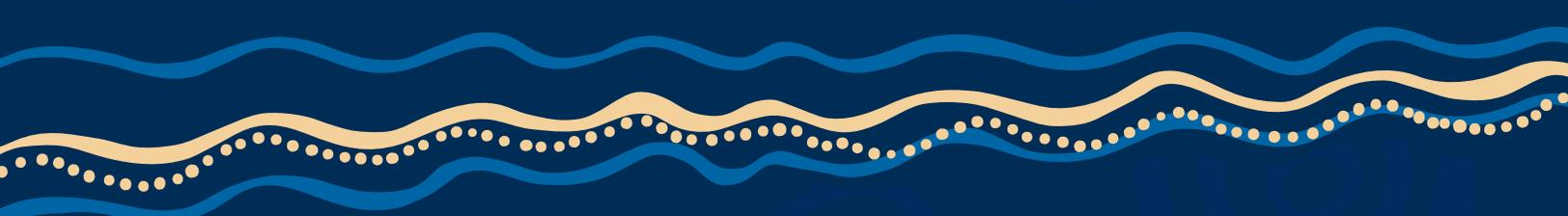


# Making Tracks

toward closing the gap in health outcomes for  
Indigenous Queenslanders by 2033

**Policy and Accountability Framework**





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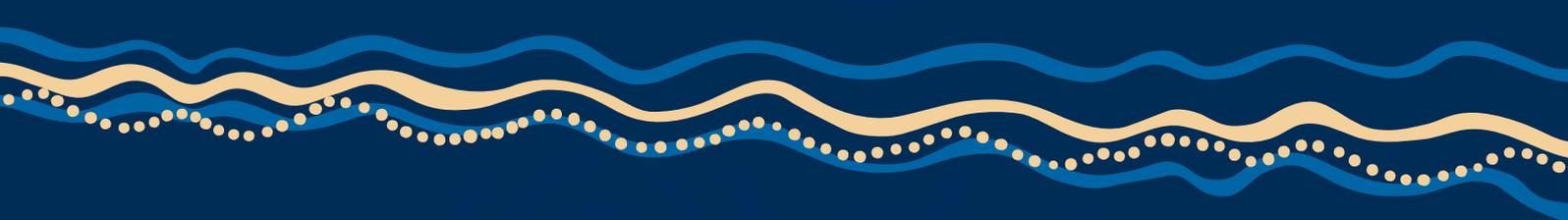
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# 2018

HALVING THE GAP IN MORTALITY RATES FOR  
INDIGENOUS CHILDREN UNDER FIVE WITHIN A DECADE



# Making Tracks

toward closing the gap in health outcomes for  
Indigenous Queenslanders by 2033

**Policy and Accountability Framework**

CLOSING THE LIFE EXPECTANCY GAP WITHIN A GENERATION

2033



This original artwork was produced for Queensland Health by Gilimbaa. Gilimbaa is an Indigenous creative agency.

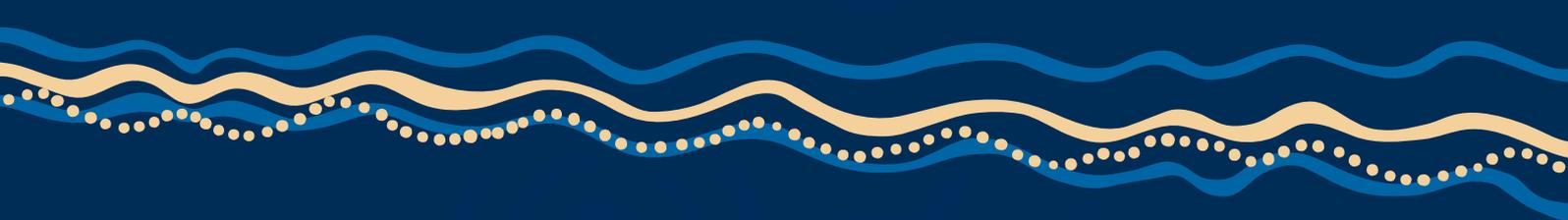
## Queensland Health - Making Tracks

This artwork represents Aboriginal and Torres Strait Islander cultures in Queensland. It speaks of the importance of traditional and cultural sensitivities, how these are communicated in the modern day health system and how health professionals can best provide health services for Indigenous people through best practice.

The central circular motif represents Health in Queensland, and the meeting place where people come to trade knowledge about best health practices and procedures.

The pathways leading both in and out of this central motif represent people traveling from different professions, different communities and different country, and the importance of everyone contributing equally to this journey. A journey of change and growth for a brighter, healthier and happier future for all Indigenous people.

The surrounding markings and motifs represent the important network of people from these communities, their connection to each other, and how they work together to empower Indigenous Queenslanders to have long, healthy, productive lives.



## Foreword

The gap in health status between Aboriginal and Torres Strait Islander Australians and the total Australian population is well known. The health literature reports the leading causes of disease and the most significant risk factors for Indigenous Queenslanders. In many cases it can give us evidence-based advice about which health interventions are most likely to be successful in closing the gap. Yet despite the resilience of many Indigenous families and communities and the efforts of dedicated health professionals to deliver evidence-based programs and services, and notwithstanding some localised examples of health improvements, the gap remains. Whilst there are significant logistical, environmental and lifestyle factors that have perpetuated the health gap, these can be overcome if governments, health service providers and Aboriginal and Torres Strait Islander people are determined to do so and work together in a systematic and sustained way.

The Council of Australian Governments' meeting on 20 December 2007 heralded an unprecedented opportunity for co-operation between the Australian Government and State/Territory governments in the administration of public policy and programs. It agreed to a comprehensive Indigenous Reform Agenda, to be pursued by all levels of governments in partnership with Aboriginal and Torres Strait Islander communities. To strive for health equality between Indigenous and non-Indigenous Australians, COAG committed to achieving the following targets:

- **Closing the life expectancy gap within a generation (by 2033); and**
- **Halving the gap in mortality rates for Indigenous children under five within a decade (by 2018).**

To give effect to this commitment in Queensland, the Government has signed a Close the Gap Statement of Intent which commits the signatories to work together *“to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030.”*

*Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033* provides a long-term, evidence based policy and accountability framework consistent with COAG's Indigenous Reform Agenda, the Statement of Intent, the Queensland Implementation Plan for the Indigenous Health Outcomes National Partnership Agreement and with the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* to which the Queensland Government remains strongly committed. Through this framework and through *Making Tracks* implementation plans that will be published every three years, the Queensland Government reaffirms its commitment to working with the Australian Government, Aboriginal and Torres Strait Islander communities and health service providers to make sustained improvements to health outcomes for Indigenous Queenslanders.

This *Making Tracks* policy and accountability framework articulates the vision for closing the health status gap by 2033. The first *Making Tracks* implementation plan (2009-10 to 2011-12) details the Queensland Government's intentions for immediate action towards closing the health gap within current policy, funding and service delivery arrangements. Future *Making Tracks* implementation plans will build on this foundation, taking account of any changes to those arrangements under the National Health and Hospitals Reform Agenda. Together, the Queensland Government and Queensland's Aboriginal and Torres Strait Islander population can make a real difference in achieving equality in health outcomes between Indigenous and non-Indigenous Queenslanders.

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## Executive Summary

An examination of the available evidence clearly shows that the leading contributors to the health gap between Indigenous and non-Indigenous Queenslanders are cardio-vascular disease, diabetes, respiratory diseases, cancers, mental disorders and injuries. Together these account for 80 per cent of the health gap. Improving early detection and treatment of these conditions will make a significant difference to Indigenous health outcomes. In addition, a focus on addressing the risk factors for chronic disease (particularly smoking and obesity which contribute 17 per cent and 16 per cent of health loss respectively) will contribute significantly to closing the health gap.

In July 2003, all Australian government jurisdictions committed to developing two five-year implementation plans to support the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* (NSFATSIH). In April 2008, the Premier of Queensland joined health service providers and other non-government organisations in signing a *Close the Gap Statement of Intent*. A key commitment under the Statement of Intent was to develop a plan of action that is targeted to address need and is evidence-based to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030.

In October 2008 and February 2009, the Premier of Queensland and the Prime Minister of Australia signed the Indigenous Early Childhood Development National Partnership Agreement (NPA) and the Indigenous Health Outcomes NPA. These agreements included two Indigenous health targets – to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation and to halve the child mortality rate for 0-5 year olds within a decade. A jurisdictional implementation plan for the Indigenous Health Outcomes NPA was signed in November 2009 which articulates nine key initiatives that will be the first step towards addressing these targets.

Cognisant of these commitments, this *Making Tracks* policy and accountability framework provides the overarching policy directions to guide the Queensland Government's effort towards closing the health gap by 2033 and maintaining sustainable health outcomes thereafter. It has been developed following an examination of the available evidence regarding the health status of Indigenous Queenslanders and what is known about the health interventions that are most likely to close the health gap. It identifies the need for a multi-faceted approach that includes:

- **increased and sustained effort across the entire health system** – delivering culturally capable and responsive mainstream health services complemented by targeted Indigenous specific programs and services, and improved integration across service settings
- **improved care across the health continuum** – promoting good health, preventing illness where possible, and improving the diagnosis, treatment and management of existing illness
- **intervention across the life span** – a focus on 0-8 years for a strong start to life, 8-18 years to avert the uptake of risky health behaviours; and adulthood to better manage existing illness
- **strategies to address the risk factors for chronic disease** – to maximise the potential for health gain by targeting the leading causes of preventable mortality and morbidity experienced by Indigenous Queenslanders, particularly smoking and obesity
- **a focus on the main contributors to the health gap** – cardiovascular disease, type 2 diabetes, chronic respiratory diseases, cancers, mental illness and injury
- **attention to the needs of urban populations and those living in discrete communities**
- **complementary action in other social policy areas**, particularly education and housing in recognition of their impact on positive health outcomes.



To achieve these objectives, the Making Tracks priority areas are:

#### A HEALTHY START TO LIFE

- Giving Aboriginal and Torres Strait Islander children 0-8 years a healthy and safe start to life through effective women's health services, ante-natal and infant care, improved education outcomes and child protection services.
- Reaching out to 8-18 year olds to maintain the contact of young Aboriginal and Torres Strait Islander people with the health and education systems and to establish positive and sustainable patterns of health behavior that will impact heavily on adult physical and mental health outcomes.

#### ADDRESSING RISK FACTORS

- Reducing the modifiable risk factors that contribute to chronic disease through effective anti-smoking initiatives, mechanisms to address harmful alcohol consumption, improved nutrition, oral health, participation in physical activity, and improved access to reproductive and sexual health information and programs.
- Improving the living environments of Indigenous Queenslanders through environmental health and housing initiatives and efforts to improve community and personal safety.

#### MANAGING ILLNESS BETTER

- Assisting Indigenous Queenslanders with chronic disease through earlier diagnosis, improved access to screening, routine tests and procedures and appropriate treatment.

#### EFFECTIVE HEALTH SERVICES

- Improving access to, and experience of, the health system by enhancing the cultural competence of the health workforce and participating in health service systems that encourage integration between programs, between the hospital and primary health care systems and across all health service providers.
- Developing a state-wide Indigenous primary health care reform framework to improve the effectiveness of service delivery mechanisms and to inform the design and delivery of state funded programs and services for Indigenous Queenslanders.

#### IMPROVING DATA AND EVIDENCE

- Continuing to improve the quality and availability of research and data, accountability mechanisms and evaluation to inform best practice approaches to health care for Indigenous Queenslanders.

## The Framework is underpinned by a commitment to the following guiding principles:

- **PARTNERSHIP** – working across government, and with the full range of service providers and with Indigenous communities, provides the best opportunity to improve health and the broader determinants of health.
- **CULTURAL RESPECT** – the cultural diversity, rights, views, values and expectations of Indigenous Queenslanders must be respected in the delivery of culturally appropriate health services.
- **INDIGENOUS HEALTH IS EVERYONE'S BUSINESS** – achieving sustainable health gains for Indigenous Queenslanders is a core responsibility and high priority for the whole health sector.
- **HOLISTIC HEALTH** – improving the health status of Indigenous Queenslanders must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and strong governance.
- **COMMUNITY CONTROL OF PRIMARY HEALTH CARE SERVICES** – recognising the demonstrated effectiveness of Aboriginal and Torres Strait Islander community controlled health services (A&TSICCHSs) in providing comprehensive primary health care and working with them to improve the level and quality of health service provision; and supporting community decision-making as a fundamental component of health service provision.
- **ACCOUNTABILITY** – for consultation, transparent decision-making and effective, sustainable services.

This *Making Tracks* policy and accountability framework also articulates the accountability and reporting mechanisms that will be utilised by the Queensland Government. It includes baseline data and forward trajectories to 2033 for key performance measures to enable effective tracking and reporting of progress over time. Reporting will occur through established COAG and NSFATSIH processes, and through the Queensland Close the Gap reports published annually.

Figure 1 provides a snapshot summary of the *Making Tracks* policy and accountability framework. It includes the policy environment, government commitments, accountability measures and the evidence which underpins and informs the identified areas for intervention that provide the best opportunity to achieve sustained health gains for Indigenous Queenslanders. It also summarises the key performance indicators by which progress in addressing Indigenous health inequality in Queensland will be measured.

The *Making Tracks* policy and accountability framework will be accompanied by implementation plans that will be renewable every three years to reflect the specific initiatives that will be implemented by the Queensland Government towards closing the health gap within the relevant three year period. Implementation of initiatives under the plans will be underpinned by adherence to the following principles:

- Service delivery and investment principles established under the COAG National Indigenous Reform Agenda.
- Meaningful consultation with key stakeholders, including A&TSICCHSs, the Australian Government, Queensland Government agencies and non-government health services providers in the design, location and delivery of services and programs.
- Meaningful consultation with Aboriginal and Torres Strait Islander communities to inform the design and delivery of site specific programs and services.
- Identification of the most effective delivery mechanisms for new services and programs, including utilising non-government service provider organisations where they exist and where to do so would enhance the effectiveness of the service or program.



# collaboration

Figure 1: The Making Tracks Policy and Accountability Framework

## Close the gap targets

2018 To halve the child mortality gap for 0-5 year olds within a decade

2033 To close the gap in life expectancy within a generation





**MULTIPRONGED STRATEGY**

Effort across the health system and the health care continuum.

Focus on people living in urban as well as rural and remote areas.

Focus on intervention points across the lifespan.

Complementary effort in other social policy areas.

**DOMAINS AND PRIORITIES**

- A healthy start to life
- Maternal and child health
- Parenting support
- Young people's health
- Hearing health
- Education
- Child safety
- Emotional and social well-being

**Addressing risk factors**

- Health promotion
- Smoking cessation
- Drug and alcohol use
- Oral health
- Obesity -nutrition and physical activity
- Sexual health
- Environmental health and housing

**Managing illness better**

- Early diagnosis and intervention
- Access to procedures, tests and treatment
- Priority areas
- Cardiovascular disease
- Type 2 diabetes
- Respiratory disease
- Cancer
- Mental illness

**MEASURING PERFORMANCE**

**A healthy start to life**

- Perinatal and infant mortality rates
- Birth weights
- Smoking rates in pregnancy
- 5 or more ante-natal visits
- Rates of anaemia in pregnancy
- Rates of gestational diabetes
- Breast feeding rates
- Levels of childhood obesity
- Injury rates in children
- Hearing loss in children
- Educational attainment
- Rates of out of home care
- Rates of risky alcohol consumption
- Rates of teenage births
- Numbers of child health checks

**Addressing risk factors**

- Smoking rates
- Rates of risky alcohol consumption
- Rates of decreased tooth decay
- Levels of activity and nutrition
- Rates of sexually transmissible infections
- Numbers of people living in overcrowded and/ or substandard housing

**Managing illness better**

- Life expectancy and HALE
- Better detection (adult health checks)
- Less hospitalisation for cardio-vascular and respiratory diseases, diabetes, cancers and mental illness.

**Better Health Services**

- Number of care plans
- Discharge against advice
- Indigenous identification
- Access to health services.

**ENABLERS**

- Better health services
- A capable workforce
- Improved access and the patient journey
  - Workforce pathways, supply and cultural competence
  - Data and Evidence
- Sustainable needs based funding

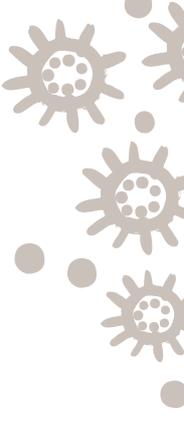
The *Making Tracks* policy and accountability framework provides the overarching policy directions to guide the Queensland Government's efforts towards closing the gap in health outcomes for Indigenous Queenslanders to 2033. The policy directions have been developed following an examination of the available evidence regarding the health status of Queensland's Aboriginal and Torres Strait Islander people and what is known about the health interventions that are most likely to close the health gap. It also articulates a strong accountability framework that includes baseline data and forward trajectories for key performance measures to enable effective tracking and reporting of progress.

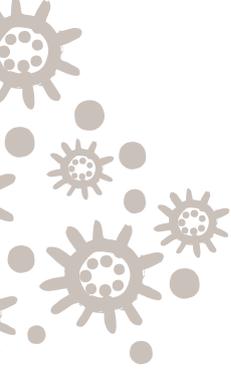
## Goal

The overall aim of the *Making Tracks* policy and accountability framework is to close the gap in health inequality between Indigenous and non-Indigenous Queenslanders by 2033 and to sustain health gains thereafter.

**The overall vision for the *Making Tracks* policy and accountability framework is for a health system that:**

- Delivers culturally capable general health services that are complemented by targeted Indigenous-specific programs and services.
- Provides coordinated and integrated care across the health continuum.
- Is responsive through critical intervention points across the life span.
- Prevents and detects illness early and enables recovery wherever possible.
- Is accessible to all Queenslanders no matter where they live.
- Is complemented by actions in other social sectors (such as education and housing) which are essential to improving the health and well-being of Indigenous Queenslanders.





# The Policy Environment

The *Making Tracks* policy and accountability framework has been developed consistent with:

> **The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013<sup>1</sup> which aims to –**

- Increase life expectancy and decrease mortality rates
- Improve access to health services
- Respond to chronic disease (cardio-vascular disease, renal disease, diabetes, respiratory disease and cancer); communicable diseases, substance use, mental disorders, trauma and suicide, injury and poisoning, child protection issues and family violence
- Provide child and maternal health and male health services and programs.

(See Appendix One for details).

> **The Council of Australian Governments' (COAG) National Indigenous Reform Agreement 2009<sup>2</sup>, which is underpinned by five Indigenous-specific and nine mainstream national partnership agreements, aims to achieve the following targets:**

- Close the life expectancy gap within a generation (by 2033)
- Halve the gap in mortality rates for Indigenous children under five within a decade (by 2018)
- Halve the gap in employment outcomes within a decade
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade
- All four year olds in remote areas have access to early childhood education within five years
- At least halve the gap for Indigenous students in Year 12 attainment rates (or equivalent) by 2020

To address the two Indigenous health targets, COAG has developed two Indigenous specific and health focussed national partnership agreements – the *Indigenous Early Childhood Development* NPA signed by the Queensland Premier in October 2008, and the *Closing the Gap in Indigenous Health Outcomes* NPA signed by the Queensland Premier in February 2009.

THE INDIGENOUS EARLY CHILDHOOD DEVELOPMENT NPA concentrates on priority areas where the evidence shows a high level of impact can be achieved to improve health outcomes for Indigenous children. The NPA is based on facilitation payments and joint investment between the Commonwealth and States/Territories for elements one and two (see below) to correspond with bilaterally agreed work plans. The NPA focuses on three elements:

- > **Element 1: early childhood integration** – children and family centres (Australian Government funding of \$75.18 million over four years in Queensland being provided to the Department of Education and Training to administer)
- > **Element 2: antenatal care, pre-pregnancy and teenage sexual and reproductive health** (Australian Government funding of \$29.95 million over four years in Queensland being provided to Queensland Health to administer)
- > **Element 3: increase access to, and use of, maternal and child health services by Indigenous families** (Australian Government contribution of \$25.5 million over four years in Queensland, being administered by the Australian Government under its New Directions program, plus \$21.25 million over five years of Queensland Government funding being administered by Queensland Health).

<sup>1</sup> Commonwealth of Australia 2004. *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Framework for Action by Governments*, NATSIHC, Canberra July 2003.

<sup>2</sup> Council of Australian Governments *National Indigenous Reform Agreement*, 2009.

THE INDIGENOUS HEALTH OUTCOMES NPA provides \$1.6 billion nationally over four years from 2009-10, with the Australian Government contributing \$806 million of Commonwealth own purpose expenditure and State/Territory governments \$772 million. The Queensland Government's co-contribution of \$162.22 million is specified in the NPA and a jurisdictional implementation plan has been developed outlining the initiatives to be implemented within Queensland to be resourced by the Queensland Government contribution. The Indigenous Health Outcomes NPA focuses on evidence-based priority areas within a scope that could be agreed by all jurisdictions.

The Queensland Government has agreed to contribute funding to support initiatives in the following areas:

- tackling smoking (\$8.97 million over 4 years)
- healthy transition to adulthood (\$11.86 million over 4 years)
- making Indigenous health everyone's business (\$3.20 million over 4 years)
- primary health care services that can deliver (\$90.79 million over 4 years)
- fixing the gaps and improving the patient journey (\$47.40 million over 4 years).

Expected outcomes of the NPA include: reduced smoking rate, reduced burden of disease, increased uptake of MBS-funded primary health care services, improved care coordination, and a reduction in the average length of hospital stay and readmissions. A summary of the Indigenous Early Childhood Development and Indigenous Health Outcomes NPAs is at Appendix Three.

> [The Close the Gap Statement of Intent<sup>3</sup>, signed by the Queensland Government in 2008 which commits the signatories to:](#)

- A long-term, evidence based plan for achieving equality of health status and life expectancy between Indigenous and non-Indigenous Australians by 2030
- Ensuring health services are capable of bridging the health gap by 2018
- Ensuring the full participation of Indigenous Australians and their representative bodies
- Addressing the social determinants that impact on achieving health equality
- Building on the evidence base and supporting evidence-based approaches
- Supporting and developing community controlled health services
- Improving access to, and outcomes from, mainstream services
- Ensuring health services are available, appropriate, accessible, affordable, and of good quality
- Measuring, monitoring and reporting on progress in closing the health gap over time.

See Appendix Three for details.

<sup>3</sup> Oxfam Australia, Australians for Native Title and Reconciliation 2008. *Close the Gap Indigenous Health Equality Summit Statement of Intent*, Brisbane April 29 2008.

# The Evidence

According to a report published in 2009<sup>4</sup>, the gap in life expectancy at birth between Indigenous and non-Indigenous Queenslanders is 10.4 years for males and 8.9 years for females. In Queensland, the child mortality rate is 2.04 times the total Queensland rate.

The six leading drivers of the health gap between Indigenous and non-Indigenous Queenslanders, and which together explain 80 per cent of the health gap, are:

- Cardiovascular disease – an estimated 28 per cent of the health gap
- Diabetes – an estimated 16 per cent of the health gap
- Chronic respiratory disease – an estimated 11 per cent of the health gap
- Cancers – an estimated 9 per cent of the health gap
- Injuries – an estimated 8 per cent of the health gap
- Mental disorders – an estimated 8 per cent of the health gap<sup>5</sup>.

Cardiovascular disease and diabetes were the main contributors to the health gap in major cities, regional centres *and* remote areas, together accounting for 44 per cent of the health gap in Queensland. In major cities and regional centres, these are followed by chronic respiratory conditions, cancers, mental disorders and injuries. In remote areas infectious and parasitic diseases are also significant contributors.

Eleven risk factors explain 37.4 per cent of the total burden of disease including:

- Consumption of smoking, alcohol and other drugs
- Obesity, low rates of physical activity and poor nutrition
- High blood pressure and high cholesterol
- Unsafe sex
- Child sexual abuse and intimate partner violence.

Of these, smoking was the largest cause of health loss, contributing 17 per cent to the health gap and one fifth of all Aboriginal and Torres Strait Islander deaths nationally<sup>6</sup>.

