



2018

AMA REPORT CARD ON INDIGENOUS HEALTH

REBUILDING THE CLOSING THE GAP HEALTH
STRATEGY: Including a Review of the 2016 and 2017
AMA Indigenous Health Report Card Recommendations



FOREWORD

AMA PRESIDENT, DR TONY BARTONE

Getting serious about Closing the Gap

Aboriginal and Torres Strait Islander people have the right to access health care that is easily available, comprehensive, and respectful of their culture.

Since 2002, the AMA's Indigenous Health Report Cards have highlighted core issues to address persistent inequalities for Indigenous people in Australia. We have advocated strongly to increase awareness among governments, politicians, the media, and the general public about the state of Aboriginal and Torres Strait Islander health.

It has been 10 years since the Closing the Gap strategy was launched. One of the main targets was to close the life expectancy gap between Indigenous and non-Indigenous Australians by 2031 - but the gap is widening, not closing. A complete restructuring of the strategy is needed to genuinely close the gap.

The 2018 AMA Report Card combines our proposals for 'Rebuilding the Closing the Gap Health Strategy' and a review of the recommendations of our 2016 and 2017 AMA Report Cards, which focused on rheumatic heart disease (RHD) and otitis media respectively.

This year's Report Card takes six recommendations mentioned in the 2018 Close the Gap Campaign Steering Committee's Ten-Year Review and outlines a 'ground up' approach that focuses on the targets required for the strategy.

We highlight the fundamental issues such as committing to equitable needs-based funding; systematically costing, funding, and implementing the health and mental health plans; identifying and filling the gaps in primary health care; addressing environmental health and housing; addressing social determinants; and Aboriginal leadership.

The Report Card highlights the practical recommendations required to achieve Closing the Gap targets, and guides the Closing the Gap 'refresh' process.

We have included good news stories on hearing health programs and the End Rheumatic Heart Disease Alliance, which give us good cause for optimism for the future of Aboriginal and Torres Strait Islander health.

The AMA is strongly committed to improving health and life outcomes for Aboriginal and Torres Strait Islander peoples, and is working to shape a health system that is responsive to the unique health and cultural needs of Indigenous patients.

We call on all levels of government to take note of these targets, and we commend this Report Card to all stakeholders involved in Indigenous health.



Dr Tony Bartone

President, Australian Medical Association
November 2018

EXECUTIVE SUMMARY

Ten years after the launch of the Closing the Gap Strategy, the Aboriginal and Torres Strait Islander life expectancy gap is actually widening, and the Strategy itself has all but unravelled. Further, an effort currently underway to refresh the Strategy runs the risk of **simply perpetuating the current implementation failures**. Commonwealth leadership and a national approach should be restored, and the Strategy itself **needs to be rebuilt** from the ground up if the health and life expectancy gap is to close by 2031. This rebuilding process should include Australian governments:

- **Committing to equitable, needs-based funding.** The Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden. However, overall Commonwealth Government spending is only 53 per cent of the needs-based requirements. Spending less per capita on those with worse health, and particularly on their primary health care services, is dysfunctional national policy. It is not 'special treatment' to provide additional health funding that is proportional to additional health needs. Further, the relative lack of spending on primary health care results in increased hospitalisation costs. It is a highly inefficient way to spend health dollars. This too must change.
- **Systematically costing, funding, and implementing the Closing the Gap health and mental health plans.** First, identify, cost, and fund the previously unimplemented parts of the 2015 *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan*; second, cost, fund and implement the 2017 *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*. Further, a rebuilt Strategy must make social and emotional wellbeing and mental health a priority.
- **Identifying and filling primary health care service gaps.** Sizeable and rapid health gains would result from additional primary health care services and targeted improvements to existing primary health services to prevent, detect, and then manage the conditions that lead to potentially preventable hospital admissions and deaths. By definition, it is these conditions that must be addressed if the life expectancy gap is to close. As already required by Strategy 1A of the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan*, these services should generally be provided by Aboriginal Community Controlled Health Services that are more accessible, perform better in key areas, and are the most cost-effective vehicles for delivering primary health care to Aboriginal and Torres Strait Islander communities.
- **Addressing environmental health and housing.** The Closing the Gap Strategy included a national, multi-billion dollar remote housing program that has been allowed to lapse. This must be revitalised and restored.
- **Addressing the social determinants of health inequality.** The Closing the Gap Strategy recognised that closing the health and life expectancy gap required a simultaneous and integrated address to a range of areas. The *My Life, My Lead* report provides a blueprint for a renewed national commitment to address the social determinants of health inequality and strengthen the cultural determinants of good health.
- **Placing Aboriginal health in Aboriginal hands.** Ultimately, a rebuilt Closing the Gap Strategy must be connected to an even bigger picture, based on a recognition of the right to self-determination of Aboriginal and Torres Strait Islander peoples in all areas of life, including health.

INTRODUCTION

This year's AMA Indigenous Health Report Card marks 10 years since the launch of the 2008 Council of Australian Governments (COAG) Closing the Gap Strategy (the Strategy) and its 2031 target to achieve Aboriginal and Torres Strait Islander life expectancy equality. It also coincides with efforts to 'refresh' the Strategy. Such efforts are timely. Ten years on, progress is limited, mixed, and disappointing, and data recently published by the Australian Institute of Health and Welfare (AIHW) indicates that the life expectancy gap is actually widening, with Aboriginal and Torres Strait Islander health gains being outpaced by non-Indigenous gains.ⁱ

Further, the Strategy itself is on 'life support', being the proverbial shadow of its former self. The achievement of life expectancy equality by 2031 depended on a 25-year joint commitment by Australian governments. Yet in 2015-16, critical funding 'national partnership agreements' were allowed to expire and with them Commonwealth leadership and a national approachⁱⁱ. While the headline 2031 life expectancy target remains in place, as found by the AMA-endorsed 2018 Close the Gap Campaign Steering Committee's *Ten-Year Review*, it is now marking little apart from the 'collective failure of Australian governments to work together and stay the course'ⁱⁱⁱ.

