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Australia's Indigenous ill–health and national social policy implications: Indigenous state of health, socio–economic contexts and recent policy developments

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Zusammenfassung

Die Dissertation untersucht zunächst den Gesundheitszustand der australischen Aborigines. Im Vergleich zu der restlichen australischen Bevölkerung leiden sie an hoher Morbidität und Mortalität - ihre durchschnittliche Lebenserwartung ist 15 bis 20 Jahre geringer.

Wie in dieser Arbeit aufgezeigt, gehören Aborigines überwiegend der untersten sozialen Schicht der australischen Bevölkerung an. Unzulängliche Lebensverhältnisse, vergleichsweise schlechte Bildung, hohe Arbeitslosigkeit und geringes Einkommen vieler Aborigines wirken sich negativ auf ihren Gesundheitszustand aus.

Mit dem Ziel die sozio-ökonomischen Verhältnisse und folglich den Gesundheitszustand der Aborigines zu verbessern, ergreift die australische Bundesregierung Maßnahmen in den Bereichen Wohnungs-, Bildungs-, Beschäftigungs- und Gesundheitspolitik. Die aktuelle Situation wird ausführlich dargestellt, spezifische Ziele und Maßnahmen genannt und deren Umsetzung und Auswirkungen diskutiert.

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Abbreviations and acronyms

$	Australian Dollar
ABS	Australian Bureau of Statistics
ABSEG	Aboriginal Secondary Grants Scheme
ABSTUDY	Aboriginal Study Assistance Scheme
ACCHSs	Aboriginal Community–Controlled Health Services
ACT	Australian Capital Territory
ADC	Aboriginal Development Commission
AHDG	Aboriginal Health Development Group
AHL	Aboriginal Hostels Limited
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHMRC	Aboriginal Health and Medical Research Council
AHPL	After–housing poverty line
AHS	Australian Housing Survey
Aids	Acquired immune deficiency syndrome
AIH	Australian Institute of Health
AIHW	Australian Institute of Health and Welfare
ALP	Australian Labor Party
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ANAO	Australian National Audit Office
ANIHI	Agreement on National Indigenous Housing Information
ARIA	Accessibility/Remoteness Index of Australia
ASSPA	Aboriginal Student Support and Parent Awareness
ATAS	Aboriginal Tutorial Assistance Scheme
ATSIC	Aboriginal and Torres Straight Islander Commission
BDP	Business Development Programme
BFS	Business Funding Scheme
BMI	Body Mass Index
CAEPR	Centre for Aboriginal Economic Policy Research
CAP	Crisis Accommodation Programme
CDC	Commercial Development Corporation
CDEP	Community Development Employment Projects Scheme
CHINS	Community Housing and Infrastructure Needs Survey
CHIP	Community Housing and Infrastructure Programme
CPI	Consumer Price Index
CSHA	Commonwealth–State Housing Agreement
DAA	Commonwealth Department of Aboriginal Affairs
DAS	Commonwealth Department of Administrative Services
DEST	Commonwealth Department of Education, Science and Training
DETYA	Commonwealth Department of Education, Training and Youth Affairs
DEET	Commonwealth Department of Employment, Education and Training

DEETYA	Commonwealth Department of Employment, Education, Training and Youth Affairs
DEWR	Commonwealth Department of Employment and Workplace Relations
DEWRSB	Commonwealth Department of Employment, Workplace Relations and Small Business
DFAT	Commonwealth Department of Foreign Affairs and Trade
DHAC	Commonwealth Department of Health and Aged Care/Ageing
FaCS	Commonwealth Department of Family and Community Services
FTB Part A	Family Tax Benefit Part A
GDP	Gross Domestic Product
GP	General medical practitioner
HBV	Hepatitis B virus
HCINS	Housing and Community Infrastructure Needs Survey
HIPP	Health Infrastructure Priority Projects Scheme
HIV	Human immunodeficiency virus
HPLs	Henderson poverty lines
HREOC	Human Rights and Equal Opportunity Commission
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
HRSCFCA	House of Representatives Standing Committee on Family and Community Affairs
IBA	Indigenous Business Australia
IBIP	Indigenous Business Incentive Programme
ICD–9	International Classification of Diseases, ninth revision
ICIHI	Independent Commission on International Humanitarian Issues
IECBs	Indigenous Education Consultative Bodies
IEDA	Indigenous Education Direct Assistance
IEP	Indigenous Education Policy
IESIP	Indigenous Education Strategic Initiatives Programme
IEU	Indigenous Education Unit
IMR	Infant mortality rate
ISBF	Indigenous Small Business Fund
LP	Liberal Party of Australia
MBS	Medicare Benefits Schedule
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
NAC	National Aboriginal Conference
NACC	National Aboriginal Consultative Committee
NACCHO	National Aboriginal Community–Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
NATSIEP	National Aboriginal and Torres Strait Islander Education Policy
NATSIS	National Aboriginal and Torres Strait Islander Survey

NHDA	National Housing Data Agreement
NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NIELNS	National Indigenous English Literacy and Numeracy Strategy
NIHIIC	National Indigenous Housing Information Implementation Committee
NP	National Party of Australia
NSW	New South Wales
NT	Northern Territory
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
PBS	Pharmaceutical Benefits Scheme
PHCAP	Primary Health Care Access Programme
PHOFAs	Public Health Outcome Funding Agreements
Qld.	Queensland
SA	South Australia
SAAP	Supported Accommodation Assistance Programme
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
$SMR_{morbidity}$	Standardised Morbidity Ratio
$SMR_{mortality}$	Standardised Mortality Ratio
SRA	Supplementary Recurrent Assistance
STEP	Structured Training and Employment Projects
TAFE	Technical and further education
TAP	Training for Aboriginals and Torres Strait Islanders Programme
Tas.	Tasmania
TOP	Targeted Outcomes Programme
TPF	Tripartite forum
UN	United Nations
VEGAS	Vocational and Educational Guidance for Aboriginals Scheme
Vic.	Victoria
WA	Western Australia
WHO	World Health Organisation
WHR	Waist–to–hip ratio

1 Executive Summary

This paper gives an insight into the current state of health of the Indigenous people of Australia and reports and discusses social policy measures that have been taken by the Commonwealth government to improve Indigenous[1] health since the late 1980s when many national strategies were initiated.

Health for Indigenous people not only includes physical well–being, but also requires socio–economic and cultural well–being of the individual and the community. This holistic view of health will be considered in this work.

The paper describes important population characteristics of the Indigenous people of Australia: Indigenous people are a minority in Australia, forming around 2 per cent of the total population; they live evenly spread throughout remote, rural and urban areas; the median age of Indigenous people is 14 years younger than that for the total Australian population; and they generally live in larger households which often include more than one family.

The state of health of the Indigenous people of Australia will be expounded from indicators of health, such as life expectancy, mortality and morbidity. The health of Indigenous people is far worse than that of other Australians. Life expectancy for Indigenous people is around 15 years less than that for non–Indigenous Australians; mortality and morbidity rates from all causes together are between two and three times higher; and mortality and morbidity rates from selected causes are up to nine times higher. Some diseases, like endocrine and metabolic diseases[2], are much more common among Indigenous people. These, and the most prevalent diseases in absolute numbers in the Indigenous population, will be examined in further detail.

The immediate causes of Indigenous ill–health will be investigated. Environmental health[3] infrastructure, housing conditions, inadequate access to health services and a generally unhealthy lifestyle all contribute to Indigenous ill–health.

However, these are not the only impediments to good health. Socio–economic disadvantage that shows in low levels of home ownership, poor education, high unemployment and poverty is the fundamental cause of Indigenous ill–health. An

[1] Note: The terms Indigenous people and Aboriginal and Torres Strait Islander people of Australia are used synonymously throughout this paper, relating to all Indigenous peoples of Australia, including Torres Strait Islander people.

[2] See Medical Glossary, p. 256.

[3] See Technical Glossary, p. 250.

analysis of the Indigenous status quo in these areas shows that Indigenous people are disadvantaged and that this disadvantage also impacts Indigenous health.

After having established these connections between causes and effects, Commonwealth policy in Indigenous affairs will be investigated. Particularly developments in health, housing, education and employment are researched as they play an important role in Indigenous health. The paper explores aims, strategies and programmes and, where possible, evaluates outcomes.

Indigenous empowerment in policy decision making, increased access to services, the involvement of the community and Indigenous individuals in service delivery, improved coordination and the efficiency and effectiveness of services and organisations are central strategies in Indigenous social policy.

The National Health Strategy offered an analysis of the status quo of Indigenous health and proposed a comprehensive strategy that centred on a holistic view of health, combining health and environmental health elements. However, implementation was incomplete. Furthermore, agreements aim at enhancing the cooperation and coordination between the different levels of governments and the government and organisations. Very recently, there has been a new approach in service delivery to Indigenous people. The Coordinated Care Trials opened up the way for the Primary Health Care Access Package, which includes elements of pooled funding and community empowerment in service delivery and planning. However, PHCAP is still in its planning process.

The Community Housing and Infrastructure Policy emphasises improvements in environmental health and the strengthening of the role of the Indigenous community housing organisations. In 2001, the housing ministers of the Commonwealth, states and territories adopted a 10–year plan to improve Indigenous housing through better coordination of services and service providers and confirmed the role of the Indigenous housing organisations.

The National Aboriginal and Torres Strait Islander Education Policy had the goal of educational equity between Indigenous and non–Indigenous Australians by the year 2000. This goal was reaffirmed in later national strategies and declarations. Nevertheless, this goal could not yet be achieved despite some improvements in Indigenous educational participation and attainment. Education is delivered to Indigenous people almost exclusively as a mainstream programme. Community–

controlled schools are very rare. Indigenous involvement and empowerment is limited in the education sector, even though they are official targets.

Employment policies aim at reducing Indigenous unemployment to non–Indigenous rates, specifically in the private sector and self–employment. Government assistance is centred upon an improved access to mainstream assistance for Indigenous people, such as Job Network services, and better transition of Indigenous Community Development Employment Projects Scheme participants to the mainstream labour market.

There have been improvements in Indigenous health and socio–economic status in some areas, in others these goals are yet to be achieved.

The strategies implemented encountered many problems and were not always completed. Cultural acceptability of services was not always given and Indigenous empowerment and involvement limited. Also, assimilationist tendencies are evolving: Indigenous people are encouraged to use mainstream services, especially in urban areas. Often, the policies did not contain detailed information on how they were to be implemented, which led to uncoordinated and slow policy implementation. Insufficient levels of funding added further constraints in the implementation of policies and strategies.

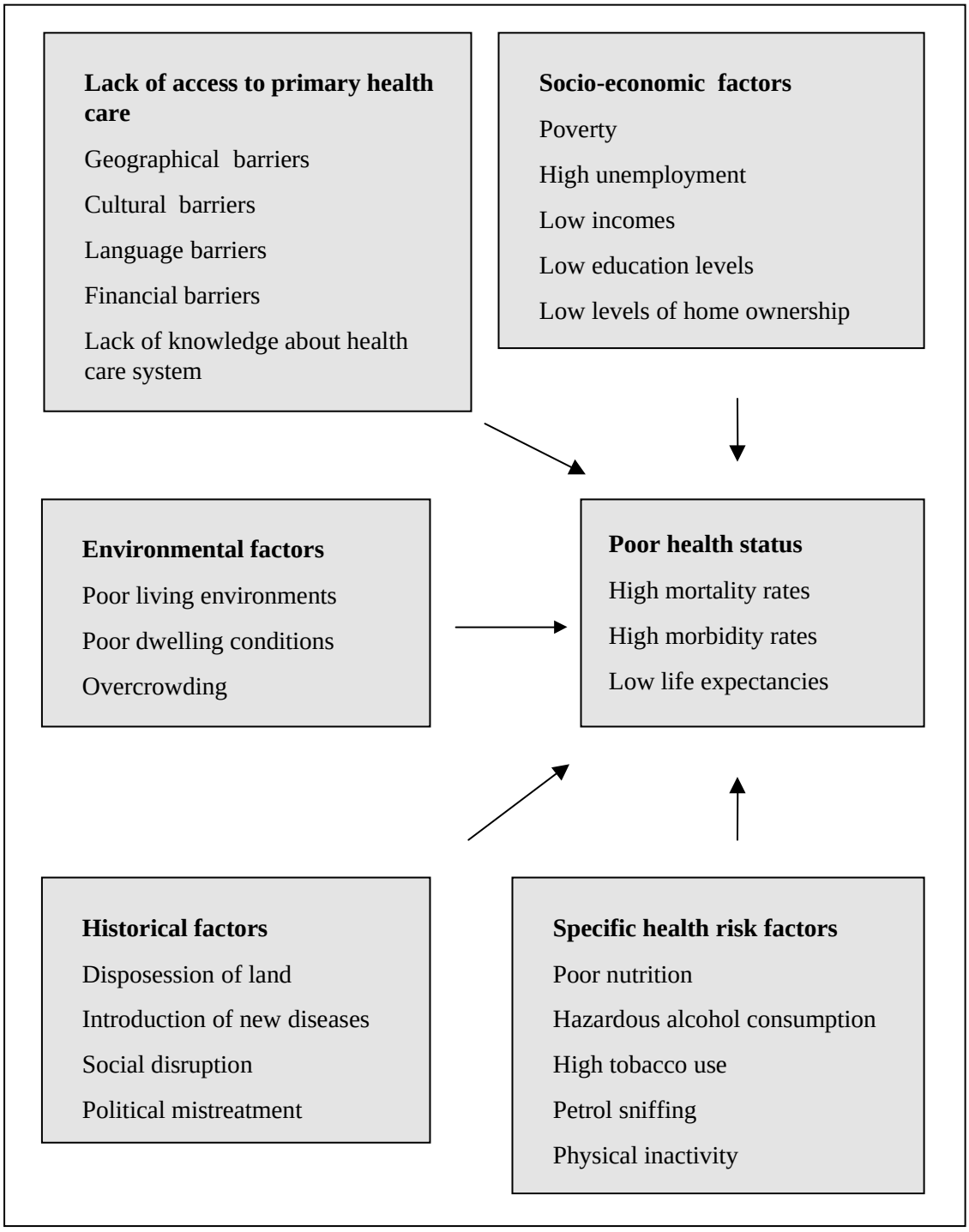


Figure 1: Factors impacting Indigenous health

2 Introduction

2.1 Definition of health

The meaning of health will be examined from a general and Indigenous perspective.

The World Health Organisation (WHO 1998a, p. 1) defines health as follows:

> A state of complete physical, social and mental well–being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction for race, religion, political belief, economic or social condition.

This definition includes the rights of every individual to adequate food, water, clothing, housing, health care, education and social services. The statement implies that access to health services is a necessary but not sufficient condition for realising health improvements (WHO 1998a, p. 20).

WHO introduced its concept of Health for All in 1978 and continued it in 1998 with Health for all in the 21st Century, which supported the following goals (WHO 1998a, p. 24):

- an increase in life expectancy and in the quality of life for all;
- an improved equity in health between and within countries; and
- access for all to sustainable health systems and services.

These goals are fully applicable for future Australian Indigenous health development. Directly relating to Indigenous health, the National Aboriginal Health Strategy (NAHS) Working Party (1989, p. ix) asserted that:

> Health to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self–esteem and of justice. It is not merely a matter of the provision of doctors, hospitals, medicine or the absence of disease and incapacity.

The National Aboriginal Community–Controlled Health Organisation (NACCHO) further stressed the importance of the health and well–being of the whole community and described health from an Indigenous perspective as:

> … not just the physical well–being of an individual but refers to the social, emotional and cultural well–being of the whole community in which each individual is able to achieve their full potential as a human being of their community. (NACCHO 1997, p. 5)

Health to Indigenous people is a multi–dimensional concept. Improved health service delivery is important but not sufficient. The health and well–being of the individual and the community depends on their living in harmony with the physical and social environment.

2.2 Identification of Aboriginal and Torres Strait Islander people

According to the Commonwealth working definition (Gray 1986, p. 8) an Aboriginal or Torres Strait Islander person is someone who:

- is of Aboriginal or Torres Strait Islander descent,
- identifies as an Aboriginal or Torres Strait Islander person and
- is accepted as an Aboriginal or Torres Strait Islander by the community in which he or she lives.

Commonwealth and many other government agencies use this definition. It is a social rather than a genetic definition, comprising three elements: descent, self–identification and community acceptance (ABS 1997b, p. 5). Other statistical data collections record people as Aboriginal or Torres Strait Islander, based on only the first two of the three criteria. The standard question used by the Australian Bureau of Statistics[1] to establish Indigenous status focuses on descent and self–identification, rather than community acceptance:

> Are you of Aboriginal or Torres Strait Islander origin? (For persons of both Aboriginal and Torres Strait Islander origin, mark both "Yes" boxes.)
> ( ) No
> ( ) Yes, Aboriginal
> ( ) Yes, Torres Strait Islander

[1] See Explanatory Notes, p. 246.

2.3 Statistical data quality and availability

Comprehensive national Indigenous health statistics are essential to adequately assess the Indigenous health status and monitor developments in Indigenous health. Social policy measures rely on dependable statistics in Indigenous health to set priority areas of concern, observe changes in Indigenous health and report on policy effectiveness and efficiency (Altman 1992, p. 1). However, while extensive data exists about the health of the total Australian population, the data available about Aboriginal and Torres Strait Islander people is limited (ABS & AIHW 1997, p. 114; Tesfaghiorghis 1996, p. 28). Surveys and administrative datasets often do not apply adequate Indigenous identifiers, which results in inaccurate and incomplete levels of identification (ANAO 1998, p. 24; Gray 1986, p. 5). In addition, exact Indigenous population estimates are needed to prevent over– or underestimation of statistical data sets (Thomson 1989, p. 38).

The main sources of Indigenous statistics are the five–yearly national Census of Population and Housing[1], specific Indigenous surveys, such as the National Aboriginal and Torres Strait Islander Survey[2] from 1994, and administrative datasets, despite ongoing identification problems.

[1] See Explanatory Notes, p. 246.
[2] See Explanatory Notes, p. 248.

3 Aboriginal and Torres Strait Islander people

3.1 Population characteristics

3.1.1 Population size

The 1996 census estimated that Aboriginal and Torres Strait Islander people comprised 2.1 per cent (386,049) of the total population of Australia (18,310,700). This represented an increase of 40,668 since the 1991 census and translates into an average annual growth rate of 2.3 per cent, which is higher than the rate for the total Australian population of 1.2 per cent (Castles 1991, p. 3; McLennan 1998, p. 2).

The magnitude of this increase can be explained only partially by the higher Indigenous birth rates and the fact that many children of Indigenous origin have one parent, rather than two, of Indigenous origin. Additionally, much of the change appears to be the result of an increasing willingness of Aboriginal and Torres Strait Islander people to declare their Indigenous origin (ABS 1997b, p. 9; ABS 1999b, p. 53; McLennan 1998, p. 1).

In 1996, around 11 per cent of the total Indigenous population was either from Torres Strait Islander descent or both Torres Strait Islander and Aboriginal descent (ABS 1997b, p. 65).

3.1.2 Age profile

The Aboriginal and Torres Strait Islander population has a younger age profile than the Australian population as a whole.[1] In 1996, the median[2] age of the total Indigenous population was 20 years, compared with 34 years for the total Australian population (ABS 1997b, p. 6). The median age for Indigenous males was 19, and 21 for females. The total Australian population median ages were 33 for males and 35 for females. According to the 1996 census, 40.0 per cent of the Aboriginal population was under 15 years, while 2.6 per cent were aged 65 years or over. In the total Australian population, 21.4 per cent were under 15 years and 12.0 per cent were over 65 years (McLennan 1998, p. 2).[3]

The age profile reflects the high mortality rate of the Indigenous population (ABS 1998, p. 2) and an extremely high number of births to young Aboriginal and Torres Strait

[1] Note: Statistical comparisons are made between Indigenous and non–Indigenous people or between Indigenous people and the total Australian population. In the latter case, differences will always be slightly smaller as Aborigines form part of the total population of Australia.

[2] See Technical Glossary, p. 253.

[3] See Table 1, p. 9.

Islander mothers (Thomson 1991, p. 40). For Indigenous women aged 20–24 years, the average number of children conceived is three times that of non–Indigenous women in the same age bracket.

Table 1: Indigenous and total Australian population age characteristics, 1996

	Indigenous people	All Australians
Median age (years)	20.1	34.0
0–14 years (%)	40.0	21.4
65 years and over (%)	2.6	12.0

Source: After McLennan 1998, p. 2

Because of the different age profiles of the Indigenous and the total Australian population, statistical comparisons between the two groups cannot be made without taking age into account, either by age standardisation[1] or the use of age–specific rates[2].

3.1.3 Geographical distribution in Australia

Distribution between states and territories

In the northern and central regions of the country, Indigenous people form a large proportion of the local population. Recently, however, the growing majority of Aboriginal and Torres Strait Islander people live in urban areas in the east of Australia (ABS 1999, p. 2).

In 1996, the states of New South Wales and Queensland had the highest estimated population of Aboriginal and Torres Strait Islander people with 28.5 per cent and 27.2 per cent respectively of the total Indigenous population.[3] Nevertheless, as a proportion of the total state population, Indigenous people only represented 1.8 per cent in New South Wales and 3.1 per cent in Queensland.

The largest proportion of the total state or territory population was found in the Northern Territory, where Indigenous people accounted for 28.5 per cent of the total population (ABS 1998, p. 1).

[1] See Technical Glossary, p. 249.
[2] See Technical Glossary, p. 249.
[3] See Table 2, p. 10.

Table 2: Geographical distribution of Indigenous people by states and territories, 1996

State/territory	Resident Indigenous population (thousand)	Proportion of total Australian Indigenous population (%)	Indigenous proportion of state/territory population (%)
New South Wales	109.9	28.5	1.8
Victoria	22.6	5.9	0.5
Queensland	104.8	27.2	3.1
South Australia	22.1	5.7	1.5
Western Australia	56.2	14.6	3.2
Tasmania	15.3	4.0	3.2
Northern Territory	51.9	13.4	28.5
ACT	3.1	0.8	1.0
Australia	**386.0**	**100.0**	**2.1**

Source: After McLennan 1998, p. 7

Distribution between urban, rural and remote areas

The Indigenous population is spread throughout remote[1], rural and urban areas. According to 1996 census figures (McLennan 1998, p. 5):[2]

- 30 per cent lived in cities with more than 100,000 inhabitants;
- 42 per cent lived in towns and other urban areas (1,000 to 99,999 inhabitants); and
- 27 per cent lived in rural or remote areas (fewer than 1,000 inhabitants).

The percentage of Indigenous people living in urban areas and cities is growing steadily. From 1991 to 1996, this percentage increased from 67.7 per cent to 72.6 per cent (DFAT 2002a, p. 1; HRSCAA 2000, p. 156). This compares to 86 per cent for the total Australian population in 1996 (HRSCFCA 1999, p. 1). This urban drift is a result of Indigenous people searching for work, their need to access urban–based services or their intention to join family who moved there earlier.

[1] See Technical Glossary, p. 254.
[2] See Table 3, p. 11.

Table 3: Distribution of the Indigenous and total Australian population by urbanisation, 1996

Geographic area	Indigenous population (%)	Total Australian population (%)
Cities and major urban area (more than 100,000 people)	30.3	62.7
Other urban area (1,000 - 99,999 people)	42.3	23.3
Rural and remote area (fewer than 1,000 people)	27.4	14.0
Total	100.0	100.0

Source: McLennan 1998, p. 5

The distribution according to the Accessibility/Remoteness Index of Australia[1] (ARIA) shows slightly different results due to differences in the definition of the accessibility categories. In 1996, almost two–thirds of Indigenous people lived in highly accessible and accessible locations, compared to 94 per cent of non–Indigenous people.

Compared to non–Indigenous Australians, Aboriginal and Torres Strait Islander people were still more likely to live in remote or rural areas, with almost one in five Indigenous people living in areas classified as very remote compared with less than one in one hundred of the total Australian population in 1996 (ABS & AIHW 2001, p. 16).[2]

Table 4: Indigenous and non–Indigenous population distribution by Accessibility/Remoteness Index of Australia region, 1996

Accessibility category	Indigenous people (%)	Non-Indigenous people (%)
Highly accessible	43.7	82.6
Accessible	20.0	11.6
Moderately accessible	10.2	3.8
Remote	7.6	1.3
Very remote	18.5	0.7
Total	100.0	100.0

Source: Commonwealth Grants Commission 2001a, p. 268

There are big differences between the states and territories regarding the percentage of Indigenous people living in rural and remote areas. In 1994, 12.8 per cent of the state

[1] See Technical Glossary, p. 249.
[2] See Table 4.

Indigenous population of New South Wales lived in rural or remote areas, whereas in the Northern Territory 58.9 per cent of the territory Indigenous population did so (McLennan 1996a, p. 142).

3.1.4 Household composition

On average, Indigenous households[1] are larger (3.6 persons in the 1996 census) than non–Indigenous households (2.7 persons) (McLennan 1998, p. 20).[2] A much greater percentage of Indigenous households has five or more resident persons. Indigenous households also have, on average, a larger number of children than non–Indigenous Australian households. The adults are younger, have lower income and education levels and are less likely to be employed than non–Indigenous Australians (Daly & Smith 1999, p. v).

Table 5: Distribution of Indigenous and non–Indigenous households by number of resident persons, 1991 and 1996

	1991		1996	
Number of resident persons	**Indigenous households** (%)	**Non-Indigenous households** (%)	**Indigenous households** (%)	**Non-Indigenous households** (%)
1	10.4	21.1	13.4	24.0
2	20.9	31.6	20.9	30.7
3	19.4	17.3	18.8	16.4
4	18.5	17.6	18.7	17.2
5	12.8	8.5	12.7	8.2
6	9.0	3.0	8.1	2.7
7	3.1	0.6	2.8	0.6
8 or more	5.9	0.3	4.6	0.2
Total	100.0	100.0	100.0	100.0
Average	**3.7**	**2.7**	**3.6**	**2.7**

Source: After Smith & Daly 1999, p. 4

Indigenous households are more likely to comprise more than one family compared with other Australian households. In 1996, 6 per cent of Indigenous homes were multiple family households compared with 1 per cent of other households (McLennan

[1] See Technical Glossary, p. 252.
[2] See Table 5.

1998, p. 19). They are also more likely to be multigenerational (Anderson & Sibthorpe 1996, p. 128).

Lone–person households are less common among Indigenous people than the total Australian population (13 per cent compared to 24 per cent in 1996).[1]

However, Indigenous households are more likely to contain single–parent families. In 1994, 20 per cent of all Indigenous families were single–parent families, compared with 12 per cent of all Australian families (Madden 1995, p. 1).

Adult mortality is an important factor driving family formation (and dissolution) among the Indigenous households because children are forced to live with relatives or friends (Hunter, Kennedy & Smith 2001, p. 1).

Table 6: Distribution of Indigenous and non–Indigenous households by household type, 1996

Household type	Indigenous households (%)	Non–Indigenous households (%)
One–family household	80.3	74.9
Lone–person household	13.4	24.0
Multiple–family household	6.3	1.1
Total	100.0	100.0

Source: After McLennan 1998, p. 19

3.2 Indigenous culture

3.2.1 Social and cultural values

Knowledge of Aboriginal and Torres Strait Islander social and cultural issues is essential for non–Indigenous people to understand the Indigenous way of thinking and behaviour.

Kinship

Aboriginal kinship and social systems are very complex and are still the foundation of social life in Indigenous communities today (Macdonald 1998, p. 301; Tonkinson 1987, p. 210). Kinship coordinates all social interaction (Bourke & Edwards 1998, p. 108) and responsibilities arising from kinship are very important (Anderson 1988, p. 2). With some exceptions, this also applies to Aborigines living in cities and urban areas (Bourke

[1] See Table 6.

& Edwards 1998, p. 112). Traditionally, Aboriginal social interactions were dependent on the system of extended kinship, in which aunts, uncles and cousins are seen as part of the immediate family.

However, there has been a disruption of Indigenous family structure since the European settlement. The deaths of many Indigenous people in the years after the colonisation and the removal of Indigenous children from their families have eroded Indigenous family structures (Burden 1998, p. 194).

Language

Before European settlement, about 200 different Indigenous languages were spoken throughout Australia (ATSIC 1998d, p. 8). More than half of these languages are now extinct, and only about 60 Aboriginal languages are still in use (ATSIC 2001b, p. 6). Today, the majority of Indigenous people speak English as their main language. In 1994, 80 per cent of Indigenous people age 13 and over reported that English was their main language, 14 per cent spoke an Indigenous language, and the rest spoke Aboriginal English[1] (Madden 1995, p. 4). However, there are regional variations: in the Northern Territory, for example, only 32 per cent spoke English as their main language.

The Indigenous way of speaking English, using vocabulary and constructing sentences is very different. Furthermore, the adherence to Indigenous cultural norms and mannerisms, such as not addressing topics directly or not making direct eye contact with people while speaking, shows how the Indigenous people have adapted English to fit their lifestyles (Anderson 1988, p. 26).

Relationship to land

Aborigines have an intrinsically different relationship to land than Europeans have. They "see themselves as custodians of particular tracts of land" (Bartlett 1998, p. 152). Aborigines use land as a source of food and shelter, but they do not see themselves as the owners of the land. Their spirituality is based on their land and its creation stories at the time of "The Dreaming" [2] (George & Davis 1998, p. 317; NAHS Working Party 1989, p. ix).

Many Indigenous people still recognise a certain area of land as their homeland[3], which is an area to which people have ancestral or cultural links.

[1] See Technical Glossary, p. 249.
[2] See Technical Glossary, p. 250.
[3] See Technical Glossary, p. 251.

In the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS), 75 per cent of Indigenous people age 13 and over recognised an area as their homeland and 30 per cent of Indigenous people lived on their homeland (Madden 1995, p. 4).

Religion

Historically, Aboriginal religion was not identical throughout Australia, as there was limited interaction between tribal groups. Nevertheless, the bond with their ancestral land and the concept of The Dreaming were common features. The advent of Christianity eliminated the traditional religion in many areas; in a few others, some attempted to combine Christianity with Aboriginal traditional beliefs and practices.

Today, most Indigenous people are Christians. Only about 9 per cent of the Indigenous population in the Northern Territory still practise their traditional religion. In the other states the numbers are even smaller, with 4 per cent in Western Australia and less than 1 per cent in the remaining states (McLennan 1998, p. 75).

3.2.2 Traditional health care and medical practice

Traditional medicine is practised very rarely in Australia today. 8 per cent of Indigenous persons interviewed in the 1994 NATSIS reported having used traditional medicine in the six months prior to the interview (McLennan 1996b, p. 19).

The traditional hunter–gatherer lifestyle of Indigenous peoples in Australia was made impossible after the invasion of the Europeans; their traditional medical practice also was damaged because it was based on this lifestyle (Saggers & Gray 1991, p. 52). Another factor for the diminished usage of traditional medicine was that the Europeans introduced many new illnesses against which traditional medicine was powerless.

Traditionally, Aborigines saw health as a result of harmony with the environment. Illness was explained as disturbance of this balance (NAHS Working Party 1989b, p. 7). Aboriginal and Torres Strait Islander people recognised that ill–health was a result of various factors, including physical, social, cultural, emotional and spiritual aspects. Therefore, treatment encompassed all of these components (Saggers & Gray 1991, p. 42). Indigenous people believed that some illnesses were caused by supernatural forces such as a violation of taboos or witchcraft. Therefore, treatment involved the ritual healing by Aboriginal doctors and traditional healers who used their supernatural healing powers to free the patient of these supernatural forces.

However, this does not mean that Indigenous people denied natural disease origins. In Western Australia, for example, people believed that skin disease could be caused by

unbalanced nutrition. To cure the disease, they would visit relatives in a different location to benefit from a change of diet (Bates & White 1985, p. 116). Other natural illnesses would be treated with herbal medicines, animal products, the application of external remedies such as heat, smoke, steam or ochre and mechanical treatment, for example massages or the encasing of fractures in clay.

Aboriginal and Torres Strait Islander people were also very conscious of the role that social conflict played in ill–health. Often, conflicts between people in a group would be diagnosed as the cause of illnesses.

It is likely that traditional medicine will be revived and regain importance if Indigenous people are encouraged and enabled to live in traditionally orientated communities, as knowledge of the traditional medical system is also an important factor of Aboriginal identity.

3.2.3 Social and cultural disruption

The health problems that Indigenous people suffer today cannot be separated from their past experience. The dispossession of their land led to a loss of economic independence and ensuing poverty. Aborigines are unable to lead their traditional lifestyle as hunters and gatherers. This had an effect on their social kinship system as well as direct physical effects through changes in nutrition and a lack of exercise (Bartlett 1998, p. 176). The lack of access to their traditional land also leads to a breakdown of their culture and spiritual health as many cultural and spiritual activities are related to the land (HRSCFCA 2000, p. 69). Moreover, the loss of language, family ties and culture also resulted in low self–esteem and problems in self–identification.

Aggravating the situation is the current–day ignorance of the true history of Indigenous people since the beginning of colonisation. Indigenous people still suffer from discrimination and racism. Racism was the basis of terra nullius[1] – the idea that a land is empty even when people live there. Today, racism can be seen in the refusal to acknowledge the injustices perpetrated upon Indigenous people. Furthermore, discrimination continues to negatively impact many aspects of life, such as employment, education, housing and health (Preparatory Committee of the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance 2001, p. 7).

[1] See Technical Glossary, p. 254.

3.3 "Fourth World community"

3.3.1 Definition

Fourth World communities exist within industrialised nations (such as Australia or the United States of America) or developing countries (for example South American nations) (O'Neil 1986, pp. 119–120). The United Nations defined a Fourth World community as follows:

> Composed of the existing descendants of the peoples who inhabited the present territory of a country wholly or partially at the time when persons of a different culture or ethnic origin arrived there from other parts of the world, overcame them and, by conquest, settlement or other means, reduced them to a non–dominant or colonial situation; who today live more in conformity with their particular social, economic and cultural customs and traditions than with the institutions of the country of which they now form a part, under a state structure which incorporates mainly the national, social and cultural characteristics of other segments of the population which are dominant. (ICIHI 1987, p. 7)

This definition can easily be applied to the Indigenous people of Australia, even though many Indigenous people do not live according to traditional customs due to social, cultural and economic disruption caused by the invasion of European settlers.[1]

Indigenous health profiles, especially those of young Indigenous Australians, resemble more those found in the developing world than those in industrialised countries (Waterford 1982, p. 9). The prevalence of infectious diseases during childhood is similar to the prevalence of diseases in Third World countries (Beck 1985, p. 10; NSW Department of Health 1991, p. 7). Many Indigenous Australians suffer from health problems predominantly found in developing countries, such as infectious and parasitic diseases, rheumatic heart disease[2] and genitourinary diseases. Additionally, they experience high rates of so–called lifestyle diseases normally found in developed countries. These are coronary heart disease, diabetes and respiratory diseases (Deeble et al. 1998, p. 49).

3.3.2 Comparison with other Fourth World communities

The state of health of the Indigenous people of Australia is by far worse than that of other Indigenous people in the United States, Canada and New Zealand. Life

[1] For details see Chapter 4.1, p. 20.
[2] See Medical Glossary, p. 258.

expectancy at birth is around 10 years lower among Australian Indigenous people than among other Indigenous people within first world countries (Kunitz 1994, pp. 16, 25).[1]

Table 7: Life expectancy at birth of various Indigenous and non–Indigenous populations, 1980s

	Indigenous population		Non-Indigenous population	
Country	**Male**	**Female**	**Male**	**Female**
United States, 1980	67.1	75.1	70.7	78.1
Canada, 1982–1985	64.0	72.8	72.4	80.1
New Zealand, 1980–1982	63.8	68.5	70.8	77.0
Australia, 1985	54.0	61.6	72.8	79.1

Source: Kunitz 1994, p. 16

Despite historical dispossession and depopulation, progress in New Zealand, Canada and the United States shows that improvements in health status of Indigenous people are possible (Deeble et al. 1998, p. 49). These countries managed to reduce the gap in life expectancy between their Indigenous population and the rest of the population to three to eight years (AMA 2000, p. 2), whereas the Indigenous people of Australia still experience a life expectancy of about 15 to 20 years less than that of non–Indigenous Australians (DHAC 2000c, p. 266).

Table 8 confirms the poor health status of Indigenous Australians compared to that of Indigenous peoples of New Zealand and the United States and to the total Australian population.

Table 8: Ratios of standardised mortality ratios for Australian Indigenous people versus Maori, Native American and all–Australian rates, 1990 to 1994 (a)

Cause of death	**Maoris/ New Zealand**	**Native Americans/ United States**	**Total population/ Australia**
Diseases of the circulatory system	1.5	2.6	2.5
Diseases of the respiratory system	3.1	4.5	6.6
Injury and poisoning	2.8	1.3	4.0
Endocrine diseases	2.4	3.2	8.5
All causes	**1.9**	**2.4**	**3.1**

Note:
(a) Mortality rates are standardised to the world standard population in 1980.

Source: After Ring & Firman 1998, p. 531

[1] See Table 7.

In the period from 1990 to 1994, Indigenous Australians died three times more frequently from respiratory diseases than Maoris, 4.5 times more often than Native Americans and 6.6 times more often than all Australians. Mortality from all causes for Indigenous Australians was 1.9 times higher than for Maoris, 2.4 times higher than for Native Americans and 3.1 times higher than for the total Australian population.

4 Health status of the Indigenous people of Australia

The poor health status of the Indigenous population today is a result of a variety of linked factors. Most Indigenous people do not live in harmony with their physical, social and cultural living environment (Waterford 1982, p. 8). In order to fully understand the health, economic and social issues that affect Aboriginal people today, it is important to understand the impact of colonisation on Aboriginal people.

4.1 Indigenous health throughout history

4.1.1 Pre–colonial times

Due to their lifestyle as hunters and gatherers, Aborigines had frequent exercise and were seldom overweight. They lived in small groups which discouraged the spread of infectious diseases (Gray, Trompf & Houston 1991, p. 85). Infant mortality is thought to have been rather high, but those who survived early infancy probably were resistant and healthy in their later life (Coombs 1994, p. 56).

All in all, the health of Indigenous people is likely to have been better than that of the Europeans at the time (Franklin & White 1991, p. 1; Hodgson & Wahlqvist 1992, p. 1). Lifestyle diseases that are predominant among Indigenous adults today were practically non–existent.

4.1.2 Health since colonisation

As there is no accurate means of estimating the numbers of the Indigenous population at the time of the European arrival, estimates vary and are impossible to validate. Today's estimates range from 300,000 to more than one million. Many scholars now accept a figure of 500,000 to 750,000 (Healey 1998, p. 1, Palmer & Short 2000, p. 264; Radcliffe–Brown 1930, pp. 687–89; White & Mulvaney 1987, p. 117).

Whatever the original population estimate, it is evident that the Aboriginal population rapidly declined during the years after colonisation to less than 70,000 by the 1930s (Borrie, Smith & de Julio 1975, pp. 200–201; Burden 1998, p. 193).

Hemming (1998, p. 16) describes the arrival of European settlers as the "beginning of great suffering and loss for Aboriginal people." As NACCHO (2000, p. 1) reviews in 2000, this suffering was to last until the very recent past:

> Massacres, restriction of movement, confiscation of land and children, malnutrition, ... intolerable working conditions, low rates of pay, and oppression dotted Aboriginal history until the 1967 referendum which gave

> Aboriginal peoples the right to be recognised as Australian citizens with equal rights to vote.

This massive population decline and obvious deterioration of health was due to three main factors:

- Dispossession of their traditional homelands due to the doctrine of terra nullius (DAA 1987, p. 2) and the following displacement and incarceration of Aboriginal people in mass settlements and reserves and its physical and psychological effects.
- Introduction of new diseases (measles, small pox, diphtheria, tuberculosis, syphilis).
- Political mistreatment and social disruption.

4.1.2.1 Dispossession of traditional land

At the beginning of Australia's colonisation, the Europeans declared Australia as terra nullius — a land belonging to no–one. The European settlers did not grant any land rights to the Australian Indigenous people. Many Aborigines were killed when trying to defend their traditional lands (Frank & White 1991, p. 5); they were hunted, shot and poisoned. Further access to their traditional homelands was denied.

Those who survived were forced to live on mission and government settlements where they were forbidden to speak their native language or to practise their traditional ceremonies (Hemming 1998, p. 30). Aborigines were unable to continue their traditional nomadic hunter–gatherer lifestyle (Burden 1998, p. 195; Coombs 1994, p. 59) and were forced to lead a sedentary one. This lack of physical exercise and poor nutrition decreased their defences against infectious diseases. Aborigines of different origins, speaking different languages, were grouped together causing additional stress (Burden 1998, p. 195). Overcrowding and inadequate housing conditions were ubiquitous and sewerage and waste disposal almost non–existent creating an unhygienic haven for disease (Burden 1994, p. 197; Palmer & Short 2000, p. 265).

4.1.2.2 Introduction of new diseases

European settlers introduced new infectious diseases to Australia. Smallpox, syphilis, leprosy, tuberculosis, measles and influenza were some of the most devastating unintentional imports. Their impact was disastrous, as the Indigenous people had no immune resistance against them (DAA 1987c, p. 2; Waterford 1982, p. 10).

New diseases as well as existing infectious diseases, such as otitis media, were enabled to spread quickly (Waterford 1982, p. 9) because of overcrowding and the gathering of large groups of people in reserves and settlements. Fewer people would have been affected and killed by these new diseases if Indigenous people had been able to live their traditional nomadic lifestyle in small groups (Saggers & Gray 1991b, p. 382).

Additionally, with time and as a result of their new lifestyle, Aborigines developed degenerative diseases like diabetes, hypertension and circulatory system diseases. Apathy, alcohol abuse and depression among other psychological diseases became more frequent (Waterford 1982, p. 8).

4.1.2.3 Political mistreatment and social disruption

Aborigines were confronted with an alien culture, which they could not understand but were forced to live in. However, the conflict of the Aborigines being forced to adopt the European lifestyle and dismiss their traditional Aboriginal culture was ignored by the English settlers (Bourke & Cox 1998, p. 73). Australia's colonisation by European settlers and their negligence of Indigenous laws induced the loss of Aboriginal autonomy and control.

From the middle of the 19th century until around 1940, government policy was directed towards achieving segregation. This time is called the "era of segregation" or "era of protection." From the 1950s, the official government goal was to obtain assimilation of the Indigenous people into the Anglo–Australian society and way of life. It was only in 1967 that Aborigines gained full citizenship rights (Davis & George 1988, p. 304).

The legacy of this history is still being carried by Aborigines today, but far from being recognised by all Australian governments or health care providers (Bartlett & Legge 1994, p. 8).

Era of segregation

White settlers believed that the way of life of Aborigines was inferior to that of the Europeans (DAA 1987a, p. 3). By the beginning of the 20th century, legislation designed to segregate and "protect" Aborigines had been introduced by the states and territories. Full–blood Aborigines were kept on missions or settlements (Eckermann et al. 1992, p. 34). Employment and property rights were restricted, and children were removed from their mothers if the father was non–Aboriginal. The ultimate goal was to destroy Aboriginal culture and eventually the entire race.

Era of assimilation

In 1937, the Commonwealth, state and territory governments agreed that Aboriginal people of mixed descent should be assimilated into the wider community. In 1951, the policy of assimilation was extended to all Aboriginal and Torres Strait Islander people. Under the new policy, Aborigines were supposed to:

> ... attain the same manner of living as other Australians and to live as members of a single Australian community enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and influenced by the same beliefs, hopes and loyalties as other Australians. (Australia Parliament – House of Representatives 1961, p. 51)

Aboriginal culture was seen as primitive and should be eradicated. Aborigines should become part of the European society (Central Australian Aboriginal Congress 2000, p. 3).

However, Aborigines did not gain full citizenship rights. The assimilation policy completely controlled the people's life. It prohibited Aboriginal and Torres Strait Islander people from going into pubs, marrying without permission or living within town boundaries (ATSIC 1998e, p. 10). The Australian social security legislation excluded Aborigines from income support payments. Aborigines did not receive industrial award wages nor were they protected by conditions of employment (Altman & Sanders 1991a, p. 208).

In a constitutional referendum in 1967, Aboriginal and Torres Strait Islander people finally gained full citizenship rights and therefore the right to vote; the Commonwealth attained the power to legislate on Aboriginal affairs (Palmer & Short 1994, p. 265).

In 1972, the Whitlam government adopted the principle of "self–determination" as central term of Aboriginal policy and the Department of Aboriginal Affairs was established (Rowley 1986, p. 33).

Stolen generation

Since the beginning of British settlement, Indigenous children were separated from their families and raised by white settlers or in institutions (Bourke & Edwards 1998, p. 101). This removal of Indigenous children was official policy since the era of segregation. In 1909, the Aborigines Protection Act was enacted in New South Wales: children could be removed from their Aboriginal parents if they were seen to be neglected in the white

settlers' point of view (Gray & Saggers 1991, p. 93). Particularly the so–called "half–caste" children were separated from their "uncivilised" environment in order to give them a chance in white society (Towers 1982, p. 48). But once in the society of the white people, they experienced racism, ignorance and prejudice as well as a loss of identity.

It was only in the 1950s that the number of families separated by force started to decrease. Nevertheless, Aboriginal and Torres Strait Islander mothers were still advised to give their babies up for adoption to non–Indigenous people (Bourke & Edwards 1998, p. 102).

A report on the removal from Indigenous children from their families, the Bringing Them Home report, was released in 1997. The report concluded that from 1910 to 1970, between 10 and 30 per cent of Indigenous children were forcibly removed from their families and communities and that this had wide–ranging impacts on the Aboriginal society (HREOC 1997, p. 2). In 1994, 10 per cent of Indigenous persons aged 25 years and over reported being taken away from their natural family as children (Madden 1995, p. 2).

4.2 Indicators of Indigenous health

The state of health of a population or a subpopulation can be judged by health indicators like life expectancy, mortality and morbidity (DHAC 1991, p. 1).

It has to be kept in mind, though, that hospitalisation, mortality and life expectancy rates deliver an underestimation of actual mortality and morbidity. This is due to the fact that the identification of Indigenous people in hospital and mortality records is incomplete. An accurate estimation of mortality and morbidity also relies on an exact estimation of Indigenous population numbers.

The examination of the health indicators shows that the standard of health of the Indigenous people of Australia is far lower than that of the total Australian population. Aborigines suffer from a greater burden of disease and die at a younger age (ABS 1997a, p. 1; Central Australian Aboriginal Congress 2000, p. 1; HRSCAA 1979, p. iii).

4.2.1 Life expectancy at birth

Life expectancy[1] remains much lower for Indigenous people and is about 15 to 20 years lower than that of other Australians (ABS & AIHW 1999, p. 4; DHAC 2000c, p. 266; NSW Department of Health 1991, p. 7). The life expectancy for Indigenous men who were born between 1991 and 1996 is 56.9 years, for Indigenous women 61.7 years. These numbers are considerably lower than life expectancies in the total population: for men it is 75.2 years and women 81.1 years for those born between 1994 and 1996.

The life expectancy of Australian Aborigines today is similar to that of other Australians at the beginning of the twentieth century (AIHW 2000a, p. 2).

4.2.2 Mortality

Mortality rates of the Indigenous population still persist at much higher levels than those of non–Indigenous people (Thomson 1991, p. 43). For all causes of death combined, there are two to three times more deaths than expected among the Indigenous population (ANAO 1998, p. 5). Infant mortality has decreased within the last 20 years, though mortality among adults has not declined to the same extent (Bartlett & Legge 1994, p. 4).

In order to consider the different age structures of the Indigenous and the total Australian population, age–specific or age–standardised mortality rates are used to examine Indigenous mortality in relation to the mortality of other or all Australians.

4.2.2.1 Mothers and babies

Infant mortality

In 1999, Australia's infant mortality rate[2] (IMR) was 5.7 deaths per 1,000 live births. Reliable data on Indigenous infant mortality were available only for three states and territories — Western Australia, the Northern Territory and South Australia — for which the combined IMR of 16.0 was almost three times that of the total population (Bhatia & Looper 2001, p. 26; NHMRC 1996, p. 3).

Indigenous infant mortality declined substantially from the early 1970s to the mid 1980s but, thereafter, decreased only very slightly (Burden 1994, p. 199; Harrison 1991, p. 123; NHMRC 2000, p. 30) at about the same rate as IMRs for the total population (Anderson, I. 1996, p. 61; Thomson 1991, p. 49).

[1] See Medical Glossary, p. 256.
[2] See Medical Glossary, p. 256.

The Indigenous IMR declined only marginally between the mid 1980s and 1990s, but with improved technology and early hospitalisation of Indigenous mothers in hospitals deaths in the neonatal phase decreased. However, the deaths in the post–neonatal phase increased, which was mainly due to the deaths of babies with low birth weight[1] and of premature babies who had survived the neonatal phase (George & Davis 1998, p. 319). Preventable infectious diseases are still the main contributing factor to high infant mortality. The prevalence of relatively low birth weights additionally disposes babies to infectious diseases (Gray 1988, p. 23; Thomson & Briscoe, p. 21). Infant deaths are further associated with the young age of the mother and high birth rates. From 1996 to 1998, more than 80 per cent of Indigenous mothers who gave birth were under 30 years of age, compared with 54 per cent of non–Indigenous mothers (ABS & AIHW 2001, p. 60). The mean[2] age of Indigenous mothers was 24.4 years, for non–Indigenous mothers 28.9 years.

Perinatal mortality

Indigenous foetal[3] and neonatal[4] mortality rates are elevated, resulting in a high perinatal mortality rate. From 1996 to 1998, the national perinatal mortality[5] for babies born to Indigenous women was twice as high as that for babies born to non–Indigenous women (20.7 compared to 9.8 per 1,000 total births).[6]

Table 9: Perinatal mortality of babies to Indigenous and non–Indigenous mothers, 1996 to 1998

Origin of mother	Mortality rates			
	Fetal (a)	**Neonatal** (b)	**Perinatal** (a)	**Infant** (b)
Indigenous	13.2	7.6	20.7	16.0
Non-Indigenous	6.8	3.0	9.8	5.7 (c)

Notes:
(a) Rate per 1,000 total births.
(b) Rate per 1,000 live births.
(c) Rate for all Indigenous babies.

Source: After ABS & AIHW 2001, p. 65

[1] See Medical Glossary, p. 257.
[2] See Technical Glossary, p. 252.
[3] See Medical Glossary, p. 256.
[4] See Medical Glossary, p. 257.
[5] See Medical Glossary, p. 257.
[6] See Table 9.

Maternal mortality

Indigenous women face a higher risk of dying while giving birth. The maternal mortality ratio for Indigenous women from 1994 to 1996 was 34.8 per 100,000 births, almost three times higher than the rate of 13.0 per 100,000 births for all Australian women (Ford et al. 2001, p. 33; Nasser & Sullivan 2001, p. 23).[1]

The overall poor health status predisposes Aboriginal women to complications during pregnancy and childbirth. High maternal mortality rates can further be attributed to their lack of access to health care services (Bastian 1993, p. 571).

Table 10: Maternal mortality ratios for Indigenous and non–Indigenous women, Australia, 1994 to 1996

Indigenous status	**Births** (No.)	(%)	**Maternal deaths** (No.)	**Maternal mortality ratio** (a) (b)
Indigenous	22,996	3.0	8.0	34.8
Non-Indigenous	744,452	97.0	75.0	10.1
Not stated			17.0	
Total	767,448	100.0	100.0	13.0

Notes:
(a) Per 100,000 births.
(b) Calculations of maternal mortality ratios for Indigenous and non–Indigenous women excluded from the denominator maternal deaths where Indigenous status was missing.

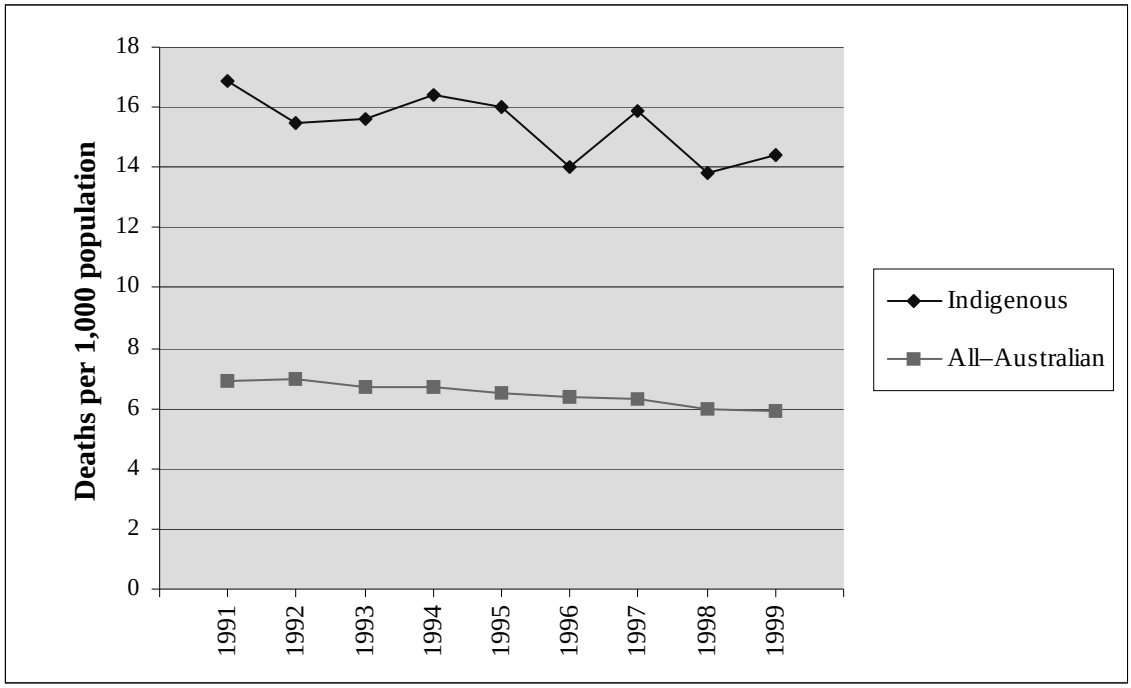
Source: After Ford et al. 2001, p. 33

4.2.2.2 Adults

Aborigines are more likely to die at younger ages than other Australians. Age–adjusted mortality rates for Aborigines are two to three times higher than those for other Australians (ABS & AIHW 2001, p. 115; Ring & Firman 1998, p. 529).

From 1991 to 1999, death rates from all causes have decreased among Indigenous Australians to a slightly greater extent than among all Australians (ATSIC 1998b, p. 7; Bhatia & Looper 2001, p. 25; NHMRC 1996, p. 3). In this period, age–standardised death rates for Indigenous Australians decreased from around 17 to 14 per 1,000 Indigenous people; all–Australian rates decreased from approximately seven to six per 1,000 Australians. Nevertheless, Indigenous death rates are still significantly higher.[2]

[1] See Table 10.
[2] See Figure 2, p. 28.



Notes:
(a) Indigenous deaths data for Western Australia, South Australia and the Northern Territory combined.
(b) Data should be used carefully. Indigenous people may be underestimated in death registrations. Also, experimental population estimates, based on the 1996 census, have been used for estimating the rates.
(c) The death rates were age–adjusted using the total Australian population as at 30 June 1991.

Figure 2: Indigenous and total Australian death rates for all causes, 1991 to 1999 (a)(b)(c)

Source: After Bhatia & Looper de 2001, p. 25

Age–specific death rates for Indigenous people exceed those for all Australians in every age group (AIHW 1998, p. 29).

From 1997 to 1999, the contrast was most marked at the age brackets of 35 to 44 and 45 to 54, where the rates for Aborigines were around five to six times higher than the all–Australian rates. In the age groups of 25 to 34 and 55 to 64, Indigenous age–specific death rates were three to almost five times higher than the all–Australian rates (ABS & AIHW 2001, p. 114).[1]

Furthermore, regional mortality data indicates that for Indigenous people the health status generally declines with increasing remoteness. Nevertheless, differences in health status between Indigenous people in different geographical areas are small compared to differences in health status between Indigenous and non–Indigenous people (Commonwealth Grants Commission 2001b, p. 2).

[1] See Tabel 11, p. 29.

Table 11: Age–specific death rates (a) for Indigenous and non–Indigenous males and females, 1997 to 1999

Age group (years)	Males			Females		
	Indigenous rate (b)	**All-Australian rate** (c)	**Rate ratio** (d)	**Indigenous rate** (b)	**All-Australian rate** (c)	**Rate ratio** (d)
0 to 1	1,607	588	2.7	1,230	476	2.6
1 to 4	77	36	2.1	60	26	2.3
5 to 14	42	16	2.6	38	12	3.2
15 to 24	291	102	2.9	110	38	2.9
25 to 34	494	138	3.6	225	50	4.5
35 to 44	962	167	5.8	504	91	5.5
45 to 54	1,735	326	5.3	1,039	207	5.0
55 to 64	3,039	909	3.3	2,260	519	4.4
65 to 74	5,686	2,636	2.2	4,242	1,436	3.0
75 and over	10,522	8,585	1.2	9,260	6,787	1.4

Notes:
(a) Per 100,000 population.
(b) Data for deaths identified as Indigenous for usual residents of Queensland, South Australia, Western Australia and Northern Territory combined.
(c) Data for all deaths of usual residents of Australia, including deaths identified as Indigenous.
(d) Indigenous rate divided by all–Australian rate.

Source: After ABS & AIHW 2001, p. 115

4.2.2.3 Leading causes of death

The leading causes of death for Aboriginal and Torres Strait Islander people and the whole Australian population are diseases of the circulatory system, injuries and poisoning and neoplasms (ABS & AIHW 2001, p. 117).

Table 12: Proportions of Indigenous deaths from selected causes, 1997 to 1999 (a)

Cause of death	Indigenous male deaths (%)	Indigenous female deaths (%)	All Indigenous deaths (%)
Circulatory	29.8	30.5	30.1
Injury and poisoning	19.7	11.0	16.0
Neoplasms	12.7	14.3	13.4
Respiratory	8.2	8.5	8.3
Endocrine/metabolic	6.7	10.8	8.5

Note:
(a) Data for Queensland, South Australia, Western Australia and the Northern Territory combined.

Source: After ABS & AIHW 2001, p. 116

From 1997 to 1999, these diseases accounted for 60 per cent of all Indigenous deaths and 75 per cent of all Australian deaths. Circulatory system diseases cause almost one–third of all Indigenous deaths. Other main causes of Indigenous deaths are diseases of the respiratory system and endocrine and metabolic diseases.[1]

Table 13 shows Indigenous mortality from selected causes compared to all–Australian mortality. The higher the Standardised Mortality Ratio[2] ($SMR_{mortality}$), the more disproportionately affected Indigenous people are by deaths caused by that disease. The highest $SMRs_{mortality}$ for Indigenous males and females were found in the group of endocrine and metabolic diseases. Deaths due to endocrine and metabolic diseases are about eight times more common among Indigenous people than among all Australians. Deaths due to respiratory, circulatory and injury and poisoning are between three to four times more frequent.

Table 13: Indigenous $SMRs_{mortality}$ from selected causes, 1997 to 1999 (a)

	$SMRs_{mortality}$ (b)		
Cause of death	**Indigenous males**	**Indigenous females**	**Total Indigenous population**
Circulatory	3.1	2.8	3.0
Injury and poisoning	2.8	3.3	2.9
Neoplasms	1.4	1.4	1.4
Respiratory	4.1	4.0	4.1
Endocrine/metabolic	7.2	9.4	8.4

Notes:
(a) Data for Queensland, South Australia, Western Australia and the Northern Territory combined.
(b) $SMR_{mortality}$ = observed deaths divided by expected deaths, based on all–Australian age, sex, and cause–specific rates.

