

## Background Guide

- the disparity these people face compared to non-indigenous Australians relates to almost every facet of life, from economics to politics. These conditions are referred to as determinants; living conditions, political representation, and economic success have a huge effect on an individual's lifestyle and thus affect their health outcomes
- However, due to issues regarding national sovereignty, existing prejudices within member states, and a lack of resources, the United Nations Permanent Forum on Indigenous Issues has not seen much success in improving indigenous health
- 1967: a constitutional amendment under Harold Holt's tenure gave the government power to legislate for indigenous Australians and called for their inclusion in the census
- Then, in the following years the Commonwealth Office of Aboriginal Affairs (which is now referred to as the Department of Aboriginal Affairs) was established and designated the creation of Aboriginal health units to address medical needs.
- In 1973, the Aboriginal Health Branch was established, beginning a decades long awareness of indigenous health issues
- They are more likely to experience cardiovascular diseases, cancer (particularly liver and lung cancer), diabetes, kidney issues, mental health illnesses, and injury. This results generally from poor health care and lifestyles, because many cannot afford to eat healthy or visit a doctor often for screenings and tests. **In addition, emotional stress can lead to alcohol and drug abuse** which dramatically increases incidences of many diseases
- As stated by the Australian Bureau of Statistics (ABS) in 2010, the life expectancy for indigenous Australians compared to the rest of the population is 11.5 years lower for men, 67.2 years versus 78.7 years, and 9.7 years lower for women, 72.9 years versus 82.6 years
- socioeconomic conditions and the lack of availability of health services among Aboriginals prevent these gaps from closing completely and reaching the level of their non-indigenous counterparts
- **In general, Aboriginal people's poor health has to do with the number of disadvantages they face such as lack of education which would allow them to understand health risks, employment, overcrowding within their housing system which leads to the increased spread of infectious disease, and poor infrastructure with a lack of quality living conditions**
- The United Nations Declaration on the Rights of Indigenous Peoples states that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health" and that all nations must "take the necessary steps... to [achieve] progressively the full realization of this right
- In 1993, working within the UN International Year of Indigenous Peoples, PAHO met to discuss this issue and the group gained a commitment from member states to prioritize the improvement the health conditions with the creation of **Resolution V**
- 1989: Convention concerning Indigenous and Tribal peoples in Independent Countries resulted in ILO 169. Overall, this called for governments to recognize indigenous peoples and work to improve their living conditions. Article 25, in particular, dealt with health. It

stated that “governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health”

- In addition to these international efforts to improve Aboriginal health, the Council of Australian Government established seven pledges to reduce inequality in 2008. These called for efforts regarding inequalities regarding infancy, education, employment, economic development, healthy lives, community growth, and constitutional recognition. All these goals did not explicitly relate to Aboriginal health, but did involve some aspects such as life-expectancy gaps and mortality rates.
- **People themselves often can't assimilate - community outreach programs**
- For example, in Botswana, in 2002, the San people were evicted from their land reserves, but four years later the High Court ruled that this was wrongful and that they could return home. This was viewed as a precedent for the rights of indigenous people in Africa and set the stage for improvements
- The Euskadi Ta Askatasuna (ETA), was a Basque nationalist group founded in 1959 which committed terrorist acts throughout the Spanish territory over a 45-year time period, resulting in over 800 deaths, all in the name of Basque independence. The group ceased operations by 2012, but its existence marks the tenuous relationship between the Basque people and Spain.
- Similarly, the Circassians of the Northwest Caucasus have historically been in conflict with Russia. This stems from Russian-Circassian War in the 19th century in which “three-fourths of the population was annihilated, and the Circassians had become one of the first stateless people in modern history” as they were expelled to the Ottoman Empire.<sup>84</sup> Campaigns to reestablish the independent Circassian state and gain recognition for the Circassian genocide have been relatively unsuccessful. However, in 2011, the Georgian parliament voted to acknowledge the genocide, becoming the first UN-recognized state to do so.<sup>85</sup> More recently, protests were held against the 2014 Sochi Olympics as the venues are considered the site of the genocide's mass graves
- **The Bolivian Constitution of 2009 re-established Bolivia as plurinational, meaning it consists of two or more preserved national groups**
- In what ways can United Nations member states contribute to the improvement of conditions for Australian Aboriginals without impeding on national sovereignty?
- How can the United Nations and the Australian government meet the standards established by the Millennium Development Goals, the Council of Australian Government, and PAHO?
- How can the Australian government improve conditions while maintaining the cultural practices and sovereignty of Aboriginal populations?
- How can the Australian government and people combat the prejudices against Aboriginal peoples that have existed for centuries?
- How can the United Nations and United Nations Permanent Forum on Indigenous Issues communicate and collaborate with indigenous peoples to improve conditions?

