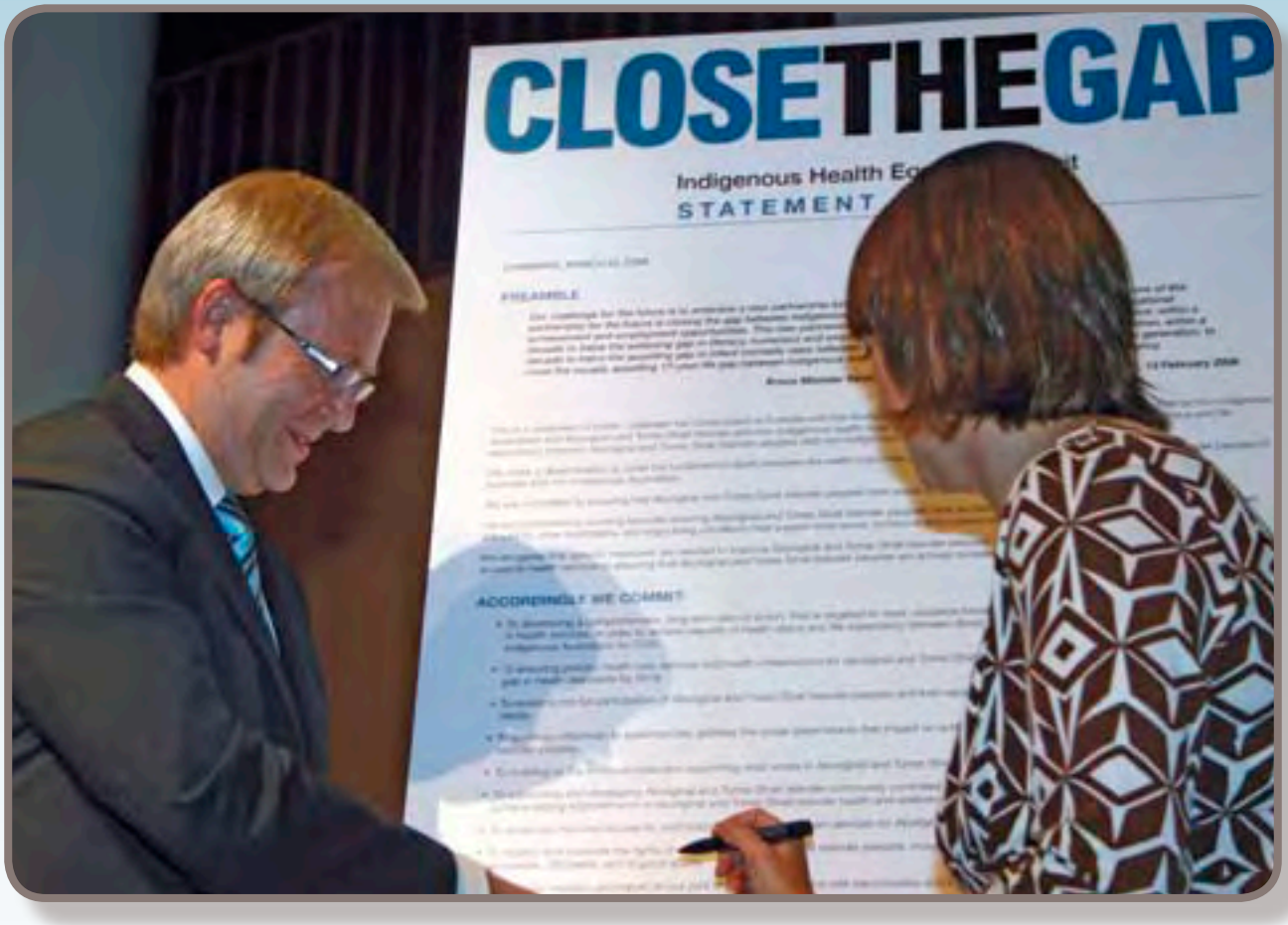
CLOSETHEGAP

National Indigenous Health Equality Targets

Outcomes from the
National Indigenous Health Equality Summit
Canberra, March 18–20, 2008



Aboriginal and Torres Strait Islander Social Justice Commissioner
and the Steering Committee for Indigenous Health Equality

Human Rights and Equal Opportunity Commission
www.humanrights.gov.au

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Cover image

The Prime Minister, the Hon. Kevin Rudd MP, and the Minister for Health and Ageing, the Hon. Nicola Roxon MP, signing the *Close the Gap, Indigenous Health Equality Summit Statement of Intent* at the Great Hall, Parliament House, Canberra, March 20, 2008.

About the Social Justice Commissioner's logo

The right section of the design is a contemporary view of traditional Dari or head-dress, a symbol of the Torres Strait Island people and culture. The head-dress suggests the visionary aspect of the Aboriginal and Torres Strait Islander Social Justice Commissioner's role. The dots placed in the Dari represent a brighter outlook for the future provided by the Commissioner's visions, black representing people, green representing islands and blue representing the seas surrounding the islands. The Goanna is a general symbol of the Aboriginal people.

The combination of these two symbols represents the coming together of two distinct cultures through the Aboriginal and Torres Strait Islander Social Justice Commissioner and the support, strength and unity which it can provide through the pursuit of Social Justice and Human Rights. It also represents an outlook for the future of Aboriginal and Torres Strait Islander Social Justice expressing the hope and expectation that one day we will be treated with full respect and understanding.

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.

The Prime Minister, the Hon. Kevin Rudd MP
Apology to Australia's Indigenous Peoples,
13 February 2008

PREFACE

On 20 December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous[1] communities to achieve the target of 'closing the gap' on Indigenous disadvantage; and notably, to close the 17-year gap in life expectancy within a generation, and to halve the mortality rate of Indigenous children within ten-years. While Australian governments had previously committed to raise the standard of Indigenous Australians' health to that of other Australians, this commitment was historic in that it was the first time Australian governments had agreed to be accountable for reaching this goal by placing its achievement within a time-frame.

In part, this was a response to the Campaign for Indigenous Health Equality, led by the National Aboriginal Community Controlled Health Organisation, the Australian Indigenous Doctors' Association, the Congress of Aboriginal and Torres Strait Islander Nurses, the Indigenous Dentists' Association of Australia, Oxfam Australia, Australians for Native Title and Reconciliation, and myself and involving a coalition of 40 or so concerned organisations. The Campaign had begun to organise in March 2006 in response to a number of recommendations for a targeted approach to achieving Indigenous health equality I had made in my Social Justice Report 2005. 'Close the Gap' was the catch cry and the public face of the Campaign.

The Campaign culminated in the National Indigenous Health Equality Summit (Summit) in Canberra over 18 – 20 March, 2008. On the final day, at the Great Hall, Parliament House, the Prime Minister, the Hon. Kevin Rudd MP, the Minister for Health and Ageing, the Hon. Nicola Roxon MP, the Opposition Leader, the Hon. Dr Brendan Nelson MP, as well as leaders of Indigenous health peak bodies[2] and the mainstream health peak bodies[3] signed a historic *Close the Gap Statement of Intent* in which they agreed to work in partnership to achieve equality in health status and life expectancy between Indigenous and non-Indigenous Australians by the year 2030. As a part of this effort they agreed to ensuring that primary health care services and health infrastructure for Indigenous Australians were capable of bridging the gap in health standards by 2018.

Importantly, they also committed to measuring, monitoring, and reporting on their joint efforts in accordance with a range of supporting sub-targets and benchmarks. The Indigenous Health Equality Targets and the benchmarks contained here are presented to that end. These have been developed with a range of experts, (and particularly Indigenous experts), with experience in Indigenous health.

I believe that the COAG commitments, the signing of the *Close the Gap Statement of Intent* and the development of the Indigenous Health Equality Targets mark a watershed in the history of Indigenous health: the moment when we dared to take our dreams of a future in which Indigenous and non-Indigenous Australians stand as equals in terms of health and life expectation and began to turn them into reality; the moment when we said 'enough is enough' and began to set in place an ambitious, yet realistic, plan to bring Indigenous health inequality to an end within our lifetimes.

Yours sincerely,

Mr Tom Calma
Aboriginal and Torres Strait Islander Social Justice Commissioner, and
Chair of the Steering Committee for the Close the Gap campaign for Indigenous Health Equality

[1] The Aboriginal and Torres Strait Islander Social Justice Commissioner recognises the diversity of the cultures, languages, kinship structures and ways of life of Aboriginal and Torres Strait Islander peoples. There is not one cultural model that fits all Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples retain distinct cultural identities whether they live in urban, regional or remote areas of Australia. Throughout this document Aborigines and Torres Strait Islanders are referred to as 'peoples'. This recognises that Aborigines and Torres Strait Islanders have a collective, rather than purely individual, dimension to their livelihoods. Throughout this document, Aboriginal and Torres Strait Islander peoples are also referred to as 'Indigenous peoples'. The use of the term 'Indigenous' has evolved through international law and is appropriately used in a human rights based context.

[2] The National Aboriginal Community Controlled Health Organisation, the Australian Indigenous Doctors' Association, the Congress of Aboriginal and Torres Strait Islander Nurses, the Indigenous Dentists' Association of Australia.

[3] The Australian Medical Association, the Royal Australian College of General Practitioners, the Royal College of Australasian Physicians and the Australian General Practice Network.

CONTENTS

Part 1

BACKGROUND

The Close the Gap Campaign for Indigenous Health Equality

In my 2005 Social Justice Report[4], I argued that it was unacceptable for a country as rich as ours, and one based on the notion of the 'fair go' and the 'level playing field', to tolerate the gross health inequality that has existed between Indigenous and non-Indigenous Australians for at long as records have been kept. I called for action, and I made recommendations that set out a broad path to bring it to an end as soon as practicable.

In particular, I recommended that the following targets be adopted by Australian governments:

- 25 years to achieve equality in health status and life expectation
- 10 years to achieve equality of opportunity in relation to access to primary health care and in relation to infrastructure that supports health (such as housing, food supplies, water, and etc.).

A further recommendation was that a number of detailed Indigenous health status and other health-related sub-targets (hereon referred to as the Close the Gap National Indigenous Health Equality Targets) be developed.

My recommendations, reproduced in full on page 9, encapsulated a human rights based approach to ending the Indigenous health crisis – one that utilises targets and benchmarks to not only provide an end in sight, but also to ensure accountability for achieving the goal of health equality. I did this not just because the right to health equality and equality of opportunity is a legally recognised right of Indigenous Australians, but also because the right incorporates sound principles whose value and utility are recognised: the need for a holistic approach to Indigenous health, for example.

Following the release of my report in March 2006, the National Aboriginal Community Controlled Health Organisation, the Australian Indigenous Doctors' Association, the Congress of Aboriginal and Torres Strait Islander Nurses, the Indigenous Dentists' Association of Australia, Oxfam Australia, Australians for Native Title and Reconciliation and I led the National Indigenous Health Equality Campaign based on the recommendations I had made. To that end we founded a Steering Committee to guide the development of the Campaign and worked with a coalition of 40 or so organisations all committed to bringing Indigenous health inequality to an end.

'Close the Gap' was the public face of the Campaign, organised with great impact by the National Aboriginal Community Controlled Health Organisation, Australians for Native Title and Reconciliation and Oxfam Australia. On 4 April 2007, the campaign was formally launched at Telstra Stadium by Catherine Freeman, Ian Thorpe, Henry Councillor, Chair of the National Aboriginal Community Controlled Health Organisation, and myself. A full-page open letter, reproduced on page 11, was also published in *The Australian* calling for Australian governments to support the campaign.

The two main goals of the Campaign were:

- First, to provide impetus for Australian governments to revitalise their existing commitments to ending Indigenous health inequality, but also – significantly – to place a time frame on these commitments, and to be accountable to them, by adopting the targets I had recommended.
- Second, to generate a range of Close the Gap Indigenous Health Equality Targets. As it eventuated, these targets were developed by 3 targets working groups of the Steering

[4] See Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission, Sydney, 2006, pp 9 – 97. This was printed as a stand alone publication: Aboriginal and Torres Strait Islander Social Justice Commissioner, *Achieving Aboriginal and Torres Strait Islander health equality within a generation*, Human Rights and Equal Opportunity Commission, Sydney, 2007 and is also available online at: www.humanrights.gov.au/social_justice/health/health_summary.html.

Committee for Indigenous Health Equality. Each was led by a notable Indigenous person with extensive health experience. The targets working groups drew on the experience of acknowledged health experts (and particularly Indigenous health experts) to create the targets. A full list of those involved is included in this publication at page 75.

This and other activities had real impact: notably, the ALP in Opposition – and now in Government – had adopted much of the language and the approach of the Campaign in its Indigenous affairs policy by the time of the 2007 federal election.

The Campaign culminated in the National Indigenous Health Equality Summit held in Canberra over 18 – 20 March, 2008. There were two streams of activity that took place at the Summit:

- First, the draft Close the Gap Indigenous Health Equality Targets were presented to a range of invited delegates, including Australian government representatives, for comments and feedback.
- Second, the Commonwealth government and the Opposition re-committed to achieving Indigenous health equality within a generation through signing a *Close the Gap Statement of Intent* (reproduced on page 15). It was signed by the Prime Minister, the Ministers for Health and Indigenous Affairs, the Opposition leader, Ian Thorpe, Catherine Freeman, and every major Indigenous and non-Indigenous health peak body.

After the Summit, the work of the 3 target working groups was integrated into a single table of targets and a summary outline. This has now been presented to the Commonwealth Government for integration into the COAG Working Group processes and is reproduced in this publication.

An important announcement made by the Prime Minister at the Summit was that that the National Aboriginal and Torres Strait Islander Health Council will be reformulated as an Indigenous Health Equality Council, with a primary role around the implementation of targets and benchmarks. This provides an opportunity to embed the targets into policy and practice nationally.

The Steering Committee continues to work with COAG and Australian governments to progress the adoption of the targets, and their integration with a variety of monitoring frameworks. A non-exhaustive list might include:

- the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Aboriginal and Torres Strait Islander Health Performance Framework;
- the Productivity Commission's Overcoming Indigenous Disadvantage framework, which measures the total impact of Australian government activities on a range of Indigenous socio-economic indicators, including health;
- the targets developed by the Building the Evidence sub-group of the COAG Working Group on Indigenous Reform;
- the social inclusion performance framework developed by the COAG Health and Ageing Working Group and the National Health and Hospital Reform Commission in relation to the Austrailan Health Care Agreements; and
- the Prime Minister's annual report to Parliament on closing the gap, announced at the National Apology to Australia's Indigenous Peoples.

It is hoped that in the near future these and other policy frameworks and indicators will be linked to benchmarks and targets to the end of achieving Indigenous health equality by 2030 or earlier.

What follows are a number of extracts and summary documents pertinent to the right to health, the Campaign for Indigenous Health Equality and the Close the Gap National Indigenous Health Equality Targets.

Recommendations of the Social Justice Report 2005

The following recommendations were made in the Social Justice Report 2005:

RECOMMENDATION 1

A commitment to achieve Aboriginal and Torres Strait Islander health equality

That the governments of Australia commit to achieving equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years.

RECOMMENDATION 2

Supporting commitments and processes to achieve equality of health status

a. That the governments of Australia commit to achieving equality of access to primary health care and health infrastructure within 10 years for Aboriginal and Torres Strait Islander peoples.

b. That benchmarks and targets for achieving equality of health status and life expectation be negotiated, with the full participation of Aboriginal and Torres Strait Islander peoples, and committed to by all Australian governments. Such benchmarks and targets should be based on the indicators set out in the *Overcoming Indigenous Disadvantage Framework* and the *Aboriginal and Torres Strait Islander Health Performance Framework*. They should be made at the national, state/ territory and regional levels and account for regional variations in health status. Data collection processes should also be improved to enable adequate reporting on a disaggregated basis, in accordance with the *Aboriginal and Torres Strait Islander Health Performance Framework*.

c. That resources available for Aboriginal and Torres Strait Islander health, through mainstream and Indigenous specific services, be increased to levels that match need in communities and to the level necessary to achieve the benchmarks, targets and goals set out above. Arrangements to pool funding should be made with states and territories matching additional funding contributions from the federal government.

d. The goal and aims of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* be incorporated into the operation of Indigenous Coordination Centres and the new arrangements for Indigenous affairs. This includes through reliance on the outcomes of regional planning processes under the Aboriginal Health Forums.

RECOMMENDATION 3

Endorsement of this commitment by all Australian Parliaments

That the Australian Health Minister's Conference agree a *National Commitment to achieve Aboriginal and Torres Strait Islander Health Equality* and that bi-partisan support for this commitment be sought in federal Parliament and in all state and territory parliaments.

