

# Shadow Report 2013

On Australian governments' progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians



# CLOSE THE GAP

Close the Gap  
Campaign  
Steering  
Committee



## Acknowledgments

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**Author:** Christopher Holland.

**Editors:** Andrew Meehan, Indigenous Rights Advocacy Lead, Public Engagement, Oxfam Australia; and Andrew Gargett, Acting Senior Policy Officer, Australian Human Rights Commission and Executive Officer, Close the Gap Campaign Steering Committee Secretariat and National Health Leadership Forum Secretariat.

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**Cover photograph:**  
Matthew Colbung, Benita Anderson and Dorinda Anderson, clients of the SWAMS mobile health clinic. Photographer: Jason Malouin/OxfamAUS.

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

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# Who we are

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*.<sup>1</sup>

The Close the Gap Campaign Steering Committee (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. 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,<sup>2</sup> signed the *Close the Gap 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. The *Close the Gap Statement of Intent* remains the touchstone of the Campaign and is reproduced on page 7.

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; and the \$564 million attached to the *National Partnership Agreement on Indigenous Early Childhood Development* that expires in June 2014.

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) established in August 2011 within Chamber 1 of the National Congress of Australia's First Peoples (Congress). The NHLF has established itself as the national representative committee for Aboriginal and Torres Strait Islander peak bodies who provide advice on health.

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

- Aboriginal and Torres Strait Islander Healing Foundation;
- 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 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 continues as the Indigenous leadership group of 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,<sup>3</sup> and in the Aboriginal and Torres Strait Islander Social Justice Commissioner's *Social Justice Report 2012*.<sup>4</sup>

### Clarification of the terms “Close the Gap” and ‘Closing the Gap’

“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 Campaign Steering Committee in 2006. The term ‘closing the gap’ entered the policy lexicon as a result of Campaign’s activities and has since been used to tag COAG and Australian Government Aboriginal and Torres Strait Islander policy-specific 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. There is a very important difference in the meaning and intention between ‘close the gap’ and ‘closing the gap’ and it is important to note that closing the gap 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 Campaign Steering Committee.



Laidley State High School students in conjunction with Kambu AMS spell out Close the Gap for National Close the Gap Day 2012. Photograph: Jason Malouin/OxfamAUS.

# Close the Gap Campaign Steering Committee

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

- Aboriginal and Torres Strait Islander Healing Foundation\*
- 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 Congress of Australia's First Peoples\*
- National Coordinator – Tackling Indigenous Smoking (Dr Tom Calma AO – 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
- ANTaR
- Australian Human Rights Commission (Secretariat)
- Australian Medical Association
- Australian Medicare Local Alliance
- 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.



# Executive Summary

## Meeting the commitment to achieve Aboriginal and Torres Strait Islander health equality by 2030 – a critical year ahead

This year marks the juncture of three critical developments that together will likely determine whether Aboriginal and Torres Strait Islander health equality is achieved by 2030:

- the scheduled completion and implementation of a *National Aboriginal and Torres Strait Islander Health Plan* (Health Plan) in mid-2013;
- the renewal with adequate funding of the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (Indigenous Health NPA) which expires on 30 June 2013; and
- the federal election – that must be held by 30 November 2013, and is an opportunity to strengthen multi-party, long-term commitment to closing the gap by 2030 and, crucially, the Health Plan over the long-term.

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. And the above three elements are essential to policy continuity and the achievement of health equality over that span of time.

The development of the Health Plan is off to a promising start, and the importance of the Plan as a potential driver of health equality cannot be underestimated. But its development cannot be understood as merely a renewal of the existing *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013* that also expires this year. The Health Plan should embody a new, rights-based and equality-focused mode of thinking and guide a multi-decade program of action if it is to be fit for purpose. Such a plan would be consistent with the multi-party commitment to close the gap by 2030.

The planning process must be robust enough to resolve the tension between developing a Health Plan that is visionary and ambitious and at the same time soundly practical: that identifies what is required, by when, who will provide it, and how will it be paid for. And that, in turn, requires partnership and the voices, expertise, leadership and experience of Aboriginal and Torres Strait Islander peoples to be central to the planning process. Such real and effective partnership is the greatest safeguard for ensuring the right plan is in place by the end of this year.

On 30 June 2013 the \$1.57 billion Indigenous Health NPA expires. Such agreements can be understood as the ‘fuel’ that would drive the Health Plan ‘vehicle’: by bringing significant funds to enable its implementation. But its expiration this year is but an arbitrary juncture in the multi-decade commitment required to close the gap. It is vital to the achievement of Aboriginal and Torres Strait Islander health equality that funding levels are at least maintained, if not increased, over the next agreement cycle and beyond.

The Health Plan must also enjoy multi-party support if it is to be effective over the next two decades. And in this federal election year, it is important to hold to the vision of what we can achieve through the Health Plan. Indeed all political parties must not only share the vision of achieving Aboriginal and Torres Strait Islander health equality within a generation but they must also support the plan to get us there. The Campaign Steering Committee will monitor closely the maintenance of multi-party support for ‘closing the gap’ and the Health Plan as the year progresses.

At this critical juncture we must build on the foundations for Aboriginal and Torres Strait Islander health equality that are in place. While it is still early days, there are many positive indications that progress towards health and life expectancy equality is occurring. If current trends continue, under-five mortality rates may fall within the range of the COAG Closing the Gap Target by 2018, though the relative lack of progress in recent years in reducing low birth weight births cause concern.

But child health is improving and a healthier child population means a healthier adult population. The roll out of the Tackling Indigenous Smoking initiative and the Indigenous Chronic Disease Package (ICDP), and the uptake of health checks by significant numbers of Aboriginal and Torres Strait Islander people, are encouraging. These initiatives, part of the Indigenous Health NPA, are too recent to be reflected in most outcome measures, but there are early indications they are starting to make a difference for the better. It is important they be given a chance to succeed over a greater time period than four years and that the momentum of program implementation is maintained. As outlined by the *Strategic Review of Indigenous Expenditure*:

The deep-seated and complex nature of Indigenous disadvantage calls for policies and programs which are patient and supportive of enduring change (including in the attitudes, expectations and behaviours of Indigenous people themselves). A long-term investment approach is needed, accompanied by a sustained process of continuous engagement.<sup>5</sup>

We must end 2013 with a fit-for-purpose Health Plan and the funding secured to implement it. The Health Plan must enjoy the support of all political parties if it is to guide the achievement of Aboriginal and Torres Strait Islander equality by 2030. This is within our grasp in 2013, and our political leaders and the nation as a whole must rise to the occasion.

#### **The Close the Gap Campaign Steering Committee calls for:**

- The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* to be renewed to ensure policy and program continuity past 2013, with funding maintained at least at the level allocated in 2012–13 adjusted for inflation.
- The maintenance and strengthening of the multi-party resolve and commitment to close the health equality gap by 2030 including commitment to the *National Aboriginal and Torres Strait Islander Health Plan* when it is completed. This should be supported by a long-term investment approach accompanied by a sustained process of continuous engagement.
- A systematic national address to the social determinants of Aboriginal and Torres Strait Islander health inequality as part of the *National Aboriginal and Torres Strait Islander Health Plan* development process, including an implementation of Recommendation 5 of the National Mental Health Commission *2012 National Report Card*.
- For closing the gap programs and related services to be quarantined from budget cuts across all federal, state and territory jurisdictions and for the reported recent cuts at a state/territory level to be renegotiated with Aboriginal and Torres Strait Islander peoples and their representatives so as not to impact these programs.
- Partnership between Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments to drive the development, implementation and monitoring of the *National Aboriginal and Torres Strait Islander Health Plan*.

# Introduction

In March 2008, the Australian Government and Opposition committed to the Close the Gap Campaign's blueprint for closing the health equality gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians – the *Close the Gap Statement of Intent*.<sup>6</sup>

In April 2008, the Australian Government committed to providing an annual report to Parliament on progress towards closing the gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians.<sup>7</sup> Each year the Campaign Steering Committee provides a complementary 'shadow' report representing its assessment of the Australian Government's progress against its commitments to achieving Aboriginal and Torres Strait Islander health equality. This is the Campaign Steering Committee's fourth shadow report.

In November 2008, the Australian Government announced almost five billion dollars in National Partnership Agreements including the \$1.57 billion Indigenous Health NPA to back up its commitments with an active program for achieving health equality.

The Indigenous Health NPA provides the 'fuel' (the funding) that drives the national effort to achieve Aboriginal and Torres Strait Islander health equality by 2030. Its renewal is essential to the implementation of the Health Plan.

**Part one** of this report assesses progress against the COAG Closing the Gap Targets for health equality. It maintains a focus on evaluating the implementation of the *Close the Gap Statement of Intent* commitments (particularly in relation to partnership and the ongoing development of the Health Plan). As a part of this it examines the renewal of the Indigenous Health NPA.

**Part two** examines developments in relation to partnership and planning. The development of the Health Plan is underway. It is essential that the Health Plan be developed in partnership with Aboriginal and Torres Strait Islander peoples and their representative bodies including the National Aboriginal Community Controlled Health Sector.



