Aboriginal and Torres Strait Islander Health

Edited by Justin Healey

ISSUES IN SOCIETY

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CHAPTER 1  HEALTH STATUS OF INDIGENOUS AUSTRALIANS
The context of Indigenous health ............................................. 1
Survey reveals health challenges for Australian Aboriginal and ............................................. 5
Torres Strait Islander peoples
Australian Aboriginal and Torres Strait Islander Health Survey: first results ............... 6
Indigenous health isn’t all bad news ........................................... 9
Life expectancy estimates for Aboriginal and Torres Strait Islander Australians .......... 11

CHAPTER 2  CLOSING THE GAP IN INDIGENOUS HEALTH
What works? Addressing the social and economic determinants .................................... 14
of Indigenous health
Closing the Gap: PM delivers mixed report card on Indigenous disadvantage ............. 19
Closing the Gap report card .................................................................................. 20
Closing the Gap Prime Minister’s Report ............................................................. 22
Living up to the Close the Gap challenge ............................................................. 27
Prime Minister’s Indigenous affairs challenge is to deliver on his ambition .......... 29
Closing the Gap: we know what works, so why don’t we do it? ............................. 31
Indigenous affairs: close the gap, but open the conversation .................................. 33
Close the Gap: progress and priorities .................................................................. 35
Aboriginal and Torres Strait Islander health performance framework ...................... 38
Indigenous reform 2011-12: comparing performance across Australia .................... 42
Slow progress in closing the gap according to COAG ........................................... 43
Federal government announces 10-year policy framework for Indigenous health .... 44
National Aboriginal and Torres Strait Islander Health Plan at a glance ................. 45
Future initiatives to improve the health and wellbeing of Aboriginal and ................ 47
Torres Strait Islander peoples
Exploring issues – worksheets and activities ......................................................... 49
Fast facts ................................................................................................................. 57
Glossary .................................................................................................................... 58
Web links .................................................................................................................. 59
Index ......................................................................................................................... 60
Aboriginal and Torres Strait Islander Health is Volume 376 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC
Aboriginal and Torres Strait Islander peoples live about 10 years less than non-Indigenous Australians. Since 2006, the ‘closing the gap’ campaign has been pursued in collaboration between government and health, welfare and rights agencies to try and close the health and life expectancy gap within a generation.

The health disadvantages experienced by Indigenous Australians are shaped by history and the broader social and economic conditions in which they live; progress has been slow and mixed.

This book evaluates the progress made towards closing the gap. How can Indigenous outcomes be improved across a range of key social and economic determinants of health and wellbeing?

SOURCES OF INFORMATION
Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:

- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

CRITICAL EVALUATION
As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES
The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH
This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
THE CONTEXT OF INDIGENOUS HEALTH

Historical context and social determinants of Indigenous health

There is a clear relationship between the social disadvantages experienced by Indigenous people and their current health status. These social disadvantages, directly related to dispossession and characterised by poverty and powerlessness, are reflected in measures of education, employment, and income. Before presenting the key indicators of Indigenous health status, it is important, therefore, to provide a brief summary of the context within which these indicators should be considered.

The historical context of Indigenous health

Indigenous peoples generally enjoyed better health in 1788 than most people living in Europe. They did not suffer from smallpox, measles, influenza, tuberculosis, scarlet fever, venereal syphilis and gonorrhoea, diseases that were common in 18th century Europe. Indigenous people probably suffered from hepatitis B, some bacterial infections (including a non-venereal form of syphilis and yaws) and some intestinal parasites. Trauma is likely to have been a major cause of death, and anaemia, arthritis, periodontal disease, and tooth attrition are known to have occurred. The impact of these diseases at a population level was relatively small compared with the effects of the diseases that affected 18th century Europe.

All of this changed after 1788 with the arrival of introduced illness, initially smallpox and sexually transmissible infections (gonorrhoea and venereal syphilis), and later tuberculosis, influenza, measles, scarlet fever, and whooping cough. These diseases, particularly smallpox, caused considerable loss of life among Indigenous populations, but the impacts were not restricted to the immediate victims. The epidemic also affected the fabric of Indigenous societies through depopulation and social disruption.

The impact of introduced diseases was almost certainly the major cause of death for Indigenous people, but direct conflict and occupation of Indigenous homelands also contributed substantially to Indigenous mortality. The initial responses of Indigenous people to the arrival of the First Fleet were apparently quite peaceful. It didn’t take long, however, before conflict started to occur – initially over access to fish stocks and then over access to other resources as non-Indigenous people started to plant crops and introduce livestock. This pattern of conflict was almost certainly widespread as non-Indigenous people spread across the country.

Conflict escalated in many places, in some instances resulting in overt massacres of Indigenous people. The 1838 massacre at Myall Creek (near Inverell, NSW) is the most infamous, but less well-known massacres occurred across Australia. As Bruce Elder notes, as “painful and shameful as they are”, the massacres “should be as much a part of Australian history as the First Fleet, the explorers, the gold rushes and the bushrangers”.

Prior to 1788, Indigenous people were able to define their own sense of being through control over all aspects of their lives, including ceremonies, spiritual practices, medicine, social relationships, management of land, law, and economic activities. In addition to the impacts of introduced diseases and conflict, the spread of non-Indigenous peoples undermined the ability of Indigenous people to lead healthy lives by devaluing their culture, destroying their traditional food base, separating families, and dispossessing whole communities. This loss of autonomy undermined social vitality, which,
in turn, affected the capacity to meet challenges, including health challenges; a cycle of dispossession, demoralisation, and poor health was established.

These impacts on Indigenous populations eventually forced colonial authorities to try to 'protect' remaining Indigenous peoples. This pressure led to the establishment of Aboriginal 'protection' boards, the first established in Vic by the Aboriginal Protection Act of 1869. A similar Act established the NSW Aborigines Protection Board in 1883, with the other colonies also enacting legislation to 'protect' Indigenous populations within their boundaries. The 'protection' provided under the provisions of the various Acts imposed enormous restrictions on the lives of many Indigenous people. These restrictions meant that, as late as 1961, in eastern Australia 'nearly one-third of all Australians recorded as being of Aboriginal descent lived in settlements'16, p.4.

The provisions of the Acts were also used to justify the forced separation of Indigenous children from their families 'by compulsion, duress or undue influence'15, p.4. The National Inquiry into the separation of the children concluded that 'between one-in-three and one-in-ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970'15, p.31. It was the 1960s, at the earliest, when the various 'protection' Acts were either repealed or became inoperative.

### The importance of contemporary social determinants and cultural concepts of Indigenous health

The health disadvantages experienced by Indigenous people can be considered historical in origin14, but perpetuation of the disadvantages owes much to contemporary structural and social factors, embodied in what have been termed the 'social determinants' of health1, 17, 18. In broad terms, economic opportunity, physical infrastructure, and social conditions influence the health of individuals, communities, and societies as a whole. These factors are specifically manifest in measures such as education, employment, income, housing, access to services, social networks, connection with land, racism, and incarceration. On all these measures, Indigenous people suffer substantial disadvantage. For many Indigenous people, the ongoing effects of 'protection' and the forced separation of children from their families compound other social disadvantages.

It is also important in considering Indigenous health to understand how Indigenous people themselves conceptualise health. There was no separate term in Indigenous languages for health as it is understood in western society19. The traditional Indigenous perspective of health is holistic. It encompasses everything important in a person's life, including land, environment, physical body, community, relationships, and law. Health is the social, emotional, and cultural wellbeing of the whole community and the concept is therefore linked to the sense of being Indigenous. This conceptualisation of health has much in common with the social determinants model and has crucial implications for the simple application of biomedically-derived concepts as a means of improving Indigenous health. The reductionist, biomedical approach is undoubtedly useful in identifying and reducing disease in individuals, but its limitations in addressing population-wide health disadvantages, such as those experienced by Indigenous people, must be recognised.

### Indicators of Indigenous social disadvantage

The key measures in these areas for Indigenous people nationally include:

#### Education

According to 2011 Australian Census20:

- 92% of 5 year old Indigenous children were attending an educational institution.
- 1.6% of the Indigenous population had not attended school compared with 0.9% of the non-Indigenous population.
- 29% of Indigenous people reported year 10 as their highest year of school completion; 25% had completed year 12, compared with 52% of non-Indigenous people.
- 26% of Indigenous people reported having a post-school qualification, compared with 49% of non-Indigenous people.
- 4.6% of Indigenous people had attained a bachelor degree or higher, compared with 20% of non-Indigenous people.

An ABS school report21 revealed, in 2011:

- The apparent retention rate for Indigenous students from year 7/8 to year 10 was 99%, from year 7/8 to year 12 it was 49%.
- For non-Indigenous students, the apparent retention rate from year 7/8 to year 10 was 101%; and from year 7/8 to year 12 it was 81%.

The 2011 national report on schooling in Australia22 showed:

- 76% of Indigenous students in year 3 and 66% in year 5 were at or above the national minimum standard for reading, compared with 95% and 93% respectively of all Australian students.
• 80% of year 3 Indigenous students and 69% of year 5 Indigenous students were at or above the national minimum standard for persuasive writing, compared with 96% of all year 3 students and 94% of all year 5 students.

• 72% of year 3 Indigenous students and 69% of year 5 Indigenous students were at or above the national minimum standard for spelling, compared with 94% of all year 3 students and 93% of all year 5 students.

• 71% of year 3 Indigenous students and 65% of year 5 Indigenous students were at or above the national minimum standard for grammar and punctuation, compared with 94% of all year 3 students and 94% of all year 5 students.

• 84% of Indigenous students in year 3 and 75% in year 5 were at or above the national minimum standard for numeracy, compared with 96% and 96% respectively of all Australian students.

Employment
According to the 2011 Australian Census:

• 42% of Indigenous people aged 15 years or older were employed and 17% were unemployed. In comparison, 61% of non-Indigenous people aged 15 years or older were employed and 5% were unemployed.

• The most common occupation classification of employed Indigenous people was ‘labourer’ (18%) followed by ‘community and personal service workers’ (17%). The most common occupation classification of employed non-Indigenous people was ‘professional’ (22%).

Income
According to the 2011 Australian Census:

• The mean equivalised gross household income for Indigenous persons was around $475 per week – approximately 59% of that for non-Indigenous persons (around $800).

Indigenous population
Based on information collected as a part of the 2011 Census of Population and Housing, the ABS has estimated the Aboriginal and Torres Strait Islander population at 669,736 people at 30 June 2011. The estimated population for NSW was the highest (208,364 Indigenous people), followed by Qld (188,892), WA (88,277), and the NT (68,901) (Table 1). The NT has the highest proportion of Indigenous people among its population (29.8%) and Vic the lowest (0.9%).

There was a 21% increase in the number of Indigenous people counted in the 2011 Census compared with the 2006 Census. The largest increases were in the ACT (34%), Vic (26%), NSW (25%) and Qld (22%). For all jurisdictions, the 55 years and over age-group showed the largest relative increase. There are two ‘structural’ reasons contributing to the growth of the Indigenous population: the slightly higher fertility rates of Indigenous women compared with the rates of other Australian women; and the significant numbers of Indigenous babies born to Indigenous fathers and non-Indigenous mothers. Two other factors are considered likely to have contributed to the increase in people identifying as Indigenous: changes in enumeration processes (i.e. more Indigenous people are being captured during the census process); and changes in identification (i.e. people who did not previously identify as Indigenous in the census have changed their response).

Based on the 2011 Census, around 33% of Indigenous people lived in a capital city. Detailed information about the geographic distribution of the Indigenous population for 2011 is not yet available, but figures from the 2006 Census indicated that the majority of Indigenous people

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Source: ABS, 2012

NOTES
1. Preliminary estimates are subject to revision; population projections are expected to be finalised by 2014.
2. Australian population includes Jervis Bay Territory, the Cocos (Keeling) Islands, and Christmas Island.
3. Proportions of jurisdiction population have used total population figures estimated from demographic information for June 2011.
lived in cities and towns\textsuperscript{16}. Slightly more than one-half of the Indigenous population lived in areas classified as ‘major cities’ or ‘inner regional’ areas, compared with almost nine-tenths of the non-Indigenous population. (As well as these two classifications of ‘remoteness’ in terms of access to goods and services and opportunities for social interaction, the Australian Standard Geographical Classification (ASGC) has four other categories: ‘outer regional’, ‘remote’, ‘very remote’, and ‘migratory’\textsuperscript{27}. ) Almost one-quarter of Indigenous people lived in areas classified as ‘remote’ or ‘very remote’ in relation to having ‘very little access to goods, services and opportunities for social interaction’\textsuperscript{18, 29}. Less than 2\% of non-Indigenous people lived in ‘remote’ or ‘very remote’ areas\textsuperscript{16}.

In terms of specific geographical areas, more than one-half (53\%) of all Indigenous people counted in the \textit{2011 Census} lived in nine of the 57 Indigenous regions (based largely on the former Aboriginal and Torres Strait Islander Commission (ATSI) regions)\textsuperscript{26}. The three largest regions were in eastern Australia (Brisbane, NSW Central and the North Coast, and Sydney-Wollongong), which accounted for 29\% of the total Indigenous population.

According to the 2011 Census, around 90\% of Indigenous people are Aboriginal, 6\% are Torres Strait Islanders, and 4\% of people identified as being of both Aboriginal and Torres Strait Islander descent\textsuperscript{28}. Around 63\% of Torres Strait Islander people lived in Qld; NSW was the only other state with a large number of Torres Strait Islander people.

The Indigenous population is much younger overall than the non-Indigenous population (Figure 1)\textsuperscript{29}. According to estimates from the \textit{2011 Census}, at June 2011 about 36\% of Indigenous people were aged less than 15 years, compared with 18\% of non-Indigenous people. About 3.4\% of Indigenous people were aged 65 years or over, compared with 14\% of non-Indigenous people.

REFERENCES


ENDNOTES

2. There is a difference between the Census ‘counts’ and ‘estimates’. The ‘estimates’ adjust for a number of factors and are more accurate.

3. Includes people who identified as Torres Strait Islanders and those who identified as being of both Aboriginal and Torres Strait Islander descent.

Survey reveals health challenges
FOR AUSTRALIAN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

First results from the Australian Aboriginal and Torres Strait Islander Health Survey have been released by the Australian Bureau of Statistics. The survey provides a platform for a range of new research into health determinants and patterns, supporting critical assessment of progress in closing the gap in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous people.

The survey focus is on long-term health conditions, health risk factors, selected social and emotional wellbeing indicators, health measurements and health-related actions, and includes Aboriginal and Torres Strait Islander people living in remote and non-remote areas. The first results released today reveal Aboriginal and Torres Strait Islander people are smoking less than ever before.

ABS First Assistant Statistician, Dr Paul Jelfs said, “The good news is the number of Aboriginal and Torres Strait Islander people smoking every day has declined 10 percentage points over the past decade. This is around 40 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over smoking on a daily basis.”

“The take up of smoking is declining, matching the trend in the non-Indigenous population. More than one third (37 per cent) of Aboriginal and Torres Strait Islander adults had never smoked, an improvement over the past 10 years (from 30 per cent).

“The proportion of young Aboriginal and Torres Strait Islander people aged 15 to 17 years who had never smoked has increased from 61 per cent to 77 per cent, with an increase from 34 per cent to 43 per cent for those aged 18 to 24 years,” said Dr Jelfs. While the smoking rate has declined in the Aboriginal and Torres Strait Islander population, the smoking rate in the non-Indigenous population has also fallen. Aboriginal and Torres Strait Islander people are still 2.6 times as likely as the non-Indigenous population to be current daily smokers.

Other results released today include a range of self-reported health assessments. Aboriginal and Torres Strait Islander people were more than three times as likely as non-Indigenous people to have diabetes or high sugar levels. The rates were between three and five times higher than the comparable rates for non-Indigenous people in all age groups from 25 years and over.

In self-assessing one’s health, Aboriginal and Torres Strait Islander people aged 15 years and over were around half as likely as non-Indigenous people to report excellent or very good health and twice as likely to report fair or poor health.

The survey found that Aboriginal and Torres Strait Islander adults experienced higher levels of psychological distress. They were nearly three times as likely as the non-Indigenous population to have experienced high to very high psychological distress in the preceding four weeks.

This is the first release in a series of results to be released progressively from the Australian Aboriginal and Torres Strait Islander Health Survey. Further information is available in the Australian Aboriginal and Torres Strait Islander Health Survey: First results 2012-13 (cat. no. 4727.0.55.001).

