Chapter 5
Progress towards achieving Aboriginal and Torres Strait Islander health equality within a generation – an update on efforts to 'Close the Gap'

Part 1: Introduction

> *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 health equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030.
>
> – Close the Gap Statement of Intent, March 2008[1]

This chapter looks at progress made in addressing Indigenous health inequality since 2005. In the *Social Justice Report 2005*, I called for a national effort to close the gap in health inequality within a generation. Since 2006, I have led a substantial national campaign to garner public support for this goal and to articulate what is required to achieve it. The Close the Gap Campaign has been unprecedented in how it has brought together the health sector with NGOs and the Australian community to champion change. The new Australian Government has responded positively to this Campaign and adopted a number of its recommendations.

Close the Gap has become part of the lexicon. It is widely used to describe the policy aspirations of Australian governments across a range of areas of socio-economic disadvantage. But this was not always the case. The previous government did not accept the recommendations of the *Social Justice Report 2005* and was unwilling to commit to a targeted approach to overcome Indigenous health inequality. It has taken sustained public lobbying from the Close the Gap Campaign partners and the Australian public to make this issue the national priority it should always have been.

We have now made a substantial breakthrough on this most pressing human tragedy. That breakthrough is to convince policy makers, politicians and the

1 *Close the Gap Statement of Intent* (signed at the Indigenous Health Equality Summit, Canberra, 20 March 2008). At www.humanrights.gov.au/social_justice/health/statement_intent.html (viewed 28 January 2009).

general public that the goal of health equality for all Australians within a generation is realistic and achievable if we act together in partnership, and in a targeted and determined manner. This chapter highlights the many positive developments that have occurred since 2005, but also looks at areas of work that remain.

Overall, I am cautiously optimistic that Indigenous Australians born in the year 2030 will look forward to the same long and healthy lives as their non-Indigenous counterparts so long as we continue to build on the substantial gains made since 2005.

Part 2: A reform agenda to achieve health equality for Indigenous peoples within a generation

1. The *Social Justice Report 2005*

The *Social Justice Report 2005* examined the longstanding challenge of Indigenous health inequality in Australia.[2] While noting there have been some improvements since the 1970s, the report found that overall progress has been slow and inconsistent. The inequality gap between Aboriginal and Torres Strait Islander peoples and other Australians remained wide and had not been significantly reduced.

Underlying the awful statistics, the report highlighted that Aboriginal and Torres Strait Islander peoples do not have an *equal opportunity* to be as healthy as non-Indigenous Australians. Indigenous people, in twenty first century Australia, do not enjoy *equal access* to primary health care or to health infrastructure (which includes safe drinking water, effective sewerage systems, rubbish collection services and healthy housing).

The report noted that Australian governments had made commitments to address Indigenous health inequality but always without a specified time frame and accordingly, without any deadlines or sense of urgency. Over time, there have been a number of well intentioned strategies and frameworks in Australia, but they have not resulted in improvements to the health of Indigenous Australians. We need to accept that the approach of the past – which has resulted in incremental funding increases – have not been enough to match Indigenous health needs. In the report, I urged that this situation not be allowed to continue in a nation as prosperous as ours.

The *Social Justice Report 2005* identified a need for fundamental change to our approach if things were to improve, and Indigenous Australians to stand as equals, in terms of health and life expectation, with other Australians.

The report proposed a human rights based approach to address the health inequality of Indigenous Australians based on their right to health. It urged governments to commit to addressing the health status of Aboriginal and Torres Strait Islander peoples within a set timeframe.

The recommendations of the *Social Justice Report 2005* are set out below.

Text Box 1: Recommendations of 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.

2 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission (2006) ch 2.

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:
Bipartisan support for a generational commitment to close the gap

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.

2. The Close the Gap Campaign

Following the release of the *Social Justice Report 2005* in March 2006, under my leadership, the National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Indigenous Doctors' Association (AIDA), the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), Oxfam Australia, Australians for Native Title and Reconciliation (ANTaR), the Fred Hollows Foundation (and later joined by the Indigenous Dentists' Association of Australia (IDAA) and Australian Indigenous Psychologists' Association (AIPA)) founded the National Indigenous Health Equality Campaign.

To that end we formed a Steering Committee to guide the Campaign. The Steering Committee also comprises representatives from the following organisations:

- Australian General Practice Network;
- Australian Medical Association;
- Cooperative Research Centre for Aboriginal Health;
- Heart Foundation;
- Menzies School of Health Research;
- Royal Australian College of General Practitioners;
- Royal Australasian College of Physicians; and
- Torres Strait and Northern Peninsula District Health Service.[3]

3 A further non-exhaustive list of organisations who have publicly expressed support for the campaign includes: 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 Institute of Health and Welfare; Australian Institute of Aboriginal and Torres Strait Islander Studies; Australian Nursing Federation; Australian Red Cross; Caritas Australia; Clinical Nurse Consultants Association of NSW; Diplomacy Training Program, University of New South Wales; Gnibi the College of Indigenous Australian Peoples, Southern Cross University; 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; 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; Public Health Association of Australia; Quaker Services Australia; 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; and the Victorian Aboriginal Community Controlled Health Organisation.

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, provide expert assistance to the Steering Committee.[4]

Collectively, these bodies and individuals are referred to in this chapter as the Close the Gap Steering Committee for Indigenous Health Equality, or the Steering Committee.

The founding of the Steering Committee is in itself an historic event, being the first time that such authoritative and influential peak bodies and key organisations from Australian civil society have worked together in partnership in such a sustained manner. Indigenous leadership, and the leadership of the Indigenous health peak bodies in particular, has also been a hallmark of the Close the Gap Campaign.

Many member organisations were required by their constitutions to formally seek the support of their members in order to participate in the Campaign. NACCHO, for example, successfully received the endorsement of its approximately 140 member Aboriginal community controlled health services to actively participate in the Campaign. For AIDA, the endorsement of their Board was required. Through these Steering Committee members' internal processes, the Campaign ensured it had significant support among both Indigenous health professionals (specifically, doctors, nurses, dentists and, later, psychologists) and the Aboriginal community controlled health services. The latter was particularly important as it was a strong indicator of broader Indigenous community support for the Campaign (given these health services draw their members from the communities they serve) and otherwise ensured that these services would play a significant role in the Campaign.

Our first year's work involved consolidating our relationship with each other. It took time to understand what each could bring to the table in terms of resources, contacts, expert assistance, and particular skills.

There was also a need to articulate exactly what we were seeking. While agreement with the recommendations of the *Social Justice Report 2005* provided a basis for coming together, it was still necessary to flesh out important areas of our collective approach, many of which are discussed in this chapter.

Dedicating valuable resources to the Campaign was also crucial. With the exception of matching funding from the Australian Government to fund the National Indigenous Health Equality Summit in 2008 (discussed below) the Campaign has been entirely self-funded by the Steering Committee members and supporting organisations to date. This has been of vital importance in demonstrating the commitment that each partner has brought to the process, and also in ensuring a sustained campaign to convince Australian governments of the need to act.

In terms of our activities, our first year was characterised by letter writing, meetings with Ministers of the then Coalition Government, other members of Parliament, and key civil servants as we attempted to raise consciousness among decision makers as to our existence and what we were asking for. From the start, we were conscious of the need to engage fully with both Government and Opposition members of Parliament as it was clear that the commitments we were seeking would require bi-partisan support over the lifetime of many parliaments.

We also began the development of what would become the *Close the Gap National Indigenous Health Equality Targets* to further one of the *Social Justice Report 2005* recommendations – that Australian governments utilise targets and benchmarks to not

4 From the initial drafting of the *Social Justice Report 2005* and inception of the Close the Gap campaign, Christopher Holland and Darren Dick of the Australian Human Rights Commission have acted as the Secretariat for the Close the Gap process, with the Social Justice Commissioner chairing and leading the committee process.

only provide an end in sight to the Indigenous health equality gap, but also to ensure accountability for achieving the goal of health equality.

The targets were developed over a period of six months by three 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, Indigenous Health Committee of the Royal Australasian College of Physicians; and
- Dr Ngiare Brown, then at the Menzies School of Health Research.

The targets working groups drew on the expertise of a wide range of health experts, and, in particular, Indigenous health experts.[5]

Steering Committee members also began to raise public consciousness through advocacy work, and by the end of the first year we were ready to launch a public campaign.

'Close the Gap' was the catch cry chosen for this, and a media and public relations campaign was organised with great impact by the National Aboriginal Community Controlled Health Organisation, Australians for Native Title and Reconciliation and Oxfam Australia. Within a few months, the 'Close the Gap' logo was a common sight, across T-shirts, on websites and billboards.

Given our limited resources, with the financial support of Oxfam Australia we particularly targeted billboards at Canberra airport knowing that they were likely to be seen by the politicians we were seeking to influence. Petitions were also organised that gathered tens of thousands of signatures from members of the public.

On 4 April 2007, the Close the Gap Campaign was formally launched at the Telstra Stadium, Sydney, by Olympians Catherine Freeman and Ian Thorpe, alongside Henry Councillor (then Chair of the National Aboriginal Community Controlled Health Organisation), journalist Jeff McMullen, and myself.

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5 The following individuals assisted with the creation of the targets: 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.

The launch was also marked by the publication of a full-page open letter in *The Australian* calling on all Australian governments to support the Campaign.[6] 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 Close the Gap Campaign in its Indigenous affairs policy by the time of the 2007 federal election.

Once in government, the Close the Gap platform became Australian Government policy. In particular, and as discussed in greater detail below, a significant milestone for the Campaign was on 20 December 2007 when the Council of Australian Governments (COAG) 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, and agreeing to close the 17-year gap in life expectancy between Indigenous and non-Indigenous Australians within a generation.[7]

The rights based approach to Indigenous health inequality set out in the *Social Justice Report 2005* and the Campaign as it gathered pace also attracted significant international attention. In particular, Professor Paul Hunt, the United Nations Human Rights Council's Special Rapporteur on the right to the highest attainable standard of health described the approach and the Campaign as world best practice.

