



Progress and
priorities report
2014

CLOSE THE GAP

Close the Gap
Campaign
Steering
Committee

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Author: Christopher Holland.

Editors: Andrew Meehan, Indigenous Rights Public Policy and Advocacy Lead, Oxfam Australia; and Andrew Gargett, Senior Policy Officer, Australian Human Rights Commission and Executive Officer, Close the Gap Campaign Steering Committee Secretariat and National Health Leadership Forum Secretariat.

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Cover photograph:

Tiara Isaacs, aged five, Mornington Island. Photograph: Lara McKinley/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 commitment to close the Aboriginal and Torres Strait Islander health and life expectancy gap by 2030 was a watershed moment for the nation. Politicians, the Aboriginal and Torres Strait Islander and non-Indigenous health sector, and human rights organisations, made a public stand in committing to this agenda. And so did the Australian public. To date almost 200,000 Australians have signed the close the gap pledge¹ and approximately 140,000 Australians participated in last year's National Close the Gap Day.² This is the generation that has taken on the responsibility to end Aboriginal and Torres Strait Islander health inequality.

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

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

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

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

- the implementation of the *National Aboriginal and Torres Strait Islander Health Plan 2013–23* (Health Plan)³ in partnership with Aboriginal and Torres Strait Islander peoples;
- continuing to build partnerships with Aboriginal and Torres Strait Islander peoples for planning and service delivery; and
- long-term funding for the national effort to close the gap, as currently delivered through national partnership agreements, and the quarantining of close the gap programs and related initiatives in ongoing reviews of the health system at state, territory and federal levels.

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

Further, the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*⁴ was launched in June 2013. The implementation of this strategy, the renewal⁵ of the *Social and Emotional Wellbeing Framework*,⁶ and a new alcohol and other drug (AOD) strategy anticipated in 2014 provide significant opportunities to progress both Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing policy and planning alongside the implementation of the Health Plan.

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

Investment in the national effort to close the gap must continue, and the cuts to health services that occurred in the past year should not be allowed to have a negative impact. The \$1.57 billion *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*⁷ expired in June 2013, and the \$564 million *National Partnership Agreement on Indigenous Early Childhood Development* will expire in June 2014.⁸ The upkeep of these foundational, nationally coordinated agreements and the continuation of guaranteed funding over significant spans of time constitutes the third critical area of continuity. Such are the 'fuel' that will drive the national effort to close the gap over the next agreement cycle and beyond.

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

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

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



Deadly Sista Girlz, a community group for Indigenous women and the Deadly Jarjums, an off-shoot of the group, for kids aged five to 17. Coffs Harbour, NSW. Photograph: Jason Malouin/OxfamAUS.

The Close the Gap Campaign Steering Committee calls:

- For multiparty resolve and commitment to close the Aboriginal and Torres Strait Islander health and life expectancy equality gap by 2030 to continue, and for policy continuity during the term of the new Australian Government.
- For the completion of the implementation of the *National Aboriginal and Torres Strait Islander Health Plan 2013–23* in genuine partnership with Aboriginal and Torres Strait Islander peoples and their representatives at the national level by:
 - Establishing a clear process that ensures a national implementation strategy is developed.
 - Finalising a national implementation strategy within 12 months. This strategy should include service models, address health infrastructure needs, contain strategies to ensure financing over long periods, and build the health workforce, as well as develop measurable benchmarks and targets to monitor progress.
 - Moving to an implementation phase, by securing the necessary funding to fully implement the plan.
- For the Australian Government to forge an agreement through the COAG process on a new *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and *National Partnership Agreement on Indigenous Early Childhood Development*.
- For the Australian Government to strengthen the national effort to close the gap by:
 - Focusing on expanding health services to meet need, particularly in the areas of mental health, maternal and child health and chronic disease. This should include a systematic inventory of service gaps, and planning to close these gaps on a region-by-region basis with a focus on health services in all areas of Australia. Further steps could also be taken to improve access to medicines. E-health systems should be utilised to enhance continuity of care.
 - Developing a dedicated Aboriginal and Torres Strait Islander mental health plan and otherwise implementing the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and completing and implementing the renewed *Social and Emotional Wellbeing Framework* and the planned AOD strategy.
 - Developing a whole-of-government mechanism across sectors and portfolios to drive an integrated response to health issues and their social and cultural determinants, including the impacts of intergenerational trauma.
 - Developing specific COAG Closing the Gap Targets in relation to incarceration rates and community safety in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, as well as state and territory governments.
 - Developing formal mechanisms that ensure long-term funding commitments, including the national partnership agreements, are linked with progress in closing the health equality gap.
 - Developing a new administrative mechanism to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis that reflects both population size and an index of need. Utilising funds to produce the best return on investment.
 - Introducing and passing legislation to formalise a process for national monitoring and reporting on the national effort to close the gap in accordance with benchmarks and targets. This legislation should include a requirement for this process to be undertaken in partnership with Aboriginal and Torres Strait Islander peoples and their representatives. It should also have a sunset clause of 2031 – the year after the date by which all parties have committed to close the gap in health equality.

Introduction

In March 2008, the then Australian Government and Opposition in signing the *Close the Gap Statement of Intent* committed to closing the health equality gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2030.

They were followed by the then Governments and Opposition Parties in 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.

The *Close the Gap Statement of Intent* is a document with national importance which provides both the Close the Gap Campaign and Australian governments with a blueprint for closing the health equality gap between Aboriginal and Torres Strait Islander peoples and other Australians by 2030.

In April 2008 the then Australian Government (and subsequently supported by the then Opposition)⁹ further committed to providing an annual report to Parliament on progress towards closing the gap with a particular focus on the achievement of the COAG Closing the Gap Targets found in the *National Indigenous Reform Agreement* (NIRA). Reflecting the long-term nature of the challenge, this has become a non-partisan annual event that generates significant national attention and is supported by all sides of parliament.

This reporting process keeps the national effort to close the gap fresh in the nation's mind and is a means for the Australian Government and the wider community to monitor and assess progress. It presents data for the nation to consider, enables accountability, recognises successes and identifies areas requiring greater improvements.

Since the first Australian Government report in 2009, the Campaign Steering Committee has provided an annual complementary 'shadow' report representing its assessment of progress, including against the COAG Closing the Gap Targets for health and life expectancy equality, and the commitments in the *Close the Gap Statement of Intent*. This is done in the spirit of an open and constructive dialogue between government, the wider community, and Aboriginal and Torres Strait Islander peoples. This progress report is this year's contribution to this ongoing dialogue.

This report affirms that the national effort to close the gap is slowly but surely working. It reaffirms that this effort is above politics – fundamentally non-partisan. It reiterates that it is a nation-building exercise of the highest importance. It calls on the new Australian Government to stay the course and ensure much-needed policy and program continuity towards the goal of health and life expectancy equality. It also outlines further steps that need to be taken to expand and strengthen the national effort to close the gap.

The report comprises three parts:

Part one: Close the gap – a shared national priority examines the effort to close the gap as a national, non-partisan effort, founded on the empowerment of Aboriginal and Torres Strait Islander communities to exercise responsibility for their health.

Part two: Progress in the national effort to close the gap assesses progress against the health-related COAG Closing the Gap Targets and also evaluates progress using other data.

Part three: Opportunities to strengthen the national effort to close the gap sets out the Close the Gap Campaign's vision for strengthening the national effort to close the gap over the current term of Parliament.

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.

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.

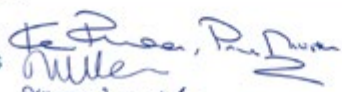
We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery and control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


ACCORDINGLY WE COMMIT:

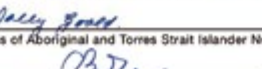
- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous 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


Congress of Aboriginal and Torres Strait Islander Nurses


Indigenous Dentists Association of Australia


National Aboriginal Community Controlled Health Organisation


Australian Indigenous Doctors Association


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

Part 1

Close the gap – a shared national priority



Willun and Alister Thorpe at the Fitzroy Stars football team's practice ground, Thornbury, Vic. Photograph: Bonnie Savage/OxfamAUS.

(a) How did we get here?

In 2008, the United Nations *Human Development Index* ranked Australia the third most developed nation in the world. Then, as now, we were an enormously wealthy nation with amongst the highest life expectancy attainable.¹¹

In the same year, Aboriginal and Torres Strait Islander Australians' life expectancy was estimated to be up to 17 years less than the broad Australian population.¹² It was a stark reminder of a great divide in the nation across education, income, housing, mental health, chronic disease, child and maternal health, access to health services, and more. It was the scar of an unhealed past and a stain on the reputation of the nation. For Aboriginal and Torres Strait Islander peoples, it was an immense and unnecessary burden of suffering and grief.

Further, the health gap was getting wider as non-Indigenous Australia continued to prosper. In 2008 it was clear that if the nation was to honour its core principles of a 'fair go' and a 'level playing field', in other words, of providing equality of opportunity to all, the time had come to act. Significantly, poorer Aboriginal and Torres Strait Islander health as a status quo was no longer acceptable. New thinking was needed.

That new thinking emerged following the release of the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Dr Tom Calma AO's, *Social Justice Report 2005*.¹³ The report called for a national effort to close the gap that included all Australian governments committing to closing the health gap within a generation. This call fostered a groundswell of action. In March 2006, Dr Calma convened a workshop that brought together peak Aboriginal and Torres Strait Islander and non-Indigenous health bodies, health professional bodies and human rights organisations. Attendees agreed to work to achieve Aboriginal and Torres Strait Islander health equality by 2030 utilising key elements and principles as set out in the text box below.

Key elements and principles of the Close the Gap Campaign

- Dedicated national (and other level) planning to achieve Aboriginal and Torres Strait Islander physical and mental health equality, including the use of targets, and with adequately funded (and otherwise full) implementation of such plans.
- Genuine partnerships, with shared decision-making power, between Aboriginal and Torres Strait Islander peoples and their representatives and Australian governments, at all levels, to progress health equality planning and related service delivery.
- Support for ACCHSs as the preferred deliverers of health services to Aboriginal and Torres Strait Islander communities (and, more broadly, support for community empowerment as a key principle).
- Evidence-based policy as the 'bottom line' in policy, program and service development: focusing on what had been proven to work.
- A parallel and substantive address to the social determinants of poorer Aboriginal and Torres Strait Islander health as a critical part of achieving health and life expectancy equality.

