Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Input to the 'Close the Gap Refresh' Process

24 January 2018

About us

Central Australian Aboriginal Congress is an Aboriginal community controlled health service based in Alice Springs in the Northern Territory. Since our establishment in 1973, we have developed a comprehensive model of primary health care delivering quality, evidence-based services on a foundation of cultural appropriateness. Led by our Board, we have developed extensive expertise on approaches to health policy and service delivery that take account of the social and cultural determinants of health, including alcohol use, social and emotional well being, poverty, housing, and early childhood development.

Purpose of this paper

Congress notes the Council of Australian Government's (COAG's) commitment in their meeting of 9 June 2017 to refreshing the Closing the Gap (CtG) agenda, *"focussing on a strength-based approach that supports Indigenous advancement, working in partnership with Aboriginal and Torres Strait Islander peoples".*

As a leading Aboriginal community controlled health service with over forty years of experience in delivering improvements in services and outcomes for Aboriginal people[1] in Central Australia, Congress is submitting this paper to the Taskforce that has been established in the Department of the Prime Minister and Cabinet to progress this important work.

The paper is framed around five key structural reforms to the CtG process and on eight specific social and cultural determinants of health and well being.

[1] This paper uses the term 'Aboriginal' to refer to 'Aboriginal and Torres Strait Islander' and/or 'Indigenous' on the basis that this is the preferred term in Central Australia where Congress is based.

Central Australian Aboriginal Congress Aboriginal Corporation
ABN 76 210 591 710 | ICN 7823
PO Box 1604, Alice Springs NT 0871
(08) 8951 4400 | www.caac.org.au

Executive Summary

Congress notes the Council Of Australian Government's (COAG's) commitment in their meeting of 9 June 2017 to refreshing the Closing the Gap (CtG) agenda, *"focussing on a strength-based approach that supports Indigenous advancement, working in partnership with Aboriginal and Torres Strait Islander peoples".*

To deliver on this commitment and drive better outcomes for our Peoples, Congress proposes five key structural reforms to the CtG process, and a range of expanded targets and indicators organised against the framework of the social and cultural determinants of health. Selection of targets and related indicators should be made only in partnership with the Aboriginal leadership (see *Reform 1*).

Structural Reforms to the CtG Process

Reform 1. Establishing a strategic Aboriginal partnership
COAG should immediately establish a formal, ongoing Aboriginal partnership structure with representation from key national Aboriginal organisations and leaders, to advise and lead the Close the Gap reform process and to participate in monitoring of implementation of CtG policies and programs (see Reform 5).

Reform 2. A commitment to increased Aboriginal-specific funding
COAG should commit to a target of increasing the absolute levels of Aboriginal-specific expenditure over the period of the next agreement, and returning the proportion of Aboriginal-specific expenditure to at least the level of 2008-09 (23%).

Reform 3. Directing expenditure through Aboriginal organisations
COAG should adopt a policy to guide allocation of all CtG related funding that recognises Aboriginal-controlled organisations as preferred providers of services in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, and their formal structures for involving Aboriginal communities in decision-making in matters that concern them.

Reform 4. Transparency in funding
COAG should commit to transparency in funding through establishing a policy whereby Australian Government and State / Territory Aboriginal-specific funding allocated for particular purposes to meet CtG targets should be pooled, to prevent cost-shifting and encourage joint responsibility and commitment for achieving outcomes.

Reform 5. Ongoing implementation and accountability structures
COAG should commit to the establishment of formal and ongoing monitoring of CtG policies and programs, undertaken by an independent organisation or statutory body and reporting to a strategic partnership body including Aboriginal and Torres Strait Islander representation (see Reform 1).

The social and cultural determinants of health & well being

Determinant 1. Empowerment, community-control and representation
Establishment of a national representative body for Australia's First Nations as recommended by the Referendum Council and captured in the Uluru Statement from the Heart as a foundation for addressing marginalisation and disempowerment of Aboriginal and Torres Strait Islander people.

Increased empowerment of Aboriginal communities in their own health care, measured by number of Aboriginal Community Controlled Health services and funding levels (absolute and as a proportion of total primary health care funding) for Aboriginal Community Controlled Health services.

Reduced systemic racism in the mainstream hospital system, measured by a set of national key performance indicators including discharge summary timeliness; rates of sentinel procedures; Take Own Leave (TOL) and Leave Against Medical Advice (LAMA) rates; medication dispensing; cultural safety; employment of Aboriginal staff including in leadership positions; and documented partnerships with local Aboriginal communities / organisations.

Determinant 2. Tackling poverty

Reduced poverty amongst Aboriginal individuals and households, measured by median household and personal income, use of citizenship entitlements in the form of income support, and unemployment rates.

Determinant 3. Strengthening culture and language

Increased proportion of Aboriginal people reporting that they speak an Aboriginal language.

Determinant 4. Early childhood development

Increased participation of Aboriginal children aged 0 to 5 in evidence-based early learning programs; tracking of Australian Early Development Census results for Aboriginal / non-Aboriginal children at a regional level.

Determinant 5. Increasing educational attainment

Improved school education outcomes for Aboriginal children and young people, measured by AECD scores; NAPLAN up to year 3 for basic writing and literacy supplemented by detailed performance measures through a broader range of assessments for high school; Year 12 attainment; and numbers of Aboriginal people completing higher education including TAFE.

Closing the Gap in adult literacy rates, measured by adult literacy rates and access to / enrolment in adult literacy courses or campaigns.

Determinant 6. Better housing

Reduced overcrowding in housing for Aboriginal families, measured by overcrowding rates at a regional level.

Determinant 7. Reducing youth incarceration rates

Reduced numbers of Aboriginal young people in criminal detention, measured in absolute numbers and as a proportion of all young people in detention.

Determinant 8. Reducing the impact of alcohol

Reduced population level alcohol-related consumption and harms, measured by a range of regional indicators including (reported separately by Aboriginality where possible) apparent per capita consumption; hospital separations for selected acute and chronic alcohol-related conditions; Alcohol-related deaths; proportion of alcohol consumed at risky and high-risk levels; proportion of the population drinking at risky and high-risk levels; and estimated acute and chronic hospital separations attributed to risky and high-risk drinking.

Structural Reforms to the CtG Process

Reform 1: Establishing a strategic Aboriginal partnership

We welcome COAG's commitment to working in partnership with Aboriginal and Torres Strait Islander peoples. Setting up durable and strategic partnership structures to enable Aboriginal leadership is the critical reform that will drive improved outcomes.

To date under the CtG Reforms, accountability has been maintained through annual reporting against the six targets. The public and regular nature of this reporting has been a strength of the CtG process. However, all responsibility for this process lies with the Australian and State / Territory governments: there has been no structured Aboriginal participation, oversight or accountability. This lack of inclusion of Aboriginal leadership has undermined progress with the CtG targets.

A formal and ongoing structure to provide Aboriginal leadership is the critical reform needed to drive more consistent improvements in reaching CtG targets. Such a structure should include representatives from key national Aboriginal representative bodies such as the National Congress of Australia's First Peoples and the National Aboriginal Community Controlled Organisation (NACCHO). This group will advise and direct community consultations; develop recommendations on existing and new targets and the actions to meet those targets; and oversee implementation and monitoring.

1. *COAG should immediately establish a formal, ongoing Aboriginal partnership structure with representation from key national Aboriginal organisations and leaders, to advise and lead the Close the Gap reform process and to participate in monitoring of implementation of CtG policies and programs (see Reform 5).*

Reform 2: A commitment to increased Aboriginal-specific funding

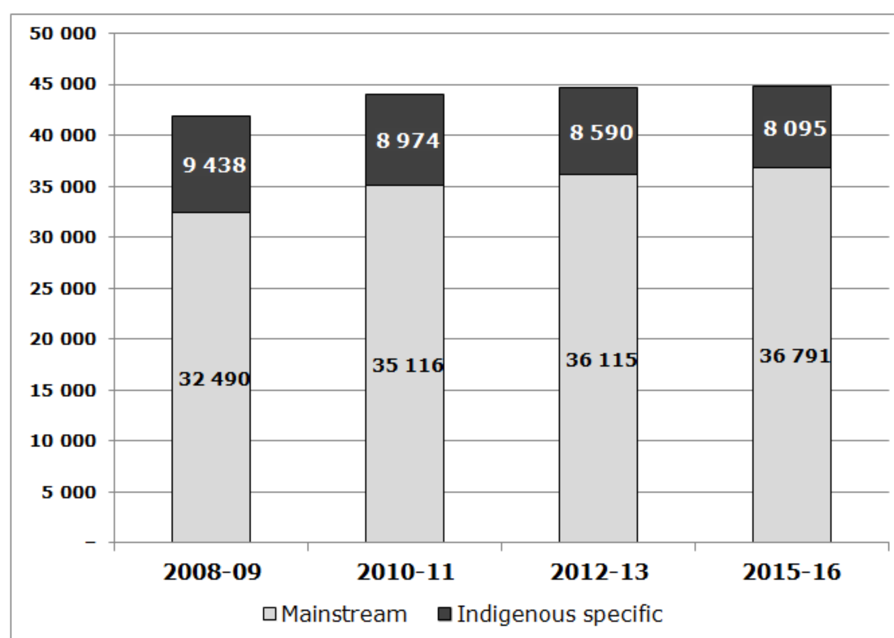
Congress acknowledges that establishing CtG targets, supported by increased funding, has helped improve the well being of Aboriginal people, with success in areas such as year 12 completion and child and maternal health. It is important that the levels of investment be maintained or increased if further gains are to be made.

