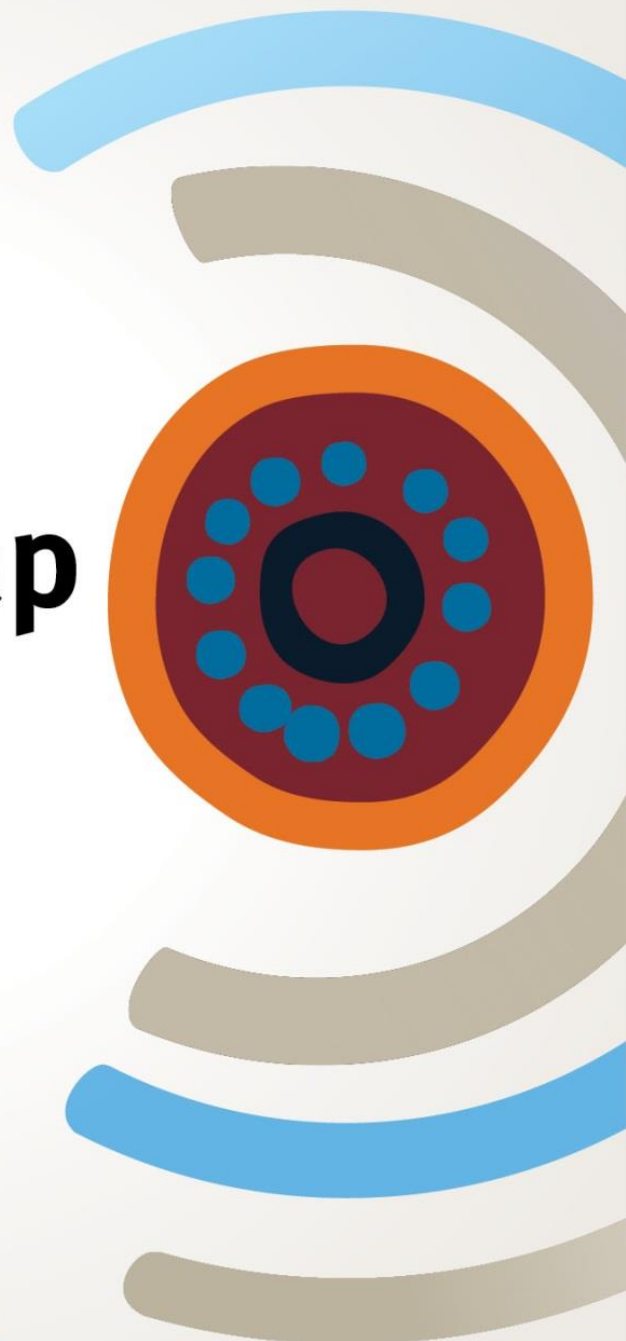


Closing the gap

Performance report 2017



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

The Queensland Government acknowledges and respects Traditional Owners and Aboriginal and Torres Strait Islander Elders past, present and emerging, on whose land we work to support the provision of safe and quality healthcare.

Indigenous artwork is by Riki Salam of Gilimbaa Indigenous Creative Agency.

Closing the gap performance report 2017

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Foreword

On reflection

This report, being published in the tenth anniversary year of the closing the gap agreement, provides an opportunity for reflection. While there have been some positive movements towards the Council of Australian Governments (COAG) targets to close the gap in life expectancy by 2031 and halve the gap in child mortality by 2018, we have not achieved the level of health improvement required. As state, territory and Australian governments look to refresh the COAG agenda, it is important to pause and reflect on where we are and how we got there.

The health gap cannot be closed by the health-sector alone. A considerable proportion of the cause of the gap lies outside the core responsibility of the health system, resulting instead from the social determinants of health: education, employment, income and housing.

However we, as a system, must consider:

1. Have done all that we could to maximise gains?
2. Did we capitalise on opportunities to innovate and enhance service delivery?
3. Did we drive the culturally capable service delivery agenda across the system?
4. Did we effectively work with Aboriginal and Torres Strait Islander people in leading change across the health care system?
5. Did we distribute funding according to evidence and potential for gain?

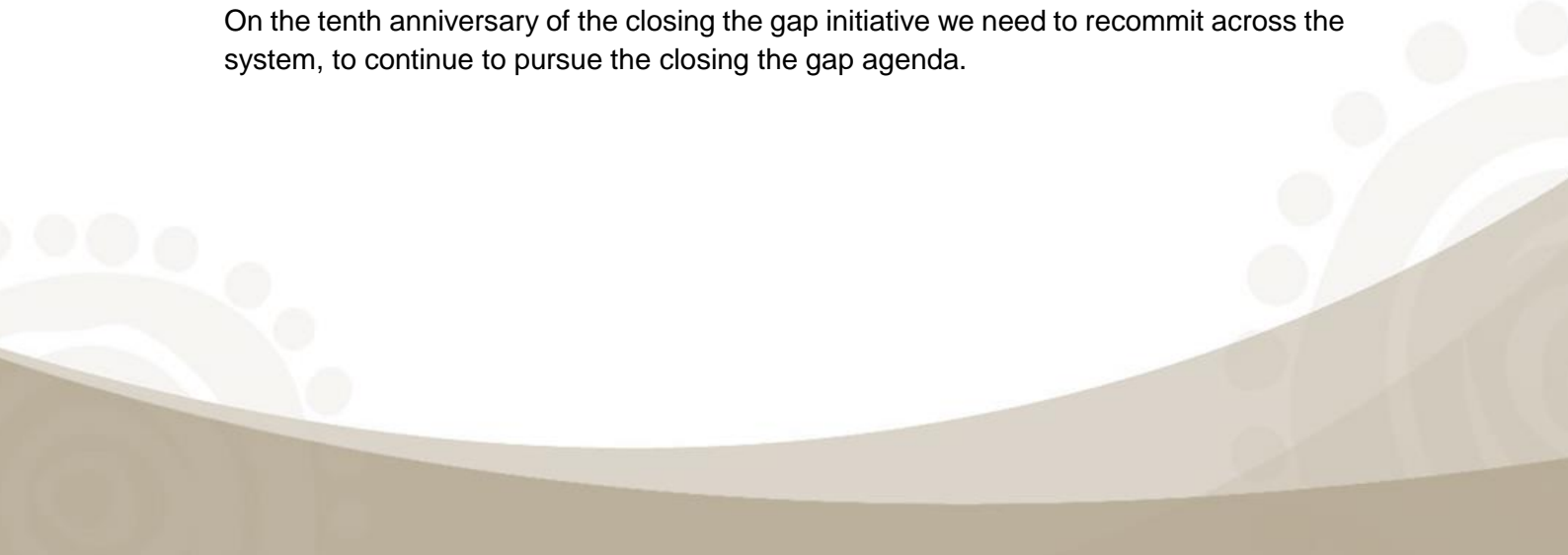
Despite the improvements detailed in this report, we are not where we want to be, we are not where we should be, or where Aboriginal and Torres Strait Islander people want us to be.

Where to now?

Closing the gap is a long journey which requires effort, investment, innovation, engagement and determination to achieve parity of health outcomes for Aboriginal and Torres Strait Islander Queenslanders. We have had significant investment and policy effort. However, this report indicates that now is the time for engagement, for innovation and most importantly for resolve.

Closing the gap is one of the great challenges facing our health system—it was never going to be straightforward or easy. It is important that we understand and acknowledge the scale of the challenge, and respond accordingly.

On the tenth anniversary of the closing the gap initiative we need to recommit across the system, to continue to pursue the closing the gap agenda.





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This report

This is the fifth annual *Closing the gap performance report* for Queensland. The primary purpose of this report is to detail Queensland's progress against the two closing the gap health targets: closing the gap in life expectancy by 2031 and halving the gap in child mortality by 2018. Given the time lag for the impact of effort against these longer term outcomes to be fully realised, reporting on these targets is supported by additional indicators that gauge progress. In this report we also examine the mortality gaps by cause of death in an effort to better understand where the potential for future gains lies.

Throughout this report examples of policy and health service responses, including culturally focussed Aboriginal and Torres Strait Islander lead service models, are provided which underpin and illustrate Queensland Health's efforts to close the gap. These examples have been branded under the following categories:

- Policy initiatives
- Making tracks investment priority areas
- Partnerships: examples of cross collaboration and partnerships
- Innovation: innovative responses to health service challenges.

Closing the gap—the national context

Through the Council of Australian Governments (COAG), in 2008, the Queensland Government committed to closing the gap between Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders on a range of health, education and employment measures. The two health outcome targets are:

- Close the gap in life expectancy within a generation (by 2031).
- Halve the gap in child mortality within a decade (by 2018).

Ten years on from this historic commitment there has been encouraging progress across a range of health measures. The health system is starting to respond to the challenge of closing the gap, evidenced through reduction in mortality and increases in life expectancy. However, this report emphasises that more effort is needed to close the gap.

The Queensland Government's commitment to closing the gap remains strong. However, we recognise the need to refresh the closing the gap agenda and have, along with other states and territories and the Commonwealth, agreed to work together with Aboriginal and Torres Strait Islander people, communities and stakeholders to refresh the closing the gap agenda and targets.

The targets—are we on track?

Life expectancy

There have been no updates to Aboriginal and Torres Strait Islander life expectancy estimates since 2010–2012. The Australian Bureau of Statistics' (ABS) estimates of Aboriginal and Torres Strait Islander life expectancy for 2015–2017 are not due to be released until November 2018. However, recent life expectancy estimates from the Australian Institute of Health and Welfare (AIHW)¹ and mortality estimates are included in this report to provide additional insight into trends and progress towards achieving the life expectancy target. While there have been some improvements in life expectancy and reductions in Aboriginal and Torres Strait Islander mortality rates, **we are not on target to close the gap in life expectancy for Aboriginal and Torres Strait Islander Queenslanders by 2031.**

