



Australian Government

Australian Institute of Health and Welfare



NACCHO
National Aboriginal Community
Controlled Health Organisation

Healthy for Life

*Aboriginal Community Controlled
Health Services*

Report Card





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Aboriginal health in Aboriginal hands
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Healthy for Life

Aboriginal Community Controlled Health Services

Report Card



Key findings

We have done well in:	We need more work to:
Increasing the proportion of adults participating in health checks	Increase the uptake of health checks among children
Providing MBS GP management plans to clients with coronary heart disease	Increase the proportion of clients with Type 2 diabetes whose HbA1c result is $\leq 7\%$
Providing MBS GP management plans to clients with Type 2 diabetes	Increase the proportion of clients with Type 2 diabetes whose blood pressure test result is less than 130/80mmHg
Providing Team Care Arrangements for clients with Type 2 diabetes	Increase the uptake of timely blood pressure testing among clients with coronary heart disease
Providing Team Care Arrangements for clients with coronary heart disease	Increase the proportion of children fully immunised
Providing timely HbA1c tests to clients with Type 2 diabetes	Raise the proportion of pregnant women attending their first antenatal visit before 13 weeks of pregnancy
Increasing the proportion of clients with Type 2 diabetes who have had a blood pressure test	Increase the proportion of pregnant women attending first antenatal visit at 13 weeks to before 20 weeks of pregnancy
Increasing the proportion of clients with coronary heart disease who have had a blood pressure result less than 140/90mmHg	Reduce risk factors such as smoking and alcohol use during pregnancy
Raising the average birthweight of Indigenous babies and reducing the proportion of babies born with low or high birthweight	
Raising the proportion of Indigenous babies born with normal birthweight	

The context

Healthy for Life (HfL) is the first Office for Aboriginal and Torres Strait Islander Health (OATSIH)–funded program with a strong focus on continuous quality improvement (CQI). It collects and reports on health outcome data that go beyond service activity reporting. The formal objectives of the program are to:

- improve services on child and maternal health care
- improve men’s health
- improve prevention, early detection and management of chronic disease and
- increase the capacity of the Aboriginal and Torres Strait Islander health workforce for improving long-term health outcomes for Indigenous Australians.

The Healthy for Life program is available to established primary health-care providers in Aboriginal Community Controlled Health Services (ACCHS), state and territory health services and Divisions of General Practice. ACCHS comprise about 65% of the services participating in the program.

A national report based on HfL data was published by AIHW early this year (AIHW 2013a). This report card was prepared by AIHW for a subset of ACCHS included in the national report with funding from NACCHO.

This report card

This report card provides data from a number of sources: preliminary population and housing data from the 2011 Census (ABS 2012a and 2012b), data from AIHW work on health expenditure and data from HfL and Online Service Reporting (OSR).

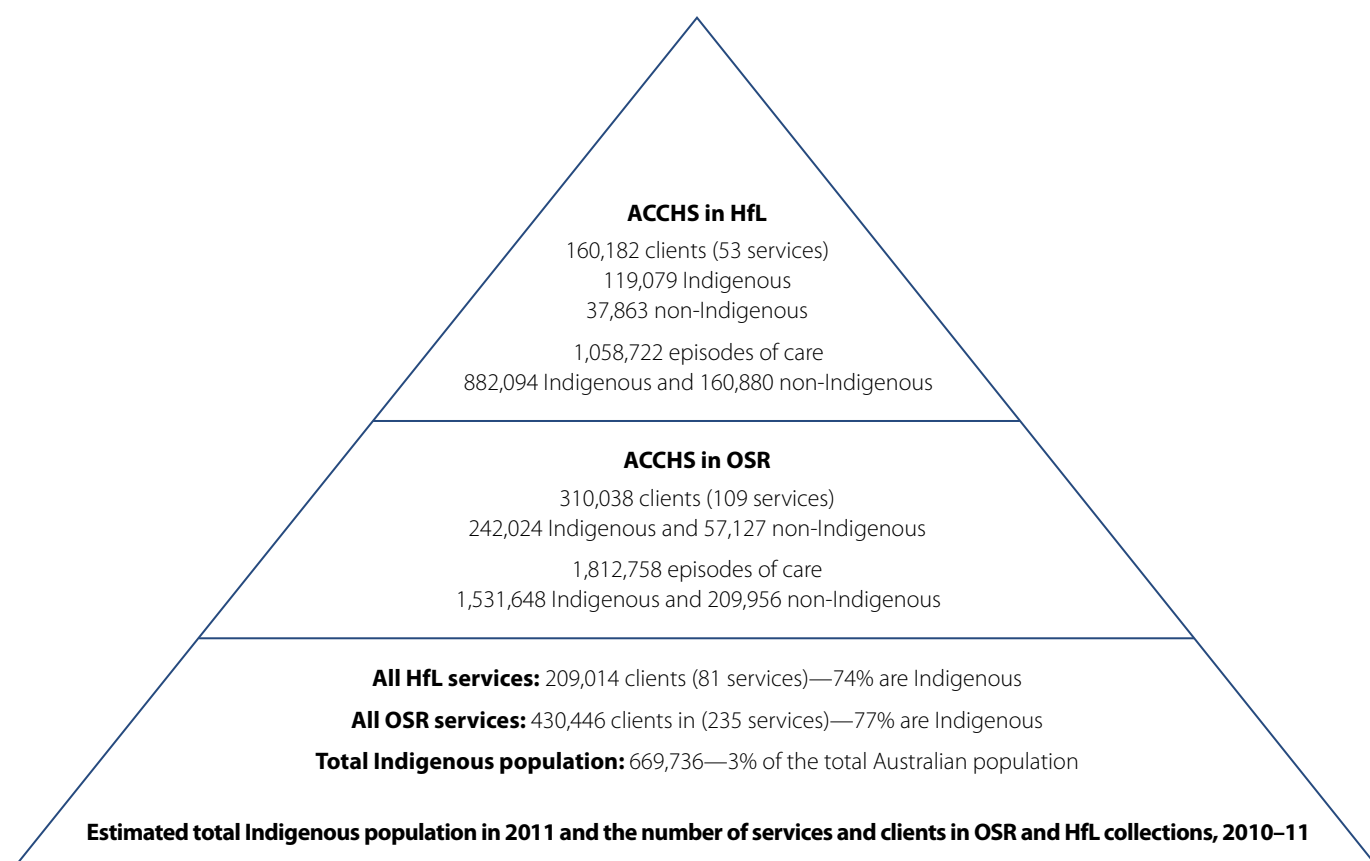
Information is provided against Essential Indicators from the HfL Program for ACCHS that have participated in the program since 2007.

Therefore, these data only provide information on the ACCHS that submitted data for the entire collection period from 2007 to 2011, not all ACCHS.

These indicators enable ACCHS to benchmark themselves and assess areas where they have done well since the inception of the HfL program, as well as areas that could be improved.

Additionally, information is presented from the Online Service Reporting (OSR) data collection on staffing, client numbers, governance, accreditation status, and use of technology to provide more context about ACCHS.

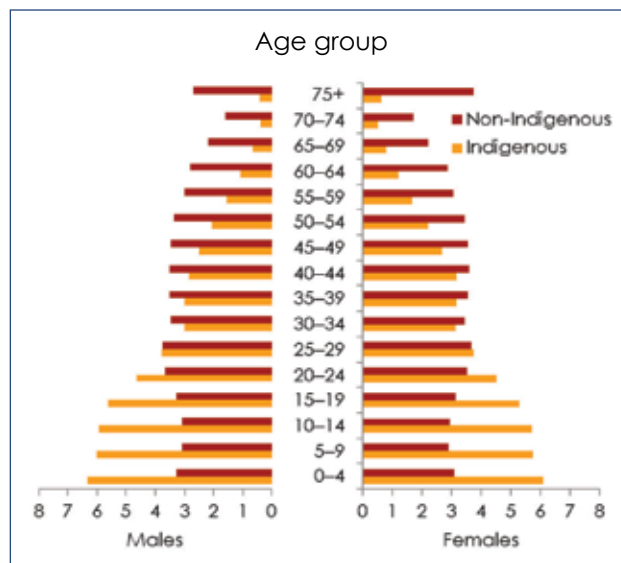
While there are no health expenditure data specific to ACCHS, data for the total Australian Indigenous population are provided to show the investments made in this area and how they are spent.



What do we know about Aboriginal and Torres Strait Islander Australians?

