

## 8. Closing the health gap for Aboriginal and Torres Strait Islander peoples

**Key messages**

- Aboriginal and Torres Strait Islander people have poor health, which is reflected in high levels of morbidity and life expectancy 17 years lower than other Australians. Closing this gap is a national priority and responsibility.
- A whole of government commitment is required to address the social determinants of health, as well as improving health services. In particular, it is estimated that health service provision can potentially contribute up to 70 per cent to closing the gap.
- Most Aboriginal and Torres Strait Islander people (75 per cent) live in larger cities and regional towns. Aboriginal and Torres Strait Islander people access health services across the delivery spectrum – for example, general practitioners, hospitals, rehabilitation, drug and alcohol, aged care, mental health and maternal and child health, as well as comprehensive community-controlled health services. These need to be culturally sensitive, responsive and focused on achieving the best possible outcomes.
- There is significant potential to reduce the gap across the life span:
  - a healthy start, maternal and child health;
  - quality care with a particular focus on critical transition times, such as infant to childhood, to adolescence, to workforce entry, to parenthood, to older years; and
  - chronic disease is estimated to account for around 70 per cent of mortality, much of which would be responsive to action on targeting risk factors at the system, community, family and individual levels.
- Aboriginal and Torres Strait Islander people are under-serviced; therefore, greater investment is needed to reach the under-served to ensure access to appropriate and responsive care, to drive good practice, quality improvement, and the achievement of better outcomes, and to influence action on the social determinants that affect health outcomes. Greater investment is likely to flush out unmet need and result in higher recorded levels of morbidity in the first instance.
- Aboriginal Community Controlled Health Services play an important role in the delivery of comprehensive primary health care, maximising people’s potential and ameliorating illness as a barrier to Aboriginal and Torres Strait Islander people’s participation in family, community and workforce. These Services need to be enabled to deliver services in an efficient manner.
- The number of Aboriginal and Torres Strait Islander people in health profession training and the number of health professionals trained in Aboriginal and Torres Strait Islander health need to be addressed.

## Our reform directions

- 8.1 We propose that the Commonwealth Department of Health and Ageing take a lead in the inter-sectoral collaboration that will be required at the national level to redress the impacts of the social determinants of health to close the gap for Aboriginal and Torres Strait Islander peoples.
- 8.2 We propose an investment strategy for Aboriginal and Torres Strait Islander Australians' health that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure.
- 8.3 We propose establishing a function to build and expand organisational capacity for community controlled health services to provide and broker comprehensive primary health care services. We would welcome feedback on the appropriate auspicing body or agency for such a support function.
- 8.4 We propose strengthening the purchasing role to lead the additional investment in Aboriginal and Torres Strait Islander health. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Aboriginal and Torres Strait Islander Australians and their families as a mechanism for closing the gap. This Authority would purchase health services from accredited providers with a focus on outcomes to ensure high quality and timely access.
- 8.5 We propose that accreditation processes for health services and education providers incorporate, as core, specific Indigenous modules to ensure quality clinical and culturally appropriate services.
- 8.6 We propose additional investment includes the funding of strategies to build an Aboriginal and Torres Strait Islander health workforce across all disciplines and the development of a workforce for Aboriginal and Torres Strait Islander health.

Aboriginal and Torres Strait Islander peoples of Australia are the oldest continuing cultures in human history.

Under the leadership of the Prime Minister, and with full support of the states and territories, significant and comprehensive work has been undertaken to identify strategies to close the life expectancy gap. This report builds on that work and identifies key strategies to maximise the health sector's contribution.

Aboriginal and Torres Strait Islander peoples make up 2.5 per cent of the Australian population, just over half a million people.<sup>1</sup> Yet, they experience far greater social, economic and educational disadvantage compared to other Australians. This disadvantage is associated with poor health and increased exposure to health risk factors.

Overcoming this disadvantage is achievable. Public awareness of the issues facing Aboriginal and Torres Strait Islander people is at an all time high, and the impetus for action is strong.

---

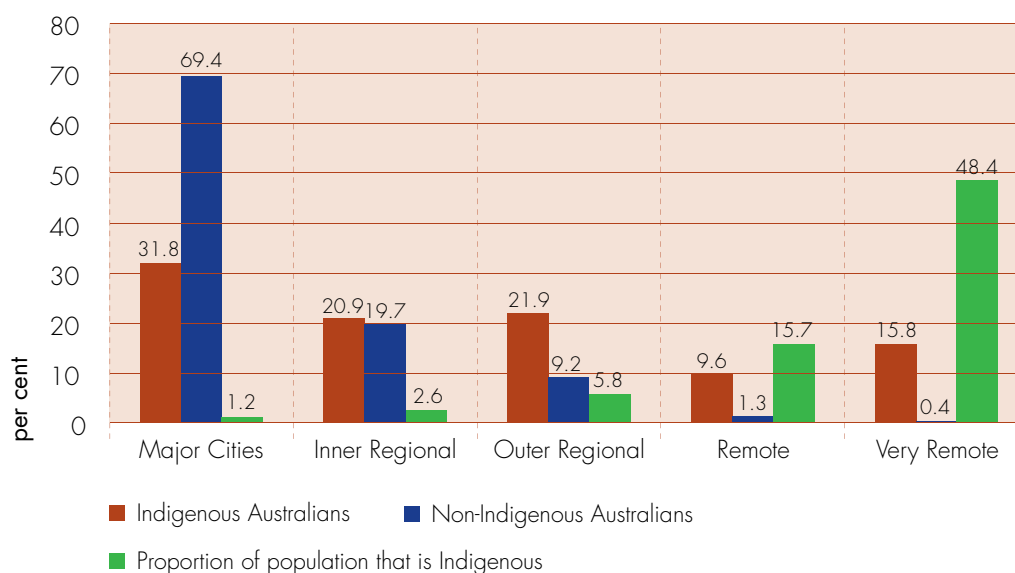
<sup>1</sup> Australian Institute of Health and Welfare (2008), *Australia's health 2008* (Australian Institute of Health and Welfare: Canberra).

## 8.1 Defining and scoping the health status of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have poorer health compared to other Australians, and poor Aboriginal and Torres Strait Islander health drives much of the difference in health status between the cities and rural Australia. Australia's Indigenous population has much poorer health than Indigenous populations in comparable countries (Canada, United States, New Zealand).<sup>2</sup>

Most Aboriginal and Torres Strait Islander people live in a major city or regional centre<sup>3</sup>, but the Aboriginal and Torres Strait Islander proportion of the total population increases with geographic remoteness, from one per cent of the total population living in major cities to 48 per cent living in very remote areas (see Figure 8.1).

**Figure 8.1: Most Aboriginal and Torres Strait Islander people live in major cities or regional centres but they make up a larger share of the population in remote areas**



Source: Australian Bureau of Statistics (2008), Population Characteristics, Aboriginal and Torres Strait Islander Australians, 2006 (Australian Bureau of Statistics: Canberra)

Overall, Aboriginal and Torres Strait Islander people are a young population with 57 per cent aged less than 25 years compared with 33 per cent of other Australians; and only three per cent aged 65 years and over compared with 13 per cent of other Australians.

Aboriginal and Torres Strait Islander people have a higher burden of disease, higher mortality at younger ages, and a life expectancy 17 years lower than for other Australians<sup>4</sup>:

<sup>2</sup> I Ring and J O'Brien (2007), 'Our hearts and minds – what would it take for Australia to become the healthiest country in the world?', *Medical Journal of Australia* 187 (8): 447–451.

<sup>3</sup> Australian Bureau of Statistics (2008), Population Characteristics, Aboriginal and Torres Strait Islander Australians, 2006 (Australian Bureau of Statistics: Canberra).

<sup>4</sup> Australian Institute of Health and Welfare (2008), *Australia's health 2008* (Australian Institute of Health and Welfare: Canberra).