Indigenous Queenslanders are hospitalised at much higher rates than non-Indigenous Queenslanders for most conditions, particularly in the far northern and north-western areas of Queensland, and present later and often with multiple and/or complex conditions. However, rates of access to health interventions in hospitals are lower for Indigenous Australians. Only 52 per cent of hospital episodes of care for Indigenous Queenslanders recorded a procedure (excluding dialysis) compared with 79 per cent of hospital episodes of care for other Queenslanders<sup>7</sup>. In addition, Indigenous Queenslanders are discharged from hospital against medical advice at 3.5 times the rate for non-Indigenous people<sup>8</sup>. This data suggests that whilst often presenting to hospitals later and in poorer health than non-Indigenous Queenslanders, Aboriginal and Torres Strait Islander people may not always receive the treatment they need.

The causes of health disadvantage cannot be addressed in isolation. Health status is affected by the impact of risk factors and the performance of the health system but it is also affected by a range of other social and economic factors outside the influence of the health system. These include:

- **SOCIO-ECONOMIC STATUS** such as low incomes, unemployment and low education levels
- **ENVIRONMENTAL FACTORS** such as substandard housing, sewerage and water quality, dry/dusty conditions and access to affordable food and adequate food storage facilities
- **HISTORICAL AND SOCIO-POLITICAL FACTORS** such as forced removal from land and/or family and culturally inappropriate services.

Sustained improvement in Indigenous health status can only be achieved if there is simultaneous effort to address these interdependent determinants of health. The *National Indigenous Reform Agreement* is the primary vehicle for addressing overall Indigenous disadvantage and is detailed at **Appendix Two**.

Further information about the health status of Indigenous Queenslanders (including separate examination of data pertaining to Torres Strait Islander people) and the evidence underpinning this *Making Tracks* policy and accountability framework is presented at **Appendix Four**.

<sup>4</sup> Australian Bureau of Statistics 2009. *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, 2005–2007* (ABS. cat. no. 3302.0.55.003) May 2009.

<sup>5</sup> S Begg, M Bright, C Harper. *Burden of disease and health-adjusted life expectancy in Health Service Districts of Queensland Health, 2006*. Queensland Health: Brisbane, 2009. [http://www.health.qld.gov.au/ph/documents/pdu/hale\\_series2.pdf](http://www.health.qld.gov.au/ph/documents/pdu/hale_series2.pdf)

<sup>6</sup> Vos T, Barker B, Stanley L, Lopez AD 2007. *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003*. Brisbane: School of Population Health, The University of Queensland.

<sup>7</sup> Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, Canberra 2008.

<sup>8</sup> Queensland Government, Queensland Health. Indigenous Strategy Team, Health Statistics Centre. *Closing the gap in Indigenous disadvantage: Trajectories for key health indicators*, March 2009 (unpublished).

## Priority Areas

Consistent with the evidence provided in **Appendix Four** the priority areas of focus for the *Making Tracks* policy and accountability framework are:

- **A HEALTHY START TO LIFE** – early childhood health, safety and education
- **ADDRESSING RISK FACTORS** – particularly smoking and obesity
- **MANAGING ILLNESS BETTER** – improving diagnosis and treatments of existing illness
- **EFFECTIVE HEALTH SERVICES** – improving access to, and the quality of, health services and health service infrastructure
- **IMPROVING DATA AND EVIDENCE** – to enable improved clinical practice and service planning.

These priority areas will be addressed at critical points across the lifespan of individuals, within urban, regional and remote populations, through sustained effort in all parts of the health system and across the health continuum.

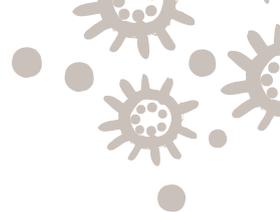
## Implementation and Reporting

**TRIENNIAL IMPLEMENTATION PLANS** will be developed under the *Making Tracks* policy and accountability framework to clearly articulate how available resources will be utilised to achieve the close the gap targets and to maximise sustainable health gains for Indigenous Queenslanders into the future.

**REPORTING ON PROGRESS** will occur annually where data is available and will focus on measuring progress against the COAG health targets and the other indicators of health status presented in this *Making Tracks* policy and accountability framework and the triennial *Making Tracks* implementation plans.



# accountability



## Priorities for health gain in Queensland

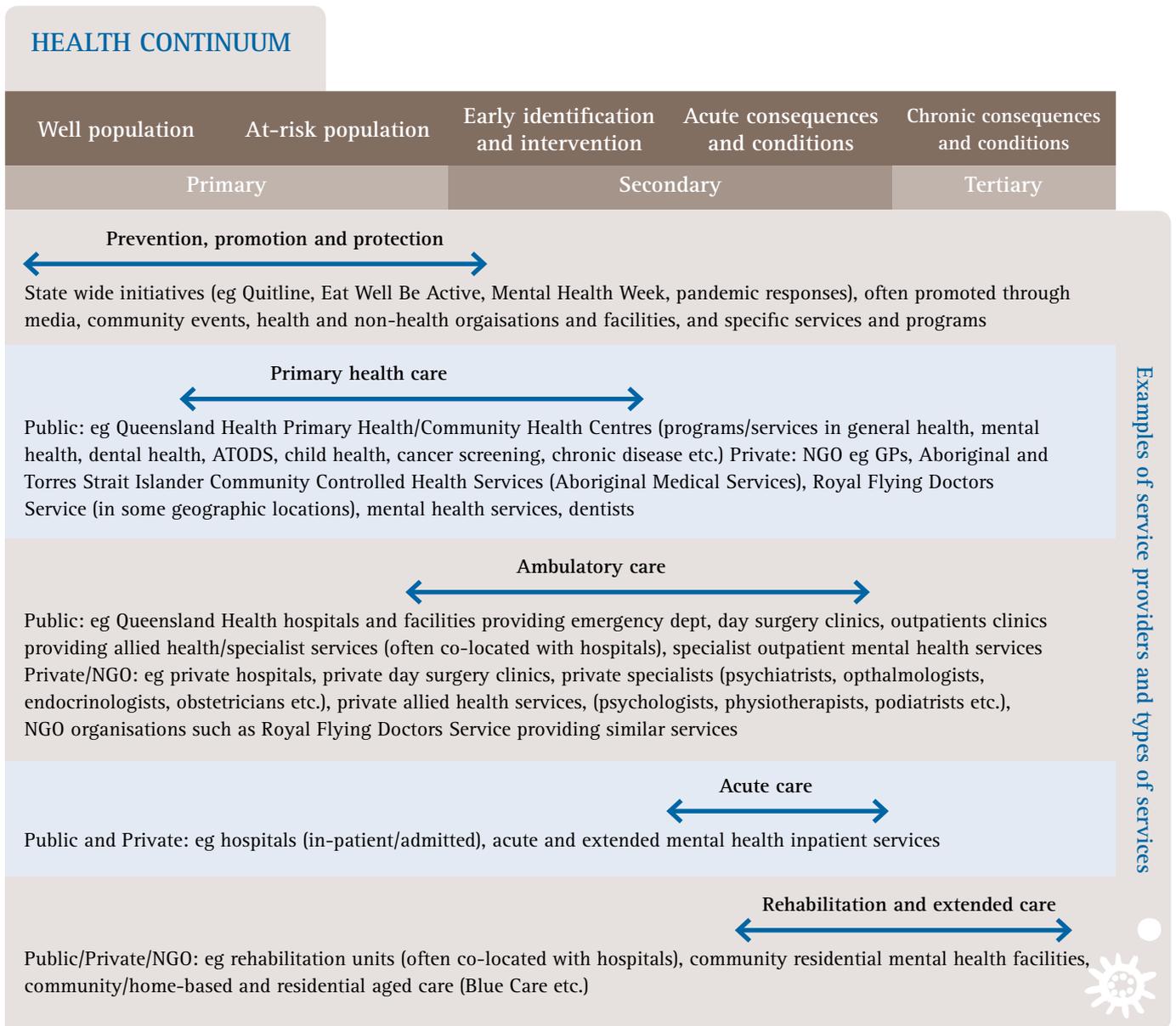
The evidence articulated in **Appendix Four** provides policy makers with clear guidance on the most effective package of health interventions and health system reform initiatives to achieve sustained health gains for Indigenous Australians. It reinforces the need for a multi-pronged strategy that includes:

- **SUSTAINED EFFORT ACROSS THE ENTIRE HEALTH SYSTEM** - delivering culturally capable and responsive general health services complemented by targeted Indigenous-specific programs and services; and providing coordinated and integrated care across service settings
- **HEALTH RESPONSES WITH CRITICAL INTERVENTION POINTS ACROSS THE LIFE SPAN** - particularly 0-8 years for a strong and healthy start to life, 8-18 years to avert the uptake of risky health behaviours, and adulthood
- **A FOCUS ON THE RISK FACTORS FOR CHRONIC DISEASE** to maximise the potential for health gain by targeting the leading causes of preventable mortality and morbidity experienced by Indigenous Queenslanders
- **EFFORT ACROSS THE HEALTH CONTINUUM** - to promote good health, to prevent illness where possible and to improve management of existing illness (see **Figure 2**).
- **ATTENTION TO THE NEEDS OF URBAN POPULATIONS AS WELL AS THOSE LIVING IN REGIONAL AND REMOTE AREAS**
- **COMPLEMENTARY EFFORT IN OTHER SOCIAL POLICY AREAS**, particularly in education and housing.





Figure 2: Health Care Continuum



(Source: Queensland Health)

The evidence clearly emphasises that to bridge the health gap between Indigenous and non-Indigenous Australians the most effective outcomes will be from interventions simultaneously implemented to address **both** of the following areas:

- **EARLY DIAGNOSIS, ACCESS TO TESTS, TREATMENT AND MANAGEMENT OF THE DISEASES** and illness that together contribute to 80 per cent of the health gap – cardiovascular disease, diabetes, chronic respiratory disease, cancers, mental disorders and injury
- **HEALTH PROMOTION AND HEALTH EDUCATION** to target the risk factors for poor health outcomes that together contribute to one-third of the health gap – in particular smoking – but also obesity, physical inactivity, alcohol and drug abuse, risky sexual practices and family violence.

Consistent with the evidence and in line with the national policy context, the Queensland Government is committed to working with Indigenous Queenslanders and health service providers towards closing the health gap by 2033 through initiatives (detailed in the accompanying *Making Tracks* implementation plans) across the following five domains:



## 2.1 A Healthy Start to Life

- Giving Aboriginal and Torres Strait Islander children 0-8 years old a healthy and safe start to life through effective women's health services, ante-natal and infant health care, improved education outcomes and child protection services.
- Reaching out to 8-18 year olds to ensure young Aboriginal and Torres Strait Islander people are in contact with the health and education systems and to establish healthy behaviours that will impact heavily on adult physical and mental health outcomes.

Children and young people up to 18 years of age represent approximately half of Queensland's total Indigenous population with almost one-third of Queensland's Indigenous population under 12 years of age. To close the child mortality and life expectancy gaps, Aboriginal and Torres Strait Islander children must have a healthy and safe start to life, free of avoidable injury and illness. To achieve this, a holistic approach to children's health is required which takes account of the health of their parents. Maternal health and female reproductive health services and programs are of major importance in establishing a healthy start to the life of a child. Male health is also crucial in contributing to the overall health and well-being of children, to the family unit and to future generations. Targeted approaches to transition young people from childhood to adolescence to adulthood with positive health behaviours and in engagement with the health and education systems will be required.

Related state-wide strategies include:

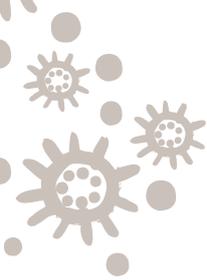
- Strategic policy for Aboriginal and Torres Strait Islander children and young people's health 2005-2010<sup>9</sup>
- Universal and Targeted Primary Health Care Model for Maternal and Child Health Services in Aboriginal and Torres Strait Islander Communities (See Appendix Seven).

## 2.2 Addressing Risk Factors

- Reducing the modifiable risk factors that contribute to chronic disease through effective anti-smoking initiatives, mechanisms to address harmful alcohol consumption, improved nutrition, oral health and participation in physical activity and improved access to reproductive and sexual health information and programs.
- Improving the living environments of Indigenous Australians through environmental health and housing initiatives and efforts to improve community and personal safety.

*Making Tracks* focuses on the major risk factors associated with the high rates of adult chronic disease and poor physical and mental health outcomes, including those associated with lifestyle and behaviour (such as smoking), living environments (such as overcrowding) and life stressors (such as community violence). It recognises the need for promotion of healthy behaviours and health education to avert the adoption of risky health practices and to help those who already have chronic diseases maximise the management of their illness by adopting a healthier lifestyle. Health promotion approaches specifically targeting Indigenous Queenslanders and the establishment of a dedicated health promotion capacity that can work with Aboriginal and Torres Strait Islander people across the risk factors are crucial to preventing the development of chronic diseases in adults.

<sup>9</sup> Queensland Government, Queensland Health 2005. *Strategic Policy for Aboriginal and Torres Strait Islander children and young people's health 2005-2010*, November 2005.



Related state-wide strategies include:

- Queensland Strategy for Chronic Disease 2005-2015<sup>10</sup> (general population)
- Queensland Health Population Health Plan 2007-2017<sup>11</sup> (general population)
- Queensland Plan for Mental Health 2007-2017<sup>12</sup> (general population)
- Queensland Health Aboriginal and Torres Strait Islander Environmental Health Plan 2008-2012<sup>13</sup>
- Queensland Implementation Plan for Remote Indigenous Housing National Partnership Agreement<sup>14</sup>

## 2.3 Managing Illness Better

- Assisting Aboriginal and Torres Strait Islander Queenslanders with chronic disease through earlier diagnosis, improved access to screening, routine tests and procedures, and appropriate treatment targeting in particular the most prevalent disease groups: cardiovascular disease, type 2 diabetes and chronic respiratory diseases.

Recent research<sup>15</sup> informs us that for Aboriginal and Torres Strait Islander people, the mortality gap is considerably greater than the disability gap, reflecting the fact that Indigenous Australians are more likely to die from an illness than non-Indigenous Australians are from the same illness. This means that there is a large potential for health gain and for reducing the gap in life expectancy through both prevention strategies and better management of existing illness. Cardiovascular disease, type 2 diabetes, chronic respiratory conditions, cancers, mental disorders and injuries account for 80 per cent of the health gap between Indigenous and non-Indigenous Queenslanders. *Making Tracks* recognises the need for attention on improving diagnosis, access to appropriate tests and procedures, clinical treatment and self-management of chronic disease in adult populations.

Related state-wide strategies relevant to this Priority Area include:

- Queensland Strategy for Chronic Disease 2005-2015 (general population)
- Queensland Statewide Cancer Treatment Services Plan 2008-16<sup>16</sup> (general population)
- Queensland Statewide Renal Health Services Plan 2008-17<sup>17</sup> (general population)

## 2.4 Effective Health Services

- Improving access to, and experience of, the health system by enhancing the cultural competence of the health workforce and participating in health service systems that encourage integration between programs, between the hospital and primary health care systems and across all health service providers.
- Developing a state-wide Indigenous primary health care reform framework to improve the effectiveness of service delivery mechanisms and integration across primary health care settings and to inform the design and delivery of state funded programs and services for Indigenous Queenslanders.

Improving access to, and the effectiveness of, health services for Aboriginal and Torres Strait Islander Queenslanders is a continuous improvement process and is multi-faceted. The effectiveness of existing health services can be enhanced to provide more culturally sensitive and responsive programs and can be staffed by a workforce that has had both the clinical and cultural training to make them competent practitioners of health service delivery for Indigenous Queenslanders.

<sup>10</sup> Queensland Government, Queensland Health 2005. *Queensland Strategy for Chronic Disease 2005-2015*, Brisbane.

<sup>11</sup> Queensland Government, Queensland Health, 2007. *Queensland Health Population Health Plan 2007-2012*, Brisbane.

<sup>12</sup> Queensland Government, Queensland Health, 2008. *Queensland Plan for Mental Health 2007-2017*, Brisbane.

<sup>13</sup> Queensland Government, Queensland Health, 2008. *Queensland Health Aboriginal and Torres Strait Islander Environmental Health Plan 2008-2012*, Brisbane.

<sup>14</sup> Queensland Government, Department of Communities 2009. *Implementation Plan for the National Partnership Agreement on Remote Indigenous Housing*, Brisbane.

<sup>15</sup> Vos et al, 2007.

<sup>16</sup> Queensland Government, Queensland Health 2008. *Queensland Statewide Cancer Treatment Services Plan 2008-16*, Brisbane.

<sup>17</sup> Queensland Government, Queensland Health 2007. *Queensland Statewide Renal Service Plan 2008-12*, Brisbane.



Attracting and retaining an effective health workforce, career pathways for Aboriginal and Torres Strait Islander health staff and strategies for encouraging greater participation of Indigenous Australians in the health workforce is an ongoing priority. Services and programs can be informed by better engagement with Indigenous communities and by the involvement of Aboriginal and Torres Strait Islander people in planning and program design and implementation. Access to health services and programs can be improved too – by promoting their availability, by making them places that Aboriginal and Torres Strait Islander Queenslanders feel confident in attending and by the provision of transport and accommodation in close proximity to services. The patient experience across the health system, particularly between primary and acute care services, can be improved through better integration of services, through increased collaboration with non-government health service providers (particularly A&T&SICCHSs) and by improved transition care arrangements, including discharge planning, transfer of patient records and follow-up care. Strategies to improve access by Aboriginal and Torres Strait Islander males to health services require particular attention given the disengagement of teenage boys and men from the health system and their poor health outcomes. Finally, improving access to health services by Indigenous Queenslanders that live in urban areas is crucial in addressing the life expectancy gap. Identifying how to reach Indigenous Queenslanders residing in metropolitan areas effectively and to engage them in health services and programs remains an ongoing priority.

Related state-wide strategies include:

- Queensland Statewide Health Services Plan 2008–2012<sup>18</sup>
- Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, Queensland Implementation Plan<sup>19</sup>
- Queensland Health Aboriginal and Torres Strait Islander Workforce Strategy 2009–2012
- Queensland Health – The Aboriginal and Torres Strait Islander Health Worker Career Structure 2007<sup>20</sup>

## 2.5 Improving Data And Evidence

- Continuing to improve the quality and availability of research and data, accountability mechanisms and evaluation.

Improving the quality and availability of data and evidence is crucial to inform evidence-based clinical practice, to get better at determining where and how to intervene to improve the health status and the health care experience of Indigenous Queenslanders. Monitoring and understanding how effective we are, whether we deliver on our commitments and, most importantly, whether we make a difference to health outcomes for Indigenous Queenslanders, is critical if we are to continue to improve within a good practice health care framework and if the close the gap targets are to be achieved.

<sup>18</sup> Queensland Government, Queensland Health 2007. *Queensland Statewide Health Services Plan 2007–2012*, Brisbane February 2007.

<sup>19</sup> Queensland Aboriginal and Torres Strait Islander Health Partnership 2005. *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework Queensland Implementation Plan*, Brisbane 2005.

<sup>20</sup> Queensland Government, Queensland Health 2007. *The Aboriginal and Torres Strait Islander Health Worker Career Structure 2007*, Brisbane 2007.





### 3. Queensland Closing the Health Gap Accountability Framework

The accountability framework articulated in this section is designed to measure progress against the health targets and indicators included in the COAG *National Indigenous Reform Agenda* as well as a range of other indicators by which achievement of sustainable health gains can be measured over time. It describes the national targets and indicators adopted by all governments, the Queensland Close the Gap Indicator Framework and the *Aboriginal and Torres Strait Islander Health Performance Framework*<sup>21</sup> which underpins the NSFATSIH and includes indicators for measuring health status, access to services and the broader determinants of health. At a regional level, Indigenous health key performance indicators and forward trajectories have been developed for Queensland Health Service Districts to enable monitoring of continuous improvement in achieving health outcomes. The framework also records the baseline data against which improvement can be measured and reported.

#### COAG national targets and indicators

The following COAG Indigenous Reform targets have been adopted by all governments.

- Close the life expectancy gap within a generation (by 2033)
- Halve the gap in mortality rates for Indigenous children under five within a decade (by 2018)
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade
- All four year olds in remote areas have access to early childhood education within five years
- At least halve the gap for Indigenous students in Year 12 (or equivalent) attainment rates by 2020.

The Queensland Government publishes quarterly and annual reports on its efforts to close the gap in Indigenous disadvantage in collaboration with Indigenous communities. The annual *Queensland Closing the Gap Report* provides regularly updated point in time data against a range of agreed indicators that are consistent with the COAG Indigenous Reform targets. The health, well-being and education indicators included in the *Queensland Close the Gap Indicator Framework*, which underpin the Queensland Close the Gap Reports, are listed at Figure 3.

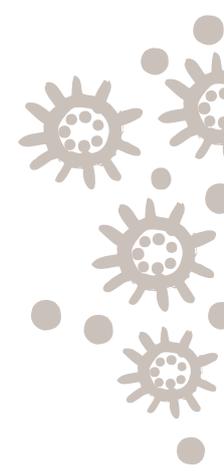
<sup>21</sup> Australian Health Ministers' Advisory Council (AHMAC) 2006. *Aboriginal and Torres Strait Islander Health Performance Framework*, Canberra 2005.