Further, the Campaign was the subject of a case study in Dr Helen Potts' (Human Rights Centre, University of Essex) landmark publication, *Accountability and the Right to the Highest Attainable Standard of Health*;[8] and also referred to in the World Health Organisation's Commission on the Social Determinants of Health's final report, *Closing the gap in a generation: Health equity through action on the social determinants of health*, a title that echoed the name of the Campaign.[9]

3. The National Indigenous Health Equality Summit

The Close the Gap Steering Committee for Indigenous Health Equality hosted the National Indigenous Health Equality Summit in Canberra from 18 – 20 March 2008.

The Summit was intended both as the culmination of the previous two years work by the Steering Committee and supporting organisations, and also aimed to build on the momentum for change provided by the commitments of Australian Governments made at the 20 December 2007 COAG meeting (as discussed above).

The first two days (18 – 19 March) involved approximately 100 invited delegates including senior representatives from Commonwealth and state/ territory level governments and health departments; specialists and experts (and particularly Indigenous ones) from a range of health and health-related areas; and representatives from Indigenous health and health related peak bodies (including from all the state and territory level Aboriginal community controlled health organisation peak bodies).

Over those two days, the overall approach of the Campaign and the draft National Indigenous Health Equality Targets were presented to the delegates, with discussion and debate around these being encouraged and fed back into the target development process.

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6 Close the Gap Campaign, Open letter to governments, *The Australian*, December 2006. At http://www.humanrights.gov.au/social_justice/health/health_OpenLetter.html (viewed 28 January 2009).

7 Council of Australian Governments, *Communique – 20 December 2007*. At http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm (viewed 28 January 2009).

8 H Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (2008) p 19. At: http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf (viewed 28 January 2009).

9 Commission on the Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health* (2008). At http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf (viewed 28 January 2009).

The final morning of the Summit (20 March) was a ceremonial occasion held at the Great Hall of Parliament House, Canberra. Here, before members of the public, the press, Members of Parliament, public servants and Summit delegates, the Summit outcomes were presented.

There were three major outcomes from the Summit:

3.1 National Indigenous Health Equality Targets

The following considerations framed the thinking of the Steering Committee and the assisting experts when developing targets:

- What targets (if achieved) will reduce disparity to the greatest degree?
- What targets (if achieved) will improve health outcomes to the greatest degree? What is the disease-specific burden experienced by Indigenous populations?
- Can we adequately measure the current/ future indicators to determine whether or not the target has been reached, or is significant additional investment, infrastructure or capacity required?
- To what targets can we hold government to account as their primary responsibility?

After the Summit, the targets were finalised by the expert members of the targets working groups and published in July 2008.[10] They identify the following five key subject areas for target setting as priorities, and the key elements of any national plan to achieve Indigenous health equality:

- Partnership;
- Health status;
- Primary health care and other health services;
- Infrastructure; and
- Social and cultural determinants (still under development).

These targets represent the 'industry perspective' on what needs to be done and the time frame for doing so in relation to achieving Indigenous health. This unprecedented body of work is intended to be the basis of negotiations with Australian governments as to the main elements and time frames of a national plan to achieve Indigenous health equality by 2030. The targets are discussed in greater detail in part 2 below.

3.2 The Statement of Intent

On 20 March 2008, as the highlight of the Summit ceremony at the Great Hall in Parliament House, Canberra, the signing of the *Close the Gap Indigenous Health Equality Summit Statement of Intent* (Statement of Intent) took place.

The main signatories to this were the:

- Prime Minister;
- Leader of the Opposition;
- Minister for Health and Ageing;
- Minister for Families, Housing, Community Services and Indigenous Affairs;
- Presidents and Chairs of the four main Indigenous health peak bodies:
  - the National Aboriginal Community Controlled Health Organisation,
  - the Australian Indigenous Doctors' Association,

10 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008). At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

  - the Congress of Aboriginal and Torres Strait Islander Nurses, and
  - the Indigenous Dentists' Association of Australia;
- Presidents and CEOs of the four main mainstream health peak bodies;
  - the Australian Medical Association,
  - the Royal Australian College of General Practitioners,
  - the Royal College of Australasian Physicians; and
  - the Australian General Practice Network;
- Aboriginal and Torres Strait Islander Social Justice Commissioner of the Australian Human Rights Commission (then the Human Rights and Equal Opportunity Commission).[11]

The Statement of Intent is one of the most significant compacts between Australian governments and civil society in Australian history. It should be seen as a foundation document for a national effort to achieve Indigenous health equality by 2030, setting out key principles that should underpin national efforts to that end.

Since the National Indigenous Health Equality Summit, the Statement of Intent has received bi-partisan support from the Parliaments of Victoria and Queensland. Efforts are underway for every Australian government to have signed the Statement of Intent by 20 March 2009.

The Statement of Intent is reproduced in full below.

Text Box 2: Close the Gap Statement of Intent[12]

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 the year 2030.

11 Other signatories included the heads of NGOs including Oxfam Australia, Australians for Native Title and Reconciliation, Reconciliation Australia, Get Up!, Catherine Freeman Foundation, Ian Thorpe's Fountain for Youth, and the Australian Doctors Trained Overseas Association. See also, *Close the Gap Statement of Intent* (signed at the Indigenous Health Equality Summit, Canberra, 20 March 2008). At www.humanrights.gov.au/social_justice/health/statement_intent.html (viewed 28 January 2009).

12 *Close the Gap Statement of Intent* (signed at the Indigenous Health Equality Summit, Canberra, 20 March 2008). At www.humanrights.gov.au/social_justice/health/statement_intent.html (viewed 28 January 2009).

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 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.

4. National Indigenous Health Equality Council

At the National Indigenous Health Equality Summit, the government announced the creation of the National Indigenous Health Equality Council (NIHEC) to progress its close the gap commitments.

The NIHEC is intended to 'provide national leadership in responding to Government's commitment to closing the gap on Indigenous disadvantage by providing advice to

Government on working towards the provision of equitable and sustainable health outcomes for Indigenous Australians.'[13]

Its terms of reference require it to:

- advise on commitments made under the March 2008 Statement of Intent on achieving Indigenous health equality;
- advise on the development and monitoring of health related goals and targets to support the Government's commitments on life expectancy and child mortality; and
- develop advice to the Minister on:
  - strategic priorities for Aboriginal and Torres Strait Islander Health;
  - meeting targets agreed by the Australian Government and the Council of Australian Governments; and
  - monitoring of progress towards 'closing the gap' of Indigenous disadvantage including through the annual report to Parliament, the Aboriginal and Torres Strait Islander Health Performance Reports and Overcoming Indigenous Disadvantage Reports; and
  - any specific matters referred to it by the Government and the AHMAC.
- as a first priority, consider workforce development issues and make recommendations to the Minister in respect of workforce development and sustainability, including providing advice on pathways to increase Indigenous workforce representation.[14]

The Steering Committee for Indigenous Health Equality has worked to establish a strong working relationship with the NIHEC since it first met in August 2008. The Steering Committee will continue to work with the NIHEC in 2009 to enable both to further their many common goals.

5. Commitments to a new partnership with Indigenous peoples

The Prime Minister has made closing the gap a defining feature of his approach to Indigenous affairs. In the *National Apology to Australia's Indigenous Peoples* on 13 February 2008 he also stated the need for 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.[15]

13 Department of Health and Ageing, *National Indigenous Health Equality Council Terms of Reference* (2008). At http://www.nihec.gov.au/internet/nihec/publishing.nsf/Content/terms (viewed 28 January 2009).

14 Department of Health and Ageing, *National Indigenous Health Equality Council Terms of Reference* (2008). At http://www.nihec.gov.au/internet/nihec/publishing.nsf/Content/terms (viewed 28 January 2009).

15 Commonwealth, *Parliamentary Debates*, House of Representatives, 13 February 2008, p 167 (The Hon Kevin Rudd MP, Prime Minister).

And he promised change in the way Australian governments would work with Indigenous Australians in the future:

> The truth is: a business as usual approach towards Indigenous Australians is not working. Most old approaches are not working. We need a new beginning. A new beginning which contains real measures of policy success or policy failure. [16]

He also flagged the importance of Australian Government leadership and national planning in this effort, stating that 'unless we as a parliament set a destination for the nation, we have no clear point to guide our policy, our programs or our purpose; no centralised organising principle.'[17]

The Prime Minister also stated that he would make an annual report to Parliament on its first working day on national efforts to close the gap, stating that:

> Closing the life expectancy gap between Indigenous and non-Indigenous Australians is a core priority of the Government I lead… [e]ach year we must know as a Government, as a people, and as a country if we had made progress closing this gap… [e]very leader knows that accountability brings with it the risk of criticism of failure, as the Prime Minister of Australia I accept that risk.[18]

The National Apology also contained a commitment to bipartisanship, to:

> [create] a kind of war cabinet on parts of Indigenous policy, because the challenges are too great and the consequences too great to just allow it all to become a political football, as it has been so often in the past. [19]

This was to be tested by the creation of a 'joint policy commission to develop a housing strategy for remote communities over the next five years'.[20]

On 27 June 2008, with the promise of the bipartisan 'war cabinet' unfulfilled, a National Policy Commission on Indigenous Housing nonetheless met for the first time in Canberra to 'provide advice to the Government on innovative proposals to improve the provision of housing in remote Indigenous communities.'[21]

Initial tasks include assessing remote Indigenous housing data to identify gaps, assessing the capacity of existing government programs to address remote Indigenous housing needs, and identifying tangible policy objectives for government in both remote and urban and regional contexts.[22]

6. The national reform agenda

The activities of the Close the Gap Steering Committee for Indigenous Health Equality took place against an unfolding background of multiple (and often overlapping) processes to reform the Australian health system and inter-governmental relationships. These have enormous potential to contribute to the achievement of Indigenous health equality by 2030.

