



Cooperative Research Centre for
Aboriginal Health

Bridging the Health Equity Gap

A Submission from the Cooperative Research Centre for Aboriginal Health
to the National Health and Hospitals Reform Commission

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KEY POINTS

1. The 'health gap' between Australian Indigenous peoples and the rest of the Australian population is wider than that between Indigenous and non-Indigenous populations elsewhere in the First World (Canada, New Zealand and the United States).
2. 'Closing the gap' requires determined action on addressing both the social determinants of health (for example, education, income and housing) with action within the health system, in both the primary health care and hospital sectors.
3. All Australian Governments should commit both to increased resourcing of Indigenous health and to health sector funding processes that provide clear and measurable incentives for the reform of service delivery for Indigenous people, both at the primary health care and hospital levels.
4. Primary health care reform should focus on improving primary health care access and quality for Indigenous people by:
 - a. extending access to Aboriginal community controlled health services (ACCHSs), with special attention to urban and other areas not currently served by an ACCHS;
 - b. improving private and other 'mainstream' general practice services by strengthening incentives to increase identification of Indigenous clients, culturally secure practice, employment of Indigenous people, population health programs, and engagement with the local community;
 - c. expanding the effort of State / Territory governments that provide primary health care services, including increased resources delivered with a maximum of local engagement, cultural security, and employment of local Indigenous community members; and
 - d. strengthening incentives for all primary health care services with Continuous Quality Improvement (CQI) processes focused on meeting the individual and population health needs of Indigenous communities.
5. Hospital reform should focus on improving links to the primary health care sector and on increasing resources to hospitals that provide improved access and quality of service to Indigenous people, through:
 - a. developing national standards for identification of Indigenous patients in the hospital system against Diagnostic Related Groups (DRGs);
 - b. accrediting hospitals with CQI processes in place that promote cultural security, develop planning and evaluation relationships with the local Indigenous community and its organisations, focus on Indigenous identification and data collection, and develop systems for internal referrals and discharge planning with the appropriate involvement of Aboriginal workers and agencies; and
 - c. developing national standards for weighting of hospital funding against Indigenous DRGs for hospitals accredited as having effective, quality services for Indigenous people.

BACKGROUND

On 13 February 2008, the Federal Government delivered an Apology to Australia's Indigenous Peoples. The Prime Minister's address to the House of Representatives, witnessed live on television by hundreds of thousands of people, was a dramatic and moving event. In his speech, and following the commitment of all Australian Governments at the Council of Australian Governments meeting in December 2007, the Prime Minister publicly pledged to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation.

Two weeks later, the Government formally approved the establishment of the National Health and Hospitals Reform Commission (NHHRC), giving it the task of developing a long-term health reform plan for a modern Australia, including the need to improve Indigenous health outcomes.

This submission from the Cooperative Research Centre on Aboriginal Health (CRCAH) will set out some of the key strategies by which this particular goal can be met. In doing so, the submission will inevitably touch upon several other of the NHHRC's terms of reference (see Appendix 1).

The Indigenous health gap

Measuring the health of the world's Indigenous populations – and especially comparing them across countries and over time – is an exercise fraught with methodological problems. Nevertheless, three clear facts emerge.

First, the health of Indigenous peoples in First World countries is everywhere measurably worse than that of the 'mainstream' populations amongst whom they live. The life expectancy gap between Indigenous and non-Indigenous peoples in New Zealand is around 8 years for men and 9 years for women; in Canada it is about 7 years for men and 5 years for women¹; and in the United States it is around 6 years².

Second, the health gap in Australia is greater than that in those other First World countries. The most recent figures give life expectancies for Australian Indigenous males and females of around 59 years and 65 years respectively, compared to 77 years and 82 years for the populations as a whole. This gives a gap in life expectancy of around 17 years for both sexes³.

Third, Australia (unlike New Zealand, Canada and the United States) has failed to significantly narrow the health gap over recent decades⁴ a fact that has been the subject of innumerable reports, campaigns and lobbying by Aboriginal communities, their representative health services, and researchers.

¹ AHMAC Australian Health Ministers' Advisory Council (AHMAC) (2006). *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*. AHMAC. Canberra.

² Hill K, Barker B, et al. (2007). "Excess Indigenous mortality: are Indigenous Australians more severely disadvantaged than other Indigenous populations?" *International Journal of Epidemiology* **36**(3): 580-589.

³ AHMAC Australian Health Ministers' Advisory Council (AHMAC) (2006). *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*. AHMAC. Canberra.

⁴ Ring, I and Firman D (1998). "Reducing indigenous mortality in Australia: lessons from other countries." *Medical Journal of Australia* **169**: 528-533.; Kunitz S J and Brady M (1995). "Health care policy for Aboriginal Australians: the relevance of the American Indian experience." *Aust. NZ J Public Health* **19**: 549-58.; AHMAC Australian Health Ministers' Advisory Council (AHMAC) (2006). *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*. AHMAC. Canberra.

The criticisms of Australia's failure as a nation to address Indigenous health is based not just on the statistics, but also on the experience of ill-health and premature mortality reported by Indigenous people. This evidence is well-documented and is properly widely accepted.

The 'health gap' between Australian Indigenous peoples and the rest of the Australian population is wider than that between Indigenous and non-Indigenous populations elsewhere in the First World (Canada, New Zealand and the United States). Unlike in these other countries, there has been no significant narrowing of the gap – measured by life expectancy – over recent decades.

