Progress and priorities report
2016

CLOSETHE**GAP**

Close the Gap
Campaign
Steering
Committee

Contents

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

Executive summary

In his 2005 *Social Justice Report*, then Aboriginal and Torres Strait Islander Social Justice Commissioner Professor Tom Calma AO described the unacceptably wide health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people in Australia and observed: 'It is not credible to suggest that one of the wealthiest nations in the world cannot solve a health crisis affecting less than 3% of its citizens.'[1]

The Commissioner then proposed a human rights-based approach to achieving Aboriginal and Torres Strait Islander health equality featuring equality-based planning and targets developed in partnerships between Aboriginal and Torres Strait Islander peoples and Australian governments.

The Commissioner's rallying cry led to the 2006 establishment of the Close the Gap Campaign under Aboriginal and Torres Strait Islander leadership. The aim of the Campaign is to achieve Aboriginal and Torres Strait Islander health equality (as measured by life expectancy equality) by 2030. For the past decade, almost every national Aboriginal and Torres Strait Islander health and health professional peak body, and general population health and health professional peak body has participated as members of Campaign Steering Committee (see page 42).

Further, the Close the Gap Campaign has enjoyed bipartisan government support at Commonwealth, state and territory levels. First by the 2008 commitment by a majority of jurisdictions of the *Close the Gap Statement of Intent*; and second by the ensuing national commitment by all Australian Governments through COAG to achieving Aboriginal and Torres Strait Islander life expectancy equality by 2030 in the COAG *Closing the Gap Strategy* that became operational in July 2009.

As reported in the 2015 *Progress and Priorities Report*, there is still tremendous effort and resources needed if Aboriginal and Torres Strait Islander life expectancy equality is to be achieved by 2030. As this and previous reports detail, progress against this headline indicator of population health has been difficult to measure but appears to have been minimal. While there is some good news to report, improvements are yet to be reported at this high level. Both absolute and relative gains are needed in future years.

For those who are troubled by the slow pace of change, the Close the Gap Campaign counsels against the perception that the *Closing the Gap Strategy* is ineffective. In fact, the 2010–2012 life expectancy estimate should be considered as the July 2009 Aboriginal and Torres Strait Islander life expectancy baseline—the situation *before* the July 2009 commencement of the *Closing the Gap Strategy*—against which future progress can be measured.

Because of the lead times between the design and roll out of programs, and for improvements to be measured, analysed and reported, the Campaign Steering Committee counsels that improvements to Aboriginal and Torres Strait Islander life expectancy should not be expected to be measurable until at least 2018.

Nonetheless, there are reasons for optimism, particularly in terms of health inputs including the significant increases to the number of health checks being reported, and the increased access to medicines. And there are improvements in infant and child health outcomes that bode well for the health of the future adult population.

'It is not credible to suggest that one of the wealthiest nations in the world cannot solve a health crisis affecting less than 3% of its citizens.'

Dr Tom Calma, AO, Close the Gap Campaign founder and former Aboriginal and Torres Strait Islander Social Justice Commissioner

'The usual lag that occurs after the implementation of any major program or policy means that we should expect to see some meaningful changes to the health outcomes of our people after a few more years of sustained effort and investment.'

Dr Jackie Huggins, Close the Gap Campaign Co-Chair and National Congress of Australia's First Peoples Co-Chair

But whatever cautious optimism the Campaign Steering Committee might have, the ten-year anniversary of the Close the Gap Campaign in 2016 is not a time to rest. In particular, the 2015 launch of the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (2013–2023)* (Implementation Plan) should reinvigorate and refocus efforts to close the health gap, including through the Implementation Plan's attention on identifying core service models and service gaps, workforce requirements and funding mechanisms, reducing racism and on the importance of culture to improved health outcomes.

This year, the Australian Government must provide appropriate funding for the Implementation Plan in the 2016 Federal Budget. Specifically, there needs to be an overall increase in resources directed towards Aboriginal and Torres Strait Islander health—in proportion to population size, service need and demand. This is critical given the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* expired in 2014 and funding under that agreement discontinued.

The Campaign Steering Committee also believes it is critical that there is clear nationally coordinated action that is agreed to by all levels of government to drive efforts to close the health gap. This should include actions taken under the 2015 Implementation Plan and the planning efforts of the Primary Health Networks (PHNs) that began operation in July 2015. Both the PHNs and the Implementation Plan should support the Campaign's preferred model for health services—Aboriginal Community Controlled Health Organisations. The Campaign Steering Committee will monitor the effectiveness of PHNs, and the progress of work under the Implementation Plan in these areas in 2016.

Another area of concern for the Campaign Steering Committee is the impact of the *Indigenous Advancement Strategy* (IAS) on the social determinants of health. The Campaign Steering Committee believes that the IAS should be nationally coordinated along with state and territory governments, and demonstrate how it will contribute to achieving the close the gap targets.

As the Campaign readies to mark its tenth anniversary in 2016, Australians are, in ever increasing numbers, demanding decisive action to support achieving Aboriginal and Torres Strait Islander health equality by 2030. In 2015, the 200,000th Australian signed the 'Close the Gap' pledge. In 2015, nearly 1600 community events across the country involving over 150,000 Australians marked the National Close the Gap Day. It's clear that this generation of Australians want to see their governments make good on the commitments made in 2008.

The message from the Close the Gap Campaign is clear. Aboriginal and Torres Strait Islander health inequality is an issue of growing national concern. We can and want to be the generation that closes the gap but we must stay the course and keep our attention and resources focused on this goal. The health gap has rightfully been described as a stain on our nation, and this generation has the opportunity and responsibility to remove it.

Recommendations

2016 Federal Election

That each political party prior to the 2016 Federal Election, commit to:

- Make Aboriginal and Torres Strait Islander health and wellbeing a major priority for their election policy platforms, and fund the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (2013–2023)* until it expires in 2023.

- An additional COAG Closing the Gap Target to reduce imprisonment rates and increase community safety.

- Working with COAG to introduce a target for Aboriginal and Torres Strait Islander people with disability as part of the Closing the Gap framework. The Australian Government should introduce this target in conjunction with the Disability Recommendations 11, 12, 14, 15 and 16 of the Aboriginal and Torres Strait Islander Social Justice Commissioner's *Social Justice and Native Title Report 2015*.

Implementation Plan for the National Aboriginal and Torres Health Plan

That through the *Implementation Plan for the National Aboriginal and Torres Health Plan*, appropriate core health service models and associated workforce and funding arrangements are urgently developed to meet Aboriginal and Torres Strait Islander health needs on a national, regional and community level, and immediate priority be directed towards regions with relatively poor health and inadequate levels of service.

That Aboriginal Community Controlled Health Services (ACCHOs) should be the preferred model for investment in primary health care services for Aboriginal and Torres Strait Islander communities and that the planning activities of the Primary Health Networks include partnership and service delivery arrangements through and by the ACCHOs.

Previous Report

That the Australian Government address the Campaign's 2015 *Progress and Priorities Report* Recommendations (see Appendix 1).

Institutional racism in the health system

That a national inquiry into racism and institutional racism in health care settings, and hospitals in particular, and its contribution to Aboriginal and Torres Strait Islander health inequality, is undertaken by the Senate Select Committee on Health.

Indigenous Advancement Strategy

That the Recommendations of the Close the Gap Campaign Steering Committee to the 2015 Senate Finance and Public Administration References Committee Inquiry into the impact of the IAS tendering process are implemented as a priority.

Introduction:
Taking stock of a decade of hope and the challenges ahead

In September 2015, the United Nations General Assembly, including Australia, unanimously adopted the *2030 Agenda for Sustainable Development* containing 17 Sustainable Development Goals (SDGs).[2] These replace and expand on the Millennium Development Goals (MDGs) adopted in 2000, and that expired in 2015.[3] Over 150 targets were also adopted to advance the SDGs.[4]

The MDGs and the associated development of a human rights-based approach to poverty eradication, particularly that stemming from gross socio-economic inequality within and between nations were aimed at developing countries.[5] In contrast, the SDGs apply to every country with 'practicable ambitious national responses' required of even wealthy nations like Australia to reduce domestic inequality, including that in relation to access to health services.[6]

The adoption of the MDGs and the human rights-based approach to poverty eradication associated with them had been instrumental in shaping the Close the Gap Campaign. As then Aboriginal and Torres Strait Islander Social Justice Commissioner Professor Tom Calma AO observed:

Dr Tom Calma AO, Close the Gap Campaign founder and former Aboriginal and Torres Strait Islander Social Justice Commissioner. Photograph: Chloe Geraghty/OxfamAUS.

It is ironic that the Government has committed to contribute to the international campaign to eradicate poverty in third world countries by 2015, but has no similar plans to do so in relation to the extreme marginalisation experienced by Aboriginal and Torres Strait Islander Australians.[7]

Subsequently, in the *Social Justice Report 2005*, the Commissioner proposed the adoption of a human rights-based approach to closing the Aboriginal and Torres Strait Islander health gap. The founding members of the Close the Gap Campaign coalesced around this approach. The year 2016 marks the tenth anniversary of their first meeting in March 2006.

Reflecting on those ten years, the Campaign notes significant achievements, but is all too aware of the need to maintain focus in the years ahead. Milestones to celebrate include:

- The March 2008 commitment of the then Australian Government and Opposition to the Close the Gap Statement of Intent signaling the adoption of the Campaign's human rights-based approach as national policy. This followed the February 2008 National Apology to Australia's Indigenous Peoples, and commits signatories to close the health and life expectancy gap by 2030, to adopt equality targets, and undertake equality focused health planning in partnership with Aboriginal and Torres Strait Islander peoples (see page 6).

- The July 2009 Council of Australian Governments' (COAG) National Indigenous Reform Agreement that contains the six Closing the Gap Targets and the National Integrated Strategy for Closing the Gap in Indigenous Disadvantage (hereon 'Closing the Gap Strategy'). This includes the 2030 life expectancy equality target, and the target to halve child mortality by 2018.[8] Additionally, associated national partnership agreements that defined funding and other responsibilities between governments commenced in July 2009.

- Funding of $4.6 billion, including $1.6 billion for health and significant allocations for housing, education, and employment, through closing the gap national partnership agreements—many of which have now been left to expire.[9]

- The 2011 establishment of the National Health Leadership Forum (NHLF) comprising Aboriginal and Torres Strait Islander peak health bodies on the Close the Gap Campaign Steering Committee. The NHLF has since proved itself as a respected leadership and partnership mechanism for working with the Australian Government in health equality planning.

- The 2013 launch of the *National Aboriginal and Torres Strait Islander Health Plan*[10] and the subsequent launch of its Implementation Plan in October 2015.[11] The NHLF and successive Australian Governments developed both in partnership. This provides a good model for future collaboration.

- The 200,000th Australian signing the 'Close the Gap' pledge in 2015,[12] demonstrating that the Campaign has garnered and maintained significant domestic support over the past decade, and can use that support to apply commensurate political pressure. With well over a 1000 events continuing to regularly mark National Close the Gap Day, it's clear that this generation of Australians want to make a difference, and will hold governments accountable for the change and reform needed.

While it is a time to pause and reflect, the 10 year anniversary is in no way a time to rest. There is still tremendous effort and resources needed if life expectancy equality is to be achieved by 2030. As this and previous reports detail, progress against this headline indicator of population health has been slow. While there is a lot of good news to report, it is yet to be reflected at this level.