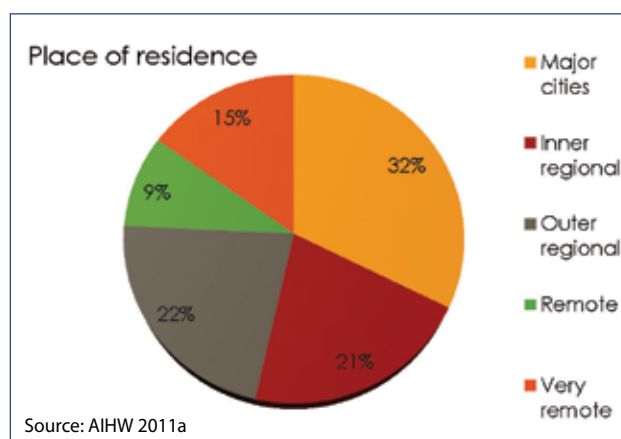
Indigenous population

An estimated 669,736 Australians identified as Aboriginal and Torres Strait Islander in the 2011 Census (ABS 2012a), representing 3% of the total population of Australia. The Indigenous population is younger than the non-Indigenous population: in 2011, 35.8% of the Indigenous population was aged less than 15 compared with 18.3% in the non-Indigenous population. Indigenous persons aged 65 and over comprised 3.4% of the total population compared with 14.1% of the non-Indigenous population.



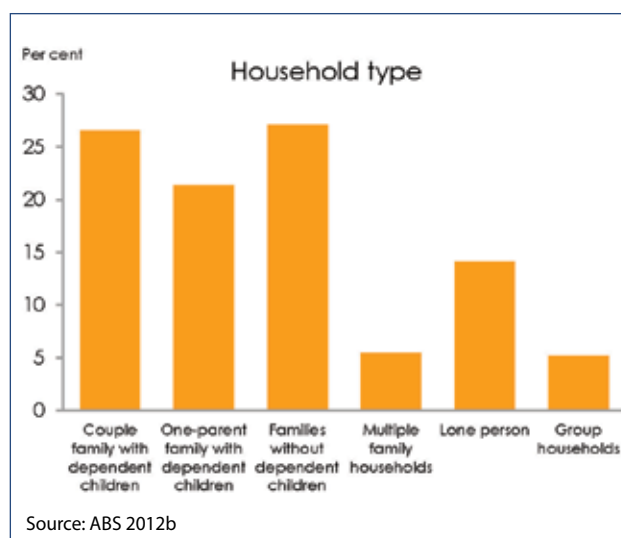
Where do they live?

In 2006 the majority (75%) of Indigenous people lived in cities and non-remote areas. 32% lived in *Major cities*, 21% in *Inner regional* areas and 22% in *Outer regional* areas. Only a quarter lived in *Remote* (9%) and *Very remote* (15%) areas.



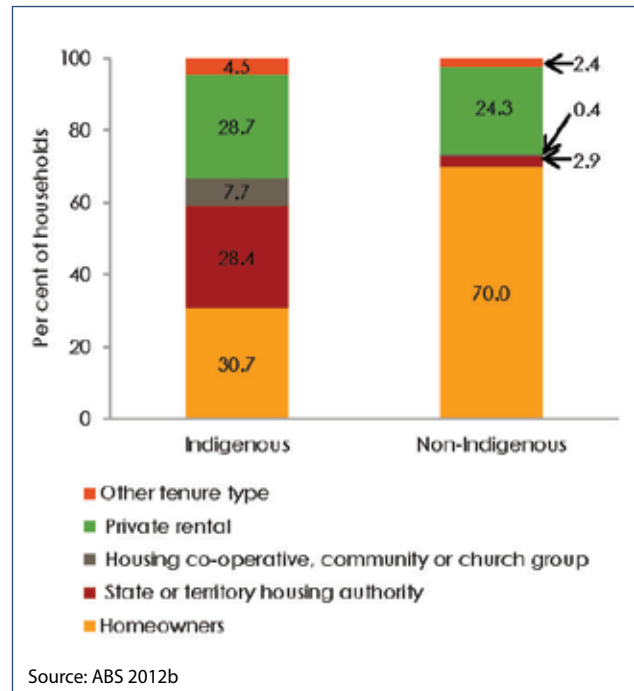
Indigenous households

In 2011 the average size of Indigenous households was 3.3 persons, while it was 2.6 in non-Indigenous households. Three-quarters (75.1%) of Indigenous households were one family households. Just over a quarter (26.6%) of Indigenous households were couple family with dependent children and a similar proportion (27.1%) was families without dependent children. One parent families with dependent children comprised 21% of all Indigenous households, while 14% were lone person households.



Housing

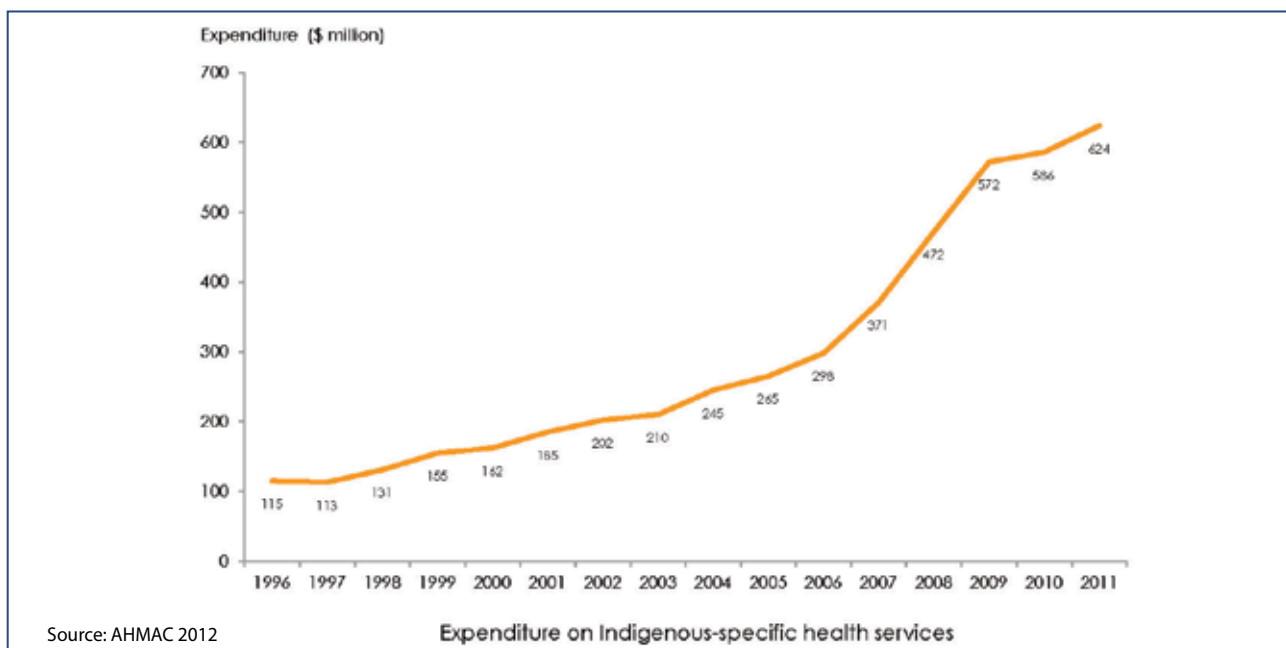
In 2011, just under a third (31%) of Indigenous households were home owners or purchasers, while 65% were renters. Of all Indigenous households 28% rented from state or territory housing authorities. In contrast 70% of non-Indigenous households were home owners and 28% were renters, but only 3% rented through state or territory housing authorities. Over a quarter (28.7%) of Indigenous households rented in the private rental market which was similar to the 24% of non-Indigenous households who rented in the private market.



