



NATIONAL RURAL  
HEALTH  
ALLIANCE INC.

## **Position Paper**

# **The health of Aboriginal and Torres Strait Islander Australians**

November 2006

*This Position Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.*

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# The health of Aboriginal and Torres Strait Islander Australians

## Executive summary

The state of Indigenous health in Australia remains unacceptably poor. Indigenous males and females die at almost three times the rate of non-Indigenous males and females, according to Australian Institute of Health and Welfare data. Indigenous Australians have higher rates of mortality from all major causes of death, with Indigenous males and females dying of endocrine, nutritional and metabolic diseases (including diabetes) at around seven and 11 times, respectively, the rates for non-Indigenous males and females.

Although statistically incomplete, hospital separation data for 1999–2000 clearly show that Indigenous Australians were admitted to hospital more frequently than non-Indigenous Australians. The rate of overall hospitalisation was two to four times higher for people identified as Indigenous living in the Northern Territory, Western Australia, South Australia and Queensland compared to non-Indigenous people for these jurisdictions.

Despite evidence of improvement in some aspects of the health status of Indigenous Australians, a great deal more needs to be done as a matter of urgency.

This Position Paper puts the Alliance's views on the public record with respect to Indigenous health. Seventy per cent of Australia's Indigenous people live outside the major cities—in regional, rural and remote areas. Indigenous health is therefore a vital rural health issue—and anyone concerned with the health of people in non-metropolitan areas has to be concerned with Indigenous health.

However, despite the ambit of the Alliance's work, this paper necessarily deals with the general Indigenous health situation—not its status specifically in rural areas. This is largely because, as one moves to areas of greater remoteness, the data on 'Indigenous health' become less available and less reliable. This does not weaken the Alliance's case, however, for the Indigenous health and well-being challenges of rural areas are the same as in the cities, only writ larger: exacerbated by poorer access, fewer services and staff, poorer physical infrastructure and higher unit costs of delivering any given bundle of health care.

A whole-of-government approach, including co-ordination between government departments and across Commonwealth, State, Territory and local governments, must be sustained. Robust and comprehensive public policy is necessary. This will ensure that linkages between government and Aboriginal and Torres Strait Islander communities and organisations in the not-for-profit sector, the wider community, and the private sector, are strengthened so that Indigenous Australians are better

able to participate in and contribute to the social and economic wealth of this country.

The Alliance accepts the following definition of health for Indigenous Australians:

Aboriginal health is not just the physical wellbeing of an individual. It is the social, emotional and cultural wellbeing of the whole community, where each individual is able to achieve their full potential. It is a whole-of-life view and includes the cyclical concept of life-death-life.<sup>1</sup>

In accepting this it must be noted that, while child and maternal health is a specific area in which improvements would contribute to better adult health, further significant investment in health services alone will not deliver substantive or cost-beneficial improvements in health outcomes. Partnerships addressing the wider determinants of health must be forged.

Three general proposals that would be of great help are:

- greater investment in quality data and their analysis to enable better measurement of relevant health determinants and the health status of Indigenous Australians
- a multi-sectoral approach to the development and application of a comprehensive social policy framework that can deliver improvement in determinants of health as they affect Indigenous Australians
- continued investment by government in collaboration with Indigenous Australians to ensure Indigenous human, produced, natural and social capital are valued and developed in a culturally secure manner.

A range of specific issues is detailed in this paper, drawing from existing Alliance publications, together with proposals for a number of more specific recommendations.

## Introduction

### Aim

The National Rural Health Alliance is committed to promoting increased awareness of the urgent need to improve the health of Aboriginal and Torres Strait Islander Australians. In order to close the gap between Indigenous<sup>2</sup> Australians' health status and that of other Australians within a reasonable timeframe, effective health policy must ensure ease of access for Indigenous people to adequate and appropriate treatment for existing illness, as well as to appropriate preventive programs. It must also address 'upstream' issues such as transportation and communication.

Although some progress has been made, Indigenous Australians continue to have poorer health outcomes than the Indigenous people of comparable countries, and

the gap between the health outcomes of Indigenous and non-Indigenous Australians remains substantial.

Indigenous aspects of health issues are embedded in most of the Alliance's existing policy statements. The purpose of this paper is to present the Alliance's consolidated policy position on Aboriginal and Torres Strait Islander people's health; and to provide a series of recommendations that, if implemented and monitored, will support genuine improvement in their health.

## Background

The health profile of Aboriginal and Torres Strait Islander Australians is very different from that of other Australians. Aboriginal and Torres Strait Islander Australians have poorer life expectancy, higher infant mortality—three times that of the general population—and adult mortality that is most marked in early adulthood to middle age. In contrast, the overall Australian population has one of the highest life expectancies on earth, relatively low infant mortality, and death rates for persons aged 35–44 and 45–54 years that are five times less than those recorded for Indigenous Australians.<sup>3</sup>

A 2004 Canadian study showed that the quality of life of Aboriginal and Torres Strait Islander people is the second worst on earth—just ahead of China—whereas non-Indigenous Australians' quality of life ranked fourth in the world after Norway, Iceland and Sweden.<sup>4</sup>

As at June 2001<sup>5</sup> Indigenous population of Australia was estimated to be 460 140, or 2.4% of the total Australian population.<sup>6</sup> Recent censuses show that the Indigenous population is growing steadily and at a greater rate than the non-Indigenous population. Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW) data predict that, based on current birth and mortality rates, the Indigenous population will have increased to between 492 700 and 525 000 by mid-2005.<sup>3</sup>

ABS data show that the majority of Aboriginal and Torres Strait Islander Australians live in south-eastern Australia.<sup>6</sup> New South Wales (NSW) has the largest resident Indigenous population—29% of the total Indigenous population, followed by Queensland (Qld) with 27%, Western Australia (WA)—14%, the Northern Territory (NT)—13%, Victoria (Vic)—6%, South Australia (SA)—6%, Tasmania (Tas)—4%, and the Australian Capital Territory (ACT)—0.9%. However, overall, Aboriginal and Torres Strait Islander people are a small proportion of the total population of most States and Territories, e.g. 2% in NSW and 3.5% in both Qld and WA. In contrast, in the NT Indigenous people—predominantly Aboriginal—comprise 29% of the population.

Torres Strait Islander people, culturally different from Aboriginal people, comprise 11% of the total Indigenous population and 26% of the Indigenous population in Qld. More than half (59%) of the Torres Strait Islander population live in Qld with 14% living on the islands of the Torres Strait. The remaining Torres Strait Islander population is spread across the other States and Territories with 18% in NSW.<sup>3</sup>

In 2001, 30% of the Indigenous population lived in major cities, 43% in regional areas and 26% in remote areas. Indigenous Australians are more likely than non-Indigenous Australians to live in non-metropolitan areas. ABS/AIHW data show that:

... approximately two-thirds (67%) of non-Indigenous people lived in major cities and only 2% lived in remote areas. As a result of these differences in distribution, the proportion of the population who were Indigenous varied from less than 1% in major cities to 58% in remote areas. In the Northern Territory, the majority of Indigenous people lived in remote areas (81%).<sup>3</sup>

The Indigenous population is much younger than the non-Indigenous population, with a median age of 21 years and 36 years respectively. These figures reflect the relatively high fertility rates of Indigenous women, as well as the higher number of Indigenous people who die in early adulthood to middle age. In 2003, the fertility rate for Indigenous women was estimated to be 2.15 children compared with 1.76 children for non-Indigenous women.<sup>3</sup> Indigenous women also commence childbearing at a younger age, and babies of Indigenous mothers are twice as likely (13% of births) to be of low birth weight<sup>7</sup> as those of non-Indigenous mothers (6%).<sup>3</sup>

## **Health status of Aboriginal and Torres Strait Islander Australians**

Among the factors identified as significant contributors to the high levels of morbidity and the early age of death of Indigenous Australians are:

- poor antenatal care
- poor child health
- chronic disease
- lack of access to appropriate health care
- other determinants, including cultural dispossession, social dislocation, poverty, poor housing, poor access to good food, poor education and lack of employment.

