

Aboriginal and Torres Strait Islander Health Status Summary

Western Australia 2013

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1.0 Overview of the health status of Indigenous people in Western Australia 2013

This report is a summary of the 'Overview of the health status of Indigenous people in Western Australia 2013' report prepared by the Australian Indigenous Health InfoNet (AIHIN), as relevant to the Outreach in the Outback programs' health priorities. The AIHIN report was prepared as a contribution to 'closing the gap' between Indigenous Australians and non-Indigenous Australians. The majority of the information included in this report has been taken directly from the AIHIN report or has been paraphrased; information from other sources has been referenced accordingly.

This report is primarily a summary of recent information and statistics relating to the health status of Aboriginal and Torres Strait Islander people living in Western Australia (WA). The data has been grouped under each of the programs which are administered by the Outreach in the Outback team. Information relating to cancer, cardiovascular disease, chronic renal (kidney) disease, chronic respiratory disease and diabetes is listed under the Medical Outreach Indigenous Chronic Disease Program. Information relating to eye health, maternal and paediatric health and mental health is listed under the Rural Health Outreach Fund. Information relating to ear and hearing health is listed under the Healthy Ears – Better Hearing, Better Listening Program.

2.0 Western Australia's Indigenous population

As of 30 June 2011 the estimated Aboriginal and Torres Strait Islander population of WA was 88,277, with 43,710 Indigenous males and 44,567 Indigenous females. In 2011, approximately 96% of Indigenous people living in WA were Aboriginal, 1.9% were Torres Strait Islanders, and 1.9% of people identified as being of both Aboriginal and Torres Strait Islander descent. The Indigenous Australian population is considerably younger than the non-Indigenous Australian population.

As of 30 June 2011, 33.0% of all Indigenous Australians lived in a capital city. From 2006-2010, the age-standardised death rate for Indigenous people in WA was 2.5 times the rate for non-Indigenous people in WA. Comparatively, during the same period, the age-standardised death rate for Indigenous people, nationwide, was 1.9 times the rate for non-Indigenous people. For Indigenous people born in WA from 2005-2007, life expectancy was estimated to be 65.0 years for males and 70.4 years for females, approximately 14 and 12.5 years less than the estimates for non-Indigenous males and females, respectively.

3.0 Underrepresentation

For a number of reasons, statistics contained within this report may be underrepresented. Reasons for this include a lack of identification of Indigenous status at birth or during health and medical treatment, unknown paternal Indigenous status relating to births, and under-reporting of various conditions on death certificates.

4.0 Historical context and social determinants of Indigenous health

There is a clear relationship between the social disadvantages experienced by Indigenous Australians and their current health status; this social disadvantage has a clear historical origin. These disadvantages relate directly to dispossession and are characterised by poverty and powerlessness. These disadvantages directly relate to the social determinants of health, as identified by the World Health Organisation (WHO), in the broader areas such as economic opportunities, physical infrastructure, and social conditions and specifically manifest in measures such as education,

employment, income, housing, access to services, social networks, racism, incarceration, and connection with land.

5.0 Terminology

Within this report, the terms 'Indigenous people' and 'Indigenous Australians' will be used to refer collectively to the two Indigenous sub-populations within Australia – Aboriginal people and Torres Strait Islander people. This terminology will be used for the purpose of consistency with the terminology used in the 'Overview of the health of Indigenous people in Western Australia 2013' report and will be used interchangeably to avoid repetition. This terminology is not intended to offend either of the aforementioned populations.

6.0 Medical Outreach Indigenous Chronic Disease Program

The aim of the Medical Outreach Indigenous Chronic Disease Program is to increase access to a range of health services, including expanded primary health for Indigenous people in the treatment and management of chronic diseases. The Medical Outreach Indigenous Chronic Disease Program will focus service delivery on the following five chronic conditions: cancer, cardiovascular disease, chronic renal disease, chronic respiratory disease and diabetes.

6.1 Cancer – Definition, prevalence and incidence, hospitalisation and mortality

Cancer can be defined as a disease in which body cells grow and multiply abnormally due to damage to the DNA (genetic material) of a cell. Cancer is termed 'benign' when damaged cells do not spread to other tissues, and is considered 'malignant' when the cells spread to other areas by a process known as 'metastasis'. Cancer can occur almost anywhere in the body.

According to the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), 1.1% of Indigenous people living in WA reported suffering from cancer, compared with 2.1% of non-Indigenous people. From 2007-2011, after age-adjustment, the overall cancer incidence rates were the same for Indigenous and non-Indigenous people in WA; however, these rates were much higher for Indigenous people for a number of cancers, including cancers of the lung, bronchus and trachea; pharynx; oesophagus; and liver. Age-standardised rates for cervical cancer in WA from 2004-2008 were twice as high for Indigenous women than rates for non-Indigenous women.

