

**NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH  
ORGANISATION (NACCHO)**

**SUBMISSION TO THE COMMONWEALTH PARLIAMENTARY  
INQUIRY INTO THE NEEDS OF URBAN DWELLING  
ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES**

**March 2001**

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***NACCHO is the national peak body in Aboriginal health, representing  
Aboriginal community controlled health services throughout Australia.***

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**Executive Summary**

This submission focuses on health and health-related issues as they impact on Aboriginal people in urban areas. General contextual issues relating to health and health services for Aboriginal people in all areas, including the Framework Agreements on Aboriginal health, funding issues, and the links between education and health, are outlined in the Appendix to this submission.

The key point that NACCHO wishes to convey to the Inquiry is that the health status and health needs of Aboriginal people are similar across urban, rural, and remote areas; and much greater efforts need to be made to improve Aboriginal health across all areas.

There is often a misconception among policy makers, and indeed, the general public, that efforts should be directed at Aboriginal people in remote areas only, as Aboriginal people in urban areas are not seen as having the same level of unmet need.

This myth needs to be overcome. Aboriginal people in all areas - urban, rural, and remote – experience similarly poor health status.

The morbidity and mortality rates experienced by Aboriginal people living in urban areas are far closer to those for Aboriginal people living in remote areas, than they are to those for non-Aboriginal people in any area. This is not surprising given that the key underlying factors of this poor health status – dispossession, poverty and disadvantage – affect Aboriginal people in all areas. Many Aboriginal people in urban areas experience ongoing racism and isolation, just as their counterparts in remote areas often do.

It is also thought by some that the lack of services in remote areas is the major issue impacting on Aboriginal health, and that because there are more doctors, pharmacies, hospitals and so on in urban areas, urban Aboriginal people do not experience barriers to access to health care. Again, this is a grave misconception. The fact that mainstream services exist in urban areas does not mean that they are appropriate or accessible to Aboriginal people. Indeed the evidence shows that there are a range of financial, cultural and other barriers to Aboriginal people in all areas accessing mainstream services.

The overwhelming conclusion to be drawn from the evidence is that Aboriginal people in all areas – urban, rural and remote – are desperately in need of positive measures to address the disadvantage they face, including appropriate health care services.

## **Background**

### ***Aboriginal health***

The state of Aboriginal health remains appalling. All of the indicators of socio-economic and health status (education, income and employment levels, infant mortality, life expectancy, adult morbidity and mortality rates) clearly show Aboriginal people to be by far the most disadvantaged group in Australia. For example, life expectancy for Aboriginal people is 15 to 20 years below that of other Australians, infant mortality is 2 to 4 times higher, and adult death rates are 3 to 4 times higher<sup>i</sup>. The improvements in Aboriginal infant mortality over the past 20 years have been offset by devastating losses of Aboriginal adults to heart and kidney disease, diabetes and injury.

The lack of progress Australia has made in improving Aboriginal peoples' health is in contrast to the significant gains being made in the health status of Indigenous peoples elsewhere in the world<sup>ii</sup>. Aboriginal people's capacity to gain from additional health care resources is consequently very high.

Over the past 20 to 30 years there have been several major inquiries into the health of Aboriginal people<sup>iii</sup>. It has become clear that the appalling, and in some respects worsening, state of Aboriginal health is embedded in the history of dispossession and alienation experienced by Aboriginal people, and in ongoing poverty and disadvantage. This has led to continuing, and in some cases increasing, high levels of illness and death arising from poverty-related and lifestyle-related problems.

As noted in the 1989 National Aboriginal Health Strategy:

“The poor underlying state of Aboriginal health are measures of their social disadvantage within Australian society. Aboriginals are poorer, experience greater unemployment, have lower educational attainment, live in poorer housing and have lower access to facilities taken for granted in most of Australia.”<sup>iv</sup>

These factors affect Aboriginal people in all settings – urban, rural and remote. There is a common misconception that Aboriginal health issues are primarily rural and remote issues. However, the effects of invasion and colonisation on Aboriginal peoples impacted earlier and have been impacting for longer, in what are now urban areas. It is therefore hardly surprising that dispossession and alienation, poverty and disadvantage are felt as keenly by Aboriginal people in urban areas as anywhere else.

### ***Aboriginal community controlled health services***

Improving Aboriginal health is not just about improving the physical well-being of an individual. It is about working towards the social, emotional, and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being. It is also based on the need to acknowledge the reality that Aboriginal people have never ceded sovereignty of their land nor their rights to self-determination.

There is no simple, quick-fix medical solution to Aboriginal health – the solutions lie in assisting Aboriginal people being able to enjoy their right to self-determination. All relevant inquiries and studies have shown conclusively that culturally appropriate, comprehensive

primary health care, based on maximum community participation, is the best way of addressing Aboriginal health.

Aboriginal community controlled health services (ACCHSs) are primary health care services initiated, planned and managed by local Aboriginal communities, aiming to deliver high quality, holistic, and culturally appropriate health care. They are also often known as Aboriginal Medical Services, or AMSs.

In keeping with the philosophy of self-determination, Aboriginal communities around Australia have been establishing these services since the early 1970s. Over one hundred ACCHSs are now operating across Australia, in all States and Territories. These range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurse practitioners to provide the bulk of primary care services, often with a preventive, health education focus. The services form a network, but each is autonomous and independent both of one another and of government. The integrated primary health care model adopted by ACCHSs is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails.

Some of the benefits that properly resourced Aboriginal community controlled health services can deliver include:

- significantly improved access - because the local community has ownership and control of the service, and because service delivery is flexible and responsive (for example, outreach services are often a feature) , Aboriginal people are more likely to access the care they need;
- the full range of primary health care services is available in one place – service delivery is integrated and holistic, rather than being built around different specialties or “body parts”;
- the care provided is culturally appropriate – the organisation is run by Aboriginal people, employs Aboriginal or culturally aware non-Aboriginal people, and delivers care in a sensitive and inclusive way;
- the sector is both cost effective and cost efficient; it delivers value for money – based on local knowledge, services are targeted at areas of local need;
- the sector represents a major source of education training, achievement, and pride, for Aboriginal people;
- the knowledge required to improve Aboriginal health status is not innate; it must be acquired. The community controlled sector has developed a large pool of knowledge and expertise about Aboriginal health issues, which enables it not only to deliver appropriate care, but also to advocate effectively for Aboriginal people in health;
- in practical terms, the Aboriginal community controlled health service sector provides leadership in primary health care in Australia in areas such as evidence-based medicine (with the development of clinical care guidelines based on systematic reviews of available evidence), and use of information technology for purposes such as patient recall.