### ***Life expectancy***

The life expectancy at birth for Indigenous Australians born between 1996–2001 is estimated to be 59.4 years for males and 64.8 years for females, compared to 76.6 years for all Australian males and 82.0 years for all Australian females born between 1998–2000. This is a difference of approximately 17 years for both males and females.<sup>3</sup>

The life expectancy of Indigenous Australians is less than that for Indigenous populations of comparable countries such as the United States, Canada and New Zealand.<sup>8</sup> Cooke et al. in their study, *Measuring Aboriginal Well-Being in Four Countries*, report that of the Indigenous populations of the four countries',



Canada's had the highest life expectancy at 72.9 years, followed by New Zealand's at 72.1, then the United States' at 70.6, with Australia's having the lowest.<sup>4</sup>

### ***Mortality***

There are substantial differences in the rate and age of death for Indigenous and non-Indigenous Australians. ABS/AIHW data show that for the period 1999–2003:

Indigenous males and females died at almost three times the rate of non-Indigenous males and females. Indigenous Australians also had higher rates of mortality from all major causes of death. For example, mortality rates for Indigenous males and females for endocrine, nutritional and metabolic diseases (including diabetes) were around seven and 11 times, respectively, those for non-Indigenous males and females.<sup>3</sup>

In the period 1999–2003, the mortality rate for Indigenous infants in WA, SA, Qld and the NT<sup>9</sup> was almost three times that for non-Indigenous infants. However, there were major falls in Indigenous infant mortality rates between 1991 and 2003. The death rate of Indigenous children (under 15 years) is around two to three times that of other Australian children.<sup>10</sup>

Death rates for the 35–44 and 45–54 years age groups were five times those recorded for non-Indigenous Australians.<sup>3</sup> However, the AIHW notes that overall death rates for Indigenous Australians in WA fell significantly between 1991 and 2003.<sup>10</sup> There is also evidence of declining mortality rates in the NT, particularly in the 0–5 age group.<sup>11,12</sup> These declines are attributed to improvements in primary health care services.

Mortality rates for Indigenous Australians are higher than those of Indigenous populations in comparable countries. Ring and Firman note that:

In 1990–94, the average Australian Indigenous mortality rate (for all causes) was 1.9 times the Maori rate, 2.4 times the American indigenous rate and 3.2 times the rate for the total Australian population ... While data problems give rise to a need for caution, the Australian Bureau of Statistics ... concluded that data problems could not entirely explain the differences.<sup>13</sup>

Lewis notes that Indigenous Australians “die as younger adults, at ages ten to fifteen years younger than members of comparable Indigenous populations overseas”.<sup>14</sup>

### ***Leading causes of death***

In 1999–2003, the three leading causes of death for Aboriginal and Torres Strait Islander people resident in Qld, SA, WA and the NT were diseases of the circulatory system, external causes of morbidity and mortality (predominantly accidents, intentional self-harm and assault) and neoplasms.

### ***Morbidity***

Although they are not comprehensive, hospital separation data give an indication of morbidity rates. The ABS/AIHW notes:

Hospital morbidity collections are limited to information about the reasons for which people are hospitalised and the procedures they undergo in hospital and do not include information on those who access other health services, such as general practitioners and community health clinics, those who have not accessed health care at all and non-admitted hospital services. Other factors, such as availability of and access to other medical services, may influence hospital utilisation; as may social factors relating to culture, socioeconomic status of patients, transport availability and the ability to speak English.<sup>15</sup>

Hospital separation data for 1999–2000 show that Indigenous Australians were admitted to hospital more frequently than non-Indigenous Australians—even allowing for a significant under-identification of Indigenous Australians in the data. The rate of hospitalisation was two to four times higher for people identified as Indigenous living in the NT, WA, SA and Qld compared to non-Indigenous people for these jurisdictions.<sup>15</sup>

### ***Leading causes of morbidity***

ABS/AIHW data show:

... that the conditions which account for most of the consultations by Indigenous Australians with General Practitioners, and are the main reasons for hospitalisation of Indigenous Australians, are circulatory diseases, diabetes, respiratory diseases, musculoskeletal conditions, kidney disease, eye and ear problems and mental and behavioural disorders.<sup>3</sup>

## **Recommendations addressed to governments**

The Alliance acknowledges that health is a different cultural construct for Aboriginal and Torres Strait Islander Australians, and is based on a whole-of-life perspective. The Alliance asserts the right of all Aboriginal and Torres Strait Islander people to have access to culturally appropriate primary health care. It also asserts that all Indigenous people, especially the aged, mothers, infants and children, have a right to live in a safe environment, free of violence and coercion, which will enhance their good health.

At the end of this paper are eleven actions to which the Alliance itself commits as part of its effort to improve the health of Indigenous Australians. In addition, there is much that can be done by governments and other authorities. The Alliance recommends as follows:

1. The number of community-controlled primary health care services should be increased, and access to Indigenous health professionals for such services improved, in line with current need and the continued growth of the Aboriginal and Torres Strait Islander population.

2. Given the practicality and effectiveness of having Indigenous people obtaining health advice and treatment from Indigenous health workers, a career structure for the Aboriginal and Torres Strait Islander health workforce should be introduced that supports the development of extended skills into areas such as maternal and infant health, and mental health.
3. Governments should invest in the economic development of rural and remote communities, and of Indigenous communities, as an essential part of medium-term plans to improve the health and well-being of Indigenous people.
4. When Indigenous health services are expanded and new programs developed, service providers must be given appropriate staff in adequate numbers and sufficient recurrent funding for the programs to be effective and sustainable.
5. Additional culturally appropriate Healthy Mothers, Healthy Babies programs should be in place so that as many Indigenous mothers as possible have access to a program that they will be comfortable attending throughout pregnancy and beyond.
6. Given the evidence of stark differences between the dental health of Indigenous and non-Indigenous children and adults, additional funding should be provided by governments for specific programs targeting Indigenous Australians' oral health needs.
7. An increased number of oral health programs should be available through community-controlled health services for Indigenous people in rural and remote areas; and a national initiative put in place to recruit Indigenous students to the disciplines of dentistry and dental health and hygiene.
8. Training, recruitment, retention and support strategies should be developed and implemented to increase the numbers of Aboriginal and Torres Strait Islander people qualified to undertake social and emotional well-being work.
9. Increased funding to assist with the implementation and monitoring of suicide prevention programs for Aboriginal and Torres Strait Islander people ought to be provided by all levels of government.
10. There should be additional funding for Indigenous substance misuse programs, including more Aboriginal and Torres Strait Islander Substance Use Services in rural and remote areas.
11. Governments must work with local communities on the question of how to give people in remote settlements access to basic services, as one of the fundamental rights of Australian citizenship. Of particular importance are adequate housing, reliable supplies of fluoridated water and electricity, satisfactory sewerage and drainage systems, education, transport, employment and telecommunications.
12. The importance of the existing Aboriginal and Torres Strait Islander Flexible Services program must be acknowledged, with more research to be conducted into the aged care requirements of Indigenous Australians and their carers,

taking into account the unique cultural requirements and differing nature of such care.

13. Research should be undertaken into programs for older Aboriginal and Torres Strait Islander Australians that are aimed at maintaining their functionality and independence, and into appropriate carer support programs for Aboriginal and Torres Strait Islander Australians.
14. Governments must continue to develop strategies and incentives for:
  - Indigenous students at primary and secondary school levels to be targeted for entry into relevant health studies
  - more Indigenous students to be retained in health studies
  - greater motivation to be provided for Indigenous health professional graduates to practise in rural and remote areas.
15. The patient accommodation and transport schemes in all States and Territories should be user-friendly for Aboriginal and Torres Strait Islander people, and practical, culturally specific strategies developed to improve promotion of the schemes and information about them.
16. Indigenous Australians in rural and remote areas must have access to appropriate telecommunications technology, thereby improving access to education and employment opportunities and improving health outcomes.

