

Submission to the National Aboriginal and Torres Strait Islander Health Plan

CLOSE THE GAP CAMPAIGN STEERING COMMITTEE

December 2012

Table of Contents

	<i>Close the Gap campaign Steering Committee</i>	<i>1</i>
1	Introduction.....	3
2	Recommendations.....	3
3	Processes for the development of the Health Plan	6
3.1	<i>Developing an effective Health Plan.....</i>	6
3.2	<i>Developing the Health Plan in partnership</i>	7
4	What needs to be in the Health Plan	8
4.1	<i>Statement of Intent.....</i>	9
4.2	<i>The right to health.....</i>	9
4.3	<i>Racism</i>	10
4.4	<i>Holistic definition of Aboriginal and Torres Strait Islander health</i>	10
4.5	<i>Policy commitments</i>	11
4.6	<i>Future directions of the health system</i>	15
4.7	<i>Engaging the broader health sector and the social determinants of health.....</i>	17
(a)	<i>Whole of government commitment to health equality</i>	17
(b)	<i>Mental health and social and emotional wellbeing.....</i>	18
5	Investing in the Health Plan	19
6	Monitoring, implementation and accountability of the Health Plan	21
7	Conclusion	22
	Appendix 1: Membership and a brief history of the Close the Gap Campaign Steering Committee	23
	Appendix 2: The National Health Leadership Forum	25
	Appendix 3: Policy commitments for the National Aboriginal and Torres Strait Islander Health Equality Plan	26
	Appendix 4: Close the Gap Statement of Intent	33
	Appendix 5: The right to health	35

1 Introduction

1. The Close the Gap Campaign Steering Committee (Campaign Steering Committee) makes this submission to the National Aboriginal and Torres Strait Islander¹ Health Plan (Health Plan).
2. Australia's peak Aboriginal and Torres Strait Islander and non-Indigenous health bodies, health professional bodies and human rights organisations operate the Close the Gap Campaign. See Appendix 1 for the membership and a brief history of the Close the Gap Campaign Steering Committee.
3. The Campaign Steering Committee is led by its Aboriginal and Torres Strait Islander member-organisations. This leadership group was the precursor for the National Health Leadership Forum (NHLF) within Chamber 1 of the National Congress of Australia's First Peoples. The NHLF has established itself as the national representative committee for Aboriginal and Torres Strait Islander peak bodies who provide advice on health. See Appendix 2 for more information on the structure and membership of the NHLF.
4. Closing the gap in Aboriginal and Torres Strait Islander health and life expectancy is a multi-decade commitment that will span policy cycles, funding agreements and governments. Consequently the Campaign Steering Committee has always placed a great significance on securing multi-party support for achieving health equality. Similarly the Health Plan with a long-term reach requires the multi-party support of all political parties to survive political cycles and provide the necessary policy continuity for the gap to close.
5. The Campaign Steering Committee supports Aboriginal and Torres Strait Islander community control in health. Community control is an essential component of a human rights based approach to addressing health equality and to the holistic definition of Aboriginal and Torres Strait Islander health.
6. The Campaign Steering Committee recognises that the 1989 *National Aboriginal Health Strategy* provides a benchmark for Aboriginal and Torres Strait Islander health plans.

2 Recommendations

7. The Campaign Steering Committee recommends:

Recommendation 1: That the National Aboriginal and Torres Strait Islander Health Plan has a timespan until 2030.

Recommendation 2: That the Australian Government ensures that the Health Plan clearly and in concrete form set out:

- what is to be done (ie what services are required and when and where they are to be provided, workforce development etc);
- who is going to do it (ie commit parties to action);

- what it will cost;
- what is the source(s) of funds; and
- how success will be measured.

Recommendation 3: That the Health Plan recognise NACCHO, NACCHO Affiliates and ACCHS as the preferred provider and vehicle for the delivery of comprehensive primary health care.

Recommendation 4: That the partnership between Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments continue to drive the Health Plan development process.

Recommendation 5: That a shared sense of ownership, between Aboriginal and Torres Strait Islander peoples and Australian governments, be maintained at all stages of the Health Plan process. This includes but should not be limited to:

- the consultation process;
- the drafting and sign off of the Health Plan;
- the implementation phase; and
- the development and implementation of accountability, monitoring and review mechanisms.

Recommendation 6: That the Health Plan specifically address each of the 13 factors identified by the Campaign Steering Committee in paragraph 22 of this submission.

Recommendation 7: That the Australian Government ensures that health planning expertise is engaged in the development of the Health Plan.

Recommendation 8: That the *Statement of Intent* commitments are acknowledged and imbedded into the Health Plan.

Recommendation 9: That the Health Plan explicitly adopts a human rights based approach and recognises and accommodates the four interrelated aspects of a rights based approach to health equality.

Recommendation 10: That tackling racism, both individual and systemic, is a priority of the Health Plan and it links with and seamlessly integrates into the National Anti-Racism Strategy.

Recommendation 11: That the Health Plan adopts a holistic definition of health including recognition of the impacts of past and contemporary policies on the health of Aboriginal and Torres Strait Islander people and the role of healing.

Recommendation 12: That the Australian Government endorses the Policy Commitments contained in Appendix 3. These Policy Commitments should be included in the Health Plan.

Recommendation 13: That the Health Plan includes the components for action within the health system outlined in paragraph 46 of this submission.

Recommendation 14: That the Health Plan seamlessly integrate and create linkages with all other government initiatives that have an impact on Aboriginal and Torres Strait Islander health. That health considerations influence, lead and direct other government initiatives to ensure that they are health promoting and/or have positive health impacts.

Recommendation 15: That the Australian Government develop, implement and resource a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* that fits seamlessly within the overall Health Plan but could also operate independently within the mental health space.

Recommendation 16: Since both COAG health goals are long term (child mortality in 10 years) and life expectancy in a generation (25 years), long term funding without interruption is essential. As such we call for the following:

- maintain the funding for the initial *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* which runs from 2009/10-2012/13, for 2013/14 at its current level and pattern while the Health Plan is being finalised and then at least maintain the level of funding but amend the distribution of funds as appropriate for implementation of the Health Plan;
- mandatory funding through the Department of Health and Ageing for Aboriginal and Torres Strait Islander primary health care;
- maintain funding from Department and Health and Ageing and other agencies for other Aboriginal and Torres Strait Islander health programs or programs relevant to Aboriginal and Torres Strait Islander health including broader programs that address the social and cultural determinants of health;
- the development of a new mechanism to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis which reflects both the population size and an index of need, and how the money so identified might best be spent to achieve optimal outcomes; and
- for health services relevant to Aboriginal and Torres Strait people that are implemented through Medicare Locals, develop or amend the guidelines for such programs so that the available funds are used to achieve the best possible outcomes and this generally implies Aboriginal and Torres Strait Islander leadership, agreements between mainstream and ACCHS providers and a presumption that ACCHS services have inherent advantages as the provider of choice in terms of both better access and higher quality of service.

Recommendation 17: That the Health Plan develops key targets and sub-targets which can be used to monitor the implementation of the Health Plan.

Recommendation 18: That an independent body comprised of Aboriginal and Torres Strait Islander people and experts in comprehensive primary health care monitors and evaluates the implementation of the Health Plan, and the effectiveness of expenditure in relation to Aboriginal and Torres Strait Islander health.

3 Processes for the development of the Health Plan

3.1 Developing an effective Health Plan

8. The Campaign Steering Committee commends the Australian Government for beginning the processes to develop a long term health plan to close the health equality gap by 2030. This reflects a key commitment of the *Statement of Intent*:

... 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.

Closing the gap is an inter-generational and multi-decade commitment. As such the Health Plan must reflect this reality with short, medium and long term time frames for action.

9. **Recommendation 1:** That the National Aboriginal and Torres Strait Islander Health Plan has a timespan until 2030.
10. The Campaign Steering Committee is firmly of the belief that the Health Plan needs to be a real plan. It has to direct action rather than simply list what should happen.
11. **Recommendation 2:** That the Australian Government ensures that the Health Plan clearly and in concrete form set out:
- what is to be done (ie what services are required and when and where they are to be provided, workforce development etc);
 - who is going to do it (ie commit parties to action);
 - what it will cost;
 - what is the source(s) of funds; and
 - how success will be measured.
12. The Campaign Steering Committee views the National Aboriginal and Community Controlled Health Organisation (NACCHO), NACCHO Affiliates and Aboriginal Community Controlled Health Services (ACCHS) as the preferred provider and vehicle for the delivery of comprehensive primary health care. Continued support in building the capacity for NACCHO, NACCHO Affiliates and the ACCHS to deliver comprehensive primary health care to Aboriginal and Torres Strait Islander people is required.

13. **Recommendation 3:** That the Health Plan recognise NACCHO, NACCHO affiliates and ACCHS as the preferred provider and vehicle for the delivery of comprehensive primary health care.

