

Healthy Lives

Aboriginal and Torres Strait Islander peoples experience significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health.

Overview

The Queensland Government is committed to working with Aboriginal and Torres Strait Islander peoples, communities and organisations, the many health-service providers, institutions and organisations across Queensland, and other levels of government, to close the life expectancy gap between Indigenous and non-Indigenous people and address the large

gap in chronic disease and disability, particularly where this is preventable.

The measures which will be used by the Queensland Government to monitor progress, as well as the strategies which will best address the gap between the health of Indigenous and non-Indigenous people, are presented below.

| | |
|----------------------|--|
| COAG TARGETS | <ul style="list-style-type: none"> • Close the gap in life expectancy within a generation • Halve the gap in mortality rates for Indigenous children under five within a decade |
| Q2 TARGETS | <p>Healthy</p> <ul style="list-style-type: none"> • Cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure |
| PROGRESS MEASURES | <ul style="list-style-type: none"> • Life expectancy • Causes of death • Disability and chronic disease <ul style="list-style-type: none"> › Diabetes and end stage renal disease › Circulatory system disease › Cellulitis › Chronic obstructive pulmonary disease |
| STRATEGIC DIRECTIONS | <ul style="list-style-type: none"> • Ensure effective primary care services that deliver on their objectives • Increase access for Indigenous Australians through culturally appropriate, integrated service delivery arrangements • Improve access to health services for Indigenous children and mothers • Encourage healthy lifestyles at all ages through good nutrition, physical activity, reduced use of alcohol, drugs and tobacco products • Expand and develop innovative, evidence-based programs for difficult to reach groups, including Indigenous men, disconnected young people and the homeless • Improve quality of, and access to, mental health services for Indigenous Queenslanders • Improve quality of, and access to, services for Indigenous Queenslanders who are frail or have a disability • Encourage use of preventative health initiatives |



The Evidence

The onset of disease and infection can often be prevented or delayed through immunisation, good hygiene, healthy lifestyle, healthy environment and protection from parasites. However, prevention of disease may be affected by socio-economic status, social marginalisation and lack of access to health and welfare services.¹

Hospitalisation rates for health conditions provide an indication of serious illness being treated in hospitals. However, they are not a measure of the prevalence of a condition in the community, as individuals may have more than one admission in any particular time period for the same condition. Hospitalisation rates for Aboriginal and Torres Strait Islander Queenslanders are much higher than for non-Indigenous Queenslanders.

Life expectancy

Queensland Aboriginal and Torres Strait Islander males have a life expectancy 17.7 years less than that of all male Australians (58.9 years compared with 76.6 years). The life expectancy of Queensland Aboriginal and Torres Strait Islander females is currently 19.4 years less than that of all female Australians (62.6 years compared with 82.0 years).²

To close a 17 year gap, Indigenous life expectancy needs to increase by around one year per year over the target period. This requires an overall reduction in Indigenous mortality of around 80 per cent. Gains of this magnitude have taken around 80 years to achieve in the Australian population as a whole.³

¹ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. The burden of disease and injury in Australia 2003. PHE 82. Canberra: AIHW.

² These data are subject to a degree of uncertainty, and apparent differences in life expectancy estimates may not be statistically significant, hence differences should be quoted with caution.

³ COAG Working Group on Indigenous Reform, Draft Measuring Progress Report.

Causes of death

All causes death rate

For the four years 2003 to 2006:

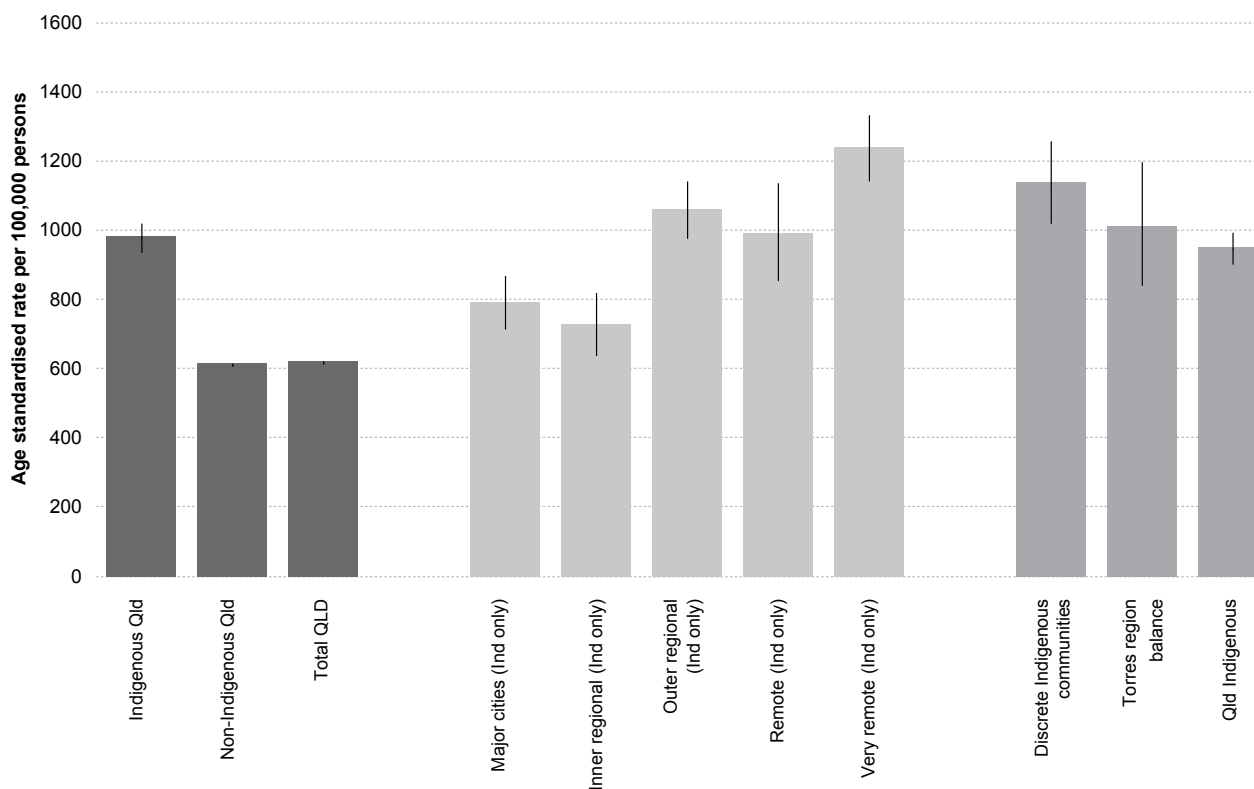
- the death rate for Aboriginal and Torres Strait Islander peoples for all causes in Queensland was 982.3 per 100,000 persons, compared with the rate of 616.0 per 100,000 for non-Indigenous persons⁴: see Figure 3.1
- the higher death rate of Aboriginal and Torres Strait Islander peoples is due to the higher prevalence of deaths at younger ages
- the death rate for Aboriginal and Torres Strait Islander peoples increases with remoteness, with the lowest rates in major cities and inner regional areas (794.1 and 729.7 per 100,000 persons respectively) and the highest rates in very remote areas (1,239.7 per 100,000). However, this difference may be due to poorer identification of Aboriginal and Torres Strait Islander deaths in urban areas compared with remote areas.⁵

⁴ Age standardised death rate.

⁵ The Australian Bureau of Statistics estimates that the implied coverage of Aboriginal and Torres Strait Islander deaths of residents of Queensland was 51% over the period 2002 to 2006. See Australian Bureau of Statistics, Deaths Australia 2006. Cat no. 3302.0.

Healthy Lives

Fig 3.1 Deaths, all causes, age standardised rate per 100,000 persons, Queensland, 2003 to 2006



Leading causes of death

Over the years 2003 to 2006:

- Aboriginal and Torres Strait Islander mortality rates were higher than non-Indigenous rates for all causes of death except nervous system diseases.
- Aboriginal and Torres Strait Islander peoples died from diabetes at around seven times the rate of non-Indigenous people (113.5 per 100,000 compared with 15.0 per 100,000).

The higher death rates from diabetes in the Indigenous population are likely to be in part due to the earlier onset of diabetes (see renal (kidney) failure for further information) in this population compared with the non-Indigenous population, combined with higher prevalence of some of

the risk factors associated with diabetes such as smoking, hypertension and obesity.

Higher death rates from diabetes may also reflect poorer management of diabetes among Indigenous people, in particular those living in rural and remote areas.⁶

It is likely that diabetes is an important contributor to the considerably higher circulatory disease mortality rate among Indigenous Australians at young ages (9–10 times higher in Indigenous men aged 25–44 years, and 12–13 times higher in Indigenous women aged 35–54 years).⁷

⁶ Wood JM and Patterson CM 1999, Diabetes and Diabetic Retinopathy in Indigenous Australians, *Clinical and Experimental Optometry*, vol 82, no 2, pp 80-3. Cited in *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander peoples*, 2008, Australian Institute of Health and Welfare.

