



BUDGET PROPOSALS TO ACCELERATE CLOSING THE GAP IN INDIGENOUS LIFE EXPECTANCY

January 2018

Widening mortality gaps require urgent action

A December 2017 report from the Australian Institute of Health and Welfare (AIHW) shows that the mortality gaps between Indigenous and non-Indigenous Australians are widening, not narrowing. Urgent action is needed to reverse these trends to have any prospect of meeting the Council of Australian Governments' goal to Close the Gap in life expectancy within a generation (by 2031). The following submission by the National Aboriginal Community Controlled Health Organisation (NACCHO) in relation to the Commonwealth Budget 2018 aims to reverse the widening mortality gaps.

The life expectancy gap means that Indigenous Australians are not only dying younger than non-Indigenous Australians but also carry a higher burden of disease across their life span, impacting on education and employment opportunities as well as their social and emotional wellbeing. Preventable admissions and deaths are three times as high in Indigenous people yet use of the main Commonwealth schemes, Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) are at best half the needs based requirements. It is simply impossible to close the mortality gaps under these conditions. No government can have a goal to close life expectancy and child mortality gaps and yet concurrently preside over widening mortality gaps. Going forward, a radical departure is needed from a business as usual approach.

Funding considerations, fiscal imbalance and underuse of MBS/PBS

The recent Productivity Commission Report found that per capita government spending on Indigenous services was twice as high as for the rest of the population. The view that enormous amounts of money have been spent on Indigenous Affairs has led many to conclude a different focus is required and that money is not the answer. Yet, the key question in understanding the relativities of expenditure on Indigenous is equity of total expenditure, both public and private and in relation to need.

In terms of health expenditure, the Commonwealth spends \$1.4 for every \$1 spent on the rest of the population, notwithstanding that, on the most conservative assumptions, Indigenous people have at least twice the per capita need of the rest of the population because of much higher levels of illness and burden of disease. This represents a significant market failure. The health system serves the needs of the bulk of the population very well but the health system has failed to meet the needs of the Indigenous population.

A pressing need is to address the shortfall in spending for out of hospital services, for which the Commonwealth is mainly responsible, and which is directly and indirectly responsible for excessive preventable admissions funded by the jurisdictions – and avoidable deaths. The fiscal imbalance whereby underspending by the Commonwealth leads to large increases in preventable admissions (and deaths) borne by the jurisdictions needs to be rectified.

Ultimately, NACCHO seeks an evidenced based, incremental plan to address gaps, and increased resources and effort to address the Indigenous burden of disease and life expectancy. The following list of budget proposals reflect the burden of disease, the underfunding throughout the system and the comprehensive effort needed to close the gap and ideally would be considered as a total package. NACCHO recommends initiatives that impact on the greatest number of Indigenous people and burden of preventable disease and support the sustainability of the Aboriginal Community Controlled Health Organisation (ACCHO) sector – see proposals 1. a) to e) and 3. a) and b) as a priority.

NACCHO is committed to working with the Australian Government on the below proposals and other collaborative initiatives that will help Close the Gap.

National Aboriginal Community Controlled Health Organisation

NACCHO is the national peak body representing 144 ACCHOs across the country on Aboriginal health and wellbeing issues. In 1997, the Federal Government funded NACCHO to establish a Secretariat in Canberra, greatly increasing the capacity of Aboriginal peoples involved in ACCHOs to participate in national health policy development. Our members provide about three million episodes of care per year for about 350,000 people. In very remote areas, our services provided about one million episodes of care in a twelve-month period. Collectively, we employ about 6,000 staff (most of whom are Indigenous), which makes us the single largest employer of Indigenous people in the country.

The following proposals are informed by NACCHO's work with Aboriginal health services, its members, the views of Indigenous leaders expressed through the Redfern Statement and the Close the Gap campaign and its engagement and relationship with other peak health organisations, like the Australian Medical Association (AMA).

Guiding principles

Specialised health services for Indigenous people are essential to closing the gap as it is impossible to apply the same approach that is used in health services for non-Indigenous patients. Many Indigenous people are uncomfortable seeking medical help at hospitals or general practices and therefore are reluctant to obtain essential care. Access to healthcare is often extremely difficult due to either geographical isolation or lack of transportation. Many Indigenous people live below the poverty line so that services provided by practices that do not bulk bill are unattainable. Mainstream services struggle to provide appropriate healthcare to Indigenous patients due to significant cultural, geographical and language disparities: ACCHOs attempt to overcome such challenges.

