory peak bodies representing the Aboriginal community controlled sector. Specifically, signatories are committed to structures and processes including:

- the development of national and State/Territory level forums involving all stakeholders in order to provide advice and input into policy and planning processes;
- the introduction of regional planning processes that aim to:
 - improve the capacity and effectiveness of primary health care services,
 - improve access to mainstream services
 - improve the appropriateness and sensitivity of mainstream services
 - establish standards and quality assurance processes;
- increasing the allocation of health sector resources to reflect the level of need; and
- giving priority to improving data collection and evaluation mechanisms.

(CDHFS, 1997)

From 1998 a clause was introduced into the *Australian Health Care Agreements* that required the Commonwealth and State/Territory governments to implement the Australian Health Care Agreements consistent with the principles outlined in the Framework Agreements (see for example section 18, Commonwealth of Australia and State of New South Wales, 1998-2003).

Within the current Commonwealth Aboriginal and Torres Strait Islander health program developmental priorities have been nominated, including:

- *Developing the infrastructure and resources necessary to achieve comprehensive and effective primary health care for Indigenous peoples;*
- *Addressing some of the specific health issues and risk factors affecting the health status of Indigenous peoples;*
- *Improving the evidence base which underpins the health interventions; and*
- *Improving communication with primary health care services, Aboriginal and Torres Strait Islander peoples and the general population*

(CDHAC 1999, unpaginated)

The first round of Framework Agreements were signed in all jurisdictions by the end of 1998 (CDHAC 1999). Although this initial round of agreements expired on 30 June 2000, the Australian Health Ministers Advisory Council (AHMAC) agreed in principle in August 1999 to develop new agreements (Anderson 2002). To date, new agreements have been signed in the Northern Territory, South Australia and Queensland (personal communication: Marianna Serghi). One of the most significant outcomes of the Framework Agreements was the development of collaborative plans for Aboriginal and Torres Strait Islander health services, which, by the

end of 2001, had been completed for approximately 96% of the country (Anderson 2002). Funds were made available through the *Primary Health Care Access Program* (PHCAP) to address priorities identified through the regional planning process in the 1999–2000 Commonwealth budget. The PHCAP has three objectives:

- increase the availability of appropriate primary health care services where they are currently inadequate;
- reform the local health system to better meet the needs of Indigenous people; and
- empower individuals and communities to take greater responsibility for their own health.

Although primary health care is a priority within this funding program – the planning documents also state that “local areas selected for funding will be required to broadly map out needs and gaps in existing services across the *whole local health system*” (CDHA 2002; emphasis in original). This health systems approach to developing primary care capacity is reinforced by the operational definitions of comprehensive primary health care that include liaison and advocacy with the acute care sector as one component [see for example: (CDHAC 2001)].

Acute care issues have also been touched upon in some national reviews – particularly with respect to policy work on specific diseases. In some cases, such as with the National Indigenous Sexual Health Strategy, a strengthened relationship between specialist clinical and public health services and Aboriginal primary care services was recommended (NIASHSWP 1997). Similarly, a review of the Commonwealth Aboriginal eye health programs recommended re-organised systems for the delivery of Aboriginal eye health services requiring regional hospitals, particularly, to play an enhanced role (Taylor 1997). Both Commonwealth and State governments have piloted and evaluated new models for the delivery of some hospital outpatient services in remote regions – such as obstetrics (Fitzpatrick 1995) and surgery (Gruen et al 2001). The extent to which there has been some focus on the specialist medical workforce in Aboriginal health workforce strategies is reflected in the fact that a number of the medical colleges now have specific policies on Aboriginal health (AHMAC 2001).

Against a broader policy context, in which there has been an increasing interest in reforming the financing and organisation of health care, Aboriginal co-ordinated care trials were initiated by the Commonwealth in order to ascertain whether such reform could provide a basis for more effective co-ordination of care and improved health outcomes. Trial sites included Katherine West (Northern Territory), Perth/Bunbury (Western Australia), Tiwi Islands (Northern Territory), Wilcannia (New South Wales). The trials demonstrated that co-ordinated and effective services could be delivered when funds are pooled (including those traditionally allocated through the acute sector) and services re-organised (KPMG 2001). Additionally, even though there was some variation between sites in outcomes the national evaluators identified outcomes that included enhanced service access; improved service appropriateness, significant progress in the development of infrastructure to enable fund-holding and care co-ordination; improved client and community empowerment in decision making processes. The Commonwealth Minister for health announced further trials in 2002 (Marianna Serghi; personal communication).