Aboriginal and Torres Strait Islander children are three times as likely to die before they reach 15 years old compared to other Australian children

- The burden of disease and injury is estimated to be 95,976 years of life lost through premature death or living with disability<sup>5</sup> – two and a half times greater than the burden of disease carried by other Australians despite the Aboriginal and Torres Strait Islander population being a young population.
- Aboriginal and Torres Strait Islander men are three times as likely to die before they reach 60 years old compared to other Australian men (32 per cent compared to 10 per cent), while Aboriginal and Torres Strait Islander women are four times as likely to die before 60 years old compared to other Australian women (23 per cent compared to six per cent).<sup>6</sup>
- Aboriginal and Torres Strait Islander children are three times as likely to die before they reach 15 years old compared to other Australian children.<sup>7</sup>
- Life expectancy at birth for Aboriginal and Torres Strait Islander people for the period 1999 to 2001 was 59 years for males and 65 years for females, 17 years lower than other Australians.<sup>8</sup>

When asked to consider their own health status<sup>9</sup>, almost one-quarter (22 per cent) of Aboriginal and Torres Strait Islander people reported their health as fair or poor; this is twice as high as other Australians. Almost two-thirds (65 per cent) reported at least one long-term health condition, with a high proportion also reporting stressors experienced by themselves, family or friends. For example:

- Stressors were reported by 81 per cent of those with kidney disease, 75 per cent of those with diabetes, 74 per cent of those with asthma and 75 per cent of those with arthritis.<sup>10</sup>
- By far the most commonly reported stressor was the death of a family member or close friend, followed by alcohol and drug problems. Other stressors included overcrowding at home, abuse or violent crime, gambling problems and unemployment.<sup>11</sup>

Chronic illness is a major issue and is estimated to account for around 70 per cent of the life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians.<sup>12</sup> Cardiovascular disease (17 per cent) and mental disorders (15 per cent) are the leading causes of disease burden (see Figure 8.2). It has been calculated that 11 modifiable risk factors, including alcohol, drug and tobacco use, physical inactivity, low fruit and vegetable intake, and high blood cholesterol account for 37 per cent of the burden of disease and for around 50 per cent of the health gap carried by Aboriginal and Torres Strait Islander Australians. Substance use, food security, and activity are all amenable to change with good support strategies and services.

5 T Vos, B Barker, L Stanley and A Lopez (2007), *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples* (School of Population Health, The University of Queensland: Brisbane).

6 T Vos, B Barker, L Stanley and A Lopez (2007), *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples* (School of Population Health, The University of Queensland: Brisbane).

7 Australian Institute of Health and Welfare (2008), *Australia's health 2008* (Australian Institute of Health and Welfare: Canberra).

8 Australian Institute of Health and Welfare (2008), *Australia's health 2008* (Australian Institute of Health and Welfare: Canberra).

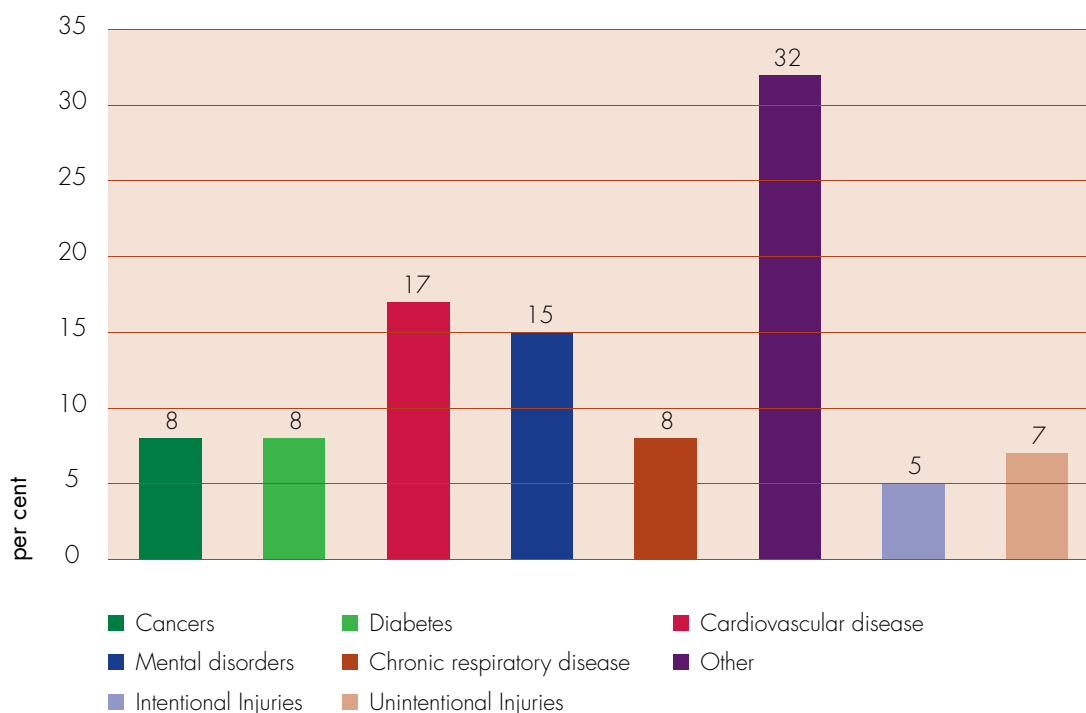
9 Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (Australian Institute of Health and Welfare: Canberra).

10 Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (Australian Institute of Health and Welfare: Canberra).

11 Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (Australian Institute of Health and Welfare: Canberra).

12 T Vos, B Barker, L Stanley and A Lopez (2007), *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples* (School of Population Health, The University of Queensland: Brisbane).

**Figure 8.2: Cardiovascular disease and mental disorders are the two leading contributors to the disease burden of Aboriginal and Torres Strait Islander Australians**



Source: T Vos, B Barker, I Stanley and A Lopez (2007), *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples* (School of Population Health, The University of Queensland: Brisbane).

On a more positive note, some improvements have been made in health status. Available data from Queensland, Western Australian, South Australia and the Northern Territory show that: all-cause mortality decreased by 16 per cent between 1991 and 2003; infant mortality declined by 44 per cent, and perinatal mortality by around 55 per cent; and sudden infant death syndrome declined by 60 per cent over the period 1997–99 to 2000–03.

## 8.2 Building on our strengths

Much work has been done by Aboriginal and Torres Strait Islander people, health professionals and researchers to educate and advocate for positive strategies to address the inequities faced by Aboriginal and Torres Strait Islander people and their communities, backed up by numerous reports, strategies and reporting mechanisms. Some key activities are described below.

The National Aboriginal Health Strategy (NAHS), developed in 1989, was a landmark document providing agreed directions for Aboriginal and Torres Strait Islander health policy in Australia.<sup>13</sup> Key priorities included building community control of Aboriginal health services, increasing Aboriginal and Torres Strait Islander participation in the health workforce, and increasing funding to Aboriginal and Torres Strait Islander health services.

An evaluation of the NAHS in 1994 found that it had not been implemented due to underfunding by all governments. This led to the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, endorsed by the Commonwealth and state and territory

13 Agreements, treaties and negotiated settlements project, at: [www.atns.net.au](http://www.atns.net.au)

governments in 2003. The goal of this framework is to ensure that Aboriginal and Torres Strait Islander people enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.<sup>14</sup> 'Importantly, it commits government to the monitoring and implementation of efforts towards improvements in Aboriginal people's health'.<sup>15</sup>

The 2005 Social Justice Report, *Achieving Aboriginal and Torres Strait Islander health equality within a generation – A human rights approach*, set out a 'human rights framework for achieving health equality within a generation' and led to the Close the Gap Campaign for Indigenous Health Equality. This work has culminated in Commonwealth and state and territory government commitment to action, supported by the Australian community.