## Policy areas

The Alliance acknowledges that service delivery to Indigenous Australians must be underpinned by Aboriginal and Torres Strait Islander people's concept of health, as outlined in the National Aboriginal Health Strategy.

Aboriginal health is not just the physical wellbeing of an individual but is the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.<sup>16</sup>

In addition, all health service delivery, whether specifically for Indigenous people or (so-called) mainstream programs, must accord with the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* endorsed by the Australian Health Ministers' Advisory Council (AHMAC).<sup>17</sup>

Key factors in ensuring better health outcomes for Indigenous Australians are disease prevention and early diagnosis, combined with well-managed care across the disease continuum starting with ease of access to culturally appropriate primary health care.<sup>18</sup>

Since the late 1990s the Alliance has published a number of Position Papers dealing with issues that impact upon the health of Aboriginal and Torres Strait Islander Australians living in regional, rural, and remote areas. The most important include those on:

- maternal, infant and child health (2003)
- oral and dental health in rural communities (1998, 2001 and 2005)
- drugs and alcohol in rural Australia (1998)
- suicide prevention in rural areas (2000)
- mental health in rural areas (2003)
- rural aged care (2005)
- health workforce issues (a number of separate papers)
- transport and accommodation assistance for patients (2005)
- telecommunications (2005).

## **Chronic disease**

Aboriginal and Torres Strait Islander Australians have high rates of chronic disease. The impact of low birth weight, poor childhood nutrition and high infection rates on the development of chronic disease has been noted. These effects are compounded by high levels of risky behaviours:

Although intra-uterine growth retardation due to poor maternal health and/or nutrition is an important factor in the onset and incidence of chronic disease in mid-life, so too are factors such as diet at all ages, cigarette smoking, a sedentary lifestyle and the use of drugs and other substances.<sup>19</sup>

Four chronic diseases are known to have a major impact on the health of Indigenous Australians: cardiovascular disease, diabetes, kidney disease and mental illness.<sup>3</sup> There is a high prevalence of these conditions and they often occur as co-morbidities, yet chronic diseases are preventable and responsive to early intervention. Aboriginal and Torres Strait Islander people living in areas where primary health care services are accessible and culturally appropriate can have chronic diseases detected early and managed more effectively.<sup>8</sup>

## **Maternal, infant and child health**

The Alliance reaffirms the position it set out in *Child and Adolescent Health in Rural and Remote Australia*:

The elevated infant mortality, hospitalisation and other indicators in remoter areas are largely due to the health status of Aboriginal and Torres Strait Islander children living in these areas.<sup>20</sup>

ABS/AIHW data show that the maternal mortality ratio for Aboriginal and Torres Strait Islander women is more than three times that for other Australian women.<sup>21</sup>

Good nutrition and antenatal care are essential to maternal as well as foetal and infant health.

Evidence shows that low birth weight and poor infant growth have lasting effects on the overall health outcomes of individuals. Indigenous infants are more likely than non-Indigenous infants to have low birth weight, malnutrition and high rates of infection. These factors contribute to the onset of chronic disease in later life and are identified as leading to the development of insulin resistance syndrome, which:

... occurs in all populations exposed to western lifestyle, but is particularly evident in indigenous populations exposed to rapid lifestyle change in the 20th century. This syndrome becomes evident after the transition from a traditional to an 'urbanised' or 'westernised' lifestyle and includes high rates of obesity, Type 2 diabetes and cardiovascular and renal disease.<sup>22</sup>

Many factors that impact on infant and child health originate during gestation and are linked with maternal health-related behaviours and health-risk factors. Poor nutrition during pregnancy can affect foetal development and growth, and smoking and excessive alcohol consumption during pregnancy can cause foetal death, premature birth and low birth weight. Foetal alcohol spectrum disorder may also result from excessive alcohol consumption.

Aboriginal and Torres Strait Islander children have the poorest health of all Australian children, and have higher death rates than those of non-Indigenous children of the same age. Infectious illnesses are more prevalent among Indigenous children and greatly impact on overall health. In 2002–03, the hospital separation rate for Indigenous children aged less than four years for infectious diseases (111 per 1000 people) was more than twice the rate for other children (48 per 1000 people).<sup>23</sup> For example, Gracey et al. showed that, in WA, gastroenteritis occurred eight times more frequently in Indigenous than non-Indigenous children.<sup>24</sup> Ear infections are also more common. In 2002–03 hospital separations for suppurative and unspecified otitis media were higher for Indigenous children aged 0–3 (5 per 1000) than other children in this age group (4 per 1000).<sup>23</sup>

### ***Key interventions***

#### *Early intervention*

Improving Indigenous women's access to maternal and child health programs is a priority in rural and remote areas. Antenatal programs can reduce the incidence of low birth weight and excessive infant mortality. These programs must reflect the different needs of Aboriginal and Torres Strait Islander mothers, infants and children in remote areas arising from issues such as cultural and language differences, poor communication, poverty, environmental considerations and lack of educational opportunities.

Among the identified reasons that Aboriginal and Torres Strait Islander women present late and in low numbers for antenatal care are:

- antenatal services are difficult to access (sometimes requiring travelling long distances and away from family support)
- services that are available can be culturally intimidating.<sup>25</sup>

A recent literature review on improving the health of Aboriginal and Torres Strait Islander mothers, babies and young children identified a number of common factors that, if included in maternal and child health services, are likely to improve health impacts and outcomes.<sup>26</sup> These factors include:

- a community base and/or community control
- a specific service location intended for women and children
- providing continuity of care and a broad spectrum of services
- integration with other services (e.g. hospital liaison, shared care)
- outreach activities
- home visiting
- a welcoming and safe service environment
- flexibility in service delivery and appointment times
- a focus on communication, relationship building and development of trust
- respect for Aboriginal and Torres Strait Islander people and their culture
- respect for family involvement in health issues and child care
- having an appropriately trained workforce
- valuing Aboriginal and Torres Strait Islander staff and female staff
- provision of transport
- provision of childcare or playgroups.

#### *Healthy mothers, healthy babies programs*

Post-natal and ongoing child care, including good nutrition, are vital across the infancy/childhood cycle. It is important that mothers know what constitutes good maternal nutrition and understand the dangers surrounding poor infant/child nutrition during the weaning process. They need to be aware of the threat of infectious diseases from poor hygiene in food preparation and know how to counteract it. The development of culturally appropriate Healthy Mothers, Healthy Babies programs has been shown to improve maternal and infant health outcomes, and where such programs are available they have been well utilised, resulting in improved health outcomes.<sup>8,26</sup>

#### *Healthy families*

Indigenous mothers, infants, children and families in general have a right to live in a safe environment, free from violence and coercion, that will enhance their good health. The violence existing in many disadvantaged communities needs to be addressed at the community level, through programs aimed at improving social cohesion and overcoming poverty and social exclusion. These programs would include those (most importantly) for education and employment, and also for the

development of social capital, such as sport, recreation and leisure pursuits. There should also be opportunities to participate in relevant cultural traditions and ceremonies, and music and language rituals.

## Oral health

Oral disease is a significant, mostly preventable, health burden that is linked to the onset and exacerbation of chronic disease. It is a priority policy area for the Alliance.

