Progress and priorities report 2015



CLOSETHEGAP

Close the Gap Campaign Steering Committee

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Cover photograph:
Peter Djandjomerr at Ubir Rock art site in Kakdu National Park, NT. Peter runs the Morle Boys program for Children's Ground in Jabiru, NT. Photograph: Jason Malouin/OxfamAUS.

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Aboriginal and Torres Strait Islander people should be aware that this document may contain images or names of people who have since passed away.

Executive summary

The Campaign Steering Committee welcomes the absolute gains in Aboriginal and Torres Strait Islander life expectancy from 2005–2007 to 2010–2012. Over that five-year period, life expectancy is estimated to have increased by 1.6 years for males and by 0.6 of a year for females. But a life expectancy gap of around ten years remains for Aboriginal and Torres Strait Islander people when compared with non-Indigenous people.

Both the modesty of the gains, and the magnitude of the remaining life expectancy gap remind us why the Council of Australian Governments' (COAG) Closing the Gap Strategy and the target to close the life expectancy gap was needed. It remains necessary today. But we must also keep in mind that closing the life expectancy gap requires time. The Closing the Gap Strategy was operationalised in July 2009 and the latest data we have is from 2012–2013. This is too short a time to adequately assess the progress of this Strategy in achieving outcomes.

Instead, the Campaign Steering Committee look to reductions in smoking rates, improvements to maternal and child health outcomes and demonstrated inroads into the impact of chronic diseases as evidence that the Closing the Gap Strategy is working.

The findings of the *National Aboriginal and Torres Strait Islander Health Measures Survey* (NATSIHMS), the largest biomedical survey ever conducted among Aboriginal and Torres Strait Islander people, are critical. The survey identified high levels of Aboriginal and Torres Strait Islander people with undetected treatable and preventable chronic conditions that impact significantly on life expectancy. Armed with this data, the Campaign Steering Committee believes the nation now has an enhanced ability to make relatively large health and life expectancy gains in relatively short periods of time.

To do this, there needs to be a **much greater focus on access to appropriate primary health care services to detect, treat and manage these conditions**. And the evidence is that Aboriginal Community Controlled Health Services (ACCHS) provide the best returns on investment in terms of providing both access to health services and the quality of those services.

As such, this report affirms the need to keep on track with the Closing the Gap Strategy and, with patience, many indicators suggest improvements to life expectancy will be seen in time. Any reduction in effort or momentum will squander the investment we have made as a nation up until now.

The comparison between the life expectancy of Maori peoples and Aboriginal and Torres Strait Islander peoples is illustrative. In 2010–12 an increase of approximately four years has been reported for the Maori life expectancy over the previous decade. But this occurred after two decades of effort in New Zealand. This demonstrates that substantial change is possible but it takes sustained and continuous effort.

The Campaign Steering Committee emphasises the need to ensure that potential changes in Commonwealth-State relations do not have the unintended effect of undermining the Closing the Gap Strategy. While recognising that all jurisdictions have a responsibility to contribute, the Campaign Steering Committee firmly supports the Australian Government's continuing leadership role in an overall national approach.

The Campaign Steering Committee recognises the value in the new Indigenous Affairs priorities of the Australian Government: education, employment and community safety. But there are concerns. In particular, a clearer connection between the Indigenous Advancement Strategy and the Closing the Gap Strategy will enhance both policies. Employment, education and community safety are drivers of improved health and wellbeing. However, good health is equally important to employment, education and community safety. Further, the health sector is the biggest employer of Aboriginal and Torres Strait Islander people and increased investment in health services will result in increased employment.

The Campaign Steering Committee is also concerned that hard won Aboriginal and Torres Strait Islander health gains could be negatively impacted by proposed measures contained in the 2014–15 Budget. Potential cuts to the Tackling Indigenous Smoking programme are of particular concern and could hinder the significant progress made in reducing Aboriginal and Torres Strait Islander smoking rates in recent years. Investment in early prevention activities saves on the provision of complex care into the future. These programmes also address and have started to make inroads into primary prevention, particularly in healthy eating, nutrition and physical activity.

The development of the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan* (Health Plan) will be pivotal in our shared efforts to close the gap. It provides an opportunity to increase the quality and efficiency of services, address service gaps by building on the existing capacity of ACCHS, and to expand the Aboriginal and Torres Strait Islander health workforce.

The Campaign Steering Committee remains steadfast in its belief that the road to closing the health gap is embodied in the *Close the Gap Statement of Intent* signed by the Australian Government and most state and territory governments. The *Close the Gap Statement of Intent* commits parties to genuine partnerships with Aboriginal and Torres Strait Islander peoples, ensuring appropriate evidence based health services, strengthening the ACCHS sector, effective planning and the use of targets, and addressing the social determinants of health.



Mark Djandjomerr and May Nango, traditional owners and community leaders in Jabiru, NT. Photograph: Jason Malouin/OxfamAUS.

The Close the Gap Campaign Steering Committee recommends:

1. That the findings of the *National Aboriginal and Torres Strait Islander Health Measures Survey* (NATSIHMS) are used to better target chronic conditions that are undetected in the Aboriginal and Torres Strait Islander population. In particular, access to appropriate primary health care services to detect, treat and manage these conditions should be increased. Aboriginal Community Controlled Health Services should be the preferred services for this enhanced, targeted response.
2. That the Australian Government should continue to lead the COAG Closing the Gap Strategy.
3. That the Australian Government revisit its decision to discontinue the National Indigenous Drug and Alcohol Committee.
4. That connections between the Indigenous Advancement Strategy and the Closing the Gap Strategy are clearly articulated and developed in recognition of their capacity to mutually support the other's priorities, including closing the health and life expectancy gap.
5. That the Tackling Indigenous Smoking programme is retained and funding is increased above current levels to enable consolidation, improvement and expansion of activities until the gap in the rates of smoking between Aboriginal and Torres Strait Islander and non-Indigenous people closes.
6. That proxy indicators are developed to provide insights into the use and availability of health services on Aboriginal and Torres Strait Islander health and life expectancy outcomes.
7. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* provides the basis for a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan. This is developed and implemented with the *National Aboriginal and Torres Strait Islander Health Plan*, the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy implementation* processes in order to avoid duplication, be more efficient, and maximise opportunities in this critical field.
8. That Closing the Gap Targets to reduce imprisonment and violence rates are developed, and activity towards reaching the Targets is funded through justice reinvestment measures.
9. That the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan* include the essential elements:
    - Set targets to measure progress and outcomes;
    - Develop a model of comprehensive core services across a person's whole of life;
    - Develop workforce, infrastructure, information management and funding strategies based on the core services model;
    - A mapping of regions with relatively poor health outcomes and inadequate services. This will enable the identification of services gaps and the development of capacity building plans;
    - Identify and eradicate systemic racism within the health system and improve access to and outcomes across primary, secondary and tertiary health care;
    - Ensure that culture is reflected in practical ways throughout Implementation Plan actions as it is central to the health and wellbeing of Aboriginal and Torres Strait Islander people;
    - Include a comprehensive address of the social and cultural determinants of health; and
    - Establish partnership arrangements between the Australian Government and state and territory governments and between ACCHS and mainstream services providers at the regional level for the delivery of appropriate health services.

Introduction

In March 2008, the then Australian Government and Opposition signed the *Close the Gap Statement of Intent*, committing to closing the health and life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2030. All Australian governments ratified this commitment when the Council of Australian Governments (COAG) set the Closing the Gap Targets found in the *National Indigenous Reform Agreement* and the Closing the Gap Strategy.

In April 2008, the then Australian Government (subsequently supported by the then Opposition) further committed to the Prime Minister providing an annual report to Parliament on progress towards closing the gap. This report would focus on the progress made in reaching the COAG Closing the Gap Targets. The report, by tradition, occurs in the first sitting week of Parliament, symbolically reminding the parliament and the nation of the importance of our collective efforts to close the gap.

In the spirit of an open and constructive dialogue between government, the wider community, and Aboriginal and Torres Strait Islander peoples, the Close the Gap Campaign annually produces this progress and priorities report alongside the Prime Minister's report.

The report comprises three chapters:

Chapter 1: Progress in the national effort to close the gap examines health outcomes as revealed by data in the last twelve months. It demonstrates that gradual improvements are beginning to be evidenced in key Aboriginal and Torres Strait Islander health outcomes.

Chapter 2: Developments in policy assesses proposals for federal relations reform, changes to the Closing the Gap Strategy, the Indigenous Advancement Strategy and other developments.

Chapter 3: Establishing effective pathways for positive change – an analysis by the Campaign Steering Committee sets out the Campaign's ideas for enhancing the Closing the Gap Strategy and improving Aboriginal and Torres Strait Islander health outcomes over the next few years.

The *Close the Gap Statement of Intent*

The *Close the Gap Statement of Intent* was signed on 20 March 2008 by Hon. Kevin Rudd MP (then Prime Minister); Hon. Nicola Roxon MP (then Minister for Health and Ageing); Hon. Jenny Macklin MP (then Minister for Families, Housing, Community Services and Indigenous Affairs); and Dr Brendan Nelson MP (then Opposition Leader).

Most state and territory governments and oppositions have also signed the *Close the Gap Statement of Intent*, including Victoria in March 2008; Queensland in April 2008; Western Australia in April 2009; the Australian Capital Territory in April 2010; New South Wales in June 2010; and South Australia in November 2010. A variety of non-government organisations including Campaign Steering Committee members, health bodies, human rights groups and community development organisations have also signed the *Close the Gap Statement of Intent* at both a national and state/territory level demonstrating broad community support for these principles.

CLOSE THE GAP

Indigenous Health Equality Summit

CANBERRA, MARCH 20, 2008

PREAMBLE

Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between indigenous and non-indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.

Prime Minister Kevin Rudd, Apology to Australia's Indigenous Peoples, 13 February 2008

This is a statement of intent – between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organizations – to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by year 2030.

We share a determination to close the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians.

We are committed to ensuring that Aboriginal and Torres Strait Islander peoples have equal life chances to all other Australians.

We are committed to working towards ensuring Aboriginal and Torres Strait Islander peoples have access to health services that are equal in standard to those enjoyed by other Australians and enjoy living conditions that support their social, emotional and cultural well-being.

We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery and control of these services.

ACCORDINGLY WE COMMIT:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-indigenous Australians by 2030.
- To ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gaps in health standards by 2018.
- To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs
- To working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.
- To building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.
- To supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.
- To achieving improved access to, and outcomes from, mainstream services for Aboriginal and Torres Strait Islander peoples.
- To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality.
- To measure, monitor, and report on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.

WE ARE: SIGNATURES

Representative of the Australian Government

National Aboriginal Community Controlled Health Organisation

Congress of Aboriginal and Torres Strait Islander Nurses

Australian Indigenous Doctors Association

Indigenous Dentists Association of Australia

Aboriginal and Torres Strait Islander Social Justice Commissioner.
Human Rights and Equal Opportunity Commission

1 Progress in the national effort to close the gap – health outcomes



National Close the Gap Day celebrations at Royal Prince Alfred Hospital, Sydney, NSW. Photograph: Michael Myers/OxfamAUS.

This chapter considers Australian governments' progress towards meeting the COAG Closing the Gap health targets: that is, to achieve life expectancy equality between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2030; and to halve Aboriginal and Torres Strait Islander deaths among children ages 0-4 years by 2018.[2]

Primary references include the COAG Reform Council's final report, *Indigenous Reform 2012–13: Five years of Performance*,[3] and the Productivity Commission's report, *Overcoming Indigenous Disadvantage 2014* (OID 2014 Report).[4] Both reports measure progress against the above targets, the latter in the context of many other indicators.

Also considered are the results of the 2012–2013 Australian Bureau of Statistics (ABS) NATSIHMS[5] – the first national biomedical survey for Aboriginal and Torres Strait Islander people, and some challenging research into closing the diabetes gap.[6]

Closing the Gap has always been a bipartisan goal and, as such, our successes and failures are always shared.[1]

Prime Minister Abbott, Prime Minister's Report on Closing the Gap 2014

1.1 Progress towards achieving the life expectancy target

(a) Absolute gains

The ABS 2010–2012 life expectancy estimates for Aboriginal and Torres Strait Islander people are still current: 69.1 years for men and 73.7 years for women.[7] Table 1 summarises the absolute gains in life expectancy from 2005–07 and 2010–12 for both Aboriginal and Torres Strait Islander people and non-Indigenous people, disaggregated by gender.