- What is currently preventing the international community and the Australian government from making significant improvements in Aboriginal health?
- What steps can the international community take to assist the Australian government in their objective to address the primary determinants (poor diet, housing, education, etc.) of Aboriginal health inequity?
- Which of these factors should be the highest priority for the United Nations Permanent Forum on Indigenous Issues to address while remaining within the scope and jurisdiction of the committee?
- How feasible is the Australian government's goal to establish indigenous health equity by the year 2031 and in what ways can the international community ensure this plan's success?
- How do the conditions of indigenous peoples in other continents affect outcomes for Aboriginals in Australia and how has the United Nations contributed to these conditions?

Improving Aboriginal health and well-being: a view from the north:

<http://theconversation.com/improving-aboriginal-health-and-well-being-a-view-from-the-north-18522>

- this imbalance will not be remedied until governments work with Aboriginal leaders and communities to address inequalities in education, economic opportunities, and housing.
- Poorly-designed mental and child health service models and the lack of adequately specialised staff is compounded by the absence of Aboriginal community leadership. And without leadership, Aboriginal people struggle to access effective and culturally safe treatment
- We know that complex chronic disease [starts in the womb](#) and we know [social distress contributes](#) to mental illness and self-harm.
- **Despite all this, [our research shows](#) many Northern Territory clinicians struggle to identify and treat anaemia and low weight in infants. Nor do they deal adequately with the persistent grief and mental and social distress of many Aboriginal people.**
- **The skills and knowledge of health practitioners and their capacity to work effectively across cultures is sorely lacking**
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- **But this requires a community-based and client-centred approach to care, rather than the current health-centre focused model.**
- **Such cultural challenges persist because there are so few Aboriginal health professionals available to provide care and teach their non-Aboriginal colleagues.**
- **Medical staff in remote communities are generally few in number and under-qualified to deal with the volume and acuity of care in child and mental health. There are no full-time, qualified child health workers devoted solely to the hundreds of children under five in large communities, for instance.**
- **Similarly, the burden of mental disorders is so severe in remote communities that it will require skills and confidence to engage in care, early intervention and provision of culturally-appropriate treatment. These skills are rarely present among the generalist staff.**

- **Midwives now work with pregnant women and new mothers in larger communities in the territory; and one known midwife provides consistent care for women transferred to regional centres for birth.**
- *This **continuity** of care has improved the quality of services – fewer women have no antenatal care and testing and smoking cessation has advice improved; there's been a reduction in fetal distress during labour; and, a higher proportion of women receive postnatal contraception advice.*
- **The remote substance misuse workforce receives daily supervision from staff in health centres, as well as face-to-face supervision, training and advocacy support from specialist alcohol and other drug-use nurses and psychologists.**

**CLOSE THE GAP! SOLUTIONS TO THE INDIGENOUS HEALTH CRISIS FACING AUSTRALIA**

- **At minimum, achieving health equality for Aboriginal and Torres Strait Islander health within 25 years will require federal, state and territory leaders from all sides of politics to commit to an agreed time frame for achieving health equality. Additionally, specific measures should be funded:**
  - **1. Improved access for Aboriginal peoples and Torres Strait Islanders to culturally appropriate primary health care, and to a level commensurate with need**
  - **2. Increasing the number of health practitioners working within Aboriginal health settings, and further development and training of the Indigenous health workforce**
  - **3. Improving the responsiveness of mainstream health services and programs to Aboriginal peoples and Torres Strait Islander health needs**
  - **4. Greater targeting of maternal and child health and greater support for Indigenous-specific population programs for chronic and communicable disease**
  - **5. Greater funding and support for the building blocks of good health such as awareness and availability of nutrition, physical activity, fresh food, healthy lifestyles, and adequate housing**
  - **6. Setting national targets and benchmarks towards achieving healthy equality, by which progress can be closely monitored**
- **most of the diseases leading to premature death, hospitalization and chronic disability are preventable if diagnosed early, and treated with affordable medicines**
- **While there is attention on the significant increases in the Office of Aboriginal Torres Strait Islander Health (OATSIH) budget, Access Economics points out that the OATSIH budget is a relatively small portion of overall expenditure on Aboriginal and Torres Strait Islander health. The crucial shortfall is in the mainstream Medical Benefits Scheme/Pharmaceutical Benefits Scheme programs. Until Aboriginal and Torres Strait Islander peoples get their share of these programs (on a needs basis), the gap in equitable funding will not narrow. (While spending on Aboriginal and Torres Strait Islander health has increased, it hasn't**

done so any faster than for the rest of the population so the expenditure gap hasn't narrowed.)

