

Closing the Gap in child mortality: Ten years on.

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In 2008, the Council of Australian Governments committed to 'Closing the Gap' between the health of Indigenous and non-Indigenous Australians. One of the key targets under this strategy was to halve the gap in mortality rates of Indigenous children under 5 years of age, within a decade. Now in 2018, 10 years on, it's now time to reflect on this ambitious target.

Child mortality and Closing the Gap

The death of any child is devastating to parents, families and the community.

Australia has made some progress in reducing Aboriginal and Torres Strait Islander child mortality, but more work needs to be done.

As researchers of the Aboriginal and Torres Strait Islander Health Program at the National Centre of Epidemiology and Population Health, we measure how common child death is by calculating the child mortality rate, which is the number of children dying in a given time period. We then divide this number by the total population of children at that time. Mortality rates are reported as the number of deaths per every 100,000 children in a given time period.

We can compare the mortality rate of two populations (such as the Aboriginal and Torres Strait Islander population and the non-Indigenous population) using measures such as the 'mortality rate difference' and the 'mortality rate ratio'. These measures look at how Aboriginal and Torres Strait Islander child mortality is changing *relative to* non-Indigenous child mortality. These are the key indicators used to measure progress against the 'Closing the Gap' 2018 target.

Ten years on: what have we achieved?

The amount of progress the country has made in reducing Aboriginal and Torres Strait Islander child mortality depends on how you look at the data.

We compared data from 2008, when the Closing the Gap strategy was announced, to the most recent available data, from 2016. The mortality rate for Aboriginal and Torres Strait Islander children under 5 years decreased between 2008 and 2016, and so did the mortality rate for non-Indigenous children overall. However, even when the Aboriginal and Torres Strait Islander under 5 mortality rate is decreasing, the 'gap' will increase if the non-Indigenous mortality rate is decreasing faster.

When we focus on the 'gap' alone, we can lose sight of progress that is occurring.

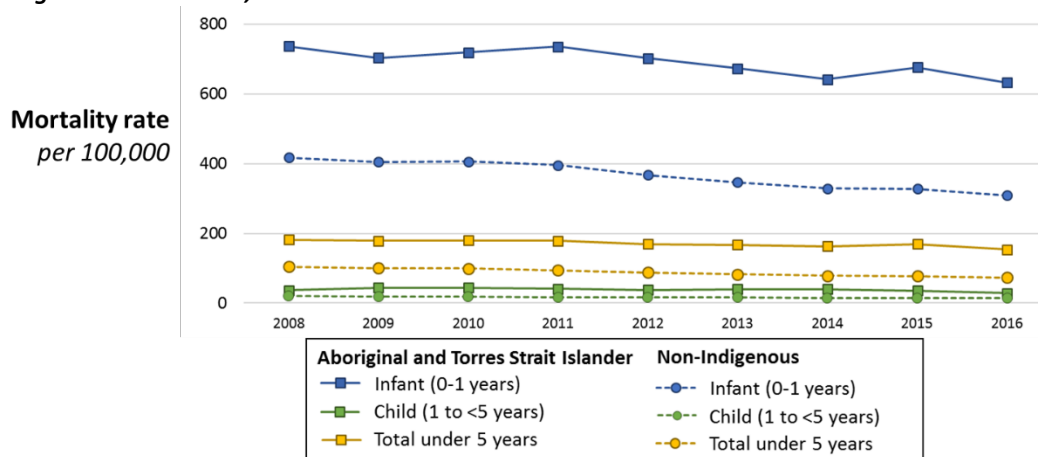
Aboriginal and Torres Strait Islander child deaths account for more than 10% of all child deaths in Australia, despite the fact that Aboriginal and Torres Strait Islander peoples only make up around 3% of the total population. In 2008, there were 125 deaths of Aboriginal and Torres Strait Islander children under 5 years and 935 deaths of non-Indigenous children under 5 years. In 2016 there were 113 deaths and 726 deaths, respectively.¹

If we look at the Aboriginal and Torres Strait Islander data on its own, we see that the mortality rate for Aboriginal and Torres Strait Islander children under 5 years changed from 181.6 deaths per 100,000 in 2008 to

153.6 deaths per 100,000 in 2016 (Figure 1). This means the under 5 mortality rate was 28.0 deaths per 100,000 population lower in 2016 compared to 2008.