Table 1: Changes in Aboriginal and Torres Strait Islander and non-Indigenous life expectancy over 2005–07 and 2010–12, disaggregated by gender[8]

		Life expectancy (years)		Increase in life expectancy from 2005–07 to 2010–12
		2005–07	2010–12	
Aboriginal and Torres Strait Islander	Men	67.5	69.1	+1.6 years
	Women	73.1	73.7	+0.6 year
Non-Indigenous	Men	78.9	79.7	+0.8 year
	Women	82.6	83.1	+0.5 year

The Campaign Steering Committee welcomes the absolute gains in estimated Aboriginal and Torres Strait Islander life expectancy. These are 'on-the ground' improvements to the lives of Aboriginal and Torres Strait Islander peoples and should not be underestimated. Another year a father can spend with his son, or a grandmother with her grandchildren, or a trusted Elder guiding the life of their community, is to be treasured.

In Chapter 3 of this report, an illustrative comparison between the life expectancy of the Maori peoples and Aboriginal and Torres Strait Islander peoples is provided. A four-year rise in Maori life expectancy was achieved between 2000–02 and 2010–12.

This positive outcome was the result of two decades of sustained national effort.[9] The Campaign Steering Committee believes that Aboriginal and Torres Strait Islander peoples could make similar absolute gains before the early 2020s if the effort to close the gap in this country is maintained. Large absolute gains will be particularly possible with a much greater focus on increasing access to appropriate health services. This need will be addressed throughout this report.

However, as important and welcome as absolute gains are, the focus of the Closing the Gap Strategy must remain on achieving **relative** gains. Closing the gap is a priority health, social justice and human rights issue in Australia.

(b) Relative gains

Over 2005–2007 and 2010–2012 the life expectancy gap for Aboriginal and Torres Strait Islander men closed by 0.8 years, and for women by only 0.1 years.[10] The small relative gain was a result of the gains in life expectancy made by non-Indigenous people. Indeed, such small relative gains are within the margin for error and could in fact be non-existent.[11]

In its final report, the COAG Reform Council concluded that the nation is not on track to meet the 2030 COAG life expectancy equality target and that larger absolute and relative gains are needed in future years.[12] They highlight particular concerns nationally for Aboriginal and Torres Strait Islander women's life expectancy, and for Northern Territory Aboriginal and Torres Strait Islander residents.[13]

(c) Being realistic about big picture change

The 2010–2012 life expectancy estimate is akin to a baseline – against which progress can be measured until 2030. This is because the 2010–2012 data is better understood as reflecting life expectancy **prior** to the Closing the Gap Strategy: in such a short period of time (since the strategy became operational in July 2009), no significant changes or 'instant results' should be expected.

Cardiovascular disease and the time required to yield results

Cardiovascular disease, the single biggest killer of Aboriginal and Torres Strait Islander people, is illustrative of the need for time to yield results. The COAG Reform Council reports that, in the five states where data is reliable, 26.1 percent of Aboriginal and Torres Strait Islander deaths were caused by cardiovascular disease in 2007–11.[14] In 2009–2011, the age-adjusted cardiovascular disease death rate for Aboriginal and Torres Strait Islander people was 1.3 times as high as that for non-Indigenous people.[15]

Over the twentieth century, cardiovascular disease mortality in Australia reached a peak in the late 1960s. Rates began to decline steadily in both sexes from 1970.[16] Between 1981 and 2011, the cardiovascular disease death rate for males fell by 71 percent – a 4.2 percent average annual decline. The female rate fell by 67 percent – a 3.8 percent average annual decline.[17]

The Australian Institute of Health and Welfare (AIHW) estimates that if cardiovascular disease death rates had remained at their 1968 peak, there would have been 190,223 deaths for cardiovascular disease in 2011 – more, in fact, than the number of deaths from all causes in that year.[18] The actual number of cardiovascular disease deaths that occurred in 2011 was 45,622.[19]

The AIHW attributes the decline in about equal measure to improved diagnosis and treatment of cardiovascular disease, as well as lowering of the rates of smoking and hypertension among the general population over that 50-year period.[20] As such, a relatively long 'lag period' can be expected until that change is reflected in available data. For example, studies suggest that it takes from between two and six years after quitting for a smoker's risk of cardiovascular disease returning to a level similar to that of a non-smoker.[21]

Cardiovascular disease is one area where targeted improvements could result in significant health benefits. In particular, when presenting to hospitals with acute coronary syndrome, Aboriginal and Torres Strait Islander peoples do not receive equivalent care as other Australians. A landmark study by the AIHW showed there were twice as many in-hospital death rates, a 40 percent lower rate of angiography, a 40 percent lower rate of coronary angioplasty or stent procedures and 20 percent lower rate of coronary artery bypass surgery.[22] Addressing this access to service differential is a critical task at hand.

A study by Hoy and colleagues further demonstrates this point. The study found that non-violent Aboriginal and Torres Strait Islander deaths with chronic disease can be halved in just over three years, through systematic application of currently available therapies.[23] Programmes like these can be enormously effective, save lives and reduce health costs over the long-term as well as providing benefits from individual, family and community perspectives. But there are no shortcuts. These results depend on well-run and adequately resourced health services being accessible to Aboriginal and Torres Strait Islander people.

1.2 New insights into chronic disease and the high rates of undetected and untreated conditions

The results of the NATSIHMS, the largest biomedical survey ever conducted among Aboriginal and Torres Strait Islander people (with around 3,300 participants), was released in September 2014.[24]

The results are sobering. However, they provide a strong indication that gains to health and life expectancy are possible through targeted and enhanced primary health services that are able to prevent, detect, treat and support the management of chronic diseases.

(a) High levels of treatable and preventable conditions

The NATSIHMS reported that Aboriginal and Torres Strait Islander people were, when compared to non-Indigenous people:

- More than three times as likely to have diabetes (rate ratio of 3.3);[25]
- Twice as likely to have signs of chronic kidney disease (rate ratio of 2.1),[26] and more than four times as likely to be in the advanced stages of chronic kidney disease (Stages 4-5);[27] and
- Nearly twice as likely to have a high amount of triglycerides in their blood – a risk factor for cardiovascular disease (rate ratio 1.9).[28]

The survey also found significant differences across remoteness areas. In particular, when compared with those living in urban areas, Aboriginal and Torres Strait Islander participants in remote areas were two and a half times as likely to have signs of chronic kidney disease (33.6 percent compared with 13.1 percent).[29]

(b) Compounding nature of chronic disease and high rates of comorbidities

The NATSIHMS also highlighted the compounding nature of chronic disease and risk factors among the Aboriginal and Torres Strait Islander population. It demonstrates that diabetes, cardiovascular disease and chronic kidney disease are all risk factors for each other and that co-morbidity between these conditions is more common for Aboriginal and Torres Strait Islander people than for non-Indigenous people.[30] For example:

- Over half (53.1 percent) of all participants with diabetes also have signs of kidney disease. This was higher than the corresponding rate for non-Indigenous people with diabetes (32.5 percent);[31] and

- Participants with diabetes were also more likely than non-Indigenous people with diabetes to have indicators of cardiovascular disease, including high triglycerides (45.1 percent compared with 31.8 percent) and lower than normal levels of HDL 'good' cholesterol (60.5 percent compared with 48.8 percent).[32]

The NATSIHMS participants also demonstrated the associations between (1) smoking and low levels of 'good' HDL cholesterol; and (2) obesity and high total cholesterol, low 'good' HDL cholesterol, and high rates of 'bad' LDL cholesterol and triglycerides. This suggests there are complex inter-relationships between the various risk factors and chronic diseases, and a corresponding need for a multi-pronged effort that tackles risk factors and chronic disease simultaneously.

(c) High levels of chronic conditions at comparatively young ages

The NATSIHMS also confirms that Aboriginal and Torres Strait Islander people tend to develop chronic diseases at younger ages – as set out in Table 2 below.

Table 2: The age gap for the development of chronic disease between Aboriginal and Torres Strait Islander people and non-Indigenous people

	Aboriginal and Torres Strait Islander people	Non-Indigenous people
Diabetes Gap starts widening by 35-44 years	9.0 percent – rate of those aged 35-44 with diabetes.[33]	8.2 percent – rate of those aged 55-64 years with diabetes.[34]
Kidney disease Gap starts widening by 45 years	Rates began to increase from early adulthood and then more noticeably from 45 years onwards.[35]	Rates remain very flat until late adulthood and only began to increase from the age of 65.[36]
Cardiovascular disease indicators Gap starts widening by 35-44 years	**High triglycerides**	
	32.2 percent of those aged 35-44 years.[37]	14.9 percent of those aged 35-44 years.[38]
	Lower than normal levels of 'good' HDL cholesterol	
	46.8 percent of those aged 35-44 years.[39]	24.5 percent of those aged 35-44 years.[40]

(d) High levels of undetected and untreated chronic conditions

Perhaps the most disturbing results of the NATSIHMS were the high levels of undetected chronic conditions. These findings demonstrate the need to increase Aboriginal and Torres Strait Islander access to appropriate health services to prevent, detect and treat these chronic conditions.

- One in five (20.4 percent) participants had high blood pressure (systolic or diastolic blood pressure equal to or greater than 140/90 mmHg). Of these, four in five (79.4 percent) did not report high blood pressure as a long-term health condition;[41]
- Nearly one in five (17.9%) had signs of chronic kidney disease, but of these, nine in ten didn't know they had these signs;[42]

- One in four adults (25 percent) had abnormal or high total cholesterol levels according to their blood test results. Yet of these, only one in ten people (9.1 percent) from this group self-reported having high cholesterol as a current long-term health condition. While this was similar to the rate found in the non-Indigenous population (10.1 percent), it nonetheless suggests that the majority of Aboriginal and Torres Strait Islander people with high total cholesterol results are either unaware that they have the condition or did not consider it to be a long-term or current problem;[43] and
- Overall, 11 percent of all participants were detected with diabetes.[44] While 9.6 percent had a diagnosis, 1.5 percent had not.[45] Almost five percent of additional participants were found to be at high risk of diabetes.[46]

The NATSIHMS also reported that of those who were diagnosed with diabetes, only two in five (38.9 percent) were effectively managing their condition (having a HbA1c test result of seven percent or less).

These results also highlight the very real opportunities for sizeable and rapid health gains through targeted improvements to primary and other health services to prevent, detect and treat these conditions. In particular, and discussed later, these results underscore the big difference that improved and enhanced ACCHS could make in this area. The ACCHS are already out-performing other services in reducing the impact of chronic disease among Aboriginal and Torres Strait Islander people,[47] and that existing strength should be built upon.

Recommendation 1

That the findings of the *National Aboriginal and Torres Strait Islander Health Measures Survey* (NATSIHMS) are used to better target chronic conditions that are undetected in the Aboriginal and Torres Strait Islander population. In particular, access to appropriate primary health care services to detect, treat and manage these conditions should be increased. Aboriginal Community Controlled Health Services should be the preferred services for this enhanced, targeted response.

1.3 Risk factors for chronic disease

In this section, the Campaign Steering Committee considers the following chronic disease risk factors: mental health conditions; smoking; excess body weight and obesity; and harmful alcohol consumption.

(a) Mental health conditions

Research over the past decade suggests a chain of causation may be present between mental health conditions (in particular, serious psychological distress) and chronic disease. A 2014 study by Reeve and colleagues correlated data from the 2004–2005 ABS *National Aboriginal and Torres Strait Islander Health Survey* and the 2008 ABS *National Aboriginal and Torres Strait Islander Social Survey* (NATSISS),[48] to make significant findings as to what was required to close the diabetes gap.

Among other findings discussed below, it found an association between people who self-reported diabetes and those who reported the forced removal of relatives. It described the finding as ‘consistent with emerging evidence that serious psychological stress contributes to a range of health problems and may be involved in the development of risk factors for metabolic syndrome, including raised blood glucose’.[49]

Such emerging evidence includes that from a 2006 international review of evidence on the association between stress and chronic disease for Indigenous populations and African Americans by Yin Paradies.[50] While the review found the strongest associations between serious psychological distress resulting from racism and mental health conditions,[51] it also identified studies that associated such psychological distress with high blood pressure, hypertension, impaired immune function, heart disease, pre-term births, increased heart rate and the thickening of arterial walls.[52] There is now a well-established link between racism and poor mental and physical health outcomes, including anxiety, depression, overweight and obesity, smoking, substance misuse and alcohol misuse.[53]

The Campaign Steering Committee is of the view that there is a clear correlation between mental health and chronic disease. The artificial divide that exists between the consideration of these conditions is unhelpful. Aboriginal and Torres Strait Islander mental health must be addressed not only as a priority in its own right, but also as an important part of addressing chronic disease.