However, while total Government investment increased from 2008-09, it has effectively stalled since (see Figure 1 on next page). Significantly, the amount of Indigenous-specific funding per person has actually fallen over that period in real terms and as a percentage of the total: in 2008-09, 23% of expenditure was Indigenous-specific and by 2015-16 this had fallen precipitously to only 18% [1].

A high proportion of the expenditure being counted in these figures and publicly quoted as part of the $30 billion being spent on Aboriginal people are in fact through mainstream services or entitlements accessed by both Aboriginal and non-Aboriginal people (e.g. schools, welfare) – they are entitlements that Aboriginal people have as citizens, not funds allocated to meet their specific needs as First Nations peoples or to address the burden of disadvantage they bear. It should also be noted that the largest proportion of total expenditure per person for Aboriginal people was on Safe Communities (24%) which includes policing, criminal and court services, juvenile justice and prisons: many of these services will not directly contribute to 'Closing the Gap'.

2. *COAG should commit to a target of increasing the absolute levels of Aboriginal-specific expenditure over the period of the next agreement, and returning the proportion of Aboriginal-specific expenditure to at least the level of 2008-09 (23%).*

Figure 1: All Government direct expenditure on Aboriginal Australians, by program and type of expenditure ($ per person, 2015-16 dollars) [1]



Reform 3: Directing expenditure through Aboriginal organisations

The effectiveness of expenditure has been further undermined by the fact that increasing amounts of the Aboriginal-specific funding have been provided to mainstream service providers. A Senate review of the 2014 Indigenous Advancement Strategy (IAS) showed that its process and policy directions were significantly flawed, with the IAS being found to have disadvantaged Aboriginal organisations, to have disregarded the enhanced outcomes stemming from Aboriginal led service delivery, and to have failed to distribute resources effectively to meet regional or local needs [2]. The IAS's processes led to only just over half (55%) of its $4.8 billion in funding going to Aboriginal organisations [3].

Focusing investment wherever possible through Aboriginal-controlled services is fundamental to delivering significant improvements in outcomes. For example, primary health care (PHC) delivered through Aboriginal Community Controlled Heath Services (ACCHSs), is known to be significantly more effective than that delivered through mainstream / government services, with the evidence showing that ACCHSs:

- contribute significantly to improved health outcomes through reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes [4];
- perform better on clinical best practice measures than mainstream services [5];
- are more effective in supporting the delivery of specialist and allied health services [6];

- are the preferred provider for most Aboriginal people due especially to their greater capacity for culturally safe care, leading to greater access to care and better adherence to treatment regimes [7, 8]; and
- generate substantial additional benefits, especially through their significantly better record in employing Aboriginal people and involving Aboriginal communities in decision-making [9].

As a result, ACCHSs are significantly more cost effective than mainstream services, with a major study concluding that:

> ... *up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [7].*

The full evidence for the effectiveness of ACCHSs is contained in the appended Congress paper *The effectiveness of primary health care delivered through Aboriginal Community Controlled Health Services* (see Appendix).

3. *COAG should adopt a policy to guide allocation of all CtG related funding that recognises Aboriginal-controlled organisations as preferred providers of services in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, and their formal structures for involving Aboriginal communities in decision-making in matters that concern them.*

Reform 4: Transparency in funding

Much Aboriginal-specific expenditure provided with a view to meeting CtG targets is non-transparent, especially with regard to cost-shifting between the Australian Government and State and Territory sources. This has been a particular feature, for example, of health funding in the Northern Territory where Australian Government PHC funds are commonly directed to Northern Territory Government agencies. Generally, these funds *are* spent by those agencies on the services for which they were intended. However, the lack of accountability and transparency allows NT government agencies to reduce the*ir own* PHC spending for those purposes, and redirect it elsewhere in the health system including to non-Aboriginal-specific services such as hospitals.

While this challenge is inherent in a federal system, it can be addressed. Australian Government and State/Territory Aboriginal-specific funding towards policies and programs that address the closing the gap targets should be pooled and administered through Australian Government agencies with the Aboriginal community controlled sector prioritised as services-providers (see above). This will ensure money is spent where it is allocated and that there is joint responsibility and effort towards achieving outcomes. Funding should be sufficient and transparent, with reporting on Aboriginal-specific and mainstream expenditure directly linked to the services and programs addressing CtG targets and measures.

4. *COAG should commit to transparency in funding through establishing a policy whereby Australian Government and State / Territory Aboriginal-specific funding allocated for particular purposes to meet CtG targets should be pooled, to prevent cost-shifting and encourage joint responsibility and commitment for achieving outcomes.*

Reform 5: Ongoing implementation and accountability structures

No plan at whatever level can be expected to succeed unless there is a robust, durable and inclusive process for implementation and accountability. A clear implementation and monitoring process is required, undertaken in conjunction with Aboriginal organisations through the governance structures outlined above (*Reform 1*), focussed on actions to close the gap, and linked to the targets and progress measures with clear responsibilities and accountabilities.

5. *COAG should commit to the establishment of formal and ongoing monitoring of CtG policies and programs, undertaken by an independent organisation or statutory body and reporting to a strategic partnership body including Aboriginal and Torres Strait Islander representation (see Reform 1).*

The social and cultural determinants of health & well being

The social and cultural determinants of poor health and well being – such as poverty, poor education, poor housing, lack of nutrition, lack of meaningful employment and racism – have a powerful effect on the health of Aboriginal people. Two fifths (39%) of the gap in health is estimated to be due to these determinants [10].

A new CtG framework should align with the social and cultural determinants of health and wellbeing within the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (NATSIHP). There is now a significant amount of research around these determinants that could be used as a platform for determining the new targets. Congress has provided a detailed evidenced-based submission to the NATSIHP Implementation Plan recommending actions to address these determinants; this submission is attached (see accompanying paper) and provides more detailed evidence on many of the issues identified below.

The suggestions below for inclusion or expansion in the CtG reforms are aligned with these social determinants, and will cut across and support the four domains of the prosperity framework we understand is being proposed by PM&C. They are not exclusive and no doubt many more could be added. They are presented here to encourage discussion but selection of the actual targets and related indicators should be made only in partnership with the Aboriginal leadership (see *Reform 1* above).

Determinant 1: Empowerment, community control representation

Since the now famous Whitehall studies of the 1970s, 'the control factor' has been recognised as an important contributor to patterns of disease with the evidence showing that the less control people have over their lives and environment, the more likely they are to suffer ill health [11]. Powerlessness has been identified as a risk factor for disease in the Australian Aboriginal context [12].

Aboriginal peoples' lack of control of their lives is expressed at a national, systemic level through the lack of a national political representative institution; at a community level through their marginalisation from decision-making about programs that affect their own communities; and at an individual level through their experience of racism.

A national representative structure

Relative to their numbers, Aboriginal and Torres Strait Islander people are politically marginalized in Australia. The seventy years following Federation saw not a single First Nations representative elected to any Australian parliament, only ending in 1971 when Neville Bonner entered the Australian Senate. Since then only 38 Aboriginal and Torres Strait Islander people have been elected to any of the State, Territory or Federal parliaments; 22 of these have been in the Northern Territory. Even today, with an unprecedented four Aboriginal and Torres Strait Islander representatives in the national parliament, this represents only 1.8% of representatives when Aboriginal and Torres Strait Islander people make up 3% of the Australian population and rising.

