

PUBLIC REPORT CARD 2003

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH TIME FOR ACTION

One year after the release of the AMA's first report card on Aboriginal and Torres Strait Islander health not much has changed.

The 2003 AMA Report Card presents new information about the health of Aboriginal and Torres Strait Islander people.

Recent data confirm Indigenous people are admitted to hospital at twice the rate of non Indigenous people. This group suffers much higher rates of renal disease, diabetes, injury and poisoning than the rest of the Australian community.

This Report Card updates estimates of the funding needed to ensure all Indigenous people get access to essential health care. While funding has increased, it does not meet the demand for primary health care, prevention and the training of additional health workers.

Government policy is moving in the right direction, but this must urgently translate into expanded services and training.

Broader changes in life opportunities are also needed to ensure that the current health problems are substantially improved.

The AMA has already highlighted major problems of access to primary health care for many Aboriginal and Torres Strait Islander communities. Similar developed countries which have made a substantial investment in primary health care have been able to improve the health of their Indigenous peoples.

The AMA remains ready to work with Indigenous communities and all governments.

Progress is possible: concerted action is needed now.



Dr Kerryn Phelps
AMA Federal President



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Health Status

Introduction

The 2002 AMA Public Report Card on Indigenous Health highlighted statistics for Indigenous Australians, which are significantly worse than those for the rest of the population. This information is included at the back of this document.

Statistics on comparative mortality rates will be updated when reliable trend data is available as year to year variations in mortality are difficult to interpret reliably.

Hospital separation rates/ratios
Admissions and separations provide a measure of the extent of hospitalisation

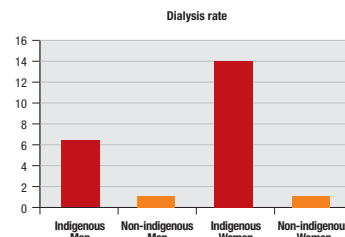
For 1999/2000 hospital separations data¹ confirm the 2002 report that Indigenous Australians are approximately twice as likely to be hospitalised as non-Indigenous people. Examples of specific diagnoses are:

For care involving **dialysis**, hospital separation rates were 6.4 times higher for Indigenous men and 14 times for women.

For **endocrine disease**, hospital separation rates were 4.2 times the rate for non-Indigenous people.

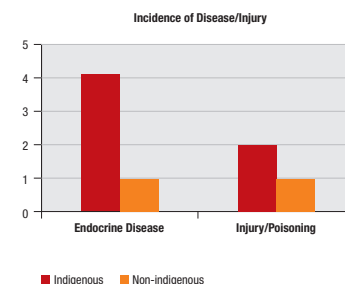
For **injury/poisoning**, the rates remain approximately double those of non-Indigenous Australians.

Such rates are likely, if anything to understate the true differences.



National Health Survey

In the National Health Survey, 11% of Indigenous people reported having diabetes compared to 3% of non-Indigenous people. In relation to injury/poisoning, 17% of Indigenous females, aged 15–24 years reported a condition as the result of an injury or accident compared to 9% of non-Indigenous females.⁶



Health Services and Service Delivery

Hospitals

The 2001 National Health Survey indicates that twice as many Indigenous Australians reported visiting hospital casualty and outpatient departments as other Australians.⁶

Importantly, Cunningham has found that Aboriginal and Torres Strait Islander public hospital patients were less likely than other patients to have a recorded principal procedure, raising the possibility of systematic differences in the treatments provided to Indigenous patients.⁷

Primary Health Care

The Government introduced the Primary Health Care Access Program (PHCAP) in 1999/2000 in acknowledgment of the need for improved access to first line medical and health services. The Program aims to provide access to appropriate primary health care including clinical care; population health programs; client/community assistance and advocacy. Funding is based on a benchmark of between two and four times the average use of the MBS to reflect health needs and the isolation faced by some communities. Funds are pooled and there is a high level of community participation/control.

Total funds allocated by OATSIH from 1999/00 to 2002/03 are \$78.8 million. OATSIH anticipates that by 30th June, 2003, approximately \$20 million will have been provided for planning, capital infrastructure, community capacity development and service expansion services for new PHCAP services. The remaining funds have gone to capital infrastructure for ACCHS, health strategies and workforce support.⁸

Total funds allocated by OATSIH from 1999/00 to 2003/04 are \$133.5 million. From 2003/04, the recurrent base for funding of PHCAP will be \$54.7 million per annum.⁸

International and Regional Comparisons

Overall Comment

The 2002 AMA Report Card highlighted the contrast between the relative lack of progress in improving infant mortality and life expectancy for Aboriginal and Torres Strait Islander people in Australia compared with the greater improvements in these measures for the Indigenous peoples of the US, Canada and NZ.