3.2 *Developing the Health Plan in partnership*

14. The Health Plan must be developed in genuine partnership with Aboriginal and Torres Strait Islander peoples and their representative organisations. This reflects a commitment from the *Statement of Intent*:
- ... ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.
15. At the national level the NHLF provides the partnership interface for the Australian Government to work with in the development of the Health Plan.
16. The Campaign Steering Committee welcomes the establishment of the Stakeholder Advisory Group (SAG) to drive the development of the Health Plan. It has been established within the parameters for partnership that had been established by the Campaign Steering Committee and adopted by the NHLF.² They include:
- co-chairing arrangements involving one Aboriginal and Torres Strait Islander peoples' representative, and one Australian Government representative, and power-sharing in relation to the approval of agendas, papers etc.; and
 - an agreed minimum level of Aboriginal and Torres Strait Islander representation and majority Aboriginal and Torres Strait Islander membership.
17. The Campaign Steering Committee welcomes the NHLF members inclusion on the SAG and also the inclusion of senior representatives from three Commonwealth agencies (in addition to the Department of Health and Ageing) to help planning in relation to social determinants and cross-sectoral planning.
18. A shared sense of 'ownership' of the Health Plan between Australian governments and Aboriginal and Torres Strait Islander peoples is a critical outcome of the planning process, and it is not capital that can be developed 'post-event'. The Campaign Steering Committee believe the partnership so far manifesting in the SAG and the consultation process provides a firm foundation for this shared ownership of the Health Plan. This must continue throughout all stages of the planning and implementation of the Health Plan.
19. **Recommendation 4:** That the partnership between Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments continue to drive the Health Plan development process.
20. **Recommendation 5:** That a shared sense of ownership, between Aboriginal and Torres Strait Islander peoples and Australian governments, be maintained at all stages of the Health Plan process. This includes but should not be limited to:

- the consultation process;
- the drafting and sign off of the Health Plan;
- the implementation phase; and
- the development and implementation of accountability, monitoring and review mechanisms.

4 What needs to be in the Health Plan

21. The Campaign Steering Committee has extensively examined previous health plans and health policy and identified factors to be considered in the development of the Health Plan for it to close the life expectancy gap by 2030.³
22. The Campaign Steering Committee believes these factors should influence the development of the Health Plan. As such we call for the Health Plan to:
 - show ambition as befitting the achievement of a 2030 life expectancy target;
 - have a generational time reach – to reach 2030 (see section 3.1);
 - use sub-targets and intermediate time frames to support the achievement of the COAG closing the gap targets for the short, medium and long term time frames (see section 6);
 - reflect the human rights of Aboriginal and Torres Strait Islander peoples particularly in relation to health, but also to participate as partners in decision-making that affects them (see section 4.2);
 - be comprehensive and address the wide range of social and cultural determinants of health inequality (see sections 4.3 and 4.7);
 - account for the health of marginalised groups and those with special need (ie, members of the Stolen Generations, youth, prisoners, people with disabilities etc.);
 - be developed and implemented on the basis of a partnership between Aboriginal and Torres Strait Islander peoples, their representatives and Australian governments (see sections 3.2 and 6);
 - include monitoring, accountability and review mechanisms (see section 6);
 - include a resources strategy (see section 5);
 - indicate how mainstream health services and mainstream programs are to work separately and together to contribute to Aboriginal and Torres Strait Islander health (see section 4.5 and Appendix 3);
 - include the continuation of a capacity building strategy for the Aboriginal Community Controlled Health Sector (see section 4.5 and Appendix 3);
 - identify and provide for the health workforce needed if health equality is to be achieved by 2030 (see section 4.5 and Appendix 3); and

- address long-standing data issues in relation to Aboriginal and Torres Strait Islander health (see section 4.5 and Appendix 3).
23. The Campaign Steering Committee will monitor the development of the Health Plan against these factors.
 24. **Recommendation 6:** That the Health Plan specifically address each of the 13 factors identified by the Campaign Steering Committee in paragraph 22 of this submission.
 25. Development of a generational Health Plan is a complex task. The Campaign Steering Committee believes that the involvement of health planning expertise in the development of the Health Plan is essential.
 26. **Recommendation 7:** That the Australian Government ensures that health planning expertise is engaged in the development of the Health Plan.

4.1 Statement of Intent

27. The *Statement of Intent* is a foundational document, guiding efforts to meet the aim of health equality for Aboriginal and Torres Strait Islander peoples. The *Statement of Intent* commitments comprise an interdependent and coherent framework for achieving health equality and are not to be selectively interpreted or implemented. The *Statement of Intent* is provided at Appendix 4.
28. **Recommendation 8:** That the *Statement of Intent* commitments are acknowledged and imbedded into the Health Plan.

4.2 The right to health

29. The Campaign adopts a human rights based approach to addressing Aboriginal and Torres Strait Islander health inequality. The Campaign Steering Committee posits that the Health Plan must be developed to recognise health as a human right.
30. The *Social Justice Report 2005* provides a comprehensive articulation of the right to health as it applies to Aboriginal and Torres Strait Islander peoples.⁴ This report forms the intellectual foundation for the Campaign.
31. Human rights standards provide a system to guide policy making and to influence the design, delivery, implementation and monitoring and evaluation of health programs and services. It is a system for ensuring the accountability of governments. In addition to international obligations, through the *Statement of Intent*, Australian governments have committed to adopting a rights based approach to health through:
 - Respecting and promoting the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable, and of good quality.

32. The Campaign Steering Committee supports and endorses the NHLF position paper on the right to health. This paper is provided at Appendix 5.
33. **Recommendation 9:** That the Health Plan explicitly adopts a human rights based approach and recognises and accommodates the four interrelated aspects of a rights based approach to health equality.

4.3 Racism

34. The health and mental health impacts of racism are well documented. In the National Aboriginal and Torres Strait Islander Social Survey Aboriginal and Torres Strait Islander peoples aged 15 years and over were asked whether they felt they had experienced racism⁵ (in the 12 months prior to interview). Twenty seven per cent of respondents reported having experienced discrimination in the previous 12 months.⁶ Rates of discrimination did not vary across characteristics in the population: including income, educational attainment and so forth.⁷ Consistent with the broader literature, racism and discrimination was associated with poorer health outcomes in 2008. Aboriginal and Torres Strait Islander people who had experienced discrimination were more likely than those who had not experienced discrimination to report high/very high levels of psychological distress (44% compared with 26%) and to be in fair/poor health (28% compared with 20%). They were also more likely to engage in binge drinking (42% compared with 35%) and to have recently used illicit substances (28% compared with 17%).⁸
35. The Campaign Steering Committee is firmly of the belief that the Health Plan must address racism. Racism exists both at the individual, and the institutional or systemic levels, and it must be a priority of the Health Plan to address this. In this regard the Health Plan must create linkages and seamlessly integrate with the National Anti-Racism Strategy.
36. **Recommendation 10:** That tackling racism, both individual and systemic, is a priority of the Health Plan and it links with and seamlessly integrates into the National Anti-Racism Strategy.

4.4 Holistic definition of Aboriginal and Torres Strait Islander health

37. The Campaign Steering Committee supports a holistic definition of health as outlined in the Health Plan Discussion Paper.⁹ In particular the Campaign Steering Committee endorses the definition of health derived from the *National Aboriginal Health Strategy*:

Aboriginal [and Torres Strait Islander] health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.

38. The philosophy of Aboriginal and Torres Strait Islander community control and self-determination reflected in the 3Cs (Community Initiated, Community Driven

and Community Owned) are key components of health service delivery for Aboriginal and Torres Strait Islander people. The practices by NACCHO, NACCHO Affiliates and ACCHS in delivering culturally appropriate comprehensive primary health care reflect a holistic definition of health.

39. The Campaign Steering Committee believes that implicit in this definition is that ill-health in Aboriginal and Torres Strait Islander communities is strongly linked to historical and ongoing processes which have undermined the well-being and health of these communities.
40. **Recommendation 11:** That the Health Plan adopts a holistic definition of health including recognition of the impacts of past and contemporary policies on the health of Aboriginal and Torres Strait Islander people and the role of healing.

4.5 Policy commitments

41. In 2008 the *Close the Gap National Indigenous Health Equality Targets* (CTG Targets) were adopted at the National Indigenous Health Equality Summit hosted by the Campaign Steering Committee in Canberra. The aim of the CTG Targets was to set down a consensus view of what would be needed to achieve the two COAG goals - halving the child mortality gap in ten years and eliminating the life expectancy gap by 2030.
42. In recognition of the critical role of the CTG Targets and the evidence that supports them in the development of the Health Plan, the Campaign Steering Committee has translated the CTG Targets into a list of policy commitments under four key policy areas. The full policy commitments document is at Appendix 3. The integrity and structure of the original CTG Targets remain and the logic of the targets allows for them to be attached to the policy commitments. This section provides an outline of the policy commitments document.

Policy Area 1: Partnership: To enhance Aboriginal and Torres Strait Islander community engagement, control and participation in health policy and program development, implementation and monitoring.

- Establish national framework agreements to secure the appropriate engagement in the design and delivery of both primary and secondary health care services.

Policy Area 2: Health Status: To close the Aboriginal and Torres Strait Islander life expectancy gap within a generation and halve the mortality gap for Aboriginal and Torres Strait Islander children under five within a decade.

2.1 Maternal and Child Health: To halve the mortality gap for Aboriginal and Torres Strait Islander children under five within a decade.

- Ensure universal access to culturally secure mother and baby programs.
- The establish a national database on childhood hospital presentations for injury.

2.2 Chronic Disease: To improve the management and reduce adverse outcomes in chronic disease.

- Universal access to appropriate prevention programs and chronic disease services in line with approved clinical guidelines including specialist and allied health services to Aboriginal and Torres Strait Islander people in all urban, rural and remote settings.

2.3 Mental health and emotional and social wellbeing: To improve the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people to the same standards enjoyed by the majority of the Australian population and reduce the impact of mental disorders on patients and their families.