Source: After ABS & AIHW 2001, p. 116

Excess deaths

Although there were excess deaths[3] from almost every cause of death, four categories of diseases account for the majority of excess deaths: circulatory system diseases, injury and poisoning, respiratory diseases and endocrine and metabolic diseases.[4] From 1997 to 1999, more than two–thirds of excess deaths among the Indigenous population were due to these four groups of diseases (ABS & AIHW 2001, p.116; Ring & Firman 1998, p. 529).

[1] See Table 12, p. 29.
[2] See Medical Glossary, p. 258.
[3] See Technical Glossary, p. 251.
[4] See Table 14, p. 31.

Table 14: Main causes of Indigenous excess deaths, 1997 to 1999 (a) (b)

Disease category	Proportion of all excess deaths	
	Indigenous males (%)	Indigenous females (%)
Circulatory	31.2	30.1
Injuries and poisoning	19.6	11.7
Respiratory	9.5	9.8
Endocrine/metabolic	8.9	14.8
Neoplasms	6.1	6.6
Digestive	5.7	6.2
All other causes	19.0	20.6
Total	100.0	100

Notes:
(a) Excess deaths are equal to observed deaths minus expected deaths.
(b) Data for Queensland, Western Australia, South Australia and the Northern Territory combined.

Source: After ABS & AIHW 2001, p. 116

4.2.3 Morbidity

Morbidity[1] patterns among Indigenous people are changing. A reduction in communicable diseases is counterbalanced by a rise in degenerative diseases (HRSCFCA 2000, p. 159). Nonetheless, preventable infections are still the main cause for child morbidity and poor rates of growth among Indigenous children (Aboriginal and Torres Strait Islander Health Policy Branch, Queensland Health 1994, p. 6). In adulthood, predominant diseases are those to be found in industrialised nations (Davis & George 1988, p. 302; Waterford 1982, p. 9). These are mainly degenerative diseases such as diabetes and degenerative circulatory and respiratory diseases. However, within the Aboriginal and Torres Strait Islander population, they generally develop at a much earlier stage in life (Burden 1998, p. 198).

Lifestyle diseases are often a consequence of poor nutrition, a lack of physical exercise, being overweight[2] or obese[3] and alcohol and drug abuse.

Indigenous people experience a higher burden of illness and disease resulting in higher hospitalisation rates than for the non–Indigenous population. Aborigines are admitted to hospital at rates about two times higher than those for non–Aborigines. Hospital admissions are more frequent in every age group and for almost every cause (AIHW 2000, p. 5; McClelland, Pirkis & Willcox 1992, p. 86).

[1] See Medical Glossary, p. 257.
[2] See Medical Glossary, p. 257.
[3] See Medical Glossary, p. 257.

It is difficult to assess the real level of sickness or disease within the Indigenous subpopulation. Hospital separations[1] do not directly measure the prevalence of disease in a population, as not all people with a disease or condition are admitted to hospital, and some people have multiple admissions for the same problem. Hospitalisation rates only measure the more acute or chronic illnesses. In addition, identification of Indigenous status of patients in hospitals is incomplete and can lead to underestimation. Nevertheless, information on hospital separations presents an indication of the state of health of a population or subpopulation.

4.2.3.1 Mothers and babies

Indigenous mothers tend to have more babies and to have them at younger ages than non–Indigenous mothers. In 1999, the average age of Indigenous mothers at confinement was 24.5 years compared with 29.0 years for non–Indigenous women. 22 per cent of Indigenous confinements were to women under 20 years old (Nasser & Sullivan 2001, p. 9).

Birth weight

Low birth weights of Indigenous babies have increased over the last two decades, but are still more prevalent among Indigenous babies than non–Indigenous babies. Babies of Indigenous women are still about twice as likely to be of low birth weight. In 1999, 13.0 per cent of all Indigenous babies were of low birth weight, compared with only 6.5 per cent of all other Australian babies (Nasser & Sullivan 2001, p. 29). The average birth weight of babies to Indigenous mothers in 1999 was 211 grams less than the national average birth weight (Nasser & Sullivan 2001, p. 30).

WHO (1980, p. 197) states that birth weight is "universally and in all population groups the single most important determinant of the chances of the newborn to survive and experience healthy growth and development." Low birth weights of Indigenous babies represent a great health concern often resulting in problems in postnatal growth and predispose children to infectious disease, ill–health and retarded growth, especially if coupled with poor nutrition and poor hygiene (ABS & AIHW 2001, p. 62; Cheek et al. 1989, p. 162; Roberts, Gracey & Spargo 1988, p. 69; Thomson, 1989, p. 75, p. 91). Babies of low birth weights may even be more vulnerable to illness in adulthood (Barker & Clark 1997, pp. 106–107).

[1] See Technical Glossary, p. 251.

The prevalence of low–birth–weight babies to Indigenous mothers has a variety of factors. Higher birth rates, as is the case with Aboriginals, are correlated to low birth weight. Low birth weights also reflect the poor nutritional status and health of the mothers (Thomson 1989, p. 75). Smoking and alcohol consumption during pregnancy is also more common among Indigenous women. Illness during pregnancy and a lack of prenatal care can also result in low birth weights. All of these factors are positively correlated with low socio–economic status (ABS & AIHW 2001, p. 62; Thomson 1989, p. 75).

4.2.3.2 Adults

Indigenous people are over–represented in hospital separation data (Thomson 1991, pp. 52–54). In 1999, the hospital separation rate for Indigenous people was approximately twice that for the whole of the Australian population (ABS 2000h, p. 57). From 1997 to 1998, the age–standardised rate of hospitalisation for all Australians was 291 per 1,000, for Aborigines 540 per 1,000 (AIHW 2000a, p. 5). Hospitalisation rates for Aborigines were higher for each age bracket (ABS 2000h, p. viii; AIHW 2000a, p. 5). The $SMRs_{morbidity}$[1] were greater than 1.0 for almost all diseases.[2] This means that Indigenous people suffer a greater burden of almost all diseases than non–Indigenous people. For all causes combined, $SMR_{morbidity}$ was 1.7 for Indigenous males and 1.8 for Indigenous females.

Main reasons for hospitalisation

Among Indigenous males, the most common reasons for hospitalisation from 1997 to 1998 were dialysis (25 per cent), diseases of the respiratory system (13 per cent), injuries (13 per cent) and diseases of the digestive system (7 per cent).[3]

Among Indigenous females, the leading causes of hospitalisation were dialysis (25 per cent), complications of pregnancy and childbirth (17 per cent), diseases of the respiratory system (9 per cent), injury (8 per cent) and diseases of the digestive system (5 per cent) (ABS 2000h, pp. 30–32, 57–58; Cunningham & Beneforti 2000, p. 28).

The high hospitalisation rates among Indigenous people may be attributed to various factors including the lack of access to appropriate services, delay in seeking treatment and the lack of follow–up treatment.

[1] See Medical Glossary, p. 258.
[2] See Table 15, p. 34.
[3] See Table 15, p. 34.

The greatest disproportion of hospitalisation of Indigenous people compared to non–Indigenous people is due to dialysis, which in most cases is a result of diabetes. The $SMRs_{morbidity}$ for dialysis were 6.7 for males and 11.2 for females.

Table 15: Hospital separations identified as Indigenous, 1997 to 1998, by cause (a)

	Proportions (%) of total Indigenous separations		$SMR_{morbidity}$ (b)	
	Males	**Females**	**Males**	**Females**
Complications of pregnancy and childbirth	0.0	16.8	0.0	1.4
Respiratory diseases	12.5	8.7	2.1	2.3
Injury	12.7	7.8	1.7	2.3
Digestive diseases	6.9	5.1	1.0	0.8
Mental disorders	5.9	3.7	2.0	1.5
Genitourinary diseases	2.2	5.4	1.0	1.1
Circulatory diseases	4.9	3.4	1.7	2.0
Nervous system diseases	4.4	3.0	1.3	1.2
Skin diseases	4.0	2.6	2.9	3.1
Communicable diseases	3.6	2.7	2.1	2.2
Endocrine, metabolic, nutritional diseases	2.4	2.0	3.4	2.9
Neoplasms	1.4	1.8	0.6	0.7
Diseases of blood and blood forming organs	0.4	0.5	0.7	1.1
Muscoskeletal diseases	2.5	1.7	0.7	0.8
Congenital anomalies	0.6	0.3	0.5	0.5
Certein perinatal conditions	1.6	1.0	0.8	0.9
Ill-defined conditions	5.1	4.5	1.4	1.4
Other reasons for contact (c)				
Dialysis	25.1	24.6	6.7	11.2
Other	3.7	4.4	0.7	0.9
Not specified	0.1	0.0	3.6	3.1
All causes	**100.0**	**100.0**	**1.7**	**1.8**

Notes:

(a) Data is for the financial year 1997–1998 for public and private hospitals. Causes were categorised according to the International Classification of Diseases, 9th Revision (ICD–9). See Technical Glossary, p. 266.

(b) $SMR_{morbidity}$ is the Standardised Morbidity Ratio. It is equal to hospital separations identified as Indigenous divided by expected separations, based on all–Australian rates.

(c) Includes all ICD–9–V codes, a supplementary classification used to indicate a variety of circumstances which influence health status or bring people into contact with the health care system but which do not fit into the main disease and injury coding system.

Source: Cunningham & Beneforti 2000, p. 28

4.3 Selected health conditions

The most prevalent diseases of Indigenous adults shifted from communicable diseases, like infections and parasitic diseases, to non–communicable diseases, such as cardiovascular diseases, diabetes and chronic respiratory diseases (Beck 1985, p. 9; HRSCAA 2000, p. 160; Thomson 1985, p. 15).

4.3.1 Circulatory system diseases

Circulatory system diseases[1] include ischaemic and rheumatic heart disease, cerebrovascular disease (stroke) and peripheral vascular disease. The main underlying causes are arteriosclerosis (fatty deposits in artery walls) and thrombosis (blood clotting) which can obstruct blood vessels.

Circulatory system disorders are unlikely to have been present to any great extent before colonisation. Since then, they have become the leading cause of death for Indigenous people. From 1997 to 1999, circulatory system disorders were responsible for 30 per cent of both the Indigenous male and female deaths (ABS & AIHW 2001, p. 116). Death rates due to circulatory system disorders are substantially higher for Indigenous people than for non–Indigenous people. From 1990 to 1999, death rates due to circulatory system disorders were around three times higher for Aboriginal and Torres Strait Islander people than for the total Australian population (DHAC & AIHW 1998a, p. 6; National Centre for Monitoring Cardiovascular Disease 1999, p. iv; Ring & Firman 1998, p. 529). Hospital separations due to circulatory system disorders were twice as high in the Indigenous population as in the total population from 1997 to 1998.[2] Deaths due to circulatory system diseases are more common than hospital separations because these diseases mostly lead to a sudden death.

Indigenous people are more likely to die from circulatory system diseases at younger ages than the Australian population as a whole. In 1999, the median age of Indigenous deaths from circulatory diseases was 59.6 years. In the total population, the median age of deaths through circulatory diseases was at 81.1 years (ABS 2000a, p. 1).

Within the category of circulatory system diseases, deaths through heart diseases are more common than deaths through cerebrovascular disease (stroke). In 1999, 74 per cent of the Indigenous deaths in this category were a result of heart diseases (57 per cent due to ischaemic heart disease and 17 per cent due to rheumatic heart disease). 22 per

[1] See Medical Glossary, p. 255.
[2] See Table 15, p. 34.

cent of circulatory system deaths were caused by cerebrovascular disease (ABS 2000a, p. 1). Death rates for rheumatic heart disease especially are far higher (11 times in 1998) than those in the total Australian population (DHAC & AIHW 1998a, p. 6). Death rates for cerebrovascular and ischaemic heart disease are also elevated, but not to the same extent. In the period from 1990 to 1999, mortality was 1.7 times higher for these diseases. In the same period, death rates for stroke were 3.0 times higher for Indigenous males and 1.7 times higher for Indigenous females than for all Australian males and females (National Centre for Monitoring Cardiovascular disease 1999, pp. 11–23).

The predominance of different circulatory system disorders differs between urban and rural areas (Thomson 1989, p. 93). Rheumatic heart disease is responsible for a large number of deaths among Indigenous people in more remote areas (Thomson 1991, p. 55), whereas ischaemic heart disease is mainly found in more urban areas.

From 1988 to 1993, death rates due to circulatory system disorders for Indigenous males decreased slightly, for Indigenous females they stayed the same. In the total population of Australia, theses rates were steadily decreasing for both females and males (DHAC & AIHW 1998a, p. 5).

Risk factors[1] for cardiovascular diseases are the same as those for the total population and can be divided into two categories: lifestyle and physiological risk factors (Bhatia 1995a, 11ff; DHAC & AIHW 1998a, p. 2). Lifestyle risk factors are tobacco smoking, physical inactivity, poor nutrition and heavy alcohol consumption. Physiological risk factors are elevated blood lipid levels, high blood pressure, being overweight or obese and diabetes.

The high rates of smoking, overweight, obesity and diabetes in the Indigenous population are of specific concern since all contribute to high levels of circulatory system diseases.

4.3.2 Injuries and poisoning

Indigenous people suffer from a greater number of injuries than non–Indigenous people. Injuries and poisoning are the second leading cause of death for Indigenous males (accounting for 20 per cent of all deaths), and the third for Indigenous females (accounting for 11 per cent of all deaths). For the one to 34–year–old age group, it is the leading cause of death for both sexes. Hospital separations due to injury and poisoning are about twice as high in the Indigenous population than in the total

[1] See Technical Glossary, p. 254.

population; death rates are about three times higher.[1] The main causes of deaths in this category are motor vehicle accidents, self–harm and assaults. Deaths due to injuries because of interpersonal violence are 11 times those of non–Indigenous deaths. $SMR_{mortality}$ for murder is 15 times higher for Indigenous males and 17 times for Indigenous females than for non–Indigenous males and females (Couzos & Murray 1999, p. 18).

The majority (71 per cent) of deaths in this category are male deaths. Motor vehicle accidents and intentional self–harm accounted for 34 per cent and 27 per cent respectively of all Indigenous male deaths in this category from 1997 to 1999 (ABS & AIHW 2001, p. 117). Among Indigenous females, the major causes of death in this category were motor vehicle accidents (31 per cent), assault (19 per cent) and intentional self–harm (17 per cent).

4.3.3 Neoplasms

The overall incidence of neoplasms among the Indigenous population seems to be lower than among non–Indigenous people (Thomson 1991, p. 72). From 1997 to 1998, the $SMR_{morbidity}$ for cancer for Indigenous males was 0.6, and for females 0.7.[2]

In contrast, cancer–related mortality is generally higher for Aboriginal and Torres Strait Islander people than for the rest of the population (ABS & AIHW 2001, p. 94). Malignant neoplasms are the second leading cause of death among Indigenous females and the third leading cause of death among Indigenous males. From 1997 to 1999, mortality data show that cancer caused 40 per cent more deaths in the Indigenous population than would have been expected if the disease occurred at the same rates as found in the total population (ABS & AIHW 2001, p. 94). Despite a relatively low incidence of neoplasms among Indigenous people, mortality is relatively high. This can at least partly be contributed to the fact that cancers among the Indigenous population are typically diagnosed at a later stage (South Australian Cancer Registry 1997, p. 12; Thomson 1991, p. 72).

For Indigenous males, cancer of the liver, prostate and pancreas are the most frequent causes of cancer death. For Indigenous females, the most common cancers are breast, lung and cervical cancer with cancer of the cervix being twice as common as among non–Indigenous females (ABS & AIHW 2001, p. 95).

[1] See Table 13, p. 30, and Table 15, p. 34.
[2] See Table 15, p. 34.

4.3.4 Diseases of the respiratory system

Respiratory diseases[1] have probably claimed more Aboriginal lives over the past 200 years than any other cause and even today remain one of the leading causes of death.

Respiratory diseases are the cause of death for 8 per cent of all Indigenous male deaths and 9 per cent of all Indigenous female deaths[2]. Indigenous people die approximately four times more often from respiratory system diseases than all Australians. Respiratory diseases are more common in the Indigenous population especially during infancy, early childhood and after the age of 25 years (Cunningham & Beneforti 2000, p. 31).

Morbidity due to respiratory diseases is about double in the Indigenous population than in the total Australian population.

Respiratory system disorders can be separated in infectious (pneumonia for example) and chronic diseases, both of which are more frequent among Indigenous people than in the total Australian population. Infective conditions were responsible for almost half of the Indigenous deaths from respiratory disease, and were nine to 11 times more common than among non–Indigenous Australians. Deaths from chronic respiratory disease were three to five times more common than could be expected from total Australian rates.

The pathogenesis of respiratory disease among Indigenous people has many factors. Substandard housing and the high prevalence of smoking make substantial contributions, as well as the poor nutritional status of many Indigenous people, especially children (Thomson 1991, p. 58).

4.3.5 Diabetes mellitus

Diabetes[3] is characterised by persisting high blood glucose concentration, caused by deficient insulin production and possible insulin resistance.

Particularly non–insulin dependent diabetes mellitus[1] (NIDDM/type 2 diabetes) has become a major health problem among the Indigenous population.

Diabetes occurs among Indigenous people at a rate at least two to four times that of non–Indigenous people (ABS 2000b, p. 1; Bhatia 1995a, pp. 11–15; DHAC 1999c, p. 6). In the 1995 National Health Survey[4], 7 per cent of the Indigenous people aged 25 to 44 years, 24 per cent of those aged 45 to 55 years and 17 per cent of those over 55 years

[1] See Medical Glossary, p. 257.
[2] See Table 12, p. 29.
[3] See Medical Glossary, p. 255.
[4] See Explanatory Notes, p. 248.

reported suffering from diabetes. Indigenous people reported diabetes as a long–term illness about seven to eight times more often than non–Indigenous people among those aged 25 to 55 years old, and twice as high among those over 55 years old (ABS 1995, p. 6). The 1994 NATSIS provided similar results. Indigenous people in remote and rural areas are more likely to suffer from NIDDM than those living in urban areas (ABS 2000b, p. 2; Thomson 1989, p. 88). Moreover, about one quarter of all hospital separations among Indigenous people are due to dialysis treatment (ABS 2000h, p. viii).[1]

Indigenous people experience higher death rates due to diabetes. From 1985 to 1994, death rates for diabetes increased by almost 10 per cent for Indigenous males and by over 5 per cent for Indigenous females (Anderson, Bhatia & Cunningham 1996, p. 2). From 1995 to 1997, death rates were about nine times greater than expected for Indigenous males and 16 times greater for Indigenous females (Cunningham & Paradies 2000, p. 40).

The development of NIDDM has a strong genetic component though there are other important risk factors, such as being overweight or obese, physical inactivity, age and low birth weight (DHAC & AIHW 1998, p. 13; Guest & O'Dea 1992, p. 346).

- Obesity: The risk of developing NIDDM rises with increasing obesity. Those classified as obese (BMI[2] greater than 30) face a risk about five to 10 times greater than those with acceptable weight (BMI under 25) (Perry, Wannamethee & Walker 1995, p. 561; Shaten, Smith & Kuller 1993, p. 1334).
- Physical inactivity: Physical activity plays a protective role against the development of NIDDM. Regular exercise can reduce the risk of developing NIDDM by 30 to 60 per cent (DHAC & AIHW 1998, p. 13).
- Age: The risk of developing NIDDM increases with age. However, NIDDM develops at an earlier age among the Aboriginal and Torres Strait Islander population than in the rest of the population (O'Dea et al. 1993, p. 1996).
- Low birth weight: Several studies indicate that low birth weight increases the lifetime risk of developing NIDDM (DHAC & AIHW 1998, p. 14).

NIDDM is associated with an increased risk of developing particular conditions. Complications of diabetes are microvascular and macrovascular diseases. Microvascular disorders include kidney disease and blindness due to retinopathy and neuropathy.

[1] See Table 15, p. 34.
[2] See Medical Glossary, p. 255.

Macrovascular complications are coronary heart disease, stroke and peripheral vascular disease[1], which can lead to amputations (DHAC & AIHW 1998b, p. 14; NAHS Working Party 1989, p. 137). NIDDM can also lead to pregnancy–related complications, such as foetal malformations, spontaneous abortions, stillbirths and neonatal hypoglycaemia (DHAC 1998, p. 14). The high prevalence of NIDDM among Indigenous people is probably an important factor to the high occurrence of circulatory system diseases.

It is not clear why diabetes is so common among Indigenous Australians. However, some authors state there is a genetic predisposition for the development of NIDDM, but this predisposition has never been scientifically proven (Saggers & Grey 1991, p. 117). The rapid change from a traditional way of life to a more westernised lifestyle, marked by decreased physical activity and a high–fat, low–fibre diet that promotes obesity, high blood cholesterol and high blood pressure (National Centre for Monitoring Cardiovascular Disease 1999, p. 40) is thought to be an important factor.

4.3.6 Infectious and parasitic diseases

Infectious and parasitic diseases are more frequent within the Indigenous population than in the total Australian population (Anderson, Bhatia & Cunningham 1996, p. 1; Bartlett & Legge 1994, p. 4; Thomson 1991, p. 47).

From 1997 to 1999, infectious and parasitic diseases accounted for more than 2 per cent of deaths among Indigenous males and females, and mortality among Indigenous people was around five times higher than in the total population.[2] Hospital separations due to infectious and parasitic diseases were around twice as high as in the total population.[3]

Infectious diseases are a problem especially during childhood (Anderson, I. 1996, p. 63). There are several reasons for the prevalence of infectious diseases among Indigenous children. Immunisation levels among Indigenous children are far lower than among non–Indigenous children (Eckermann et al. 1992, p. 177). Poor living conditions — inadequate washing facilities, waste removal and sewerage — facilitate the spread and infection by diseases (Pholeros, Rainow & Torzillo 1993, p. 7). In addition, Indigenous children are predisposed to infections through malnutrition and their overall poor health status. Infectious diseases also multiply the effects of nutritional deficits and contribute to Aboriginal infant growth retardation (Anderson, I. 1996, p. 63).

[1] See Medical Glossary, p. 257.
[2] See Appendix A, Table A, p. 202.
[3] See Table 15, p. 34.

Diseases transmitted by inhalation

- Tuberculosis: Tuberculosis is caused by the Mycobacterium tuberculosis. The lung is the most commonly infected organ. Untreated tuberculosis destroys lung tissue and can lead to death.

  In 1996, the rate of notification of new disease was 16.1 per 100,000 for Indigenous people, compared with 1.2 per 100,000 for non–Indigenous Australians (Gilroy, Oliver & Harvey 1998, pp. 174–175). From 1998 to 2000, the crude notification rate[1] for tuberculosis among Indigenous people in Western Australia, South Australia and the Northern Territory was 21.0 compared to 6.0 among the total population of these states (ABS & AIHW 1999, p. 101).

  The high incidence of tuberculosis is related to poor housing, malnutrition, chronic chest diseases and alcohol abuse.
- Meningococcal disease: This infection is caused by Neisseria meningitides. The notification rate from 1996 to 1998 for Indigenous people was 7.9 per 100,000, more than three times the all–Australian rate of 2.5 (ABS & AIHW 1999, p. 101).

  Meningococcal disease can result in meningitis, septic arthritis and chronic meningococcaemia (DHAC 2002a, p. 1).
- Haemophilus influenza type B: The notification rate for Indigenous people was 1.7 per 100,000, compared with 0.3 per 100,000 for the total Australian population (ABS & AIHW 1999, p. 101). The bacterium can cause meningitis, pneumonia, septic arthritis, osteomyelitis and pericarditis.

Sexually transmitted diseases

Sexually transmitted diseases have higher notification rates for Aborigines than for non–Aborigines. Syphilis, gonorrhoea, hepatitis B and HIV/Aids have become major health problems for Indigenous people.

- Syphilis: Syphilis is caused by the bacterium Treponema pallidum. Untreated syphilis can lead to serious damage to the nervous system and other body organs, and ultimately to death.

  There are only limited data available on the incidence of syphilis among the Indigenous people in Australia. From 1996 to 1998, the combined notification

[1] Note: The crude notification rate does not take different age profiles of the two populations into account.

rate for Western Australia, South Australia and the Northern Territory for Indigenous people was 233 per 100,000, compared with 12 per 100,000 for the total population in these states (ABS & AIHW 2001, p. 93).

- Gonorrhoea: Gonorrhoea is caused by the bacterium Neisseria gonorrhoea. The disease is highly contagious and easily transmitted. Symptoms include a yellowish discharge, irritation of the external genitals and painful and frequent urination. Gonorrhoea can result in infertility.

  From 1998 to 2000, the combined notification rate for Indigenous people in Western Australia, South Australia and the Northern Territory was 1,405 per 100,000, compared with 75 per 100,000 for the total population of these states (ABS & AIHW 2001, p. 93). 72 per cent of all notifications in these states were for Indigenous people.
- Hepatitis B: In South Australia, Western Australia and the Northern Territory from 1998 to 2000, combined notification rates for Indigenous people were 17 per 100,000, compared with notification rates of 3 per 100,000 for the total population in these three states.

  Transmission occurs from contact with blood and other body fluids (semen, vaginal fluids and saliva) from an infected individual. A mother may also transmit HBV to the foetus during pregnancy.

  Only one–third of people acutely infected with HBV will experience obvious symptoms, such as jaundice, loss of appetite and mild flu–like symptoms, including fever, fatigue, headache, nausea and vomiting. Patients may develop pain in the joints, especially in the hands. There are three main long effects of hepatitis B: chronic active hepatitis, liver cirrhosis, and primary liver cancer.
- HIV/Aids: The rates of HIV infection for Indigenous and non–Indigenous people seem to be similar. For the seven–year period from 1992 to 1998, the rate of HIV notification of 5.2 per 100,000 for Indigenous people was similar to that for non–Indigenous people (5.5 per 100,000). However, the similarity of overall rates conceals different trends for the two populations — the rate for non–Indigenous people declined steadily over the period, but the rate for Indigenous people remained relatively stable (ABS 2001b, p. 346; Guthrie et al. 2000, p. 267). Other important differences were that the proportion of women infected was higher for Indigenous than non–Indigenous people (28 per cent compared with 6 per cent) and that the infection was more commonly

acquired heterosexually by Indigenous people (38 per cent compared with 18 per cent) (ABS & AIHW 2001, p. 93).

A point of concern is that HIV has similar routes of transmission as HBV, which is more prevalent among the Indigenous population.

Gastrointestinal infections

Gastrointestinal infections are mainly a problem during childhood. Symptoms are fever, diarrhoea, stomach cramps and vomiting.

Certain bacteria, viruses and parasites can cause gastrointestinal infections. Infections occur through the intake of germs through the mouth.

Between 1981 and 1986, hospital separations for Indigenous infants due to gastro–enteritis were 16 to 20 times more frequent than for non–Indigenous infants, and for young children 11 to 15 times more frequent (Thomson 1989, p. 163). In the Northern Territory in 1983, Indigenous males of all ages were admitted to hospital 9.7 times more frequently and Indigenous females 9.3 times more frequently than their non–Indigenous counterparts.

Additionally, intestinal parasites are still relatively frequent among Indigenous people in remote and rural areas, particularly among children.

4.3.7 Ear disease

Indigenous people, especially children, encounter continuing high levels of chronic ear disease. Hearing loss, like ear disease, is significantly worse in the Indigenous population than in the total population (Kelly & Weeks 1991, p. 241). Between 10 per cent and 30 per cent of Indigenous children suffer from perforations of the eardrum and 10 per cent to 40 per cent suffer from hearing loss, a complication from ear disease (Thomson 1991, p. 58). Deafness is estimated to be around 15 per cent among Indigenous children, compared to around 5 per cent among non–Indigenous children (Thomson 1984, p. 940).

Hearing impairment can lead to major problems in education, particularly through the delayed acquisition of language skills (Anderson, I. 1996, p. 63; NHIMG 2000, p. 23; Thomson 1989, p. 115; Thomson 1991, p. 58). It is a serious obstacle to the development of Aboriginal children and exacerbates disadvantages generally faced by Indigenous people.

Otitis media

Otitis media, an infection of the middle ear clefts, is very common among Indigenous people, especially among babies and children.

The most characteristic form seen in Indigenous people begins at a very young age, often only a few weeks after birth, and shows as a sudden and painless discharge from one or both ears (Thomson 1989, p. 115). Recurrent infections often lead to a perforation of the eardrum and therefore hearing impairment.

Otitis media is responsible for much of the hearing loss experienced by Indigenous people of all ages (Couzos, Melcalf & Murray 1999, p. 242).

4.3.8 Eye disorders

Aboriginal and Torres Strait Islander people face a high prevalence of preventable eye pathology and disproportionately suffer from bad vision or blindness. According to the National Trachoma and Eye Health Programme[1], 15 out of 1,000 Indigenous people suffer from blindness, compared with 2 out of 1,000 in the non–Indigenous group (Royal Australian College of Ophthalmologists 1980, p. 5). The prevalence of blindness was seven times that of other Australians. In those over 60 years, 20 per cent of Aborigines were blind compared to 5 per cent of non–Aborigines.

Among the Indigenous population, major causes of blindness are trachoma, cataracts and injuries.

Trachoma

Trachoma[2] is a form of conjunctivitis caused by the bacterium Chlamydia trachomatis (Thomson 1991, p. 59). The initial form of the disease is follicular trachoma and is common in early childhood and young adolescence. Follicular trachoma can lead to cicatricle trachoma, which involves scarring and other damage to the eyelids and eyes. Blindness occurs due to the scarring of the cornea.

In the National Trachoma and Eye Health Programme, 38 per cent of the examined Indigenous people showed some form of trachoma, compared with only 2 per cent of the non–Indigenous people. Until 1987, the prevalence of trachoma had declined slightly but still 32 per cent of Indigenous children from birth to nine years old had some form of trachoma, compared with only two per cent of non–Indigenous children in that age bracket (DAA 1987c, p. 1). Today, trachoma is virtually absent in the non–

[1] See Explanatory Notes, p. 248.
[2] See Medical Glossary, p. 258.

Indigenous population but continues to exist with a prevalence of 20 per cent or more in some Indigenous communities in Western Australia, South Australia and the Northern Territory (OATSIH 2001d, p. xiii; Thomson & Paterson 1998, p. 12).

Substandard conditions, in which many Indigenous people in rural and remote areas live, and resulting poor personal hygiene contribute to the high prevalence of trachoma (Thomson 1989, p. 136).

Cataract

Cataract[1] is opacity of the crystalline lens of the eye and prevents light from reaching the retina, leading to reduced vision and blindness. Cataract is about twice as common among Indigenous people than among the total population.

The main risk factor for cataract is increasing age, followed by exposure to ultraviolet–B radiation, a lack of dietary anti–oxidant vitamins, the presence of diabetes, severe dehydration and the use of alcohol and cigarettes (OATSIH 2001d, p. 7).

Diabetic retinopathy

Diabetic retinopathy[2] is another threat to the vision of Indigenous people, considering the high prevalence of NIDDM. Retinal microvascular lesions can lead to poor sight and blindness (Taylor 1997, p. 6). Main risk factors for diabetic retinopathy include the duration of diabetes and inadequate glycaemic control.

The crude prevalence of diabetic retinopathy among diabetic Aborigines appears to be similar to that documented for the general Australian diabetic population. The prevalence of vision threatening retinopathy is between 6 and 13 per cent among diabetics in the Indigenous population (Thomson & Paterson 1998, p. 19). However, two important aspects have to be considered. Firstly, a higher percentage of Indigenous people suffer from diabetes. Secondly, the Indigenous population affected by diabetes, and by diabetic retinopathy as one of its possible complications, is younger than the non–Aboriginal population affected. Therefore, diabetic retinopathy affects more Indigenous Australians at younger ages than non–Indigenous Australians.

[1] See Medical Glossary, p. 255.
[2] See Medical Glossary, p. 256.

4.4 Risk factors for ill–health

Health risk factors are those factors that increase the chance of an individual to develop an illness or injury. They include behavioural and biomedical factors. The prevalence of the latter can be influenced by environmental exposure, an inherited characteristic or behaviour.

4.4.1 Behavioural risk factors

4.4.1.1 Malnutrition

Diet is a major determinant of health. The contemporary diet of most Indigenous people is energy–dense and high in fat, refined carbohydrates and sugars (McGrath et al. 1991, p. 17). A lack of healthy nutrition can exacerbate other risk factors, such as hypertension, obesity and hyperlipidaemia, and therefore lead to multiple conditions, for example diabetes type 2, kidney disease, cancer or cardiovascular disease. Poor nutrition is also associated with a predisposition to infectious diseases. Moreover, a healthy nutrition during pregnancy and a child's early life is very important and may have life–long effects. Malnourishment during pregnancy can cause low birth weights and foetal malformations.

Traditional diet

Indigenous people traditionally lived as hunters and gatherers deriving their diet from a variety of uncultivated plants and wild animals (NHMRC 2000, p. 35). Their diet varied throughout the seasons and also on a day–to–day basis (O'Dea 1991, pp. 234–235). Traditional diets were generally low in energy density but high in nutrient density, i.e. high in protein, complex carbohydrate, fibre and micronutrients and low in sugars and saturated fat. In some cases, people are continuing to access traditional food in a regular way, especially those living in the most remote situations such as outstations. In larger communities, such access tends to be restricted to weekends or special occasions. Many people are denied the opportunity to hunt or gather food from the local area because they have no rights to access their traditional land.

Transitional diet

The majority of Indigenous people lost access to their traditional food sources (NHMRC 2000, p. 2) and were forced to adopt an European–style diet. Those who were forced to live in reservations and missions received food rations, mostly existing of white flour, sugar, tea and salted meat (Taylor 1977, p. 154). The rations had to be cheap,

non–perishable and easy to transport (Franklin & White 1991, p. 11), making vegetables and fruits unavailable. In some settlements and missions, communal feeding was introduced which derived Aboriginal people from the acquisition and preparation of their own food as well as related traditions (Hamilton 1972, pp. 34–36).

Contemporary diet

The diet of most Indigenous people today is very high in energy, fat, highly refined carbohydrates and sugars (McGrath et al. 1991, p. 17). The 1994 NATSIS reported that 48 per cent of the interviewed Indigenous people had too much sugar in their diet and 27 per cent too much fat. Their diet often consists of white flour, white sugar, white bread and rice, cheap fatty meats, carbonated soft drinks, canned food and a high consumption of take away food. The intake of these foods is much higher among the Aboriginal population than among the rest of the population (Lee at O'Dea & Mathews 1994, pp. 192–193).

Furthermore, Indigenous people on average have a low intake of vitamins, complex carbohydrates, fibre and minerals. Especially in those remote Aboriginal communities where people do not make use of traditional food sources the style of diet is rather monotonous and includes a low intake of fresh food, such as vegetables and fruits.

Reasons for poor diet

Some Indigenous people, especially those in remote areas, lack an affordable food supply of quality (Bowcock & Roe 1994, pp. 8–9; Public Health Association of Australia 2000, p. 10) or are forced to go without food entirely from time to time. It can be difficult to purchase affordable and healthy food in remote areas of Australia as a result of high transport and storage costs and poorly equipped storage facilities (ABS & AIHW 2001, p. 69; Public Health Services, Queensland Health 2001, p. 38). Food costs in remote areas may range from 50 to 100 per cent more than capital city prices (National Aboriginal and Torres Strait Islander Health Clearinghouse 1998, p. 12). Many Aborigines and Torres Strait Islander people cannot afford to buy healthy food with their limited income. Moreover, certain foods are simply not available or only in a limited range. Stores in remote areas are also less likely to stock food items of a better nutritional value, such as reduced fat milk, wholemeal bread or lean meat. Perishable items like fresh fruit, vegetables and dairy products are often limited (Burden 1994, p. 206; Stewart 1997, p. 26).

Additionally, food choices of Indigenous people are often influenced by problems with cooking appliances and a lack of electricity, gas or refrigeration. Therefore, non–perishable convenience foods are often chosen over more healthy food choices that require preparation, storage and refrigeration.

4.4.1.2 Alcohol consumption

Excessive use of alcohol plays an important role in Indigenous mortality and morbidity. The consumption of hazardous amounts of alcohol[1] is a risk factor for conditions such as alcohol liver disease (cirrhosis), high blood pressure, stroke, coronary heart disease and some cancers of the digestive system. Alcohol consumption also plays an important role in motor accidents, injuries, violence, murder and suicides (Burden 1994, p. 207; Unwin, Thomson & Gracey 1994, p. 18). Alcohol consumption during pregnancy can lead to foetal malformation. Unfortunately, the role of alcohol is rarely acknowledged in the information provided on the medical death certificate, so many alcohol–related deaths are not accounted for.

Contrary to popular belief, Indigenous people are not more predisposed to drinking alcohol than other populations, however, those who do drink alcohol are more likely to do so at hazardous levels (AIHW 1998, p. 35; ABS & AIHW 1997, p. 2; Burden 1994, p. 207; Healey 1998, p. 3).

According to the 1995 National Health Survey, 59 per cent of the interviewed Indigenous males over 18 years and 66 per cent of the non–Indigenous males drank alcohol in the week prior to interview.[2] Corresponding figures for Indigenous females were 40 per cent and for non–Indigenous females 46 per cent (ABS 1995, p. 7).

However, the 1995 NHS further revealed that 21 per cent of Indigenous male drinkers (13 per cent of all Indigenous males) were consuming alcohol at hazardous levels, compared with 8 per cent of non–Indigenous male drinkers (5 per cent of all non–Indigenous males).

Indigenous female drinkers were less likely to be in the high–risk category (9 per cent of Indigenous female drinkers or 3.5 per cent of all Indigenous females) than their male counterparts, but were still more likely to be consuming alcohol at hazardous levels than the non–Indigenous women drinkers (3 per cent of non–Indigenous female drinkers or 1 per cent of all non–Indigenous women) (ABS 1999a, p. 8).

[1] See Technical Glossary, p. 250, for definition of alcohol risk levels.
[2] See Table 16, p. 49.

Table 16: Alcohol consumption by Indigenous and non–Indigenous Australians, 1995 (a) (b) (c)

	Indigenous			Non-Indigenous		
Alcohol intake	**Male** (%)	**Female** (%)	**Persons** (%)	**Male** (%)	**Female** (%)	**Persons** (%)
Intake at						
low alcohol risk level	36.0	32.9	34.4	55.4	39.4	47.3
medium alcohol risk level	10.7	3.9	7.1	5.4	4.8	5.1
high alcohol risk level	12.6	3.5	7.8	5.0	1.3	3.1
Total	**59.3**	**40.3**	**49.3**	**65.8**	**45.5**	**55.5**
No consumption	**40.7**	**59.7**	**50.7**	**34.2**	**54.5**	**44.5**
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes:
(a) Data from the 1995 National Health Survey.
(b) Persons aged 18 or more.
(c) Refer to Technical Glossary, p. 264, for definition of alcohol risk levels.

Source: After ABS 1999a, p. 38

Alcohol abuse causes higher rates of deaths and hospitalisation among Aborigines. In Western Australia from 1989 to 1991, the age–standardised rate of deaths caused by alcohol use was 5.2 times higher for Indigenous people than non–Indigenous people (Unwin, Thomson & Gracey 1994, p. 12). In the same period, the age–standardised rate for hospital admissions caused by alcohol was 9.3 times higher for Indigenous males than for non–Indigenous males and for Indigenous females 12.8 times higher than for non–Indigenous females (Unwin, Thomson & Gracey 1994, p. 22).

Alcohol consumption in Indigenous history

The Indigenous people of Australia made use of alcoholic beverages even before the European colonisation. Tribes on the northern coast of Australia traded with Indonesian fishermen in order to get palm wine, brandy and gin (Brady 1991, p. 176). The Torres Strait Islander people had introduced kava to Australia. However, alcoholic beverages had only been consumed during tribal festivities.

After the colonisation, alcohol was available in large amounts. The consumption of alcohol was not restricted to tribal gatherings anymore (Brady 1991, p. 178). Very soon, alcohol was manufactured industrially and easily available.

Between 1838 and 1929, laws were enacted in most states and territories that prohibited serving and selling of alcohol to Aborigines. This was based on the belief that alcohol

triggered a “serious evil” in Aborigines. It was only between 1957 and 1972 that these laws were abolished in all states and territories.

Different explanations have been offered for the high level of hazardous alcohol consumption among Indigenous people. Aspects of individual psychopathology, sociological aspects, such as socio–cultural deprivation, dependence, powerlessness and dispossession, as well as the positive social functions of alcohol consumption are mentioned (Brady 1991, p. 188; Brady & Palmer 1984, p. 77; Thomson 1989, p. 203). The fact that discriminatory laws existed for so long may also contribute to the current problem of Indigenous alcohol abuse (Brady 1991, p. 180).

4.4.1.3 Cigarette smoking

Cigarette smoking is associated with the increased incidence of and mortality from coronary heart disease, stroke, chronic respiratory tract diseases, various kinds of cancer, including lung, cervical and bladder cancer, and pregnancy–related conditions, such as low birth weight and malformations (ABS 2000c, p. 1; AIHW 1996b, 1¸ Unwin, Thomson & Gracey 1994, p. 2).

Indigenous people are more likely to smoke than non–Indigenous people (AIHW 1996b, p. ix). The 1994 NATSIS reported that 56 per cent of Indigenous males and 48 per cent of Indigenous females over 18 years smoked (Cunningham 1997, p. 4).

Table 17: Tobacco smoking among Indigenous and non–Indigenous Australians, 1995 (a)

	Indigenous			Non-Indigenous		
Smoking status	**Male** (%)	**Female** (%)	**Persons** (%)	**Male** (%)	**Female** (%)	**Persons** (%)
Smoking	55.8	46.3	50.7	26.9	20.0	23.4
Non–smoking	44.2	53.7	49.3	73.1	80.0	76.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note:
(a) Data from the 1995 National Health Survey.

Source: ABS 1999a, p. 37

The 1995 NHS found that 51 per cent of adult Indigenous Australians smoked (56 per cent of Indigenous males and 46 per cent of Indigenous females), compared to 23 per cent of all Australians (27 per cent of non–Indigenous men and 20 per cent of

non–Indigenous women) (ABS 1999a, p. 37).[1] At every age, a higher proportion of Indigenous adults smoked than of other Australians.

Tobacco smoking contributes to higher rates of death and hospitalisation among Indigenous people than among non–Indigenous people. In Western Australia from 1989 to 1991, the age–standardised rate for tobacco–caused deaths of Indigenous males was 2.4 times that of non–Indigenous males. The rate for Indigenous females was 3.7 times that of non–Indigenous females (Unwin, Thomson & Gracey 1994, p. 12). The age–standardised rate of hospital admissions caused by tobacco use for Indigenous males was 2.6 times that of non–Indigenous males and for Indigenous females 4.7 times that of non–Indigenous females (Unwin, Thomson & Gracey 1994, p. 22).

4.4.1.4 Petrol sniffing

Indigenous people are at a higher risk of ill–health than non–Indigenous people through petrol sniffing. Petrol sniffing is the deliberate inhalation of volatile hydrocarbons emitted by petrol in order to achieve alteration in mood (Brady 1992, p. 7).

Inhalation of petrol and other aerosols was first reported in the 1940s. Petrol sniffing has since become a major problem in some Indigenous communities, particularly for young people between the ages of 10 and 25. A survey undertaken in three remote communities in 1984 showed that 112 (34 per cent) of 330 children and young adults aged 10 to 24 got high from sniffing. Of the 112 users, 66 (59 per cent) were chronic users (Freeman 1987, pp. 88–89).

Petrol sniffing is more widespread in rural and remote areas, as petrol, unlike other drugs, is easily accessible and affordable. The areas most affected are Western Australia, South Australia and the Northern Territory (Brady 1984, p. 6; Brady & Torzillo 1994, p. 177). However, due to its secretive nature, it is almost impossible to assess the actual prevalence of petrol sniffing. Brady (1992, p. 7) estimates that in Western Australia, South Australia and the Northern Territory, about 2 to 3 per cent (between 600 and 1,000) of the Indigenous population between 10 and 25 years regularly engage in the practice of petrol sniffing.

Through organo–lead compounds and aromatic hydrocarbons, petrol sniffing can cause an impairment of cognitive functions, a lack of coordination, confusion, aggression, respiratory problems, cardiac dysrhythmia as well as chronic effects and disability

[1] See Table 17, p. 50.

through encephalopathy and polyneuropathy (Brady 1991, p. 205; D'Abbs & McLean 2000, p. 14; Goodheart & Dunne 1994, p. 180).

Causes for the inhalation of volatile substances are, once again, seen in the oppression of the Indigenous people since the European colonisation, their substandard living conditions and socio–economic disadvantage.

4.4.1.5 Physical inactivity

A lack of physical activity together with an unbalanced diet can lead to obesity, diabetes type 2 and circulatory system disorders. Physical inactivity can also lead to musculoskeletal health problems (AIHW 2000, p. 134).

As Indigenous people had to quit their hunter–gatherer lifestyle and adopt a sedentary way of life, exercise levels have been reduced. Traditionally, Indigenous people would hunt and gather and lead a lifestyle that entailed a high level of physical activity. After the European arrival, however, Europeans claimed possession of the Aboriginal land. Aborigines were prohibited their nomadic way of life. Instead they were settled in missions and settlements.

Today, Indigenous Australian adults are more likely than other Australian adults to report no physical activity in their leisure–time.

Table 18: Physical activity by Indigenous and non–Indigenous people, 1995 (a) (b) (c)

	Indigenous			Non-Indigenous		
Exercise level (d)	**Male** (%)	**Female** (%)	**Persons** (%)	**Male** (%)	**Female** (%)	**Persons** (%)
None	37.6	41.7	39.8	33.6	34.3	33.9
Low	23.9	36.5	30.6	30.0	38.2	34.2
Medium	19.2	11.1	14.9	17.7	16.6	17.1
High	19.3	10.7	14.7	18.7	10.9	14.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes:
(a) Data from the 1995 National Health Survey.
(b) Persons aged 18 years or more.
(c) Refers to exercises for sport, recreation and fitness only.
(d) Exercise levels reflect the frequency of exercise, the average lenght of each session and the intensity.

Source: After ABS 1999a, p. 39

In 1995, 40 per cent of Indigenous Australians reported no leisure–time physical activity, compared with 34 per cent of other Australians (ABS 1995, p. 11).[1] Indigenous

[1] See Table 18.

women of all ages were more likely than their non–Indigenous Australian counterparts to be physically inactive in their leisure–time (ABS 1999a, p. 39; National Centre for Monitoring Cardiovascular Health 1999, p. 28). However, the reported levels of medium to high levels of activity were slightly higher among Indigenous men than among non–Indigenous men.

4.4.2 Biomedical risk factors

Biomedical risk factors, such as body weight, blood pressure and blood lipid levels, are important factors affecting health. The levels of these factors in an individual are the result of behaviour and genetic predisposition.

4.4.2.1 Overweight and obesity

Excessive weight in adults are now a common condition among Indigenous people and are caused by physical inactivity and an excessive intake of calories.

Aboriginal and Torres Strait Islander people are slightly less likely to be overweight, but more likely than the rest of the Australian population to be obese (ABS 1995, p. 8). The 1994 NATSIS found that 36 per cent of Indigenous males and 29 per cent of Indigenous females aged 18 or more were overweight. Another 25 per cent of Indigenous males and another 28 per cent of Indigenous females were classified as obese. This adds up to a total of 61 per cent of Indigenous males and 57 per cent of Indigenous females who were either overweight or obese (Cunningham & Mackeras 1998, p. 21). These numbers compare with 63 per cent of all Australian males and 49 per cent of all Australian females being classified as overweight or obese in the 1995 NHS (Cunningham & Mackeras 1998, p. 22). Of all Australian males and females, 19 per cent each were obese (National Centre for Monitoring Cardiovascular Health 1999, p. 38).[1]

As a result of high levels of overweight and obesity, there are now alarming levels of so–called lifestyle diseases, such as NIDDM, hypertension and circulatory system diseases, among Indigenous people (Saggers & Gray 1991, p. 108).

The risk of developing NIDDM rises with increasing body weight. A BMI greater than 30 implicates a risk of developing NIDDM which is about five to 10 times higher than the risk with a BMI lower than 25 (Shaten, Smith & Kuller 1993, pp. 1333–1335¸ Wannamethee & Walker 1995, pp. 561). Overweight and obesity also increase the predisposition to high blood pressure and therefore coronary heart disease and stroke.

[1] See Table 19, p. 54.

Table 19: Overweight and obesity among Indigenous and all Australian males and females, 1994/1995

	Indigenous Australians (a)		**All Australians** (b)	
Condition	**Males** (%)	**Females** (%)	**Males** (%)	**Females** (%)
Overweight (c)	36	29	42	30
Obese (d)	25	28	19	19
Overweight or obese	61	57	63	49

Notes:
(a) Data from the 1994 National Aboriginal and Torres Strait Islander Survey.
(b) Data from the 1995 National Health Survey.
(c) BMI between 25 and 30.
(d) BMI greater than 30.

Sources: After ABS 1999a, p. 40; Cunningham & Mackeras 1998, p. 21

Central obesity[1] in particular is associated with a high risk of development of NIDDM and cardiovascular disease (Harrison 1991, p. 153).

It is characteristic that overweight in both Indigenous males and females has a central pattern of fat distribution, whereas in the non–Indigenous population mostly men have so. A survey in southeast Australia showed that central obesity is most common among Indigenous females. 75 per cent of Indigenous females aged 20 to 40 years had a waist–to–hip ratio higher than the WHO point for increased risk of cardiovascular disease, compared with 43 per cent in non–Indigenous females. In Indigenous and non–Indigenous males, the prevalence was the same (NHRMC 2000, p. 147).

4.4.2.2 High blood serum lipid levels

Blood serum lipids include cholesterol and triglycerides. Indigenous people mainly suffer from elevated blood triglyceride levels. High alcohol and sugar intake is associated with increased triglyceride synthesis. High triglyceride levels are particularly related to cardiovascular disease due to blood clogging (McGrath et al. 1991, p. 23).

Studies have not shown any difference in blood cholesterol levels between Indigenous and other Australians (National Centre for Monitoring Cardiovascular Disease 1999, p. 36).

4.4.2.3 Hypertension

Hypertension[2] is one of the major factors leading to coronary heart disease and cerebro–vascular disease. Blood pressure levels are generally higher in Indigenous people than in

[1] See Medical Glossary, p. 255.
[2] See Medical Glossary, p. 256.

non–Indigenous people. In the 1995 NHS, 12 per cent of Aborigines aged 25 to 44 years, 33 per cent of those aged 45 to 54 years and 32 per cent of those over 55 years reported elevated blood pressures. Percentages in the same age brackets in the non–Indigenous groups were lower, with 4 per cent, 14 per cent and 36 per cent respectively (ABS 1995, pp. 22–23).

Table 20: Hypertension among Indigenous and non–Indigenous Australians, 1995

Age group	Indigenous population (%)	Non-Indigenous population (%)
25–44 year olds	12.0	4.4
45–54 year olds	32.6	14.2
55 years and over	32.0	36.4

Source: After ABS 1995, pp. 22–23

5 Immediate causes for ill–health

5.1 Environmental health infrastructure

It is widely recognised that many Aborigines suffer from poor living conditions and that this is a major factor contributing to their level of ill–health (NSW Task Force on Aboriginal Health 1983, p. 22; Torzillo & Kerr 1991, p. 328). Improving environmental health conditions can lead to better health outcomes for Aboriginal and Torres Strait Islander people (ABS & AIHW 2001, p. 24).

Despite their essential role for improvement in Aboriginal health, environmental health infrastructure services have failed to be delivered to all Aboriginal and Torres Strait Islander people (NHRMC 1996, p. 22).

Indigenous communities, especially those in rural and remote areas, are often affected by an inadequate and poorly maintained infrastructure (DHAC 1999e, p. 23). Fresh water or gas supply, electricity, sewerage and garbage disposal are not always present or experience frequent breakdowns (Totaro 1989, p. 3).

5.1.1 Fresh water supply

Many rural and remote Indigenous communities temporarily or permanently suffer from a lack of safe drinking water or clean water for cleaning purposes. In 1996, up to 72 per cent of Indigenous rural communities were under restrictions of fresh water supply (NHRMC 1996, p. 22). According to the 1999 Community Housing and Infrastructure Needs Survey[1], one third of the interviewed discrete Indigenous communities[2] in rural and remote areas had one or more water restrictions in the 12 months prior to the interview. The main reason for water restrictions was equipment breakdown (McLennan 1999, p. 15).

Some Indigenous communities also face health risks from polluted drinking water. The 1992 Housing and Community Infrastructure Needs Survey[3] found that in 306 of the 838 examined communities in Western Australia, South Australia, the Northern Territory and Queensland the supplied fresh water was unsuitable for human consumption due to intoxications, infections or parasitic diseases found in contaminated water (ABS 1999, p. 18).

[1] See Explanatory Notes, p. 247.
[2] See Technical Glossary, p. 250.
[3] See Explanatory Notes, p. 248.

5.1.2 Sewerage

In 1992, 15 per cent of Indigenous remote communities did not have a sewerage system (NHRMC 1996, p. 22). By 1999 the situation had improved, but still 71 of 1,291 discrete communities (around 5 per cent) could not access a sewerage system and 58 per cent of discrete communities had experienced an overflow or leakage from sewerage systems in the 12 months prior to the interview (McLennan 1999, p. 18). In the 2001 CHINS, 48 per cent of Indigenous communities had experienced an overflow or leakage from the sewerage system in the 12 months prior to the interview (ABS 2002b, p. 4).

Inadequate sewerage facilities encourage the spread of infections and parasitic diseases.

5.1.3 Electricity

Today, there are still discrete Indigenous communities that do not have access to electricity (7 per cent of discrete communities in 2001) (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 13). However, there has been an improvement since 1999, when 133 of 1,291 identified discrete Indigenous communities (around 10 per cent) did not have an electricity system (McLennan 1999, p. 16) and since 1992, when 28 per cent of all discrete Indigenous communities did not have access to electricity.

5.1.4 Roads

Access to remote communities can be very hard. Roads are in poor conditions and in wet periods often impassable (Torzillo & Kerr 1991, p. 338). The provision and maintenance of both access and internal roads are especially a critical issue for rural and remote communities. According to the 1994 NATSIS, 42 per cent of Indigenous households in rural areas are located on unsealed roads (McLennan 1996a, p. 144).

Internal unsealed roads often create dust problems, leading to unhygienic living conditions, which themselves can cause diarrhoeic and respiratory diseases, infections of eyes, ears, skin and many more diseases (HRSCAA 2000, p. 60; NHRMC 2000, p. 67).

5.2 Housing

Aborigines experience a poor standard of housing that is characterised by overcrowding and poor dwelling conditions. The great dependence of Indigenous people on welfare and their low incomes maintain their housing status at a relatively low level.

Adequate housing decreases the risk of diseases and injury and also contributes to the physical, mental and social well–being of the occupants (ACOSS 1993, p. 17; WHO 1998b, p. 127; Waters 2001, p. 1). Indigenous people, however, tend to live in inadequate, poorly maintained and overcrowded housing conditions more often than non–Indigenous people. This applies to remote, rural and urban areas (Carcach & Mukherjee 1996, p. 156).

Homelessness

From 1996 to 1997, there were around 12,000 homeless Aborigines (HRSCAA 2000, p. 158). Homelessness among Indigenous people can arise due to different factors: a lack of sufficient income to rent privately, reluctance of some landlords to rent to Indigenous people and a shortage of public and community housing[1] which results in extended waiting periods (Jones 1991, p. 5).

Homelessness is associated with a higher incidence of infections and other health problems (Best 1999, p. 52).

5.2.1 Dwelling conditions

Indigenous people are more likely to live in unsatisfactory dwelling conditions, which can include inadequate home heating, broken household utilities, dampness, poor building maintenance or the presence of toxins. In 1996, 31 per cent of all households in Australia living in improvised dwellings[2] were Indigenous households, even though Indigenous households only represent around 2 per cent of all households in Australia (ABS & AIHW 1999, p. 46; AIHW 2000, p. 9). Findings from the 1999 Australian Housing Survey[3] (AHS) further show that dwellings of Indigenous households are three times more likely than those of non–Indigenous households to be in high need of repair (24 per cent versus 7 per cent) (McLennan 1999, p. 18).

The 1999 CHINS indicated that the housing conditions of Indigenous people are generally poorer in rural and remote communities than in urban areas (ABS & AIHW 2001, p. 23). The survey also reported that 29 per cent of housing stock of Indigenous housing organisations[4] was in need of major repairs (McLennan 1999, p. 3). In 2001, it was 27 per cent (ABS 2002b, p. 3).

[1] See Technical Glossary, p. 250 and p. 254.
[2] See Technical Glossary, p. 251.
[3] See Explanatory Notes, p. 246.
[4] See Technical Glossary, p. 252.

Indigenous people living in unsatisfactory dwellings were more likely to have low incomes (less than $12,000 per year), to receive their main income from government payments and to be employed in the Community Development Employment Projects Scheme[1] (CDEP) (McLennan 1996b, p. 45).

5.2.2 Overcrowding

Overcrowded living conditions[2] increase the risk of the spread of infectious diseases (FaCS 1999, p. 59; Waters 2001, p. 16). Overcrowding can also lead to stress through a lack of privacy and high noise levels (Shaw, Dorling & Davey Smith 1999, p. 216).

Aboriginal and Torres Strait Islander people experience overcrowded living conditions more often than other Australians (ATSIC 1998b, p. 30; Jones 1999, p. 105; Neutze 1998, p. 3; Neutze, Sanders & Jones 2000, p. 12).

In 1996, 10 per cent of Indigenous households in major urban areas were overcrowded, 15 per cent in other urban areas and 27 per cent in rural areas. Only 4 per cent of non–Indigenous households in major urban areas were overcrowded and 3 per cent for both other urban and rural areas (Jones 1999, p. 106).

In the same year, 7 per cent of the Indigenous people lived in a dwelling together with nine or more inhabitants. This is more than 50 times that of non–Indigenous people (0.14 per cent) (HRSCAA 2000, p. 158).

5.3 Use of health care services

5.3.1 Geographical barriers

Indigenous Australians often experience difficulties in accessing health services due to geographical barriers (NHMRC 1996, p. 13). They often have to travel long distances to get to the closest general practice or hospital, as they are more likely to live outside urban areas than the total Australian population, and mainstream services are mostly located in larger population centres (Kilham 1994, p. 1). Relatively few general medical practitioners (GPs) can be found in rural and remote areas (DHAC, ATSIC, AHMRC of NSW & NSW Department of Health 2000, p. 37). In 1995, 15.4 per cent of all GPs in Australia were situated in rural and remote areas, catering for 30 per cent of the total Australian population (AIHW 1998, p. 45). In 1998, there were 144 GPs per 100,000

[1] See Chapter 7.5.3.2.1, p. 167.
[2] See Technical Glossary, p. 253.

population employed in rural and remote areas, compared with 306 GPs per 100,000 population in cities and metropolitan areas (AIHW 2000b, p. 3).

In 1994, 30 per cent of Aboriginal households in rural and remote areas did not have access to medical services or nursing staff within a 25 kilometre radius. 35 per cent did not have a community health centre within 25 kilometres (AIHW 1996a, p. 26).

Additionally, getting transport to health services may be problematic, especially in rural and remote areas, because public transport is often limited. In many communities only a few people have access to private transport, resulting in delays in getting to health services, particularly hospitals and specialist services. In urban areas, Indigenous people are heavily reliant on public transport due to their low socio–economic status.

5.3.2 Language barriers

Some Aborigines do not speak English, and health workers and doctors very rarely speak an Aboriginal language. Even when Indigenous people do speak English or speak Aboriginal English (a separate dialect from standard Australian English), communication problems can arise. Aborigines use language in a different way. They tend not to address topics or problems directly. Direct questions are often embarrassing for them and do not lead to any result. There are also differences in non–verbal communication. Direct eye contact, for instance, is avoided and regarded as impolite in Aboriginal culture.