Figure 3: Queensland Close the Gap Indicator Framework – health related indicators

EDUCATION AND TRAINING		
Target	Indicators	Measure
Halve the Gap in reading writing an numeracy within a decade	Literacy and numeracy	Yr 3, 5, 7 and 9 Percentage of students at or above the national minimum standard in reading
		Yr 3, 5, 7 and 9 Percentage of students at or above the national minimum standard in writing
		Yr 3, 5, 7 and 9 Percentage of students at or above the national minimum standard in numeracy
		Yr 3, 5, 7 and 9 Rates of participation in NAPLAN testing
Halve the gap for year 12 students in year 12 or equivalent attainment	Year 12 achievement	Proportion of 20-24 year olds having attained at least a year 12 certificate or equivalent
		Apparent retention rates from year 7/8 to year 10
		Apparent retention rate from year 7/8 to year 12
		Attendance rates year 1 to year 10
		Proportion of year 12 students by QCE outcomes
		Proportion of year 12 completers meeting QCE literacy and numeracy requirements

HEALTHY LIVES		
Target	Indicators	Measure
Close the life expectancy gap within a generation	Life expectancy	Estimated life expectancy at birth
	Mortality rate by cause of death	Age standardised mortality rate per 100,000 persons by cause of death
	Hospitalisation rates by principal diagnosis	Age standardised rate of admission to hospital per 100,000 person (excluding dialysis) by ICD 10 chapter
	Access to health care compared with need	Proportion of persons accessing health care by type of service Proportion of persons who needed to access to health care but did not
	Chronic disease	Age standardised rate of admission to hospital per 100,000 persons dialysis Age standardised rate of admission to hospital per 100,000 persons pyelonephritis Age standardised rate of admission to hospital per 100,000 persons diabetes and complications Age standardised rate of admission to hospital per 100,000 persons cellulitis Age standardised rate of admission to hospital per 100,000 persons circulatory disease Age standardised rate of admission to hospital per 100,000 persons end stage renal disease Age standardised rate of admission to hospital per 100,000 persons chronic obstructive pulmonary disease Incidence of renal failure, Indigenous: non-Indigenous





**HEALTHY LIVES cont.**

Target	Indicators	Measure
	Chronic disease cont.	Median age at which treatment for renal failure commenced and age specific rate of treatment onset for renal failure Proportion of persons by main reason for renal failure
	Discharge against medical advice	Percentage of admissions who discharge against medical advice
	Rates of current daily smokers	Proportion of persons aged 18 years and older smoking daily
	Average daily alcohol consumption and associated risk levels	Proportion of persons aged 18 years and older drinking at risky or high risk levels
	Levels of obesity	Proportion of persons aged 15 years and older considered overweight or obese
	Level of physical activity	Proportion of persons aged 15 years and older with sedentary/low level exercise
	Safe and supportive communities	Age standardised rate of admission to hospital per 100,000 persons assault

**EARLY CHILD DEVELOPMENT**

Target	Indicators	Measure
Halve the gap in mortality rates for Indigenous children under five within a decade	Child under 5 mortality rates	Perinatal mortality rate per 1000 births
		Infant mortality per 1000 live births
		1-4 year mortality rate per 10,000 children
		0-4 year mortality rate per 10,000 children
		Mortality 0-4 years by leading cause
	Child under 5 hospitalisation rate by principal diagnosis	Hospital admissions per 1000 children by ICD 10AM Chapter
	Low birth weight	Low birth weight babies (<2500 grams) per 1000 live singleton births
	Tobacco smoking during pregnancy	Proportion of women who smoked at any time during pregnancy
The proportion of Indigenous children who are enrolled in (and attending) a preschool program in the year before formal schooling.	Antenatal care	Proportion of women attending 5 or more antenatal visits (32 weeks or more gestation)
		Proportion of women attending first antenatal visit in first trimester
	Early childhood education	Proportion of four year olds enrolled in a pre-primary program
	Early childhood education	Proportion of 5 year olds enrolled full-time in prep year programs

Figure 3: Queensland Close the Gap Indicator Framework – health related indicators (continued from previous page)

HOME ENVIRONMENT		
Target	Indicators	Measure
Close the life expectancy gap within a generation	Overcrowding	Proportion of persons living in overcrowded households

SAFE AND SUPPORTIVE COMMUNITIES		
Target	Indicators	Measure
Close the life expectancy gap within a generation	Child safety	Rate of substantiated notifications per 1000 children aged 0-17 years
		Rate of notifications per 1000 children aged 0-17 years
		Rate of child protection orders per 1000 children aged 0-17 years
		Placement in accordance with Indigenous child placement principal
Family violence	Family violence	Rate of domestic violence protection orders by Indigenous status of the aggrieved per 1000 persons, 17 years and older
		Proportion of applicants who were police, aggrieved
		Number of orders issued by Indigenous status of accused
Community safety - offending	Community safety - offending	Rate of domestic violence protection orders by Indigenous status of the accused per 1000 persons, 17 years and older
		Age standardised rate of offenders against the person per 100000 persons aged 10 years and older
Community safety - responses	Community safety - responses	Age specific offending rates per 1000 persons
		Age standardised rate of adult imprisonment per 100,000 persons
		Rate of distinct young people in Qld youth detention centres, detention and remand status
		Number and proportion of Indigenous youth either on remand or sentence



# Aboriginal and Torres Strait Islander Health Performance Framework

The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) was developed by the Standing Committee on Aboriginal and Torres Strait Islander Health in 2005 and is based on the *National Health Performance Framework* developed for the mainstream health system in 2001. The HPF enables monitoring of health system performance and the broader determinants of health in improving Aboriginal and Torres Strait Islander health and provides a basis for measuring progress in meeting the objectives of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* and the *COAG Indigenous Health Outcomes National Partnership Agreement*. The *Aboriginal and Torres Strait Islander Health Performance Framework* comprises three tiers of indicators:

- **Tier One - health status and health outcomes** - measures the prevalence of disease or injury, human function, life expectancy and well-being.
- **Tier Two - determinants of health status** - measures the determinants of health including socio-economic status, educational levels, environmental factors and health behaviours.
- **Tier Three - health system performance** - measures the effectiveness, responsiveness, accessibility and sustainability of the health system.

Appendix Five details the performance indicators reported biennially under the HPF. Data for the first (2006) HPF report<sup>22</sup> provides a baseline against which to monitor progress in closing the health status gap. Queensland data from the 2008 HPF report, including a summary of national trends that have begun to emerge, are recorded at Appendix Six.

## Queensland Health Key Performance Indicators

The following Queensland Health key performance indicators have been adopted by all Health Service Districts and progress against these indicators will be reported annually.

1. The proportion of patients who discharge themselves from hospital against medical advice.
2. The proportion of Indigenous patients accurately identified as being of Aboriginal and Torres Strait Islander status within the Queensland Hospital Admitted Patient Data.
3. The proportion of women who give birth who had 5 or more antenatal visits during pregnancy.
4. The proportion of live birth, singleton babies born weighing less than 2500 grams.
5. The proportion of pregnant women who smoked at any time during pregnancy.
6. The proportion of pregnant women who smoked at any time during pregnancy but had quit by 20 weeks gestation.
7. The direct standardised rates of potentially preventable hospitalisations:
  - Acute conditions
  - Chronic conditions
  - Vaccine preventable conditions
8. Rates of hospitalisation of children aged 0-14 for selected conditions:
  - Influenza and pneumonia
  - Upper respiratory infections
  - Gastro-intestinal infections and dehydration
  - Selected skin infections
  - Injury and assault
  - Selected dental conditions
  - Asthma
  - Selected ear, nose and throat conditions
  - Epilepsy and convulsions

<sup>22</sup> Australian Health Ministers' Advisory Council (AHMAC), 2006. *Aboriginal and Torres Strait Islander Health Performance Framework*, Report 2006 AHMAC, Canberra.

## Baseline Data and Tracking Progress Over Time

The Queensland Government is committed to achieving equality of health status and life expectancy between Indigenous and non-Indigenous Queenslanders by 2033 and has signed a Statement of Intent to this effect. Through COAG, the Queensland Government is prioritising the achievement of specific health targets: to close the gap in life expectancy between Indigenous Queenslanders and the rest of the Queensland population within a generation (by 2033) and to halve the mortality gap for Indigenous children under five within a decade (by 2018). Figure 4 features data related to life expectancy, comparing Indigenous and non-Indigenous males and females in Queensland and Australia. These data provide a baseline against which to measure progress in achieving life expectancy gain. Figures 5 and 6 feature data related to child mortality and provide both a baseline against which to measure progress and an indication of data trends over time.

Figure 4: Life expectancy at birth in years, 2005–2007

(Indigenous to non-Indigenous)	Indigenous	Non- Indigenous	Life expectancy gap
Males – Queensland	68.3	78.6	10.4*
Males – Australia	67.2	78.7	11.5
Females – Queensland	73.6	82.5	8.9
Females – Australia	72.9	82.6	9.7

Note: Life expectancy data is subject to a degree of uncertainty. Due to changes in calculation methodology, these figures cannot be directly compared with previous life expectancy estimates. \* Differences in calculation of the gap for Queensland males are due to rounding. Source: ABS cat no. 3302.0.55.003

Figure 5: Perinatal mortality rates per 1,000 births, 1991–2001 and 2002–2005

	1999–2001			2002–2005		
	No.	Rate per 1,000	Rate ratio	No.	Rate per 1,000	Rate ratio
<b>Queensland</b>						
Indigenous	134	13.9	1.6*	158	11.3	1.4*
Non-Indigenous	1,136	8.5		1,521	8.2	
<b>Qld, WA, SA and NT</b>						
Indigenous	350	16.5	2.0*	372	12.5	1.6*
Non-Indigenous	2,103	8.1		2,798	7.9	

Source: ABS Deaths Registration Database in AIHW, 2008.

Figure 6: Infant mortality rates per 1,000 live births 1999–2001, 2002–2004 and 2005–2006

	Indigenous				Non-Indigenous				
	Deaths	Rate per 1,000	LCL 95%	UCL 95%	Deaths	Rate per 1,000	LCL 95%	UCL 95%	Rate ratio
					1999–2001				
Qld	111	11.7	9.5	13.9	721	5.5	5.1	5.9	2.1*
Qld, WA, SA and NT	296	14.2	12.6	15.8	1,228	4.7	4.5	5.0	3.0*
					2002–04				
Qld	111	10.9	8.9	12.9	643	4.7	4.4	5.1	2.3*
Qld, WA, SA and NT	270	12.5	11.0	14.0	1,088	4.2	3.9	4.4	3.0*
					2005–06				
Qld	81	11.4	8.9	13.9	452	4.6	4.2	5.1	2.4*
Qld, WA, SA and NT	185	12.1	10.4	13.8	803	4.3	4.0	4.6	2.8*

Source: AIHW analyses of National Mortality Database in AIHW, 2008.

Whilst the previous tables are directly relevant to the two COAG targets, the largest gains in effecting positive change in life expectancy and child mortality data will come from decreasing the impact of preventable and modifiable illness. Figure 7 provides baseline data on rates of avoidable mortality which can be reduced through a sustained focus on the identified risk factors. Appendix Six includes more recent data and an analysis of early identifiable trends.

Figure 7: Avoidable mortality, by cause of death, persons aged 0–74 years, 2000–2004

Cause of death	Per cent		Rate per 100,000		Ratio
	Indig	Non-Indig	Indig	Non-Indig	
	Queensland				
Ischaemic heart disease	22.4	21.3	161.0	40.2	4.0*
Cancer	15.7	35.8	121.9	66.7	1.8*
Diabetes	11.6	3.0	96.6	5.6	17.2*
Suicide	8.5	7.0	25.9	13.0	2.0*
Road traffic injuries	4.0	4.7	13.5	8.7	1.6*
Cerebrovascular disease	4.7	6.0	36.3	11.4	3.2*
Alcohol related disease	5.0	2.4	25.2	4.5	5.6*
Chronic obstructive pulmonary disease	4.5	5.4	39.0	10.2	3.8*
Selected invasive bacterial and protozoal infections	3.8	1.9	21.0	3.5	6.0*
Nephritis and nephrosis	1.9	0.7	13.6	1.3	10.5*
Violence	2.2	0.7	6.8	1.3	5.2*
Birth defects	3.1	1.8	5.8	3.3	1.7*
Rheumatic and other valvular heart disease	1.5	0.3	6.8	0.6	12.2*
Other	11.1	9.2	50.4	17.3	2.9*
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>623.9</b>	<b>187.6</b>	<b>3.3*</b>
	Per cent		Rate per 100,000		
	Indig	Non-Indig	Indig	Non-Indig	
	Qld, WA, SA and NT				
Cause of death					Ratio
Ischaemic heart disease	19.9	21.1	163.2	38.3	4.3*
Cancer	13.3	35.9	120.3	64.6	1.9*
Diabetes	11.1	3.2	104.7	5.8	18.1*
Suicide	7.7	6.9	27.2	12.6	2.2*
Road traffic injuries	6.5	4.9	25.9	8.9	2.9*
Cerebrovascular disease	4.5	6.0	40.6	10.9	3.7*
Alcohol related disease	6.1	2.4	37.6	4.3	8.8*
Chronic obstructive pulmonary disease	4.2	5.0	45.0	9.1	4.9*
Selected invasive bacterial and protozoal infections	4.8	2.0	30.7	3.7	8.2*
Nephritis and nephrosis	3.2	0.8	28.0	1.5	18.2*
Violence	3.0	0.6	11.6	1.2	10.0*
Birth defects	2.6	1.6	6.5	2.9	2.2*
Rheumatic and other valvular heart disease	1.8	0.3	10.2	0.5	19.1*
Other	11.3	9.3	58.6	17.0	3.5*
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>710.1</b>	<b>181.4</b>	<b>3.9*</b>

Source: AIHW analysis of National Mortality Database in AIHW, 2006.



Median age at admission to hospital further illustrates the gap between the non-Indigenous and Indigenous populations for chronic conditions where there is an increasing incidence and prevalence with age, such as heart disease and renal disease. Figures 8 and 9 show the median age of Indigenous and non-Indigenous Queenslanders admitted to hospital, and the resulting gap. It is clear from this data that many Indigenous Queenslanders will require hospitalisation for a range of chronic diseases at a much younger age than the non-Indigenous population. This can significantly affect quality of life during early and middle adulthood when most people can expect to live healthy and productive lives. Figure 27 (Appendix 6) gives an indication of the modest gains to date in closing the gap in median age of admissions to hospital.

Figure 8: Indigenous Queenslanders Median age at admission to hospital 2004-05 to 2007-08

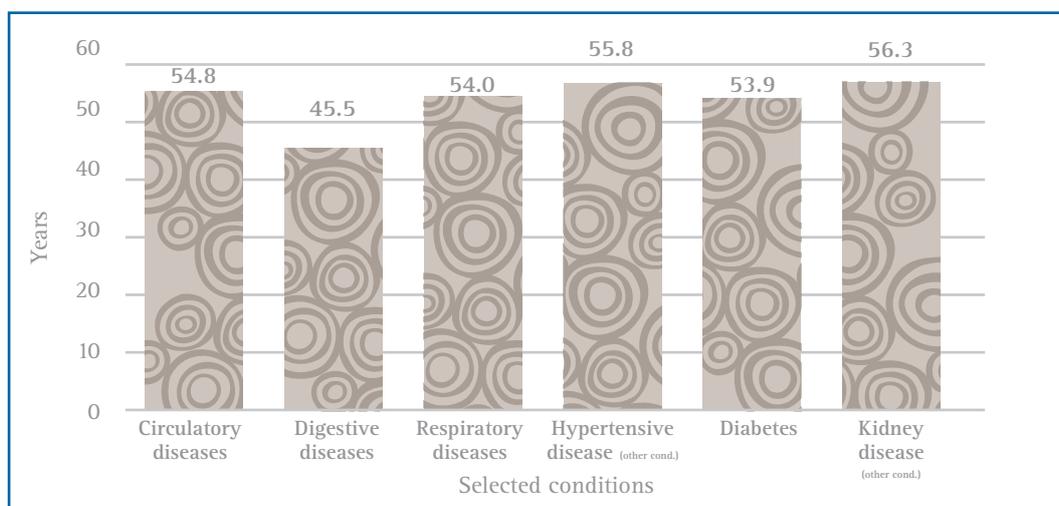
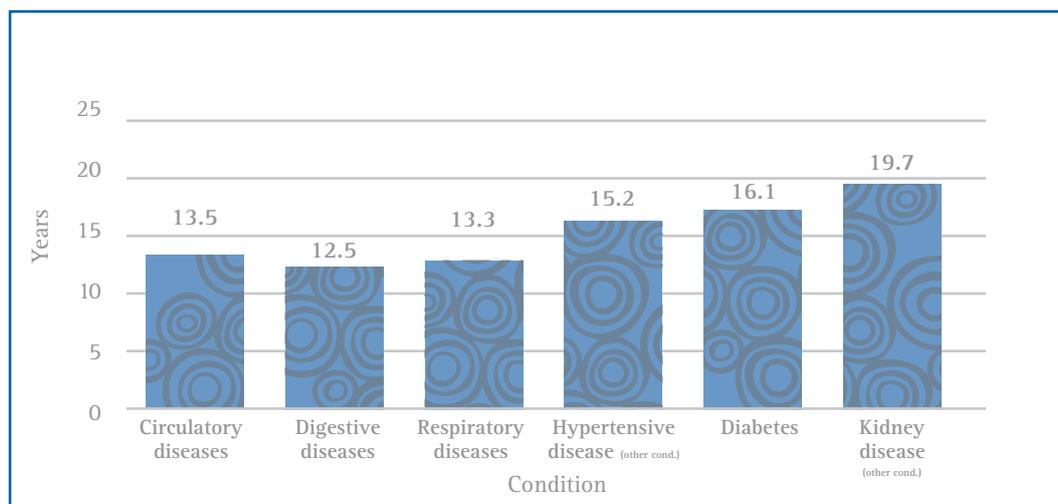


Figure 9: The gap between Indigenous and non-Indigenous Queenslanders in median age at admission to hospital (persons over 30 years)



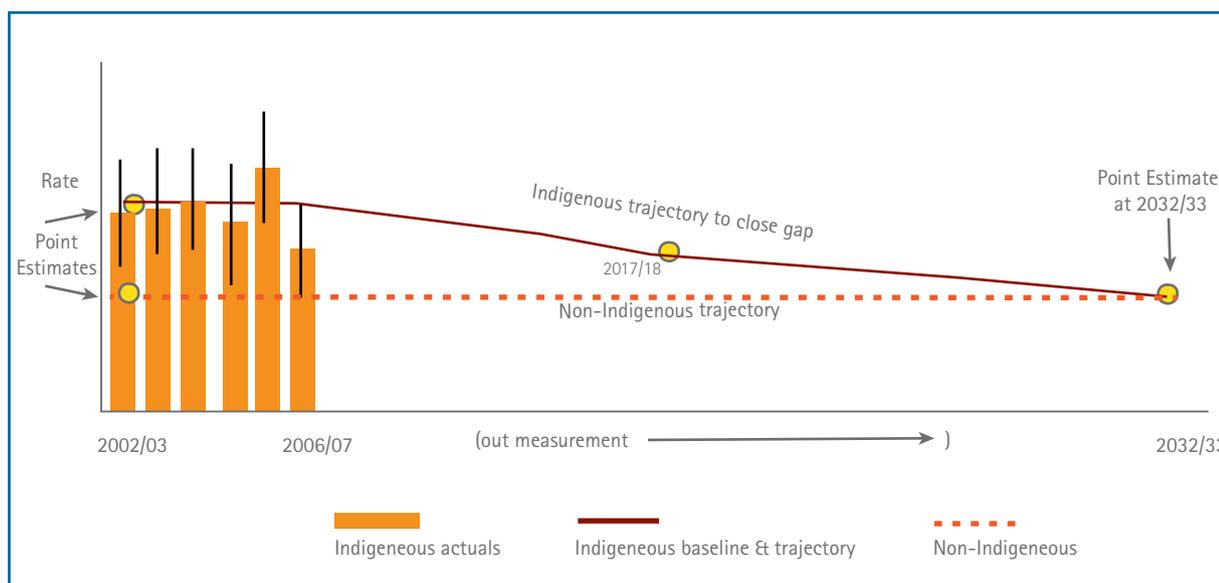
Note: To enable comparison of some conditions where incidence is high in the very young (such as chronic respiratory infections) admissions for persons less than 30 years of age have been excluded from the analysis. Source: Queensland Health 2009.

## Establishment of Close the Gap Trajectories

In order to track improvements towards achieving set targets at regular intervals, Queensland Health has developed trajectories for 12 key Indigenous health indicators<sup>23</sup> that will guide and inform progress in closing the health gap. In developing the trajectories, four key steps were undertaken:

1. Extraction and analysis of historical trends for the Indigenous and non-Indigenous populations.
2. Regression analysis from which a non-Indigenous trajectory to 2017-2018 (the target for halving child mortality rates) and 2032-2033 (the target for closing the life expectancy gap) could be estimated.
3. Establishment of an Indigenous baseline using the latest available data.
4. Development of a trajectory for the Indigenous population from the current Indigenous baseline to the non-Indigenous trajectory target at 2017-2018 and 2032-2033. From this, selected summary statistics can be derived, such as the current Indigenous and non-Indigenous rates and rate ratios, and the estimated rate or point reduction required per year to stay on track with the trajectory.

Figure 10: Diagrammatic representation of developing a trajectory



Trajectories have been developed for the following indicators:

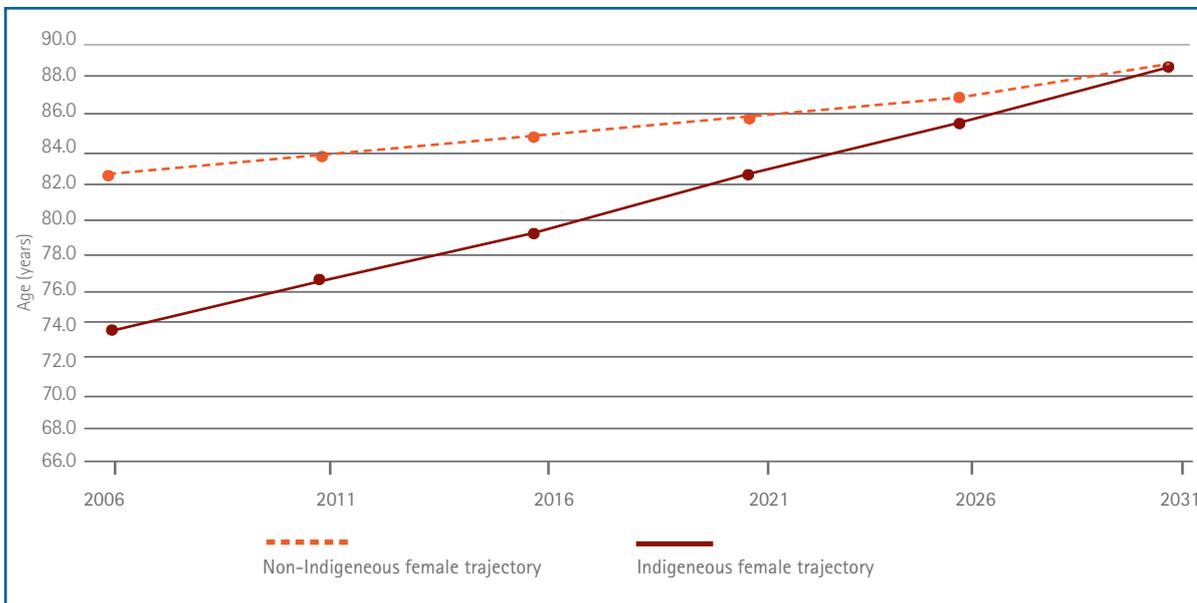
- Life expectancy at birth for males and females
- Perinatal mortality
- Infant/young child 0-4 years mortality
- Women who smoked at any time during pregnancy
- Births to teenage mothers (less than 20 years of age)
- Antenatal visits (5 or more)
- Low birth weight (less than 2500 grams)
- Low gestational age (less than 37 weeks)
- Selected potentially preventable hospitalisations (acute, chronic and vaccine preventable conditions)
- Discharge against medical advice.

Of these, trajectories pertaining to life expectancy, infant mortality, birth weight and selected potentially preventable hospitalisations are presented in the following tables. However, in monitoring and reporting on progress towards closing the Indigenous health gap, Queensland Health will provide progress reports against all the indicators for which trajectories have been developed at intervals ranging from annually to every five years depending on the availability of data.

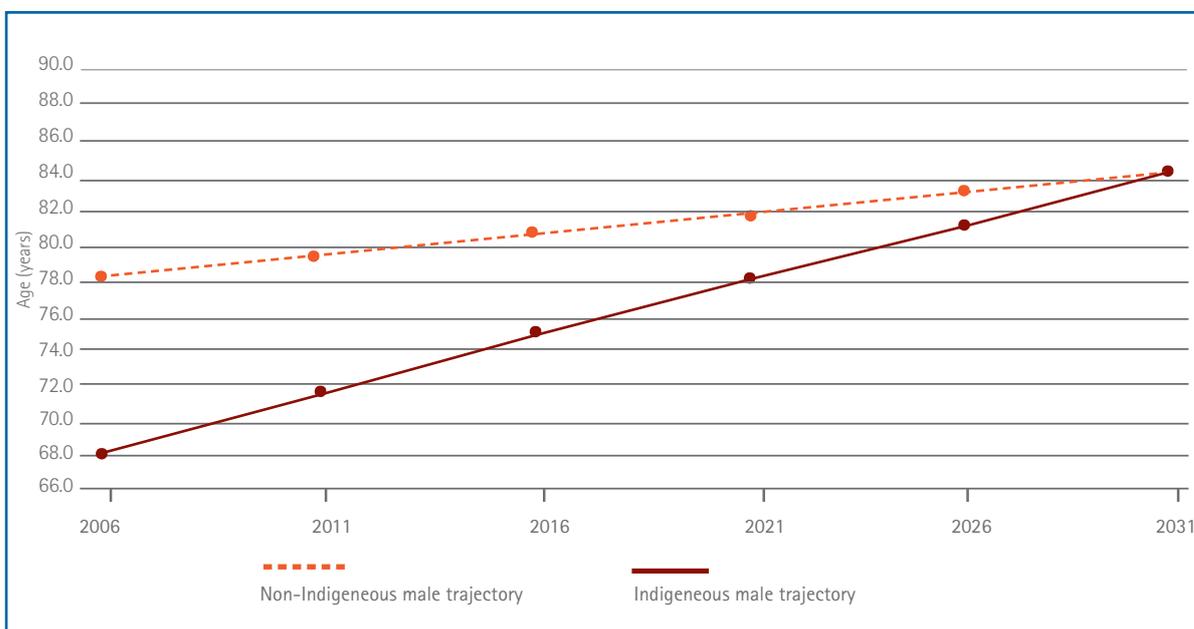
<sup>23</sup> Queensland Government, Queensland Health. Indigenous Strategy Team, Health Statistics Centre. *Closing the gap in Indigenous disadvantage: Trajectories for key health indicators*, May, 2010 (unpublished).

