Chapter 2

Achieving Aboriginal and Torres Strait Islander health equality within a generation – A human rights based approach

Improving the health status of Aboriginal and Torres Strait Islander peoples is a longstanding challenge for governments in Australia. While there have been improvements made in some areas since the 1970s (notably in reducing high rates of infant mortality[1]) overall progress has been slow and inconsistent. The inequality gap between Aboriginal and Torres Strait Islander peoples and other Australians remains wide and has not been progressively reduced. With a significant proportion of Aboriginal and Torres Strait Islander peoples in younger age groups, there is an additional challenge to programs and services being able to keep up with the future demands of a burgeoning population.

Unless substantial steps are taken now, there is a very real prospect that the health status of Aboriginal and Torres Strait Islander peoples could worsen. A steady, incremental approach will not reduce the significant health disparities between Aboriginal and Torres Strait Islander peoples and other Australians. There is a need for commitments to a course of action, matched with significant funding increases over the next 20-25 years, if there is to be real and sustainable change.

This chapter outlines a human rights based campaign for achieving Aboriginal and Torres Strait Islander health equality within a generation. Such a goal is achievable through building on existing approaches to Aboriginal and Torres Strait Islander health, by seizing opportunities that currently exist through the new arrangements on Indigenous affairs at the federal level and by capitalising on the overall healthy economic situation of the country. Ultimately, the purpose of such an approach is to ensure that Aboriginal and Torres Strait Islander peoples, along with all other Australian citizens, are able to enjoy 'the highest attainable standard of health conducive to living a life in dignity.'[2]

1 Significant reductions to the infant mortality rate occurred in the 1970s and 1980s but since that time progress has slowed. This is attributed to the often poor health of Aboriginal and Torres Strait Islander mothers; their exposure to risk factors; and the generally poor state of health infrastructure in which infants are being raised. Thomson, N., 'Responding to our spectacular failure', in Editor, Thomson, N., *The Health of Indigenous Australians,* Oxford University Press, Melbourne, 2003, p490.

2 United Nations Committee on Economic, Social and Cultural Rights, *General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights),* UN Doc E/C.12/2000/4, 11 August 2000, para 1. See further Appendix 4.

1. The challenge – addressing Aboriginal and Torres Strait Islander health inequality

The poor health status of Aboriginal and Torres Strait Islander peoples is a well known fact. Substantial inequalities exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, particularly in relation to chronic and communicable diseases, infant health, mental health and life expectation.

Governments of all persuasions have made commitments to address this situation over a prolonged period of time, accompanied with incremental funding increases. Governments have detailed strategies and national frameworks in place, developed through engagement with Aboriginal and Torres Strait Islander peoples, which clearly articulate the need for a holistic address to Aboriginal and Torres Strait Islander health and acknowledge the complex interaction of issues.

Yet despite all of this, what data exists suggests that we have seen only slow improvements in some areas of health status and no progress on others over the past decade. The gains have been hard-fought. But they are too few. And the gains made are generally not of the same magnitude of the gains experienced by the non-Indigenous population, with the result that they have had a minimal impact on reducing the inequality gap between Aboriginal and Torres Strait Islander peoples and other Australians.

There are a number of disturbing trends among Aboriginal and Torres Strait Islander peoples that reveal an entrenched health crisis. In particular, there remain:

- high rates of chronic diseases such as renal failure, cardio-vascular diseases and diabetes;
- continued higher rates of poor health among Aboriginal and Torres Strait Islander infants, as well as far too common occurrence of otitis media (middle ear infection) and eye conditions such as trachoma, which can impact on educational attainment and employment;[3]
- a continuing tendency towards poor access to primary health care, as evidenced by high rates of sexually transmitted infections and relatively high rates of HIV/AIDS prevalence; and
- high rates of unhealthy and risky behaviour, including an increased prevalence of substance abuse and alcohol and tobacco use.

On top of this, I fear that Aboriginal and Torres Strait Islander peoples face substantial health problems which are often left undiagnosed, and hence untreated. This is particularly in relation to mental health, as well as oral / dental health problems. These issues do not receive adequate attention in health frameworks and needs to be redressed.

There are three main failings in the approach of Australian governments to date in addressing Aboriginal and Torres Strait Islander health inequality.

3 Couzos, S., Lea, T., Mueller, R., *(et al)* 'Chronic suppurative otitis media in Aboriginal children and the effectiveness of ototopical antibiotics: A community-based, multi-centre, double-blind randomized controlled trial' (2003) 4 *Medical Journal of Australia* 179, pp185-90, available online at: www.mja.com.au/public/issues/179_04_180803/cou10214_fm.html.

First, governments of all persuasions have not activated their commitments by setting them within an achievable time frame. Governments have instead left the achievement of equality to an unspecified future time. By doing so, all Australian governments have been unaccountable for progress in achieving health equality.

Second, they have not matched their commitments with the necessary funds and program support to realise them. And third, while they have accepted in health frameworks the need to address Aboriginal and Torres Strait Islander health in a holistic manner, they have not engineered their health programs consistent with this understanding nor considered the impact of their broader policy and program approach on Aboriginal and Torres Strait Islander health.

It is ten years since the Social Justice Commissioner has given detailed consideration to Aboriginal and Torres Strait Islander health issues. The comments of my predecessor at that time, apply equally today. He stated that:

> We have all heard them – the figures of death, and of disability… Every few years, (the) figures are repeated and excite attention. But I suspect that most Australians accept them as being almost inevitable. A certain kind of industrial deafness has developed. The human element in this is not recognised. The meaning of these figures is not heard – or felt.
>
> The statistics of infant and perinatal mortality are our babies and children who die in our arms… The statistics of shortened life expectancy are our mothers and fathers, uncles, aunties and elders who live diminished lives and die before their gifts of knowledge and experience are passed on. We die silently under these statistics.[4]

As he noted in the *Social Justice Report 1994:*

> The gap between the numbers of our people who live and the number who should be alive is one measure of the inequality we have endured. The gap between the numbers living a healthy, socially-functional life and those living a life of pain, humiliation and dysfunction is another measure. They are both measures of our loss of elementary human rights.
>
> There should be no mistake that the state of Indigenous health in this country is an abuse of human rights. A decent standard of health and life expectancy equivalent to other Australians is not a favour asked by our peoples. It is our right – simply because we too are human.[5]

There is no reason for this to be happening. Evidence shows that dramatic improvements in health status can be achieved and that gains on many issues can occur within even short time frames. Other comparable countries have made greater progress in improving the health status of indigenous peoples than what we have achieved in Australia.[6]

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4 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report – 2nd report, 1994,* Australian Government Publishing Services (AGPS), Canberra, 1995, pp99-100.

5 *ibid.,* p100.

6 As the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* notes, 'in countries comparable to Australia, the health outcomes for Indigenous population has improved so that… (those Indigenous populations) enjoy significantly better health than Australian Aboriginal and Torres Strait Islander peoples': National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Context,* NATSIHC, Canberra, 2003, p12.

And we must remember that we are a wealthy nation. 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. Research suggests that addressing Aboriginal and Torres Strait Islander health inequality will involve no more than a 1% per annum increase in total health expenditure in Australia over the next ten years. If this funding is committed, then the expenditure required is then likely to decline thereafter.

Aside from addressing obvious and vitally important issues of equality and fairness, a campaign to overcome Aboriginal and Torres Strait Islander health inequality will also result in significant future health savings. This is pertinent given that managing the health of an ageing general population is expected to place a significant extra financial burden on the health system over the coming decades.[7]

I noted in the introduction to the *Social Justice Report 2004* my intention to focus on Aboriginal and Torres Strait Islander health issues during 2005 and 2006. I stated that:

> perhaps more so than any other area of life, programmes for addressing Indigenous health reveal the problem of a lack of implementation of human rights. It doesn't matter whether we look at the National Aboriginal Health Strategy of 1989 or the current *National Strategic Framework* for Aboriginal and Torres Strait Islander Health. The issue is the same with both.
>
> Each of these frameworks has been agreed by the Commonwealth with the states and territories. They provide a detailed series of commitments and identify a range of areas that require attention. Both documents identify, from a human rights perspective, the key issues that must be addressed to improve Indigenous health. They are good, solid policy documents.
>
> And yet they have made very little difference to Indigenous health. It appears that the lack of progress can not be explained as a result of there not being any answers to the problems faced by Indigenous people – instead it appears to be a matter of taking the necessary steps to implement what are… universally agreed solutions.[8]

In that report I suggested that we require *a campaign for Aboriginal and Torres Strait Islander health equality within our lifetime*. This chapter details a framework for achieving this. It seeks to build on existing policy frameworks and to learn from current successes and failings.

I consider it feasible for governments to commit to ensuring an equitable distribution of primary health care and equitable standards of health infrastructure (such as water, sanitation, food and housing) within a reasonable time period of no more than 10 years.

It is equally feasible for governments to commit to the goal of achieving equality of health status and life expectation within the next generation (approximately 25 years). This will also require a focus on specific diseases and conditions, an address to social determinants of health such as income, education and functional communities, and an address to the position of Aboriginal and Torres Strait Islander peoples in Australian society.

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7 Department of Health and Aged Care, *The Ageing Australian Population and Future Health Costs: 1996 -2051,* DOHC Occasional Paper: New Series No.7, Commonwealth of Australia, Canberra, 1999, p41.

8 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2004,* HREOC, Sydney, 2005, p6.

I have developed this framework with five key factors in mind. First, it proposes a **human rights based approach** to addressing Aboriginal and Torres Strait Islander health inequality. There have been significant developments in the international human rights system over the past decade that has demonstrated the clear link between human rights and health. As this chapter shows, a human rights based approach to Aboriginal and Torres Strait Islander health *creates an empowering environment for Aboriginal and Torres Strait Islander peoples* and one which focuses on the accountability of governments to achieve improved outcomes within a reasonable time period. It is a framework with the potential to address the flaws of the current system.

Second, it recognises that the inequality in health status endured by Aboriginal and Torres Strait Islander peoples is linked to systemic discrimination. Historically, Aboriginal and Torres Strait Islander peoples have not had the same opportunity to be as healthy as non-Indigenous people. This occurs through the inaccessibility of mainstream services and lower access to health services, including primary health care, and inadequate provision of health infrastructure in some Aboriginal and Torres Strait Islander communities. The Royal Australasian College of Physicians describes these health inequities as 'both *avoidable and systematic*'.[9] This legacy remains to be fully addressed and is a significant barrier to the full enjoyment of the right to health for Aboriginal and Torres Strait Islander peoples.

Third, it addresses the issue of how to make meaningful the stated commitments of governments. At the federal level, for example, the Ministerial Taskforce on Indigenous Affairs has identified Aboriginal and Torres Strait Islander health as a major priority. It has also set out its desire for there to be a 20-30 year vision for Aboriginal and Torres Strait Islander Australia. That is exactly what this framework provides.

Fourth, it addresses Aboriginal and Torres Strait Islander health in a holistic manner reflecting both the social determinants of health inequality as well as the broader issues identified by Aboriginal and Torres Strait Islander people as impacting on their health.

Finally, it seeks to build on both the opportunities and the challenges that have emerged with the recently introduced changes to the administration of Indigenous affairs at the federal level. There can be no issue that is more appropriate for applying a whole of government and holistic approach than Aboriginal and Torres Strait Islander health. I also consider that there is significant potential to utilise the new agreement making processes under these new arrangements (namely, Shared Responsibility Agreements, Regional Participation Agreements and Bilateral Agreements between the Commonwealth and states and territories) to achieve significant improvements in Aboriginal and Torres Strait Islander health status, and to support Indigenous primary health care in particular.

9 Royal Australasian College of Physicians, *Inequity and Health – A Call to Action – Addressing Health and Socioeconomic Inequality in Australia – Policy Statement 2005,* RACP, Canberra, 2005, p3.

Text Box 1: Definitions of equality and related terms

The term 'Health and life expectation equality' refers to statistical equality between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians in relation to life expectation and across a range of health indicators. Health status equality has been the goal of Aboriginal and Torres Strait Islander health policy in Australia since 1973[10] and remains so today.[11]

Equality of opportunity in relation to health means that different population groups have the same opportunity to be healthy. This is supported by the right to health, which:

> is not to be understood as a right to be *healthy*… [It is] the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[12]

The focus of the right to health is on health services and health infrastructure because these are the main ways a government can provide opportunities to be healthy.[13] The focus on the campaign I am proposing is on ensuring that primary health care is as accessible to Aboriginal and Torres Strait Islander people as it is to non-Indigenous people (that is, that it is equitably distributed between the population groups) and that housing, water and sanitation and food supplies conform to the same health standards as those enjoyed by non-Indigenous Australians – that is, that they are of an equitable standard.

An equitable distribution of primary health care and an equal standard of health infrastructure should not be measured in terms of formal equality – that is that the same per capita resources are being devoted to Aboriginal and Torres Strait Islander and non-Indigenous health. It should be expected that greater per capita resources would need to be devoted to Aboriginal and Torres Strait Islander health for at least the duration of the campaign I am proposing.

Significant investment in Aboriginal and Torres Strait Islander health is required to re-balance decades of under-investment. Also, until health and life expectation equality is achieved, Aboriginal and Torres Strait Islander peoples will have greater health care needs than the non-Indigenous population. The remoteness of many communities will add to per capita expenditure. Approximately 26% of Aboriginal and Torres Strait Islander peoples live in remote or very remote areas, compared to two per cent of the non-Indigenous population.[14]

In the longer term, it can be expected that the per capita resources needed to be devoted to Aboriginal and Torres Strait Islander health would decrease. This should result as Aboriginal and Torres Strait Islander health status improves – reducing the demand on health services – and as the high costs of health infrastructure capital works give way to the lesser costs of maintenance.

10 The *Ten Year Plan for Aboriginal Health* released in 1973 by the Aboriginal Health Branch of the Commonwealth Department of Health aimed to achieve Aboriginal and Torres Strait Islander health and life expectation equality within ten years. House of Representatives Standing Committee on Aboriginal Affairs, *Aboriginal Health: report from the Standing Committee on Aboriginal Affairs,* AGPS, Canberra, 1979, piii.

11 See Text Box 7 below.

12 Committee on Economic, Social and Cultural Rights, *General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights),* UN Doc E/C.12/2000/4, 11 August 2000, para 8. See also Text Box 10 below.

13 *ibid.,* paras 9, 11.

14 Australian Bureau of Statistics, *Population characteristics: Aboriginal and Torres Strait Islander Australians* 2001, *op.cit.,* p22, Table 2.5.

My call to address Aboriginal and Torres Strait Islander health inequality joins that of many others over recent years. This includes the National Aboriginal Community Controlled Health Organisation (NACCHO),[15] the Australian Indigenous Doctor's Association,[16] the Fred Hollows Foundation,[17] the Heart Foundation Australia,[18] Australians for Native Title and Reconciliation,[19] Oxfam Community Aid Abroad,[20] the Australian Medical Association;[21] the House of Representatives Standing Committee on Family and Community Affairs;[22] and health commentators including Professor John Deeble,[23] Professor Ian Anderson,[24] Dr Ngiare Brown and Professor Ian Ring.[25]

15 The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia. See, for example: National Aboriginal Community Controlled Health Organisation, *Proposal to increase access of Aboriginal people to appropriate primary health care,* December 1998, available online at: http://www.naccho.org.au/Ruralhealth_policy.html; and National Aboriginal Community Controlled Health Organisation, *What's needed to improve child health in the Aboriginal and Torres Strait Islander Population,* June 2003, pp17-20, available online at: http://www.naccho.org.au/ChildHealth.html.

16 The Australian Indigenous Doctors' Association (AIDA) is a professional organisation for Aboriginal and Torres Strait Islander medical students and graduates from across the country. See, for example, Australian Indigenous Doctors Association, *Healthy Futures, defining best practice in the recruitment and retention of Indigenous medical students,* AIDA, Canberra, September 2005, p1, available online at: http://aidauser.brinkster.net/default.aspx.

17 For more information on the Fred Hollows Foundation's (FHF) Indigenous Health Program and briefing papers setting out their call for an address to health inequality see the FHF website: www.hollows.org/content/TextOnly.aspx?s=146.

18 For more information on the Heart Foundation, Australia's (HFA) Aboriginal and Torres Strait Islander Program and a link to their proposals for action to reduce the rate of cardiovascular disease among Aboriginal and Torres Strait Islander peoples see the HFA website: www.heartfoundation.com.au/index.cfm?page=43.

19 For more information on Australians for Native Title and Reconciliation's (ANTaR) Healing Hands Indigenous Health Rights Campaign see the ANTaR website: www.antar.org.au/health.

20 For more information on Oxfam Australia's Indigenous Australia Program, of which one of the themes is improving Aboriginal and Torres Strait Islander emotional and social well-being, see the Oxfam Australia website: www.oxfam.org/world/pacific/australia/index.html. Oxfam's *Indigenous Australians Rights* campaign includes promoting and recognising Aboriginal and Torres Strait Islander health rights. See the Oxfam website: http://www.oxfam.org.au/campaigns/indigenous/index.html.

21 For more information see Australian Medical Association (AMA), *Position Statement on Aboriginal and Torres Strait Islander Health,* AMA, Canberra, 2005, available online at: www.ama.com.au/web.nsf/topic/policy-public-health?opendocument&cat=Aboriginal%20Health. The AMA is an advocate for improving Aboriginal and Torres Strait Islander health and since 2003 has produced an annual report card on government performance in relation to this.

22 In the *Health Is Life* report on their inquiry into Indigenous health, the House of Representatives Standing Committee on Family and Community Affairs called for an address to the backlog of health infrastructure needs then identified in communities within five years and for the provision of adequate water supplies to communities within 3-years, House of Representatives Standing Committee on Family and Community Affairs, Health is Life, Parliament of Australia, Canberra, 2000, ppxix-xx, Recommendations 14 and 17.

23 Deeble, J., *Expenditures on Aboriginal and Torres Strait Islander Health,* AMA, 2003, p5, available online at: http://www.ama.com.au/web.nsf/doc/WEEN-5N6285/$file/AMA_03Deble.pdf.

24 Professor Ian Anderson is the Director of the Centre for Health and Society, and of the VicHealth Koori Health Research and Community Development Unit. See, for example: Anderson, I., *Overview of Indigenous Health Status in Australia,* Speech to the World Health Organisation's Regional Committee for the Western Pacific, 24 September 2004, available online at: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-about-cmo-indhea.htm.

25 See: Brown, N. and Ring, I., 'Indigenous Health; chronically inadequate responses to damning statistics', (2002) 177 (11) *Medical Journal of Australia* 629, available online at http://www.mja.com.au/public/issues/177_11_021202/rin10435_fm.html; Brown, N., and Ring, I., *Achieving Sustainable Improvements in Aboriginal and Torres Strait Islander Health,* In Search of Sustainability Conference Paper, November 2003, available online at www.isosconference.org.au/papers/Ring2.pdf; Ring, I., Firman, D., 'Reducing Indigenous mortality in Australia; lessons from other countries', (1998), 169 *Medical Journal of Australia,* 528-533.

As a nation, we have perhaps never been as well placed as we currently are to turn the current situation faced by Aboriginal and Torres Strait Islander peoples around. We have the necessary commitments and mechanisms for whole of government coordination to achieve this. We have a historically large budget surplus, just a small fraction of which could lead to dramatic improvements in Aboriginal and Torres Strait Islander peoples' health status. And we have an unprecedented opportunity, with new agreement making processes, to engage and empower Aboriginal and Torres Strait Islander peoples to overcome existing health inequalities.

The central argument of this chapter is that a human rights based approach to Aboriginal and Torres Strait Islander health demonstrates that the situation faced by Aboriginal and Torres Strait Islander peoples in this country over the next twenty five years is not inevitably one of failure and inequality. A dynamic, targeted approach to Aboriginal and Torres Strait Islander health can yield significant improvements.

In my view, the time for concerted action is now. Accordingly, I have chosen to commence this chapter by outlining the challenge for governments through the following headline recommendation.[26]

Recommendation 1

That the governments of Australia commit to achieving equality of health status and life expectation between Aboriginal and Torres Strait Islander peoples and non-Indigenous people within 25 years.

My Office will be vigorous over the next twelve months in promoting debate on this objective and to seek more concrete commitments and action from governments to achieve it.

26 See further section 6 of this chapter, which outlines the full details of the proposed campaign for health equality.

2. An overview of the health status of Aboriginal and Torres Strait Islander peoples

This section provides an overview of the current health status of Aboriginal and Torres Strait Islander peoples. It makes comparisons to non-Indigenous Australians, and identifies where there have been improvements in health status over the past decade. It also provides current information about the provision of infrastructure and primary health care to Aboriginal and Torres Strait Islander communities, and identifies issues relating to social determinants of health.

a) The health status of Aboriginal and Torres Strait Islander peoples

Text Box 2 provides an overview of the current status of Aboriginal and Torres Strait Islander health. It clearly establishes the challenge ahead if we are to address Aboriginal and Torres Strait Islander health inequality. The following key issues are apparent from the statistics:

- First, 'the health status of Australia's Aboriginal and Torres Strait Islander peoples is poor in comparison to the rest of the Australian population.'[27] There remains a large inequality gap in Australia.
- Second, Indigenous peoples do not have an equal opportunity to be as healthy as non-Indigenous Australians. As the Australian Institute of Health and Welfare have noted, 'the relative socioeconomic disadvantage experienced by Aboriginal and Torres Strait Islander people compared to non-Indigenous people places them at greater risk of exposure to behavioural and environmental health risk factors'[28] as does the higher proportion of Indigenous households that 'live in conditions that do not support good health'.[29] Indigenous peoples also do not enjoy equal access to primary health care and health infrastructure (including safe drinking water, effective sewerage systems, rubbish collection services and healthy housing).[30]
- Third, there has been very little progress in reducing this inequality gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians over the past decade, for example in relation to long term measures such as life expectation.
- Fourth, while there have been improvements on some measures of Aboriginal and Torres Strait Islander health status, they have not matched the rapid health gains made in the general population in Australia. For example, death rates from cardiovascular disease in the general population have fallen 30% since 1991, and 70% in the last 35-years.[31] In contrast, while the picture is ultimately unclear, Aboriginal and Torres Strait Islander people do not appear to have made

27 Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005,* ABS cat. no. 4704.0, Commonwealth of Australia, Canberra, 2005, pxvii, available online at: www.aihw.gov.au/publications/ihw/hwaatsip05/hwaatsip05.pdf.

28 *ibid.,* pxxiii.

29 *ibid.,* pxxii.

30 Communicable and water-borne diseases and parasites are indicators of poor health infrastructure. Infants and children are particularly vulnerable to these diseases.

31 National Health and Medical Research Centre, *Promoting the health of Australians, Case studies of achievements in improving the health of the population,* AGPS, Canberra, 1997, p35.

any reduction in death rates from cardiovascular disease over this period.[32]

- Fifth, the young age structure of the Aboriginal and Torres Strait Islander population means that the scope of the issues currently being faced is expected to increase in the coming decades. The increase in absolute terms of the size of the Aboriginal and Torres Strait Islander youth population will require significant increases in services and programs simply to keep pace with demand and maintain the status quo, yet alone to achieve a reduction in existing health inequality.

Text Box 2: The health status of Aboriginal and Torres Strait Islander peoples[33]

Life expectation	Over 1996–2001, there was an estimated difference of approximately 17 years between Aboriginal and Torres Strait Islander and non-Indigenous life expectation.[34] Life expectancy at birth for Aboriginal and Torres Strait Islander Australians was estimated to be 59.4 years for males and 64.8 years for females, compared with 76.6 years for all males and 82.0 years for all females for the period 1998-2000.[35]
Death age and rate	Over 1999-2003, in Queensland, South Australia, Western Australia and the Northern Territory, 75% of Aboriginal and Torres Strait Islander males and 65% of females died before the age of 65 years compared to 26% of males and 16% of females in the non-Indigenous population.[36] For all age groups below 65 years, the age-specific death rates for Aboriginal and Torres Strait Islander Australians were at least twice those experienced by the non-Indigenous population.[37]
Infant and child health	In 2000-02, babies with an Aboriginal and Torres Strait Islander mother were twice as likely to be low birthweight babies (those weighing less than 2,500 grams at birth) as babies with a non-Indigenous mother.[38] In 1999-2003, the infant mortality rate for Aboriginal and Torres Strait Islander infants was three times that of non-Indigenous infants.[39]

32 Thomson, N. and Brooks, J., 'Cardiovascular Disease', in Editor, Thomson, N., *The Health of Indigenous Australians,* Oxford University Press, Melbourne, 2003, p186.

33 This textbox is a *summary* of the key trends in Indigenous health status. For more detail about particular indicators see: Aboriginal and Torres Strait Islander Social Justice Commissioner, *A statistical overview of Aboriginal and Torres Strait Islander peoples in Australia,* available online at: www.humanrights.gov.au/social_justice/statistics/index.html. See also Australian Institute of Health and Welfare and Australian Bureau of Statistics, *op.cit.*

34 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *op.cit.,* p148.

35 *ibid.*

36 *ibid.*

37 *ibid.,* p151.

38 *ibid.,* p79.

39 *ibid.,* p150.

Chronic diseases	In 1999–2003, 2 of the 3 leading causes of death for Aboriginal and Torres Strait Islander people in Queensland, South Australia, Western Australia and the Northern Territory were chronic diseases of the circulatory system and cancer.[40] Hospitalisation for ischaemic heart disease for Aboriginal and Torres Strait Islander males was double the rate, and for Aboriginal and Torres Strait Islander females four times the rate, than for the general population. Hospitalisations for hypertensive disease were also substantially higher.[41]
Communicable diseases	In 2003, notification rates among Aboriginal and Torres Strait Islander Australians for the majority of communicable diseases were higher than among other Australians. Rates of chlamydia, gonococcal infection and syphilis infection among Aboriginal and Torres Strait Islander people were up to 93 times the rates among other Australians. This may facilitate HIV transmission in the Aboriginal and Torres Strait Islander population.[42] Rates of bacteriological intestinal disease and tuberculosis are also significantly higher.[43] The Western Australian Aboriginal Child Health Survey reported that 18% of Aboriginal children had a recurring ear infection, 12% had a recurring chest infection, 9% had a recurring skin infection and 6% had a recurring gastro-intestinal infection.[44]
Oral health	In 2003-04 there were approximately 2,000 hospitalisations of Aboriginal and Torres Strait Islander people for diseases of the oral cavity, salivary glands and jaw. The majority of these hospitalisations were for dental caries (54%), followed by diseases of the pulp and periapical tissues (16%) and embedded and impacted teeth (9%). The Child Dental Health Survey in 2001, in New South Wales, South Australia and the Northern Territory reported that Aboriginal and Torres Strait Islander children aged 4-10 years had higher rates of decayed, missing or filled baby (deciduous) and adult (permanent) teeth than for non-Indigenous children; the difference being particularly high among those aged less than seven years.[45]

40 *ibid.,* p152.