(b) Rates of current daily smokers

Tobacco smoking is estimated to be the leading cause of burden of disease for Aboriginal and Torres Strait Islander people: responsible for around 12 percent of the total burden of disease and injury.[54]

Smoking is a major preventable contributor to the Aboriginal and Torres Strait Islander life expectancy gap due to the high rates of cardiovascular and respiratory diseases associated with it.[55] It also impacts on low birth rate and infant child mortality. As noted, over 2007–2011 cardiovascular disease was the most common cause of Aboriginal and Torres Strait Islander deaths (responsible for 26.1 percent of deaths). Respiratory diseases were the fifth most common cause of deaths accounting for 7.7 percent of the total deaths.[56]

Comparing the results of the 2002 and 2008 NATSISS results with those of the 2012–2013 ABS *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS) enables the rates of smoking among Aboriginal and Torres Strait Islander people to be tracked over time. Similar surveys in the general population enable further comparisons.

The surveys show a progressive decrease in daily smoking rates for Aboriginal and Torres Strait Islander people: declining from 51 percent in 2002, to 45 percent in 2008, and then to 41 percent in 2012–13.[57] While the daily smoking rate remains high, such gains are welcome.

However, there have been only small relative gains when compared to the rates of smoking among non-Indigenous people over the past 15 years. From 2008 – to 2012–2013, the fall in the Aboriginal and Torres Strait Islander smoking rate was 3.6 percent. However, among non-Indigenous people the rate of smoking fell by 2.9 percent – and from a much lower baseline.[58] As a result the gap in the rates of smoking has remained unchanged at the 2008 level of 25.2 percent,[59] and has decreased by only two percent since 2001 when the gap was 27 percentage points.[60] The largest gaps are in major cities (22.4 percent gap between the two population groups) and inner regional areas (23.1 percent gap).[61]

The evidence of the impact of anti-smoking campaigns among the non-Indigenous population highlights the need for a sustained and properly resourced anti-smoking focus over decades to make significant and consistent population health gains.

In 1945, more than three out of every four men and one in every four women in Australia were regular smokers.[62] In fact, smoking rates remained high until the Quit campaigns became established in each state from 1983 onwards.[63] These used social marketing to 'sell' the message that smoking was harmful.[64] Health education in schools remained a major theme, but this was complemented with more vigorous efforts to stop retailers from selling cigarettes to children.[65]

Since the 1980s, a relatively steady decline in smoking rates has been evident with the exception of a period in the mid-1990s. This is believed to correspond with reduced expenditure on public campaigns, highlighting the need for a sustained and properly resourced anti-smoking focus over decades to make significant and consistent population health gains.[66]

This is why more time must be allowed for the Tackling Indigenous Smoking programme, operational only since 2010, to build on the impressive results already apparent in the data. The Campaign Steering Committee believes that it is reasonable to expect further significant reductions in smoking rates over the next decade if investment in the Tackling Indigenous Smoking programme is sustained. As such it is critical that funding and other support for the programme continues in order for the wider promise of the programme to be realised. As in so many other areas, the Campaign Steering Committee counsels a long-term perspective will be rewarded in this area.

(c) Excess body weight and obesity

In Recommendation 1 of its final report, the COAG Reform Council identifies the 'higher rates of obesity among Aboriginal and Torres Strait Islander people as an area that requires further attention from COAG as part of its efforts to achieve life expectancy equality'.[67] The Campaign Steering Committee supports this recommendation. Excess body weight, especially obesity, is a risk factor for chronic disease including diabetes, cardiovascular disease and cancer. Risks increase with greater weight.[68]

Among Aboriginal and Torres Strait Islander people in 2011–13, 41.7 percent were obese compared with 27.2 percent of non-Indigenous people.[69] Even more concerning is that while the non-Indigenous rate of overweight and obesity was almost twice that of normal weight, the Indigenous rate of overweight and obesity was almost three times the normal weight rate.[70]

Nationally in 2011–13, there was a significant gap of 8.8 percent between the proportion of Aboriginal and Torres Strait Islander and non-Indigenous people with excess body weight.[71] That is, 71.4 percent of the former were overweight or obese, compared with 62.6 percent of the latter.[72] Only the Northern Territory had a significantly lower proportion of Aboriginal and Torres Strait Islander people with excess body weight (59.8 percent) than the national non-Indigenous rate.[73]

The Campaign Steering Committee recognises the efforts and positive outcomes achieved by the Tackling Smoking and Healthy Lifestyle Workers. These workers raise awareness in Aboriginal and Torres Strait Islander communities of the health benefits of keeping active, making informed decisions on food and carbonated drink intake, and stopping smoking. Consequently, we recommend that the Tackling Indigenous Smoking Programme and funding for Tackling Smoking and Healthy Lifestyle Workers be at minimum maintained and, in the immediate future, increased.



Minjaara Atkinson sends a letter to the Prime Minister at a Close the Gap Day event in Carlton, Vic. Photograph: Lara McKinley/Oxfam AUS.

(d) Alcohol consumption and at-risk drinking

Nationally in 2011–13, Aboriginal and Torres Strait Islander people abstained from drinking alcohol at almost twice the rate of non-Indigenous people (26.1 percent and 16.3 percent respectively).[74] Yet high alcohol consumption and at-risk drinking remain challenges to closing the life expectancy and health gap.

High alcohol consumption can have harmful short and long term effects on a person's physical, social and mental health and safety. Ongoing harmful use of alcohol is associated with several diseases that may cause disability or death including cancer, diabetes and cardiovascular disease.[75]

The COAG Reform Council refers to the following as harmful patterns of alcohol consumption:

- Lifetime risky drinking – consuming an average of two standard drinks or more per day, on average, in a week.[76] In 2011–2013, approximately 19 percent of both Aboriginal and Torres Strait Islander and non-Indigenous people drank at levels that put them at lifetime risk of harm from alcohol.[77] Both population groups also report small but significant declines since 2004–2005: the former from 20.3 to 19.2 percent; and the latter from 21.9 to 19.5 percent.[78]
- Binge drinking – consuming more than four standard drinks in a single session.[79] In 2011–2013, Aboriginal and Torres Strait Islander people reported binge drinking in the previous year at higher rates than non-Indigenous people (51.8 percent compared to 45.3 percent of respondents respectively),[80] but reported binge drinking less often (13.1 per cent, compared to 33 percent of non-Indigenous people reported binge drinking on a weekly basis).[81]
- Among people who drank at least once in the past 12 months, a significantly higher proportion of Aboriginal and Torres Strait Islander people drank higher volumes in a single session than non-Indigenous people. Among Aboriginal and Torres Strait Islander men, 42 percent reported drinking 11 or more standard drinks on a single occasion compared with 32.7 percent of non-Indigenous men; and 29.7 percent of Aboriginal and Torres Strait Islander women reported drinking seven or more standard drinks on a single occasion, compared with 20.4 percent of non-Indigenous women.[82]

Perhaps what is of greatest concern is what could be referred to as 'daily binge drinking'. The COAG Reform Council report approximately 14 percent of Aboriginal and Torres Strait Islander men and 12.7 percent of non-Indigenous men aged 15 and over were drinking an average of over five standard drinks per day.[83] A significantly larger proportion of Aboriginal and Torres Strait Islander men (8.1 percent) than non-Indigenous men (6.1 percent) were drinking more than seven standard drinks per day.[84] Similarly more Aboriginal and Torres Strait Islander women (4 percent) than non-Indigenous women (2.8 percent) were drinking more than five standard drinks per day.[85]

The OID 2014 Report finds that in 2012–13, Aboriginal and Torres Strait Islander people were admitted to hospital for acute intoxication at around 12.1 times the rate for non-Indigenous people – the rate in remote and very remote areas was double the rate in major cities.[86] The gap increased from 5.7 to 12.1 times the rate of admission from 2004–05 to 2012–13.[87]

At-risk drinking is also linked with injury, disability and death through accidents, violence and suicide:[88]

- From 2003–2007 to 2008–2012, the alcohol induced death rate for Aboriginal and Torres Strait Islander people in jurisdictions where data is deemed reliable was around five times the rate for non-Indigenous people;[89]
- The majority of Aboriginal and Torres Strait Islander homicides each year involved alcohol consumption;[90]
- It is estimated that the prevalence of Fetal Alcohol Spectrum Disorders (FASD) for Aboriginal and Torres Strait Islander people is between 2.76 and 4.7 per 1,000 births compared to between 0.06 and 0.68 per 1,000 births for all Australians;[91] and
- Evidence demonstrates that high levels of alcohol misuse is associated with family violence in Aboriginal and Torres Strait Islander communities.[92]

Tackling harmful drinking among Aboriginal and Torres Strait Islander people is an important part of closing the health and life expectancy gap. As such, the Campaign Steering Committee welcomes the ongoing development of a dedicated *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* (Drug Strategy). The Drug Strategy will address problem alcohol and other drug consumption and replace the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*.[93]

Implementing the Drug Strategy in a coordinated way with the implementation of the Health Plan, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* (in development at the time of writing)[94] and the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*[95] remains a key challenge for 2015 as discussed later. The Drug Strategy is discussed further in the text box below.

National Aboriginal and Torres Strait Islander Peoples' Drug Strategy

The *National Drug Strategy 2010–2015* committed to the development of seven sub-strategies to be developed, one of which is the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* (Drug Strategy).[96] In 2013, the Working Group for the Drug Strategy released a background paper that provides insight into the purpose and some of the main areas for consideration to be discussed in the final document.[97]

The Drug Strategy is intended to act as a guide for governments, Aboriginal and Torres Strait Islander communities, service providers and individuals by identifying some of the key issues and areas for action relating to the harmful use of tobacco, alcohol and other drugs. It should consider the types of actions that could help to reduce the impact of these things on Aboriginal and Torres Strait Islander peoples and communities, and contribute to improved health and social outcomes.[98]

In delivering on this purpose, it is expected the Drug Strategy will consider the three pillars that underpin the National Drug Strategy: demand reduction; supply reduction and harm reduction.[99]

The Drug Strategy should recognise that problem tobacco, alcohol or other drug use in any context should not be considered in isolation, as there are many contributing factors that can underpin problem usage. It should also recognise that Aboriginal and Torres Strait Islander peoples draw strength from social and emotional wellbeing: this includes connectedness to family, culture and identity.[100]

The Drug Strategy should acknowledge that 'Aboriginal and Torres Strait Islander populations are diverse, as are their experiences of health and social problems and in acknowledgement of this diversity seek to promote a shared responsibility and ownership of the issues and solutions that are identified by working in active partnership with Aboriginal and Torres Strait Islander peoples'.[101]

In October 2014, the Australian Medical Association's National Alcohol Summit issued a Communique calling for Australian Government leadership in developing and implementing a dedicated national alcohol strategy, independently from the National Drug Strategy. A National Alcohol Strategy would include a specific focus on the needs of Aboriginal and Torres Strait Islander peoples, but connect these to general population alcohol policy to enable coordinated responses to both Aboriginal and Torres Strait Islander and non-Indigenous problem drinking at regional and national levels. The strategy would address pricing, availability, promotion and treatment for alcohol problems.[102]

1.4 Progress towards achieving the child (under-five) mortality target

The COAG Reform Council reports that Australian governments are on track to meet COAG's target to halve the gap in child death rates by 2018. However, the death rate for Aboriginal and Torres Strait Islander children is still more than double the rate for non-Indigenous children.[103]

There are five jurisdictions with good quality data for this indicator: New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory.[104] Even across these jurisdictions, however, the numbers of child deaths are relatively small and five years' data (i.e. data that includes years in which the COAG Closing the Gap reform agenda was operating – effectively from July 2009 on) are not enough to reliably show change.[105] Because of this, the Council adopts a 1998 baseline to allow for up to fifteen years of data to be assessed and better identify trends.[106]

This shows that deaths of both Aboriginal and Torres Strait Islander and non-Indigenous children fell significantly from 1998 to 2012:

- The death rate for Aboriginal and Torres Strait Islander children decreased by an average of 6.5 deaths per 100,000 per year;[107] and
- The death rate for non-Indigenous children decreased by 2.0 deaths per 100,000 per year.[108]

This reduced the Aboriginal and Torres Strait Islander child death gap from 139.0 deaths per 100,000 in 1998 to 87.6 per 100,000 in 2012 and has been interpreted to mean that the nation is on track to meet the COAG target and halve the gap by 2018.[109] However, as noted by the COAG Reform Council, child mortality for the non-Indigenous population is also improving and the ratio of the Aboriginal and Torres Strait Islander child mortality rate to the non-Indigenous rate has not changed over the last 10 years and remains almost twice as high (1.9 times). The gap cannot close until this ratio declines.

