

## PUBLIC REPORT CARD 2002

# ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH NO MORE EXCUSES

The health of Aboriginal and Torres Strait Islander people remains poor compared to that of other Australians. Overall, little progress has been made compared to other countries such as Canada, the US and NZ in relation to their Indigenous peoples.

This report card brings together much relevant information. It contains specific recommendations.

The AMA acknowledges the improvements that have been made, but highlights the areas where these are insufficient. These areas include, in particular, the availability of primary health care services and facilities such as clean water, sanitation and electricity for all communities. The report card includes issues such as the need to improve educational outcomes for Indigenous children and to make progress towards reconciliation.

The report card contains many statistics, graphs and information but barely touches the reality of the situation for Aboriginal and Torres Strait Islander people. It is a situation that cannot be allowed to continue. It is unacceptable for Australia to lag behind the rest of the developed world.

What is required is a major increase in funding of effective primary health care services so that funding matches health need and services are available to all.

I hope the report card will raise awareness of the reality of the situation. Progress in other countries and in some regional programs in Australia shows what is possible.

The AMA is ready to work with Aboriginal and Torres Strait Islander communities and governments to achieve real progress. It is a matter of urgency.

**Dr Kerry Phelps**  
AMA Federal President



# AMA

## Dimensions

## Overall Australian Statistics

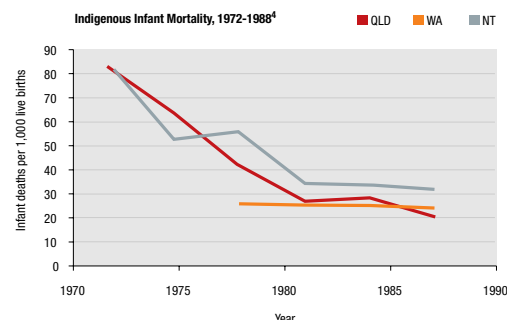
### Health Status

#### Infant Mortality Rate (IMR)

*This is the number of deaths of children under one year of age per 1,000 live births.*

In 2000, the Indigenous infant mortality rate (IMR) was 14 per 1,000 infants born ie almost three times that of the total Australian infant mortality rate of 5.2<sup>1</sup>. In 1965, the Indigenous IMR was about 138; by 1981 it had dropped to about 26<sup>2</sup>. The Australian population had a rate of about 26 in the 1940s and 1950s<sup>3</sup>.

In summary, the rate dropped rapidly in the 1970s but since then improvement has been gradual, with the rate remaining about 2½ times that of the total population<sup>3</sup>.



#### Low Birth Weight

*The number of babies born weighing less than 2,500 grams.*

In 1996-1998, babies of Indigenous mothers were about twice as likely as babies of non-Indigenous mothers to be of low birthweight<sup>5</sup>. Since 1991 there appears to have been little change in the proportion of low birthweight babies born to Indigenous mothers<sup>5</sup>.

Low birth weight is important as an indicator of later illness, particularly chronic illness.

#### Life Expectancy

*This is the average number of years a person born in a particular year can expect to live if the age specific rates of mortality at that time continue to apply.*

In 1997-1999, Indigenous Australians could expect to live approximately 20 years less than non-Indigenous Australians<sup>2</sup>. This is similar to the situation in 1991-1996<sup>5</sup>.

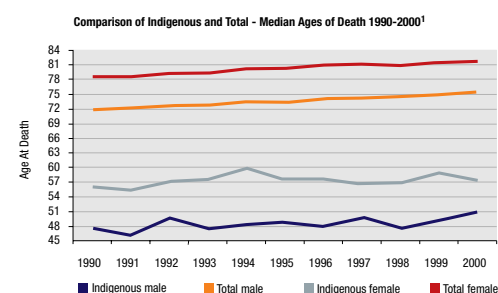
Indigenous people in the late 1990s had the same life expectancy as the Australian population experienced as a whole in the early part of the 20th century<sup>2</sup>.

#### Median Age of Death

*The age by which 50% of the population dies.*

In 2000, the median age of death was 53 years for Indigenous people, which was 25 years less than the median age of death for the Australian population as a whole<sup>1</sup>.