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Aboriginal and Torres Strait Islander Health Survey: first results

THE LATEST KEY FINDINGS FROM THE AUSTRALIAN BUREAU OF STATISTICS

GENERAL HEALTH
- In 2012-13, around two in five (39.2%) Aboriginal and Torres Strait Islander people aged 15 years and over considered themselves to be in very good or excellent health, while 7.2% rated their health as poor.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people aged 15 years and over were around half as likely as non-Indigenous people to have reported excellent or very good health (rate ratio of 0.6).

Aboriginal and Torres Strait Islander people in non-remote areas were twice as likely as those in remote areas to have asthma.

LONG-TERM HEALTH CONDITIONS

Asthma
- In 2012-13, one in six (17.5%) Aboriginal and Torres Strait Islander people had asthma.
- Aboriginal and Torres Strait Islander people in non-remote areas were twice as likely as those in remote areas to have asthma (19.6% compared with 9.9%).
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people were twice as likely as non-Indigenous people to have asthma (rate ratio of 1.9).

Ear diseases and hearing loss
- In 2012-13, around one in eight (12.3%) Aboriginal and Torres Strait Islander people reported diseases of the ear and/or hearing problems.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people were more likely than non-Indigenous people to have diseases of the ear and/or hearing problems (rate ratio of 1.3).

Heart and circulatory diseases
- In 2012-13, around one in eight (12.0%) Aboriginal and Torres Strait Islander people had heart disease.
- Aboriginal and Torres Strait Islander rates for heart disease were significantly higher than the comparable rates for non-Indigenous people in all age groups from 15-54 years.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people were more likely than non-Indigenous people to have heart or circulatory diseases (rate ratio of 1.2).

Diabetes/high sugar levels
- In 2012-13, around one in twelve (8.2%) Aboriginal and Torres Strait Islander people had diabetes mellitus and/or high sugar levels in their blood or urine.
- Aboriginal and Torres Strait Islander rates for diabetes/high sugar levels were between three and five times as high as the comparable rates for non-Indigenous people in all age groups from 25 years and over.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people were three times as likely as non-Indigenous people to have diabetes/high sugar levels (rate ratio of 3.3).

HEALTH RISK FACTORS

Tobacco smoking
- In 2012-13, two in five (41.0%) Aboriginal and Torres Strait Islander people aged 15 years and over smoked on a daily basis.
- Rates of daily smoking for Aboriginal and Torres Strait Islander people have come down from 50.9% in 2002 and 44.6% in 2008.
- In 2012-13, current daily smoking was still more prevalent among Aboriginal and Torres Strait Islander people than non-Indigenous people in every age group.
- Based on age standardised proportions, the gap between the daily smoking rate in the Aboriginal and
Torres Strait Islander population and non-Indigenous population was 27 percentage points in 2001 and was 25 percentage points in 2012-131.

**Alcohol consumption**
- In 2012-13, around one in six (18.0%) Aboriginal and Torres Strait Islander people aged 15 years and over had consumed more than two standard drinks per day on average, exceeding the lifetime risk guidelines.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people aged 15 years and over and non-Indigenous people were exceeding the lifetime risk guidelines at similar rates (rate ratio of 1.0).
- In 2012-13, just over half (53.6%) Aboriginal and Torres Strait Islander people aged 15 years and over had consumed more than four standard drinks on a single occasion in the past year, exceeding the threshold for single occasion risk.
- Aboriginal and Torres Strait Islander women aged 35 years and over were significantly more likely than non-Indigenous women in this age group to have exceeded the threshold for single occasion risk.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people aged 15 years and over were more likely than non-Indigenous people to have exceeded the single occasion risk guidelines (rate ratio of 1.1)1.

**Obesity rates for Aboriginal and Torres Strait Islander females and males were significantly higher than the comparable rates for non-Indigenous people in almost every age group.**

**Illicit substance use**
- In 2012-13, just over one in five (21.7%) Aboriginal and Torres Strait Islander people aged 15 years and over said that they had used an illicit substance in the previous year.
- Marijuana was the most commonly reported illicit drug, having been used by one in six (18%) Aboriginal and Torres Strait Islander people aged 15 years and over in the previous year.

**Overweight and obesity**
- In 2012-13, almost one-third (30.4%) of Aboriginal and Torres Strait Islander children aged 2-14 years were overweight or obese according to their BMI.
- In 2012-13, two-thirds (65.6%) Aboriginal and Torres Strait Islander people aged 15 years and over were overweight or obese (28.6% and 37.0% respectively), according to their BMI.
- Obesity rates for Aboriginal and Torres Strait Islander females and males were significantly higher than the comparable rates for non-Indigenous people in almost every age group.

**Exercise levels – non-remote areas only**
- In 2012-13, three in five (62%) Aboriginal and Torres Strait Islander people aged 18 years and over were physically inactive and one in ten (10%) had exercised at high intensity.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander adults in non-remote areas were more likely than non-Indigenous people to have been sedentary or exercising at low intensity (rate ratio of 1.1) and were only half as likely to have been exercising at high intensity (rate ratio of 0.6)1.
- In 2012-13, just under half (46%) of Aboriginal and...
Torres Strait Islander adults in non-remote areas had met the National Physical Activity (NPA) Guidelines target of 30 minutes of moderate intensity physical activity on most days (or a total of 150 minutes per week).

- Based on age standardised proportions, Aboriginal and Torres Strait Islander adults in non-remote areas were less likely than non-Indigenous people to have met the NPA targets of 150 minutes of moderate intensity exercise per week or 150 minutes and 5 sessions per week (rate ratio of 0.8 for both).

PHYSICAL MEASUREMENTS

Waist circumference

- In 2012-13, 60.4% of Aboriginal and Torres Strait Islander men aged 18 years and over had a waist circumference that put them at an increased risk of developing chronic diseases, while 81.4% of women had an increased level of risk.
- On average, Aboriginal and Torres Strait Islander men aged 18 years and over had a waist measurement of 99.7 cm, while women had a waist measurement of 97.4 cm.

Blood pressure

- In 2012-13, one in five (20.3%) Aboriginal and Torres Strait Islander adults had measured high blood pressure (systolic or diastolic blood pressure equal to or greater than 140/90 mmHg).
- Based on age standardised proportions, Aboriginal and Torres Strait Islander adults were more likely than non-Indigenous people to have high blood pressure (rate ratio of 1.2).

HEALTH-RELATED ACTIONS

Consultations with health professionals

In 2012-13, in the Aboriginal and Torres Strait Islander population:

- Just over one in five (21.9%) people had consulted a GP or specialist in the last two weeks.
- One in five (18.5%) people had visited a health professional (other than a doctor) in the last two weeks.
- One in twenty (4.8%) people aged two years and over had visited a dental professional in the last two weeks.
- Between 2001 and 2012-13, use of health professionals (other than GP/specialist) increased significantly from 16.3% to 18.5%.
- Between 2001 and 2012-13, consultation rates for GP/specialist and dental professionals have remained largely unchanged.

Hospital visits and admissions

In 2012-13, in the Aboriginal and Torres Strait Islander population:

- Around one in sixteen (6.0%) people had visited the casualty/outpatients/day clinic in the last two weeks.
- Around one in six (18.0%) people had been admitted to a hospital in the previous year.

ENDNOTE

1. Difference between the age standardised proportion for Aboriginal and Torres Strait Islander people and non-Indigenous people is statistically significant.

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INDIGENOUS HEALTH ISN’T ALL BAD NEWS

It’s easy to feel disheartened by the bombardment of negative statistics about Indigenous health, but we shouldn’t ignore the many successes, writes Lisa Jackson Pulver

The media loves a bad news story – and the response to the latest report on Aboriginal and Torres Strait Islander health is no exception.

*The Sydney Morning Herald* called the past 10 years a ‘wasted decade’, highlighting increasing rates of diabetes, kidney disease, asthma and osteoporosis among Indigenous people, along with the 11-year gap in life expectancy between Indigenous and non-Indigenous Australians.

But the largest-ever survey of Aboriginal and Torres Strait Islander health released by the Australian Bureau of Statistics also has some good news to report that was all too easily passed over.

Fewer Indigenous people are taking up smoking, and those who do smoke are giving up the habit. This is despite nicotine being an addictive substance, highly influenced by social norms. For years, smoking rates have been much higher in the Indigenous community than in the non-Indigenous community. But according to the Bureau, the proportion of young Aboriginal and Torres Strait Islander people aged 15 to 17 years who have never smoked has increased from 61 per cent to 77 per cent, with an increase from 34 per cent to 43 per cent for those aged 18 to 24 years.

This result is matched by the non-Indigenous community.

While it must be acknowledged that this is only one indicator of success, it is still a win. So, where are the accolades for all the tobacco control programs, the Aboriginal Health Worker mentors and those with the resolve to never smoke or to stop? Why is this not the story?

Among the findings in the ABS report, Indigenous Australians are reported as being more than three times as likely as non-Indigenous Australians to have diabetes. While this is cause for concern, many of the major health problems for Indigenous communities are not only affected by health spending, but by the wider determinants of health. This means it will take much longer before we see viable gains.

So it should come as no surprise that in such a short period, since 2009, the Closing the Gap policy framework and funding did not produce positive health outcomes on all measures. The period surveyed (2012-2013) cannot have benefitted from the new money that flowed as a result of Closing the Gap. It is too early. More importantly, the severe disadvantage many of these data reflect reinforces the argument for concerted action and sustained funding over the longer term.

We must also remember that early prevention and intervention is important, so we need to continue to look for the early and intermediate signs of what will become a long-term improvement in health – which of course includes lower smoking rates, a top risk factor for a wide array of other health conditions.
Likewise, we should not simply focus on the current rates of chronic disease, but also the factors that contribute to good health in the future: nutritional status and healthy diets, physical activity, access to antenatal care, not smoking, engagement in family and community activities, housing quality and whether there is overcrowding, employment and cultural and psychological wellbeing – all of which lay the foundations to health.

Aboriginal and Torres Strait Islander health, like everyone’s health, is much more than the absence of disease. It involves physical, social, emotional, cultural, spiritual and ecological wellbeing and fulfilment of potential to contribute to the wellbeing of the whole community. Looking more deeply, we can see the outstanding successes in Aboriginal and Torres Strait Islander primary healthcare services, visual and performing arts, drama, music, tertiary education and sport as examples of early indicators that many people are flourishing.

It is very easy to see only the negative, given the statistics that seem to bombard us. That’s unfortunate because it promotes a sense of hopelessness, when what is needed is energy, positive models of change and positive commitment over the long term. There would be great value in capturing these positive changes, in collecting and amplifying the voices of those young people in particular who have made conscious decisions to live well and let these voices join the growing chorus of role models, exemplars and successful ventures in our communities.

Closing the Gap is a great start – and a much needed catalyst for change – but it is necessary to shift the lens towards the kinds of deeper changes that lead to lifelong health, including not smoking.

Instead of focusing on the negatives, why not support those effective, community-driven enterprises and programs already having positive impacts, so that the children of our children will again enjoy the great opportunities that life in this magnificent country has to offer.

Lisa Jackson Pulver holds the Inaugural Chair of Indigenous Health and is a Professor of Public Health at the University of NSW.

On 15 November, 2013 the ABS released the latest official estimates of life expectancy for Aboriginal and Torres Strait Islander peoples. These are the fifth set of life expectancy estimates released by the ABS since the first set was released in 1997.

Life expectancy is only a summary indicator for a population, rather than an exact measure of how long individuals will actually live.

The latest estimates show that in 2010-2012, life expectancy at birth for Aboriginal and Torres Strait Islander men was 69.1 years and 73.7 years for women. This suggests that Aboriginal and Torres Strait Islander men, on average, live 10.6 years less than non-Indigenous men, while Aboriginal and Torres Strait Islander women, on average, live 9.5 years less than non-Indigenous women. This gap has reduced over the last five years by 0.8 years for men and 0.1 years for women.

This means, 69.1 is the average number of years that a group of newborn, male, Aboriginal and Torres Strait Islander babies would be expected to live if current death rates remain unchanged. For newborn, female, Aboriginal and Torres Strait Islander babies, the average number is 73.7 years.

What is life expectancy?

Life expectancy summarises the mortality experience of a population by measuring how long, on average, a group of people born in the same year would be expected to live, if current death rates at each age remained the same.

Life expectancy can be calculated for any age using life tables (a table which shows the probability of dying at each age), though life expectancy at birth is what most people focus on. Life expectancy at birth is the average number of years that a group of newborn babies would be expected to live if current death rates remain unchanged. Since death rates in the population will change during a person’s lifetime and a person may die at an earlier or older age, life expectancy is only a summary indicator for a population, rather than an exact measure of how long individuals will actually live.

By the time a child reaches their first birthday, their chances of living longer increase (since they have survived their first year). By the time they reach late adulthood, their chances of surviving to a very old age are quite good. For example, although the average life expectancy for Aboriginal and Torres Strait Islander men is around 69 years, a five year old is expected to live another 65 years, making their life expectancy 70 years. If an Aboriginal and Torres Strait Islander man reaches age 65, they will have an expected average of 14 additional years left to live, making their life expectancy 79 years, 10 years longer than the average life expectancy at birth.

Does that mean that most people will only live to 69 years and 74?

The latest estimates show that Aboriginal and Torres Strait Islander men born in 2010-2012 would live to an average of 69 years, while women would live to an average of 74 years if current mortality rates continued. However, this does not mean that all or most Aboriginal and Torres Strait Islander people born during 2010-2012 will die at or around these ages. These are average values, so some people die before reaching the average life expectancy.
at birth (including in their first year), while others will live well beyond that age.

**What is life expectancy used for?**

Life expectancy is widely used as a key measure of the health of a population. Since life expectancy is expressed in years of life, it is often seen as an intuitive indicator that is more easily interpreted than other measures of mortality (e.g. standardised death rates, preventable death rates, etc). Life expectancy is also not affected by different population age structures, so can be compared across subpopulations, jurisdictions and over time.

However, since it’s a summary measure, changes in life expectancy are often much smaller than the changes in other measures. For instance, life expectancy at birth for the population of Australia changed by around 0.25 years of life per year, from 1901 to 2001, despite major changes in infant and child mortality and other mortality trends.

**Quantity of life versus quality of life**

While life expectancy at birth measures how long, on average, a group of people born in the same year can expect to live, it does not take account of how healthy they are expected to be throughout their life. Health adjusted life expectancy estimates are not regularly published, with the most recent data published by the University of Queensland in *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003*.

**How does the ABS calculate life expectancy?**

Life expectancy is calculated using life tables, which bring together deaths data and population estimates. By temporarily linking death registration records and Census records, the ABS is able to confirm that there are a number of Aboriginal and Torres Strait Islander people who are not identified as such on their death registration. From this the ABS is able to estimate how many deaths there would have been in the Aboriginal and Torres Strait Islander population, had all of the people who died been identified as they were in the Census.

This method, known as the ‘direct method’, was first used by the ABS for the previous estimates of Aboriginal and Torres Strait Islander life expectancy (for 2005-07). The estimates produced by this method are considered to be more accurate than those from the previous method (the ‘indirect method’, which required the ABS to make a range of assumptions in the calculation).

For the 2010-12 estimates the ABS again used the ‘direct method’, though it also made a small refinement to the methodology, which the ABS estimates would have made a difference of over one year to the previous estimates. As a result, revised estimates (incorporating this small refinement) for 2005-07 were also produced and can be seen in the table below.

**For further information**

See *Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012* (cat. no. 3302.0.55.003).

The ABS would like to thank Dr. Darren Benham, from the Department of the Prime Minister and Cabinet, for his valuable contribution to the explanations contained in this fact sheet.

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**TABLE 1: LIFE EXPECTANCY AT BIRTH ESTIMATES, 2005-07 AND 2010-12**

<table>
<thead>
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<th>2010-2012</th>
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<td>Non-Indigenous men</td>
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<td>The gap – men</td>
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<tr>
<td>The gap – women</td>
<td>9.6</td>
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</table>

1. 2005-07 estimates revised using the 2010-12 method, to enable effective comparisons over time.

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TABLE 1.3: LIFE EXPECTANCY AT BIRTH, INDIGENOUS STATUS – 2010-2012

<table>
<thead>
<tr>
<th></th>
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<tr>
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<td>Aust.(c)(d)</td>
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<td>-3.5</td>
</tr>
</tbody>
</table>

. . not applicable

a. Differences are based on unrounded estimates.
b. Estimates of life expectancy at birth for the total population presented in this release differ from estimates in Deaths, Australia, 2012 (cat. no. 3302.0). See paragraph 32 of the Explanatory Notes for more information.
c. These estimates are not the headline estimates for Australia, because they are calculated without an age-adjustment, but are provided to enable effective comparison with the state and territory, and remoteness area estimates.
d. Includes all states and territories.