This systemic under-representation of Aboriginal people is mirrored in senior decision-making roles within public services across Australia. It is a powerful contributor to the lack of an accountable, informed, and sustained approach to Aboriginal issues, and the limited success in reaching the CtG targets.

This is evidenced by the poor record of implementation of the recommendations of numerous inquiries into issues surrounding the health and wellbeing of the nation's First Peoples. Over the last three decades these have included most significantly the *National Aboriginal Health Strategy* (1989), the *Royal Commission Into Aboriginal Deaths In Custody* (1991) and the *Bringing Them Home* report (1997). There have also been many parliamentary inquiries into issues surrounding Aboriginal disadvantage [13].

A genuine commitment to 'closing the gap' would therefore include the establishment of a national representative body for Australia's First Nations, as recently recommended by the Referendum Council after extensive consultation with Aboriginal and Torres Strait Islander communities across Australia, along with a Makarrata Commission to supervise a process of agreement-making and truth-telling between governments and Aboriginal and Torres Strait Islander peoples. These changes, foreshadowed in the *Uluru Statement from the Heart,* have the support of the overwhelming majority of Aboriginal people and would provide the basis for substantive change in Aboriginal lives, as opposed to mere symbolic recognition.

Target / Indicators: Establishment of a national representative body for Australia's First Nations as recommended by the Referendum Council and captured in the Uluru Statement from the Heart *as a foundation for addressing marginalisation and disempowerment of Aboriginal and Torres Strait Islander peoples.*

Community empowerment through Aboriginal community controlled services

The establishment of Aboriginal community controlled health services (ACCHSs) from the 1970s onwards has been in response to mainstream health systems that have failed to meet the needs Aboriginal people and have contributed to the health gap. The ACCHS model links community empowerment, overcoming disadvantage, and improving health outcomes through the provision of health services [14].

ACCHSs embody an empowered model of service delivery that guarantees community input into decision-making and high levels of Aboriginal leadership across the organisation. The ACCHS sector employs almost 3,500 Aboriginal and Torres Strait Islander workers, making it the largest industry employer of Aboriginal and Torres Strait Islander people in Australia [8].

As well as employment, ACCHSs have governance structures that ensure community input into decision-making. Of PHC organisations receiving Commonwealth funding, almost all (99%) of ACCHSs have Boards composed fully or of a majority of Aboriginal and Torres Strait Islander people; by contrast three quarters (75%) of mainstream PHC organisations have no formal Aboriginal and Torres Strait Islander community input into decision making, having either no Board or no Aboriginal and Torres Strait Islander representation on a Board [9].

Increased investment in Australia and in the Northern Territory in PHC delivered through ACCHSs has led to significant improvements in Aboriginal and Torres Strait Islander health outcomes, particularly in the areas of child and maternal health and avoidable mortality (see Appendix for details).

Target / Indicators: Increased empowerment of Aboriginal communities in their own health care, measured by the number of Aboriginal Community Controlled Health services and funding levels (absolute and as a proportion of total primary health care funding) for Aboriginal Community Controlled Health services.

Racism

The experience of racism is overwhelmingly common for Aboriginal people and affects their physical, social and emotional wellbeing through the stress and other negative emotions it creates, or through the direct experience of racially-motivated violence, or through increased use of tobacco, alcohol and other drugs [15, 16].

Systemic racism within the health system, while often hidden to those operating those systems, further contributes to ill health by creating a barrier to access for Aboriginal people and through differential access to timely health procedures. For example, systemic differences in care provided by hospitals contribute to Aboriginal people's low level of trust for hospitals as institutions and the fact that Aboriginal people are many times as likely to take their own leave or leave hospital against medical advice or be discharged at their own risk compared to other Australians [17].

An important strategy to improve access to and quality of hospital services to the Aboriginal community is to universally establish and report on a set of national key performance indicators as a basis for Continuous Quality Improvement (CQI), to include:

- Discharge summary timeliness
- Rates of sentinel procedures disaggregated by Aboriginality
- Take Own Leave (TOL) and Leave Against Medical Advice (LAMA)
- Medication Dispensing
- Cultural Safety
- Employment of Aboriginal staff including Aboriginal staff in leadership positions
- Documented partnerships with local Aboriginal communities / organisations.

Target / Indicators: Reduced systemic racism in the mainstream hospital system, measured by a set of national key performance indicators including discharge summary timeliness; rates of sentinel procedures; Take Own Leave (TOL) and Leave Against Medical Advice (LAMA) rates; medication dispensing; cultural safety; employment of Aboriginal staff including in leadership positions; and documented partnerships with local Aboriginal communities / organisations.

Determinant 2: Tackling poverty

Risk factors for disease and illness are not evenly distributed across a society: the distribution of ill health in a population is strongly correlated with a social gradient, where those with lower incomes tend to be significantly sicker and die significantly earlier than those with higher incomes [18]. As well as absolute deprivation (poverty), relative deprivation (inequality) is related to higher infant and adult mortality rates, to reduced life expectancy, and to higher rates of illness [19].

Aboriginal people today continue to endure both poverty and inequality. Australia is a wealthy country with a Gross Domestic Product well above the OECD's average, but this wealth is not distributed evenly: on average, Aboriginal people receive a personal income that is only two-thirds that of the non-Indigenous population [20]. Aboriginal people use government income support such as the Newstart Allowance, the Parenting Payment and the Youth Allowance at disproportionally higher rates than non-Aboriginal people, and more so in remote communities [21]. These payments all fall below the poverty line [22].

Therefore, any policies which increase poverty or increase the gap between rich and poor, such as reductions in government income support, will affect Aboriginal people disproportionately, drive poorer health and wellbeing outcomes and work to widen rather than close the gap. Global government policies to reduce poverty must therefore be seen as important contributors to closing the gap in health outcomes.

Target / Indicators: Reduced poverty amongst Aboriginal individuals and households, measured by median household and personal income, use of citizenship entitlements in the form of income support, and unemployment rates.

Determinant 3: Strengthening culture and language

Fundamental to the gap between Aboriginal and non-Aboriginal people are the historical and ongoing impacts of colonisation such as dispossession from Country, racism, and the forcible removal of children from their families. The combined impact of these social forces is intergenerational trauma, which manifests as high rates of suicide, poor mental health and social and emotional wellbeing including panic attacks, anxiety, sleep disturbance, severe obesity; smoking, illicit drug use, and misuse of alcohol [23-25].

Conversely, culture plays a major role in enhancing the resilience of Aboriginal families and communities. Language is central to culture, identity and attachment to place. Past policies of Australian governments have contributed to the loss of language and culture in many Aboriginal communities. According to the National Aboriginal and Torres Strait Islander Social Survey, 11% of Aboriginal and Torres Strait Islander people spoke an Australian Indigenous language as their main language at home and 20% of Aboriginal and Torres Strait Islander people can speak some words of an Australian Indigenous language.

Retention and knowledge of Aboriginal languages is integral to better health outcomes (e.g. reduced smoking rates in teens), school retention, educational attainment, literacy, and reduces in antisocial behaviour and there is now a role for governments to support communities re-establish and teach language to their children, particularly when long standing social problems diminishes the capability of a community to be able to do so for itself [26].

Target / Indicators: Increased proportion of Aboriginal people reporting that they speak an Aboriginal language.

Determinant 4: Early childhood development

Social and environmental influences in early childhood shape health and wellbeing outcomes across the life course. Adverse childhood experiences are highly correlated to a wide range of physical health problems, as well as to increased levels of depression, suicide attempts, sexually transmitted infections, smoking, and alcoholism [27].

Aboriginal children, particularly in remote areas, are much more likely to be developmentally vulnerable than non-Aboriginal children. According to the 2015 Australian Early Development Census, 41% of Aboriginal children were developmentally vulnerable on one or more domains, double the rate (22%) of all Australian children.

It is too late to wait until a child is ready for school at around age five to address vulnerabilities in development, as by this point many developmental gateways have been passed, and a child's developmental trajectory already set. After this point, interventions while necessary require increasing amounts of resources and produce diminishing returns as the child gets older [28].

Well-designed, evidence-based early childhood development programs are a highly cost-effective intervention to address and offset the effects of poor early childhood experience. There is very strong evidence that such programs can lower the risk of chronic disease; reduce the use of alcohol and other substances by young adults; increase school retention rates; and dramatically reduce youth incarceration rates. This evidence has been collated, developed and championed by the Nobel Laureate, Prof James Heckman (https://heckmanequation.org/)

Investments in early childhood development are also a corner-stone for economic development and productivity with the Organisation for Economic Co-operation and Development (OECD) has advised that investing in early childhood is the single most important thing Australia can do to grow its economy and be competitive in the future [29, 30]

Access to quality Early Childhood Development services for Aboriginal families is therefore critical to addressing this disparity and the long term determinants of health and well-being.