The Indigenous:non-Indigenous ratio for cancer incidence (0.6) is lower than the Indigenous:non-Indigenous ratio for deaths due to cancer (1.5); this could be due to a number of factors including poorer screening rates, later diagnoses, poorer treatments and poorer prognosis in Indigenous people.

From 2007-2011, cancer incidence rates in WA were similar or slightly higher for Indigenous males and females than for their non-Indigenous counterparts across all age-groups. For males, the greatest difference occurred among those aged 25-29 years, with an Indigenous:non-Indigenous rate ratio of 1.6; the greatest difference for females was among those aged 10-14 years, with an Indigenous:non-Indigenous rate ratio of 2.3.

Age-standardised hospitalisation rates for cancer were lower for Indigenous people than that for non-Indigenous people (11 and 17 per 1,000, respectively). Hospitalisation rates increased with age in WA in 2008-2010, however, Indigenous:non-Indigenous rate ratios were highest for the 0-34 years age-group (rate ratio of 1.1, as compared with rate ratios ranging from 0.5 to 0.9 for other age groups).

Indigenous cancer incidence rates may be lower than non-Indigenous cancer rates for some cancers;

however, Indigenous death rates tend to be higher than non-Indigenous rates. There were 351 deaths from cancer among Indigenous people living in WA in 2006-2010; after age-adjustment, the death rate for cancer was 1.5 times higher for Indigenous Australians than that for non-Indigenous Australians. The Indigenous death rate for WA rate was higher than the Indigenous death rate for NSW, Qld, WA, SA and the NT combined.

Age-standardised death rates for cancer were higher for Indigenous people living in WA than those of their non-Indigenous counterparts for all types of cancer in 2006-2010. Indigenous people died from lung cancer at 1.8 times the rate and from cervical cancer at 6.0 times the rate of non-Indigenous people. The patterns of Indigenous cancer incidence and mortality are largely explained by the higher level of risk factors, most notably tobacco use. For example, high rates of smoking are the likely cause of a high incidence of cancers of the lung, mouth and throat.

6.2 Cardiovascular disease – Definition, prevalence, hospitalisation and mortality

Cardiovascular disease (CVD) is a term encompassing all diseases affecting the heart and blood vessels (WHO 2013b). Cardiovascular diseases affecting high proportions of Indigenous Australians include but are not limited to coronary heart disease (or ischaemic heart disease), cerebrovascular disease, hypertension and rheumatic heart disease (RHD).

There were 7,594 Indigenous people in WA who reported having heart and circulatory problems in 2004-2005, this sub-population represented 11.0% of WA's Indigenous population at the time. A similar proportion of the Indigenous population nationwide (12.0%) reported having the condition. After age-adjustment, a higher proportion of Indigenous females in WA reported heart and circulatory conditions during this period than their non-Indigenous counterparts; the proportions of Indigenous and non-Indigenous males were the same. The prevalence of heart and circulatory conditions increased with age; Indigenous people aged 55 years and over had the highest prevalence of self-reported heart and circulatory conditions (48.0%). The largest disparity in prevalence between Indigenous and non-Indigenous people were among those aged 35-44 years (ratio of 2.2).

In 2004-2005, 6% of Indigenous males and 8% of Indigenous females in WA reported having hypertension. Hypertension can be defined as blood pressure that is persistently higher than normal (WHO 2013f). After age-adjustment, Indigenous females in WA were 1.5 times more likely than non-Indigenous females to have hypertension; Indigenous males were only slightly more likely than non-Indigenous males to report having hypertension (ratio of 1.1). Indigenous people living in remote areas of WA were more likely than those living in non-remote areas to report having hypertension. In 2010-2011, there were 21 new and recurrent cases of acute rheumatic fever (ARF) notified in WA, all of which occurred among Indigenous people. Note: ARF generally occurs when a throat or tonsil infection, caused by streptococcal bacteria spreads to and damages the heart and heart valves (WHO 2013a). On 30 June 2011, there were 158 patients with confirmed RHD registered on the WA Rheumatic Heart Disease Register. All of the RHD patients were Indigenous; the majority of patients were female (61%). Approximately 42% of patients with RHD were aged 0-24 years (67 cases), 36.0% were aged 25-44 years (57 cases), and 22% were aged 45 years and over (34 cases).

There were 2,872 hospitalisations of WA Indigenous people with a principal diagnosis of heart or circulatory disease between July 2008 and June 2010. The age-standardised hospitalisation rate for circulatory diseases was 1.9 times higher for Indigenous people living in WA than that for their non-Indigenous counterparts. The hospitalisation rate for Indigenous people living in WA was similar to the rate for Indigenous people living in NSW, Vic, Qld, WA, SA and the NT combined.