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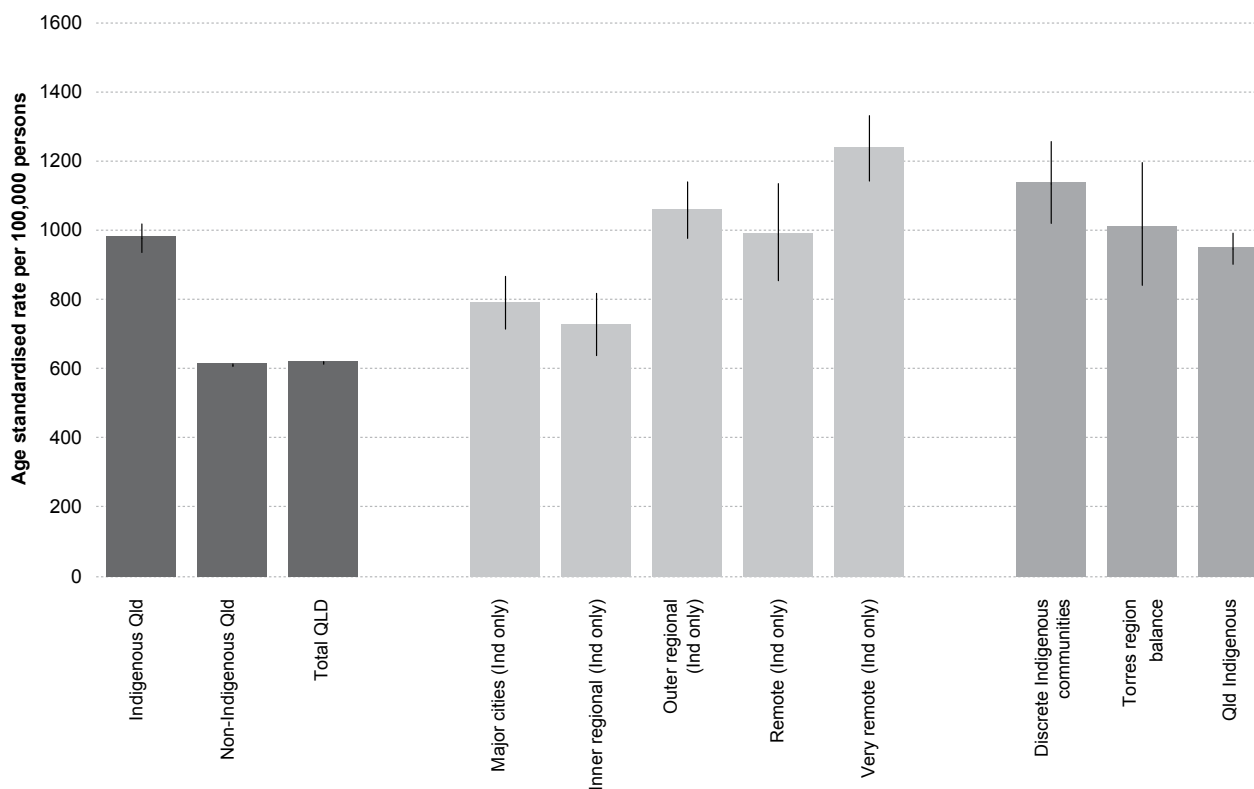
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Healthy Lives

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The leading cause of death for Aboriginal and Torres Strait Islander Queenslanders was circulatory disease (326.0 per 100,000 persons) followed by cancer (210.5 per 100,000 persons): see Table 3.1.

| Table 3.1 Cause of death, age standardised, per 100,000 persons, 2003 to 2006 | Indigenous | Non-Indigenous |
|--|-------------------|-----------------------|
| Circulatory diseases | 326.0 | 226.2 |
| Cancer | 210.5 | 182.0 |
| Endocrine/metabolic diseases | 127.9 | 21.5 |
| <i>Diabetes</i> | <i>113.5</i> | <i>15.0</i> |
| Respiratory diseases | 78.7 | 51.7 |
| Accidents/poisoning/violence | 70.0 | 38.6 |
| <i>Suicide</i> | <i>18.4</i> | <i>10.4</i> |
| Other causes | 52.4 | 32.5 |
| Digestive diseases | 49.7 | 20.5 |
| Kidney disease | 28.4 | 13.1 |
| Infectious/parasitic diseases | 17.1 | 6.7 |
| Nervous system diseases | 15.4 | 20.1 |
| Conditions originating in the peri-natal period | 6.4 | 3.1 |
| All causes | 982.3 | 616.0 |

Note: The addition of each cause of death rate does not equal the all causes of death rate. This is because some categories are sub-categories of others – e.g. diabetes is a subcategory of endocrine and metabolic disorders, as is suicide of accidents/poisoning/violence – these are shown in italics.