5.3.3 Lack of knowledge about health care system

Educational disadvantages represent an impediment to the use of health care services. A relatively high percentage of Indigenous people are still not able to read or write (Kilham 1994, p. 1), and, hence, experience difficulties in accessing health care. Aborigines also often face a lack of information about available health services. Furthermore, many Aborigines are not aware of the importance of a quick diagnosis and treatment of illnesses.

5.3.4 Culturally inappropriate service delivery

Cultural insensitivity of health services is another key factor limiting access to mainstream services by Aboriginal people. Non–Indigenous service providers have been reported to show negative attitudes and a lack of respect towards Indigenous people and their values. They are often insensitive to the customs and beliefs of Aboriginal people. The absence of cultural awareness at many hospitals and practices alienates Indigenous

Australians (Anderson 1997, p. 124), who consequently delay seeking treatment. Many Aborigines cannot adjust to the western–style medical environment. The impersonal atmosphere in clinics and the western medicine of body parts — opposite to the holistic view of health held by Indigenous people — form part of environments in which Aboriginal concepts of health and aetiology of health problems are generally ignored (Eckermann et al. 1992, p. 178). In addition, many Indigenous people are only comfortable if treated by health staff of the same sex (Mobbs 1991, p. 318).

The acceptance of health services rises with factors such as community control of the service and availability of Aboriginal and Torres Strait Islander staff (ABS & AIHW 2001, p. 44; Ivers et al. 1997, p. 28). In the 1994 NATSIS, 78 per cent of Indigenous people interviewed reported that the involvement of Aboriginal and Torres Strait Islander people in health services was important to them (Madden 1995, p. 24). Nevertheless, the proportion of Indigenous people employed in health services, especially in mainstream health services, is very low. Aborigines and Torres Strait Islander people represent 2 per cent of the total Australian population but only about 0.05 per cent of Australian doctors.

5.3.5 Financial barriers

Many general medical practitioners do not make use of the Medicare Benefits Schedule (MBS) bulk billing system.[1] This results in money out of pocket for patients not covered by private health insurance. In 1995, only a minority of Indigenous people (11 per cent) had private health insurance, compared with 43 per cent of the non–Indigenous people, thus also reducing their access to specialist care in a private hospital (ABS 1999, p. 13).

As Aborigines more often live in poverty and to avoid costs for transport or patient co–payments for medical treatment and pharmaceuticals, they delay seeking treatment and only visit GPs or hospitals in critical cases (National Aboriginal and Torres Strait Islander Health Clearinghouse 1999, p. 7).

[1] See Chapter 7.2.3.1.1, p. 105.

6 Socio–economic impediments to Indigenous health

Socio–economic factors play an important role in Indigenous ill–health. The relationship between socio–economic status and health is well established, with people at the lowest socio–economic levels experiencing the highest rates of illness and death (Kaplan et al. 1996, p. 999). This gradient from poorest to wealthiest has been observed for most of the major causes of death (Turrel 1999, p. 42).

Compared with other Australians, Aboriginal and Torres Strait Islander people experience social inequality, seen in low levels of education and incomes, high levels of unemployment and a substandard physical environment (Thomson 1995, p. 163; Waterford 1982, p. 8). Most of the Aboriginal and Torres Strait Islander people of Australia are part of the lowest socio–economic group, where risk factors such as smoking and obesity are statistically more common (NHRMC 2000, p. 54). Low levels of education lead to high unemployment and a prevalence of Aboriginal people in unskilled jobs, which in turn, results in an inequality in the distribution of income between Indigenous and non–Indigenous people.

In order to improve the health status of the Indigenous people of Australia, not only does the health care system need to be improved, but the socio–economic and political situations need to be addressed and the problems rectified. Low educational levels, unemployment and low incomes can lead to circumstances that contribute to poor health outcomes. But it is also clear that, in turn, poor health can create barriers to effective participation in education and the workforce.

The NAHS Working Party (1989, p. 90) concluded in its report A National Aboriginal Health Strategy from 1989 that “cultural, traditional, political and socio–economic factors of Aboriginal history and Aboriginal society … must be taken into account if there is to be a marked improvement in Aboriginal health.”

6.1 Housing

The availability of adequate and affordable housing is important for emotional and physical well–being. In rural and remote areas, the inadequacy and shortage of housing often contributes to overcrowding and health problems (HRSCAA 2001, p. 127). In urban areas, housing affordability is the major issue. High housing costs result in a high percentage of Indigenous people living in poverty after meeting their housing costs.

Furthermore, Indigenous people are still disadvantaged in terms of housing tenure, being only half as likely as non–Indigenous people to own their home.

6.1.1 Housing tenure

Indigenous people are much more likely to be renters than owners or purchasers of their home (McLennan 1996b, p. 47). This stands in contrast to the non–Indigenous population, of which the majority are home owners. The 1999 AHS stated that 39 per cent of the Indigenous population, compared with 71 per cent of the rest of the population owned or were purchasing their own home (ABS 1999, p. 3).[1]

Table 21: Housing tenure, by Indigenous status, 1999

Tenure	Indigenous households (%)	Non–Indigenous households (%)
Owner without mortgage	12.8	39.3
Owner with mortgage	26.0	31.4
Owners with and without mortgage	**38.8**	**70.7**
Private rental housing	27.3	20.1
Public rental housing	22.4	4.8
Community housing	8.5	1.7
Total renters	**58.2**	**26.7**
Other tenure (a)	3.0	2.6
Total	100.0	100.0

Note:
(a) Includes life tenure schemes, rent/buy schemes and tenure types not included elsewhere (e.g. house–sitting, payment in kind for a specific service).

Source: ABS 2001a, p. 2

There has been a slight increase in home ownership rates among Indigenous people within the last decade, from 25 per cent in 1994, 31 per cent in 1996 to 39 per cent in 1999.[2] Nevertheless, these numbers are not directly comparable due to different methodologies and definitions used, but can give a broad indication of development.

Despite some progress, Indigenous home ownership rates still lag far behind non–Indigenous rates. As a consequence, Indigenous people are more reliant on rental housing, including private, community and public rental housing. In 1999, almost a third (31 per cent) of all Indigenous households lived in public housing provided by state and territory housing authorities (22 per cent) or community housing (9 per cent),

[1] See Table 21.
[2] See Table 22, p. 64.

compared to 5 per cent and 2 per cent of the non–Indigenous households (ABS 2001a, p. 2; Jones 1999, p. 118).[1] Community housing is the principal form of non–monetary housing assistance in remote areas, while public housing is more common in urban areas.

Table 22: Housing tenure of Indigenous households, 1994, 1996 and 1999

	Indigenous households			
Year	**Owner** (%)	**Renter** (%)	**Other** (%)	**Total** (%)
1994 (a)	25.3	70.1	4.6	100.0
1996 (b) (c)	30.8	63.8	5.4	100.0
1999 (b) (d)	38.8	58.2	3.0	100.0

Notes:
(a) Data from the 1994 NATSIS. In the 1994 NATSIS an Indigenous household is defined as a household with one ore more members of Indigenous descent.
(b) In the 1996 Census of Population and Housing and the 1999 AHS, a household is generally defined as Indigenous if the reference person or his/her spouse is Indigenous. However, for the data from AHS and the census used in this table, Indigenous households are defined as households that contain at least one Indigenous member that is aged 15 years or over.
(c) Data from the 1996 Census of Population and Housing.
(d) Data from the 1999 AHS.

Sources: After ABS 2001, p. 3; McLennan 1998, p. 22; McLennan 1996a, p. 143; McLennan 1996b, p. 2

6.1.2 Housing affordability

As housing is the largest single household expenditure, high housing costs can impose financial stress and poverty on households. If housing costs are high, households may not have sufficient finances to afford other necessary expenditures, for example healthy food or clothing. High housing costs may also result in moving to lower standard dwellings or sharing dwellings with other households which leads to overcrowding (Burke 1998, p. 165; Phibbs 1999, p. 11).

Generally, two approaches to measuring the affordability of housing are considered (Commonwealth Grants Commission 2001a, p. 165):

- The ratio approach assumes that housing is affordable if no more than a certain percentage of income is used to pay for housing.
- The residual income approach assumes that housing is affordable if, after paying for housing costs, the household has sufficient income to pay for non–housing needs.

[1] See Table 21.

In the following, housing affordability by reference to the residual income approach will be examined. First, income levels that are sufficient to meet non–housing needs have to be determined. They are called non–housing income needs and are represented by the after–housing poverty lines (AHPLs), which are calculated in accordance with the Henderson poverty lines[1] (HPLs).

To measure after–housing poverty, AHPLs are determined for singles, couples and dependant children. The AHPL of a household is calculated by adding the AHPL values of its members (Jones 1999, p. 72).

A household is deemed to be in after–housing poverty if the household income (after tax) after paying mortgage or rent is less than the specified AHPL. Households can already be in poverty before housing, if their after–tax income is less than their AHPL before paying housing costs (Jones 1994, p. 72).

Indigenous households are more likely to experience housing–related poverty than non–Indigenous households. In 1996, poverty before housing affected 4.5 per cent of non–Indigenous households and 13.1 per cent of Indigenous households (Jones 1996, p. 113).[2] After accounting for housing costs, another 16.4 per cent of Indigenous households were in after–housing poverty, compared to 8.6 per cent of non–Indigenous households (Jones 1999, pp. 41–47).

The cost of housing is the main cause of poverty especially in urban areas where 12 per cent of Indigenous households are in poverty before housing costs are taken into account. After adjusting for housing costs, 30 per cent of Indigenous people in urban areas are in poverty (HRSCAA 2001, p. 137).

Table 23: Housing poverty of Indigenous and non–Indigenous households, 1996 (a)

Poverty	Indigenous households (%)	non–Indigenous households (%)
Before–housing poverty	13.1	4.5
After–housing poverty	16.4	8.6
Total housing poverty	**29.5**	**13.1**

Note:
(a) Data from the 1996 Census of Population and Housing.

Source: After Jones 1999, pp. 111–113

[1] See Technical Glossary, p. 251.
[2] See Table 23.

No improvements have been achieved recently. In 1991, a total of 27.4 per cent were either in before–housing or after–housing poverty and by 1996, this proportion had even slightly increased to 29.5 per cent.[1] This was due to an increase in before–housing poverty; after–housing poverty itself decreased in this period.

Table 24: Housing poverty among Indigenous households, 1991 and 1996 (a)

	Indigenous households		
Year	Before–housing poverty (%)	After–housing poverty (%)	Total housing poverty (%)
1991	7.3	20.1	27.4
1996	13.1	16.4	29.5

Note:
(a) Data from the 1991 and 1996 Census of Population and Housing.

Sources: After Jones 1999, pp. 111–113

6.2 Education

Indigenous people generally only achieve a very low standard of education (Ross 1996, p. 103). Literacy and numeracy levels are still low compared to non–Indigenous standards, as are participation and attainment rates. Although the number, and to a lesser extent the proportion, of Indigenous students in higher education is increasing, academic success and retention rates have not increased to the same extent.

Low levels of education negatively affect employment opportunities and levels of income (Daly 1996, p. 97; MCEETYA Taskforce on Indigenous Education 2001, p. 10). People with low levels of education often lack an understanding of their rights and of their life choices (NACCHO 1998a, p. 2). On the other hand, educational outcomes can be hindered by poor health, such as hearing loss or malnutrition, culturally inadequate schooling and a lack of access to schooling facilities (HRSCFCA 2000, p. 72). Low socio–economic background also correlates negatively with educational outcomes (Schwab 1999, p. 23).

6.2.1 School participation and retention

Despite an increase in Indigenous educational participation over the last two decades, Indigenous school participation rates[2] still remain far lower than those of the general

[1] See Table 24.
[2] See Technical Glossary, p. 254.

Australian population (MCEETYA 1998, p. 80; Smallwood 1995, p. 13).

School participation rates are lower for Indigenous than non–Indigenous youth and decrease to a greater extent among Indigenous youth with increasing age. Indigenous students are far less likely to continue schooling beyond the compulsory years.[1] According to the 1994 NATSIS, 81 per cent of Indigenous 15 year olds attended school, compared with 92 per cent of all 15 year olds. At the age of 17, the Indigenous school participation rate dropped to 31 per cent, compared to 60 per cent for all Australian students (Madden 1995, p. 34).[2]

However, the percentage of Indigenous youth participating in primary and secondary school is increasing and participation gaps between Indigenous and non–Indigenous students are diminishing (Madden 1995, p. 39, MCEETYA 1996, p. 47).

Table 25: Indigenous participation in education, 1994

Age (years)	**Indigenous participation** (%)	**All–Australian participation** (%)
15	81	92
16	57	80
17	31	60
18	6	13
18–24 in post-secondary education	10	28
25 and over in post–secondary education	6	5

Source: After Madden 1995, p. 39; MCEETYA 1996, p. 48

Despite recent improvements in participation, there is still a considerable proportion of Indigenous people that have never attended school. In 1996, 2.8 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over, compared with 0.7 per cent of the total population, had never attended school (McLennan 1998, p. 68). The level of attendance is far lower for Indigenous students in both primary and secondary schooling. In secondary school, absenteeism among Indigenous students is up to three times that of non–Indigenous students (DEST 2001, p. 1).

Indigenous retention levels have risen over the last decade. At school year 10, apparent school retention rates[3] for Indigenous students rose from 70 per cent to 83 per cent

[1] See Appendix C, Figure C, p. 204.
[2] See Table 25.
[3] See Technical Glossary, p. 254.

between 1989 and 1992. Thereafter, school retention rates slightly dropped but started to recover in 1997. From 1989 to 1998, the retention rate gap of school year 10 (the difference in retention rates between the two groups) decreased by 12.6 per cent from 27.0 per cent to 14.4 per cent.[1] Retention rates in school year 12 steadily increased since 1989 from 14.4 per cent to 32.1 per cent of Indigenous students in 1998 and 36 per cent in 2001 (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 5). The retention rate gap of school year 12 between Indigenous and all Australian students decreased from 45.9 per cent in 1989 to 40.6 per cent in 1998.

6.2.2 Post–secondary educational attainment

Indigenous Australians are much less likely than the total population to hold a post–secondary qualification.[2]

According to the 1996 census, 13.6 per cent of Indigenous people, compared with 34.4 per cent of the non–Indigenous population aged 15 and over had a post–secondary qualification (McLennan 1998, p. 70).[3] Indigenous Australians had particularly low levels of tertiary educational attainments.

The 1994 NATSIS showed similar results regarding Indigenous educational attainment.[4]

Table 26: Educational attainment of Indigenous and non–Indigenous people, 1996 (a)

Highest level of education attained	Indigenous (%)	Non-Indigenous (%)
Have post-school qualfication	**13.6**	**34.4**
Bachelor degree or higher	2.0	10.4
Diploma (b)	2.2	6.1
Skilled vocational qualification	4.5	10.7
Basic vocational qualification	1.9	2.9
Inadequately described	3.0	4.3
Do not have post-school qualification	**86.4**	**65.6**
Never attended school	2.8	0.7
Total	**100.0**	**100.0**

Notes:
(a) Data from the 1996 Census of Population and Housing.
(b) Includes undergraduate and associate diploma.

Source: After McLennan 1998, p. 70

[1] See Figure 3, p. 69, and Appendix D, Table D1, p. 205.
[2] See Technical Glossary, p. 253.
[3] See Table 26.
[4] See Appendix D, Table D2, p. 206.

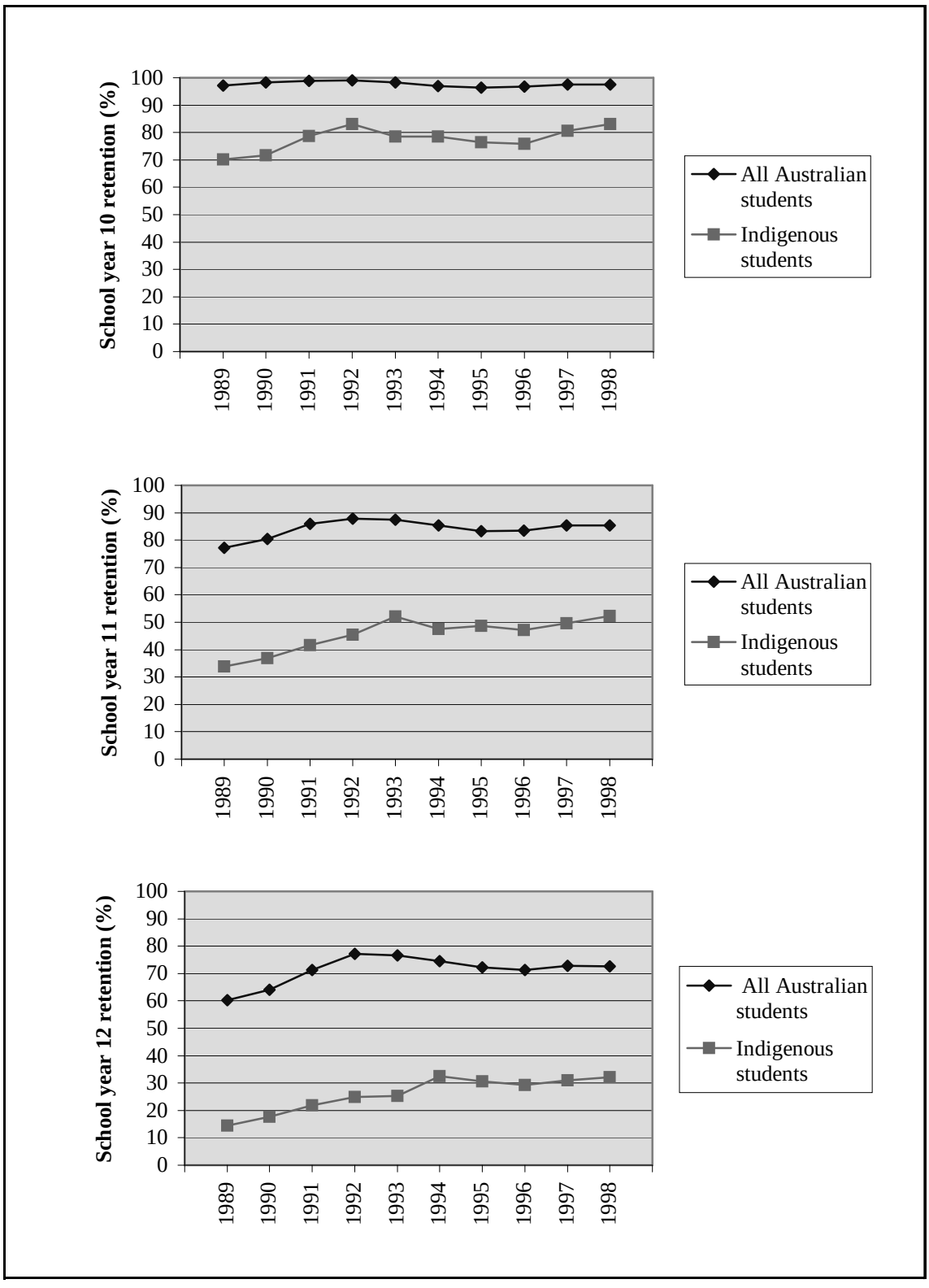


Figure 3: Retention rates to school year 10, 11 and 12 for Indigenous and all Australian students, 1989 to 1998

Sources: After MCEETYA 1997, p. 72; MCEETYA 1998, p. 80

6.2.3 Indigenous students in higher education

Indigenous student enrolments in higher education more than doubled between 1989 and 1999. Enrolments of Indigenous students as a proportion of the total number of enrolments in higher education rose from 0.8 per cent to around 1.2 per cent.[1]

Even though Indigenous commencements in higher education increased, their academic retention and success rates still remain relatively low. In 1989, Indigenous award course completions represented 0.6 per cent of all Australian completions, while the Indigenous population made up 1.6 per cent of the Australian total population. In 1996, Indigenous award completions represented around 0.7 per cent of all completions.[2] However, the Indigenous share of the total population rose to 2.1 per cent in the same period, which makes the increase illusory. In 1999, the Indigenous students represented about 0.8 per cent of all award course completions.

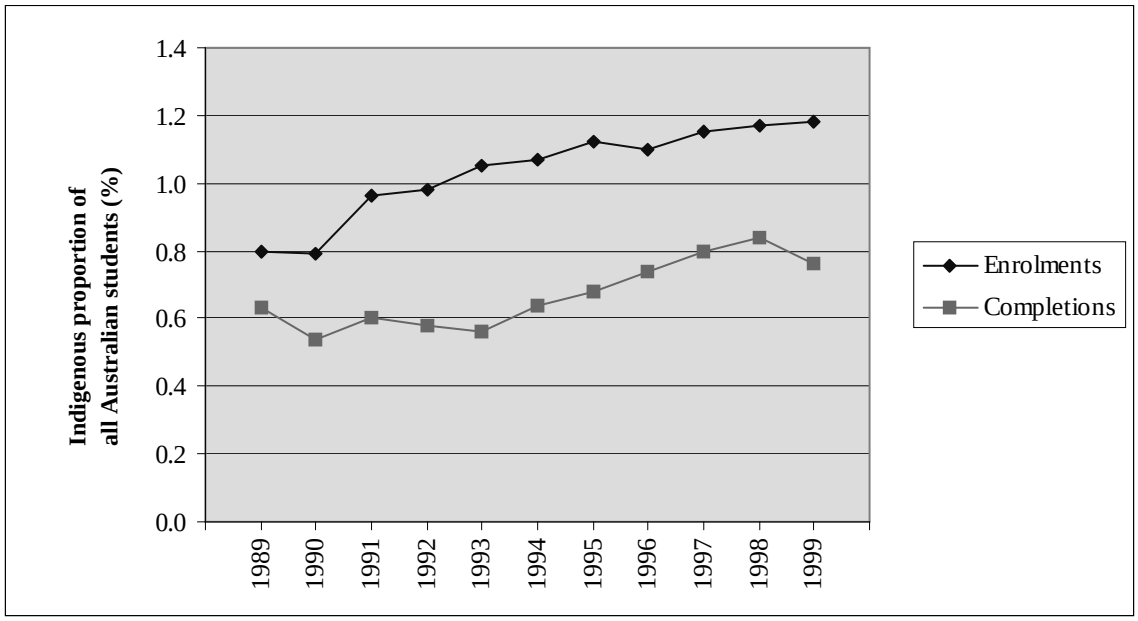


Figure 4: Indigenous student enrolments and award course completions as proportion of all Australian enrolments and completions, 1989 to 1999

Sources: After DEETYA 1996, pp. 77, 100, 116; DETYA 2000e, p. 36; DETYA 1999c, pp. 2–4; Schwab 1996, p. 4

[1] See Appendix D, Table D3, p. 206.
[2] See Figure 4 and Appendix D, Table D4, p. 207.

6.3 Employment

6.3.1 Unemployment

Aborigines face higher unemployment rates than other Australians. In 1996, the rate of unemployment among Indigenous people was 22.7 per cent, compared with 9.2 per cent among the total Australian population (McLennan 1998, p. 33). The rate of unemployment would have been even higher (more than 40 per cent), if those participating in the Community Development Employment Projects Scheme (CDEP) had been counted as unemployed (Altman 2000, p. 5; HRSCAA 2000, p. 158; McLennan 1998, pp. 39–40).

The unemployment rate interacts with the remoteness of an Indigenous community. The higher the remoteness, the more likely a higher percentage of Indigenous people are unemployed (Office of the Minister for Aboriginal and Torres Strait Islander Affairs 1992, p. 4). This can be attributed to low labour market opportunities (HRSCAA 2001, p. 105). Indigenous people in urban areas have access to better job opportunities but also have to compete with a larger number of non–Indigenous job seekers (HRSCAA 2001, p. 106).

Other factors contributing to high unemployment among Indigenous people are low educational qualifications and remaining prejudice among non–Indigenous employers (Ross & Whiteford 1992, p. 93).

6.3.2 Occupational inequalities

Occupational status

Aborigines are more likely to be employed in less–skilled and lower–income occupations. In 1996, 26 per cent of the Indigenous employed were classified as unskilled workers or labourers compared to 9 per cent of the non–Indigenous employed (Altman 2000, p. 5; Commonwealth Grants Inquiry 2000, p. 141; McLennan 1998, p. 35). Conversely, a higher percentage of the non–Indigenous employed is managers, administrators and other professionals (26 per cent) compared with 14 per cent of the Indigenous employed. A smaller percentage of Indigenous people are employers or self–employed. In 1996, only 3.2 per cent of the Aboriginal and Torres Strait Islander people were self–employed, compared to 8.4 per cent of all Australians (Council for Aboriginal Reconciliation 2000, p. 3; Hunter 1996, p. 54).

Sector

Indigenous people are over–represented in the government sector and CDEP. In 1996, 28 per cent of Indigenous jobs were in the government sector and 15 per cent in CDEP,

compared with 18 per cent and less than 1 per cent for the total labour force. 80 per cent of the non–Indigenous employed worked in the private sector, compared with only 53 per cent of the Indigenous employed (McLennan 1998, p. 34).

6.4 Income

In general, Indigenous people have smaller incomes than the total population because of low levels of education, high rates of unemployment and greater employment in unskilled occupations (Saggers & Gray 1991, p. 91; Thomson 1995, p. 168). The difference in income, however, cannot be completely explained by difference in the occupation held or level of qualification: Indigenous employees had a lower median income than all employees for almost every occupation group and level of qualification (ABS & AIHW 1999, p. 22). Income is generally higher in urbanised areas and cities and lower in more rural and remote areas (Ross 1996, pp. 81–82).

Within any one country, people with the least education and income tend to have the worst health (DHAC 1999a, p. 3; Matthew 1998, p. 625). An adequate level of income is necessary to provide a healthy living environment, such as physically safe housing or beneficial consumption behaviour. In low–income families in Australia, serious chronic illnesses for children aged zero to 14 years are more frequent than in high–income families. Furthermore, Australians with a low income are more likely to smoke, drink, be overweight or obese and lack physical exercise (DHAC 1999a, p. 4).

6.4.1 Personal income

In 1996, the median weekly income by all employed and unemployed Indigenous people was $218, compared with $294 for the total population (McLennan 1998, p. 47).

Differences between median incomes for Indigenous people and the total population vary across the states and territories. In 1996, the greatest disparity was found in the Northern Territory ($185), followed by the Australian Capital Territory ($126), Western Australia ($96) and New South Wales ($70). In Tasmania the difference in the median weekly income was $32 and in Victoria $42 (McLennan 1998, p. 47).

The median weekly income for employed Indigenous people in 1996 was $366. This was 25.6 per cent lower than the median weekly income of the total employed population ($492) (McLennan 1998, p. 48).

6.4.2 Source of income

In 1994, most Indigenous people (55 per cent) received their main income through government social security payments (McLennan 1996a, p. 122). Another 9 per cent obtained their main income from CDEP income. CDEP income is most frequently received in rural and remote areas. A greater proportion of Indigenous people in capital cities have non–CDEP earned income as their main income source than in other urban and rural areas.

6.5 Poverty

It is beyond question that illnesses occur more commonly among those people living in poverty than those with greater social and economic resources. Poverty can be linked to poor health due to the reduced financial capacity to meet essential costs for housing, food, clothing, medical expenses, heating and other expenses. This can result, among other things, in hazardous physical environments, inadequate household amenities, overcrowding, limited choices with respect to nutrition and delayed medical treatment (Bartlett & Legge 1994, p. 6; NHRMC 2000, p. 55).

In an industrialised country like Australia, poverty is perceived in relative rather than absolute terms. Poverty is not defined in terms of a lack of sufficient resources to meet basic needs, but rather as lacking the resources required to be able to participate in the lifestyle and consumption patterns enjoyed by other Australians. To be relatively poor is thus to be forced to live on the margins of society, to be excluded from the normal spheres of consumption and activity.

There is no universally accepted definition of poverty in Australia. Within the range of definitions of poverty available, there are two main groups: one where poverty is seen in terms of a lack of adequate income, and the other where poverty is seen as a more complex pattern of socio–economic and social disadvantage (Hunter 2000, p. 3). Also, there is no official poverty line in Australia or official equivalence scales for adjusting income to account for the needs of households of different sizes and compositions.

In the following, Indigenous poverty will first be examined in terms of income using two different approaches. The median income[1] approach measures the income of Indigenous people in comparison with the median income of all Australians; the application of the Henderson poverty line investigates the proportion of the Indigenous

[1] See Technical Glossary, p. 253.

population with income below this poverty line. Thereafter follows a short summary of Indigenous disadvantage in various socio–economic spheres of life, demonstrating the depth of Indigenous poverty.

6.5.1 Poverty in terms of income

Most poverty research focuses on whether disposable income[1] is sufficient to meet needs. This is an indirect measure of poverty because actual experienced living standards are not measured directly. Instead income is measured as a resource on which living standards depend (King 1998, p. 71).

Median income approach

The median income approach measures Indigenous income and poverty relative to 40, 50 and 60 per cent of Australia's median income. The OECD equivalence scale is used in order to consider the real costs of large households and to adjust income for the size and composition of a household.

According to the households' raw income data, Indigenous households do not suffer from a greater burden of income poverty than other Australian households. From 1994 to 1995, fewer Indigenous Australian households had incomes below 40 and 50 per cent of the Australian median income than all Australian households (13.9 per cent and 23.3 per cent compared with 17.1 and 25.4 per cent) (Hunter 1999, p. 9).[2]

Raw income, however, does not consider the real costs of large households. Therefore, the OECD equivalence scale is used to adjust income for the size and composition of households. The OECD scale gives a weight of one to the first adult, 0.7 to the second and subsequent adults and 0.5 to all dependants. The application of equivalence scales to household incomes disproportionately increases Indigenous poverty compared to overall Australian poverty. After adjusting for household size and composition, Indigenous households are about two to three times more likely to be impoverished than all Australian households (Hunter 1999b, p. vi): 31.4 per cent of all Indigenous households had an income less than 50 per cent of the Australian median income, compared to 11.7 per cent of all Australian households from 1994 to 1995.[2]

[1] Note: Income is measured after the receipt of cash benefits from government and after the payment of personal income taxes to government.

[2] See Table 27, p. 75.

Table 27: Indigenous and all–Australian poverty as measured by the proportion of households with income below various percentages of the Australian median income, 1994–1995 financial year

	Indigenous Australian households (%) with income			All Australian households (%) with income		
Income	<40% of Australian median income	<50%	<60%	<40% of Australian median income	<50%	<60%
Households' raw income (a)	13.9	23.3	31.8	17.1	25.4	31.1
Equivalent income, OECD scale (b)	12.8	31.4	49.2	6.2	11.7	25.8

Notes:
(a) Raw income poverty does not adjust income by equivalence scales to account for the size and composition of households.
(b) OECD equivalence scale:

IE = IH / SI	IE is equivalent income, IH raw household income and SI the equivalence scale.
SI = 1+a (A–1) + bK	A is the number of adults in the household and K is the number of children in the household. The OECD equivalence scale equals a and b 0.7 and 0.5 respectively.

Source: After Hunter 1999, p. 9

Henderson poverty lines

The Henderson poverty lines (HPLs)[1] are income–based relative poverty lines. HPLs are a widely used method of estimating poverty in Australia. The poverty lines are set depending on the type of family and the labour force status of the head of the income unit[2] or family. Further, poverty can be calculated on the basis of income before or after accounting for housing costs.[3]

According to a study by Ross and Mikalauskas (1996, pp. 13–15) based on data from the 1991 Census of Population and Housing, poverty rates according to HPLs are much higher among Indigenous than non–Indigenous families. For all sizes of families, a greater proportion of Indigenous families than non–Indigenous families experienced poverty. Half of all Indigenous families with children had incomes below HPL, compared to 21 per cent of non–Indigenous families (Ross & Mikalauskas 1996, p. 11).[4] Poverty rates increased with the number of children in the family and were higher for sole–parent families.

[1] See Appendix B, Table B, p. 203, for HPL rates in 2001.
[2] See Technical Glossary, p. 252.
[3] Note: Housing costs are not taken into account in this approach, but were referred to in Chapter 6.1.2, p. 64.
[4] See Table 28, p. 76.

Differences between Indigenous and non–Indigenous sole–parent families were smaller, as poverty also is a problem amongst non–Indigenous sole–parent families.

Table 28: Proportion of Indigenous and non–Indigenous income units below the Henderson poverty line, 1991

Income unit type	Indigenous (%)	Non–Indigenous (%)
Couple with		
one child	15.7	8.1
two children	23.3	9.4
three children	46.6	17.6
four/more children	74.4	32.5
Sole parent with		
one child	67.6	46.3
two children	79.1	57.5
three/more children	88.6	67.8
All families with children	**50.1**	**20.9**

Source: Ross & Mikalauskas 1996, p. 11

The prevalence of poverty among Indigenous people is mainly due to three factors (Daly & Smith 1999, p. 9): Indigenous people suffer from high unemployment, are more likely to live in larger households and more often are members of sole–parent families.

The most important factor associated with Indigenous poverty is the employment status. Indigenous families are about twice to three times more likely than non–Indigenous families to have no employed member and therefore to rely on social security payments. This is partly due to the higher proportion of Indigenous sole–parent families (33 per cent compared to 22 per cent among non–Indigenous families), but also a result of high unemployment rates and low wages among Indigenous people (Ross & Mikalauskas 1996, p. 15).

Indigenous households are more likely to contain large families, with 35 per cent having three or more children, compared to 23 per cent of non–Indigenous families (Ross & Mikalauskas 1996, p. 8). The already low incomes of Indigenous people become even lower once corrected for household size.

6.5.2 Multi–dimensional nature of Indigenous poverty

Given the multi–dimensional disadvantage and the actual living standards Indigenous people experience, it may not seem appropriate to rely solely on income–based measures to indicate poverty (ACOSS 1974, p. 1). The focus in this approach lies in quantifying inequality in particular aspects of living conditions and identifying poverty directly rather than indirectly only through income measures.

Indigenous poverty is associated with poor outcomes and restrictions of choice in other spheres of life (Eckermann et al. 1992, p. 64; Hupalo & Herden 1999, p. 4). Many Indigenous people are caught in a vicious cycle of poverty, poor education, substandard housing, low employment and ill–health.

Table 29 illustrates that one distinguishing feature of the Indigenous poor is the depth of poverty they experience across a range of welfare indicators (Hunter 1999b, p. 17).

Table 29: Multi–dimensional poverty among Indigenous households (a), 1994

	Quintile of equivalent household income (OECD scale)				
Social indicator	**1**	**2**	**3**	**4**	**5**
Education (highest qualification attained)					
Degree or diploma (%)	2.0	1.6	1.9	3.2	6.2
Vocational qualification (%)	4.9	5.4	5.6	7.2	10.8
Other qualification (%)	2.9	3.2	2.3	4.4	5.3
Year 10 certificate (%)	0.8	0.8	0.7	0.9	1.0
Year 12 certificate (%)	0.4	0.3	0.5	0.2	0.5
No qualification (%)	89.1	88.8	89.1	84.0	76.2
Employment					
Employed non-CDEP (%)	3.7	6.5	16.3	36.6	69.9
CDEP (%)	7.2	8.6	9.3	12.8	9.0
Unemployed (%)	27.6	28.9	21.7	17	7.6
Not in labour force (%) (b)	61.5	56.0	52.7	33.6	13.5
Housing					
Number of bedrooms per person	0.9	0.8	0.9	0.8	1.2
Has all household utilities (%) (c)	93.7	95.0	94.9	94.3	97.1
All household utilities work (%)	83.8	84.8	85.3	85.7	87.5
Household composition					
Number of adults aged 15 years and over	2.0	2.4	2.5	2.8	2.4
Number of dependents	2.34	2.02	1.83	1.53	0.75

Notes:
(a) Based on a sample of 3,433 Indigenous households.
(b) Includes people aged 15 years or more who were neither employed nor unemployed. This category includes people who are retired, pensioners and people engaged in home duties.
(c) Household utilities include electricity, gas, running water, sewerage, toilets and bathroom.

Source: After Hunter 1999, pp. 11, 13

Indigenous households with lower incomes generally have lower secondary, tertiary and vocational qualifications. They suffer from higher unemployment rates and more seldom are employed in the mainstream labour market. Further, low income households experience more problems with housing, such as a lack or breakdown of utilities. They also tend to have fewer adult and more dependent household members.

Middle class people, compared to people form the lower socio–economic classes, have more time and money for leisure activities. Against popular belief, they experience fewer stresses to be relieved with addictive substances. They have financial and educational resources to obtain a healthy diet and lifestyle and safe housing (Saggers & Gray 1991a, p. 193).

Table 30: A synoptic view of socio–economic differences between Indigenous and non–Indigenous Australians

Social indicator	Indigenous	Non-Indigenous	Ratio Indigenous/ non-Indigenous
Employment, 1996 (b)			
Unemployment rate (%)	22.7	9.2	2.5
Occupation			
Occupation unskilled (labourers) (%)	25.9	8.8	2.9
Managers, administrators, professional (%)	14.0	26.0	0.5
Self-employed (%)	3.2	8.4	0.4
Income, 1996			
Median income, adults ($ per week) (b)	218	294	0.7
Housing (a), 1999 (c)			
Currently renting (%)	58.2	26.7	2.2
Home owner or purchasing (%)	38.8	70.7	0.5
Education, 1996 (b)			
Did not go to school (%)	2.8	0.7	4.4
18-24 year olds in post-secondary education (%)	10.0	28.0	0.4
Post-school qualification (%)	13.6	34.4	0.4
Health, 1996 (b)			
Male life expectancy at birth (years)	56.9	75.1	0.8
Female life expectancy at birth (years)	61.7	81.1	0.8
Population aged 65 years or over (%)	2.6	12.0	0.2

Note:
(a) Indigenous households are defined as households in which the reference person or the reference person's spouse is Indigenous. It should also be noted that in some circumstances home ownership is not possible for Indigenous people owing to the communal nature of land tenure.
(b) Data from the 1996 Census of Population and Housing.
(c) Data from the 1999 AHS.
(d) Data from the 1994 NATSIS.

Sources: After ABS 2001a, p. 2; ABS 1998, pp. 12–16; Altman 2000, p. 6

Table 30 summarises indicators of Indigenous socio–economic disadvantage compared with non–Indigenous Australians in the areas of health, housing, education and employment.

7 National social policy

Until the 1970s, Indigenous health policy was almost non–existent. There was no national policy on Aboriginal health and responsibilities were left to the states and territories, most of which did not have distinct Indigenous policies (Bartlett 1998, p. 242). The same was true for Indigenous housing, education and employment policies. It was not until 1967 that the Indigenous people in Australia got full citizenship rights and that the Commonwealth assumed responsibility for Aboriginal affairs. Only then did the Commonwealth government start to develop nation–wide strategies to improve Indigenous health.

It was obvious that the ill–health of the Indigenous people of Australia could not be attributed to the inappropriateness of the health care system alone, but was, and still is, a consequence of economic, social and political disadvantage. Measures would have to be taken in all areas of social policy in order to break the vicious cycle of Indigenous socio–economic disadvantage and as a result obtain long–term improvements in Indigenous health.

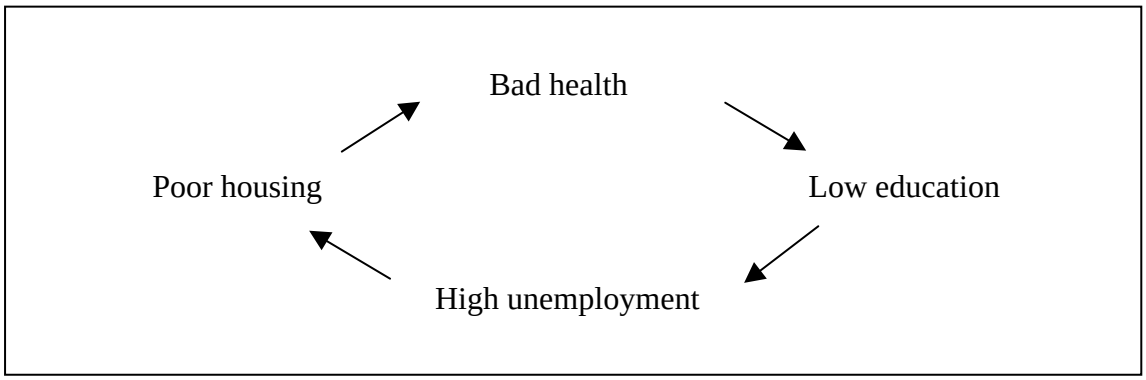


Figure 5: Vicious cycle of Indigenous ill–health and socio–economic conditions
Source: After Saggers & Gray 1991a, p. 193

Poor housing conditions or overcrowding can lead to psychological and physical stress and increase the risk of disease or injury. Poor health can represent a direct obstacle to employment or indirectly reduce employment prospects through its negative impacts on education. Long–term health problems generally restrict a person's ability to engage in education or obtain post–secondary qualifications. With low levels of education, job opportunities in the labour market are restricted to unskilled work on low incomes, which in turn do not allow for appropriate and safe housing.

WHO also recognised the need to coordinate primary health care with other sectors of socio–economic development in 1978. Even though the following statement referred to developing countries, it also applies to the Indigenous people of Australia, being a Fourth World community:

> Health cannot be attained by the health sector alone. In developing countries in particular economic development, anti–poverty measures, food production, water, sanitation, housing, environmental protection and education all contribute to health and have the same goal of human development. (WHO 1978, p. 10)

The following chapters will concentrate on policy developments since the end of the 1980s. This was a time when many new national policies for the improvement of Indigenous health and socio–economic background were developed and introduced. First, the major Australian parties and the evolution of their political agendas in Indigenous affairs will be outlined. Then, political developments affecting Indigenous health, housing, education and employment will be reconstructed. As a result of these policies, existing programmes have been altered and new programmes established to improve Indigenous health, housing, educational and employment situation. An overview of these programmes will be given.

7.1 Major parties and their policy directions

The Australian party system is dominated by the contest between the social democratic Australian Labor Party (ALP) and the coalition of the conservative Liberal Party of Australia (LP) with the National Party of Australia. In November 2001, the Liberal and National Coalition Parties were re–elected as the Commonwealth government.[1] Generally it seems that the Labor Party is more in favour of the acceptance of Aboriginal rights than the Liberal or National Parties (Bennett 1999, p. 62). The results of a survey of members of parliament at Commonwealth and state levels from 1991 to 1992 verify this statement.

Responding to a general question on support for Aboriginal aspirations, the vast majority of Labor, Liberal and National politicians were supportive. When asking specific questions, though, the support of Liberal and National political leaders lessened. Particularly in regards to land rights and cultural protection, Labor politicians appeared to be more sympathetic than members of the Coalition Parties.[2] Furthermore,

[1] See Appendix F, p. 209, for prior Commonwealth governments.
[2] See Table 31, p. 82.

an alarming 58 per cent of Liberal politicians supported the idea of Indigenous assimilation (Galligan 1994, p. 102).

Table 31: Support for recognition and acceptance of Aborigines among politicians of the Labor Party and the Liberal/National Coalition Parties, 1991 to 1992 (a)

	Support (%) of the	
Statement	**Labor Party**	**Liberal and National Parties**
Aboriginal aspirations should be recognised (b)	96.8	89.6
Government has responsibility to grant land rights (c)	93.2	40.8
Settle land claims before development (d)	78.2	24.4
Aborigines should have special cultural protection (e)	76.6	43.7
Aborigines should not be assimilated (f)	80.3	42.2

Notes:
(a) All political leaders of the Labor, Liberal and National Party at Commonwealth and state levels were surveyed with a response rate of 74 per cent.
(b) Percentage who agree or agree strongly with the statement: "It is important for the well–being of Australian society that the aspirations of Aboriginal people will be recognised."
(c) Percentage who believes that government has a responsibility to grant land rights to Aborigines.
(d) Percentage who believes that land claim settlements with Aboriginal people should be reached before using their land for economic purposes.
(e) Percentage who agree or agree strongly with the statement: "As the first Australians, Aborigines should have special cultural protection that other groups don't have."
(f) Percentage who mainly disagrees with the statement: "In the long run, it would be best for Aboriginal people to be completely assimilated into Australian society."

Source: After Galligan 1994, p. 102

7.1.1 Australian Labor Party

It was the Australian Labor Party that started a national policy supporting the Indigenous people of Australia. In 1972, under Prime Minister Whitlam, Labor ranked the self–determination of Aboriginal and Torres Strait Islander people as one of the government's main goals in Indigenous politics. Whitlam stated that the Labor Party's aim was "to restore to the Aboriginal people of Australia their lost power of self–determination in economic, social and political affairs" (Whitlam 1973, p. 697). For the first time, the Commonwealth government explicitly supported the rights of Aboriginal and Torres Strait Islander people in Australia (Lippman 1991, p. 57).

In 1972, the Commonwealth Department of Aboriginal Affairs was established and replaced the Council for Aboriginal Affairs, which had been established in 1967 but limited to an advisory role. The Whitlam government adopted the first national Aboriginal health policy, the National Ten–Year Plan for Aboriginal Health, and started

the Commonwealth funding of Aboriginal Medical Services and other community–controlled organisations. However, allocated funding for Indigenous–specific services was inadequate and issues like housing, education, unemployment and living standards were not properly addressed (Bartlett 1998, p. 160). The Labor Party lost power in 1975 and went into opposition until 1983.

The new Labor government under Prime Minister Hawke in 1983 was committed to address the issues of Aboriginal land rights, housing, education and community infrastructure. According to the new government, Aborigines should be more deeply involved in health service delivery, meaning Aboriginal Community–Controlled Health Services should be the main method of health service delivery and more Indigenous people should enter into the health workforce (DAA 1984, pp. 34–35). The general Aboriginal policy supported self–determination and consultation of Aboriginal people in regards to policy planning (DAA 1984, pp. 41–42). The Labor government acknowledged Aboriginal culture as "an integral part of Australia's cultural life and heritage" (DAA 1987b, p. 2). Furthermore, the policies and programmes were intended to increase Indigenous economic independence and reduce disadvantages in housing, health and education. One year after the ALP's election to the Commonwealth government in 1983, an Aboriginal head of DAA was introduced, reinforcing the principle of self–determination (Lippman 1991, p. 71). Nevertheless, the Labor Commonwealth government failed to adequately fund Aboriginal–controlled bodies and services.

In 1987, the Aboriginal Employment Development Policy was announced which planned to decrease welfare dependence by improving educational and training opportunities and ensuring access to the conventional labour market (DAA 1987a, pp. 44–45). CDEP projects were extended by adding another 23 communities to the 40 communities already taking up the programme. In 1987, the first steps toward the establishment of ATSIC, and its replacement of DAA, were made.

Finally, ATSIC was established in 1990 as an elected representative body that decides on priorities, formulation and implementation of Indigenous policies and programmes to improve social, economic and cultural conditions of the Indigenous people. The responsibility for Indigenous health was relocated again, this time from DAA to ATSIC. In July 1995, however, the Indigenous health portfolio was transferred to the then Department of Health and Aged Care[1].

[1] See Appendix G, p. 210 for name changes of Commonwealth departments.

ACCHSs were seen as the main health provider for Indigenous people and main Commonwealth funding was transferred from state–operated services to ACCHSs.
Other aims were to establish national health statistics for Indigenous people, to provide essential services to Indigenous communities and to improve training for Indigenous health workers.
As to Indigenous land rights, it was Labor who started to lay down legislation in favour of native title[1] (ALP 2001, p. 1) before the the Coalition Parties gained power in 1996. In 2000, the Labor Party promised, if elected to government, to reconsider many of the 1998 Native Title Amendment Acts that were established by the Coalition government and that reduced Indigenous people's rights to native title (ALP 2000, pp. 12–18).

The Labor Party, in stark contrast to the Liberal Party of Australia, still uses the term self–determination when speaking about Indigenous people and their rights. Indigenous people should be involved in the development of their own projects, and "adequate resourcing of those Aboriginal groups, organisations and communities during planning, development and implementation of these projects and programmes" provided (Australian Labour Party WA Branch 1989, p. 1). Self–determination, in comparison to the term "self–management" used by the Liberal Party, emphasises the rights of Indigenous people to their own decision making in their affairs. Still, self–determination does not include Indigenous sovereignty or self–government, as seen in the 2000 ALP platform (2000a, pp. 12–16): "Labor believes that Indigenous Australians must be able to … exercise their right to self–determination within the Australian nation." [2]

7.1.2 Liberal and National Parties of Australia

In 1975, the newly elected Liberal–National Coalition government[3] under Prime Minister Fraser changed the central term of Indigenous policy from self–determination to self–management (Saggers & Gray 1991a, p. 133). Self–management suggested the restriction of Aboriginal authority to "management of the means rather than determination of the ends" (Bartlett 1998, p. 147). It also meant that Aborigines should not only be involved in their future development, but also be held responsible for the success or failure of this development (Bennett 1989, p. 26). The Coalition government cut spending on Aboriginal concerns by about 20 per cent (Lippman 1991, p. 62).

[1] See Technical Glossary, p. 253, and Appendix E, p. 208, for native title legislation.
[2] See also Chapter 8.2, p. 186.
[3] Note: The Liberal Party is the more powerful party of the two Coalition parties.

Nevertheless, the Fraser government generally maintained the policies and programmes of the Whitlam government, for example the federal funding of ACCHSs.

The Howard Liberal–National Coalition government, which has been in place since 1996, demanded that the Indigenous people of Australia contribute to the reduction of Australia's household deficit (Altman 1996, p. 6). Very shortly after its election in 1996, an inquiry into the spending practices of ATSIC was announced (Rintoul 1999, p. 184). Funding for ATSIC was cut in the Coalition government's first budget (Clark 2002b, p. 1). This meant that funds for programmes administered and funded by ATSIC were reduced. Programmes administered by the then DHFS and DEETYA were to be conserved, expressing the Coalition Parties' emphasis of mainstream programmes in the delivery of health and other services to Indigenous people (Altman 1996, p. 6; McConaghy 2000, p. 13; National Party of Australia 2001, p. 3).

Due to the cuts in funding, rigid accountability measures were imposed on Indigenous organisations in order to ensure an effective use of the remaining funding (McConaghy 2000, p. 13). With increasing evaluation of programmes, outcomes–based funding was to be introduced. This meant that only those programmes that could prove their positive outcomes were to be funded.

The Coalition formally supports the process of reconciliation (Miles 1994, p. 310), though, is not willing to officially apologise for the injustices done to the stolen generation. Another principle that Indigenous people see as crucial for reconciliation is the right of self–determination. Prime Minister Howard and the Coalition Parties, however, do not support the idea of self–determination. They prefer the principle of self–management, which reduces the rights of Indigenous people to determine their own future (Miller 2001, p. 159). Furthermore, the Liberal Party rejects a treaty to be negotiated between Indigenous and non–Indigenous people because a treaty would not improve relations between Indigenous and non–Indigenous people or the social conditions of the Indigenous people (Miles 1994, p. 329):

> The proposed treaty serves to highlight racial differences, at a time when we need to accept that what we have in common is far more important. … A treaty between Australians will undermine the unity and cohesion of the Australian people as a nation.

Concerning Indigenous land rights, LP does not support native title to the same extent as ALP. This can be seen in the Native Title Amendment Acts of 1998.[1]

[1] See Appendix E, p. 208, for native title legislation.

The Coalition Parties want to free Indigenous people of their welfare dependency (National Party 2001, p. 2). The Coalition government is convinced that neither land nor welfare will compensate for disadvantages in health, housing, education and employment. Instead, the government's focus lies on improving the education and employment of Indigenous people. In the 2001 Liberal Party election booklet, the Liberal Party confirmed their goal of self–reliance of Indigenous people through greater economic independence (Liberal Party of Australia 2001c, p. 34). Therefore, the Coalition government further aimed to improve Indigenous outcomes in vocational and tertiary education (Liberal Party of Australia 2001a, pp. 3–6).

In the 1998 election policy statement Beyond Welfare of the Liberal Party of Australia, the Minister for Aboriginal and Torres Strait Islander Affairs, John Herron, declared the aim of decentralisation of decision making in Indigenous affairs (p. 2), "The coalition is committed to working with the Indigenous community and ATSIC to develop appropriate regional models, and to devolve, where possible, decision making and management to the local level."

After the Coalition's re–election in 2001, further plans in Indigenous affairs include a greater involvement of Indigenous communities at a local level in setting the priorities and needs of their area, improved health and housing outcomes as well as encouraging self–sufficiency, self–reliance and employment through education, training and business opportunities (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 10).

7.1.3 Concluding comparison

In the following, a short comparison summarises the major principles in Indigenous affairs of the Australian Labor Party and the Liberal and National Parties of Australia.

Labor Party

- Initiated federal policy making in Indigenous affairs in the 1970s.
- Supports the principle of self–determination.
- Promotes Indigenous land rights and native title.
- Made Indigenous–specific services the preferred mode of service delivery.
- Supports the idea of a treaty between the Indigenous people of Australia and the Commonwealth/rest of the population.
- The majority of members reject assimilationist ideas.

Liberal Party and National Party

- Sponsored the constitutional referendum in 1967, which gave citizenship rights to Indigenous people.
- Support the principle of self–management.
- Emphasise the importance of mainstream services.
- Introduced outcomes–based funding of Indigenous services.
- Emphasise the importance of education, training and employment to increase self–reliance and reduce welfare dependency.
- Indigenous land rights are not seen as appropriate vehicle for Indigenous social and economic development.
- Reject a treaty.
- Foster assimilationist tendencies in Indigenous policies.

7.2 Health policy

7.2.1 Aims and strategies

Indigenous people experience high levels of morbidity and mortality (Minister for Aboriginal and Torres Strait Islander Affairs 1999, p. 6). Nevertheless, many Indigenous people still face limited access to health services.

The main goal of Commonwealth Indigenous health policy is improving the health status of the Indigenous people of Australia and includes "improved life expectancy, health expectancy and infant mortality rates for Aboriginal and Torres Strait Islanders so that they are comparable with the general population" (DHAC 2000d, p. 8). This can only be reached through coordinated measures in the areas of health, housing, education and employment. It is not only a matter of health policy and improved access to health services. In this chapter, implications within the health sector will be examined. The main focus will be on primary health care[1] and public health[2]. In the following, subordinate goals and strategies to achieve the goal of increased health for Indigenous people are outlined.

- Increased access to health services.

  The government aspires to raise the health status of Aboriginal and Torres Strait Islander people by "ensuring better access to comprehensive, effective,

[1] See Technical Glossary, p. 254.
[2] See Technical Glossary, p. 254.

high quality primary health care and population health programmes" (DHAC 2002b, p. 161). The aim is to facilitate access to primary health care, population health and health promotion activities for prevention of illnesses and early treatment.

The current Commonwealth government emphasises the importance of mainstream services for Indigenous people, especially for those living in cities and urban areas. Therefore, culturally sensitive Indigenous–specific initiatives have been included in mainstream programmes to make them more appropriate and accessible to Indigenous clients (OATSIH 2001a, p. 89).

For Indigenous people in rural and remote areas, health service delivery should be guaranteed by Indigenous–specific services, such as ACCHSs, as access to mainstream services can be limited.

- Increased participation of Indigenous people in health policy decision making.

  Indigenous participation and empowerment in policy decision making is crucial to enable Indigenous people to take control of their own affairs and determine their own priorities. Therefore, decisions on Aboriginal health should be made by or in consultation with Aborigines (ANAO 1998, p. 30; DHAC 1992, p. 22). Under the Coalition government, localised decision making by Indigenous people and organisations is expanded. Local Indigenous communities can define their health needs and priorities and decide on appropriate health service delivery (Standing Committee on Aboriginal and Torres Strait Islander Health 2002, p. 2). Nation–wide policy is increasingly made and implemented by mainstream agencies with intermittent consultation and advice of Indigenous organisations.

- Indigenous health workforce development.

  A competent health workforce is needed to improve Indigenous poor health. The government aims to raise the participation of adequate and skilled Indigenous people in the health workforce which increases involvement in health service delivery. Indigenous community involvement ensures the delivery of culturally sensitive service delivery (DHAC 2001, p. 185). This implies that Indigenous people have to be enabled to reach educational and training outcomes that allow them to participate in all levels of the health

workforce. A greater participation of Indigenous people in mainstream services, for example hospitals, improves acceptability of mainstream services. Furthermore, the role, recognition and training of Aboriginal health workers[1] have to be clarified. Since the 1970s, Aboriginal health workers have been employed in almost all ACCHSs. Additionally, some private and public service providers of primary health care employ Aboriginal health workers to make their services more culturally acceptable to Indigenous people (Saggers & Gray 1991, p. 406). Aboriginal health workers have close ties to the community and a vital knowledge of its needs and aspirations. They are a link between western medicine and Indigenous social and cultural traditions. Acknowledging their important role in Indigenous health, OATSIH has granted funding for Aboriginal health worker training programmes for a number of years.

Additionally, non–Indigenous health professionals need to be able to work effectively in a cross cultural context (OATSIH 2001a, p. 89). High–quality and effective services can only be delivered to Indigenous people if the non–Indigenous health workforce is trained in Indigenous health issues.

- Improved coordination of service delivery.

  In the past, state–administered services competed with Commonwealth–administered services for funds and duplicated services (Anderson 1997, p. 124). In order to prevent duplication of service delivery and maximise the efficiency of financial resources, the coordination between different levels of governments has to be enhanced (ATSIC 1994c, pp. 2–3). Integrated health service delivery facilitates access and use by Indigenous people (OATSIH 2001a, p. 91). Cooperation between governments, health service providers and Indigenous organisations and communities also needs to be increased in order to improve outcomes and appropriate service delivery (NHMRC 1996, p. xiv).

- Enhanced quantity and quality of health data on Indigenous people.

  Effective policy making and health intervention depend on the availability of reliable data (DHAC 2001d, p. 185; DHAC 2000c, p. 267). Health data on Indigenous Australians is essential to evaluate health programmes and measure achievements (ANAO 1998, p. 25). Indigenous identifiers in surveys

[1] Note: All Aboriginal health workers are of Aboriginal descent by definition.

> (for example the census) and administrative data collections (for example birth and death registrations) has to be improved to ensure Indigenous identification. Furthermore, data on health outcomes of policy measures should be collected for evaluation of the efficiency and effectiveness of services. This will include analysing information gained from service activity reporting[1] data from ACCHSs and from governments reporting against National Aboriginal and Torres Strait Islander Health Performance Indicators (DHAC 2002, p. 164).[2]

Relevant government bodies

The Department of Health and Ageing (DHAC)[3] advises the Commonwealth government on health and aged care issues and implements government policy. DHAC comprises the Office for Aboriginal and Torres Strait Islander Health (OATSIH), which was established in 1995 when DHAC resumed responsibility for Aboriginal and Torres Strait Islander health at the federal level from ATSIC (ABS 2000e, p. 2).

OATSIH has state and territory offices, which are responsible for the implementation and funding of programmes on regional and local levels. OATSIH funds Indigenous health services and substance misuse services and develops strategies on how to improve the health of the Australian Aborigines. It works closely with the Commonwealth, state, territory and regional governments as well as Aboriginal and Torres Strait Islander organisations and communities.

ATSIC has a statutory responsibility to monitor health service delivery to Indigenous Australians and advise the Minister for Aboriginal and Torres Strait Islander Affairs on its effectiveness. ATSIC also holds an advisory role to the Department of Health and Ageing (DHAC).

7.2.2 Recent policy developments

In the 1980s, national enquiries into the health of all Australians were undertaken by the Better Health Commission and the Health Targets and Implementation Committee. Even though it was their purpose to define national priority areas for improvements, they did not highlight the ill–health of the Indigenous people, demonstrating the low priority of Indigenous issues.

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[1] See Appendix Q, p. 232, and Appendix R, p. 233.
[2] See Appendix O, p. 226, and Appendix P, p. 230.
[3] See Appendix G, p. 210, for recent name changes of DHAC.

