

**Embargoed until
1 pm, Thursday
11 February
2010**



Photo: Lara McKinley/OxfamAUS.

Shadow report

**on the Australian Government's progress towards
closing the gap in life expectancy between Indigenous
and non-Indigenous Australians**

A Close the Gap Steering Committee for Indigenous Health Equality report

February 2010

Acknowledgments

This shadow report is a collaborative effort of the Close the Gap Steering Committee for Indigenous Health Equality. Special acknowledgement is owed to NSW Aboriginal Health and Medical Research Council, Aboriginal Medical Service Alliance Northern Territory, Drug Health Services Royal Prince Alfred Hospital, National Drug Research Institute, Sunrise Health Service, Healthabitat, Many Rivers Alliance, Medical Deans for Australia and New Zealand, Queensland Aboriginal and Islander Health Council, Queensland Alcohol and Drug Research and Education Centre, the Inala Indigenous Health Service, Victorian Aboriginal Community Controlled Health Organisation and the Victorian Aboriginal Health Service for their contributions to this research. Funding for, and project management of the report was provided by Oxfam Australia.

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Published by Close the Gap Steering Committee for Indigenous Health Equality in February 2010.

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Copies of this report and more information are available to download at: www.hreoc.gov.au/social_justice/health/index.html and <http://www.oxfam.org.au/closethegap>

Who we are

Close the Gap is a coalition of Australia's leading Indigenous and non-Indigenous health and human rights organisations committed to working with Federal, State and Territory governments to close the life expectancy gap between the Aboriginal & Torres Strait Islander population and other Australians within a generation.

The Close the Gap Steering Committee is led by the Aboriginal and Torres Strait Islander Social Justice Commissioner and includes the National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Indigenous Doctors' Association (AIDA), the Australian Human Rights Commission, the Indigenous Dentists' Association of Australia, the Council of Aboriginal and Torres Strait Islander Nurses (CATSIN), Oxfam Australia, the Australian Medical Association (AMA), Australians for Native Title and Reconciliation (ANTaR), the Australian General Practice Network (AGPN), the Cooperative Research Centre for Aboriginal Health, the Fred Hollows Foundation, the National Heart Foundation, the Menzies School of Health Research, Indigenous Allied Health Australia, the Royal Australian College of General Practitioners and the Royal Australasian College of Physicians, the Australian Indigenous Psychologists' Association (AIPA) and Bullana – the Poche Centre for Indigenous Health.¹

Aboriginal and Torres Strait Islander people should be aware that this document may contain images or names of people who have since passed away.

Contents

Executive summary	5
Introduction: The commitments of the Australian Government	6
Part I: The Australian Government's progress in meeting its commitments in the Close the Gap Statement of Intent	8
1. A national plan for the achievement of health equality for Aboriginal and Torres Strait Islander peoples by 2030	8
2. Health care services and health infrastructure for Indigenous Australians	10
3. A partnership between Australian governments and Aboriginal and Torres Strait Islander peoples and their representatives	14
4. The social and cultural determinants of Aboriginal and Torres Strait Islander health	16
5. The use of targets in relation to health outcomes; monitoring and accountability for Aboriginal and Torres Strait Islander health	18
Conclusion	20
Summary of what's needed	21
Part II: Case studies	
Victorian Aboriginal Health Service (VAHS)	22
Many Rivers Alliance	23
Sunrise Health Service	23
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	24
The Inala Indigenous Health Service	24
Australian Indigenous Doctors Association (AIDA) collaboration with Medical Deans Australia and New Zealand	25
Appendices	26

CLOSE THE GAP

Indigenous Health Equality Summit

CANBERRA, MARCH 20, 2008

PREAMBLE

Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between indigenous and non-indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.

Prime Minister Kevin Rudd, Apology to Australia's Indigenous Peoples, 13 February 2008

This is a statement of intent – between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organizations – to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by year 2030.

We share a determination to close the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians.

We are committed to ensuring that Aboriginal and Torres Strait Islander peoples have equal life chances to all other Australians.

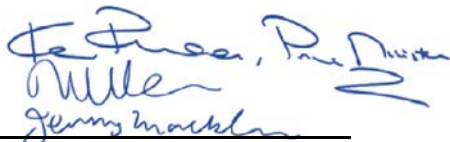
We are committed to working towards ensuring Aboriginal and Torres Strait Islander peoples have access to health services that are equal in standard to those enjoyed by other Australians and enjoy living conditions that support their social, emotional and cultural well-being.

We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery and control of these services.

ACCORDINGLY WE COMMIT:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-indigenous Australians by 2030.
- To ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gaps in health standards by 2018.
- To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs
- To working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.
- To building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.
- To supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.
- To achieving improved access to, and outcomes from, mainstream services for Aboriginal and Torres Strait Islander peoples.
- To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality.
- To measure, monitor, and report on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.

WE ARE: SIGNATURES



Representative of the Australian Government



National Aboriginal Community Controlled Health Organisation



Paddy Gossett
Congress of Aboriginal and Torres Strait Islander Nurses



Neal Hargrett
Australian Indigenous Doctors Association



Indigenous Dentists Association of Australia



Aboriginal and Torres Strait Islander Social Justice Commissioner.
Human Rights and Equal Opportunity Commission

Executive summary

Unprecedented public support to end the Aboriginal and Torres Strait Islander health crisis led to the Australian Government committing to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.

The *Close the Gap Statement of Intent*, signed by the Prime Minister, Ministers for Health and Indigenous Affairs, the Opposition Leader, Aboriginal health leaders and others, includes a number of commitments to support the achievement of the 2030 (or generational) target.

This report, by the Close the Gap Steering Committee for Indigenous Health Equality, representing a coalition of more than 40 Aboriginal and Torres Strait Islander and other organisations, assesses the Government's progress towards health equality for Indigenous Australians against the commitments it made in the *Statement of Intent*. It provides a shadow report to the Prime Minister's annual report to Parliament on progress in 'closing the gap', reflecting the views of stakeholders from Aboriginal and non-Aboriginal health organisations.

Since the signing of the *Statement of Intent* in March 2008, the Government has made significant progress, such as:

- The Prime Minister reporting annually to Parliament on progress in 'closing the gap';
- The appointment of a National Indigenous Health Equality Council to advise it on its efforts to achieve Indigenous health equality;
- The Council of Australian Governments (COAG) developing a *National Indigenous Reform Agreement* and an *Integrated Strategy for Closing the Gap on Indigenous Disadvantage* backed up by \$5 billion in National Partnership Agreements;
- The appointment of a Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery;
- Initiating an unprecedented number of reform processes in health policy (including Indigenous health policy), the most important of these being the National Health and Hospital Reform Commission report; and
- Establishing a national Indigenous representative body (National Congress of Australia's First Peoples).

However, key commitments from the *Statement of Intent* remain unmet and there is little indication from the Australian Government as to when they will be met. These include commitments:

- **To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequalities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030;**
- **To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs; and**
- **To supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.**

This is important not simply because these are unmet commitments but because they are good policy. Without these elements the progress highlighted above could come to little and the ambitious 2030 (or generational) Indigenous life expectancy equality target be unmet. The case studies in this report demonstrate that planning, participation and effective Aboriginal community controlled health are possible. These examples highlight approaches Government can draw on to address its crucial commitments.

A national effort informed by the principles that underpin the *Statement of Intent* is critical to achieve Indigenous health equality by 2030. While acknowledging the progress that has been made, the Close the Gap Steering Committee urges the Australian Government to meet these commitments as a matter of priority.

Introduction

THE COMMITMENTS OF THE AUSTRALIAN GOVERNMENT



Photo: AAP Image/Alan Porritt.

The Australian Government has made ‘closing the gap’ in Aboriginal and Torres Strait Islander disadvantage a defining feature of its approach to Indigenous affairs.

The approach has been shaped by the recommendations for the achievement of health equality for Indigenous Australians within a generation set out in the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma’s landmark Social Justice Report 2005.² These recommendations underpin the Close the Gap Campaign for Indigenous Health Equality (Close the Gap Campaign) first convened by Commissioner Calma in March 2006.

A feature of the Campaign is a human rights based approach to achieving Aboriginal and Torres Strait Islander health equality within a generation. Ultimately, the purpose of such an approach is to ensure that Aboriginal and Torres Strait Islander peoples,

along with all other Australian citizens, are able to enjoy the highest attainable standard of health conducive to living a life in dignity.³

As key elements of a rights based approach, the Campaign includes fixing targets in the context of a comprehensive national plan for health equality and a partnership between Australian governments and Aboriginal and Torres Strait Islander peoples and their representatives to support the design and implementation of the plan. Crucial to this effort is support for Aboriginal Community Controlled Health Services – services established by Aboriginal people for Aboriginal people over 30 years ago. These elements together form part of an overall integrated approach to achieving health equality for Aboriginal and Torres Strait Islander people and cannot be selectively adopted.

With the election of the current Government many of the aims of the Close the Gap Campaign were adopted and the term ‘closing the gap’ entered the policy lexicon. But not just the name was adopted: commitments matched key aspects of the Close the Gap Campaign.

In December 2007, under Prime Minister Rudd’s leadership, COAG set two ambitious targets for the health of Aboriginal and Torres Strait Islander peoples. To:

- close the life expectancy gap within a generation; and
- halve the gap in mortality rates for Indigenous Australian children under five within a decade.

Two education and two employment targets would follow.