Child Mortality

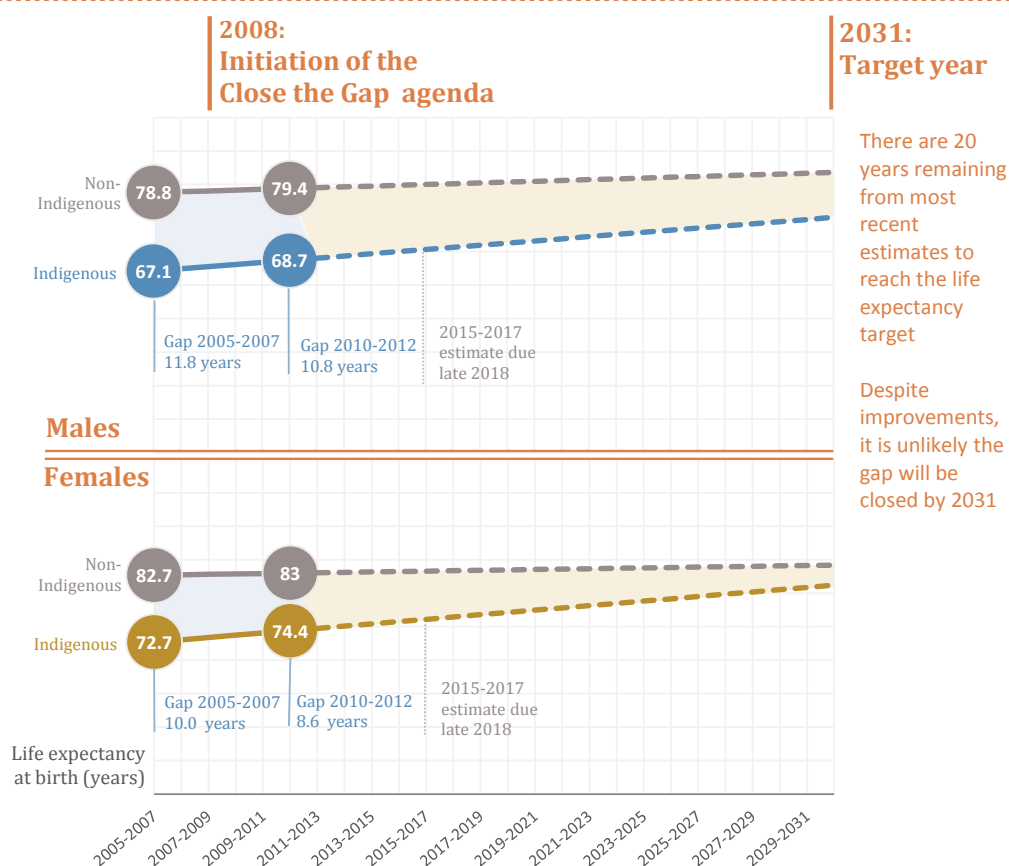
While data to assess performance against the 2018 target will not be available until late 2019, current available data indicates that **we are not on target to halve the gap in child mortality by 2018.**

The recently released *Closing the gap Prime Minister's report 2018*² identifies this target as being on track nationally. There are a range of different assumptions that can be used to interpret progress on performance indicators. Those used in the Prime Minister's report differ to those used in this report and that has led to a different assessment of whether this target is on track (see Appendices).

Performance snapshot

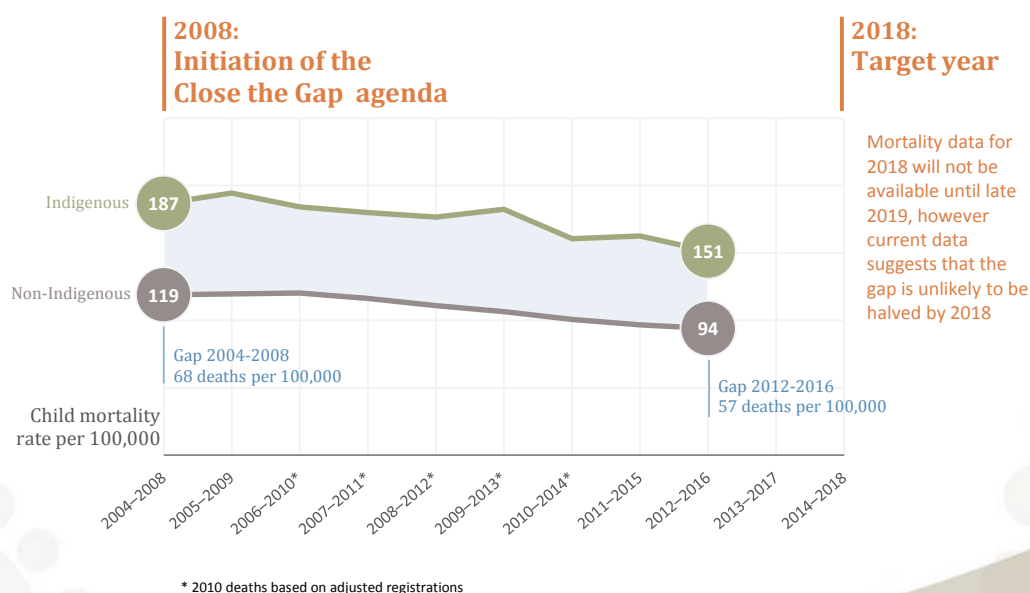
TARGET:

Close the gap in life expectancy by 2031



TARGET:

Halve the gap in child mortality by 2018



Challenges

One of the fundamental challenges of the closing the gap health targets is that success is dependent on not only the health outcomes of the Aboriginal and Torres Strait Islander population, but also those of the non-Indigenous population. When assessing progress towards the closing the gap targets, gains in Aboriginal and Torres Strait Islander health are offset by gains in non-Indigenous health. This creates particular policy and performance challenges, and progress made to date should not be understated.

From 2005–2007 to 2010–2012 life expectancy at birth increased for non-Indigenous Queenslanders. From 2004–2008 to 2012–2016 non-Indigenous child mortality decreased. These improvements in the non-Indigenous population mean even greater gains than those required at baseline if Aboriginal and Torres Strait Islander Queenslanders are to achieve the targets.

In assessing the feasibility of making these gains, we have looked at life expectancy gains in other countries in recent times.

Global trends—life expectancy

Aboriginal and Torres Strait Islander life expectancy requires steep growth to meet the 2031 target, exceeding any sustained gains seen in the total Queensland or Australian population in the last century.

Internationally, sustained life expectancy gains equivalent to those required to meet the 2031 target have been observed in a small number of countries, however they are low and middle income countries with less developed and resourced health systems and are not translatable to the Australian context. During this time of rapid life expectancy growth, these countries underwent considerable economic and social developments that led them through an epidemiologic transition like that which occurred for the majority of Australians decades ago.

In contrast, Aboriginal and Torres Strait Islander people are delayed in this transition. They have suffered poorer health outcomes due to sustained political, social and economic disadvantage in an otherwise wealthy, advantaged population. Addressing the causes of this political, social and economic disadvantage must be part of a broader move to genuine reconciliation. This requires a renewed responsiveness and understanding of specific cultural needs that acknowledge the wrongs of the past in an effort to create a shared Indigenous/non-Indigenous future. While this will yield improved health outcomes, this will not be achieved through the more easily implemented, non-specific programs that can be deployed to achieve health gains in other countries.

Social determinants of the gap

An additional challenge is that child mortality and life expectancy are strongly influenced by social and economic determinants, such as education, employment and housing.

The proportion of the life expectancy and child mortality gap that is due to remaining socio-economic differences in the Queensland Aboriginal and Torres Strait Islander and non-Indigenous populations is unknown. However, a study based in the Northern Territory estimated that between one-third to one-half of the life expectancy gap was due to socio-economic disadvantage.³ It is therefore likely that a sizable proportion of the

health gaps cannot be closed before there is further progress in closing the socio-economic gaps. This emphasises the need for bi-partisan, whole-of-government support, at all levels of government and across the non-government sector and in collaboration with Aboriginal and Torres Strait Islander people, to focus effort as part of a broader policy response.

Opportunities

Despite the challenges, progress towards closing the gap has occurred. Further improvement is achievable through evidence-based resourcing, advances in technology, culturally appropriate and coordinated service provision and a focus on the broader determinants of health.

Understanding the cause of the child mortality and life expectancy gaps will help the health system to focus efforts and better understand where the greatest gains can be made.

This report, together with current research, knowledge of what interventions work and an understanding of the broader factors impacting on health, provide policy makers and clinicians with the evidence to target effort where it will make the biggest impact.

The seven closing the gap targets established by COAG in 2008 focus on health, education and employment. Effort to close the health gap must recognise the interrelationship between these domains. Progress in one domain (e.g. education) will contribute to the others (e.g. health and employment) although the impact may not be immediately recognised or evident for many years. Efforts towards closing the gap present opportunities for coordinated, integrated and innovative effort across government partners, service providers and communities to work together to make improvements across all three domains simultaneously.

Time and knowledge is needed to fully assess the impact of policies and programs. The impact of current interventions may take many years to fully realise, and slow progress against targets should not deter immediate action towards long term outcomes. To maintain momentum over a long period ongoing investment into research is required to enhance our understanding of what works and to develop robust epidemiological models of evaluation. The results of this research must be shared widely with our stakeholders to broaden the interventional evidence base to support funders, policy makers and service providers to best target resources and effort.

Closing the gap refresh

In 2017, as the anniversary of the 2008 Apology^a and establishment of the national closing the gap agenda approach—the Australian Government launched a refresh of the closing the gap agenda, including a review of targets across all domains. The refresh presents an opportunity for a renewed strengths-based focus to reassess the usefulness of the current targets and provide input into new and more specific, measurable and

^a The national apology to the Stolen Generations made by Prime Minister Kevin Rudd on behalf of the Australian Government, 13 February 2008

useful targets. Importantly, it provides the opportunity for the Commonwealth, states and territories to recommit to valuing and working in partnership with Aboriginal and Torres Strait Islander people and communities.

In Queensland Health, to achieve progress against the two targets, an important policy initiative to drive increased accountability and visibility of action for the public health system is the development of the Queensland Health Statement of Action towards closing the gap in health outcomes. This was developed as the policy response to the Statement of Commitment to Reconciliation and as a response to a number of mechanisms that identified the need for Queensland Health to continue to change its practice.

Closing the gap: current policy initiatives

The journey to close the gap requires a multi-faceted response that ensures Aboriginal and Torres Strait Islander people have access to appropriate care, delivered where possible close to home and community, from culturally capable people in a system free from barriers.

The purpose of closing the gap is greater than simply achieving targets. It is about reaching and sustaining equity of health outcomes for Aboriginal and Torres Strait Islander people. To ensure sustainability of health gains, Aboriginal and Torres Strait Islander people and communities must be better represented and engaged in the health system at all levels. In order to facilitate this change, policy and investment effort must be sustained and built upon.

Building upon the momentum from the *Making Tracks Policy and Accountability Framework: towards closing the gap in health outcomes for Indigenous Queenslanders by 2033*, the department has developed the following:

- *Statement of action towards closing the gap in health outcomes.*
- Triennial Making Tracks implementation plans/investment strategies.
- *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework* review.



Policy initiative

Statement of Action

The *Queensland Health Statement of Commitment to Reconciliation*, which was signed by the Director General and the Commissioner of Queensland Ambulance Service in December 2016, articulates that all Queensland Health staff have responsibilities for achieving the closing the gap targets.

The *Statement of action towards closing the gap in health outcomes* (the statement) which was endorsed by all Hospital and Health Service (HHS) Board Chairs in December 2017 aims to address systemic barriers to the improvement of Aboriginal and Torres Strait Islander health in Queensland.

The statement will be incorporated into Queensland Health system-wide processes, and systems, to provide greater visibility and accountability for HHSs to improve health outcomes of all Aboriginal and Torres Strait Islander Queenslanders. Embedding the statement requires tangible commitment and leadership across Queensland Health through:

- increasing representation of Aboriginal and Torres Strait Islander people in Queensland Health wide governance arrangements and leadership structures, and within senior and executive management in the health workforce;
- more formalised community engagement; and
- improving visibility and accountability for closing the gap in Aboriginal and Torres Strait Islander health through public communication in annual reports, performance reporting and other activities.

All of Queensland Health, including the Department of Health, HHSs and Queensland Ambulance Service is responsible for implementing the statement across the entire Queensland Health system.