In this context, a superficially 'refreshed' yet unfunded or underfunded Strategy is not enough and runs the risk of **simply perpetuating the current implementation failures**. Indeed, to meet its own targets the Closing the Gap Strategy requires significant interventions: it needs to be rebuilt from the ground up with the question of the what, who, how and cost of implementation being at the forefront of thinking.

The abovementioned *Ten-Year Review* included six recommendations that the AMA endorses. Among other things, these go to the question of renewing Commonwealth leadership and a national approach. This Report Card aims to complement these recommendations by considering a 'ground-up' approach to rebuilding the Closing the Gap Strategy through six targets.

Target 1: Australian governments commit to equitable, needs-based expenditure

The concept of equitable, needs-based health expenditure means in practice that some population groups receive more funding than others because of their greater health needs. It is an uncontroversial proposition; for example, governments spend proportionally more on the health of elderly people when compared to young people because elder peoples' health needs are proportionally greater.

Responsible Australian political leaders and commentators must tackle the misguided thinking that equates 'special treatment' with equitable treatment.

The same principle should be applied when assessing what equitable Aboriginal and Torres Strait Islander health expenditure is, relative to non-indigenous health expenditure:

- A starting point is that the AIHW estimates the Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden.^{iv}
- The next step is using the 2.3 disease burden ratio as the basis of a needs index. By this, the Aboriginal and Torres Strait Islander population has 2.3 times the health needs of the non-Indigenous population.
- And, based on this, equitable expenditure per Aboriginal and Torres Strait Islander person should be about 2.3 times that spent per non-Indigenous person.

But this kind of expenditure has not been, and is not, the case. As set out in Table 1 below, 2013-14 expenditure levels reported in the Commonwealth Government’s 2017 *Aboriginal and Torres Strait Islander Health Performance Framework* show there are significant ‘equity shortfalls’ in Commonwealth health expenditure.

Table 1: 2013-14 Commonwealth expenditure on Aboriginal and Torres Strait Islander health^v

	Per capita expenditure: Aboriginal and Torres Strait Islander	Per capita expenditure: Non-Indigenous	Equitable health expenditure per \$1 spent on a non-Indigenous person is:	Aboriginal and Torres Strait Islander expenditure per \$1 spent on non-Indigenous person:	Actual spend as percentage of equitable spend is:
Commonwealth primary health care expenditure on medical services, including Medicare Benefits Schedule	\$271	\$302	\$2.30	\$0.90	39% (Shortfall 61%)
Pharmaceutical Benefits Schedule expenditure	\$471	\$741		\$0.63	27% (Shortfall 73%)
Total Commonwealth expenditure	\$3,261	\$2,698		\$1.21	53% (Shortfall 47%)

Spending less than needs-based funding on Aboriginal and Torres Strait Islander citizens with significantly measurably worse health than non-Indigenous citizens is untenable national policy and that must be rectified.

Overall, in 2013–14, 77 per cent of Aboriginal and Torres Strait Islander health expenditure was from Australian Governments (39 per cent from State and Territory Governments; 38 per cent from the Commonwealth). Overall the total government spend was \$1.38 expenditure per capita Aboriginal and Torres Strait Islander person for every dollar expenditure per capita non-Indigenous person: about 60 per cent of what equity requires.

But this does not include private (out of pocket) health expenditure, including on health insurance. Overall, 23 per cent of total Aboriginal and Torres Strait Islander health expenditure was private expenditure; compared to 32 per cent of the total health expenditure on the non-Indigenous population^{vi}. This highlights a further source of inequity in the health system overall.

Spending less per capita on those with worse health, and particularly on their primary health care services, is dysfunctional national policy. As a result, Aboriginal and Torres Strait Islander expenditure on hospital-based health care is six times higher than Aboriginal and Torres Strait Islander expenditure on prevention-oriented general practitioner (GP) and other medical practitioner health care^{vii}. This compares with just twice as high for the non-Indigenous population^{viii}.

Further, and in part as a result of the above, the States and Territories combined spend roughly \$2 per Aboriginal and Torres Strait Islander person for every dollar spent per non-Indigenous person^x. While ostensibly an improvement on the Commonwealth's underspend (at 87 per cent of equitable expenditure), to the degree this is being spent on expensive Aboriginal and Torres Strait Islander potentially preventable admissions (PPAs) to hospital, it is a highly inefficient way of spending health dollars, which are far better spent on prevention-oriented primary health care.

In fact, it is the long-term failure of Australian governments (and the Commonwealth in particular) to properly invest in primary health care that is the cause of much of the waste in the currently configured health system and a major contributor to the failure to close the expensive Aboriginal and Torres Strait Islander health and life expectancy gaps.

Recommendation 1:

Equitable, needs-based expenditure targets based on at least 2.3 times greater population health needs should be agreed with Aboriginal and Torres Strait Islander health leaders and leadership bodies, and incorporated into a rebuilt Closing the Gap Strategy. National or template tri-lateral expenditure agreements should be made at the national level, and in each jurisdiction, with Aboriginal and Torres Strait Islander health leaders and leadership bodies specifying the roles, responsibilities, and expenditure obligations for each Commonwealth, State and Territory government.

Recommendation 2:

The new Indigenous Productivity Commissioner role should report each year to Parliament (coincident with the PM's 'Closing the Gap Report') on Aboriginal and Torres Strait Islander expenditure, including health expenditure, but taking into account both public and private expenditure and level of need, as a specific input to closing the life expectancy gap.

Further, as discussed in Text Box 1, the myth that equitable health expenditure on Aboriginal and Torres Strait Islander peoples is some form of special treatment must be addressed, with leadership in this area shown by Australian governments and media outlets.

Text Box 1: Addressing the myth that equitable health expenditure on Aboriginal and Torres Strait Islander peoples is some form of special treatment

It is time to address the myth that allows the 'equity underspend' on Aboriginal and Torres Strait Islander health to happen: that it is some form of 'special treatment' to provide additional health funding that relates to additional Aboriginal and Torres Strait Islander health needs. Indeed, what is sought for Aboriginal and Torres Strait Islander people is not some kind of 'special deal' but simply the same level of health expenditure that anyone else in the population with equivalent need would expect and receive.