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan*.

2.4 Data: Achieve specified levels of completeness of identification in health records.

- Address the capacity to assess progress against the COAG Close the Gap Target for life expectancy. This includes reliable recording of Aboriginal and Torres Strait Islander status on health records and death certificates and improving regular reporting against supporting indicators. The aim is to have data quality, that meets AIHW standards, in all jurisdictions.

Policy Area 3: Primary Health Care and Other Health Services: To ensure Aboriginal and Torres Strait Islander peoples have equal access to health services that are equal in standard to those enjoyed by other Australians; and that these services are commensurate to need.

3.1 ACCHS and other Primary Health Care providers: To increase access to culturally appropriate primary health care to bridge the gap in health standards.

- A 5 year Capacity Building Plan for ACCHS and other primary health care providers, including recurrent and capital funding, to meet the level of need based on needs based funding rather than competitive or submission based models.
- Mechanisms and funding to support the establishment and good governance of new ACCHSs.
- Three year funding at least three times the per capita MBS utilisation by non-Indigenous Australians (with a rural and remote loading of up to an additional three times).

3.2 Mainstream primary health care services: Improve the responsiveness of mainstream health services and programs to Aboriginal and Torres Strait Islander people's health needs.

- Strategies to enhance the utilisation and relevance of the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits

Scheme (PBS), including uptake of the PIP Indigenous Health Incentive.

- Support to enable general practices to identify the Aboriginal and Torres Strait Islander status of their patients and to record and report data relating to this.
- State and Federal bilateral financing agreements to commit to health equity within mainstream programs.
- Systems for programs delivered through private general practices commit to health equity, including:
 - The Multi-Program Funding agreement between the Department of Health and Ageing and Medicare Locals have provisions to facilitate:
 - systemic engagement strategy for ACCHS and mainstream services working together with Aboriginal and Torres Strait Islander guidance; and
 - best practice service delivery to Aboriginal and Torres Strait Islander people.

3.3 *Maternal and child health services: National coverage of maternal and child health services is provided.*

- Commit to national coverage of culturally appropriate maternal and child health services for Aboriginal and Torres Strait Islander people.
- Develop, implement and resource a *National Health Plan for Aboriginal and Torres Strait Islander Mothers and Babies*.
- A national 'nutritional risk' scheme for mothers, infants and children.
- Health promotion programs targeting smoking and alcohol consumption in pregnancy.

3.4 *Aboriginal and Torres Strait Islander specific population programs for chronic and communicable disease: Enhance Aboriginal and Torres Strait Islander specific population programs for chronic and communicable disease.*

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Chronic Disease Strategy* which 'closes the gap' in excess disease.
- Develop, implement and resource coordinated Aboriginal and Torres Strait Islander peoples' Programs for tobacco control, alcohol and substance misuse, nutrition and physical activity.
- An oral health program as an integral component of comprehensive primary health care.
- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Adolescence or Youth Health Strategy* to ensure Aboriginal and Torres Strait Islander adolescents and

youth have equal access to health services that are equal in standard to those enjoyed by other Australian adolescents and youth.

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Men's Health Strategy* to make health services more accessible and appropriate to Aboriginal and Torres Strait Islander men.
- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy* to reduce STI and HIV/Hepatitis C rates.
- The National Flu and Pneumococcal vaccine program is expanded to increase vaccine coverage.
- Develop, implement and resource a *National Rheumatic Fever/Heart Disease Strategy* for increased coordination between primary health care services and population health programs to improve preventive interventions and access to surgery.
- Trachoma control programs are expanded through implementation of SAFE strategy.

3.5 *Mental health and social and emotional wellbeing.*

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan*.

Policy Area 4: Infrastructure: To ensure primary health infrastructure for Aboriginal and Torres Strait Islander peoples is capable of bridging the gap in health standards by 2018.

4.1 *The size and quality of the health workforce: Provide an adequate workforce to meet Aboriginal and Torres Strait Islander health needs by increasing the recruitment, retention, effectiveness and training of health practitioners working within Aboriginal and Torres Strait Islander health settings and build the capacity of the Aboriginal and Torres Strait Islander health workforce.*

- Develop, implement and resource a *National Training Plan* for Aboriginal and Torres Strait Islander doctors, nurses, dentists, allied health professionals, AHWs and EHWs.
- Develop, implement and resource a *Recruitment and Retention Strategy* to provide the required numbers for each discipline.
- Develop, implement and resource a strategy to train, recruit and retain a skilled and sufficient workforce for Aboriginal and Torres Strait Islander health including primary health care, allied health, specialists and hospital care.

- Develop implement and resource a National Network of Centres of Teaching Excellence in every State and Territory.
- Ensure appropriate training on Aboriginal and Torres Strait Islander health in all relevant undergraduate and postgraduate curricula, including outside of health.
- All new staff and existing staff providing services to Aboriginal and Torres Strait Islanders complete a relevant cultural safety training/security programme.
- Work place and work force reform that implements a model that is based on care at the first level of competence.
- Establish programmes that increase the availability of a multi disciplinary and trans disciplinary workforce at the local level.

4.2 Mental health/social and emotional wellbeing workforce: Build an effective mental health/social and emotional wellbeing workforce.

- To be developed as a component of a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan*.

4.3 Housing, environmental health and health services capital works: To immediately commence improvement of the most basic facilities within all existing Aboriginal and Torres Strait Islanders houses to ensure safety and access to critical health facilities.

- Ensure the development of community level health service facility standards and ensure that all community level facilities meet the health service facility standards.
- Ensure that adequate staff housing is available.
- Implement and resource the *National Aboriginal and Torres Strait Islander Housing Guide* principles.

43. **Recommendation 12:** That the Australian Government endorses the Policy Commitments contained in Appendix 3. These Policy Commitments should be included in the Health Plan.

4.6 Future directions of the health system

44. The Campaign Steering Committee believes that the current Closing the Gap activities have been extremely useful (dedicated \$1.57 billion Aboriginal and Torres Strait Islander health resources). However at this stage of roll out, there remain some gaps in effective health service delivery for the Aboriginal and Torres Strait Islander population and serious concerns that if the lessons from the initial four years are not reflected in the Health Plan and future budgets, the COAG goals are unlikely to be achieved.

45. The Campaign Steering Committee supports and endorses the principle of Aboriginal and Torres Strait Islander leadership and community control in the delivery of comprehensive primary health care services.¹⁰ As a consequence ACCHSs should be the preferred source for funding of comprehensive primary health care services.
46. The Campaign Steering Committee endorse the following key components for action addressing reforms within the health system that the Health Plan should target:
- A key piece of work needs to be done to ensure that Closing the Gap activities are more defined and articulated with current national health reforms with a mapping process to identify key areas of overlap with ACCHSs and deficits with the current policy and program alignment.
 - ACCHSs are the preferred and default source of comprehensive primary health care service.
 - Ongoing Closing the Gap activities built into the new Health Plan - based on a more rigorous intellectual process including but not limited to:
 - Core services defined – definition of the actual service requirements for these services¹¹ as *baseline* service delivery activities. It is essential to define the requirements for services for mothers and babies, chronic disease and social and emotional wellbeing and other issues as outlined in the policy commitments (see Appendix 3).
 - Supportive service level infrastructure to deliver core services – what is needed to ensure the core services are effective, including community capacity development and community engagement at the local level.
 - Continued ACCHS governance development.
 - Through the existing National Partnership Agreement arrangements continued use of State/Territory Joint Planning Forums with representation of Commonwealth and State/Territory governments, NACCHO Affiliates and ACCHS.
 - Workforce development as based on core services needed and includes capacity building and training of the Aboriginal and Torres Strait Islander health workforce as well as the general health workforce.
 - Inventory of current services, gap analysis, and capacity building plans to address service gaps.
 - Population based – core services quantified and commensurate with population numbers and level of need.
 - The Multi-Program Funding agreement between the Department of Health and Ageing and Medicare Locals in Australia to have provisions to facilitate:

- systematic engagement strategy for ACCHS and mainstream services to work together with Aboriginal and Torres Strait Islander guidance; and
 - best practice service delivery to Aboriginal and Torres Strait Islander people.
 - Agreements between Medicare Locals and ACCHSs for Closing the Gap funding and for mainstream programs delivered through Medicare Locals, which foster partnership rather than dysfunctional competition and build on good models for agreements between ACCHS and Medicare Locals for service delivery where there is:
 - i) Aboriginal and Torres Strait Islander leadership;
 - ii) in general new services are attached to those services which will produce the highest access for Aboriginal and Torres Strait Islander people and the most effective services. The expectation is that this will usually be ACCHSs but this is a matter for discussion at a regional or area level;
 - iii) access to mainstream specialists by ACCHS services; and
 - iv) e-Health systems to provide continuity of care and quality enhancement across ACCHS and mainstream providers.
 - Introduction of formal procedures to ensure that Aboriginal and Torres Strait Islander people receive an equitable share, of all relevant mainstream health programs (the 2011 census estimated the population proportion as 3% and based on a conservative estimate of need of twice the Australian average, the share would be at least 6%), and formal consideration of how best to use the identified funds to produce the best results for Aboriginal and Torres Strait Islander people.
 - Circuit breakers in early childhood.
 - A transition plan from the current Closing the Gap programs and funding to the new approaches.
 - A timetable and process for undertaking the steps outlined above over the next 12 months.
47. **Recommendation 13:** That the Health Plan includes the components for action within the health system outlined in paragraph 46 of this submission.

