CHAPTER 2

WHAT ARE THE PRIORITY ISSUES FOR IMPROVING AUSTRALIA'S HEALTH?

- groups experiencing health inequities
- research and analyse Aboriginal and Torres Strait Islander peoples and ONE other group experiencing health inequities by investigating:
  - the nature and extent of the health inequities
  - the sociocultural, socioeconomic and environmental determinants
  - the roles of individuals, communities and governments in addressing the health inequities

Despite Australia's ranking as one of the healthiest nations in the world, our high life expectancy, low mortality rates and improving health status of the whole population are not shared by all groups. Aboriginal and Torres Strait Islander people suffer extraordinarily poor health status, while other groups including socioeconomically disadvantaged people, people in rural and remote areas, overseas-born people, the elderly and people with disabilities also experience different health status and experience a variety of health inequities.

- Aboriginal and Torres Strait Islander peoples

Currently, 75% of Indigenous Australians live in cities and regional centres, while 25% live in remote areas. The median age of the Indigenous population is 21 years, compared with 36 years for the non-Indigenous population.

- the nature and extent of the health inequities

The magnitude of the health inequities experienced by Indigenous Australians is starkly demonstrated by a comparison of life expectancy data. For example, the life expectancy of an Indigenous female born in 2001 is 65 years. This is equivalent to the life expectancy for a non-Indigenous female born in 1922! The life expectancy of 59 years for an Indigenous male born in 2001 equates to the life expectancy for a non-Indigenous male born in 1910!

The gap between Indigenous and non-Indigenous life expectancy is currently about 17 years.
Mortality

Mortality rates for Indigenous Australians continue to be unacceptably high in comparison to other Australians. Between 2001 and 2005, death rates for Indigenous males and females in most states were almost three times those for non-Indigenous males and females.

Infant mortality (measured per 1000 live births) remains about three times higher than for the whole population at 15 for males and 12 for females.

The five leading causes of death for Indigenous people were:

• diseases of the circulatory system
• cancers
• endocrine, metabolic and nutritional disorders (including diabetes)
• respiratory diseases
• injuries.

Note that injuries caused by transport, assault and self-harm, were responsible for deaths amongst young Indigenous males at three times the non-Indigenous rate.

There are, however, some positive trends too. Indigenous mortality rates decreased significantly in Western Australia between 1991 and 2005; and throughout Australia the gap between Indigenous and non-Indigenous infant mortality rates has closed considerably since 1991.
Morbidity

Indigenous Australians continue to experience lower health status than other Australians as a result of higher levels of disability and reduced quality of life. The burden of disease among Indigenous Australians represents 3.6% of all disability-adjusted life years (DALYs), yet they represent only 2.5% of the total population.

<table>
<thead>
<tr>
<th>CAUSE</th>
<th>DALYS NUMBER</th>
<th>PROPORTION OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease</td>
<td>16786</td>
<td>17.5</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>14860</td>
<td>15.5</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>8587</td>
<td>8.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8498</td>
<td>8.9</td>
</tr>
<tr>
<td>Cancers</td>
<td>7817</td>
<td>8.1</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>6989</td>
<td>7.3</td>
</tr>
<tr>
<td>Intentional injuries</td>
<td>5395</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>27044</td>
<td>28.2</td>
</tr>
<tr>
<td>All causes</td>
<td>95976</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**TABLE 2.1**

Disability-adjusted life years (DALYS), broad cause group, Indigenous persons, 2003

In 2004–2005, Indigenous adults were twice as likely as non-Indigenous adults to report their health as fair or poor (29% compared with 15%), as well as twice as likely to report high or very high levels of psychological distress compared to non-Indigenous adults.

**FIGURE 2.3**

Health inequities experienced by Aboriginal and Torres Strait islanders

<table>
<thead>
<tr>
<th>ATSI</th>
<th>Non-ATSI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life expectancy</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>65</td>
<td>83</td>
</tr>
<tr>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>59</td>
<td>78</td>
</tr>
<tr>
<td><strong>Infant mortality</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td><strong>Death rates (per 100,000)</strong></td>
<td></td>
</tr>
<tr>
<td>(people aged 35–54, 2001–05)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>51</td>
<td>74</td>
</tr>
<tr>
<td>CHD</td>
<td>Diabetes</td>
</tr>
<tr>
<td>87</td>
<td>6</td>
</tr>
<tr>
<td>Injury</td>
<td>CHD</td>
</tr>
<tr>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>Suicide</td>
<td>Injury</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Assault</td>
<td>Suicide</td>
</tr>
<tr>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Mental illness</td>
<td>Assault</td>
</tr>
<tr>
<td>10</td>
<td>&lt;1</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
</tr>
<tr>
<td></td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

The main causes of poor health among Indigenous people include mental disorders, circulatory diseases, diabetes, respiratory diseases, cancers, musculoskeletal conditions, eye and ear problems and kidney disease (which has increased markedly between 2001 and 2004–2005).