In accordance with the National Aboriginal Health Strategy and commitments made in the Framework Agreements, Aboriginal primary health care services should be Aboriginal community controlled in structure wherever this is feasible.

In practical terms, the benefits of a strong Aboriginal community controlled health sector are already being demonstrated through health gains such as measurable improvements in immunisation rates and reductions in STD rates in several areas with Aboriginal community controlled health services. Valuable partnerships are also being developed at national, state, regional and local level between the Aboriginal community controlled health sector and other players such as hospitals, GPs, specialists, other health and community organisations, academic institutions, and so on. Improved and more flexible resourcing to increase Aboriginal access to appropriate primary health care services offers the potential for greater gains in the future.

However, the Aboriginal primary health care sector across Australia is severely under-resourced, which impacts in many ways on the capacity of these services to meet the health needs of their communities. These resourcing issues are discussed in more detail in the Appendix to this submission.

## **The health of Aboriginal people in urban, rural and remote areas**

Morbidity and mortality statistics across urban, rural and remote areas confirm that while rural and remote health is primarily an Aboriginal issue, Aboriginal health is not just a rural and remote issue. Although underlying health issues may vary across areas, Aboriginal people experience similarly poor health status across urban, rural and remote areas, and the health status of Aboriginal people in any area is markedly worse than the health status of non-Aboriginal people.

An overview of available national statistical information relating to the health of Aboriginal people in urban, rural and remote areas is set out below. However, there are many gaps in the available data. For example, there is little reliable, up to date information available on the underlying health issues affecting Aboriginal people across different locations. There is a need to improve the quality of the data available on these issues.

### ***Location of Aboriginal people***

Aboriginal and Torres Strait Islander people are more likely than other Australians to live outside of urban areas (about one in four versus one in seven in 1996). Although Aboriginal and Torres Strait Islander people represent a higher proportion of the local population in the northern and central parts of the country, the majority of Aboriginal and Torres Strait Islander people live in the south-eastern part of Australia.<sup>v</sup>

Unlike the general Australian population, Aboriginal and Torres Strait Islander peoples are distributed relatively evenly across the urban, rural and remote zones with 36.3% in the metropolitan, 34% in the rural and 29.7% in the remote zone.

While Aboriginal and Torres Strait Islander people comprise only 2.1% of the Australian population, they make up 1% of the population of the metropolitan zone, 3% of the rural zone, 13% of 'remote centres' and 26% of 'other remote areas' (Rural, Remote and Metropolitan Area (RRMA) classification system).

### ***Death rates***

It is certainly true that much of the difference in total death rates between metropolitan, rural and remote areas is attributable to the higher proportion of Aboriginal people resident in remote areas. This indicates that rural and remote health is largely an Aboriginal issue. However, the converse – that Aboriginal health is largely a rural and remote issue – is definitely untrue. The difference in death rates between Aboriginal people in different

regions is much less significant than the difference in death rates between Aboriginal people in any region, and non-Aboriginal people in any region. This is illustrated by Table 1 below.

**Table 1. Impact of the Aboriginal and Torres Strait Islander population on the total death rate for all Australians, 1992-96 (deaths per 100,000 population)**

Population group	Metropolitan	Rural	Remote	Total
<b>Males</b>				
Indigenous	1,500.4	1,559.0	1,879.2	1,739.6
Non-Indigenous	800.0	836.9	873.5	811.0
All Australians	804.6	845.8	1,055.1	830.5
<b>Females</b>				
Indigenous	983.9	1,170.2	1,418.2	1,273.9
Non-Indigenous	520.7	521.3	494.5	520.3
All Australians	524.4	528.1	708.5	535.0

Based on data for South Australia, Western Australia and the Northern Territory

Aged-standardised to the Australian population at 30 June 1991

Source: AIHW 1998, p 15

### ***Life expectancy at birth***

Life expectancy at birth represents the average number of years a newborn baby could expect to live if the mortality rates of today were to continue throughout the baby's life. In the period 1991-96, life expectancy at birth for all Australians was 75.2 years for males and 81.1 years for females. By contrast, for Aboriginal and Torres Strait Islander people, life expectancy at birth was estimated to be 56.9 years for males and 61.7 years for females – almost 20 years less than for other Australians, and similar to the figures for third world countries such as Western Sahara and Bolivia. Although there were differences in estimated life expectancy between Aboriginal and Torres Strait Islander people living in urban, rural and remote areas, and in eastern and western parts of Australia, these minor differences were far less significant than the large gap between Aboriginal and Torres Strait Islander people and other Australians.<sup>vi</sup>

### ***Housing and homelessness***

The greater cost of living and the cost of housing in particular is a great problem for Aboriginal people in urban areas, the majority of whom still live in extreme and lifelong poverty. Lack of access to home ownership, the lack of suitable and affordable rental housing in urban areas, and racism in the rental property market, all contribute to overcrowding and homelessness amongst urban Aboriginal people.

Nearly a third of all "improvised dwellings" counted in the 1996 Census were occupied by Aboriginal and Torres Strait Islander people. This category includes sheds, humpies, tents (other than in caravan parks), park benches, etc, and is seen as an indicator of homelessness. For both Aboriginal and Torres Strait Islander people, and for other Australians, these improvised dwellings were more commonly found in rural and remote areas than urban areas, but the proportion of Aboriginal dwellings was similar in urban and non-urban areas, at nearly one third.<sup>vii</sup> This is obviously vastly greater than the proportion of Aboriginal people in the population, and indicates that homelessness is a serious issue for Aboriginal people in all areas.

There is also evidence that the abrogation by State governments of their responsibility to provide affordable rental housing for disadvantaged people over recent years, has had a

particular impact on urban Aboriginal people. An evaluation of ATSIC's Health Infrastructure priorities program in 1999 reported that:

“The housing situation in the Indigenous population has improved a little from 1991 to 1996 with less crowding in Indigenous households, and a lesser proportion living in improvised dwellings. The improvement is greater in rural areas than in urban areas, indicating there has been a positive and real impact of the governmental funding focus on housing in rural and remote Indigenous communities... this evaluation finds there is also a need to provide more assistance to urban dwellers who suffered much more from the reduction in access to State government housing from 1991 to 1996 without the compensation of increased access to community housing available to their rural counterparts.”<sup>viii</sup>

### ***Social and emotional well-being***

Aboriginal people in urban areas are often from communities which have suffered greatly from a long period of invasion, colonisation, and dispossession. This has had an enormous impact on communities, families, and individuals, and has left many urban Aboriginal people feeling alienated, isolated, and lost. Ties to land, traditional culture, and extended family have often been torn apart, and young people in particular may have great difficulty coming to grips with their cultural identity. Colonisation has therefore had a devastating effect on the social and emotional well-being of many urban Aboriginal people.