4.7 Engaging the broader health sector and the social determinants of health

(a) Whole of government commitment to health equality

48. To be successful the Campaign Steering Committee believes the Health Plan must address the social and cultural determinants of health as there are many drivers of ill-health that lie outside the direct responsibility of the health sector. As

a consequence a cross government collaborative and inter-sectoral approach is needed.

49. The Campaign Steering Committee believes that the Health Plan must seamlessly integrate with other government strategies, initiatives and plans, both within the health context and the broader policy context.
50. However the Campaign Steering Committee believes that to close the health gap, whole of government approaches must go beyond coordination. In this regard it is imperative that health considerations should influence, lead and direct other government initiatives to ensure that they are health promoting and/or have positive health impacts.
51. All government initiatives need to work together to positively impact on a holistic definition of health and to address the social and cultural determinants of health. This includes, for example:
- National Primary Health Care Strategic Framework;
 - The National Disability Insurance Scheme;
 - National Anti-Racism Strategy;
 - National Cultural Policy;
 - Indigenous Economic Development Strategy;
 - housing initiatives; and
 - child, family and community safety initiatives.
52. **Recommendation 14:** That the Health Plan seamlessly integrate and create linkages with all other government initiatives that have an impact on Aboriginal and Torres Strait Islander health. That health considerations influence, lead and direct other government initiatives to ensure that they are health promoting and/or have positive health impacts.

(b) *Mental health and social and emotional wellbeing*

53. The Campaign Steering Committee believes that it is not possible to consider mental and physical health as independent domains: poor physical health and mental health are often caught in compounding cycles. Likewise poverty and disadvantage are driving mental health problems (including high rates of trauma and alcohol and substance abuse). Conversely, mental and physical health problems are driving poverty and disadvantage. Up to 22% of the ten year life expectancy gap with non-Indigenous Australians has been attributed to mental health conditions.¹²
54. The Campaign Steering Committee in its policy commitments (see Appendix 3) calls on the Australian Government to develop, implement and resource a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan*. The Campaign Steering Committee conceives such a mental health plan would sit seamlessly within the overall Health Plan, but could also operate independently within the mental health space.

55. In developing the Health Plan it is imperative that:
- The lessons of the disconnect between the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013* and the current *Social and Emotional Wellbeing Framework* are not lost. It's vital that both plans be fully integrated and developed in a way that fully takes the other into account.
 - That mental health and social and emotional wellbeing not become overlooked in the mix. Historically in planning, when Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing concerns are included with broader health concerns (for example, in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*) they have not received the attention they deserve.
56. In the mental health space an equitable approach is imperative:
- Mental health is receiving a significant amount of attention from policy-makers at the moment. 2010-11 saw \$2.2 billion allocations over 5 years. Significant work remains to be done to ensure Aboriginal and Torres Strait Islander MH&SEWB benefits in an equitable fashion. To capitalise on current and future opportunities a discreet mental health and social and emotional wellbeing plan is essential.
57. **Recommendation 15:** That the Australian Government develop, implement and resource a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* that fits seamlessly within the overall Health Plan but could also operate independently within the mental health space.

5 Investing in the Health Plan

58. Closing the gap in Aboriginal and Torres Strait Islander health and life expectancy is a multi-decade commitment that will span policy cycles, funding agreements and governments. There is eighteen years to go until 2030, the target date for the achievement of Aboriginal and Torres Strait Islander health and life expectancy equality.
59. Long term goals and commitments require long term investment. The Campaign Steering Committee believes that the Health Plan is the appropriate vehicle to drive this long term investment.
60. The Campaign Steering Committee acknowledges the ongoing funding that is committed by the Department of Health and Ageing and other agencies to Aboriginal and Torres Strait Islander primary health care. These funds form the foundation for further investment that will need to be committed in the implementation of the Health Plan. While the Health Plan may influence the priorities of ACCHS, the recurrent funding currently provided must continue.

61. There are three main sources of funding for a National Aboriginal and Torres Strait Islander Health Plan:
- the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (\$1.57 billion 2009/10-2012/13);
 - other relevant Aboriginal and Torres Strait Islander specific funding from the Department of Health and Ageing and other government agencies, including funding that addresses the social determinants of health; and
 - Aboriginal and Torres Strait Islander share of mainstream health programs based on a resource allocation formula.
62. A Health Plan without a resources strategy for the longer term and otherwise allocated funding is not a plan in any meaningful sense. It would fail to meet the Campaign's criteria for a health equality plan that would operate over the next two decades.
63. **Recommendation 16:** Since both COAG health goals are long term (child mortality in 10 years) and life expectancy in a generation (25 years), long term funding without interruption is essential. As such we call for the following:
- maintain the funding for the initial *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* which runs from 2009/10-2012/13, for 2013/14 at its current level and pattern while the Health Plan is being finalised and then at least maintain the level of funding but amend the distribution of funds as appropriate for implementation of the Health Plan;
 - mandatory funding through the Department of Health and Ageing for Aboriginal and Torres Strait Islander primary health care;
 - maintain funding from Department of Health and Ageing and other agencies for other Aboriginal and Torres Strait Islander health programs or programs relevant to Aboriginal and Torres Strait Islander health including broader programs that address the social and cultural determinants of health;
 - the development of a new mechanism to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis which reflects both the population size and an index of need, and how the money so identified might best be spent to achieve optimal outcomes; and
 - for health services relevant to Aboriginal and Torres Strait Islander people that are implemented through Medicare Locals, develop or amend the guidelines for such programs so that the available funds are used to achieve the best possible outcomes and this generally implies Aboriginal leadership, agreements between mainstream and ACCHS providers and a presumption that ACCHS services have inherent advantages as the provider of choice in terms of both better access and higher quality of service.

6 Monitoring, implementation and accountability of the Health Plan

64. The Campaign Steering Committee believes that no plan can be expected to succeed unless there are processes for monitoring, implementation and accountability. Progress with earlier Aboriginal and Torres Strait Islander health plans has been undermined by poor implementation structures and processes.
65. Given the history of incomplete monitoring and accountability of previous health plans, the new Health Plan should set up and maintain monitoring processes to ensure its implementation proceeds according agreed commitments. This includes ensuring that monitoring and accountability processes are:
- *robust*: they are resourced and supported to ensure their effectiveness;
 - *durable*: they are maintained over time;
 - *inclusive*: they include all parties with an interest in the implementation of the plan, including government, Aboriginal and Torres Strait Islander peoples and their representative organisations, and (as necessary) health systems and reporting expertise;
 - *appropriate*: that they are measured with appropriate evidence based indicators based on quality data collection processes; and
 - *Reciprocal*: 'upwards' accountability of the ACCHS to government is balanced with 'downwards' accountability of government structures that are flexible enough to respond to innovation and complexity in an effective way.¹³
66. In addition to this the *Statement of Intent* commits the Australian Government:
- 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.
 - To building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.

Effective monitoring requires the use of targets and supporting sub-targets to ensure progress is being made to close the gap. This will require additional measures to be tied into the *National Aboriginal and Torres Strait Islander Health Performance Framework* to enable effective monitoring and reporting of the key targets agreed to in the Health Plan.

67. **Recommendation 17:** That the Health Plan develops key targets and sub-targets which can be used to monitor the implementation of the Health Plan.
68. The Campaign Steering Committee believes that a transparent, independent national monitoring and evaluation body is required to assess the implementation of the Health Plan and the effectiveness of all expenditure including service delivery in relation to Aboriginal and Torres Strait Islander health.
69. The Campaign Steering Committee is committed to the principle of Aboriginal and Torres Strait Islander leadership. For Aboriginal and Torres Strait Islander people

to own their own health issues and to be part of the solution requires mechanisms throughout implementation and accountability structures where Aboriginal and Torres Strait Islander representatives can monitor and provide feedback on implementation issues. As such the Campaign Steering Committee believes that this monitoring body should be a skills based Board of Aboriginal and Torres Strait Islander people.

70. **Recommendation 18:** That an independent body comprised of Aboriginal and Torres Strait Islander people monitors and evaluates the implementation of the Health Plan, and the effectiveness of expenditure in relation to Aboriginal and Torres Strait Islander health.

7 Conclusion

71. The Campaign Steering Committee believes that it is critical that the Health Plan demonstrates ambition and reach befitting the target to close the life expectancy gap by 2030. It is equally imperative that the Health Plan continue to be developed in genuine partnership with Aboriginal and Torres Strait Islander peoples and their representative organisations. Furthermore, for the implementation of the Health Plan to be effective it must have a resources strategy and monitoring and accountability mechanisms.
72. The Campaign Steering Committee will continue to work with the NHLF as Health Plan is being developed. It will also actively monitor this process and the subsequent implementation of the Health Plan.

Appendix 1: Membership and a brief history of the Close the Gap Campaign Steering Committee

Who we are

Referred to in this report as the 'Campaign Steering Committee'.