Indigenous females and males were hospitalised at 2.3 and 1.6 times the rates of their non-Indigenous counterparts, respectively. Ratios were particularly high for Indigenous females aged 45-54 years (rate ratio of 4.2). Between 1998-1999 and 2009-2010, there were significant decreases in the hospitalisation rates for circulatory diseases for Indigenous and non-Indigenous people in WA; between 2004-2005 and

2009-2010, there was a significant decrease for Indigenous people, but no significant decrease for non-Indigenous people.

Of the different diseases of the circulatory system, coronary heart disease (including heart attack) was the condition accounting for the highest rate of hospitalisation among Indigenous people in WA in 2010-2011. Indigenous people in WA were hospitalised for coronary heart disease at nearly three times the rate of non-Indigenous people. Indigenous people in WA were hospitalised at 7.4 times the rate for non-Indigenous people for acute rheumatic fever/RHD, and at nearly four times the rate for hypertension.

From 2006-2010, diseases of the circulatory system were the leading cause of death among Indigenous people living in WA, accounting for 26% of Indigenous deaths. After age-adjustment, the death rate was 2.3 times higher for Indigenous people than for non-Indigenous people. The death rate was higher for Indigenous people living in WA than that for Indigenous people living in NSW, Qld, WA, SA and the NT combined (AIHIN 2012). Coronary heart disease, cerebrovascular disease, and rheumatic and other valvular heart diseases were the most common avoidable causes of CVD-related death among the Indigenous population in WA. Between 2001 and 2010, mortality from circulatory diseases decreased among non-Indigenous people but there was no significant change for Indigenous people.

6.3 Diabetes – Definition and background, prevalence and incidence, hospitalisation and mortality

Diabetes can be defined as a chronic disease occurring when the pancreas does not produce enough insulin to maintain normal blood sugar levels, or cases where the body cannot effectively utilise the insulin produced (WHO 2013d). Types of diabetes include type I diabetes (caused by deficient insulin production), type II diabetes (caused by the body's inability to utilise insulin), gestational diabetes (diabetes first recognised or beginning during pregnancy), impaired glucose tolerance and impaired fasting glycaemia (intermediate conditions during the transition from normality to diabetes) (WHO 2013d). Although type I diabetes is quite uncommon in the Indigenous population, type II diabetes is considerably more common and has an earlier onset age than for non-Indigenous Australians. Additionally, Indigenous Australians are more likely to die at a younger age as a result of type II diabetes (AIHIN 2012).

According to the 2004-2005 NATSIHS, diabetes/high blood sugar levels were reported by 8.8% of Indigenous people living in WA, with similar proportions for Indigenous people living in remote and non-remote areas. The overall proportion for WA was higher than that for any other state or territory, and higher than the national proportion of 6.1%. After age-adjustment, diabetes/high blood sugar levels were 3.7 times more common for Indigenous people living in WA than for their non-Indigenous counterparts.

Information from Australia's National Diabetes Register (NDR) reveals that in 2005-2007, 5.6% of people in WA who began using insulin to treat their diabetes were Indigenous. This figure was higher than the national proportion (2.9%), but lower than that for the NT (39%) and Qld (6.3%). For insulin-treated type 2 diabetes, 5.8% of new cases in WA were identified as Indigenous (compared with 2.6% Australia-wide). Around 6.5% of new cases of insulin-treated GDM among women aged 15-49 years in WA were identified as Indigenous (compared with 2.2% Australia-wide).

Between July 2008 and June 2010, the WA age-standardised rates for hospital separations for a principal diagnosis of diabetes were 6.2 times higher for Indigenous females, and 4.4 times higher for Indigenous males, than the rates for their non-Indigenous counterparts. Age-adjusted hospital separation rates for diabetes were higher for Indigenous people living in WA than for Indigenous people living in NSW, Vic, Qld, WA, SA and the NT combined. In WA in 2008-2010, age-specific separation rates for diabetes were higher for Indigenous people than those for non-Indigenous people in every age-group, except for the 0-4 years and 5-14 years age-groups. The Indigenous:non-Indigenous rate ratio was highest for the 45-54 years age group.

From 2006-2010, diabetes was responsible for 8.5% of deaths among Indigenous people in WA. After age-adjustment, the death rate for diabetes was 8.7 times higher for Indigenous Australians than for their non-Indigenous counterparts. This ratio was the highest of all health conditions.

6.4 Renal disease – Definition, background, prevalence and incidence, treatment, hospitalisation, and mortality

Chronic kidney disease (CKD) can be defined as kidney damage or reduced kidney function that lasts for three months or more, and is particularly prevalent in Indigenous Australians. Untreated CKD can decrease kidney function to the extent where kidney replacement therapy is required at a great cost both financially and to an individual's quality of life.

