

**Submission
No 8**

INQUIRY INTO OVERCOMING INDIGENOUS DISADVANTAGE

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The Public Health Association of Australia (PHAA) acknowledges that the causes of persistent poor health among Aboriginal people are complex. The ongoing consequences of the colonial experience with the subsequent destruction of Aboriginal culture and the forced loss of connectivity to the land, an integral part of Aboriginal identity, all constitute an important dynamic in maintaining poor health status.

We support Tom Calma's view that it is simply not credible to suggest that a country as wealthy as Australia cannot fix a health crisis affecting less than three per cent of our citizens.

Improving the health status of Indigenous people, especially high mortality experienced by young adults cannot be achieved simply through technical interventions but also requires working with communities on innovative and diverse programs that strengthens families, promotes community action, economic development and spiritual healing.

Community controlled health services and other community controlled organisations are the main community development vehicles through which Indigenous communities are working together for better health and from which they can build effective partnerships with mainstream institutions and practitioners.

New South Wales is well aware of the problems facing Aboriginal communities; we believe it is time to move away from simply describing the problem to fully resourcing those existing successful programs to reach all people and all communities in our State.

There are a number reports documenting the success stories in promoting and improving health. We commend a number publications including:

1/ Australians for Native Title and Reconciliation; Success stories in Indigenous Health; A showcase of successful Aboriginal and Torres Strait Islander health projects www.antar.org.au/success

2/ Tom Calma: Social Justice Report 2005; Report of the Aboriginal and Torres Strait Islander Social Justice Commissioner

3/ World Health Organisation, Interim Statement of the Commission on Social Determinants of Health 2007, http://www.who.int/social_determinants/resources/interim_statement/en/index.html

At the population level the award-winning work being done by the ACCHO in the far west of our state has demonstrated good health outcomes and should be fully evaluated to determine the reasons for success and rolled out across the State, if appropriate.

The NSW Aboriginal Maternal and Infant Strategy is also showing promising results and requires full recurrent funding commitments and across government support.

Poor educational outcomes among Aboriginal people, with illiteracy rates increasing in some jurisdictions are a major barrier to better health. Programs that encourage greater education and workforce participation should also be considered for recurrent funding and rollout including the Cowra Breakaway Project, the Broulee Public School program, and the population health scholarship program in the Illawarra.

Successful programs have all demonstrated the key is respecting and working with local communities through a sustained effort not linked to repeated 'pilot' programs and short term funding grants. Continued success in improving Aboriginal Health will be achieved through a mix of short and long-term strategies with a particular focus on the early years, in a concentrated effort to break the cycle.

The PHAA has a current national policy that is relevant to this inquiry and I have attached this for the Committee's information. The policy affirms the principles in working with Aboriginal people to improve health and has a number of recommendations that substantiate this.

The NSW Branch would welcome the opportunity to speak to the Committee on this issue or around this policy.



PUBLIC HEALTH ASSOCIATION
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ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH POLICY

This policy reflects the current environment in which Aboriginal and Torres Strait Islander health exists. It complements all existing PHAA policies on Aboriginal and Torres Strait Islander Health and should be read in conjunction with these policies. These policies are:

- Aboriginal health;
- Indigenous Health: the consequences of colonisation;
- Improving Aboriginal and Torres Strait Islander Peoples access to the Food they need for health.

The Public Health Association of Australia notes:

(a) The ‘new’ Aboriginal and Torres Strait Islander national policy context

1. The Australian government introduced a ‘new’ Aboriginal and Torres Strait Islander policy approach in 2004 that is based on concepts such as: shared responsibility, partnership, whole-of-government, regional focus, flexibility and outcomes.¹
2. These concepts are embedded in Aboriginal community control of primary health care services and have been endorsed by government in current policy documents such as the National Aboriginal and Torres Strait Islander Strategic Framework and the Aboriginal Health Framework Agreements.
3. Increasing numbers of Aboriginal and Torres Strait Islander community organisations have signed ‘shared responsibility agreements’ (SRAs) as a condition of receiving Government funds (more than 70 SRAs had been signed by June 2005). Health programs have been included in some of these agreements. For example, the Mulan community in NW Western Australia (WA) signed an agreement to receive \$172,260 from the Commonwealth government to fund petrol bowsers and to receive regular screening for trachoma, skin infections and worms from the WA government; and in return it was required to ensure that kids showered, washed their faces and attended school and the clinic, and that rubbish bins were used and emptied, yards were clean, rents were paid, the rubbish tip was maintained, household pest control happened quarterly, the petrol used was not used for petrol-sniffing, and that these commitments would be monitored.²
4. The Aboriginal and Torres Strait Islander Commission (ATSIC) was abolished on 23 March 2005.³
5. Services previously provided or funded by Aboriginal and Torres Strait Islander Commissioner (ATSIC) will now be provided or funded by ‘mainstream’ government departments. The responsibility for Aboriginal and Torres Strait Islander health