Figure 11: Estimated life expectancy at birth - trajectory to close the gap

**Queensland - Female Indigenous Life Expectancy Trajectory**



**Queensland - Male Indigenous Life Expectancy Trajectory**

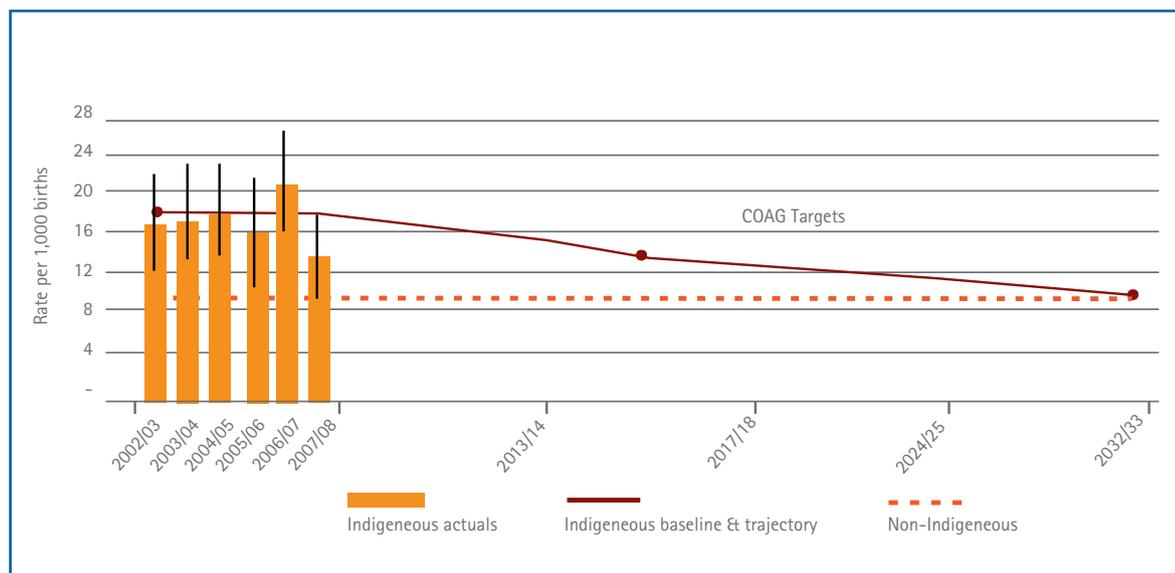


**Trajectory Methodology Notes:**

Life expectancy estimates will only be available every 5 years. Trajectory targets for non-Indigenous life expectancy of 0.24 gain per year were held constant. This estimated annual gain was derived from Australian total population trends for the past 25 years using OECD data.

**Source:** Australian Bureau of Statistics Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, Cat No. 55.003, May 2009.

Figure 12: Perinatal mortality rates (per 1,000 births) Queensland 2002-03 to 2032-33 – trajectory to close the gap



**Trajectory Methodology Notes:**

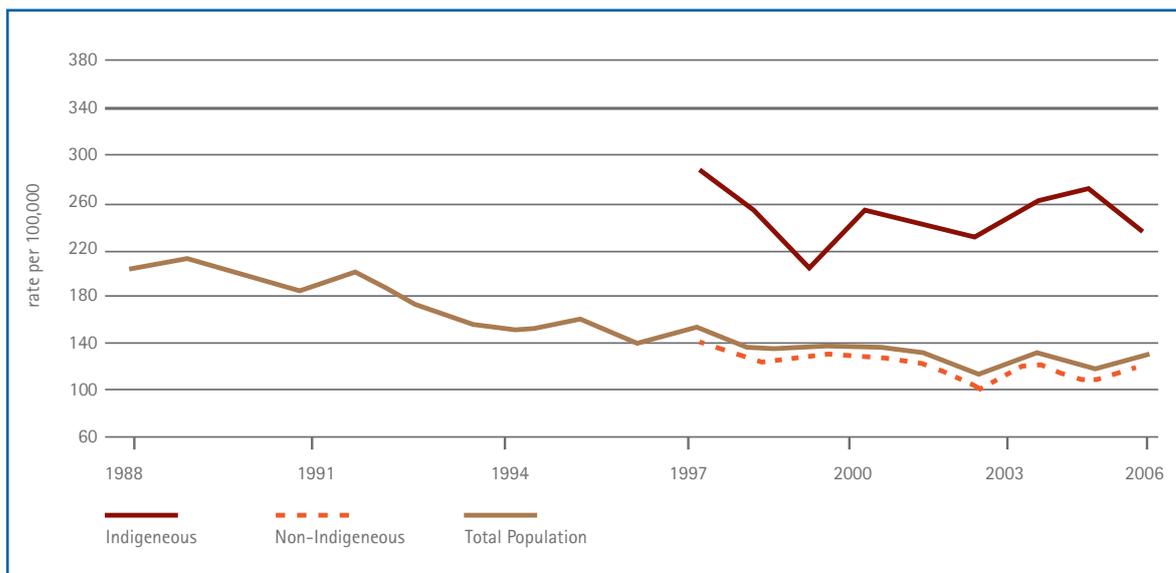
Targets for the first 10 years (2008-09 to 2017-18) are based on *halving* the gap between Indigenous and non-Indigenous perinatal mortality rates. Targets for the next 15 years (2018-19 to 2032-33) are based on *closing* the gap between Indigenous and non-Indigenous perinatal mortality rates. Trajectory for non-Indigenous perinatal mortality rates was held constant based on the assumption that further significant improvement in non-Indigenous rates will be small. Unknown Indigenous status of the mother is included within the non-Indigenous category. Perinatal mortality includes stillborns (either born at 20 weeks or more gestation or weight at least 400 grams at birth) and neonatal deaths (live-born that have died within 28 days).

Source: Queensland Health Perinatal Data Collection, 2002-03 to 2007-08.

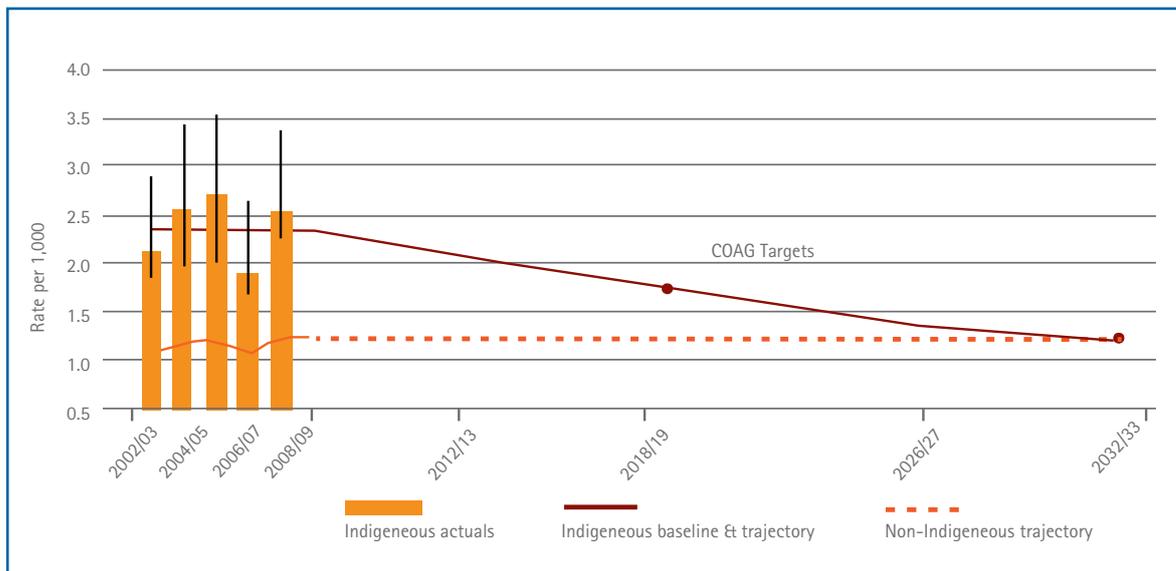


Figure 13: Infant/young child (0-4 years) mortality rates, Queensland, 2002-03 to 2032-33 – trajectory to close the gap

Queensland - Mortality (0 to 4 years), rate per 100,000 population, 1988 to 2006



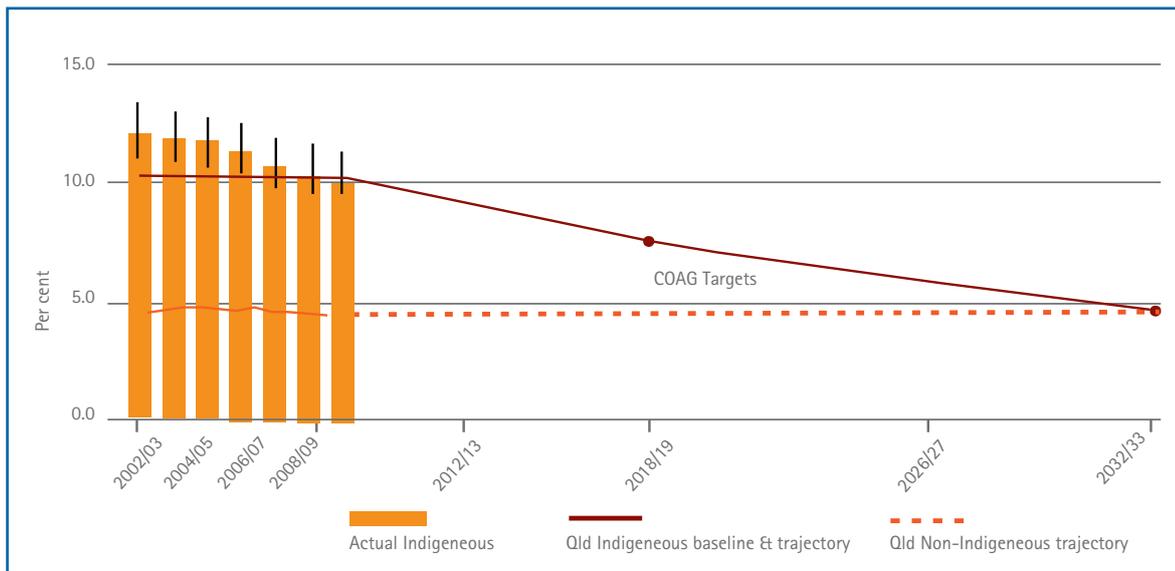
Queensland - Mortality (0 to 4 years), rate per 100,000 population 2002-03 to 2032-33 trajectory



**Trajectory Methodology Notes:**

\* Expected number derived by applying the non-Indigenous Queensland rate of mortality to the total number of among children aged 0-4 years. Targets for the first 10 years (2008-09 to 2017-18) are based on halving the gap between Indigenous and non-Indigenous young child mortality rates. Targets for the next 15 years (2019-2033) are based on closing the gap between Indigenous and non-Indigenous young child mortality rates. Trajectory for non-Indigenous young child mortality rates were held constant at 2002-03 to 2006-07 levels (1.2 per 1,000) based on the assumption that further significant improvement in non-Indigenous rates will be small. Years are based on year of registration of deaths. Source: ABS Cause of Death data collection 2002-03 to 2006-07

Figure 14: Proportion of low birth weight babies (less than 2500 grams at birth) born to Aboriginal and Torres Strait Islander women, 2003 to 2033 – trajectory to close the gap



**Trajectory Methodology Notes:**

Targets for the first 10 years (2008-09 to 2017-18) are based on halving the gap between Indigenous and non-Indigenous perinatal mortality rates. Targets for the next 15 years (2018-19 to 2032-33) are based on closing the gap between Indigenous and non-Indigenous perinatal mortality rates. Trajectory for non-Indigenous low birth weight rate was held constant based on the assumption that further significant improvement in non-Indigenous rates will be small. Unknown Indigenous status of the mother is included within the non-Indigenous category.

Source: Queensland Health Perinatal Data Collection, 2002-03 to 2007-08

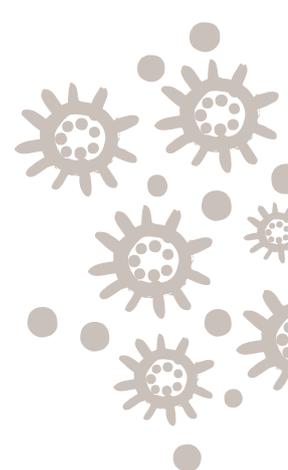
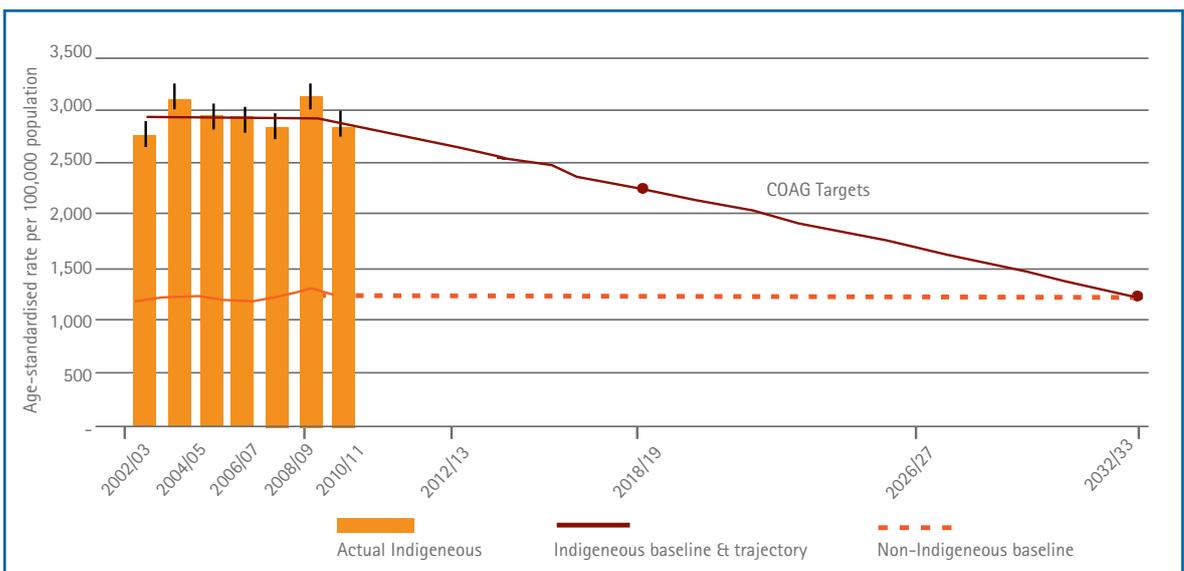


Figure 15: Selected potentially preventable hospitalisation – vaccine preventable, acute and chronic conditions

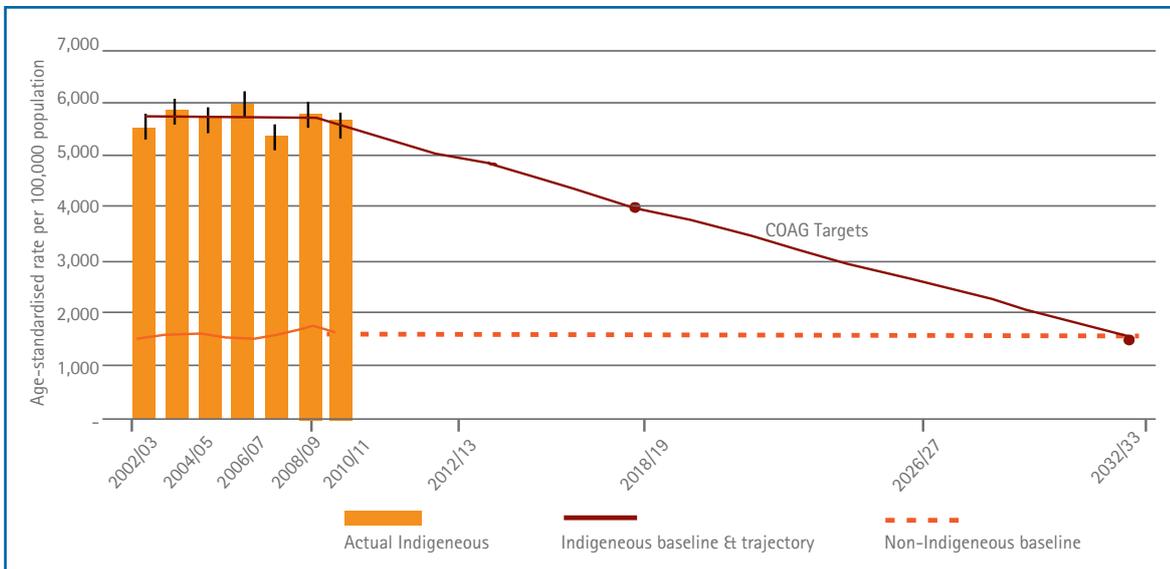
**Queensland - Potentially Preventable Hospitalisations - Vaccine Preventable Conditions**  
**Indigenous and non-Indigenous age standardised rates and trajectory to 2033**



**Queensland - Potentially Preventable Hospitalisations - Acute Conditions**  
**Indigenous and non-Indigenous age standardised rates and trajectory to 2033**



**Queensland - Potentially Preventable Hospitalisations - Chronic Conditions**  
**Indigenous and non-Indigenous age standardised rates and trajectory to 2033**



**Trajectory Methodology Notes:**

2002–2003 data are the earliest available that enables consistent ICD-10 AM coding of conditions to compare. Trajectories for non-Indigenous preventable rates were held constant based on the assumption that further significant improvement in non-Indigenous rates would be small. Unknown Indigenous status is included within the non-Indigenous category. Source: Queensland Health Admitted Patient Data Collection (Queensland Health APDC), 2002–2003 to 2007–2008

## Implementation, monitoring and reporting

IMPLEMENTATION PLANS will be developed every three years to give effect to this *Making Tracks* policy and accountability framework. Implementation plans will clearly articulate how available resources will be utilised to maximise health gains for Indigenous Queenslanders.

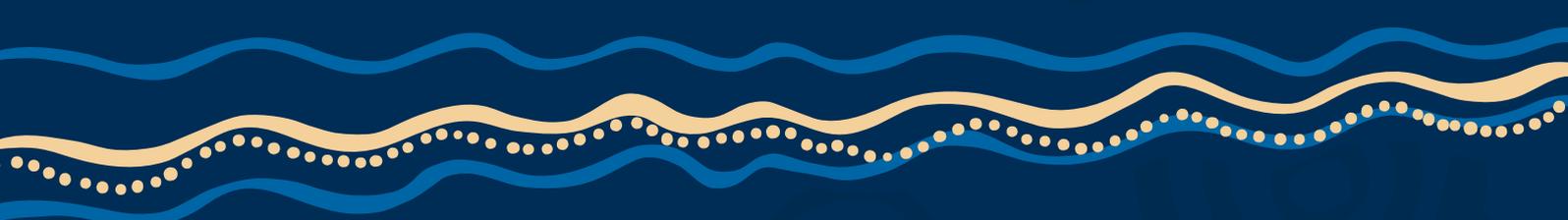
REPORTING ON PROGRESS in meeting the policy objectives and health performance measures contained in this *Making Tracks* policy and accountability framework, and associated triennial implementation plans, will occur annually where data is available. Survey data used to report against several key indicators are not collected annually.

Health portfolio performance will be monitored using the following mechanisms:

- Queensland and national health data collected and analysed for the national reports against the *Aboriginal and Torres Strait Islander Health Performance Framework* prepared by the Australian Institute of Health and Welfare every two years.
- Queensland Health collections including hospital and perinatal data, Queensland Health Indigenous key performance indicators, median age of hospitalisation and data for which trajectories have been established.
- Data collected and analysed for the annual reports against the COAG *Indigenous Health Outcomes* NPA and the *Indigenous Early Childhood Development* NPA.

Non-health portfolio performance will be monitored using the following mechanisms:

- Data collected and analysed from relevant Queensland Government agencies for the quarterly and annual Queensland Closing the Gap reports.
- Data collected and analysed from relevant Queensland Government agencies for the national biennial reports against the *Aboriginal and Torres Strait Islander Health Performance Framework*.
- Reporting mechanisms agreed through the Council of Australian Governments for monitoring progress under the *National Indigenous Reform Agreement*.



# Appendix One

THE POLICY CONTEXT



# National Strategic Framework for Aboriginal and Torres Strait Islander Health

In July 2003, the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* was endorsed by each State and Territory government, the Australian Government, the National Aboriginal and Torres Strait Islander Commission and the National Aboriginal Community Controlled Health Organisation. It was signed by the health minister of each government as a commitment to implementing a ten year agenda for action to address the health status of Indigenous Australians through a whole of government effort by every jurisdiction.

## National Aims And Objectives

The overarching national goal of the National Strategic Framework is *“to ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.”*

Its aims are to:

- Increase life expectancy to a level commensurate with the general population
- Decrease mortality rates in the first year of life and infant morbidity
- Decrease all causes mortality rates across all ages
- Strengthen the service infrastructure required to improve access to health services by Indigenous Australians and to respond to:
  - Chronic disease – particularly cardio-vascular disease, renal disease, diabetes, respiratory disease and cancers
  - Communicable disease – particularly infections in children and the elderly, sexually transmissible infections and blood borne diseases
  - Substance misuse, mental disorder, stress, trauma and suicide
  - Injury and poisoning
  - Family violence including child abuse and sexual assault
  - Child and maternal health and male health.

The National Strategic Framework focuses on the following priority areas:

- Strengthening comprehensive primary health care across the health system through Indigenous specific and general health services delivered by a range of health service providers including A&T&SICCHSs, state and territory governments, private health sector and non-government organisations
- Emotional and social well-being including mental health problems and suicide prevention, the protection of children from abuse, neglect and violence, responses to misuse of alcohol, tobacco and other drugs, and male health
- Addressing the pre-determinants of chronic disease in adult populations with a particular emphasis on nutrition and physical activity, child and maternal health and oral health
- Addressing the health needs of Indigenous Australians in custodial settings
- Improving data availability and quality.

Under the *National Strategic Framework*, each jurisdiction committed to develop two five-year implementation plans in which each government would identify its priorities and articulate its plans for specific initiatives and reforms that would contribute to achieving equality of health status for Indigenous Australians.

The first Queensland Government Plan (2004-08)<sup>24</sup> identified the following priority areas:

- **Chronic Disease** – with an emphasis on reducing risk factors and improving primary health care programs in the areas of early diagnosis, intervention and management. This effort is reflected in general and Indigenous specific service and program responses articulated in the Queensland Strategy for Chronic Disease 2005-15
- **Healthy Children and Families** – including health promotion and delivery of integrated prevention, early intervention and support services, health and nutrition services and child protection interventions. This culminated in the development of the Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People's Health 2005-2010
- **Strengthening responses to alcohol and substance misuse** – including promoting harm minimisation, demand reduction and supply reduction strategies
- **Improving environmental health** – including the development of an Aboriginal and Torres Strait Islander environmental health action plan and implementation of a Community Governance Improvement Strategy<sup>25</sup>

<sup>24</sup> Queensland Government, Queensland Health 2004. *Implementation Plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2004-2008*, Queensland 2004.

<sup>25</sup> Queensland Government, Department of Local Government and Planning. *Community Governance Improvement Strategy*, Queensland, December 2004.

- **Improving data, research and evidence** – including the development of an operational level Indigenous Health Information Management and Use project to maximise the quality, availability and use of existing information on the management and provision of health services. Specific Indigenous health performance measures were developed and introduced for all Queensland health service districts.

In developing this *Making Tracks* policy and accountability framework and the associated triennial implementation plans, consideration has been given to the policy and reform agenda being pursued under COAG, the current evidence on the health status of Indigenous Queenslanders and the areas of health service system reform and expansion that have been identified through the Queensland Aboriginal and Torres Strait Islander Health Partnership and Regional Health Forums. The development of *Making Tracks* provides an opportunity to reaffirm the Queensland Government's commitment to the National Strategic Framework and to commence a concerted plan of action that will begin the process of achieving sustainable health gains for Indigenous Queenslanders.