41 *ibid.,* p101.

42 The *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008* notes that these figures reflect on small numbers and may reflect localised occurrences rather than national patterns: Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008,* Commonwealth of Australia, 2005, p9, available online at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-sexhealth.htm.

43 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *op.cit.,* p120-121, Table 7.34.

44 Zubrick, S., Lawrence, D., Siburn, S., *(et al), The Western Australian Aboriginal Child Health Survey; The Health of Aboriginal Children and Young People,* (Vol. 1), Telethon Institute for Child Health Research, Perth, 2004, p142.

45 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *op.cit.,* p127.

Mental health	In 2003-04, Aboriginal and Torres Strait Islanders were up to twice as likely to be hospitalised for mental and behavioural disorders as other Australians. Hospitalisation rates for assault or intentional self-harm may also be indicative of mental illness and distress. In 2003–04 Aboriginal and Torres Strait Islander males were 7 times more likely, and females 31 times as likely as for males and females in the general population; hospitalisation rates for intentional self-harm was twice as high.[46]
Disability	In 2002, just over one third of Aboriginal and Torres Strait Islander people aged 15 years or older reported a disability or long term health problem in the National Aboriginal and Torres Strait Islander Social Survey,[47] spread relatively evenly over remote and non-remote areas.[48] Overall, 7 % of respondents reported an intellectual disability; 23.6% a physical disability and 13.7% a disability in relation to hearing, speech or sight (with many respondents reported more than one type of disability).[49]

Aboriginal and Torres Strait Islander peoples also disproportionately suffer from a range of communicable and chronic diseases. For example:

- *Trachoma*

  Trachoma is a parasite that attacks the eyes. It was traditionally a disease of the urban slums and was rampant in Australia in the 19th century. It was reported in 2001 that in areas with severe trachoma in Australia, one in five of Aboriginal and Torres Strait Islander people have in-turned lashes, and about half of these are either blind already or will eventually go blind. While many of these people require surgery, a long term solution rests in an address to health infrastructure in these communities.[50]

- *Rheumatic heart disease*

  Australia Aboriginal people living in the Top End of the Northern Territory and the Kimberly regions experience among the highest incidence rates of rheumatic heart disease in the world. Hospitalisation for Aboriginal and Torres Strait Islander males was six times as high, and among females was eight times as high, as the rates among the non-Indigenous population. Males die at 16 times, and females at 22 times, the rates in the non-Indigenous population.[51]

46 *ibid.,* p131.

47 Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Social Survey,* ABS cat. no. 4714.0, Commonwealth of Australia, Canberra, 2004, pp7-8.

48 *ibid.,* p41, Table 13.

49 *ibid.*

50 Taylor, H., 'Trachoma in Australia', (2001), 175 *Medical Journal of Australia* 371, pp371-372, available online at: http://www.mja.com.au/public/issues/175_07_011001/taylor/taylor.html.

51 Australian Institute of Health and Welfare, 'Rheumatic heart disease: all but forgotten in Australia except among Aboriginal and Torres Strait Islander peoples', *AIHW Bulletin no. 16,* (August 2004), p9, Table 5.

- *Scabies and skin infections*

  Poor health infrastructure helps the spread of communicable skin diseases that contribute to chronic diseases. Scabies, caused by mites, causes inflammation and itching that can result in infection by pathogens such as Group A streptococcal skin infection. Like scabies itself, the transmission of the infection is closely related to overcrowding and poor sanitation. Post streptococcal infections can play a significant role in kidney disease, which occurs at a disproportionately high rate in the Aboriginal and Torres Strait Islander population[52] and also rheumatic fever which can result in rheumatic heart disease.

- *Otitis media*

  High rates of hearing loss among Aboriginal and Torres Strait Islander peoples were confirmed in the 2001 *National Health Survey*. In some remote communities up to 40% of children will have developed a chronic suppurative ear infection causing hearing loss by the age of ten.[53] Total or partial hearing loss was more likely to be reported than by the non-Indigenous population in all age groups from infancy to 55 years of age. In children aged 0-14 years, 7% reported hearing loss compared with 2% of the non-Indigenous population.[54]

b) Equality of opportunity in relation to health

As set out in Text Box 3, Aboriginal and Torres Strait Islander peoples do not have an equal opportunity to be as healthy as non-Indigenous Australians. Aboriginal and Torres Strait Islander peoples do not enjoy equal access to primary health care and health infrastructure (including safe drinking water, effective sewerage systems, rubbish collection services and healthy housing).[55]

Text Box 3: Equality of opportunity and health

Access to primary health care	It is estimated that in 2004, Aboriginal and Torres Strait Islander peoples enjoyed 40% of the per capita access of the non-Indigenous population to primary health care provided by general practitioners.[56]
Housing	5.5% of Aboriginal and Torres Strait Islander households lived in overcrowded conditions. The proportion of overcrowded households was highest for those renting from Aboriginal

52 Couzos, S. and Currie, B., 'Skin Infections', in Editors, Couzos, S., and Murray, R., *Aboriginal Primary Health Care,* (2nd ed.), Oxford University Press, Melbourne, 2004, p252.

53 Couzos, S., 'Practical measures that improve human rights – towards health equity for Aboriginal children', (2004), 15 (3) *Health Promotion Journal of Australia* 186, p186.

54 Department of Health and Ageing, *Report on Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander Peoples – Strategies for future action,* Commonwealth of Australia, Canberra, October 2002, p31.

55 Communicable and water-borne diseases and parasites are indicators of poor health infrastructure. Infants and children are particularly vulnerable to these diseases.

56 This figure is subject to a number of caveats. Access Economics, *Indigenous Health Workforce Needs,* Australian Medical Association, Canberra, 2004, p37. See also: Britt, H., Miller, G., Knox, S., *(et al), General practice activity in Australia: 2001-02,* AIHW, Canberra, 2002, p114, available online at: www.aihw.gov.au/publications/index.cfm/title/8149.

	and Torres Strait Islander or community organisations (25.7%). Among the jurisdictions, the proportion of overcrowded households was highest in the Northern Territory (23.7%).[57]
Water	Of the 1,216 discrete communities surveyed in the *Community Housing and Infrastructure Needs Survey* 2001 (CHINS), 784 communities drew their drinking water supply from bores; 51 from wells and springs; and 99 from rivers or reservoirs.[58] Water from these sources should be tested regularly: both the presence of bacteriological and mineral factors can make water fail standards for drinking.[59] Of the 213 communities reliant on bores, reservoirs and rivers with a population of 50 or more, the CHINS found that 43 had not had their water tested in the prior 12 months.[60]
Sanitation	Forty nine percent of communities reported on in the CHINS were reliant on septic tanks with a leach drain. These systems rely on the absorption of the end-product into the ground. Waste can be a health hazard if it leaches into groundwater or flows into rivers and reservoirs.[61] Forty-eight percent of communities with populations of over 50 reported sewerage overflows or leaks.[62] Fifty-six community's water had failed testing at least once in the year prior to the survey.[63]
Diet	The Western Australian Child Health Survey reported that the diet of only one in five Aboriginal children met all four of its indicators of dietary quality.[64] What studies exist have found the consumption of sugar, white flour and sweetened carbonated beverages at much higher levels than in the non-Indigenous population in remote communities.[65] Despite the poverty reported in communities, food has been reported as up to 150% -180% more expensive than that in major centres.[66]

57 Australian Institute of Health and Welfare, *Indigenous housing indicators 2003-2004,* AIHW, Canberra, 2005, p29.

58 Australian Bureau of Statistics, *Housing and Infrastructure in Aboriginal and Torres Strait Islander communities 2001,* ABS series cat. no. 4710.0, Commonwealth of Australia, Canberra, 2002, pp17, Table 3.7.

59 Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators, 2003,* Productivity Commission, Canberra, 2003, pp10.12 -10.13.

60 Australian Bureau of Statistics, *Housing and Infrastructure in Aboriginal and Torres Strait Islander communities, op.cit.,* p19, Table 3.10.

61 *ibid.,* pp22-23.

62 *ibid.,* p22.

63 *ibid.,* p19, Table 3.10.

64 Telethon Institute for Child Health Research, *The Health of Aboriginal Children and Young People, Summary booklet,* Telethon Institute for Child Health Research, Perth, 2005, pp18-19.

65 National Health and Medical Research Council, *Nutrition in Aboriginal and Torres Strait Islander peoples,* Commonwealth of Australia, Canberra, 2000, pp42-43.

66 Thomson, N., *Nutrition of Australian Aboriginal peoples – past and present,* Food for Healthy People and a Healthy Planet, Nature and Society Conference Proceedings, Sept 2001, cited in Fred Hollows Foundation, *Nutrition and health – Fred Hollows Foundation Indigenous program,* Fred Hollows Foundation fact sheet, 2004, available online at http://www.hollows.org/upload/3388.pdf.

c) Social determinants of health status

Since the 1980s it has been recognised that social inequalities are associated with health inequality.[67] The evidence base for these 'social determinants' of health inequality has been accepted by the World Health Organization[68] and, in Australia, by the Royal Australian College of Physicians.[69] The Royal Australian College of Physicians reports that Aboriginal and Torres Strait Islander communities are *the* prime example of negative social determinants of health in Australia.[70]

Research has demonstrated associations between an individual's social and economic status and their health. Poverty is clearly associated with poor health.[71] For example:

- Poor education and literacy are linked to poor health status, and affect the capacity of people to use health information;[72]
- Poorer income reduces the accessibility of health care services and medicines;
- Overcrowded and run-down housing is associated with poverty and contributes to the spread of communicable disease;
- Poor infant diet is associated with poverty and chronic diseases later in life;[73]
- Smoking and high-risk behaviour is associated with lower socio-economic status.[74]

Research has also demonstrated that poorer people also have less financial and other forms of control over their lives.[75] This can contribute to a greater burden of unhealthy stress[76] where 'prolonged exposure to psychological demands where

67 Editors, Marmot, M. and Wilkinson, R., Social Determinants of Health, Oxford University Press, New York, 1999, p2.

68 In 2004, the Director-General of the World Health Organisation (WHO) established a Commission on Social Determinants 'to act upon the social and environmental causes of health inequity by advocating for political change'. For further information see the WHO website: http://www.who.int/social_determinants/en/ and Marmot, M. and Wilkinson, R., *Social Determinants of Health: The Solid Facts,* (2nd ed.), WHO, Copenhagen, 2003.

69 Royal Australian College of Physicians, *For Richer, for Poorer, in Sickness and in Health: The Socio-Economic Determinants of Health,* Health & Social Policy Position Paper, (3rd ed.), Sydney, 1999, available online at: http://www.racp.edu.au/hpu/policy/richer/intro.htm

70 *ibid.,* p.12.

71 See generally Editors Marmot, M. and Wilkinson, R., *Social Determinants of Health, op.cit.*

72 Fred Hollows Foundation, *Literacy for Life,* Australian National University, Canberra, 2004, pp10-12, available online at http://www.hollows.org/content/TextOnly.aspx?s=244 . See also the issues raised in: Malin, M., *Is schooling good for Indigenous children's health?* Cooperative Research Centre for Aboriginal and Tropical Health & Northern Territory University, 2003, available online at: http://www.acer.edu.au/research/special_topics/ind_edu/report_papers.html.

73 Wadsworth, M., *Early Life,* in (eds.), Marmot, M. and Wilkinson, R., *Social Determinants of Health,* Oxford University Press, New York, 1999, p44. Chronic diseases that have poor diet as a determinant include cardiovascular disease, Type 2 diabetes and renal disease. Connections have been made between poor foetal nutrition and the presence of chronic diseases later in life: National Health and Medical Research Council, *Nutrition in Aboriginal and Torres Strait Islander peoples – An information paper,* Commonwealth of Australia, 2000, p15.

74 Jarvis, M. and Wardie, J., 'Social pattering of individual health behaviours; the case of cigarette smoking', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health, op.cit.,* pp241-244.

75 In 2002, 54% of indigenous people aged 15 or over were living in households where the household spokesperson reported that household members would be unable to raise $2000 within a week in a time of crisis. Australian Bureau of Statistics and Australian Institute of Health and Welfare, *op.cit.,* pp12-13.

76 Shaw, M., Dorling, D. and Davey-Smith, G., 'Poverty, social exclusion, and minorities', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health, op.cit.,* pp32-37.

possibilities to control the situation are perceived to be limited and the chances of reward are small.'[77] Chronic stress can impact on the body's immune system, circulatory system, and metabolic functions through a variety of hormonal pathways and is associated with a range of health problems from diseases of the circulatory system (notably heart disease)[78] and mental health problems[79] through to men's violence against women and other forms of community dysfunction.[80]

Text Box 4 provides an overview of a range of socio-economic factors that impact on the health status of Aboriginal and Torres Strait Islander peoples.

Text Box 4: Socio-economic status of Aboriginal and Torres Strait Islander peoples

Education	In 2002, Aboriginal and Torres Strait Islander people were less than half as likely as a non-Indigenous people to have completed a post-secondary qualification of certificate level 3 or above (that is post-graduate degree, graduate diploma or certificate, bachelor degree, advanced diploma, diploma and certificate levels 3 and 4).[81]
	Nationally in 2004, Aboriginal and Torres Strait Islander students were around half as likely to continue to year 12 as non-Indigenous students.[82]
Income	In the Census 2001, the average equivalised gross household income for Aboriginal and Torres Strait Islander peoples was $364 per week, or 62% of the rate for non-Indigenous peoples ($585 per week).[83]
	Income levels generally decline with increased geographic remoteness: from 70% of the corresponding income for non-Indigenous persons in major cities to 60% in remote areas, and just 40% in very remote areas.[84]
Employment	At the 2001 Census, 52% of Aboriginal and Torres Strait Islander peoples aged 15 years and over reported that they were participating in the labour force. Labour force participation rates for Aboriginal and Torres Strait Islander people declines with remoteness, with a 57% participation rate in major cities compared with 46% in very remote areas.[85]

77 Brunner, E., Marmot, M., 'Social Organization, stress and health', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health, op.cit.,* p 17.

78 *ibid.,* pp32-37.

79 Marmot, M., 'Health and the psychosocial environment at work', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health, op.cit.,* p124.

80 Wilkinson, R., 'Prosperity, redistribution, health and welfare', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health*, *op.cit.,* pp260-265.

81 Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage, Key Indicators 2005,* Productivity Commission, Melbourne, 2005, p3.26.

82 *ibid.,* p3.19.

83 Australian Bureau of Statistics, *Population characteristics: Aboriginal and Torres Strait Islander Australians 2001,* ABS cat. no. 4713.0, Commonwealth of Australia, Canberra, 2003, p81.

84 *ibid.,* p82.

85 *ibid.,* p65.

	At the 2001 Census, the unemployment rate for Aboriginal and Torres Strait Islander people was 20%; three times higher than the rate for non-Indigenous Australians.[86] About one in six of all Aboriginal and Torres Strait Islander people who were classified as employed were engaged in Community Development Employment Projects (CDEP).[87]
Health risk factors	In 2002, just under one-half of the Aboriginal and Torres Strait Islander population aged15 years or over smoked on a daily basis.[88] One in six reported consuming alcohol at risky or high risk levels and just over one-half had not participated in sport or physical recreation activities.[89]
Personal stressors	In 2002, 82.3% Aboriginal and Torres Strait Islander people reported experiencing at least one stressor[90] in the last 12 months. Higher rates of fair or poor health and health risk behaviour were reported among Aboriginal and/or Torres Strait Islander people who had been exposed to these stressors.[91] One of the possible stressors survey participants could identify was racism.[92]

There are a range of *collective* health determinants that may also be impacting on Aboriginal and Torres Strait Islander peoples:

- Racism is a collective stressor that has been reported to affect both mental and physical health. A 2003 review of 53 studies in the United States found a decline in mental health status as racism increased.[93] Eight out of 11 studies found links between the elevated prevalence of high blood pressure in Afro-Americans and racism.[94]
- In relation to Aboriginal and Torres Strait Islander peoples, it may be that the lack of *collective* control acts as a determinant of poor health. This might manifest on a community level, providing another reason for effective community governance and the community control of services. However, there may be wider ramifications still. Aboriginal and Torres Strait Islander peoples have long asserted that their health is linked to their collective ability to control their lives and cultures

86 *ibid.,* p66.

87 *ibid.,* p67.

88 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *op.cit.,* p135.

89 *ibid.,* pp135-137.

90 Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Social Survey, op.cit.,* p39, Table 12.

91 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *op.cit.,* p141.

92 A life stressor is defined as a serious illness; accident or disability; the death of a family member or close friend; mental illness; divorce or separation; inability to obtain work; involuntary loss of a job; alcohol or drug-related problems; witnessing violence; being the victim of abuse or violent crime; trouble with the police; gambling problems; incarceration of self or a family member; overcrowding; pressure to fulfil cultural responsibilities; and discrimination or racism, *ibid.,* Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Social Survey, op.cit.,* p79.

93 Williams, R., Neighbours, H. and Jackson, J., 'Racial/Ethnic Discrimination and Health: Findings from Community Studies', (Feb 2003), 93(2) *American Journal of Public Health* 200, p200.

94 *ibid.,* p201.

and the recognition of their rights[95] as have indigenous peoples around the world.[96]

- In the *National Aboriginal Health Strategy,* Aboriginal and Torres Strait Islander peoples linked their health to 'control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.'[97]
- There is also evidence of discrimination in health services, as reported in relation to secondary and tertiary cardiovascular disease interventions. A study based around on data from the National Morbidity Database for hospital separations over 1997 and 1998 reported that Aboriginal and Torres Strait Islander patients with cardiovascular disease were significantly less likely to undergo major procedures, such as angiography: at a rate of about half of that of non-Indigenous patients.[98] There were also significant differences in the rates of bypass surgery or angioplasty between the two groups.[99]

Access to traditional lands can also act as a determinant of health status, particularly where that land is culturally significant and provides sources of food, water and shelter. To illustrate this, my Office invited Ms Leanne Liddle, Aboriginal Parks and Wildlife Coordinator with the Department for Environment and Heritage in South Australia to describe her experiences managing the Kuka Kanyini project. This is currently underway in Wattaru, South Australia in the Anangu Pitjantjatjara Lands.

Text Box 5: Case study: The Kuka Kanyini project, Anangu Pitjantjatjara Lands

The goals of managing country, conserving biodiversity, maintaining culture, providing employment and training and improving the diet of remote communities coincide in the Kuka Kanyini project, initiated in 2003 as a pilot around the remote community of Watarru in the far north west Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. The project is a local community- government partnership funded by the South Australian Department of Environment and Heritage and the APY land management. The Kuka Kanyini model, it is hoped, will be extended throughout the APY Lands in time.

Watarru has a seasonal population of between 60 and 100 people and is located in an extremely remote part of the APY Lands. It is a lawfully strong, proud and socially cohesive community, generally free of problems like petrol sniffing and domestic violence that occur elsewhere on the APY Lands. However, despite these positive points, a visit to Watarru by staff members of HREOC in 2003 noted high rates of

95 National Aboriginal Health Strategy Working Group, *National Aboriginal Health Strategy,* AGPS, Canberra, 1989, ppix and xiii.

96 *Geneva Declaration on the Health and Survival of Indigenous People* (1999), WHO consultation on indigenous health, Geneva, 23-26 November 1999, Part II, available online at http://www.healthsite.co.nz/hauora_maori/resources/feature/0001/002.htm.

97 National Aboriginal Health Strategy Working Group, *National Aboriginal Health Strategy,* AGPS, Canberra, 1989, pix.

98 Cunningham, J., 'Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous', (2002), 176(2) *Medical Journal of Australia* 58, p60.

99 Walsh, W., Ring, I., Brown, A., *(et al),* 'Ischaemic Heart Disease', in Editors Couzos, S. and Murray, R., Aboriginal Primary Health Care, (2nd ed.), Oxford University Press, Melbourne, 2003, p337.

diabetes and other chronic diseases self-reported by community members. There was a limited range of foods stocked at the Watarru community store. Convenience foods high in saturated fat and sugars are often the preferred foods by community members.

Land management is an integral part of the project. This includes maintaining the traditional pattern of fire management regimes that helps minimise the impact of accidental fires that can otherwise devastate the local mulga woodlands from which foods (grubs, mistletoe fruit, honey ants, mulga apples and seeds) and pharmacopeia are found. Fire also is used to encourage regrowth of foods preferred by kangaroos and emus that assist Anangu when hunting. It also includes the control of populations of feral rabbits, foxes, camels, and cats that have had a significant impact on the population of small sized native mammals in the region. Feral camels and horses also foul and damage water sources that native animals rely on and compete with the community for several plant food-sources and are of high cultural significance.

To date the project has exceeded expectations. It continues to employ a minimum of 12 people on a full time basis, increasing the level of self esteem and valuing the 40,000 yr information base of the local people to assist western science. By combining contemporary and traditional skills we are now able to best manage the land. To date, the increase in the physical activity by participants has assisted in the control of diabetes. The guaranteed wage ensures that people are now saving for large items and buying healthy foods. The increase in self- esteem is obvious with the younger people wanting to participate; young men in particular seek to working with camels and learn fire skills as these are considered prestigious occupations.

Since the project began, over 1,000 camels have been mustered, many which have been sold to the overseas market with the profits returning back to the community. Two significant rock holes have been covered to provide protection from camels. A major spring is also being fenced off.

We have located many new mallee fowl nests and great desert skink holes. Anangu are now recognising that animals that they once thought were there are no longer around and are addressing this by shooting feral cats and wild dogs. A helicopter in the area also allowed those less mobile to see the condition of country and advise the younger people as to what land management work was required.

In the preparation of this chapter, my Office also invited Professor Sir Michael Marmot to comment on the implications of the health status of Aboriginal and Torres Strait Islander peoples from an international perspective. Professor Marmot is acknowledged as a pioneering international researcher on the social determinants of health and is a noted public health expert.[100]

100 Professor Sir Michael Marmot MBBS, MPH, PhD, FRCP, FFPHM is currently the Director, International Centre for Health and Society, and Professor of Epidemiology and Public Health, University College London.

Text Box 6: Aboriginal and Torres Strait Islander health status – a comment by Professor Sir Michael Marmot

Poverty exerts its malign influence on health in a variety of ways. The most obvious, and heart-rending, is in the death of infants and young children. The unhappy title for the world leader in these stakes goes to Sierra Leone with an under five mortality rate in 2000 of 316 per 1,000 live births; and an infant mortality rate of 181 per 1,000 live births.[101] It is not difficult to see how poverty of material conditions, poor sanitation and gross malnutrition, added to lack of quality medical care, can be responsible for such tragically foreshortened lives – a life expectancy at birth of 34 years.

At the other end of the scale lie Iceland, Finland and Japan with under-five mortality rates of 3, 4 and 5 per 1000 live births. On this scale, Aboriginal and Torres Strait Islanders people, infant mortality rate 12.7,[102] look more like Iceland than Sierra Leone. If infant mortality rates were the sole criterion of health disadvantage, Aboriginal and Torres Strait Islanders people, would look quite good: better than all of sub-Saharan Africa, better than most of Latin America, better than China and much of South and South-East Asia. There are two problems with such a rosy conclusion.

First, with life expectancy of 59.4 years for men and 64.8 for women,[103] Australian Indigenous peoples do not at all appear to be advantaged. For example, China with infant mortality of 31 per 1000 has life expectancy of 69.6 for men and 72.7 for women. Costa Rica with infant mortality rate of 10, has life expectancy of 74.8 for men and 79.5 for women. Aboriginal health is clearly much lower than it could be, but the problem is one of adult mortality, in addition to avoidable deaths among young children.

Second, the relevant comparison, surely, should be the national average for Australia. Here we see a twenty year gap in life expectancy. Australia has an impressive health picture, except for its Indigenous populations.

The fact that infant and child mortality rates – sensitive indicators of the effects of poverty on health – are low on a world scale might be thought to exonerate poverty as a cause of the health disadvantage of Aboriginal and Torres Strait Islanders people. It does not. We need to think about poverty in a different way. Dirty water and low calorie supply will not, in themselves, account for the fact that major contributors to the lower than average life expectancy are cardiovascular diseases, cancers, endocrine nutritional and metabolic diseases (including diabetes), external causes (violence), respiratory, and digestive diseases. It is the causes of these diseases that we need to understand. The social determinants of health are crucial.[104]

Aboriginal and Torres Strait Islanders people are disadvantaged in a variety of ways beyond material disadvantage. The task is urgent to sort out the nature of that disadvantage, how it leads to such an increased burden of non-communicable disease in adults, and what to do about it.

A wealth of information, internationally, shows that simply telling disadvantaged people to behave better will do little to combat obesity, smoking, or alcohol abuse, important as these behaviours are.

101 World Health Organization, *The World Health Report 2004: Changing history,* WHO, Geneva, 2004.

102 National Indigenous infant mortality rate, 1999-2001: Australian Bureau of Statistics, *Deaths,* ABS cat. no. 3302.0, Canberra, 2001, p23.

103 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *op.cit.,* p148.

104 Marmot, M. and Wilkinson, R., *Social determinants of health, op.cit.*

Changing the marginal position in society of Aboriginal and Torres Strait Islanders people will need an approach that takes in the whole of life, starting with women of child bearing age, focussing on the care of infants and young children and proceeding through the life course. If the problem lent itself to easy solutions it would have been solved. On the other hand, the health situation of indigenous peoples in New Zealand, the USA and Canada has also been poor compared to the majority society. But their disadvantage is now less than that of Aboriginal and Torres Strait Islanders people.