Current health status

Despite the undoubted poor health of Australia's Indigenous peoples, the widely held public perception that 'nothing ever changes in Aboriginal health' is overly simplistic, and the latest data show a mixed picture.

The most recent *Aboriginal and Torres Strait Islander Health Performance Framework Report (2006)*⁵, presents a number of reasons for cautious optimism in assessing current Indigenous health status in Australia. In particular:

overall mortality rates decreased by 16% between 1991 and 2003;

infant mortality fell by 44% and perinatal mortality by around 55% over the same period; and

child immunisation has improved to the point where it is close to the rates for other Australian children.

Other data from the Northern Territory show:

death rates for a number of chronic diseases are slowing and even, for some conditions, beginning to fall⁶;

an increase in Aboriginal women's life expectancy of almost three years (from around 65 to 68 years) between 1996-2000 and 2001-2003⁷; and

significant gains in life expectancy for both men and women in the NT since the 1960s (although these gains were offset by those experienced by the non-Indigenous Territory population such that the gap in life expectancy between the two populations seems to have narrowed for women, but widened for men)⁸.

Many of these improvements have been attributed to improved primary health care services.

⁵ AHMAC Australian Health Ministers' Advisory Council (AHMAC) (2006). *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*. AHMAC. Canberra.

⁶ Thomas, D P, Condon J R, et al. "Long-term trends in Indigenous deaths from chronic disease in the Northern Territory; a foot on the brake, a foot on the accelerator." **185**: 145-149.

⁷ DHCS (NT Department of Health and Community Services) (2006) NT Health Gains Fact Sheet http://www.nt.gov.au/health/docs/hgains_factsheet_mortality2006.pdf

⁸ Wilson, T, Condon J R, et al. (2007). "Northern Territory indigenous life expectancy improvements, 1967-2004." *Australian and New Zealand Journal of Public Health* **31**(2): 184-8.

Nevertheless, it is important not to overstate these gains. The Indigenous population bears two-and-half times a greater burden of disease and injury than the general Australian population⁹, and many health indicators show little or no improvement or are even worsening¹⁰:

tobacco smoking is the major single cause of disease for Indigenous Australians, being associated with 12% of the total burden of illness and 20% of all mortality¹¹; smoking rates remain double those in the non-Indigenous community and show no sign of falling¹²;

deaths caused by chronic diseases other than cardiovascular disease remain very high;

physical activity may be declining and overweight and obesity increasing;

Indigenous women continue to receive antenatal care later and less frequently than for other women, and low birth weight is twice as common;

physical violence, alcohol & substance abuse, mental illness, suicide, premature death, and financial stress remain significant issues;

end stage kidney disease registrations have more than tripled over the last decade;

rates of ear disease and hearing problems are 2 or 3 times those of the non-Indigenous population; and

chlamydia and gonorrhoea increased between 1994 and 2004.

Added to these 'objective' measures of health status must be added self-reported health: Indigenous Australians are twice as likely to report their health as only fair or poor as non-Indigenous Australians, and there has been a decrease in reported good health and an increase in reported fair or poor health by Indigenous Australians in recent years¹³.

Such figures should be of particular concern as the goals of the health system cannot just be measured in terms of mortality and life expectancy; health systems are also significantly about preventing and relieving suffering and promoting 'wellness'.

There are differences in the health of Indigenous Australians according to where they live: those in remote areas (about one quarter of the Indigenous population) make up 40% of the health gap; those in towns and cities (about three quarters of Indigenous people) bear the remaining 60%¹⁴. In other words, while those with the greatest need

⁹ Vos T, Barker B, Stanley L, Lopez A (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003, School of Population Health, The University of Queensland, Brisbane.

¹⁰ Unless otherwise stated, figures from AHMAC Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

¹¹ Vos T, Barker B, Stanley L, Lopez A (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003, School of Population Health, The University of Queensland, Brisbane.

¹² Australian Bureau of Statistics (2006). National Aboriginal and Torres Strait Islander Health Survey: Australia, 2004-05. Canberra, Australian Bureau of Statistics.

¹³ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

¹⁴ Vos T, Barker B, Stanley L, Lopez A (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003, School of Population Health, The University of Queensland, Brisbane.

are those in remote areas, the greatest burden of ill health occurs in urban areas. This is an important point for policy makers.

Some indicators of Indigenous health are improving, especially overall mortality rates and infant and perinatal mortality. In particular there seem to be important advances in recent times in the Northern Territory. However, many other indicators show little or no improvement, or are actually declining.

Indigenous people themselves are twice as likely to report their health as only fair or poor as non-Indigenous Australians, and there has been a decrease in reported good health by Indigenous Australians in recent years.

The quarter of Indigenous people living in remote areas are those with the greatest health needs; however, the three quarters of Indigenous people living in urban areas collectively make the greatest contribution to the health gap between Indigenous and non-Indigenous Australia.

Policy and resourcing responses

Policy and public concern about continuing high levels of ill health in the Indigenous community is at a high point at the moment, following the previous Federal Government's 'Emergency Intervention' into the Northern Territory, and the current commitment to closing the health gap. Nevertheless, the last twenty years have seen a number of efforts to address Indigenous health disadvantage.

The 1989 National Aboriginal Health Strategy (NAHS) – endorsed and supported by the Royal Commission Into Aboriginal Deaths in Custody the following year – outlined an approach to addressing Indigenous ill-health substantially based on the provision of comprehensive primary health care and the role of environmental health; in doing so it emphasised the critical importance of Aboriginal community controlled primary health care services.

