



## The 2008-2030 National Indigenous Health Equality Targets: suggestions for transforming potential into sustainable health improvements for Indigenous Australians

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### Abstract

**Objective:** Over the past several decades, Australian Indigenous groups, governments and civil society organisations have implemented strategies for reducing Indigenous health inequality gaps. A recent initiative in this regard is the 2008-2030 National Indigenous Health Equality Targets ('Close the Gap'). This article reviews the 'Close the Gap' document and suggests refinements to facilitate its use as a sustainable framework for health improvement of Australia's Indigenous people.

**Methods:** Drawing on associated reviews and comparisons with strategies for Indigenous health improvement in New Zealand, United States and Canada, the author highlights several strengths of the 'Close the Gap' framework, discusses its weaknesses, and suggests initiatives for transforming its potential into a sustainable and demonstrable health improvement framework for Indigenous Australians.

**Conclusions:** The 'Close the Gap' framework represents an important milestone in effective intersectoral collaboration and integrated strategic planning for Indigenous health improvement. Nevertheless, reforms are needed to: address structural encumbrances that have stalled previous Indigenous health improvement efforts; detail accountability frameworks for each of its targets, refine its partnership and infrastructure targets, and; develop comprehensive social determinants targets.

**Implications:** The 'Close the Gap' strategy document has several distinct positive attributes which enhance its potential as a credible strategy for Indigenous health improvement. Coordinated efforts to address its weaknesses and facilitate achievement of its stated

objectives will improve its prospects, not only as a sustainable platform for improving the health and wellbeing of Indigenous Australians, but also as a credible framework for achieving and maintaining parity between Indigenous health outcomes and those of other Australians.

**Keywords:** Indigenous Australians, Close the Gap, Remote and Rural Health.

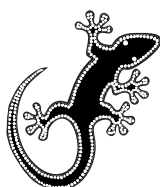
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## Introduction

As at 2009, the estimated Indigenous resident population in Australia was 550,818, or 2.5% of the total Australian population [1]. About 464,000 or 90% were estimated as being of Aboriginal origin only, 33,100 or 6% were of Torres Strait Islander origin only, and 20,200 or 4% were of both Aboriginal and Torres Strait Islander origin. Over the past several decades, significant disparities between Indigenous and non-Indigenous health outcomes have directed national and international attention to health inequalities suffered by Australia's Indigenous populations (Table 1).

Geographical, areas-based, socio-economic indexes revealed that 45 per cent of Indigenous people aged 0-18 years live in highly disadvantaged areas, particularly in rural and remote regions [2]. A recent study on socio-economic differentials between Indigenous and non-Indigenous people living in urban areas indicated that on all indicators of social determinants of health, Indigenous urban residents were on average 45 percentile points below the corresponding non-Indigenous population [3]. Thus, Indigenous disadvantage is not only because Indigenous Australians are more likely to live in rural and remote towns or outstations.

Health inequalities between Indigenous and non-Indigenous Australians are well documented. Almost half of the 11 years' life expectancy gap between Indigenous and non-Indigenous

is attributable to 11 risk factors including: smoking (about 45% of Indigenous Australians smoke and this has not changed since 1995); overweight and obesity (60% of Indigenous Australians are overweight); physical inactivity (47% of Indigenous Australians are physically inactive); alcohol; and low fruit and vegetable intake [4]. The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey showed that Indigenous Australians were twice as likely as non-Indigenous Australians to report their health as fair or poor [5]. This survey also showed that Indigenous Australians aged 15 years and over in non-remote areas were more likely than those in remote areas to report fair or poor health (23% compared with 19%). However, a 2008 review of health performance indicators in rural and remote regions of Australia indicate that rural and remote residents had less access to coronary care, disability care and aged care services, despite increasing need for such services [6]. Chronic underfunding, rural-urban migration of youth, inadequate rural community improvement infrastructure and policies, high cost and limited availability of quality food and community amenities, sub-optimal entrepreneurial support in rural regions, unfavourable economies of scale for provision of health and social services, and poorly coordinated stakeholder involvement in rural improvement initiatives form facets of a vicious cycle that have combined to leave remote Indigenous Australians, in particular, with little in the way of an economy, quality services or effective health infrastructure [7] [8].