The Sustainable Development Goals also refer to Indigenous peoples as a vulnerable group who 'must be empowered' through the SDG-achievement process.[13] This includes in the context of national reviews of progress against the SDGs that 'should draw on contributions from indigenous peoples… National parliaments as well as other institutions can also support these processes.'[14]

In that regard, it is a positive achievement that since 2009 successive Australian Prime Ministers have annually presented a national review of achievement against the Closing the Gap Targets in the first sitting week of Parliament. In parallel, the Close the Gap Campaign has issued its own reports, providing an independent assessment. This Report is the Campaign Steering Committee's seventh.

For the Close the Gap Campaign, 2016 marks ten years of hard work and achievement. Such milestones and this report provide us with a reason to celebrate success, and also an opportunity to identify areas of further challenge, and—in what is also a Federal Election year—to propose further reform.

This report comprises three parts:

- **Part 1:** Progress over the life of the Closing the Gap Strategy, examining health outcomes as revealed by data in the six years since July 2009.

- **Part 2:** New insights into health service usage by Aboriginal and Torres Strait Islander people, examining data on health services use from the 2012–13 National Aboriginal and Torres Strait Islander Health Survey and other sources.

- **Part 3:** Priorities in the next term of Parliament sets out the Campaign Steering Committee's ideas for reinvigorating the Closing the Gap Strategy and other action for the next Australian Government.

Close the Gap Statement of Intent

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 (then 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 Victoria in March 2008; Queensland in April 2008; Western Australia in April 2009; the Australian Capital Territory in April 2010; New South Wales in June 2010; and South Australia in November 2010. A variety of non-government organisations including Close the Gap Campaign members (see page 42), health bodies, human rights groups and community development organisations have also signed the *Close the Gap Statement of Intent* at both a national and state/territory level demonstrating broad community support for these principles.

CLOSETHEGAP

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:
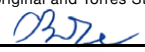
- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-indigenous 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
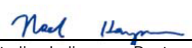
Representative of the Australian Government	National Aboriginal Community Controlled Health Organisation
Congress of Aboriginal and Torres Strait Islander Nurses	Australian Indigenous Doctors Association
Indigenous Dentists Association of Australia	Aboriginal and Torres Strait Islander Social Justice Commissioner. Human Rights and Equal Opportunity Commission

Progress over the life of the Closing the Gap Strategy

Palm Island community member, Winston, is a supervisor in the Campbell Page employment services multimedia jobskills program. Photograph: Jason Malouin/OxfamAUS.

This part of the report considers progress towards meeting the COAG Closing the Gap health targets:

- to achieve life expectancy equality between Aboriginal and Torres Strait Islander people and non-Indigenous people by 2030; and

- to halve the deaths of Aboriginal and Torres Strait Islander children aged 0–4 years by 2018.[15]

Because there is little new data in relation to both targets, proxy indicators are also considered. Proxy indicators gauge progress against a range of risk factors to supplement life expectancy data. For example, risk factors for chronic disease (mental health, smoking, poor nutrition, physical inactivity, alcohol use, obesity) were considered in the 2015 *Progress and Priorities Report.* The report noted the declining rates of daily smoking in absolute terms as an indicator that life expectancy would increase over time, in turn, suggesting the positive impact of the Closing the Gap 'Tacking Indigenous Smoking' program.[16]

Primary references in previous years' reports included the now defunct COAG Reform Council reports of progress against the COAG Closing the Gap Targets.[17] For this report, the Australian Health Ministers Advisory Council's 2015 *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, (hereon 'AHMAC') is used as the primary, most current data source for health information.[18]

1.1 Assessing progress against the life expectancy target

An estimated 17-year gap between the life expectancy of Aboriginal and Torres Strait Islander people and non-Indigenous people existed at the 2006 commencement of the Close the Gap Campaign. For 1996–2001, the Australian Bureau of Statistics (ABS) had estimated Aboriginal and Torres Strait Islander life expectancy to be 59.4 years for males and 64.8 years for females. That compared with 76.6 years for all males and 82 years for all females over 1998–2000.[19]

Just prior to the July 2009 commencement of the *Closing the Gap Strategy*, the ABS adopted a new and totally different methodology for calculating Aboriginal and Torres Strait Islander life expectancy. This combined deaths data for three-year periods linked to the Census of Population and Housing (Census) held every five years.[20]

The 2009 methodology was first applied to 2005–2007 data, linked to the 2006 Census, to produce an Aboriginal and Torres Strait Islander male life expectancy estimate of 67.2 years and for females 72.9 years. This compared with 78.7 years for non-Indigenous males and 82.6 years for females: a gap of 11.5 years for males, and 9.7 years for females.[21] This does not of itself indicate a reduction in the size of the gap from the previous estimates, but rather a fundamental change in the method of estimation.

The 2009 methodology continues in use, but concerns about some aspects of the methodology and the accuracy of the estimates should be noted.[22] Because of their reliance on the Censuses, Aboriginal and Torres Strait Islander life expectancy estimates are published at five-year intervals: so far for 2005–2007 and 2010–2012. Going on past practice, the next estimate (for 2015–2017) should be published in 2018 or 2019.

(a) Life expectancy

The ABS 2010–2012 life expectancy estimates for Aboriginal and Torres Strait Islander people published in the 2015 *Progress and Priorities Report* are still current: 69.1 years for men and 73.7 years for women. Table 1 summarises the estimates of absolute gains in life expectancy from 2005–2007 and 2010–2012 for both Aboriginal and Torres Strait Islander people and non-Indigenous people, disaggregated by gender.

		Life expectancy (years)		Absolute increase in life expectancy from 2005–07 to 2010–12
		2005–07	2010–12	
Aboriginal and Torres Strait Islander	Men	67.5	69.1	+1.6 years
	Women	73.1	73.7	+0.6 year
Non-Indigenous	Men	78.9	79.7	+0.8 year
	Women	82.6	83.1	+0.5 year

Between 2005–2007 and 2010–2012, the life expectancy gap for Aboriginal and Torres Strait Islander men closed by 0.8 years, and for women by only 0.1 years. But such small relative gains are within the margin for error and could in fact be non-existent.[24]

In its final 2014 report on progress against the life expectancy target, the COAG Reform Council concluded that the nation was not on track to meet it, and that larger absolute and relative gains are needed in future years.[25]

The Campaign Steering Committee reiterates the 2015 *Progress and Priorities Report* position that the 2010–2012 life expectancy estimate should be considered the July 2009 life expectancy baseline (i.e. before the *Closing the Gap Strategy* commenced) against which future progress can be measured.

Over the last 125 years, life expectancy at birth for the Australian population has increased by more than 30 years, indicating that dramatic increases in life expectancy are possible but take time.[26] Life expectancy estimates generally move slowly, currently at around 0.25 years of life per year for the total Australian population, although more rapid gains in health of the Aboriginal and Torres Strait Islander populations are both necessary and possible.[27]

AHMAC estimates that life expectancy for Aboriginal and Torres Strait Islander males has increased by 0.32 years per year since 2005–07, and by 0.12 years per year for Aboriginal and Torres Strait Islander females.[28] However, to meet the life expectancy target by 2030, gains of 0.6 to 0.8 years per year are needed,[29] but that momentum will take time to build. It will need to be coordinated at a national level, and draw on inputs from all areas of government activity including increased expenditure, better access to primary and other health care, and improvements in areas of social determinants including employment, education, housing and access to infrastructure.

(b) Mortality as a proxy measure for life expectancy

Mortality (or 'all causes standardised death rates'), like life expectancy, is a proxy indicator of population health but is measurable at shorter intervals.[30] Assessing the declining gap in mortality rates, and particularly the avoidable mortality rate, suggests that long-term progress towards closing the gap is being made.

Over 2009–2013, the first four years of the *Closing the Gap Strategy*, the mortality rate for Aboriginal and Torres Strait Islander people was 1.7 times higher than that for non-Indigenous people.[31] Over the 15 years from 1998 to 2013, AHMAC report there was an absolute 16% reduction in all-cause mortality rates for Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA, and the NT where data is deemed reliable.[32] There was also a significant 15% narrowing of the gap in mortality rates.[33] However, the rate of improvement in Aboriginal and Torres Strait Islander and non-Indigenous rates had been approximately the same so that the Aboriginal and Torres Strait Islander mortality rate remains approximately 1.7 times higher than that for non-Indigenous people.

From 1998 to 2012 there was a significant absolute decline of 40% in death rates due to circulatory diseases,[34] and of 27% for respiratory diseases.[35] Further, there was a significant narrowing of the gap.[36] For these conditions though, cardiovascular disease (CVD) mortality rates have remained approximately 1.6 times higher for Aboriginal and Torres Strait Islander people. Similar gains for kidney disease mortality were made over 2006 to 2012.[37]

Avoidable and preventable mortality refers to deaths from conditions that are considered avoidable given timely and effective health care (including disease prevention and population health initiatives).[38]

Over 2008–2012, Aboriginal and Torres Strait Islander people died from all avoidable causes at three times the rate of non-Indigenous people.[39] However, between 1998 and 2012 there was a significant 27% decline in Aboriginal and Torres Strait Islander deaths due to avoidable causes reported and a narrowing of the avoidable mortality gap.[40]

(c) Causes of death

Over 2008–2012, in the five jurisdictions where data is deemed reliable the most common causes of death for Aboriginal and Torres Strait Islander people were:

- 25%—circulatory diseases;
- 20%—neoplasms (including cancer); and
- 15%—external causes.[41]

Suicide was the leading cause of death due to external causes for Aboriginal and Torres Strait Islander people—accounting for 32% of such deaths, compared with 27% of all Australians.[42]

In attributing relative contributions to the mortality gap over 2009–2013, AHMAC estimate:

- 24% of the gap is attributed to circulatory disease;
- 21%—endocrine, metabolic and nutritional disorders (including diabetes);
- 12%—neoplasms (including cancer); and
- 12%—respiratory diseases.[43]

The Australian Institute of Health and Welfare (AIHW) identified cardiovascular disease as the largest contributor to the gap in fatal burden in 2010, accounting for 29% and 25% of the gap for males and females respectively.[44] Aboriginal and Torres Strait Islander people experienced a rate of fatal burden from this disease group of around three times the rate of their non-Indigenous peers.[45] [1]

Deaths due to diabetes over 2008–2012 were six times higher for Aboriginal and Torres Strait Islander people than non-Indigenous people, and the leading cause of the gap for females.[46] No significant absolute or relative changes were detected over those four years.[47]

Also, since 2006 a growing 'cancer gap' is evident as rates of cancer among Aboriginal and Torres Strait Islander people increase in both absolute and relative terms.[48] As such, the Campaign Steering Committee welcomes the 2015 release of Cancer Australia's *National Aboriginal and Torres Strait Islander Cancer Framework* to improve Aboriginal and Torres Strait Islander cancer outcomes. The framework covers the full range of cancer control, including cancer prevention, screening and early detection, diagnosis and treatment, palliative care and survivorship; and the policy, systems, research and infrastructure that surround these service areas.[49]

As noted in the 2015 *Progress and Priorities Report*, the COAG Reform Council's final report highlighted the difference in Aboriginal and Torres Strait Islander and non-Indigenous survival rates from cancer in 1999–2007 in NSW, Qld, WA, and the NT—as set out again in Table 2 below.