CHAPTER 2
Closing the gap in Indigenous health

What works? Addressing the social and economic determinants of Indigenous health

This issues paper summary from the Closing the Gap Clearinghouse reviews actions addressing the social and economic determinants of Indigenous health

WHAT WORKS

There are significant health inequities between Indigenous and non-Indigenous Australians, and the health disadvantages experienced by Indigenous Australians are shaped by the broader social and economic conditions in which they live. In this paper, we review evidence relating to improving Indigenous outcomes and ‘closing the gap’ across a range of key social and economic determinants of health and wellbeing.

For each key determinant area, there are particular issues which contribute towards success, and we have identified these in the relevant chapters. Below are some general issues which are relevant across all determinant areas and characterise successful programs and interventions when taking a social determinants approach. A social determinants approach considers the broad social, political, economic, cultural and environmental context in which people live and the impact these contexts have on health and wellbeing. The causal pathways between social determinants and health are complex and multi-directional.

For the programs we have reviewed in each determinant area, establishing direct causal relationships with health outcomes is not possible. It is possible, however, to make causal inferences by linking the program activity with other factors that are known to be associated with improved health. In identifying ‘what works’, we have identified successful (or unsuccessful) elements of programs which, if they improve outcomes for Indigenous people in that particular area, may be associated with long-term benefits for health and wellbeing.

Effective approaches are characterised by the following:

- Holistic approaches which work with Indigenous people in ways which take into account the full cultural, social, emotional and economic context of their lives, including an awareness of the ongoing legacy of trauma, grief and loss associated with colonisation.
- Active involvement of Indigenous communities in every stage of program development and delivery, in order to build genuine, collaborative and sustainable partnerships with Indigenous peoples, and build capacity within Indigenous communities.
- Collaborative working relationships between government agencies and other relevant organisations in delivering services and programs, acknowledging the interrelatedness of key social and economic determinants across multiple life domains for Indigenous Australians.
- Valuing Indigenous knowledge and cultural beliefs and practices which are important for promoting positive cultural identity and social and emotional wellbeing for Indigenous Australians.
- Clear leadership and governance for programs, initiatives and interventions. This includes commitment from high level leadership of relevant organisations and agencies to the aims of reducing Indigenous disadvantage and addressing determinants of health and wellbeing.
- Employing Indigenous staff and involving them fully in program design, delivery and evaluation, and providing adequate training, where necessary, to build capacity of Indigenous staff.
- Developing committed, skilled staff (Indigenous and non-Indigenous) and providing diversity and cultural awareness training.
- In cases where programs demonstrate success, it is important to provide adequate, sustainable resources for long-term, rather than short-term funding.
• Adopting a strengths-based perspective which builds and develops the existing strengths, skills and capacities of Indigenous people.
• Clear plans for research and evaluation to identify successful aspects of programs, provide a basis to amend and improve, demonstrate success and build an evidence base to justify allocation of ongoing resources.

**WHAT DOESN’T WORK**

The evidence reviewed in the paper suggests the following aspects hinder the ability of programs and interventions to be successful in addressing the social determinants of health to reduce health inequities:
• Not involving Indigenous communities in design, delivery and evaluation of programs, and limited consultation with, and opportunities for the participation of Indigenous representatives.
• Not training and employing Indigenous staff to contribute towards program implementation and delivery.
• Short-term funding and not continuing to fund programs which have demonstrated success – which can contribute towards Indigenous people feeling loss, disappointment and anger at being let down by the system.
• Ad hoc approaches to implementation which may rely upon a handful of people but have no clear leadership or governance.
• Not having plans for built-in research, evaluation and monitoring which can build an evidence base and can be used as a basis for advocacy for good practice interventions.

**WHAT WE DON’T KNOW**

The following points relate to information ‘gaps’ that restrict our ability to specifically identify ‘what works’ in relation to addressing the social determinants of Indigenous health:
• Across all of the key determinant areas, there is a lack of high quality, publicly available evaluation data regarding programs and interventions, which limits the ability to identify success associated with such programs.
• Because social and economic determinants of health are ‘upstream’ or distal causes of population health outcomes that are mediated through a variety of pathways, there are no clear causal links as the relationships are complex and multi-directional.
• Furthermore, it is difficult to identify which social and economic determinants contribute directly to cause particular health outcomes, or the relative contribution of different social determinants to different health outcomes. This would require extensive multivariate modelling of high quality longitudinal epidemiological data, and is beyond the scope of this issues paper.

**SUMMARIES FROM KEY SECTIONS**

The following boxes contain summaries drawn from each section of this paper, which highlight the characteristics of successful programs and initiatives. These summaries are also reproduced in the relevant sections of the paper.

**Summary 1: Educational attainment**

There is evidence of an association between educational attainment and indicators of wellbeing for Indigenous Australians, although the causal pathways between educational attainment and improved health outcomes are not so clear. At all educational levels, factors identified with positive education outcomes for Indigenous Australians include:

- Having high expectations of students and promoting a positive Indigenous identity
- Adopting a community development focus which involves active collaboration with Indigenous communities
- Having a ‘whole of institution’ (for example, school, university) approach to improving Indigenous outcomes, involving senior management
- Well-trained, high quality teachers
- The inclusion of Indigenous culture and knowledge in educational curricula.

The two evaluated programs reviewed in this section contributed towards positive outcomes for Indigenous Australians, including positive attitudes towards education, improved confidence with school work, and increased self-efficacy as learners. However, links between program activities and improved educational attainment were not established. The programs have some shared characteristics that contributed towards the success they achieved:

- Extensive involvement and consultation with local Indigenous communities
- Highly skilled and committed staff who can build trusting relationships with students
- Good connections with services and organisations in the local community
- Flexibility to be adapted to the needs of the local community (especially where mainstream education programs are provided to Indigenous Australians).
Summary 2: Connection to family, community, culture and country

Evidence suggests that feeling connected to family, community and Indigenous culture is positive for Indigenous Australians’ overall wellbeing, with some caveats. In relation to social connections with family and friends, evidence suggests that feelings of obligation to provide social support to others can be an emotional burden. Being connected with traditional culture is associated with positive wellbeing but has also been linked with psychological distress, particularly for Indigenous Australians living in non-remote settings. Research has demonstrated that maintaining a connection with traditional land and country is associated with benefits for the health and wellbeing of Indigenous Australians living in remote and non-remote contexts.

Evaluation data suggest that the initiatives reviewed in this section contributed towards positive social and emotional wellbeing for Indigenous Australians. It was not, however, possible to establish direct causal links between program activities and improved health outcomes on the basis of the available data. Characteristics of these programs include:

- Delivery by organisations with clear direction, planning and vision
- Locally driven programs led and owned by Indigenous communities that work in collaboration with community organisations
- Building on traditional cultural approaches and activities as pathways to healing
- Involvement of Elders in teaching of traditional culture and skills
- Drawing on land and country as a means to heal
- Building on the strengths of Indigenous Australians and cultures to enable healing
- Working with women and supporting them to undertake leadership and governance roles
- Having committed, trained and skilled staff
- Having strategic, intersectoral partnerships.

Summary 3: Employment and income

The causal pathways between employment, income and health outcomes for Indigenous Australians are complex. However, enabling Indigenous Australians to participate in paid work leads to higher incomes which in turn, provide resources which are positive for health and wellbeing. In relation to employment service agencies supporting Indigenous Australians to secure work, evidence suggests the importance of the following:

- Highly skilled, culturally competent staff, including Indigenous staff
- Provision of cross-cultural training for all workers
- Strong vision and commitment to supporting Indigenous job seekers and communities
- Collaborative relationships with local communities and businesses
- Collaborative partnerships with Indigenous leaders and communities
- Holistic support provided to Indigenous job seekers.

Indigenous Australians are more likely than non-Indigenous Australians to be living on low incomes. Apart from increasing participation in paid employment, other interventions have focused on income, and particularly welfare benefits paid to Indigenous people, in order to reduce Indigenous disadvantage:

- Income management has been the subject of much debate and the evidence of its success is not clear. The Cape York Welfare Reform trial suggests that income management, when used as one of a number of strategies as part of the Families Reform Commission process, can promote positive behaviour change, school attendance, and improvements in financial management skills among families. The Cape York trial has been less successful in generating economic development which is related to the limited employment options and lack of economic opportunities in remote Australia.
Summary 4: Housing

The relationship between housing and health is complex and multi-directional, but living in poor quality, inadequate, insecure or unaffordable housing is associated with poor health. Inadequate health hardware can create risks to health and lead to problems for physical health such as infectious disease. Other housing issues, such as overcrowding and affordability, can increase stress and put negative pressures on health and wellbeing.

In remote areas, the evaluated program we have reviewed here was successful in regard to fixing houses to improve health hardware and bring them to adequate standards of safety and functioning. Although health outcomes were not examined, it can be assumed from previous research that improving the health hardware safety of houses would promote better health. Important aspects of this program included:

- Focusing on improving health hardware, such as physical infrastructure relating to sanitation, food preparation and water supply, using a standardised methodology
- Building community capacity through training of Indigenous community members to complete basic tasks and gain skills
- Securing the collaboration and support of Indigenous communities and housing associations.

In a metropolitan area, the program we reviewed succeeded in preventing Indigenous families from becoming homeless and supporting Indigenous families to remain in their homes. Doing this is likely to promote wellbeing. Important aspects included:

- A collaborative working relationship between two Australian Government agencies and a local non-government organisation
- Skilled staff (including Indigenous staff) who had knowledge of cultural issues and could build trust with Indigenous families
- Using a strengths-based, holistic case management approach
- Working with families before they became homeless
- Linking families with other relevant services
- Enabling the family to be self-managed.

Summary 5: Racism

Racism has a negative effect on the social and emotional wellbeing of Indigenous Australians. Racism is experienced by a significant proportion of Indigenous Australians, and operates through a number of pathways to affect health and wellbeing negatively. Despite limited Australian evidence on what works to reduce racism, that available suggests reducing racism should include: universal interventions, targeted interventions across different settings (such as schools, workplaces, public sector and sports/recreation organisations), organisational development, communications and social marketing, and direct participation programs. We reviewed evaluated examples of two anti-racism programs: a communications and social marketing campaign and a diversity training intervention. Data from these evaluations suggest the following success factors:

- Targeting specific false beliefs, for example that all Indigenous people are unemployed or receive ‘special treatment’
- Well-designed and specific program content designed to challenge negative beliefs and specifically address behaviours
- Provision of accurate information about Indigenous culture, and how racism affects Indigenous Australians
- Having a focus on specific areas of discrimination – such as employment
- Highlighting shared values between Indigenous and non-Indigenous Australians
- Ensuring that Indigenous communities are involved in campaign design and development.
**Summary 6: Interaction with government systems**

There are significant inequities in access to health care between Indigenous and non-Indigenous Australians, and Indigenous Australians have high levels of contact with the criminal justice system. Both of these issues are intrinsically connected with other social and economic determinants (for example racism, connection to family, community, culture, education, income) and contribute significantly to the social and economic disadvantage experienced by Indigenous Australians. Inequities in access to adequate health care and higher levels of contact with the criminal justice system (such as higher levels of incarceration) have been clearly linked with negative health outcomes.

Among the programs designed to improve access to health services and prevent contact with the criminal justice system the evaluations suggested some common themes:

- Having skilled, committed and culturally competent staff – including Indigenous staff
- Culturally appropriate service delivery – facilitated by cultural competency training and collaboration between Indigenous and non-Indigenous staff
- Training and support provided to Indigenous staff to enable them to gain professional skills
- Collaborative relationships and partnerships between workers and across agencies that link Indigenous Australians with a range of support services in areas such as health care, education, housing, income and family support
- Having a holistic, strengths-based focus
- In relation to health care: taking a primary health care approach
- In regard to prevention of contact with criminal justice system: taking a long-term ‘whole of community approach’ to community development and providing quality youth services which support young people and provide gender-specific activities.

**Summary 7: Health behaviours**

Negative health outcomes among Indigenous Australians can be linked with health behaviours such as poor nutrition, low physical activity, smoking and consumption of alcohol. All of these behaviours are influenced by the broader social, cultural and economic environment in which Indigenous Australians live. In this section, we reviewed evaluated programs which acknowledged the significance of broader social and economic determinants, and did not have a focus solely on lifestyle interventions or individual behaviour change. Evaluation data suggest that these programs had success in promoting positive health behaviours such as decreased smoking, petrol sniffing and increased self-management of chronic conditions (including physical activity and healthy eating), although health outcomes were not established. Characteristics of these programs which contributed towards success included:

- A community development approach, and investing in community capacity building
- Well trained, community-based staff, including Indigenous staff
- Commitment of health professionals and other staff to develop culturally appropriate health promotion services
- Collaborative partnerships between health agencies and others — for example, outlets selling tobacco products and petrol
- Community ownership, including the leadership and involvement of Indigenous Elders
- Restricting the supply of harmful substances
- Taking into account the history of colonialism in responses to risky behaviours
- Youth services to support young people to engage in alternative behaviours and activities
- Using strong relationships within the community to build on strengths.

Mr Abbott has delivered this year’s Closing the Gap Report, which covers areas such as life expectancy, education and unemployment, and aims to breach the divide between Indigenous and non-Indigenous Australians by 2030.

He told MPs that the targets to halve the gap in child mortality within a decade and to have 95 per cent of remote children enrolled in preschool are on track.

However, he revealed the “bad news” that there has been almost no progress in closing the life expectancy gap and very little improvement in literacy.

“And Indigenous employment, I deeply regret to say, has, if anything, slipped backwards over the past few years,” he said.

“So we are not on track to achieve the more important and the more meaningful targets.

“Because it’s hard to be literate and numerate without attending school.

“It’s hard to find work without a basic education and it’s hard to live well without a job.”

The report states that non-Indigenous Australians live about 10 years longer than Aboriginal Australians, that the progress in closing the gap in literacy has improved in only Year 3 and Year 5 Reading (based on NAPLAN results) and that only 30 per cent of Indigenous adults in remote areas were employed in a mainstream job.

Abbott sets new target for school attendance

As part of his first Closing the Gap Report, Mr Abbott, who is also the minister responsible for Indigenous affairs, announced he wants to set a new target to close the gap between Indigenous and non-Indigenous school attendance within five years.

“We are all passionate to close the gap,” he said.

“We may be doomed to fail, I fear, until we achieve the most basic target of all: the expectation that every child will attend school every day.”

“One of the worst forms of neglect is failing to give children the education they need for a decent life.”

Mr Abbott said that in remote areas, only 31 per cent of Indigenous students met the national standards for reading skills.

“Yet it’s being demonstrated in places like Aurukun that a strong education in traditional culture is actually helped by a good education in English,” he said.

“Right around our country, it should be possible to be proudly Aboriginal and a full participant in modern Australia.

“That doesn’t just mean access to a good education in cities, towns and remote settlements – it means actually going to school.

“One of the worst forms of neglect is failing to give children the education they need for a decent life.”

The Prime Minister said when school attendance is above 90 per cent for all schools, regardless of the number of Aboriginal students enrolled, the gap will have been closed.

Opposition Leader Bill Shorten has said the ALP will support Mr Abbott’s move.

“And we hope that the 44th Parliament will build upon the progress of the 42nd and the 43rd,” he said.

“But the challenge of Closing
Closing the Gap report card

In 2008, the Council of Australian Governments set targets for closing the gap between Indigenous and non-Indigenous Australians. In early 2014 the Federal Government released a report card on progress towards the goals. Below is a brief summary of its findings.

**LIFE EXPECTANCY**

**Goal**

*Close the life expectancy gap within a generation, by 2031.*

**Little progress**

The life expectancy gap remains about a decade. The Northern Territory is the only area on track to meet its 2031 target.

**CHILD MORTALITY**

**Goal**

*Halve the gap in mortality rates for Indigenous children under 5 within a decade.*

**On track**

If the trend from 1998 to 2011 continues, the 2018 target will be achieved.

**EARLY CHILDHOOD EDUCATION**

**Goal**

*Ensure access to early childhood education for all Indigenous four-year-olds in remote communities within 5 years.*

**On track**

88 per cent of Indigenous children were enrolled in pre-school in 2012. Later this year (2014), data will reveal whether the 95% benchmark has been met.

**YEAR 12 ACHIEVEMENT**

**Goal**

*Halve the gap in Indigenous Year 12 achievement by 2020.*

**On track**

This target is on track to be met.

**READING, WRITING AND NUMERACY**

**Goal**

*Halve the gap in reading, writing and numeracy achievements for children within a decade.*

**Very little improvement**

Only 2 out of 8 areas have shown significant improvement since 2008.

**EMPLOYMENT**

**Goal**

*Halve the gap in employment outcomes within a decade.*

**Slipping backwards**

No progress has been made towards meeting this target. Prime Minister Tony Abbott says outcomes have, if anything, gone backwards.