Aboriginal and Torres Strait Islander communities are at significant risk of poor oral health, experiencing dental decay at higher rates than non-Indigenous populations. ABS/AIHW data show that for 2003–04 there were approximately 2000 hospitalisations of Indigenous people for diseases of the oral cavity, salivary glands and jaw.<sup>3</sup> The data also indicate that oral health problems are greater for Indigenous children than for non-Indigenous children across all age groups. Oral health is included as a key priority health issue in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by governments*.<sup>27</sup>

The Alliance reaffirms the policy position outlined in *Public dental services in Australia—whose responsibility?* In particular, the recommendation that:

... greater funding for specific programs targeting Indigenous Australians is needed, as evidenced by the stark differences between the dental health of Indigenous and non-Indigenous children.<sup>28</sup>

The Alliance emphasises the need to increase the number of community-controlled health services capable of providing appropriate primary (including preventive) oral health care services for Indigenous people in rural and remote areas. It stresses the need for increased recruitment of Indigenous students into the health disciplines of dentistry and dental health/hygiene. It supports the key role of Aboriginal and Torres Strait Islander health workers in the delivery of preventive oral health programs to Indigenous people and communities. Further, it notes the absence of fluoridation in the water supply of many small and remote communities and the subsequent lack of preventive benefit to Indigenous and non-Indigenous residents in those communities in relation to oral and dental health.

The Alliance supports the following goals developed and endorsed at the National Aboriginal and Torres Strait Islander Oral Health Workshop held in 2002:

Provide culturally appropriate oral health services to all Aboriginal and Torres Strait Islander people;

Increase the oral health workforce available to improve the oral health of Aboriginal and Torres Strait Islander people;

Increase oral health promotion activity with the aim of improving health outcomes for Aboriginal and Torres Strait Islander people;



Improve the collection, quality and dissemination of oral health information about Aboriginal and Torres Strait Islander people; and

Foster the integration of oral health within health systems and services, particularly with respect to primary health care and Aboriginal and Torres Strait Islander people.<sup>29</sup>

## Mental health

The World Health Organization reports that determining the full burden of mental illness within communities is very difficult due to issues such as different classification systems and the social stigma still attached to mental illnesses. However, it notes that five of the ten leading causes of disability worldwide are identified as mental disorders:

... major depression, alcohol use, bipolar disorder, schizophrenia and obsessive compulsive disorder. Depression is estimated to be the leading cause of DALYs [disability adjusted life years] lost in the world in the 15–44 age group and the leading cause of disability (YLD) [years of life lost to disability] in the entire world ...<sup>30</sup>

The true burden of mental illness among Aboriginal and Torres Strait Islander Australians is not known. Many Indigenous people are not admitted to hospital for treatment for acute severe mental illness, and when they are there is under-identification of Indigenous patients in the data. Even so, there are more hospitalisations of Indigenous Australians than other Australians for most types of mental and behavioural disorders. In particular, hospitalisation of Indigenous males and females for “mental and behavioural disorders due to psychoactive substance use” is around four and three times the rate for non-Indigenous males and females respectively. Hospitalisation rates for mental and behavioural disorders were highest among people aged 25–44 years, where rates for Indigenous males were three times those for other males, and rates for Indigenous females were twice those for other females.<sup>3</sup>

The Alliance has outlined its general position on mental health in rural and remote Australia in *Mental health in rural areas*.<sup>31</sup> Evidence quoted in the paper regarding factors leading to mental illness applies equally to the Indigenous population and, in addition, there is evidence of the impact on mental health of social factors specific to Indigenous Australians. For instance a 2005 WA study found that:

... members of the Stolen Generation were generally more likely to live in households where there were problems related to alcohol abuse and gambling. They were less likely to have a trusting relationship and more likely to have been arrested for an offence. They were more likely to have been in contact with mental health services. Children of members of the Stolen Generation had a much higher rate of emotional and behavioural difficulties and had high levels of alcohol and other substance abuse compared to Aboriginal children whose parents were not a member of the Stolen Generation.<sup>32</sup>

The Alliance recognises that the problems faced by Aboriginal and Torres Strait Islander people with mental disorders are exacerbated in rural and remote areas by poor access to appropriate primary health care and specialist mental health services. The difficulties identified in the 2003 paper regarding recruitment of mental health professionals are pertinent to services for Aboriginal and Torres Strait Islander people, but with the added dimension of a significant lack of Indigenous health professionals. As the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* points out:

Increasing the numbers of Aboriginal and Torres Strait Islander people qualified to do social and emotional well being work requires specific strategies to enhance recruitment, retention and support to students ... On-the-job and informal training, recognition of existing personal and cultural skills and articulation of training provided in the Vocational Education and Training sector within the tertiary sector is required.<sup>33</sup>

The Alliance re-emphasises the critical role of Aboriginal and Torres Strait Islander health workers in mental health service delivery, and the ongoing need to broaden their skills. As Robinson et al. point out:

Clinical practice is only a part of the role of the AMHWs [Aboriginal mental health workers]: their ability to develop skills in counselling and in health promotion, education and community liaison are equally important. GPs all point to the fact that much of what they see is not necessarily amenable to medical treatment, and that the most important priorities for their communities are in the areas of community development, engagement of community leadership to address alcohol and drug misuse, child welfare, family violence and suicide prevention, with perhaps some role for traditional authority as a basis for health promotion and community education, and so on. The AMHWs firmly stated that problems such as marijuana smoking, suicide and risk taking behaviour among the young, petrol sniffing, alcohol abuse and domestic violence were among their greatest concerns. These concerns extend well beyond the area of clinical practice ...<sup>34</sup>

## Suicide

The report *Overcoming Indigenous Disadvantage: Key Indicators 2005*, notes that:

Suicide death rates were much higher for Indigenous people (between 12 and 36 per 100 000 people) than other people (between 11 and 16 per 100 000 people) in 1999–2003, in most States and Territories for which data are available. Between 2001–02 and 2002–03, the age standardised hospital separation rate (admissions) for intentional self-harm increased for Indigenous people from 2.8 to 3.2 per 1000 people, while it remained the same for other people.<sup>23</sup>

ABS/AIHW data show that intentional self-harm (including suicide) was the leading external cause of death for Indigenous males for the 1999–2003 period. The suicide rate was more than twice that for non-Indigenous males. The suicide

rate for Indigenous females aged 0–24 years was five times the corresponding age-specific rate for non-Indigenous females.<sup>3</sup>

Factors identified with increased risk of suicide include: mental illness, family problems, physical and/or sexual abuse, issues of sexuality, poverty, homelessness and substance misuse.<sup>35</sup> Added factors for Aboriginal and Torres Strait Islander people include cultural dispossession and forced family dislocation.

The Alliance Position Paper, *Suicide prevention in rural areas*, addressed the issue of the rising incidence of suicide in rural and remote Australia and in it the Alliance undertook to:

Lobby for funding from the Federal Government to undertake further research to assist with the development of suicide prevention programs for men in rural and remote areas, and for Aboriginal and Torres Strait Islanders.<sup>35</sup>

Since 2000, there have been a number of new initiatives targeting suicide in Aboriginal and Torres Strait Islander communities implemented by the Australian Government, including:

- Key Result Area 4 of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by governments* targets mental health, suicide, alcohol and substance misuse and family violence issues, including child abuse
- a range of other initiatives—including local ones—targeting suicide reduction are outlined in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009*.

The Alliance supports these initiatives but notes that funding and other resources in this area, as in many other areas, are currently inadequate to deal with the magnitude of the problem.

## **Alcohol and other drugs**

The joint ABS/AIHW report shows that for 2002, approximately one in six Indigenous people (15%) aged 15 years or over reported risky/high-risk alcohol consumption in the last 12 months.<sup>3</sup> The rate of risky/high-risk consumption was higher for Indigenous males than for females and peaked among those aged 35–44 years (20%).

