Sydney South West Area Health Service

Aboriginal Health Plan 2010 - 2014

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Policy and Practice

Terminology used within this report reflects the authors understanding of relevant NSW Government policy directives. The term "Aboriginal" is used in preference to "Aboriginal and Torres Strait Islander" in recognition that Aboriginal people are the original inhabitants of NSW (NSW Health Circular 2003/55). The term "Indigenous" has been avoided wherever possible as some Aboriginal people feel that the term diminishes their Aboriginality. The instances where it is used are on quotation from secondary documents which employ this terminology. The practice adopted is consistent with *Communicating positively – A guide to appropriate Aboriginal terminology*, NSW Health 2004.

Story behind the front cover art work:

The art work on the cover is the work of Susan Grant, a well renowned and respected Aboriginal artist. Susan commenced painting in 1991 and since that time has achieved many awards and recognition from her community in the greater western Sydney region. Susan is a descendant of the Wiradjiri people of south–west NSW. Susan's artwork has become more intense over time which she contributes to a special gift handed down by her Aboriginal ancestral.

Susan in her painting has captured the spiritual and cultural meaning inherent in the framework that underpins Aboriginal Health in Sydney South West Area Health Service.

The inner circle represents the camp fire, the giver of warmth that nourishes the family and community connecting the family and community to the earth. The family sitting around the fire are connected to each other by this secure base; this foundation that is important to our mothers and babies and families.

The middle circle represents traditional lore, men's business and women's business, the nurturing of babies by mothers and grandmothers and the passing of cultural knowledge through stories, music, dance and painting. This traditional lore with its spiritual guidance holds communities together and provides connection to land and people. It keeps Aboriginal people strong in body and mind.

Within the outer circle is an Aboriginal man who is disconnected; lost from his traditional way of life and spiritual connectedness. He is on the fringe looking inwards and can reenter with help from his people and services in the community.

This sense of disconnect, powerlessness and not belonging is a result of colonisation and breakdown of traditional life. The lines coming in from each corner represents chaos, those things that have made Aboriginal people unhealthy; racism, discrimination, tobacco, drugs, diseases, alcohol and domestic violence.

The blood is seen running from the camp fire; the blood of the lives of Aboriginal people who are much sicker and die much earlier than non Aboriginal people.

This magnificent artwork with vibrant earthy ochre colours gives us hope like the Aboriginal man looking in lost but able and wanting to become reconnected to land to community; the pink ochre significant for Aboriginal people and their journey back to health.

SYDNEY SOUTH WEST AREA HEALTH SERVICE

Head Office
Liverpool Hospital (Eastern Campus)
Elizabeth Street Liverpool NSW 2170

Mailing Address
Locked Bag 7017
Liverpool BC NSW 1871

ISBN No: *978 1 74079 116 8*

Date: April 2010

Health Services Planning Report No: 2010/02

PDF copies are freely available on the SSWAHS Internet and Intranet sites.

For additional hard copies, please contact Vicki Wade, Area Director Aboriginal Health, at the above address

Chief Executive's Message

" Our challenge for the future is to cross that bridge and, in so doing, to embrace a new partnership between Indigenous and non-Indigenous Australians …. the core of this partnership for the future is to close the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities.

We need a new beginning – a new beginning which contains real measures of policy success or failure; a new beginning, a new partnership, on closing the gap with sufficient flexibility not to insist on a one-size-fits-all approach …. but instead allowing flexible, tailored, local approaches …. a new beginning that draws intelligently on the experiences of new policy settings across the nation."

Extract from the speech on Apology to the Stolen Generations, 13 February 2008
The Hon Kevin Rudd MP, Prime Minister

During this historical broadcast on Feb 13th 2008, The Hon Kevin Rudd MP, Prime Minister, apologised on behalf of the Australian Government to members of the Stolen Generations. In his speech the Prime Minister pledged the Government to lead a national effort to close the gap between the life opportunities experienced by Indigenous and non Indigenous Australians. Closing the gap is one of the biggest challenges facing contemporary Australia and the health care system.

Sydney South West Area Health Service (SSWAHS) is committed to closing the gap and has a long history of working to improve Aboriginal Health. SSWAHS accords the highest priority to service developments which aim to help close the gap for local Indigenous communities. The challenge is most marked in the many communities within SSWAHS of high socioeconomic disadvantage. Aboriginal and Torres Strait Islander peoples of SSWAHS are disadvantaged across all socioeconomic markers. These differences directly contribute to the poor health outcomes and gap in life expectancy between Aboriginal and non Aboriginal people in SSWAHS.

This comprehensive, detailed and thought provoking plan will guide SSWAHS efforts to close the gap and requires commitment to action by all our services. It is equally responsive to the needs of highly urbanised inner city communities such as Redfern/Waterloo and to those communities on the urban fringe such as Camden. It recognises the impact that spiritual belief and social and cultural context have on access to and engagement with health services; and the importance of placing individuals, families and community at the centre of care. The art work on the cover of the documents dynamically depicts the values and principles within the cultural context of the plan.

The Plan builds on a number of innovative, ground-breaking and successful Aboriginal Health programs in SSWAHS. It is grounded in the cultural values and principles held by local Aboriginal communities, recognising that joint action across services and within communities is necessary to bring about improvements in health.

Aboriginal and Torres Strait Islander people will continue to be at the forefront in shaping SSWAHS services to meet the needs of their local communities. This occurs not only through acting on the advice of Aboriginal community organisations and partnering in service provision, but also through creating employment opportunities for Aboriginal people in the health workforce. SSWAHS is committed to expanding its Aboriginal workforce and to training and nurturing individuals to reach their potential. Aboriginal representation within our health services is the most tangible way to improve access, ensure cultural safety and engage with Aboriginal communities in health improvement. It also makes an important contribution to building the capacity of communities.

This Plan brings together the evidence base, principles of action and the prioritised strategies that are of prime relevance to local Aboriginal communities. It will provide the blue print for services to achieve long term sustainable outcomes in Aboriginal Health.

I thank all those who have contributed to the plan and look forward to a future where its implementation has contributed to closing the gap in our generation.

Mike Wallace
Chief Executive

Table of Contents

1. Preamble

The SSWAHS Aboriginal Health Plan is presented in four documents, including a summary in question and answer format; two supporting papers, covering firstly the population need, policy imperatives and service delivery responses to date and secondly the framework principles upon which services will be provided in the future reflecting community views; and a fourth core document outlining detailed future agendas for action. In total, all four documents provide the schema on how SSWAHS will proceed to improve Aboriginal health over the next five years and make inroads towards closing the gap within our generation.

The approach in providing separate documents reflects both practical considerations in providing accessible and focused exploration of the key health issues for the Aboriginal populations of SSWAHS; and recognition that the diverse target audience for the Plan, including SSWAHS Aboriginal communities, SSWAHS service providers and Aboriginal health workers, managers, policy and planning staff, researchers and those undertaking academic pursuits, may all focus on different aspects of the SSWAHS experience in Aboriginal health.

The Supporting Paper, *Policy and Practice*, surveys the policy environment that has been explored in Aboriginal Health, nationally, statewide and locally, and the impact of these policy directions on the Aboriginal Communities of SSWAHS. Demographic and health status data is presented to profile the characteristics of Aboriginal communities that impact on health. Available data is presented on mainstream services used by Aboriginal people and the range of targeted programs offered in Aboriginal Health is outlined. This Paper identifies the baseline state of play on which future action is built.

The Supporting Paper, *Principles for Progress*, outlines the way in which SSWAHS will proceed to address Aboriginal Health in the future. It reveals the views of Aboriginal communities on needs, gaps and priorities, the principles that will be observed as SSWAHS engages with these communities to improve health and the framework initiatives that will be applied across SSWAHS to ensure that closing the gap remains core organisational business. These initiatives seek to cut through the barriers created by geographic, clinical, craft group or agency silos to develop a shared agenda for progress. It also identifies the rationale for action in priority areas, both corporate and specific to health need. This paper outlines the enabling organisational framework on which future action is built.

The core activities for SSWAHS in closing the gap are outlined in *Agendas for Action* which identifies the specific actions SSWAHS will be taking to improve Aboriginal Health in the future. Building on the evidence presented in the Supporting Papers, it identifies specific initiatives to improve Aboriginal Health and explicitly links these to existing policy and best practice evidence. Lessons from history and the model of care proposed are clearly outlined along with areas of action, responsibilities of partners in action and the projected resources required. The domains for performance indicators and the mechanisms for monitoring and evaluation of programs are also identified. *Agendas for Action* provides the concrete strategies which will shape future action.

2. Background to Planning Process

Sydney South West Area Health Service (SSWAHS) was created as an entity in late 2005 from the amalgamation of the previously existing South West Sydney Area Health Service (SWSAHS) and Central Sydney Area Health Service (CSAHS). At the time of amalgamation there were current Aboriginal Health Plans for the pre-existing areas, with a planning horizon of 2001-06 for SSWAHS and 2005-08 for CSAHS. The Executive of SSWAHS considered that with amalgamation and the imminent expiry of timeframes for the existing plans, an Area-wide Aboriginal Health Plan was required for SSWAHS.

It was decided that the planning process would be undertaken in-house utilising the resources of the Aboriginal Health Unit (AHU) and the Health Services Planning Unit (HSPU) to facilitate the process. This would ensure maximum exposure of the planning process to the views and aspirations of the local Aboriginal communities within SSWAHS.

A Steering Committee was formed in 2007 to oversight the planning process, chaired by the Director Population Health, Planning and Performance. Steering Committee members were chosen on the basis of their ability to bring to the table experience and knowledge of Aboriginal Health issues, as clinical leaders in health areas of high priority for Aboriginal communities, as representatives of key stakeholders in Aboriginal Health service provision or as leaders who can drive key corporate/infrastructural changes within the AHS to benefit Aboriginal populations.

There was extensive representation on the steering committee from across the Aboriginal communities of SSWAHS with invitations to senior Aboriginal Health managers and workers within SSWAHS and each of the two Aboriginal Medical Services (AMS) at Redfern and Tharawal. There were also representatives from mainstream clinical services within SSWAHS of particular relevance to Aboriginal health and the Divisions of General Practice (DGP) within SSWAHS. Other members, including from Aboriginal communities, were co-opted to the committee over the period of its deliberations.

Terms of Reference were established for the Steering Committee as outlined at Attachment A.

A scoping paper was prepared for the planning process outlining the organisational arrangements and timeframes for planning, the parameters within which planning would proceed and the key fields of inquiry that would be explored. This paper identified some of the key generic questions to be addressed in planning and the issues that would be explored in addressing these questions. Key points from the scoping paper are summarised at Attachment A.

Early on, the steering committee established seven Priority Area Working Groups (PAWG), in what were considered to be the major focus areas in which existing initiatives to improve Aboriginal Health needed to be consolidated, strengthened and expanded:

- Early Years, Children and Young People
- Chronic Diseases and Ageing
- Corporate Initiatives
- Cross-Cutting Themes
- Mental and Drug Health
- Infectious Diseases and Sexual Health
- Oral Health

Over time, it became clear that work on the mental health and drug health initiatives would need to pursued separately.

The original issues identified for investigation by each PAWG are also recorded at Attachment A. These issues framed the inquiries of the PAWGs and were broadened and varied as each PAWG undertook their work.

3. The Policy Environment

This chapter outlines the policy and planning framework at National, State and local levels within which the initiatives of the SSWAHS Aboriginal health plan have been developed. These policy directions and planning documents are reflected in the Aboriginal health initiatives that have been proposed for implementation, the models of care that are proposed and the performance indicators that will be developed for each initiative.

Attachment B outlines the specific references to Aboriginal Health in the national and NSW core overarching policy documents. These documents also include more generic references to mainstream policy directions that equally apply to Aboriginal communities.

3.1 National Directions

National policy on Aboriginal Health is administered through Commonwealth Departments of:

- **Families, Housing, Community Services and Indigenous Affairs** - supports national implementation of the Australian Government's whole-of-government arrangements in Indigenous Affairs and manages the network of multi-agency Indigenous Coordination Centres (ICCs) across Australia; supports the COAG Working Group on Indigenous Reform; administers a number of Indigenous-specific programs, particularly in the areas of housing, community development, leadership and land; assists the Australian Government in negotiating bilateral agreements with State/Territory Governments under the National Framework of Principles for Government Service Delivery to Indigenous Australians.
- **Health and Ageing (DoHA)** - one of 23 portfolio outcomes is improved access by Aboriginal and Torres Strait Islander peoples to effective primary health care and substance use services and population health programs; administers the Office for Aboriginal and Torres Strait Islander Health; administers a range of programs impacting on Aboriginal Health including Mental health services in Rural and Remote Areas, Enhanced Primary Care Program, Puggy Hunter Memorial Scholarship Scheme, Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme, Sharing Health Care Initiative, Prevocational General Practice Placements Program, National Aboriginal & Torres Strait Islander Flexible Aged Care Program, Healthy for Life, Indigenous Child Health Check, Longitudinal study of Indigenous Children.

National policy is also informed by a number of reports and investigations funded by the Australian Government e.g. Steering Committee for the Review of Government Service Provision (SCRGSP) and Productivity Commission reports on Overcoming Indigenous Disadvantage.

For many years national policy agendas in Aboriginal health were based on the *National Aboriginal Health Strategy* (NAHS), released in 1989, which was built on extensive community consultation. Although never fully implemented (as indicated by a 1994 evaluation), the NAHS remained a key document in Aboriginal health.

In 2003, the *National Strategic Framework for Aboriginal and Torres Strait Islander Health, Framework for action by Governments* was prepared by the National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers' Conference. This document built on the 1989 NAHS and addressed approaches to primary health care and population health within the contemporary policy environments and planning structures.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 was endorsed by the Australian and State/Territory governments through their respective Cabinet processes and signed by all Health Ministers in July 2003. It was seen as providing, for the first time, a multilateral commitment to improving Aboriginal and Torres Strait Islander health through a sustained approach supported by Aboriginal and Torres Strait Islander health organisations. In recognition of the many economic and social factors that impact on health status such as poverty, education and housing it aimed to provide a whole of government approach and action under a range of government departments and programs at the Commonwealth and State/Territory level.

Under this Framework, the *Australian Government Implementation Plan 2003-2008* outlined proposed actions by the Commonwealth Government, as its contribution to improving health outcomes for Aboriginal and Torres Strait Islander Australians over this five year timeframe. It covered programs and policy approaches which were the Commonwealth's primary responsibility as well as areas where the Commonwealth was contributing to multilateral effort.

The framework for National policy development changed over the last three years of the previous Liberal/National Country Party Coalition Government. Previous co-ordinating bodies such as the Aboriginal and Torres Strait Islander Commission (ATSIC) and the Aboriginal and Torres Strait Islander Services (ATSIS) were abolished and Aboriginal Health programs became administered by mainstream agencies and within a whole-of-government approach.

A Blueprint for Action in Indigenous Affairs was developed in 2006 identifying three priority areas for special attention:

- Early childhood intervention;
- Safer communities;
- Building wealth, employment and an entrepreneurial culture

Under the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*, a revised Australian Government Implementation Plan 2007-2013 was developed, with an overarching goal "To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice."

This Plan identified within nine key result areas, actions of immediate priority (to be addressed within 1 year) and longer term priorities. The following table summarises the areas where actions were identified.

Table 3.1 National Policy Focus Areas from 2007-2013 Implementation Plan

Key Result Area	Immediate Action	Longer Term Priority
Community controlled primary health care services	Continued support of ACCHCS through service expansion, improvements in quality, organisational capacity, information management, capital infrastructure.	Improving quality of ACCHCs, establish linkages and partnerships with mainstream health infrastructure, enhance partnership forums, community capacity building in management.
Health system delivery framework	Enhance primary health care service provision through targeted service enhancement, workforce development, coordinated service delivery, population health approaches, targeting child and maternal health-low birth weight, immunisation, hearing and chronic disease. Telecommunication enhancement in rural and remote areas. Awareness of risk factors for chronic disease – overweight and obesity, smoking, nutrition, alcohol, physical activity. Integration and continuity of chronic disease prevention and care. Accommodation support for those requiring treatment e.g. renal patients.	Improve access to mainstream health services. More effective and responsive mainstream services through cultural respect and responsiveness, support of general practice, medical education, multidisciplinary teams, practice nurses and nurse practitioners, allied health workers, support to rural and remote practitioners. Improve access to mainstream programs through PBS and S100 arrangements, MBS billing arrangements, hearing services, telehealth. Transport needs. Chronic disease prevention and management. Oral health. Workforce development. Data development, data quality and research.
A competent health workforce	Continue implementation of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework – indigenous content in training, curriculum development, scholarships, qualifications and competencies, training networks, cultural safety training. Education, career choices and pathways – high school career advice, financial support and mentoring for transition from school.	Cross-portfolio mechanisms for improving recruitment and retention of Aboriginal people in health workforce. Address staff shortages in ACCHS' Industry-based opportunities to provide health training. Competencies and qualifications for population health workforce. Develop data and research in workforce development.
Social and emotional well-being	Social justice and across Government approaches addressing violence, child abuse, drug and alcohol treatment and rehabilitation services. Population health approaches to reduce the harmful effects of alcohol, drugs and other substance use. Improving access to mainstream services addressing social and emotional well-being and mental health service delivery. Petrol Sniffing strategy.	Addressing intergenerational effects of disadvantage and discrimination on social and emotional well-being. Intersectoral approaches to providing for social and emotional development needs of Indigenous children. Population health promotion and prevention approaches. Access to drug and alcohol treatment and rehabilitation services. Upskill health workforce in mental health, social and emotional wellbeing and substance use issues. Train and support Aboriginal Health workers in identifying early signs of mental illness.

Key Result Area	Immediate Action	Longer Term Priority
Environmental health	Continue implementation of the *Home Ownership on Indigenous Land* initiative	Regional Partnership agreements to meet environmental health needs. Improvements in capacity of environmental health workforce. Environmental health conferences. Australian Remote Indigenous Accommodation (ARIA) program. Housing support arrangements to facilitate access to mainstream housing assistance. Widespread use of national indigenous Housing Guide. Fund *Fixing Houses for Better Health* projects recognising connection between healthy living practices and housing quality.
Wider strategies that impact on health	Integrated services approach to early childhood services inc. *Innovative Child Care Service Hubs*. Implement *Indigenous Economic Development Strategy*. Converting *Community Development Employment Projects* (CDEP) positions into jobs.	**Early Childhood** – *National Agenda for Early Childhood*, linkages and partnerships, parenting and family support, healthy life skills. **School education** – social and emotional wellbeing support services to those in education, encourage school attendance and healthy lifestyles, safe and supportive school environments, place-based opportunities. **Pathways to training, employment and higher education** – leadership and personal development, vocational training and education, career advice, Structured workplace learning opportunities, Youth Pathways. **Employment and Economic Development** – *Indigenous Arts Centres Strategy*, broad-ranging and joint activities in shared facilities. **Blood borne viruses and sexually transmissible infections** - implement and evaluate *National Aboriginal and Torres Strait Islander Sexual health and Blood Borne Virus Strategy 2005-2008*, increased access to testing, treatment and management of STIs, prevention through education, increase understanding and awareness, increase AHW workforce, Increase NSPs. **Male Health**. **Aged care** – cross-agency links, aged care training, dementia training, ACAT services. **Disability** - cross-agency links, improve take-up of disability services, support carers, assist in gaining and maintaining employment. **Workforce** – recruiting, retaining and supporting in early childhood, education and training, aged care, National Respite for carer Program. **Data and research** – early childhood, blood borne viruses and STIs, aged care, disability.
Data, research and evidence	Implement the *National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data* (NAGATSIHID) Strategic Plans	**Data and Information** – data needs/gaps, Aboriginal perspectives on collection and use. **Research** – develop NHMRC capacity, 5% NHMRC grant funding, capacity building strategies in health research, ethical review, industry and research partnerships, inter-sectoral funding, primary heath care sector. **Knowledge Translation** – evidence base, research collaboratives.
Resources and finance	**Regional planning** – build cross-agency links in planning processes.	**Regional planning** – nationally consistent evidence-based approach, potential additional sustainable sources of funding, Geographic Information System (GIS) analysis, Regional Priority Plans.
Accountability (all initiatives are both immediate and long term)	**OATSIH funded health services** – Standard, Multi-Year Funding Agreements, Service Development and Reporting Framework, accountability for health service outputs. **Government agencies** - annual health portfolio performance reporting and biennial whole of government performance reporting. **Mainstream Health Programs** – investigate accessibility, appropriateness etc for Aboriginal communities, accountability requirement for improving outcomes for Aboriginal people	

National priorities in Aboriginal health have continued to evolve following the change of Government in late 2007. Initiatives in Aboriginal health have figured prominently in the Commonwealth Budgets 2008-09 and 2009-10.

The key objectives of National policy on Aboriginal Health as outlined in the 2008-09 Budget papers relating to the Department of Health and Ageing responsibilities are to:

- Improve access to effective primary health care, substance use, and social and emotional well-being services for Aboriginal and Torres Strait Islander people;
- Improve child and maternal health;
- Work with other governments and the broader health sector to improve health outcomes for Aboriginal and Torres Strait Islander people.

Initiatives outlined in the 2008-09 Budget include:

- improve and expand Indigenous-specific comprehensive primary health care services, substance use treatment, preventative health programs and social and emotional well-being services, particularly in regional and remote areas;
- provide additional infrastructure and staff for new and existing services, including residential rehabilitation, to enable more people in regional and remote communities to access these services;
- tackle high smoking rates in the Aboriginal and Torres Strait Islander population through the Indigenous Tobacco Control Initiative, with particular emphasis on young smokers;
- expand Link Up and Bringing Them Home social and emotional well-being services, particularly for Aboriginal and Torres Strait Islander people affected by the practices of past governments around the forced removal of children from their families, increasing the number of counsellors nationally and enable more reunions for Stolen Generation members to reconnect with their families and communities;
- address the barriers Indigenous Australians face when accessing Medicare benefits and the Pharmaceutical Benefits Scheme;
- fund and manage capital works projects predominantly in rural and remote areas to construct, upgrade and maintain vital health clinics, substance use facilities and staff housing;
- risk assessment procedures and funding training for managers of Indigenous health services;
- develop and implement new national qualifications for Aboriginal Health Workers;
- incorporate Indigenous curriculum content in all medical courses;
- support Indigenous students, and graduate doctors and nurses;
- work on estimating Indigenous mortality rates, developing guidelines for improving Indigenous identification in key health datasets and the development of social and emotional well-being data.
- production of the 2008 Aboriginal and Torres Strait Islander Health Performance Framework Report.

Initiatives in Child and Maternal Health from the 2008-09 Budget include:

- New Directions: An Equal Start in Life for Indigenous Children early childhood strategy involving health, education, and parenting support initiatives, home visiting, access to antenatal care; standard information about baby care; practical advice and assistance with parenting; monitoring of developmental milestones; and health checks for Indigenous children before starting school;
- child and maternal health services to complement Health@Home Plus, which provides nurse-led home visiting for children from birth through to two years of age, with child and family support through to age eight;
- build upon the Healthy for Life Program to support child and family health, and improve the prevention, early detection and management of chronic disease for Aboriginal and Torres Strait Islander people;
- Medicare Benefits Schedule item for comprehensive health assessments of Aboriginal and Torres Strait Islander children up to 14 years of age.

The key objectives of National policy on Aboriginal Health as outlined in the 2009-10 Budget papers is in closing the gap in life expectancy and child mortality rates for Indigenous Australians, including through primary health care, child and maternal health and substance use services. This outcome is to be achieved through:

- Prevention and management of chronic disease – measures to tackle chronic disease risk factors, improve chronic disease management and follow-up care and increase the capacity of the primary care workforce and the Indigenous health sector to deliver effective health care;
- Improved child and maternal health – expand mothers and babies services in high needs localities and provide a strategy to support efforts to control acute rheumatic fever and manage rheumatic heart disease;
- Improved access to effective health services - regional reform of remote Indigenous primary health care services in the Northern Territory including continuation of the Remote Area Health Corps; additional infrastructure and staff for drug and alcohol treatment including residential rehabilitation; building the capacity of primary health care services including assistance for Indigenous health services to become

accredited; through the Divisions of General Practice network funding for 80 FTE local Indigenous people to work as Indigenous outreach workers, supported by 80 FTE project officers;
- Improved social and emotional well-being – Bringing Them Home counsellor positions to reduce the impact of loss, grief and trauma for members of the Stolen Generations;
- Improved workforce capacity – support for education training of Aboriginal Health workers, nurses and doctors and inclusion of Indigenous health issues in medical, nursing and health sciences curricula;
- Financial framework reforms – through COAG outcome measures tied to ensuring access to effective health care for Aboriginal and Torres Strait Islander populations.

Other initiatives specific to Aboriginal health outlined in the 2009-10 Budget include:
- Completion of follow up services for dental and ear, nose and throat conditions identified through the Northern Territory Emergency Response child health checks;
- expansion of the current Mobile Outreach Service to respond to child abuse-related trauma;
- Improving access to eye and ear health care across Australia, particularly in remote and rural areas including provision of at least 1,000 additional eye and ear surgical procedures; increase in services to address trachoma with at least 10 regional teams across regions where trachoma is identified; expansion of the Visiting Optometrist Scheme; training of health workers to help early diagnosis of hearing problems; hearing medical equipment; and hearing health promotion to increase awareness of ear disease and the importance of providing and following treatment to reduce hearing loss in Indigenous communities.
- Improving Indigenous oral health by piloting the use of mobile dental facilities to deliver dental care services to rural and regional Indigenous communities.
- Enhancing the Quality Assurance for Aboriginal Medical Services program to improve pathology services supporting the effective management of diabetes among Indigenous people.

National Health and Hospitals Reform Commission

In July 2009 the Final Report of the National Health and Hospitals Reform Commission, *A Healthier Future for all Australians*, was presented to the Australian Government. A consultation process with national stakeholders is to be undertaken over 2009-10 to help frame the Government's response to the over 100 recommendations in this Report. There are some quite significant recommendations within the report that address the health needs of Aboriginal and Torres Strait Islander peoples. Some of the more significant recommendations include:
- The Commonwealth Government to assume full responsibility for the purchasing of all health services for Aboriginal people through a National Aboriginal and Torres Strait Islander Health Authority, which would commission and broker services presently provided through mainstream State Health and ACCHS';
- The Commonwealth Government through DoHA, take the lead role in inter-sectoral collaboration to redress the impacts of social determinants of health to close the health gap for Aboriginal peoples;
- A substantial increase in expenditure through an investment strategy reflective of health need, service delivery costs and desired outcomes;
- Strengthening and expanding organisational capacity and sustainability of ACCHS';
- Incorporation of core Indigenous modules within accreditation processes for health services and education providers;
- Additional investment to build an Aboriginal and Torres Strait islander workforce across all disciplines, including a comprehensive national strategy to recruit, retain and train at undergraduate and postgraduate levels; incorporating targets and rewards for education providers, support for students commencing in secondary education and strengthening accreditation criteria around cultural safety;
- Providing options for Aboriginal peoples to enrol with a single primary health care service as their principal "health care home", to strengthen the continuity, coordination and range of multidisciplinary care available;
- An integrated package to improve the affordability of fresh food, particularly fruit and vegetables, in targeted remote communities.

Closing the Gap

Impetus to developing the Closing the Gap campaign came from the Social Justice Report 2005 which proposed a human rights based campaign to address the health inequality of Indigenous Australians, asking governments to commit to addressing the health status of Aboriginal and Torres Strait Islander peoples within a set timeframe.

The human rights based approach advocates that Aboriginal and Torres Strait Islander peoples have a right to health, encompassing four essential elements:
- **Availability** - proper public health and health care facilities and programs have to be available in sufficient numbers across Australia;

- **Accessibility** - health facilities must be within safe physical reach for all sections of the population especially disadvantaged groups such as Indigenous Australians;
- **Acceptability** - all medical services must respect medical ethics as well as the culture of individuals;
- **Quality** - As well as being culturally appropriate, health services must be of a good quality.

The report suggested that it was realistic for governments to commit to ensuring an equitable distribution of primary health care and equitable standards of health infrastructure (such as water, sanitation, food and housing) in a time period of no more than 10 years and to commit to the goal of achieving equality of health status and life expectation within the next generation (25 years). Also, that benchmarks and targets for achieving equality of health status and life expectation should be negotiated, with the full participation of Aboriginal and Torres Strait Islander peoples, and committed to by all Australian governments.

The report proposed a National commitment to achieving equity and a program of action to address this inequality. Governments should also commit to achieve improved access to mainstream services as well as continued support for community controlled health services with the full participation of Aboriginal and Torres Strait Islander peoples.

In April 2007, 40 of Australia's leading Indigenous and non-Indigenous health peak bodies and human rights organisations joined forces to launch a campaign to 'Close the Gap' on health inequality. Close the Gap is a coalition of some of Australia's leading health, human rights and Aboriginal organisations committed to working with Federal, State and Territory Governments to narrow the life expectancy gap between the Aboriginal & Torres Strait Islander population and other Australians within a generation. More than 115,000 Australians have signed the Close the Gap pledge, calling on governments to increase annual Indigenous primary health funding, ensure equal access to health services and Indigenous participation in their delivery, and take action on social determinants such as housing and education that are leading contributors to the poor health of Indigenous people.

National Close the Gap Day (22 April 2008) illustrated the breadth of support for the campaign, with 637 community events held across Australia. In 2009 (2 April 2009) 492 events were held across Australia with more than 20,000 Australians involved on the day. More than 130,000 Australians have now signed the Close the Gap pledge.

Council of Australian Governments' (COAG)

Aboriginal Health considerations have been high on the agenda of COAG considerations, with a working group on Indigenous Reform established. The objective of this working group has been to develop strategies to close the gap on Indigenous disadvantage and in particular to:
- close the life expectancy gap within a generation;
- halve the gap in mortality rates for Indigenous children under five within a decade;
- halve the gap in reading, writing and numeracy achievements within a decade in a partnership between all levels of government and with Indigenous communities.

It is recognised that the pathway to closing the gap is inextricably linked to economic development and improved education outcomes. COAG has agreed to, as a basis for further work, the Indigenous specific elements contained in 23 of the 26 implementation plans prepared by other COAG working groups, to ensure Commonwealth election commitments in health, education and housing address Indigenous disadvantage where appropriate. This includes the following specific targets:
- at least 48,000 dental services for Indigenous people over four years under the Commonwealth Dental Health Program;
- universal access to early learning for all four year olds by 2013 including Indigenous children and all Indigenous four year olds in remote Indigenous communities have access to a quality early childhood education program;
- targeting the needs of Indigenous Australians through the Transition Care initiative, the elective surgery waiting list reduction plan and the Place to Call Home program for homeless people.

In addition there is an Indicative Forward Work Program underway from March 2008 covering:
- Identification of duplication and overlap between Commonwealth and States with new framing recommendations on roles and responsibilities.
- Ensuring that new Commonwealth/State agreements in health, schools and housing contain specific targets for Indigenous Australians.
- Reducing alcohol and substance abuse and its impact on families, safety and community wellbeing.
- Addressing passive welfare.

- Identifying further joint reforms and implementation timetables by the end of 2008, including in the following areas:
- basic protective security from violence for Indigenous parents and children;
- early childhood development interventions;
- a safe home environment;
- access to suitable primary health services;
- supporting school attendance;
- employment and business development opportunities; and
- involving local Indigenous people in the formulation of programs that support them.
- Optimal service delivery for small remote communities.

Additional high level targets have been agreed:
- halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade;
- in five years all Indigenous four year olds in remote Indigenous communities will have access to a quality early childhood education program;
- at least halve the gap for Indigenous students in Year 12 or equivalent attainment rates by 2020.