This commitment should:

- acknowledge the existing inequality of health status enjoyed by Aboriginal and Torres Strait Islander peoples;
- acknowledge that this constitutes a threat to the survival of Aboriginal and Torres Strait Islander peoples, their languages and cultures, and does not provide Aboriginal and Torres Strait Islander peoples with the ability to live safe, healthy lives in full human dignity;
- confirm the commitment of all governments to the *National Strategic Framework* and the *National Aboriginal Health Strategy* as providing over-arching guidance for addressing Aboriginal and Torres Strait Islander health inequality;
- commit all governments to a program of action to redress this inequality, which aims to ensure equality of opportunity in the provision of primary health care services and health infrastructure within ten years;
- note that such a commitment requires partnerships and shared responsibility between all levels of government, Aboriginal and Torres Strait Islander peoples and communities, non-government organisations and the private sector;
- acknowledge that additional, special measures will be necessary into the medium term to achieve this commitment;
- acknowledge that significant advances have been made, particularly in levels of resourcing, since 1995 to address this situation;
- commit to celebrate and support the success of Aboriginal and Torres Strait Islander peoples in addressing health inequality;
- accept the holistic definition of Aboriginal and Torres Strait Islander health and the importance of Aboriginal community controlled health services in achieving lasting improvements in Aboriginal and Torres Strait Islander health status;
- commit to engage the full participation of Aboriginal and Torres Strait Islander peoples in all aspects of addressing their health needs;
- commit to continue to work to achieve improved access to mainstream services, alongside continued support for community controlled health services in urban as well as rural and remote areas; and
- acknowledge that achieving such equality will contribute to the reconciliation process.

The full text of chapter 2 of the report can be found at: www.humanrights.gov.au/social_justice/sj_report/sjreport05/chap2.html.

Open Letter to Australian Governments, published in The Australian, 4 April 2007

Indigenous children are dying at almost three times the rate of non-Indigenous children

A CALL FOR HEALTH EQUALITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Dear Prime Minister, State Premiers and Territory Chief Ministers, parliamentarians and Australian public,

We, the undersigned, are deeply concerned that Aboriginal and Torres Strait Islander peoples have not shared in the health gains enjoyed by other Australians in the last 100 years. It is a national scandal that Indigenous Australians live 17 years less than other Australians. Indigenous Australians continue to needlessly suffer and die early, not from a lack of solutions or government commitments, but from a lack of political will and action.

We call on all Australian Governments to commit to a plan of action to achieve health equality for Indigenous peoples within twenty-five years.

This commitment must receive bipartisan support from federal, state and territory parliaments as well as all sections of Australian society.

Indigenous Australians die from preventable diseases such as rheumatic heart disease, eradicated among the rest of the Australian population and they have lower access to primary health care and health infrastructure that the rest of Australia takes for granted.

This is not acceptable. We need to intensify our efforts and treat the Indigenous health crisis as a national priority.

There are already national commitments and policies in place to address Indigenous health inequality – what is missing are appropriately funded programs that target the most vulnerable. There are many stories of Indigenous success and high achievement that exist, which we can celebrate and learn from.

The signatories to this letter are committed to working in close and active collaboration with Indigenous peoples, communities and governments to achieve health equality within a generation. We commit ourselves to being engaged in identifying necessary actions and finding solutions.

At minimum, achieving health equality will require:

- measures to ensure equal access for Indigenous peoples to primary health care and health infrastructure
- increased support for developing the Indigenous health workforce
- a commitment to support and nurture Indigenous community controlled health services
- a focus on improving the accessibility of mainstream health services for Indigenous peoples
- an urgent focus on early childhood development, maternal health, chronic illness and diseases
- supporting the building blocks of good health, such as awareness and availability of nutrition, physical activity, fresh food, healthy lifestyles, adequate housing and the other social determinants of health.

It is inconceivable that a country as wealthy as Australia cannot solve a health crisis affecting less than 3% of its population.

Rapid improvements can be achieved in the health of Indigenous peoples by comprehensive, targeted and well resourced government action, through partnership with Indigenous peoples.

We call on the support of the people of Australia to help stop this needless suffering.

Yours respectfully,

Extracts from COAG Communiqués and related materials issued prior to December 2007 containing commitments by Australian governments in relation to Indigenous health

See the website of the Council of Australian Governments: www.coag.gov.au/meetings/archive.htm.

COAG Communiqué, 3 November 2000

'Governments can make a real difference in the lives of indigenous people by addressing social and economic disadvantage, including life expectancy, and improving governance and service delivery arrangements with indigenous people.

Governments have made solid and consistent efforts to address disadvantage and improvements have been achieved. For example, indigenous perinatal mortality rates have dropped from more than 60 per 1,000 births in the mid-1970s to fewer than 22 per 1,000 births in the mid-1990s. However, much remains to be done in health and the other areas of government activity.

Drawing on the lessons of the mixed success of substantial past efforts to address indigenous disadvantage, the Council committed itself to an approach based on partnerships and shared responsibilities with indigenous communities, programme flexibility and coordination between government agencies, with a focus on local communities and outcomes…'

Steering Committee for the Review of Government Service Provision (Productivity Commission) *Overcoming Indigenous Disadvantage: Key Indicators, 2003 Report*

Driving this Report is a commitment by Australian governments at the highest level to reducing Indigenous disadvantage. Behind the Report is the vision of an Australia in which Indigenous people come to enjoy the same overall standard of living as other Australians – that they are as healthy, live as long and are as able to participate in the social and economic life of the nation.

This means that this Report must be more than a collection of data – it provides policy makers with a broad view of the current state of Indigenous disadvantage and where things need to change if the vision is to be realised.

COAG Communiqué, 25 June 2004

COAG today committed at all levels of government to cooperative approaches on policy and service delivery between agencies and to maintaining and strengthening government effort to address indigenous disadvantage.

To underpin government effort to improve cooperation in addressing this disadvantage, COAG agreed to a National Framework of Principles for Government Service Delivery to Indigenous Australians. The principles address sharing responsibility, harnessing the mainstream, streamlining service delivery, establishing transparency and accountability, developing a learning framework and focussing on priority areas. They committed to indigenous participation at all levels and a willingness to engage with representatives, adopting flexible approaches and providing adequate resources to support capacity at the local and regional levels.

These principles will provide a common framework between governments that promotes maximum flexibility to ensure tailored responses and help to build stronger partnerships with indigenous communities. They also provide a framework to guide bi-lateral discussions between the Commonwealth and each State and Territory Government on the Commonwealth's new arrangements for indigenous affairs and on the best means of engaging with indigenous people at the local and regional levels. Governments will consult with Aboriginal and Torres Strait Islander people in their efforts to achieve this.

COAG Communiqué 14 July 2006

COAG agreed that a long-term, generational commitment is needed to overcome Indigenous disadvantage. COAG agreed the importance of significantly closing the gap in outcomes between Indigenous people and other Australians in key areas for action as identified in the *Overcoming Indigenous Disadvantage: Key Indicators Report* (OID) released by COAG in 2003.

COAG's future work will focus on those areas identified for joint action which have the greatest capacity to achieve real benefits for Indigenous Australians in the short and long term.

COAG has agreed to establish a working group to develop a detailed proposal for generational change including specific, practical proposals for reform which reflect the diversity of circumstances in Australia.

The working group will consider how to build clearer links between the OID framework, the National Framework of Principles for Delivering Services to Indigenous Australians, the COAG Reconciliation Framework and the bilateral agreements between the Commonwealth and State and Territory Governments. The working group will report back to COAG by December 2006.

COAG Communiqué 13 April 2007

COAG reaffirmed its commitment to closing the outcomes gap between Indigenous people and other Australians over a generation and resolved that the initial priority for joint action should be on ensuring that young Indigenous children get a good start in life.

COAG requested that the Indigenous Generational Reform Working Group prepare a detailed set of specific, practical proposals for the first stage of cumulative generational reform for consideration by COAG as soon as practicable in December 2007. National initiatives will be supported by additional bi-lateral and jurisdiction specific initiatives as required to improve the life outcomes of young Indigenous Australians and their families.

COAG also agreed that urgent action was required to address data gaps to enable reliable evaluation of progress and transparent national and jurisdictional reporting on outcomes. COAG also agreed to establish a jointly-funded clearing house for reliable evidence and information about best practice and success factors.

COAG requested that arrangements be made as soon as possible for consultation with jurisdictional Indigenous advisory bodies and relevant Indigenous peak organisations.

The December 2007 COAG Communiqué (extracts)

Indigenous Australia

COAG agreed the 17 year gap in life expectancy between Indigenous and non-Indigenous Australians must be closed.

COAG today agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage. COAG committed to:

- closing the life expectancy gap within a generation;
- halving the mortality gap for children under five within a decade; and
- halving the gap in reading, writing and numeracy within a decade.

COAG recognised the pathway to closing the gap is inextricably linked to economic development and improved education outcomes.

COAG also specifically addressed the importance of tackling the debilitating effect of substance and alcohol abuse on Indigenous Australians.

The Commonwealth agreed to double the $49.3 million in funding previously provided by COAG in 2006 for substance and alcohol rehabilitation and treatment services, particularly in remote areas.

The States and Territories, in turn, committed to complementary investments in services to support this initiative.

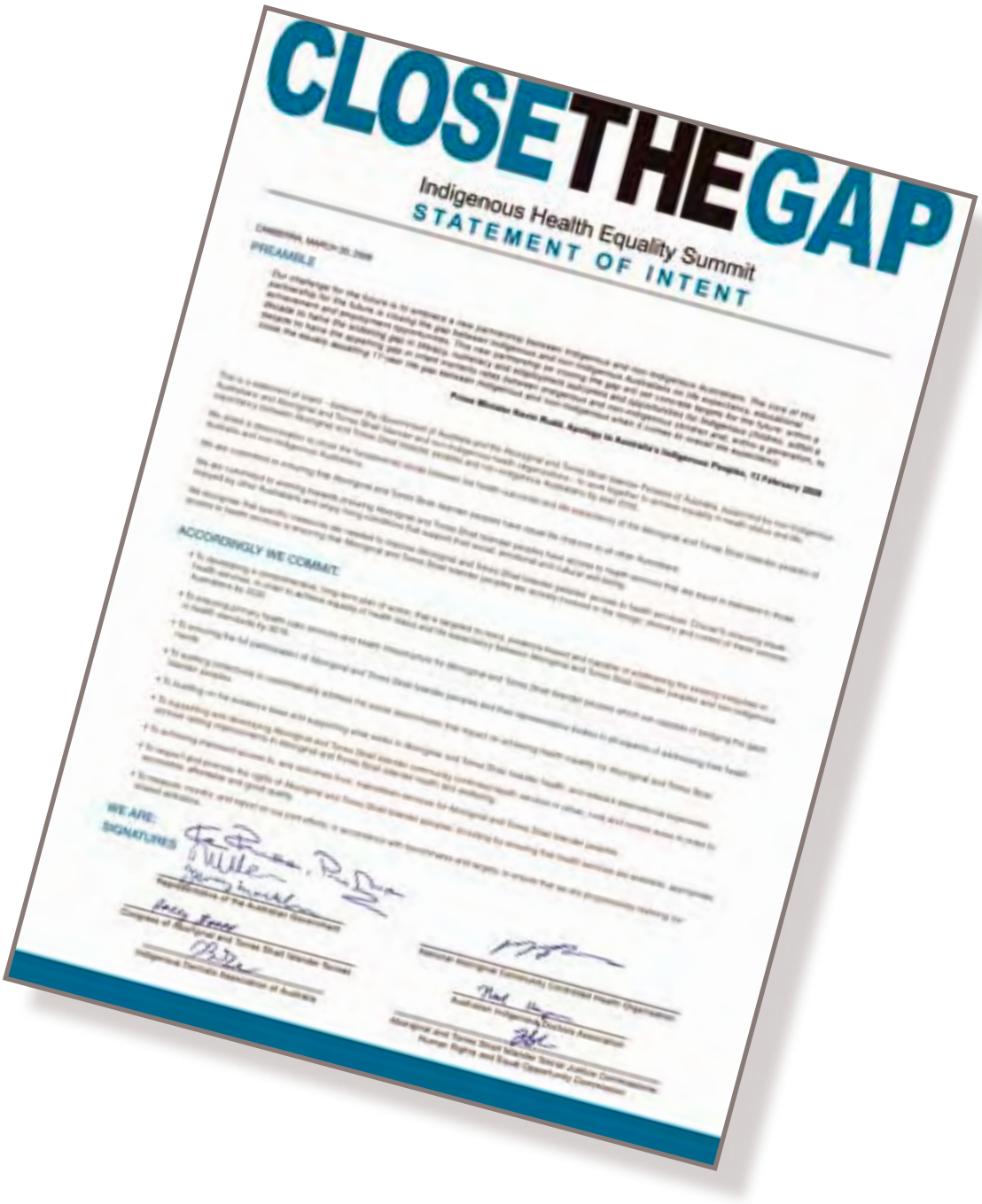
These will include, but are not limited to, strengthened policing of alcohol management plans and licensing laws and additional treatment and family support services.

COAG has also agreed that States and Territories will report transparently on the use of their Commonwealth Grants Commission funding which is on the basis of Indigenous need funding for services to Indigenous people.

Part 2

OUTCOMES FROM THE NATIONAL INDIGENOUS HEALTH EQUALITY SUMMIT

The Close the Gap Statement of Intent


CLOSE THE GAP

Indigenous Health Equality Summit

STATEMENT OF INTENT

PREAMBLE

ACCORDINGLY WE COMMIT:

WE ARE:

SIGNATURES

CLOSE THE GAP

Indigenous Health Equality Summit
STATEMENT OF INTENT

CANBERRA, MARCH 20, 2008

PREAMBLE

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

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

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

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

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

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

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

ACCORDINGLY WE COMMIT:

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

WE ARE:

SIGNATURES

Representative of the Australian Government

National Aboriginal Community Controlled Health Organisation

Congress of Aboriginal and Torres Strait Islander Nurses

Australian Indigenous Doctors Association

Indigenous Dentists Association of Australia

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

On a separate sheet, the following signed this Statement of Intent: the Hon. Dr Brendan Nelson MP, Leader of the Opposition; Dr Rosanna Capolingua, President, Australian Medical Association; Ms Kate Carnell, Chief Executive Officer, Australian General Practice Network; Dr Vasantha Preetham, President, Royal Australian College of General Practitioners; Professor Napier Thomson, President, Royal Australasian College of Physicians; Mr Andrew Hewett, Executive Director, Oxfam Australia; Professor Michael Dodson, AM, Co-Chair, Reconciliation Australia; Ed Coper, Get Up!; Gary Highland, National Director, Australians for Native Title and Reconciliation; Catherine Freeman, Catherine Freeman Foundation; Ian Thorpe, Ian Thorpe's Fountain for Youth; and Mr Andrew Schwartz, President, Australian Doctors Trained Overseas Association.

Close the Gap National Indigenous Health Equality Summit Targets Outline Summary

The Council of Australian Governments has agreed to a partnership between all levels of government to work with Indigenous Australian communities to achieve the target of closing the gap on Indigenous disadvantage. COAG committed to:

- closing the life expectancy gap within a generation;
- halving the mortality gap for children under five within a decade; and
- halving the gap in reading, writing and numeracy within a decade.

The aim of these targets is to achieve the three COAG goals, and particularly the two health goals. Hence they address:

- the main components of excess child mortality – low birth weight, respiratory and other infections, and injuries;
- the main components of life expectancy gap – chronic disease (cardiovascular disease (CVD), renal, diabetes), injuries and respiratory infections account for 75% of the gap. CVD is the largest component and a major driver of the life expectancy gap (~1/3); and
- mental health and social and emotional well being, which are central to the achievement of better health.

The achievement of the COAG goals requires a far more effective approach to Aboriginal and Torres Strait Islander health and in particular, those factors which are major contributors to current gaps in child mortality and the life expectancy gap.

The Campaign partners are therefore presenting an integrated set of Close the Gap targets. These targets are designed to support the commitment in the Statement of Intent, signed in Parliament House Canberra on March 20, 2008:

> *"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"*

While it is essential to ensure that there are effective programs, 'cherry picking' specific targets will not achieve the COAG goals. Effective delivery of health services for any individual topic requires an adequate infrastructure for general health service delivery.

The primary health care model used all around the world is that services are delivered by generalist health workers and medical practitioners, backed up by specific staff and resources. However, having a sufficient supply of generalist health workers and medical practitioners is a prerequisite for the specific programs.

Campaign partners places far more reliance on programs to achieve the goals of equal access for equal need and equal health outcomes. It is of limited value to say a particular condition or factor is important unless it is clear what the health target is, how it is to be achieved, indicative expenditure required (both recurrent and capital), program, workforce and infrastructure requirements to provide the necessary services and the monitoring, evaluation and management processes required. The integrated sets of targets are designed to deal with these requirements, and mark a turning point for Aboriginal and Torres Strait Islander services. In particular as agreed by COAG, a partnership approach is proposed, involving Aboriginal people and their representative bodies, health agencies, government agencies and the wider community.