Target / Indicators: Increased participation of Aboriginal children aged 0 to 5 in evidence-based early learning programs; tracking of Australian Early Development Census results for Aboriginal / non-Aboriginal children at a regional level.

Determinant 5: Increasing educational attainment

School education

Notwithstanding early childhood development (see above) and the importance of adult literacy to support children's engagement in school (see below), the education system has a responsibility to improve educational engagement and results in schools for Aboriginal children.

All schools should implement evidenced-based teaching to achieve student outcomes and quality improvement. Targeted teaching using data and individual student plans has been shown to be one of the most powerful teaching strategies to improve student progress. It requires teachers to identify learning needs of individual students and adapt

their teaching, track individual student's progress and provide feedback or more support [31].

Properly resourced and adapted for the Aboriginal context, schools that have children on individual learning plans with appropriate support services are able to make a significant difference to learning outcomes even when children begin school developmentally vulnerable on a number of domains in the AEDC scores [32]

Standardised tests, such as NAPLAN, have a role in assessing student learning. NAPLAN however is primarily designed to provide high level information about student learning to make school performance more transparent and to inform policy at a school, system, state and national levels, though it is not refined enough to make decisions around improving learning outcomes [31]. Further, if children are not achieving basic literacy and numeracy skills by year 3, they are unlikely to improve significantly by year 7 or year 9 without significant investments. Hence NAPLAN as an ongoing measure beyond Year 3 is unlikely to show gains in CtG targets.

Last, NAPLAN does not measure how children are progressing on a range of attributes that will engage them and keep them at school, and to be confident and successful students e.g. social and emotional wellbeing, physical development, sense of identity and cultural safety, creativity, and positive relationships. A broader range of assessment programs are required to ensure that Aboriginal children are progressing and improving and evaluating what works. The right data could be used to inform practice and to continuously improve performance of schools [33].

Targets in education services should ensure that all children are developmentally equal by age 7 or year 2 (similar to Canada). This would require annual follow up of all the children identified as developmentally vulnerable in the Australian Early Development Census.

Finally, success at school can be measured by the number of Aboriginal school leavers graduating from year 12, and then completing higher education including TAFE and university.

Target / Indicators: Improved school education outcomes for Aboriginal children and young people, measured by AECD scores; NAPLAN up to year 3 for basic writing and literacy supplemented by detailed performance measures through a broader range of assessments for high school; Year 12 attainment; and numbers of Aboriginal people completing higher education including TAFE.

Adult literacy

Literacy levels among Aboriginal adults in Australia are significantly lower than those in the non-Aboriginal population. While there has been no national-level attempt to measure literacy levels in the Aboriginal community, evidence from various sources suggests that at least 35% of the Aboriginal and Torres Strait Islander adult population have minimal English language literacy, with the figure rising much higher in rural and remote areas such as in much of the Northern Territory [34]

Improving adult literacy is critical to addressing the drivers of disadvantage, social inequality, poverty, poor school performances, and incarceration. It is also fundamental to developing 'literacy practices' (reading, writing, interpreting text) within families, which then support children to engage and perform well at school. While adult literacy

courses delivered through formal education providers may be successful with individuals, they are unable to reach a large enough number of people to have a population level effect on literacy. An alternative approach being implemented in Aboriginal communities of Western NSW by the Literacy for Life Foundation is the mass campaign model, which uses local leaders and literacy facilitators to help adults in the community to achieve a basic level of English language literacy proficiency and build a culture of community literacy to support everyone, adults and children, to value learning [35].

Target / Indicators: Closing the Gap in adult literacy rates, measured by adult literacy rates and access to / enrolment in adult literacy courses or campaigns.

Determinant 6: Better housing

Poorly designed, inadequately maintained and overcrowded housing is a common feature of many Aboriginal communities, especially in remote areas. Overcrowding and poor living conditions have a wide range of health, social and well being consequences including:

- poorer physical and developmental outcomes for children [36] and decreased school attendance [37];
- mental health issues such as depression, anxiety and suicide [38]. The social stress associated with over-crowding may also be a contributor to family and sexual violence [39, 40];
- communicable diseases, including bacterial ear infections and scabies, Rheumatic Heart Disease, and bronchiectasis [39];
- exposure of the family to tobacco smoke, with increased risk of respiratory disease and (for children and babies), heightened risk of Sudden Infant Death Syndrome, asthma, and ear infections [41]
- exposure to smoke and dust associated with a range of respiratory and other conditions, particularly in children [42].

Over the last decade, additional government investment in housing through programs such as the National Partnership Agreement on Remote Indigenous Housing (NPARIH) has reduced housing overcrowding in Aboriginal Australia. Nevertheless the housing situation for Aboriginal communities remains very poor, particularly in remote areas and in the Northern Territory. In 2008, nearly three in every five (57%) Aboriginal Territorians were living in overcrowded houses[2]; this has improved but still over half (52%) were in overcrowded houses in 2014 [21].

While government has increased investment in remote housing, there has been a reduction in urban public housing stock – in the Northern Territory, in the twelve years to 2014-15, there was a 12% decline in the number of public housing dwellings available for low-income families [43]. Homelessness is a significant problem for Aboriginal people across the country.

Target / Indicators: Reduced overcrowding in housing for Aboriginal families, measured by overcrowding rates at a regional level.

[2] Overcrowded houses are houses where one or more additional bedrooms are required.

Determinant 7: Reducing youth incarceration rates

Aboriginal young people are held in criminal detention at much higher rates than non-Aboriginal young people, with around one half of young people in detention at any point in time are Aboriginal [44].

Prevention approaches, and those that divert young offenders away from detention, are the most important strategies to deal long-term with the issue of youth detention. For Aboriginal young people, diversion programs have been shown to lead to reduced drug and substance use and reoffending, especially if programs include culturally appropriate treatment and rehabilitation and Aboriginal and community Elders or facilitators (Closing the Gap Clearinghouse, AIHW & AIFS, 2013).

For that small number of young people where detention is necessary, the focus should be on therapeutic treatment in smaller residential units rather than punishment in large institutions. Such an approach has been shown to achieve exceptional reductions in juvenile recidivism [45].

The recommendations of the *Royal Commission into the Protection and Detention of Children in the Northern Territory* should be implemented as soon as possible, in collaboration with Aboriginal Community Controlled Services.

Target / Indicators: Reduced numbers of Aboriginal young people in criminal detention, measured in absolute numbers and as a proportion of all young people in detention.

Determinant 8: Reducing the impact of alcohol

Harmful alcohol consumption is associated with a wide range of health problems for the drinker (such as liver disease, high blood pressure, stroke, and some cancers), as well as more short-term health threats to both the drinker and those around them (including injuries from traffic accidents, assault and family violence, and self-harm). It also contributes to other social problems such as crime, violent anti-social behaviour, increased levels of incarceration, family breakdown, unemployment and impoverishment.

The three pillars of alcohol harm minimisation that are the basis of national approaches to reducing alcohol-related harm in Australia are [46]:

- *Demand Reduction*: strategies to prevent the uptake of alcohol use, delay the first use of alcohol, and reduce the harmful use of alcohol in the community. It includes supporting people to recover from dependence and re-integration with the community.
- *Supply Reduction*: strategies to control, manage or regulate the supply of alcohol.
- *Harm Reduction*: strategies that aim to reduce the negative outcomes from alcohol use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.

Of these , there is incontrovertible evidence that increasing the price of alcohol, and particularly that of cheap alcohol, reduces consumption and alcohol related harm; it is also a highly cost effective intervention [47]. Introduction of a floor price for alcohol is particularly effective in reducing alcohol consumption and related harms most amongst disadvantaged populations and young people [48].

Target / Indicators: Reduced population level alcohol-related harms, measured by a range of regional indicators including (reported separately by Aboriginality where possible) apparent per capita consumption; hospital separations for selected acute and chronic alcohol-related conditions; Alcohol-related deaths; proportion of alcohol consumed at risky and high-risk levels; proportion of the population drinking at risky and high-risk levels; and estimated acute and chronic hospital separations attributed to risky and high-risk drinking.

