

## ***Aboriginal and Torres Strait Islander Health***

*This document represents the current, official position of the Pharmaceutical Society of Australia (PSA) with respect to issues relating to Aboriginal and Torres Strait Islander Health.*

### **Background**

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- Aboriginal and Torres Strait Islander people, who represented approximately 2% of the Australian population at the 1996 census [1,2], continue to be the most disadvantaged in our country, particularly in relation to health [1,3]. The overall health outcomes are poorer for this group of Australians, no matter whether they live in urban or rural and remote areas. The causes for the disparity in health status between Indigenous and non-Indigenous Australians are complex and the evidence suggests it is growing [1].
- The life expectancy at birth of Aboriginal and Torres Strait Islander people, in the period 1991–1996, was 57 years and 62 years respectively for males and females, almost 20 years shorter than the life expectancy for all Australians for the same period [1–3]. Death rates for Indigenous Australians were higher than for non-Indigenous Australians across all age groups [2,3] and 5–7 times higher for people in the 25–54 year age range [2].
- Morbidity in Aboriginal and Torres Strait Islander children is almost entirely due to preventable infections, with infant and childhood malnutrition contributing to growth retardation and their predisposition to infectious disease [1]. Since the 1970s infant mortality rates have been decreasing [1,3] and birth weights increasing [1]. However, babies of Indigenous Australian mothers are still twice as likely to be low birthweight (less than 2500g) and the risks of perinatal death are more than twice that of babies born to non-Indigenous Australian mothers [1–3].
- The Commonwealth and the States and Territories contribute almost equally to funding health services. The majority of the Commonwealth's contribution is provided indirectly through the Australian Health Care Agreements (AHCA) [1]. The AHCA do not specifically address Aboriginal and Torres Strait Islander health issues but include a clause requiring that they are implemented according to the principles of the Framework Agreements. These latter Agreements, developed by the Commonwealth with each State and Territory, cover aspects of Aboriginal and Torres Strait Islander health relating to policy development, service access and delivery, resource allocation, and data collection and evaluation [1].
- The Commonwealth is also the principal source of funding for approximately 100 community controlled Aboriginal Medical Services (AMS). The principal role of the AMS is to provide primary health care. They were developed to more effectively respond to the health care needs of Aboriginal and Torres Strait Islander people in a culturally appropriate manner [1].
- Per capita health spending for Aboriginal and Torres Strait Islander people was only 8% higher than for non-Indigenous Australians in 1995/96 [1,2,4]. Aboriginal and Torres Strait Islander people rely more heavily on publicly funded hospital and community health services than other Australians [1,4] and this is reflected in public expenditure for Indigenous Australians being one and a half times the average for non-Indigenous Australians [4].
- Aboriginal and Torres Strait Islander people gain little benefit from the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). Their 'drawing rates' on Medicare and the PBS compared to non-Indigenous Australians are about 27% and 22%, respectively [4]. Aboriginal and Torres Strait Islander people experience significant barriers to accessing the MBS and PBS, especially those living in rural and remote areas [5].
- In August 1998, following consideration of the identified barriers and advice from the Australian Pharmaceutical Advisory Council (APAC), the Minister for Health approved arrangements for the supply of pharmaceutical benefits under Section 100 of the National Health Act to clients of eligible remote area AMS. These arrangements are now being extended to remote services funded by the States and Territories [6].

- Traditional medicines are extremely important to Aboriginal and Torres Strait Islander people [1] and the pivotal role Aboriginal Health Workers (AHW) play in delivering health services in their communities is well recognised [1,7]. The AHW also play an important role in ensuring the acceptability of health services to Aboriginal and Torres Strait Islander people by bridging the cultural gap between Indigenous Australians and non-Indigenous health service providers [1].
- Difficulties with provision of culturally sensitive health services are common across all health professions. This can contribute to Aboriginal and Torres Strait Islander people experiencing mainstream health services as alienating and uncomfortable to the extent that they may delay seeking treatment [1]. The importance of general practitioners having an enhanced understanding of Indigenous health needs and cultural context to apply in their professional practice has been recognised. A commitment to ensuring they receive appropriate education and training in Indigenous health has also been re-affirmed [7].
- The active participation of Aboriginal and Torres Strait Islander people in planning and decision making as well as delivery and monitoring of services in their communities has been identified as critical to the success of initiatives intended to address Indigenous health [1,8]. Aboriginal and Torres Strait Islander self-determination in health care through community control has been strongly endorsed [7,9] and is seen as a key strategy for reducing the inequalities in health [7].
- The commitment of Australian Health Ministers to obtaining better quality health statistics for Aboriginal and Torres Strait Islander people has been noted [4]. Deficiencies exist in the identification of Indigenous Australians and the availability and completeness of data required to more accurately assess their health status and health financing needs [1,2,4]. Though available data does not allow the need for additional resources to be quantified [4] it has been proposed that, to raise the health status of the Indigenous population, higher levels of expenditure will be required over a period of at least 10 years [10].
- The need for research into Aboriginal and Torres Strait Islander health has also been recognised [1,7,10], particularly in the area of delivering cost effective, culturally appropriate health services [10]. The full engagement of the community under study is an important factor for achieving benefit from any research initiative [1]. Research should, in addition, focus on improving health outcomes, building research capacity in the Indigenous Australian population and informing health policy and/or programs [1,7].
- Initiatives intended to impact on the health of Aboriginal and Torres Strait Islander people will need to take account of the underlying levels of disadvantage, cultural differences and heterogeneity in Indigenous communities and adopt a flexible approach to determining the funding and service delivery models. Success will require coordination of health sector activities with those of other sectors as well as collaboration between the Commonwealth and jurisdictional governments, with clear delineation of responsibilities [1].