In February 2008 in his National Apology to Australia’s Indigenous Peoples, Prime Minister Rudd heralded a new partnership with Indigenous Australians stating that *‘the core of this partnership for the future is the closing of the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities’*.⁴

On 20 March 2008, the Prime Minister,⁵ further demonstrated the alignment of his Government’s approach with that of the Close the Gap Campaign when he signed the *Close the Gap Statement of Intent (Statement of Intent)*.⁶ This is set out on page 4. The *Statement of Intent* commitments embody the approach of the Close the Gap Campaign:

notably, the need for targets, a national plan for Indigenous health equality, funding based on need and supporting a national partnership to that end.

Prime Minister Rudd has committed to making an annual report to Parliament on national efforts to close the gap, with the first annual report to Parliament on Closing the Gap taking place in February 2009.

The Prime Minister said that:

*'Closing the life expectancy gap between Indigenous and non-Indigenous Australians is a core priority of the Government I lead... [e]ach year we must know as a Government, as a people, and as a country if we had made progress closing this gap... [e]very leader knows that accountability brings with it the risk of criticism of failure, as the Prime Minister of Australia I accept that risk.'*⁷

However, the monitoring and reporting of progress is not the sole responsibility of Federal, State and Territory governments and a variety of stakeholders should play a role in measuring the outcomes of policies and approaches to improve the health of Aboriginal and Torres Strait Islander peoples. This shadow report is the Close the Gap Steering Committee for Indigenous Health Equality's contribution to that process, by assessing the Government's progress against the *Statement of Intent* and providing a platform for the views of stakeholders from Aboriginal and non-Aboriginal health organisations.

The report has two parts. The first assesses the Government's progress against the commitments contained in the *Statement of Intent*. The context at November 2007, on the election of the current Government, is detailed, followed by an assessment of progress since then. The Close the Gap Steering Committee provides recommendations on what is needed to meet the commitment and the views of stakeholders from Aboriginal and non-Aboriginal health organisations are presented.

The second is a series of case studies developed for this report to highlight why the principles contained in the *Statement of Intent* are important. In essence, these case studies demonstrate how the *Statement of Intent* links to practice on the ground, as well as the types of approaches that can contribute to closing the gap and meeting the Government's targets.

Part 1: THE AUSTRALIAN GOVERNMENT'S PROGRESS IN MEETING ITS COMMITMENTS IN THE *CLOSE THE GAP STATEMENT OF INTENT*

1. A NATIONAL PLAN FOR ACHIEVING HEALTH EQUALITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES BY 2030

In the *Statement of Intent*, the Australian Government commits to:

- Developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030.

The situation in November 2007, on the election of the Rudd Government.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (NSFATSIH) was adopted by Australian health ministers in 2003. Although the NSFATSIH is comprehensive in scope and the *Aboriginal and Torres Strait Islander Health Performance Framework* provides a good basis to measure progress towards targets it is not adequate to reach the commitments of the Government. To summarise:

- It is not long term enough to meet the 2030 target, expiring in 2013;
- While comprehensive in scope, key areas such as mental health and social and emotional well being need greater attention;
- It lacks targets;
- It lacks an explicit equality focus; and
- It does not adequately address resource issues.

An elaboration on these points is provided in Appendix 1 to this report.

Progress since 2007

- In July 2009, COAG outlined three new strategies to Close the Gap in Indigenous Disadvantage: the *National Indigenous Reform Agreement (NIRA)*, a *National Integrated Strategy for Closing the Gap (Integrated Strategy)* and the *National Urban and Regional Service Delivery Strategy*. At this stage, this includes Indigenous specific National Partnership Agreements (NPAs),⁸ including to improve health outcomes,⁹ and housing¹⁰ and other mainstream NPAs that are explicitly linked to improving Indigenous outcomes;
- The reform directions in the proposed primary health care and preventative health strategies, as well as the National Health and Hospital Reform Commission (NHHRC) recommendations provide an excellent basis for the development of a comprehensive approach to health equality for Aboriginal and Torres Strait Islander peoples.¹¹

However, actions to date do not meet the Australian Government commitment to a national plan to achieve Indigenous health equality by 2030. The NSFATSIH is inadequate to the task. The NIRA and the Integrated Strategy are a good start towards addressing such disadvantage. However, they lack the focus to constitute a long term strategy for the achievement of health equality. The NPAs associated with the Integrated Strategy, for example, expire in 2015, fifteen years short of the 2030 target. The NIRA and Integrated Strategy do not specify a coordination mechanism, timeframes or allocate responsibilities – key elements of any comprehensive and measureable strategy.¹² An elaboration on these points is provided in Appendix 2 to this report.

What's needed?

A new health equality component within the Integrated Strategy is required to address the questions critical to delivering a strategy: what is to be done to improve the situation for Aboriginal and Torres Strait Islander peoples?; by when (targets)?; who is going to do it?; what will it cost?; how will it be financed?; how will it be implemented?; and how will we evaluate progress?

Such a plan would:

- Build on the strengths of the NSFATSIH;
- Incorporate existing Australian Government commitments in the *Statement of Intent* and the COAG targets and otherwise take into account the changes to health policy since December 2007;
- Be designed and implemented in real partnership with Aboriginal and Torres Strait Islander peoples and their representative bodies;
- Be integrated with other national health reform processes; and
- Complement the NIRA and the Integrated Strategy.

What have stakeholders said?

Respondents from a number of Aboriginal and non-Aboriginal health organisations support the Steering Committee view that Government has not yet fulfilled its commitment to a comprehensive national plan towards Aboriginal and Torres Strait Islander health equality.

A respondent from a non-Aboriginal peak health body felt that close the gap initiatives are not being pursued strategically for the long-term. Instead, it was felt the Government was:

*“Pursuing the same programmes, with a new cycle of people. There is a lack of institutional and policy memory and information is not being passed on”.*¹⁴

Another said:

*“Government cannot discharge the commitment without a strategic plan. In November last year COAG said it would develop a national integrated strategy. We had high expectations for an integrated plan but the strategy is weak, it’s neither a strategy nor a plan [for Indigenous health equality]”.*¹⁵

Many respondents felt that without the Government systematically identifying and planning for gaps in services there would a lack of attention paid to health issues that are fundamental to closing the gap. For example several respondents identified oral health as a pressing issue¹⁶ that needed to be part of a national and regionalised strategy, yet to date it has not be recognised as a priority.¹⁷ The financial investment of nearly \$5 billion within the National Partnership Agreements was welcomed by many respondents. Even so, for many it was unclear how these mainstream and Indigenous-specific Agreements would work together to address such health inequality.

According to a respondent from a peak Aboriginal health organisation:

*“It is an unprecedented amount of money but there are issues around it. It is hard on its own to make an impact. We need a plan to effectively make the most of money and all National Partnership Agreements”.*¹⁸

On his recent visit, the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mr Anand Grover commented on the importance of national plan in the following way:

*“In accordance with a rights-based approach I would like to highlight the need for a long-term national plan of action with clear targets, benchmarks and indicators to evaluate progress and guide State and Commonwealth priorities and actions”.*¹³

Read case studies on collaborative regional and long-term planning:

- Many Rivers Alliance, page 23
- Aboriginal Medical Services Alliance of the Northern Territory, page 24

2. HEALTH CARE SERVICES AND HEALTH INFRASTRUCTURE FOR INDIGENOUS AUSTRALIANS

In the *Statement of Intent*, the Australian Government commits to:

- Ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which is capable of bridging the gap in health standards by 2018.
- Supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.
- Achieving improved access to, and outcomes from, mainstream services for Aboriginal and Torres Strait Islander peoples.

Government progress will be assessed in two parts: firstly in relation to primary health care commitments and secondly in relation to infrastructure that provides a foundation for good health (housing, adequate food etc).

(a) In relation to the primary health care commitments

The situation in November 2007, on the election of the Rudd Government.

- A network of approximately 150 Aboriginal Community Controlled Health Services (ACCHS) exist across Australia. These are agreed to be the best model for culturally appropriate and comprehensive primary health care service delivery to the Aboriginal population.¹⁹ However, many Aboriginal and Torres Strait Islander people are unable to access these services, and many of these services need to be expanded if they are to offer the comprehensive primary health care needed to tackle chronic disease and otherwise promote healthy behaviour;²⁰
- The mainstream primary medical care system mainly comprises General Practices and State operated clinics. There is clear evidence to show that while Aboriginal and Torres Strait Islander people do use these services, for a significant number there are barriers to access;
- Poor access of Aboriginal and Torres Strait Islander people to primary care services is evidenced by the significant under-utilisation of the

Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). The result is low levels of prevention and primary care treatment services, under-use of MBS-funded specialists and under-servicing in the hospital system compared to equally ill non-Aboriginal patients;²¹

- In terms of tertiary services Aboriginal and Torres Strait Islander peoples face serious disparities in care, where they are more likely to be hospitalised than non-Indigenous Australians, and less likely to be treated by medical or surgical procedure while in hospital;²²
- Overall Australia lacks a competent and accessible health workforce for addressing such health inequality. There is low participation of Indigenous Australians in the health workforce. For example, Aboriginal and Torres Strait Islander peoples represent 1.9% of the total population aged 15 years and older, but make up only 1% of the total health workforce.²³ In mainstream services not all health care professionals are prepared with the skills, knowledge and attributes to provide quality²⁴ and culturally safe²⁵ care to Indigenous Australians. The *National Indigenous Workforce Training Plan* is not comprehensive enough to meet the gaps in the health workforce or the 2018 goal.