- **What's needed most of all is a comprehensive national program to improve maternal and child health as a starting point towards improving the health of the next generation of Indigenous Australians. Such programs would aim to improve antenatal and neonatal care, increase birth weight and reduce premature delivery**
- These improvements are testament to the fact that change can be made. But as most of the changes to communicable disease prevalence are due to the introduction of specific initiatives such as better vaccines and expanded primary healthcare, the magnitude of these gains would be multiplied significantly if investments commensurate with need were made to core primary healthcare services.
- WHATS ALREADY DONE
- Core primary healthcare delivered by Aboriginal community controlled health and clinical services
  - Primary clinical care such as treatment of illness using standard treatment protocols, 24 hour emergency care, provision of essential drugs and management of chronic illness
  - Population health/preventive care such as immunisation, antenatal care, appropriate screening and early intervention (including adult and child health checks and secondary prevention of complications of chronic disease), and communicable disease control
  - Clinical support systems such as pharmaceutical supply system and comprehensive health information system (population registers, patient information recall systems, and systems for quality assurance) 1. Support Services Internal to the health service
  - Staff training and support such as Aboriginal health worker training, cross cultural orientation, continuing education
  - Management systems that are adequately resourced, financially accountable and include effective recruitment and termination practices
  - Adequate infrastructure at the community level such as staff housing and clinical facilities, and functional transport facilities External to the health service
  - Systems for supporting visiting specialists and allied health professionals (including dental, mental health etc), medical evacuation or ambulance services; access to hospital facilities
  - Training role for tertiary and other students
  - Special Programs
    - Based on locally relevant priorities and the availability of funds for programs directed at rheumatic fever, substance misuse, nutrition, environmental health, particular target groups such as youth, aged and disabled people, young mothers, school children etc.
  - Advocacy and policy development Support for the community on local, state and federal issues

- There is currently a shortfall of more than 400 doctors, more than 600 nurses and associated shortfalls in numbers of Aboriginal health workers and allied health workers supporting Aboriginal and Torres Strait Islanders. Without these staff, services such as core primary healthcare and population programs cannot be optimally delivered. Current recruitment opportunities are hindered by the inability for Aboriginal-specific primary healthcare services to provide competitive salaries and having to compete with the state hospital sector and private sector salaries which are substantially higher

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Improving the health of rural and remote Aboriginal communities through state-wide education and employment initiatives:

[https://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Simpson\\_Aeron\\_E7.pdf](https://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Simpson_Aeron_E7.pdf)

- **fresh food costing between 150-180% of capital city prices in some remote communities (which has a weighted factor given many Indigenous Australian are on work for the Dole programs with limited disposable income)**
- education, numeracy and literacy levels being significantly lower in many Aboriginal than nonAboriginal communities
- basic health services being non-existing or not accessible to many Aboriginal people residing outside metropolitan and regional areas
- lower employment availability, skill mix may not be suitability for employment options, or distances to employment may be too great to justify.
- **increase in the number of Aboriginal health professionals**
- To address these concerns in Aboriginal health, education and employment, the Office of Aboriginal Health (OAH) is working in consultation with the Western Australian Department of Education and Training (DET) to develop an innovative Vocational Education and Training in Schools (VETiS) program. This project is being driven by item 1.8 of the West Australian Aboriginal and Torres Strait Islander Employment Framework: Utilise existing training programs and support mechanisms to achieve Aboriginal employment targets.
  - The Program aims to deliver Certificate II in ATSI Primary Health Care to year 11 students, with the intent of graduating year 12 students in Certificate III ATSI Primary Health Care. The Program is being piloted at four sites across the Kimberley, Pilbara, Goldfields and Metropolitan region through a mix of Indigenous and mainstream registered training organisations.
- **Developing community participation and control—Action areas:**
- **Reinforce healthy Aboriginal lifestyles with whole-of-life involvement**
- **Develop partnerships for protocols in health service delivery with Aboriginal people**
- **Develop community action plans for health issues including continuing care**
- **Train local Aboriginal people for Health Board and Hospital Board appointments**
- **Strengthen regional focus in health activities.**
- Increase health services especially mental, dental, aged care and prison health services

The main health problems experienced by these Aboriginal populations are:

Infants	High rates of low birth weight, high rates of growth faltering (or failure-to-thrive), high rates of infections (particularly respiratory and gastrointestinal)
Young children (3-8 yrs)	Repeated and/or chronic infections (particularly of the skin, ears/nose/throat, eye, respiratory system, gastrointestinal and genitourinary), under nutrition, anaemia, intestinal parasites
Older children 9-14 (yrs)	Repeated infections, growth retardation, accidents, alcohol and drug abuse
Youth (15-20 yrs)	Communicable disease, incarceration, suicide, self harm, injury, poisonings, alcohol and drug abuse
Adults (21-40 yrs)	Respiratory diseases, digestive system disorders, obesity, hypertension, cardiovascular disease, diabetes (type 2), complications of pregnancy; chronic renal diseases and renal failure, alcohol-related disorders, psychosocial stress and mental disorders, accidents and violence
Elderly (>40 yrs)	Disabilities, immobility, chronic diseases requiring regular clinical care and supervision, provision of adequate and culturally appropriate services and facilities