These targets should be seen as the first step in a continuing process, where their refinement and implementation can be conducted through a genuine partnership between government and Aboriginal and Torres Strait Islander and other organisations.

The details of the structure and processes of this partnership will have to be determined and are essential to the achievement of the COAG goals. A fresh Government approach to partnership and to its management, monitoring, evaluation and review processes is essential for the achievement of the COAG goals – a little bit more of the same will not close the gap.

The main elements of the targets are set out below, preceded by relevant extracts from the Statement of Intent in text boxes.

1. Partnership Targets

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 the year 2030.

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.

We commit: To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.

(a) Frameworks for participation:

The establishment of national framework agreements to secure the appropriate engagement of Aboriginal and Torres Strait Islander peoples and their representative bodies in the design and delivery of accessible, culturally appropriate and quality health services.

2. Health Status Targets

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.

(a) Maternal and Child Health

Reduce low birth weight, control infections particularly gastroenteritis and respiratory infections, maternal education, dedicated services for mothers and babies.

(b) Chronic disease:

- Secondary prevention of chronic disease – risk identification and management including health checks.
- Acute care – reduce time to admission and implementation of care guidelines for CVD, diabetes, chronic kidney disease (CKD).
- Tertiary prevention – services for cardiac rehabilitation, CKD, stroke.

(c) Mental health and emotional and social well-being:

- Reduce the impact of loss, grief and trauma.
- Reduce the disparity in suicide rates and mental health disorders including depression, and psychosis.
- Improve mental health outcomes and reduce adverse events for Indigenous patients including Indigenous people with chronic disease, substance abuse or in custody.

3. Primary Health Care and other Health Services Targets

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.

We commit: To ensuring primary health care services for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gap in health standards by 2018

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 of good quality.

(a) A Capacity Building Plan

For culturally appropriate Aboriginal and Torres Strait Islander primary health care services (governance, capital works and recurrent support) to provide comprehensive care to an accredited standard to meet the level of need.

(b) Mainstream health services

Improve access to MBS/ PBS, AHCA, GP Divisions, specialist outreach.

(c) Specific Programs:

- *Mothers and children* – national coverage of Maternal and Child Health services (see Health targets), Rheumatic Fever/ Rheumatic Heart Disease (see Health targets), home visits, nutrition,
- *Chronic disease* – implement National Chronic Disease Strategy and National Service Improvement Framework, screening,
- *Prevention* – smoking, alcohol and substance misuse, physical activity and nutrition
- *Mental and social-emotional well-being* – mental health, men's health including suicide prevention.
- *Other* – men's health, oral, environmental, vaccine preventable, communicable disease.

4. Infrastructure Targets

We commit: To ensuring primary health infrastructure for Aboriginal and Torres Strait Islander peoples which is capable of bridging the gap in health standards by 2018.

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.

(a) Workforce

National Training Plan for Aboriginal and Torres Strait Islander doctors, nurses, allied health workers, dentist, AHWs; recruitment and retention, training programs for non-Indigenous health workforce; National Network of Health Centres of Excellence for services, teaching and research.

(b) Capital works and equipment

(c) Engagement of Aboriginal and Torres Strait Islander communities

(d) Housing

Home maintenance, housing design.

(e) Environment.

(f) Health information and data.

5. Social Determinants Targets

(A separate process is required for the development of targets for these topics of fundamental importance.)

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

We commit: To working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.

(a) Education.

(b) Community safety.

(c) Employment.

(d) Community development.

(e) Culture/language.

(f) Criminal justice system review and reform.

(g) Other.

The details of each of these targets, together with timelines and indicative resource requirements, are outlined in the tables that follow.

Close the Gap National Indigenous Health Equality Targets

The Council of Australian Governments has agreed to a partnership between all levels of government and Indigenous Australian communities to achieve the target of closing the gap on Indigenous disadvantage. In relation to Indigenous Australians' health, COAG has committed to:

- closing the Aboriginal and Torres Strait Islander life expectancy gap within a generation; and
- halving the mortality gap for Aboriginal and Torres Strait Islander children under five within a decade.

Proposed set of targets to achieve the COAG Commitments

1. PARTNERSHIP TARGETS					
Goal: To enhance Aboriginal and Torres Strait Islander community engagement, control and participation in Indigenous health policy and program development, implementation and monitoring					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Within 2 years: * Establish a national framework agreement to secure the appropriate engagement of Aboriginal people and their representative bodies in the design and delivery of accessible, culturally appropriate and quality primary health care services.		Within 4 years: * 60% of communities and representative bodies are active partners in regional planning of primary health care at the State/Territory level.	Within 8 years: * 100% of communities and representative bodies are active partners in regional planning of primary health care at the State/Territory level.		
* Ensure that nationally agreed frameworks exist to secure the appropriate engagement of Aboriginal people in the design and delivery of secondary care services.		* 50% of hospitals have appropriate mechanisms to engage Aboriginal people in the design and delivery of secondary care services.	* The 100% of hospitals have appropriate mechanisms that engage Aboriginal people in the design and delivery of secondary care services.		

2. HEALTH STATUS TARGETS

Goals: To close the Aboriginal and Torres Strait Islander life expectancy gap within a generation and halve the mortality gap for Aboriginal and Torres Strait Islander children under five within a decade

2.1 MATERNAL AND CHILD HEALTH

Goal: To achieve comparable rates in perinatal and infant mortality

TARGET	PROCESS	INDICATORS/TIME FRAME BY 2013	INDICATORS/TIME FRAME BY 2018	INDICATORS/TIME FRAME BY 2028	COMMENTS, REFERENCES, RESOURCES
All Indigenous women and children have access to appropriate mother and baby programs.	Access	5–10 years	5–10 years		
50% reduction in the difference between Indigenous and non-Indigenous Australian's rates of premature birth and LBW. 75% of all pregnant women present for first antenatal assessment within the first trimester.	Antenatal Care	Premature birth and LBW rates 5–10 years	Premature birth and LBW rates 5–10 years		
50% reduction in the difference in hospital rates of acute respiratory infections.	ARI prevention through Immunisation, nutrition, SDIH	ARI hospitalisation rates 5–10 years	ARI hospitalisation rates 5–10 years		
>90% of children diagnosed with ARI receive full treatment and appropriate follow-up.	ARI Treatment				
20% reduction in rates of hospitalisation for gastroenteritis.	Gastro prevention through immunisation, nutrition, SDIH	Gastroenteritis hospitalisation rates 5–10years	Gastroenteritis hospitalisation rates 5–10years		
The establishment of a national database on childhood hospital presentations for injury.		5 years			

2. HEALTH STATUS TARGETS (cont.)

2.2 CHRONIC DISEASE

A. PRIMARY PREVENTION

Goal: To reduce the level of absolute risk of vascular events among Aboriginal and Torres Strait Islander Australians by 2.5% within 10 years

TARGET	PROCESS	INDICATORS/TIME FRAME BY 2013	INDICATORS/TIME FRAME BY 2018	INDICATORS/TIME FRAME BY 2028	COMMENTS, REFERENCES, RESOURCES
Reduction in smoking rates to parity with non-Indigenous Australians 2% annual reduction – population 4% annual reduction – pregnant women.	Smoking rates		Reduce per capital consumptions rates to the national average rates (by 2020).		Requires multi-layered approach to smoking cessation. (See also Primary Health Care and Health Related Services Targets, table 3(d)).
>90% of Aboriginal and Torres Strait Islander families can access a standard healthy food basket (or supply) for a cost of less than 25% of their available income.	Nutrition and Food security		By 2018		Significant reform beyond health sector. (See also Primary Health Care and Health Related Services Targets, table 3(d)).
>80% of eligible Indigenous Australian adults having at least one risk assessment within each 2 year period.	Population Risk Assessment		Absolute risk of vascular events reduced by 2.5% in 10 years.		
Improve access to and receipt of medicine and non-medicine management of elevated vascular risk among all Aboriginal people.	Population Risk	5 years			(See also Primary Health Care and Health Related Services Targets, table 2.1).

B. SECONDARY PREVENTION – (I) GENERAL

Goal: To improve the management and reduce adverse outcomes in chronic disease

Increase coverage and availability of specialists services including outreach to Aboriginal and TSI clients in ACCHOs and other urban, rural and remote settings.	Specialist outreach				(See also Infrastructure Targets, table 4(a)).

2. HEALTH STATUS TARGETS (cont.)					
2.2 CHRONIC DISEASE (cont.)					
(I) GENERAL (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
> 80% of patients requiring routine prophylaxis receive greater than 80% of yearly scheduled injections.	Rheumatic fever/ rheumatic heart disease/ prophylaxis	5 years			(See also Primary Health Care and Health Related Services Targets, table 3(d)).
Ensure all patients with CHD, CKD and DM undergo regular review of HbA1c, lipids, BP, renal function, proteinuria, weight, visual acuity and absolute cardiovascular risk.	Assessment and management	2–5 years			
Ensure all patients with CHD, CKD and DM undergo regular assessment of psychological distress and psychosocial risk.	Assessment and management	2–5 years			
(II) CHRONIC HEART DISEASE					
Goal: To improve the management and reduce adverse outcomes in chronic disease					
>80% of all patients experiencing Acute Coronary Syndrome (ACS) present for and receive appropriate and timely care.	Reducing time to Care	5–10 years	5–10 years		Requires multiple systems improvements and raised patient awareness.
>80% of all high-risk ACS patients have access to and receive appropriate management and care.	In Hospital Management	5–10 years	5–10 years		Coronary angiography as a minimum.

2. HEALTH STATUS TARGETS (cont.)					
2.2 CHRONIC DISEASE (cont.)					
(II) CHRONIC HEART DISEASE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Reduce excess case fatality (compared to non-Aboriginal patients) at 12 months from acute CHD from 30% to 10%.	Will require improved in-hospital treatment; appropriate discharge evidence based care; long term management of CVD and improved continuity of care across the sectors.	Case fatality 3–5 years			
(III) TYPE 2 DM AND CKD					
Goal: To improve the management and reduce adverse outcomes in chronic disease					
Ensure >75% all T2DM patients have BP <130/80mmHg.		5 years			Reduce complications.
Ensure all patients with T2DM undergo regular review of HbA1c, lipid profile, BP, renal function and visual acuity.	Scheduled Care	2–5 years			
50% of known patients with T2DM have an HbA1c less than 7%.	DM Control	5 years			
All patients with T2DM are receiving appropriate medicine and non-medicine management.	Treatment	2–5 years			
Stabilize all-cause incidence of end-stage kidney disease within 5–10 years.	Incidence		10 years		

2. HEALTH STATUS TARGETS (cont.)					
2.2 CHRONIC DISEASE (cont.)					
(C) TERTIARY PREVENTION					
Goal: To improve the management and reduce adverse outcomes in chronic disease					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
>50% eligible patients surviving ACS have access to and receive appropriate cardiac rehabilitation.	CR		10 years		Aboriginal CR $20m / 4 years Must consider alternate models of CR.
Increase the proportion of Indigenous Australian patients with ESKD who receive appropriately timed and managed access to dialysis.	ESKD Referral / Access	5 years			
All CKD patients complete assessment and work-up for transplantation within 12 m, then parity in transplant rates.	Transplant Access	5 years			
Increase the proportion of Aboriginal and Torres Strait Islander people accessing appropriate rehabilitation and respite care following stroke.	Rehab				
2.3 MENTAL HEALTH AND EMOTIONAL AND SOCIAL WELL BEING					
Goal: To improve the mental health and SWEB of Indigenous Australians to the same standards enjoyed by the majority of the Australian population and reduce the impact of mental disorders on patients and their families					
Reduce the impact of loss, grief and trauma on mental health across the lifespan.	Resource appropriate mental health education, support and intervention services.	2–5 years			Chronic stress in childhood linked to poor adult outcomes including diabetes, cardiovascular disease and depression.

2. HEALTH STATUS TARGETS (cont.)					
2.3 MENTAL HEALTH AND EMOTIONAL AND SOCIAL WELL BEING (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Reduce the disparity in suicide rates and mental health disorders including depression, and psychosis across the lifespan.	Support and resource appropriate mental health service provision across all areas of remoteness.	5 years			Baseline Indigenous mental health services are grossly inadequate in rural and remote areas, particularly in regard to children and youth.
Improve mental health outcomes and reduce adverse events for Indigenous patients including Indigenous people with chronic disease, substance abuse or in custody.	Implement a national policy framework for Indigenous mental health. Support appropriate monitoring and standards of care for Indigenous mental health patients. Ensure availability of effective treatments for all Indigenous patients especially those in rural and remote areas.	2 years 5 years 2–5 years			Little data available on interventions and outcomes of mental health care, especially follow up for suicide attempts or hospital admissions. Most National data relates to hospital admissions and diagnosis. Very little data related to the impact of mental health problems and chronic disease despite international evidence.
2.4 DATA					
Goal: Achieve specified levels of completeness of identification in health records					
Recording of Indigenous status in every jurisdiction to achieve 80% accuracy.		Indigenous Australians Identification in National Datasets. 2–5 years.			(See also Infrastructure Targets, table 4(d)).

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS					
(A) ABORIGINAL AND TORRES STRAIT ISLANDER PRIMARY HEALTH CARE SERVICES					
Goal: To increase access to culturally appropriate primary health care to bridge the gap in health standards					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Access to culturally appropriate comprehensive PHC services, at a level commensurate with need.	1.1 A 5 year Capacity Building Plan for Aboriginal and Torres Strait Islander primary health care services is developed (including governance, capital works and recurrent support) to provide comprehensive primary health care to an accredited standard and to meet the level of need.	1.1.1 Services are funded by a single core of pooled funds for a minimum of 3 years at a time, and at least three times the per capita MBS utilisation by non-Indigenous Australians (with a rural and remote loading of up to an additional three times). 1.1.2 To complement uptake of PBS and MBS by Aboriginal peoples and Torres Strait Islanders increased to at least 1.2 times the per capita utilisation for the non-Indigenous Australian population. 1.1.3 All ACCHSs have access to pharmaceuticals through Section 100 or its equivalent. 1.1.3 Capital works programs to assist Aboriginal communities wishing to develop a new ACCHS are established.	Reduced hospital admission rates for ambulatory conditions. The disparity in vaccine preventable disease rates is eliminated. Reduced prevalence of chronic disease risk factors. Decreased childhood mortality rates. Increased life expectancy.	Aboriginal and non-Aboriginal hospital admission rates for ambulatory conditions are equivalent.	Additional grants to Aboriginal primary health care services of $150m, $250m, $350m, $400m, $500m per annum over 5 years with the $500m sustained in real terms thereafter until the Indigenous Australian health gap closes. The proposed expenditure provides for staff salaries (doctors, nurses, Aboriginal Health Workers, allied health, dental, administrative/management and support staff) including training, transport provision, and ancillary programs and all other operational costs including the annualised cost of infrastructure. This also includes housing for staff in remote areas. In some areas, the required infrastructure will not be readily available and capital works programs will be required by one or all levels of government.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(A) ABORIGINAL AND TORRES STRAIT ISLANDER PRIMARY HEALTH CARE SERVICES (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
		1.1.4 80% of ACCHSs are accredited in the new accreditation framework which includes governance, capital works, and service delivery and maintained to accreditation status. 1.1.5 80% of ACCHS provide home visiting services and have facilities for provision of visiting allied health and specialist services. 1.1.6 Established mechanisms for community engagement initiatives. 1.1.7 Resources are in place for NACCHO Affiliates and Torres Strait Islanders CCHS to support every Aboriginal and Torres Strait Islander community that wishes to develop their Aboriginal &Torres Strait Islander primary health services into legally incorporated community-controlled services.			This is consistent with the Rudd Governments Super Clinics pledge for mainstream services.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(B) MAINSTREAM PRIMARY HEALTH CARE SERVICES					
Goal: Improve the responsiveness of mainstream health services and programs to Aboriginal and Torres Strait Islander peoples health needs					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Mainstream services provided to Aboriginal and Torres Strait Islander people in a culturally sensitive way and at a level commensurate with need.	2.1 Increase Aboriginal people's access to medicines and services.	2.1.1 Uptake of PBS by Aboriginal peoples and Torres Strait Islanders increased to at least 1.2 times the per capita utilisation for the non-Indigenous Australian population. 2.1.2 An established quality use of medicines scheme for Aboriginal primary health care services in non-remote areas that also increases access to medicines. 2.1.3 The S100 remote area PBS access scheme has an incorporated quality use of medicines component.			$80m per annum. Implementation of Goal 1 will enhance the success of and complement this initiative.
	2.2 Develop national strategies to enhance the utilisation and relevance of the Medicare Benefits Schedule (MBS). (ie Increase Aboriginal peoples and Torres Strait Islander access to Australia's universal health scheme).	2.2.1 Outcomes-based incentives are introduced for increased use of Indigenous specific health assessments. 2.2.2 Uptake of MBS by Aboriginal peoples and Torres Strait Islanders increased to at least 1.2 times the per capita utilisation for the non-Indigenous Australian population. 2.2.3 All jurisdictions have a registration process in place for AHWs.			$30m over 5 years.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(B) MAINSTREAM PRIMARY HEALTH CARE SERVICES (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
	2.3 State and federal bilateral financing agreements to commit to health equity within mainstream programs, such as through public health or health care agreements.	2.3.1 Australian Health Care Agreements commit to monitor and report on access to health programs by Aboriginal peoples and Torres Strait Islanders. 2.3.2 Performance indicators are agreed for which funding is contingent, that pertains to meeting targets that improve Aboriginal peoples and Torres Strait Islanders access to hospital and other services. 2.3.3 Targets are developed and agreed to under the Health Care Agreements including for kidney dialysis; population health programs (such as sexual health, cervical screening, Breastscreen); rehabilitation services (eg cardiac rehabilitation, Commonwealth Hearing Services Program); residential aged care services, and immunisation. 2.3.4 Commonwealth and State/Territory health programs agree to health impact assessments of policies relevant to Aboriginal and Torres Strait Islanders in order to ensure their accessibility.			Under the Australian Health Care Agreements.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(B) MAINSTREAM PRIMARY HEALTH CARE SERVICES (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
		2.3.5 Equity audits for access to essential mainstream services are undertaken.			
	2.4 Systems for programs delivered through private general practices commit to health equity.	2.4.1 The Multi-Program Funding Agreement between the Department of Health and Ageing with Divisions of General Practice in Australia have a set of performance expectations pertaining to delivery of services to Aboriginal peoples and Torres Strait Islanders. 2.4.2 All Australian Governments commit to make it part of the accreditation process that all government funded and private general practices provide culturally sensitive services to Aboriginal and Torres Strait Islander people. 2.4.3 All health care providers to commit to a Charter detailing the level of service an Aboriginal and Torres Strait Islander patient will receive, including arrangements to ensure cultural issues are recognised and addressed within each service, [and] a system to provide interpretation and cultural support where necessary for patients.			