In fact, the largely failed implementation of the Closing the Gap Strategy to date is inseparable from the failure to provide equitable, needs-based funding. And this underscores that the battle to secure equitable expenditure to meet greater health needs - something that is taken for granted by other cohorts with greater health needs - is still being fought for Aboriginal and Torres Strait Islander peoples. It is, in fact, a primary example of a stubborn form of institutional racism that still challenges Aboriginal and Torres Strait Islander population health. Yet 'closing the gap' requires the necessary long-term investment of equitable funding to meet the additional health needs of Aboriginal and Torres Strait Islander peoples.

As such, a rebuilt Closing the Gap Strategy must include Australian governments agreeing to provide equitable levels of funding in the long-term (until at least 2031) as a cross-party and inter-governmental commitment. Expenditure itself must also cease to be a 'political football'. And responsible Australian political leaders and commentators have to tackle the irresponsible equating of equitable expenditure with special treatment that has hitherto hindered efforts to secure the levels of funding required to close the health and life expectancy gap.

Target 2: Australian Governments systematically costing, funding, and implementing the Closing the Gap health and mental health plans

Two significant developments under the Closing the Gap Strategy have occurred in the past three years, and through which the Closing the Gap Strategy could be refreshed, and equitable levels of funding at least in part channeled. These are the development of the:

- 2015 *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* (NATSIHPIP), based on the 2013 *National Aboriginal and Torres Strait Islander Health Plan*, and the
- 2017 *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* (National Strategic Framework).

Strategy 1A of the NATSIHPIP in particular is that Aboriginal Community Controlled Health Services 'are supported to provide high-quality, comprehensive and accountable services that are locally responsive to identified Aboriginal and Torres Strait Islander health needs'. Further, it calls for (among other things) a 'core services framework for comprehensive primary health care and access to specialist medical care' and:

'methodology to map health needs, workforce capability and service capacity [to be] developed. Focus will be targeted to areas with poor health outcomes and inadequate services. Systematic assessment of health outcomes/needs, workforce capability and service capacity [will be] undertaken to inform the development of the core services model, future workforce requirements and investment and capacity building priorities.'^x

Yet nothing like this has occurred in the three years since the NATSIHPIP was launched. Instead, actions in the NATSIHPIP are being 'cherry picked' for implementation though the Indigenous Australians Health Program with a relatively narrow focus on 20 goals, of which progress is currently able to be reported on in relation to 10.^{xi} In short, the NATSIHPIP has become a plan largely of words but not of action, with inadequate progress on the key issues of identifying and filling health service gaps, addressing workforce requirements, and practical steps to monitor and improve the quality of existing services.

A rebuilt strategy, then, must systematically identify, cost and fund the unimplemented parts of the NATSIHPIP starting with Strategy 1A (and discussed further as 'Target 3').

Recommendation 3

Australian governments commit to systematically identify, cost and fund the unimplemented parts of the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* (NATSIHPIP) with the National Aboriginal Community Controlled Health Organisation, jurisdictional Aboriginal Community Controlled Health Service peak bodies, and national Aboriginal and Torres Strait Islander leaders. This should commence with costing and implementing Strategy 1A - identifying and filling health service gaps with new or expanded Aboriginal Community Controlled Health Services.

Further, as discussed in Text Box 2 below, a rebuilt Closing the Gap Strategy must make Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health a priority alongside physical health by the systematic costing, funding, and implementation of the National Strategic Framework, within the broader context of the implementation of the Fifth National Mental Health and Suicide Prevention Plan.

Text Box 2: Mental health as a priority in a rebuilt Closing the Gap Strategy

As the AIHW reported in 2016, in 2011 while chronic diseases grouped together remain the single biggest health challenge, *'the disease group causing the most burden [of disease] among Indigenous Australians was mental & substance use disorders (19 per cent of the total)'^{xii}*. Injury including suicide was the second most significant contributor to the health gap in 2011^{xiii}.

Further, and suggestive of a growing mental health crisis that must be addressed, in 2017 the Australian Bureau of Statistics ranked suicide as the second leading cause of death for Aboriginal and Torres Strait Islander males,^{xiv} and reported that over the period of 2008-12 and 2013-17 the rate of suicide deaths in the Aboriginal and Torres Strait Islander population has increased by 21%^{xv}. In short, the suicide and the mental health gaps had likely only increased since 2011, and must be addressed if the health and life expectancy gap is to close.

Indeed, the AMA supports Recommendation 5 of the 2014 National Mental Health Commission's *Contributing Live, Thriving Communities* report of its national review of mental health services and programs to:

Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.^{xvi}

In other words, the Strategy needs to be rebuilt with mental health prioritised alongside chronic disease. And, without such an additional mental health focus, a merely 'refreshed' and underfunded Closing the Gap Strategy will not only be remiss in failing to target a major contributor to health inequality, it will not reflect the evidence base. This is already acknowledged in the mental health space where the Fifth National Mental Health and Suicide Prevention Plan states that:

Governments have recognised that achieving the COAG Closing the Gap targets will require simultaneous action to address chronic disease and mental illness in Aboriginal and Torres Strait Islander peoples, families and communities.^{xvii}

The above includes trauma and intergenerational trauma, which significantly affects social and emotional wellbeing and mental health at the population level. As reported in the 2018 AIHW and Aboriginal and Torres Strait Islander Healing Foundation's report: *Aboriginal and Torres Strait Islander Stolen Generations and descendants; Numbers, demographic characteristics and selected outcomes*, about 17,150 members of the Stolen Generations are still alive today, and they experience higher levels of adversity in relation to almost all health and welfare outcomes, much of which relates to untreated and unhealed trauma.^{xviii}

Recommendation 4:

Australian governments commit to: (a) making Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health a national priority in a rebuilt Closing the Gap Strategy; and (b) systematically cost, fund, and implement the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* with the national Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention leaders.

Developing both the above plans was an important activity, but it is now time to 'turn the page'. The plans are in place. The next 10 years of the rebuilt Closing the Gap Strategy must be about providing equitable funding for Aboriginal and Torres Strait Islander health, including for the systematic implementation of the two plans. It's time to roll up our collective sleeves and deliver on them.