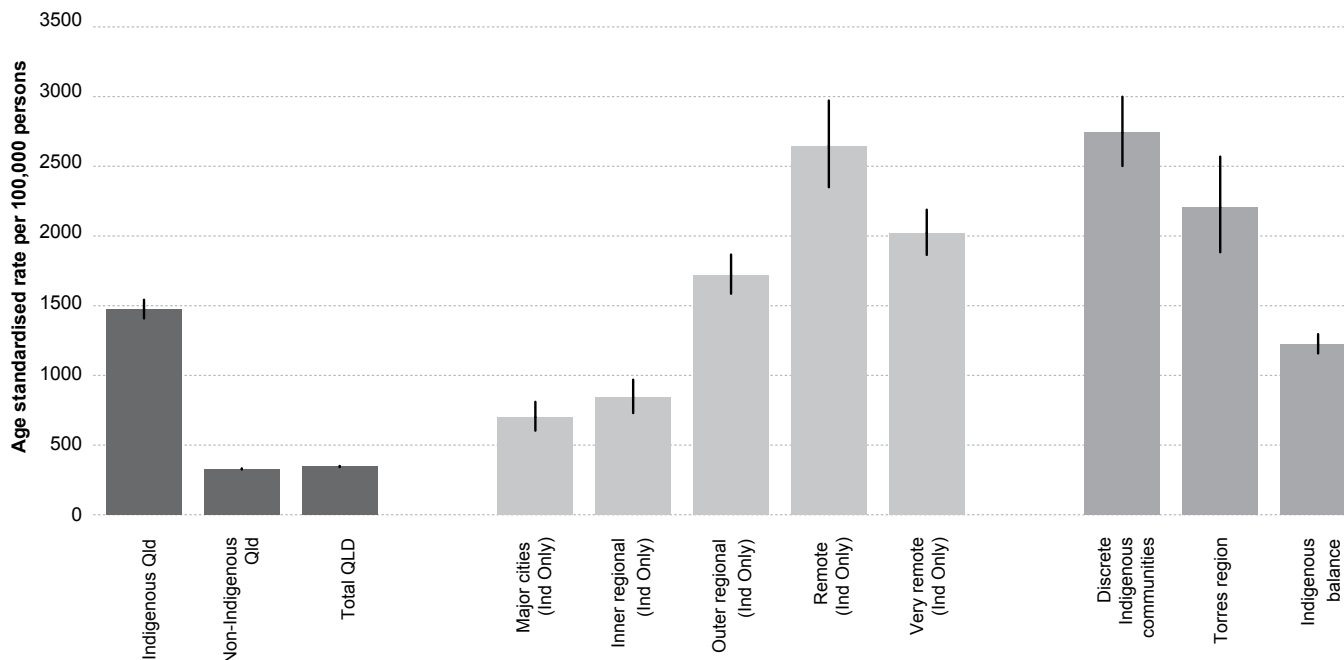
Healthy Lives

Diabetes and end stage renal (kidney) failure

For the two years 2005/06 to 2006/07:

- Aboriginal and Torres Strait Islander Queenslanders were at least four times more likely to be admitted to hospital for diabetes and related complications than non-Indigenous Queenslanders (1,449 per 100,000 compared with 322 per 100,000): see Figure 3.2
- hospitalisation for diabetes was highest in remote areas. The highest rate was for Aboriginal and Torres Strait Islander residents of remote areas (2,601 per 100,000 compared with 1,986 per 100,000 or less in other areas)
- the most common reason for hospitalisation of Aboriginal and Torres Strait Islander peoples in Queensland was for dialysis (36,146 per 100,000 compared with 3,508 per 100,000 for non-Indigenous Queenslanders). Dialysis is necessary to maintain life after the onset of renal failure
- patients in the discrete communities who make the decision to take up renal dialysis treatment are required to relocate to access treatment. Relocation affects patients' quality of life and their ability and willingness to maintain treatment regimes and often results in financial difficulties and social and cultural isolation.⁸

Fig 3.2 Hospital admissions for diabetes and complications, age standardised rates, Queensland, 2005/06 to 2006/07



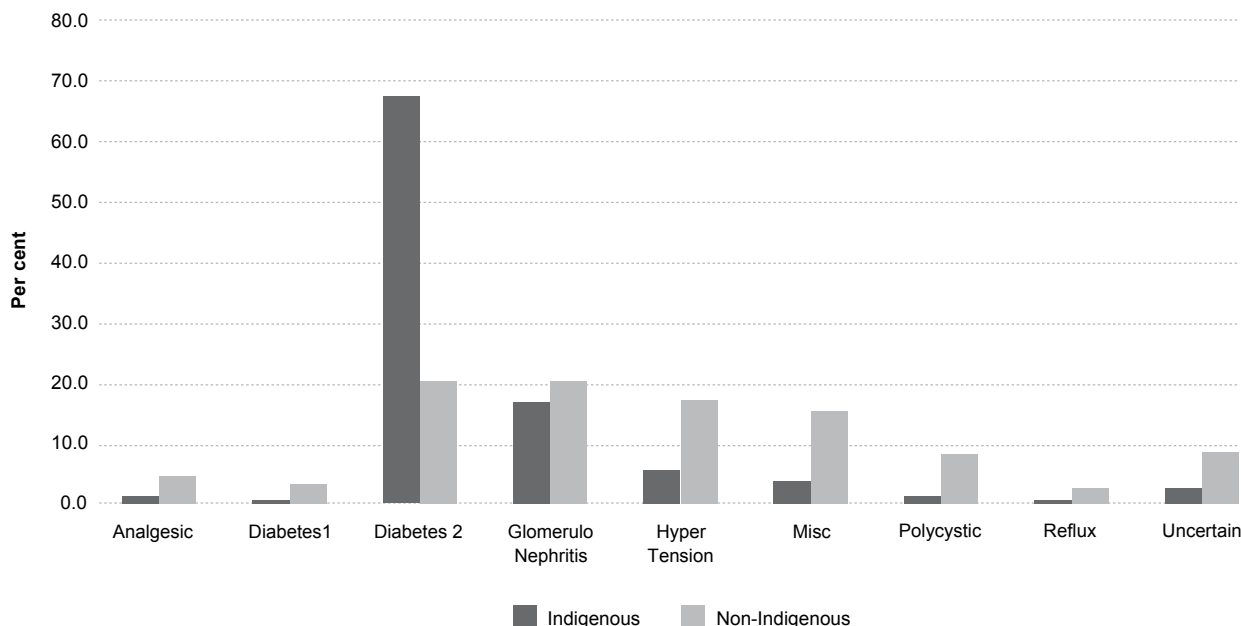
Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Queensland Health.

⁸ Preston-Thomas A, Cass A and O'Rourke P. Trends in the incidence of treated end-stage kidney disease among Indigenous Australians and access to treatment. Australian and New Zealand Journal of Public Health, 2007 vol. 31 no. 5 pp. 419-421.