A number of risk factors are associated with kidney disease, including diabetes, high blood pressure, infections, low birth weight, and obesity. These conditions are common among Indigenous people and contribute to high rates of CKD within this population. Likewise, a number of social and health determinants are linked to kidney disease: these include sub-standard living conditions, inadequate environmental sanitation, poverty, poor diet, low physical activity levels, alcohol and tobacco use, and access to medical care.

Australia-wide, the level of CKD is higher among Indigenous people than among non-Indigenous Australians. Between 2001 and 2004-2005, there was a significant increase in the proportion of Indigenous Australians reporting kidney problems; after age-adjustment, the level of kidney disease in 2004-2005 was ten times higher for Indigenous people than for non-Indigenous people (AIHIN 2012).

From 2008-2010, 132 new Indigenous patients were identified with end-stage kidney disease (ESKD) in WA, as compared with 610 non-Indigenous people in WA. After the age-adjustment, the notification rate for Indigenous people was 11.7 times the rate for non-Indigenous people. Incidence rates were 8.1 times higher for Indigenous males and 20 times higher for Indigenous females than those for their non-Indigenous counterparts. The high rates of ESKD are a major public health problem for Indigenous people, particularly those living in remote parts of the country. Indigenous:non-Indigenous rate ratios also increased with remoteness: Indigenous people in major cities were 3.6 times more likely to have ESKD than non-Indigenous people in major cities; Indigenous people living in very remote areas were 20 times more likely to have ESKD than non-Indigenous people in very remote areas.

Treatment for CKD involves dialysis or, for those with ESKD, kidney replacement therapy. Dialysis, specifically haemodialysis (HD) conducted in urban or regional clinics and hospitals, is the most common form of treatment for Indigenous people with ESKD. Note: dialysis or peritoneal dialysis is an artificial method for the kidney function involving the removal of waste products and water from the blood and the regulation of circulating blood chemical levels, this method occurs inside the body, using the peritoneal membrane in the abdomen as a filter; haemodialysis is a name for this process occurring outside of the body via a machine (AIHW 2010). A total of 193 Indigenous people, Australia-wide commenced dialysis during 2010, an increase from 187 in 2009, but a decrease from 249 in 2008.

After age-adjustment, hospitalisation rate for dialysis and CKD was 15.3 times higher for Indigenous people than that for non-Indigenous people living in WA in 2008-2010. Rates were higher for Indigenous females than for Indigenous males, with Indigenous females being hospitalised at 24 times the rate, and Indigenous males at 11 times the rate, of their non-Indigenous counterparts. Hospitalisation rates were higher for Indigenous people living in WA than those for Indigenous people living in NSW, Vic, Qld, WA, SA and the NT combined.

From 2006-2010, the age-standardised death rate for kidney disease for Indigenous people was 5.4 times the rate for non-Indigenous people in WA. The rate was higher for Indigenous people living in WA than for those living in NSW, Qld, WA, SA and the NT combined.

6.5 Respiratory disease – Definition, background, prevalence, hospitalisation, hospitalisation in children, and mortality

Chronic respiratory disease (CRD) can be defined as diseases affecting the airways and other structures of the lungs. Preventable CRD's include asthma and respiratory allergies, chronic obstructive pulmonary disease (COPD), occupational lung disease, cancer, sleep apnoea syndrome and pulmonary hypertension (WHO 2013c).

Respiratory disease represents a significant burden of ill-health, hospitalisation, and mortality among Indigenous people, particularly among the very young and older people. CRD is associated with a number of contributing factors, including poor environmental conditions, socioeconomic disadvantage, risky behaviours (particularly tobacco, alcohol, and substance use), and existing medical conditions.

In WA, after age-adjustment, the overall levels of respiratory disease were similar for Indigenous and non-Indigenous people in 2004-2005. A higher proportion of Indigenous females than Indigenous males reported having a respiratory condition. In 2004-2005, 14.0% of Indigenous people living in WA reported having asthma, making it the most commonly reported respiratory condition among Indigenous people, and the third most commonly reported health condition within this population. Asthma was reported more frequently by Indigenous people living in non-remote areas (17%) than by those living in remote areas (11%), and was reported more commonly by Indigenous females than by Indigenous males.

After age-adjustment, the hospitalisation rate for Indigenous people was 4.0 times that for non-Indigenous people. The age-adjusted hospitalisation rate for Indigenous people living in WA was 1.3 times higher than that for Indigenous people living in NSW, Vic, Qld, WA, SA and the NT combined.