An ACCHO is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management. They form a critical part of the Indigenous health infrastructure, providing culturally safe care with an emphasis on the importance of a family, community, culture and long-term relationships. Studies have shown that ACCHOs are 23% better at attracting and retaining Indigenous clients than mainstream providers and at identifying and managing risk of chronic disease. Indigenous people are more likely to access care if it is through an ACCHO and patients are more likely to follow chronic disease plans, return for follow up appointments and share information about their health and the health of their family. ACCHOs provide care in context, understanding the environment in which many Indigenous people live and offering true primary health care. More people are also using ACCHOs. In the 24 months to June 2015, our services increased their primary health care services, with the total number of clients rising by 8%. ACCHOs are also more cost-effective providing greater health benefits per dollar spent; measured at a value of \$1.19:\$1. The lifetime health impact of interventions delivered by

our services is 50% greater than if these same interventions were delivered by mainstream health services, primarily due to improved Indigenous access. If the gap is to close, the growth and development of ACCHOs across Australia is critical and should be a central component to policy considerations.

Mainstream health services also have a significant role in closing the gap in Indigenous health, providing tertiary care, specialist services and primary care where ACCHOs do not exist. The Indigenous Australians' Health Programme accounts for about 13% of government expenditure on Indigenous health. Given that other programs are responsible for 87% of expenditure on Indigenous health, it reasonable to expect that mainstream services should be held more accountable in closing the gap than they currently are.

Greater effort is required by the mainstream health sector to improve its accessibility and responsiveness to Indigenous people and their health needs, reduce the burden of disease and to better support ACCHOs with medical and technical expertise. The health system's response to closing the gap in life expectancy involves a combination of mainstream and Indigenous-specific primary care providers (delivered primarily through ACCHOs) and where both are operating at the highest level to optimise their engagement and involvement with Indigenous people to improve health outcomes. ACCHO's provide a benchmark for Indigenous health care practice to the mainstream services, and through NACCHO can provide valuable good practice learnings to drive improved practices.

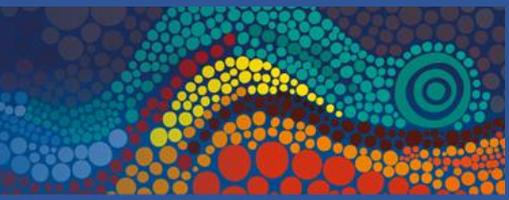
NACCHO also acknowledges the social determinants of health, including housing, family support, community safety, access to good nutrition, and the key role they play in influencing the life and health outcomes of Indigenous Australians. Elsewhere NACCHO has and will continue to call on the Australian and state and territory governments to do more in these areas as they are foundational to closing the gap in life expectancy. Addressing the social determinants of health is also critical to reducing the number of Indigenous incarceration. Comprehensively responding to the Royal Commission into the Protection and Detention of Children in the Northern Territory must be a non-negotiable priority.

Proposals

The following policy proposals are divided into four areas below and summarised in the following table:

1. Proposals that strengthen and expand ACCHOs' capacity and reach to deliver health services for Indigenous people
2. Proposals that improve responsiveness of mainstream health services for Indigenous people
3. Proposals that address specific preventable diseases
4. Proposals that build in an Indigenous position into policy considerations that impact on health.

NACCHO is committed to working with the Australian Government to further develop the proposals, including associated costings and implementation plans and identifying where current expenditure could be more appropriately targeted.