The child (under-five) rate for Aboriginal and Torres Strait Islander children is 165 deaths per 100,00 while the rate for non-indigenous children is 77 deaths per 100,000.[110] This is still unacceptable.

The COAG Reform Council is critical of the continuing use of the trajectory that Australian governments agreed for closing the child death gap in 2009, found in the *National Indigenous Reform Agreement*.[111] This is because it is based on a projected non-Indigenous rate based on the 1998 to 2008 rate of decline and yet the rate of decline has significantly increased since that time.[112] As such, what it means to achieve equality has also significantly changed.

(a) Low birth weight babies

Birth weight is a key indicator of infant health and a major determinant of a baby's chance of survival and good health. Low birth weight is of particular concern.[113] AIHW defines a low birth weight baby as one with a weight of less than 2,500 grams. Research that indicates that babies weighing less than 2,500 grams at birth are at least 20 times as likely to die within their first year of life than those who weighed at least that amount.[114]

In 2011, babies born to Aboriginal and Torres Strait Islander mothers were twice as likely as those born to non-Indigenous mothers to be of low birth weight: 12.6 percent of babies born to Aboriginal and Torres Strait Islander mothers weighed less than 2,500 grams compared with 6 percent of babies born to non-Indigenous mothers.[115]

Between 2000 and 2011, AIHW reported a statistically significant decrease in the low birth weight rate among live born singleton babies of Aboriginal and Torres Strait Islander mothers, with the rate declining by 9 percent over the period. In contrast, there was no significant change in the corresponding rate for non-Indigenous mothers.[116]

As such, over the period 2000 to 2011, there was a small but statistically significant narrowing of the birth weight gap in this period as set out in Table 3.

Table 3: Narrowing of the gap in Aboriginal and Torres Strait Islander and non-Indigenous low birth weight births, 2001–2011[117]

	Low birth weight births, per 100 births		
	2001	2011	Narrowing of the gap
Aboriginal and Torres Strait Islander	11.7	11.1	
Non-Indigenous	4.5	4.5	
Rate difference (Aboriginal and Torres Strait Islander rate minus the non-Indigenous rate, per 100 births)	7.2	6.6	13 percent
Rate ratio (Aboriginal and Torres Strait Islander rate divided by the non-Indigenous rate)	2.6	2.5	7 percent



Binning kids and Children's Ground participants playing at the pool in Jabiru, NT. Photograph: Jason Malouin/Oxfam AUS.

Some of the key determinants for low birth weight babies are:

- Access to antenatal care – such care can reduce the chance of low birth weight due to early diagnosis and treatment of pregnancy complications, with the World Health Organization recommending that women receive antenatal care at least four times during pregnancy;
- Smoking – babies born to mothers who smoke are more likely to be of low birth weight than other babies. Passive exposure to smoke is also associated with lower birth weight;
- Pre-term births (defined as before 37 weeks of gestation) – factors associated with pre-term births include chronic conditions like diabetes and high blood pressure;
- The mother's diet and nutritional status at conception and during the pregnancy;
- Drug and alcohol consumption during pregnancy – particularly alcohol consumption that leads to FASD; and
- The age of mothers – low birth weight is more common among younger mothers (aged less than 20) and older mothers (aged 35 and over).[118]

These determinants are often underpinned by social determinants. Mothers living in relative poverty are more likely to have low birth weight babies (with this potentially related to factors such as nutrition, maternal health and behavioural characteristics such as smoking).[119]

In Table 4 below, the gaps between Aboriginal and Torres Strait Islander people and non-Indigenous people for three of the above determinants for low birth weight are considered.

Table 4: Selected determinants of low birth weight babies 2011, with changes in the gap between Aboriginal and Torres Strait Islander people and non-Indigenous people for these determinants[120]

	2011		Gap – changes over 2001–2011
	Aboriginal and Torres Strait Islander	Non-Indigenous	
Antenatal care	99 percent of mothers had at least one antenatal session, and 83 percent had five or more.	Nearly all (99.9 percent) of mothers had at least one antenatal session, and 95 percent had five or more.	In 2001–2011, in NSW, South Australia and Queensland, there was a statistically significant increase in the rate of Aboriginal and Torres Strait Islander mothers attending at least one antenatal care session during pregnancy, but no significant change among non-Indigenous women. This resulted in a narrowing of the gap in these three jurisdictions.
Smoking	Half (50 percent) of mothers reported smoking during pregnancy.	12.1 percent of mothers reported smoking during pregnancy.	Between 2005 and 2011, there was a statistically significant six percent decline in Aboriginal and Torres Strait Islander mothers who smoked during pregnancy, but a much greater drop of 25 percent among non-Indigenous mothers. **The gap thus increased significantly**.
Pre-term births	12.5 percent of all live births.	7.5 percent of all live births.	Decline of 14 percent in the rate ratio; and 19 percent in the rate difference in 2001–2011.

Looking forward, the Campaign Steering Committee believe that increased focus must be maintained in relation to reducing smoking during pregnancy and to increasing access to antenatal care. Once again, the demonstrated strengths of ACCHS in providing maternal and infant care already demonstrated by the ACCHS should be utilised.

ACCHS' 'mums and bubs' programmes have long been established and have a track record in improving mother and child health outcomes. For example, the Baby Basket programme developed in 2009 by the Apunipima Cape York Health Council. This encourages expecting Aboriginal and Torres Strait Islander mothers to have earlier and more frequent engagement with antenatal and postnatal health services. The programme also provides Baby Baskets, with practical gifts for mum and baby, health education material and food vouchers to purchase fruit and vegetables at the first trimester, immediately prior to birth and six months post birth.

The programme also provides Health Workers or clinicians with opportunities to engage with mothers, their partners and families about issues affecting their growing baby – such as healthy choices around smoking, alcohol and diet. A 2014 evaluation of the programme noted that at a relatively small cost of $874 per participant, the programme was resulting in a higher proportion of women making antenatal visits, that the women involved were less likely to be iron deficient, and they were more likely to be making healthy choices such as eating fruit and vegetables and quitting smoking.[121]

2 Developments in policy



Carly Zandstra, teacher at Nowra High School. Photograph: Peter Izzard/OxfamAUS.

2.1 Proposed changes in Commonwealth-State relations and their impact on the Closing the Gap Strategy

The Closing the Gap Strategy aims to address Aboriginal and Torres Strait Islander disadvantage by achieving outcomes and equality across seven 'building blocks' or areas of life (early childhood, schooling, health, economic participation, healthy homes, safe communities, governance and leadership).[123] This coherent and integrated approach is aligned with the holistic idea of health supported by Aboriginal and Torres Strait Islander peoples,[124] and with social determinants of health theory.[125]

The Closing the Gap Strategy is led by the Australian Government and involves the commitment of all the states and territories. As such, it also provides a national and consistent approach to closing the gap that can be sustained over the long term – until 2030. As the Department of Finance's 2009 *Strategic Review of Indigenous Expenditure* noted, with these strong foundations in place the 'key challenge from this point lies not so much in further policy development as in effective implementation and delivery'.[126]

However, the Campaign Steering Committee is concerned that despite continued Australian Government commitment to closing the gap, broader structural reform to the federal system of the type that is currently being discussed could potentially have an adverse impact on the Closing the Gap Strategy.

(a) Reforms to the federal system

The Australian Government's National Commission of Audit flagged structural reform to the federal system in its March 2014 report. It recommended clear delineation of respective roles and responsibilities and reform of the Commonwealth's financial relations with the states and territories.

The Australian Government supports ensuring 'that, as far as possible, the states are sovereign in their own sphere'.[127] To that end, the Terms of Reference for the development of a *White Paper on the Reform of the Federation* (White Paper) were released on 28 June 2014.[128]

This is intended to set out the Australian Government's position on the practical application of what 'the states being sovereign in their own spheres' might mean for programme and service delivery, including in Indigenous Affairs.[129]

Issues Paper 1 *A Federation for Our Future* was released in September 2014.[130] This states that:

> A major part of the [current] problem [with the federation] is that over time, the Commonwealth has become, for various reasons, increasingly involved in matters which have traditionally been the responsibility of the States and Territories.[131]

This, of course, could include aspects of Indigenous Affairs. Reform along these lines then could potentially signal a break with the spirit of the 1967 referendum. In this, over 90 percent of Australians supported the potential for Australian Government involvement (and the Campaign Steering Committee believes leadership) in Indigenous Affairs. This was, at least in part, because of the failure of the states and territories to effectively address Aboriginal and Torres Strait Islander disadvantage and protect basic human rights since at least federation.[132]

If there is one message I want Governments to hear from this report it is: Do not press the reset button! … If we continue to start over again the foundations previously laid will be pulled up time and again, never allowing enough time or energy to build the structure required to close the gap on Indigenous disadvantage.[122]

Brian Gleeson, the Coordinator General for Remote Indigenous Services

In relation to the Closing the Gap Strategy, the Issues Paper suggests:

> In Australia, we should be particularly mindful of the difference in life chances that exist as a result of socio-economic disadvantage, especially in respect of Aboriginal and Torres Strait Islander peoples, and make it a priority to achieve governments' commitment to Close the Gap in Indigenous life expectancy, child mortality, education and employment.[133]

Later the Issues Paper acknowledges that 'sometimes a national approach is more appropriate than pursuing different approaches across the States and Territories' and cites addressing Aboriginal and Torres Strait Islander disadvantage as an example of such a national objective.[134] However, other than this reference it does not significantly address the issue of what 'clear delineation of responsibilities for different levels of government' will mean for Aboriginal and Torres Strait Islander Affairs.[135] Critically for the Campaign Steering Committee, all governments must ensure that actions are taken with clearly articulated responsibilities to address disadvantage.

Issues Paper 3 *Roles and Responsibilities in Health*, discusses Aboriginal and Torres Strait Islander health and health services at some length. It notes that there is a high degree of overlap between the Commonwealth and state and territory-level involvement in Indigenous health 'but that the effect of this overlap on Indigenous health is unclear'.[136]

Further, it discusses the role of the Australian Government in addressing health inequities:

> Commonwealth involvement in a policy area is sometimes argued on equity grounds. While the Commonwealth may be best placed to address equity concerns in some circumstances, the States and Territories also work to improve and ensure equity for their communities. The States and Territories are closer to where services are being delivered and are often best placed to know how equity concerns can be addressed.[137]



Community member Marlene Nabulwad teaching kids in Kunwinjku, the traditional local Aboriginal language. Jabiru, NT.
Photograph: Jason Malouin/Oxfam AUS.

The Campaign Steering Committee supports the need for the clarification of roles and responsibilities among Australian governments to ensure the best health outcomes can be achieved for Aboriginal and Torres Strait Islander peoples.

The Campaign Steering Committee firmly believes that the Australian Government has the responsibility to lead the national approach to the Closing the Gap Strategy. Reform to the federal system should not adversely affect this.

(b) Continued national leadership of the Closing the Gap Strategy

In December 2013, COAG decided not to renew the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*.[138] The Campaign Steering Committee is not wedded to a national partnership agreement to further the Closing the Gap Strategy as it pertains to health. It is, however, concerned to ensure that the substitution of a national partnership agreement with tri-lateral Australian Government agreements with the states and territories and jurisdictional representatives of the Aboriginal and Torres Strait Islander health services, does not weaken or fragment the Closing the Gap Strategy. The tri-lateral agreements are being developed through AHMAC and existing Indigenous Health Partnership Forums.[139]

As highlighted in the Campaign Steering Committee's two previous reports,[140] there have been significant cuts to mainstream health expenditure in Queensland,[141] New South Wales[142] and South Australia in recent years – particularly to preventative health programmes.[143]

While not aimed at Aboriginal and Torres Strait Islander people, services or programmes, these cuts are likely to have disproportionate and detrimental impacts on preventative health efforts in these jurisdictions among Aboriginal and Torres Strait Islander peoples.[144] One critic has highlighted the likelihood for increases in cardiovascular diseases, diabetes and mental health conditions over time.[145]

As argued in last year's report, the Campaign Steering Committee believe such jurisdictional health cuts demonstrate the need for **greater** Australian Government leadership to ensure a consistent national approach in the implementation of the Closing the Gap Strategy. They demonstrate the need for **stronger** and nationally consistent agreements (whether struck nationally or otherwise) to continue the Closing the Gap Strategy.