Co-chairs

- Ms Jody Broun, Co-chair of the National Congress of Australia's First Peoples*
- Mr Mick Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, Australian Human Rights Commission

Members

- Australian Indigenous Doctors' Association*
- Australian Indigenous Psychologists' Association*
- Congress of Aboriginal and Torres Strait Islander Nurses*
- Indigenous Allied Health Australia Inc.*
- Indigenous Dentists' Association of Australia*
- National Aboriginal Community Controlled Health Organisation*
- National Aboriginal and Torres Strait Islander Health Workers' Association*
- National Association of Aboriginal and Torres Strait Islander Physiotherapists*
- National Coordinator — Tackling Indigenous Smoking (Dr Tom Calma - Campaign founder and former Aboriginal and Torres Strait Islander Social Justice Commissioner)
- National Indigenous Drug and Alcohol Committee
- The Lowitja Institute*
- Torres Strait Island Regional Authority*
- Australian College of Nursing
- Aboriginal Health and Medical Research Council
- Australian Human Rights Commission (Secretariat)
- Australian Medical Association
- Australian Medicare Local Alliance
- Australians for Native Title and Reconciliation
- The Fred Hollows Foundation
- Heart Foundation Australia
- Menzies School of Health Research
- Oxfam Australia
- Palliative Care Australia
- Royal Australasian College of Physicians
- Royal Australian College of General Practitioners
- Professor Ian Ring (expert adviser)

** Denotes additional membership of the National Health Leadership Forum of the National Congress of Australia's First Peoples.*

A brief history

Australia's peak Aboriginal and Torres Strait Islander and non-Indigenous health bodies, health professional bodies and human rights organisations operate the Close the Gap Campaign. The Campaign's goal is to raise the health and life expectancy of Aboriginal and Torres Strait Islander peoples to that of the non-Indigenous population within a generation: to close the gap by 2030. It aims to do this through the implementation of a human rights based approach set out in the Aboriginal and Torres Strait Islander Social Justice Commissioner's *Social Justice Report 2005*.¹⁴

The Campaign Steering Committee first met in March 2006. Our patrons, Catherine Freeman OAM and Ian Thorpe OAM, launched the Campaign in April 2007. To date, 186 000 Australians have formally pledged their support. In August 2010, 2011 and 2012 the National Rugby League dedicated a round of matches as 'Close the Gap' rounds, reaching around between 2.5 and 3.5 million Australians. Eight hundred and fifty community events involving 130 000 Australians were held on National Close the Gap Day in 2012.

The Campaign began to shape policy in 2007-08.¹⁵ Notably:

- COAG set six 'Closing the Gap' Targets, including to achieve Aboriginal and Torres Strait Islander life expectancy equality within a generation, and to halve the Aboriginal and Torres Strait Islander under-fives mortality rate gap within a decade; and
- Australian Government and Opposition party representatives including former Prime Minister Kevin Rudd and former Opposition Leader Dr Brendan Nelson signed the *Close the Gap Statement of Intent (Statement of Intent)* in March 2008 at the Campaign's National Indigenous Health Equality Summit. The current Prime Minister and Opposition Leader, along with the Greens, have indicated their parties' continuing support on subsequent occasions. It is a foundational document, guiding efforts to meet this aim of health equality for Aboriginal and Torres Strait Islander peoples. This should be reflected in the Health Plan

The Campaign has also provided significant impetus for the seven 'closing the gap' National Partnership Agreements agreed since November 2008. These have brought with them approximately five billion dollars in additional resources, including the \$1.57 billion attached to the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* that expires in June 2013.

Appendix 2: The National Health Leadership Forum

The NHLF is currently co-chaired by Ms Jody Broun, Co-chair of National Congress of Australia's First Peoples, and Mr Justin Mohamed, Chair of the National Aboriginal Community Controlled Health Organisation. The current members are (in alphabetical order):

- Australian Indigenous Doctors' Association;
- Australian Indigenous Psychologists' Association;
- Congress of Aboriginal and Torres Strait Islander Nurses;
- Indigenous Allied Health Australia Inc.;
- Indigenous Dentists' Association of Australia;
- The Lowitja Institute;
- National Aboriginal and Torres Strait Islander Healing Foundation;
- National Aboriginal and Torres Strait Islander Health Workers' Association;
- National Aboriginal Community Controlled Health Organisation;
- National Association of Aboriginal and Torres Strait Islander Physiotherapists;
and
- Torres Strait Regional Authority.

The NHLF draws on the Congress' structure to facilitate engagement and consultation with Aboriginal and Torres Strait Islander people, families and communities in relation to health matters. The NHLF now leads the Close the Gap Campaign for Indigenous Health Equality with Jody Broun and Mick Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, co-chairing the Campaign Steering Committee. Further information about the NHLF was provided in the 2012 Shadow Report,¹⁶ and in the Aboriginal and Torres Strait Islander Social Justice Commissioner's *Social Justice Report 2012*.¹⁷

Appendix 3: Policy commitments for the National Aboriginal and Torres Strait Islander Health Equality Plan

In 2008 the National Indigenous Health Equality Targets (CTG Targets) were adopted at the National Indigenous Health Equality Summit held in Canberra.¹⁸ The aim of the CTG Targets was to set down a consensus view from the Close the Gap coalition, of what would be needed to achieve the two COAG goals - halving the child mortality gap in ten years and eliminating the life expectancy gap by 2030. The logic was that five interlocking sets of targets needed to be defined:

- i. Partnership between governments and Aboriginal people (without which the targets would be unachievable);
- ii. The health status issues which were responsible for the child mortality gaps;
- iii. The health services required to tackle those health status issues;
- iv. Infrastructure requirements for those health services;
- v. Social determinants (still to be developed).

The CTG Targets were developed over a period of six months by working groups of the Close the Gap Campaign Steering Committee (Campaign Steering Committee). The working groups drew on the expertise of a wide range of health experts, in particular Aboriginal and Torres Strait Islander health experts.

In recognition of the CTG Targets potential usefulness in the development of National Aboriginal and Torres Strait Islander Health Plan, the Campaign Steering Committee has translated the CTG Targets into a list of policy commitments. This list constitutes a systematic analysis of what needs to be done to achieve the two COAG health goals, and as such represent key items for inclusion in Health Plan. The integrity and structure of the original CTG Targets remain and the logic of the targets allows for them to be attached to the policy asks and process targets.

The policy commitments outlined in this document constitute a systematic analysis of what needs to be done to achieve the two COAG health targets. They are also capable of being monitored to help ensure progress in addressing Aboriginal and Torres Strait Islander health inequality.

Policy Area 1 – Partnership

Goal – To enhance Aboriginal and Torres Strait Islander community engagement, control and participation in Aboriginal and Torres Strait Islander health policy and program development, implementation and monitoring.

- Establish a national framework agreement to secure the appropriate engagement of Aboriginal and Torres Strait Islander people and their representative bodies in the design and delivery of accessible, culturally appropriate and quality primary health care services.

- Ensure that nationally agreed frameworks exist to secure the appropriate engagement of Aboriginal and Torres Strait Islander people in the design and delivery of secondary care services.

Policy Area 2 – Health Status

Goal - To close the Aboriginal and Torres Strait Islander life expectancy gap within a generation and halve the mortality gap for Aboriginal and Torres Strait Islander children under five within a decade.

2.1 Maternal and Child Health

Goal – To halve the mortality gap for Aboriginal and Torres Strait Islander children under five within a decade.

- All Aboriginal and Torres Strait Islander women and children have access to evidence based universal centre based and home visiting mother and baby programs that are culturally secure. This also needs to include non- Aboriginal and Torres Strait Islander women having Aboriginal and Torres Strait Islander babies.
- The establishment of a national database on childhood hospital presentations for injury.

2.2 Chronic Disease

Goal - To improve the management and reduce adverse outcomes in chronic disease.

- All Aboriginal and Torres Strait Islander people have access to appropriate prevention programs and chronic disease services in line with approved clinical guidelines. Increase coverage and availability of specialist and allied health services including outreach to Aboriginal and Torres Strait Islander clients in ACCHSs and other urban, rural and remote settings.

2.3 Mental health and emotional and social wellbeing

Goal – To improve the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islanders to the same standards enjoyed by the majority of the Australian population and reduce the impact of mental disorders on patients and their families.

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan*, incorporating:
 - Resource appropriate mental health education, support and intervention services;
 - Support and resource appropriate mental health service provision across all areas of remoteness;
 - Support appropriate monitoring and standards of care for Aboriginal and Torres Strait Islander mental health patients; and
 - Ensure availability of effective treatments for all Aboriginal and Torres Strait Islander patients especially those in rural and remote areas.

2.4 Data

Goal – Achieve specified levels of completeness of identification in health records.

Goal – Develop a consistent and comparable standard of data for Aboriginal and Torres Strait Islander health across States and Territories.

- Urgently address the capacity of Australian governments to assess progress against the CAOG Close the Gap Target for life expectancy. This includes:
 - Addressing the reliability of recording Aboriginal and Torres Strait Islander status on health records and death certificates.
 - Improving regular reporting against supporting indicators.
- The aim is to have data quality, that meets AIHW standards, in all jurisdictions.

Policy Area 3 – Primary Health Care and Other Health Services

Goal – To ensure Aboriginal and Torres Strait Islander peoples have equal access to health services that are equal in standard to those enjoyed by other Australians; and that these services are commensurate to need.

3.1 Aboriginal Community Controlled Health Services

Goal - To increase access to culturally appropriate primary health care to bridge the gap in health standards.