Alcohol, other drugs or a mixture of both are thought to be major contributing factors in the high rates of external causes of morbidity and mortality for Aboriginal and Torres Strait Islander people, being linked to road injuries, falls, burns and suicide. Excessive alcohol consumption is a key risk factor in the development of chronic diseases such as liver disease and diabetes. Alcohol and other drugs are also linked to domestic violence leading to injury. The ABS/AIHW

report notes that “alcohol ... has the potential to evoke anti-social behaviour, domestic violence and family breakdown”.<sup>3</sup>

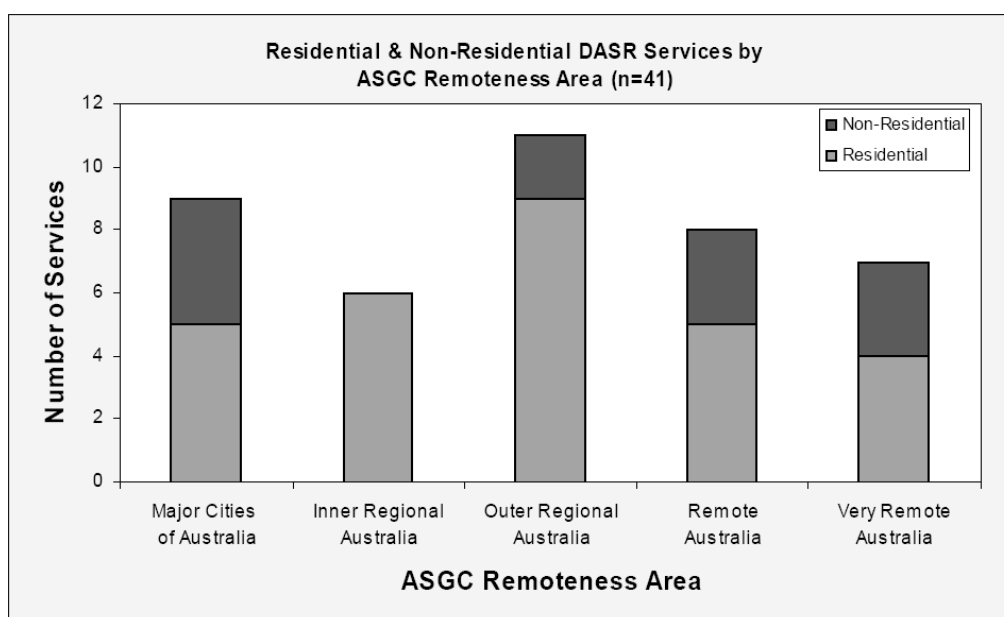
Yet overall, Indigenous people are less likely than non-Indigenous people to drink alcohol—in 1993 and 1994 for example, 33% of the urban Indigenous population were current regular drinkers, compared with 45% of the non-Indigenous population.<sup>36</sup>

The *2003–2004 Drug and Alcohol Service Report (DASR)*, which collects data from Australian Government funded Aboriginal and Torres Strait Islander Substance Use Specific Services, shows that:

... 36 DASR Services (88%) indicated that alcohol was the one substance/drug that affected the largest number of their clients. Of the remainder of Services, 2 (4.9%) reported that the substance/drug that affected the largest number of clients was petrol, 1 (2.4%) reported this to be cannabis, multiple drug use or amphetamines.<sup>37</sup>

According to the 2003–2004 DASR there are 42 Australian Government funded Aboriginal and Torres Strait Islander Substance Use Specific Services. Other community-controlled primary health care services and State and Territory health services also provide substance use services, but their data are not included in this survey. Figures from the report show that the distribution of DASR by geographic area is comparatively uniform (Figure 1), although the overall number of services is relatively small, given the size of the problem. An extension of these services in rural and remote areas, as well as the effective delivery of culturally appropriate preventive and curative programs across all primary health care services, remains a key priority in this area of Aboriginal and Torres Strait Islander health care.

**Figure 1** Number of respondent DASR services (residential and non-residential) by remoteness area



Source: OATSIH (2005)

## Socio-economic determinants

Dwyer et al. note that:

Health is determined by environmental, social, economic and biological factors, and health care alone is not the answer to any community's health problems. Indigenous people's health in particular is affected by the history of colonisation, and the ensuing economic and educational disadvantage, cultural dislocation, social exclusion, remoteness and other factors specific to their situations.

Both Indigenous and other commentators refer to a failure of public policy to address the broader social, economic and cultural determinants of poor health outcomes for Indigenous Australians. The deep and widespread problems of poverty, breakdown in family relationships and family violence, youth alienation, and abuse of alcohol and drugs have complex causation.<sup>8</sup>

The structural determinants that significantly impact on the health of Aboriginal and Torres Strait Islander Australians include:

- socio-cultural factors—including social exclusion and cultural dislocation, as well as issues of language and communication
- environmental factors—including poor housing, inadequate hygiene, overcrowded housing, stress, exposure to violence, and removal from family impacting across generations. Nearly a third of Australian households living in impoverished houses are Indigenous; and Indigenous Australians also have higher rates of overcrowding and homelessness. The ABS/AIHW note that Aboriginal and Torres Strait Islander people, in particular those living in remote communities, do not have adequate quality housing, reliable supplies of water and electricity, or adequate sewerage and drainage systems, all of which are relevant to health<sup>38</sup>
- low socio-economic status—Aboriginal and Torres Strait Islander Australians suffer disadvantage in the areas of education, income and employment—all factors known to affect health status. The 2001 census data show high rates of unemployment, low weekly income and poor education outcomes for Indigenous compared to non-Indigenous Australians<sup>39</sup>
- behavioural risk factors—including inappropriate diet (in rural and remote areas this can be related to lack of access to fresh food), smoking, alcohol, other drug use and lack of physical activity. These all have a marked effect on the health outcomes of Indigenous Australians and are linked to the preceding factors.

The Alliance reaffirms its position on these issues, as outlined in *Rural Health: 30% Fair Share*.<sup>35</sup> Its findings are of particular importance to the health of Aboriginal and Torres Strait Islander people living in rural and remote areas:

Health status is closely linked to socio-economic and employment status, social and geographic location and education level. It is therefore impossible to consider health in isolation from other social and economic factors. Rural

and remote areas need their 30% fair share of allocations to physical and human infrastructure, as well as a loading to reflect the higher cost of infrastructure development and its poorer status. The most important parts of this infrastructure are education, transport and telecommunications.

The Alliance considers that funding allocations for Aboriginal and Torres Strait Islander communities living in rural and remote areas must take into account the added burden of poorer health status and the slow rate of improvement to that status compared with other Australians.

## Aged care

ABS/AIHW data show that:

... Aboriginal and Torres Strait Islander people utilise aged care services at a younger age, consistent with poorer health status and lower life expectancy. Of those admitted to permanent or respite residential care during 2003–04, almost 29% were under 65 years of age, compared with fewer than 5% of other Australians. Of all Indigenous Australians receiving Community Aged Care Packages at 30 June 2004, 46% were aged below 65 years compared with 8% among other Australians. Of all clients receiving home and community care, 18% of Indigenous clients were aged 75 years or over compared with 57% of other clients.<sup>3</sup>

The Alliance's position on aged care is presented in *Older people and aged care in rural, regional and remote Australia*.<sup>28</sup> The agendas for action—urgent, medium and longer term—provided in the paper encompass the Indigenous and mainstream populations and the Alliance reaffirms this policy position.

In addition, aged care policy specific to Aboriginal and Torres Strait Islander Australians requires additional well-defined targets including: access to adequate and culturally appropriate service provision when and where necessary, (e.g. in line with differences in the age structure of the Indigenous population); appropriate preventive strategies to assist the elderly to maintain or restore independence in the activities of daily living as they age; and the development of programs capable of meeting the needs of Indigenous carers of the aged—as defined within an Indigenous context.

Some progress has been made in these areas but more is needed. In 1994, the *Aboriginal and Torres Strait Islander Aged Care Strategy* was put into place. Its aim is to improve access to aged care services for Indigenous people, including those living in the rural and remote areas. The Aboriginal and Torres Strait Islander Flexible Services program was established under this Strategy and provides aged care services—including residential and community care places—that aim to be flexible enough to meet a community's current needs. Multi-purpose Services provide flexible care places for both Indigenous and non-Indigenous clients when rural and remote locations are too small to support the standard systems of aged care provision.<sup>3</sup>

The Australian Government Department of Health and Ageing reports that this flexible model supports 29 approved and 25 operating aged care services with 348

residential care places.<sup>40</sup> Many of them have been established in remote areas where no aged care services were previously available. In addition, there are 29 mainstream residential aged care services funded under the *Aged Care Act 1997*, either auspiced by, or mainly servicing, Aboriginal and Torres Strait Islander communities.