The Hon. Kevin Rudd MP (then Prime Minister), Hon. Nicola Roxon MP (then Minister for Health and Ageing), and Hon. Jenny Macklin MP, the Minister for Families, Housing, Community Services and Indigenous Affairs sign the *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

  
National Aboriginal Community Controlled Health Organisation

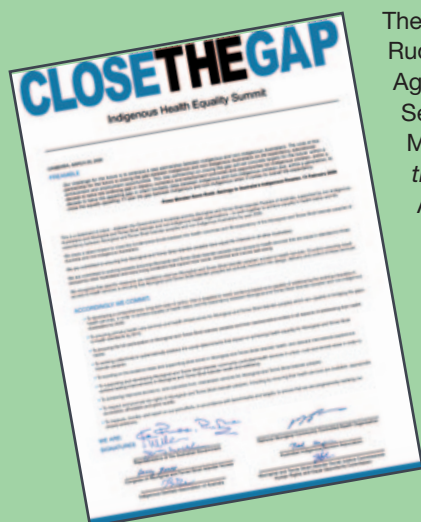
  
Congress of Aboriginal and Torres Strait Islander Nurses

  
Australian Indigenous Doctors Association

  
Indigenous Dentists Association of Australia

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

## Australian governments' commitments to achieving Aboriginal and Torres Strait Islander health equality



The *Close the Gap Statement of Intent* was signed on 20 March 2008 by Hon. Kevin Rudd MP (then Prime Minister); Hon. Nicola Roxon MP (then Minister for Health and Ageing); Hon. Jenny Macklin MP, the Minister for Families, Housing, Community Services and Indigenous Affairs; and Dr Brendan Nelson MP (then Opposition Leader). Most State and Territory Governments and Oppositions have also signed the *Close the Gap Statement of Intent* including Queensland, New South Wales, Western Australia, Australian Capital Territory, and Victoria.

In addition to the commitments in the *Close the Gap Statement of Intent*, the Australian Government and COAG have committed to the COAG Closing the Gap Targets, and a partnership approach to 'closing the gap' in Aboriginal and Torres Strait Islander disadvantage as a part of the *National Apology to Australia's Indigenous Peoples*. Further, the Australian Government has endorsed the *United Nations Declaration on the Rights of Indigenous Peoples* (Declaration). This includes recognition of rights relevant to achieving health equality. The Campaign Steering Committee welcomes these commitments which are summarised below.

	Commitment by	Commitment
<b>COAG meeting December 2007</b>	All Australian governments	COAG Closing the Gap Targets: <ul style="list-style-type: none"> <li>To close the Aboriginal and Torres Strait Islander life expectancy gap within a generation; and</li> <li>To halve the gap in mortality rates for the Aboriginal and Torres Strait Islander children under-five children within a decade.</li> </ul>
<b>National Apology to Australia's Indigenous Peoples February 2008</b>	Former Prime Minister Rudd for the Australian Government	"A commitment to a new partnership between the Australian Government and Aboriginal and Torres Strait Islander peoples: the core of this partnership for the future is the closing of the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities."
<b>Endorsement of the United Nations General Assembly Declaration on the Rights of Indigenous Peoples April 2009</b>	Australian Government	[Recognition of the following rights:] <ul style="list-style-type: none"> <li><b>Article 24(2)</b> – '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.'</li> <li><b>Article 23</b> – '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.'</li> <li><b>Article 18</b> – '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.'</li> <li><b>Article 19</b> – '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.'</li> </ul>

### ***UN Declaration on the Rights of Indigenous Peoples<sup>8</sup>***

The Declaration was adopted by the United Nations General Assembly on 13 September 2007. Australia signalled its formal support for the Declaration in April 2009.

The Declaration has 46 substantive articles and 24 preambular paragraphs. It does not create any new rights or legal standards under international law. Instead, it enunciates and explains the particular entitlement of Indigenous peoples to existing universal human rights standards under instruments such as the *United Nations Charter*, the *Universal Declaration of Human Rights*, and international human rights treaties.

The Declaration addresses both individual and collective rights. It recognises the obligation of States to protect Indigenous cultural rights and identity, the rights to education, health, employment, traditional languages, and the right to self-determination. It condemns discrimination against Indigenous peoples, and promotes their full and effective participation in all matters that concern them. It also ensures their right to remain distinct groups, and to pursue their own priorities in economic, social and cultural development based upon the principle of free, prior and informed consent.

Following its adoption by the General Assembly, the Declaration is now an active international legal instrument. According to the *United Nations Charter*, this means that all states are now bound to consider the Declaration in their dealings with Indigenous peoples. It provides the most authoritative guidance to States as to how their existing human rights obligations apply to Indigenous peoples.

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.<sup>9</sup>



Mick Gooda, Close the Gap Day, Parliament House Canberra. Photograph: Richard Kendall/OxfamAUS.



## Part 1:

# Progress towards the achievement of Aboriginal and Torres Strait Islander health equality within a generation



Kayne Hayes with GRAMS health worker Eric Dalgety. Photograph: Jason Malouin/OxfamAUS.

## 1. Progress against the COAG Closing the Gap Targets

It is important to note that the information in the COAG and other reports, mainly relates to the period leading up to Indigenous Health NPA which was introduced in 2009. These reports provide further information on why the initiative was introduced. However, it is still too early to have anything other than preliminary data available to assess the impact of the Agreement. Future reports will be progressively more able to monitor progress towards the COAG targets on closing the gap.

### Summary of progress against the COAG Closing the Gap Targets

- Based on a downward trend in death rates over 1998–2010, at this stage the Northern Territory is the only jurisdiction believed by the COAG Reform Council to be on track to meet the COAG Aboriginal and Torres Strait Islander life expectancy equality target by 2030. While in absolute terms the overall trend is to increasing Aboriginal and Torres Strait Islander longevity, the capacity of these gains to close the gap remains an issue.
- If current trends continue, under-five Aboriginal and Torres Strait Islander mortality rates may fall within the range of the COAG Target to halve the gap in under-five mortality by 2018. However the relative lack of progress in recent years and the widening differential on the critical factor of low birth weight cause concern.

In December 2007, COAG agreed two Closing the Gap Targets for achieving Aboriginal and Torres Strait Islander health equality in the *National Indigenous Reform Agreement* (NIRA),<sup>12</sup> the national framework for addressing Aboriginal and Torres Strait Islander disadvantage. They are:

- To close the gap in life expectancy within a generation. (“Within a generation” equates to “by 2030”, the date committed to by the Australian Government and Opposition in the *Close the Gap Statement of Intent*).<sup>13</sup>
- To halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five within a decade (by 2018).

### (a) Progress against the target to close the gap in life expectancy within a generation

Information as to whether Aboriginal and Torres Strait Islander life expectancy increased over 2008–12 – years when the Indigenous Health NPA and other National Partnership Agreements were established and became operational – will not be available until at least late 2013.<sup>14</sup> This means we are reliant on proxy indicators for life expectancy to assess whether the target is on track to being achieved.

### Where does the data come from?

At time of writing, the most current data source is the COAG Reform Council's report *Indigenous reform 2010–11: Comparing performance across Australia* (April 2012).<sup>10</sup>

The Steering Committee looks forward to the contribution of the National Health Performance Authority (NHPA) to future shadow reports. The NHPA was established in 2011 to provide nationally consistent information on the performance of healthcare organisations and health systems. The NHPA, when fully operational, will draw on a set of nearly 50 indicators that were agreed by COAG to measure the performance of hospitals and other health service providers.<sup>11</sup>

The most current data available will be approximately eight-years old by the time a new Aboriginal and Torres Strait Islander life expectancy estimate is available in late 2013. In 2005–07 – prior to the ‘closing the gap’ National Partnership Agreements – the life expectancy of Aboriginal and Torres Strait Islander males at birth was estimated to be 67.2 years, approximately 12 years less than for non-Indigenous males (78.7 years); for females it was estimated to be 72.9 years, 10 years less than that of non-Indigenous females (82.6 years).<sup>15</sup>

### **The censuses and Aboriginal and Torres Strait Islander life expectancy**

In 2009 the Australian Bureau of Statistics (ABS) began to estimate Aboriginal and Torres Strait Islander life expectancy over periods of three years (to utilise a larger deaths’ data pool) and to use the five-yearly Census of Population and Housing to verify the accuracy of the identification of Aboriginal and Torres Strait Islander people on death certificates.<sup>16</sup> One immediate result of this change in methodology was a reduction of approximately six-years in the estimated life expectancy gap. Prior to 2008, the life expectancy gap was estimated in the order of 17 years.<sup>17</sup>

Eighteen years remain until 2030, the year by which health equality is to be achieved. In that time a Census will be held in 2016, 2021, and 2026 (with a further Census held in 2031, with data from this being used to assess whether the target was met).

There is therefore a reliance on the Census which allows for only three points at which life expectancy can be assessed and the Health Plan adjusted, if necessary, prior to 2030. This is contrary to the enjoyment of the right to health by Aboriginal and Torres Strait Islander peoples which requires regular and accurate monitoring of outcomes in order to ensure (a) that targeted approaches to achieving health equality are working, and (b) that governments are accountable for the success or not of programs and policy.<sup>18</sup> Such monitoring is also of sound practical importance – ensuring that resources are optimally used, with failing or otherwise inefficient programs identified reasonably quickly.