This information is included at the back of this document.

In 1996, the incidence of End Stage Renal Disease (ESRD) in the NT for Aboriginal people reached 838 per million; doubling every four years.² The majority with ESRD are in rural and remote areas.

In the Torres Strait Islands, for 2000, 24% of those over 15 years had Type 2 diabetes – the highest prevalence in Australia.³

Leonard et al (2002) demonstrated in a study of Torres Strait Islander people that almost 45% of women and 50% of men had 3 or more risk factors for diabetes and cardiovascular disease.⁴

In a Queensland study, McDermot et al (2001), showed a 32% reduction in hospital admissions for diabetes related conditions through systematic recall and diabetes outreach.⁵

The 2002 Report Card noted the continuing poor health of Aboriginal and Torres Strait Islander people. While some improvements have been made, overall little progress has been achieved. Australia's performance in achieving progress is poor compared to similar developed countries. In these countries there has been a considerable and earlier emphasis on primary health care services.

Hospital statistics released since then confirm the picture of ill health drawn by the 2002 Report Card. This is particularly the case for chronic diseases such as end stage renal disease, conditions involving dialysis and endocrine disease as well as injury/poisoning. The statistics on diabetes and end stage renal disease in Aboriginal and Torres Strait Islander communities are of major concern, being among the highest in the world.

Indigenous populations in countries such as the US, Canada, and NZ are also facing an increased burden of chronic disease. Having established primary health care programs earlier, however, these countries are better placed to manage the problem.

Studies in the US have found reduced probability of African American hospital inpatients having a range of procedures than other Americans. A further study found that whites had higher rates of discretionary procedures while blacks had higher rates for medical rather than surgical procedures.⁷

Hoy demonstrated that a systematic treatment program in the Tiwi Islands resulted in an estimated 57% lower dialysis rate than in a control group. There was a marked decrease in rates of natural death in the treatment as opposed to the control group, estimated at 50%. A rapid and sustained reduction in blood pressure was found for participants after two years.^{8,21}

A follow up evaluation by the Tiwi Health Board highlighted the difficulties of sustaining such results in an ongoing primary health care service as distinct from an intensive research program. Key factors appear to be intensive preventive monitoring, simple treatment protocols and an effective teamwork environment.¹⁰

PHCAP services are being implemented on a regional basis in the context of regional priorities. Services in the Northern Territory and South Australia are targeted to become operational in 2003/04. These include Northern Barkley, Warlpiri, Anmatjere, Eastern Arrente/Alyawarra and Luritja/Pintupi in Central Australia, and Hills/Mallee/Southern, Riverland, Port Augusta. North Metro Adelaide in South Australia is now operational.

Services piloted in the Coordinated Care trials have been transferred to PHCAP funding: Tiwi Islands; Katherine West, Wilcannia, Derbarl Yerrigan.

State and Territory implementation strategies under the Workforce Strategic Framework are currently in the planning phase with priorities agreed. Implementation plans have been drafted by NT and WA.

The greater use of in-patient hospital services and visiting of casualty/outpatient departments are consistent with the higher burden of disease and lack of accessible primary health care. Systematic differences may extend to receiving appropriate treatment while in hospital. This requires further exploration.

Further initiatives are required to link primary health care with hospital outreach and specialist care. Out of hospital treatment services, such as dialysis treatment units, may be relatively inaccessible.

Research demonstrates that significant improvements can be achieved for Aboriginal and Torres Strait Islander people in the management of chronic disease and risk factors. Examples of successful preventive programs suggest that effective prevention is possible.

To be effective, primary health care needs to be sufficiently intensive. This has implications for the design, funding and staffing of the PHCAP. Central issues are adequate funding and the streamlining of the planning and administrative process. It is essential that service delivery on the ground is expedited in the next year.