within the Federal Government had been transferred from ATSIC to the Office for Aboriginal and Torres Strait Islander Health Services in the Department of Health and Ageing in 1995.

6. The coordination of the government services to Aboriginal and Torres Strait Islander people will be the responsibility of Indigenous Coordination Centres and the national Office of Indigenous Policy Coordination in Canberra.
 7. There is no elected representative Aboriginal and Torres Strait Islander body to replace ATSIC. The National Indigenous Council is appointed by the minister of Aboriginal and Multicultural Affairs rather than elected by Aboriginal and Torres Strait Islander people. It will only meet four times a year and has few resources.
 8. The Federal Minister for Aboriginal and Multicultural Affairs has stated that the Australian Government will consult and negotiate directly with Aboriginal and Torres Strait Islander people rather than with Aboriginal and Torres Strait Islander organisations (such as Aboriginal Community Controlled Health Services (ACCHSs)), but has not described how this consultation will occur in practice.⁴
 9. There is discussion of even further replacement of Aboriginal and Torres Strait Islander initiatives, organisations and Aboriginal and Torres Strait Islander -specific services with private sector alternatives, including the promotion of the privatisation of Aboriginal and Torres Strait Islander communally-owned land.⁵
 10. Most of this policy discussion and the implementation of these policies has related to Aboriginal and Torres Strait Islander people living in remote Australia, whereas 30% of Aboriginal and Torres Strait Islander people live in major cities, another 20% in inner regional and 23% in outer regional areas, and only 9% live in remote and 18% in very remote areas.⁶
- (b) Improvements in Aboriginal and Torres Strait Islander health can happen and were happening already**
11. Nationally Aboriginal and Torres Strait Islander health outcomes remain much worse than for other Australians (e.g. life expectancy at birth is 56 and 63 years for Aboriginal and Torres Strait Islander males and females compared with 77 and 82 years for all Australians, and Aboriginal and Torres Strait Islander infant mortality is 2.6 times the rate for all Australians)⁷ whilst the health outcomes of Indigenous peoples in comparable countries (USA, Canada and NZ) are much closer to those of other citizens.⁸
 12. Health care expenditure per person is only 18% higher for Aboriginal and Torres Strait Islander Australians in spite of this demonstrable greater health need.⁹
 13. Monitoring changes in Aboriginal and Torres Strait Islander health outcomes remains difficult in most of Australia because of the under-identification of Aboriginal and Torres Strait Islander people in routine health datasets in many states (including NSW which has the highest Aboriginal and Torres Strait Islander population of any state or territory).