Table 2: The difference in Aboriginal and Torres Strait Islander and non-Indigenous survival rates from cancer in 1999–2007 in NSW, Qld, WA, and the NT, all levels of remoteness[50]

Cancer	Aboriginal and Torres Strait Islander survival rate	Non-Indigenous survival rate
All cancers	40%	52%
Lung cancer	7%	11%
Breast cancer in women	70%	81%
Bowel cancer	47%	53%
Prostate cancer	63%	72%
Cervical cancer	51%	67%

In terms of specific reasons for these gaps, the COAG Reform Council pointed to factors such as advanced cancer at diagnosis, reduced access to and uptake of treatment, higher rates of comorbidities, and language barriers.[51] Further, below in this report, the Campaign Steering Committee consider this and similar inequality in health outcomes as due, at least in part, to institutional racism.

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1   'Fatal burden' is measured in years of life lost, which is the sum of the number of years of life lost due to premature death from disease and injury.

1.2 Assessing progress against the child mortality target

In the 2015 *Progress and Priorities Report*, it was noted that the COAG Reform Council (assessing data received until 2012), believed that Australian governments are on track to meet COAG's target to halve the gap in Aboriginal and Torres Strait Islander child death rates by 2018. However, the 2015 Report also noted that continuing to use non-Indigenous trajectories based on the rates of decline over 1998 to 2008 as a comparator was problematic. This is because the non-Indigenous rate of decline had significantly increased since 2008. As such, what it means to achieve equality has also significantly changed.[52]

In 2013, without comment as to whether Australian governments remain on track or not to meet the child mortality target, AHMAC, considering data from 2009–13, assessed that the mortality rate for Aboriginal and Torres Strait Islander:

- **Children aged 0–4 years was 1.9 times** the non-Indigenous rate.[53] Further, between 1998 and 2013 there has been a decline in Aboriginal and Torres Strait Islander child mortality rates of 31%, and a 35% narrowing of the gap with non-Indigenous children in the five jurisdictions.[54]

- **Infants (under one year old) was 1.7 times** the non-Indigenous rate.[55] Further, there was a 64% decline in the mortality rate for Aboriginal and Torres Strait Islander infants and an 83% narrowing of the gap between 1998 and 2012.[56] This is a very significant result as the rate of improvement for Aboriginal and Torres Strait Islander infants has been greater than for the rest of the population. The slower relative improvements in child mortality indicate the importance of more effective strategies to reduce the impact of injuries in the 1–4 year age group.

Birth weight is a key indicator of infant health and a major determinant of a baby's chance of survival and good health. The AIHW define a low birth weight baby as one with a weight of less than 2,500 grams. Research indicates that babies weighing less than 2,500 grams at birth are at least 20 times more likely to die within their first year of life than those who weighed at least that amount.[57]

Data from 2011, discussed in the 2015 Progress and Priorities Report, remains the latest available. In that year, babies born to Aboriginal and Torres Strait Islander mothers were twice as likely as those born to non-Indigenous mothers to be of low birth weight: 12.6% of babies born to Aboriginal and Torres Strait Islander mothers compared with 6% born to non-Indigenous mothers.[58]

Between 2000 and 2011, AIHW reported a statistically significant decrease in the low birth weight rate among live born singleton babies of Aboriginal and Torres Strait Islander mothers, with the rate declining by 9% over the period. In contrast, there was no significant change in the corresponding rate for non-Indigenous mothers.[59]

In a 2012 study on *Closing the Gap in Low Birthweight Births between Indigenous and Non-Indigenous Mothers*, a multivariate analysis of perinatal data in Queensland for the period 2009–11, AHMAC concluded that 51% of low birthweight births for Aboriginal and Torres Strait Islander mothers were attributable to smoking while pregnant, compared with 19% for other Australian mothers. It was further estimated that if the smoking rate among Aboriginal and Torres Strait Islander pregnant women was the same as it was for other Australian mothers, the proportion of low birthweight babies could be reduced by 26%.[60]

Recommendation 5 of the Close the Gap Campaign's 2015 *Progress and Priorities Report* called for an increased focus on reducing smoking during pregnancy as a critical contributor to improved infant health.[61] This is repeated as a part of a wider recommendation below.

> ### Recommendation
>
> That the Australian Government address the Campaign's 2015 *Progress and Priorities Report* Recommendations (see Appendix 1).

Improved access to antenatal health care is essential to reducing infant mortality rates. Again, data from 2011 remains the latest available.[62] As reported last year, in 2011, 99% of Aboriginal and Torres Strait Islander mothers had at least one antenatal session, and 83% had five or more.[63] However, Aboriginal and Torres Strait Islander mothers, on average, accessed services later in the pregnancy and had significantly fewer antenatal care sessions. In 2011, half of all Aboriginal and Torres Strait Islander mothers had their first antenatal session in the first trimester of pregnancy compared with 66% of non-Indigenous mothers.[64]

Over 2001–2011, in NSW, South Australia and Queensland, there was a statistically significant increase in the rate of Aboriginal and Torres Strait Islander mothers attending at least one antenatal care session during pregnancy, but no significant change among non-Indigenous women.[65] This resulted in a narrowing of the gap in these three jurisdictions.[66] Access to care in the first trimester varied by state (61% in NSW compared with 36% in WA) and to a lesser degree by remoteness (e.g. 55% in inner regional areas and 47% in major cities and very remote areas).[67]

> ### Fetal Alcohol Spectrum Disorders
>
> Fetal alcohol spectrum disorders (FASD) is an umbrella term to describe a range of physical, cognitive and behavioural abnormalities that result from fetal exposure to alcohol consumption during pregnancy'.[68] FASD is entirely preventable if mothers are educated and supported to stop alcohol consumption during pregnancy.[69]
>
> Within FASD, Fetal Alcohol Syndrome (FAS) is a diagnosis with indicators including growth deficiency, distinct facial characteristics and central nervous system damage.[70] Partial Fetal Alcohol Syndrome (pFAS) is a diagnosis where it is known that alcohol was consumed during pregnancy, but the person presents without some or any of the physical symptoms of FAS.[71]
>
> The Lililwan Project worked to estimate the prevalence of FASD and associated factors in the Fitzroy Valley Aboriginal community in the Kimberley, Western Australia.[72] About 95% of children born over 2002–2003 in the community were involved.[73] FAS or pFAS was diagnosed in 12% of this cohort.[74]

1.3 Understanding a generational health equality trajectory

In the five years since the Closing the Gap life expectancy target was set, there has been limited time for investments to impact on population level death rates. For example, reductions in population level smoking rates take 5 years to impact on heart disease and up to 20 years for cancer.[75]

Likewise, improvements to social determinants will take time to impact on health outcomes. AHMAC estimate that higher school educational attainment among Aboriginal and Torres Strait Islander children and young people will take 20 to 30 years to result in lower death rates from chronic disease.[76]

The Campaign Steering Committee continues to counsel governments to consider the generational effort that is required to attain health equality, rather than chop and change approaches based on an unrealistic appreciation of the health gains possible only a few years after an initiative is introduced. This is particularly the case in relation to expectations that significant improvements against the life expectancy target would flow instantly from the *Closing the Gap Strategy*. Rather, the slow pace reflects the relatively low impact of responses in place **before** the July 2009 commencement of the *Closing the Gap Strategy* and, as such, demonstrates why it was needed in the first place.

Because of the lead times between the design and roll out of programs, and for improvements to be measured, analysed and reported, and then accrue as improvements to life expectancy, the high level health impacts of the *Closing the Gap Strategy* should not be expected to be measured in data until at least 2018.

In the meantime, the positive impacts of the *Closing the Gap Strategy* are measurable but in terms of inputs to better health that will contribute to better health outcomes over time.

(a) A need for government to focus on inputs

Perhaps most tellingly, there have been demonstrable improvements in access to, and usage of, primary health services since July 2009, as reported by AHMAC. In particular, trend analysis shows the rate of uptake of health assessment by Aboriginal and Torres Strait Islander people, **though still too low relative to need**, has nearly tripled over July 2009 to June 2014. In 2013–2014:[77]

- 47,400 health assessments of Aboriginal and Torres Strait Islander children aged 0–14 years took place—19% of children in the target group;[78]

- 80,600 health assessments of Aboriginal and Torres Strait Islander people aged 15–54 years took place—21% of this population;[79] and

- 22,300 health assessments of Aboriginal and Torres Strait Islander people aged 55 years and over took place (representing 33% of this population).[80]

This expanding reach is also true of General Practitioner Management Plans (GPMP) and team care arrangements (TCA). In the five years from July 2009 to June 2014, Medicare services claimed by Aboriginal and Torres Strait Islander people for these items have doubled. Rates per 1,000 in the population are now higher for these services than for non-Indigenous people.[81] However, the Medicare services uptake is not as high as it should be to deal with the higher levels of illness.

A 2014 analysis also noted the increase in the uptake of health assessments, but struck a note of caution at the relatively limited delivery of follow-up care and Medicare Benefit Scheme (MBS)-billing for Aboriginal and Torres Strait Islander-specific follow-up items. Particular constraints were noted around lack of practitioner education and awareness of MBS-item numbers and billing against non-Indigenous-specific items or more general follow-up items, and limited capacity to arrange and facilitate follow-up. Communication and transport challenges for patients were also cited as barriers. The analysis concluded that work was required in these areas if the full potential of the health checks was to be realised.[82]

To close the gap within a generation, the Campaign Steering Committee asserts the need to ensure that high levels of avoidable disease are addressed within the scope of the mainstream health financing system (MBS) for primary care. For too long, the broader preventative strategies have been left to a raft of uncertain and often inaccessible funded programs, which have varying life cycles, multiple administrative and reporting arrangements and are at times implemented too late to effectively address emerging health issues.

Consideration must be given to the MBS capacity to focus clinical support and interventions upstream, to ensure we do not continue to see Aboriginal and Torres Strait Islander people predominantly engaged in post diagnosis/treatment-related occasions of service. A parallel focus on early intervention and prevention activities is critical if we wish to ensure the Gap is closed and Aboriginal and Torres Strait Islander peoples remain well.

The Closing the Gap Pharmaceutical Benefits Scheme (PBS) Co-payment Measure[83] commenced in July 2010.[84] Up to 30 June 2014, 280,885 eligible Aboriginal and Torres Strait Islander people had benefited from it, and over 99% of pharmacies have participated in the measure. A prescription volume of 8.8 million has been dispensed since the measure commenced. Between 2001–02 and 2010–11, average expenditure on pharmaceuticals per Aboriginal and Torres Strait Islander person rose from 33% to 44% of the amount spent per non-Indigenous person ($369 compared with $832 in 2010–11).[85]

The improvement is encouraging, however, it is necessary to build on this success and achieve equality in access to medicines, as discussed in the text box below.

Further work towards improving access to medicines

Aboriginal and Torres Strait Islander peoples' access to medicines has improved through the Close the Gap PBS Co-payment measure, Quality Use of Medicines Maximised (QUMAX) program,[86] and the Remote Area Aboriginal Health Service (RAAHS) program (enabled by Section 100 of the *National Health Act*).[87]

However, the above initiatives do not work seamlessly for eligible Aboriginal and Torres Strait Islander patients travelling for treatment between remote and urban areas, and between hospitals and their homes. For example, because hospitals are not eligible prescribers,[88] they cannot prescribe medicines under the Close the Gap PBS Co-payment measure to patients upon discharge—even for measure-registered patients. Further, patients who otherwise might access medicines under the s100 RAAHS program in one location are unable to then rely on the Close the Gap PBS Co-payment Measure in remote Aboriginal Medical Services (AMS) as the prescribers are ineligible to participate.