- Develop, implement and resource a 5 year Capacity Building Plan for Aboriginal Community Controlled Health Services (including definition of core service, governance, capital works and recurrent support) to provide comprehensive primary health care to an accredited standard and to meet the level of need. Funding modelling is to be needs based as opposed to competitive funding. The capacity building plan must be based on needs based funding rather than competitive or submission based models.
 - Fund services by a single core of pooled funds for a minimum of 3 years at a time, and at least three times the per capita MBS utilisation by non-Indigenous Australians (with a rural and remote loading of up to an additional three times);
 - All ACCHSs have access to pharmaceuticals through Section 100 or its equivalent;
 - Capital works programs to assist Aboriginal communities wishing to develop a new ACCHSs are established;
 - Capital works programs for existing ACCHSs to maintain and manage standards of ACCHS facilities;
 - Established mechanisms for community engagement initiatives;
 - Resources are available to support the incorporation of new ACCHSs and good governance practices of all ACCHSs; and
 - Resources are available for appropriate equipment and technology for all ACCHSs.

3.2 Mainstream primary health care services

Goal - Improve the responsiveness of mainstream health services and programs to Aboriginal and Torres Strait Islander people's health needs.

- Develop national strategies to enhance the utilisation and relevance of the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) including through mainstream services, including uptake of the PIP Indigenous Health Incentive.
- Support to enable general practices to identify the Aboriginal and Torres Strait Islander status of their patients and to record and report data relating to this.
- State and Federal bilateral financing agreements to commit to health equity within mainstream programs, such as through public health or health care agreements.
- Systems for programs delivered through private general practices commit to health equity, including:
 - The Multi-Program Funding agreement between the Department of Health and Ageing and Medicare Locals in Australia have provisions to facilitate:
 - systematic engagement strategy for ACCHS and mainstream services to work together with Aboriginal and Torres Strait Islander guidance; and
 - best practice service delivery to Aboriginal Peoples and Torres Strait Islanders.
 - Include ongoing cultural safety training for Aboriginal and Torres Strait Islander people as a requirement for accreditation for all General Practice services; and
 - Develop and implement a charter for health providers detailing the level of service an Aboriginal and Torres Strait Islander patient will receive, including arrangements to ensure cultural issues are recognised and addressed within each service, [and] a system to provide interpretation and cultural support where necessary for patients.

3.3 *Maternal and child health services*

Goal - National coverage of maternal and child health services is provided.

- Commit to national coverage of culturally appropriate maternal and child health services for Aboriginal and Torres Strait Islander people.
- Develop, implement and resource a *National Health Plan for Aboriginal and Torres Strait Islander Mothers and Babies* encompassing the targets and processes detailed in the CTG targets document.
- Develop, implement and resource a national 'nutritional risk' scheme for at-risk mothers, infants and children.
- Develop, implement and resource health promotion programs targeting smoking and alcohol consumption in pregnancy.

3.4 *Aboriginal and Torres Strait Islander specific population programs for chronic and communicable disease.*

Goal - Enhance Aboriginal and Torres Strait Islander specific population programs for chronic and communicable disease.

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Chronic Disease Strategy* which 'close the gap' in excess disease.
- Develop, implement and resource coordinated Aboriginal and Torres Strait Islander peoples' Programs for tobacco control, alcohol and substance misuse, nutrition and physical activity.

Goal - Comprehensive and culturally appropriate oral health care services organised and coordinated on a regional basis.

- Develop, implement and resource an oral health program as an integral component of comprehensive primary health care including:
 - Community water fluoridation;
 - A coherent oral health promotion strategy; and
 - High quality, comprehensive and culturally appropriate oral health care services organised and coordinated on a regional basis.

Goal – To ensure Aboriginal and Torres Strait Islander adolescents and youth have equal access to health services that are equal in standard to those enjoyed by other Australian adolescents and youth; and that these services are commensurate to need.

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Adolescence or Youth Health Strategy* to make health services more accessible and appropriate to them.

Goal – To ensure Aboriginal and Torres Strait Islander men have equal access to health services that are equal in standard to those enjoyed by other Australian men; and that these services are commensurate to need.

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Men's Health Strategy* to make health services more accessible and appropriate to Aboriginal and Torres Strait Islander men.

Goal – Communicable disease programs implemented

- Develop, implement and resource a *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy* to reduce STI and HIV/Hepatitis C rates.
- The National Flu and Pneumococcal vaccine program is expanded to increase vaccine coverage.
- Develop, implement and resource a *National Rheumatic Fever/Heart Disease Strategy* for increased coordination between primary health care services and population health programs is developed to improve preventive interventions and access to surgery.
- Trachoma control programs are expanded through implementation of SAFE strategy.

3.5 *Mental health/ social and emotional wellbeing*

Goal - Improve access to timely and appropriate mental health care in PHCS and specialised mental health care services across the lifespan.

- To be developed as a component of a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* that is the subject of the policy ask under 2.3.

Goal – Build community capacity in understanding, promoting wellbeing and responding to mental health issues

- To be developed as a component of a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* that is the subject of the policy ask under 2.3.

Goal – Promoting mental health recovery.

- To be developed as a component of a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* that is the subject of the policy ask under 2.3.

Policy Area 4 – Infrastructure

Goal – To ensure primary health infrastructure for Aboriginal and Torres Strait Islander peoples is capable of bridging the gap in health standards by 2018.

4.1 The size and quality of the health workforce

Goal - Provide an adequate workforce to meet Aboriginal and Torres Strait Islander health needs by increasing the recruitment, retention, effectiveness and training of health practitioners working within Aboriginal and Torres Strait Islander health settings and build the capacity of the Aboriginal and Torres Strait Islander health workforce.

- Develop, implement and resource a *National Training Plan* for Aboriginal and Torres Strait Islander doctors, nurses, dentists, allied health professionals, AHWs, EHWs, etc. including:
 - Provide an additional 430 medical practitioners;
 - Provide an additional 1500 AHWs;
 - Develop a skilled alcohol and drug workforce; and
 - Develop a skilled oral health workforce.
- Develop, implement and resource a *Recruitment and Retention Strategy* to provide the required numbers for each discipline (medical, dental, nursing and allied health workers that include AHWs).
- Develop, implement and resource a strategy to train, recruit and retain a skilled and sufficient workforce for Aboriginal and Torres Strait Islander health including primary health care, allied health, specialists and hospital care.

Goal - Increase the quality of the health services and the workforce.

- Develop implement and resource a National Network of Centres of Teaching Excellence in every State and Territory to deliver high quality health services, providing multidisciplinary teaching and conduct applied research on improved methods of health service delivery.
- Ensure implementation of appropriate training on Aboriginal and Torres Strait Islander health including cultural safety in all relevant undergraduate and postgraduate curricula, including outside of health..
- Ensure that all new staff and existing staff providing services to Aboriginal and Torres Strait Islanders complete a relevant cultural safety training/security programme. Continue to update this on a 12/24 month basis for Continue Quality Improvement.
- Implement a program of work place and work force reform that implements a model that is based on care at the first level of competence.
- Establish programmes that increase the availability of a multi disciplinary and trans disciplinary workforce at the local level in Aboriginal and Torres Strait Islander health.

4.2 Mental health/social and emotional wellbeing workforce

Goal – Build an effective mental health/social and emotional wellbeing workforce.

- To be developed as a component of a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* that is the subject of the policy ask under 2.3.

4.3 *Housing, environmental health and health services capital works*

Goal – To immediately commence improvement of the most basic facilities within all existing Aboriginal and Torres Strait Islanders houses to ensure safety and access to critical health facilities.

- Ensure the development of a set of community level health service facility standards that are nationally agreed.
- Ensure that all community level facilities meet the health service facility standards.
- That adequate staff housing is available.
- Ensure that all community facilities have access to the appropriate equipment and technology necessary to deliver comprehensive primary health care to Aboriginal and Torres Strait Islander communities in a timely manner.
- Implement and resource the *National Aboriginal and Torres Strait Islander Housing Guide* principles.

Appendix 4: Close the Gap Statement of Intent

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.

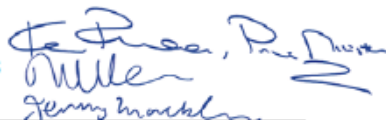
We are committed to working towards ensuring Aboriginal and Torres Strait Islander peoples have access to health services that are equal in standard to those enjoyed by other Australians and enjoy living conditions that support their social, emotional and cultural well-being.

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



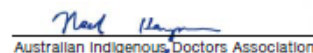
Congress of Aboriginal and Torres Strait Islander Nurses



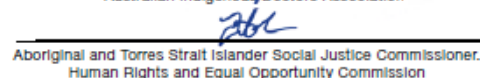
Indigenous Dentists Association of Australia



National Aboriginal Community Controlled Health Organisation



Australian Indigenous Doctors Association



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

CLOSE THE GAP

Indigenous Health Equality Summit STATEMENT OF INTENT

This Statement of Intent is supported by:

Brendan Nelson MP
Rosanna Capodacqua ANA

Adrian Hewitt *Adrian Hewitt's*

Michael Deane RA

Ed Copar Get Up!

Dr Kim HEART FOUNDATION

Suzanne ANTAH

Catharine Freeman Catherine Freeman Foundation

John Thompson Ian Thompsons Fountain for Youth

Vanessa Beetham RACGP.

Kate Cornell AGPN

R. J. PRACP.

Dr. J. S. AOTAA

Appendix 5: The right to health



The National Health Leadership Forum

Position paper: The right to health

The *Social Justice Report 2005* provides a comprehensive articulation of the right to health as it applies to Aboriginal and Torres Strait Islander peoples.¹⁹ This report formed the intellectual foundation for the Close the Gap Campaign for Indigenous Health Equality, from which the National Health Leadership Forum emerged out of, and continues to lead.