In 2005–2006, Indigenous people were hospitalised at 5 times the rate of non-Indigenous people and at 14 times the rate for care involving dialysis.

In positive indicators, fewer Indigenous people suffer skin cancers and cases of prostate cancer than the overall population. Additionally, rates of asthma, back pain and hearing problems among Indigenous people have all declined between 2001 and 2005.

In the 2004–2005 NATSIHS survey, when Indigenous Australians were asked about their feelings of calmness and happiness, 71% reported being happy, 56% reported being peaceful, and 55% reported being full of life all or most of the time.
the sociocultural, socioeconomic and environmental determinants

Indigenous Australians experience significant socioeconomic and sociocultural challenges. Cultural divisions and conflicts since European settlement, ill-advised or ineffective programs of integration, separation, education and welfare support have all contributed to the poor state of Indigenous health. Even as recently as 2008, the Australian Government’s intervention into Indigenous communities, designed to reduce reported widespread child abuse, has demonstrated just how complex the interaction of social, cultural and political factors can be (see Feature Article on the following page).

In the 21st century our holistic understanding of health and its multiple determinants is needed to address many health inequities. The most critical challenges for Indigenous Australians include:

• Lower incomes: Median household income for Indigenous families in 2006 was equal to about 55% of median household income for non-Indigenous families.

• Higher rates of unemployment: The unemployment rate of 16% for Indigenous people in 2006 was three times the rate of 5% for non-Indigenous people.

• Lower educational attainment: The proportion of Indigenous people who had completed Year 12 in 2006, ranged from 36% of people aged 18–24 years (less than half the non-indigenous rate) to 9% of people aged 55 years and over (just over a quarter of the non-indigenous rate). Overall, Indigenous males and females reported similar rates of Year 12 completion (22% compared with 24%). Poor levels of school attendance are a major problem for many Indigenous groups.

• Lower rates of home ownership: The proportion of Indigenous families who owned or were purchasing their own homes in 2006 was half the rate of other Australian households (34% compared with 69%). Despite the inequities reflected by these social indicators, progress is being made in some areas.

There are other less tangible cultural factors that can be observed, though perhaps not so easily measured, in the Indigenous population, or in some groups within that population. There is a reported sense of ‘loss of control of their own lives’ among some Indigenous Australians, which contributes further to the level of inequity. Communal approaches to family and parenting, the remoteness of some communities, incompatibility with many aspects of Australia’s political, legal and educational systems, and lack of role models in some areas of society have all been identified as social determinants that contribute in some way to the inequities experienced by Australia’s Indigenous people.

It is difficult to precisely measure the relationship between these social determinants, multiple risk factors and health status. However, in the 2008 AIHW on Aboriginal health and welfare, it emphasised that the underlying social determinants mentioned above, clearly increase the likelihood of exposure to a number of the following health risk factors.
Intervention ‘has done lasting harm’

The Howard Government’s intervention into Northern Territory communities has caused ‘immediate and lasting harm’ to Aborigines and provoked mistrust and anger towards western culture, doctors say.

Far from helping indigenous people, the emergency reforms launched in June last year have compounded feelings of disempowerment and had a negative impact on wellbeing and health.

The claims have been made by the Australian Indigenous Doctors Association (AIDA) in a submission to the review board, headed by Peter Yu.

It will report back to the Rudd Government later this year on the progress of the controversial measures to combat child sex abuse, with its recommendations to determine the future course of indigenous policy in Australia.

In an 18-page submission, the AIDA acknowledges ‘in principle support’ for aspects of the intervention, such as an increase in police, additional teachers and ‘much-needed government attention’ on the issue of Aboriginal health.