Maintaining a national and consistent effort under Australian Government leadership could, to some degree, help immunise the effort to close the health gap from the ever-turning wheels of state and territory-level political fortune.

Recommendation 2

That the Australian Government should continue to lead the COAG Closing the Gap Strategy.

Elements of the Closing the Gap Strategy that have been discontinued in the past year

The Campaign Steering Committee is also concerned about the de-commissioning of the COAG Reform Council in the Budget measures for 2014–2015.[146] This independent body has provided an authoritative annual report across many areas of COAG activity and, in particular, the Closing the Gap Strategy.

In relation to the Closing the Gap Strategy, the COAG Reform Council was the only body that provided an independent and national assessment of progress against the Closing the Gap Targets – it independently monitored the performance of the Australian and the state and territory governments. In this way it complemented – not duplicated – the Prime Minister's annual progress report. The Department of the Prime Minister and Cabinet's Portfolio Budget Statement indicated, that with the abolition of the COAG Reform Council, it would continue to monitor state and territory performance.[147] The Campaign Steering Committee is concerned that this does not clarify how independent and national-level annual public reporting on progress against the Closing the Gap Targets will occur.

Given the importance of strengthening efforts to close the Aboriginal and Torres Strait Islander health gap and disadvantage more broadly, the lack of clarity around who will report in future on the Closing the Gap Strategy is of great concern. The ongoing need for this important monitoring role should be addressed by the Australian Government as a priority.

Further, the Campaign Steering Committee also emphasises its concern that the Australian Government will provide no further funds to the Closing the Gap Clearinghouse. Since its establishment in 2007 the Clearinghouse has played an important role in establishing and setting out the evidence base for the Closing the Gap Strategy.[148]

The Australian Government has also discontinued the National Indigenous Drug and Alcohol Committee, with its functions to be absorbed within the Australian National Council on Drugs.[149] This will further limit the Government's access to Aboriginal and Torres Strait Islander specialist advice and leadership. Regrettably the decision means there is now no national voice or committee on alcohol and other drugs for Aboriginal and Torres Strait Islander peoples.

Recommendation 3

That the Australian Government revisit its decision to discontinue the National Indigenous Drug and Alcohol Committee.

2.2 The Indigenous Advancement Strategy and the Closing the Gap Strategy

The Indigenous Affairs priorities of the Australian Government are:

- Getting children to school;
- Getting adults to work; and
- Building safer Indigenous communities.[151]

The Indigenous Advancement Strategy (IAS) is the vehicle for delivering these three priority objectives. The IAS commenced on 1 July 2014 and consolidated more than 150 individual programmes and activities into five broad-based programme streams that are being coordinated from the Department of the Prime Minister and Cabinet (PM&C). It does not include the bulk of health and mental health programmes that remain located in the Department of Health. The primary exception is the 'Social and Emotional Wellbeing Programme' which was transferred to PM&C.[152]

The 2014–15 Budget, delivered in May 2014, detailed that the IAS consolidation will save the Australian Government $534.4 million over five years through programme rationalisation.[153] The Campaign Steering Committee supports the reduction of red tape and duplication. However, the lack of detail on how these savings or cuts will apply and their impact on services and health outcomes is an ongoing concern.

The Campaign Steering Committee also notes that the IAS has been developed with minimal input from Aboriginal and Torres Strait Islander peoples and their representative organisations, apart from the Indigenous Advisory Council. This is despite the Australian Government seeking greater levels of engagement with Aboriginal and Torres Strait Islander peoples within the IAS itself. As noted by the Aboriginal and Torres Strait Islander Social Justice Commissioner:

> The Federal Government has outlined its intention for a new engagement with Aboriginal and Torres Strait Islander people. To achieve this goal, surely it must at least have a discussion with us before proceeding with a radical re-shaping of government policy that so profoundly affects us? The Aboriginal and Torres Strait Islander leadership stands ready for this conversation with Government. All it takes is an assurance that we will be heard.[154]

Without such engagement, these sweeping changes to programme funding have and continue to cause anxiety within Aboriginal and Torres Strait Islander organisations across the country. As further noted by the Aboriginal and Torres Strait Islander Social Justice Commissioner:

> To give some idea of the magnitude of the changes confronting the Department of the Prime Minister and Cabinet is the rationalisation of approximately 150 programs and activities down to five. This affects about 1,440 organisations with just over 3,000 funding contracts. On top of this, the Department will have to manage a budget cut in the vicinity of $400 million over the next four years.[155]

In November 2014, the Australian Government stated it would delay announcing the assessment of IAS applications until March 2015.[156] This delay underlines the difficulties of the process and is a further cause of anxiety for Aboriginal and Torres Strait Islander organisations.

The new policy framework developed by COAG (as reflected in the National Indigenous Reform Agreement and the Closing the Gap strategy) represents a comprehensive, coherent and ambitious agenda for reform. The key challenge from this point lies not so much in further policy development as in effective implementation and delivery.[150]

Strategic Review of Indigenous Expenditure

The five IAS programme streams are set out in the text box below.

The five programme streams of the Indigenous Advancement Strategy[157]

- **Jobs, Land and Economy Programme**
  This programme aims to get adults into work, foster viable Indigenous business and assist Indigenous people to generate economic and social benefits from land and sea use and native title rights, particularly in remote areas.
- **Children and Schooling Programme**
  This programme focuses on getting children to school, improving education outcomes including Year 12 attainment, improving youth transition to vocational and higher education and work, as well as, supporting families to give children a good start in life through improved early childhood development, care, education and school readiness.
- **Safety and Wellbeing Programme**
  This programme is about ensuring the ordinary law of the land applies in Indigenous communities, and that Indigenous people enjoy similar levels of physical, emotional and social wellbeing enjoyed by other Australians.
- **Culture and Capability Programme**
  This programme will support Indigenous Australians to maintain their culture, participate equally in the economic and social life of the nation and ensure that Indigenous organisations are capable of delivering quality services to their clients.
- **Remote Australia Strategies Programme**
  This programme will address social and economic disadvantage in remote Australia and support flexible solutions based on community and government priorities.

Generational change takes time, commitment and a long-term strategic approach to ensure success. While we welcome the Australian Government's IAS focus on improving employment, education outcomes and community safety, the Campaign Steering Committee believes the IAS needs to be coordinated within the national COAG Closing the Gap Strategy. Without such a national, coordinated approach, Indigenous Affairs is at risk of splitting along departmental and jurisdictional lines and becoming less effective and efficient.

Articulating and strengthening links between the IAS and the Closing the Gap Strategy will ensure that the IAS would achieve its goals. This is because a focus on health and wellbeing is fundamental to achieving improvements in school attendance, employment and safer communities.

As set out in the report of Mr Andrew Forrest, *Forrest Review – Creating Parity*, employment cannot be addressed in isolation, as:

> A significant proportion of these [unemployed Aboriginal and Torres Strait Islander] individuals suffer from lifestyle and health conditions that pose considerable obstacles to employment...[158]

The report of the Forrest Review also stresses the importance of maternal and early childhood health as key determinants of employment later in life.[159]

The IAS could also be used to support the recruitment and employment of Aboriginal and Torres Strait Islander staff in health services. As discussed in the Campaign Steering Committee's *Progress and priorities report 2014*, the 2011 Census results show that health services (including, but not limited to, ACCHS) employ 14.6 percent of employed Aboriginal and Torres Strait Islander people. Health services are thus the single biggest 'industry' source of employment, which has expanded by almost 4,000 places since 2006.[160]

Health services also provide pathways to employment for community members through internships and 'in-house' training. This reduces welfare dependency and connects individuals, families and communities to the wider economy. Flow-on benefits include the enabling of healthy norms and routines for community members and their families. Investment in health has a multiplier effect in communities beyond the critical improvements in health that they deliver.

The Campaign Steering Committee believes that connecting the IAS to the existing Close the Gap Strategy will bring advantages to both, contributing to a broader, holistic approach that includes health at the national level.

Another important finding of the Reeve study (discussed above) into the 'diabetes gap' was an association between lower levels of school education and higher prevalence of diabetes, possibly due to reduced capacity to access, interpret and act upon information.[161] The study concludes:

> If the significance of education is indicative of the capacity to access and act on health information, health promotion initiatives that provide information about healthy lifestyles and encourage increased engagement with primary care services should aid in prevention through earlier detection of pre-diabetes.[162]

This again underscores the connectedness of education (an IAS priority) and health and the need to develop and expand the linkages between the IAS and the Closing the Gap Strategy for the enhancement of both.

Recommendation 4

That connections between the Indigenous Advancement Strategy and the Closing the Gap Strategy are clearly articulated and developed in recognition of their capacity to mutually support the other's priorities, including closing the health and life expectancy gaps.

2.3 Potential negative impact of proposed Budget measures

The Campaign Steering Committee is concerned about the potential negative impact of proposed measures contained in the 2014–15 Budget.

Reported cuts of up to $130 million over five years from the Tackling Indigenous Smoking programme are of particular concern. While this is now being explained in terms of a 'freeze' on recruitment of staff to the Tackling Smoking and Healthy Lifestyle Teams, which are central to delivery of the programme, it is still not clear what the long-term prospect for the programme is. Following a review, the future shape of the programme is due to be announced in early 2015. The freeze on recruitment reduces the reach of the programme, undermines the momentum built to date, and erodes the programme's goodwill developed with Aboriginal and Torres Strait Islander communities.

The reduction in Aboriginal and Torres Strait Islander smoking rates by 10 percent over the last decade, as well as the marked increase in the number of Aboriginal and Torres Strait Islander people not taking up smoking, demonstrates that efforts to cut smoking rates are working and that further gains are possible. As explored in Chapter 1, there is a clear link between smoking and poor outcomes in child mortality and life expectancy.

The recommendation below requires not only maintaining current levels of funding, but increasing funding as the Tackling Smoking and Healthy Lifestyle Teams are fully established and start to consolidate and expand their activities. Reducing smoking among Aboriginal and Torres Strait Islander mothers while pregnant should remain a particular focus, along with prevention of take-up by Aboriginal and Torres Strait Islander children and youth, through a population health campaign approach.

Recommendation 5

That the Tackling Indigenous Smoking programme is retained and funding is increased above current levels to enable consolidation, improvement and expansion of activities until the gap in the rates of smoking between Aboriginal and Torres Strait Islander and non-Indigenous people closes.

The Campaign Steering Committee is also concerned that the $89 million will be saved by slowing investments in primary health care funding prior to the implementation of the new funding approach and that funding in relation to activities under the expiring *National Partnership Agreement on Indigenous Early Childhood Development* will not be replaced.[163]

As noted in the Forrest Review, reducing funding for early childhood programmes is short-sighted in terms of health outcomes among the resulting adult population. It is also an incredibly inefficient way of making cuts – a dollar saved in the early childhood years may result in many more dollars being spent later on:

> If we get early childhood development and school education right, we don't need to invest in or waste money by the billions in other areas as we do now. Measures relating to early childhood and school education are a long-term fix.[164]



Hayley Walker, Nahomi Sandry, Felicity Hunt at Nowra High School's Close the Gap Day. The girls are holding signs listing their wish or pledge about the future. Photograph: Peter Izzard/Oxfam AUS.

Recommendation 1 of the Forrest Review is for all governments to prioritise investment in early childhood, from conception to three years of age.[165] While the Campaign Steering Committee has concerns with the Forrest Review including the breadth of its recommendations,[166] nonetheless it wholeheartedly supports the recognition of the importance of early childhood development. At the time of writing this report the Australian Government was yet to respond to the Forrest Review.

The Campaign Steering Committee also notes the creation of the *Indigenous Australians' Health Programme* and the new funding allocation methodology for Indigenous health grants.[167] The Campaign Steering Committee supports a new funding formula for Aboriginal and Torres Strait Islander health services that is developed with the full and effective participation of Aboriginal and Torres Strait Islander peoples and their representative organisations.