PHCAP services need to be supported by an adequately and appropriately staffed workforce. A funded National Training Plan is required to allocate additional training numbers on an annual basis. Staffing strategies should include focus on access to both primary health care and specialist services. The absolute minimum numbers of health workers for which action must be taken in 2003/04 and in subsequent years are: Medicine 30; Nursing 40; Allied/public health 20; Managers 10; Graduate Aboriginal Health Workers 50. A total of 150 per annum.

Health Services and Service Delivery

Workforce

The Government has established a Workforce Strategic Framework to increase the health workforce available to deliver primary health care and specialist services to Indigenous people. The Australian Health Ministers Advisory Council (AHMAC) now has a responsibility for ensuring this policy framework is translated into effective implementation strategies. OATSIH has committed \$9.2 million towards workforce training and support programs with additional funds sought from State/Territory governments.⁸

Government Inputs

Funding – Health Services

Based on comparative death rates, Professor John Deeble¹² estimated in 2000 that an equitable allocation of health funds would have required an additional \$245 million per annum. Nearly all of this would have had to come from governments. Medicare and the PBS are the areas where uptake by Indigenous people is lowest. In 1998–99, the ratio of Indigenous to non-Indigenous expenditures per person was 0.38 for the MBS and 0.31 for pharmaceutical benefits respectively, despite their greater need.

Funding – Prevention

In his recently updated estimates, Professor Deeble notes that Indigenous-specific health spending by the Commonwealth government rose by \$70 million between 1998–99 and 2001–02. Spending by the States and Territories has almost certainly increased as well. However all Australian health expenditures rose by at least 22% per person over the same period, most of it on the services which Aboriginal and Torres Strait Islander people use least – private hospital and specialist care for example. Indigenous people are entitled to a similar increase. He estimates that in 2001–02, an equitable allocation would still have required a further \$250 million annually.

Most of this money would have to go to primary health care where early illness identification and intervention would yield the largest dividend. Professor Deeble argues for an additional \$50 million annually for public health and preventive programs of health promotions, health education and screening which other Australians enjoy. In the long run, these are the areas of greatest need.

The need for preventive population health programs is evidenced by the data on risk factors found by the National Health Survey.⁶

- Indigenous adults aged 18 years and over are twice as likely as non-Indigenous adults to indicate they are current smokers.
- While Indigenous adults are less likely to have consumed alcohol in the previous week than others, a slightly higher proportion reported risky levels of consumption.
- 61% of Indigenous Australians were more likely to be classified as overweight or obese compared with 48% for other Australians.

Aboriginal Community Controlled Health Services (ACCHS)

OATSIH funding for specific Indigenous programs, including Aboriginal and Community Controlled Health Services (ACCHS), increased in the late 1990s and leveled off in the period 1998/99 to 1999/2000.

Funding increased to \$166.3 M in 2000/01 and \$201.8 M in 2001/02.

Episodes of care provided by ACCHS in the period 1997/98 to 1999/2000 increased by almost 40% to 1,200,000.

In 2000–2001, 1,340,000 episodes of health care were provided by these services. This represents a further 9.8% increase from the previous year.

Funding from OATSIH for ACCHS was \$135.2 million in 2000–2001 and \$164.138 million for 2001–02.⁸

International and Regional Comparisons

Overall Comment

In NZ, planning to increase equity in the health workforce has occurred stemming from obligations under the Treaty of Waitangi. People of a Maori background now make up 5% of the health workforce.¹¹

The Government has recently announced additional education places for doctors and nurses. The AMA has advocated for the above minimum numbers to be identified for students of Aboriginal and Torres Strait Islander background. Current differentials in Indigenous/non-Indigenous ratios need to be halved in the next 10 years.

While much useful policy development and coordination with appropriate government agencies has been achieved, the Workforce Strategy requires more effective targeted implementation if it is to make a difference. This requires clear financial commitment at both Commonwealth and State/Territory level.

Initiatives to overcome lack of access to the PBS enable Aboriginal Medical Services and government services in remote areas to obtain bulk supplies. This Section 100 arrangement has not yet been taken up by all States. The initiative is to be evaluated in the next year.