This impact of colonisation on the social and emotional well-being of Aboriginal people has been recognised by the report of the recent Parliamentary inquiry into Indigenous health which linked the poor mental health status of Aboriginal and Torres Strait Islander people to

“the loss of loved ones, childhood trauma, alcohol and drug related misery, violence, ongoing racism, stereotyping and discrimination, and the accumulated loss of two hundred and eleven years of cultural destruction and dispossession.”<sup>ix</sup>

This enormous loss can manifest in many ways, including in diagnosed mental health problems. For example, in the ACT, Aboriginal and Torres Strait Islander people have a significantly higher hospital separation rate due to mental and emotional conditions of 29.5 per 1,000 separations, compared with the non-Aboriginal rate of 20.6 per 1,000.<sup>x</sup>

Self-harm, including suicide, is a major issue of concern, but should not be seen as separate from other social and emotional well-being issues as they are all manifestations of cultural destruction and dispossession. For example, a recent study of young Aboriginal and non-Aboriginal sole parents in urban State housing in Adelaide found that the tendency to self-harm was linked with “increased familial alcohol abuse, physical and sexual abuse, economic difficulty, poor self esteem and perceived discriminatory treatment by welfare agencies and, in the case of Aboriginals, by police.”<sup>xi</sup>

The emotional and social well-being of young Aboriginal people in urban areas is a major concern. The Victorian Aboriginal Health Service (VAHS) has recently undertaken a study of young people's health and well-being<sup>xii</sup>. Although the study described many strengths of young Kooris<sup>xiii</sup>, including the importance and protective effects of the extended family, many issues of concern were also uncovered. These included high rates of contact with the justice system, of substance misuse, and of depression and suicidal feelings. Key findings of the study are attached.

Frequently experienced manifestations of the impact of colonisation include substance misuse, violence, including family violence, and so on. These are discussed further below.

## **Language**

Reflecting the impact of colonisation and Westernisation, Aboriginal people living in urban areas are less likely to speak their traditional languages. Overall, about 13% of Aboriginal and Torres Strait Islander people reported that they spoke an Indigenous language at home in 1996. The proportion varied from 2% of those in Major Urban areas to 39% in Bounded Localities and 32% in the Rural Balance. Aboriginal and Torres Strait Islander people were most likely to speak an Indigenous language at home in the NT and northern WA, while a very low proportion in eastern and southern States said they spoke an Indigenous language at home.<sup>xiv</sup>

## **Substance misuse**

Reflecting the harmful impact of colonisation and dispossession, substance misuse is a serious problem affecting Aboriginal peoples. The 1989 National Aboriginal Health Strategy noted that:

“Alcohol abuse, its complications and manifestations have been identified by Aboriginal communities during the consultation process as one of their major health problems. Non-Aboriginal Australia must recognise that alcoholism is an introduced illness caused primarily by political, social, economic and cultural deprivation imposed by non-Aboriginal society... Alcohol abuse is simultaneously a health problem, a cause of other health problems, and a symptom of socio-political related problems.”<sup>xv</sup>

## **Illicit drug use**

Within the overall category of substance misuse, illicit drug use is a major and growing problem affecting Aboriginal people, including (but not limited to) people living in urban areas. The widespread availability of illicit drugs in urban areas, and the alienation and isolation of many young Aboriginal people living in towns and cities, makes it highly likely that illicit drug use is a greater problem for urban Aboriginal people.

As long ago as the mid-1980s, the Redfern Aboriginal Community was registering its alarm regarding the dramatically escalating use of heroin among its young people, and the devastating effects this was having<sup>xvi</sup>.

The most recent source of national information on the use of illicit drugs by Aboriginal and Torres Strait Islander people are the 1993 and 1994 National Drug Strategy surveys, which were conducted in urban areas. According to these surveys, over half the Aboriginal and Torres Strait Islander population aged 14 years and over in urban areas said they had tried at least one illicit drug, compared with 38% of the general urban population.<sup>xvii</sup>

There is statistical as well as anecdotal evidence that the use of illicit drugs is increasing. For example, a study of hospital admissions for an illicit drug problem in WA for the period 1980-95 revealed a rapid increase in first-time admission rates, particularly for Aboriginal people. The age-standardised admission rates per 100,000 rose from 9.2 for Aboriginal people and 16.4 for non-Aboriginal people in 1980, to 180.7 and 95.5 respectively in 1995.<sup>xviii</sup>

The Victorian Aboriginal Health Service (VAHS) Injecting Drug Use Project has found that a major problem for the Koori community in Melbourne is lack of access to appropriate substance misuse services, such as detoxification, rehabilitation, and counselling services. There is an urgent need to address this.<sup>xix</sup>

### ***Exposure to violence***

Aboriginal and Torres Strait Islander people are more likely than other Australians to be victims of violence, and this appears to be pronounced in urban areas.

Of the Aboriginal and Torres Strait Islander people aged 13 years and over interviewed in the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS), 13% reported they had been physically attacked or verbally threatened in the year prior to the survey, and 11% of households were reported as having been a victim of break and enter, and theft. By contrast, in the 1993 National Crime and Safety Survey of the general Australian population, only 2.5% of respondents aged 15 and over said they were victims of assault in the year prior to interview, and 7% of households were reported to have been victims of an actual or attempted break and enter. In the NATSIS, Aboriginal people in capital cities were more likely to report having been physically attacked or verbally threatened than people in other urban areas.<sup>xx</sup>

Again, exposure to violence reflects a range of underlying factors including racism, socio-economic disadvantage, social and emotional well-being issues, substance misuse problems, and so on. The 1989 National Aboriginal Health Strategy listed the etiological factors relating to trauma and injury from external sources as alcohol and drugs, substance abuse, car accidents, and injuries such as stabbings, bashings, burns, domestic violence, and accidents at work and at home. To address this, the NAHS recommended the development and presentation of culturally appropriate education program in a range of relevant areas.<sup>xxi</sup> This recommendation is still relevant 12 years on.

### ***Incarceration***

The disproportionately high levels of incarceration of Aboriginal people are yet another reflection of racism and disadvantage. In the 1997 National Prisoner Census, there were 3,580 prisoners (3,347 males and 233 females) identified as Aboriginal or Torres Strait Islander, which represented 19% of the total Australian prison population at that time. In Australia as a whole, Aboriginal and Torres Strait Islander adults were imprisoned at the rate of 1,625 per 100,000, which is over 14 times the rate for the non-Indigenous adult population (125 per 100,000).<sup>xxii</sup>

These high levels of incarceration have important implications for health and well-being. For instance, the disproportionate representation of Aboriginal people in the correctional system, where it is acknowledged there is a high risk of sharing injecting equipment and acquiring blood borne diseases, means that exposure to blood borne viruses may be disproportionately high among Aboriginal users of injecting drugs.