The right place to start is documentation of the problem. Its solution will require broad social action that goes well beyond the health sector.[105]

105 Marmot, M., *Status Syndrome – How your social standing directly affects your health and life expectancy,* Bloomsbury, London & Henry Holt, New York, 2004.

3. Existing policy approaches for improving the health status of Aboriginal and Torres Strait Islander peoples

There have been a number of developments in Indigenous policy over recent years where governments have made commitments to addressing Aboriginal and Torres Strait Islander health inequality a major priority.

This has been through the processes of the Council of Australian Governments (COAG) that has made a number of commitments to address Aboriginal and Torres Strait Islander disadvantage as well as through the agreement of a specific health sector framework for addressing Aboriginal and Torres Strait Islander health issues.

The combination of these commitments provides a substantial foundation from which to address Aboriginal and Torres Strait Islander health inequality. They provide a number of opportunities and challenges, particularly as a consequence of the recently introduced changes to the administration of Indigenous affairs at the federal level. These new arrangements, introduced in July 2004, are intended to operate across all areas of government activity – including programs and services relating to Aboriginal and Torres Strait Islander health.

This section provides an overview of the commitments and processes that have been entered into by governments and the potential contributions of each of these to addressing Aboriginal and Torres Strait Islander health inequality.

a) The commitments of the Council of Australian Governments to address Indigenous disadvantage

Commitments to address Aboriginal and Torres Strait Islander disadvantage, including inequality in Aboriginal and Torres Strait Islander health status, have been made at the inter-governmental level over many years.

For example, COAG endorsed the 'National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal peoples and Torres Strait Islanders' in 1992. This recognised the need to address the underlying and fundamental causes of Aboriginal and Torres Strait Islander inequality and disadvantage and for governments to work together in partnership to address this.[106] Very little was done by COAG to advance this commitment during the 1990s.

COAG stated its commitment to reconciliation in its communiqué of November 2000. It noted that, 'Governments can make a real difference in the lives of Indigenous people by addressing social and economic disadvantage, including life expectancy, and improving governance and service delivery arrangements with Indigenous people'. While noting that, 'governments have made solid and consistent efforts to address disadvantage and improvements have been achieved', they also noted that, 'much remains to be done in health and the other areas of government activity'.[107]

Accordingly, COAG committed itself to 'an approach based on partnerships and shared responsibilities with Indigenous communities, programme flexibility and coordination between government agencies, with a focus on local communities

106 Council of Australian Governments, Communiqué, 7 December 1992, available online at www.coag.gov.au/meetings/071292/index.htm#aboriginal.

107 Council of Australian Governments, Communiqué, 3 November 2000, available online at www.coag.gov.au/meetings/031100/index.htm#reconciliation.

and outcomes'.[108] COAG also agreed that, '[w]here they have not already done so, Ministerial Councils will develop action plans, performance reporting strategies and benchmarks'[109] in accordance with these commitments.

Progress in implementing this commitment was initially slow.[110] However, subsequent COAG communiqués have built on this commitment and given content and meaning to it.

In April 2002, COAG agreed to conduct up to 10 whole-of-government community trials for coordinated service delivery to Aboriginal and Torres Strait Islander peoples. At the same meeting, COAG agreed to commission a regular report against key indicators of Aboriginal and Torres Strait Islander disadvantage in order 'to measure the impact of changes to policy settings and service delivery and provide a concrete way to measure the effect of the Council's commitment to reconciliation through a jointly agreed set of indicators.'[111]

Known as the *Overcoming Indigenous Disadvantage Framework,* it reports on progress in addressing both the larger, cumulative or 'headline indicators' that provide a snapshot of the overall state of Aboriginal and Torres Strait Islander disadvantage (such as life expectancy) and a number of supporting 'strategic change indicators' to measure progress within the shorter term. Ultimately, the Framework is built on the vision that 'Indigenous people will one day enjoy the same overall standard of living as other Australians. They will be as healthy, live as long, and participate fully in the social and economic life of the nation.'[112]

In June 2004, COAG then agreed to a *National Framework of Principles for Government Service Delivery to Indigenous Australians* in order to 'underpin government effort to improve cooperation in addressing (Indigenous) disadvantage.'[113] It was also agreed that this framework of principles would 'guide bi-lateral discussions between the Commonwealth and each State and Territory Government on the Commonwealth's new arrangements for Indigenous affairs and on the best means of engaging with Aboriginal and Torres Strait Islander people at the local and regional levels'.[114]

As a consequence of these COAG commitments:

- There is now a joint commitment from all governments in Australia to coordinated service delivery with the objective of addressing Aboriginal and Torres Strait Islander disadvantage, including health inequality.

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108 *ibid.*

109 *ibid.*

110 Most Ministerial Action Plans never materialised: See the commentary in Aboriginal and Torres Strait Islander Social Justice Commissioner, Social Justice Report 2002, HREOC, Sydney, 2002, Chapters 3 and 4. This is also acknowledged by COAG in its communiqué of April 2002: Council of Australian Governments, Communiqué, 5 April 2002, available online at www.coag.gov.au/meetings/050402/index.htm#reconciliation..

111 *ibid.*

112 The Overcoming Indigenous Disadvantage Framework is available online at: www.pc.gov.au/gsp/reports/Indigenous/keyindicators2005/index.html and is reproduced in Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2004, ibid.,* Appendix 1 – Chronology.

113 Council of Australian Governments, Communiqué, 25 June 2004, available online at www.coag.gov.au/meetings/250604/index.htm#attachments.

114 *ibid.*

- Efforts towards this goal are to be guided by the *National Framework of Principles for Government Service Delivery.* These address the following themes: sharing responsibility; harnessing the mainstream; streamlining service delivery; establishing transparency and accountability; developing a learning framework; and focusing on priority areas.[115]
- Progress in addressing these commitments is able to be measured against the *Overcoming Indigenous Disadvantage Framework* on a biennial basis.

b) Commitments to address Aboriginal and Torres Strait Islander health inequality at the inter-governmental level

In addition to these commitments to address Aboriginal and Torres Strait Islander disadvantage generally, specific commitments have also been made at the inter-governmental level to address Aboriginal and Torres Strait Islander health inequality. This is through the development of a specific Aboriginal and Torres Strait Islander health policy framework and partnership process.

■ *The National Strategic Framework for Aboriginal and Torres Strait Islander Health*

The *National Aboriginal Health Strategy* (NAHS) of 1989 remains the key document in this regard. The document itself presented problems in terms of implementation (for example, it contained no recommendations). But as a statement of guiding principles, it enjoys broad support among all governments and Aboriginal and Torres Strait Islander peoples.

In July 2003, all Australian Governments renewed their commitments to Aboriginal and Torres Strait Islander health with the agreement of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (or the *National Strategic Framework*).[116] This establishes a ten year plan for Aboriginal and Torres Strait Islander health, building on the principles of the NAHS.[117]

The *National Strategic Framework* reflects developments that had occurred since 1996, when responsibility for Aboriginal and Torres Strait Islander health and the implementation of the NAHS was transferred from ATSIC to the Department of Health and Ageing. The first *Framework Agreements for Aboriginal and Torres Strait Islander Health* were also completed and Aboriginal health planning forums were established during this period.

Through the *National Strategic Framework*, all governments recognise that progress in improving Aboriginal and Torres Strait Islander health status has been too slow and is unacceptable. The foreword to the Strategy's *Framework for Action by Governments* states:

> At the beginning of the 21st century, the devastating impact of poor health on Aboriginal and Torres Strait Islander peoples and communities cannot go on. *It is timely for us to commit to a long-term collaborative approach to addressing the*

115 *ibid.* These are also reproduced at: Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2004,* HREOC, Sydney, 2005, p182.

116 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments,* NATSIHC, Canberra, 2003.

117 The *National Strategic Framework* is described by governments as supplementing the principles established in the NAHS and giving content to them: *ibid.,* p2.

health status of Aboriginal and Torres Strait Islander peoples as a matter of urgency. It is time for us to work together across governments and across portfolios in a spirit of bi-partisanship and in full collaboration with Aboriginal and Torres Strait Islander health leaders and communities to progress long-term strategies for sustainable outcomes.[118]

The key commitments of the *National Strategic Framework* are set out in the text box below.

Text Box 7: The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* and specific health strategies

The goal of the *National Strategic Framework* is 'to ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice'.[119]

The Strategy also lists the following specific aims to measure whether this goal is achieved:

1. Increase life expectancy to a level comparable with non-Indigenous Australians.
2. Decrease mortality rates in the first year of life and decrease infant morbidity by:
   - Reducing relative deprivation; and
   - Improving well-being and quality of life.
3. Decrease of all-causes mortality rates across all ages.
4. Strengthen the service infrastructure essential to improving access by Aboriginal and Torres Strait Islander peoples to health services and responding to:
   - Chronic disease, particularly cardiovascular disease, renal disease, diseases of the endocrine system (such as diabetes), respiratory disease and cancers;
   - Communicable disease, particularly infections in children and the elderly, sexually transmissible infections and blood borne diseases (including Hepatitis C);
   - Substance misuse, mental disorder, stress, trauma and suicide;
   - Injury and poisoning;
   - Family Violence, including child abuse and sexual assault; and
   - Child and maternal health and male health.[120]

The Framework identifies nine **'key result areas'** for achieving this goal and these aims. These relate to measures to:

- *achieve a more effective and responsive health system* (including a focus on community controlled health care services; the health system delivery framework; development of a health workforce; and focus on social and emotional well-being);
- *influence the health impacts of the non-health sector* (such as through environmental health and wider strategies that impact on health); and
- *provide the infrastructure to improve health status* (including adequate data, research and evidence; resources and finance; and accountability mechanisms).[121]

118 *ibid.,* p2. Emphasis added.

119 *ibid.,* p7.

120 *ibid.*

121 These are set out in more detail in the framework: *ibid.,* pp13-38.

The *National Strategic Framework* also commits governments to work in accordance with the following nine **principles**:

- *Cultural respect:* ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services.
- *A holistic approach:* recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance.
- *Health sector responsibility:* improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use.
- *Community control of primary health care services:* supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.
- *Working together:* combining the efforts of government, non-government and private organisations within and outside the health sector, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.
- *Localised decision making:* health authorities devolving decision making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander health and health related services and mainstream health services.
- *Promoting good health:* recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.
- *Building the capacity of health services and communities:* strengthening health services and building community expertise to respond to health needs and take shared responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, fostering leadership, governance and financial management.
- *Accountability:* including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, government is responsible for ensuring that all Australians have access to appropriate and effective health care.[122]

122 *ibid.,* pp2-3.

Specific health strategies

Key Result Area Four of the *National Strategic Framework* is specifically aimed at enhancing the emotional and social well-being of Aboriginal and Torres Strait Islander peoples. An important commitment made was to develop a strategic framework for emotional and social well-being[123] This was released in October 2005: *A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well-being 2004-2009.*

The Framework aims to achieve for Aboriginal and Torres Strait Islander peoples 'three basic elements of care':[124]

- Action across all sectors to enhance social and emotional well-being, promote mental health and prevent problems from arising;
- Access to well-resourced and professional primary health care service, including Social Health Teams linked to community initiatives and to mainstream services; and
- Responsive mainstream health services linked in and accessible through the primary health care system.[125]

Implementation will sit within the implementation, monitoring and evaluation arrangements of the *National Strategic Framework* and the *National Mental Health Plan* (2003-2008).[126]

The *National Strategic Framework* also includes a commitment to implement the *National Aboriginal and Torres Strait Islander Hearing Strategy.*[127] The strategy focuses on improving the ear and hearing health of infants and children aged 0-5 years by improving access to health care services and improving standards of care. It was implemented in 1996 with initiatives in four complimentary areas: training and equipment; child health sites; capital infrastructure; and strategic research.[128]

A review of the strategy in 2002 found that although there was much to commend in the strategy, 0-5 year olds were not being effectively reached by it because of its focus on older, school-aged children.[129] There is some suggestion that this is in turn is linked to inadequate reach of primary health care in communities, resulting in a lack of screening of infants.[130]

There is also a commitment to implement the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy*[131] in the *National Strategic Framework*. This is intended to complement the *National HIV/AIDS Strategy 2005-2008*; the *National Hepatitis C Strategy 2005-2008*; and the *National Sexually Transmissible Infections Strategy 2005-2008*. The purpose of the Strategy is to highlight the additional

123 *ibid.,* p17.

124 Australian Health Ministers Advisory Council, *A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009,* Commonwealth of Australia, Canberra, 2004, p4.

125 *ibid.*

126 *ibid.*

127 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for action by governments, op.cit.,* p13.

128 Office of Aboriginal and Torres Strait Islander Health, *National Aboriginal and Torres Strait Islander Hearing Strategy 1995-1999,* 22 September 2004, OATSIH Website: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-hearing.htm. (Accessed June 14, 2004).

129 Department of Health and Ageing, *Report on Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander Peoples – Strategies for future action,* Commonwealth of Australia, Canberra, October 2002, p6, Key finding no 2.

130 *ibid.,* p18.

131 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for action by governments, op.cit.,* p13.

priorities and special issues that are unique to the prevention and treatment needs of Aboriginal and Torres Strait Islander people.[132]

Other health-specific strategies and strategies that are committed to by the *National Strategic Framework* include:

- The *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan*[133] which builds on the *National Tobacco Strategy 2004-2009*[134] and the *National Alcohol Strategy: a plan for action 2001-2003/4*;[135]
- The development of a national Aboriginal and Torres Strait Islander child and maternal health framework;[136]
- The development of a national approach to Aboriginal and Torres Strait Islander oral health[137] and the health of males;[138]
- The *Commonwealth, State and Territory Strategy on Healthy Ageing* (with an Indigenous implementation plan currently being developed);[139] and
- The *Active Australia* strategy.[140]

In accordance with the *National Strategic Framework*, Aboriginal and Torres Strait Islander Health Framework Agreements have been negotiated between the Commonwealth and each state or territory. The Agreements are intended to:

- increase the level of resources for Aboriginal and Torres Strait Islander health to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples;
- improve access to mainstream and Indigenous specific health and health-related programs;
- establish joint planning processes which allow for 'full and formal Aboriginal and Torres Strait Islander participation in decision-making and determination of priorities'; and
- improve data collection and evaluation mechanisms.[141]

132 Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008,* Commonwealth of Australia, Canberra, 2005, pviii.

133 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for action by governments, op.cit.,* p17. Ministerial Council on Drug Strategy, *National Drug Strategy: Indigenous Peoples Complementary Action Plan,* Commonwealth of Australia, Canberra, 2003.

134 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for action by governments, op.cit.,* p17. Ministerial Council on Drug Strategy, *National Tobacco Strategy 2004-2009,* Commonwealth of Australia, Canberra, 2004.

135 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for action by governments, op.cit.,* p17. National Expert Advisory Committee on Alcohol, *National Alcohol Strategy 2001-2003/4,* Commonwealth of Australia, Canberra, 2001.

136 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for action by governments, op.cit.,* p22.

137 *ibid.,* p10.

138 *ibid.,* p17.

139 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Context, op.cit.,* p29.

140 *ibid.*, p23. Department of Health and Ageing, *Developing an Active Australia: A framework for physical activity and health,* Department of Health and Ageing, Canberra, 1998.

141 *ibid.*

In accordance with these agreements and the *National Strategic Framework*, each government is required to develop its own implementation plan for addressing the goal and aims of the Framework. This process, including qualifications on how the commitments will be met, is described in the foreword of the *National Strategic Framework* as follows:

> This *National Strategic Framework* commits governments to monitoring and implementation within their own jurisdictions, working together at the national level and working across government on joint initiatives between health departments and other portfolios. Through their Framework Agreement partnership structures, each jurisdiction will develop and publish a detailed Strategic Framework implementation plan including accountabilities for progressing the action areas, timeframes and reporting mechanisms.
>
> Provision of financial resources to implement the Strategic Framework will depend on fiscal management strategies and competing funding priorities as determined by each jurisdiction's budget processes. An independent mid term review of progress against the implementation plan and outcomes achieved will be undertaken and published and an independent evaluation of the *National Strategic Framework*'s outcomes will be conducted and published at its completion. Health portfolios will report on progress annually to the Australian Health Ministers' Conference and biennial whole of government progress reports will be prepared and published. Progress with implementation of this *National Strategic Framework* will be monitored by the Australian Health Ministers' Advisory Council through a joint meeting of its Standing Committee of Aboriginal and Torres Strait Islander Health and the National Aboriginal and Torres Strait Islander Health Council.[142]

Governments have acknowledged that they have failed in the past to make good on their commitments to Aboriginal and Torres Strait Islander peoples in relation to health service provision.[143] They have acknowledged, for example, the findings of the 1994 evaluation of the *NAHS* which stated that it was 'never effectively implemented' due to:

- underfunding by governments in rural and remote areas targeted at meeting the objective of environmental equity by 2001;
- a lack of political will and commitment from all government ministers and ATSIC;
- a lack of accountability for implementation;
- the absence of meaningful partnerships between the mainstream health system and Aboriginal and Torres Strait Islander peoples; and
- the fact that other portfolios, such as housing, essential services, education and local government were not party to the strategy.[144]

Accordingly, the foreword to the *National Strategic Framework* states that:

> Governments intend this *National Strategic Framework* for Aboriginal and Torres Strait Islander Health to inspire confidence amongst Aboriginal and Torres Strait Islander communities, organisations and leaders that we recognise the broader context of health disadvantage amongst Aboriginal and Torres Strait Islander peoples and have a long-term and bipartisan commitment to working with them to address it.[145]

142 *ibid.,* p4.

143 *ibid.,* p4.

144 Aboriginal and Torres Strait Islander Commission, *The National Aboriginal Health Strategy: An evaluation,* ATSIC, Canberra, 1994.

145 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, op.cit.,* p4.

In correspondence with my Office, the federal Department of Health and Ageing has noted the progress in developing implementation plans in the past year:

> During 2004-05 the Department developed the Australian Government Implementation Plan 2003-2008 against the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* and worked with jurisdictions on a reporting framework for the Implementation Plans that of all jurisdictions will replace the existing Framework Agreement reporting and assist in streamlining reporting.[146]

They also note progress in finalising the Health Performance Framework for monitoring and evaluation progress under the *National Strategic Framework*:

> During 2004-05, the Department provided a significant contribution to the development of the new Aboriginal and Torres Strait Islander Health Performance Framework which is being auspiced by the Standing Committee on Aboriginal and Torres Strait Islander Health. This Framework has been developed to provide the basis for quantitative measurement of the impact of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*. It will replace the existing National Performance Indicators from 2006 and will provide the focus for improvements in Indigenous health data in the longer term.
>
> The Aboriginal and Torres Strait Islander Health Performance Framework… includes a set of around 90 performance measures in three Tiers:
>
> – health outcomes;
> – determinants of health; and
> – health system performance.
>
> *Tier 1 Health Outcomes* includes measures of health conditions, life expectancy and mortality. *Tier 2, Determinants of Health* includes measures of socioeconomic factors, environmental factors and risk factors that all have an influence on final health outcomes. *Tier 3, Health System Performance* measures the effectiveness, capability and sustainability of the health system in relation to Indigenous health. It measures inputs and intermediate outcomes of the health system (such as antenatal care, immunisation, screening, management of chronic illness etc where there is clear evidence in the literature of a linkage between health system activity and health outcomes). The Health Performance Framework measures the performance of the whole health system in relation to Aboriginal and Torres Strait Islander health.
>
> The new Health Performance Framework is consistent with the COAG principles for service delivery and incorporates the majority of the health related performance measures from the National Reporting Framework on Indigenous Disadvantage and extends these to cover health outcomes more broadly such as health conditions, mortality by leading causes and health system performance beyond the issue of accessibility.[147]

Despite this extensive system of monitoring, the *National Strategic Framework* does not require the setting of timeframes within which to achieve the goal and aims set out in the Framework. It states that:

> each jurisdiction will develop and publish a Strategic Framework Implementation Plan against which progress in the jurisdiction will be measured. *Within this implementation plan each jurisdiction will be responsible for determining its own specific initiatives, priorities and timeframes…*

146 Department of Health and Ageing, Correspondence with Aboriginal and Torres Strait Islander Social Justice Commissioner regarding the Social Justice Report 2005, 21 July 2005, p4.

147 *ibid.,* p4. Emphasis added.

> This *National Strategic Framework* sets agreed direction for reform in Aboriginal and Torres Strait Islander health *without imposing specific targets or benchmarks on the Commonwealth, State and Territory governments in recognition of the different histories, circumstances and priorities of each jurisdiction.* Therefore, reporting will record progress in areas consistent with the action areas detailed in each key result area and against the stated aims and, over time, chart each government's progress against their own baselines.[148]

The *National Strategic Framework* does, however, indicate in general terms the type of results that can be anticipated over the life of the Framework:

> Some results of the *National Strategic Framework* for Aboriginal and Torres Strait Islander Health will be seen in the shorter term, such as the provision of enhanced primary care services under the Primary Health Care Access Program, outcomes of environmental health surveys, and outcomes of existing workforce capacity building initiatives.
>
> In the medium term, it will be important to assess the aims of the key result areas to ensure that important initiatives are being implemented, including changes to service delivery, enhanced community participation and increases in the numbers of Aboriginal and Torres Strait Islander health professionals.
>
> Some impacts on health outcomes may be expected in the medium term, such as changes to the health care provided to infants and young children and reductions in communicable diseases as a result of improved health information and immunisation programs. However, some results will take longer to achieve. Change in health outcomes must be monitored and the aim of reducing incidence, prevalence and impact of these disorders kept firmly in mind.[149]

In summary, the *National Strategic Framework*:

- sets out a coordinated framework for all governments to work in partnership to address Aboriginal and Torres Strait Islander health inequality;
- recognises that addressing Aboriginal and Torres Strait Islander health inequality is a shared responsibility between governments and requires partnerships with Aboriginal and Torres Strait Islander communities;
- acknowledges that governments have, in part, failed to deliver on their commitments in the past, and so introduces a more comprehensive monitoring framework which involves bilateral agreements between the Commonwealth and the states and territories, implementation plans and health planning forums;
- is now supported by a revised Aboriginal and Torres Strait Islander Health Performance Framework, which has been agreed at the inter-governmental level to report progress on the *National Strategic Framework*;
- sets the goal as achieving health equality, with a number of identified aims to support this;
- acknowledges the urgency of addressing Aboriginal and Torres Strait Islander health inequality, although it does not set a timeframe, targets

148 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, op.cit.,* pp39-40. Italics added.

149 *ibid.,* p40.

or benchmarks for achieving the goals and aims of the Framework; and

- recognises the importance of addressing a wide variety of related issues outside of the health sector which have an impact on Aboriginal and Torres Strait Islander people's well-being.

■ *Public health strategies relating to Aboriginal and Torres Strait Islander peoples*

The National Public Health Partnership Group (NPHP) was established in 1996 by the Australian Health Ministers' Advisory Council to provide a mechanism for the Commonwealth, States and Territory governments to come together to develop joint approaches to public health. It currently operates under a Memorandum of Understanding signed by all Australian Health Ministers in February 2003, for the period 2003-2007.[150]

In 2002, the NPHP published *Guidelines for the development, implementation and evaluation of National Public Health Strategies in relation to Aboriginal and Torres Strait Islander peoples*.[151]

A number of national strategies and commitments in relation to environmental health workers, housing and the supply of food have also been developed. An overview of these frameworks is provided in the Text Box below. All require governments to work with Aboriginal and Torres Strait Islander communities to plan and deliver aspects of health infrastructure. However, there is yet to be developed an overarching strategy to address health infrastructure needs in communities in an integrated fashion.

Text Box 8: Public health strategies relating to health infrastructure

(a) National Environmental Health Strategy

The *National Environmental Health Strategy* has as an outcome 'environmental health justice' for Aboriginal and Torres Strait Islander peoples. It sets out establishing collaborative approaches and partnerships to address housing, adequate safe water, food supplies and waste disposal as priorities.[152] The *National Environmental Health Strategy Implementation Plan* sets out the 'challenge' of 'improv[ing] the health status of Indigenous Australian communities through the development of appropriate environmental health standards commensurate with the wider Australian population'.[153] The enHealth Council, responsible to the National Public Health Partnership, is responsible for providing national leadership and pursuing the partnerships necessary to implement the plan.[154]

In relation to Aboriginal and Torres Strait Islander communities, the *National Environmental Health Strategy Implementation Plan* commits to training Environmental Health Workers (EHW) to provide services and maintain health infrastructure on the

150 See the National Public Health Partnership (NPHP) website for the history of the NPHP: http://www.nphp.gov.au/about/background.htm; and its terms of reference and objectives: http://www.nphp.gov.au/about/tor.htm.

151 National Public Health Partnership, *Guidelines for the development, implementation and evaluation of National Public Health Strategies in relation to Aboriginal and Torres Strait Islander peoples,* NPHP, Canberra, 2002.

152 Department of Health and Aged Care, *National Environmental Health Strategy,* Commonwealth of Australia, Canberra, 1999, p23.

153 *ibid.,* p14.

154 *ibid.,* p6.

ground in Aboriginal and Torres Strait Islander communities on a day to day basis.[155] Developing a consensus on national standards for the education and training of EHWs is an important component of the approach.[156] The health sector has committed to supporting the strategy through the *National Strategic Framework*, although it is not yet clear whether that will translate into extra funds to provide workers on the ground.[157]

(b) Eat Well Australia

Eat Well Australia 2000-2010 is the national public health nutrition strategy developed under the auspices of the NPHP. It includes the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010* (NATSINSAP), developed by a working party and endorsed by Australian Health Ministers, in 2001.[158]

In common with many of the other the plans and strategies discussed in this chapter, there were no recommendations for funding attached to the *NATSINSAP*. The Office for Aboriginal and Torres Strait Islander Health, has provided funding for the employment of a Project Officer to support targeted national implementation through the Strategic Inter-Governmental Nutrition Alliance. The National Steering Committee is focusing on two of the key action areas: Workforce and Food Supply.[159]

(c) Building a better future

The Commonwealth Government, with the States, helps to fund Indigenous-specific public housing provided through Indigenous Housing Organisations. The Aboriginal Rental Housing Program (AHRP), a component of the Commonwealth-State Housing Agreements, aims to improve the healthiness and expand upon the housing stock available for rental by Aboriginal and Torres Strait Islander people through IHOs.[160]

In 2001, Indigenous Housing Agreements (IHAs) were negotiated between the Commonwealth Government, some State and Territory governments and, originally, ATSIC.[161] Each agreement is different (some covering housing as well as health infrastructure programs). However, they share common features:

- The pooling of funds and the delivery of CHIP and ARHP as one program;
- The establishment of an Indigenous Housing Authority in each State and Territory to provide for greater Aboriginal and Torres Strait Islander decision making and community involvement in the delivery of housing programs.