From 2006 to 2010, diseases of the respiratory system were responsible for 6.6% of all deaths of Indigenous people living in WA. After age-adjustment, the death rate for Indigenous people was 2.9 times that for non-Indigenous people. The death rate was higher for Indigenous people living in WA than that for Indigenous people living in NSW, Qld, WA, SA and the NT combined.

7.0 Rural Health Outreach Fund

The aim of the Rural Health Outreach Fund is to improve health outcomes for people living in regional, rural and remote locations by supporting the delivery of outreach health activities. The Rural Health Outreach Fund focuses on a multi-disciplinary team approach to health care with a focus on four priorities: eye health, maternal and paediatric health, mental health and support for chronic disease management.

7.1 Eye health problems – Background, prevalence in adults, prevalence in children, hospitalisation, access to eye services, and mortality

Eye health can be affected by a number of factors including genetic factors, ageing, premature birth, diseases such as diabetes, smoking, injuries, ultra violet light exposure, and nutrition. Related issues include an increased risk of injury, limited opportunities in education, employment and social engagement, as well as dependence on others. A number of factors can limit the timely identification, management and treatment of eye health problems for Indigenous people; these include geographical location, economic disadvantage, lack of access to transportation and a lack of access to services.

According to the 2004-2005 NATSIHS, eye and sight problems were the most common long-term health conditions reported by Indigenous people in WA (29%). There have been improvements to the eye health of Indigenous people; however, Indigenous people are still more likely than non-Indigenous people to have higher levels of preventable eye conditions. Trachoma has been virtually eliminated in the developed world, but still occurs among Indigenous Australians (AIHIN 2012). Note: trachoma is a contagious eye infection occurring as a result of *Chlamydia trachomatis*, if left untreated trachoma can cause irreversible blindness (WHO 2013e). According to the 2008 National Indigenous Eye Health

Survey (NIEHS), 60% of Indigenous communities in very remote areas of Australia had endemic trachoma. In 2010, the prevalence of endemic trachoma among children was reported at 19% in SA, 12% in the NT and 9% in WA (AIHIN 2012).

The NIEHS estimated that 94.0% of vision loss among Indigenous people in Australia was preventable or treatable (AIHIN 2012). The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) reported that 9.3% of Indigenous children aged 4-14 years had some form of eye of sight problems; the most common being refractive errors such as long-sightedness (37%), and short-sightedness (28.0%). The survey also found that major causes of vision loss and blindness among Indigenous adults in WA were similar to those nationally: refractive error was responsible for 5%, cataracts 5%, diabetic retinopathy 1.8%, trachoma 0.7% and other causes 1.4%. Of all states and territories, WA had the highest prevalence of low vision among Indigenous adults (12%) and the second highest prevalence among Indigenous children (1.9%).

From 2004-2005 to 2009-2010, the hospitalisation rate for eye disease among Indigenous people in WA remained relatively unchanged, but this has been suggested to be due to less access to hospital services rather than a lower prevalence of eye diseases. Overall, Indigenous people are less likely to access eye care services than non-Indigenous people. Nationally, eye and vision health issues increase mortality at least two-fold, and are responsible for 11% of years of life lost to disability for Indigenous Australians, as well as constituting the fourth leading cause of the gap between Indigenous and non-Indigenous Australians.

7.2 Maternal and paediatric health – Fertility, birth weight, maternal mortality and paediatric mortality

In 2011, almost one fifth (19.0%) of all Indigenous Australian births were those of teenaged mothers, as compared with 3.8% of all Australian mothers (AIHIN 2012). The median age of Indigenous mothers was 24.8 years, compared with 30.6 years for all mothers (AIHIN 2012). The fertility rate of teenage Indigenous women (78 babies per 1,000 women) was almost five times that of all teenage women (16 babies per 1,000 women). Note: fertility rate is the number of children born to 1,000 women at the current age pattern of fertility (AIHIN 2012). The highest total fertility rate for Indigenous women was for WA (3,011 babies per 1,000 women) (AIHIN 2012). Note: the total fertility rate is the number of live births a woman would have if, throughout her reproductive years, she had children at the rates prevailing in the reference calendar year; it the sum of the age-specific fertility rates for that calendar year (AIHIN 2012).

In 2010, the average weight of babies born to Indigenous mothers living in WA was 3,139 grams; this is 214 grams lighter than the average for babies born in WA. Comparatively, the average birth weight of babies born to all Australian Indigenous mothers in 2010 was 3,190 grams, almost 190 grams less than the average for non-Indigenous mothers (3,376 grams) (AIHIN 2012). Babies born to Indigenous mothers in WA in 2010 were more than twice as likely to be of low birth weight (less than 2,500 grams) (13.6%) than those born to non-Indigenous women (6.1%).

From 2003-2005, maternal mortality rates for all Indigenous women were 2.7 times higher than for all non-Indigenous women (AIHIN 2012). From 2007-2011, infant mortality rates for Indigenous babies were higher than for non-Indigenous babies (AIHIN 2012).