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16 Commonwealth, *Parliamentary Debates*, House of Representatives, 13 February 2008, p 167 (The Hon Kevin Rudd MP, Prime Minister).

17 Commonwealth, *Parliamentary Debates*, House of Representatives, 13 February 2008, p 167 (The Hon Kevin Rudd MP, Prime Minister).

18 Prime Minister, 'Annual Prime Ministerial Statement on Closing the Gap' (Media Release, 5 April 2008). At http://www.pm.gov.au/media/Release/2008/media_release_0166.cfm (viewed 29 January 2009).

19 Commonwealth, *Parliamentary Debates*, House of Representatives, 13 February 2008, p 167 (The Hon Kevin Rudd MP, Prime Minister).

20 Commonwealth, *Parliamentary Debates*, House of Representatives, 13 February 2008, p 167 (The Hon Kevin Rudd MP, Prime Minister).

21 Prime Minister, 'Indigenous housing meeting' (Media Release, 27 June 2008). At http://www.alp.org.au/media/0608/msfcspm270.php (viewed 29 January 2009).

22 Prime Minister, 'Indigenous housing meeting' (Media Release, 27 June 2008). At http://www.alp.org.au/media/0608/msfcspm270.php (viewed 29 January 2009).

As already noted, at the 20 December 2007 COAG meeting, all Australian governments 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'.[23]

This included agreement that:

- the 17 year gap in life expectancy between Indigenous and non-Indigenous Australians must be closed within a generation; and
- the infant mortality gap for Indigenous children under five halved within a decade.[24]

At this and over subsequent meetings, COAG adopted four more Indigenous equality targets:

- to halve the gap in literacy and numeracy achievement between Aboriginal and Torres Strait Islander students and other students within a decade;
- to halve the gap in employment outcomes for Aboriginal and Torres Strait Islander people within a decade;
- to at least halve the gap in attainment at Year 12 schooling (or equivalent level) by 2020; and
- to provide all Aboriginal and Torres Strait Islander four year olds in remote communities with access to a quality pre-school program within five years.

The context of these commitments was a National Reform Agenda, agreed to by Australian Governments in part to enable the new Australian Government's election platform to be implemented. In the Communiqué from the 20 December meeting, COAG noted a 'unique opportunity for Commonwealth-State cooperation' and that on this foundation they could fundamentally change the way the states, territories and federal government interacted in the delivery of services across a range of areas.[25]

COAG identified seven areas for its 2008 work agenda:

- Health and Ageing
- Productivity Agenda – including education, skills, training and early childhood
- Climate Change and Water
- Infrastructure
- Business Regulation and Competition
- Housing
- Indigenous Reform

To progress this agenda, seven working groups were established to progress reform across these seven areas. The work of each is overseen by a Commonwealth Minister.[26]

The Working Group on Indigenous Reform was established to provide COAG an integrated strategy regarding closing the gap focusing on the six nationally agreed targets discussed previously in the text.[27] The Steering Committee has worked

23 Council of Australian Governments, *Communique – 20 December 2007*. At http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm (viewed 28 January 2009).

24 Council of Australian Governments, *Communique – 20 December 2007*. At http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm (viewed 28 January 2009).

25 Council of Australian Governments, *Communique – 20 December 2007*. At http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm (viewed 28 January 2009).

26 Council of Australian Governments, *Communique – 20 December 2007*. At http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm (viewed 28 January 2009).

27 Council of Australian Governments, *Communique – 20 December 2007*. At http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm (viewed 28 January 2009).

intermittently with members of this working group, through a Building the Evidence Base sub group of the working group, in 2008.

Opportunities to work with this working group will increase in 2009, and it is hoped by the Steering Committee that such fundamentally important planning processes are opened to the input and scrutiny of Indigenous peoples and their representatives – not the least of which the Steering Committee, in relation to health planning.

7. New national framework for federal financial relations

At the meeting of COAG on 26 March 2008, a new National Framework for Federal Financial Relations underpinning the National Reform Agenda was clarified. The framework has an enormous potential to facilitate the achievement of Indigenous health equality by linking Commonwealth funding to the states and territories to specific performance indicators to further reform agendas, including that of Indigenous health equality.

As set out below, this framework is twofold: covering National Specific Purpose Payments, which will be the main means through which the Commonwealth delivers funding to the states and territories to meet their service delivery obligations; and National Partnerships, which are agreements around specific reforms or projects.

Text Box 3: New National Framework for Federal Financial Relations[28]

The financial new framework will take the form of an Intergovernmental Agreement on Commonwealth-State financial arrangements to commence on 1 January 2009.

Five or six new National Specific Purpose Payments are being developed to replace the current 90 or so Specific Purpose Payments. The new National Specific Purpose Payments will clarify the roles and responsibilities of different levels of government, reduce duplication and waste, and, importantly, reduce Commonwealth prescriptions on service delivery. Blurred roles and responsibilities between differing levels of government, as well as duplication and overlap, are costly aspects of Australia's federal system, particularly where they undermine accountability.

The new federal financial framework includes a further clarification of responsibilities to ensure the community knows which level of government is accountable for the delivery of a particular service. By moving away from input controls to focus on agreed objectives, outcomes and outputs, the new framework will provide the states and territories with greater flexibility to allocate resources to areas where they will produce the best outcomes for the community.

With agreed objectives and outcomes, and the COAG Reform Council's reporting, the new system seeks to establish improved accountability from the states and territories.

National Partnerships

In addition to the National Specific Purpose Payments, the new financial framework will include new National Partnership arrangements. These National Partnerships will provide funding in areas of joint responsibility for specific projects or to facilitate reforms, and reward states and territories that deliver on reform.

28 Council of Australian Governments, *COAG Reform Council News*, 2/2008 (2008). At http://www.coag.gov.au/about_coag/crc/docs/CRCnews022008.pdf (viewed 29 January 2009).

These National Partnerships, especially the reform facilitation and reward payments, will provide a framework through which the Commonwealth and a state or territory can agree on important reforms and pursue them, separately from the main cooperative funding framework for service delivery – delivered through Specific Purpose Payments.

Some of the kinds of reforms that may be driven through National Partnerships arrangements include: reform to address Indigenous disadvantage under the heading of 'closing the gap'.

The COAG Reform Council will independently assess whether states and territories have achieved the predetermined milestones and performance benchmarks in National Partnerships before incentive payments to reward reforms are made. Final decisions on the making of incentive payments will remain with the Australian Government.

8. Social inclusion agenda

Another promising development is the Australian Government's commitment to a social inclusion agenda, which has its origins in the Australian Labor Party's November 2007 election platform. It seeks, in part, to ensure that the continuous economic growth of the past almost two decades in Australia is enjoyed by all Australians. However, it also acknowledges that social exclusion is a multi-dimensional issue, and that for some population groups, social exclusion has been intergenerational.[29]

Social inclusion has been broadly defined by the Australian Government as more than simply an economic issue but as 'the opportunity to: secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and [for people] to have their voices heard.'[30]

To progress its social inclusion agenda, the Australian Government established an Australian Social Inclusion Board on 21 May 2008. The role of the Board is to consult with the community and advise the Australian Government as to practical ways it can implement the Social Inclusion agenda.[31] The Australian Government has also established a Social Inclusion Committee of Cabinet, and a Social Inclusion Unit in the Department of the Prime Minister and Cabinet to further this agenda.[32]

The Australian Government has identified as a priority in its social inclusion agenda 'closing the gap for Indigenous Australians'.[33] Through a number of sub-committees, work is ongoing as to how to best progress this agenda through the work of the Board. The Board is otherwise supportive of the Close the Gap Indigenous Health Equality Campaign.

29 Shadow Minister for Employment, Industrial Relations and Social Inclusion and Shadow Minister for Workforce Participation, *An Australian Social Inclusion agenda* (2007). At http://www.labor.com.au/download/now/071122_social_inclusion.pdf (viewed 29 January 2009).

30 Shadow Minister for Employment, Industrial Relations and Social Inclusion and Shadow Minister for Workforce Participation, *An Australian Social Inclusion agenda* (2007). At http://www.labor.com.au/download/now/071122_social_inclusion.pdf (viewed 29 January 2009).

31 Minister for Employment, Workplace and Industrial Relations, 'Australian Social Inclusion Board' (Media release, 21 May 2008). At http://www.deewr.gov.au/Ministers/Gillard/Media/Releases/Pages/Article_081009_115713.aspx (viewed 29 January 2009).

32 See Australian Government, *Social Inclusion*, http://www.socialinclusion.gov.au (viewed 29 January 2009).

33 Minister for Employment, Workplace and Industrial Relations, 'Australian Social Inclusion Board' (Media release, 21 May 2008). At http://www.deewr.gov.au/Ministers/Gillard/Media/Releases/Pages/Article_081009_115713.aspx (viewed 29 January 2009).

9. The National Health Sector Reform Agenda

Within the broader context of the National Reform Agenda, the Government has also started work on developing a National Health and Hospitals Reform Plan to improve health outcomes for patients in Australia's health and hospital system.

