

National Strategic Framework for Aboriginal and Torres Strait Islander Health

Context

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ABOUT THE National Strategic Framework for Aboriginal and Torres Strait Islander Health

Background

The 1989 *National Aboriginal Health Strategy* (NAHS) was a landmark document in Aboriginal and Torres Strait Islander health policy. The principles underpinning the 1989 NAHS are still vital today. It was developed following a comprehensive and inclusive national consultation process and is therefore widely owned by Aboriginal and Torres Strait Islander peoples. As a critical document articulating Aboriginal and Torres Strait Islander peoples' health aspirations and goals within a rights based framework, it is extensively used by health services and service providers and continues to guide policy makers and planners.

Since 1989, and consistent with the NAHS recommendations, there have been significant changes to the structures within which Aboriginal and Torres Strait Islander health policy and planning is addressed. In particular, partnerships have been developed between the Commonwealth, State and Territory governments, the Aboriginal and Torres Strait Islander Commission (ATSIC), the Torres Strait Regional Authority (TSRA) and affiliates of the National Aboriginal Community Controlled Health Organisation (NACCHO). These partnerships identify the roles and responsibilities of each, common aims and approaches and allow for reporting against agreed national indicators of progress.

This *National Strategic Framework* is not a replacement of the 1989 NAHS. It is a complementary document, which addresses contemporary approaches to primary health care and population health within the current policy environment and planning structures. It aims to guide government action over the next ten years through a coordinated, collaborative and multi-sectorial approach supported by Aboriginal and Torres Strait Islander health stakeholder organisations.

Development

This *National Strategic Framework* was developed following consultation on the *National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion, February 2001*, produced by the National Aboriginal and Torres Strait Islander Health Council (NATSIHC). *The Draft for Discussion* was based on the 1989 NAHS and the report of its 1994 evaluation. It took into account the recommendations of the 1991 *Royal Commission into Aboriginal Deaths in Custody*, the *Bringing Them Home* Report, submissions made to the *House of Representatives Inquiry into Indigenous Health* and its final report entitled *Health is Life*. It also considered existing state and territory, regional and local Aboriginal and Torres Strait Islander health policies, strategies and plans. All these have been fundamental to shaping this *National Strategic Framework*.

NATSIHC comprises members from the Commonwealth Government, the Australian Health Ministers' Advisory Council representing State and Territory governments, NACCHO, ATSIC, the TSRA, the Australian Indigenous Doctors Association, the Congress of Aboriginal and Torres Strait Islander Nurses and individuals with specific expertise appointed by the Commonwealth Minister responsible for health. The chairperson of the National Health and Medical Research Council (NHMRC) also sits on NATSIHC as an ex-officio member. NATSIHC provides advice to the Commonwealth Minister on Aboriginal

and Torres Strait Islander health programs and policies. The majority of its members are Aboriginal or Torres Strait Islander people.

Evidence Base

It is difficult to draw together a comprehensive evidence base from published reports to support approaches in Aboriginal and Torres Strait Islander health. Academic literature has been heavily biased towards largely non-Aboriginal and Torres Strait Islander academics working within well-resourced institutions that have the capacity to publicise their activities. Health services and programs have historically had limited funding and have developed in a climate of such need that service delivery has been given priority over monitoring and evaluation. In the community sector, past experiences with research and researchers has frequently resulted in a legacy of ambivalence and mistrust associated with data collection activities. It is also widely acknowledged that there are large gaps in information and data, that quality of information and data varies significantly from state to state and that current data collections are hampered by under-reporting and non-identification of Aboriginal and Torres Strait Islander status. In the light of this, this document recognises and promotes local programs where less formal evidence of health gain exists. It also acknowledges that while health gain may be evident in the short term, many of these programs have not yet been shown to be sustainable in the longer-term.

The approaches detailed in this *National Strategic Framework* are consistent with State and Territory government policies and plans and are supported by Aboriginal and Torres Strait Islander stakeholder organisations as the way forward for government action into the 21st century. A significant task will be to tackle the shortcomings of existing data and evidence and continue to build a comprehensive evidence base that includes the systematic documentation and reporting of local approaches where sustained health gains are achieved.

Commitment

This document has been endorsed as a plan to guide all Australian governments in a coordinated, collaborative and multi-sectorial approach to improving Aboriginal and Torres Strait Islander health over the next ten years. It has received the support of each government's cabinet committee, providing a whole-of-government commitment to its implementation in each State and Territory and at the Commonwealth level. Whilst it is appropriate that health ministers and health departments take the lead in realising its objectives, areas of action within the portfolio responsibilities of other ministers and departments will be appropriately referred and joint actions taken where required.

An initial joint meeting of NATSIHC and the Standing Committee of Aboriginal and Torres Strait Islander Health will identify which level of government is responsible for progressing each action area and the relevant national performance indicator and/or reporting mechanism by which progress against each action area will be measured. Each jurisdiction will develop and publish its own National Strategic Framework implementation plan against which its progress will be measured. Within the implementation plan, each jurisdiction is responsible for determining its own specific initiatives, priorities and timeframes. This *National Strategic Framework* sets agreed directions for reform in Aboriginal and Torres Strait Islander health without imposing specific targets or benchmarks on individual governments in recognition of the different histories, circumstances and priorities of each jurisdiction. Therefore annual reporting will record progress against each government's implementation plan, consistent with this *National Strategic Framework* and will, over time, chart each government's progress against their own baselines.

Table of contents

Table of contents.....	iii
Index of tables and figures.....	iv
CHAPTER ONE: BACKGROUND.....	1
1.1 Aboriginal and Torres Strait Islander peoples	3
1.2 The arrival of Europeans: health impact on Aboriginal and Torres Strait Islander peoples	4
1.3 Contemporary Aboriginal and Torres Strait Islander health status.....	6
1.4 Policy implications of previous reports.....	13
CHAPTER TWO: CURRENT POLICY CONTEXT.....	17
2.1 The Australian health service delivery system.....	18
2.2 Contemporary national policy and planning structures.....	22
APPENDICES.....	29
List of Appendices	31
Appendix One: Glossary	33
Appendix Two: References.....	39
Appendix Three: Abbreviations used in this document	45
Names of organisations and programs.....	45
Abbreviations of Document Titles Used in this Document	46
Appendix Four: National Aboriginal and Torres Strait Islander Health Council.....	47
Membership and Terms of Reference	47
Appendix Five: Current National Performance Indicators for Aboriginal and Torres Strait Islander Health (National Performance Indicators).....	51
Background.....	51
Current National Performance Indicators for Aboriginal and Torres Strait Islander Health.....	52
Appendix Six: Submissions and Consultations	55
Input to the <i>National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion - Submissions received (2000)</i>	55
Comment on the <i>National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion - Submissions Received (2001)</i>	55
Comment on the <i>National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion - Consultations Conducted (2001)</i>	58
Comment on the <i>National Strategic Framework for Aboriginal and Torres Strait Islander Health – Submissions received from Framework Agreement partners (2002)</i>	59
Appendix Seven: List of Major Reports in Aboriginal and Torres Strait Islander Health	61
Appendix Eight: Examples of Local Level Health Issues, Determinants and Responses.....	65
Appendix Nine: The Australian Health System.....	73
Roles and responsibilities	73
Health Care Delivery in Australia.....	74
Provisions for special needs groups	75
Medicare	75
Pharmaceutical Benefits.....	76
Administration, Consultation and Negotiation Arrangements	76
Funding for Aboriginal and Torres Strait Islander health services	77

Index of tables and figures

Figure 1: Age standardised death rates for selected causes, 1995-97.....	7
Figure 2: Factors impacting on Aboriginal and Torres Strait Islander health status - Interactions of social and physiological determinants of health.....	10
Figure 3: Developmental Model of Chronic Illness in Aboriginal and Torres Strait Islander populations	11
Figure 4: Trends in annual directly standardised all-cause mortality rates for Indigenous people in Australia, the United States, and New Zealand, and for all Australians.....	12
Figure 5: National policy and planning structures	26
Figure 6: Relative mortality rates for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian populations.....	77
Figure 7: Health expenditure on Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian populations, 1998-99, and adjusted for remoteness and health status to show ‘buying power’	78
Figure 8. Estimated government expenditure per person for Aboriginal and Torres Strait Islander peoples and for all Australians by quintile of equivalent family income, 1993-94	79
Figure 9: Source of funding for recurrent health expenditure for Aboriginal and Torres Strait Islander peoples, 1998-99.....	79
Figure 10: Direct Commonwealth, State and Territory Funding for Primary Health Care - 1995/96 (per capita).....	80
Figure 11: Estimated total expenditures per person for Indigenous and non-Indigenous Australians, by area of expenditure 1998-99	80

Chapter One: Background

1.1 Aboriginal and Torres Strait Islander peoples

Aboriginal cultures are numerous and diverse, made up of hundreds of different kinship and language groups that have adapted to enormously diverse living conditions throughout Australia over many thousands of years. Torres Strait Islanders are a separate people with distinct identity and culture. Aboriginal cultures and Torres Strait Islander cultures are still dynamic and evolving and, for Aboriginal and Torres Strait Islander individuals and communities, form the context for the development of health policy.

The Australian Bureau of Statistics (ABS) reports that in 2001, more than half of all Aboriginal and Torres Strait Islander peoples lived in New South Wales (29%) and Queensland (27%), with the majority living in urban areas. Whilst New South Wales had the highest number of Aboriginal and Torres Strait Islander peoples, the Northern Territory had the highest proportion, with about 29% of its population reporting Aboriginal and/or Torres Strait Islander status. One in four of all Aboriginal and Torres Strait Islander peoples live in “remote and very remote” areas compared with 2% of the non-Indigenous population and almost one third in major cities. Therefore, although Indigenous Australians comprise 2.4% of the total population, this proportion varies from 1% in “major cities” to 45% in “very remote” areas. Of the 458,520 people reporting Aboriginal and Torres Strait Islander status following the 2001 Census, about 6% reported that they were of Torres Strait Islander origin and a further 4% reported they were of both Aboriginal and Torres Strait Islander origin.¹

Therefore, Aboriginal people live all over Australia - in remote communities, in rural towns and surrounding areas, and in Australia’s major cities. Torres Strait Islanders live in the Torres Strait and on the mainland in regional and urban locations. The geographic location of people is an important consideration when determining health interventions and responses need to consider local needs and priorities. For example, in the Torres Strait Islands proximity to and traffic of people and wildlife between Papua New Guinea and the islands exposes Torres Strait Island dwellers to a range of complex health problems not experienced to the same degree in other parts of Australia.

In the past the main focus has been on addressing the health needs of people living in remote areas, confining the problem to availability of health services. Whilst this continues to be of fundamental importance, we know that proximity to services does not necessarily equate with greater access as additional barriers to utilising available services exist. These include health service provider attitudes and practice, communication issues, poor cultural understanding and racism. The availability of health services including mainstream health services that are culturally equipped to provide services to Aboriginal and Torres Strait Islander peoples² is one of a number of factors that contribute to improved health. Other determinants of health status include socio-economic status, education, good quality housing and a safe environment.

The 1989 *National Aboriginal Health Strategy* (NAHS) states 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,

¹ Australian Bureau of Statistics and Australian Institute of Health and Welfare (2003). *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples* (ABS & AIHW, 2003)

² Commonwealth Grants Commission 2001, *Report on Indigenous Funding*, Canberra (CGC, 2001)

and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.”³

This definition calls for a holistic approach to health issues. For Aboriginal and Torres Strait Islander peoples health does not just entail the freedom of the individual from sickness but requires support for healthy and interdependent relationships between families, communities, land, sea and spirit. The focus must be on spiritual, cultural, emotional and social well-being as well as physical health.

Therefore, to be effective, the policies and practices of health services must recognise the rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples. Every stage of the development and delivery of health care needs to involve genuine consultation and negotiation processes to determine the most appropriate models of service delivery.

This document recognises these issues and aims to provide a framework for coordinated activity in the mainstream health sector and Aboriginal Community Controlled Health Services (ACCHSs) and across the range of non-health sectors whose contribution is fundamental to making a difference to the health status of Aboriginal and Torres Strait Islander peoples. It also recognises that any national framework for action must be able to be translated into activity at the local, regional and state/territory level to take account of local circumstances and foster local partnerships.

1.2 The arrival of Europeans: health impact on Aboriginal and Torres Strait Islander peoples

All over the world the arrival of Europeans has had a profound impact on the health of Indigenous peoples and Australia is no exception. The impact upon the emotional, social and cultural well-being of individuals and communities was strongly articulated in the 1989 NAHS.⁴

Before first contact, Aboriginal peoples in Australia were responsible for their own health through traditional healing practices and traditional practitioners, linked to spiritual and cultural values. In the Torres Strait, traditional values emphasised the authority of elders, the sea and market garden-based economies⁵ and were supported by a body of customs, traditions, observances and beliefs linked to the island of origin.⁶ Studies suggest that there were probably high rates of infant and child mortality (as there were for Europeans by modern developed country standards), some injuries but little infectious or life-style related disease.⁷

With European occupation came introduced diseases such as smallpox and tuberculosis that decimated the Aboriginal and Torres Strait Islander populations. For example, the smallpox epidemics of 1789 and 1829-31 are reported to have killed approximately half the Aboriginal

³ National Aboriginal Health Strategy Working Party (1989). *National Aboriginal Health Strategy (NAHSWP)*

⁴ Newfong, J in NASHWP, 1989, op.cit

⁵ Torres Strait Regional Authority, 1994, *Corporate Plan 1994-95*, ATSI and TSRA, Canberra (TSRA, 1994)

⁶ House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 1997, *Torres Strait Islanders: a new deal*, Parliament of the Commonwealth of Australia, Canberra (HOR, 1997)

⁷ Franklin MA and White I, in Reid, J & Trompf, P. (eds) *The Health of Aboriginal Australia*. Harcourt Brace Jovanovich Group (Australia) Pty Ltd. 1991

population in the areas affected.⁸ Introduced diseases such as influenza, other respiratory diseases, pneumonia and measles are also recorded as major causes of mortality.⁹ Overcrowding on reserves, missions and stations, poor health care, and elimination of the traditional nomadic family lifestyle that protected against infectious disease, contributed to the impact of imported diseases. Today, poor environmental health standards and introduced diseases persist as significant contributors to Aboriginal and Torres Strait Islander health disadvantage.

Prior to European occupation, both Aboriginal peoples and Torres Strait Islanders had a healthy mixed diet.¹⁰ Since then, many Aboriginal and Torres Strait Islander peoples have lost access to, resource management over, or knowledge of traditional foods and lifestyles which were based on traditional use of, and care for, land, water and sea. On missions, reserves and stations rations focussed on flour, sugar, tea, alcohol and tobacco.¹¹ Loss of traditional foods has continued in the Torres Strait with depletion of food stocks, pollution and use of the land and sea environments for other industrial purposes.¹² Poor nutrition has had a major impact upon incidence of chronic disease and oral health problems of Aboriginal and Torres Strait Islander peoples.

People removed from their lands onto mission, reserves and stations often experienced overcrowded living conditions, poor diet, contact with introduced diseases and lack of adequate health care. In some cases Aboriginal and Torres Strait Islander family groups were broken up and communities were formed that bore little relationship to traditional kinship structures. Until the last few decades legislation supported different systems of wages, rights, education and health and welfare services for Aboriginal peoples than for other Australians. When mainstream systems were extended, there was insufficient attention to ensuring their responsiveness to the needs and wishes of Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander peoples are still the most disadvantaged group of Australians. In a number of communities Aboriginal and Torres Strait Islander peoples do not have adequate access to safe water, housing, power, roads or sewerage, contributing to the burden of ill health. The health statistics for Aboriginal peoples and Torres Strait Islanders are the worst of any group in Australia and worse than those for comparable Indigenous populations overseas.

The sense of grief and loss experienced by generations of Aboriginal and Torres Strait Islander peoples in relation to dispossession, to the disruption of culture, family and community and to the legislated removal of children has contributed to ongoing problems in emotional, spiritual, cultural and social well-being for Aboriginal and Torres Strait Islander individuals, families and communities.

Aboriginal and Torres Strait Islander organisations have been working to address factors in the behaviour of Aboriginal and Torres Strait Islander individuals, families and communities that contribute to poorer health outcomes, such as promoting restrictions on alcohol use and encouraging healthy dietary practices. Within the historical and cultural context this is a

⁸ Sagers, S & Gray, D, *Aboriginal Health & Society: The Traditional and Contemporary Aboriginal Struggle for Better Health*. Allen & Unwin Pty Ltd. 1991

⁹ Thompson, N "Australian Aboriginal Health and Health-Care". *Social Sciences and Medicine*. 18: 1984

¹⁰ Sagers, S & Gray, D in Reid and Trompf, 1991, op.cit

¹¹ Reid and Trompf, 1991 op.cit

¹² House of Representatives Standing Committee on Family and Community Affairs, *Inquiry into Indigenous Health, Discussion Paper*, Parliament of the Commonwealth of Australia, Canberra (HOR 1999b)

challenging task which must be supported by programs to reduce social disadvantage and increase community capacity to manage available health resources.

1.3 Contemporary Aboriginal and Torres Strait Islander health status

1.3.1 Health status of Aboriginal and Torres Strait Islander peoples

Australians in general are one of the healthiest populations of any developed country and have access to a world-class health system. Indigenous Australians in general are the least healthy of all Indigenous populations within comparable developed countries¹³ and have a significantly lower level of access to appropriate health care than non-Indigenous Australians.¹⁴

Current mortality and morbidity data shows that the health of the Aboriginal and Torres Strait Islander population is the worst of any population in Australia, including groups of similar socio-economic status and non-English speaking migrant populations.¹⁵

Figure 1 illustrates the major causes of excess mortality for the Aboriginal and Torres Strait Islander population. Four major health conditions account for the majority of excess deaths: diseases of the circulatory system, respiratory disease, endocrine conditions such as diabetes and injury and poisoning. Other evidence shows life expectancy 21 years for males and 19 years for females below that of other Australians, deaths and low birth weights of new born babies twice as likely, and much higher prevalence of diseases such as diabetes, hypertension, and a range of communicable diseases¹⁶. Rates of non-fatal injury and self-harm, mental illness and harmful substance use are also higher.¹⁷

There is evidence that Aboriginal and Torres Strait Islander populations suffer a disproportionate impact from both increased exposure to environmental hazards and decreased access to environmental health services. Aboriginal and Torres Strait Islander peoples are more likely to live in conditions considered to be unacceptable by general Australian standards. This includes overcrowding, poorly maintained buildings, high housing costs relative to income¹⁸, and a lack of basic environmental health infrastructure, such as adequate sanitation, water supplies and appropriate housing.¹⁹

¹³ Australian Bureau of Statistics, 1997. *Mortality of Aboriginal and Torres Strait Islander Australians*, ABS Occasional Paper 3315.0; Kunitz SJ, 1996, "The History and Politics of US Health Care Policy for American Indians and Alaskan Natives" in *American Journal of Public Health*, 86(10); Statistics New Zealand, Te Tari Tatau 1997, *New Zealand Life Tables 1995-97 – Reference Reports*

¹⁴ Australian Institute of Health and Welfare and Department of Health and Aged Care, *Expenditures on Health for Aboriginal and Torres Strait Islander Peoples, 1998-99 (AIHW, 2001)*; AIHW, *Australia's Health 2000 (AIHW 2000)*.