Human rights provide a framework for addressing the consequences of the health inequality experienced by Aboriginal and Torres Strait Islander peoples. This includes recognising the underlying causes of health inequality as well as the inter-connections with other issues. Human rights require more than a rhetorical acknowledgement of the existence of inequality and general commitments to overcome this situation at some unspecified time in the future. Ultimately, human rights standards provide a system to guide policy making and to influence the design, delivery and monitoring and evaluation of health programs and services. It is a system for ensuring the accountability of governments.

In addition to international obligations, through the *Close the Gap Statement of Intent* Australian governments have committed to adopting a rights based approach to health, including commitments to:

- Ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.
- Respecting and promoting the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable, and of good quality.²⁰

As a consequence, the National Health Leadership Forum posits that human rights standards should inform the development of the National Aboriginal and Torres Strait Islander Health Plan.

This paper will briefly examine four interrelated aspects of a rights based approach to health; a) non-discrimination, b) progressive realisation, c) the content of the right to health, and d) participation in decision-making.

A) Non-discrimination

Non-discrimination is a cornerstone of human rights, all people are entitled to be treated equally and enjoy their rights without discrimination. Australia's human rights obligations require it to take steps to redress inequality in the enjoyment of rights, such as the right to health.²¹ These actions are a form of differential treatment that is considered non-discriminatory. This is because they are aimed at achieving substantive equality or equality 'in fact' or outcome.

The principle of non-discrimination frames the right to health as a right of equal opportunities to be healthy; essentially the right to opportunities to be healthy. This includes the enjoyment of a variety of facilities (ie health infrastructure), goods (ie access to fresh food), services (ie access to doctors)

and conditions (ie social determinants) necessary for the realisation of the highest attainable standard of health. By necessity this requires an examination of health systems; governments have a duty to design such systems so that they accommodate difference.²² It should not be up to Aboriginal and Torres Strait Islander people to navigate their way through systems that do not take into account their particular needs and circumstances. The principle of non-discrimination therefore also incorporates addressing issues of structural racism within the health system.

B) Progressive realisation

Human rights standards acknowledge that some human rights (for example, the right to health for Aboriginal and Torres Strait Islander people) may be difficult to achieve in a short period of time. However, this difficulty does not excuse inaction. To the contrary, it creates an obligation to take deliberate, concrete and targeted steps to achieve the full realisation of the relevant right. This is known as the progressive realisation principle.²³ In relation to Aboriginal and Torres Strait Islanders peoples' right to health it demands governments:

- Develop a thoroughly worked out plan (taking into account all the major determinants of health inequality) to reach the goal of health equality; and
- Commit to a time frame for the achievement of health equality using ambitious but realistic targets or benchmarks to monitor progress over time.

C) The content of the right to health

Article 24(2) of the *United Nations Declaration on the Rights of Indigenous Peoples* (the Declaration) and article 12 of the *International Covenant on Economic, Social and Cultural Rights* recognises the right of Aboriginal and Torres Strait Islanders "to the highest attainable standard of physical and mental health", or the right to health. It can be understood to have four essential elements:

- **Availability.** Functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity within a country.
- **Accessibility.** Health facilities, goods and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:
 - *Non-discrimination:* health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination.
 - *Physical accessibility:* health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as Indigenous populations. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.
 - *Economic accessibility (affordability):* health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.
 - *Information accessibility:* includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
- **Acceptability.** All health facilities, goods and services must be respectful of medical ethics as well as respectful of the culture of individuals, minorities, peoples and communities,

sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

- **Quality.** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.²⁴

D) Participation in decision-making

Active participation in the decision-making is a fundamental component of a rights based approach. It is particularly important for Indigenous peoples who have historically been marginalised from such processes.²⁵ The Declaration states:

Article 18

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

Article 19

States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

To enable effective participation in decision-making, governments have obligations to ensure consultation and engagement processes have the objective of obtaining the consent or agreement of the Aboriginal and Torres Strait Islander peoples concerned.²⁶

The *Statement of Intent* articulates the right to participate in decision-making through a commitment to a partnership between Aboriginal and Torres Strait Islander peoples, their representatives and Australian governments that will underpin the national effort to address health inequality. To be effective, partnership must extend from the development stages of health planning, policy and programs through to their implementation and monitoring.²⁷ The formation of a partnership should be formalised through a framework agreement that articulates rules of engagement and has genuine power sharing arrangements. Attachment 1 provides more detail on partnership in relation to health.

Attachment 1: Position paper on achieving Aboriginal and Torres Strait Islander health equality within a generation

Articles 24(2) and 23 of the *United Nations Declaration on the Rights of Indigenous Peoples* state:

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

In relation to the achievement of Aboriginal and Torres Strait Islander health equality within a generation, this position paper is an expression of these rights by the following national Aboriginal and Torres Strait Islander health peak bodies and key stakeholders:

- Aboriginal and Torres Strait Islander Social Justice Commissioner of the Australian Human Rights Commission;
- Australian Indigenous Doctors' Association;
- Australian Indigenous Psychologists' Association;
- Congress of Aboriginal and Torres Strait Islander Nurses;
- Indigenous Allied Health Australia Inc.;
- Indigenous Dentists' Association of Australia;
- Lowitja Institute;
- National Aboriginal and Torres Strait Islander Healing Foundation;
- National Aboriginal and Torres Strait Islander Health Workers' Association;
- National Aboriginal Community Controlled Health Organisation;
- National Congress of Australia's First Peoples;
- National Coordinator, Tackling Indigenous Smoking; and
- National Indigenous Drug and Alcohol Committee.

These positions also reflect those agreed by the following national workshops, hosted by the Close the Gap Campaign for Indigenous Health Equality and attended by representatives from across the Aboriginal and Torres Strait Islander health sector and Australian governments:

- Close the Gap - National Indigenous Health Equality Summit, Canberra, March 2008;
- Close the Gap - Partnership in Action Workshop, Sydney, November 2008; and
- Close the Gap – Making it Happen Workshop, Canberra, June 2010.

1. Principles to underpin a national effort to achieve Aboriginal and Torres Strait Islander health equality

- Achieving Aboriginal and Torres Strait Islander health equality within a generation (health equality) is a national priority.
- The *Close the Gap Statement of Intent* is a foundational document, guiding efforts to meet this aim of health equality for Aboriginal and Torres Strait Islander peoples.
- The Statement of Intent commitments comprise an interdependent and coherent framework for achieving health equality and are not to be selectively interpreted or implemented. Therefore, the social and cultural determinants of Aboriginal and Torres Strait Islander health inequality must be addressed as a part of a national effort to achieve health equality, and within a national health equality plan.
- By meeting the commitments in the Statement of Intent, Australian governments will:

- adopt ‘best practice’ policy, targets and guidelines for achieving health equality, as supported by research findings and the evidence base;
- adopt the most efficient way of achieving health equality. Partnership, in particular, should be considered as an efficiency measure: helping to maximise the health outcomes from the resources available; and
- align their efforts with the human rights of Aboriginal and Torres Strait Islander peoples, including those set out in the *United Nations Declaration on the Rights of Indigenous Peoples*.
- To drive this national commitment, the Prime Minister should lead the effort for achieving health equality through COAG and partnership with Aboriginal and Torres Strait Islander peoples through their representative organisations. This collective leadership should enable and be accountable for achieving the:
 - vital intergovernmental and intersectoral cooperation needed to achieve health equality;
 - public sector to work in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, particularly when developing and implementing a health equality plan; and
 - national effort for health equality to be enhanced and be integral to the roll out of the National Health and Hospital Network (NHHN) and future reforms.
- Reflecting this, the Prime Minister should continue to report to the Parliament and the nation on efforts to ‘close the gap’ (including in relation to health outcomes) on the opening day or the first session of federal Parliament each year.

2. A partnership between Aboriginal and Torres Strait Islander peoples, their representatives and Australian governments

- A partnership between Aboriginal and Torres Strait Islander peoples, their representatives and Australian governments (partnership) must underpin the national effort to achieve health equality.
- The mechanism to achieve a sustainable partnership will be through;
 - the thirteen signatories (including the National Congress of Australia’s First Peoples) creating a single community partnership interface. The signatory bodies pledge to work together and engage with Australian governments as equal partners at the national level to progress health equality.
 - Australian governments creating a single government partnership interface that should include:
 - the Minister for Health and Ageing and the Minister for Indigenous Health;
 - the Minister for Indigenous Affairs; and
 - State and Territory Governments.
 - The support of all Opposition parties, minor parties and Independents for the partnership arrangements set out in this paper should be secured to ensure continuing political support for the achievement of health equality until 2030.
- The partnership should be formalised through a framework agreement that clearly articulates the *rules of engagement* between all parties, based on the *United Nations Declaration on the Rights of Indigenous Peoples*, paying particular attention to:
 - The Second Preambular paragraph *Affirming* that indigenous peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such.