Many Aboriginal community controlled health services provide services to Aboriginal people in prison, even in the absence of funding to do so, as there is generally no other accessible and culturally appropriate health care available for Aboriginal people in custody.

### ***Access to health care by Aboriginal people in urban areas***

There is often a misconception that Aboriginal people in urban areas do not suffer a similar level of health problems, or a similar lack of access to health care services, as Aboriginal people in remote areas.

However, mainstream service providers often do not recognise the existence of an Aboriginal community, let alone have the commitment and knowledge required to offer culturally appropriate services. Aboriginal people will often not access mainstream services until their health is in crisis, for reasons including lack of knowledge of the services available, lack of transport to reach services (Aboriginal people generally live in highly disadvantaged urban



areas with a lack of services close by), lack of money to pay for services, or a concern that the service provider may be racist or judgmental. This often results in late presentation, reduced compliance with treatments, and low rates of attendance at follow-up appointments.

As a recent study noted:

“...reluctance to access services, especially in times of crisis, relates in part to perceptions of care services and that, for Aboriginals, the value of culturally appropriate community-run services have specific public health and policy implications.”<sup>xxiii</sup>

The lower “visibility” of Aboriginal people in some urban areas can in fact contribute to a lack of appropriate services. For example, appropriate substance misuse, dialysis, and dental care services are sorely needed in urban areas as in other areas. However, Aboriginal people in urban areas frequently find themselves in a position where they have to prove and defend their Aboriginality.

Access to mainstream medical and pharmaceutical services can also be problematic in urban areas, despite the relative abundance of doctors’ surgeries and pharmacies. The 1997 Keys Young report on Aboriginal access to Medicare and PBS noted that:

“The incidence of Aboriginal and Torres Strait Islander peoples having no effective Medicare number/card ranges between 15-38%, as reflected in a recent Queensland survey and supported by evidence gathered in the course of this research. An assumption held before this study began was that relatively few problems would be found in urban areas, however it was found that somewhere in the order of 15-20% of Aboriginal and Torres Strait Islander people using urban health services do not have access to a current Medicare number.”<sup>xxiv</sup>

“Immediate access to medications by many Aboriginal and Torres Strait Islander peoples when they present at a clinic/ACCHS is generally felt to be necessary by health services personnel... virtually all ACCHSs dispense some medication directly, even in urban areas with chemists nearby, because they regard it as essential to ensuring a patient receives what s/he requires.”<sup>xxv</sup>

In addition, Aboriginal-specific services in urban areas are generally under-resourced to deliver primary health care to the large populations of Aboriginal people resident in these areas, and experience similar difficulties to Aboriginal-specific services in other areas in terms of recruitment and retention of an adequate skilled workforce.

### ***Use of health services***

Aboriginal and Torres Strait Islander people in metropolitan areas may be marginally higher users of health services than other Aboriginal and Torres Strait Islander people. In the 1995 National Health Survey, some 75% of those living in capital cities and 69% of those in other non-remote areas reported taking a health-related action. However, these figures are lower than the corresponding figures for other Australians, despite the much higher level of morbidity experienced by Aboriginal and Torres Strait Islander people.<sup>xxvi</sup>

### ***Aboriginal primary health care services in urban areas***

The majority of Commonwealth-funded Aboriginal primary health care services and their clients are located in urban areas.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Department of Health and Aged Care, and NACCHO jointly collect annual Service Activity Reporting (SAR) data from Commonwealth-funded Aboriginal primary health care services. Of the 110 such services which provided SAR data for 1998-99 (the majority of which were ACCHSs), 32 were in areas classified as highly accessible, 25 in areas classified as accessible, and 12 in areas classified as moderately accessible under the Accessibility and Remoteness Index of Australia (ARIA) classification system.<sup>xxvii</sup> The remaining 41 services were located in remote and very remote areas under the ARIA classification system.

This makes a total of 69 of the 110 services, or nearly 63%, which were located in areas which would generally be considered urban (either metropolitan cities or rural towns). The estimated populations in the health service areas of these “urban” services also accounted for nearly 80% of the populations in the health service areas of Commonwealth funded Aboriginal primary health care services. These figures are unsurprising, given that as outlined above, the majority of Aboriginal people live in metropolitan and rural, rather than remote areas.

## **Summary**

This submission has described the background of colonisation and dispossession, and continuing racism and socio-economic disadvantage, that affects Aboriginal people in all areas – urban, rural and remote. It has also alluded to contextual issues including the lack of adequate resourcing for appropriate Aboriginal primary health care, which affect Aboriginal people in all areas, issues which are discussed further in the Appendix.

It is clear that while underlying health issues may differ between areas, the health status and health needs of Aboriginal people are similar across urban, rural, and remote areas; and much greater efforts need to be made to improve Aboriginal health across all areas.

Aboriginal people in all areas – urban, rural and remote – are desperately in need of positive measures to address the disadvantage they face, including appropriate health care services. Political will is urgently needed to provide adequate resources to address this desperate need.

**NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH  
ORGANISATION (NACCHO)**

**SUBMISSION TO THE COMMONWEALTH PARLIAMENTARY  
INQUIRY INTO THE NEEDS OF URBAN DWELLING  
ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES**

**March 2001**

**Appendix: Contextual Issues**

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**This Appendix to NACCHO's submission outlines a number of contextual issues relating to health and health services for Aboriginal people across all areas - urban, rural and remote.**

***Framework Agreements in Aboriginal and Torres Strait Islander Health***

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***The following is an excerpt from an August 1999 NACCHO submission to AHMAC. Note that a new round of Framework Agreements is currently being negotiated.***

Framework Agreements on Aboriginal and Torres Strait Islander health were signed in each State and Territory between Commonwealth and State Governments, the Aboriginal community controlled health sector, and the Aboriginal and Torres Strait Islander Commission, between July 1996 and February 1999.

The Agreements run to June 2000 and aim to improve health outcomes for Aboriginal and Torres Strait Islander peoples through improved access to health and health related programs, increased allocation of resources and transparent and regular reporting for all services and programs, and joint planning processes to inform resource allocation.

NACCHO's view is that the content of the Framework Agreements on Aboriginal and Torres Strait Islander health is basically sound. The Framework Agreements have produced several positive outcomes:

- The planning mechanisms established under the Agreements have led to improved intersectoral communication and collaboration in several States/Territories and regions.
- Joint regional Aboriginal health plans are underway or completed in several areas.
- NACCHO and most of its State/Territory affiliates have accessed some resourcing since the signing of the Agreements.