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(C) MATERNAL AND CHILD HEALTH SERVICES					
Goal: National coverage of child and maternal health services is provided					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
National coverage of culturally appropriate maternal and child health services for Aboriginal and Torres Strait Islander people.	3.1 Increase the Aboriginal and Torres Strait Islander populations' access to culturally appropriate maternal and child health care services.	3.1.1 A national health plan for Aboriginal and Torres Strait Islander mothers and babies is developed, costed, and implemented. 3.1.2 Aboriginal and Torres Strait Islander primary health care services are supported to deliver child and maternal health services as core activity. These services act as hubs for parenting support referrals. 3.1.3 Aboriginal and Torres Strait Islander primary health care services are supported to deliver culturally appropriate home visiting programs as core activity, and there is integration in this activity with other home visiting service providers. 3.1.4 Incentive programs for the immunization of the Aboriginal and Torres Strait Islander population, including development of an Aboriginal and Torres Strait Islander immunisation workforce to address continuing high rates of vaccine preventable diseases.	Halve the gap in mortality rates between Indigenous and non Indigenous Australian children under the age of five within a decade. 70% of Aboriginal and Torres Strait Islander children have a child health assessment by aged 2 years. 90% of Aboriginal and Torres Strait Islander children have a hearing assessment prior to school entry. Immunisation rates sufficient to achieve herd immunity and achieve national targets.		$92.2m over 4 years (Labor Pledge). $37.4 m for home visiting provided in the 2007–08 federal Budget. See also Goal 1 which enables this. (Goal 3 cannot succeed without Goal 1). Nutrition is an integral part of MCH.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(C) MATERNAL AND CHILD HEALTH SERVICES (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
		3.1.5 Performance indicators for hearing service providers under the Commonwealth Hearing Services Program are developed to improve hearing services provision and rehabilitation services. 3.1.6 All State and Territory health services capacity to monitor ear disease and allow the hearing ability of Indigenous Australian children to be tested by 3years of age, forms part of the criteria for service accreditation.			
	3.2. Develop a national 'nutritional risk' scheme for at-risk mothers, infants and children.	3.2.1 Scheme developed. 3.2.2 Eligibility for such a scheme includes a low household income, pregnancy, postpartum, or breast-feeding, or a child under the age of five years, in the presence of nutritional risk assessed by a health professional. This risk may include: inadequate diet; abnormal weight gain during pregnancy; a history of high-risk pregnancy; child growth problems such as stunting, underweight, or anaemia; and homelessness.	Reduced incidence and prevalence of under nutrition. Reduced low birth weight rates to levels of non-Aboriginal and Torres Strait Islander people.		$50m over 4 years. Target 3.1 Mother and Child Health teams would intersect with and refer clients to this program. $20m over four years.* As above. * Heart Foundation, *Close The Gap: Improving Chronic Disease Prevention and Cardiovascular Disease Outcomes for Aboriginal and Torres Strait Islander Peoples* 2008.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(C) MATERNAL AND CHILD HEALTH SERVICES (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
		3.2.3 Nutritionists are partnered with Indigenous Health/Nutrition Workers to support the maternal and child health nurse home visiting teams.			
	3.3. Develop health promotion programs targeting smoking and alcohol consumption in pregnancy.	3.3.1 Effective programs developed. 3.3.2 Incentive programs for Aboriginal and Torres Strait Islander primary health care services to meet patient population targets.	4% annual reduction of smoking in pregnant women. Reduce foetal alcohol syndrome rates. Reduce per capita consumptions rates in pregnancy to the national average rates.		
(D) INDIGENOUS-SPECIFIC POPULATION PROGRAMS FOR CHRONIC AND COMMUNICABLE DISEASE					
Goal: Enhance Indigenous-specific population programs for chronic and communicable disease					
National coverage of Aboriginal and Torres Strait Islander peoples for funded and effective programs for chronic and communicable disease.	4.1 Develop and implement a national chronic disease strategy which 'close the gap' in excess disease.	4.1.1 The recommendations of the National Chronic Disease Strategy and National Service Improvement Frameworks for national health priority areas (pertaining to Indigenous Australians) are incorporated within a Plan funded and implemented. 4.1.2. Cardiac rehabilitation programs for Aboriginal and Torres Strait Islander peoples are developed.			$20m over 4 years.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(D) INDIGENOUS-SPECIFIC POPULATION PROGRAMS FOR CHRONIC AND COMMUNICABLE DISEASE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Minimise the harm associated with the use and misuse of alcohol, tobacco and other drugs.	4.2 Fund coordinated Aboriginal and Torres Strait Islander peoples' Programs for tobacco control, alcohol and substance misuse, nutrition and physical activity.	4.2.1 A National Tobacco control campaign is developed. 4.2.2 Population-based smoking cessation programs (including components assisting pregnant women to quit) are developed and implemented. 4.2.3 The Complementary Drug and Alcohol Action Plan is implemented. Programs targeting: control of supply; harm reduction; harm minimisation; intervention; early intervention implemented Reduced hospitalisation rates of Indigenous people with alcohol and other drug related morbidity and mortality. 4.2.4 Culturally appropriate and accessible alcohol and other drugs services [which involve] partnerships between Aboriginal and mainstream health services at a regional level, are provided including the provision of patient assisted transport schemes. 4.2.5 An Aboriginal and Torres Strait Islander National Physical Activity.	Reduce per capital consumptions rates to the national average rates (by 2020).		Requires multi-layered approach to smoking cessation. $24m over 4 years for Tobacco. Cost to be determined for other substances. Implementation of programs run and integrated through NACCHO affiliates where possible and where preferred. As a link to the uptake of health checks through the promotion of physical activity in PHC. (See also Health Status Targets, table 2.2(a)).

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(D) INDIGENOUS-SPECIFIC POPULATION PROGRAMS FOR CHRONIC AND COMMUNICABLE DISEASE (cont.)					
Goal: National nutrition plan, developed, funded and implemented					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
> 90% of Aboriginal and Torres Strait Islander families can access a standard healthy food basket (or supply) for a cost of less than 25% of their available income. (See also Health Status Targets, table 2.2(a)).	Food Security. Focus on affordability and accessibility of healthy food choices.	National nutrition plan, developed, costed, funded and implemented.			Resource requirements to be determined.
	Nutrition interventions for at-risk communities – recognizing the link between poverty and poor quality diets. Community stores to commit to healthy nutrition goals and targets as well as financial goals and targets.				Heart Foundation, "Everyday Foods" of Heart Foundation Buyer's Guide for managers of remote Indigenous community stores and takeaways 2008.
Goal: Comprehensive and culturally appropriate oral health care services organised and coordinated on a regional basis					
By 2020 high quality, comprehensive and culturally appropriate oral health care services will be organised and coordinated on a regional basis. All Indigenous communities with a population of more than 1000 will have a fluoridated water supply by 2015.	4.3. Develop and implement an oral health program as an integral component of comprehensive primary health care including: – Community water fluoridation; and – A coherent oral health promotion strategy.	The Federal Government. to coordinate a National Indigenous Australians' Oral Health Care Program which allocates resources and responsibilities for the provision of clinical care by State/Territory public dental providers and NACCHO on a regional basis.			$290 million for a Commonwealth Dental Health Program over three years (Labor pledge). Proposed that the Federal Government initiate a small community water fluoridation program, suitable for remote and rural locations, and work with State/Territory Governments, local water authorities and communities to implement the program.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(D) INDIGENOUS-SPECIFIC POPULATION PROGRAMS FOR CHRONIC AND COMMUNICABLE DISEASE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
All Indigenous communities with a population of more than 500 will have a fluoridated water supply by 2020. Implementation of a coherent national oral health promotion strategy by 2010.	High quality, comprehensive and culturally appropriate oral health care services organised and coordinated on a regional basis.	4.3.1 Culturally appropriate and accessible oral health services [which involve] partnerships between Aboriginal and Torres Strait Islander and mainstream health services at a regional level, are provided including the provision of patient assisted transport schemes. 4.3.2. An oral health promotion campaign is supported for Aboriginal peoples and Torres Strait Islander (stand alone and/or integral to chronic disease programs). 4.3.3. Access to oral hygiene materials is increased.			Resource the Australian Research Centre for Population and Oral Health to develop an oral health promotion strategy with NACCHO, Indigenous Dentists' Association of Australia, RCADS, professional representative organisations and State/ Territory health promotion agencies.
Goal: To be developed (adolescent and youth health)					
4.4 A national Indigenous adolescents or youth health strategy is developed to make health services more accessible and appropriate to them.	4.4.1 Strategy developed.				
Goal: To be developed (men's health)					
4.5 A national Indigenous men's health strategy is developed to make health services more accessible and appropriate to Indigenous men.	4.5.1 Strategy developed.				

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(D) INDIGENOUS-SPECIFIC POPULATION PROGRAMS FOR CHRONIC AND COMMUNICABLE DISEASE (cont.)					
Goal: Communicable disease programs implemented					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
	4.6.1 A National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy is funded to reduce STI and HIV/Hepatitis C rates. 4.6.2 The National Flu and Pneumococcal vaccine program is expanded to increase vaccine coverage. 4.5.3 A national rheumatic fever/heart disease strategy for increased coordination between primary health care services and population health programs is developed to improve preventive interventions and access to surgery. 4.5.4 Trachoma control programs are expanded through implementation of SAFE strategy.	Reduced rates of invasive pneumococcal disease, etc. >80% of patients requiring routine prophylaxis receiving greater than 80% of yearly scheduled injections.			Also depends on Goal 1. Federal Labor "New Directions" package includes rheumatic fever and heart disease control.
(E) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELL BEING					
Goal: Improve access to timely and appropriate mental health care in PHCS and specialised mental health care services across the lifespan					
Completed service plans and partnerships.	Implement in consultation a service plan to respond to the mental health needs of PHC services and Indigenous communities.	5 years Yearly evaluation of service agreements.			Emphasis on specialist mainstream services being responsible for supporting PHCS.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(E) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELL BEING (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
	Implement National Cultural Respect Framework for mainstream services.	Evaluate mainstream services appropriateness and responsiveness in line with National Cultural Respect Framework.			
Increase access to and total number of mental health professionals working in PHCS. Increased screening for risk factors for mental health in general health checks.	Build and strengthen capacity in PHC services to respond to mental health needs across the lifespan including access to SEWB centres and Bringing them home (BTH) counselling Implement screening tools and protocols for identifying and managing psychosocial risk Comprehensive health checks and Chronic Disease management plans to include mental health concerns	Benchmark Baseline data. Audit of policy frameworks, service provision and programs. Training data for mental health courses for PHCS staff. Mental Health Staff numbers 5 years. Increased referral to support programs – 2 years to develop protocols.			Ref: *Bringing Them Home* Report, National Strategic Framework for Aboriginal and Torres Strait Islander mental health and SEWB.
Protocols for identifying and managing psychological or behavioural distress and mental illness across the lifespan in PHCS including custodial populations and homeless with priority given to children and youth, and children in out of home care implemented.	Mental health management plans initiated and completed Develop 'Best Practice' guidelines.	Protocols and guidelines implemented 2 years. Mental health patient contacts in PHCS data base ongoing. Decrease Deliberate Self Harm and suicide rates 2–5 years. Decrease acuity, ED contacts and hospital admissions/readmissions. Decrease prevalence of common disorders such as Depression and Anxiety 10 years.			Identifying and managing mental health problems early in their course will improve overall mental health and SEWB outcomes, especially in the youth population. Managing 'stress' will also improve general health outcomes.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(E) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELL BEING (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Standardised referral pathways to specialised services such as drug and alcohol, family violence, trauma and grief counselling, Psychiatric services and suicide prevention programmes implemented.	Referrals to specialised services developed and standardised.	Decreased delay in time of referral to specialised care. Increased Indigenous patient mental health services contacts – 2 years to implement protocols.			
	Improved outcomes for mental health care for Indigenous Australians including co-morbidity issues of substance use.	Decrease incarceration rates for mental health patients. Monitor referrals under the Mental Health Act (ongoing). Reduced DSH and mortality rates. Reduced rates of substance use in mental health patients Improved Outcome and follow up data including access to medications and specialists. Decrease prevalence of severe mental illness 5–10 years.			
All Indigenous women to have access to culturally appropriate maternal and infant mental health services.	Support development and resourcing of maternal/ infant mental health services alongside antenatal services across all communities.	5–10 years.			Known association with poorer birth, physical and mental health and life outcomes for infants born to mothers with antenatal and postnatal mental health disorders and exposure to chronic stress in utero.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(E) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELL BEING (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
All Indigenous women have access to mental health screening perinatally.	Support the cultural adaptation of the Edinburgh post-natal depression scale (EPDS) and other culturally relevant instruments. Identify and manage at risk Indigenous mothers through appropriate mental health screening tools perinatally.	5 years			Current evidence of efficacy of the EPDS and intervention in mainstream populations.
All Indigenous children and youth to have access to appropriate mental health screening and referral pathways to mental health services as appropriate. Reduce the disparity for Indigenous children at risk by 50%.	Support resources for identifying children and youth at risk through community, health and education services. Identify and reduce the impact of negative life stress events on child development.	5–10 years	5–10 years		WAACHS Vol 2 found 24% of Indigenous children aged 4–17 years at high risk of clinically significant emotional or behavioural difficulties compared to 15% of non-indigenous children. Multiple negative life stress events was the strongest predictor.
Improve access and base level rehabilitation and support services for chronic mental health problems and disorders throughout the lifespan for all Indigenous patients and their families.	Support and resource rehabilitation, accommodation, educational, life skills and recreational services for patients with chronic illness and their families, especially in rural and remote areas. Support adequate data collection on Indigenous patients under the Mental Health Act, compulsory treatment orders and their outcomes.	2–5 years			Few rehabilitation and support services exist in for Indigenous mental health patients in remote locations. Children of parents with chronic disease and/or mental disorders are at high risk of poor life, health and wellbeing outcomes placing the next generation at risk.

3. PRIMARY HEALTH CARE AND OTHER HEALTH SERVICE TARGETS (cont.)					
(E) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELL BEING (cont.)					
Goal: Build community capacity in understanding, promoting wellbeing and responding to mental health issues					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
	Develop mental health Promotion, Prevention and Early Intervention (PPEI) programs through the PHC sector.	Number of communities and people accessing programs 2 years. Number and review of community action plans 2–5 years. Number and evaluation of PPEI programs operating. Decrease in observable risk factors, eg, substance use. Increase in observable protective factors, eg, family functioning. Increased family and community wellbeing. Measures for cultural recovery and continuity 2–5 years.			
Goal: Promoting mental health recovery across the lifespan					
Increased access to education, accommodation and employment programs for mental health patients. Increased access to recreation, social, cultural and family support programs.	Develop targeted accommodation, recreational, life skills, employment and education programs for patients with mental health problems.	Number of patients in employment, education and training programs. Number of patients in supported accommodation and number of people accessing support programs 2–5 years.			