The Council of Australian Governments (COAG) in December 2007 agreed to 'a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage'<sup>16</sup> in relation to health inequality as well as education and employment.

This commitment was reaffirmed by the Prime Minister in the *National Apology to Australia's Indigenous Peoples* on 13 February 2008 and formalised with the signing of the *Statement of Intent* in March 2008:

*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.*<sup>17</sup>

The National Indigenous Health Equity Council has been established to 'provide national leadership in responding to the Government's commitment to closing the gap on Indigenous disadvantage by providing advice to Government on working towards the provision of equitable and sustainable health outcomes for Indigenous Australians'.<sup>18</sup>

On 30 November 2008, COAG announced \$4 billion in funding to 'improve housing, health, employment and to drive fundamental reforms to Indigenous service delivery over the next ten years'<sup>19</sup>, of which \$1.6 billion is for the National Partnership on health service reform. The National Partnership is expected to contribute to: a reduction of smoking rates among Aboriginal and Torres Strait Islander peoples; a reduction in the burden of disease among Aboriginal and Torres Strait Islander peoples; an increase in the uptake of Medicare Benefits Schedule-funded primary care services to Aboriginal and Torres Strait Islander people, where half of the Aboriginal and Torres Strait Islander adult population (ages 15–65 years) will receive two adult health checks over the next four years; an improvement in coordination across the continuum of care; and a reduction in the average length of hospital stay and readmissions (over time).<sup>20</sup>

---

14 National Strategic Framework for Aboriginal and Torres Strait Islander Health (2008), at: [www.health.gov.au](http://www.health.gov.au)

15 S Couzos and R Murray (2008), *Aboriginal Primary Health Care: An evidence-based approach* (Oxford University Press: Oxford).

16 Council of Australian Government Meeting Outcomes (2 December 2007), at: [www.coag.gov.au](http://www.coag.gov.au)

17 Prime Minister of Australia (2008), *Apology to Australia's Indigenous Peoples*, House of Representatives, Parliament house, Canberra.

18 National Indigenous Health Equality Council Terms of Reference, at: <http://www.nihec.gov.au/internet/nihcec/publishing.nsf/Content/terms>

19 Prime Minister and Minister for Families, Housing, Community Services and Indigenous Affairs, Media Release, Canberra 30 November, at: [http://www.pm.gov.au/media/Release/2008/media\\_release\\_0674.cfm](http://www.pm.gov.au/media/Release/2008/media_release_0674.cfm)

20 Council of Australian Governments, Council of Australian Governments meeting communiqué, 29 November 2008, Parliament House, Canberra.

At a program level, a wide range of policy approaches has been implemented or trialled to improve Aboriginal and Torres Strait Islander access to health services and health outcomes. Many of these activities have made significant gains from which policy makers can draw lessons.

The Pharmaceutical Benefits Scheme Section 100 arrangements, which enable eligible services in remote areas to supply PBS medication free of charge and without a prescription, have greatly improved access to medications for Aboriginal and Torres Strait Islander people living in these areas.<sup>21</sup>

The Audit for Best Practice in Chronic Disease (ABCD) is a continuous quality improvement approach to improving chronic disease detection and management in Aboriginal primary health care services, and is described in Figure 8.3.

### Figure 8.3: The ABCD approach

*The ABCD works with health professionals, centres and services to improve the delivery of care using a structured and collaborative approach to review the systems that support care such as recall, clinical guidelines, and cycles of care to assess clinical performance against best practice guidelines.*

*The evaluation report found that, over the first three years of the program, participating health centres improved their levels of evidence-based care, and interim health outcomes also improved:*

*After two cycles of the CQI intervention, 12 participating Aboriginal community health centres have maintained their active engagement in the project and achieved impressive improvements in a number of key indicators of the quality of chronic illness care.*

*Key findings and lessons include:*

- *scheduled diabetes services delivered increased from 31 per cent to 54 per cent;*
- *improvement in the proportion of people with diabetes with a record of a blood pressure check within three months from 63 per cent at baseline to 78 per cent;*
- *improvement in the proportion of people with diabetes with a record of an HbA1c check within six months from 41 per cent at base line to 75 per cent;*
- *improvement in the proportion of people with diabetes whose most recent HbA1c check was < 7 per cent from 19 per cent at baseline to 28 per cent;*
- *improvement in the proportion of people with diabetes whose most recent total cholesterol was < 4 mmol/L from 22 per cent at baseline to 30 per cent;*
- *some key indicators of diabetes care such as blood pressure control did not show improvement;*
- *the delivery of preventive services to the general adult population show relatively little improvement;*
- *health centre staff and management indicate an important factor in the success of the project has been the participatory approach;*
- *the availability of resources and the quality of management and organisational systems are important in driving improvements in quality of care; and*
- *best practice medical management and self-management support needs to be strengthened to ensure early diagnosis and good monitoring result in improved health outcomes.*

Source: Audit and Best Practice for Chronic Disease Project Progress Report prepared for Department of Health and Ageing: Health for Life, November 2005

21 Urbis Keys Young, Aboriginal and Torres Strait Islander Access to Major Health Programs: Final Report July 2006, at: [http://www.medicareaustralia.gov.au/public/services/indigenous/files/aboriginal\\_torres\\_strait\\_islander\\_access\\_to\\_major\\_health\\_programs.pdf](http://www.medicareaustralia.gov.au/public/services/indigenous/files/aboriginal_torres_strait_islander_access_to_major_health_programs.pdf)

The Specialist Outreach Service (SOS) in the Northern Territory also works well. This program was set up in response to 'problems of access for remote community people, mostly Aboriginal, to surgical, obstetric and gynaecological specialists, and subsequently to ophthalmic and ENT (ear, nose and throat) specialist care.'<sup>22</sup> The program resulted in a total of 3647 consultations and procedures in remote community clinics between June 1997 and September 1999, with up to five times more specialist consultations taking place than previously, when patients were transferred to Darwin hospital. This region also has regular paediatric and physician outreach embedded in the primary health care regional outreach team.

Aboriginal Community Controlled Health Services have contributed significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes, including reductions in preterm births and increases in birth weight.<sup>23</sup> Reasons for their success include the delivery of culturally appropriate comprehensive primary health care, including population health programs, as well as other services such as facilitating access to secondary and tertiary care, transport, social and emotional wellbeing and family support.

The Nganampa Health Council is one example where gains have been made in the areas of child and maternal health and the control of sexually transmitted diseases (see Figure 8.4).

#### Figure 8.4: Targeting maternal and child health makes a difference

*The Nganampa Health Council has been operating on the Anangu Pitjantjatjara Yankunytjatjara Lands in the northwest of South Australia since the mid 1980s. The catchment area for the Nganampa Health Council is approximately 105,000 square kilometres.*

*When first established, the Nganampa Health Council identified that women were not having regular antenatal visits or check-ups, and were often not presenting at a clinic until late in their second trimester. They set targets to improve antenatal care:*

- *ensuring first presentation is made before 20 weeks;*
- *having more than five antenatal visits per pregnancy; and*
- *performance of ultrasounds in all pregnancies – this includes ultrasounds for estimating gestational age.*

*Results show that, between 1993 and 1999, women accessing antenatal care for the first time less than 20 weeks into their pregnancy had increased from 60 per cent, to around 90 per cent. Furthermore, data indicated a decrease in perinatal mortality rates and decreases in low birth weights.*

*The Nganampa Health Council has also implemented a strategy for dealing with sexually transmitted infections through a program of screening 12–40 year olds. Through this, the prevalence of syphilis that requires treatment has been reduced from 20 per cent in 1985 to less than one per cent in 2000. Further, the prevalence of gonorrhoea and chlamydia has been reduced by 62 per cent and 56 per cent respectively.*

Source: Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians (2001) (Commonwealth of Australia).