2018-19 Budget Proposals

Proposals that strengthen and expand ACCHOs' capacity and reach to deliver health services for Indigenous people

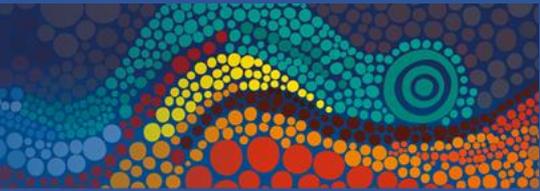
- Fund a 5-year plan to provide infrastructure for satellite and outreach ACCHOs in areas with higher levels of preventable Indigenous admissions and deaths and lower use of Medicare Benefits Schedule (MBS) / Pharmaceutical Benefits Scheme (PBS).
- Create ACCHOs clinics in 10 areas identified by the AIHW as having no ACCHOs service within one hour's drive, and fund regular visits by mobile clinics in 30 identified areas with populations of less than 600.
- Assign ACCHOs as preferred providers for Australian Government funded health services for Indigenous people unless it can be shown that alternative arrangements can produce better outcomes in quality of care and access to services.
- Provide secure and long-term funding to ACCHOs to expand into areas where there are known service gaps including mental health, disability services and aged care.
- Provide support to NACCHO and its member organisations to:
 - operate with commercial astuteness, including developing robust funding frameworks and maximising available streams through the MBS / PBS
 - prioritise capital for business expansion through Indigenous Business Australia
 - streamline funding arrangements to improve accountability and better reflect service delivery governance, models and needs.

Proposals that improve responsiveness of mainstream health services for Indigenous people

- Extend and then mandate the implementation of National Safety and Quality Health Service (NSQHS) Standards to improve cultural safety and competence within the health system.
- Fund Indigenous organisations to assist Primary Health Networks (PHN) and other medical services to meet the mandated cultural competency standards.
- Scope the establishment an Indigenous accreditation body to ultimately monitor and assess the implementation of cultural competency standards across the health system.
- Develop a coordinated workforce strategy that, over time, will embed a strong Aboriginal and Torres Strait Islander workforce within the health sector, including medical and allied health professionals in all health services.
- Fund the Lowitja Institute to conduct an annual national survey of the Indigenous health workforce across all sectors.



NACCHO
National Aboriginal Community
Controlled Health Organisation



2018-19 Budget Proposals (cont)

Proposals that address specific preventable diseases

- Identify options that enable remote health care workers (other than doctors) to order point of care pathology and administer treatment for Sexually transmitted infections (STIs) and blood-borne viruses (BBVs)
- Fund surge workforce capability to undertake targeted testing and treatment of STIs and BBVs in areas of identified need.
- Fund Regional Sexual Health Coordinators in ACCHOs in key areas across Australia to implement ongoing STIs and BBV management strategies.
- Develop and fund a coordinated national strategic response to chronic otitis media be developed by a National Indigenous Hearing Health Taskforce under Indigenous leadership for the Council of Australian Governments and as part of the Closing the Gap strategy.
- Include additional MBS items to support the provision of dialysis in remote communities by Aboriginal health practitioners and health workers.
- Funding of Aboriginal and Torres Strait Islander Suicide Prevention, health and wellbeing and alcohol and other drugs back to be delivered through Aboriginal organisations and ACCHOs.
- Increase investment through the Aboriginal and Torres Strait Islander Suicide Prevention Strategy, underpinned by trauma approaches and to be led by local Aboriginal organisations and communities.

Proposals that build in an Indigenous position into policy considerations that impact on health

- The MBS Review Taskforce and relevant committees to include representation from NACCHO and its member organisations.
- The assessment and review of the NSQHS standards scheduled for the beginning of in 2019 to include an Indigenous advisory committee comprised of NACCHO and other peak Indigenous health organisations.
- Establish an Aboriginal and Torres Strait Islander Commonwealth Advisory Group to support consideration, implementation and monitoring of an Indigenous position in efforts to Close the Gap and on jurisdictional agreements that have high impact on Indigenous peoples.

1. Strengthen and expand the Aboriginal Community Controlled Health Services Sector

- a) Fund a 5-year plan to provide infrastructure for satellite and outreach ACCHOs in areas with higher levels of preventable Indigenous admissions and deaths and lower use of Medicare Benefits Schedule (MBS) / Pharmaceutical Benefits Scheme (PBS).
- b) Create ACCHOs clinics in 10 areas identified by the AIHW as having no ACCHOs service within one hour's drive, and fund regular visits by mobile clinics in 30 identified areas with populations of less than 600.
- c) Assign ACCHOs as preferred providers for Australian Government funded health services for Indigenous people unless it can be shown that alternative arrangements can produce better outcomes in quality of care and access to services.