(West Australian Department of Health)

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- The establishment of Aboriginal Community Controlled Health Services (ACCHOs) promotes the responsibility and understanding that Aboriginal people need in order to be involved in health delivery
- While the Aboriginal health workforce is one of the principal and crucial elements in improving the health of Aboriginal people, it is often a workforce that is the least prepared educationally, the least supported professionally, and the least rewarded financially. **The Aboriginal health workforce requires adequate and appropriate infrastructure to increase opportunities for Aboriginal people to participate in appropriate health training programs.**
- **Intersectoral action can take many forms and use a wide range of strategies. The critical dimension of intersectoral action is that it is based on organisations recognising their interdependence in achieving a common end. Improving agency cooperation through mechanisms such as joint projects, and collaboration on service planning and delivery will assist in making a positive contribution to health outcomes.**
  - **Necessity for the health sector to work with other sectors and organisations to achieve health gain rather than act independently**
  - **Support from the wider community, building on existing policy initiatives and opportunities**
  - **Capacity of the other sectors and organisations to undertake action including commitment, knowledge and resources • Willingness to establish and strengthen relationships between those involved so that action can be undertaken and sustained**
  - **Identified, well planned action that can be implemented and evaluated • Provision to sustain outcomes**
  - **External funding sources through stakeholder involvement.**

<http://www.healthinonet.ecu.edu.au/health-infrastructure/health-promotion/reviews/our-review>

Summary of developments in Indigenous health promotion

- In terms of Indigenous health promotion, a significant development was the Indigenous initiative in establishing community-controlled health services

- The operations of Aboriginal community-controlled health services (ACCHSs), the first of which was established in Redfern (Sydney) in 1971, are directed by the local community to ensure that the services are provided in a culturally appropriate manner

It was not until 1995, however, that serious efforts were made to stimulate activities through the development of a network of Indigenous health workers involved in health promotion. In that year, the Australian Centre for Health Promotion (at the University of Sydney) convened a meeting of Indigenous health workers who had an interest in and/or experience in health promotion. [The Australian Indigenous Health Promotion Knowledge Network](#), established at that meeting, was given responsibility for implementation of an 'Agenda for action'. That agenda has formed the basis for the work that has been carried out by the Network since that time [10].

The Network works in a number of ways to support Indigenous people engaged in health promotion by:

- enabling regular communication about their work;
- advising on conferences, workshops, policy reviews and literature;
- linking with international Indigenous health and health promotion networks;
- facilitating professional exchange opportunities; and organising professional development opportunities.
- The Network assists by identifying the education and training needs of Indigenous health promotion practitioners, researchers and policy makers [10]. It has worked with universities and colleges to develop and implement relevant professional preparation and education courses in Indigenous health and health promotion, and has supported and advised on Indigenous health promotion curriculum development. The Network provides assistance in disseminating relevant health and public policy documents. It also contributes to national debate and decision-making about infrastructure support and funding required for Indigenous health promotion, and acts as an advisory body on policy, education and work practices that improve the health status of Indigenous people.

Closing the gap: Improving the accessibility of health services in urban and regional settings for Indigenous people

<http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs27.pdf>

- Addressing physical and economic barriers through strategies such as:
  - providing services locally
  - providing transport to health services
  - having flexibility in setting appointments
  - using home visitation as part of a multi-faceted engagement strategy
  - increasing services that do not require co-payment
  - improving access to private health insurance and private health services. •

Addressing cultural competence, acceptability and appropriateness through strategies such as:

- developing services around the holistic model of health and wellbeing
- building therapeutic and clinical relationships based on trust and mutual respect
- employing Indigenous health professionals and health workers to promote culturally safe service delivery