4. INFRASTRUCTURE TARGETS

(A) THE SIZE AND QUALITY OF THE HEALTH WORKFORCE

Goal: Provide an adequate workforce to meet Aboriginal and Torres Strait Islander health needs by increasing the recruitment, retention, effectiveness and training of health practitioners working within Aboriginal and Torres Strait Islander health settings and build the capacity of the Indigenous health workforce

TARGET	PROCESS	INDICATORS/TIME FRAME BY 2013	INDICATORS/TIME FRAME BY 2018	INDICATORS/TIME FRAME BY 2028	COMMENTS, REFERENCES, RESOURCES
Develop a funded National Training Plan for Indigenous doctors, nurses, dentists, allied health workers, AHWs. Design, fund and implement a recruitment and retention strategy to provide the required numbers for each discipline (medical, dental, nursing and allied health workers that include AHWs). Design, fund and implement a career pathway for AHWs. Increase the number of health practitioners working by 430 within Aboriginal (and Torres Strait Islander) health settings* of whom 270 are primary care doctors. Build capacity of the Indigenous health workforce. ** AMA Discussion Paper 2004 – Update.*	Aboriginal and Torres Strait Islander student recruitment and support units in selected universities in every State and Territory.	Specify numbers to be trained in each discipline.			Specify shortfall in each discipline 1st level competence. CDAMS – ref AMA $36.5m pa.
	A financial and non-financial incentive scheme for health staff to work within Aboriginal and Torres Strait Islander primary health care services and to retain and expand the workforce pool to meet specified service requirements.	GP workforce salaries are on a par with mainstream primary health care services. Disparities in recruitment and retention of GPs, nurses, AHWs and allied health within Aboriginal and Torres Strait Islander PHC services are reduced.			See above. Locations based on need. Other strategies include HECS reimbursements. Retention packages needed as well.

4. INFRASTRUCTURE TARGETS (cont.)					
(A) THE SIZE AND QUALITY OF THE HEALTH WORKFORCE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
		Non-financial incentives include regulatory mechanisms which include geographic restriction of provider numbers based on population and with preferential access to the most popular locations based on length of services in areas of need. The National Aboriginal and Torres Strait Islander Workforce framework has been funded and implemented.			
Increase coverage and availability of specialists services including outreach to Aboriginal and Torres Strait Islander clients in Aboriginal and Torres Strait Islander primary health care services and hospitals and rural and remote settings.	Increase the Aboriginal and Torres Strait Islander populations' access to specialist Services in accordance with need.	Agreed benchmarks in rural and remote areas developed regarding specialist to population ratio's so as to ensure that Aboriginal peoples and Torres Strait Islanders have access at least to the same level as other Australians. The Medical Specialists Outreach Assistance Program is funded to a level where all Aboriginal peoples and Torres Strait Islanders can get access to specialists services as close to their community as possible.			$12m over 4 years. This includes referrals. (See also Health Status Targets, table 2 (b) (1)).

4. INFRASTRUCTURE TARGETS (cont.)					
(A) THE SIZE AND QUALITY OF THE HEALTH WORKFORCE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Provide an additional 1500 AHWs.	Introduce a national program to fully implement the national Aboriginal Health Worker Qualifications within the Aboriginal Community Controlled health services sector including career structure, pay equity and professional development.	$20m over 5 years.			Link in with Vocational, educational and training Programs (VET).
Develop a skilled alcohol and drug workforce.	Number of alcohol and drug workers.				
Develop a skilled oral health workforce.	The Federal Government to coordinate a focused process with the Dental Schools, the Australian Dental Council, RCADS, the Indigenous Dentists' Association of Australia and the professional representative organisations to promote careers in oral health and support students and practitioners.			100 Indigenous dentists, dental therapists and dental hygienists by 2020. 300 dentists, dental therapists and dental hygienists, 30 specialist dentists, 10 dental educators by 2030.	
Goal: Increase the quality of the health services and the workforce					
Develop a National Network of Centres of Teaching Excellence in every State and Territory to deliver high quality health services, providing multidisciplinary teaching and conduct applied research on improved methods of health service delivery.		Establish and cost pilot centres. Cultural safety training programs are delivered in partnership with and recognised by ACCHSs and their representative bodies.	National network		$10m seed funds in year 1.

4. INFRASTRUCTURE TARGETS (cont.)					
(A) THE SIZE AND QUALITY OF THE HEALTH WORKFORCE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Ensure implementation of appropriate training on Aboriginal and Torres Strait Islander health including cultural issues in all relevant undergraduate curricula. Ensure that all new staff and existing staff providing services to Aboriginal peoples and Torres Strait Islanders complete a relevant cultural safety training/security programme. Implement a program of work place and work force reform that implements a model that is based on care at the first level of competence. Establish programmes that increase the availability of a multi disciplinary and trans disciplinary workforce at the local level in Aboriginal and Torres Strait Islander health.					Entry level. Step back training programs before ITAS. $5m over 5 years.
(B) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELLBEING WORKFORCE					
Goal: Build an effective Mental Health/Social and Emotional Wellbeing workforce					
Increase Indigenous mental health professionals to 1:500 population.	Promote parity for Indigenous mental health professionals across all mental health professional groups.	Baseline measure. Yearly increments to profession/population ratios to 50% by 10 years.			Ref: *Ways Forward* Report.

4. INFRASTRUCTURE TARGETS (cont.)					
(B) MENTAL HEALTH/SOCIAL AND EMOTIONAL WELLBEING WORKFORCE (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
		Intake of students Retention rates Graduates 10–20 years.			
	Establish recognition and registration for Aboriginal Mental Health Workers (AMHW's).	Baseline data Agreed competencies Registration numbers 5 years.			
Increase competency of mental health professionals working with Indigenous peoples.	Improve competency of the non-Indigenous mental health workforce (students and staff) through education and training.	University curriculum development in Indigenous mental health (IMH). Agreed standards of competency in IMH. Cultural safety training completed by all staff. 5 years.			Ref: CDAMS Indigenous health curriculum framework.
(C) HOUSING, ENVIRONMENTAL HEALTH AND HEALTH SERVICES CAPITAL WORKS					
Goal: To immediately commence improvement of the most basic facilities within all existing Indigenous Australians' houses to ensure safety and access to critical health facilities					
Ensure the development of a set of community level health service facility standards that are nationally agreed. Ensure that all community level facilities meet the health service facility standards.		Within 2 years.	Within 10 years.		

4. INFRASTRUCTURE TARGETS (cont.)					
(C) HOUSING, ENVIRONMENTAL HEALTH AND HEALTH SERVICES CAPITAL WORKS (cont.)					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
That adequate staff housing is available. Ensure that all community facilities have access to the appropriate equipment and technology necessary to delivery comprehensive primary health care to Aboriginal and Torres Strait Islander communities in a timely manner.		Within 5 years.			
Ensure immediate maintenance of houses at time of assessment using a safety and health priority. Use a majority of local Indigenous teams for house assessment and maintenance.	Use a standardised, repeatable assessment of houses based on the National Indigenous Housing Guide (NIHG) principles of safety and health determine the function of houses.	Critical healthy living practices* are available in 75% of all houses (*electrical safety, gas safety, structural safety and access, working washing, laundry and toilet facilities, all waste water safely removed from the house and yard, and the ability to store prepare and cook food).	Assess that the goal of 75% of all houses functioning has been maintained.	Assess that the goal of 75% of all houses functioning has been maintained	
Ensure that EHW are provided with capacity development support.	Career pathways to all environmental health workers to move through different levels of competency. Develop support and mentoring programs for EHWs. Ensure new entrants have appropriate numeracy and literacy skills.				

4. INFRASTRUCTURE TARGETS (cont.)					
(D) DATA					
Goal: Achieve specified levels of completeness of identification in health records					
TARGET	**PROCESS**	**INDICATORS/TIME FRAME BY 2013**	**INDICATORS/TIME FRAME BY 2018**	**INDICATORS/TIME FRAME BY 2028**	**COMMENTS, REFERENCES, RESOURCES**
Recording of Indigenous status in every jurisdiction to achieve 80% accuracy. Define an Indigenous Australians' oral health data set.	The Federal Government will resource the Australian Research Centre for Population and Oral Health to develop and negotiate an agreed Indigenous Australians' oral health data set with public dental providers, NACCHO and the Indigenous Dentists' Association of Australia.	Indigenous Australians Identification in National Datasets – 2–5 years.			(See also Health Status Targets, table 2.4).

The National Indigenous Health Equality Summit, March 20th 2008, Great Hall, Parliament House, Canberra

The Prime Minister, the Hon. Kevin Rudd MP, Mr Ian Thorpe and Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner.

Front Row L–R: The Hon. Nicola Roxon MP, Minister for Health and Ageing, Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, Dr Vasantha Preetham, President, Royal Australian College of General Practitioners, the Hon. Dr Brendan Nelson MP, Leader of the Opposition.

Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner.

Chair of the National Aboriginal Community Controlled Health Organisation, Dr Mick Adams, MC for the event.

L–R: The Prime Minister, the Hon. Kevin Rudd MP, Ms Catherine Freeman, the Hon. Nicola Roxon MP, Minister for Health and Ageing, the Hon. Jenny Macklin MP, Minister for Indigenous Affairs.

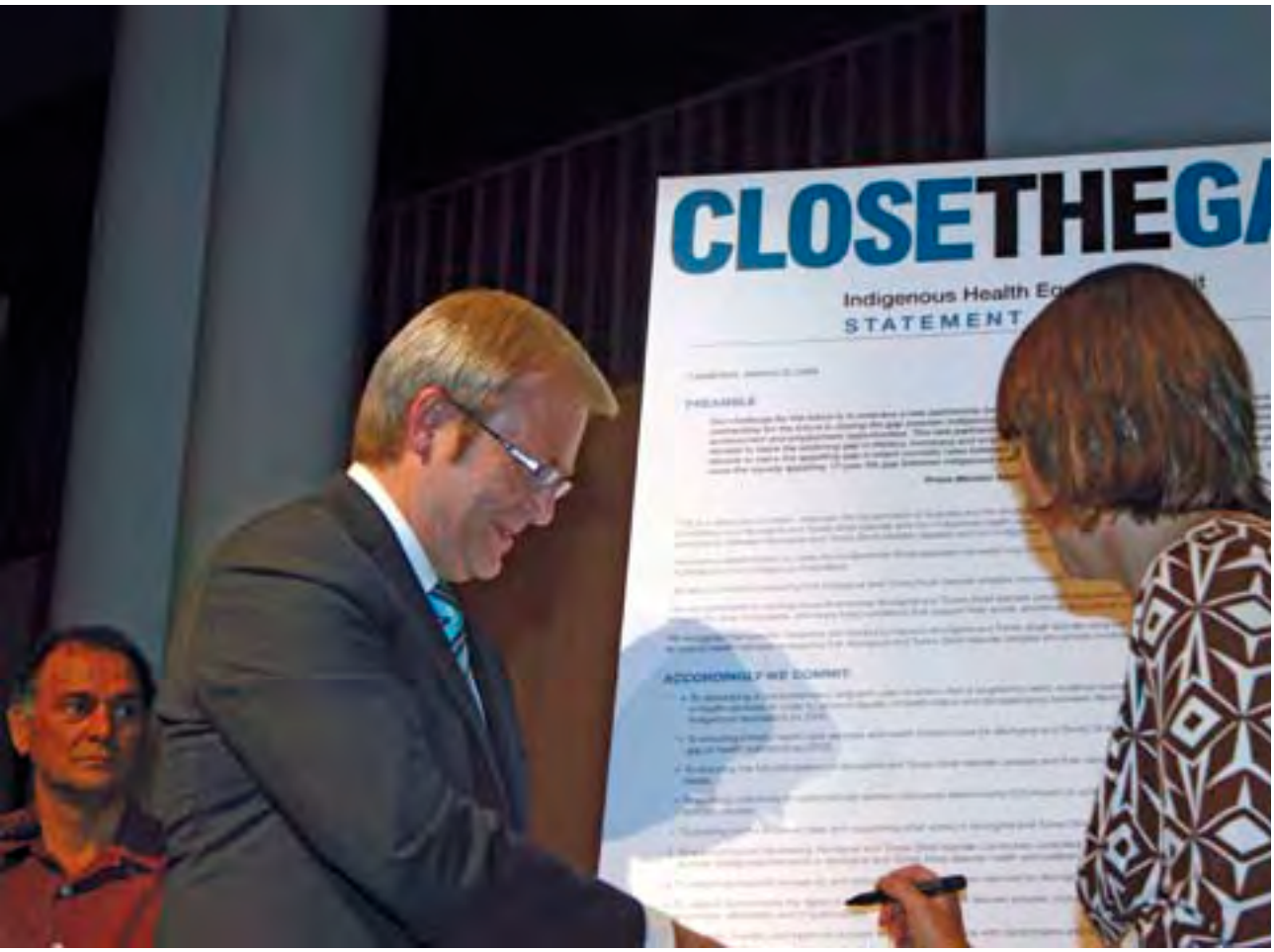
Mr Gary Highland, National Director, Australians for Native Title and Reconciliation, introducing Ms Catherine Freeman and Mr Ian Thorpe.

Ms Catherine Freeman and Mr Ian Thorpe.

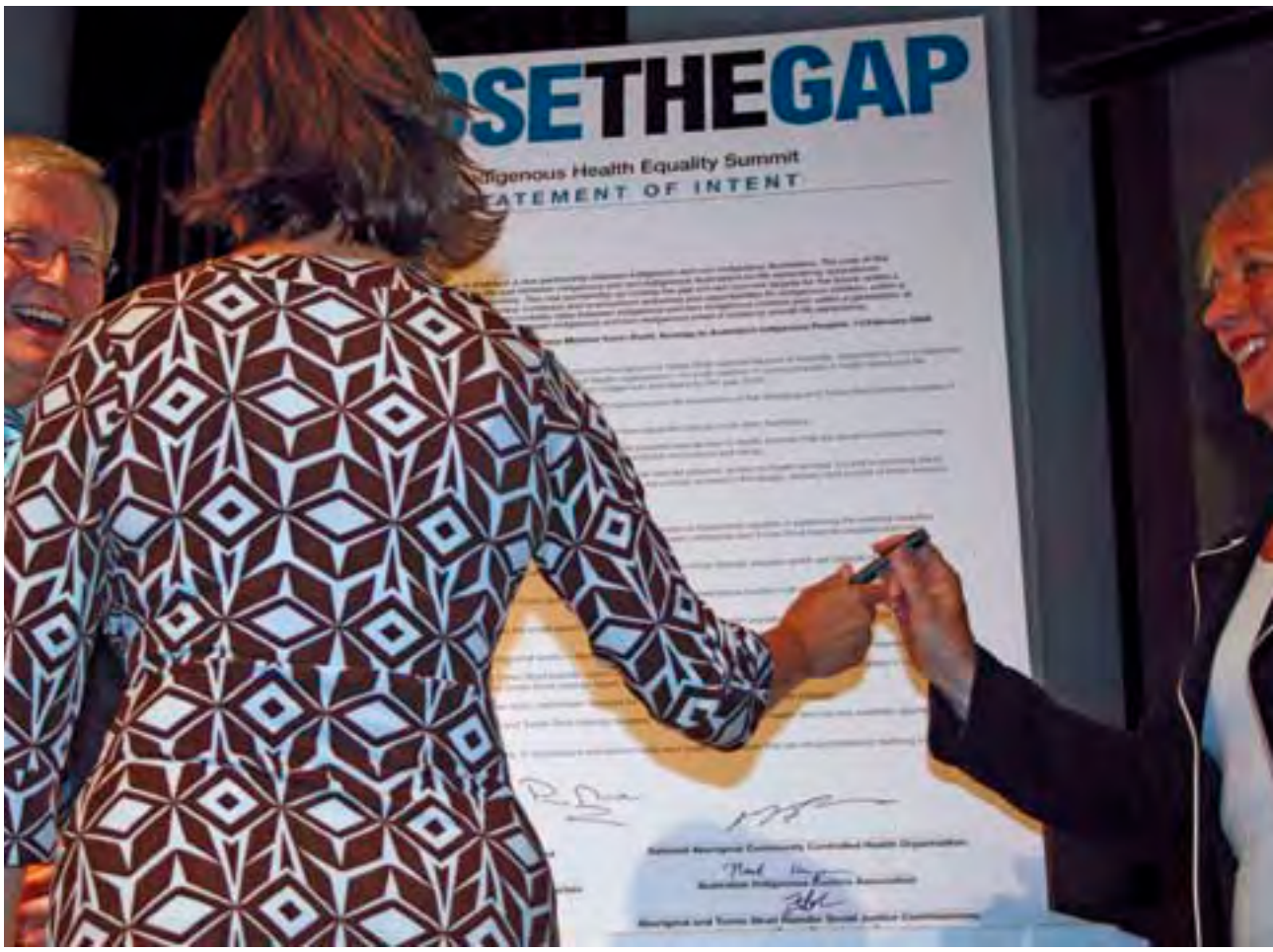
The Hon. Nicola Roxon MP, Minister for Health and Ageing.