- regional hospitalisation rates for pyelonephritis (an infection of the kidneys and ureters) followed a similar pattern to diabetes hospitalisations, with the highest rates in remote and very remote areas (1,201 and 1,043 respectively per 100,000 compared with 612 per 100,000 or less in other areas). State-wide, Aboriginal and Torres Strait Islander Queenslanders were three times as likely to be hospitalised for pyelonephritis as non-Indigenous Queenslanders (635 per 100,000 compared with 210 per 100,000)
 - Aboriginal and Torres Strait Islander patients were younger on average than non-Indigenous patients when they commenced treatment for renal failure (median age: 54.1 years compared with 68.3 years), with the highest age specific rate occurring in the 55-64 year old age group (283 per 100,000). In contrast, the highest rate of onset among non-Indigenous patients was among those aged 65 years or older (42.5 per 100,000)
 - Type 2 diabetes was the most common reason for renal failure among Aboriginal and Torres Strait Islander Queenslanders, being the primary cause of 67.5 per cent of new cases: see Figure 3.3.
- During the three years 2004 to 2006:
- Aboriginal and Torres Strait Islander Queenslanders were 7.9 times more likely to be diagnosed with renal failure than non-Indigenous Queenslanders (incidence rate: 79 per 100,000 compared with 10 per 100,000)

Fig 3.3 Reason for renal failure in new patients, Queensland, 2004 to 2006



Source: ANZDATA Registry Report 2007, data analysis undertaken by Queensland Health.

Healthy Lives

Circulatory system disease

Circulatory system diseases include: coronary heart disease, hypertension, stroke, vascular disease and heart failure. Rheumatic heart disease is also included in this category. Rheumatic heart disease is caused by long term damage done to heart muscle or valves and is a complication of acute rheumatic fever, a preventable disease.⁹

During the two years 2005/06 to 2006/07:

- Aboriginal and Torres Strait Islander Queenslanders were about 1.7 times more likely to be admitted to hospital for circulatory system diseases than non-Indigenous Queenslanders (3,299 per 100,000 compared with 1,950 per 100,000)
- hospitalisations of Aboriginal and Torres Strait Islander Queenslanders for circulatory system disease were highest in remote areas of Queensland at 4,430 per 100,000
- almost 30 per cent of Aboriginal and Torres Strait Islander admissions were for residents from very remote areas of Queensland. However, the largest proportion of Aboriginal and Torres Strait Islander patients resided in outer regional areas of Queensland (29%)
- in contrast to Aboriginal and Torres Strait Islander hospitalisations, there were only small differences between major cities, inner and outer regional areas for non-Indigenous hospitalisations for circulatory diseases (range: 2,363 to 4,429 per 100,000 compared with 1,924 to 1,985 per 100,000).

Cellulitis

Cellulitis is an acute skin infection caused by bacteria and is most common on the lower legs and the arms or hands. Cellulitis is a preventable cause of illness and mortality among Aboriginal and Torres Strait Islander peoples.

Over the two years 2005/06 to 2006/07:

- Aboriginal and Torres Strait Islander Queenslanders were three times more likely to be hospitalised for cellulitis than non-Indigenous Queenslanders (493 per 100,000 compared with 149 per 100,000): see Figure 3.4
- there were 1,071 hospitalisations for this disease during the reporting period. It was particularly problematic in remote and very remote regions where the rate of admission was 1,106 and 980 per 100,000 respectively – more than double the rate of other regions
- admissions of residents of the discrete Indigenous communities were also high at 1,493 per 100,000 and accounted for 38 per cent of all Aboriginal and Torres Strait Islander hospitalisations for cellulitis.