Consistent with the available epidemiological evidence, it is intended that the future *Making Tracks Implementation Plan* for the triennium 2018 to 2021 will continue to broadly focus on the current investment priorities. These priority areas are critical to the delivery against the two targets as they address health disadvantage across the life course. They also allow for investment into areas which will maximise health gains.



Making Tracks investment

Making Tracks Investment Strategy

Through the *Making Tracks Investment Strategy 2015–2018*, Queensland Health is funding a broad range of value for money initiatives. The five priority areas are:

1. **A healthy start to life:** Recognises that to achieve sustainable health gains for Aboriginal and Torres Strait Islander people, children must have a healthy and safe start to life free of avoidable illness and injury.
2. **A healthy transition to adulthood:** Focussed on establishing and promoting positive health seeking behaviours, averting the uptake of risky health behaviours in Aboriginal and Torres Strait Islander young people.
3. **Preventing and treating chronic disease:** Targeting investment towards initiatives that aim to address the top broad cause contributors to the Aboriginal and Torres Strait Islander burden of disease and reducing avoidable hospitalisation through prevention, early diagnosis and treatment.
4. **Improving access and the patient journey:** Focussed on providing an integrated and effective health system that supports patients to navigate the hospital environment and improving the cultural capability of health services.
5. **Innovation effectiveness and value for money:** Ensuring that funding is used for maximum impact on health outcomes through appropriate and innovative models of care and service delivery arrangements.

This approach is also consistent with the widely held view that achieving sustainable, long-term gains in Aboriginal and Torres Strait Islander health outcomes requires an evidence-based, consistent and sustained funding effort.

The successor to the investment strategy, the *Making Tracks Implementation Plan 2018–2021*, will apply from 1 July 2018.

To ensure the sustainable systemic change that underpins closing the gap, cultural capability must be embedded into all aspects of service delivery. The *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*, released in 2010, was developed as part of the initial closing the gap effort to embed cultural capability into the design, delivery and evaluation of Queensland Health services.



Policy initiative

Cultural capability review

Since the development of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework*, a number of initiatives, ranging from direct service delivery, policy development and service reform have been gradually but consistently implemented.

In 2017 a strengths-based external review of the implementation of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework* was undertaken. This review focused on identifying gains achieved and provided a road map for moving forward in achieving system-wide cultural capability to better meet the needs of Aboriginal and Torres Strait Islander Queenslanders.

The external reviewers undertook extensive engagement with staff and stakeholders. Key themes emerging in the report suggest a need to take a strengths-based approach and build on current achievements to:

- enhance the cultural input into strategic planning, funding, performance and monitoring frameworks;
- support Aboriginal and Torres Strait Islander leadership at all levels across the Queensland Health system;
- establish more culturally-minded consumer engagement mechanisms and governance structures;
- continue to increase the cultural capability of the current and emerging Queensland Health workforce; and
- improve communication, information sharing and reporting.

It is intended that, as a result of this review, Queensland Health will roll out a series of new and reinvigorated round of actions from 2018–19 and re-focus efforts to continue to embed cultural capability into the Queensland Health system.

Target: Close the gap in life expectancy within a generation (by 2031)

Key points

From 2005–2007 to 2010–2012:

- Aboriginal and Torres Strait Islander life expectancy increased by 1.7 years females and 1.6 years for males.
- The life expectancy gap narrowed by 1.4 years for females and 1.0 year for males.
- While there have been gains, they are slower than anticipated.
- If these gains are sustained, **it would not be sufficient to meet the 2031 COAG target.**

Life expectancy

Table 1: Life expectancy at birth (years), 2005–2007 and 2010–2012

	2005–2007			2010–2012			Change 2005–2007 to 2010–2012		
	Indigenous	Non-Indigenous	Gap	Indigenous	Non-Indigenous	Gap	Indigenous	Non-Indigenous	Gap
Males									
Qld	67.1	78.8	11.8	68.7	79.4	10.8	1.6	0.6	-1.0
Aust	65.7	78.9	13.1	67.4	79.8	12.4	1.7	0.9	-0.7
Females									
Qld	72.7	82.7	10.0	74.4	83.0	8.6	1.7	0.3	-1.4
Aust	71.7	82.7	11.0	72.3	83.2	10.9	0.6	0.5	-0.1

Source: ABS, 2009 & 2013, Cat no. 3302.0.55.003

- Life expectancy estimates have not been updated since the previous report, *Closing the gap performance report 2016*. Estimates for 2015–2017 are expected to be released by the ABS in November 2018.⁴
- Life expectancy is improving for both Aboriginal and Torres Strait Islander males and females in Queensland and the life expectancy gap with the non-Indigenous population has decreased (Table 1).

- Life expectancy improved for Aboriginal and Torres Strait Islander Queenslanders by 1.7 years for females and 1.6 years for males based on the 2005–2007 and 2010–2012 estimates.
- In 2010–2012, the life expectancy gap was 8.6 years for females and 10.8 years for males, showing a narrowing of the gap by 1.4 years for females and 1.0 year for males. This gain is not sufficient to meet the 2031 COAG target.
- Improvements in Aboriginal and Torres Strait Islander life expectancy have not been fully reflected in reducing the gap due to gains in the life expectancy of the non-Indigenous Queensland population.
- Despite improvements in Aboriginal and Torres Strait Islander life expectancy, the gap is unlikely to be closed by 2031, due to both:
 - slower than required gains; and
 - increasing non-Indigenous life expectancy effectively moving the target upward.

Table 2: Required growth rate of Indigenous life expectancy to close the gap

Observed growth in life expectancy from 2005–2007 to 2010–2012 (months per year)		
	Female	Male
Indigenous	4.1	3.8
Non-Indigenous	0.7	1.4
Growth required to close the gap in life expectancy (months per year)		
2010–2012 to 2031 (excl. NI growth)**	5.2	6.4
2010–2012 to 2031 (incl. NI growth)***	5.9	7.9
Ratio of observed to required growth***		
	0.7	0.5

Notes:

NI = Non-Indigenous

** Indigenous growth required to close the life expectancy gap from 2005–07 independent of NI growth

*** Indigenous growth required to close the life expectancy gap from 2005–07 including non-Indigenous growth

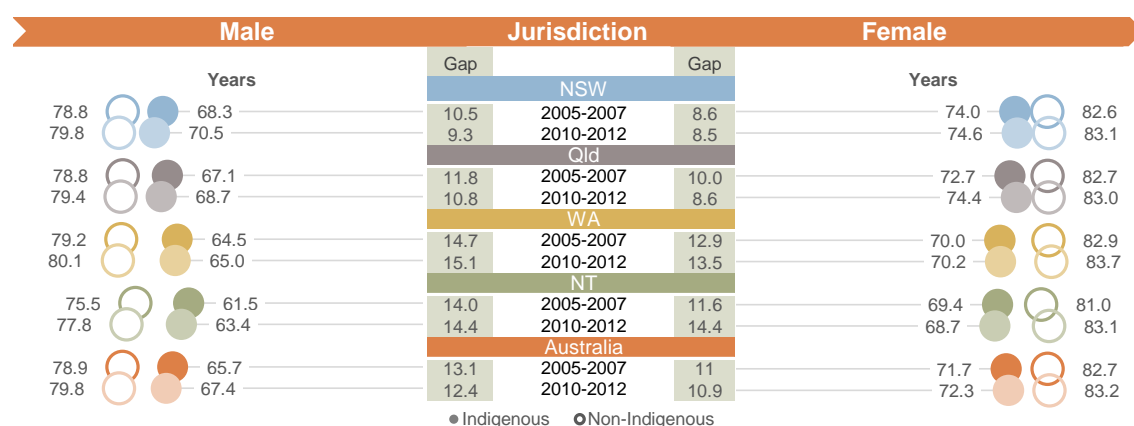
- The life expectancy of Aboriginal and Torres Strait Islander people grew faster than non-Indigenous people between 2005–2007 and 2010–2012 (Table 2). However, the rate of life expectancy growth for Aboriginal and Torres Strait Islander people will have to increase if the gap is to be closed by 2031.
- The growth in life expectancy for Aboriginal and Torres Strait Islander people will have to exceed the non-Indigenous growth rate by 5.2 months per year for females and 6.4 months per year for males (once accounting for anticipated non-Indigenous growth this increases to 5.9 and 7.9 months per year respectively). The required level of sustained growth has never been observed in the total Queensland population.
- The ratio of required growth indicates that while we are closer to achieving the required growth for females—observed growth was 70 per cent of what was required to close the gap—this is not the case for males. For males the observed growth was 50 per cent of what was required—approximately 2.1 times the growth observed between 2005–2007 and 2010–2012 (3.8 months) is required to achieve parity by 2031.

AIHW estimates

The AIHW recently estimated life expectancies for Aboriginal and Torres Strait Islander people for the period 2001–2015.¹ Despite using a different methodology to the ABS, the gap in life expectancy and trends validate the conclusion that current gains are not enough to close the gap by 2031.

According to the AIHW, in 2011–2015 the Queensland Aboriginal and Torres Strait Islander male and female life expectancies were 69.8 years and 75.1 years respectively with differences to the non-Indigenous population of 10.8 years and 9.7 years respectively. These estimates show an improvement of 3.0 years and 2.1 years for Aboriginal and Torres Strait Islander males and females respectively over the 10 years, 2001–2005 to 2011–2015. The values are similar to the ABS data above and assist in validating reported figures.

Figure 1: Life expectancy by Indigenous status and jurisdiction, 2010–2012



Data source: ABS 2013, cat no. 3302.0.55.003

- Aboriginal and Torres Strait Islander Queenslanders have the second highest life expectancy and second smallest gap with non-Indigenous life expectancy, of any of the reporting jurisdictions(Figure 1)^b.
- The national life expectancy gap is higher than in Queensland. The *Closing the gap Prime Minister's report 2018* reported that the gap is also unlikely to be closed nationally by 2031.

^b Victoria, South Australia, the Australian Capital Territory and Tasmania are not reported due to relatively small Aboriginal and Torres Strait Islander populations.

Global Gaps

The Lowitja Institute^c in collaboration with The Lancet^d has reported on life expectancies and gaps for several indigenous populations around the world.⁵ For 2012 the estimated number of indigenous peoples living across the globe was 300 million.

Table 3: Global life expectancy and gap (years), indigenous and non-indigenous peoples⁵

Country, year and indigenous population	Indigenous	Non-Indigenous	Gap
Cameroon 2013. Baka Pygmies	35.5	57.0	21.5
Kenya 2001. Maasai	43.5	56.6	13.1
Canada 2017. Inuit	68.5	81.0	12.5
Australia 2010–2012	71.4	81.4	10.0
Greenland 2009–13. Inuit	70.3	79.5	9.2
Panama 2012.	69.7	77.3	7.6
New Zealand 2012–14. Maori descent	75.1	82.1	7.0
Canada 2017. First Nations	75.5	81.0	5.5
USA 2009. American Indians and Alaska Natives	73.7	78.5	4.8
Canada 2017. Metis	77.0	81.0	4.0
India 2011. Scheduled tribes	63.9	67.0	3.1
USA 2000. Hawaiian and Pacific Islanders	74.3	76.8	2.5
China 2010. Tibetans	72.6	74.8	2.2
China 2000. Dai people	67.2	68.5	1.3

Source: Anderson I, Robson B, Connolly M, Al-Yaman F, Bjertness E, King A, et al. Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. *Lancet* 2016;388:131–157.