- where feasible, providing a choice between Indigenous-specific and non-Indigenous-specific health professionals and services
- adopting strategies that support cultural competency and safety at the systemic, organisational and individual levels, including appropriate communication styles, and working through community Elders and kinship networks
- providing services in non-traditional settings.
- Even given the limited number of evaluations, available literature indicates that the following strategies can be ineffective in improving Indigenous access to health services:
  - fee-for-service approaches—these can prevent many low-income Indigenous clients from accessing needed care
  - short consultation times coupled with poor health literacy—complex and chronic conditions require longer consultation times
  - highly structured programs
  - a purely biomedical approach to health promotion and treatment—such an approach fails to acknowledge and demonstrate respect for holistic Indigenous understandings of health and wellbeing
  - assumptions that fluency in English means effective communication can occur around culturally specific biomedical conceptions of health and the treatment of illness—Indigenous cultures can differ from non-Indigenous cultures in their views and communication practices about the treatment of illness
  - ignoring the importance of kin and kinship systems in caring for an individual patient.
- Pharmaceutical costs are an additional, often hidden, economic barrier to accessible health care. Also, some Indigenous people’s lack of confidence or familiarity with using pharmacies to purchase medicines further compounds their poor access to required medications (Stoneman & Taylor 2007a, 2007b). The elimination of co-payments on medications in some parts of Australia has helped to improve access to medications for Indigenous Australians. A 1999 amendment to the National Health Act—‘the S100 Scheme’—allowed approved remote and very remote ACCHSs to bulk-purchase and dispense pharmaceuticals to Aboriginal clients without requiring co-payments
- **Separation of families and children and dislocation of families**
- *For example, Indigenous cultures tend to have a more holistic understanding of health, in which ‘physical, mental, emotional, spiritual and cultural are all intrinsically intertwined and linked’*
- Internationally, studies of Indigenous health in colonised nations refer frequently to the effects of the colonial past on the willingness and confidence of contemporary Indigenous populations to access even the most physically and economically accessible health services (Stoneman & Taylor 2007a). These effects include the following:
  - **fear, due to forced removals of children or relocation of families (for example, Barwick 2000; Hayman et al. 2009; Homel et al. 2006; O’Neill et al. 2004; Scrimgeour & Scrimgeour 2008)**
  - **ongoing individual, institutional and systemic racism (Gallaher et al. 2009; Homel et al. 2006; Paradies et al. 2008). Some health services fail to deliver**

**care to all without discrimination. It has been found that, compared to non-Indigenous clients with the same medical needs, Indigenous clients were about one-third less likely to receive appropriate medical care across all conditions (Paradies et al. 2008)**

- **shame and 'shyness' due to previous negative interactions with authorities (Barwick 2000; Maher 1999; NCAHS 2009).**

- **Miscommunication**

- Specific examples of miscommunication include the following:
- eye contact—direct eye contact is considered polite in many Western cultures, but it can be interpreted in some Indigenous cultures as 'asserting power over or reprimanding someone' (NCAHS 2009:35). When Indigenous clients avoid eye contact, it should be understood as a sign of respect rather than rudeness
- saying 'yes' or 'no' by default—shame and embarrassment could result from not fully understanding a question or explanation. Therefore, an Indigenous person might default to answering 'yes' where they do not understand (NCAHS 2009)
- shyness—some clients stay silent about pain during treatment or in situations where they do not fully understand what is being said to them
- avoiding contradictions—in some Aboriginal languages, it is impolite to directly contradict or challenge the propositions of a speaker, especially in contexts of uneven power or unfamiliarity (Lowell et al. 2005). Therefore, some clients respond to questions with what they think the health professional wants to hear
- using metaphors to explain foreign medical concepts—each language has its own set of metaphors and imagery, and these do not always directly translate (Lowell et al. 2005)
- abstract and concrete concepts—Indigenous languages and thought patterns might retain direct links between abstractions and concrete reality, whereas Western abstractions tend to sever that link (Bain 2011). This could result in general statements about health issues being received by Indigenous clients as implied insults, which may offend. Similarly, non-Indigenous health professionals need to exercise care when presenting a range of treatment options in order to fully inform an Indigenous patient. Indigenous clients could interpret the first option being offered as the non-Indigenous health practitioner's preferred approach. In that case, only one option might be considered as the decided treatment (Bain 2011).

- **Respect and respond to Indigenous relationships and gendered behaviour protocols**