APPENDIX

The effectiveness of primary health care delivered through Aboriginal Community Controlled Health Services

Three sets of evidence support continued and expanded investment in comprehensive primary health care (PHC) delivered through Aboriginal Community Controlled Health Services (ACCHSs) as a key strategy to improving Aboriginal and Torres Strait Islander health and wellbeing:

- population-level evidence about the importance of PHC, and the factors that make it effective, mainly from overseas but supported by consistent evidence within Aboriginal and Torres Strait Islander Australia;
- service or sector-level evidence from within Australia about the effectiveness of ACCHSs in relation to Aboriginal and Torres Strait Islander health and wellbeing; and
- evidence from the social and cultural determinants of health.

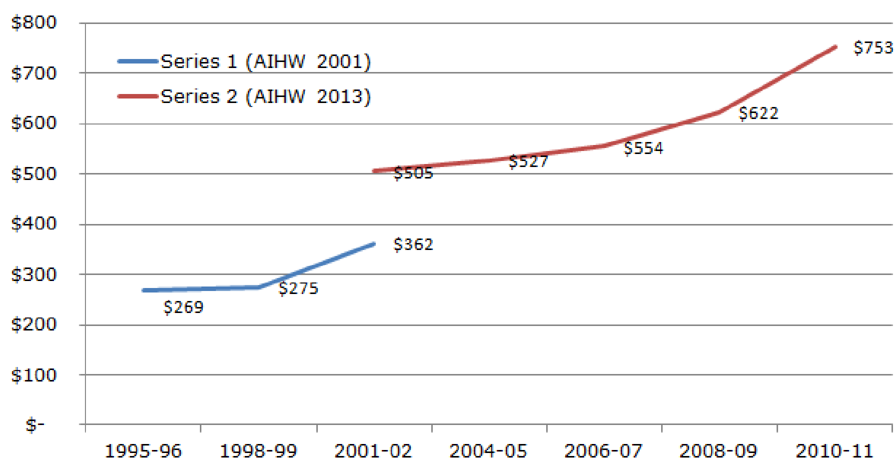
Population-level evidence on the importance of PHC

1. The social determinants of ill-health such as inequality; poverty; lack of access to education and employment; and social exclusion and racism exert a powerful effect on the health and wellbeing of all peoples [18].
2. However, health care – and particularly primary health care – can offset the harmful health effects of the social determinants of health. The international evidence is clear that stronger primary health care systems are associated with:
   - better population health outcomes, especially relating to maternal and child health as measured by low birth weight and infant mortality [49] and to lower mortality rates including from heart disease, kidney disease and cancer [50, 51];
   - more equally distributed health outcomes across a population, a finding especially significant where 'closing the gap' in health outcomes is a priority [52];
   - lower hospitalisation rates for conditions managed by or prevented by PHC, including especially chronic conditions which currently account for about 80% of the health gap between Aboriginal and non-Aboriginal Australians [53]; and
   - lower national health care costs and greater economy in resource use [49, 52].
3. Particular features of primary health care systems and the policies that underpin them are critical to their effectiveness. These features include: universal financial coverage under government control or regulation; equitable distribution of resources; a comprehensive model of service delivery; and low or no co-payments for access to care [52]. The ACCHSs service model embodies these principles, and closely aligns with the most effective, evidence based international systems of PHC.
4. The picture in Aboriginal and Torres Strait Islander Australia is consistent with the international evidence, as the following demonstrates.

Increased investment in PHC delivered by the ACCHS sector

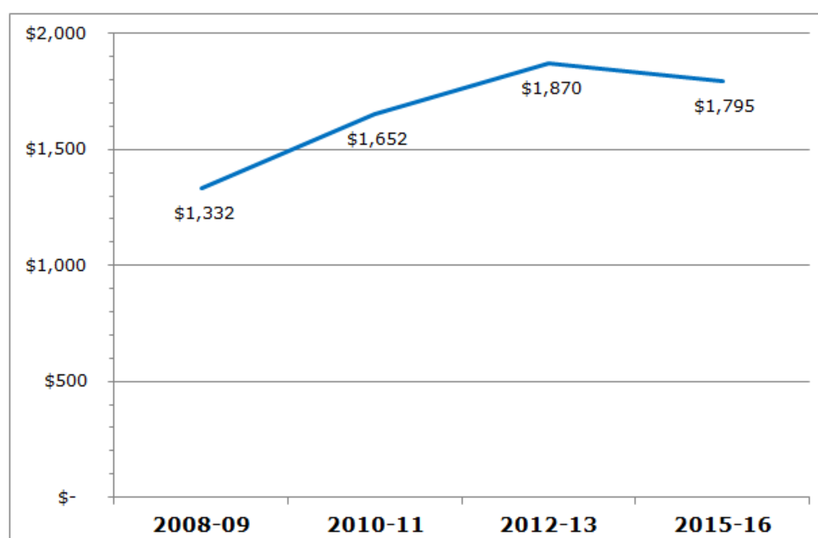
5. The 1995 transfer of responsibility for Aboriginal and Torres Strait Islander primary health care from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health was a critically important reform. Beginning under the leadership of the former Federal Coalition Minister for Health, Dr Michael Wooldridge (1996-2001) and continuing thereafter, this reform led to increases in national funding for PHC directed through ACCHSs (see *Figure 1*).

Figure 2: National Commonwealth funding of ACCHS, 1995-96 to 2010-11, $ per Indigenous person (constant prices) [54, 55]



6. Unfortunately the gains described below flowing from this increased investment are now under threat, with per capita Indigenous specific funding for public and community health services (excluding subsidies) falling in recent years (see Figure 3 noting that this is a different, though related funding measure to that in Figure 2).

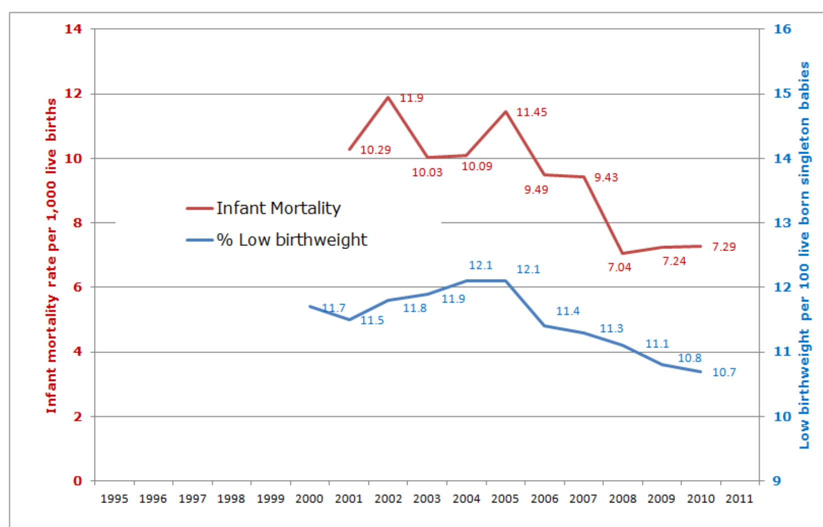
Figure 3: All Government Indigenous specific direct expenditure on Aboriginal and Torres Strait Islander Australians ($ per person), 2008-09 to 2015-16 (2015-16 dollars)



Population health outcomes

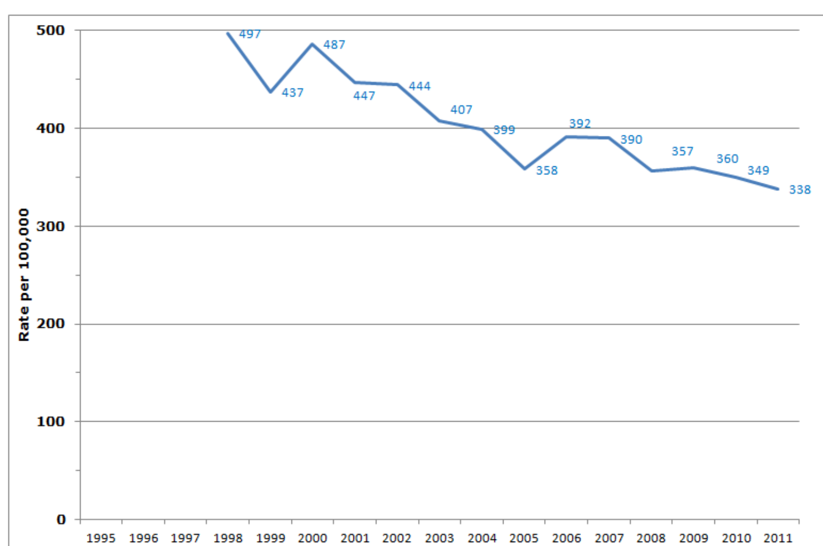
7. Low birth weight and infant mortality rates in the Aboriginal and Torres Strait Islander community have declined significantly over the period of increased investment in PHC delivered through the ACCHS sector.