At 30 June 2004, there were 29 Community Aged Care Packages operating under the *Aboriginal and Torres Strait Islander Aged Care Strategy*, providing 243 packages to Indigenous clients. In addition around 4% of people receiving mainstream Community Aged Care Packages identify as being of Aboriginal or Torres Strait Islander origin.<sup>41</sup>

The Home and Community Care (HACC) program is a mainstream program that is used by a higher proportion of Indigenous Australians than non-Indigenous Australians in all age groups examined.<sup>3</sup> Of all clients receiving HACC services, 18% of Indigenous clients were aged 75 years or over compared with 57% of other clients. Yet more emphasis needs to be paid to improving community-based care for older Indigenous people to enable them to remain in their own communities.

In addition, it is particularly important to bear in mind that, as the Commonwealth Grants Commission noted:

The number of older Indigenous people will increase, particularly if health status is improved. However, it will not increase at the same rate as the elderly non-Indigenous population. It is important that with the overall increased need for aged and community care occurring in the coming decades, the Indigenous population is not marginalised in its access to services.<sup>42</sup>

### ***Maintaining function in the elderly***

The Alliance's 2005 policy statement (*Older people and aged care in rural, regional and remote Australia*) drew attention to the fact that there is an inadequate focus on preventive programs for the elderly living in rural and remote areas. Such programs aim to prevent disability and to maintain function and independence. There is evidence that one of the most effective barriers to prevention of disability in the aged is the perception that, even in the absence of disease, age equates to disability.<sup>43</sup> This inaccurate view permeates Australian society, even though there is strong evidence that, at least for the mainstream population, function can be maintained, and the risk of falls etc reduced, through the use of prevention strategies such as:

- exercise—specifically, training in balance, co-ordination and reaction time, and weight resistance—that occurs more than once per week and is sustained over the long-term
- weight reduction and smoking cessation programs
- nutrition programs
- early access to the effective use of assistive technology

- early access to home- or community-based rehabilitation.

There is a lack of research into what preventive programs are most suited to older Aboriginal and Torres Strait Islander people. In addition, many of the programs identified above are simply unavailable to Aboriginal and Torres Strait Islander people in rural and remote areas, where most services lack the resources to provide more than reactive short-term acute care.

There appears to be little research in the area of the specific aged care needs of Indigenous Australians and therefore of the appropriate models of service delivery. However, in 2006 the Minister for Ageing announced a project, to be undertaken by Charles Darwin University, that “will examine evidence for the widely held policy assumption that Indigenous Australians aged over 50 have the same set of age-associated conditions and care needs as non-Indigenous Australians aged over 70 years”.<sup>44</sup> This type of research is overdue in respect to the needs of aged persons within the Aboriginal and Torres Strait Islander community and the findings will be important in directing future policy.

### ***Carers***

Little information is available on the specific needs of Aboriginal and Torres Strait Islander carers, including the responsibilities placed upon them within their discrete cultural context. There may be difficulties defining the meaning of what it is to be a carer, and how caring is perceived within this context. The key role of carers in aged care is very relevant to Indigenous Australians even though current mainstream carer support programs may be ineffective in meeting their specific needs.

## **Workforce**

### ***The health workforce***

The Alliance considers access to an adequate and appropriate health workforce to be a keystone to improved health outcomes for all people living in rural and remote areas. Lack of an adequate, stable health workforce highlights the inequity of access to health care faced by people living in rural and remote areas. The Alliance has developed many policy statements covering a range of workforce issues. Since 2001 they have included:

- *Allied health professionals in rural and remote Australia* (2001)<sup>35</sup>
- *Action on nursing in rural and remote areas: recommendations and action plan* (2002)<sup>45</sup>
- *Bonded medical scholarships and university places* (2003)<sup>46</sup>
- *A quality rural placement system for health students* (2004)<sup>46</sup>
- *An ethical approach to the training and supply of health care professionals: in support of the Melbourne Manifesto* (2004)<sup>46</sup>



- *Nursing in rural and remote areas* (2003)<sup>31</sup>
- *Current issues for Australia's rural and remote health workforce* (2004)<sup>46</sup>
- *Under pressure and under-valued: allied health professionals in rural and remote areas* (2004)<sup>47</sup>
- *Supporting health service managers in rural and remote Australia* (2004)<sup>48</sup>
- *Advanced nursing practice in rural and remote areas* (2005)<sup>28</sup>
- *Aboriginal and Torres Strait Islander Health Workers* (2006).<sup>47</sup>

In the context of delivering health services to Aboriginal and Torres Strait Islander Australians, there are added dimensions to workforce requirements. Strategies to meet these needs have been developed, and there has been some success in implementing them. In particular, the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, agreed by AHMAC in 2002, presents a 5–10 year reform agenda.<sup>49</sup> Implementation of the *Workforce Strategic Framework* is being carried out at both national and State/Territory levels, and undergoes a mid-term review in 2006.

The *Workforce Strategic Framework* acknowledges that delivery of appropriate primary health care to Aboriginal and Torres Strait Islander people depends on access to an adequate and competent workforce. These primary health care professionals have the skills required to deal with high levels of co-morbidity and the demands of appropriate preventive care, as well as the ability to work within the cultural imperatives of Aboriginal and Torres Strait Islander communities.

Difficulties in recruiting and retaining appropriate staff, especially in remote areas, are well known. There are also challenges related to the effectiveness of current health professional education on Indigenous health issues; the ability to attract non-Indigenous health professionals to work in Indigenous health; and, in particular, the small number of Indigenous people qualified as health professionals.

The internationally recognised, culturally appropriate approach of health care provided by Indigenous people to Indigenous people has been endorsed by the AIHW (2001) and the Australian Medical Association (AMA) (2004) as a strategy to improve health care access and increase the health status and life expectancy of Australia's Aboriginal and Torres Strait Islander people. It has impacted on the improvement of Indigenous health outcomes in countries such as the United States, Canada and New Zealand, which all have higher numbers of Indigenous health professionals than Australia.<sup>50</sup>

The urgent need for more Indigenous health professionals is well recognised and many requests—with some success—have been made to governments to fund strategies and incentives to

- support Indigenous students at primary and secondary school levels for entry into health studies

- retain more Indigenous students in the health studies
- provide motivation for Indigenous health professional graduates to practise in rural and remote areas.

Whilst some gains have been made, the needs remain urgent. ABS/AIHW data on the numbers of Indigenous people employed as health professionals show:

At the time of the 2001 Census, Indigenous people comprised 2% of the Australian population aged 20 years or over and accounted for around 1% of all people employed in selected health-related occupations ... Aboriginal and Torres Strait Islander people comprised 0.8% of all nursing workers, 0.6% of dental workers, 0.5% of allied health workers, 0.3% of medical workers, and 0.1% of pharmacists.

In 2001, there were 88 Indigenous people working as medical practitioners and 1,881 Indigenous people working as nurses, 982 of whom were registered or enrolled nurses. After nursing, Indigenous people were most commonly employed as Aboriginal and Torres Strait Islander health workers (838 people). Aboriginal and Torres Strait Islander health workers may be employed as specialists in such areas as alcohol, mental health, diabetes, eye and ear health, and sexual health, or they may work as generalist members of primary care teams, or as hospital liaison officers.