The Prime Minister, the Hon. Kevin Rudd MP.

L–R: The Prime Minister, the Hon. Kevin Rudd MP signing the Statement of Intent, with Dr Mick Adams, Chair of the National Aboriginal Community Controlled Health Organisation.



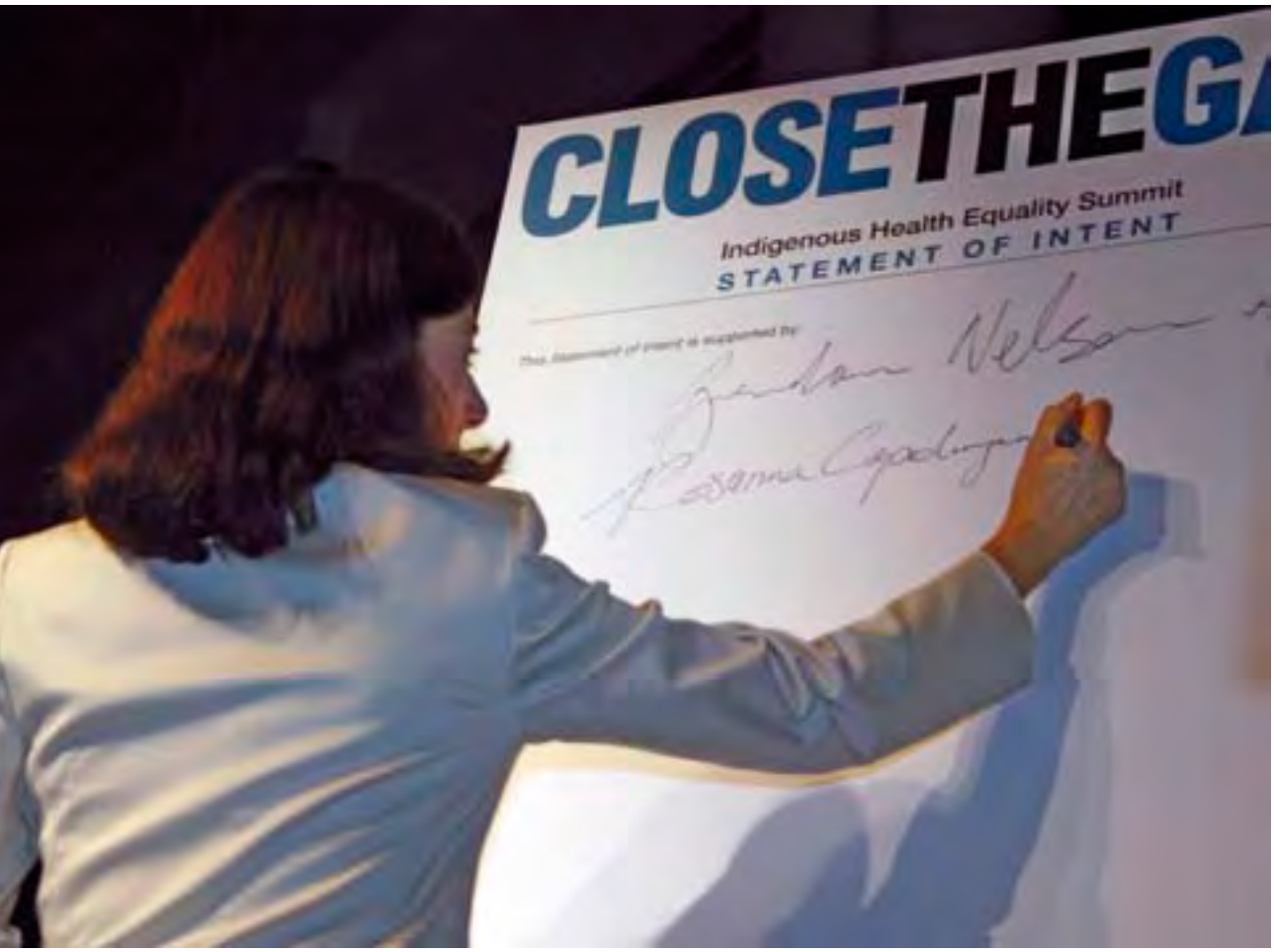
Background: Associate Professor Dr Noel Hayman, Royal Australasian College of Physicians. Foreground: The Prime Minister, the Hon. Kevin Rudd MP with the Hon. Nicola Roxon MP, Minister for Health and Ageing signing the Statement of Intent.



L–R: The Prime Minister, the Hon. Kevin Rudd MP, with the Hon. Nicola Roxon MP, Minister for Health and Ageing, passing the pen to the Minister for Indigenous Affairs, the Hon. Jenny Macklin MP.

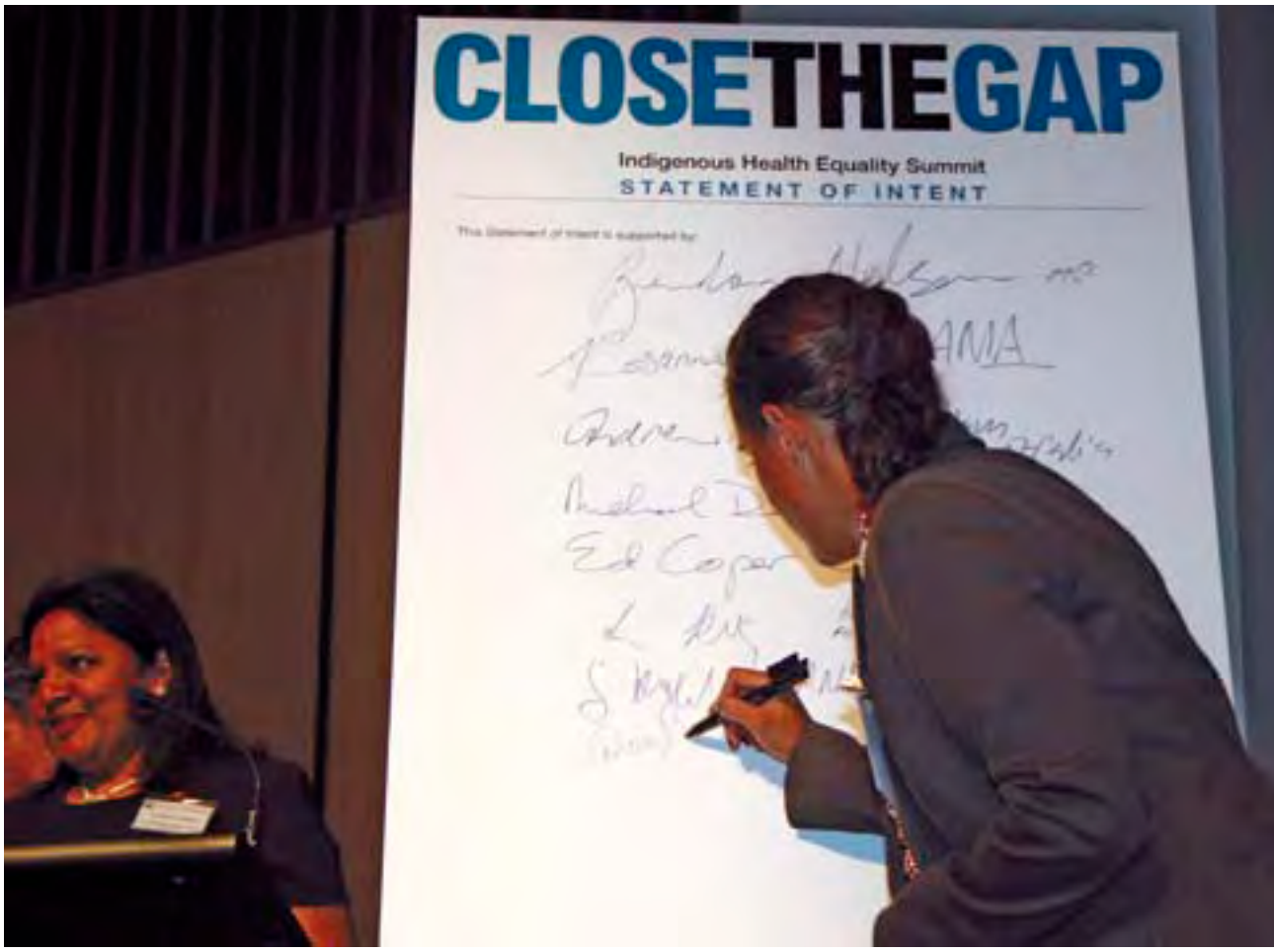
Leader of the Opposition, the Hon. Dr Brendan Nelson MP.

L–R: Dr Mick Adams, Chair of the National Aboriginal Community Controlled Health Organisation with the Hon. Dr Brendan Nelson MP, Leader of the Opposition signing the Statement of Intent.



President of the Australian Medical Association, Dr Rosanna Capolingua, signing the Statement of Intent.

Professor Michael Dodson AM, Co-Chair, Reconciliation Australia.

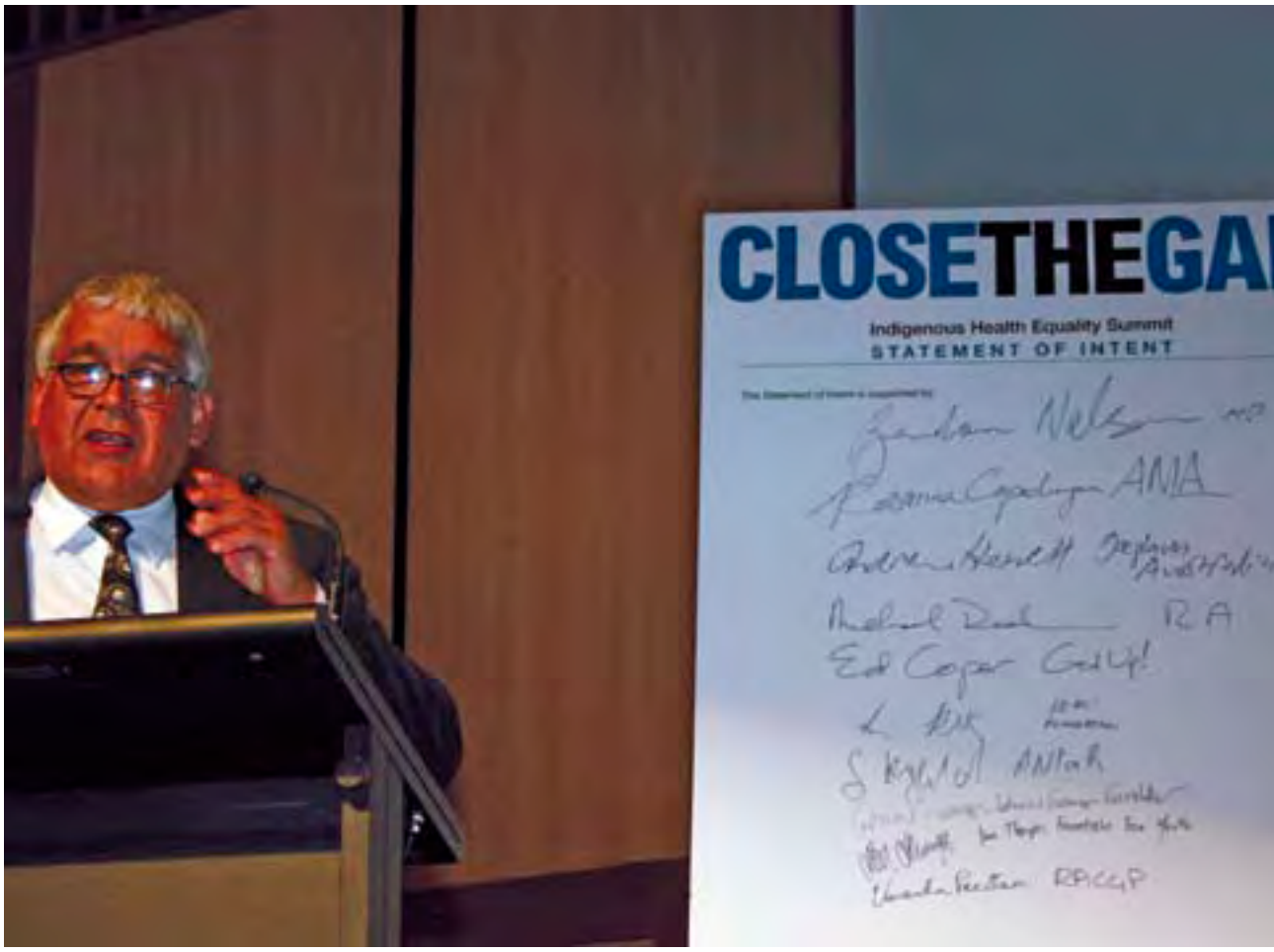


Background: Dr Vasantha Preetham, President, Royal Australian College of General Practitioners, at the podium. Foreground: Ms Catherine Freeman signing the Statement of Intent.

L–R: Dr Rosanna Capolingua, President of the Australian Medical Association, the Hon. Dr Brendan Nelson MP, Leader of the Opposition and Professor Michael Dodson AM, Co-Chair, Reconciliation Australia.

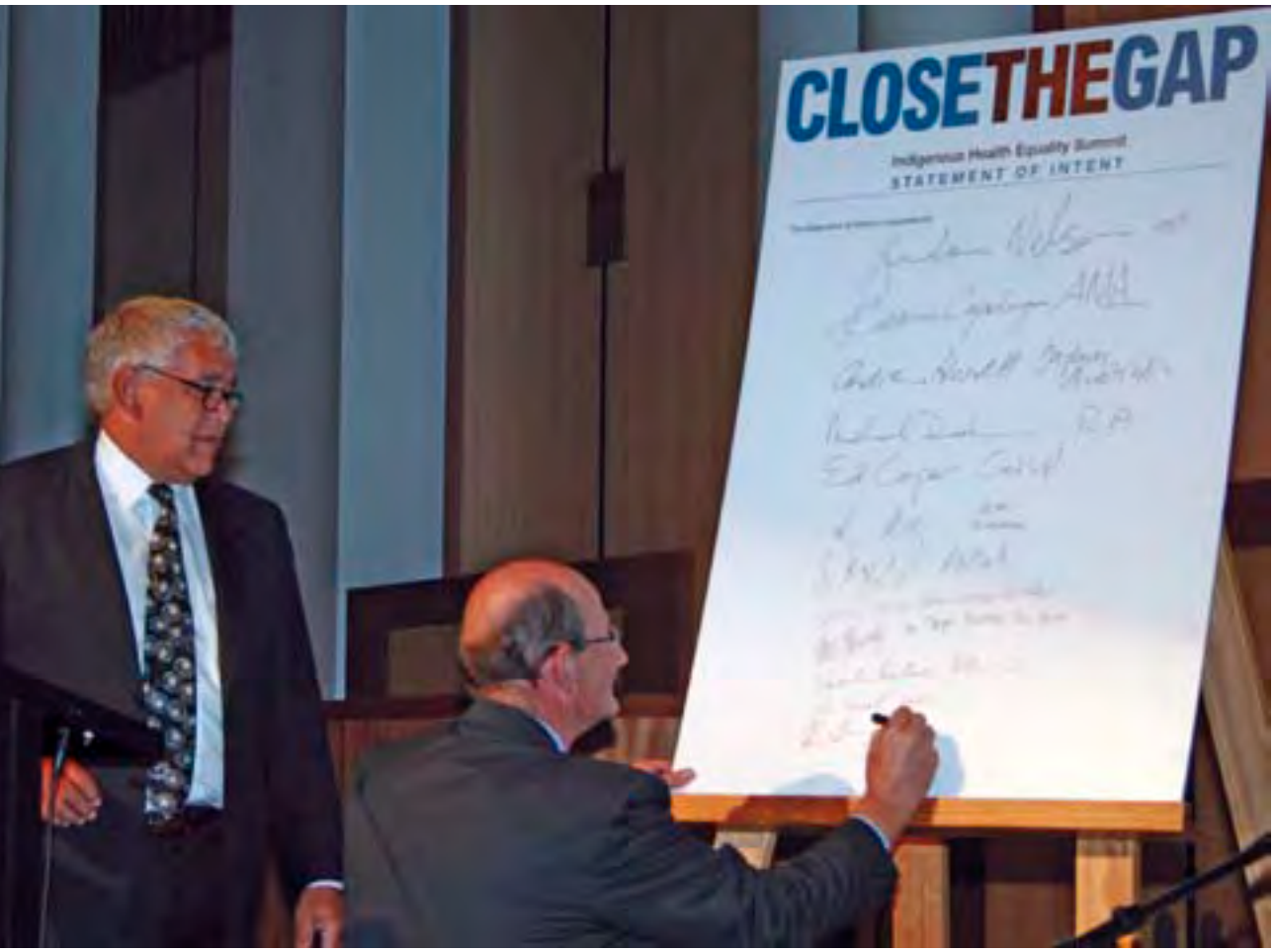
Chair of the Congress of Aboriginal and Torres Strait Islander Nurses, Dr Sally Goold OAM.