### **Aboriginal and Torres Strait Islander peoples’ life expectancy compared with non-Indigenous population’s**

According to the United Nations 2011 Human Development Index, Australian (general population) life expectancy is the fifth highest in the world.<sup>19</sup> An Australian boy born in 2010 can expect to live an average of 79.5 years, while a girl can expect to live to 84.0 years. Since 1990, life expectancy has increased by approximately six years for men and approximately four years for women in the general population, contributing to the ageing of Australia’s population.<sup>20</sup>

As noted in last year’s shadow report, locating the life expectancy of Aboriginal and Torres Strait Islander peoples on the Human Development Index is problematic and should be undertaken with caution as methods for calculating life expectancy vary from nation to nation. Nonetheless it is illuminating that the life expectancy of Aboriginal and Torres Strait Islander peoples lines up with that of Trinidad and Tobago, Belarus, Suriname, Azerbaijan and Vanuatu – found at the lower end of the scale of “medium development” nations (i.e. just emerging from “low development” status). In terms of a ranking, this would place Aboriginal and Torres Strait Islander Australia at approximately 90–100th highest life expectancy of 180 nations.<sup>21</sup>

In 2011 the COAG Reform Council estimated that by 2031 Aboriginal and Torres Strait Islander life expectancy needs to increase by 20.6 years for males (from 67.2 to 87.8 years) and 15.9 years for females (from 72.9 years to 88.8 years) for equality with the rapidly increasing life expectancy of the general population to be achieved. This equates to an annual improvement of around 0.8 years for males and 0.6 years for females over the target period.<sup>22</sup>



## Proxy indicators for assessing improvements to Aboriginal and Torres Strait Islander life expectancy

There are currently seven supporting indicators for assessing improvements to life expectancy:

- Mortality rate by leading causes;
- Hospitalisation rates by principal diagnosis;
- Rates of current daily smokers;
- Average daily alcohol consumption and associated risk levels; rates of alcohol consumption at long-term risky to high risk levels;
- Levels of obesity;
- Level of physical activity; and
- Access to health care compared to need.<sup>23</sup>

A November 2011 review of the NIRA Performance Framework has recommended to COAG that these be reduced to four (and otherwise slightly modified). That is to:

- Mortality rate by leading causes;
- Rates of current daily smokers;
- Levels of risky alcohol consumption; and
- Prevalence of overweight and obesity.<sup>24</sup>

Hospitalisation data, for example, was recommended to be omitted because it is of only limited use as an indicator of changes to life expectancy, and cannot be used for comparisons over time without significant caution. For example, an increase in hospitalisation may indicate better access to treatment and therefore of improving population health or a decline in that more people are suffering illness for which hospitalisation is necessary.<sup>25</sup>

At the time of writing, COAG is yet to approve the above recommendation (although it is expected to) and the seven indicators remain. But of the seven *in practice* the COAG Reform Council to date has only reported against the mortality rate by leading causes, and on hospitalisation rates by principal diagnosis. In this report we confine our analysis to mortality rates given the problems with interpreting hospitalisation rate data.

### The proxy target – Closing the gap in mortality rates

The COAG Reform Council describes closing the gap in mortality rates by 2030 as providing a ‘proxy target’ for the COAG life expectancy target, and it is through measuring progress in relation to this indicator that progress in closing the life expectancy gap has been inferred to date.<sup>26</sup>

For its 2010–11 report the COAG Reform Council used mortality data from New South Wales, Queensland, South Australia and the Northern Territory – jurisdictions where deaths data is deemed reliable. In 2013 it is expected that Western Australian data will become reliable and can be used to flesh out a more representative national picture covering the majority of Aboriginal and Torres Strait Islander peoples in Australia.<sup>27</sup>

A mixed picture emerges about death rates in the four reliable jurisdictions depending on the baseline year adopted. In 2006 baseline data for mortality rates was established for the purposes of the NIRA. Against this baseline, the Council reports there were no significant changes in death rates between 2006 and 2010.<sup>28</sup>

Using 1998 baseline data in order to establish reliable longer-term trends is the preferred method of the COAG Reform Council. From 1998 to 2010 in New South Wales and South Australia there has been no significant change in Aboriginal and Torres Strait Islander death rates. This is in contrast to Queensland and the Northern Territory where death rates have significantly decreased.

However, the Queensland decrease was in absolute terms only, and – while welcome – was not enough to be closing the gap in relative terms.<sup>29</sup> The COAG Reform Council therefore reports that – assuming these trends continue – the Northern Territory is the only jurisdiction on track to close the gap by 2031.<sup>30</sup>

The COAG Reform Council highlight the following causes contributing to the gap in death rates based on 2009 data with particular inequalities evident in different jurisdictions:

- **Circulatory disease:** Aboriginal and Torres Strait Islander death rates are approximately twice as high as non-Indigenous rates in each of the four jurisdictions.
- **Cancers:** Death rates are higher overall but only significant in Queensland (1.4 times higher) and the Northern Territory (1.7 times higher).
- **External causes (eg accidents, suicide, assault):** Aboriginal and Torres Strait Islander death rates are higher overall but only significant in Queensland (1.6 times higher) and the Northern Territory (2.2 times higher).
- **Respiratory diseases (eg pneumonia, asthma, bronchitis):** The gap in death rates is only significant in New South Wales and Queensland – it was twice as high in both jurisdictions.
- **Endocrine, metabolic and nutritional disorders (eg diabetes):** In the Northern Territory Aboriginal and Torres Strait Islander peoples were seven times as likely to die of endocrine and related disorders. In Queensland it was nearly six times and in New South Wales it was nearly three times the rate of non-Indigenous Australians.<sup>31</sup>

It is important to keep in mind that the 1998–2010 mortality trends are based on data that includes only one year of the closing the gap programs (which commenced in 2009), and it is unrealistic to expect improvements to life expectancy as a result of these programs in such short time frames. Chronic diseases take many years to become established (in both individuals and population cohorts) and also many years to turn around. There are many foundation elements now in place to tackle chronic disease on a population-wide basis in Aboriginal and Torres Strait Islander peoples and, based on these, the Campaign Steering Committee is confident improvements to mortality and life expectancy can be expected to be measured over the coming years.



Dr Kim Peillon of GRAMS administers an ultrasound to Megan Roberts. Part of GRAMS' successful child and maternal health program. Photograph: Jason Malouin/Oxfam AUS.

## **(b) Progress against the target to halve the gap in mortality rates for Indigenous children under five within a decade**

The COAG Reform Council relies on a 1998 baseline to determine whether the under-five Aboriginal and Torres Strait Islander mortality target is being achieved, rather than the 2006 baseline that would provide a focus on the efficacy of the Indigenous Health NPA and the *National Partnership Agreement on Indigenous Early Childhood Development* (Indigenous Childhood NPA).

While data on under-five mortality is generally more reliable than that of death rates over 2006–10, there are still problems that prevent definitive monitoring. Due to the limited number of under-five deaths each year, the approach of the COAG Reform Council is to combine data from New South Wales, Queensland, Western Australia, South Australia and the Northern Territory and provide a national, rather than jurisdictional, picture. However, Western Australian deaths data (including that of under fives' deaths) is deemed unreliable for 2007 and 2009 and this has the combined effect of both excluding those years from having national counts and also preventing the creation of trajectories over 2006–2010 from which potential target achievement (or not) can be extrapolated.<sup>33</sup>

In all, over 2006–2010 there are significant limitations on measuring Aboriginal and Torres Strait Islander child mortality rates. The average death rate for Aboriginal and Torres Strait Islander children aged 0–4 years was highest in the Northern Territory (322.2 per 100,000 children) and lowest in New South Wales (157.4 per 100,000 children). The gap is, however, evident – the rate of death for under-five Aboriginal and Torres Strait Islander children was higher than for non-Indigenous children in each of the five jurisdictions.<sup>34</sup>

The fog clears somewhat when a longer-term perspective (from a 1998 baseline) is taken, as is the practice of the COAG Reform Council. Over 1998–2010 national death rates for Aboriginal and Torres Strait Islander children aged 0–4 decreased from 252.3 deaths per 100,000 children in 1998 to 202.6 per 100,000 children in 2010. But there was also a smaller decrease for non-Indigenous children from 113.3 to 94.8 per 100,000. Gains are therefore both absolute and relative and the gap trending towards closing. However, this conclusion rests on an unexplained apparent halving of child mortality between 1991 and 1998 and there has been little subsequent improvement. Indigenous child mortality has largely remained between 3.0 and 3.5 times higher than non-Indigenous child mortality since 1994. That said it is clear that there has been substantial improvement in child mortality and the Campaign Steering Committee welcomes this development.

Supporting indicators also give cause for optimism:

- The proportion of Aboriginal and Torres Strait Islander mothers who smoked during pregnancy, (which can be harmful to the fetus and the health of infants), decreased between 2007 and 2009 in all jurisdictions except New South Wales and Queensland. The largest decreases were in South Australia (6.1 percentage points) and the Northern Territory (5.6 percentage points). The rate for non-Indigenous mothers also decreased.<sup>35</sup>
- Aboriginal and Torres Strait Islander mothers' attendance at antenatal care at least once in the first trimester increased from 2007 to 2009 in New South Wales, South Australia and the Northern Territory where there was reliable data. The rate for non-Indigenous mothers, however, also increased.<sup>36</sup>

## **Fetal Alcohol Spectrum Disorders and low birth weight babies**

Fetal Alcohol Spectrum Disorders (FASD) result from *in utero* exposure to alcohol. They include life-long physical, behavioural and cognitive impacts. They also contribute to the higher rates of lower birth weight babies born to Aboriginal and Torres Strait Islander peoples. A 2007 study in far north Queensland estimated a FASD prevalence of 1.5 per cent in the Aboriginal and Torres Strait Islander child population, with a prevalence of 3.6 per cent in one community.<sup>32</sup>



In last year's shadow report we expressed concern<sup>37</sup> about a 13% increase in low birth weight babies born to Aboriginal and Torres Strait Islander mothers reported between 1991 and 2008,<sup>38</sup> but also anticipated improvements as a result of the closing the gap programs focusing on maternal health.

This year's shadow report is the first in which we are able to examine the post-2008 situation but it is still too early for most measures to be able to assess changes attributable to the Indigenous Health NPA. Some slight absolute reductions are evident: 10.9% of babies born to Aboriginal and Torres Strait Islander mothers were of low birth weight in 2009, a slight absolute reduction from 11.2% reported in 2007. Likewise, slight relative gains can be seen – the gap being 6.8% in 2007 and 6.4% in 2009.<sup>39</sup>

Failing to close this particular gap has ramifications for both the COAG child mortality and life expectancy target. Low birth weight babies are at greater risk of death before the age of five as well as poorer health across their life-span. The Campaign Steering Committee while welcoming this apparent progress, albeit slight, also notes that there is no room for complacency based on this one year 'trend'. A consistent, gap-closing long-term trend down in the rates of Aboriginal and Torres Strait Islander low birthweight babies needs to be established. Australian Government efforts including through the Indigenous Childhood NPA, must be maintained and increased over the coming decades. The resultant impact on education attainment and progression is also noted.