## National Health System Reform

In December 2007, COAG initiated the reform of Commonwealth/State funding arrangements in order to rationalise existing Specific Purpose Payments, including the hospital funding administered under the Australian Health Care Agreement and public health funding, resulting in the development of one national health funding agreement. The *National Healthcare Agreement* (NHCA), which took effect in July 2009, includes a Statement of Objectives and Outcomes which forms part of the strategic policy framework to improve the health outcomes of all Australians and the sustainability of the health system. Consistent with the COAG Indigenous health targets, the NHCA performance benchmarks for Social Inclusion and Indigenous Health are:

- **Close the gap in life expectancy for Indigenous Australians within a generation**
- **Halve the mortality gap for Indigenous children under five within a decade.**

At the same time, COAG established the National Health and Hospitals Reform Commission to provide advice to governments by June 2009 on practical reforms to the Australian health system in order to:

- reduce inefficiencies
- improve integration and care coordination across all aspects of the health care system particularly between primary care and hospital services and between acute care and aged care services
- bring a stronger focus on prevention, promotion of healthy lifestyles and early intervention
- improve health services in rural areas
- improve Indigenous health outcomes
- provide a well-qualified and sustainable workforce<sup>26</sup>.

In April 2008, the National Health and Hospitals Reform Commission released an interim report<sup>27</sup> entitled *Beyond the Blame Game: accountability and performance benchmarks for the next Australian Health Care Agreements*. The report identified twelve health and health care challenges, the first of which was closing the gap in Indigenous health status. It cited several proven interventions including improving maternal and child health, targeting the incidence and impact of chronic disease, and providing culturally sensitive drug and alcohol rehabilitation programs. It proposed that the Australian Government have primary responsibility and accountability for Indigenous and general primary health care services and health promotion with the state and territory governments retaining responsibility and accountability for public hospital services, mental health, public health and maternal and child health services. Following national consultation, the Commission published an interim report in December 2008 entitled *A Healthier Future for All Australians*<sup>28</sup>. The report observed that health service provision can potentially contribute up to 70 per cent to closing the gap and that there is significant potential to reduce the gap across the life span by focusing on maternal and child health, quality health care that focuses on critical transition times and targeting the risk factors for chronic disease. It also observed that Aboriginal and Torres Strait Islander people access health services across the delivery spectrum thereby requiring all health services to be culturally sensitive, responsive and focused on achieving the best possible outcomes.

The Queensland Government currently has policy, funding and service delivery responsibility for some elements of primary health care. However, as the National Health and Hospitals Reform agenda progresses, the Queensland Government may need to reassess its role. Any changes to policy, funding and service delivery arrangements arising from the National Health and Hospital Reform process will be reflected in future *Making Tracks* implementation plans.

<sup>26</sup> National Health and Hospitals Reform Commission 2008. *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*, April 2008.

<sup>27</sup> NHHRC 2008.

<sup>28</sup> National Health and Hospitals Reform Commission 2008. *A Healthier Future for All Australians, Interim Report*, December 2008.



# Council of Australian Governments: Close the Gap Reform Agenda

The Council of Australian Governments has agreed to the following specific targets to address Indigenous disadvantage:

## COAG Targets

- Close the life expectancy gap within a generation (by 2033)
- Halve the gap in mortality rates for Indigenous children under five within a decade (by 2018)
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade
- All four year olds in remote areas have access to early childhood education within five years
- At least halve the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020

These targets are detailed in the **National Indigenous Reform Agreement** which is a schedule to the Agreement on Federal Financial Relations and is underpinned by five Indigenous-specific and nine mainstream national partnership agreements. The five Indigenous-specific agreements (focusing on early childhood development, health outcomes, remote service delivery, housing and economic participation) total \$4.6 billion of combined Australian Government and State/Territory government investment over 10 years. All agreements are available on the COAG website ([www.coag.gov.au](http://www.coag.gov.au)) and summarised at **Appendix Two**.

To address the two Indigenous health targets, COAG has developed two Indigenous specific and health focussed national partnership agreements – the *Indigenous Early Childhood Development National Partnership Agreement* (NPA) signed by the Queensland Premier in October 2008, and the *Indigenous Health Outcomes NPA* signed by the Queensland Premier in February 2009.

The **COAG Indigenous Early Childhood NPA** concentrates on priority areas (elements) where the evidence shows a high level of impact can be achieved to improve health outcomes for Indigenous children. The NPA is based on facilitation payments and joint investment between the Commonwealth and States/Territories for elements one and two to correspond with bilaterally agreed work plans.

The NPA focuses on three elements:

- **Element 1: early childhood integration** – children and family centres (Australian Government funding of \$75.18 million over four years in Queensland being provided to the Department of Communities to administer)
- **Element 2: antenatal care, pre-pregnancy and teenage sexual and reproductive health** (Australian Government funding of \$29.95 million over four years in Queensland being provided to Queensland Health to administer)
- **Element 3: increase access to, and use of, maternal and child health services by Indigenous families** (Australian Government contribution of \$25.5 million over four years in Queensland, being administered by the Australian Government under its New Directions program, plus \$21.25 million over four years of Queensland Government funding being administered by Queensland Health).

The **Indigenous Health Outcomes NPA** provides \$1.6 billion nationally over four years from 2009-10, with the Australian Government contributing \$806 million of Commonwealth own purpose expenditure and State/Territory governments \$772 million. The Queensland Government's co-contribution of \$162.22 million is specified in the Agreement and a jurisdictional implementation plan has been developed outlining the initiatives to be implemented within Queensland to be resourced by the Queensland Government contribution. The National Partnership Agreement focuses on evidence-based priority areas within a scope that could be agreed by all jurisdictions.

Under the Indigenous Health Outcomes NPA Queensland Implementation Plan (see **Appendix Three**), the Queensland Government has agreed to contribute funding to support initiatives in the following areas:

- tackling smoking (\$8.97 million over 4 years)
- healthy transition to adulthood (\$11.86 million over 4 years)
- making Indigenous health everyone's business (\$3.20 million over 4 years)
- primary health care services that can deliver (\$90.79 million over 4 years)
- fixing the gaps and improving the patient journey (\$47.40 million over 4 years).

Expected outcomes of the NPA include: reduced smoking rate, reduced burden of disease, increased uptake of MBS-funded primary health care services, improved care coordination, and a reduction in the average length of hospital stay and readmissions. The first *Making Tracks* triennial implementation plan (2009-10 to 2011-12) details the initiatives that will be progressed in Queensland under these two National Partnership Agreements.

<sup>29</sup> National Health and Hospitals Reform Commission 2009. *A Healthier Future for All Australians, Final Report*, June 2009.



## Indigenous Health Equality Summit: Close the Gap Statement of Intent

On 18-19 March 2008, a Summit was convened by the Aboriginal and Torres Strait Islander Social Justice Commissioner that brought together Indigenous and mainstream health organisations, governments and Indigenous health experts, to contribute ideas to the national COAG targets for Indigenous health. The Summit culminated in the signing of a Close the Gap Statement of Intent by the Prime Minister and representatives of national peak Indigenous health organisations.

The Queensland Government was the first state government to sign a Statement of Intent. The Queensland Premier and Minister for Health and the Chair of the Queensland Aboriginal and Torres Strait Islander Health Council (QAIHC) formally signed the Close the Gap Statement of Intent on 29 April 2008.

### The Statement of Intent commits the Queensland Government to:

- Developing a comprehensive long-term plan of action, targeted to need and evidence-based to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2030.
- Ensuring primary health care services and health infrastructure for Indigenous Australians which are capable of bridging the health gap by 2018.
- Ensuring the full participation of Indigenous Australians and their representative bodies.
- Working collectively across government to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander people.
- Building on the evidence base, supporting evidence-based approaches to improving the health status of Indigenous Australians and supporting Indigenous community controlled health services across Queensland.
- Achieving improved access to, and outcomes from, mainstream services for Indigenous Australians.

- Respecting and promoting the rights of Indigenous Australians, including by ensuring that health services are available, appropriate, accessible, affordable, and of good quality.
- Measuring, monitoring and reporting on progress in realising the Close the Gap agenda over time.

The text of the Statement of Intent is at Appendix Three.

In July 2008, the Aboriginal and Torres Strait Islander Social Justice Commissioner submitted to the Australian Government the *Close the Gap National Indigenous Health Equality Targets: Outcomes from the National Indigenous Health Equality Summit* report<sup>30</sup>. The report includes a comprehensive table of health performance targets designed to achieve two overarching health equality targets that were proposed in the 2005 Social Justice Report:

- 25 years to achieve equality in health status and life expectancy
- 10 years to achieve equality of opportunity in relation to access to primary health care and the infrastructure that supports health (such as housing, food supplies, water etc).<sup>31</sup>

<sup>30</sup> Human Rights and Equal Opportunity Commission 2008. *Close the Gap: National Indigenous Health Equality Targets – Outcomes from the National Health Equality Summit*, Canberra, March 18-20, 2008. Sydney, 2008.

<sup>31</sup> Human Rights and Equal Opportunity Commission, 2006. *Aboriginal and Torres Strait Islander Commissioner, Social Justice Report 2005*, Sydney 2006.

## Indigenous Partnership Agreement

The Indigenous Partnership Agreement July 2007 (IPA) is an agreement between the Queensland Government and 15 Aboriginal and Torres Strait Islander community councils. The IPA is a three year agreement that provides a framework for government and the councils to collaborate by strengthening leadership, engagement, capacity and service delivery, for the well-being of community members. It outlines priorities and expectations for both government and community action and is to be complemented by Local Indigenous Partnership Agreements (LIPAs) which are agreed and revised over time to address arising priorities. The initial priorities identified for possible inclusion in LIPAs are:

- Child safety and family well-being
- Chronic disease
- Housing and home ownership
- Alcohol and other substance abuse (including petrol) and associated behaviours such as violence
- Education and training
- Land tenure and access
- Employment
- Policing
- Community governance.

The communities of Mornington Island, Doomadgee and Napranum have finalised their Local Indigenous Partnership Agreements and other LIPAs continue to be developed. The Queensland Government has established a \$2.125 million one-off pool of funds to support initiatives in LIPAs.

Under the COAG *Remote Service Delivery National Partnership Agreement* which came into effect in 2009, Local Implementation Plans are to be developed for priority communities. In Queensland, the initial priority communities are Mornington Island, Doomadgee, Hope Vale and Aurukun, with continuing work in Coen and Mossman Gorge as part of the Cape York Welfare Reform trial. The Local Implementation Plans will give effect at the local level to the Australian and Queensland Government's commitments under the *Remote Service Delivery National Partnership Agreement* and provide a vehicle for implementing and monitoring the commitments made under the five related Indigenous-specific COAG national partnership agreements.

## Queensland Government health priorities

### Queensland Health Aboriginal And Torres Strait Islander Cultural Capability Framework 2010-2033

The Cultural Capability Framework provides principles for the governance, policy, planning infrastructure, information systems, human resource management, quality improvement, education and training, and every aspect of health service delivery for Indigenous Queenslanders. It aims to equip all Queensland Health staff with the skills, knowledge and behaviours essential for the provision of culturally appropriate health services for Aboriginal and Torres Strait Islander people. The Department of Communities has also endorsed a cultural capability framework for its staff and other Queensland Government agencies are considering mechanisms to enhance the cultural capability of the workforce.

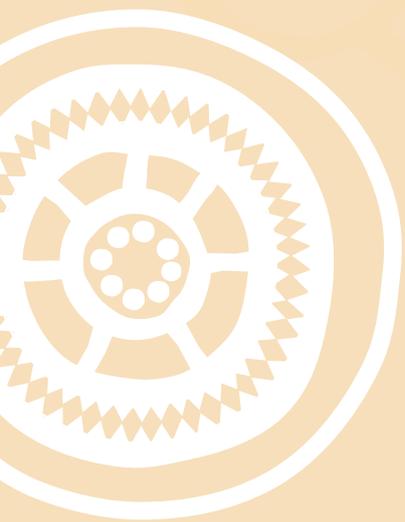
### Other Relevant State Policies And Plans

Action to improve the health status of Indigenous Queenslanders will also be realised through the Queensland Government's commitment to the following mainstream and Indigenous specific state-wide health plans:

- The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework – Queensland Implementation Plan 2005
- Queensland Health Aboriginal and Torres Strait Islander Workforce Strategy 2009-2012
- Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People's Health 2005-10
- Deadly Ears, Deadly Kids, Deadly Communities 2009-2013 – Making tracks to close the gap in ear health for Aboriginal and Torres Strait Islander young people in Queensland
- Queensland Health Aboriginal and Torres Strait Islander Environmental Health Plan 2008-2012
- Queensland Strategy for Chronic Disease 2005-2015
- Queensland Health Population Health Plan 2007-2012
- Queensland Statewide Cancer Treatment Services Plan 2008-16
- Queensland Plan for Mental Health 2007-2017
- Queensland Statewide Renal Health Services Plan.

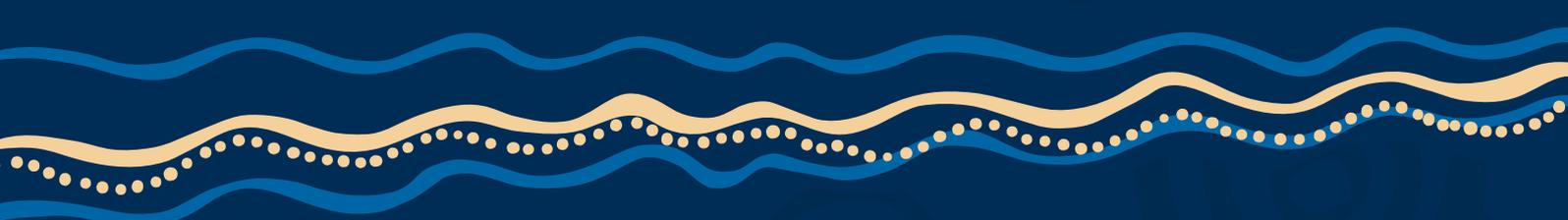
<sup>32</sup> Queensland Government, Department of Premier and Cabinet 2008. *Toward Q2: Tomorrow's Queensland*, Brisbane September 2008.

Queensland Government, Queensland Health 2010. *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033*.



# working together





# Appendix Two

CLOSING THE GAP IN INDIGENOUS DISADVANTAGE

# COAG – National Indigenous Reform Agreement

Under the National Indigenous Reform Agreement, governments have recognised that to overcome Indigenous disadvantage a long-term generational commitment will be required with effort across a range of strategic platforms or Building Blocks, which support reforms against the six specific targets. The Building Blocks are:

- Early childhood
- Schooling
- Health
- Economic Participation
- Healthy Homes
- Safe Communities
- Governance and Leadership.

The following schema<sup>33</sup> summarises national areas for Indigenous policy and reform and associated outcomes.

Figure 16: COAG Closing the Gap in Indigenous Life Outcomes

Closing the gap in Indigenous Life Outcomes		
Close the life expectancy within a generation		
Halve the gap in mortality rates for Indigenous children under five within a decade		
Ensure all Indigenous four year olds in remote communities have access to early childhood education within five years		
Halve the gap for Indigenous students in reading, writing and numeracy within a decade		
At least halve the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020		
Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade		
Building Blocks	COAG Indigenous Specific Outcomes	COAG Policy and Reform Directions
Early Childhood	<ul style="list-style-type: none"> <li>• Indigenous children are born and remain healthy</li> <li>• Indigenous children have the same health outcomes as other Australian children</li> <li>• Children benefit from better social inclusion and reduced disadvantage</li> <li>• Quality early childhood education and care supports the workforce participation choices of parents in the years before formal schooling</li> <li>• Indigenous children acquire the basic skills for life and learning</li> <li>• Indigenous children have access to affordable, quality early childhood education in the year before formal schooling as a minimum</li> </ul>	<p><b>Indigenous Early Childhood Development NP agreement</b> To improve the early childhood outcomes of Indigenous children by addressing the high levels of disadvantage they currently experience, to give them the best start in life.</p> <p><b>Early Childhood Education NP agreement</b> To ensure universal access to quality early childhood education in the year before school.</p> <p><b>TAFE Fee Waivers for Childcare Qualifications NP agreement</b> TAFE and other government providers will not levy fees on students undertaking eligible child care courses in 2009.</p> <p><b>Investing in the Early Years – National Early Childhood Development Strategy</b> To develop an effective early childhood development systems by 2020.</p>

<sup>33</sup> COAG, 2009.

## Closing the gap in Indigenous Life Outcomes

Close the life expectancy within a generation

Halve the gap in mortality rates for Indigenous children under five within a decade

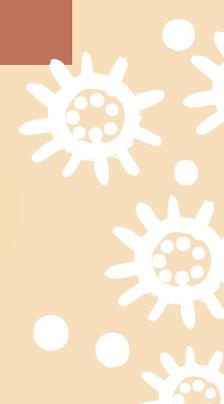
Ensure all Indigenous four year olds in remote communities have access to early childhood education within five years

Halve the gap for Indigenous students in reading, writing and numeracy within a decade

At least halve the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020

Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

Building Blocks	COAG Indigenous Specific Outcomes	COAG Policy and Reform Directions
Schooling	<ul style="list-style-type: none"> <li>• Schooling promotes social inclusion and reduces educational disadvantage</li> <li>• Indigenous children and youth meet basic literacy and numeracy standards, and overall levels of literacy and numeracy are improving</li> <li>• Indigenous young people successfully transition from school to work and/or further study</li> </ul>	<p><b>National Education Agreement</b> All Australian school students acquire the knowledge and skills to participate effectively in society and employment in a globalised economy.</p> <p><b>Low Socio-Economic Status School Communities NP agreement</b> To improve student engagement, educational attainment and well-being in schooling, make inroads into entrenched disadvantage, contribute to broader social and economic objectives and improve understanding about effective interventions.</p> <p><b>Smarter Schools – Improving Teacher Quality NP agreement</b> To sustain a quality teaching workforce.</p> <p><b>Smarter Schools – Literacy and Numeracy NP agreement</b> Focus on the key areas of teaching, leadership and the effective use of student performance information to deliver sustained improvements in literacy and numeracy outcomes for all students.</p> <p><b>Building the Education Revolution</b> Provide new facilities and refurbishments in schools under the National Building and Jobs Plan.</p>
Health	<ul style="list-style-type: none"> <li>• Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population</li> <li>• Indigenous Australians have ready access to suitable and culturally inclusive primary health and preventive services</li> <li>• Indigenous Australians remain healthy and free of preventable disease</li> </ul>	<p><b>Closing the Gap in Indigenous Health Outcomes NP agreement</b> To address the gap in health outcomes experienced by Aboriginal and Torres Strait Islander people.</p> <p><b>National Healthcare agreement</b> To improve health outcomes for all Australians and the sustainability of the health system</p> <p><b>National Disability agreement</b> Key areas of reform for the provision of government support services for people with disabilities.</p> <p><b>Hospital and Health Workforce Reform NP agreement</b> To improve the health workforce, hospitals and capacity.</p> <p><b>Preventative Health NP agreement</b> To prevent the lifestyle risks that cause chronic disease.</p>



## Closing the gap in Indigenous Life Outcomes

Close the life expectancy within a generation

Halve the gap in mortality rates for Indigenous children under five within a decade

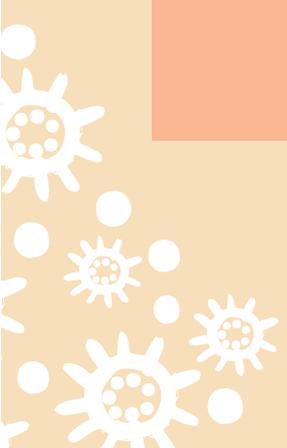
Ensure all Indigenous four year olds in remote communities have access to early childhood education within five years

Halve the gap for Indigenous students in reading, writing and numeracy within a decade

At least halve the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020

Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

Building Blocks	COAG Indigenous Specific Outcomes	COAG Policy and Reform Directions
Economic Participation	<ul style="list-style-type: none"> <li>• The Indigenous working age population has the depth and breadth of skills and capabilities required for the 21st century labour market</li> <li>• Indigenous people of working age participate effectively in all sectors and at all levels of the labour market</li> </ul>	<p><b>Indigenous Economic Participation NP agreement</b> To contribute to the COAG target to halve the gap in employment outcomes within a decade.</p> <p><b>National Agreement for Skills and Workforce Development</b> Identifies the long term objectives of the Australian Government and state/territory governments.</p> <p><b>Productivity Places Program NP agreement</b> To increase qualification commencements and course enrolments to reduce skills shortages and increase the productivity of industry and enterprise.</p> <p><b>Youth Attainment and Transitions NP agreement</b> To increase the qualifications and skill levels of young Australians and improve their capacity to make successful transitions from schooling into further education, training or employment.</p> <p><b>Remote Indigenous Public Internet Access NP agreement</b> To improve public access internet facilities and related computer training in remote Indigenous communities.</p>
Healthy Homes	<ul style="list-style-type: none"> <li>• Indigenous children's living environments are healthy</li> <li>• Indigenous families live in appropriate housing with access to all basic utilities</li> <li>• Indigenous people have improved housing amenities and reduced overcrowding, particularly in remote areas and discrete communities</li> <li>• Indigenous people have the same housing opportunities as other Australians</li> </ul>	<p><b>Remote Indigenous Housing NP agreement</b> To facilitate reform in the provision of housing for Indigenous Australians in remote communities and to address overcrowding, homelessness, poor housing conditions and severe housing shortages in remote Indigenous communities.</p> <p><b>National Affordable Housing Agreement</b> A framework within which all tiers of government will work together to improve housing affordability for Australians.</p> <p><b>Homelessness NP agreement</b> Facilitate reforms to reduce homelessness.</p> <p><b>Social Housing NP agreement</b> Facilitates the establishment of a 'Social Housing Growth Fund' that will support reforms to increase the supply of social housing.</p> <p><b>Social Housing</b> To significantly increase the supply of social housing, particularly for Australians who are homeless or at risk of becoming homeless.</p>



## Closing the gap in Indigenous Life Outcomes

Close the life expectancy within a generation

Halve the gap in mortality rates for Indigenous children under five within a decade

Ensure all Indigenous four year olds in remote communities have access to early childhood education within five years

Halve the gap for Indigenous students in reading, writing and numeracy within a decade

At least halve the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020

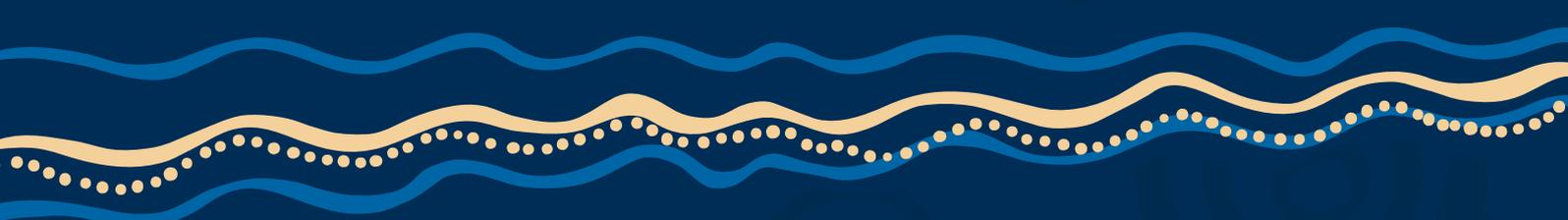
Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

Building Blocks	COAG Indigenous Specific Outcomes	COAG Policy and Reform Directions
<b>Safe Communities</b>	<ul style="list-style-type: none"> <li>Indigenous children and families are safe and protected from violence and neglect in their homes and communities</li> <li>Alcohol and other drug abuse among Indigenous Australians is overcome</li> <li>Breaking cycles of criminal behaviour and violence normalisation</li> </ul>	<p><b>National Framework for Protecting Australia’s Children</b></p> <p>Provides strategies to be delivered through a series of three-year action plans and indicators of change that can be used to monitor the success of the Framework.</p>
<b>Governance and Leadership</b>	<ul style="list-style-type: none"> <li>Indigenous communities are empowered to participate in policy making and program implementation</li> <li>Indigenous communities are represented through credible consultation/governance mechanisms</li> <li>Connecting the way government agencies work in remote areas (the governance of governments) and developing community capacity</li> </ul>	<p><b>Remote Service Delivery NP agreement</b></p> <p>To ensure more efficient and effective planning, analysis, coordination, delivery and evaluation of services and better use of resources in selected remote locations.</p>



# health well-being





# Appendix Three

CLOSING THE HEALTH GAP IN QUEENSLAND

# COAG – Indigenous Early Childhood Development National Partnership Agreement

The Queensland Government’s contribution towards closing the gap in health outcomes for Indigenous Queenslanders is detailed in the first *Making Tracks* triennial implementation plan (2009-10 to 2011-12) and will include the initiatives summarised in Figures 17 and 18.