But, the submission says, research conducted by AIDA suggests the intervention has done far more harm than good. ‘Our research shows that the NTER (NT Emergency Response) has caused immediate and lasting harm,’ it says. ‘As medical professionals, we are deeply concerned about the impacts.’ It also warns some negative impacts of the reforms may ‘not be realised until further down the track’.

The organisation said the child health checks often duplicated existing services and should be viewed as the basic right of all Australians to access to health care. ‘Community members expressed feelings of loss of responsibility, loss of control, loss of power and a hardening of mistrust towards the Australian Government and dominant western culture in Australia. ‘This has resulted in feelings of anger and powerlessness, it has caused cultural, social and emotional harm.’

Many Aboriginal people also felt the reforms, such as welfare quarantining and grog bans, were discriminating against them, it said. ‘Our interviews very powerfully evoked a sense a regressing to the old days: many people referred to the feelings of shame, humiliation and loss of dignity that particularly characterised an earlier ‘protectionist period’ when the government controlled every aspect of indigenous people’s lives.’

AIDA has recommended the Government adopt an approach using existing good practice in indigenous health along with a genuine partnership with Aboriginal people.

Tobacco use

Tobacco use was the main contributor to the burden of disease among Indigenous Australians. In 2004–2005, 50% of the Indigenous population reported being daily smokers, with the majority having taken up smoking before 13 years of age. Smoking rates among Indigenous people are twice those for other Australians. Regular smokers also reported higher levels of illicit substance use.

Alcohol consumption

In 2004–2005, 1 in 6 Indigenous Australians reported chronic levels of risky drinking. This was a slight increase from 2001 and similar to non-Indigenous levels. More Indigenous than non-Indigenous Australians are likely to abstain from drinking, especially in remote areas, but Indigenous Australians binge drink at twice the rate of other Australians.

Illicit drug use

Twice as many Indigenous Australians over 15 years old (28%) reported using an illicit drug in the past 12 months as other Australians (15%). Substance use is a contributing factor to illness and disease, accident and injury, violence and crime, family and social disruption, and workplace problems. Marijuana and amphetamines were the most commonly used drugs. Apart from alcohol, illicit substance use contributed most to the burden of disease.

Overweight and obesity

Over 50% of Indigenous Australians are overweight, similar to non-Indigenous rates. Obesity rates among Indigenous Australians living in non-remote locations have increased since 1995 and become more prevalent with age.

Poor nutrition

There is little difference between Indigenous and non-Indigenous compliance with the National Health and Medical Research Council (NHMRC) nutritional guidelines. Fresh fruit intake is slightly lower in remote areas due to availability.

Physical inactivity

Indigenous Australians, in particular females, were more likely than non-Indigenous Australians to be sedentary or to exercise at low levels.

Exposure to violence

The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) reported Indigenous exposure to violence at twice the rate of other Australians. This rate had doubled since 1994. Exposure was three times more likely in remote locations. Young men were the most likely to have experienced physical or threatened violence.

Poor housing conditions

In a 2004 survey, overcrowding was reported to affect 1 in 4 Indigenous Australians, and was most prevalent in rented dwellings. In 2006, over 30% of Indigenous community housing dwellings needed major repairs or replacement.
Environment

With regard to environmental determinants, housing standards are clearly a priority issue. Other environmental issues that affect health in remote communities include water supply, training for ATSI environmental officers, transport, communication and health and safety relating to dogs.

It is important to make the point, though, that despite the detrimental effect of some of these risk factors, positive achievements are also being made in reducing exposure to them and their underlying determinants.

The AIHW report, *The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples 2008*, provides a comprehensive overview of the health and welfare of Australia’s Indigenous population. The full report can be downloaded from the AIHW website:


- the roles of individuals, communities and governments in addressing the health inequities

Aboriginal health is a major problem for this nation. Given the generally poor state of current health indicators, it is fair to say that the strategies and programs undertaken so far have had limited success.

Modern approaches to healthcare and health promotion acknowledge the fact that Indigenous health status results from the interaction of multiple determinants, and requires a similarly multi-faceted response from the healthcare system. This should include an ‘intersectoral’ approach, based on partnerships between people and agencies at many levels and in a variety of sectors.