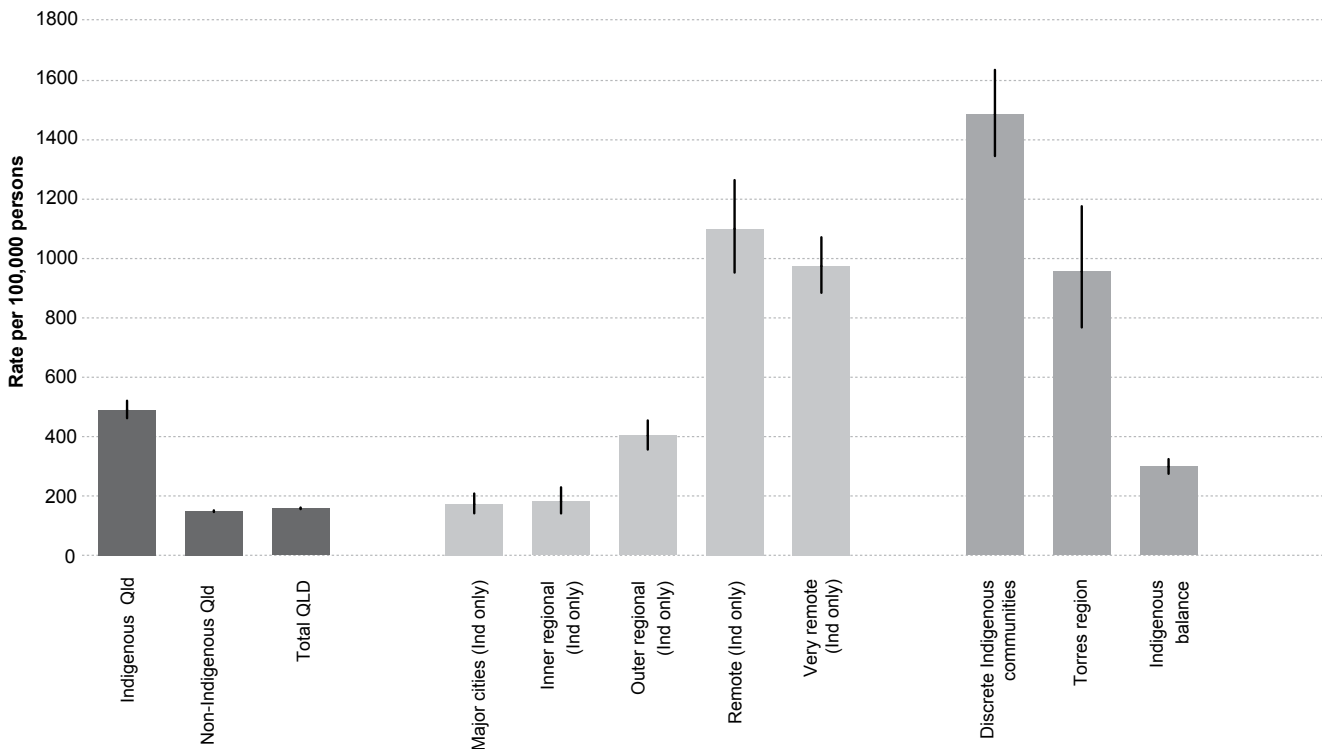
Overcrowding, poor dwelling conditions and inadequate basic services can pose serious health risks.¹⁰ The high level of overcrowding and deficient infrastructure in the discrete communities is well documented, as is the link between poor standards of housing and infrastructure and infectious and parasitic diseases. It is likely that these issues contribute significantly to the high rates of hospitalisation for cellulitis in remote and very remote areas, the Torres Region and the discrete communities.

⁹ http://www.heartfoundation.org.au/document/NHF/ARF_RHD_PP-593_Mgnt_QuickRefGuide_0606.pdf accessed 11/09/08.

¹⁰ Australian Institute of Health and Welfare. Health and Welfare of Australia's Aboriginal and Torres Strait Islander peoples 2005. The Aboriginal and Torres Strait Islander Health Series. AIHW Cat. No. IHW-11. Canberra: AIHW, 2005.



Fig 3.4 Hospital admissions for cellulitis, age standardised rates, Queensland, 2005/06 to 2006/07



Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Queensland Health

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a long-term lung disease characterised by shortness of breath that becomes progressively worse over time. COPD is a major cause of mortality, illness and disability among Aboriginal and Torres Strait Islander Queenslanders and there is no known cure. The Australian Institute of Health and Welfare notes that tobacco smoking is by far the strongest risk factor for COPD and estimated that in 1998 about 71 per cent of deaths from COPD (74% for men and 65% for women) was attributable to smoking.¹¹

During the two years from 2005/06 to 2006/07:

- Aboriginal and Torres Strait Islander Queenslanders were admitted to hospital for COPD at four times the rate of non-Indigenous Queenslanders (1,102 compared with 264 per 100,000)
- with the exception of remote areas, there was little difference in regional rates. Rates were highest in remote areas (2,463 per 100,000 compared with 1,417 per 100,000 or less elsewhere).

¹¹ Cited in Australian Institute of Health and Welfare 2005. Chronic respiratory diseases in Australia: their prevalence, consequences and prevention. AIHW Cat. No. PHE 63. Canberra: AIHW.

Key Queensland Government actions to close the gap

The Queensland Government is investing significantly in health care and services for all Queenslanders through the **\$10 billion Health Action Plan**, which has laid the foundation for a better public health system — more hospital beds, more doctors and nurses and improved clinical quality and safety, benefiting all Indigenous and non-Indigenous Queenslanders. Recurrent funding of \$110 million has been committed in 2008/09 (\$654 million over four years) and capital funding of \$190 million (\$472 million over four years) for expansions to the nursing and medical workforce, refurbishment and redevelopment of hospitals, improved ambulatory care and rehabilitation services and renal health initiatives.

During 2008, the Queensland and the Australian governments have signed up to the Closing the Health Gap Statement of Intent. Along with other states and territories, the Queensland Government has been negotiating with the Australian Government for a new national healthcare agreement and specific National Partnership Agreements including for Indigenous health, chronic conditions, preventative health and better cancer care to contribute to closing the gap in life expectancy and health status.

In recent years, the Queensland Government has committed to a **range of programs specifically addressing health issues impacting on Indigenous people**, including a significant investment of approximately \$89 million, over four years, which was announced in 2005/06 to support the first Queensland Government implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Health. In 2007/08, funding was made available for **approximately 60 additional service delivery positions** specifically focusing on Aboriginal and Torres Strait Islander health. The majority of these positions were placed with non-government sector service providers and many were filled by

Aboriginal and Torres Strait Islander people, thus contributing to the provision of culturally appropriate health services. The positions addressed the health issues of: nutrition; physical activity and healthy lifestyle; alcohol, tobacco and other drugs; child and youth health; sexual and reproductive health; cervical screening; and women's sexual health.