These artificial barriers can contribute to patients going without their medicines and otherwise have the unintended effect of reducing Aboriginal and Torres Strait Islander peoples' access to medicines. Attaching eligibility for the Close the Gap PBS Co-payment measure to the patient rather than the location or prescriber would enable Aboriginal and Torres Strait Islander patients to access medicines in a more seamless way. Integration of these initiatives, recognising that patients move between systems and locations, would enhance the patient journey and improve access to medicines.

In October 2015, the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Pharmacy Guild of Australia released a national Joint Position Paper calling for improvements in the CTG PBS Co-payment measure. The Campaign Steering Committee supports these proposals.[89]

The increase in health assessment uptake and access to pharmaceuticals above underscore the importance of dedicated 'Closing the Gap' action to improve Aboriginal and Torres Strait Islander health outcomes. They also provide a timely reminder to focus on inputs (health services, expenditure, pharmaceuticals and so on) required at this stage of the national effort so that the desired health outcomes may be achieved. The increased uptake of such inputs, albeit often from a low base, offers encouragement for improved health outcomes in the future, but such outcomes are reliant on such inputs.

In the 2015 *Progress and Priorities Report*, the Campaign Steering Committee noted that the COAG Reform Council concluded its final report on the *Closing the Gap Strategy* by questioning the exclusive focus on outcome indicators in it. It proposed broadening the range of indicators adopted to include improved access to health services, specialists, medications and other indicators of increased opportunity to be healthy—in addition to outcome measures.[90] The Campaign Steering Committee continues to support that call as reflected in the recommendations of this Report.

The Close the Gap Campaign is confident that improved health outcomes will become measurable particularly for high-level targets of population health such as life expectancy, provided there is a long-term commitment and a steadfast pursuit of the Close the Gap Targets. Commentators who characterise the *Closing the Gap Strategy* as failing, are themselves failing to appreciate how (and over what time spans) success should be measured. Positive outcomes require inputs: they don't improve in a resource vacuum. Measurable improvements in relation to inputs such as increased expenditure, better access to primary and other health care, and improvements in areas of social determinants provides hope, and also indicates where attention should be focused.

2 New insights into health service use by Aboriginal and Torres Strait Islander people and the contribution of improved access to health services to closing the health gap

Oral hygiene assistant Kirrily Phillips examine's Janice Blackman's teeth at the Morayfield AMS.
Photograph: Jason Malouin/OxfamAUS.

Aboriginal Community Controlled Health Organisations (ACCHOs) are the Close the Gap Campaign's preferred primary health care providers to Aboriginal and Torres Strait Islander communities for two reasons:

- They are associated with better health outcomes for Aboriginal and Torres Strait Islander people. The 2015 *Progress and Priorities Report* referred to a literature survey undertaken by Panaretto and colleagues to evaluate whether ACCHOs performed better for Aboriginal and Torres Strait Islander people than GPs. This was found to be so particularly in relation to access to services and the prevention, detection and treatment of chronic disease.[91] The (then) Department of Health and Ageing also documented the success of ACCHOs in improving maternal and child health.[92] These findings provide strong support for properly resourced ACCHOs as foundation services for the achievement of health equality.

- ACCHOs are better positioned to provide a culturally competent service that enhances both their accessibility and the quality of the service received. ACCHOs are community controlled—usually by a governing committee. With such control in place, they can offer a comprehensive primary health care model of service that is aligned with Aboriginal and Torres Strait Islander peoples' holistic concept of health.[93] ACCHOs are also manifestations of Aboriginal and Torres Strait Islander communities' right to self-determination.[94]

In 2015, the Aboriginal Health and Medical Research Council of NSW published an evidence review on the contribution of ACCHOs to improving Aboriginal health. The review highlights the above and other advantages associated with ACCHOs.[95]

This part of the report assesses data about access to health services as an indicator of improving population health from the ABS 2012–2013 *National Aboriginal and Torres Strait Islander Health Survey* (NATSIHS). This includes data on around 9,300 respondents' use of health services.[96] The Report was demographically aligned to Aboriginal and Torres Strait Islander populations.

The Survey explored service preferences and found consistency with the annual *Online Services Reports for Aboriginal and Torres Strait Islander Health Organisations* ('Service Reports') compiled by AIHW. In 2015, the Service Report collated data from 269 organisations and reported 323,600 individual Aboriginal and Torres Strait Islander clients.[97] There has been a steady rise in the number of Aboriginal and Torres Strait Islander primary health care organisations, from 108 in 1999–2000[98] to 203 today.

2.1 Usual service use and preferred service use

NATSIHS respondents were asked if they had a 'usual place' to go for health problems and advice: 86% indicated that they did. They were also asked where they would 'like to go.' The results are set out below:

Health service	Usually go[99]	Would like to go[100]
Doctor	54%	53%
AMS	17%	26%
Community clinic	10%	9%
Hospital	5%	(not reported)

The Campaign Steering Committee notes that 27% of respondents who said they would like to go to an AMS did not have an AMS available in their local area, suggesting the unmet need for Aboriginal and Torres Strait Islander-specific primary health care services.[101] However, the Campaign Steering Committee also notes that the picture presented above contrasts with that presented in the 2015 Service Report.

At the time of the 2011 Census, the ABS estimates the Aboriginal and Torres Strait Islander population to number 669,900 persons.[102] In the 2015 Service Report, the 203 Aboriginal and Torres Strait Islander primary health care organisations reported 419,000 clients of whom 323,600 identified as Aboriginal and Torres Strait Islander people.[103] Further, ACCHOs identify as having 327,000 individual clients of whom 78% were Aboriginal and Torres Strait Islander.[104]

Extrapolating, the above suggests that Aboriginal and Torres Strait Islander primary health care organisations had approximately 48.3% of the total Aboriginal and Torres Strait Islander population as clients. And for the ACCHOs, with an estimated (based on the above) 255,060 Aboriginal and Torres Strait Islander clients, approximately 38% of the total estimated Aboriginal and Torres Strait Islander population. To their total clients (including but not limited to Aboriginal and Torres Strait Islander people), ACCHOs provided around 2.6 million episodes of care, or—on average—about eight episodes of care per reported client in 2012–2013.[105]

In relation to the NATSIHS data, AHMAC notes that respondents might not have clearly differentiated between a 'doctor', 'AMS' and a 'community clinic' that may help explain the discrepancy between the NATSIHS and Service Report data. The Campaign Steering Committee also notes that no differentiation between AMS and community clinics was made in relation to both services used and what service a respondent would like to go to.[106]

In light of the Service Reports data above, this percentage of respondents using AMS/ACCHOs might be far higher. And the answers about preferred services must also be considered open to error.

By the NATSIHS, respondents tended to express a preference for the services they currently use, and services perceived to be available in their local area.[107] The 2015 Service Reports locate only 11% of the 139 ACCHOs in major cities; with 33% in very remote areas.[108] Perhaps not surprisingly then GPs were the preferred health service providers of respondents in major cities (68%) compared with 10% in very remote areas;[109] and 95% of those living in major cities reported GPs being available compared with 31% in very remote areas.[110]

Another factor that might be shaping perceptions of AMS and ACCHOs are resource limits on the services they can offer. With appropriate resources, an ACCHO is able to implement a comprehensive primary health care model based on the culturally shaped, holistic concepts of health understood by the communities they serve.[111] However, in the 2015 Service Reports, of the 203 Aboriginal and Torres Strait Islander primary health care organisations including ACCHOs, 55% reported service gaps for mental health and social and emotional wellbeing, 53%—youth services; 47%—alcohol, tobacco and drug services; 42%—service gaps for the prevention and early detection of chronic disease.[112]

A further factor that could negatively impact the services offered by ACCHOs is the 2012 freeze on GP and non-GP Medicare rebates continuing until July 2018, announced by the Australian Government along with its decision not to proceed with a 2014–15 Federal Budget proposal to introduce a GP co-payment.[113]

The freeze is continuing despite the fact health care costs continue to rise above the rate of inflation. In April 2015 the Australian Government permitted private health insurance companies to increase their annual premiums by an average of 6.2%.[114] The peak body for private health insurance companies, Private Healthcare Australia, explains that the 'the increasing costs of treatments and services (in particular increased costs due to technology and higher provider and contracting costs) and higher utilisation of treatments and services' justify the increase.[115]

A recent study has estimated that by 2017–18, the freeze would amount to a 7.1% reduction in GP rebate income compared with 2014–15.[116] It is generally expected that GPs will pass increased costs onto patients, as many do already. But ACCHOs don't pass on such costs—to ensure their services remain affordable (and therefore economically accessible) to Aboriginal and Torres Strait Islander people. At worst then the freeze could result in staff or service cuts. Whatever its impact, it will be a disproportionate one on ACCHOs and the users of ACCHOs, who are predominantly Aboriginal and Torres Strait Islander people, over other primary health services and their clients.

There are further risks on the horizon. In April 2015, a Medicare Benefits Schedule (MBS) Review Taskforce was established to consider how MBS items can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. While there are potential benefits that could accrue to Aboriginal and Torres Strait Islander people through the review, there are also risks that items may be de-listed with a disproportionate impact on Aboriginal and Torres Strait islander people. Similar risks attach to the ongoing roll out of the Primary Health Networks and a broad review of primary health care currently underway.[117]

In the 2015 *Progress and Priorities Report*, the Campaign called for Aboriginal and Torres Strait Islander health impacts to be actively considered in all policies from design through to implementation. This would adequately reflect closing the gap as a national priority. While further work is required to ascertain the best mechanism and processes to achieve this goal, this call is repeated here.

The Campaign Steering Committee will continue to monitor and report on the above and other general population health reforms initiated over the next year that could disproportionately impact on ACCHOs and Aboriginal and Torres Strait Islander people.

2.2 Blocks to service use, including racism and institutional racism in services

For respondents to the NATSIHS, racism was both a common experience in daily life, and a barrier to health services: 16% of respondents reported being 'treated badly because they are Aboriginal/ Torres Strait Islander'[118] in the previous 12 months.[119] Of this cohort, 8% reported this occurred 2–3 times per week and 5% reported this was a daily occurrence.[120] The most common situation of racially discriminatory behaviour or racism was by members of the public (45%) and applying for work or while at work (29%).[121]

Of the cohort reporting being 'treated badly because they are Aboriginal/ Torres Strait Islander'[122] in the previous 12 months, 20% reported being treated in a racially discriminatory way by doctors, nurses or other staff in hospitals or doctors' surgeries (about 3.2% of all respondents).[123]

About 7% of respondents reported that they had avoided seeking health care because they had been treated unfairly.[124]

The Campaign Steering Committee has long maintained that confronting racism in health services should be a priority for Australian governments. It is for this reason that part of the *National Aboriginal and Torres Strait Islander Health Plan's* vision is for 'a health system …free of racism and inequality.'[125]

Otherwise, data collections suggest the presence of 'institutional racism' in the health system. This 'refers to the ways in which racist beliefs or values have been built into the operations of social institutions'. A simple example is a monolingual service operating in multilingual area: it will inherently discriminate against those who do not speak the service-language unless it makes concerted efforts to overcome this barrier. Because it does not have to be overtly racist, institutional racism often goes unrecognised by services.[126]

A further example, often unrecognised as institutional racism, is provided by the failure of health services to ask patients whether they are Aboriginal and Torres Strait Islander either because they are assumed not to be, or else because the question is perceived as awkward to ask. This may explain why in the Bettering Evaluation and Care of Health (BEACH) survey of GP activity only 1.7% of patients were identified as Aboriginal and Torres Strait Islander in 2014–2015. While up from 1% in 2005–2006, at face value this is still a significant under-representation given that 3% of the population were estimated to be Aboriginal and Torres Strait Islander at the time of the 2011 Census.[127]

In this report, the Campaign Steering Committee has already suggested that the gap in cancer survival might be indicative of institutional racism. Further, AHMAC report that in the two years to June 2013, excluding care involving dialysis, 59% of hospital episodes for Aboriginal and Torres Strait Islander people had a procedure recorded, compared with 80% of hospital episodes for other Australians.[128]

In other words, despite Aboriginal and Torres Strait Islander people having significantly worse health at the population level, and despite the fact that they are more likely to be hospitalised when compared to non-Indigenous people, they are *less* likely to receive a medical or surgical procedure while in hospital.