#### **The Close the Gap Campaign Steering Committee repeats its calls for:**

- An urgent address to the capacity of the Australian governments to assess progress against the COAG Closing the Gap Target for life expectancy.
- Australian governments to maintain and develop, as a part of the *National Aboriginal and Torres Strait Islander Health Plan*, targeted, long term initiatives, and specifically enhanced services for mothers and babies in relation to the achievement of the Close the Gap Target for under-five mortality, and to continue to monitor the rates of low birth weight babies being born to Aboriginal and Torres Strait Islander women.
- Life expectancy target trajectories to be included in the *National Indigenous Reform Agreement* and the *Overarching Bilateral Indigenous Plans* to ensure all jurisdictions are accountable for the achievement of the Closing the Gap life expectancy target.<sup>40</sup> It is particularly important that these trajectories are ready for the publication of the next Aboriginal and Torres Strait Islander life expectancy estimate in 2014 to enable progress towards closing the gap in life expectancy to be assessed.

## **2. Progress in relation to the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes***

As noted, the Indigenous Health NPA commits \$1.57 billion over four years from 1 July 2009 to 30 June 2013 to the achievement of Aboriginal and Torres Strait Islander health equality. The ICDP is an important component of the package addressing the single biggest killer of Aboriginal and Torres Strait Islander people – with chronic disease accounting for up to 80% of the mortality gap.<sup>41</sup> It aims to target health risk factors such as smoking and problem drinking; to improve chronic disease management and follow-up; expand the capacity of the Aboriginal Community Controlled Health Sector; and increase the Aboriginal and Torres Strait Islander health workforce.

In last year's shadow report we discussed the Australian Government's 2009–10 report on the ICDP. In October 2011 the Australian Government issued its second report for 2010–11 and from which the information presented here is drawn.<sup>42</sup> A third report is expected in early 2013.

To prepare this report, state and territory governments were asked three questions about the Indigenous Health NPA and the possible renewal process. Below is provided a summary table of their responses and the calls and comments of the Steering Committee.

Question	Summary of responses	Comments of the Steering Committee
<b>Can you identify the three most significant ways the Indigenous Health NPA has contributed to closing the life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous residents [in your jurisdiction]? How have they been effective?</b>	<ul style="list-style-type: none"> <li>Five out of eight jurisdictions highlighted the focus on chronic disease risk factors and reductions to smoking rates – by far the single greatest point of agreement.</li> <li>Three point to increased access to integrated primary health care services.</li> <li>Three cite the importance of partnerships with Aboriginal and Torres Strait Islander communities and across sectors as being of major importance.</li> </ul>	<ul style="list-style-type: none"> <li>Chronic disease programs implemented through the Indigenous Health NPA must be given the time to succeed through the renewal of the Indigenous Health NPA.</li> </ul>
<b>In what ways has the Indigenous Health NPA failed to deliver against its anticipated outcomes? What lessons can be incorporated into the next Indigenous Health NPA?</b>	<ul style="list-style-type: none"> <li>Five out of eight jurisdictions report that the four-year lifespan of the Indigenous Health NPA is incompatible with a generational effort to improve health outcomes. Longer funding periods were proposed. And frustration at being required to report in the short term (i.e. over four years) against long-term targets was also shared.</li> <li>Four cited the lack of coordination between Commonwealth and jurisdictional efforts.</li> <li>Three cited problems with the implementation phase of the Indigenous Health NPA with particular issues being recruiting staff, including Aboriginal and Torres Strait Islander staff, and services and programs developing in an unforeseen fashion after the Indigenous Health NPA Implementation Plan was agreed. This could result in a mismatch between the Indigenous Health NPA Implementation Plan and what was happening on the ground.</li> <li>One indicated the Indigenous Health NPA did not pay adequate attention to regional and urban Aboriginal populations.</li> </ul>	<ul style="list-style-type: none"> <li>A renewed Indigenous Health NPA should better support an effort for generational change by having a time-reach greater than four years.</li> <li>Greater flexibility in the development and implementation of a renewed Indigenous Health NPA is important to allow jurisdictions to cater to local and regional differences, and to support partnerships with Aboriginal and Torres Strait Islander peoples and their representatives at the state and territory level.</li> <li>Greater coordination across all levels of government for the implementation should feature in a renewed Indigenous Health NPA.</li> </ul>
<b>How will [your jurisdiction] ensure that Aboriginal and Torres Strait Islander peoples are able to partner in the negotiation of the new Indigenous Health NPA?</b>	<ul style="list-style-type: none"> <li>All jurisdictions indicate that they intend to draw on jurisdictional partnership and engagement arrangements and/or consult with Aboriginal and Torres Strait Islander peoples and their representatives in relation to the probable renewal of the Indigenous Health NPA. What is not clear is whether this will influence a renewed Indigenous Health NPA in the negotiation, or merely the implementation phase – as happened with the current Indigenous Health NPA.</li> <li>One jurisdiction indicated that the exclusion of Aboriginal and Torres Strait Islander peoples and their representatives from the negotiation of the current Indigenous Health NPA had been detrimental to the relationship of the government and the Aboriginal Community Controlled Health Sector in that State.</li> </ul>	<ul style="list-style-type: none"> <li>It is a human right of Aboriginal and Torres Strait Islander peoples to be involved, as partners, in decision-making that affects them. The COAG ‘Closing the Gap’ related-processes are among the most important. Yet these are currently the domains of the governments only: Aboriginal and Torres Strait Islander peoples are not recognised as partners; and vitally important areas of policy and planning are decided without them. The ‘contract’ underpinning COAG should be renewed to enable Aboriginal and Torres Strait Islander peoples and their representatives to participate in COAG in the same way that local government participates through the Australian Local Government Association. This should occur as quickly as possible – ideally prior to the renewal of the Indigenous Health NPA so that Aboriginal and Torres Strait Islander expertise and experience informs it.</li> </ul>

Chronic disease, as the name suggests, takes time to develop, and – equally – it takes time to recover from, or halt, its progress. It is therefore of particular importance to the long-term impact of the ICDP programs that they are sustained over time, in fact for many decades. The drive to reduce smoking rates through the Tackling Indigenous Smoking initiative of the ICDP, for example, must be allowed to until at least 2018 to reduce smoking rates in the Aboriginal and Torres Strait Islander population to at least half that in the general population.

It should not be forgotten that the dramatic reductions in smoking rates among Aboriginal and Torres Strait Islander peoples hoped for, took five decades to achieve in the non-Indigenous population – with sustained anti-smoking campaigns from the 1970s on leading to the pioneering of smoke free zones in the early 2000s. Initiatives such as uniform, brand-free packaging are continuing the drive to the present day.

And the Tackling Indigenous Smoking initiative/ICDP has delivered – including the ‘Break the Chain’ anti-smoking campaign directed specifically at Aboriginal and Torres Strait Islander peoples through television, radio and newspapers. Other initiatives include the roll out of Regional Tackling Smoking and Healthy Lifestyle Teams headed up by Regional Tobacco Coordinators to implement community-based prevention and education activities and referral to cessation support in Aboriginal and Torres Strait Islander communities – including local culturally appropriate and resonant anti-smoking campaigns and activities. Aboriginal Community Controlled Health Organisations, among others, host, train and support these teams. But these programs and efforts are only three years old, at maximum. If we are to close the gap in Aboriginal and Torres Strait Islander smoking rates then much more time and effort and consistent roll-out is needed. And similar programs that are focused on improving diet and raising awareness about chronic disease, including a revised ‘Live Longer’ type campaign, will also take time and involve generational behavioral change. These programs must be given the chance to succeed and that is why the Steering Committee is calling for the Indigenous Health NPA to be renewed, and for related programs to be quarantined from budget cuts.



Rabbitohs players, Dylan Farrell and Nathan Merritt with a young fan at the Redfern AMS for NAIDOC Week 2012.  
Photograph: Micheal Myers/OxfamAUS.



### **Mental health and social and emotional wellbeing**

The current plan for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing (MH&SEWB) is the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* (MH&SEWB Framework).

The MH&SEWB Framework has its strengths – for example, it places the Aboriginal Community Controlled Health Services (ACCHS) at the centre of MH&SEWB service-delivery.<sup>43</sup> However, it does not contain a plan of action to improve Aboriginal and Torres Strait Islander peoples' MH&SEWB. It also lacks an equality focus.

In the MH&SEWB space a *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan* (MH&SEWB Plan) is needed. Australian governments increasingly realise the importance of mental health to the nation as evidenced by the multi-billion dollar investments in MH&SEWB made in 2010 and 2011. In this context, placing Aboriginal and Torres Strait Islander peoples MH&SEWB at the centre of the Closing the Gap Agenda and developing a MH&SEWB Plan merely reflects the growing awareness of the importance of MH&SEWB to population health – but in an Aboriginal and Torres Strait Islander-specific context.

The MH&SEWB Framework is currently being renewed and a *Ten Year Roadmap for National Mental Health Reform* has been announced. With these reform processes underway, and a fluid policy space resulting, now is the ideal time to create a MH&SEWB Plan. Such a plan must be capable of operating independently with the MH&SEWB space, but that also sits seamlessly within the Health Plan.