Just as the *National Strategic Framework* is intended to be a guide to the planning activities of the Partnership Forums, the *Building a Better Future: Indigenous Housing to 2010* (BBF) strategy is designed to guide the planning activities of Indigenous Housing Authorities and a whole of government approach.

155 *ibid.,* pp9-10.

156 enHealth Council, *National Review of Indigenous Environmental Health Workers, Discussion Paper,* Department of Health and Ageing, Canberra, 2004, p3.

157 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for Action by Governments, op.cit.,* p20, Key Result Area 5.

158 National Aboriginal and Torres Strait Islander Nutrition Working Party, *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010,* NPHP, Canberra, 2001, p8.

159 Office of Aboriginal and Torres Strait Islander Health, *Correspondence with Aboriginal and Torres Strait Islander Social Justice Commissioner,* 5 November, 2004.

160 Department of Family and Community Services website: http://www.facs.gov.au/internet/facsinternet.nsf/indigenous/programs-arhp.htm, 27 May 2005, (Accessed 12 September 2005).

161 McIntosh, G. and Phillips, J., 'Commonwealth-State Housing Agreements', Parliamentary Library of Australia website: http://www.aph.gov.au/library/intguide/sp/statehouseagree.htm, 29 November 2001. (Accessed September 2, 2004).

BBF also considers environmental health, self management of communities, Aboriginal and Torres Strait Islander communities as partners in service delivery and the investigation of other forms of housing tenure to community housing including public housing, mainstream community housing and home ownership.

BBF includes the following vision for Aboriginal and Torres Strait Islander housing:

Aboriginal and Torres Strait Islander people throughout Australia will have:

- access to affordable and appropriate housing which contributes to their health and well-being;
- access to housing which is safe, well-designed and appropriately maintained.
- a vigorous and sustainable Aboriginal and Torres Strait Islander community housing sector, operating in partnership with the Australian Government and State and Territory and local governments; and
- Aboriginal and Torres Strait Islander housing policies and programs are well developed and administered in consultation and cooperation with Aboriginal and Torres Strait Islander communities with respect for Aboriginal and Torres Strait Islander cultures.[162]

A draft *Framework for Evaluating Building a Better Future: Indigenous Housing to 2010* was completed in June 2005 by the National Indigenous Housing Implementation Committee.[163]

c) Aboriginal and Torres Strait Islander health and the new arrangements for the administration of Indigenous affairs at the federal level

The COAG commitments noted above and the health sector specific processes underway for Aboriginal and Torres Strait Islander health exist alongside newly introduced arrangements for the administration of Indigenous affairs at the federal level. These new arrangements are intended to ensure:

- direct engagement with Aboriginal and Torres Strait Islander peoples at the local level (including through Shared Responsibility Agreements);
- needs-based planning at a regional level (including through Regional Partnership Agreements and the operation of regional Indigenous Coordination Centres);
- improved whole of government coordination (both between federal departments and between levels of government); and
- improved accessibility of mainstream services.[164]

The new arrangements apply to *all* federal government activity, including the delivery of health programs and services. It is also anticipated that the states and territories will align their service delivery processes with the new arrangements. This is asserted based on the agreement of the *National Framework of Principles*

162 Department of Family and Community Services, *Community Housing and Infrastructure Program, Program Guidelines 2005-06,* FACS, Canberra, 2005, (no page nos.), Section 1.

163 Rogers, P., Stevens, K. and Briskman, L., *(et al), Framework for Building a Better Future Indigenous Housing to 2010, Vol. 2: Proposed Evaluation Framework,* Australian Housing and Urban Research Institute, Canberra, June 2005, available online at http://www.ahuri.edu.au/global/docs/doc843.pdf?CFID=406747&CFTOKEN=29475227.

164 For a detailed overview of the new arrangements see Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2004,* HREOC, Sydney, 2005, Chapter 2 and Appendix 1.

for Government Service Delivery to Indigenous Australians and the negotiation of bilateral agreements on Indigenous affairs based on these principles.[165]

There is already an extensive focus within the health sector on the type of issues that the new arrangements are grappling with. For example, the Framework Agreements on Aboriginal and Torres Strait Islander Health in each state and territory establish processes for advancing policy development, planning and resource allocation in a coordinated manner at the inter-governmental level and in partnership with Aboriginal and Torres Strait Islander communities (through community controlled health organisations).

Similarly, the Primary Health Care Access Program (PHCAP), which is the main program for the delivery of primary health care services to Aboriginal and Torres Strait Islander communities:

- is underpinned by a regional planning process which seeks to engage with Aboriginal and Torres Strait Islander communities to identify the key health needs and planning priorities for each region;
- recognises the importance of Aboriginal community controlled service delivery, and is supportive of local Aboriginal and Torres Strait Islander participation;
- is focused on improving the accessibility of mainstream services, such as through establishing mechanisms to improve access to Medicare and the Pharmaceutical Benefits Scheme and the funding available through these;
- involves coordinated care trials which have focused on achieving improved whole of government and holistic service delivery; and
- includes capacity building as a significant component of all strategies for improved access to health care.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* notes that while a responsive health system is fundamentally important, 'action in areas such as education, employment, transport and nutrition is also required if sustainable health gains are to be achieved'.[166] Accordingly, one of the groupings of Key Result Areas in the *National Strategic Framework* relates to influencing the health impacts of the non-health sector. It states:

> The health sector can contribute to action on the agendas of other portfolios through research, advocacy, partnerships and linkages. Comprehensive primary health care services provide the infrastructure, and the *Framework Agreements* the partnership arrangements for intersectoral collaboration between the health sector, members of Aboriginal and Torres Strait Islander communities, other government agencies, the private sector and voluntary organisations. It is clear, however, that action on broader intersectoral issues also requires a commitment to undertake activity consistent with the overall vision of this *National Strategic Framework* from government ministers in other portfolios at the Commonwealth and state/territory level.[167]

165 These bilateral agreements related to service delivery to Indigenous peoples generally, and are in addition to existing framework agreements in specific areas, such as health and housing.

166 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, op.cit.,* p24.

167 *ibid.*

Achieving such integration has been a central challenge for the health sector over the past decade. As discussed above, the 1994 evaluation of the *National Aboriginal Health Strategy* found that one of the reasons for the failure of that strategy had been the lack of engagement with the strategy by portfolios other than health.

The new arrangements provide the opportunity to sharpen the focus of service delivery so that it addresses those related issues that impact on Aboriginal and Torres Strait Islander health and to do so within an integrated framework.

The potential of the new arrangements to address these issues has been acknowledged by the Department of Health and Ageing. In correspondence with my Office, they note:

> In light of the changed arrangements in Indigenous Affairs, ICCs (Indigenous Coordination Centres) now represent the key mechanism that Aboriginal communities can use to contribute to the whole of government health planning and priority setting.[168]

They also acknowledge the potential to better utilise the existing processes set up in accordance with the framework agreements on Aboriginal and Torres Strait Islander health with the states and territories and under the Primary Health Care Access Program (PHCAP):

> Under PHCAP, regional planning arrangements provide an important mechanism for promoting effective working relationships with Indigenous communities through the activities of joint planning forums, local regional steering committees and planning consultants. These planning processes enable direct engagement with Indigenous communities in the identification of key health needs and planning priorities. The momentum gained through the planning processes and structures needs to be maintained after regional plans are completed… in order to capitalise on the benefits of continued community involvement.
>
> The regional plans developed to date include a broad examination of health needs – including analysis of the underlying determinants of health such as the quality and availability of housing, environment issues (e.g. clean water supply and adequate sanitation) and adequate employment and education opportunities. *Specific recommendations emerging from the regional planning process could prove useful in the inter-agency negotiations conducted through the ICCs*.[169]

As at 30 June 2005, the arrangements for aligning activities in the health sector with those of ICC's, and more generally under the new arrangements, were as follows:

- The Department of Health and Ageing had four staff nationally who were located in ICC's (two in Broome, one in Port Hedland and one in Darwin).[170]
- The Department intends to use the 'staffing resources transferred to it with the abolition of ATSIC and ATSIS to establish its physical presence in Indigenous Coordination Centres across the country. These resources comprised a mix of occupied and unoccupied positions across a range of APS levels in a range of locations and will be used to

168 Department of Health and Ageing, *Correspondence with Aboriginal and Torres Strait Islander Social Justice Commissioner regarding the Social Justice Report 2005, op.cit.,* p8.

169 *ibid.,* p5. Emphasis added.

170 The substantive levels of these staff were as follows: 1 x Executive Level 1, 2 x APS6, 1 x APS4: *ibid.,* p1.

recruit, over time, solution brokers at the APS6 – EL1 levels. Solution brokers will represent the Department's programs within ICCs, and in particular, in the development of Shared Responsibility Agreements (SRAs) and Regional Partnership Agreements (RPAs)'.[171]

- Until these solution brokers are recruited and placed in ICCs, '*ICC Contact Officers* have been established in the Department's State and Territory offices' who serve as 'an important point of contact for ICC managers in relation to SRA development around health issues'.[172]
- To date, six (6) SRAs have been finalised which involve funding contributions from programs run by the Department of Health and Ageing.[173] Further SRA's are under negotiation which involve either funding contributions from the Department or other support and assistance to Aboriginal and Torres Strait Islander communities.[174]
- The Department of Health and Ageing has also invited State policy managers from the Office of Indigenous Policy Coordination to participate in the state-level Aboriginal Health Forums, in order to facilitate engagement with Aboriginal and Torres Strait Islander communities at the regional level.[175]
- The Department have also noted that 'Over time, the work of ICCs will link in to health planning processes established under the… Framework Agreements (on Aboriginal and Torres Strait Islander health) and implemented through Aboriginal Health Forums at the State and Territory level.'[176]

These actions to align activities on Aboriginal and Torres Strait Islander health with the operation of ICC's are welcomed. The clear recognition from the Department of Health and Ageing of the central role of ICCs in coordinating federal government activity at the regional level is also welcomed.

I acknowledge that the efforts to build the capacity of the Department of Health and Ageing to fully participate in the new arrangements are at an early stage.

It is also acknowledged that further improvements in coordination of activity will most likely be built into the Framework Agreements on Aboriginal and Torres

171 Department of Health and Ageing, *Correspondence with Aboriginal and Torres Strait Islander Social Justice Commissioner regarding the Social Justice Report 2005, op.cit.,* p7. At the time of finalising this report, it was understood that an extensive recruitment process was underway for these positions.

172 *ibid.*

173 These are Larrakia Nation Aboriginal Corporation SRA (Darwin, NT) – funding to support the Larrakia Tank Art Project – Youth at Risk Project; Aboriginal Community of Wanarn (WA) (attached to the Ngaanyatjarra RPA) – funds to build a nutrition and training centre attached to the store; Lockhart River SRA (QLD) – funds for the employment of a number of part-time community education and diversion coordinators; Yungngora SRA (WA) – funds towards the establishment of an ablution block and laundry; Cape Barren Island SRA (TAS) – funds towards the establishment of the Cape Barren Island Community Well-being Centre; and Western Desert Nganampa Walytja Palyantjaku Tjutaku (WDNWPT) SRA (NT) – funds for the purchase of a bus to facilitate access to health services and the maintenance of social networks for renal patients and their families while they are in Alice Springs. Source: *Correspondence between Social Justice Commissioner's Office and Office of Aboriginal and Torres Strait Islander Health,* 4-5 October 2005.

174 These SRAs are in addition to those being brokered through the Anangu Pitjantjatjara Lands (APY Lands) COAG Trial site.

175 Department of Health and Ageing, *Correspondence with Aboriginal and Torres Strait Islander Social Justice Commissioner regarding the Social Justice Report 2005, op.cit.,* p7.

176 *ibid.,* pp7-8.

Strait Islander Health when they are next renegotiated between governments. It must be recognised, however, that the COAG *Principles for government service delivery to Indigenous Australians* already require governments to work together to better coordinate their service delivery and so, strictly speaking, the alignment of health service delivery with the new arrangements is not dependent on the re-negotiation of the framework agreements.

Overall, it is fair to say that the Department of Health and Ageing has not played a significant role in the roll-out of the new arrangements for the administration of Indigenous affairs to date. In particular, the Department does not as yet have a significant presence in Indigenous Coordination Centres and has limited capacity to influence the strategic directions underpinning engagement at the regional level and through agreement making processes such as SRAs. Similarly, the new arrangements have not sought to build on the significant progress and experience of the health sector. At this early stage, the new arrangements are yet to:

- apply the methodologies and lessons learned from the health sector;
- build upon the significant community resources and capacity that exists through the Aboriginal community controlled health sector – for example, by building a relationship between the Aboriginal Community Controlled Health Organisations and ICCs at the regional level; or
- build on the findings and recommendations of the regional planning processes conducted under the state-wide Aboriginal Health Forums – despite these processes identifying the priority health needs of Aboriginal and Torres Strait Islander people for each region and involving broad-based community consultation and providing a solid evidence base.

As a consequence, there is a disconnect between existing programs relating to Aboriginal and Torres Strait Islander health and the whole of government approach adopted through the new arrangements. This is despite the clear inter-connections between the issues. Even though there is recognition by governments that Aboriginal and Torres Strait Islander health outcomes require a holistic response in order to achieve lasting and sustainable improvements, in most instances issues are still being addressed separately.

d) Summary – Existing policy frameworks and the challenge of addressing Aboriginal and Torres Strait Islander health inequality

So what can we ascertain about the existing policy environment for addressing Aboriginal and Torres Strait Islander health inequality?

First, there has been significant work completed over the past 3 years to reinvigorate the commitments of governments to address Aboriginal and Torres Strait Islander health inequality through the *National Strategic Framework*. This commits governments to work in a holistic, whole of government manner and in partnership with Aboriginal and Torres Strait Islander peoples.

Second, processes have been put into place to administer the *National Strategic Framework* and through which to achieve the Framework's goal and aims. This includes through the finalisation of bilateral health agreements between the Commonwealth and states and territories; the establishment of state level health forums; the development of regional plans which identify needs and priorities;

and the establishment of a national performance monitoring framework. The 'whole of government' machinery necessary to implement the commitments of COAG is in place.

Third, there has been significant work to address many public health issues affecting Aboriginal and Torres Strait Islander peoples, notably commitments in place in relation to environmental health workers, food and housing. There is, however, an absence of an overarching strategic response to public health issues (notably health infrastructure) faced by Aboriginal and Torres Strait Islander peoples.

Fourth, the specific commitments to address Aboriginal and Torres Strait Islander health inequality have progressed parallel to the agreement by COAG of commitments and processes to address Aboriginal and Torres Strait Islander disadvantage more generally (such as through the establishment of the *Overcoming Indigenous Disadvantage* reporting framework and the principles for service delivery to Aboriginal and Torres Strait Islander peoples). The health specific and Aboriginal and Torres Strait Islander disadvantage commitments are being progressed in a consistent manner, and are mutually reinforcing. However, both processes could benefit from better coordination of activities, including through building on the achievements and structures that have been established in relation to health.

Fifth, the more established approach in the health sector has not played a significant role during the first twelve months of these new arrangements for the administration of service delivery at the federal level. There remains much potential to learn from the achievements and structures of the health sector, particularly through its engagement with Aboriginal and Torres Strait Islander communities and assessment of need on a regional basis. The health sector could be more actively engaged in progressing the new arrangements. This would also clearly benefit efforts to address health issues that are impacted on through the activities of other departments.

Finally, the current processes recognise the urgency of the need to address Aboriginal and Torres Strait Islander health inequality. There is acknowledgement that efforts to address this in the past, such as those undertaken in accordance with the NAHS from 1989 to 1994, were insufficient. There is now a more sophisticated basis for planning activities and monitoring progress than in the past. There is also no broader agenda for setting a timeframe within which to achieve equality in health status or to match funding contributions and activities to the achievement of this goal.

Accordingly, the key issue for Aboriginal and Torres Strait Islander health remains the need to implement the extensive commitments of governments and to ensure that the quantum and pace of activities is sufficient to achieve the goal of addressing Aboriginal and Torres Strait Islander health inequality.

4. The human rights based approach to health

Human rights provide a framework for addressing the consequences the health inequality experienced by Aboriginal and Torres Strait Islander peoples. This includes recognising its underlying causes as well as the inter-connections with other issues. Human rights require more than a rhetorical acknowledgement of the existence of inequality and general commitments to overcome this situation at some unspecified time in the future.

Ultimately, human rights standards provide a system to guide policy making and to influence the design, delivery and monitoring and evaluation of health programs and services. It is a system for ensuring the accountability of governments.

This section of the chapter outlines the human rights based approach to health. While issues relating to health and human rights have been of international concern since the establishment of the United Nations, 'the actual linkages between health and human rights had not been recognized even a decade ago.'[177] Since then:

> a "health and human rights" language (has developed)… which has allowed for the connections between health and human rights to be explicitly named, and therefore for conceptual, analytical, policy and programmatic work to begin to bridge these disparate disciplines and to move forward. In the last few years human rights have increasingly been at the centre of analysis and action in regard to health and development issues.[178]

There are three main issues at the international level which are drawn on in setting out a human rights based approach to health. These are the application to the right to health of *over-arching principles of non-discrimination and progressive realisation*; the emergence in international practice of the *connection between human rights standards and participatory development processes*; and the content of *the right to health itself*.

a) Non-discrimination and the progressive realisation principle

Article 2 of the International Covenant on Economic, Social and Cultural Rights states that:

> 1. Each State Party to the present Covenant undertakes to take steps… to the *maximum of its available resources*, with a view to *achieving progressively* the full realization of the rights recognized in the present Covenant by *all appropriate* means, including particularly the adoption of legislative measures. *(emphasis added)*.
>
> 2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The non-discrimination principle outlined above (in Article 2(2)) applies to all human rights. It establishes a baseline position that all people are entitled to be treated equally and to be given equal opportunities. The progressive realisation principle (as outlined in Article 2(1)) gives meaning to this principle where such

177 Gruskin, S. and Tarantola, D., *Health and human rights,* in Editors, Detels, R. and Beaglehole, R., The Oxford Textbook of Public Health, Oxford University Press, Oxford, 2001, p311.

178 *ibid.*

equality does not exist for a particular group defined by race, sex or range of other characteristics.

There are two key features to the obligation 'to take steps' in Article 2(1). First, it allows governments to introduce specific measures to addressing the lack of equality experienced by a particular group within society. This includes a group defined by race, such as Aboriginal and Torres Strait Islander peoples.

Each of the main human rights treaties contains a provision which encourages (and indeed requires)[179] governments to redress inequality in the enjoyment of economic, social, cultural or civil and political rights. These provisions are sometimes referred to as 'special measures' provisions.[180] They are a form of differential treatment that is considered non-discriminatory. This is because they are aimed at achieving substantive equality *or* equality 'in fact' *or* outcome.

The rationale for such measures is that 'historical patterns of racism entrench disadvantage and more than the prohibition of racial discrimination is required to overcome the resulting racial inequality'.[181] Special measures are time limited, in that they can only be justified for so long as there is a situation of inequality which they are aimed at redressing. They cannot, therefore, lead to the maintenance of separate rights for different racial groups and are not to be continued after the objectives for which they were taken have been achieved.[182]

Second, the obligation 'to take steps' in Article 2(1) also means that governments must progressively achieve the full realisation of relevant rights and to do so without delay. Steps must be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.[183]

The High Commissioner for Human Rights has described this principle and its relevance to policy-making as follows:

> Since the realization of most human rights is at least partly constrained by the availability of scarce resources, and since this constraint cannot be eliminated overnight, the international human rights law explicitly allows for progressive realization of rights… While the idea of progressive achievement is common to all approaches to policy-making, the distinctiveness of the human rights approach is that it imposes certain conditions on the behaviour of the State so that it cannot use progressive realization as an excuse for deferring or relaxing its efforts.
>
> First, the State must take immediate action to fulfill any rights that are not seriously dependent on resource availability. Second, it must prioritize its fiscal operations so that resources can be diverted from relatively non-essential uses to those that are essential for the fulfillment of rights that are important for poverty reduction. Third, to the extent that fulfillment of certain rights will have to be deferred, the State must develop, in a participatory manner, a time-bound plan of action for their progressive realization. The plan will include a set of intermediate as well as

179 For example, Article 2(2) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) requires governments to pay attention to the socio-economic situation of ethnic or minority groups 'in order to ensure that their development in the social, economic and cultural spheres takes place on an equal footing with that of the general population': Valencia Rodriguez, L., 'The International Convention on the Elimination of All Forms of Racial Discrimination' in United Nations Centre for Human Rights, *Manual on human rights reporting under six major international human rights instruments,* UNCHR Geneva/New York 1991, p131.

180 This is the term given to such remedial programs in Articles 1(4) and 2(2) of ICERD.

181 Race Discrimination Commissioner, *The CDEP scheme and racial discrimination,* HREOC, Sydney, 1997, p40.

182 Article 1(4), ICERD.

183 Committee on Economic, Social and Cultural Rights (CESCR), *General Comment 3: The nature of States parties obligations.* Contained in UN Doc: E/1991/23, 14/12/90 para 2.

> long-term targets, based on appropriate indicators, so that it is possible to monitor the success or failure of progressive realization. Finally, the State will be called to account if the monitoring process reveals less than full commitment on its part to realize the targets.[184]

Accordingly,

> The idea of progressive realization has two major strategic implications. First, it allows for a time dimension in the strategy for human rights fulfillment by recognizing that the full realization of human rights may have to occur in a progressive manner over a period of time. Second, it allows for setting priorities among different rights at any point in time since the constraint of resources may not permit a strategy to pursue all rights simultaneously with equal vigour.[185]

This approach requires that governments identify appropriate indicators, in relation to which they should set ambitious but achievable benchmarks, so that the rate of progress can be monitored and, if progress is slow, corrective action taken. Setting benchmarks enables government and other parties to reach agreement about what rate of progress would be adequate. Such benchmarks should be:

- Specific, time bound and verifiable;
- Set with the participation of the people whose rights are affected, to agree on what is an adequate rate of progress and to prevent the target from being set too low; and
- Reassessed independently at their target date, with accountability for performance.[186]

My predecessor as Social Justice Commissioner elaborated on this rights-based approach in the context of addressing Aboriginal and Torres Strait Islander disadvantage. In particular, he identified five integrated requirements that need to be met to incorporate a human rights approach into redressing Aboriginal and Torres Strait Islander disadvantage and to provide sufficient government accountability. Namely:

- Making an unqualified national commitment to redressing Indigenous disadvantage;
- Facilitating the collection of sufficient data to support decision-making and reporting, and developing appropriate mechanisms for the independent monitoring and evaluation of progress towards redressing Indigenous disadvantage;
- Adopting appropriate benchmarks to redress Indigenous disadvantage, negotiated with Indigenous peoples, state and territory governments and other service delivery agencies, with clear time-frames for achievement of both longer term and short-term goals;
- Providing national leadership to facilitate increased coordination between governments, reduced duplication and overlap between services; and

184 Hunt, P., Osmani, S. and Nowak, M., *Summary of the draft guidelines on a human rights approach to poverty reduction,* OHCHR, Geneva, 2004, paras 19-20.

185 High Commissioner for Human Rights, *Human rights and poverty reduction – a conceptual framework,* United Nations, Geneva 2004, p22.

186 United Nations Development Programme, *Human Development Report 2000,* as quoted in Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2002,* HREOC Sydney 2002, p101.

- Ensuring the full participation of Indigenous organisations and communities in the design and delivery of services.[187]

b) The human rights based approach to development

There have been a number of developments at the international level in recent years which have seen a clearer understanding emerge of the relationship between human rights and development and poverty eradication. Past Social Justice and Native Title Reports have highlighted this work[188] – such as the extensive focus on human rights by the United Nations Development Programme, including through its annual Human Development Reports; increased focus on the right to development; and also through the drafting of guidelines on human rights and poverty eradication by the High Commissioner for Human Rights and the United Nations Development Programme.

These have emerged largely as a result of the objective set in 1997 by the Secretary-General of the United Nations, Mr Kofi Annan, to mainstream human rights into all United Nations activities. This has been reaffirmed through the Millennium Declaration of 2000 and the commitment of all countries to achieve the *Millennium Development Goals*[189] (MDGs) by 2015.

The focus of the MDGs is very much centred on developing nations. The usual context in which the involvement of countries like Australia is discussed is in relation to international aid, technical assistance and debt relief. But the implications of this focus on poverty eradication clearly relate to the situation of Aboriginal and Torres Strait Islander peoples in Australia. 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.

One of the most significant outcomes of this focus on integrating human rights and development and poverty eradication activities has been the agreement among the agencies of the United Nations of the *Common Understanding of a Human-Rights Based Approach to Development Cooperation*.[190]

This document outlines the human rights principles that are common to the policy and practice of the UN bodies. The *Common Understanding* states that these principles are intended to guide programming in relation to health, among other issues.[191] This includes all development cooperation directed towards the achievement of the *Millennium Development Goals* and the Millennium Declaration.

187 *Social Justice Report 2002, ibid.*, p93.

188 See in particular: *Social Justice Report 2000; Social Justice Report 2002;* and *Native Title Report 2003*.

189 The goals are: eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development.

190 United Nations, *The Human Rights-Based Approach to Development Cooperation: Towards a Common Understanding Among the UN Agencies*, United Nations, New York 2003, available online at: www.unescobkk.org/fileadmin/user_upload/appeal/human_rights/UN_Common_understanding_RBA.pdf.