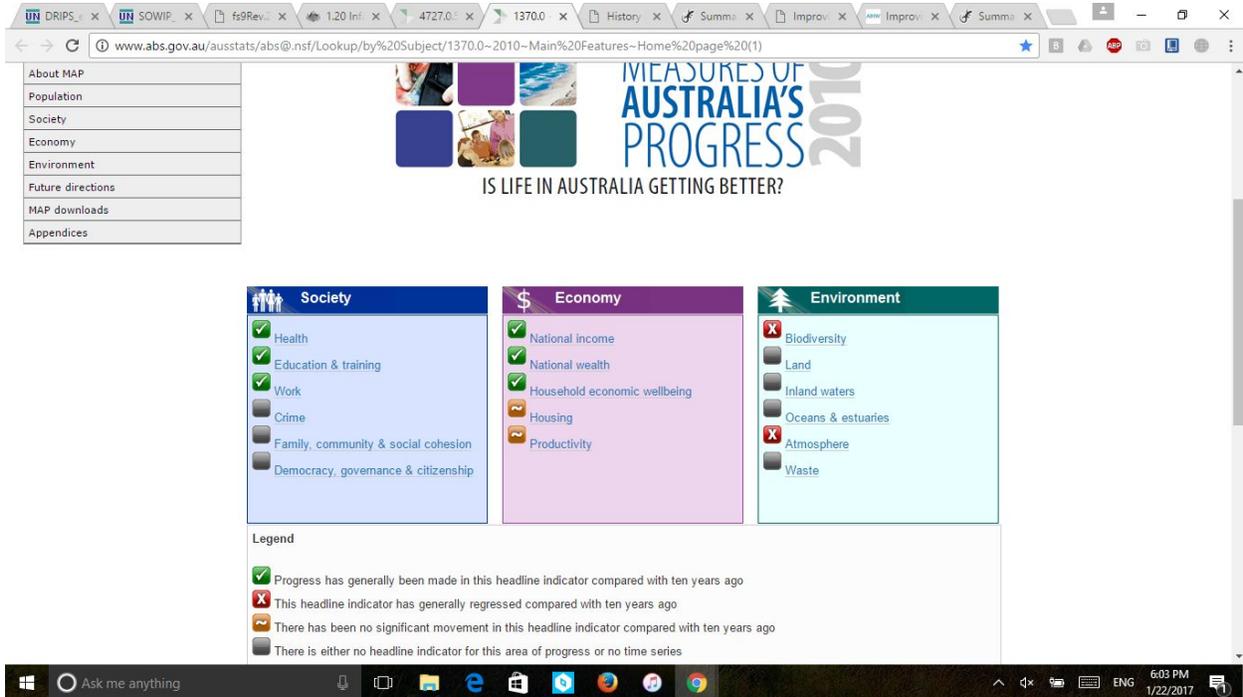
- Gender separation involves more than just men talking to men, and women to women. It involves a determination of who has the appropriate gender to discuss particular topics (Scougall 2008). Therefore, it could be entirely appropriate in some contexts (for example, health promotion events) for a female to be presenting information to men or vice versa.
- **transport services need to employ drivers who are of the same gender as the clients (Barwick 2000)**

- different waiting rooms and different entry and exits for men and women can be created to help clients to maintain avoidance relationships (Coffin 2007)
- procedures such as showering, toileting, catheterisation and genital examinations need to be conducted by health staff of the same gender as the patient (Maher 1999)
- norms of men's and women's business need to be understood and respected to encourage the use of services and prevent shame (NCAHS 2009)
- access to multiple translators and staff must be set up to allow Indigenous staff and clients to maintain any avoidance relationships within their community (Maher 1999; NCAHS 2009)
- health professionals need to familiarise themselves with who has the right and responsibility to discuss a given topic, then ensure that only the appropriate people are involved in relevant discussions.
- Flexible programs appear to be more successful in attracting Indigenous clients, with flexibility noted in the literature in terms of:
  - day-to-day structure (for example, no fixed appointments, drop-in services) (SNAICC 2010)
  - the provision of different entry points to assist clients in maintaining avoidance relationships
  - being well-coordinated and working effectively together. Longer consultations are important to Indigenous clients, due partly to the more complex nature of conditions with which they tend to present
- Health promotion programs are best developed in conjunction with Indigenous community members
- Health workers should avoid asking questions or making assertions that are too direct or confronting (NCAHS 2009).
- Health workers must maintain open, relaxed and non-confrontational body language and postures, and avoid prolonged eye contact (NCAHS 2009).
- Employing a receptionist with appropriate cultural skills (or providing training) can make Indigenous people feel welcome and secure (Scrimgeour & Scrimgeour 2008), as the receptionist is frequently the first point of contact for clients.
- Supportive relationships are crucial for working effectively across cultures (Dudgeon et al. 2010), including with Aboriginal and Torres Strait Islander people—individually as clients, professionally as co-workers, and with the community as partners with services.
- Any effective health program needs to recognise, respect, support and promote the importance of family and country to many Aboriginal and Torres Strait Islander people (Stamp et al. 2008). Aboriginal family and kinship relationships are the primary structures that provide cultural and social and emotional cohesion and support for many Aboriginal people (Walker 2011). This kinship network includes large extended family members, often biological and non-biological.

- As health service providers implement cultural competence training and attempt to integrate culturally competent behaviours into everyday practice, it is important to track and measure the level of competence being achieved (Trenerry et al. 2010). This could involve organisational audits, which can include assessment of workplace practices, policies and procedures that support cultural diversity and reduce discrimination (Trenerry et al. 2010).