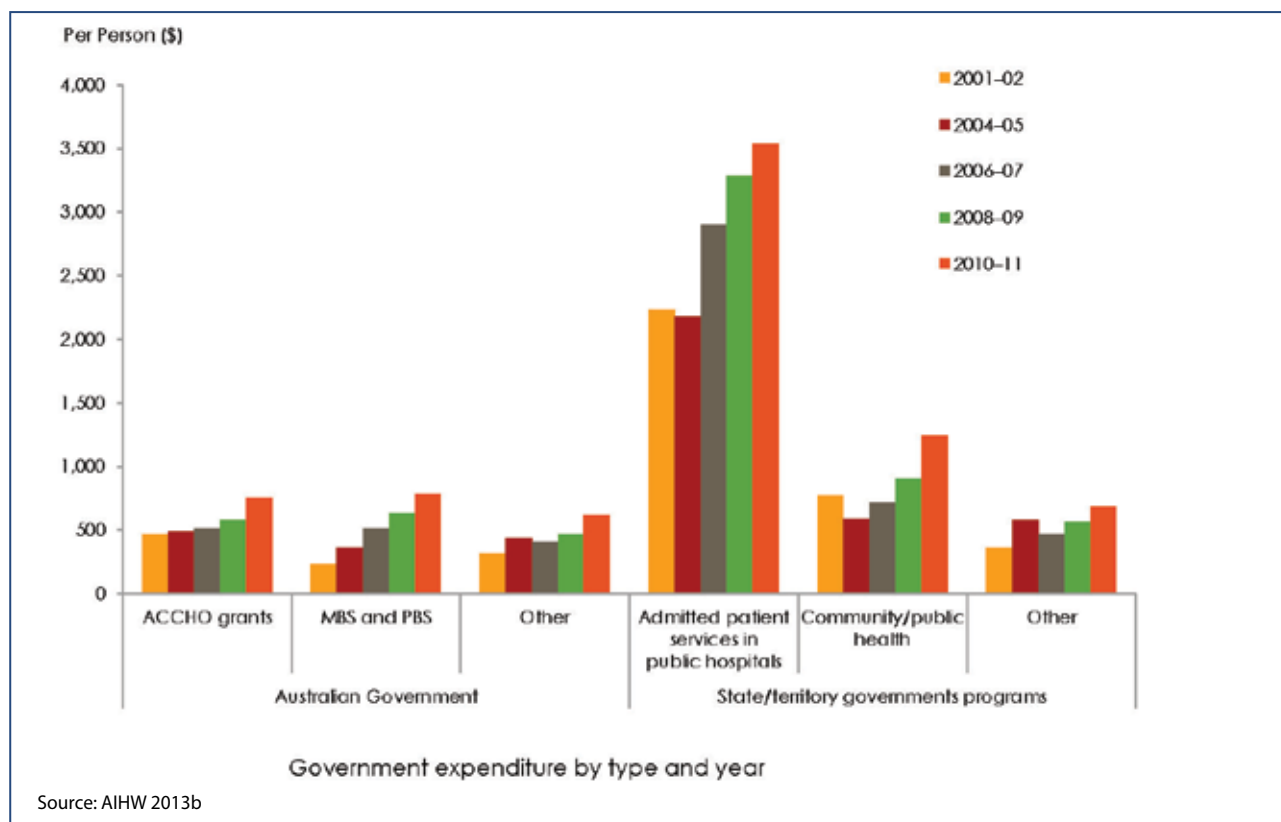
How much money is spent by Australian governments on health of Indigenous Australians?

Indigenous health expenditure was estimated to be \$4.55 billion in 2010–11, 3.7% of the total Australian health expenditure. The corresponding figure for non-Indigenous Australians was \$119 billion. In 2010–11 health expenditure per Indigenous person was \$7,995, an increase of 12.0% from \$7,139 in 2008–09. For non-Indigenous people per person expenditure in 2010–11 was \$5,436. For every dollar spent per non-Indigenous Australian \$1.47 was spent per Indigenous Australian (AIHW 2013b).

Australian Government expenditure on Indigenous-specific health services has continuously increased since 1995–96. In 2010–11, the Commonwealth funding for Indigenous-specific programs was \$624 million. This is a real growth of 265% since 1995–96 (AHMAC 2012).

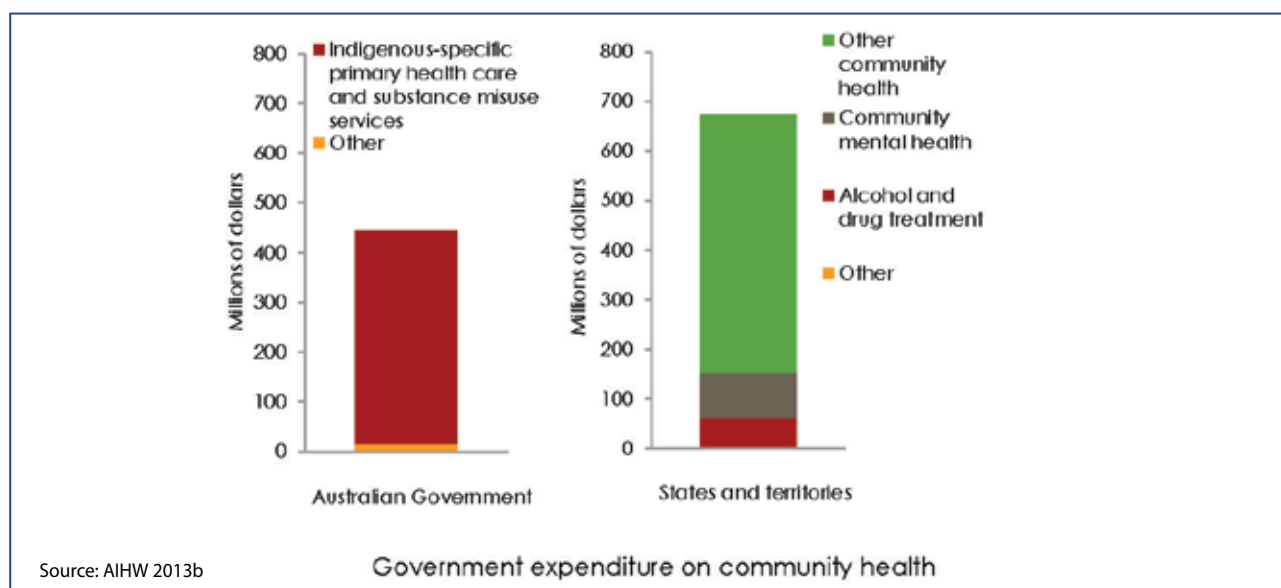


Much of the health expenditure was spent on hospital services.
Per person health expenditure has been increasing over time across all areas.



Community health expenditure

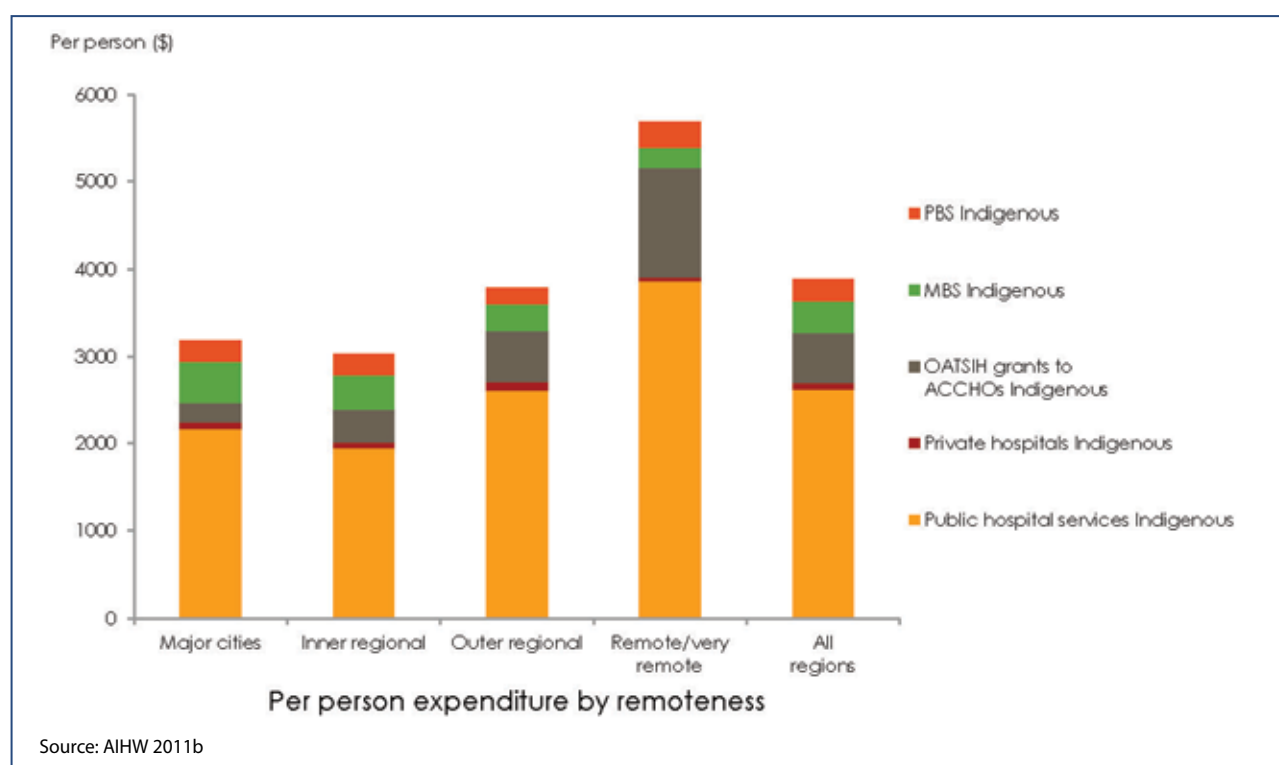
In 2010–11, total health expenditure on community health services for Aboriginal and Torres Strait Islander Australians was \$1,119.6 million. Of this \$444 million (36.3% of the total Indigenous health expenditure) was directly administered by the Australian Government, while states and territories spent \$673 million (21.6% of total Indigenous health expenditure by state and territory governments) on community health services. An estimated \$429 million of Australian Government expenditure on community health services was administered through Aboriginal Community Controlled Health Services (ACCHS).