The creation of ATSIC (in 1990), however, led to a situation where health service needs had to compete for resourcing with the myriad other demands faced by Indigenous communities. A review of the implementation of the NAHS in 1994 found that much of the Strategy was not implemented, largely because the \$232 million over five years allocated fell far short of the estimated cost of fully implementing the strategy.

The failure to properly resource the NAHS led to a campaign by sections of the Aboriginal community-controlled health sector and others to have funding responsibility for Aboriginal primary health care transferred from ATSIC to the Commonwealth Health Department. This transfer was effected in 1995.

This has led to increased funds for Indigenous primary health care, including through such new programs as the Primary Health Care Access Program. Funding for Aboriginal community controlled health services increased from \$233 per Indigenous person in 1998-99 to \$426 per person in 2004-05 (in constant 2004-05 dollars), an increase of 83% to a total of \$193 million.¹⁵

¹⁵ Australian Institute of Health and Welfare (2008). Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05. AIHW. Canberra.

Further, reforms to the Medical and Pharmaceutical Benefits Schemes (MBS and PBS) to ensure that funding reached those Indigenous communities not served by private General Practitioners or pharmacies also led to increased Indigenous use of these schemes, from \$237 per Indigenous person in 1998-99 to \$364 in 2004-05, up 53%. (It is worth noting, however, that Aboriginal and Torres Strait Islander per capita expenditure for these schemes remains under half of that for other Australians)¹⁶.

There have been, however, only minor changes (\$27 per person or 4%) in State / Territory expenditures on community and public health for Aboriginal and Torres Strait Islander people over the last ten years.

These figures demonstrate an increase in investment in primary health care for Indigenous communities since the 1990s. They have led to an increase in the staffing and episodes of services delivered by the Aboriginal community-controlled sector, and greater access to prescription medicines through the PBS section 100 arrangements¹⁷.

Nevertheless, these increases are modest at best given the high burden of morbidity and mortality in the Indigenous community and the fact that the Indigenous population continues to increase. A recent study¹⁸ estimated that total health spending on Indigenous communities would need to be increased to between 3 and 6 times the national average per capita expenditure to achieve equitable access to effective care; currently across the whole health system, average expenditure on health for Indigenous people is only 18% higher than for non-Indigenous Australians, with little change in this proportion since 1998-99¹⁹.

The last decade has seen an increase in Australian Government funding to Indigenous primary health care providers, and improved access for Indigenous Australia to the MBS and PBS. State and Territory expenditures on community and public health for Indigenous people have seen little or no change.

These increases in funding are modest given the high burden of morbidity and mortality in the Indigenous community and the fact that the Indigenous population continues to increase.

Overall average expenditure on health for Indigenous people is only 18% higher than for non-Indigenous Australians, with little change over the last ten years. It has been estimated that per capita Indigenous health spending would need to be between 3 and 6 times the national average to achieve equitable access to effective care.

THE SOCIAL DETERMINANTS OF HEALTH

Much public debate centres around the assumption that 'good health' is more-or-less directly the product of a good health system. However, in the last fifteen years or so, a

¹⁶ Australian Institute of Health and Welfare (2008). Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004-05. AIHW. Canberra.

¹⁷ Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

¹⁸ Dwyer J, Silburn K and Wilson 2004, *National Strategies for Improving Indigenous Health and Health Care*. Aboriginal and Torres Strait Islander Primary Health Care Review Consultant Report No 1 Commonwealth of Australia: Canberra.

¹⁹ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

body of evidence and a theoretical paradigm has grown up that locates many of the major factors determining the health of populations outside the health care system.

According to the theory of the social determinants of health – now powerfully supported by numerous studies and substantial evidence as reviewed by the World Health Organisation²⁰ – a person’s social and economic position in society, their early life experiences, their exposure to stress, their educational attainment, their employment status, their exclusion from participation in society, and transport, all exert a powerful influence on their health throughout life. Of particular importance are socioeconomic status and education, including parental (and especially maternal) education.

The social determinants of health in Indigenous Australia

However, the evidence of improvements in the social determinants of health in Indigenous Australia are mixed at best²¹.

While literacy and numeracy levels and school participation rates are improving, gaps in achievement remain evident when Indigenous children enter school and widen from there at a rate of about nine months for every year at school²².

Similarly, with employment and income: while it appears that unemployment rates fell from 30% in 1994 to 20% in 2002 for Aboriginal and Torres Strait Islander people, these results must take into account the possible masking effect of CDEP, the relatively low degree of labour force participation, and the high number of long-term unemployed. Significantly, 42% of Indigenous people remain in the lowest quintile of incomes. These figures lead to the conclusion that poverty continues to be a major driver of poor health outcomes in the Australian Indigenous community.

Little or no improvement has been seen in recent years in Indigenous remote communities’ access to a safe water supply, sewerage and electricity; overcrowding in houses remains a significant issue.

There are also signs that exposure to violence, child abuse and neglect and contact with the criminal justice system (including imprisonment) are trending worse.

High levels of disadvantage in many Indigenous communities in terms of income, education and infrastructure, continue to exert a strong negative effect on health.

Social determinants and health systems

In locating some of the major drivers of health and ill health outside of the health system, the theory of the social determinants of health have presented a major challenge to health professionals and policy makers, particularly where dealing with the health of disadvantaged populations such as Indigenous Australians.