Progress since 2007

- The COAG has agreed to a \$1.6 billion *National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes* that includes measures to address chronic disease factors through adult health checks; improving chronic disease management and follow up care; improving access to medicines; and workforce expansion and support;²⁶ However, these funding commitments are largely directed towards mainstream health services;²⁷ and
- Other initiatives relate to smoking and maternal and child health services, including the *National Partnership Agreement on Indigenous Early Childhood Development*.

A lack of adequate data collection and monitoring over many years has meant that a detailed breakdown of health services gaps in relation to Aboriginal and Torres Strait Islander people is currently not available.

What's needed?

A comprehensive audit of health service needs in Indigenous communities and an inventory of existing services against those needs is required to understand the gaps that must be bridged to meet the 2018 target.

A national plan towards health equality would address Indigenous Australians' inadequate access to primary health care, and would include a focus on expanding ACCHSs. A capacity building plan to provide the necessary additional services in the Aboriginal Community Controlled Health sector is vital. Any strategic response should be integrated with the proposed national primary health care strategy and preventative health strategy both of which need to better articulate their role in augmenting culturally appropriate primary health care to Aboriginal and Torres Strait Islander peoples.

A well-connected health care system and well-integrated services are required to ensure that, wherever patients choose to access care, they will be provided with a quality service and receive appropriate continuity of care.

The Close the Gap Steering Committee believes that Government must:

- Ensure access to culturally appropriate comprehensive primary health care services, at a level commensurate with need; and
- Develop a 5 year Capacity Building Plan for Aboriginal and Torres Strait Islander primary health care services (including governance, capital works and recurrent support) to provide comprehensive primary health care to an accredited standard and to meet the level of need.

A national plan for Indigenous health equality (outlined in the previous section) should provide a targeted and properly funded approach to address Indigenous Australians' inadequate access to primary health care with the 2018 target in mind. Equally, a strategic approach to health infrastructure in communities as part of a national plan for Indigenous health equality should include a focus on the following major infrastructure gaps:

- Workforce development: funded education, recruitment and retention strategies for clinically and culturally competent primary care practitioners and specialists, sufficient to achieve the COAG health goals;
- Engagement with Aboriginal and Torres Strait Islander communities and their representative bodies;
- Health service facilities and capital works;
- Housing and environmental health; and
- Data quality issues.

It was estimated in 2008 that to provide access to culturally appropriate comprehensive primary health care services, a staggered approach to investment in Aboriginal Community Controlled Health Services of \$150 million, \$250 million, \$350 million, \$400 million, \$500 million per annum over five years, with \$500 million sustained in real terms thereafter, is required. This additional cost is for enhanced infrastructure and services to close the health gap for Aboriginal and Torres Strait Islander people.²⁹ The investment should not add to the already burdensome reporting requirements on Aboriginal Community Control Health Organisations.

In relation to mainstream services, the Close the Gap Steering Committee believes Government must continue to ensure they are provided to Aboriginal and Torres Strait Islander people in a culturally sensitive way and at a level commensurate with need, particularly where close the gap funding is directed to mainstream services.

In regions where both mainstream and Aboriginal Community Controlled Health Services provide services for Aboriginal and Torres Strait Islander people, and where service providers agree, there is a need to enhance collaborative partnership arrangements under Aboriginal and Torres Strait Islander leadership and as directed by the Aboriginal community.

As well as improving access to primary health care services, the disparities in care in the hospital setting and the continuity and quality of tertiary care must also be addressed.

Regarding workforce training, the Australian Indigenous Doctors' Association's *'A Blueprint for Action: Pathways into the Health workforce for Aboriginal and Torres Strait Islander people'*³⁰ can provide a foundation for a plan of action for the training of an Aboriginal and Torres Strait Islander health workforce in order to meet the 2018 target.

In its 2007 report card the AMA called for government to commit to:

- Indigenous Aboriginal community control as the preferred option for providing appropriate and accessible comprehensive primary health care for Aboriginal and Torres Strait Islander peoples; and
- For all health services provided specifically for Aboriginal and Torres Strait Islander peoples to be designed, developed, and controlled by the communities they serve, in collaboration with mainstream services.²⁸

(b) In relation to the health infrastructure commitments (health infrastructure refers to the things that provide a foundation for good health: healthy housing, adequate food, sanitation and so on.)

The situation in November 2007, on the election of the Rudd Government.

- A widespread prevalence of overcrowded and otherwise inadequate housing in Aboriginal and Torres Strait Islander communities, particularly remote communities;
- An under-funded housing and infrastructure program for the Aboriginal and Torres Strait Islander population in need;
- Long-standing problems with service coordination in many communities with a solution being proposed in a network of Indigenous Coordination Centres;
- Long-standing issues with access to adequate food in many remote Aboriginal communities. An under-funded National Aboriginal and Torres Strait Islander Nutrition Action Plan; and
- Poor maintenance and development of health infrastructure and access to primary health care services in regional and remote Australia.

Progress since 2007

- The approximately \$2 billion *National Partnership Agreement on Remote Indigenous Housing* that includes a target of 20% Indigenous employment in projects;
- *The Remote Indigenous Service Delivery National Partnership Agreement* including the establishment of a Coordinator-General for Remote Indigenous Services for 29 Indigenous communities; and
- A national Remote Indigenous Food Security Strategy in development.

The Australian Government has indicated it takes the issue of Aboriginal housing and infrastructure seriously. Problems remain, however, with the implementation of many of the relevant National Partnership Agreements. For example, in October 2009 it was reported that the 2008-2009 housing targets for the *National Partnership on Remote Indigenous Housing* had not been met.³¹ The consultation process appears to have encouraged community participation in some rural and remote communities in the Northern Territory but in other cases it has been reported as less than adequate.³² The Federal Government has established new organisational arrangements to provide closer oversight of the implementation of the *National Partnership on Remote Indigenous Housing*.

What's needed?

A strategy to address health infrastructure in communities is a key element of a national plan for Indigenous health equality and should be developed with the 2018 target in mind.

What have stakeholders said?

One respondent reported that despite the substantial increase in funding for Aboriginal people's health seen in the past decade, not enough focus is being given to supporting and expanding the Aboriginal Community Controlled Health Services (also known as Aboriginal Medical Services):

"The worry is, it is not Government's plan to fill in the gaps and they don't like to fund struggling Aboriginal Medical Services (AMS). The fear is that there will be fewer AMS in the future than there already are".³³

Many respondents were concerned that the \$1.6 billion in funds attached to the *National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes* were being focused on developing mainstream services to better serve Aboriginal people instead of strengthening, enhancing, and expanding the Aboriginal Community Controlled Health Services through bolstering workforce capacity and health services infrastructure in a comprehensive way.³⁴

A respondent from an Aboriginal peak health organisation felt that Government's commitment to address health inequality through increased community participation and control was not being realised:

"Government with its social justice lens has been favouring Indigenous rights and community control but this has not been seen in a fiscal response under COAG."

Respondents thought it critical that the Government find a balance between strengthening the mainstream's contribution to Aboriginal and Torres Strait Islander people's health while supporting and building on comprehensive primary health care delivered through Aboriginal Community Controlled Health Organisations.

There remains a long standing concern that programmatic and siloed funding streams delivered as part of COAG will worsen the burden on the Aboriginal Community Control Health Sector. As has long been noted, inefficiencies and burdens in having to deal with multiple funding agreements over quite short time frames can have an impact on service provision.³⁵

In several (mainstream) hospitals around Australia one respondent reported that a lot of work was being done with health professionals in the area of ensuring the cultural safety of Indigenous Australians who use these services but it is necessary to extend this work to incorporate non-medical staff.³⁶

In relation to housing facilities, one respondent asserted that *"if people don't have these basic facilities (such as a working shower, toilet and lighting) then health suffers"*.³⁷ If the funding associated with the *National Partnership Agreement for Remote Indigenous Housing* is not correctly targeted, then it is quite possible that a number of houses will be built with limited health gains.

Some specific concerns were highlighted by respondents from the Aboriginal Community Control Health Sector in relation to:

- The potential for duplication of positions and lack of integration of initiatives with existing programs such as *Healthy for Life*;
- Absorbing the new workforce which will require an investment not just in individual program areas, but also in management, supervision, training, support and infrastructure;
- The conflict and competition between organisations due to Government tendering of contracts for the implementation of initiatives; and
- Siloed, non-recurrent and short-term funding instead of core funding for infrastructure and workforce capacity.

Read case studies on improving primary health care in both community controlled and mainstream service contexts, and on using an evidence base to develop the Indigenous health workforce:

- Victorian Aboriginal Health Service, page 22
- Sunrise Health Service, page 23
- Inala Indigenous Health Service, page 24
- Australian Indigenous Doctors' Association collaboration with Medical Deans Australia and New Zealand, page 25

3. A PARTNERSHIP BETWEEN AUSTRALIAN GOVERNMENTS AND ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES AND THEIR REPRESENTATIVES

In the *Statement of Intent*, the Australian Government commits to:

- Ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.

The situation in November 2007, on the election of the Rudd Government.

- The National Indigenous Council had been appointed following the closure of the Aboriginal and Torres Strait Islander Commission; and
- A network of Aboriginal Health Forums was designed to implement the National Strategic Framework for Aboriginal and Torres Strait Islander Health. Often, at the state and territory level, these have provided a foundation for partnership arrangements.