- Australia has the fourth largest gap in life expectancy between the Aboriginal and Torres Strait Islander and non-Indigenous populations (Table 3).
- Compared to developed countries with comparable health systems (Canada and New Zealand), Aboriginal and Torres Strait Islander people had a life expectancy lower than Maori of New Zealand, and First Nations of Canada. Inuit people from Canada had a lower life expectancy.
- The comparatively high life expectancy gap for Aboriginal and Torres Strait Islander Queenslanders indicates that there is much more than we can do to bring about positive health change.
- A better understanding of successful engagement and program delivery, particularly focussed on Canada, New Zealand and the USA would certainly enhance our own understanding of how to better derive health outcomes for Aboriginal and Torres Strait Islander Queenslanders as all indigenous populations within these countries (except the Inuit) have lower life expectancy gaps than Aboriginal and Torres Strait Islander Queenslanders.

^c Australia's national institute for Aboriginal and Torres Strait Islander health research

^d The Lancet publishes peer reviewed medical journals, one of which is a specialty journal in public health

A key element of improved health outcomes for international First Nations peoples has been the development of Indigenous led and staffed health services that engage with the community and allow for community ownership of health service delivery. The following are examples of service models which are improving health outcomes for Aboriginal and Torres Strait Islander people in Queensland.



Making Tracks investment
Priority areas: 1, 2, 3, 4, 5

Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (Centre of Excellence)

The Inala Indigenous Health Service established in 1995 has evolved from pure service delivery to incorporating teaching, research and community development under the banner of the Centre of Excellence. It also provides for training of workforce in Aboriginal and Torres Strait Islander health and a research agenda around best practice models of care.

The purpose built Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care, funded by the Queensland Department of Health, opened in 2013 with the completion of Stage 1. This provided facilities for general clinical services (GP) fully integrated with onsite specialist services for ophthalmology (including on site laser), paediatrics, hepatology, endocrinology and cardiology (echocardiograms, exercise stress tests done on site) all within a primary health care setting. This state of the art facility has increased the number of clients accessing the service from 12 in 1995 to now over 6000 patients.

The opening of Stage 2 in January 2018, supported entirely by the Queensland Department of Health, further enhanced the service through access to specialist care in the primary care setting including integration of adult, child and adolescent psychiatry, expansion of hepatology services to include treatment of hepatitis C out of the hospital system and increased occasions of service across all these clinical areas, the majority of which will attract Medicare revenue.

\$17.5 million in capital has been provided for the construction of phases 1 and 2 of the Centre of Excellence.

The opening of the Centre of Excellence has been very successful and is a unique and important milestone in establishing high quality health services for all Aboriginal and Torres Strait Islander Queenslanders.



Making Tracks investment
Priority areas: 2, 3

Deadly Choices

Deadly Choices was developed by the Institute for Urban Indigenous Health (IUIH) as a community based chronic disease prevention and education program to encourage Aboriginal and Torres Strait Islander Queenslanders to make healthy choices, focussing on chronic disease and risk factors such as physical activity, smoking and substance abuse and good nutrition.

The program addresses priorities identified in the Queensland Governments *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033* which

emphasises the importance of health promotion and health education to target the risk factors for poor health outcomes that contribute to one-third of the health.

The program targets Indigenous Queenslanders of all ages and involves a school based health education program aimed at Aboriginal and Torres Strait Islander young people; community based programs that are aimed at adults and community events designed to promote healthy lifestyle choices in the wider community.

Queensland Health was provided an opportunity to support this program in 2013, through the establishment of the Deadly Choices Broncos Partnership formed to promote the Deadly Choices program. This partnership capitalised on the profile and popularity of Broncos players and branded merchandise to draw increasing numbers of Aboriginal and Torres Strait Islander people to Deadly Choices Community Days. The success of the partnership has prompted the formation of new relationships with prominent Indigenous sportspeople, artists and musicians who act as Deadly Choices Ambassadors and use their role as an opportunity to deliver healthy choices messages.

The Deadly Choices brand has proven to be a powerful vehicle for positive change in Queensland's Aboriginal and Torres Strait Islander communities. Evaluation activities have found that Deadly Choices has been successful in improving health awareness in the community. This awareness has translated into a significant increase in the number of Aboriginal and Torres Strait Islander Queenslanders accessing community controlled services and taking control of their health.

Recognising the important role that health prevention plays in closing the health gap, the Queensland Government has commitment to provide \$16M to expand the Deadly Choices Program. This expansion will bring together existing health promotion and health education initiatives into a comprehensive Deadly Choices Healthy Lifestyle Program and will extend the reach and coverage to priority locations across Queensland. The IUIH will work with local Aboriginal and Torres Strait Islander Community Controlled Organisations to deliver an expanded program which will:

- Integrate the Deadly Choices Ambassador program, School Education, Licences, existing Work It Out program, Community and Sporting events and the Tackling Indigenous Smoking Initiative.
- Be complementary to the Queensland Health 'My Health for Life' program which aims to reach 1600 Aboriginal and Torres Strait Islander Queenslanders over four years.
- Develop and implement state-wide integrated marketing and communication strategies.
- Establish a Deadly Choices Work Out program open to Indigenous Queenslanders at risk of developing chronic disease and be complementary to the Work-It-Out chronic disease management and rehabilitation program.
- Contribute to smoke free workplaces and homes.
- Provide employment opportunities for Aboriginal and Torres Strait Islander as Deadly Choices facilitators, personal trainers, data managers, media officers and create junior traineeship opportunities.



The Lower Gulf Strategy

The partnership, referred to as the Lower Gulf strategy, engages North West Hospital and Health Service (NWHHS), Gidgee Healing and Western Queensland Primary Health Network (PHN) and now supports a collective regional approach to health service system reform, integration, planning and delivery. Conceptually this has involved the integration of primary, secondary and tertiary services within a primary health care (PHC) framework. In practical terms, integration has been strengthened through the increasing co-location and/or integration of Gidgee Healing services within NWHHS facilities in Mornington Island, Doomadgee and Normanton and the joint planning of allied health across the region.

The longer term vision is for identified Queensland Health services to transition fully to community control under Gidgee Healing. Gidgee Healing is both a partner under the Lower Gulf strategy in providing services and strategic oversight, and also has the lead role for Aboriginal and Torres Strait Islander health in the Lower Gulf region through the delivery of PHC.

The Lower Gulf strategy also works in partnership with the Royal Flying Doctor Service (RFDS) and North and West Remote Health (NWRH) to deliver PHC services to communities in the Lower Gulf.

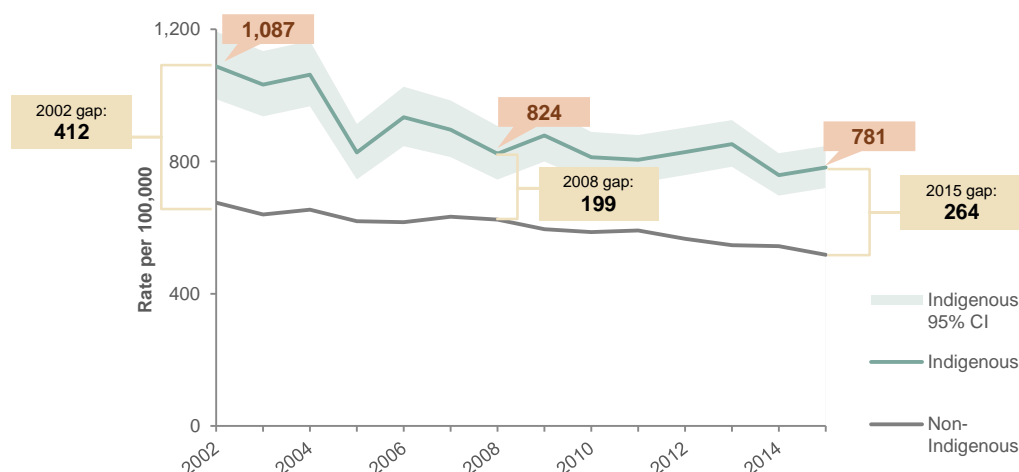
The Lower Gulf Strategy is important as it is a genuine commitment to changing how services are delivered and who delivers them. Leadership demonstrated by the North West HHS, the Primary Health Care Network and Gidgee Healing has been instrumental in driving the Lower Gulf Strategy.

This is a clear example of the effectiveness of the partnership and commitment to achieve improved health outcomes of the Lower Gulf region. It is clearly about who is best placed to deliver the service and reflects a focus on those in the community most at need.

Supporting indicators

Mortality

Figure 2: Mortality rate by Indigenous status, Queensland 2002 to 2015



Notes:

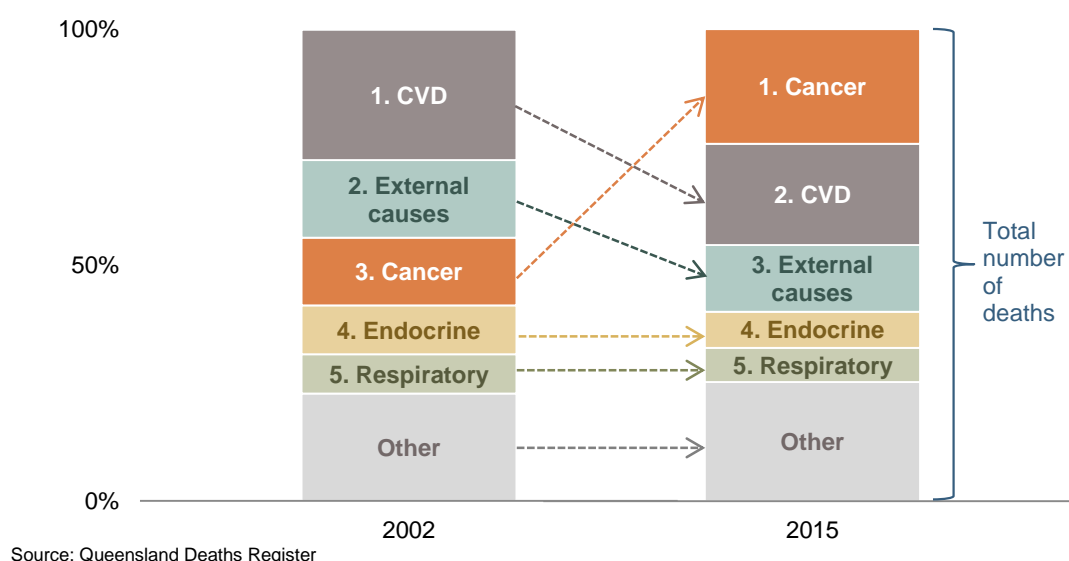
Directly age standardised to the 2001 Australian population