7.2.2.1 National Aboriginal Health Strategy

Following a meeting of representatives of Indigenous community–controlled services, Commonwealth, state and territory health and Aboriginal affairs ministers, the National Aboriginal Health Strategy Working Party was established in December 1987. Its task was to develop a National Aboriginal Health Strategy (NAHS) (ATSIC 1994c, p. 14; DAA 1989, p. 8). The Working Party comprised members of NACCHO and representatives of Aboriginal communities and of Commonwealth, state and territory health departments.

Almost two years later, in 1989, the NAHS Working Party delivered a conceptional framework and strategy to improve the health of Aboriginal and Torres Strait Islander people.

Goals

The overall aim of NAHS was to improve the health of Indigenous people by providing all Indigenous people with the same level of access to health services and facilities as non–Indigenous Australians. The strategy was further founded on a holistic view of Indigenous health. Not only the physical well–being of an individual, but also the social, emotional and cultural well–being of the community should be ensured (Anderson & Sanders 1996, p. 10; ATSIC 1994c, p. 14). NAHS stressed the importance of Aboriginal community control and Aboriginal participation in health care (Bartlett 1998, p. 261) as critical aspects of improving Aboriginal health, alongside the improvement of community infrastructure. ACCHSs were seen as the key deliverers of primary health care to Indigenous people. Moreover, cooperation among the different sectors — health, housing, education and employment — should be increased to ensure that the non–health sectors worked in a way that maximised the health impact of their activities (Anderson 1997, p. 120; Bartlett 1998, p. 277).

The specific goals were (ATSIC 1994c, p. 14; HRSCAA 1993, p. 106; NAHS Working Party 1989, p. xxxivff):

- to improve Indigenous health standards and raise life expectancy;
- to provide better access to health services;
- to improve housing and infrastructure in Indigenous communities;
- to maximise involvement of Aboriginal and Torres Strait Islander people in health decision–making processes, including representation in national forums;

- to improve training and employment opportunities for Indigenous people in health–related work;
- to provide better support in the areas of information, education, training, research and evaluation;
- to establish new community–controlled Indigenous health organisations and upgrade existing ones; and
- to decrease the amount of substance abuse and to provide drug and alcohol prevention and counselling services.

The report recommended that a Council of Aboriginal Health be established in order to assess the progress of implementation of NAHS and review the development of national Aboriginal health statistics (Bartlett 1998, p. 263). However, the composition of the council was not specified.

Moreover, tripartite forums (TPFs) between the Commonwealth, state and territory governments and ACCHSs should be established for each state and territory in order to analyse and resolve problems relating to intersectoral collaboration (Anderson 1997, p. 127).

Implementation

After the presentation of the NAHS report, the Aboriginal Health Development Group (AHDG) was established to examine the report and develop a strategy for implementation (Anderson 1997, p. 125; McMichael 1989, p. 38). AHDG comprised representatives from state, territory and Commonwealth government agencies, but none of Aboriginal community–controlled services. After protests of communities, the Community Advisory Group — consisting of Aboriginal community representatives — was established. The Community Advisory Group produced its own report in response to AHDG. Nevertheless, in the end the government adopted the recommendations of AHDG.

AHDG fundamentally agreed on the original recommendations of the NAHS Working Party, but reduced the number of recommendations and broadened their contents (ATSIC 1994c, p. 14). The importance of cooperation between Aboriginal communities and state, territory and Commonwealth governments was emphasised, as was the control of the communities of planning, implementation and evaluation of programmes (AHDG 1989, p. 3).

AHDG also decided on the composition of the Council of Aboriginal Health: it should comprise one ATSIC Commissioner, one representative each of the Department of Community Services and Health, ATSIC, the Department of Employment, Education and Training and each state/territory and one Aboriginal representative from each of the 17 ATSIC zones (Bartlett 1998, p. 268).

The report of AHDG was presented to the Joint Ministerial Forum of Commonwealth, State and Territory Ministers for Health and Aboriginal Affairs in June 1990, which accepted the recommendations.

Funding

Various existing Commonwealth–funded programmes were grouped under NAHS. These comprised health, housing, substance abuse and infrastructure programmes funded by ATSIC and other specific programmes, for example Indigenous housing programmes by the then Department of Community Services and Health (Thomson & English 1992, p. 26).

In addition to existing programmes, the Commonwealth government announced a budgetary commitment of $232.2 million for the implementation of NAHS over a period of five years. The majority of these funds ($171 million) were designated to improvements in housing and infrastructure. $47 million was allocated to health services, $6.3 million to recurrent costs of ATSIC, $7.3 million for the National Campaign Against Drug Abuse Of Indigenous People and $0.6 million to the Australian Institute of Health (Australian Indigenous Healthinfonet 2000, p. 5).[1]

Table 32: Commonwealth NAHS funding, 1990–1991 to 1994–1995

Area of funding	1990–1991 ($million)	1991–1992 ($million)	1992–1993 ($million)	1993–1994 ($million)	1994–1995 ($million)	Total ($million)
ATSIC						
Health	6.57	9.09	9.98	10.43	10.88	46.95
Community housing and infrastructure	2.10	18.00	33.00	58.00	60.00	171.10
ATSIC running costs	0.34	1.12	1.33	1.73	1.78	6.30
Commonwealth health portfolio	1.43	1.51	1.58	1.66	1.72	7.90
Total	**10.44**	**29.72**	**45.89**	**71.82**	**74.38**	**232.25**

Source: ATSIC 1994c, p. 19

[1] See Table 32 and Table 33, p. 94, for NAHS funding.

Originally, the Commonwealth delivered its funding on the condition that the states and territories provide comparable amounts of funding. In the end, the states and territories only committed negligible amounts of funding for NAHS (Tickner 2001, p. 290).

In 1994, the Commonwealth government announced plans to extend NAHS for five years with an extra $500 million, $338 million of which was allocated to community housing and infrastructure programmes and $162 million to health programmes (Bhatia 1995b, p. 7). However, many people argued that only around $85 million was new funding and the rest would be required to continue existing NAHS funding (Gardiner–Garden 1994, p. 21).

Table 33: Commonwealth NAHS funding, 1994–1995 to 1998–1999

Area of funding	**1994–1995** ($million)	**1995–1996** ($million)	**1996–1997** ($million)	**1997–1998** ($million)	**1998–1999** ($million)	**Total** ($million)
Health	25.10	36.99	38.10	39.24	22.46	161.89
Community housing and infrastructure	15.00	77.06	79.37	81.76	84.21	337.40
Total	**40.10**	**114.05**	**117.47**	**121.00**	**106.67**	**499.29**

Source: ATSIC 1994c, p. 19

Outcomes

The development of NAHS was a "milestone in the history of Aboriginal health" (Anderson 1997, p. 119) with respect to the national census that was achieved for strategic directions in Indigenous health. Priority areas specified in NAHS are still of great importance today.

However, the original recommendations of NAHS were never implemented due to a lack of funding of NAHS initiatives (ATSIC 1994c, p. 3). Although increased resources had been allocated in some areas, governments had not committed the overall level of resources required (AHDG 1989, p. 24).

Besides, there was enormous confusion in the early period about the roles of the different bodies, who made the funding and where exactly NAHS funding was allocated. There is more evidence of NAHS in current environmental health and housing policy and programmes, where the allocation of funds was also more evident.

The Council of Aboriginal Health was finally established in 1992. Its goals were to develop short and medium–term strategies to overcome Aboriginal health problems and to assist in reviewing the effectiveness of health services to Aboriginal people and the

progress in implementation of NAHS. However, the Council of Aboriginal Health officially met only four times during the first five years of NAHS. ATSIC and the community–controlled health services had different understandings of the Council. The Council of Aboriginal Health was not adequately funded (ATSIC 1994c, p. 3; DHAC 2000b, p. 2) and lacked political support from Commonwealth, state and territory health ministers and ATSIC. In March 1993, a review of the Council of Aboriginal Health was carried out. Various recommendations were given, but never implemented and the Council never met again after the review.

Within the newly founded ATSIC, a new Office of Aboriginal Health was established. It was to implement the strategy, assess the infrastructure and environmental conditions of Aboriginal communities, monitor and evaluate Commonwealth activities in Aboriginal health and to provide reports to the Council of Aboriginal Health and state, territory and Commonwealth governments.

The role of tripartite forums in the resource allocation mechanisms was never really evident. TPFs were meant to help formalise partnership between the Aboriginal community and the government and advise state and territory governments on the implementation of the strategy. TPFs' task was to provide advice to funding proposals, but funding decisions were mostly made without consultation of TPFs (ATSIC 1994c, p. 69). Instead, regional councils of ATSIC decided over funding for Aboriginal primary health care services without any further consultation (Anderson 1997, p. 129).

Until 1996, no mechanisms for improved collaboration among health, housing, education and employment sectors, for example between state, territory and Commonwealth governments and ACCHSs, had been negotiated.

7.2.2.2 Memorandum of Understanding

Federal political responsibility for Aboriginal health has been transferred various times within the last two decades. Originally, responsibility for Aboriginal health lay within the Department of Health but was transferred to DAA in 1984. ATSIC assumed responsibility at its establishment in 1990. Five years later, in 1995, the responsibility was moved back to the then Department of Human Services and Health. Within the department, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) was established. In November 1995, a Memorandum of Understanding was signed by ATSIC and the Department of Human Services and Health in order to ensure ATSIC's advisory role in the development of Indigenous health programmes after the transferral

of the responsibility for Indigenous health to OATSIH (ATSIC 1998b, p. 4). Even though ATSIC has no programme funding powers in the provision of health services, the Memorandum of Understanding requires regular consultations of OATSIH with ATSIC regional councils and community–controlled services.

However, the transfer also demonstrated that Indigenous health should be more targeted by mainstream health services. After 1995, OATSIH developed strategies and programmes to make mainstream programmes more accessible to Indigenous people. As a consequence, mainstream health services were supplemented with Indigenous initiatives.

7.2.2.3 Framework Agreements on Indigenous Health

The improvement of health service delivery to Indigenous people was hindered by a lack of clear responsibility, cooperation and coordination between the Commonwealth, state and territory governments, and between governments and Indigenous organisations. In order to improve coordination and therefore health outcomes, the Framework Agreements on Indigenous Health were signed by the health ministers of the states and territories, the Commonwealth health minister, ATSIC, NACCHO and the state and territory peak bodies for ACCHSs between July 1996 and February 1999 (National Aboriginal and TSI Health Clearinghouse 1999, p. 12). All agreements expired in August 2000, but were extended for three more years until August 2003 (DHAC 2002, p. 162).

The agreements recognised that these partners needed to work together more constructively in order to address key problems in Aboriginal health. To monitor the implementation of the Framework Agreements, the National Aboriginal and Torres Strait Islander Health Council was established in 1996. It comprised representatives of NACCHO, ATSIC, the Australian Health Ministers' Advisory Council[1] (AHMAC), the National Health and Medical Research Council (NHMRC) and DHAC and health experts appointed by the Commonwealth Minister for Health and Aged Care (OATSIH 2001, p. 8). Apart from overseeing the implementation of the Framework Agreements, the Council advises the Minister for Health on issues relating to Indigenous health (ANAO 1998, p. 55). More specifically, the Council provides advice on strategies to improve coordination and cooperation between different programmes within DHAC to raise Indigenous health outcomes.

[1] See Explanatory Notes, p. 246.

The Framework Agreements aimed to improve results of health policy measures by (HRSCAA 2000, p. 26; National Aboriginal and Torres Strait Islander Health Clearinghouse 1999, p. 12; NHRMC 1996, p. 14):

- improving access to mainstream and Indigenous–specific services;
- increasing the levels of resources which reflect the greater need;
- joint planning;
- participation of Aborigines in decision making;
- improving coordination and cooperation between and within Indigenous–specific and mainstream services;
- clarifying the responsibilities of the single organisations; and
- improving data collection and evaluation.

The Framework Agreements connect all spheres of government with the community health sector. They provide a framework for improved cooperation between all stakeholders in the planning and provision of health care services to Indigenous Australians (DHAC 1999a, p. 37). They were meant to provide for regional joint planning forums in each state and territory in order to identify shortcomings in service delivery and set priorities for future policy directions (OATSIH 2001, p. 4) and, therefore, result in improved health outcomes at the state and territory level (ATSIC 2001c, p. 5; National Aboriginal and Torres Strait Islander Health Council 2001, p. 12). State, territory and Commonwealth governments report annually against the National Performance Indicators and Targets on Aboriginal and Torres Strait Islander health.[1] Additionally, all signatories of the agreements report annually on their funding for community–controlled health services, improved outcomes for mainstream services and links between community–controlled and mainstream services (OATSIH 2001c, p. 7).

Outcomes

In a review of the outcomes of the Framework Agreements, NACCHO found that communication among the health, housing, education and employment sectors and cooperation in some states and territories had improved. In some areas, jointly planned Aboriginal health prevention programmes were being undertaken. Also, NACCHO and some affiliates received additional funding since the signing of the agreement (NACCHO 1999c, p. 13).

[1] See Appendix P, p. 230.

However, NACCHO also reported on shortcomings. The regional planning component was not being implemented to the same extent in all states and territories (HRSCFCA 1999, p. 9). Quite often, national, state and territory forums as well as the National Aboriginal and Torres Strait Islander Health Council were confronted with political decisions rather than integrated in the process of decision making. Moreover, the Aboriginal community–controlled health sector was legally not an equal partner because of regulations relating to funding and information, as ACCHSs are funded by the Commonwealth. A further shortcoming was that accountability requirements were not fulfilled by all ACCHSs (NACCHO 1999c, p. 9).

All in all, the Framework Agreements have not yet lead to a mutual commitment by all signing partners.

> The Framework Agreements are 'in–principle' agreements without any detail committing the parties to undertake specific action, provide a level of funding or achieve quantifiable outcomes within an agreed timeframe. Furthermore there is no recourse for DHAC where states and territories do not comply with the requirements of the Agreements. (ANAO 1998, p. 96)

7.2.2.4 Public Health Outcome Funding Agreements

The Public Health Outcome Funding Agreements (PHOFAs) are bilateral funding agreements between the Commonwealth and each state and territory that provide general–purpose funding from the Commonwealth to the states and territories for a range of mainstream public health programmes included in PHOFAs[1] (Commonwealth Grants Commission 2001b, p. 31). States and territories receive one block grant rather than individual payments for these programmes. Each state and territory can then decide how to allocate this block grant to the different programmes but has to achieve agreed outcomes (De Abreu Lourenco et al. 1999, p. 23, DHAC 2001b, p. 38). Approximately 80 per cent of Commonwealth funding to states and territories for population health programmes is provided through PHOFAs.

The states and territories agreed in PHOFAs that public health activities should include an Indigenous focus and to report against Indigenous–specific performance report indicators, which are the same as in the Framework Agreements[2] (DHAC 2000e, p. 31; OATSIH 2000c, p. 2).

[1] Included are the following programmes: Breast Screen Australia, National Drug Strategy, HIV/Aids Matched Funding, National Women's Health, Alternative Birthing, National Education Female Genital Mutilation, National Cervical Cancer Screening and National Childhood Immunisation.

[2] See Appendix O, p. 226, and Appendix P, p. 230.

The first PHOFAs were for the two financial years 1997–1998 and 1998–1999. A second set of PHOFAs is now in place, covering the five financial years 1999–2000 to 2003–2004.

7.2.2.5 Aboriginal and Torres Strait Islander Coordinated Care Trials

Four Coordinated Care Trials were conducted in Aboriginal communities between 1997 and 1999 as part of establishing Coordinated Care Trials for the general community.

The long–term aim of the trials was to improve the health status of clients by improving access to primary health care services through a more coordinated approach of health care delivery in Aboriginal communities. Key elements of the Aboriginal and Torres Strait Islander Coordinated Care Trials were a matching of services to need, funds pooling across multiple agencies and capacity building at an organisational, community and individual level. Community–based organisations managed a pool of funds provided by Commonwealth, state and territory governments for the provision of health care services and population health interventions (Pilla 2000, p. 493). The Commonwealth provided pooled Medicare Benefits Schedule and Pharmaceutical Benefits Scheme funding to the trials equivalent to the estimated average cost of MBS and PBS services for all users of such services in Australia. Furthermore, hospital funding and existing funding of local health care services were pooled.

The success of the trials was measured against the following indicators (OATSIH 2001e, p. 18):

- Improved access to health services.
- Provision of appropriate services.
- Organisational capacity, both local and regional.
- Appropriate funding and administrative arrangements.
- Client empowerment.
- Community empowerment.

The Aboriginal Coordinated Care Trials showed success in a number of areas. Communities and individuals were involved in the management of their health care. Local capacities for the managing of funds and the development of health programmes were created in community–based organisations. The trial period was too short to evaluate long–term effects, but improvements in the coordination of health programmes as well as improved access and appropriateness were expected (Pilla 2000, p. 505).

Dr Michael Wooldridge, Commonwealth Minister for Health and Ageing, positively assessed the Aboriginal and Torres Strait Islander Coordinated Care Trials (OATSIH 2001e, p. 2):

> The success of the trials is evidence of the progress that can be made in improving Aboriginal health when governments, local communities and health services and organisations work together in partnership.

7.2.2.6 Primary Health Care Access Programme

Following the positive outcomes of the Aboriginal Coordinated Care Trials, the Primary Health Care Access Programme was announced in the 1999–2000 budget. PHCAP has similar objectives as the Aboriginal Coordinated Care Trials. The programme intends to provide comprehensive primary health care services as well as population health activities (DHAH 2001c, p. 189). Communities should be empowered to adopt managing responsibility for their members in primary health care. Consequently, access to primary health care and its appropriateness would be improved. Funds pooling and an improved cooperation between ATSIC, state/territory governments and the Aboriginal community–controlled health sector are other characteristics of the programme (Commonwealth Grants Commission 2001b, p. 18). Commonwealth funding is allocated on a per capita basis. The Commonwealth's average national per capita contribution through MBS is adjusted for Indigenous people's higher need for health care due to their poorer health status. Additional per capita funding is provided in remote locations, considering higher health care costs in these regions (DHAC 2001b, p. 39).

Planning for PHCAP is currently in progress where joint regional plans have been completed (Northern Territory, Queensland and South Australia) and in the former four Aboriginal Coordinated Care Trial sites. Programme planning is undertaken at the level of local area strategic regions, of which there are five in each state and territory. Programme planning identifies health needs, current health services and gaps, future funding requirements and community involvement (DHAC 2000, p. 77).

The 1999–2000 federal budget provided $78.8 million over four years for PHCAP. The 2001–2002 budget announced an extra $19.7 million each year starting in the 2003–2004 financial year (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 16; OATSIH 2002b, p. 1). New or enhanced services that increase access to comprehensive primary health care will be available to at least 40 communities.

7.2.2.7 Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework

The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework was introduced in May 2002. It was developed by the Commonwealth, State and Territory Government Standing Committee on Aboriginal and Torres Strait Islander Health for endorsement by the Australian Health Ministers' Advisory Council (Standing Committee on Aboriginal and Torres Strait Islander Health 2002, p. 3). The National Aboriginal and Torres Strait Islander Health Council will oversee the implementation of the framework. The overall aim of the framework is:

> ... to transform and consolidate the workforce in Aboriginal and Torres Strait Islander health to achieve a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples supported by appropriate training, supply, recruitment and retention strategies. (Standing Committee on Aboriginal and Torres Strait Islander Health 2002, p. 3)

The framework seeks to increase the number of Indigenous people working across all health professions and to improve the recognition of Aboriginal and Torres Strait Islander health workers. Further, vocational education and training of Aboriginal health workers is to be regulated and clarified. The framework also intends to improve cross–cultural training of non–Indigenous health workers in the delivery of primary health care to Indigenous people.

In addition, performance indicators will be developed to measure accountability of state and territory efforts and programmes (OATSIH 2001a, p. 2).

7.2.2.8 Health data development

In 1984, a Commonwealth Government Task Force first reached agreements with all states and territories except Queensland to identify Aboriginal status in birth and death registration systems and in hospital morbidity and perinatal data collections (AIHW 1994, p. 216). In 1986, birth and infant death data was available for 37 per cent of the Indigenous population and hospitalisation data was collected in Western Australia, South Australia and the Northern Territory (Thomson 1989, p. 3). Today, all states and territories collect information about Indigenous status in their birth and death notification forms, perinatal data collection forms and hospital separation and cancer registration collections. However, the quality of the identification is not always

adequate to allow for accurate reporting (Bhatia & Anderson 1995, p. 5). Furthermore, inconsistencies remain in the definitions of Aboriginality that are used in different data collections (Gaminiratne & Tesfaghiorghis 1992, p. 102). As a result, it is still not possible to report on all indicators on a national basis. The Australian Bureau of Statistics, for instance, currently publishes detailed death statistics of Indigenous people only for Western Australia, South Australia and the Northern Territory (NHRMC 2000, p. 7).

Within the last decade, some developments have been in progress to improve the quality of Indigenous data collections. A National Indigenous Health Information Plan was adopted in 1997 by AHMAC. The plan acknowledged that Indigenous information was crucial for health information development in Australia (Aboriginal and Torres Strait Islander Health and Welfare Information Unit 1997, p. 38). The plan aimed at the development of an infrastructure for the collection of Indigenous data, at technical improvements required to support the collection and at an effective coordination across all jurisdictions (ABS & AIHW 2001, p. 144).

Additionally, health ministers agreed on the necessity of jurisdictions and organisations reporting against performance indicators in order to evaluate the effectiveness of policies and programmes in improving Indigenous health.

Another strategy for improving the collection of Indigenous statistics has recently been developed by ABS in consultation with government agencies and other key stakeholders, including representatives of Aboriginal and Torres Strait Islander communities.

Its key elements are: a six–yearly Indigenous General Social Survey (to be conducted first in 2002), the inclusion of a supplementary Indigenous sample in the National Health Survey (the first supplement was included in the 2001 National Health Survey), the identification of Indigenous people in the Labour Force Survey, improved identification of Indigenous people in administrative datasets and the improvement of the quality of Indigenous data from the five–yearly Census of Population and Housing (ABS & AIHW 2001, p. 1; National Centre for Aboriginal and Torres Strait Islander Statistics 2000, pp. 12–14; NHMRC 2000, p. 8; OATSIH 2001c, pp. 37–39).

7.2.3 Health services

The health of Aboriginal and Torres Strait Islander people is addressed by mainstream programmes, Indigenous–specific components of mainstream programmes and specific Indigenous programmes (OATSIH 2000c, p. 2).[1]

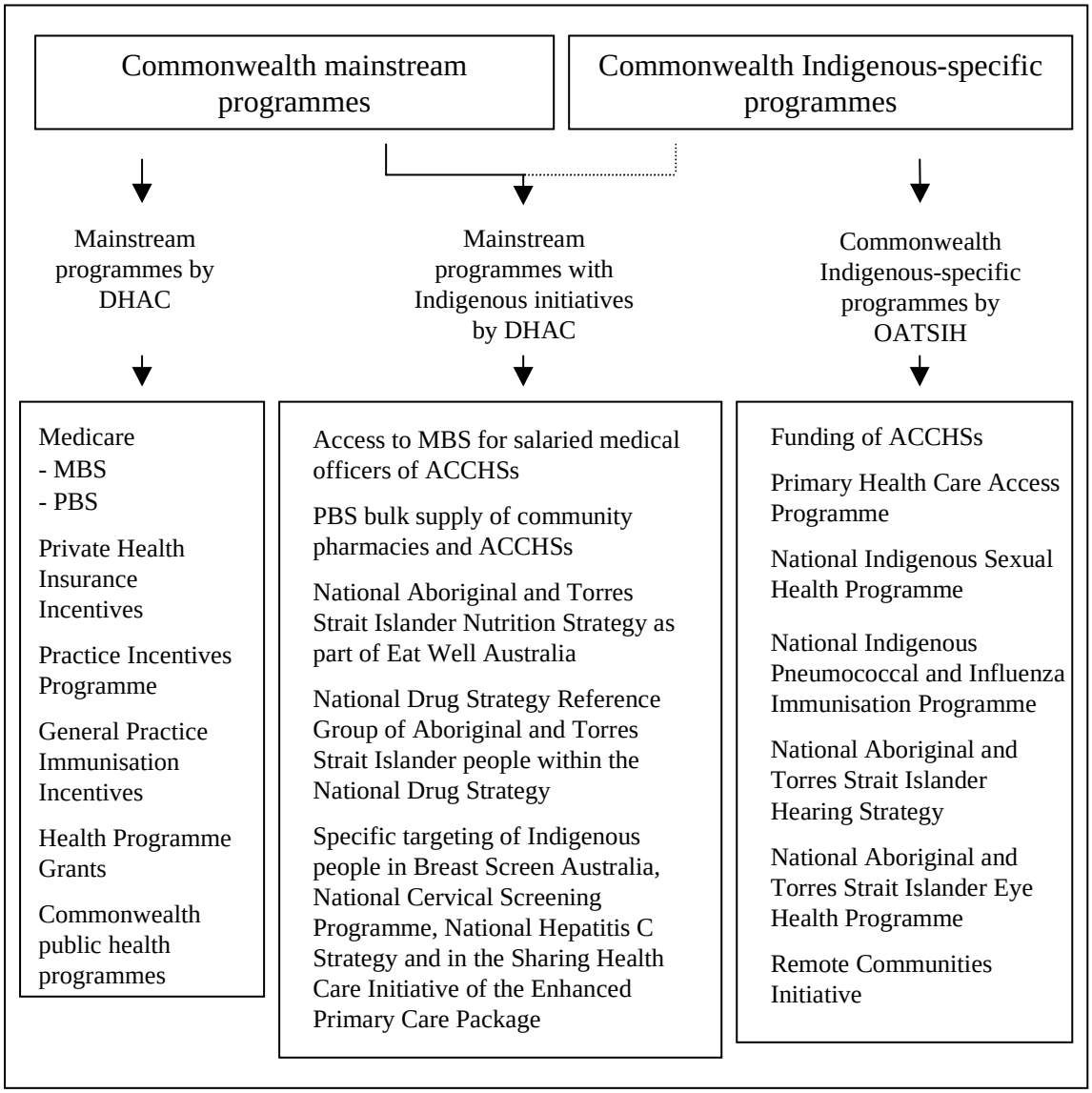

Figure 6: Mainstream and Indigenous–specific Commonwealth health programmes

Like all other Australians, Indigenous people are entitled to access mainstream services. Mainstream services have been seen as the main mode of service delivery to Indigenous people by the Commonwealth government, especially since 1996. Indigenous–specific

[1] See Figure 6.

services are only targeted at those Indigenous people most in need and are not meant to deliver services to all Indigenous people. This is illustrated by the ratio of Commonwealth's expenditure on health programmes specifically for Aboriginal and Torres Strait Islander people to the national expenditure on health. From 1995 to 1996, the expenditure on Aboriginal–specific programmes was only a fraction of 1 per cent of national expenditure on health. Considering the far worse health of Indigenous people, it is clear that these programmes cannot fully meet their needs (ATSIC 1998b, p. 13).

7.2.3.1 Mainstream health services

Medicare is the basis of the national health care system. It provides universal access to the doctor of choice for out–of–hospital care and free public hospital care through the Medicare Benefits Schedule and subsidised pharmaceuticals through the Pharmaceutical Benefits Scheme (Duckett 1995, p. 41; OATSIH 2000c, p. 30). Medicare is a Commonwealth responsibility and is administered by the Health Insurance Commission[1] (HIC). Medicare in its current form has existed since 1984.

All Australian and New Zealand citizens and permanent residents as well as temporary residents and visitors from countries with which Australia has mutual health agreements are entitled to access Medicare services (DHAC 1999b, p. 18).

Funding

Medicare services are funded by general taxes and the income–related Medicare levy. The Medicare levy is paid by individuals at a rate of 1.5 per cent of taxable income above certain income thresholds. In 2000, this income threshold was $13,550 per year for a single person or $22,865 per year for families (plus an extra $2,100 allowed for each child).

Since July 1997, individuals with high incomes (over $50,000 per year) and families (over $100,000 plus a further $1,500 per each child) who do not have private health insurance have to pay an additional one per cent of taxable income (ABS 2000d, p. 3; DHAC 1999b, p. 3).

Total income through Medicare levies from 1998 to 1999, for instance, was estimated at $4.1 billion, which represented around 17 per cent of the total Commonwealth health expenditure (ABS 2000d, p. 3).

[1] See Explanatory Notes, p. 247.

7.2.3.1.1 Medicare Benefits Schedule

The Medicare Benefits Schedule covers services by general medical practitioners and specialists, eye examinations by optometrists and some specialised dental surgery services.

MBS lists medical consultations, procedures and tests and their relevant schedule fees. Patients are entitled to a reimbursement of 85 per cent of the schedule fee through MBS. The gap has to be paid by the patient or, if applicable, by the private health insurance.

When an individual's or a family's out–of–pocket payments exceed a certain amount within a year, all further benefits in that year are paid in–full by Medicare at up to 100 per cent of the schedule fee. Maximal gap payments for a single person in 2000 were $285 (ABS 2000d, p. 7).

Medical practitioners can charge higher rates than those listed in MBS, which results in higher out–of–pocket fees for the patient.

Bulk billing

Medical practitioners can elect to direct bill Medicare (bulk billing). Services that are bulk billed are provided free of charge to the patient. The practitioner bills Medicare and accepts a rebate of 85 per cent of the schedule fee as full payment.

In 1999, 72 per cent of services for which MBS benefits were paid were bulk billed and 81 per cent were charged at or below MBS schedule fees (DHAC 1999a, p. 19).

7.2.3.1.2 Pharmaceutical Benefits Scheme

The purpose of the Pharmaceutical Benefits Scheme is to provide timely, affordable and reliable access to necessary and cost–effective prescription medicines (ANAO 1997, p. 15). PBS subsidises medicines according to a list of benefits covering 550 drug substances and nearly 2000 different drug products.

Patients are required to pay a prescription charge. There are two levels of prescription charges based on the patient's financial situation: one for general patients and one for concessional patients, such as pensioners or unemployed people. In May 2002, general patients had to pay a prescription charge of up to $22.40 per prescription, concessional patients up to $3.60.

There is a safety net to limit a patient's expenditure on PBS medicines. After reaching the annual threshold, general patients pay for any other PBS prescriptions at the

concessional rate for the rest of the calendar year and concessional patients are supplied free. In May 2002, the threshold for general patients was at $686.40 and for concessional patients at $187.20 (DHAC 2002c, p. 2).

The Coalition Parties announced an increase in patient co–payment and safety net limits in the 2002–2003 budget, starting from August 2002.[1]

7.2.3.1.3 Other Commonwealth mainstream health programmes

Private Health Insurance Incentives Scheme

In 1999, the Private Health Insurance Incentives Scheme was initiated. Private insurance holders receive a reimbursement of 30 per cent of the premium costs through the Commonwealth (AIHW 2000a, p. 251).

Due to a far smaller proportion of Indigenous people having private health insurance compared to all Australians (approximately 4 per cent compared to 30 per cent) (AIHW 2001, p. 36), Indigenous Australians benefit to a much lower extent from this scheme.[2]

Health Programme Grants

Health Programme Grants are a supplementary form of funding to MBS and PBS. They are provided especially in remote areas where mainstream services are difficult to access and deficient. Up until December 1999, there were 40 Health Programme Grants of a total of $75 million (DHAC 2001b, pp. 42–43).

The majority of grant funding assisted pathology services. Furthermore, oncology services and medical, pharmaceutical and rehabilitation services were funded.

Practice Incentives Programme

The Practice Incentives Programme offers additional funding to general practitioners who undertake activities that improve patient care. Such activities are, for example, after hours care, rural and remote practice, teaching of medical students and information management (DHAC 1999d, p. 1). The programme was introduced in August 1999. The Commonwealth allocates $184 million annually to this programme (Commonwealth Grants Commission 2001b, p. 69).

[1] See Appendix J, Table J, p. 215, for details of changes.
[2] See Appendix I, p. 214, for more information on private health insurance in Australia.

General Practice Immunisation Incentives

General practitioners who observe and provide appropriate immunisation to children below the age of seven years, receive financial incentives. Annual recurrent funding is $38 million (Commonwealth Grants Commission 2001b, p. 70).

Commonwealth population health programmes

There are several national population health programmes which aim at prevention and early detection of diseases. Such programmes are, for example, the National Drug Strategy, the National Tobacco Campaign, the National Women's Health Programme, the National HIV/Aids Strategy, Immunisation Australia, the National Diabetes Strategy and cancer control initiatives (DHAC 1999a, pp. 45–55).

7.2.3.2 Indigenous–specific initiatives within mainstream health programmes

Mainstream health strategies with specific targeting of Indigenous needs are undertaken at a Commonwealth level to better focus and target Indigenous health (ATSIC 1995, p. 15; DHAC 2001b, p. 3f; OATSIH 2000c, p. 3ff). These specific initiatives within mainstream services have mostly been introduced since 1996, after the transferral of the responsibility for Indigenous health from ATSIC to the former Department of Human Services and Health. As Indigenous–specific services are only funded for the delivery of services in areas of severe disadvantage, mainstream services must deliver services to Indigenous people in order to reach equity in access to health services (Council for Aboriginal Reconciliation 1996, p. 18).

- In 1997, access to MBS for salaried medical officers in ACCHSs was introduced (OATSIH 2000c, p. 122), providing an additional $4.8 million to ACCHSs in the 1998–1999 financial year (OATSIH 2001c, p. 5). From 1998 to 1999, 83 per cent of ACCHSs that employed doctors claimed MBS benefits.
- Within PBS, an initiative to improve access to PBS for clients of remote area ACCHSs was introduced in 1998. ACCHSs can receive PBS medicines on a bulk supply through their community pharmacy (Bell et al. 2000, p. 82). As a consequence, clients of ACCHSs can receive PBS medicines at the time of consultation and free of charge. In 2000, 39 ACCHSs already participated in this initiative.
- The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan has been established as part of the mainstream programme Eat

Well Australia. The aim is to appropriately apply public health nutrition strategies to Indigenous communities (DHAC 2000b, p. 3).

- The National Drug Strategy Reference Group of Aboriginal and Torres Strait Islander Peoples, which was founded in June 1999, advises the National Drug Strategy how to address specific drug issues relating to Aboriginal and Torres Strait Islander people.
- Breast Screen Australia and the National Cervical Screening Programme undertake specific activities to facilitate participation and access by Aboriginal and Torres Strait Islander women.
- The National Hepatitis C Strategy acknowledges key issues and challenges for responding to hepatitis C infection among Indigenous communities (DHAC 2001b, p. 10).
- The Sharing Health Care Initiative is a component of the Enhanced Primary Care Package for older Australians and those with chronic and complex conditions. From 2000 to 2004, $1 million out of $14.4 million are set aside for Indigenous projects, acknowledging the high prevalence of chronic diseases at young ages among the Indigenous population (DHAC 2000b, p. 3). One element provides for MBS benefits for voluntary health assessments for Indigenous people over 55 years of age. For other Australians, this benefit is available for people aged 75 and over (OATSIH 2001c, p. 6).

7.2.3.3 Indigenous–specific health services

When it was clear in the early 1970s that the mainstream health care system did not cope with Indigenous ill–health (Martin 1976, pp. 226–227), the Commonwealth started to fund special health services for Aboriginal and Torres Strait Islander people, such as ACCHSs, national health initiatives and state operated programmes. Therefore, many of the programmes specifically for Indigenous people provide services that are available to other Australians through mainstream programmes.

7.2.3.3.1 Aboriginal Community–Controlled Health Services

ACCHSs[1] developed in the 1970s out of the need for appropriate primary health care for Indigenous people. Indigenous people did and do not attend private practices as often as non–Indigenous people. While the average Australian goes to a GP five times a year,

[1] Note: Two terms are used synonymous: Aboriginal Medical Services (AMSs) and Aboriginal Community–Controlled Health Services (ACCHSs).

Indigenous people go fewer than two times a year on average (NACCHO 1999a, p. 7). Reasons for this are cultural, geographic and financial barriers. Many private practices do not bulk bill, which increases costs for the patient.

Definition

Aboriginal Community–Controlled Health Services are independent non–government organisations under local community control.

The definition of Aboriginal Community–Controlled Health Services according to OATSIH (2002a, p. 2) is:

> Aboriginal Community–Controlled Health Services are autonomous organisations initiated by Aboriginal communities that are governed by a body which is elected by the local Aboriginal community to deliver holistic, culturally appropriate, primary health care services to the communities which it serves.

ACCHSs are heavily accepted within the Aboriginal population. This is probably due to the fact that most employees are Indigenous themselves and the non–Indigenous health staff shows a sincere interest in Indigenous health and culture (Saggers & Gray 1991, p. 401). In contrast to most of the state, territory and Commonwealth programmes, Aborigines control and manage ACCHSs. As such, the services provide a significant vehicle for Aboriginal community development.

Advantages of ACCHSs (National Aboriginal and Torres Strait Islander Health Clearinghouse 1999, pp. 7–8) are:

- Improved access to health services for Aboriginal and Torres Strait Islanders.
- The full range of primary health care services are in one place, integrated and holistic.
- Culturally appropriate care.
- Effectiveness and efficiency — specific local problems are tackled directly and immediately.
- A source of education, training and pride for Aborigines.
- Cooperation between ACCHSs to build a pool of knowledge and expertise about Aboriginal health.

Services

Aboriginal Medical Services range from major multi–functional regional services employing several medical practitioners to small local organisations without medical

practitioners, which rely on Aboriginal health workers or nurses (HRSCAA 2000, p. 36; National Aboriginal and Torres Strait Islander Health Clearinghouse 1999, p. 1). The range and magnitude of services offered by an ACCHS depend on the size of the service (number of employees and also the size of needs of the Aboriginal community) and the degree to which it is resourced. Different ACCHSs cover a few or many of the following areas according to its size, funding and needs (Anderson, I. 1996, p. 71; Saggers & Gray 1991b, p. 403):

- Delivery of primary health care services (HRSCAA 2000, p. 18) including GP and basic emergency services and dispensing of medicines.
- Secondary services, such as physiotherapy and specialist medical services to a certain degree.
- Referral services for patients who need mainstream services or further specialist care (Franklin & White 1991, p. 31).
- Health promotion and education programmes to improve lifestyle factors, such as nutrition, physical activity, consumption of alcohol, tobacco and drugs and hygiene, in order to reduce risk factors leading to chronic or communicable diseases (Burden 1998, p. 213; Winroe 1988, p. 16).
- Preventive services, such as immunisation programmes and pap smears.
- Dental programmes.
- Teaching and skills development in Aboriginal health care issues.

Funding arrangements

ACCHSs can receive Commonwealth funding through different ways:

- Direct grants from OATSIH.
- Funding through MBS and PBS.
- Direct funding from other programme areas, such as public health programme funding.

ACCHSs are funded by the Commonwealth through direct operational grants. Only for special programmes, mostly in public health, do they receive funding from the states or territories (HRSCFCA 1999, p. 11).

Initially, the Department of Health was responsible for the funding of ACCHSs. This responsibility was transferred to DAA in 1984 and to ATSIC in 1990. Under ATSIC, funding was allocated on an annual grants basis following submissions by applicants. In

1995, the responsibility for funding was transferred back to DHAC (HRSCAA 2000, p. 36). Within the department, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) is responsible. OATSIH approached a system of needs– and outcomes–based funding mixed with historical funding for ACCHSs.

In addition, ACCHSs have gained access to Medicare. The claim of MBS benefits for ACCHSs was facilitated from 1997 onwards. From 1998 to 1999, 83 per cent of ACCHSs that employed doctors claimed MBS benefits (AIHW 2001a, p. 32). Since 1998, community pharmacies and ACCHSs are supplied with a bulk supply of medicines. The costs of these medicines are directly reimbursed by HIC at no costs to the patients. Until November 1999, 37 ACCHSs made use of this bulk supply of medicines (DHAC 2001c, p. 39; NACCHO 1999a, p. 10).

ACCHSs may also receive funding from the states and territories to deliver public health programmes within their jurisdictions, for example nutrition or sexual health programmes.

From 1996 to 1997, total Commonwealth funding of ACCHSs was approximately $70 million, of which almost half ($32 million) was directed to remote area services (ANAO 1998, p. 58). Nevertheless, ACCHSs are still struggling for funding support and for developing effective relationships with mainstream services providers, which often see ACCHSs as rivals or duplicating services.

7.2.3.3.2 Commonwealth Indigenous–specific health programmes

The Commonwealth funds and undertakes a range of health promotion and illness prevention activities and other programs to increase access to health services.

- The National Aboriginal and Torres Strait Islander Eye Health Programme was initiated in 1998. It aims to increase remote and rural access to specialist eye health services by coordinating services on a regional basis (DHAC 2001b, p. 123). The programme involved the establishment of 29 regional eye health coordinators in key ACCHSs across Australia (DHA 2001a, p. 173). The regional eye health coordinators organise visits of eye specialists in remote communities within their areas. Additional ophthalmic equipment and specific eye health training for regional coordinators and Aboriginal health workers is an extension of the programme.
- Since 1996, the National Aboriginal and Torres Strait Islander Hearing Strategy has sought to improve access to primary hearing health care

programmes including increased access to detection services for ear diseases. Hearing problems as a consequence of ear disease are intended to be reduced.

- The National Indigenous Pneumococcal and Influenza Immunisation Programme was launched in 1999. It aims to increase immunisation rates for Indigenous people in order to reduce the rate of respiratory illness and death among Indigenous people. States and territories receive Commonwealth funding for the purchase and distribution of vaccines. Free annual influenza vaccines and five–yearly pneumococcal vaccines are provided for all Indigenous people over 50 years and Indigenous people between 15 and 50 years who are in high–risk groups. Vaccinations are available through ACCHSs, state and territory immunisation clinics and general practitioners (OATSIH 2001a, p. 57; OATSIH 2000c, p. 126).
- The National Indigenous Sexual Health Programme replaced the special funding of the mainstream programme for HIV/Aids in 1997 and is administered by OATSIH. The programme addresses the prevention, treatment and research of sexually transmitted diseases, such as HIV/Aids or donovanosis, in the Indigenous population.

  The National Indigenous Australians' Sexual Health Strategy was launched in March 1997 and was complemented by the National HIV/AIDS Strategy 1999–2000 to 2003–2004: Changes and Challenges. The Commonwealth funds the strategy with approximately $8 million per year (OATSIH 2000c, p. 127).
- The Remote Communities Initiative aims to improve access to primary health care in remote Aboriginal and Torres Strait Islander communities. From 1997 to 2000, $23 million was spent on the improvement of services in around 40 Indigenous communities. Remote communities are provided with primary health care services through outreach services of ACCHSs or state government services and joint arrangements between communities and other health groups (OATSIH 2000c, p. 3).
- The Substance Misuse Programme of OATSIH establishes substance misuse services delivering education and prevention programmes, early intervention strategies, treatment and residential rehabilitation within non–custodial settings. From 2000 to 2001, 62 substance abuse services were assisted with a total funding of $19.7 million (OATSIH 2000c, p. 133).

7.2.4 Discussion

Despite some improvements in Indigenous health, mortality and morbidity rates for Indigenous Australians are still at least twice as high as those of all Australians. Mortality among Indigenous people has declined by around 2 per cent per annum between 1991 and 1999, which is a decline similar to that in the total Australian population (Bhatia & Looper 2001, p. 25). In the same period, the combined Indigenous IMR for Western Australia, South Australia and the Northern Territory[1] declined from 21.9 to 16.0; the all–Australian rate fell from 7.1 to 5.7 (Bhatia & Looper 2001, p. 26).
It must be noted that in some areas Indigenous health status is actually declining. The prevalence of chronic diseases, such as diabetes or heart disease, is increasing and are the main causes of mortality and morbidity among Indigenous adults.

The 1989 NAHS was a nation–wide approach to reduce differences in the health of Indigenous and non–Indigenous people. NAHS offered an in–depth analysis of Indigenous ill–health and a comprehensive strategy of how to improve Indigenous health. The strategy included both health and environmental health components. Its implementation, however, was fragmented and uncoordinated, especially within the health component of the strategy; the environmental health and infrastructure component was more comprehensible. Another shortcoming was that the states and territories only committed very small amounts of funding.
Today, it is somewhat unclear where and to which extent NAHS funding still exists. The continuation of NAHS is under review. The National Aboriginal and Torres Strait Islander Health Council released a draft version of NAHS in 2001 for public consultation. The council will redraft the strategy based on the submissions received (DHAC 2001a, p. 166) and the final draft will have to be endorsed by all signatories of the Framework Agreements. The future NAHS will be based on the basic principles of the 1989 NAHS.

Since 1996, assimilationist tendencies have emerged through the focus on mainstream health services in the delivery of health services to Indigenous people. ACCHSs are only the preferred method of service delivery in remote areas where access to mainstream services is limited due to geographical barriers. Increasing the acceptance of mainstream services for Indigenous people is a positive development. Nevertheless, decreasing the availability of community–controlled health services in urban areas is

[1] Note: These are the only states and territories for which reliable data are available.

questionable given the poor health of Indigenous people in remote, rural and urban areas.

The new approach of coordinated health service delivery on a community basis seems to be promising in improving access to health services and securing Indigenous community involvement. The Aboriginal Coordinated Care Trials opened the way for PHCAP, which are in the planning process. This development acknowledges the need for alternative service delivery to Indigenous people to improve their ill–health.

On a national, state and territory level, cooperation, coordination and Indigenous participation in health policy planning is realised through consultative mechanisms, such as in the Framework Agreements or the Memorandum of Understanding. The transfer of the responsibility for Indigenous health funding from ATSIC to DHAC, however, undermined Indigenous empowerment in decision making and policy planning, even if the Memorandum of Understanding secures ATSIC's advisory role in Indigenous health. The Framework Agreements led to improvements in some states and territories. In others, coordination and cooperation was not significantly enhanced.

The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework recognised the need for the development of a more appropriate health workforce that includes a higher proportion of Indigenous health professionals and an improved education on Indigenous health issues of non–Indigenous health professionals. The Commonwealth is negotiating with the relevant bodies to include Indigenous health issues in medical and nursing curricula in Australian universities. Decisions on course content, however, ultimately lie within the training institutions themselves (OATSIH 2001c, p. 33).

Performance reporting has been introduced to measure the effectiveness and efficiency of health programmes and services. However, jurisdictions are not yet able to report on all performance indicators due to a lack of data on Indigenous status in vital and administrative data collections.

There is also a need for further research into health problems in urban Indigenous people, as most research has been conducted in remote communities (Lake 1992, p. 15; NHMRC 2000, p. 9). People tend to focus on the Aboriginal and Torres Strait Islander people who live in remote areas. One reason for this may be that many health problems are more obvious (HRSCAA 2000, p. 157). Furthermore, health problems can more easily be attributed to poor infrastructure, housing and hygienic conditions. One last

reason is that the Indigenous population can be identified more readily in remote than in urban areas, where communities are less confined to a geographical location (Saggers & Gray 1991a, p. 139).

It has to be acknowledged that it is impossible to cure Indigenous ill–health in a period of one or two decades. Indigenous ill–health results from a history of political maltreatment, dispossession, racism and resulting socio–economic disadvantage. Improvements in Indigenous health are not only a consequence of health policy. Therefore, a coordinated effort across all sectors is needed. Measures in all areas of social policy will have to be taken to achieve real improvements in Indigenous health. Health policy, however, should contribute its share and ensure equitable access to appropriate health services for Indigenous people.

7.3 Housing and environmental health policy

7.3.1 Aims and strategies

Appropriate housing is critical for physical, social and economic well–being (Commonwealth Grants Commission 2001a, p. 146; Saggers & Gray 1991, p. 92). However, Indigenous Australians experience great disadvantage with regards to housing conditions and housing tenure. They suffer from homelessness, overcrowding, poor infrastructure and unsafe housing to a far greater extent than other Australians. Additionally, a much lower proportion of Indigenous people own their home, compared to non–Indigenous people. Improving infrastructure and housing conditions for Indigenous people and communities also contributes to better Indigenous health (Minister for Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, p. 8). In this sense, various strategies are being pursued:

- Improving the quality and appropriateness of Indigenous community housing.
  As a great percentage of Indigenous people still live in improvised dwellings, measures need to improve the availability and quality of housing. Safe and sustainable housing has to provide for hygienic food storage and preparation and safe sewage disposal. Where new housing is constructed, the appropriateness of the dwellings for Indigenous people has to be ensured. The dwelling design has to take into account climatic, lifestyle and cultural factors. It has to be considered, for example, that Indigenous families and households are larger than non–Indigenous households and families (ATSIC 1998b, p. 30).

- Improving environmental health infrastructure.

  Poor infrastructure is ubiquitous in Indigenous communities in rural and remote areas. Improvements in infrastructure, such as electricity, sewerage and roads, have to complement housing upgrades for a sustainable improvement of housing conditions. It is important to decrease the number of Indigenous communities that do not have access to basic infrastructure services or suffer from frequent breakdown of these systems (Liberal Party of Australia 2001c, p. 9).

- Expanding supply and effectiveness of Indigenous community housing organisations.

  Indigenous community housing organisations play an important role in providing flexible and appropriate forms of housing to Indigenous people. However, financial, administrative, training and management practices need to be improved in order to obtain effective and efficient use of resources and better address the needs of their Indigenous clients (Minister for Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, p. 8).

- Increasing home ownership rates.

  An important goal in recent housing policy has been to increase the share of Aboriginal and Torres Strait Islander people who own their own home and thereby reduce the disparity between the Indigenous and wider Australian communities (AIHW 1997, p. 163; ATSIC Office of Evaluation and Audit 1996, p. 1; Sanders 1996, p.107). Home ownership is most easily attainable in cities and urban areas where infrastructure and quality of housing are not major problems. Subsidised home loan schemes encourage Indigenous people to purchase their own homes, thus allowing for the accumulation of assets and an escape from welfare dependency (Liberal Party of Australia 2001c, p. 3). Home ownership is associated with a higher probability of employment and leads to a higher security, stability and self–esteem in Aboriginal lives. Home ownership in Australia also represents a means of provision for old age as age pensions are rather low. By increasing home ownership rates among Indigenous people, poverty in old age can be reduced. Other expected benefits of increased home ownership rates among Indigenous Australians are a sense of empowerment and security and a greater commitment to maintaining

employment in the labour market (ATSIC Office of Evaluation and Audit 1996, p. 16).

Home ownership in rural and remote areas is often bound to traditional community ownership and therefore not a principal aim in these areas.

- Increasing Indigenous involvement in the planning and delivery of housing services.

  Indigenous individuals and communities should participate in the planning, administration and delivery of housing programmes and services (ATSIC 2001d, p. 1), and the Commonwealth, state, territory and local governments are to involve ATSIC and local communities in decision–making processes. Indigenous people and governments have to work collaboratively to ensure that programmes and services are delivered with respect to Indigenous needs and aspirations.

- Better coordination of services.

  Improvement should be made through a "whole of government" approach, the coordination of services through different levels of government. Additionally, roles and responsibilities of the different stakeholders in the delivery of services have to be clarified. This helps to reduce duplication of services and related high administration costs. Furthermore, it leads to a more comprehensive system of service delivery whose services are easier to access.

- Building a stronger database and linking programme performance to accountability.

  The outcomes of housing programmes have to be reported against national housing performance indicators in order to ensure that objectives are met and resources are used wisely. To enable performance reporting, national performance indicators have to be determined. Furthermore, reliable information on the housing needs and status of Indigenous people in Australia has to be collected.

Relevant government bodies

The Department of Family and Community Services[1] (FaCS) funds the mainstream Commonwealth housing assistance payments and the Aboriginal Rental Housing

[1] See Explanatory Notes, p. 247.

Programme. Other Indigenous–specific housing programmes are funded and administered by ATSIC, which supplements the funding and services of the states and territories in order to accelerate provision of basic services to Aboriginal and Torres Strait Islander people. States and territories are the main provider of public housing and infrastructure services to all Australians. Mainstream housing assistance and programmes funded under CSHA are administered by state and territory housing departments or the state and territory Indigenous Housing Authorities if they exist.

7.3.2 Recent policy developments

7.3.2.1 National Aboriginal Health Strategy

A major objective of the 1989 National Aboriginal Health Strategy was to improve environmental health in Indigenous communities through construction and repair of housing and the provision of infrastructure, such as water, sewerage and related systems (ANAO 1999, p. 5). NAHS provided for joint assessments of infrastructure needs in Indigenous communities by stating funding should be provided for the construction of water and sewerage systems, roads, housing and power, especially in remote Indigenous communities (ATSIC 1994, p. 14). The current environmental health and infrastructure component of NAHS includes two programmes: the Health Infrastructure Priority Projects (established in 1994) and the Army Community Assistance Project (launched in 1996), which are part of ATSIC's Community Housing and Infrastructure Programme (CHIP). The majority of NAHS funding was allocated to community housing and infrastructure improvements ($171 million from a total funding budget of $232 million from 1990–1991 to 1994–1995). Nevertheless, this level of funding was not sufficient to seriously raise Indigenous living environment standards (ATSIC 1994c, p. 10). In 1989, the Aboriginal Health Development Group estimated that approximately $2.5 billion would be needed to improve housing and infrastructure in Indigenous communities (AHDG 1989, p. 24).

7.3.2.2 Bilateral Agreements

In December 1992, the National Commitment to Improved Outcomes in the Delivery of Services to Aboriginal and Torres Strait Islander Peoples was signed by the Commonwealth, state and territory governments. It provided the framework for clarifying roles and responsibilities of all tiers of government. State and Commonwealth ministers committed themselves to ensuring that bilateral housing agreements were put in place to improve the coordination of planning and delivering housing services

(ATSIC 1998c, p. 16). As a consequence of the National Commitment, bilateral agreements were signed in all states and territories between 1995 and 2001. The agreements include strategies to improve housing outcomes for Indigenous people through (ANAO 1999, pp. 18–21):

- streamlining of housing programmes to maximise efficiency and programme effectiveness;
- reducing duplication between programmes and departments;
- joint planning and coordination involving ATSIC and the relevant state and territory housing and other related agencies;
- the establishment of clear roles and responsibilities for the participating parties;
- pooling of all funds that are specific to Indigenous housing; and
- the empowerment of Indigenous people in the planning, decision making, management and evaluation of housing provision.

An integral part of the agreements is the establishment of an Indigenous Housing Authority in each state and territory. The Indigenous Housing Authority makes decisions on Indigenous housing matters, coordinates pooled Indigenous housing funds and provides public housing and housing–related services to Indigenous people. In 2002, only in three states and territories, namely New South Wales, South Australia and the Northern Territory, were there Indigenous housing authorities established to administer and deliver programmes (Commonwealth Grants Commission 2001a, p. 155).

7.3.2.3 Commonwealth–State Working Group on Indigenous Housing

In 1996, the Commonwealth, state and territory housing ministers established the Commonwealth State Working Group on Indigenous Housing to develop practical strategies to improve housing outcomes for Indigenous Australians (AIHW 1999, p. 154). The Working Group comprised senior officials from FaCS, ATSIC and from state and territory housing authorities.

The Working Group highlighted four major areas of future strategies:

- identify the housing needs of Indigenous people;
- improve the viability of Indigenous housing organisations;
- establish safe, healthy and sustainable housing for Indigenous people, especially in rural and remote areas; and

- build a national framework for the development and delivery of improved housing outcomes to Aborigines by states, territories and community providers.

A highlight of this collaboration was the development of the National Framework for the Design, Construction and Maintenance of Indigenous Housing and the National Indigenous Housing Guide, both of which aim to ensure that infrastructure and dwellings are safe, functional and sustainable (Commonwealth, State and Territory Housing Ministers' Working Group on Indigenous Housing 1999, p. 1).

Furthermore, the Working Group supported the need for a national data agreement and strategy in order to improve quality and consistency of information on Indigenous housing used to monitor the effectiveness of Indigenous housing assistance.

7.3.2.4 Community Housing Infrastructure Programme Policy

The Community Housing Infrastructure Programme (CHIP) Policy was introduced in 1997. The goals were to raise Indigenous housing standards to those of all Australians and to improve health of Indigenous people by enhancing living conditions. Environmental health and housing affordability and appropriateness were identified as key features of Indigenous housing and infrastructure needs (ATSIC 1998c, p. 10). The policy aimed to develop the capability of Indigenous community organisations to control and manage community housing, infrastructure and essential services in a manner that reflects the views and aspirations of the community through joint contribution, planning and coordination of government resources. It also emphasised the importance of self–determination of communities. The communities should have control over the design of housing and living environments. They should be enabled to make decisions depending on their unique social and cultural needs. Furthermore, housing costs should not create poverty among Indigenous tenants of community housing.

The policy was implemented through the Community Housing and Infrastructure Programme. To measure the effectiveness of CHIP, project performance indicators were set according to the different components.[1] ATSIC reports against these indicators on the performance of the programme in meeting needs. Some of the indicators are mandatory for reporting, others are optional depending on the purpose of the programme or activity (ATSIC 1998c, p. 68).

ATSIC introduced a new phase of CHIP for the period 2002 to 2005.

[1] Note: The four components are community housing, community infrastructure, municipal services and NAHS community housing and infrastructure. See Appendix S, p. 239.

7.3.2.5 Commonwealth–State Housing Agreement

The Commonwealth–State Housing Agreement (CSHA) is an agreement, authorised under the Housing Assistance Act 1996, between the Commonwealth, states and territories. The current agreement covers the period 1 July 1999 to 30 June 2003 (SCRCSSP 2002, p. 862). The Department of Family and Community Affairs administers CSHA. The purpose of this agreement is to provide funding to assist those in greatest need. The agreement determines funding and service delivery mechanisms for housing programmes. No particular target group was identified. Nevertheless, CSHA contains an Indigenous–specific programme, the Aboriginal Rental Housing Programme .

The Commonwealth distributes funds to the states and territories in form of general assistance and tied funds for identified programmes (the Aboriginal Rental Housing Programme, CAP, the Community Housing Programme) on a modified per capita basis. States and territories contribute additional funding from their own resources. The current CSHA will provide more than $4 billion for housing assistance for the period 1999 to 2003.

The Commonwealth advises the state and territory governments on objectives and reports on performance to the Commonwealth Parliament. In turn, the states and territories develop, implement and manage services in order to reach agreed outcomes and report against performance indicators (SCRCSSP 2002, p. 862).

Under CSHA, following programmes are accumulated: Private Rental Assistance, Home Purchase Assistance, public housing, community housing, Crisis Accommodation and the Aboriginal Rental Housing Programme.

7.3.2.6 Housing Ministers' Indigenous Strategy to 2010

In a Housing Ministers' conference in May 2001, the Commonwealth, state and territory housing ministers reaffirmed their commitment to improve Indigenous housing conditions.

The Commonwealth–State Working Group on Indigenous Housing presented their final report and a ten–year statement, Building a Better Future: Indigenous Housing to 2010 (ATSIC 2001a, p. 108). The conference adopted the ten–year plan. The partnership of the Commonwealth, states, territories and Indigenous communities should ensure the provision of better housing for Indigenous people and improve coordination of housing programmes and services.

The specific aims were defined as follows (ATSIC 2001d, pp. 1–2; FaCS 2001, p. 1; SCRCSSP 2002, pp. 880–881):

- Increase the number of houses available to Indigenous people.
- Ensure access to affordable, appropriate, safe and well–maintained housing for Indigenous people.
- Improve effectiveness and efficiency of housing services through better coordination of services and service providers.
- Create a sustainable Indigenous community housing sector that works in cooperation with Commonwealth, state and territory governments.
- Increase involvement of Indigenous people in government planning, delivery of services and decision making.
- Improve performance linked to accountability.

The role of Indigenous community housing organisations would be further strengthened and their capacity to work efficiently and effectively increased. Governments and Indigenous communities should work collaboratively in policy development, planning, service delivery and evaluation. A review will be conducted in 2005.