- Article 3
Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
- Article 18
Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.
- Article 19
States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.
- Genuine sharing of decision-making power is essential to this partnership. This should be reflected in:
 - co-chairing arrangements between Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments in all partnership fora;
 - the agreement of quorums in partnership fora that ensure an agreed minimum level of Aboriginal and Torres Strait Islander representation at times of decision-making;
 - acknowledgement of Aboriginal and Torres Strait Islander leadership, experience and knowledge at all stages of the national effort to achieve health equality, including in relation to the development and implementation of a health equality plan; and
 - adequate resource allocations and flexibility in funding arrangements to the Aboriginal and Torres Strait Islander partnership organisations to enable them to participate effectively in the partnership.
- For specific issues within the domains of the peak bodies and stakeholders, engagement with those peak bodies and stakeholders would continue to occur.
- The National Indigenous Health Equality Council will continue to advise the Minister for Indigenous Health and the Minister for Health and Ageing.
- State and territory-level Aboriginal and Torres Strait Islander health forums would continue as before, with the affiliates of the National Aboriginal Community Controlled Health Organisation (NACCHO) who are parties connecting to the national level process through NACCHO's participation in the national forum.

3. The development of a health equality plan

- Several dimensions of health-related planning are needed in a national effort to achieve health equality: to address both health inequality itself, and its social and cultural determinants. The negative impact of racism, intergenerational trauma and disempowerment, in particular, must be addressed.
- A health equality plan development process should be efficient and not absorb unnecessary time or resources. The *National Aboriginal Health Strategy* (1989) and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003 – 2013) provide a starting point.
- A health equality plan must be 'owned' by both Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments. This reinforces the need for partnership as the basis for developing and implementing a health equality plan.
- Empowerment will be a vital contributor to health equality. Any policy or program under a health equality plan should be assessed as to how it will increase the ability of Aboriginal and Torres Strait Islander individuals, families and communities to take control of their own lives.

- The commitment to achieve Aboriginal and Torres Strait Islander health equality within a generation, and the approach to this set out in the Close the Gap Statement of Intent, must be embedded in all current and future health reform processes.

Content of a health equality plan

- The *Close the Gap National Indigenous Health Equality Targets, Overcoming Indigenous Disadvantage Framework* indicators and the *Aboriginal and Torres Strait Islander Health Performance Framework* provide a starting point for the agreement of the targets and sub-targets. The former has been developed by peak bodies and experts in the field of Aboriginal and Torres Strait Islander health.
- The plan should:
 - invest in and build Aboriginal and Torres Strait Islander leadership at all levels of the health system;
 - build the capacity and enhance the leadership of the Aboriginal and Torres Strait Islander Community Controlled Health Sector;
 - address the mental health and social and emotional well-being of Aboriginal and Torres Strait Islander peoples, including problematic alcohol and drug use;
 - address the social and cultural determinants of health; and
 - ensure data collections and other measures are in place to enable the effective monitoring of progress towards health equality, and an evaluation of the quality of the plan, over time.
- The Statement of Intent commitments to achieve Aboriginal and Torres Strait Islander health equality within a generation must be embedded in the NHHN reforms.
- A strong national Aboriginal and Torres Strait Islander leadership should oversee those parts of the national effort for health equality that will be delivered through the NHHN.

¹ A person is an Aboriginal and/or Torres Strait Islander if they can establish the three part definition:

- descent (the individual can prove that a parent is of Aboriginal and/or Torres Strait Islander descent);
- self-identification (the individual identifies as an Aboriginal and/or Torres Strait Islander); and
- Community recognition (individual is accepted as such by the Aboriginal and/or Torres Strait Islander community in which he/she lives).

² See Attachment 1 of Appendix 5: National Health Leadership Forum, *Position paper on achieving Aboriginal and Torres Strait Islander health equality within a generation* (2010), section 2.

³ See The Close the Gap Campaign Steering Committee, *Close the Gap Shadow Report 2011: On Australian governments' progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians* (2011), p 9. At http://humanrights.gov.au/social_justice/health/OAus-CloseTheGapShadowReport-0211.pdf?ref=593 (viewed 4 December 2012); The Close the Gap Campaign Steering Committee, *Close the Gap Shadow Report 2012: On Australian governments' progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians* (2012), p 16. At http://humanrights.gov.au/social_justice/health/OAus-CloseTheGapShadowReport-0212.pdf?ref=687 (viewed 4 December 2012).

⁴ T Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission (2005), chapter 2 (see particularly pp 48-57).

⁵ Defined in the survey as “treated unfairly in certain situations because they are Aboriginal or Torres Strait Islander”.

⁶ Australian Bureau of Statistics, *4704.0 - The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Social and Emotional Wellbeing: Discrimination* (2010). At <http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter450Oct+2010> (viewed 4

December 2012). See also VicHealth, *Mental health impacts of racial discrimination in Victorian Aboriginal communities, Experiences of Racism survey: a summary* (2012). At <http://www.vichealth.vic.gov.au/Publications/Freedom-from-discrimination/Mental-health-impacts-of-racial-discrimination-in-Victorian-Aboriginal-communities.aspx> (viewed 4 December 2012).

⁷ Australian Bureau of Statistics, above note 6.

⁸ Australian Bureau of Statistics, above note 6.

⁹ Department of Health and Ageing, *Development of a National Aboriginal and Torres Strait Islander Health Plan, Discussion Paper* (2012), p 2. At

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/natsihp-discussion-paper>

(viewed 4 December 2012). See also National Aboriginal Community Controlled Health Organisation, *Preliminary Briefing Paper 1 for the National Aboriginal and Torres Strait Islander Health Equity Council (NATSHEC) Roundtable for the development of a Aboriginal and Torres Strait Islander Health Plan Canberra 29 to 30 March 2012* (2012), Key Principle 1. At

http://www.naccho.org.au/download/aboriginal_health_plan-natsihp_consultation/NACCHO%20NATSHP%20Briefing%20Paper%20with%20intro%20from%20Justin%20Mohamed.pdf (viewed 4 December 2012).

¹⁰ National Aboriginal Community Controlled Health Organisation, above note 9, Key Principles 3 and 4.

¹¹ That is what does an effective service look like, how is it staffed and what does it achieve, operating/capital funding requirements etc. This could be based on E Tilton (Edward Tilton Consulting) and D Thomas (the Lowitja Institute), *Core functions of primary health care: a framework for the Northern Territory*, Northern Territory Aboriginal Health Forum (October 2011). At http://www.lowitja.org.au/sites/default/files/docs/Core_PHC_Functions_Framework_Oct_2011%5B1%5D.pdf (viewed 4 December 2012).

¹² T Vos, B Barker, L Stanley, AD Lopez, *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003* (2007), p 2. At

<http://www.lowitja.org.au/sites/default/files/docs/Indigenous-BoD-Policy-Brief.pdf> (viewed 4 December 2012).

¹³ National Aboriginal Community Controlled Health Organisation, above note 9, Key Principle 6.

¹⁴ T Calma, above note 4.

¹⁵ "Close the Gap" was adopted as the name of the human rights based campaign for Aboriginal and Torres Strait Islander health equality led by the Close the Gap Campaign Steering Committee in 2006. The term 'closing the gap' entered the policy lexicon as a result of the Close the Gap Campaign's activities and has since been used to tag COAG and Australian Government Aboriginal and Torres Strait Islander policy initiatives aimed at reducing disadvantage - from the COAG Closing the Gap Targets to the National Partnership Agreement to Closing the Gap on Indigenous Health Outcomes.

As a general rule, any initiative with "closing the gap" in the title is an Australian Government or COAG initiative. It is important to note that it does not necessarily reflect the human rights-based approach of the Close the Gap Campaign, nor does the use of the term reflect an endorsement of them by the Close the Gap Campaign Steering Committee.

¹⁶ The Close the Gap Campaign Steering Committee, *Close the Gap Shadow Report 2012*, above note 2, pp 16 – 19.

¹⁷ M Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2012* (2012), pp 199-205. At http://humanrights.gov.au/social_justice/sj_report/sjreport12/index.html (viewed 4 December 2012).

¹⁸ A copy of the Close the Gap Targets can be downloaded from:

http://www.humanrights.gov.au/social_justice/health/targets/index.html.

¹⁹ T Calma, above note 4, chapter 2 (see particularly pp 48-57).

²⁰ *Close the Gap Indigenous Health Equality Summit Statement of Intent* (2008).

²¹ These are actions are known as special measures. For example *International Convention on the Elimination of All Forms of Racial Discrimination*, 1965, article 2(1). For more information see Australian Human Rights Commission, *Guidelines to understanding 'Special measures' in the Racial Discrimination Act 1975 (Cth): Implementing 'special measures' under the Racial Discrimination Act 1975 (Cth)* (2011). At

http://www.humanrights.gov.au/racial_discrimination/publications/special_measures2011.html (viewed 5 June 2012).

²² See *United Nations Declaration on the Rights of Indigenous Peoples*, GA Resolution 61/295 (Annex), UN Doc A/RES/61/295 (2007), preambular paragraph 2.

²³ *International Covenant on Economic and Cultural and Social Rights*, 1966, article 2(1).

²⁴ Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the highest attainable standard of health*, UN E/C.12/2000/4 (2000), para 12; Calma, above note 4, pp 53-54.

²⁵ Expert Mechanism on the Rights of Indigenous Peoples, *Expert Mechanism advice No. 2 (2011): Indigenous peoples and the right to participate in decision-making* (2011), para 1. At http://www.ohchr.org/Documents/Issues/IPeoples/EMRIP/Advice2_Oct2011.pdf (viewed 5 June 2011).

²⁶ *Report of the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people*, James Anaya, Report to the Human Rights Council, 12th session, UN Doc A/HRC/12/34 (2009), para 65. For more detail on effective consultation and engagement processes also M Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Native Title Report 2010*, Australian Human Rights Commission (2011), chapter 3.

²⁷ Committee on Economic, Social and Cultural Rights, above note 24, para 54.