²⁰ World Health Organisation (2003). Social determinants of Health: The Solid Facts, 2nd edition, Marmot, M and Wilkinson, R (eds.), International Centre for Health and Safety, Denmark.

²¹ Unless otherwise stated, the figures following are taken from Australian Health Ministers’ Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

²² Commonwealth of Australia (2006) *National Report to Parliament on Indigenous Education and Training, 2004* Australian Government Printer. Canberra. pp 40-45.

On the one hand, all too often the reaction is to acknowledge the importance of these 'upstream' factors that influence health, but then consign them to the background, as issues that are too hard to address and outside the responsibility of the health system²³.

Alternatively, while few if any researchers on the social determinants of health claim that health care has no effect on the health of populations, there may be some who come to abandon the belief that the health system has any effect on the health of populations at all.

Definitive figures on what proportion of the health gap is attributable to 'social determinants' and what to lack of access to quality health services are yet to be produced. However, there have been a number of studies that have demonstrated the link between socioeconomic status and mortality in the Australian Indigenous context, and these estimate that income, employment status and education account for between one-third and one-half of the gap in health status between Indigenous and non-Indigenous Australia²⁴.

Similarly, the recent comprehensive examination of the burden of disease of Indigenous Australians concludes, amongst its many important findings, that half the Indigenous health gap can be attributed to risk factors such as tobacco, alcohol and poor diet – with morbidity constituting the remainder. This points to the significant potential of improved access to quality care to address the Indigenous health gap²⁵.

It has been estimated that around one-third and one-half of the gap in health status between Indigenous and non-Indigenous Australia is attributable to the social determinants such as income, employment and education. This points to the significant potential of improved access to quality care to address the Indigenous health gap.

Such estimates are consistent with the international evidence, and point strongly to an approach which combines action on addressing the social determinants of health with action to improve and extend health services – particularly primary health care.

THE ROLE OF PRIMARY HEALTH CARE

The evidence for primary health care

Internationally amongst 'mainstream' populations, there is good evidence that the strength of a nation's primary health care system is associated with a number of important health measures, and in particular that stronger primary health care is significantly related to lowered mortality of infants from 1 to 12 months of age and with lower overall national health care costs²⁶.

²³ Griew, R. and T. Weeramanthri (2003). Investing in Prevention and Public Health in Northern Australia. [UK Australia Seminar: Federalism, Financing and Public Health](#). Canberra, The Nuffield Trust and Australian Government.

²⁴ Booth, A. and Carroll, N. (2005) [The health status of Indigenous and non-Indigenous Australians](#), Discussion Paper No. 486, Centre for Economic Policy Research, ANU, Canberra.

²⁵ Vos T, Barker B, Stanley L, Lopez A (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003, School of Population Health, The University of Queensland, Brisbane.

²⁶ Starfield, B. and L. Shi (2002). "Policy relevant determinants of health: an international perspective." [Health Policy](#) 60(3): 201-218.

Similarly, extensive studies in the United States have found that increased primary care resources are associated with lower mortality rates²⁷, with better child and maternal health²⁸, and with lower rates of mortality from heart disease and cancer²⁹. Importantly, these studies found that while the influence of socioeconomic variables – including income inequality – on health was powerful, primary health resources could offset these effects to some extent, leading the authors to conclude:

*From a policy perspective, improvement in population health is likely to require a multi-pronged approach that addresses sociodemographic determinants of health as well as strengthening primary care.*³⁰

Amongst Indigenous peoples elsewhere, the comparative success of the United States in reducing the life expectancy gap between Indigenous and non-Indigenous peoples has been attributed to the federal government's adoption of responsibility for the provision of health care to Native Americans through the Indian Health Service (IHS)³¹. There is quantitative evidence that access to integrated, universal health care with a strong primary and preventive focus incorporating health promotion and disease prevention through the IHS, has improved the health and life expectancy of Native Americans, despite their socioeconomic disadvantage³². There is also evidence from New Zealand that decreased access to preventive and primary health care services is associated with higher mortality amongst Indigenous people³³.

For Australian Indigenous peoples, from the 1970s onwards, primary health care has been seen by policy makers, health professionals and the Indigenous community as the key strategy for improving the health of Indigenous Australians.

To the extent that there have been improvements in the health of Australia's Indigenous peoples, these have often been credited by researchers, government and health services to improved primary health care. For example, improvements in infant mortality rates are consistent with better access to primary health care services, and changes in disease mortality patterns – including the shift from mortality due to infectious disease to mortality due to chronic conditions – are well documented and are plausibly related to the development and actions of primary health care services.

Even where measurable improvements are limited (for example in chronic disease mortality rates), the conclusion has been drawn that while the social determinants

²⁷ Shi, L., J. Macinko, et al. (2005). "Primary care, race, and mortality in US states." *Social Science & Medicine* 61: 65-75.

²⁸ Shi, L., J. Macinko, et al. (2004). "Primary care, infant mortality, and low birth weight in the states of the USA." *J Epidemiol Community Health* 58(5): 374-80.

²⁹ Shi, L., J. Macinko, et al. (2005). "Primary care, social inequalities, and all-cause, heart disease, and cancer mortality in US counties, 1990." *Am J Public Health* 95(4): 674-80.

³⁰ Ibid.