Expenditure by remoteness

The average expenditure on health for Indigenous Australians was lowest in *Inner regional* areas and *Major cities* in 2008–09 (the most recent year for which figures are available). Expenditure per capita on hospital care within public hospitals for Indigenous people was greatest in the more remote areas.

Pharmaceutical Benefits Scheme (PBS) expenditures were greater in more remote areas where the section 100 arrangements apply. Under section 100 of the National Health Act 1953, clients of approved remote area Aboriginal Health Services (AHSs) are able to receive PBS medicines directly from the AHS at the time of medical consultation, without the need for a normal prescription form and without charge. Expenditure through OATSIH grants to ACCHS was also higher in *Remote* and *Very remote* areas.



Aboriginal Community Controlled Health services (ACCHS)

In 2010–11, a total of 235 primary health care services provided data for OSR (AIHW 2012) and 117 of these were ACCHS. In total, 310,038 clients attended 109 ACCHS in 2010–11 and of these 78% were Aboriginal and Torres Strait Islander clients. In the following section data are presented for ACCHS that submitted data in 2010–11 which ranged from 109 to 117 services (See box 1 for additional information).

The OSR collection mainly includes data on clinical and non-clinical staffing, both paid by the service and visiting; primary health care services delivered including health prevention; numbers of clients; and episodes of care. Contextual information such as governance, accreditation and access to technology are also from OSR.

- Most ACCHS were located in *Inner* and *Outer regional* areas, followed by *Very remote* areas
- Most ACCHS had governing bodies which were 100% Indigenous
- All services had internet/web access, but 18% had no broadband
- The majority of services used an electronic patient information recall system but 15% did not
- The clients of ACCHS also came predominantly from *Inner* and *Outer regional* areas followed by *Remote* and *Very remote* areas

- Although the client numbers were highest in *Inner* and *Outer regional* areas, this is not reflected in the availability of clinical staff
 - Clinical staff per 1,000 clients in these regions were lower than in others
 - Distribution of AHWs were similar in all regions, but nurses were less available in *Inner* and *Outer regional* areas compared with *Major cities*, *Remote* and *Very remote* areas
- The rate of administrative staff per 1,000 clients was relatively high in *Remote* and *Very remote* areas
- The availability of drivers/field officers was high in *Remote* areas
- The number of dental health staff was highest in *Major cities*, with far fewer dental health staff in other regions.

Box 1: Issues to consider in interpreting the data from the Online Services Reporting (OSR) collection

In 2010–11, a total of 235 primary health care services provided data for OSR and 117 of these were ACCHS. Valid data were available from all 117 ACCHS for indicators on service location, governance, and computer use while 112 services provided data on primary care services, 111 services provided data on staffing and 109 provided data on client numbers and episodes of care. In total, 310,038 clients (242,024 Indigenous and 57,127 non-Indigenous) attended 109 ACCHS in 2010–11 and of these 78% were Aboriginal and Torres Strait Islander clients.

A total of 1,812,758 episodes of care (1,531,648 Indigenous and 209,956 non-Indigenous) were provided to clients attending the 109 ACCHS in 2010–11.

In some ACCHS data on the number of clients, episodes of care and visiting staff were based on an estimate rather than an actual count of these events. This may lead to an over or underestimation of the actual numbers pertaining to these events.

As ACCHS participating in the OSR collection are a subset of total services, they may not be representative of all services participating in that data collection.

ACCHS locations

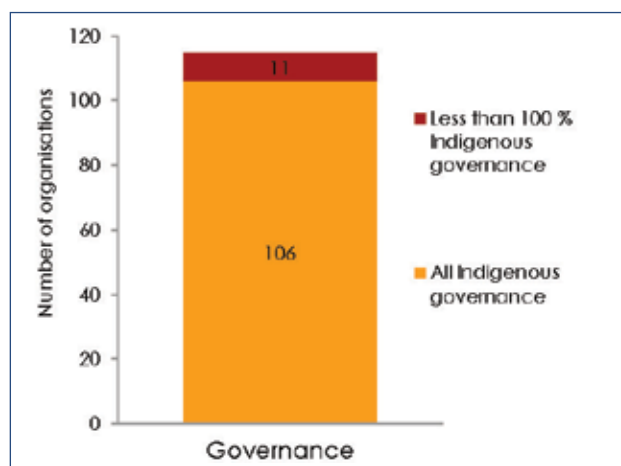
Of the 117 ACCHS participating in HfL, the majority were in *Inner* and *Outer regional* areas of Australia (30 services in each of the regions). There were 17 ACCHS in *Major cities* and in *Remote* areas, while 23 were in *Very remote* areas.

Note that regions are defined using the ABS ASGC remoteness classification. Accordingly, for Queensland, services in Brisbane are classified as being located in *Major cities*, those in Dalby as *Inner regional*, in Chinchilla as *Outer regional* and in Roma and Longreach as *Remote* and *Very remote* areas respectively.



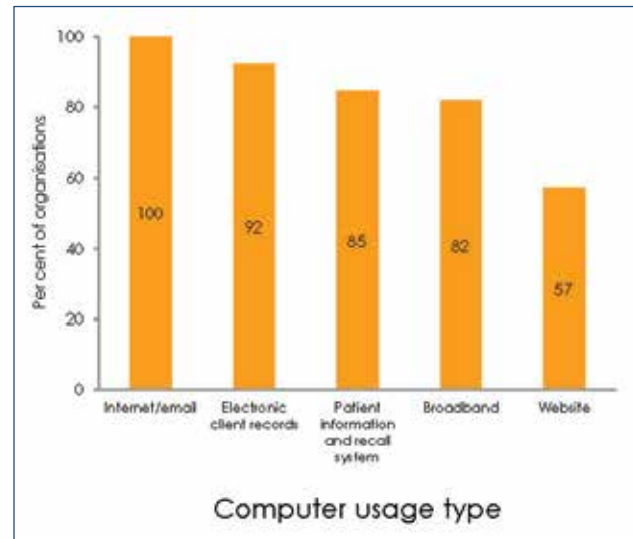
ACCHS Indigenous governance

The majority of ACCHS participating in OSR have governance structures entirely controlled by Indigenous people.



Computer use by ACCHS

The frequency of computer use was generally high and varied, with 100% (117 services) of ACCHS using computers for internet/email, and 57% of ACCHS having a website.



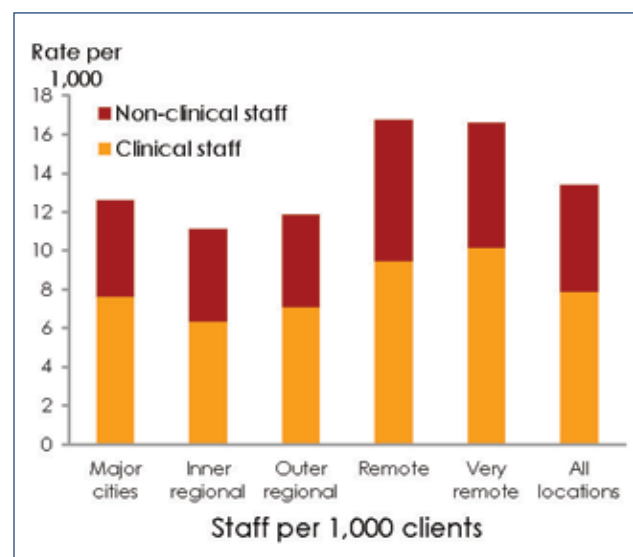
ACCHS client locations

In total, the 109 ACCHS participating in OSR in 2010–11 had 310,038 clients. ACCHS in *Outer regional* areas had 82,828 clients, more than any other area. In contrast, *Very remote* ACCHS had 39,466 clients, fewer than any other area.