In terms of improvements in access, there has been a significant increase in Aboriginal and Torres Strait Islander hospitalisation rates with a procedure recorded between 2004–2005 and 2012–13 in NSW, Victoria, Qld, WA, SA and the NT combined to the extent that the gap for those jurisdictions has halved.[129] Nonetheless, the current situation requires urgent attention. In all states and territories, the current situation is that Aboriginal and Torres Strait Islander people remain less likely to receive a procedure, with the gap increasing with remoteness.[130]

This is of significant importance to closing the health gap. Between July 2011 and June 2013, among those hospitalised with coronary heart disease, Aboriginal and Torres Strait Islander people were nearly *half* as likely to receive coronary procedures as other Australians,[131] despite CVD being the single largest cause of death. For hospitalisations related to diseases of the digestive tract, Aboriginal and Torres Islander patients also received a corresponding procedure at significantly lower rates that their non-Indigenous peers.[132]

At least *part* of the reason appears to be negative perceptions or experiences Aboriginal and Torres Strait Islander people have of and in hospitals. While specific reasons are not provided, between July 2011 and June 2013, AHMAC reports that 5% of all hospitalised Aboriginal and Torres Strait Islander people left hospital against medical advice or were discharged at their own risk.[133] This compares with 0.5% for non-Indigenous people.[134]

There is other evidence of a problem with hospitals and their relationship to Aboriginal and Torres Strait Islander people. Referring to the previously discussed 30% of NATSIHS respondents who reported that they needed to but didn't go to a health care provider in the previous 12 months, 27% reported barriers in relation to hospitals.[135]

Based on the above discussion, the following recommendation is made.

Recommendation

That a national inquiry into racism and institutional racism in health care settings, and hospitals in particular, and its contribution to Aboriginal and Torres Strait Islander health inequality, is undertaken by the Senate Select Committee on Health.

The Campaign Steering Committee notes that the presence of Aboriginal Health Workers has been shown to reduce the number of discharges from hospital by Aboriginal and Torres Strait Islander people against medical advice.[136] In particular, this has increased participation in cardiac rehabilitation, which, in turn, has been shown to have a significant impact on survival rates for CVD.[137] How to improve Aboriginal and Torres Strait Islander people's experience and perception of hospitals as well as other health services is discussed below.

The Close the Gap Campaign welcomes the ongoing work of member the Australian Healthcare and Hospitals Association and its partners to validate the Marrie Institutional Racism Matrix (MIRM).[138] This was developed in 2014 as 'a tool for external assessment purposes to identify, measure and monitor racism in an institutional setting' and 'to provide a measure for public health sector engagement with Aboriginal and Torres Strait Islander people in the decision-making, planning, implementation and accountability processes regarding Aboriginal and Torres Strait Islander community healthcare needs and service delivery'.[139] It is hoped the MIRM will make a significant contribution to understanding institutional racism in health services over the next decade.

2.3 Cultural competence/respect of services

The Australian Health Ministers' Advisory Council developed the *Australian Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* as a guiding principle in policy construction and service delivery for use by different jurisdictions. The Framework has seven guiding principles: a holistic approach, health sector responsibility, community control of primary health care services, working together, and promoting good health, building the capacity of health services and communities, and accountability for health outcomes. It is aimed to influence health services and their delivery and covers the four key areas of: (1) improved outcomes and quality; (2) more efficient and effective services; (3) expenditure reduction; and (4) improved customer satisfaction.

Preparing undergraduates and health professionals to deliver culturally respectful health services requires education programs that are evaluated for long-term improvements to practice.[140] Communities of practice such as the Leaders in Indigenous Medical Education are working to embed lifelong learning skills for cultural competency within medical curricula. Such training across the sector is critical to achieving the institutional, professional and personal commitment required for systemic change. Healthcare providers need to not only reflect on their own attitudes, but take the lead to work collectively to effect systemic change.[141] Self-reflection to eliminate bias, relationships with Aboriginal and Torres Strait Islander people and partnership building are seen as key to reducing health disparities.[142] The importance of relationships can be the following study of health service cultural respect strategies.

A 2014 study involved six primary health care service providers including an ACCHO and a government-run Aboriginal Health Team being assessed for 'cultural respect': defined with reference to the *Australian Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* as 'the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples.'[143] Assessment included Aboriginal and Torres Strait Islander client feedback.[144]

By this method, contributors to ensuring a culturally respectful service included (but were not limited to):

- A 'social view' of health that saw health and social problems as coterminous and services that could work with both.

- Aboriginal health professionals—with which clients reported feeling more comfortable talking about health problems.

- Aboriginal health workers or liaison officers to accompany clients to external appointments and build confidence in external services. This was important to help mitigate the racism and poor treatment clients sometimes experienced in external services (as noted above, in hospitals).

- Proactive strategies to support access—including by provision of transport and outreach services.

- Cultural protocols and cultural advisory boards working with the governance framework of the service.[145]

The study found a particular strength of the community controlled model was the freedom and capacity of the service to respond to the local situation, and incorporate local community and cultural knowledge into program development and service delivery.[146]

As has been discussed, this is a primary reason for the Close the Gap Campaign's support for ACCHOs above all other models of primary health service delivery in Aboriginal and Torres Strait Islander communities. But ACCHOs are also able to meet high clinical standards: in 2013–2014, 94% were accredited either with the RACGP or against organisational standards.[147]

In other (non-community controlled) contexts, the study reported that the personal commitment of staff to cultural respect principles was critical.[148] As such, the employment of Aboriginal and Torres Strait Islander staff, particularly from the local community, was a central strategy for achieving cultural respect across all health services.[149]

The Service Reports do not disaggregate employment data for ACCHOs, but in Indigenous primary health care organisations overall 53% of full time staff employed were Aboriginal and Torres Strait Islander people.[150] While relatively few doctors and nurses were Aboriginal and Torres Strait Islander (7% and 12% respectively),[151] about 99% of Aboriginal and Torres Strait Islander health workers were,[152] as were 87% of drivers and field officers,[153] and 74% of those in other health positions.[154]

Otherwise, preparing non-Indigenous undergraduates and health professionals to deliver culturally competent health services, or effective health services across cultural boundaries requires training and placements in ACCHOs.[155] Such training across the sector is critical to achieving the institutional, professional and personal commitment required for systemic change.

2.4 Targeting the right mix of health services for closing the gap

The avoidable and preventable mortality gap was discussed in Part 1 of this Report. Here the Campaign Steering Committee considers using this data to enable policy makers to focus on the kinds of health services needed to close the gap.

According to AHMAC, over 2008–2012 the greatest contributors to the avoidable and preventable mortality gap were:

- 19%—ischaemic heart disease[156] (22% of the gap);[157]
- 18%—cancer[158] (14% of the gap);[159] and
- 10%—diabetes[160] (17% of the gap).[161]

As a result, AHMAC report that the greatest opportunities to reduce avoidable mortality for Aboriginal and Torres Strait Islander people relate to:

- primary prevention (53% of avoidable deaths);
- secondary interventions (24%); and
- tertiary interventions (23%).[162]

Hospitalisations for conditions that can be effectively treated in a non-hospital setting are referred to as 'potentially preventable admissions' in data collections. These include conditions for which hospitalisation could potentially be avoided through effective preventive measures or early diagnosis and treatment in primary health care.[163]

According to AHMAC, from July 2011 to June 2013 hospitalisation rates for selected potentially preventable conditions were:

- 7.3 times as high for Aboriginal and Torres Strait Islander people living in remote areas;
- 3.5 times as high in very remote areas;
- 2.8 times as high in outer regional areas;
- 2.7 times as high in major cities; and
- 2.1 times as high in inner regional areas.[164]

A recent spatial mapping exercise by AIHW confirmed that a significant number of Aboriginal and Torres Strait Islander communities are without access to any Indigenous-specific primary health services. The AIHW noted that 61% of these populations reported higher rates of potentially preventable hospitalisations,[165] suggesting the impact of the absence of these services.

The Campaign Steering Committee also notes a 2014 study, *The cost-effectiveness of primary care for Indigenous Australians with diabetes living in remote Northern Territory communities*, demonstrates increased investment in primary health care could be expected to yield health and cost dividends. As noted, deaths due to diabetes were six times higher for Aboriginal and Torres Strait Islander people than non-Indigenous people, and the leading cause of the gap for females.[166] No significant absolute or relative changes were detected over 2008–2012.[167]

The 2014 study reported that those who visited primary care 2–11 times per year had lower rates of death and hospitalisations than those who visited less than twice a year.[168] But further, investing $1 in medium-level primary care for people with diabetes in remote Aboriginal and Torres Strait Islander communities could save $12.90 in hospitalisation costs. **Investing $1 in high-level primary care use could save $4.20**.[169]

The health and cost benefits, and the potential contributions to closing the health gap, from increasing Aboriginal and Torres Strait Islander peoples' access to primary health care, particularly in relation to the effective detection, treatment and management of diabetes should not be underestimated.

The UN Sustainable Development Goals

Delivering a *National Statement* to the UN General Assembly on 29 September 2015, Foreign Affairs Minister, The Hon Julie Bishop MP, underscored her government's support for the Sustainable Development Goals (SDGs), reminding delegates of Australia's crafting of Article 56 of the 1945 UN Charter, known as the 'Australia Pledge'. By this, UN members commit to 'achieve higher standards of living… solutions to international economic, social, health and related problems… and universal respect for and observance of human rights and fundamental freedoms.'[170] Minister Bishop continued:

> Today I reiterate that pledge. The 2030 Agenda for Sustainable Development… is a manifestation of the Australia Pledge … Should we realize all 17 Goals, we will transform our world for the betterment of humankind. We must ensure that the remarkable spirit of cooperation displayed during the negotiation process is maintained as we work to turn these ambitious Goals into reality.[171]

In particular, the SDGs are directly relevant to the achievement of health equality for Aboriginal and Torres Strait Islander peoples. For example combining Goal 10 (to reduce inequality within nations) and Target 3.8 to 'achieve universal health coverage, including… access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all' is capable of driving domestic action to achieve health equality.[172]

The Campaign Steering Committee welcomes the Australian Government's commitment to the SDGs, and looks forward to their domestic implementation as appropriate, and the further impetus they should provide to the *Closing the Gap Strategy* and to closing the health inequality gap, as well as to the *Indigenous Advancement Strategy*. It highlights the Department of Foreign Affairs and Trade's *Indigenous Peoples Strategy 2015–2019: A framework for action* as a model for how implementation could be progressed.

3 Priorities for 2016 and the next term of Parliament

The new Close the Gap Campaign Co-Chair Jackie Huggins at a campaign event at Allens Lawyers in Brisbane. Photograph: Jason Malouin/OxfamAUS.

This part of the report sets out the kind of action the Campaign Steering Committee would like to see take place over 2016, including in the 45th Australian Parliament following the next federal election.