¹⁵ ABS & AIHW 2003, op. cit

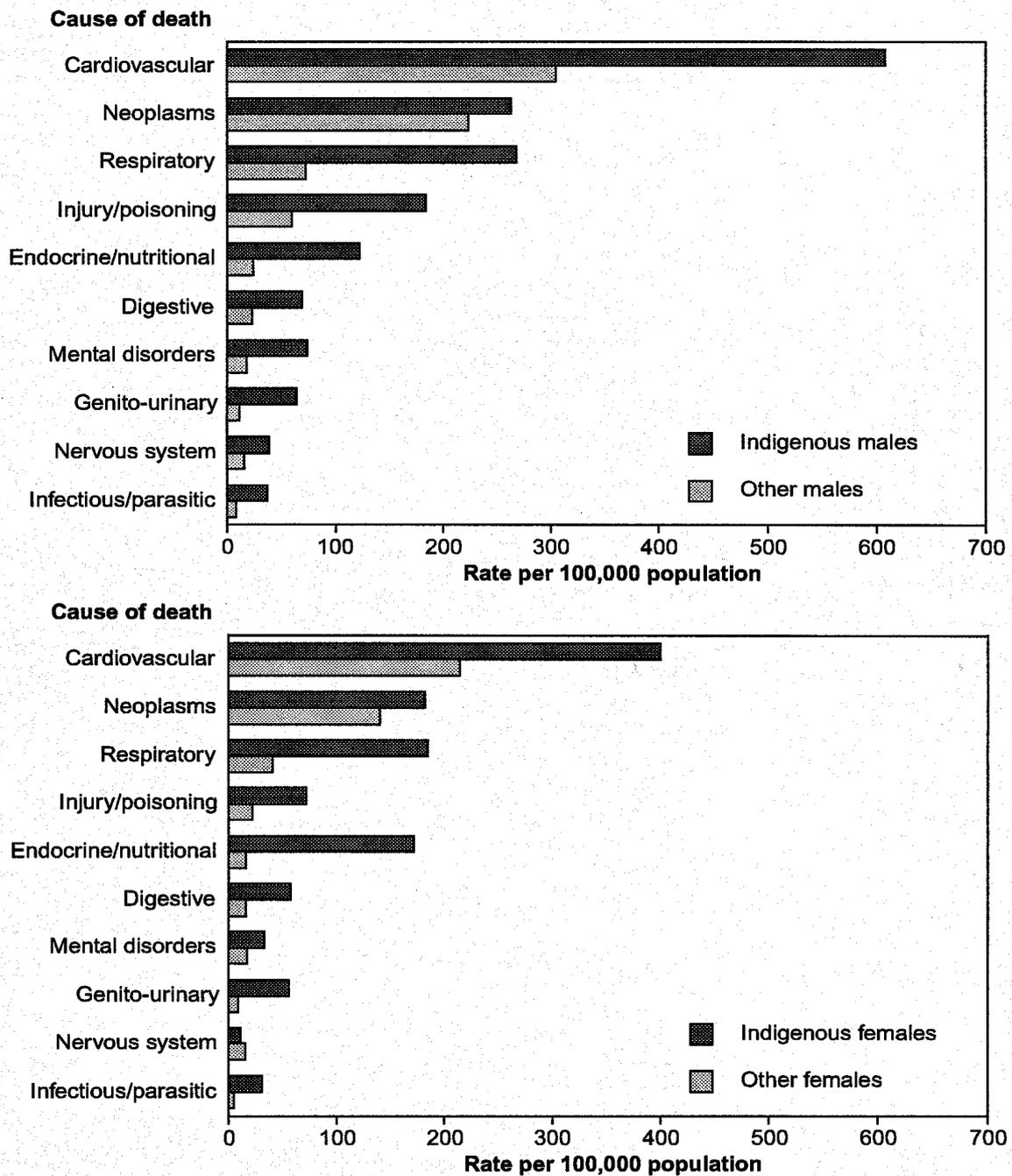
¹⁶ Ibid

¹⁷ Swan P and Raphael B, *Ways Forward: National Consultancy report on Aboriginal and Torres Strait Islander Mental Health*, National Mental Health Strategy, AGPS, Canberra 1995

¹⁸ ABS & AIHW 2003, op cit

¹⁹ For example: National Environmental Health Forum, *Indigenous Environmental Health*, Department of Human Services, Adelaide, 1999; House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 1992. *Mainly Urban: Report of the Inquiry into the needs of urban dwelling Aboriginal and Torres Strait Islander people*, AGPS, Canberra (HOR, 1992)

Figure 1: Age standardised death rates for selected causes, 1995-97²⁰



²⁰ AIHW (2000) op cit

1.3.2 Cumulative disadvantage and health status

International research shows a correlation between low socio-economic status and higher rates of communicable diseases, mental disorder, self-harming behaviour and chronic disease.²¹ Disadvantage and poor health in childhood have particularly been linked to mental health problems, substance misuse and development of chronic health problems in later life.²² Particularly vulnerable populations for increased health risk include children and young people and those who have come into conflict with the law. These social causes are not independent of each other and the cumulative effects of disadvantage multiply.

In the 2001 census the unemployment rate for Indigenous Australians was 22%, compared to 8% for non-Indigenous adults. These figures may underestimate underlying unemployment, as many reported as employed had part time subsidised jobs such as through the Community Development Employment Program. The median weekly income for those who were working was significantly lower in almost every occupation group and every level of qualification whilst education levels were also lower.²³ Indigenous Australians were more likely to live in overcrowded or substandard houses. Torres Strait Islanders were more likely than Aboriginal peoples (and less likely than the general population) to have stayed at school to age 16, but were similarly disadvantaged in terms of employment, housing and income.²⁴

1.3.3 Responding to multiple determinants of health

Figure 2 illustrates the impact of a range of social and environmental factors on health status, and of health risk behaviours such as smoking, alcohol misuse and lack of exercise. Risk conditions such as poverty lead to psychosocial stress reactions which themselves cause physical pathology, and the adoption of unhealthy, stress-coping behaviours such as smoking, personal isolation and unhealthy eating habits.

Studies in Aboriginal communities have shown reductions in clinic presentations following programs to improve housing and environmental health²⁵ and links between environmental hazards and prevalence of particular health conditions. Overcrowded housing has been associated with higher rates of respiratory disease and trachoma, poor water quality with urinary tract infections, and poor sanitation with intestinal parasites, diarrhoea and higher prevalence of anaemia among Aboriginal children.²⁶ Improving housing, water, sewerage, power and waste services to the same standards enjoyed by the broader Australian population can significantly improve Aboriginal and Torres Strait Islander health status.²⁷

²¹ For example Marmot, M “Social determinants of health: from observation to policy”, *Medical Journal of Australia (MJA)*, Volume 172, 2000; Turrell, G and Mathers, CD, “Socioeconomic status and health in Australia”, *MJA*, Vol 172, 2000; Reijneveld SA and Schene AH, Higher prevalence of mental disorders in socioeconomically deprived urban areas”, *J Epidemiol Community Health*, 1998, Vol 52

²² For example Oldenberg B et al, Socioeconomic determinants of health in Australia: policy responses and intervention options” *MJA*, Vol 172; Gulis, G “Life expectancy as an indicator of environmental health”, *Eur J Epidemiol*, Feb 2000 16(2)

²³ ABS & AIHW 2003, op.cit

²⁴ Ibid

²⁵ For example: Pholeros P, Rainow S and Torzillo P (1993), *Housing for health: towards a healthy living environment for Aboriginal Australia*, Health Habitat, NSW; Hardy B (1998) *Ramingining Manyak Wangu Program 1997-98 report*, Ramingining Community Council, Ramingining

²⁶ EnHealth (1999), *The National Environmental Health Strategy*, DHAC 1999

²⁷ Australian National Audit Office 1999, *National Aboriginal Health Strategy – Delivery of Housing and Infrastructure to Aboriginal and Torres Strait Islander Communities*. Audit Report No 39, 1998-99.

Similarly, international research demonstrates that increased education,²⁸ particularly for women, and social equity²⁹ can lead to improved population health. Poor maternal and child health is linked to higher risk of adult chronic disease so that effective antenatal and postnatal services are also an important preventative strategy³⁰. Evidence also exists for links between education and health,³¹ whereby higher education and income levels are correlated with lower use of alcohol and other substances amongst Indigenous Australians.³²

Poor nutrition is related to availability and affordability of healthy food and traditional food sources as well as to advertising of less healthy foods in the media.³³ Food costs in rural and remote areas are a key factor in the determination of food choices in those communities where healthy foods are more expensive and less available than in urban areas. Most of the factors that determine food supply (including transportation, costs, storage, refrigeration, display and health promotion strategies) lie outside the control of the health sector and require the involvement of other sectors to address. *Health is Life*³⁴ observed that improving child nutrition in these areas may involve community stores, food wholesalers, distribution networks, community councils, schools, the media and health services.

Access to health services (particularly specialist services) is hampered by a lack of available and affordable transport not only in remote areas but also in the outer suburbs of some urban communities with poor public transport infrastructure. The 2001 Census shows that Aboriginal and Torres Strait Islander families are less likely than non-Indigenous families to own a motor vehicle³⁵ making them more reliant on public transport. In remote areas, access to services can be affected by the distance and costs incurred in travelling to services, the availability of roadworthy vehicles, the condition of roads and the condition and proximity of airstrips. The Commonwealth Grants Commission found that whilst State and Territory governments provide subsidies for patient transport, there is evidence that these schemes do not operate effectively due to overly restrictive and inconsistent eligibility and payment criteria across jurisdictions.³⁶

Clearly the health sector is only one of a number of portfolios with a responsibility to work in partnership to address the range of issues in a cohesive way. *Section 2.2* outlines the structures currently in place to facilitate partnership approaches to respond to the health needs of Indigenous Australians (*see Figure 5*). *Key Result Areas Five and Six* aim to strengthen and extend those structures to facilitate multilateral approaches to areas such as education, environmental health, housing, employment, nutrition, transport and prison health.

²⁸ White IR et al, "Educational attainment, deprivation-affluence and self reported health in Britain", J Epidemiol Community Health, 1999 Vol 53.

²⁹ Lynch J et al, "Social Capital: Is it a good investment strategy for public health?", J Epidemiol Community Health, 2000, Vol 54.

³⁰ Barker DJP, *Mothers, babies and health in later life*, Second Edition. Sydney, Churchill, Livingstone, 1998.

³¹ Boughton B, *What is the connection between Aboriginal Education and Aboriginal Health*, Cooperative Research Centre for Aboriginal and Tropical Health, Occasional paper Series, Issue No 2, Jan 2000, CRC, Australia

³² ABS & AIHW 2003, op cit

³³ National Health and Medical Research Council, *Nutrition in Aboriginal and Torres Strait Islander Peoples: An Information Paper*, 1 August 2000, NHMRC, Canberra

³⁴ House of Representatives Standing Committee on Family and Community Affairs 2000, *Health is Life: Report of the Parliamentary Inquiry into Indigenous Health*, Parliament of the Commonwealth of Australia, Canberra 2000 (HOR, 2000)

³⁵ ABS & AIHW 2003 op cit.

³⁶ CGC 2001, op cit.

Figure 2: Factors impacting on Aboriginal and Torres Strait Islander health status - Interactions of social and physiological determinants of health

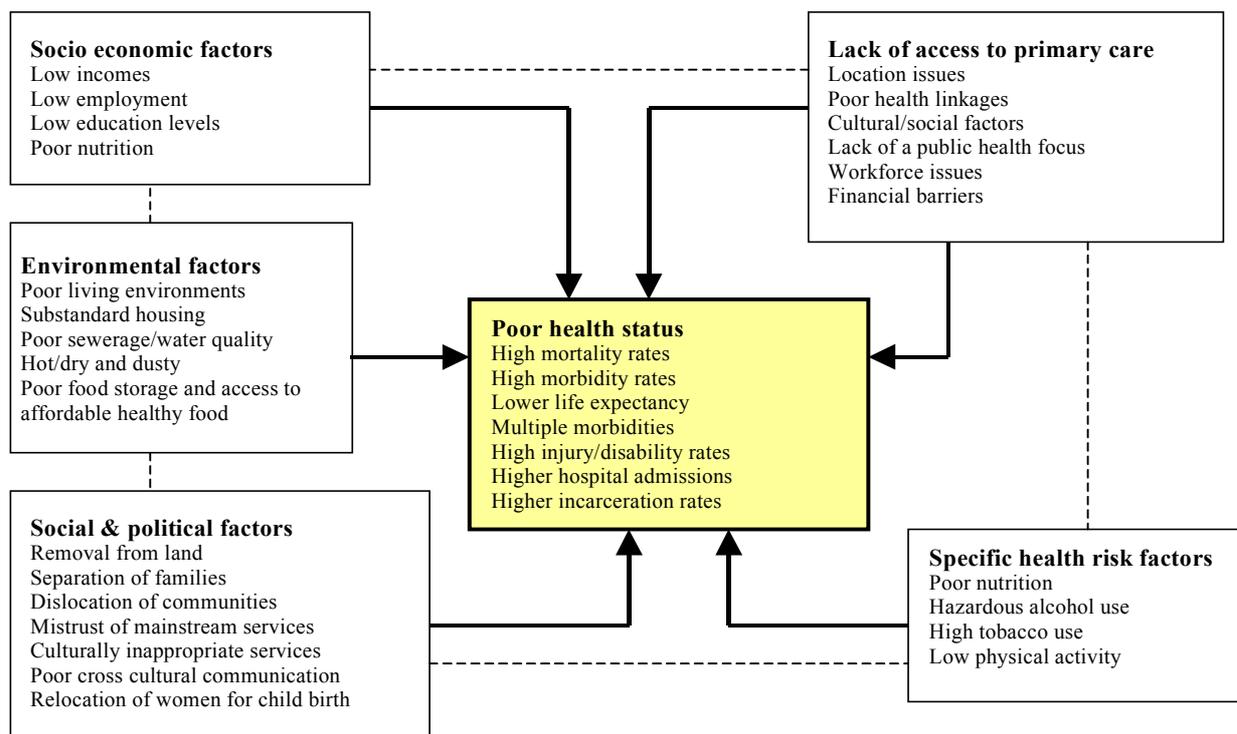


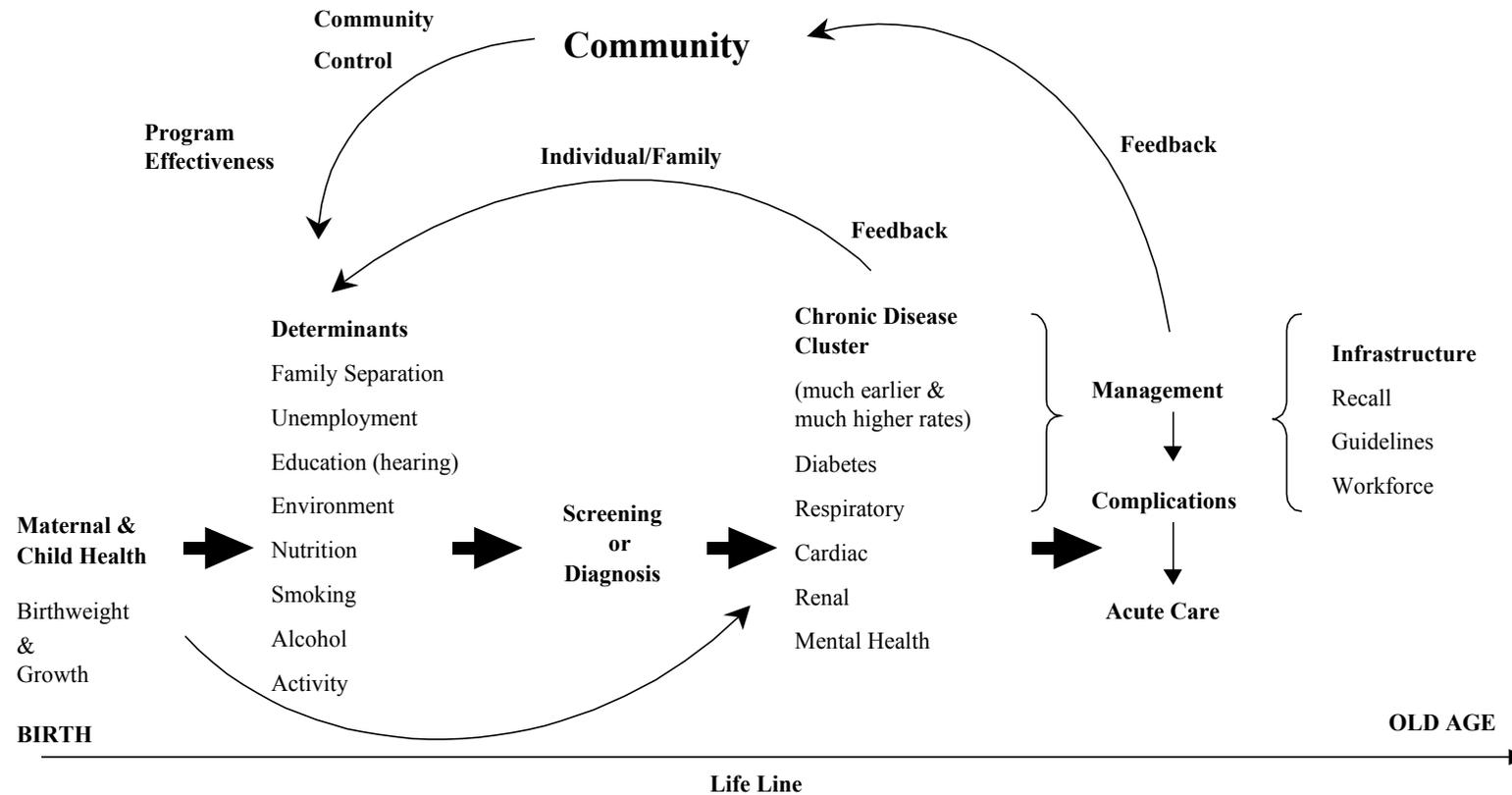
Figure 3 identifies the factors that impact on the earlier development, greater prevalence, and higher rates of disability and death resulting from chronic disease in Indigenous Australians. It identifies determinants and service responses for a range of chronic conditions across life stages such as:

- chronic infections, low birth weight and failure to thrive among children and infants;
- social and emotional problems and substance misuse among young adults; and
- late identification and sub-optimal management of multiple chronic disease in adults.³⁷

The provision of treatment for existing health conditions, particularly chronic disease, mental illness and substance use, provides the basis for identification of local priorities and feedback to communities regarding risk factors. Within this context, comprehensive primary health care provides the opportunity to build on good quality clinical care through early diagnosis and health promotion and illness prevention programs. Community control of health services provides the mechanism for feedback to the community and for community leadership to address health risk behaviours and environmental conditions.