There has been no consistent increase in the median age of death for the Aboriginal and Torres Strait Islander population between 1990-2000, compared with a steady increase of three years in the total population in the same period<sup>1</sup>.

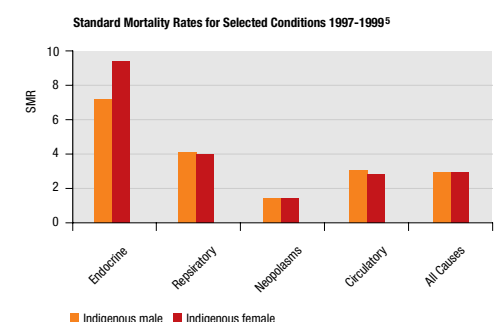


#### Standardised Mortality Ratios (SMR)

*These enable valid comparisons of mortality to be made that take account of differences eg in the age profile of the two populations.*

In 1997-1999, the age standardised death rates for Aboriginal and Torres Strait Islander people were approximately 3 times those of the total Australian population<sup>5</sup>.

The significantly higher rates of Indigenous deaths (ie number of times more death than the rest of the population) for particular causes of death are shown in the graph: endocrine conditions such as diabetes, respiratory conditions, cancer, circulatory diseases and all causes.



## International and Regional Comparisons

## Overall Comment

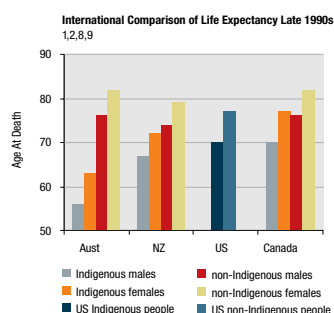
In 1998, the NZ Maori population had an IMR of 7 compared with 5 for the total population. In 1996-8, the US Indigenous populations experienced an IMR of 9 compared with 7 for the total population<sup>1</sup>.

These rates are substantially lower than the Australian Indigenous IMR of 14.

There is evidence that programs can make a difference in reducing the number of low birth weight babies.

The NT *Strong Women, Strong Babies, Strong Culture* program reduced the number of low birth weight babies from 19.8% to 11.3% in the years 1990-1991 to 1994-1996<sup>6</sup>.

Likewise, the Nganampa Health Council Antenatal Care Program reduced the number of low birthweight babies from 14.2% to 8.1% in the years 1984-1996<sup>7</sup>.



In the late 1990s, Canada, NZ and the US reduced the gap between their Indigenous and non-Indigenous populations to between 5 and 7 years – compared to Australia's 20 years<sup>1,8,9</sup>.

The gap between Indigenous and non-Indigenous populations was between 7-12 years in the US and Canada in the 1970s. In NZ in the 1950s it was between 13-15 years<sup>8,9,10</sup>. The gap in life expectancy has narrowed over time in these countries. This has not been the case in Australia.

One unpublished study suggests that there was a 13% reduction in overall mortality rates for Indigenous people due to respiratory disease between 1986-96 and a further 43% between 1996-1999<sup>11</sup>.

Reduction in recent years may be due, in part, to the introduction of vaccines, particularly pneumococcal and influenza, demonstrating the importance of such public health measures<sup>11</sup>.

In Far North Queensland, there was early introduction (1996) of vaccination targeting Indigenous people at high risk prior to the introduction of the national vaccination program in 1999. From 1993-1994 to 1999-2000 the number of pneumococcal disease cases fell from 111 cases per 1,000,000 to 28 cases per 1,000,000 in Far North Queensland<sup>12</sup>.