Figure 17: Indigenous Early Childhood Development National Partnership Agreement – Queensland initiatives

<p><b>Element 1: Integration of Early Childhood Services</b> Establishment of Children and Family Centres</p>	<p>\$75.18 million over four years (Australian Government funding)</p>
<p><b>Element 2: Antenatal Care, pre-pregnancy and teenage sexual and reproductive health</b> Youth Well-being Program Safe Sex Resources Improve sexual health in prisons and youth detention centres Youth Peer Based Sexual Health and Positive Lifestyle Program Community Women’s Health Forum Expand the role of mobile women’s health nurses and women’s health workers Expand the Smoke Check Program for staff of Indigenous child, maternal and oral health programs Increase support for pregnant women in major hospital antenatal care, maternity and birthing units Expand the Young Pregnant and Parenting Support Program Establish midwifery models of care Strengthen the Indigenous maternity workforce</p>	<p>\$29.95 million over four years (Australian Government funding)</p>
<p><b>Element 3: Increase access to, and use of, maternal and child health services by Indigenous families</b> Expand the Deadly Ears Program Continue implementing the Indigenous Health Chronic Disease Package through an enhanced maternity initiative for implementation in rural areas with a high number of Indigenous births and a child health initiative in north Brisbane Continue implementation of the Cape York Maternal and Child Health Package, including the Baby Basket Initiative.</p>	<p>\$25.5 million over four years (Australian Government funding) \$21.25 million over five years (Queensland Government funding)</p>



# COAG – Indigenous Health Outcomes National Partnership Agreement

Figure 18: Indigenous Health Outcomes National Partnership Agreement – Queensland initiatives

Priority	Expected Outcomes*	Queensland Initiatives**	Old \$ (m)
Tackling Smoking	Reduced smoking rate Reduced burden of tobacco related disease for Indigenous communities	QG1.1 Smoke Check expansion QG1.2 Quitline enhancements QG1.3 Promote staff quit smoking program QG1.4 Smoking cessation programs in custody QG1.5 Local social marketing and education QG1.6 Smoke-free message expansion	8.97
Primary Health Care (PHC) Services that can Deliver	Implementation of national best practice standards and accreditation processes for Indigenous health services delivering PHC Increased uptake of MBS- funded PHC services by Indigenous people Improved access to quality PHC through improved co-ordination across the health care continuum, particularly for people with chronic diseases and/or complex needs Provision of improved cultural security in services and increased cultural competence of the PHC workforce	QG2 Centre of Excellence in Indigenous PHC QG3 Statewide Framework for Indigenous PHC QG4 Establish Multidisciplinary care teams	90.79
Fixing the Gaps and Improving the Patient Journey	Reduced average length of stay in the long term Improved level of engagement between Indigenous patients, referred care providers and primary level providers (private or public) to deliver better follow up and referral processes Improved long term stability in primary provider choice Improved patient satisfaction with the care and patient journey (based on domains of concern to patients) Reduced admissions and incomplete treatments for Indigenous patients	QG5.1 New or expanded patient accommodation QG 5.2 New or expanded patient transport QG 6.1 Indigenous hospital liaison project QG6.2 New Cultural Capability Framework QG 7 New Care Connect pilot initiative	47.4
Healthy Transition to Adulthood	Increased sense of emotional and social well-being Reduced uptake of alcohol, tobacco and illicit drugs Reduced rates of sexually transmissible infections Reduced hospitalisations for violence and injury Reduced excess mortality and morbidity among Indigenous men	QG8: Establish a network of health professionals focusing on Indigenous male, youth, drug and alcohol and mental health services.	11.86
Making Indigenous Health Everyone's Business	Improved multi-agency, multi-program and inter-sectoral collaboration and coordination to meet the needs of Indigenous families and communities Improved access to targeted early detection and intervention programs by high need Indigenous families Reduced waiting times for health services Reduction in early mortality	QG9.1 Define models for social service partnerships QG9.2 Family Support pilot initiative	3.2
<b>TOTAL</b>			<b>162.2</b>

\*Expected outcomes as a result of the impact of both Commonwealth and State/Territory initiatives.

\*\* Queensland initiatives complement initiatives to be rolled out nationally by the Australian Government.

# Queensland Statement of Intent

Queensland, April 29, 2008

## Preamble

Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between Indigenous and non-Indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.

Prime Minister Kevin Rudd, Apology to Australia's Indigenous Peoples', 13 February 2008

This is a statement of intent – between the Queensland Government and the Aboriginal and Torres Strait Islander peoples, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organisations – to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030.

We share a determination to close the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians.

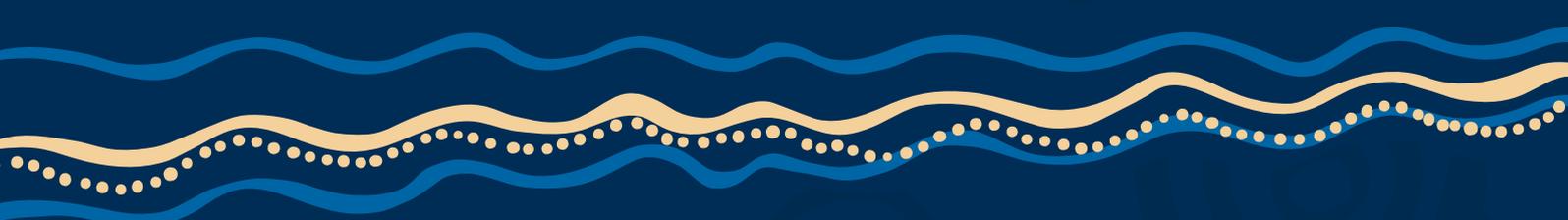
We are committed to ensuring that Aboriginal and Torres Strait Islander peoples' have equal life chances to all other Australians.

We are committed to working towards ensuring Aboriginal and Torres Strait Islander peoples have access to health services that are equal in standard to those enjoyed by other Australians, and enjoy living conditions that support their social, emotional and cultural well-being.

We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services.

## Accordingly We Commit:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030.
- To ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gap in health standards by 2018.
- To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.
- To working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.
- To building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience. To supporting and developing Aboriginal and Torres Strait Islander community-controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and well-being.
- To achieving improved access to, and outcomes from, mainstream services for Aboriginal and Torres Strait Islander peoples.
- To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable, and of good quality.
- To measure, monitor, and report on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.



# Appendix Four

THE EVIDENCE BASE

# The health status of Indigenous Queenslanders

The estimated Aboriginal and Torres Strait Islander resident population of Queensland at June 30 2008 was 152,527 people<sup>34</sup> with 27.6 per cent living in major cities, 46.6 per cent in inner and outer regional centres and 25.8 per cent in remote and very remote areas.<sup>35</sup> Aboriginal and Torres Strait Islander Queenslanders comprise 28.3 per cent of the total Indigenous Australian population and 3.6 per cent of the total Queensland population. Torres Strait Islander people make up around 10 per cent of all Indigenous Australians and 23 per cent of Indigenous Queenslanders. The Indigenous population of Australia is younger than the non-Indigenous population with a median age of 21 years compared with 37 years due primarily to higher fertility rates and deaths occurring at younger ages.<sup>36</sup> In 2008, 57.9 per cent of Indigenous Queenslanders were aged less than 25 years and 2.8 per cent were aged 65 years and older, compared with 33.5 per cent of non-Indigenous people aged less than 25 years and 12.6 per cent aged 65 years and older<sup>37</sup>.

National data establishes that Aboriginal and Torres Strait Islander people experience much poorer health than other Australians. There continues to be a significant gap in life expectancy that has been widening over time due to simultaneous gains in non-Indigenous life expectancy. The leading causes of death for Indigenous Queenslanders are circulatory diseases (28 per cent), cancer (18 per cent), and injury and poisoning (14 per cent).<sup>38</sup> Approximately 60 per cent of mortality for Indigenous Australians is caused by chronic disease and evidence indicates rates of chronic disease are increasing.<sup>39</sup>

The mortality rate for Indigenous children less than five years is up to five times higher than for non-Indigenous children<sup>40</sup> with infant mortality contributing 83 per cent to the overall child mortality rate. In Queensland, the Indigenous child mortality rate is 2.04 times the non-Indigenous rate. The most common causes of death for Aboriginal and Torres Strait Islander children less than five years of age are injury and poisoning (43 per cent) followed by diseases of the nervous system (13 per cent). The most common causes of death for infants were conditions originating during the perinatal period (46 per cent), such as birth trauma and complications during pregnancy, disorders relating to foetal growth and respiratory and cardiovascular disorders. Deaths caused by respiratory diseases were nine times more likely than for the non-Indigenous population, deaths from Sudden Infant Death Syndrome were five times more likely and deaths from infectious and parasitic diseases were four times more likely<sup>41</sup>.

A national report on the Indigenous burden of disease released in 2008<sup>42</sup> describes the health problems facing Indigenous Australians as the 'Indigenous health gap'; that is, the difference between the Indigenous burden of disease estimates and those for the general population. Estimating that the total burden of disease would have been 59 per cent lower had Indigenous Australians had the same levels of mortality and disability as the general population, the report proposes that there is a large potential for health gain. The report also advises that for Aboriginal and Torres Strait Islander people the mortality gap is considerably greater than the disability gap. This reflects the fact that Indigenous Australians are more likely to die from an illness than non-Indigenous Australians from the same illness<sup>43</sup>, suggesting that a large part of the health gap is preventable and can be addressed.

The Queensland Government aims to close the gap in health outcomes for Indigenous Queenslanders by 2033 and will measure progress in meeting this objective against the life expectancy and child mortality indicators emphasised by COAG and the other indicators of health status presented in this *Making Tracks* policy and accountability framework.

## Life Expectancy

All jurisdictions through COAG have committed to closing the gap between Indigenous and non-Indigenous life expectancy at birth within a generation (by 2033). When this target was established in 2008, the gap in life expectancy between Indigenous and non-Indigenous Australians was estimated to be about 17 years at 2001, the latest estimate available at that time.

However, a detailed review of the indirect method used for calculating the gap found the 17 year gap estimate to be methodologically flawed. In response to the review, a direct method for Indigenous life expectancy estimates for 2005–2007 has been utilised which has produced significantly higher life expectancy estimates<sup>44</sup>. The gap between Indigenous and non-Indigenous Queenslanders is now estimated to be 10.4 years for males and 8.9 years for females<sup>45</sup>. These latest figures cannot be directly compared with earlier published figures and cannot be attributed to a recent gain in Indigenous health status.

For the Australian population overall, life expectancy at birth has increased by an average of 0.25 years per year since the year 1900. Increases in overall life expectancy for the last 25 years have been maintained close to that trend, 0.24 years per year. If this trend continues, by the 2031 Census there will be an approximate gain in overall Australian life expectancy of 6 years. To close the gap between Indigenous and non-Indigenous life expectancy by the 2031 Census a gain in Queensland Indigenous life expectancy of 16.4 years for males and 15 years for females over the next 25 years will be required (see Figure 19).

<sup>34</sup> Office of Economic and Statistical Research (OESR), Queensland Treasury, and Statistical and Library Services Centre, Queensland Health, 2008 *Experimental Indigenous estimated resident populations by ages, sex and Statistical Local Areas*, Queensland.

<sup>35</sup> Australian Bureau of Statistics, 2007. *Population Distribution, Aboriginal and Torres Strait Islander Australians 2006*. Catalogue Number 4705.0, Canberra, August 2007.

<sup>36</sup> Commonwealth of Australia, 2008. Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, Canberra, 2008.

<sup>37</sup> OESR, 2008. <sup>38</sup> AIHW 2008. <sup>39</sup> ABS and AIHW 2008. <sup>40</sup> ABS and AIHW 2008; AIHW 2008.

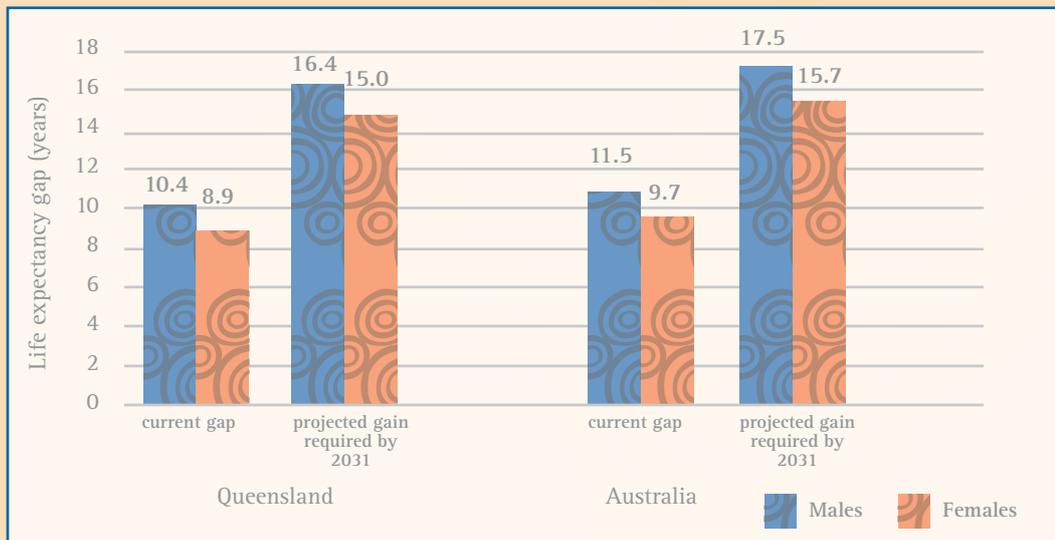
<sup>41</sup> AIHW, 2008. <sup>42</sup> Vos et al, 2007 <sup>43</sup> Vos et al, 2007

<sup>44</sup> Australian Bureau of Statistics, 2008. *Assessment of Methods for Developing Life Tables for Aboriginal and Torres Strait Islander Australians, 2006* (ABS. cat. no. 3302.0.55.002) November 2008.

<sup>45</sup> Australian Bureau of Statistics, (cat. no. 3302.0.55.003) 2009.

In Queensland, this equates to a gain of 0.66 years per year for Indigenous males and 0.60 years per year for Indigenous females; nearly three times the gains achieved by the overall Australian population in the last 25 years. Closing the gap between Indigenous and non-Indigenous life expectancy by the 2031 census will require a rate of gain in life expectancy which took over 60 years for the overall Australian population to attain. Thus, while the estimated gap is less than previous estimates, it will require a concerted effort to achieve the 2033 COAG target.

Figure 19: The current Queensland life expectancy gap (2005–2007) and projected gain required



Source: ABS cat no. 3302.0.55.003

### Health Adjusted Life Expectancy

Whilst life expectancy provides an estimate of the average years of life a person can expect to live at various ages given the current risks of mortality, health-adjusted life expectancy (HALE) acknowledges the importance of not only living longer, but of living longer without ill health. It extends the concept of life expectancy by reducing the expected duration of life by the proportion of time spent at each age in states of less than perfect health, adjusted for the relative severity of those health states. The typical age estimates in both life expectancy and HALE are compared between populations at birth. A difference in HALE between two populations is due to the different average rates of mortality and disability experienced by the respective populations. When the difference – or health gap – is analysed by individual causes of ill-health, it is possible to determine the number of extra years in full health the population with lower HALE would gain if rates of mortality and disability for a particular cause were modified through an intervention to be the same as rates in the population with higher HALE.

This type of analysis explains the causal drivers of health inequalities between populations and helps illustrate the possible impact of interventions across different sections of the health continuum. It does not, however, provide an assessment of the cost or effectiveness of any particular intervention.

Through an analysis of HALE data, a recent study by Queensland Health<sup>46</sup> indicated that the six leading drivers of the health gap between Indigenous and non-Indigenous Queenslanders in 2006 were:

- Cardiovascular diseases – 3.7 years or 28 per cent of the health gap
- Diabetes – 2.2 years or 16 per cent of the health gap

- Chronic respiratory conditions – 1.4 years or 11 per cent of the health gap
- Cancers – 1.2 years or 9 per cent of the health gap
- Injuries – 1.1 years or 8 per cent of the health gap
- Mental disorders – 1.1 years or 8 per cent of the health gap.

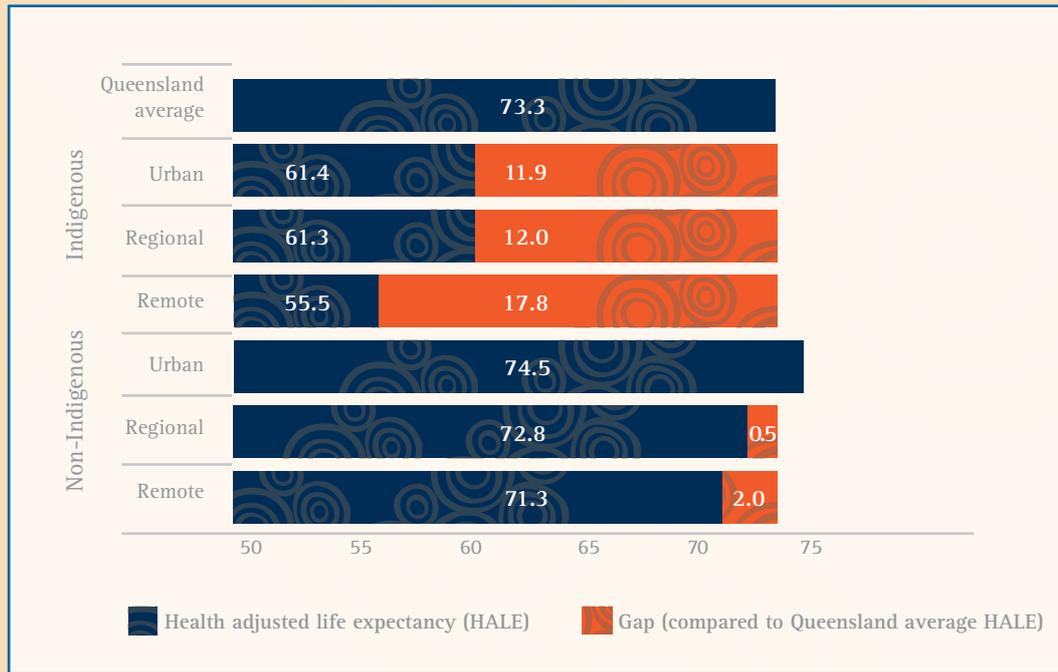
Together these causes explain 80 per cent of the total health gap experienced by Indigenous Queenslanders. This analysis demonstrates that the Indigenous health gap in Queensland could be reduced substantially if rates of mortality and disability for these six causes alone were reduced toward average state levels.

The two leading drivers of the overall health gap in Queensland – cardiovascular disease and diabetes – were also the main contributors to the health gap in major cities, regional centres and remote areas. These two causes alone account for 44 per cent of the Indigenous health gap in Queensland. In major cities and regional centres, these are followed by chronic respiratory conditions (11 per cent), cancers (10 per cent), mental disorders (9 per cent) and injuries (6 per cent). In remote areas the next most significant contributors to the health gap were injuries (13 per cent), chronic respiratory conditions (9 per cent), cancers (7 per cent) and infectious and parasitic diseases (6 per cent). The Indigenous health gap is greatest for people living in remote and very remote parts of Queensland. However, as a large proportion of Queensland's Indigenous population live in major cities and regional centres, the health status of Queensland's urban Indigenous population contributes significantly to the overall burden of disease. Therefore, health interventions and service delivery must address the health needs of people living in urban areas as well as those living in remote/regional areas.

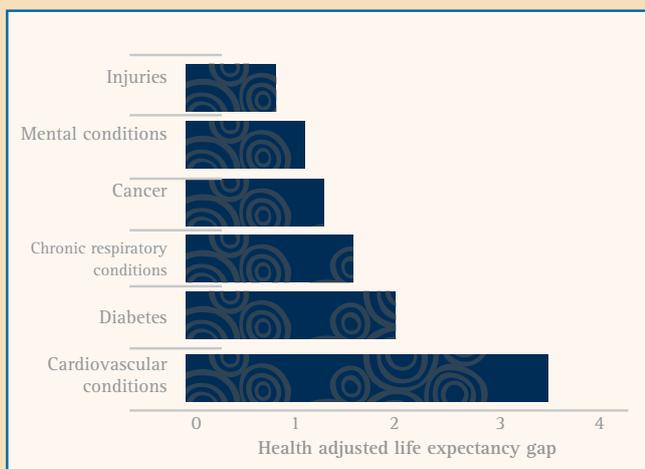
<sup>46</sup> S Begg, M Bright, C Harper, 2008.

Figure 20: Indigenous and non-Indigenous health gaps in Queensland

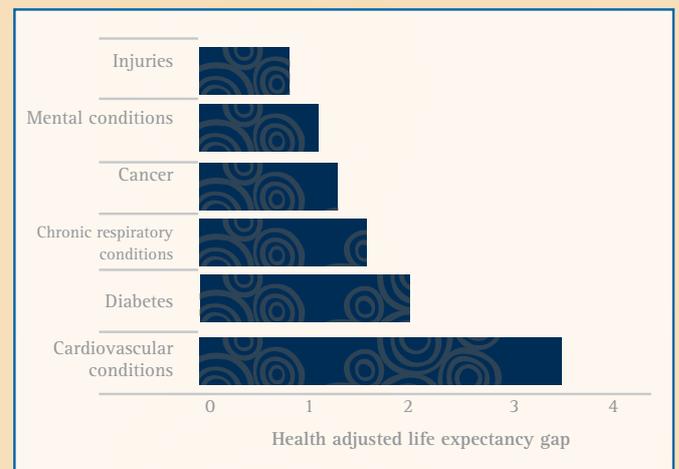
What is the size of the health gap in different areas of Queensland compared with the Queensland average health-adjusted life expectancy?



What causes the Indigenous health gap in urban areas of Queensland?



What causes the Indigenous health gap in regional areas of Queensland?



What causes the Indigenous health gap in remote areas of Queensland?

Source: Queensland Health: S. Begg, unpublished analyses, 2009.

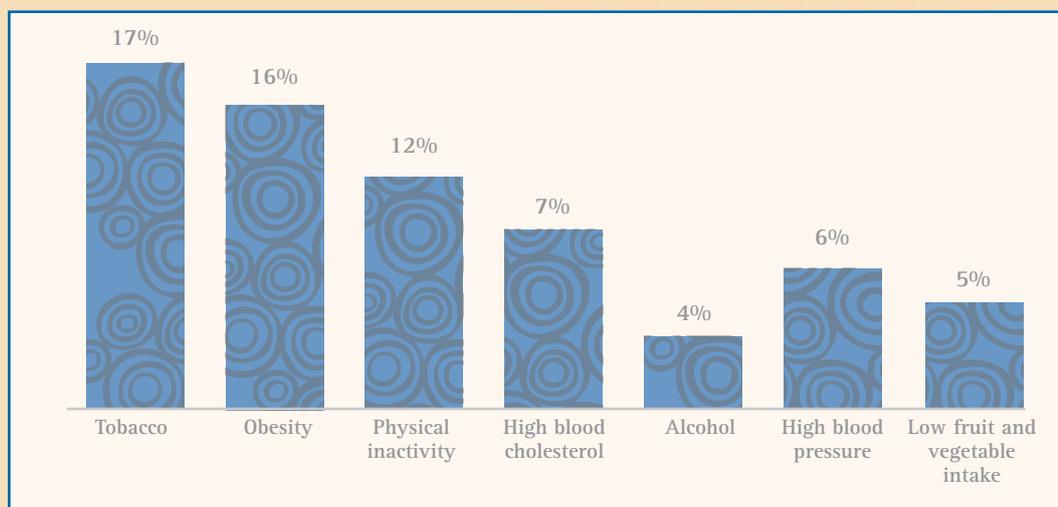
## Health Risks

Utilising disability-adjusted life expectancy data, the University of Queensland<sup>47</sup> identified 11 risk factors that together explained 37.4 per cent of total health loss in Aboriginal and Torres Strait Islander people which, if addressed, would significantly contribute to closing the health gap. These are:

- consumption of tobacco, alcohol and other drugs
- obesity, low rates of physical activity and nutrition
- high blood pressure and high cholesterol
- unsafe sex
- child sexual abuse and intimate partner violence.