Staffing per client in ACCHS

ACCHS in *Remote* and *Very remote* Australia had the most staff per 1,000 clients. They also had the most clinical staff per 1,000 clients. ACCHS in *Inner regional* areas had the lowest ratios of both clinical and total staff to clients.



Types of staff per client in ACCHS

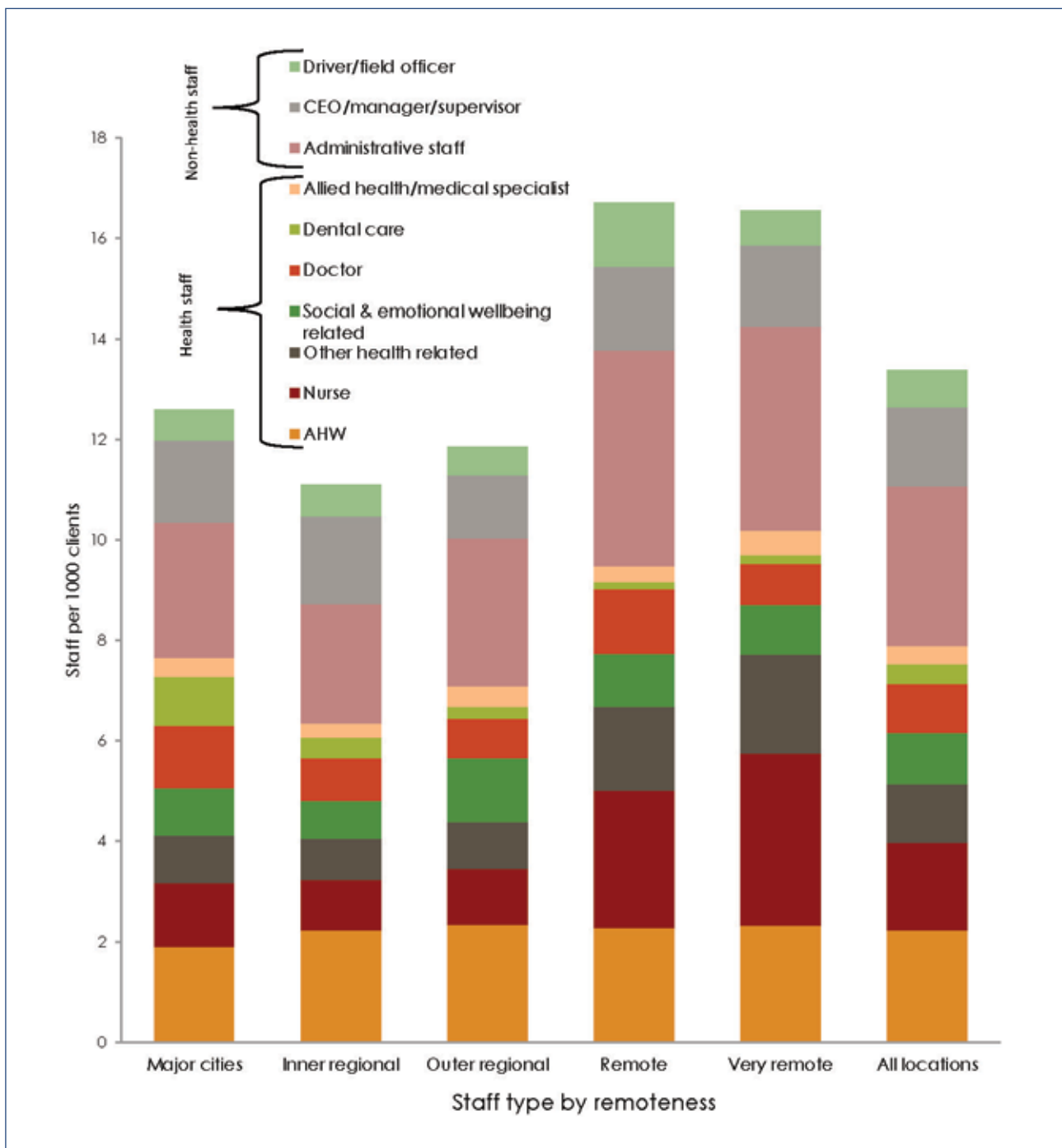
The ratio of particular staffing types to clients varied by remoteness.

There were more doctors per 1,000 clients in ACCHS in *Remote* areas (1.3) and *Major cities* (1.2) than in *Inner regional* (0.9), *Outer regional* (0.8) and *Very remote* areas (0.8).

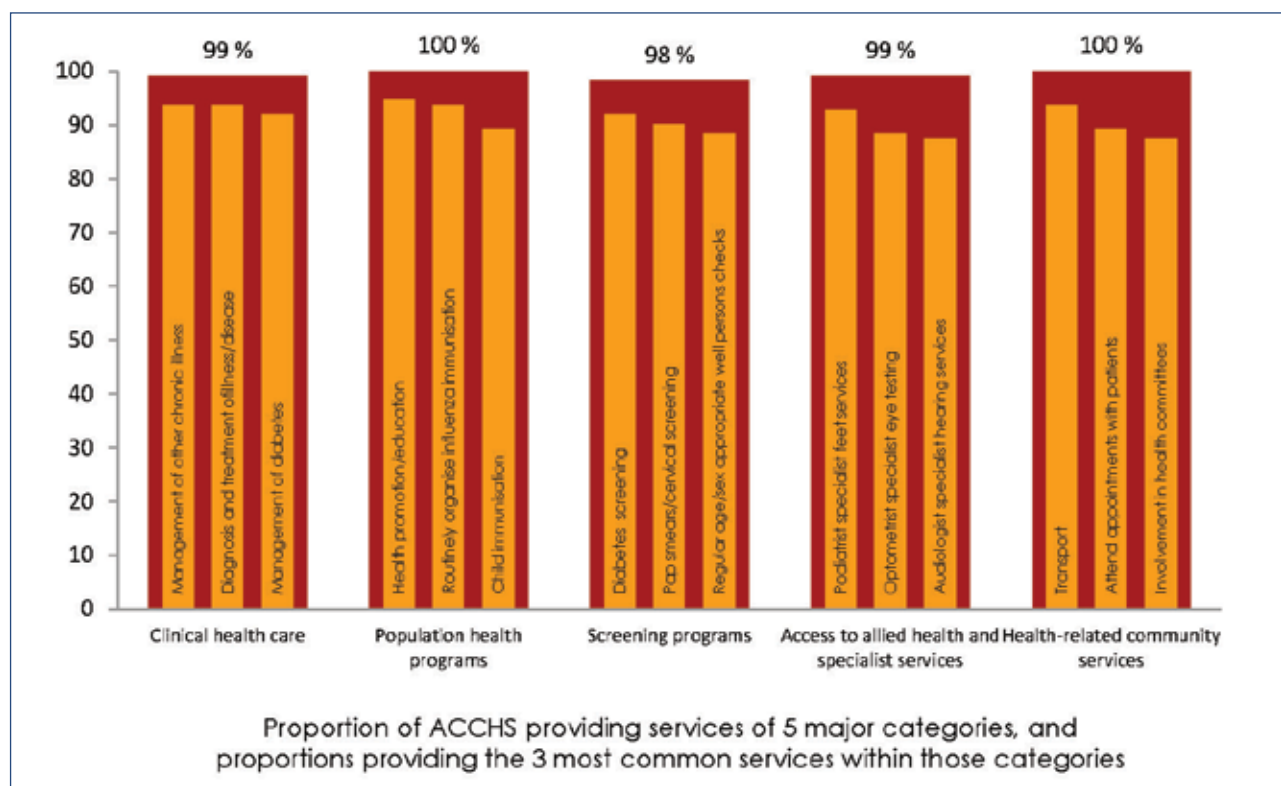
In contrast, *Very remote* and *Remote* areas had the most nurses per 1,000 clients (3.4 and 2.7, respectively). There were fewer nurses per 1,000 clients in *Major cities* (1.2), *Outer regional* (1.1) and *Inner regional* areas (1.0).

There was 1 dental care staff member per 1,000 clients in *Major cities*, compared with 0.1 in *Remote areas* and 0.2 in *Very remote* areas.

All geographic regions had about 2 Aboriginal Health Workers per 1,000 clients.



Nearly all ACCHS provided clinical care which largely involved services designed to help manage chronic diseases. Transport was the major type of health-related community services provided by ACCHS with over 90% of ACCHS providing transport services.



Box 2: Issues to consider in interpreting the data from the Healthy for Life (HfL) collection

In 2010–11, 53 ACCHS provided services to 160,182 clients, 119,079 (74.3%) of these were Indigenous and 37,863 non-Indigenous. Altogether 1,058,722 episodes of care were provided by 53 ACCHS (882,094 Indigenous and 160,880 non-Indigenous).