Another national development, relevant to acute care, was the agreement, made by AHMAC in 1997, to a set of national performance indicators and targets for Aboriginal and Torres Strait Islander health (Anderson 2002). Subsequently, a technical and procedural guide has been produced and two annual reports have been collated and analysed (CDHAC 1999 & 2000; NHIMG 1999 & 2001), although some of the agreed indicators have not been reported on because of deficiencies in the quality of data. Reporting on the national indicators requires the collaboration of a number of agencies, including: the Commonwealth Department of Health and Ageing (CDHA), State and Territory Health departments, the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS). Currently, a number of indicators directly relate to the acute care sector (these are described in appendix A). There are also a number of other indicators relating to performance across a range of health services including acute care (such as standardised mortality rates). The current round of Australian Health Care Agreements include a reference to reporting requirements, which in the case of Aboriginal and Torres Strait Islander health, are the acute care subset of the national performance indicators.

Despite the focus in national policy on primary health care – it does seem to be recognised that capacity development within this sector needs to occur within a health systems approach. However, the implications of this have yet to be fully developed within national Aboriginal health strategy. To date, strategy documents do not consider in detail the intersection of strategies to improve access to acute care services and strategies to develop the capacity of primary health care service and workforce. Even though the Framework Agreements that link with the Australian Health Care Agreements and the National Performance Indicators in Aboriginal and Torres Strait

Islander health provide a structural framework in which these issues can be further developed, no specific mechanism has been established that enables stakeholders to develop more detailed strategies in this area. However, national policy is moving to take on these issues more systematically. In the *Draft National Strategic Framework for Aboriginal and Torres Strait Islander Health* strategies to develop primary health care capacity are required to:

Implement effective protocols for health service delivery to Aboriginal and Torres Strait Islander peoples by the range of health professionals and improve referral, shared care, discharge planning and information sharing between acute care and primary care services including both mainstream and Aboriginal and Torres Strait Islander specific services at the regional and local level.

(NATSIHC, 15: 2002)

While the development of this area of national policy has been relatively slow -the significant exception to is with respect to those national processes that have been established in order to improve the quality of health information in Aboriginal health. In the sections that follow we overview progress in the implementation of these health information strategies and consider some of the key policy issues that arise from the analysis of this data. We will then return to consider in the concluding sections of this paper how national health development strategies in Aboriginal health, that focus on primary care, could articulate more effectively with local and regional strategies to improve access to acute care services for Aboriginal Australians.

National health information strategies and Aboriginal acute care

There has been an increasing focus on the implementation of national strategies that aim to improve the quality of population and health data relevant to Aboriginal health. To this end, the Australian Health Ministers Advisory Council (AHMAC) endorsed the *National Aboriginal and Torres Strait Islander Health Information Plan* in 1997 (CDHFS, 1997; ABS/AIHW, 1997). Currently the priorities that are being addressed by the ABS and AIHW, in collaboration with key stakeholders, which focus on improving the quality of:

- Aboriginal and Torres Strait Islander population estimates.
- data available through surveys, and
- the quality of Aboriginal identification within administrative datasets particularly hospital separation data and the recording of Aboriginal births and deaths.

A number of strategies have been developed, within the context of this national framework, to improve the quality of Aboriginal and Torres Strait Islander identification in acute care data. For instance, most states are now implementing or planning training programs for staff while others are conducting data quality audits (AIHW/ABS 2002: 142). The Aboriginal and Torres Strait Islander Health and Welfare Information Unit (ATSIHWIU), in the ABS, is developing a set of procedures that detail the steps that a hospital, group of hospitals and State and Territory health departments can follow to implement a data quality assessment exercise within their collection(s) (ABS/AIHW 2002: 141). Other strategies that are being used include awareness-raising for the general public and data collectors, and documentation of best practice procedures.