## **Position**

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- PSA believes that a parallel process that recognises the status of the Aboriginal and Torres Strait Islander population should accompany efforts directed to improving the health outcomes of Indigenous Australians.
- PSA recognises there is lack of good quality data on which to assess the health status and health financing needs of Aboriginal and Torres Strait Islander people and plan programs to improve their health and encourages all relevant agencies to collaborate in establishing an appropriate national data set to support decision making.
- PSA acknowledges the value of Aboriginal community control in addressing health matters and is committed to enhancing community control in initiatives intended to address the health status of Indigenous Australians.
- PSA is committed to working with the other members of APAC, including the National Aboriginal Community Controlled Health Organisation, to understand the pharmaceutical needs of Aboriginal and Torres Strait Islander people and provide appropriate advice to government for addressing these needs through research, policy development or program design.

- PSA is committed to promoting Quality Use of Medicines (QUM) in Indigenous communities through initiatives such as those covered by the *Allowance for support to Aboriginal health services* in the Third Community Pharmacy Agreement (CPA). Integral to this commitment is a desire to improve access to the services and expertise of pharmacists.
- PSA recognises the need to improve the awareness and understanding of Aboriginal and Torres Strait Islander health issues amongst its members. It encourages pharmacists to address cultural issues likely to impact on the effectiveness and acceptability of their services and to develop cooperative arrangements with the Indigenous communities they service to optimise the health benefits to community members.
- PSA is committed to supporting initiatives, such as those in the CPA, directed at ensuring the community pharmacy network and pharmacy workforce are able to meet the pharmaceutical service needs of all Australians. This commitment is particularly relevant to those Australians living in rural and remote areas, many of whom are Indigenous Australians.
- PSA believes there is value in pharmacy students being exposed to Aboriginal and Torres Strait Islander health and cultural issues in undergraduate pharmacy training courses and other relevant training courses, such as those offered by University Departments of Rural Health.

### **Additional Resources**

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The following resource(s) may provide additional useful information to pharmacists.

- Couzos S, Murray R. *Aboriginal Primary Health Care – an evidenced-based approach*. Produced by the Kimberley Aboriginal Medical Services Council. Melbourne: Oxford University Press, 1999.
- Quality Use of Medicines (QUM) Mapping site. Available from: URL: <http://www.qummap.health.gov.au> [accessed 31 January 2001].

### **References**

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3. Australian Institute of Health and Welfare. *Australia's health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare*. Canberra: AIHW. 2000.
4. Deeble J, Mathers C, Smith L, Goss J, Webb R, Smith V. *Expenditure on health services for Aboriginal and Torres Strait Islander people*. AIHW Catalogue No. HWE-6. Canberra: National Centre for Epidemiology and Population Health, Australian Institute of Health and Welfare and Commonwealth Department of Health and Family Services. 1998.
5. [Cited in 1 above.] Keys Young. *Market research into Aboriginal and Torres Strait Islander access to Medicare and the Pharmaceutical Benefits Scheme*. Canberra: Health Insurance Commission. 1997.
6. Commonwealth Department of Health and Aged Care. *Update on implementation of arrangements for the supply of pharmaceutical benefits to remote area Aboriginal Health Services under Section 100 of the National Health Act 1953*. Tabled at Australian Pharmaceutical Advisory Council 20th meeting. 20 May, 2000.
7. Royal Australian College of General Practitioners. *Aboriginal health [position statement]*. August 2000. Available from: URL: <http://www.racgp.org.au/policy/positions/aboriginal.htm> [accessed 13 October 2000].
8. National Aboriginal and Torres Strait Islander Health Council. *National Aboriginal and Torres Strait Islander Health Strategy. Consultation Draft*. Canberra: NATSIHC. 2000.
9. Public Health Association of Australia. *Aboriginal health [policy statement]*. 1989. Available from: URL: <http://www.phaa.net.au/policy/aborigin.htm> [accessed 9 October 2000].
10. Mooney GH, Wiseman VL, Jan S. *How much should we be spending on health services for Aboriginal and Torres Strait Islander people?* *Med J Aust* 1998;169:508–9. Available from: URL: <http://www.mja.com.au/public/issues/nov16/mooney/mooney.html> [accessed 31 January 2001].

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