Government

There are two peak agencies which coordinate Indigenous health services at the federal government level, while a third peak body in New South Wales oversees Indigenous health at a state level.
The Office of Aboriginal and Torres Strait Islander Health (OATSIH)

This agency has been established within the Department of Health and Ageing to bring greater focus to the Australian Government's delivery of mainstream health services to Indigenous Australians. It is also responsible for administering and funding ATSNI community controlled health and substance use services.

OATSIH provides direct grants to around 245 organisations, of which around 80% are ATSNI community controlled or managed.


The National Aboriginal Community Controlled Health Organisation (NACCHO)

This agency works with the Department of Families, Housing, Community Services and Indigenous Affairs. It is the national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia. It is an autonomous body that advocates for improvements to ATSNI health.

www.naccho.org.au

The Aboriginal Health and Medical Research Council of NSW (AH&MRC)

This is the peak body for Aboriginal health in New South Wales and is comprised of over 60 Aboriginal Community Controlled Health Organisations throughout the state.

The AH&MRC provides vital health and health-related services in association with its member organisations. These combined services include:
- health service delivery
- supporting Aboriginal community health initiatives
- development and delivery of Aboriginal Health education
- research in Aboriginal Health
- collecting, evaluating and disseminating Aboriginal health data
- policy development and evaluation.

The AH&MRC aims to 'reduce ill health, suffering, distress and helplessness in Aboriginal communities by the direct provision of primary healthcare, including social and emotional wellbeing services and support programs for Aboriginal communities'.

www.ahmrc.org.au
Community

Indigenous Australians do not access primary healthcare services to the extent they should, as a consequence of lack of availability of services, transport and distance to services, cost and language or cultural barriers.

OATSISH, NACCHO and the AH&MRC all aim to improve the access of Indigenous people to primary healthcare services. These agencies base their strategies on the principle of working in partnership with the Aboriginal and Torres Strait Islander community controlled health sector. Improved access and stronger delivery of comprehensive primary healthcare at the community level are the most sustainable ways of making a significant long-term difference to Indigenous health status.

Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Medical Services (AMSSs) are primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate healthcare to the community that controls it.

Aboriginal communities run hundreds of such local health services. Some are large, providing a wide range of services through numerous medically trained staff. Others are small, relying solely on Aboriginal health workers and nurses to deliver primary care, education and preventative services. All of these services are independent, but together they form a health network that shares the philosophies of self-determination and a holistic view of health.

The nature of the services provided varies from one community to another, though generally they include clinical care, health education, promotion, screening, immunisation and counselling, as well as specific programs such as men’s and women’s health, aged care, transport to medical appointments, hearing health, sexual health, substance use and mental health.

“Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.” (NAHS, 1989).
The responsibility for producing Aboriginal health solutions lies with the local Indigenous people working in their own communities and using their own philosophies, to promote healthy behaviours and deliver culturally appropriate primary healthcare services.

Individuals

An individual's capacity to reduce their risky health behaviours and to increase their protective health behaviours or promote good health in others is influenced by a variety of factors; these include age, family history, community support, education, role modelling, access to health services and socioeconomic status. While individual responsibility for health might differ in some ways for mothers, fathers, the elderly, health professionals or educators, it is education and access that appear to have the greatest impact.

There is a strong focus in many Aboriginal Health Services on providing education and support for Indigenous mothers and children, on increasing the number of Aboriginal health workers, community support workers and medically trained staff and on increasing community capacity by empowering individuals. Health services focus on improving the knowledge and skills of community members. Women and mothers are often targeted as custodians of health knowledge and practice. A recent initiative to target men's health has also been introduced and funded by OATSIH.

The Healthy for Life (H4L) Program provides support for local health services and programs, including improved health training and education for Indigenous people. Among its initiatives is the National ATSIC Child and Maternal Health Exemplar Site Initiative, which identified and documented three outstanding child and maternal health services. The resultant website has been used to educate and promote best practice in this area of health.

- socioeconomically disadvantaged people

Socioeconomic status (SES) describes the 'position' or 'power' of a person or group in the community. In Australia, Socioeconomic Indexes for Areas (SEIFA), which measure the average SES of people living in a local area, such as within a postcode region, are used to produce an Index of Relative Socioeconomic Disadvantage (IRSD).

Socioeconomic disadvantage is the existence of:
- limited material resources (including income)
- reduced access to educational opportunities

![Figure 2.9: Index of relative socioeconomic disadvantage scores by health area, NSW 2006](source: ABS Socioeconomic Indices for Areas)