ACCHOs consistently deliver improved health outcomes for Indigenous people, performing better for Indigenous people than general practitioners in mainstream services particularly in relation to access to services and the prevention, detection and treatment of chronic disease. Funding should be prioritised to the services that deliver the best outcomes for Indigenous people.

NACCHO would welcome an opportunity to work with the Australian Government to develop a 'preferred provider policy' for Australian Government funding for all Indigenous health service delivery. ACCHOs could be prioritised through changes to the Commonwealth Grant Rules reflecting something like the successful Australian Government Indigenous Procurement Policy.

There are extensive service gaps where Indigenous people do not have access to culturally appropriate medical services. The AIHW has identified 40 areas across Australia where there is no Indigenous specific health service within one hour's drive. Eleven of these areas have a population of more than 600 people, and more than half of these areas have high rates of preventable hospitalisations.

Providing at least a doctor in these areas on a regular basis would still be well below the 3.4 doctors per 1000 people in Australia but would be a significant step towards closing the gap in Indigenous health outcomes. Further, without a platform for increased service delivery, Indigenous people will continue to miss out on chronic disease and primary care services and preventable hospital admissions and deaths will continue to increase. The proposed increase in specialist services for otitis media care, mental health, disability and aged care services and others services responsive to current gaps require an extended service delivery platform to be sustainable and effective.

A working group with the Department of Health, NACCHO and Indigenous health representatives from these areas should be immediately established to map out, cost and progress the proposal.

- d) Provide secure and long-term funding to ACCHOs to expand into areas where there are known service gaps including mental health, disability services and aged care.

Indigenous Australians are twice as likely to die by suicide or be hospitalised for mental health or behavioural reasons as non-Indigenous Australians and are missing out on much needed mental health services. The AIHW found that mental health and substance abuse accounted for about 19% of the health gap and were the biggest single contributor to the burden of disease. Funding should be provided to ACCHOs to meet this service gap and should include the skill development and training of the 1900 or more Aboriginal health practitioners employed through ACCHOs to build their mental health support capabilities.

The service gap is similar for Indigenous people's need for and access to appropriate disability and aged care services close to where Indigenous people live.

Delivering these much-needed services through ACCHOs, rather than establishing a new service, would deliver economies of scale and would draw from an already demonstrated successful model of service delivery.

e) Provide support to NACCHO and its member organisations to:

- operate with commercial astuteness, including developing robust funding frameworks and maximising available streams through the MBS / PBS;
- prioritise capital for business expansion through Indigenous Business Australia;
- streamline funding arrangements to improve accountability and better reflect service delivery governance, models and needs.

Increasingly there is pressure for ACCHOs to operate in a growing commercial context, where available streams of mainstream funding are maximised and resources are accounted for. ACCHOs must also be planning for an increasing Indigenous population with changing health needs. The average annual growth rate of the Indigenous population is 3.4% (over twice as high as the non-Indigenous population, which was 1.4% from 2011 to 2016).

NACCHO should be funded to work with other expertise to develop and deliver a package of support to ACCHOs to respond to these challenges, to operate with more commercial astuteness and maximise access to mainstream funding support to Indigenous patients whilst maintaining its unique governance and primary health care model. This would include developing a rolling plan for Medicare Liaison Officers to visit ACCHOs across Australia to provide continuing Medicare education and training to health service staff about Indigenous health care plans and the Medical Benefit Schedule (MBS) items available for Indigenous customers, increase Aboriginal and Torres Strait Islander Australians enrolments in Medicare and ensure correct Medicare benefits are claimed.

2. Proposals that improve responsiveness of mainstream health services for Aboriginal people

- a) Extend and then mandate the implementation of National Safety and Quality Health Service (NSQHS) Standards to improve cultural safety and competence within the health system.
- b) Fund Indigenous organisations to assist Primary Health Networks (PHN) and other medical services to meet the mandated cultural competency standards.
- c) Scope the establishment an Indigenous accreditation body to ultimately monitor and assess the implementation of cultural competency standards across the health system.

Racism is a key driver of ill-health for Indigenous people, impacting not only on their access to health services but their treatment and outcomes when in the health system. Exposure to racism is associated with psychological distress, depression, poor quality of life, and substance misuse, all of which contribute significantly to the overall ill-health experienced by Indigenous people. Institutional racism means that Indigenous people do not always receive the care that they need from Australia's hospital and health system.