7.3.2.7 Initiatives for a stronger Indigenous community housing sector

The Indigenous community housing sector has a critical role in delivering housing to Indigenous people. However, Indigenous housing organisations often face a shortage of funds as they normally cannot generate sufficient income to cover their recurrent costs. This means that dwellings deteriorate rapidly due to a lack of maintenance and often need to be replaced prematurely.

In 2001, the Commonwealth, state and territory housing ministers agreed to strengthen the role of the Indigenous community housing sector. Commonwealth, states and territories are currently working with community organisations to improve the capacity of the Indigenous community housing sector to manage and maintain housing assets more efficiently. Initiatives in this area include:

- Aboriginal Rental Housing Programme funds being directed towards housing management and maintenance functions, as well as being used for the construction and upgrade of houses.
- Developing the National Skills Development Strategy for Indigenous Community Housing Management.

- Improving rent collection for Indigenous community housing organisations through the introduction of Centrepay, a scheme that allows income support recipients to automatically direct a portion of their Centrelink[1] payments to their housing organisation for payment of rent and other essential services. In January 2000, 243 Indigenous Community Housing Organisations had joined Centrepay, and 4,318 Centrelink customers had deductions paid directly to these organisations (ATSIC 2000c, p. 95).
- Funding of Indigenous housing organisations based on need and effectiveness. Indigenous Housing Organisations are required to provide business plans in order to receive funding form ATSIC under CHIP. The business plan is required to include objectives, needs assessment and financial and tenancy management plans.

In 1999, there were around 700 Indigenous community housing organisations, managing about 20,000 dwellings predominantly in rural and remote areas (ATSIC 2001a, p. 116). The number of houses managed or owned by the Indigenous community housing organisations has increased from about 12,000 in 1992 to more than 20,000 in 1999 (DFAT 2000, p. 4).

7.3.2.8 Improvements in statistical data resources

A variety of data development initiatives have been implemented to improve housing data availability and consistency. An important development is the Agreement on National Indigenous Housing Information (ANIHI). This agreement seeks to improve data quality and the compatibility of information about housing assistance.

Agreement on National Indigenous Housing Information

ANIHI was signed in December 1999. It is an agreement between Commonwealth, state and territory Indigenous housing administrators and key data agencies to fund and undertake national data development activities. The usage of national housing performance indicators aims at developing a greater understanding of the housing situation of Indigenous Australians and, in turn, improving housing outcomes (SCRSCCP 2002, p. 881).

The National Indigenous Housing Minimum Data Set Subcommittee implements activities agreed on in ANIHI. The National Indigenous Housing Information

[1] See Explanatory Notes, p. 247.

Implementation Committee (NIHIIC) is the management committee overseeing the implementation.

7.3.3 Housing assistance programmes

As all other Australians, Indigenous people can obtain housing assistance from mainstream housing programmes, such as the Commonwealth Rent Assistance or assistance from programmes under the Commonwealth–State Housing Agreement. However, there is little information about the use of mainstream housing programmes by Indigenous people, as identification is often optional (AIHW 1999, p. 154).

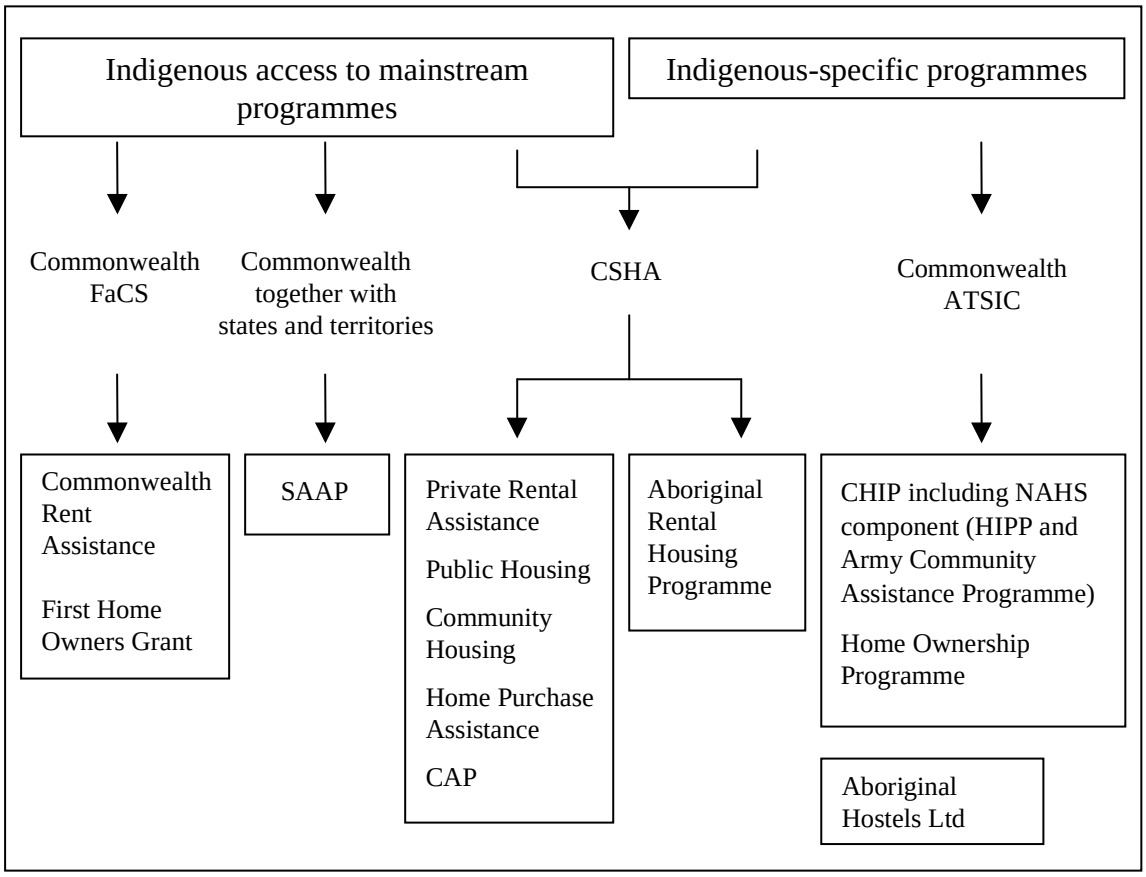

Figure 7: Housing assistance to Indigenous people

Additionally, Indigenous people have access to Indigenous–specific housing services (as seen in Figure 7). The Aboriginal Rental Housing Programme is funded by tied funds under CSHA and administered by the Indigenous policy unit within FaCS. Furthermore, ATSIC delivers housing programmes to Indigenous people through its Home Ownership Programme, the Community Housing and Infrastructure Programme,

the Army Community Assistance Programme and the Health Infrastructure Priority Programme.

7.3.3.1 Mainstream programmes

Housing assistance for all Australians are delivered through Commonwealth programmes (Rent Assistance and First Home Owners Grant) and the various programmes under CSHA, such as the Private Rental Assistance, Home Purchase Assistance, Public Housing, Community Housing and Crisis Accommodation Programme (CAP). Programmes under CSHA are jointly funded by the Commonwealth, states and territories and administered by state/territory Indigenous housing authorities (New South Wales, South Australia and the Northern Territory) or the state/territory housing departments. Additionally, the Supported Accommodation Assistance Programme is funded and administered jointly by the Commonwealth and the states/territories outside CSHA.

7.3.3.1.1 Commonwealth programmes

Commonwealth Rent Assistance

The Commonwealth Rent Assistance (RA) is targeted at pensioners, recipients of income support payments and low–income family payment recipients (Family Tax Benefit Part A[1]) who rent in the private market and pay rent above minimum threshold rental levels. RA is a non–taxable income supplement payment added onto the pension, allowance or benefit of eligible income support customers. It is funded by FaCS and jointly administered with Centrelink.

In order to receive RA, a person must first qualify for a social security income support payment, Family Tax Benefit or a service pension. Additionally, a person must:

- pay private rent above the applicable rent threshold for their principal home;
- be an Australian resident living in Australia;
- not be a home owner;
- not be an aged care resident;
- not have a partner receiving more than the base rate of FTB Part A or a rent–increased pension ; and
- not live at the home of parent(s) if single under 25.

[1] See Technical Glossary, p. 251.

RA is paid at the rate of 75 cents for every dollar of rent paid above the specified minimum rent threshold until the maximum rate is reached. Depending on family situation and number of children, maximum rates and thresholds vary. For singles without children, the maximum rate is also determined by whether accommodation is shared with others.[1]

In March 2000, 937,078 income units received RA (SCRCSSP 2001, p. 760), of which an estimated 16,000 units (1.7 per cent) were Indigenous income units (Commonwealth Grants Commission 2001a, p. 150). Total expenditure on RA was $1.5 billion in the 1999–2000 financial year (ABS 2001b, p. 315).

First Home Owners Grant Scheme

The First Home Owners Grant Scheme is a Commonwealth initiative and was introduced in July 2001 to offset the increased costs through the Goods and Services Tax, which began in July 2000. As of May 2002, it provided eligible first home owners with a grant of $7,000 for the purchase of an existing home and an additional $3,000 for the building or purchase of a previously unoccupied home (Office of State Revenue, NSW Treasury 2002a, p. 1). The extra $3,000 First Home Owner Grant for new homes ended on 30 June 2002. The additional grants were funded by the Commonwealth, basic grants are funded by the states and territories (Office of State Revenue, NSW Treasury 2002b, p. 2). The Revenue Offices of each state and territory are responsible for administering the First Home Owner Grants Scheme.

7.3.3.1.2 Programmes under the Commonwealth–State Housing Agreement

Private Rental Assistance

Private Rental Assistance is a suite of housing assistance programmes, provided by the states and territories through CSHA and is aimed at assisting low–income households experiencing difficulty in securing or maintaining private rental accommodation. Assistance is provided in the form of rent payments, including advance rent payments and cash assistance additional to Commonwealth Rent Assistance, bond loans and other assistance (such as relocation expenses, utilities connection, advice and information).

Under CSHA, Private Rental Assistance was provided to around 200,000 households from 1998 to 1999 (AIHW 2001a, p. 69).

[1] See Appendix K, Table K1, p. 216, for RA payment rates.

Home Purchase Assistance

Home Purchase Assistance is provided for people who wish to buy their own house but need help with financing. First–time home purchasers with low or moderate income can receive home loans from state and territory governments with lower deposits and lower interest rates than required by the private sector (AIHW 1997, p. 163). Assistance can also be in the form of deposit assistance, government guarantees, mortgage relief, access to surplus public housing stock and home purchase advisory and counselling services.

Public housing

Dwellings owned by state and territory housing authorities are made available to tenants at low costs. Rents are set at a maximum rate of 25 per cent of the tenant's income.

Public housing is administered by the states and territories, which provide publicly owned dwellings funded through CSHA and used to provide appropriate, affordable and accessible accommodation for low–income earners who are unable to enter the private market. Eligibility for public housing is determined by multi–faceted criteria designed to identify those most in need.

Expenditures from 1999 to 2000 were $1.3 billion (ABS 2001b, p. 314).

Community housing

Community housing is provided by non–profit community, church, charity and local government organisations and offers a range of housing choices that may not be available through the public or private housing markets. Rental and rooming houses for people with low incomes are made available.

Community housing is available to people who are eligible for public housing and who may have special needs best catered for by a community–managed organisation (AIHW 2001a, p. 60). Several forms of community housing, such as emergency, medium–term or long–term accommodation, exist.

The number of community housing dwellings in Australia is small, compared with public and private rental housing and home ownership (AIHW 2001a, p. 75).

Community housing is funded by a tied fund under CSHA with $64 million annually. States and territories can also spend additional untied CSHA funds on community housing programmes.

Crisis Accommodation Programme

The CSHA Crisis Accommodation Programme provides emergency accommodation when homeless. Funds are used for the purchase, lease and maintenance of dwellings that provide accommodation assistance to people who are homeless or in crisis.

Governments, churches and other welfare organisations use community housing organisations to provide a range of housing services to assist people who are in need. The Commonwealth provides annual funding of $40 million (ABS 2001b, p. 315).

7.3.3.1.3 Other programmes

Supported Accommodation Assistance Programme

The Supported Accommodation Assistance Programme is jointly funded and managed by the Commonwealth, state and territory governments. However, it is not part of CSHA. Funds are provided to community organisations and local governments for services such as temporary accommodation, domestic violence counselling, employment assistance, advocacy services and living skills development for homeless people or people who are in imminent risk of homelessness (ABS & AIHW 2001, p. 31).

From 1999 to 2000, 14 per cent of all people assisted under this scheme were Indigenous (Wang & Wilson 2000, p. 14). This is a significant over–representation as the Indigenous population formed only 2 per cent of the total Australian population.

In the 1999–2000 financial year, the programme was funded by both levels of government to a total of $246 million (Commonwealth Grants Commission 2001a, p. 170). As to future funding, the Commonwealth, states and territories signed an agreement that ensures a minimal national funding of $1.4 billion from 2000 to 2005 (ABS 2001b, p. 315).

7.3.3.2 Indigenous–specific programmes

Funding for Indigenous–specific housing programmes has increased over the last decade. Total funding for Indigenous–specific housing has increased from around $150 million from 1990 to 1991 to $305 million from 1999 to 2000 (Commonwealth Grants Commission 2001a, p. 157). Part of the funding increase has been due to new funds available through NAHS from 1990 onwards.

From 2002 to 2003, the government will spend around $350 million on CHIP and the Aboriginal Rental Housing programme (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 13).

7.3.3.2.1 Aboriginal Rental Housing Programme

The Aboriginal Rental Housing Programme is an element of CSHA and is funded by FaCS. Programme delivery is the responsibility of the states and territories.

Under this programme, specific funds for the accelerated provision of public and community housing for Indigenous people are made available. Furthermore, upgrades, repairs and maintenance of existing houses are undertaken. Recently, funds have been predominantly directed to community housing rather than public housing (ATSIC 2001a, p. 114). Around 550 houses are either purchased or constructed every year. From 1996, funding has been directed mostly to rural and remote areas.

$91 million of Commonwealth funding has been allocated to this programme annually from 1999 to 2003 under CSHA. The states and territories supplement the funds provided by the Commonwealth. From 1998 to 1999, $86 million was made available (Commonwealth Grants Commission 2001b, p. 128). From 2002 to 2003, the Commonwealth will invest an extra $9 million in this programme (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 32).

7.3.3.2.2 Community Housing and Infrastructure Programme

The Community Housing and Infrastructure Programme is funded and administered by ATSIC and was formed in 1993. The programme aims to improve the living environment of Indigenous Australians by providing housing, associated infrastructure and municipal services, especially to those who reside in small communities and do not receive services by mainstream agencies. These mainly locally limited projects are funded from grants approved by ATSIC regional councils.

CHIP is the second largest area of expenditure of ATSIC, even though the prime responsibility for the provision of infrastructure and essential services lies within the state, territory and local governments. However, in many rural and remote areas these governments fail to deliver, and ATSIC remains the sole funder. Around 70 per cent of CHIP funding is channelled towards remote areas, while 25 per cent is expended in rural areas and the remainder in urban areas (HRSCAA 2001, p. 136).

Grants and loans are provided to Indigenous housing organisations to build, buy and upgrade affordable and appropriate rental accommodation in urban, rural and remote areas (Tickner 1992, p. 55). Supplementary recurrent funding is available for general administration costs of Indigenous housing organisations and for the maintenance of

existing housing stock where rental income and service charges are not sufficient to meet the costs involved.

The infrastructure element of this programme grants funding to state, territory and local governments in order to accelerate the provision of basic services, such as water, sewerage, electricity, roads and municipal services to rural and remote Aboriginal communities.

ATSIC funds CHIP with approximately $220 million per year (ATSIC 1997, p. 1). From 2001 to 2002, funding was $240 million. Infrastructure was upgraded in 900 communities, including 500 new dwellings and 1,000 housing upgrades. The living environment of 40,000 people was improved (Clark 2002b, pp. 1–2). Planned funding for 2002 to 2003 is $250 million (Clark 2002b, p. 1).

Total CHIP expenditure between 1990–1991 and 1998–1999 for housing, infrastructure and related essential services was $1.83 billion (DFAT 2000, p. 3) and included:

- $622 million on construction or purchase of 5,798 houses;
- $105 million on upgrades and renovation of 6,175 houses;
- $69 million towards the cost of managing and maintaining housing stock;
- $590 million on capital costs of housing related infrastructure (water, power, sewerage);
- $425 million on recurrent costs of maintaining housing and infrastructure and municipal services; and
- $20 million on research and programme support activities, such as the Housing and Infrastructure Needs Survey.

Health Infrastructure Priority Projects

CHIP contains a separate NAHS element, the Health Infrastructure Priority Projects Scheme (HIPP). HIPP provides capital funding for large–scale environmental health projects for rural and remote communities most in need that are too large for regional council budgets (Minister for Aboriginal and Torres Strait Islander Affairs 1998, p. 9). The scheme was initiated after a NAHS evaluation in 1994 found that NAHS was never really implemented and significant improvements in environmental health conditions had not been achieved.

HIPP initially was a pilot programme to test new management strategies in large–scale projects. A major innovation was the use of outsourced private sector programme

managers who were employed to supervise major programmes because ATSIC and Indigenous communities lacked special expertise (ANAO 1999, p. 5).

In 1995, 31 HIPP pilot projects were commenced with an average cost of $2 million each. In 1996, the trial was extended with additional 28 projects with an approved total cost of $80 million. After the pilot projects showed positive outcomes, triennial funding for 1996–1997 to 1999–2000 of $218 million was allocated. In 1998, a further $196 million was approved for the period 2000 to 2003 (ANAO 1999, p. 6).

The ATSIC Office of Evaluation and Audit (1999, p. 5) found that HIPP was successful in improving the delivery of housing and infrastructure to Indigenous communities. New houses were constructed, existing houses renovated, water and power supply improved and sewerage systems upgraded. Overcrowding has been reduced and more hygienic living conditions created.

Army Community Assistance Programme

The Army Community Assistance Programme undertakes infrastructure projects in remote locations as part of the NAHS element of CHIP (DHAC 2001b, p. 109). The programme, initiated in 1996, is carried out by ATSIC, the Australian Army and DHAC. It delivers new housing, waste management systems, transport and infrastructure upgrades and enhances water supply to Indigenous communities (ATSIC 2000b, p. 109). The Army Community Assistance Programme contributes to better health through providing better infrastructure that prevents infectious diseases. The programme also enables better access to health services through improvements to roads and airstrips as well as providing housing for health professionals in the community.

$10 million was allocated to the programme at its beginning. In 1999, the programme received an additional funding of $41.2 million over four years by DHAC and ATSIC (ATSIC 2001a, p. 128; Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 29).

7.3.3.2.3 Home Ownership Programme

The ATSIC Home Ownership Programme provides home loans to low–income Indigenous people who are unlikely to be able to secure financing from commercial lenders. Strictly means–tested concessional home loans are available for people wanting to buy private dwellings in the mainstream home market or build their own home (Office of the Minister for Aboriginal and Torres Strait Islander Affairs 1992, p. 11).

Loans have lower deposit requirements and lower interest rates than commercial schemes (ATSIC 1994a, p. 129).

Applicants with a combined income of less than $30,000 can receive loans with reduced initial interest rates and deposits. In June 2002, interest rates started at 4.5 per cent per year and increased by 0.5 per cent per year up to 1 per cent below the Commonwealth Savings Bank housing loan interest rate (ATSIC 2002b, p. 2).

Repayments generally are between 20 per cent and 30 per cent of the loan recipient's gross income. Applicants must deposit either $3,000 or 5 per cent of the total cost of the home, whichever is the lesser. For applicants with combined earnings less than $25,000, deposit requirements are $1,500 or 5 per cent.

The number of newly granted loans is limited to approximately 500 per year (ATSIC 1999c, p. 33).

From 1999 to 2000, around 450 loans were made of a total value of $280 million (ABS 2001b, p. 316). The programme is mainly self–funded with an annual additional funding of $60 million from ATSIC (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 14).

7.3.3.2.4 Aboriginal Hostels Limited

Aboriginal Hostels Limited (AHL) operates as a company in the Immigration and Multicultural and Indigenous Affairs Portfolio. AHL is largely staffed and managed by Indigenous Australians. Hostels are developed and managed by Aboriginal Hostels Limited or by community organisations with AHL funds. They provide temporary, low cost accommodation for Indigenous people (ATSIC 1998, p. 32; Read 2000, p. 11). Primary, secondary and tertiary education hostels enable children from rural and remote areas to receive schooling and training that they cannot get if they live at home. Hostels for the homeless provide accommodation and support to help homeless people. Substance abuse rehabilitation hostels offer accommodation for Indigenous people participating in rehabilitation programmes.

In May 2002, AHL was operating 48 Aboriginal hostels and funding another 86 community hostels with around 3,400 beds altogether (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 14).

7.3.4 Discussion

The Commonwealth government has acknowledged the appalling state of Indigenous housing and its role in Indigenous ill–health.

The Indigenous housing situation has improved slightly since 1991, especially in rural and remote areas. Overcrowding has been reduced as well as the number of Aboriginal people living in improvised dwellings. The proportion of discrete Indigenous communities in rural and remote areas without electricity, sewerage or safe fresh water supply is slowly diminishing. The overall state of existing housing stock of Indigenous housing organisations seems to have improved as well: in 1992, 44 per cent of the housing stock was reported to be in need of major repair, compared to 29 per cent in 1999 (HRSCAA 2000, p. 52). The appropriateness of newly built houses is ensured through joint planning of housing projects.

Furthermore, it should be acknowledged that many Indigenous people do not want European style accommodation, but one that is designed according to their social and cultural values. Unfortunately, this has rarely been put into practice. Nevertheless, there is hope that through policies of self–determination, for example in the CHIP policy and increased importance of Indigenous community housing, Indigenous people will be empowered to make decisions on community housing development. Two national frameworks have been compiled to provide for appropriate and sustainable Indigenous housing construction.

Indigenous home ownership rates rose from 25 per cent in 1991 to 31 per cent in 1996. However, Indigenous rates are still far behind non–Indigenous home ownership rates.

Despite this progress, there is still a great backlog of housing and infrastructure needs in Indigenous communities and many Indigenous people continue to live in alarming conditions, especially rural dwellers continue to need more assistance. To clear this backlog, the current rate of funding would have to be increased. ATSIC estimates that around $2.2 billion is needed to address capital Indigenous housing needs (HRSCAA 2001, p. 132). This is about seven times the current annual Indigenous housing funding of all sources. Another problem is the rising Indigenous population, which will create an even greater demand for housing of Indigenous people in future.

Increased involvement of Indigenous people in the planning, decision making and delivery of housing to Indigenous people is mainly being addressed through the increased role of Indigenous housing organisations. The number of houses owned or

managed by Indigenous Community Housing Organisations has increased from about 12,000 in 1992 to more than 20,000 in 1999 (DFAT 2002b, p. 2). The introduction of programme performance indicators for CHIP aims at measuring success and accountability of the programme.

ATSIC has some influence on Indigenous housing policies through its participation in the Commonwealth–State Housing Group on Indigenous Housing and its role as an advisory body to the Commonwealth government. ATSIC also delivers housing and infrastructure programmes to Indigenous people and communities.

7.4 Education policy

7.4.1 Aims and strategies

Indigenous people today remain significantly disadvantaged in terms of their low levels of education. Indigenous educational participation and achievement at primary and secondary school levels are far below those of the total Australian population. They also experience much lower levels of attainment in the vocational education and training sector, which is in part due to poor educational outcomes in primary and secondary schooling. Finally, Indigenous students are less likely to undertake university studies and are under–represented among higher education graduates. The continuing educational disadvantage that Indigenous students experience in terms of the national standards impacts their post–school options.

Education, knowledge and skills are important to fully participate in society, find employment and to achieve one's full potential. Good education can be a means of escaping welfare dependency and achieving a higher standard of living (NACCHO 1998a, p. 3). High levels of education lead to better employment chances and higher and reliable incomes.

Achieving equitable educational access and closing the gaps in educational outcomes for Indigenous Australians remain principal educational challenges facing Australia. The Commonwealth government targets increasing attendance, participation and retention rates in pre–school, primary and secondary schooling and post–compulsory education. The following strategies are being implemented to achieve these goals:

- Access equality.

  Income support payments through the Aboriginal Study Assistance Scheme (ABSTUDY) lessen economic barriers to education. ABSTUDY provides

Indigenous students with limited financial resources with a living allowance and possible further add–on benefits, such as rent assistance. ABSTUDY also has special benefits for Indigenous students who have to leave home to attend school.

The Commonwealth also funds programmes that inform Indigenous students on possible school and career choices. Further, Indigenous student participation in early childhood and pre–school programmes is encouraged to facilitate the transition to primary school.

Tuition is provided for Indigenous students in primary and secondary schooling to help them overcome English language or other school problems. Additionally, literacy and numeracy programmes are provided to Indigenous students to raise educational outcomes (Liberal Party of Australia 2001c, p. 8).

- Outcomes–based funding.

  Education authorities are required to report against targets that measure educational outcomes of Indigenous students. If performance targets are met, special funding is provided by the Commonwealth. Funding of some institutions depends on the number of enrolled Indigenous students.

- Increased Indigenous involvement in educational policy decision making.

  In order to receive better outcomes of Indigenous students in schooling and reduce cultural barriers, Indigenous people have to be involved in the educational decision making and service delivery (MCEETYA 1998, p. 77). One way of involving Indigenous people in educational issues is to enhance the participation of Indigenous parents in their children's education (ATSIC 1998b, p. 26). Moreover, Indigenous people should be encouraged to seek employment and training in the education sector.

- Improved education of all Australians on Indigenous culture and identity.

  All Australian students should be taught about Indigenous culture and other issues. School curricula have to be extended to comprise information on Indigenous affairs which helps to increase cultural sensitivity in the schooling system (Commonwealth Grants Commission 2001a, p. 201).

Relevant government bodies

Even though the responsibility for the delivery of school education lies within the states and territories, the Commonwealth holds the policy leadership role. The Commonwealth

further provides grants to the states and territories for the funding of schools and, in turn, the states and territories have to report on outcomes.

The Department of Education, Science and Training (DEST) is responsible for mainstream and Indigenous–specific educational policies. The Indigenous Education Branch of DEST supports the department in developing policies for Indigenous people across primary, secondary, tertiary and skilled vocational education[1].

ATSIC does not administer any educational programmes, but provides policy advice to the government.

7.4.2 Recent policy developments

7.4.2.1 National Aboriginal and Torres Strait Islander Education Policy

The Commonwealth appointed an Aboriginal Education Policy Task Force in 1988. Its findings were that Aborigines were still the most educationally disadvantaged group in Australia (Aboriginal Education Policy Task Force 1988, p. 1): "The disadvantages faced by Aboriginal people in securing their right to an education remain far more severe than for any other group in Australian society."

The task force indicated the need for a new Aboriginal education policy. Subsequently, the Commonwealth, states and territories developed in consultation with Indigenous community representatives and with education providers a national Aboriginal education policy in 1989 (Senate Employment, Workplace Relations, Small Business and Education References Committee 2000, p. 21). The resulting policy, the National Aboriginal and Torres Strait Islander Education Policy (NATSIEP), came into effect in January 1990.

NATSIEP's central goal was "to achieve broad equity between Aboriginal people and other Australians in access, participation and outcomes in all forms of education" (DEET 1989, p. 9). NATSIEP established 21 national long–term goals[2] that have been consolidated under four broad themes as set in the 1989 Indigenous Education (Supplementary Assistance) Act (Commonwealth of Australia 1991b, p. 345; DEET 1989, p. 9):

- Involvement of Aboriginal people in educational decision making: Aboriginal and Torres Strait Islander students, parents and community members should be enabled to participate in the planning, delivery and evaluation of educational

[1] See Technical Glossary, p. 254.
[2] See Appendix L, p. 219.

services. The number of Aboriginal and Torres Strait Islander people employed in educational services and its administration and decision making should be increased.

- Equality of access to education services: Equitable access to pre–school services, primary and tertiary schooling and any further education have to be ensured.
- Equity of educational participation: School participation rates and lengths of Indigenous students have to be increased to the same level as that of non–Indigenous students.
- Equitable and appropriate educational outcomes: Indigenous students have to be enabled to achieve the same skills as non–Indigenous students. Furthermore, Indigenous culture, identity and history should be acknowledged and taught in school.

The policy emphasised the importance of cooperation between the Commonwealth, state and territory governments and educational authorities to achieve the agreed goals (DEET 1989, p. 11). NATSIEP also included a commitment to increased funding and, for the first time, introduced a triennial funding model, which allowed for longer term planning of programmes (Schwab 1995, p. 7).

NATSIEP is still in place in the educational agenda today (Senate Employment, Workplace Relations, Small Business and Education References Committee 2000, p. 20).

The Indigenous Education Strategic Initiatives Programme (IESIP) has been the major vehicle for the delivery of NATSIEP, complemented by ABSTUDY and the Indigenous Education Direct Assistance Programme (IEDA).

The prime focus of IESIP is to increase literacy, numeracy and attendance among Indigenous school students as these skills are fundamental to all future learning (DETYA 2000a, p. 9):

> No greater need exists in Australian education at this time than that of a dramatic improvement in the experience and successful outcomes in the areas of literacy, numeracy and attendance for Australia's Indigenous children.

IESIP comprises six elements: the Supplementary Recurrent Assistance, the Targeted Outcomes Programme, the English as a Second Language – Indigenous Language Speaking Students Programme, IESIP Away–from–Base, the Short Term Special Assistance and the National Indigenous English Literacy and Numeracy Strategy.

ABSTUDY delivers income support payments to eligible Indigenous secondary and tertiary students in order to encourage them to complete secondary education and progress to tertiary education.

IEDA offers tutorial assistance and career guidance to primary and secondary students and expands the involvement of parents in schools (Minister for Aboriginal and Torres Strait Islander Affairs 1999, p. 7). IEDA includes the following components: the Aboriginal Tutorial Assistance Scheme (ATAS), the Aboriginal Student Support and Parent Awareness Programme (ASSPA) and the Vocational and Educational Guidance for Aboriginals Scheme (VEGAS).

$445 million was allocated in the 2002–2003 budget to reduce Indigenous disadvantage in education (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 7). Of this sum, $167.9 million was allocated to IESIP, $64.9 million to IEDA and $183.7 to ABSTUDY (Minister for Education, Science and Training 2002, p. 1).

Outcomes

The Taskforce for the Education of Aboriginal and Torres Strait Islander People was established in 1995 to report on the educational status of Indigenous Australians and to review the operation and effectiveness of NATSIEP. In its report, the taskforce identified that Indigenous people needed to be more strongly represented in educational decision making and service delivery. The taskforce also stressed the importance of self–determination of Indigenous Australians in order to reach equality between Indigenous and non–Indigenous Australians in education (DEET 1995, p. 23; Groome 1998, p. 184). Indigenous Australians should be able to determine their own needs and delivery models. The review also found a few positive outcomes of NATSIEP between 1989 and 1993: retention rates of school year 12 students rose from 14 per cent to 25 per cent; Indigenous tertiary student numbers doubled; and approximately 2,500 parent committees had been established across Australia (McConaghy 1887, p. 123).

7.4.2.2 National Strategy for the Education of Aboriginal and Torres Strait Islander Peoples

Following the NATSIEP's review, the Commonwealth government declared its ongoing commitment to NATSIEP and endorsed the National Strategy for the Education of Aboriginal and Torres Strait Islander Peoples (1996–2002). The strategy aggregated the 21 NATSIEP goals into eight priority areas (MCEETYA 1995, p. 1):

- Establishment of effective arrangements for the participation of Aboriginal and Torres Strait Islander people in educational decision making.

  The strategy supported the establishment of an independent national Indigenous educational and training advisory body which advises the Commonwealth government on Indigenous educational issues. Furthermore, state, territory and local Aboriginal Education Consultative Groups should be formed to attain Indigenous involvement in the jurisdictions.
- Increase in the number of Indigenous Australians employed in education and training.

  Employment helps to reduce social disadvantage Indigenous people experience. The Commonwealth government further aims to create equitable employment conditions for Indigenous people in the education sector.
- Equitable access for Aboriginal and Torres Strait Islander students to education and training services.

  In this context, access is defined as physical access. Education has to be accessible in remote areas. Additionally, education should enable Indigenous students to achieve their academic potential (MCEETYA 1995, p. 4) in Indigenous terms and in the mainstream education system.
- Higher participation rates of Indigenous students in education and training.

  In order to reach higher Indigenous participation rates, Indigenous learning needs have to be met in schools and Indigenous parents must be involved in their children's education. Indigenous identity has to be affirmed in schools and racist practices eradicated.
- Equitable and appropriate educational achievements for Indigenous students.

  Culturally inclusive methodologies have to be adopted to obtain equitable educational outcomes. Literacy and numeracy skills are prerequisites for educational outcomes and are a major priority.
- Promotion and support of the teaching of Aboriginal and Torres Strait Islander studies, cultures and languages to all Indigenous and non–Indigenous students.

  All Australians should acquire a knowledge of Indigenous culture and history. Indigenous studies will be embedded in the school curriculum and available at Australian universities. Moreover, all Australian teachers will have qualifications in Indigenous studies.

- Provision of community development training services including proficiency in English literacy and numeracy for Aboriginal and Torres Strait Islander adults. This element aims at improving literacy and numeracy among Indigenous adults.
- Improvement of NATSIEP implementation, evaluation and resourcing arrangements.

The aim is to implement the 21 goals of NATSIEP by 2002, not by 2000 as previously planned in NATSIEP. Indigenous advisory mechanisms as described in priority one are to be introduced. Education and training providers will have to prepare triennial operational plans as the main planning mechanism for the implementation of NATSIEP.

7.4.2.3 Adelaide Declaration of National Goals in the 21st Century

The Adelaide declaration was endorsed at a meeting of state, territory and Commonwealth ministers of education in 1999. It was a document that declared goals in the national education of all Australians. Two out of the 17 national goals related to socially just schooling for Indigenous Australians (MCEETYA 1999, p. 2). They are:

- Indigenous students should have equitable access to, and opportunities in, schooling so that their learning outcomes improve and they attain levels similar to those of other students.
- Schooling should create knowledge and understanding of Indigenous culture and its values among all Australian students to contribute to reconciliation between Indigenous and non–Indigenous Australians.

In the Adelaide declaration, the Ministerial Council on Education, Employment, Training and Youth Affairs reaffirmed its commitment to NATSIEP and the national priority areas as agreed to in the 1996 National Strategy for the Education of Aboriginal and Torres Strait Islander people (DETYA 2000d, p. 116).

7.4.2.4 National Indigenous English Literacy and Numeracy Strategy

After declaring Indigenous education as urgent national priority, the Commonwealth launched the National Indigenous English Literacy and Numeracy Strategy (NIELNS) in March 2000 under IESIP (DETYA 2000a, p. 18). NIELNS's objective is to raise the levels of literacy and numeracy among Indigenous students to the levels of other Australian students and to ensure that all children leaving primary school are numerate and are able to read, write and spell at an appropriate level. Features of the strategy are an

improved coordination of services through a whole–of–government approach as well as the introduction of accountability measures for schools and teachers (DETYA 2000f, p. 5). A further element of the strategy is to increase the proportion of Indigenous children in pre–school education to facilitate their entry in primary education. The strategy also aims at tackling underlying health causes for poor educational outcomes of Indigenous students, such as poor nutrition and hearing problems (DETYA 2001, p. 138). $27 million are available for the implementation of this strategy for the period 2000 to 2004 (DEST 2001, p. 4).

7.4.3 Programmes and services

The Indigenous Education Branch within DEST is responsible for the development, implementation and evaluation of Indigenous–specific programmes.

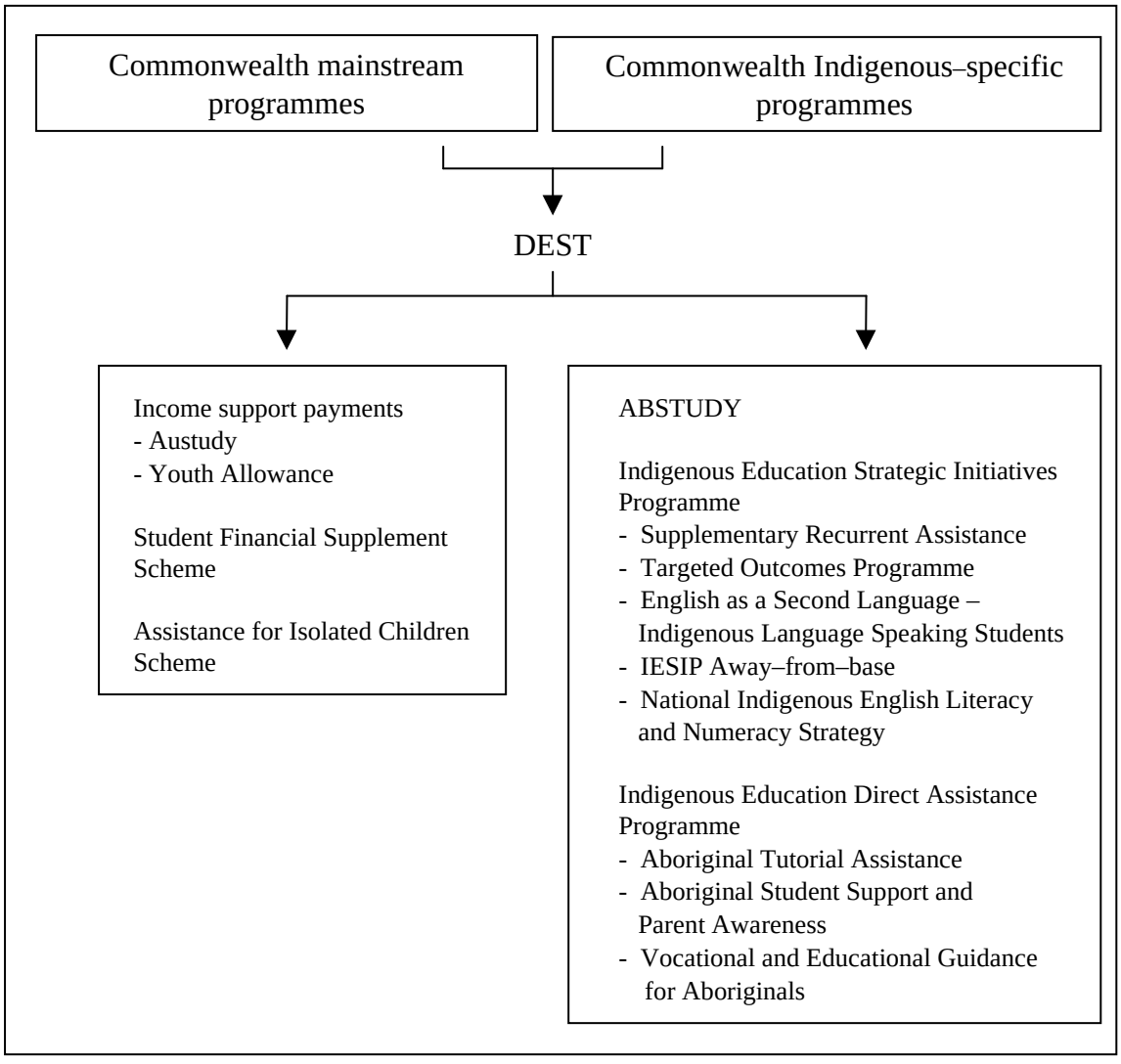

Figure 8: Commonwealth education assistance to Indigenous Australians

These programmes are the Indigenous Education Strategic Initiatives Programme and the Indigenous Education Direct Assistance. The branch also holds responsibility for policies regarding ABSTUDY, which is delivered by Centrelink.
Additionally, Indigenous Australians have access to mainstream assistance.[1]

7.4.3.1 Mainstream services

7.4.3.1.1 Income support for students

Austudy

Austudy is available for students who are residents of Australia, over age 25 and doing an approved full–time course at an approved institution.[2] As students over 25 years of age are considered independent (Centrelink 2002e, p. 1), no parental means test applies, but there are personal and partner income and assets tests. Austudy is administered by FaCS and Centrelink. Prior to 1998, DEETYA was responsible for the administration of the then AUSTUDY[3] payment.

Youth Allowance

Youth Allowance is an income support payment for students who are residents of Australia.
Students are eligible for Youth Allowance[4] if they are:

- aged 16 to 24 and studying full time; or
- aged 15, studying full time and considered independent; or
- aged over 25 and studying full time (if having received Youth Allowance immediately before turning 25 and still doing the same course); or
- aged 16 to 20 and looking for full–time work.

For students who are dependant on their parents, a family means test applies but not for those considered independent. Instead, personal and partner income tests are requested (Centrelink 2001b, p. 13).

Student Financial Supplement Scheme

Since 1993, the Student Financial Supplement Scheme offers tertiary students the option of borrowing money through a financial supplement loan to help cover living expenses.

[1] See Figure 8, p. 141, for a summary of Commonwealth education assistance to Indigenous Australians.
[2] See Appendix K, Table K4, p. 217, for payment rates.
[3] Note: AUSTUDY was named Austudy in 1998.
[4] See Appendix K, Table K3, p. 217, for payment rates.

The scheme is delivered and administered by Centrelink; FaCS is responsible for policy formulation.

Tertiary students are eligible for a loan if they:

- are receiving Austudy, Youth Allowance or ABSTUDY payments; or
- are a dependant tertiary student who is not eligible for Austudy, Youth Allowance or ABSTUDY only because of the parental income and family means test and whose parents' adjusted income and actual family means are below $61,200 (2002 threshold).

The financial supplement loan is deposited into the recipient's bank account in fortnightly instalments (Centrelink 2002h, p. 1). The loan is paid up to a maximum of one year. Loans are provided by the Commonwealth Bank of Australia through an agreement with the Commonwealth government. The Commonwealth government pays the interest charged on the loan. Compulsory repayments start five years after the first instalment of the loan was paid if the taxable income is at or above the level of average earnings (Centrelink 2002h, p. 2).[1]

Tertiary students receiving Austudy, Youth Allowance or ABSTUDY payments can forego part or all of their payment to receive double the amount as financial supplement loan. The maximum loan amount is $7,000; for other eligible tertiary students it is $2,000.

36,128 students received student financial supplement loans for a total of $154 million from 1999 to 2000. Of these students, Youth Allowance recipients accessed $39 million in loans, Austudy recipients $68 million and ABSTUDY recipients $47 million (ABS 2002a, p. 1).

7.4.3.1.2 Other programmes

Assistance for Isolated Children Scheme

The primary objective of the Assistance for Isolated Children Scheme (AIC) is to provide school education access to all Australian children (DETYA 2000d, p. 148). AIC helps primary students, secondary students under 19 years of age, and tertiary students under 16 years of age who do not have access to an appropriate school due to geographic isolation. The scheme offers boarding allowance, second–home allowance and distance–education allowance. Except for the boarding allowance, allowances are not

[1] Note: The threshold for repayment for the 2001–2002 income year was $32,918.

subject to income or assets tests. Policy responsibility for AIC lies within DEST. AIC is administered and delivered by Centrelink. 11,900 students accessed AIC in the 1999–2000 financial year. Expenditure was $31million (ABS 2002a, p. 1).

7.4.3.2 Indigenous–specific programmes and their services

7.4.3.2.1 Aboriginal Study Assistance Scheme

ABSTUDY represents a major component of the Commonwealth government's National Aboriginal and Torres Strait Islander Education Policy to provide equal educational opportunities to Indigenous people. ABSTUDY is administered and delivered by Centrelink. DEST is responsible for ABSTUDY policy development.

Basic conditions of eligibility (Centrelink 2002a, p. 14) are:

- Student is of Aboriginal or Torres Strait Islander descent and Australian resident;
- studying an approved course at an approved education institution; and
- not receiving other government assistance for study.

ABSTUDY payments consist of a fortnightly living allowance as well as additional components to help with the costs associated with attending educational institutions.[1]

Living allowances are only available for full–time secondary or tertiary students. The student's personnel or family circumstances determine the level of living allowance.

The living allowance is means tested. Applicants under 25 years are generally assessed against parental income, whereas older applicants are assessed against their and their partner's income and assets. Students older than 21 generally receive higher payment rates.

Recent changes

ABSTUDY was established in 1989, when the programmes Abstudy[2] and Absec[3] were amalgamated into the current ABSTUDY programme with two components: ABSTUDY (Tertiary) and ABSTUDY (Schooling). ABSTUDY (Tertiary) assists Indigenous students in approved courses offered by universities, colleges of advanced education, TAFE[4] colleges and other educational institutions. ABSTUDY (Schooling)

[1] For payment rates see Appendix K, Table K5, p. 218.
[2] See Technical Glossary, p. 249.
[3] See Technical Glossary, p. 249.
[4] See Technical Glossary, p. 254.

assists Indigenous students with approved secondary education. There are also allowances for primary students aged 14 or over.

At the same time, ABSTUDY income support became income tested. In 1990, tutorial assistance provisions and provision for parent meetings were moved to IEDA as ATAS and ASSPA. Additionally, the vocational and educational guidance programmes were removed from ABSTUDY to form VEGAS in IEDA.

In 1993, the government introduced an Austudy/ABSTUDY/Youth Allowance supplement, the Student Financial Supplement Scheme[1], to enable eligible students to access voluntary loans at lower interest rates from the Commonwealth Bank of Australia. In the same year, thresholds for the personal income test for AUSTUDY and ABSTUDY were increased by 20 per cent. Maximum benefits for both schemes were tied to the Consumer Price Index. Further, in recognition of the difficulties faced by students living independently, the government reduced the age of independence from 25 to 24 in 1993, to 23 years in 1994 and to 22 years in 1995 (Stanley & Hanson 1998, p. 35).

In 1998, the Minister for Employment, Education, Training and Youth Affairs announced further changes to ABSTUDY, which came into effect in January 2000 (DEST 2002a).

The principal change was to align the ABSTUDY living allowance[2] to the existing Youth Allowance and Newstart allowance rates available to all young Australians.

Additional components available under ABSTUDY were also aligned, unless the disadvantage addressed by the benefit was considered unique to, or disproportionately concentrated on Indigenous students. A retained special supplementary benefit of ABSTUDY is the School Fee Allowance and the School Fare Allowance for Indigenous secondary students who have to live away from home to attend school. School fees are paid directly to the school. A boarding supplement is paid to the boarding school for secondary students under 16. The relevant mainstream scheme, Assistance for Isolated Children, provides boarding costs, but excludes fares or school fees (Commonwealth Grants Commission 2001b, p. 261).

The School Term Allowance (for costs of books, uniforms, etc.) and School Fees Allowance (paid directly to the school) for under 16–year–old secondary school students from low–income families who live at home have been retained, as was the

[1] See previous Chapter.

[2] See Appendix M, Table M, p. 221, for details on changes of ABSTUDY living allowances.

Incidentals Allowance for mature–aged secondary[1] and tertiary students, which covers general course costs and is paid at the beginning of the school year (Centrelink 2001a, p. 10).

The changes also meant that ABSTUDY recipients gained access to the Pharmaceutical Benefit Allowance and Rent Assistance. Over 9,000 ABSTUDY students were receiving Rent Assistance and Remote Area Allowances in 2000 (Commonwealth Grants Commission 2001b, p. 157). Away–from–base payments for mixed–mode[2] course delivery were no longer made to students but to institutions as block grants under IESIP.

Numbers of ABSTUDY recipients are steadily increasing. From 1991 to 1992, over 43,000 students were assisted (Office of the Minister for Aboriginal and Torres Strait Islander Affairs 1992, p. 11). In 1996, the number approached 49,000 with outlays of $122 million (ATSIC 1998b, p. 27). From 1997 to 1998, 49,800 Indigenous students received ABSTUDY payments. In 2001, 50,451 Indigenous students were assisted by this programme (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 9). Expenditures on ABSTUDY have been increasing. From 1992 to 1993, $106 million was spent (Tickner 1993, p. 84). The 2002–2003 budget plans to spend around $183.7 million through ABSTUDY.

7.4.3.2.2 Indigenous Education Strategic Initiatives Programme

The Indigenous Education Strategic Initiatives Programme[3] was launched in 1990 and is the major channel for the delivery of NATSIEP. The Indigenous Education Branch of the Department of Education, Science and Training administers IESIP.

IESIP supplements the costs of delivering educational services to Indigenous students (Tickner 1993, p. 83). Through IESIP, the Commonwealth complements its normal provisions of recurrent and capital funding to the states and territories and non–government education providers through funding on a per capita basis to pre–schools, schools and vocational education and training providers. IESIP also provides funding for travel, accommodation and related expenses for tertiary distance education Indigenous students. Targets of IESIP are the same as the eight priority areas of the National Strategy for the Education of Aboriginal and Torres Strait Islander Peoples (1996 to 2002).

[1] Note: Over 18 years of age on 1 January in the year of study.
[2] See Technical Glossary, p. 253.
[3] Note: IESIP was known as Aboriginal Education Strategic Initiatives Programme (AESIP) before 1997.

Education providers have to report annually through IESIP performance reports on outcomes in literacy, numeracy, attendance, the employment of Indigenous staff, cross cultural awareness training of teachers, apparent retention rates from school year 10 to school year 12, grade progression ratios and senior secondary outcomes[1].

IESIP provides funding through five components: the Supplementary Recurrent Assistance, the Targeted Outcomes Programme, English as a Second Language – Indigenous Language Speaking Students Programme, IESIP Away–from–base and the National Indigenous English Literacy and Numeracy Strategy. Besides, state and territory Indigenous Education Consultative Bodies (IECBs) are funded under IESIP. IECBs provide policy advice to the state and territory governments and facilitate consultation with Indigenous communities on key educational issues (Bourke 1998, p. 183). IECBs have existed since the 1970s. They received Commonwealth funding of $1.5 million in the 2000–2001 financial year. IECBs receive additional funds from the state and territory governments and, in some instances, are accommodated in state and territory government offices.

Funding for IESIP has grown immensely from $89 million in the 1995–1996 financial year to $154 million in the 2000–2001 financial year (Commonwealth Grants Commission 2001a, p. 206; Tickner 1993, p. 83). [2]

Table 34: Commonwealth funding for IESIP, 1995–1996 to 2000–2001

Financial year	Total current funding ($million)
1995–1996 (a)	88.85
1996–1997 (a)	96.29
1997–1998 (a)	132.16
1998–1999 (a)	112.77
1999–2000 (b)	158.01
2000–2001 (b)	153.90

Notes:
(a) Actual expenditure.
(b) Estimated expenditure.

Source: Commonwealth Grants Commission 2001a, p. 206

[1] The number of Indigenous and non–Indigenous school year 12 students who meet the requirements for a school year 12 certificate as a percentage of the number of students who commenced school year 11 in the previous year.
[2] See Table 34.

Supplementary Recurrent Assistance

Supplementary Recurrent Assistance (SRA) provides supplementary per capita funding to education providers in the pre–school, school and vocational education and training sectors that have a minimum number of enrolments of Indigenous students (DEETYA 1998, p. 10). Approximately 70 per cent of total IESIP funding is provided as SRA (Commonwealth Grants Commission 2001a, p. 206). Funding reflects the costs of service delivery to Indigenous students. Rates vary according to the sector of education (government or non–government), the level of education and location (remote or non–remote area).

Before organisations can receive funding through SRA, they have to enter into an Indigenous Education Agreement with the Commonwealth (DEETYA 1998, p. 7). The agreement contains conditions for the receipt of funding. It comprises performance targets that organisations have to report against in their yearly performance reports (DEETYA 1998, p. 16). The performance reports have to include reporting on educational and financial outcomes (DEST 2000a, p. 26). In the Indigenous Education (Targeted Assistance) Act 2000, the Commonwealth tied funding of education providers even more tightly to their performance (Commonwealth Grants Commission 2001a, p. 206).

Targeted Outcomes Programme

Education providers with fewer enrolled Indigenous students than required to be eligible for SRA can establish a cluster with other education providers in order to become eligible for SRA. However, funding is only provided to one designated provider on behalf of all members of the cluster (DEETYA 1998, p. 23; DEST 2002c, p. 1).

English as a Second Language – Indigenous Language Speaking Students Programme

This programme provides English–language tuition to eligible students who start formal schooling in English but whose English skills are insufficient. It was introduced in 1998 and is aimed at Indigenous students who have very limited exposure to, or use of, English in their communities (DEST 2002c, p. 1; DETYA 2000b, p. 8). The one–off Commonwealth grant ($3,079 in 1998) per eligible student is allocated to education authorities that arrange the intensive English tuition. In 1998, approximately 2,400 students were assisted at a total cost of $7.4 million (MCEETYA, 1998, p. 170).

IESIP Away–from–Base

Mixed–mode away–from–base assistance was formerly funded under ABSTUDY and was transferred to IESIP in January 2000. Educational institutions receive block grants under the Indigenous Education Agreements. Away–from–base assistance is aimed to meet costs for travel, meals and accommodation for ABSTUDY secondary and tertiary students participating in compulsory course activities.

Students do not need to apply to Centrelink for away–from–base assistance payable under IESIP. Indigenous students approved for ABSTUDY assistance and enrolled in a mixed–mode course receive assistance from the institution in which they are enrolled. The institution is responsible for paying the accommodation and travel providers (DETYA 2000c, p. 5).

National Indigenous English Literacy and Numeracy Strategy

The National Indigenous English Literacy and Numeracy Strategy[1] is a programme to improve student and school truancy rates, address health problems that undermine learning, attract and retain good teachers and use teaching methods appropriate to the needs of Indigenous school students (DEST 2002e, p. 2; DETYA 2000b, p. 9).

Initiatives include programmes such as the provision of physical aids in classrooms for students with hearing deficiencies, nutrition programmes in schools and an improved mechanism for reporting attendance and performance to Indigenous parents (DETYA 2000f, p. 6).

7.4.3.2.3 Indigenous Education Direct Assistance Programme

The Indigenous Education Direct Assistance Programme was established in 1991. IEDA comprises the following subprogrammes (DFAT 2000, p. 1):

- the Aboriginal Tutorial Assistance Scheme (formerly under ABSTUDY);
- the Aboriginal Student Support and Parent Awareness Programme (formerly under IESIP); and
- the Vocational and Educational Guidance for Aboriginals Scheme.

IEDA is delivered through the network of Indigenous Education Units of DEST. IEUs hold the main responsibility for the administration of IEDA. They provide advice and guidance to students and parents and process applications and payments.

[1] See Chapter 7.4.2.4, p. 140, for more details.

Table 35: Commonwealth funding for IEDA, 1997–1998 to 1999–2000

Subprogramme	1997–1998 (a) ($million)	1998–1999 (a) ($million)	1999–2000 (b) ($million)
ATAS	23.73	25.51	24.75
ASSPA	18.75	18.04	19.00
VEGAS	7.70	8.11	8.49
Total	**50.18**	**51.66**	**52.24**

Notes:
(a) Actual expenditure.
(b) Estimated expenditure.

Source: Commonwealth Grants Commission 2001b, p. 260

There are currently 45 Indigenous Education Units located throughout Australia. As can be seen from Table 35, funding for IEDA only increased slightly recently (from $50 million from 1997 to 1998 to $52 million from 1999 to 2000). The 2002–2003 budget allocated $64.9 million to IEDA.

Aboriginal Tutorial Assistance Scheme

The main purpose of the Aboriginal Tutorial Assistance Scheme is to help Indigenous students achieve equal education outcomes as non–Indigenous students through special tutorial assistance (DEST 2002b, p. 3).

ATAS is directed to Indigenous students in primary and secondary school, TAFE and university who need additional assistance with their studies. Tutors are made available to them as well as specific homework centres where they can receive their tuition and study (DETYA 2000a, p. 19).

By 1999, around 900 homework centres had been established in Australia serving 29,400 Indigenous school students (DETYA 2000a, p. 76). In 1999, 14 per cent of Indigenous primary students and 8 per cent of Indigenous secondary students received individual or small group tuition. A further 30 per cent of Indigenous primary students and 22 per cent of Indigenous secondary students benefited from tuition in homework centres (DETYA 2000a, p. 21).

In 2000, 87 per cent of Indigenous primary students and 89 per cent of secondary students were receiving ATAS tuition in literacy and numeracy related subjects (DETYA 2000a, p. 6). 80 per cent of students participating have improved their literacy and numeracy outcomes (DEST 2000b, p. 6). In some instances, particularly in relation to universities and some boarding schools, ATAS is delivered on behalf of the

department by the institution. These institutions are bulk funded; that is, the institution receives an amount based on a funding formula incorporating the number of Indigenous students at the institution.

Aboriginal Student Support and Parent Awareness Programme

The major goal of ASSPA is to raise and strengthen the involvement of Indigenous parents in educational decision making (DEST 2002b, p. 2). The programme assists the establishment of parent committees, which are involved in educational decision making at the school level.

Commonwealth funding to Indigenous pre–school and school committees is made available and is dependent on the number of Indigenous students in the school and the location, i.e. whether the institution is located in a remote area or not. The resources may be in the form of direct funding, advice from DEST staff or training materials.

The committees comprise parents of Indigenous pre–school or school students, community representatives and representatives of the school or pre–school, and in secondary schools Indigenous students. The committees undertake activities according to the needs of the children in their community. Activities can include measures to improve access, participation and attendance in schools, parental involvement in their children's school or assistance to enable Indigenous students to participate in school–based sporting or cultural events and excursions (DETYA 2000a, pp. 34–38).

In 1991, there were around 2,000 ASSPA committees in Australia. By the year 1999, the number had increased to 3,839 covering approximately 90 per cent of all Indigenous pre–school and school students (DETYA 2000a, p. 32, 79). In 2002, almost 115,000 students were supported by this programme (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 8).

The 1999–2000 Commonwealth expenditure for ASSPA was at approximately $19 million (DETYA 2000a, p. 78).

Vocational and Educational Guidance for Aboriginals Scheme

Under this scheme, funds are provided for organisations that conduct projects to assist Aboriginal and Torres Strait Islander people to make informed education and career choices. The aim of VEGAS is to inform Indigenous students and their parents on further study and career options (MCEETYA 1998, p. 180).

Commonwealth expenditures under VEGAS have increased rapidly from $1.1 million from 1992 to 1993 to $8.65 million from 1999 to 2000 (DETYA 2000a, p. 82; Tickner

1993, p. 85). In 1999, around 530 projects were being undertaken in Australia with about 30,000 participating students (DETYA 2000a, p. 82).

7.4.4 Discussion

NATSIEP attempted a coordinated national approach to improve Indigenous poor educational outcomes. It has brought progress in a range of areas, but not succeeded in all of its aims. While access and participation rates have improved, equity issues are problematic. The participation of Indigenous Australians in higher education has shown a fairly steadily increasing trend since 1987. However, the educational status of Indigenous Australians remains poor relative to that of non–Indigenous Australians. Indigenous educational participation, retention and attainment are still lagging well behind the non–Indigenous rate.

The apparent retention rate to school year 12 for Indigenous students is less than half that for other students. Nevertheless, there have been improvements within the last decade. Indigenous school retention rates for school year 12 have more than doubled from 1989 to 1998; and the percentage of Indigenous higher education students of all Australian students has increased from 0.8 to 1.18 per cent. The number of Indigenous award course completions has doubled from 1989 to 1999, with the Indigenous completion rates as a percentage of all Australian completions rising from 0.63 to 0.76.
Literacy levels have successfully been raised, though Indigenous literacy levels are still lower than all–Australian rates. The 1996 National School English Literacy Survey showed that approximately 70 per cent of all students in school year 3 surveyed met the identified performance standards in reading and writing, compared to less than 20 per cent of Indigenous students (National School English Literacy Survey Management Committee 1997, pp. 90–94). The release of the 1999 National school year 3 reading data showed that almost 87 per cent of Australian school year 3 students and 66 per cent of Indigenous school year 3 students met the national standard in reading (MCEETYA Taskforce on Indigenous Education 2000, pp. 89–90).