³¹ Kunitz, S. J. (1994). *Disease and social diversity: the European impact on the health of non-Europeans*. New York, Oxford University Press, Kunitz, S. J. and M. Brady (1995). "Health care policy for Aboriginal Australians: the relevance of the American Indian experience." *Aust. NZ J Public Health* 19: 549-58. See also Kunitz, S. J. (1994). *Disease and social diversity: the European impact on the health of non-Europeans*. New York, Oxford University Press.

³² Hisnanick, J. and D. Coddington (1995). "Measuring human betterment through avoidable mortality: a case for universal health care in the USA." *Health Policy* 34(1): 9-19.

³³ Tobias, M. and G. Jackson (2001). "Avoidable mortality in New Zealand, 1981-97." *Australian and New Zealand Journal of Public Health* 25(1): 12-20.

continue to drive high levels of ill health, improved primary health care services are at least providing a brake on what would otherwise be accelerating mortality rates.³⁴

Overall the evidence suggests that:

*The progress of recent years demonstrates that sustained and increased effort can be achieved; government investment, particularly in primary health care, is beginning to pay dividends in some areas.*³⁵

Internationally, stronger primary health care systems are associated with better infant health indicators and lower overall national health care costs, and increased primary health care resources are shown to be able to offset some of the harmful health effects of socioeconomic disadvantage and inequality.

Evidence from the United States and New Zealand suggest that primary health care has contributed to narrowing the life expectancy gap between Indigenous and non-Indigenous peoples in those countries, with the Indian Health Service in particular credited with a major contribution in the US. There is also evidence that poorer access to primary health care is associated with a widening life expectancy gap.

Improved access to, and quality of, primary health care are central to recent improvements in Australian Indigenous health status. The evidence points to further and sustained investment in primary health care, along with action on the social determinants, as a crucial strategy for 'closing the gap' in life expectancy between Indigenous and non-Indigenous Australians.

The components of comprehensive primary health care

Much work has been done within Australia in recent years to define the elements of successful comprehensive primary health care, extending and building on the concept described at Alma Ata in 1978 in the light of the Australian Indigenous experience and evidence.

A number of definitions exist, but most agree on some of the key elements³⁶:

Clinical Services including both primary medical care services and population health programs such as chronic disease screening and management, immunisation and maternal and child health;

Preventive Programs to address determinants of health outside the boundaries of clinical health services including specific programs that require community action, for example to address smoking, alcohol abuse, nutrition or domestic violence;

³⁴ Thomas, D. P., J. R. Condon, et al. (2006). "Long-term trends in Indigenous deaths from chronic disease in the Northern Territory; a foot on the brake, a foot on the accelerator." *MJA* **185**: 145-149.

³⁵ Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra. See also, for example: Wilson, T, Condon J R, et al. (2007). "Northern Territory indigenous life expectancy improvements, 1967-2004." *Australian and New Zealand Journal of Public Health* **31**(2): 184-8.

³⁶ Adapted from Dwyer, J., Shannon, C. & Godwin, S. 2007, Learning from Action: Management of Aboriginal and Torres Strait Islander Health Services, Cooperative Research Centre for Aboriginal Health, Darwin., and the AMSANT Administration Manual (<http://www.amsantmanual.com/03aboriginalhealth.html#a04>).

Support programs including facilitation of access to secondary and tertiary care and allied health services, as well as training/ education and administration;

Advocacy at both a client and system level, including engagement with other sectors and action for system change such as equitable access to programs and resources for better health.

Such an approach is an important strategy to address those areas critical for closing the health gap, namely chronic disease, maternal and child health, and active and informed engagement with those social determinants of health that lie outside the direct responsibility of the health system.

Access to primary health care

Aboriginal Community Controlled Health Services (ACCHSs) are the Australian Indigenous community's unique response to their own ill health. Also known as Aboriginal Medical Services, they were first established by Aboriginal communities in the 1970s and are now predominantly funded by the Commonwealth Department of Health and Ageing. Today, there are 140 such services around the country, ranging from large comprehensive primary health care services in urban areas to clinics in remote communities with only a few staff.

These diverse services delivered an estimated 1,600,000 episodes of health care in 2003–04³⁷. Almost one third (30%) of Indigenous people report attending an ACCHS as a regular source of health care; this varies from less than one sixth (15%) in major cities to over three quarters (76%) in very remote areas³⁸. Given the often-stated preference of Indigenous people for seeking their health care from ACCHSs, this indicates a significant shortfall in access to these services for Indigenous communities, especially those in urban settings.

Culturally appropriate and comprehensive services that meet the needs of the client holistically are the foundation of the ACCHS approach, and where present, they are frequently the service of choice for the Indigenous community. They aspire to offer a comprehensive model of primary health care, beyond the primary medical care generally provided by private GPs, including population health programs such as maternal and child health services, chronic disease detection and management and health promotion, as well as other services including facilitating of access to secondary and tertiary care, transport, social and emotional well-being and family support.

Significantly, primary health care services delivered by ACCHSs aim to promote a multi-disciplinary team approach to service delivery, in which Aboriginal Health Workers (AHWs) play a significant role alongside nurses, doctors and other health care professionals.

Their effectiveness has long been recognised. At the local level, many Indigenous primary health care services are able to document better health outcomes for the communities

³⁷ Australian Institute of Health and Welfare (2005). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*, 2005. Canberra.

³⁸ Australian Health Ministers' Advisory Council (AHMAC) (2006). *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*. AHMAC. Canberra.

they serve. A recent review found that they contributed significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birthweight³⁹.