Other promising initiatives include the Closing the Gap PBS Co-payment Measure – something that the Aboriginal Community Controlled Health Sector advocated strongly for and helped develop. Since commencing in July 2010 it has provided almost 80,000 eligible Aboriginal and Torres Strait Islanders with more affordable, and in some instances free, PBS medicines. This is a substantial proportion of the total Aboriginal and Torres Strait Islander population.<sup>44</sup> And the number of Aboriginal and Torres Strait Islander health checks for those aged 15 years and over was also taken up by significant numbers of Aboriginal and Torres Strait Islander peoples – approximately 50,000 in 2010–11: an increase of 64% over 2009–10 data.<sup>45</sup> The involvement of significant percentages of the total Aboriginal and Torres Strait Islander population in various ICDP programs bodes well for the achievement of health equality over time and shows the potential reach of a Health Plan and closing the gap overall, in terms of the numbers of Aboriginal and Torres Strait Islander peoples whose health that can be improved.

Through a focus on service delivery through ACCHS including community-driven and tailored health promotion and interventions within the context of a national approach, we have perhaps never been better poised to see a dramatic lowering to the rates of chronic disease in Aboriginal and Torres Strait Islander peoples than through the ICDP – but it must be allowed time to show results and take effect.<sup>46</sup> It is absolutely vital that the renewed Indigenous Health NPA and the ICDP are funded at least at 2012–13 levels from 2013 onwards to keep the momentum going.

### **The Close the Gap Campaign Steering Committee calls for:**

The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* to be renewed to ensure policy and program continuity, with funding maintained at least the same levels as allocated in 2012–13 adjusted for inflation.

### 3. Expenditure on Aboriginal and Torres Strait Islander health

In September 2012 the Productivity Commission released its second *Indigenous Expenditure Report* in which government health expenditure on Aboriginal and Torres Strait Islander peoples' health was reported to be \$4.7 billion, or 5.1 per cent of total government health expenditure in 2010–11.<sup>47</sup> This represents a significant increase on expenditure prior to the commencement of the Indigenous Health NPA in 2009–10.<sup>48</sup>

The Productivity Commission reported that 74% of Aboriginal and Torres Strait Islander health expenditure was through use of 'mainstream' (general population) health services, such as public hospitals and community health services, (the responsibility of State and Territory governments but co-funded by the Commonwealth). Aboriginal and Torres Strait Islander-specific services and programs, including those in the Indigenous Health NPA and the ACCHS, accounted for \$1.2 billion (26%) of health expenditure, and are mostly Commonwealth-funded.

Government health spending was \$8,190 per Aboriginal and/or Torres Strait Islander person and \$4,054 per non-Indigenous person in 2010–11 – a ratio of 2.02 to 1.<sup>49</sup> The Productivity Commission reports that the disparity arises because of Aboriginal and Torres Strait Islander peoples' greater reliance on public health services (including Aboriginal and Torres Strait Islander-specific services). For example:

- hospital services – \$2.22 was spent per Aboriginal and/or Torres Strait Islander person for every dollar spent per non-Indigenous person,<sup>50</sup> with almost 90% of the disparity attributed to greater use of the services relating to greater health needs;<sup>51</sup> and
- public and community health services – \$4.89 was spent per Aboriginal and/or Torres Strait Islander person for every dollar spent per non-Indigenous person.<sup>52</sup> The Productivity Commission attribute the disparity to two factors (a) greater service use related to greater health needs – to which 75% of the disparity is attributed and (b) the additional costs involved in providing Aboriginal and Torres Strait Islander-specific complementary health services – to which is attributed about 25% of the disparity.<sup>53</sup> In relation to the latter, higher costs are, in part, associated with the delivery of health services to remote and very remote communities – where a significantly higher proportion of Aboriginal and Torres Strait Islander people live compared to the non-Indigenous population.

Government spending, while substantial, is not the entirety of health spending in Australia. Significant private spending (for example on private health insurance) also occurs. When this is factored in, the disparities above can be expected to decrease.

The greater reliance on public health services also reflects Aboriginal and Torres Strait Islander peoples' lower access to Medicare subsidised GP-services (that are mostly private) and PBS-subsidised medicines. In 2010–11 only \$0.66 was spent per Aboriginal and/or Torres Strait Islander person for every dollar spent per non-Indigenous person in relation to subsidised health goods and services according to the Productivity Commission.<sup>54</sup>

Although data is not available for 2010–11, the Australian Institute of Health and Welfare has published information about total health spending in 2008–09. It found that \$1.39 was spent per Aboriginal and/or Torres Strait Islander person for every \$1.00 spent per non-Indigenous person. This ratio (1 to 1.39) was an increase from 1 to 1.31 in 2006–07.<sup>55</sup> When the significantly greater need for health services resulting from poorer health status is factored in (the Campaign Steering Committee estimates this at *at least* double as a general rule) the relative lack of total funding available for Aboriginal and Torres Strait Islander health is evident.

In the context of achieving Aboriginal and Torres Strait Islander health equality, 'false economies' must be critically examined – a dollar saved today may result in the need to spend many more in years to come. In fact the longer-term prospect is that spending on Aboriginal and Torres Strait Islander health will begin to reach parity with the non-Indigenous population as health equality is achieved (and the need for health services is reduced) but at this point in time spending must be maintained and even increased.

### Aboriginal Community Controlled Health Services

ACCCHS are considered by many stakeholders to be the preferred health services providers for Aboriginal and Torres Strait Islander peoples. ACCCHS embody Aboriginal and Torres Strait Islander peoples' right to self-determination as applied to health services as set out in the Declaration. They have a history of delivering improved health outcomes in communities where other health services have not.<sup>56</sup> ACCCHS are culturally competent services and employ high numbers of Aboriginal and Torres Strait Islander peoples as staff.<sup>57</sup> They are also best placed to offer traditional and innovative contemporary healing practices.

The expansion of the number of ACCCHS services to reach as many Aboriginal and Torres Strait Islander communities as possible should occur through a capacity building plan in the Health Plan.

Every dollar that can be redirected into primary health care services, and particularly to ACCCHS, from the public hospital system is money well spent. In a sense, it 'proactively' contributes to better health outcomes rather than being 'reactive' spending that does not drive health improvements.



Staff at GRAMS, Geraldton. Photograph: Jason Malouin/OxfamAUS.



### **Reports of damaging cuts to health services and closing the gap programs in New South Wales and Queensland**

In September 2012, the New South Wales Government announced savings of \$3 billion over four years to be made from NSW Health.<sup>58</sup> Major cuts are planned for what has been described as ‘health bureaucracy’. This means a significant downsizing of NSW Health’s corporate office with regional offices playing a greater governance role.<sup>59</sup>

The New South Wales Opposition Leader, John Robertson, warned the cuts could mean the loss of 3,600 jobs in the health sector. However, the New South Wales Government has indicated that cutting overtime, or not relying on locum doctors or agency nurses, could find savings: the decisions would be made by local health district authorities.<sup>60</sup>

Also in September 2012, the Queensland Government announced 14,000 job cuts across the public service. Aboriginal and Torres Strait Islander health programs, particularly preventive health programs so important to closing the gap, have not been spared.<sup>61</sup>

Cuts have been made to the number of Indigenous Sexual and Reproductive Health Officers, Indigenous Alcohol and Drug Prevention Workers, Indigenous Child Health Workers, Healthy Lifestyle Workers and preventative health positions. Community controlled organisations have felt these impacts the hardest as many of these positions were embedded within multi-disciplinary teams supporting overall improvements in chronic disease management in many communities.<sup>62</sup>

These cuts were met with alarm by stakeholders including the National Aboriginal and Torres Strait Islander Health Workers’ Association,<sup>63</sup> and the Queensland Aboriginal and Islander Health Council who also noted the lack of consultation in deciding which programs should be affected by the cuts.

Unfortunately, even though evidence suggests that the most significant gains in health outcomes are achieved through a multi-disciplinary approach in community controlled services, the reductions have been made despite the long-term impacts.

Because of the cost-benefits associated with greater spending on Aboriginal and Torres Strait Islander health in the shorter term to the end of achieving health equality in the long-term it is appropriate to speak of closing the gap spending as an ‘investment’.

The Campaign Steering Committee welcomes the additional expenditure associated with the Indigenous Health NPA evident in the 2010–11 data, and have already called for this level of expenditure to be maintained in this report. This means through the renewal of the Indigenous Health NPA at its 2012–13 funding level adjusted for inflation.

### **The Close the Gap Campaign Steering Committee calls for:**

For closing the gap programs and related services to be quarantined from budget cuts across all federal, state and territory jurisdictions and for the reported recent cuts at a state/territory level to be renegotiated with Aboriginal and Torres Strait Islander peoples and their representatives so as not to impact these programs.



Aaron Simon, Aboriginal Health Promotion Officer, Sydney South West Local Health District, in the Tharawal Aboriginal Corporation's community garden. Photograph: Nicola Bailey/[www.nicolabailey.com](http://www.nicolabailey.com)



## Part 2:

# Developments in relation to partnership and planning



Healthcare worker Steven Hayes and Benjamin Narkle at SWAMS clinic at St John Of God Hospital, Bunbury, Western Australia.  
Photograph: Bonnie Savage/OxfamAUS.



On 3 November 2011, the Ministers for Health and Ageing and Indigenous Health announced a process for the development of a Health Plan. It is essential that the Health Plan be developed in partnership with Aboriginal and Torres Strait Islander peoples and their representative bodies including the Aboriginal Community Controlled Health Sector. It is equally imperative that the Health Plan facilitates partnership in the delivery of health services.

## 1. Partnership

### (a) Developing the plan in partnership

The Health Plan is now in development under the direction of a 'Stakeholder Advisory Group' (SAG). The Campaign Steering Committee welcomes the establishment of the SAG within the parameters for partnership that had been established by the Campaign Steering Committee and adopted by the NHLF within the Congress. Such parameters were set out in an NHLF Position Paper that was included as an Appendix to the 2011 Shadow Report.<sup>64</sup> 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 and so on; and
- an agreed minimum level of Aboriginal and Torres Strait Islander representation – in this case, the agreement was majority Aboriginal and Torres Strait Islander membership.