³⁷ Flick B, Miller P, Torzillo P, and Wilson J. “Aboriginal Health Services Delivery in Remote Australia” in Weeks W and Quinn M, *Issues Facing Australian Families, Third Edition*, Longman 2000, Melbourne

Figure 3: Developmental Model of Chronic Illness in Aboriginal and Torres Strait Islander populations

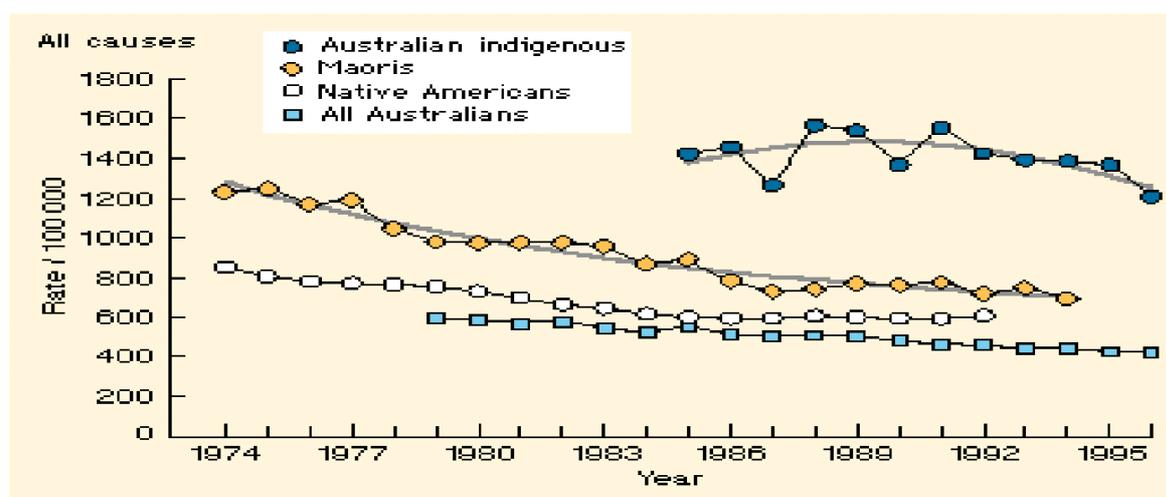


This diagram demonstrates the development of chronic disease in Aboriginal and Torres Strait Islander populations and the potential impact of good prevention and intervention programs. Determinants of ill-health, including social issues, risk behaviours and poor maternal and child health contribute to the development of chronic illness. Good management of chronic disease can lead to a healthy life for the individual and their family, reducing complications and the need for acute care. Feedback to communities, combined with community control provides the basis for sound health promotion programs.

1.3.4 International comparisons of Indigenous health status

International comparison shows that the health of Indigenous populations in a range of English-speaking countries is worse than the health of their non-Indigenous populations. However, in countries comparable to Australia, the health outcomes for Indigenous populations has improved so that for example Maoris in New Zealand, Native Americans and Aboriginal Canadians all enjoy significantly better health than Australian Aboriginal and Torres Strait Islander peoples.³⁸ (See Figure 4)

Figure 4: Trends in annual directly standardised all-cause mortality rates for Indigenous people in Australia, the United States, and New Zealand, and for all Australians³⁹



The health sector in these countries has had a key role in improving the health status of their Indigenous populations. An important difference between these countries and Australia has been their long history of government involvement and commitment to addressing these health disparities. In Australia, this commitment began to flow from the 1970s onwards, whereas in the United States, New Zealand and Canada, it began decades earlier.

A range of factors is considered to have contributed to improved health outcomes for Indigenous populations in the United States, Canada and New Zealand. These include improved environmental health; the continuing provision of good quality comprehensive primary health care services supported by adequate resources for a substantial period of time; a public health care approach with a prominent role for health education and promotion, the development of strong community involvement in health services and issues, pro-active

³⁸ Matheson D, General Manager Public Health, Health Funding Authority, Wellington, New Zealand, *Keynote Presentation to Second International Primary Health Care Conference*, Melbourne, 2000; King, Annette, Minister for Health, *The Future Shape of Primary Health Care: A discussion document*, Ministry of Health, Wellington, New Zealand, 2000. See website: www.moh.govt.nz/primarycare.html; Scrimgeour D, 1994, *Community Involvement in Health Services for Indigenous Peoples of Canada, Norway and New Zealand*, NHMRC, Australia.

³⁹ Ring I and Firman D, "Reducing indigenous mortality in Australia: lessons from other countries" in *Medical Journal of Australia*, 169, 1998

workforce strategies focussed on training Indigenous people, and attention to developing the capacity of the health system to collaborate with agencies outside the health sector.⁴⁰

1.4 Policy implications of previous reports

Many previous national reports have recognised the need to improve the health of Aboriginal and Torres Strait Islander populations. Each state and territory has developed reports, policies or strategies relating to Aboriginal and Torres Strait Islander health and many regions have developed health plans. A range of national, state, territory and local reports and programs relating to specific health issues, such as eye health, sexual health, and emotional and social well-being have also been developed. Approaches to address disadvantage experienced by Aboriginal and Torres Strait Islander peoples have been developed in other portfolios such as housing and education. *Appendix 7* lists key national and state/territory strategies addressing Aboriginal and Torres Strait Islander health.

Whilst these provide important directions at national, state/territory, regional and local levels or detail approaches to respond to particular health conditions, this document provides a national framework which brings them together, and represents a commitment to a sustained multilateral and cross portfolio approach to Aboriginal and Torres Strait Islander health.

The 1989 *National Aboriginal Health Strategy*, (NAHS) remains the most comprehensive articulation of the health aspirations of Aboriginal and Torres Strait Islander peoples. Despite this, the 1994 *Evaluation of the 1989 National Aboriginal Health Strategy* stated that “*the National Aboriginal Health Strategy was never effectively implemented*”, and cited the following reasons for this:

- Underfunding by governments of initiatives in rural and remote areas targeted at meeting the objective of environmental equity by the year 2001.
- A lack of political will and commitment from Commonwealth, State and Territory 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.⁴¹

Since publication of the NAHS, a number of other reports with significant implications for Aboriginal and Torres Strait Islander health have been released, such as the *Royal Commission into Aboriginal Deaths in Custody*,⁴² the *Bringing Them Home*⁴³ report, *Ways Forward*⁴⁴, and the *Health is Life*⁴⁵ report. The Council of Australian Governments (COAG)

⁴⁰ Kunitz SJ and Brady M, “Health care policy for Aboriginal Australians: the relevance of the American Indian experience” *Australian Journal of Public Health*, 1995, Vol 19; Kunitz SJ, ‘Disease and destruction of Indigenous populations’ *Working Paper no 15*, National Centre for Epidemiology and Population Health, the Australian National University, Canberra, 1990; Scrimgeour, 1994 op cit

⁴¹ Aboriginal and Torres Strait Islander Commission (ATSIC), *The National Aboriginal Health Strategy: An Evaluation*, ATSIC, Canberra, 1994

⁴² HREOC, *Royal Commission into Aboriginal Deaths in Custody*, AGPS, Canberra 1991

⁴³ HREOC, *Bringing them home: a guide to the findings and recommendations of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*, Sydney HREOC 1997

⁴⁴ Swan P and Raphael B, 1995, op cit

has also agreed on a framework to continue their efforts to advance reconciliation and address the disadvantage experienced by Aboriginal and Torres Strait Islander peoples.⁴⁶ This document incorporates the findings and recommendations of these reports.

While there has been considerable progress in addressing the recommendations of these reports, it is important that momentum continues and approaches to the following are consolidated through the actions detailed in the key result areas of this *National Strategic Framework*:

- Aboriginal Community Controlled Health Services, including increasing Aboriginal and Torres Strait Islander participation in the operations of mainstream health services and enhancing their control over Aboriginal and services specifically for Aboriginal and Torres Strait Islander peoples. (see *Key Result Area One and Two*).
- Structural reform of the health system, including the need for improvements in general health services, improved intersectoral collaboration and coordination of mainstream health services with ACCHSs. (see *Key Result Area One, Two, Four and Six*).
- Reform of mainstream programs and services to make them more responsive to the needs of Aboriginal and Torres Strait Islander individuals and communities. (see *Key Result Area Two, Three and Four*).
- Increased Aboriginal and Torres Strait Islander participation in the health workforce and a more accessible and responsive mainstream workforce, (see *Key Result Area Three*)
- Improved environmental health, including environmental hazards such as poor sanitation and water quality, overcrowded and substandard housing, and poor infrastructure maintenance. (see *Key Result Area Five*).
- Focussing on broader health issues; including the necessity of links between health and areas such as education, employment, transport, nutrition, justice and corrections. (see *Key Result Area Six*).
- Improving the evidence base for identifying effective interventions to assist policy makers, health service managers and Aboriginal and Torres Strait Islander communities make informed decisions about priorities, programs and clinical care. (see *Key Result Area Seven*)
- Resource allocation; in particular, it has been noted that the Australian health financing system does not provide adequate resources given the burden of illness experienced by Aboriginal and Torres Strait Islander peoples compared to non-Indigenous populations and the high cost of providing services, particularly in remote areas. (see *Key Result Area Eight*)

In general, reviews and evaluations broadly agree on existing policy directions but have raised a number of concerns regarding *implementation* of policy. Past reviews have suggested

⁴⁵ HOR 2000, op cit

⁴⁶ Council of Australian Governments 2001. *Draft COAG Reconciliation Framework: Report on COAG Reconciliation Agenda*.

that governments have not committed adequate resources or effort to implementation.⁴⁷ They have also suggested that there have been changes in direction of policy, failure to maintain a consistent focus for a sufficient term, and lack of joint coordination and planning.⁴⁸ Efforts to improve Aboriginal and Torres Strait Islander health have at times conflicted with policy directions in other sectors.⁴⁹

This *National Strategic Framework* addresses these deficiencies. The Framework provides a long term and bipartisan commitment by all governments to a unified approach between governments and across sectors to improving the health status of Aboriginal and Torres Strait Islander peoples in partnership with Aboriginal and Torres Strait Islander peoples.

⁴⁷ For example: ATSIIC 1994, op cit; Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner (OATSISJC), *Indigenous Deaths in Custody 1986 to 1996*, ATSIIC, Sydney 1996; HOR 2000, op cit

⁴⁸ Gardiner-Garden J, 1994, op cit; HOR, 2000 ibid

⁴⁹ Australian National Audit Office 1999, op cit.; OATSISJC, 1996, op cit

Chapter Two: Current Policy Context

This Chapter reviews the contemporary policy environment and planning structures within which governments, health service providers and Aboriginal and Torres Strait Islander health leaders work today. It shows how the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* must build on the historical and cultural experiences and the health aspirations articulated in the 1989 NAHS and other major policy and strategy documents developed over the last decade.

2.1 The Australian health service delivery system

Health service delivery is a key component of improving the health status of populations. Understanding the operations of the Australian health system overall underpins an understanding of health policy options, directions and partnerships.

In Aboriginal and Torres Strait Islander health policy and planning is underpinned by the *Agreements on Aboriginal and Torres Strait Islander Health* known as Framework Agreements (*see 2.2.1.*) Decisions on developing and operationalising initiatives in Aboriginal and Torres Strait Islander health are most effectively made collaboratively by the four Framework Agreement partners. They are the state/territory affiliate of NACCHO, the State or Territory government, the Commonwealth government and ATSIC⁵⁰ in each state and territory and their roles are outlined below. Representatives of the four partners are members of the National Aboriginal and Torres Strait Islander Health Council who developed this *National Strategic Framework*. The roles and responsibilities of each partner are detailed at *Appendix 9*.

2.1.1 Aboriginal Community Controlled Health Services (ACCHSs)

NACCHO defines an Aboriginal Community Controlled health service as “*a primary health care service initiated by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their communities. Their board members are elected from the local Aboriginal community.*”⁵¹

The Redfern Aboriginal community in New South Wales developed the first community controlled Aboriginal health service in the early 1970s in response to a range of barriers inhibiting Aboriginal access to mainstream primary health care services (*see 2.1.3*) and in recognition of the principles of self-determination.⁵² Aboriginal people for the first time set directions for services and engaged health professionals to work for them. There are now well over 100 Aboriginal community controlled health services throughout urban, rural and remote Australia.

The Aboriginal community controlled health sector has developed a large pool of knowledge and expertise about Aboriginal health issues enabling it to deliver appropriate care and to advocate for the health interests of Aboriginal peoples. Community control ensures that care is culturally secure and appropriate because Aboriginal people manage the organisation and are the employers of any non-Aboriginal professionals. ACCHSs deliver care services to their local community that take account of the holistic context of health service delivery described earlier and can ensure that a range of primary health care services are available.

⁵⁰ In the Torres Strait Framework Agreement Indigenous Australians are represented by the Torres Strait Regional Authority rather than ATSIC.

⁵¹ National Aboriginal Community Controlled Health Organisation Website: www.naccho.org.au

⁵² *Ibid*

Over the last decade more funding has been allocated by Commonwealth, State and Territory governments to ACCHSs, although it is contended by NACCHO that increases have been incremental and insufficient to meet identified need.⁵³ Aboriginal organisations argue that adequately resourced ACCHSs can deliver significantly improved access to services, because service delivery is flexible, responsive and cost-effective in addressing local priorities. Factors such as different levels of resourcing, location and the capacity of the local community to manage a comprehensive primary health care service impact upon the quality and range of services able to be provided. Whilst some communities have access to a full range of services provided through, or coordinated with, their health centre or service, others have only a few staff providing basic services.

ACCHSs work within a framework of accountability to the local community and to funders for the delivery of services. Accountability to the local community is achieved through a Board of Directors (elected from the local community), Annual General Meetings and annual reports.⁵⁴ Services funded by the Commonwealth Government also provide annual Service Activity Reports and are moving towards a more outcome-based model of reporting (*see* 2.2.7).

Community control of Aboriginal health services has been an important achievement for and by Aboriginal peoples and has made the majority contribution to improvements in access to appropriate primary health care services.⁵⁵ ACCHSs, and their peak bodies representing Aboriginal health services in every state and territory and at the national level, are an integral part of the health system participating as partners with governments in every aspect of policy development and planning activity.

2.1.2 General (mainstream) health services

In Australia all levels of government and the private sector and non-profit sectors are involved in funding and/or delivery of health services. Five elements of the Australian health system are intended to provide access to high quality health services commensurate with need for all Australians. The first two are the Commonwealth's *Medicare Benefits* and *Pharmaceutical Benefits* schemes. The third is the delivery of public hospital services by State and Territory governments, which are also primarily responsible for the delivery of population health and environmental health services. Strengthening infrastructure and response capacity for evidence based national population health action is the fourth element. This is supported through the National Public Health Partnership, a working arrangement between the Commonwealth, State and Territory governments, and funding arrangements such as the *Public Health Outcomes Funding Agreements*. The fifth element is the private health insurance system.

The Commonwealth's *Medicare Benefits Schedule* (MBS) subsidises the costs incurred by patients receiving private doctors' services (both general practitioners and specialists). Under this system doctors can set their own fee and patients claim reimbursement of a proportion of a scheduled fee from Medicare.

⁵³ House of Representatives Standing Committee on Family and Community Affairs, *Inquiry into Indigenous Health, Submissions, Vol 1, 2, 3, and 4*, Parliament of the Commonwealth of Australia, Canberra, 1999a, Submission by the National Aboriginal Community Controlled Health Organisation

⁵⁴ NAHSWP (1989), *op cit*

⁵⁵ Kunitz SJ and Brady, M (1995), *op cit*

Approved pharmaceuticals prescribed by doctors and dispensed in the community are subsidised by the Commonwealth's *Pharmaceutical Benefits Scheme* (PBS).

State and Territory governments are primarily responsible for the delivery and management of *public health services*, including public hospital services available at no cost to eligible public patients. The Commonwealth provides funding through the Australian Health Care Agreements to support delivery of public hospital services.

Population health programs have an emphasis on health promotion and prevention of disease and ill health and are delivered in many settings both across and outside the health care system. National approaches and community partnerships are central to the success of such programs.

Aboriginal and Torres Strait Islander peoples are entitled to receive high quality, appropriate services from these universal access programs, as are other Australians.

Apart from these universally available programs, some specialised health care arrangements have been developed to meet the unique needs of particular populations. Examples include community health programs supported by State and Territory governments, which in some states and territories include *specialised Aboriginal and Torres Strait Islander health services*. The Commonwealth, State and Territory governments jointly fund the *Royal Flying Doctor Service* and *Multipurpose Services* to meet the needs of Australia's rural and remote communities. Commonwealth funding for the *Aboriginal and Torres Strait Islander health program* is another specialised health program.

2.1.3 Barriers to accessing health services

There are a number of reasons for the poor performance of the Australian health system in meeting the needs of Aboriginal and Torres Strait Islander peoples. These include:

- the location of health services in places that are hard for Aboriginal and Torres Strait Islander peoples to reach;
- low Medicare enrolment rates amongst Aboriginal and Torres Strait Islander peoples;
- financial barriers to the provision of private and community based health care including up-front fees for services and medications;
- health care services that are felt to be unwelcoming or unfriendly to Aboriginal and Torres Strait Islander peoples;
- poor linkages between private, government and specialist sectors of health services and poor linkages between health services and other related programs;
- poor performance of the health system in meeting the needs of those with complex and multiple conditions;
- general (mainstream) health promotion approaches, which until recently, were not designed to meet the needs of Aboriginal and Torres Strait Islander peoples;
- a workforce which is largely non-Indigenous and not trained in the issues relevant to Aboriginal and Torres Strait Islander individuals, families and communities and generally not willing to work in rural and remote areas.

2.1.4 Comprehensive primary health care

International evidence suggests that, as part of a multi-pronged approach, the delivery of comprehensive primary health care for a sustained period of time is essential if Aboriginal and Torres Strait Islander health outcomes are to be improved (*see Figure 4*).⁵⁶ In Australia, coordinated and sustained national efforts to improve Aboriginal and Torres Strait Islander health have only been begun in the last few decades and have not been supported by adequate resources or a comprehensive approach.