The non-Indigenous under 5 mortality rate was 104.4 deaths per 100,000 in 2008 and 73.2 deaths per 100,000 in 2016. This means the non-Indigenous under 5 mortality rate decreased by 31.2 deaths per 100,000 population lower in 2016 compared to 2008.

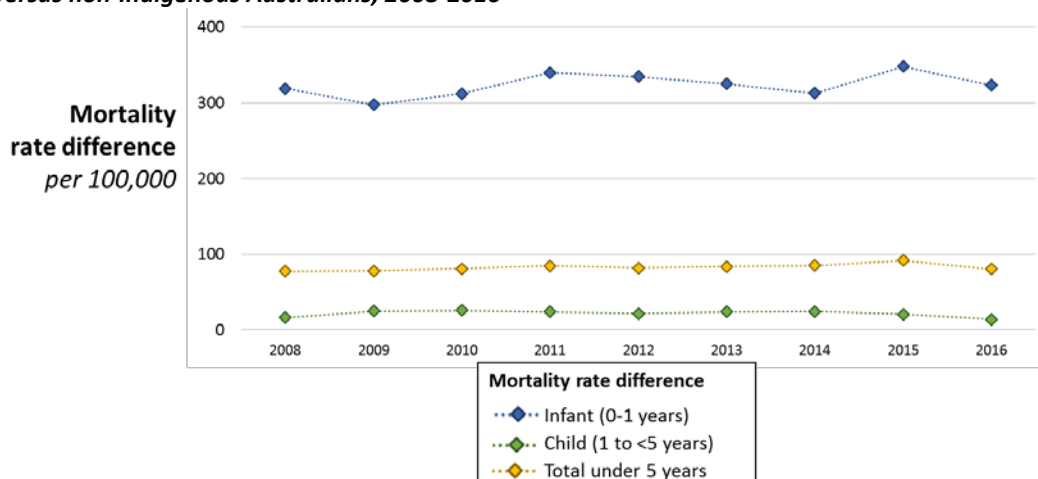
Figure 1. Infant, child and total under 5 mortality rates for Aboriginal and Torres Strait Islander and non-Indigenous Australians, 2008-2016¹



This means that the child mortality rate decreased for Aboriginal and Torres Strait Islander children and for non-Indigenous children. The decrease was similar for non-Indigenous children and Aboriginal and Torres Strait Islander children.

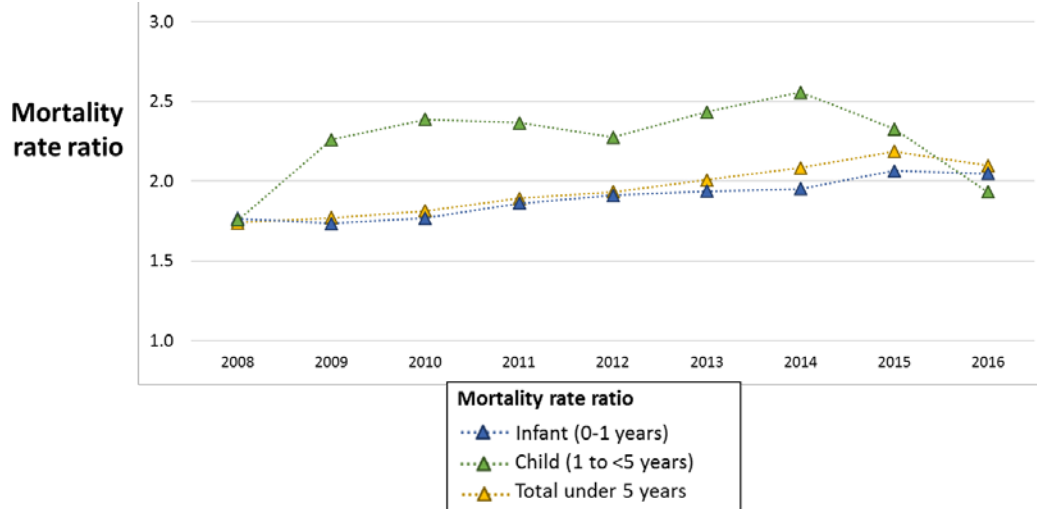
When we look at the absolute difference in mortality rates for Aboriginal and Torres Strait Islander children compared to non-Indigenous children under 5 years, we see that the mortality rate difference was 77.2 deaths per 100,000 in 2008 (181.6 minus 104.4) and 80.4 deaths per 100,000 (153.6 minus 73.2) in 2016 (Figure 2).