The COAG Health and Ageing Working Group and the National Health and Hospitals Reform Commission (NHHRC) have been established to progress this reform agenda. The NHHRC was established on 25 February 2008. Its terms of reference mandate that by June 2009 it will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to improve Indigenous health outcomes.[34]

Their initial focus of the working group and the NHHRC was on the Australian Health Care Agreements (AHCAs). The AHCAs form the basis of the funding and service delivery relationship between the Australian government and the states and territories. The Australian Government signalled that it wanted to expand the scope of the AHCAs to ensure they include specific reform benchmarks. This is something I had advocated in my *Social Justice Report 2005* in relation to securing funding for Indigenous health services.[35]

In its first report *Beyond the Blame Game* (April 2008) the NHHRC listed closing the gap in Indigenous health as its first national priority for health reform. It proposed a series of performance indicators attached to the AHCAs including in relation to Indigenous life expectation and infant mortality.[36]

Since the founding of the NHHRC, the Close the Gap Steering Committee for Indigenous Health Equality has met with the NHHRC members and made submissions to them setting out our approach to Indigenous health equality and how this can be progressed through its work. The main recommendations are set out below.

Text Box 4: Summary recommendations made to the NHHRC by the Close the Gap Steering Committee, July 2008

- That an appropriately funded, long-term national plan of action to achieving Indigenous life expectation and health equality by 2030 is established as a priority, and that within this are integrated a range of health status and other targets as set out in the *Close the Gap National Indigenous Health Equality Targets*.
- That the Australian Government establish a coordination body or mechanism (or designate an existing one) to oversee the activities of the range of government agencies with varying degrees of responsibility for Indigenous health with the primary aim of supporting the Australian Government's target of achieving Indigenous life expectation and health equality by 2030.

34 National Health and Hospital Reform Commission, *Terms of Reference* (2008). At http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/terms-of-reference (viewed 29 January 2009).

35 See Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission (2006) p 85.

36 National Health and Hospital Reform Commission, *Beyond the Blame Game, Accountability and performance indicators for the next Australian Health Care Agreements* (2008) p 29. At http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/commission-1lp (viewed 29 January 2009).

- That the Australian Government establish a monitoring body or mechanism to monitor the activities of the range of government agencies with varying degrees of responsibility for Indigenous health with the primary aim of supporting the Australian Government's target of achieving Indigenous life expectation and health equality by 2030.
- That accountability and responsibility for the achievement of Indigenous health equality by 2030 and the determinants of this (including, but not limited, to equity of access to primary health care and hospital services) be clearly defined and appropriately established among Australian governments.
- That appropriate Indigenous health equality targets for the Commonwealth, states and territories are set out in the Australian Health Care Agreements in relation to those areas of the health system for which they are responsible.[37]

The Close the Gap Steering Committee for Indigenous Health Equality welcome that the NHHRC has listed the achievement of Indigenous health equality as the first national healthcare challenge, when it articulated goals to shape the reform of the health and hospital system.[38]

The National Health and Hospitals Reform Plan (NHHRP) has the potential to radically re-shape the Australian health system and holds great potential for facilitating improvements to the health of Indigenous Australians. A number of other health system reform processes and inquiries have also commenced at the same time the NHHRP is undertaking its task. These are outlined below.

9.1 Preventative Health Taskforce

The Preventative Health Taskforce was established on 9 April 2008 to provide 'evidence-based advice to governments and health providers on preventative health programs and strategies, focusing on the burden of chronic disease currently caused by obesity, tobacco and the excessive consumption of alcohol'.[39] The Taskforce will report directly to the Minister for Health and Ageing.

The Taskforce's main task for 2008–09 will be to provide the Government with advice on the framework for the Preventative Health Partnerships between the Commonwealth and the state and territories and to develop a National Preventative Health Strategy. According to its terms of reference, the taskforce will also provide advice on the most effective strategies for targeting prevention in high risk sub-populations including Aboriginal and Torres Strait Islander peoples.[40]

The work of this Taskforce is vital to the achievement of Indigenous health equality given the heavy toll on Indigenous health taken by chronic diseases and associated factors such as tobacco smoking and obesity.

In November 2008, the Steering Committee for Indigenous Health Equality in a submission to the Taskforce recommended the adoption of the following targets;

- *Smoking cessation:* By 2020, to have reduced the rate of smoking in the Indigenous population to that of the non-Indigenous population;

37 Steering Committee for Indigenous Health Equality, *Submission to the National Health and Hospital Reform Commission* (18 August 2008).

38 National Health and Hospital Reform Commission, *Beyond the Blame Game, Accountability and performance indicators for the next Australian Health Care Agreements* (2008) p 12. At http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/commission-1lp (viewed 29 January 2009).

39 See Preventative Health Taskforce, http://www.preventativehealth.org.au (viewed 29 January 2009).

40 See Preventative Health Taskforce, http://www.preventativehealth.org.au (viewed 29 January 2009).

- *Food and nutrition:* By 2018 (within ten years) at least 90% of Indigenous families have access to a standard healthy food basket (or supply) at the cost of less than 25% of their available income;
- *Alcohol consumption:* Reduce per capita consumption rates of alcohol and other drugs to the national average by 2020.

All these are taken from the *National Indigenous Health Equality Targets*. We also recommended targeted approaches to mental health, mothers and babies, wider programmes for smoking, nutrition, alcohol and physical activity, oral health including the fluoridisation of community water supplies, communicable diseases and housing and environmental health.

More broadly we recommended that the work of the National Preventative Health Taskforce in relation to Indigenous peoples be located within a long-term national plan of action for achieving equality in Indigenous life expectation and health equality by 2030.[41]

9.2 Office of Rural Health

The Office of Rural Health was established on 1 July 2008 within the Department of Health and Ageing to drive rural health reform in response to the findings of the Audit of Health Workforce in Rural and Regional Australia. The audit found that the current supply of health professionals is not sufficient to meet current needs and the supply of health professionals in many rural and regional areas is low to very poor.

As a first priority, over the next 12 months the Office will review the Australian Government's 60 targeted rural health programs, as well as the classification systems that determine eligibility for rural program funding. It is anticipated that there will be broader stakeholder consultation at appropriate stages throughout the process. [42]

Preliminary discussions between my Office and the Office of Rural Health have confirmed that many of the rural health programs under review have strong Indigenous components. The Steering Committee will actively engage with the consultation process around this review in 2009.

9.3 The development of a Primary Health Care Strategy

An Expert Reference Group for the National Primary Health Care Strategy was established on 11 June 2008. The reference group will look at how to deliver better frontline care to families across Australia as it develops a National Primary Health Care Strategy.

This strategy could have an enormous impact on the delivery of primary health care services to Indigenous Australians, and the Australian government's commitment in the Statement of Intent to have in place the necessary primary health care by 2018 to support the achievement of Indigenous health equality by 2030. Such a strategy could also impact enormously on the capacity of the Aboriginal community controlled health services.

A review of the Medicare Benefits Schedule primary care items is also being undertaken alongside development of the Primary Health Care Strategy – with a focus on reducing red tape for doctors, simplifying the Medicare schedule, and giving more support to

41 Steering Committee for Indigenous Health Equality, *Submission to the National Preventative Health Taskforce* (4 December 2008).

42 Minister for Health and Ageing, 'Office of Rural Health Established' (Media Release, 2 July 2008). At http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr102.htm?OpenDocument&yr=2008&mth=7 (viewed 29 January 2009).

prevention.[43] Such a review should also look at how Indigenous Australians can also access Medicare subsidies at the same rate as other Australians, and in a way that supports the achievement of Indigenous health equality by 2030.

A discussion paper, *Towards a National Primary Health Care Strategy*, was released by the Australian Government as part of this review on 15 October 2008. This highlighted poorer Indigenous health and the need for an address to Indigenous peoples' access to primary health care as a priority. It also signaled the beginning of a public consultation process due to close on 27 February 2009.[44]

9.4 Review of maternity services

Established on 10 May 2008, the Review is described as

> the first step in developing a comprehensive plan for maternity services into the future. It aims to canvass a wide range of issues relevant to maternity services, including antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the perinatal period; ensure that all interested parties have an opportunity to participate; and inform the development of a National Maternity Services Plan.[45]

The Steering Committee welcome the fact that the discussion paper released by the review team as the basis of its consultation process *Improving Maternity Services in Australia* was developed with reference to the *Framework for Implementation of Primary Maternity Services in Australia,* which in turn endorsed a guiding set of principles in relation to reform of the delivery of maternity services including: 'working to reduce the health inequalities faced by Aboriginal and Torres Strait Islander mothers and babies'.

The discussion paper also refers to:

- the inequalities in access to maternity services experienced by Indigenous women. The discussion paper acknowledged the association between an increase in access to maternity services and a decline in the infant mortality rate;
- the significantly higher rates of smoking during pregnancy reported among Indigenous women when compared to non-Indigenous women;
- the reported decline in the rates of breastfeeding among Indigenous mothers.[46]

The Steering Committee's main recommendations to the review team are set out below.

43 Minister for Health and Ageing, 'National Primary Health Care Strategy' (Media Release, 11 June 2008). At http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr096.htm (viewed 29 January 2009).

44 Department of Health and Ageing, *Towards a New Primary Health Care Strategy* (2007). At http://www.health.gov.au/internet/main/publishing.nsf/Content/PHS-DiscussionPaper viewed 29 January 2009).

45 Department of Health and Ageing, *Maternity Services Review*, www.health.gov.au/maternityservicesreview (viewed 29 January 2009).

46 Department of Health and Ageing, *Improving Maternity Services in Australia: A discussion paper from the Australian Government* (2008), p 4–7. At http://www.health.gov.au/internet/main/publishing.nsf/Content/25923C2181709220CA2574BB00001D9F/$File/Improving_Maternity_Services_In_Australia.pdf (viewed 29 January 2009).