**Table 1.** Comparison of Australian and non-Australian health using select indicators.

Indicator	Aboriginal Populations	Non-Aboriginal populations
Life expectancy at birth (2005-2007)	Males - 67.2 years (11.5 years less than the life expectancy at birth for non-Indigenous males); Females - 72.9 years (9.7 years less than that for non-Indigenous females).	Males - 78.7 years; Females - 82.6 years
Infant mortality rate	7 (South Australia) to 14 (Northern Territory) deaths/1000 births	4.1 deaths/ 1000 births
Prevalence of hypertension at age 55 or above	48%	32%
Age-specific death rates per 100,000 population in the 34-54 years age group from respiratory and other intra-thoracic cancers	Males - 31.9; Females - 21.1	Males - 8.1; Females - 2.6
Crude Chlamydia notification rate	1470/100,000 population	180/100,000
Percentage of population aged 35 years or older reporting complete or partial deafness.	9%	4%
Proportion of population consuming alcohol at high-risk levels	27%	21%
Proportion of regular tobacco smokers	45%	19%

Source: [1]

Since the inaugural 1989 National Aboriginal Health Strategy (shown by a 1994 review to have been ineffectively implemented [9]), successive Australian governments have collaborated with Indigenous organisations to develop strategies aimed at closing the health inequality and life expectancy gaps, with limited success. The most recent national strategy document for reducing health inequalities between Indigenous and non-Indigenous Australians, is the 2008-2030 National Indigenous Health Equality Targets ('Close the Gap'). Preceding the formal launch of the strategy document in July 2008 by the 'Close the Gap' Committee, supported by the Australian Human Rights Commission, a 'Close the Gap' statement of intent was signed by key stakeholders at the Indigenous Health Equality Summit in Canberra on 20 March 2008 [10].

Although the 2008 National Indigenous Health Equality Targets ('Close the Gap') document has so far received strong support at federal, state and territory government levels, as well as among many Indigenous groups, medical associations and civil society groups, it has secured only cautious support from some Indigenous health researchers and policy analysts [11] [12]. Critics of the 'Close the Gap' document view many of its health equality targets as recycling of previous, largely unsuccessful, approaches that had predominantly individualistic and deficit foci. While acknowledging the need for quantifiable targets in the strategy document, critics opposed their excessive privileging above equally important, but admittedly difficult-to-measure health determinants such as 'self determination', social capital and 'racism' [13] [14]. The author provides a review on the 'Close the Gap' document from the following perspectives: (1) Strengths of the strategic framework; (2) Structural issues hindering the optimal utilisation of the 'Close the Gap' targets; (3) Important targets which are missing from the document; (4) Targets in the document which may require refinement.

## Strengths of the strategic framework

The document has five interlocking sets of goals, processes and timelines – partnerships, the specific health issues that would have to be addressed if the gap is to be closed, the health services required to address those health issues, the infrastructure required for the delivery of the health services, and, (accompanied by very little detail), social determinants. These goals underscore the document's objective of attempting to comprehensively address core determinants of relatively poor Indigenous health – socio-economic disadvantage, resource alienation, political oppression and failing health systems. Studies have shown the strong potential of such multi-disease-based, integrated, inter-programmatic, and/or inter-sectoral approaches in effectively addressing determinants like housing, socio-political status and resource alienation, which are essentially outside of the health sector [15] [16] [17].

As recently acknowledged by the Australian Prime Minister in a speech to Parliament, entrenched Indigenous health disadvantage is 'a product of failed policy. Our Indigenous reform agenda seeks to redress decades of underinvestment, buck-passing, confused responsibilities within our Federal system, and piecemeal and poorly targeted investments [18]'. Through working with government and other stakeholders to address both health and non-health influences on Indigenous health in an integrated fashion, the 'Close the Gap' coalition brings together every significant organisation, Indigenous and mainstream, with expertise in Aboriginal and Torres Strait Islander health. These are the same stakeholders that will have to play a key implementation role if the health inequality gap is to be closed, and they all speak with one voice.