Whilst a few jurisdictions have a relatively high degree of completeness in the recording of Aboriginality within their inpatient data, New South Wales, Victoria, Queensland, Tasmania and the Australian Capital Territory considered their 1998–99 Aboriginal hospital inpatient data to be in need of improvement (ABS/AIHW 2000: 141). A jurisdiction-wide audit conducted in 1997 in the Northern Territory showed a 94% agreement with respect to Aboriginal status between hospital records and patient reports (Condon et al 1998). This level of agreement is significantly higher than that reported in a number of smaller scale studies (including other jurisdictions). For example, the ATSIHWIU conducted a review in eleven hospitals and found that the accuracy with which a person's Aboriginal status was recorded ranged from 55% to 100% of those interviewed (ABS/AIHW, 2000: 141). Through the AHMAC all jurisdictions were asked to assess the completeness of recording of Aboriginal status in their hospital data collections, by the end of 2001 (ABS/AIHW 2000: 141).

In the following sections we review the evidence about Aboriginal utilisation of the acute care sector – focusing on patterns of admission to hospitals and length of stay.

Aboriginal utilisation of acute care services

A recent analysis of trends in hospital utilisation within the Northern Territory (for the years 1993-1997) reported that the total separations, for all ethnic and age groups combined, increased by 7% over this period – with non-Aboriginal separations increasing by 8.5% and Aboriginal separations by 5%. This occurred during a period in which the population of the Northern Territory grew by 9.6% (Moo et al 1998, see also Fisher and Ruben 2002). Yet if these separations are weighted to take account of case complexity, the increase was 5% annually for the Aboriginal population and 4% for the non-Aboriginal population. Between the years 1993 to 1997 the average weight per separation increased from 0.93 to 1.07 for the Aboriginal population, but from 0.88 to 0.94 for the non-Aboriginal population (Moo et al 1998).

There have been a number of reports in the literature that demonstrate that Aboriginal people are admitted to hospital care at a higher rate relative to non-Aboriginal Australians. For example, Gracey (et al 1992) reported that Aborigines were admitted to hospital in Western Australia 2.7 times that of other persons for the years 1977-1988 with the highest relative admission rate in the 0-5 year old age group - mostly for respiratory infections and gastroenteritis. Similarly, Ishak (1998a) found that Aboriginal people from New South Wales had a higher indirect and direct standardised admission rate relative to non-Aboriginal people from the same state. Despite these higher admission rates, there have been documented improvements in the rates for particular conditions. For example, for the decade 1971-1980, a decline in the number of Aboriginal infants and children admitted with infections was recorded (particularly gastroenteritis and other infections from rural regions such as the Kimberly region) (McNeilly et al 1983). This trend in decreasing admissions for Aboriginal paediatric gastroenteritis and respiratory infections continued to be documented over the period 1980-91 (Gracey and Gee 1994).

The higher overall rate of admission for Aboriginal people is not uniformly distributed across all disease categories. Aboriginal people have consistently been shown to be considerably more likely to be admitted for infectious diseases (particularly in paediatric age groups) (for example: Gracey et al 1992; Gracey et al 1994; Read et al 1994). On the other hand, Whybourne et al (1999) demonstrated, from a retrospective review of Royal Darwin Hospital separation data, that the Aboriginal hospitalisation rate for asthma was significantly lower relative to non-Aboriginal people. With respect to New South Wales, Ishak (1998b) identified that Aboriginal admissions for drug and alcohol conditions were five times higher amongst women, and eight times higher amongst men. On the other hand, the same study demonstrated that conditions requiring surgical procedures (such as breast surgery, cardiothoracic and gastrointestinal surgery) were generally shown to have a lower rate of Aboriginal admission. The Aboriginal and Torres Strait Islander Casemix Study demonstrated, using an Australia wide sampling framework, that Aboriginal people were admitted at a greater rate for infectious diseases whilst non-Aboriginal people were admitted more frequently for degenerative and neoplastic conditions (Fisher, et al 1998). Variation in patterns of admission according to disease category reflects either actual differences in the incidence of disease and/or differential treatment and referral patterns.

It is important that we have a more developed understanding of the factors that impact on Aboriginal admission rates. Munoz, demonstrated a correlation between rates of admission and social and environmental factors conducive to poor health in Northern Territory admissions with respect to infectious diseases (Munoz et al 1992a,b). Some studies have also pointed to rurality as a critical factor (particular with respect to length of stay).