The COAG meeting of July 2008 agreed in principle to a National Partnership with joint funding of around $547.2 million over six years to address the needs of Indigenous children in their early years. This reflects evidence that improvements in Indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services and integrated child and family services.

The COAG National Indigenous Reform Agreement was agreed to in November 2008, committing all jurisdictions to achieving the Closing the Gap targets; defining responsibilities and accountability among governments; establishing a roadmap for future action; and providing significant funding through National Partnership Agreements to assist in meeting the targets in remote housing, health, early childhood development, jobs and improvements in remote service delivery.

COAG has further agreed to consider in mid 2009 broader reform agendas to overcoming Indigenous children's disadvantage, including the role that conditions on benefit payments could play in increasing the take up by vulnerable families, including vulnerable Indigenous families, of early childhood, family support and child and maternal health services.

The COAG Working Group on Indigenous Reform (WGIR) has continued to develop reform proposals for improving community safety, remote service delivery and Indigenous economic development and active welfare.

As of May 2009 there were five COAG Indigenous National Partnerships in operation addressing aspects of Aboriginal Health:
- *Indigenous Early Childhood National Partnership* - commenced on 1 January 2009 with joint funding of $564.0 million over 6 years to 2014. Consisting of three elements – establishing a minimum of 35 Children and Family Centres across Australia in areas of high Indigenous population and disadvantage; increasing access to antenatal care, pre-pregnancy and teenage sexual and reproductive health programs by Indigenous young people; increasing access to, and use of, maternal and child health services by Indigenous families.
- *National Partnership on Closing the Gap in Indigenous Health Outcomes* – with $1.6 billion joint funding over four years to address the COAG agreed Closing the Gap targets for Indigenous Australians - closing the life expectancy gap within a generation and halving the mortality gap for Indigenous children under five within a decade. Addressing chronic disease risk factors, improved chronic disease management in primary care, improved follow up care and increasing the capacity of the primary care workforce to deliver effective health care.
- *Remote Indigenous Housing* - $5.5 billion funding over 10 years to address significant overcrowding, homelessness, poor housing conditions and the severe housing shortage in remote Indigenous communities. The aim is for 4,200 new houses to be built in remote Indigenous communities; and upgrades to around 4,800 existing houses - the States deliver standardised tenancy management and support consistent with public housing tenancy management;
- *Indigenous Economic Participation National Partnership* - $228.8 million joint funding over five years to assist up to 13,000 Indigenous Australians into employment. Focusing on job creation in areas of government service delivery that have previously relied on subsidies through the Community Development Employment Projects program and public sector Indigenous employment and career development strategies to reflect Indigenous working age population share by 2015;

- *Indigenous Remote Service Delivery National Partnership* - $291.2 million joint funding over six years to improve access to services by Indigenous Australians in twenty-six selected remote locations.

A COAG meeting focused on closing the gap was held late in 2009 to progress the reform agenda.

Bilateral Policy Initiatives with NSW Government

Under the auspices of COAG the Australian Government signed overarching agreements with each of the States to further the whole-of-government approach to Aboriginal health, with the aim of setting out strategic approaches for joint and innovative action by governments in partnership with communities. The NSW Agreement was announced on 17 April 2006.

Under this agreement priority action areas were identified based on the areas for strategic change developed in the *Overcoming Indigenous Disadvantage* report(s):

- reducing incarceration and breaking the cycle of family violence;
- improving Year 3 and 5 literacy and numeracy, and school retention rates;
- reducing incidence of otitis media (conductive hearing loss);
- improving living conditions;
- early childhood intervention, a key focus of which will be improved mental and physical health, and in particular primary health, and early educational outcomes;
- safer communities (which includes issues of authority, law and order, but necessarily also focuses on dealing with issues of governance to ensure that communities are functional and effective);
- building Indigenous wealth, employment and entrepreneurial culture, as these are integral to boosting economic development and reducing poverty and dependence on passive welfare.

The Agreement acknowledges that a large proportion of Aboriginal people in NSW reside in urban areas and that achieving improved outcomes in urban areas will require action through both mainstream and Aboriginal-specific programs. The Agreement also acknowledges that the policy foundation for action from the NSW perspective will be the NSW Government's *Two Ways Together*, the NSW Aboriginal Affairs Plan 2003-12.

Futures Planning – the 2020 Summit

The Australian Government commissioned the 2020 Summit undertaken on 19 & 20 April 2008 with a view to shaping a long-term strategy and agenda for policy actions for Australia over a 10+ years horizon. Ten major policy challenges were identified, one of which was options for the future of Indigenous Australia. Some of the other major policy challenges, particularly a long-term health strategy; and strengthening communities, supporting families and social inclusion; are also of relevance to Aboriginal health policy setting.

The report of the Summit does not necessarily reflect the views of the Australian Government but does provide an indication of the longer term policy directions favoured by important stakeholders in the development of Aboriginal health policy.

The work on Indigenous Affairs was framed by the following policy questions:

- What is required for Australians to come to understand the complexity of Indigenous disadvantage, so that they will have a better understanding of the resources and time frames required to close the gap?
- What would improve access to mainstream services for Indigenous Australians living in urban and regional areas?
- What targeted interventions have the best hope of achieving change in remote communities?
- What is the role of Indigenous leadership development?
- What can be done to best promote and preserve Indigenous cultures, languages and traditions?
- Where will Indigenous culture be placed in 2020? What is the Indigenous role in what Australia as a whole aspires for in terms of identity and culture?
- What is the role for non-Indigenous Australians in working with Indigenous communities towards shared goals?

Key areas and corresponding top ideas (selected on the basis of immediate relevance to Aboriginal health) and indicating possible areas for further inter-sectoral collaboration included:

- **Families and children** - education policy framework that can integrate health strategies in an early childhood intervention strategy; expanded options for children to obtain high-quality schooling; individual learning and health compacts for each Aboriginal child; Aboriginal Children's Fund; Aboriginal liaison staff in schools and childcare centres; school exchanges; reinvigorate multi-functional childcare centres.

- **Government reform and accountability** - build accountability, reporting and monitoring in Indigenous policy initiatives; Aboriginal–led strategic policy development; incentives for self-help and development of skills that support independence; service delivery mechanisms that are people centred and more convenient - community hub, 'one-stop shops', services coordinated across governments and agencies; move from words and concepts focused on disadvantage and dysfunction to strength-based words and concepts such as 'development' and 'capacity building; database clearing house.
- **Health** - eradicate trachoma amongst Indigenous children within five years; equity-based reconstruction fund to build infrastructure and services designed to promote better health; a child health nurse in every school accessible by young mothers and their babies in the community; reinvigorate Aboriginal and Torres Strait Islander service delivery models; a National Healing Foundation.

The work on a national health agenda recommended a Health Equalities Commission to address health inequalities across the health system. The first priority would be to reduce the 17 year gap in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous people and initial efforts should focus on improved health outcomes in the early years of life (including providing antenatal care to all Aboriginal mothers starting in their first trimester and continuing through delivery, providing continuity of health care in the early years of childhood, and focusing on preparing children for schooling). The Commission would create a broad definition of 'health' to include indices of remoteness, social inclusion, cultural competence and function and implement a task force as an initial activity, dealing with Aboriginal and Torres Strait Islander health inequalities.

The establishment of a health and education task force was also recommended, with the first priorities to identify risk profiles (those with chronic illness, disabilities, Aboriginal people, remote and the ageing population).

It was also suggested that all major Australian research institutions have responsibility to develop partnerships with Indigenous communities to build the Indigenous health and medical research skill base and focus research on addressing major Indigenous health problems.

The work on strengthening communities, supporting families and social inclusion also addressed aspects of policy of potential relevance to Aboriginal communities, including the impact on health. One of its headline ideas was to close the gaps in Indigenous health and, until these gaps are closed, provide financial assistance to deal with funeral costs, as well as community support.

3.2 NSW Directions

NSW policy agendas in Aboriginal health have for many years been developed in partnership with and after extensive consultation with Aboriginal communities. The NSW Aboriginal Health Strategic Plan (1999) was an initiative of the NSW Aboriginal Health Partnership and the NSW Aboriginal & Torres Strait Islander Health Agreement (1996). Key priorities in this Plan included:

- Improving access to health services;
- Addressing identified health issues – priority attention to diabetes and diseases of the circulatory system, eye health, maternal, infant and child health and oral health;
- Improving social and emotional well being – priority attention to stolen generations, prevention of youth suicide, substance abuse and information, local issues and education;
- Increasing the effectiveness of health promotion – priority attention to injury prevention, family violence and maternal and child health;
- Creating an environment supportive of good health.

Two Ways Together

In recognition that single Agency Plans addressing issues of Aboriginal health and well-being were less likely to have an impact on the multifactorial causes of disadvantage in Aboriginal communities, the NSW Government initiated planning processes in the early 2000's to ensure a coordinated approach across agencies and the close involvement of Aboriginal communities in setting priorities for action. It was considered that working in a coordinated way to do business with Aboriginal People would cut duplication, and result in less wastage and fewer gaps in services.

The *New South Wales Aboriginal Affairs Plan, 2003-2012* sub-titled, *Two Ways Together. Partnerships: A new way of doing business with Aboriginal people* adopts a whole-of-government approach to develop partnerships between Aboriginal people and government to improve the social, economic, cultural and emotional wellbeing of Aboriginal people in NSW. The areas for business were negotiated between Aboriginal people and Government after extensive community discussion and consultation identified seven priority areas for action:

- Health - priority attention to the health and well being of Aboriginal mothers and children, otitis media and conductive hearing loss, injury, ill health and disease from substance misuse; and physical health (such as diabetes and cardiovascular disease);
- Housing;
- Education;
- Culture and Heritage;
- Justice;
- Economic Development; and
- Families and Young People.

The priority areas also correspond strongly to the national range of indicators on Aboriginal disadvantage arising from the Productivity Commission work and COAG considerations.

Two Ways Together recognises that Aboriginal people have inherent rights as the first peoples of Australia. It recognises that these rights were never ceded and that they exist in addition to citizenship rights. The inherent rights of Aboriginal people include the right to determine the direction of their social, economic and political development and the right to maintain culture, language and identity.

The NSW Department of Health became the lead agency for the *Health Cluster Group*, one of seven cross-agency groups originally established in the priority areas for action in NSW. Over time the cluster groups were consolidated into four, with each chaired by a lead agency and including representation from 60 relevant NSW and Australian Government agencies and five Peak Aboriginal Bodies. The cluster groups developed Action Plans for 2005-2007 to coordinate interventions and monitor outcomes through key indicators. For the Health cluster these indicators measure outcomes in areas such as life expectancy, infant mortality, low birthweight babies, antenatal care, cardiovascular disease, diabetes, trauma injuries associated with alcohol, vaccine-preventable diseases and immunisation in children, acute respiratory infections, skin infections, and gastrointestinal illness. These indicators are reported in a specific chapter of the Chief Health Officers Report.

At the regional level *Two Ways Together* is administered through the ten Regional Coordination Management Group (or RCMG) regions in New South Wales, which are coordinated by the NSW Premier's Department. Regional Engagement Groups (or REGs) are constituted as sub-committees of RCMGs and have a role in ensuring that government agencies are meeting community needs at a local level. REGs are coordinated by the Department of Aboriginal Affairs' Regional Managers. The LGA coverage of RCMGs of relevance to SSWAHS is as follows (SSWAHS LGAs in italics):

- **Western and South Western Sydney** – Auburn, *Bankstown*, Blacktown, Blue Mountains, Baulkham Hills, *Camden, Campbelltown, Fairfield*, Holroyd, Hawkesbury, *Liverpool,* Parramatta, Penrith, *Wollondilly*;
- **Coastal Sydney** – *Ashfield*, Botany Bay, *Burwood*, *Canada Bay*, *Canterbury*, Hornsby, Hunters Hill, Hurstville, Kogarah, Ku-ring-gai, Lane Cove, *Leichhardt*, Manly, *Marrickville*, Mosman, North Sydney, Pittwater, Rockdale, Randwick, Ryde, *Strathfield, Sydney*, Sutherland, Warringah, Waverley, Willoughby, Woollahra;
- **Illawarra/South-East** – Bega Valley, Bombala, Boorowa, Cooma-Monaro, Eurobodalla, Goulburn-Mulwaree, Kiama, Palerang, Queanbeyan, Shellharbour, Shoalhaven, Snowy River, Upper Lachlan, *Wingecarribee*, Wollongong, Yass Valley.

For each RCMG regional reports have been developed outlining the available statistics on demographic and socioeconomic characteristics of the Aboriginal populations of these regions. Regional Action Plans 2007-09 have been developed for some of the REGs operating within the RCMGs. The focus of these action plans may be RCMG wide or at the local level where partnership communities have been established. The action plans address three goals:
- Stronger partnerships between community and Government agencies;
- Aboriginal children are ready for school;
- Improved prevention and access to treatment for chronic diseases.

Under the Partnership Community Program, partnership communities have been identified covering around 45% of the NSW Aboriginal population. It is expected that a DAA 0.5 FTE position will be allocated to each Partnership Community location, including Campbelltown-Macarthur, to develop a Partnership Community Action Plan. A Community Resilience Toolkit is also being developed under the auspices of this program, by the Department of Environment and Climate Change.

Also, within the TWT framework, DAA and the Sydney Indigenous Coordination Centre (ICC) have identified the Campbelltown/Macarthur area as a priority community to improve the outcomes for Aboriginal families. Within

a holistic view of family covering a range of social justice issues balanced against family responsibility, a scoping study of families and their needs is underway aiming to:

- Map locations and structures of families and family support mechanisms;
- Assess families needs across housing, education, health, early childhood development, law and justice;
- Identify services and programs that support families and the extent of service gaps;
- Identify avenues for the Aboriginal community to influence services and programs;
- Develop a broad implementation plan.

NSW Aboriginal Health Partnership Agreement 2008-2013

This partnership agreement between NSW Health and the Aboriginal Health & Medical Research Council was signed by the Minister of Health at the Coalition for Research to Improve Aboriginal Health (CRIAH) Conference on 30 April 2008. The aim of the Partnership is to ensure that the expertise and experience of the Aboriginal community controlled Health sector is brought to health care processes. The NSW Aboriginal Health partnership Committee is constituted under this Agreement to provide leadership and ongoing advice on general health policy, strategic planning, service issues and equity in allocation of resources.

Under the Agreement there are overarching goals of ensuring Aboriginal health retains a high priority in the health system; is integrated as a core element in all NSW Health policies and their implementation; is advanced through a partnership approach; and that the outcomes are communicated to Aboriginal communities.

Whole of Government Strategies Targeting Aboriginal Communities

These include the following.

Aboriginal Child, Youth and Family Strategy

With DoCS as the lead agency, this strategy focuses on better coordination and targeting of existing government and non-government resources, ensuring mainstream services are meeting the needs of Aboriginal people and testing new ways of supporting these communities. Building on the *Families NSW* (targeting families with children aged 0-8 years) and *Better Futures* (targeting children and young people aged 9 to 18 years), the intention is to bring together key stakeholders and key policies and initiatives for planning and service development.

The *Families NSW* approach focuses on:

- Helping parents to build their skills and confidence in parenting;
- Supporting parents and carers so they can respond to problems early;
- Building communities that support children and families;
- Improving the way agencies work together to make sure families get the services they need.

State-wide priority areas have been developed for *Families NSW* for 2007-2011:

- Enhancing antenatal and postnatal care to Aboriginal mothers, teenage mothers and mothers in lower socioeconomic areas;
- Parenting information provided after birth;
- State-wide rollout of parenting programs;
- Transition to school.

A *Metro South West Region Families NSW Strategic Plan 2008/09 – 2010/11* has been developed, which includes a regional priority to Improve program and service reach to Aboriginal communities. This plan will be progressed through the Greater Western Sydney Regional Coordination Management Group (RCMG) and South Western Sydney Human Services and Justice Senior Officers Group (SOG).

The regional plan acknowledges that in the South West there is a large Aboriginal population but a relatively small NGO infrastructure and that effort needs to be invested in capacity building and developing effective engagement mechanisms with Aboriginal communities. There is specific targeting of Aboriginal communities within priorities and key regional outcomes identified in the Plan:

- Support and assistance for vulnerable children and their families - improve reach of Home Visiting Services to Aboriginal mothers;
- Improve school readiness outcomes for children - make FNSW services more accessible to Aboriginal families through Aboriginal Home Visiting, running Aboriginal pre-school, transition to school and attendance programs, promote and support ACYFS projects to FNSW sector;

- Improve program and service reach to Aboriginal communities – promote culturally sensitive practice through training provided to child & family services, develop learning and career path options in children's and child and family services for Aboriginal communities;

The *Better Futures* approach focuses on:
- prevention and early intervention as effective, cost-effective in the long term, and empowering to individuals and communities;
- community and individual strengths and capacity building;
- risk and resilience theory and the place of connection to family, school and community as a protective factor against the development of other at-risk behaviours.

The strategy purchases services such as after-school holiday programs, youth groups, transition to school programs, resilience building programs and parental support and development through household budgeting and family nutrition. It incorporates the Aboriginal Youth Leadership Project to encourage and support Aboriginal youth development, leadership and participation in civic life. This project is based on the successful UK Keyfund program, which helps young people learn through developing projects with the support of a trained volunteer facilitator.

NSW Aboriginal Mental Health and Well Being Policy 2006 - 2010

This policy aligns with the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004-2009*. It addresses relevant targets included in the NSW State Plan and NSW State Health Plan including in reduction of hospital readmissions for Aboriginal people, increasing the percentage of Aboriginal people with a mental illness who are employed and increasing the community participation rates of Aboriginal people with a mental illness. The Policy aims to:
- encourage partnerships between Aboriginal communities and service providers that build on the strengths of communities;
- promote mental health and prevention of mental ill health, strengthen primary mental health care approaches and improve access to specialist, culturally sensitive and appropriate mental health care;
- implement mental health services and programs that are endorsed by Aboriginal people and that meet their needs across the life span;
- facilitate, promote and disseminate knowledge, expertise and experience in Aboriginal mental health and well being through workforce development, research and training;
- promote the development of Aboriginal mental health workers and increase education, recruitment and retention of Aboriginal people in mental health service delivery.

The strategies identified within the Plan are presented within broad categories:
- Partnerships – strong working relationships:
- Accessible and responsive mental health services;
- Mental health care for all ages – priority target groups;
- Increased expertise and knowledge;
- Supported and skilled workforce.

The strategies developed within this Plan by the mental health PAWG have been developed within the framework of these broad strategic directions.

Making it Our Business – Improving Aboriginal Employment in the NSW Public Sector – Policy Statement 2006-2008

This statement outlines the NSW Government's policy on increasing Aboriginal employment in the NSW public sector, including a Strategic Framework and Resource Guide outlining employment strategies and case studies of good practice. The Policy emphasises that an effective way of targeting Aboriginal employment and professional learning is through agencies:
- developing an Aboriginal Employment Strategy;
- having a senior designated Aboriginal person as the first point of contact for all Aboriginal employment, professional learning and career development initiatives.

This framework is considered essential for all agencies that have an important role in the direct delivery of services to Aboriginal people in the community.

The Policy Statement aims to facilitate progress against Key Result Areas established by the NSW Aboriginal Employment and Development Steering Committee:

- Recruitment - increase the representation of Aboriginal people to 2% (minimum) employed in the workforce; increase the permanent employment of Aboriginal people in the workforce; provide opportunities within the workforce to enable Aboriginal people to gain skills and experience that may assist them in gaining permanent employment; promote innovation and flexibility in the recruitment and selection of Aboriginal people into the workforce.
- Skills Acquisition & Career Development - provide professional learning and career development opportunities for Aboriginal employees; increase the number of Aboriginal people progressing to middle and senior management levels.
- Retention - develop and foster support mechanisms and networks for Aboriginal employees.
- Cultural Education - build an environment that affirms and respects Aboriginal cultural values in the workplace.
- Community Engagement - develop and strengthen positive relationships and partnerships with Aboriginal communities and groups; promote NSW public sector employment opportunities to Aboriginal people and communities, identify skills shortages and provide appropriate training and support to Aboriginal people and communities to fill vacancies.

NSW Aboriginal Justice Plan – Beyond Justice 2004-2014

Produced under the auspices of the Aboriginal Justice Advisory Council (AJAC) and reflecting the views of 60 Government and non-Government agencies and more than 700 Aboriginal community members, gathered through community forums (September to October 2002) and regional summits (February to March 2003), this Plan aims to ensure the justice system works effectively for both Aboriginal victims and offenders, while also tackling those factors that can be clearly linked to offending in Aboriginal communities. It includes initiatives addressing the clear linkages between poor education levels, housing conditions, unemployment, family disruption, alcohol consumption, long term health problems and Aboriginal involvement in the criminal justice system.

Consultation with Aboriginal communities strongly urged that resources be directed towards early intervention and prevention activities, particularly those targeting the needs of Aboriginal children, young people and their families. Aboriginal communities stressed the need to place Aboriginal people at the centre of defining and resolving their own problems and healing their communities through application of a holistic, family and cultural approach. This recognises that tackling generations of grief and trauma is a necessity when addressing the many social problems. Management and implementation of the Plan is envisaged at a local level through structures that engage and empower Aboriginal communities in the justice system and in preventing crime in their communities.

Goals of the Plan are to:
- *Reduce the number of Aboriginal people coming into contact with the criminal justice system* in its entirety – for offenders, Aboriginal victims of crime and the broader Aboriginal community.
- *Improve the quality of services* for Aboriginal people. This aspect applies to all services offered by the Government to Aboriginal people, with the specific aim of redressing the factors that lead to offending by improving the quality of services and ensuring that they are responsive to the needs and aspirations of the Aboriginal community.
- *Develop safer communities* by recognising that the majority of victims of offences committed by Aboriginal people are other Aboriginal people and that many offences are not reported through the criminal justice system. It recognises that there is a clear desire among Aboriginal communities to resolve their own crime and offending problems and for communities themselves to work together to improve their own safety and the safety of others.

The Plan includes seven strategic directions, an objective for each and a number of strategic actions:
- Aboriginal Children - *Provide Aboriginal children with the best start in life by supporting their early childhood development, growth and schooling and giving attention to needs of their carers and families* - build the capacity, self-worth and resilience of Aboriginal children; improve the quality of health services for Aboriginal children; create safe households for Aboriginal children; improve quality of health services in school for Aboriginal children; reform the education system to meet the needs of Aboriginal children; build the capacity, self-worth and life skills of Aboriginal children's carers.
- Aboriginal Young People - *Build the skill capacity, self-worth and resilience of Aboriginal young people to create healthy young individuals* - create vibrant and functioning young Aboriginal people; build the knowledge base of young Aboriginal people's understanding about their legal rights and obligations; support Aboriginal young people to maximise education and employment opportunities; improve quality of services to Aboriginal young people to meet their specific needs; reduce the overrepresentation of young Aboriginal people in the criminal justice system.

- Community Well-Being - *Create safe and strong Aboriginal communities by minimising the factors that contribute to offending and maximising the factors that bring healing to Aboriginal communities* - build the skill capacity, self-worth and resilience of Aboriginal women and men to create strong functioning families; support local Aboriginal communities to develop early intervention and prevention programs, targeted specifically at underlying causes of offending in their communities; build Aboriginal communities' knowledge and understanding about their legal rights and obligations; improve quality of health services to Aboriginal people; improve quality and appropriateness of housing for Aboriginal communities; improve environmental health of Aboriginal communities; improve the safety of Aboriginal people in their home and social environments; work with Aboriginal communities to reduce substance misuse amongst Aboriginal people.
- Sustainable Economic Base - *Engage Aboriginal communities in the broader economy and generate employment, education and training opportunities that create a sustainable economic base for Aboriginal people* - create strong labour markets, particularly in economically depressed communities; reduce unemployment rates and increase household and individual income and assets amongst Aboriginal people.
- Criminal Justice System - *Create a justice system that openly engages Aboriginal communities to reduce offending and the over-representation of Aboriginal people and responds to the needs of Aboriginal communities* - improve Aboriginal community trust and confidence in the criminal justice system by establishing local Aboriginal community justice mechanisms; reduce offending and re-offending in Aboriginal communities by targeting specific areas of over representation; improve the quality of services to Aboriginal victims of crime; address the needs of Aboriginal juveniles in detention centres; establish responsive policing that meet Aboriginal community's crime concerns; ensure Aboriginal defendants have full access to bail; maintain the highest quality court services and legal representation for Aboriginal people; ensure that criminal justice processes act to reduce offending behaviours to reduce the number of Aboriginal defendants proceeding through the criminal justice system; establish high quality services for Aboriginal inmates to facilitate their transition into the community and reduce the likelihood of their re-offending; establish the ongoing review and reform of criminal legislation, policy and initiatives to ensure they meet the needs of Aboriginal communities.
- Systemic Reform - *Establish a continuous process of innovation and reform in government activity to ensure the emerging and diverse needs of Aboriginal people are met* - support Aboriginal people to protect, practice and promote their cultural values; reduce discriminatory practices against Aboriginal people across a range of services; ensure policy decisions affecting Aboriginal people are negotiated with Aboriginal people at state, regional and local levels of government; build the organisational capacity of governments to meet the diverse cultural needs of Aboriginal communities; apply flexible funding arrangements across a range of government and non-government services; establishing a process of continuous service improvement for Aboriginal communities; establish uniform data standards across governments.
- Leadership and Change - *Improve coordination and leadership at the state level to drive Aboriginal justice business in NSW* - improve central coordination and accountability for Aboriginal justice issues in NSW; review, streamline and strengthen the governance structure for Aboriginal affairs policy in NSW; entrench structures which ensure stronger Aboriginal involvement in the development of NSW Government policy.

Whole of Government Community Renewal Strategies Impacting on Aboriginal Communities

The NSW Government has also developed place specific community renewal strategies for a range of disadvantaged communities across NSW.

The Redfern-Waterloo Authority (RWA) has legislative authority to undertake planning and implement strategies to revitalise the built environment, generate employment and enterprise and improve the delivery of human services in Redfern-Waterloo. As part of that process Redfern-Waterloo Human Services Plans Phase 1 and Phase 2 have been developed, in partnership with National, State and Local government agencies, service providers and the local community. The Plans provide a framework for improving the coordination, quality and access to health, education, disability, transport, employment and other human services in Redfern and Waterloo. The Plans relate to all of the communities of Redfern-Waterloo, including community-wide strategies of benefit to Aboriginal communities and strategies specific to Aboriginal communities.

The Redfern-Waterloo Human Services Plan Phase 1 focuses on improving services delivered to children and families, Aboriginal people and young people. Ten key outcome areas and associated strategies were identified as follows:

- Improve the health and wellbeing of children – coordination of services which help the transition from antenatal to postnatal care and improve support for families with children aged 0–5 years;

- Lift local school numeracy and literacy levels to at least the state average - enhance the environments that contribute to the development of early literacy and numeracy and strengthen transition programs for pre-school aged children;
- Lift local school attendance and retention rates to at least the state average - enhance services provided for children and young people at risk of poor attendance and suspension;
- Improve support for vulnerable people - Integrate drug, alcohol and mental health treatment programs and link with training and employment opportunities; provide coordinated early intervention services for at risk families and children;
- Reduce the incidence of family violence - strengthen community based anti-violence education and prevention initiatives which respond to local needs and are delivered in a culturally appropriate manner;
- increase participation and involvement of young people in the community; consolidate and coordinate services for young people and children, including after hours activities programs; increase opportunities for young people to develop communication and leadership skills that strengthen the voice of young people in decision making; integrate local government and non-government youth health services in the area;
- Increase numbers of young people accessing employment and training - improve school to employment transition by enhancing linkages to vocational training and employment opportunities;
- Reduce drug and alcohol misuse - develop and deliver health promotion and health education programs focusing on legal and illegal drugs; improve access to culturally appropriate drug treatment, detoxification and rehabilitation programs; establish an accessible community health facility delivering primary health services which complements existing health services in the area.
- Reduce offending and recidivism - increase community safety by preventing crime and reducing anti-social behaviour;
- Build community capacity - develop broad-based social partnerships and networks to foster community initiative and community participation through improved communications and training.

The Redfern-Waterloo Human Services Plan Phase 2 focuses on eight priority areas as well as improvements to service delivery for older people, people with disabilities, migrant communities and homeless people. The priorities and associated strategies are:
- Improving dementia support - provide more flexible, responsive and accessible services to people with dementia in conjunction with more and better information about dementia;
- Improving service quality for migrant communities - provide migrant communities with well-coordinated services delivered in a culturally and linguistically appropriate manner;
- Improving access to aged care and health services by Aboriginal people 45 years and older - increase access to and use of health, aged care and other community support services by older Aboriginal people;
- Reducing homelessness - develop services capable of providing adequate support for people experiencing
- homelessness in Redfern-Waterloo, as well as pathways out of homelessness and into more stable accommodation and living patterns;
- Improving identification of need and access to services for people with a Disability - improve delivery of services for people with a disability, and their carers, building on the NSW Government's Stronger Together: A New Direction for Disability Services in New South Wales 2006-2016 Plan and Australian
- Government policies;
- Reducing social isolation - increase social inclusion in Redfern and Waterloo through enhanced community
- engagement, community building and service delivery strategies;
- Improving access to local and community transport for people who are transport disadvantaged - improve transport options for frail older people, people with a disability and their carers and people who are transport disadvantaged;
- Improving safety and amenity - improve general amenity by revitalising community facilities, improving housing options, public open spaces and providing a greater range of human services within close proximity to public housing tenants; implement community engagement and community building programs and strategies in Redfern-Waterloo that encourage intergenerational initiatives.

3.3 Local Planning

Area Aboriginal Health Plans

Both the former South West Sydney and Central Sydney Area Health services completed Aboriginal Health plans during the 2000's.

The South West plan identified priority health issues of:
- Child and youth health;
- Mental health;
- Drug and alcohol;
- Diabetes;

- Cardiovascular health
- Infectious diseases;
- Oral health.

Key challenges identified included:
- Partnership arrangements recognising holistic health care approaches;
- Commitment to prevention and early intervention;
- Improving access;
- Organisational commitment to supportive infrastructure.

The Central Sydney plan identified priority health issues of:
- Supporting families with young children;
- Cardiovascular risk assessment and management;
- Drug health;
- Mental health.

Infrastructural initiatives identified included:
- Working collaboration with Aboriginal community controlled organisations;
- Working in collaboration with general practice;
- Increasing Aboriginal employment opportunities;
- Improving access through enhancing cultural sensitivity;
- Implementing Aboriginal Health Impact Statements in service planning and policy development;
- Improving identification of Aboriginality in data collection;
- Improving accommodation and support options for those travelling long distances for treatment;
- Improving transport arrangements;
- Improving research and evaluation of interventions.

The content and strategic directions outlined in these plans are quite similar and give a good foundation for preparation of an Aboriginal Health Plan for SSWAHS, formed from the amalgamation of these previous Areas.

Partnership Arrangements – Aboriginal Community Controlled Health Services

SSWAHS has entered into Partnership arrangements with the two Aboriginal Community Controlled Health Services in SSWAHS, Redfern and Tharawal Aboriginal Medical Services.

Partnership Arrangements – Land Councils

SSWAHS also works with the three Aboriginal Local Land Councils with jurisdiction over lands that are within SSWAHS boundaries:
- Gandangara – traditional custodians the Cabrogal Clan of the Darug Nation and also accessed by peoples of the Durawal and Gandangara Nations;
- Metropolitan – traditional custodians the 29 clan groups referred to collectively as the Eora Nation.
- Tharawal – traditional custodians the Tharawal (sometimes referred to as Dharawal) Nation who lived in coastal and inland areas southwards from around Botany Bay to Wreck Bay (near Jervis Bay).