Chaired by Mr Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, the 'Close the Gap' Steering Committee's targets were developed through a collaborative process that included scores of individuals and organisations directly or indirectly involved with improving Aboriginal health. The highly influential and broad-based membership of the 'Close the Gap' committee is reflected in its composition, which includes representatives from National Aboriginal Community Controlled Health Organisation, Indigenous doctors and nurses, the National Heart Foundation and the Australian Medical Association. The continuing support received by the committee from current Australian Federal and State governments, and dozens of credible health related associations and civil society groups position the document as a prime instrument for achieving strategic consensus in narrowing Indigenous health inequality nationally. The 'Close the Gap' document is a significant improvement in relation to consensus development and integrated strategic planning for Indigenous health improvement, compared with previous national strategies since 1989.

Furthermore, no other Australian Indigenous health improvement document has received as much technical input, moral, financial or political support from a wide section of the Australian community as the 'Close the Gap' document. About 120,000 Australians have so far signed the pledge (via HREOC, Oxfam, GetUp, Caritas and ANTaR websites) to call on government to take concerted action to address Indigenous health inequality. Such broad-based support for the document is expected to enhance its credibility and generate needed broad-based long-term support required by such a generational strategy.

## Structural impediments

First, according to the national coordinator of the Close the Gap Steering Committee, the strategic document was developed primarily as an advocacy framework. Such a role limits its usefulness, as the committed architects of this strategy document are not allocated any real responsibility. Transforming the 'Close the Gap' document from an advocacy tool to an implementation framework

will require extensive consultations with governments at all levels to streamline implementation of strategies and programs for health improvement of Indigenous people, particularly in rural areas, and allocate specific functions to the members of the 'Close the Gap' steering committee.

Second, several major Indigenous health initiatives are replete with the phrase 'Close the Gap', creating confusion as to exactly which document is being referred to. In such contexts, overlapping Indigenous health improvement programs are likely to be developed and implemented concurrently, leading to inefficient use of resources. For example, a related strategy to reduce Indigenous disadvantage implemented by the Commonwealth of Australian Governments (COAG) in 2009 is titled: 'Closing the Gap: National Urban and Regional Service Delivery Strategy for Indigenous Australians' [19]. Although the COAG document's priorities in health, housing and homelessness, education, early childhood development, and economic participation have correlates in the the Health Equality Targets, the extent to which the 'Close the Gap' document influenced the development of COAG's priorities is unknown, as the document was not cited in the COAG strategy, and as the strategic approach on health in the documents was not fully identical. The effectiveness of the 'Close the Gap' document as an advocacy tool will be difficult to evaluate in the absence of adequate information on the way in which the document's goals and strategies feed into the COAG's urban and regional service delivery strategy as well as other programs related to reducing Indigenous health inequalities.

Third, in the quest to minimise statistical inequality between Indigenous and non-Indigenous people, the benchmark for narrowing health equality in the document is invariably non-Indigenous Australians. The 'Close the Gap' document may be enriched by extending its benchmarks to include successful interventions for health inequality narrowing in other OECD nations with Indigenous populations, such as New Zealand's approach to developing productive partnerships between Indigenous people, non-Indigenous health professionals and government health agencies, and Native Americans' frameworks for community capacity building [20] [21].

Fourth, the 'Close the Gap' document is not structured to reflect specific needs of the 25% of the Indigenous population residing in rural and remote locations of Australia. For instance, the role of adequate quantity, quality and distribution of health workers in reducing maternal mortality and improving child survival is well established. In most nations, rural and remote locations have less health workforce than required for optimum primary health care provision [22]. The 2008 review of health system performance in rural and remote areas of Australia [6] indicated that critical shortages of core healthcare workers worsened with increasing remoteness. The approach of the 'Close the Gap' strategy is to utilise a health-worker: population ratio approach as the core yardstick

for determining adequacy of health workforce, which may not necessarily augur well for valid monitoring of human resources in health requirements in sparsely populated and geographically vast remote regions of Australia. It is important to also consider how evidence-based models of health care delivery in rural and remote areas of Australia may be used to estimate health workforce requirements [23]. It is noteworthy that in his second annual report on Indigenous health inequality on 11 February 2010, Prime Minister Rudd announced funding of \$9.1 million over three years for 10 new mainly rural and remote mothers and babies services in order to improve Australia's Indigenous maternal and child health outcomes.