Figure 2. Infant, child and total under 5 mortality rate differences for Aboriginal and Torres Strait Islander versus non-Indigenous Australians, 2008-2016¹



When we look at the mortality rate ratio for Aboriginal and Torres Strait Islander compared to non-Indigenous children under 5 years, we see that the mortality rate ratio was 1.7 in 2008 (181.6 divided by 104.4) and 2.1 in 2016 (153.6 divided by 73.2) (Figure 3).

Figure 3. Infant, child and total under 5 mortality rate ratios for Aboriginal and Torres Strait Islander versus non-Indigenous Australians, 2008-2016¹



When we focus on these measures of the ‘gap’ in child mortality, it looks like things are not improving. The ‘gap’ remains similar or, if anything, is getting wider – it is certainly not narrowing.

Why haven’t we seen more progress in child mortality?

Our use of a single measure of under 5 child mortality makes it difficult to see progress where it is occurring.

Current Closing the Gap targets are based on mortality rates for those under 5 years of age which combines infants (0 to 1 year old) with children (1 to less than 5 years old). This is problematic because we see a different story for infant mortality compared to child mortality.

Most of the deaths that happen in the first years of life are infant deaths. For example, in 2016, 98 out of the 113 (87%) Aboriginal and Torres Strait Islander deaths under 5 years were infant deaths.¹ Aboriginal and Torres Strait Islander infant mortality rates have decreased substantially over the past decade (Figure 1), and this is what is largely driving the decrease we see in total under 5 mortality.^{2,3} However, when we combine infants and children together, we dilute the reduction in infant mortality rate, and we overstate the reduction in child mortality rate.

If we look at deaths in the first year of life only, we see that the Aboriginal and Torres Strait Islander infant mortality rate has decreased substantially, from 736.1 deaths per 100,000 in 2008 to 631.8 deaths per 100,000 in 2016 (decrease of 104.3 deaths per 100,000). There was a similar decrease in the non-Indigenous infant mortality rate during that time (416.9 to 308.7, decrease of 108.2 deaths per 100,000).

In contrast, we see a much absolute smaller reduction in child (aged 1 to 5 years) mortality rates during that time period. The Aboriginal and Torres Strait Islander child mortality rate dropped from 37.4 deaths per 100,000 in 2008 to 29.0 deaths per 100,000 in 2016 (decrease of 8.4 deaths per 100,000). The non-Indigenous child mortality rate dropped from 21.3 deaths per 100,000 to 15.0 deaths per 100,000 (decrease of 6.3 deaths per 100,000).

In addition, current Closing the Gap targets are based on deaths due to all causes, but mortality rates and trends vary for different causes of death. By grouping all causes of death together, we lose sight of areas where progress is being made, and areas where more attention is needed. For example, the Aboriginal and Torres Strait Islander infant mortality rate due to sudden infant death syndrome (SIDS) dropped by half between 2002-06 and 2008-11. This drop in SIDS was responsible for a quarter of the total drop in the infant mortality rate for that time period.³ We have seen less progress in other causes of infant deaths, such as respiratory diseases and injury/poisoning,³ which may require additional policy and program focus.