The formula must be indexed for population growth and inflation, be geographically equitable and focus on areas with poor health outcomes and inadequate health services. Further, the evidence which demonstrates that ACCHS have inherent advantages as the provider of choice in terms of both better access and higher quality of service is to be utilised in developing this funding allocation.[168]

The 2014–15 Budget and subsequent related developments also contains a number of proposed 'mainstream' measures that, if passed into law, will likely have a disproportionate impact on Aboriginal and Torres Strait Islander health. These include:

- The various proposed changes by the Australian Government regarding a co-payment for the Medicare Benefits Scheme (MBS) and the proposed increase to co-payments to the Pharmaceutical Benefits Scheme (PBS).[169] The Campaign is firmly of the view that increasing out-of-pocket expenses for health care will further entrench existing barriers to equitable healthcare access for Aboriginal and Torres Strait Islander peoples.
- The cuts to preventative health programmes in the budget.[170] Preventative health initiatives could also have significant impacts on Aboriginal and Torres Strait Islander peoples because of the negative effect this will have on addressing chronic disease. As outlined in Chapter 1 of this report chronic disease is a significant contributor to the health equality gap.
- The proposal to withdraw funding from hospitals.[171]

In Chapter 3 the Campaign Steering Committee briefly considers the impact of proposed welfare reforms on Aboriginal and Torres Strait Islander youth.

3 Establishing effective pathways for positive change – an analysis by the Campaign Steering Committee



Abraham Dakglawuy teaches Keith Naborlhborlh traditional painting as part of Children's Ground Morle Boy program. Kakdu National Park, NT. Photograph: Jason Malouin/OxfamAUS.

3.1 Staying to the path

The Campaign Steering Committee, while sobered by the size of the task remaining, is heartened by small but significant absolute life expectancy gains reported in 2010–2012. Further, it is more convinced than ever of the imperative for patience and that a focus is kept on the long-term, generational impact of the Closing the Gap Strategy. Further a sustained and targeted focus improving access to appropriate services is required.

As discussed in our *Progress and priorities report 2014*, the life expectancy estimate for 2010–2012 is the first new estimate published within the lifetime of the Closing the Gap Strategy – just two and a half years after the July 2009 commencement of the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and the Indigenous Chronic Disease Package. As we have noted, the 2010–2012 life expectancy estimate therefore should be considered as akin to a baseline life expectancy estimate against which to measure progress until 2030 and beyond.

As outlined in Chapter 1, New Zealand Maori life expectancy over the past two decades can be usefully compared to the gains made by Aboriginal and Torres Strait Islander peoples to assess the latter's progress, as set out in Table 5. The table includes life expectancy estimates for Maori men and women in 2000–2002, 2005–2007 and 2010–2012.

Life expectancy comparisons between Australia and New Zealand should be approached with caution because of different methodologies to make estimates. Nevertheless the comparison is a useful indicator and suggests that the life expectancy of Aboriginal and Torres Strait Islander peoples today is about a decade behind that of the Maori.

Table 5: A comparison of Maori and Aboriginal and Torres Strait Islander life expectancy in 2010–2012, by gender[173]

Indigenous peoples	Years	Male	Female
Maori	2010–2012	72.8 years	76.5 years
	2005–2007	70.4 years	75.1 years
Aboriginal and Torres Strait Islander	2010–2012	69.1 years	73.7 years
Maori	2000–2002	69.0 years	73.2 years

As can be seen in Table 5 above, the comparison suggests what long term focused action towards achieving health equality for Aboriginal and Torres Strait Islander peoples can yield valuable results. In 2010–2012 the Closing the Gap health reforms associated with the Closing the Gap Strategy were just getting started. Because of this time lag, the Campaign Steering Committee believe that significant increases in life expectancy, like those seen among the Maori, should be expected before the early 2020s if the national effort to close the gap is maintained.

> The need for a long-term approach and bipartisan support across the political divide [for addressing Aboriginal and Torres Strait Islander disadvantage] was stressed by those attending consultations across Australia and in the hundreds of written submissions to the review. First Australians and those working with them are rightly cynical about new government reform and how long it will last. The fundamentals of the… Closing the Gap strategy have bipartisan support and give us solid ground to build on.[172]
>
> The Forrest Review

New Zealand efforts to close the Maori health equality gap

Since 1992, the New Zealand Government's Maori health policy objectives have required regional health authorities and the Public Health Commission to be guided by an objective 'to improve Maori health status so that in the future Maori will have the same opportunity to enjoy the same level of health as non-Maori'. By this, services must recognise the special needs and cultural values of Maori.[174]

This objective was to form the basis of much of the growth and development of Maori health initiatives throughout the 1990s.[175] A Maori health branch of the New Zealand Ministry of Health was established in 1993. In 2000, it became a directorate.[176] A Maori Capacity and Capability Plan was released in 2001. The Plan sought to build Maori management and workforce capacity, and to strengthen the knowledge and awareness of Maori health issues across the entire health system, including within the Ministry of Health and Maori health directorate. Consultation on the *He Korowai Oranga* (the Maori Health Strategy) began in the same year.[177]

The *Public Health & Disability Act 2000* (NZ) now incorporates a number of significant references to Maori health. In particular, it requires district health boards to establish and maintain processes to enable Maori to participate in and contribute to strategies for Maori health improvement.[178] Part 3 of the Act provides for the establishment of district health boards and sets out their objectives and functions. They include the objective of reducing health disparities by improving health outcomes for Maori and other population groups, and to reduce, with a view to eliminating, health outcome disparities between the various population groups.[179]

The Ministry of Health today continues to describe Maori health inequality as unacceptable, and continues to work towards equality as a priority.[180]

The Campaign Steering Committee believes we will start to see reductions in cardiovascular disease, indeed all chronic disease, among Aboriginal and Torres Strait Islander people as the new services, health checks, preventative health campaigns and other initiatives take effect. Assessing the impact of these measures requires a realistic understanding of the lag times between the rollout of programmes and the availability of measurements to assess their impact. The same applies to the effort to close the gap more broadly.

3.2 The role of culture

As noted, creating better connections between the IAS and Closing the Gap Strategy could strengthen existing responses to school attendance, employment and community safety and help improved health outcomes. The IAS could also provide a further building block – culture – to enhance the Closing the Gap Strategy. This is entirely consistent with the position of the Health Plan that asserts the central place of culture in affecting positive outcomes in the health of Aboriginal and Torres Strait Islander peoples.[181]

Culture is not an 'add-on' but rather underpins effective service and programme delivery. The role of culture as an additional building block in an enhanced Closing the Gap Strategy is discussed in the text box below.

Culture, the Indigenous Advancement Strategy and an enhanced Closing the Gap Strategy

In the context of service and programme delivery, 'culture' refers to the cultural underpinnings of Aboriginal and Torres Strait Islander family and community life as well as cultural activities and other expressions of culture. A building block based on the importance of culture would make a decisive contribution to the Indigenous Affairs priorities of the Australian Government in ways which may not be currently considered explicitly by the IAS and the Closing the Gap Strategy. For example:

- A recent Australian National University study of Aboriginal and Torres Strait Islander child truancy by Biddle found that there were strong associations between family functioning and truancy. In fact, household stress, housing issues and family crises were the most important predictors of school non-attendance.[182] Strengthening families, including by supporting the cultural underpinning of family life, is likely to result in improved school attendance.
- Dockery's analysis of the 2008 NATSISS identified Aboriginal and Torres Strait Islander people with strong cultural attachment are significantly more likely to be in employment than those with moderate or minimal cultural attachment.[183] Furthermore, Aboriginal and Torres Strait Islander people who participate in cultural activities and who speak Indigenous languages are more likely to be employed than those who do not.[184] While the casual factors are the focus of continuing research, the data suggests that positive cultural participation will contribute to supporting employment outcomes.
- It should be noted that cultural industries provide economic opportunities for Aboriginal and Torres Strait Islander peoples. In fact, the practice and production of Indigenous visual arts and the employment it generates is a multi-million dollar industry.[185] In 2006, it was reported that 12 percent of Aboriginal and Torres Strait Islander people in remote areas received payment for making arts or crafts; performing theatre, music, or dance; or writing or telling stories.[186]

3.3 Including access to services as a measure of success

The COAG Reform Council closes its final report on the Closing the Gap Strategy questioning whether the indicators that the health and life expectancy gap is closing need to be reconsidered. In particular, it questions the utility of the exclusive focus on improved outcomes (when such outcomes may take many years to show themselves). In this context it proposes broadening them to include improved access to health services, specialists, medications and other indicators of increased opportunity to be healthy in addition to outcome measures.[187]

This approach is in line with the Campaign Steering Committee's often stated belief that it is improved access to health services that will, over time, translate into improved outcomes. Access to proximal, available and culturally appropriate services is prerequisite to improved health outcomes.

The COAG Reform Council notes that the current indicators give a good overview of health behavioural risk factors (smoking, obesity and alcohol consumption) contributing to the burden of chronic disease affecting Aboriginal and Torres Strait Islander people. It also measures the burden of death from chronic disease itself. However, as highlighted in Chapter 1, it critically fails to account for the fact that these conditions are also treatable and manageable conditions with effective assistance from appropriate health services. In other words, deaths as a result of both the risk factors and chronic conditions are not inevitable if appropriate interventions occur.

To illustrate this point, the COAG Reform Council highlights the difference in Aboriginal and Torres Strait Islander and non-Indigenous survival rates from cancer in 1999–2007 in New South Wales, Queensland, Western Australia, and the Northern Territory – as set out in Table 6 below.

Table 6: The difference in Aboriginal and Torres Strait Islander and non-Indigenous survival rates from cancer in 1999–2007 in New South Wales, Queensland, Western Australia, and the Northern Territory, all levels of remoteness[188]

Cancer	Aboriginal and Torres Strait Islander survival rate	Non-Indigenous survival rate
All cancers	40 percent	52 percent
Lung cancer	7 percent	11 percent
Breast cancer in women	70 percent	81 percent
Bowel cancer	47 percent	53 percent
Prostate cancer	63 percent	72 percent
Cervical cancer	51 percent	67 percent

The gap in survival rates can be explained by factors such as advanced cancer at diagnosis, reduced access to and uptake of treatment, higher rates of comorbidities, and language barriers.[189]

The current indicators and targets do not account for access to health services. Access is a critical factor in closing the gap. Accessing health services and appropriate interventions on treatable conditions can and does prevent deaths and reduce the burden of disease.

And, despite the much higher health needs of Aboriginal and Torres Strait Islander peoples, the most recent comparable data suggests that their overall access to health services is only marginally higher than that of non-Indigenous people and considerably less than appropriate for the level of need.[190]

The 2011 review of the *National Indigenous Reform Agreement* referred to work on an improved measure for access compared to need to the NIRA Performance Information Management Group. This reference found that available measures of access compared to need were too conceptually complex for public reporting under the Agreement framework (this work will shortly be published by the AIHW).[191]

However, the Campaign Steering Committee supports the development of other proxy indicators to provide insights into how use and availability of health services affects Aboriginal and Torres Strait Islander life expectancy. These indicators should complement existing measures on behavioural risk factors as part of an enhanced Closing the Gap Strategy.

Recommendation 6

That proxy indicators are developed to provide insights into the impact of the use and availability of health services on Aboriginal and Torres Strait Islander health and life expectancy outcomes.