7.3 Mental health – Definition, prevalence, prevalence in children, hospitalisation, and mortality

Mental health can be described as a state of social and emotional wellbeing in which individuals can cope with the normal stressors of life and realise their potential. It is a complex interplay of biological, psychological, social, environmental and economic factors. For Indigenous people, the definition of mental health is broader and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual (Social Health Reform Group 2004).

Prior to the 2004-2005 NATSIHS, the extent of mental illness and mental health problems in the Indigenous population had been poorly documented. The NATSIHS systematically collected information

on the mental health and wellbeing of Indigenous Australians at a national level. Among Aboriginal and Torres Strait Islanders living in WA, almost two-thirds (65%) reported having experienced low to moderate levels of psychological distress, with 33% reporting high to very high indicators of psychological distress in the previous 12 months. Indigenous people in WA experienced high to very high levels of psychological distress at almost three times the rate reported by non-Indigenous people.

Despite these high levels of psychological distress, Indigenous people in WA experienced high levels of positive wellbeing. Several indicators of positive wellbeing found that 92% of Indigenous people in WA felt happy either some or most of the time. The proportion of Indigenous people in WA reporting these positive feelings was higher than that of the nation.

Information collected by the Western Australian Aboriginal Children's Health Survey (WAACHS) regarding social and emotional wellbeing of children over a two year period beginning in 2000, found that nearly one-quarter (24%) of Indigenous children aged 4-17 years were at high risk of clinically significant emotional or behavioural difficulties, with Indigenous male children twice as likely as Indigenous female children to be at high risk of such difficulties. This compares with 15% of similarly aged children in the State's general population.

The WAACHS also collected information on suicidal thoughts and behaviours among Indigenous young people, revealing that almost 16% of Indigenous Islander young people in WA aged 12-17 years had seriously considered ending their life in the 12 months prior to the survey. Of these people, 39% had attempted suicide in the previous 12 months. The factors associated with suicidal thoughts included: being female, being at risk of clinically significant emotional or behavioural difficulties, having had exposure to family violence, having experienced racism, having low self-esteem, and having friends who had attempted suicide.

Analysis of the hospitalisation rates in WA for mental health-related conditions over a 12 month period revealed minimal change in the hospitalisation rate of Indigenous people from 1998-1999 to 2009-2010. In contrast, there was a significant decline in the rate for non-Indigenous people during this period (decreasing from 17 per 1,000 to 12 per 1,000).

For the two year period from 2008-2010, after age-adjustment, the hospitalisation rate for WA Indigenous males with mental health-related conditions was 3.1 times higher than the rate for non-Indigenous males. The age-adjusted hospitalisation rate for Indigenous females was 2.1 times higher than for non-Indigenous females.

Of the 2,400 Indigenous deaths recorded in WA from 2005-2009, 3.0% were attributed to mental and behavioural disorders. The mortality rate for mental and behavioural disorders for Indigenous people was 3.4 times higher than the rate for non-Indigenous people. The death rate for Indigenous males was 4.0 times the rate for non-Indigenous males, and the death rate for Indigenous females was 3.0 times the rate for non-Indigenous females. In 2011, intentional self-harm was the third leading cause of death for Indigenous people in WA, but was ranked 11th as the leading cause of death for non-Indigenous people in WA.

8.0 Healthy Ears – Better Hearing, Better Listening Program

The aim of the Healthy Ears – Better Hearing, Better Listening Program is to increase access to a range of health services including expanded primary health for Indigenous children and youth (0-21 years) for the diagnosis, treatment and management of ear and hearing health. The program acknowledges that there is a high incidence of ear disease for Indigenous Australian children and youth, which impacts on their health, social interaction, language, communication, literacy and numeracy development.

8.1 Ear health and hearing – Background, prevalence in children, and hospitalisation

Exceptionally high levels of ear disease and hearing loss have been reported for many years in many Australian Indigenous communities, particularly in remote areas. Inflammation and infection of the middle ear, which is almost always associated with fluid in the middle ear is known as otitis media (OM). OM is generally caused by a virus or bacteria or both, and often occurs as a result of another illness such as a cold. Partial hearing loss may occur, and if the condition becomes chronic and the individual does not receive adequate treatment, there is a risk of permanent hearing loss. OM can affect Indigenous babies within weeks of birth and a high proportion of children living in some remote communities may continue to suffer from chronic suppurative otitis media (CSOM) throughout their developmental years. Note: CSOM is the term for a persistent ear discharge through a perforation/hole in the tympanic membrane/ear drum.