Of these, tobacco was the largest cause of health loss, contributing 17 per cent to the health gap (see Figure 21) and one-fifth of all Indigenous deaths nationally. Cardiovascular disease, lung cancer and chronic respiratory disease were the leading causes of tobacco-related mortality in Indigenous Australians.

Figure 21: Risk factors contributing to the health gap



Source: Vos et al, 2007

## Health Service Utilisation

Aboriginal and Torres Strait Islander Queenslanders continue to be hospitalised at much higher rates than non-Indigenous Queenslanders for most conditions. For example in 2006-07:

- Congestive cardiac failure – 3.6 times the non-Indigenous rate
- Chronic obstructive pulmonary disease – 3.9 times the non-Indigenous rate
- Cellulitis – 3.0 times the non-Indigenous rate.

There were regional variations in hospitalisation rates across Queensland, but in general, hospitalisation rates for Aboriginal and Torres Strait Islander Queenslanders for many chronic and acute conditions were higher in the far northern and north-west areas of Queensland than elsewhere. Notably, of the total hospital separations for Indigenous Queenslanders one-third are for renal dialysis.

Aboriginal and Torres Strait Islander people also have poorer outcomes of care (for example, non-Indigenous cancer patients survive longer than Indigenous patients) and have lower access to health interventions (for example, cardiac catheterisation is lower for Indigenous people).<sup>48</sup> Approximately 52 per cent of hospital episodes of care for Indigenous Queenslanders (excluding dialysis) recorded a procedure compared with 79 per cent of hospital episodes of care for other Queenslanders.<sup>49</sup>

<sup>47</sup> Vos et al, 2007

<sup>48</sup> NHHRC 2008.

<sup>49</sup> AIHW, 2008

### The Health Status of Torres Strait Islander People

Overall, the health status of Torres Strait Islander people is very similar to that of Aboriginal people but with a few significant differences in several key indicators of socio-economic disadvantage and causes of disease burden. The leading cause of disease burden for both Aboriginal people and Torres Strait Islander people is cardiovascular disease. However, Torres Strait Islander people are more likely than Indigenous Australians overall to die from cancer (21 per cent compared with 15 per cent) and less likely to die as a result of external causes including injury (10 per cent compared with 16 per cent). The Torres Strait region also has the highest rates of hospitalisation for type 2 diabetes at 21.2 times the Queensland rate. In the period 1996 to 2006, the incidence of water, environmental and hygiene associated communicable diseases decreased significantly in the Torres Strait associated with improvements to environmental health infrastructure in the region. Torres Strait Islanders have higher rates of educational attainment and labour force participation but rates of smoking, harmful alcohol consumption, physical inactivity and other risk factors for ill health remain similar to the rest of the Indigenous population of Queensland.<sup>50</sup> As the risk factors for ill health are equally significant and there are very high rates of chronic disease experienced by Torres Strait Islander people, the *Making Tracks* policy and accountability framework, and associated implementation plans, will focus on initiatives that will improve the health status of the whole Indigenous population of Queensland.

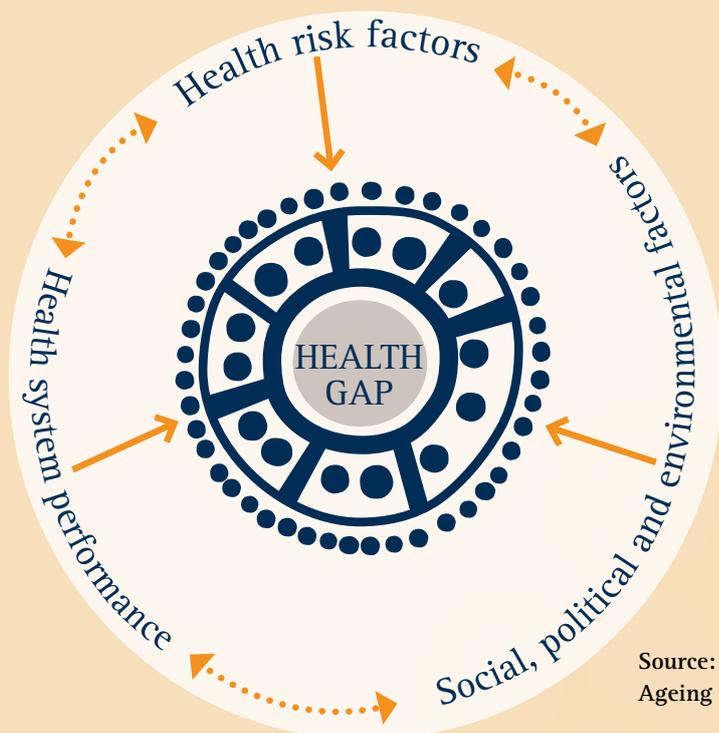
### The Determinants of Health

The notion that disadvantage has multiple causes which need to be addressed simultaneously is well documented.<sup>51 52</sup> Indigenous Australians experience very high levels of disadvantage against all socio-economic indicators. In Queensland, 99-100 per cent of Aboriginal and Torres Strait Islander people living in regional and remote areas experienced high levels of disadvantage and 84 per cent of Indigenous Queenslanders living in major cities reside in areas of greatest disadvantage.<sup>53</sup>

The causes of health disadvantage are multi-faceted, inter-linked and cannot be addressed in isolation. Health status is affected by the impact of risk factors and the performance of the health system in addressing health needs. Health status is also affected by a range of social and economic factors outside the influence of the health system including:

- socio-economic status (eg low income, unemployment, low education levels, poor nutrition)
- environmental factors (eg substandard housing, sewerage/ water quality, dry/dusty conditions, access to affordable food and food storage facilities)
- socio-political factors (eg removal from land and/or family, culturally inappropriate services).

Figure 22: Factors that contribute to the health gap



Source: Department of Health and Ageing 2009

<sup>50</sup> ABS and AIHW, 2008.

<sup>51</sup> Steering Committee for the Review of Government Service Provision 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra.

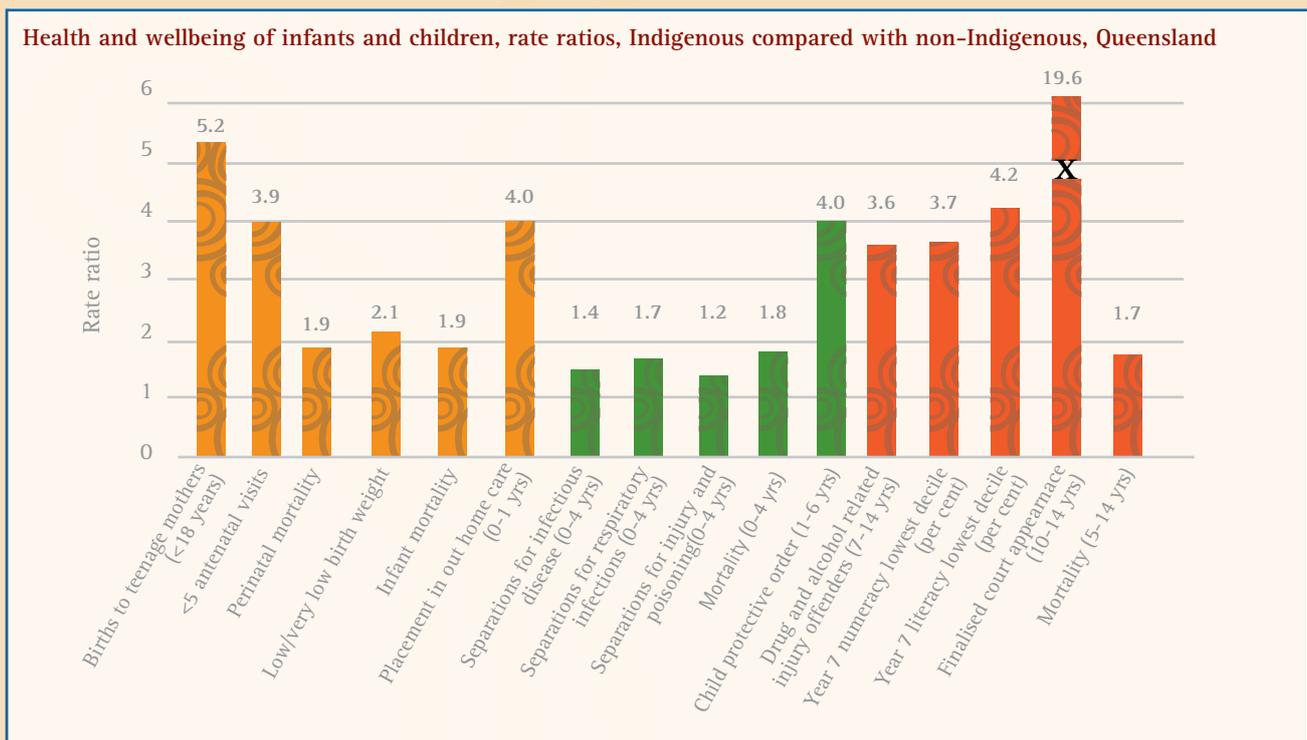
<sup>52</sup> Commonwealth of Australia, 2004.

<sup>53</sup> Kennedy, B and Firman D. *Indigenous SEIFA-revealing the ecological fallacy*. Paper presented at: Australian Population Association conference, 2004, Canberra.

Factors such as poverty and unemployment can lead to psychosocial stress and the adoption of unhealthy, stress-coping behaviours such as smoking and personal isolation. There are strong links between overcrowded living conditions and higher rates of respiratory disease and trachoma; and poor water and sanitation with a range of infections. Higher education and income levels are associated with lower rates of alcohol and substance use. Lack of transport remains a major barrier to accessing health services.<sup>54</sup>

There is a particularly strong inter-relationship between health outcomes and education levels – children with high levels of education are more likely to have better socio-economic opportunities and have higher health literacy levels positioning them for better health outcomes. Healthier children have a higher capacity for educational attainment. For example, chronic ear disease, (the prevalence of which in some Aboriginal and Torres Strait Islander communities has been recorded at over 70 per cent), has a profound impact on the development and social skills of Aboriginal and Torres Strait Islander children. An inability to hear in school can lead to truancy and subsequent low education levels, which is associated with a downward spiral of unemployment, low self-esteem, incarceration, substance use, domestic violence and even suicide.<sup>55</sup>

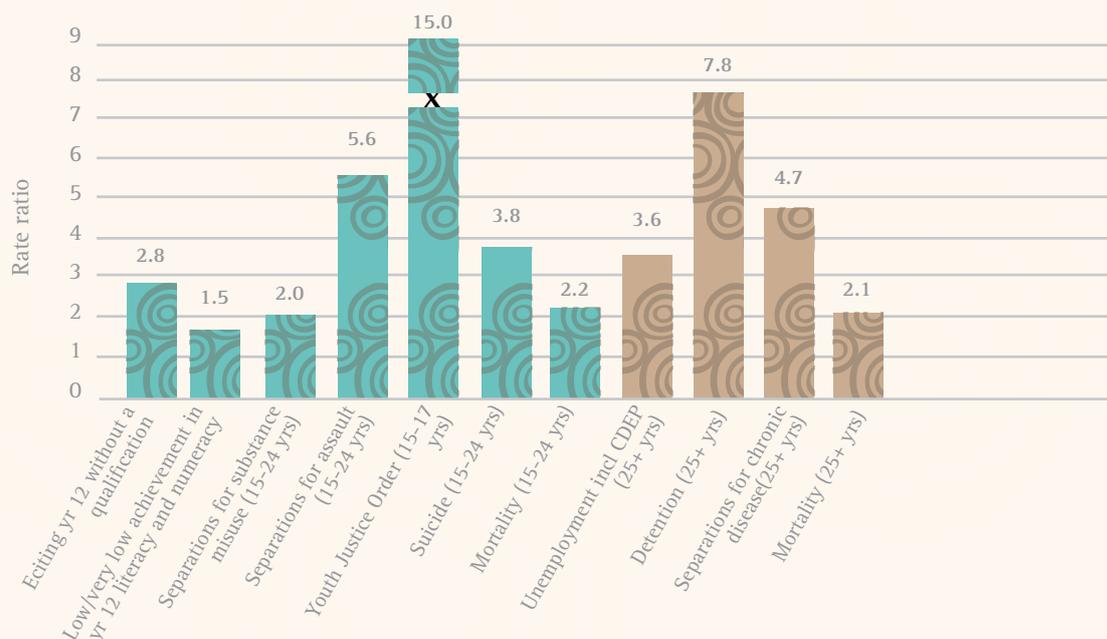
Figure 23: Health and well-being of Indigenous Queenslanders



<sup>54</sup> NATSIHC, 2003.

<sup>55</sup> Zubrick et al, as cited at <http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf>

### Health and wellbeing of youth and adults, rate ratios, Indigenous compared with non-Indigenous, Queensland



Source: Queensland Health, 2008

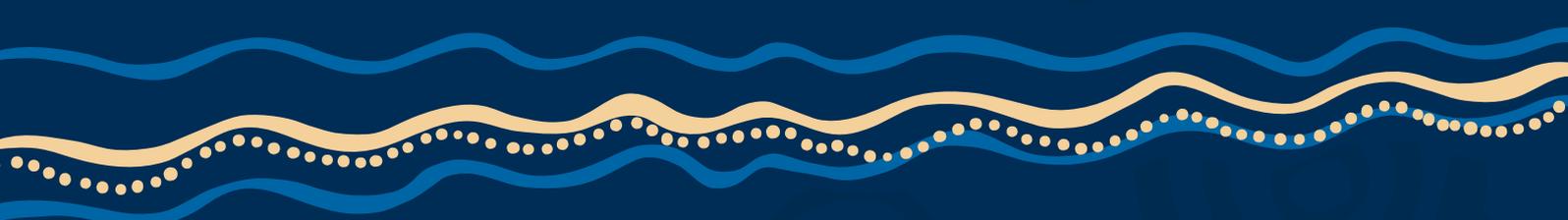
Sustainable health gains will contribute to improvements in outcomes across all these indicators. For example, healthier people are more likely to sustain meaningful employment thereby improving socio-economic status and effecting changes in incarceration rates, homelessness, home ownership and a range of other social and economic indicators of disadvantage. Furthermore, healthy people are more likely to pass on the benefits of good health and positive health behaviours to future generations.

#### Evidence Based Chronic Disease Interventions

A report commissioned for the Northern Territory Department of Health<sup>56</sup>, which attempts to identify the most cost effective evidence-based Indigenous chronic disease interventions, recommends initiatives in the following areas to reduce the onset of adult chronic disease:

- breastfeeding and preventing childhood malnutrition
- childhood immunisation
- smoking cessation
- five minute advice sessions to heavy consumers of alcohol in a primary health care setting
- nutrition, weight loss and physical activity programs in high risk populations
- early detection and screening for hypertension, type 2 diabetes, obesity, smoking and alcohol
- adult immunisation
- aggressive blood pressure lowering to prevent progression of renal disease
- prevention of complications of diabetes – for example screening for retinopathy and foot care
- aggressive management of heart attacks and known cardiovascular disease
- rehabilitation and outreach programs (cardiac, respiratory and renal).

<sup>56</sup> Northern Territory Government: Weeramanthri TS, Edmond K. *Northern Territory Chronic Disease Strategy – the Evidence Base*. Darwin: Territory Health, 1999.



# Appendix Five

NATIONAL HEALTH PERFORMANCE INDICATORS

# Aboriginal and Torres Strait Islander Health Performance Framework

Figure 24: Aboriginal and Torres Strait Islander Health Performance Framework Indicators

<b>HEALTH STATUS AND OUTCOMES (TIER 1)</b>		
<p><b>Health Conditions</b></p> <ul style="list-style-type: none"> <li>1.01 Low birthweight infants</li> <li>1.02 Top reasons for hospitalisation</li> <li>1.03 Hospitalisation for injury and poisoning</li> <li>1.04 Hospitalisation for Pneumonia</li> <li>1.05 Circulatory disease</li> <li>1.06 Acute rheumatic fever and heart disease</li> <li>1.07 High blood pressure</li> <li>1.08 Diabetes</li> <li>1.09 End stage renal disease</li> <li>1.10 Decayed, missing, filled teeth</li> <li>1.11 HIV/AIDS, Hepatitis C and STIs</li> <li>1.12 Children’s hearing loss</li> </ul>	<p><b>Human Function</b></p> <ul style="list-style-type: none"> <li>1.13 Disability</li> <li>1.14 Community functioning</li> </ul> <p><b>Life Expectancy and Well-being</b></p> <ul style="list-style-type: none"> <li>1.15 Perceived health status</li> <li>1.16 Social and emotional well-being</li> <li>1.17 Life expectancy at birth</li> <li>1.18 Median age at death</li> </ul>	<p><b>Deaths</b></p> <ul style="list-style-type: none"> <li>1.19 Infant mortality rate</li> <li>1.20 Perinatal mortality</li> <li>1.21 Sudden infant death syndrome</li> <li>1.22 All causes age-standardised death rates</li> <li>1.23 Leading causes of mortality</li> <li>1.24 Maternal mortality</li> <li>1.25 Avoidable and preventable deaths</li> </ul>
<b>DETERMINANTS OF HEALTH (TIER 2)</b>		
<p><b>Environmental Factors</b></p> <ul style="list-style-type: none"> <li>2.01 Access to functional housing with utilities</li> <li>2.02 Overcrowding in housing</li> <li>2.03 Environmental tobacco smoke</li> </ul> <p><b>Socio-economic Factors</b></p> <ul style="list-style-type: none"> <li>2.04 Years 3,5 and 7 literacy and numeracy</li> <li>2.05 Years 10 and 12 retention and attainment</li> <li>2.06 Educational participation/ attainment of adults</li> <li>2.07 Employment including CDEP participation</li> <li>2.08 Income</li> <li>2.09 Housing tenure type</li> <li>2.10 Index of disadvantage</li> </ul>	<p><b>Community Capacity</b></p> <p><b>Demography</b></p> <ul style="list-style-type: none"> <li>2.11 Dependency ratio</li> <li>2.12 Single-parent families by age</li> </ul> <p><b>Safety and Crime</b></p> <ul style="list-style-type: none"> <li>2.13 Community safety</li> <li>2.14 Contact with justice system</li> <li>2.15 Child protection</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>2.16 Transport</li> <li>2.17 Access to traditional lands</li> </ul>	<p><b>Health Behaviours</b></p> <p><b>Tobacco, alcohol and other drugs</b></p> <ul style="list-style-type: none"> <li>2.18 Tobacco use</li> <li>2.19 Tobacco smoking during pregnancy</li> <li>2.20 Risky and high alcohol consumption</li> <li>2.21 Drug and other substance use</li> </ul> <p><b>Physical activity</b></p> <ul style="list-style-type: none"> <li>2.22 Level of physical activity</li> </ul> <p><b>Nutrition</b></p> <ul style="list-style-type: none"> <li>2.23 Dietary behaviours</li> <li>2.24 Breast feeding practices</li> <li>2.25 Self reported unsafe sex</li> <li>2.26 Prevalence of overweight and obesity</li> </ul>
<b>HEALTH SYSTEM PERFORMANCE (TIER 3)</b>		
<p><b>Effective/Appropriate/Efficient</b></p> <ul style="list-style-type: none"> <li>3.01 Ante-natal care</li> <li>3.02 Immunisation (child and adult)</li> <li>3.03 Early detection and early treatment</li> <li>3.04 Chronic disease management</li> <li>3.05 Differential access to hospital procedures</li> <li>3.06 Ambulatory care sensitive admissions</li> <li>3.07 Health promotion</li> </ul> <p><b>Responsive</b></p> <ul style="list-style-type: none"> <li>3.08 Discharge against medical advice</li> <li>3.09 Access to mental health services</li> <li>3.10 Indigenous Australians in health workforce</li> <li>3.11 Competent governance</li> </ul>	<p><b>Accessible</b></p> <ul style="list-style-type: none"> <li>3.12 Access to services by types of service compared to need</li> <li>3.13 Access to prescription medicines</li> <li>3.14 Access to after hours primary health care</li> </ul> <p><b>Continuous</b></p> <ul style="list-style-type: none"> <li>3.15 Regular GP or health service</li> <li>3.16 Care planning for clients with chronic diseases</li> </ul>	<p><b>Capable</b></p> <ul style="list-style-type: none"> <li>3.17 Accreditation</li> <li>3.18 Indigenous Australians in training education for health related disciplines</li> </ul> <p><b>Sustainable</b></p> <ul style="list-style-type: none"> <li>3.19 Expenditure on Indigenous health compared to need</li> <li>3.20 Recruitment and retention of clinical management staff (including GPs)</li> </ul>

Source: AHMAC, 2006.

## Healthy for Life Indicators

The Healthy for Life Program is funded by the Australian Government to deliver maternal and child health services and prevention and care for people with chronic conditions. Several Queensland Health Service Districts are in the process of implementing the Healthy for Life Program. Under this program, service providers (including Queensland Health) are required to collect and report against the nationally agreed performance measures listed below:

### Short To Medium Term (1-4 Years)

Increase in first attendance for antenatal care in first trimester

10 per cent increase per year of adult and child health checks, with associated plans for follow-up

30 per cent improvement in best practice service delivery for people with chronic conditions.

### Longer Term (5-10 Years)

Increase in mean birth weight up to within 200g of the non-Indigenous population

Decrease in incidence of low-birth weight by 10 per cent

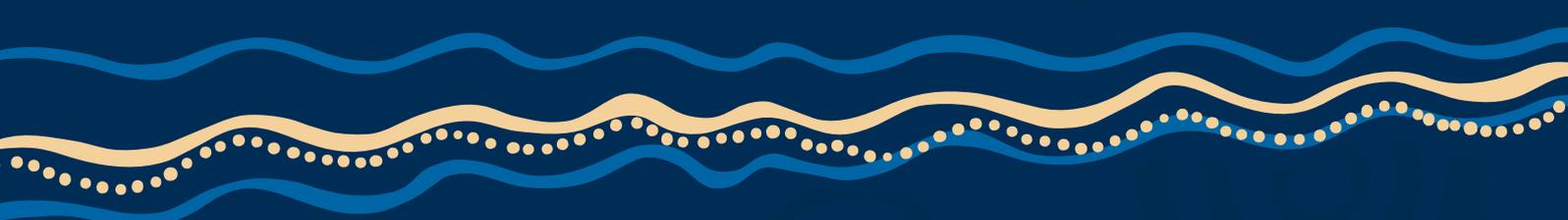
Reduction in selected behavioural risk factors (eg smoking and alcohol misuse among others) in pregnancy by 10 per cent

30 per cent reduction in hospital admissions for chronic disease complications.

30 per cent improvement in number of patients with intermediate health outcomes within an acceptable range.

# sustainable health gains





# Appendix Six

TRACKING PROGRESS OVER TIME

Figure 25 enables the commencement of a process of comparison in achieving progress against a range of avoidable mortality indicators. Figure 26 summarises the national health trend data reported in the Health Performance Framework Report 2008 across a range of important measures of Indigenous health status, the determinants of health and health system performance. Whilst modest improvements have been identified in some significant areas (including mortality rates), continuous effort will be required in order to build on and sustain these trends into the future. Furthermore, particular attention will be required on those measures of health status where trends show little change or continued decline.