191 Such as education, governance, nutrition, water and sanitation, HIV/AIDS, employment and labour relations, and social and economic security.

The *Common Understanding* has three principles. Namely, that:

- all programmes, policies and technical assistance should further the realisation of human rights;
- human rights standards guide all development cooperation and all phases of programming; and
- development cooperation contributes to the development of the capacity of 'duty-bearers' to meet their obligations and of 'rights-holders' to claim their rights.[192]

The *Common Understanding* also identifies the following elements that are 'necessary, specific, and unique to a human rights-based approach' to development.[193]

Text Box 9: Elements of a human rights based approach to development

- Assessment and analysis identify the human rights claims of rights-holders and the corresponding human rights obligations of duty-bearers as well as the immediate, underlying, and structural causes of the non-realisation of rights.
- Programs assess the capacity of rights-holders to claim their rights and of duty-bearers to fulfill their obligations. They then develop strategies to build these capacities.
- Programs monitor and evaluate both outcomes and processes guided by human rights standards and principles.
- Programming is informed by the recommendations of international human rights bodies and mechanisms.

Other elements of good programming practices that are also essential under a human rights based approach include that:

(i) People are recognised as key actors in their own development, rather than passive recipients of commodities and services.
(ii) Participation is both a means and a goal.
(iii) Strategies are empowering, not disempowering.
(iv) Both outcomes and processes are monitored and evaluated.
(v) Analysis includes all stakeholders.
(vi) Programs focus on marginalised, disadvantaged, and excluded groups.
(vii) The development process is locally owned.
(viii) Programs aim to reduce disparity.
(ix) Both top-down and bottom-up approaches are used in synergy.
(x) Situation analysis is used to identity immediate, underlying, and basic causes of development problems.
(xi) Measurable goals and targets are important in programming.
(xii) Strategic partnerships are developed and sustained.
(xiii) Programs support accountability to all stakeholders.

These principles provide useful guidance for incorporating participatory development principles into domestic policies and programs relating to Aboriginal and Torres Strait Islander health.

192 United Nations, *op.cit.,* p2.
193 *ibid.,* p3.

c) The right to the enjoyment of the highest attainable standard of health

Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

A detailed overview of the content of this right is provided at **Appendix 4** of this report. The key elements of this right are set out in the following text box. It reflects the understanding of the progressive realisation principle and participatory development practice as set out above.

Text Box 10: Key elements of the right to health[194]

1. The right to health includes the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health. It is not to be understood as a right to be *healthy* (which is something that cannot be guaranteed solely by governments).

2. The right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

3. The right to health contains the following interrelated and essential elements:

(a) *Availability*. Functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity within the country.

(b) *Accessibility*. Health facilities, goods and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:

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

194 This textbox contains extracts from: United Nations Committee on Economic, Social and Cultural Rights, *General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), op.cit.*

(c) *Acceptability*. All health facilities, goods and services must be respectful of medical ethics as well as respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

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

4. Governments have immediate obligations in relation to the right to health. These include the guarantee that the right will be exercised without discrimination of any kind; and the obligation to take deliberate, concrete and targeted steps towards the full realisation of the right to health (known as the progressive realisation principle).

5. Governments are under the obligation to respect, protect and fulfil the right to health. This requires:

(a) *Respect*. Governments refrain from denying or limiting equal access for all persons to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy; and abstain from imposing discriminatory practices relating to women's health status and needs.

(b) *Protect*. Governments adopt legislation or take other measures to ensure equal access to health care and health-related services provided by third parties; ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.

(c) *Fulfil*. Governments give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realising the right to health. They ensure provision of health care and equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions.

Governments also take positive measures that enable and assist individuals and communities to enjoy the right to health, and undertake actions that create, maintain and restore the health of the population. Such obligations include:

- fostering recognition of factors favouring positive health results, e.g. research and provision of information;
- ensuring that health services are culturally appropriate and that health care staff are trained to recognise and respond to the specific needs of vulnerable or marginalised groups;
- ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; and
- supporting people in making informed choices about their health.

6. Governments have a **core obligation** to ensure the satisfaction of, at the very least, minimum essential levels of rights, including essential primary health care. This includes ensuring:

- access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- access to the minimum essential food which is nutritionally adequate and safe;
- access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; and
- equitable distribution of all health facilities, goods and services.

7. Governments are also required to:

- ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- provide immunisation against the major infectious diseases occurring in the community;
- take measures to prevent, treat and control epidemic and endemic diseases;
- provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; and
- provide appropriate training for health personnel, including education on health and human rights.

8. In determining whether an action or an omission amounts to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a government to comply with its obligations. A government which is unwilling to use the maximum of its available resources for the realisation of the right to health is in violation of its obligations. If resource constraints render it impossible for a government to comply fully with its obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations. A government cannot under any circumstances whatsoever justify its non-compliance with the core obligations set out above.

9. ICESCR clearly imposes a duty on each government to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

10. The formulation and implementation of national health strategies and plans of action should respect the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, program or strategy developed to discharge governmental obligations. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health.

11. Governments should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. National health strategies should identify appropriate right to health indicators and benchmarks. These should include provisions on:

- the targets to be achieved and the time-frame for their achievement;
- the means by which right to health benchmarks could be achieved;
- the intended collaboration with civil society, including health experts, the private sector and international organisations;
- institutional responsibility for the implementation of the national strategy and plan of action; and
- possible recourse procedures.

Specifically in relation to Indigenous peoples, it has also been noted that:

> Indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of Indigenous peoples should also be protected. The Committee notes that, in Indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension…[195]

d) Summary

Overall, the human rights based approach to health has the following components. It:

- emphasises the accountability of governments for socio-economic outcomes among different sectors of civil society by treating these outcomes as a matter of legal obligation, to be assessed against the norms established through the human rights system;
- establishes fundamental principles to guide policy development – such as that Indigenous peoples are not discriminated against and are provided with *equality of opportunity*, including through recognising their distinct cultural status;
- highlights that governments have immediate responsibilities to guarantee that the right to health will be exercised without discrimination of any kind, and to take deliberate, concrete and targeted steps towards the full realisation of the right to health;
- recognises as legitimate, and as non-discriminatory, the establishment of specific programs for particular groups (such as based on race) which are taken with the purpose of addressing inequality;
- establishes that the obligation of government is to respect, protect and fulfil the right to health, which requires a combination of responses ranging from refraining from committing harmful acts, introducing measures to prevent others from committing such acts, and taking positive steps to realise the right to health;
- emphasises *process* for achieving improvements in these outcomes, with the free, active and meaningful participation of Indigenous peoples being critical;
- establishes criteria against which to assess health policy and program interventions to ensure that services are appropriate, accessible, available and of sufficient quality, and that they also do not fall below a core minimum or essential level of rights;
- requires governments, working in partnership with Indigenous peoples, to demonstrate that they are approaching these issues in a targeted manner, and are accountable for the achievement of defined goals within a defined timeframe; and

195 *ibid.,* para 27.

- places the burden on government of justifying that it has made every effort to use all available resources at its disposal in order to satisfy, as a matter of priority, the right to health.

While the right to health has been recognised for some time, it is only in recent years that detailed consideration has been given to it. This framework therefore offers a relatively new perspective on the factors necessary to address health inequalities and ensure to all people the right to the enjoyment of the highest attainable standard of health.

It is timely to consider the existing health frameworks for Aboriginal and Torres Strait Islander people within Australia against this perspective. This is particularly so given the slow pace of progress that has been made in recent decades in reducing Aboriginal and Torres Strait Islander health inequality and the opportunities that currently exist to address these issues in a coordinated, whole of government manner.

5. Aboriginal and Torres Strait Islander health inequality and human rights

This section notes the strengths and deficiencies of the current framework for Aboriginal and Torres Strait Islander health from a human rights perspective. The following section then proposes how the existing health framework should be enhanced in order to achieve the goal of Aboriginal and Torres Strait Islander health equality within a generation.

There are two aspects of the current health situation faced by Aboriginal and Torres Strait Islander peoples in terms of human rights compliance.

a) The human rights implications of the current health status of Aboriginal and Torres Strait Islander peoples

The first is that the extent of health inequality experienced by Aboriginal and Torres Strait Islander peoples raises issues of compliance with Australia's human rights obligations.

Both the *International Covenant on Economic, Social and Cultural Rights* (Article 12) and the *International Convention on the Rights of the Child* (Article 24) recognise the right of all people to the enjoyment of the highest attainable standard of health. By entering into these treaties, the Government has guaranteed the exercise of this right without discrimination.

The extent of inequality experienced by Aboriginal and Torres Strait Islander peoples indicates that they do not enjoy this and related rights in a non-discriminatory manner. The size of the inequality gap indicates the need for urgent attention to this issue. This has been acknowledged by successive governments in Australia.[196]

In September 2005, the United Nations Committee on the Rights of the Child expressed concern at the level of inequality experienced by Aboriginal and Torres Strait Islander children, particularly in relation to health related issues. The Committee's comments included the following:

> 47… (T)he Committee remains concerned at Indigenous children malnutrition and under-nutrition compared with over-nutrition, overweight and obesity at national level. Furthermore, the Committee, despite recent studies suggesting that Indigenous infant mortality has declined in the past years, remains concerned at the disparity in the health status between Indigenous and non-Indigenous children and at unequal access to health care experienced by children living in rural and remote areas.
>
> 48. The Committee recommends that the State Party undertake all necessary measures to ensure that all children enjoy the same access to and quality of health services, with special attention to children belonging to vulnerable groups, especially Indigenous children and children living in remote areas. In addition, the Committee recommends that the State party take all adequate measures to overcome, in a time-bound manner, the disparity in the nutritional status between Indigenous and non-Indigenous children.

196 See, for example, the 2nd and 3rd periodic report of Australia to the Committee on the Rights of the Child (submitted 29 December 2004, UN Doc: CRC/C/129/Add.4, p5) and the 14th periodic report of Australia to the Committee on the Elimination of Racial Discrimination (submitted 1 April 2004, UN Doc: CERD/C/428/Add.2, paras 80-81).

> 51. The Committee… remains concerned that youth suicide rate is still high, especially among Indigenous children… and that mental health problems and substance abuse are increasing.
>
> 53. The Committee… is concerned at recent reports showing that the number of Indigenous (peoples) diagnosed with AIDS has more than doubled in the past four years.
>
> 54. The Committee recommends that the State party continue to closely look into the issue of HIV/AIDS, and in particular:
>
> > c) urgently address the marked increase of AIDS diagnosis among Indigenous peoples, including through culturally sensitive safe sex campaigns tailored for Indigenous communities
>
> 75. Despite the numerous measures taken by the State party's authorities, including the Indigenous Child Care Support Programme, the Committee remains concerned about the overall situation of Indigenous Australians, especially as to their health, education, housing, employment and standard of living.
>
> 77. The Committee recommends that the State party strengthen its efforts to continue developing and implementing – in consultation with the Indigenous communities – policies and programmes ensuring equal access for Indigenous children to culturally appropriate services, including social and health services and education.[197]

In March 2005, the United Nations Committee on the Elimination of Racial Discrimination also identified that the extent of inequality in health status of Aboriginal and Torres Strait Islander peoples raises issues of compliance with Article 5 of the *International Convention on the Elimination of All Forms of Racial Discrimination*. The Committee stated:

> While noting the improvement in the enjoyment, by the Indigenous peoples, of their economic, social and cultural rights, the Committee is concerned over the wide gap that still exists between the Indigenous peoples and others, in particular in the area of employment, housing, health, education and income. (Article 5)
>
> The Committee recommends that the State party intensify its efforts in order to achieve equality in the enjoyment of rights and allocate adequate resources to programmes aimed at the eradication of disparities. It recommends in particular that decisive steps be taken in order to ensure that a sufficient number of health professionals provide services to Indigenous peoples, and that the State party set up benchmarks for monitoring progress in key areas of Indigenous disadvantage.[198]

b) Is the current framework for addressing Aboriginal and Torres Strait Islander health inequality consistent with the human rights based approach?

The second issue to consider in terms of human rights compliance receives less attention – namely, whether the current processes in place to address Aboriginal and Torres Strait Islander health inequality comply with the key elements of the human rights based approach to health.

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197 United Nations Committee on the Rights of the Child, *Concluding Observations – Australia,* unedited version, UN Doc: CRC/C/15/Add.268. The Committee also expressed concern at the discriminatory disparities existing towards Aboriginal and Torres Strait Islander children, especially in terms of provisions of and accessibility to basic services (para 24); and the inadequate standard of living and housing of Indigenous children and children living in rural and remote areas (paras 55, 57).

198 United Nations Committee on the Elimination of Racial Discrimination, *Concluding observations of the Committee on Australia,* UN Doc:CERD/C/AUS/CO/14, para 17.

The human rights based approach to health is practical in that it acknowledges that inequality and discrimination may be the result of long term, perhaps even historical, treatment and cannot be overcome in the short term. While a rights based approach does not excuse such inequality, it is primarily focused on considering the steps that are currently being taken by governments to address this situation.

Accordingly, it is focused on determining the *suitability* of the steps being taken. For example, do the steps taken by government respect, protect and fulfil the right to the highest attainable standard of health for Aboriginal and Torres Strait Islander peoples? Are programs and services accessible, available, appropriate and of a sufficient quality? Do they involve the full participation of Aboriginal and Torres Strait Islander peoples? Do they target the systemic barriers faced by Aboriginal and Torres Strait Islander peoples?

It is also focused on determining the *adequacy* of the steps being taken. For example, are they meeting core minimum obligations? Are they resulting in a progressive improvement in the realisation of the right to health for Aboriginal and Torres Strait Islander peoples? Is the rate of progress sufficient, given the extent of the inequality? Do data collection, performance monitoring and evaluation processes exist which enable progress to be monitored? Are programs targeted, delivered and financed at a level that is capable of addressing the level of inequality?

From this perspective, there are a number of aspects of the current approach to Aboriginal and Torres Strait Islander health that *do* meet the requirements of the human rights based approach to health. But there are also aspects of the current approach that *do not* meet these requirements. The strengths and weaknesses of the current framework are identified in the two boxes below.

Text Box 11: Positive aspects of the existing approach to Aboriginal and Torres Strait Islander health from a human rights perspective

The following aspects of the existing framework for Aboriginal and Torres Strait Islander health are consistent with the requirements of the human rights based approach to health.

1. **Commitments to address Aboriginal and Torres Strait Islander health inequality**
   - The existence of significant disparities in the health status of Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is acknowledged by all governments and recognised as unacceptable.
   - All governments have committed, through the *National Strategic Framework*, to the goal of achieving health equality for Aboriginal and Torres Strait Islander peoples. This includes through committing to provide equality in access to primary health care and health infrastructure issues.
   - All governments have accepted the holistic definition of Aboriginal and Torres Strait Islander health, as set out in the *National Aboriginal Health Strategy*. This recognises that 'health to Aboriginal peoples is a matter of determining all

aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice'.[199]

- All governments recognise the importance of addressing a wide variety of related issues outside of the health sector which have an impact on Aboriginal and Torres Strait Islander people's well-being (and have identified influencing the health impacts of the non-health sector as a key result area for the *National Strategic Framework*).

2. National leadership

- The *National Strategic Framework* has been adopted, providing a national health policy with a detailed plan for realising the right to health. This is consistent with the obligation to fulfil the right to health.
- Related commitments have also been made by COAG to address Aboriginal and Torres Strait Islander disadvantage and to work cooperatively and in a whole of government manner. All governments have agreed to the *National Framework of Principles for Government Service Delivery* to guide these commitments.
- The 'whole of government' machinery necessary to implement the *National Strategic Framework* is in place. This includes through the finalisation of bilateral health agreements between the Commonwealth and states and territories; the establishment of state level health forums; the development of regional plans which identify needs and priorities; and the establishment of a national performance monitoring framework.
- There is recognition among governments that addressing Aboriginal and Torres Strait Islander health inequality is a shared responsibility between governments and requires partnerships with Aboriginal and Torres Strait Islander peoples and communities.

3. Performance indicators and monitoring and evaluation processes

- Ensuring that there is adequate data collection, research and evidence is identified as a key challenge to support the commitments of governments. Various strategies and processes have been put in place to address this, albeit with uneven rates of progress.[200]
- The *Aboriginal and Torres Strait Islander Health Performance Framework* has been finalised at the inter-governmental level, in accordance with the *National Strategic Framework*. It provides a solid basis for monitoring the performance of governments, while also taking into account variations across jurisdictions in capacity, mortality, morbidity and other issues.

199 National Aboriginal Health Strategy Working Party, *op.cit.*, as cited in National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Context, op.cit.*, p4.

200 The Aboriginal and Torres Strait Islander Research Agenda Working Group (RAWG) is a sub-committee under the National Health and Medical Research Council. In April 2002, the RAWG endorsed a draft strategic framework for Indigenous health research, known as the Road Map. The Road Map is intended to guide Indigenous health research taking place through the National Health and Medical Research Council and nationally. This is the first time such a framework has existed. The Road Map identifies major themes and approaches for Aboriginal and Torres Strait Islander research. Commonwealth Department of Health and Ageing, 2001-02 *Annual Report – Outcome Reports,* http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubs-annrepar2002-part2-02_7203.htm, 24 September 2004, (Accessed May 5, 2005). In December 2002, the Cooperative Research Centre for Aboriginal Health was established, linking 19 universities and research institutions to further trans-disciplinary research into Aboriginal and Torres Strait Islander health. It has a budget of $145 million over 7 years, Latrobe University, *La Trobe wins Aboriginal Research Funds,* Media release, 19 December 2002, available online at http://www.latrobe.edu.au/news/2002/mediarelease_124.html. See also the Cooperative Research Centre for Aboriginal Health website http://www.crcah.org.au/index.cfm?attributes.fuseaction=aboutus.

- A comprehensive monitoring framework has been agreed at the inter-governmental level, which involves bilateral agreements between the Commonwealth and the states and territories, implementation plans and health planning forums.
- Each government has finalised its individual implementation plan for the *National Strategic Framework*.
- Progress in addressing Aboriginal and Torres Strait Islander health inequality is also able to be measured on a whole of government basis against the *Overcoming Indigenous Disadvantage Framework*. This framework includes headline indicators and strategic change indicators that are included within the Aboriginal and Torres Strait Islander Health Performance Framework. It also presents this data in a holistic manner, alongside other 'non-health sector' outcomes so that the inter-connections between these can be better understood.

4. Participation of, and partnerships with, Aboriginal and Torres Strait Islander peoples

- The *National Strategic Framework* commits to the use of Aboriginal Community Controlled Health Organisations as the primary vehicle for delivery of primary health care programs and also to facilitating local participation of Aboriginal and Torres Strait Islander peoples.
- The participation of Aboriginal and Torres Strait Islander peoples in the design of Aboriginal and Torres Strait Islander health programs is provided through the state-wide Aboriginal Health Forums and in the development of regional plans.
- This is consistent with the requirement to ensure the participation of Aboriginal and Torres Strait Islander peoples in decision-making processes which may affect their development, as well as the requirement that health promotion must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health.

5. Accessibility of health services

- The *National Strategic Framework* identifies as a key result area achieving a health system that is more effective and responsive to Aboriginal and Torres Strait Islander needs. It is recognised that this requires a focus on Indigenous specific services (such as community controlled health care services) as well as improvements to the mainstream health system. This provides a focus on the human rights requirements for services to be available, accessible, acceptable and of a sufficient quality (even though there remain some concerns that these requirements are not being fully met at present).
- While there is still significant progress required, there is evidence of 'increasing capacity in the primary health care system and greater engagement by the mainstream health system'.[201] There is evidence of the effectiveness of primary health care which warrants the further investment required[202] and evidence of the success of trials to improve access to mainstream programs and funding, such as through the coordinated care trials in providing improved access to Medicare and Pharmaceutical Benefits Scheme funding.

201 Dwyer, J., Silburn, K., and Wilson, G., *National Strategies for Improving Indigenous Health and Health Care,* Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 1, Commonwealth of Australia, Canberra, 2004, pxi.

202 *ibid.*

Text Box 12: Areas for improvement in the existing approach to Aboriginal and Torres Strait Islander health from a human rights perspective

Despite these positives, there remain a number of concerns about the adequacy of the current framework for addressing Aboriginal and Torres Strait Islander health inequality. Many of these concerns relate to the need for the key features of the current framework, some of which are acknowledged as positive developments above, to be extended so that they are more comprehensive and better linked to overcoming existing levels of inequality.

1. Lack of equal access to primary health care and health infrastructure

- Aboriginal and Torres Strait Islander peoples today still do not have the equal opportunity to be as healthy as non-Indigenous Australians. This is due to a continued lack of equal access to primary health care and health infrastructure, and the continued inaccessibility of mainstream programs.[203] This raises concerns about the availability, accessibility, acceptability and quality of health services for Aboriginal and Torres Strait Islander peoples.
- In 2004, it was estimated that Aboriginal and Torres Strait Islander peoples enjoyed 40% of the per capita access of the non-Indigenous population to primary health care provided by general practitioners.[204]
- In terms of *availability:* Health services are not available as widely for Aboriginal and Torres Strait Islander peoples as non-Indigenous peoples, particularly in rural and remote areas. In 2002, there were twice as many medical practitioners per person in major cities than in remote areas and ten times the number of specialists[205]
- In terms of *accessibility:* The *Community Infrastructure and Housing Needs Survey* 2001 (CHINS) reported that 174 communities representing 3,255 people lived over 100 kilometres from both a community health centre and a hospital while over 151 communities representing 2,453 people lived over 100 kilometres from the nearest first aid clinic.[206] This is compounded by a lack of access to transport: the 2002 National Aboriginal and Torres Strait Islander Social Survey reported that 23% of households with Aboriginal and Torres Strait Islander persons did not have access to a motor vehicle (compared to 10% in the non-Indigenous population).[207]
- In terms of *acceptability:* Aboriginal and Torres Strait Islander peoples do not tend to use mainstream primary health care even where it is otherwise available and physically accessible, for example in urban areas.[208] Governments have accepted the importance of maintaining distinct health services in urban centres for Aboriginal and Torres Strait Islander people as a consequence of this.
- The lack of equal access to primary health care and health infrastructure may also raise issues as to whether governments are meeting their *core minimum*

203 *ibid.* See also Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Aboriginal and Torres Strait Islander People 2005, op.cit.,* p179.

204 Britt, H., Miller, G. and Knox, S., *(et al), General practice activity in Australia: 2001-02,* AIHW cat. no. GEP 10, Commonwealth of Australia, Canberra, 2002, p114, available online at: http://www.aihw.gov.au/publications/index.cfm/title/8149.

205 *ibid.,* p181.

206 *ibid.,* p182.

207 *ibid.,* p183.

208 Commonwealth Grants Commission, *Report on Indigenous Funding,* CGC, Canberra, 2001, pp116 and 135.

obligations in some remote communities. This is particularly in relation to access to the minimum essential food which is nutritionally adequate and safe; and access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water.

2. Matching commitments to address Aboriginal and Torres Strait Islander health inequality to the progressive realisation principle

- Existing commitments to address Aboriginal and Torres Strait Islander health inequality do not acknowledge that:
  - While there has been progress on some individual indicators of health status for Aboriginal and Torres Strait Islander peoples, this has not been sufficient to close the inequality gap.
  - The burgeoning size and young age structure of the Aboriginal and Torres Strait Islander population creates additional urgency for redressing the existing level of health inequality. This is on the basis that the current lack of equal access to health care and infrastructure has the potential to compound the poorer health outcomes experienced by Aboriginal and Torres Strait Islander peoples during the timeframe of the *National Strategic Framework*.
- These factors, and the lack of equal access referred to above, require more than an acknowledgement of the existence of inequality. It requires:
  - an acknowledgement of the urgency to address this health inequality and of its ongoing and compounding effects;
  - that commitments extend to supporting the adoption of 'special measures' programs at a quantum that can address ongoing systemic barriers, as well as redress historical exclusion and lack of equality; and
  - for this to occur on a holistic basis, recognising the inter-connections between issues.

3. Performance indicators, targets and benchmarks

- As noted, the *National Strategic Framework* provides a national health policy with a detailed plan for realising the right to health. However, it does not:
  - include the necessary targets at a jurisdictional level which indicate when *equality of opportunity* is intended to be achieved, with intermediate and short term targets to assess progress; and
  - ensure that the resources available are realistically capable of meeting these targets and ultimately of achieving the goal and aims of the *National Strategic Framework*.
- As an example, the most recent review of the primary health care scheme notes that current access to and investment in Aboriginal and Torres Strait Islander primary health care is too low to address existing need.[209] Accordingly, existing resources are not enough to meet the goal and aims of the *National Strategic Framework*.
- The current framework provides a suitable basis for the creation of time bound benchmarks and the matching of resources to these. This is evidenced in the indicators developed through the *Aboriginal and Torres Strait Islander Health Performance Framework;* the Aboriginal Health Forums; regional planning processes and role of Aboriginal Community Controlled Health Organisations.
- The *Overcoming Indigenous Disadvantage Framework* also provides an appropriate basis for measuring progress in a holistic manner, once benchmarks and targets have been agreed.

209 Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* ppxiii-xiv.

4. Needs based funding

- The Aboriginal and Torres Strait Islander health system continues to be under-funded. Recent reports have suggested that an additional $300-400 million per annum is required to address the shortfall for primary health care needs alone.[210]
- While there have been some positive developments in identifying models for needs based planning and resource allocation, this requires further work. There remains a need for great scientific rigour in these processes.
- While this funding shortfall continues, it is acknowledged that governments have steadily increased the level of funding available in the health sector over the past decade, particularly since 1995.[211] There have also been corresponding increases in the health workforce and the capacity of the primary health care system.[212]
- In relative terms, there has been little change in funding levels for Aboriginal and Torres Strait Islander health *when compared* to non-Indigenous health funding in recent years. This is despite the continuation of a significant inequality gap between the two groups. As the most recent report on health expenditure by the Australian Institute of Health and Welfare found:

  > the relative position of Indigenous Australians compared with non-Indigenous people has changed little since… 1998-99. This finding relates to both their shares of national health spending and the structure of health expenditures. Indeed, there have been only small changes since the first report for 1995-96. However, health expenditure for both Indigenous and non-Indigenous people has risen substantially.[213]

5. Participation of, and partnerships with, Aboriginal and Torres Strait Islander peoples

- The replacement on the Aboriginal Health Forums of ATSIC representation (following its abolition) with State Managers of the Office of Indigenous Policy Coordination is not appropriate to ensure regional or informed representation of Aboriginal and Torres Strait Islander peoples in decision making and planning processes.
- The new arrangements for the administration of Indigenous affairs have not engaged sufficiently with the health sector in settling regional priorities and engaging with Aboriginal and Torres Strait Islander communities.