Analysis of acute care data also consistently demonstrates a tendency in the Aboriginal population to relatively longer periods of hospitalisation. For example, an analysis of linked data files of birth records and hospital admissions investigated patient morbidity for Aboriginal and non-Aboriginal children under the age of 2 years and found that non-Aboriginal children had a mean length of stay of 7.4 days compared with 26.5 days for Aboriginal children (Read et al see also Waddell et al 1986). The Aboriginal and Torres Strait Islander Casemix Study demonstrated that Aboriginal and Torres Strait Islander patients had consistently longer average lengths of stay for most major diagnostic categories with the exception of MDC 19 (mental disease and disorders) and MDC 20 (alcohol/drug use and alcohol/drug induced organic mental disorders) (Fisher 1998).

One analysis (Russell-Weisz and Hindle 2000) examined high length of stay outliers in remote rural community with high proportion of Aboriginal patients. Of all the high length of stay outlier episodes examined, 70% were Aboriginal (even though Aborigines constituted only 14% of regional population and 42% of admissions). A relatively high proportion of these outliers were young children (26% of the outliers in this study were under

the age of 10 compared with 5.7% of Victorian exceptional episodes). This finding is reinforced in research by Lee and Codde (2000) who used a Cox regression model to analyse Western Australian data and found that rural Aboriginal patients had a higher risk of prolonged hospitalisation relative to non-Aboriginal patients.

Ruben et al (1998) examined data collected for children under 10 years from the Royal Darwin Hospital from July 1 1991 to 30 June 1996 in order to identify some of the correlates of length of stay. They identified that length of stay was influenced by variables such as age under 2 years, living in a remote area and presence of two or more co-morbidities. It has been identified in other studies (such as Read et al 1994) that the prevalence of co-morbidities is higher in Aboriginal patients relative to non-Aboriginal patients.

These tendencies to longer length of stay and greater complexity in presentations suggest a possible cost impact. It has already been identified in national expenditure studies that the per capita expenditure on acute care services for Aboriginal people is 2.02 times higher for admitted public hospital patients and 2.22 times higher for non-admitted public hospital patients (AIHW 2001) – findings that are consistent with an earlier national study (Deeble et al 1998). The National Aboriginal and Torres Strait Islander Casemix study reported significant differences in the actual costs case mix adjusted costs per patient episode (\$1856 compared with \$1558 for non-Aboriginal patients) (Fisher et al 1998).

Utilisation and access to acute care service – issues for policy

Whilst acknowledging the deficits in public hospital data – it should be clear that Aboriginal people utilise acute care services differently relative to non-Aboriginal Australians. Aboriginal people tend to be admitted at a greater rate, for longer periods of time and, with a greater likelihood of co-morbidities. These are reason enough to develop a focus in health strategy on access in order to ensure that access is appropriate for need. There are no direct measures of access. However, McDermott et al, used the ratios of death rates and hospitalisation rates to construct an index of access that they used to analyse trends in hospital utilisation in the Northern Territory. Using this measure – Aboriginal access to acute care had improved over the years 1979-88 – albeit with a substantial shortfall remaining. A similar finding resulted from the analysis of data from the Northern Territory for the period 1979-1996 (Territory Health Services: 2001: 167).

While policy in Aboriginal health should continue to give priority to strategies to improve access – a parallel focus is required on the quality and effectiveness of care. A retrospective analysis of data in the National Hospital Morbidity database (for the period 1 July 1997 to 30 June 1998) demonstrated that Aboriginal and Torres Strait Islander public hospital patients were significantly less likely than other patients to have a principal procedure recorded, even after adjusting for patient, episode and hospital characteristics (Cunningham et al 2002). Whilst the policy implications of this particular analysis have yet to be fully explored – it does highlight the need to ensure that ‘access’ and ‘health outcomes’ are linked through strategy.

If strategy in Aboriginal acute care is to extend its focus from access to include quality, it is critical that acute care strategy takes into account how quality is developed within the continuum of care. This requires the development of strategy that considers the functional relationship between the acute care sector and other aspects of the health system, particularly the primary care sector.

In taking these issues on in policy, it is important to keep in mind some of the differences in the way in which Aboriginal Australians interact with, and are referred between, health services. For example: Ong and Weeramanthri (2000) examined delay times and management of acute myocardial infarction in Aboriginal and non-Aboriginal people in the Northern Territory. They found that there were significantly greater delays in presentation for rural and urban Aboriginal people as well as non-Aboriginal people living in rural areas. Some of this difference may reflect different values or priorities in health. Some of it may also reflect existing service capacity. For example, from a comparative analysis of separations for ambulatory sensitive diagnostic related groups (with data from Western Australia, Northern Territory, New South Wales and Queensland) it was demonstrated that the rate of admission for these diagnostic related groups was between 1.7-11 times higher than for non-Aboriginal patients (Stamp et al 1998). The findings of this study echoes the finding of a very early study that reported a 33% decrease in the number of Aboriginal children admitted to Kempsey hospital with a 44 per cent decline in bed days following the establishment of an Aboriginal medical service (although the study design did not take account of other possible influential factors, Copeman, 1980).