Leonard and et al found levels of obesity in the Torres Strait Islands that were three times higher than for other Australians.⁴

Studies of Indigenous populations in both Canada and NZ have indicated both lower overall alcohol consumption but higher risky levels of drinking on single occasions.^{13,14} Similar differentials were found in Canada and NZ in relation to smoking rates.¹⁵

An injury prevention program significantly reduced the number of injuries in a Queensland Aboriginal community demonstrating that such prevention programs can be successful.¹⁶

In Australia, the Government has only recently acted to enhance the establishment of accessible primary health care services through PHCAP. The recurrent funding is significant and welcome. Despite this, the Government has not made the quantum leap necessary to establish services on an equitable basis in line with the estimates provided by Professor Deeble.

Such a major increase requires a staged implementation plan with annual cumulative increments. In addition, funds need to be allocated from the Education sector to support the implementation of a National Training Plan on an annual basis.

Deeble's estimates of funding necessary for additional preventive and population strategies for Indigenous communities also require a staged implementation plan. The importance of these is evident from the high levels of risk factors illustrated by National Health Survey data as well as the continuing high level of chronic disease.

There is evidence that effective prevention and illness management is achievable.

While it takes time to establish services and provide staff services, it is possible to have measurable change in the foreseeable future. High quality, accessible and adequately funded programs on the ground are the essential ingredient.

Related Policy Areas

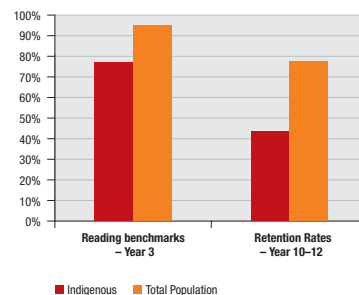
Education

There is an intrinsic link between health status and education with improvements in one leading to improvements in the other.

Reading benchmarks

Year 3 These show some improvement overall from 1999, with 76.9% of indigenous students achieving the benchmark in 2000 compared to 92.5% of all students.¹⁷

Year 10–12 The apparent retention rates from year 10–12 have increased from about 35% in 1999 to 43.6% in 2001 compared to 76.2% for non-Indigenous students. The retention rate for Indigenous students to year 10 is 12.4% lower than for non-Indigenous students.¹⁷



Research

The NHMRC has acknowledged the importance of ensuring that the target of at least 5% of funding be directed to Indigenous research. This was the target set in the Health is Life report. The NHMRC reports that this target was met in the 2002 funding round.¹⁸

Social Justice and Reconciliation

The recent Census¹⁹ provides an indication of the systemic differences experienced by Aboriginal and Torres Strait Islander people and other Australians.

Income

Weekly income between \$1 and \$299 – 8.2% of Indigenous families compared with 2.8% of other families;

Weekly income of between \$1,000 and \$1,999 – 19% of Indigenous families compared to 31% of other families.

Employment status

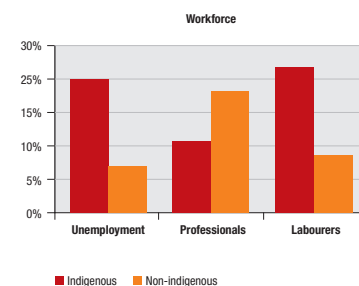
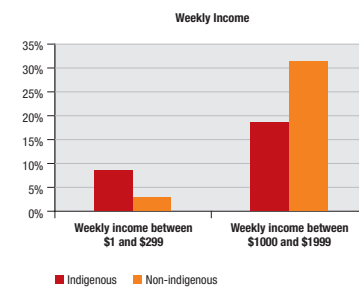
Unemployment rated for those identifying as Indigenous and aged over 15 years was 20% compared to 7% of non-Indigenous people.

Occupation – 11.1% of employed Indigenous people were professionals; 23.5% were labourers and related workers. This compares to 18.4% and 8.4% among non-Indigenous employed people.

Justice

For 2001–02, the national imprisonment rate per 100,000 Indigenous adults was 1746.3 compared with 115.5 for non-Indigenous adults.¹⁷

Concern at the extent of disadvantage and lack of commitment to overcome this was expressed by the 2002 Report of the Aboriginal and Torres Strait Islander Social Justice Commissioner.²⁰



International and Regional Comparisons

Overall Comment

In 2000, the NT had the lowest number of Indigenous students reaching the year 3 reading benchmark.

In 2001, the apparent retention rates for Indigenous students to Year 12 were lowest in WA. In the NT, it appears there is a difference of approximately 20% in retention rates between Indigenous and non-Indigenous students. Many students are ungraded.¹⁹ It appears that participation rates for Indigenous students are lowest in States/Territories where Indigenous students are in remote areas.