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 coordination. It is also pleasing that there is representation on the SAG from a state and territory level through the Australian Health Ministers' Advisory Council (AHMAC).<sup>65</sup>

On 11 September 2012 the Australian Government released a Health Plan Discussion Paper. Its stated aim was "to start a conversation about the development of the Health Plan and important health issues for Aboriginal and Torres Strait Islander peoples."<sup>66</sup>

The Discussion Paper was designed to inform a nationwide series of 17 community consultations, including at least one in each State and Territory, and an additional consultation focusing on Aboriginal and Torres Strait Islander youth. In addition, a number of special consultations about MH&SEWB, drugs and alcohol, early childhood, cultural models and traditional healing and health systems are scheduled to take place in February and March 2013.

The Campaign Steering Committee welcomes the consultations for the Health Plan and the opportunities it offers for government to work in genuine partnership with Aboriginal and Torres Strait Islander peoples and their representatives at national, state/territory and regional levels. The NHLF had representation at each of the 17 consultations and the Co-Chairs attended as many consultations as possible. Such partnership has the potential to move beyond business as usual involving real participation in all stages of the development and implementation of the plan, from mapping a consultation process, drafting the consultation discussion paper, to drafting the plan based on those consultations.

### ***The Close the Gap Statement of Intent commits all signatories to the following in relation to partnership and planning:***

- 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 the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies, including the Aboriginal Community Controlled Health Sector, in all aspects of addressing their health needs.

In preparing this report, state and territory governments were also asked two questions pertaining to planning for Aboriginal and Torres Strait Islander health equality. These responses are summarised below, again with the comments of the Steering Committee.

Question	Summary of responses	Comments of the Steering Committee
<b>Given the need for a long-term commitment when addressing chronic disease, how will [your jurisdiction] ensure policy continuity between the Indigenous Health NPA and a renewed Indigenous Health NPA so that any gains are not lost?</b>	<ul style="list-style-type: none"> <li>• Six out of eight jurisdictions cited their longer-term jurisdictional Aboriginal and Torres Strait Islander health plans (and related strategies) as encompassing the renewal of the Indigenous Health NPA – potentially for an extended period.</li> <li>• Two indicated that they were active in lobbying the Commonwealth for renewal of the Indigenous Health NPA.</li> </ul>	<ul style="list-style-type: none"> <li>• Since 2008, Indigenous Health NPA-implementation has driven much state and territory-level Aboriginal and Torres Strait Islander health planning but, unlike the Indigenous Health NPA, these plans have generational time reach (for example, Queensland's <i>Making Tracks</i> framework has a reach until 2033).<sup>67</sup></li> <li>• Relying on longer-term jurisdictional plans to ensure continuity across NPAs appears to be an effective approach to the challenge of working with shorter-term NPAs. However, a weakness in this approach is that it, in turn, relies in a circular fashion on the renewal of the Indigenous Health NPA – without which the sustainability of such plans is in doubt.</li> <li>• As called for above, the Indigenous Health NPA should (a) be renewed and (b) be renewed with as long a time-reach as possible – acknowledging the need for continuity so state and territory plans and, more generally, chronic disease programs – have a chance to be effective over the longer term.</li> </ul>
<b>How will you ensure that the development of a Health Plan is coordinated with your jurisdictional Aboriginal and Torres Strait Islander health planning and efforts to close the gap?</b>	<ul style="list-style-type: none"> <li>• Two states are using their membership of the AHMAC and their AHMAC-representative role on the SAG developing the Health Plan to ensure planning is coordinated. One is also using their membership of the National Aboriginal and Torres Strait Islander Health Equality Council to that end.</li> <li>• Two states indicate they are participating through other consultation processes.</li> <li>• Three states are lobbying the Commonwealth for the Health Plan to reflect state and territory-level planning.</li> </ul>	<ul style="list-style-type: none"> <li>• Coordinating the Health Plan with state and territory-level plans is an important task facing the SAG and the Australian Government in developing the Health Plan. Just as it is important that Aboriginal and Torres Strait Islander stakeholders feel a sense of 'ownership' of the Health Plan, so too states and territories must be included in the development process and have their voices heard in it.</li> <li>• The Committee welcomes the opportunities States and Territories have to participate in the Health Plan development process.</li> </ul>



Kacey Narkle at SWAMS clinic at St John Of God Hospital, Bunbury, Western Australia. Photograph: Bonnie Savage/OxfamAUS.

A shared sense of ‘ownership’ of the Health Plan between Australian governments and Aboriginal and Torres Strait Islander peoples and their representatives (including the ACCHS sector) is a critical outcome of 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 at the national, state/territory, regional and local levels from the start and believe this must continue throughout all stages of the planning and implementation of the Health Plan.

## **(b) Partnership in the delivery of health services**

The delivery of health services is a critical area for partnership. To that end, the Campaign Steering Committee have, since 2008, called for 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 and secondary health care services.<sup>68</sup> The Health Plan offers an opportunity to embed a national framework agreement on partnership on health services into the policy space.

While consistency is usually the goal of a national framework agreement, the need for flexibility to accommodate different jurisdictional circumstances is equally important, as is the recognition and accommodation of the developed, functioning partnerships that already exist at the state, territory and regional levels.

The partnership framework at the state and territory level could, for example, build on the existing partnership models that were discussed in last year’s shadow report (for example, the Queensland Aboriginal and Torres Strait Islander Health Partnership; the partnership arrangements in the Victorian Indigenous Affairs Framework; and the South Australian Aboriginal Health Care Plan Implementation Committee).<sup>69</sup>

Regional partnership bodies for health planning, such as Regional Closing the Gap Committees in Victoria, were also noted in last year’s shadow report.<sup>70</sup> The importance of such bodies will likely increase with the roll out of the Medicare Locals – which have the potential to make a significant contribution to Aboriginal and Torres Strait Islander health equality.

In particular, the relationship of Medicare Locals and ACCHS within Medicare Local jurisdictions needs to be defined to ensure there is no duplication of services – and also unnecessary competition between them. This is essential to ensure a smooth patient journey between and within health service providers. Partnership arrangements are ideal vehicles to resolve these issues. And where there are significant Aboriginal and Torres Strait Islander populations, Aboriginal and Torres Strait Islander leadership in these arrangements is essential if the programs are to be as effective and appropriate as possible for the people for whom the services are provided.

For example, the Multi-Program Funding agreement between the Department of Health and Ageing and Medicare Locals in Australia should 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.

The National Aboriginal and Community Controlled Health Organisation has started to explore the potential of such partnerships with the Australian Medicare Local Alliance, the peak body for Medicare Locals. The ACCHS sector is also looking to develop its capacity through these arrangements rather than through the traditional competitive funding processes that tend to place under-resourced ACCHS at a disadvantage. Such arrangements could be guided by a flexible framework agreement between the two bodies.



Partnership is a fundamental element of the Close the Gap Campaign's approach to achieving Aboriginal and Torres Strait Islander health equality. It is not something that can be 'added on' after the event. Not only is it a key element of the right to health of Aboriginal and Torres Strait Islander peoples, but it is also the best way of ensuring the Health Plan is both ambitious and yet practical enough to achieve health equality by 2030, and also that Aboriginal and Torres Strait Islander peoples 'own' the Health Plan from the start. From the writing of discussion and other papers, to consultations, to plan writing, to plan-sign off, and to implementation and beyond, real and effective partnership must underpin the decades of hard work ahead if we are to achieve Aboriginal and Torres Strait Islander health equality by 2030.

**The Close the Gap Campaign Steering Committee call for:**

Partnership between Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments to drive the development, implementation and monitoring of the *National Aboriginal and Torres Strait Islander Health Plan*.

## 2. Planning

### **(a) The Health Plan development process is more than the renewal of the National Strategic Framework for Aboriginal and Torres Strait Islander Health**

One challenge that the Campaign Steering Committee perceive as the Health Plan development process commences is that it is incorrectly understood as a 'routine' renewal of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013* (NSF) rather than the start of an entirely new way of doing business in Aboriginal and Torres Strait Islander health – with the ambitious goal of achieving Aboriginal and Torres Strait Islander health equality by 2030. In particular, the reach of the Health Plan requires a break with past thinking. Planning for generational change requires a long-term vision that transcends funding cycles, short term policy fixes and the fortunes of governments and political parties.

The Health Plan should address Aboriginal and Torres Strait Islander health in a holistic and comprehensive manner – including MH&SEWB, and a full address to the social determinants of health. In its submission to the Health Plan the Campaign Steering Committee recommended that the Australian Government develop, implement and resource a MH&SEWB Plan that fits seamless within the overall Health Plan but could also operate independently within the MH&SEWB space.<sup>71</sup> The MH&SEWB Plan should also contain the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* in development, as well as a renewed *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complimentary Action Plan 2003–2009*. In reference to MH&SEWB, the Campaign Steering Committee supports the implementation of Recommendation 5 of the *National Mental Health Commission 2012 National Report Card*.<sup>72</sup>

In June 2010, in preparation for its 'Close the Gap – Making it Happen' national workshop, the Campaign Steering Committee established a number of criteria or principles that the Health Plan should embody. This was in addition to content such as an address to chronic disease and its determinants: smoking and alcohol misuse, etc. At the same time, we assessed the NSF against these criteria. We republish these in slightly modified form here. The Campaign Steering Committee believes that the Health Plan must not simply be a renewal of the NSF. Ambition, new ways of doing business and innovative ways of thinking are required if the Aboriginal and Torres Strait Islander health gap is to be closed by 2030.