Figure 4: Aboriginal and Torres Strait Islander infant mortality and low birth weight rates, 1995 to 2011 [56, 57]



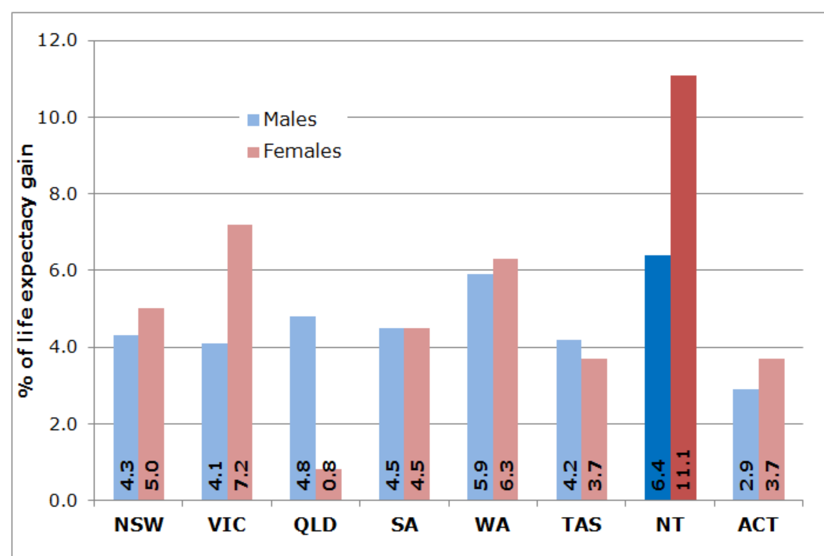
8. Mortality rates for avoidable conditions for Aboriginal and Torres Strait Islander people have also fallen significantly over this period.

Figure 5: Age-standardised avoidable mortality rates for Aboriginal and Torres Strait Islander people, 1995 – 2011 [58]



9. As well as the national evidence, there is powerful data from the Northern Territory, where the gains in life expectancy over the twenty years from 1995 are disproportionately concentrated amongst infants (aged less than 1 year) (Figure 6). These above average falls in infant mortality are consistent with the increased investment in PHC delivered through ACCHSs because, compared to other jurisdictions, the ACCHS sector provides a significantly greater proportion of the NT's primary health care.

Figure 6: Proportion of life expectancy gain for infants, 1995 to 2015, by state / territory [59]



10. While formal research to confirm the link is needed, what the publicly available data shows is clearly consistent with the international evidence: increased investment in Australia and in the Northern Territory in PHC delivered through ACCHSs has led to significant improvements in Aboriginal and Torres Strait Islander health outcomes, particularly in the areas of child and maternal health and avoidable mortality.

Evidence within Australia about the effectiveness of ACCHSs

11. Assessing the effectiveness of ACCHS in comparison to mainstream primary health care is hampered by the fact that the ACCHS service population has significantly more complex health needs and is more likely to live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge.

12. In addition, unlike mainstream general practice, the comprehensive model of PHC offered by ACCHSs goes beyond the treatment of individual clients for discrete medical conditions to include a focus on cultural security; patient transport; patient advocacy; population health programs including health promotion and prevention; public health advocacy and inter-sectoral collaboration; participation in health planning processes; structures for community engagement and control; and significant employment of Aboriginal and Torres Strait Islander people.

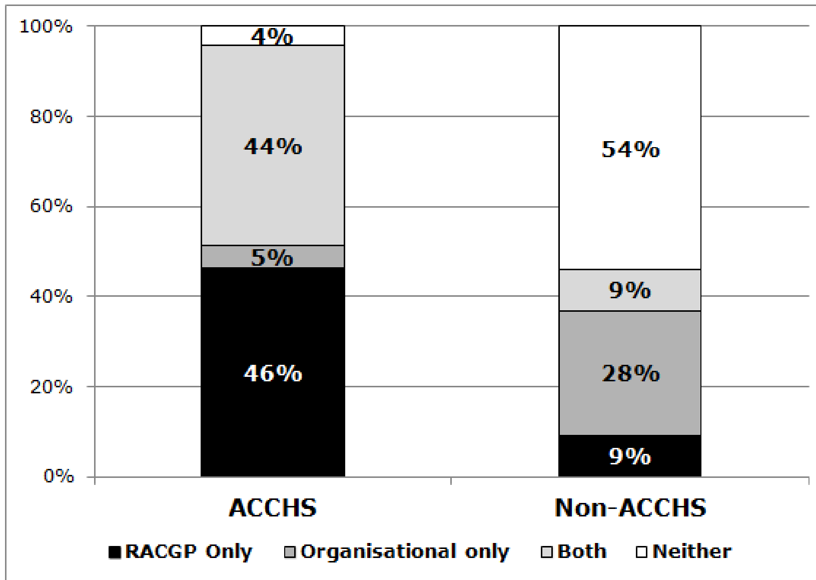
13. Despite the difficulty of the comparison, the evidence shows that within Australia:

    - ACCHSs contribute significantly to improved health outcomes through reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birth weight [4] – see also *Figures 1, 2 and 3* above and accompanying text.

    - ACCHS are more effective in delivering outcomes than mainstream PHC, achieving comparable outcomes, but with a more complex caseload [60];

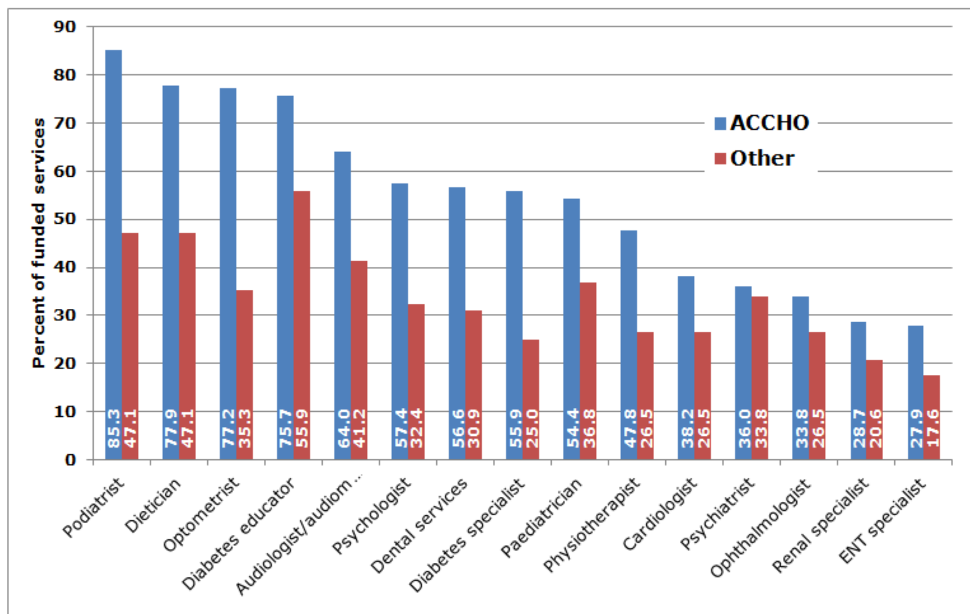
- ACCHSs perform better on clinical best practice than mainstream services [5]. Driven by their focus on Continuous Quality Improvement (CQI), this is reflected in much higher rates of accreditation against RACGP or other standards such as ISO. Almost all (96%) of ACCHSs receiving Commonwealth PHC funding are accredited compared to less than half for non-ACCHS organisations (46%).

Figure 7: Proportion of Commonwealth funded PHC services, by accreditation status and type [9][3]



- ACCHSs are more effective in supporting the delivery of specialist and allied health services, providing integrated, co-located services to, for example, manage chronic disease in the community[6].

Figure 8: Proportion of primary health-care organisations providing onsite specialist services, 2015-16 [9]



[3] Figures may not sum to 100% due to rounding.