*The health status of Aboriginal and Torres Strait Islander people is significantly poorer than for Australians as a whole. While there have been some improvements, overall little progress has been achieved.*

*The stark differences in infant mortality rates, numbers of low birth weight babies, life expectancy, and standardised mortality ratios between Indigenous people and other Australians are continuing.*

*Both infant mortality rates and low birth weight are significant because they are indicative of factors such as poor nutrition and living conditions that impact on health. These are not typical of developed countries such as Australia.*

*The continuing significant gap in life expectancy coupled with the low age of death highlights the inequity in life chances experienced by Australia's Aboriginal and Torres Strait Islander population.*

*Aboriginal and Torres Strait Islander people die of the same causes of death as the rest of the population – however they die younger and at higher rates of these conditions. This applies to endocrine, respiratory, cancer, renal, circulatory conditions and to all causes.*

*The prevalence of diabetes in particular is very significantly higher than for the rest of the Australian population.*

*In addition, Aboriginal and Torres Strait Islander people experience other conditions such as rheumatic fever, endemic skin infections and trachoma, which are more typical of underdeveloped countries. In contrast, there are apparent improvements in deaths from respiratory conditions possibly linked to the introduction of the pneumococcal and influenza vaccine.*

*Hospital admission rates are twice those for the total population reflecting both higher rates of illness and a lack of accessible, culturally appropriate primary health care.*

*Australia's performance in achieving progress in these measures is poor compared to other developed countries.*

*Improvements in life expectancy for Indigenous peoples occurred in the mid 1950s for the US and Canada and earlier in NZ. Improvements appear to have occurred through more adequate provision of primary health care, public health facilities and initiatives relating to social justice.*

*International experience indicates that progress is achievable.*

*It is unacceptable that Australia continues to lag behind.*

Dimensions		Overall Australian Statistics																	
Health Status																			
<b>Hospital Rates</b>  <i>Admissions and separations provide a measure of the extent of hospitalisation.</i>		<p>Hospital admissions indicate that Indigenous people are about twice as likely as non-Indigenous Australians to be admitted to hospital<sup>5</sup>. Indigenous people experience a higher burden of disease and illness resulting in hospitalisation than does the rest of the population<sup>5</sup>.</p> <p>In 1998-1999, age standardised hospital separation rates (ASHSR) for endocrine diseases were about 3 times as high based on hospitalisation rates for the total Australian population<sup>5</sup>. For injury, the ASHSR was about double and for dialysis it was 7-11 times higher<sup>5</sup>. Incidence of end stage renal disease among Indigenous people in remote areas is 30 times higher than the total national incidence<sup>13</sup>.</p> <p>There is evidence suggesting that the Aboriginal and Torres Strait Islander people have one of the highest rates of Type 2 diabetes in the world<sup>14</sup>. The overall prevalence is estimated to be between 10%-30%, which is at least 2-4 times that of non-Indigenous Australians<sup>15</sup>. Part of the disease burden for Aboriginal and Torres Strait Islander people also consists of diseases characteristically seen in underdeveloped countries such as endemic skin infections, trachoma and rheumatic fever<sup>16</sup>.</p>																	
Health Services and Service Delivery																			
<b>Access to primary health care services</b>		<p>The 2001 Community Housing and Infrastructure Needs Survey found that:</p> <ul style="list-style-type: none"><li>• 52% of communities (with populations over 50 and over 10 kms from a hospital) had daily access to a female Aboriginal Health Worker compared to 60% in 1999;</li><li>• 49% of communities had daily access to a registered nurse; compared to 52% in 1999;</li><li>• 11% of communities had daily access to a doctor; compared to 9% in 1999;</li><li>• 53% of people were located 100 kms or more from the closest hospital; compared to 54% in 1999;</li><li>• 88% of people (100kms or more from the closest hospital) had access to emergency air medical services compared with 86% in 1999<sup>17,18</sup>.</li></ul>																	
<b>Access to health services - workforce</b>		<p>A recent government review on Aboriginal and Torres Strait Islander health workforce requirements aims to address the staffing difficulties impeding the adequate delivery of primary health care to Aboriginal and Torres Strait Islander communities<sup>20</sup>.</p> <p>A consultancy report prepared for the government estimates the total number of doctors (Indigenous and non-Indigenous) required as ranging from 486 to 1,469 depending on the index of need used<sup>21</sup>. The most conservative estimate of percentage increase required for doctors is 59%<sup>21</sup>. For nurses it is 24.3%<sup>21</sup>.</p> <p>The report estimated the minimum increase in the number of Indigenous people required in the health workforce as being 3,200<sup>21</sup>. This estimate includes 750 Aboriginal Health Workers, 1,356 nurses, 258 allied health workers and 644 doctors<sup>21</sup>.</p>																	
Public Health Infrastructure																			
		<p>The Community Housing and Infrastructure Needs Survey collected data on housing and related infrastructure such as water, electricity and sewerage. The survey was undertaken in 1992 (906 communities), 1999 (1,291 communities) and 2001(1,216 communities)<sup>18, 22</sup>. While there have been improvements in the availability of services many communities are still without basic amenities<sup>17, 18, 22</sup>.</p> <div><p>Changes in Availability of Selected Services for Selected Years <sup>17,18, 22</sup></p><table><thead><tr><th>Service</th><th>1992</th><th>1999</th><th>2001</th></tr></thead><tbody><tr><td>No Water</td><td>60</td><td>20</td><td>20</td></tr><tr><td>No Electricity</td><td>250</td><td>140</td><td>90</td></tr><tr><td>No Sewerage</td><td>150</td><td>80</td><td>100</td></tr></tbody></table></div>		Service	1992	1999	2001	No Water	60	20	20	No Electricity	250	140	90	No Sewerage	150	80	100
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## International and Regional Comparisons