Progress since 2007

- Strong statements in support of partnership made by Prime Minister Rudd, notably in the National Apology, and in broader commitments to resetting the relationship between Australian governments and Indigenous Australians;
- The National Indigenous Health Equality Council (NIHEC) established to advise the Minister for Health and Ageing on achieving Indigenous health equality;
- Funding and support to establish an Aboriginal and Torres Strait Islander representative body at the national level;
- Northern Territory Government support for the *'Pathways to Community Control'*³⁸ initiative which recognises the necessity of developing and strengthening Comprehensive Primary Health Care and Aboriginal Community Control through planning, development and delivery at local and regional levels in the Northern Territory; and
- Appointment of a Minister of Indigenous Health who has already demonstrated a strong commitment to working with Indigenous Australians.

At present, only ad-hoc arrangements exist for the engagement of Indigenous Australians and their representatives.

The Government is relying on appointed bodies and experts to advise it on policy implementation but not policy development at the national level, rather than developing a more inclusive and genuine partnership process.

The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mr Anand Grover reported on the importance of partnership between government and Indigenous peoples:

“...including the indigenous population in policy and decision-making processes is necessary to build relationships which would ensure genuine protection of their interests, while securing their respective cultural identities and self-determination, and restoring respect and dignity”.³⁹

A major roadblock to partnership is that the Australian Government bureaucracy is lagging behind the Government's stated aims. In this regard, there has been little shift from previous decades. In relation to the *National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes* the Department of Health and Ageing and the Office of Aboriginal and Torres Strait Islander Health has conducted some consultations with Aboriginal health peak bodies and other stakeholders regarding their implementation only - there was no involvement in the development of the National Partnership Agreements.

What's needed?

A genuine and inclusive approach to partnership with Aboriginal and Torres Strait Islander peoples and their representatives is required. A national partnership agreement for the achievement of Aboriginal and Torres Strait Islander health equality by 2030 touching on all the determinants of inequality would address this need. If appropriate as it develops, the National Congress of Australia's First Peoples could be a vehicle for such a partnership.

The NT Aboriginal Health Forum *Pathways to Community Control* strategy could be supported nationally as a positive and systematic framework for working

towards a primary health care system for Aboriginal peoples that maximises local community control. Progressing a national primary health care plan that provides community elected Aboriginal leadership over national health policy development and promotes pathways to Aboriginal community control will require a formalised partnership between Government and the Aboriginal Community Controlled Health sector, particularly in the form of a new National Framework Agreement. This should build on, and perhaps be modelled on, the successful State and Territory Aboriginal Health Forums and the partnerships they embody.

Moreover, a commitment to cultural change in the Australian Government bureaucracy is needed to facilitate partnership arrangements.

What have stakeholders said?

Respondents suggested that despite progress at a policy level since the election of the Rudd Government, there needs to be substantial improvement in the ways the Australian Government engages with Aboriginal and Torres Strait Islander representatives and communities.⁴⁰

There is a particular concern about an apparent lack of bureaucratic “buy in” to the Government Close the Gap commitments to partnership.⁴¹

*“...the Chronic Disease Package was devised as a predetermined exercise by Government and COAG behind closed doors. This is how Government has functioned for years when working on Aboriginal issues, it just so happens now that we are dealing with a substantial amount of money and hence there is greater potential for wastage based on poor ideas”.*⁴²

For example, COAG funded the roll out of the ‘Indigenous Outreach Worker’ component of the *National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes* through mainstream and Aboriginal health services despite the Aboriginal Community Control Health Sector expressing deep and valid concerns about it.⁴³ Rather than funding the expansion and improvement in Aboriginal Health Workers’ conditions, COAG has funded the establishment of new workers – Indigenous Outreach Workers. This left the sector feeling powerless and coopted in the process, renaming those positions within the sector as ‘trainee Aboriginal Health Workers’ and having to manage the concomitant training, credentialing, and salary issues.

In another jurisdiction, implementation processes for the *National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes* reportedly bypassed the existing decision-making and partnership capacities of the Aboriginal Health Forum.⁴⁴

Read case studies on partnership and engaging Aboriginal and Torres Strait Islander peoples and their representatives in developing policy and programs:

- Many Rivers Alliance, page 23
- Aboriginal Medical Services Alliance of the Northern Territory, page 24
- Australian Indigenous Doctors’ Association collaboration with Medical Deans Australia and New Zealand, page 25

4. THE SOCIAL AND CULTURAL DETERMINANTS OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

In the *Statement of Intent*, the Australian Government commits to:

- Working collectively to systematically address the social determinants that impact on achieving health equality of Aboriginal and Torres Strait Islander peoples
- Respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality.

The situation in November 2007, on the election of the Rudd Government.

- The *National Strategic Framework on Aboriginal and Torres Strait Islander Health* acknowledged the importance of the health sector influencing the non-health sector to improve Aboriginal and Torres Strait Islander health outcomes. This however appears to have had minimal impact in shaping overall Australian Government policy;
- The *Overcoming Indigenous Disadvantage* monitoring framework was based on the acknowledgment of the wide range of the determinants of health beyond the health sector (education, employment etc) and that Government action on all fronts was needed if health and other outcomes were to be improved; and
- The Aboriginal Community Controlled health sector has been delivering comprehensive, culturally appropriate community controlled health care to Aboriginal and Torres Strait Islander people for over three decades. Aboriginal Community Controlled Health Organisations respond to the physical well-being of a person and

work to address the social, emotional and cultural determinants of health of an individual and the community within which they are a part. As such they are mediators of social change, building community capacity and resilience.

Progress since 2007

- Indigenous specific National Partnership Agreements, in particular, the *National Partnership Agreement on Indigenous Economic Participation* and the *National Partnership Agreement on Remote Indigenous Housing* and the associated targets;
- The proposal for a national Indigenous Education Action Plan;⁴⁵
- The structure of the NIRA and the National Integrated Strategy which acknowledge that a range of determinants impact, for better or worse, on the health of Indigenous Australians. If used as intended by policy makers, the NIRA shows promise as the basis of an integrated approach to the social determinants of health inequality (although it is not, in itself, adequate as a national plan for attaining health equality of Aboriginal peoples);
- At present there is no comprehensive, targeted national plan for addressing the social and cultural determinants of health; and
- The establishment of an Indigenous controlled Aboriginal and Torres Strait Islander Healing Foundation.

What's needed?

A national plan, addressing all the determinants of health inequality would incorporate a range of social and cultural determinant targets in addition to the existing COAG education and economic participation targets. Again the focus would be on enhancing the capacity of the Aboriginal Community Controlled Health Sector to deliver culturally appropriate health care commensurate to need. A broader and informed debate is also required about the role cultural determinants such as human rights, constitutional change and reconciliation can play in relation to improving the health of Aboriginal and Torres Strait Islander peoples.

The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing (SEWB) 2004-2009* was designed to complement the *National Mental Health Plan* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*. Strategies with clear roles and

responsibilities have been developed to oversee the implementation of the SEWB framework at local, State/Territory and National levels. However the Framework was never fully implemented. That Framework has expired and was due to be evaluated by December 2009. Currently there is no social and emotional well-being and mental health plan for Indigenous Australians at the national level. It is essential that a plan be developed in genuine partnership with Aboriginal and Torres Strait Islander representatives.

What have stakeholders said?

Respondents from across the health sector agreed that more needs to be done to comprehensively address the social determinants of Indigenous Australians' health. Housing was highlighted by several respondents as a key issue for consideration. Respondents from the drug and alcohol services reported that there is inadequate coverage of their services for Indigenous Australians.⁴⁶

The chronic disease package in the *National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes* raises the issue of trauma, mental health, and alcohol and drug issues. However one respondent noted that the current approach lacks rigor, is poorly integrated and is not comprehensive, coordinated or systematic enough to adequately address Indigenous mental health and social and emotional wellbeing, highlighting the need for national planning:

"The current approach to addressing Indigenous mental health is a mess. It is uncoordinated and the Commonwealth, States and non-government organisations do piecemeal work in their own silos".⁴⁷

There were also concerns that there is inadequate coordination and national leadership in bringing the sectors together that impact on health to work together. This is a long-standing issue.⁴⁸

Read a case study on addressing the social determinants of health:

- Victorian Aboriginal Health Services, page 22.
- Sunrise Health Service, page 23

5. THE USE OF TARGETS IN RELATION TO HEALTH OUTCOMES; MONITORING AND ACCOUNTABILITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

In the *Statement of Intent*, the Australian Government commits to:

- Measure, monitor and report on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.
- Building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.

The situation in November 2007, on the election of the Rudd Government.

- The NSFATSIH provided key action areas and the *Aboriginal and Torres Strait Islander Health Performance Framework* measures progress against baselines, but no targets were set by governments for Aboriginal and Torres Strait Islander peoples to attain health equality;
- In many key areas, there are poor and inconsistent data collection; and
- Very little accountability for Aboriginal health related outcomes.

Progress since 2007

- The adoption of the 6 COAG targets and 'building blocks' that underpin the targets⁴⁹ and the alignment of the *Overcoming Indigenous Disadvantage Framework* with them;
- The making of commitments, such as those in the *Statement of Intent*, against which the Australian Government can be held accountable;
- Improved reporting around Aboriginal health outcomes including the Prime Minister's report on the first sitting of Parliament each year and an annual report by the COAG Reform Council against key performance indicators;
- \$46m devoted to improving data collection in the NIRA and the Integrated Strategy;
- Agreement to work with key research institutions to strengthen evidence-based health initiatives for the Aboriginal population;
- It is understood that NIHEC is currently developing a set of detailed health targets; and
- The 'Closing the Gap Clearinghouse' has been established to provide access to a collection of information to monitor progress on closing the gap.⁵⁰

Challenges remain: the use of targets is inconsistent and there are no supporting sub-targets below the overall targets at the COAG level. Accountability for health outcomes in the Aboriginal and Torres Strait Islander population is still spread across many agencies and jurisdictions with the onus of reporting inappropriately burdening ACCHSs. Although non-Aboriginal mainstream organisations receive substantial funding for the improvement of Aboriginal people's health, there are poor measures and indicators of outcomes and limited mechanisms for reporting.