3.4 Building on the strengths of Aboriginal Community Controlled Heath Services

It is essential to invest in those services which have been shown to perform best in the identification of risk factors, performance of health checks, care planning, and the management of Aboriginal and Torres Strait Islander patients. With their model of comprehensive primary health care and community governance, ACCHS have reduced unintentional racism, barriers to access to health care, and are progressively improving individual health outcomes for Aboriginal and Torres Strait Islander people.[193]

In 2012–2013, 260 services delivered primary health-care, substance-use rehabilitation and treatment services, and social and emotional wellbeing (including Bringing them home and Link-Up counselling and family reunion) services primarily to Aboriginal and Torres Strait Islander people. They report to the Australian Government and these services' reports are published regularly.[194] Of these, 205 are defined as Indigenous-specific primary health organisations (ISPHO) including 175 ACCHS.[195]

In their 2014 analysis of the performance of ACCHS, Panaretto and colleagues looked at the evidence supporting Aboriginal and Torres Strait Islander people's relative use of ACCHS and general practice in Queensland by comparing ABS 2011 Census data and ACCHS service use data. They report that 'access to services is critical and, where ACCHS exist, the community prefers to and does use them'.[196] In addition the study found that:

> [T]he number of Aboriginal patients making one visit in 2 years to… regional ACCHSs is higher than the resident Indigenous population… For 11 of 17 services, over 60% of Aboriginal people living in their catchments within a 30-minute drive had visited in the 2 years to September 2012… for six of these ACCHSs, all classified Remoteness Area 2 or 3, the data suggest up to 100% of the Aboriginal population living within a 30-minute drive are using their services, with many patients travelling longer than 30 minutes.[197]

Also, as set out in the text box below, Panaretto and colleagues surveyed the literature to evaluate whether ACCHS performed better for Aboriginal and Torres Strait Islander people than general practices. This was particularly in relation to the prevention, detection and treatment of chronic disease. Their findings provide strong support for properly resourced ACCHS. The positive effectiveness of ACCHS has also been documented in recent Department of Health research.[198]

It is critical that ACCHS continue to be funded and expanded to ensure the Aboriginal and Torres Strait Islander population is able to access them. This becomes particularly important when considering the potential significant health gain to be made by the high proportions of treatable and preventable conditions that are not currently being addressed as shown in the NATSIHMS (discussed in Chapter 1).

A good start in developing the services use and access indicators we propose would be to link them to meeting existing services gaps within ACCHS. The two key advantages of ACCHS are better access and a more culturally appropriate, community-based holistic approach, which in many ways offers, in the long term, a better return on investment of the health dollar.

Decades of Indigenous controlled health service delivery have seen the Aboriginal community controlled health sector become a leading provider of primary health care services and a significant employer of Aboriginal and Torres Strait Islander peoples. This sector has mature organisations with a depth of expertise and capabilities, particularly in remote and regional areas, surpassing the level of mainstream health services in some areas.[192]

Mr Warren Mundine, Chair of the Indigenous Advisory Council, 2014

Panaretto and colleagues compare the performance of Aboriginal Community Controlled Health Services in Queensland with general practice[199]

(extract, without references)

The medical literature has many reports of well-implemented research programs, often integrated with everyday care in ACCHS, showing improved health outcomes. Sexual health, maternal and child health, smoking cessation and cardiovascular programs have been successfully run and monitored in ACCHS.

Care delivered in ACCHS for prevention and chronic disease management appears to be equal to if not better than that delivered by general practices. Queensland Aboriginal and Islander Health Council… data show good performance in risk factor monitoring and the management of hypertension and chronic disease…

The Torpedo study, a randomised controlled trial of the use of an electronic decision-support system measuring absolute cardiovascular risk, shows ACCHS outperforming general practices in managing risk… Data collected in late 2011 show that the ACCHS sites had significantly more patients at high risk being prescribed best-practice medications than the general practice sites at baseline, and this gap was sustained through the intervention period.

Data from the Australian Primary Care Collaboratives (APPC) program, often not published, can examine performance between ACCHS and general practice clusters. Data for 2012, from Wave 2 of the APCC e-health program, show that ACCHSs in Queensland had more diagnoses coded (as opposed to use of free text) in medical histories and a higher proportion of medications on their current medication lists prescribed within the preceding six months than their general practice counterparts.

This pattern is similar to that reported for cardiac and diabetes care in 2013 and seen in recent years in the QAIHC Closing the Gap Collaborative, where ACCHS were the higher performers in identification of risk factors and completion of health checks.

In 2012–2013, the most common service gaps reported by all 260 organisations in the service reports were around mental health and social and emotional wellbeing (62 percent of organisations).[200] The existence of this gap provides support for an increased focus on mental health and social and emotional wellbeing services and programmes within an enhanced Closing the Gap Strategy.

But equally, a concerted effort is needed to ensure ACCHS and ISPHO are properly resourced to address chronic disease and services for mothers and babies. Nearly half of all 260 organisations reported alcohol, tobacco and other drugs (48 percent) and youth services (47 percent) as service gaps in 2012–2013.[201] Prevention and early detection of chronic disease was reported as a gap by 45 percent of organisations.[202]

3.5 Building an Aboriginal and Torres Strait Islander health workforce

Equally critical to the above is the training of an Aboriginal and Torres Strait Islander health workforce, and support for the Aboriginal and Torres Strait Islander professional bodies. These bodies are working hard to increase the number of health professionals in the various health professions to achieve employment/population parity within them.

Such a workforce will also assist to shape a culturally safe, high quality health care system that is capable of supporting real improvements in Aboriginal and Torres Strait Islander health outcomes. Further, the health sector as the largest employer of Aboriginal and Torres Strait Islander people provides an exemplar for creating sustainable jobs and career pathways. Investing in the Aboriginal and Torres Strait Islander health workforce, including professional bodies, has a multiplier effect, of improved health and employment outcomes and their associated benefits.

The text box below provides an example of these programmes, and in particular, the benefits of investing in Aboriginal and Torres Strait Islander youth.

Murra Mullangari – Pathways Alive and Well[203]

In 2013, the Australian Indigenous Doctors' Association (AIDA) auspiced the inaugural *Murra Mullangari – Pathways Alive and Well* programme. This national Aboriginal and Torres Strait Islander health careers programme was held in partnership with the following peer Indigenous peak health organisations: Indigenous Allied Health Australia; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; National Aboriginal Community Controlled Health Organisation; Australian Indigenous Psychologists Association; Indigenous Dentists' Association of Australia; and National Aboriginal and Torres Strait Islander Health Workers' Association.

Thirty students from years 10, 11 and 12 participated in the programme which aimed to:

- increase knowledge of health careers;
- increase knowledge of pathways into tertiary study; and
- build the aspiration and confidence of Aboriginal and Torres Strait Islander students to stay in the education pipeline and achieve a career within the health profession.

With funding from the (then) Commonwealth Department of Education, Employment and Workplace Relations, the programme was delivered in two components over a period of six months. The first component, a one-week residential workshop in Canberra, provided students with: information about pathways into vocational and higher education; knowledge of a broad range of health professions; the opportunity to network with Indigenous health professionals and leaders; and exposure to a range of national institutions. The second component, mentoring, allowed programme participants to build upon the experiences gained during the residential workshop by connecting the participant with an Indigenous mentor within their desired career.

An in-depth evaluation process of the *Murra Mullangari – Pathways Alive and Well* programme demonstrates that the programme achieved its aims and objectives. Programme participants reported an increase in their knowledge of the various health careers and pathways into university study and vocational education and training. They also reported an increase in their knowledge of the health issues impacting on Indigenous people. Students advised that the programme built their confidence and aspirations toward achieving a career within the health profession. Four programme participants who completed their schooling in 2013 have commenced tertiary studies in health disciplines since the completion of the programme.

3.6 Addressing mental health and suicide prevention as a new priority focus

There is an entrenched mental health crisis among Aboriginal and Torres Strait Islander peoples that must be addressed. Mental health problems, including self-harm and suicide, have been reported at double the rate of that of non-Indigenous people for at least a decade. Recent data suggests the situation is getting worse, as set out in the text box below.

The Aboriginal and Torres Strait Islander mental health gap

- **Psychological Distress:** In 2012–13, 30 percent of respondents to the AATSIHS over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview.[204] That is nearly three times the non-Indigenous rate.[205] In 2004–05, high and very high psychological distress levels were reported by 27 percent of respondents suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.[206]
- **Mental Health Conditions:** Over the period July 2008 to June 2010, Aboriginal and Torres Strait Islander males were hospitalised for mental health-related conditions at 2.2 times the rate of non-Indigenous males; and Aboriginal and Torres Strait Islander females at 1.5 times the rate of non-Indigenous females.[207] Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.[208]
- **Suicide:** The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate over 2001–10.[209] Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2012, 117 suicides were reported.[210] The OID 2014 Report shows that hospitalisations for intentional self-harm increased by 48 percent since 2004–2005.[211]



Sisters Alicia Engelhardt, 16 and Sophia Engelhardt, 15 from Canberra, ACT. Photograph: Jason Malouin/Oxfam AUS.

The Campaign Steering Committee believes that strengthening social and emotional wellbeing, building resilience and reducing psychological distress is of direct importance to the Indigenous Affairs priorities of the Australian Government and the IAS, in the following ways:

- Among adults who reported high/very high levels psychological distress, 38 percent were unable to work or carry out their normal activities for significant periods of time because of their feelings in the NATSISS 2008.[212] (Note that the AATSIHS data that would connect reported rates of high and very high psychological distress to inability to work in 2012–13 has not yet been published – hence the reliance on NATSISS 2008 data to indicate the connection between high and very high psychological distress and inability to work).
- In the NATSISS 2008, adults with high/very high levels of psychological distress were also more likely to drink at chronic risky/high risk levels (21 percent compared with 16 percent with low/moderate levels of psychological distress) and to have used illicit substances in the previous 12 months to the survey (27 percent compared with 18 percent).[213] Substance abuse is a community safety issue and is associated with violence, child maltreatment, high rates of imprisonment, and other challenges facing communities.
- Promoting social and emotional wellbeing and resilience should also contribute to improving school attendance and performance because it will support children to cope with bullying and racism.[214]

As the Campaign Steering Committee argued in its 2014 report, a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan is needed. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* provides the basis for such a plan.

This should be developed and implemented along with the Health Plan, the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy*. A coordinated implementation process for all four will avoid duplication, be more efficient, and maximise opportunities in this space.

The Campaign Steering Committee notes the Commonwealth funding of a comprehensive evaluation of suicide prevention programmes for Aboriginal and Torres Strait Islander peoples and looks forward to reporting on the findings later this year.[215]

The text box in the margins provides an example of a successful strategy of targeting racism, a preventative measure for addressing mental health issues.

Stop. Think. Respect. Campaign – Using primary prevention to address racism as a social determinant of poor mental health[216]

In 2014, *beyondblue* launched a national anti-discrimination campaign addressing the impact of racial discrimination on the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples. In developing the campaign, *beyondblue* carried out extensive research and consultation with Aboriginal and Torres Strait Islander peoples. The campaign was also guided by an Advisory Group, comprising a mix of representatives from Aboriginal and Torres Strait Islander organisations, other organisations and individuals with specific knowledge and expertise.

The campaign focused on the harmful impacts of subtle forms of interpersonal discrimination, and encouraged everyone in Australia to check their behaviour. With over 3.74 million online views to date, 'The Invisible Discriminator' campaign advertisement has attracted significant community interest.

Preliminary independent evaluation results show that the campaign is having an impact on the target audience of non-Indigenous people aged 25–44 years. Awareness of the prevalence of discrimination increased by up to seven percent when compared to the pre-campaign baseline survey, demonstrating increased awareness of the behaviours which constitute discrimination. There has been a statistically significant reduction in the proportions of people who do not consider that several of the campaign scenarios are discriminatory in nature. Seventy-five percent of people consider that the campaign is raising awareness of the mental health impacts of discrimination. One in five people thought about what they could do to reduce discrimination against Aboriginal and Torres Strait Islander peoples after seeing the campaign.

These results show that investment in primary prevention campaigns can make a difference by tackling the social determinants of ill-health.

Recommendation 7

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* provides the basis for a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan. This is developed and implemented with the Health Plan, the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* implementation processes in order to avoid duplication, be more efficient, and maximise opportunities in this critical field.

3.7 A target to reduce imprisonment rates

The Campaign Steering Committee also recommends that the Closing the Gap Strategy is enhanced by the development of targets to reduce rates of imprisonment and violence and that achieving the targets is funded by a justice reinvestment approach. In doing so we build upon a number of earlier recommendations calling for reform:

- Recommendation 1 of the Aboriginal and Torres Strait Islander Social Justice Commissioner's 2009 *Social Justice Report* that the Australian Government, through COAG, set criminal justice targets that are integrated into the Closing the Gap Strategy.[217]
- Recommendation 2 of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs' June 2011 report, *Doing Time – Time for Doing: Indigenous youth in the criminal justice systems* that the Commonwealth Government endorse justice targets developed by the Standing Committee of Attorneys-General for inclusion in the Closing the Gap Strategy.[218]

Justice reinvestment refers to policies that divert a portion of the funds for imprisonment to local communities where there is a high concentration of offenders. The money that would have been spent on imprisonment is reinvested into services that empower communities to address the underlying causes of crime. This could be a particularly useful way of funding much needed mental health services and programmes.