**NEW GOAL**

*To close the gap in school attendance within five years. The target is 90% attendance for all schools, regardless of their percentage of Indigenous students.*

The Gap does not belong to the Parliament alone. It belongs to the nation and the work of our generation.

“Success will only come when Aboriginal people are central to the political process, not just subject to it.

“Let us empower Aboriginal and Torres Strait Islander families, teachers, nurses, not-for-profits and business to tell us what works – rather than demanding policies that fit the rhetoric of the moment – an approach that empowers, not directives from the top-down.

“Aboriginal people deserve better than being told it’s as simple as: ‘go to school, go to work and obey the law’. In his reply to the report, Mr Shorten focused on the bipartisan support for Indigenous recognition in the Constitution and the damage caused by alcohol abuse.

“The rivers of grog are flowing again – and violence is being borne along in their current,” he said.

Warren Mundine, who chairs the Government’s Indigenous advisory council, says the speeches were heartening but action is now needed.

He is pushing to get a 100 per cent school attendance rate by the end of the year.

“That’s a personal commitment I have given to myself. If I have to personally go out in these communities and work with those parents and work with those community leadership and those kids, I will do that,” he said.

“The Minister’s also made a commitment to that as well because you can’t get an education if you’re not at school.

“From there we need the work on what they have been taught and how to make the schools more attractive, but unless the kids are going to school we’re wasting our time.”

**Indigenous parliamentarians say there is still much work to be done**

Earlier today, the first female Indigenous federal parliamentarian, NT Labor Senator Nova Peris, said women in the Territory were 80 times more likely to be hospitalised...
due to assault than non-Indigenous Territorians.

“As of right now, life is not a bed of roses for Aboriginal people,” she said. “This is a horrific statistic that no Australian should accept.

“Whilst the Northern Territory has made more progress towards closing the gap targets than any other jurisdiction, I fear that our gains may be lost.”

The nation’s first Indigenous MP, the Liberal member for Hasluck, Ken Wyatt, said: “We’ve still got a lot of work to do.”

“I think the issues of incarceration rates, certainly employment and long-term [school] attendance, are important measures that we have to achieve,” he told ABC News 24’s Capital Hill program.

“Education is the way in which we acquire knowledge, make discernible choices and then pick opportunities and take opportunities that give us a better pathway.”

Northern Territory Health Minister Robyn Lamley welcomes the Federal Government’s focus on Indigenous school attendance.

“I think education, getting kids to school, is an obvious area that we need to work on,” she said.

“We are closing the gap in lots of respects in health, in fact we are leading the way in lots of measures. We’ve got to keep working on this, obviously a large proportion of our population is Indigenous so the emphasis is on us to continue to provide top quality services throughout the Territory.

“It is a huge challenge.”

“Success will only come when Aboriginal people are central to the political process, not just subject to it.”

Indigenous affairs close to PM’s heart

Mr Abbott has emphasised how “personal” the issue is to him and, in a speech he wrote himself, has spoken of his visits to Indigenous communities and the time he spent, while an MP, as a teacher’s aide and a truancy helper.

“Many of us have been on a long journey. I can’t say that I have always been where I am now,” he said.

“The further this journey has gone, the more, for me, Aboriginal policy has become personal rather than just political.

“It has become a personal mission to help my fellow Australians, to open their hearts as much as to change their minds on Aboriginal policy.”

Mr Abbott said that he will spend a week in East Arnhem Land later this year and will make Indigenous affairs “if only for a few days, the focus of our national Government”.

“There is probably no aspect of public policy on which there is more unity of purpose and readiness to give others the benefit of the doubt,” he told federal MPs.

“On this subject at least, our Parliament is at its best and our duty is to make the most of this precious moment.”

This is the sixth annual Closing the Gap Report.

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OVERVIEW OF THE GOVERNMENT’S AGENDA FOR INDIGENOUS AFFAIRS

Indigenous affairs: a long-term commitment

A new engagement with Aboriginal and Torres Strait Islander people should be one of the hallmarks of this Government.

As this report highlights, no one should be under any illusion about the difficulty of swiftly overcoming two centuries of comparative failure. Nevertheless, it would be complacent, even negligent, to not redress, from day one, the most intractable difficulty our country has ever faced.

One of the first acts of the new Government was to bring the administration of more than 150 Indigenous programmes and services, from eight different government departments, into the Department of the Prime Minister and Cabinet.

The Department, the Minister for Indigenous Affairs, Senator the Hon Nigel Scullion and the Parliamentary Secretary to the Prime Minister, the Hon Alan Tudge MP, are working with the Prime Minister to ensure that the changes result in improved performance across government.

For too long, there has been overlap and inconsistency in the administration of Commonwealth-funded Indigenous services. Placing all Indigenous programmes in the Department of the Prime Minister and Cabinet is an opportunity to overhaul the system, to make it simpler and less burdensome, and to ensure that the right resources supported by the right capabilities go to those who need them most.

Improving governance is an essential element of strengthening the work that is already being done in communities across Australia.

The Prime Minister’s Indigenous Advisory Council, chaired by Mr Warren Mundine, is informing the Government’s policy work. The Council is focusing on practical changes to improve people’s lives.

Later this year, the Prime Minister will take senior officials to a remote Indigenous community for a week. This annual commitment to help in an Indigenous community reflects the Prime Minister’s belief that national leaders make better decisions when grounded in the real life of our country.

Preserving Indigenous culture and building reconciliation means doing more to ensure that children go to school, adults go to work and the ordinary rule of law operates throughout our country.

Getting children to school

Getting children to school is the Australian Government’s number one priority in Indigenous Affairs. Poor attendance means that Indigenous children find it hard to perform at school.

We must break the cycle of non-attendance to ensure today’s kids are educated and equipped to become future leaders in their communities.

From Term 1 this year, we introduced a plan to get Indigenous children back to school in 40 remote communities in the Northern Territory, South Australia, New South Wales, Queensland and Western Australia.

Getting adults to work

Our next priority is getting people into real jobs. Too often, employment and training programmes provide ‘training for training’s sake’ without delivering the practical skills people need to get real jobs.

The Government has commissioned a review of employment and training programmes led by Mr Andrew Forrest. This review will provide recommendations to make Indigenous training and employment services better targeted and administered to connect unemployed Indigenous people with real and sustainable jobs.

Safer Indigenous communities

All Australians have a right to live in a community where they can be safe. The Government wants Indigenous Australians to live in communities where crime rates are low and people can go about the ordinary business of making a living and raising a family.
We will continue to support tough alcohol regulations across the country so all community members, particularly women, children and the elderly, can live peacefully and safely in their own homes.

Through the Council of Australian Governments (COAG), the Government will work with state and territory governments to establish a permanent police presence in some additional remote Indigenous communities.

**ANALYSIS OF THE NEED FOR A NEW DIRECTION**

In too many areas, people’s lives are not improving or not improving fast enough.

The COAG Reform Council recently concluded there had been no improvement in Indigenous school attendance over five years. While there are some isolated examples of success, such as Cape York Welfare Reform, existing strategies are having no overall impact on school attendance.

The record of progress against other targets has also been disappointing. There has been no progress on the employment target and while Indigenous life expectancy has improved, the pace of change is far too slow to close the gap by 2031.

While the COAG targets have provided a useful focus, there has been a proliferation of National Partnership Agreements, frameworks and strategies. Some of these National Partnerships – such as the Remote Service Delivery National Partnership – have very complicated and detailed reporting requirements that have diverted attention from actually delivering better outcomes. There is too much focus on whether bureaucratic processes have been completed and not enough focus on delivering better services and outcomes.

We should not equate spending money with getting results. Spending more money on Indigenous Australians is not a sign of success and is not something that should be celebrated for its own sake.

There is also a need to engage Indigenous people more in solving their own problems. We have to stop pretending that a government policy or programme on its own can overcome Indigenous disadvantage. No matter how well coordinated or organised they are, government programmes alone will never close the gap. We also need to more honestly assess the impact of policies and programmes and, where success is not being achieved, be prepared to change tack and try new things.

**PROGRESS IN MEETING THE GOVERNMENT’S COMMITMENTS**

The Australian Government is honouring its key election commitments in Indigenous Affairs. Actions undertaken include:

- Moving the administration of more than 150 Indigenous programmes and services, from eight different government departments, into the Department of the Prime Minister and Cabinet.
- Establishing the Prime Minister’s Indigenous Advisory Council.
- Implementing the $28.4 million Remote School Attendance Strategy.
- Commissioning a review of Indigenous employment and training programmes.
- Providing up to $45 million to fast-track the implementation of a demand-driven Vocational Training and Employment Centres training model.
- Providing $5 million to support the design of the Empowered Communities initiative.
- Working to build support for a successful referendum to recognise the first Australians in our Constitution.

**UPDATE ON CURRENT CLOSING THE GAP TARGETS**

**Progress against the targets**

Key findings:

- While there has been a small improvement in Indigenous life expectancy, progress will need to accelerate considerably if the gap is to be closed by 2031.
- The target to halve the gap in child mortality within a decade is on track to be met.
- In 2012, 88 per cent of Indigenous children in remote areas were enrolled in a pre-school programme. Data for 2013, to show whether the 95 per cent benchmark for this target has been met, will be available later this year.
- New data on whether enrolled children are actually attending school should also be available later this year.
- Progress against the target to halve the gap in reading, writing and numeracy within a decade has been disappointing. Only two out of eight areas have shown a significant improvement since 2008.
- The target to halve the gap for Indigenous people aged 20-24 in Year 12 or equivalent attainment rates by 2020 is on track to be met.
- No progress has been made against the target to halve the employment gap within a decade.

**CLOSING THE GAP TARGETS**

**Target**

Close the life expectancy gap within a generation (by 2031)

Life expectancy is affected by a range of factors such as education, employment, housing, exposure to violence and poverty which in turn impact on health risk behaviours and the physiological impact of stress.

In 2010-12, Indigenous life expectancy was estimated to be 69.1 years for males and 73.7 years for females. The gap in life expectancy between Indigenous and non-Indigenous people was 10.6 years for males and 9.5 years for females. Over the last five years, there has been a small reduction in the gap of 0.8 years for males and 0.1 years for females. The current rate of progress will have to gather considerable pace from now on if the target is to be met by 2031.

Life expectancy for Indigenous males living in outer regional, remote and very remote areas was estimated to be 0.7 years lower than for those living in major cities.
and inner regional areas (67.3 years compared with 68.0 years) and 0.8 years lower for females (72.3 compared with 73.1 years).

**Target**

**Halving the gap in mortality rates for Indigenous children under five within a decade (by 2018)**

There have been significant improvements in Indigenous child mortality in recent years. During the period 1998-2012, the Indigenous child mortality rate declined by 32 per cent, outpacing the decline in non-Indigenous child mortality. This has led to a significant (37 per cent) narrowing of the gap in child mortality between non-Indigenous and Indigenous children over this period. Changes in Indigenous child mortality since the 2008 baseline are currently within the range required to meet the target by 2018.

**Target**

**Ensuring all Indigenous four-year-olds in remote communities have access to early childhood education within five years (by 2013)**

The benchmark for the achievement of this target is 95 per cent enrolment for Indigenous four-year-old children in remote communities by 2013.¹

The new National Early Childhood Education and Care Collection is used to assess progress. These data show that in August 2012, 88 per cent of Indigenous children in remote areas were enrolled in a pre-school programme in the year before full-time schooling. While this is lower than the estimate for 2011 of 91 per cent, this apparent fall represents improvements in data quality (such as the removal of duplicate records).

Data on pre-school enrolment in remote areas for 2013 will be available in March 2014. Revised population data will be available in April 2014.

**Target**

**Halve the gap for Indigenous children in reading, writing and numeracy within a decade (by 2018)**

This target is measured using outcomes of the annual National Assessment Program – Literacy and Numeracy (NAPLAN). The gap is measured as the difference between the proportion of Indigenous and non-Indigenous students at or above the National Minimum Standards (NMS) in reading and numeracy at Years 3, 5, 7 and 9.²

Between 2008 and 2013, the proportion of Indigenous students at or above the NMS in reading and numeracy has shown a statistically significant improvement in only two out of eight instances – Years 3 and 5 Reading.

The improvement in Year 5 Reading from 2008-2013 reflects a very large improvement in 2013 which should be treated with some caution.³ This very large increase of 18.6 percentage points in one year is out of step with the pattern observed in previous years. It will be important to confirm this large improvement when NAPLAN data for 2014 becomes available.

Another way to assess progress is to compare actual results against agreed trajectories. In 2013, results in four of the eight areas were consistent with or above the required trajectory points at the national level: Years 3, 5, and 9 Reading and Year 5 Numeracy. In the other four areas, 2013 results were below the required trajectory points.

NAPLAN results for Indigenous students vary sharply by remoteness area. As an example, in 2013, 81 per cent of all Indigenous students in metropolitan areas met or exceeded the NMS for Year 9 Reading compared to only 31 per cent of Indigenous students in very remote areas. As results for non-Indigenous students vary considerably less by remoteness area, the ‘gap’ is much wider in very remote areas than it is in metropolitan areas.

**Target**

**Halve the gap for Indigenous people aged 20-24 in Year 12 or equivalent attainment rates (by 2020)**

The main data source used to assess progress against this target is the Census. Data from the 2011 Census show that 53.9 per cent of Indigenous Australians aged between 20 and 24 had attained a Year 12 or equivalent qualification, which is up from 47.4 per cent in 2006.

Progress is currently ahead of schedule to meet this target as the proportion of Indigenous 20-24 year olds with a Year 12 or equivalent qualification is higher than the 2011 trajectory point (52.8 per cent).

While not directly comparable with Census data, the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) provides a secondary source of data for this target. According to the AATSIHS, 59.1 per cent of Indigenous 20-24 year olds had a Year 12 or equivalent qualification in 2012-13, which

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Aboriginal and Torres Strait Islander Health

Issues in Society | Volume 376
represents a rise of 13.7 percentage points from 45.4 per cent in 2008.

While improvements in Year 12 or equivalent attainment are welcome, results vary sharply by remoteness area. Figure 1 shows that in 2012-13, 68.1 per cent of Indigenous 20-24 year olds in inner regional areas had a Year 12 or equivalent qualification compared to only 38.5 per cent of Indigenous 20-24 year olds in very remote areas.

**Target**

**Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (by 2018)**

In late 2013, employment data from the *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS) became available. This data suggested that the proportion of Indigenous people aged 15-64 who are employed fell from 53.8 per cent in 2008 to 47.8 per cent in 2012-13. As the proportion of non-Indigenous people who are employed rose from 75 per cent to 75.6 per cent, this means that the employment gap widened.

Some care is required in assessing progress on this target as the Australian Bureau of Statistics (ABS) counts participants in Community Development Employment Projects (CDEP) as being employed. The policy goal is to increase mainstream (non-CDEP) employment not the number of CDEP participants – CDEP is not intended to be a substitute for mainstream employment.

There has been a large fall in the number of CDEP participants from 2008 to 2012-13, which accounts for more than 60 per cent of the decline in the Indigenous employment rate over this period. The Indigenous mainstream (non-CDEP) employment rate also fell from 48.2 per cent in 2008 to 45.9 per cent in 2012-13. However, this fall was not statistically significant.

The mainstream employment gap widened from 2008 to 2012-13 but this change was not statistically significant. However, on the data presented, it is clear that no progress has been made against the target to halve the gap in employment outcomes within a decade (by 2018). Mainstream (non-CDEP) Indigenous employment rates vary sharply by remoteness area. Only 30.2 per cent of Indigenous adults aged 15-64 in very remote areas were employed in a mainstream job in 2012-13 compared to 51.4 per cent in inner regional areas.

**FOCUS ON SCHOOLING**

The Australian Government’s highest priority in Indigenous Affairs is getting children to school.

A good education provides a passport to more opportunities and a better life. It is a key pathway to prosperity and wellbeing for all Australians. Education is also the fundamental building block to establishing strong, sustainable communities.

Within the first 100 days of Government, the Prime Minister sought and received agreement from Premiers and Chief Ministers to have a stronger focus on school attendance, including improved reporting, support and compliance measures.

The Government has already acted to increase school attendance. Actions include:

- Rolling out the $28.4 million Remote School Attendance Strategy to 40 communities in the Northern Territory, Western Australia, Queensland, New South Wales and South Australia.
- Committing to expand the Improving School Enrolment and Attendance through Welfare Reform Measure (SEAM) from 15 to 23 communities over the next two years.
- Continuing the $22 million committed in the 2013-14 Budget to expand scholarship opportunities for Indigenous students.
- Working with the states and territories to ensure school-by-school attendance data is available and published on a regular basis.

In addition, the Government is committed to supporting remote primary schools to implement evidence-based teaching methods.
to improve English literacy.