## Overall Comment

The NT has been particularly successful in introducing Hib vaccination for children under 5 years, with a reduction from 141 per 100,000 incidence of invasive Hib disease in the prevaccination era to 19 per 100,000 in the post vaccination era<sup>7</sup>.

Access to primary health care facilitates both preventive activities and early intervention. Lack of access to these may lead to higher morbidity and mortality.

The higher Indigenous cancer mortality rate may be partly due to lack of access to primary care including screening, for example, for cancer of the cervix<sup>19</sup>.

There are examples of effective programs, such as the cervical cancer screening program at Yuendumu in the NT, where between March 1992 and June 1993, the rate of eligible women who were screened increased to 78%. Prior to this, screening rates had varied between 2%-51%<sup>7</sup>.

Despite staffing difficulties, Aboriginal Community Controlled Health Services provide a model and a network of culturally appropriate primary health care services.

There are also examples of mainstream services, such as the Inala Health Centre General Practice in Queensland linking with Aboriginal communities to provide a better service<sup>7</sup>.

*Measures of accessibility are neither comprehensive nor highly reliable. The available data, however, suggest that there are major problems of access to primary health care for Aboriginal and Torres Strait Islander people.*

*There has been little evidence of improvement in recent years in relation to access to primary health care services and even some indications that access to some primary health care workers may have declined. Ensuring access to culturally appropriate primary health care is a strategic necessity if the inequity in health status is to be overcome.*

*An appropriate and adequately resourced and skilled health workforce is a key component of provision of primary health care. Available data is inadequate, but what data there is shows significant shortfalls in the numbers of doctors, Aboriginal Health Workers, allied health workers and nurses required. There also needs to be a higher proportion of Indigenous workers in the health system. The government is currently developing a new workforce strategy.*

*What is required is a National Training Plan accompanied by clear targets in defined time frames to train the health personnel required to deliver health services to Aboriginal and Torres Strait Islander people. A range of incentives and other measures to improve the ability to recruit and retain staff is required. Initiatives are also needed to increase the numbers of Aboriginal and Torres Strait Islander people working as health professionals.*

*While, overall, the number of communities without clean water, sanitation, electricity and sewerage has decreased, there are still significant gaps. If these occurred in the rest of Australia, there would be outrage.*