Further initiatives must be taken to improve educational achievement by Indigenous Australian children throughout Australia. This is essential to ensure that life opportunities are not lost. Educational achievement is linked to the ability to maintain health.

Appropriate research is essential to support policy and service delivery. The NHMRC should be commended for meeting the 5% target for research funding for Indigenous research in the 2002 funding round.

As in other countries, however, effective change will require broader change than in the Health sector alone – societal changes which provide greater equity of life opportunities for Aboriginal and Torres Strait Islander people are essential. This requires greater Government commitment.

The AMA has supported consultation with Indigenous communities in relation to the establishment of a Treaty.

EXTRACT
REPRINTED 2003

PUBLIC REPORT CARD 2002
ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH
NO MORE EXCUSES

Aboriginal Health painting **Jillie Nakamarra**

2002 REPORT CARD

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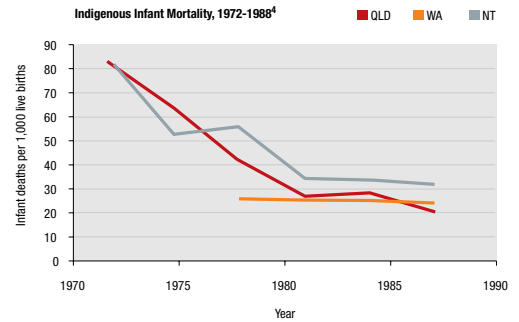
Health Status

Infant Mortality Rate (IMR)

This is the number of deaths of children under one year of age per 1,000 live births.

In 2000, the Indigenous infant mortality rate (IMR) was 14 per 1,000 infants born ie almost three times that of the total Australian infant mortality rate of 5.2¹. In 1965, the Indigenous IMR was about 138; by 1981 it had dropped to about 26². The Australian population had a rate of about 26 in the 1940s and 1950s³.

In summary, the rate dropped rapidly in the 1970s but since then improvement has been gradual, with the rate remaining about 2½ times that of the total population³.



Low Birth Weight

The number of babies born weighing less than 2,500 grams.

In 1996-1998, babies of Indigenous mothers were about twice as likely as babies of non-Indigenous mothers to be of low birthweight⁵. Since 1991 there appears to have been little change in the proportion of low birthweight babies born to Indigenous mothers⁵.

Low birth weight is important as an indicator of later illness, particularly chronic illness.

Life Expectancy

This is the average number of years a person born in a particular year can expect to live if the age specific rates of mortality at that time continue to apply.

In 1997-1999, Indigenous Australians could expect to live approximately 20 years less than non-Indigenous Australians². This is similar to the situation in 1991-1996⁶.

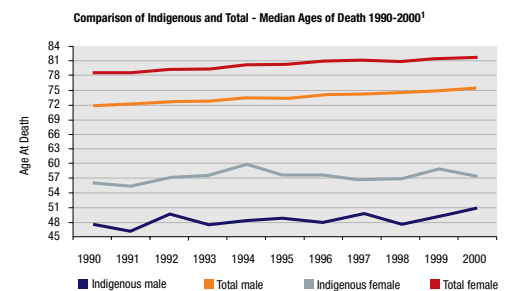
Indigenous people in the late 1990s had the same life expectancy as the Australian population experienced as a whole in the early part of the 20th century².

Median Age of Death

The age by which 50% of the population dies.

In 2000, the median age of death was 53 years for Indigenous people, which was 25 years less than the median age of death for the Australian population as a whole¹.

There has been no consistent increase in the median age of death for the Aboriginal and Torres Strait Islander population between 1990-2000, compared with a steady increase of three years in the total population in the same period¹.

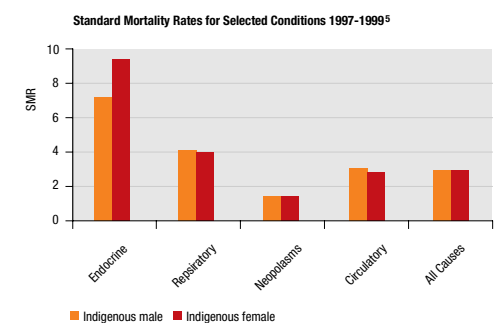


Standardised Mortality Ratios (SMR)

These enable valid comparisons of mortality to be made that take account of differences eg in the age profile of the two populations.