Initiatives to improve ear health and hearing are giving Indigenous children a better start to their education. Being able to hear properly makes learning easier, helps engagement and supports literacy and numeracy development.

The Care for Kids’ Ears initiative is providing community-level communications and activities to improve understanding of the causes, prevention and treatment of ear disease.

FOCUS ON JOBS

Ensuring Indigenous adults are working is critical if Indigenous adults and their families are to enjoy better economic opportunities.

Too often, employment and training programmes provide ‘training for training’s sake’ without providing the practical skills people need to get jobs.

This is one of the reasons why the Government has commissioned a review of Indigenous training and employment programmes, led by Mr Andrew Forrest. This review will provide recommendations to ensure Indigenous training and employment services are more effectively linked to employment outcomes.

We will ensure Job Services Australia (JSA) is focused on delivering better outcomes for Indigenous jobseekers and making sure training is targeted at sustainable jobs. JSA will have a stronger emphasis on working with employers to ensure jobseekers have the skills demanded by employers, work experience is job-focused and post-placement support is provided to deliver sustainable jobs.

We are also investing up to $45 million to deliver demand-driven Vocational Training and Employment Centres, along the lines developed by GenerationOne, to train up to 5,000 Indigenous Australians for guaranteed jobs.

On 29 November 2013, the Government announced immediate changes to the Remote Jobs and Communities Programme (RJCP). These changes will ensure that people in remote communities are engaged in training that leads to real jobs, or are participating in activities that benefit their communities.

FOCUS ON SAFER COMMUNITIES

All Australians have a right to live in a community where the ordinary law of the land is observed.

This applies to Indigenous communities just as much as it does to the general community.

Improving community safety is one of the Australian Government’s key priorities in Indigenous Affairs.

We will continue to support the efforts of Indigenous communities to combat alcohol-fuelled violence through tough alcohol regulations so all community members, particularly women, children and the elderly, can live peacefully and safely.

The Australian Government has committed $5 million to support the Empowered Communities initiative that aims to strengthen local leadership and governance and build strong, healthy, prosperous and safe communities. The Government is working with the Jawun Indigenous Corporate Partnerships as part of this process. A taskforce that includes Indigenous leaders, governments and representatives of the business community has been established to lead the design work.

Through COAG, governments have agreed to work together to make larger Indigenous communities safer. This includes establishing a permanent police presence in some additional communities.

In 2014, the Government will further address the issue of petrol sniffing in the Top End by expanding the rollout of low aromatic fuel across Northern Australia.

CONSTITUTIONAL RECOGNITION

The Australian Government wants a successful referendum to recognise the first Australians in our Constitution and will put forward a draft amendment in late 2014.

A successful referendum would be a unifying moment for our nation – as in 1967 when more than 90 per cent of Australian voters approved a referendum in support of Indigenous Australians, and in 2008 when the National Apology was made to Australia’s Indigenous people.

Recognising the first Australians in our Constitution would acknowledge our shared history and the value we place on Australia’s Aboriginal and Torres Strait Islander heritage.

In December 2013, we established a Joint Select Committee on Constitutional Recognition of Aboriginal and Torres Strait Islander Peoples which will work to build a secure, strong multi-partisan parliamentary consensus around the timing, content and wording of referendum proposals.

The Government continues to support Reconciliation Australia’s Recognise campaign to build public awareness and community support for recognising the first Australians in our Constitution.

ENDNOTES

1. The target of 95 per cent, rather than 100 per cent, enrolment reflects the fact that early childhood education is not compulsory.
2. Prior to 2011, measurement of this target also used the NAPLAN Writing test. In 2011, the Writing test for all year levels was altered from an assessment of Narrative Writing to Persuasive Writing. This change in the Writing test has created a break in the data series over time. Writing results from 2011 onwards cannot be directly compared to the Writing results from previous years, and so have been excluded.
3. The proportion of Indigenous students at or above NMS in Year 5 Reading rose from 64.7 per cent in 2012 to 83.3 per cent in 2013.
4. The 2008 data is from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS).

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Department of the Prime Minister and Cabinet (2014). Closing the Gap Prime Minister’s Report 2014, pp. 2-16.
Living up to the Close the Gap challenge

Our nation is at its best when it comes together in shared spirit of achievement and a shared desire to achieve a common goal, Mick Gooda and Kirstie Parker write in ‘The Guardian’

In 2008, our political leaders came to the fore in a demonstration of leadership, putting aside partisan politics. The Australian public joined them. And as a nation we united to take a stand.

Together we agreed that this would be the generation to close the unacceptable health and life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians.

We committed to close the health and life expectancy gap within a generation: by 2030. As a result we now have a national effort to close the gap, a priority for government action until the goal is met.

Health inequality is a stark reminder of a great divide in the nation across education, income, housing, mental health, chronic disease, child and maternal health, access to health services, and more. It is a scar of an unhealed past and a stain on the reputation of the nation. For Aboriginal and Torres Strait Islander peoples, it is an immense and unnecessary burden of suffering and grief.

But we are optimistic that we can make real inroads into our shared goal if we continue to place a high priority on it. At a government level this means renewing the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and forging an implementation plan for the Aboriginal and Torres Strait Islander Health Plan in partnership with Aboriginal and Torres Strait Islander people.

We must remember that despite times of fiscal austerity Australia is enormously wealthy nation with very high standards of health and life expectancy. However, Aboriginal and Torres Strait Islanders do not share the same standards of health. Aboriginal and Torres Strait Islander people are all too aware of this. Often our children have attended dozens of funerals by their early teens. Our elders are denied longer, healthier lives, and our communities are all the poorer for it.

The Close the Gap Campaign was touched directly by this harsh reality early on in the campaign. In 2009, just two years after the campaign was launched, Clarence Paul (pictured) from Mornington Island whose photo with his grandson became an iconic campaign photo passed away at age 48. This is 31 years less than the average life expectancy for non-Indigenous Australians.

Health inequality is a stark reminder of a great divide in the nation ... it is a scar of an unhealed past and a stain on the reputation of the nation.
The Campaign contacted Mr Paul’s family to ask if they would like us to stop using the photo that had become the defining image of what the campaign was all about. The response was instant and clear – the nation must stop the passing of our mob prematurely. We must as a nation achieve health equality for our people. We were told that the campaign should continue to use Mr Paul’s image to help with the national effort to close the gap.

The photo stands as a memorial to a much loved uncle, father, grandfather, brother, son and respected community member. It stands as a reminder of the task at hand. We thank his family for the inspiration they provided the campaign in those early days.

Five years later, we continue to work with all sides of politics and engage the public in our efforts.

Last year, six years into the campaign, nine hundred and seventy-two community events involving 140,000 Australians were held on National Close the Gap Day in 2013. Today, almost 200,000 people have joined us in this effort.

We are starting to see some progress – there are reductions in smoking rates and improvements in maternal and child health. We must build on these. Turning around Aboriginal and Torres Strait Islander health equality requires a concerted national effort over years. It requires continuity and diligence. And it requires investment.

Achieving Aboriginal and Torres Strait Islander health and life expectancy equality by 2030 is an agreed national priority. The Australian public demand that government, in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, build on the close the gap platform to meet this challenge.

They believe that we can and should be the generation to finally close the gap. We should all live up to the challenge that Clarence Paul’s family set us – stop our mob from dying prematurely.


Mick Gooda and Kirstie Parker are co-chairs of the Close the Gap Campaign.

Achieving Aboriginal and Torres Strait Islander health and life expectancy equality by 2030 is an agreed national priority. The Australian public demand that government, in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, build on the close the gap platform to meet this challenge.
Prime Minister’s Indigenous affairs challenge is to deliver on his ambition

There have been so many declarations of good intentions followed by minimal progress that it is hard to dare hope real advancement might be made in Aboriginal affairs in the next few years. Yet, we have to ask, if not now, then when? By Michelle Grattan

Prime Minister Tony Abbott is putting maximum political capital into the task. Indigenous affairs has a full time cabinet minister (Nigel Scullion, the Nationals Senate leader) and a parliamentary secretary (Victorian Liberal Alan Tudge). Administrative responsibility for most programs has been brought within the Prime Minister’s department.

Abbott is personally deeply engaged. How well he does will be one benchmark of the success or failure of his prime ministership.

The PM gets the importance of symbolism – a contrast with John Howard, who just before he lost office admitted he hadn’t appreciated its role. Howard (until his late conversion) thought “practical reconciliation” was the only thing that really mattered. Abbott understands that the practical must march in tandem with the symbolic.

Kevin Rudd’s 2008 apology was a big leap forward in that regard. But politically, it was much easier than what now needs to come – a successful referendum for constitutional recognition. That will be a massive hurdle for the Abbott government to surmount.

The Rudd government also took important steps on the practical side, instigating Closing the Gap targets. Abbott this week reported on how these were going, and it was a very mixed picture.

The target of halving the gap in child mortality within a decade is on track, as is that of halving the gap in year 12 attainment by 2020, while having 95% of remote children enrolled in pre-school is close to being achieved.

But there is “almost no progress” in closing the difference (about a decade) in life expectancy between Aborigines and other Australians;

Abbott has this week added another target to the Closing the Gap list: “to end the gap between Indigenous and non-Indigenous school attendance within five years.”

Achieving this bold target (which some observers see as a blunt instrument) will require a complex effort from federal, state and territory governments. Getting children into the classrooms (where the teaching has to be skilled and appropriate to special needs) also puts a good deal of weight on parents, and that opens up issues ranging from housing conditions to alcohol availability. Crucially, the drive must win the support from the people who have to make the changes.

Fred Chaney, Aboriginal affairs minister in the Fraser government who as 2014 senior Australian of the Year will devote much of his efforts to Indigenous causes, praises “the positive signs” that have come...
from the Abbott government. “It’s starting with a high level of political commitment and bureaucratic and financial resources – the thing it has to do is to get it to work on the ground.”

This has always been the problem for governments: translating worthy policies into successful administration can be enormously hard.

Chaney says that well-documented previous experience has shown how administration needs to be fashioned if it is to succeed. “In shorthand, this involves bottom up work at a regional level. But governments have traditionally found this difficult, because their timetables generally preclude genuine community involvement.”

Another challenge is keeping advisers and stakeholders broadly in the tent. Healthy debate is desirable but serious division, especially among Indigenous leaders, can be destructive.

So can fractures between levels of government. Nevertheless, the Abbott government would have to be ready to be tough with the Northern Territory if necessary, given the serious issues there surrounding alcohol. This is tricky when minister Scullion is a Territorian.

Ambit claims can also pose problems for a government that is trying to move things forward by consensus. One such came from Warren Mundine, chair of Abbott’s Indigenous advisory council, when he said in his Australia Day speech that “for true reconciliation to occur I believe there needs to be ... a treaty between Australia and each of the Aboriginal and Torres Strait Islander nations.”

“For true reconciliation to occur I believe there needs to be ... a treaty between Australia and each of the Aboriginal and Torres Strait Islander nations.”

Warren Mundine

Abbott has committed to spending a week in East Arnhem Land later this year, and to use the time for a shout out, taking along “enough officials to make it, if only for a few days, the focus of our national government”.

To the maximum extent, bipartisanship is desirable in the Indigenous area (although, inevitably and rightly, sometimes there will be debate over policy directions). Bipartisanship involves giving due credit to what has gone before as well as reaching across the contemporary political aisle. Abbott is seeking to emphasise continuity; on Thursday he marked the anniversary of Rudd’s apology, describing it as “the end of a damaging period of division and denial”.

He is well served by the fact that the two Indigenous MPs, Ken Wyatt and Nova Peris come from opposite sides. They are chair and deputy of the parliamentary committee on constitutional recognition.

There is also a useful bipartisan link through Recognise, the offspring of Reconciliation Australia that is promoting constitutional recognition. Its head is Tim Gartrell, former ALP national secretary (who knows a thing or two about running campaigns).

Abbott’s critics on the left doubt his sincerity on the Indigenous issue, while some of his spruikers on the right are appalled by his passion.

The PM told parliament: “Many of us have been on a long journey. I can’t say that I have always been where I am now. The further this journey has gone, the more, for me, Aboriginal policy has become personal rather than just political. It has become a personal mission to help my fellow Australians to open their hearts, as much as to change their minds, on Aboriginal policy.”

There is no reason to believe Abbott’s commitment is other than deep and genuine. This is not an issue that brings political points. But it does go to the soul of the nation and the wellbeing of many of its citizens, now and in the future. Abbott should be given marks for his ambitions, but living up to them will stretch him to the limit.

Michelle Grattan is Professorial Fellow at the University of Canberra.

The assumption of media stories and many politicians is that gap closing is a ‘wicked’ problem – that is, it’s too hard because of faults of the Indigenous targets.

It is easier to blame others when good intentions fail, but there is a much more mundane explanation, backed by substantial evidence: poor outcomes could be the result of flaws in how officials devise and deliver programs and funding.

Many programs designed to reduce Indigenous disadvantage fail to meet the federal government’s clear criteria for what works. These criteria come from the Commonwealth’s own major advisers’ analysis of performance and research data.

Multiple agencies monitor the effectiveness of government programs. They include the Australian National Audit Office (ANAO), the Ombudsman, a range of internal evaluation units and the Australian Institute of Health and Welfare (AIHW). The last of these is a particularly significant source of data for the current issue as it runs the official Closing the Gap Clearinghouse.

Reports on programs delivered plus summaries called Key Learnings are based on analysis of multiple publications. These reports clearly extract data on what works and what does not work in general and in particular program areas – for example, early childhood services. Another reputable advisory body, the Productivity Commission, extensively quotes these reports in its series of publications on Overcoming Indigenous Disadvantage.

The AIHW collection and the related papers from 2009 onwards offer a range of painstakingly rigorous findings of what worked and didn’t work. Their brief criteria summaries emphasise the importance of good processes in decision-making.

**WHAT WORKS**

The Clearinghouse has continued to find that there are high-level principles and practices that underpin successful programs for Indigenous Australians.

These include:

- Flexibility in design and delivery so that local needs and contexts are taken into account
- Community involvement and engagement in both the development and delivery of programs
- A focus on building trust and relationships
- A well-trained and well-resourced workforce, with an emphasis on retention of staff
- Continuity and coordination of services.

**WHAT DOESN’T WORK**

- “One size fits all” approaches
- Lack of collaboration and poor access to services
- External authorities imposing change and reporting requirements
- Interventions without local Indigenous community control and culturally appropriate adaptation
- Short-term, one-off funding, piecemeal interventions, provision of services in isolation and failure to develop Indigenous capacity to provide services.

I have been collecting data on what works and doesn’t work in Indigenous policy making as part of examining the use of evidence in this policy area through Jumbunna.

We have examined aspects of the Northern Territory Emergency Response (NTER) and its sequel, Stronger Futures. Both interventions have been criticised as procedurally flawed and have not shown many positive findings for very disruptive and costly programs.

We are concerned that, despite the data from AIHW and their use by the Productivity Commission, the service delivery sections of government and their political masters show few signs that many were taking the criteria seriously. If they had, they would have changed their top-down, culturally inappropriate design, delivery and funding processes.

In an effort to publicise these flawed processes and the possible improvements for communities and bureaucrats, and maybe politicians, I am collating a range of quotes from mainly federal agency reports...
that list the reasons for successes and failures of Indigenous policy programs.

The extracts from about 30 diverse reports on specific programs confirm the repeating problems of flawed processes of design. In particular, there are consistent failures to consult communities before decisions are taken, to engage locally and to make decisions with and not for local groups.

The first step towards success is to close the gap between political and bureaucratic cultures and the community inequities that need to be overcome.

Backing the legitimacy of these generally professional critiques and top-down analyses are similar views recorded by many affected communities. A recent extensive consultative process with NSW Aboriginal communities documented similar complaints of poor processes by funders and service deliverers.

The diverse sources show why too many Indigenous-focused programs regularly failed to deliver needed services effectively. Poor government processes meant the programs were often too badly designed to work.

Until now, politicians have not acknowledged this but maybe the new players will loosen the old bureaucratic and political biases. The following extracts from Prime Minister Tony Abbott’s speech on the sixth annual Closing the Gap report suggest he may see options for reviewing processes:

Even as things began to change, a generation or two back our tendency was to work ‘for’ Aboriginal people rather than ‘with’ them. We objectified Aboriginal issues rather than personalised them. We saw problems to be solved rather than people to be engaged with ...

Every education department knows the attendance rate for every school. The lower the attendance rate, the more likely it is that a school has problems. The lower the attendance rate, the more likely it is that a school is failing its students.

However, a later part of Abbott’s speech signalled that the punitive element – we know better what is good for them – is still there.

One of the worst forms of neglect is failing to give children the education they need for a decent life. That’s why every state and territory has anti-truancy laws. That’s why the former government, to its credit, tried to quarantine welfare payments for families whose children weren’t at school.