It is not credible to suggest that one of the wealthiest nations in the world cannot solve a health crisis affecting less than 3% of its citizens.

Dr Tom Calma AO, Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005¹⁰

These bodies later formed the Campaign Steering Committee which launched the Close the Gap Campaign (Campaign) in 2007. Reflecting his stewardship of the process, Dr Calma became the inaugural Chair of the Campaign.

The Campaign garnered immediate public support and in 2007, the first National Close the Gap Day was held. Today it has become the largest and highest profile Aboriginal and Torres Strait Islander health event in the country. Nine hundred and seventy two community events involving 140,000 Australians were held on National Close the Gap Day in 2013.¹⁴ Almost 200,000 people have formally pledged their support for the Campaign.¹⁵

The ambitious but realistic goal that the health inequality gap could be closed within a generation, united the Campaign Steering Committee and the supporters of the Campaign across the nation. It was a goal set in full awareness of the challenges involved. The Campaign Steering Committee firmly believed then, and do today, that with political will and multiparty support (critical for such a generational challenge), it is possible to close the gap over the next 16 years.

(b) A nation-building exercise that is above political affiliation

It is not a Labor project, it is not a Liberal project. If it is to succeed, it must be a national project.

The Prime Minister Hon Tony Abbott MP, in response to the 2013 Annual Report to Parliament on Closing the Gap when Opposition Leader, 6 February 2013¹⁶

Through leadership, investment, and partnerships built on trust and respect, we can meet the closing the gap targets and build on our achievements: there are now more Indigenous children than ever before participating in preschool or early education programs. I affirm my commitment to the Closing the Gap framework.

The Opposition Leader Hon Bill Shorten MP, January 2014¹⁷

The Close the Gap Campaign's framework was based on a clear assessment of responsibility between Aboriginal and Torres Strait Islander communities and government.

A bold assertion of Aboriginal and Torres Strait Islander peoples' responsibility underpinned the Close the Gap Campaign. Australian governments on their own can never make Aboriginal and Torres Strait Islander people and their communities healthy.¹⁸

However, it was also clear that such responsibility could not exist in a vacuum. In fact, critical government support is required to empower individuals, families and communities such that responsibility can be meaningfully exercised. In other words, there has to be a maternity class or clinic operating in a community for a mother to attend one; or for a doctor to be available to provide the health check-ups.

Government responsibility in this context is to empower Aboriginal and Torres Strait Islander individuals, families and communities with the opportunities to exercise responsibility for their health. Critically, this includes ensuring that Aboriginal and Torres Strait Islander people have access to health programs and services, medicines, and health information through health promotion campaigns and preventative health activities (such as anti-smoking campaigns).

Further, it stands to reason that Aboriginal and Torres Strait Islander people must be empowered with the *same opportunities* as all other Australians to access doctors, medicines, allied health services and so on, if health equality is to be achieved. There can no longer be a racially defined 'opportunity gap' when it comes to health. This opportunity gap has not yet closed, and nor can

the health gap be expected to close until it does. This remains the nation-building challenge ahead, and for the next 16 years.

Genuine partnership, with shared decision-making power, in planning processes at the national, jurisdictional and community level is an extension of that clear articulation of where responsibility lies. It also further empowers: enabling the voices of communities to be heard in policy, service and program design and delivery.

Case study: A partnership to prevent unnecessary blindness in the Northern Territory¹⁹

Blinding cataract is 12 times more common in Aboriginal Torres Strait Islander adults than non-Indigenous adults but the rates of cataract surgery are seven times lower. Cataracts cause 32% of blindness in Aboriginal and Torres Strait islander adults and 27% of low vision. The good news is that up to 94% of vision loss for Aboriginal and Torres Strait Islander people is preventable or treatable,²⁰ but only 65% of those with vision loss caused by cataracts have received surgery.²¹

A significant eye care success story is emerging in the Northern Territory as a result of the long-term partnership between the Australian Government, Northern Territory Government, Anyinginyi Health Aboriginal Corporation, Central Australia Aboriginal Congress and The Fred Hollows Foundation.

Since 2007, these organisations have collectively held 14 intensive eye surgery weeks to address the backlog of cataract surgery for Aboriginal people from the remote Central and Barkley regions. This involves taking sight-saving screening and laser surgery to remote Aboriginal communities.²²

During that time, 664 Aboriginal patients have travelled by plane, bus or community health clinic vehicles from remote communities to receive this life-transforming operation.²³

These core concepts were elaborated in the Campaign's blueprint for action: the *Close the Gap Statement of Intent* – signed by the nation's political leaders. In the years since, the majority of Australian governments have signed up to the blueprint for action in the document.

The signing of the *Close the Gap Statement of Intent* established once and for all that bringing a timely end to Aboriginal and Torres Strait Islander health inequality was part of the nation's core business.

The national effort to close the gap is above politics. As a nation-building exercise it has been, and should continue to be, set apart from the day-to-day fray. Indeed, as noted in the media,²⁴ it is to our nation's leaders' credit that in the past three years of a hung parliament, at no time was the national effort to close the gap politicised, or its fundamental features undermined.

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

The Campaign Steering Committee calls on the new Australian Government to not only ensure policy continuity in critical areas of the national effort to close the gap, but to take further steps in building on and strengthening the existing platform as set out in part three of this report.

(c) Empowered communities

The national effort to close the gap is an empowerment-based approach to achieving health equality. Among its underpinning principles is that the existing strengths in Aboriginal and Torres Strait Islander individuals, families and communities can, and should, be supported to enable them to exercise responsibility for their health.

ACCHSs are one way in which Aboriginal and Torres Strait Islander communities have exercised responsibility for their members' health. The first ACCHS was established in 1971 in Redfern, Sydney, by community members, for community members.²⁵ There are currently over 150 ACCHSs. They are defined as 'a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management'.²⁶

The ACCHS model is a good example of supporting a community to exercise responsibility for its health. The roll out and expansion of ACCHSs is a means of community empowerment and supports:

- increased accessibility to health services;
- cultural continuity; and
- increased employment and participation in education and training by community members.



Close the Gap round hosted by the Gold Coast Titans 2012. The Titans have launched the 'I CAN' program to inspire Indigenous students in Surat and Bowen Basin communities to complete year 12 and pursue further education. Photograph: Jason Malouin/Oxfam AUS.

The community development and control of ACCHSs fosters culturally competent services.²⁸ In particular, the acculturating force of high numbers of Aboriginal and Torres Strait Islander people who work in ACCHSs has been demonstrated to increase the accessibility of such services by contributing to a sense of cultural safety.²⁹

ACCHSs can operate as ‘one stop shops’ for clients displaying complex presentations that touch on many areas of their lives – not just their physical health. They connect their clients to services that may operate outside the health sector, and in so doing, breaks down artificial walls between a health condition per se, and the health impacts of poverty, poor housing, or a lack of cultural support.

There has been a steady rise in the number of dedicated Aboriginal and Torres Strait Islander primary health care services (about 75% of which are community controlled),³⁰ from 108 services in 1999–2000 to 235 services in 2010–11. From 2008–09, supported by additional funding from national partnership agreements, there has been an increase of 30 services overall, with an additional 400,000 episodes of care delivered.³¹ These services, enabled by the national effort to close the gap, are targeted at addressing and overcoming the opportunity gap discussed above.

Cultural continuity and community controlled health services

Research among Indigenous peoples in Canada by Professor Michael Chandler has demonstrated the presence of community-controlled (health and other) services in a community, as part of a matrix of indicators of community empowerment, is associated with lower suicide rates among its members.

Chandler’s findings support Aboriginal and Torres Strait Islander-led research around community empowerment. The *‘Hear Our Voices’ Report* identified a high level of need among communities in the Kimberley for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs and strategies.³²

Culture was seen as a core component of any empowerment program. Importantly, the content, design and delivery of programs need to have legitimate community support and engagement, and be culturally appropriate, locally based and relevant to people’s needs.³³ Reflecting Chandler’s findings, community empowerment programs were identified as potentially effective strategies for enhancing social and emotional wellbeing and addressing suicide risk factors, especially among young people.³⁴

ACCHSs (and indeed other Aboriginal and Torres Strait Islander community controlled services, such as legal services) provide a model for the community control of other health services and sectors as they expand. This includes community-controlled AOD services as described in the case study below. In particular, services dedicated to mental health and social and emotional wellbeing could be developed according to the ACCHSs model.

A clear message from the recent past is that policies and programs must be targeted to local needs, in close engagement and active partnership with the people they are designed to assist...

Key challenges to effective service delivery include: identifying a range of suitable governance and decision-making processes that effectively balance the variety of Indigenous governance styles with governments’ responsibilities for properly managing public funds. These governance approaches should be designed to empower Indigenous people and communities, including equipping them with relevant skills, so that they can progressively take meaningful control of their futures.

Strategic Review of Indigenous Expenditure, 2010²⁷

Case study: Council for Aboriginal Alcohol Program Services³⁵

The Council for Aboriginal Alcohol Program Services (CAAPS) is an Aboriginal community-controlled organisation based in Darwin. It provides community-based substance misuse services that support families experiencing AOD issues. In addition to rehabilitation and withdrawal, CAAPS is also a Registered Training Organisation delivering nationally accredited courses in community services. Their clients and students come from communities across Australia, and their remote training and outreach staff travel across the Top End to deliver services on the ground. The service includes four main programs:

- **Community Outreach Program:** The Community Outreach Team works on the ground to reach a community's most vulnerable members. This includes individuals and families residing in town communities and camps within the Darwin and Palmerston areas who may not otherwise actively seek engagement with service providers. To these groups, the Team provides information on CAAPS services, conducts assessments for entry into the 12-week Rehabilitation Program and provides referrals to other services as required. In addition, the Outreach Team also makes regular visits to local hostels and crisis shelters to conduct assessments and provide brief interventions to interested individuals and their families.
- **Volatile Substance Abuse (VSA) Program:** This aims to assist in the treatment and recovery of volatile substance use through a range of activities, including VSA and AOD education, along with sessions that teach young people better self-care through health, hygiene and nutritional education. Young people also participate in numeracy and literacy education during their stay with the program.
- **Dolly Garinyi Hostel:** This provides supported accommodation in purpose-built client accommodation units in a semi-bush setting. These units can accommodate up to 30 clients participating in CAAPS programs.
- **Healthy Families 12 Week Residential Program.** This focuses on providing families with a safe and supportive environment in which to address substance use issues. The program consists of a range of different education sessions and activities that cover substance use, healthy lifestyles, livelihood, cultural sessions, art therapy, and family relationships – including the Triple P Parenting Program. In addition, participants of the program have access to onsite counseling, peer support groups, housing and livelihood support.