Text box 5: Main recommendations of the Steering Committee to the Maternity Services Review Team[47]

1. That the commitments made by the Council of Australian Governments (COAG) and the Australian Government in relation to the achievement of Indigenous health status and life expectation equality by 2030, as set out in the *Close the Gap National Indigenous Health Equality Summit Statement of Intent*, inform the findings of the Review, and provide its broader context.
2. That the development of any new strategy for the provision of maternity services to Indigenous women is integrated with a national plan of action towards achieving Indigenous health equality by 2030.
3. That any new strategy in relation to the provision of maternity services to Indigenous women (in the broader context of a national plan of action towards achieving Indigenous health equality by 2030) is developed in partnership with Indigenous Australians and their representatives.
4. That a range of targets and indicators, as set out in the *Close the Gap National Indigenous Health Equality Targets* are adopted in relation to the provision of maternal health services for Indigenous women, and the health status of Indigenous mothers and infants. These include:
   - That all Indigenous women and children have access to culturally appropriate mother and baby programs within 5 – 10 years with reference to the process and indicators set out in the *National Indigenous Health Equality Targets*.[48]
   - That a 50 per cent reduction in the difference between Indigenous and non-Indigenous Australian's rates of preterm birth and low birth weight (LBW) be achieved within 5 – 10 years;[49]
   - That at least 75% of all pregnant women present for their first antenatal assessment within the first trimester within 5 – 10 years;[50]
   - Developing health promotion programs targeting smoking and alcohol consumption in pregnancy by 2013.[51]
   - A 4% annual reduction in the rate of Indigenous women smoking during pregnancy with a view to Indigenous and non-Indigenous rates equalising by 2020.[52]

47 Steering Committee for Indigenous Health Equality, *Submission to the Maternity Services Review* (31 October 2008).

48 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 23, 34–36. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

49 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 23, 34–36. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

50 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 23. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

51 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 36. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

52 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 24. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

- The development and implementation of a national 'nutritional risk' scheme for at-risk mothers, infants and children by 2018. 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.[53]

10. The future funds

The Australian Government has also signalled that it will establish a $10 billion Health and Hospital Fund to support strategic investments in health. This is the single biggest investment in health infrastructure ever made by an Australian Government, drawn from the 2007–08 and 2008–09 surpluses. A proportion of future surpluses may be allocated to the Fund as appropriate. Expenditure from the Health and Hospital Fund will be subject to consideration through the Budget process each year.[54]

The future fund has the potential to bring enormous benefits to Indigenous communities, and the Steering Committee have flagged discussions with the guardians of the fund once it is established in early 2009.

On 5 January 2009, by a legislative instrument, *HHF Evaluation Criteria* were determined by the Minister for Ageing. These indicate that a primary focus of the fund is to progress health infrastructure development. [55]

We believe that at very least allocations from this fund to Indigenous health infrastructure should reflect the proportion of Indigenous peoples in relation to the total population. In other words, that at least 2.5% of the total funding allocated should be allocated to directly benefit Indigenous communities. Ideally, this percentage would be closer to 5% in recognition of the historical lack of investment in Indigenous health services, and their greater health needs.

The Steering Committee has made a similar proposal in relation to the Building Australia Fund as set out in Text box 6 below.

Text Box 6: Building Australia Fund and infrastructure in Indigenous communities[56]

Infrastructure Australia was created on 9 April 2008 to create a strategic blueprint for the nation's infrastructure needs and assist its implementation. It also advises the Australian Government on the expenditure of the $20 billion Building Australia Fund. It does this with reference to a national Infrastructure Priority List that it is charged with compiling. To qualify for the list, an infrastructure need must be defined as of national significance.

53 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 35. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

54 Minister for Health and Ageing, 'Investing in a health system for the future' (Media release, 13 May 2008). At http://www.health.gov.au/internet/budget/publishing.nsf/Content/1A1A16A835BDAADACA257448002D6D07/$File/08_health001.pdf (viewed 29 January 2009).

55 Minister for Ageing, *HHF Evaluation Criteria 2009* (2009).

56 Steering Committee for Indigenous Health Equality, *Submission to Infrastructure Australia* (15 October 2008).

In a submission made to Infrastructure Australia in July 2008, the Steering Committee stated that they believed that an address to infrastructure needs in Indigenous communities falls within that remit, pertaining not only to economic development in those communities, but also to the Australian Government's goal of providing the necessary infrastructure by 2018 to support the achievement of Indigenous health and life expectation equality by 2030, as set out in the *Close the Gap National Indigenous Health Equality Statement of Intent.*

The Steering Committee focused on addressing five national infrastructure equality gaps that directly contribute to the significantly poorer state of health found among Australia's Aboriginal and Torres Strait Islander peoples when compared to the non-Indigenous population.

More broadly we submitted that in defining the Infrastructure Priority List, Infrastructure Australia should consider the goal of achieving Indigenous health equality an outstanding national priority, reflecting the importance placed on this by the Australian Government as reflected in the Statement of Intent.

To support these commitments, we recommended the adoption of a targeted, and properly funded national plan to address the following major infrastructure gaps in Indigenous communities by 2018 (as set out in detail in the body of the submission):

- Housing, environmental health and health services capital works;
- Transport infrastructure;
- Food provision related infrastructure;
- Communications infrastructure; and
- Water and electricity supply.

We further recommended that, as a minimum, the inclusion of Indigenous infrastructure projects on the Infrastructure Priority List should reflect the proportion of Indigenous peoples in relation to the total population. In other words, that at least 2.5% of the total funding allocated to infrastructure projects should be allocated to infrastructure that will directly benefit Indigenous communities. Ideally, this percentage would be closer to 5% in recognition of the historical lack of investment in Indigenous communities' infrastructure.

We also recommend that this plan be developed in partnership with Indigenous Australians and their representatives, and that it be coordinated with an overall plan to achieve Indigenous health equality by 2030.[57]

11. The Australian Charter of Healthcare Rights

A significant domestic application of the right to health in an Australian domestic context occurred with the endorsement of the *Australian Charter of Healthcare Rights* (the Charter) by Australian health ministers in July 2008. The Charter was developed by the Australian Commission on Safety and Quality in Healthcare, founded by the Australian Health Ministers Conference in December 2006.

The Charter allows patients, consumers, families, carers and services providers to have a common understanding of the rights of people receiving healthcare.

The Charter is significant as it explictly acknowledges the right to health as one of its three guiding principles, and, as such recognises 'everyone's right to have the highest possible standard of physical and mental health'; as well as specific rights in relation to participation and cultural respect (as set out in text box 7, below). This recognition of the right to health in a domestic context by Australian governments underscores the validity

57 Steering Committee for Indigenous Health Equality, Submission to Infrastructure Australia (15 October 2008).

of the approach of the Close the Gap Campaign which is essentially an application of the right to health in the context of Indigenous health inequality in Australia.

Text Box 7: The Australian Charter of Healthcare Rights (extracted in full)[58]

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1. Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
2. The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.
3. Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

My rights	What this means
Access	
I have a right to health care.	I can access services to address my health needs.
Safety	
I have a right to receive safe and high quality care.	Receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration	The care provided shows respect to me and my culture, beliefs, values and personal characteristics
Communication	
I have a right to be informed about services, treatment options and cost in a clear and open way	I receive open, timely and appropraite communication about my health care in a way I understand.

58 Australian Commission on Safety and Quality in Health Care, *Australian Charter of Healthcare Rights*, 2008. Available online at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01

Participation	
I have a right to be included in decisions about my health care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have aright to comment on my care and have my concerns addressed.	I can comment on or complain abot my care and have my concerns dealt with promptly.

The Charter applies to 'all health settings anywhere in Australia, including public hospitals, private hospitals, general practice and other ambulatory care environments. rights of patients and consumers when seeking or receiving healthcare services.'[59] While the significance of the Charter is therefore limited – it could not, for example, be used to leverage the provision of services where there are none (as is often the case in remote Indigenous communities)[60] – the Close the Gap Campaign partners are exploring how the Charter may prove a useful tool for helping to ensure that urban-based Indigenous Australians, in particular, are able to access mainstream health services in urban settings as well as contributing to a mainstream health services' culture that is more responsive to Indigenous patients.

Complaints in relation to the upholding of rights in the Charter by health services are to be handled by state based Health Care Complaints Commissioners.[61]

12. Additional resourcing for Indigenous health related issues

All of this activity has also begun to translate into substantial resource commitments (amounting to over 5 billion dollars) towards Indigenous health equality by Australian governments in the past 12 months. These commitments are set out below.

59 Australian Commission on Safety and Quality in Health Care, *Healthcare Rights Charter Endorsed for Australia*, (Media release) 23 July 2008. Available online at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/MediaRelease_2008-07-23-CharterOfRights.

60 See Australian Commission on Safety and Quality in Health Care, *Roles in Realising the Australian Charter of Healthcare Rights*. This notes that 'an individual's right to health may be limited by his or her geographic location and the availability of health services' and asks patients to ' understand that in some circumstances you may need to travel or wait for the services you need'. Australian Commission on Safety and Quality in Health Care, *Roles in Realising the Australian Charter of Healthcare Rights*, 2008. Available online at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01.

61 Australian Commission on Safety and Quality in Health Care, *Australian Charter of Healthcare Rights, A guide for patients, consumers, carers and their familes*, 2008. Available online at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01.

Text Box 8: Significant financial commitments to closing the Indigenous life expectation gap

Close the Gap spending 2008–09 Budget

The Australian Government announced $334.8 million worth of expenditure towards closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation at the 2008–09 budget.

Measures included $101.5 million extra funding for maternal and child health services:

- an additional $90.3 million, as well as matched funding of $75 million from State and Territory governments, to improve child and maternal health services; and
- $11.2 million to tackle acute rheumatic fever and rheumatic heart disease among Indigenous children.

Measures in relation to alcohol, tobacco and substance abuse:

- a commitment of $49.3 million over four years, through the Council of Australian Governments (COAG), to improve access to drug and alcohol services, including residential treatment and rehabilitation facilities.; and
- a $14.5 million investment over four years in the Indigenous Tobacco Control Initiative, to help tackle high rates of smoking in Indigenous communities.