The quote shows Abbott fails to understand that most children will go to school if it works for them. Fairfax Media reports of this speech offered the following Indigenous responses: Kirstie Parker, co-chairman of the National Congress of Australia’s First Peoples, said ‘punitive’ measures alone would not lift attendance. She said:

We want to see as much energy and focus on making schools places that our kids want to go and our families trust and genuinely feel a part of.

Indigenous educator Chris Sarra, the principal of Cherbourg school in Queensland, lifted attendance rates from 62% to 94%. He said the underlying causes of truancy usually related to the school rather than the child or their family. Sarra said:

You’ve got to look at why kids have rejected school in the first place.

A recent contribution in The Conversation quoted a similar statement by another new major player, but also expresses doubts that this will happen.

Recently, Indigenous affairs minister Nigel Scullion claimed that he will prioritise Indigenous participation in policy making because it improves outcomes and creates better policy. This is sensible, but it subordinates the question of how the government values and interacts with Indigenous people to the question of the best method to reduce disadvantage.

The generally poor results of Closing the Gap strategies should signal the need to review how decisions are made and why policy makers fail to adopt and apply their own evidence of ‘what works’. Part of the answer is that it is processes rather than content that undermine the potential of programs to succeed.

The first step towards success is to close the gap between political and bureaucratic cultures and the community inequities that need to be overcome.

Eva Cox is Professorial Fellow Jumbunna IHL at the University of Technology, Sydney.
The sixth annual Closing the Gap statement, delivered to federal parliament earlier this week, had the same message as previous years. There is some progress, some regress and more work needed to achieve the six health, education and employment priorities on schedule.

Again, Prime Minister Tony Abbott – and opposition leader Bill Shorten in reply – vowed to redouble their efforts.

This annual Closing the Gap ritual is important in many ways. It is a rare moment of both parliamentary bipartisanship and political humility in the face of ongoing failure to meet clearly stated goals. It also refocuses national attention on a policy area that is often sidelined.

Yet as the impact and political currency of the intervention wanes, closing the gap in statistical disadvantage is now the dominant way of framing the relationship between Indigenous and settler Australia, and of directing our efforts to change this relationship. It is, in effect, our national Indigenous policy.

It is worth asking deeper questions about what Closing the Gap brings to the political conversation and what it leaves out.

Performance measurement is not policy

Repeatedly stating our commitment to progress – and measuring our (lack of) progress – does not actually make that progress happen. Closing the Gap is a ‘report card’: a set of performance measurements rather than a substantive policy program.

It can too easily become a placeholder for real policy change, allowing political leaders to demonstrate commitment at the opening of parliament without following through for the rest of the year.

Whether the Abbott government will ‘walk the talk’ to close the gap is still unclear. Abbott has a ‘passionate’ personal commitment to this area. He reaffirmed on Wednesday his election promise to spend one week a year in a remote Indigenous community.

The continual focus on the ‘gap’ itself sidelines public debate about why the gap exists and how it can be closed.

But as Abbott himself acknowledges, good intentions have never been in short supply in this ‘wicked’ policy area and are no guarantee of change.

The challenge is compounded by the increasingly complex Indigenous policy environment. The Howard-era decision to mainstream Indigenous health, education and social services has fragmented policy, and made state governments into central players in a way they have not been since 1967.

Further, Abbott continues the top-down NT intervention. He has appointed his own advisory council on Indigenous affairs, rather than engaging with the elected National Congress. This sits uncomfortably with his commitment to ‘a new engagement’ with Indigenous Australia.

Personal exhortations and federal bureaucratic reshuffling will only go so far in leveraging change in this environment.

The seduction of numbers

More importantly, the continual focus on the ‘gap’ itself sidelines public debate about why the gap exists and how it can be closed. It is an appealingly neutral approach to such an uncomfortable and contentious policy area. This is because it presents us with a technical rather than political problem that is objectively defined and agreed upon by all.

With it, both sides of politics feel they can set aside ‘ideology’ and...
come together in hard, practical work to achieve measureable goals. Yet the bipartisan approach to Closing the Gap is built on a highly political account of the nature of Indigenous disadvantage. In this account, the gap is caused by specific Indigenous behavioural deficiencies rather than complex interactions between issues or underlying structural factors.

Abbott offered school attendance as the key behavioural change required:

Because it’s hard to be literate and numerate without attending school; it’s hard to find work without a basic education; and it’s hard to live well without a job.

In turn, Abbott has created a new performance measurement of an Indigenous behaviour (school attendance). He will send out officials to enforce that behaviour (truancy officers). One gets the feeling that if it was possible to just tell Aboriginal people to live longer and to send out officers to enforce it, he would be doing this too.

This narrative account of the underlying problem is not argued but presented as a self-evident fact in the context of a discussion of apparently technical statistics and an affirmative bipartisan moment of commitment to Aboriginal wellbeing. It is hard to disagree with Abbott’s particular framing of the problem without appearing to undermine consensus and hold up practical efforts with political bickering.

While school attendance may indeed be critical, the case needs to be argued rather than asserted. Different policy options to achieve this goal should also be carefully weighed.

**Relationships can’t be measured**

Lastly, there is the question of what is left out of the gap as it is currently defined. Incarceration rates, which are climbing dramatically, are one concrete area of inequality that should clearly be included. More broadly, though, it leaves out the question of the social and political relationship between Indigenous and settler Australia.

Recently, Indigenous affairs minister Nigel Scullion claimed that he will prioritise Indigenous participation in policymaking because it improves outcomes and creates better policy. This is sensible, but it subordinates the question of how the government values and interacts with Indigenous people to the question of the best method to reduce disadvantage.

Such logic can and has been used to justify the opposite course of action: exclusion of Indigenous perspectives, and even coercive paternalism. Instead, we need to recognise this relationship as a good in itself.

Bureaucracy, not constitutional wording, is the frontline of the encounter between Indigenous people and the state. How the government conducts itself in this area creates lasting effects.

Political negotiation and social change are not outcomes; they are processes. And they can’t be measured using numbers.

Elizabeth Strakosch is a lecturer in Public Policy and Governance at the University of Queensland.

**THE CONVERSATION**

The commitment to close the Aboriginal and Torres Strait Islander health and life expectancy gap by 2030 was a watershed moment for the nation. Politicians, the Aboriginal and Torres Strait Islander and non-Indigenous health sector, and human rights organisations, made a public stand in committing to this agenda. And so did the Australian public. To date almost 200,000 Australians have signed the Close the Gap pledge and approximately 140,000 Australians participated in last year’s National Close the Gap Day. This is the generation that has taken on the responsibility to end Aboriginal and Torres Strait Islander health inequality.

A substantial foundation has been built that will help underpin the national effort to close the gap over the next two decades.

Data released in 2013 demonstrates the stark reality of health inequality still faced by Aboriginal and Torres Strait Islander peoples. It reminds us why the national effort to close the gap is a multi-decade commitment that will span policy cycles, funding agreements and governments. It reminds us why it is fundamentally non-partisan in nature. At this juncture, with 16 years to go, the need to build on success, to continue key elements of the national effort, and to expand and strengthen it in key areas with bold policy initiatives, is critical.

We are beginning to see reductions in smoking rates and improvements in maternal and childhood health that can be expected to flow into increases in life expectancy. These positive outcomes provide evidence that the national effort to close the gap is working, and that generational change is possible. They provide encouragement that the gap will close by 2030 even though more time must be allowed for significant change to be seen.

The demonstrated impact of ‘closing the gap’-related investment in the Aboriginal Community Controlled Health Services (ACCHSs) provide further signs of positive change occurring. In this, a substantial foundation has been built that will help underpin the national effort to close the gap over the next two decades.

Staying on course with the national effort to close the gap requires acknowledgement that there are ‘green shoots’ evident, and foundation elements that are now in place, for which continuity is critical. It also requires a commitment to redouble our efforts.

In particular:

• The implementation of the National Aboriginal and Torres Strait Islander Health Plan 2013-23 (Health Plan) in partnership with Aboriginal and Torres Strait Islander peoples
• Continuing to build partnerships with Aboriginal and Torres Strait Islander peoples for planning and
service delivery, and
• Long-term funding for the national effort to close the gap, as currently delivered through national partnership agreements, and the quarantining of close the gap programs and related initiatives in ongoing reviews of the health system at state, territory and federal levels.

Achieving Aboriginal and Torres Strait Islander health and life expectancy equality by 2030 is an ambitious yet achievable task.

The Health Plan was launched in July 2013. It is a framework document that requires further elaboration and a formal implementation process to drive outcomes; and it needs measurable benchmarks and targets to ensure accountability. The importance of continuing planning to a significant level of detail over 2014 (including the identification of what needs to happen, by when, who is responsible, and how much it will cost) cannot be underestimated.

Further, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was launched in June 2013. The implementation of this strategy, the renewal of the Social and Emotional Wellbeing Framework, and a new alcohol and other drug (AOD) strategy anticipated in 2014 provide significant opportunities to progress both Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing policy and planning alongside the implementation of the Health Plan.

Real and effective planning and service delivery partnerships with empowered Aboriginal and Torres Strait Islander communities through ACCHSs and their representatives will enable the best possible implementation processes for the above. Such partnerships not only empower communities to exercise responsibility for the health of their members, but also provide a risk-management framework to minimise waste. They...
help ensure resources go to services and programs that will have maximum impact in communities, the areas of health where they are needed most.

Investment in the national effort to close the gap must continue, and the cuts to health services that occurred in the past year should not be allowed to have a negative impact. The $1.57 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes expired in June 2013, and the $564 million National Partnership Agreement on Indigenous Early Childhood Development will expire in June 2014. The upkeep of these foundational, nationally coordinated agreements and the continuation of guaranteed funding over significant spans of time constitutes the third critical area of continuity. Such are the ‘fuel’ that will drive the national effort to close the gap over the next agreement cycle and beyond.

This year, 2014, also provides opportunities for the new Australian Government to build on the national effort to close the gap. These opportunities are discussed in part three of the report and summarised in the text box on the previous page.

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

The Close the Gap Campaign Steering Committee (Campaign Steering Committee) calls on the new Australian Government to ensure policy continuity in critical areas of the national effort to close the gap, and to also take further steps in building on and strengthening the existing platform.

ENDNOTES
2. Correspondence, Oxfam Australia and the author, 2 December 2013 (on file).
EXECUTIVE SUMMARY

The Aboriginal and Torres Strait Islander Health Performance Framework 2012 Detailed analyses report finds areas of improvement in the health of Aboriginal and Torres Strait Islander people, including:

- A 33% decline in overall mortality for Indigenous Australians from 1991 to 2010 and a 24% decline in avoidable mortality from 1997 to 2010.
- A 41% decline in deaths due to circulatory disease, the leading cause of death for Indigenous Australians from 1997 to 2010.
- A significant decrease (39%) in deaths due to respiratory disease from 1997 to 2010.
- A 62% decline in infant mortality rates from 1991 to 2010, and a significant narrowing of the gap between Indigenous and other Australians.
- A significant increase in health assessments recorded through Medicare since the introduction of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes in July 2009, and corresponding increases in allied health care services claimed by Indigenous Australians through Medicare since 1 July 2009.
- Immunisation coverage rates for Indigenous children are close to those for other Australian children by age 2.
- An increase in episodes of care provided by Indigenous primary health care services between 1999-00 and 2010-11 (from 1.2 million to 2.5 million).

Areas of concern include:

- High rates of smoking during pregnancy (52%).
- Lower rates of access to antenatal care in the first trimester of pregnancy (56% for Indigenous mothers compared to 75% for non-Indigenous mothers).
- Half of Indigenous Australians aged 15 years and over had a disability or long-term health condition in 2008 and about 8% had a profound or severe core activity limitation.

Mortality rates for chronic diseases are much higher for Indigenous Australians.

- Mortality rates for chronic diseases are much higher for Indigenous Australians (almost 7 times the rate of non-Indigenous Australians for diabetes and twice the rate for circulatory diseases).
- A large increase (96%) in incidence rates of treated end-stage renal disease since 1991 (currently 7 times the rate for non-Indigenous Australians).
- High rates of hospitalisations and deaths due to injury (particularly assault, suicide and transport accidents).
- About one-quarter (25%) of Indigenous Australians aged 15 years and over live in overcrowded housing.
- Barriers to accessing appropriate health care, such as cultural competency, continue to remain a problem.
- Lower access to procedures in hospitals.

KEY FINDINGS

A summary of the key findings from this report against the Aboriginal and Torres Strait Islander Health Performance Framework is outlined below. The main areas of improvement and areas of continuing concern are discussed for each Tier of the Framework (Health status and outcomes; Determinants of health; and Health system performance). A table of key statistics from the report is presented in Table S1 on pp.xiii-xviii of the report.

Health status and outcomes

Areas of improvement

Overall mortality

- Between 1991 and 2010, there was a 33% decline in the mortality rate for Indigenous Australians living in Western Australia, South Australia and the Northern Territory combined.

Avoidable mortality

- Deaths from avoidable causes declined by 24% for Indigenous Australians between 1997 and 2010 in Western Australia, South Australia and the Northern Territory combined.
Circulatory diseases
- Deaths from circulatory diseases declined by 41% for Indigenous Australians between 1997 and 2010.

Respiratory diseases
- Deaths from respiratory diseases declined by 39% for Indigenous Australians between 1997 and 2010.

Infant and child mortality
- The Indigenous infant mortality rate declined by 62% between 1991 and 2010, and the gap between Indigenous and other Australians narrowed by 67%.
- Significant declines were also evident for child mortality, with a 47% decline in the rate for Indigenous children and a 48% narrowing of the gap between Indigenous and other Australian children between 1991 and 2010.

Areas needing further work
Chronic disease
- The majority (68%) of Indigenous deaths in 2006-2010 were due to chronic diseases (for example, circulatory disease, cancer, diabetes, respiratory disease, kidney disease). Indigenous Australians died at almost 7 times the rate of non-Indigenous Australians from diabetes and at twice the rate from circulatory diseases.
- Diabetes is 3 times more prevalent among Indigenous Australians than non-Indigenous Australians based on data from the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).

Cancer
- Between 1997 and 2010 there was a significant increase (53%) in the gap between mortality rates for Indigenous and other Australians from cancer in Western Australia, South Australia and the Northern Territory combined.

Kidney disease
- The incidence rate of treated end-stage renal disease (ESRD) for Indigenous Australians increased by 96% between 1991 and 2010, and is currently 7 times the rate for non-Indigenous Australians.

Injury
- Hospitalisation rates for assault for Indigenous Australians were 12 times the rate for non-Indigenous Australians during the period July 2008 to June 2010. Indigenous Australians were twice as likely to be hospitalised for injury and poisoning as non-Indigenous Australians.

Disability
- In 2008, half (50%) of Indigenous Australians aged 15 years and over had a disability or long-term health condition. Approximately 8% had a profound or severe core activity limitation. Indigenous Australians aged 15 years and over living in non-remote areas were twice as likely as non-Indigenous Australians to have a profound or severe core activity limitation.

Low birthweight
- Over the period 2007 to 2009, babies of Indigenous mothers were twice as likely to be of low birthweight as babies born to non-Indigenous mothers (12% compared with 6%).

Diabetes is three times more prevalent among Indigenous Australians than non-Indigenous Australians.

Eye health
- In 2008, about 9% of Indigenous adults had low vision and 2% were blind. Of those adults with vision impairment, the most common causes were refractive error (54%), cataract (27%), diabetic retinopathy (12%) and trachoma (2%).

Determinants of health
Areas of improvement
Access to functional housing
- In 2008, 99% of Indigenous households reported that they had working facilities for washing people, 94% reported working facilities for washing clothes/bedding, 94% reported working facilities for storing/preparing food and 98% reported working sewerage systems.

Education
- There have been some increases in the proportion of Indigenous Years 3, 5, 7 and 9 students achieving literacy benchmarks between 2008 and 2011, and the gap has narrowed. For example, the proportion of Indigenous students achieving the Year 3 reading benchmark increased from 68% to 76%; the proportion reaching the Year 3 grammar/punctuation
Aboriginal and Torres Strait Islander Health Issues in Society | Volume 376

benchmark increased from 65% to 71%; the proportion reaching the Year 7 reading benchmark increased from 72% to 77%; and the proportion reaching the Year 7 grammar/punctuation benchmark increased from 63% to 67%.

Employment

- The employment rate for Indigenous Australians increased from 44% to 54% between 2001 and 2008.

Unemployment rates continue to remain higher for Indigenous Australians than corresponding rates for non-Indigenous Australians.