3.1 Staying on track for the longer term, and reinvigorating the *Closing the Gap Strategy*

The *Closing the Gap Strategy* is founded on a bipartisan, intergenerational commitment that transcends the terms of governments and the vagaries of politics. It is critical that all Australian governments, regardless of their particular focuses, maintain their overall commitment to the *Closing the Gap Strategy*, and that all feel the importance of their respective contributions to what is in effect a 'nation-building' effort that requires sustained attention over decades.

In the Campaign's 2013 *Building on the Close the Gap platform: Commitments for an incoming government*, prepared for the Federal Election that year, it set out an agenda for reinvigorating the *Closing the Gap Strategy*. Many of these recommendations remain relevant to the forthcoming election, as reflected in the recommendations of this report.

Further, the renewal of the *National Indigenous Reform Agreement* (NIRA) in 2018 provides opportunity for a reinvigoration of the *Closing the Gap Strategy*. As noted in the NIRA, it is:

> …like other National Agreements… a living document subject to enhancement over time to reflect additions and changes to existing and new National Agreements and National Partnership agreements. As COAG agrees to additional reforms to Close the Gap in Indigenous disadvantage, these will be reflected in this Agreement.[173]

(a) Evaluation, monitoring and reporting

The Campaign Steering Committee would like to see formal ongoing processes for national monitoring and reporting on efforts to close the gap associated with the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan* in accordance with benchmarks and targets—in association with formal management use of the information to progressively improve service standards and effectiveness.

This should include a requirement for this process to be undertaken in partnership with Aboriginal and Torres Strait Islander peoples and their representatives. If legislated, it should also have a sunset clause of 2031—the year after the date by which all parties have committed to close the gap in health equality. This would have the added advantage of helping enshrine the *Closing the Gap Strategy* over the next fifteen years, when sustained focus on achieving equality must be maintained, and the temptation to achieve short-term gains over longer term sustainable health and other gains resisted.

In its 2013–2014 Performance Assessment of the NIRA, the Productivity Commission made the following findings:

- While tracking progress towards an outcomes end point can inform policy making, it is not a substitute for examining the role of specific policies in reducing disadvantage, and assessing their cost effectiveness in absolute terms and relative to other approaches.

- The critical role that robust policy evaluation could, and should, play in improving outcomes for Aboriginal and Torres Strait Islander people is widely acknowledged.

- Though such evaluation can be challenging, a much stronger evaluation culture in the Indigenous policy area should be promoted. It is important that such evaluations consider the effectiveness of mainstream services which account for 80% of Aboriginal and Torres Strait Islander expenditure.

- Options for invigorating evaluation include: an overarching review of policy evaluation in the Indigenous area; COAG committing to evaluating policy settings in a target area or a sub-set of policies in a particular area (say education); and adding a procedural, evaluation-focused target to the Closing the Gap initiative.[174]

The Campaign supports these calls. In particular, a greater focus on quality policy evaluation will be a significant step towards achieving thoroughly considered health impacts in all policies from design through to implementation—as called for in the 2015 *Progress and Priorities Report*.

Willun, aged 7, in Thornbury, Victoria. Photograph: Bonnie Savage/OxfamAUS.

(b) Additional Closing the Gap Targets

In 2013, the Campaign Steering Committee proposed that in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, COAG develop additional Closing the Gap Targets in relation to incarceration rates and community safety. These calls are as relevant as ever in 2016. The 2015 adoption of a Closing the Gap Target for rates of school attendance by COAG shows the potential of adding other targets to the *Closing the Gap Strategy*.[175]

The Campaign remains particularly concerned about imprisonment rates and community safety (particularly family violence)—which are only getting worse. In 2013, the age standardised imprisonment rate for Aboriginal and Torres Strait Islander people was 13 times greater than for non-Indigenous Australians in 2015.[176] The year 2016 marks a grim milestone in the numbers of Aboriginal and Torres Strait Islander people being held in custody. Under current projections, for the first time over 10,000 will be in custody on the night of the annual prison census, 30 June 2016, including over 1,000 women.[177] Currently, Aboriginal and Torres Strait Islander people comprise 27% of all sentenced prisoners,[178] and 29% of un-sentenced prisoners,[179] despite being only 3% of the population.[180]

The following recommendation also draws on earlier discussion about the need for input targets and indicators, rather than exclusive reliance on those for outcomes.

The Campaign commends the 2015 Australian Medical Association's *Report Card on Indigenous Health—Closing the Gap on Indigenous Imprisonment Rates* for its proposals around reducing imprisonment in part by addressing the health problems associated with incarceration, in particular mental health problems, substance abuse disorders and cognitive disabilities.[181]

(c) An increased focus on disability

The Campaign Steering Committee also supports the adoption of a Closing the Gap Target for access to the National Disability Insurance Scheme (NDIS)—as first proposed by the (then) Minister for Families, Community Services and Indigenous Affairs at the May 2013 launch of Campaign member First Peoples Disability Network's (FPDN) *Ten-point plan for the implementation of the NDIS in Aboriginal communities*.[182]

Developed by a working group led by the FPDN Executive Officer, a target that 90% of eligible Aboriginal and Torres Strait Islander people will be receiving funded support from the NDIS (then Disability Care Australia) by 2020 was eventually agreed,[183] but never formally adopted.

The 2015 Aboriginal and Torres Strait Islander Social Justice Commissioner's *Social Justice and Native Title Report* highlights the extent of disability in the Aboriginal and Torres Strait Islander population (as set out in the text box below). It describes the work of the FPDN in this space and it considers the challenges in this space particularly in relation to the NDIS. In particular, the Campaign supports the recommendations made in this report. The Campaign Steering Committee calls for the inclusion of a target for Aboriginal and Torres Strait Islander people with disability in 2016 and also calls on the Australian Government to act on the recommendations (11–16) of the 2015 *Social Justice and Native Title Report*.[184]

Recommendation 14 of that Report is about Disability Support Organisations (DSOs) that the National Disability Insurance Agency is funded to assist NDIS participants, and their families and carers to engage with the NDIS by providing information and support. So far, 18 community organisations, including the FPDN and the Aboriginal Disability Network NSW have been funded to act as DSOs. Each operates up to 20 local support groups. The Campaign, in turn, recommends that services for Aboriginal and Torres Strait Islander people with disabilities are implemented as a priority.

Significantly, for the *Closing the Gap Strategy* and the IAS, severe and profound disability in particular is associated with both lower educational attainment and higher rates of unemployment. The data suggests that any attempt to improve outcomes in these areas will need to substantially address disability as a determinant of lower educational attainment and unemployment, as well as being a significant contributor to the health equality gap.

A snapshot of the rates of disability among Aboriginal and Torres Strait Islander people

The Australian Institute of Health and Welfare conceptualises disability as 'an impairment of body structure or function, a limitation in undertaking activities and/or a restriction in participation in life situations'.[185] In the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) 2012–13, among Aboriginal and Torres Strait Islander respondents:

- 36% (equivalent to about 228,000 people) had some form of disability;

- 6.4% (equivalent to about 41,000 people) had severe or profound disability, with rates spread relatively evenly over remote and non-remote areas.[186] As such, Aboriginal and Torres Strait Islander people were twice as likely as non-Indigenous Australians to have severe or profound disability.[187] Rates were significantly higher in all age groups except those aged under 15 and those aged 65 and over.[188]

- The most common disability types among those with severe or profound disability were physical disability (70%) and sight, hearing or speech-related disabilities (53%).[189]

In the AATSIHS 2012–13, among respondents aged 20 and over, Year 12 or equivalent completion rates:

- were significantly lower among those with a severe or profound disability (19%) than among those people who did not (26%);[190] and

- were significantly lower among those with severe or profound disability than all Australians with severe or profound disability (19 and 29% respectively).[191]

Further, among respondents aged 15 to 64, employment-to-population ratios:

- were significantly lower among respondents who had severe or profound disability (21%) than among those who did not (50%);[192] and

- were significantly lower among respondents with severe or profound disability than all Australians with severe or profound disability (21% and 38%, respectively).[193]

(d) Social and emotional wellbeing and mental health

The Campaign Steering Committee also notes the recurrent theme of social and emotional wellbeing and mental health continuing to be highlighted by services, evaluation and policy reviewers as a significant service gap. We note the recommendations contained within the 2015 Mental Health Commissions Report *Contributing Lives*, *Thriving Communities – Review of Mental Health Programmes and Services*, *2015.* The Report highlighted that there is a significant mental health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people, with Aboriginal and Torres Strait Islander people more likely to experience psychological distress, hospitalisation for mental illnesses and death from intentional self-harm. Despite having greater needs, Aboriginal and Torres Strait Islander people experience lower access to mental health services than the rest of the population.

The Campaign Steering Committee supports the Mental Health Commission's recommendations:

- **Recommendation 5** – Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.

- **Recommendation 18** – Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

(e) New approaches to funding based on equitable principles

Long-term policy requires long-term funding models. In a time of fiscal constraint, the Campaign Steering Committee repeats its 2013 calls for the securing of an equitable share of mainstream funding to contribute to closing the health gap and reinvigorate the *Closing the Gap Strategy*.

This will require the development of a new mechanism to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis that reflects both the population size and an index of need and the adoption of the public policy principle that services be provided by agencies that can deliver the best results in terms of access and quality. Given that the available evidence indicates that ACCHOs outperform mainstream services in terms of identification of risk and service provision, the implication is that funds should be directed through ACCHOs, unless it can be shown that other services could provide better results, also taking into account employment and capacity building in wider terms.

As has been discussed, it is critical to focus on health inputs as much as outcomes in the effort to achieve Aboriginal and Torre Strait Islander health equality. Further, that complaints about the effectiveness of the *Closing the Gap Strategy* often neglect the economic framework in which it is operating. While it may be stating the obvious, it is critical to grasp that outcomes from a system, including a health system, will depend on the quantum and quality of inputs. As highlighted by Alford in her 2015 critique, this disconnect in policy is demonstrated by the fact that nearly a third of health system performance indicators of the 2015 World Health Organization's 100 core health indicators relate to expenditure.[194] In contrast, the *Aboriginal and Torres Strait Islander Health Performance Framework* has only one indicator dedicated to expenditure.

As Alford highlights, Australian governments have failed to maintain Aboriginal and Torres Strait Islander health expenditure over time, in line with the rapid growth of the Aboriginal and Torres Strait Islander population, as recorded in the 2011 Census. While Australian Government health expenditure is expected to increase by 8% over the two years to 2015–16, the Aboriginal and Torres Strait Islander funding proportion will fall by 2%, a cut of $88 million in real terms. As a result, the proportion of the health budget allocated to Aboriginal and Torres Strait Islander health will shrink, from 1.18% in 2013–14 to 1.07% in 2015–16.[195]

As the Campaign Steering Committee has highlighted in previous reports, government expenditure is not commensurate with the substantially greater and more complex health needs of Aboriginal and Torres Strait Islander people and should be indexed to reflect these needs and the critical shortfall is in the circuit breaking field of primary health care. While the average health expenditure per Aboriginal and Torres Strait Islander person is 1.47 times that for non-Indigenous people, an expenditure index of (at least) double may appropriately reflect greater health needs.

(f) Connections to the Indigenous Advancement Strategy

In the 2015 *Progress and Priorities Report*, the Campaign Steering Committee called for greater connections from the IAS to the *Closing the Gap Strategy*. It argued that such connections will bring advantages to both, contributing to a broader, holistic approach that includes health and social determinants equally.