The issue of equality of access is addressed by a number of programmes under ABSTUDY, IESIP and IEDA. They include income support payments, tuition assistance and services and financial support for Indigenous students in remote areas. All these programmes aim to increase Indigenous access and success in mainstream educational institutions. Outcomes–based funding was introduced in the Supplementary

Recurrent Assistance of education providers and NIELNS to monitor and direct Indigenous educational outcomes.

The major goal of NATSIEP in 1989 was to reach equity in educational outcomes between Indigenous and non–Indigenous students. The meaning of equity, however, was not further defined and can have different meanings (DEET 1994, pp. 14–16; Schwab 1996, p. 4). Firstly, equity can be seen as Indigenous students achieving equal outcomes as non–Indigenous students within the mainstream schooling system. Historical and structural disadvantage is acknowledged, but Indigenous students have to lift their performance to the level of other Australians. Secondly, equity can imply equal outcomes, but consider cultural factors and their effects on Indigenous learning. This approach includes appropriate teaching and learning strategies for Indigenous students. Yet it still assumes that Indigenous students should obtain the same educational outcomes as non–Indigenous students. And lastly, equity for Indigenous students can be justified by communities setting outcomes which their students should achieve. This means that outcomes differ from those for other Australians, but are set according to Indigenous standards and aspirations.

Currently, the majority of Australian schools apply a mixture of the first two approaches described above. The overall aim of equity in education between Indigenous and non–Indigenous Australians, as it is implemented today, does not give room to Indigenous ideas, preferences and their special position in education and other spheres of life (Anderson et al. 1998, p. 2). Indigenous individuals are to be assimilated into established institutions, rather than to change these institutions or offer alternative educational models. School education is almost exclusively delivered as a mainstream service. The current policy is primarily concerned about Indigenous participation and success in the mainstream educational system rather than support for community–controlled initiatives (DEET 1995, p. 24; Schwab 1995, p. 23; Senate Employment, Workplace Relations, Small Business and Education References Committee 2000, p. 27). There are only a few Indigenous community–controlled schools in Australia (approximately 20 in 1994) with only 1.6 per cent of all Indigenous students enrolled in 1994 (Schwab 1996, p. 5). According to the 1994 NATSIS, there was a substantial percentage (33 per cent) of Indigenous people who would prefer to send their children to Indigenous community–controlled schools (Madden 1995, p. 40), while the majority (48 per cent) preferred not to. This is somewhat surprising, given the general request by

Indigenous people for more self–determination. Further research into this topic is needed.

Besides the fact that education is delivered to Indigenous people almost exclusively through mainstream schooling, further assimilationist tendencies have emerged within Indigenous educational policies. Aligning levels of assistance of Indigenous–specific services with those of mainstream services denies historical educational disadvantage that is still experienced by Aboriginal people today. The changes to ABSTUDY in 2000 had negative impacts by eroding the nature of ABSTUDY as an Indigenous–specific scheme.

Historically, there has not been a real strategy how to increase Indigenous empowerment in education, even though this was an explicit aim of NATSIEP. There are some consultative mechanisms between DEST, Indigenous communities and education providers, but Indigenous people are still not directly involved in decision–making policy. Indigenous parent committees are being formed, but their influence is limited to the community level. Indigenous Education Consultative Bodies have been established at state and territory levels in order to provide advice on Indigenous educational issues. Unfortunately, they do not seem to take an active role in Indigenous educational policy making. Due to their small number, community–controlled schools do not have a real influence on Indigenous education.

As a consequence of improved educational levels and qualifications, Indigenous people will be able to acquire professions and positions in which they can influence and determine policies and decisions in Indigenous education, but only if they are not discriminated against by employers and society.

The aim of improving the education of all Australians on Indigenous culture and other Indigenous issues was stressed in the National Strategy for the Education of Aboriginal and Torres Strait Islander Peoples (1996–2002) and reconfirmed in the Adelaide Declaration of 1999. There has not been a report on the achievement of this goal since.

7.5 Employment and economic development policy

7.5.1 Aims and Strategies

Indigenous Australians experience much higher unemployment rates and receive smaller incomes than non–Indigenous Australians. Most Indigenous people are part of the lowest socio–economic group and face interrelated problems, such as poor health, low levels of education and bad housing conditions.

The Commonwealth aspires to reduce the welfare dependency of Indigenous Australians and increase their self–reliance (ATSIC 1998e, p. 4). The main goal is to reach income and employment equity between Indigenous and non–Indigenous Australians. Therefore, the Commonwealth subordinate goals and strategies are to:

- Increase employment.

  Employment opportunities have to be created for Indigenous people to enable them to increase their economic status. Commonwealth measures specifically target an increase in private sector employment, where Indigenous employment is even lower than in other sectors (Commonwealth Grants Commission 2001b, p. 358). Therefore, programmes have been established to improve outcomes of CDEPs in helping participants to make their transition to private sector employment. Indigenous job seekers and CDEP participants are helped and encouraged to move to paid employment through personal counselling services, job referral services and wage subsidies for employers (Commonwealth Grants Commission 2001a, p. 235). The government also aims to improve government assistance for Indigenous Australians to find work in mainstream employment. Special programmes target improvements in Indigenous outcomes of Job Network, the Australian government's national employment network.

- Increase self–employment through a higher number of Indigenous businesses.

  The Commonwealth intends to increase management skills among Indigenous Australians in order to enable them to successfully own and run businesses and support their moving from welfare dependency (Liberal Party of Australia 1998, p. 7). Furthermore, capital funding and consulting services for Indigenous businesses are made available. Economic programmes to help establish businesses are operated on a commercial basis. Closer links with industry stakeholders are intended to be established.

- Develop labour force skills of Indigenous Australians.

  The Commonwealth government seeks to increase job skills while people are unemployed or during community work such as CDEP. Indigenous job seekers are required to partake in vocational or educational training in order to increase their chances for paid employment. Other employment programmes aim at improving job search skills of Indigenous job seekers.

Relevant government bodies

Today, the Department of Employment and Workplace Relations (DEWR), ATSIC, Indigenous Business Australia (IBA) and Centrelink are the main policy making and service delivery bodies.

DEWR holds responsibility for mainstream employment policy. The department comprises the Indigenous Employment Branch, which is responsible for Indigenous employment policies and also administers the Indigenous Small Business Fund, jointly with ATSIC.

ATSIC is further responsible for the Business Development Policy (BDP) and the Community Development Employment Projects Scheme (CDEP). IBA, which was formerly named Commercial Development Corporation (CDC), promotes Indigenous businesses through loans along commercial guidelines. Before the establishment of ATSIC and CDC in 1990, the Department of Aboriginal Affairs was in charge of Indigenous employment policies and programmes and the Aboriginal Development Commission[1] was responsible for providing funds through loans to Indigenous businesses. Centrelink is the gateway to Job Network services and administers income support payments.

7.5.2 Recent policy developments

7.5.2.1 Aboriginal Employment Development Policy

In 1984, the Committee of Review of Aboriginal Employment and Training Programmes was appointed to investigate the success and implementation of the Commonwealth National Employment Strategy for Aboriginals, which had been initiated in 1977. The Committee found that the strategy had not effectively been implemented and indicated the need for a new Aboriginal employment policy (Commonwealth of Australia 1991b, pp. 361–363).

[1] See Explanatory Notes, p. 246.

The Commonwealth government responded with the announcement of the Aboriginal Employment Development Policy in 1987. AEDP was jointly developed by the former Department of Aboriginal Affairs, the Department of Employment, Education and Training and the Aboriginal Development Commission. From 1990, DEET and ATSIC coordinated AEDP.

AEDP intended to improve Indigenous people's participation in the national economy, principally by addressing the high levels of unemployment among Indigenous Australians (Altman & Smith 1992, p. 1). Its central goal was the achievement of Aboriginal employment and income equity by the year 2000 in order to reduce the differences in socio–economic status between Indigenous and non–Indigenous Australians (Australian Government 1987a, p. iii). It further aimed to decrease the level of welfare dependency of Indigenous Australians to that of other Australians.

A special feature of AEDP was that the Commonwealth government specified statistical targets that should be reached by the year 2000 (Australian Government 1987a, pp. 3–4):

- Increase in the proportion of Aboriginal people aged 15 and above who are employed from 37 per cent to around 60 per cent.
- Doubling of the median income of Aboriginals.
- Reduction in Aboriginal welfare dependency on the unemployment benefit from the current level of around 30 per cent of the working age population to only 5 per cent.

The policy highlighted the importance of CDEP, which led to a large increase in the number of Indigenous people working for unemployment benefits. CDEP annually grew by approximately 3,000 participants between 1987 and 1992 (Sanders 1998, p. 149).

Employment was to be increased particularly in the private sector.[1] The Australian government anticipated that two–thirds of the required growth in employment to reach equality in the mainstream employment market could be reached by an increase in employment in the private sector (Australian Government 1987b, p. 1). Consequently, the government planned to create 1,100 private–sector workplaces every year through government subsidies until the year 2000 (Altman & Taylor 1994, p. 1). Further, Indigenous people should be encouraged to found businesses.

From 1986 to 1990, AEDP expenditure was $765 million (Altman & Sanders 1991b, p. 12).

[1] Note: The private sector also comprises industries that are fully dependant on government subsidies, such as Indigenous community service organisations.

The implementation of AEDP relied almost exclusively on the Training for Aboriginals and Torres Strait Islanders Programme (TAP) (Bourke 1998, p. 235). Apart from TAP, there was a range of smaller programmes, which helped unemployed Indigenous people establish businesses through capital, management support and wage subsidies (Australian Government 1987b, pp. 2–5). The Enterprise Employment Assistance Scheme, for example, provided assistance with labour costs in Aboriginal community enterprises (Bourke 1998, p. 236). The Small Business Funding Programme offered loan assistance at concessional interest rates (Australian Government 1987b, p. 6). CDEP was also part of AEDP.

Training for Aboriginal and Torres Strait Islanders Programme

The Department of Employment, Education, Training and Youth Affairs administered TAP. It provided employment–based training and transition assistance, such as career guidance or referral services, for Indigenous people in order to raise their level of skills and employment (ABS 1996, p. 182). Under its employment strategies element, TAP also offered wage subsidies to public and private sector employers for the training and recruitment of Indigenous job seekers. From 1995 to 1996, 11,900 Aboriginal and Torres Strait Islander people took part in this programme (ATSIC 1998b, p. 39). Programmes of the Indigenous Employment Policy replaced TAP in 1999.

A review of AEDP was undertaken in 1994. It found that some improvement in the Indigenous employment situation had been achieved. From 1986 to 1991, the employment of Aboriginal and Torres Strait Islander people in the private sector grew at a higher rate than that of non–Indigenous people (Taylor 1993, p. 64). Though, most of this increase was due to a higher employment in Indigenous community organisations, which are ultimately funded by the public sector (Daly 1992, p. 127; Hunter 1996, p. 55; Altman & Sanders 1991, p. 13; Altman & Taylor 1994, p. 1). At the same time, however, Indigenous people were still dependent on welfare (ATSIC 1994b, p. xiii) and more than three times more likely to be unemployed (38 per cent of Indigenous people compared to 10 per cent of all Australians) and of these, over 50 per cent had been unemployed for more than twelve months (Bourke & Edwards 1998, p. 235).

7.5.2.2 Commercial Development Corporation

The Aboriginal and Torres Strait Islander Commercial Development Corporation was founded in 1990 in order to assist Indigenous people in establishing their own businesses. The operations of CDC served the purposes of AEDP in enhancing Aboriginal and Torres Strait Islander self–management and economic self–sufficiency (ATSIC 1998e, p. 10). CDC was renamed to Indigenous Business Australia in 2001 (HRSCAA 2001, p. 126). Its main goals were and are to promote and encourage Aboriginal and Torres Strait Islander participation in the ownership and control of companies.

IBA is required to act in accordance with sound business principles (ATSIC 1998e, p. 10). Its approach is not to offer subsidies, concessional loans or grants but to enter into sound commercial ventures that have the potential to create local and sustainable economic outcomes (Department of Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, p. 7). IBA will only invest in businesses that are assessed as being, or likely to be, commercially viable.

IBA operates with a board of Indigenous and non–Indigenous directors, selected by the Minister for Aboriginal and Torres Strait Islander Affairs on the basis of their expertise in commerce or industry. IBA assesses the viability of projects, negotiates the ownership and managerial structures, lends equity capital to the Indigenous partners and mentors them to develop their managerial expertise within the joint ventures. The Indigenous partners are required to repay their loan to IBA, in effect buying them out of the venture.

IBA received seed funding from the government over the first four years, but is now required to finance its operations from its investments (Bourke 1998, p. 237). IBA operates with a capital base of $67 million (IBA 2001, p. 1).

7.5.2.3 ATSIC business policies

ATSIC was established in 1990. It assumed responsibility for ADC’s business programmes and CDEP from the former DAA.

From 1995, ATSIC launched new Indigenous business policies and strategies for achieving economic equality for Indigenous Australians. The new Business Funding Scheme (BFS) and the Indigenous Business Incentive Programme (IBIP) were launched. The emphasis lay on the development of Indigenous businesses, increased

employment and skill development and greater utilisation of Indigenous assets. BFS and IBIP were replaced by the Business Development Programme in 1999.

Business Funding Scheme

BFS commenced in 1995. Its objectives were to "promote the economic independence of Indigenous individuals and corporations by assisting their acquisition, ownership and development of commercially successful businesses" (ATSIC 1998e, p. 10). The scheme provided low interest business loans to Indigenous people and organisations to purchase business enterprises. BFS also contributed business advice to borrowers. From 1995 to 1996, 123 applicants were approved, receiving $14 million in total funds (ATSIC 1998d, p. 37).

Indigenous Business Incentive Programme

ATSIC launched this programme in 1997, replacing the Aboriginal Community Enterprise Incentives Scheme.[1] IBIP focused less on community–based enterprise and placed greater emphasis on business opportunities for individuals and joint ventures with a greater economic perspective. IBIP's objectives were identical to those of BFS. It assisted Indigenous people who otherwise had difficulty to get funding. Assistance depended on applicants having a sound business proposal with the capacity to create new and sustainable employment. The emphasis was on providing grants and training assistance to newly established businesses (ATSIC 1998e, p. 10).

Business Development Programme

BDP replaced the Business Funding Scheme and the Indigenous Business Incentive Programme in 1999. BDP is administered and funded by ATSIC. Its objectives are the same as those of BFS and IBIP (ATSIC 1999d, p. 2).

BDP is designed to provide business support services and financial help to Indigenous people and organisations who wish to start and operate commercial businesses (ATSIC 1999c, p. 2). It comprises two separate services: Business Support services and Business Finance services.[2] Business Support mainly provides Indigenous businesses with management training; Business Finance supplies loans at relatively low interest rates to Indigenous businesses.

[1] Note: The Community Enterprise Initiatives Scheme provided grants to Aboriginal corporations to establish or develop small–scale income generating enterprises. Outlays in 1995–1996 totalled $20 million on 136 projects (ATSIC 1998b, p. 37).

[2] See Chapter 7.5.3.2.3, p. 172, for details.

7.5.2.4 Indigenous Employment Policy

The Indigenous Employment Policy (IEP) initiative was announced by DEWR in May 1999 and progressively implemented until June 2000. Recognising the ongoing extreme disadvantage experienced by Indigenous people in the labour market, IEP was introduced to complement mainstream employment assistance available to Indigenous job seekers. The policy objective is to generate more employment opportunities for Indigenous Australians in recognition of their disadvantage. The Indigenous Employment Policy supplements Job Network[1] where it does not operate or is insufficient to meet local needs. In particular, the policy focuses on (DFAT 2000, p. 2; Shergold 2001, p. 67):

- Increasing the level of Indigenous people's participation in private sector employment.
- Assisting Community Development Employment Projects sponsors to place their work–ready participants in open employment.
- Supporting the development and expansion of Indigenous small business.
- Improving outcomes for Indigenous job seekers through Job Network.

The policy has three main elements[2]:

- Indigenous Employment Programme: a programme to replace the Training for Aboriginals and Torres Strait Islanders Programme.
- Indigenous Small Business Fund: a fund to provide improved access to business preparation and support. It complements ATSIC's programmes for business development.
- New Indigenous–specific Job Network measures to improve outcomes for Indigenous job seekers.

There are 50 Indigenous employment officers located in regional centres and capital cities to promote IEP within Indigenous communities and to provide advice.

$52 million per year was allocated for IEP programmes (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 29) and $35 million was spent on Indigenous Employment Policy services from 1999 to 2000 (Commonwealth Grants Commission 2001b, p. 242).

[1] Job Network is the mainstream national employment network. See also Chapter 7.5.3.1.3, p. 164.
[2] See Chapter 7.5.3.2.2, p. 169, for details.

7.5.2.5 Australians Working Together

The Commonwealth welfare reform package Australians Working Together was announced in May 2001 and was to be implemented as of February 2002. Under this mainstream programme, unemployed people on income support receive more coordinated assistance, but also have to fulfil work or training obligations. Australians Working Together includes measures to improve Indigenous employment outcomes.

In areas where job opportunities exist, selected CDEP organisations additionally adopt the role of Indigenous Employment Centres. Indigenous Employment Centres help CDEP participants to find work outside of CDEP. Participants are offered work experience, job search support, access to training and mentoring assistance. The Indigenous Employment Centres will collaborate with local employers and Job Network members. The first Indigenous Employment Centre opened in April 2002, with others commencing operation in July 2002 (DEWR 2002a, p. 1). $48 million was made available over four years (Shergold 2001, p. 71). Funding by DEWR of $31 million has been earmarked for this programme. In addition, $17 million will be redirected from current IEP funding (Champion 2002, p. 3).

Additionally, around 100 remote Indigenous communities will receive extra funding under the Community Participation Agreements. Indigenous people will be helped to determine themselves what they can do for their local community in return for their Centrelink income support payments (DEWR 2002a, p. 2). $32.2 million is available over a period of four years (Champion 2002, p. 2).

Furthermore, 12 new Remote Area Servicing Centres are being established to cater to Indigenous people in remote areas and enable them to access Centrelink services (Minister for Reconciliation and Multicultural and Indigenous Affairs 2002, p. 12). There, Indigenous people will get individual help from a trained Centrelink personal adviser. $9.2 million has been allocated for this programme element. The proposed implementation date was September 2002 (Champion 2002, p. 2).

7.5.3 Employment and economic development programmes

Indigenous Australians are, like all other Australians, entitled to access mainstream services, for example under Job Network, and to receive income support payments. Further, Indigenous–specific programmes, such as IEP or the CDEP Scheme, are in place to improve Indigenous employment.

Figure 9 provides an overview of employment assistance to Indigenous Australians.

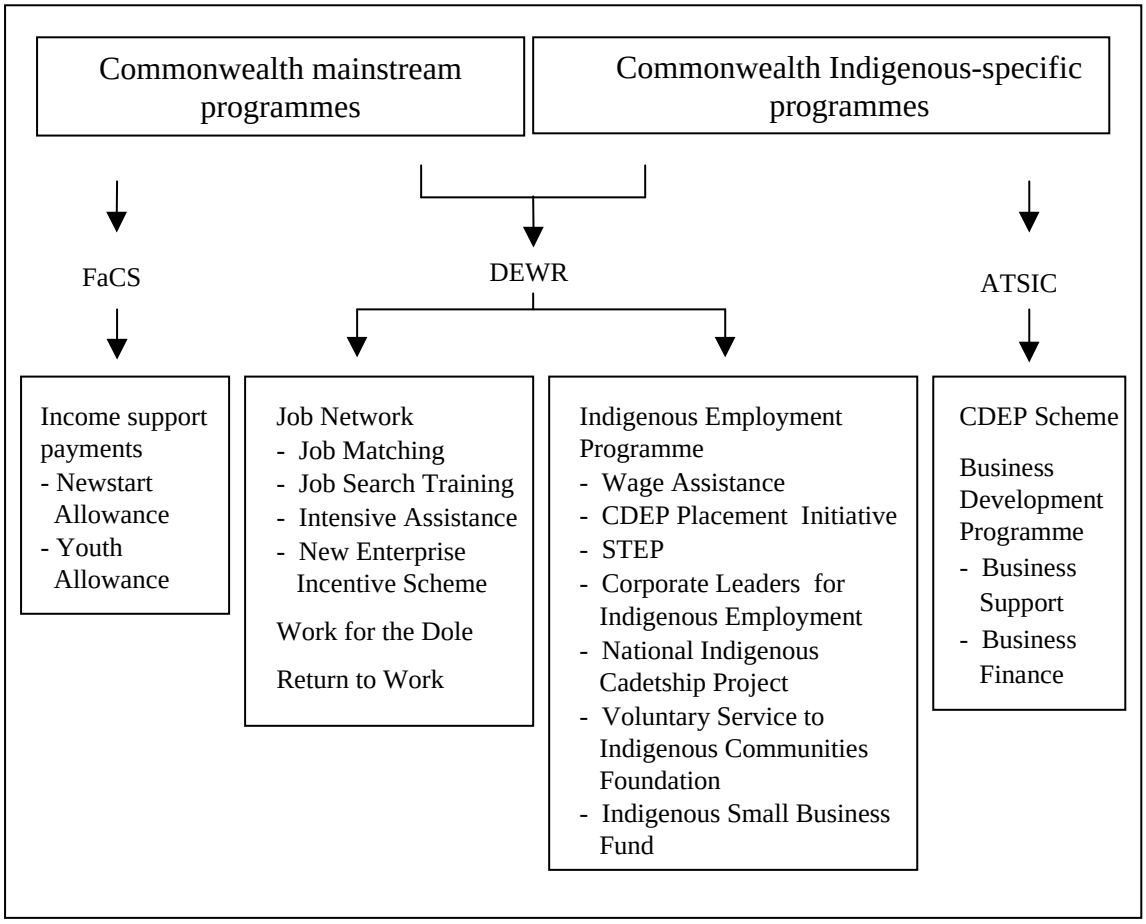

Figure 9: Commonwealth employment assistance to Indigenous Australians

7.5.3.1 Mainstream programmes

As every other Australian citizen, Aboriginal and Torres Strait Islander are entitled to mainstream employment programmes. These are provided primarily by DEWR, as are programmes to facilitate Indigenous participation in mainstream programmes. FaCS is responsible for policy developments of income support payments, which are delivered by Centrelink.

7.5.3.1.1 Income support for the unemployed

Youth Allowance

Youth Allowance[1] is the income support payment available to Australian residents aged 16 to 20 years. Recipients have to be looking for full–time work. Clients who have been receiving Youth Allowance for more than six months and are over 18 years, have to take part in an approved activity, such as vocational training, self–employment

[1] See Appendix K, Table K3, p. 217, for payment rates.

development or voluntary work due to mutual obligation[1] requirements (Centrelink 2002b, p. 1).

New Start Allowance

Newstart Allowance[2] is the income support payment for the unemployed aged 21 years and over. To be eligible for Newstart Allowance, the recipient must be an Australian resident, unemployed, actively seeking work and take part in a programme to prepare for work. If having received New Start Allowance for 12 months or more (if over 25 years) or six months or more (if under 25 years), the recipient has to meet mutual obligation requirements (Centrelink 2002h, p. 1).

7.5.3.1.2 Work for the Dole

The Work for the Dole Scheme started in 1997 as a key element of the government's mutual obligation policy where unemployed have an obligation to contribute to the community in return for their unemployment social security payments. The programme is managed by DEWR.

The scheme funds projects that offer work experience for up to six months in areas of broad community benefit, such as community care or the environment. The Work for the Dole Scheme was expanded from 25,000 places in 1998 to 32,500 places in 1999 and 50,000 places in 2000 (DEWRSB 2000a, pp. 74–75). About 5 per cent of its clients are Indigenous Australians. $67 million was spent on services to Indigenous people from 1999 to 2000 (Commonwealth Grants Commission 2001a, p. 252).

Job seekers may be required to take part in Work for the Dole if they are:

- aged 18–24 years, getting the full rate of Youth Allowance or Newstart Allowance, and have been getting payments for six months or more; or
- aged 25–34 years, getting the full rate of Newstart Allowance, and have been getting payments for 12 months or more.

All participants in the Work for the Dole Scheme receive an extra $20.80 per fortnight in addition to their unemployment benefit.

7.5.3.1.3 Job Network

Job Network is Australia's national employment network, especially for the long–term unemployed. It was initiated in May 1998, replacing the Commonwealth Employment

[1] See Technical Glossary, p. 253.
[2] See Appendix K, Table K2, p. 216, for payment rates.

Services, which delivered services through 300 government offices (Shergold 2001, p. 67).

Job Network is a national network of around 200 private, community and government organisations committed to finding jobs for unemployed people, including Indigenous Australians. Acknowledging the fact that Indigenous people avoid using the services offered by Job Network, DEWR introduced a new Indigenous initiative within Job Network in 1999: the Wage Assistance Programme.[1]

$26.3 million of $754.1 million was spent on Indigenous purposes in the 1999–2000 financial year (Commonwealth Grants Commission 2001a, p. 242).

In the following, employment services available under Job Network are listed.

Job Matching

Job Matching helps employers find personnel and job seekers find suitable vacancies (Labour Market Policy Group 2000, p. 45). Job seekers also receive help preparing résumés. Job Matching services were initially available to income support recipients, participants in CDEP and unemployed people aged 20 years or under. Since 1998, the availability of services was extended to job seekers who work less than 15 hours per week and do not receive income support payments. Around 400,000 people are assisted each year (Commonwealth Grants Commission 2001a, p. 242).

Job Search Training

This training assists job seekers to improve their job search skills. Job Search Training comprises training in interview and job search techniques and résumé writing. Job Search Training is available to job seekers registered as unemployed with Centrelink for more than 3 months who (Labour Market Policy Group 2000, p. 60):

- receive government income support; or
- are aged between 15 and 20 years and not in full–time education or training; or
- are an Indigenous Australian participating in CDEP; or
- are returning to the workforce after two years of unpaid care giving.

Approximately 90,000 job seekers participate annually (Commonwealth Grants Commission 2001a, p. 243). Between May 1998 and September 1999, 0.6 per cent of participants declared they were Indigenous Australians (Labour Market Policy Group 2000, p. 63).

[1] See Chapter 7.5.3.2.2, p. 169.

Intensive Assistance

Long–term unemployed can receive intensive personalised assistance on a one–to–one basis between job seeker and case manager. Vocational training, work experience, language and literacy training or help with transport costs to get to work are offered (HRSCAA 2001, p. 107). Intensive Assistance is specialised help for those job seekers who are registered with Centrelink as unemployed for at least 12 months, or those who are experiencing difficulty in getting a job and are:

- receiving Newstart or Youth Allowance or another form of qualifying government income support, or
- a person aged 15 to 20 years and not in full–time education or training, or
- an Aboriginal or Torres Strait Islander participating in CDEP.

From 1998 to 1999, 5 per cent of all registrations for Intensive Assistance were Indigenous Australians (Labour Market Policy Group 2001, p. 27). If looking at the outcomes of Intensive Assistance (people who after receiving Intensive Assistance are placed in employment for at least 26 weeks), Indigenous people only represent 4 per cent of outcomes (Shergold 2001, p. 68).

New Enterprise Incentive Scheme

NEIS was introduced as a pilot scheme in 1985 and subsequently permanently established in 1987. In May 1998 it became part of Job Network. This scheme is a self–employment programme helping unemployed people with good business ideas to establish their own businesses. To be eligible, the applicant must be registered as unemployed, be 18 years or over, currently looking for work and receive some form of qualifying income support. Business ideas must meet eligibility requirements. NEIS comprises training in business skills and business management, business advice and mentor support during the first year of business operation and an allowance for one year, which is at the basic adult rate of the Newstart Allowance. Specialist NEIS providers or Job Network members deliver NEIS.

The scheme is relatively small, with around 6,000 new participants each year (Centre for Labour Market Research 2001, p. 10). Indigenous Australians represent 4.3 per cent of the Job Network eligible population but only 0.6 per cent of NEIS participants from 1998 to 1999 (Labor Market Policy Group 2000, p. 106).

7.5.3.1.4 Return to Work Programme

The Return to Work Programme commenced in February 2000. The programme is delivered by DEWR. It provides advice and training assistance for income support recipients and people who have been out of the workforce for two years or more as care givers. The programme delivers help in areas such as skills assessment and access to training.

$25 million has been allocated for 35,000 places nationwide over the period 2000 to 2004 (DEWRSB 2000b, p. 1).

7.5.3.2 Indigenous–specific programmes

Indigenous–specific employment and economic development services are funded and provided by ATSIC and DEWR. DEWR has a specific Indigenous Employment Branch administering Indigenous employment programmes.

7.5.3.2.1 Community Development Employment Projects Scheme

The Community Development Employment Projects Scheme provides employment for Indigenous people in a wide range of community projects and enterprises. ATSIC administers CDEP.

CDEP basically is a “work for the dole” scheme for Indigenous Australians. It started in 1977 in remote communities and was expanded to rural and urban communities from 1984 (ATSIC Office of Evaluation and Audit 1997, p. 1). From 1987, CDEP was placed within the framework of AEDP and became one of its major programmes. In 2002, CDEP provided around a quarter of Indigenous employment. Without the scheme, the Indigenous unemployment rate would exceed 50 per cent (Clark 2002b, p. 1). Two–thirds of projects are located in remote areas of Australia where mainstream labour market opportunities are very small (ATSIC 1998a, p. 46).

The formal CDEP objective is “to provide work for unemployed Aboriginal persons and Torres Strait Islanders in community managed activities which assist the individual in acquiring skills which benefit the community, develop business enterprises and/or lead to unsubsidised employment” (ATSIC 2001a, p. 155).

To participate in CDEP, unemployed members of a community decide to forego their individual unemployment benefits in order to work part time on community projects for a wage. Wages are set at the same levels as the foregone unemployment benefits. Communities participating in CDEP receive a grant from ATSIC, which includes

participant wages calculated on an average per participant rate, recurrent costs and assistance for capital purchases (ATSIC 1998b, p. 38; Morony 1991, p. 101).

CDEP projects comprise various community development activities, including construction, repair and maintenance of community infrastructure and management of projects that create community income. The communities themselves make decisions about the kind of work undertaken.

Provided that positions are available, CDEP is open to any member of an Aboriginal or Torres Strait Islander community over 16 years old who is eligible for certain types of Centrelink income support benefits.

The recent refocusing of the scheme puts greater emphasis on business development, accredited training and CDEP as a means to get jobs in the mainstream labour market. The 1999 Indigenous Employment Policy provides a subsidy to CDEP organisations that are able to place participants in jobs outside CDEP.

A major issue for many years was the CDEP participants' lack of access to certain benefits, for example Rent Assistance, available to other low–income earners and unemployment benefit recipients (Sanders 1998, p. 151). CDEP participants gained access to income–support add–on benefits from 20 September 1999. An independent review of CDEP found that:

> CDEP has been critical to developing an improved sense of pride in community and culture and has provided the basis for acquiring greater skills, employment and enterprise development resulting in ongoing social and economic growth. (Spicer 1997, p. 2)

Spicer suggests that CDEP has been effective in providing employment in Indigenous communities, especially in remote areas where the labour market is limited (Spicer 1997, p. 156). The ATSIC Office for Evaluation and Audit (1997, p. 53) acknowledged that CDEP delivered additional training opportunities for Indigenous people and enhanced cultural identity of the communities.

The scheme has expanded enormously since 1987, when it had approximately 6,000 participants in 63 communities (ATSIC Office of Evaluation and Audit 1987, p. 1). From 1995 to 1996, in 274 communities across Australia, 28,600 Aboriginal and Torres Strait Islander people decided to work on Community Development Employment Projects Schemes (ATSIC 1998b, p. 38; Office of the Minister for Aboriginal and Torres Strait Islander Affairs 1992, pp. 4–5).

Expenditure on CDEP accounts for almost half of the expenditure by ATSIC (Office of the Minister for Aboriginal and Torres Strait Islander Affairs 1992, p. 5).

In the 1999–2000, expenditure on the scheme was $424 million with 32,000 places funded (Commonwealth Grants Commission 2001a, p. 242). From 2001 to 2002, $450 million of ATSIC's total budget of $1.1 billion was allocated to CDEP assisting around 34,000 participants (Clark 2002a, p. 1). IN the financial year 2002–2003, CDEP will be funded with around $480 million (Clark 2002b, p. 1).

A large component of CDEP funding is CDEP wages, which are a direct substitute for unemployment allowance entitlements.

7.5.3.2.2 Indigenous Employment Programme

Wage Assistance for Job Network

The Wage Assistance Programme was implemented in July 1999 as part of the Indigenous Employment Programme funded through DEWR. Wage Assistance is an initiative of Job Network and is a wage subsidy programme for employers who employ Indigenous job seekers. Wage Assistance helps Indigenous job seekers to find long term jobs, particularly in the private sector, either through Job Network or their own efforts, using an eligibility card issued by Centrelink (Centrelink 2002c, p. 37; DEWRSB 2001a, p. 79). Job seekers receive a Wage Assistance Card if they are registered as unemployed with Centrelink and identified as Indigenous and if they are (DEWR 2001e, p. 2):

- receiving an income support payment, or
- a CDEP participant, or
- under 21 years of age, not on any allowance and registered with Centrelink.

Wage Assistance pays up to $4,400 to an employer for full–time work of at least 35 hours per week over 26 weeks and $2,200 for part–time work of at least 20 hours per week over 26 weeks (Commonwealth Grants Commission 2001, p. 253).

Since July 1999, more than 5,200 Indigenous people have been employed through Wage Assistance (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 10); 1,600 were employed in the first year alone (Shergold 2001, p. 69). Around 83 per cent of placements are in the private sector and about 50 per cent of the job seekers are still at work three months after the completion of the subsidy (DEWRSB 2001a, p. 79; Shergold 2001, p. 69).

CDEP Placement Incentives

Community Development Employment Projects Placement Incentives is a programme of the Indigenous Employment Policy. CDEP organisations receive a bonus of $2,200 for each of their participants placed in work of at least 20 hours per week and off CDEP. The placement incentives were introduced in September 1999 (DEWR 2001a, p. 2).

In this way, CDEP organisations s are encouraged to support participants in progressing to mainstream markets. However, since its introduction, only around 0.5 per cent of CDEP participants have moved to mainstream labour markets.

Structured Training and Employment Projects Programme

The STEP Programme provides flexible financial assistance for projects that offer structured training for Indigenous people, as apprenticeships and traineeships for example, that leads to lasting job opportunities. Projects may be with private or public sector employers as well as regional and Indigenous community–based employment organisations. Funds are made available on the basis of employment outcomes and value for money (DEWR 2001d, p. 3).

Since the introduction of STEP in 1999, over 9,800 Indigenous job seekers have made use of this programme and gained access to accredited training and employment (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 10). From July 2001 until May 2002, more than 190 STEP projects were approved and supported by $41 million. From 2000 to 2001, around 55 per cent of projects were realised in the private sector and 53 per cent of commencements resulted in employment outcomes (DEWRSB 2001a, p. 79). From 2002 to 2003, 130 structured training and employment projects were to begin, with a value of over $28 million (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 32).

Corporate Leaders for Indigenous Employment Project

The Commonwealth has entered into a partnership with major private sector companies to generate more jobs for Indigenous Australians. Companies commit to employing Indigenous people while the government provides flexible funding for that purpose (usually STEP).

By May 2002, 57 companies had signed up to be Corporate Leaders, providing over 3,000 jobs (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 11).

Voluntary Service to Indigenous Communities Foundation

The foundation links skilled volunteers with Indigenous organisations and communities. The skilled volunteers provide business, technical or financial skills where need has been identified.

National Indigenous Cadetship Project

This programme has been in operation since 1992 and is part of IEP since 1999. It provides opportunities for Indigenous undergraduates to gain the professional qualifications needed for a range of jobs in both the public and private sectors. With a new emphasis on the private sector, employers will be assisted to recruit Indigenous undergraduates by offering cadetship places. Cadets will be paid a study allowance while studying full time and will be provided with a paid work placement during their long semester break. Usually, employers offer their cadets employment when they have finished their cadetship.

60 new cadetships were funded in the financial year 2001–2002. As of April 2002, the programme was assisting 176 participants (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 11).

Indigenous Small Business Fund

The Indigenous Small Business Fund (ISBF) was launched in October 1999 and is part of the Indigenous Employment Policy initiative and a joint initiative between the Department of Employment, Workplace Relations and ATSIC. ISBF complements existing Indigenous Business Programmes available through ATSIC and DEWR.

The fund helps to develop business management skills; identify and clarify business opportunities; and enhance business prospects by supporting skills development programmes such as mentoring, networking activities, advisory services and market development initiatives (HREOC 2001, p. 47).

DEWR is responsible for the funding of business proposals of community organisations. Funding between $5,000 and $100,000 is available for business development projects. Funding for individuals is available through ATSIC (DEWR 2001b, p. 1).

As of March 2002, a total of 79 projects had been approved (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 12). Around $11 million has been allocated annually to this programme by DEWR and ATSIC (DEWR 2002b, p. 1).

7.5.3.2.3 Business Development Programme

ATSIC's Business Development Programme comprises business support and business finance services. They replaced the Business Funding Scheme and the Indigenous Business Incentive Programme.

Only Indigenous people and corporations that are controlled directly or indirectly by Indigenous people can receive assistance through BDP. The average annual funding is around $36 million. In June 1999, ATSIC's business loans portfolio totalled 503 current accounts with a discharge balance of $47.3 million (ATSIC 2000c, p. 1).

Business Support

Business Support provides assistance in the development and presentation of a business proposal for a successful fund application and facilitates access to business and management training. It also offers on–going access to professional assistance to ensure continued viability of the enterprise.

The level of free Business Support services available to each business before they commence operating, or before ATSIC finance is approved, whichever is appropriate, is limited to $50,000 per business of individuals, partnerships and private incorporations and to $200,000 for business of community organisations.

Business Finance

Business Finance makes loans available at base interest rates charged at the lowest commercial bank business rate. Access to interest concessions (less 30 per cent) or interest–free loans are determined with reference to the eligibility criteria.

Eligibility requirements for Business Finance are (ATSIC 1999d, pp. 3–6):

- Commercial viability: Applicants must show that their businesses can be commercially viable after an initial help and will not need further assistance.
- Need: ATSIC will only provide the amount and form of funding that is adequate and the minimum necessary to make the business commercially viable.
- Net benefit: The net benefit is determined by comparing the value of benefit with the cost of the subsidy. The net benefit criterion will only be applied where the applicant can demonstrate that the business needs to have a concession and/or grant in order to be commercially viable. Businesses that

will be commercially viable at the base interest rate will not be considered for concessions and therefore do not need to show net benefit.

The minimum loan available through Business Finance is $5,000. There is no maximum amount for an individual loan, but the amount is subject to the limit of available funds and the eligibility criteria.

Grants may be included in a finance package in addition to a loan or guarantee. Grants may be given for purchases of capital or stock, contribution to wages, working capital, debt repayment or rescheduling. There is no minimum grant amount, but the total value of ATSIC finance must be greater than $5,000 including any grant component. The maximum amount of grant, however, will not exceed 25 per cent of the total funding needed. Grants will only be provided where net benefits can be identified and achieved.

Where an applicant is seeking funds from a commercial lending organisation, ATSIC may guarantee the loan. The minimum loan amount guaranteed under BDP is $5,000.

ATSIC will seek a specific time limit on guarantees and will not accept the full risk associated with guaranteed funding as a general rule. The lender will be expected to accept some of the risk.

As of March 2002, 145 business loans had been approved for the financial year 2001–2002 (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 12).

7.5.4 Discussion

Reflecting locational and educational factors, Indigenous unemployment rates remain unacceptably high despite some progress within the last decade. The unemployment rate for Indigenous people decreased from 31 per cent in 1991 to 23 per cent in 1996, compared to the non–Indigenous rate of 9 per cent in 1996. Most of this improvement was due to a higher employment in CDEPs, as Indigenous people working in CDEPs are not accounted for as unemployed.

The income gap between Indigenous and non–Indigenous Australians is significant and continues to grow. The median income per week for an Indigenous individual was $231 in 2001, representing an increase of 22 per cent since 1996. The median income per week for a non–Indigenous Australian however rose to $387, which represents an increase of 31 per cent since 1996.

Through ATSIC and DEWR programmes self–employment among Indigenous Australians has increased but still falls short of the level of self–employment of all Australians. The ratio of self–employment rates of the Indigenous to the non–

Indigenous workforce increased from 0.15 in 1986 and 0.26 in 1991 to 0.31 in 1996 (Hunter 1999a, p. v). The Indigenous Small Business Fund, for instance, has provided financial assistance to around 80 Indigenous businesses since its October 1999 start (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 12).

In 1987, AEDP announced its goals of employment and income equity between Indigenous and non–Indigenous Australians. The equity goal of AEDP was destined to fail. Compared to the non–Aboriginal population, a high proportion of Aborigines live in rural and remote areas with small or non–existent labour markets (Altman 1991, p. 159) and they would have to move to urban areas to find mainstream work. Statistical equality in employment can only be achieved if the geographical distribution of Indigenous and non–Indigenous people is the same. Therefore, it seems questionable whether the goal of equity in the sense of statistical equality in employment rates and income is desirable. Furthermore, Indigenous people are still subjected to discrimination in the labour market, so those with the same qualifications and work experience as non–Indigenous people are paid less (Daly 1994, p. 1).

Due to mutual obligation requirements, Indigenous people are, like all other Australians, required to undertake training or work while on unemployment income support. CDEP is the Indigenous–specific counterpart to Work for the Dole. However, CDEP was launched in 1977, long before the policy of mutual obligation was introduced.

CDEP is an appropriate means of creating employment in remote locations where no mainstream labour market exists. Additionally, projects are managed by the community and deliver services to the community. The downside is that CDEP participants receive benefit–like wages that are ultimately funded by ATSIC. In urban areas, the employment of Indigenous people in mainstream workplaces is a much better option. Therefore, special programmes for the transition of CDEP participants to mainstream labour market have been introduced in the Indigenous Employment Policy. IEP seeks to improve Indigenous outcomes of Job Network measures through Indigenous–specific programmes that facilitate access. In addition to mainstream programmes, STEP and the National Indigenous Cadetship Programme offer professional training to Indigenous people. IEP's outcomes seem to be higher than in mainstream assistance programmes (HREOC 2001, p. 47). However, IEP's emphasis on the importance of transitions away from CDEP into mainstream employment is unlikely to succeed unless Indigenous workers have the basic educational qualifications required to compete in the mainstream labour market (Hunter 2002, p. 21).

The high growth rate of the Aboriginal population and the young age cohort indicate that more jobs will have to be created just to maintain the current unemployment rates (Taylor & Hunter 1998, p. 4). An enormous increase in employment opportunities and in government funding will be necessary.

7.6 Expenditures in Indigenous affairs

7.6.1 Commonwealth funding of Indigenous–specific programmes

Total funding for Indigenous–specific programmes in current figures has increased from $1.4 billion in the 1993–1994 financial year to $2.4 billion in the 2001–2002 financial year. In 1999–2000 prices, expenditures rose from $1.5 billion to $2.2 billion in this period. Budget estimates for Indigenous–specific funding for 2002 to 2003 are $2.5 billion (Minister for Immigration and Multicultural and Indigenous Affairs 2002, pp. 33–42).

Indigenous–specific funding is very rarely directed at individuals as cash payments or loans. In total, only 10 per cent of Commonwealth Indigenous–specific funding is in form of payments to individuals (Gardiner–Garden 1998, p. 8). Most programmes provide funding for Indigenous organisations, such as ACCHSs, or grants to states and territories to undertake Indigenous–specific programmes.

Furthermore, Indigenous–specific programmes often substitute mainstream programmes that are not used by Indigenous people for various reasons. ABSTUDY, for instance, is a substitute programme for the Austudy and Youth Allowance schemes. Against popular belief, Indigenous–specific programmes and their entitlements are generally not more generous than mainstream programmes. CDEP participants, for example, receive community wages that are not higher than Newstart Allowance payments. ABSTUDY payments have been aligned in 2000. Only in very limited conditions do Indigenous students on ABSTUDY receive additional benefits.

7.6.1.1 Immigration and Multicultural and Indigenous Affairs Portfolio

The greatest part of expenditure on Indigenous–specific services is administered by the Immigration and Multicultural and Indigenous Affairs Portfolio and by ATSIC within the portfolio. ATSIC receives around 90 per cent of total Indigenous–specific funding within the portfolio. There are other organisations receiving Indigenous–specific funding within this portfolio, examples of which are Aboriginal Hostels Limited and several land–related councils.

The funding of the Immigration and Multicultural and Indigenous Affairs Portfolio has constantly been increasing since 1993. However, the portfolio's share of total Commonwealth Indigenous–specific funding decreased: from 71 per cent in the 1993–1994 financial year to 54 per cent in the 2002–2003 financial year.

ATSIC

Commonwealth funding of ATSIC and its programmes has increased. However, like the total portfolio's funding, ATSIC's funding as a proportion of Commonwealth funding for all Indigenous–specific programmes has decreased because the Commonwealth tends to channel new Indigenous–specific funding towards mainstream agencies.

From 1993 to 1994, actual expenditure through ATSIC programmes was $888 million representing 65 per cent of all expenditure on Indigenous–specific programmes. In the 2002–2003 budget, $1.16 billion was allocated to ATSIC, which equalled approximately 47 per cent of all expenditure on Indigenous–specific programmes.[1]

ATSIC's main programmes are CDEP and CHIP. These two programmes form more than half of total ATSIC expenditures, with CDEP being the largest and CHIP the second largest programme expenditure.

From 1997 to 1998, $374 million (37 per cent) of ATSIC's total budget of approximately $1 billion was spent on CDEP and $233 million (23 per cent) on CHIP (ATSIC 1999b, p. 68). 1999–2000 expenditures for CDEP had risen to $424 million and for CHIP to $255 million (representing 40 per cent and 24 per cent of ATSIC's total budget in that financial year) (ATSIC 2000a, p. 203).

CDEP participants forego their unemployment benefits, which otherwise would be payable by Centrelink as Newstart Allowance. Therefore, approximately two–thirds of CDEP costs can be offset against the savings in the expenditures through Newstart Allowance (ATSIC 1999b, p. 15).

Further ATSIC expenditure areas are other employment, training and enterprise programmes, land–related programmes, home ownership, legal aid and community and youth support programmes (ATSIC 1998b, p. 24).

[1] See Table 36, p. 177.

Table 36: ATSIC's share of total expenditure on Indigenous–specific services, 1993–1994 to 2002–2003

Financial year	ATSIC ($million)	Total Indigenous-specific funding ($million)	ATSIC's share of total Indigenous-specific funding (%)
1993–1994 (a)	888	1,362	65.2
1994–1995 (a)	942	1,473	64.0
1995–1996 (a)	972	1,722	56.4
1996–1997 (a)	940	1,701	55.3
1997–1998 (b)	1,002	1,852	54.1
1998–1999 (b)	985	1,997	49.3
1999–2000 (b)	1,068	2,218	48.2
2000–2001 (b)	1,106	2,324	47.6
2001–2002 (b)	1,134	2,397	47.3
2002–2003 (c)	1,164	2,501	46.5

Notes:
(a) Actual expenditure.
(b) Revised estimates of expenditure.
(c) Budget estimate of expenditure.

Sources: After Gardiner–Garden 1998, p. 8; Minister for Aboriginal and Torres Strait Islander Affairs 1998, pp. 23–29; Minister for Aboriginal and Torres Strait Islander Affairs 1999, pp. 11–17; Minister for Aboriginal and Torres Strait Islander Affairs 2000, pp. 19–22; Minister for Immigration and Multicultural and Indigenous Affairs 2002, pp. 33–42; Minister for Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, pp. 28–33

7.6.1.2 Funding of Indigenous–specific services by other Commonwealth portfolios

The funding of Indigenous–specific services in the Health and Ageing Portfolio in current figures has doubled since 1995 when DHAC assumed responsibility for Indigenous health. The health portfolio's share of total funding for Indigenous–specific services also increased, from 8 per cent to 12 per cent between 1995–1996 and 2001–2002.[1]

Funding for Indigenous–specific services from the Education, Training and Youth Affairs Portfolio and the Employment and Workforce Portfolio increased from 1993–1994 to 2000–2001, but has since stagnated. As a proportion of total Indigenous–specific funding, education and employment services through mainstream portfolios remained at around 20 per cent of total funding.

[1] See Appendix N, Table N3, p. 224.

Expenditure by the Family and Community Services Portfolio has doubled since 1995. Its share of total Indigenous–specific funding increased from 6 per cent to 8 per cent. Before 1995, funding for Indigenous–specific services had not been separately specified.

7.6.1.3 Functional dissection of Indigenous–specific funding

The functional distribution of Indigenous–specific funding has not changed significantly within the last decade.

Employment and economic development programmes equal the greatest expenditure and are followed by education and housing and infrastructure expenditures. In the 2002–2003 budget, funding of employment and economic development programmes accounted for more than a quarter of all Indigenous–specific funding.[1] Educational programmes represented about 20 per cent of total Indigenous–specific funding (Minister for Aboriginal and Torres Strait Islander Affairs 1998, p. 2). The proportion of funding for housing and infrastructure programmes decreased slightly and was at around 17 per cent. The share of health programme funding increased to more than 10 per cent (Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 3).

7.6.2 Expenditures on Indigenous health

7.6.2.1 Total health service expenditure on Indigenous health

Total health service expenditures include all levels of government as well as private expenditure[2]. The majority of government funding for Indigenous health is not specifically targeted through Indigenous–specific programmes. It simply represents the proportion of the general health budget used by Indigenous people accessing mainstream health services. Estimates on the costs of Indigenous people using of mainstream services enable estimates of total health expenditure on health services and has been estimated for two financial years: 1995 to 1996 and 1998 to 1999.

The total health expenditure estimate on health services for Indigenous people was $853 million from 1995 to 1996. This represented 2.2 per cent of total health expenditure in that year (AIHW 2000a, p. 241). The estimated expenditure per person was 8 per cent higher for Indigenous people: $2,320 compared to $2,163 for non–Indigenous people (Deeble et al., p. 22).

[1] See Appendix N, Figure N, p. 225.

[2] Note: Private funding includes out–of–pocket payments by patients and private health insurance funding.

From 1998 to 1999, an estimated total of $1.25 billion were spent on health services by and for Indigenous people (AIHW 2001b, p. 2). This was 2.6 per cent of the total health expenditure for all Australians and translates into $3,065 for each Indigenous person, compared with $2,518 for each non–Indigenous person (AIHW 2001b, p. 2). Total expenditures per person therefore were 22 per cent higher per Indigenous person.[1]

7.6.2.2 Expenditure by source of funds

The total health expenditure can be split into its sources of funds: public and private.

As can be seen from Table 37, the composition of funding of health services for Indigenous and non–Indigenous people is very different. Health service funding for Indigenous people relies more heavily on government funding than that for other Australians.

Table 37: Estimated expenditures per person, by source of funds, Indigenous and non–Indigenous people, 1998 to 1999

	Indigenous		Non–Indigenous		
Source of funds	**Expenditure per person** ($)	**Proportion of total expenditure per person** (%)	**Expenditure per person** ($)	**Proportion of total expenditure per person** (%)	**Ratio Indigenous/ Non–Indigenous**
Commonwealth government funding					
Indigenous–specific programmes	298	9.7	-	-	-
MBS and PBS	196	6.4	506	20.1	0.39
Other Commonwealth programmes	163	5.3	366	14.5	0.45
Payments to states/territories	735	24.0	334	13.2	2.20
Total Commonwealth funding	1,393	45.5	1,206	47.9	1.15
State government funding	1,376	44.9	484	19.2	2.84
Local government funding	15	0.5	9	0.4	1.57
Total government funding	**2,784**	**90.8**	**1,699**	**67.5**	**1.64**
Total private funding	281	9.2	819	32.5	0.34
Total health funding	**3,065**	**100.0**	**2,518**	**100.0**	**1.22**

Source: After AIHW 2001, p. 6

[1] Note: It has to be kept in mind that figures from 1998–1999 cannot directly be compared with previously published estimates because of inflation and differences in methodologies used in estimation.

Governments funded about 91 per cent of Indigenous health care costs from 1998 to 1999. Private funding was only around 9 per cent. For non–Indigenous people, governments financed around 68 per cent of health care costs. Almost 33 per cent were funded by private sources.

Therefore, expenditures per person from public funding sources were around 64 per cent higher for Indigenous people. This is mainly due to a greater reliance on the public health system, lower use of private health services, lower consumption of non–prescription medicines and a smaller proportion of Indigenous people with private health insurance.

Commonwealth government funding

Commonwealth outlays contain direct and indirect components. Direct Commonwealth funding for Aboriginal health consists of specific direct operational grants, predominantly to ACCHSs, and the estimated Indigenous share of outlays for nation–wide mainstream health services, mainly MBS, PBS and public health programmes (ABS 2000j, p. 1; HRSCAA 2000, p. 18; NAHS Working Party 1989, pp. 31–33). The Commonwealth also directly subsidises the private sector, for example through private health insurance subsidies.[1]

Indirect outlays are grants to states and territories to share costs of public hospitals and other services (Daffen 1995, p. 16; HRSCAA 2000, p. 25). From 1998 to 1999, about 50 per cent of Commonwealth funding was indirect (AIHW 2001, p. 6).

Direct Commonwealth funding is lower for Indigenous people than for non–Indigenous Australians, which is mainly a result of lower usage of MBS and PBS by Indigenous people.

From 1998 to 1999, Commonwealth direct health expenditure was $658 per Indigenous person, compared with $786 per non–Indigenous person.[2] This translates into a ratio of 0.84. Commonwealth expenditure for Medicare was $146 per Indigenous person and $356 per non–Indigenous person. Commonwealth expenditure per person for PBS was three times higher for non–Indigenous people, with $50 per non–Indigenous person and $151 per non–Indigenous person.

[1] See Appendix I, p. 214.
[2] See Table 38, p. 181.

Table 38: Commonwealth recurrent health service expenditure for Indigenous people (excluding payment to states and territories), 1998 to 1999

Area of expenditure	Indigenous person ($)	Non-Indigenous person ($)	Indigenous/ non–Indigenous per person ratio
Medicare	146.11	355.53	0.41
PBS	50.25	150.59	0.33
Indigenous–specific health services	298.22	0.57	..
Other health services including general administration	163.24	279.29	0.58
Comonwealth funding of health expenditure (a) (excluding payments to states and territories)	**657.82**	**785.97**	**0.84**

Notes:
(a) Commonwealth funding of health expenditure includes some funding of private sector programmes through private health insurance subsidies.

Source: After AIHW 2001, p. 26

State and territory government funding

All state and territory expenditures are direct, which means that states and territories only fund programmes that they administer themselves. The states and territories mainly provide services to people of low socio–economic status who have to rely on public hospitals and state–run health services. Funding to Aboriginal health is delivered through direct grants to Indigenous–specific services, specific programmes, for example in public health, and general mainstream services, such as public hospitals.

In all states and territories, funding for Indigenous people was almost three times higher than for non–Indigenous people (NHIMG 2000, p. 24). From 1998 to 1999, the average state government funding per Aboriginal and Torres Strait Islander was $1,376, compared with $484 per non–Indigenous person (AIHW 2001b, p. 6).[1]

In addition to their own funding, states and territories receive grants from the Commonwealth for the delivery of their services. From 1998 to 1999, the expenditure per person from these Commonwealth grants was more than twice as high per Indigenous person than per non–Indigenous person ($735 compared to $334).[1]

The differences in funding at the different government levels are a result of the different usage of the Australian health system services. Indigenous people, compared with non–Indigenous people, more often use publicly funded services in community and public

[1] See Table 37, p. 179.

health, public hospitals and less frequently consume services of private hospitals, MBS and PBS (ABS & AIHW 2001, p. 45; National Aboriginal and TSI Health Clearinghouse 1999, p. 9). The low use of MBS and PBS is probably due to the socially and culturally inappropriate service delivery in private practices (NACCHO 1998b, p. 2).

8 Current issues in Indigenous social policy

8.1 Mainstream programmes versus Indigenous–specific programmes

8.1.1 Mainstream programmes

Mainstream services aim at providing services for all Australians, including Aboriginal and Torres Strait Islander people. Relevant mainstream services in the areas of health, housing, education and employment have been outlined in previous chapters. These services are delivered by the Commonwealth and the states and territories. As mainstream services aim at providing services to all Australians, Indigenous and non–Indigenous people should have equal access to mainstream services. Given the levels of disadvantage experienced by Indigenous people, it should be expected that they use mainstream services at greater levels than non–Indigenous people. However, this is not the case. Indigenous Australians access mainstream services at much lower rates than non–Indigenous Australians. This is a result of various factors, which include:

- A culturally inappropriate service delivery and service delivery environment: Most mainstream services do not consider specific Indigenous needs. In health service delivery, for example, the western medicine of body parts alienates Indigenous people, who share a holistic view of health. The impersonal service delivery environment, such as in practices and hospitals, does not correspond to Indigenous needs. It rather deters Indigenous people from seeking treatment.
- Geographical barriers: A great percentage of Indigenous people live far away from urban areas where mainstream services mainly are situated.
- Economic barriers: Many Indigenous people cannot afford co–payments for medical treatment by a GP or prescription medicines. Furthermore, Indigenous people do not have financial resources to take out private insurance or seek treatment of health professionals that are not covered under MBS.
- A lack of Indigenous health professionals: Indigenous people are underrepresented among health professionals, especially in mainstream services.
- A lack of knowledge on Indigenous health: Non–Indigenous health professionals often still have no or little knowledge on the multifactoral aetiology of Indigenous ill–health, Indigenous culture or Indigenous perception of health and illness.

Some mainstream programmes deliver services that cannot be provided by Indigenous–specific services, such as specialist hospital services or other highly specialised medical services. Therefore, Indigenous people have to be enabled to access these mainstream services if an improvement in Indigenous health is to be achieved (Commonwealth Grants Commission 2001a, p. 91).

In 1996, the Coalition government declared their aim of a national unity which said the same level and quality of services delivery should be available to all Australians in order to unify the Australian population. Mainstream services have been supplemented by Indigenous–specific measures to increase access by Aboriginal and Torres Strait Islander people. Another step towards mainstreaming was the transfer of responsibility for Indigenous health programmes from ATSIC to the then Department of Human Services and Health in 1995. This transfer was meant to create a greater focus on Indigenous health needs within mainstream programmes. An example for the mainstreaming undertaken in the area of education are the ABSTUDY changes implemented in 2000, which aligned ABSTUDY living allowances with Austudy and Newstart Allowance rates. Only few ABSTUDY–specific, add–on benefits have been retained.

It is necessary to increase access to mainstream services for Indigenous Australians. Unfortunately, extended targeting of mainstream measures at Indigenous people seems to result in decreased funding for Indigenous–specific programmes and services. This could be seen as a revival of assimilationist ideas (Fletcher 1996, p. 1; McConaghy 2000, p. 13). Considering the extreme ill–health and socio–economic disadvantage of Indigenous people, it does not seem appropriate to reduce funding for Indigenous–specific services.

8.1.2 Indigenous–specific programmes

Indigenous–specific programmes try to provide supplementary services where mainstream services are inaccessible or inadequate. Therefore, Indigenous–specific programmes are a substitute for programmes that other Australians receive through mainstream programmes. They recognise and respond to urgent Indigenous needs that have not been met by mainstream services (ATSIC 1999b, p. 31). Indigenous–specific services are delivered through Indigenous–specific programmes by Commonwealth, state and territory agencies or by Indigenous organisations. In regards to the acceptability of services, the provision of services through Indigenous organisations,

particularly community organisations, can be seen as most adequate, as the involvement of the community is important to Indigenous people and increases service acceptance. Indigenous–specific services are more likely to be culturally appropriate and accessible, especially if the Indigenous community is involved in the management and delivery of the services (ATSIC 1999f, p. 9).