The following maps and description indicates the land areas covered by these Local Aboriginal Land Councils.

Gandangara Land Council lands

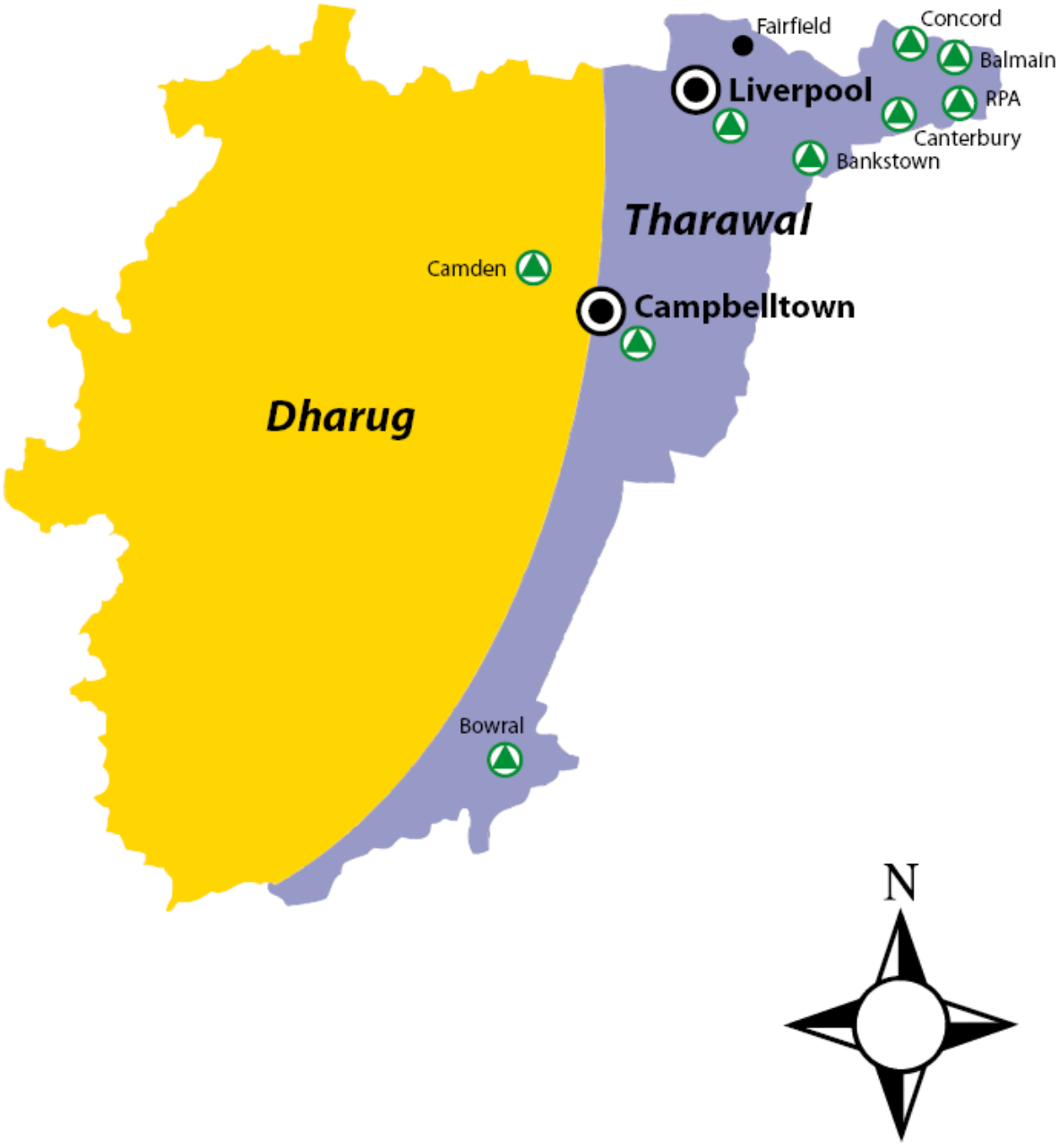
Source: Gandangara Local Aboriginal land Council, *Community Land and Business Plan 2009-2013*, p.10

Metropolitan Land Council lands

Source: www.metrolalc.org.au/Pages/aboutus-map.html, accessed June 2009

Tharawal Land Council lands cover all of the lands of the Wollondilly, Camden and Campbelltown Local Government Areas.

The following map provides an indication of the geographic coverage of traditional Aboriginal Nations compared to the boundaries of SSWAHS and the location of the hospital facilities.



4. Population Profile of Aboriginal Communities in SSWAHS

The demographic data presented in this chapter on Aboriginal and Torres Strait Islander people resident in SSWAHS is mainly derived from the 2006 Census. It is important to note that in many instances the data presented is raw census data not taking into account the level of underenumeration estimated from the ABS Post Enumeration Survey and other factors which are included in the higher official Estimated Resident Population (ERP) statistics. Raw census data also includes only those who choose to identify as Aboriginal and Torres Strait islander. The ERP data includes adjustments to take account of these factors. It is generally considered that the demographic data presented in this chapter underestimates the actual number of Aboriginal people living within SSWAHS boundaries.

Data not specific to SSWAHS but representative of the experience of Aboriginal people dwelling in urban areas is also presented, derived from a variety of sources including *Two Ways Together* (*TWT*), including from the *TWT* Regional Reports on Western and South-Western Sydney and Coastal Sydney, and Australian Bureau of Statistics (ABS) publications.

This chapter presents data not only on the age, gender and geographic distribution of the Aboriginal population of SSWAHS, but also the available data on socio-economic characteristics. For consistency with *Two Ways Together* reporting frameworks, the available data is presented according to the domains of Education, Economic Development, Justice, Families and Young People, Culture and Heritage and Housing (see Attachment D.2 for summary of *Two Ways Together* NSW Indicators data). Health status data is presented at Chapter 4.

4.1 Age, Gender and Population Distribution

The 2006 Census ERP data estimated the Total Aboriginal and Torres Strait Islander population in Australia at 517,174 (2.5% of Australian population). For NSW the estimated population is 148,178 (2.2% of total population). The ERP estimated Aboriginal population for NSW is approximately 7% higher than that indicated by the raw census data. The raw Census data indicates an Aboriginal population in SSWAHS of 14,080, which with an estimated 7% ERP adjustment is equivalent to 15,066. At this level, the Aboriginal population of SSWAHS accounts for 1.12% of the SSWAHS ERP in 2006 of 1,340,378.

Under *Two Ways Together*, regional comparative data is reported according to Regional Coordination Management Group regions. These regions are not contingent with Area Health service boundaries with SSWAHS residents included within more than one RCMG and the relevant RCMG that includes the majority of SSWAHS residents also including residents of other AHS'. The RCMG data does reveal that the Sydney metropolitan region has a lower concentration of Aboriginal population compared to regions outside Sydney and that within Sydney the concentration of the Aboriginal population is higher in the Southwest and Western region compared to the coastal Sydney region.

The concentration of the Aboriginal population varies across SSWAHS LGAs (Attachment C Table C.1). On the raw 2006 Census data, the highest concentration is in Campbelltown at 3,833 or 2.68%, followed by Wollondilly at 762 or 1.89%, Marrickville at 1,078 or 1.50% and Liverpool at 2,194 or 1.33%. The lowest concentrations are at Strathfield at 85 or 0.27%, followed by Canada Bay at 215 or 0.33%, Burwood at 120 or 0.39% and Ashfield at 194 or 0.49%. Overall, 72% of the Aboriginal population resides in South Western LGAs (former SWSAHS) i.e. 10,206 people or 1.29% of the total South West population. Inner West LGAs (former CSAHS) account for 28% of the Aboriginal population i.e. 3,874 people or 0.76% of the total Inner West population.

Aboriginal communities exhibit a younger age profile than non-Aboriginal communities across Australia and although there are some variations at the LGA level across SSWAHS, overall the Aboriginal community age profile is consistent with that demonstrated across NSW and Australia. The percentage of the SSWAHS population aged 0-14 identifying as Aboriginal is around double that of the average for the total SSWAHS population and remains higher than the average through the age cohorts to age 24 (see Figure 4.1). In the older age cohorts particularly aged 60+, the % of population identifying as Aboriginal is half or less than the average for the total population. The disparities in age distribution are also illustrated by the more traditional age pyramid presented at Figure 4.2.

A corollary of these differences is the shorter life expectancy of Aboriginal than non-Aboriginal people. For NSW, this gap is 16.4 years for males and 16.8 years for females.

Figure 4.1. SSWAHS Residents - % Identifying Aboriginality by Age Cohort

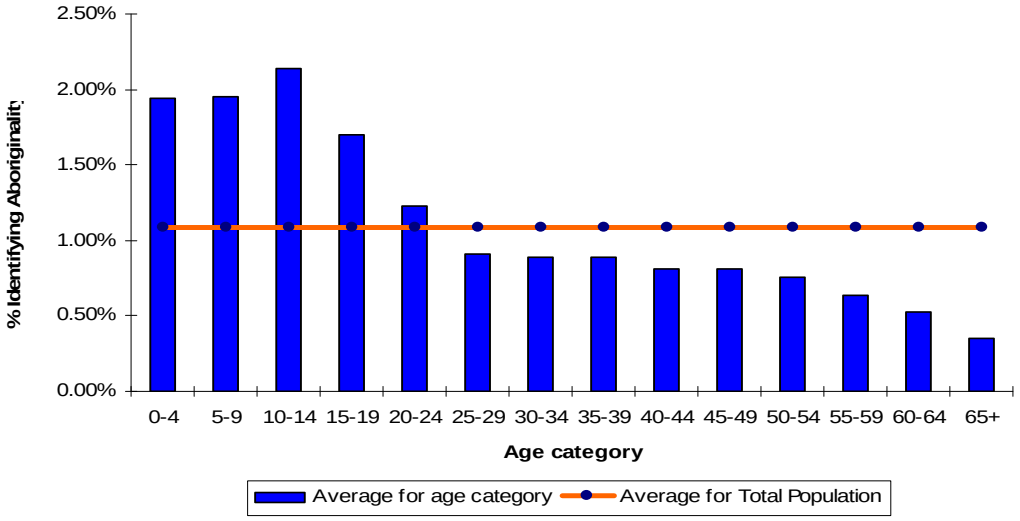
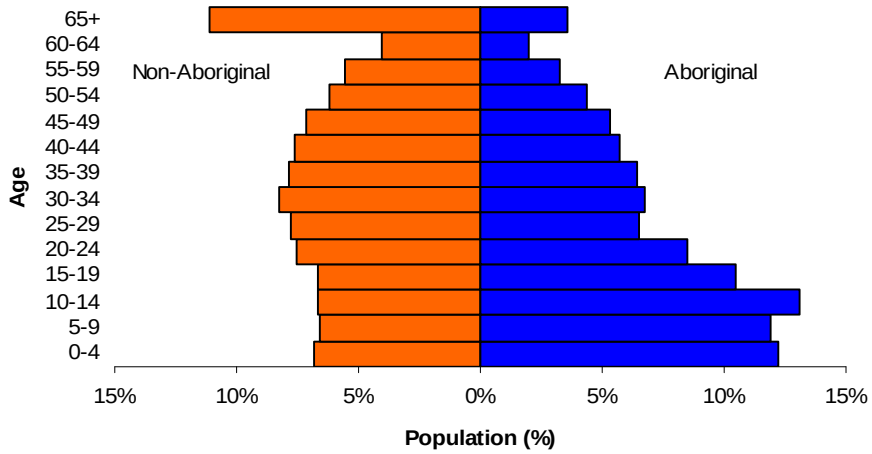


Figure 4.2. SSWAHS Residents – Population Pyramid – Aboriginal and Non-Aboriginal



On demographic data alone Aboriginal children and youth would be considered a high priority for service attention.

4.2 Educational attainment

Two Ways Together reinforces the view that improvements in health status for Aboriginal communities can be facilitated and enhanced through increasing educational attainments that enable greater self determination and increased participation in health enhancing lifestyles.

There is a significant gap in education outcomes between Aboriginal and Non-Aboriginal people. For Aboriginal people, retention within education and outcomes whilst within the educational sector lag behind those of non-Aboriginal people. Nevertheless the essentially younger age distribution of Aboriginal populations gives significant opportunity for cooperative activities within pre-schools, schools and higher education facilities to contribute to better health outcomes as children and youth progress to adulthood.

Attachment C Tables C.2.1 and C.2.2 indicates by LGA the Census 2006 raw data relating to the numbers of Aboriginal enrolments in education and the educational attainments of the adult Aboriginal communities of SSWAHS. This data indicates that across SSWAHS, there are 2,190 children identifying as Aboriginal in infants/primary school (2.2% of school population), 1,474 in secondary school (1.8% of school population), 418 in TAFE (1.2% of school population) and 336 in University and Tertiary education (0.6% of University population).

A significantly lower proportion of the Aboriginal population aged over 15 years reports having completed school at greater than Year 10 compared to the non-Aboriginal population. For South West LGA residents the disparity is 28.8% to 47.2%, for Inner West LGA residents, the disparity is 41.4% to 66.5%.

There is no data available on primary school educational attainments specific to the SSWAHS population. However, data is available on the educational attainment of NSW metropolitan residents indicating for students who identify as Aboriginal and the total school population, the percentage of students in Years 3, 5 and 7 who have achieved Australian benchmarks for reading writing and numeracy. It is important to note that given the much smaller sample size of students identifying as Aboriginal, the 95% confidence intervals are higher for Aboriginal students (± 4-5%) compared to the total schools population (± 1-2%).

Table 4.1 Percentage of Students Achieving Benchmark, NSW Metropolitan 2005

School Year	NSW Metropolitan Areas					
	All Students			Students Identifying as Aboriginal		
	Reading	Writing	Numeracy	Reading	Writing	Numeracy
Yr 3	93.7	94.3	95.9	82.1	82.8	88.2
Yr 5	91.0	94.5	93.1	75.6	83.6	79.9
Yr 7	89.1	93.8	74.1	70.5	80.8	42.7

Source: National Report on Schooling in Australia 2006

4.3 Economic Development

Economic development is one of the seven priority areas identified under *Two Ways Together*, in recognition that increasing Aboriginal employment will assist in building the capacity of Aboriginal communities for self determination, enhance community connectedness and empower communities to address preventable health issues. Employment of Aboriginal people in health and other public sector human services industries is a key determinant in the delivery of effective, workable and acceptable health services to meet the needs of Aboriginal people.

Across NSW the labour force participation rate of the Aboriginal population aged 15+ years is around 12% less than that of the total NSW population (55.6% compared to 63.0%). Unlike the total population where labour force participation has risen over recent years, over the period 2002-06 the participation rate for the NSW Aboriginal population fell by one percentage point.

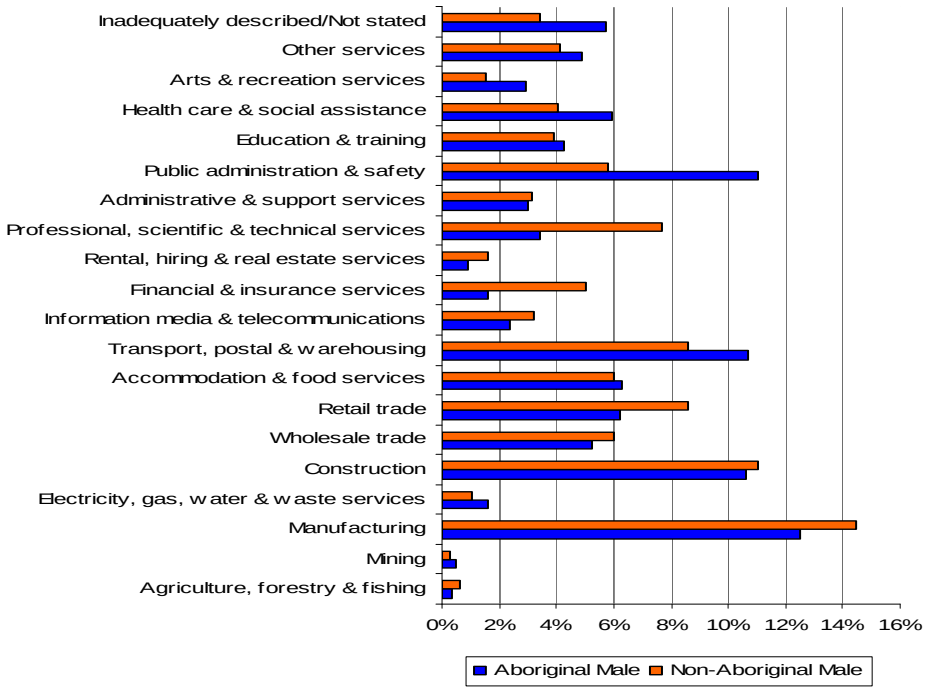
Labour force participation varies by gender and region in both Aboriginal and non-Aboriginal communities. The following table compares labour force participation by gender across the LGAs of SSWAHS (Census 2006).

Table 4.2 Labour Force Participation Rates by LGA 2006

LGA	Male		Female	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Sydney (part)	49.4	76.5	45.1	69.0
Leichhardt	59.2	80.0	55.6	72.8
Marrickville	62.4	74.4	53.1	66.6
Ashfield	65.4	70.6	54.1	59.4
Burwood	62.8	66.7	64.6	53.6
Strathfield	45.9	68.2	74.1	54.2
Canada Bay	67.1	74.7	67.0	62.4
Canterbury	61.4	65.2	51.1	47.6
Campbelltown	60.9	74.1	47.0	58.0
Camden	74.4	80.0	61.7	64.4
Wollondilly	70.6	76.4	65.4	61.9
Liverpool	61.3	72.0	46.2	53.9
Fairfield	54.4	64.0	42.2	44.6
Bankstown	60.6	65.3	45.7	47.0
Wingecarribee	62.0	66.9	45.9	52.0

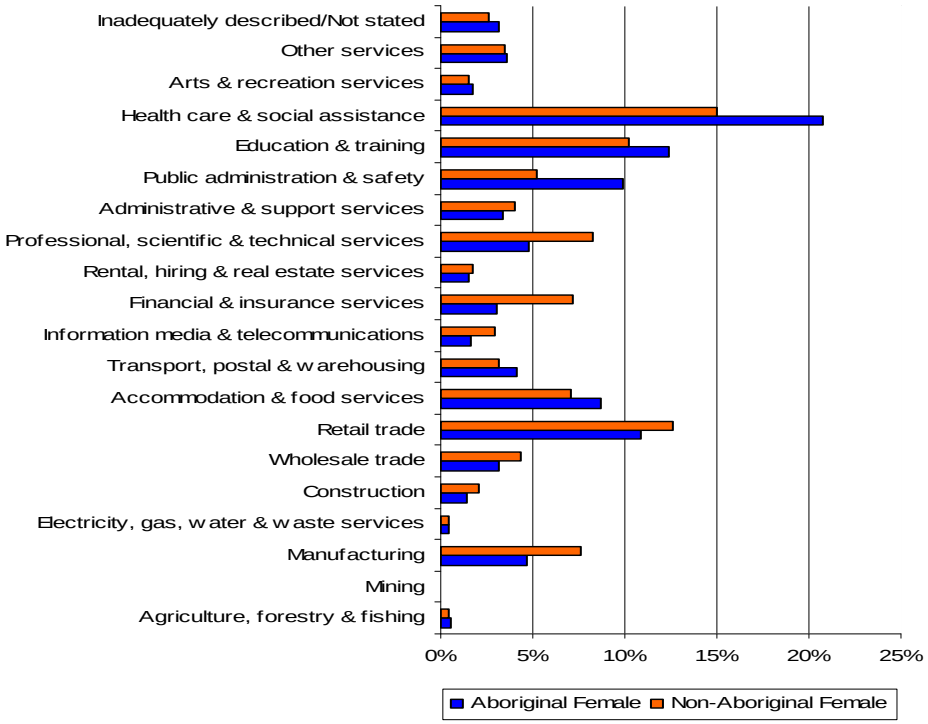
Generally, the disparity in labour force participation between Aboriginal and non-Aboriginal communities is higher for males than females. Within SSWAHS there are also disparities between Aboriginal and non-Aboriginal populations in the employing industries they work within. The following graphs show the % distribution of employed SSWAHS residents by Aboriginality and gender.

Figure 4.3 SSWAHS Mix of Employing Industries by Aboriginality – Males 2006



In terms of employment category mix, Aboriginal males resident in SSWAHS are more likely to be employed in public administration and safety, transport, postal and warehousing, health care and social assistance, than non-Aboriginal people. Aboriginal males are not strongly represented in professional, scientific and technical services or financial and insurance services and also have less % representation in retail and manufacturing.

Figure 4.4 SSWAHS Mix of Employing Industries by Aboriginality – Females 2006



In terms of employment category mix, Aboriginal females resident in SSWAHS are more likely to be employed in health care and social assistance, public administration and safety and education and training than non-Aboriginal people. Aboriginal females are not strongly represented in professional, scientific and technical services, financial and insurance services or information media and telecommunications and also have less % representation in retail and manufacturing.

Unemployment rates among Aboriginal males and females are higher than in the non-Aboriginal population seeking employment. Across NSW, TWT reports that the unemployment rate for males is 3.3 times the non-Aboriginal rate and the respective female comparison is 3 times the rate. Data for the Aboriginal and non-Aboriginal populations of SSWAHS LGAs is at Tables C.1.1 and C.1.2. TWT reports that the lowest unemployment rates among the Aboriginal population of NSW are in Coastal Sydney.

Unemployment rates for both Aboriginal and non-Aboriginal populations tend to be higher in the South West LGAs than the Inner West LGAs, although the disparity is higher for the non-Aboriginal population. In the Inner West, the unemployment rate for the Aboriginal population is a little more than 2½ times that of the non-Aboriginal population and in the South West the rate is a little less than 2½ times that of the non-Aboriginal population. The highest unemployment rates for the Aboriginal population are evident in the LGAs of Fairfield (22.3%), Campbelltown (19.5%), Sydney (19.0%), Bankstown (17.0%) and Wingecarribee (16.9%).

Likewise, using median household income as an indicator of economic prosperity, the average household income for both Aboriginal and non-Aboriginal populations tends to be higher in the Inner West compared to the South West LGAs, around 35% higher for non-Aboriginal populations, but only 13% higher for the Aboriginal population. The corollary to this is that in the South West non-Aboriginal household incomes are around 22% higher than Aboriginal household incomes, with the comparable figure for the Inner West being 46% higher. The lowest average household incomes for the Aboriginal populations are reported in Sydney ($598), Fairfield ($739), Campbelltown ($743), Wingecarribee ($750) and Leichhardt ($793).

Generating employment opportunities for Aboriginal people in the public sector is considered to be an important strategy to assist in raising overall levels of economic prosperity. *TWT* reports that at 30 June 2006 the proportion of Aboriginal people in the NSW public sector was 1.9%, with the comparable figure for the Australian Public Service being 1.7%. For SSWAHS the figure at 30 June 2006 was 1.3%. Historically the proportion identifying as Aboriginal in SSWAHS employ has been within the range 1.2% to 1.5%. The most recent target set by NSW Health is 2.4%.

TWT reports that by RCMG region, the lowest proportions of NSW public sector employees who identified as Aboriginal were in South Western Sydney (1.4%) and Coastal Sydney (1.5%).

Enhancing the employment opportunities for Aboriginal people within SSWAHS will be an important initiative to help address economic disadvantage and consequent impact on health disadvantage in Aboriginal communities (as well as more direct impacts in enhancing cultural safety, acceptability and access to services).

4.4 Justice

Justice is one of the seven priority areas identified under *Two Ways Together*, in recognition of the clear linkages between poor education levels, housing conditions, unemployment, family disruption, alcohol consumption, long term health problems and Aboriginal involvement in the criminal justice system. Two Ways Together emphasises that to address the underlying causes of offending behaviour requires a broad based, holistic response aimed at prevention and early intervention.

Government policy in respect to Aboriginal Justice issues is guided by the NSW Aboriginal Justice Plan, with leadership through the Attorney General's Department and associated bodies such as the NSW Aboriginal Justice Advisory Council. Health has a partnership role in addressing these issues as there are many strategic directions in the NSW Aboriginal Justice Plan requiring health actions e.g. in improving the quality of health services for pre-school and in-school children, youth and families and in creating safe households for Aboriginal children. Also, the consequences of contact with crime and the criminal justice system e.g. in terms of trauma, self-harm, psychological distress, disease transmission and risky health behaviours, come within the responsibility of Health.

Across NSW (and Australia) Aboriginal people are at much greater risk both of offending and of falling victim to crime.

TWT reports that Aboriginal people, particularly females, remain significantly over-represented among reported victims of sexual assault, domestic violence related assault and personal crimes. Aboriginal people, particularly males, remain overrepresented as victims of non-domestic assault. The Bureau of Crime Statistics has reported that Aboriginal people are between 2.7 times and 5.2 times more likely than residents of NSW as a whole to become victims of violent crime. Aboriginal women are between 2.2 times and 6.6 times more likely to become victims of violent offences than NSW women as a whole.

Aboriginal people are also over-represented generally among persons arrested by police. In New South Wales (NSW), the rate of Aboriginal appearance in court on criminal charges is 13 times that of non-Aboriginal people (Snowball & Weatherburn 2006). The rate of Aboriginal imprisonment in NSW is ten times that of non-Aboriginal people. The rates of court appearance and imprisonment for Aboriginal people are now higher than they were at the time of the Royal Commission into Aboriginal Deaths in Custody. The higher rate at which Aboriginal offenders are sent to prison stems mainly from a higher rate of conviction for violent crime and a higher rate of re-offending, particularly following the imposition of sanctions intended as alternatives to full-time imprisonment.

Studies have shown that Aboriginal people are far more likely to have been charged with, or imprisoned for, an offence if they abused drugs or alcohol, failed to complete Year 12 or were unemployed. Other factors that increase the risk of being charged or imprisoned include: experiencing financial stress, living in a crowded household and being a member of the 'stolen generation'.

There are currently over 9,200 people in jail in NSW on any one day. Over 18,000 individuals cycle through the NSW prison system each year. Males make up 92.7% of NSW prisoners (20% of the adult male prison population is Aboriginal) and women 7.3% (33% of the adult female prison population is Aboriginal). At the end of June 2005, there were 1,682 Aboriginal offenders in custody in full-time custody in NSW, accounting for 17.6% of the total offenders in custody and comprising more than 1 in 80 (1.25%) of the total NSW Aboriginal population (comparable figure is 0.12% of the non-Aboriginal population). This represents a decrease from 2003 when Aboriginal offenders in custody made up 21% of the offenders in custody. The largest proportion of the Aboriginal offenders in custody is aged 20-24 years (25.0%), while the most prevalent age group for non-Aboriginal prisoners is 25-29 years.

Offenders in custody engage in a range of health risk behaviours, such as smoking tobacco, consuming harmful or hazardous quantities of alcohol, and injecting drugs. In NSW in 2001, Aboriginal offenders in custody who had ever used illicit drugs represented 89.7% of the total Aboriginal offenders in custody, compared to 77.2% of the non-Aboriginal offenders in custody. Aboriginal offenders in custody who engaged in hazardous or harmful alcohol use represented 62.0 % of the Aboriginal offenders in custody compared to 38.5% of the non-Aboriginal offenders in custody. 82.1 % of Aboriginal offenders in custody were current smokers compared to 77.2% of non-Aboriginal offenders in custody.

Of the Aboriginal offenders in custody, 25.7% had a high cholesterol level compared with 30.6% of the non-Aboriginal population. Aboriginal offenders in custody with high blood pressure (19.7%) accounted for a similar proportion as the non-Aboriginal population (19.1%). However, a higher proportion of Aboriginal offenders in custody (7.0% compared with 5.1%) had high blood sugar level reflecting the higher prevalence of diabetes in the Aboriginal population.

For the prison population as a whole, the NSW Inmate Health Survey 2001 (Butler et al, 2001) found that 64% of adult women inmates and 40% of adult men had hepatitis C and over 80% had histories of alcohol or other drugs use. The 2003 NSW Young People in Custody Health Survey (NSW Department of Juvenile Justice, 2003) found hepatitis C prevalence of 8% among young male detainees and 18% among females. The Hepatitis C Council of NSW reports that young people under juvenile orders from NSW police have HCV prevalence rates of 5% and that young people in detention / under custodial orders have HCV prevalence rates of 9%. This can be compared to the broader Australian community HCV prevalence rate of between 1-2%.

There is little data available that isolates the experience of SSWAHS Aboriginal residents contact with the criminal justice system. Although only Berrima Correctional Centre and Reiby Juvenile Justice Centre are located within SSWAHS boundaries, the 2006 NSW Inmate Census (NSW Department of Corrective Services, 2006) showed that 20% of all inmates had a last known address within SSWAHS, including: Fairfield/Liverpool - 8.6%; Canterbury/Bankstown - 5.7%; Outer South Western Sydney - 4.0%; Inner Western Sydney - 1.6%. If these percentages hold for Aboriginal inmates, it would be likely that a significant number of Aboriginal inmates would gravitate to the Inner and South West of Sydney on release. In addition, there are a number of halfway houses for ex-prisoners in the Inner West of Sydney, run by a range of organisations including charities and private boarding house owners.

4.5 Families and Young People

Protecting and improving the wellbeing of families, children and young people is considered a critical aspect within TWT in achieving the State Plan priority goal of improving health, education and social outcomes for Aboriginal people.

The lead NSW Government agency responsible for protecting and promoting the wellbeing of families, children and young people is the NSW Department of Community Services (DoCS), through its responsibilities in child protection, support for children and young people who can no longer live at home, regulation of child care and pre-schools and community support for the homeless and families in transition to independent living. DoCS activities in these areas is guided by its *Aboriginal Child, Youth and Family Strategy*, which includes initiatives such as parenting programs, school/high school transition programs, leadership courses, supported playgroups, youth development programs and afterschool and school holiday programs. It also provides for the employment of Aboriginal family workers, Aboriginal youth development officers and the establishment of afterschool activities programs across NSW.

Health has a partnership role in supporting DoCS, in addition to the child, adolescent and family health services that it provides as core business. This includes providing casework, counselling, groupwork and therapeutic intervention on referral from DoCS, screening and identification of abuse including forensic medical work and health education, promotion and community development activities around these issues.

There is no quantitative data available that isolates the relative need of SSWAHS Aboriginal residents for service provision in these areas.

The Supported Accommodation Assistance Program (SAAP) provides accommodation and support services to help people who are homeless or at risk of becoming homeless, including families in crisis, single adults, young people and women and children affected by domestic violence. Across NSW in 2005/06, 13.5% of male SAAP clients and 20.9% of female SAAP clients identified as Aboriginal. In total 4,300 clients were recorded as Aboriginal. TWT reports that 23% of all clients who accessed SAAP services with children in 2005/06 were Aboriginal.

DoCS data on child protection activities do not normally provide a regional breakdown. It is known that for the overall NSW population over 70% of child protection reports received by DOCS are referred to a Community service centre (CSC) or Joint Investigative Response Team (JIRT) for further assessment. TWT reports that although Aboriginal children and young people comprise 4% of the total population in NSW, they account for 13.7% of all CSC/JIRT referrals.

4.6 Culture and Heritage

TWT recognises that culture and heritage are of central importance to Aboriginal communities. Strengthening community resilience and empowering communities to effect change are key underlying strategies at national, state and regional levels in addressing Aboriginal health disadvantage.