What's needed?

A wider range of targets and sub-targets is needed to be incorporated into the national plan for health equality. A major effort to improve accuracy, coverage and availability of health data in relation to fixing long-standing data gaps is vital if setting targets is to be meaningful.

Clear lines of responsibility and evaluation mechanisms must be established, particularly in relation to the meeting of targets.

What have stakeholders said?

Accountability and the effective monitoring of programs was considered vital by stakeholders. For example, the outcomes of the *National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes* should be measured (against the COAG targets) over a period of time to understand what has worked and what needs to change.⁵¹

One respondent from the Aboriginal Community Controlled Health Services Sector asserted:

*“We want to see evidence that Aboriginal people have more access to health care and quality health care as a result of the COAG funding to mainstream services. We want to see evidence that those in need are being targeted through diversion of funds in this direction”.*⁵²

The need to monitor specific outcomes effectively was also commented on because:

*“Whilst an evaluation of the COAG package might show more Medicare claims and referrals we won’t know if these people are already users of the health system. Are we reaching the hard to reach”?*⁵³

A respondent from the non-Indigenous health sector stressed the need for a joint commitment to monitoring across the sector. He commented that:

*“The point is that the commitment to improve Indigenous health has been made. It must be seen as a shared commitment and the monitoring of the commitments must be a collective response”.*⁵⁴

Again, a pressing concern was the potential for an increased reporting burden on Aboriginal Community Controlled Organisations related to the implementation of COAG initiatives.⁵⁵

Read case studies on monitoring and using an evidence base to improve services and supporting what works:

- Victorian Aboriginal Health Service, page 22
- Australian Indigenous Doctors’ Association collaboration with Medical Deans Australia and New Zealand, page 25

6. CONCLUSION

Since the Close the Gap campaign began in 2007, more than 135,000 Australians have pledged their support for an end to the health crisis affecting the Aboriginal and Torres Strait Islander population.

In response, Federal, State and Territory governments accepted the challenge and committed to Close the Gap. They have also committed substantial new funding (through to 2012) as part of their initial response.

So far, we have seen some positive progress from Government. However, key commitments from the Statement of Intent remain unmet with, as yet, little indication from the Australian Government as to when they will be. These include commitments:

- **To a comprehensive, long-term plan of action... in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030;**
- **To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs; and**
- **To supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.**

All of the commitments in the *Statement of Intent* are critical to closing the gap if we are to end the health crisis that sees Indigenous Australian men suffering heart disease and stroke at three times the rate of other Australian men, and Indigenous Australian women dying from cervical cancer at a rate five times higher than their non-Indigenous counterparts.

A national effort informed by all the principles that underpin the *Statement of Intent* is necessary to achieve health equality for the Aboriginal and Torres Strait Islander population by 2030. The Close the Gap Steering Committee – representative of the country's key Aboriginal and Torres Strait Islander and non-Indigenous health organisations – urges Australian governments to meet these commitments as a matter of urgency.

SUMMARY OF WHAT'S NEEDED

NATIONAL PLAN FOR THE ACHIEVEMENT OF HEALTH EQUALITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES BY 2030

- A comprehensive, long-term plan of action that is targeted to need, evidence-based and capable of addressing the existing inequalities in Indigenous health.

HEALTH CARE SERVICES AND HEALTH INFRASTRUCTURE FOR INDIGENOUS AUSTRALIANS

- A five year Capacity Building Plan for Aboriginal Community Controlled Health Services (including governance, capital works and recurrent support) to provide comprehensive primary health care to an accredited standard and to meet the level of need;
- A comprehensive audit of health service needs in Indigenous communities and an inventory of existing services against those needs;
- A strategic address to health infrastructure in communities as a key element of a national plan for Indigenous health equality;
- A well-connected health care system and well-integrated services to ensure that, wherever patients choose to access care, they will be provided with a quality service and receive appropriate continuity of care;
- Culturally appropriate comprehensive primary health care services, at a level commensurate with need;
- A comprehensive plan of action for the training of an Aboriginal and Torres Strait Islander health workforce to meet the 2018 target as part of the national plan.

A PARTNERSHIP BETWEEN AUSTRALIAN GOVERNMENTS AND ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES AND THEIR REPRESENTATIVES

- A genuine and inclusive approach to partnership with Aboriginal and Torres Strait Islander peoples and their representatives;
- A national partnership agreement for the achievement of Aboriginal and Torres Strait Islander health equality by 2030 touching on all the determinants of inequality.

THE SOCIAL AND CULTURAL DETERMINANTS OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

- As a part of a national plan, an address to all the determinants of health inequality that incorporates a range of social and cultural determinant targets in addition to the existing COAG education and economic participation targets;
- As a part of a national plan, a social and emotional well-being and mental health plan developed in genuine partnership with Aboriginal and Torres Strait Islander peoples and representatives.

THE USE OF TARGETS IN RELATION TO HEALTH OUTCOMES; MONITORING AND ACCOUNTABILITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

- A wider range of targets and sub-targets incorporated into the national plan for health equality. The Close the Gap Health Equality Targets are intended to be a start to this process and can inform further work in this area;
- Improvement of accuracy, coverage and availability of health data in relation to fixing long-standing data gaps;
- Clear lines of responsibility and evaluation mechanisms, particularly in relation to the meeting of targets.

PART II

CASE STUDIES

Photo: Lara McKinley/OxfamAUS



Community Elder Aunty Elma Thorpe from Victorian Aboriginal Health Service (VAHS).

There are many examples around the country of organisations, people, and communities working to close the gap in health equality between Indigenous and non-Indigenous Australians. This section provides a snapshot of just a few approaches that highlight why the principles contained in the Statement of Intent are important. In essence, they demonstrate how the Statement of Intent links to practice on the ground, as well as the types of approaches that can contribute to closing the gap and meeting the Governments' targets.

Victorian Aboriginal Health Service (VAHS)

For the last three decades, the Victorian Aboriginal Health Service has provided a “one stop shop” of culturally appropriate primary health care to the Victorian Aboriginal community in the Metropolitan region of Melbourne. VAHS takes a holistic approach to health care and emphasises preventative medicine and community care, together with clinical care. This includes medical services (sexual health, health assessments), family counselling and outreach programs, dental and health programs (such as maternal and child health) and community programs (such as Active Elders Program).

VAHS also works to address generational social disadvantage, grief and trauma and improve health outcomes with extensive mental health and social and emotional well being programs. VAHS offers adult mental health programs, gamblers help programs, and child and adolescent mental health. The service’s holistic approach extends to building the livelihood opportunities, self-esteem and confidence of unemployed Aboriginal youth and in collaboration with Mission Australia and the Victorian Government, VAHS has developed a social enterprise restaurant – Charcoal Lane – in inner-city Melbourne to develop the professional and life skills of Aboriginal youth for a career in the hospitality industry.

VAHS’ strength is in its evidence-based model of service delivery that ensures the service is reviewed and adapted to meet community needs. For example VAHS has developed a health record diary to support clients in the *Healthy for Life* program to record medication requirements, contacts and appointments. The capacity of VAHS to strengthen its service delivery, coordination of care, and meet priority needs is enhanced through partnerships with mainstream health services and other Aboriginal health providers. For example, to improve hospital discharge planning and referral pathways VAHS has established the ASK program - Access to Services for Koories limited - with the Northern Division of General Practices to ensure clients are engaged and able to access services from General Practitioners and specialists.

VAHS is unique in its ability to offer a “home away from home” for Aboriginal people and in its capacity to continue to reach the most disadvantaged. Its comprehensive primary health care services are provided in a setting that Aboriginal people can identify with. This offers an opportunity to socialise with others and access information in a non-threatening and comfortable environment. VAHS comprehensive approach to health in an urban setting allows it to attract a broad base of clinical staff and to offer a high quality and a range of allied health, specialist and non-clinical care services to Aboriginal people.

Many Rivers Alliance

The Many Rivers Alliance is an alliance of Aboriginal Community Controlled Health Services.

The Alliance brings together five Aboriginal Community Controlled Health Services (Biripi, Durri, Galambilia, Bulgarr Ngaru, Dharah Gibinj) and two Aboriginal Medical Services (Bullina, Bugalaweena) on the North Coast of NSW. The purpose is to jointly decide on the best use of resources and to plan at a regional level. The rationale was to ensure organisations are not competing over limited resources but instead taking a region-wide view of what services and resourcing was required, and where they should be directed. The Alliance strengthens members' capacity to present a more strategic, collective position to Government and the Area Health Service in relation to resource allocation and programs.

Meeting every six weeks, the Alliance considers which organisations are best placed to auspice new positions or programs proposed by Government. It also considers issues such as joint research or pilot programs that might inform the work of Alliance members or provide the evidence to advocate for Government support for programs. Good practice in individual organisations policies is shared among Alliance members, resulting in improved services and increased consistency across the region. One example of this is in relation to human resources where, as a result of different and diverse funding sources, the same positions in different organisations are paid differently. This causes difficulties for some organisations to compete in the labour market. The Alliance is trying to move towards greater parity in pay and conditions for similar positions.