CI = confidence intervals

Source: Queensland Deaths Register

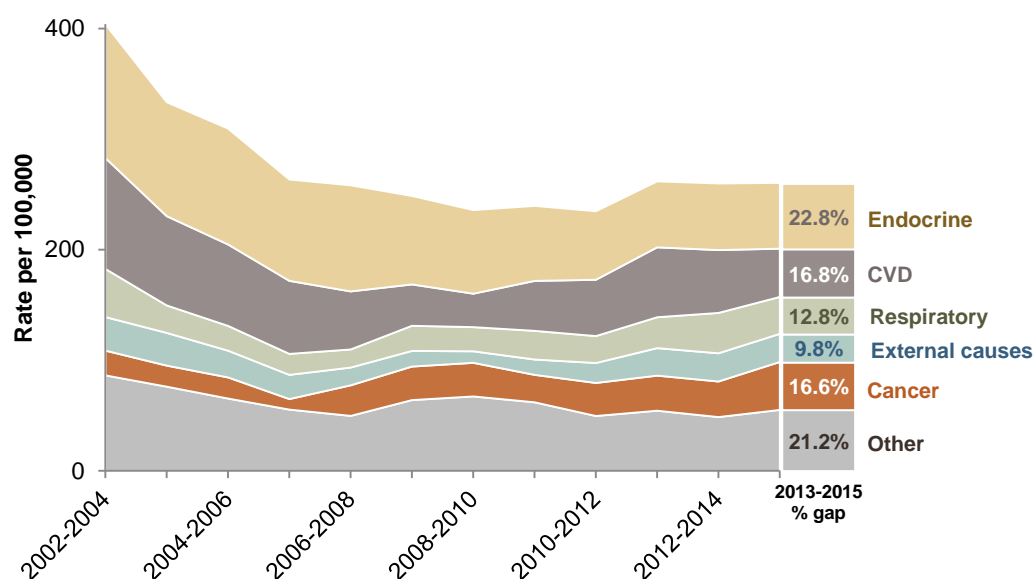
- The all-cause mortality rate of Aboriginal and Torres Strait Islander Queenslanders significantly decreased between 2002 and 2015, with the most substantial reductions occurring between 2002 and 2008 (Figure 2). Improvements in mortality since the closing the gap agenda was launched in 2008 were more protracted, with smaller reductions in mortality than the non-Indigenous population.
- Despite an overall improvement in Aboriginal and Torres Strait Islander mortality between 2008 and 2015, the mortality gap with non-Indigenous Queenslanders increased. This is in part due to variability of the Aboriginal and Torres Strait Islander mortality rate, but also reflects improvements in the mortality rate of the non-Indigenous population. The impact of the baseline year also has an effect on measurement of the mortality gap, as 2008 had the lowest mortality rate gap of any year between 2002 and 2015.

Figure 3: Leading causes of Indigenous mortality, Queensland 2002 and 2015



- Figure 3 depicts the leading causes of death for Aboriginal and Torres Strait Islander Queenslanders in 2002 and 2015. Each cause is ranked by its proportional contribution to total number of deaths in each year.
- The leading cause of mortality for Aboriginal and Torres Strait Islander Queenslanders differed between 2002 and 2015 and reflects a change in the structure of death and disease within the population. Cancers were the leading cause of death in 2015, due to both an increase in the number of cancer related deaths and falling mortality from cardiovascular diseases (CVD).
- Deaths due to cancer increased by 186 between 2002–2004 and 2013–2015, of which 67 (36.0 per cent) were deaths from lung cancer. This is expected to remain a challenge into the future due to a slower decline in Aboriginal and Torres Strait Islander smoking rates compared to the non-Indigenous population, a considerably higher smoking rate, and the latent period for lung cancer which can be up to 30 years.

Figure 4: Mortality rate gap by leading causes, Queensland 2002–2004 to 2013–2015

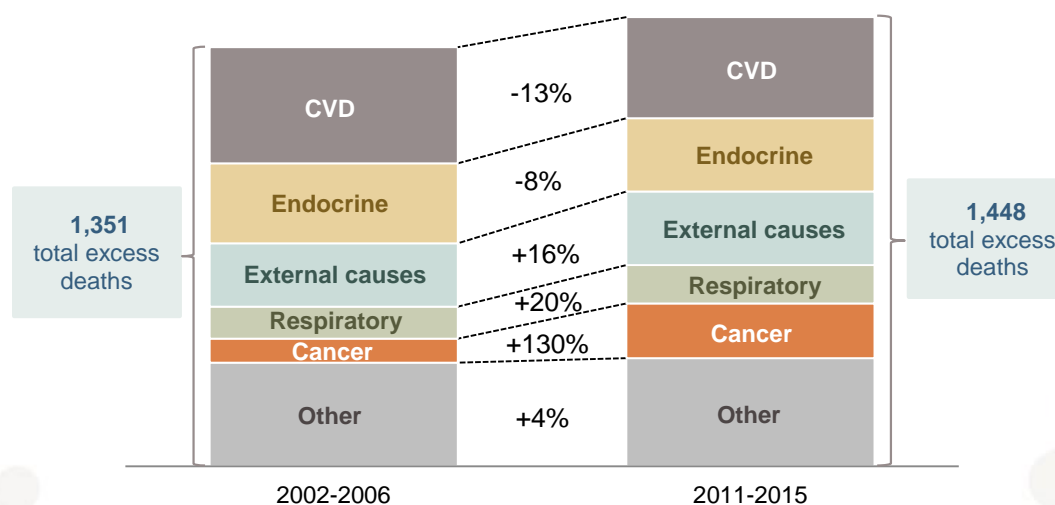


Directly age standardised to the 2001 Australian population

Source: Queensland Deaths Register

- Figure 4 shows the mortality rate gap between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders and provides the underlying cause specific breakdown of the gap over time. The mortality gap is the difference between non-Indigenous and Aboriginal and Torres Strait Islander cause specific mortality rates, after adjusting for the differing age structure of the populations.
- The contribution of endocrine disorders and CVD more than halved between 2002–2004 and 2013–2015. Despite this improvement, endocrine disorders and CVD remain the leading contributing causes to the mortality gap.
- The contribution of cancer to the mortality gap more than doubled due to an improvement in the non-Indigenous rate of mortality from cancers that was not reflected in the Aboriginal and Torres Strait Islander population.

Figure 5: Excess Indigenous deaths by leading cause, Queensland 2002–2006 to 2011–2015



Source: Queensland Deaths Register

- Figure 5 shows the number of excess Aboriginal and Torres Strait Islander deaths in 2002–2006 and 2011–2015, which is the observed (actual) deaths less the number of deaths expected if mortality rates were equal to the non-Indigenous population. Excess deaths quantify the number of deaths that would not have occurred had the mortality rates of Aboriginal and Torres Strait Islander people been at parity with the non-Indigenous population.
- Although the number of excess deaths has increased, this is attributable to population growth and change in age structure between the two periods; the rate of excess deaths per population has decreased over this time. The total number of excess deaths increased between 2002–2006 and 2011–2015 driven by a number of leading causes including cancer, respiratory disease, and external causes (Figure 5).
- Between 2002–2006 and 2011–2015 excess deaths from CVD and endocrine disorders decreased by 13 per cent and 8 per cent respectively, reflecting a falling rate of mortality related to these conditions relative to the non-Indigenous population.
- Excess deaths from cancer increased by 130 per cent between 2002–2006 and 2011–2015, driven by a declining rate of cancer mortality in the non-Indigenous population, which was not reflected in the Aboriginal and Torres Strait Islander population.

Driven by a declining rate of cancer mortality in the non-Indigenous population, excess deaths from cancer increased – this emphasises the need for a renewed policy focus on cancer

The health system is complex and multi-dimensional and presents a significant challenge for people with high chronic disease burden to navigate. However, successful navigation of the system can optimise health outcomes, maximise health gain and reduce premature mortality. The examples below provide a clear illustration of how Queensland Health is looking to support access for Aboriginal and Torres Strait Islander people through innovative approaches to health service access.



Innovation

Navigating the system

With funding allocated by the Queensland Government for nurse navigators, the Gold Coast HHS is preparing to recruit an Indigenous Identified Nurse Navigator position and explore options to support and increase Aboriginal and Torres Strait Islander pathways into Nurse Navigator roles.

The Nurse Navigator position will deliver end-to-end coordinated clinically and culturally capable health services to Aboriginal and Torres Strait Islander patients with complex health conditions. The Nurse Navigator will be a high level clinical position focussed on improving health outcomes for Aboriginal and Torres Strait Islander people.

Nurse Navigators have demonstrated to educate and help patients to better understand their health conditions and enable them to self-manage or participate in decisions about their healthcare. In some cases, this may even reduce the need for hospital admission. Therefore, the identified Nurse Navigator position may also increase access to health services and improved health outcomes for Aboriginal and Torres Strait Islander people due to the targeted program.



Healthy Skin Program

Since 2014, the Healthy Skin Program has been delivering community care across North West Queensland to reduce skin infection related mortality and morbidity rates among Aboriginal and Torres Strait Islander people.

Untreated skin ailments can lead to serious conditions such as rheumatic fever and rheumatic heart disease, acute post-streptococcal inflammation of the kidney, and chronic renal disease. By improving the early detection, prevention and treatment of infection causing pathogens, the Healthy Skin Program is contributing towards reducing the burden of disease currently experienced by Aboriginal and Torres Strait Islander people.

The program will transition to Gidgee Healing in 2018–19 as a part of the Lower Gulf Strategy in partnership with the North West Hospital and Health Service (NWHHS). The program will continue to run in collaboration with community-based organisations, integrating with Ngukuthati Children and Family Centre, local schools, women's shelters and men's groups.

In 2016–17, the program provided 1136 occasions of service, and made significant achievements in engaging previously disengaged community members and families. By decreasing rates of skin conditions and related infections, the program also contributes to improved social outcomes, such as reducing school absenteeism.