TWT aims to promote Aboriginal culture and heritage through initiatives in land management, access and use; reflecting heritage concerns of Aboriginal people in making planning and development considerations; and providing opportunities for Aboriginal people to learn, express and revive their culture.

TWT recognises that there is much work to be done to identify a way of measuring and reporting on the link between increased cultural strength and its contribution to addressing health disadvantage in Aboriginal communities.

Nationally, some data is available relating to cultural and heritage issues from the ABS National and Torres Strait Islander Social Survey 2002 (next survey scheduled for 2008). This survey included measures relating to culture and heritage such as:

- Culture and language — including main language spoken; Indigenous language fluency and participation in cultural activities.
- Family and community — including family context; social networks; removal from natural family; child care; and voluntary work.
- Information technology — including access to a working telephone; computer use; and internet use.
- Transport — including transport use; access; and perceived difficulties.

This data is available for NSW and broken down by residence in a remote or non-remote area (i.e. within reasonable road distance to an urban centre). For Aboriginal people in non-remote areas in NSW, the data indicates:

- 31.2% indicated that a person or relative had been removed from their natural family;
- 41.5% identified with a clan, tribal or language group;
- 22.3% currently lived in their homelands/traditional country;
- 57.8% had attended cultural events in last 12 months;
- 3.2% spoke an indigenous language;

- 8.6% cannot or often had difficulty getting to places needed;
- 62.8% had used a computer in last 12 months;
- 50.1% had accessed the internet in the last 12 months.

The NSW Health Survey also collects self reported data on some variables related to social capital and the degree of social connectedness which impact on considerations of culture and heritage. This data shows the following for SSWAHS Aboriginal residents and for the overall NSW Aboriginal population.

Self Reported Social Capital – SSWAHS & (NSW)

- **Participation in the Local Community –** 37.1% (56.4% across NSW) of Aboriginal adults had attended a local community event in the last 6 months, more females – 39.5% (61.9% across NSW) than males – 34.8% (50.5% across NSW) but with overall little rural/urban difference.
- **Feelings of trust** – 51.5% (60.6% across NSW) of Aboriginal adults agree that most people can be trusted, with more males – 58.9% than females – 41.6% (but no gender difference across NSW) – across NSW, Aboriginal adults aged 65–74 years were the most likely to agree that most people can be trusted.
- **Social reciprocity and neighbourhood connection** – 62.3% (69.7% across NSW) of Aboriginal adults had visited someone in their neighbourhood in the last week, more males – 79.5% (72.5% across NSW) than females – 39.0% (67.1% across NSW) and higher rates for rural residents (72.0 per cent) than urban residents (65.9 per cent).

Source: 2002-2005 Report on Adult Aboriginal Health from the NSW Population Health Survey

Census data at the LGA level can provide a regional break-up on very few of the variables of relevance to cultural and heritage considerations (see Tables C2.1 and C2.2). For example, for the South West LGAs, 56.6% of the Aboriginal population were living in the same address as 5 years ago and 49.9% were in the Inner West. These levels are marginally less than reported by the non-Aboriginal population. The % of the Aboriginal population living in a house with an internet connection was 47.9% in the South West (11.1% points less than for non-Aboriginal people) and 45.4% in the Inner West (20.0% points less than for non-Aboriginal people).

Provision of unpaid childcare may also be an indicator of family responsibilities and extended family connectedness. For the South West LGAs 33.1% of the Aboriginal population reported providing unpaid childcare (27.9% for the non-Aboriginal population) and in the Inner West 23.9% reported providing unpaid childcare (21.0% for the non-Aboriginal population).

4.7 Housing and infrastructure

TWT recognises that access to good quality, affordable and appropriate housing is an important contributor to health and wellbeing and can have a significant impact on social and economic participation.

The lead NSW Government agency responsible for improving the access of Aboriginal people to safe and sustainable housing and infrastructure is the NSW Department of Housing (DoH), including the NSW Aboriginal Housing Office (AHO), with responsibilities in providing and maintaining social housing, funding and supporting Aboriginal controlled organisations to provide housing and related services and in funding construction and maintenance of environmentally healthy infrastructure in Aboriginal communities.

Health has a partnership role in supporting DoH, in a range of activities such as in providing advice on environmental health and cross-agency work in the delivery of government services for homeless people, and improving coordination of services for people with complex needs.

Census data provides some indication of housing status for Aboriginal residents of SSWAHS (Tables C2.1 and C2.2). The average household size for households with an Aboriginal person resident is 3.3 in the South West (3.0 for non-Aboriginal households) and 2.6 in the Inner West (2.5 for non-Aboriginal households). A smaller proportion of Aboriginal people live in lone person households – 11.9% in the South West (17.7% for non-Aboriginal people) and 24.9% in the Inner West (28.0% for non-Aboriginal households).

Home ownership is one measure of economic prosperity that is linked to measures of social and health disadvantage. In the South West LGAs the percentage of households in rented accommodation for the Aboriginal population (58.8%) is more than double that of the non-Aboriginal population (27.6%). For the Inner West LGAs the disparity is less but still significant, at 73.0% for the Aboriginal population and 41.9% for the non-Aboriginal population, or 67% higher in the Aboriginal population.

5. Health Status of Aboriginal Communities in SSWAHS

The health status data on Aboriginal and Torres Strait Islander people presented in this chapter is derived from a variety of sources, including the NSW Chief Health Officer's Report, the NSW Health Survey and *TWT* Regional Reports on Western and South-Western Sydney and Coastal Sydney. Summary data on health status of the overall Aboriginal population at National and State level is included at Attachment D from AIHW and *TWT* sources. There is a limited amount of health status information available specific to the Aboriginal populations of SSWAHS; however, it is not considered that the health status of SSWAHS residents would differ significantly from the overall health status of urban Aboriginal populations in NSW.

The health status of Aboriginal populations in NSW is generally poorer than their non-Aboriginal counterparts across a range of measures. The following provides an indication of areas of significant disparity.

Summary of comparative health status data for Aboriginal people in NSW

- Aboriginal people are more likely to die at younger ages. People aged less than 25 years make up around 10% of deaths of Aboriginal people, compared with 2% of deaths among non-Aboriginal people. Deaths among those aged 65 years and over comprise around 41% of Aboriginal deaths, compared with 81% of non-Aboriginal deaths.
- The infant mortality rate for babies born to Aboriginal mothers at 7.5 per 1,000 births has been almost twice the rate for all NSW babies.
- The leading causes of death for Aboriginal people are the same as for non-Aboriginal people—cardiovascular disease and cancer. However, Aboriginal people are more than twice as likely as non-Aboriginal people to die as a result of diabetes or from injuries.
- Aboriginal people are approximately 1.7 times more likely to be admitted to hospital than non-Aboriginal people. Renal dialysis accounts for the largest number of hospitalisations for Aboriginal people. Compared with rates for non-Aboriginal people, hospitalisation rates for Aboriginal people in NSW are:
  - 140% higher for conditions for which hospitalisation can be avoided through prevention and early management;
  - 210% higher for diabetes;
  - 40% higher for cardiovascular diseases
  - 230% higher for chronic respiratory diseases;
  - 50% higher for injury and poisoning;
  - 240% higher for alcohol-related conditions.
- Lung cancer accounts for 14.9% of new cancer cases in Aboriginal people, compared with 9.0% in non-Aboriginal people, whilst cervical cancer comprises 5.8% of new cancer cases in Aboriginal women, more than 3.6 times the non-Aboriginal figure.
- Current smoking rates for Aboriginal adults are around double those for the general population across all age groups; while reported rates of risk drinking are around 1.4 times higher across all age groups.

Source: Chief Health Officers Report 2008, The Health of the People of NSW – Data Book – Aboriginal Peoples p.1

5.1 Headline Performance Domains from Area Performance Agreement

The SSWAHS Area Performance Agreement includes some indicators specific to Aboriginal populations which reflect priority areas of attention on Aboriginal Health by the NSW Government and where it is expected that AHS' can make an impact on improving the health of Aboriginal communities. The "Health on a Page" section of the 2008-09 SSWAHS Performance Agreement highlights Aboriginal Health initiatives under Strategic Directions and Current Priorities:

SD1 *Make prevention everybody's business* – Aboriginal Health Strategies including Aboriginal and Torres Strait Islander Health Performance Framework for Aboriginal Health, Two Ways Together, Smoke Check;

SD2 *Create better experiences for people using health services* - Aboriginal Chronic Care Program;

SD3 Strengthen primary health and continuing care in the community – Aboriginal Health strategies, including Aboriginal Maternal and Infant Health Strategy, Implementation of the Aboriginal Health Impact Statement, Otitis Media Screening Program for Aboriginal Children;

SD4 Build regional and other partnerships for health – Aboriginal Health strategies, including Partnership agreements, Families and Communities Cluster action plan, Commonwealth/State/ACCHS Health Forum, Aboriginal Drug and Alcohol Network.

Indicators within the Area Performance Agreement that measure performance for Aboriginal communities separate to the overall SSWAHS population include:

- Potentially avoidable deaths – persons aged <75 years;
- Avoidable hospital admissions - for conditions suitable for management in the home;
- Antenatal visits – confinements where first visit was before 20 weeks gestation;

- Low birth weight babies – weighing less than 2,500 grams;
- Aboriginal staff – as a proportion of total.

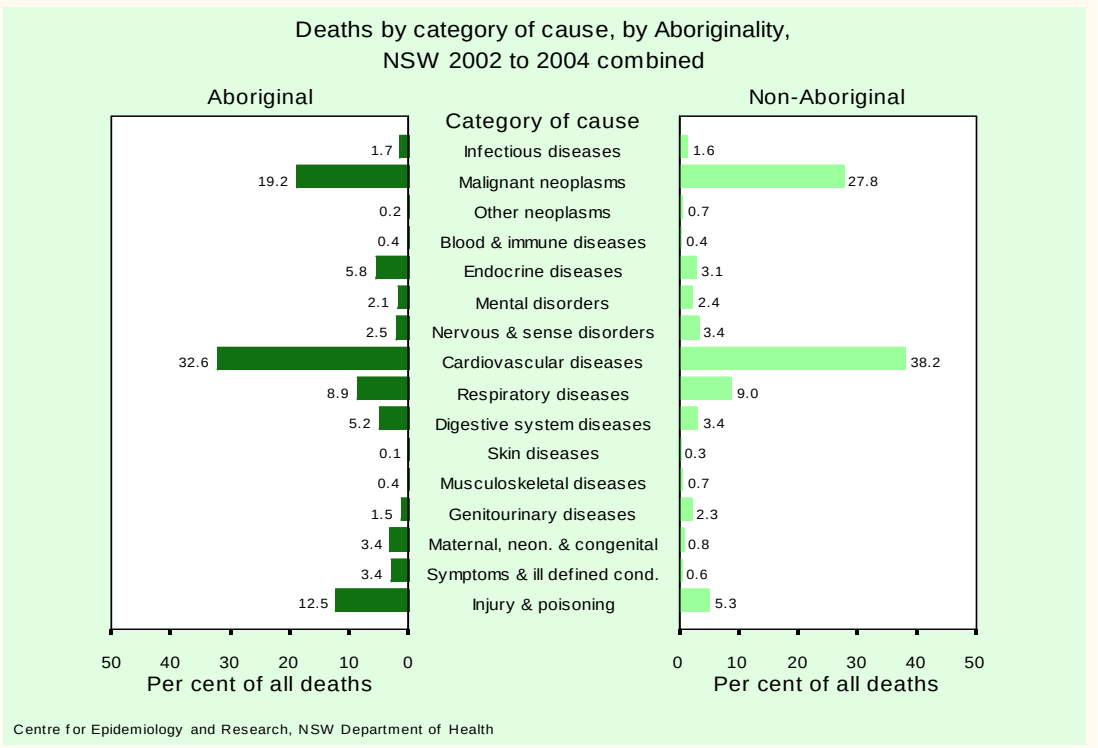
5.2. Mortality

The significant gap in life expectancy for Aboriginal communities compared to the Australian population as a whole is evident across Australia and in NSW is around 17 years for both males and females. Because of the long-standing issues pertaining to the identification of an Aboriginal person as the deceased on death certificates and the small sample size at regional level, regional life expectancy data is not produced, however, variations are considered unlikely among urban Aboriginal populations. The ABS estimates that data capture of Aboriginal deaths reflects a high level of coverage in the Northern Territory and to a lesser extent in Western Australia and South Australia, but that there appears to be substantial under coverage in New South Wales, Victoria and Queensland.

Causes of death

Data is not available at SSWAHS regional level, however, NSW data indicates a higher proportion of deaths in the Aboriginal population for endocrine diseases which includes diabetes (5.8% cf. 3.1%) and injury and poisoning (12.5% cf. 5.3%), digestive system diseases (5.2% cf. 3.4%) and maternal and neonatal and congenital diseases (3.4% cf. 0.8%). Although still the leading causes of death, there were a lower proportion of deaths attributable to cardiovascular diseases (32.6% cf. 38.2%) and malignant neoplasms (19.2% cf. 27.8%).

Figure 5.1 Causes of Death – Comparison of Aboriginal & Non-Aboriginal NSW Populations



Source: Report of the NSW Chief Health Officer 2006 (p. 109)

Potentially avoidable deaths

The CHO Report indicates that of premature deaths (<75 years) in NSW Aboriginal communities in 2004, more than three-quarters (76.4%) were potentially avoidable (i.e. could have been avoided given current understanding of causation, and available disease prevention and health care) compared to just over two-thirds (67.2%) of non-Aboriginal deaths. Between 1998 and 2004, rates of potentially avoidable premature death declined by 21.2% in non-Aboriginal people, but only 5.3% in Aboriginal people.

Cardiovascular diseases account for 33.2% of all potentially avoidable premature deaths of Aboriginal people, slightly higher than the 31.6% of non-Aboriginal deaths. Malignant neoplasms account for 16.4% of all potentially avoidable premature deaths of Aboriginal people but almost twice this percentage (34.2%) for non-Aboriginal people. Injuries, diabetes mellitus and neonatal causes all accounted for a higher proportion of potentially avoidable premature deaths in the Aboriginal population compared to the non-Aboriginal population.

Infant mortality

The infant mortality rate (no. of deaths < 1 year, per 1,000 live births) is an internationally recognised measure of population health. In NSW in the period 2002-04, the infant mortality rate for babies born to Aboriginal mothers was 8.5 per 1,000 births, almost twice the rate for NSW babies overall (4.6 per 1,000)(ABS, 2004).

The perinatal mortality rate (no. of stillbirths and deaths < 28 days, per 1,000 live births) in NSW in the period 2002-04, was 12.5 per 1,000 live births to Aboriginal mothers, compared to 8.7 per 1,000 live births to non-Aboriginal mothers. The 2005 data from the Midwives data collection shows a perinatal mortality rate across NSW of 15.2 per 1,000 live births, compared to 8.6 per 1,000 live births to non-Aboriginal mothers. There are less than 40 perinatal deaths p.a. to Aboriginal mothers across NSW, meaning that calculation of rates at AHS level would be at excessive margins of statistical error.

5.3 Early Years of Life

Antenatal Care

Ensuring children receive a healthy start to life commences before birth. Antenatal care monitors and promotes the health of both mothers and babies, identifies antenatal complications and enables early intervention where necessary. Good practice is for mothers to receive their first antenatal assessment prior to 20 weeks gestation.

In NSW in 2002-04, 69.5% of Aboriginal mothers attended their first antenatal visit before 20 weeks gestation, compared to 87.3% for non-Aboriginal mothers. The data for 2005 reports rates of 74.9% (63.0% for SSWAHS residents) for Aboriginal mothers and 88.0% (81.9% for SSWAHS residents) for non-Aboriginal mothers. The rate in SSWAHS is the lowest of all AHS for both Aboriginal and non-Aboriginal mothers and initiatives to improve the rate are included in the SSWAHS Maternity Services Plan 2008-2012. The NSW Aboriginal Maternal and Infant Health Strategy aims to bring the rates for Aboriginal mothers to parity with the general community.

Prematurity and Low Birthweight

Prematurity and low birth weight is associated with many neonatal problems and may sometimes be associated with long-term disabilities (NHMRC, 1997). Across NSW in 2004, the rate of low birth weight (<2,500 grams) in Aboriginal babies was 12.9% compared to 6.2% for non-Aboriginal babies and the rate of prematurity (<37 weeks) was 11.7% compared to 7.2% in non-Aboriginal babies.

For SSWAHS residents in 2005, the rate of low birth weight (<2,500 grams) in Aboriginal babies was 12.1% compared to 6.2% for all babies and the rate of prematurity (<37 weeks) was 13.7% compared to 6.72% for all babies.

Risk factors for low birth weight and prematurity include smoking in the second half of pregnancy and being a teenage (<20 years) or older (>35 years) mother. Across NSW, in 2004, 55.2% of Aboriginal mothers reported smoking in the second half of pregnancy, compared with 14.2% of non-Aboriginal mothers. The rate in SSWAHS is on parity with the State average. In the same year, 21.4% of Aboriginal mothers were teenagers, compared to 4% of non-Aboriginal mothers and 9.6% were aged >35 years, compared to 19.9% of non-Aboriginal mothers (Centre for Epidemiology and Research 2005).

Childhood Immunisation

The immunisation status of all Australian children under seven years of age is recorded within the Australian Childhood Immunisation Register (ACIR). Across NSW there appears to be only a marginal disparity in immunisation status associated with Aboriginality, with data at the end of December 2005 indicating 88% of Aboriginal children aged 12 - <15 months were fully immunised, compared to coverage for non-Aboriginal children of 91%. There is concern that delayed vaccination of Aboriginal infants may be an important contributor to higher rates of pertussis among Aboriginal infants. In SSWAHS the immunisation coverage rate reported at December 2005 was 89% for both Aboriginal and non-Aboriginal children.

Pertussis

Nationally, it is known that the notification rate for pertussis (whooping cough) for Aboriginal infants 0-4 years is almost twice that of non-Aboriginal infants. In NSW in the period 1993-94 to 2004-05, hospitalisation rates for pertussis were consistently higher among Aboriginal children aged less than 15 years compared with non-Aboriginal children, with most of the children hospitalised for pertussis aged 0-4 years. However, the absolute numbers of patients are very small with 16 being the highest annual tally since 1993-94 of Aboriginal infants hospitalised.

Otitis Media

Repetitive unresolved episodes of otitis media (middle ear infection commonly a sequelae of upper respiratory tract infection) can lead to perforations of the ear drum, hearing loss, and particularly with younger children delayed speech development, reduced learning ability and reduced social interaction. Nationally, the prevalence of otitis media in Aboriginal communities is significantly higher than in non-Aboriginal communities, particularly in rural and remote localities. The NSW Health Otitis Media Screening Program for 0-6 year old Aboriginal children addresses this health disadvantage.

Respiratory Disease

Infants and children under 5 years of age are more susceptible to developing respiratory conditions due to factors like low levels of hand and face washing, and of childhood immunisation, parental smoking, poor nutrition (including aspects related to infant-feeding and weaning practices), and poor environmental conditions.

Oral Health in Childhood

Nationally, compared to the overall Australian population, it has been reported that Aboriginal children generally have more than twice the caries experience and a greater proportion of untreated caries. The NSW Child Dental Health Survey indicates that across NSW, 33.2% of Aboriginal children 5-12 years had no caries experience compared to 51.6% of non-Aboriginal children; the SSWAHS data with a small sample size for Aboriginal children shows a ratio of 27.3% to 53.1% respectively.

5.4 Diseases of Adulthood

Vascular Diseases - Cardiovascular

The CHO report 2006 indicates that In NSW in 2004-05, the age-adjusted hospitalisation rate for cardiovascular diseases for Aboriginal people was 1.5 times (1.6 times for males; 1.3 times for females) the rate for non-Aboriginal people. Aboriginal hospitalisation rates for cardiovascular disease increased by 33% between 1993-94 and 2004-05, while the non-Aboriginal rate decreased by 12% over this period. This is thought to partly reflect an improvement in the recording of Aboriginality in hospital data over this period. Data on hospitalisation for cardiovascular related ESRGs for Aboriginal and non-Aboriginal residents of SSWAHS are outlined at Attachment E. This data is not age standardised to account for the significant variation in age structures between Aboriginal and non-Aboriginal communities, so does not take account of the impact of ageing on the risk of hospital admission for cardiovascular disease. Some indication of the disparity in rates of hospitalisation for vascular syndrome related diseases for SSWAHS populations can seen by confining analysis to adults aged 40-65, as at Table 5.1.

Table 5.1 Hospitalisation for Vascular Disease Related ESRGs – SSWAHS Residents Aged 40-65

ESRG		Aboriginal and/or Torres Strait Islander				Non Aboriginal 2006-07	Per 100,000 Non Aboriginal pop
		2004-05	2005-06	2006-07	Per 100,000 Aboriginal pop		
111	Chest Pain	44	40	35	1,367.82	2787	706.00
112	Unstable Angina	4	7	4	172.41	293	74.22
113	Heart Failure and Shock	4	8	4	183.91	249	63.08
114	Non-Major Arrhythmia and Conduction	6	3	8	195.40	643	162.88
115	AMI W/O Invasive Cardiac Inves Proc	6	10	3	218.39	384	97.27
119	Other Cardiology	11	9	14	390.80	726	183.91
121	Invasive Cardiac Inves Proc	11	18	17	528.74	1087	275.36
122	Percutaneous Coronary Angioplasty	13	17	7	425.29	786	199.11
129	Other Interventional Cardiology	2	1	1	45.98	123	31.16
141	Diabetes	5	10	3	206.90	280	70.93
211	Stroke	10	1	5	183.91	343	86.89
212	TIA	0	1	2	34.48	164	41.54
221	Renal Failure	0	1	0	11.49	105	26.60
229	Other Renal Medicine	3	9	7	218.39	485	122.86
231	Renal Dialysis	394	246	384	11,770.11	20778	5,263.45
421	Coronary Bypass	3	2	4	103.45	169	42.81
429	Other Cardiothoracic Surgery	4	0	1	57.47	180	45.60
Total Vascular Related ESRGs		**520**	**383**	**499**	**16,114.94**	**29582**	**7,493.67**

This table suggests hospitalisation rates (in public hospitals) for vascular syndrome related ESRGs among the adult Aboriginal populations of SSWAHS aged 40-65 that are in total, over double that of the comparable non-Aboriginal adult population. This differential holds across the majority of the ESRGs.

Diabetes

The NSW Population Health Survey (2002-05) indicates that 10.6% of Aboriginal people aged 16 years and over report having diabetes or high blood sugar, compared to 7.6% of NSW adults overall in 2005. Among Aboriginal people, diabetes or high blood sugar increases with age from 4.5% in the 16-24 year age group (3.0% in general population) to 27.9% in the 65-74 year age group (16.8% in general population). Diabetes prevalence is reported as much higher among rural compared to urban Aboriginal populations. For SSWAHS residents 6.5% of Aboriginal people aged 16+ report having diabetes or high blood sugar, compared to an average figure of 6.1% of SSWAHS adults for 2007. For adults aged 40-65, hospitalisation rates for diabetes in the SSWAHS Aboriginal population are over double that of the comparable non-Aboriginal adult population (Table 5.1)

Renal Disease

It is known that kidney damage, indicated by protein in the urine, is common among Aboriginal Australians and that many are at risk of progressing to chronic kidney disease (CKD) and end-stage renal disease. Across Australia, it is estimated that incidence rates of treated end-stage kidney disease in Aboriginal populations, adjusted for age and sex, are eight times the rate observed for non-Aboriginal populations. There are significant regional variations in rates, from double those of the non-Aboriginal population in the capital cities of Brisbane and Sydney, to 30 times the rate in both tropical and desert areas of the Northern Territory and Western Australia. Differentials in rates are particularly marked at ages 45–54 years and 55–64 years.

The excess burden of ESKD in Aboriginal communities is thought to reflect greater prevalence of traditional risk factors, in particular diabetes and high blood pressure, as well as poor nutrition, high rates of smoking, alcohol abuse and streptococcal skin and throat infections. Strong statistical associations with regional ESKD incidence have been demonstrated for social and economic characteristics such as education level, unemployment rate, income, house crowding and proportion of births less than 2500g.

Between 2001 and 2003, 9% of new patients registered with ANZDATA in Australia identified as Aboriginal, a much higher proportion than Aboriginal representation in the total population (2.4%). The majority of new Aboriginal patients between 2001 and 2003 were receiving dialysis, with only 52 transplants performed in Aboriginal people (10% of new Aboriginal patients). In contrast, 30% of new non-Aboriginal patients during this period received kidney transplants. This is thought to partly reflect the lower number of donors compatible with Aboriginal patients and the generally poorer health status of Aboriginal patients making them less suitable candidates for transplant. For those Aboriginal patients who do receive a transplant, there is generally a poorer survival rate than for non-Aboriginal recipients.

Risk Factors for Vascular Diseases

Some behavioural risk factors for vascular disease are more prevalent in the Aboriginal population than the non-Aboriginal population. These include tobacco smoking, physical inactivity, poor diet and heavy alcohol consumption. The 2004-05 National Aboriginal and Torres Strait Islander Health Survey reported that Aboriginal adults aged 15 years and over were more likely than their non-Aboriginal counterparts to be classified as overweight or obese (64.4% compared with 51.4%); Aboriginal adults aged 18 years and over were more than twice as likely as their non-Aboriginal counterparts to be current smokers (47.6% compared with 20.8%); and 79% of Aboriginal adults living in non-remote areas reported their levels of exercise as either sedentary or low (ABS, 2006).

The NSW Population Health Survey (2002-05) reports on a range of self-reported health behaviours that impact on risk of developing vascular disease. The following table shows the reported prevalence of behaviours for adults aged 16+, for Aboriginal (2002-05) and total (2001-2006) populations of SSWAHS and NSW.

Table 5.2 Prevalence of Risk Behaviours for Vascular Disease

Risk Behaviour (%)	SSWAHS						NSW					
	Aboriginal			Total Population			Aboriginal			Total Population		
	M	F	All	M	F	All	M	F	All	M	F	All
Risk Alcohol Drinking	47.9	32.2	40.7	30.0	26.9	28.4	54.2	37.8	45.9	37.3	28.4	32.8
High Risk Alcohol Drinking	41.1	18.9	32.3	11.3	7.4	9.3	35.6	21.0	29.2	12.5	6.5	9.5
Adequate Physical Activity	76.8	37.1	57.6	55.1	49.7	52.4	58.0	45.6	51.6	60.4	49.6	54.9
Current or Occasional Smoking	55.6	39.3	47.7	17.8	18.5	18.2	44.7	41.8	43.2	19.2	16.2	17.7

This data would indicate scope to address in particular the higher prevalence of high risk alcohol drinking and smoking among Aboriginal males in SSWAHS, compared to both their non-Aboriginal counterparts in SSWAHS and across NSW and other Aboriginal males in NSW. For Aboriginal females in SSWAHS there is a considerably

lower prevalence of adequate physical exercise, compared to both their non-Aboriginal counterparts in SSWAHS and across NSW and other Aboriginal females in NSW.

The NSW Aboriginal Vascular Health Program works in collaboration with Area Health Services and Aboriginal Community Controlled Health Services to prevent and manage conditions including diabetes, heart disease, stroke, hypertension and kidney disease among Aboriginal people.

Ambulatory care sensitive conditions

Ambulatory care sensitive conditions are those for which a hospital stay could be avoided through preventive care and early disease management provided in primary care and include vaccine-preventable (e.g. influenza, bacterial pneumonia, tetanus, measles, mumps, rubella, pertussis and polio), acute (e.g. dehydration and gastroenteritis, kidney infection, perforated ulcer, cellulitis, pelvic inflammatory disease, ear nose and throat infections, dental conditions, appendicitis, convulsions and epilepsy, and gangrene) and chronic (diabetes complications, asthma, angina, hypertension, congestive heart failure, chronic obstructive pulmonary disease, and iron deficiency anaemia and nutritional deficiencies) conditions.

In NSW over the period 1991-92 to 2004-05, rates of hospitalisation for ambulatory care sensitive conditions were consistently more than double those for non-Aboriginal people, both overall and across the vaccine-preventable, acute and chronic categories.

The SSWAHS Performance agreement includes a target to reduce the number of avoidable hospital admissions for both Aboriginal and non-Aboriginal populations. Avoidable admissions are defined as cellulitis; deep vein thrombosis; community-acquired pneumonia; urinary tract infections; certain chronic respiratory disorders such as emphysema and chronic obstructive pulmonary disorder; bronchitis and asthma; certain blood disorders such as anaemia; and musculo-tendinous disorders such as acute back pain. A list of ANDRGs have been developed covering these conditions. The following table outlines separations from hospital for Aboriginal and non-Aboriginal residents of SSWAHS over the five year period to 2007-08 and the rate per head of estimated population as at 2006.

Table 5.3 Avoidable Hospital Admissions 2003-04 to 2007-08

ANDRG		Aboriginal and/or Torres Strait Islander						Non Aboriginal 2007-08	Per 100,000 Non Aboriginal pop
		2003-04	2004-05	2005-06	2006-07	2007-08	Per 100,000 Aboriginal pop		
J646B	Cellulitis (Age >59 W/O Cat or Severe	29	37	34	57	60	308.24	2086	155.40
E69C	Bronchitis and Asthma Age <50 W/O	31	30	40	29	26	221.59	1705	127.02
E62C	Respiratory Infections/Inflammations	18	13	17	16	14	110.80	1387	103.33
E65B	Chronic Obstructive Airways Disease	18	21	16	14	27	136.36	1244	92.68
Q61C	Red Blood Cell Disorders W/O Cat or	8	13	11	12	8	73.86	2412	179.69
L67C	Other Kidney & Urinary Tract Diag W/O	1	3	9	8	7	39.77	1121	83.51
I71C	Other Musculotendinous Disorders Age	4	2	3	5	1	21.31	160	11.92
F63B	Venous Thrombosis W/O Cat or Severe	1	3	4	1	2	15.63	268	19.97
Total Vascular Related ESRGs		**110**	**122**	**134**	**142**	**145**	**927.56**	**10383**	**773.51**

Although overall the hospitalisation rate (not age standardised) for the Aboriginal population of SSWAHS is only 17% higher than non-Aboriginal population, a higher differential is evident for cellulitis and bronchitis and asthma.

Respiratory Disease

Respiratory diseases represent a significant burden of ill-health in Aboriginal populations, at all parts of the age spectrum. Contributing factors include poor environmental conditions, socioeconomic disadvantage, risky behaviour (particularly cigarette smoking), and pre and co-morbid conditions. Among adults, common risk factors include tobacco smoking, use of alcohol and other substances, diabetes mellitus and chronic renal disease.

Acute communicable respiratory illnesses, including upper respiratory infections, influenza and pneumonia remain a major health problem for Aboriginal people. In NSW in 2004-05, the hospitalisation rate for acute respiratory infections among Aboriginal people was approximately twice that of non-Aboriginal people and is reported to have increased from the previous year.

Aboriginal populations are also at greater risk of developing chronic respiratory diseases. In NSW for the period 1993-94 to 2004-05, age-adjusted hospitalisation rates for chronic respiratory diseases were around three

times higher than for non-Aboriginal people and rates have been reported to be increasing. Cigarette smoking is the most important risk factor for COPD.

As indicated at table 5.2, for SSWAHS residents, for the period 2004-05 to 2006-07, the hospitalisation rates for acute and chronic respiratory disease (ESRGs 241, 242, 243 and 249) for Aboriginal people aged 40-65, were overall about 2/3 higher than for the comparable non-Aboriginal cohort.