Criteria	How the Health Plan must differ from the <i>National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013</i>
<p><b>Ambition</b></p> <p>COAG have committed ‘to close the gap in life expectancy within a generation’. An equally ambitious and focused plan is necessary to realise this target.</p>	<p>The NSF lacks ambition, nor does it aim for equality. Rather it aims to ‘reduce’ relative deprivation, ‘improving wellbeing’, and ‘improve access’ to ‘commensurate’ or ‘comparable’ levels with the non-Indigenous population.</p>
<p><b>Time reach</b></p> <p>The Health Plan should account for the period up and until 2030.</p>	<p>The NSF expires in 2013 and is tied to ten-year policy cycles. The new Health Plan must, while being flexible, support a sustained effort for 20 years with short, medium and long-term time frames.</p>
<p><b>Financing</b></p> <p>A major problem with past planning around Aboriginal and Torres Strait Islander health relates to the adequacy of resources attached to the plans. A resource strategy is an essential part of a Health Plan.</p>	<p>There are no resources attached to the NSF, or resource strategy. This is a vital part of the Health Plan and should include continued and greater funding for the ACCHS to support an expansion in its capacity.</p>
<p><b>Sub-targets/time frames</b></p> <p>Without these embedded in the Health Plan the COAG Closing the Gap Targets are unlikely to succeed in galvanising the breadth of the Aboriginal and Torres Strait Islander health space, and beyond, to the task of achieving health equality.</p>	<p>The NSF was completed in a policy environment which did not include a commitment to targets. While the NSF contains important aims that would support the setting of targets, it does not set targets. A range of sub-targets is needed to do this in the Health Plan – such as the CTG <i>National Indigenous Health Equality Targets</i>. Other targets/performance indicators already in the policy space would also be evident in a plan. The <i>Aboriginal and Torres Strait Islander Health Performance Framework</i> provides an excellent basis to measure progress towards targets and has existing measures that will allow this to occur in the Health Plan.</p>
<p><b>Data issues</b></p> <p>Long-standing data issues must be addressed to make the setting of targets a meaningful process. They are also vital to ensuring accountability.</p>	<p>THE NSF does not include targeted strategies to rapidly address current problems with data. The Health Plan will need to.</p>
<p><b>Rights based</b></p> <p>The Health Plan should reflect and acknowledge the right to health and the human rights framework including the Australian Government’s support for the Declaration.</p>	<p>NSF does not explicitly reflect the right to health and the human rights framework, nor is it explicitly linked to an equality framework. The Health Plan should be explicitly based on rights based approaches (see below).</p>
<p><b>Marginalised and vulnerable groups</b></p> <p>Ensuring such groups are covered by a Health Plan is essential if Aboriginal and Torres Strait Islander health equality overall is to be achieved (prisoners, adolescents, Stolen Generations, aged people, remote living, etc).</p>	<p>While mentioned in the NSF, there are no explicit commitments to deliver improvements to the health of marginalised groups within the Aboriginal and Torres Strait Islander population. The Health Plan should do so.</p>

Criteria	How the Health Plan must differ from the <i>National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013</i>
<p><b>Comprehensiveness/ greater focus on MH&amp;SEWB</b></p> <p>In addition to all key health issues, ensuring all the key social and cultural determinants of poorer health and the priority health issues are addressed is common sense if health equality is to be achieved. MH&amp;SEWB has long been the ‘poor cousin’ of health and needs a detailed treatment in the Health Plan.</p>	<p>Through its ‘Aims’ and ‘Priorities’, the NSF addresses life expectancy, mortality and infant mortality; chronic diseases; communicable disease; substance misuse, mental disorder, stress, trauma and suicide; injury and poisoning; family violence, including child abuse and sexual assault; child and maternal health and male health. Much of the content of the NSF remains relevant in the current policy environment, but could be strengthened. In particular, MH&amp;SEWB and substance use require considerable strengthening despite the development of the MH&amp;SEWB Framework.</p>
<p><b>Partnership in development and implementation</b></p> <p>Aboriginal and Torres Strait Islander peoples are best placed to understand the health issues in their communities. Otherwise a ‘top down’ approach has not worked in many areas of Indigenous affairs.<sup>73</sup></p>	<p>The NSF was created in a vastly different environment in terms of partnership options. The Health Plan must contain provision for a national framework agreement on partnership and embody partnership in its development and implementation.</p>
<p><b>Building the capacity of the ACCHS</b></p> <p>An adequate plan must contain a capacity building strategy for the ACCHS.</p>	<p>While acknowledging the key role of the ACCHS in securing better health outcomes for Aboriginal and Torres Strait Islander peoples, the NSF does not include a capacity building plan for ACCHS. The Health Plan should do so.</p>

Mentioned in the table above was a reference to the key role of the right to health in the development of a Health Plan. The right to health did not feature adequately in the Discussion Paper.<sup>74</sup>

The entire approach of the Close the Gap Campaign and the *Close the Gap Statement of Intent* is based on the right to health. This is no less practical and pragmatic than other approaches. Rather, anchoring the plan to human rights has important and concrete ramifications. Not only does it require governments to plan for the progressive realisation of health equality between population groups within its jurisdiction, and particularly so when inequality is the result of historical racial discrimination, but it also obliges the use of targets to enable the achievement of equality to be time-bound while keeping governments accountable.<sup>75</sup> The right to health embodies the ambition that the Campaign Steering Committee calls for the Health Plan to contain. The Campaign Steering Committee’s submission to the Health Plan called for an explicit adoption of a rights-based approach to Aboriginal and Torres Strait Islander Health.<sup>76</sup>

#### **The Close the Gap Campaign Steering Committee call for:**

A systematic national address to the social determinants of Aboriginal and Torres Strait Islander health inequality as part of the *National Aboriginal and Torres Strait Islander Health Plan* development process, including an implementation of Recommendation 5 of the National Mental Health Commission 2012 *National Report Card*.



## (b) Plan Content

In March 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 Closing the Gap Targets discussed previously – halving the child mortality gap in ten years and closing the life expectancy gap by 2030. The logic was that five interlocking sets of targets needed to be defined in relation to:

- partnership between governments and Aboriginal people (without which the targets would be unachievable);
- the health status issues which were responsible for the child mortality gaps;
- the health services required to tackle those health status issues;
- infrastructure requirements for those health services; and
- social determinants.<sup>77</sup>

Prior to the Summit, the CTG Targets were developed over a period of six months by working groups of the 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 their potential usefulness to the development of Health Plan, the Campaign Steering Committee has translated the CTG Targets into a list of policy commitments.<sup>78</sup> This list constitutes a systematic analysis of what needs to be done to achieve the two COAG Closing the Gap Targets, and as such represents key content for inclusion in the 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 commitments.



Tania Hill, HACC worker at SWAMS, Bunbury Western Australia. Photograph: Bonnie Savage/OxfamAUS.

In addition to incorporating these policy commitments in the Health Plan the Campaign Steering Committee made a number of recommendations in our submission to the Health Plan. These include embedding the *Close the Gap Statement of Intent* into the Health Plan and ensuring that the Health Plan tackles racism, both at the individual and systemic levels.<sup>79</sup>

The development of the Health Plan is off to a promising start. And its importance as a potential driver of health equality cannot be underestimated. Developing a Health Plan that is visionary and ambitious in the long-term and at the same time soundly practical: that identifies what is required, by when, who will provide it and how it will be paid for, are challenges for the planning process. The Health Plan is a highly complex planning task and as such, needs the involvement of those with the necessary health planning expertise and cannot be allowed to be a 'business as usual' document.

And that, in turn, requires partnership and the voices, expertise, leadership and experience of Aboriginal and Torres Strait Islander peoples to be heard from the centre of the planning process, including from the ACCHS sector. Such real and effective partnership is the greatest safeguard for ensuring the right plan is in place by the end of this year.

### 3. Implementation of the plan – the need for adequate funding and innovative models of service delivery

As noted already, a Health Plan without a resources strategy for the longer term and otherwise allocated funding is not a plan in any meaningful sense and would fail to meet the Campaign's criteria for a health equality plan that would operate over the next two decades. In an era of fiscal constraint, just as new ways of thinking and doing business should characterise the Health Plan, so too must new ways of thinking about funding be considered. There are two main sources of funding for the Health Plan that are obvious to the Campaign Steering Committee and that can feature in a resources strategy:

- the renewal of the Indigenous Health NPA in July 2013 and the Indigenous Childhood NPA in July 2014; and
- securing an equitable share of mainstream (general population) health funding and programs for Aboriginal and Torres Strait Islander health equality.

We have already called for the renewal of the Indigenous Health NPA at its current level of funding, adjusted for inflation. But there is also a need to think creatively about ways Aboriginal and Torres Strait Islander peoples can benefit from mainstream funding in ways that contribute to the achievement of health equality.

An interesting model to consider has arisen from the Tier 2 Aboriginal and Torres Strait Islander-specific components of the Access to Allied Psychological Services (ATAPS) program in the mental health space.

In the context of this program, the Aboriginal and Torres Strait Islander Mental Health Advisory Group to the Department of Health and Ageing recommend that all Medicare Locals delivering ATAPS services enter an MOU or contractual service arrangement with their local ACCHS. We have already discussed these in broader terms, but in this specific instance it is to ensure that ACCHS and private Aboriginal and Torres Strait Islander psychologists and psychiatrists be the providers of first choice for the delivery of culturally appropriate short-term psychological strategies to Aboriginal and Torres Strait Islander peoples.<sup>80</sup>

But the scope for such agreements could of course be broader. Medicare Locals could, for example, deliver outreach specialist mental health services through ACCHS when the ACCHS itself lacks the capacity to provide the service in-house. Such agreements could also include fee-arrangements for the delivery of local level cultural awareness training by ACCHS to ATAPS service providers as a component of ensuring mainstream services are culturally competent. Partnership agreements and MOUs would clearly specify roles, responsibilities and expected outcomes.<sup>81</sup>

Ensuring an equitable share of mainstream allocations from any given program reaches Aboriginal and Torres Strait Islander peoples requires the establishment of a formal and independent mechanism at the national level. This mechanism should operate transparently and use evidence based processes to calculate allocation formulae based on relative Aboriginal and Torres Strait Islander peoples and non-Indigenous needs indices.