<b>Dimensions</b>	<b>Overall Australian Statistics</b>												
<b>Related Policy Areas - Education</b>													
	<p>There is an intrinsic link between health status and education with improvements in one leading to improvements in the other <sup>23</sup>.</p> <p><b>Reading benchmarks:</b> 66% Indigenous Year 3 students attained the reading benchmark versus 87% of non-Indigenous Year 3 students in 1999<sup>3</sup>. This is compared with 20% and 70% in 1996. <sup>24</sup></p> <p><b>Retention rates to Year 12:</b> These appear to have increased from about 25% in 1993 to nearly 35% in 1999 <sup>3</sup>.</p>												
<b>Government Inputs</b>													
<b>Funding</b>	<p>The real increase in all Aboriginal and Torres Strait Islander health program funding by Commonwealth and State/Territory governments and other programs from 1995-1996 to 1998-1999 was 15%<sup>16</sup>. The Australian Institute of Health and Welfare estimates that in 1998-1999, for every dollar spent on health services for a non-Indigenous person, about \$1.22 was spent on an Indigenous person, up from \$1.08 in 1995-1996<sup>3</sup>. This is considerably less than would be expected given the poor health status of Indigenous people<sup>3</sup>.</p> <table border="1"> <caption>Total OATSIH funding for ACCHS from 1995-96 to 1999-2000(3)</caption> <thead> <tr> <th>Financial Year</th> <th>Total OATSIH Funding for ACCHS (\$m)</th> </tr> </thead> <tbody> <tr> <td>1995-6</td> <td>~90</td> </tr> <tr> <td>1996-7</td> <td>~85</td> </tr> <tr> <td>1997-8</td> <td>~115</td> </tr> <tr> <td>1998-9</td> <td>~135</td> </tr> <tr> <td>1999-2000</td> <td>~136</td> </tr> </tbody> </table> <p>One of the areas where government spending on Indigenous people is much lower than the population as a whole is MBS and PBS. The ratio of Indigenous to non-Indigenous expenditure was 0.38 and 0.31 respectively in 1998-1999 despite Indigenous people having three times the level of illness<sup>16</sup>.</p> <p>Professor Deeble has argued for a needs index for government services of 1.93 ie almost double that of the non-Indigenous population<sup>26</sup>. In the year 2000 this would have amounted to an additional \$245 million per annum based on 1995-1996 figures<sup>26</sup>. In 1998-1999 the ratio of Indigenous to non-Indigenous expenditure for government programs was 1.56<sup>16</sup>. The impact of this shortfall is greatest in crucial primary health care services providing prevention, early treatment and continuing care.</p> <p>OATSIH funding of Aboriginal Community Controlled Health Services has increased from \$90.156 million in 1995-1996 to \$136.492 million in 1999-2000.<sup>3</sup></p> <p>Approximately 1,200,000 episodes of care were reported to be provided by Aboriginal Community Controlled Health Services in 1999-2000 compared with 1,060,000 in 1998-1999 and 860,000 in 1997-1998<sup>27,28</sup>. This represents an increase of 23% in episodes of care from 1997-1998 to 1998-1999 and an increase of 13% from 1998-1999 to 1999-2000. The overall increase from 1997-1998 to 1999-2000 was almost 40%.</p>	Financial Year	Total OATSIH Funding for ACCHS (\$m)	1995-6	~90	1996-7	~85	1997-8	~115	1998-9	~135	1999-2000	~136
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<b>Aboriginal Community Controlled Health Services (ACCHS)</b>													
<b>Government Coordination and Planning</b>	<p>Over the last two years, the AMA has been made aware of problems of lack of coordination. These particularly apply to the difficulties in coordination of project funding and of planning initiatives by different government bodies.</p> <p>The government has taken a range of initiatives to improve coordination including the establishment of the Aboriginal and Torres Strait Islander Health Council, Framework Agreements and regional planning. The Australian Health Ministers are currently considering including Indigenous Health in the 2003-2008 Health Care Agreements.</p>												
<b>Reconciliation</b>	<p>The recently tabled Social Justice Report 2001 raises serious concerns about Australia's progress in achieving the exercise of Indigenous rights<sup>30</sup>. The Commissioner has called for a Senate inquiry into the reconciliation process and, in particular, into the recommendations in documents produced by the Council for Aboriginal Reconciliation and the Social Justice Report 2000<sup>30</sup>.</p> <p>In 2001, ATSIC commenced a process of discussion with Aboriginal communities in relation to the feasibility of a treaty as a basis of reconciliation. The AMA Federal Council passed a resolution in 2001 supporting calls for such consultation<sup>31</sup>.</p>												

## International and Regional Comparisons

## Overall Comment

While overall there are some indications that gaps in educational outcomes are narrowing, there are also indications that in some locations, outcomes are not improving.