Table 5.4 Hospitalisation for Respiratory Disease Related ESRGs – SSWAHS Residents Aged 40-65

ESRG		Aboriginal and/or Torres Strait Islander				Non Aboriginal 2006-07	Per 100,000 Non Aboriginal pop
		2004-05	2005-06	2006-07	Per 100,000 Aboriginal pop		
241	Bronchitis and Asthma	5	2	5	137.93	280	70.93
242	Chronic Obstructive Airways Disease	20	12	20	597.70	621	157.31
243	Respiratory	8	14	19	471.26	521	131.98
249	Other Respiratory Medicine	8	7	11	298.85	800	202.65
Total Respiratory Related ESRGs		**41**	**35**	**55**	**1,505.75**	**2222**	**562.87**

Asthma rates have been collected in the NSW Population Health Survey. For the period 2002-05, for Aboriginal adults aged 16+ resident in SSWAHS, 23.3% reported current asthma, with a much higher rate in females (29.4%) than males (17.6%). These rates are the highest reported of any AHS. The comparable figure for the whole population of SSWAHS is 7.3%, with much less variation between females (7.8%) and males (6.8%) and rates considerably less than the state average (10.55 overall). Statewide the disparity in rates associated with Aboriginality is most evident in young adults aged 16-24 years, and those aged 45 years and over.

The National Aboriginal Pneumococcal and Influenza Immunisation Program provides free vaccines to Aboriginal people to protect them from communicable respiratory illnesses, pneumococcal disease and influenza. The NSW Aboriginal Chronic Conditions Area Health Service Standards aim to optimize the accessibility and appropriateness of health services and programs for the prevention and management of chronic conditions, including chronic respiratory conditions.

Cancer

The impact of cancer on Aboriginal populations is under recognised, because the level of identification of Aboriginal people in cancer notifications has only recently been improving from a poor baseline and also because often population impact is reported in terms of the proportions of deaths caused rather than rates. It is known that some cancers occur as a direct result of smoking (in particular, lung cancer), dietary influences (especially cancers of the digestive system), infectious agents (especially cervical cancer through exposure to the human papilloma virus) or exposure to radiation (especially melanomas through excessive sun exposure). Other cancers may be a result of an inherited genetic predisposition (for example, prostate and breast cancer are higher for persons with a family history of these cancers).

However, the greatest risk factor for most cancers in the general population is advancing age, with the median age of first diagnosis for all cancers being 69 years for men and 65 years for women. The disparity in age structures between Aboriginal and non-Aboriginal populations can therefore be seen as explaining the findings of most studies that incidence rates of cancer for Aboriginal people are slightly lower than those for non-Aboriginal people. However recent work from AIHW indicates that across Australia, the comparison varies significantly by cancer type.

Among the most common cancers, age standardised incidence, even with known under-reporting, was higher among Aboriginal males and females for lung cancer, cancers of the mouth and throat and cancer of unknown primary site. The rates for cervical cancer among Aboriginal women were more than double those for non-Aboriginal women. Incidence was lower among Aboriginal people for colorectal cancer, prostate cancer and lymphomas. High incidence of cancers of the lung, mouth and throat are caused by high rates of smoking earlier in life, while high cervical cancer incidence is preventable by early detection in Pap test screening. High incidence of cancer of unknown primary site is likely to be associated with late diagnosis.

Among the less common cancers, age standardised incidence was also higher in the period 2000–2004 for the Aboriginal population than for the non-Aboriginal population for cancers of the liver and gallbladder, pancreatic cancer, cancer of the oesophagus, and, in males only, thyroid cancer.

Although for the general population cancer survival in NSW is amongst the highest in the world, with 2/3 of people diagnosed with cancer living for five years or longer, it is known that for Aboriginal people, mortality rates from cancer are generally higher. NSW Cancer Council research has found that the overall mortality from cancer in Aboriginal people is 60% higher than that of non-Aboriginal people. For some specific cancer sites the

mortality rates are more than three times that of non-Aboriginal people. Reasons advanced for this include the high rate of cigarette use (smoking related cancers generally have a poor prognosis), low participation in population-based cancer screening programs difficulties in accessing transport to medical treatment and lack of culturally-appropriate general health care, hospital care and palliative care.

Although cancer incidence data for the Aboriginal population of SSWAHS is not known, it is possible to examine rates of hospitalisation where a primary cancer has been noted in the medical record. As indicated at table 5.3, for SSWAHS residents, for the period 2004-05 to 2006-07, the hospitalisation rates for cancer related SRGs for Aboriginal people aged 40-65, were overall about 22% less than for the comparable non-Aboriginal cohort. At the SRG level the numbers reported for the Aboriginal population are very small and would be subject to high statistical error levels, however, they do suggest there may be higher rates of hospitalisation for respiratory medicine and lower rates for palliative care, with rates close to parity for medical oncology and haematology.

Table 5.5 Hospitalisation for Cancer Related SRGs – SSWAHS Residents Aged 40-65

SRG		Aboriginal and/or Torres Strait Islander				Non Aboriginal 2006-07	Per 100,000 Non Aboriginal pop
		2004-05	2005-06	2006-07	Per 100,000 Aboriginal pop		
24	Respiratory Medicine	1	0	11	137.93	182	46.10
19	Medical Oncology	7	5	8	229.89	869	220.13
17	Haematology	2	5	7	160.92	659	166.94
86	Palliative Care	0	4	2	68.97	486	123.11
22	Renal Medicine	1	0	3	45.98	53	13.43
	Other SRGs	14	5	14	379.31	2961	750.08
Total SRGs		**25**	**19**	**45**	**1,022.99**	**5210**	**1,319.79**

Mental Health

Data specific to the Aboriginal populations of SSWAHS has recently been analysed by the SSWAHS Population Health Directorate's Research, Evidence, Management & Surveillance (REMS) Unit (in print). This preliminary data indicates that in 2007-08, for SSWAHS Aboriginal males, the hospitalisation rate for mental disorders was 2.6 times higher than for non-Aboriginal males; and that for Aboriginal females, the rate was 2.2 times higher than for non-Aboriginal females. For the period 2003/04 – 2007/08, hospitalisation rates for intentional self-harm (includes attempted suicide and purposely self-inflicted poisoning or injury) for SSWAHS Aboriginal males were 4 times higher than for non-Aboriginal males; with the comparable rate for SSWAHS Aboriginal females being 3 times higher than for non-Aboriginal females.

5.5 Self Reported Health Status

Data is available through the NSW Health Survey and other sources on self reported health status of Aboriginal populations. The sample size for Aboriginal respondents is insufficient to allow statistically valid data to be reported at a regional level. The following outlines key self-reported health status data for the NSW Aboriginal population as a whole.

Self Reported Health Status of Aboriginal people

- **Overall health** – 76.3 per cent of Aboriginal adults rated their health positively, with no gender or urban/rural difference and with younger and older Aboriginal adults rating their health positively.
- **Asthma** - 16.2 per cent of Aboriginal adults currently have asthma, with rates twice as high in females (20.4 per cent) as males (11.8 per cent), highest in young women (31.7 per cent) and older women (22.6 to 31.0 per cent) and higher in urban areas (17.1 per cent) than rural areas (15.7 per cent).
- **Diabetes or high blood glucose** - 10.6 per cent of Aboriginal adults have diabetes or high blood glucose, with no gender difference, increasing rates with age from 4.5 per cent in the 16–24 year age group to 26.2 per cent in the 65+ age group and higher rates for rural residents (13.9 per cent) than urban residents (5.5 per cent).
- **Oral health** – 4.2 per cent of Aboriginal adults reported having all of their natural teeth missing, with no gender or urban/rural difference and increasing rates of all natural teeth missing from 0 per cent in the 16–24 year age group to 28.5 per cent in the 65+ age group.
- **Overweight and obesity** - 55.3 per cent of Aboriginal adults were overweight or obese, with no gender difference, increasing rates with age from 30.0 per cent in the 16-24 year age group to 69.5 per cent in the 55–64 year age group and higher rates for rural residents (58.0 per cent) than urban residents (51.1 per cent).
- **Psychological distress** - 23.8 per cent of Aboriginal adults reported high or very high levels of psychological distress, more females (26.8 per cent) than males (20.5 per cent) and higher rates in rural residents (24.4 per cent) than urban residents (22.6 per cent), with increasing rates with age, peaking in the 35–44 year age group (34.9 per cent) before declining in older age groups.

Source: 2002-2005 Report on Adult Aboriginal Health from the NSW Population Health Survey

The NSW Health Survey also provides self reported data on health risk behaviours.

Self Reported Health Risk Behaviours among Aboriginal people

- **Nutrition** - 37.2 per cent of Aboriginal adults consumed the recommended daily intake of fruit (2 serves or more), more females (40.6 per cent) than males (33.6 per cent); 10.2 per cent consumed the recommended daily intake of vegetables (5 serves or more), more females (14.6 per cent) than males, higher for urban residents (12.7 per cent) than rural residents (8.6 per cent); 15.1 per cent of Aboriginal adults had run out of food in the last 12 months and could not afford to buy more.
- **Physical activity** - 51.6 per cent of Aboriginal adults undertook adequate levels of physical activity, more males (58.0 per cent) than females (45.6 per cent) and higher for urban residents (55.5 per cent) than rural residents (49.3 per cent).
- **Smoking** - 43.2 per cent of Aboriginal adults were current smokers, with no gender difference and the highest rates in young adults, particularly young men aged 16–24 years (58.9 per cent) and higher for rural residents (44.4 per cent) than urban residents (41.2 per cent); 69.4 per cent of Aboriginal adults live in a smoke-free home.
- **Immunisation** - 44.9 per cent of Aboriginal adults aged 50 years and over had an influenza vaccination in the last 12 months, with no gender difference, proportions increasing with age and higher in rural areas (48.1 per cent) than urban areas (45.4 per cent). 20.6 per cent of Aboriginal adults aged 50 years and over had a pneumococcal vaccination in the last 5 years, with no gender or urban/rural difference and proportions increasing with age.

Source: 2002-2005 Report on Adult Aboriginal Health from the NSW Population Health Survey

Anecdotally, it is reported that smoking rates within some Aboriginal communities of SSWAHS are higher than those reported overall for NSW.

6. Services Used By the Aboriginal Populations of SSWAHS

The Aboriginal communities of SSWAHS have access to the full range of mainstream health care services offered within the public health system including acute, sub and non acute hospitalisation; outpatient and ambulatory care outreaching from hospital campuses; community based health services including those offered in specialised areas such as chronic diseases, mental health, drug health, sexual health, oral health and palliative care; and population health including health promotion and the public health unit.

In addition to mainstream services, SSWAHS offers a number of services targeted specifically to Aboriginal communities, with in most instances Aboriginal Health Workers (AHW) having a key role in service provision, policy development, planning and liaison with mainstream services. Sometimes this will also involve a degree of case management like activities to facilitate holistic health provision. AHWs operate both within specialty clinical services and also in a more generic support role to Aboriginal communities.

SSWAHS Aboriginal communities have their primary care medical needs met through either ACCHS' at Redfern and Tharawal or through private sector general practitioners.

Data Quality

There is variation among services as to the degree that they are able to capture Aboriginality as an identifier within client registration systems and in reporting activity. It is well known that across Australia, data collected at the point of service delivery may undercount Aboriginality, because of a lack of understanding about why the Aboriginality question is being asked, reluctance on the part of some staff to ask the question and/or reluctance on the part of some clients to identify themselves as Aboriginal. This undercounting applies to varying degrees across data sets such as hospital separations, cancer registrations, general practice, community mental health services, alcohol and other drug treatment services, juvenile justice, children protection, disability services, aged care and housing assistance services.

Some work has been done to estimate the degree of under reporting. For birth registrations the ABS has compared the number registered (in which at least one parent was Indigenous) with the number expected, using low-series experimental Indigenous population estimates/projections and a constant set of age-specific fertility and paternity rates (see ABS 2004b, 2004d). This analysis estimated that for the period 1998–2003 in NSW, registered Aboriginal births represented 85.4% of the expected Aboriginal births. The CHO Report 2006 reports an estimate for 2003, that of all babies born to Aboriginal mothers, only 67% were recorded as having an Aboriginal mother.

For deaths, comparison of the number of registered deaths with the expected number of deaths, using a life table, for 1999-2003 in NSW, indicates implied coverage of only 45%. For communicable disease notifications for the National Notifiable Disease Surveillance System (NNDSS), work in 2004 suggested a completeness rate in NSW of only 21% for identification of Aboriginality. For cancer registration, the Northern Territory registry has reported that approximately 18% of Indigenous cases remained incorrectly recorded as non-Indigenous.

For hospital statistics, based on a range of information, including data quality assessments sought from health authorities, the AIHW used factors to adjust for under-identification of separations for Indigenous patients for use in its report on health expenditure for Indigenous people for 2001–02 (AIHW 2005b). The factors were New South Wales, 30%; Victoria, 25%; Queensland, 20%; Western Australia, 6%; and the Australian Capital Territory, 30%. (adjustment was deemed unnecessary for the South Australia and Northern Territory data, and no factor was provided for the Tasmania data.) The issue relates to under-reporting as non-reporting of Indigenous status has since 1996–97 been recorded in NSW as only about 0.5–0.7% of separations at public hospitals and about 0.1% of separations at private hospitals

Survey methodology is generally considered the 'gold standard' for assessment of the quality of Aboriginal identification in hospital records as it is believed that more accurate information is collected at interview as a result of well-trained interviewers asking each patient's Indigenous status strictly in accord with the standard ABS question, as opposed to other practices that might be used as part of patient admission procedures. Generally, NSW hospitals have not been well covered in surveys; however, the two largest surveys undertaken (11 hospitals in 5 jurisdictions and 26 hospitals in WA) have suggested 85%-86% correct identification.

NSW Health has conducted assessments based on the linking of individual patients within annual sets of data from its hospital separations data collection. Results for 1997–98 suggested that Aboriginality was incorrectly specified for 12% of admissions of Aboriginal people. This study also found that under-identification was much

higher at hospitals in metropolitan areas (where the proportion of the population that is Aboriginal is relatively low) than in the remote areas (where it is relatively high).

Aboriginal Use of Mainstream Health Services

Aboriginality is collected as an identifier across most of the data registration systems in use within mainstream public funded health services available within SSWAHS. Previous comments regarding the varying degree of undercounting of Aboriginality within these data systems apply. The data available cannot be construed to provide an indication of the relative degree of access of Aboriginal communities to mainstream services. Issues of access to health services for Aboriginal communities are discussed in Volume 2. Disparities in the demographic and socioeconomic profile between Aboriginal and non-Aboriginal communities create differing needs among populations for health care services. The following table gives an indication of the quantity and proportion of mainstream service activity where the client has identified at registration as Aboriginal. Where available, an estimate is given of the degree of capture of Aboriginality within the data system.

Table 6.1 Data on Aboriginal Usage of Mainstream SSWAHS Services

Collection	Data Item	Period	No. Aboriginal	No. Non-Aboriginal	% Aboriginal	Estimated % data capture
Admitted Patients	All separations from public hospitals for SSWAHS residents.	2007-08	3,891	294,197	1.31%	85%
	Separations from designated psychiatric units for SSWAHS residents.	2007-08	253	6,964	3.50%	85%
	Sub & Non-acute separations from public hospitals for SSWAHS residents[1].	2007-08	38	8,551	0.44%	85%
Emergency Departments	Presentations to Emergency Departments	2007-08 Canterbury RPAH Concord Camden Fairfield Liverpool Campbelltown Bankstown Bowral **SSWAHS Total**	 222 1,722 70 80 177 792 1,329 197 337 **4,976**	 32,169 58,853 30,511 10,810 31,703 59,434 47,400 42,159 17,913 **330,952**	 0.7% 2.9% 0.2% 0.7% 0.6% 1.3% 2.7% 0.5% 1.8% **1.5%**	Unknown
NSW Midwives Data Collection	SSWAHS resident mothers giving birth	2005	181	19,532	0.92%	43.6%[2]
Community Health and Outpatient Care	As identified in *Community Health at the Crossroads* (2008) documentation, current community health information systems are inadequately structured to provide accurate data on service usage by Aboriginal populations. Within SWAHS Cerner applications are progressively being introduced starting with community nursing, which will provide the basis for SSWAHS contribution to the NSW Community Health and Outpatient Care Data Collection (CHOCIP) . Data in areas such as Early Childhood nursing is yet to be incorporated.					
Aged Care Assessment Program	Accepted referrals for ACAT assessment by SSWAHS teams	2006-07	76	13,900	0.54%	Unknown
Drug Health	Drug Health Minimum Data Set	07 & 08 calendar 08/09 financial Residential[3] (08/09)	527 25	6,766 684	7% (07/08) 8% (08/09) 4% (08/09)	Suspected underreported
AN_SNAP	Interrogation of the SSWAHS Australian National Sub-Acute and Non-Acute Patient (AN-SNAP) Classification data collection suggested data quality issues with identification of Aboriginality. Only one client (with multiple visits) was identified as Aboriginal in the most recent summary report. Underreporting is suspected.					
SHIP	Clinical occasions of service provided through HARP funded services.	2006	706	25,936	2.65%	Unknown

1 Predominately rehabilitation, palliative care or maintenance care.

2 NSW Mothers and Babies 2005, NSW Public Health Bulletin Supplement, Vol 18, No. S-1, p. 37.

3 Includes detoxification and rehabilitation.

Broad level analysis of this data indicates that residents of SSWAHS identifying as Aboriginal exhibit a slightly higher level usage of public hospital services than the percentage of the population identifying as Aboriginal at the 2006 census, without any adjustment for the younger age profile of Aboriginal populations. Admissions to psychiatric units are more than double the proportion of the population and admissions to sub- and non-acute care around 1/3 of the proportion of the population.

There is also self-reported data on Aboriginal use of mainstream health services available through the NSW Population Health Survey. At an Area Health Service level there are quite large confidence intervals with this data, with 928 respondents only across NSW.

Self Reported Health Service Usage among Aboriginal people – SSWAHS & (NSW)

- **Emergency departments** – 17.5% (23.8% across NSW) of Aboriginal adults presented to an emergency department in the last 12 months, more females – 29.6% (27.6% across NSW) - than males – 6.0% (19.8% across NSW), with across NSW, young females aged 16–24 having the most presentations (35.6%).
- **Hospital admissions** – 15.4% (16.2 % across NSW) of Aboriginal adults were admitted to a hospital for at least one night in the previous 12 months, with more females – 31.5% (21% across NSW) - than males – 0.0% (11.3% across NSW).
- **Community health centres** – 12.9% (13.9% across NSW) of Aboriginal adults had attended a community health centre in the previous 12 months, with more females – 19.1% (16.4% across NSW) - than males – 6.9% (11.2% across NSW) and no urban/rural difference.
- **Public dental services** – 10.8% (10.0% across NSW) of Aboriginal adults attended a public dental service in the previous 12 months, with no gender, rural/urban or age group difference.

Source: 2002-2005 Report on Adult Aboriginal Health from the NSW Population Health Survey

Targeted Aboriginal Health Programs

There are a range of programs provided by SSWAHS which are specifically targeted to Aboriginal communities. The interface of these programs with Aboriginal communities is normally through the direct involvement of AHWs in service provision and to facilitate pathways to specialist care provided by SSWAHS. Table 6.1 profiles the key programs that have been resourced to specifically target Aboriginal populations, classified within broad areas of health interest (although services are generally provided using a holistic health construct that ranges across health issues and determinants of health).

It is noted that within most clinical services there have been targeted efforts to ensure the relevance of service provision to Aboriginal populations, with table 6.1 focussing on formalised programs which are addressing needs in particular themed areas of clinical need.

Other significant activities that have targeted the needs of Aboriginal communities, which may not have been consolidated into formal clinical programs or may not be specific to a clinical theme, are outlined following Table 6.2.

Table 6.2 Profile of SSWAHS clinical stream programs specifically targeted at Aboriginal communities

Program/Strategy	Target Population	Model of Care and Services Provided	Resources Allocated	Service Development Directions
Child and Maternal - aimed at reducing infant mortality, increasing birth weights, improved antenatal and postnatal care. Note: SSWAHS has also instituted innovative early childhood programmes as part of Families First; the current focus is on ensuring that Universal Home Visiting performance targets are achieved. Antenatal psychosocial screening has been implemented across SSWAHS.				
Aboriginal Teenage Mothers Home Visiting Project (Bringing Services Together)	Teenage Aboriginal mothers and infants identified as vulnerable and needing additional support. Participants recruited through antenatal services and the Aboriginal Medical Services, at birth or post-nasally, with vulnerability identified by a Comprehensive Psychosocial Assessment.	A comprehensive evidence-based program of ongoing nurse home visits provided by Early Childhood Health sustained home visiting nurses, from antenatal period until the child's second birthday (frequency of visiting reducing over time – up to 30 visits pre and post natally to 2 years). Services tailored to the needs of the family with a coordinated care plan linking with other relevant health services (e.g. youth, mental, oral and drug health, child development services), and government and community services and groups. The relative needs of mothers are assessed early and where significant vulnerability is identified services are provided at a ratio of 1:25 to those who will benefit from the intervention. Very high risk clients (Drug dependency and/or domestic violence) are referred to the DoCS Early Intervention Program and low risk clients are supported by AHEOs. Home visiting incorporates a parent education and health promotion program based on the *Parents and Teachers* model used by Aboriginal child and family services in urban, rural and remote NSW communities.	2 RN (1st Year) 3 RN (2nd Year+) Allows staff/family ratio of 1:50 (1st Year) and 1:67 (2nd Year). This is well below NSW Health recommended ratio of 1:25	Seek additional funding to improve staff/family ratio towards the 1:25 NSW Health benchmark. Evaluate program at the end of 2009 and assess future directions on the basis of performance indicators e.g. number of mothers recruited and the recruitment rate; timeliness of referral; number of ante- and post-natal home visits; number and proportion of mothers who remain engaged; and measures of satisfaction with the service and case planning.
Macarthur Aboriginal Antenatal Home Visiting Team Aboriginal home visiting team – Macarthur	Established in 2000, provides culturally relevant and appropriate antenatal and postnatal care to Aboriginal mothers in Macarthur who choose not to use mainstream hospital services (due to reasons of access and cultural appropriateness). Provided in partnership with staff from Tharawal Aboriginal Corporation.	Home visiting undertaken after listening to the family's story and establishment of trust and in a manner consistent with common courtesy acknowledging the visitor's status as a guest in the family's home. Focussing on the strengths of the family, celebrating their successes and promoting positive messages. Encouraging social connectedness, helping families identify whom they can turn to for support, facilitating new connections or links into the broader Families First network. Opportunistic provision of Health education and information anticipatory guidance and preventative public health interventions e.g., accident prevention. Provide coaching and role modelling and mentorship to assist parents to understand normal growth, develop early attachment relationships, respond to the individual unique needs of their infant and appropriately response to challenging behaviours. Encouraging the family to form a relationship with a General Practitioner and facilitate access to immunization and other public health initiatives.		Evaluate whether the program outcomes are consistent with good practice rationale that home visiting by nurses and other health professionals leads to significant improvement in all-important aspects of the family environment including maternal-infant attachment, confidence and general positive attitude to parenting. On basis of evaluation, assess potential for expansion of program within and beyond Macarthur.
Aboriginal early childhood services RPA	Young Aboriginal parents birthing at RPAH	▪ Joint nurse and AHEO Home visiting for young parents. ▪ Ante natal group with AHEOs providing health educational parenting sessions and addressing social issues arising following the mainstream ante natal clinic at RPA. ▪ Joint cooking classes with Sydney Day Nursery and Redfern Waterloo		

Program/Strategy	Target Population	Model of Care and Services Provided	Resources Allocated	Service Development Directions
		Authority. ▪ Providing support to the Aboriginal supported playgroup with Connect Marrickville ▪ Health education- breastfeeding, smoking cessation, contraception ▪ Transport referrals from AMS to ante natal clinics at RPA.		
New Directions Mothers and Babies Services (OATSIH funded) – component of Commonwealth's *New Directions: An Equal Start in Life for Indigenous Children – Child and Maternal Health Services*	Within Liverpool, Fairfield & Bankstown regions: ▪ Women who are pregnant with an Aboriginal and/or Torres Strait Islander child; ▪ Mothers of Aboriginal and/or Torres Strait Islander children from 0 to 8 years; ▪ Aboriginal and/or Torres Strait Islander children under 8 years	Program aims to provide: ▪ Access to antenatal care for women pregnant with an Aboriginal and/or Torres Strait islander child; ▪ Standard information about baby care for mothers of Aboriginal and/or Torres Strait islander children; ▪ Practical advice and assistance with breastfeeding, nutrition and parenting skills for mothers of Aboriginal and/or Torres Strait Islander children; ▪ Monitoring of Aboriginal and/or Torres Strait Islander children's weight gain, immunisation status, infections and early developmental milestones by a dedicated primary health care service; and ▪ Testing, early detection and timely treatment of Aboriginal and/or Torres Strait Islander children's hearing, sight, speech and other development issues.	New Program to be managed by Community Health Services in partnership with the SSWAHS Aboriginal Health Unit and Marumali. Recurrent funding of approx. $400,000 p.a. secured.	To be considered following establishment of services.
Chronic Care – formerly known as Aboriginal Vascular Health Program, this program receives recurrent funding from NSW Health				
Aboriginal Chronic Care Program	Adult Aboriginal people with chronic disease living in the Inner West and Liverpool, recruited following attendance at RPAH or Miller CHC.	Early detection and management of chronic disease in the community with view to reducing unplanned admissions.		Expand the program to include: ▪ self-management and rehabilitation ▪ pilot cardiac rehabilitation model at Liverpool Hospital. ▪ enhanced linkages with GPs ▪ care planning/coordination; ▪ brief intervention smoking cessation; ▪ training program for AHWs; ▪ Data base, KPIs, QA program; ▪ Early intervention for kidney disease; ▪ nutrition programs with cooking classes; ▪ Increased outreach clinics. ▪

Program/Strategy	Target Population	Model of Care and Services Provided	Resources Allocated	Service Development Directions
Walgan Tilly – NSW Health Statewide Clinical Redesign project.	Aboriginal persons aged 15+ with or at risk of chronic conditions particularly in cardiovascular and respiratory diseases and diabetes.	Focussing on Tier 3 and Tier 2 chronic disease i.e. ▪ Tier 3: people with chronic disease who are at high risk of hospitalisation, requiring care coordination and ongoing support to avoid complications, slow down progression and maintain good health. ▪ Tier 2: people with or at high risk of chronic disease who can be optimally cared for in the community (GP and other community based services), with self-management support and care coordination. Aiming to: ▪ Build practical steps and real solutions to improve access for Aboriginal families and communities; ▪ Build working relationships between Aboriginal services and chronic disease services; ▪ Identify and share best practice in meeting the needs of Aboriginal people with chronic disease. SSWAHS has established Steering Committee and Working Group focusing on the solution: ▪ The provision of a culturally sensitive and effective discharge plan with follow up within 24-48 hours.	State level identification and validation of themes and issues. SSWAHS has undertaken Solution Design Workshops to prioritise issues.	▪ Communication Strategy is being rolled out. ▪ In-services being provided to all key stakeholders within SSWAHS; ▪ External agencies to also receive training. ▪ NSW Health to collect data on client identification. ▪ NSW Health has developed a data collection system for 48hr follow-up. ▪ Enrolment into program from RPAH, Liverpool and Campbelltown Hospitals commenced from May 2009.
Drug Health - Aboriginal people are a priority target group for Drug Health services in areas such as HIV prevention and care, early access to drug treatment including detoxification and the Opioid Treatment Program, court diversion programs (MERIT) and Perinatal and Family Drug Health programs. Aboriginal Health D & A Advisory Committees (inc. representation from the ACCHS', Redfern and Tharawal), guide the development, implementation and evaluation of Aboriginal Drug Health programs.				
Aboriginal Women's Support Group	Aboriginal women clients of the Opioid Treatment Program at RPAH.	Established in June 2005, the group meets weekly to address the women's needs, retain them in treatment, improve their physical, emotional and mental health and prevent relapse to drug use. Facilitated by the DHS Aboriginal Health project officer and Drug Health counsellor, the group meetings enable secondary prevention strategies to be provided in a clinical setting. The structure, education and activity content of the group is determined by the women ensuring a flexible, culturally appropriate and confidential service. The facilitators provide case management and welfare support across the domains of housing, food, debt management, probation issues, grief counselling, domestic violence, relationship issues, child custody problems and court matters. The group offers practical assistance and support. Evaluation from the women, Drug Health staff and key stakeholders has been extremely positive.	DHS Aboriginal Health project officer DHS Drug Health counsellor	
Perinatal and Family Drug Health Services	Pregnant women affected by substance use (a high risk obstetric group characterised by poor maternal health, low attendance for antenatal care, poor neonatal birth weights and subsequently	Early intervention mode of care aimed at: early engagement of pregnant drug using women; increased attendance at antenatal care; improved maternal health issues including nutrition and dental care; improved neonatal outcomes. Although a mainstream program, a 2005-06 evaluation showed that of 194 women with substance use issues in pregnancy recruited (174 requiring intensive intervention to address their D & A issues and reduce the risk of	2 X CNCs coordinating teams in both the Inner and South west of SSWAHS.	Continuation of program on basis of 2006 evaluation showing improvements in - engagement in antenatal care (82%); commencement on drug health treatment (44%); increased neonatal birth weights (64% greater than

Program/Strategy	Target Population	Model of Care and Services Provided	Resources Allocated	Service Development Directions
	poor neonatal outcomes).	adversity) - 32% of clients were Aboriginal, 88% had socio economic disadvantage, 83% were unemployed; 77% lived in public housing and 83% received a government benefit. Also, the service provides extensive support to vulnerable communities including Redfern/Waterloo (28%), Liverpool (12%) and public housing estates (77%). A service mapping across the Area as well as outcomes of several RCAs conducted in SSWAHS prompted establishment of an Area Perinatal and Drug Health Steering Committee to guide the program.		2700grams); reduction in neonatal deaths (2%); and reduced risks associated with domestic violence and child protection to the family unit. Steering Committee is developing a service model which establishes minimum standards of care, clinical pathways, collaborative care planning, standardised assessment tools and key performance indicators.
Court Diversion (MERIT Program)	On referral from the Court system (Court diversion programs provide an entry in drug treatment for a cohort that may otherwise not make contact with drug treatment services0.	Comprehensive strategy involving: monitoring referrals; coordinating access; collaborating with Aboriginal community organisations and primary health care providers; consulting with clients; establishing the Aboriginal Women's Support Group; employment of Aboriginal clinicians to increase referrals of Aboriginal defendants.		Expand the service to cater for increasing referrals e.g. in 2005-06 there was an increase of 54% in referrals from the Local Courts.
Mental Health – a focus on improving the social and emotional wellbeing of Aboriginal people across all age groups has been a priority since the mid 1990s.				
Area Mental Health Services	Aboriginal people across all age groups	In the South West, significant increases in clinical positions within community mental health services have been funded, including generalist positions working with individuals, their families and community groups and positions specifically allocated to support children, adolescents and their families. In the Inner West development of services has occurred in conjunction with the Redfern Aboriginal Medical Service. To consolidate progress it is proposed that an Area-wide Aboriginal Mental Health steering committee with broad representation that includes Drug Health Services. The aim is to develop (in partnership with the AMS') specific targeted mental health programs for Aboriginal people of all ages who have or are at risk of mental illness. Services are also focussing on increase expertise and knowledge of mental illness in Aboriginal communities through the implementation of Aboriginal Mental Health First Aid programs.		Enhance working partnerships between the AMHS and Aboriginal community organisations, inc. the AMS' Redfern and Tharawal; Improve mental health service responsiveness for Aboriginal people, their families and carers across emergency and acute, early intervention and prevention, and rehabilitation and recovery services. Workforce development through local training initiatives and by establishing effective links with universities inc. student placement programs.