Therefore, the development strategies in Aboriginal primary health care should consider how to strengthen the interface between the primary and acute care sectors. Optimal health outcomes require a seamless integration between these two sectors. Strategies to improve access to acute care should therefore focus on improving referral between primary care practitioners and the acute care sector. Within this priority, strategies are also needed to strengthen the referral relationship between hospitals and the Aboriginal community controlled primary health organisations. Hospitals are also reservoirs of skills and expertise critical to the development of ongoing professional support of general practitioners, primary care nurses and others in the primary care sector. It is possible that hospital workers may play a role in the development of skills and workforce capacity in the primary care sector through skills transfer processes associated with training programs or effective working collaborations. However, these issues require further development with key stakeholders if the national approach to Aboriginal health strategy is to integrate more effectively with the local and regional development of strategies to improve Aboriginal access to acute care services.

Comprehensive focus on quality in Aboriginal acute care

Even if national policy were to address the system issues between the acute and primary care services to provide a system-wide focus for Aboriginal health development – the issues of organisational capacity would still need to be addressed. In order to put in place a framework that enables a system-wide approach to improving health care capacity for Aboriginal and Torres Strait Islander people, mechanisms are required in order to develop a systematic approach to promoting and guiding organizational practices related to Aboriginal acute care services. Quality assurance processes are one potential vehicle for pursuing this policy aim.

There is sufficient evidence upon which to build valid practice guidelines and standards aimed at improving data quality and services. The guidelines and standards should be sufficiently detailed to be practical yet allow for the development of locally relevant strategies in collaboration with Aboriginal communities and organisations. Given the demographic variation in the size of the local Aboriginal community, differences in health need, and the requirement of the local hospital to develop relationships with the local Aboriginal community – the standards and guidelines should probably place a strong emphasis on process with greater emphasis on outcomes as organizations develop over time.

The development of practice guidelines and standards without an implementation strategy is unlikely to lead to organizational change. Additional incentives are required. By linking the standards and guidelines to accreditation programs due emphasis can be placed on the issues that need to be addressed. Accreditation programs that foster continuous quality improvement are appropriate as they support, over time, the building of organizational capacity to effectively address Aboriginal health issues. They can also encourage the development of industry forums for sharing good practice or ‘benchmarking’ related to Aboriginal health.

Conclusion

There has been over two decades of reform focussed on the improving access to acute and related services for Aboriginal people. To date, within national policy, issues with respect to acute care have been approached tangentially – in relation to other priorities. Notwithstanding, there has been a significant body of work that provides a focus on acute care issues – particularly with respect to the quality of health data, and performance measurement. Further integration of strategies to improve acute care access and quality to the national strategic framework can be achieved through a developmental focus on the interface between primary care and the acute care sector and related specialist services. Such strategies can build on the existing structural framework, provided by the Framework Agreements which link with the Australian Health Care Agreements. However, any approach to reform should consider the mechanisms that are critical to comprehensively engage the acute care sector, and focus reform activities at the local or regional level. We argue that this can be achieved through quality processes and the potential integration of such within hospital accreditation processes.

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There are two major groups of indigenous people in Australia: Aborigines and Torres Strait Islanders. This article is written from a south-eastern Australia Aboriginal perspective and this is accordingly reflected in our choice of language. However, many of the issues raised are common to both groups.