Health services are also channels for economic growth in communities. The Australian Bureau of Statistics (ABS) 2011 Census results show that health services (including, but not limited to, ACCHSs) currently employ 14.6% of employed Aboriginal and Torres Strait Islander people. Health services are the single biggest 'industry' source of employment, which has expanded by almost 4,000 places since 2006.³⁶ Health services, including ACCHSs, 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 ACCHSs has a multiplier effect in communities beyond the critical improvements in health that they deliver.

ACCHSs are supported by State and Territory representative bodies who have played a critical role in developing long-standing and highly effective partnerships with state and territory governments (as examples, the Queensland Aboriginal and Torres Strait Islander Health Partnership; the partnership arrangements in the Victorian Indigenous Affairs Framework; and the South Australian Aboriginal Health Care Plan Implementation Committee, as discussed in the Campaign Steering Committee's 2012 Shadow Report).³⁷

A further notable example is the partnership established in 1997 between the Aboriginal Health and Medical Research Council (the peak body for the ACCHSs in New South Wales), and the New South Wales Government. In 2012, the partners developed the *New South Wales Aboriginal Health Plan*.³⁸ This partnership, based on trust and mutual respect, has created an enduring platform for the robust interactions that are required when addressing complex situations such as Aboriginal and Torres Strait Islander health. It is an example of how working together in partnership with trust is a productive and essential exercise.

In turn, these state and territory level partnerships can provide an umbrella for regional partnerships following the administrative boundaries for health service delivery within a state or territory. Regional partnership bodies for health planning, such as Regional Closing the Gap Committees in Victoria, was also discussed in the Campaign Steering Committee's 2012 Shadow Report,³⁹ and is illustrated by our case study below. The launching of Medicare Locals in 2010 and the restructuring of the previous health regions provides further opportunities for such regional partnerships to develop to benefit ACCHSs and Aboriginal and Torres Strait Islander peoples.

Case study: Katherine West Health Board⁴⁰

Katherine West Health Board Aboriginal Corporation (KWHB) operates seven health centres providing comprehensive primary, emergency and preventative health services for approximately 3,500 people in remote communities and pastoral outstations.

KWHB has worked diligently with community members and funding bodies to improve the region's health facilities. In 2013, a new health centre, designed with the community, opened in Lajamanu. It has a separate male and female entry point, and separate waiting areas to enable culturally appropriate access to care.

As a result of the focus on community needs, and working with communities in the design of facilities, the numbers of patients accessing KWHB's service has increased by 7,000 episodes of care in the last year alone, with a long term trend of increased uptake of service.

KWHB are also an active employer of local Aboriginal people in its health centres and has a growing complement of trainee Aboriginal Health Practitioners from the local area. It employs AOD Support Officers who work across the region in close consultation with the regional AOD Program Coordinator and the Tackling Indigenous Smoking Program.

KWHB works closely with local shires and service providers to ensure better access to health specialists, housing services and a range of health-related services in the communities they serve.

KWHB has recently worked with Indigenous Hip Hop Projects on a series of health promotional videos focusing on health issues such as trachoma, tackling smoking, good hydration and nutrition, embracing community values, healthy bush tucker, teeth and oral care, the importance of self-confidence, getting enough sleep, not gambling, concentrating in class and avoiding alcohol consumption.

In 1979, the peak body for the ACCHSs at the national level, now known as the National Aboriginal Community Controlled Health Organisation (NACCHO), was established.⁴¹ National Aboriginal and Torres Strait Islander health leadership bodies emerged for doctors,⁴² nurses,⁴³ health workers,⁴⁴ dentists,⁴⁵ psychologists and psychiatrists,⁴⁶ physiotherapists,⁴⁷ allied health professionals.⁴⁸ Self-empowered, they assumed responsibility for the position of Aboriginal and Torres Strait Islander people within their professions and institutions. These national organisations promote their cultural and other expertise in working in communities and have helped create employment pathways, resulting in the health sector being a significant employer of Aboriginal and Torres Strait Islander people.

In the Campaign Steering Committee these and other organisations and allies from the non-Indigenous health space and human rights organisations first spoke with a common voice.

In recent years, and with the addition of the National Congress of Australia's First Peoples (Congress) and the Torres Strait Regional Authority, these bodies have begun working together collectively as the National Health Leadership Forum (NHLF) (as discussed in previous Close the Gap Campaign shadow reports⁴⁹) to partner with Australian governments to develop health policy. The NHLF worked closely with the Australian Government to develop the Health Plan.⁵⁰

The development of the Health Plan demonstrates that the capital in the knowledge (including cultural knowledge), leadership and lived experience of this leadership group should not be underestimated. In particular, the emphasis in the Health Plan on the importance of social and emotional wellbeing;⁵¹ culture;⁵² and the need to address racism as a negative social determinant of Aboriginal and Torres Strait Islander health;⁵³ can be identified as unique contributions of the NHLF to this key strategic document in the national effort to close the gap.

Case study: Developing an effective staff team in a pharmacy in a remote community⁵⁴

Thursday Island is the administrative centre for the Torres Strait region. Lyn Short discusses what it was like to take on the management of a pharmacy there, and how she utilised the Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme (ATSIPATS) to develop a workforce able to meet the communities' needs.

In 2007, the Pharmacy Guild of Australia established ATSIPATS to improve pathways for Aboriginal and Torres Strait Islander people in pharmacy careers. It is a project funded by the Australian Government's Department of Health as part of the Fifth Community Pharmacy Agreement, administered by the Pharmacy Guild of Australia.

Lynn:

When I first took over at Thursday Island the previous owner was retiring after 32 years. We had six staff including myself but no qualified pharmacy assistants. We had no qualified staff in the community, and no specialised employment agencies for pharmacy employees as you may find in the city.

I believe a pharmacy in an Indigenous area must provide local staff who know the people, culture and language to ensure communication and the best customer service. For many people living in the Torres Strait, Island Creole is their first language; and English their second. My staff had to be able to speak Creole to communicate effectively with customers in the pharmacy and on the phone. I soon realised that I needed to train my own staff and that would have to be through in-store training given the remoteness of my pharmacy.

I first heard about ATSIPATS at a conference in Albury. Here was a solution to my staffing dreams! The program provides wages for both students undertaking the 'in-house' training and the pharmacists delivering the training and individual tuition. The funding also covers the cost of trainers from the Pharmacy Guild to travel to Thursday Island and deliver training modules.

We started our first ATSIPATS students in May 2008. I now employ 25 staff, both male and female pharmacy assistants, most of whom are Torres Strait Islanders. I'm happy with my trained employees, they are happy with their education and qualifications, and the district benefits with experienced pharmacy assistants.

(d) A holistic approach that encompasses social determinants of health

Through the COAG Closing the Gap Agenda, significant funding and other support reaches Aboriginal and Torres Strait Islander communities to address poor health, poverty, unemployment and lower educational attainment. At the heart of the Agenda is the NIRA which, along with the *Close the Gap Statement of Intent*, is a foundation document to the national effort to close the gap. Like the *Close the Gap Statement of Intent*, the NIRA represents a national consensus and commitment: all Australian governments have signed up to its program.

Key features of the NIRA are the six COAG Closing the Gap Targets, and the seven 'building blocks' or areas of particular focus: Early Childhood; Schooling; Health; Economic Participation; Healthy Homes; Safe Communities; and Governance and Leadership.⁵⁶ Further, all the Aboriginal and Torres Strait Islander-specific national partnership agreements, in addition to the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and the *National Partnership Agreement on Indigenous Early Childhood Development* are intended to contribute to better health outcomes.

Without the broader context of the COAG Closing the Gap Agenda, health programs and services operating on their own are likely to have, at best, an unsustainable short-term impact. While the focus of this report is on health, the Campaign Steering Committee counsel that the COAG Closing the Gap Agenda cannot be cherry-picked, and health cannot be viewed in isolation from the social determinants of health. This broader, multi-dimensional approach to addressing health must continue. All 'fronts' of the health and disadvantage gap must be engaged simultaneously for life expectancy to improve, and the foundations and gains so far must not be squandered by failing to maintain momentum in relation to the social determinants of health.

(e) Conclusion

The national effort to close the gap is a response to the unnecessary death, grief and suffering experienced by Aboriginal and Torres Strait Islander peoples as a result of long-standing health inequality. It is a response to a great stain on our national character.

The national effort to close the gap is a nation-building effort, built on clarity and a new consensus about responsibility. So armed, this is the generation to close the gap. Empowerment, and the capacity and demonstrated ability of Aboriginal and Torres Strait Islander peoples to exercise responsibility for their health is one side of the closing the gap approach. The other is the responsibility of government to provide the necessary opportunity and support.

Health inequality diminishes us all and it is for this reason that the Australian public support the national effort to close the gap. It is clear that Australians demand that government, in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, build on the national effort to close the gap. They believe that we can and should be the generation that finally closes the appalling life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

Poverty is both a cause and a result of poor health. People living in poverty live in environments that make them sick with inadequate housing or overcrowding, for example. Poor health in turn keeps people and communities in poverty...

Mr Warren Mundine, The Baker IDI Central Australia Oration, 4 October 2013⁵⁵

Part 2

Progress in the national effort to close the gap



Michelle Munns, Joyce Dimmer and Denise Jetta at the 2012 Close the Gap Day event held at South West Aboriginal Medical Service (SWAMS), Bunbury, WA. Photograph: Jeff Henderson/OxfamAUS.