- ACCHSs are significantly more cost effective, with a major study concluding that: *up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [7].*

14. Aboriginal and Torres Strait Islander people show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes [7, 8]. The capacity of ACCHS to deliver culturally safe care is fundamental to this preference, which in turn is founded upon formal processes that guarantee Aboriginal community input into the design and delivery of services (see *Addressing the 'control factor'* below)

Evidence from the social and cultural determinants of health

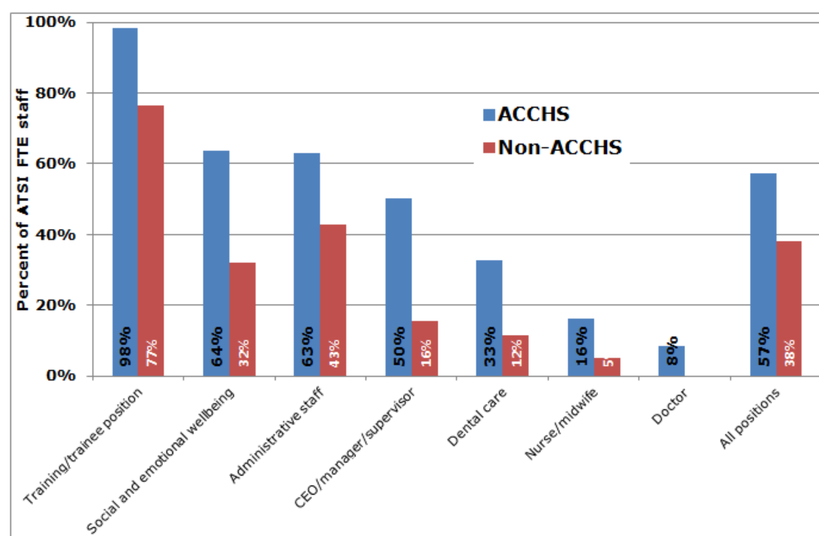
15. It is estimated that between one-third and one-half of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is the result of the social determinants of health, particularly relating to socio-economic status [10]. The ACCHS sector addresses the social determinants of health is ways that other sectors are unable to do, through the following factors.

Aboriginal and Torres Strait Islander employment

16. The ACCHS sector employs almost 3,500 Aboriginal and Torres Strait Islander workers, making it the largest industry employer of Aboriginal and Torres Strait Islander people in Australia [8]. This is in a context where the health and social care sector employs 15% of the total Aboriginal and Torres Strait Islander workforce; almost four times as many as the mining industry (4%) [61].

17. ACCHSs are significantly more effective in employing Aboriginal and Torres Strait Islander people than government or mainstream NGOs – overall 57% of the Commonwealth-funded ACCHS PHC workforce is Indigenous, compared to only 38% in non-ACCHS organisations. Particularly significant is the much greater commitment of ACCHS organisations to employing Aboriginal and Torres Strait Islander people in training positions, and in leadership roles such as CEOs, managers or supervisors.

Figure 9: Proportion of Aboriginal and Torres Strait Islander FTE staff, by selected position type and organisation type, 2015–16 [9]

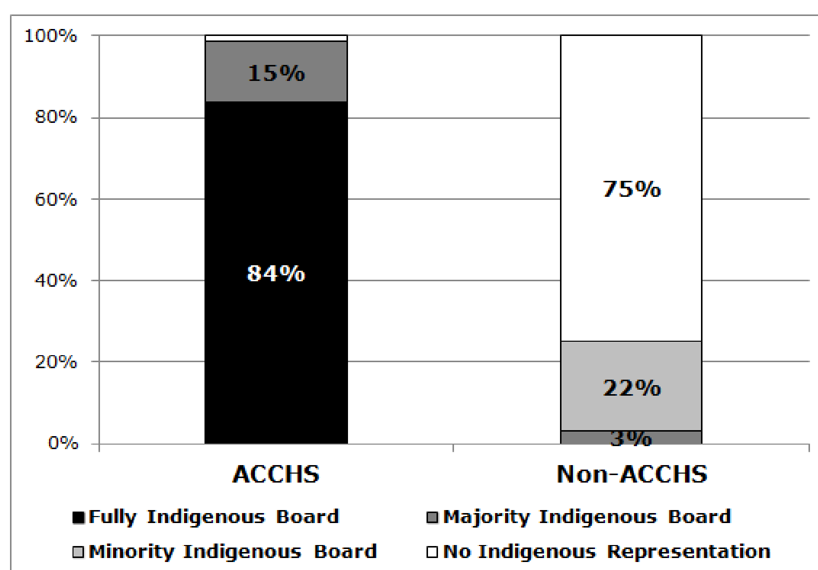


Addressing the 'control factor'

18. The less control people have over their lives and environment, the more likely they are to suffer ill health [11] and powerlessness has been shown to be a risk factor for disease in the Australian Indigenous context [62].

19. ACCHSs embody an empowered model of service delivery that guarantees community input into decision-making and high levels of Aboriginal leadership across the organisation. As well as employing much higher numbers of Aboriginal and Torres Strait Islander people, including in in leadership positions, ACCHSs have governance structures that ensure community input into decision-making. Of PHC organisations receiving Commonwealth funding, 99% of ACCHSs have Boards composed fully or of a majority of Aboriginal and Torres Strait Islander people; by contrast 75% of non-ACCHS organisations have no Aboriginal and Torres Strait Islander formal community input into decision making, either having no Board, or no Aboriginal and Torres Strait Islander representation on a Board (see Figure 7).

Figure 10: Proportion of Commonwealth funded PHC organisations by Board composition and type, 2015-16 [9]



Advocacy on the broader social determinants of health

20. ACCHSs were formed by Aboriginal communities from the 1970s onwards with a dual role as both service delivery organisations and advocates for addressing the broader social determinants of health driving poor health and wellbeing advocates, including the experience of racism both within and outside mainstream health services.

21. In the years since, the ACCHS sector has continued to work at all levels to address the health and social effects of the social determinants of health, including racism and social exclusion, housing, access to land and out-stations, and availability of alcohol and other drugs.

22. The ACCHS sector has also been a key advocate for collaborative health system planning which is key to developing a strategic approach to closing the gap in health and wellbeing.

Notes

1. Steering Committee for the Review of Government Service Provision, *2017 Indigenous Expenditure Report*, P. Commission, Editor. 2017: Canberra.
2. Senate Finance and Public Administration References Committee, *Commonwealth Indigenous Advancement Strategy tendering processes*. 2016, Parliament of Australia: Canberra.
3. Schokman B and Russel L, *Moving beyond recognition: respecting the rights of Aboriginal and Torres Strait Islander Peoples*. 2017, Oxfam Australia.
4. Dwyer J, Silburn K, and Wilson G, *National Strategies for Improving Indigenous Health and Health Care*. 2004, Commonwealth of Australia: Canberra.
5. Panaretto K S, et al., *Prevention and management of chronic disease in Aboriginal and Islander Community Controlled Health Services in Queensland: a quality improvement study assessing change in selected clinical performance indicators over time in a cohort of services.* BMJ Open, 2013. **3**(4).
6. Thompson S, et al., *Effective primary health care for Aboriginal Australians*. 2013, University of Western Australia: Perth.
7. Vos T, et al., *Assessing Cost-Effectiveness in Prevention (ACE–Prevention): Final Report*. 2010, ACE–Prevention Team: University of Queensland, Brisbane and Deakin University: Melbourne.
8. National Aboriginal Community Controlled Health Organisation (NACCHO), *Economic Value of Aboriginal Community Controlled Health Services*, in *Unpublished paper*. 2014, NACCHO: Canberra.
9. Australian Institute of Health and Welfare (AIHW), *Aboriginal and Torres Strait islander health organisations: Online Services Report — key results 2015–16*. 2017, AIHW: Canberra.
10. Australian Health Ministers Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Editor. 2017, Commonwealth of Australia: Canberra.
11. Marmot M, Siegrist J, and Theorell T, *Health and the psychosocial environment at work*, in *Social determinants of health*, Marmot M and Wilkinson R, Editors. 2006, Oxford University Press: Oxford.
12. Tsey, K., et al., *Empowerment and Indigenous Australian health: a synthesis of findings from Family Wellbeing formative research.* Health Soc Care Community, 2010. **18**(2): p. 169-79.
13. Aboriginal and Torres Strait Islander Peak Organsations, *The Redfern Statement*. 2016: Sydney.
14. Panaretto K S, et al., *Aboriginal community controlled health services: leading the way in primary care.* Med J Aust, 2014. **200**(11): p. 649-52.
15. Paradies Y, *A Systematic Review of Empirical Research on Self-reported Racism and Health.* International Journal of Epidemiology, 2006. **35**(4): p. 888-901.
16. Ferdinand A, Paradies Y, and M. Kelaher, *Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey*. 2012, The Lowitja Institute: Melbourne.
17. Cunningham J, Cass A, and Arnold P C, *Bridging the treatment gap for Indigenous Australians. Demands for efficiency should not be met at the expense of equity.* Med J Aust, 2005. **182**(10): p. 505-6.
18. Wilkinson, R. and M. Marmot, eds. *The Social Determinants of Health The Solid Facts*. 2003, World Health Organization.
19. Baum F, *The new public health (third edition)*. 2nd ed. 2007, Oxford: Oxford Univeristy Press.
20. Australian Bureau of Statistics (ABS). *Census 2016: what's changed for Indigenous Australians?* 2017; Available from: https://theconversation.com/census-2016-whats-changed-for-indigenous-australians-79836.