Comprehensive primary health care involves the delivery of a broad range of services. Whilst it is possible for a stand-alone health service to provide all the necessary service elements, it is more likely that a range of health providers and organisations will work together to provide the different service elements of the system for the given population. Service providers include ACCHSs, general practitioners, visiting nurses and allied health professionals, State and Territory government health services, the Royal Flying Doctor Service, public health units, community organisations, schools and local governments. At a local level, the key elements of comprehensive primary health care include:

- Clinical services (including the treatment of acute illness, emergency care and the management of chronic conditions);
- Population health programs such as immunisation, antenatal care, screening and specific health promotion programs
- Specific public health programs for health gain (for example nutrition, social and emotional well-being and substance misuse);
- Facilitation of access to secondary and tertiary health services and related community services such as aged care and disability services; and
- Client/community assistance and advocacy on health related matters within the health and non-health sectors.⁵⁷

The *Primary Health Care Access Program* (PHCAP) provides for the expansion of comprehensive primary health care services in Aboriginal and Torres Strait Islander communities including clinical care, illness prevention and early intervention activities and management support systems. PHCAP provides for increased comprehensive primary health care in areas identified as having the highest relative need and capacity to utilise funding through a completed regional planning process, agreed between ATSIC, ACCHSs and Commonwealth, State and Territory governments. It provides a mechanism to improve local health systems that include both general (mainstream) and health services for Aboriginal and Torres Strait Islander peoples utilising funds from both general and specific funding sources.

Expanding and strengthening comprehensive primary health care is an immediate national priority and is a key element of this *National Strategic Framework's* agenda for the future.

⁵⁶ For example: Kunitz SJ and Brady M, 1995 op cit; HOR ,1999b op cit; DHAC 2001, op cit.

⁵⁷ DHAC 2001, op cit.

2.1.5 Aboriginal and Torres Strait Islander health service funding

The Commonwealth Grants Commission has noted that “*there is no evidence that any State, region or location has resources excessive to those required to address the health need of Indigenous people*”⁵⁸.

Despite the much higher rates of preventable illness and death, and higher costs of delivering services given the relatively high proportion of Aboriginal and Torres Strait Islander peoples living in remote areas, per capita expenditure on health services for Aboriginal and Torres Strait Islander populations is only 22% higher than average per capita expenditure on non-Indigenous Australians⁵⁹. When these factors are taken into account there is evidence of relative under-expenditure on Aboriginal and Torres Strait Islander health.

The need for higher than average per capita expenditure on health services for Aboriginal and Torres Strait Islander peoples is consistent with patterns of expenditure for other groups of Australians who have worse than average health status. For example:

- Australians over the age of 65 use 2.1 times the national average MBS⁶⁰; and
- Australians with multiple health conditions use higher levels of health funding, for example around four times the average where two conditions are involved, seven times the average for three conditions, and up to twelve times the average for five conditions⁶¹.

The lower than average incomes of Aboriginal and Torres Strait Islander peoples limits their ability to contribute to the costs of health care through private expenditure. Adequate government funding is therefore essential if appropriate access to health services is to be attained. This is no different to arrangements that exist for other Australians in low socio-economic groups. More detailed information on the funding system for Aboriginal and Torres Strait Islander health services is at *Appendix 9*.

2.2 Contemporary national policy and planning structures

This section gives a brief overview of the Aboriginal and Torres Strait Islander policy and planning structures currently operating at the national level. The current arrangements were established in recognition that:

- Spheres of government are jointly responsible for responding to the needs of Aboriginal and Torres Strait Islander peoples;
- Governments must work closely with ACCHSs which play a major role in providing services, policy and program advice and facilitating the participation of Aboriginal and Torres Strait Islander peoples in policy and program development;
- Collaboration with mainstream health providers and services, health professionals and educational institutions is essential;

⁵⁸ CGC 2001, op cit

⁵⁹ Australian Institute of Health and Welfare and Department of Health and Aged Care, *Expenditures on health services for Aboriginal and Torres Strait Islander people, 1998-99*. (AIHW and DHAC, 2001).

⁶⁰ DHAC, *Medicare Statistics 1984-85 to June quarter 1998*.

⁶¹ DHAC, 2000, *Insights into the utilisation of health services in Australia based on linked administrative data*, Occasional Paper, New Series, No 9.

- A close working relationship with ATSIC, which has responsibility for providing housing and essential infrastructure services and program to Aboriginal and Torres Strait Islander communities, is essential; and
- Collaboration between portfolios to improve health outcomes is essential, in particular housing, education, employment and family services.

This document aims to extend and strengthen these arrangements and foster new arrangement where required to progress cross-government and cross-agency initiatives identified in the *Framework for Action by Governments* document (see Figure 5).

2.2.1 Agreement on Aboriginal and Torres Strait Islander Health (Framework Agreements)

The *Framework Agreements* have been developed between the Commonwealth Government, the State or Territory Government, ATSIC (or the TSRA in the Torres Strait Agreement) and the state/territory affiliate of NACCHO and operate in every state and territory and the Torres Strait. The aim of the agreements is to improve health outcomes for Aboriginal and Torres Strait Islander peoples through improving access to health and health related programs, increasing the level of resources allocated across the health system in recognition of the higher level of need, joint planning and data collection. Although the Agreements were due to expire on 30 June 2000, all parties have agreed, in principle, to recommit to the Agreements and work is currently underway to revise them for signature. In 2001 and 2002, new agreements were signed in the Northern Territory, South Australia, Western Australia, Queensland and Victoria. Negotiations are continuing in all other jurisdictions.

2.2.2 Partnership forums

Partnership Forums have been established in every state and territory and are comprised of the four Framework Agreement partners in each jurisdiction. The Partnership Forums undertake the joint needs analysis and planning specified in the *Framework Agreements*. They are responsible for identifying need and capacity for service expansion and provide advice to governments on the impact of programs such as the Primary Health Care Access Program (see 2.1.4). Partnership Forums provide a resource for advice on the progression of state/territory strategies and plans and national plans aimed at addressing specific health conditions. They also provide a mechanism for engaging in dialogue with non-health portfolios to progress common objectives for improving the health status of Aboriginal and Torres Strait Islander peoples.

2.2.3 Regional and local area planning

Through the collaborative planning forums established under the *Framework Agreements*, planning regions have been agreed in each jurisdiction except in Tasmania where work is progressing. Factors taken into account in determining regions include Aboriginal language groups, communities of interest, the geographic locations of Aboriginal and Torres Strait Islander communities and existing mainstream health regions. In short, the regions are those that make most sense to the local people involved in or affected by planning, most importantly Aboriginal and Torres Strait Islander peoples and communities.

Planning is intended to identify regions and communities with the greatest need for additional or improved health care services, but also to identify communities with the greatest capacity

to make most effective use of additional resources. The planning process also identifies those sites having a high need but limited physical infrastructure or experience in managing or delivering health care and which would benefit from assistance to enhance their capacity to deliver a health service. Factors taken into account in planning include demographics, health infrastructure and health status. Regional plans have now been completed in almost every state and territory. Reports outlining progress made in implementing the commitments under the *Framework Agreements* (including regional planning) are presented to the Australian Health Ministers' Conference on an annual basis.

Aboriginal and Torres Strait Islander communities are diverse, with differences in local history and culture, in prevailing health issues, in health infrastructure and community resources, in patterns of service delivery, and in population, size and geographic location. It is important that local priorities for action, based on local health profiles, are developed in partnership between health services and the local community and supported by a national framework that is consistent with State/Territory government strategies and plans.

Addressing health issues at a local level requires a comprehensive approach, building on good information and data, which responds to needs across the lifespan, age and gender, and across a range of health conditions. In developing local health plans it is important to take into account:

- the existing community infrastructure to support further work;
- the full range of health services that it is the government's responsibility to provide;
- the capacity of community leaders to take responsibility for health issues;
- the immediate opportunities available for action;
- employment and training opportunities for members of the local community;
- the relative costs of health services; and
- local health needs and priorities.

Work to increase capacity and infrastructure may need to precede the development of specific programs.

Service providers involved in the development of community health plans must make available any relevant information and evidence that they have acquired regarding the demographics and health needs of the community, and listen respectfully to information from community leaders about community priorities. Community representatives must have the skills and knowledge to understand health issues and systems, and the power to ensure that health and related services are culturally secure and meet the priorities identified by the local community.

The matrix at *Appendix 8* provides examples of possible programs that could be developed between communities and health services at a local or regional level, supported by specialist services. It is not intended to be prescriptive, or to reduce the responsibility of communities and health services to work together to develop comprehensive local approaches. It is intended to recognise the broad range of determinants of different health conditions, and to illustrate possible responses in terms of health promotion and prevention programs, environmental health improvements, and clinical responses across life stages.

Whatever health service delivery options are most appropriate to a particular Aboriginal or Torres Strait Islander community, it is important to develop formal agreements between the community, funders and services at the local, regional, and state/territory level as well as at the national level. Formal agreements will enable the community to purchase or negotiate services, advocate for their own health needs, and choose a combination of providers of primary and preventive health care and specialist services. Health service development initiatives should also be linked to economic development, employment and training opportunities for Aboriginal and Torres Strait Islander peoples within each region.

2.2.4 Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH)

SCATSIH is the subcommittee of the Australian Health Ministers' Advisory Council (AHMAC) responsible for Aboriginal and Torres Strait Islander health. Where AHMAC comprises the Chief Executive Officers (CEOs) of the Commonwealth and State/Territory departments responsible for health and reports to health ministers, SCATSIH comprises the heads of Aboriginal and Torres Strait Islander health units at the Commonwealth and state/territory level and senior executives with oversight of mainstream health policy. It is chaired by a member of AHMAC thereby providing cross-membership. SCATSIH provides a forum where national activity, involving all government jurisdictions, can be discussed and progressed. With advice from NATSIHC, SCATSIH will be responsible for driving implementation of this *National Strategic Framework* in the health sector and for coordinating activity with non-health agencies at the Commonwealth and State/Territory government level.

2.2.5 National Aboriginal and Torres Strait Islander Health Council (NATSIHC)

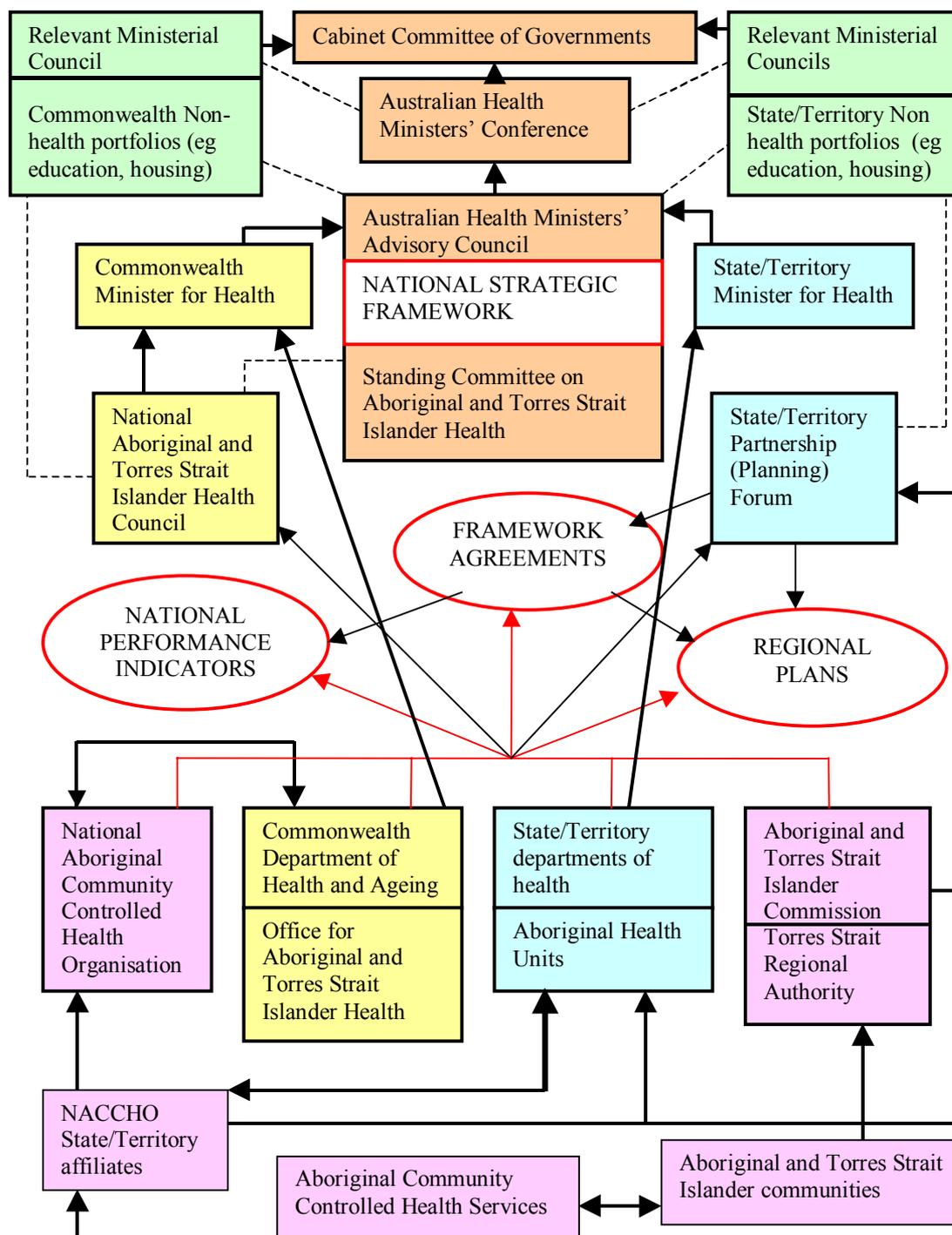
NATSIHC provides advice to the Commonwealth Minister for Health and Ageing on matters relating to the health and substance misuse services provided to Aboriginal and Torres Strait Islander peoples. It monitors and advises on implementation of the Framework Agreements and on ways to improve the interaction between mainstream services and ACCHSs at the national level. Its membership includes representatives of the four Framework Agreement partners (*see 2.2.1*), the Australian Indigenous Doctors Association and the Congress of Aboriginal and Torres Strait Islander Nurses, the Chairperson of the NHMRC in an ex-officio capacity and ministerial appointees with expertise in Aboriginal and Torres Strait Islander health. NATSIHC developed this *National Strategic Framework* to guide government action across all jurisdictions and will develop a plan for mid-term and final evaluations of progress with implementing this *National Strategic Framework* and of outcomes achieved.

2.2.6 Memoranda of Understanding

Agreements between funding agencies and Aboriginal and Torres Strait Islander communities have been developed at the Commonwealth and state/territory level to encourage a more coordinated approach and to clarify the responsibility of mainstream agencies for improving outcomes for Aboriginal and Torres Strait Islander populations. Examples include:

- the *National Framework for the Design, Construction and Maintenance of Indigenous Housing* agreed by the Commonwealth, State and Territory Housing Ministers' Working Group on Indigenous Housing;

Figure 5: National policy and planning structures



- the 2002 *Memorandum of Understanding* signed between ATSIC and the Department of Health and Ageing, that sets out mutual responsibilities for supporting health and environmental health policy and programs to Aboriginal and Torres Strait Islander populations;

- state/territory level agreements such as the agreement between the Western Australian Government and ATSIC on the delivery of environmental health services to 26 Aboriginal communities in Western Australia,⁶² and
- Agreements between funders in each jurisdiction which outline the principles and arrangements for the impact of specific programs, such as the Memoranda of Understanding for the Primary Health Care Access Program.

2.2.7 Existing Reporting Mechanisms

The *National Performance Indicators for Aboriginal and Torres Strait Islander Health* were developed through a collaboration of the Aboriginal Health Units in each State and Territory Government and the Commonwealth Government on behalf of the Australian Health Ministers' Advisory Council. They were compiled with advice from technical experts, NHMRC, NACCHO, the Aboriginal community controlled health sector and public health agencies, ATSIC, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs, the ABS and the AIHW. The indicators were intended as a blueprint for governments to use in monitoring and reporting on efforts towards improving Aboriginal and Torres Strait Islander health in a consistent way and help to provide a national picture of progress. Draft indicators were adopted by the Ministers responsible for health portfolios in every government in 1997. Revised indicators that were technically refined and included the addition of indicators for emotional and social well being were agreed and published in September 2000.⁶³ All jurisdictions are required to report annually against the indicators to the Australian Health Ministers Conference. The complete set of revised National Performance Indicators is at *Appendix 5*.

The *Service Activity Report* is a joint data collection project between NACCHO and the Commonwealth's Office for Aboriginal and Torres Strait Islander Health (OATSIH). The questionnaire collects service level data on health care and health related activities covering a twelve month period from over 100 Commonwealth funded Aboriginal primary health care services. The 2001-2002 SAR is the fifth annual SAR data collection. It provides unique and valuable information that NACCHO, OATSIH and the sector can use in formulating policy, in planning, and to profile the work of Aboriginal primary health care services.

The *Reports against the Agreements on Aboriginal and Torres Strait Islander Health* (Framework Agreements) are annual reports to the Australian Health Ministers' Conference by all government jurisdictions and NACCHO. They detail progress in meeting the objectives of the Framework Agreements in each state and territory, including details of government expenditure on specific projects.

⁶² ATSIC, the WA Government and the Commonwealth Minister for Aboriginal and Torres Strait Islander Affairs signed the *Agreement for the Provision of Essential Services to Aboriginal Communities in Western Australia* in October 2000.

⁶³ Cooperative Centre for Aboriginal and Tropical Health, *Technical Refinement of the National Performance Indicators for Aboriginal and Torres Strait Islander Health*, 2000, Northern Territory

Appendices

List of Appendices

- Appendix One: Glossary
- Appendix Two: References
- Appendix Three: Abbreviations
- Appendix Four: The National Aboriginal and Torres Strait Islander Health Council
- Appendix Five: *Aboriginal and Torres Strait Islander Health Interim Performance Indicators*
- Appendix Six: List of contributors
- Appendix Seven: List of major national and state/territory reports
- Appendix Eight: Examples of Local Level Health Issues, Determinants and Responses
- Appendix Nine: The Australian Health System

Appendix One: Glossary

Aboriginal or Torres Strait Islander Health Worker

Means an Aboriginal person or a Torres Strait Islander person who is employed in a health service, involved in the delivery of health care and may have undertaken accredited education and training on Aboriginal and Torres Strait Islander health work.