(a) Progress against the achievement of life expectancy equality

In 2009, the ABS began to estimate Aboriginal and Torres Strait Islander life expectancy over periods of three years (to have a greater deaths certificates 'pool' than that provided by one-year periods) and to use the five-yearly Censuses to verify the accuracy of the identification of Aboriginal and Torres Strait Islander people on death certificates.⁵⁷

As noted in the Campaign Steering Committee's 2012 Shadow Report, the reliance on the Census data for the verification of deaths data allows for only three points at which life expectancy can be assessed prior to 2030: 2016, 2021, and 2026. The Census in 2031 will provide data to assess whether the 2030 target was met.⁵⁸

In the years in between, the COAG Reform Council has relied on mortality rates data as proxy indicators for life expectancy, with both 1998 and 2006 baselines for data established. Using a 1998 baseline, the COAG Reform Council's 2011–12 Report shows decreasing deaths rates in Queensland and the Northern Territory. These decreases drive an overall positive change in what it refers to as a 'five state total'. The 'five state total' is the five states whose deaths data is deemed reliable and which therefore acts as a proxy national indicator. This good news should be tempered by the findings that there were no significant changes to death rates in three of the states (South Australia, New South Wales and Victoria). Further, the Northern Territory remained the only 'on target' jurisdiction likely to meet the 2031 equality target.⁵⁹

Average annual change in Indigenous death rates per 100,000 from 1998 to 2011 and change required to meet 2031 target

	Average annual change 1998–2011		Average annual change required from 2011 to meet 2031 target
	Indigenous	Non-Indigenous	Indigenous
NSW	ns	-6.5	-34.4
Qld	-18.0	-10.1	-40.7
WA	ns	-9.2	No published target
SA	ns	-6.8	-29.2
NT	-47.0	-10.8	-47.1
Total	-12.2	-7.8	-40.3

Note: ns = no significant change.

Source: COAG Reform Council, *Indigenous Reform 2011–12: Comparing Performance Across Australia*, p 14.

In 2013, noting the slow progress against the life expectancy target seen so far, the COAG Reform Council noted that 'efforts to improve Indigenous life expectancy may take many years to show results'.⁶⁰

In November 2013, the ABS published a revised life expectancy estimate for Aboriginal and Torres Strait Islander people in 2010–12. The ABS used this estimate as evidence of a slight reduction in the life expectancy since 2005–07.

The Campaign Steering Committee did not expect that turning round years of health inequality would occur rapidly at the startup phase of the national effort to close the gap – that commenced in July 2009. It is reasonable to assume that many of the Aboriginal and Torres Strait Islander deaths that occurred over 2005–06 – 2010–12 were the result of chronic conditions that built up in the decades prior to 2009.

Improvements to life expectancy

In November 2013, the ABS published a revised life expectancy estimate for Aboriginal and Torres Strait Islander people in 2010–2012,⁶¹ being 69.1 years for Aboriginal and Torres Strait Islander men and 73.7 years for women.⁶² Although within the margin for error,⁶³ this was taken at face value by the ABS as evidence of a slight reduction in the life expectancy gap of 0.8 years for men and 0.1 years for women since 2005–07.⁶⁴

	2005–07	2010–12	Change from 2005–07 to 2010–12
Men	11.4	10.6	-0.8
Women	9.6	9.5	-0.1

The Campaign Steering Committee did not expect that turning round years of health inequality would occur rapidly at the startup phase of the national effort to close the gap – that commenced in July 2009. In that regard it is reasonable to assume that many of the Aboriginal and Torres Strait Islander deaths that occurred over 2005–06 – 2010–12 were the result of chronic conditions that built up in the decades prior to 2009. This is borne out by the analysis of the COAG Reform Council mortality data referred to above. It found for the five state total, over 2011–12 the greatest single cause of Aboriginal and Torres Strait Islander deaths was circulatory diseases (26.3%) that it defined to include heart attacks and strokes.⁶⁵

Comment by the Campaign Steering Committee on the new Aboriginal and Torres Strait Islander life expectancy estimate

The Campaign Steering Committee notes that almost all of the data used to create the new estimate relates to the period prior to the commencement of the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* in July 2009.

The new estimate demonstrates the existence of a disparity in life expectancy, exactly why the national effort to close the gap and the associated national partnership agreements is required. However, it is simply too early to be able to assess the impact of these major new initiatives.

With continued commitment on the part of policy-makers and governments, it is likely that we will start to see the outcomes required to meet the 2030 target in the next life expectancy estimate. This will be as the new services, health checks, preventative health campaigns, and so on, take effect.

The new estimate provides us with another reminder why, as a generational effort, the national effort to close the gap was placed above politics and remains a constant across political cycles.

Reductions in smoking rates and improvements in maternal and child health

Further evidence for the slow pace of change that might be expected in reducing rates of chronic disease without the national effort to close the gap was provided by the November 2013 release of the 2012–13 ABS *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS) results.⁶⁶

The data clearly demonstrated the stark reality of health inequality in this nation. However, the survey showed a significant drop in the rate of tobacco smoking among Aboriginal and Torres Strait Islander people. ABS data shows, in 2012–13, two in five (41%) Aboriginal and Torres Strait Islander people aged 15 years and over smoked on a daily basis, a decrease from 51% in 2002. This represented a progressive decrease in daily smoking rates for Aboriginal and Torres Strait Islander people, declining from 51% in 2002 to 45% in 2008, and then to 41% in 2012–13.⁶⁷

However, despite the decrease in the proportion of Aboriginal and Torres Strait Islander daily smokers reported in 2012–13, the ABS estimates that health outcomes will continue to reflect the smoking patterns in 2002 as the damage from these high levels of smoking will take some time to dissipate.⁶⁸

AATSIHS also provided sobering evidence of the need for a continuing focus on changing behaviours, apart from smoking, that contribute to chronic disease. It also demonstrates the folly of cutting preventative health programs for Aboriginal and Torres Strait Islander people while the national effort is underway. Of particular concern, the survey found no significant change over time in 'lifetime risk' for consumption of alcohol over 2005–07 and 2012–13.⁶⁹ It also highlighted the need for greater focus on reducing the rates of obesity⁷⁰ and increasing the number of Aboriginal and Torres Strait Islander people engaging in daily exercise – areas where significant gaps with the non-Indigenous population are evident.⁷¹



Overturning negative stereotypes often found in tabloid media, this image resonated strongly with many Australians and became the signature image of the Close the Gap campaign in its early years. Clarence Paul has since passed away, but his family still want his photo associated with the campaign as his early death is an example of why Indigenous health equality is so vital. Photograph: Wayne Quilliam/OxfamAUS.

(b) Evidence that the foundations for the achievement of health and life expectancy equality by 2030 are in place

Smoking is estimated to be the single biggest cause of death for Aboriginal and Torres Strait Islander people⁷² and is estimated to contribute to 12% of the disease and mortality gap.⁷³ The decline in smoking rates highlighted above is good news.

There are similar 'green shoots' evident in maternal and child health data that indicate slow but sure generational health improvements are occurring among Aboriginal and Torres Strait Islander people. Many of these trends were evident prior to the commencement of the national partnership agreement on 2 July 2009.⁷⁴ However the national effort to close the gap can be expected to demonstrate an acceleration of these trends over time as the programs are given time to have impact.

From 1998 to 2011, the mortality rate of Aboriginal and Torres Strait Islander children under the age of five years decreased at a significantly faster rate than the non-Indigenous rate (by an average of 5.7 deaths per 100,000 per year compared to 1.7 deaths per 100,000 for non-Indigenous children).⁷⁵ As a result, the five-State total is on track to meet the COAG Closing the Gap Target to halve the gap in child mortality rates by 2018. If the trend from 1998 to 2011 continues, the 2018 target will be achieved.⁷⁶

However, much of this reduction has been driven by reduction in Sudden Infant Death Syndrome and the scope for further reductions from this cause is diminishing.⁷⁷ While it is likely that treatment gains have played a significant role, as discussed in last year's Shadow Report,⁷⁸ birth weight trends indicate the need for a stronger focus on services for mothers and babies. Nonetheless the improvements being seen suggest that significant and real improvements can be expected over time as these children grow up to become healthier adults than in previous generations.

This highlights the need to maintain funding and programs associated with the successful child and maternal health programs operated by the ACCHSs, and that were expanded by the 2008 COAG *National Partnership Agreement on Indigenous Early Childhood Development* with funding of \$547 million over five years. Services through this agreement are delivered primarily, but not exclusively, through ACCHSs.

As an example, the New Directions Mothers and Babies Services, an element of the above national partnership agreement, were established in 82 sites by 2013.⁷⁹ Initial funding of \$90.3 million for 2007–11 was followed by an additional \$133.8 million for four years in 2011–12.⁸⁰ A second element of the national partnership agreement is a broad program for increasing access to antenatal care, pre-pregnancy and teenage sexual and reproductive health services particularly for young women. Total funding for this initiative is \$107 million over six years.⁸¹

The positive outcomes provide support for continuing funding for the *National Partnership Agreement on Indigenous Early Childhood Development* beyond July 2014.

But perhaps most importantly, these positive outcomes provide evidence of the possibility of generational change when Australian governments and Aboriginal and Torres Strait Islander peoples, work in partnership with empowered communities to address long-standing health issues.

The \$1.57 billion COAG *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* has helped contribute to the expansion of the ACCHSs (although the Campaign Steering Committee would like to see significantly more expansion through a renewed agreement). It has also underpinned programs that provide further evidence for the establishment of a foundation for significant health improvements over the next 16 years.

The Campaign Steering Committee welcomes the news that, under the leadership of the National Coordinator for Tackling Indigenous Smoking, Dr Tom Calma AO, Tackling Indigenous Smoking Teams are operational in 57 identified regions nationwide as of 30 June 2013.⁸²

In all, an additional 344 full time equivalent population health workers have been funded under the program which has been rolled out since 2010.⁸³ Each Regional Tackling Smoking and Health Lifestyle Team generally comprises one Regional Tobacco Coordinator, three Tobacco Action Workers and two Healthy Lifestyle Workers.⁸⁴ These teams work on the ground in communities to develop local programs that empower and support community members to quit including by referring them to clinicians, Quitlines and being available for one-on-one support if necessary. Among young people the focus is on preventing them from taking up smoking in the first instance.⁸⁵

The Campaign Steering Committee believes the accelerating impact of the Tackling Indigenous Smoking Program provides significant support for the national effort to close the gap. It also provides evidence of the value of genuine partnerships between Australian governments and Aboriginal and Torres Strait Islander communities in the national effort.

With this important foundation for reducing smoking rates in place, the Campaign Steering Committee expect further significant reductions over the next decade. The Campaign Steering Committee notes that the National Healthcare Agreement target to halve the Aboriginal and Torres Strait Islander smoking rate by 2018 provides a measure for progress.⁸⁶ However, it is critical that funding and other support for the program continues if this is to occur and the wider promise in the program realised.