Change takes time

Change (health improvement) does not occur immediately after a strategy such as Closing the Gap is announced. There is a delay between when the strategy is announced and when programs hit the ground, when these programs improve health behaviours and health resources, when this translates to improved health outcomes, when data become available to monitor changes in these health outcomes, and when findings are communicated to stakeholders.^{2,3} Ten years on, we are just now at the stage that we may be able to measure improvements in mortality rates resulting from programs implemented under the Closing the Gap strategy.^{2,33}

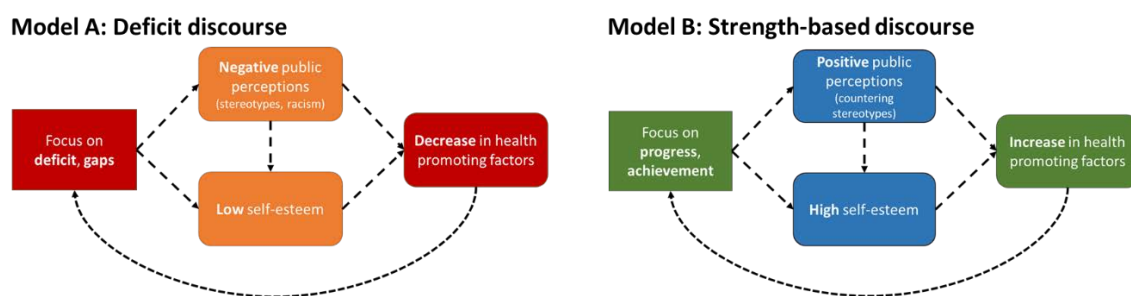
How we talk about Closing the Gap matters

In addition to the issues described above, the Closing the Gap rhetoric is problematic because it focuses on Aboriginal and Torres Strait Islander health relative to non-Indigenous health. According to the current metrics, we can only 'close the gap' if Aboriginal and Torres Strait Islander health improves *more quickly* than non-Indigenous health improves. This is a fundamental flaw. While the 'gap' between Aboriginal and Torres Strait Islander and non-Indigenous health certainly has value as a benchmark, it should not be the only way we measure progress in improving Aboriginal and Torres Strait Islander health. We also need to track what is happening *within* the Aboriginal and Torres Strait Islander population.

How we talk about Closing the Gap matters because focus on the persisting gap can have detrimental impacts on the wellbeing of Aboriginal and Torres Strait Islander peoples (Figure 4).⁴ For example, negative reporting perpetuates negative stereotypes about Aboriginal and Torres Strait Islander peoples, and can fuel and galvanise discrimination and racism. It can also impact negatively on the self-esteem and the emotional health of Aboriginal and Torres Strait peoples, as they continue to hear negative stories about themselves, their families and communities. This can then influence health behaviours. For example, because of discrimination, Aboriginal people may avoid using health services, or they might not receive best-practice medical care when they do. It can also affect the public appetite for programs, particularly if the impression is given that no progress is being made. This can create a cycle, where the constant focus on gaps can actually make the gaps bigger – and perpetuate inequality.

This is why we also need to focus on improvements that are occurring *within* the Aboriginal and Torres Strait Islander population, as well as keeping an eye on the 'gap'. Examples of progress include large declines in smoking prevalence, cardiovascular mortality, and infant mortality. Such achievements should be accessible as a source of pride to communities, and communicating these improvements may feed additional improvement.

Figure 4. Potential impacts of deficit discourse versus strength-based discourse on Aboriginal and Torres Strait Islander health and wellbeing



Are current Closing the Gap targets achievable?

There are no biological impediments to achieving equality in health outcomes for Aboriginal and Torres Strait Islander peoples.

To improve Aboriginal and Torres Strait Islander health and close the gap:

- We must stay the course, with enhanced and sustained investment over the long-term.
- We must set targets that are evidence-based. We need to maintain current measures but also include more sensitive measures that tell us about improvement *within* the Aboriginal and Torres Strait Islander population.

- We should track progress against intermediate indicators that can change over a shorter time frame, in addition to our primary indicators (such as mortality rates) which take a longer time to change.
- We need to use rigorous and transparent methods to measure change over time.

Note: *The mortality rate difference is the absolute difference of the two mortality rates (Aboriginal and Torres Strait Islander child mortality rate minus non-Indigenous mortality rate). The mortality rate ratio is the ratio of Aboriginal and Torres Strait Islander mortality relative to non-Indigenous mortality rate (Aboriginal and Torres Strait Islander child mortality rate divided by non-Indigenous mortality rate).*

References

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4. Nicholson RA, Kreuter MW, Lapka C, et al. Unintended effects of emphasizing disparities in cancer communication to African-Americans. *Cancer Epidemiology and Prevention Biomarkers* 2008;17(11):2946-53.