However, it is unfortunately, not the case that all Indigenous communities, especially those in urban areas, have access to ACCHSs. Strengthening and extending Indigenous community-controlled comprehensive primary health care services is a key strategy for closing the health gap between Indigenous and non-Indigenous Australia⁴⁰.

Aboriginal community controlled health services provide a significant amount of the primary health care services accessed by Indigenous Australians, and because of their culturally secure and holistic services are frequently the service of choice for Indigenous people.

Aboriginal community controlled health services aspire to a comprehensive model of primary health care, including population health programs such as maternal and child health services, chronic disease detection and management and health promotion. They also promote a multi-disciplinary team approach to service delivery, in which Aboriginal Health Workers play an important role.

Extending access to Aboriginal community controlled health services – paying particular attention to extending access in urban settings – is a key strategy for closing the health gap between Indigenous and non-Indigenous Australia.

Private General Practitioners are the predominant source of primary health care for the 'mainstream' Australian population; they also provide a significant proportion of primary health care services to the Indigenous population – 60% of those surveyed in the National Aboriginal and Torres Strait Islander health survey of 2004-05 reported that they went to a doctor if they had a problem with their health. This figure varies widely according to where Indigenous people live: from 80% in major cities to only 6% in very remote areas⁴¹.

However, there are significant barriers to accessing GP services by Indigenous people, reflected by the low consultation rate in private general practices: nationally only 1.1% of consultations are recorded as being with Indigenous people who make up 2.4% of the population and are also significantly sicker than the general population. Many reasons contribute to this discrepancy, including low identification rates of Indigenous peoples by GPs, geographic distribution of GPs not reflecting that of the Indigenous population; lower use of GP services by Indigenous peoples where Aboriginal community controlled health services exist; and Indigenous peoples' use of hospital emergency departments as a source of primary medical care for cost or other reasons⁴². Nevertheless, while some

³⁹ Dwyer, J, Silburn, K & Wilson, G 2004, National Strategies for Improving Indigenous Health and Health Care, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report no. 1, Commonwealth of Australia, Canberra.

⁴⁰ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra. Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

⁴¹ Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

⁴² Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

GPs no doubt do provide culturally appropriate services, it is persistently reported that the cultural awareness and sensitivity of mainstream general practice to the needs of Indigenous people is patchy at best and that this remains a significant barrier to access⁴³.

Mainstream general practice remains a significant source of primary care for Indigenous Australians. There are, however, a number of barriers to access to private GPs for Indigenous people, including issues of cultural awareness and security. In general, they do not provide comprehensive, population health programs.

Health sector reforms should include increased incentive systems to promote and extend appropriate mainstream General Practice care for Indigenous people, including identification of Indigenous clients, culturally secure practice, employment of local Indigenous community members, population health programs, and engagement with the local community.

State / Territory run primary health care clinics provide much health care to remote Indigenous communities across Northern Australia. Generally speaking these clinics provide primary medical care at the local level, with population health and other services provided from central locations on a visiting basis, if at all. These jurisdictions also run community health centres and programs which are also used by Indigenous people in urban and regional areas.

In both cases, the degree of engagement with local communities, their commitment to culturally secure practice, and the degree to which they support local employment varies. Unfortunately, as noted above, State or Territory Governments have not matched increases in community and public health funding to their Indigenous citizens provided by the Australian Government.

State and Territory governments need to ensure that their commitment to 'closing the gap' means expanded primary health care resources at the community level, delivered with a maximum of local engagement, cultural security, and employment of local Indigenous community members.

Effective primary health care

Many factors go towards making a primary health care service effective. A recent as yet unpublished Government report⁴⁴ identified the following factors for success while noting that the importance of development and adaptation of programs at a local level means that no simple 'formula for success' can be replicated in all locations:

the active involvement and engagement of the local Indigenous community, either through formal structures of community control or (for non-community controlled health services) an ethic and practice of community involvement;

⁴³ Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

⁴⁴ Griew R, Tilton E, Thomas D and Cox N (2008). The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. A Report for the Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing. Canberra.

a collaborative approach that see primary health care services working with other service sectors, other community-based health service delivery organisations, and other levels of the health care system particularly hospitals / specialists;

delivery of core primary health care programs (see above);

an evidence-based approach that is reflective, that is based on a continuous quality improvement approach⁴⁵ and that involves the local community in adapting what is known to work elsewhere to local conditions and priorities (see below);

a multidisciplinary team approach that involves the employment of local community members, and which includes continuous training and support;

approaches which harmonise with local Aboriginal ways of life; and

adequate and secure resourcing to allow focus on the management and delivery of non-acute care.

THE ROLE OF HOSPITALS

The national focus of efforts to improve Indigenous health has often been on the primary health care sector. That sector's role in prevention, detection and management of disease, as well as its importance in working with other sectors on addressing the social determinants of health, certainly make it central to progress. However, access to quality hospital care for Indigenous people is also critical in efforts to close the health gap and for Indigenous people to have long, healthy and well lives.

Access to hospital care

Indigenous access to hospital care is different from that of non-Indigenous people in two key respects.