Of significant concern is the finding in the OID 2014 Report, that mental health (as indicated by rates of psychological distress)[219] and rates of imprisonment and juvenile detention[220] were getting worse over time. This approach could help address both.

As discussed in last year's *Progress and priorities report*, the incidence of mental health conditions and substance abuse problems among the Aboriginal and Torres Strait Islander prison population is apparent. A 2009 survey of New South Wales prisoners found that 55 percent of Aboriginal and Torres Strait Islander men and 64 percent of women reported an association between drug use and their offence. In the same sample group, 55 percent of men and 48 percent of women self-reported mental health conditions.[221] In an even more recent Queensland study, at least one mental health condition was detected in 73 percent of male and 86 percent of female Aboriginal and Torres Strait Islander prisoners; with 12 percent of males and 32 percent of females diagnosed with Post-Traumatic Stress Disorder.[222]

The IAS could also be meaningfully connected to this approach. After all, a prison record can be a major barrier to employment and families with members in prison are put under tremendous financial and emotional stress with the major impact being felt by children – potentially affecting school attendance and performance. Effective implementation of a justice reinvestment programme will immediately reduce the number of victims and make our communities safer.

Recommendation 8

That Closing the Gap Targets to reduce imprisonment and violence rates are developed, and activity towards reaching the targets is funded through justice reinvestment measures.

3.8 Health in all Aboriginal and Torres Strait Islander policy approach

An analysis by AIHW suggests that the social determinants account for a larger proportion of the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians than behavioural risk factors. Individually, social determinants were estimated to be responsible for 31 percent of the gap, compared with 11 percent for behavioural risk factors.[223] Interactions between social determinants and behavioural risk factors were estimated to account for a further 15 percent of the gap.[224]

It is clear that Aboriginal and Torres Strait Islander health outcomes are significantly influenced by many determinants outside the direct control of the health sector. Consequently, it is imperative that policies from outside the health sector are developed considering their impact, positive or negative, on Aboriginal and Torres Strait Islander health outcomes. Unfortunately this is rarely the case.

The Campaign Steering Committee believes that the time has come to ensure that the Aboriginal and Torres Strait Islander health impacts are actively considered in all policies from design through to implementation. This would adequately reflect closing the gap as a national priority. Further work is required to ascertain the best mechanism and processes to achieve this goal.

One option to explore is Health Impact Statements which assess government or other activity for positive, negative and/or unintended health consequences of policy initiatives using the known evidence base, and where an initial assessment indicates a formal health impact assessment could take place. Aboriginal and Torres Strait Islander Health Impact Statements are already being issued in New South Wales,[225] Western Australia,[226] and South Australia[227] but their scope is limited to health policy.

While the types of Health Impact Statements already adopted in Australia at the state-level are different, they all comprise a checklist that policy and programme-developers are required to complete and address. In summary, the issues that they are required address include:

- **Policy development** – Were Aboriginal and Torres Strait Islander stakeholders and representative groups consulted?
- **Policy content** – Have the effects on Aboriginal and Torres Strait health outcomes been identified and addressed? Is the effect disproportionate on Aboriginal and Torres Strait Islander peoples and communities? If so, what measures have been taken to address this?
- **Implementation and evaluation** – Will the policy be implemented and its effects evaluated with Aboriginal and Torres Strait Islander stakeholders?[228]

The Campaign Steering Committee will undertake further work in this area in 2015.

3.9 The implementation of the National Aboriginal and Torres Strait Islander Health Plan

The implementation of the Health Plan provides a significant opportunity to address many of the challenges to closing the health and life expectancy gap raised in this report. It has particular potential for improving Aboriginal and Torres Strait Islander access to appropriate health care. The Campaign Steering Committee believes effective implementation of the Health Plan is essential to achieving the goal of health and life expectancy equality by 2030.

The Health Plan was launched in July 2013 and marked the partial fulfilment of a major commitment by all signatories to the *Close the Gap Statement of Intent* – to develop a comprehensive, long-term plan of action. However the Health Plan is a framework document that requires further elaboration through an effective Implementation Plan to drive outcomes and help close the gap.

In mid-2014, the Assistant Minister for Health, the Hon. Fiona Nash, announced that the Australian Government was beginning work on such an Implementation Plan.[229] The Australian Government is working with the National Health Leadership Forum (NHLF),[230] comprised of national Aboriginal and Torres Strait Islander health peak and professional bodies whose core business is health, in this process.

The Campaign Steering Committee believes that the Implementation Plan requires the following essential elements:

- Set targets to measure progress and outcomes. Target setting is critical to achieving the COAG goals of life expectancy equality and halving the child mortality gap. The *Close the Gap Health Equality Targets*[231] are the starting point for developing these targets;
- Develop a model of comprehensive core services across a person's whole of life with a particular focus, but not limited to, maternal and child health, chronic disease, and mental health and social and emotional wellbeing;
- Develop workforce, infrastructure, information management and funding strategies based on the core services model;
- A mapping of regions with relatively poor health outcomes and inadequate services. This will enable the identification of service gaps and the development of capacity building plans, especially for ACCHS, to address these gaps;
- Identify and eradicate systemic racism within the health system and improve access to and outcomes across primary, secondary and tertiary health care;
- Ensure that culture is reflected in practical ways throughout Implementation Plan actions as it is central to the health and wellbeing of Aboriginal and Torres Strait Islander people;
- Include a comprehensive address of the social and cultural determinants of health; and
- Establish partnership arrangements between the Australian Government and state and territory governments and between ACCHS and mainstream services providers at the regional level for the delivery of appropriate health services.

The Implementation Plan is capable of driving progress towards the provision of the best possible outcomes from investment in health and related services. The Campaign Steering Committee believes if the Implementation Plan contains the essential elements outlined above it can drive significant, rapid and progressive inroads into health and life expectancy gaps.

Recommendation 9

That the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan* include the above essential elements.

Conclusion

This report affirms the need to stay the course with the Closing the Gap Strategy and to be patient for improvements sought to Aboriginal and Torres Strait Islander health and life expectancy – progress which many indicators suggest will be seen in time. It should not be forgotten that the Closing the Gap Strategy commenced in July 2009 and that intergenerational change cannot be expected in less than four years. Processes and programmes require courage and leadership to ensure that their full potential and impact is realised.

The Campaign Steering Committee recognises the value in the new Indigenous Affairs priorities of the Australian Government – improving employment, education outcomes and community safety – and believes the IAS should be better connected to the national, COAG Closing the Gap Strategy that already addresses these areas.

Articulating and strengthening links between the IAS and the Closing the Gap Strategy will strengthen both policies and also ensure that health remains a priority at the national level. It is clear from the evidence that positive health outcomes are connected to achieving the goals of the IAS.

The Campaign Steering Committee remains steadfast in its belief that the road to closing the health gap is embodied in the principles of the *Close the Gap Statement of Intent*. That is, in effective planning and the use of targets, and maintaining the course through long-term policy approaches such as the Closing the Gap Strategy.

It is also critical that Australian governments continue to work with Aboriginal and Torres Strait Islander health leaders and stakeholders to deliver the most effective and efficient health outcomes for Aboriginal and Torres Strait Islander peoples, so that the health gap closes within a generation.

In particular, this requires a new focus on the importance of enabling Aboriginal and Torres Strait Islander people to access appropriate health services, particularly primary health care services. The release of the NATSIHMS in 2014 highlights the burden of undetected chronic disease in Aboriginal and Torres Strait Islander people. Detecting and properly treating and managing these hitherto 'hidden' conditions could significantly contribute to closing the health gap.

The Campaign Steering Committee believes that effectively implementing the Health Plan could drive significant, rapid and progressive inroads into the health and life expectancy gaps.



Andrew Illin-Lovett and Willun Thorpe, both seven at Thornbury Primary School, Vic. Photograph: Bonnie Savage/OxfamAUS.

Who we are

Australia's peak Aboriginal and Torres Strait Islander and non-Indigenous health bodies, health professional bodies and human rights organisations operate the Close the Gap Campaign. The Campaign's goal is to raise the health and life expectancy of Aboriginal and Torres Strait Islander people to that of the non-Indigenous population within a generation: to close the gap by 2030. It aims to do this through the implementation of a human rights-based approach set out in the Aboriginal and Torres Strait Islander Social Justice Commissioner's *Social Justice Report 2005*.[232]

The Campaign Steering Committee first met in March 2006. Our patrons, Catherine Freeman OAM and Ian Thorpe OAM, launched the campaign in April 2007. To date, almost 200,000 Australians have formally pledged their support.[233]

The Close the Gap Campaign is a growing national movement:

- Every year since 2010 the National Rugby League has dedicated a round of matches to Close the Gap. The Close the Gap rounds are broadcast to between 2.5 and 3.5 million Australians each year.
- In 2007 the first National Close the Gap Day was held. It involved five large State events and more than 300 community events. National Close the Gap Day has become an annual event since 2009. Australians across every state and territory participate in this event. Health services, schools, businesses, hospitals, government departments, ambulance services, non-government organisations and others hold events to raise awareness and show support for the Campaign and its goals. Reflecting the importance of the Campaign to nation, it has become the largest and highest profile Aboriginal and Torres Strait Islander health event in the country. On National Close the Gap Day in 2014, 1,300 community events were held involving approximately 150,000 Australians.

The current members of the Close the Gap Campaign Steering Committee are:

Co-chairs

- Ms Kirstie Parker, Co-chair of the National Congress of Australia's First Peoples
- Mr Mick Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, Australian Human Rights Commission

Members

- Aboriginal and Torres Strait Islander Healing Foundation
- Aboriginal Health and Medical Research Council
- ANTaR
- Australian College of Midwives
- Australian College of Nursing
- Australian Human Rights Commission (Secretariat)
- Australian Indigenous Doctors' Association
- Australian Indigenous Psychologists' Association
- Australian Medical Association
- Australian Physiotherapy Association
- Australian Student and Novice Nurse Association
- beyondblue
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- CRANA*plus*
- First Peoples Disability Network
- Heart Foundation Australia

- Indigenous Allied Health Australia
- Indigenous Dentists' Association of Australia
- Menzies School of Health Research
- National Aboriginal and Torres Strait Islander Health Workers' Association
- National Aboriginal Community Controlled Health Organisation
- National Association of Aboriginal and Torres Strait Islander Physiotherapists
- National Congress of Australia's First Peoples
- National Coordinator – Tackling Indigenous Smoking (Dr Tom Calma AO – Campaign founder and former Aboriginal and Torres Strait Islander Social Justice Commissioner)
- Oxfam Australia
- Palliative Care Australia
- PHILE Network
- Public Health Association of Australia
- Royal Australasian College of Physicians
- Royal Australian College of General Practitioners
- The Fred Hollows Foundation
- The Lowitja Institute
- The Pharmacy Guild of Australia
- Torres Strait Regional Authority
- Victorian Aboriginal Community Controlled Health Organisation



Nowra High School's Close the Gap Day. Nowra, NSW. Photograph: Peter Izzard/OxfamAUS.

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‘Close the Gap’ and ‘Closing the Gap’ and the ‘national effort to close the gap’

‘Close the Gap’ was adopted as the name of the human rights-based campaign for Aboriginal and Torres Strait Islander health equality led by the Close the Gap Campaign Steering Committee in 2006.

As acknowledged in the *National Indigenous Reform Agreement*, ‘the Closing the Gap agenda was developed in response to concerns raised with governments by Indigenous and non-Indigenous persons, including through the Close the Gap Campaign and the National Indigenous Health Equality Summit.’ While the Campaign Steering Committee welcome this fact, it has also led to some confusion in the use of terms.

In particular, the term ‘Closing the Gap’ has entered the policy lexicon and has since been used to tag COAG and Australian Government Aboriginal and Torres Strait Islander policy-specific initiatives aimed at reducing disadvantage.

In this report, we use the phrase ‘national effort to close the gap’ to indicate both the popular movement and Australian governments’ efforts to achieve Aboriginal and Torres Strait Islander health equality by 2030. Key components include:

- the commitments in the *Close the Gap Statement of Intent*;
- the Council of Australian Governments’ *National Indigenous Reform Agreement* including the health equality targets therein;
- the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*; and the *National Partnership Agreement on Indigenous Early Childhood Development*;
- the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*; and
- the *Social and Emotional Wellbeing Framework* (currently being renewed) and the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (2013).

CLOSETHEGAP