The NSQHS Standards were developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers and the second edition was issued in late 2017. The primary aim of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. Whilst the second edition goes some way to seeking improvements in the standard of care and safety for Indigenous patients, further work is needed to ensure there are requirements for cultural intelligence training to all medical and health staff, cultural competence practices are embedded within a service, efforts are undertaken to employ and train Indigenous staff and there are mechanisms for engagement and feedback from the local Indigenous community groups to support continuous improvement.

NACCHO should be funded to work with ACCHOs to help local PHN and hospitals meet the cultural competency standards and to monitor and improve the quality of care (CQI). Support from a local Indigenous organisation to health services to meet and maintain the standards will ensure changes are implemented in a culturally appropriate manner, as well as providing employment and business opportunities to Indigenous organisations.

In the longer term, the establishment of an Indigenous Islander accreditation body to monitor and assess the implementation of cultural competency standards across the health system should be scoped. Such a body will ensure that it is Indigenous people that are ultimately deciding whether a health service is culturally appropriate or not.

- d) [Develop a coordinated workforce strategy that, over time, will embed a strong Aboriginal and Torres Strait Islander workforce within the health sector, including medical and allied health professionals in all health services.](#)
- e) [Fund the Lowitja Institute to conduct an annual national survey of the Indigenous health workforce across all sectors.](#)

Indigenous health staff are critical to improving access to culturally appropriate care and Indigenous health outcomes, as well as employment itself leading to improved health for Indigenous people. ACCHOs are collectively the largest employer of Indigenous workers in the country. Currently, the highest Indigenous representation in ACCHOs is amongst non-clinical staff. Increased effort is required to develop career pathways to secure more Indigenous doctors, nurses and allied health professionals. Across Australia, there are only about 170 Indigenous medical practitioners, 730 Indigenous allied health professionals, and 2,190 Indigenous nurses. A long-term plan for building the workforce capabilities of ACCHOs is overdue. Additionally, mainstream health services should be significant employers of Indigenous health professionals as part of a strategy to increase their responsiveness to Indigenous health needs.

A national, coordinated and funded strategy is needed that, over time, will embed a strong Indigenous workforce within the health sector, including medical and allied health professionals in all health services. The workforce strategy should include pathways from school and through tertiary and other education as well as on the job and in the work place support and professional development. The workforce strategy should be developed in partnership with NACCHO and its member organisations, COAG, and educational institutions and their representatives. The Lowitja Institute, Australia's national institute for Aboriginal and Torres Strait Islander health research, should be funded to conduct an annual Indigenous workforce survey to identify assess progress and identify areas for improved effort in recruitment, professional development and retention.

3. Proposals that address specific preventable diseases

The following proposals address specific preventable diseases, diseases that disproportionately affect Indigenous people.

Sexually transmitted infections and blood-borne viruses

- a) Identify options that enable remote health care workers (other than doctors) to order point of care pathology and administer treatment for BBVs and STIs.
- b) Fund surge workforce capability to undertake targeted testing and treatment of STIs and BBVs in areas of identified need.
- c) Fund Regional Sexual Health Coordinators in ACCHOs in key areas across Australia to implement ongoing STIs and BBV management strategies.

ACCHOs have a vital role in addressing sexual health issues and managing serious public health outbreaks on the ground particularly in remote Australia. A significant barrier to STI and BBV testing and treatment in rural and remote areas is lack of access to Medical Officers currently required under the MBS to request pathology testing. Enabling trained and approved nurses and Aboriginal Health Practitioners in endemic areas to access independent MBS provider numbers would allow immediate diagnosis and treatment and initiate contact tracing.

A surge workforce is required to address current outbreaks and areas of high need and to undertake targeted testing and treatment of STIs and BBVs. Ideally this would be an Indigenous surge workforce supported by and linked back to their respective ACCHOs to support improved access, follow up and continuity of care.

Building on the successful Nganampa Health Service (APY Lands, South Australia) model, Regional Sexual Health Coordinators working from ACCHOs should be implemented across key at risk regions. Regional coordinators would be responsible for implementing pandemic protocols, supporting data collection and surveillance and coordinating outbreaks responses and managing surge workforces.