Areas needing further work

Smoking

- In 2008, 47% of Indigenous Australians aged 15 years and over were current daily smokers, which was more than twice the rate of non-Indigenous Australians.
- In 2009, 52% of Indigenous mothers smoked during pregnancy which was 3.7 times the rate of non-Indigenous mothers.
- In 2008, 65% of all Indigenous children aged 0-14 years lived in households with a current daily smoker compared with 32% of non-Indigenous children.

Physical activity

- In 2004-05, after adjusting for differences in age structure, 51% of Indigenous Australians aged 15 years and over living in non-remote area reported their physical activity level as sedentary, compared with 33% of non-Indigenous Australians of the same age.

Nutrition

- Compared with non-Indigenous Australians, in 2004-05, Indigenous Australians aged 12 and over were 7 times as likely to report no usual daily vegetable intake, and twice as likely to report no usual daily fruit intake.

Overweight and obesity

- In 2004-05, Indigenous adults were almost twice as likely as non-Indigenous adults to be obese (34% compared with 18%).
- For Indigenous Australians aged 18 years and over living in non-remote areas, rates of overweight and obesity increased between 1995 (51%) and 2004-05 (60%).

Risky/high risk alcohol consumption

- In 2008, 46% of Indigenous Australians aged 15 years and over reported drinking at low risk levels and 35% had abstained from drinking alcohol in the 12 months prior to the National Aboriginal and Torres Islander Social Survey (NATSIS).

Overcrowding

- In 2008, about 25% of Indigenous Australians aged 15 years and over lived in overcrowded households, compared with 4% of non-Indigenous Australians.

Education

- Despite some improvements in literacy and numeracy, the proportion of Indigenous students achieving the reading, writing and numeracy benchmarks in Years 3, 5, 7 and 9 remain below the corresponding proportions for all students.

Unemployment

- Unemployment rates continue to remain higher for Indigenous Australians than corresponding rates for non-Indigenous Australians (11% compared with 3% in 2008).

Income

- In 2008, 49% of Indigenous Australians aged 18 years and over were in the bottom 20% of mean equivalised household incomes. This compared with 20% of non-Indigenous Australians.

Community safety

- Indigenous Australians are more likely to experience exposure to violence, child abuse and neglect, and contact with the criminal justice system (including imprisonment) than other Australians.

Transport

- In 2008, 50% of Indigenous households in non-remote areas reported that they did not have access to motor vehicles, compared with 15% of other Australian households.
- In 2008, about 11% of Indigenous Australians aged 18 years and over reported that they often had difficulty, or could not get to, places when needed, compared with 4% of non-Indigenous Australians.
Health system performance

Areas of improvement

Chronic disease detection and management

• There has been a significant increase in the number of health assessments provided to Indigenous Australians since the introduction of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes in July 2009.
• There has been an increase in the total number of other allied healthcare services claimed through Medicare by Indigenous Australians between 2009-10 and 2010-11 from 25,961 to 35,731 services.
• Rates of general practitioner management plan claims (GPMPs) and team care arrangements (TCAs) were nearly twice as high for Indigenous Australians compared with non-Indigenous Australians in 2010-11.

Indigenous Australians are more likely to experience exposure to violence, child abuse and neglect, and contact with the criminal justice system than other Australians.

Increased availability of Indigenous-specific services

• There has been a 96% increase in episodes of care provided by Indigenous primary health care services between 1999-2000 and 2010-11 (from 1.2 million to 2.5 million).

Antenatal care

• The proportion of Indigenous women accessing antenatal care at least once during pregnancy has increased in New South Wales, Queensland and South Australia combined between 1998 and 2009. In 2009, 97% of Indigenous women accessed antenatal care at least once during their pregnancy.

Immunisation

• Immunisation coverage rates for Indigenous children are similar to those for other children by the age of 2 (92.3% compared with 92.6%).

Areas needing further work

Barriers to accessing health care

• In 2008, 26% of Indigenous Australians aged 15 years and over reported having problems accessing health services. Of those who had problems accessing health services, about 20% had problem with accessing dentists, 10% reported problems accessing doctors, and 7% reported problems accessing hospitals.
• Selected potentially preventable hospitalisation rates for Indigenous Australians were 5 times the non-Indigenous rate during the period July 2008 and June 2010.
• Indigenous Australians had lower rates of hospitalisations with a procedure recorded compared with non-Indigenous Australians, and they also had lower rates of elective surgery.

• Indigenous Australians were discharged from hospital against medical advice at 5 times the rate of non-Indigenous Australians between July 2008 and June 2010.

Screening

• Breast cancer screening rates for Indigenous women aged 50-69 are lower than for other women of this age (37% compared with 56% in 2008-09).

Antenatal care

• In 2009, in New South Wales, Queensland, South Australia and the Northern Territory combined, 56% of Indigenous mothers had their first antenatal visit in the first trimester of pregnancy, compared with 75% of non-Indigenous mothers.

Health workforce

• In 2006, 1.2% of the Indigenous population was employed in health-related occupations, compared with 3% of the non-Indigenous population.
• Indigenous Australians are under-represented in training for various health professions. In 2010, 1.8% of undergraduate students enrolled in, and 1% of undergraduate students who had completed, health-related courses were Indigenous.

Resources

• In non-remote areas, 15% of Indigenous Australians were covered by private health insurance compared with 51% for the rest of the population. The most common reason that Indigenous Australians did not have private health insurance was that they could not afford it (65%).

There has been good progress on three of six Indigenous reform targets, but concerning results for the other three, according to these key findings and recommendations from a report by the COAG Reform Council.

**KEY FINDINGS**

The National Indigenous Reform Agreement sets six targets to address Indigenous disadvantage. We report on progress toward COAG’s targets each year. This year, we have enough data to report on components of all six targets, though our reporting for some targets is only partial (see Appendix A of the report).

**Results in three areas – Indigenous reading and numeracy, death rates and employment outcomes – are of concern**

Between 2008 and 2012, for Years 3, 5 and 7, the national gap narrowed in reading but widened in numeracy. For Year 9, the gap widened in reading and narrowed in numeracy.

**For 3 targets, Indigenous outcomes are catching up with those of other Australians**

Australia is on track to halve the gap in child death rates by 2018. From 1998 to 2011, the gap between the Indigenous and non-Indigenous child (0-4 years) death rates reduced from 139.0 to 109.9 deaths per 100,000.

The Indigenous child death rate fell by an average of 5.7 deaths per 100,000 per year over this period. Data are for the total of NSW, Queensland, Western Australia, South Australia and the Northern Territory only.

In 2011, 91% of Indigenous children in remote communities were enrolled in a preschool program in the year before formal schooling. This result is close to COAG’s target – only 4 percentage points improvement is needed to achieve 95% enrolment by 2013.

From 2006 to 2011, the rate of Indigenous Year 12 or equivalent attainment rose from 47.4% to 53.9%. The attainment gap narrowed by 4.4 percentage points. The largest reduction in the gap was in the Northern Territory (6.8 percentage points). Western Australia, South Australia, the Northern Territory, the ACT and the nation as a whole are on track to halve the gap by 2020.

There were significant improvements for Indigenous students in Year 3 reading at the national level, and in Queensland and Western Australia. Over five years, however, there were no significant improvements in Indigenous numeracy in any year or jurisdiction. Nationally, Indigenous numeracy rates declined in Year 3 and Year 7.

Only the Northern Territory is on track to close the gap in Indigenous death rates within a generation (by 2031). Death rates decreased in Queensland but not by enough to meet its target. Although the death rate also decreased for Western Australia, that jurisdiction does not have a published trajectory or target. There were no significant changes in the death rate in NSW and South Australia and they are not on track to close the gap. Data are available only for these five States.

Looking at the five-State total, in 2011, Indigenous people died at nearly twice the rate of non-Indigenous people. We note that this target has a long timeframe. Efforts to improve Indigenous life expectancy may take many years to show results.

From 2006 to 2011, the employment gap widened on three measures – employment, unemployment and
The COAG Reform Council has released the fourth independent assessment of progress towards Closing the Gap targets. The report highlighted some success in dealing with Indigenous disadvantage, as well as causes for concern.

- Australia is on track to halve the gap in Indigenous child death rates, but the Northern Territory is the only jurisdiction on track to meet the 2031 target to close the gap on overall death rates – the NT death rate fell by an average of 47 people a year from 1998 to 2011.
- However, the Territory also recorded the highest Indigenous child death rate for the past five years – 312 deaths per 100,000 children, compared with 94 non-Indigenous children.
- The report also found the rate of Indigenous students attaining Year 12 or equivalent school results has risen, but so has Indigenous unemployment. The rate of Indigenous people attaining Year 12 or equivalent rose from 47% to almost 54%. The Territory saw the largest improvement in Year 12 attainment, but also recorded the worst result for Indigenous unemployment, of about 19%, compared to 17.2% nationally.
- Indigenous students are still not faring well in reading and numeracy – numeracy is showing some decreases since the National assessment program (NAPLAN) began in 2008.
- Prime Minister Tony Abbott said the new education target would aim to ensure 90% of enrolled Indigenous children across Australia attend a quality early childhood education program in the year before they start full-time school.

RECOMMENDATIONS

Recommendation 1

The COAG Reform Council recommends COAG note the following areas of good progress in Indigenous reform:

a. Australia is on track to halve the gap in death rates between Indigenous and non-Indigenous children by 2018.

b. Based on the most recent data for 2011, Australia is close to the target of enrolling 95% of Indigenous four year olds in remote communities in early childhood education by 2013.

c. Australia is on track to halve the gap for Indigenous people aged 20-24 in Year 12 or equivalent attainment rates by 2020. In 2011, Australia as a whole, Western Australia, South Australia, the Northern Territory and the ACT met or exceeded their indicative trajectories for halving this gap.

Recommendation 2

The COAG Reform Council recommends COAG agree that greater effort is needed to achieve the targets for reducing Indigenous death rates, for improving reading and numeracy, and for improving employment outcomes, given the following findings:

a. Only the Northern Territory is on track to close the gap in death rates by 2031 based on trends since 1998. From 1998, death rates fell significantly in Queensland but not fast enough to meet the target. Death rates in NSW, Western Australia and South Australia did not change significantly from 1998.

b. There has been little improvement in Indigenous reading and significant decreases in Indigenous numeracy since 2008. Nationally, the only improvement was in Year 3 reading, driven by gains in Queensland and Western Australia. There were no significant gains in numeracy since 2008 and Year 3 numeracy declined in all jurisdictions except Queensland and the ACT.

c. Between 2006 and 2011, the national gap widened in employment, labour force participation and unemployment. Only NSW reduced the employment rate gap. While post school qualification rates – linked to better employment outcomes – improved in all jurisdictions, only NSW and the ACT narrowed the gap.

Recommendation 3

The target year for the Indigenous early childhood education target (2013) has been reached. To continue momentum and improve public accountability, the COAG Reform Council recommends COAG agree on a new Indigenous early childhood education target.

ENDNOTE

1. Changes to the Community Development and Employment Projects scheme in 2009 should be considered when interpreting these results (see Box 1 in Chapter 6 of the report for an explanation).
Federal government announces 10-year policy framework for Indigenous health

The federal government says its new 10-year policy framework for Aboriginal and Torres Strait Islander health will make a real difference to people’s lives, according to this report from ABC News

The blueprint builds on the Government’s 2008 Closing the Gap health objectives and will guide policy and programs to improve Indigenous health over the next decade at a cost of $12 billion.

“For too long racism has been a major barrier in people’s access to health services.”

The Government held 17 consultations on the plan, along with roundtable meetings, and accepted more than 140 written submissions.

Indigenous Health Minister Warren Snowdon says annual reporting to Parliament will make the Government accountable.

“This is the first time such a plan has been developed. I think that in itself will be a difference,” he said.

“And by the way, we will make a difference, we will meet our target on child mortality rates by 2018, and that is clear.

“But we’ve got to do a lot more. The life expectancy gap – if we want to close it by 2030, which is the objective – we’ve got to do a lot more work.”

A statement from the Minister says the plan emphasises the centrality of culture in the health of Indigenous people and the rights of individuals to a safe, healthy and empowered life.

Co-chair of the National Congress of Australia’s First Peoples, Jody Broun, says for too long racism has been a major barrier in people’s access to health services.

“There might be a hospital or there might be a health service in a town; people won’t use it if they have had a negative experience and what they perceive as a racist experience in that place,” she said.

“We heard far too often that that was happening, so we really have to make sure that that is eliminated from the health system so that people feel comfortable.”

The Federal Opposition says the framework announcement is underwhelming.

The Coalition’s spokesman, Andrew Laming, says the budget already forecasts $1.2 billion for Indigenous health each year and the announcement is just an extension of the existing funding model.

“There might be a hospital or there might be a health service in a town; people won’t use it if they have had a negative experience and what they perceive as a racist experience in that place.”

“Far from being groundbreaking, we are struggling to find any detail in this plan being announced today to show Aboriginal kids, or Australians, will be better off than they are today,” he said.

“We don’t think the document is terribly ambitious. The document wasn’t shown to anyone before it was released so stakeholders were completely in the dark.”

The Health Department has published full details of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 on its website, www.health.gov.au

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VISION
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.

PRINCIPLES
Four principles of the Health Plan:
1. Health Equality and a Human Rights Approach
2. Aboriginal and Torres Strait Islander Community Control and Engagement
3. Partnership
4. Accountability.

The priorities of the health plan are underpinned by Culture where Aboriginal and Torres Strait Islander people have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country.

- Older people are able to live out their lives as active, healthy, culturally secure and comfortable as possible
- Adults have the health care, support and resources to manage their health and have long productive lives
- Youth get the services and support they need to thrive and grow into healthy young adults
- Growth and development of children lays the basis for long, healthy lives
- Mother and babies get the best possible care and support for a good start to life.

Editor's note:
See the following page for a diagram which represents how the Health Plan proposes to enable Aboriginal and Torres Strait Islander peoples to have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country.

© Commonwealth of Australia 2013.
Continually striving to improve accessibility, appropriateness and impact

A robust, strong, vibrant and effective community controlled health sector

Supported by housing, education, employment and other programs focused on eliminating the causes of health inequality

Based on the best possible evidence

Free of racism and inequality

Growth and development of children lays the basis for long, healthy lives

Youth get the services and support they need to thrive and grow into healthy young adults

Adults have the health care, support and resources to manage their health and have long, productive lives

Older people are able to live out their lives as active, healthy, culturally secure and comfortable as possible

Individuals and communities actively engage in decision making and control

Social and emotional wellbeing as a central platform for prevention and clinical care

Co运营和 Torres Strait Islander peoples have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country

Mothers and babies get the best possible care and support for a good start to life

Youth get the services and support they need to thrive and grow into healthy young adults

Adults have the health care, support and resources to manage their health and have long, productive lives

Older people are able to live out their lives as active, healthy, culturally secure and comfortable as possible

CULTURE

Aboriginal and Torres Strait Islander peoples have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country

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Future initiatives to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples

Continuing to close the health gap will require innovation; long-term, systematic approaches that improve the quality and integrity of data; collaborations and partnerships that reflect an ecological approach to health, and recognition of the proper place and contribution of Aboriginal and Torres Strait Islander peoples in Australian society. An article from the *Medical Journal of Australia* by Kerry Arabena

At long last there are signs that the gaps between the health of Aboriginal and Torres Strait Islander people and non-Indigenous people are closing. Of course there remain areas where the gap persists or in some cases has grown, including chronic disease, injury, cancer, disability and low birthweight babies. It appears that in some areas (such as cancer) improvements in the quality, accessibility and impact of treatment are resulting in significantly improved death rates for non-Indigenous Australians, but Aboriginal and Torres Strait Islander people are missing out. The causes of this discrepancy seem to lie in disparities in stage at diagnosis, treatment received and survival rates.

According to the 2012 report of the Aboriginal and Torres Strait Islander Health Performance Framework, a number of positive trends in Aboriginal and Torres Strait Islander health include:

- The mortality rate has declined significantly (by 33%) between 1991 and 2010 among people living in Western Australia, South Australia and the Northern Territory combined
- Deaths due to avoidable causes decreased significantly in WA, SA and the NT combined, down 24% between 1997 and 2010
- Deaths from respiratory disease decreased significantly from 1997 to 2010, and the gap with non-Indigenous Australians has also narrowed, and
- Mortality among infants aged less than 1 year declined by 62% between 1991 and 2010, perhaps reflecting the benefits of immunisation, improved access to primary health care services, the use of antibiotics and earlier evacuation to hospital for acute infections.¹

Cutting across these trends are persistent gaps in the quality of data. Our inability to know whether large investments made in recent years in Aboriginal and Torres Strait Islander health are paying off should be a major focus for future strategies. In general, our population does not seem to be benefitting from the same level of sophisticated population-level tracking, health assessment or data integrity that majority populations take for granted.² Good data are crucial, not just to know the impact of what we have done, but to guide what we are doing.