Deputy Chair of the National Aboriginal Community Controlled Health Organisation, Mr Justin Mohamed.



Mr Mick Gooda, CEO of the Cooperative Research Centre for Aboriginal Health.

CEO of the Australian General Practice Network, Ms Kate Carnell.



Mr Mick Gooda, CEO, Cooperative Research Centre for Aboriginal Health with the President of the Royal Australasian College of Physicians, Professor Napier Thomson, signing the Statement of Intent.

President of the Royal Australian College of General Practitioners, Dr Vasantha Preetham.

L–R: Mr Justin Mohamed, Deputy Chair, National Aboriginal Community Controlled Health Organisation, Dr Rosanna Capolingua, President, Australian Medical Association, Ms Kate Carnell, CEO, Australian General Practice Network, Professor Napier Thomson, President, Royal Australasian College of Physicians and Dr Vasantha Preetham, President, Royal Australian College of General Practitioners.

L–R: Mr Mick Gooda, CEO, Cooperative Research Centre for Aboriginal Health, Mr Justin Mohamed, Deputy Chair, National Aboriginal Community Controlled Health Organisation, Dr Rosanna Capolingua, President, Australian Medical Association, Ms Kate Carnell, CEO, Australian General Practice Network, Professor Napier Thomson, President, Royal Australasian College of Physicians, Dr Vasantha Preetham, President, Royal Australian College of General Practitioners and Associate Professor Dr Noel Hayman, Royal Australasian College of Physicians.

L–R: Professor Napier Thomson, President, Royal Australasian College of Physicians, Associate Professor Dr Noel Hayman, Royal Australasian College of Physicians and the CEO of the Australian Indigenous Doctors' Association, Mr Romlie Mokak.

Mr Gary Highland, National Director, Australians for Native Title and Reconciliation.

Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, with Mr Ed Coper from Get Up!

Part 3

LOOKING TO THE FUTURE

Essentials for Social Justice: Close the Gap

A speech by Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, IQPC Collaborative Indigenous Policy Conference, Brisbane, 11 June 2008

I begin by paying my respects to the Jagera and Turrubual peoples, the traditional owners of the land where we gather today. I pay my respects to your elders, to the ancestors and to those who have come before us. And thank you for your generous welcome to country for all of us.

This speech is the fourth in a series of six that I will be delivering nationally outlining an agenda for change across all areas of Indigenous affairs. I have termed this series of speeches "Essentials for Social Justice".[4]

The first speech in this series was titled "Sorry" and outlined an agenda for addressing the needs of the stolen generations and the delivery of a national apology. The second – "Reform" – focused on the need for structural reform within government so that government is capable of meeting its commitments and ambitions. The third – "Protecting Indigenous children" – focused on addressing family violence and child abuse and the NT intervention.

Today's speech is titled "Close the Gap" – a title that is a lot more popular now than it was when I started using it a few years ago.

Remaining speeches in the "Essentials for Social Justice" series in the coming months will address the importance of land and culture in creating economic development; and a look back at the progress of the Rudd government over its first 8 months in office.

But today – Close the Gap. So, what then is the gap being referred to? And why does it need closing?

The gap is the big one between the health status and life expectation of Indigenous and non-Indigenous Australians.

It is well known, for example, that there is an estimated difference of approximately 17 years between Indigenous and non-Indigenous Australians life expectation. To look at this another way, that means that 75% of Indigenous males and 65% of females will die before the age of 65 years compared to 26% of males and 16% of females in the non-Indigenous population. For all age groups below 65 years, the age-specific death rates for Indigenous peoples were at least twice those experienced by the non-Indigenous population.

In fact, there are a number of disturbing indicators and trends that reveal an entrenched health crisis in the Indigenous population that need addressing if this gap is to close:

- High rates of chronic diseases such as renal failure, cardio-vascular diseases and diabetes. In 1999–2003, two of the three leading causes of death for Indigenous people in Queensland, South Australia, Western Australia and the Northern Territory were chronic diseases of the circulatory system and cancer.
- High rates of poor health among Indigenous infants do not bode well for the future adult population. In 2000–02, babies with an Indigenous mother were twice as likely to be low birth weight babies (those weighing less than 2,500 grams at birth) as babies with a non-Indigenous mother.
- High rates of unhealthy and risky behaviour, including an increased prevalence of substance abuse and alcohol and tobacco use in the Indigenous population.

[5] These speeches can be found at: www.humanrights.gov.au/social_justice/essentials/index.htm.

With a significant proportion of Indigenous peoples in younger age groups, there is an additional challenge to programs and services being able to keep up with the future demands of a burgeoning population. Unless substantial steps are taken now, there is a very real prospect that the health status of Indigenous peoples could worsen and the gap get bigger still.

So that is the 'gap' I am referring to: a health status gap that divides the life experience of black and white Australians. I will not be the first to be observe that the situation it is something like having two nations in one: on one hand, the non-Indigenous population enjoying some of the best health in the world, and – at the other end – the Indigenous population being forced to settle for something far less.

And behind this gap, there are other divides. Most importantly a divide between the opportunities to be healthy presented to black and white Australians. And I think this is a vital point to realise – particularly for those who would blame Indigenous peoples for their own poorer health. For while it is true that we are all ultimately responsible for the choices we make that affect our health, it is equally true that for a variety of reasons Indigenous Australians have fewer choices to make for health than other Australians.

For example, given that Indigenous peoples' poorer health status would indicate a greater need for primary health care services, it is disturbing that in 2004 it was estimated that Indigenous peoples enjoyed 40% of the per capita access of the non-Indigenous population to primary health care provided by mainstream general practitioners. In other words, many Indigenous peoples cannot make the same kind of choices to see a doctor when they are ill, be checked up, or take advice from doctors about healthy living. There are many reasons for this. Because a higher proportion of the Indigenous population live in rural and remote areas, the doctor shortage in the bush is having a greater impact on Indigenous peoples when compared to the non-Indigenous population, for example.

But even in the urban centres, where the majority of Indigenous Australians live, many choose against using mainstream primary health care even where it is otherwise available and physically accessible. This can be for many reasons including a lack of cultural 'fit', language barriers, or the perception that mainstream services are not welcoming to Indigenous peoples. Australian governments have long accepted the importance of maintaining distinct health services in urban centres for Indigenous people as a consequence of this.

Per capita Medicare under spend estimates have been used to assess the quantum of the Indigenous primary health care shortfall. Estimates of the shortfall range from $250 million per annum to $570 million per annum depending on the quality of service offered. So in an era of record ten and twenty billion budget surplus on top of record budget surplus, we are not talking big sums to close this particular divide.

Another area where there is a divide is in relation to health infrastructure, a term used here to describe all the things that support good health, but that are not health services. Examples include potable water supplies, healthy food, healthy housing, sewerage and sanitation, and so on.

The dominant feature of health infrastructure inequality in Australia relates to Indigenous peoples' housing. Nationally, 5.5% of Indigenous households live in overcrowded conditions. The proportion of overcrowded households was highest for those renting from Indigenous or community organisations (25.7%). Among the jurisdictions, the proportion of overcrowded households was highest in the Northern Territory (23.7%).

In relation to health infrastructure, a century of neglect of health infrastructure in Indigenous communities has left what could be a $3–4 billion project for this generation, but again – in the scheme of things – these sums should not discourage us, particularly if one thinks of a ten year program, for example, over which the overall cost would be spread.

And, of course, a wide range of social factors (such as income, education and so on) also determine good or bad health in a population group. Research has demonstrated associations between an individual's social and economic status and their health. In short, poverty is clearly associated with poor health. And as is well known, Indigenous peoples in Australia experience socio-economic disadvantage on all major indicators.

And there are other divides too. While poverty is an example of a social determinant that will impact on both Indigenous and non-Indigenous Australians, there are some social determinants evident in Australia that will only impact on Indigenous peoples.

The unfinished business of colonisation and ongoing second class status afforded Indigenous peoples in Australian society is an example. This includes the stalled efforts to reconciliation (hopefully reignited by the recently offered National Apology to the Stolen Generations), and the ongoing uncertainty surrounding the issues of land, control of resources, cultural security, the rights of self-determination and sovereignty.

Racism too is likely to affect the social and emotional (as well as mental and physical) health of Indigenous Australians in a way not experienced by most other Australians.

So the gap I am referring too, the gap in the health status and life expectation enjoyed by non-Indigenous and Indigenous Australians, can be conceived of as a manifestation of other divides that exist in areas like health services provision, health infrastructure and broader social and economic factors that narrow the choices for health that Indigenous Australians can make. And all these must be addressed if the health status and life expectation gap between black and white Australia is to close.

In my 2005 Social Justice Report, I argued that it was unacceptable for a country as rich as ours, and one based on the notion of the 'fair go' and the 'level playing field', to tolerate the gap, or the divides that underlie it.

The 2005 report set forth a human rights based approach to achieving Aboriginal and Torres Strait Islander health equality within a generation. It made three recommendations to this end.

The first recommendation was that the governments of Australia commit to achieving equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years.

The second recommendation set out a process for what would need to occur for this commitment to be met. It called for:

- The governments of Australia to commit to achieving equality of access to primary health care and health infrastructure within 10 years for Aboriginal and Torres Strait Islander peoples;
- The establishment of benchmarks and targets for achieving equality of health status and life expectation – negotiated with the full participation of Aboriginal and Torres Strait Islander peoples, and committed to by all Australian governments;
- Resources to be made available for Aboriginal and Torres Strait Islander health, through mainstream and Indigenous specific services, so that funding matches need in communities and is adequate to achieve the benchmarks, targets and goals set out above; and
- A whole of government approach to be adopted to Indigenous health, including by building the goal and aims of the National Strategic Framework for Aboriginal and Torres Strait Islander Health into the operation of Indigenous Coordination Centres regionally across Australia.

The final recommendation then recommended that the Australian Health Minister's Conference agree to a National Commitment to achieve Aboriginal and Torres Strait Islander Health Equality and that bi-partisan support for this commitment be sought in federal Parliament and in all state and territory parliaments.

That was two years ago.

Since the release of the Social Justice Report 2005 I have been working with a growing coalition of organisations who have committed to working in partnership to see these recommendations implemented. It encompasses every major Indigenous and non-Indigenous peak health body in the country, as well as reconciliation groups, human rights organisations and NGOs. It is an extraordinarily committed group of organisations and individuals, across a vast array of different sectors of the community.

The campaign progressed over the past 2 years without any financial support from Australian governments – it has been self-funded.

Overall, the campaign has been led by a leadership group comprising the National Aboriginal Community Controlled Health Organisation, the Australian Indigenous Doctors' Association, the Congress of Aboriginal and Torres Strait Islander Nurses, the Indigenous Dentists' Association of Australia, Oxfam Australia and HREOC.

'Close the Gap' was the public title for the Campaign.

One of our primary aims at the time was to obtain the commitment of all Australian governments – through COAG – and of the Australian government in particular due to its significant responsibilities for primary health care – to commit to closing the gap on Indigenous life expectancy within a generation. And it was to obtain this commitment on a basis of partnership and shared ambition with a wide range of sectors of the community.

As you will be aware, the Councils of Australian Governments did exactly that on 20 December 2007. In their Communiqué they stated:

> COAG agreed the 17 year gap in life expectancy between Indigenous and non-Indigenous Australians must be closed.
>
> COAG today agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage. COAG committed to:
>
> - Closing the life expectancy gap within a generation;
> - Halving the mortality gap for children under five within a decade; and
> - Halving the gap in reading, writing and numeracy within a decade.

The first stage of the Campaign culminated in the National Indigenous Health Equality Summit held in Canberra over 18 – 20 March, 2008. There were two streams of activity that took place at the Summit:

- First, a series of Indigenous Health Equality Targets were extensively workshopped to provide the means by which commitments to close the gap can be met.
- Second, the Commonwealth government and the Opposition were invited to formally re-commit to achieving Indigenous health equality within a generation.

On 20 March 2008 the Summit concluded in the Great Hall of Parliament House with a formal ceremony at which a *Statement of Intent* was signed by the Prime Minister, the Ministers for Health and Indigenous Affairs, the Opposition leader, and every major Indigenous and non-Indigenous health peak body across Australia.

This Statement of Intent commits each of these bodies to a new partnership to close the gap. It states:

> 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.

And accordingly, the signatories have agreed to the following commitments. I quote:

- 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 gap 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 of 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.

This is a major development and one that we now need to work together to capitalise on. Many people see this as a watershed in Indigenous policy – so the time is now to realise our goals and seize this moment.

To progress this new partnership, the Summit also finalised a series of targets to close the health inequality gap. These targets note that the achievement of the COAG goals requires a far more effective approach to Aboriginal and Torres Strait Islander health and in particular, those factors which are major contributors to current gaps in child mortality and the life expectancy gap.

We have therefore developed an integrated set of Close the Gap National Indigenous Health Equality Targets. These targets are grouped under four broad headings:

- Partnership Targets – to lock into place a collaborative approach to Indigenous health;
- Targets that focus on specific priority areas of child and maternal health, chronic disease and mental health and emotional and social wellbeing;
- Primary Health Care and other Health Services Targets; and
- Infrastructure Targets.

We note that ‘cherry picking’ specific targets or illnesses will not achieve the COAG goals.

Instead, we place far more reliance on integrated approaches to achieve the goals of equal access for equal need and equal health outcomes.

We argue that it is of limited value to say a particular condition or factor is important unless it is clear what the health target is, how it is to be achieved, indicative expenditure required (both recurrent and capital), program, workforce and infrastructure requirements to provide the necessary services and the monitoring, evaluation and management processes required.

The integrated sets of targets are designed to deal with these requirements, and mark a turning point for Aboriginal and Torres Strait Islander services. In particular as agreed by COAG, a partnership approach is proposed, involving Aboriginal people and their representative bodies, health agencies, government agencies and the wider community.

These targets should be seen as the first step in a continuing process, where their refinement and implementation can be conducted through a genuine partnership between government and Aboriginal and Torres Strait Islander and other organisations.

The details of the structure and processes of this partnership will have to be determined and are essential to the achievement of the COAG goals. A fresh Government approach to partnership and to its management, monitoring, evaluation and review processes is essential for the achievement of the COAG goals – a little bit more of the same will not close the gap.

These targets will be formally presented to the government and publicly released in the coming weeks. We are currently working with COAG Working Groups to ensure that the targets can be integrated into the COAG reform agenda for Indigenous issues.

And so, I want to conclude by considering the essential components for Closing the Gap.

The first is a principle of broad application. That is the need for partnership. This is what the Statement of Intent for a new partnership is all about.

We can't achieve health equality by treating this as an issue solely for government to address, or solely for Indigenous peoples.

I believe we have now reached a pint where people have begun to be convinced that achieving health equality is achievable. This is what the evidence tells us, even if we lost faith over the past decade.

So such partnership requires an honesty and integrity about what needs to occur and transparency about how we are travelling, and whether we are doing everything we can to achieve our longer term goal.

Secondly, we need to ensure the full participation of Indigenous peoples in policy making processes and health programs in particular. We need to adopt a proactive approach to Indigenous health that has a prevention focus and builds a comprehensive primary health care approach.

Third, and related to this, is that high quality, integrated primary health care should be prioritised.

A focus on primary health care interventions addressing chronic diseases can be expected to have a significant impact on Aboriginal and Torres Strait Islander peoples' life expectation. Critically for the Indigenous population, primary health care identifies and treats chronic diseases (including diabetes, cardiovascular and renal disease) and their risk factors. Primary health care also acts as a pathway to specialist and tertiary care, and enables local (or regional) identification and response to health hazards; transfer of knowledge and skills for healthy living; and identification and advocacy for the health needs of the community.

There should also be continued support for Aboriginal community controlled health services. There is evidence that they are a highly effective process for the provision of primary health care. There should also be independent research conducted to determine the success factors and governance issues which contribute to achieving the most effective community controlled health services possible.

The expansion of community controlled health services must take place alongside efforts to improve the accessibility of mainstream services. It should also be accompanied by health care programs focusing on specific diseases. If, through these, early stage symptoms are detected not only can suffering be prevented, but cost savings made.

The fourth requirement, is that we integrate targets for health equality into policy and programs across all governments. The Prime Minister announced at the National Indigenous Health Equality Summit in March that a new National Indigenous Health Equality Council will be established and operate from July this year. Its role should include advising on the implementation of targets and benchmarks. This provides an opportunity to embed the targets into policy and practice nationally.

And this is very much a work in progress. The Steering Committee for the Close the Gap Campaign continues to work with COAG and Australian governments to progress the adoption of the targets, and their integration into the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Aboriginal and Torres Strait Islander Health Performance Framework as well as the Productivity Commission's Overcoming Indigenous Disadvantage framework. It is hoped that in the near future these policy frameworks and indicators will be linked to benchmarks and targets to the end of achieving Indigenous health equality by 2030 or earlier.