However, the implementation of the Agreements is lacking in several areas:

- The national and State/Territory forums are frequently being presented with policy and program decisions after the event rather than being active participants in these decisions, and in some cases their advice is not acted upon by Governments. In many cases, funding decisions continue to be made without reference to the agreed planning structures.

- The Aboriginal community controlled health sector is not an equal partner in the partnerships and planning processes, due to resource and information inequalities.
- There has been an inability to enforce the accountability requirements implicit in the Framework Agreements.
- The Agreements have not to date led to the provision of adequate, needs-based resourcing for Aboriginal health. Increases in funding have been incremental.

These issues need to be addressed in the implementation of the next round of Framework Agreements which will cover the period from July 2000.

### *Recommendations*

- 1) Each State/Territory Partnership/Forum should be required to develop an agreed and detailed action plan for each element of the next round of Framework Agreements, to ensure their effective implementation.
- 2) Performance Indicators should be developed to allow for monitoring and reporting against the implementation of the Framework Agreements. The process for the development of such Performance Indicators should be funded by the Commonwealth.
- 3) Major Commonwealth health funding reforms should be introduced to improve access to health care, particularly appropriate primary health care, by Aboriginal and Torres Strait Islander people.
- 4) The emphasis on resourcing for Aboriginal health should be shifted away from the hospital sector and towards the primary health care sector in the community.
- 5) The Public Health Outcome Funding Agreements (PHOFAs) should include a requirement for State/Territory Governments to collaborate with Aboriginal communities and organisations on the development and implementation of public health programs.
- 6) Funding decisions in Aboriginal health should be based on agreed, effective needs based planning processes, noting that needs based funding will require a major injection of new resources into Aboriginal health.
- 7) The membership and role of the National Aboriginal and Torres Strait Islander Health Council should reflect the spirit of the 1990 agreement by the Joint Ministerial Forum of Ministers for Aboriginal Affairs and Health to establish a Council for Aboriginal Health.
- 8) OATSIH and AHMAC should make a clear public statement regarding the role of the Heads of Aboriginal Health Units in Aboriginal health policy, recognising that an all-Government policy forum which bypasses the Aboriginal community in policy development is unacceptable.
- 9) NACCHO should receive a guaranteed level of core funding on an ongoing basis sufficient to fulfil its role as the national peak body in Aboriginal health, and this should be channelled through the central area of the Health Department rather than through the Office for Aboriginal and Torres Strait Islander Health.
- 10) When a new Framework Agreement is signed for the ACT, the Aboriginal community controlled health sector must be a formal signatory, either through AHMRC or through Winnunga Nimmityjah in its own right signing the Agreement.

- 11) The South Australian Aboriginal Health Partnership should become a sub-Committee of the Aboriginal Health Council of South Australia after 30 June 2000.
- 12) A community consultation brokerage fund(s) should be established to allow for regional community consultation in areas throughout Australia where new health services are being established.
- 13) The Forums/Partnerships established under the Framework Agreements should have a more proactive role in identifying needs and priorities, and strategies to address these; and State/Territory Health and Aboriginal Affairs Ministers should take advice from the Partnerships. The State/Territory Forums/Partnerships should also have formal linkages with the National Aboriginal and Torres Strait Islander Health Council.
- 14) The Commonwealth should act to ensure that an immediate commitment is made by the Queensland Government to provide adequate recurrent funding to the Queensland Aboriginal and Islander Health Forum (QAIHF).
- 15) The Northern Territory and/or Commonwealth Governments should upgrade the funding provided to AMSANT for Secretariat services to the Northern Territory Aboriginal Health Forum, in accordance with the demands upon the Secretariat and the responsibilities of the Forum.
- 16) Each NACCHO State/Territory affiliate should receive a guaranteed level of core funding on an ongoing basis sufficient to fulfil the role of each as the State/Territory peak body in Aboriginal health.
- 17) In areas with significant Aboriginal populations, the Aboriginal health planning forums should be involved in planning for State/Territory funded mainstream services, and the relationship between mainstream regional health planning and Aboriginal-specific health planning in these regions should be clarified.

## **Funding for Aboriginal health**

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***The following is an excerpt from an April 2000 NACCHO submission to the Commonwealth Grants Commission Indigenous Funding Inquiry.***

### ***The overall inadequacy of funding for Aboriginal health***

Contrary to popular belief, Commonwealth Government expenditure on Aboriginal health is not high. Taking Medicare expenditure, Pharmaceutical Benefits Scheme (PBS) expenditure, Aboriginal health funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), and other Commonwealth programs into account, the Commonwealth currently spends significantly less per head on the health of each Aboriginal person than on the health of each non-Aboriginal person.

Approximately 63 cents per head is spent by the Commonwealth on health services to Aboriginal and Torres Strait Islander people, for each dollar spent per head on the health of other Australians (\$472 per capita for Aboriginal and Torres Strait Islander people, compared with \$748 per head for non-Indigenous people)<sup>xxviii</sup>. Only a portion of the 63 cents is spent on culturally acceptable and effective services to Aboriginal people.

As the *House of Representatives Standing Committee Inquiry into Indigenous Health (1999)* reported:

*“the level of expenditure on Aboriginal and Torres Strait Islander health...is not excessive and would generally seem to be insufficient to meet the present level of need for health and related services.”<sup>xxxix</sup>*

The current low level of accessibility to appropriate primary health care for Aboriginal people contributes to poor health status. Lack of meaningful access to primary care is also contributing to a higher dependence by Aboriginal people on hospital-based care,<sup>xxx</sup> a result of failed prevention and the immediate burden of disease. This is expensive to the health care system and less than optimal for the individuals concerned.

Equitable access to appropriate primary health care, complemented by other reforms, has the potential to bring about real long-term improvements to Aboriginal health outcomes.

Organised and comprehensive preventive health care delivered by primary health care services is potentially very cost effective. This is particularly true in delivering comprehensive programs to the Aboriginal population who suffer a greater burden and risk for disease.

When the risk is high, the benefit from an intervention (that is the reduction in absolute risk for the disease) will be greater. This is true when the relative risk reduction of the intervention remains constant (and is independent of risk status) which is usually the case.<sup>xxxi</sup>

For example, screening 20,000 people with a low risk for renal disease will prevent one case of end-stage renal failure (ESRF),<sup>xxxii</sup> but the same screening applied to high-risk Aboriginal clients could prevent at least 40 cases of ESRF. This translates to a considerable reduction in cost relativities.