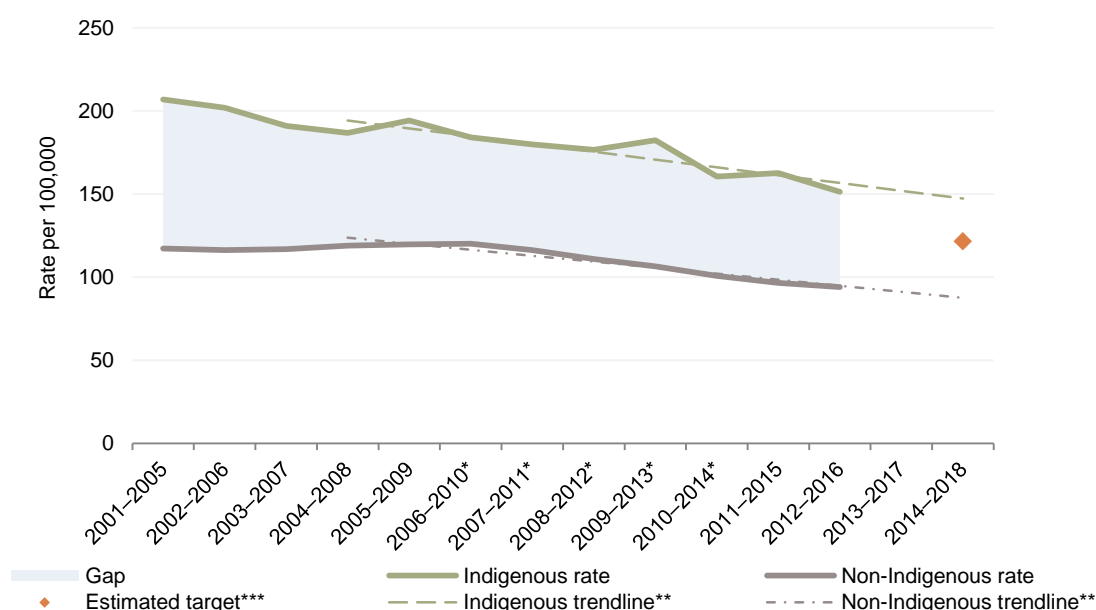
Target: Halve the gap in child mortality within a decade (by 2018)

Key points

- The Aboriginal and Torres Strait Islander child mortality rate has reduced by 19% from 2004–2008 to 2012–2016.
- The gap in child mortality has reduced by 15% from 2004–2008 to 2012–2016.
- Data for reporting against 2018 will not be available until 2019.
- Based on the recent trends in child mortality, the **target to halve the gap in mortality rates is unlikely to be achieved by 2018.**

Child mortality

Figure 6: Child mortality rates and projected trends by Indigenous status, Queensland 2001–2005 to 2014–2018



Notes: * 2010 deaths based on adjusted registrations

** Trendline based on linear trend of 2004–2008 to 2012–2016 data (trend since targets agreed to)

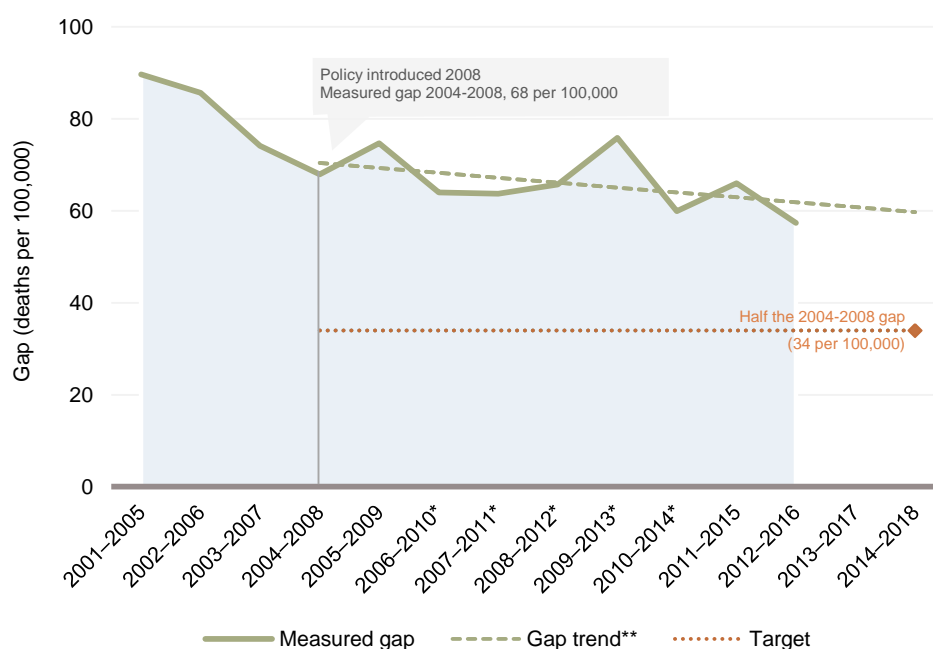
*** Estimated target based on the projected non-Indigenous estimate for 2014–2018 plus half the measured gap (Indigenous rate minus non-Indigenous rate) in 2004–2008

Source: Australian Bureau of Statistics (2017), Deaths, Year of registration, Indigenous status, Age at death, Sex, Five State/Territory. ABS.Stat. Findings based on use of ABS.Stat data.

The difference in the child (0–4 years) mortality rate between Queensland’s Aboriginal and Torres Strait Islander children and other Queensland children highlights that inequalities in health outcomes begin at the earliest stages of life. The life course approach to health tells us that babies that are born strong and healthy have the best chance of progressing to adulthood in good health, and avoiding chronic conditions that have been associated with low birth weight.

- Since the COAG targets were agreed to in 2008, significant reductions in the child mortality rate have occurred in both the Aboriginal and Torres Strait Islander and non-Indigenous populations (Figure 6). This parallel improvement indicates little change in the gap.
- However, Aboriginal and Torres Strait Islander child mortality has improved significantly over period 2004–2008 to 2012–2016, with a 19 per cent reduction in the mortality rate.

Figure 7: Child mortality gap, Queensland 2001–2005 to 2014–2018



Notes: The gap is the Indigenous minus the non-Indigenous child mortality rates

* 2010 deaths based on adjusted registrations

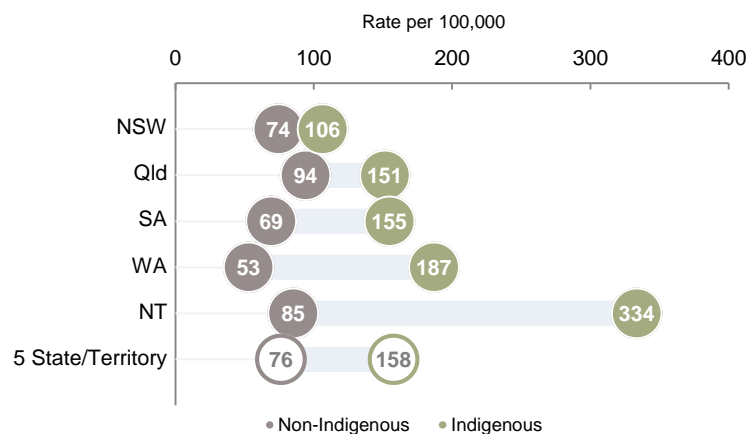
** Trendline based on linear trend of 2004–2008 to 2012–2016 gap (trend since targets agreed to)

Source: Australian Bureau of Statistics (2017), Deaths, Year of registration, Indigenous status, Age at death, Sex, Five State/Territory.ABS.Stat. Findings based on use of ABS.Stat data.

- Figure 7 charts the child mortality gap between the Aboriginal and Torres Strait Islander and non-Indigenous populations. It shows that the measured gap in child mortality continues to narrow, albeit slowly. At this rate, the target of halving the child mortality gap by 2018 is unlikely to occur.
- At baseline of 2004–2008, the gap in child mortality rates between Aboriginal and Torres Strait Islander and other Queenslanders was 68 child deaths per 100,000. Latest estimates (2012–2016) indicate that the child mortality gap has been reduced by approximately 15 per cent to 57 per 100,000.
- To be on track to halving the gap in Aboriginal and Torres Strait Islander and non-Indigenous child mortality, the gap needed to reduce by an average of 3.4 deaths per 100,000 per year. However, in the eight years since establishment of the targets the annual reduction has been around a third of this—1.1 per 100,000 per year.

The average annual reduction in the gap has been one third of what is required to halve the gap by 2018 – this suggests that we may not have optimised opportunities for health improvement

Figure 8: Child mortality by Indigenous status and jurisdiction, 2012–2016



- Of the five jurisdictions with high quality Aboriginal and Torres Strait Islander mortality data, Queensland's child mortality rate was the second lowest following New South Wales (Figure 8).
- Given higher mortality rates in remote parts of the country, it is likely that the comparatively smaller percentage of remote populations in New South Wales may contribute to the significantly lower child mortality rates in that state.

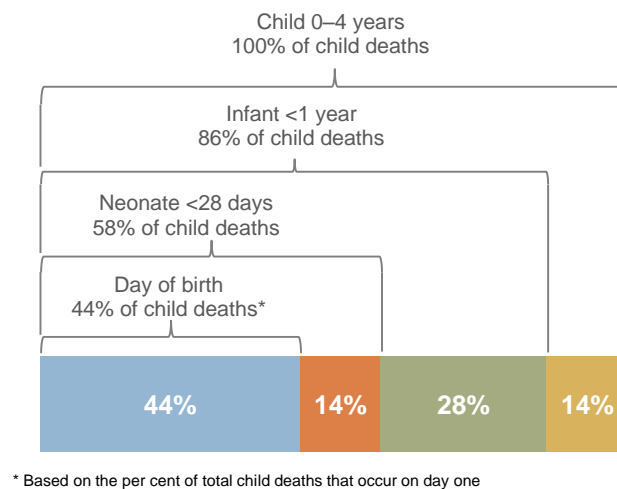
Table 4: Age specific mortality rate by Indigenous status, Queensland 2012–2016

Age at death	Indigenous		Non-Indigenous		Rate ratio
	Number	Rate*	Deaths	Rate*	
<1 year	168	636.1	1149	399.3	1.59
1–4 years	31	30.1	219	18.8	1.60
0–4 years	196	151.5	1368	94.1	1.61

* Mortality rate per 100,000

- For both infants (children aged less than 1 year) and children aged 1–4 years, the mortality rate for Aboriginal and Torres Strait Islander children was around 60 per cent higher than the non-Indigenous rate (Table 4).

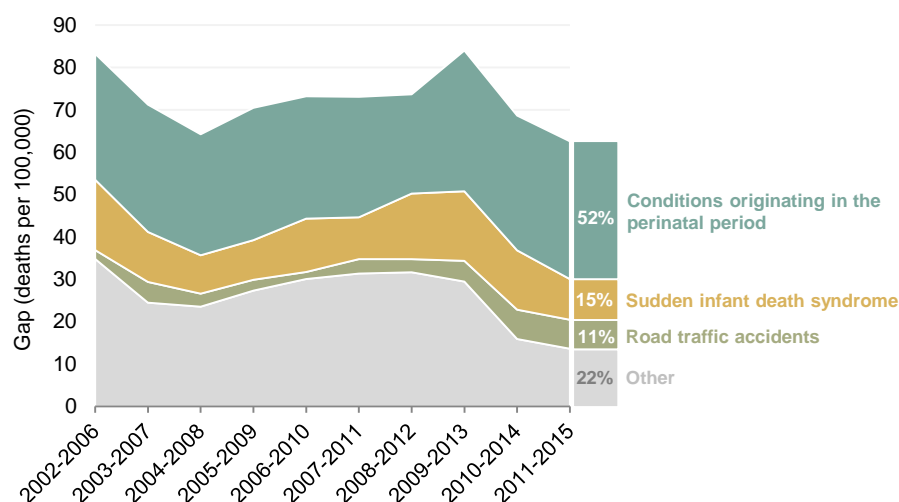
Figure 9: Distribution of child deaths by age at death, Indigenous Queenslanders, 2012–2016



- Most deaths occur in infancy (Figure 9). This highlights the importance of the impact of infant mortality on the child mortality rate—to improve child mortality rates and reduce the gap in child mortality preventing infant deaths is vital.
- Prevention of infant deaths begins prior to pregnancy. Focusing on improving the health of Aboriginal and Torres Strait Islander women in the years leading up to and of child bearing age is essential. It is also important to ensure the availability of responsive, culturally appropriate health care, and to engage women with antenatal care early in pregnancy, throughout pregnancy, birth and the postnatal period.