Program/Strategy	Target Population	Model of Care and Services Provided	Resources Allocated	Service Development Directions
Infant, Child & Adolescence Mental Health	Aboriginal mothers, young families and their children.	Certificate IV in Peri Natal Infant mental Health for Aboriginal Health Workers Parenting camps focussing on attachment theory and circle of security Development of a cultural appropriate depression scale with Beyond Blue for post natal depression based on the Edinburgh Depression Scale Linking attachment theory and circle of security with the AMIHS and Aboriginal Home visiting programs.		
Health Promotion - NSW Health provides funding for targeted health promotion activities in Aboriginal communities, for programs addressing chronic disease.				
Aboriginal Health Promotion Action Plan 2007-2011	Aboriginal people at risk of developing chronic disease.	The Plan aims to contribute to a reduction in health disparities for Aboriginal people through minimisation/reduction of chronic disease and improvement in the social determinants of health. It includes strategies to prevent chronic disease caused by tobacco use, inadequate physical activity and poor nutrition and also addresses social determinants of health in areas such as access to affordable healthy food, adequate public transport, secure housing, social isolation and welfare dependence.	Plan requires: 4 X AHEO positions covering Inner West, Liverpool, Canterbury/ Bankstown and Macarthur regions.	Secure sufficient resources to implement the Plan. Build and strengthen partnerships with Aboriginal Community Controlled Organisations Build and strengthen inter-agency relationships

Sexual Health Services

Significant activity has been undertaken in addressing the sexual health education and health promotion needs of Aboriginal communities within SSWAHS. Some highlights of this activity include:

- A survey in 2006 to elicit the perceived needs of Aboriginal communities;
- redesign and updating of Aboriginal safe sex packs to include additional information and area-wide contact details.
- Aboriginal HEOs coordination of Aboriginal specific HIV Update for AIDS funded staff, including NGOs.
- nursing student placement with Liver/Gastro Services, RPAH.
- coordinated of stalls at community events e.g. at OZ Tag (school touch rugby competition) with Marrickville Council and local youth service representatives;
- undertaking literature review on the benefits of adopting a Health Promotion Framework when discussing sexual health issues with Aboriginal Men;
- Interviews on the 2SER Jailbreak program to promote key messages and clinical services.
- Coordination of Metro Sydney Aboriginal Sexual Health Workers Network meetings.

Sexual Health services have also been addressing the provision of clinical outreach services to Aboriginal populations, with the significant progress to date including:

- Operating procedures inc. competency assessments have been developed for 'Active' Outreach (urine-testing) to be provided at venues that attract youth inc. significant numbers of Aboriginal youth;
- Participation in a piloted Chlamydia testing and education project targeting young people in youth settings (with reasonable proportion of Aboriginal clients)
- Continuing client related work with HIV+ men and women identifying as Aboriginal.

Oral Health Services

SSWAHS Oral Health Services have been actively engaged in improving Aboriginal Oral Health through:

- Partnership arrangements with ACCHS' Tharawal (staff capacity building and service) and Redfern (Orthodontics and site support);
- Proposed establishment of an Aboriginal Oral Health Clinic at the Sydney Dental Hospital (SDH) and in outreach rural clinical rotations to rural ACCHS';
- Aboriginal Traineeships – two have been proposed for 2009, which add to the many such traineeships in Oral Health and through the Elsa Dixon Scholarship provided in recent years;
- Oral health promotion activities through the Early Childhood Oral Health Programme;
- Clinical activity in caring for Aboriginal people – presently around 4% of service provision is to Aboriginal people and further active encouragement to access services is being pursued;
- past participation in the Biyani Camp and provision of a dedicated clinic for Aboriginal people at Hoxton Park;
- Willingness to participate in any partnerships addressing Aboriginal Oral Health and oral health promotion.

Men's Health

SSWAHS has developed an Aboriginal Men's Health Plan to enable Aboriginal men living in SSWAHS to improve their health, social & emotional wellbeing and to take action to improve the health of the other men in their communities. The focus is on empowerment through increasing knowledge and capacity to improve one's own health and advocating for improved men's health in their own communities through:

- culturally appropriate activities for Aboriginal men
- Providing programs on men's health issues;
- discussion groups on social & emotional issues that involve local Aboriginal men;
- facilitating access to the broad range of health services;
- providing culturally specific health services for Aboriginal Men.

The engagement with Aboriginal men is targeted around the priority health areas identified through consultations including:

- Alcohol &Other Drugs
- Mental Health
- Dental health
- Maternal, Child and Youth Health
- Chronic Diseases
- Sexual health

This community engagement acknowledges the central importance of the extended family and emphasises cooperative work with other government departments and agencies. Through self-determination and involvement Aboriginal Men are being encouraged to take personal responsibility in improving health status and playing their rightful role as leaders, fathers, uncles, husbands and grandfathers. Traditional roles such as in ensuring young men have a clear passage to manhood through a culturally appropriate system of initiation

can also help in having intergenerational impact. An important aspect is in redressing the loss of traditional Aboriginal cultural identity arising from segregation, assimilation and institutionalisation policies which forbade practice and participation in traditional rituals and customs. The pain and bitterness of these experiences passed down from generation to generation has resulted in feelings of anger, frustration, grief, depression and alienation. Empowerment of Aboriginal males is seen as crucial to raising self-esteem, quality of life, health status and spiritual well-being.

The principles underpinning the Men's Health community engagement process emerged through a comprehensive consultation process and are closely aligned with the principles that have been used to guide the NSW Aboriginal Health Policy, 1999 and the NSW Aboriginal Men's Health Implementation Plan 2003.

In hospital care

Aboriginal Liaison Officers assist Aboriginal and Torres Strait Islander people and their families while they are in hospital by:

- Working with other health staff to ensure the best possible service for patients and their families;
- Providing emotional, social and cultural support to patients and families.
- Linking patients and families with Aboriginal health services
- Working with Aboriginal Medical Services to improve the health of Aboriginal and Torres Strait Islanders living in NSW.

A key role undertaken is in facilitating access for patients, carers and their families to the range of social support and assistance available over the period of inpatient care and immediately prior and post discharge. This may include access to:

- Centrelink for pensions and benefits;
- Home Care for help at home, Meals on Wheels, equipment and aids to daily living;
- Short term accommodation for patients and carers;
- Department of Housing.;
- Isolated Patients Travel and Accommodation scheme.

Aboriginal Employment and Training

SSWAHS has entered into a partnership with the Commonwealth Department of Education, Employment and Workplace Relations (DEEWR) to conjointly fund a traineeship program to provide Aboriginal people with skills and qualifications required to enter the health workforce. Traineeships are seen as an important mechanism to facilitate an increase in the proportion of the SSWAHS workforce identifying as Aboriginal as after the 1-2 years of training, translation into on-going employment is likely. The program will build on existing traineeships offered within SSWAHS, with already a number of trainee positions being available, particularly in Macarthur. Initial investigation by Area General Managers of opportunities has already identified around 20 potential placements as at May 2009.

Traineeships are jobs that combine work and structured training and the qualifications specific to the Health workplace that can be obtained through this process outlined at table 6.3.

Table 6.3 Health industry qualifications available through traineeships

Qualification	Duration	Work Roles
HLT21207 Certificate II Health Support	1 year	Cleaners; Food Services; Grounds Maintenance Worker; Stores Assistant; Support Services Worker; Ward Assistant
HLT32507 Certificate III in Health Services Assistance	1 year	Assistant in Nursing; Patient Support Assistant Theatre Support; Wardsperson
HLT32407 Certificate III in Allied Health Assistance	1 year	Therapy Assistant; Physiotherapy Assistant; Occupational Therapy Assistant; Speech Pathology Assistant; Allied Health Assistant
HLT31107 Certificate III in Sterilisation Services	1 year	Sterilisation Assistant
HLT31407 Certificate III in Hospital/Health Services Pharmacy Support	2 years	Pharmacy Assistant
HLT32607 Certificate III in Pathology	2 years	Pathology Assistant; Pathology Collector
BSB30407 Certificate III in Business Administration	1 year	Clerical Assistant

Traineeships offer:

- Paid work placement of 1-2 year duration under the Public Hospital (Training Wage) (State) Award;
- "hands on" work in appropriate facilities and training at work to acquire the knowledge and skills needed to complete the traineeship;
- Opportunity to complete a nationally recognised qualification through a registered training organisation;
- Full support and mentorship during the traineeship.

ATTACHMENT A - Fields of Inquiry for SSWAHS Aboriginal Health Planning *(extracts from Scoping Paper for Plan)*

The Steering Committee for the Aboriginal Health Plan was constituted with the following Terms of Reference.

- Oversee the development of an Aboriginal Health Plan for Sydney South West Area Health Service (SSWAHS) building on and drawing together the strands of existing plans for South West Sydney (2001-2006) and Central Sydney (2005-2008);
- Identify the focus areas of the plan, including but not restricted to areas identified in the existing South West and Central Sydney plans:
    - Increasing Aboriginal employment opportunities in the AHS;
    - Identification of Aboriginality in data collection;
    - Access to health facilities;
    - Enhancing cultural sensitivity of Area health services and employees;
    - Making facilities more welcoming for Aboriginal people;
    - Accommodation options for Aboriginal people travelling for treatment;
    - Transport arrangements for Aboriginal clients of facilities;
    - Partnerships with Aboriginal Controlled Organisations;
    - Improving research and evaluation of interventions;
    - Enhancing health promotion and health literacy;
    - Enhancing primary and secondary preventative health activities;
    - Health/clinical focus areas – children, youth and families, vascular syndromes (inc. cardio, diabetes, renal), mental health, drug health, infectious diseases, oral health.

- Advise on the structure of the planning process to be undertaken;
- Review implementation of existing plans and identify implementation gaps, barriers and priorities for action;
- Advise on best practice models in indigenous health;
- Advise on the community consultation process to be undertaken for the plan;
- Advise on monitoring and evaluation mechanisms to be established over the life of the plan;
- Review and sign-off of the Plan documentation.

The scoping paper for the planning process provided not only an outline of the organisational arrangements and timeframes for planning but also the parameters within which planning would proceed and the key fields of inquiry that would be explored.

The Scoping Paper identified some of the key generic questions to be addressed in planning:

- What are the best practice principles and models of care that should be implemented in developing/expanding targeted Aboriginal health programs in SSWAHS;
- What are the key principles in ensuring Aboriginal communities can maximise access to mainstream SSWAHS health services;
- What partnerships in service development require development, who are the partners, what are the principles/frameworks within which partnerships need to be fostered;
- What activities do SSWAHS health services need to take the lead in developing and what activities do SSWAHS need to participate in but not lead;
- What are the priority health needs of Aboriginal communities in SSWAHS, for which of these needs can SSWAHS service provision have the most impact in improving health outcomes;
- What resources are required in developing/expanding targeted Aboriginal health programs in SSWAHS, can a source be identified for these resource requirements, is the present distribution of resources between services and across geographic space consistent with available evidence of relative population need;
- Are there specific existing health needs in the Aboriginal community that are not being addressed by SSWAHS services but that are appropriate and of sufficient relative priority for service provision;
- Are there emerging epidemiological or service delivery needs that indicate a need to vary the existing service provision mix;
- Are the existing targeted Aboriginal health programs provided by SSWAHS consistent with the reasonable expectations of the Aboriginal community;
- Can useful performance indicators and targets be developed to reflect reasonable expectations of outcomes from the provision of targeted Aboriginal health programs.

It also identified key components to the planning process in pursuing these fields of inquiry:

- Identifying best practice principles for targeted Aboriginal health programs and for ensuring access of the Aboriginal community to mainstream health programs;
- Identifying partnerships and the relative roles of agencies in providing holistic health care to Aboriginal communities;
- Understanding the priority health needs in the Aboriginal community where SSWAHS service provision can make a difference in the achievement of health outcomes;
- Ensuring equitable access for the Aboriginal populations across SSWAHS to targeted Aboriginal health programs of proven efficacy;
- Matching the targeted Aboriginal health programs provided by SSWAHS to Commonwealth/State policy priorities and identifying gaps;
- Identifying the resources required in developing/expanding targeted Aboriginal health programs in SSWAHS and potential funding sources for these resources;
- Developing performance indicators and targets.

A range of issues were also developed for each of the Priority Area Working Groups (PAWG) to guide their development of initiatives to improve Aboriginal Health within their health area:

Early Years, Children and Young People

- Providing culturally appropriate antenatal care for Aboriginal women;
- Early intervention to support families in establishing positive parenting;
- Supporting children and families through preschool and transition to school.
- Supporting youth and families through the school years;
- Supporting youth in transition from school to workforce or other post school life;
- Engaging youth to support healthy lifestyles.

Chronic Diseases and Ageing

- Primary and secondary disease prevention and health promotion initiatives in chronic disease;
- Management of chronic disease;
- Aging and frailty in Aboriginal communities.

Corporate Initiatives

- Increasing Aboriginal participation in the SSWAHS workforce and building the skills and capacity of Aboriginal health workers;
- Improving access to SSWAHS services;
- Improving transport options for travel to SSWAHS services;
- Expanding accommodation options for Aboriginal patients and their families travelling long distances to access SSWAHS services;
- Improving cultural safety for Aboriginal patients and their families accessing SSWAHS services;
- Improving data collection and reporting on Aboriginality service utilisation across relevant data collections;
- Ensuring a corporate structure to support advances in Aboriginal Health Area wide.

Cross-Cutting Themes (Framework Initiatives)

- Enhancing community and social capital;
- Strengthening primary and community care;
- Ensuring holistic care;
- Strengthening partnerships with Aboriginal controlled health services and other Aboriginal controlled organisations;
- Strengthening partnerships with general practice and other primary care services inc. community health;
- Developing research, monitoring and evaluation frameworks addressing key health outcomes and performance indicators.

Mental and Drug Health

- Early intervention and health promotion/prevention in mental health and drug health;
- Appropriateness and adequacy of clinical programs in mental health and drug health for the Aboriginal community;
- Coordination and integration of mental health and drug health services for Aboriginal people;
- Improving the continuity and cultural appropriateness of mental health and drug health care available to the Aboriginal community;
- Breaking down barriers to treatment for aboriginal communities in accessing drug health and mental health services.

Infectious Diseases and Sexual Health

- Health promotion and disease prevention programs in sexual health and infectious diseases increasing awareness, knowledge and capacity to reduce risk of transmission;
- Increasing STI testing within priority populations;
- Improving diagnosis, treatment and management of STIs and other infectious diseases;
- Ensuring appropriate links and care continuity with other clinical programs;
- Ensuring appropriate clinical interchange with primary care providers in Aboriginal Controlled Health Organisations and general practice.

Oral Health

- Providing culturally appropriate and accessible oral health services;
- Increasing oral health promotion activity for Aboriginal communities linked to other health promotion/prevention activities in chronic diseases, drug and mental health;
- Integrating oral health care within primary care practice through Aboriginal controlled health organizations, community health and general practice.

ATTACHMENT B - Specific References to Aboriginal Health in Core Overarching Policy Documents

Categorised within NSW Health's Strategic Directions (SD) and covering the following care overarching policy documents:

- Framework Document – Overarching Agreement on Aboriginal Affairs between The Commonwealth of Australia and the State of NSW 2005-2010
- NSW Government *State Plan – A new direction for NSW*
- NSW Government *State Health Plan Towards 2010 – A new direction for NSW*
- *Two Ways Together Partnerships: A New way of Doing Business with Aboriginal People NSW Aboriginal Affairs Plan 2003-2012* and associated Cluster Group Action Plans (Family and Community Support, Economic Development, Justice, Culture and Heritage) – timeframe for Cluster Group Plans finished 2007 and are presently being renegotiated - NSW Health will be participating in the Human Services and Justice Cluster Group Planning and revised action Items from this process are expected to become available during 2008.
- A New Direction for Sydney South West – Health Service Strategic Plan Towards 2010

Note: This table outlines only specific references to Aboriginal Health. More generic references to mainstream policy directions not mentioned here equally apply to Aboriginal communities.

Overarching Agreement on Aboriginal Affairs – Agreed Priority Areas	State Plan: A New Direction for NSW	State Health Plan: Towards 2010	Two Ways Together: NSW Aboriginal Affairs Plan 2003-2012 Cluster Action Plans (end 2007)	A New Direction for Sydney South West: Health Service Strategic Plan Towards 2010
Make prevention everybody's business				
Early childhood intervention, a key focus of which will be improved mental and physical health, and in particular primary health, and early educational outcomes.	R4: Increase participation in volunteering, sports, cultural and artistic activity, especially for people from low income, non-English speaking and Aboriginal communities.	Maintain immunisation rates for non-Aboriginal 1yr olds above 90%, and increase rates for Aboriginal children above 85%. Increase immunisation rates of Aboriginal people over 50 years of age for influenza and pneumococcal disease. Enhance services for early detection, prevention and management of chronic disease in Aboriginal people including diabetes, quit smoking programs and prevention of vascular disease.	Nil specific identified.	In collaboration with community members and other agencies, develop and implement an Aboriginal Health Plan, Multicultural Health plan, Refugee Health plan, Mental Health Plan and Disability Plan.
Create better experiences for people using health services				
		Implement a new annual patient satisfaction survey program commencing in 2007, the experiences of Aboriginal people and other culturally and linguistically diverse patients will be drawn out from this survey.		
Strengthen primary health and continuing care in the community				
Reducing incidence of otitis media (conductive hearing loss).	F1: Improved health and education for Aboriginal people – reduce unnecessary	Further develop clinical service networks to improve access for rural people, including expansion of specialist outreach services, transport initiatives, clinical	Nil specific identified.	Continue to implement the NSW Aboriginal Chronic Conditions AHS Standards.

Overarching Agreement on Aboriginal Affairs – Agreed Priority Areas	State Plan: A New Direction for NSW	State Health Plan: Towards 2010	Two Ways Together: NSW Aboriginal Affairs Plan 2003-2012 Cluster Action Plans (end 2007)	A New Direction for Sydney South West: Health Service Strategic Plan Towards 2010
	hospital admissions for Aboriginal people by 15% over 5 years.	videoconference support and innovative health programs for Aboriginal and non-Aboriginal people. Early detection screening for inflammation of middle ear in Aboriginal children. Programs to reduce violence, sexual assault and child abuse in communities, particularly Aboriginal communities. Provide better primary and community health services for Aboriginal people, including Aboriginal women during pregnancy, young mothers and their children. Promote better use of these services by Aboriginal people. Continue implementation of the Aboriginal Housing for Health program for the creation of safe and healthy environments. Continue to build on the successes of the National Strategic Framework for Aboriginal and Torres Strait Islander Health.		Actively participate in the Families First, Better Futures and Aboriginal Child, Youth and Family Strategy initiatives to improve the health and wellbeing of young people and families and reduce child abuse and neglect.
Build regional and other partnerships for health				
Reducing incarceration and breaking the cycle of family violence. Improving Year 3 and 5 literacy and numeracy, and school retention rates. Improving living conditions. Safer communities (which includes issues of authority, law and order, but necessarily also focuses on dealing with issues of governance to ensure all communities are functional and effective).	F1: Improved health and education for Aboriginal people – improve Aboriginal primary school numeracy and literacy rates.	Base planning on a better understanding of local health needs, including the needs of disadvantaged groups, such as Aboriginal and refugee communities. Enhance and strengthen partnerships with Aboriginal people and other key groups, to implement the NSW Aboriginal Health Partnership Agreement and 'Two Ways Together': the NSW Aboriginal Affairs Plan 2003-2012 to achieve measurable health improvements for Aboriginal people. There will be an initial focus on Otitis Media screening, oral health, family violence and mental health. Consult with the Aboriginal community to build the capacity of the Aboriginal mental health and drug and alcohol workforce in NSW.	Families Children & Young People Cluster Action Plan 2005-07 – DoCS Lead Agency. Health as supporting agency in following actions: 1. Family and Community Support Develop and promulgate a Resource Kit to assist local councils to work more effectively with Aboriginal communities. The Kit will include information regarding Two Ways Together, the NSW Aboriginal Affairs Plan, and address the role of local government in relation to a	Enhance and strengthen partnerships with Aboriginal people and other key groups to achieve measurable health improvements for Aboriginal people.

Overarching Agreement on Aboriginal Affairs – Agreed Priority Areas	State Plan: A New Direction for NSW	State Health Plan: Towards 2010	Two Ways Together: NSW Aboriginal Affairs Plan 2003-2012 Cluster Action Plans (end 2007)	A New Direction for Sydney South West: Health Service Strategic Plan Towards 2010
			number of key priorities of the Plan. 2. Family Violence Implement new Schools as Community Centres in Illawarra, South Coast, Dareton, Franklin and Narrandera to provide cross-agency support to families with children aged 0-8, so that children have good school readiness and early progress. The Family Violence Focus Group to participate and supply Indigenous input to the work of the Senior Officers Group (SOG) on the Review of NSW Domestic/Family Violence Funding & Services. 3. Child Protection Child protection units based in tertiary hospitals to provide services for children and families where abuse, neglect or exposure to domestic violence has been confirmed by DoCS. Services are not Indigenous specific however Units may have identified Indigenous workers. Fund 7 positions to develop policy and run programs on child protection, sexual assault,	

Overarching Agreement on Aboriginal Affairs – Agreed Priority Areas	State Plan: A New Direction for NSW	State Health Plan: Towards 2010	Two Ways Together: NSW Aboriginal Affairs Plan 2003-2012 Cluster Action Plans (end 2007)	A New Direction for Sydney South West: Health Service Strategic Plan Towards 2010
			FV and victims of crime (Child Protection and Violence Prevention Unit). Programs developed by the Unit will be for the total NSW population however, individual services may employ workers to work specifically with Indigenous communities.	
Make smart choices about costs and benefits of health services				
Nil specific identified.	Nil specific identified.	Nil specific identified.	Nil specific identified.	Nil specific identified.
Build a sustainable health workforce				
Building indigenous wealth, employment and entrepreneurial culture, as these are integral to boosting economic development and reducing poverty and dependence on passive welfare.	Nil specific identified.	Increase the number of Aboriginal staff in the NSW Health workforce and create an environment that respects Aboriginal heritage and cultural values. Increase the number of Aboriginal people in university health courses and cadetships. Identify opportunities for skills and career development for Aboriginal staff to work in a range of health related roles.	Nil specific identified.	Implement key findings of the Aboriginal and Torres Strait Islander Workforce Development Program project. Expand the Aboriginal Health workforce to ensure representation of Aboriginal people across all key clinical and non-clinical areas.
Be ready for new risks and opportunities				
Nil specific identified.	Nil specific identified.	Ensure NSW Health is ready to respond to changes in Commonwealth/State relations across a range of areas, particularly in relation to Aboriginal health issues.	Nil specific identified.	Nil specific identified.

ATTACHMENT C - Demographic Profile – Census 2006

Table C1: SSWAHS Aboriginal Population by LGA and Age Cohort - 2006 Census [1]

SSWAHS Aboriginal Population by LGA and Age Cohort - 2006 Census [1]

LGA	Measure	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	Total
	Total Pop	3,456	2,165	1,874	4,247	11,920	13,847	12,220	8,381	6,241	5,104	4,449	4,026	2,887	7,026	87,843
	Indigenous	90	75	109	103	103	77	87	96	65	58	53	37	26	47	1,026
Sydney (part)	% Indigenous	2.60%	3.46%	5.82%	2.43%	0.86%	0.56%	0.71%	1.15%	1.04%	1.14%	1.19%	0.92%	0.90%	0.67%	1.17%
	Total Pop	3,435	1,934	1,632	1,697	2,775	4,568	6,328	5,638	4,310	3,339	3,223	3,123	2,112	4,663	48,777
	Indigenous	32	29	33	45	40	23	37	31	39	37	17	19	12	16	410
Leichhardt	% Indigenous	0.93%	1.50%	2.02%	2.65%	1.44%	0.50%	0.58%	0.55%	0.90%	1.11%	0.53%	0.61%	0.57%	0.34%	0.84%
	Total Pop	4,274	3,022	2,671	3,054	5,541	7,413	8,345	7,671	6,189	5,202	4,365	3,717	2,836	7,513	71,813
	Indigenous	106	95	112	103	106	80	102	99	70	68	48	40	21	28	1,078
Marrickville	% Indigenous	2.48%	3.14%	4.19%	3.37%	1.91%	1.08%	1.22%	1.29%	1.13%	1.31%	1.10%	1.08%	0.74%	0.37%	1.50%
	Total Pop	2,210	2,009	1,911	1,981	3,048	3,574	3,611	3,325	3,291	2,854	2,454	2,133	1,502	5,764	39,667
	Indigenous	15	11	19	18	15	9	15	21	21	21	11	3	0	15	194
Ashfield	% Indigenous	0.68%	0.55%	0.99%	0.91%	0.49%	0.25%	0.42%	0.63%	0.64%	0.74%	0.45%	0.14%	0.00%	0.26%	0.49%
	Total Pop	1,441	1,602	1,745	2,004	3,097	2,889	2,213	2,160	2,248	2,109	1,875	1,679	1,221	4,643	30,926
	Indigenous	12	6	13	7	14	13	5	10	5	10	7	7	6	5	120
Burwood	% Indigenous	0.83%	0.37%	0.74%	0.35%	0.45%	0.45%	0.23%	0.46%	0.22%	0.47%	0.37%	0.42%	0.49%	0.11%	0.39%
	Total Pop	1,545	1,890	2,306	2,404	3,008	2,887	2,173	2,099	2,444	2,395	2,011	1,579	1,237	4,005	31,983
	Indigenous	12	8	8	15	12	8	5	0	3	0	6	0	0	8	85
Strathfield	% Indigenous	0.78%	0.42%	0.35%	0.62%	0.40%	0.28%	0.23%	0.00%	0.12%	0.00%	0.30%	0.00%	0.00%	0.20%	0.27%
	Total Pop	4,159	3,379	3,290	3,318	4,153	5,185	6,233	5,715	5,104	4,799	4,129	3,958	3,041	9,280	65,743
	Indigenous	21	15	18	19	19	21	19	17	17	12	8	11	5	13	215
Canada Bay	% Indigenous	0.50%	0.44%	0.55%	0.57%	0.46%	0.41%	0.30%	0.30%	0.33%	0.25%	0.19%	0.28%	0.16%	0.14%	0.33%
	Total Pop	9,453	8,876	8,056	7,836	8,874	9,539	9,945	10,189	10,044	9,214	7,773	6,886	5,748	17,531	129,96
	Indigenous	94	74	71	66	76	54	54	57	43	49	31	25	22	30	746
Canterbury	% Indigenous	0.99%	0.83%	0.88%	0.84%	0.86%	0.57%	0.54%	0.56%	0.43%	0.53%	0.40%	0.36%	0.38%	0.17%	0.57%
	Total Pop	29,973	24,877	23,485	26,541	42,416	49,902	51,068	45,178	39,871	35,016	30,279	27,101	20,584	60,425	506,71
Inner West	Indigenous	382	313	383	376	385	285	324	331	263	255	181	142	92	162	3,874
Total	% Indigenous	1.27%	1.26%	1.63%	1.42%	0.91%	0.57%	0.63%	0.73%	0.66%	0.73%	0.60%	0.52%	0.45%	0.27%	0.76%
	Total Pop	12,707	12,274	12,424	12,132	11,766	11,170	11,782	11,732	12,040	11,794	10,279	9,392	7,196	23,801	170,48
	Indigenous	114	124	149	115	92	57	58	69	71	50	65	57	25	78	1,124
Bankstown	% Indigenous	0.90%	1.01%	1.20%	0.95%	0.78%	0.51%	0.49%	0.59%	0.59%	0.42%	0.63%	0.61%	0.35%	0.33%	0.66%
	Total Pop	12,024	12,880	13,881	13,746	13,597	11,764	12,112	12,708	13,531	13,799	12,151	10,341	7,275	20,085	179,89
	Indigenous	143	132	154	116	93	60	71	68	54	58	48	45	23	48	1,113
Fairfield	% Indigenous	1.19%	1.02%	1.11%	0.84%	0.68%	0.51%	0.59%	0.54%	0.40%	0.42%	0.40%	0.44%	0.32%	0.24%	0.62%
	Total Pop	13,604	13,767	13,555	12,048	11,829	11,664	13,220	13,134	13,211	11,501	9,410	8,207	5,896	13,559	164,60
	Indigenous	306	284	305	221	167	154	133	117	128	104	75	75	38	87	2,194
Liverpool	% Indigenous	2.25%	2.06%	2.25%	1.83%	1.41%	1.32%	1.01%	0.89%	0.97%	0.90%	0.80%	0.91%	0.64%	0.64%	1.33%

LGA	Measure	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	Total
	Total Pop	10,655	11,179	12,186	12,239	11,497	9,716	9,613	9,493	10,383	10,894	10,140	8,950	5,522	10,609	143,07
	Indigenous	571	550	571	416	322	253	243	207	188	163	153	81	51	64	3,833
Campbelltown	% Indigenous	5.36%	4.92%	4.69%	3.40%	2.80%	2.60%	2.53%	2.18%	1.81%	1.50%	1.51%	0.91%	0.92%	0.60%	2.68%
	Total Pop	4,235	4,268	4,182	3,724	2,970	3,055	4,219	4,242	3,885	3,370	2,915	2,596	1,763	4,222	49,646
	Indigenous	60	77	93	90	62	39	32	42	37	39	28	18	14	20	651
Camden	% Indigenous	1.42%	1.80%	2.22%	2.42%	2.09%	1.28%	0.76%	0.99%	0.95%	1.16%	0.96%	0.69%	0.79%	0.47%	1.31%
	Total Pop	3,024	3,371	3,395	3,236	2,290	2,085	2,815	3,095	3,167	3,212	2,813	2,519	1,737	3,585	40,344
	Indigenous	90	138	100	80	46	37	45	35	41	45	33	33	13	26	762
Wollondilly	% Indigenous	2.98%	4.09%	2.95%	2.47%	2.01%	1.77%	1.60%	1.13%	1.29%	1.40%	1.17%	1.31%	0.75%	0.73%	1.89%
	Total Pop	2,532	2,988	3,253	2,973	1,660	1,556	2,118	2,682	3,101	3,160	2,768	3,046	2,845	7,591	42,273
	Indigenous	59	53	89	57	34	28	43	36	20	36	27	11	20	16	529
Wingecarribee	% Indigenous	2.33%	1.77%	2.74%	1.92%	2.05%	1.80%	2.03%	1.34%	0.64%	1.14%	0.98%	0.36%	0.70%	0.21%	1.25%
	Total Pop	58,781	60,727	62,876	60,098	55,609	51,010	55,879	57,086	59,318	57,730	50,476	45,051	32,234	83,452	790,32
South West	Indigenous	1,343	1,358	1,461	1,095	816	628	625	574	539	495	429	320	184	339	10,206
Total	% Indigenous	2.28%	2.24%	2.32%	1.82%	1.47%	1.23%	1.12%	1.01%	0.91%	0.86%	0.85%	0.71%	0.57%	0.41%	1.29%
	Total Pop	88,754	85,604	86,361	86,639	98,025	100,912	106,947	102,264	99,189	92,746	80,755	72,152	52,818	143,877	1,297,
	Indigenous	1,725	1,671	1,844	1,471	1,201	913	949	905	802	750	610	462	276	501	14,080
SSWAHS Total	% Indigenous	1.94%	1.95%	2.14%	1.70%	1.23%	0.90%	0.89%	0.88%	0.81%	0.81%	0.76%	0.64%	0.52%	0.35%	1.09%
Sydney	Total Pop	268,801	263,540	264,761	270,261	299,952	304,789	325,551	316,176	310,136	292,948	259,619	237,661	179,388	491,530	4,085,
Indigenous	Indigenous	4,934	4,937	5,234	4,442	3,616	2,863	2,959	2,898	2,463	2,106	1,698	1,327	859	1,467	41,803
Region Total	% Indigenous	1.84%	1.87%	1.98%	1.64%	1.21%	0.94%	0.91%	0.92%	0.79%	0.72%	0.65%	0.56%	0.48%	0.30%	1.02%
	Total Pop	420,433	431,924	446,562	439,861	431,853	424,153	466,891	474,685	483,157	475,232	429,102	401,922	317,626	905,777	6,549,
	Indigenous	17,221	17,702	18,262	14,905	10,872	8,461	8,930	9,067	8,224	7,060	5,644	4,313	2,946	4,899	138,50
NSW Total	% Indigenous	4.10%	4.10%	4.09%	3.39%	2.52%	1.99%	1.91%	1.91%	1.70%	1.49%	1.32%	1.07%	0.93%	0.54%	2.11%

1 Census First Release data not taking into account the level of underenumeration estimated from the ABS Post Enumeration Survey and other factors which are included in the higher official Estimated Resident Population statistics. The 2005 ERP release estimated SSWAHS 2006 population as 1,340,378.