First, Indigenous Australians spend time in hospital at a greater rate than non-Indigenous Australians: Indigenous people are admitted to hospital at a about twice the rate as non-Indigenous people, with particularly high rates in the age group of 35 to 64 years⁴⁶. In the last full year for which there is data, there were just over a quarter of a million Indigenous hospital admissions in Australia, close to 95% of which were to public hospitals. Most of the difference in rates of admission is due to high rates of care for renal dialysis and for other potentially preventable chronic conditions: Indigenous men were admitted for dialysis at 9 times and Indigenous women at 17 times the rate of other Australian men and women and both sexes were hospitalised for potentially

⁴⁵ The 'ABCD' Program is a continuous quality improvement (CQI) approach to improving chronic disease detection and management in Aboriginal primary health care services that is being implemented in over 70 health centres in the Territory, Queensland, New South Wales and Western Australia with the support of the Cooperative Research Centre for Aboriginal Health. See Bailie RS, Dowden M, Si D, O'Donohue L, Kelly A (2005). Audit and Best Practice for Chronic Disease Project Progress Report. Menzies School of Health Research / CRC for Aboriginal Health. Darwin; and Bailie RS, Damin S, O'Donohue L, Dowden M (2007). Indigenous health: effective and sustainable health services through continuous quality improvement, MJA, 186(10) 525-530.

⁴⁶ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

preventable chronic conditions at seven times the rate of other Australians. Indigenous Australians were also commonly hospitalised for injury, pregnancy and childbirth, respiratory diseases, and digestive diseases⁴⁷. Note that due to under-counting of Indigenous clients in hospitals, these figures are likely to be underestimates of the true figures.

Second, once admitted, Indigenous people tend to stay in hospital longer than other Australians⁴⁸. There are a number of possible reasons for this, including a higher presence of co-morbidities in Indigenous patients, and their late presentation for acute care, frequently associated with lack of access to primary health care services⁴⁹.

Indigenous Australians are admitted to hospital more often and for longer periods than non-Indigenous Australians. Much of this disparity is due to high rates of admissions for renal dialysis and for other potentially preventable chronic conditions upon which a well-resourced primary health care could be expected to act.

Quality of hospital care

Indigenous people's high level of use of hospital care raises the crucial issue of the quality of the care they receive when they are in hospital.

Despite the increased burden of disease they carry, Indigenous patients are *less likely* to undergo a procedure once admitted to hospital than other patients. A recent analysis of admissions to Australia's public hospitals found that Indigenous patients are only two-thirds as likely to have a procedure recorded; for some disease categories the figure was as low as one half⁵⁰. This difference can be partly explained by patient, episode of care or hospital characteristics, but a considerable difference remains, leading to the conclusion that within Australia's public hospitals, "there may be systematic differences in the treatment of patients identified as Indigenous"⁵¹.

These findings are supported by studies showing that Indigenous people have poorer survival rates for cancer, explainable by their being less likely to have treatment, by their having to wait longer for surgery, and by the fact that they tend to be referred later for specialist treatment⁵².

Such systematic differences in access to care reinforce Indigenous people's low level of trust for hospitals as institutions, born no doubt from the fact that until well into the 1960s

⁴⁷ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

⁴⁸ Otim M, Anderson I et al (2002). Aboriginal and Torres Strait Islander Hospital accreditation project: a literature review. Vic Health Koori Health Research and Community Development Unit. Discussion Paper No 9.

⁴⁹ Anderson I, Clarke A et al (2002) Linking acute care to a strategy for improving Aboriginal health. Australian Health Review 25:118-129.

⁵⁰ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

⁵¹ Cunningham J (2002). Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. MJA 2002; 176 (2): 58-62

⁵² Valery PC, Coory M, Stirling J & Green AC (2006). Cancer diagnosis, treatment, and survival in Indigenous and non-Indigenous Australians: a matched cohort study. Lancet 367:1842-8., Condon JR, Barnes T, Armstrong BK, Selva-Nayagam S & Elwood JM 2005. Stage at diagnosis and cancer survival for Indigenous Australians in the Northern Territory. Medical Journal of Australia 182(6):277-80.

some hospitals segregated Indigenous and non-Indigenous wards and participated in the removal of children⁵³.

This level of distrust is reflected in the fact that Indigenous people are still much more likely to leave hospital against medical advice or be discharged at their own risk: around 3% of all Indigenous admissions have been measured to conclude in this way. Overall, Indigenous patients have been shown to be discharged from hospital against medical advice at 19 times the rate of other Australians⁵⁴. Figures such as this raise questions about the responsiveness of hospitals to Indigenous needs and about the overall quality of care they receive.

Despite the greater burden of disease they carry, once in hospital, Indigenous patients were *less likely* to undergo a procedure than other patients. This points to systemic barriers to care for Indigenous people within the hospital system.

The failure of the hospital system in general to provide services appropriate to the Indigenous community is reflected the very high rates of Indigenous patients self-discharging or leaving against medical advice.

Identification and data

As with other mainstream services, identification of Indigenous status and data collection is often poor in hospitals. Poor data and identification of Indigenous patients mean that hospitalisation rates for Indigenous Australians are under-estimated, that the scale of their health needs likely to be undervalued, and measurement of progress in meeting the health needs of the Indigenous community at the local, jurisdictional, and national levels undermined.

Many jurisdictions have recognised the need to improve the identification of Indigenous people in their hospital systems as Indigenous patients continue to be under-reported (especially in New South Wales, Victoria, Queensland, Tasmania and the Australian Capital Territory)⁵⁵. Recently, the quality of the data has improved, but more work is needed⁵⁶.

Despite recent improvements, many hospitals' identification of their Indigenous patients remains poor, leading to under-estimation of the scale of Indigenous health needs and to difficulties in measuring progress in narrowing the health gap between Indigenous and non-Indigenous Australians.