Aboriginal person or Torres Strait Islander person

An Aboriginal or Torres Strait Islander person is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements)

The main purpose of the Framework Agreements is to have a common commitment in each jurisdiction to regional planning, data collection, increased resources and increased access to the mainstream health sector. Framework Agreements are in place in every state and territory and in the Torres Strait. Under the Agreements, partnership forums have been established to undertake regional planning and to provide a mechanism for the community sector to be involved in policy development and planning. The four signatories to the *Agreements on Aboriginal and Torres Strait Islander Health* operating in every state and territory and the Torres Strait which are:

- The Commonwealth Government
- The State or Territory government
- The State or Territory affiliate of the National Aboriginal Community Controlled Health Organisation; and
- The Aboriginal and Torres Strait Islander Commission (or the Torres Strait Regional Authority in the Torres Strait Framework Agreement).

Casemix

The range and types of patients (the mix of cases) treated by a hospital or other health service. This provides a way of describing and comparing hospitals and other services for planning and managing health care. Casemix classifications put patients into manageable numbers of groups with similar conditions that use similar health care resources so that activity and cost-efficiency of different hospitals can be compared.

Chronic disease

The chronic disorders of ischaemic heart disease, type 2 diabetes, renal disease, hypertension, stroke and chronic airways disease can be grouped together from a public health perspective as they have common underlying factors. These are most notably poor nutrition, inadequate environmental health conditions, alcohol misuse and tobacco smoking. The origins of these diseases are set in utero and early childhood (most notably through low birth weight, malnutrition, and repeated childhood infections) and are worsened by lifestyle changes (weight gain, lack of physical activity and substance abuse). The diseases and their risk factors are also inextricably linked with the broader socio-economic determinants of health and quality of life, particularly education and employment. Lifestyle choices are often more

reflective of unrelenting socio-environmental constraints rather than personal preferences. Therefore an integrated, intersectoral and whole of life approach is needed.

Communicable disease

Communicable diseases include those diseases that can be transferred from person to person through infection. Significant communicable diseases in Aboriginal and Torres Strait Islander communities include chronic infections in early childhood, pneumonia in the elderly and sexually transmitted or blood borne diseases among sexually active populations.

Community Aged Care Packages

Community Aged Care Packages are a key element in ensuring that staying at home rather than entering residential care is a real option for those older Australians who choose to do so.

Community Aged Care Packages offer an integrated package of services for frail older people, providing for example, home help, laundry, shopping, assistance with meals and bathing. Packages are extremely popular as they are based on a single point of contact for people assessed as needing a range of services. To receive a package older people must be assessed as eligible by an Aged Care Assessment Team (ACAT).

Community capacity

The characteristics of communities that affect their ability to identify, mobilise and address social and public health problems, and the cultivation and use of transferable knowledge, skills, systems and resources that affect community and individual level changes consistent with public health related goals and objectives.

Community control

The 1989 *National Aboriginal Health Strategy* describes community control as being “*the community having control of issues that directly affect their community ... [where] Aboriginal people must determine and control the pace, shape and manner of change and decision-making at local, regional, state and national levels.*”⁶⁴

A number of different mechanisms for increasing community control and participation have been developed by Aboriginal and Torres Strait Islander health services and mainstream health services around Australia. These include appointment of Aboriginal and Torres Strait Islander peoples to hospital and health service boards of management, participation in the Aboriginal Coordinated Care Trials, development of Memorandums of Understanding between some Aboriginal and Torres Strait Islander community councils and health services, and hand over of existing services to community organisations.

In some cases there have been problems with establishing community control. Issues have included under-resourcing of services so that no real choices can be exercised, diversity of interests within externally defined “communities” and the capacity of communities to manage services, given literacy or language difficulties, resources, and competing pressures on the time and energy of community leaders. At times, some communities have chosen to purchase, negotiate or advocate for improved government services rather than to manage their own services. In other instances, Aboriginal and Torres Strait Islander representative organisations have perceived that government efforts at partnership, participation or control have not provided for an equal voice in decision making.

⁶⁴ NAHSWP, 1989 op cit

The most comprehensive definition of Aboriginal community control is that advocated by the National Aboriginal Community Controlled Health Organisation (NACCHO), consistent with that adopted by the 1989 *National Aboriginal Health Strategy*. It defines an Aboriginal community controlled health service as an incorporated Aboriginal organisation, initiated by and based in a local Aboriginal community, governed by an Aboriginal body that is elected by the local Aboriginal community and delivering a holistic and culturally appropriate health service to the community that controls it. It is the direct employer of the health professionals who work in it and has provision for annual general meetings open to all members of the community it serves, and election to a management committee from its general membership. A service that contains these elements represents true community control and best practice. However, it is acknowledged that there are a variety of governance structures currently in place that may be considered stages along a process that can lead over time to the development of a fully community controlled best practice service.

Community Development

Community development refers to the process of facilitating the community's awareness of the factors that affect their health and quality of life, and ultimately helps empower them with the skills needed for taking control over and improving those conditions in their community which affect their health and way of life. It often involves helping them to identify issues of concern and facilitating their efforts to bring about change in these areas.

Community Participation and Community Involvement

Process that enable individuals and groups in the community to contribute to debate and decision making about a particular activity. In relation to health, this means opportunities for members to participate in planning, implementing managing and evaluating health services and identifying health issues and ways of addressing them.

Comprehensive Primary Health Care

Comprehensive Primary Health Care services provide a range of services to the community including clinical services, policy and program management, substance misuse, sexual health, mental health, community development and population health programs, including a focus on nutrition and lifestyle factors.

Coordinated Care Trials

As part of a significant health service reform agenda, four Aboriginal and Torres Strait Islander Coordinated Care Trials were conducted across five states and territories between 1997 and 1999. The aim of the trials was to achieve a more coordinated approach to the delivery of health care services to people with a diverse range of complex and chronic health care needs. The trials were located in Katherine (NT), Wilcannia (NSW), the Tiwi Islands, (NT) and Perth/Bunbury (WA). All first round Aboriginal and Torres Strait Islander trials were invited to develop proposals for further coordinated care trials in September 1999, with one - WA - deciding to apply. Out of eight Expressions of Interest received for further trials specifically targeting Aboriginal and Torres Strait Islander populations, three were selected for detailed development: the WA trial, Katherine East/Jawyong (NT), and Mid-North Coast (NSW).

Early Intervention

An early intervention is recognising a problem as soon as possible and doing something to stop the harm that the problem will cause.

Emotional and social well-being

Is used in this document to mean the whole state of health, with the focus on mental health so that Aboriginal and Torres Strait Islander peoples can reach their full physical, emotional, cultural and spiritual potential at the individual, family and community level.

Endocrine conditions

Endocrine conditions result from abnormalities in the hormone (chemical messenger) system in the body. For example, diabetes results from an inadequacy in the action of the hormone insulin.

Environmental health

The National Environmental Health Strategy defines environmental health as being about “creating and maintaining environments which promote good public health”. In this *National Strategic Framework* it includes provision of basic environmental health infrastructure such as housing, water and sewage.

Framework Agreements

See *Agreements on Aboriginal and Torres Strait Islander Health*.

Framework Agreement partners

See *Agreements on Aboriginal and Torres Strait Islander Health*.

Health and health related services

Are those services covered by the holistic definition of health and include such services as substance misuse, health promotion and disease prevention services, women’s and men’s health, aged care, services for people with a disability, mental health services as well as clinical and hospital services.

Health Forum

Refers to groups convened under the *Agreements on Aboriginal and Torres Strait Islander Health* (Framework Agreements) in each jurisdiction representing the four partners (signatories) collaborating to advance Aboriginal and Torres Strait Islander health.

Health Sector

The health sector consists of organised public and private health services, the policies and activities of health departments, health related non-government and community organisations and professional associations.

Intersectoral collaboration

Is defined in the 1989 *National Aboriginal Health Strategy* as the dependency that exists between health and all other sectors of a community’s activity. In health, intersectoral collaboration recognises the fact that improvement in health cannot be achieved through the efforts of the health sector alone. Vital to the efforts to improve health and wellbeing are the contributions of a variety of sectors including agriculture, land, animal husbandry, socio-political, cultural, food, industry, education, communications, and community infrastructure such as housing and public works.

Low birth weight

Low birth weight is defined in the National Performance Indicators as of less than 2,500 grams. Percentages of low birth weight babies are higher for Aboriginal and Torres Strait

Islander mothers than non-Indigenous mothers. Low birth weight constitutes a risk factor for diseases of early childhood and chronic disease in later life.

Mainstream health service

Means health and health related services that are available to, and accessed by, the general community.

Mortality rate

The mortality rate is the number of deaths registered in a given calendar year expressed as a proportion of the estimated resident population at June 30 that year. Age specific death rates are the number of deaths at a specified age as a proportion of the resident population of the same age. Higher age specific death rates in younger age groups indicate excess or unnecessary early deaths.

Partnership Forum

See Health Forum

Perinatal Mortality

Death of a child at the time of birth or within 28 days following.

Morbidity

Refers to ill health in an individual and to levels of ill health in a population or group.

Prevalence

Indicates how often a particular health condition can be found within a particular population. Higher prevalence of a disorder indicates that more people in that population have the disease or condition at any one point in time.

Primary Health Care

Primary health care is generally understood as the health care that is available to the general community in their local area. It is the first point of contact between the community and the health care system. Primary health care includes general practitioner, community and bush nursing, the Royal Flying Doctor Service, community health, dental health and Aboriginal and Torres Strait Islander health care services. It may also include outpatient services provided by a general hospital. Primary health care services provide clinical, and community health care, and play a gatekeeper role in facilitating access to specialist health services.

Aboriginal and Torres Strait Islander community controlled health services operate primary health care according to the working definition of primary health care as defined in the 1989 *National Aboriginal Health Strategy*. “*Essential health care based on practical, scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in the communities in which they live through their full participation at every stage of development in the spirit of self-reliance and self-determination.*”

Primary Health Care Access Program (PHCAP)

The Primary Health Care Access Program is a Commonwealth program that supports the continuation of services established through the Coordinated Care Trials. PHCAP also provides for increased primary care services in Aboriginal and Torres Strait Islander communities identified as having the highest relative need and capacity to utilise funding through a completed regional planning process, agreed between ATSIC, Aboriginal

community controlled health organisations and Commonwealth, State and Territory governments. Funding will be provided on a per capita basis to levels more commensurate with the health needs of these regions and will take into account the extra costs involved in providing health services in remote areas. Capacity development is an importance part of the overall program.

Population Health

Is the organised response by society to protect and promote health and to prevent illness, injury and disability. Population health is characterised by planning and intervening for better health in populations rather than focussing on the health of identifiable individuals and takes account of the broad behavioural, social, physical and environmental determinants of health.

Quintile

A group derived by ranking the population according to specified criteria and dividing it into five equal parts.

RAWG Road Map

The *RAWG Road Map: A Strategic Framework for Aboriginal and Torres Strait Islander Health Research* was produced by the National Health and Medical Research Council's Research Agenda Working Group in 2002. Its overall objective is to support the NHMRC to advise Aboriginal and Torres Strait Islander communities throughout Australia, on the achievement and maintenance of the highest practicable standards of individual and public health and to foster research in the interests of improving those standards.

Resources

Refers to funding (in real terms), staffing, and any other efforts directed towards policy, planning, implementation and evaluation of services.

Social capital

Social capital refers to the processes between people that establish networks, norms, social trust and facilitate coordination and cooperation for mutual benefit. It comes about through changes in the relations among people that facilitate action. Indicators of social capital in communities include levels of civic engagement such as voter turnout, newspaper readership, or membership of societies, clubs and associations. In regions with strong social capital, there are numerous active community organisations, and social and political networks are organised horizontally rather than hierarchically. These communities value solidarity, civic participation, integrity, alliances across difference, and reciprocity. The existence of trust in relationships emerges as the key factor to determining the extent to which a community or society can be seen to have a high level of social capital. Together, reciprocity and trust characterise societies in which people are able to cooperate effectively and to achieve common civic goals. There is growing international research evidence that societies with strong social capital are healthier, as well as more economically successful.

[This glossary includes definitions from the Northern Territory Department of Health and Community Services' Bush Book and the Australian Institute of Health and Welfare publication Australia's Health 2000]

Appendix Two: References

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Appendix Three: Abbreviations used in this document

Names of organisations and programs

AACAP	ATSIC/Army Community Assistance Program
ABS	Australian Bureau of Statistics
ACCHSs	Aboriginal Community Controlled Health Services
AGPS	Australian Government Publishing Service
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIHW	Australian Institute of Health and Welfare
ANCARD	Australian National Council on Aids and Related Diseases
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIHWIU	Aboriginal and Torres Strait Islander Health and Welfare Information Unit
CACPs	Community Aged Care Packages
CRC	Cooperative Research Centre for Aboriginal and Tropical Health
CSTHMWGIH	Commonwealth, State and Territory Housing Ministers' Working Group on Indigenous Housing
DETYA	Commonwealth Department of Employment, Training and Youth Affairs
DEWRSB	Commonwealth Department of Employment, Workplace Relations and Small Business
DHAC	Commonwealth Department of Health and Aged Care
DHFS	Commonwealth Department of Health and Family Services (now the Commonwealth Dept of Health and Aged Care)
FaCS	Commonwealth Department of Family and Community Services
HDWA	Health Department of Western Australia
HoR	House of Representatives
HREOC	Human Rights and Equal Opportunity Commission
IEP	Indigenous Employment Program
KAMSC	Kimberley Aboriginal Medical Services Council
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NCEPH	National Centre for Epidemiology and Population Health
NIPAC	National Injury Prevention Advisory Council
NHMRC	National Health and Medical Research Council
NHSWP	National Health Strategy Working Party on the development of the 1989 <i>National Aboriginal Health Strategy</i>

National Strategic Framework for Aboriginal and Torres Strait Islander Health

OATSIH	Office for Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Aged Care
OATSIHS	Office for Aboriginal and Torres Strait Islander Health Services, DHAC, (now OATSIH)
PBS	Pharmaceutical Benefits Scheme
PHCAP	Primary Health Care Access Program
QATSHP	Queensland Aboriginal and Torres Strait Health Program
RAWG	Research Agenda Working Group of the NHMRC
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SADHS	South Australian Department of Health and Aged Care
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
TSRA	Torres Strait Regional Authority
UN	United Nations
USA	United States of America
VDHS	Victorian Department of Human Services
WHO	World Health Organisation

Abbreviations of Document Titles Used in this Document

AIHWJ	Aboriginal and Islander Health Worker Journal
BMJ	British Medical Journal
Eur J Epidemiol	European Journal of Epidemiology
J Epidemiol Community Health	Journal of Epidemiology and Community Health
J Public Health Med	Journal of Public Health Medicine
MJA	Medical Journal of Australia
NAHS	National Aboriginal Health Strategy
Soc Sci Med	Journal of Social Science and Medicine

Appendix Four: National Aboriginal and Torres Strait Islander Health Council

Membership and Terms of Reference

Terms of Reference

The National Aboriginal and Torres Strait Islander Health Council provides advice to the Commonwealth Minister for Health and Ageing on matters relating to the health and substance abuse services of Aboriginal and Torres Strait Islander peoples.

The Council will:

- advise on a national strategy to take Aboriginal and Torres Strait Islander health into the twenty first century, drawing on existing reports including the 1989 *National Aboriginal Health Strategy*, the 1998 Australian National Audit Office Performance Audit of the Aboriginal and Torres Strait Islander Health Program and on the report of the House of Representatives Standing Committee on Family and Community Affairs inquiry into Indigenous Health, when it becomes available;
- advise the Minister on how its strategies and mechanisms to improve the health outcomes for Aboriginal and Torres Strait Islander peoples will support the Council of Aboriginal Reconciliation's agenda on reconciliation between Aboriginal and Torres Strait Islander and non-Indigenous Australians;
- monitor and advise on implementation of the State/Territory Framework Agreements;
- advise on ways to improve the interaction between mainstream services and specialist Aboriginal and Torres Strait Islander health facilities to achieve better health outcomes for Aboriginal and Torres Strait Islander peoples;
- advise on issues related to research, data collection and use and ethics;
- improve inter-sectoral collaboration will be sought through links with related health, infrastructure and environmental health programs at the national and regional level; and
- not advise on specific funding proposals or on particular planning or program matters related to individual communities or regions.

Sub-Committees

The Council has the capacity to address key issues by establishing time-limited sub-committees, subject to approval of the Minister. This allows for the engagement of expert advice in certain areas for a specific purpose.

Operation of the Council

The Council meets four times a year. The fourth meeting each year includes all State and Territory Government and state/territory National Aboriginal Community Controlled Health Organisation affiliated representatives. The purpose of this fourth meeting is to report and provide advice on strengthening the Aboriginal and Torres Strait Islander Framework Agreement partnerships and to provide opportunities for information sharing.

Composition

The National Aboriginal and Torres Strait Islander Health Council comprises:

- two representatives from the Department of Health and Ageing;
- two representatives from the National Aboriginal Community Controlled Health Organisation;
- two members from State/Territory governments nominated by the Australian Health Ministers' Conference;
- one member from ATSIC;
- one member from the Australian Indigenous Doctors Association;
- one member from the Congress of Aboriginal and Torres Strait Islander Nurses;
- one member from the Torres Strait Regional Authority; and
- members with extensive experience in Aboriginal and Torres Strait Islander health appointed by the Minister for Health and Ageing.

A member from the National Health and Medical Research Council attends ex-officio.

Current membership

The Council currently consists of 13 members:

- Ms Jane Halton, Secretary of the Department of Health and Ageing and Chairperson of the Council;
- Mr Henry Councillor, Acting Chairperson of the National Aboriginal Community Controlled Health Organisation (NACCHO) and Deputy Chairperson of the Council;
- Ms Helen Evans, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing;
- Dr Naomi Mayers, Acting Deputy Chairperson of NACCHO;
- Commissioner Cliff Foley, Aboriginal and Torres Strait Islander Commission (ATSIC);
- Mr Terry Waia, Chairperson of the Torres Strait Regional Authority;
- Mr Jim Birch, Australian Health Ministers' Advisory Council (AHMAC) representative and Chief Executive Officer, Department of Human Services, South Australia;

- Mr Stanley Nangala, Queensland Director of Aboriginal and Torres Strait Islander Health, AHMAC representative;
- Ms Barbara Flick, Ministerial Appointee;
- Mr Scott Wilson, Ministerial Appointee;
- Dr Sandra Eades, Ministerial Appointee;
- Dr Mark Wenitong, representing the Australian Indigenous Doctors' Association; and
- Dr Sally Goold, representing the Congress of Aboriginal and Torres Strait Islander Nurses.