Table C2.1 Indigenous Population Characteristics - Inner West LGAs - Census 2006

Indigenous Population Characteristics - Inner West LGAs - Census 2006

	Population Characteristic	Sydney (part)		Leichhardt		Marrickville		Ashfield		Burwood		Strathfield		Canada Bay		Canterbury		Inner West Tot	
		Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]
Demographic	No. identifying as indigenous	1,553	86,288	410	48,366	1,078	70,735	194	39,473	120	30,806	93	31,890	215	65,527	745	129,963	4,408	503,048
	% Male	48.8%	51.9%	48.0%	47.8%	45.8%	49.5%	50.0%	48.8%	47.5%	49.0%	55.9%	49.6%	45.6%	48.1%	46.7%	49.4%	47.7%	49.5%
	% aged 0-11	21.0%	7.0%	17.8%	12.3%	22.9%	11.5%	18.6%	12.6%	15.8%	12.1%	20.4%	13.4%	20.5%	13.4%	27.9%	16.5%	22.1%	12.6%
	% aged 12-24	25.0%	19.6%	25.6%	11.1%	25.4%	14.1%	20.1%	15.5%	25.0%	19.8%	28.0%	21.4%	24.2%	14.3%	23.2%	16.3%	24.7%	16.3%
	% aged 25-49	37.7%	52.4%	40.7%	49.7%	38.9%	48.8%	46.4%	42.2%	38.2%	37.8%	33.7%	37.5%	38.6%	41.1%	34.2%	37.9%	38.0%	43.6%
	% aged 50-64	12.0%	12.9%	12.0%	17.4%	10.2%	15.3%	7.2%	15.4%	17.9%	15.5%	7.6%	15.4%	10.7%	17.0%	10.6%	15.8%	11.1%	15.6%
	% aged 65+	4.3%	8.1%	3.9%	9.6%	2.6%	10.6%	7.7%	14.6%	4.2%	15.1%	9.7%	12.5%	6.0%	14.1%	4.0%	13.5%	4.2%	12.0%
Housing	Average Household Size[3]	2.4	2.0	2.4	2.2	2.7	2.3	2.3	2.4	2.9	2.8	3.2	2.9	2.7	2.5	2.8	2.8	2.6	2.5
	% Lone person household	33.5%	36.7%	23.3%	31.3%	20.9%	31.0%	22.8%	29.3%	16.4%	21.8%	13.0%	19.8%	9.9%	24.2%	20.9%	23.2%	24.9%	28.0%
	% in rented property	77.8%	60.1%	71.2%	41.0%	74.8%	43.1%	69.0%	41.4%	67.9%	36.1%	66.7%	37.4%	55.7%	31.3%	69.9%	36.1%	73.0%	41.9%
Educational	% completed school >Yr10	39.9%	78.6%	41.1%	75.1%	43.1%	67.2%	45.8%	66.3%	46.1%	65.7%	50.0%	70.0%	42.9%	64.4%	38.2%	55.2%	41.4%	66.5%
	No. in infants/primary school	155	1,987	37	2,294	127	3,346	15	2,434	15	2,039	8	2,351	16	4,158	89	10,032	462	28,641
	No. in secondary school	125	1,744	29	1,633	90	2,603	19	1,961	5	1,908	9	2,500	21	3,401	62	7,540	360	23,290
	No in TAFE	56	2,224	21	819	30	1,945	9	1,051	6	828	6	845	8	1,292	22	3,570	158	12,574
	No. in Uni/Tertiary	79	9,982	16	2,860	61	4,704	7	2,759	9	2,629	10	2,520	7	3,339	24	4,851	213	33,644
Socioeconomic & Connectivity	Median weekly household income	$598	$1,250	$793	$1,742	$905	$1,165	$1,025	$1,102	$1,250	$1,071	$1,233	$1,093	$1,612	$1,509	$1,517	$1,600	$946	$1,377
	% Unemployment	19.0%	5.2%	15.7%	3.1%	13.5%	5.0%	15.4%	5.4%	5.2%	6.5%	0.0%	5.9%	7.4%	3.3%	13.6%	7.8%	13.7%	5.3%
	% providing unpaid childcare	21.4%	12.5%	26.5%	23.2%	27.6%	20.5%	19.1%	21.9%	26.4%	21.2%	20.9%	22.5%	20.0%	24.8%	24.8%	24.1%	23.9%	21.0%
	% profound/severe disability	6.1%	2.6%	5.9%	3.2%	5.1%	4.0%	7.1%	5.5%	7.6%	4.8%	0.0%	3.7%	4.2%	3.5%	4.1%	4.7%	5.4%	4.0%
	% in house with internet	38.4%	70.2%	51.2%	73.7%	44.3%	65.0%	50.4%	65.4%	55.4%	65.5%	60.9%	69.3%	70.3%	70.6%	45.1%	54.4%	45.4%	65.4%
	% living same address 5 yrs ago	51.1%	34.1%	59.6%	48.8%	44.6%	52.5%	45.3%	55.3%	57.0%	58.7%	44.0%	54.2%	45.8%	57.4%	52.2%	63.7%	49.9%	53.5%

[1] Indigenous i.e. identifying as Aboriginal and/or Torres Strait Islander in the Census 2006

[2] Non-Indigenous i.e. not identifying as Aboriginal and/or Torres Strait Islander in the Census 2006

[3] Indigenous household where at least one person identifies as such in Census

Table C2.2 Indigenous Population Characteristics – South West LGAs - Census 2006

Indigenous Population Characteristics - South West LGAs - Census 2006

	Population Characteristic	Campbelltown		Camden		Wollondilly		Liverpool		Fairfield		Bankstown		Wingecarribee		South West Tot	
		Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]	Indig[1]	NIndig[2]
Demographic	No. identifying	3,832	139,244	650	48,995	761	39,583	2,194	162,409	1,113	178,780	1,124	169,365	529	41,743	10,203	780,119
	% Male	46.7%	49.2%	52.6%	49.0%	45.9%	50.4%	46.9%	49.8%	48.6%	49.5%	48.1%	49.3%	47.1%	48.0%	47.4%	49.4%
	% aged 0-11	35.0%	18.1%	27.1%	20.2%	34.5%	18.8%	32.4%	19.7%	30.6%	16.5%	25.4%	17.2%	29.5%	15.9%	32.1%	17.9%
	% aged 12-24	28.4%	21.6%	31.3%	18.4%	25.0%	18.5%	26.1%	19.2%	26.8%	19.9%	27.4%	18.3%	25.8%	15.6%	27.4%	19.3%
	% aged 25-49	27.5%	35.2%	29.3%	38.2%	26.6%	36.0%	29.0%	38.5%	28.1%	35.8%	27.1%	34.5%	30.9%	30.0%	28.1%	35.9%
	% aged 50-64	7.4%	17.5%	9.4%	14.7%	10.4%	17.7%	8.5%	14.4%	10.2%	16.7%	13.2%	16.0%	10.8%	20.6%	9.1%	16.4%
	% aged 65+	1.6%	7.6%	2.9%	8.6%	3.5%	9.1%	4.0%	8.3%	4.2%	11.2%	6.9%	14.1%	3.0%	18.2%	3.3%	10.7%
Housing	Average Household Size[3]	3.4	2.9	3.3	3.0	3.5	3.0	3.3	3.1	3.2	3.2	3.0	2.9	3.3	2.5	3.3	3.0
	% Lone person household	10.5%	17.8%	10.3%	14.2%	9.6%	15.7%	13.5%	16.1%	15.6%	15.5%	14.2%	20.7%	7.8%	24.6%	11.9%	17.7%
	% in rented property	66.2%	30.2%	38.4%	18.9%	31.2%	15.2%	63.8%	29.9%	66.3%	29.7%	55.0%	28.6%	46.4%	21.2%	58.8%	27.6%
Educational	% completed school >Yr10	28.0%	45.1%	33.3%	44.9%	31.1%	40.0%	28.5%	50.9%	26.9%	46.5%	30.2%	48.4%	26.5%	47.1%	28.8%	47.2%
	No. in infants/ primary school	699	13,385	112	5,315	165	4,172	353	16,388	151	15,182	169	14,571	79	3,825	1,728	72,838
	No. in secondary school	435	11,184	80	3,871	87	3,085	220	11,904	113	13,970	111	11,895	68	3,275	1,114	59,184
	No. in TAFE	93	3,874	21	1,077	23	953	56	4,283	23	5,382	29	4,416	15	989	260	20,974
	No. in Uni/Tertiary	38	3,548	11	1,135	7	199	31	4,077	9	5,007	24	4,937	3	663	123	19,566
Socioeconomic & Connectivity	Median weekly household income	$743	$1,074	$1,166	$1,358	$1,064	$1,188	$850	$1,086	$739	$875	$902	$927	$750	$1,000	$834	$1,019
	% Unemployment	19.5%	7.2%	10.3%	3.8%	8.5%	4.2%	15.4%	7.0%	22.3%	10.4%	17.0%	7.3%	16.9%	4.2%	16.7%	7.3%
	% providing unpaid childcare	35.6%	29.6%	36.3%	37.0%	38.7%	33.5%	30.6%	28.7%	30.7%	23.8%	24.5%	25.9%	40.1%	29.2%	33.1%	27.9%
	% profound /severe disability	5.6%	4.0%	4.5%	3.2%	2.9%	3.0%	5.3%	4.0%	5.8%	5.2%	5.9%	4.9%	4.9%	4.2%	5.3%	4.4%
	% in house with internet	44.2%	61.2%	65.1%	70.6%	61.3%	67.5%	45.5%	61.0%	40.9%	52.4%	50.0%	55.2%	52.1%	63.4%	47.9%	59.0%
	% same address 5 yrs ago	55.3%	64.8%	51.7%	57.5%	56.1%	63.6%	55.7%	61.9%	60.1%	69.0%	61.1%	67.9%	58.7%	57.2%	56.6%	64.9%

[1] Indigenous i.e. identifying as Aboriginal and/or Torres Strait Islander in the Census 2006

[2] Non-Indigenous i.e. not identifying as Aboriginal and/or Torres Strait Islander in the Census 2006

[3] Indigenous household where at least one person identifies as such in Census

ATTACHMENT D.1 - Australian Profile – National data on Aboriginal Health status

Executive Summary Extract – *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (AIHW)*.

Demography

- At 30 June 2006, the estimated resident Indigenous population was 517,200, representing 2.5% of the total Australian population.
- Most Indigenous people live in capital cities and regional areas—an estimated 32% of Indigenous people were living in major cities, 43% in regional areas and 25% in remote areas.
- The Indigenous population has a younger age profile, with a median age of 21 years, compared with 36 years for the non-Indigenous population.

Education

- Retention rates for Indigenous students to Year 10 and beyond increased between 1998 and 2007, and the differences between Indigenous and non-Indigenous retention rates decreased.
- Between 2001 and 2006, Year 12 completion rates for Indigenous people aged 15 years and over increased from 20% to 23%.
- Compared with Indigenous adults who had left school in Year 9 or below, those who had completed Year 12 were, in 2004–05:
  - more likely to report excellent or very good self-assessed health
  - less likely to report high or very high levels of psychological distress
  - less likely to smoke regularly.

Labour Force Status and Income

- Between 2001 and 2006, the unemployment rate for Indigenous people aged 15–64 years decreased from 20% to 16%, while the labour force participation rate increased from 52% to 54%. However, the unemployment rate for Indigenous people in 2006 was three times the rate for non-Indigenous people (16% compared with 5%).
- The median equivalised household income for Indigenous people was $362 per week, equal to 56% of the median equivalised household income for non-Indigenous people ($642).

Housing and Homelessness

- The rate of home ownership for Indigenous households increased from 31% in 2001 to 34% in 2006. However, the proportion of Indigenous households who owned or were purchasing their own homes in 2006 was half the rate of other Australian households (34% compared with 69%).
- One in every two Indigenous households were receiving some form of government housing assistance, such as living in public or community housing, or receiving rent assistance.
- One in seven Indigenous households (14%) were overcrowded in 2006 and around one-quarter of the Indigenous population (27% or 102,300 people) were living in overcrowded conditions.
- Indigenous people were over-represented in the national Supported Accommodation Assistance Program (SAAP) for the homeless and those at risk of homelessness, comprising 17% of all SAAP clients.
- Nearly three-quarters of Indigenous clients using SAAP services were women.

Health Status

- In 2004–05, Indigenous adults were twice as likely as non-Indigenous adults to report their health as fair/poor (29% compared with 15%).
- Long-term health conditions responsible for much of the ill-health experienced by Indigenous people include circulatory diseases (including heart disease), diabetes, respiratory diseases, musculoskeletal conditions, kidney disease and eye and ear problems.
- Indigenous adults were twice as likely as non-Indigenous adults to report high/very high levels of psychological distress.
- In 2005–06, Indigenous people were hospitalised at 14 times the rate of non-Indigenous people for care involving dialysis, and at three times the rate for endocrine, nutritional and metabolic diseases (which includes diabetes).
- Indigenous Australians were hospitalised for potentially preventable conditions at five times the rate of non-Indigenous Australians.

Health risk factors

- In 2004–05, half of Indigenous adults were regular smokers—twice the rate of non-Indigenous adults.
- One in six Indigenous adults (16%) had consumed alcohol at long-term risky/high risk levels in the past week. This was similar to the rate for non-Indigenous adults.

- More than half (57%) of Indigenous people aged 15 years and over were overweight or obese. Indigenous women were around one-and-a-half times as likely as non-Indigenous women to be overweight/obese, while the rates for Indigenous and non-Indigenous men were similar.

Mortality
- Life expectancy for Indigenous Australians was 59 years for males and 65 years for females, compared with 77 years for all males and 82 years for all females, a difference of around 17 years.
- In the period 2001–2005, the mortality rates for Indigenous males and females in Queensland, Western Australia, South Australia and the Northern Territory combined, were almost three times those for non-Indigenous males and females.
- The five leading causes of death for Indigenous people were: diseases of the circulatory system; injury; cancers; endocrine, metabolic and nutritional disorders (including diabetes); and respiratory diseases.
- There were significant declines in the all-cause mortality rates for Indigenous males and females in Western Australia between 1991 and 2005.
- There were also significant declines in Indigenous infant mortality rates in Western Australia, South Australia and the Northern Territory over the same period.

Health Services
- In 2004–05, $1.17 was spent on Aboriginal and Torres Strait Islander health for every $1.00 spent on the health of non-Indigenous Australians, only 17% higher despite the poorer health of the Indigenous population.
- More than two-thirds of this expenditure was on publicly provided health services such as public hospitals (46%) and community health services (22%).
- Indigenous males and females were more than twice as likely to be hospitalised as other Australian males and females.
- Aboriginal and Torres Strait Islander people may experience difficulties accessing health care. Indigenous people in non-remote areas were more likely than those in remote areas to report cost as a reason for not seeking health care, while for those in remote areas, transport/distance and the service not being available in the area were more commonly reported reasons.
- In 2006, Indigenous people aged 15 years and over were under-represented in almost all health-related occupations and comprised 1% of the health workforce. They were better represented in welfare and community service-related occupations, comprising 3.6% of this workforce.

Community Services
- Indigenous children were over-represented in the child protection system in 2005–06, with the rate of Indigenous children on care and protection orders over six times the rate of other Australian children.
- Indigenous youth were under juvenile justice supervision at a rate of 44 per 1,000, compared with 3 per 1,000 for other Australian youth.
- Compared with other Australians, Aboriginal and Torres Strait Islander people used both disability and aged care services at younger ages, consistent with their poorer health status and high mortality rates.

Sub-Populations of Special Interest
Torres Strait Islander Peoples
- The estimated resident Torres Strait Islander population in 2006 was 53,300, or 10% of the total Indigenous population
- Some 15% of Torres Strait Islander people were living in the Torres Strait Indigenous Region, 47% in other parts of Queensland and 15% in New South Wales.
- Compared with all Indigenous Australians, Torres Strait Islander people had higher rates of Year 12 completion and labour force participation, as well as higher equivalised household income.
- Torres Strait Islander people living in the Torres Strait Indigenous Region had higher rates of Year 12 completion and labour force participation and lower unemployment rates than those living in other parts of Australia.

Mothers and Children
- Aboriginal and Torres Strait Islander females have higher fertility, with an estimated total fertility rate of 2.1 babies, compared with 1.8 babies for all Australian females.
- The median age of Indigenous females who gave birth in the period 2001–2004 was 25 years, compared with a median age of 30 years for other mothers.
- In the period 2003–2005, the perinatal mortality rate for Indigenous babies in Queensland, Western Australia, South Australia and the Northern Territory combined was 1.5 times the rate for non-Indigenous babies.
- The perinatal mortality rate for Indigenous babies, however, declined significantly in Western Australia between 1991–93 and 2003–05.

- The mortality rate for Indigenous infants and Indigenous children aged 1–14 years in the period 2001–2005 was around three times that for non-Indigenous infants and children.

People with disability and Carers

- Some 4% of Aboriginal and Torres Strait Islander people in 2006 were identified as needing assistance with self-care, physical mobility or communication.
- After adjusting for differences in the age structure of the two populations, Indigenous people were almost twice as likely as non-Indigenous people to need assistance with core activities.
- In the 2006, one in eight Indigenous people aged 15 years and over (12%) were carers.
- The median age of Indigenous carers was 37 years; 12 years less than the median age of non-Indigenous carers.
- After adjusting for differences in the age structure of the two populations, Indigenous people were 1.2 times as likely as non-Indigenous people to be carers.

ATTACHMENT D.2 - NSW Profile - status report on issues within scope of Two Ways Together

Executive Summary Extract - *Two Ways Together Report on Indicators 2007*.

Demography

- At the 2006 census NSW had Australia's largest Aboriginal population at 148,178, or 2.2% of the population.
- Twenty nine percent of the total Aboriginal Estimated Residential Population of Australia live in NSW, and more Aboriginal people reside in NSW than Victoria, South Australia, Tasmania, ACT and Northern Territory combined.
- Seventy seven percent of Aboriginal people in NSW live in major cities or inner regional areas, and 53% live in the corridor encompassing the major cities of Newcastle, Sydney and Wollongong.
- Fifty seven percent of the Aboriginal population of NSW are aged 24 or younger and 83% are aged 44 or younger. (In the general population, these percentages are 33% and 62% respectively).
- The Aboriginal population of New South Wales grew by 13,290 people between 2001 and 2006, representing 6% of total NSW population growth.

Health

- Aboriginal people have a shorter life expectancy than the population as a whole. Aboriginal males in NSW have an average life expectancy of 60 years, 16.4 years less than all NSW males, and Aboriginal females in NSW have an average life expectancy of 65.1 years, 16.8 years less than all NSW females.
- The infant mortality rate for NSW Aboriginal infants, at 8.4 per 1,000 live births, is 79% higher than the total infant mortality rate. However, there has been a significant reduction in the gap between Aboriginal and total infant mortality rates. Part of this reduction in infant mortality may be attributable to the increasing percentage of Aboriginal expectant mothers making antenatal visits to health professionals within the first 20 weeks of pregnancy.
- Aboriginal people are more likely to report their health status as fair or poor than are non-Aboriginal people, and are more likely to report three or more long term health conditions.
- Hospitalisations for long term conditions, including diabetes and cardiovascular disease are higher for Aboriginal people than for the total NSW population and the gap in hospitalisation rates between the Aboriginal and total populations is increasing.
- While there is no significant difference in the percentage of Aboriginal and non-Aboriginal people who report engaging in risky alcohol consumption, Aboriginal people are 2 to 3 times more likely to be treated in hospital for alcohol related trauma or disease, and almost 5 times more likely to account for closed treatment episodes in drug and alcohol treatment programs. The gap in hospitalisation and treatment rates for the Aboriginal and total population is increasing.
- More than a quarter of Aboriginal people report high or very high levels of psychological distress, around twice the level of non Aboriginal people. The hospitalisation rate for self harm is 2.7 times higher for Aboriginal people than for the whole population, and the gap is increasing.
- Hospitalisation rates for whooping cough, measles and influenza in the Aboriginal population have fallen and are now level with the general population rate. However, other conditions that are generally amenable to prevention and early intervention through primary health care, including injury and poisoning, otitis media and dental disease, account for increasing hospitalisation rates for Aboriginal people.
- Hospitalisation rates for cardiovascular disease, diabetes, injury and poisoning, alcohol trauma and ambulatory care sensitive conditions are far higher in the Western NSW RCMG region, though these rates have been falling, in contrast to other regions, where rates have generally been rising. This may be associated with improved access to primary care in the Western region although no data on primary care services are available.

Education

- There is a gap of more than 10 percentage points between Aboriginal students in NSW and all NSW students reaching national literacy and numeracy benchmarks in Years 3, 5 and 7 with the gap increasing from Year 3 to Year 7. There was no narrowing of the gap between Aboriginal and all students from 2001 to 2005.
- Since 2001 there has been a substantial increase in the percentage of NSW Aboriginal 3 and 4 year olds attending a preschool and the percentage is now higher than for all 3 and 4 year olds.
- There is a 14 percentage point gap between Aboriginal and all children aged 15 attending a secondary school in NSW and the gap widens to 33.5% at age 17 years.
- Year 10 Aboriginal students in NSW are around half as likely to complete Year 12 as all students.
- TAFE enrolments and qualifications completed by NSW Aboriginal students aged 15 to 19 have increased and the gap between Aboriginal and all students completing TAFE qualifications has narrowed.

Economic development

- Labour force participation by Aboriginal people in NSW was 7.4 percentage points lower than for the total NSW population in 2006 and the gap has increased from 5.6 percentage points in 2002.
- The unemployment rate for Aboriginal people in NSW was 11.5 percentage points higher than for the total population; however the gap has narrowed from 12.3 percentage points in 2001. It is difficult to draw firm conclusions about movements in participation and unemployment rates because of possible sampling errors in the data.
- Unemployment is highest for Aboriginal people with education to Year 9, and lowest for those with a postgraduate degree, similar to the non Aboriginal population.
- Unemployment rates were highest for Aboriginal people in the New England North West region and lowest in the Coastal Sydney region. The highest unemployment rates for non-Aboriginal people were in the North Coast region, and the lowest rates, as with Aboriginal people, were in the Coastal Sydney region.
- In NSW the main employers of Aboriginal people are health care and social assistance (14.5%), public administration and safety (9.9%), education and training (9.4%) and retail trade (9.1%).
- The representation of Aboriginal people in the NSW public sector has increased from 1.3% in 2001 to 1.9% in 2006, close to the *Two Ways Together* target of 2%. However, the proportion of Aboriginal staff in the Australian public service in New South Wales fell from 2.2% in 2002 to 1.7% in 2006.
- In 2006, the median personal income for Aboriginal people aged 15 and over in NSW was $296, compared to $461 for all NSW residents. The median weekly income for Aboriginal households was $727, compared to $1,034 for all NSW households.
- Incomes across regions vary considerably. The highest median income for Aboriginal people in any region was Coastal Sydney, at $416, while the Western NSW region had the lowest median income at $242.
- The percentage of Aboriginal people in NSW owning or purchasing their home in 2006 was 36.2 compared to 64% of non-Aboriginal households. The gap has narrowed since 2001.

Justice

- The gap between Aboriginal and non-Aboriginal reported crime in NSW did not change between 2002 and 2006.
- Aboriginal people in NSW, particularly women, remain significantly over-represented among reported victims of sexual assault, domestic violence related assault and personal crimes. Aboriginal females are 4.3 times more likely than the general female population to be the victim of one of these crimes.
- Aboriginal people in NSW, particularly males, remain significantly over-represented as victims of non-domestic assault. In 2006, the rate of recorded personal violence against Aboriginal males was 80% higher than the general male population.
- Aboriginal adults and young people in NSW are around 7 times more likely to appear in a criminal court than the general population. In 2006, 22% of adult Aboriginal males in NSW appeared in court, compared to 3% of the total adult male population, and 7% of adult Aboriginal females appeared in court, compared to less than 1% of all females.
- In NSW, Aboriginal incarceration is significantly higher than the total population. In 2006, 20% of the adult male prison population was Aboriginal and 33% of the adult female prison population was Aboriginal. The rate of imprisonment among Aboriginal men and women rose in 2006.
- Aboriginal males in NSW had a remand rate 12 times higher than the total male rate and this rate has risen by 49% since 2001.
- The rate of NSW Aboriginal juveniles on remand and the rate of juveniles serving control orders were both 10 times higher than the rates for all juveniles and this had not changed since 2001.
- Repeat offending among NSW Aboriginal adults is 24 percentage points higher than for all adults although the Aboriginal repeat offending rate has dropped by 3 percentage points from 2000 to 2004.

Families and young people

- Young NSW Aboriginal people aged 15 to 24 years are twice as likely as non-Aboriginal people in the same age range to be hospitalised for self harm. Hospitalisations for self-harm have been rising in both Aboriginal and non-Aboriginal people in recent years, especially in young people. The rise has been greater in the Aboriginal population.
- Aboriginal children and young people in NSW are 3 times more likely than all children and young people to be reported to police as victims of domestic violence related assault and sexual assault. Aboriginal females are nearly 6 times more likely than are all NSW females to be recorded as victims of domestic violence. The gap in victimisation rates between Aboriginal and other children and young people has narrowed slightly because of greater rises in victimisation rates in the general population.
- Aboriginal clients accounted for 23% of all clients accessing SAAP services with children in NSW in 2005/06. Two thirds of all Aboriginal SAAP clients are female and the proportion is rising slowly. Over 90% of Aboriginal people who access SAAP services to escape domestic violence are female.
- The number of children involved in reports referred to the NSW Department of Community Services for further assessment is increasing and the number of Aboriginal children involved is increasing at a faster

rate than for all children. Despite accounting for just 4% of the total population of children and young people in the NSW population, Aboriginal children and young people make up 13.7% of all reports referred for further assessment in 2006/07.
- Thirty percent of all children in out-of-home care in NSW are Aboriginal, a significant over-representation, and this percentage has increased from 27% in 2003.
- In 2007, 85% of Aboriginal children in out-of-home care in NSW were placed in accordance with the Aboriginal Child Placement Principle and 64% were placed with relatives or kin.

Culture and heritage

- Almost one quarter of Aboriginal people aged 15 years or over in NSW live in homelands or traditional country. Aboriginal people in remote areas are more likely than those in non-remote areas to be living in traditional country.
- Forty two percent of Aboriginal people in NSW identify with a particular clan, tribal or language group but only about 800 Aboriginal people in NSW speak an Aboriginal language at home.
- The number of Aboriginal owned or controlled lands in NSW rose from 10 in 2002 to 81 in 2006. This increase was largely due to the granting of 62 land claims under the *Aboriginal Land Rights Act 1983* over the period.
- The number of formal access agreements providing for Aboriginal community access to NSW public lands rose from 3 in 2002 to 30 in 2006. Many access agreements between Aboriginal communities and government agencies are informal.

Housing and infrastructure

- The gap between Aboriginal and non-Aboriginal people in NSW owning or purchasing their own home has narrowed between 2001 and 2006. However, the proportion of Aboriginal households owning or purchasing a home was still 31.7 percentage points lower than non-Aboriginal households.
- The proportion of NSW Aboriginal households living in social housing is higher than the general population, and has been increasing, reflecting the socio-economic disadvantage that many Aboriginal people experience, and the difficulties that Aboriginal people can face in securing housing in the private market, including a lack of affordable housing, lack of appropriate housing and discrimination.
- The proportion of Aboriginal households living in mainstream public housing is generally higher in the NSW western regions, and the proportion of new public housing allocations has been highest in the Western NSW region.
- Homelessness is a considerable issue for Aboriginal people, who are significantly over-represented as clients of the Supported Accommodation Assistance Program (SAAP). It has been estimated that 1.1% of the NSW Aboriginal population is homeless.
- A range of environmental health factors can impact on disease rates and can contribute to poorer outcomes in education and employment. Such factors include overcrowding in housing, and poor standards of housing and infrastructure.
- Within social housing in NSW, Aboriginal households are nearly three times more likely to live in overcrowded conditions.
- The provision of safe and effective water, sewerage and waste collection services is a critical issue for discrete Aboriginal communities in NSW. While data on the number of communities with water, sewerage or waste disposal problems is limited, it is clear that Aboriginal people living in discrete Aboriginal communities face much greater environmental health risks and receive a much lower level of water, sewerage and waste disposal services than do mainstream communities.
- The Housing for Health program improves health hardware in houses with Aboriginal residents, and has been provided to 871 houses in Aboriginal communities in NSW since 2002 as part of the Aboriginal Community Development Program (ACDP). Almost 3,300 Aboriginal people have benefited from the Housing for Health program.