In 2002–03, 64% of the ‘full time equivalent’ positions paid by Australian Government funded Aboriginal and Torres Strait Islander primary health care services were held by Aboriginal or Torres Strait Islander people. All traditional healers and most Aboriginal and Torres Strait Islander Health Workers (97%), drivers/field officers (96%) and environmental health workers (83%) were Indigenous people. Most doctors (98%), dentists (92%), allied health professionals (86%), and nurses (79%) were non-Indigenous people.<sup>3</sup>

The AMA (2004) estimates that achieving the same proportion of Aboriginal and Torres Strait Islander people working as health professionals as non-Indigenous people, would require an additional:

928 [Indigenous] doctors, 149 medical imaging professionals, 161 dentists, 2570 nurses, 275 pharmacists, 119 occupational therapists, 59 optometrists, 213 physiotherapists ... [and] 2000 Aboriginal health workers.<sup>50</sup>

The Australian government has acknowledged the additional workforce needs in the area of Aboriginal and Torres Strait Islander health—although not specifically in rural and remote areas—in the 2005–06 budget, and included some funds for staff recruitment and retention. Much more is needed urgently.

### ***Aboriginal and Torres Strait Islander health workers***

The education, training and retention of Aboriginal and Torres Strait Islander health workers is a matter of great importance to the health outcomes of Indigenous people, particularly in rural and remote areas. In 2006 the Alliance published its Position Paper, *Aboriginal and Torres Strait Islander Health Workers*, detailing their key role in the delivery of appropriate health services to Indigenous Australians.<sup>51</sup>

Among other things, this paper reiterates the importance of this specific discipline in health service provision where Aboriginal and Torres Strait Islander people attend for health care in the primary, secondary and tertiary care sectors. It details challenges and benefits of increasing the support and professional development of these workers in order to boost their numbers participating in the workforce, retain that workforce and develop the workforce to improve its capacity in health care delivery.

Recommendations include attention to the issues noted above, and extend to recommending a national registration body and the support for a national professional association for Aboriginal and Torres Strait Islander health workers.

### *The aged care workforce*

The serious difficulties identified in the recruitment and retention of aged care workers in general are magnified in rural and remote areas, creating solid obstacles to service delivery. They include:

- low levels of remuneration
- ageing of the aged care workforce itself, including the nursing workforce
- the poor image and status of the sector
- gender issues—the majority of community care personal carers are women
- inability to attract young workers and males to the industry
- lack of qualifications and training for the para-professional workforce
- large part-time and casual workforce
- lack of identified career structures within the sector.

The Alliance, in its submission to the 2005 Senate Inquiry into Aged Care, stated that aged care workforce issues are acute in rural and remote areas, particularly in delivering community-based care.<sup>52</sup> Difficulties identified include:

- the national shortage of nurses who, together with personal care workers, provide aged and community care services. The shortage is amplified in rural and remote areas, where staff turnover is even higher than in urban areas and recruitment is more difficult
- providers have difficulty in finding staff with skills and experience in aged care service delivery
- there is a shortage of the types of health professionals needed to provide specific services to the aged in rural and remote areas. These professionals include general practitioners, dentists, optometrists, and allied health professionals such as podiatrists, physiotherapists and occupational therapists
- there are issues regarding the role and appropriate training of personal care workers who provide the bulk of community-based aged care services. The ability to undertake adequate workforce planning and provide good career

ladders for workers presents added difficulties for rural and remote service providers

- training opportunities are often unavailable locally and funding for outside training is prohibitive
- workforce recruitment is often inhibited by lack of housing for workers moving to rural and remote areas
- there are increased occupational health and safety risks in rural and remote areas.

The provision of appropriate services to Aboriginal and Torres Strait Islander rural and remote area communities is also constrained by:

- language and cultural awareness issues
- the cultural imperatives regarding respect for Elders, and the unique requirements of their care in line with their levels of responsibility within Indigenous communities
- the need for services to be provided by Aboriginal and Torres Strait Islander health and welfare professionals.

## **Patient transport and accommodation assistance**

The Alliance has detailed its policy position on health-related transport and accommodation assistance in the 2005 paper: *Transport and accommodation assistance for health patients from rural and remote areas*.<sup>28</sup> The position regarding support for Indigenous Australians is reproduced here.

Overall, Indigenous people living in rural and remote Australia have lower incomes and are less likely to have their own transport. In addition, most remote communities have no access to public transport, so patients from such areas face considerable barriers to accessing the ‘mainstream’ health system. They also experience more cultural difficulties when interacting with that system.

For many reasons, then, it is appropriate that additional assistance be given, such as reduction in the required distance for travel for eligibility when there is no public transport, and ‘topping-up’ of assistance payments when patients have no resources to add to the subsidy received. The lack of additional assistance and issues such as inability to travel at certain times, and lack of communication and understanding of the health care system, significantly contribute to Indigenous patients’ non-attendance for care and treatment.

Many Indigenous people from outer rural and remote areas are unaware that most jurisdictions have specific programs to assist them when they need to travel to access specialist health care. If they are to receive outpatient treatment, arrangements are usually made for them to stay at a hostel, where some additional support is given in a culturally appropriate environment. For Indigenous patients in

the NT and SA, for example, specific patient liaison units arrange travel and accommodation in advance and at the receiving hospital Aboriginal liaison officers help with paperwork and forward it to the administrator of the scheme. In NSW, Aboriginal health organisations may transport eligible Indigenous patients to specialist appointments in major centres, and can claim travel and accommodation assistance directly on behalf of their clients. Such initiatives are to be applauded and should be adopted by all States and Territories.

A recent study documenting the experiences of Indigenous people travelling to and from remote areas to city hospitals reinforced these views and, in addition, emphasised the cost in terms of family and cultural dislocation:

Funding and equity of the Patient Assisted Transport Scheme (PATS) created problems. Raising payments for PATS and extra costs to clients were big issues. Antisocial arrival times, separation from family, transport to hospital and accommodation all caused distress and confusion. Potentially dangerous misunderstandings happened through language and cultural differences. Traditional people travelling unaccompanied were at risk.<sup>53</sup>

Because Indigenous people living in rural and remote areas have to travel regularly to acute care services, the authors suggest that the PATS scheme should be made more user-friendly for Aboriginal and Torres Strait Islander people and strategies should be developed to improve communication. They add the practical suggestion that a space and campfire in hospital grounds where traditional people and their families may gather would be helpful. Other suggestions focus on culturally sensitive issues such as the need for same-sex toileting facilities in hospitals.

These suggestions accord with the views outlined in AHMAC's *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*, which draws attention to the fact that:

There is a growing understanding that a comprehensive response to addressing the marginalisation of Aboriginal and Torres Strait Islander peoples must sharpen the focus on improving the performance and accountability of mainstream services. The health system, overall, does not provide the same level and quality of care to treat illness for Aboriginal and Torres Strait Islander peoples and is so culturally inappropriate or inadequately resourced that their needs cannot be met.<sup>17</sup>

## Telecommunications

The Alliance presented its policy position on telecommunications in the paper *Holding the line on health: telecommunications in rural and remote Australia*.<sup>28</sup>

The Alliance considers an adequate national telecommunications system of such economic and social importance that all efforts must continue to provide equality of access to all residents, wherever they may be. This equality of access must include all forms of telecommunication services. It must be recognised by government and industry as being a continuous evolution, as technological development continues to drive telecommunications improvements, rather than a steady state to be reached in a given time frame. All appropriate mechanisms—in

the market, or government activity where the market fails—need to be mobilised to deliver an effective telecommunications system right across the country.

This position holds true for the Indigenous and non-Indigenous communities in rural and remote Australia. For Indigenous Australians, telecommunications technology will assist health outcomes in ways beyond the provision of direct health services, having the potential to also improve access to education and employment opportunities, key factors that impact on overall health.

The Australian Government has made a start, with assistance to such programs as the Computer Offer to Indigenous communities and the Broadband for Health program, anticipated to provide broadband Internet access to general practitioners and Aboriginal community controlled health services across Australia. There is a need to further expand telecommunication initiatives for Aboriginal and Torres Strait Islander communities across rural and remote areas.

## Conclusion

Improvements are occurring in the health and welfare of Aboriginal and Torres Strait Islander Australians, but they are slow and much less comprehensive than required.