In 1998, for example, the number of Indigenous students achieving the reading benchmarks in Year 3 in the NT was 31% compared with 82% for non-Indigenous students. For Indigenous students for whom English is a second language, this dropped to 9%<sup>25</sup>.

*The areas of health and education are interlinked, with improvements in one leading to improvements in the other.*

*There is a need to significantly improve educational outcomes for Aboriginal and Torres Strait Islander people. The evidence about progress in narrowing inequity in educational outcomes suggests that some improvement is occurring in attainment of reading benchmarks and in retention until Year 12. However, it also appears that this is not being uniformly attained. There are indications that, in some areas, particularly rural and remote, educational outcomes may even be worsening. Measures required include ensuring cultural and linguistically appropriate education.*

The Primary Health Care Access Program (PHCAP) was first established in 1999-2000. It is a national program which is being implemented on a regional basis.

The program aims to provide comprehensive primary health care in areas where joint regional planning has been completed<sup>29</sup>.

Funding of \$78.8 million has been allocated over four years. The 2001-2002 budget announced an additional \$19.7 million each year from 2003-2004 bringing a total recurrent base to \$54.8 million per annum<sup>29</sup>.

As part of PHCAP, the Commonwealth government has established a benchmark for its funding to fill the gap posed by the relatively smaller use of the MBS and PBS by Indigenous people. This benchmark will be between two and four times the average use of the MBS to reflect need<sup>29</sup>.

**Funding** *The increases in funding to health services for Aboriginal and Torres Strait Islander people by governments fall far short of the levels estimated by Professor John Deeble to be an additional \$245 million per annum over 1995-96 figures to provide health services on a needs basis. It is clear that there are major problems in access to the Commonwealth MBS and PBS programs.*

*The current mythologies that too much is being spent on health for Aboriginal and Torres Strait Islander people are without foundation.*

*The AMA calls for a government commitment to a 5-year plan to phase in the increases in funding estimated as necessary by Professor Deeble.*

*Aboriginal Community Controlled Health Services (ACCHS) provide a network of accessible primary health care services. They represent a model of culturally appropriate services shaped by the communities to meet their needs.*

*Commonwealth funding has increased significantly over the last 5 years. However, the scale of this increase is insufficient. ACCHS and their peak body the National Aboriginal Community Controlled Health Organisation (NACCHO), need to be resourced to ensure they are able to continue to expand services supported by an adequate workforce.*

*A promising recent initiative introduced by the Commonwealth is the Primary Health Care Access Program (PHCAP). This is underpinned by the Framework Agreements and regional planning to ensure appropriate targeting and coordination at the local and regional level. This program needs to be facilitated on a national basis, with funding consistent with the Deeble recommendations, so that there is an expanded, effective and accessible primary health care sector.*

**Coordination** *The Framework Agreements, regional planning, the National Aboriginal and Torres Strait Islander Health Council all have the potential to increase coordination. The inclusion of Indigenous Health into the Health Care Agreements, with AHMAC playing a coordinating role, is strategically important. The AMA has also called for better high level coordination between Commonwealth Departments, the Health Council and NACCHO.*

**Planning** *It is essential that the government commits to a properly resourced National Aboriginal and Torres Strait Islander Health Strategy with defined time lines and outputs.*

**Reconciliation** *It is important that initiatives to achieve progress in health and in education are underpinned by measures to promote reconciliation and social justice. Current consultations between ATSIC and Aboriginal and Torres Strait Islander communities in regards to a treaty are a part of a solution. Further initiatives must be taken to promote reconciliation and social justice for Aboriginal and Torres Strait Islander people.*

Ring and Firman, 1998 note that "treaties, no matter how loosely worded, have appeared to play a significant and useful role in the development of health services, and in social and economic issues, for the Indigenous people of New Zealand the United States and Canada"<sup>32</sup>.

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