The Campaign Steering Committee has always appreciated the contribution of negative social determinants to health inequality. A commitment in the *Close the Gap Statement of Intent* is to: '[work] collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples' (see previously in this report). For this reason it views the IAS as being entirely compatible with the achievement of health equality and the Closing the Gap Strategy.

In fact, the *Closing the Gap Strategy* already works in areas that overlap with the IAS, but more holistically, through its seven 'building blocks' model that includes: Early Childhood; Schooling; Healthy Homes; Safe Communities; Economic Participation; and Governance and Leadership and Health. The model is intended to achieve not only better health outcomes, but better outcomes in all seven building block areas, recognising their interdependence.[196]

In 2014, AIHW undertook a review of research into the underlying causes of the Aboriginal and Torres Strait Islander health equality gap. They also conducted their own evaluations using health survey data and models. They estimated that social determinants and behavioural risk factors accounted for up to 57% of the health gap.[197] That is:

- **Social determinant**—one-third (31%) of the gap.[198] Household income, highest level of school, and employment status had the largest estimated impact.[199]

- **Behavioural factors**—11% of the gap.[200] Smoking status, body mass index, and binge drinking were the most important.[201]

- **Interactions between social determinants and behaviours risk factors**—additional 15% of the health gap.[202]

Other factors, and particularly **access to health services, accounted for 43% of the health gap**. However, the AIHW cautioned that the 'complex relationship between health service access, social disadvantage, health behaviours, and health outcomes' should be noted when considering their estimations.[203] In other words, low income (a social determinant) could dissuade people from 'out of pocket' health service or medication use, for example. Indeed, as cited in Part 2 of this report, in the NATSIHS 2012–2013 30% of respondents who indicated they needed to go a health service didn't go. Of these, cost was cited by 13% as a reason.

Further, as noted in the 2015 *Progress and Priorities Report*:

> If the significance of education is indicative of the capacity to access and act on health information, health promotion initiatives that provide information about healthy lifestyles and encourage increased engagement with primary care services should aid in [ill-health] prevention...[204]

The connectedness of income/employment and education (both IAS priorities) to health and vice versa (good health being a pre-requisite for effective participation in the workforce and in education) underscores the need to develop and expand the linkages between the IAS and the *Closing the Gap Strategy* for the enhancement of both.

Regardless of the precise contributions of social determinants and the lack of access to health services to the health gap, there is no doubt that both contribute to health inequality. As such, the Campaign Steering Committee has always maintained that both sustained investment in primary health care and health services *and* action on the social determinants is a critical for closing the gap.[205]

Former Co-Chair Kirstie Parker and current Co-Chair Mick Gooda at the 2015 National Close the Gap Day event in Sydney.
Photograph: Australian Human Rights Commission.

Griew's 2008 analysis of *The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians* for the (then) Office of Aboriginal and Torres Strait Islander Health reminds us that an exclusive focus on social determinants is misguided: 'notwithstanding the powerful effects of the broader social determinants of health and socioeconomic factors in particular, health systems do have a significant effect on the health of populations.'[206]

Further, what is often overlooked in the arguments for universal primary health care is that 'increased primary health care resources are… able to offset some of the harmful health effects of socioeconomic disadvantage and inequality.'[207]

The Campaign believes that connections between the *Closing the Gap Strategy* (and the achievement of health equality in particular), and the IAS should be articulated to make both more effective and holistic overall response to Aboriginal and Torres Strait Islander disadvantage.

3.2 Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan

In previous reports, the Close the Gap Campaign welcomed the July 2013 the *National Aboriginal and Torres Strait Islander Health Plan* (Health Plan) jointly launched by then Indigenous Health Minister, The Hon Warren Snowdon MP and the then National Health Leadership Forum Chair Jody Broun. As discussed, the Health Plan was developed by the Aboriginal and Torres Strait Islander health peaks of the NHLF working in partnership with the Australian Government.

From mid-2014 through to October 2015, the NHLF and the Australian Government led by Rural Health Minister, Senator the Hon Fiona Nash, again worked in partnership to develop an implementation component. On 22 October 2015, Minister Nash and NHLF Chair, Romlie Mokak, launched the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health*. The Campaign Steering Committee considers the work in partnership between the NHLF and the previous two governments in the development of the Health Plan and the Implementation Plan is a good model for policy development in this space.

Looking forward, the Campaign Steering Committee identify the following as challenges in the ongoing implementation process:

- **Identifying areas with relatively poor health and not enough services**. This is in order to make capacity building of services in those areas a priority. This includes for ACCHOs that, as highlighted above, service gaps for mothers and babies, mental health, chronic disease and youth, drug and alcohol.

- Defining the core services and associated workforce and funding strategies needed to close the gap. Once in place, there is a need to (a) develop the right funding models to support the services and (b) focus on education and training of the health workforce to meet the additional service needs including across all professions and specialisations.

'increased primary health care resources are… able to offset some of the harmful health effects of socioeconomic disadvantage and inequality.'

Robert Griew, 2008

'The Government, through Minister Nash, has worked in genuine partnership with Aboriginal and Torres Strait Islander people to develop an effective plan for achieving better health outcomes for our people…From here, we must all ensure implementation of the plan, including addressing the wider social and cultural determinants of health and wellbeing.'

Romlie Mokak, Chair, National Health Leadership Forum

- Continuous Quality Improvement (CQI) processes. Getting everyone, and all services involved, to understand and implement CQI within the above service model development and refinement process.

- Improving management and information processes. Ensuring eHealth technology is used in an equitable and needs based fashion to support the monitoring and improvement of quality and continuity of care for clients as they transition across the health system.

A further critical challenge is to develop an appropriate set of targets to support achieving health equality. The Campaign Steering Committee has consistently supported the use of targets in the national effort to close the gap, noting that their use is a hallmark of the human rights-based approach to eradicating poverty and inequality. To that end, the Campaign Steering Committee developed the 2008 *National Indigenous Health Equality Targets*;[208] and the *Close the Gap Statement of Intent* includes a commitment 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'.

As discussed in this and previous Campaign reports, targets should not just measure outcomes, but should be used to back the increase in inputs needed to support the implementation of new service models and expansion of existing services. And such should in particular focus on health expenditure. Targets for service capacity, workforce and funding in line need to be developed within twelve months.

There is also a need for public servants, administrators and clinicians to be trained to be provide the necessary skills to implement the *Implementation Plan for the National Aboriginal and Torres Health Plan*. This includes, but is not limited to, cultural respect training as discussed in Part 2 of this report. Also critical, is the employment of Aboriginal and Torres Strait Islander public servants, administrators and clinicians, including at the highest levels of the Department of Health, to help implement it.

3.3 Primary Health Networks that support Community Controlled health

Australia's health system has a history of weak coordination between primary health providers including GPs, pharmacists, nurses, allied health professionals, ACCHOs; and between primary health and secondary and acute health care. Such an uncoordinated approach has implications for the coordination of patient care,[209] which is particularly important for Aboriginal and Torres Strait Islander people with chronic disease. It also creates inefficiencies and waste across the health system as a whole: resources that could be better invested, including in Aboriginal and Torres Strait Islander health.

Successive Australian governments have taken steps to rectify this. In the 1990s, 110 Divisions of General Practice were introduced to promote the better coordination of GPs. These were replaced in 2011–2012 by 61 Medicare Locals focused on integration of services and joint Commonwealth and State government planning for service delivery and access.[210]

Medicare Locals (MLs) were non-profit companies that operated independently. They were designed to take an active role in identifying gaps in primary health care and developing strategies to meet these gaps including by partnerships and collaboration between health service providers in their area, including ACCHOs. A particular focus was to plan for and support local after hours GP services. They also worked closely with Local Hospital Networks (LHNs) and aged care services for better patient transitions across the entire health care system.

In December 2013, the Australian Government announced a review into the MLs. Reporting in March 2014, the Australian Government's response to the review was announced in the 2014–15 Budget: MLs would be replaced by Primary Health Networks (PHNs).

The PHNs will do broadly similar work to the Medicare Locals, but with some differences:

- There are about half the number of PHNs (31) when compared to MLs (61). As was the case with MLs, some PHNs have enormous jurisdictions encompassing many Aboriginal and Torres Strait Islander communities and ACCHOs.

- The PHN jurisdictions are broadly aligned with that of the LHNs—these are responsible for hospital performance within their jurisdictions.

- Rather than directly providing services themselves, PHNs will primarily be commissioning organisations, purchasing services in response to gaps and shortages.[211] Where it is not possible to purchase services due to market failure, with permission of the Commonwealth Department of Health, a PHN may provide services. PHNs may also provide some services for a short period as part of the transition from Medicare Locals.[212]

In July 2015, following a tender process PHNs began operating. The majority of the successful bidders were either consortia of former MLs or have a ML as the lead applicant. In fact, in the ACT, Tasmania and Northern Territory Medicare Locals will simply have a name change to PHN. In Queensland, several PHNs have been won by local Hospital and Health Services rather than MLs, including Northern and Western Queensland PHNs.[213]

The Australian Government has set six priority areas for address by PHNs: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.[214]

Certainly, PHNs have been placed at the centre of primary mental health care delivery. In November 2015, the Australian Government response to the National Review of Mental Health Programmes and Services was announced. A key element is the shift towards regional mental health service integration by PHNs. In addition to their wider responsibilities, PHNs will be responsible for mental health planning and integration, and the commissioning of services to meet needs gaps. These activities will be guided by a *National Service Planning Framework*, and stepped model of mental health care.[215] The PHNs are also required to prepare a mental health service plan for Aboriginal and Torres Strait Islander peoples as a part of their overall responsibilities.[216]

Further, in its response to the report of the National Ice Taskforce, PHNs were provided about $240 million to commission treatment services, and to ensure local coordination and better patient management. This includes funding to support the delivery of Aboriginal and Torres Strait Islander-specific treatment services.[217]

The PHN's should ensure resources are applied in order to meet the nationally agreed policy targets to Close the Gap, and include identification of service gaps and demand, as well as cultural safety, to this end. The Campaign Steering Committee will monitor the PHNs in 2016 and our findings will be a primary focus of the 2017 *Progress and Priorities Report*. In particular, the Campaign will focus on:

- PHNs proactive engagement with Aboriginal and Torres Strait Islander communities within their regional boundaries, including working with community protocols and culturally-informed governance structures. Recognising the barriers many communities face, PHNs must actively support the involvement of communities in the various planning and community engagement mechanisms designed to ensure they have a voice in PHN and related regional structures.

- The cultural safety of the above planning forums in which Aboriginal and Torres Strait Islander communities and other representatives are intended to participate. This may involve the use of translators if required, and ensuring that these forums are culturally respectful, culturally aware and otherwise sensitive to the cultural differences and different needs based on these.

- The employment of Aboriginal and Torres Strait Islander people at all levels of PHN organisations. In part, this is to increase a sense of cultural safety for communities interacting with the PHN (as above). Otherwise, their very presence may help by 'acculturating' the service to local needs.

Finally, in broad terms, and where available, ACCHOs not only provide good points of contact with communities for health matters, but they are also ideally placed for PHNs to partner with in relation to identifying a range of services needs and gaps, and to shape the commissioning of services. Where possible, services for Aboriginal and Torres Strait Islander communities should be integrated with mental health, social and emotional wellbeing and substance abuse services provided by the ACCHOs.