Further, as discussed in part one of this report, in many Aboriginal and Torres Strait Islander communities, ACCHSs already provide a solid foundation for the necessary health gains to be made over the next 16 years and their capacity to do so was expanded by the additional funding and capacity-building provided under the national effort to close the gap. From 2008–09, supported by additional funding from national partnership agreements, there has been an increase of 30 services overall and an additional 400,000 episodes of care delivered.⁸⁷



SWAMS' employees Manfred Heiartz and Peter Michael in Brunswick Junction, WA with their mobile clinic. Photograph: Jason Malouin/OxfamAUS.

It is critical, that in looking forward, Australian governments continue to build on this foundation. The *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report* attributes a number of significant improvements to the national partnership agreements. These include:

- A significant increase in a range of Medicare Benefits Schedule (MBS) services claimed by Aboriginal and Torres Strait Islander people for identifying and managing chronic disease since the introduction of the Indigenous Chronic Disease Package.⁸⁸
- Significant increases in the number of health checks since the commencement of the national partnership agreement.⁸⁹
- Significant increases in the number of GP management plans and team care arrangements claimed by Aboriginal and Torres Strait Islander people through Medicare;⁹⁰
- Significantly improved access to medicines through the Closing the Gap Pharmaceutical Benefits Scheme (PBS) co-payment measure, with 96% of pharmacies reported to be participating in the measure.⁹¹
- Drug and alcohol services have seen a 9% rise in clients over 2009–10 and 2010–11.⁹²

These findings are elaborated in the Australian Institute of Health and Welfare (AIHW) and NACCHO's 2013 *Healthy for Life Aboriginal Community Controlled Health Services Report Card*.⁹³ They provide a measure of the concrete results and positive health outcomes that flow from the presence of ACCHSs in communities and that can be attributed to the national effort to close the gap.

In demonstrating this service capability, ACCHSs have demonstrated their capacity to empower communities to make the necessary health gains to close the gap over the next two decades. In particular, with this essential foundation in place, significant outcomes in relation to chronic disease and maternal health can be expected over time.

(c) Necessary increases in health expenditure since 2009

The Productivity Commission's 2012 *Indigenous Expenditure Report* found that government health spending was \$2.02 per Aboriginal and/or Torres Strait Islander person for every dollar spent per non-Indigenous person in 2010–11.⁹⁴

Government spending increased by \$847 per Aboriginal and/or Torres Strait Islander person over 2008–09 to 2010–11. This equated to an average annual growth rate of 6.1%, and contributed to an overall 12% increase in total Aboriginal and Torres Strait Islander health expenditure in that period.⁹⁵ This is to be welcomed and reflects much needed increased funds as a result of the national partnership agreements.

Government expenditure is only part of the overall health expenditure picture. Significant private expenditure also occurs (i.e. private health insurance) and must be factored in. In fact to focus only on government significantly distorts the expenditure picture. Over 2010–11 Australian governments provided 91.4% of total Aboriginal and Torres Strait Islander health expenditure compared to 68.1% of total non-Indigenous health expenditure.⁹⁶

Health expenditure for Aboriginal and Torres Strait Islander people varies considerably across the states and territories. For example, over 2010–11, the Northern Territory spent on average \$8,498 per person on Aboriginal and Torres Strait Islander people, more than twice the amount spent in New South Wales (\$3,977).⁹⁷ AIHW note that this is likely to reflect, at least in part, the higher cost of delivering services in remote areas and the economies of scale in the more populous states. It is also likely that the demand for dialysis varies in different parts of Australia. A similar but less pronounced pattern was observed for non-Indigenous Australians, with the Northern Territory spending approximately 29% more per non-Indigenous person than New South Wales.⁹⁸ Nonetheless the differences between various jurisdictions are notable and are worthy of further analysis and consideration.

Comment by the Campaign Steering Committee on cuts to health services and the impact on the national effort to close the gap

As reported in the Campaign Steering Committee's 2013 Shadow Report,¹⁰⁰ Queensland¹⁰¹ and New South Wales¹⁰² have made deep cuts to their general population health expenditure with detrimental impacts on the national effort to close the gap in the past year. This year, South Australia also made a significant cut, including to preventative health programs.¹⁰³

Such cuts are of major concern to the Campaign Steering Committee as these jurisdictions are partners to the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*. This highlights the importance of a nationally coordinated approach through the COAG process that ensures that all jurisdictions are playing their part and contributing to the national effort to close the gap. This includes through the maintenance of this and other relevant national partnership agreements.

In this context, the Campaign Steering Committee welcomes the pre-election commitments of the new Australian Government that there would be no cuts to health spending at the federal level.¹⁰⁴ However, it also notes subsequent reports that cuts to the PBS had been proposed by its Commission of Audit.¹⁰⁵ The Campaign Steering Committee also notes that the new Minister for Health has proposed cuts to key agencies that play a role in the national effort to close the gap.¹⁰⁶

The Campaign Steering Committee calls on the Australian Government to consider the impact of any such cuts on the national effort to close the gap. Programs and activities within organisations that contribute to the national effort should be quarantined and preserved.

Such cuts, in addition to being fiscally shortsighted, represent a significant setback to the national effort to close the gap. The clear need for preventative services continuing is demonstrated by the data that highlights the generational, long-term nature of programs to tackle chronic disease.

In fact, when the significantly greater need for health services resulting from Aboriginal and Torres Strait Islander people's poorer health status is factored in (the Campaign Steering Committee estimates this to be *at least* double as a general rule), a relative lack of total funding available for Aboriginal and Torres Strait Islander health is still evident. As such the cuts and potential cuts discussed above are a regrettable blow to the national effort to close the gap.

Achieving parity, with need factored in, requires that the total health expenditure on Aboriginal and Torres Strait Islander be increasing, not decreasing, and that false economies presented by cuts be avoided. In part three of this report, we call for an administrative mechanism to ensure that Aboriginal and Torres Strait Islander peoples benefit in a truly equitable fashion from health programs and services expenditure.

Private health insurance and Aboriginal and Torres Strait Islander people

Non-government expenditure was \$386 per capita Aboriginal and/or Torres Strait Islander person compared with \$1,750 per non-Indigenous person in 2010–11, a per person ratio of 0.22. This is primarily due to the low private health insurance membership of Aboriginal and Torres Strait Islander people. The most recent estimates from 2004–05 showed that 17% of the Aboriginal and Torres Strait Islander population had private health insurance compared with 51% of the non-Indigenous population.⁹⁹

In terms of total health expenditure over 2010–11, \$1.47 was spent per Aboriginal and/or Torres Strait Islander person for every dollar spent per non-Indigenous person.¹⁰⁷ This ratio (1.47) was a slight increase from the ratio of 1.39 reported in 2008–09, prior to the implementation of the national partnership agreements.¹⁰⁸

AHW note that the differences in per capita total health expenditure between Indigenous and non-Indigenous Australians are likely to reflect:

- Differences in the average costs of delivering goods and services to the two populations. In 2010–11, 23.3% of Aboriginal and Torres Strait Islander people lived in remote and very remote areas of Australia where the cost of providing health goods and services is significantly higher than for the vast majority of non-Indigenous Australians who do not.¹⁰⁹
- Differences in the way Aboriginal and Torres Strait Islander people use the health system. In 2010–11, 40% of total Aboriginal and Torres Strait Islander health expenditure was for the use of hospitals, compared to approximately 25% of total non-Indigenous expenditure.¹¹⁰ Every dollar that can be redirected into primary health care service, from the hospital system, is money better spent and ‘proactively’ contributes to better health outcomes rather than being ‘reactive’ spending that does not drive health improvements.

Looking forward, the Campaign Steering Committee is concerned that the next tranches of Aboriginal and Torres Strait Islander people’s health expenditure data, for 2012–13 and 2014–15, may show significant cuts to Aboriginal and Torres Strait Islander health expenditure.



Greg (Noddy) Jennings and Freddie Ah Sam in the men’s garden at Tharawal Aboriginal Corporation, Campbelltown, NSW.
Photograph: Juan Martorana/Oxfam AUS.

(d) Conclusion

Since the commencement of the national effort to close the gap in July 2009, reductions in smoking rates and maternal and child health outcomes in particular have been demonstrated. These positive outcomes provide some evidence that the national effort to close the gap is working, and that generational change is possible and they provide encouragement that the gap will close by 2030.

The demonstrated impact of 'closing the gap'-related investment in the ACCHSs is another sign of change occurring. In this, a substantial foundation has been built that will help underpin the long-term address to chronic disease necessary over the next two decades.

Time must be allowed for 'big picture' change to be seen. Life expectancy rates, in particular, can only be expected to change at a slow pace. It did not surprise the Campaign Steering Committee that the new Aboriginal and Torres Strait Islander life expectancy estimate indicated only small absolute and relative gains over 2005–07 and 2010–12. This is because the estimate largely relates to the period prior to the national effort to close the gap and the associated funds 'hitting the ground' and having an impact. It tells us why the national effort and the national partnership agreements were, and remain, necessary. It is still too early to assess the impact of the national effort and the agreements themselves with such information.

In the context of achieving Aboriginal and Torres Strait Islander health equality, the 'false economy' of short-term savings as evidenced in the past 18 months must be examined critically. A dollar saved today may result in the need to spend many more in years to come. In particular, the national effort to close the gap requires a shift from expenditure on hospitals to that on primary health care with its preventative emphasis, as well as preventative health programs per se, and health promotion activities.

The longer-term prospect (i.e. by around 2030) is that spending on Aboriginal and Torres Strait Islander health will begin to reach parity with the non-Indigenous population as health equality is achieved. However, at this point in time and for the foreseeable future increased spending should be expected.

In particular, investment in the national effort to close the gap must continue and shortsighted cuts to preventative and related programs must stop. The \$1.57 billion *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* expired in June 2013, and the \$564 million *National Partnership Agreement on Indigenous Early Childhood Development* will expire in June 2014. The upkeep of such agreements and the continuation of guaranteed funding over significant spans of time is a critical factor. Funding levels must be maintained at least over the next agreement cycle, if not beyond.

Part 3

Opportunities to strengthen the national effort to close the gap



Kaurna Elder Auntie Josie welcomes guests at the Signing of the Statement of Intent at Parliament House, Adelaide, SA in 2010. Photograph: Ben Macmahon/OxfamAUS.