Indigenous health is integrally linked with the well–being of the whole community. Therefore, Indigenous communities have to become active participants in Aboriginal policy and service delivery. Community–controlled organisations, such as health, substance abuse, employment and housing services, are community development vehicles (Gardiner–Garden 1998, p. 12; Public Health Association 2000, p. 15; Saggers & Gray 1991, p. 403). Indigenous community organisations possess a great knowledge of Aboriginal issues and the needs of their communities. Consequently, they can work more effectively and efficiently and provide a source of education and training to Indigenous people (HRSCFCA 1999, p. 11; NAHS Working Party 1989, p. xvii).

However, the empowerment of Indigenous people through Indigenous community organisations also encounters problems. Indigenous people generally lack managerial skills due to their low levels of education. The delivery of Indigenous–specific services can result in the duplication of services if looking specifically at the type of service. If considering the acceptability and appropriateness of services by Indigenous people, a duplication of services does not occur (Saggers & Gray 1991, p. 405). Therefore, it seems questionable whether a restriction to mainstream services for Indigenous people in urban areas is justified, particularly given the high levels of ill–health Indigenous people experience.

ATSIC and mainstream agencies such as DEST and DEWR fund Indigenous–specific services — preferably in areas where mainstream services are limited or not available. Since the Coalition government has gained power in 1996, Indigenous–specific services have been restricted to provide targeted assistance to supplement mainstream services, not to replace them or duplicate their services. Indigenous–specific services are meant to operate in remote areas, where mainstream services are not accessible due to locational barriers. In urban areas, where access is not restricted by geographical barriers, mainstream services are the preferred model of service delivery to Indigenous people. However, for various reasons, mainstream services in urban areas may still not be appropriate and consequently not accessible for Indigenous Australians. Many

Indigenous people, if given a choice, tend not to use mainstream services, but Indigenous community services instead (HRSCAA 2001, p. 25).

Indigenous–specific services and programmes rarely lead to Indigenous people getting more than other Australians. Only a few programmes are more generous than their mainstream counterparts in order to meet disadvantage that is disproportionately great among Indigenous people.

8.2 Indigenous empowerment

8.2.1 Self–determination and self–management

There is no commonly agreed upon definition of self–determination and self–management in Australia. Therefore it seems appropriate to explore the meanings and connotations of both terms as used in Australian politics today. Both self–determination and self–management are meant to imply more responsibility upon Aboriginal people. They stress the right to make decisions on issues relating to them and to manage their own affairs.

Self–determination

In international law and politics, self–determination is seen as a collective human right of peoples to decide their own "political, economic, social and cultural condition" (HREOC 1997, p. 6; Lawson & Bertucci 1996, p. 1228). However, the Indigenous people of Australia are a small minority within an existing nation that categorically denies the possibility of any kind of Indigenous self–government. Therefore, it seems more appropriate to adopt the definition of the Encyclopaedia of Aboriginal Australia that defines self–determination as "the right to take responsibility for setting the course for further change, to specify the agenda for action and to control policy implementation" (Horton (ed.) 1994, p. 977).

It was the Australian Labor Party that introduced the term of Indigenous self–determination in the 1970s and overturned the previous paternalistic treatment of Indigenous people. Since 1972, self–determination has been described as the "cornerstone" and "central word" of Indigenous affairs policy by the Labor Party (O'Donoghue 1992, p. 7).

Indigenous self–determination requires Indigenous involvement and empowerment in the policy making of Indigenous affairs (Martin & Finlayson 1996, p. 10; Minister for Aboriginal Affairs 1987, p. 2). Indigenous self–determination is also important in

service delivery, where Indigenous communities and organisations should be in control of funding and service delivery decisions (Commonwealth of Australia 1991a, pp. 188–190).

Self–determination according to O'Donoghue (1992, p. 15), a former ATSIC chairman, is characterised by "well–being" and "full citizenship rights." It required similar employment prospects, education opportunities, housing and municipal facilities and a life expectancy the same as for other Australians. O'Donoghue further defined self–determination as "Aboriginal communities deciding the pace and nature of their future development as significant components within a diverse Australia" (O'Donoghue 1992, p. 7).

There are and have been Aboriginal organisations that adopted more radical definitions of self–determination. The National Aboriginal and Islander Legal Service, for example, demanded a fundamental restructuring of power relations between Indigenous and other Australians. Others noted that the Indigenous people had never ceded their sovereign rights as a nation and therefore called for self–government.

However, all Australian governments have rejected the idea of Indigenous self–government or sovereignty as a result of self–determination (Roberts 1998, p. 259). This means that self–determination will always have to operate within boundaries imposed by the government (Bern & Dodds 2000, p. 163; Cowlishaw 1988, p. 196; Tonkinson & Howard 1990, p. 70). Instead, the governments prefer a "bringing together" of Indigenous people with the rest of the population into one state. The Labor government under Keating (1991–1996), for example, issued their "One Nation" policy to reinforce their restriction of self–determination to an incorporation of Indigenous people within the Australian state.

The introduction of self–determination also encountered problems. One of them was that Indigenous people were meant to adopt management roles without having appropriate academic qualifications (Morre 2000, p. 4). As a result, many Aboriginal organisations were doomed to fail. Following this line of reasoning, it has often been argued that current arrangements in Indigenous affairs only amount to community self–management of individual programmes, rather than self–determination.

Self–management

After the Liberal Party had gained power in 1975, the term self–determination was officially changed to self–management. The Liberal Party, as well as the National Party, preferred the term self–management in order to demonstrate a different policy approach

(Benett 1999, p. 195) and to clarify that Indigenous sovereignty was unattainable and undesirable.

The much criticised notion of self–management is that it describes a delegated function whereby a group or some type of formal authority carries out tasks with funds and programme designs determined by others outside the group or region (ATSIC 1999f, p. 23; Eckermann et al. 1992, p. 40). Through self–management of Indigenous people, the Australian government still holds primary responsibility for policy directions and control over Indigenous developments.

Today, the issue of accountability is often discussed in relation to self–management of Indigenous organisations (ATSIC 1999e, p. 18). Current funding arrangements for Indigenous organisations are directed by various Commonwealth, state and territory government agencies that decide the functional areas and guidelines for expenditure. The agencies determine also whether particular applicants' proposed projects are of high enough priority within those guidelines to warrant funding (Australia Institute 2000, p. 4). Aboriginal communities and organisations are held accountable for their expenditures according to those guidelines. This can create problems for Indigenous community organisations, which also are accountable to the Indigenous community they deliver, as government guidelines and regulations do not always conform with interests of their communities. Self–determination requires that there should be at least some aspects within the funding arrangements that allow Indigenous incorporated bodies to determine their own priorities and strategies.

8.2.2 Means of Indigenous empowerment

8.2.2.1 Aboriginal and Torres Strait Islander Commission

The Aboriginal and Torres Strait Islander Commission was established in March 1990 under the ATSIC Act as an independent statutory authority. It replaced the Department of Aboriginal Affairs and the Aboriginal Development Commission, combining their representative, policy–making, administrative and funding elements (ATSIC 1992, p. 2; Sullivan 1996, p. 106).

ATSIC is the key agency for providing advice to Commonwealth, state, territory and local governments on Indigenous issues and monitors their programmes (DAA 1989, p. 4). ATSIC is also a funding provider to Indigenous people. It funds services that are supplementary to mainstream services in the fields of housing, infrastructure, business and employment. ATSIC was responsible for Indigenous health until 1995 when

responsibility was transferred to OATSIH within DHAC (Office of the Minister for Aboriginal and Torres Strait Islander Affairs 1992, p. 6).

Structure

ATSIC is a decentralised organisation that consists of an elected arm and an administrative arm (Dillon 1996, p. 92). The elected arm itself comprises 35 regional councils and the Board of Commissioners. The regional councils are elected every three years. Each of the 35 regions elects between 10 and 20 regional council members, depending on the size of the region. Regional councils draw up regional plans and play an important role in regional funding decisions. ATSIC's regional councils administer around 70 per cent of ATSIC's programme funding (Daffen 1995, p. 17). The regional councils elect the 18 members of the Board of Commissioners from amongst their members. The board, in turn, elects the commission chairman. The elected arm has a national advisory and advocacy role and is responsible for national funding and policy–making decisions (Smith 1996, p. 25). ATSIC's administration supports the elected arm and is staffed by public servants.

Aims

ATSIC principal aims are stipulated in the Aboriginal and Torres Strait Islander Commission Act of 1989 (HRRSCAA 1994, pp. 68–69). The commission seeks to maximise participation of Aboriginal and Torres Strait Islander people in the formulation and implementation of policies, to develop self–management and self–determination among Indigenous people and to ensure cultural, economic and social development.

ATSIC's functions are:

- the formulation and implementation of policies and programmes for Aboriginal and Torres Strait Islander people;
- the monitoring of effectiveness of programmes, also of programmes conducted by other bodies;
- the development of policy proposals to meet needs at national, state, territory and regional levels;
- assisting, advising and cooperating with Aboriginal and Torres Strait Islander communities, organisations and individuals; and
- the advising of the Minister for Aboriginal and Torres Strait Islander Affairs.

ATSIC and self–determination

ATSIC was the first democratically elected national representative body for Aborigines and the first governmental body that gave Indigenous people executive power rather than restricting them to an advisory role (Commonwealth of Australia 1991b, p.7). ATSIC's first chairperson O'Donoghue praised ATSIC as "the culmination of a long line of attempts to achieve Aboriginal self–determination at the government level."

Through its regionally elected arm, ATSIC enables Aboriginal and Torres Strait Islander people to participate in Aboriginal politics on a regional and national level, embodying the principle of Indigenous self–determination (Fletcher 1996, p. 16). ATSIC provides a framework to empower Indigenous peoples to participate at national and regional levels (ATSIC 1999f, p. 11) by:

- being an advocate for the rights of Indigenous peoples, particularly in respect of native title, land rights and protection of culture and heritage;
- representing Indigenous community interests (Fletcher 1999, p. 121);
- providing advice to government at all levels to ensure Indigenous perspectives are taken into account in policy development and service provision;
- using supplementary funding to enable Indigenous peoples to set their own priorities and improve outcomes in housing, infrastructure and employment; and
- monitoring Indigenous–specific initiatives and programmes of mainstream agencies (DAA 1989, p. 4).

However, there are critics of ATSIC's dual role as an Indigenous representative body and its function similar to a Commonwealth government department that includes implementation of government policies and accounting responsibilities.

The Federation of Land Councils was strongly critical that ATSIC had the authority to speak on behalf of Indigenous people, as its central function was to administer government services (Roberts 1998, p. 275). Further, the Royal Commission into Aboriginal Deaths in Custody also suggested that ATSIC was not truly a means of self–determination as:

> [The] staff remains Commonwealth public servants whose primary accountability, in the performance of duties and in the interpretation of policy guidelines, is to the chief executive officer, a full–time public servant appointed by the minister. (Commonwealth of Australia 1991b, p. 8)

Indeed there may be some truth to these accusations. While ATSIC's organisational structure allows advice and representation from Indigenous communities as well as decision making at regional and local levels, it remains a bureaucratic structure that does not truly conform to the Indigenous way of decision making. ATSIC is funded by the Commonwealth government and accountable to the Minister for Aboriginal Affairs (Coombs & Robinson 1996, p. 10; Fletcher 1994, p. 14; Sanders 1993, p. 12). ATSIC has often lacked financial capacity to properly fund projects in Indigenous communities.

8.2.2.2 Aboriginal Community–Controlled Health Services

Aboriginal Community–Controlled Health Services represent a means of self–determination in the fields of health service delivery. ACCHSs are based on the principles of self–determination and community control and on Aboriginal cultural concepts of health care (Anderson 1997, p. 123).

The first ACCHS was founded in Redfern, an inner city suburb in Sydney, in 1971. ACCHSs were developed because mainstream services were not responding to the communities' needs for the provision of more accessible and appropriate health care. Since the 1970s, ACCHSs have obtained an important role in the delivery of primary health care and related services to Aboriginal communities (Anderson 1997, p. 123).

Today, primary health care is provided through around 120 ACCHSs around Australia, which may bulk bill wherever there is a permanent doctor. ACCHSs now employ some 200 doctors and a total staff of 1,500, 70 per cent of whom are Indigenous (ATSIC 2001c, p. 12).

ACCHSs are based on a holistic concept, which sees health in the context of social and economic living conditions (Burden 1998, p. 211). ACCHSs emphasise the significance of a functioning infrastructure and good housing. The employment of Aboriginal health workers is of key importance as they contribute the crucial knowledge and expertise of their own community and mediate between the patients and the medically trained staff (Winroe 1988, p. 18). Traditional Aboriginal healing techniques are respected and are used (Coombs 1994, p. 64). ACCHSs also play their part in the improvement of the community's infrastructure by pointing out shortcomings and their consequences for ill–health (Saggers & Gray 1991, p. 401).

Means of self–determination

Prior to the existence of ACCHSs "the majority of health care networks provided for Aboriginal communities [were] directed by centralised white bureaucrats who [were]

usually both physically and culturally separated from their clients" (HRSCAA 1979, p. 113).

Indigenous community–controlled organisations are widely acknowledged as the best, most effective and efficient vehicle for service delivery to Aboriginal and Torres Strait Islander communities (ATSIC 2001c, p. 12; HRSCAA 2001, p. 53). They embody the principles of community control and empowerment. Aborigines have their say in the development of their own health services (Anderson, I. 1996, p. 72). Community control of primary health care services enables Indigenous people and their communities to make decisions regarding management and delivery of primary health care services which target specific community needs.

ACCHSs respond to the needs of the community, and are accountable to the community (Pagan 1988, p. 24). They deliver culturally appropriate health services in forms, settings and languages that are accepted by the Indigenous population (Aboriginal and Torres Strait Islander Health Policy Branch, Queensland Health 1994, p. 11).

8.2.2.3 National Aboriginal Community–Controlled Health Organisation

At a national level, the National Aboriginal Community–Controlled Health Organisation represents ACCHSs. NACCHO was established in 1991 after funding was withdrawn from its predecessor, the National Aboriginal and Islander Health Organisation because of an unsatisfactory audit report in 1986 (DAA 1984, p. 35). NACCHO is managed by an elected executive committee, which exists of members of the boards of ACCHSs. At the state and territory levels, affiliated regional bodies represent the ACCHSs in that state or territory.

NACCHO's major activities are (National Aboriginal and Torres Strait Islander Health Clearinghouse 1999, p. 2):

- Assisting member ACCHSs.
- Development and assistance of culturally appropriate health services, for example ACCHSs.
- Cooperating with governments, organisations and Indigenous communities on matters relating to the well–being of Indigenous people.
- Representing and advocating for Indigenous communities, their health services and programmes.
- Assessing the health needs of Aboriginal communities and taking steps to meet these.

NACCHO undertakes health policy planning together with state and territory governments and ATSIC representatives (NACCHO 1999b, p. 3). It enables representatives of ACCHSs to partake in health policy planning and decision making. NACCHO is a means of representing needs of ACCHSs and their communities at a national level. In this sense, NACCHO enhances Indigenous self–determination.

8.3 Performance reporting

Performance reporting has gained importance with the increased emphasis of accountability and outcomes–based funding for Indigenous programmes and services.

Evaluation through performance reporting is applied to ensure the best use of the available funds, and measures to what extent requested outcomes are reached. Evaluation is a tool for further policy planning.

Performance indicators are generally used to evaluate efficiency and effectiveness of programmes or organisations. Efficiency assesses the relationship between inputs and outputs and ensures that funding is used wisely. Effectiveness judges to what extent outcomes meet the objectives (Anderson & Brady 1995, p. 2). Reporting allows governments to assess performance against their targets and criteria (National Aboriginal and TSI Health Council 2001, p. 126). Performance measurements through performance indicators can (SCRCSSP 2002, p. 7):

- inform about government performance;
- inform about programme performance;
- encourage performance improvement; and
- encourage efficient service delivery.

Evaluation of Indigenous services has been a controversial issue in the past. Indigenous organisations often experienced evaluations as a means to cut funding if services did not meet certain standards, instead of a first step towards service improvements. As a consequence, many Indigenous health services and other Indigenous organisations are still uneasy about evaluations of their performance and outcomes (Torzillo & Kerr 1991, p. 371) and fear that evaluation procedures are used against them rather than to improve service delivery (Saggers & Gray 1991, p. 415).

8.3.1 National Performance Indicators and Targets for Indigenous Health

The Commonwealth has leadership in developing and coordinating the implementation of national performance indicators on Indigenous health.

In 1998, an interim set of National Performance Indicators and Targets for Indigenous Health was endorsed by AHMAC.[1] The Commonwealth, state and territory governments reported annually against these indicators and targets to AHMAC to monitor improvements in Indigenous health (ANAO 1998, p. 26).

The interim National Performance Indicators were arranged according to:

- life expectancy and mortality,
- morbidity,
- access to health services and health services impacts,
- workforce development,
- risk factors,
- intersectoral issues,
- community involvement, and
- quality of service provision.

Targets for a number of the indicators were established and included (ANAO 1998, p. 26):

- an increase in life expectancy consistent with a 20 per cent reduction in age–standardised all causes mortality rate ratios over ten years;
- a 50 per cent reduction in ten years in the age–standardised mortality rates of Indigenous people for the main causes of death, namely heart disease, injury and poisoning, pneumonia and cervical cancer, and a 20 per cent reduction for diabetes; and
- a 50 per cent reduction within ten years in the death rate for infants.

During the 1998 and 1999 round of reporting, jurisdictions experienced difficulties in gathering data due to data quality problems and a lack of data and methods to collect data. Only four jurisdictions were able to report against indicators of life expectancy and mortality. All other jurisdiction did not report against these indicators because of problems with identifying Indigenous status in relevant administrative data sets (for example birth and death registrations) (NHIMG 2001, p. vii).

[1] See Appendix O, p. 226.

Additionally, problems arose because performance indicators were not clearly defined (NHIMG 2001, p. iii). This was the case for most performance indictors in category three, which measure access to health services.

A refinement of the indicators was undertaken and a new set of indicators was endorsed in October 2000.[1] Jurisdictions have been required to report against the new set of indicators since the 2000 reporting round. The new set of indicators clarifies definitions of indicators and determines which agencies have to report on specific indicators (NHIMG 2001, p. ix). The new performance indicators were regrouped according to their relation to (OATSIH 2000a, pp. 10–11):

- government outputs,
- social equity,
- access to health services,
- risk markers, and
- outcomes for Indigenous people.

However, no information on the reporting against these new indicators had been released when this paper was written.

In addition to the annual jurisdictional reports on the National Aboriginal and Torres Strait Islander Health Performance Indicators and Targets, all signatories to the Framework Agreements annually report to the Australian Health Ministers' Conference[2] (AHMC) on progress against the indicators.

8.3.2 Service activity reporting requirements

Since 1998, Commonwealth–funded ACCHSs report annually to OATSIH and NACCHO on their activities through their service activity report. Information collected predominantly focuses on the range of services provided by ACCHSs and information on their workforce and clients.[3] The purpose of service activity reporting is to identify resource gaps and monitor outcomes of ACCHSs (OATSIH 2001c, p. 14).

Service activity reporting is a policy and funding planning tool (DHAC 2000c, p. 272). The evaluation ensures that community participation and control is realised and that national objectives are pursued. Nevertheless, ACCHSs are concerned that many of

[1] See Appendix P, p. 230.
[2] See Explanatory Notes, p. 246.
[3] All areas on which information is collected can be seen in Appendix Q, p. 232. Service activity reporting questions are in Appendix R, p. 233.

their important social and cultural activities could be devalued because they are not considered in the relatively small number of performance indicators (Aboriginal and TSI Health and Welfare Information Unit 1997, p. 41).

8.3.3 CHIP performance reporting

ATSIC has to report against programme performance indicators for the different components of CHIP:

- Community housing.
- Community infrastructure.
- Municipal Services.
- NAHS Community Housing and Infrastructure.

There are project and programme performance indicators for each component. Some of the indicators are mandatory, others are optional.[1] Organisations that are funded through CHIP are required to deliver information against the project performance indicators for each funded activity to ATSIC. ATSIC, in turn, reports against the programme performance indicators on outputs and outcomes in its annual report. The overall output sought is improved access for all Indigenous people to adequate housing, infrastructure and municipal services (ATSIC 2002a, p. 54).

8.3.4 IESIP performance reporting

Education providers have to report annually through IESIP performance reports against performance indicators across the eight priority areas agreed to by MCEETYA in 1995. These areas are (DETYA 2000c, p. 42):

- improving Indigenous literacy;
- improving Indigenous numeracy;
- increasing the employment of Indigenous Australians in education and training;
- improving educational outcomes for Indigenous students;
- increasing Indigenous enrolments;
- increasing the involvement of Indigenous parents and community members in educational decision making;

[1] See Appendix S, p. 239, for details on CHIP project and performance indicators.

- increasing professional development for staff involved in Indigenous education;
- expanding culturally inclusive curricula.

Core performance indicators measure developments in each of the priority areas.[1] IESIP funding recipients negotiate with the Commonwealth targets for each core performance indicator. The provider reports the outcomes achieved against each of the core performance indicators (MCEETYA Taskforce on Indigenous Education 2000, p. 23). Furthermore, education providers can negotiate additional performance indicators.

[1] See Appendix T, p. 242.

9 Conclusion

Over the past decades, there has been an improvement in some aspects of the health of Aboriginal and Torres Strait Islander people. Life expectancy has increased; infant mortality has declined as well as the prevalence of infectious and parasitic diseases. However, due to health improvements in the total population, the gap between the health status of Indigenous and non–Indigenous people persists (NHMRC 1996, p. 3). Additionally, the incidence of chronic disease is increasing. Aborigines and Torres Strait Islander people still remain the "least healthy identifiable subpopulation in Australia," (Thomson 1991, p. 37) as they were at the beginning of the 1990s.

Housing conditions of Indigenous people have improved slightly. Strategies specifically aim to enhance infrastructure services to discrete Indigenous communities and the quality of the housing stock of Indigenous housing organisations. Nevertheless, in rural and remote areas, many Indigenous people still live in appalling housing conditions with poor infrastructure. In urban areas, housing affordability is the main problem.

Educational participation and outcomes are improving, but equity has not been achieved. Also, education is delivered almost exclusively in a mainstream system. Unemployment rates have decreased but are still almost three times those of the overall Australian population. Indigenous poverty is so intense that the use of different methods does not materially change the findings (Hunter 1999b, p. 8). Indigenous poverty has its roots in the historical process of colonisation of the Australian continent. While white settlement resulted in the economic development of Australia, this development was based on the dispossession of Indigenous people and the removal from their traditional lands.

At the end of the 1980s, a new wave of national social policy strategies (NAHS, AEDP, NATSIEP) evolved. A range of policy measures were announced in the areas of health, housing, environmental health, education and employment. The evidence presented in this paper points to the conclusion that national strategies were announced, but their implementation often was problematic and incomplete. Targets were set too high to be achieved. National strategies in education and employment announced statistical targets that were to be reached by the year 2000. Policy aims were to reach equity between the Indigenous and non–Indigenous Australian population in health, education and employment. The strategies contributed to some improvements, but all of them failed to achieve their official targets. Strategies could not be implemented due to many factors,

such as a lack of data resources, finances, coordination or simply time. Unrealistic goals with unrealistic timeframes that continuously fail do not contribute to government credibility nor its policies.

To this day, mostly non–Indigenous people decide on Indigenous affairs. Mainstreaming tendencies are re–emerging and mainstream departments assume an increasing responsibility for policy making in Indigenous affairs and for service delivery.

ATSIC's role is diminishing. The responsibility for Indigenous health was removed from ATSIC and transferred to DHAC. ATSIC's role in the funding of Indigenous–specific services is also decreasing. ATSIC was established as a funder for supplementary services to Indigenous people who did not receive services from mainstream departments. With the new emphasis on mainstream services, ATSIC's funding has decreased. However, it seems too early to restrict ATSIC's responsibility because service delivery to Indigenous people through mainstream services has not yet improved acceptably. All in all, mainstreaming services will not lead to accelerated improvements in Indigenous health.

There is no real intention to accept Indigenous ideas if those are contradictory to western beliefs. Australia categorically denies the possibility of self–government of Indigenous tribes or regions. Indigenous empowerment is restricted within the boundaries of Australia and its existing structure as a state. Indigenous empowerment is mainly promoted on a local and community basis. Indigenous involvement in policy making at the Commonwealth level is still limited.

Since the 1970s, attempts at Indigenous social policy are recurring. New committees and reviews declared similar goals and recommendations. Since the late 1980s, various national strategies in health, housing, education and employment aimed at a national and coordinated approach to improve Indigenous health and socio–economic disadvantage have been pursued. In principle, agreements and strategies lacked details for implementation. They often focused on goals and desired outcomes, but did not specify measures in detail. Moreover, the intended cooperation and coordination was very time consuming and did not always result in positive outcomes.

When all is said and done, the gap between the Indigenous and the non–Indigenous population still persists. If comparing the outcome with the aims, most of the strategies have failed.

As to reconciliation, the Indigenous population is unlikely to feel part of the Australian community while the government fails to acknowledge responsibility for the personal and cultural disruption suffered by the stolen generation (Hunter 1999b, p. 18). The current Commonwealth government under Prime Minister John Howard officially supports reconciliation between the Indigenous and non–Indigenous Australians, but does not offer a formal national apology for the stolen generation and the history of loss and trauma. Dealing with Indigenous affairs under the Coalition government is problematic. The Commonwealth government attempts to improve Indigenous health, education, employment and housing, but restricts native title rights and defers reconciliation through their denial of an apology to the stolen generation.

Indigenous policies should contribute to a better general atmosphere and opinion of Indigenous matters and should not deny the legacies of the past.

Many Australians still have racist attitudes or show indifference towards Indigenous Australians and there is a widespread belief that Indigenous Australians receive too much financial help from the governments. These people still are of the opinion that Indigenous Australians are disadvantaged through fault of their own and that non–Indigenous Australians are not the cause. Consequently they believe that the non–Indigenous population should not have to contribute to the reduction of Indigenous disadvantage financially or by giving land back to the Indigenous people.

It is questionable whether specific measures in health, housing, education and employment will be successful under these circumstances. The Commonwealth government should create an atmosphere of reconciliation and mutual respect instead of fostering disrespect and indifference towards Indigenous people and their history. The Commonwealth government has announced goals and strategies to improve Indigenous health and socio–economic conditions. However, the motive does not seem to be an intrinsic desire to do so but an imposed task from external powers, such as the world–wide public eye or more specifically, the UN through its Committee on the Elimination of Racial Discrimination. The committee criticised inadequate participation of Indigenous people in decision making, the 1998 amendments to the Native Title Act and high Indigenous imprisonment rates (Committee on the Elimination of Racial Discrimination 2000, pp. 4–12).

Disadvantages that developed within two centuries will not be cured in a timeframe of one or two decades. The multi–dimensional nature of the problem requires government initiatives on all government levels and different sectors. Moreover, the different culture

of the Indigenous people has to be considered as a prerequisite for any improvement in Indigenous health. Some Indigenous people are still hesitant to work with non–Indigenous people because they fear discrimination. Furthermore it is hard, especially in national politics, to coordinate all demands of Indigenous people, as demands vary between regions. Also, government departments and organisations are restricted by underlying funding constraints. Funding needs to be channelled to those most in need yet the amounts of funding are too small to address all disadvantages faced by Indigenous Australians. Funding for Indigenous affairs has increased slightly, but even higher levels of funding would be required to clear the backlog. To ensure the efficient and effective use of the available financial resources, stringent accountability measures were imposed on governments and organisations and need to be continuously monitored.

The Commonwealth needs to acknowledge the role the European settlers and their governments have had in Indigenous history. Only then can the Commonwealth accept its responsibility to improve Indigenous health. Indigenous people need to have access to mainstream and Indigenous–specific assistance to realise fast improvements in Indigenous health, even if additional funding is needed. Therefore, it is also necessary that Indigenous people and Indigenous affairs gain more importance in domestic affairs and in the minds of all Australians. In the 21st century, Australians should not turn a blind eye to the Indigenous people and their deplorable state of health.

Appendices

Appendix A: Additional statistical information on Indigenous deaths from selected causes

Table A: Indigenous death rates from selected causes, 1997 to 1999 (a)

Cause of death	Total Indigenous population			Indigenous males			Indigenous females		
	No.	SMR (b)	(%) (c)	No.	SMR (b)	(%) (c)	No.	SMR (b)	(%) (c)
Circulatory	1,318	3.0	30.1	750	3.1	29.8	568	2.8	30.5
Injury and poisoning	701	2.9	16.0	496	2.8	19.7	205	3.3	11.0
Neoplasms	587	1.4	13.4	320	1.4	12.7	267	1.4	14.3
Respiratory	365	4.1	8.3	206	4.1	8.2	159	4.0	8.5
Endocrine/metabolic	371	8.4	8.5	169	7.2	6.7	202	9.4	10.8
Digestive	215	4.8	4.9	119	4.7	4.7	96	4.9	5.2
Mental disorders	96	2.4	2.2	62	2.4	2.5	34	2.3	1.8
Genitourinary	143	6.8	3.3	58	5.8	2.3	85	7.6	4.6
Infectious/parasitic	103	4.9	2.4	58	4.2	2.3	45	5.4	2.4
Nervous system	94	2.0	2.2	55	2.3	2.2	39	1.8	2.1
Ill-defined	119	5.7	2.7	76	6.0	3.0	43	5.3	2.3
Other causes (d)	267	-	6.0	146	-	5.8	121	-	6.5
All causes	**4,379**	**2.9**	**100.0**	**2,515**	**2.9**	**100.0**	**1,864**	**2.9**	**100.0**

Notes:
(a) Data from Queensland, South Australia, Western Australia and the Northern Territory combined.
(b) $SMR_{mortality}$ = observed deaths divided by expected deaths, see Medical Glossary, p. 258.
(c) Percentage of all deaths in that population category.
(d) Includes complications of pregnancy and childbirth, diseases of skin and subcutaneous tissue, musculoskeletal diseases, congenital anomalies and certain perinatal conditions.

Source: After ABS & AIHW 2001, p. 116

Appendix B: Henderson poverty lines in Australia, 2001

Table B: Henderson poverty lines in Australia, December 2001 (a)

Type of income unit	Including housing		Other than housing	
	Head in workforce ($ per week)	**Head not in workforce** ($ per week)	**Head in workforce** ($ per week)	**Head not in workforce** ($ per week)
Couple	392.28	336.81	286.91	231.39
Couple with				
one child	471.54	416.07	356.64	301.17
two children	550.80	495.33	426.37	370.91
three children	630.05	574.59	496.10	440.64
four children	709.31	653.85	565.06	509.60
Single person	293.24	237.78	197.35	141.88
Single parent with				
one child	376.47	320.95	271.05	215.58
two children	455.67	400.21	340.78	285.31
three children	534.93	479.47	410.51	355.04
four children	614.19	558.73	480.24	424.77

Note:
(a) All figures refer to income after tax.

Source: After Melbourne Institute of Applied Economic and Social Research 2001, p. 1

Appendix C: Compulsory schooling in Australia

Schooling is compulsory from the age of six to 15 years in all states and territories except Tasmania, where compulsion extends to 16. In most states, however, children start primary school at the age of five, when they enrol in a preparatory or kindergarten year, after which primary education continues for either six or seven years, depending on the state or territory.

<table>
<tr><th>Level</th><th>NSW, Vic., Tas., ACT</th><th>NT, SA</th><th>Qld., WA</th></tr>
<tr><td>Year 12
Year 11
Year 10
Year 9
Year 8</td><td rowspan="2">seconday</td><td rowspan="2">secondary</td><td rowspan="2">seconday</td></tr>
<tr><td>Year 7</td></tr>
<tr><td>Year 6
Year 5
Year 4
Year 3
Year 2
Year 1</td><td rowspan="2">primary</td><td rowspan="2">primary</td><td rowspan="2">primary</td></tr>
<tr><td>Pre-Year 1</td></tr>
<tr><td></td><td>(a)</td><td>(b)</td><td></td></tr>
</table>

Notes:
(a) Pre–year 1 is known as Kindergarten in NSW and ACT and Preparatory in Vic. and Tas.
(b) Pre–year 1 is known as Reception in SA and Transition in NT.

Figure C: The structure of primary and secondary schooling in Australia

Source: MCEETYA 1997, p. 4

Appendix D: Additional statistics on Indigenous education

Table D1: Comparative retention rates to school years 10, 11 and 12 for Indigenous students and all Australian students, 1989 to 1998 (a)

	School year 10 (c)		School year 11 (d)		School year 12 (e)	
Year	Indigenous students (b) (%)	All Australian students (%)	Indigenous students (b) (%)	All Australian students (%)	Indigenous students (b) (%)	All Australian students (%)
1989	70.1	97.1	33.9	77.2	14.4	60.3
1990	71.7	98.2	36.8	80.5	17.6	64.0
1991	78.7	98.8	41.6	86.0	21.8	71.3
1992	83.0	99.1	45.5	87.8	24.9	77.1
1993	78.5	98.3	52.0	87.4	25.2	76.6
1994	78.6	97.0	47.5	85.3	32.5	74.6
1995	76.5	96.4	48.7	83.3	30.6	72.2
1996	75.8	96.7	47.2	83.4	29.2	71.3
1997	80.6	97.6	49.6	85.3	30.9	72.8
1998	83.1	97.5	52.3	85.4	32.1	72.7

Notes:
(a) Retention is defined as the number of students who re–enrol at an institution at a given year, as a proportion of the students who were enrolled in the previous year.
(b) States and territories started collecting data on Indigenous students in different years. See below.
(c) 1989 to 1990 – 6 states; 1991 – 7 states; and from 1992 – 8 states.
(d) 1989 to 1991 – 6 states; 1992 – 7 states; and from 1992 – 8 states.
(e) 1989 – 3 states; 1990 to 1992 – 6 states; 1993 – 7 states; and from 1994 – 8 states.

Sources: After MCEETYA 1997, p. 72; MCEETYA 1998, p. 80

Table D2: Educational attainment of Indigenous people, 1994 (a)

Highest level of education attained	Indigenous men (%)	Indigenous women (%)	All Indigenous people (%)
Have a post–school qualification	**18.3**	**15.6**	**16.9**
Bachelor degree or higher	0.8	1.7	1.3
Diploma (b)	1.7	2.8	2.2
Skilled vocational qualification	7.3	0.9	4.1
Basic vocational qualification	3.2	5.8	4.5
Inadequately described	5.2	4.4	4.8
Do not have a post–school qualification	**81.7**	**84.4**	**83.1**
Year 12	6.0	7.2	6.6
Below year 12	70.9	71.8	71.4
Never attended school	4.7	5.4	5.0
Total	**100.0**	**100.0**	**100.0**

Notes:
(a) Data from the 1994 NATSIS.
(b) Includes undergraduate and associate diploma.

Source: After McLennan 1996a, p. 75

Table D3: Australian student enrolments in higher education, 1989 to 1998

Year	Indigenous students (No.)	Non-Indigenous students (No.)	Indigenous students as a proportion of all students (%)
1989	3,307	437,769	0.80
1990	3.607	481,466	0.79
1991	4,807	529,731	0.96
1992	5,105	554,260	0.98
1993	5,578	570,039	1.05
1994	6,264	579,132	1.07
1995	6,805	597,372	1.12
1996	6,956	627,138	1.10
1997	7,461	651,388	1.15
1998	7,789	664,064	1.17

Sources: After DETYA 1999c, pp. 2–4, Schwab 1996, p. 4

Table D4: Comparison of award course completions for Indigenous and all Australian students, 1989 to 1999

Year	Indigenous (No.)	All Australian completions (a) (No.)	Indigenous completions as proportion of all Australian completions (%)
1989	549	86,908	0.63
1990	483	88,879	0.54
1991	606	100,151	0.60
1992	646	111,428	0.58
1993	682	121,796	0.56
1994	800	125,481	0.64
1995	863	127,256	0.68
1996	949	128,088	0.74
1997 (b)	1,070	134,160	0.80
1998 (b)	1,142	136,423	0.84
1999 (b)	1,029	136,160	0.76

Notes:

(a) Overseas completions in Australia excluded.

(b) Data from 1997 onwards were compiled in a different way to data for prior years to take into account the coding of combined courses to two fields of study. As a consequence, the total for some broad fields of study show larger increases than would be the case if data for only one field were to be counted.

Counting both fields of study for combined courses means that the totals for each year may be less than the sum of all broad fields of study.

Sources: After DEETYA 1996, pp. 77, 100, 116; DETYA 2000e, p. 36

Appendix E: Timeline of native title land rights legislation

The acknowledgement of native title was precluded by the application of terra nullius. In the following, the most important developments in legislation referring to native title are outlined.

1972 *Gove land rights case*
The federal court found in the first native title case that traditional land rights were not recognised by Australian courts (Northern Land Council 1995, p. 5).

1976 *Northern Territory Aboriginal Land Rights Act*
This act was the Commonwealth's first land rights legislation. It returned approximately 30 per cent of land in the Northern Territory to its traditional owners (Pollard 1988, p. 107).

1992 *Mabo judgement*
The Mabo case was the second native title case in Australia. The High Court of Australia stated that at the time of occupation Australia was not terra nullius and rejected the application of this doctrine and its consequences for native title.

1993 *Native Title Act*
The Native Title Act recognises and protects native title, and gives Indigenous land rights, as stated in the Mabo case (ATSIC 1995, p. 24). However, it also stated certain limitations to native title land rights. Indigenous people cannot claim land over which a freehold or leasehold interest has been granted. To be successful, the native title claimants must have continuously maintained their traditional association with the land claimed.
A national native title tribunal was established to help mediate claims, as well as an Indigenous Land Fund to assist those whose native title had already been extinguished. The Native Title Act set in place procedures to protect native title by requiring that native title holders be consulted in advance if governments plan to grant certain interests in their land to mining companies or other parties. This is called the "Right to Negotiate."

1996 *Wik Case*
The High Court found that pastoral leases and native title could co–exist. Pastoral leases did not give exclusive possession to the pastoralists. Therefore, the grant of a pastoral lease did not necessarily extinguish all native title rights. However, should there be a conflict, native title rights are subordinate to those of the pastoral leaseholder.

1998 *Native Title Amendment Act*
The overall effects of the amendments diminish the ability of native title holders to have a meaningful say in respect of developments on native title land which may impair or extinguish their native title rights.
The Native Title Amendment Act replaces the Right to Negotiate with schemes of lesser notification and consultation rights for native title holders on pastoral leases and reserved lands such as national parks.

Appendix F: Timeline of Commonwealth governments since 1972

	Government	Prime Minister
1972–1975	Labor	Edward Whitlam
1975–1983	Liberal–National Coalition	John Fraser
1983–1996	Labor	Robert Hawke (1983–1991) Paul Keating (1991–1996)
1996 – present	Liberal–National Coalition	John Howard

Sources: Liberal Party of Australia 2001b, p. 1; Parliament of Australia 2002, p. 1

Appendix G: Name changes of relevant Commonwealth departments

Commonwealth Department of Health and Ageing

Until 1987	*Department of Health*
July 1987	*Department of Community Services and Health* Through merge with Department of Community Services.
June 1991	*Department of Health, Housing and Community Services* Transfer of housing industry programmes from the Department of Industry, Technology and Commerce to the Department of Health, Housing and Community Services.
March 1993	*Department of Health, Housing, Local Government and Community Services* Joined with the Department of Local Government.
March 1994	*Department of Human Services and Health* Only change of name. The department assumes control of the health portfolio for Indigenous people (formerly under ATSIC) in 1995.
March 1996	*Department of Health and Family Services* Only change of name.
October 1998	*Department of Health and Aged Care* Responsibility for family and children's services and housing were transferred to the Department of Family and Community Services.
November 2001	*Department of Health and Ageing* Only name change.

Commonwealth Department of Education, Science and Training

March 1983	*Department of Education and Youth Affairs* The Department of Education and Youth Affairs is established. The responsibility for youth affairs is moved to the Department of the Prime Minister and Cabinet in December 1984.
July 1987	*Department of Employment, Education and Training* The Department of Employment, Education and Training is established (DEET). The responsibility for employment is transferred from the former Department of Employment and Industrial Relations.
March 1996	*Department of Employment, Education, Training and Youth Affairs* The department is renamed the Department of Employment, Education, Training and Youth Affairs (DEETYA) after the federal election.

October 1998	*Department of Education, Training and Youth Affairs* Employment responsibilities are transferred out of the department, which becomes the Department of Education, Training and Youth Affairs (DETYA).
November 2001	*Department of Education, Science and Training* The youth affairs component is transferred to the Department of Family and Community Services, and the science portfolio becomes part of the department now called the Department of Education, Science and Training (DEST).

Commonwealth Department of Family and Community Services

October 1981	*Department of Social Security*
October 1998	*Department of Family and Community Services* FaCS assumes responsibility for family and children's services from the Department of Health and Family Services. All social security payments and services are now administered by Centrelink.
November 2001	The department assumes responsibility for youth affairs from the Department of Science, Education and Training.

Commonwealth Department of Employment and Workplace Relations

May 1982	*Department of Employment and Industrial Relations*
July 1987	*Department of Industrial Relations* The responsibility for employment is moved to the new Department of Employment, Education and Training.
July 1997	*Department of Workplace Relations and Small Business*
October 1998	*Department of Employment, Workplace Relations and Small Business* The department assumes responsibility for employment from DEETYA.
November 2001	*Department of Employment and Workplace Relations*

Sources: DETYA 2001, pp. 84–86, pp. 116–119; DEWRSB 2001b, pp. 2–4; DHAC 2001c, p. 2

Appendix H: Main characteristics of the Australian health care system

Improving health service delivery is one component of raising the health status of Australia's Indigenous people. To comprehend health policy options and directions, a basic knowledge of the Australian health care system is essential. The Australian health care system is characterised by a mix of public and private health service delivery and funding, and the separation of policy making and service delivery between different government levels.

Mix of public and private health service delivery

Private health care and public health care are supplemented by state health departments, which provide community and public health services, such as health promotion activities, school health and disease control through vaccination (Saggers & Gray 1991, p. 129).

The private health sector offers health services that range from services through private hospitals, GPs, paramedical professionals, pharmacies, and private health insurance (ABS 2000g, p. 1). Salaried medical officers and public hospitals form the public health sector.

Mix of public and private health care funding

The Australian health care system is financed by a mixture of public and private funding (DHAC 2000a, p. 2). Generally, public health services are funded through government funds, while private health services are financed through a mixture of public and private funds. To fund health services, the Commonwealth collects income tax and a health levy.

There are five main points of the Commonwealth health funding (ABS 2000d, pp. 1–3; ABS 2000f, p. 1):

- Health Care Agreement Grants of the Commonwealth and state and territory governments are responsible for the funding of public hospitals and further services.
- Medical benefits to patients under Medicare.
- Pharmaceutical benefits under PBS.
- Health Programme Grants to private and public health services providers; and

- Reimbursement of 30 per cent of the premiums for private health insurance to individuals.

Overall, public funding delivers around two thirds and private funding around one third of all health expenditure. From 1997 to 1998, public expenditures accounted for 68.6 per cent, of which 45.2 per cent was Commonwealth and 23.4 per cent was state, territory and local expenditures. The private sector accounted for 31.4 per cent of total health expenditure (AIHW 2000, p. 235). The governments' share of total health expenditure has been decreasing slightly over the last two decades, with the private sector's share increasing accordingly. The decrease in government expenditure is partly due to the decrease of Commonwealth hospital benefits in 1987 from 85 per cent to 75 per cent through Medicare and a decrease in the Commonwealth subsidisation of medicines (AIHW 1996a, p. 23).

Separation of policy making and service delivery between different government levels

There are three levels of government in Australia: the Commonwealth (also Federal or National), the state, territory and the local governments.[1]

The Commonwealth holds the policy leadership role. It regulates health services and is responsible for the funding of all health services except for hospital services, which are jointly funded with the states and territories (ABS 2000d, p. 1; DHAC 1999a, p. 3; DHAC 1999b, p. 4). MBS and PBS are under the administration of the Commonwealth (Palmer & Short 2000, p. 10). The Commonwealth has only a small role in direct service delivery, which is the main responsibility of the states and territories (Davis & George 1988, p. 106; DHAC 1999a, p. 3; Saggers & Gray 1991, p. 127). However, the Commonwealth has a specific responsibility for the provision of services to Indigenous people.

States and territories are responsible for environmental health, such as safe drinking water, air pollution and sewerage, and the delivery of hospital services (DFAT 1997, p. 1; Palmer & Short 2000, p. 12).

[1] Note: Australia consists of six states (New South Wales, Western Australia, South Australia, Queensland, Tasmania and Victoria) and two territories (Northern Territory and the Australian Capital Territory). Additionally, there are regional and local governments, about 800 throughout Australia (Palmer & Short 2000, p. 9).

Appendix I: Private health insurance

All Australians can take out a private health insurance to cover charges in private hospitals, for private status in public hospitals, ancillary health treatment, dental and or physiotherapy treatment (ABS 2000i, p. 1; AIHW 1996a, p. 13). Private health insurance can also cover the potential gap between the MBS reimbursement and the actual fee of visiting a GP. In 2000, 44 profit and non–profit organisations offered private health insurance.

Since the introduction of Medicare in 1984, the overall participation rate in private health insurance has declined significantly from about 50 per cent in 1984 to around 31 per cent in 1999. Since then, there has been a slight increase up to 33 per cent in March 2000. A smaller percentage of Indigenous Australians have private health insurance, compared to non–Indigenous Australians. The 1995 NHS found that only 0.3 per cent of Australians holding private health insurance were Indigenous (AIHW 2001, p. 36). That translates into 4 per cent of Indigenous people having private health insurance (AIHW 2001, p. 74).

The levels of the payable premiums of private health insurers underlie the principle of community rating (ABS 2000i, p. 2). This means that private health insurers cannot set premiums on the basis of the health risk of an individual person. The principle of community rating is supported by a system of reinsurance. Funds are transferred from insurance firms with low proportions of aged and chronically ill customers to insurance firms with high proportions thereof (ABS 2000i, p. 2). Community rating ensures that private health insurance is available to a wide range of people in the community. The only limitation to community rating is the Lifetime Health Cover, which was introduced in 2000 and which sets premiums according to age at the point of entry (DHAC 2000c, p. 1).

To encourage people to purchase private health insurance, the Commonwealth introduced a series of measures. In the late 1980s, a front–end deductible insurance was introduced to insure against hospital costs above a certain threshold. Exclusionary and non–exclusionary tables that included or excluded certain costs and services were created in 1995 in order to enable clients to insure according to their personal needs and preferences. In 1999, the Private Health Insurance Incentives Scheme was initiated. Private insurance holders now get a reimbursement of 30 per cent of the premium costs through the Commonwealth (AIHW 2000a, p. 251).

Appendix J: PBS patient co–payments and safety thresholds

Table J: PBS patient co–payments and safety net thresholds, May 2002 and announced changes

	01/05/2002	01/08/2002 (c)	01/01/2003 (c)	01/01/2004 (c)
Concessional patients				
Co–payment ($) (a)	3.60	4.60	4.60	Indexed by CPI (d)
Safety net ($) (b)	187.20	187.20	239.20	Indexed by CPI (d)
General patients				
Co–payment ($) (a)	22.40	28.60	28.60	Indexed by CPI (d)
Safety net ($) (b)	686.40	686.40	874.90	Indexed by CPI (d)

Notes:
(a) Co–payment per prescription.
(b) Limit a patient's expenditure on PBS medicines. After reaching the annual threshold, general patients pay for further PBS prescriptions at the concessional rate for the rest of the calendar year and concessional patients are supplied free.
(c) Changes as announced in the budget for 2002–2003 in May 2002.
(d) CPI = Consumer Price Index.

Source: After DHAC 2002c, p. 2

Appendix K: Payment rates of selected social security payments

Table K1: Rent Assistance payment rates, July 2002

Status	Maximum rate of RA ($ per fortnight)	Rent threshold ($ per fortnight)	Rent at which max. rate of RA is payable ($ per fortnight)
Single			
Single, no children	90.60	80.40	201.20
Single, no children, sharer	60.40	80.40	160.93
Single, 1 or 2 children	106.26	105.84	247.52
Single, 3 or more children	120.12	105.84	266.00
Couple			
Couple, no children	85.40	131.00	244.87
Couple, 1 or 2 children	106.26	156.66	298.34
Couple, 3 or more children	120.12	156.66	316.82
Partnered, illness separated, no children	90.60	80.40	201.20
Partnered, temporarily seperated, no children	85.40	80.40	194.27

Source: FaCS 2002, p. 3

Table K2: Newstart Allowance payment rates, July 2002

Status	Newstart Allowance rate ($ per fortnight)
Single	
aged 21 or over, no children	369.00
aged 21 or over, with children	399.00
aged 60 or over, after nine months	399.00
Couple (each)	332.80

Source: Centrelink 2002g, p. 1

Table K3: Youth Allowance payment rates, July 2002

Status	Youth Allowance rate ($ per fortnight)
Single, no children:	
Under 18, at home	165.10
Under 18, away from home	301.70
18 and over, away from home	301.70
18 and over, at home	198.60
Single, with children	395.30
Partnered, no children	301.70
Partnered with children	331.30
Special rate for long–term unemployed or migrant English students 21 years or over commencing full–time study:	
Single, living at home	243.90
Single, living away from home	366.40
Partnered, no children	331.30

Source: Centrelink 2002f, p. 1

Table K4: Austudy payment rates, July 2002

Status	Austudy payment rate ($ per fortnight)
Single	301.70
Single, with children	395.30
Partnered, no children	301.70
Partnered, with children	331.30
Special rate for long–term unemployed commencing full–time study:	
Single	366.40
Partnered, no children	331.30

Source: Centrelink 2002e, p. 1

Table K5: ABSTUDY payment rates, July 2002

Status	ABSTUDY payment rate ($ per fortnight)
Students – standard	
Under 16 years tertiary	22.80
17 years and under 16 in State Care and Foster Care Allowance paid	165.10
18–20 years in State Care and Foster Care Allowance paid	198.60
20 years and under in State Care and no Foster Care Allowance paid	301.70
16–20 years in State Care and no Foster Care Allowance paid	301.70
16–17 years	165.10
18–20 years	198.60
21 years and over	369.00
Students – away from home	
Under 16 years	165.10
16–20 years	301.70
21 years and over	369.00
Independent students – single, no children	
20 years and under	301.70
17 years and under at home	165.10
18–20 years at home	198.60
21 years and over	369.00
Single, aged 60 or over	399.00
Independent student – partnered, no children	
under 16 years	301.70
16–20 years	301.70
21 years and over	332.80
Independent student – single with dependent child	
under 16 years	395.30
16–20 years	395.30
21 years and over	399.00
Independent student – partnered with dependent child	
under 16 years	331.30
16–20 years	331.30
21 years and over	332.80
Masters and Doctorate students	675.40

Source: Centrelink 2002d, p. 1

Appendix L: The 21 goals of the National Aboriginal and Torres Strait Islander Education Policy

Involvement of Aboriginal people in educational decision making

Goal 1 To establish effective arrangements for the participation of Aboriginal parents and community members in decisions regarding the planning, delivery and evaluation of pre–school, primary and secondary education services for their children.

Goal 2 To increase the number of Aboriginal people employed as educational administrators, teachers, curriculum advisers, teachers' assistants, home–school liaison officers and other education workers, including community people engaged in teaching of Aboriginal culture, history and contemporary society, and Aboriginal languages.

Goal 3 To establish effective arrangements for the participation of Aboriginal students and community members in decisions regarding the planning, delivery and evaluation of post school education services, including technical and further education colleges and higher education institutions.

Goal 4 To increase the number of Aboriginal people employed as administrators, teachers, researchers and student services officers in technical and further education colleges and higher education institutions.

Goal 5 To provide education and training services to develop the skills of Aboriginal people to participate in educational decision making.

Goal 6 To develop arrangements for the provision of independent advice for Aboriginal communities regarding educational decisions at regional, state, territory and national levels.

Equality of access to educational services

Goal 7 To ensure that Aboriginal children of pre–primary school age have access to pre–school services on a basis comparable to that available to other Australian children of the same age.

Goal 8 To ensure that all Aboriginal children have local access to primary and secondary schooling.

Goal 9 To ensure equitable access for Aboriginal people to post–compulsory secondary schooling, to technical and further education, and higher education.

Equity of educational participation

Goal 10 To achieve the participation of Aboriginal children in pre–school education for a period similar to that for all Australian children.

Goal 11 To achieve the participation of all Aboriginal children in compulsory schooling.

Goal 12 To achieve the participation of Aboriginal people in post–compulsory secondary education, in technical and further education, and in higher education, at rates commensurate with those of all Australians in those sectors.

Equitable and appropriate educational outcomes

Goal 13 To provide adequate preparation of Aboriginal children through pre–school education for the schooling years ahead.

Goal 14 To enable Aboriginal attainment of skills to the same standard as other Australian students throughout the compulsory schooling years.

Goal 15 To enable Aboriginal students to attain the successful completion of school year 12 or equivalent at the same rates as for other Australian students.

Goal 16 To enable Aboriginal students to attain the same graduation rates from award courses in technical and further education, and in higher education, as for other Australians.

Goal 17 To develop programmes to support the maintenance and continued use of Aboriginal languages.

Goal 18 To provide community education services which enable Aboriginal people to develop the skills to manage the development of their communities.

Goal 19 To enable the attainment of proficiency in English language and numeracy competencies by Aboriginal adults with limited or no educational experience.

Goal 20 To enable Aboriginal students at all levels of education to have an appreciation of their history, cultures and identity.

Goal 21 To provide all Australian students with an understanding of and respect for Aboriginal traditional and contemporary cultures.

Source: DEST 2002d, pp. 1–2

Appendix M: ABSTUDY changes, 2000

Table M: ABSTUDY changes, 2000

Living allowances for	Benefit at or below income test threshold ($ per fortnight)	Affected beneficiaries (No.)	Income test effect above threshold income
Secondary school students			
Under 16 and living away from home	No change	Not estimated	Now income tested on both student income and parental income under Youth Allowance
Tertiary students			
20 years and under – standard or away from home or independent with partner & child	No change	Not estimated	More regressive income test applied with benefit ineligibility reached at a lower income level
20 years and under – independent single	25.65 higher	730	As above
20 years and under – independent with partner or independent single with child	5.00 higher	165	As above
21 years & over – standard	43.32 higher	165	As above
21 years & over – away from home, independent single	65.00 lower	6,110	As above
21 years & over – independent with partner	97.00 lower	955	As above
21 years & over – independent single with child	59.00 lower	550	As above
21 years & over – independent with partner & child	66.00 lower	2,335	As above
Masters & Doctorate	No change	Not estimated	No change

Source: After ATSIC 1999a, p. 22

Appendix N: Commonwealth funding of Indigenous–specific programmes

Table N1: Commonwealth funding of Indigenous–specific programmes, 1993–1994 to 1997–1998 (a) (b) (c)

Portfolio	1993–1994 ($million)	1994–1995 ($million)	1995–1996 ($million)	1996–1997 ($million)	1997–1998 ($million)
Immigration and Multicultural and Indigenous Affairs					
ATSIC	888.1	941.5	971.9	940.2	1,001.9
CDC/IBA	10.0	0.0	0.0	0.0	0.0
Aboriginal Hostels Limited	35.8	29.1	28.9	28.0	28.4
Others	32.6	56.6	101.6	81.7	88.8
Portfolio total	**966.5**	**1,027.2**	**1,102.4**	**1,050**	**1,119.1**
Employment, Education and Training	**279.4**	**291.9**	**335.1**	**355.9**	**416.3**
Housing	**93.7**	**91.0**	(f)	-	-
Health	(d)	(d)	**136.6**	**144.1**	**161.2**
Social Security	(e)	(e)	**102.1**	**102.5**	**102.7**
Other portfolios	**22.2**	**63.1**	**46.0**	**48.4**	**53.1**
Total Indigenous–specific funding					
Current prices	**1,361.8**	**1,473.2**	**1,722.2**	**1,700.7**	**1,852.5**
Average 1999-2000 prices	**1,488.3**	**1,584.1**	**1,807.1**	**1,756.9**	**1,890.3**

Notes:
(a) As the names of the Commonwealth portfolios have changed over the time, only general descriptors of portfolios are used.
(b) Financial years 1993–1994 to 1996–1997 are actual expenditure.
(c) Financial year 1997–1998 are revised estimates.
(d) Indigenous–specific health programmes administered by ATSIC until 1995.
(e) Not specified.
(f) Function absorbed by Social Security Portfolio.

Sources: After Minister for Aboriginal and Torres Strait Islander Affairs 1999, pp. 11–17; Minister for Aboriginal and Torres Strait Islander Affairs 1998, pp. 23–29;

Table N2: Commonwealth funding of Indigenous–specific programmes, 1998–1999 to 2002–2003 (a) (b) (c)

Portfolio	1998–1999 ($million)	1999–2000 ($million)	2000–2001 ($million)	2001–2002 ($million)	2002–2003 ($million)
Immigration and Multicultural and Indigenous Affairs					
ATSIC	985.0	1,068.1	1,105.8	1,134.3	1,163.9
CDC/IBA	5.4	5.2	6.1	9.8	7.7
Aboriginal Hostels Ltd.	38.6	43.3	43.0	44.5	44.5
Other	71.4	112.2	122.9	131.7	133.4
Portfolio total	**1,100.4**	**1,229.0**	**1,277.8**	**1,320.4**	**1,349.5**
Education, Training and Youth Affairs	**418.2**	**434.8**	**443.0**	**438.5**	**445.1**
Employment and Workplace Relations	**55.4**	**54.5**	**67.1**	**66.8**	**67.2**
Health	**188.0**	**226.6**	**238.2**	**267.6**	**302.7**
Social security	**128.7**	**155.3**	**171.6**	**194.3**	**209.5**
Other portfolios	**106.4**	**117.7**	**125.9**	**109.1**	**126.5**
Total Indigenous–specific funding					
Current prices	**1,997.1**	**2,217.9**	**2,323.6**	**2,396.7**	**2,500.5**
Average 1999-2000 prices	**2,042.0**	**2,171.8**	**2,215.1**	**2,233.7**	-

Notes:
(a) As the names of the Commonwealth portfolios have changed over the time, only general descriptors of portfolios are used.
(b) Revised estimates.
(c) Budget estimates.

Sources: After Minister for Aboriginal and Torres Strait Islander Affairs 1998, pp. 23–29; Minister for Aboriginal and Torres Strait Islander Affairs 1999, pp. 11–17; Minister for Aboriginal and Torres Strait Islander Affairs 2000, pp.19–22; Minister for Immigration and Multicultural and Indigenous Affairs 2002, pp. 33–42; Minister for Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, pp. 28–33

Table N3: Proportional distribution of Commonwealth funding for Indigenous–specific services among portfolios, 1993–1994 to 2002–2003 (a) (b) (c)

Portfolio	1993–1994 (%)	1994–1995 (%)	1995–1996 (%)	1996–1997 (%)	1997–1998 (%)
Immigration and Multicultural and Indigenous Affairs	71.0	69.7	64.0	61.7	60.4
Employment, Education, Training and Youth	20.5	19.8	19.5	20.9	22.5
Housing	6.9	6.2	(d)		
Health	(e)	(e)	8.0	8.5	8.7
Social Security	(f)	(f)	5.7	6.0	5.6
Other	1.6	4.3	2.8	2.9	2.8
Total	100.0	100.0	100.0	100.0	100.0

Portfolio	1998–1999 (%)	1999–2000 (%)	2000–2001 (%)	2001–2002 (%)	2002–2003 (%)
Immigration and Multicultural and Indigenous Affairs	55.1	55.4	55.0	55.1	54.0
Education, Training and Youth (g)	20.9	19.6	19.1	18.3	17.8
Employment and Workplace Relations (g)	2.8	2.4	2.9	2.8	2.7
Health	9.4	10.2	10.2	11.2	12.1
Social security	6.5	7.0	7.4	8.1	8.4
Other	5.3	5.4	5.4	4.5	5.0
Total	100.0	100.0	100.0	100.0	100.0

Notes:
(a) As the names of the Commonwealth portfolios have changed over the time, only general descriptors of portfolios are used.
(b) Financial years 1993–1994 to 1996–1997 based on actual expenditure.
(c) Financial years 1997–1998 to 2001–2002 based on revised estimates.
(d) Function absorbed by Social Security portfolio.
(e) Indigenous–specific health programmes administered by ATSIC.
(f) Not separately specified.
(g) The Employment, Education, Training and Youth portfolio was divided into two separate portfolios.