In relation to health services and health workforce:

- a $21.5 million commitment over five years to improve the capacity of Northern Territory health services; and
- $19 million over three years towards a National Indigenous Health Workforce Training Plan to develop an Indigenous health workforce.

In addition, the Government committed:

- $99.7 million to expand primary health care in the Northern Territory, including establishing a remote area health corps agency to recruit more doctors, nurses and other health professionals to work in remote Indigenous communities.
- $13.6 million to complete the delivery of follow-up dental, hearing and ear, nose and throat services for Aboriginal children in remote communities and town camps in the Northern Territory in 2008–09. This brings the total Australian Government commitment for health initiatives under the Northern Territory Emergency Response to $196.2 million over three years.[62]

National Partnership to address the needs of Indigenous children

At the July COAG meeting, COAG agreed in principle to a National Partnership with joint funding of around $547.2 million over six years to address the needs of Indigenous children in their early years:

62 Minister for Families, Housing, Community Services and Indigenous Affairs and Minister for Health and Ageing, 'Closing the Gap in Indigenous Health' (Media Release, 13 May 2008). At http://www.jennymacklin.fahcsia.gov.au/internet/jennymacklin.nsf/content/budget08_i-health_13may08.htm (viewed 29 January 2009).

> The National Partnership is based on evidence that improvements in Indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services and integrated child and family services. Bilateral plans for implementing the reforms will be agreed between each jurisdiction and the Commonwealth for COAG's consideration in October 2008. COAG further agreed to consider in mid 2009 a progress report and advice about the contribution of COAG's broader reform agenda to overcoming Indigenous children's disadvantage. The Commonwealth will continue to explore with the States the role that conditions on benefit payments could play in increasing the take up by vulnerable families, including vulnerable Indigenous families, of early childhood, family support and child and maternal health services.[63]

National Partnerships announced at the 29 November 2008 COAG meeting

On 29 November 2008, COAG agreed to a significant package of measures to close the gap in Indigenous health and on related issues.

The Communiqué from the meeting notes that:

> COAG has previously agreed to six ambitious targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas. Since the targets were agreed in December 2007 and March 2008, all governments have been working together to develop fundamental reforms to address these targets. Governments have also acknowledged that this is an extremely significant undertaking that will require substantial investment. COAG has agreed this year to initiatives for Indigenous Australians of $4.6 billion across early childhood development, health, housing, economic development and remote service delivery.
>
> These new agreements represent a fundamental response to COAG's commitment to closing the gap. Sustained improvement in outcomes for Indigenous people can only be achieved by systemic change. Through these agreements, all governments will be held publicly accountable for their performance in improving outcomes in these key areas…
>
> To progress the targets for closing the gap between Indigenous and non-Indigenous Australians, all governments have been developing fundamental reforms recognising that substantial investment is required.
>
> Governments will develop Implementation Plans in consultation with Indigenous people.
>
> (In addition to) targeted initiatives for Indigenous Australians… (there will also be) a strong focus on better Indigenous outcomes through the new National Agreements and general NPs, aimed at assisting disadvantaged groups, including in education, health and housing.
>
> In this way, COAG is ensuring that the closing the gap targets are being supported across the range of reformed financial arrangements between the Commonwealth and the States.

Health National Partnership

The Commonwealth and the States agreed to an Indigenous Health National Partnership (HNP) worth $1.6 billion over four years, with the Commonwealth contributing $806 million and the States $772 million. This is intended to contribute to addressing the COAG agreed closing the gap targets for Indigenous Australians, closing the life expectancy gap within a generation and halving the mortality gap for children under five within a decade. It includes expanded primary health care and targeted prevention activities to reduce the burden of chronic disease.

63 Council of Australian Governments, *Communique – 3 July 2008*. At http://www.coag.gov.au/coag_meeting_outcomes/2008-07-03/index.cfm (viewed 28 January 2009).

The Health National Partnership is described by COAG as 'a down payment on the significant investment needed by both levels of government to close the unacceptable gap in health and other outcomes between Indigenous and non-Indigenous Australians'.

The HNP is focused on:

- reduced smoking rate among Aboriginal and Torres Strait Islander peoples;
- reduced burden of diseases for Aboriginal and Torres Strait Islander communities;
- increased uptake of Medicare Benefits Schedule-funded primary care services to Indigenous people with half of the adult population (15 65 years) receiving two adult health checks over the next four years;
- significantly improved coordination of care across the care continuum; and
- over time, a reduction in average length of hospital stay and reduction in readmissions.

This means that over a five-year period, around 55 per cent of the adult Indigenous population (around 155,000 people) will receive a health check with about 600,000 chronic disease services delivered. More than 90,000 Indigenous people with a chronic disease will be provided with a self-management program, while around 74,500 Indigenous people will receive financial assistance to improve access to Pharmaceutical Benefits Scheme medicines.

National Partnership on Remote Indigenous Housing

All States and the Northern Territory have agreed to a new 10-year National Partnership on remote Indigenous housing, in which the Commonwealth will provide an additional $1.94 billion over 10 years ($834.6 million over five years) to address significant overcrowding, homelessness, poor housing conditions and the severe housing shortage in remote Indigenous communities. Improving housing conditions will provide the foundation for lasting improvements in health, education and employment and make a major contribution towards closing the gap in Indigenous disadvantage.

The total package of $1.94 billion over 10 years will provide:

- up to 4,200 new houses to be built in remote Indigenous communities; and
- upgrades to around 4,800 existing houses with a program of major repairs commencing in 2008–09.

The National Partnership also clarifies the responsibilities of the Commonwealth, the states and the Northern Territory, with the states the main deliverer of housing in remote Indigenous communities, providing standardised tenancy management and support consistent with public housing tenancy management.

The states and the Commonwealth will work towards clearer roles and responsibilities and funding with respect to municipal services and ongoing maintenance of infrastructure and essential services in remote areas.

The National Partnership will commence on 1 January 2009 with implementation plans to be finalised by 1 April 2009.

Further national partnerships

A further two new National Partnerships were agreed relating to Economic Participation ($228.8 million – $172.7 million Commonwealth funding and $56.2 million state funding over five years) and Remote Service Delivery ($291.2 million over six years).[64]

64 Council of Australian Governments, *Communique – 29 November 2008.* At http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm (viewed 29 January 2009).

The Close the Gap Steering Committee for Indigenous Health Equality welcomes these commitments and understands the magnitude and ambition that they represent. They are a substantial down payment. It is hoped that in the future they will be seen as the watershed moment in the efforts of all Australian governments to close the life expectancy gap.

Financial commitments of this size, accompanying the current reform agenda, bodes well for the future of a partnership between Indigenous peoples and their representatives and the future of our collective efforts to close the Indigenous health and life expectancy gap.

Part 3: Securing health equality within a generation

The past two years have seen a significant shift in approaches to address Indigenous health inequality. As the developments outlined above reveal, there is momentum and a depth of commitment to close the life expectancy gap faced by Indigenous Australians that is unprecedented.

Of particular significance are the following developments:

- First, is the mobilisation and organisation of the Indigenous health peak bodies, the mainstream health peak bodies and NGOs behind the 'Close the Gap' Campaign for Indigenous Health Equality, speaking with one voice about what needs to be done to achieve Indigenous health equality. The Campaign approach has brought together considerable expertise across the health, human rights and NGO sectors who are committed to working together in order to meet this national challenge. The approach has not been to blame government or place the responsibility for change solely at the feet of government. It has created the opportunity for an unprecedented new partnership between government, the health sector and civil society where all have a role to play.
- Second, is the unprecedented level of bipartisan commitment as well as partnerships between all Australian governments to close the gap. The Prime Minister's personal support and leadership has also been a critical factor in driving change and in creating the momentum for a national effort to achieve Indigenous health equality by 2030. The signing of the Statement of Intent constitutes the basis for a national partnership across society, and across governments, to achieve Indigenous health equality by 2030.
- Third, the development of *National Indigenous Health Equality Targets* provides a focus for the specific challenges that exist if we are to meet the generational objective of health equality. They have challenged the health sector to consider specific needs to be addressed so that we can break though from the approaches of the past.
- Fourth, is the multiple reform processes and bodies that have been established in the last year to progress various aspects of health sector reform, including with explicit reference to improving Indigenous health. When combined with the National Reform Agenda through COAG this provides unprecedented opportunity to ensure sufficient accountability for performance across different areas of the health sector and across governments. The central place of close the gap indicators in the COAG reform agenda is testament to this.

The challenge now is to build on this reform agenda and on the weighty commitments that have been made to ensure that any change is enduring and is capable of meeting the generational challenge of health equality.

The Statement of Intent for Indigenous Health Equality provides a framework to ensure that our efforts are sustained over the next 25 years. As set out above, it commits the Australian Government and other signatories 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 health equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030;
- 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;
- ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs;
- 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 defines the major challenges for closing the gap over the next generation. Each of these challenges is discussed in further detail below.

1. Creating a partnership for change

Many of the developments described above refer to initiatives by government. What remains is for detailed engagement with Indigenous peoples, organisations and communities, so that Close the Gap is truly a shared ambition.

When talking of partnership, the Close the Gap Steering Committee for Indigenous Health Equality mean a partnership between:

- Indigenous peoples and their representatives;
- Australian governments (with an internal, cross sectoral dimension; and at the intergovernmental level); and
- Key players in the Indigenous and non-Indigenous health sector.

The Close the Gap Steering Committee have identified partnership as being so fundamental to the achievement of Indigenous health equality that they included partnership targets in the *National Indigenous Health Equality Targets*. These targets propose that within 2 years (meaning by the end of 2009):

- 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 is established; and
- that nationally agreed frameworks exist to secure the appropriate engagement of Aboriginal people in the design and delivery of secondary care services.[65]

As already discussed, there have been many developments in the past year where the Australian Government has reiterated the desire and need for a new partnership with Indigenous peoples to progress closing the gap across a range of indicators including health.