(a) The responsibility of Australian governments

Aboriginal and Torres Strait Islander peoples' responsibility for their health is one side of the national effort to close the gap. The other half belongs to Australian governments: to provide the support needed so Aboriginal and Torres Strait Islander peoples can exercise that responsibility.

The national effort to close the gap sits at the juncture where these two areas of responsibility overlap. In this space, the gap will close with both parties working in partnership. With 'green shoots' evident, as set out in part two, it is critical at this stage that the national effort continues to build on successes, and be strengthened over time. Strengthening this effort is the focus of this part of the report.

The Close the Gap Campaign welcomed Prime Minister Abbott's May 2013 speech at the Sydney Institute (as Leader of the Opposition). In his speech, he declared he was 'reluctant to decree further upheaval in an area [i.e. Indigenous Affairs] that's been subject to one and a half generations of largely ineffectual reform'.¹¹² In doing so he was recognising the insufficient good, and sometimes harm, that decades of an ever-changing policy landscape in Indigenous Affairs had caused.

The Campaign also welcomed the promise of continuity in the Coalition's September 2013 Indigenous health platform:

The Coalition will work collaboratively with State and Territory Governments, as well as the community health sector through existing national frameworks, to ensure that our efforts to close the Indigenous health gap achieve the real and lasting outcomes that all Australians expect.

Aboriginal and Torres Strait Islander Health continues to be an urgent priority for the Coalition. We have a long and proud record of improving Indigenous health outcomes and we remain fully committed to achieving health equality between Indigenous and non-Indigenous Australians within a generation...

Continued investment in clinical health services for all Indigenous Australians will remain a priority for the Coalition. However, the Coalition is also determined to address the social determinants of health that will be key to improving Indigenous health outcomes.

The Coalition has provided in-principle support for Closing the Gap initiatives and will maintain the funding in the Budget allocated to Closing the Gap in Health...¹¹³

The Campaign also welcomed the Australian Labor Party¹¹⁴ and Australian Greens Indigenous Affairs¹¹⁵ election platform. Both committed to continuing the national effort to close the gap. As a consequence the Australian public went to the election with consensus support from all major parties for the national effort to close the gap.

In August 2013, the Campaign Steering Committee released a position paper, *Building on the Close the Gap Platform, Commitments for an Incoming Government*, which called for policy continuity from the new Australian Government, irrespective of which party was elected to power. It also highlighted opportunities to strengthen the national effort to close the gap into the future. A summary of these calls, updated to reflect the current state of affairs, is set out below. The remainder of this part of the report elaborates on these opportunities.

The deep-seated and complex nature of Indigenous disadvantage calls for policies and programs which are patient and supportive of enduring change... A long-term investment approach is needed, accompanied by a sustained process of continuous engagement...

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.

[Strategic Review of Indigenous Expenditure 2010](#)¹¹¹

Opportunities for the new Australian Government to strengthen the national effort to close the gap

Continuing the close the gap initiatives

- Complete the implementation of the Health Plan in genuine partnership with Aboriginal and Torres Strait Islander peoples and their representatives at the national level by:
 - Establishing a clear process that ensures a national implementation strategy is developed;
 - Finalising a national implementation strategy within 12 months. This strategy should include service models, address health infrastructure needs, contain strategies to ensure financing over long periods, and build the health workforce, as well as develop measurable benchmarks and targets to monitor progress; and
 - Moving to an implementation phase, by the securing of the necessary funding to fully implement the plan.
- Forge an agreement through the COAG process on a new *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*.
- Forge an agreement through the COAG process on a new *National Partnership Agreement on Indigenous Early Childhood Development* to ensure the seamless continuation of programs.

Building on the close the gap platform

- Focusing on expanding health services to meet need, particularly in the areas of mental health, maternal and child health and chronic disease. This should include a systematic inventory of service gaps, planning to close these gaps on a region-by-region basis and with a focus on health services in all areas of Australia. Further steps could also be taken to improve access to medicines. E-health systems should be utilised to enhance continuity of care.
- Developing a dedicated Aboriginal and Torres Strait Islander mental health plan and otherwise implementing the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and completing and implementing the *Social and Emotional Wellbeing Framework* and the planned AOD strategy.
- Developing a whole-of-government mechanism across sectors and portfolios to drive an integrated response to health issues and their social and cultural determinants, including the impacts of intergenerational trauma.
- Developing specific COAG Closing the Gap Targets in relation to incarceration rates and community safety in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, as well as state and territory governments.
- Developing formal mechanisms that ensure long-term funding commitments, including the national partnership agreements, are linked with progress in closing the health equality gap.
- Developing a new administrative mechanisms to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis that reflects both the population size and an index of need. Utilising the funds to produce the best return on investment.
- Introducing and passing legislation to formalise a process for national monitoring and reporting on efforts to close the gap in accordance with benchmarks and targets. This legislation should include a requirement for this process to be undertaken in partnership with Aboriginal and Torres Strait Islander peoples and their representatives. It should also have a sunset clause of 2031 – the year after the date by which all parties have committed to close the gap in health equality.

(b) Continuing the closing the gap initiatives

There are two developments that together will determine whether the national effort to close the gap stays on course and whether Aboriginal and Torres Strait Islander health equality is achieved by 2030:

- The implementation of the Health Plan; and
- The renewal with adequate funding of the expired *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and the soon-to-expire *National Partnership Agreement on Indigenous Early Childhood Development*.

The July 2013 launch of the Health Plan marked the fulfillment of a major commitment made by all signatories to the *Close the Gap Statement of Intent*. It completed a year of intense work by a Strategic Advisory Group (SAG), a plan-development partnership forum comprising the NHLF and Australian governments, co-chaired by Jody Broun, the then Co-chair of the NHLF (also then Co-chair of the National Congress of Australia's First Peoples and the Campaign Steering Committee), and a senior representative from the (then) Department of Health and Ageing.

The SAG process provided a precedent for partnerships between the Australian Government and the NHLF. While there are lessons to be learned from the process and a review of its operations is timely, it nonetheless provides a platform to build on for future planning partnerships at the national level.

The Health Plan is a framework document that emphasises a whole of life approach with focus on a number of priority areas. The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and the Health Plan are complementary and action on both is essential. If supported by necessary funding and effectively implemented, the Health Plan will play a critical role in closing the health gap.



Alyssa Fegusson, a member of the Deadly Jarjums which runs health, exercise and well-being activities for kids aged five to 17 in Coffs Harbour, NSW. Photograph: Jason Malouin/OxfamAUS.

The next step is the development of a national implementation strategy for the Health Plan that sets out detailed and comprehensive commitments, with measurable targets and benchmarks to monitor progress over time. This needs to be developed in partnership with the Aboriginal and Torres Strait Islander leadership and other stakeholders. A new partnership vehicle that builds on the precedent set by the SAG could be established to that end.

As noted, the previous SAG had been co-chaired by an NHLF Co-chair and a representative from the Department of Health and Ageing under the previous machinery of government arrangements. However, with its reach across so many areas of Indigenous Affairs policy (see pages 33-34), there are strong arguments to support the fact that the Department of Prime Minister and Cabinet may be a better partner in implementation than the Department of Health. Wherever the development of the implementation phase of the Health Plan occurs, the Australian Government must ensure those charged with responsibility for this work, including public servants and service providers, have the necessary health planning and service provision capacity.

It is equally critical for the new Australian Government to strike an agreement with the states and territories through the COAG process on a new *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*, and maintain the pledged minimum Commonwealth investment of \$777 million from July 2013 – July 2016, which was made in the 2013–14 federal Budget by the previous Government¹¹⁶ and supported by the new Australian Government while in Opposition.¹¹⁷ We will continue to monitor the striking of this agreement as a major Campaign focus.

We also note the expiration of the *National Partnership Agreement on Indigenous Early Childhood Development* in June 2014 and call on the Australian Government to begin negotiating its renewal with at least the current levels of funding.

The risk of not continuing to support these and other national partnership agreements is that over time their cumulative impact will dissipate and the hard won gains in critical areas, as set out in part two, may then begin to reverse. The Close the Gap Campaign believes this would be an unacceptable course of action as it would also represent a squandering of the over two billion dollars of investment in these areas in the past five years through the two mentioned national partnership agreements.

Despite competing economic agendas, we must as a nation find the resources to maintain the momentum of existing efforts and build on the successes. However, there are also opportunities for the new Australian Government to strengthen and shape the national effort to close the gap, as discussed below.

(c) Building on the close the gap platform

Strengthening access to services and medicines

As discussed previously, the national effort to close the gap is one that requires ensuring Aboriginal and Torres Strait Islander people enjoy equal opportunity to be as healthy as other Australians. This requires an emphasis on strengthening health services such as mental health, mothers and babies and chronic disease-related services. Where necessary, additional services should be put in place.

Such an opportunity presents itself through the implementation of the Health Plan, as discussed previously. In relation to this, the Campaign Steering Committee advocates for a structured process whereby, on the basis of agreed service models, a national inventory of health services gaps is conducted on a regional basis. Planning would then take place to ensure gaps are closed – also on a region-by-region basis. This would, optimally (as a default position), involve the strengthening and expansion of existing ACCHSs with additional services and the establishment of new ACCHSs. Alternatively it could involve partnership agreements between ACCHSs and mainstream service providers to enable services to be provided through ACCHSs.

In view of the most recent estimates of life expectancy showing a persistent gap across urban, rural and remote areas,¹¹⁸ it is essential to focus on health services in all areas of Australia. Investment should generally be 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.

E-health systems should be utilised to monitor and enhance continuity of care against benchmarked standards for both mainstream and ACCHS providers.

Further enhancements could also be made to improve access to medicines by Aboriginal and Torres Strait Islander people through the Closing the Gap PBS co-payment measure.¹¹⁹

Key issues that need addressing include eligibility status and the interaction between programs and mobility of people living in remote areas. One solution to consider is attaching eligibility to the patient and not to location or prescriber – as is the current position.

Mechanisms are needed to enable the suite of PBS medicines programs to complement each other to better meet people's needs with particular regard to travel between remote and urban areas, and between hospital and home, whilst still maintaining access to their PBS medicines.

ACCHSs in remote locations cannot currently provide both Closing the Gap prescriptions and medicines under the s 100 Remote Aboriginal Health Service Program (RAHSP). These services should be able to provide services at their own discretion based on the needs of the patient whether under the s 100 RAHSP or the Closing the Gap PBS co-payment measure.