22 R Gruen and R Bailie (2000), Evaluation of the Specialist Outreach Service in the Top End of the Northern Territory, at: [www.menzies.edu.au](http://www.menzies.edu.au)

23 J Dwyer, K Silburn and G Wilson (2004), National Strategies for Improving Indigenous Health and health Care, Aboriginal and Torres Strait Islander Review: Consultant Report No. 1 (Commonwealth of Australia).

## 8.3 Identifying the case for change

### 8.3.1 Closing the life expectancy gap

Closing the gap by 2030 is a national priority. It requires a whole of government commitment to addressing the social determinants of health and improving health services across the care continuum and life course.

Aboriginal and Torres Strait Islander people experience far greater social disadvantage than other Australians in terms of education, housing, and employment, and this, in turn, has a direct impact on health. This was emphasised in our national consultations and in submissions:

*High levels of disadvantage in many Indigenous communities in terms of income, education and infrastructure continue to exert a strong negative effect on health.<sup>24</sup>*

*To improve health outcomes in Northern Territory and to close the gap between Indigenous and non-Indigenous health outcomes and the remote areas will rely on other portfolios and funding streams, to improve housing, education, transport, recreation etc. Health outcomes and socio-economic status are closely related.<sup>25</sup>*

In 2001, the average income of Aboriginal and Torres Strait Islander families was 62 per cent of the mean for other Australian families – \$364 per week compared with \$585 per week for other families. Using the national distribution of income ‘quintiles’, 72 per cent of Aboriginal and Torres Strait Islander households were in the two lowest income quintiles, compared with 39 per cent for other Australians. This directly impacts on Aboriginal and Torres Strait Islander people’s capacity to pay for health services as well as clothing, housing and food – all directly related to health.

The relationship between health and social determinants such as employment, education and housing works both ways. For example, higher levels of education may lead to people engaging in positive health behaviour (for example, exercising, regular health check ups) while poor health may lead to low educational attainment as people are unable to attend school.<sup>26</sup> In 2004–05, Aboriginal and Torres Strait Islander adults who had completed Year 12 compared with adults who had left school in Year 9 or below were: more likely to report excellent or very good self-assessed health; less likely to report high or very high levels of psychological distress; and less likely to smoke regularly.

This link between health and social determinants emphasises the importance of cross-sectoral action. Estimates on the contribution of how much health services and other determinants contribute to the health gap suggest that socio-economic factors account for between 30 and 50 per cent.<sup>27</sup> The balance is thought to be ‘driven by access to health services (health supply driven), health behaviour (patient driven), environmental factors, or a combination of all of these’.<sup>28</sup> The Australian Indigenous Doctors’ Association summarises that:

*Australian governments must work together to improve outcomes on issues such as education, employment, housing and environmental health.<sup>29</sup>*

■ Closing the gap by 2030 is a national priority. It requires a whole of government commitment to addressing the social determinants of health and improving health services across the care continuum and life course

24 Cooperative Research Centre for Aboriginal Health (2008), Submission 527 to the National Health and Hospitals Reform Commission.

25 Northern Territory Dept of Health and Families (2008), Submission 520 to the National Health and Hospitals Reform Commission.

26 Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

27 A Booth and N Carroll (2005), The Health Status of Indigenous and Non-Indigenous Australians, Discussion Paper No. 486 (Centre for Economic Policy Research).

28 A Booth and N Carroll (2005), The Health Status of Indigenous and Non-Indigenous Australians, Discussion Paper No. 486, (Centre for Economic Policy Research).

29 Australian Indigenous Doctors Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

By taking a life course approach targeting health and socio-economic risk factors, as outlined in earlier chapters, there is significant potential within the health system to reduce the gap. It has been estimated that 50 per cent of the health gap carried by Aboriginal and Torres Strait Islander Australians is attributable to risk factors that could be modified (see Figure 8.5).<sup>30</sup> The Queensland Aboriginal and Islander Health Council emphasises that:

*Most of the diseases leading to premature death, hospitalisation and chronic disability amongst Aboriginal and Torres Strait Islander people are preventable if diagnosed early. Indeed, most of the general health gains that have been made in recent years can largely be attributed to initiatives in the primary health care sector such as childhood vaccination programs, disease-specific screening programs and antenatal programs<sup>31</sup>*

Positive parenting practices and experiences will impact on child development and subsequent academic attainment, and health and wellbeing

■ As outlined in Chapter 3, the early years provide the foundations for a person's health and wellbeing in life – good maternal health pre-conception is important for reducing the risk of low birth weight babies, who are prone to ill health in childhood, and may also be more prone or 'programmed' to chronic disease in adulthood. Currently, low birth weight is twice as common for Aboriginal and Torres Strait Islander babies.<sup>32</sup> Significant health improvements for mothers, babies and future adults can be gained by tackling the high smoking rates in pregnant women (around half of Aboriginal and Torres Strait Islander women smoke during pregnancy), and other risk factors such as alcohol consumption and healthy eating. Similarly, positive parenting practices and experiences will impact on child development and subsequent academic attainment, and health and wellbeing.

Adolescents, people moving from schools to work, people becoming parents and families, and older people will also face a range of risks and challenges that if addressed sooner rather than later will have a positive impact on their immediate and long-term health and wellbeing.

---

30 T Vos, B Barker, L Stanley and A Lopez (2007), *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples* (School of Population Health, The University of Queensland: Brisbane).

31 Queensland Aboriginal and Islander Health Council (2008), *Submission 483 to the National Health and Hospitals Reform Commission*.

32 Australian Health Ministers' Advisory Council (2006), *Aboriginal and Torres Strait Islander Health Performance Framework*, AHMAC, Canberra.

Figure 8.5: Indigenous burden and health gap is attributable to 11 risk factors

	Disease burden		Health gap	
	DALYs	% of total	DALYs	% of total
<b>Total burden</b>	<b>95,976</b>	<b>100</b>	<b>56,455</b>	<b>100</b>
<i>Attributable burden</i>				
Tobacco	11,633	12	9,816	17
Obesity	10,919	11	8,953	16
Physical inactivity	8,032	8	6,554	12
High blood cholesterol	5,262	5	3,994	7
Alcohol	5,171	5	2,362	4
High blood pressure	4,417	5	3,215	6
Low fruit & vegetable intake	3,344	3	2,873	5
Illicit drugs	3,264	3	2,150	4
Intimate-partner violence	2,469	3	1,836	3
Child sexual abuse	1,390	1	869	2
Unsafe sex	1,174	1	926	2
<b>11 risk factors combined</b>	<b>35,908</b>	<b>37</b>	<b>27,383</b>	<b>49</b>

Source: T Vos, B Barker, L Stanley and A Lopez (2007), *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples* (School of Population Health, The University of Queensland: Brisbane).

Note: DALY = Disability Adjusted Life Year

Importantly, Aboriginal and Torres Strait Islander people who live in cities and regional centres suffer almost the same health gap as those who live in remote communities. Improving Aboriginal and Torres Strait Islander health is not just an issue for remote communities, it is an issue for every community: city, rural and remote. We need to enhance both mainstream and Aboriginal and Torres Strait Islander specific health services to improve access to, and the impact of, primary health care and linkages with services across the delivery spectrum. It is about making absolutely sure that services, including hospitals, in all communities are effective and accessible.

■ Improving Aboriginal and Torres Strait Islander health is not just an issue for remote communities, it is an issue for every community: city, rural and remote

### 8.3.2 Investing in Aboriginal and Torres Strait Islander health care

We were told at the national consultations and in submissions that health care services for Aboriginal and Torres Strait Islander people are under-resourced. This means the focus tends to be on providing reactive and emergency services with little capacity to provide the full range of services needed to provide early diagnosis, clinical intervention, prevention and promotion activities to address health risk and life opportunity factors.