The Alliance is pleased to note that the latest ABS/AIHW report on the health and welfare of Australia's Aboriginal and Torres Strait Islander people indicates that, although the health of Aboriginal and Torres Strait Islander people remains poor compared to the rest of the Australian population, there are emerging changes, with some improvements in education, employment, home ownership and health status, including life expectancy.<sup>3</sup>

In addition, the Alliance welcomes the funding announced in the 2005–06 Australian Government Budget for Indigenous health care services and the establishment of the Healthy for Life program. The Australian Government Department of Health and Ageing notes that the Healthy for Life program:

... will provide \$102.4 million over four years, to improve the health of Aboriginal and Torres Strait Islander mothers, babies and children, enhance that quality of life for people with a chronic disease, and over time, reduce the incidence of chronic disease. Over 80 Healthy for Life sites will be established over four years, with 20–25 sites commencing in 2005–06, to undertake focused activities, early intervention and quality improvements in health service delivery to improve the health of Aboriginal and Torres Strait Islander people. Healthy for Life will also increase the number of Aboriginal and Torres Strait Islander Australians being trained as health professionals. Approximately 86 new scholarships for Indigenous students will be offered, over four years, through the Puggy Hunter Memorial Scholarship Scheme.<sup>40</sup>

Welcome as these programs are, they are not enough. It is important to ensure that interested parties carefully monitor the expected benefits from all new initiatives, to make sure that funding is well targeted. Service providers should be assured of

sufficient support, including management support, to meet the increased demands placed upon them by new initiatives.

Lack of health services and lack of capacity within existing services continue to be stumbling blocks to achieving the desired health outcomes for Aboriginal and Torres Strait Islander peoples. Counteracting strategies must be in place if they are to be overcome.

## NRHA commitments

Improving the health of Aboriginal and Torres Strait Islander Australians cannot be achieved by the health sector alone. Success is reliant upon action across all levels of government and all portfolios. The impact of the health sector, however, is critical.

The Alliance commits to the following actions.

1. The NRHA will advocate for increased resources for community-controlled primary health care services, including for the purpose of augmenting their work on maternal and child health programs.
2. The Alliance will continue to lobby governments for greater funding for oral health programs targeting Indigenous Australians.
3. The Alliance will undertake to:
  - lobby the Australian Government to increase the number of community-controlled primary health care services that have the infrastructure and capacity to deliver comprehensive primary mental health care services including referring rights to specialists
  - lobby governments regarding the critical need to support Aboriginal and Torres Strait Islander health workers and to expand the skills base of existing Aboriginal and Torres Strait Islander mental health workers.
4. The Alliance will retain an interest in the suicide prevention programs linked to the goals of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by governments*, and the *National Strategic Framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Well-being 2004–2009*, and raise relevant issues regarding such programs with appropriate organisations where necessary.
5. The Alliance will work with Indigenous health organisations to advocate for additional Indigenous alcohol and other drug services, and for the increased recruitment of appropriate health professional personnel within this area of expertise.
6. The Alliance will support the purposes of the Healthy for Life program.

7. The Alliance will continue to argue that health initiatives developed for the mainstream Australian community may not be suitable for Indigenous Australians, and to advocate for increased funding to identify and address the discrete health needs of Indigenous Australians.
8. The Alliance will lobby the Australian Government for an increase in the number of Aboriginal and Torres Strait Islander aged care programs; for the provision of specific interventions for primary and secondary prevention programs for the Indigenous elderly, aimed at maintaining functionality and independence; and for the development of programs for Indigenous carers.
9. The Alliance will seek to ensure that aged care assessments of Aboriginal and Torres Strait Islander people are undertaken, as far as possible, by an Indigenous person, and conducted within the guidelines of the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*.
10. In partnership with other relevant organisations, the Alliance will continue to lobby governments to build on the work being undertaken in the education and health portfolios to increase the number of Indigenous people taking up and completing studies in health and health service management courses.
11. The Alliance affirms the absolute right of Indigenous Australians to cultural safety in all aspects of life and acknowledges the impact that this has on health outcomes. The Alliance will lobby State and Territory governments to ensure that the principles of the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* are widely implemented by mainstream health service providers. The principles include:
  - development of improved communication strategies between city, regional and rural hospitals and their Aboriginal and Torres Strait Islander patients
  - development of workforce planning strategies that ensure that the number of Aboriginal and Torres Strait Islander hospital liaison officers is matched to Aboriginal and Torres Strait Islander patient throughput.



## Notes

1. National Aboriginal Health Strategy Working Party (1989). *A National Aboriginal Health Strategy*. Commonwealth of Australia. Canberra.
2. The term Indigenous, when used in this document, refers to the original inhabitants of Australia—that is, all first nation Aboriginal people (inclusive) and Torres Strait Islander people. The term acknowledges the diversity of the Aboriginal people of Australia in language, culture and place of origin; and that the term Aboriginal incorporates a range of region-specific identities, for example Koori, Murri, Anangu. It also acknowledges that Torres Strait Islander people too have more specific identities that relate to language and place. When referring to Australia’s first people the adjective is capitalised.
3. Australian Bureau of Statistics and Australian Institute of Health and Welfare (ABS/AIHW) (2005). *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2005*, ABS cat. no. 4704.0, AIHW Catalogue No. IHW14, Canberra.
4. Cooke M, Beavon D and Guimond E (2004). *Measuring Aboriginal Well-Being in Four Countries: An Application of UNDP’s Human Development Index to Aboriginal People in Canada, the United States, New Zealand and Australia*. Paper presented at the 18th World Conference on Health Promotion and Health Education, Melbourne, April 2004. (quoted in *The Age*, 27 April 2004)
5. Based on latest available census data; 2006 census data are expected to be available in 2007.
6. Australian Bureau of Statistics (ABS) (2002). *Population distribution Aboriginal and Torres Strait Islander Australians 2001*, ABS Cat No. 4705, Canberra.
7. Defined as weighing less than 2500 grams at birth.
8. Dwyer J, Silburn K and Wilson G (2004). *National Strategies for Improving Indigenous Health and Health Care*. Office for Aboriginal and Torres Strait Islander Health, Australian Department of Health and Aging, Canberra.
9. ABS/AIHW (2005) notes: “While there is incomplete coverage of Indigenous deaths in all state and territory registration systems, some jurisdictions have been assessed by the Australian Bureau of Statistics (ABS) as having a sufficient level of coverage to enable statistics on Aboriginal and Torres Strait Islander mortality to be produced. These jurisdictions are Queensland, South Australia, Western Australia and the Northern Territory, and their data have been combined for 1999–2003 for an analysis of Indigenous mortality. Longer term mortality trends ... are based on an analysis of data from three jurisdictions—South Australia, Western Australia and the Northern Territory—being the only jurisdictions with 12 years of reasonable coverage of Indigenous deaths registrations.”
10. Australian Institute of Health and Welfare (AIHW) (2006). *Australia’s Health 2006*. The tenth biennial health report of the Australian Institute of Health and Welfare. AIHW Cat No. AUS 73, Canberra.

11. Condon J, Barnes T, Cunningham J and Smith L (2004). "Improvements in Indigenous mortality in the Northern Territory over four decades " *Aust NZ J Public Health*, 28.
12. Thomas D, Condon J, Anderson I, Q Li S, Halpin S, Cunningham J and Guthridge S (2006). "Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator". *MJA* 185(3).
13. Ring and Firman (1998) quoted in Dwyer et al. 2004.
14. Lewis M (2003). *The People's Health. Public Health in Australia, 1950 to the Present*. Contributions to Medical Studies, No 9, Vol 2. Praeger, Westport, Connecticut.
15. Australian Bureau of Statistics (ABS) (2002a). *Hospital Statistics, Aboriginal and Torres Strait Islander Australians*, ABS Cat No. 4711.0, Canberra.
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