Target 3: Identify and fill primary health care service gaps

The Commonwealth 'equitable underspend' discussed above occurs, in part, because the Medicare Benefits Schedule (MBS) subsidises the cost of health services delivered by private GPs and medical practitioners whose practices are effectively small businesses. And as small businesses, market forces tend to dictate that private GPs and medical practitioners tend to operate outside of lower socio-economic and/or remote areas with smaller or poorer 'customer bases', including Aboriginal and Torres Strait Islander communities.

In other words, private health practitioner and service 'market failure' has contributed to the Commonwealth MBS underspend because fewer such services exist in Aboriginal and Torres Strait Islander communities in the first place and, hence, MBS expenditure is less. Such market failure has two implications for the Close the Gap refresh:

- it underscores the need for continuing and greater government interventions to ensure that those living in areas of private health practitioner and service market failure (including Aboriginal and Torres Strait Islander communities) are ensured equitable access to primary health care (i.e. according to need); and
- to the degree that MBS and PBS underspend can be disaggregated by regions and communities, areas of market failure – in other words, private practitioner and service gaps - can be identified to support the effective and efficient targeting of such interventions.

Further, Aboriginal and Torres Strait Islander potentially preventable admissions (PPAs) to hospitals are three times higher than in the non-Indigenous population^{xx}, and potentially preventable deaths (PPDs) are 3.3 times higher than in the non-Indigenous population^{xx}. This has serious implications: **it is simply impossible, by definition, for the Aboriginal and Torres Strait Islander life expectancy gap to close while this situation persists.**

Further, the conditions that lead to PPAs/PPDs, by definition, are those to which health services *must be able to respond* if the health and life expectancy gap is to close. And the mapping high rates of PPAs/PPDs provides additional tools to support the identification of health practitioner and service gaps at the regional or community level.

A concrete example of the prevalence of potentially preventable conditions among the Aboriginal and Torres Strait Islander population that might lead to PPAs/PPDs was provided by the 2014 Australian Bureau of Statistics (ABS) *National Aboriginal and Torres Strait Islander Health Measures Survey* (NATSIHMS), the largest biomedical survey ever conducted among Aboriginal and Torres Strait Islander participants.^{xxi}

As highlighted in Text Box 3, perhaps the most disturbing findings among the 3300 blood samples analysed in the survey were the reported high levels of undetected, generally early stage, symptoms of chronic health conditions.

Text Box 3: Findings of the 2014 ABS *National Aboriginal and Torres Strait Islander Health Measures Survey* (NATSIHMS)^{xxii}

In addition to highlighting the burden of diabetes and other chronic conditions among the Aboriginal and Torres Strait Islander population, the NATSIHMS also provided evidence of high rates of undetected symptoms of chronic conditions:

- One in five (20.4 per cent) participants had high blood pressure (systolic or diastolic blood pressure equal to or greater than 140/90 mmHg). Of these, four in five (79.4 per cent) did not self-report high blood pressure as a long-term health condition.
- Nearly one in five (17.9 per cent) had symptoms of chronic kidney disease, but of these, nine in ten didn't know they had these signs.
- One in four adults (25 per cent) had abnormal or high total cholesterol levels according to their blood test results. Yet of these, only one in ten people (9.1 per cent) self-reported having high cholesterol as a current long-term health condition.

Critically, however, these are also preventable conditions, that will respond to treatment. Further, targeting responses and primary health care at them will not only make a significant contribution to closing the health and life expectancy gap, but also result in far better value from Aboriginal and Torres Strait Islander health spending. For example:

- A 2014 10-year study tracked health system use by 180 Aboriginal people with diabetes in remote Northern Territory communities. It reported that investing \$1 in medium-level primary care could save \$12.90 in hospitalisation costs for this cohort^{xxiii}.
- A 2010 study, *Assessing Cost Effectiveness in Prevention*, reported that – regardless of primary health care setting – ensuring Aboriginal and Torres Strait Islander peoples’ access to a range of preventative health strategies would deliver around \$1.20 in cost savings compared to \$1 saved per non-Indigenous person, due to the former’s greater comorbidities and severity of disease, which leads to higher potential cost savings as a result of preventive interventions^{xxiv}.

A 2014 10 year study tracked health system use by 180 Aboriginal people with diabetes in remote Northern Territory communities. It reported that investing \$1 in medium-level primary care could save \$12.90 in hospitalisation costs for this cohort.

But which primary health care services are optimal for closing the gap? The answer is suggested by studies that have found that, for Aboriginal and Torres Strait Islander peoples, access to services is critical (whether access is measured in terms of distance, cost, or cultural safety) and, where Aboriginal Community Controlled Health Services (ACCHSs) exist, the community prefers to, and does, use them.^{xxv}

ACCHSs also perform better in key areas^{xxvi} and are the most cost-effective vehicles for delivering primary health care to Aboriginal and Torres Strait Islander communities. *Assessing Cost Effectiveness in Prevention* also reported that, while the short-term cost of delivering a health intervention through an ACCHS is higher because the consultations provided are more intensive (based on the comprehensive model of health care used in ACCHSs) and - in particular - because so many patients require transport to reach the services.^{xxvii}

The lifetime health impact of any of these interventions delivered to the Indigenous population by ACCHSs is 50% greater than if these same interventions were delivered by mainstream health services, due to improved Indigenous access.^{xxviii}

Improved adherence to treatment was an additional benefit of ACCHS-use, the study reported^{xxix}. In other words, ACCHSs are better at the critical issues of access, attracting and retaining Aboriginal and Torres Strait islander clients, and better health outcomes than mainstream services.^{xxx}

ACCHSs today provide about three million episodes of care each year for about 350,000 people, with a rising client base.^{xxxi} While impressive, this data suggests that upwards of half of the Aboriginal and Torres Strait Islander population do not or cannot access ACCHSs.

ACCHSs are better at the critical issue of access, attracting and retaining Aboriginal and Torres Strait islander clients, and result in better health outcomes than mainstream services.