In this context it is pleasing to see the recent process of developing a new national plan to guide future investments in Aboriginal and Torres Strait Islander health, developed through a collaborative process including Aboriginal and Torres Strait Islander peak bodies, communities, services, researchers, advocates and clinicians.³ The new national plan needs to set directions for the next 10 years and expand...
and align with an ecological view of health, include concepts important to Aboriginal and Torres Strait Islander peoples and influence other sectors that affect health, such as education, employment, housing and early childhood development. This multifocal approach could have implications for the design, implementation and evaluation of projects, and will necessitate a reconceptualisation of partnerships and collaborations, while fostering innovations and knowledge exchange.

**Racism has had and continues to have a real and damaging impact on the health of Aboriginal and Torres Strait Islander people.**

Finally, we will need to redress some of the less palatable aspects of the health system that contribute to inequality, such as racism. Embodied in dubious practices, disparities in access and subtle variations in effort within health and other institutions and programs, racism has had and continues to have a real and damaging impact on the health of Aboriginal and Torres Strait Islander people. It is clear that full health equality cannot be achieved until racism and other practices that deny our status and rights as the original and First Peoples of Australia can be overcome.

My hope is that not only do we redress racism in health and other systems, but that this nation recognises and enables each and every Aboriginal and Torres Strait Islander person the opportunity to rise to the full potential of our existence.

**NOTES**


Kerry Arabena, Director and Chair of Indigenous Health, and Chair.
1. Onemda VicHealth Koori Health Unit, University of Melbourne, Melbourne, Vic.
2. National Aboriginal and Torres Strait Islander Health Equality Council, Canberra, ACT.

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WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

CONTENTS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRAINSTORM</td>
<td>50</td>
</tr>
<tr>
<td>WRITTEN ACTIVITIES</td>
<td>51</td>
</tr>
<tr>
<td>RESEARCH ACTIVITIES</td>
<td>52</td>
</tr>
<tr>
<td>DESIGN ACTIVITIES</td>
<td>53</td>
</tr>
<tr>
<td>DISCUSSION ACTIVITIES</td>
<td>54</td>
</tr>
<tr>
<td>MULTIPLE CHOICE</td>
<td>55-56</td>
</tr>
</tbody>
</table>
Brainstorm, individually or as a group, to find out what you know about Aboriginal and Torres Strait Islander health.

1. What does ‘Closing the Gap’ mean, and why is it important to Aboriginal and Torres Strait Islanders?

2. What does life expectancy mean, and why does it differ for Indigenous and non-Indigenous Australians?

3. What are the major health risk factors for Aboriginal and Torres Strait Islander peoples?

4. What is a mortality rate, and why is it significant in relation to Indigenous Australians?
Complete the following activity on a separate sheet of paper if more space is required.

List five different areas that have been identified as being in need of improvement or further work in relation to the health of Aboriginal and Torres Strait Islander peoples. Provide a brief explanation, including statistics, to back up your selections.

1. ____________________________________________
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Complete the following activity on a separate sheet of paper if more space is required.

Do your own research on each of the following topics and write a few paragraphs on how they relate to Aboriginal and Torres Strait Islander health. Explain the relationship between each topic and Indigenous health, and also include examples in your answers.

a. Community and culture
b. Employment
c. Education
d. Housing
e. Racism
Complete the following activity on a separate sheet of paper if more space is required.

Create a concept for an art project to express a range of perspectives on the Closing the Gap strategy which aims to reduce Indigenous disadvantage and improve health outcomes. Any appropriate medium may be selected as a means to convey your concept, e.g. digital artwork, painting, photography, a short video. Include relevant images, text, locations, and storyboard ideas for the selected medium to create your message. Use the space below to outline your artwork ideas.
Complete the following activity on a separate sheet of paper if more space is required.

Form small groups to discuss the following goals from the Closing the Gap campaign. Provide explanations, examples and statistics in your answers and determine the level of progress to date.

1. Close the life expectancy gap within a generation.

2. Halve the gap in mortality rates for Indigenous children under five within a decade.
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

1. Which of the following illnesses which were common in 18th century Europe, were introduced into the Indigenous Australian population after 1788? (select all that apply)
   a. Smallpox
   b. Ebola virus
   c. Tuberculosis
   d. HIV/AIDS
   e. Gonorrhoea
   f. Cancer
   g. Measles
   h. Influenza
   i. Scarlet fever
   j. SARS

2. The Closing the Gap campaign aims to close the health equality gap between Indigenous and non-Indigenous Australians by what year?
   a. 2007
   b. 2013
   c. 2018
   d. 2020
   e. 2023
   f. 2028
   g. 2030

3. In what year was the Victorian *Aboriginal Protection Act* first established to ‘protect’ Indigenous Australians from the impact of introduced disease, conflict and the loss of autonomy?
   a. 1788
   b. 1869
   c. 1883
   d. 1969
   e. 1988
   f. 2007
   g. 2013

4. In what year was the Close the Gap campaign officially launched?
   a. 1788
   b. 1869
   c. 1883
   d. 1969
   e. 1988
   f. 2007
   g. 2013
5. Match the following terms to their correct definitions:

1. Mortality
   a. Ratio of the observed number of deaths in a study population to the number expected if the study population had the same age-specific rates as a standard population.

2. Age standardisation
   b. Incidence of death or the number of deaths in a population.

3. Standardised mortality ratio (SMR)
   c. Illness that is prolonged in duration, does not often resolve spontaneously, and is rarely cured completely.

4. Chronic disease
   d. Disease or injury which initiates the morbid train of events leading directly to death.

5. Underlying cause of death
   e. Incidence of ill health in a population.

6. Morbidity
   f. Procedure for adjusting rates (such as death rates) to minimise the effects of differences in age composition and facilitate valid comparison of rates for populations with different age compositions.

7. Life expectancy
   g. Summarises the mortality experience of a population by measuring how long, on average, a group of people born in the same year would be expected to live, if current death rates at each age remained the same.
In 2012-13, around one in six (18.0%) Aboriginal and Torres Strait Islander people aged 15 years and over considered themselves to be in very good or excellent health, while 7.2% rated their health as poor. (ABS, Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13). (p.6)

In 2012-13, around one in eight (12.3%) Aboriginal and Torres Strait Islander people reported diseases of the ear and/or hearing problems. (ibid). (p.6)

In 2012-13, one in six (17.5%) Aboriginal and Torres Strait Islander people had asthma. ATSI people in non-remote areas were twice as likely as those in remote areas to have asthma (19.6% compared with 9.9%). (ibid). (p.6)

In 2012-13, two in five (41.0%) Aboriginal and Torres Strait Islander people aged 15 years and over smoked on a daily basis. ATSI smoking rates have come down from 50.9% (2002) and 44.6% in 2008 (ibid). (p.6)

In 2012-13, around one in six (18.0%) Aboriginal and Torres Strait Islander people aged 15 years and over had consumed more than two standard drinks per day on average, exceeding the lifetime risk guidelines (ibid). (p.6)

In 2012-13, two in thirds (65.6%) Aboriginal and Torres Strait Islander people aged 15 years and over were overweight or obese (28.6% and 37.0% respectively) (ibid). (p.7)

In 2012-13, 60.4% of Aboriginal and Torres Strait Islander men aged 18 years and over had a waist circumference that put them at an increased risk of developing chronic diseases, while 81.4% of women had an increased level of risk (ibid). (p.8)

The proportion of young Aboriginal and Torres Strait Islander people aged 15 to 17 years who have never smoked has increased from 61% to 77%, with an increase from 34% to 43% for those aged 18 to 24 years (Pulver, LP, Indigenous health isn’t all bad news). (p.9)

The latest estimates show that in 2010-2012, life expectancy at birth for Aboriginal and Torres Strait Islander men was 69.1 years and 73.7 years for women (ABS, Life Expectancy Estimates for Aboriginal and Torres Strait Islander Australians). (pp. 11, 23)

Indigenous Australians are more likely than non-Indigenous Australians to be living on low incomes (Osborne, K, Baum, F and Brown, L, Issues Paper no. 7). (p.16)

Racism is experienced by a significant proportion of Indigenous Australians, and operates through a number of pathways to affect health and wellbeing negatively (ibid). (p.17)

There are significant inequities in access to health care between Indigenous and non-Indigenous Australians (ibid). (p.18)

The life expectancy gap remains about a decade. The Northern Territory is the only area on track to meet its 2031 target (Griffiths, E, Closing the Gap: Tony Abbott delivers mixed report card on Indigenous disadvantage). (p.20)

During the period 1998-2012, the Indigenous child mortality rate declined by 32%, outpacing the decline in non-Indigenous child mortality (Department of the Prime Minister and Cabinet, Closing the Gap Prime Minister’s Report 2014). (p.24)

Almost 200,000 Australians have signed the Close the Gap pledge and approximately 140,000 Australians participated in the 2013 National Close the Gap Day (Close the Gap Campaign Steering Committee for Indigenous Health Equality, Close the Gap Campaign Steering Committee Progress and priorities report 2014). (p.35)

Immunisation coverage rates for Indigenous children are close to those for other Australian children by age 2 (AIHW, Aboriginal and Torres Strait Islander Health Performance Framework 2012). (pp. 38, 41)

Half of Indigenous Australians aged 15 years and over had a disability or long-term health condition in 2008 and about 8% had a profound or severe core activity limitation (ibid). (pp. 38, 39)

Mortality rates for chronic diseases are much higher for Indigenous Australians (almost 7 times the rate of non-Indigenous Australians for diabetes and twice the rate for circulatory diseases) (ibid). (p.38)

Diabetes is 3 times more prevalent among Indigenous Australians than non-Indigenous Australians (ibid). (p.39)

Selected potentially preventable hospitalisation rates for Indigenous Australians were 5 times the non-Indigenous rate during the period July 2008 and June 2010 (ibid). (p.41)

In non-remote areas, 15% of Indigenous Australians were covered by private health insurance compared with 51% for the rest of the population (ibid). (p.41)

Deaths from respiratory disease decreased significantly from 1997 to 2010, and the gap with non-Indigenous Australians has also narrowed (Arabena, K, Future initiatives to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples). (p.47)
Aboriginal and Torres Straight Islander peoples
People who are of Aboriginal and Torres Straight Islander descent, and identify as Australian Aboriginals and/or Torres Straight Islanders, and are accepted as such by the community in which they live or have lived.

Age standardisation
A procedure for adjusting rates (such as death rates) to minimise the effects of differences in age composition and facilitate valid comparison of rates for populations with different age compositions.

Child mortality rate
Child mortality rates are calculated as the number of child deaths per 100,000 people aged 1-4 years.

Closing the gap
This term relates to a commitment by the federal government to reduce the gap between Indigenous and non-Indigenous health and living standards. Commitments include: halving the mortality gap between Indigenous children and other children under five by 2018; halving the literacy and numeracy gaps by 2018; halving the attainment gap for Year 12 students by 2020; closing the life expectancy gap within a generation; and halving within a decade the employment gap between Indigenous and other Australians.

Discrimination
Situations and/or places in which a person is treated unfairly because of their Aboriginal or Torres Strait Islander origin. Includes but is not limited to: being treated rudely, as if they are inferior or with disrespect; ignored, insulted, harassed, stereotyped or discriminated against; or unfair assumptions are made about them.

Indigenous Australians
The original inhabitants of the Australian continent and nearby islands. It is an inclusive term used when referring to both Aboriginal and Torres Strait Islander peoples.

Infant mortality rate (IMR)
Number of infant deaths per 1,000 live births.

Life expectancy
Refers to how long, on average, a person could expect to live if current mortality rates remained the same across their life span.

Long-term health condition
Refers to medical conditions (illness, injury or disability) which have lasted at least six months, or which the respondent expects to last for six months.

Mortality
Any subjective or objective departure from a state of physiological or psychological wellbeing.

Multiple causes of death
Includes all morbid conditions, diseases and injuries entered on the death certificate. These include those involved in the morbid train of events leading to death which were classified as either the underlying cause, the immediate cause, or any intervening causes and those conditions which contributed to death, but were not related to the disease or condition causing death. For deaths where the underlying cause was identified as an external cause (injury or poisoning) multiple causes include circumstances of injury, the nature of injury as well as any other conditions reported on the death certificate.

Prevalence
The number of instances of a given disease or other condition in a given population at a designated time.

Risk factor
A ‘risk factor’ can be an aspect of lifestyle or behaviour, a health condition, an environmental exposure, or an inborn or inherited characteristic, known to be associated with health-related conditions which are considered important to prevent. An attribute or exposure that is associated with an increased probability of a specified outcome, such as the occurrence of a disease. Not necessarily a causal factor.

Self-determination
Self-determination is about Aboriginal and Torres Strait Islander peoples deciding their own economic, social, cultural and political futures.

Standardised mortality ratio (SMR)
The ratio of the observed number of deaths in a study population to the number expected if the study population had the same age-specific rates as a standard population. (The SMR is expressed sometimes as the ratio multiplied by 100).

Underlying cause of death
The disease or injury which initiated the morbid train of events leading directly to death. Accidental and violent deaths are classified to the external cause, that is, to the circumstance of the accident or violence which produced the fatal injury rather than to the nature of the injury.

Welfare
Welfare can mean anything from the wellbeing of an individual or society to the system of welfare services and assistance and includes states of social and economic wellbeing, such as education, employment, income and living conditions. Welfare services include aged care services, child care services, services for people with disabilities, housing assistance, child welfare services and other community services.
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› Australian Bureau of Statistics
› Closing the Gap Clearinghouse
› Close the Gap Campaign Steering Committee.

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INDEX

A
Abbott, Prime Minister Tony 19, 21, 22-26, 29, 30, 32, 33
Aboriginal affairs 22-26, 29-30, 31-32, 33-34
policy 33-34, 35-37, 44
Aboriginal and Torres Strait Islander Health Performance Framework 38-41, 47
alcohol consumption 7, 40
antenatal care 41
asthma 6
Australian Aboriginal and Torres Strait Islander Health Survey 5, 6-8, 9

B
birthweight, low 39
blood pressure 8

C
cancer 39
breast cancer screening 41
child death rates see mortality rates ‘closing the gap’ 14-48
Close the Gap Campaign 27-28, 35-37
targets 20, 23-25
progress against 19-21, 23-25
Close the Gap: Progress and Priorities Report 35-37
Closing the Gap Report 19-21, 22-26, 32, 33-34
COAG Reform Council 23, 42-43
community safety 22-23, 26, 40
culture, Aboriginal and Torres Strait Islanders 26

D
death rates see mortality rates
diabetes 6
disability 39

diseases
chronic 10, 39, 41
circulatory 39
introduced 1
respiratory 39

E
ear diseases 6
education 2-3, 39-40 see also school attainment 15
early childhood 20, 24, 42, 43
employment 3, 16, 20, 22, 25, 26, 40, 42, 43
and training programmes 26
outcomes 42
exercise levels 7-8
eye health 39

H
health
actions, related 8
behaviours 18
care, barriers to accessing 41
conditions, long-term 6
determinants of 39-40
equality 45, 48
general 6
professionals, consultations with 8
risk factors 6-8
status and outcomes 38-39
system performance 41
workforce 41

I
immunisation 41
incarceration rates 34
income 3, 16, 40
Indigenous affairs see Aboriginal affairs
Indigenous health
cultural concepts of 1-4
determinants economic 14-18
social 1-4, 14-18
effective approaches to 14-15
historical context of 1-4
policy programs 31-32
programs and initiatives 15-18
Indigenous population 3-4
by state/territory 3

I
Indigenous Reform 2011-12: Comparing performance across Australia 42-43
infant mortality see mortality rates
injury 39
insurance, private health 41

J
jobs see employment

K
kidney disease 39

L
life expectancy 11-13, 20, 23-24, 28
literacy and numeracy 20, 24, 42, 43

M
mortality
rates 38-39, 42, 47
child 20, 24, 42, 43

N
National Aboriginal and Torres Strait Islander Health Plan 2013-23 27,
35-37, 44, 45-46
Northern Territory 42, 43
Northern Territory Emergency Response (NTER) 31
nutrition 40

O
overcrowding 40
overweight and obesity 7, 40

P
physical activity 40
physical measurements 8

R
racism 17, 44, 48
Reconciliation 22, 26, 29, 30

S
school
attendance 19, 20, 21, 22, 25, 34
year 12 or equivalent attainment rates 20, 24-25, 42, 43
smoking rates, tobacco 5, 6-7, 9, 28, 40
social disadvantage, indicators of Indigenous 1-2
substance use, illicit 7

T
transport 40

U
unemployment 40 see also employment

W
waist circumference 8

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