Sources: After Minister for Aboriginal and Torres Strait Islander Affairs 1998, pp. 23–29; Minister for Aboriginal and Torres Strait Islander Affairs 1999, pp. 11–17; Minister for Aboriginal and Torres Strait Islander Affairs 2000, pp.19–22; Minister for Immigration and Multicultural and Indigenous Affairs 2002, pp. 33–42; Minister for Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, pp. 28–33

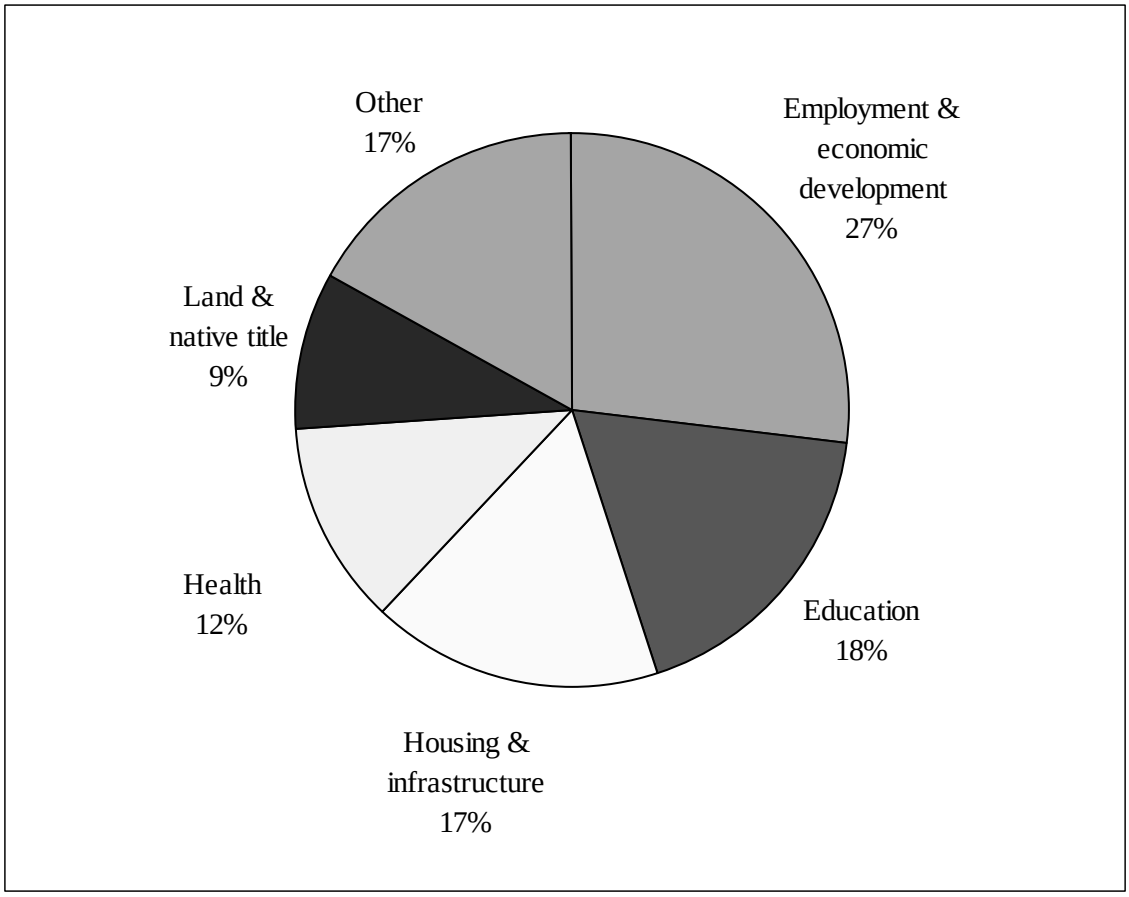

Figure N: Functional dissection of the 2002–2003 budget for Indigenous affairs (total $2.5 billion)

Source: After Minister for Immigration and Multicultural and Indigenous Affairs 2002, p. 33

Appendix O: Interim National Performance Indicators for Indigenous Health

1 Life expectancy and mortality

1.1 Life expectancy at birth by sex
1.2 Age–standardised all–causes mortality rates by sex
1.3 Age–specific all–causes mortality rates by sex
1.4 Age–standardised all–causes mortality rate ratio by sex
1.5 All–causes age–specific rate ratio by sex
1.6 The chance of dying between 20 and 54 years by sex
1.7 Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1,000 total births to Aboriginal and Torres Strait Islander mothers
1.8 Death rate of Aboriginal and Torres Strait Islanders from birth to one year of age
1.9 Age–standardised mortality rates for ischaemic heart disease and rheumatic heart disease by sex for Aboriginal and Torres Strait Islanders and non–Aboriginal and Torres Strait Islanders
1.10 Age–standardised mortality rates for injury and poisoning by sex for Aboriginal and Torres Strait Islanders and non–Aboriginal and Torres Strait Islanders
1.11 Age–standardised mortality for pneumonia by sex for Aboriginal and Torres Strait Islanders and non–Aboriginal and Torres Strait Islanders
1.12 Age–standardised mortality rates from diabetes by sex for Aboriginal and Torres Strait Islanders and non–Aboriginal and Torres Strait Islanders
1.13 Age–standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non–Aboriginal and Torres Strait Islander women

2 Morbidity

2.1 Notification rates for selected vaccine preventable diseases: pertussis, measles, and hepatitis B
2.2 Percentage of Aboriginal and Torres Strait Islander children at school entry having >25dB hearing loss averaged over three frequencies
2.3 Proportion of Aboriginal and Torres Strait Islander new–borns with birth weight <2,500g, per 1000 live births
2.4 Age–standardised all–causes hospital separation rate ratio by sex
2.5 Age–standardised hospitalisation rate and ratio by sex for acute myocardial infarction
2.6 Age–standardised hospitalisation rate ratio by sex for injury and poisoning
2.7 Age–standardised hospitalisation rate ratio by sex for respiratory diseases
2.8 Age–standardised hospitalisation rate ratio by sex for diabetes
2.9 Age–standardised hospitalisation rate ratio by sex for tympanoplasty

3 Access

3.1 Availability of comprehensive health services
  3.1.1 Proportion of Aboriginal and Torres Strait Islander people whose ordinary residence is <30 minutes routine travel time from a full–time permanent primary care service by usual means of transport

3.1.2 Proportion of Aboriginal and Torres Strait peoples whose ordinary residence is <one hour's routine travel time from a hospital that provides acute inpatient care with the continuous availability of medical supervision Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander people compared with expenditure for the total population

3.1.3 Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander people compared with non–Aboriginal and Torres Strait Islander people

3.2 Development of community control and capacity

3.2.1 Proportion of primary care services, and the resources allocated to these services

3.2.2 Health services should be classified into those services managed by:
a) incorporated Aboriginal health organisations
b) community councils
c) State/territory governments

3.2.3 Extent of community participation in health services
a) What number of local or regional health/hospital boards have Aboriginal and Torres Strait Islander members?
b) Is this membership mandated by terms of reference?

3.3 Small communities and outstations

3.3.1 Proportion of communities, with usual populations of <100, within one hour's usual travel time to primary health care services

3.3.2 Per capita recurrent expenditure by governments on health care services to communities with populations <100, as compared with expenditure for the general population

4 Health service impacts

4.1 The expenditure on, and description of, health promotion programmes specifically targeting Aboriginal and Torres Strait Islander people

4.2 Number of pap smears among Aboriginal and Torres Strait Islander females aged 18–70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group

4.3 Proportion of Aboriginal and Torres Strait Islander children aged two years and six years old that are fully immunised as recorded in the National Childhood Immunisation Register

4.4 The proportion of Aboriginal and Torres Strait Islander people aged >50 years who have received pneumococcal vaccine in the last 6 years compared with the Aboriginal and Torres Strait Islander population in that age group

4.5 Proportion of children aged two and six years who are fully immunised against hepatitis B, as recorded in the National Childhood Immunisation Register

4.6 Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension

4.7 Age–standardised Aboriginal and Torres Strait Islander and non– Aboriginal and Torres Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders

4.8 Proportion of total consultations by condition and by care provider

5 Workforce development

5.1 Training

5.1.1 Number of Aboriginal and Torres Strait Islander people who have a) graduated in the previous year and b) are in training in key health related fields

5.1.2 Number and proportion of Aboriginal health workers who graduated in the previous year or are participating in accredited training

5.2 Employment

5.2.1 The proportion of vacant funded full time equivalent positions for doctors, nurses and Aboriginal health workers in a) Aboriginal health services and b) other organisations providing primary care for Aboriginal and Torres Strait Islander people on a given date

5.2.2 Number of vacant funded full time equivalent positions for doctors, nurses and Aboriginal health workers in hospitals where >25 per cent of separations are Aboriginal and Torres Strait Islander people on a given date

5.3 Cross cultural issues

5.3.1 Number of Aboriginal identified positions in health sector

5.3.2 Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander

5.3.3 Proportion of accredited hospitals for which the accreditation process required Aboriginal cross–cultural awareness programmes for staff to be in place

6 Risk factors

6.1 Proportion of Aboriginal and Torres Strait Islander people aged >13 years who currently smoke by age and sex

6.1 Proportion of Aboriginal and Torres Strait Islander people with a Body Mass Index >25, by sex and age

6.3 Proportion of Aboriginal and Torres Strait Islander people who reported usually consuming >4 drinks on the occasions when they drank alcohol in the last two weeks relative to the total numbers who reported on consumption

7 Intersectoral issues

7.1 The proportion of households where after–tax income available to the household after paying the mortgage or rent is less than the amount specified by the poverty line

7.2 Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives

8 Community involvement

8.1 Establishment of a forum representing the Aboriginal health sector, ATSIC and state jurisdiction in each state and territory

8.2 Do forums exist? If yes, what is its membership? Frequency and method of operation of meetings? Description of important outcomes? Brief description of the effectiveness and value of the meetings independently drafted by each member

8.3 Cooperative community planning with the implementation of the regional planning processes

9 Quality of service provision

9.1 Critical incidence reporting and complaints mechanisms at all levels of health services

Source: AHMAC 1998, pp. 4–59

Appendix P: National Performance Indicators for Indigenous Health, from 2001

Indicators primarily related to government inputs

1 Efforts to improve identification of Aboriginal and Torres Strait Islander people in data collections
2 Government expenditure on health services for Aboriginal and Torres Strait Islander people
3 Government expenditure on health services for Aboriginal and Torres Strait Islander people living in small homeland communities and outstations
4 Government expenditure on and description of selected health promotion programmes

Indicators primarily related to social equity

5 Life expectancy at birth
6 Infant mortality rate
7 Income poverty
8 Completed secondary school education
9 Employment status
10 Housing with utilities
11 People in prison custody
12 The development of governance capacity in health
13 Aboriginal and Torres Strait Islander representation on health/hospital boards
14 Reporting of complaints in hospitals
14.1 Reporting of complaints and critical incidents in hospitals (to replace 14 when available)

Indicators primarily related to access to health services

15 Aboriginal and Torres Strait Islander Community–Controlled Health Services
16 Distance to a primary health care centre
17 Distance to a hospital
18 Access to primary health care services – small homeland communities and outstations
19 Management of key conditions
20 Aboriginal and Torres Strait Islanders in the health workforce
21 Higher education and training in key health professions
23 Workforce availability in hospitals that provide services to Aboriginal and Torres Strait Islander people
24 Cross–cultural training for hospital staff

Indicators primarily related to risk markers

25 Pap smear screening
26 Childhood immunisation rates
27 Coverage of adult pneumococcal vaccine
28 Low birth weight infants
29 Smoking prevalence
30 Alcohol consumption
31 Overweight and obesity
32 Substantiated notifications of child abuse and neglect
33 Problem gambling
36 Community grief
35 Injuries presenting to hospital accident and emergency facilities

Indicators primarily related to outcomes for people

36 Prevalence of anxiety and depression
37 Notification rates – selected vaccine preventable disease
38 Notification rates – meningococcal disease
39 Notification rates – sexually transmitted diseases
40 Ratios for all hospitalisations
40.1 Hospitalisation ratios by urgency of admission (to replace 40 when data available)
41 Hospitalisation ratios for circulatory diseases
42 Hospitalisation ratios for injury and poisoning
43 Hospitalisation ratios for respiratory diseases and lung cancer
44 Hospitalisation ratios for diabetes
45 Hospitalisation ratios for tympanoplasty associated with otitis media
46 Hospitalisations for mental health conditions
47 Children's hearing loss
48 Stillbirths to Aboriginal and Torres Strait Islander mothers
49 Early adult death
50 Age–specific all–cause death rates and ratios
51 Standardised mortality ratio for all causes
52 Standardised mortality ratios for circulatory diseases
53 Standardised mortality ratios for injury and poisoning, including suicide
54 Standardised mortality ratios for respiratory diseases and lung cancer
55 Standardised mortality ratios for diabetes
56 Standardised mortality ratios for cervical cancer

Source: OATSIH 2000a, pp. 10–11

Appendix Q: Service activity reporting by ACCHSs

1 Clients

- Total number of health care episodes provided by the services during the year
- Number of client contacts by type of worker
- Percentage of services provided to people who normally reside outside of the health service area
- Percentage of services provided to Torres Strait Islander clients, non–Indigenous clients and Aboriginal and Torres Strait Islander clients

2 Activities

- Type of activities undertaken by the services according to the following categories: Clinical health services
  Preventative care programmes
  Specialist and ancillary services on site
  Screening programmes
  Health related and community support programmes
  Emotional and social well–being
  Pharmaceutical
  Medical records
- Additional detail is collected on substance misuse and emotional and social well–being activities.

3 Links with other services

- Other services with whom the ACCHS has a good working relationship
- Links with the public health unit in the area

4 Operations of the governing committee or board

5 Service staffing

- Full time employed workers by type of worker
- Vacancies
- Staff training

6 Access and use of computers

7 Funding

- Total income received by the service
- Sources of funding
- Adequacy of funding and priorities for new funding

Source: DHAC, ATSIC, AHMRC of NSW & NSW Department of Health 2000, p. 76

Appendix R: ACCHS service activity reporting questionnaire, 2000 to 2001

1 Client contacts and population base

1.1 How many "episodes" of health care were provided by this health service during the period 1 July 2000 to 30 June 2001?

- *Aboriginal and Torres Strait Islander episodes of health care (male, female, total)*
- *Non–Indigenous episodes of health care (male, female, total)*
- *Total episodes of health care (male, female, total)*

1.2 Visitors/transients: What percentage of the episodes shown above were for people who normally live outside the health service area?

1.3 Torres Strait Islanders: Please estimate the percentage of episodes of health care provided for Torres Strait Islanders.

1.4 How many individual client contacts were made by each type of worker from your service during the period 1 July 2000 to 30 June 2001?

- Aboriginal and Torres Strait Islander Health Workers (AHW) (involving provision of health care)
- Doctors
- Nurses
- Dentists/dental therapists
- Dental support e.g. dental assistants, dental technicians
- Qualified counsellors/social workers/psychologists
- Substance misuse workers
- Medical specialists/other allied health professionals (please specify)
- Transport – AHW/field officer/driver contacts:
  – taking clients to see health professionals who do not work for this service
  – taking clients to see health professionals who do work for this service
- Traditional healers
- Contacts with other staff members (please specify)

1.5 How was the information for the two preceding questions?

- *Appointment book/client contact register*
- *Diary/field log book*
- *Computer records*
- *Estimates*
- *Other (please specify)*

1.6 Did any of the following affect the number of clients seen during the year?

- *Vacant staff positions/staff away for long periods*
- *Clinic closed for part of the year/service recently opened*
- *New programmes/services*
- *Moving clinic*
- *More/less visitors*
- *Other (please specify)*

1.7 What is the total Aboriginal and Torres Strait Islander resident population of your health service area?

1.8 What sources of data were used to answer the preceding question?

- *Medical records/patient files*
- *Local council population estimates*
- *ATSIC regional population estimates*
- *Australian Bureau of Statistics figures*
- *Estimates*
- *Land council*
- *Other (please specify)*

2 Governing committee or board

2.1 Did the governing committee or board for this service meet regularly during 2000/2001 as outlined in the constitution?

2.2 Were detailed income and expenditure statements presented to the committee or board on at least two occasions during 2000/2001?

2.3 Did this service have a strategic plan and/or business plan during 2000/2001?

2.4 Were all of the governing committee or board members Aboriginal or Torres Strait Islander people?

2.5 Did committee or board members receive training during 2000/2001?

2.6 Please comment on any area where support could be provided to the committee or board e.g. training, resources for manuals etc.

3 Indicators of an adequate skilled health workforce

3.1 How many "full time equivalent" positions did this service pay the wages/salaries/fees for, as at 30 June 2001 in the following categories?

- *Aboriginal and Torres Strait Islander Health Workers*
- *Doctors*
- *Nurses*
- *Dentists/dental therapists*
- *Dental support e.g. dental assistants, dental technicians*
- *Qualified counsellors/social workers/psychologists*
- *Substance misuse workers*
- *Environmental health workers*
- *CEOs/administrators/managers*
- *Traditional healers*
- *Medical Specialists/other allied health professionals (please specify)*
- *Drivers/field officers*
- *Trainers/educators*
- *Accountants/book–keepers*
- *Information systems/data staff*
- *Administrative support e.g. secretaries/receptionists*
- *Cleaners/cooks/gardeners*
- *Other staff (please specify)*

3.2 How many other people worked at this service during the period 1 July 2000 to 30 June 2001 who were not paid by this service? Show as full time equivalent positions.

3.3 As at 30 June 2001 did you have any vacant staff positions?

3.4 If Yes, what positions were vacant and how long have they been vacant? Please specify details of the number of full time equivalent positions for each category of worker.

3.5 How many staff attended training in the period 1 July 2000 to 30 June 2001? Specify type of staff and type of training.

3.6 How many staff attended formal training in counselling skills and mental health or alcohol and substance misuse counselling during the period 1 July 2000 to 30 June 2001?

3.7 Comment on staffing and training issues.

3.8 Please indicate which of the following health related activities were undertaken by this service during the period 1 July 2000 to 30 June 2001.

- *Health related and community support services*
- *Clinical health care provided by your services*
- *Traditional health care*
- *Preventative care programmes, pharmaceutical services*
- *Medical records and health information*
- *Screening programmes*
- *Other*

3.9 Contact between your service and nearby hospital(s)?

- *There is no regular liaison between our service and hospitals.*
- *Our service refers and/or admits patients to hospital(s).*
- *The hospital(s) regularly provides information to our service on the condition of the patient who has been admitted.*
- *The hospital(s) regularly provides information to a patient's family on the condition of the patient who has been admitted.*
- *Discharge planning for Aboriginal and Torres Strait Islander patients is well coordinated with our service (e.g. provision of medicines, arrangements for transport, liaison with GP and family).*
- *There are effective shared care arrangements for management of people with chronic conditions between our service and hospital(s).*
- *There are effective ante–natal shared care arrangements between our service and hospital(s).*
- *There are regular meetings between health staff and/or management of our service and the hospital(s) for planning and coordination.*
- *Our service works with Aboriginal Liaison Officer(s) at the hospital(s).*
- *Other (please specify).*

3.10 How far are the hospital(s) from your service?

- *Less than 10 kilometres*
- *11 to 24 kilometres*
- *25 to 49 kilometres*
- *50 to 99 kilometres*
- *100 to 249 kilometres*
- *250 kilometres and over*

3.11 Contact between your service and the local division of general practice?

- ❑ *GPs from our service are members of the local division of general practice.*
- ❑ *There is regular liaison between our service and the local division of general practice.*
- ❑ *Our local division of general practice is working collaboratively with us on immunisation programmes.*
- ❑ *Our local division of general practice is working collaboratively with us on diabetes programmes.*
- ❑ *Our local division of general practice is working collaboratively with us on new MBS items for primary care.*
- ❑ *Not applicable/no liaison with division of general practice.*
- ❑ *Other (please specify) / or any other comments.*

3.12 Contact between your service and local general practitioners?

- ❑ *There are no GP(s) working in the local area.*
- ❑ *No regular liaison with local GP(s).*
- ❑ *There is liaison with some local GP(s).*
- ❑ *There is liaison with all local GP(s).*

3.13 We are keen to promote the achievements of Aboriginal Community–Controlled Health Services – you may like to give us examples of achievements and success stories for your service which could be shared with the broader community and other services. Do you have a report or information in your records about this achievement? Please feel free to include any such reports.

4 Resource issues

4.1 Do you use any computers at this service?

4.2 If Yes, what are they used for?

4.3 What software packages do you use?

4.4 Comment on the adequacy of computers, software, printers, telephone lines/connections and computer training/support.

4.5 If you do not currently have a computer, please comment on your needs in this area.

4.6 What was this health service's income from all funding sources for the year 1 July 2000 to 30 June 2001? (optional question)

4.7 Indicate sources of funding (optional):

- ❑ *OATSIH*
- ❑ *State/territory Department of Health*
- ❑ *State/territory other departments*
- ❑ *Medicare*
- ❑ *CDEP*
- ❑ *ATSIC*
- ❑ *Other Commonwealth department*
- ❑ *Other*

4.8 Please comment on funding issues for your service e.g. clinic facilities, vehicles, other infrastructure needs. Indicate priorities against each issue.

5 Substance Use

5.1 Which substance use issues does your service deal with?

- ❑ *Alcohol*
- ❑ *Tobacco*
- ❑ *Cannabis*
- ❑ *Heroin*
- ❑ *Petrol/other inhalants*
- ❑ *Other legal drugs*
- ❑ *Others*

5.3 What substance use services are provided by your service?

- ❑ *Management of conditions related to substance abuse*
- ❑ *Management of hepatitis C*
- ❑ *Information/education about substance use*
- ❑ *School education and visits*
- ❑ *Community based education*
- ❑ *Support groups*
- ❑ *Individual/group counselling*
- ❑ *Telephone counselling*
- ❑ *Cultural activities*
- ❑ *Detoxification support and referral*
- ❑ *Others*

6 Emotional and Social Well–being

6.1 What mental health/emotional and social well–being activities does your service provide?

- ❑ *Short term counselling*
- ❑ *Dedicated emotional and social well–being counsellor(s) within your Service*
- ❑ *Visiting psychologist, psychiatrist and/or social worker provides care at this service*
- ❑ *This service regularly participates in case management with other agencies in the care of patients with mental illness.*
- ❑ *Clients with mental health problems are referred to this service from other services.*
- ❑ *Workers visit clients at home for emotional and social well–being*
- ❑ *Outreach services to public/private psychiatric institutions*
- ❑ *Mental health promotion activities (e.g., youth camps, drop–in centres)*
- ❑ *Others*

6.2 Which emotional and social well–being issues does your service deal with?

- ❑ *Grief and loss counselling*
- ❑ *Serious mental illness (e.g., schizophrenia, depression)*
- ❑ *Anxiety/stress*
- ❑ *Self harm/suicide prevention*
- ❑ *Stolen generation issues*
- ❑ *Family/relationship issues*
- ❑ *Family violence*
- ❑ *Others*

6.3 Please comment on the emotional and social well–being issues in your area, e.g. new issues and resource needs.

6.4 Identify the links your service has with other services in relation to emotional and social well–being issues.

- *Case conferencing*
- *Formal services agreements*
- *Traditional healers*
- *Visiting counsellor/nurse*
- *Others*

7 General comments

7.1 Please provide any other general comments.

Source: NACCHO & DHAC 2001d, pp. 4–23

Appendix S: National performance indicators for CHIP

Community housing component

Programme performance indicators

- Increase in the net number of houses that provide functional and healthy shelter for families (mandatory)
- Number of houses purchased or constructed (mandatory)
- Number of houses refurbished or extended (mandatory)
- Performance of housing service provider (mandatory)
- Number of training and employment opportunities for Indigenous people on construction and maintenance of housing

Project performance indicators

- Number of Indigenous people housed as a result of this project (mandatory)
- Number of houses owned or managed by grantee upon completion of this project (mandatory)
- Number of houses purchased or constructed as a result of this project (mandatory)
- Estimated average cost of each house planned to be purchased or constructed as a result of this project (mandatory)
- Number of vacant blocks purchased for future housing (mandatory)
- Number of houses refurbished or extended as a result of this project (mandatory)
- Estimated average cost of each house planned to be refurbished or extended as a result of this project (mandatory)
- Percentage of rent which has been collected as a percentage of the total rents charged (mandatory)
- Total rent collected (mandatory)
- Number of Indigenous men employed full–time as a result of this project
- Number of Indigenous men employed part–time as a result of this project
- Number of Indigenous women employed full–time as a result of this project
- Number of Indigenous women employed part–time as a result of this project
- Number of Indigenous men completing accredited training as a result of this project
- Number of Indigenous women completing accredited training as a result of this project

Community infrastructure component

Programme performance indicators

- Contribution to meeting the Indigenous infrastructure need (mandatory)
- Level of state, territory and local government funding and support for Indigenous housing and infrastructure
- Number of training and employment opportunities for Indigenous people on construction and maintenance of infrastructure

Project performance indicators

- Number of Indigenous people provided with infrastructure capital for water, sewerage, power, roads etc. as a result of this project (mandatory)

- Number of communities provided with infrastructure capital for water, sewerage, power, roads etc. as a result of this project (mandatory)
- Type of infrastructure provided (mandatory)
- Funding amount contributed by other agencies
- Other contributions by other agencies
- Number of Indigenous men employed full–time as a result of this project
- Number of Indigenous men employed part–time as a result of this project
- Number of Indigenous women employed full–time as a result of this project
- Number of Indigenous women employed part–time as a result of this project
- Number of Indigenous men completing accredited training as a result of this project
- Number of Indigenous women completing accredited training as a result of this project

Municipal services component

Programme performance indicators

- Number of Indigenous people provided with essential services (mandatory)
- Number of communities provided with essential services (mandatory)
- Type of municipal service provided (mandatory)
- Number of employment and training opportunities for Indigenous people on projects and in service provision

Project performance indicators

- Number of Indigenous people provided with municipal services as a result of this project (mandatory)
- Number of communities provided with municipal services as a result of this project (mandatory)
- Number of outstations benefiting from the municipal services funding provided
- Type of municipal service provided (mandatory)
- Number of Indigenous men employed full–time as a result of this project
- Number of Indigenous men employed part–time as a result of this project
- Number of Indigenous women employed full–time as a result of this project
- Number of Indigenous women employed part–time as a result of this project
- Number of Indigenous men completing accredited training as a result of this project
- Number of Indigenous women completing accredited training as a result of this project

NAHS community housing and infrastructure component

Programme performance indicators

- Environmental health impacts of capital construction or upgrade
- Contribution to meeting the need for housing of Indigenous people (mandatory)
- Number of houses purchased or constructed (mandatory)
- Level of state, territory and local government funding and support in project and programme delivery
- Number of employment and training opportunities for Indigenous people on construction and maintenance of infrastructure

- Progress with developing agreements with other governments on responsibilities for managing and ongoing repairs and maintenance of housing and infrastructure assets

Project performance indicators

- Environmental health impact of this project
- Number of Indigenous people housed as a result of this project (mandatory)
- Number of Indigenous people provided with infrastructure capital for water, sewerage, power, roads, etc. as a result of this project (mandatory)
- Number of communities provided with infrastructure capital for water, sewerage, power, roads, etc. as a result of this project
- Number of outstations provided with services such as water, sewerage, power, roads, etc. as a result of this project
- Type of infrastructure provided (mandatory)
- Number of houses purchased or constructed as a result of this project (mandatory)
- Number of houses refurbished or extended as a result of this project (mandatory)
- Estimated average cost of each house planned to be purchased or constructed as a result of this project (mandatory)
- Estimated average cost of each house planned to be refurbished or extended as a result of this project (mandatory)
- Funding amount contributed by other agencies
- Other contributions by other agencies
- Number of Indigenous men employed full–time as a result of this project
- Number of Indigenous men employed part–time as a result of this project
- Number of Indigenous women employed full–time as a result of this project
- Number of Indigenous women employed part–time as a result of this project
- Number of Indigenous men completing accredited training as a result of this project
- Number of Indigenous women completing accredited training as a result of this project
- Progress with developing agreements with other government agencies on responsibilities for managing and ongoing repairs and maintenance of housing and infrastructure assets

Source: ATSIC 1998c, pp. 70–72

Appendix T: IESIP priority areas and core performance indicators

Literacy

- Percentage of students who meet or exceed the school year 3 literacy benchmark; and
- Percentage of students who meet or exceed the school year 5 literacy benchmark.

Numeracy

- Percentage of students who meet or exceed the school year 3 numeracy benchmark; and
- Percentage of students who meet or exceed the school year 5 numeracy benchmark.

Attendance

Choice of:

- Average attendance of Indigenous students compared with non–Indigenous students of primary school students and secondary students to school year 10; or
- Absence distribution of Indigenous and non–Indigenous students of primary school students and secondary students to school year 10.

Indigenous employment

- The number and full time equivalent Indigenous and non–Indigenous staff employed in the categories of staff generally active in schools and executive staff and staff not generally active in schools.

Participation and retention

- Apparent grade progression ratios from school year 7 to 8, school year 8 to 9 and school year 9 to 10; and choice of:
- Apparent retention rates from school years 10–12 and apparent grade progression ratios from school year 10 to 11 and school year 11 to 12; or
- Progression rates of 15 to 19 year olds in education and training.

Senior secondary outcomes

- Percentage of students who meet the requirements for a school year 12 certificate as a proportion of those who commenced school year 11 in the previous year.

Indigenous cross cultural awareness training

- Percentage of staff undertaking Indigenous cross cultural awareness training in the previous 3 years (to be reported every two years).

Source: MCEETYA Taskforce on Indigenous Education 2000, pp. 26–27

Appendix U: Timeline of major developments in national Indigenous social policy

1967 A constitutional amendment referendum gives the Indigenous people of Australia full citizenship rights. The Commonwealth government gains constitutional power over Aboriginal affairs.

1968 The Commonwealth Office of Aboriginal Affairs is established within the Department of the Prime Minister.

The Council of Aboriginal Affairs is formed to advise the government on Indigenous affairs.

1971 The first ACCHS is initiated in Redfern, NSW.

1972 The Whitlam Labor government is elected.

The Whitlam government declares the right of self–determination of the Aboriginal and Torres Strait Islander people as its aim.

The Department of Aboriginal Affairs (DAA) is established, replacing the Office of Aboriginal Affairs and the Council of Aboriginal Affairs.

DAA starts to make direct grants to ACCHSs.

1973 The National Aboriginal Consultative Committee (NACC), an Aboriginal–elected body, is created with an advisory role to the government.

1974 The National Aboriginal and Islander Health Organisation (NAIHO) is formed as an umbrella organisation for ACCHSs.

1975 The new Liberal–National Coalition government changes the aim of self–determination to self–management.

1977 NACC becomes the National Aboriginal Conference (NAC) and is together with the Council for Aboriginal Development the main advisory body of the government.

1980 The Aboriginal Development Commission (ADC) is formed. It provides advice to the Minister of Aboriginal Affairs on matters relating Indigenous social and economic development.

1981 The Commonwealth government initiates a $50 million five–year Aboriginal Public Health Improvement Programme. The programme is administered by DAA and focuses on the improvement of environmental conditions.

1984 Responsibility for all Commonwealth Aboriginal health programmes is amalgamated in the Department of Aboriginal Affairs.

1985 The Australian Institute of Health (AIH) is established within the Commonwealth Department of Health with the responsibility of the development of Indigenous health statistics.

1986 NAC is abolished.

1987 The NAHS Working Party is formed. Its responsibility is to develop a strategy on Indigenous health that encompasses issues like funding, Indigenous participation, intersectoral coordination and monitoring.

The Aboriginal Employment Development Policy (AEDP) is launched with the aim of increasing Indigenous employment and reaching income equity between Indigenous and non–Indigenous Australians.

1988 NAIHO is abolished.

1989 The NAHS Working Party final report is released.

Aboriginal Health Development Group (AHDG) is formed, comprised of Commonwealth, state and territory government representatives, to assess the report and its implementation.
AMSs protest against the limited representation of Indigenous community interests in AHDG and establish the Aboriginal Health Advisory Group.

1990 AHDG releases its recommendations on the implementation of NAHS in a report. The Commonwealth government accepts the AHDG report and allocates $232.2 million over 5 years for implementation.

ATSIC replaces the Department of Aboriginal Affairs and the Aboriginal Development Commission and assumes responsibility for Indigenous health.

The Indigenous Commercial Development Corporation (CDC) is initiated to undertake commercially orientated business programmes for Indigenous people.

The National Aboriginal and Torres Strait Islander Education Policy (NATSIEP) is initiated. Its goal is to achieve equity in educational outcomes between Indigenous and non–Indigenous people.

1992 The Council of Aboriginal Health is formed. It is intended to advise governments on Indigenous health policy and monitor the performance of NAHS. After a few meetings in 1992 and a review, the council never meets again.

1993 The National Aboriginal Community–Controlled Health Organisation (NACCHO) is established.

1994 An evaluation of the National Aboriginal Health Strategy is published.
The Commonwealth announces a $500 million five–year health package, the majority of which involves a continuation of the NAHS activities.

ATSIC initiates the Health Infrastructure Priority Projects Scheme (HIPP), which addresses environmental health issues.

1995 The Indigenous health portfolio is transferred from ATSIC to the Department of Human Services and Health. The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is formed within the department.

1995 The multilateral Framework Agreements are formed to provide for the establishment of consultative national and state/territory forums to provide policy and planning advice on Indigenous health issues. By the end of 1996, six of the eight states and territories had signed the Framework Agreements.

The Department of Human Services and Health and ATSIC instituted a Memorandum of Understanding defining their roles and responsibilities.

Between 1995 and 2001, bilateral housing agreements are signed between the Commonwealth and the states and territories to improve Indigenous housing outcomes.

ATSIC launches the Business Funding Scheme (BFS).

1996 Establishment of the Aboriginal and Torres Strait Islander Health Council as agreed on in the Framework Agreements.

The National Strategy for the Education of Aboriginal and Torres Strait Islander Peoples (1996–2002) confirms the Commonwealth's commitment to the NATSIEP goals.

1997 The Community Housing and Infrastructure Programme Policy is introduced.

ATSIC initiates the Indigenous Business Incentive Programme (IBIP).

1998 The remaining two states and territories sign the Framework Agreements.

1999 The Commonwealth–State Housing Agreement between the Commonwealth and the states and territories provides assistance for those in greatest need. CSHA includes the Indigenous–specific Aboriginal Rental Housing Programme.

The mainstream educational policy document "Adelaide Declaration of National Goals in the 21st Century" includes the aims of improved Indigenous educational outcomes and of greater knowledge transfer of Indigenous culture in schools.

ATSIC's Business Development Programme (BDP) combines BFS and IBIP.

2000 The National Indigenous English Literacy and Numeracy Strategy is launched to raise levels of Indigenous numeracy and literacy.

2001 The Australian Health Ministers' Advisory Council (AHMAC) agreed to the development of an Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. The framework objectives were endorsed by AHMAC in October.

The Housing Ministers' Indigenous Strategy to 2010 to improve Indigenous housing conditions is released.

The reform package Australians Working Together is launched to reduce welfare dependency.

CDC is renamed to Indigenous Business Authority (IBA).

Explanatory Notes

Aboriginal Development Commission (ADC)
ADC was established in 1980. The functions of ADC were to acquire land for Aboriginal communities, to administer Indigenous housing programmes and to lend and grant money to Aboriginals for business enterprises. ADC could not reconcile the welfare aspects of its housing programmes with its economic development charter. ADC was disbanded in 1990 and its functions were absorbed into ATSIC.

Australian Bureau of Statistics (ABS)
ABS is the main statistical authority for the Commonwealth government. In the field of health, ABS is responsible for the collection, analysis and publication of statistical information on the health status of Australians as well as their need for and use of health services. Moreover, information on health costs and the health labour force is gathered.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC consists of senior Commonwealth, state and territory health officials. It considers health matters referred by the Australian Health Ministers' Conference (AHMC) or any health minister and reports on these matters to the annual meeting of AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC's aim is to promote a consistent and coordinated national approach to health policy development and implementation. See also Australian Health Ministers' Advisory Council.

Australian Housing Survey (AHS)
The Australian Housing Survey collected information from persons in private dwellings throughout Australia, excluding sparsely settled or remote areas, and was conducted between September and December 1999. Topics covered include the characteristics, affordability and adequacy of dwellings and the demographics, tenure and housing costs of persons and households.

Australian Institute of Health and Welfare (AIHW)
The Australian Institute of Health and Welfare is an independent Commonwealth statutory authority. AIHW was established in 1985 and is represented in Parliament by the Minister of Health (Palmer & Short 2000, p. 11). It provides information and analysis on the health and welfare of Australians and their health and welfare services. Further responsibilities of AIHW encompass the collection of health related statistical data, research on the effectiveness of health service delivery and health technology.
AIHW has a specific Aboriginal and Torres Strait Islander Health Unit, which specialises in the collection of Aboriginal health data. These data are published twice yearly in the Aboriginal Health Information Bulletin.

Census of Population and Housing
The Census of Population and Housing measures the number of people in Australia and their key characteristics. The census is a count of the whole Australian population and is conducted every five years.
At the time of writing, results from the 2001 census had not been released. Therefore, results from the 1996 census have been used.

Centrelink
Centrelink is the Commonwealth service delivery agency — an independent statutory authority in the Family and Community Services Portfolio with responsibility for the integrated service delivery of Commonwealth social welfare payments and services under purchaser/provider agreements. It was founded in 1997.
Centrelink is the sole contact for applicants and recipients of social security allowances and benefits.

Community Housing and Infrastructure Needs Survey (CHINS)
The Community Housing and Infrastructure Needs Survey was conducted twice, in 1999 and 2001. It was commissioned by ABS on behalf of ATSIC. Although called a survey, CHINS is a complete enumeration of all Indigenous housing organisations and discrete Indigenous communities. This includes organisations and communities located in urban and sparsely settled areas in all Australian states and territories.
The survey collected information from: Indigenous housing organisations, concerning the number, characteristics and condition of their housing stock, the amount of rent collected and expenditure on repairs and maintenance; and from discrete Indigenous communities, concerning housing and related infrastructure, such as water and power supply, sewerage systems, drainage and roads. Information relating to access to health, education and other services was also obtained.

Department of Family and Community Services (FaCS)
FaCS is responsible for a broad range of social policy issues affecting Australian society and the living standards of Australian families, communities and individuals. The department is responsible for income support, housing policy, community support, disability services, childcare services and family issues, including family payments, child support and family relationships.
The Indigenous policy unit within the Community Branch works to ensure that programmes are of maximum benefit to Indigenous people.
The responsibilities of the Indigenous policy unit include:

- assisting other areas of FaCS with policy development, policy advice and research on Indigenous issues,
- policy development and programme management in relation to Indigenous housing (especially the Aboriginal Rental Housing Programme), and
- managing the arrangements with Centrelink for the delivery of services, including income support to Indigenous people.

Department of Reconciliation and Aboriginal and Torres Strait Islander Affairs
The Department Reconciliation and Aboriginal and Torres Strait Islander affairs was established in January 2001. It absorbed the functions of the Office of Indigenous Policy, which had been part of the Department of the Prime Minister and Cabinet. The department's aim is to coordinate Indigenous government policies and programmes (Department of Reconciliation and Aboriginal and Torres Strait Islander Affairs 2001, p. 6).

Health and Medical Research Council (NHMRC)
NHMRC is the Commonwealth government's main funding body for health and medical research.

Health Insurance Commission (HIC)
The Health Insurance Commission is a statutory authority. Its purpose is to administer Medicare. It processes and pays Medicare claims and benefits and records relevant data.

Housing and Community Infrastructure Needs Survey (HCINS)
This survey was commissioned by ATSIC in 1992, collecting housing and infrastructure information from Indigenous people all over Australia. Due to differences in methodologies and definitions used in the 1992 HCINS and the 1999 CHINS, direct comparisons between their results cannot be made.

National Aboriginal and Torres Strait Islander Survey (NATSIS)
NATSIS was conducted by ABS in cooperation with ATSIC in 1994. It was the first national survey of Australia's Indigenous people and was aimed to provide information at the national level on their social, demographic, economic and health status (Altman & Taylor 1996, p. 193).
A sample of 15,700 Indigenous people were interviewed, who comprised about 6.6 per cent of the total Indigenous population (ABS & AIHW 2001, p. 166; NHRMC 2000, p. 220).

National Health Survey (NHS)
The 1989 NHS was the first major health survey to provide for Aboriginal identification, but no measures were taken to ensure that an adequate sample of Aborigines was included (AIHW 1994, p. 216; Thomson 1998, p. 39). In 1994, information about health status, health actions and health–related behaviours was gained from a sample of close to 55,000 Australian residents. The 1994 NHS included an additional sample of around 1,000 Indigenous respondents, bringing the total sample of Indigenous people to around 2,000.
This survey disallows responses from all people, Indigenous and non–Indigenous, living in sparsely settled areas because of concerns about data quality. Since 1994, no NHS has been conducted.

National Trachoma and Eye Health Programme
This programme was initiated in 1975. It was administered by the Royal Australian College of Ophthalmologists and funded by the Commonwealth Department of Health. In the period from 1976 to 1979, the programme undertook an Australia–wide screening and treatment programme of eye disease as well as en evaluation of physical environment factors. It examined 62,000 Aboriginal and Torres Strait Islander people and 32,660 non–Indigenous people. There has not been an eye screening programme of similar size since.

Royal Commission into Aboriginal Deaths in Custody
The Royal Commission into Aboriginal Deaths in Custody was originally established in 1991 to enquire into the high numbers of Aboriginal deaths in custody. The resulting report not only concentrates on the criminal justice system but also researches into the socio–economic living environment and health of Australia's Indigenous people (Cordner 1991, p. 813).
The report confirmed that, for almost all disease categories, the health of Indigenous people was worse than that of other Australians. The report also found that health services available did not meet the needs of Indigenous people.

Glossaries

Technical Glossary

Aboriginal English
The term "Aboriginal English" comprises different dialects of English, which are spoken by Aboriginal people throughout Australia. Aboriginal English contains features of Aboriginal languages, especially in grammar and accent.

Absec
This scheme was introduced under the name of ABSEG in 1970. Grants were made available to Indigenous students over 14 years of age but under 21, for payment of compulsory fees, a textbook and a uniform allowance. In 1973, ABSEG was extended to include all Indigenous secondary school students regardless of age. In 1985, ABSEG's name was changed into Absec. ABSEG/Absec allowances were increased several times until 1989. Absec was included into ABSTUDY in 1989.

Abstudy
This scheme was initially introduced in 1960 mainly to improve Indigenous students' employment prospects through post–school training. Indigenous students at universities, colleges and other approved institutions were eligible for Abstudy grants. Grants comprised living allowances and allowances for study material, travel for studying away from home, as well as payment of compulsory fees for full–time students. Part–time students were eligible for a small annual allowance and payment of compulsory fees. In the first year, 115 Indigenous students received Abstudy awards (Stanley & Hanson 1998, p. 30). In 1989, Abstudy was replaced by the new scheme ABSTUDY.

Accessibility/Remoteness Index of Australia (ARIA Index)
The ARIA Index was developed by the National Key Centre for Social Applications of Geographical Information Systems at the University of Adelaide. This classification of localities measures accessibility and remoteness in terms of a location's road distance from service centres with populations of 5,000 or more. Each location in Australia is classified into one of five categories: highly accessible, accessible, moderately accessible, remote or very remote.

Age–specific rates
To exclude the effects of different age compositions of populations, age specific rates only compare rates in specific age groups. Age–specific death or birth rates are the number of deaths or births in a calendar year per 1,000 people of the same age group.

Age standardisation
A procedure for adjusting rates (such as population death rates) to minimise the effects of differences in age composition and thus facilitate valid comparison of rates for populations with different age compositions.

Alcohol risk levels
In the National Health Survey 1995, consumption levels were derived from the reported average daily consumption of alcohol during the week prior to interview. Consumption levels were then grouped into relative risk levels as follows:

	Consumption per day in mls	
Relative risk	Males	Females
Low	Less than 50	Less than 25
Moderate	50 to 75	25 to 50
High	Greater than 75	Greater than 50

Community–controlled health
Community control is the local community having control of issues that directly affect their community. Aboriginal people must determine and control the pace, shape and manner of change and decision making at local, regional, state and national levels.

Community Development Employment Project (CDEP) Scheme
The CDEP Scheme enables members of Aboriginal and Torres Strait Islander communities to exchange unemployment benefits for opportunities to undertake work and training in activities that are managed by a local Aboriginal or Torres Strait Islander community organisation. The scheme is funded and supported through ATSIC.

Community housing
Community housing comprises dwellings owned or managed by Indigenous housing organisations. This category also includes dwellings that are owned by state or territory housing authorities but managed by Indigenous housing organisations.

Discrete Indigenous community
A discrete Indigenous community is a geographical location that is inhabited predominantly (more than 50 per cent) by Indigenous people, with housing and infrastructure that is either owned or managed on a community basis. This definition covers discrete communities in urban, rural and remote areas. About 27 per cent of the Indigenous population lived in discrete communities in 1996.

Dreaming, The
According to Aboriginal belief, ancestor beings or totemic spirits created the earth, animals and human beings at the time of the Dreaming.

Dwelling
A structure or a discrete space within a structure, intended for people to live or where a person or group live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence.

Environmental health
Environmental health includes those aspects of human health determined by physical, chemical and biological factors in the environment.

Excess deaths
Excess deaths are the number of observed deaths minus the number of expected deaths. Excess deaths are indicated by an $SMR_{mortality}$ greater than 1.0.

Family Tax Benefit (FTB) Part A
FTB Part A is a support payment for parents or carers to help with the costs of raising children if the dependent child under 20 years of age or between 21 and 24 years of age is undertaking full–time study. FTB Part A is subject to an income test.

Governance
Governance is about the structures and processes for decision making. This word has no single accepted definition, but it is generally understood to encompass stewardship, leadership, direction, control, authority and accountability.

Henderson poverty lines
The first systematic attempt to estimate the extent of poverty was undertaken in the mid–1960s at the Melbourne University. The research team, led by Professor Ronald F. Henderson, estimated poverty in Melbourne using a poverty line for a reference two–adult, two–child family set at an income equal to the value of the basic wage plus child endowment payments (later called family allowances).
Updated estimates of the HPLs have been published regularly since 1979 and reported by welfare organisations. Updating the poverty line by average earnings was replaced by the use of household disposable income per capita in 1981, the latter measure being more comprehensive in scope but also preferable because it incorporates changes in personal tax payments. HPLs are widely used to measure poverty in Australia.

Homeland or outstation
A discrete Indigenous community that has a population of less than 50 people and administered by, or linked to, an Indigenous organisation or larger parent discrete Indigenous community for the provision and maintenance of services. Homelands are normally established on an area of land to which Aboriginal or Torres Strait Islander people have ancestral and cultural links.

Hospital separation
Refers to the process by which an admitted patient completes an episode of care in hospital, by being discharged, transferred to another hospital or dying. A hospital separation record gives details such as age, sex, Indigenous status, reasons for hospitalisation and treatments performed.

Household
A group of people who live and eat together as a single unit within a dwelling in the sense that they have common housekeeping arrangements—i.e. they have some common provision for food and other essentials of living. This may be (ABS 1991, p. 60):

- a group of two or more related or unrelated people who usually reside in the same dwelling who make common provision for food or other essential for living; or
- a person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.

Improvised dwelling
A private dwelling that does not have working kitchen, toilet or bathroom facilities.

Income unit
One person, or a group of related persons within a household whose command over income is assumed to be shared. Income sharing is considered to take place between partners in a couple relationship and between parents and their dependants (ABS 1995, p. 95).

Indigenous
Persons who are of Aboriginal or Torres Strait Islander descent and identify as Aboriginal or Torres Strait Islander.

Indigenous household
According to the ABS definition a household is an Indigenous household if it comprises an Indigenous reference person or spouse or only consists of one person of Indigenous origin. The Census of Population and Housing and AHS use this definition.
NATSIS defines a household as Indigenous if one or more members are of Indigenous descent.

Indigenous housing organisation
An Indigenous housing organisation is any Aboriginal or Torres Strait Islander organisation that manages housing or provides housing support services. It may also be a multi–functional, community service organisation that has a housing related function or unit.

International Classification of Diseases, Clinical Modification (ICD–9–CM)
The World Health Organisation (WHO) International Classification of Diseases (ICD) is used to code illness and death to produce Australia's morbidity and mortality statistics.
The source quoted in this paper uses the ninth revision (ICD–9):

(001–139) Infectious and parasitic diseases
(140–239) Neoplasms
(240–279) Endocrine, nutritional, metabolic diseases and immunity disorders
(280–289) Diseases of the blood and blood–forming organs
(290–319) Mental disorders
(320–389) Diseases of the nervous system and sense organs
(390–459) Diseases of the circulatory system
(460–519) Diseases of the respiratory system
(520–579) Diseases of the digestive system
(580–629) Diseases of the genitourinary system
(630–676) Complications of pregnancy and child birth
(680–709) Diseases of the skin and subcutaneous tissue
(710–739) Diseases of the musculoskeletal system and connective tissue
(740–759) Congenital abnormalities
(760–779) Certain conditions originating in the perinatal period
(780–799) Symptoms, signs and ill–defined conditions
(800–999) Injury and poisoning
V Codes: Include a variety of circumstances which influence health status or bring people into contact with the health care system but which do not fit into the main disease and injury coding system.

Mean
The sum of values divided by the number of values.

Median
The middle value of a set of values when the values are sorted in order.

Median income
This is the level of income at which half the income units or households have higher incomes and half have lower incomes.

Mixed–mode course delivery
This is a term used to describe courses delivered through a combination of distance education and face–to–face teaching for students who are based in their home communities and need regular on–campus tuition to complement the distance education component of the course.

Mutual obligation
The mutual obligation principle asserts that the provision of government assistance is not just a right or entitlement of residents, but something that must be reciprocated through meeting a range of obligations and responsibilities (HREOC 2001, p. 33). These obligations and responsibilities comprise activities, such as seeking work actively, undertaking training or accepting temporary work. Penalties for failure of comply apply. The mutual obligation approach has been the basis of the Australian welfare system since 1996.

Native title
The term native title refers to Indigenous property rights held by Indigenous inhabitants by virtue of their prior occupation as recognised by the High Court in the Mabo judgement (3 June 1992). The Mabo judgement overthrew the legal fiction of terra nullius – that the land of Australia had belonged to no one when the British arrived in 1788. See also Appendix E, p. 208, for native title legislation.

Overcrowding
There is currently no universally accepted definition of overcrowding.
AIHW employs the definition of a bedroom occupancy standard of one bedroom per couple, one bedroom per adult household member, and a maximum of two dependant children per bedroom. A dwelling is referred to as overcrowded if there are not enough rooms to satisfy the standard occupancy.
The 1999 AHS uses the Canadian National Occupancy Standard, the criteria of which are:

- There should be no more than two persons per bedroom.
- Children less than 5 years of age of different sexes may share a bedroom; if 5 years and older, they should have a separate bedroom.
- Children less than 18 years of age and of the same sex may share a bedroom.
- Single household members 18 years and over should have a separate bedroom, as should parents and couples.

Post–secondary qualification
A post–secondary qualification is any qualification gained after leaving secondary school, such as a trade qualification, certificate, diploma or degree.

Primary health care
According to WHO, primary health care is an essential health care based on practical, scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in their communities in which they live through their full participation at every stage of development in the spirit of self–reliance and self–determination.
Primary health care comprises health promotion, diagnosis, treatment and prevention of disease. It includes the services of GPs and other health professionals who provide first contact care.

Public health
Public health aims to protect, promote and restore people's health (Palmer & Short 2000, p. 8). It is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programmes, services and institutions involved emphasise the prevention of disease and the health needs of the population as a whole.

Public housing
Public housing comprises dwellings owned and managed by mainstream state and territory housing authorities.

Remote
The term describes areas with a dwelling density of fewer than 57 dwellings per 100 square kilometres.

Rural
This term comprises localities and towns with a total population of fewer than 1,000 people.

Risk factor
An aspect of lifestyle or behaviour, a health condition, an environmental exposure or an inborn or inherited characteristic, known to be associated with disease.

School participation rate
The number of school students of a particular age, expressed as a proportion of the total population of the same age.

School retention rate
Retention is defined as the number of students who re–enrol at an institution in a given year, as a proportion of the students who were enrolled in the previous year.

Skilled vocational qualification
Skilled vocational qualifications include all trade certificates and equivalent qualifications.

Technical and further education (TAFE)
A range of technical and vocational education and training courses and other programs, e.g. entry and bridging courses or language and literacy courses.

Terra nullius
The first English settlers considered Australia terra nullius (empty land) despite their knowledge of Aborigines living there.

Medical Glossary

Body Mass Index (BMI)
BMI is defined as a person's weight in kilograms divided by the square of his or her height in metres: BMI = Body weight (kg)/height^2 (m^2). Depending on a person's BMI, he or she is classified as underweight, of healthy weight, overweight or obese.

BMI	Condition
Less than 18.5	Underweight
From 18.5 to 25	Acceptable, healthy weight
From 25 to 30	Overweight
Greater than 30	Obese

It must be added that BMI is not fully applicable to Aboriginal and Torres Strait Islander people due to their relatively high limb:trunk ratios. Aboriginal people in general have lighter skeletons (Abbie 1974, p. 471). Aboriginal women tend to have a higher percentage of body fat (Rutishauser & McKay 1986, p. 8). Nevertheless, BMIs greater than 25 are still useful for assessing trends in body weight.

Cataract
A cataract is an opacity of the crystalline lens of the eye, which can prevent light from reaching the retina at the back of the eye. Cataract is increasingly frequent as people grow older and its occurrence doubles with each decade after the age of 40 years. The disease develops progressively. At an early stage, cataract may only reduce vision a little, but with time a mature cataract can cause marked blindness.

Central obesity
Central obesity is measured as the waist–to–hip ratio (WHR):

WHR = waist circumference (cm) / hip circumference (cm).

WHR defines increased risk for cardiovascular disease for men over 19 years for a WHR greater than 0.9 and for women for a WHR greater then 0.8.

Circulatory system diseases
Circulatory system diseases comprise all diseases of the heart and blood vessels, such as ischaemic heart disease, rheumatic heart disease, stroke and peripheral vascular disease.

Diabetes mellitus
Diabetes is characterised by high blood levels of glucose, caused by deficient insulin production or resistance to its action or both. The main categories of diabetes are:

Diabetes type 1: Type 1 diabetes is characterised by a complete deficiency of insulin and requires injections of insulin. Therefore it is also referred to as insulin–dependent diabetes mellitus (IDDM). IDDM is estimated to account for 10 to 15 per cent of diabetes cases in Australia, but is rare in Aborigines. Type 1 diabetes normally develops in childhood.

Diabetes type 2: Type 2 diabetes is the predominant form of diabetes in Australia, characterised by a relative insufficiency of insulin and resistance to its action. This form initially does not require insulin injections, though these may become necessary as the disease develops.

	Type 2 diabetes is also referred to as non–insulin–dependent diabetes mellitus (NIDDM). It is a chronic disease that develops in adulthood, normally among people 40 years and over. Lifestyle related risk factors such as nutrition, obesity and physical activity play an important role in its development.
Gestational diabetes:	Gestational diabetes occurs during pregnancy in about 4 to 6 per cent of women. Gestational diabetes increases the risk of developing diabetes type 2 later in life.
Other types:	This category includes forms of diabetes secondary to other biological, metabolic and distinct genetic abnormalities.

Diabetic retinopathy
One of the complications of diabetes is damage to small blood vessels, including those in the retina. The presence of retinal microvascular lesions is known as diabetic retinopathy. The earliest lesions are termed non–proliferative retinopathy, including micro–aneurysms, haemorrhages and hard exudates. The proliferative stage is characterised by growth of new vessels and fibrous tissue and oedema. Non–proliferative diabetic retinopathy is not vision–threatening, but may proceed to proliferative diabetic retinopathy, which is.

Endocrine and metabolic diseases
Include diabetes, thyroid disease, gout, obesity and high blood cholesterol levels.

Foetal death
Death of a baby during birth.

Foetal mortality rate
The number of foetal deaths per 1,000 births.

Hypertension
Resting blood pressure above 140mmHg systolic and 90mmHg diastolic is diagnosed as hypertension.

Infant death
Death of a child under one year of age.

Infant mortality rate (IMR)
The number of infant deaths in a year per 1,000 live births.

Ischaemic heart disease
Narrowing or blockage of one or more of the coronary arteries resulting in decreased blood supply to the heart (ischaemia).

Life expectancy at birth
The average number of years at birth that a new–born could be expected to live if the mortality rates were to continue throughout that baby's life.

Low birth weight
A new–born is considered to be of low birth weight if its weight is less than 2,500 grams.

Weight	Condition
Less than 2,500 grams	Low birth weight
Less than 1,500 grams	Very low birth weight
Less than 1,000 grams	Extreme low birth weight

Maternal death
The death of a woman while pregnant or within 42 days of the termination of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.

Morbidity
Any departure, subjective or objective, from a state of physiological or psychological well–being.

Neonatal
Within 28 days of birth.

Neonatal death
Death of a live born infant within 28 days of birth.

Neonatal mortality rate
The number of neonatal deaths in a year per 1,000 live births in the same year.

Obesity
A BMI over 30. See BMI.

Overweight
A BMI between 25 and 30. See BMI.

Perinatal death
A foetal or neonatal death, i.e. a death of a new–born within 28 days of birth.

Perinatal mortality rate
The number of perinatal deaths per 1,000 total births in the same year.

Peripheral vascular disease
The narrowing of blood vessels in the legs or arms, causing pain and possibly tissue death (gangrene) as a result of a reduced flow of blood to areas supplied by the narrowed vessels.

Respiratory (system) diseases
Include asthma, sinusitis, hayfever, influenza, the common cold, bronchitis and emphysema.

Rheumatic fever
A disorder that may follow a streptococcal throat infection; characterised by an inflammatory response that may cause arthritis and, more importantly, damage to the heart valves.

Rheumatic heart disease
One of the complications of rheumatic fever involving irreversible damage to the heart valves, which do not open enough or not close properly anymore, causing the heart to pump harder.

Standardised morbidity ratio ($SMR_{morbidity}$)
$SMR_{morbidity}$ shows the ratio of the observed number of cases of a certain disease in a study population to the number expected if the study population had the same age–specific morbidity patterns as the standard population.

Standardised mortality ratio ($SMR_{mortality}$)
$SMR_{mortality}$ shows the ratio of the observed number of deaths in a study population to the number expected if the study population had the same age–specific rates as the standard population.

Stroke
An injury of the brain due to bleeding or an interruption of the blood supply.

Trachoma
Trachoma is a form of conjunctivitis caused by the bacterium Chlamydia trachomatis. The initial form of the disease, follicular trachoma, is largely a disease of childhood and early adolescence with a peak prevalence in children aged two to three years. Longstanding and moderately severe follicular trachoma can lead to cicatricial trachoma, involving scarring and other damage to the eyelids and eyes. Severe scarring of the eyelids and in–turning of the eyelashes can lead to opacification of the cornea and blindness.

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