Around half the gap in child mortality was caused by conditions originating in the perinatal period

Figure 10: Child mortality gap by cause, 2002–2006 and 2011–2015



Source: Cause of Death Unit Record File, Australian Coordinating Registry

When considering opportunities to reduce the gap in child mortality, targeting those conditions that contribute most to the gap presents the greatest opportunity for gain.

- In the most recent period where we have cause of death information, conditions originating in the perinatal period (for example, fetal growth disorders) caused around half of the gap in child mortality (Figure 10). A further 15 per cent were due to differences in the sudden infant death syndrome rate, and 11 per cent were due to road traffic accidents.

A focus on preventing infant deaths and the health of the mother pre-conception, and during pregnancy is vital

Diseases of disparity continue to impact on Aboriginal and Torres Strait Islander health in Queensland. Conditions that were once common but now virtually eradicated in the non-Indigenous population remain prevalent in Aboriginal and Torres Strait Islander Queenslanders. Rheumatic heart disease is a perfect example of this phenomenon. To address this Queensland Health has developed an *Aboriginal and Torres Strait Islander Rheumatic Heart Disease Action Plan 2018–2021*.



Policy initiative

Rheumatic Heart Disease Action Plan

“While acute rheumatic fever has become a rare curiosity in Australia’s non-Indigenous population, its incidence in Indigenous Australians living in remote areas remains among the highest reported in the world. It is unlikely that such a stark contrast between two populations living within the same national borders exists for any other disease or on any other continent.”⁶

Rates and incidences of acute rheumatic fever (ARF) and rheumatic heart disease (RHD) are unacceptably high in Queensland’s Aboriginal and Torres Strait Islander population, particularly but not exclusively in the HHSs of Cairns & Hinterland, North West, Torres & Cape and Townsville.

RHD manifests as permanent damage to the heart muscle or heart valves as a result of ARF. ARF and RHD induced damage can reduce cardiovascular capacity of the heart to pump blood effectively around the body, leading to symptoms such as shortness of breath, feelings of fatigue and weakness. If unmanaged these diseases can result in serious incapacity with clients with RHD often requiring cardiac valve replacement, and can result in fatality.

To address ARF/RHD, the Aboriginal and Torres Strait Islander Health Branch is leading the development of an ARF/RHD Action Plan. This Action Plan will seek to build on the collective will and commitment of the entire health system to improve the response which will be a significant step forward in reducing the number of people with ARF and RHD.

The Action Plan will look to strengthen the connections between the different parts of the health system, increase awareness of best practice care and share information to support better coordinated care for the patient.

Living in a clean and healthy environment is key to foundational physical wellbeing. A living situation free of environmental hazards is not always present in communities, and infrastructure or workforce capacity issues can cascade into significant public health risks. Availability of clean drinking water is one of the fundamental environmental factors

in maintaining a healthy population, and a targeted program in Far North Queensland aims to strengthen this capacity in several communities.



Policy initiative

Safe and Healthy Drinking Water in Indigenous Local Government Areas

The “Safe and Healthy Drinking Water in Indigenous Local Government Areas Project Pilot” being undertaken by Tropical Public Health Services (Cairns) is designed to safeguard selected Far North Queensland Indigenous communities from public health risks including potential harm of illness caused by exposure to unsafe drinking water or lack of a continuous water supply.

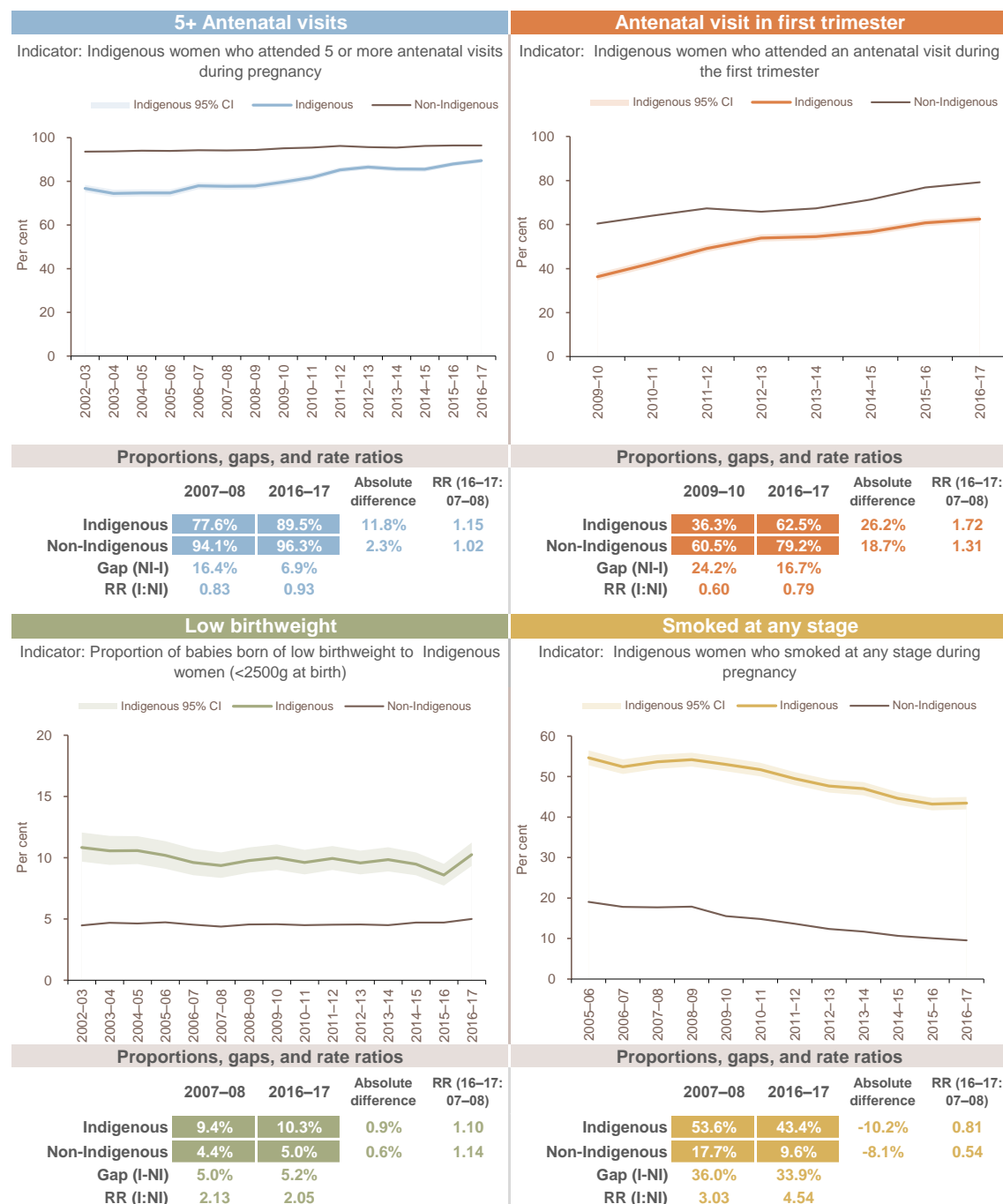
The project adopts a new approach to building the capacity of Indigenous water operators to assure the ongoing safety and quality of water supplied by Indigenous Local Governments and improved regulatory compliance. The project is also a key strategy for promoting the well-being of the Indigenous population in the Far North and is an essential step towards ‘Closing the Gap’.

To date the project has been rolled out to five (5) pilot sites in the Torres Strait being Hammond Island, Warraber Island, Coconut Island and two communities on Moa Island (Kubin and St Pauls). The project has now expanded to Saibai and Boigu Islands.

A key objective of the project is to implement a support strategy to promote drinking water and public health awareness as well as embed community support and mentoring into water operations to ensure a safe drinking water. Other objectives include facilitating upgrades to infrastructure and technology, primarily around disinfection and monitoring, which is essential to remove microbiological pathogens and verify the safety of drinking water. It also builds capacity through introducing local operators to technology and systems that are standard in most major centres around Australia.

Supporting indicators

Figure 11: Child and maternal health indicators, Queensland



Notes: CI Confidence interval; RR Rate ratio
Source: Perinatal data collection, preliminary data extracted 19 February 2018

Antenatal visits

Access to quality and appropriate antenatal care provides expectant mothers with information and early screening that can identify and manage issues that may affect birth outcomes. Antenatal care also presents an opportunity for primary prevention initiatives, and to raise awareness and counsel expectant mothers about risk factors during pregnancy.

- The gap in the proportion of Aboriginal and Torres Strait Islander and non-Indigenous pregnant women that attended five or more antenatal visits has improved significantly. Almost 9 in 10 Aboriginal and Torres Strait Islander women that gave birth in 2016–17 attended five or more antenatal visits (Figure 11).
- The proportion of pregnant women that had an antenatal visit in the first trimester increased substantially for Aboriginal and Torres Strait Islander women in the seven years to 2016–17. Despite this, there remains a large gap relative to the non-Indigenous population.

Low birth weight

Low birth weight babies have a higher risk of mortality in the neonatal period, infancy and into early childhood. Infants born with low birth weight are at increased risk of developing diabetes, renal disease and CVD as adults and are at greater risk of mortality than adults that were not classified as low birth weight. While the differentials in low birth weight persist, it is likely that Aboriginal and Torres Strait Islander people will continue to experience higher rates of burden from these chronic conditions for decades. And, while important, any impacts of current interventions will not be fully realised for many years.

Risk factors for low birth weight include smoking during pregnancy, maternal infections during pregnancy, and pre-existing hypertension. Culturally appropriate antenatal care that engages with Aboriginal and Torres Strait Islander expectant mothers early on in their pregnancy, and retains that engagement throughout pregnancy will be instrumental in being able to help lower rates of low birth weight babies. Pre-pregnancy health is also important.

- There was no improvement in the proportion of babies born to Aboriginal and Torres Strait Islander mothers with low birthweight between 2007–08 and 2016–17. Risk of having a low birthweight baby for Aboriginal and Torres Strait Islander women continues to be around two times the risk in non-Indigenous women (Figure 11).