## Missing targets

The social determinants of health targets are missing from the document. The author's enquiry with Coordinator of the 'Close the Gap' steering committee provided information that the Social Determinants targets are being developed, for inclusion in the document in 2010. The non-inclusion of the Social Determinants targets in the 'Close the Gap' document at its inauguration is disappointing. As defined by Raphael, 'social determinants of health are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole. Social determinants of health are the primary determinants of whether individuals stay healthy or become ill' [24]. Anderson [25] stresses that most of the social determinants of Australian Indigenous health lie outside of the health sector, and include factors such as the adverse effects of a welfare economy, the criminal justice system, racism, and transgenerational poverty. As a result of this glaring omission, the 'Close the Gap' document currently presents as a narrowly focused strategy for health improvement compared with, for example, the COAG 2009 strategy document on urban and regional service delivery for Indigenous Australians [19].

Also missing from the document are wellbeing targets. Wellbeing may be defined as; 'The presence of the highest possible quality of life in its full breadth of expression, focussed on but not necessarily exclusive to; good living standards, robust health, a sustainable environment, vital communities, an educated populace, balanced time use, high levels of civic participation, and access to and participation in dynamic arts, culture and recreation' [26]. For example, measurable community vitality indicators among Indigenous people might include self-reports of volunteering, participation in group and community activities, involvement in property or violent crime, and experience of discrimination or racism. In Canada, the introduction of 'community vitality' indicators enabled determination of falling crime rates and improving social relations. Unlike many measures of health inequality, community vitality measures monitor not just shifts in individual health-related attitudes and behaviour, but also changes in the broader social dynamic within Indigenous communities. In

relation to wellbeing targets, the Australian Ministerial Taskforce on Overcoming Indigenous Disadvantage has identified three key priorities which encapsulate seven strategic areas for action: early childhood intervention, a key focus of which will be improved mental and physical health, and in particular primary health, and early educational outcomes; safer communities (which includes issues of authority, law and order, but necessarily also focuses on dealing with issues of governance to ensure that communities are functional and effective); building Indigenous wealth, employment and entrepreneurial culture, as these are integral to boosting economic development and reducing poverty and dependence on passive welfare [27].

The inclusion of qualitative targets in the Close the Gap document to complement its quantitative focus will be in keeping with the Canadian Indigenous health concept of a 'successful community', defined as 'one that is continually creating and improving those physical and social environments and strengthening those community resources which enable people to mutually support each other in performing all the functions of life and achieving their maximum potential' [28]. Implicit in this definition is the emphasis on process. In other words, a 'successful community' may not necessarily be one with the highest incomes or health status but one that is conscious of health and wealth, that is continually striving to be healthier and wealthier and takes health and wealth into account when making decisions or policy at the local level.

Furthermore, given the importance of adequate housing in health improvement, specific housing targets may be indicated to provide adequate, affordable and culturally appropriate housing for Indigenous communities. A 2008 report by the Australian Housing and Urban Research Institute found that six key elements are required to enable sustainable housing: these are noted as culturally responsive design, eco-efficiency, healthy living practices, household related training and employment, life-cycle costing of projects and innovation in procurement, ownership and construction systems [29]. The 'Close The Gap's' housing-related targets deal mainly with provision and maintenance of housing, and do not adequately address these equally important housing-related elements.

## Targets that may require refinement

**Partnership targets:** Given that the the 'Close the Gap' campaign was championed by an impressive array of well-regarded professionals, as well as Indigenous and non-Indigenous individuals and groups, it is important that partnership targets incorporate measures to facilitate functional collaboration between non-governmental organisations, researchers and Aboriginal communities. Such partnerships are valuable in facilitating social inclusion, providing additional services, technical support, and improved links

between Aboriginal communities and civil society organisations. For example, in New Zealand, a three year partnership between alcohol researchers and two Maori organisations aimed at reducing alcohol-related traffic accidents among indigenous New Zealanders exemplifies the potential of successful partnerships to achieve optimal health outcomes [30]. Also important, is cultivating true partnerships in development and implementation of health inequality reduction strategies. As exemplified by the disconnect between the COAG's 2008 National urban and regional service delivery strategy for Indigenous Australians and the 'Close the Gap' document, true partnership is required for efficient utilisation of the valuable skills of members of the Close the Gap coalition as well as the implementation of the integrated strategies in the Close the Gap document.