*The challenge for Indigenous health will be to integrate preventative programs while at the same time addressing an excess of acute and chronic morbidity, including co-morbidities. Aboriginal and Torres Strait Islander primary health care services are often overwhelmed by the curative demand and the sector is chronically under resourced. It is important therefore that effective preventative programs can be implemented while at the same time the existing burden of disease is addressed.*<sup>33</sup>

Funding is from multiple sources, with tight rules for what it could be spent on, affording little scope for flexibility; and neither holistic nor necessarily reflecting local needs or local priorities. For example, 26 funding streams resulted in 26 separate accounts and 26 demands for accountability for the Danila Dilba Aboriginal Medical Centre in Darwin.<sup>34</sup> Some funding is also short-term which creates problems in terms of sustainability of outcomes and continuity of care.<sup>35</sup> We were also told:

*Stop the body parts funding – the system is meant to look after people, not a kidney*<sup>36</sup>.

In 2004–05, estimated total health expenditure for Aboriginal and Torres Strait Islander people was \$2,304 million or 2.8 per cent of the total health expenditure. On a per person basis, average expenditure was \$4718 – 17 per cent higher than expenditure for other Australians (\$4019).

Aboriginal and Torres Strait Islander Australians carry a higher burden of illness and, like all other Australians, those whose health is compromised require, and should receive, more care accordingly

■ But this funding is not equitable because, on average, Aboriginal and Torres Strait Islander Australians carry a higher burden of illness and, like all other Australians, those whose health is compromised require, and should receive, more care accordingly.

Studies undertaken on the level of investment needed to improve health outcomes and reduce the life expectancy gap for Aboriginal and Torres Strait Islander peoples all conclude that significantly higher levels of expenditure are required. Estimates of the funding required range from doubling all government health expenditure, to increasing all health expenditure per capita on Aboriginal and Torres Strait Islander people to a bit over twice the average for the rest of the population, to increasing per capita health expenditure to three to six times the level for the rest of the population.<sup>37,38,39,40,41,42</sup>

The importance of adequate investment is further highlighted in a study by Beaver and Zhao<sup>43</sup> (see Figure 8.6).

33 Australian Indigenous Doctors Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

34 B Henty, S Houston and G Mooney (2004), 'Institutional Racism in Australian healthcare: a plea for decency', *Medical Journal of Australia* 180 (10): 517–520.

35 C Shannon and H Longbottom (2004), Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No. 4 (Commonwealth of Australia).

36 Health professional (3 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Darwin.

37 G Mooney (2000), 'What's fair in funding indigenous health care? We don't know, but isn't it time we did?', *the Drawing Board: An Australian Review of Public Affairs* 1 (2): 75–85.

38 J Deeble, How much is needed? A needs based funding formula for Aboriginal and Torres Strait Islander health, cited in AMA Public Report Card 2002, Aboriginal and Torres Strait Islander Health: No more excuses, at: <http://www.ama.com.au/node/3188>

39 Econotech Pty Ltd (2004), Costings Models for Aboriginal and Torres Strait Islander Health Services, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No. 3 (Commonwealth of Australia).

40 Australian Medical Association (2008), Institutionalised inequity. Not just a matter of money, 2007 Report Card, at: [www.ama.com.au/web.nsf/doc/WEEN-7EYGV](http://www.ama.com.au/web.nsf/doc/WEEN-7EYGV)

41 Queensland Aboriginal and Torres Strait Islander Health Council (2008), Submission 483 to the National Health and Hospitals Reform Commission.

42 J Dwyer, K Silburn and G Wilson (2004), National Strategies for Improving Indigenous Health and Health Care, Aboriginal and Torres Strait Islander Review: Consultant Report No. 1 (Commonwealth of Australia).

43 C Beaver and Y Zhao (2004), Investment analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No. 2 (Commonwealth of Australia).

### Figure 8.6: Adequate health care funding is important

*In 2003, Carol Beaver and Yuejen Zhao undertook an investment analysis of the Aboriginal and Torres Strait Islander primary care program in the Northern Territory. They tested five investment scenarios using nine categories of preventable diseases: hypertension, diabetes, renal diseases, ischaemic heart disease, chronic obstructive pulmonary disease, respiratory and related ear infections, diarrhoea, malnutrition, and skin infection.*

*The study showed that:*

- *changing the funding mix by shifting \$1 million from clinical primary health care to health promotion and prevention would result in a gain of 14,000 disability adjusted life years in five years but this benefit would be offset by the loss of 18,600 disability adjusted life years as a result of shifting resources away from diagnosis, treatment and continuing care for chronic diseases;*
- *withdrawal of primary care funding would lead to a loss of 2.6, 6.1 and 12.6 years per Aboriginal and Torres Strait Islander person in 5, 10 and 20 years time; and*
- *a staged increase in funding in primary health care across the continuum of health promotion, prevention and clinical care rising to double the 2001–02 levels over a period of ten years would increase life expectancy by three years per person in five years, 5.7 years per person in ten years, and 9.9 years per person in 20 years.*

*Beaver and Zhao also assessed the potential impact of achieving higher engagement from other sectors. Analysis shows that it might be possible to increase the benefits of primary health interventions by around 35 per cent if services can be delivered in a way that more effectively meets the needs of people at the local level and enables people to take greater responsibility for their own health.*

Source: C Beaver and Y Zhao (2004), *Investment analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 2* (Commonwealth of Australia)

### 8.3.3 Building a health system to meet the needs of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people access health services across the delivery spectrum. Barriers to accessing health services across the delivery spectrum, including those provided by mainstream and Aboriginal Community Controlled Health Services, need to be addressed if we are to build a health system that meets the needs of all Aboriginal and Torres Strait Islander people and translates into better outcomes.

Around 30 per cent of Aboriginal and Torres Strait Islander people report that their usual source of care is an Aboriginal medical service, while around 60 per cent said that a doctor was their usual source.<sup>44</sup> For Aboriginal and Torres Strait Islander people living in very remote regions, an Aboriginal medical service is the usual source of care.

Expenditure provides some insight into health service use. Figure 8.7 shows that Aboriginal and Torres Strait Islander people tend to be high users of public hospitals, patient transport services, and community health services, and comparatively low users of medical, pharmaceutical and other health services compared with other Australians.

44 Australian Health Ministers' Advisory Council (2006), *Aboriginal and Torres Strait Islander Health Performance Framework 2006 report*, AHMAC, Canberra.

Figure 8.7: Aboriginal and Torres Strait Islander people are low users of privately-provided services and high users of publicly provided services

	<i>Indigenous</i>	<i>Non-Indigenous</i>	<i>Ratio (a)</i>
<i>Hospitals</i>	2213	1386	1.6
<i>Public hospital services (b)</i>	2147	1067	2.0
• Admitted patient services	1637	1067	2.0
• Non-admitted patient services	510	244	2.1
<i>Private hospitals</i>	66	319	0.2
<i>High-level residential care</i>	85	319	0.3
<i>Patient transport</i>	212	69	3.1
<i>Medical services</i>	337	734	0.5
<i>Community health services</i>	1019	155	6.6
<i>Dental and other health practitioners</i>	160	396	0.4
<i>Medications</i>	224	561	0.4
<i>Aids and appliances</i>	38	131	0.3
<i>Public health</i>	182	68	2.7
<i>Research</i>	94	85	1.1
<i>Health administration</i>	153	114	1.3
<b>Total</b>	<b>4718</b>	<b>4019</b>	<b>1.2</b>

(a) Average per person expenditure on Indigenous Australians divided by the average per person expenditure on other Australians