Yet, as noted in the *Ten-Year Review*, while some expansion to ACCHSs occurred over the life of the Closing the Gap Strategy, there was no systematic assessment of need and identification of current service gaps, let alone a plan put in place to meet that need despite this action being Strategy 1A of the 2015 NATSIHPIP discussed above. Indeed, a major criticism of the Closing the Gap Strategy is the apparent reluctance of Australian governments to fund ACCHSs, often utilising mainstream providers with no clear rationale as to why.^{xxxii}

What makes the lack of action around Strategy 1A particularly egregious is that much of this was to have occurred by 2018, providing a firm foundation of primary health care delivered by ACCHSs for at least a decade's further work in Aboriginal and Torres Strait Islander communities to accumulate better health outcomes towards life expectancy equality by 2031. As it stands, Australian governments are still yet to commence this fundamental task, without which closing the health gap is likely to remain out of reach in our lifetimes, and with any successful efforts in particular areas of health unsustainable in the longer term. (See Recommendation 3 in relation to this point.)

Indeed, the Commonwealth Government appears to be developing a strategy to constrain the growth and effectiveness of the ACCHS sector through the ongoing development of the Indigenous Australians' Health Programme Funding Model^{xxxiii}. Although details are still being worked out, the important parts of the model appear to be:

- an indefinite freeze on current total national expenditure on the ACCHS sector ('capped quantum');
- an activity-based formula (i.e. relating to episodes of care, etc.) for the distribution of the capped quantum among existing ACCHSs;
- any additional funding for Aboriginal and Torres Strait Islander health that might otherwise have been provided to ACCHSs, being distributed through Primary Health Networks; and
- ACCHSs being reliant on MBS rebates for additional funding into the future.

The proposal of such a model contradicts many years of calls for the development of a needs-based funding formula from the National Aboriginal Community Controlled Health Organisation and the ACCHS sector. Critically, a needs-based formula would be equitable by including consideration of, and weighting for, remoteness, population, burden of disease, the prevalence of particular conditions (for example, rheumatic heart disease or otitis media) and so on.

Another form of institutional racism appears to be operating here. As discussed, ACCHSs are in part necessary in response to private health practitioner and service market failure in Aboriginal and Torres Strait Islander communities, as measured by lower MBS expenditure. Yet current MBS expenditure – proposed here as a non-Indigenous equivalence to expenditure on ACCHSs - is not being frozen. The proposal is that only the ACCHS sector is subjected to such a freeze; and at a time of, more than ever, a rapidly increasing Aboriginal and Torres Strait Islander population and worsening health demand ACCHSs-sector expansion.

Recommendation 5:

The Commonwealth Government withdraws plans to place a cap on program funding for the Aboriginal Community Controlled Health Service sector and, in association with the sector, develops a needs-based funding formula to ensure that funding growth into the future will expand to meet the need.

The deliberate or otherwise pattern of PHNs being allocated Aboriginal and Torres Strait Islander-specific health funding continues a pattern already evident in Aboriginal and Torres Strait Islander-specific mental health and suicide prevention expenditure in recent years that has been allocated to PHNs without any significant accountability as to how funds are directed.

This trend defies a fundamental public policy principle - to maximise the return on investment of public funds, including in relation to health services. And, as discussed, the evidence base demonstrates ACCHS outperform mainstream services in many areas.

Yet, by current arrangements, while PHNs are, on paper, required to work in partnership to identify and meet gaps in Aboriginal and Torres Strait Islander communities, including with ACCHSs, they retain the power to decide which services are commissioned to fill those gaps, including through competitive tendering processes.

Such can have the perverse outcome of favouring mainstream providers (who can afford to fund the writing of impressive 'on paper' applications) over long-established and successful Aboriginal and Torres Strait Islander organisations, including ACCHSs, whose applications might not otherwise be as competitive on paper.

This is in fact another example of a form of institutional racism - where the needs of Aboriginal and Torres Strait Islander peoples are not met because principles that may have currency in the general population (i.e. competitive tendering), work against the interests of the Aboriginal and Torres Strait Islander population in practice, particularly when applied in an ideological or blanket way without regard for different impacts on different groups.

Recommendation 6

That, as part of a rebuilt Closing the Gap Strategy, the Commonwealth Government requires Primary Health Networks to utilise the procedure of preferred provider when considering meeting primary health care, mental health, and suicide prevention services gaps in Aboriginal and Torres Strait Islander communities. By this, Aboriginal Community Controlled Health Services (ACCHSs) should be specified as preferred providers, and Primary Health Network funds for health, mental health, and suicide prevention services and programs should be directed to ACCHSs unless it can be clearly demonstrated that alternative arrangements can produce better results in terms of i) access to services and ii) service outcomes.

Target 4: Address environmental health and housing

Primordial prevention aims to stop disease before it starts by targeting ‘upstream’, ostensibly non-health related issues that, nonetheless, can lead to ill-health. In particular, a 2010 NSW report demonstrated the preventive health impacts of better housing. In Aboriginal and Torres Strait Islander communities whose housing was improved, the rate of potentially preventable hospital admissions for infectious diseases was 40 per cent less than in communities where no housing improvements had taken place.^{xxxiv}

As discussed in the Close the Gap Campaign Steering Committee’s Ten-Year Review, while the Closing the Gap Strategy included a multi-billion-dollar remote housing program, a November 2016 evaluation of the program reported that efforts were complicated by poor governance and constantly changing policy settings.^{xxxv} It further estimated an additional 5,500 homes are required by 2028 to reduce levels of overcrowding in Aboriginal and Torres Strait Islander communities to acceptable levels.^{xxxvi}

In relation to the systematic meeting of health service needs ... we are still yet to commence this fundamental task, without which closing the health gap is likely to remain out of reach in our lifetimes

Yet the 2018 Federal Budget saw the final nails in the coffin of a gap-closing national approach to improving Aboriginal and Torres Strait Islander housing, and the formal relinquishment of the Commonwealth’s leadership and funding role. For while it agreed to provide \$550 million over five years as part of a bilateral agreement with the Northern Territory Government for remote housing, previous funding to Queensland, Western Australia and South Australia (\$392.2 million in total over 2017-18) ceased. Hand in hand with an address to primary health care, this part of the Closing the Gap Strategy must be rebuilt if the health and life expectancy gap is to close.