The Alliance enjoys a good working relationship with Government. However, with all partnerships and organisations, the Alliance faces some challenges. There is no recurrent funding, which limits forward planning and certainty. There is also a preference on the part of governments when considering new projects to fund pilot positions rather than ongoing programs. This limits the capacity of organisations to attract, retain and develop staff. While engagement with the Alliance by Government is welcome and positive, the development of policy for the region is still exclusive of the Alliance, that is, the Department develops a regional plan every year prior to presenting it to the Alliance for endorsement, rather than developing the plan jointly with the Alliance.



Photo: Juan Martorana/OxfamAUS.

Bruce Hall and Aboriginal Health Worker from Sunrise AMS, Jefferson Thorpe.

The Many Rivers Alliance is an example of how Aboriginal Community Controlled Health Organisations can work together in partnership, develop strategic approaches to regional planning and engage positively with Government.

Sunrise Health Service

Sunrise Health Service is an Aboriginal Community Control Health Service that provides primary health care services to remote Aboriginal communities and pastoral stations from nine health centres spread across the Katherine region.

Consistent with the work of Aboriginal Community Controlled Health Services elsewhere, Sunrise offers comprehensive primary health that include primary clinical and emergency care, health promotion and social support, chronic disease, nutrition and aged care programs, women's, men's and child health and physical activity programs.

The Sunrise Board sets the policy direction. Ten Community Health Committees (CHC) have been established to ensure local autonomy and involvement in planning the development of the health services at the community level.

Sunrise is guided by a principle of genuine community control of the service. It sees good governance as critical to sustainability. It has therefore invested in building the governance of every CHC and the Sunrise Health Service Board, focussing on business and financial management, work practices and accountability, and applying a mix of visual, oral and written communication strategies that could be locally understood. It has worked to enhance the capacity of each CHC to solve local issues.

A particular challenge for the organisation has been the siloed funding arrangements that exist for Aboriginal health.

As a result, Sunrise has faced difficulty integrating Government-led programs and specialist services, particularly those related to the Northern Territory Emergency Response, with existing service delivery frameworks.

Sunrise has focused on developing and building partnerships that sustain strong connections with communities and growth in line with local priorities. Further partnerships with Fred Hollows Foundation, Ian Thorpe Foundation for Youth Trust and Honda Foundation have been based on strengthening local structures and have resulted in enhanced capacity in the area of literacy, nutrition, child health and aural health.

The work undertaken in relation to transparent governance processes, appropriate and localised communication strategies, Aboriginal workforce and local ownership of the health service have been particularly important to the organisation's success. While meeting the community needs and expectations for expansion the organisation has ensured the strong elements of Aboriginal community control remain intact.

Aboriginal Medical Services Alliance Northern Territory (AMSANT)

AMSANT is the peak body for Aboriginal Community Controlled Health Services in the NT. There are some 26 member services across the NT. To improve Aboriginal health outcomes, AMSANT seeks the provision of high quality comprehensive primary health care services to address the significant health needs that exist in all Aboriginal communities.

AMSANT, together with Northern Territory and Commonwealth health authorities have entered into a formal partnership (the Northern Territory Aboriginal Health Forum) to oversee Aboriginal health delivery, funding and policies. This Forum meets quarterly to review progress, plan future activities and share information.

Forum priorities in the 2008-2010 period involve reform of the Aboriginal primary health care delivery to improve efficiency, quality and ensure Aboriginal people get improved access to the core primary care services needed to "Close The Gap". A key element in this plan is an expansion in the coverage of regionally-based Aboriginal community controlled primary health care services to cover all parts of the Northern Territory. This project builds on the successes of the two existing regional Aboriginal health boards in the Katherine district and the many successful community based services that are now integrating into a regional service model.

To assist this ambitious plan, the Forum recently launched the document *Pathways to Community Control* to provide the policy framework needed to guide the transfer of services to new regional Aboriginal Community Controlled Services. The Pathways document represents the shared commitment of the NT Aboriginal Health Forum to the development of a strategy to secure greater levels of Aboriginal community control in the delivery of comprehensive primary health care in the NT.

At the regional level of the NT throughout 2009, there was extensive activity and consultation around the formulation of multi-provider regional health plans and consideration of long-term health governance options. This work will continue well into 2010. In the meantime, an increased investment in health service delivery by the Commonwealth is allowing a welcome increase in access to primary health care services by Aboriginal people.

Photo: AMSANT



A recent health regional summit, hosted by AMSANT, held in Alice Springs.

The Inala Indigenous Health Service

The Inala Indigenous Health Service (IIHS) is a mainstream primary health care service based in the Inala suburb of South-West Brisbane. IIHS was established in 1995 by Queensland Health in response to an extremely low number of Aboriginal and Torres Strait Islander patients (12) attending the mainstream service, despite 8% of the Inala population identifying as Indigenous Australian.

Inala offers a "one stop shop" for Aboriginal and Torres Strait Islander clients. It provides access to chronic disease

prevention and management, health checks across the life span, allied health and child health services, mental health and alcohol and other drug services. Over the last 14 years, it has increased access to services for the Aboriginal and Torres Strait Islander population. In 2009 there were 3500 patients registered with around 1,200 medical consultations completed each month.

Systemic and cultural changes have been important to this success. An Indigenous doctor in a strong leadership position, Indigenous staff, culturally sensitive non-Indigenous staff and a more relaxed medical setting (such as culturally appropriate waiting room, flexibility about time) have contributed to increased cultural safety of the mainstream service. The one stop shop approach, combined with the ability to bulk bill patients, has increased access and led to the employment of extra staff to meet the demand.

Indigenous leadership has assisted the organisation to partner and link with other Aboriginal and Torres Strait Islander health organisations at the local, State and Commonwealth level. This has contributed to Inala's ability to sustain the change in service delivery and continue to offer quality, comprehensive and relevant care to Aboriginal and Torres Strait Islander clients. Community consultation and participation of local elders in the development and implementation of IIHS's services has also been fundamental to sustainability. Strong links with the elders has created trust within the community and led to improved access to the service and increased community participation in the design and implementation of community-based health initiatives.

The Queensland Government has recognised the merit of the IIHS model for improving Aboriginal and Torres Strait Islander health and has agreed to fund the development of IIHS to become a Centre of Excellence in Indigenous Primary Health Care. The Centre will not only offer comprehensive primary health care but will also aim to address current shortfalls in workforce development through specialised training, and linking with universities to deliver high quality teaching to medical students about primary health care, including the management and treatment of chronic disease. An applied research agenda focused on Aboriginal and Torres Strait Islander health issues and specialist outreach clinics to improve access will also be integrated components of the centre.

[Australian Indigenous Doctors Association \(AIDA\) collaboration with Medical Deans Australia and New Zealand](#)

In October 2008 Australian Indigenous Doctors' Association and the Medical Deans Australia and New Zealand (Medical Deans) signed a Collaboration Agreement 2008-2011 (the *Agreement*)⁵⁶ to progress tangible long-term improvements in the health and wellbeing of Aboriginal and Torres Strait Islander peoples, as well as adequately address health workforce shortages. The Agreement is a joint commitment to work together to realise the potential of Aboriginal and Torres Strait Islander medical students and to strengthen non-Indigenous medical graduates' capacity to practice with cultural competence and confidence in Aboriginal and Torres Strait Islander health settings.

The Agreement has been operationalised within the two organisations. The result is a high level and sustained commitment to collaborate to improve Aboriginal and Torres Strait Islander health, financial investment in identified priorities and a transfer of knowledge across the two organisations. For example, the Indigenous Knowledge Initiative for Deans - an initiative of the *Agreement* - has exposed Medical Deans to a particular set of health issues that they may not have been familiar with, having a significant impact on the ways in which Medical Deans deal with Aboriginal and Torres Strait Islander issues.

AIDA and Medical Deans have also jointly influenced broader structural reform and policy and program agendas in both national health and education. For example joint program work is ongoing on a variety of tools for supporting medical school reform and revised standards and procedures for the accreditation of medical schools, such as the *Indigenous Health Curriculum Framework* and the *Healthy Futures* recommendations for the recruitment and retention of Indigenous medical students.

The collaboration is based on mutual respect and a commitment to joint decision-making, priority setting, and constant learning and reflection. The commitment of AIDA and Medical Deans to work together and the successes in relation to the joint work program is evidence of how the priority issues to close the gap in Aboriginal and Torres Strait Islander health can be progressed in real partnership.

Appendix 1:

The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) 2003-13 and the post-Dec 2007 policy landscape

The NSFATSIH is a national plan for Aboriginal and Torres Strait Islander health created prior to many of the features of the current and emerging policy landscape.

In tabular form below is an analysis of the National Strategic Framework as it stands with suggested reform directions that would need to be addressed if it were to be revised as a plan for Aboriginal and Torres Strait Islander health equality within a generation.