Data on Essential Indicators in this report card are for ACCHS that submitted valid data for each indicator in every reporting period since the beginning of reporting (July–December 2007 for indicators reported every 6 months and July 2007–June 2008 for those reported annually) to the most recent reporting period ending in June 2011. Only services with valid data over the 4 year period were included in the analysis presented in this report. The number of these services ranged from 20 to 39 services, depending on the indicator.

As ACCHS participating in the HfL collection are a subset of total services, there is the potential for a selection bias in the ACCHS in the HfL collection relative to non-ACCHS. In addition, the trend analysis focused only on a small subset of services that consistently provided valid data for the HfL over the 4 year period which means these services may not be representative of other ACCHS or non-ACCHS participating in the HfL program but not included in this analysis.

Interpreting trends in numbers and proportions

Over the period of 4 years, 2007–08 to 2010–11, both the number of events (numerator) and the population (denominator, regular clients) for which the events were counted have increased, decreased or stayed the same. Depending on the relative change of events and population, the proportions for each indicator may increase, decrease or stay the same.

Example 1: Both the numerator and denominator increased but the proportion decreased— the number of women attending their first antenatal visit before 13 weeks increased from 284 to 382; however, the number of women attending antenatal care (denominator) increased to a greater extent over time from 631 to 888. Although both the numerator and denominator increased over the period, the resulting proportion decreased from 45% to 43%.

Example 2: Both the numerator and denominator increased but the proportion remained the same— the number of clients with Type 2 diabetes who had a blood pressure test result less than or equal to 130/80mm increased from 1,404 to 1,948 and the number of clients with Type 2 diabetes who had a blood pressure test (denominator) also increased over time from 3,406 to 4,683. Although both the numerator and denominator increased over the period, the resulting proportion remained similar (41.2% to 41.6%).

Healthy for Life

The Healthy for Life Program data cover a range of qualitative and quantitative indicators over the period from 2007 to 2011. These provide information on service profile, organisational infrastructure as well as clinical outcomes in 3 health priority areas: maternal health, child health and chronic disease.

The project provides both the Australian Government and local health services with data that can be used to inform regular cycles of decision-making to improve health service delivery (at both local and national levels) and program management and policy. It also helps build health services' capacity to use the data for their continuous quality improvement processes.

Between 2007 and 2011, approximately 100 primary health care services providing care to Indigenous Australians provided data for the HfL Program and 71 of them were ACCHS. The number of ACCHS submitting data varied in each year, however, in 2010–11, 81 services that provided services to 209,014 clients participated in the HfL Program. Of these, 53 were ACCHS that saw 160,182 clients, 74.3% of whom were Indigenous.

The analyses below are for ACCHS that submitted valid data for all reporting periods from 2007–08 to 2010–11, ranging from 20 to 39 services (See Box 2 on page 13 for additional information).

Essential Indicators	Change between 2007 and 2011
Health checks: 0–14 year olds	↓
Health checks: 15–54 year olds	↑
Health checks: over 55 year olds	↑
Chronic Disease Management Plans, GP Management Plans and Team Care Arrangements*	↑
Glycosylated haemoglobin (HbA1c) blood tests for clients with Type 2 diabetes (whether done in the last 6 months)*	↑
Glycosylated haemoglobin (HbA1c) blood test result $\leq 7\%$ for clients with Type 2 diabetes*	↓
Blood pressure tests for clients with Type 2 diabetes (whether done in the last 6 months)*	↑
Blood pressure result is less than 130/80mmHg*	↔
Blood pressure tests for clients with coronary heart disease (whether done in the last 6 months)*	↔
Blood pressure result is less than 140/90mmHg*	↑
Average birthweight	↑
Babies with normal birthweight	↑
Low and high birthweight babies	↓
Timing of first antenatal visit before 13 weeks	↓
Risk factors identified during pregnancy	↓
Immunisation rates	↓

* Reported 6-monthly.

↑ increased ↓ decreased ↔ no change

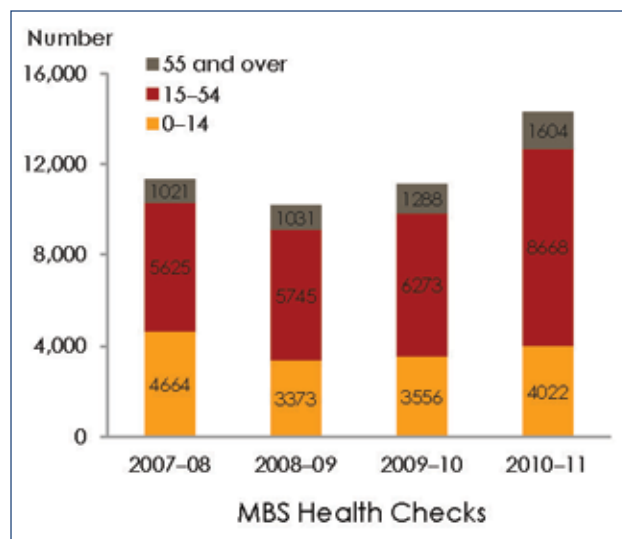
Improved access to primary health care is one of the key objectives of the National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes. Increasing the uptake of MBS funded primary health care services by Indigenous people and providing improved coordination across the continuum of care for people with chronic diseases are some of the outcomes expected through the NPA. ACCHS play a major role in ensuring that essential primary health care services are delivered to Indigenous Australians in a culturally secure manner.

Areas where ACCHS have performed well

MBS Health Checks

The number of clients with valid MBS health checks for all age groups increased from 11,310 to 14,294 between 2007–08 and 2010–11.

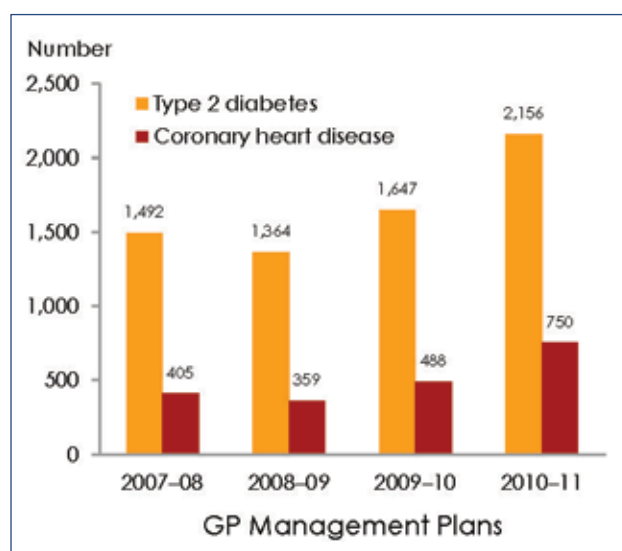
The proportion with a valid health check was 16% in 2007–08 and 14% in 2010–11 for those aged 0–14. The proportion increased from 10.7% to 14.8% for those aged 15–54, and increased from 13.7% to 20.1% for those aged 55 and over.



GP Management Plans (GPMPs)

The number of Indigenous clients with Type 2 diabetes who had a GPMP increased by about 50% from 1,492 to 2,156 between 2007–08 and 2010–11. Over the same period, the number of Indigenous clients with coronary heart disease with a GPMP almost doubled, from 405 to 750.

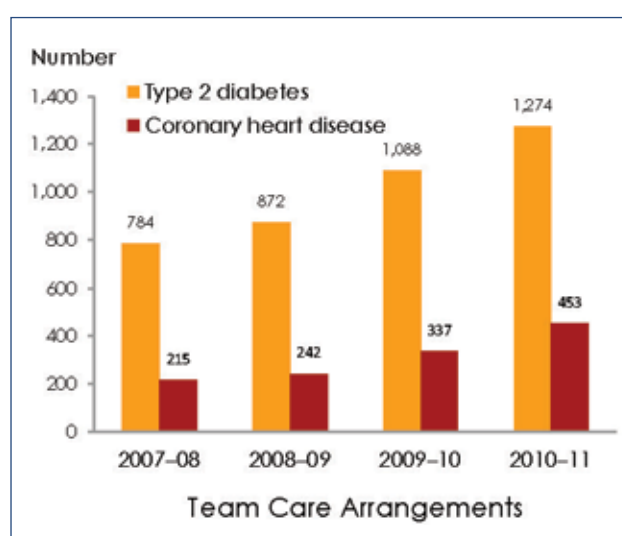
The proportion of clients with Type 2 diabetes who had an MBS GPMP within the last 2 years was 25% in 2007–08 and 32% in 2010–11. The proportion of clients with coronary heart disease who had a GPMP increased from 23% in 2007–08 to 34% in 2010–11.