Preventative and primary health initiatives

The Queensland Government is working with Indigenous Queenslanders to ensure that they remain healthy and free of preventable disease through a number of preventative health measures including:

- as part of the **Immunise Australia Program**, the National Indigenous Childhood Hepatitis A Vaccination Program offers free vaccination state-wide to all Indigenous children under five years old. Similarly, the **National Indigenous Pneumococcal and Influenza Immunisation Program** aims to reduce respiratory illness by giving vaccines to Indigenous people. In both cases, the vaccines are provided by the Australian Government with Queensland Health undertaking the inoculations
- **the Queensland Aboriginal and Torres Strait Islander Women's Cervical Screening Strategy 2006–2010**, which is showing some significant results, with increased participation by women in the discrete communities. In Queensland, between 1991 and 2004, there was a 51 per cent reduction in the incidence of cervical cancer and a 45 per cent decrease in mortality associated with it. This downward trend is expected to continue as a result of the 2006–2010 Strategy



- **BreastScreen Queensland**, an established program which aims to make effective, culturally appropriate breast cancer screening services available to all Queensland women. Working closely with Indigenous health workers in rural and urban areas has been effective in encouraging Indigenous women to attend the program
- the **Queensland Bowel Cancer Screening Program**, which includes a project among people living in remote Indigenous communities implemented in Cairns and Townsville with culturally appropriate resources.

The Queensland Government is also committed to Indigenous people remaining healthy and free of preventable disease through access to primary health care. The Queensland and Commonwealth Governments jointly fund a **Medical Specialist Outreach Assistance Program** to provide specialist health services to remote and discrete communities, such as the **Cardiac Outreach Service** operating from Cairns (see case study at the end of this section). Other support includes: the **Healthy Women's Initiative** which aims to provide a state-wide workforce of Indigenous health workers to promote women's health in their communities and the **Certificate IV in Aboriginal and Torres Strait Islander Primary Health (Community Care – Women's Health)**, which is currently being piloted with Indigenous health workers.

Healthy lifestyles

The Queensland Government is supporting Aboriginal and Torres Strait Islander Queenslanders to remain healthy and free of preventable disease through good nutrition, physical activity and reduced levels of smoking and use of alcohol and drugs through general and Indigenous-specific programs, including funding for councils, community organisations and sport and recreation bodies across Queensland.

Sport and recreation plays an integral role in facilitating healthy lifestyles; providing positive role models for communities; building self-esteem; improving health outcomes; improving self-discipline and teamwork; breaking down barriers; increasing social cohesion; and offering a healthy and positive diversion to a range of behavioural issues such as alcohol and drug abuse and juvenile offending.

Given poor health status and limited infrastructure in remote Indigenous communities, the Department of Local Government, Sport and Recreation (DLGSR) is investing some \$4.4 million in 2008/09 providing sport and recreation opportunities in these communities. DLGSR's key initiatives supporting healthy lifestyles include:

- **investing more in Police-Citizens Youth Clubs (PCYCs)** as a primary provider of sport and recreation opportunities in Indigenous communities. The Yarrabah, Mornington Island and Palm Island PCYC centres continue to provide a focal point for sports and a centre for youth activities. The CAPE – PCYC program in Hope Vale, Wujal Wujal and Napranum has a similar role, utilising existing infrastructure in discrete communities
- funding sport and recreation infrastructure from the **Major Facilities Program**, including multipurpose centres, sports fields, and shade structures over outdoor courts, at a total cost of \$2 million in 2007/08
- supporting the **Former Origin Greats Program** to foster the participation of community members in sporting activities by using well-known role models. \$150,000 in funding was provided for developmental and mentoring services to particular Indigenous communities
- providing \$300,000 in funding to State Sporting Organisations including Netball Queensland, AFL Kickstart and Queensland Rugby League for **developmental and coaching clinics** in select Indigenous communities
- providing \$105,000 to PASS Sports Australia to support **35 student placements** within their Sports Leadership program across Queensland. The program encourages Indigenous youth to complete Year 12 and on completion of the training they are provided with through the program, they will gain a Certificate II in Sports Leadership. The program also increases the participation of primary school students in sport.

Under the Queensland Government's **Chronic Disease and Indigenous Health package**, 29 Indigenous-specific alcohol, tobacco, and other drug prevention and clinical positions are funded state-wide and 11 new positions were established in 2007/08.

Healthy Lives

Other initiatives underway to increase participation in physical activity, improve eating patterns and encourage healthy lifestyles include:

- a **Healthy Eating** project between Islander Board of Industry and Service (IBIS) stores in the Torres Strait, the Aboriginal and Torres Strait Islander Partnerships Retail Stores Unit and Queensland Health for a nutritionist to be placed with each of the retail groups to engage with the community to provide advice and education, and to improve the availability and minimise the cost of healthy foods and drinks
- the **Community Partnerships Grants Program**, a joint initiative between the DLGSR, Queensland Health and the Department of Education, Training and the Arts which supports breakfast programs and nutrition awareness sessions, community gardens, and a variety of physical activity opportunities in Indigenous communities
- a state-wide intervention program, **SmokeCheck**, for Indigenous people to help them reduce or quit smoking. More than 200 Indigenous health workers were trained in the program in 2007/08, and over 600 have been trained since it began in 2005
- the Queensland Government has recently been **actively encouraging healthy lifestyles** due to Queensland's increasing inactive lifestyles and rising levels of obesity and related health issues such as Type 2 diabetes. This has been supported by the Q2 vision which has set an ambitious target of cutting obesity rates by a third. The Queensland Government administers a number of innovative programs such as the **Inala Chronic Disease Management Service** to assist people in developing and maintaining healthy lifestyles. This service treats people with Type 2 diabetes by providing care in the community and helping people to self-manage their diabetes, including maintaining healthy living habits.