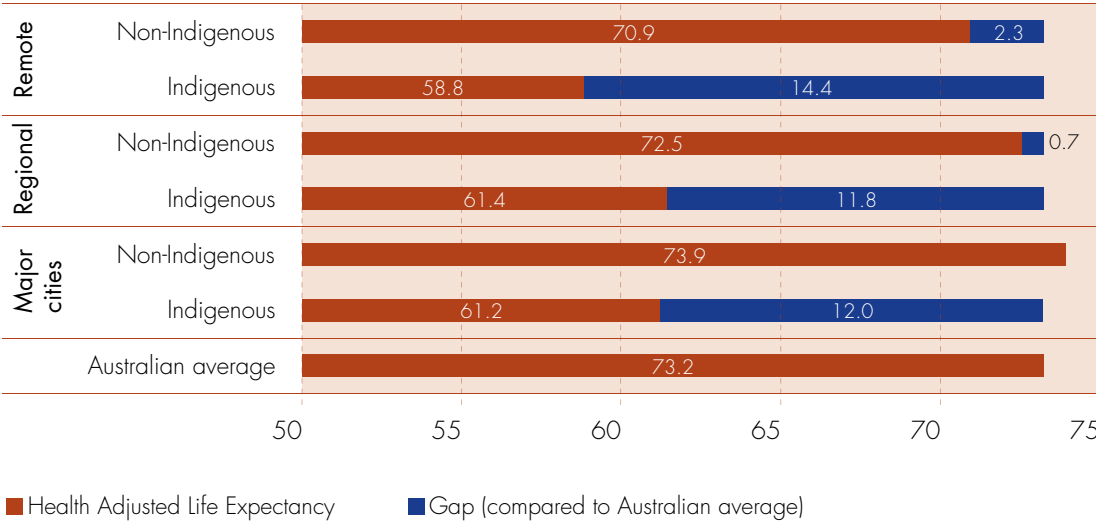
(b) Excludes any dental services, community health services, public health and health research undertaken by the hospital

Source: Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

Aboriginality is a stronger predictor of life expectancy than place of residence

Where you live has a strong influence on whether services are available but, for Aboriginal people, Aboriginality is a stronger predictor of life expectancy than place of residence (see Figure 8.8). The number of years an Aboriginal and Torres Strait Islander person can expect to live without a disability ranges from 58.8 years (if living in a remote centre) to 61.4 years (if living in a regional centre) to 61.2 years (if living in a major city). This is between 11.8 years and 14.4 years below the Australian average of 73.2 years. As most Aboriginal and Torres Strait Islander people live in cities and regional centres, and as the expectancy gap is almost the same between city and remote populations, it is misleading to think of improving Aboriginal and Torres Strait Islander health as solely an issue of addressing problems in remote Aboriginal and Torres Strait Islander communities.

**Figure 8.8: The health gap for Aboriginal and Torres Strait Islander people does not differ greatly across geographic locations**



Source: Personal communication with S Begg, School of Population Health, University of Queensland

While well documented, barriers to access range from (but are not limited to) cultural and social factors; to geographic; to financial; to poor linkages; to a lack of population focus; to workforce.

Generally, the health system delivers services in a way that is better suited to the needs of the broader population rather than the particular needs of Aboriginal and Torres Strait Islander people. In addition to enhancing and expanding Aboriginal Community Controlled Health Services, it is important to get the mainstream health care system working in a way that delivers effective services for Aboriginal and Torres Strait Islander people. This includes improving linkages between Aboriginal Community Controlled Health Services and mainstream services.

Available data tells us that Aboriginal and Torres Strait Islander people don't systematically receive the levels of care, investigation and follow-up that clinical pathways recommend. For example:

- In 2005–06, Aboriginal people and Torres Strait Islanders were admitted to hospital for kidney dialysis at 14 times the rate of other Australians. They were also admitted to hospital at three times the rate for diabetes and diseases of the skin.<sup>45</sup>
- When admitted to hospital, Aboriginal and Torres Strait Islander patients are only two-thirds as likely to have a procedure recorded. For some categories it was as low as half.<sup>46</sup>
- Around three per cent of Aboriginal and Torres Strait Islander admissions result in the person leaving hospital against medical advice or being discharged at their own risk. Overall, Aboriginal and Torres Strait Islander patients are discharged from hospital against medical advice at 19 times the rate of other Australians.<sup>47</sup>

45 Australian Institute of Health and Welfare (2008), Australia's health 2008 (Australian Institute of Health and Welfare: Canberra).

46 Australian Institute of Health and Welfare (2005), The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005 (Australian Institute of Health and Welfare: Canberra).

47 Australian Health Ministers' Advisory Council (2006), Aboriginal and Torres Strait Islander Health Performance Framework 2006 report, AHMAC, Canberra.

Our submissions and national consultations suggested a number of strategies to improve clinical care (and competence), including accreditation for continuous quality improvement for Aboriginal and Torres Strait Islander health care. The Cooperative Research Centre for Aboriginal Health noted that:

*Some hospitals have made efforts to provide culturally secure, quality services, including through the use of Aboriginal Hospital Liaison Officers, interpreters, engagement with the local Indigenous community, and development of written protocols on culturally secure practice<sup>48</sup>*

For example, the Mater Health Care Services Brisbane has developed specifically tailored services to meet the needs of Aboriginal and Torres Strait Islander people, including an Aboriginal and Torres Strait Islander Liaison service to provide increased access to services and to facilitate the admission, discharge planning and referral processes.<sup>49</sup> However, the problem is that these strategies have not been universally adopted.

A possible continuous quality improvement framework is described in Figure 8.9. Cultural competence, improving linkages across the health care system, encouraging more Aboriginal and Torres Strait Islander people to become health professionals, and the need to build a clinically and culturally competent workforce were also suggested.

**Figure 8.9: A framework for Continuous Quality Improvement**

*The Cooperative Research Centre for Aboriginal Health proposes a continuous quality improvement framework against which hospital services can be audited in terms of their services to the Indigenous community, which could include:*

- *promoting and requiring staff values, skills and knowledge related to cultural security;*
- *developing planning and evaluation relationships with the local indigenous community and its organisations and services;*
- *undertaking inter-agency and inter-disciplinary planning and evaluation focusing on the health needs of aboriginal people;*
- *developing systems and resources for internal referrals and discharge planning with the appropriate involvement of Aboriginal workers and agencies; and*
- *developing systems that support recording of Indigenous status and data collection, and that evaluates the effectiveness of that system.*

Source: Cooperative Research Centre for Aboriginal Health (adapted from the Australian Institute for Primary Care (2002), Aboriginal and Torres Strait Islander Accreditation: Final Report)

Participants at our national consultations reminded us of the importance of being culturally aware and sensitive to Aboriginal and Torres Strait Islander needs:

*Greater attention needs to be given to patient communication in the cross-cultural context. Many Aboriginal patients arrive in hospital in Alice Springs with no family support, unable to speak the language and not familiar with how to use basic facilities such as taps, toilets etc. There are reports that patients consent to treatment without fully understanding the implications of procedures.<sup>50</sup>*

48 Cooperative Research Centre for Aboriginal Health (2008), Submission 527 to the National Health and Hospitals Reform Commission.

49 Catholic Health Australia (2008), Submission 527 to the National Health and Hospitals Reform Commission.

50 Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

One way of ensuring services were more responsive to Aboriginal and Torres Strait Islander needs was to establish cultural brokerage services such as those provided by Karpa Ngarrattendi at the Flinders Medical Centre, Adelaide. As shown in Figure 8.10, the provision of culturally appropriate services does improve access for Aboriginal and Torres Strait Islander people.