In 1997-1999, the age standardised death rates for Aboriginal and Torres Strait Islander people were approximately 3 times those of the total Australian population⁵.

The significantly higher rates of Indigenous deaths (ie number of times more death than the rest of the population) for particular causes of death are shown in the graph: endocrine conditions such as diabetes, respiratory conditions, cancer, circulatory diseases and all causes.



International and Regional Comparisons

Overall Comment

In 1998, the NZ Maori population had an IMR of 7 compared with 5 for the total population. In 1996-8, the US Indigenous populations experienced an IMR of 9 compared with 7 for the total population¹.

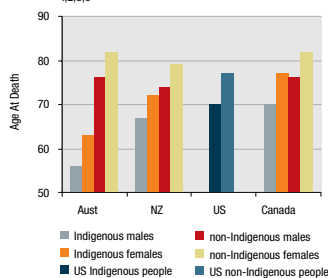
These rates are substantially lower than the Australian Indigenous IMR of 14.

There is evidence that programs can make a difference in reducing the number of low birth weight babies.

The NT *Strong Women, Strong Babies, Strong Culture* program reduced the number of low birth weight babies from 19.8% to 11.3% in the years 1990-1991 to 1994-1996⁶.

Likewise, the Nganampa Health Council Antenatal Care Program reduced the number of low birthweight babies from 14.2% to 8.1% in the years 1984-1996⁷.

International Comparison of Life Expectancy Late 1990s
1,2,8,9



In the late 1990s, Canada, NZ and the US reduced the gap between their Indigenous and non-Indigenous populations to between 5 and 7 years – compared to Australia's 20 years^{1,8,9}.

The gap between Indigenous and non-Indigenous populations was between 7-12 years in the US and Canada in the 1970s. In NZ in the 1950s it was between 13-15 years^{8,9,10}. The gap in life expectancy has narrowed over time in these countries. This has not been the case in Australia.

One unpublished study suggests that there was a 13% reduction in overall mortality rates for Indigenous people due to respiratory disease between 1986-96 and a further 43% between 1996-1999¹¹.

Reduction in recent years may be due, in part, to the introduction of vaccines, particularly pneumococcal and influenza, demonstrating the importance of such public health measures¹¹.

In Far North Queensland, there was early introduction (1996) of vaccination targeting Indigenous people at high risk prior to the introduction of the national vaccination program in 1999. From 1993-1994 to 1999-2000 the number of pneumococcal disease cases fell from 111 cases per 1,000,000 to 28 cases per 1,000,000 in Far North Queensland¹².

The health status of Aboriginal and Torres Strait Islander people is significantly poorer than for Australians as a whole. While there have been some improvements, overall little progress has been achieved.

The stark differences in infant mortality rates, numbers of low birth weight babies, life expectancy, and standardised mortality ratios between Indigenous people and other Australians are continuing.

Both infant mortality rates and low birth weight are significant because they are indicative of factors such as poor nutrition and living conditions that impact on health. These are not typical of developed countries such as Australia.

The continuing significant gap in life expectancy coupled with the low age of death highlights the inequity in life chances experienced by Australia's Aboriginal and Torres Strait Islander population.

Aboriginal and Torres Strait Islander people die of the same causes of death as the rest of the population – however they die younger and at higher rates of these conditions. This applies to endocrine, respiratory, cancer, renal, circulatory conditions and to all causes.

The prevalence of diabetes in particular is very significantly higher than for the rest of the Australian population.

In addition, Aboriginal and Torres Strait Islander people experience other conditions such as rheumatic fever, endemic skin infections and trachoma, which are more typical of underdeveloped countries. In contrast, there are apparent improvements in deaths from respiratory conditions possibly linked to the introduction of the pneumococcal and influenza vaccine.

Hospital admission rates are twice those for the total population reflecting both higher rates of illness and a lack of accessible, culturally appropriate primary health care.

Australia's performance in achieving progress in these measures is poor compared to other developed countries.

Improvements in life expectancy for Indigenous peoples occurred in the mid 1950s for the US and Canada and earlier in NZ. Improvements appear to have occurred through more adequate provision of primary health care, public health facilities and initiatives relating to social justice.

International experience indicates that progress is achievable.

It is unacceptable that Australia continues to lag behind.

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