Table 25: Avoidable mortality, by cause of death, persons aged 0–74 years, 2002–2006

Cause of death	Number		Per cent		Age standardised rate per 100,000		Ratio
	Indig.	Non-Indig.	Indig.	Non-Indig.	Indig.	Non-Indig.	
<b>Queensland</b>							
Ischaemic heart disease	389	6,109	22.3	20.2	141.7	34.1	4.2*
Cancer	282	11,337	16.1	37.5	111.9	62.4	1.8*
Lung cancer	112	4,023	6.4	13.3	50.0	22.2	2.3*
Diabetes	198	931	11.3	3.1	87.4	5.2	16.7*
Suicide	143	2,009	8.2	6.7	23.4	11.3	2.1*
Alcohol-related disease	103	821	5.9	2.7	27.9	4.4	6.3*
Road traffic injuries	85	1,394	4.9	4.6	13.8	7.8	1.8*
Cerebrovascular disease	81	1,819	4.6	6.0	33.7	10.3	3.3*
Chronic obstructive pulmonary disease	74	1,570	4.2	5.2	35.7	8.9	4.0*
Selected invasive bacterial and protozoal infections	61	582	3.5	1.9	18.1	3.3	5.5*
Birth defects	53	517	3.0	1.7	5.6	3.0	1.9*
Nephritis and nephrosis	42	247	2.4	0.8	14.7	1.4	10.4*
Complications of perinatal period	38	243	2.2	0.8	3.1	1.4	2.2*
Epilepsy	29	167	1.7	0.6	6.3	0.9	6.8*
Rheumatic and other valvular heart disease	28	80	1.6	0.3	7.2	0.4	15.9*
Other	142	2,371	8.1	7.9	36.8	13.3	2.8*
<b>Total avoidable</b>	<b>1,748</b>	<b>30,197</b>	<b>100.0</b>	<b>100.0</b>	<b>567.3</b>	<b>168.1</b>	<b>3.4*</b>
<b>Qld, WA, SA and NT</b>							
Cause of death	Number(d)		Per cent		Age standardised rate per 100,000		Ratio
	Indig.	Non-Indig.	Indig.	Non-Indig.	Indig.	Non-Indig.	
Ischaemic heart disease	956	11,541	20.0	19.9	149.7	32.7	4.6*
Cancer	658	21,721	13.8	37.5	115.2	60.8	1.9*
Lung cancer	245	7,576	5.1	13.1	47.0	21.3	2.2*
Diabetes	507	1,870	10.6	3.2	94.5	5.3	17.7*
Suicide	370	3,883	7.8	6.7	26.3	11.1	2.4*
Alcohol-related disease	309	1,505	6.5	2.6	37.1	4.1	9.0*
Road traffic injuries	334	2,853	7.0	4.9	26.3	8.2	3.2*
Cerebrovascular disease	215	3,409	4.5	5.9	36.5	9.8	3.7*
Chronic obstructive pulmonary disease	182	2,784	3.8	4.8	39.2	8.0	4.9*
Selected invasive bacterial and protozoal infections	229	1,244	4.8	2.1	27.2	3.6	7.6*
Birth defects	108	900	2.3	1.6	5.9	2.7	2.2*
Nephritis and nephrosis	162	568	3.4	1.0	27.0	1.6	16.4*
Complications of perinatal period	108	448	2.3	0.8	4.2	1.4	3.1*
Epilepsy	71	346	1.5	0.6	7.4	1.0	7.5*
Rheumatic and other valvular heart disease	93	165	2.0	0.3	10.7	0.5	22.7*
Other	467	4,743	9.8	8.2	49.1	13.6	3.6*
<b>Total avoidable</b>	<b>4,769</b>	<b>57,980</b>	<b>100.0</b>	<b>100.0</b>	<b>656.3</b>	<b>164.5</b>	<b>4.0*</b>

Source: AIHW analyses of National Mortality Database in AIHW 2008.

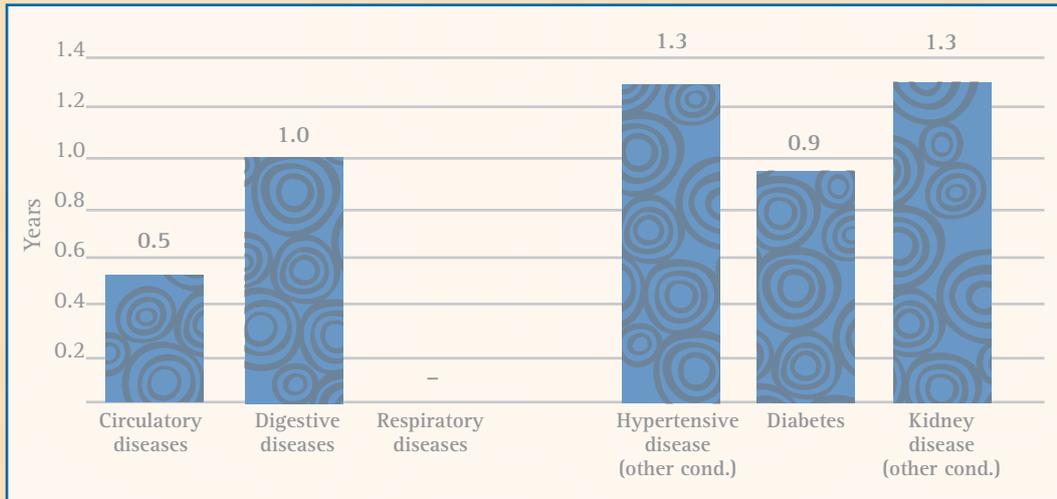
Figure 26: Health status trends

Health status and health outcomes		Determinants of health		Health system performance	
Improving	Ongoing concern	Improving	Ongoing concern	Improving	Ongoing concern
All cause mortality Declined by 15% for women and 9% for men (1991-2006)	Low birth weight Twice the non-Indigenous rate	Access to functional housing Connection to town water doubled (2001-2006)	Overcrowding Five times more likely to live in overcrowded homes (2006)	Availability of staff and number of services	Antenatal care Indigenous women are presenting later and less frequently than other women
Deaths from circulatory disease Declined by 31% (1997-2006)	Ear disease No improvement (2001-05)	School retention Steady increase (2001-2006)	Income 40% of Indigenous adults are in the lowest 20% of incomes (2006)	Usual source of care 91% of Indigenous people report going to the same GP or medical service.	Access to health care More likely to visit casualty departments. Less likely to access dentists
Infant mortality Declined by 47% - gap closed by 20% (1991-2006)	End Stage Renal Disease Increased by 185% (1991-2006)	Literacy and numeracy Steady increase (2001-2006)	Violence Number of violence victims increased 13% to 24% (1994-2002)	Access to medicines Average expenditure per person through the PBS doubled between 1995 and 1999 and increased by a further 64% (1998-2005)	Barriers to health care access Cost, transport, availability, sustainability and appropriateness
Perinatal mortality Declined by 51% - gap closed by 33% (1991-2005)	Oral health No improvement in last decade (NT data)	Year 12 completion Increased from 21% to 25% (2001-2006)	Imprisonment Adult rate increased from 1265 to 1787 per 100,000 (2000-2007)	Child immunisation Similar to rates across the whole population.	Key hospital procedures 55% of hospital separation involved a procedure compared with 80* for other Australians
Hospitalisation for Pneumonia (Indigenous children)	Sexual health Chlamydia rate increased by 188%. Gonorrhoea rate increased by 74% (1994-2006)	Unemployment Still twice as high but declining from 13% to 9% (1996-2006)	Child abuse and neglect More substantiated child protection notifications since 1999 - 5 times higher than for other children		Discharge from hospital against medical advice 13 times the rate for other Australians (2004-2006)
	Social and emotional well-being Several indicators	Home ownership Modest increase from 27% to 29% (1996-2006)	Smoking No improvement in ten years despite gains for other Australians - half of all Indigenous adults smoke		Avoidable admissions Continually increased especially for chronic conditions. The relative gap has widened from a ratio of 4.4 to 6.5 (2000 - 2006)
			Risky alcohol intake Although less likely to drink than other adults, 50% who do drink to high risk levels		Mental health services Twice as many contact with services as other Australians (2005-2006)
			Substance Use Increased from 25% in 2002 to 28% in 2004-05		Health workforce 1% of the health workforce, 1.6% of tertiary health courses and 5% of VET health courses (2006)
			Obesity Continuous rise - 60% of Indigenous adults are overweight and obesity twice as likely (2004-2005)		Health expenditure Only 17% higher per capita expenditure compared with the burden of illness and cost of delivering services; declined since 1998-99

(Source: AIHW 2008)



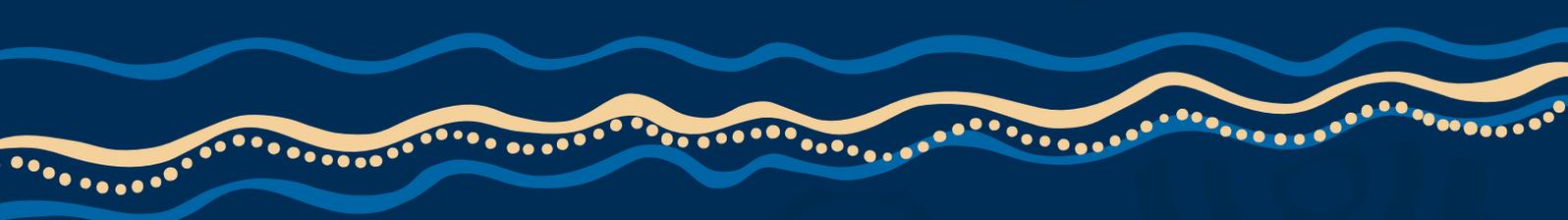
Figure 27: Gain in median age of hospitalisation 2000-01/2003-04/2007-08



Source: Queensland Health

A comparison of the median age at admission to hospital between Indigenous and non-Indigenous populations indicates that Indigenous Queenslanders are hospitalised at a much younger age than non-Indigenous Queenslanders for the same chronic condition (see Figure 8 and 9). Reducing the gap in median age of hospitalisation will indicate gains in reducing the burden of illness at ages when most people can expect to be relatively illness and disability free. Figure 27 shows that some small gains have been achieved in reducing the gap in median age of hospital admission.

# tracking progress over time



# Appendix Seven

MATERNAL AND CHILD HEALTH SERVICES MODEL

## Universal and Targeted Primary Health Care Model for Maternal and Child Health Services for Aboriginal and Torres Strait Islander Communities

Research in far north Queensland has identified the high rates of preventable health problems experienced by children in remote communities and the need for urgent public health intervention. The Paediatric Outreach Service over a four and a half year period identified ten key health/disease conditions with chronic suppurative otitis media, suspected child abuse and neglect and failure to thrive as the three most common presentations. High rates of anaemia, prematurity, asthma, hearing impairment, foetal alcohol syndrome, congenital heart disease and rheumatic heart disease were also identified.<sup>57</sup> Other research states that for many children born in remote communities by the age of 10 years, up to 40 per cent will have developed a chronic suppurative ear infection causing hearing loss, 10-15 per cent will have developed malnutrition and about 30 per cent will have anaemia. Some will suffer the highest rate of rheumatic heart disease in the world and a further 5 per cent will have been hospitalised for preventable pneumonia.<sup>58</sup>

Comprehensive primary prevention maternal and child health services have been proved to be an effective investment in promoting the healthy growth and development of children in the critical early years. The Universal and Targeted Primary Health Care Model aims to strengthen the capacity of existing primary health care services in remote communities by establishing community based Maternal and Child Health Primary Prevention Teams supported by visiting Maternal and Child Health Intervention Teams. The model, which has been trialled in Cape York from 2008, promotes protective behaviours and safe environments for children, enhances primary prevention services to address risk factors and increases accessibility to medical and allied health specialist services. A Program Support and Coordination Team oversees the establishment and implementation of the two teams and the implementation design for the universal and targeted delivery integration model.

**Other communities that would benefit from the application of this model include:**

- **Cluster 1** - Cairns and Cape York – Kowanyama, Pormpuraaw, Laura, Coen, Aurukun, Lockhart River, Napranum, Old Mapoon, Yarrabah, Wujal Wujal, Hope Vale Cooktown, and Mossman Gorge
- **Cluster 2** – Torres Strait Islands and Northern Peninsula Area – Seisia, Injinoo, New Mapoon, Bamaga, Umagico, Top Western Cluster, Near Western Cluster, Central Cluster, Eastern Cluster and Inner islands
- **Cluster 3** – Doomadgee, Mornington Island and Palm Island
- Cherbourg and Woorabinda.

## Comprehensive Primary Prevention Maternal and Child Health Services – Design Features

### Feature A: Primary Prevention Maternal and Child Health Services

- Good quality, antenatal care and education services
- Personal and family support programs
- Intensive home based interventions to support parents/caregivers
- Breastfeeding, child nutrition and immunisation programs
- Early identification of developmental problems and disability for children through the promotion of well child health checks and referral services
- First time mothers support groups and young parent support programs to promote infant care
- Improved parenting skills
- Information for parents on the promotion of child development and education
- Early childhood programs and school health checks for school age children
- Injury prevention programs.

### Feature B: Workplace Training and Education

Effective instruction for Indigenous Health Workers and completion of the Certificate IV in Child and Youth Health (Aboriginal and Torres Strait Islander) will address the educational needs that are the difference between current knowledge and performance and the desired level of knowledge or performance. There is general agreement that staff training is crucial for the management and provision of quality comprehensive primary prevention maternal and child health services.

<sup>57</sup> Rothstein J, Heazlewood R and Fraser M 2007. "Health of Aboriginal and Torres Strait Islander Children in Far North Queensland Findings of a Paediatric Outreach Service" in *The Medical Journal of Australia* Vol 186, No. 10.

<sup>58</sup> Couzos, S 2004. *Aboriginal Health: Perspective*, ABC Radio National Transcript 15 January 2004.

## Aims of the Model

To improve antenatal services which better respond to the needs of all pregnant women and significantly improve the proportion of children that are born healthy by:

- Reducing the incidence of teenage pregnancy
- Providing targeted antenatal information and services to teenage and vulnerable mothers
- Increasing maternal knowledge, skills and confidence regarding protective and risk factors for a healthy pregnancy
- Providing antenatal education to all women
- Reducing maternal risk factors such as tobacco and alcohol use and sexually transmissible infections
- Reducing perinatal and infant death due to low birth weight and sudden infant death syndrome
- Decreasing the incidence of low birth weight and prematurity.

To improve the health and development of children from birth to five years by intervening early through:

- Increasing access to health checks and screening of growth and development and early identification of health problems and conditions for infants, children and young people
- Increasing numbers of children vaccinated
- Increasing long term breastfeeding rates and child nutrition
- Reducing intentional injury and non-intentional injury
- Increasing the capacity of communities and families to provide physically and psychologically safe and supportive environments
- Decreasing child abuse and neglect
- Decreasing the incidence of preventable conditions such as respiratory disease, obesity, malnutrition, neurodevelopmental delay and disorders, oral health conditions, rheumatic heart disease, sexually transmissible infections, skin and subcutaneous conditions, early onset of diabetes mellitus type 2, asthma and group A streptococcus
- Strengthening parents' knowledge and skills.

## Structure of the Model

The Universal and Targeted Primary Health Care Model is based on a structure comprised of three critical tiers:

- Tier 1 – Maternal and Child Health Primary Prevention Teams (community based)
- Tier 2 – Maternal and Child Health Intervention Response Teams (visiting)
- Tier 3 – Program Support and Coordination Team

### Tier 1: Maternal and Child Health Primary Prevention Teams (community based)

Maternal and Child Health Primary Prevention Teams will provide universal primary prevention services. The teams will build on existing primary health care services in each community and will provide referrals to the Maternal and

Child Health Intervention Response Teams. The role of the primary prevention teams is to provide intensive early intervention and prevention programs in maternal and child health including prenatal care, universal and targeted post birth support through home visiting, parent education on infant care, child health checks (including growth monitoring, developmental screening, social and emotional developmental assessment, iron deficiency and anaemia), parenting programs to address behavioural management, injury prevention, school nutrition programs, parent and child empowerment programs, health education in schools, including 'core of life' program, sexual and reproductive health education and support programs for young people who are pregnant and/or who are parents.

### Tier 2: Maternal and Child Health Intervention Response Teams (visiting)

The response teams will provide secondary level intervention services including strategies to promote good antenatal care, paediatric specialists assessments for child development (such as low birth weight, prematurity, respiratory disease and foetal alcohol spectrum disorder), childhood diseases (such as rheumatic fever and rheumatic heart disease, congenital heart and hearing impairment), abuse and neglect, physical, speech and social and emotional developmental assessments and behavioural management.

### Tier 3: Program Support Coordination Team

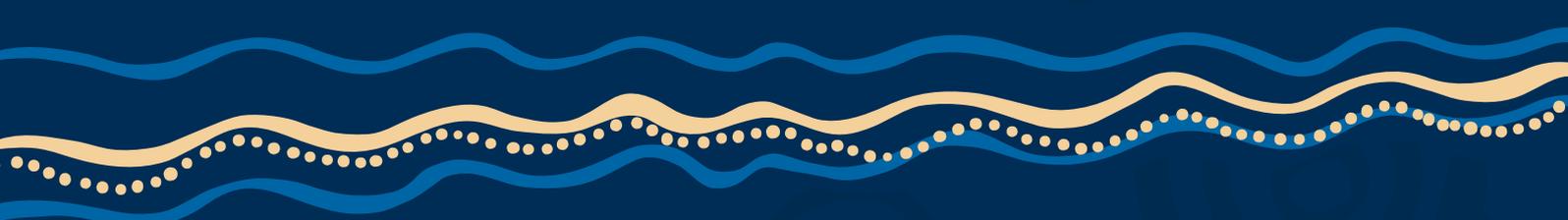
The support team will oversee the establishment and implementation of the Maternal and Child Health Primary Prevention and Intervention Response Teams and will develop the implementation design for the universal and targeted service delivery integration model. The support team will work in collaboration with Queensland Health service districts to assist in the recruitment and selection of staff, service scheduling, development and implementation of policy and procedures for the operation of the teams and the establishment of a data collection and monitoring system.

## Clinical Education, Clinical Supervision and Mentoring

The success of the model is reliant on having sufficiently trained and experienced health care providers working collaboratively within each tier of the model. To ensure the transfer of knowledge and the facilitation of learning, five maternal and child health educators and a Senior Indigenous Health Worker will be tasked with the development of a workplace based learning environment and culture. Most of the clinical learning or training will be conducted within the workplace and a mentorship model most suitable to each clinical setting will be adopted.

# capacity building





# Appendix Eight

GLOSSARY

# Definitions

## Aboriginal or Torres Strait Islander Health Worker

A Queensland Health Aboriginal and Torres Strait Islander Health Worker is an Aboriginal or Torres Strait Islander person who works within a primary health care framework to achieve better health outcomes and better access to health services for Aboriginal and Torres Strait Islander individuals, families and communities; is required to hold the specified Aboriginal and Torres Strait Islander primary health care qualification; and advocates for the delivery of services in accordance with the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health.

## Aboriginal and Torres Strait Islander Community Controlled Health Services

The community controlled health sector defines a community controlled health service as an incorporated Aboriginal or Torres Strait Islander organisation, initiated by and governed by an Aboriginal or Torres Strait Islander body that is elected by the local community, delivering a holistic and culturally appropriate primary health care to the community that controls it. However, it is widely acknowledged that there are a variety of governance structures currently in place that may be considered stages along a process that can lead over time to the development of a fully community controlled primary health care service.

## Chronic Disease

The chronic disorders of ischaemic heart disease, type 2 diabetes, renal disease, hypertension, stroke and chronic respiratory disease can be grouped together from a public health perspective as they have common underlying risk factors. These are most notably poor nutrition, inadequate environmental health conditions, alcohol misuse and tobacco smoking. The diseases and their risk factors are also inextricably linked with the broader socio-economic determinants of health and quality of life, particularly education and employment. Lifestyle choices are often more reflective of unrelenting socio-economic environmental constraints than person preferences.

## Disability Adjusted Life Expectancy

The number of healthy years of life lost due to premature death and disability.

## Early Intervention

An early intervention is recognising a health problem as soon as possible and intervening to stop the harm that the problem will cause.

## Emotional and Social Well-Being

Refers to the whole state of health, with the focus on mental health, so that Indigenous Australians can reach their full physical, emotional, cultural and spiritual potential at the individual, family and community level.

## Environmental Health

Creating and maintaining environments which promote good public health including provision of basic environmental health infrastructure such as housing, water and sewerage.

## Health Adjusted Life Expectancy

Reduces the expected duration of life by the proportion of time spent at each age in states of less than perfect health, adjusted for the relative severity of those health states.

## Health Gap

Refers to the difference between the burden of disease estimates for Indigenous Australians in a given calendar year and what the estimates would have been if Indigenous Australians had experienced mortality and disability at the level of the total Australian population.

## Health Sector

Consists of organised public and private health services, the policies and activities of health departments, health related non-government and community organisations and professional associations.

## Health Services

Includes alcohol and drug services, health promotion and disease prevention services, women's and men's health, child and maternal health, aged care services, services for people living with a disability, mental health services as well as clinical and hospital services.

## Indigenous Queenslanders

The term "Indigenous Queensland" is used in this document to describe a person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal person or a Torres Strait Islander, is accepted as such by the community in which he or she lives, and who resides in Queensland.

## Low Birth Weight

Defined in the Aboriginal and Torres Strait Islander Health Performance Framework as of less than 2,500 grams. Percentages of low birth weight babies are higher for Aboriginal and Torres Strait Islander mothers than non-Indigenous mothers. Low birth weight constitutes a risk factor for diseases of early childhood and chronic disease in later life.

## Mainstream Health Service or Program

Refers to health and health related services that are available to, and accessed by, the general population. Improving access by Indigenous Queenslanders to mainstream services and improving the cultural capacity of mainstream services continues to be a high priority.

## Median Age

For every 100 persons the median age is the age of the 51st person.

## Morbidity

Refers to ill health in an individual and to levels of ill health in a population or group.

## Mortality Rate

The number of deaths registered in a given calendar year expressed as a proportion of the estimated resident population at June 30 that year. Age specific death rates are the number of deaths at a specified age as a proportion of the resident population of the same age. Higher age specific death rates in younger age groups indicate excess of unnecessary early deaths.

## Population (Public) Health

The organised response by society to protect and promote health and to prevent illness, injury and disability. Population health is characterised by planning and intervening for better health in populations rather than focussing on the health of identifiable individuals and takes account of the broad behavioural, social, physical and environmental determinants of health.

## Prevalence

Indicates how often a particular health condition can be found within a particular population. High prevalence of a disorder indicates that more people in that population have the disease or condition at any one point in time.

## Primary Health Care

The health care available to the general community in their local area. It is the first point of contact between the community and the health care system. Primary health care in Queensland is provided through general practitioners, government operated community health services and primary health care clinics, the Royal Flying Doctor Service, public and private dental health services and Aboriginal and Torres Strait Islander community controlled health services. It also includes some outpatient services provided by a general hospital. Primary health care services provide clinical and community health care and facilitate access to specialist health services.

## Regional Health Forums

There are 10 Regional Health Forums across Queensland planning regions which comprise representative of the Australian Government (Department of Health and Ageing) and Queensland Government (Queensland Health), A&TSICCHSs and Divisions of General Practice within the region, and other relevant health service provider organisations such as the Royal Flying Doctor Service in remote regions. The Regional Health Forums provide an opportunity for joint service planning and inform resource allocation to Indigenous health programs and services within the region.

(Sources: NATSIHC 2003; Vos et al 2007; Queensland Health 2007)

# Abbreviations

ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
A&TSICCHSs	Aboriginal and Torres Strait Islander Community Controlled Health Services
COAG	Council of Australian Governments
CHICs	Connecting Health in Communities forums
COPD	Chronic Obstructive Pulmonary Disease
HALE	Health adjusted life expectancy
HPF	Aboriginal and Torres Strait Islander Health Performance Framework
KPIs	Key Performance Indicators
IPA	Indigenous Partnership Agreement
LIPA	Local Indigenous Partnership Agreement
NPA	National Partnership Agreement
OESR	Office for Economic and Statistical Research
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RHFs	Regional Health Forums
STIs	Sexually transmissible infections

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# notes

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