14. There are some signs of slow improvement in Aboriginal and Torres Strait Islander health: e.g. there has been a small but steady annual reduction in the NT Aboriginal and Torres Strait Islander mortality rates of every age group (most markedly in children under 5 years) in the last forty years, but this has been less than the greater improvement seen in the total Australian population.¹⁰ However, where there has been good news, this should be celebrated.
15. In inner-city Redfern in 1972, the local Aboriginal community established the first Aboriginal community controlled health service, and since then more than 100 similar services have been established by local Aboriginal and Torres Strait Islander communities across the country. This innovative model of health care is consistent with the much promoted 'comprehensive primary health care' approach which was endorsed by the WHO and UNICEF at their historic meeting in Alma Ata in 1978.
16. There have been other recent achievements in Aboriginal and Torres Strait Islander health: e.g. improved access to appropriate health services, a growing Aboriginal and Torres Strait Islander health workforce, and improved Aboriginal and Torres Strait Islander health research capacity; and achievements in reducing specific diseases, for example: high vaccination rates, blood pressure control and monitoring of Aboriginal patients with diabetes, a rapid decline in the incidence of invasive *Haemophilus influenzae* B infections, reduced hospitalisation from diarrhoeal diseases in children, reduced incidence and severity of trachoma, reduced notifications of some STDs in response to prevention programs, reduced prevalence of markers of hepatitis B, increased access to and uptake of cervical cancer screening and improved diet in response to nutrition programs.^{11, 12}
17. In each state and territory in the late 1990s, the key parties involved in Aboriginal and Torres Strait Islander health (the state or territory health department, the Royal Flying Doctor Service, the local ACCHS sector, ATSIC, and OATSIH in the Australian Department of Health and Ageing) signed Framework Agreements and created new partnership arrangements to ensure Aboriginal and Torres Strait Islander participation in health planning and to better coordinate Aboriginal and Torres Strait Islander health care policy and services.
18. In 2003, the Australian Government and all state and territory governments endorsed the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013, which builds on the 1989 National Aboriginal Health Strategy. The Framework promised to increase resources and access to both Aboriginal and Torres Strait Islander specific and mainstream health programs to reflect greater need, to allow Aboriginal and Torres Strait Islander participation through joint planning processes, and to improve data collection and evaluation.¹³
19. Joint planning and development when complemented by funding arrangements which do not allow Commonwealth / State evasion of responsibilities permits improved access to and operation of primary health care services. This could be achieved by either for example an expanded commitment to funds pooling such as has occurred in the successful Aboriginal Coordinated Care Trials, or having one level of government solely responsible for funding.

20. The Primary Health Care approach incorporates collaboration for health gains. Collaboration for health gains includes discussion of broader social determinants for health. State/ Territory Fora provide a point of collaboration for health gain.

The Public Health Association of Australia affirms the following principles for improving Aboriginal and Torres Strait Islander health:

21. Aboriginal and Torres Strait Islander peoples have special rights to self-determination because they are the original owners of this country.
22. Health services and programs are more likely to be effective if Aboriginal and Torres Strait Islander peoples determine their design and participate in their implementation.
23. ACCHSs are a readily available structure to enable this Aboriginal and Torres Strait Islander participation in health policy and program development and implementation including mental health and community health programs.
24. Aboriginal and Torres Strait Islander health outcomes are determined by historical, social, economic and political determinants as well as primary health care services (the international empirical evidence is most convincing for this claim)^{14, 15}. The histories of colonisation, in particular, have a continuing impact on Aboriginal and Torres Strait Islander health today. Thirty-eight per cent of Aboriginal and Torres Strait Islander people over 15 years have had a family member removed (or were removed themselves) as part of the Stolen Generations¹⁶ – the PHAA President apologised in 1997 for the role of public health workers and organisations in the policies of child removal.
25. Aboriginal and Torres Strait Islander health policy and health care must meet the needs of Aboriginal and Torres Strait Islander peoples in different contexts – it must address the different needs of Aboriginal and Torres Strait Islander peoples living in the towns and the cities as well as those living in the bush.
26. More privatised health care systems have been shown to be more expensive and less effective than largely publicly funded health care systems.¹⁷
27. Governments have an obligation to provide basic services (health care, education, health infrastructure such as water and sewerage, etc.) for their citizens. Shared responsibility includes government responsibility.

The Public Health Association of Australia recommends:

28. The Australian, state and territory governments continue to work with ACCHSs at both a local, regional and national level as the most practical representative Aboriginal and Torres Strait Islander voice on health matters, and at the state or territory level through joint planning arrangements.
29. The Australian government re-affirms its commitment to the details of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 in

the light of recent changes to the Aboriginal and Torres Strait Islander policy environment.

30. The obligations on Aboriginal and Torres Strait Islander organisations, communities and individuals in 'shared responsibility agreements' relate directly to the services and funding being provided. These obligations (beyond the usual requirements for financial accountability) should not be required for basic services (particularly health care services) available to other citizens.
31. Australian and State/Territory governments continue to explore and expand funds pooling models for joint responsibility for funding primary health care delivery as well as planning.

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This Policy was adopted at the Annual General Meeting of the Public Health Association of Australia held on 28th September 2005 in Perth.