6. A focus on urgent issues

- While the *National Strategic Framework* is supported by a number of additional policies on specific issues, there remains inadequate attention to serious issues such as maternal and child health; substance abuse; dental health and mental health (although a draft social and emotional well-being framework is currently being considered for adoption at the inter-governmental level, which would see the commitment to a 5 year framework for action on mental health and social and emotional well-being).

210 The level of under-resourcing and recent estimates is discussed further below.

211 For details of this see: Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* pp19-20, Figure 2.

212 *ibid.*

213 Australian Institute of Health and Welfare, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001-02,* AIHW, Canberra, 2005, pi. Further, the report estimated in 2001–02 that $1.18 was spent per capita on health goods and services for Aboriginal and Torres Strait Islander peoples for every dollar spent on non-Indigenous people. This was less than the ratio of Indigenous to non-Indigenous spending reported in the previous study into health expenditure for Indigenous Australians. This decline in the relativity between spending on health for Indigenous Australians and non-Indigenous people occurred despite the continued poorer health status of Indigenous Australians and recognition by all levels of government of the need to address this imbalance.

- For example, Aboriginal and Torres Strait Islander peoples enjoy less access to dental services. Many dental services involve direct out-of-pocket payments by patients. To the degree this makes those services economically inaccessible, this is likely to have a greater impact on Aboriginal and Torres Strait Islander people than on other Australians.[214]
- Aboriginal and Torres Strait Islander communities also experience disproportionate and high rates of illnesses such as trachoma, rheumatic heart disease and otitis media. Disease-focused strategies will be necessary to address these in addition to attention being provided to health infrastructure and primary health care issues.[215]
- The antecedents to chronic disease in adulthood require a focus on maternal and child health to prevent low birth weights, improve childhood nutrition, reduce early onset ear infections, and enhance immunisation coverage. The much higher rates of these problems affecting Aboriginal children impact directly on higher rates of chronic diseases such as kidney failure, diabetes and heart disease in adulthood. Maternal and child health should be an urgent priority.

214 Australian Bureau of Statistics and Australian Instititute of Health and Welfare, *The Health and Welfare of Aboriginal and Torres Strait Islander People 2005*, *op.cit.*, pp130, 184.

215 Taylor, H., *op.cit.*

6. A campaign for Aboriginal and Torres Strait Islander health equality within a generation

What this chapter shows is that significant opportunities currently exist to make lasting inroads into the longstanding problem of health inequality for Aboriginal and Torres Strait Islander peoples.

There is significant capacity in the health sector which can be built on. The new arrangements for Indigenous affairs at the federal level and associated commitments of COAG also provide perhaps unprecedented leverage for coordinating health programs with other departments and agencies.

We need to acknowledge these foundations and encourage them to achieve better compliance with the human rights based approach. If we do not do this, we are unlikely to see improvements in Aboriginal and Torres Strait Islander health status. In fact, it is possible that by not providing sufficient attention and resources the inequality gap currently experienced by Aboriginal and Torres Strait Islander peoples could widen further.

Perhaps the factor that is most striking, in its absence from the current framework, is the lack of a timeframe for achieving Aboriginal and Torres Strait Islander health equality. The human rights treaty committees quoted above express their concerns about Australia's progress in addressing Aboriginal and Torres Strait Islander health inequality. Their concern lies in terms of the need for governments to take adequate measures (including through the allocation of adequate resources) to overcome, in a time-bound manner, the disparity in rights experienced by Aboriginal and Torres Strait Islander peoples.

We should not be timid about setting a timeframe for when the solid commitments of government will be realised. The absence of such timeframes promotes a lack of accountability of governments. It sends a tacit message that it is fine for things to simply drift along.

But it is not fine. We are facing an urgent and emerging health crisis and all aspects of government activity should reflect this. This includes:

- stating that high priority is attached to addressing Aboriginal and Torres Strait Islander health inequality;
- sending a message to the general community that additional steps are necessary to address this;
- contributing the necessary resources to actually achieve this; and
- setting targets and benchmarks which enable the community to determine whether government progress is sufficient.

The failure of the policies and programs of the past twenty years to achieve significant improvements in Aboriginal and Torres Strait Islander health status, yet alone to reduce the inequality gap, reveal two things that Aboriginal and Torres Strait Islander peoples and the general community can no longer accept from governments.

First, we can no longer accept the making of commitments to address Aboriginal and Torres Strait Islander health inequality *without* putting into place processes and programs to match the stated commitments. Programs and service delivery must be adequately resourced and supported so that they are capable of achieving the stated goals of governments.

Second, and conversely, we can also not accept the failure of governments to commit to an urgent plan of action. It is not acceptable to continually state that the situation is tragic and ought to be treated with urgency, and then fail to put into place bold targets to focus policy making over the short, medium and longer term or to fund programs so they are capable of meeting these targets. *A plan that is not adequately funded to meet its outcomes cannot be considered an effective plan*. The history of approaches to Aboriginal and Torres Strait Islander health reflects this: Australian governments have proved unwilling to fund Aboriginal and Torres Strait Islander health programs based on the need and, as a result, plans have failed.[216]

The following description of Australia's human rights obligations to fulfil the right to health identifies the key issue that we presently face:

> In determining whether an action or an omission amounts to a violation of the right to health, *it is important to distinguish the inability from the unwillingness of a government to comply with its obligations. A government which is unwilling to use the maximum of its available resources for the realisation of the right to health is in violation of its obligations.* If resource constraints render it impossible for a government to comply fully with its obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations.[217]

The commitments exist. The processes for implementing them also exist. But can it be said that government efforts are operating at the maximum of available resources?

A budget surplus of $13.6 billion as at 30 June 2005 at the federal level suggests that resource availability is not the issue. It is not credible to suggest that government efforts are being held back by an 'inability' to take action.

Such action does, of course, need to be linked to the capacity of the health sector. The progressive realisation principle, however, requires that this be done *in a time bound manner* and as expeditiously as possible. Resourcing should be increased to the maximum extent possible and rolled out in accordance with regional plans and benchmarks.

The combination of the healthy economic situation of the country, the substantial potential that currently exists in the health sector and the national leadership being shown through the COAG process, means that the current policy environment is ripe for achieving the longstanding goal of overcoming Aboriginal and Torres Strait Islander health inequality. Steps taken now could be determinative.

As set out in the introductory sections of this chapter, I consider that we need to commit to a campaign for Aboriginal and Torres Strait Islander health equality within a generation. This final section of this chapter sets out some of the necessary elements that I consider need to be addressed for this to be achieved. It also sets out how my Office will seek to broaden public debate on this issue over the coming year.

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216 See for example, Commonwealth Grants Commission, *Report on Indigenous Funding 2001,* CGC Canberra 2001.

217 United Nations Committee on Economic, Social and Cultural Rights, *General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), op.cit.,* para 47. Emphasis added.

This goal can be met. And it can be done by building on the existing *National Strategic Framework*, through the commitments and processes of COAG and in accordance with the new arrangements for Indigenous affairs at the federal level.

a) The goal – Achieving Aboriginal and Torres Strait Islander health equality within a generation

At the beginning of this chapter I set out my first recommendation for addressing Aboriginal and Torres Strait Islander health inequality.

Recommendation 1

That the governments of Australia commit to achieving equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years.

This recommendation seeks to place a time dimension on the goal and aims of the *National Strategic Framework* for *Aboriginal and Torres Strait Islander Health* as well as on the commitments of the Council of Australian Governments (COAG) to overcome Aboriginal and Torres Strait Islander disadvantage. It provides a long term vision to focus government activity.

I note the following factors relating to this commitment.

i) This commitment should not stand in isolation

A focus **solely** on such a goal would be impractical and difficult. This point has been acknowledged through the Aboriginal and Torres Strait Islander Health Performance Framework and the development of COAG's Overcoming Indigenous Disadvantage Framework.

The *Overcoming Indigenous Disadvantage Framework* recognises that changes in indicators such as life expectancy cannot be expected within short timeframes or as a consequence of a single policy intervention. Accordingly, the Framework also identifies seven strategic areas for action and strategic change indicators, which are designed to show progress over the shorter term. They also allow us to identify progress on individual areas which have a cumulative impact on the larger and longer term indicators like life expectancy.[218] The *Aboriginal and Torres Strait Islander Health Performance Framework* also seeks to trace the links from strategic action through to headline indicators.

A commitment to achieve equality in life expectancy within a generation is not meaningless or problematic. It does, however, require that such a target be supported with the establishment of other, more detailed targets and benchmarks on a number of discrete, smaller indicators relating to health status and which exist over the short and medium term. *The Overcoming Indigenous Disadvantage Framework*, as well as the *Aboriginal and Torres Strait Islander Health Performance Framework* provide an appropriate basis for establishing time bound targets and benchmarks in the short and medium term across a variety of

218 Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2005, op.cit.*, ppxxii-xxiii.

contributing areas that should ultimately contribute to the achievement of equal rates of life expectancy.

Such targets and benchmarks also need to be developed at a regional level and with recognition of the variations in health status between communities. Additional work is required to ensure that data collection methods can support such disaggregation and account for regional variations.

Prior to 2000, the *Aboriginal and Torres Strait Islander National Performance Indicators* were linked to health targets. A selection of these are set out in Table 1 below. They indicate the type of targets that could be aimed for, with appropriate commitments of resources and effort to match.

Table 1: National Performance Indicators and Targets to monitor governments' efforts to improve Aboriginal and Torres Strait Islander health, 1998-2000

Life expectancy and mortality targets (various)	A 20% reduction in age standardised all mortality rate ratios over ten years[219]
Stillbirths	A 50% reduction within 10 years[220]
Infant mortality ratio	A 50% reduction within 10 years[221]
Mortality from CVD and rheumatic heart disease	A 50% reduction in 10 years[222]
Morality from injury or poisoning	A 50% reduction in 10 years[223]
Mortality from pneumonia	A 50% reduction in 10 years[224]
Mortality from diabetes	A 20% reduction in 10 years[225]
Mortality from cervical cancer	A 50% reduction in 10 years[226]
Women at risk from cervical cancer	Equivalent to the level in the non-Indigenous community within 3 years[227]

In addition, broader commitments at the level of the Council of Australian Governments (COAG) to address Indigenous disadvantage can also be considered an address to Aboriginal and Torres Strait Islander health to the degree they address the social determinants of health.

ii) There must also be a commitment to provide equality of opportunity for Aboriginal and Torres Strait Islander peoples

In terms of medium term targets to support a commitment to achieve equality within 25 years, there are two clear areas of need which must be addressed to render such a commitment realistic. These are commitments to ensure equal

219 Australian Health Ministers Advisory Council, *National Performance Indicators and Targets for 1998-2000 to monitor governments' efforts to improve Aboriginal and Torres Strait Islander health,* Department of Health and Ageing, Canberra, 1998, pp.4-9.

220 *ibid.,* p10.

221 *ibid.,* p11.

222 *ibid.,* p12.

223 *ibid.,* p13.

224 *ibid.,* p14.

225 *ibid.,* p15.

226 *ibid.,* p16.

227 *ibid.,* p38.

access to primary health care services for Aboriginal and Torres Strait Islander peoples, and equal access to health infrastructure.

It is a simple fact that Aboriginal and Torres Strait Islander peoples still do not enjoy the same opportunities to be healthy as non-Indigenous Australians, due to the lack of equal access to primary health care and infrastructure provision.

If we compare the health situation of Aboriginal and Torres Strait Islander peoples with other Australians, there is some evidence to suggest that Aboriginal and Torres Strait Islander peoples today enjoy a similar state of health as non-Indigenous Australians did almost a century ago. For example, life expectation for Aboriginal and Torres Strait Islander males in 1999-2000 was estimated to be the same as the total male population in 1901-1910, while for Aboriginal and Torres Strait Islander females it is similar to the total female population in 1920-22;[228] Adelaide was recorded as having an infant mortality rate of 140 deaths per 1,000 live births at the end of the nineteenth century,[229] similar to Aboriginal and Torres Strait Islander peoples in the 1960s and 1970s; trachoma was common in the capital cities of the late nineteenth century, as it is in some Aboriginal and Torres Strait Islander communities today.[230]

What happened over the twentieth century is that the non-Indigenous population gained *opportunities to be healthy* that were not extended to Aboriginal and Torres Strait Islander peoples. As a result, life expectancy for Australian women increased 26.7 years over the past century; while for males it increased 28.7 years.[231] This overall gain can be linked to a raft of smaller gains in specific areas. For example: as noted previously, death rates from cardiovascular disease have fallen 30% since 1991, and 70% in the last 35-years,[232] and; the infant mortality rate figure reduced 25% over 1993-2003 and 48% over 1983-2003.[233]

A commitment to achieve equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years therefore requires commitments to address inequality of opportunity for Aboriginal and Torres Strait Islander peoples. Accordingly, governments should also commit to achieving equal access to primary health care and health infrastructure within 10 years for Aboriginal and Torres Strait Islander peoples.

This will require improving processes to ensure needs based assessment of resource allocations, as well as targets and benchmarks across a range of matters. The *Aboriginal and Torres Strait Islander Health Performance Framework* contains appropriate measures for access to primary health care. These include proxy indicators such as access to Medicare and the Pharmaceutical Benefits Scheme, rates of hospitalisation from preventable diseases, rates of Sexually Transmitted Infections and so on.

228 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2001,* ABS cat. no. 4704.0, Commonwealth of Australia, Canberra, 2001, p121.

229 Baum F, *The New Public Health,* (2nd ed.), Oxford University Press, Melbourne, 2002, p21.

230 Taylor, H., *op.cit.*

231 Baum, F., *op.cit.,* p198.

232 National Health and Medical Research Centre (NHMRC), *Promoting the health of Australians, Case studies of achievements in improving the health of the population,* AGPS, Canberra, 1997, p35.

233 Australian Bureau of Statistics, *Deaths 2003,* ABS cat. no. 3302.0, Canberra, Commonwealth of Australia, 2004, p15.

iii) High quality, integrated primary health care should be prioritised

It is generally accepted that:

> Ready access to local primary health care (PHC) is … the foundation of a functioning health system. Primary health care provides an immediate response to acute illness and injury; it protects good health through screening, early intervention, population health programs (such as antenatal care and immunisation) and programs to promote social and emotional well-being and prevent substance abuse.
>
> Critically for the Indigenous population, primary health care identifies and treats chronic diseases (including diabetes, cardiovascular and renal disease) and their risk factors. Primary health care also acts as a pathway to specialist and tertiary care, and enables local (or regional) identification and response to health hazards; transfer of knowledge and skills for healthy living; and identification and advocacy for the health needs of the community.[234]

However, it must be emphasised that while many communities have a primary health care service, the quality of that service may not be adequate. It is vital that these services are high quality and *integrated* (that is services in which health promotion, screening and treatment for various conditions are coordinated) to achieve lasting change in the health status of Aboriginal and Torres Strait Islander peoples.

It is for this reason the *National Strategic Framework* contains a commitment to 'comprehensive' primary health care encompassing 'clinical/medical care, illness prevention services, specific population health programs for health gain, access to secondary and tertiary health services and client/community support and advocacy.'[235]

The most recent review of the Aboriginal and Torres Strait Islander primary health care system argues that:

> The available evidence of health impact in Indigenous populations, and the known effective interventions of primary health care, indicates that the impact of effective primary health care is seen in:
>
> - reduced prevalence and incidence of communicable diseases that are susceptible to immunisation programs;
> - reduced complications of chronic disease through effective chronic disease management programs;
> - improved maternal and child health outcomes (such as birth weight) through the implementation of culturally appropriate antenatal and early childhood programs; and
> - reduction in social and environmental risks through effective local public health advocacy, such as changes to liquor licensing regulations.
>
> The available evidence of intermediate health outcomes achieved by effective Indigenous-specific health services gives grounds for governments to increase their investment in improving access to comprehensive primary health care. Further, there is no reason to believe that health interventions that are of proven effectiveness for the general population cannot be effective in Indigenous populations, provided that the delivery system that brings these interventions is effectively tailored to the needs of Indigenous communities.[236]

234 Dwyer, J., Silburn, K. and Wilson, G, *op.cit.,* ppxii-xiii.

235 National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health, Framework for action by Governments, op.cit.,* p13.

236 Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* p33.

A focus on primary health care interventions addressing chronic diseases can be expected to have a significant impact on Aboriginal and Torres Strait Islander peoples' life expectation. Table 2 below indicates the potential gains to Aboriginal and Torres Strait Islander life expectancy through addressing five chronic conditions.[237]

Table 2: Potential years of life expectancy gained by Aboriginal and Torres Strait Islander peoples if death rates from five chronic disease groups were reduced to that of the total population (1998-2000)[238]

Chronic Disease group	Aboriginal and Torres Strait Islander males can expect to gain	Aboriginal and Torres Strait Islander females can expect to gain
Diseases of circulatory system (inc. heart diseases, strokes)	6.5 years of life if rates of death lowered to that of non-Indigenous population	6.4 years of life if rates of death lowered to that of non-Indigenous population
Neoplasms (inc. cancers)	2.4 years of life if rates of death lowered to that of non-Indigenous population	2.5 years of life if rates of death lowered to that of non-Indigenous population
Diseases of respiratory system	2.0 years of life if rates of death lowered to that of non-Indigenous population	1.7 years of life if rates of death lowered to that of non-Indigenous population
Endocrine, nutritional and metabolic diseases (inc. diabetes)	1.6 years of life if rates of death lowered to that of non-Indigenous population	2.5 years of life if rates of death lowered to that of non-Indigenous population
Diseases of the digestive system	1.0 years of life if rates of death lowered to that of non-Indigenous population	0.8 years of life if rates of death lowered to that of non-Indigenous population

iv) Aboriginal Community Controlled Health Organisations have a vital role to play

The current approach to improving primary health care access is based on a combination of support for Aboriginal and Torres Strait Islander-specific services alongside improving the accessibility of the mainstream primary health care system (such as through adjustments to Medicare and the Pharmaceutical Benefits Scheme). Both Aboriginal and Torres Strait Islander community controlled and mainstream services are needed by Aboriginal and Torres Strait Islander communities. It should be noted that in regions with no other services,

237 Note: This is included for illustrative purposes only. These calculations are based on the life expectation formula which was subsequently changed in 2003. Similarly, given the complex interaction between diseases and causes of death, the impact of addressing each chronic disease would not necessarily be cumulative.

238 Australian Bureau of Statistics, *Australian Social Trends 2002,* ABS cat. no. 4102.0, Commonwealth of Australia, Canberra, p90.

Aboriginal community controlled services are an essential service which are also used by the non-Indigenous population.

There should be continued support for Aboriginal community controlled health services. There is evidence that they are a highly effective process for the provision of primary health care. Reports and studies have found that community controlled health services can offer:[239]

- better communicable disease control through vaccination;[240]
- improved treatment of communicable diseases – i.e. reduced rates of STIs and scabies;[241]
- increased screening for cancer – i.e. cervical cancer screening;[242]
- early detection and reduced complications of chronic diseases;[243]
- early detection and reduced complications of mental illness;[244]
- improved child and maternal health outcomes – i.e. reduced infant mortality and low birth weight babies;[245]
- reductions in social and environmental risks – i.e. reduced alcohol consumption and ill-health resulting from injuries;[246] and
- increased access to primary and specialist health care, including mainstream services and major gains in diabetes management.[247]

The following text box is extracted from the recent review of Aboriginal primary health care services, and illustrates some of the benefits of Indigenous-specific health services.

Text Box 13: Examples of impacts and outcomes of Indigenous-specific health services[248]

Communicable diseases control through vaccination

- Increased childhood immunisation rates – to 91% of children in the Tiwi Islands and 100% in Wilcannia.
- Aboriginal and Torres Strait Islander people who attend an Indigenous-specific medical service are more likely to be appropriately vaccinated for pneumococcal disease than Aboriginal and Torres Strait Islander persons who attend a general practitioner (76% versus 32% respectively).

Treatment of communicable diseases

- By 1997-98, the prevalence of gonorrhoea in a region was reduced by 46% and chlamydia by 20%. Prevalence has since remained stable at 5% and 6% respectively. Approximately 70% of the adult population served by the Aboriginal community controlled health service participate in an annual Sexually Transmitted Infection screen.[249]

239 See Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* pp91-106, Appendix.
240 *ibid.,* pp91-92.
241 *ibid.,* p93.
242 *ibid.,* p94.
243 *ibid.,* pp95-96.
244 *ibid.,* pp96-97.
245 *ibid.,* pp98-101.
246 *ibid.,* p102.
247 *ibid.,* pp103-106.
248 *ibid.,* pxvi.
249 The communities for this item have been de-identified.

Cancer screening

- The Northern Territory Well Women's Program, which operates in a region with a high proportion of Aboriginal women and has a long history of engagement with women and local Aboriginal Health Services, has achieved a high rate of cervix screening (61%) in the Alice Springs remote area, which is comparable to the rate for Australian women generally (62%).

Reduced complications of chronic disease

- In 1999 a trial to improve diabetes care in the Torres Strait Islands resulted in an 18% fall in hospital admission rates and a reduction of 41% in the number of people admitted to hospital for diabetes-related conditions. On follow-up in 2002 there was a continuing reduction in hospital admissions for diabetes complications (from 25% in 1999 to 20% in 2002). The proportion of people with good glycaemic control increased from 18% to 25%, and the proportion of people with well-controlled hypertension increased from 40% to 64%.
- A mental health project at the Geraldton Regional Aboriginal Medical Service reduced psychiatric admissions of Aboriginal and Torres Strait Islander people to Geraldton Regional Hospital by 58%.

Improved maternal and child health outcomes

- Since 2000 the Townsville Aboriginal and Islander Health Service's Mums and Babies Project increased the numbers of women presenting for antenatal care (from 40 to over 500 visits per month in 1 year). The number of antenatal visits made by each woman has doubled, with the number having less than four visits falling from 65% to 25%. Pre-natal deaths per 1,000 reduced from 56.8 prior to the program to 18 in 2000; the number of babies with birth weights less than 2,500 grams has dropped significantly; and the number of premature births has also decreased.
- Since 1990 an antenatal program at Daruk Aboriginal Community Controlled Medical Service, Western Sydney has achieved increased awareness among Aboriginal women of the importance of antenatal care. Thirty-six (36) per cent of Indigenous women presented within the first trimester, compared with 21% at Nepean and 26% at Blacktown Hospitals' antenatal clinics; and women attended more antenatal visits (an average of 10 at Daruk compared to 6 at Nepean and 9 at Blacktown).

As the recent review of Aboriginal and Torres Strait Islander primary health care also noted:

> the role of Indigenous-specific services is not simply one of substitution for mainstream services. They also provide a base for training of both Indigenous and non-Indigenous health professionals, and for research and development of new approaches to Indigenous health (either alone or in partnership with mainstream agencies and researchers). This aspect is particularly important in urban services, because of their proximity to medical schools etc. and to the headquarters of mainstream specialist providers (e.g. the leadership of child and adolescent mental health services tends to be based in capital cities). Indigenous specific services in all areas provide the referral pathway to specialist and tertiary services, and support the providers in their responses to Indigenous patients. They are

also the appropriate base for community development approaches to improving health.[250]

It is acknowledged, however, that there is limited research that highlights what works well in community controlled health organisations. Accordingly, it can be difficult to identify those factors which lead to a high performing and effective service. While support for Aboriginal community controlled health services should continue, there should also be independent research conducted to determine the success factors and governance issues which contribute to achieving the most effective community controlled health services possible.

The expansion of community controlled health services must take place alongside efforts to improve the accessibility of mainstream services. It should also be accompanied by health care programs focusing on specific diseases. If, through these, early stage symptoms are detected not only can suffering be prevented, but cost savings made.

A positive development in relation to these issues is the recently introduced 'Healthy for Life' program. This was introduced in the 2005-06 Budget and has funding totalling $113.6m over the next 5 years. This initiative involves the establishment of a number of 'Healthy for Life' sites providing primary health care interventions. These are aimed to improve the quality of child and maternal health care and the early detection and management of chronic diseases. Each site will be subject to a formal evaluation process and has benchmarks set for the life of the program. These include halving incidence of low-birth weight babies within 5 years.[251] This program does not, however, exist at a level that can address the need in Aboriginal and Torres Strait Islander communities. Greater attention is required to address child and maternal health as an urgent priority alongside increases in core funding for primary health care services.

In terms of mainstream accessibility, I welcome the development of a *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health* to guide policy and service delivery for utilisation by the mainstream health care system.[252] It aims to ensure that the mainstream health system is able to deliver 'assurances of cultural safety' to Aboriginal and Torres Strait Islander people and that 'traditional Aboriginal and Torres Strait Islander peoples' healing practices are legitimised'.[253] It is an ambitious document that aims to embed cultural respect at the 'corporate, organisational and care delivery levels' of the health system.[254]

v) Investing in primary health care is cost-effective

It should be noted that investing in Aboriginal and Torres Strait Islander health care needs offers significant cost benefits. In particular, money spent on primary

250 Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* pxiv. The study also found that an effective primary health care system for Indigenous Australians requires Indigenous specific services in urban as well as rural and remote areas. While a much higher proportion of Australian Government health care spending for Indigenous people in remote regions is through OATSIH funding (over 90% of primary health care spending in remote areas was through OATSIH in 1998–99) more than half of all spending for urban and rural people was also through OATSIH (between 50% and 60%), in spite of the much greater availability of mainstream services: *ibid.*

251 Information available online at: www.atsia.gov.au/budget/budget05/c_fact_sheet_8.pdf.

252 Australian Health Minister's Advisory Committee, *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004-2009,* Commonwealth of Australia, Canberra, 2004, p3.