Mental health services

The Queensland Government is investing in enhanced mental health services for Indigenous Queenslanders. The **Queensland Plan for Mental Health 2007–2017** aims to provide dedicated strategies to reduce suicide risk and mortality with a focus on specific high risk groups, including Aboriginal and Torres Strait Islander populations. To date, a total of **107 Indigenous mental health workers** are employed in community mental health services in Queensland. More Indigenous mental health workers are needed state-wide, and over \$5 million has been allocated to 13 new positions over three years.

The **Queensland Government Suicide Prevention Strategy** adopts a whole-of-life suicide prevention framework and incorporates a particular focus on population groups known to be at higher risk such as Indigenous communities. As part of this strategy, the Department of Communities has funded Indigenous-specific projects including the **Rural and Remote and Indigenous Communities Suicide Prevention Project** which operates in the communities of Aurukun, Cunnamulla, Doomadgee, Mornington Island, Mount Isa and St George. The project raises awareness of suicide risk factors and helps community members to intervene effectively, focusing on cultural strengths from within family or clan groups.

Disability Services Queensland (DSQ) has allocated \$1.3 million over three years (2006-2009) for the **Transition from Correctional Facilities Program**, to provide non-clinical support to people with moderate to severe mental illness exiting a Queensland correctional facility, including people with an Indigenous background. It will provide valuable support to people from an Aboriginal and Torres Strait Islander background to transition to community for up to six months post-release. DSQ will work with Queensland Health to evaluate the program.

Sexual health

There is a disproportionately high incidence of sexually transmissible infections (STIs) in rural and remote Indigenous communities. The Queensland Government is working



in partnership with communities to support Indigenous Queenslanders in remaining healthy and free of preventable disease through improved sexual health.

The Queensland Government has taken action to reduce the incidence of STIs through education and clinical services, including contact-tracing. In 2007/08, funding of \$1.6 million was allocated to provide an additional **14 Indigenous Sexual Health Worker positions**, and in 2008/09 the budget increased to \$2.2 million to create a further eight positions. Filling the positions presents difficulties because of skills shortages and therefore an **Indigenous Sexual Health Worker short course** is being developed to train generalist Indigenous health workers in sexual health. At least 25 health workers are to be trained over three years.

Disability services

Disability Services Queensland (DSQ) is responsible for developing and providing policies, services and programs that support people with a disability, frail older people and those with a mental illness, their families and carers. It also funds a range of non-government services to provide disability, mental

health and aged care services to Queenslanders. Investment in specialist disability services through the Commonwealth State-Territory Disability Agreements in 2007/08 was \$716.8 million,¹² \$348.5 million for the Home and Community Care Program and \$16.5 million for mental health services provided by non-government service providers¹³.

Through the **Home and Community Care Program (HACC)**, DSQ allocated \$14 million in 2007/08 to Indigenous service providers for the provision of services to frail older Aboriginal and Torres Strait Islander people. The program currently provides services through 62 contracted Indigenous service providers as well as a broad range of non-Indigenous-specific service providers across Queensland. The HACC Queensland Triennial Plan 2008-2011 proposes growth funding of \$5.4 million over three years to purchase additional HACC services specifically directed to Aboriginal and Torres Strait Islander peoples. The program is reviewed regularly as part of the recurrent funding process.

¹² Source: CSTDA NMDS, Queensland tables, 2006/07 and DSQ Budget 2008/09.
¹³ Ministerial Portfolio Statement 2007/08 State Budget.

CASE STUDY: Indigenous Cardiac Outreach Clinics

The Indigenous Cardiac Outreach Clinic program recognises that a purely medical model approach to service delivery has not produced positive or sustained impacts on Indigenous cardiac (heart) health.

This innovative program was initiated through the concerns raised by the Cardiac Clinical Network through Dr Darren Walters about the increasing gap in Indigenous Cardiac Health. Program authors David Tibby (Director of Nursing, Cardiology) and Rohan Corpus (Indigenous Program Coordinator), both of The Prince Charles Hospital in Chermside, Brisbane, have developed a model of care which is more effectively assessing and treating Indigenous patients and empowering Indigenous people to take a proactive approach to their health. The cardiac outreach model is based on a carefully constructed relationship between the clinical team delivering the service and those community members who attend the outreach clinics. Mutual respect and responsibility is not only the underlying philosophy for how the clinic operates, it is also the foundation for enhancing the ability of local Indigenous community members to take greater control and care of their heart health.

The clinics successfully began delivering an Outreach Service in 2007 to 16 sites throughout the state. Community participation has been evident by the overwhelming number of community members engaging in ongoing clinical sessions.