These formulae would be similar to those developed by the Commonwealth Grants Commission in 2000–01 based on needs indices that factored in the additional costs associated with remoteness (among other factors) and by which the relative needs of Aboriginal and Torres Strait Islander peoples in remote areas compared to non-remote areas could be assessed.<sup>82</sup> For example, in this way it was calculated that for every health services dollar spent per Aboriginal and Torres Strait Islander person in Perth, for equity to be achieved a person in Narrogin would need to have \$1.80 spent, and in Warburton \$5.66.<sup>83</sup>

Such indices and formula could be used to proactively ensure that Aboriginal and Torres Strait Islander peoples receive an equitable, needs-based, share of mainstream funding through specific allocations from mainstream programs. Or at very least be used in monitoring frameworks to keep mainstream health program administrators accountable to Aboriginal and Torres Strait Islander peoples within their jurisdictions.

Once the quantum of these allocations has been decided by the independent national mechanism, the next step would be to work out how it should be spent. Working out this should take place in partnership with Aboriginal and Torres Strait Islander peoples' representatives, experts and stakeholders, be evidenced-based, and the default position should be that if possible the allocations should be delivered through ACCHS in partnership with Medicare Locals. If services are not delivered through ACCHS a sound argument for not doing so should be made, and the issue of the cultural competence of the alternative service addressed.



Joyce Dimer, SWAMS Social and Emotional Wellbeing Worker running a youth healing circle in Bunbury.  
Photograph: Jason Malouin/Oxfam Australia.



## 4. Multi-party, long-term political support for the Health Plan

The Close the Gap Campaign has always placed a great significance on securing bi-partisan support for the Campaign's approach to achieving Aboriginal and Torres Strait Islander health equality. Nowhere is this better demonstrated than in the fact that Australian Government and Opposition party representatives, including former Prime Minister Kevin Rudd and former Opposition Leader Dr Brendan Nelson,<sup>84</sup> signed the *Close the Gap Statement of Intent* in March 2008 at the Campaign's National Indigenous Health Equality Summit. Since that time we have worked to also secure the support of governments and opposition parties at the state and territory level.

With a 2030 target for achieving Aboriginal and Torres Strait Islander health equality, the Campaign Steering Committee accept that it must work across political cycles and divides: of change to governments and leadership. Thus it is encouraging that the current Prime Minister and Opposition Leader, along with the Greens, have provided continuing support for the *Close the Gap Statement of Intent*. Another example of continuity is the April 2008 commitment of Prime Minister Rudd to providing an annual report to Parliament on progress towards closing the gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians.<sup>85</sup> This is now entrenched as a parliamentary tradition, continued by Prime Minister Gillard in February 2013. The Campaign Steering Committee expects all parties will maintain this reporting and accountability commitment until the health equality target is met.

Just as with the above examples, a Health Plan with long-term reach also requires the support of all political parties to survive political cycles and provide the necessary policy continuity for the gap to close. There is little point developing a plan whose integrity cannot be guaranteed over decades, regardless of who is in power. The Campaign Steering Committee will proactively seek support from all the parties for the Health Plan. The Campaign Steering Committee encourages the Australian Government to engage with the Opposition and the Greens as the Plan is developed, with the aim of ensuring the maintenance of strong multiparty support for Close the Gap and the Plan.

This challenge must be met if Aboriginal and Torres Strait Islander health equality is to be achieved by 2030.

### **The Close the Gap Campaign Steering Committee call for:**

The maintenance and strengthening of the multi-party resolve and commitment to close the health equality gap by 2030, including the *National Aboriginal and Torres Strait Islander Health Plan* when it is completed. This should be supported by a long-term investment approach accompanied by a sustained process of continuous engagement.

# Conclusion

Despite our cautious optimism at the current state of affairs including progress on child health, uptake of MBS items, rollout of smoking cessation education and intervention, government agreement on partnership and the Health Plan, there is no room for complacency. As has been discussed, at this critical juncture we are faced with significant challenges. But these are challenges of political will only. None are insurmountable if we hold to the vision of what could be achieved, and allow ourselves as a nation to be inspired by it: Aboriginal and Torres Strait Islander health equality within our lifetimes, within a generation.

It is vital that the Health Plan is a plan with ambition and reach. Not only is partnership a right of Aboriginal and Torres Strait Islander peoples and their representatives to be realised through the planning process as it unfolds, but it is also the best guarantee of delivering a plan that lives up to the promise of delivering health and life expectancy equality for Aboriginal and Torres Strait Islander peoples.

Perhaps the greatest challenge stems from the environment of fiscal constraint within which we operate. Yet despite this context, it is unthinkable that the Indigenous Health NPA would not be renewed at 2012–13 levels, adjusted for inflation and a long-term resources strategy for closing the gap put in place. Continuity of funding is essential. Stop/start funding is potentially disastrous.

And there is also the need to maintain long-term, multi-party political support for the Health Plan across the upcoming federal election and into the future, at least until 2030. The Parliament should reflect on the lessons advocated in the *Strategic Review of Indigenous Expenditure Report*<sup>86</sup> and on the obligations enshrined in the Declaration.

The Campaign Steering Committee will pay particular attention to these challenges over the coming year and report in next year's shadow report on developments.



Latisha Ugle (left) and Amy Williams at Collie Yorgas in Western Australia. Photograph: Bonnie Savage/OxfamAUS.

# Endnotes

- 1 Aboriginal and Torres Strait Islander Commissioner, *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission, 2005, chapter 2. Available online at: [www.humanrights.gov.au/social\\_justice/sj\\_report/sjreport05/index.html](http://www.humanrights.gov.au/social_justice/sj_report/sjreport05/index.html).
- 2 Also signed by the Hon. Nicola Roxon MP (then Minister for Health and Ageing) and the Hon. Jenny Macklin MP, the Minister for Families, Housing, Community Services and Indigenous Affairs.
- 3 Close the Gap Campaign Steering Committee, *Shadow Report 2012 – On Australian governments’ progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians*, Oxfam Australia, 2012, pp 16-19. Available online at: [www.humanrights.gov.au/social\\_justice/health/OAus-CloseTheGapShadowReport-0212.pdf?ref=687](http://www.humanrights.gov.au/social_justice/health/OAus-CloseTheGapShadowReport-0212.pdf?ref=687).
- 4 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2012*, Australian Human Rights Commission, 2012, pp 199-205. Available online at: [www.humanrights.gov.au/social\\_justice/sj\\_report/sjreport12/index.html](http://www.humanrights.gov.au/social_justice/sj_report/sjreport12/index.html).
- 5 Department of Finance and Deregulation, *Strategic Review of Indigenous Expenditure: Report to the Australian Government*, 2010, p 15. Available online at: [www.finance.gov.au/foi/disclosure-log/2011/docs/foi\\_10-27\\_strategic\\_review\\_indigenous\\_expenditure.pdf](http://www.finance.gov.au/foi/disclosure-log/2011/docs/foi_10-27_strategic_review_indigenous_expenditure.pdf).
- 6 The *Close the Gap Statement of Intent* sets out the approach government must take in order to close the gap by 2030 and provides the basis against which to hold government to account for meeting commitments. The *Close the Gap Statement of Intent* is reproduced on the opposite page.
- 7 Including on health, housing, employment and education as indicated by progress against the COAG Closing the Gap Targets. The first report was delivered in February 2009 and the second in March 2010. Prime Minister Julia Gillard delivered her first report in February 2011.
- 8 For further information see: Australian Human Rights Commission, *Community Guide to the UN Declaration on the Rights of Indigenous Peoples*, 2010. Available online at: [www.humanrights.gov.au/declaration\\_indigenous/index.html](http://www.humanrights.gov.au/declaration_indigenous/index.html).
- 9 *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 see Aboriginal and Torres Strait Islander Social Justice Commissioner, *Native Title Report 2010*, Australian Human Rights Commission, 2011, chapter 3. Available online at: [www.humanrights.gov.au/social\\_justice/nt\\_report/ntreport10/index.html](http://www.humanrights.gov.au/social_justice/nt_report/ntreport10/index.html).
- 10 COAG Reform Council, *Indigenous Reform 2010–11: Comparing performance across Australia*, 2012. Available online at: [www.coagreformcouncil.gov.au/reports/indigenous.cfm](http://www.coagreformcouncil.gov.au/reports/indigenous.cfm).
- 11 National Health Performance Authority website: [www.nhpa.gov.au/internet/nhpa/publishing.nsf](http://www.nhpa.gov.au/internet/nhpa/publishing.nsf).
- 12 The NIRA was agreed by COAG in November 2008. The agreement: commits all jurisdictions to achieving the Closing the Gap targets and sets out an integrated strategy for achieving the targets in urban and regional areas, as well as in remote Australia. The NIRA can be found on the website for the Ministerial Council of Federal Financial Relations at: [www.federalfinancialrelations.gov.au/content/national\\_agreements/indigenous\\_reform/National\\_Indigenous\\_Reform\\_Agreement\\_from\\_13\\_Feb\\_11.pdf](http://www.federalfinancialrelations.gov.au/content/national_agreements/indigenous_reform/National_Indigenous_Reform_Agreement_from_13_Feb_11.pdf).
- 13 Most State and Territory Governments and Oppositions have also signed the *Close the Gap Statement of Intent* including Queensland, New South Wales, Western Australia, Australian Capital Territory, and Victoria
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