253 *ibid.,* p11.

254 *ibid.,* p13.

health care could be expected to reduce Aboriginal and Torres Strait Islander peoples' demand on clinical and hospital services, resulting in savings.

This was highlighted in a report commissioned by the Commonwealth Department of Health and Ageing to assess the cost-effectiveness of current services provided for Aboriginal and Torres Strait Islander Australians in the Northern Territory.[255] The report aimed to provide an understanding of what might happen if investment increased and decreased for primary care over time, looking at hypertension, diabetes, renal disease, ischaemic heart disease, chronic obstructive pulmonary disease, respiratory and related ear infections, diarrhoea, malnutrition and skin infections.[256]

The study considered the cost benefit of existing investment in primary health care, noting that:

> [I]f this funding was not provided, it was estimated that total health costs on other parts of the system would be higher, exceeding $136 million over five years after funding was no longer provided, $470 million in 10 years, and $1,261 million over 20 years (which is largely expected to be hospital, renal dialysis and some Medical Benefits Scheme (MBS)/Pharmaceutical Benefits Scheme (PBS) costs). Also, without these investments, late diagnosis and treatment could be expected to lead to worse health outcomes, with a loss of healthy life years due to premature death and increased disability equivalent to 2.6, 6.1 and 12.6 years per person over five, ten and 20 years time respectively.[257]

The report also considered the potential impact of a staged increase in investments in primary health care across the continuum of health promotion, prevention and clinical care over a ten year period. It found that:

> this investment would save an additional 3 disability adjusted life years per person over five years, 5.7 years per person over ten years, and 9.9 years per person over 20 years due to reduced rates of disability and death (these years would be otherwise lost due to the nine preventable diseases modelled). The total benefit/cost ratio is 28 over five years, 17 over ten years, and 12 over 20 years.[258]

vi) An Aboriginal and Torres Strait Islander health workforce is an essential first step

An equitable distribution of primary health care rests on a prior effort to increase the numbers of health professionals to provide the services. For example:

- Professor Deeble estimated in 2001 that 500 new general practitioners and over 3,000 new nurses and Aboriginal Health Workers were needed.[259]
- Access Economics in 2004 estimated an annual increase in health personnel costs in the order of $280 million per annum was required to address Indigenous health needs, including primary health care.[260] Personnel costs would go towards the following positions, based on

255 Beaver, C. and Zhao, Y., *Investment Analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory,* Aboriginal and Torres Strait Primary Health Care Review, Consultant Report No. 2, Commonwealth of Australia, 2002, p1.

256 *ibid.*

257 *ibid.*

258 *ibid.,* p2.

259 Deeble J., *Expenditures on Aboriginal and Torres Strait Islander Health 2003,* AMA, Canberra, 2003, p5.

260 Access Economics, *Indigenous Health Workforce Needs,* AMA, Canberra, 2004, pp21-22, 36.

an assessment of need: the equivalent access to at least 430 medical professionals (at least 250 of these being general practitioners needed in primary health care);[261] 450 dentists and other health professionals; approximately 1,000 nurses and 2,000 more Aboriginal health workers.[262] Training up this workforce, Access Economics estimate, would cost $167 million over 6 years; $36.5 million in the first three years, then tailing off.[263]

There is some overlap between the *workforce needs* shortfall in relation to Indigenous health care with the Indigenous *health workforce representation* shortfall – Indigenous under-representation in the health workforce based on 2.4% of the population being Indigenous. Rectifying the imbalance requires training 928 Indigenous general practitioners and specialists; 161 dentists; 2,570 nurses and 275 pharmacists, according to Access Economics.[264]

There is some overlap between the *workforce needs* shortfall in relation to Aboriginal and Torres Strait Islander health care with the Aboriginal and Torres Strait Islander *health workforce representation* shortfall – Aboriginal and Torres Strait Islander under-representation in the health workforce based on 2.4% of the population being Aboriginal and Torres Strait Islander. Rectifying the imbalance requires training 928 Aboriginal and Torres Strait Islander general practitioners and specialists; 161 dentists; 2570 nurses and 275 pharmacists, according to Access Economics.[265]

In 2001, while Aboriginal and Torres Strait Islander people held 67% of positions in Aboriginal Community Controlled Health Services, 98% of the doctors and 87% of the nurses were non-Indigenous.[266] Significant attention is needed in relation to the recruitment and retention of Aboriginal and Torres Strait Islander health professionals.[267]

Any substantive address must begin at school – students must not only complete school, but they must receive a thorough grounding in maths and science to enter medicine. Recruitment campaigns must start focusing on Aboriginal and Torres Strait Islander young people at an early age.

More broadly, there is a national shortage of health professionals that is only beginning to be addressed. At present, general practitioners are being recruited into primary health care from Australian hospitals, leaving hospitals to recruit from overseas. Recent initiatives have been announced to train up many more nurses and doctors. It is not yet clear how many of those positions are intended to be filled by Aboriginal or Torres Strait Islander people. While there are a number of initiatives designed to encourage Aboriginal and Torres Strait Islander people to study in the area of medicine, including scholarships and incentives to universities to enrol more Aboriginal and Torres Strait Islander students in health

261 *ibid.,* pp16 -17, 36.
262 *ibid.,* pp20, 36.
263 *ibid.*
264 *ibid.,* p3.
265 *ibid.,* p3.
266 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003, op.cit.,* p63.
267 *ibid.,* p67, Table 4.18.

related fields there is no plan to quarantine places for Aboriginal and Torres Strait Islander people in relation to this shortfall.[268]

The *Indigenous Health Workforce National Strategic Framework* (Workforce Framework) is the response to the health workforce shortfall. The Aboriginal and Torres Strait Islander Health Workforce Working Group was established by the Australian Health Ministers' Advisory Council in 2002 to oversee the national level implementation of the *Workforce Framework* and to ensure effective national level coordination of workforce policies and activities.[269] It includes:

> Objective 5. Include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process.[270]

In May 2002 the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) was established to oversee implementation of the *Workforce Framework*.[271] Important developments to date include:

- The development of new national Aboriginal and Torres Strait Islander Health Worker generalist primary health care competencies;[272]
- The development of jurisdictional plans such as NSW Health *Aboriginal Workforce Development Strategic Plan 2003–2007*;[273]
- The development of an *Indigenous Health Curriculum Framework* developed by the Committee of Deans of Australian Medical Schools in 2004;[274]
- The report by AIDA: *Healthy Futures, defining best practice in the recruitment and retention of Indigenous medical students (Healthy Futures)*[275] in 2005;
- The continuation of scholarships (such as the funding of the Puggy Hunter Memorial Scholarship Scheme for Aboriginal and Torres Strait Islander students in medicine, nursing, health management and Aboriginal Health Worker courses by the Department of Health and Ageing.[276]

However, despite Objective 5 of the *Workforce Framework* outlined above, the Office of Aboriginal and Torres Strait Islander Health has indicated that at present

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268 Minister for Education, Science and Training, (Nelson, B.), *Correspondence with Social Justice Commissioner,* 31 August 2004.

269 Aboriginal Health Ministers' Advisory Committee (AHMAC), *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, Commonwealth of Australia, Canberra, 2002, p5.

270 *ibid.,* p3.

271 Aboriginal and Torres Strait Islander Health Workforce Working Group, *Annual Report 2002- 2003,* AHMAC, Canberra, 2004, pp6-7.

272 *ibid.*

273 New South Wales Department of Health, *Aboriginal Workforce Development Strategic Plan 2003-2007,* NSW Health, Sydney, 2003 available online at http://www.health.nsw.gov.au/pubs/a/pdf/ab_work_strat.pdf.

274 Phillips, G., Committee of Deans of Australian Medical Schools, *Indigenous Health Curriculum Framework,* VicHealth Koori Health Research and Community Development Unit, Melbourne, 2004, available online at http://www.cdams.org.au/pdf/CDAMS%20Indigenous%20Health%20Curriculum%20Framework.pdf.

275 Australian Indigenous Doctors Association, *op.cit.*

276 For the 2005 academic year 30 scholarships were awarded. The scholarship program is not linked to targets. Department of Health and Ageing, *Annual Report 2004-05,* DOHA, Canberra, p187 (Outcome 7).

there are no national targets associated with its implementation.[277] In September 2003, the ATSIHWWG agreed to establish an Evaluation Group to progress issues related to workforce performance measures and aligning implementation with the *National Strategic Framework*. A full evaluation of the implementation of the *Workforce Framework* will occur in 2007.[278]

By contrast, the Australian Indigenous Doctor's Association propose the following headline workforce targets by 2010:

- Australian medical schools will have established specific pathways in to medicine for Indigenous Australians;
- Committee of Deans of Medical Schools Indigenous Health Curriculum Framework will be fully implemented by Australian medical schools; and
- There will be 350 extra Indigenous students enrolled in medicine.[279]

vii) The proposed timeframes are achievable

There is sufficient evidence to demonstrate that the improvements sought in Aboriginal and Torres Strait Islander peoples' health status are achievable. For example, the most recent review of Aboriginal primary health care states that:

> international figures demonstrate that optimally and consistently resourced primary health care systems can make a significant difference to the health status of populations, as measured by life expectancy, within a decade. For example, in the 1940s to the 1950s in the United States, Native American life expectancy improved by about 9 years; an increase in life expectancy of about twelve years took place in Aotearoa/New Zealand over two decades from the 1940s to the 1960s. Figures from within Australia demonstrate dramatic improvements in infant mortality (for example from 200 per 1,000 in mid 1960s Central Australia to around 50 per 1,000 by 1980) through the provision of medical services.[280]

A number of programs in Australia have also achieved rapid improvement in Aboriginal and Torres Strait Islander peoples' health in response to specific program interventions. For example, death rates among Aboriginal and Torres Strait Islander people from pneumonia have dropped 40% since 1996 due to the rolling out of pneumococcal vaccinations;[281] and the Strong Babies, Strong Culture program has shown that significant reductions in the number of low birth weight babies can occur within a matter of years.[282]

The following case study of the impact of a four year program targeting kidney disease in one Aboriginal community vividly demonstrates the progress that can be made even over a short timeframe.

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277 Office of Aboriginal and Torres Strait Islander Health, *Correspondence with Aboriginal and Torres Strait Islander Social Justice Commissioner regarding the Social Justice Report 2005,* November 11, 2004.

278 Aboriginal and Torres Strait Islander Health Workforce Working Group, *op.cit.,* pp6-7.

279 The Australian Indigenous Doctor's Association targets reflect those proposed by Access Economics discussed further below: *ibid.*

280 Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* p40.

281 Figure cited as being drawn from Australian Bureau of Statistics sources in Ring, I. and Brown, N., 'Indigenous Health; chronically inadequate responses to damning statistics', *op.cit.*

282 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 1999,* ABS cat. no. 4704.0, Commonwealth of Australia, Canberra, 1999, p87, Text Box 6.8.

Text Box 14: Case study: Tackling end-stage renal disease in one Aboriginal community

Notifications of Aboriginal and Torres Strait Islander people with end-stage renal disease occur at nine times the rate of notifications in relation to the non-Indigenous population. The onset of end-stage renal disease among non-Indigenous people occurs largely among older people, but rates among Aboriginal and Torres Strait Islander people are high from the 25-34 years age group. For people aged 35-64 years, the rates among Aboriginal and Torres Strait Islander people were 12-18 times higher than the rates for non-Indigenous people over 1997-2001.[283]

In the Northern Territory, the incidence of kidney disease requiring dialysis rose from fewer than 400 per million Aboriginal people in 1984 to almost 1,300 per million in 2001. This is at a cost of more than $112,000 per person each year. In 2004, there were only two dialysis centres in the Northern Territory – one in Alice Springs, one in Darwin. People from the remote communities with renal failure have to move from their communities to receive treatment. This profoundly disrupts their community and family life, and can lead to despair, demoralisation, and voluntary withdrawal from dialysis treatment.

A four-year treatment program in one community, however, was able to reduce the incidence of kidney disease by 62 per cent. The death rate in people with kidney disease was also halved. Savings on kidney dialysis amounted to $3 million during the program, which involved fewer than 300 people.

The program involved education about diet, exercise, health behaviours and medical treatment. Medical treatment consisted of blood pressure control, particularly in relation to hypertension. Participants were seen at least monthly while medications were introduced or changed, then at least every three months for the first year, and at least every six months thereafter. After a start-up period, the day-to-day program was largely conducted by local health workers and community project officers, who were supported by telephone contacts and regular visits by nurse coordinators from Darwin.[284]

viii) Resources must be provided at a level that is capable of meeting need

There currently exist significant programs which focus on improving primary health care and health infrastructure for Aboriginal and Torres Strait Islander communities – such as the Primary Health Care Access Program and the Community Housing and Infrastructure Program and other mainstream programs and services. These schemes do not, however, operate at a level that matches the need in communities.

As noted, the Primary Health Care Access Program (PHCAP), a Commonwealth initiative, is the main vehicle for the expansion of existing primary health care services in communities and the establishment of new services. Announced in the 1999/2000 budget, the original Commonwealth contribution of $78.8 million over 4 years was increased by a further $19.7 million in the 2003/04 budget taking

283 Australian Health InfoNet, *Summary of renal and other urologic disorders among Indigenous Australians,* http://www.healthinfonet.ecu.edu.au/html/html_health/specific_aspects/chronic/renal/renal_2.htm#summary, 15 August 2005, (Accessed 1 September 2005).

284 Hoy, W., Baker, P., Kelly, A., *(et al),* 'Reducing premature death and renal failure in Australian Aboriginals – a community based cardiovascular and renal protective program' (2000) 172 *Medical Journal of Australia* 473, pp473-478.

the recurrent funding base of the project to $54.8 million.[285] The 2005/06 Budget announced an additional $40 million for the four years until 2008/09.[286]

PHCAP has never been fully or appropriately funded. Not all zones have been rolled out and there are no plans to roll out further PHCAP zones in the Top End. Similarly, the Department of Health and Ageing has not provided estimates of the funding required to implement PHCAP up to the benchmark funding level in Aboriginal and Torres Strait Islander communities over the next 5 years.

The spending shortfall on Aboriginal and Torres Strait Islander peoples by the Commonwealth Government through Medicare and the Pharmaceutical Benefits Scheme (PBS) provides a basis for gauging the size of the primary health care shortfall. Through these programs, the Commonwealth Government facilitates the general populations' access to primary health care as provided by general practitioners and other private health services. PBS and Medicare expenditure by Aboriginal peoples remains 39 cents for every dollar and this discrepancy (despite 3 times greater disease burden) has not been alleviated in the last several years.[287]

Per capita Medicare underspend estimates have been used to assess the quantum of the Aboriginal and Torres Strait Islander primary health care shortfall. Factoring in greater health needs has created the following estimates of costs:

- In 2003, the Australian Medical Association (AMA) calculated there was a $250 million per annum shortfall in Medicare and related spending on Aboriginal and Torres Strait Islander peoples by the Commonwealth that, if made up, could be devoted to primary health care.[288] The AMA added that $50 million was required to increase public heath, preventative programs, screening and health education in communities, to compensate for the fact that national health campaigns did not reach Aboriginal and Torres Strait Islander communities as they reached the general population.[289]
- Access Economics estimated there was approximately a $400 million per annum shortfall that should be devoted to an Aboriginal and Torres Strait Islander health program including provision of an equitable distribution of primary health care in a report published in May 2004.[290]

285 Dwyer. J., Silburn, K. and Wilson, G., *op.cit.,* p16.

286 Department of Immigration, Multiculturalism and Indigenous Affairs, *Indigenous Budget Measure 12: Primary Health Care Access programme – additional funding,* (fact sheet) http://www.atsia.gov.au/budget/budget05/c_fact_sheet_12.pdf July 2005 (Accessed 3 August 2005).

287 Australian Institute of Health and Welfare, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001-02,* AIHW cat. no. HWE 30, Canberra, 2005, p24.

288 Deeble, J., *Expenditures on Aboriginal and Torres Strait Islander Health 2003,* AMA, Canberra, 2003, p5.

289 *ibid.*

290 Access Economics, *Indigenous Health Workforce Needs,* Australian Medical Association, Canberra, 2004, p36, available online at: http://www.ama.com.au/web.nsf/doc/WEEN-63Q9J7. Access Economics and Deeble used different models quantify need. Deeble uses rates of Indigenous mortality as an approximation of the rate of morbidity as a measure of health needs, while also factoring in costs associated with providing services to remote areas. Access Economics uses a more disgregated range of indicators because, they argue, that would more directly reflect health needs (use of medical services, hospital use, and weighted risk factors). They also factoring in the cost of services at a distance, using the same cost loading as Deeble. Access Economics, *op.cit.,* p39.

In 2004, the report *Costings Models for Indigenous Health,* estimated the cost of extending Indigenous specific universal primary health care to be between $409 million and $570 million depending on the quality of service offered.[291] The consultants based their lower estimate on a needed health spending ratio of 2.21:1 (Aboriginal and Torres Strait Islander to non-Indigenous) based only on extra needs. There was no adjustment made for the additional costs of remoteness or for culturally appropriate services. The higher estimate relates to the cost of funding services to the level currently provided to a set of eight 'best practice' services.

A recent review of their findings noted problems with the model and estimated that spending ratios of between 3:1 and 6:1 might be required to provide universal and comprehensive primary health care to communities.[292]

It should be noted that addressing this need offers significant cost benefits to Australian governments and allows for the most efficient targeting of resources in relation to health. In particular, money spent on primary health care could be expected to reduce Aboriginal and Torres Strait Islander peoples' demand on hospital services, resulting in savings at that end; while money spent on health infrastructure could be expected to significantly reduce Aboriginal and Torres Strait Islander peoples' use of health services in general.

In relation to health infrastructure, a century of neglect of health infrastructure in Aboriginal and Torres Strait Islander communities has left what could be a $3-4 billion[293] project for this generation.

The Community Housing and Infrastructure Program (CHIP) is the program for the provision of capital works infrastructure to communities. In 2004, the program was transferred from ATSIC to the Department of Family and Community Services. The Commonwealth spent $256 million on the CHIP in 2004-2005.[294] Over the decade 1991-2001, $725m was spent on construction or purchase of 5901 houses; $106m on upgrades/renovation of 6534 houses; and $645m on capital costs of housing related infrastructure (water, power, sewerage).[295]

CHIP is not a strategic plan to ensure that an equal standard of infrastructure is provided to Aboriginal and Torres Strait Islander communities. Funding is not linked to need under this program. It was estimated in 2001 that at the current rate of funding it would take at least 20 years to achieve an equal standard of infrastructure in communities.[296]

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291 Econtech, *Costings Models for Aboriginal and Torres Strait Islander Health Services,* Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No.3, Commonwealth of Australia, Canberra, 2004, pxi.

292 Dwyer, J., Silburn, K., and Wilson, G., *op.cit.,* pxxv.

293 The Aboriginal and Torres Strait Islander Commission estimated the cost of meeting healthy infrastructure needs in communities to be $3.5 billion in 2001. Aboriginal and Torres Strait Islander Commission, *ATSIC Health Policy,* http://www.atsic.gov.au/issues/disadvantage/health/health_policy_2001.asp, February 2001, (Accessed 3 February 2004).

294 Senate Community Affairs Legislation Committee, *Examination of Budget Estimates 2005 -2006, Additional Information Received, Vol 1, Family and Community Service Portfolio,* September 2005, p83, available online at http://www.aph.gov.au/Senate/committee/clac_ctte/estimates/bud_0506/vol1_facs_Sep05.pdf.

295 Etherington, S. and Smith, L., 'Construction, – The design and construction of Indigenous housing: the challenge ahead', article in Australian Bureau of Statistics, *Year Book Australia 2004,* ABS, Commonwealth of Australia, Canberra, 2004, p553.

296 Aboriginal and Torres Strait Islander Commission and the Cooperative Research Centre for Aboriginal and Tropical Health, *Atlas of Health Related Infrastructure in Discrete Indigenous Communities,* ATSIC, Melbourne, 2002, p10.

There is a danger that if infrastructure needs are not addressed expeditiously, the rapidly growing Aboriginal and Torres Strait Islander population may put such pressure on existing infrastructure that much of the good work of the past decade will be undone. Planning to address this historical lack of infrastructure is an essential joint step with the provision of primary health care if improvements to health are to be realised. There is, however, currently no overall plan to address these needs that meets with the human rights principle of progressive realisation- i.e., that the inequality is steadily being reduced with the commitment of the maximum of available resources.

Only with funding commitments that are proportionate to the outstanding need in communities will it be feasible for governments to meet the outstanding primary health care and infrastructure needs of Aboriginal and Torres Strait Islander communities within 10 years.

While the estimated amounts required to address primary health care access and infrastructure provision are significant, they represent about 1% of the current national per annum spending on health. Total expenditure on health goods and services, health-related services and capital formation in Australia in 2003–04 was estimated at $78.4 billion. This was an increase of $6.1 billion over the previous year.[297]

ix) Responsibility for addressing the funding shortfall should be shared between governments

Addressing this funding shortfall is a shared responsibility between levels of government. The most recent review of expenditure patterns on Aboriginal and Torres Strait Islander Health notes that:

> the Australian Government provided 43.1% of the total funding for Indigenous health expenditures, the state and territory governments provided 49.5%, and 7.3% came from non-government sources, including out-of-pocket payments. The corresponding figures for non-Indigenous people were 47.8% from the Australian Government, 19.5% from the states and territories and 32.7% from private sources.
>
> An estimated 70.5% of expenditures were through programs managed by the state and territory governments; 23.4% were through Australian Government programs; and the remaining 6.2% were for services that were essentially the responsibility of non-government providers.[298]

Generally, primary health care is a responsibility of the federal government – but savings made here can prevent engagement of Aboriginal and Torres Strait Islander peoples with the secondary and tertiary systems, which are predominately responsibilities of the states and territories. The states and territories also have significant responsibilities for service delivery in areas which impact on health outcomes, such as housing.

297 Australian Institute of Health and Welfare, *Health Expenditure 2003-2004,* AIHW cat. no. HEW 32, Canberra, 2005, p6.

298 Australian Institute of Health and Welfare, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02, op.cit.,* pxxiv. Notably, the federal government spends comparatively *less* on Indigenous peoples to non-Indigenous peoples in percentage terms: 43.1% of total Indigenous health expenditure compared to 47.8% for total non-Indigenous health expenditure.

In light of the comprehensive national frameworks and strategies in place, it would appear that there exists a solid basis for governments to work together to address the projected funding shortfall. Additional funding to the states and territories could be made contingent on the agreement of states and territories to match federal contributions. This was done in the negotiation of the Australian Health Care Agreements for 2003-2008.[299]

In the last round of negotiations of the Australian Health Care Agreements (AHCAs) such leverage was not used by the federal government to seek improvements in funding or performance from the states and territories on Aboriginal and Torres Strait Islander health.[300]

x) Data collection and methodological issues remain to be addressed

To support these commitments and proposed targets, further reform of health financing models and data collection methods is required.

There has been significant work done to improve health financing models towards processes that identify the level of need. For example, quantifying the Medicare Benefit Scheme spending shortfall on Aboriginal and Torres Strait Islander peoples has provided a basis for quantifying the primary health care shortfall and stimulated initiatives to ensure Aboriginal and Torres Strait Islander enjoy greater access to Medicare and the Pharmaceutical Benefits Scheme. Further work is required to quantify enable the level of need to be quantified nationally, as well as at a regional and sub-regional level for both primary health care access and health infrastructure provision.

This raises the broader issue of the poor quality of data in many areas upon which to base planning. This is a long standing issue. Developing appropriate standards of Aboriginal and Torres Strait Islander health information was identified as a national health information priority in 1995, with the *National Indigenous Health Information Plan* (1997) being developed as a consequence.[301] However, the plan remains largely unimplemented.[302] The Overcoming Indigenous Disadvantage report has also identified concerns about the quality of data available on health measures contained in that framework.[303]

The National Public Health Partnership has produced guidelines for the assessment of need in Aboriginal and Torres Strait Islander communities.[304] These aim to promote accurate and comprehensive processes to identify Aboriginal and Torres Strait Islander need, including adequate processes for data collection.

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299 For details see: Prime Minister, *Australian Health Care Agreements 2003-2008,* Media release, 23 April 2003, available online at: http://www.pm.gov.au/news/media_releases/media_Release 143.html, (accessed 21 November 2003).

300 The Australian Health Care Agreements Improving Indigenous Health Reference Group, established prior to the negotiations of the 2003-2008 agreements, proposed that a detailed schedule be attached to the AHCA to forward the implementation of the *National Strategic Framework*. The Commonwealth Government did not accept the need for the schedule at the time. See: Australian Health Care Agreements Improving Indigenous Health Reference Group, *Improving Indigenous Health*, 2003, p136, available online at www.health.gov.au/haf/Indigenous. pdf. (Accessed 12 August, 2003).

301 Thomson, N., *The Need for Indigenous Health Information,* in Editor, Thomson, N., *The Health of Indigenous Australians, op.cit.,* p2.

302 *ibid.,* p4.

303 Steering Committee for the Review of Government Service Provision, *op.cit.,* pp2.17, 3.13, 5.5, 8.4, 10.4.

304 National Public Health Partnership, *op.cit.,* pp18-19.

b) What role should health issues play in the new arrangements for the administration of Indigenous Affairs?

Improving Aboriginal and Torres Strait Islander peoples' health will not occur by focusing exclusively on the health sector. It also requires commitments and action from other sections of government and the community. As recently noted:

> Much could also be gained if current initiatives to strengthen community capacity and coordinate investments in Indigenous communities are successful in addressing some of the social determinants of ill-health; and if Indigenous communities and governments are successful in fostering an environment that enables communities, families and individuals to engage more actively in sharing responsibility for their own health.[305]

For this reason, the new arrangements for the administration of Indigenous affairs at the federal level provide a good opportunity to build on the strategic focus and structures that are in place to address Aboriginal and Torres Strait Islander health inequality.