[http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Main%20Features~Home%20page%20\(1\)](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Main%20Features~Home%20page%20(1))

### 1370.0 - Measures of Australia's Progress, 2010



<http://www.naccho.org.au/about/aboriginal-health/history/>

### Major developments in national Aboriginal health policy since 1967

- 1967 - A constitutional amendment referendum held during Liberal Prime Minister Harold Holt's term in office, gave the Commonwealth Government power to legislate for Indigenous Australians, and allowed for their inclusion in the census [1].
- 1968 - The Commonwealth Office of Aboriginal Affairs was established [2].
- 1969 - The Office identified health as one of four major areas for Indigenous development and initiated specific purpose grants to the States for the development of special Aboriginal health programs [3] [4] [5]. State government health authorities decided to establish Aboriginal health units to address the health needs of the Indigenous population and to administer the Commonwealth funds [2] [4].
- 1971 - The first Aboriginal Medical Service (AMS) was initiated on a voluntary basis in Redfern, Sydney [6].
- 1972 - The Whitlam Labor Government was elected and replaced the Office of Aboriginal Affairs with the Department of Aboriginal Affairs (DAA) [7]. The DAA

continued with the States grants programs initiated by the Office but also began to make direct grants to the newly-emerging AMSs [8].

- The Federal Court decision in Australia's first native title case, the Gove Land Rights Case, found that traditional laws, customs and land rights were not recognised by Australian courts.
- 1973 - The Commonwealth Government made a formal offer to the State Ministers to assume from them full responsibility for Indigenous affairs policy and planning. With the exception of Queensland, all the States accepted the offer and negotiations commenced for the transfer of responsibility for Indigenous policy, planning and coordination from the States to the Commonwealth. The Department of Aboriginal Affairs was given central authority for policy administration[9]. An Aboriginal Health Branch was established in the Commonwealth Department of Health to provide professional advice to the Government [10]. One of its first actions was to propose a Ten Year Plan for Aboriginal Health
- 1974 - The national AMS umbrella organisation, the National Aboriginal and Islander Health Organisation (NAIHO), was formed
- 1976 - The Commonwealth asked the House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) to conduct a review of Aboriginal health
- 1977 - The HRSCAA inquiry was initiated [13].
  - The Australian Parliamentary report Alcohol problems of Aboriginals was published
- 1979 - The HRSCAA's report Aboriginal Health was released
- 1981 - The Commonwealth Government initiated a \$50 million five-year Aboriginal Public Health Improvement Program in response to recommendations outlined in the HRSCAA report [7]. The program, administered by the DAA, focused on unsatisfactory environmental conditions associated with inadequate water, sewerage and power systems
- 1984 - Universal health insurance was reintroduced as Medicare [11].
  - A Commonwealth Task Force on Aboriginal Health Statistics was established
- 1987 - The Australian Institute of Health (AIH) became an independent statistics and research agency. It continued to play an important role in the development of Indigenous health statistics [17].
  - A meeting of Commonwealth, State and Territory Health and Aboriginal Affairs Ministers led to the formation of a Joint Ministerial Forum on Indigenous health and the appointment of a National Aboriginal Health Strategy Working Party (NAHSWP). The NAHSWP was to develop a strategy on Indigenous health that would encompass issues pertaining to funding, Indigenous participation, intersectoral coordination and monitoring and meet with the approval of all stakeholders
- 1988 - The Royal Commission into Aboriginal Deaths in Custody was initiated.
- 1989 - The National Aboriginal Health Strategy Working Party (NAHSWP) final report, A National Aboriginal Health Strategy (NAHS) [19], was presented to the Joint Ministerial Forum [1].

- The Ministerial Forum established the Aboriginal Health Development Group (AHDG), comprised primarily of Commonwealth, State and Territory government representatives, to assess the report and advise on its implementation [1] [7].
- AMSs protested against the limited representation of Indigenous community interests on the AHDG and a community advisory group, the Aboriginal Health Advisory Group (AHAG), was subsequently established in parallel to the AHDG [1][7].
- The third national health survey (conducted by the ABS) provided, for the first time, for the identification of Indigenous people
- 1990: The Aboriginal and Torres Strait Islander Commission (ATSIC) was established, replacing the DAA and the Aboriginal Development Commission, and assumed national responsibility for Indigenous health.