Team Care Arrangements (TCAs)

The number of Indigenous clients diagnosed with Type 2 diabetes who had a TCA increased by over 60%, from 784 in 2007–08 to 1,274 in 2010–11. Over that period, the number of clients with coronary heart disease who had a TCA increased by over 100% from 215 to 453.

The proportion of clients with Type 2 diabetes who had a TCA increased from 15% in 2007–08 to 22% in 2010–11, and from 13% to 22% for those with coronary heart disease.



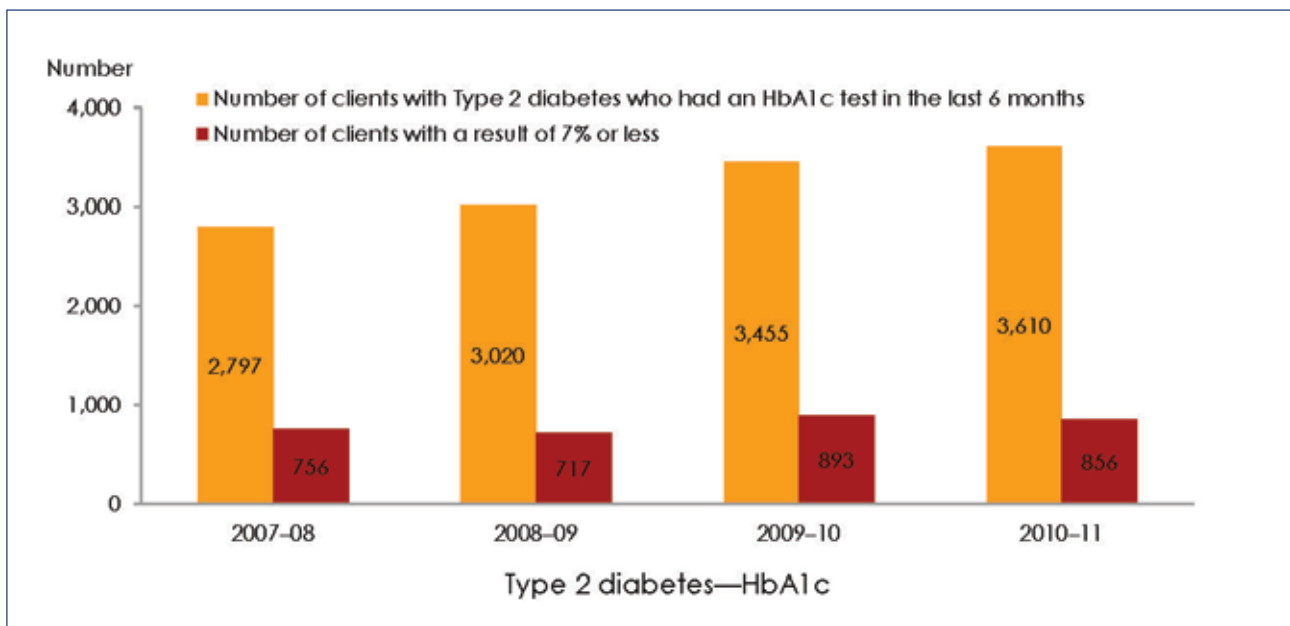
Type 2 diabetes—HbA1c

The number of clients diagnosed with Type 2 diabetes who had an HbA1c increased from 2,461 to 3,610 between 2008 and 2011.

The proportion of Indigenous clients with Type 2 diabetes who had an HbA1c test in the preceding 6 months increased from 46% in July- December 2007 to 56% in January-June 2011.

The number of Indigenous clients with Type 2 diabetes whose HbA1c was less than or equal to 7% increased from 717 in July-December 2007 to 856 in January-June 2011.

The proportion of Indigenous clients with Type 2 diabetes who had an HbA1c result less than or equal to 7% declined from 34% to 29% between 2007 and 2011.



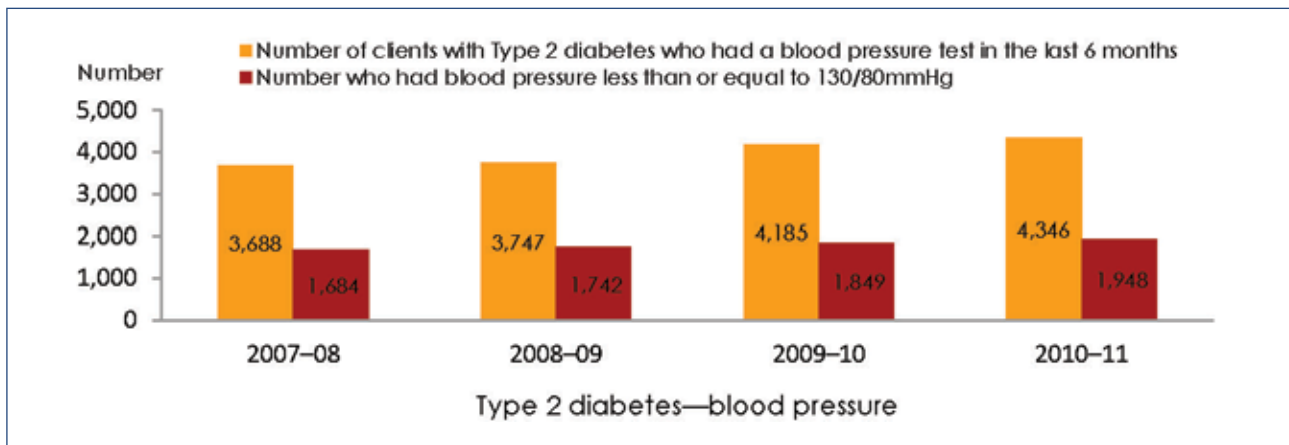
Type 2 diabetes—blood pressure

The number of clients diagnosed with Type 2 diabetes who had a blood pressure test in the last 6 months increased from 3,170 in July-December 2007 to 4,346 in January-June 2011.

The proportion who had a blood pressure test increased from 55% in July-December 2007 to 64% in July-December 2009 and then remained relatively stable (64%-65%) to January-June 2011.

The number of clients with Type 2 diabetes who had a blood pressure result less than or equal to 130/80mmHg increased from 1,404 in July-December 2007 to 1,948 in January-June 2011.

The proportion who had a blood pressure test result less than or equal to 130/80mmHg was 41% in July-December 2007, and 42% in January-June 2011. The proportion was higher between these periods.



Coronary heart disease—blood pressure

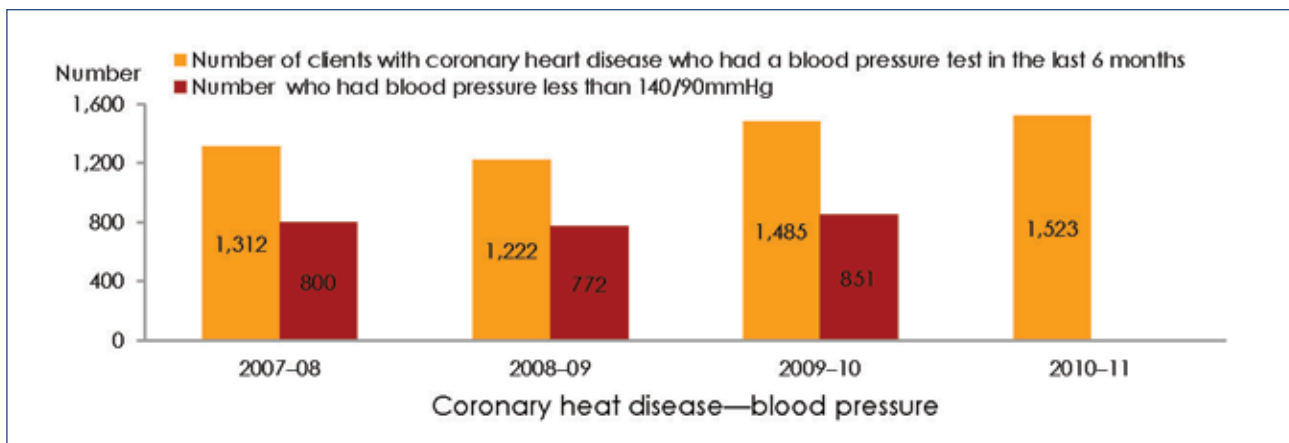
The number of Indigenous clients with heart disease who had a blood pressure test increased from 1,156 in July-December 2007 to 1,523 in January-June 2011.