The National Health and Medical Research Council is represented on the Council by its Chairperson, Professor Nicholas Saunders, in an ex-officio capacity.

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 - Mr Chris McCarthy, Mr Peter Taylor and Ms Tania McInnes, ATSIC
 - Mr Mike Reid, former Director General, NSW Health
 - Mr Stephen Smyth, FaCS
 - Dr Ronnie Wasaga, TSRA (until May 2000)
- Technical and medical advice on development of the document was provided by:
 - Associate Professor Ian Anderson, Koori Health Research Centre

National Strategic Framework for Aboriginal and Torres Strait Islander Health

- Dr John Mathews (Department of Health and Aged Care)
- Dr Patricia Fagan (Department of Health and Aged Care)
- Dr David Ashbridge (Territory Health Services)

Special editorial comment was provided by Ms Pat Turner.

Appendix Five: ***Current National Performance Indicators for Aboriginal and Torres Strait Islander Health (National Performance Indicators)***

Background

In its February 1996 meeting AHMAC directed their Heads of Aboriginal Health Units (HAHU now renamed SCATSIH) to develop a set of performance indicators that governments could use to monitor and report on efforts and progress towards improving Aboriginal and Torres Strait Islander health.

Performance indicators can have a dual purpose. Reporting assists with working towards compiling a national picture of progress and also allows each jurisdiction to assess its own performance against its own criteria. Data come partly from health departments' own collections but also depend heavily on data from national agencies such as the Australian Bureau of Statistics.

Interim National Performance Indicators were developed with advice from technical experts, NHMRC, NACCHO, the Aboriginal community health sector and public health agencies, ATSIC, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

The Australian Health Ministers' Conference (AHMC) agreed that jurisdictions should report annually against the indicators and targets to AHMC. Where data is inadequate, jurisdictions should report on their progress in developing the capacity to report. They further agreed that additional refinement and consultation should be undertaken.

Reports have now been completed for 1997, 1998 and 1999.

The process of reporting confirmed the need for further refinement of the indicators. This was recently completed by the Cooperative Research Centre for Aboriginal and Tropical Health and subsequently endorsed by AHMAC.

The refinement process was guided by recognition that the purpose of the indicators was to provide high-level information about changes pertinent to health. A particular focus during the refinement was to align, where appropriate, the definitions of the indicators with those of other indicator sets being used in Australia.

The revised indicator set has been conceived with a broad interpretation of the terms "performance" and "indicator". This broad interpretation has been derived through extensive consultation with Aboriginal and Torres Strait Islander communities, government agencies responsible for Aboriginal and Torres Strait Islander health, and agencies responsible for health information management.

The refinement process also included a set of indicators for social and emotional wellbeing in order to reflect the combination of the concepts of social justice and mental health. These indicators will be trialed over two periods of reporting.

Current National Performance Indicators for Aboriginal and Torres Strait Islander Health

Indicators primarily related to government inputs

- 1 Efforts to improve identification of Aboriginal and Torres Strait Islander peoples in data collections
- 2 Government expenditure on health services for Aboriginal and Torres Strait Islander people
- 3 Government expenditure on health services for Aboriginal and Torres Strait Islander peoples living in small homeland communities and outstations
- 4 Government expenditure on and description of selected health promotion programs

Indicators primarily related to social equity

- 5 Life expectancy at birth
- 6 Infant mortality rate
- 7 Income poverty
- 8 Completed secondary school education
- 9 Employment status
- 10 Housing with utilities
- 11 People in prison custody
- 12 The development of governance capacity in health
- 13 Aboriginal and Torres Strait Islander representation on health/hospital boards
- 14 Reporting of complaints in hospitals
- 14.1 Reporting of complaints and critical incidents in hospitals (to replace 14 when available)

Indicators primarily related to access to health services

- 15 Aboriginal and Torres Strait Islander community controlled health services
- 16 Distance to a primary health care centre
- 17 Distance to a hospital
- 18 Access to primary health care services - small homeland communities and outstations
- 19 Management of key conditions
- 20 Aboriginal and Torres Strait Islanders in the health workforce
- 21 Higher education and training in key health professions
- 23 Workforce availability in hospitals that provide services to Aboriginal and Torres Strait Islander people
- 24 Cross-cultural training for hospital staff

Indicators primarily related to risk markers

- 25 Pap smear screening
- 26 Childhood immunisation rates
- 27 Coverage of adult pneumococcal vaccine
- 28 Low birthweight infants
- 29 Smoking prevalence
- 30 Alcohol consumption
- 31 Overweight and obesity
- 32 Substantiated notifications of child abuse and neglect
- 33 Problem gambling
- 36 Community grief
- 35 Injuries presenting to hospital accident and emergency facilities

Indicators primarily related to outcomes for people:

- 36 Prevalence of anxiety and depression
- 37 Notification rates - selected vaccine preventable disease
- 38 Notification rates - meningococcal disease
- 39 Notification rates – sexually transmitted diseases
- 40 Ratios for all hospitalisations
- 40.1 Hospitalisation ratios by urgency of admission (to replace 40 when data available)
- 41 Hospitalisation ratios for circulatory diseases
- 42 Hospitalisation ratios for injury and poisoning
- 43 Hospitalisation ratios for respiratory diseases and lung cancer
- 44 Hospitalisation ratios for diabetes
- 45 Hospitalisation ratios for tympanoplasty associated with otitis media
- 46 Hospitalisations for mental health conditions
- 47 Children’s hearing loss
- 48 Stillbirths to Aboriginal and Torres Strait Islander mothers
- 49 Early adult death
- 50 Age-specific all-cause death rates and ratios
- 51 Standardised mortality ratio for all causes
- 52 Standardised mortality ratios for circulatory diseases
- 53 Standardised mortality ratios for injury and poisoning, including suicide
- 54 Standardised mortality ratios from respiratory diseases and lung cancer
- 55 Standardised mortality ratios from diabetes
- 56 Standardised mortality ratios from cervical cancer

Appendix Six: Submissions and Consultations

Input to the National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion - Submissions received (2000)

Aboriginal and Torres Strait Islander Commission
Commonwealth Department of Health and Aged Care
Health Department of Western Australia
Territory Health Services
Queensland Health
Victorian Department of Health and Human Services
Australian Bureau of Statistics
Australian Institute of Health and Welfare
Department of Prime Minister and Cabinet
Department of Family and Community Services
Commonwealth Attorney-General's Department
Department of Education, Training and Youth Affairs
Department of Employment, Workplace Relations and Small Business
Centrelink
Australian Federal Police
Department of Veterans Affairs
South Australian Department of Human Services

Comment on the National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion - Submissions Received (2001)

Private Citizens

1. Apryan (e-mail)
2. M Ryan Japarta – NT
3. Julpia N Jones and John E Thompson – ACT
4. John Gwilliam – ACT
5. Mr R Brook (letter) – Dalby, Qld
6. Dr Lois Achimovich – WA

National Strategic Framework for Aboriginal and Torres Strait Islander Health

7. Mr Rhys Davies, Pharmacy Department, Thursday Island Hospital – QLD
8. Associate Prof. Sally Rushton – School of Community Health, Charles Sturt University – SA – Private Submission

Indigenous Medical Services and Organisations

9. National Indigenous Male Health Working Group - National – Alliance of government and non-government organisations
10. National Aboriginal Community Controlled Health Organisation – national
11. National Secretariat Mainland Torres Strait Islander Organisations – national
12. Aboriginal Medical Services Alliance Northern Territory – NT –
13. Western Australian Aboriginal Community Controlled Health Organisation (inc) (WAACCHO) – WA
14. Tangentyere Council (Alice Springs)
15. Katherine West Health Board Aboriginal Corporation – NT
16. Aboriginal and Torres Strait Islander Community Health, Education and Training (South East Queensland) – Queensland
17. Winnunga Nimmityjah Aboriginal Health Service - ACT
18. Central Australian Aboriginal Congress Inc – NT
19. Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) – national
20. Victorian Aboriginal Community Controlled Health Organisation (VACCHO) – Victoria
21. Aboriginal Health and Medical Research Council of NSW - NSW

Non Government Organisations

22. Queensland Rural Medical Support Agency – Queensland
23. Australian Dental Association Inc – national
24. Communicable Diseases Network Australia – national
25. Australian Nursing Council Inc- national
26. Royal Australian College of General Practitioners – Melbourne – National Preventive and Community Medicine Committee (Aboriginal Health Statement) – national
27. Brisbane North Division of General Practice – Qld
28. Australian Medical Association Limited – national
29. Vision2020/Christian Blind Mission International/International Centre for Eyecare Education – national
30. Australian Institute of Biological Medicine – National – Non-government organisation
31. Queensland Divisions of General Practice – Queensland – Non-government organisation

National Strategic Framework for Aboriginal and Torres Strait Islander Health

32. Queensland Public Health Forum – Queensland
33. Australian Institute of Environmental Health – national
34. Australian Physiotherapy Association – national
35. Rural, Remote Aboriginal and Torres Strait Islander Program, National Heart Foundation – national
36. Mental Health Council of Australia – national
37. Women’s Health Victoria – VIC –
38. Alcohol and other Drugs Council of Australia –national
39. Public Health Association of Australia – national
40. Society of St Vincent De Paul – NSW
41. Brisbane Southside Central Division of General Practice – QLD

Commonwealth Government Agencies

42. Department of Health and Ageing
43. Aboriginal and Torres Strait Islander Commission NT State Policy Centre – NT
44. Commonwealth Department of Reconciliation and Aboriginal and Torres Strait Islander Affairs
45. Department of The Prime Minister and Cabinet
46. Commonwealth Grants Commission
47. Australian Institute of Health and Welfare
48. Department of Transport and Regional Services
49. Human Rights and Equal Opportunity Commission
50. Commonwealth Department of the Treasury
51. Australian Bureau of Statistics
52. Aboriginal and Torres Strait Islander Commission WA State Council
53. National Health and Medical Research Council
54. Department of Education, Science and Training
55. Department of Defence
56. Aboriginal and Torres Strait Islander Commission NSW Office

State/Territory Government Agencies

57. Centre for Mental Health, NSW Health – NSW
58. ACT Department of Health and Community Care – ACT
59. Department of Health and Human Services Health Advancement Division –
60. NSW Health – NSW
61. Queensland Health – QLD

National Strategic Framework for Aboriginal and Torres Strait Islander Health

62. NT Department of Health and Community Services – NT –
63. Dr Amanda Lee , Public Health Nutritionist, Queensland Health – QLD
64. Human Services Training Advisory Council Inc – NT
65. Health Department of Western Australia, Office of Aboriginal Health – WA

Inter-governmental Working Groups

66. National Public Health Partnership Group – National – Alliance of government and non-government organisations
67. National Health Priority Action Council - National – Alliance of government and non-government organisations

Education Institutions

68. The New South Wales College of Nursing – NSW
69. TAFE NSW – Western Institute – NSW
70. Central Australian Remote Health Training Unit (CARHTU) – NT
71. James Cook University – School of Public Health and Tropical Medicines – Queensland

Comment on the National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion - Consultations Conducted (2001)

- A. ATSIC Tasmania State Advisory Committee meeting – Launceston, Tasmania – 16 May 2001.
- B. ATSIC Northern Territory State Policy Committee – Alice Springs, Northern Territory – 17 May 2001.
- C. ATSIC Central Queensland Regional Council – Gayndah, Queensland – 6 June 2001.
- D. Northern Australian Indigenous Health Alliance – Cairns, Queensland – 8 June 2001.
- E. Binaal Billa ATSIC Regional Council – Condobolin, NSW – 17 September 2001.
- F. ACT Health Forum Partners – Narooma, NSW – 27 September 2001.
- G. ATSIC SE Queensland Regional Council – Gold Coast, Queensland – 9 October 2001.
- H. SA Aboriginal Health Partnership – Adelaide, South Australia – 12 October 2001.
- I. ATSIC, State Health, Aboriginal Health Service Providers – Launceston, Tasmania – 25 October 2001.
- J. Malraabah, Kullarri and Wunan ATSIC Regional Councils (WA Kimberley Region) – Broome, Western Australia – 12 November 2001.

Comment on the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* – Submissions received from Framework Agreement partners (2002)

Aboriginal and Torres Strait Islander Commission/Torres Strait Regional Authority

ATSIC Administrative Arm (incorporating comments from Regional Councillors)

Aboriginal Community Controlled Health Sector

National Aboriginal Community Controlled Health Organisation

Central Australian Aboriginal Congress

Aboriginal Health Council of South Australia

State and Territory Governments

Department of Health and Community Services – Northern Territory

Department of Health and Human Services - Tasmania

Office of Aboriginal Health, Health Department of Western Australia

Department of Human Services – South Australia

New South Wales Health Department

New South Wales Cabinet Office

Queensland Health

Department of Health and Community Care – Australian Capital Territory

Department of Human Services – Victoria

Commonwealth Government Agencies

Department of Health and Ageing

Department of Prime Minister and Cabinet

Australian Bureau of Statistics

Department of Immigration and Multicultural and Indigenous Affairs

Department of Employment and Workplace Relations

Department of Transport and Regional Services

Department of Finance and Administration

Department of Family and Community Services

National Health and Medical Research Council

Department of Veterans' Affairs

Department of the Treasury

Department of Defence

Appendix Seven:

List of Major Reports in Aboriginal and Torres Strait Islander Health

Chronology of National and Commonwealth Reports

1969	Commonwealth Office of Aboriginal Affairs established Aboriginal and Torres Strait Islander health as one of its four major priorities.
1973	Commonwealth Department of Health <i>Ten Year Plan for Aboriginal Health</i>
1979	House of Representatives Standing Committee on Aboriginal Affairs released its report <i>Aboriginal Health</i> .
1989	National Aboriginal Health Strategy Working Party produced <i>A National Aboriginal Health Strategy</i>
1990	Aboriginal Health Development Group <i>Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health</i>
1991	ATSIC <i>Interim Aboriginal and Torres Strait Islander Health Goals and Targets</i>
1991	Human Rights and Equal Opportunities Commission, <i>Royal Commission into Aboriginal Deaths in Custody</i>
1992	COAG: <i>National Commitment to Improved Outcomes for Aboriginal and Torres Strait Islander People</i>
1992	House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, <i>Mainly Urban: Report of the Inquiry into the needs of urban dwelling Aboriginal and Torres Strait Islander peoples</i>
1991	Aboriginal and Torres Strait Islander Commission and National Better Health Program, <i>Aboriginal and Torres Strait Islander Health Goals and Targets</i>
1992	Council of Australian Governments <i>National Commitment to Improved Outcomes for Aboriginal and Torres Strait Islander People</i>
1994	ABS: <i>National Aboriginal and Torres Strait Islander Survey 1994: health of Indigenous Australians and detailed findings</i>
1994	ATSIC <i>Evaluation of the National Aboriginal Health Strategy</i>
1994	<i>Aboriginal and Torres Strait Islander Social Justice Commissioners Report</i>
1995	National Mental Health Strategy <i>Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health</i>
1996	<i>Agreements on Aboriginal and Torres Strait Islander Health</i> (Framework Agreements) signed in all States and Territories
1996	DHFS: <i>Future directions in Aboriginal and Torres Strait Islander emotional and social well being (mental health): action plan</i>
1997	ABS and AIHW: <i>The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples</i>
1997	Aboriginal and Torres Strait Islander Health and Welfare Information Unit : <i>The Aboriginal and Torres Strait Islander health information plan</i>
1997	HREOC <i>Bringing them Home: Report into the Separation of Aboriginal and Torres Strait Islander Children from their Families</i>

1997	ANCARD Working Party on Indigenous Australians' Sexual Health: <i>The National Indigenous Australians' Sexual Health Strategy</i>
1998	Deeble J et al. (AIHW) <i>Expenditures on health services for Aboriginal and Torres Strait Islander People</i>
1998	Australian National Audit Office reviews, <i>Aboriginal and Torres Strait Islander Health Program, and Delivery of Housing and Infrastructure</i>
1999	ANAO: <i>The Aboriginal and Torres Strait Islander Health Program</i> . Audit Report no 13.
1999	ANAO: <i>National Aboriginal Health Strategy – Delivery of Housing and Infrastructure to Aboriginal and Torres Strait Islander Communities</i> . Audit report No 39.
2000	National Health Information Management Group: <i>National summary of the 1998 jurisdictional reports against the Aboriginal and Torres Strait Islander Health Performance Indicators</i> .
2000	House of Representatives Standing Committee on Family and Community Affairs <i>Health is Life: Report on the Inquiry into Indigenous Health</i>
2001	DHAC: <i>The Aboriginal and Torres Strait Islander coordinated care trials national evaluation report</i>
2001	Aboriginal and Torres Strait Islander Nutrition Working Party : <i>National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan</i> ,
2001	DHAC: <i>Better health care: studies in the successful delivery of primary health care services for Aboriginal and Torres Strait Islander Australians</i> .