Ambition and focus	<ul style="list-style-type: none"> It is not linked to an equality framework or to targets; A revised plan would need to include reference to the COAG and the Close the Gap <i>Statement of Intent</i> targets.
Timeframe	<ul style="list-style-type: none"> Expires in 2013.
Sub-targets/ time frames	<ul style="list-style-type: none"> NSFATSIH was signed off by ministers in 2003 in a policy environment that did not include a commitment to targets; Contains a number of important aims that would support the setting of targets it does not set quantifiable targets; The <i>Aboriginal and Torres Strait Islander Health Performance Framework</i> provides an excellent basis to measure progress towards targets and has existing measures that will allow this to occur. However, while the 2008 Performance Framework Report acknowledges the targets it does not explicitly state them or comment on progress towards achieving them.
Rights based	<ul style="list-style-type: none"> Does not explicitly reflect a human rights framework.
Comprehensiveness	<ul style="list-style-type: none"> Through its 'Aims' and 'Priorities', the NSFATSIH addresses a range of health concerns including: life expectancy, mortality and infant mortality; chronic diseases; communicable disease; substance misuse, mental disorder, stress, trauma and suicide; injury and poisoning; family violence, including child abuse and sexual assault; child and maternal health and male health. <ul style="list-style-type: none"> Much of the content is expressed as Key Result Areas (KRAs) which require considerable strengthening as identified below. Key Result Area 4 – (Mental health, social and emotional wellbeing and substance use) <ul style="list-style-type: none"> Despite the development of the Social, Emotional Well-being Framework progress has been slow; In relation to substance use, specific strategies are essential in relation to reducing smoking rates among Indigenous Australians – no significant reduction has occurred in 10 years.
Marginalised groups	<ul style="list-style-type: none"> Some areas such as youth and men's health do not have strong and explicit commitments to deliver improvements.
Partnerships	<ul style="list-style-type: none"> Issues to address include: the continued/ expanded role of NACCHO and affiliates; the role of NIHEC / the national Indigenous representative body; partnerships at national, regional and local levels; and the role of professional bodies such as Australian Indigenous Doctors' Association (AIDA), Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), Indigenous Allied Health Australia (IAHA), Australian Indigenous Psychologists Association (AIPA) and Indigenous Dentists' Association of Australia (IDAA) etc
Accountability	<ul style="list-style-type: none"> Key Result Area 9 (Accountability). <ul style="list-style-type: none"> Accountability should be explicitly linked to targets.
Resourcing	<ul style="list-style-type: none"> There were no resources attached to the National Strategic Framework. Key Result Area 8 (Resources) <ul style="list-style-type: none"> The period since the finalisation of the NSFATSIH has seen a very significant increase in resources allocated to primary health care. It is time to commit to further resource allocations to build on that increase and to address important areas such as substance use, social and emotional well-being and population health.
Harnessing the mainstream	<ul style="list-style-type: none"> Key Result Area 2 (Mainstream health) <ul style="list-style-type: none"> A stronger commitment to measurable improvements in mainstream health system delivery for the Aboriginal and Torres Strait Islander population is warranted; Despite a range of initiatives to improve the health system, it is clear that significant deficiencies remain. Key Result Areas 5 and 6 (Environmental health, wider strategies) <ul style="list-style-type: none"> While the recognition of the social determinants of health in a health strategy was a significant step when the NSFATSIH was developed, it is timely to review the relative emphasis given to these and particularly to give a strong focus to education and employment.
Building the capacity of ACCHS	<ul style="list-style-type: none"> Key Result Area 1 (ACCHS) <ul style="list-style-type: none"> This could include a capacity building plan for ACCHS.
Health workforce	<ul style="list-style-type: none"> Key Result Area 3 (Health workforce) <ul style="list-style-type: none"> To include explicit targets for an appropriate and skilled workforce and to reflect significant policy changes since 2003.
Data issues	<ul style="list-style-type: none"> Key Result Area 7 (Data) <ul style="list-style-type: none"> There is a need to include strategies to address current problems with data; The NSFATSIH should also include targets towards the rapid resolution of data issues that limit its capacity to report; The value of retaining existing reporting structure to enable time series analysis is acknowledged, however, the addition of a chapter in the Health Performance report that shows relevant measures against the COAG and other targets could easily be achieved.

Appendix 2:

The National Indigenous Reform Agreement and the National Integrated Strategy for Closing the Gap – a national address to Indigenous disadvantage.

The National Indigenous Reform Agreement (NIRA) is the framework for a national address to Indigenous disadvantage within a generation. The Integrated Strategy is 'organically' generated from the NIRA framework and represents a national plan to achieve Aboriginal and Torres Strait Islander health equality. It is associated with 7 building blocks: early childhood; schooling; health; economic participation; healthy homes; safe communities; and governance and leadership. It is attached to 7 Indigenous-specific National Partnership Agreements, and explicitly linked to over 20 mainstream National Partnership Agreements.

The Integrated Strategy as it stands does not provide the focus and specific direction to be considered a national plan for Aboriginal and Torres Strait Islander health equality within a generation. The tabular form below identifies the characteristics of such a plan against the Integrated Strategy:

Ambition and focus	<ul style="list-style-type: none"> To consider the Integrated Strategy as a plan for health equality requires trust that health and life expectation equality will emerge from the 'organic' developmental process of the Integrated Strategy. With an ambitious 'in a generation (2030)' target for the achievement of life expectation equality in place, an equally ambitious, focused plan is needed to realise it.
Reach	<ul style="list-style-type: none"> The current Integrated Strategy is linked to National Partnership Agreements that have a 4-6 year timeframe. A long-term timeframe is required to meet the generational targets.
Sub-targets, time frame	<ul style="list-style-type: none"> The current Integrated Strategy does not reflect full range of targets in current health policy. For example: <ul style="list-style-type: none"> <i>Statement of Intent</i> – 2018 health services / health infrastructure target. No broader commitment to use sub-targets to support the main life expectation target as committed to in the <i>Statement of Intent</i>.
Rights based	<ul style="list-style-type: none"> The focus on equality and access issues is welcome but, particularly in relation to partnership, the Integrated Strategy does not explicitly acknowledge a human rights framework.
Comprehensive-ness	<ul style="list-style-type: none"> The following issues have a good start through the Integrated Strategy: <ul style="list-style-type: none"> Diet and Nutrition – <i>National Remote Indigenous Food Security Strategy</i>; Chronic Disease / Tobacco, alcohol etc – <i>National Partnership on Closing the Gap in Indigenous Health Outcomes</i>; Maternal and child health – <i>National Partnership for Indigenous Early Childhood</i>; Following issues are not directly addressed (for example): <ul style="list-style-type: none"> Mental health/social and emotional well-being issues; Communicable disease – vaccines, sexual transmitted infections; While an approach to education, employment and community governance through the building blocks is welcome, there are many social determinants that remain unaccounted for, such as cultural determinants.
Marginalised groups	<ul style="list-style-type: none"> Men, prisoners, adolescents and youth (among others) are not effectively targeted.
Partnership	<ul style="list-style-type: none"> While the Integrated Strategy sets out directions for partnership arrangements, in the implementation of the <i>National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes</i> this has been limited to working with appointed advisory groups (i.e. NIHEC and the DOHA working groups for the NP's implementation). This is inadequate from a human rights perspective; The role of the national Indigenous representative body will need clarification.
Implementation	<ul style="list-style-type: none"> Bilateral plans between Commonwealth and States/Territories for each National Partnership Agreement under NIRA.
Accountability	<ul style="list-style-type: none"> Responsibility/ accountability is spread very thin; Role of a potential National Aboriginal and Torres Strait Islander Health Authority is not clear [as recommended by the NHHRC].
Resourcing	<ul style="list-style-type: none"> No overall investment or resourcing strategy; Does not address Medicare Benefits Schedule access.
Harnessing the mainstream	<ul style="list-style-type: none"> This is an absolutely vital issue, particularly given the explicit linking of so many mainstream National Partnerships to the Integrated Strategy but it is not addressed within the Integrated Strategy; Historically, 'harnessing the mainstream' is an ongoing challenge in Aboriginal and Torres Strait Islander health; A strategy for ensuring Indigenous Australians benefit from mainstream National Partnerships is necessary along the same lines as the <i>National Urban and Regional Service Delivery Strategy for Indigenous Australians</i> ensures that urban and regional based Aboriginal and Torres Strait Islander populations benefit from Indigenous specific National Partnerships.
Building the capacity of ACCHS	<ul style="list-style-type: none"> There is no capacity building plan within the Integrated Strategy.
Health workforce	<ul style="list-style-type: none"> In relation to the mainstream Health and Hospital Workforce Reform National Partnership it is particularly vital that Indigenous Australians are included in efforts, but not clear how this will occur.
Data issues	<ul style="list-style-type: none"> A \$46m data improvement package forms part of the NIRA and is a good start, however, its implementation will need to be clarified.

Appendix 3:

National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes

Implementation of NPA Indigenous Health Outcomes (Commonwealth Chronic Disease Package)	Cost
Tackle Smoking	161 million over 4 years
- National action to reduce Indigenous smoking rates	100.6 million
- Local Indigenous community campaigns to promote better health	22.7 million
- Manage chronic conditions and adopt healthy lifestyle choices with 100 lifestyle workers trained and education to 25,000 individuals and families	37.53 million
Primary health care that delivers	474 million over 4 years
- Improving access to Pharmaceutical Benefits Scheme medicines	88.69 million
- Improving chronic disease management in primary care by providing incentives and support for accredited general practices and Indigenous health services to detect, treat and manage chronic disease more effectively	115 million
- Increasing the uptake of Medicare Benefits Schedule funded primary care services by Aboriginal and Torres Strait Islander people including adult health checks	140 million
- Support indigenous Australians to better manage chronic disease with 400 outreach workers trained to provide activities to over 50,000 individuals	18.5 million
- Improving chronic disease follow-up care by increasing access to affordable specialist, allied health care and multi-disciplinary health care for Indigenous Australians with a chronic disease	70.78 million
- Monitor and evaluation	39.9 million
Fixing the gaps and improving the patient journey	171 million over 4 years
- Build the Indigenous workforce and training initiatives with the expansion of nursing scholarships working in AMS, 38 additional GP posts and expand the nursing placement program	17.74 million
- Improve capacity of indigenous workforce to provide care for people living with chronic health conditions	143 million
- Generate interest to work in Indigenous health through marketing and recruitment campaign	7 million
- Strategies to improve the cultural security of services and practice within mainstream clinical practice	3 million