62% had a blood pressure test in July-December 2007, and 63% had one in January-June 2011, with fluctuation from 59% to 68% between these periods.

The number of clients with coronary heart disease with a blood pressure result less than 140/90mmHg increased from 672 to 947.

The proportion that had a blood pressure result less than 140/90mmHg ranged from 61% in July-December 2007 and January-30 June 2010 to 66% in July-December 2010.

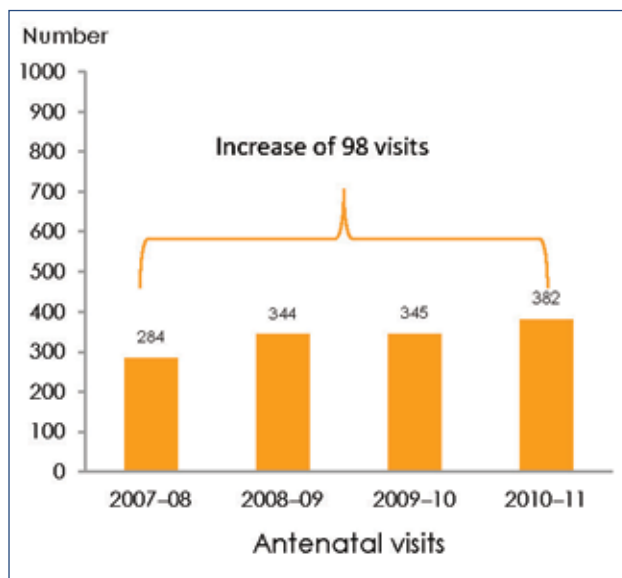
The data specified for this indicator changed in January-30 June 2011, precluding comparisons with this period.



Antenatal visits

The number of women who were clients at ACCHS who gave birth to an Indigenous baby and had an antenatal visit before 13 weeks increased from 284 in 2007–08 to 382 in 2010–11.

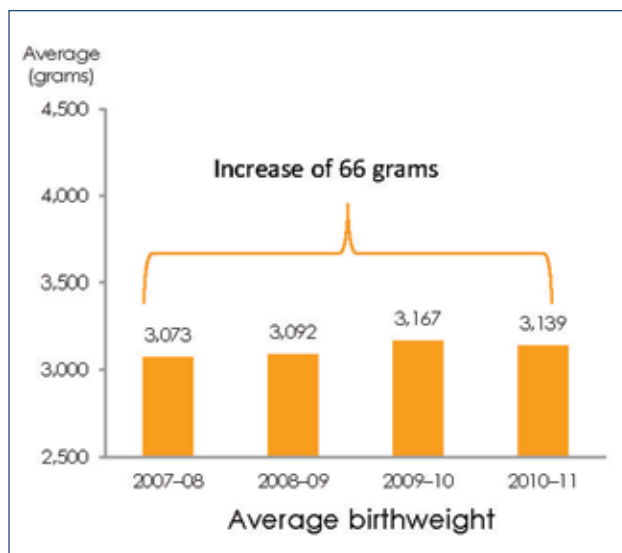
The proportion of women who gave birth to an Indigenous baby and had their first antenatal visit before 13 weeks of pregnancy declined slightly between 2007–08 (45%) and 2010–11 (43%). The proportion with a first visit at 13 weeks to before 20 weeks increased from 18% to 21%.



Average birthweight

The average birthweight of Indigenous babies increased from 3,073 grams in 2007–08 to 3,139 grams in 2010–11, with the highest average birthweight (3,167 grams) recorded in 2009–10.

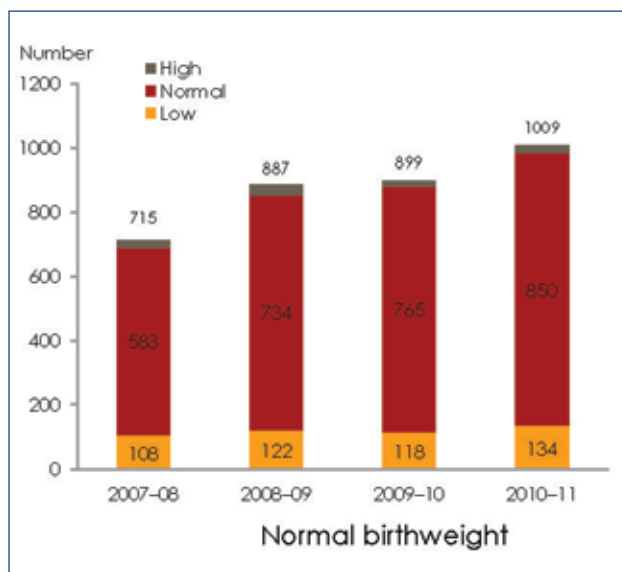
The number of babies whose birthweight was recorded at these ACCHS increased from 789 in 2007–08 to 1,028 in 2010–11.



Normal birthweight

The number of Indigenous babies with normal birthweight increased from 583 in 2007–08 to 850 in 2010–11.

The proportion of Indigenous babies with normal birthweight increased from 81.5% to 84.2% over the same period, and was highest in 2009–10 (85.1%).

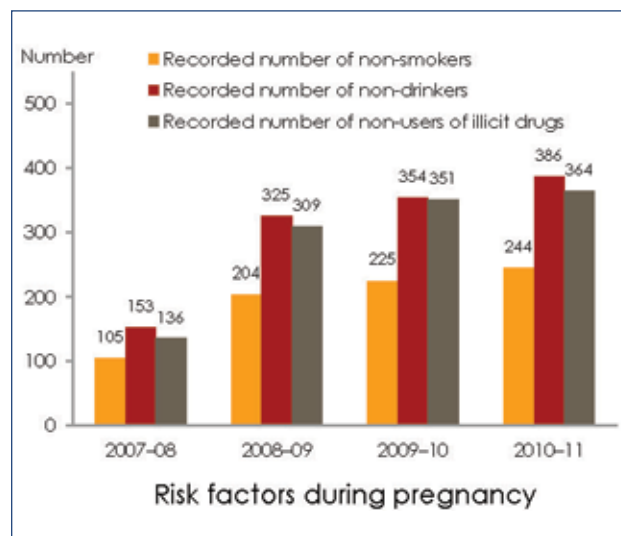


Areas for improvement

Risk factors during pregnancy

The number of women recorded as not smoking in the third trimester more than doubled, from 105 in 2007–08 to 244 in 2010–11. The number recorded as not consuming alcohol also more than doubled, from 153 to 386, while the number recorded as not using illicit drugs almost tripled, from 136 to 364.

The proportion of clients who did not smoke was 50.5% in 2007–08 and 48.8% in 2010–11. The proportion who did not consume alcohol was 83.2% and 85.2% and the proportion who did not use illicit drugs was 88.3% and 84.1% in the same period.



Other areas for improvement

- Children's participation in health checks
- Indigenous clients with Type 2 diabetes whose HbA1c result is $\leq 7\%$
- Indigenous clients with Type 2 diabetes whose blood pressure test result is less than 130/80mmHg
- Uptake of timely blood pressure testing among clients with coronary heart disease
- Children who are fully immunised
- Pregnant women attending their first antenatal visit before 13 weeks of pregnancy
- Pregnant women attending first antenatal visit at 13 weeks to before 20 weeks of pregnancy.

References

ABS 2012a. Australian Demographic Statistics. Cat. no. 3101.0. Canberra: ABS.

ABS 2012b. Census of Population and Housing: Aboriginal and Torres Strait Islander Peoples (Indigenous) Profile, 2011. Cat. no. 2002.0. Canberra: ABS.

AHMAC (Australian Health Ministers' Advisory Council) 2012. Aboriginal and Torres Strait Islander Health Performance Framework 2012. Canberra: AHMAC.

AIHW 2011a. The health and welfare of Australia's Aboriginal and Torres Strait Islander people: an overview 2011. Cat. no. IHW 42. Canberra: AIHW.

AIHW 2011b. Expenditure on health for Aboriginal and Torres Strait Islander people 2008-09: an analysis by remoteness and disease. Health and welfare expenditure series no. 45. Cat. no. HWE 54. Canberra: AIHW.

AIHW 2012. Aboriginal and Torres Strait Islander health services report, 2010-11: OATSIH services reporting - key results. Cat. no. IHW 79. Canberra: AIHW.

AIHW 2013a. Healthy for life: results for July 2007-June 2011. Cat. no. IHW 84. Canberra: AIHW.

Australian Institute of Health and Welfare 2013b. Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11. Health and welfare expenditure series no. 48. Cat. no. HWE 57. Canberra: AIHW.



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