In WA, the 2004-2005 NATSIHS found that 4.2% of WA Indigenous children aged 0-14 years were reported to have OM, this prevalence was more than twice that of non-Indigenous children (1.8%). The prevalence of diseases of the ear and mastoid was higher among Indigenous children aged 5-14 years (14%) than among those aged 0-4 years (5%). The prevalence of complete or partial deafness of hearing loss was more than twice as high among Indigenous children (5%) than among non-Indigenous children (2.3%).

Information collected by the WAACHS in 2001-2002 revealed that 18.0% of Indigenous children in WA aged 0-17 years were reported by carers as having had recurring ear infections. Younger children aged 0-3 years (20%) and 4-11 years (20%) were more likely to have recurring ear infections than children aged 12-17 years (14%). According to the national Bettering the Evaluation of Care and Health (BEACH) survey, nationwide rates of GP attendances for the period April 2006 to March 2011 for Indigenous children aged 0-14 years were 1.1 times higher than the non-Indigenous rates for OM/myringitis (inflammation of the tympanic membrane/ear drum) and 1.2 times the non-Indigenous rate for all diseases of the ear.

For the two year period from July 2008 to June 2010, after age-adjustment, hospitalisation rates for disease of the ear and mastoid process was 1.5 times higher for Indigenous people than for their non-Indigenous counterparts in WA. Similar to other areas of Indigenous health, high levels of recurring ear infections are associated with poverty, nutritional deficiencies, crowded housing conditions, inadequate access to clean water and function sewerage systems and poor access to health care. Hearing loss related to ear infections may be a large contributor to poor education and/or unemployment, which are risk factors for contact with the justice system.

9.0 Key facts

9.1 Cancer

From 2007 to 2011, age-adjusted cancer incidence rates were similar for Indigenous people and non-Indigenous people; however, the age-standardised hospitalisation rates for Indigenous people were lower than for non-Indigenous people.

From 2006 to 2010, the age-adjusted mortality rate for all cancers in Indigenous people was 1.5 times higher than that for non-Indigenous people; the Indigenous death rate for WA rate was higher than the Indigenous death rate for NSW, Qld, WA, SA and the NT combined.

From 2007 to 2011, the most commonly diagnosed cancers among Indigenous people were lung and breast cancer.

From 2006 to 2010, Indigenous people in WA died from lung cancer at 1.8 times the rate and from cervical cancer at 6.0 times the rate of non-Indigenous people in WA.

9.2 Cardiovascular disease

In 2004 to 2005, 11% of Indigenous people in WA reported having a long-term cardiovascular or related condition.

From 2008 to 2010, Indigenous people in WA were hospitalised for cardiovascular disease at 1.9 times the rate of non-Indigenous people.

From 2006 to 2010, cardiovascular disease was the leading cause of death for Indigenous people in WA, accounting for 26% of Indigenous deaths; for this period the age-adjusted death rate for Indigenous people was 2.3 times higher than the rate for non-Indigenous people.

9.3 Diabetes

In 2004-2005, 8.8% of Indigenous people in WA reported having diabetes; after age-adjustment, Indigenous people were 3.7 times more likely to report some form of diabetes than non-Indigenous people.

From 2006 to 2010, Indigenous people in WA died from diabetes at 8.7 times the rate of non-Indigenous people.

9.4 Ear and hearing health

In 2008, 9.0% of Indigenous children in WA aged 0-14 years had ear or hearing problems.

In 2004-2005, 4.2% of Indigenous children in WA aged 0-14 years were reported to have OM, as compared with 1.8% of the equivalent non-Indigenous population.

In 2004-2005, prevalence of diseases of the ear and mastoid was higher among Indigenous children living in remote areas of WA (16% of males and 12% of females) than among those living in non-remote areas (9% of males and 7% of females).

9.5 Eye health

In 2004-2005, eye and sight problems were reported by 29% of Indigenous people in WA, making eye and sight problems the most common long-term health condition reported by this population.

The NIEHS estimated that 94.0% of vision loss among Indigenous people in Australia was preventable or treatable (AIHIN 2012).

In 2008, WA was the jurisdiction with the highest prevalence of low vision among Indigenous adults (12%) and the second highest prevalence among Indigenous children (1.9%).

9.6 Maternal and paediatric health

In 2011, there were 2,506 births in WA with one or both parents identified as Indigenous (8% of all births registered).

In 2011, Indigenous mothers in WA were younger than non-Indigenous mothers; the median age was 24.2 years for Indigenous mothers and 30.3 years for all mothers.

In 2011, total fertility rates were 3,011 births per 1,000 for Indigenous women in WA and 1,953 per 1,000 for all women in WA.

In 2010, the average birth weight for babies born to Indigenous mothers living in WA was 3,139 grams compared with 3,353 grams for babies born to non-Indigenous mothers.