Recommendation 7

That as a part of a rebuilt Closing the Gap Strategy, either national or template tri-lateral funding agreements should be agreed at the national level, or in each jurisdiction, with Aboriginal and Torres Strait Islander leaders and leadership organisations specifying the roles, responsibilities and funding for each Commonwealth, State and Territory government, and the Aboriginal and Torres Strait Islander health sector in relation to:

- a national audit of housing and conditions in Aboriginal and Torres Strait Islander communities; and
- co-designing and co-implementing a 10-year plan to achieve healthy housing and living conditions, coupled with environmental health literacy programs based on meeting need in the above audit. The Plan would include a: cohesive and robust design standards framework for better health in Aboriginal and Torres Strait Islander housing and communities; and a preferred provider principle – that housing improvements are best delivered through locally adapted arrangements, responsive to local conditions and cultural norms, in partnership with existing community providers, and which would have a specific aim of boosting local Indigenous training and employment.

Target 5: Address the social determinants of health inequality

Since at least the 1980s, socio-economic factors such as income, education and housing have been recognised as critical determinants of individuals' and populations' health. There is, in particular, a well-documented gradient linking health to wealth.

This is a critical health gap-closing consideration because, across Australia, researchers report that nowhere does the Aboriginal and Torres Strait Islander population have better or even relatively equal socio-economic status compared with the non-Indigenous population.^{xxxvii} And in 2014, the AIHW estimated that social determinants and behavioral risk factors (many a response to desperate conditions related to socio-economic factors) accounted to up to 57 per cent of the health gap.^{xxxviii}

Racism is also a significant social determinant of health inequality. The 2012-13 ABS Aboriginal and Torres Strait Islander Health Survey reported racism to be a common experience for Aboriginal and Torres Strait Islander people. Sixteen percent of respondents reported being 'treated badly because they are Aboriginal/ Torres Strait Islander' in the previous 12 months.^{xxxix} The impacts of interpersonal racism on mental health in particular are well documented.^{xl}

Further, institutional racism across the health system must be addressed - as highlighted in this Report Card and emphasised in the *National Aboriginal and Torres Strait Islander Health Plan* whose Vision is that:

The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.^{xi}

One of the strengths of the Closing the Gap Strategy was a recognition that improvements to Aboriginal and Torres Strait Islander health required a simultaneous and integrated address to a range of areas including: Early Childhood; Schooling; Health; Healthy Homes; Safe Communities; Economic Participation; and Governance and Leadership.^{xlii}

The 2015 *Indigenous Advancement Strategy* (IAS), however, re-focused the Commonwealth into a narrower range of subject matters: community safety, employment, and school attendance and was connected to NATSIHPIP as the primary vehicle to address social determinants.^{xliii}

In contrast, in December 2017, following a six-month development and consultation process and endorsement by Cabinet, the Commonwealth Government released the *My Life, My Lead* report as the blueprint for a national response to Aboriginal and Torres Strait Islander social determinants and recognising that culture is a determinant of good health, and particularly mental health and wellbeing, in Aboriginal and Torres Strait Islander peoples.^{xliv}

My Life, My Lead priority areas

- Culture at the centre of change
- Success and wellbeing for health through employment
- Foundations for a healthy life
- Environmental health
- Healthy living and strong communities
- Health service access
- Health and opportunity through education

Minister for Indigenous Health, the Hon Ken Wyatt MP, has indicated that *My Life, My Lead* is intended to inform the ongoing development, implementation, and delivery of future policy and programs including the Closing the Gap ‘refresh’.^{xlv} The AMA supports this approach.

Further, the need to address social determinants provides another reason to support ACCHSs. As the single biggest employers of Aboriginal and Torres Strait Islander people in the country, ACCHSs make significant contributions to their communities’ economic lives, and the Aboriginal and Torres Strait Islander population’s economic life.^{xlvi}

Target 6: Aboriginal health in Aboriginal hands

International research demonstrates that empowering Indigenous communities to control design and implementation processes associated with health activities and processes means that better outcomes can be expected.^{xlvii} Likewise, and at the national level, the AMA supports calls from the National Health Leadership Forum, the collective of Aboriginal and Torres Strait Islander health leadership bodies, for Aboriginal and Torres Strait Islander governance of a rebuilt Closing the Gap Strategy’s health programs.

In the mental health space, there is similar momentum. In particular, the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) promotes the *Gayaa Dhuwi (Proud Spirit) Declaration’s* support for Aboriginal and Torres Strait Islander peoples’ presence and, critically, leadership within the mental health system as ‘[providing] a platform for governments to work collaboratively to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples’.^{xlviii}

Ultimately, a rebuilt Closing the Gap Strategy must be connected to an even bigger picture based on a recognition of the right to self-determination of Aboriginal and Torres Strait Islander peoples in all areas of life, including health, through Constitutional recognition, and reform. As noted in the AMA-supported Uluru Statement from the Heart:

We seek Constitutional reforms to empower our people and take a rightful place in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.^{xlix}

Aboriginal health in Aboriginal hands ultimately means the transfer of key health decision-making power and responsibility to Aboriginal and Torres Strait Islander health and community leaders and leadership bodies. This will both help end the imposition of failed ‘top down’ approaches, and support a reinvigorated Strategy built from the ground up on culture (rather than culture as an ‘add on’), and as required by the 2013 *National Aboriginal and Torres Strait Islander Health Plan*.¹

CONCLUSION

A further unfunded or underfunded Closing the Gap Strategy 'refresh' that does not, as the above targets aim to do, address the fundamental weaknesses of the post-2015 Closing the Gap Strategy will be nothing but a further blow to Aboriginal and Torres Strait Islander peoples' right and expectations to enjoy **the same opportunities as other Australians to enjoy among the highest levels of life expectancy in the world.**

It will also be a further **blow to all who seek a socially just and reconciled Australia** that has addressed the fundamental issue of institutional racism in the health system. Closing the widening Aboriginal and Torres Strait Islander life expectancy gap requires **a real commitment to implementation and real investment**, and it is hoped a rebuilt, not merely refreshed, Closing the Gap Strategy will provide that so this generation sees the closing of the health and life expectancy gap.