65 Aboriginal and Torres Strait Islander Social Justice Commissioner and Close the Gap Steering Committee for Indigenous Health Equality, *National Indigenous Health Equality Targets* (2008) p 22. At http://www.hreoc.gov.au/social_justice/health/targets/health_targets.pdf (viewed 28 January 2009).

The Close the Gap Steering Committee for Indigenous Health Equality believes that Australian governments are aspiring to engage with Indigenous peoples more effectively as partners. The challenge is to identify *how* this is to be achieved.

The human rights based approach to development provides the starting point for such a new relationship.

The Australian Human Rights Commission and the United Nations Permanent Forum on Indigenous Issues have prepared international guidelines on developing partnerships with Indigenous peoples, based on human rights principles. These are contained in the following document: *Engaging the marginalised: Partnerships between Indigenous Peoples, governments and civil society.* The guidelines recommend:

- *A human rights based approach to development* – whereby indigenous peoples have the right to full and effective participation in decisions which directly or indirectly affect their lives; and with such participation based on the principle of free, prior and informed consent, which includes governments and the private sector providing information that is accurate, accessible, and in a language the indigenous peoples can understand.
- *Mechanisms for representation and engagement* – whereby Governments should establish transparent and accountable frameworks for engagement, consultation and negotiation with indigenous peoples and communities; and where indigenous peoples have the right to choose their representatives and the right to specify the decision making structures through which they engage with other sectors of society;
- *Design, negotiation, implementation, monitoring, and evaluation* – whereby frameworks for engagement should allow for the full and effective participation of indigenous peoples in the design, negotiation, implementation, monitoring, evaluation and assessment of outcomes; and where indigenous peoples and communities should be invited to participate in identifying and prioritizing objectives, as well as in establishing targets and benchmarks (in the short and long term).
- *Capacity-building (of government and Indigenous communities)* – whereby governments support efforts to build the capacity of indigenous communities so that they may participate equally and meaningfully in the planning, design, negotiation, implementation, monitoring and evaluation of policies, programs and projects that affect them; and similarly, where the capacity of government is also built, including by increasing knowledge of indigenous peoples and awareness of the human rights

based approach to development so that they are able to effectively engage with indigenous communities.[66]

In order to facilitate the development of such a partnership, the Close the Gap Steering Committee for Indigenous Health Equality hosted a 'Partnerships in Action' workshop in Sydney over 26 – 27 November 2008. To this were invited key Australian government officials, including those from the health sectors and those active in the COAG and other reform processes.

This workshop identified the foundational elements of such a partnership as including:

- *A common vision* for the task ahead;
- *Trust* – something that must be built over time, from all sides;
- *Respectful engagement*;
- *Understanding of each others' potential contribution to the task*. Through rigorous investigation, the parties must agree as to each others strengths and weaknesses, resources and so, and decide what each can appropriately bring to the table;
- *Embracing cultural change* – on everyone's part, recognising that partnership means that ways of working are going change.
- *Sharing responsibility* for outcomes; and
- *Accountability* to each other.[67]

It was also noted that there are examples already of successful relationships between Australian governments and Aboriginal community controlled health services at the state/territory level. These provide models for partnership mechanisms at the national level.

A key area for partnership is in relation to service delivery. Australian governments, historically, have failed to effectively deliver services to Indigenous communities. In particular, there needs to be a shifting in the mindset of government on service delivery:

- there is a need for government to relinquish absolute control in relation to service delivery. Empowering people at the local level will bring the greatest change;

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66 Other elements of good programming practices that are also essential under a human rights based approach include that:
- People are recognised as key actors in their own development, rather than passive recipients of commodities and services.
- Participation is both a means and a goal.
- Strategies are empowering, not disempowering.
- Both outcomes and processes are monitored and evaluated.
- Analysis includes all stakeholders.
- Programs focus on marginalised, disadvantaged, and excluded groups.
- The development process is locally owned.
- Programs aim to reduce disparity.
- Both top-down and bottom-up approaches are used in synergy.
- Situation analysis is used to identity immediate, underlying, and basic causes of development problems.
- Measurable goals and targets are important in programming.
- Strategic partnerships are developed and sustained.
- Programs support accountability to all stakeholders.

See United Nations, *The Human Rights-Based Approach to Development Cooperation: Towards a Common Understanding Among the UN Agencies* (2003). At www.unescobkk.org/fileadmin/user_upload/appeal/human_rights/UN_Common_understanding_RBA.pdf (viewed 29 January 2009).

67 Steering Committee for Indigenous Health Equality, *Partnership in Action Workshop Report* (2008).

- it is important to build on current structure and breadth of knowledge, in particular that of the Aboriginal community controlled health services; and
- there is a need to be open to different views and approaches, particularly where things haven't worked in the past.

Partnerships themselves can be 'measured' and monitored in a variety of ways. This could be in terms of inputs, outputs or outcomes:

- inputs, by establishing processes for partnership, or by putting structures for partnership in place;
- outputs, by measuring the number of meetings and who participated in them; and
- outcomes, by measuring 'close the gap' outcomes.

This would include a qualitative component to test whether partners feel engaged in the process.

It is absolutely vital that attention is paid to the creation of such a partnership over 2009. There are many questions surrounding such a partnership, not least of which is the potential role of a national Indigenous representative body.

Regardless, Australian governments must sit down with the relevant parties and work out how this is to be realised as soon as possible. The foundation of such a partnership should be laid at the dedicated COAG Close the Gap meeting scheduled to take place in mid 2009.[68]

2. A national plan of action

As noted, the Statement of Intent commits the Australian Government 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'.

It is common sense that such a plan be created in order to take into account all the determinants of the poorer health of Indigenous Australians, and in a way that can meet the 2030 target. In that regard it is vital as well that the many reform efforts underway (as discussed in part 1 of this chapter) are integrated into such a national plan of action. Without such coordination, there is the risk of duplication of effort on the one hand and on the other hand, of significant issues that do not squarely fall within the purview of one reform process not receiving sufficient attention.

At its 28 November 2008 meeting, COAG also agreed to the National Indigenous Reform Agreement (NIRA) which

> captures the objectives, outcomes, outputs, performance measures and benchmarks that all governments have committed to achieving through their various National Agreements and NPs in order to close the gap in Indigenous disadvantage. The NIRA provides an overarching summary of action being taken against the closing the gap

68 In October 2008, COAG agreed to convene a dedicated meeting in 2009 on closing the gap on Indigenous disadvantage. COAG has asked for advice on how the National Agreements will collectively lead to a closing of the gap and what further reforms are needed. COAG has also asked for a Regional and Urban Strategy to coordinate the delivery of services to Indigenous Australians and examine the role that private and community sector initiatives in education, employment, health and housing can make to the success of the overall strategy. COAG noted that it will work to develop a further reform proposal, including benchmarks and indicators for improvements in services and related outputs relevant to family and community safety, for consideration at the Closing the Gap COAG meeting to be held in 2009. See Council of Australian Governments, *Communique – 29 November 2008*. At http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm (viewed 29 January 2009).

> targets as well as the operation of the mainstream national agreements in health, schools, VET, disability services and housing and several NPs. The NIRA will be a living document, refined over time based on the effectiveness of reforms in closing the gap on Indigenous disadvantage.[69]

Such a plan could form the basis of a national plan of action for Indigenous health equality.

There is a clear need to work towards a process for developing a comprehensive, national action plan. The attributes of a long term, action plan include the clear identification of:

- What is to be done;
- The time frame for doing it;
- Who is going to do it;
- The cost;
- Where the funds will be found;
- How is it to be implemented; and
- How is it to be evaluated.

The Statement of Intent sets out the main principles underlying such a plan, namely:

- 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; and
- To ensure processes 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.

The Statement of Intent also sets out some core targets for such a national plan: as noted, that Indigenous health equality is achieved by 2030; and that 'primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples …are capable of bridging the gap in health standards by 2018'.

In addition to the targets in the Statement of Intent, the *National Indigenous Health Equality Targets* are intended to provide a further foundation for the creation of a comprehensive national plan of action to close the Indigenous health equality gap by 2030. These targets focus on:

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69 Council of Australian Governments, *Communique – 29 November 2008*. At http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm (viewed 29 January 2009).

- Specific, focused strategies that, if achieved, would deliver the greatest reduction in morbidity and mortality for Indigenous peoples; and
- The synergy between primary care, infrastructure, social and cultural determinants.

The specific targets on Primary Health Care focus on:

- access to culturally appropriate comprehensive primary health care services, particularly through Aboriginal community controlled services, at a level commensurate with need;
- Mainstream services provided to Aboriginal and Torres Strait Islander people in a culturally sensitive way and at a level commensurate with need; and
- Appropriate funding and resourcing – for comprehensive primary care; targeted programs; and access to mainstream funding schemes.

The specific infrastructure targets focus on:

- Workforce development: primary care practitioners, specialists, mental health and social and emotional wellbeing, and oral health;
- A clinically and culturally competent workforce;
- Health service facilities and capital works;
- Housing and environmental health; and
- Data quality issues.

Ultimately, the intention is that these targets provide a foundation point for negotiation – they were developed by individuals and organisations with extensive experience and expertise, and are evidenced based. They require high level political commitment – such as was demonstrated through the Statement of Intent – as well as long term, strategic planning for implementation and action.

3. Monitoring and accountability

A vital part of any national plan of action will include, in the words of the Statement of Intent: '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'.

The Steering Committee has taken the view that all efforts to monitor and introduce accountability for the achievement of Indigenous health equality need to hang off a comprehensive, national action plan to achieve Indigenous health equality by 2030.