Health facts - not necessary

<http://www.healthinfonet.ecu.edu.au/health-facts/summary>

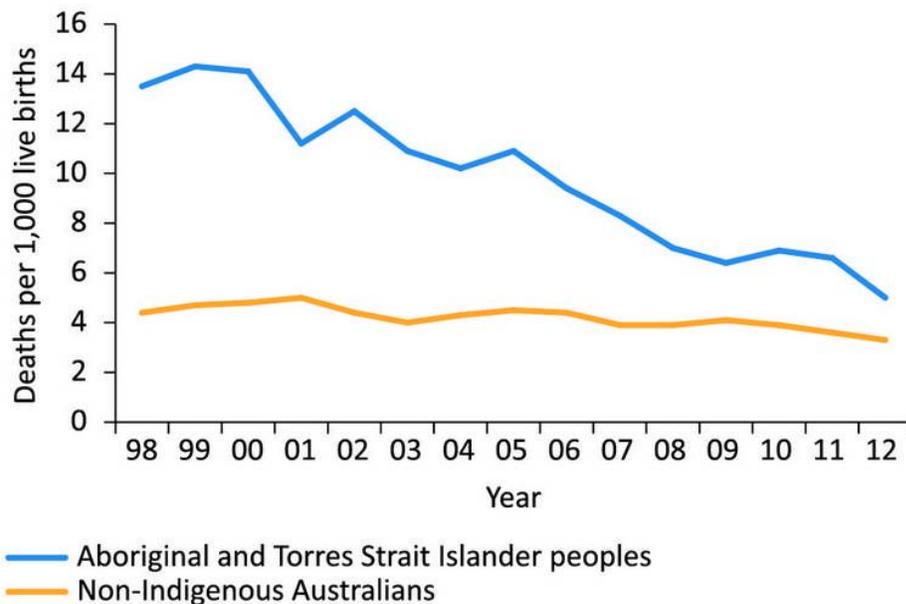
Infant and Child mortality

<https://www.dpmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-1-health-status-and-outcomes/120-infant-and-child-mortality.html>

- Improvements in Australia's infant mortality rates in the last 100 years were largely due to improved social and public health conditions such as sanitation and health education in the first half of the twentieth century, followed by the development of immunisation, and in more recent years by better treatment in neonatal intensive care and interventions for Sudden Infant Death Syndrome (SIDS)
- In the period 2008–12, the mortality rate for Indigenous infants was 1.7 times the non-Indigenous rate (6.2 per 1,000 live births compared with 3.7 per 1,000 live births). The Indigenous infant mortality rate declined by 64% between 1998 and 2012, compared with a decline of 25% for non-Indigenous infants.
- The 2014–15 Federal Budget provided funding of \$94 million from July 2015 for the Better Start to Life approach to expand efforts in child and maternal health to support Indigenous children to be healthy and ready for school.
  - The Better Start to Life approach included \$54 million to increase the number of New Directions: Mothers and Babies services from 85 to 136. These services provide Aboriginal and Torres Strait Islander families with access to antenatal care, practical advice and assistance with parenting, and health checks for children.
  - The Better Start to life approach will also provide \$40 million to expand the Australian Nurse Family Partnership Program (ANFPP) from 3 to 13 sites. The ANFPP aims to improve pregnancy outcomes by helping women engage in good preventive health practices, support parents to improve their child's health and development, and help parents develop a vision for their own future, including continuing education and finding work.
  - The 2014–15 Federal Budget also committed \$25.9 million in 2014–15 for a new Indigenous Teenage Sexual and Reproductive Health and Young Parent Support measure to continue Indigenous teenage sexual and reproductive health and

antenatal care services to provide information to young people to make informed decisions about their reproductive health and health behaviours during pregnancy

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#### The Australian Aboriginal Health Survey

- The Australian Health Survey (AHS) includes a nationally representative sample of around 13,000 Aboriginal and Torres Strait Islander people. As part of the Australian Health Survey, the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) which commenced in April 2012 collects information from the Aboriginal and Torres Strait Islander population in non-remote areas and remote areas, including discrete communities. It combines the existing ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) together with two new elements - a National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS) and a National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS), will include:
  - estimates of the prevalence of certain chronic diseases and conditions and selected behavioural risk factors- including physical activity participation and sedentary behaviour
  - objective measures of selected chronic diseases, nutrition status and other risk factors which can be combined with self-reported data about health status and conditions (e.g. diabetes)

- health risk factors and outcomes for different population groups of interest, such as different age groups and people living in remote and non-remote areas.
- **Background stats**
- In 2012–13, around two in five (39.2%) Aboriginal and Torres Strait Islander people aged 15 years and over considered themselves to be in very good or excellent health, while 7.2% rated their health as poor.
- Based on age standardised proportions, Aboriginal and Torres Strait Islander people aged 15 years and over were around half as likely as non-Indigenous people to have reported excellent or very good health (rate ratio of 0.6).

#### Asthma

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

Based on age standardised proportions, Aboriginal and Torres Strait Islander people were more likely than non-Indigenous people to have heart or circulatory diseases (rate ratio of 1.2)

Aboriginal and Torres Strait Islander rates for diabetes/high sugar levels were between three and five times as high as the comparable rates for non-Indigenous people in all age groups from 25 years and over.

Based on age standardised proportions, Aboriginal and Torres Strait Islander people were three times as likely as non-Indigenous people to have diabetes/high sugar levels (rate ratio of 3.3)

In 2012–13, two in five (41.0%) Aboriginal and Torres Strait Islander people aged 15 years and over smoked on a daily basis.

Based on age standardised proportions, the gap between the daily smoking rate in the adult Aboriginal and Torres Strait Islander population and non-Indigenous population was 27 percentage points in 2001 and was 25 percentage points in 2012–13

Consultations with health professionals

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

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