Smoking during pregnancy

Smoking during pregnancy is a major risk factor for low birth weight. The Queensland Aboriginal and Torres Strait Islander Burden of Disease and Injury Study found that in 2011, 28 per cent of low birth weight burden was attributable to smoking during pregnancy.⁷

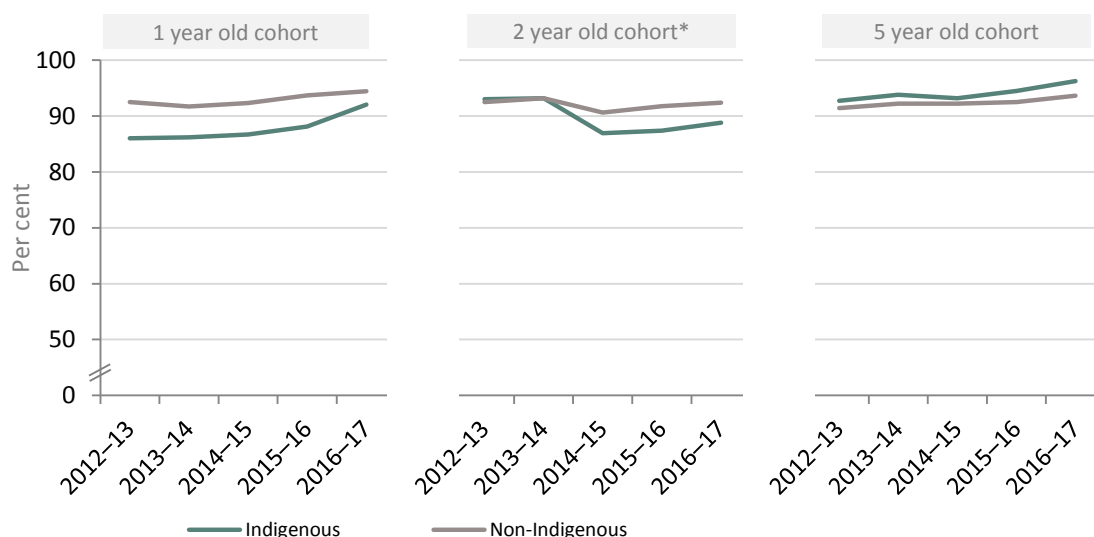
- The proportion of women that smoked during pregnancy decreased for both Aboriginal and Torres Strait Islander and non-Indigenous women. The gap remains large and relatively unchanged since 2007–08 (Figure 11).
- Despite reducing rates of smoking during pregnancy in the Aboriginal and Torres Strait Islander population the prevalence is still very high (43 per cent). The impact of smoking on both the mother's and child's health, and the large remaining gap mean that there are still large opportunities for gain in this area.
- The rate of smoking after 20 weeks gestation was 39 per cent among Aboriginal and Torres Strait Islander women and 7.6 per cent for non-Indigenous women.

Important for policy is the need to focus on smoking at key intervention points including the transition to adulthood, as well as during the pregnancy period for both females and

males and their families. While smoking rates remain high in the community, success in reducing smoking during pregnancy will be limited.

Immunisation

Figure 12: Trends in fully immunised coverage rates by Indigenous status and age group, Queensland 2012–13 to 2016–17



Source: Australian Immunisation Register

- For the first time, in 2016–17 vaccination rates for Aboriginal and Torres Strait Islander children aged five years reached the national and Queensland target of 95 per cent fully immunised (96.2 per cent) (Figure 12). This target was not met for non-Indigenous children in Queensland (93.7 per cent).

In order to close the child mortality gap, addressing child and maternal health is essential, while there have been improvements in many metrics, there is still significant work to be done to achieve parity. To drive this change Queensland Health is developing an *Aboriginal and Torres Strait Islander Maternity Services Action Plan 2018-2021*.



The Aboriginal and Torres Strait Islander Maternity Services Action Plan

Given the importance of maternal health and wellbeing to child health outcomes, Queensland Health is currently developing a three-year *Aboriginal and Torres Strait Islander Maternity Services Action Plan* (the action plan).

The development of an action plan was the main outcome of a major Aboriginal and Torres Strait Islander maternal health forum held in August 2017, the *Growing Deadly Families, a healthy start for mums and bubs* forum.

Reflecting the key themes that emerged from the forum, issues underpinning the draft action plan include:

- partnering with Aboriginal and Torres Strait Islander community controlled health organisations to identify goals, co-design, implement and evaluate an integrated maternal health care system;
- community empowerment, including appropriate leadership and governance arrangements;
- changing the workforce to reflect the community and its needs, i.e. enhancing the Aboriginal and Torres Strait Islander maternal health workforce; and
- culturally appropriate wrap-around social and family services including midwifery, clinical care and comprehensive primary health care.

Building on these key themes, the action plan will provide a road map for the provision of improved, culturally appropriate maternal health services for Aboriginal and Torres Strait Islander women in Queensland. A particular aim of the action plan is to facilitate access to culturally appropriate and responsive maternal health services, while effectively coordinating the provision of targeted services that respond to the needs of Aboriginal and Torres Strait Islander mothers and their babies.

The action plan is scheduled to be released in July 2018.

Towards 2031

This report clearly illustrates three things:

1. There is progress towards closing the gap.
2. There is significant effort and activity being delivered across the system to address Aboriginal and Torres Strait Islander health disadvantage.
3. The progress to date is not what we hoped to achieve, nor what we should have achieved.

To move beyond where we are now, we must critically assess what is working and what is not working and modify our investment and efforts accordingly.

We must focus our efforts and continue to challenge ourselves and the system in the pursuit of the COAG goals. Most importantly, we must build the structures and mechanisms which not only include but are led by Aboriginal and Torres Strait Islander people.

We must continue to develop policies and strategies that target investment, drive change and foster culturally capable service responses. We must continue to challenge ourselves to implement policies and programs which involve Aboriginal and Torres Strait Islander people in all aspects of health care, from the development of policy and strategy to the delivery and management of health care services.

The system is continuing to take steps in the long journey to closing the gap in life expectancy for Aboriginal and Torres Strait Islander Queenslanders. The improvement evident in this report illustrates Aboriginal and Torres Strait Islander health equality is possible, we must now increase efforts to work together and make it the norm.

"Let us hope that an Indigenous baby born in 2030 has the same life expectation, the same access to quality health services and the same life outcomes as non-Indigenous Australians." Tom Calma

Appendices

Methods for assessing progress towards halving the child mortality gap

In this report we have determined that the gap in child mortality rates (0–4 years) between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders is not on track to halve by 2018. The recently released *Closing the gap Prime Minister's report 2018* (the Prime Minister's Report), identifies this target as being on track nationally.² While it may appear that Queensland is not performing well compared to the country as a whole, this assessment is due to different methodologies and assumptions in determining “on track” status.

To anticipate where the Aboriginal and Torres Strait Islander and non-Indigenous child mortality rates, and Indigenous child mortality target rate are likely to be in 2018, we have looked at the linear trend in child mortality rates from baseline (2004–2008^e) to the most recent available data (2012–2016). The Prime Minister's report however uses data from 1998 to 2012 to determine the non-Indigenous and Indigenous trajectory—this includes the 10-year period preceding the baseline year (2008^f). The decade prior to 2008 saw greater reductions in Aboriginal and Torres Strait Islander child mortality and smaller reductions in non-Indigenous child mortality. Using the 1998 to 2007 data to estimate progress towards halving the gap produces a more positive conclusion by increasing the projected 2018 non-Indigenous estimate. In the Prime Minister's report it states that while there was a significant narrowing of the gap early on, in the period from 2008 “the gap has not changed significantly.”

An additional difference between the methods we use in this report and the Prime Minister's Report is the use of trajectory bands (also called variability bands) in the latter. Variability bands reflect the distribution of error around a trajectory and are used to assist in determining if a measure is on target.⁸ Because success for this target will be determined by whether the measured gap in child mortality in 2018 (nationally) or 2014–2018 (jurisdictionally) is half of what it was at baseline, rather than whether the gap falls into a range of values, we have decided not to determine progress based on variability bands. This makes it harder to assess performance as being “on track”. When final data on this measure is reported in 2020 for the 2018 target year, it will not be possible to state that the target was achieved if the child mortality rate falls within a variability band but is still a long way from the target, as is the case in this year's Prime Minister's Report.

Adjustment of deaths registered in 2010

In 2010, the Queensland Register of Births, Deaths and Marriages undertook a deaths registration initiative which resulted in the registration of 374 previously unregistered deaths that occurred between 1992 and 2006.⁹ Most of these were deaths Aboriginal

^e For jurisdictional estimates of child mortality 5-year rates are used

^f For national estimates of child mortality single years are used

and Torres Strait Islander people (284). Child mortality data in this report are based on year of registration to align with the national closing the gap reporting. To enable more meaningful interpretation of the trend in child mortality rates we adjust the number of deaths registered in 2010 based on data supplied by the ABS.¹⁰

Change to identification of Aboriginal and Torres Strait Islander deaths

Prior to 2015, Indigenous status of deaths registered in Queensland was ascertained from the Death Registration Form (DRF) and, where this field was left blank, from the Medical Certificate Cause of Death (MCCD). From 2015, Indigenous status has been derived from both the DRF and the MCCD. This administrative change has led to a subsequent increase in the number of deaths that were identified as Aboriginal and Torres Strait Islander and decrease in the number of deaths for which the Indigenous status was 'not stated'.¹¹ Approximately 4% of deaths registered in Queensland that were identified as Aboriginal and Torres Strait Islander in 2015 and 2016 were ascertained using the new methods—that is, approximately 35 deaths annually were identified as Aboriginal and Torres Strait Islander where previously they would have been classified as “not stated” or “non-Indigenous” (ABS, personal communication, 17 November 2017). While this apparent increase in deaths should be kept in mind when interpreting trends in mortality, at this stage the change has not been large enough to affect the overall interpretation of trends.

Abbreviations

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
CVD	Cardiovascular disease
HHS	Hospital and Health Service
PDC	Perinatal Data Collection
RR	Rate ratio

Glossary

Age standardised rates (ASR) provide an indication of the frequency of an event within a population adjusted for the confounding effect of different age structures in the populations (or time periods) being compared. In this report ASRs refer to directly age standardised rates to the Australian standard population 2001 in 5 year age groups to age 65+ years.

Chronic disease is a disease of long duration and generally slow progression which often does not resolve spontaneously and is rarely cured completely. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes contribute significantly to premature mortality for Aboriginal and Torres Strait Islander people.

External causes refer to those disease groups used in International Classification of Diseases 10th Edition Australian Modification (ICD-10-AM) classification developed in Australia by the National Centre for Classification in Health, which was based on the World Health Organisation ICD-10. External causes include, but are not limited to, injury, poisoning, burns and trauma.

‘Gap’ refers to the rate difference between Aboriginal and Torres Strait Islander and non-Indigenous populations. For trend analyses, references to the widening or narrowing of the gap refer to changes in the age standardised rate difference over time.

Health gap refers to the difference between the burden of disease estimates for Aboriginal and Torres Strait Islander Australians in a given calendar year and what the estimates would have been if Aboriginal and Torres Strait Islander Australians had experienced mortality and disability at the level of the total Australian population.

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

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

Hospital and Health Services are statutory agencies established and funded by the Queensland Government to deliver a range of integrated services, including hospital inpatient, outpatient and emergency services, community and mental health services, aged care services, public health and health promotion programs.

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

Life expectancy measures the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout their lifetime. In this report life expectancy refers to life expectancy at birth.

Low birth weight is defined as less than 2500 grams. Low birth weight constitutes a risk factor for diseases of early childhood and chronic disease in later life.

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

Neonatal deaths refer to deaths within the first 28 days after birth.

Preventative health refers to services designed to protect and promote health and to prevent illness, injury and disability.

Primary health care is the first point of contact between the community and the health system. Primary healthcare in Queensland is provided through:

- general practitioners
- government operated community health services
- primary healthcare clinics
- the Royal Flying Doctor Service
- public and private dental health services
- Aboriginal and Torres Strait Islander community-controlled health services.

It also includes some outpatient services provided by a general hospital. Primary healthcare services provide clinical and community healthcare, and facilitate access to specialist health services.

Targeted health services refer to services and programs that are designed and provided for Aboriginal and Torres Strait Islander people.

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