### ***Funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH)***

The Aboriginal and Torres Strait Islander Health Program administered by OATSIH is only a minute element of Commonwealth health expenditure - only 0.8% in 1995-96<sup>xxxiii</sup>. Most Commonwealth health expenditure on Aboriginal people is through this very small, capped program, which is unable to meet the needs of Aboriginal and Torres Strait Islander people across Australia for adequate access to appropriate primary health care.

Based on annual reporting by the Commonwealth Health Department<sup>xxxiv</sup>, the Commonwealth has gradually increased expenditure over recent years through the Aboriginal and Torres Strait Islander Health Program. However, it is important to note that these increases have not all gone into direct grants to services – indeed, the proportion of OATSIH funding expended as direct grants to services has been decreasing in recent years, as shown by the table below.

### **Direct grants as a proportion of total OATSIH expenditure, 1996-97 to 1998-99<sup>xxxv</sup>**

<b>Financial Year</b>	<b>Total OATSIH expenditure</b>	<b>Direct grants from OATSIH</b>	<b>Direct grants as a proportion of total OATSIH expenditure</b>
1997-98	\$130.6m	\$104.8m	80.2%
1998-99	\$155.0m	\$112.8m	72.8%

### ***Aboriginal access to mainstream programs***

Aboriginal people have a right to equitable access to mainstream programs, and mainstream programs have a responsibility to ensure equitable access for Aboriginal people. There is very clear evidence that Aboriginal access to mainstream Commonwealth health funding programs is extremely limited, and there are concerns about the appropriateness of both

Commonwealth and State funded mainstream services. There are also major queries about the new public health funding arrangements and whether and how these arrangements will address Aboriginal health issues.

### **Aboriginal access to Medicare and the Pharmaceutical Benefits Scheme (PBS)**

The limited Aboriginal-specific health funding provided by the Commonwealth Government is insufficient to meet the high level of unmet need in Aboriginal primary health care, and this funding needs to be seen as a complementary ‘gap-closing’ measure.

Aboriginal people need to also have equitable access to Medicare, which (along with the PBS) is the major source of funding for primary health care for the Australian population. Medicare is intended to be a universal scheme, accessible to everyone in the community as a citizenship right. While Medicare fee-for-service arrangements appear to work fairly well for the general community and mainstream service providers, the model of short consultations in a private practice setting does not fit with the needs of Aboriginal people for holistic, comprehensive care in a culturally appropriate setting<sup>xxxvi</sup>. The result, as indicated by the table below, is that the Commonwealth spends only 27 cents per person from Medicare on Aboriginal and Torres Strait Islander people, for each Medicare dollar spent per head on other Australians<sup>xxxvii</sup>.

### **Estimated benefit payments for Indigenous and non-Indigenous people through Medicare and the Pharmaceutical Benefits Scheme, per person, 1995-96<sup>xxxviii</sup>**

	<b>Indigenous \$</b>	<b>Non-Indigenous \$</b>	<b>Ratio</b>
Medicare	88	331	0.27:1
PBS	27	123	0.22:1

Given the huge excess burden of acute and chronic disease, Aboriginal people should be accessing primary health care at much higher rates than the general community, but they are unable to do this because of the lack of resourcing for appropriate service provision.

Aboriginal people currently have very limited access to mainstream Commonwealth funded health care. Access by Aboriginal people to private general medical practices, which are the first point of contact with the health care system for most Australians, is limited. While the average Australian sees a GP five times per year<sup>xxxix</sup>, Aboriginal and Torres Strait Islander people average fewer than two GP consultations a year<sup>xl</sup>.

Many Aboriginal health services have difficulty attracting and retaining doctors. A 1995 study of the medical workforce in Australia showed that while there was one doctor for each 372 people in Australia overall, Aboriginal communities averaged only one Aboriginal health service doctor for each 676 Aboriginal people.<sup>xli</sup> Aboriginal access to privately practising doctors is also limited, as Aboriginal people often do not attend private clinics for cultural and other reasons, and Aboriginal people are more likely to live in rural and remote areas where there are fewer doctors.

There is an urgent need to increase access by Aboriginal people to appropriate primary health care. The cultural, locational, financial, and other barriers to access by Aboriginal people to mainstream services have been comprehensively described in a recent study<sup>xlii</sup>, and it is clear that for many Aboriginal people these barriers are very significant. In many cases Aboriginal people are not comfortable attending a private general practice, and will do so only where there is no alternative and their health problem has become extreme. Some private medical practices do not bulk bill, and this creates a financial barrier for Aboriginal people, a large proportion of whom experience extreme and life-long poverty. Distance and lack of transport

also represent physical access barriers, particularly (but not only) for Aboriginal people in remote areas.

### ***State/Territory resourcing for Aboriginal and Torres Strait Islander health***

Such resourcing is delivered both through Aboriginal-specific programs, and through the provision of mainstream programs, particularly hospital-based programs, which are accessed by Aboriginal and Torres Strait Islander people.

NACCHO has some concerns about the transparency and accountability of States and Territories for the provision of health care to Aboriginal and Torres Strait Islander people.

The Deeble report estimated total per capita expenditure by States and Territories on the health of Aboriginal and Torres Strait Islander people in 1995-96 at \$1,753 per head, compared with \$785 for each non-Indigenous person, a ratio of 2.23:1<sup>xliii</sup>. The accuracy of this estimate is questionable given that the paucity of data on Aboriginal and Torres Strait Islander uptake of mainstream services (due to the lack of standard protocols for identification of Aboriginality, etc) led to a need to base the estimate on assumptions and projections from the limited robust data available.

However, it is notable that on Deeble's findings, the majority of this expenditure was in the hospital sector (inpatient and outpatient services), and it is certainly likely that Aboriginal people have an uptake of hospital-based care at significantly higher rates than their non-Aboriginal counterparts, due to higher morbidity and lack of access to primary care. This high level of uptake of hospital care inflates the overall expenditure figures for Aboriginal health, concealing the real level of inequality of access to appropriate health care.

The reliance by Aboriginal people on hospital-based care is both expensive to the system and inappropriate for the community. In many cases admission to hospital reflects a failure of early intervention in the primary care setting. For this reason, any consideration of the adequacy of expenditure on Aboriginal health should consider primary care separately from hospital based care, rather than rolling the two together. There is a clear need to shift the emphasis on resourcing for Aboriginal health away from the hospital sector and towards the primary health care sector. This will in many cases require State/Territory Governments to restructure their health care funding and consider cashing out some of the resources currently tied up in hospital based care, so that these resources can contribute to better provision of primary care in the community.

Although Aboriginal and Torres Strait Islander people have relatively high levels of uptake of hospital based services (as outlined above), there are major concerns regarding the appropriateness of and access to hospital-based services. There are also major concerns regarding the quality and cultural safety of State/Territory funded Aboriginal health clinics.