In Part 2, the Campaign Steering Committee discussed that ACCHOs were the preferred provider of health services to Aboriginal and Torres Strait Islander communities. Here we synthesize this point with recommendations about the Implementation Plan and the work of the PHNs.

Recommendation

That through the *Implementation Plan for the National Aboriginal and Torres Health Plan*, appropriate core health service models and associated workforce and funding arrangements are urgently developed to meet Aboriginal and Torres Strait Islander health needs on a national, regional and community level, and immediate priority be directed towards regions with relatively poor health and inadequate levels of service.

Queensland Aboriginal and Islander Health Council (AIHC) staff at the 2014 National Close the Gap Day event in West End, Brisbane. Photograph: Jason Malouin/OxfamAUS.

> **Recommendation**
>
> That Aboriginal Community Controlled Health Services (ACCHOs) should be the preferred model for investment in primary health care services for Aboriginal and Torres Strait Islander communities and that the planning activities of the Primary Health Networks include partnership and service delivery arrangements through and by the ACCHOs.

3.4 Reform the Indigenous Advancement Strategy

The total Aboriginal and Torres Strait Islander-specific funding managed by the Department of the Prime Minister and Cabinet (PM&C) is $8.6 billion consisting of $4.9 billion over four years to the *Indigenous Advancement Strategy* (IAS) and $3.7 billion allocated through other means including national partnership agreements.[218]

The IAS Guidelines allow the Government to fund demand driven activity directly.[219] Otherwise, a competitive grant round for organisations seeking funding under the IAS commenced in September 2014 and closed on Friday 17 October.[220] This was for activities that commenced in January 2015 (i.e. calendar year funding) or from July 2015 (i.e. financial year funding).[221]

In this way, the Australian Government flagged its intention that routine funding for services and activities will be handled.[222]

In 2015, the Campaign Steering Committee made a submission to the Senate Finance and Public Administration References Committee Inquiry into the impact of the IAS tendering process.[223] The Inquiry was established following widespread concern across Aboriginal and Torres Strait Islander organisations and communities. The Campaign Steering Committee urge that its IAS submission recommendations be implemented as a priority (see Appendix 2).

In particular, the Campaign Steering Committee was concerned with the rushed implementation, and there was little consultation with key Aboriginal and Torres Strait Islander representative and service organisations.

The move to tendering has created widespread uncertainty and distress in Aboriginal and Torres Strait Islander organisations who were otherwise, and up until then, funded by other means. Many organisations did not have the capacity or the resources to put together the kind of application required by the tender process and felt that they lacked support during the process. Some had to hire consultants for submission writing. Others, despite the good work they might be doing, simply did not have the capacity or resources to submit an application.

Furthermore, the timeframe imposed on the application process was onerous.

The selection of successful applicants lacked transparency. Questions remain as to whether it adequately considered community need and cultural competence as critical selection criteria—in particular, by the weighting given to these. In short, it was not clear whether the process valued, or was intended to prioritise, Aboriginal and Torres Strait Islander organisations and their cultural competence and the cultural and other capital within.

Finally, it is believed that the IAS process had a disproportionately negative impact on Aboriginal and Torres Strait Islander organisations and communities. The publicly available list of organisations recommended for funding indicates that a large number of non-Indigenous organisations were successful. This will have a negative impact on outcomes across health and wellbeing and the social determinants and health and wellbeing and potentially result in services gaps.

The Campaign Steering Committee has also heard anecdotal reports of job losses among Aboriginal and Torres Strait Islander people who worked in organisations that were defunded through the IAS tendering process.[224]

The Campaign Steering Committee believes that many of these concerns with the IAS could have been prevented had the key aspects of the program design been developed in consultation with appropriate Aboriginal and Torres Strait Islander representative and service organisations. This is a long-established best practice approach to Aboriginal and Torres Strait Islander policy development and implementation.

Aboriginal and Torres Strait Islander organisations are best placed for engaging with communities to develop solutions and deliver services. The Campaign strongly supports the funding of Aboriginal and Torres Strait Islander organisations as a way of empowering local Aboriginal and Torres Strait Islander leadership in decision-making and privileging cultural identity within those processes.

Recommendation

That the Recommendations of the Close the Gap Campaign Steering Committee to the 2015 Senate Finance and Public Administration References Committee Inquiry into the impact of the IAS tendering process are implemented as a priority.

Conclusion

The relatively limited progress evident against the 2030 Closing the Gap Target for life expectancy equality must be seen in context. The *Closing the Gap Strategy* commenced in July 2009. Improvements to life expectancy should not have been expected to show in data from 2010–2012, and may not be evident until at least 2018. While there is some good news to report, fundamentally the improvements in health outcomes for Aboriginal and Torres Strait Islander people must be greater than those of the rest of the population in order to achieve parity.

We are, however, seeing improvements in relation to many of the important health inputs and other areas from which better health outcomes will flow. In particular, in relation to smoking rates and infant mortality, as reported last year, but also this year in relation to the uptake of Closing the Gap health checks.

Achieving health equality by 2030 is an ambitious yet achievable task. It is also an agreed national priority. With well over 200,000 Australians supporting action to close the gap, it is clear that the Australian public demand that government, in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, build on the close the gap platform to meet this challenge. They believe that we can and should be the generation to finally close the appalling life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

The year 2016 and the next term of the Australian Government will be critical to achieving the 2030 goal. The next incoming government must ramp up the ambition and take further steps in building on the existing platform. In particular, the challenges of operationalising the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan*, the work of the Primary Health Networks and reinvigorating the *Closing the Gap Strategy* remain key tests of our nation's intergenerational will and commitment to Aboriginal and Torres Strait Islander peoples and their health and wellbeing.

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 people 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*.[225]

The Close the Gap 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, almost 200,000 Australians have formally pledged their support.[226]

The Close the Gap Campaign is a growing national movement. In 2007 the first National Close the Gap Day was held. It involved five large State events and more than 300 community events. National Close the Gap Day has become an annual event since 2009. Australians across every state and territory participate in this event. Health services, schools, businesses, hospitals, government departments, ambulance services, non-government organisations and others hold events to raise awareness and show support for the Campaign and its goals. Reflecting the importance of the Campaign to nation, it has become the largest and highest profile Aboriginal and Torres Strait Islander health event in the country. On National Close the Gap Day in 2015, nearly 1,596 community events were held involving approximately 150,000 Australians.

The current members of the Close the Gap Campaign are:

Chairs

- Mr Mick Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, Australian Human Rights Commission
- Dr Jackie Huggins, Co-Chair for the National Congress of Australia's First Peoples

Members

- Aboriginal and Torres Strait Islander Healing Foundation
- Aboriginal Health and Medical Research Council of New South Wales
- Australian Healthcare and Hospitals Association
- Aboriginal Health Council of South Australia
- ANTaR
- Australian College of Midwives
- Australian College of Nursing
- Australian Human Rights Commission (Secretariat)
- Australian Indigenous Doctors' Association
- Australian Indigenous Psychologists' Association
- Australian Medical Association
- Australian Physiotherapy Association
- Australian Student and Novice Nurse Association

- beyondblue
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- CRANA*plus*
- Expert Adviser – alcohol and other drugs (Pat Dudgeon)
- Expert Adviser – epidemiology and public health (Ian Ring)
- Expert Adviser – mental health and social and emotional wellbeing (National Aboriginal and Torres Strait Islander Leadership in Mental Health) (Ted Wilkes)
- First Peoples Disability Network
- Healing Foundation
- Heart Foundation Australia
- Indigenous Allied Health Australia
- Indigenous Dentists' Association of Australia
- Kidney Health Australia
- Menzies School of Health Research
- National Aboriginal and Torres Strait Islander Health Workers' Association
- National Aboriginal Community Controlled Health Organisation
- 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 Heart Foundation of Australia
- Oxfam Australia
- Palliative Care Australia
- PHILE Network
- Public Health Association of Australia
- Reconciliation Australia
- Royal Australasian College of Physicians
- Royal Australian College of General Practitioners
- The Fred Hollows Foundation
- The Lowitja Institute
- The Pharmacy Guild of Australia
- Torres Strait Regional Authority
- Victorian Aboriginal Community Controlled Health Organisation
- Winnunga Nimmityjah Aboriginal Health Service

Appendix 1

2015 The Close the Gap Campaign Steering Committee Report recommendations:

1. That the findings of the National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS) are used to better target chronic conditions that are undetected in the Aboriginal and Torres Strait Islander population. In particular, access to appropriate primary health care services to detect, treat and manage these conditions should be increased. Aboriginal Community Controlled Health Services should be the preferred services for this enhanced, targeted response.

2. That the Australian Government should continue to lead the COAG Closing the Gap Strategy.

3. That the Australian Government revisit its decision to discontinue the National Indigenous Drug and Alcohol Committee.

4. That connections between the Indigenous Advancement Strategy and the Closing the Gap Strategy are clearly articulated and developed in recognition of their capacity to mutually support the other's priorities, including closing the health and life expectancy gap.

5. That the Tackling Indigenous Smoking programme is retained and funding is increased above current levels to enable consolidation, improvement and expansion of activities until the gap in the rates of smoking between Aboriginal and Torres Strait Islander and non-Indigenous people closes.

6. That proxy indicators are developed to provide insights into the use and availability of health services on Aboriginal and Torres Strait Islander health and life expectancy outcomes.

7. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing provides the basis for a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan. This is developed and implemented with the National Aboriginal and Torres Strait Islander Health Plan, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 and the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy implementation processes in order to avoid duplication, be more efficient, and maximise opportunities in this critical field.

8. That Closing the Gap Targets to reduce imprisonment and violence rates are developed, and activity towards reaching the Targets is funded through justice reinvestment measures.

9. That the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan* include the following essential elements:

   • Set targets to measure progress and outcomes

   • Develop a model of comprehensive core services across a person's whole of life

   • Develop workforce, infrastructure, information management and funding strategies based on the core services model

   • A mapping of regions with relatively poor health outcomes and inadequate services. This will enable the identification of services gaps and the development of capacity building plans

   • Identify and eradicate systemic racism within the health system and improve access to and outcomes across primary, secondary and tertiary health care

   • Ensure that culture is reflected in practical ways throughout Implementation Plan actions as it is central to the health and wellbeing of Aboriginal and Torres Strait Islander people

   • Include a comprehensive address of the social and cultural determinants of health

   • Establish partnership arrangements between the Australian Government and state and territory governments and between ACCHS and mainstream services providers at the regional level for the delivery of appropriate health services.

Appendix 2

Close the Gap Campaign Submission to the Senate Finance and Public Administration References Committee Inquiry into the impact of the IAS tendering process:

Recommendation 1

That a review of the IAS is established to consider:

- How to ensure a genuine partnership approach in development and implementation of IAS funded services, including consideration of establishing an Aboriginal and Torres Strait Islander taskforce or leadership forum with representation from all the relevant representative organisations.

- The development of a culturally valid and reliable Aboriginal and Torres Strait Islander Outcomes Framework for developing measures and analysing outcomes according to local community needs.

- The development of principles to ensure the empowerment of local communities including an Aboriginal and Torres Strait Islander agencies first approach to funding and programme delivery.

- Replacement of the competitive tendering with a consultative, community needs-based process that is clearly aligned with an Aboriginal and Torres Strait Islander Outcomes Framework.

- A moratorium on the IAS funding processes be implemented until the above process is completed.

Recommendation 2

That where it is appropriate for a mainstream service to receive IAS funding, demonstration of cross-cultural safety/competence is required as a key selection criteria and that well defined mechanisms are established to verify claims of cultural competence made in tender submissions.

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