**Figure 8.10: Culturally appropriate health services improve access**

*A recent report into chronic care for Aboriginal and Torres Strait Islander people presented the following example of a culturally appropriate health service:*

*Inala is an urban area in Queensland, with an Aboriginal population of approximately eight per cent of the total population. A review conducted by the Inala Health Centre General Practice identified problems concerning poor access to health care services by Aboriginal people.*

*In response, in July 1995 strategies aimed at increasing Aboriginal people's access to the Inala Health Centre General Practice were implemented. The strategies included employing an Aboriginal person in the centre, purchasing culturally appropriate health posters and artefacts for the centre to make Aboriginal people feel more at home, providing cultural awareness talks to all staff within the centre, disseminating information into the Aboriginal community about what services are available at the centre and promoting intersectoral collaboration.*

*Before implementation the centre was not well used by local Aboriginal people, recording only 12 Aboriginal patient contacts in one year. In the program's first year of operation, there were 890 Aboriginal patient contacts, increasing to 3894 in 2000–01.*

Source: NSW Health (2008), *The Walgan Tilly Project: Chronic Care for Aboriginal People, Final Report*

Clinical excellence is as important as cultural safety, and a strong focus on both is needed to improve outcomes. Critical areas where there are proven strategies to achieve better health outcomes and improve life expectancy are maternal and child health (see Figure 8.4). As highlighted earlier, there is also significant potential to improve life expectancy by improving chronic disease care, and addressing those modifiable risk factors which contribute to chronic disease such as smoking, alcohol consumption and physical activity (see Figure 8.5). It may be appropriate that all services for Aboriginal and Torres Strait Islander people be required to demonstrate that they have evidence-based programs to address these as a key focus of their service delivery.

There are critical shortages of all health professions across Australia, and Aboriginal and Torres Strait Islander people are under-represented in the health professions, with the exception of Aboriginal Health Workers. As outlined in Chapter 14, Aboriginal and Torres Strait Islander people make up only 1.6 per cent of the national health workforce.<sup>51</sup> While Aboriginal and Torres Strait Islander people account for 95.5 per cent of Aboriginal Health Workers, they only represent 0.2 per cent or less of all other health professions.<sup>52</sup>

■ Clinical excellence is as important as cultural safety, and a strong focus on both are needed to improve outcomes

51 A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people, Commonwealth of Australia 2008.

52 A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people, Commonwealth of Australia 2008.

Maximising Aboriginal and Torres Strait Islander participation in the health workforce is a key strategy for improving access, health outcomes and life expectancy

- The level of skilled professionals who are able to meet clinical and cultural needs is also an issue.<sup>53</sup> A focus on workforce development is an important element in delivering quality care. Maximising Aboriginal and Torres Strait Islander participation in the health workforce is a key strategy for improving access, health outcomes, and life expectancy.<sup>54, 55</sup> As emphasised in our national consultations:

*Training of non-Indigenous professionals in cultural awareness and competence is crucial for those working in hospitals and other settings. The mainstream health environment needs to become 'safe' for Indigenous people and mechanisms need to be put in place to make hospitals 'comfortable' for Aboriginal staff and students.<sup>56</sup>*

The importance of removing financial barriers and creating linkages with other services is captured in the following comment made by a participant at the Alice Springs consultation:

*Chronic disease is managed by so many different services that people can fall through the gaps. One major barrier is that no [private] GPs bulk bill. This makes it difficult for people who need regular services from a GP to access practitioners who could help them manage their condition.<sup>57</sup>*

### 8.3.4 Supporting community controlled health services

Community controlled health services play an important role in the delivery of comprehensive primary health care, maximising people's potential and removing illness as a barrier to Indigenous people's participation in family, community and workforce. Over 140 services are operating across Australia, ranging from large comprehensive primary health care services in urban areas to clinics in remote communities with only a few staff.

We heard through our consultations and submissions strong support for the enhancement of community controlled health services. This support is echoed in the statement:

*Community controlled Aboriginal Health Services offer holistic primary health care and provide integrated primary health care models for indigenous people, including medical care, support for pregnancy and a good start to life, chronic and complex disease management and programs that address social and emotional health. However, there are gaps in investment and the workforce that need to be recognised and resourced. The sector needs to be supported to have the leadership role in the front line primary health care for Indigenous people.<sup>58</sup>*

As Figure 8.7 shows, Aboriginal and Torres Strait Islander people are relatively higher users of 'community health services' (the classification used for community controlled health organisations) and relatively lower users of general medical services. Community controlled health organisations are and will remain critical to the provision of good quality care to Aboriginal and Torres Strait Islander people. The Close the Gap Steering Committee for Indigenous Health Equality urged greater recognition of the vital role played by community controlled health services, including closer engagement by the Commonwealth Government with this sector.<sup>59</sup>

There is considerable diversity within the community controlled health sector with significant differences in the levels of infrastructure and staffing, and consequently the range of services offered

53 The National Evaluation of the Second Round of Coordinated Care Trials, Final Report.

54 A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people, Commonwealth of Australia 2008.

55 Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

56 Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

57 Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

58 Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

59 Close the Gap Steering Committee for Indigenous Health Equality (2008), Submission 510 to the National Health and Hospitals Reform Commission.

and their effectiveness. A critical mass is needed to ensure sustainability of these organisations. The Queensland Aboriginal and Islander Health Council summarised the issues facing community controlled health services, and the need for support:

*There is a minimum size below which health care organisations cannot be effective. Achieving critical mass and addressing capacity issues is important to ensure sustainability of programs ... funding increases will not lead to improved outcomes unless organisations are supported to improve capacity in terms of financial planning and management, recruiting and retaining a mix of staff, implementing health information systems and leadership.*

*Governments urgently need to provide more enabling policy frameworks and program guidelines that actively promote Indigenous capacity and authority. At a minimum, governance needs to meet broader standards of corporate governance as well as ensuring cultural legitimacy and that organisations are run productively and in a way that reflects local priorities. People involved in the organisation (the board, the chief executive officer, administrators, and clinical staff) all need to understand their roles and responsibilities, and be supported to work within these boundaries.<sup>60</sup>*

## 8.4 Creating a better future

Our reform directions focus on what we believe needs to happen to close the health gap and to build a health system that is responsive to the needs of Aboriginal and Torres Strait Islander people regardless of where people live. There are several inter-related dimensions to doing this.

First, we believe that there is significant potential to close the life expectancy gap within the health sector alone, but that there will be a positive compounding effect if all social determinants of health were tackled in a whole of government and whole of community approach.

### Reform direction 8.1

We propose that the Commonwealth Department of Health and Ageing take a lead in the inter-sectoral collaboration that will be required at the national level to redress the impacts of the social determinants of health to close the gap for Aboriginal and Torres Strait Islander peoples.

Second, we are strongly of the view that additional investment is needed if the goal of closing the gap by 2030 is to be achieved. We believe that funding should be determined on the basis of health need but also take account of the additional costs associated with delivering services outside metropolitan areas. We also believe that increased ongoing investment should be staged over five years to build primary health care capacity across the continuum of health promotion, prevention and clinical care. We note that the Close the Gap National Indigenous Health Equity Targets suggest that additional funding is needed of \$150m, \$250m, \$350m, \$400m, and \$500m per annum over 5 years with the \$500m sustained in real terms until the health gap is closed.<sup>61</sup> We also note the additional investment announced by COAG on 30 November 2008.

■ We are strongly of the view that additional investment is needed if the goal of closing the gap by 2030 is to be achieved

### Reform direction 8.2

We propose an investment strategy for Aboriginal and Torres Strait Islander Australians' health that is proportionate to health need, the cost of service delivery and the achievement of desired outcomes. This requires a substantial increase on current expenditure.

60 Queensland Aboriginal and Islander Health Council (2008), Submission 483 to the National Health and Hospitals Reform Commission.

61 Close the Gap Steering Committee for Indigenous Health Equality (2008), National Indigenous Health Equality Targets.

Our third reform direction concerns Aboriginal Community Controlled Health Services. We believe that increased investment is required to ensure equitable access to effective primary health care. This means additional coverage of some areas, and increased capacity in others.