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Abbreviations

ATSIHWIU	Aboriginal and Torres Strait Islander Health and Welfare Information Unit
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AHMAC	Australian Health Ministers Advisory Council
ATSIIC	Aboriginal and Torres Strait Islander Commission
CDHA	Commonwealth Department of Health and Aging
CDHHS	Commonwealth Department of Health and Human Services
CDHFS	Commonwealth Department of Health and Family Services
CDHAC	Commonwealth Department of Health and Aged Care
NIASHSWP	National Indigenous Australians Sexual health Strategy Working Party.
NATSIHC	National Aboriginal and Torres Strait Islander Health Council

Appendix A:

National Aboriginal and Torres Strait Islander health performance indicators and acute care

ITEM & INDICATOR NUMBER	DESCRIPTION
Efforts to improve identification of Aboriginal and Torres Strait Islander people in data collections (1)	A brief description of actions taken by the jurisdictions to improve the identification of Aboriginal and Torres Strait Islander people in the datasets used for reporting on the indicators
Government expenditure on health services for Aboriginal and Torres Strait Islander people (2)	Overall per capita annual expenditure by governments on primary and secondary/tertiary care for Aboriginal and Torres Strait Islander health compared to the total population.
Aboriginal and Torres Strait Islander representation on health/hospital boards (13)	The number of Health/Hospital Boards that have (a) Aboriginal and Torres Strait Islander representation and (b) The proportion that have Aboriginal and Torres Strait Islander representation mandated by terms of reference or legislation.
Reporting of complaints in hospitals (14)	(a) The ratio of complaints to hospital separations in the Aboriginal and Torres Strait Islander population compared to the all-Australian population. (b) The structures and mechanisms available to assist Aboriginal and Torres Strait Islander people who want to make a complaint.
Distance to a hospital (17)	The proportion of Aboriginal and Torres Strait Islander communities that are more than 50 kilometres from the nearest acute hospital.
Aboriginal and Torres Strait islander people in the health workforce (20)	The proportion of the health workforce employed by the jurisdiction that identify as Aboriginal or Torres Strait Islander

National Aboriginal and Torres Strait Islander health performance indicators and acute care

ITEM & INDICATOR NUMBER	DESCRIPTION
Workforce availability in hospitals that provide services to Aboriginal and Torres Strait Islander populations (23)	The number of positions for doctors, nurses, Aboriginal Health Workers and Aboriginal Liaison Officers in acute care hospitals where more than 25% of the separations are for Aboriginal and Torres Strait Islander people.
Cross cultural training for hospital staff (24)	a) The proportion of acute care hospitals where staff receive information about Aboriginal and Torres Strait Islander values and cross cultural issues as part of orientation b) The proportion of new staff in acute care hospitals who have completed orientation training in the past year.
Injuries presenting to hospital accident and emergency facilities (35)	The proportion of consultations at accident and emergency facilities by Aboriginal and Torres Strait Islander people that are for acute injury conditions.
Ratios for all hospitalisations (40)	Standardised hospital separations ratio (SHSR) for all hospitalizations in the Aboriginal and Torres Strait Islander population compared to the all Australian population, by sex, for ages 0-74 years.
Hospitalisation ratios for circulatory diseases (41)	Standardised hospital separations ratio (SHSR) for (a) circulatory diseases (b) coronary heart disease & (c) rheumatic fever and rheumatic heart disease as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, by sex, for ages 0-74 years.
Hospitalisation ratios for injury and poisoning (42)	Standardised hospital separations ratio (SHSR) for (a) injury and poisoning (b) road vehicle related injury (c) other accident (d) self-harm & (e) assault as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, by sex, for ages 0-74 years.
Hospitalisation ratios for respiratory diseases and lung cancer (43)	Standardised hospital separations ratio (SHSR) for (a) all respiratory disease (b) pneumonia & (c) lung cancer as the principal diagnosis in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, by sex, for ages 0-74 years.
Hospitalisation ratios for diabetes (44)	a) Standardised hospital separations ratio (SHSR) for (a) diabetes as the principal diagnosis (b) diabetes as an associated diagnosis (excluding separations for which routine dialysis was the principal diagnosis) & (c) diabetes as a principal or an associated diagnosis (excluding separations for which routine dialysis was the principal diagnosis) in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, by sex, for ages 0-74 years
Hospitalisation ratios for tympanoplasty associated with otitis media (45)	Standardised hospital separations ratio (SHSR) with tympanoplasty for otitis media as a procedure in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, sexes combined, 0-14 years
Hospitalisation ratios for mental health conditions (46)	Standardised hospital separations ratio (SHSR) for (a) depressive disorders (b) anxiety disorders (c) substance use disorders & (d) psychotic disorders as the primary diagnosis in the Aboriginal and Torres Strait Islander population compared to the all-Australian population, by sex, for ages 0-74 years

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