In 2010, the proportion of low birth weight babies born to Indigenous mothers in WA was twice that of non-Indigenous women (13.6% compared with 6.1%).

9.7 Mental health and wellbeing

In 2008, Indigenous people in WA experienced high to very high levels of psychological distress at almost three times the rate reported by non-Indigenous people.

In 2008, 92% of Indigenous people in WA felt happy either some, most, or all of the time.

In 2000-2001, 24% of WA Indigenous children aged 4-17 years were at high risk or clinically significant emotional or behavioural difficulties; this compares with 15% of similarly aged children in the State's general population.

From 2008 to 2010, after age-adjustment, the hospitalisation rate for Indigenous males and females in WA with mental-health related conditions was 3.1 and 2.1 times higher than the rates for their non-Indigenous counterparts, respectively.

From 2005 to 2009, the death rate for intentional self-harm for Indigenous people living in WA was 3.1 times the rate for non-Indigenous people.

9.8 Renal disease

From 2008 to 2010, after age-adjustment, the notification rate of ESRD was 11.7 times higher for Indigenous people than for non-Indigenous people in WA.

From 2008 to 2010, the age-adjusted hospitalisation rate for dialysis and CKD were 15.3 times higher for Indigenous people than for non-Indigenous people living in WA.

From 2006 to 2010, the age-standardised death rate from CKD was 5.4 times higher for Indigenous people than for non-Indigenous people in WA.

9.9 Respiratory disease

In 2004-2005, the overall levels of respiratory disease were similar for Indigenous and non-Indigenous people in WA.

From 2008 to 2010, the age-standardised hospitalisation rate for respiratory disease was 4 times higher for Indigenous people than for non-Indigenous people in WA.

From 2006 to 2010, after age-adjustment, the death rate for Indigenous people was 2.9 times higher than that for non-Indigenous people in WA. The death rate was higher for Indigenous people living in WA than that of Indigenous people living in NSW, Qld, WA, SA and the NT combined.

10.0 Acronyms used within this report

AIHIN - Australian Indigenous Health InfoNet

BEACH - Bettering the Evaluation of Care and Health

ANZDATA - Australian and New Zealand Dialysis and Transplant Registry

CKD - Chronic kidney disease

COPD - chronic obstructive pulmonary disease

CSOM – chronic suppurative otitis media

CRD – chronic renal disease

CVD - Cardiovascular disease

DNA – Deoxyribonucleic acid (genetic material)

ESKD – End-stage kidney disease

NATSIHS – National Aboriginal and Torres Strait Islander Health Survey

NATSISS – National Aboriginal and Torres Strait Islander Social Survey

NIEHS - National Aboriginal and Torres Strait Islander Eye Health Survey

NT – Northern Territory

NSW – New South Wales

OM – otitis media

Qld – Queensland

RHD – Rheumatic heart disease

SA – South Australia

Vic – Victoria

WA – Western Australia

WAACHS – Western Australian Aboriginal Children’s Health Survey

WHO - World Health Organisation

11.0 References

- Australian Institute of Health and Welfare. (2010). Dialysis and kidney transplantation in Australia 1991-2010. Retrieved January 7, 2014 from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422288>
- Australian Indigenous Health InfoNet. (2012). Overview of Indigenous health status 2012. Retrieved January 6, 2014 from <http://www.healthinfonet.ecu.edu.au/health-facts/overviews>
- Australian Indigenous Health InfoNet. (2013). Overview of the health of Indigenous people in Western Australia 2013. Retrieved January 6, 2014 from <http://www.healthinfonet.ecu.edu.au/states-territories-home/wa/reviews/our-review>
- Social Health Reference Group (SHRG) (2004). National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009. Australian Department of Health and Ageing, Canberra.
- World Health Organisation. (2013a). Acute rheumatic fever. Retrieved December 23, 2013 from http://www.who.int/cardiovascular_diseases/publications/trs923/en/
- World Health Organisation. (2013b). Cardiovascular disease. Retrieved December 23, 2013 from http://www.who.int/cardiovascular_diseases/en/
- World Health Organisation. (2013c). Chronic respiratory disease. Retrieved December 23, 2013 from <http://www.afro.who.int/en/clusters-a-programmes/dpc/non-communicable-diseases-managementndm/programme-components/chronic-respiratory-diseases.html>
- World Health Organisation. (2013d). Diabetes. Retrieved December 23, 2013 from <http://www.who.int/mediacentre/factsheets/fs312/en/>
- World Health Organisation. (2013e). Trachoma. Retrieved December 23, 2013 from <http://www.who.int/topics/trachoma/en/>
- World Health Organisation. (2013f). Q & A's on hypertension. Retrieved December 23, 2013 from <http://www.who.int/features/qa/82/en/>