### ***Maldistribution of current funding***

There is an urgent need for funding decisions in Aboriginal health to be based on agreed, effective needs-based planning processes.

Aboriginal access to mainstream health programs (such as private GP care, hospital care, pharmaceutical care), is dependent on the availability and proximity of services, rather than on community need. Compounding this, current funding for Aboriginal-specific health care services is ad hoc and historically based, rather than needs-based.

This has led to a situation where, *within the context where there is vastly inadequate overall funding available for Aboriginal health, and nearly all Aboriginal communities have*



*inadequate access to primary health care*, there are also considerable inequities between Aboriginal communities in terms of their access to health services. The Deeble study confirmed that per-capita expenditures on services to Aboriginal and Torres Strait Islander people vary considerably across States/Territories:

**Gross expenditures on services to Aboriginal and Torres Strait Islander people by State/Territory and Commonwealth Governments, per person, 1995-96<sup>xliv</sup>**

Gross expenditures per person (\$)			
State	Commonwealth		Total
	AMS	Other	
New South Wales	1,334	226	1,669
Victoria	1,326	226	1,870
Queensland	1,518	226	1,891
Western Australia	2,152	226	2,748
South Australia	1,500	226	2,226
Tasmania	1,227	226	1,574
ACT	659	226	979
Northern Territory	3,221	226	3,882
<b>Australia</b>	<b>1,753</b>	<b>226</b>	<b>2,232</b>

Although some of the differences may be attributable to the additional costs of remote area service delivery, these figures indicate the lack of a nexus between population and expenditure, let alone need and expenditure. There have been no mechanisms in the past to measure unmet need in Aboriginal health care, to model the costs of meeting this need, and to ensure equity in overall allocations from all sources. The latter is an important point, as indicated by a recent Audit Office analysis of a sample of services which showed that the OATSIH grant as a proportion of total income varies greatly between services.<sup>xlv</sup> In moving towards needs based funding, the total funding picture will need to be taken into account.

Although all parties acknowledge and agree on the need to move to needs-based funding, progress towards this is painfully slow. A recent Audit Office report noted that OATSIH had no timeframe in place for the implementation of needs-based funding, and recommended that such a timeframe be established.<sup>xlvi</sup>

***Moves towards needs-based planning***

There are several initiatives underway which might assist in the implementation of needs-based funding:

1. The development of regional planning under the Framework Agreements provides an opportunity for all parties to examine current service provision, assess unmet need, and make joint decisions on the equitable allocation of new funding.
2. The implementation of Service Activity Reporting for OATSIH-funded primary health care services also provides an opportunity to identify areas of need, by benchmarking infrastructure and staffing levels against population and throughput figures.
3. OATSIH, in liaison with NACCHO, is also developing an Output Costing Project which seeks to provide better information on the range of comprehensive Aboriginal primary health care outputs and their costs. This is intended to help in establishing what level of funding is needed globally, and for individual components of primary health care, and may help to assess funding requirements in various locations.

However, the availability of new funding is the limiting factor in these efforts. NACCHO has made it clear that it would be unacceptable to attempt to remedy existing funding inequities by redistributing existing funding across States/Territories or across services. Any moves towards needs-based funding must be made through the allocation of new funding to areas of highest unmet need; funding for existing services must not be reduced.

### ***How much new funding is needed?***

Deeble has recently provided the Australian Medical Association with a methodology and calculations for needs-based funding in Aboriginal health, based on available data. Deeble has estimated that an increase of at least \$240 million per year in overall expenditures is required in order to provide a per capita allocation of resources to the health care of Aboriginal and Torres Strait Islander people which is the same as that consumed by other Australians with similar levels of health and socio-economic need.<sup>xlvii</sup>

Needs-based funding cannot be implemented in a context where containment of Government expenditure is the major objective, and funding increases for Aboriginal primary health care are only incremental. Community needs across the country cannot be met within current funding levels. A move to needs-based funding will require a major injection of new resources into Aboriginal health, which in turn will require political will.

## ***Education and Health***

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***The following is an excerpt from a June 1999 NACCHO submission to the Senate Inquiry into Indigenous Education.***

### ***Health Education and Healthy Schools***

There are a range of national public health strategies that seek to achieve collaboration with the education system in their implementation. The National Tobacco Strategy, National Nutrition Strategy, the National Drug Strategy, Illicit Drug Strategy, National Sexual Health Strategy (and the inclusive Indigenous Australian's Sexual Health Strategy) all seek to address preventive health issues through health promoting messages to school-aged children.

A comprehensive mechanism is required to avoid piece-meal and ad-hoc school-based approaches. Health promotion interventions in schools are a key context to reach most children and young people. The National Aboriginal Health Strategy (NAHS, 1989) supported the inclusion of specific subject matter about health within school curriculums.<sup>xlviii</sup>

The World Health Organisation have recommended the promotion of 'life management skills' in schools and this has been encouraged by the Acheson Inquiry in addition to specific and comprehensive 'substance misuse' and 'sex education' health promoting messages.

Healthy schools are also required. In England, children within disadvantaged families on welfare are entitled to a free school lunch. About 15 per cent of pupils receive a free lunch. School lunch is thus an important component of the diet of children from disadvantaged families. Furthermore, it has been recommended that free fruit be available to school-children.<sup>xlix</sup>

In Australia, there is evidence that Aboriginal families go without food because of lack of money. Thirty-three percent of Aboriginal people living in rural areas were worried about going without food.<sup>1</sup>

The school environment, particularly the facilities available to Aboriginal children in rural and remote areas, also needs to be examined. The NAHS recommended that an adequate range of sporting and recreational facilities be available in all Aboriginal communities.<sup>li</sup> The school environment should be seen to encourage healthy living.

#### Summary of Recommendations

The Senate Inquiry into Education give a clear and unequivocal commitment to identify, promote and implement policy that acts to eliminate the health and socioeconomic inequities faced by Aboriginal people and Torres Strait Islanders as a matter of public health urgency and in recognition of the determinants of the poor education of Aboriginal people.

Comprehensive, coordinated and systematic mechanisms to introduce health promotion messages into schools be developed. The key health issues should arise from national public health strategies, be evidence-based, and include issues that affect Aboriginal people.

The school environment should be seen to encourage healthy living and there should be an adequate range of sporting and recreational facilities in schools regardless of the location and size of the school.

The nutrition of Aboriginal children should be enhanced through provision of free school lunches for those Australian children from disadvantaged families.

It is critical that efforts are concentrated on increasing the proportion of Aboriginal children that complete primary and secondary schooling in the first instance but also clearly meet the standards of literacy and numeracy in achieving those education levels.

‘Bridging courses’ are important in enhancing the educational improvement of Aboriginal Health Workers to enable them to attain tertiary level training.