ATTACHMENT E - Separations and Separation Rates – SSWAHS Residents *(Aboriginal and Non-Aboriginal)*

2004-05 to 2006-07

Separations and Separation Rates - SSWAHS Residents (Aboriginal and Non-Aboriginal)
2004-05 to 2006-07

ESRG		Aboriginal and/or Torres Strait Islander				Non Aboriginal 2006-07	Per 100,000 Non Aboriginal pop
		2004-05	2005-06	2006-07	Per 100,000 Aboriginal pop		
111	Chest Pain	61	61	61	433.24	5311	413.96
112	Unstable Angina	9	8	4	49.72	766	59.71
113	Heart Failure and Shock	10	13	12	82.86	2200	171.48
114	Non-Major Arrhythmia and Conduction Disorders	7	8	12	63.92	2132	166.18
115	AMI W/O Invasive Cardiac Inves Proc	10	14	5	68.66	1155	90.03
119	Other Cardiology	22	11	21	127.84	2228	173.66
121	Invasive Cardiac Inves Proc	14	24	23	144.41	2350	183.17
122	Percutaneous Coronary Angioplasty	20	22	9	120.74	1510	117.70
129	Other Interventional Cardiology	2	3	2	16.57	658	51.29
131	Dermatology	14	8	17	92.33	834	65.01
141	Diabetes	21	22	14	134.94	1075	83.79
149	Other Endocrinology	6	5	12	54.45	1300	101.33
151	Oesophagitis, Gastroent and Misc Digestive System Disorders	15	38	33	203.60	4059	316.38
152	Gastroscopy	16	22	24	146.78	3370	262.67
153	ERCP	3	4	9	37.88	730	56.90
159	Other Gastroenterology	24	45	54	291.19	3468	270.31
161	Other Colonoscopy	24	15	28	158.62	4072	317.39
162	Other Gastrsocopy	26	25	14	153.88	2404	187.38
172	Lymphoma and Non-Acute Leukaemia	2	4	5	26.04	1431	111.54
173	Haematological Surgery			4	9.47	96	7.48
179	Other Haematology	8	6	8	52.08	2810	219.02
181	Cellulitis	36	37	58	310.13	2521	196.50
182	Septicaemia, Viral and Other Infectious Diseases	48	45	47	331.44	3510	273.59
183	HIV	4	11	4	44.98	115	8.96
191	Respiratory Neoplasms	3	6	3	28.41	600	46.77
192	Digestive Malignancy	6	2		18.94	392	30.55
199	Other Medical Oncology	11	10	9	71.02	1553	121.05
201	Chemotherapy	3			7.10	953	74.28
211	Stroke	13	4	9	61.55	1635	127.44
212	TIA	1	2	2	11.84	625	48.72
213	Seizures	31	39	30	236.74	1547	120.58
219	Other Neurology	31	24	42	229.64	4158	324.09
221	Renal Failure	7	5	1	30.78	484	37.73
229	Other Renal Medicine	9	16	21	108.90	1707	133.05
231	Renal Dialysis	574	501	708	4221.12	53577	4176.04
241	Bronchitis and Asthma	42	45	37	293.56	2749	214.27
242	Chronic Obstructive Airways Disease	41	42	47	307.77	2928	228.22
243	Respiratory Infections/Inflammations	31	43	45	281.72	3670	286.06
244	Respiratory System OR Procedures	2	6	5	30.78	259	20.19
249	Other Respiratory Medicine	35	26	32	220.17	3596	280.29
251	Rheumatology	4	3	6	30.78	876	68.28

ESRG		Aboriginal and/or Torres Strait Islander					
		2004-05	2005-06	2006-07	Per 100,000 Aboriginal pop	Non Aboriginal 2006-07	Per 100,000 Non Aboriginal pop
261	Pain Management	10	7	13	71.02	1041	81.14
271	Kidney and Urinary Tract Infections	17	21	23	144.41	2249	175.30
272	Gastroenteritis	17	21	27	153.88	1801	140.38
273	Syncope and Collapse	9	7	6	52.08	1303	101.56
274	Laryngotracheitis and Acute Bronchiolitis	51	26	29	250.95	1316	102.58
279	Other Non Subspecialty Medicine	71	102	89	620.27	8127	633.46
411	Breast Surgery	2	2	11	35.51	1030	80.28
421	Coronary Bypass	4	3	4	26.04	398	31.02
429	Other Cardiothoracic Surgery	7	7	4	42.61	620	48.33
431	Major S and L Bowel Procs incl Rectal Resection	2	5	7	33.14	1079	84.10
439	Other Colorectal Surgery	15	8	18	97.06	2384	185.82
441	Cholecystectomy	19	19	22	142.05	1827	142.40
442	Disorders of Biliary Tract and Pancreas	29	32	24	201.23	1296	101.02
449	Other Upper GIT Surgery	2	5	5	28.41	850	66.25
451	Thyroid Procedures		4	2	14.20	404	31.49
459	Other Head and Neck Surgery	3	7	6	37.88	425	33.13
461	Head Injuries	3	7	6	37.88	302	23.54
462	Craniotomy	6	3	3	28.41	576	44.90
463	Neurosurgery - Non-procedural	11		10	49.72	906	70.62
469	Other Neurosurgery	7	3	5	35.51	784	61.11
471	Dental Extractions and Restorations	26	26	24	179.92	962	74.98
481	Tonsillectomy or Adenoidectomy	11	11	21	101.80	783	61.03
482	Myringotomy W Tube Insertion	8	8	11	63.92	265	20.66
483	Non-Procedural ENT	24	27	19	165.72	1697	132.27
489	Other Procedural ENT	16	14	14	104.17	1258	98.05
491	Injuries to limbs - Medical	34	34	38	250.95	3606	281.07
492	Wrist and Hand Procedures incl Carpal Tunnel	32	20	20	170.45	1973	153.78
493	Hip and Knee Replacement	5	5	9	44.98	1638	127.67
494	Knee Procedures	12	6	12	71.02	1048	81.69
495	Other Orthopaedics - Surgical	37	44	53	317.23	4826	376.16
499	Other Orthopaedics - Non-Surgical	18	18	16	123.11	1584	123.46
502	Non-procedural Ophthalmology	6	4	3	30.78	606	47.23
503	Glaucoma and Lens Procedures	11	16	13	94.70	2935	228.77
509	Other Eye Procedures	9	11	13	78.13	1229	95.79
511	Microvascular Tissue Transfer or Skin Grafts	4	9	11	56.82	870	67.81
512	Skin, Subcutaneous Tissue and Breast Procedures	14	17	14	106.53	1949	151.91
513	Maxillo-Facial Surgery	4	4	10	42.61	246	19.17
514	Burns - Medical	6	2	6	33.14	296	23.07
515	Dental and Oral Disease excl extractions	13	10	13	85.23	628	48.95
519	Other Plastic and Reconstructive Surgery	9	6	10	59.19	738	57.52
521	Cystourethroscopy	4	10	8	52.08	1952	152.15
522	Urinary Stones and Obstruction	3	7	5	35.51	1430	111.46
523	TURP	1		2	7.10	502	39.13
524	Other Non-procedural Urology	8	9	9	61.55	1155	90.03
525	Male Sterilisation	1	3	2	14.20	178	13.87
529	Other Urological Procedures	16	20	17	125.47	2278	177.56
531	Vein Ligation and Stripping	3	3	4	23.67	370	28.84

ESRG		Aboriginal and/or Torres Strait Islander				Non Aboriginal 2006-07	Per 100,000 Non Aboriginal pop
		2004-05	2005-06	2006-07	Per 100,000 Aboriginal pop		
532	Non-procedural Vascular Surgery incl Skin Ulcers	4	9	5	42.61	953	74.28
539	Other Vascular Surgery Procedures	7	7	9	54.45	1220	95.09
541	Injuries - Non-surgical	50	58	69	419.03	3423	266.80
542	Abdominal Pain	30	36	39	248.58	2402	187.22
543	Appendicectomy	8	13	15	85.23	1256	97.90
544	Digestive System Diagnoses incl GI Obstruction	5	13	19	87.59	1668	130.01
545	Inguinal and Femoral Hernia Procedures Age>0	7	3	3	30.78	1133	88.31
546	Post-operative Infections and Sequlae of Treatment	11	8	16	82.86	1063	82.86
547	Other non-Specialty Surgery - No procedure	9	9	17	82.86	738	57.52
549	Other Non-specialty Surgery	38	33	46	276.99	3436	267.82
611	Transplantation					61	4.75
621	Extensive Burns	5	1	2	18.94	117	9.12
631	Tracheostomy	8	8	13	68.66	575	44.82
711	Abortion W DandC, Aspiration Curettage or Hysterotomy	17	16	19	123.11	1640	127.83
712	Endoscopic Procedures for Female Reproductive System	15	13	5	78.13	716	55.81
713	Conisation, Vagina, Cervix and Vulva Procedures	12	9	10	73.39	1094	85.27
714	Diagnostic Curettage or Diagnostic Hysteroscopy	8	12	9	68.66	1182	92.13
715	Hysterectomy	8	7	9	56.82	789	61.50
716	Other Gynaecological Surgery	30	33	17	189.39	2528	197.04
717	Non-procedural Gynaecology	14	19	18	120.74	1073	83.63
721	Ante-natal Admission	127	146	219	1164.77	6988	544.68
722	Vaginal Delivery	150	182	191	1238.16	12532	976.80
723	Caesarean Delivery	50	64	64	421.40	4074	317.55
724	Post-natal Admission	9	12	6	63.92	531	41.39
731	Qualified Neonate	48	52	55	366.95	2067	161.11
741	Unqualified Neonate	169	201	210	1373.11	15429	1202.61
751	Perinatology	10	30	30	165.72	615	47.94
811	Drug and Alcohol	159	165	197	1233.43	4233	329.94
821	Schizophrenia	64	52	65	428.50	1755	136.79
822	Major Affective Disorders	19	16	28	149.15	1056	82.31
829	Other Psychiatry	90	206	123	991.95	5801	452.16
831	Psychiatry - Non Acute	3	3	2	18.94	257	20.03
841	Rehabilitation	21	28	21	165.72	5384	419.65
851	Non Acute Geriatric			1	2.37	243	18.94
861	Palliative Care	1	10	4	35.51	2025	157.84
871	Maintenance		2	2	9.47	615	47.94
991	Unallocated	2	6	23	73.39	2490	194.08
999	Unallocated	1	4	2	16.57	204	15.90
Total All ESRGs		**3075**	**3344**	**3751**	**24076.70**	**290500**	**22642.90**

Source: FLOWINFO V9.1 - all separations including acute, unqualified neonates (well babies), sub-acute, psychiatric and other.

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACCAHSS	Aboriginal Chronic Conditions Area Health Service Standards
ACE	Adolescents Coping with Emotions
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACYFS	Aboriginal Child Youth and Family Strategy
AHEO	Aboriginal Health Education Officer
AHET	Aboriginal Health Executive Team
AHIS	Aboriginal Health Impact Statement
AHMAC	Australian Health Ministers' Advisory Council
AHMRC	Aboriginal Health & Medical Research Council of NSW
AHO	Aboriginal Housing Office
AHP	Allied Health Professional
AHS	Area Health Service
AHSM	Aboriginal Health Service Manager
AHU	Aboriginal Health Unit (Bangala)
AHW	Aboriginal Health Worker
AIDB	AIDS/Infectious Diseases Branch (NSW Health)
AIHW	Australian Institute of Health and Welfare
ALO	Aboriginal Liaison Officer
AMHS	Area Mental Health Service
AMHW	Aboriginal Mental Health Worker
AMIHS	Aboriginal Maternal and Infant Health Strategy
AMS	Aboriginal Medical Service
AN_SNAP	Australian National Sub-Acute and Non-Acute Patient Classification
ANTaR	Australians for Native Title and Reconciliation
ANZDATA	Australian & New Zealand Dialysis & Transplant Registry
ASHM	Australasian Society for HIV Medicine
ASHW	Aboriginal Sexual Health Worker
BBV	Blood Borne Virus
CAAH	Centre for the Advancement of Adolescent Health
CAMHS	Child & Adolescent Mental Health Services
CAPACS	Community Acute & Post Acute Care Service
CBT	Cognitive Behavioural Therapy
CEWD	Centre for Employment and Workforce Development
CFHN	Child & Family Health Nurse
CHC	Community Health Centre
CHETRE	Centre for Health Equity Training, Research & Evaluation
CHOCIP	Community Health and Outpatient Care Data Collection
CKD	Chronic Kidney Disease
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CPITN	Community Periodontal Index of Treatment Needs
CRIAH	Coalition for Research to Improve Aboriginal Health
CSAHS	Central Sydney Area Health Service (former)
DADHC	Department of Ageing, Disability & Homecare
DAA	Department of Aboriginal Affairs
D&A	Drug & Alcohol
DHS	Drug Health Services
DMFT	Decayed, Missing or Filled Teeth
DoCS	Department of Community Services
DoH	Department of Housing
DoHA	Department of Health and Ageing (Commonwealth)
DV	Domestic Violence
ECOH	Early Childhood Oral Health
ED	Emergency Department
EDD	Estimated Date of Discharge
EPC	Enhanced Primary Care
ESKD	End Stage Kidney Disease
ESRG	Enhanced Service Related Group
FAE	Foetal Alcohol Effects
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FAS	Foetal Alcohol Syndrome
G&S	Goods and Services
GP	General Practice
HACC	Home & Community Care Program
HARP	HIV and Related Programs
HASI	Housing & Accommodation Support Initiative
HCV	Hepatitis C Virus
HIC	Health Insurance Commission
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HS&JMSRN	Human Services & Justice Metropolitan Sydney Regional Network
HS&JSOG	Human Services & Justice Senior Officers Group
HSNet	Human Services Network
ICC	Indigenous Coordination Centre(s)
IDU	Intravenous Drug User
IPTASS	Isolated Patient Transport & Accommodation Assistance Scheme
JGoS	Joint Guarantee of Service
KPI	Key Performance Indicator
LGA	Local Government Area
LOS	Length of Stay
MDS	Minimum Data Set
MHDAO	Mental Health and Drug and Alcohol Office
MH-OAT	Mental Health Outcomes Assessment Tool
MOU	Memorandum of Understanding
N/A	Not Applicable
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aborigines and Islanders Day Observance Committee

NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCIRS	National Centre for Immunisation Research & Surveillance of Vaccine Preventable Diseases
NGO	Non Government Organisation
NSP	Needle & Syringe Program(s)
NSW Health	NSW Department of Health
OATSIH	Office for Aboriginal & Torres Strait Islander Health
OHFSS	Oral Health Fee for Service Scheme
Oxfam	from Oxford Committee for Famine Relief (1942)
PAWG	Priority Area Working Group
PBS	Pharmaceutical Benefits Scheme
PDHPE	Personal Development, Health and Physical Education
PDS	Pensioners Dental Scheme
PECC	Psychiatric Emergency Care Centre
PHU	Public Health Unit
POA	Principles of Action
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RCMG	Regional Coordination Management Group
REMS	Research Evidence Management & Surveillance (SSWAHS Unit)
REG (*TWT*)	Regional Engagement Group (*TWT*)
REPIDU	Resource & Education Program for Injecting Drug Users
RPAH	Royal Prince Alfred Hospital
SAAP	Supported Accommodation Assistance Program
SAOG	Senior Aboriginal Officers Group
SCATSIH	Standing Committee (to AHMAC) on Aboriginal and Torres Strait Islander Health
SDH	Sydney Dental Hospital
SDPP	Sydney Diabetes Prevention Program
SHIP	Sexual Health Information Program
SNAP	Sub and Non-Acute Patients Data Collection
SOG	Senior Officers Group
SSWAHS	Sydney South West Area Health Service
SSWOHS	Sydney South West Oral Health Services
STI	Sexually Transmissable Infection
SW	Social Work(er)
SWSAHS	South Western Sydney Area Health Service (former)
TACP	Transitional Aged Care Program
TAFE	Technical & Further Education
TAG	Transport Access Guide
TOR	Terms of Reference
TWT	*Two Ways Together*

References

Aboriginal Affairs Chief Executive Officers Group, *Two Ways Together: Alignment with the State Plan*, 23 February 2007

Aboriginal Health & Medical Research Council Consultancy Service in association with Mandala Consulting, *Increasing access to services in NSW for Aboriginal people at Risk of Contracting or who have Blood Borne Infections*, 2004, Sydney.

Aboriginal Health & Medical Research Council & NSW Health, *NSW Aboriginal Health Partnership Agreement* (2008), Sydney, NSW.

Aboriginal Health & Medical Research Council & the Sax Institute Research Partnerships for Better Health (Dec 2007), *CRIAH Tools for Collaboration*, Sydney, NSW.

Aboriginal and Torres Strait islander Social Justice Commissioner and the Standing Committee for Indigenous Health Equality (2008), *Close The Gap National Indigenous Health Equality Targets – Outcomes from the National Indigenous Health Equality Summit*, Canberra, March 18-20, 2008, Human Rights and Equal Opportunity Commission, Canberra, ACT.

Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Health Survey, Australia 2004-05*, Cat. 4715.0, Canberra, ACT

Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Social Survey 2002*, Cat. 4714.0, Canberra, ACT

Australian Bureau of Statistics, *National Health Survey: Aboriginal and Torres Strait Islander Results, Australia 2001*, Cat. 4715.0, Canberra, ACT

Australian Bureau of Statistics & Australian Institute of Health and Welfare (2008), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, Canberra, ACT

Australian Government (2006), Department of Health and Ageing, *Aboriginal and Torres Strait Islander Health Performance Framework*, Commonwealth of Australia, Canberra, ACT

Australian Government (2007), Department of Health and Ageing, *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-13, Australian Government Implementation Plan 2007-2013*, Commonwealth of Australia, Canberra, ACT

Australian Institute of Health and Welfare (November 2007), *Older Australia at a glance*, 4th edition, Canberra, ACT

Australian Institute of Health and Welfare (2005), *Chronic kidney disease in Australia 2005*, AIHW cat. No. PHE 68, Canberra, ACT

Australian Institute of Health and Welfare (2005), *Improving the quality of Indigenous identification in hospital separations data*, AIHW cat. No. HSE 101, Canberra, ACT

Australian Institute of Health and Welfare (2006), *International Group for Indigenous Health Measurement, Vancouver 2005,* AIHW cat. No. IHW 18, Canberra, ACT

Australian Institute of Health and Welfare & Australian Bureau of Statistics (2006), *Recent developments in the collection of Aboriginal and Torres Strait Islander health and welfare statistics 2005*, AIHW cat. No. IHW 15, ABS cat. No. 4704.0.55.001, Canberra, ACT

Australian Health Ministers' Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework 2005*, 2006, AHMAC, Canberra, ACT

Australian Health Ministers' Advisory Council, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, May 2002, Canberra, ACT

Australian Institute of Health and Welfare, *Homeless people in SAAP: SAAP National Data Collection annual report 2005-06 NSW supplementary tables*, SAAP NDCA report Series 11. Cat no. HOU 157, 2007, Canberra, ACT

Australian Institute of Health and Welfare, *International Group for Indigenous Health Measurement, Vancouver 2005*, Cat. No. IHW 18, 2006, Canberra, ACT

Australian Institute of Health and Welfare, *Older Australia at a glance: 4th edition*, 2007, Cat. No. AGE 52, Canberra, ACT

Banks G, Chairman, Productivity Commission, *Indigenous disadvantage: are we making progress?*, Address to the Committee for Economic Development in Australia (CEDA), 21 September 2005

Black A (2007), *Evidence of Effective Interventions to Improve the Social and Environmental Factors Impacting on Health, Informing the development of Indigenous Community Agreements*, Office for Aboriginal and Torres strait Islander Health, Commonwealth of Australia, Canberra, ACT

Brady M (1992), *The Health of Young Aborigines, A report on the health of Aborigines aged 12 to 25 years prepared for the national Youth Affairs Research Scheme*, Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, ACT.

Cass,A. et al, *The Economic Impact of End-Stage Kidney Disease in Australia*. Kidney Health Australia, Melbourne, 2006 [available at http://www.kidney.org.au/].

Centre for Epidemiology and Research, NSW Department of Health (2007), *NSW Mothers and Babies 2005*, NSW Public Health Bulletin 2007: 18(S-1)

Close the Gap, *Solutions to the Indigenous Health Crisis facing Australia*, A Policy Briefing Paper from the National Aboriginal Community Controlled Health Organisation and Oxfam Australia, April 2007, Sydney

Condon J, Cooperative Research Centre for Aboriginal and Tropical Health, *Cancer, Health Services & Indigenous Australians*, Consultant Report No. 5, Aboriginal and Torres Strait Islander Primary Health Care Review, Commonwealth of Australia, 2004

Daly, A & Smith, D (2003), *Reproducing exclusion or inclusion? Implications for the wellbeing of Indigenous Australian children,* Discussion Paper No. 253, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Dwyer J, Silburn K & Wilson G, La Trobe University, *National Strategies for Improving Indigenous Health and Health Care*, Consultant Report No. 1, Aboriginal and Torres Strait Islander Primary Health Care Review, Commonwealth of Australia, 2004

Eades S, Menzies School of Health Research, *Maternal and Child Health Care Services: Actions in the Primary Health Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children*, Consultant Report No. 6, Aboriginal and Torres Strait Islander Primary Health Care Review, Commonwealth of Australia, 2004

Eagar K et al. (2008), *Community health at the crossroads: which way now? Final report of the NSW Community Health Review*, Centre for Health Service Development, University of Wollongong.

Eagar K , Owen A, Cranny C, Samsa P and Thompson C (2008), *Community health: the state of play. A report for the NSW Community Health Review*, Centre for Health Service Development, University of Wollongong.

Epidemiology Unit, Division of Population Health for the Evaluation Sub-Committee of the Implementation Committee, South Western Sydney Area Health Service Aboriginal Health Strategic Plan (2003), *Ngalawa Bunga Mana (Life information) Aboriginal Health and Demography in South Western Sydney*, SSWSAHS, Sydney.

Families NSW supporting families to raise children (2008), Metro South West Region, *Families NSW Strategic Plan 2008/09-2010/11*.

Fitzgerald J & Weatherburn D, *Aboriginal Victimisation and Offending: The Picture from Police Records*, Crime and Justice Statistics Bureau Brief, NSW Bureau of Crime Statistics and Research, December 2001

Framework Document, *Overarching Agreement on Aboriginal Affairs between the Commonwealth of Australia and the State of New South Wales 2005-2010*,

Grotberg EH (2004), *Children and Caregivers: The Role of Resilience*, paper presented at the International Council of Psychologists (ICP) Convention - Jinan, China, July, 2004

Grote E (2008), *Principles and Practices of Cultural Competency: A Review of the Literature*, paper prepared for the Indigenous Higher education Advisory Council (IHEAC), Department of Education, Employment and Workplace Relations, Canberra, ACT.

Holmes W et al, *Researching Aboriginal health; experience from a study of urban young people's health and well-being*, Social Science & Medicine, Vol 54 (2002), pps 1267-1279.

Inner West Aboriginal Community Co Ltd, *Growing Up Strong Guring*, Aboriginal Child, Youth and Family Strategy, September 2006

Ivers R, Palmer A, Jan S & Mooney G, *Issues Relating to Access to Health services by Aboriginal and Torres strait Islander People*, Discussion Paper 1/97, 2007, Department of Public Health and Community Medicine, University of Sydney

Lasker R D and Weiss E S, *Broadening Participation in Community Problem Solving: a Multidisciplinary Model to Support Collaborative Practice and Research*, Journal of Urban Health: Bulletin of the New York Academy of Medicine 2003; Vol 80 No 1: 14-60

Leahy T, Khan G & Doyle M, 2006, *What is the future of cultural safety training? Report on the post-pilot development of training for GPs to assist them to work better with Aboriginal and Torres Strait Islander people*, Aboriginal Health Council of WA, Perth, Western Australia

Legislative Council (June 2008), Standing Committee on Social Issues, *Overcoming Indigenous disadvantage in New South Wales – Interim Report*, Report 40, Sydney, NSW.

Lutschini M, *Engaging with holism in Australian Aboriginal health policy – a review*, Australian and New Zealand Health Policy 2005, Vol 2, No 15

McIntyre PB et al, *Immunisation: reducing health inequality for Indigenous Australians*, MJA, Vol 182 No 5, 7 March 2005.

Ministerial Council on Drug Strategy (May 2006), *National Drug Strategy, Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*, Canberra, ACT

Ministerial Council on Education, Employment, Training and Youth Affairs (2008), *National Report on Schooling in Australia 2006, Preliminary Paper, National Benchmark Results Reading, Writing and Numeracy Years 3, 5 and 7*, Canberra, ACT.

Morris K et al (2004), *Research Gaps in Indigenous Sexual Health, Establishing evidence-based best practice for social and behavioural interventions: Technical Report*, Australian Research Centre in Sex, Health and Society, La Trobe University & VicHealth Koori Health Research & Community Development Unit, Melbourne.

National Aboriginal Community Controlled Health Organisation (2006), *2006/07 Overview and Action Plan, Aboriginal Peoples Making the Health System Equitable*, Canberra, ACT

National Aboriginal Community Controlled Health Organisation (2001), *The Management of Middle Ear Infection in Aboriginal and Torres Strait Islander Populations – Plain Language Summary of the Systematic Review on the Management of Otitis Media in Aboriginal and Torres Strait islander Populations,* For the Office for Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Aged Care, Canberra, ACT.

National Aboriginal Community Controlled Health Organisation, *National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples*, prepared for the Royal Australian College of General Practitioners, August 2005

National Advisory Committee on Oral Health (A Committee established by the Australian Health Ministers' Conference), *healthy mouths, healthy lives - Australia's National Oral Health Plan 2004-2013*, July 2004

National Health and Hospitals Reform Commission, *A Healthier Future for All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009*, Commonwealth of Australia 2009

National Health and Medical Research Council (2005), *Keeping research on track, A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*, Commonwealth of Australia, Canberra, ACT

National Health and Medical Research Council (2003), *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, Commonwealth of Australia, Canberra, ACT

National Youth Commission (2008), *Australia's Homeless Youth, A Report of the National Youth Commission Inquiry into Youth Homelessness*, Brunswick, Victoria.

NSW Department of Aboriginal Affairs, *Two Ways Together Regional Plans Planning Framework*, 25 January 2007

NSW Health (2003), *Aboriginal Workforce Development Strategic Plan 2003-2007,* NSW Department of Health, Sydney, NSW.

NSW Health (2005), *NSW Aboriginal Chronic Conditions Area Health Service Standards, Cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer,* NSW Department of Health, Sydney, NSW.

NSW Health (1998), *NSW Aboriginal Health Information Guidelines,* NSW Department of Health, Sydney, NSW.

NSW Health (2007), *NSW Aboriginal Mental Health and Well Being Policy 2006-2010,* Policy Directive, NSW Department of Health, Sydney, NSW.

NSW Health (2007), *NSW Immunisation Strategy 2008-2011,* NSW Department of Health, Sydney, NSW.

NSW Health (Oral Health Promotion Statewide Steering Committee), *NSW Oral Health Promotion: A Report on the Literature, You can't be healthy without good oral health*, August 2004

NSW Health (Oral Health Promotion Statewide Steering Committee), *NSW Oral Health Promotion: Framework for Action 2010, Aboriginal and Torres Strait Islander Peoples, You can't be healthy without good oral health*, October 2004

NSW Health, *Principles for better practice in Aboriginal health promotion*, The Sydney Consensus Statement NSW Health 2002, 2004.

NSW Health, *The health of the people of New South Wales, Report of the Chief Health Officer, 2006*, NSW Department of Health, December 2006, Sydney, NSW.

NSW Premier's Department (2006), Public Employment Office, *Making It Our Business, Improving Aboriginal Employment in the NSW Public Sector, NSW Policy Statement 2006-2008*, July 2006, Sydney, NSW.

Peiris, D., *CVD Risk Assessment & Management for Aboriginal People,* Powerpoint presentation 2007, Indigenous Health Services Research Program, The George Institute for International Health, Sydney.

Pollitt C, 2003, *Joined-up Government — A survey*, Political Studies Review, vol. 1, pp. 34-49.

Redfern-Waterloo Authority (2005), *Redfern-Waterloo Human Services Plan Phase One*, Sydney

Redfern-Waterloo Authority (2008), *Redfern-Waterloo Human Services Plan Phase Two*, Sydney

Scrimgeour M & Scrimgeour D, 2007, *Health Care Access for Aboriginal and Torres Strait Islander People Living in Urban Areas, and Related Research Issues: A Review of the Literature*, Cooperative Research Centre for Aboriginal Health, Darwin.

Shannon C & Longbottom H, School of Population Health, University of Queensland, *Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies*, Consultant Report No. 4, Aboriginal and Torres Strait Islander Primary Health Care Review, Commonwealth of Australia, 2004

Snowball L & Weatherburn D, *Indigenous over-representation in prison: The role of offender characteristics*, Crime and Justice Bulletin, NSW Bureau of Crime Statistics and Research, No. 99, September 2006

Swan P & Raphael B (1995), *Ways Forward, National Aboriginal and Torres Strait Islander Mental Health Policy, National Consultancy Report*, Commonwealth of Australia, Canberra, ACT

Sydney South West Area Health Service (2008), Draft *Aboriginal Health Promotion Action Plan 2008-2011*, SSWAHS, Sydney, NSW.

Sydney South West Area Health Service (2008), Draft *Aboriginal Men's Health Implementation Plan 2008-2011*, SSWAHS, Sydney, NSW.

Sydney South West Area Health Service (2007), *SSWAHS Community Health Strategic Plan 2007 - 2012,* SSWAHS, Sydney, NSW.

Sydney South West Area Health Service (2006), *SSWAHS Otitis Media Action Plan 2006-2008,* SSWAHS, Sydney, NSW.

Sydney South West Area Health Service (2007), *SSWAHS Transport for Health Plan,* SSWAHS, Sydney, NSW.

Sydney South West Area Health Service (2008), *Walgan Tilly Project High Level Implementation Plan – Culturally Sensitive and Effective Discharge Planning & Improving Access to Primary Health Care Setting*, SSWAHS, Sydney, NSW.

Taylor R, *Indigenous Community Capacity Building and the relationship to sound governance and leadership*, National NT Conference, June 2003.

The California Wellness Foundation, *Reflections on Capacity Building*, Vol 2, No. 2, April 2001

Two Ways Together, *Partnerships: A New Way of Doing Business with Aboriginal People, New South Wales Aboriginal Affairs Plan 2003-2012*, NSW Department of Aboriginal Affairs, Sydney.

Two Ways Together *Regional Report (Public Report) Coastal Sydney*, November 2006, NSW Department of Aboriginal Affairs, Sydney.

Two Ways Together *Regional Report (Public Report) Western and South-Western Sydney*, November 2006, NSW Department of Aboriginal Affairs, Sydney.

Two Ways Together, *Report on Indicators 2007*, NSW Department of Aboriginal Affairs, Sydney, NSW.

United Nations, Commission on the Social Determinants of Health, *Social determinants and Indigenous health: The International experience and its policy implications*, Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health, 2007, Adelaide, SA.

Urbis Keys Young, *Aboriginal and Torres Strait Islander Access to Major Health Programs*, Prepared for Medicare Australia and the Department of Health and Ageing, November 2006

Vale M J et al (2003), *Coaching On Achieving Cardiovascular Health (COACH), A Multicenter Randomized Trial in patients With Coronary Heart Disease*, Archives of Internal Medicine, Vol 163, Dec 8/22 (2003), pps 2775-2783.

Vale M J et al (2002), *Coaching patients with coronary heart disease to achieve the target cholesterol: A method to bridge the gap between evidence-based medicine and the "real world" – randomized controlled trial,* Journal of Clinical Epidemiology, Vol 55 (2002) pps 245-252.

Vicary D & Bishop B (2005), *Western psychotherapeutic practice: Engaging Aboriginal people in culturally appropriate and respectful ways*. Australian Psychologist, 40(1), 8-19.

Victorian Department of Human Services (2007), Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP), *Best Practice Information Package – Discharge planning for Aboriginal and Torres Strait Islander patients*, November 2007.

Weatherburn D, Snowball L & Hunter B, *The economic and social factors underpinning Indigenous contact with the justice system: Results from the 2002 NATSISS survey*, Crime and Justice Bulletin, NSW Bureau of Crime Statistics and Research, No. 104, October 2006

Wenitong, M (2006), *Aboriginal and Torres Strait Islander male health, wellbeing and leadership*, MJA, Vol 185 No 8, 16 October 2006.

Westerman T (2004), *Engagement of Indigenous clients in mental health services: What role do cultural differences play?* Australian e-Journal for the Advancement of Mental Health, 3(3).

Williams, R (undated), *Cultural safety – What does it Mean for our Work Practice*, Faculty of Aboriginal & Torres strait Islander Studies, Northern Territory University, Darwin, NT.

Willis J, Anderson I & Morris K (2005), *Sexual Health Promotion for Aboriginal and Torres Strait Islander People, A community guide to evidence-based best practice in social and behavioural interventions*, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne

Working Party of Aboriginal and Torres Strait Islander Male Health & Well Being Reference Committee, 2003, *A National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males: exposure draft,* The Office for Aboriginal and Torres Strait Islander Health, Canberra, ACT