Adoption of the recommendations in this report, particularly in relation to the expansion of primary health services delivered by ACCHSs, would require only relatively modest expenditure, would go a considerable way towards restoring trust with Aboriginal and Torres Strait Islander peoples, would enjoy general public support and, most importantly, would deliver sizeable and rapid gains in the health of Australia's Aboriginal and Torres Strait Islander peoples towards the achievement of health and life expectancy equality.

SPECIAL REPORT: UPDATE ON AUSTRALIAN GOVERNMENT RESPONSES TO THE 2016 AND 2017 REPORT CARDS' RECOMMENDATIONS

1. Australian government responses to: *A Call to Action to Prevent New Cases of Rheumatic Heart Disease in Indigenous Australia by 2031* (2016 AMA Indigenous Health Report Card)

Recommendation 1: For Australian governments to commit to a target to prevent new cases of RHD reported among Indigenous people by 2031. As a milestone to achieving this target, Australian governments should also commit to a sub-target that no child in Australia dies of ARF and its complications by 2025.

Response:

- There is yet to be an Australian government commitment to a target to prevent new cases of rheumatic heart disease (RHD) reported among Indigenous people by 2031, or a sub-target to have stopped deaths from acute rheumatic fever (ARF) by 2025.
- Advocacy for establishing targets is ongoing and supported by increasingly rigorous epidemiologic analysis as new data becomes available.
- The End Rheumatic Heart Disease Centre of Research Excellence (END RHD CRE) has adopted the AMA call to prevent new cases of RHD by 2031.

Recommendation 2: To achieve the targets in Recommendation 1, Australian governments to work in partnership with Indigenous health bodies, experts, and key stakeholders to develop, fully fund, and implement a strategy to end RHD as a public health problem in Australia by 2031, comprising:

- an interim strategy (operational from 2016-2017 until 2021); and
- upon the 2020 receipt of the final report of the END RHD CRE, a comprehensive 10-year strategy (operational from 2021-2031).

Response:

- While a strategy to end RHD as a public health problem in Australia by 2031 is yet to be announced, Minister Wyatt convened a roundtable of key stakeholders in Darwin in February 2018 and committed to the development of a roadmap to end RHD in Australia.
- RHD was discussed as part of the COAG Health Agenda in August 2016.
- END RHD CRE is on track to deliver the Endgame Strategy report in February 2020, with the promise of a fully costed action plan or roadmap to end RHD in Australia by 2031.
- In Queensland, an Action Plan was launched in 2018 to address RHD through to 2020.
- A *National Partnership Agreement on Rheumatic Fever Strategy – continuation and expansion* was announced in the 2017-18 Health Budget. This included renewed funding for Rheumatic Heart Disease Australia (RHD Australia) for 2017-2021.

Good news:

- A major stream of work for RHD Australia under its current funding agreement is the development and implementation of culturally safe resources for people living with ARF and RHD and their communities.
- The 3rd edition of the Australian Guidelines for the diagnosis, prevention and management of ARF and RHD includes a section on culturally appropriate care for health systems: the first time this has been attempted within a clinical guideline on any topic in Australia. (Yet to be published.)
- Major new efforts to accelerate Strep A vaccine development are underway including a regional meeting in early 2017, a major new publication on vaccine progress and further global meetings in 2018 and efforts to develop a global Strep A vaccine consortium.
- As discussed in Text Box 4, the END RHD alliance was established after the release of the 2016 Report Card. End RHD has been active in advocacy for ending RHD and shares its activities through newsletters and social media. Recently, an advocacy event at Parliament House on the 23rd October 2018, co-hosted by END RHD and the Snow Foundation, brought together community representatives, health workers, and medical experts, asking for a commitment to end the disease in Australia. Minister Wyatt and Shadow Assistant Minister for Indigenous Health Warren Snowdon both made public commitments to tackling RHD as a non-partisan issue.

Text Box 4: The END RHD Alliance

The 2016 AMA Report Card not only highlighted the enormous impact of rheumatic heart disease (RHD) in Australia, but the need for more collaboration to build on the collective strengths of the communities, organisations, and individuals already working hard to tackle the disease.

United by the common goal and belief that no child born in Australia should die of rheumatic heart disease, the END RHD alliance was formed.

Founding members include the five peak Aboriginal Community Controlled Health Organisations in jurisdictions with the highest burden of disease – **Aboriginal Medical Services Alliance Northern Territory, Aboriginal Health Council of Western Australia (AHCWA), Aboriginal Health Council of South Australia, Queensland Aboriginal and Islander Health Council**, and the **Aboriginal Health and Medical Research Council of NSW** – as well as the national peak body for Aboriginal health, the **National Aboriginal Community Controlled Health Organisation**. They're joined by the **AMA, Heart Foundation, RHD Australia** based at the **Menzies School of Health Research**, and the **END RHD Centre of Research Excellence** based at **Telethon Kids Institute**.

Together as END RHD, the group are developing and advocating for Aboriginal and Torres Strait Islander-owned, community-led strategies to tackle the disease; and support the development of a plan or roadmap to end RHD in Australia as discussed in the text. Other organisations and individuals committed to a shared vision of an Australia free of rheumatic heart disease have been invited to join the alliance through signing the *Charter to END RHD*.

Two years since the alliance was formed, momentum continues to grow. The evidence base of how we can best eliminate the disease continues to strengthen, with the learnings from a range of community-led, research-backed projects in Aboriginal communities. Professor Jonathan Carapetis AM, END RHD Co-Chair, says that after 25 years researching RHD, he believes Australia has never been in a stronger position to eliminate the disease.

“Aboriginal and Torres Strait Islander organisations are taking the lead and working hand in hand with communities. We researchers are bringing the evidence to support them. If there is one country in the world that should be able to eliminate RHD, it is Australia,” he said.

Charter to END RHD

We are committed to ending rheumatic heart disease in Australia.

We recognise that rheumatic heart disease is preventable. It is a disease born of social inequity and disadvantage which continues to disproportionately impact the lives of Aboriginal and Torres Strait Islander people.