[Note: this is not an exhaustive list]

State and Territory Reports and Strategies

ACT	Dept of Health and Community Care: <i>Australian Capital Territory Aboriginal and Torres Strait Islander regional health plan (2000)</i>
NSW	Health Department Centre for Mental Health: <i>Aboriginal mental health policy: a strategy for the delivery of mental health services for Aboriginal people in New South Wales (1997)</i>
NSW	New South Wales Health and Aboriginal Health Resource Cooperative: <i>Ensuring Progress in Aboriginal Health: A framework for the NSW Health System (1999)</i>
NSW	NSW Aboriginal Health Partnership: <i>NSW Aboriginal Health Promotion Program: Directions Paper (2001)</i>
NSW	NSW Health: <i>Better Practice Guidelines to improve the level of Aboriginal and Torres Strait Islander identification in the NSW Public Health System (2000)</i>
NSW	NSW Aboriginal Health Partnership: <i>New South Wales Aboriginal Health Strategic Plan (1999)</i>
NT	Territory Health Services: <i>Environmental health standards for remote communities in the Northern Territory (2001)</i>
NT	Territory Health Services: <i>Aboriginal Health Policy (1996)</i>
NT	Northern Territory Government: <i>Aboriginal Employment and Career Development Strategy (1997)</i>
NT	Territory Health Services: <i>The Aboriginal public health strategy and implementation guide, 1997-2002 (1998)</i>

National Strategic Framework for Aboriginal and Torres Strait Islander Health

NT	<i>Territory Health Services: NT Food and Nutrition Policy and 5 year Strategic Plan (1996)</i>
QLD	<i>Queensland Health: Aboriginal and Torres Strait Islander Health Policy (1994)</i>
QLD	<i>Queensland Aboriginal and Torres Strait Islander Health Partnership: Queensland Framework for Action in Aboriginal and Torres Strait Islander Health (1999)</i>
QLD	<i>Queensland Health: Profile of Queensland Health's indigenous workforce (1998)</i>
QLD	<i>Queensland Health: Health of Queensland's Aborigines and Torres Strait Islanders: Status Report (1996)</i>
QLD	<i>Queensland Health: Our Jobs, Our Health, Our Future: Queensland Health Indigenous Workforce Management Strategy (1999)</i>
QLD	<i>University of Queensland and Queensland Health: Queensland Aboriginal and Torres Strait Islander Food and Nutrition Strategy</i>
SA	<i>Aboriginal Health Organisation: Mental health and behavioural problems in the urban Aboriginal population (1991)</i>
SA	<i>Aboriginal Health Council of South Australia: Aboriginal health: dreaming beyond 2000: our future is in our history: South Australian Aboriginal health policy and strategic framework (1994)</i>
TAS	<i>DHAC: A demographic overview of Tasmania's Aboriginal and Torres Strait islander population (1999)</i>
VIC	<i>Department of Human Services and VACCHO: Achieving Improved Aboriginal Health Outcomes: An Approach to Reform (1996)</i>
VIC	<i>Department of Human Services: Information about Koori Women and their Babies (1996)</i>
VIC	<i>Department of Human Services: Improving Human Services for Victorian Kooris</i>
WA	<i>Joint Planning Forum: Western Australian Aboriginal Health Strategy (2000)</i>
WA	<i>Office of Aboriginal Health: Purchasing Intentions for Aboriginal Health (1999)</i>
WA	<i>Office of Aboriginal Health: Aboriginal Food and Nutrition Policy for Western Australia (1997)</i>
WA	<i>A Comparative Overview of Aboriginal Health in Western Australia 1987-96</i>
WA	<i>WA Health: Western Australian Diabetes Strategy</i>
WA	<i>Environmental Health Needs Coordinating Committee: Environmental Health Needs of Aboriginal Communities in Western Australia: survey and its findings (1997)</i>

[Note: This is not an exhaustive list]

Appendix Eight: Examples of Local Level Health Issues, Determinants and Responses

Conditions	Determinants	Possible Local Strategies			
		Maternal and child health	Young people	Adults	Elders
Preventable Chronic Diseases					
Cardiovascular Disease Diabetes Mellitus Chronic Lung Disease Kidney Disease	Socio-economic disadvantage and lack of control over life circumstances Unhealthy living conditions and food Health risk behaviours: diet, exercise, smoking, alcohol and other drugs Hypertension Genetic predisposition Stress Low birth weight Infant and childhood infections Undetected disease	<u>Population Health</u> Promoting healthy behaviours Screening Improving educational and employment opportunities Encourage breastfeeding Strategies to reduce tobacco and alcohol consumption <u>Environmental Health</u> Appropriate infrastructure such as housing and sporting facilities Access to affordable and nutritious food Store management policies <u>Primary Clinical Care</u> Antenatal care Postnatal care Risk factor management Early detection and treatment Comprehensive	<u>Population Health</u> Health promotion Screening Improving educational and employment opportunities Strategies to reduce tobacco and alcohol consumption <u>Environmental Health</u> Appropriate infrastructure such as housing and sporting facilities Access to affordable and nutritious food <u>Primary Clinical Care</u> Risk factor management Early detection and treatment Comprehensive coordinated health care	<u>Population Health</u> Health promotion Screening Improving employment opportunities Strategies to reduce tobacco and alcohol consumption <u>Environmental Health</u> Appropriate infrastructure such as housing and sporting facilities Access to affordable and nutritious food <u>Primary Clinical Care</u> Early detection and treatment Comprehensive, coordinated health care Chronic disease self-management Carer support <u>Secondary and Tertiary Care</u> Renal dialysis and	<u>Population Health</u> Health promotion Screening Strategies to reduce tobacco and alcohol consumption <u>Environmental Health</u> Appropriate infrastructure such as housing, sporting facilities Access to affordable and nutritious food <u>Primary Clinical Care</u> Early detection and treatment Comprehensive, coordinated health care Chronic disease self-management Carer support <u>Secondary and Tertiary Care</u> Renal dialysis and transplant facilities

National Strategic Framework for Aboriginal and Torres Strait Islander Health

		coordinated health care		transplant facilities Acute medical and surgical treatment Rehabilitation	Acute medical and surgical treatment Rehabilitation
<p>Related Key Result Areas: One and Two: Health Care Delivery, Two: Primary Health Care, One: Support for Community Initiatives, Five: Environmental Health, Six: Wider Issues that impact on health</p>					

National Strategic Framework for Aboriginal and Torres Strait Islander Health

Conditions	Determinants	Possible Strategies			
		Maternal and child health	Young people	Adults	Elders
Communicable Diseases					
<p><u>Major Conditions</u> Sexually transmissible infections HIV/AIDS Viral hepatitis (A, B, C) Influenza Pneumonia Vaccine Preventable Childhood Diseases Diarrhoeal Disease</p>	<p>Living conditions Community cohesion and shared values Sexual violence Health risk behaviours: violence, alcohol, drugs, unprotected sex Undetected infections Lack of access to treatment/screening Community leadership and understanding, Individual health information and control Issues of sexuality High mobility</p>	<p><u>Population Health</u> Immunisation programs Health education Community development</p> <p><u>Environmental Health</u> Improved housing and sanitation Physical security of local communities</p> <p><u>Primary Clinical Care</u> Antenatal screening with informed consent Early detection and treatment Follow up, recall Clinical guidelines</p> <p><u>Secondary & Tertiary Care</u> Paediatric services Coordination of care Specialist outreach</p>	<p><u>Population Health</u> Screening programs Immunisation programs Availability of health hardware Health education in schools</p> <p><u>Environmental Health</u> Improved housing and sanitation Physical security of local communities</p> <p><u>Primary Clinical Care</u> Regular health checks Opportunistic screening Early detection and treatment Follow-up, contact tracing and recall Clinical guidelines</p> <p><u>Secondary & Tertiary Care</u> Coordination of care Specialist outreach</p>	<p><u>Population Health</u> Screening programs Immunisation programs Availability of health hardware Health education in community and school</p> <p><u>Primary Clinical Care</u> Regular health checks Opportunistic screening Early detection and treatment Follow up, contact tracing and recall Clinical guidelines</p> <p><u>Secondary & Tertiary Care</u> Coordination of care Specialist outreach</p>	<p><u>Population Health</u> Screening programs Immunisation programs Health education in community Availability of health hardware</p> <p><u>Primary Clinical Care</u> Regular health checks Opportunistic screening Early detection and treatment Follow-up, contact tracing and recall Clinical guidelines</p> <p><u>Secondary & Tertiary Care</u> Coordination of care Specialist outreach</p>
<p>Related Key Result Areas: Two: Health Care Delivery, One, Two and Three: Health Service Capacity, Two: Primary Health Care, One: Support for Community Initiatives, Five: Environmental Health, Six: Wider strategies that impact on health, Seven: Data, Research and Evidence</p>					

Conditions	Risk Factors	Strategies			
		Maternal and child health	Young people	Adults	Elders
Emotional and Social Well-being					
Grief and loss	Loss of culture	<u>Population Health</u> Parent, social skills and relationship education and support	<u>Population Health</u> Building pride in self and culture	<u>Population Health</u> Building pride in self and culture	<u>Population Health</u> Recognition and respect for elders
Anxiety	Separation from and loss of family members	Playgroups	Youth voice in local decision making	Community development	Recognition of the role of community leaders, traditional healers, and those working to resolve community problems
Depression	Experience of racism	Access to training and education	Education that builds on achievements, not failures	Community education: grief and loss, substance misuse	Activities that promote mental stimulation for elders
Suicide	Poverty	Self-protective behaviours taught in schools	Relationship and social skills training	Recognition of the role of community leaders, traditional healers and those working to resolve community problems	Cultural programs
Violence and crime	Educational disadvantage		Education and holistic programs/activity to address substance misuse		Oral history and story-telling programs
Substance misuse	Poor and crowded housing	<u>Primary Care</u> Parent mentoring	Education about coping with grief and loss	<u>Primary Care</u> Counselling for those experiencing grief and loss and substance use issues	<u>Primary Care</u> Grief and loss and substance use counselling
Family breakdown	Loss of pride, low self-esteem	Counselling for parental traumas experienced in childhood	Diversional activities	Relationship counselling	Family reunion programs
Child neglect and/or abuse	Scarcity of employment options	Monitoring at risk children	Community education	Programs for victims and perpetrators of violence	Programs for victims and perpetrators of violence
		Counselling for victims and perpetrators of violence	<u>Primary Care</u> Counselling for those experiencing grief and loss and substance use issues	Family reunion programs	Inter-agency collaboration in family health and well-being
		Relationship counselling	Early intervention for those at risk of suicide and self-harm	Inter-agency collaboration in family health and well-being	
		Access to legal aid and emergency housing	Mentoring programs for those with a history of self-harm, low self-esteem, depression etc		
		Time out for parents	Community justice for those causing disruption		
		Inter-agency collaboration in family health and well-being			

National Strategic Framework for Aboriginal and Torres Strait Islander Health

			in the community Inter-agency collaboration in family health and well-being		
Related Key Result Areas: Four: Emotional and Social Well-being, Two: Health Care Delivery, Two: Primary Health Care, One: Support for Community Initiatives, Five: Environmental Health					

National Strategic Framework for Aboriginal and Torres Strait Islander Health

Conditions	Risk Factors	Strategies			
		Maternal and child	Young people	Adults	Elders
Other Health Issues					
Poor pregnancy outcomes	Unhealthy food	<u>Population Health</u> Health promotion: Nutrition, hygiene, eye/ear Care, child and pregnancy	<u>Population Health</u> Screening Awareness programs for teachers	<u>Population Health</u> Screening Oral health promotion Strategies to reduce tobacco and alcohol use	<u>Population Health</u> Screening Oral health promotion Strategies to reduce tobacco and alcohol consumption
High infant mortality	Living conditions: dust, water, sewerage	Oral health Screening Strategies to reduce Tobacco and alcohol use SIDS prevention	Oral health promotion Strategies to reduce tobacco and alcohol use		
Child growth faltering	Educational and social Disadvantage			<u>Environmental Health</u> Water supplies, sewerage Housing and infrastructure Recreational facilities	
Ear health			<u>Environmental Health</u> Water supplies, sewerage Housing and infrastructure Classroom design Recreational facilities		<u>Environmental Health</u> Water supplies, sewerage Housing and infrastructure Recreational facilities
Eye health	Dispossession, social disruption, alienation				
Oral health	High rates of smoking	<u>Environmental Health</u> Water supplies, sewerage Housing and infrastructure Classroom design Recreational facilities			
	Undetected disease		<u>Primary Clinical Care</u> Provision of equipment Training of Aboriginal & Torres Strait Islander Health Workers	<u>Primary Clinical Care</u> Provision of health equipment Training of Aboriginal and Torres Strait Islander Health Workers	<u>Primary Clinical Care</u> Provision of equipment Training of Aboriginal and Torres Strait Islander Health Workers
	Chronic infections	<u>Primary Clinical Care</u> Provision of equipment Health worker training Coordinated services Ante & postnatal care Dental health services	Coordinated service provision Dental health services	Coordinated service provision Dental health services	Coordinated service provision Dental health services
	Lack of access to screening services				
	Lack of access to quality Health management and follow up services	<u>Secondary and Tertiary Care</u> Birthing services Specialist services Shared care Surgical interventions Hearing aids	<u>Secondary and Tertiary Care</u> Specialist services and shared care Hearing aids Surgical interventions	<u>Secondary & Tertiary Care</u> Specialist services and shared care Hearing aids Surgical interventions	<u>Secondary and Tertiary Care</u> Specialist services and shared care Hearing aids Surgical interventions
	Early and frequent Pregnancies				
	Lack of oral hygiene, dental facilities and education				

Related Key Result Areas: Two: Health Care Delivery, One and Three: Building Capacity, Two: Primary Health Care, Five: Environmental Health, Six: Wider Issues that impact on health, Seven: Data, Research and Evidence

Appendix Nine: The Australian Health System

Roles and responsibilities

In 1946 the Australian Constitution was amended to enable the Commonwealth Government to provide health benefits and services, without altering the powers of the State and Territory governments in this regard. Consequently the two levels of government have overlapping responsibilities in this field.

Policy and planning decisions affecting Aboriginal and Torres Strait Islander health are made collaboratively by the four partners to the *Aboriginal and Torres Strait Islander Health Framework Agreements* through mechanisms established under the Agreements, in place in every state and territory and the Torres Strait. These mechanisms are the partnership forums at the state, territory and regional level and the National Aboriginal and Torres Strait Islander Health Council at the national level. The four partners are the Commonwealth Government, the State or Territory government, the National Aboriginal Community Controlled Health Organisation (NACCHO) or its state/territory affiliate, and the Aboriginal and Torres Strait Islander Commission (ATSIC). In the Torres Strait Agreement, the Torres Strait Regional Authority is represented in place of ATSIC.

State and Territory Governments

Through their departments responsible for health/human services, State and Territory governments are responsible for the funding and delivery of mainstream health programs, including hospitals, clinical care and public health programs and health services specifically for Aboriginal and Torres Strait Islander peoples within their jurisdictions. State, territory and local governments and authorities are responsible for funding and delivery of environmental health services which are supplemented in targeted Aboriginal and Torres Strait Islander communities by ATSIC.

Departments of health/human services also have a role in creating links with other departments and agencies that have an impact upon the health status of Aboriginal and Torres Strait Islander peoples in areas such as housing, education, etc. In some states and territories a number of critical portfolios such as health, housing and community services are brought together in one large department, making links and coordinated approaches easier.

The Commonwealth, State and Territory governments jointly fund public hospitals and community care for aged and disabled persons.

Commonwealth Government

Through its Department of Health and Ageing, the Commonwealth Government is primarily responsible for funding primary health care services such as fee for service General Practitioner, pathology and pharmacy services, community controlled health services and specific Aboriginal and Torres Strait Islander primary health care services. The Commonwealth Government also funds most health research and provides a 30 per cent subsidy to individuals who acquire private health insurance.

The Department of Health and Ageing has a direct role in developing Aboriginal and Torres Strait Islander specific health improvement initiatives and a coordination and advocacy role in relation to access to mainstream health improvement initiatives for Aboriginal and Torres Strait Islander peoples. Both the Department of Health and Ageing and the Department of Immigration, Multicultural and Indigenous Affairs have an advocacy and peer leader role in relation to portfolios responsible for education, employment, family and community services and transport whose activities impact upon the health status of Aboriginal and Torres Strait Islander peoples.

National Aboriginal Community Controlled Health Organisation (NACCHO)

NACCHO is the peak national body on Aboriginal health and well-being, representing about 100 health and substance misuse services throughout Australia that are operated by organisations that are incorporated and controlled by Aboriginal people. These organisations aim to provide direct, comprehensive primary health care services and are the employers of the health professionals who work in them. NACCHO at the national level and its affiliates at the state/territory level, provide a voice for Aboriginal community controlled health services in national negotiations, forums and consultation, policy development and planning.

Aboriginal and Torres Strait Islander Commission/Torres Strait Regional Authority

In 1990 ATSIC was established to give Aboriginal and Torres Strait Islander peoples greater control over Commonwealth programs and services. ATSIC's network of local and regional representatives elected directly by Aboriginal and Torres Strait Islander peoples provide a voice in the administration of Commonwealth programs. ATSIC supplements Commonwealth, State and Territory government mainstream services to Aboriginal and Torres Strait Islander peoples with specific programs relating to areas of disadvantage such as employment, housing, environmental health, law and justice, largely through funding to regional councils and incorporated community organisations.

The Torres Strait Regional Authority (TSRA) is a Commonwealth statutory authority established in 1994 under the Aboriginal and Torres Strait Islander Commission Act 1989. It *“aims to strengthen the economic, social and cultural development of the Torres Strait to improve the lifestyle and well-being of Torres Strait islanders and Aboriginal people living in the region.”*⁶⁵ Under the Act, the TSRA must fulfil a number of requirements including monitoring the effectiveness of programs for Torres Strait Islanders and Aboriginal people living in the Torres Strait area. The TSRA also represents Torres Strait Islander people at national and state level forums and consultations.

Health Care Delivery in Australia

As indicated above, a mix of public and private sector providers delivers health services.

The majority of doctors are self-employed. A small proportion consists of salaried employees of Commonwealth, state/territory or local governments. Other doctors may contract with public hospitals to provide medical services. There are many independent pathology and diagnostic imaging services operated by doctors. For some allied health / paramedical professions, there is a significant proportion self-employed. Others are mainly employed by State and local government health organisations.

⁶⁵ Torres Strait Regional Authority Website: www.tsra.gov.au

Public hospitals include hospitals established by governments and in addition hospitals originally established by religious or charitable bodies but now directly funded by government. A small number of hospitals built and managed by private firms provide public hospital services under arrangements with State and Territory governments. Large urban public hospitals provide most of the more complex types of hospital care.

Medicines or pharmaceuticals prescribed by doctors and dispensed in the community by independent private sector pharmacies are directly subsidised by the Commonwealth Pharmaceutical Benefits Scheme (PBS). Public hospitals do not attract PBS subsidies. Non-prescription medicines are available from pharmacies and in some cases other suppliers such as supermarkets.

State and territory organisations provide school dental care and dental care for people on low incomes. Other dental care is financed and delivered wholly in the private sector.

Provisions for special needs groups

There are some specialised health care organisations arising out of Australia's unique history and needs. Notable among these are: the Royal Flying Doctor Service which delivers medical care to remote areas; the Aboriginal community controlled health services which aim to meet the special needs of Aboriginal peoples; and Multipurpose Services configured to best suit the needs of people living in rural and remote communities.

Medicare

The aim of the national health care funding system is to give universal access to health care while allowing choice for individuals through a substantial private sector involvement in delivery and financing.

The major part of the national health care system is the Medicare Benefits Schedule, known as "Medicare". Commonwealth funding for Medicare is mainly provided as subsidies for prescribed medicines and private medical and optometry services, substantial grants to State and Territory governments to contribute to the costs of providing access to public hospitals and health services, and specific purpose grants to State/Territory governments and other bodies. State and Territory governments supplement Medicare funding with their own revenues.

All people eligible for Medicare are entitled to free medical, nursing and other care as public patients or some assistance towards treatment as private patients. State and Territory governments are responsible, under agreements with the Commonwealth Government, for ensuring that services adequate to meet public patient entitlements are available to all people eligible for Medicare.

Medicare benefits subsidise services by doctors, refraction testing by optometrists, and, in some circumstances, certain specialised dental surgery services.