There is sufficient evidence to demonstrate that a targeted approach will work and that the improvements sought in Aboriginal and Torres Strait Islander peoples' health status are achievable. For example, a recent review of Aboriginal primary health care states that:

> international figures demonstrate that optimally and consistently resourced primary health care systems can make a significant difference to the health status of populations, as measured by life expectancy, within a decade. For example, in the 1940s to the 1950s in the United States, Native American life expectancy improved by about 9 years; an increase in life expectancy of about twelve years took place in Aotearoa/New Zealand over two decades from the 1940s to the 1960s. Figures from within Australia demonstrate dramatic improvements in infant mortality (for example from 200 per 1,000 in mid 1960s Central Australia to around 50 per 1,000 by 1980) through the provision of medical services.

The fifth essential is the adequate resourcing of commitments to Indigenous health. Research suggests that addressing Aboriginal and Torres Strait Islander health inequality will involve no more than a 1% per annum increase in total health expenditure in Australia over the next ten years. If this funding is committed, then the expenditure required is then likely to decline thereafter.

Only with funding commitments that are proportionate to the outstanding need in communities will it be feasible for governments to meet the outstanding primary health care and infrastructure needs of Aboriginal and Torres Strait Islander communities within 10 years.

This has been acknowledged in the Statement of Intent which talks of funding matching need to achieve equality.

Generally, primary health care is a responsibility of the federal government – but savings made here can prevent engagement of Aboriginal and Torres Strait Islander peoples with the secondary and tertiary systems, which are predominately responsibilities of the states and territories. The states and territories also have significant responsibilities for service delivery in areas which impact on health outcomes, such as housing.

In light of the comprehensive national frameworks and strategies in place, it would appear that there exists a solid basis for governments to work together to address the projected funding shortfall. Additional funding to the states and territories could be made contingent on the agreement of states and territories to match federal contributions.

An equitable distribution of primary health care rests on a prior effort to increase the numbers of health professionals, and particularly Indigenous health professionals, to provide the services.

Any substantive address must begin at school – students must not only complete school, but they must receive a thorough grounding in maths and science to enter medicine. Recruitment campaigns must start focusing on Aboriginal and Torres Strait Islander young people at an early age.

Finally, to support these commitments and proposed targets, further reform of health financing models and data collection methods is required.

There has been significant work done to improve health financing models towards processes that identify the level of need. For example, quantifying the Medicare Benefit Scheme spending shortfall on Aboriginal and Torres Strait Islander peoples has provided a basis for quantifying the primary health care shortfall and stimulated initiatives to ensure Aboriginal and Torres Strait Islander enjoy greater access to Medicare and the Pharmaceutical Benefits Scheme. Further work is required to quantify enable the level of need to be quantified nationally, as well as at a regional and sub-regional level for both primary health care access and health infrastructure provision.

Ultimately, there is no larger challenge to the sense of decency, fairness and egalitarianism that characterizes the Australian spirit than the current status of Aboriginal and Torres Strait Islander health. Closing the Gap is not only a major human rights issue in Australia, but it should be a matter of pride for us all.

And "Closing the Gap" is not impossible, although it will require long term action and commitment. Committing to a 2030 year time frame to achieve this is feasible. It is also a long time in which to accept that inequality would continue to exist.

But history shows us that an absence of targeted action and a contentedness that we are 'slowly getting there' is not going to result in the significant improvements in health status that Aboriginal and Torres Strait Islander peoples deserve – simply by virtue of the fact that we are members of the human race and of the Australian community.

We have an unprecedented opportunity to make this happen due to the recent commitments of Australian governments and the adoption of National Indigenous Health Equality Targets, but targets on their own will not suffice – we need action on many fronts to address the many divides that lay behind the gap. And we do need to augment current efforts.

The failure of the policies and programs of the past twenty years to achieve significant improvements in Aboriginal and Torres Strait Islander health status, yet alone to close the gap, reveal two things that Aboriginal and Torres Strait Islander peoples and the general community can no longer accept from governments.

First, we can no longer accept the making of commitments to address Aboriginal and Torres Strait Islander health inequality *without* putting into place processes and programs to match the stated commitments. Programs and service delivery must be adequately resourced and supported so that they are capable of achieving the stated goals of governments.

Second, and conversely, we can also not accept the failure of governments to resource programs properly. *A plan that is not adequately funded to meet its outcomes cannot be considered an effective plan*. The history of approaches to Aboriginal and Torres Strait Islander health reflects this.

The combination of the healthy economic situation (at least in terms of the surpluses) of the country, the substantial potential that currently exists in the health sector and the national leadership being shown through the COAG process, means that the current policy environment is ripe for achieving the longstanding goal of overcoming Aboriginal and Torres Strait Islander health inequality. Steps taken now could be determinative.

The gap – the Indigenous health equality gap – can be closed, and closed in our lifetimes. The foundations are in place, but none of us can afford to rest on our laurels – it is imperative that hold Australian governments to their commitments so that by 2030 any Indigenous child born in this country has the same chances as his or her non-Indigenous brothers and sisters to live a long, healthy and happy life.

Thank you.

Note: This is the fourth in a series of six speeches outlining an agenda for change in Indigenous Affairs. The *"Essentials for Social Justice"* series will be presented between December 2007 and August 2008, and will be available online at: www.humanrights.gov.au/social_justice/essentials/index.html.

Part 4

ACKNOWLEDGMENTS

The coalition for Indigenous Health Equality

Since the release of the 2005 Social Justice Report, a coalition of organisations and individuals has worked for the adoption of its recommendations and an end to Indigenous health inequality in Australia:

- Aboriginal Medical Services Alliance Northern Territory;
- Amnesty International Australia;
- Australian Catholic Bishops' Social Justice Committee;
- Australian College of Rural and Remote Medicine;
- Australian Council of Social Services;
- Australian Council for International Development;
- Australian General Practice Network;
- Australian Indigenous Doctors' Association;
- Indigenous Dentists' Association of Australia;
- Australian Institute of Health and Welfare;
- Australian Institute of Aboriginal and Torres Strait Islander Studies;
- Australian Medical Association;
- Australian Nursing Federation;
- Australian Red Cross;
- Australians for Native Title and Reconciliation;
- Caritas Australia;
- Clinical Nurse Consultants Association of NSW;
- Congress of Aboriginal and Torres Strait Islander Nurses;
- Cooperative Research Centre for Aboriginal Health;
- Diplomacy Training Program, University of New South Wales;
- Fred Hollows Foundation;
- Gnibi the College of Indigenous Australian Peoples, Southern Cross University;
- Human Rights and Equal Opportunity Commission;
- Human Rights Law Resource Centre;
- Ian Thorpe's Fountain for Youth;
- Indigenous Law Centre, University of New South Wales;
- Jumbunna, University of Technology Sydney;
- Make Indigenous Poverty History campaign;
- Menzies School of Health Research;
- National Aboriginal Community Controlled Health Organisation and NACCHO Affiliates;
- National Aboriginal and Torres Strait Islander Ecumenical Council;
- National Association of Community Legal Centres;
- National Children's and Youth Law Centre;
- National Rural Health Alliance;
- Oxfam Australia;
- Public Health Association of Australia;
- Professor Ian Anderson, Onemda Health Unit, VicHealth;
- Quaker Services Australia;
- Reconciliation Australia;
- Royal Australasian College of Physicians;
- Royal Australian College of General Practitioners;

- Rural Doctors Association of Australia;
- Save the Children Australia;
- Sax Institute;
- Sisters of Mercy Aboriginal Network NSW;
- Sisters of Mercy Justice Network Asia Pacific;
- UNICEF Australia;
- Uniya Jesuit Social Justice Centre; and
- Victorian Aboriginal Community Controlled Health Organisation.

The Steering Committee for Indigenous Health Equality

The Steering Committee for the campaign was formed in March 2006.

The Leadership group of the Committee comprises:

- Chair, Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, Human Rights and Equal Opportunity Commission;
- Dr Mick Adams, Chair, National Aboriginal Community Controlled Health Organisation;
- Dr Christopher Bourke, Indigenous Dentists' Association of Australia;
- Dr Sally Goold OAM, Chair, Congress of Aboriginal and Torres Strait Islander Nurses;
- Mr Andrew Hewett, Executive Director, Oxfam Australia; and
- Dr Tamara Mackean, President, Australian Indigenous Doctors' Association.

The Steering Committee comprises representatives from the following organisations:

- Chair, Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, Human Rights and Equal Opportunity Commission;
- Australian General Practice Network;
- Australian Indigenous Doctors' Association;
- Australian Medical Association;
- Australians for Native Title and Reconciliation;
- Congress of Aboriginal and Torres Strait Islander Nurses;
- Cooperative Research Centre for Aboriginal Health;
- Fred Hollows Foundation;
- Heart Foundation;
- Indigenous Dentists' Association of Australia;
- Menzies School of Health Research;
- National Aboriginal Community Controlled Health Organisation;
- Oxfam Australia;
- Royal Australian College of General Practitioners;
- Royal Australasian College of Physicians; and
- Torres Strait and Northern Peninsula District Health Service.

Steering Committee member representatives have included:

- Ms Vicki Bradford, Congress of Aboriginal and Torres Strait Islander Nurses;
- Dr Ngiare Brown, Menzies School of Health Research;
- Ms Lisa Briggs, Oxfam Australia;
- Dr Margaret Chirgwin, Australian Medical Association;
- Ms Donna Clay, Oxfam Australia;
- Ms Dameeli Coates, Oxfam Australia;
- Mr Henry Councillor, former Chair, National Aboriginal Community Controlled Health Organisation;

- Dr Sophie Couzos, National Aboriginal Community Controlled Health Organisation;
- Ms Dea Delaney Thiele, National Aboriginal Community Controlled Health Organisation;
- Mr Darren Dick, Human Rights and Equal Opportunity Commission;
- Mr Brian Doolan, Fred Hollows Foundation;
- Mr Alison Edwards, Fred Hollows Foundation;
- Mr James Ensor, Oxfam Australia;
- Mr Bruce Francis, Oxfam Australia;
- Mr Rohan Greenland, Heart Foundation;
- Ms Mary Guthrie, Australian Indigenous Doctors' Association;
- Mr Gary Highland, Australians for Native Title and Reconciliation Australia;
- Mr Christopher Holland, Human Rights and Equal Opportunity Commission;
- Ms Bettina King, Human Rights and Equal Opportunity Commission;
- Mr Traven Lea, Heart Foundation;
- Dr Tamara Mackean, Australian Indigenous Doctors' Association;
- Dr Naomi Mayers, National Aboriginal Community Controlled Organisation;
- Mr Romlie Mokak, Australian Indigenous Doctors' Association;
- Ms Cyndi Morseau, Torres Strait and Northern Peninsula District Health Service;
- Ms Mary Osborn, Royal Australasian College of Physicians;
- Dr Maurice Rickard, Australian Medical Association;
- Mr Justin Mohamed, National Aboriginal Community Controlled Health Organisation;
- Mr Poyana Pensio, Torres Strait and Northern Peninsula District Health Service;
- Ms Jo Pride, Oxfam Australia; and
- Dr Mark Wenitong, Australian Indigenous Doctors' Association.

Professor Ian Ring, Professorial Fellow, Faculty of Commerce, Centre for Health Services Development, University of Wollongong, and Daniel Tarantola, Professor of Health and Human Rights at the University of New South Wales, provided expert assistance to the Steering Committee.

The targets working groups

The targets presented here have been developed by 3 working groups of the Steering Committee. Each was led by a notable Indigenous person with extensive health experience:

- Dr Mick Adams, Chair, National Aboriginal Community Controlled Health Organisation;
- Associate Professor Dr Noel Hayman, Royal Australasian College of Physicians; and
- Dr Ngiare Brown, Menzies School of Health Research.

Target Working Group members and advisors included:

- Dr Christopher Bourke, Indigenous Dentists' Association of Australia;
- Ms Vicki Bradford, Congress of Aboriginal and Torres Strait Islander Nurses;
- Mr Tom Brideson, Charles Sturt University's Djirruwang Aboriginal and Torres Strait Islander mental health program;
- Dr David Brockman, National Centre in HIV Epidemiology and Clinical Research;
- Dr Alex Brown, Baker IDI Heart and Diabetes Institute;
- Professor Jonathon Carapetis, Menzies School of Health Research;
- Dr Alan Cass, The George Institute for International Health;
- Professor Anne Chang, The Queensland Centre for Evidence Based Nursing and Midwifery;
- Dr Margaret Chirgwin, National Aboriginal Community Controlled Health Organisation;
- Dr John Condon, Menzies School of Health Research;
- Mr Henry Councillor, former National Aboriginal Community Controlled Health Organisation;
- Dr Sophie Couzos, National Aboriginal Community Controlled Health Organisation;

- Professor Sandra Eades, Sax Institute;
- Ms Dea Delaney Thiele, National Aboriginal Community Controlled Health Organisation;
- Mr Mick Gooda, Cooperative Research Centre for Aboriginal Health;
- Dr Sally Goold OAM, Chair, Congress of Aboriginal and Torres Strait Islander Nurses;
- Ms Mary Guthrie, Australian Indigenous Doctors' Association;
- Associate Professor Colleen Hayward, Kulunga Research Network and Curtin University;
- Ms Dawn Ivinson, Royal Australasian College of Physicians;
- Dr Kelvin Kong, Australian Indigenous Doctors' Association;
- Dr Marlene Kong, Australian Indigenous Doctors Association;
- Mr Traven Lea, Heart Foundation;
- Dr Tamara Mackean, Australian Indigenous Doctors' Association;
- Dr Naomi Mayers, National Aboriginal Community Controlled Organisation;
- Mr Romlie Mokak, Australian Indigenous Doctors' Association;
- Professor Helen Milroy, Associate Professor and Director for the Centre for Aboriginal Medical and Dental Health;
- Professor Kerin O'Dea, Menzies School of Health Research;
- Dr Katherine O'Donoghue, Indigenous Dentists' Association of Australia;
- Ms Mary Osborn, Royal Australasian College of Physicians;
- Professor Paul Pholeros AM, University of Sydney;
- Professor Ian Ring, Professorial Fellow, Faculty of Commerce, Centre for Health Services Development, University of Wollongong;
- Professor Fiona Stanley AC, Telethon Institute for Child Health Research;
- Professor Paul Torzillo AM, Department of Respiratory Medicine, Royal Prince Alfred Hospital;
- Dr James Ward, Collaborative Centre for Aboriginal Health Promotion;
- Ms Beth Warner, Royal Australasian College of Physicians;
- Associate Professor Ted Wilkes, National Indigenous Drug and Alcohol Committee of the Australian National Council on Drugs; and
- Dr Mark Wenitong, Australian Indigenous Doctors' Association.

Target Secretariat

- Ms Lisa Briggs, Oxfam Australia;
- Mr Christopher Holland, Human Rights and Equal Opportunity Commission; and
- Professor Ian Ring, Professorial Fellow, Faculty of Commerce, Centre for Health Services Development, University of Wollongong.

Others

The Campaign and Summit Secretariat

- Ms Jessica McAlary, Human Rights and Equal Opportunity Commission;
- Ms Cara Bevington, Oxfam Australia;
- Ms Lisa Briggs, Oxfam Australia;
- Ms Kirsten Cheatham, Human Rights and Equal Opportunity Commission;
- Ms Dameeli Coates, Oxfam Australia;
- Mr Darren Dick, Human Rights and Equal Opportunity Commission;
- Ms Amber Doyle, Oxfam Australia;
- Mr Brett Harrison, Human Rights and Equal Opportunity Commission;
- Mr Christopher Holland, Human Rights and Equal Opportunity Commission;
- Ms Christina Kenny, Human Rights and Equal Opportunity Commission; and
- Ms Julia Mansour, Human Rights and Equal Opportunity Commission.

The Campaign and Summit communications/media team

- Mr David Britton, Fred Hollows Foundation;
- Ms Dameeli Coates, Oxfam Australia;
- Mr Chris Hallet, National Aboriginal Community Controlled Health Organisation;
- Mr Gary Highland, Australians for Native Title and Reconciliation Australia;
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- Mr Grant Hill, Oxfam Australia;
- Mr Neil Holden, Congress of Aboriginal and Torres Strait Islander Nurses;
- Mr Juan Martorana, Oxfam Australia;
- Ms Ann Matson, Oxfam Australia; and
- Ms Karina Menkhorst. Oxfam Australia.

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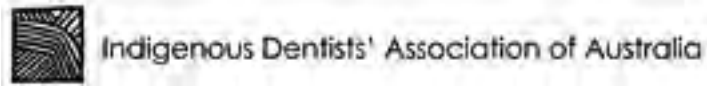
And thank you to any other person or organisation that has been involved in the Campaign or the Summit but has been inadvertently omitted from this list.



Torres Strait and
Northern Peninsula
District Health Service