Hospitals should be able to issue people with discharge Closing the Gap scripts. Prescriptions from hospitals are excluded from this measure, even if the patient is already registered for the measure. This change would assist with the continuity of care for patients regardless of location or health care setting.



Dr Scott Hahn teaching children about hand washing and hygiene at Morayfield AMS, Qld. Photograph: Jason Malouin/OxfamAUS.

A dedicated Aboriginal and Torres Strait Islander mental health plan and alcohol and other drug strategy and implementation of other related key strategic documents.

Two areas that are yet to receive dedicated attention through the national effort to close the gap are mental health and AOD. AATSIHS results provide a timely reminder that mental health and harmful AOD use remains a crisis in many Aboriginal and Torres Strait Islander communities.

As a 'family stressor', mental illness among family members or friends was reported by 16% of Health Survey respondents. High levels of mental illness among friends and families were reported by 18% of respondents in non-remote areas and 8% of respondents in remote areas.¹²⁰

Of concern self-reported high and very high rates of psychological distress have increased from 27% – 30% over 2004–05 and 2012–13.¹²¹ There were also significant differences in the proportion of men and women who had experienced high or very high levels of psychological distress (24% compared with 36%). Rates of high/very high psychological distress were significantly higher for women than men in every age group, apart from those aged 45–54 years.¹²²

As discussed in its 2013 Shadow Report, the Campaign Steering Committee supports an overarching goal to close the mental health gap between Aboriginal and Torres Strait Islander people and the non-Indigenous population through the implementation of the Health Plan and other strategic documents.¹²³ Mental health is considered in Health Plan under the Priority Area 'Mental Health and Social and Emotional Wellbeing' where a goal is to enable Aboriginal and Torres Strait Islander people to 'have the best possible mental health and wellbeing'.¹²⁴

In relation to AOD, we have noted significant reductions in Aboriginal and Torres Strait Islander smoking rates in part two of this report. Despite this improvement, Aboriginal and Torres Strait Islander people aged 15 years and over are still 2.6 times more likely to be daily smokers.¹²⁵ In relation to alcohol consumption, in 2012–13 approximately 20% of Aboriginal and Torres Strait Islander people aged 18 years and over exceeded the lifetime risk guidelines. It should be noted that whilst this is a similar proportion as non-Indigenous Australians it has significant negative health impacts that need to be addressed as part of AOD strategy.¹²⁶ Further, in 2012–13 one in five (22%) Aboriginal and Torres Strait Islander people aged 15 years and over said that they had used an illicit substance in the previous year.¹²⁷ This also needs to be addressed in the strategy.

If Aboriginal and Torres Strait Islander people are to enjoy the same opportunities to lead a healthy and full life as other Australians, the gaps in both these areas must close – but there is currently no overarching strategic response to achieve this. Addressing the mental health gap will also contribute to the closing of other gaps and forms of Aboriginal and Torres Strait Islander disadvantage. Of particular note are the high rates of incarceration, harmful alcohol and substance use and poverty that are entwined in compounding negative cycles with mental health conditions.¹²⁸

Significant opportunities are presented in the new Indigenous Affairs space. Listed in the table below are six strategic responses that touch on the Aboriginal and Torres Strait Islander mental health and AOD space. Against them is an indication of their stage of development and implementation.

This cumulation of responses demonstrates that the Health Plan, as a mental health plan, must not be implemented in isolation. In that regard, we welcome that a key strategy of the Health Plan is to implement both the *Roadmap for National Mental Health Reform* and the *Social and Emotional Wellbeing Framework*.¹²⁹ The Health Plan should also support the anticipated new AOD strategy.

Strategic response	Status
The Health Plan ¹³⁰	Unimplemented
The <i>Social and Emotional Wellbeing Framework</i> ¹³¹	To be completed and implemented in 2014
AOD strategy	Anticipated in 2014
<i>National Aboriginal and Torres Strait Islander Suicide Prevention Strategy</i> ¹³²	Unimplemented
General population mental health planning including the <i>National Mental Health Plan</i> (2009–14) that includes planning for mainstream mental health services that Aboriginal and Torres Strait Islander people use ¹³³	To be renewed in 2014
The COAG <i>Roadmap for National Mental Health Reform</i> – Ten of the 45 strategies are Aboriginal and Torres Strait Islander-specific ¹³⁴	Partially implemented

Noting that all six relevant strategic documents are either in a late-development or pre-implementation stage, the Campaign Steering Committee further supports the development of a dedicated national Aboriginal and Torres Strait Islander mental health strategy with the goal of closing the health gap as a vehicle for the implementation of all six (to the degree they pertain to Aboriginal and Torres Strait Islander mental health) over 2014.

In this way the risk of scattered and diffuse responses to mental health in our communities is turned into an opportunity, enabling all six strategic responses to work together towards a common goal and avoid duplication.

A whole-of-government coordination mechanism

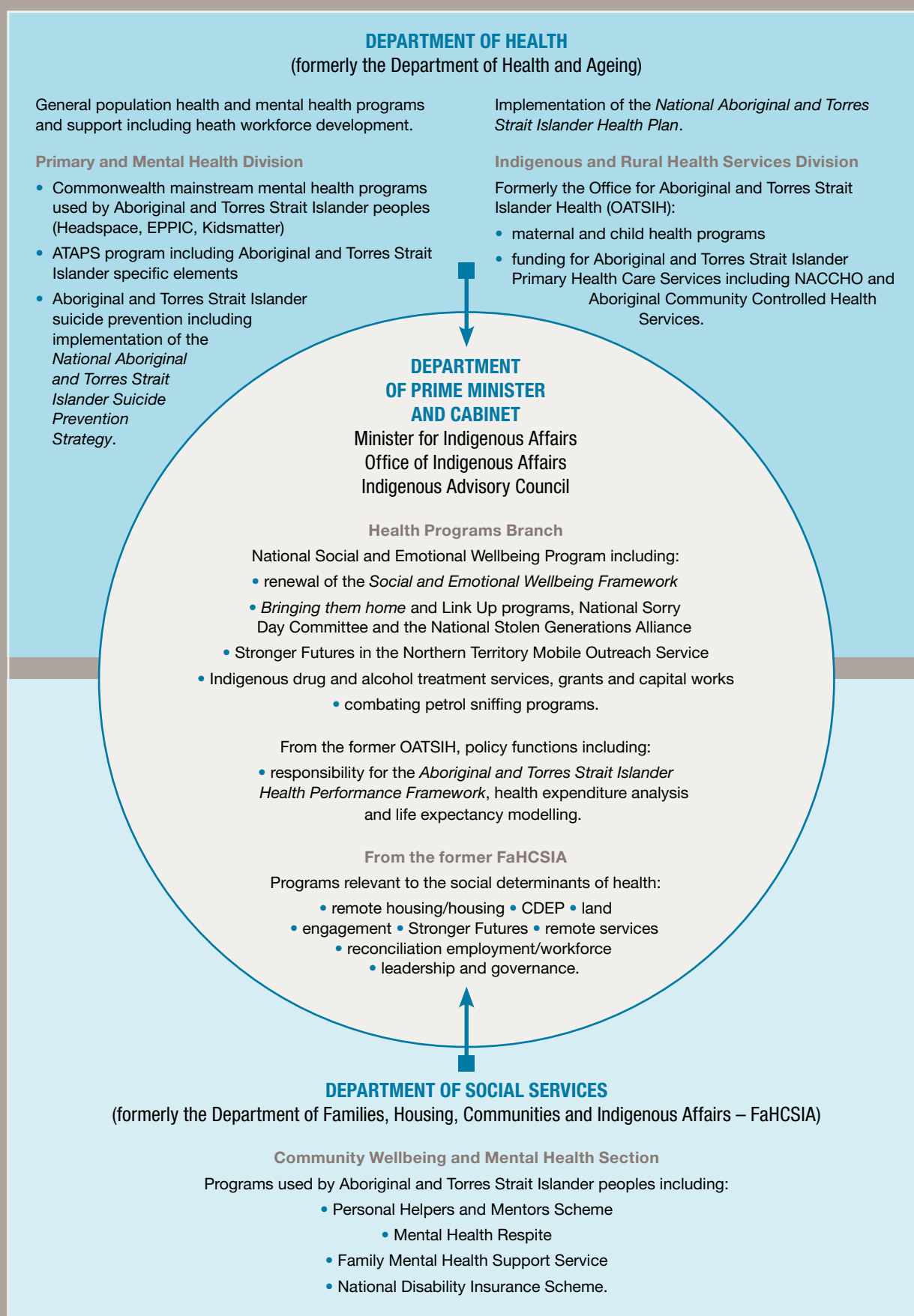
The Health Plan and the COAG Closing the Gap Agenda commits government to action on the social and cultural determinants of health including education and employment. A whole-of-government approach led by the Prime Minister is required to coordinate and drive complementary action across jurisdictions and sectors. Such is the opportunity presented by the new machinery of government for Indigenous Affairs.

The Campaign Steering Committee welcomes that, since the election, Prime Minister Abbott has brought together within the Department of Prime Minister and Cabinet a dedicated Office for Indigenous Affairs under a dedicated Minister for Indigenous Affairs.

The dedicated Office comprises significant elements of the Aboriginal and Torres Strait Islander health program. Responsibility for the ACCHSs continues to reside in the Department of Health (formerly the Department of Health and Ageing) in a new Indigenous and Rural Health Services Division (that replaces the former Office for Aboriginal and Torres Strait Islander Health). However almost all the Indigenous programs operated by the previous Department of Families, Housing, Community and Indigenous Affairs have moved to Prime Minister and Cabinet.

The diagram below summarises these changes at time of writing.

Machinery of government changes around Aboriginal and Torres Strait Islander health



The Campaign Steering Committee calls on the Australian Government to capitalise on these changes to the machinery of government. That is, by developing a whole-of-government mechanism at least across the Department of Prime Minister and Cabinet, Department of Health and the Department of Social Services to drive an integrated response to closing the gap including health issues and their social and cultural determinants.

Bureaucratic reform should ensure that public servants working in Aboriginal and Torres Strait Islander health are, preferably, Aboriginal and Torres Strait Islander people, but otherwise have the requisite technical skills and service delivery experience particularly in ACCHSs. The changes to the machinery of government for Indigenous Affairs provide an opportunity to make these improvements.