Partnership targets that may be monitored include adequacy of consultation processes for selection of members into Indigenous advisory committees and boards types and outcomes of health and wellbeing-related projects jointly undertaken by Aboriginal communities and professional associations or civil society organisations. In rural and remote regions, partnerships with organisations such as NGOs, like the Lions Club which provides optometry services, is particularly important given the greater need by remote communities for the services of such non-governmental health care organisations [31].

**Health status targets:** Since pregnant Indigenous teenagers are at greater risk of having premature births and low birth weight babies [32], it may be useful to expand the targets relating to this indicator to include reducing the percentage of teenage births among Indigenous women to less than twice (from four times) the teenage birth rates in the general Australian population by 2030. Teenage pregnancy creates formidable obstacles to female education, a social determinant of health, and here the Kamehameha schools system, has demonstrated how to improve health outcomes among Indigenous Hawaiians in the United States [33]. In Australia, making formal education more attractive than teenage parenthood needs to be complemented with contextual information on the motivations of teenage females who engage in consensual unprotected sex, as well as strict enforcement of penalties for offences related to under-age sex [34].

**Infrastructure targets:** It may be useful to separate infrastructure targets from workforce targets. Some non workforce-related infrastructure targets in the document may be better suited for explication under the social determinants targets. Given the importance of adequate housing infrastructure in health improvement, targets and processes for implementing the current Commonwealth Government's \$672 million Strategic Indigenous Housing and Infrastructure Program may be usefully incorporated into this section of the document. Indigenous patterns of mobility contribute to market failure in relation to indigenous housing. Partnerships between Indigenous and non-Indigenous groups in

the implementation of the housing and infrastructure program would create jobs, skills, and a sense of community responsibility and involvement in the execution of infrastructure projects. Approaches for addressing such temporary-migration induced homelessness include employing the concept of the service population rather than the residence population when calculating service demand in areas with a high number of visitors, as well as the development of a mobility index that can be built into funding models so that budgets provide for the fluctuations in service demand associated with temporary mobility of Aboriginal people [35].

## Conclusion

Conditions related to social exclusion, discrimination, marginalisation from mainstream labour, and economic deprivation have major adverse impacts on Indigenous health. Inclusion of the missing social determinants targets will help to improve the value of the 'Close the Gap' document as an effective and credible framework for addressing Indigenous health shortfalls. In addition to well established social determinants of Indigenous health such as poverty, it will be helpful if the COAG initiatives aimed at tackling smoking, healthy transition into adulthood, and responsiveness to indigenous health outcomes from non-health services such as juvenile justice and corrections, are incorporated into the Social Determinants section of the 'Close the Gap' document.

Also, the current 'Close the Gap' document has a predominantly deficit focus, which inevitably leads to exclusion of features uniquely positive about Indigenous people from the document's monitoring indicators. Inclusion of such indicators will serve as a challenge to policy makers to work towards closing cultural competency gaps in 'mainstream' health care delivery. For example, delivery of culturally sensitive health services in areas such as obstetric care exemplify positive features of Indigenous health care practices to which mainstream health care practices may aspire [36]. When all health sector workers have the training and enthusiasm to provide culturally appropriate health service, all Australians benefit.

The 'Close the Gap' document is an important milestone in bottom-up strategic development and intersectoral collaboration. It has a strong potential to complement existing initiatives in reducing health inequalities between Indigenous and non-Indigenous Australians. Integration of political, economic, and socio-cultural interventions to address the determinants of indigenous health inequality, taking into account that health is a human right and a requirement for human development [37], will enhance the effectiveness of the National Indigenous Health Equality Targets in meeting its objectives.

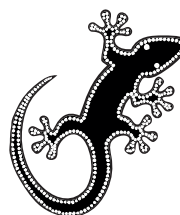
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The Australian Indigenous *HealthBulletin* (ISSN 1445-7253) is the electronic journal of the Australian Indigenous *HealthInfoNet*.

The purpose of the Australian Indigenous *HealthBulletin* is to facilitate access to information of relevance to Australian Indigenous health. Reflecting the wide range of users – policy makers, service providers, researchers, students and the general community – the *HealthBulletin* aims to keep people informed of current events of relevance, as well as recent research. Research information is provided in two ways – the publication of original research and the presentation of abstracts of research published or presented elsewhere.

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