⁵³ Dwyer, J, Silburn, K & Wilson, G 2004, National Strategies for Improving Indigenous Health and Health Care, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report no. 1, Commonwealth of Australia, Canberra.

⁵⁴ Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

⁵⁵ Australian Institute of Health and Welfare (2005). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005. Canberra.

⁵⁶ Department of Health and Ageing (2008). The State of our Hospitals – June 2008 Report. <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-ahca-sooph-index08.htm>.

Reforming the hospital system

The issues outlined above concerning access and quality of services, and the need to identify and have good data on the Indigenous use of hospital services have been recognised for some time. Several key strategies should be put in place to address these.

1. **A strong primary health care system**, with good links between the acute and primary levels of care (including specialist outreach services to Indigenous communities and a safe and appropriate pathway for Indigenous patients to travel to and from hospital care⁵⁷) is an important way of increasing the access to and effectiveness of hospital care for Indigenous communities. This will ensure that Indigenous people are referred to hospital at an appropriate stage, and also that post-acute management of their conditions is effective at reducing their need for further hospitalisation.
2. **Improved identification and data collection.** Some jurisdictions have good data for the Indigenous use of hospitals and can report this against DRGs (Diagnostic Related Groups). However, this is far from universal and its lack undermines efforts to prioritise services to the Indigenous community and measure progress in meeting Indigenous health needs.
3. **Accreditation for Continuous Quality Improvement for Indigenous health care.** Many hospitals have made efforts to change the way they operate to improve their services to their Indigenous patients. Commonly, such moves have centred around the employment and use of Aboriginal Hospital Liaison Officers (AHLOs), as well as improving culturally secure practice through Indigenous input into hospital governance structures and processes, ensuring access to interpreter services, written protocols on maternal and birthing services, and end-of-life protocols that respect local Indigenous culture⁵⁸.

Such measures undoubtedly improve the cultural security of the hospital environment, and (in the case of AHLOs) provide an important way of linking the hospital to the Aboriginal community and its organisations, as well as assisting patients access other levels of care.

However, they have not been universally adopted. A critical way forward to improve access to and quality of hospital services to the Indigenous community is to universally establish and reward quality improvement processes developed by hospitals at a local level in collaboration with the Aboriginal community and its organisations⁵⁹.

A Continuous Quality Improvement (CQI) framework against which hospital services can be audited in terms of their services to the Indigenous community could include⁶⁰:

⁵⁷ See for example, Lawrence M, Dodd Z, Dunn S et al. (2008) [Improving the patient journey – achieving positive outcomes for remote Aboriginal cardiac patients](#). Cooperative Research Centre for Aboriginal Health (forthcoming research report).

⁵⁸ Australian Health Ministers' Advisory Council (AHMAC) (2006). Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. AHMAC. Canberra.

⁵⁹ Anderson I, Clarke A et al (2002) Linking acute care to a strategy for improving Aboriginal health. Australian Health Review 25:118-129.

⁶⁰ Adapted from Australian Institute for Primary Care (2002). Aboriginal and Torres Strait Islander Accreditation: Final report. Unpublished report: Centre for Quality in Health and Community Services / Vic Health Koori Health Research and Community Development Unit, University of Melbourne.

promoting and requiring staff values, skills and knowledge related to cultural security;

developing planning and evaluation relationships with the local Indigenous community and its organisations and services;

undertaking inter-agency and inter-disciplinary planning and evaluation focusing on the health needs of Aboriginal people;

developing systems and resources for internal referrals and discharge planning with the appropriate involvement of Aboriginal workers and agencies; and

developing systems that support recording of Indigenous status and data collection, and that evaluates the effectiveness of that system.

- 4. Accreditation linked to funding.** Having Indigenous health CQI systems effectively in place could be current hospital accreditation systems, and thereby to hospital funding formulas. Some jurisdictions already have a system where hospitals receive weighted funding for Indigenous DRGs. A uniform national system that agreed to provide weighted additional funding to those hospitals accredited as having Indigenous health CQI in place would provide a powerful incentive not just for the better identification of Indigenous patients, but also for culturally secure practice⁶¹.

Improving access to hospital care for Indigenous people should include a focus on establishing better links between the acute and primary care sectors, including specialist medical outreach services.

Some hospitals have made efforts to provide culturally secure, quality services, including through the use of Aboriginal Hospital Liaison Officers, interpreters, engagement with the local Indigenous community, and development of written protocols on culturally secure practice.

Culturally secure practice, identification of Indigenous patients and delivery of quality services to the Indigenous community should be embedded within established hospital accreditation systems and linked to hospital funding formulas.

⁶¹ Australian Institute for Primary Care (2002). Aboriginal and Torres Strait Islander Accreditation: Final report. Unpublished report: Centre for Quality in Health and Community Services / Vic Health Koori Health Research and Community Development Unit, University of Melbourne. See also Otim M, Anderson I et al (2002). Aboriginal and Torres Strait Islander Hospital accreditation project: a literature review. Vic Health Koori Health Research and Community Development Unit. Discussion Paper No 9.

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APPENDIX 1: NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION TERMS OF REFERENCE

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.
2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
 - a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
 - b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
 - c. bring a greater focus on prevention to the health system;
 - d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;
 - e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
 - f. improve the provision of health services in rural areas;
 - g. improve Indigenous health outcomes; and
 - h. provide a well qualified and sustainable health workforce into the future

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and between four to six part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.