Monitoring is not an end in itself, but a way of progressively improving services. Data should drive change, not just tell us what exists. To this end, the Steering Committee welcomed the announcements made at the 28 November 2008 COAG meeting that COAG had agreed to a new framework for the Productivity Commission's *Overcoming Indigenous Disadvantage Report* (OID) so that it is aligned with the six COAG closing the gap targets.[70]

70 In April 2002, COAG commissioned the Productivity Commission's Steering Committee for the Review of Commonwealth/State Service Provision to produce a regular report against key indicators of Indigenous disadvantage, with a focus on areas where governments can make a difference. The resulting Overcoming Indigenous Disadvantage (OID) Report has been published every two years since 2003: Council of Australian Governments, *Communique – 29 November 2008*. At http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm (viewed 29 January 2009).

Challenges identified relating to existing frameworks, including the OID Framework, and data collection in general include:

- the monitoring of partnership, health status, heath services, infrastructure, social determinants – the subject matters of the National Indigenous Health Equality Targets;
- measuring the quality of services delivered to Indigenous peoples;
- ensuring consistency of data in the multiple frameworks that exist – rather than different and conflicting sources of data or definitions;
- ensuring more accurate data (identification issues) as well as more comprehensive data (filling gaps in collections);
- ensuring that the proliferation of reporting and data that exists does not take away from time for actual work on the ground or is not a time cost issue for service delivery;
- the need to shift emphasis or rebalance the focus on monitoring of Indigenous services from financial accountability to program performance and outcomes;
- disaggregation – by service, region, jurisdiction, nationally and so on;
- standardised reporting formats for community use, service use, public use; and
- defining processes as to how the data will be used to drive change.[71]

There is also a need for a major effort to improve accuracy, coverage and availability of health data. In particular, the Steering Committee believe it is important to introduce accountability for fixing long-standing data gaps. The Steering Committee propose that:

- the Australian Bureau of Statistics should lead the effort in relation to vitals data (births, deaths etc);
- the Australian Institute of Health and Welfare should lead the effort in relation to hospital data (perinatal care, cancer, etc); and
- each jurisdiction should have specified levels of data completeness, perhaps attached to incentives and penalties to ensure compliance.

In the spirit of partnership, data collections should also be accessible to communities so that they can 'own' them as a tool for advocacy, and also to enable the partners to be accountable to each other.

4. Coordination of activities

In addition to a national plan of action, a coordinating body or mechanism to coordinate the many levels and sectors of Australian governments who would be involved in the achievement of Indigenous health equality is necessary.

In our submission to the National Health and Hospitals Reform Commission, the Steering Committee indicated that such a body would ideally satisfy the following criteria:

- Ministerial leadership (preferably the Minister of Health and Ageing);
- Clear terms of reference;
- It should be guaranteed appropriate, long-term funding to operate;

71 Steering Committee for Indigenous Health Equality, *Partnership in Action Workshop Report* (2008).

- It should have strong Indigenous representation among its membership/ staff and leadership roles; and
- It should be capable of independent reporting and making proposals for improvements to the coordination of efforts for achieving Indigenous health equality by 2030, as needed.[72]

Further work in this direction is being undertaken by the National Aboriginal Community Controlled Health Organisation (NACCHO) in a separate but complementary process to the Close the Gap Campaign.

In 2008, NACCHO began to develop proposals for what they initially called 'a new architecture of the delivery of Aboriginal and Torres Strait Islander Health'.[73] To facilitate this process they have published discussion papers[74], and held two 'Think Tanks'. The first, held in August 2008, was attended largely by NACCHO member organisations and set an initial agenda for the process.[75]

A second Think Tank titled 'Investing in Community Control' is proposed for January 2009. It will bring together a broader range of stakeholders to consider the question of what legislative and administrative arrangements were needed to enable both the achievement of Indigenous health equality by 2030, and to ensure that as many Indigenous people as possible are able to access an Aboriginal community controlled health service.

There are some successful coordination and partnership mechanisms that are already working well, but these are mainly at the state/ territory level. A key challenge is to harness what is transferrable from these examples and ensure they are consistently applied to build a national coordination mechanism for the achievement of Indigenous health equality by 2030.

This will also require clear specification of accountability and responsibility:

- For each level of government;
- For COAG processes; and
- For services and programs (but with mutual responsibility between funder and service provider).

5. Beyond the health sector

The Statement of Intent includes a commitment '[t]o working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples'.

As I noted in the *Social Justice Report 2005,* it has long been recognised that social inequalities are associated with health inequality. Without an address to the social determinants of Indigenous poorer health within the context of an overall plan to close the Indigenous health equality gap by 2030, lasting health equality is not likely to be achieved. This is particularly so in Indigenous Australia. As I reported back in 2005,

72 Steering Committee for Indigenous Health Equality, *Submission to the National Health and Hospital Reform Commission* (18 August 2008).

73 National Aboriginal Community Controlled Health Organisation, Development of a New Architecture for the Delivery of Aboriginal and Torres Strait Islander Health, Fact Sheet No. 1: Background of the project, NACCHO, Canberra, 2008.

74 National Aboriginal Community Controlled Health Organisation, A new beginning: The problem with business as usual, NACCHO, Canberra, October 2008; National Community Controlled Health Organisation, A new Beginning: Charting a better way, NACCHO, Canberra, October 2008.

75 National Aboriginal Community Controlled Health Organisation, Development of a New Architecture for the Delivery of Aboriginal and Torres Strait Islander Health, Fact Sheet No. 2: outcomes of the first think tank, NACCHO, Canberra, 2008.

Aboriginal and Torres Strait Islander communities have been characterised as *the* prime example of negative social determinants of health in Australia.[76]

Over 2009, the Steering Committee for Indigenous Health Equality will oversee the development of social and cultural determinants targets, with the help of a range of experts, to complete the *National Indigenous Health Equality Targets.* In turn it is hoped that the complete set of targets will provide a foundation for national planning towards Indigenous health equality.

The social determinants of health include the commonly accepted ones, including employment, education, income, community safety, and also overlaps with what is called health infrastructure: secure and accessible healthy food supplies, housing for health and health-enhancing community infrastructure.

Uniquely, the Steering Committee is also developing *cultural* determinants of health that will reflect the importance of strong and thriving cultures to the health, notably the mental health, of Indigenous Australians.

Once these targets have been developed, they will provide a foundation for the Steering Committee to actively engage with sectors beyond the health sector, and with responsibilities in relation to the social and cultural determinants of Indigenous health.

This will provide a challenge both for the Steering Committee, and, we anticipate, for those government sectors that have not traditionally seen themselves as having health responsibilities.

As noted earlier, COAG has also agreed to changes to the *Overcoming Indigenous Disadvantage* (OID) framework to link these to the six Close the Gap targets that have been adopted by COAG. A goal of these indicators is to be able to measure the total impact of government activity on Indigenous disadvantage, including Indigenous health, and thereby discouraging a 'siloed' approach from any given sector.

This remains an outstanding challenge for Australian governments, first noted in the *National Aboriginal Health Strategy* of 1989. The linking of the targets to the OID indictors may help stimulate a lasting change in government culture that facilitates a national effort to improve the social and cultural determinants of poorer Indigenous health from all sectors, as part of a wider national plan to achieve Indigenous health equality by 2030.

76 Steering Committee for Indigenous Health Equality, *Submission to the National Health and Hospital Reform Commission* (18 August 2008) p 12.

Part 4: Conclusion

The Close the Gap Campaign and the closing the gap commitments of all Australian governments have the potential to be a turning point in Indigenous affairs in Australia. They do not simply involve rhetorical commitments. Already, we have seen substantial investments and the beginning of health system reforms to back them up. They have elevated the urgency of dealing with the Indigenous health crisis to a national priority and one that shares bipartisan support.

The groundwork has now been laid to make inroads into this longstanding issue. It is, however, a task that will take a generation. And there remains significant work to be done. This includes:

- the creation of a new partnership between Indigenous Australians and their representatives and Australian governments to underpin the national effort to achieve Indigenous health equality;
- the development of an appropriately funded, long-term national plan of action to achieve Indigenous health equality, in part to coordinate the many different streams of activity underway that have the potential to contribute to that end; and
- the establishment of adequate mechanisms to coordinate and monitor the multiple service delivery roles of governments that impact on Indigenous health, and to monitor progress towards the achievement of Indigenous health equality.

It is vital that these elements are put into place as soon as possible if we are to achieve Indigenous health equality by 2030. There is no room for complacency. Indigenous peoples' health continues to be significantly poorer on average than non-Indigenous Australians.

In concluding, I recall the words with which I launched the Close the Gap Campaign at the Sydney Olympic Stadium on 4 April 2007:

> Let's stop being disappointed at our lack of achievement on Indigenous health and dare to dream about a positive future for all Australians.
>
> To do so is not a pipedream. For we know that overcoming Indigenous inequality in health status is achievable…
>
> Our primary message is not to simply scream 'crisis'. Our message, and our goal, is to champion hope and to focus on solutions. This crisis is not insurmountable. We can triumph.
>
> We are making steps, but they are too slow and not broadly focused enough.
>
> It will require additional funds, although this alone is not the solution.
>
> It will also require a focus on the social determinants of health – living conditions, overcrowding in housing, education and employment. This is not just a health sector responsibility. This requires a whole-of-government, cross departmental approach...
>
> And make no mistake, genuine progress requires genuine partnerships – between governments, Indigenous organizations, the corporate and philanthropic sectors and the broader community.
>
> Let us work together to commit to a timeframe for action to address this health crisis.
>
> We implore governments to be true to their words in addressing this critical issue. And we beseech all members of the Australian community to join with us, to show us your support and let governments know in no uncertain terms that the time for action and progress has arrived to address this crisis.
>
> That time is now.