ENDNOTES

- 1 A further non-exhaustive list of organisations who have publicly expressed support for the campaign includes: Aboriginal Medical Services Alliance Northern Territory; Amnesty International Australia; Australian Catholic Bishops' Social Justice Committee; Australian College of Rural and Remote Medicine; Australian Council of Social Services; Australian Council for International Development; Australian Institute of Health and Welfare; Australian Institute of Aboriginal and Torres Strait Islander Studies; Australian Nursing Federation; Australian Red Cross; Caritas Australia; Clinical Nurse Consultants Association of NSW; Diplomacy Training Program, University of New South Wales; Gnibi the College of Indigenous Australian Peoples, Southern Cross University; Human Rights Law Resource Centre; Ian Thorpe's Fountain for Youth; Indigenous Law Centre, University of New South Wales; Jumbunna, University of Technology Sydney; Make Indigenous Poverty History campaign; National Aboriginal and Torres Strait Islander Ecumenical Council; National Association of Community Legal Centres; National Children's and Youth Law Centre; National Rural Health Alliance; Public Health Association of Australia; Quaker Services Australia; Rural Doctors Association of Australia; Save the Children Australia; Sax Institute; Sisters of Mercy Aboriginal Network NSW; Sisters of Mercy Justice Network Asia Pacific; UNICEF Australia; and the Victorian Aboriginal Community Controlled Health Organisation.
- 2 Social Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report, 2005*, Australian Human Rights Commission, 2005. Available online at: http://www.hreoc.gov.au/social_justice/sjreport/sjreport05/index.html
- 3 *Social Justice Report, 2005*, op.cit.
- 4 *The core of this partnership for the future is the closing of the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous Australians, within a decade to halve the appalling gap in infant mortality rates between Indigenous and non-Indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous in overall life expectancy.* Prime Minister Kevin Rudd, Apology to Australia's Indigenous Peoples, 13 February 2008.
- 5 Along with the Minister for Health and Ageing and the Minister for Families, Housing, Community Services and Indigenous Affairs representing the Government, and the Opposition Leader.
- 6 *Close the Gap Statement of Intent* (signed at the Indigenous Health Equality Summit, Canberra, 20 March 2008). Available online at: www.humanrights.gov.au/social_justice/health/statement_intent.html
- 7 Prime Minister, 'Annual Prime Ministerial Statement on Closing the Gap' (Media release, 5 April 2009). Available online at: <http://www.pm.gov.au/node/5866>
- 8 Note that these are partnerships between Australian governments and do not include partnership arrangements with Aboriginal and Torres Strait Islander peoples.
- 9 *National Partnership Agreement for Indigenous Early Childhood, National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, National Partnership Agreement on Indigenous Economic Participation, National Indigenous Education Plan, and the National Partnership Agreement on Remote Service Delivery.*
- 10 *National Partnership Agreement for Remote Indigenous Housing.*
- 11 Based on synergies between the three reform processes the main proposals relevant to such a development are for:
 - The adoption of targets such as the 'Healthy Australia 2020 Goals' (tobacco use, alcohol use, obesity) and the National Access Targets proposed by the NHHRC Shift from hospital based health to comprehensive primary health care (PHC) and preventative health strategies and programs;
 - The creation of a Preventative Health Agency;
 - Increased use of targets ('2020 Healthy Australia' targets, and the 'Health Access Targets');
 - The creation of a National Aboriginal and Torres Strait Islander Health Authority;
 - Greater emphasis on partnerships and consumer empowerment;
 - Regional basis for PHC services planning and delivery;
 - An Indigenous health workforce strategy; and
 - Strengthening the role of Aboriginal Community Controlled Health Services.
- 12 Close the Gap Steering Committee presentation to the Minister of Indigenous Health, Minister of Indigenous Health, Rural and Regional Health and Regional Services Delivery, Hon Warren Snowdon. 5 November 2009.
- 13 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Preliminary Observations and Recommendations*, Canberra 4th December 2009.
- 14 Interview with peak non-Indigenous health organisation, 2 November 2009.
- 15 Interview with peak non-Indigenous health organisation, 2 November 2009.
- 16 Interview with peak Indigenous health organisation, 4 December 2009; interview with Aboriginal Community Controlled Health Sector organisation, 17 November 2009; 10 December 2009.
- 17 Interview with peak Indigenous health organisation, 4 December 2009.
- 18 Interview with peak Indigenous health organisation, 17 November 2009.
- 19 Australian Medical Association, *Australian Medical Association report card series 2007: Aboriginal and Torres Strait Islander Health*. Australian Medical Association, 2007. Available online at: <http://www.ama.com.au/node/3229>
- 20 National Health and Hospital Reform Commission, *A Healthier Future For All Australians Interim Report*. Commonwealth of Australia, 2009.
- 21 *Australian Medical Association report card series 2007: Aboriginal and Torres Strait Islander Health 2007*, op.cit.

- 22 *Aboriginal and Torres Strait Islander Health Performance Framework 2008 report*. Australian Institute of Health and Welfare, 2008.
- 23 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*. Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008.
- 24 Anderson, I; Ewen, S; and Knoche, D. Indigenous workforce development: current status and future directions. *Medical Journal of Australia*, 190:10, 2009.
- 25 Cultural safety can be defined as an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening. Robyn Williams, n.d. *Cultural Safety - What does it mean for our work practice?*
- 26 See Appendix 3 for a table summary of the Chronic Disease Package.
- 27 Couzos, S; and Thiele, D. The new "Indigenous health" incentive payment: issues and challenges *Medical Journal of Australia*, Rapid Online Publication. 7 December, 2009.
- 28 Australian Medical Association, *Australian Medical Association report card series 2009: Aboriginal and Torres Strait Islander Health*, The health of Indigenous males, capacity building, securing the future. Australian Medical Association, 2009, Available online at: <http://www.ama.com.au/node/5114>
- 29 *Australian Medical Association report card series 2007: Aboriginal and Torres Strait Islander Health*, op. cit.
- 30 National Aboriginal and Torres Strait Islander Health Council, *A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*. Commonwealth of Australia, 2008.
- 31 Commonwealth of Australia, *Proof Committee Hansard Senate. Community Affairs Legislation Committee Estimates*. 23 October, 2009.
- 32 Interview with national civil society organisation, 24 November 2009.
- 33 Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009.
- 34 Interview with peak non-Indigenous health organisation, 2 November 2009; Interview with Aboriginal Community Control Health Sector organisation, 17 November, 2009; Interview with National Indigenous Rights organisation, 11 November 2009.
- 35 Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009.
- 36 Interview with peak non-Indigenous health organisation, 2 November 2009.
- 37 Interview with national civil society organisation, 24 November 2009.
- 38 Northern Territory Aboriginal Health Forum, *Pathways to Community Control: an Agenda to further promote Aboriginal community control in the provision of Primary Health Care Services*, 2009.
- 39 *Preliminary Observations and Recommendations*, op.cit.
- 40 Interview with peak Indigenous health organisation 14 October 2009, 13 November 2009, and 17 November 2009; Interview with Aboriginal Community Health Control Sector organisation, 17 November 2009; Interview with Aboriginal Community Control Health organisation, 16 October 2009 and 17 November 2009.
- 41 Interview with peak Indigenous health organisations, 14 October 2009, 13 November 2009 and 17 November 2009; Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009 and 16 October 2009
- 42 Interview with Aboriginal Community Health Control Sector organisation, 17 November 2009.
- 43 Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009.
- 44 Interview with Aboriginal Community Control Health Sector organisation, 1 December 2009.
- 45 The proposal for a national Indigenous education action plan outlines activities that will be undertaken at the national, state and local level to close the gap between the educational outcomes of Indigenous and non-Indigenous students. It focuses on action across six areas that evidence shows will have the most impact on closing the gap: Readiness for school; Engagement and connections; Attendance; Literacy and numeracy; Leadership, quality teaching and workforce development; and pathways to real post-school options.
- 46 Interview with non-Indigenous health organisation, 1 December 2009 and 24 November 2009.
- 47 Interview with peak Indigenous health organisation, 13 November 2009.
- 48 Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009 and 1 December 2009.
- 49 COAG is directing its Close the Gap efforts across seven building blocks which include: early childhood; schooling; health; economic participation; healthy homes; safe communities; and governance; and leadership.
- 50 The Closing the Gap Clearinghouse is a COAG initiative launched in October 2009 to provide a central source of research and information on work to Close the Gap on Indigenous disadvantage. Clearinghouse resources focus on topics related to COAG 'building blocks'.
- 51 Interview with peak non-Indigenous health organisation, 18 November 2009.
- 52 Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009.
- 53 *ibid.*
- 54 Interview with peak non-Indigenous health organisation, 18 November 2009.
- 55 Interview with Aboriginal Community Control Health Sector organisation, 17 November 2009.
- 56 The *Collaboration Agreement* follows an *Agreement of Collaboration* between Committee of Deans of Australian Medical Schools (CDAMS) and AIDA, signed in 2005.



(L-R) Shannon Drake, Joanne Day-Atkinson, and Sara Day measure blood pressure at Rumbalara Medical Centre. Rumbalara is a highly respected Aboriginal Medical Centre near Shepparton in central Victoria. This centre offers culturally sensitive health services as well as a range of programs designed for particular segments of the population including the youth and the elderly in the community.

Photo: John Sones/OxfamAUS.