Funding to schools should reflect need and socioeconomic disadvantage. The distribution of educational resources should be calibrated to the levels of disadvantage in the school.

The prevention of poor educational outcomes from hearing loss should be minimised by exploring the access to and utilisation of specialist and rehabilitative services by Aboriginal populations; improving the capacity of comprehensive primary health care services to deliver opportunistic care; optimising the use of hearing aids by Aboriginal children and sound-field amplification devices in classrooms for teaching purposes including the support of family and improving the reliability of devices; and enhancing service provider recognition of chronic otitis media.

<sup>i</sup> Australian Bureau of Statistics/Australian Institute of Health and Welfare (1999), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*.

<sup>ii</sup> Australian Medical Association (February 1998), *Submission to the House of Representatives Inquiry into Indigenous Health*, February 1998.

<sup>iii</sup> Eg *National Aboriginal Health Strategy, Report of the Royal Commission into Aboriginal Deaths in Custody*, etc. *National Aboriginal Health Strategy (1989)*, p.24.

<sup>v</sup> ABS/AIHW (1999), pp.2,15.

<sup>vi</sup> ABS/AIHW (1999), p.134.

<sup>vii</sup> ABS/AIHW (1999), p.46.

<sup>viii</sup> Office of Evaluation and Audit (1999) *Evaluation of the Health Infrastructure Priority Projects Program*, Canberra, ATSC.

<sup>ix</sup> House of Representatives Standing Committee on Family and Community Affairs (1999), *Inquiry into Indigenous Health: Discussion Paper*.

<sup>x</sup> ACT Department of Health and Community Care, quoted in “ACT Parliamentary Inquiry into Indigenous Health: A Submission by Winnunga Nimmityjah Aboriginal Health Service”.

<sup>xi</sup> Radford, A.J., et al (1999), “The ‘Easy Street’ Myth: Self harm among Aboriginal and non-Aboriginal female sole parents in urban state housing”, *Australian and New Zealand Journal of Public Health*, Vol 23, no. 1, pp 77-85.

<sup>xii</sup> Victorian Aboriginal Health Service Co-operative Ltd (June 1999), *Study of Young People's Health and Well-Being*.

<sup>xiii</sup> Victorian Aboriginal Health Service Co-operative Ltd (June 2000) *Study of Young People's Health and Well-Being: The Strengths of Young Kooris*.

<sup>xiv</sup> ABS/AIHW (1999), p.18.

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- <sup>xv</sup> *National Aboriginal Health Strategy (1989)*, p.192.
- <sup>xvi</sup> *National Aboriginal Health Strategy (1989)*, Appendix X, *AMS Redfern Youth Drug and Alcohol Program, Submission, October 1986*.
- <sup>xvii</sup> ABS/AIHW (1999), p.57.
- <sup>xviii</sup> ABS/AIHW (1999), p.58.
- <sup>xix</sup> Correspondence from VAHS to NACCHO, 19 February 2001.
- <sup>xx</sup> ABS/AIHW (1999), p.59
- <sup>xxi</sup> *National Aboriginal Health Strategy (1989)*, p.155.
- <sup>xxii</sup> ABS/AIHW (1999)
- <sup>xxiii</sup> Radford, A.J., et al, *op cit*.
- <sup>xxiv</sup> Keys Young (November 1997), *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*, p.ii.
- <sup>xxv</sup> Keys Young (1997), p.iv.
- <sup>xxvi</sup> ABS/AIHW (1999), p.73.
- <sup>xxvii</sup> Information in this section relating to SAR data is drawn from the Department of Health and Aged Care and NACCHO (2000), "Service Activity Reporting: 1998-1999 Key Results".
- <sup>xxviii</sup> Deeble et al, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, May 1998, p.11 (Table 2.2).
- <sup>xxix</sup> House of Representatives Standing Committee Inquiry into Indigenous Health (September 1999) *Discussion Paper*, Page 8 (2.11).
- <sup>xxx</sup> Deeble et al, *op cit*, p.16 (Table 2.7).
- <sup>xxxi</sup> Glasziou PP, Irwig LM An evidence based approach to individualising treatment. *BMJ* 1995 Nov 18;311(7016):1356-9.
- <sup>xxxii</sup> Barratt A, Craig J, Cumming R, Irwig L, Salked G. A feasibility study of the early detection and treatment of renal disease by mass screening. University of Sydney, Department of Public Health and Community Medicine, October 1999.
- <sup>xxxiii</sup> Joint Commonwealth/NACCHO Aboriginal Health Financing Working Group, Working Paper, 14 April 1998 (unpublished).
- <sup>xxxiv</sup> Annual Reports, Department of Health and Family Services/Department of Health and Aged Care
- <sup>xxxv</sup> Commonwealth Department of Health and Aged Care, *Agreement on Aboriginal and Torres Strait Islander Health: Outcomes Report 1999*, p.8.
- <sup>xxxvi</sup> Keys Young (November 1997), *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*.
- <sup>xxxvii</sup> Deeble et al, *op cit*, p.22 (Table 2.13).
- <sup>xxxviii</sup> Adapted from Deeble et al, *op cit*, p. 22, Table 2.13.
- <sup>xxxix</sup> *The Government's Response to the Reviews of General Practice: General Practice – Foundation for the Future*, (June 1998), p.5.
- <sup>xi</sup> Deeble et al, *op cit*, p.20 (Table 2.11).
- <sup>xii</sup> Australian Institute of Health and Welfare, *Medical Labour Force 1995*.
- <sup>xiii</sup> Keys Young, *op cit*, November 1997.
- <sup>xiii</sup> Deeble et al, *op cit*, p.16 (Table 2.7).
- <sup>xiv</sup> Deeble et al, *op cit*, p. 23 (From Table 2.14)
- <sup>xiv</sup> Australian National Audit Office (November 1998), *The Aboriginal and Torres Strait Islander Health Program, Department of Health and Aged Care*, Audit Report No. 13, Performance Audit, p. 66.
- <sup>xvi</sup> Australian National Audit Office, *op cit*, p. 60.
- <sup>xvii</sup> Deeble, J (April 2000), *How much is needed? A need-based funding formula for Aboriginal and Torres Strait Islander Health* (commissioned by the Australian Medical Association)
- <sup>xviii</sup> National Aboriginal Health Strategy (NAHS) Working Party. National Aboriginal health strategy working party report. AGPS, Canberra, 1989 Page 111.
- <sup>xix</sup> Acheson D. *Op. Cit*.
- <sup>i</sup> Madden R. National Aboriginal and Torres Strait Islander Survey 1994.
- <sup>ii</sup> NAHS page 135.