Develop COAG Closing the Gap Targets in relation to incarceration rates and community safety

The overrepresentation in imprisonment and crime victimisation rates for Aboriginal and Torres Strait Islander people requires urgent, coordinated action from government. The Campaign Steering Committee proposes that this action should include the setting of nationally agreed targets.

It has been reported that Aboriginal and Torres Strait Islander women are 31 times – and men 25 times – more likely than other Australians to be admitted to hospital as a result of family violence-related assaults.¹³⁵ The Campaign Steering Committee is of the view that personal safety and freedom from abuse are a critical determinant of the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.¹³⁶ Concerted action led by empowered Aboriginal and Torres Strait Islander communities is critical if these shocking statistics are to be reduced as part of the national effort to close the gap.

One in four people in the prison system today is an Aboriginal and/or Torres Strait Islander¹³⁷ – even though they comprise only one in 33 of the total population. The incidence of mental health conditions and substance abuse problems among the prison population is apparent. A 2009 survey of New South Wales prisoners found that 55% of Aboriginal and Torres Strait Islander men and 64% of women reported an association between drug use and their offence. In the same sample group, 55% of men and 48% of women self-reported mental health conditions.¹³⁸ In an even more recent Queensland study, at least one mental health condition was detected in 73% of male and 86% of female Aboriginal and Torres Strait Islander prisoners; with 12% of males and 32% of females diagnosed with Post-Traumatic Stress Disorder.¹³⁹

Prison itself has many health and health-related impacts. Not the least of these are mental health impacts¹⁴⁰ but there are other indirect impacts on health and wellbeing. 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.

A target to reduce imprisonment rates should be introduced,¹⁴¹ and investing in mental health and drug and alcohol services be considered as a justice reinvestment measure.¹⁴² 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 address the underlying causes of crime in these communities.¹⁴³

Overall, Aboriginal and Torres Strait Islander people have significantly lower access to mental health services, private or public, than other Australians.¹⁴⁴ Consequently it makes sound policy and economic sense that investing in mental health services for them is an avenue to explored through justice reinvestment programs.

Guaranteed funding for the duration of the national effort to close the gap – and beyond

In relation to this, the Close the Gap Campaign calls for:

- Formal mechanisms that ensure long-term funding commitments, including the national partnership agreements, are linked with progress in closing the health equality gap.
- New administrative mechanisms to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis that reflects both the population size and an index of need and the way to spend the funds to produce the best return on investment.

To be sustainable over the long-term it is essential that funding be tied to efforts to close the gap. Long-term policy requires long-term funding models.

We must now also take the next step, and secure an equitable share of mainstream funding to closing the gap. This may require the development of a new mechanism to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis that reflects both the population size and an index of need. It must also ensure the most effective services to receive those funds for service delivery in terms of access and quality of service.

Other sources of new funding are evident and would support policy objectives such as lowering the Aboriginal and Torres Strait Islander imprisonment rate as discussed above. A recent cost-benefit analysis by the National Indigenous Drug and Alcohol Committee reported that \$111,458 per offender could be saved by diversion to community residential rehabilitation programs when compared to the costs of imprisonment.¹⁴⁵ This form of modelling supports the justice reinvestment argument that imprisonment simply does not make good economic sense, and – conversely – that investing in mental health services in our communities does.

However, it is important to make the right kinds of investment. This includes in, wherever possible, ACCHSs. It is also critical to train more Aboriginal and Torres Strait Islander people to work at all levels of the health system to meet needs, and also to ensure that the non-Indigenous workforce is culturally competent.

Formalise monitoring and reporting arrangements

The national effort to close the gap must involve a coordinated and planned national response across federal, state and territory governments through the COAG process if it is to be successful. A national issue requires a national response. This national response must be monitored against benchmarks and targets so that we know whether we are on track to close the gap.

One of the issues that the Campaign has grappled with since 2008 has been the lack of reliable data against which to measure the COAG Closing the Gap Targets. As noted, this year marks the first that an update on Aboriginal and Torres Strait Islander life expectancy has been available. In addition to this, AATSIHS data is welcome and demonstrates the need for the national effort to close the gap, without shedding light on high level outcomes. Such data and reporting issues are evident across the health system. There is still a need for good information systems and regular review across the national effort to close the gap to see what is working and what is not, and to fine-tune responses if necessary.

In response, the Close the Gap Campaign calls on the Australian Government to introduce and pass legislation to formalise a process for national monitoring and reporting on efforts to close the gap in accordance with benchmarks and targets for the duration of the national effort.

This legislation should include a requirement for this process to be undertaken in partnership with Aboriginal and Torres Strait Islander peoples and their representatives. It should also have a sunset clause of 2031 – the year after the date by which all parties have committed to close the gap in health equality.

Conclusion

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

Because of this leadership, and the willingness to 'draw a line in the sand', we are seeing reductions in smoking rates and improvements in maternal and childhood health that will eventually flow into significant increases in life expectancy. This provides early positive signs that people on the ground are responding to the initiatives and demonstrates that Aboriginal and Torres Strait Islander communities are taking responsibility for their health as they are being provided with increasing opportunities to do so.

Achieving health equality by 2030 is an ambitious yet achievable task. It is an agreed national priority and it is clear that the Australian public demand that government, in partnership with Aboriginal and Torres Strait Islander peoples and their representatives, build on the close the gap platform to meet this challenge.

For this reason, the Close the Gap Campaign has stressed the need for the new Australian Government to stay the course, to ensure policy continuity and to strengthen the national effort. This term of government will be critical to achieving the 2030 goal and we call on the new Australian Government to not only ensure policy continuity in critical areas of the national effort to close the gap, but to take further steps in building on and strengthening the existing platform.



Thornbury Primary School student Celine O'Meara participated in traditional Victorian Aboriginal games held in Federation Square as part of National Close the Gap Day in 2009. Photograph: Lara McKinley/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*.¹⁴⁶

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.¹⁴⁷

Australian Government and Opposition party representatives, including the then Prime Minister and Opposition Leader, signed the Close the Gap Campaign's *Close the Gap Statement of Intent* in March 2008 at the Campaign's National Indigenous Health Equality Summit. Successive Prime Ministers, Opposition Leaders, and Greens Party leaders have indicated their continuing support. The *Close the Gap Statement of Intent* was subsequently signed by the Governments and Opposition Parties of 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.

As acknowledged in the NIRA, 'the [COAG] 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'.¹⁴⁸ As such, the Campaign has provided significant impetus for the Council of Australian Governments:

- Setting six 'Closing the Gap' Targets, including to achieve Aboriginal and Torres Strait Islander life expectancy equality within a generation, and to halve the Aboriginal and Torres Strait Islander under-fives mortality rate gap within a decade; and
- Agreeing, by November 2008, the 'Closing the Gap' national partnership agreements. These have brought with them approximately five billion dollars in additional resources, including the \$1.57 billion attached to the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* that expired in June 2013; and the \$564 million attached to the *National Partnership Agreement on Indigenous Early Childhood Development* that expires in June 2014.

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. Nine hundred and seventy-two community events involving 140,000 Australians were held on National Close the Gap Day in 2013.

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
- Australian Indigenous Doctors' Association
- Australian Indigenous Psychologists' Association
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Indigenous Allied Health Australia
- Indigenous Dentists' Association of Australia
- National Aboriginal Community Controlled Health Organisation
- National Aboriginal and Torres Strait Islander Health Workers' Association
- 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)
- National Indigenous Drug and Alcohol Committee
- The Lowitja Institute
- Torres Strait Island Regional Authority
- Australian College of Nursing
- Aboriginal Health and Medical Research Council
- Australian Human Rights Commission (Secretariat)
- Australian Medical Association
- Australian Medicare Local Alliance
- Australian Physiotherapy Association
- ANTaR
- Beyondblue
- The Fred Hollows Foundation
- Heart Foundation Australia
- Menzies School of Health Research
- Oxfam Australia
- Palliative Care Australia
- PHILE Network
- Public Health Association of Australia
- The Pharmacy Guild of Australia
- Royal Australasian College of Physicians
- Royal Australian College of General Practitioners
- Professor Ian Ring (expert adviser)

Endnotes

- 1 More than 188,000 people have signed the pledge at time of writing. Oxfam Australia, *Close the Gap*, (undated web page). URL: <https://www.oxfam.org.au/my/act/sign-the-close-the-gap-pledge/> (Accessed 14 January 2014).
- 2 Correspondence, Oxfam Australia and the author, 2 December 2013 (on file).
- 3 *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, Commonwealth of Australia, 2013. URL: <https://www.health.gov.au/natsihp> (Accessed 14 January 2014).
- 4 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Commonwealth of Australia, 2013. URL: www.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc (Accessed 14 January 2014).
- 5 *Development of a Renewed Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework – Discussion Paper*, Commonwealth of Australia, 2013. URL: <https://www.sprc.unsw.edu.au/about-us/doha-sewb-framework-consultation/discussion-paper/> (Accessed 14 January 2014).
- 6 *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004 – 2009)*, Commonwealth of Australia, 2004. URL: www.health.gov.au/internet/publications/publishing.nsf/Content/indig-sew-frame04-toc (Accessed 14 January 2014).
- 7 *National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes*, Council of Australian Governments, 2008. URL: www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/national_partnership.pdf (Accessed 14 January 2014).
- 8 *National Partnership Agreement on Indigenous Early Childhood Development*, Council of Australian Governments, 2008. URL: www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-early-childhood/national_partnership_superseded.pdf (Accessed 14 January 2014).
- 9 See for example: Scullion, N. (Shadow Minister for Indigenous Affairs), *Ministerial Statements – Closing the Gap Prime Ministers' Report of 2012*, 27 February 2012. URL: www.nigelscullion.com/electorate/speeches/ministerial-statements-closing-gap-prime-ministers-report-2012 (Accessed 14 January 2014).
- 10 Calma, T. (Aboriginal and Torres Strait Islander Commissioner), *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission, 2005, p 12. URL: www.humanrights.gov.au/publications/social-justice-report-2005-home (Accessed 14 January 2014).
- 11 United Nations Development Program, *Human Development Report 2007/8*, 2007, p 229 (Table 1).
- 12 Australian Bureau of Statistics, *Deaths 2006* (cat. no. 3302.0), Commonwealth of Australia, 2007, p 76.
- 13 See above note 10.
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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.’¹⁴⁹ 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).

CLOSE THE GAP