21. Australian Bureau of Statistics (ABS). *4714.0 - National Aboriginal and Torres Strait Islander Social Survey, 2014-15*. 2016 2 February 2017]; Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02014-15?OpenDocument#Publications.
22. Australian Council of Social Services (ACOSS), *Poverty in Australia 2016*. 2016, ACOSS: Strawberry Hills.
23. Dudgeon P, et al., *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people*. 2014, Produced for the Closing the Gap Clearinghouse. Australian Institute of Health and Welfare / Australian Institute of Family Studies: Canberra / Melbourne.
24. Wall L, Higgins D, and Hunter C, *Trauma-informed care in child/family welfare services*. 2016, Australian Institute of Family Studies: Melbourne.
25. Atkinson J, *Trauma-informed services and trauma-specific care for Indigenous Australian children*. 2013, Australian Institute of Health and Welfare & Australian Institute of Family Studies: Canberra / Melbourne.
26. Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Our Land Our Languages*. 2012, Australian Parliamnent (House of Representatives): Canberra.
27. Anda R F and Felitti V J. *Adverse Childhood Experiences and their Relationship to Adult Well-being and Disease: Turning gold into lead*. The National Council Webinar, August 27, 2012 2012 [cited 2016 22 March 2016]; Available from: http://www.thenationalcouncil.org/wp-content/uploads/2012/11/Natl-Council-Webinar-8-2012.pdf.
28. Ramey C T and Ramey S L, *Early learning and school readiness: Can early intervention make a difference?* Merrill-Palmer Quarterly, 2004. **50**(4): p. 471-491.
29. The Equality Trust. *Childhood*. 2016 28 April 2016]; Available from: https://www.equalitytrust.org.uk/childhood.
30. Hutchens, G., *OECD: G20 commitment to boost GDP by 2 per cent in doubt*, in *The Age*. 2016.
31. Goss P and Hunter J, *Targeted teaching : how better use of data can improve student learning*. 2015, Grattan Institute: Carlton
32. Milligan L, *Melbourne school uses neuroscience to boost grades and improve wellbeing of students*, in *ABC News Online 1 September 2015*. 2015, ABC.
33. Dreise T. *Closing the gap: Indigenous students and NAPLAN*. 16 March 2016; Available from: https://rd.acer.org/article/closing-the-gap-indigenous-students-and-naplan.
34. Boughton B, *Popular Education for Literacy & Health Development in Indigenous Australia.* Australian Journal of Indigenous Education, 2009. **38**: p. 103 - 108.
35. Boughton B, et al., *An Aboriginal Adult Literacy Campaign in Australia using Yes I Can.* Literacy and Numeracy Studies, 2011. **21**(1): p. 5-32.
36. Dockery A M, et al., *Housing and children's development and wellbeing: evidence from Australian data,* . 2013, Australian Housing and Urban Research Institute Melbourne.
37. Silburn S, et al., *Unpacking Educational Inequality in the Northern Territory*, in *Research Conference 2014: Qulaity and Equity*. 2014.
38. Reeves A, et al., *Reductions in the United Kingdom's Government Housing Benefit and Symptoms of Depression in Low-Income Households.* American Journal of Epidemiology, 2016. **184**(6): p. 421-429.
39. Bailie R S and Wayte K J, *Housing and health in Indigenous communities: key issues for housing and health improvement in remote Aboriginal and Torres Strait Islander communities.* Aust J Rural Health, 2006. **14**(5): p. 178-83.
40. Wild R and Anderson P, *Little Children are Sacred: Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*. 2007, Northern Territory Government: Darwin.

41. Thomas D P and Stevens M, *Aboriginal and Torres Strait Islander smoke-free homes, 2002 to 2008.* Australian and New Zealand Journal of Public Health, 2014. **38**(2): p. 147-153.
42. Clifford H D, et al. *Environmental health challenges in remote Aboriginal Australian communities: clean air, clean water and safe housing*. Australian Indigenous HealthBulletin 15(2) 2015; Available from: http://healthbulletin.org.au/articles/environmental-health-challenges-in-remote-aboriginal-australian-communities-clean-air-clean-water-and-safe-housing.
43. NT Shelter, *NT Shelter Housing Factsheets - Ten Year Housing Affordability Report Card*. 2016, NT Shelter: Darwon.
44. Australian Institute of Health and Welfare (AIHW), *Youth detention population in Australia 2015*. 2015, Canberra: AIHW.
45. McGinness A and McDermott T, *Review of Effective Practice in Juvenile Justice: Report for the Minister for Juvenile Justice*. 2010, Noetic Solutions Pty Limited: Manuka, ACT.
46. Australian Government. *Draft National Drug Strategy 2016-2025*. 2015; Available from: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/draftnds.
47. Babor T and Caetano R, *Alcohol: no ordinary commodity*. 2010, Oxford: Oxford University Press.
48. Stockwell T, et al., *Does minimum pricing reduce alcohol consumption? The experience of a Canadian province.* Addiction, 2012. **107**(5): p. 912-920.
49. Starfield, B. and L. Shi, *Policy relevant determinants of health: an international perspective.* Health Policy, 2002. **60**(3): p. 201-218.
50. Shi, L., et al., *Primary care, race, and mortality in US states.* Social Science & Medicine, 2005. **61**: p. 65-75.
51. Shi, L., et al., *The relationship between primary care, income inequality, and mortality in US States, 1980-1995.* J Am Board Fam Pract, 2003. **16**(5): p. 412-22.
52. Starfield B, *Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012.* Gac Sanit, 2012. **26 Suppl 1**: p. 20-6.
53. Ansari Z, Laditka J N, and Laditka S B, *Access to health care and hospitalization for ambulatory care sensitive conditions.* Med Care Res Rev, 2006. **63**(6): p. 719-41.
54. Australian Institute of Health and Welfare (AIHW), *Expenditures on health services for Aboriginal and Torres Strait Islander people 1998–99*. 2001, Australian Institute of Health and Welfare and Commonwealth Department of Health and Aged Care: Canberra.
55. Australian Institute of Health and Welfare (AIHW), *Expenditure on health for Aboriginal and Torres Strait Islander people 2010–11*, in *Health and welfare expenditure series no. 48*. 2013, AIHW: Canberra.
56. Australian Institute of Health and Welfare (AIHW), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. 2010, AIHW: Canberra.
57. Australian Institute of Health and Welfare (AIHW), *Birthweight of babies born to Indigenous mothers*, in *Cat. no. IHW 138*. 2014, AIHW: Canberra.
58. Australian Health Ministers Advisory Council (AHMAC). *Aboriginal and Torres Strait Islander Health Performance Framework 2017: Online data tables*. 2017; Available from: https://www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents/summary.
59. Australian Bureau of Statistics (ABS). *Life Tables, States, Territories and Australia, 2014-2016* 2017; Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/3302.0.55.001Feature%20Article12014-2016?opendocument&tabname=Summary&prodno=3302.0.55.001&issue=2014-2016&num=&view.

60. Mackey P, Boxall M, and Partel K, *The relative effectiveness of Aboriginal Community Controlled Health Services compared with mainstream health service*, in *Deeble Institute Evidence Brief*. 2014, Deeble Institute for Health Policy Research; Australian Healthcare and Hospitals Association.
61. The Asutralia Institute. *Is the mining industry the largest Indigenous employer?* . 2013; Available from: http://www.factsfightback.org.au/is-the-mining-industry-the-largest-indigenous-employer-check-the-facts/.
62. Tsey, K., et al., *Social determinants of health, the 'control factor' and the Family Wellbeing Empowerment Program.* Australasian Psychiatry, 2003. **11**(3 supp 1): p. 34–39.