The Medicare Benefits Schedule defines the type of medical service that the Commonwealth will fund and sets a scheduled fee for these services. The Medicare rebate is 85% of this scheduled fee. Doctors can set their own fee, patients pay this fee and then claim the Medicare rebate. Most doctors will bulk bill patients who have a health care card and some

doctors will bulk bill all their patients. Where this occurs the doctor will send the bill directly to Medicare, agreeing to accept the rebate as payment in full for the service and the patient receives the service free of charge. For this to occur, the patient must be enrolled in Medicare and be able to provide their Medicare number.

Pharmaceutical Benefits

The Pharmaceutical Benefits Scheme (PBS) aims to provide access to effective and necessary prescription medications at a reasonable cost to the patients. Pharmaceutical benefits are usually paid direct to private sector pharmacists who dispense the medicines. Around 75 per cent of all prescriptions issued in Australia are subsidised under the PBS. The other major source of subsidised medicines is public hospitals where medicines are provided free.

Persons in receipt of certain pensions, benefits or concession cards pay a smaller amount per item prescribed than other patients. Pharmacists must check patients' entitlement cards before providing medicines at the concessional rates.

Administration, Consultation and Negotiation Arrangements

In the field of health, the peak consultative body between Commonwealth, State and Territory governments is the Australia Health Ministers' Conference (AHMC). The major health funding agreements are bilateral agreements between the Commonwealth government and each State and Territory government, with the broad parameters being agreed multilaterally by AHMC. Strategic public health and other partnerships are negotiated in similar ways. There are subordinate bodies in which officials represent Commonwealth, State and Territory health departments. These include, the Australian Health Ministers' Advisory Council, (AHMAC) comprising the Chief Executive Officers of each government's health department and its sub-committee, the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) which comprises the heads of Aboriginal and Torres Strait Islander health units in each government.

The National Health and Medical Research Council (NHMRC) is funded by the Commonwealth government but is independent. It advises governments, other organisations and health workers on a wide range of health matters, and allocates substantial medical research funds provided by the Commonwealth. The Council's membership includes representatives of the major stakeholders in the health system, appointed from the public and private sectors. In addition to its peak council, the NHMRC has several ongoing committees and ad hoc working groups. The main ongoing committees are the National Health Advisory Committee, the Australian Health Ethics Committee, the Research Committee which oversees most Commonwealth medical research funding, and the Strategic Research Development Committee.

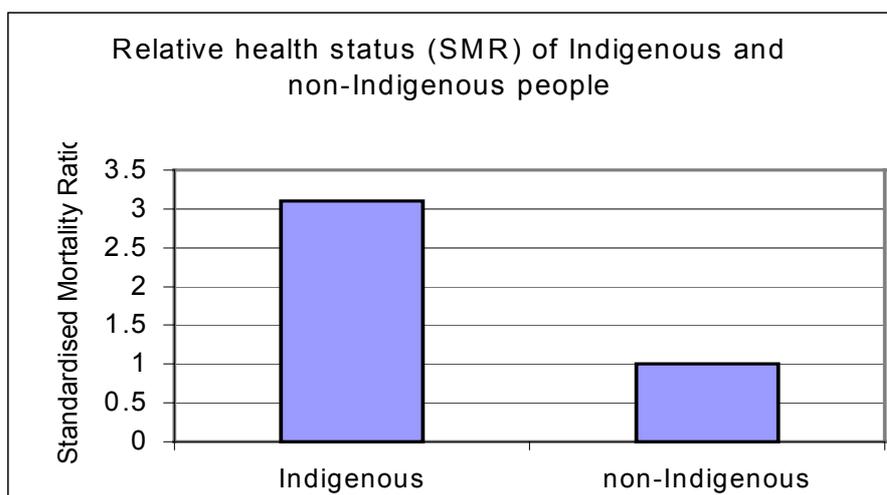
The Commonwealth Department of Health and Ageing advises the Commonwealth Minister for Health and Ageing. The Health Insurance Commission and its Medicare Offices administer enrolment in Medicare, claims for Medicare benefits, pharmaceutical benefits and a range of other Commonwealth programs. The State and Territory governments also have arrangements for advising their Ministers and for administering public hospital and other health care programs.

Funding for Aboriginal and Torres Strait Islander health services

There is evidence of under-expenditure on Aboriginal and Torres Strait Islander health, and the Commonwealth Grants Commission has noted that “*there is no evidence that any State, region or location has resources excessive to those required to address the health need of Indigenous people*”⁶⁶.

Despite the much higher rates of preventable illness and death (*Figure 6*), and higher costs of delivering services given the relatively high proportion of Aboriginal and Torres Strait Islander people living in remote areas, expenditure on health services for Aboriginal and Torres Strait Islander populations is only 22% higher than for non-Indigenous Australians⁶⁷. This is illustrated in *Figure 7*, which shows how adjusting for the extra costs of remote service provision and poorer health status reduces the buying power of available funding. Increased expenditure is required both for primary health care services and for access to specialist clinical services.

Figure 6: Relative mortality rates for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian populations



The need for higher than average expenditure on health services for Aboriginal and Torres Strait Islander peoples is consistent with patterns of expenditure for other groups of Australians who have worse than average health status. For example:

- participants in mainstream Coordinated Care Trials in NSW and Victoria showed expenditure of 5 to 6.6 times average MBS and PBS expenditure⁶⁸;
- Australians over the age of 65 use 2.1 times the national average MBS⁶⁹; and
- Australians with multiple health conditions use higher levels of health funding, for example around four times the average where two conditions are involved, seven times the average for three conditions, and up to twelve times the average for five conditions⁷⁰.

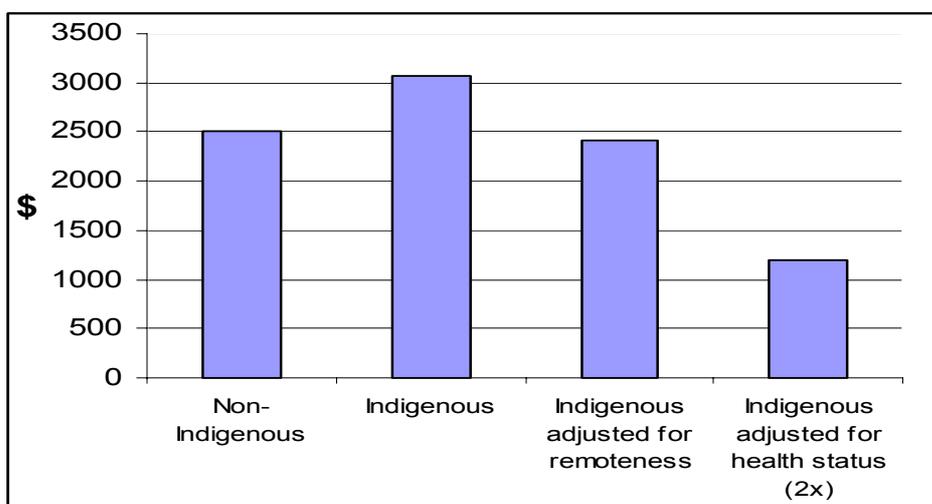
⁶⁶ CGC 2001, op cit

⁶⁷ AIHW and DHAC, 2001, op cit.

⁶⁸ KPMG Consulting, op cit.

⁶⁹ DHAC, *Medicare Statistics 1984-85 to June quarter 1998*, op cit.

Figure 7: Health expenditure on Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian populations, 1998-99, and adjusted for remoteness and health status to show ‘buying power’

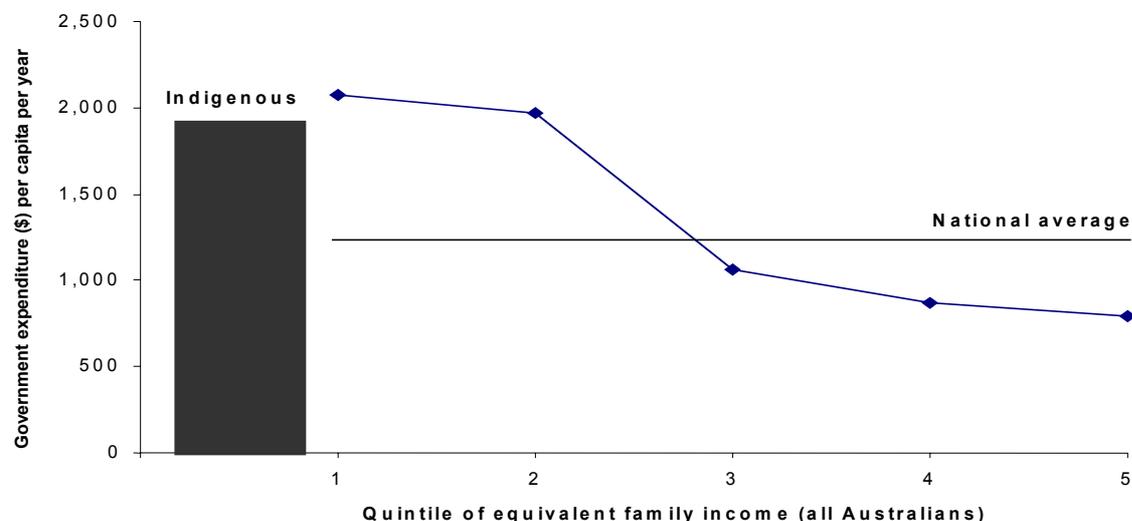


Source: Columns 1 & 2, AIHW and DHAC, 2001. Columns 3 & 4 based on calculations by Department of Health and Aging. The remoteness adjustment in column 3 is on the basis of it being twice as expensive to provide services in remote areas. Column 4 includes the remoteness adjustment and assumes that the poor health status of Indigenous people increases need for health services by a factor of 2

The lower than average incomes of Aboriginal and Torres Strait Islander peoples limits their ability to contribute to the costs of health care through private expenditure. Adequate government funding is therefore essential if appropriate access to health services is to be attained. This is no different to arrangements that exist for other Australians in low socio-economic groups (see Figure 8).

⁷⁰ DHAC, 2000, *Insights into the utilisation of health services in Australia based on linked administrative data*, Occasional Paper, New Series, No 9.

Figure 8. Estimated government expenditure per person for Aboriginal and Torres Strait Islander peoples and for all Australians by quintile of equivalent family income, 1993-94⁷¹



Responsibility for funding health services provided to Aboriginal peoples and Torres Strait Islanders is shared between the Commonwealth and State/Territory governments. In 1998-99 45.5% of these funds were sourced from the Commonwealth and 44.9 % from State and Territory governments. (See Figure 9⁷²).

Figure 9: Source of funding for recurrent health expenditure for Aboriginal and Torres Strait Islander peoples, 1998-99.

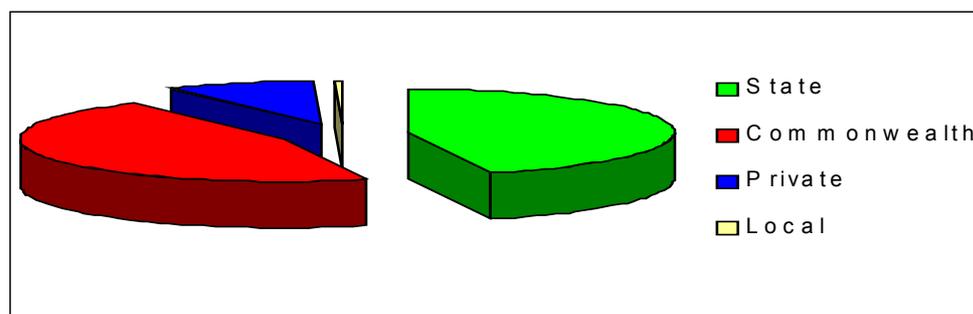
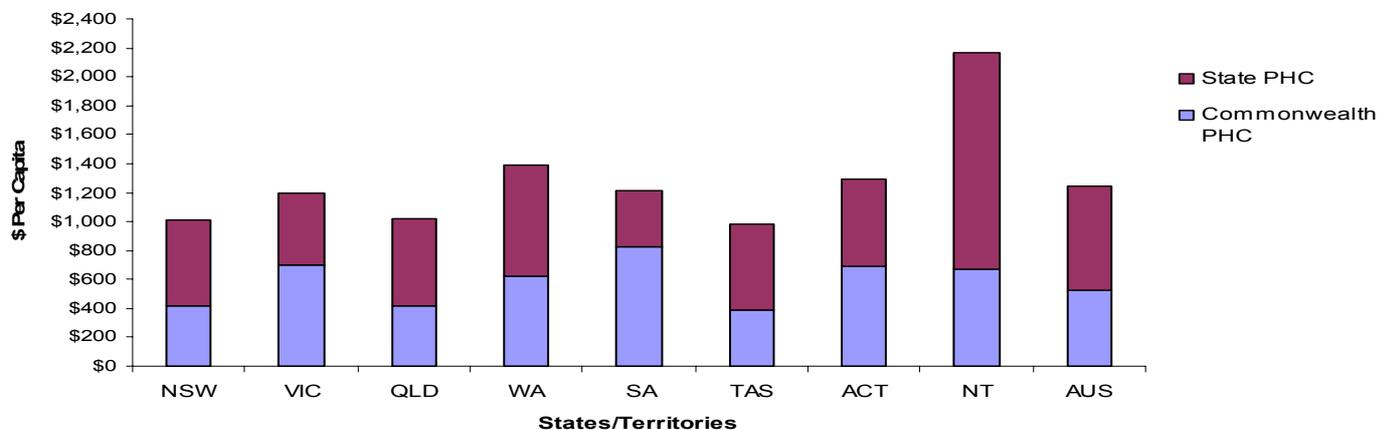


Figure 10 illustrates the different levels of Commonwealth, State and Territory expenditures on primary health care to Aboriginal and Torres Strait Islander communities in the 1998-99 financial year.

⁷¹ Deeble J et al, op cit

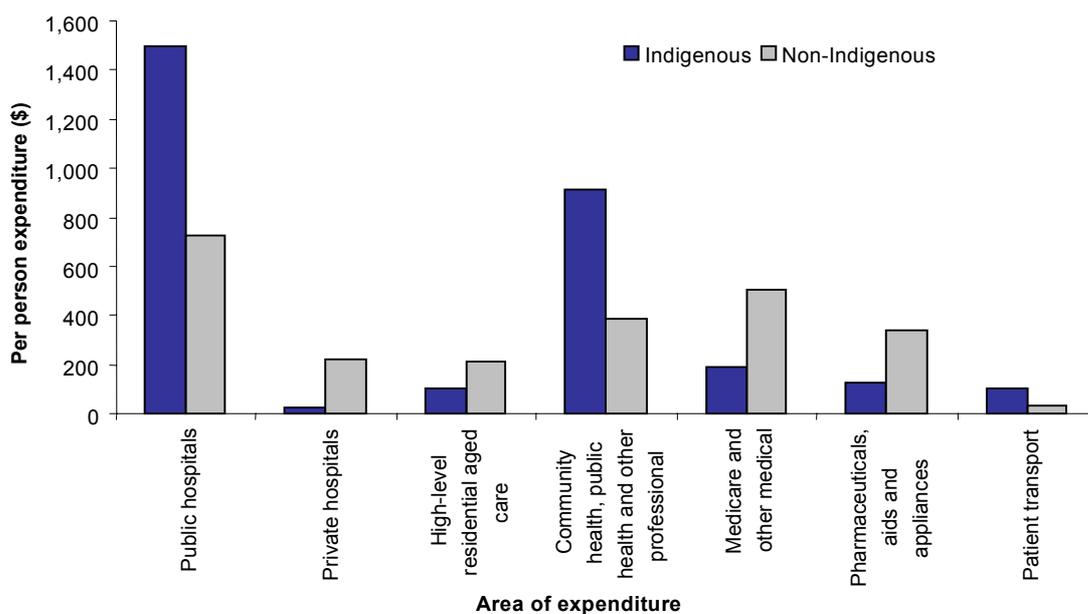
⁷² AIHW and DHAC 2001, op cit

Figure 10: Direct Commonwealth, State and Territory Funding for Primary Health Care – 1998/99 (per capita)⁷³



The key areas of expenditure on Aboriginal and Torres Strait Islander peoples’ health are in the hospital sector, the local primary health care setting (which covers community health, private medical practitioners and pharmacists), dental and allied health, patient travel, residential aged care and other areas. *Figure 11* shows the relative funding levels for the various components, and illustrates the different patterns of service use by Aboriginal and Torres Strait Islander peoples. This is characterised by higher use of hospitals, patient transport and State funded community health services, and lower use of Medicare and pharmaceuticals.

Figure 11: Estimated total expenditures per person for Indigenous and non-Indigenous Australians, by area of expenditure 1998-99⁷⁴



⁷³ Deeble et al 1998, op cit

⁷⁴ AIHW and DHAC 2001, ibid

Higher hospital costs for Aboriginal and Torres Strait Islander peoples are in line with expectations given the poorer health status of this group compared with that of the general population. However, analysis of casemix data shows that there is a very high use of hospitals for conditions that should be treated in a primary health care setting⁷⁵. There is also evidence that Aboriginal and Torres Strait Islander patients are less likely to have a principal procedure recorded when in hospital⁷⁶. This indicates both a need to improve the primary health care system to better meet the needs of Aboriginal and Torres Strait Islander peoples as well as a need to facilitate appropriate access to therapeutic and diagnostic procedures, and other in-hospital services.

Funding for community-based primary health care, generally delivered through private practising GPs, pharmacists and community health clinics for Aboriginal and Torres Strait Islander peoples is lower than expected when the poorer health status of this group and higher costs of delivery in remote areas are taken into account. This is due in part to the lower access to services provided under the MBS and PBS schemes, which are only partially compensated through higher community health funding.

There is significantly less spending (both government and private) on dental and allied health services for Aboriginal and Torres Strait Islander peoples compared with the rest of the population, despite significantly greater needs in this area.⁷⁷ Private spending plays a major part here for non-Aboriginal or Torres Strait Islander Australians. Funding provision that better reflects the needs of Aboriginal and Torres Strait Islander peoples in delivery of appropriate aged care facilities is also needed.

In summary, if Aboriginal and Torres Strait Islander peoples are to have access to equivalent health services based on need, particular effort is needed in primary care by Commonwealth, State and Territory governments, with further action also needed in allied health, aged care and acute care programs.

⁷⁵ Stamp KM, Duckett SJ and Fisher DA, 1998, "Hospital Use for Potentially Preventable Conditions in Aboriginal and Torres Strait Islander and Other Australian Populations", *Australian and New Zealand Journal of Public Health*, Vol 22, No 6 (ANZJPH)

⁷⁶ Cunningham, J, 2002, "Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous". *Medical Journal of Australia*, Vol 176,

⁷⁷ AIHW, *Oral health and access to dental services among Indigenous Australians*, AIHW Dental Statistics Unit, Research Report, March 2000