This is particularly through the coordination role of the Indigenous Coordination Centres (with solution brokers from different departments, including Department of Health and Ageing, to operate as a contact point for multiple programs and funding sources, and to ensure better coordination of mainstream and Indigenous specific programs); the focus on local level engagement and participation of Aboriginal families, clans and communities; and the Regional Partnership Agreement and Shared Responsibility Agreement processes.

As noted earlier in this chapter, the Department of Health and Ageing has not played a significant role in the new arrangements to date. There remains a disconnect between existing programs relating to Aboriginal and Torres Strait Islander health and the operation of the new arrangements despite the clear inter-connections between the issues. Even though there is recognition by governments that Aboriginal and Torres Strait Islander health outcomes require a holistic response in order to achieve lasting and sustainable improvements, in most instances issues are still being addressed separately.

My Office has been informed that staffing levels in the Office of Aboriginal and Torres Strait Islander Health (OATSIH) within DOHA have not permitted a fuller engagement in the new arrangements to date. There had been a reduction in staffing within OATSIH which limits their ability to participate in policy debates and the new arrangements. OATSIH have indicated that they have recently conducted a recruitment campaign which should see increased capacity in the near future. In addressing the issues raised here, however, there should be no diversion of resources away from the roll out and management of the PHCAP scheme.

I consider that the new arrangements can make a significant contribution to efforts to achieve health equality for Aboriginal and Torres Strait Islander peoples in the following ways.

i) Matching programs to need on a regional basis

The health sector provides substantial evidence of the level of need in communities, particularly as it relates to health issues. The new arrangements should build on this.

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305 Dwyer, J., Silburn, K. and Wilson, G., *op.cit.,* pxi.

Indigenous Coordination Centres should utilise the findings and recommendations of the regional planning processes conducted under the state-wide Aboriginal Health Forums, as well as other regionally based information in developing coordinated regional approaches.

Text Box 15 below illustrates the type of information that is available and which could be utilised to achieve an improved focus on health issues through the new arrangements. It provides a brief overview of some of the planning tools that are available in relation to two regions in Western Australia.

Text Box 15: Case studies: Regional planning tools on health in two regions of Western Australia

a) Wunan (East Kimberly) Region

1. *Kimberly Regional Aboriginal Health Plan* (1999)

The plan identifies need across the Kimberly Region, including the East Kimb erly.

- *Health services:* as an 'absolute minimum' an additional $13 million per annum spending was required to meet the need for PHC.[306] Ten additional GPs were needed (increasing by one every two years to cope with population increases), as well as 12 community nurses and 100 Aboriginal Health Workers (AHW).[307]
- *Health infrastructure:* 300 new homes were needed every year for 5 years to address overcrowding.[308]

2. *Community Housing and Infrastructure Needs Survey* (2001)

Of 368 dwellings managed by an Indigenous Housing Organisation in the East Kimberly region, 85 (23%) were declared in need of replacement, 58 (16%) were in need of major repair, and all of the remainder needed minor repair.[309]

3. *ATSIC Wunan Regional Council: Regional Plan 2004-2007* (2004)

- *Health services:* need for functioning, effective and efficient Aboriginal Health Services in the region; Patient Management Plans and Patient Recall Systems; regular specialist visits to communities.
- *Environmental health:* regular environmental health surveys; environmental health standards; safe and reliable water supplies and; effective dust control.
- *Improved health awareness:* regular screening for chronic diseases; nutrition and healthy lifestyles programs; healthy food available at reasonable prices.[310]

306 Atkinson, D., Bridge, C., and Gray, D., *Kimberley Regional Aboriginal Health Plan*, The University of Western Australia, Nedlands, 1999, p84, Recommendation 27, p7.

307 *ibid.,* p85, Recommendation 31.

308 *ibid.,* p78, Recommendation 6. Note also that in the 1992 and 1999 Community Housing and Infrastructure Needs Surveys and the 1997 WA Environmental Health Needs Survey, the East Kimberley region was reported as having the greatest Aboriginal housing need of all WA regions and quantifications of that need occurred. Taylor, J., *Aboriginal Population Profiles for Development Planning in the Northern East Kimberley,* Centre for Aboriginal Economic Policy Research, Research Monograph No. 23, Australian National University, Canberra, 2003, p62.

309 *ibid.,* (Taylor, J.). See also Australian Bureau of Statistics, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities 2001, op.cit.*

310 Atkinson, D., Bridge, C., and Gray, D., *op.cit.,* p6.

4. *WA Environmental Health Needs Survey* (2004)

Sixty three communities from the region were surveyed and further disaggregation to community level is available. Regionally, it reported 76% needed additional housing; 66% of communities had no monthly testing of water supplies; 86% of communities' solid waste dumping area was not well fenced; 70% of communities had no access to a septic tank, or pump out equipment; and 80% of communities had no dust suppression program.[311]

5. *Western Australian Aboriginal Child Health Survey* (2005)

This is disaggregated for all ATSIC Regions in WA including the Wunan (Kununurra) ATSIC Region:

- Volume 1 (general health) reported children were significantly reliant on nurses and Aboriginal Health Workers despite higher rates of ear, chest, skin and gastrointestinal infections than reported in Aboriginal children in the rest of WA:[312] only 39% had seen a doctor in the six months prior to the survey compared to 49% for other Aboriginal children.[313] Childrens' diets were found to be poorer, particularly their access to vegetables.[314]
- Volume 2 (emotional and social health) noted the need for strategies to combat family stress[315] and high levels of tobacco, alcohol and marijuana use among children. Of particular concern 21% of children had only a limited understanding of sexual health and contraception.[316]

b) Perth and surrounding area

1. *Nyoongar Health Plan* (1999)

The Plan contained a goal of reducing the ratio of Aboriginal and Torres Strait Islander to non-Indigenous premature deaths from approximately 1:2.5 to 1:1.9 by 2010.[317] It identified as priorities the establishment of an AMS in the Wheatbelt area and the decentralisation of the AMS in Perth to Aboriginal population centres. It recommended that the Aboriginal Health-Related workforce be expanded.[318] Special programs in relation to dental health, alcohol and substance abuse, smoking and pregnant women were identified as needs.[319]

2. *Perth Noongar ATSIC Regional Council Action Plan* (2004)

The plan identifies as needs: accessible and appropriate health services, an address to substance misuse (including health promotion in relation to this) and an address to infant mortality. It sets as a goal the development of a 'Noongar centre for healing' for the healing of 'physical, mental and spiritual injury and disease'.[320]

311 Environmental Health Needs Coordinating Committee, *Environmental Health Needs in Indigenous Communities in Western Australia,* EHNCC, Perth, 2005, p115.

312 Telethon Institute, *The Health of Aboriginal Children and Young People, Wunan (Kununurra) ATSIC Region, Summary of Findings from Volume One of the Western Aboriginal Child Health Survey,* Telethon Institute, Perth, 2005, p9.

313 *ibid.,* p7.

314 *ibid.*

315 Thirty four per cent of Aboriginal children were living in families that had experienced 'high stress events' compared to 22% across WA. Telethon Institute, *The Social and Emotional Well-being of Aboriginal Children and Young People, Wunan (Kununurra) ATSIC Region, Summary of Findings from Volume Two of the Western Aboriginal Child Health Survey,* Telethon Institute, Perth, 2005, (no page numbers).

316 *ibid.*

317 Western Australian Aboriginal Health Joint Planning Forum, *Nyoongar Health Plan,* WAAHJF, Perth, 1999, pp33-37.

318 *ibid.,* p73.

319 *ibid.,* pp47-52.

320 Perth Noongar ATSIC Regional Council, *Regional Plan,* ATSIC, Perth, 2004, pp7-9.

3. *WA Environmental Health Needs Survey* (2004)

Three communities (non-metropolitan) were surveyed and disaggregation to community level is available. The main needs related to transport and access to services; and an address to waste disposal; dust suppression and dog programs.[321]

4. *Western Australian Aboriginal Child Health Survey* (2005)

- Volume 1 (general health) reported more children in the region had seen doctors in the six months prior to the survey that in the rest of WA and were less reliant on nurses and AHWs (56% in Perth compared to 49% in WA).[322]
- Volume 2 (emotional and social health) noted the need for strategies to combat family stress and high levels of tobacco, alcohol and marijuana use among children.[323]

Solution Brokers in ICCs and 'ICC Contact Officers' in state offices of the Department of Health and Ageing are well placed to bring this experience and information to the process.

ii) Engaging with the Aboriginal community controlled health sector

The new arrangements should also build upon the significant community resources and capacity that exists through the Aboriginal community controlled health sector. Aboriginal medical services are often at the centre of community life. They provide a valuable tool for engaging with communities as well as providing basic information to communities about the new government processes.

Aboriginal primary health care providers would also be able to identify strategies and processes that are complementary and additional to the delivery of health services to the community, such as sport and recreation activities or support for governance and capacity building among sections of communities. *These are the types of activities that would be amenable to local level agreements and trials of new activities.*

Relationships should be developed between Aboriginal Community Controlled Health Organisations and ICCs at the regional level. These could be advanced through the negotiation of Regional Partnership Agreements. This could also be advanced by negotiating with the peak representatives of Aboriginal Community Controlled Health Organisations such as state and territory affiliates of the National Aboriginal Community Controlled Health Organisation (NACCHO).

I note that this may place additional burdens on Aboriginal Community Controlled Health Services. NACCHO had expressed concern about the potential implications of this to the Senate Inquiry into the abolition of ATSIC. They noted that 'mainstreaming' may have adverse effects on the Aboriginal Community Controlled Health sector through:

- Increased demands on the sector for consultation, advice and coordination from several government departments.

321 Environmental Health Needs Coordinating Committee, *op.cit.,* p149.

322 Telethon Institute, *The Health of Aboriginal Children and Young People, Perth Noongar ATSIC Region, Summary of Findings from Volume One of the Western Aboriginal Child Health Survey,* Telethon Institute, Perth, 2005, p9.

323 Telethon Institute, *The Social and Emotional Well-being of Aboriginal Children and Young People, Perth Noongar ATSIC Region, Summary of Findings from Volume Two of the Western Aboriginal Child Health Survey,* Telethon Institute, Perth, 2005, (no page numbers).

- The lack of Aboriginal and Torres Strait Islander focus, experience and knowledge in mainstream government departments.
- The operation of staff from departments who do not have an Aboriginal and Torres Strait Islander focus and will compete with a 'broader policy agenda' will find it difficult to prioritise Indigenous issues.
- The lack of coordination among departments and levels of government when responding to Aboriginal and Torres Strait Islander health issues.
- The difficulty in developing policy expertise and experience in the area of Aboriginal and Torres Strait Islander issues when it is seen as a tertiary part of a department's activities.
- The poor present and historical record of government departments in addressing Aboriginal and Torres Strait Islander disadvantage.[324]

iii) Shared Responsibility Agreements and health promotion

A number of the Shared Responsibility Agreements and other funding initiatives have already been introduced that involve activities that are intended to have a significant health benefit.[325] These include the 'no school, no pool' policy; provision of sport and recreation facilities or equipment; support for market gardens and nutrition programs; through to support for women's groups and child care services.

Text Box 16 below provides a case study of the type of program that is susceptible to coordinated federal government engagement, including through Shared Responsibility Agreements. The Community Stores Program was initiated by the Jawoyn Association in the Katherine region of the Northern Territory in partnership with the Fred Hollows Foundation in 1999. This has seen the federal government work with the private sector and non-government sector to improve food quality and availability. It has the potential to be extended into other communities and regions.

Text Box 16: Nyirranggulung Nutrition Project

The *Nyirranggulung* ('all together as one mob') *Nutrition Project* is an umbrella name for a number of programs that aim to secure long-term improvements in nutrition in communities, in particular by increasing the availability of affordable, nutritious food.

It involves a school meals program, developed and run by a local Women's Centre and sustained through deductions from family allowances paid through Centrelink. The Fred Hollows Foundation has provided a cool room and commercial cooking facilities for the program.

Accessible nutrition advice is also provided through the appointment of a nutritionist, based at the Sunrise Health Service, to advise families, stores and take-away outlets and the school meals program.

324 National Aboriginal Community Controlled Health Organisation, *Submission to the Senate Select Committee on the Administration of Indigenous Affairs,* August 2004, p8, available online at http://www.naccho.org.au/SenateCommittee.html.

325 An overview of finalised Shared Responsibility Agreements is provided in Chapter 3 of this report.

It also involves the Community Stores Program.

For the past two years, Woolworths Limited has provided an experienced store manager to mentor, train and advise community store management committees, local managers and staff in the Jawoyn communities. As a result, the two major communities in the region have regained control of their stores and transformed them in just over 18 months.

Store committees have developed a range of relevant store policies which have been documented in a regularly updated Stores Procedures Manual – for example, "book up" (or credit) is limited to aged pensioners and kept to $50.00 per person; alcohol sales are restricted to certain hours and can limits strictly enforced; healthy foods are priced at cost recovery only; and store operational and management systems have been improved.

There had also been significant increases in employment. In one community this had created an additional $120,000 in wages over eight months. Stores have progressively turned around debt and made profits; local Aboriginal managers and staff have received accredited training; store infrastructure, such as refrigerated display units, have been upgraded, enabling stores to stock a full range of affordable, quality fresh produce including fresh fruit, meat, vegetables and dairy products; and a broader range of goods that support health such as refrigerators, washing machines, shoes and clothing are now for sale.

Commonwealth Government funding of $1.5 million in 2004 enabled the program to be extended to the communities in the west of Katherine and in Central Australia.

Eventually, it is hoped that the program will reach other regions in the north of South Australia and Queensland. It is anticipated that other food retailers will also participate in the program in the future.[326]

Shared Responsibility Agreements (SRAs) provide a significant opportunity to advance non-health sector issues which impact on Aboriginal and Torres Strait Islander health status. They are able to target social determinants of health, as well as support partnership approaches to addressing some issues relating to infrastructure provision and management within communities.

While SRAs are appropriate for targeting social determinants of health and supporting some (non-essential) infrastructure provision, there are limits on when they should be used.

Principles relating to the making of Shared Responsibility Agreements from a human rights perspective are set out in Chapter 3 of this report and apply to the making of agreements relating to health issues. These principles note the following:

> The Committee on Economic, Social and Cultural Rights has identified the following as included within core minimum obligations that would not be appropriate for inclusion within SRAs:
>
> – access to the minimum essential amount of water, that is sufficient and safe for personal and domestic uses to prevent disease;
> – physical access to water facilities or services that provide sufficient, safe and regular water;

326 Fred Hollows Foundation, *The Fred Hollows Foundation Welcomes Federal Government Support of $1.5 Million for Remote Indigenous Community Stores Program,* Media release, 12 June 2004, available online at http://www.hollows.org/upload/9400.pdf.

- measures to prevent, treat and control diseases linked to water, in particular ensuring access to adequate sanitation;[327]
- the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;[328]
- basic shelter, housing and sanitation;[329] and
- essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs.[330]

Respecting, protecting and fulfilling rights: Governments are obliged to fulfil all human rights. *Fulfilling* human rights is a positive obligation that places an onus on governments to ensure that human rights subject matters (such as water, food and housing) are provided to its population and that they are equally accessible to different population groups.[331]

Accordingly, SRAs must respect human rights and protect the rights of Indigenous peoples from third party abuse. But they may also be used to fulfil Indigenous peoples' enjoyment of human rights. The United Nations Committee on Economic, Social and Cultural Rights has provided the following illustrations of measures to fulfil economic, social and cultural rights:

- In relation to *food:* proactively engaging in activities intended to strengthen people's access to and utilisation of resources and means to ensure their livelihood, including food security.[332]
- In relation to *water:* to take steps to ensure that there is appropriate education concerning the hygienic use of water, protection of water sources and methods to minimize water wastage.[333]
- In relation to *health:* taking positive measures that enable and assist individuals and communities to enjoy the right to health, and undertake actions that create, maintain and restore the health of the population. This includes: disseminating appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; and supporting people in making informed choices about their health.[334]

  SRAs should not be used to negotiate the delivery of primary health care access or the delivery of essential infrastructure provision – such as water supply, sanitation and sewerage.

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327 United Nations, *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies,* UN Doc. HRI/GEN/1/Rev.6, 2003, p113, para 37, (United Nations Committee on Economic, Social and Cultural Rights, General comment 15: the right to water). United Nations Committee on Economic Social and Cultural Rights, *General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), op.cit.,* para 43.

328 *ibid.*

329 *ibid.*

330 *ibid.*

331 Governments also have obligations to respect and protect human rights. *Respect* for human rights places an onus on governments to restrain itself from acting in a manner that breaches human rights. *Protecting* human rights places an onus on governments to monitor and regulate the behaviour of non-government parties to ensure that they do not breach human rights.

332 United Nations, *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, op.cit.,* p66, para 15 (United Nations Committee on Economic, Social and Cultural Rights, General comment No. 12: the right to adequate food).

333 *ibid.,* p112, para 25 (United Nations Committee on Economic, Social and Cultural Rights, General comment 15: the right to water).

334 United Nations Committee on Economic Social and Cultural Rights, *General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), op.cit.,* paras 36-37.

NACCHO have also argued that state government *core minimum obligations* could include disease control responsibilities under their relevant Public Health Acts. The responsibility for trachoma control, rheumatic fever and a range of other communicable diseases is a core obligation. However, there is little accountability, benchmarking and forward targeting for this activity.

In relation to the Shared Responsibility Agreement with the Mulan community, NACCHO note:

> The problem with the Mulan agreement is that it includes the provision of government services which are already required under the WA Health Act (1911) and should be delivered regardless of the SRA. In other words, unlike every other Australian town or community, this particular community has to sign an agreement to receive these government services. It would be an outrage if any other rural or remote town had to sign an agreement with the government before public health authorities would evaluate disease control and environmental health standards. These are required under Public Health Acts and are a mandatory responsibility of State governments. Most analysts have not examined this fundamental issue and have focused only on the obligations required in order to obtain petrol bowsers, not the obligations required for the provision of services (required under the Act).
>
> In addition, there is a focus on the obligation to "ensure children shower daily and wash their faces twice a day." There are other obligations placed on communities which are not often alluded to. These include actions to prevent petrol sniffing amongst others. Efforts to prevent petrol sniffing are a huge ask! What would constitute an effort? How would a community know what would be the best approach? What funding would be provided to assist this community to implement such a public health intervention? These questions are relevant in freely choosing to participate. It is difficult to speculate on the discussions which must have ensured around this agreement but it is likely that there was some degree of coercion and misunderstanding from both partners in the transaction.
>
> Clearly a community can agree to do whatever it wants in exchange for goods and services, but perhaps the question should be – is the transaction ethical, acceptable and evidence-based? From a public health analysis, the evidence underpinning a community obligation is paramount. A policy analyst should be asking, what is the evidence for face washing in the prevention and disease control of trachoma? If the community undertook these actions, given it is so difficult to mandate by local council, would trachoma rates be reduced? Unfortunately, the answer is no (there is an abundance of literature on this matter which shows that face washing alone does not affect trachoma rates – the SAFE approach is necessary). So, is this Mulan Agreement setting up the community to fail? Will it be judged by the media as having failed on its agreement with government if trachoma is still endemic? There are a number of appalling consequences in a non-evidence-based approach to SRAs.[335]

335 Unpublished NACCHO policy paper. Information provided by NACCHO to the Aboriginal and Torres Strait Islander Social Justice Commissioner.

Similarly, the Office of Aboriginal and Torres Strait Islander Health within the Department of Health and Ageing should remain firmly fixed on expanding primary health care services and implementing existing health programs such as *Healthy for Life*. We should not see resources diverted from this approach to SRAs. The placement of solution brokers from the Department of Health and Ageing within ICCs will, however, be of great benefit in ensuring that the experience and frameworks of the health sector are able to be incorporated and utilised in the Shared Responsibility Agreement process and in the establishment of Regional Partnership Agreements. Funds should be made available to do both.

At the National Reconciliation Workshop in Canberra in May 2005, the Prime Minister stated:

> I simply, along with I'm sure all of you, want an Australia where an Aboriginal child - whether born in a remote community or in one of our cities or in regional centres - can grow up and reach their full potential in life. I want that child to be loved and nurtured and morally guided, to be healthy, educated, optimistic, ambitious and to feel a full part of the Australian community. Economic opportunity and prosperity and social stability and cohesion; these goals I sometimes talk about [are] as relevant to our first citizens and to that Aboriginal child…. as … to the rest of our society…
>
> The journey towards reconciliation will only be complete when Indigenous Australians enjoy the same opportunities as other Australians. And that frankly is going to take a very long time. And… we do ourselves harm if we impose unrealistic time limits on what can be achieved...
>
> I am a realist and the work of reconciliation will be the work of generations. And it does require… a long term commitment. But as well as being a realist I'm an optimist… I believe in the human spirit and I believe in the potential of individuals and of families and of communities not only in Indigenous Australia but all around our great country. I'm an optimist because I believe very much in the courage shown by many Indigenous leaders; individuals with the courage to challenge conventional thinking, to promote economic opportunity, wealth creation and self-reliance; to assert the view that individual responsibility on the part of Indigenous Australians is as much a part of the reconciliation process as is the discharge of government responsibilities in the name of the rest of the Australian community.
>
> And finally I'm an optimist because I believe in the essential decency, fairness and egalitarianism of the Australian people. It is not always on perfect display and there are some that do that notion shame. But fundamentally it is at the core of the way in which Australians live their lives. And the reason why the notion of reconciliation, however inadequately and differently expressed, has survived and how a gathering as representative of people who care about the future of the Indigenous people of Australia as this gathering - the reason why it has come together is I believe a reflection of that innate decency, fairness and egalitarianism.[336]

There is no larger challenge to this sense of decency, fairness and egalitarianism than the current status of Aboriginal and Torres Strait Islander health.

Addressing inequality in health status is not insurmountable, although it will require long term action and commitment. Committing to a 25 year time frame to achieve this is feasible. It is also a long time in which to accept that inequality would continue to exist.

But history shows us that an absence of targeted action and a contentedness that we are 'slowly getting there' is not going to result in the significant improvements in health status that Aboriginal and Torres Strait Islander peoples deserve – simply by virtue of the fact that we are members of the human race and of the Australian community.

336 Prime Minister, *Address at the National Reconciliation Planning Workshop,* Transcript, 30 May 2005, available online at: www.pm.gov.au/news/speeches/speech1406.html.

We have an unprecedented opportunity to make this happen due to the solid work in the health sector over the past decade and the new coordinated service delivery processes. But we do need to augment current efforts.

Accordingly, I have chosen to make the following recommendations to achieve long term commitments to the goal of health equality for Aboriginal and Torres Strait Islander peoples within a generation. My Office will follow up these recommendations up with governments over the next twelve months, and through consultation with Aboriginal Community Controlled Health Organisations and their representatives, Aboriginal and Torres Strait Islander peoples, the non-government and private sector.

Recommendations

Recommendation 1: A commitment to achieve Aboriginal and Torres Strait Islander health equality

That the governments of Australia commit to achieving equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years.

Recommendation 2: Supporting commitments and processes to achieve equality of health status

a) That the governments of Australia commit to achieving equality of access to primary health care and health infrastructure within 10 years for Aboriginal and Torres Strait Islander peoples.

b) That benchmarks and targets for achieving equality of health status and life expectation be negotiated, with the full participation of Aboriginal and Torres Strait Islander peoples, and committed to by all Australian governments. Such benchmarks and targets should be based on the indicators set out in the *Overcoming Indigenous Disadvantage Framework* and the *Aboriginal and Torres Strait Islander Health Performance Framework*. They should be made at the national, state/ territory and regional levels and account for regional variations in health status. Data collection processes should also be improved to enable adequate reporting on a disaggregated basis, in accordance with the *Aboriginal and Torres Strait Islander Health Performance Framework*.

c) That resources available for Aboriginal and Torres Strait Islander health, through mainstream and Indigenous specific services, be increased to levels that match need in communities and to the level necessary to achieve the benchmarks, targets and goals set out above. Arrangements to pool funding should be made with states and territories matching additional funding contributions from the federal government.

d) The goal and aims of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* be incorporated into the operation of Indigenous Coordination Centres and the new arrangements for Indigenous affairs. This includes through reliance on the outcomes of regional planning processes under the Aboriginal Health Forums.

Recommendation 3: Endorsement of this commitment by all Australian Parliaments

That the Australian Health Minister's Conference agree a *National Commitment to achieve Aboriginal and Torres Strait Islander Health Equality* and that bi-partisan support for this commitment be sought in federal Parliament and in all state and territory parliaments.

This commitment should:

- acknowledge the existing inequality of health status enjoyed by Aboriginal and Torres Strait Islander peoples;
- acknowledge that this constitutes a threat to the survival of Aboriginal and Torres Strait Islander peoples, their languages and cultures, and does not provide Aboriginal and Torres Strait Islander peoples with the ability to live safe, healthy lives in full human dignity;
- confirm the commitment of all governments to the *National Strategic Framework* and the *National Aboriginal Health Strategy* as providing over-arching guidance for addressing Aboriginal and Torres Strait Islander health inequality;
- commit all governments to a program of action to redress this inequality, which aims to ensure equality of opportunity in the provision of primary health care services and health infrastructure within ten years;
- note that such a commitment requires partnerships and shared responsibility between all levels of government, Aboriginal and Torres Strait Islander peoples and communities, non-government organisations and the private sector;
- acknowledge that additional, special measures will be necessary into the medium term to achieve this commitment;
- acknowledge that significant advances have been made, particularly in levels of resourcing, since 1995 to address this situation;
- commit to celebrate and support the success of Aboriginal and Torres Strait Islander peoples in addressing health inequality;
- accept the holistic definition of Aboriginal and Torres Strait Islander health and the importance of Aboriginal community controlled health services in achieving lasting improvements in Aboriginal and Torres Strait Islander health status;
- commit to engage the full participation of Aboriginal and Torres Strait Islander peoples in all aspects of addressing their health needs;
- commit to continue to work to achieve improved access to mainstream services, alongside continued support for community controlled health services in urban as well as rural and remote areas; and
- acknowledge that achieving such equality will contribute to the reconciliation process.