We believe that community-led solutions and leadership, based on the aspirations and priorities of the communities most affected, are the foundation to end rheumatic heart disease in Australia.

The knowledge, evidence, and resources exist to do this now, and present a critical opportunity to close the gap in Aboriginal and Torres Strait Islander health. This will mean improving the social and economic environments where people live, learn, and work, and ensuring equitable access to culturally respectful health care for all.

2. Australian government responses to A National Strategic Approach to Ending Chronic Otitis Media and its Life Long Impacts in Indigenous Communities (2017 AMA Indigenous Health Report Card)

The specific recommendations for a coordinated national strategic response to chronic otitis media to be developed by National Indigenous Hearing Health Taskforce under Indigenous leadership for the Council of Australian Governments (Recommendation 1) and a wider address to otitis media-related developmental impacts and hearing loss (Recommendation 2), including in relation to the unacceptably high rates of Indigenous imprisonment (Recommendation 3), are yet to be responded to.

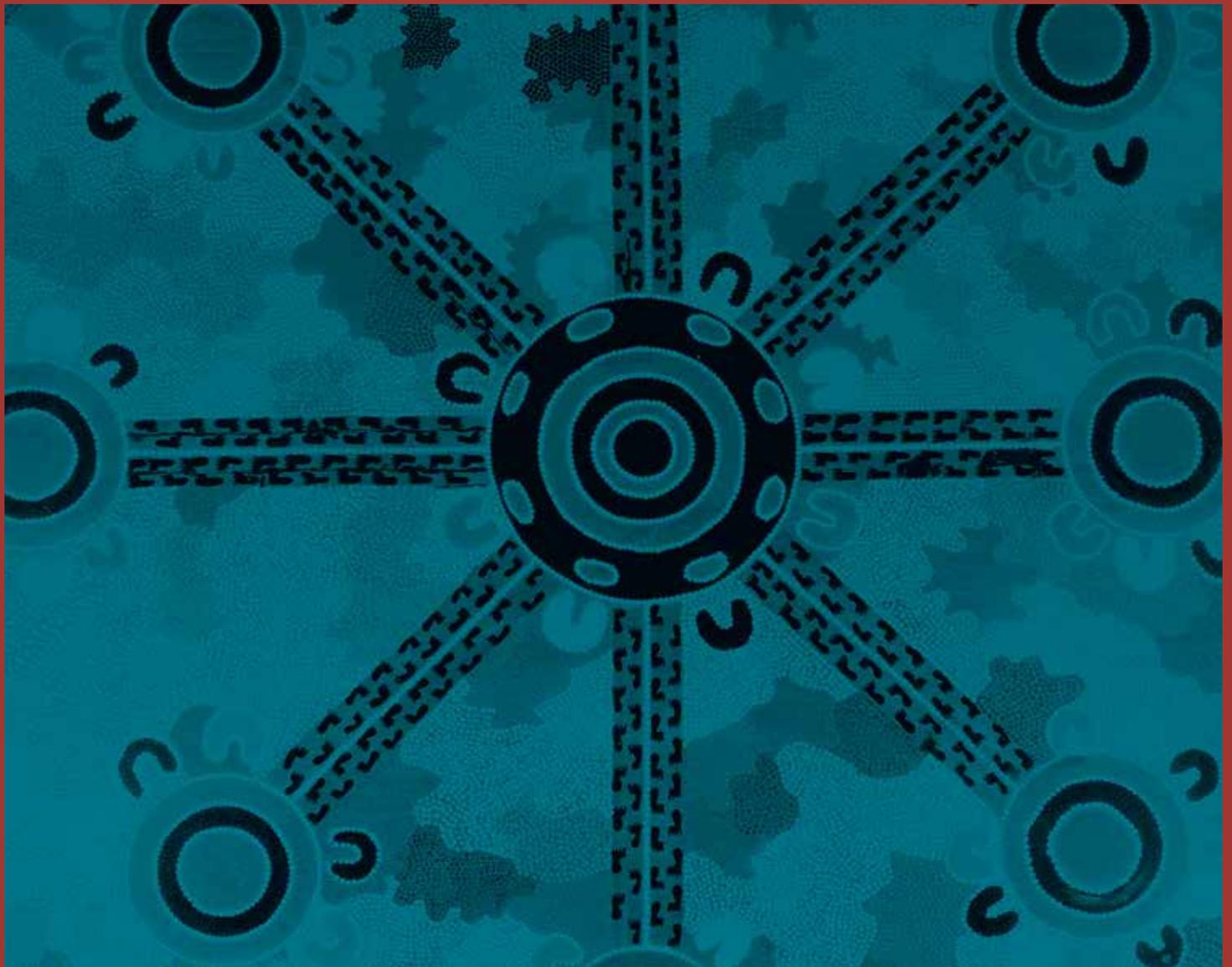
The urgent need for the above was highlighted by recent research begun by the Menzies School of Health Research examining if otitis media-related and other forms of hearing loss are associated with higher rates of Indigenous child protection reports. This has been described in past qualitative research and, if confirmed by quantitative results, will provide a new perspective on the challenges facing Indigenous families, and suggest new ways to help families and child protection workers prevent Indigenous children entering the child protection system.ⁱⁱ

Good news:

- In March 2018, \$29.4 million was committed by the Commonwealth to extend the *Healthy Ears - Better Hearing, Better Listening Program* until 2021-22, building on its successes in 21 Indigenous communities. In the program, multi-disciplinary teams of providers including audiologists, speech pathologists, Aboriginal health workers, nurses, occupational therapists and ear, nose and throat specialists work with local health services and families to improve ear health.
- The Departments of Health and Education in the Northern Territory (NT) and Australian Hearing have developed *Hearing health care plans* to provide teachers with strategies to ameliorate hearing loss to implement in their classrooms. Teachers are also able to consolidate strategies to cover groups of students and/or the whole class. In the first six months, teachers of more than 2000 students in 79 rural, regional and remote NT schools have been helped by the plans. The feedback received from different schools for the program has been encouraging.ⁱⁱⁱ

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