We also believe additional support is required to assist Aboriginal Community Controlled Health Services build organisational capacity. We expect that this would include governance and leadership, financial planning and management, and recruitment. Existing partnership and planning arrangements have a role to play, but the critical need is implementation.

Some Aboriginal Community Controlled Health Services are small and the regulatory burden on them is sometimes out of proportion to the funds they manage. Establishing new fragile organisations to help address the health gap is not the way to go. Strategies to strengthen Aboriginal Community Controlled Health Services could include greater sharing of administrative resources, skills development of staff and boards, establishing central or regional support services, and tighter grouping of some organisations. These support functions are important and are critical to building a strong network of Aboriginal Community Controlled Health Services.

The 'support' function should possibly be separate from the 'purchasing' function or there may be a potential conflict of interest in promoting the rigorous accountability for care quality that we envisage will be part of the role of the National Aboriginal and Torres Strait Islander Health Authority (see reform direction 8.4).

#### Reform direction 8.3

We propose establishing a function to build and expand organisational capacity of Aboriginal Community Controlled Health Services to provide and broker comprehensive primary health care services. We would welcome feedback on the appropriate auspicing body or agency for such a support function.

Our fourth reform direction concerns funding flows. We believe that a new approach to purchasing health services for Aboriginal and Torres Strait Islander people is needed if Australia is going to address the 17-year life expectancy gap for this 'discrete, disadvantaged' group of Australians.

We have argued the critical need to improve access to primary health care through both Aboriginal and Torres Strait Islander-specific and mainstream services. The community controlled sector needs to be expanded to achieve access to primary health care, particularly in rural and remote areas. The mainstream health sector needs to become more culturally appropriate to root out residual racism and to pay more attention to the particular needs of Aboriginal and Torres Strait Islander people. We believe that this can be done by changing the way funds flow to all services, and by strengthening the accountability of mainstream services (including hospitals and general practices).

We have argued in Chapters 2 and 3 that we can improve care of people with chronic disease and care of people in their early years if we work with a defined population, identified through voluntary enrolment. Aboriginal and Torres Strait Islander people should also be able to enrol with a primary health care service, including Aboriginal Community Controlled Health Services. In addition, we suggest that this concept could be further extended so that Aboriginal and Torres Strait Islander people have an entitlement to services that are purchased through a new 'purchasing' organisation.

#### Reform direction 8.4

We propose strengthening the purchasing role to lead the additional investment in Aboriginal and Torres Strait Islander health. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Aboriginal and Torres Strait Islander Australians and their families as a mechanism for closing the gap. This Authority would purchase health services from accredited providers with a focus on outcomes to ensure high quality and timely access.

Underpinning the establishment of an Aboriginal and Torres Strait Islander Health Authority (Authority) would be acknowledgement that improvement in Aboriginal and Torres Strait Islander health is important to Australia and that there is a need for consolidated, affirmative action to build a system that will meet the needs of Aboriginal and Torres Strait Islander people, similar to that afforded to the veteran community.

We envisage the Authority would function for the Aboriginal and Torres Strait Islander people in much the same way as the Repatriation Commission/Department of Veterans' Affairs does for the veteran community. Initially, the Authority could potentially use the same contractual arrangements and the same quality assurance mechanisms as does the Department of Veterans' Affairs.

The Authority would have a 20-year life cycle linked to the timing of the Prime Minister's commitment to close the life expectancy gap by 2030, but subject to evaluation on a regular basis to ensure that the Authority is driving the improvements that it has been set up to achieve. The first evaluation, after, say, two years of existence, would evaluate whether it has established robust systems of contracting with appropriate internal evaluation mechanisms.

The Authority would be funded to broker/purchase health services for Aboriginal and Torres Strait Islander people and to ensure appropriate advocacy services. Purchasing may seem bureaucratic, but purchasing determines the way funding flows to health services in ways that can deliver improved outcomes. The Authority would have two sources of funding:

- funding currently directly allocated for mainstream services – for example, under the Australian Health Care Agreements and Medicare, Closing the Gap additional investment, and through the Office of Aboriginal and Torres Strait Islander Health; and
- additional funding to meet need, for advertising campaigns, and supplementary services.

The Commonwealth Government's Department of Health and Ageing would still have overall responsibility for Aboriginal and Torres Strait Islander health, and should continue to ensure that Aboriginal and Torres Strait Islander health is 'everybody's business'.

Services would be purchased from Aboriginal Community Controlled Health Services, mainstream primary health care services and hospitals, and other services. The Authority would ensure that all purchased services meet set criteria including clinical standards, cultural appropriateness, appropriately trained workforce, data collection and performance reporting against identified targets such as the national Indigenous Health Equality Targets.

Aboriginal and Torres Strait Islander people would need to register to receive services funded through the Authority. Registration would be voluntary, and those not registered would still be covered by existing Medicare arrangements.

This approach would support access to health services for Aboriginal and Torres Strait Islander people through direct billing, the provision of clinically sound and culturally appropriate services within mainstream primary health care, and improved linkages between all health services. The Authority should also be able to simplify contractual and accountability arrangements for Aboriginal Community Controlled Health Services.

We expect that the Authority would publish a three year plan and report each year on how its activities are contributing to closing the health gap.

The Authority could be established separately or within the Office for Aboriginal and Torres Strait Islander Health (OATSIH) – either way, it will represent a significant change for OATSIH. But, we consider that the policy and purchasing functions for Aboriginal and Torres Strait Islander health should remain separate.

The Authority would also have some capacity to address socio-economic determinants of health. Similar to the Victorian Transport Accident Commission, which funds advertisements and other interventions to encourage people to drive safely, the Authority could also have a capacity to run targeted campaigns to address risk factors – for example, an anti smoking campaign aimed at primary school children.

Governments have recognised that 'more of the same' is not an adequate response and will not close the health gap

■ Governments have recognised that 'more of the same' is not an adequate response and will not close the health gap. A new approach is required to drive improvement in the quality and responsiveness of the whole health system for Aboriginal and Torres Strait Islander people.

Interestingly, there is at least one small scale 'purchasing' or brokerage of services already operating. The North Coast Aboriginal Corporation for Community Health operates on a brokerage model, with 22 voluntary referral officers, and approximately 150 service providers registered for referral.<sup>62</sup> Eligible clients are issued with a health access card.

Our fifth reform direction relates to the accreditation of health services. We believe that accreditation linked to high quality clinical and culturally secure services will improve access and treatment for Aboriginal and Torres Strait Islander people. As described earlier, evidence suggests that Aboriginal and Torres Strait Islander people do not routinely receive the same level of care afforded to other Australians.

#### Reform direction 8.5

We propose that accreditation processes for health services and education providers incorporate, as core, specific Indigenous modules to ensure quality clinical and culturally appropriate services.

Our sixth reform direction relates to workforce, but has two dimensions.

The first dimension is the need to encourage more Aboriginal and Torres Strait Islander people into the health professions as a strategy for improving access for other Aboriginal and Torres Strait Islander people to health services; to provide professional opportunities for Aboriginal and Torres Strait Islander people; for providing role models within the community; and for increasing productivity.

The second dimension is about building a workforce for Aboriginal and Torres Strait Islander health. This would ensure that all health professionals are clinically and culturally competent and understand the public health issues specific to Aboriginal and Torres Strait Islander health, and would be able to respond in a way that is effective and meets their health needs. This is explained in more detail in Chapter 14 on workforce.

#### Reform direction 8.6

We propose additional investment includes the funding of strategies to build an Aboriginal and Torres Strait Islander health workforce across all disciplines and the development of a workforce for Aboriginal and Torres Strait Islander health.

<sup>62</sup> C Shannon and K Panaretto, Analysis of Maternal and Child Health Services in Selected Aboriginal Community Controlled Health Services in Queensland, Queensland Aboriginal and Islander Health Council.