Ear health

- d) Develop and fund a coordinated national strategic response to chronic otitis media be developed by a National Indigenous Hearing Health Taskforce under Indigenous leadership for the Council of Australian Governments and as part of the Closing the Gap strategy.

In its 2017 Report Card on Indigenous Health, the AMA called for a national response to the disproportionate rates of chronic otitis media by Indigenous children and the impacts this has across the life span. NACCHO supports this call. The strategy should include national surveillance reporting and a focus on primary prevention including promotion of a single integrated health hygiene message and promotion that includes explanation of disease processes and causal links targeted. For most non-Indigenous Australian children, otitis media is readily treated, but for many Indigenous children, it is not. Estimates show that an average Indigenous child will endure middle ear infections and associated hearing loss for at least 32 months, from age two to 20 years, compared with just three months for a non-Indigenous child.

Renal health

- e) Additional MBS items to support the provision of dialysis in remote communities by Aboriginal health practitioners and health workers.

There is inadequate support for Indigenous people requiring treatment for renal disease. In remote and very remote areas the incidence of End Stage Kidney Disease is especially high (rates almost 20 times higher than non-Indigenous people) and requires many Aboriginal community members, and often their families supporting them, to relocate to access dialysis services.

The MBS review of renal health has recommended additional items to support the provision of dialysis in remote communities by Aboriginal health practitioners and health workers, which if adopted by the Australian Government, will significantly address the need to relocate for treatment and provide a sustainable funding source. The direct costs of providing staffed dialysis services in very remote areas will be high but consideration should be given to the broader impacts for patients and their families of relocation. This has the potential to be transformative for many Aboriginal people and the community controlled health sector. Receiving treatment on country is critically important to effective management and well-being for people from remote areas.

Mental health and wellbeing

- a) Funding of Aboriginal and Torres Strait Islander Suicide Prevention, health and wellbeing and alcohol and other drugs back to be delivered through Aboriginal organisations and ACCHOs.
- b) Increase investment through the Aboriginal and Torres Strait Islander Suicide Prevention Strategy, underpinned by trauma approaches and to be led by local Aboriginal organisations and communities.

Indigenous adults are three times more likely to experience high or very high levels of psychological distress than other Australians. They are also hospitalised for mental and behavioural disorders and suicide at almost twice the rate of non-Indigenous population. Local Aboriginal community controlled services are the preferred providers of suicide prevention activities to their communities. The Australian Government funding should be prioritised to on the ground Aboriginal organisations to deliver suicide prevention, trauma and other wellbeing services.

Increased investment through the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy should maintain focus on action areas including early intervention and building strong communities through community-focused, holistic and integrated approaches to suicide prevention. In implementing the activities listed under the action areas the focus should, where possible, be on providing the widest possible benefit to Aboriginal and Torres Strait Islander peoples, with additional effort focussed on those at greater risk or disadvantage. The move to the NFA also represents an opportunity to return funding for Aboriginal and Torres Strait Islander suicide prevention, health and wellbeing and alcohol and other drugs from the IAS to the IAHP and to reinstate the growth funding previously diverted to the Ice Task Force.

4. Proposals that build in an Indigenous position into policy considerations that impact on health

- a) The MBS Review Taskforce and relevant committees to include representation from NACCHO and its member organisations.

- b) The assessment and review of the NSQHS standards scheduled for the beginning of in 2019 to include an Indigenous advisory committee comprised of NACCHO and other peak Indigenous health organisations.
- c) Establish an Aboriginal and Torres Strait Islander Commonwealth Advisory Group to support consideration, implementation and monitoring of an Indigenous position in efforts to Close the Gap and on jurisdictional agreements that have high impact on Indigenous peoples.

The essential requirement to Close the Gap in life expectancy and new thinking needed in this area is a properly funded absolute commitment to evidence-based policy, created in partnership with Indigenous Australians. If the health system is to adequately respond to Indigenous needs, Indigenous people must be part of the design and decision making within that system.

There needs to be representation proportionate to need from Indigenous health experts and consumers on consideration of key issues that impact on Indigenous people's access to health care and burden of disease. Representation on the MBS Review Taskforce, its related committees, and on the review committee of the NSQHS standards would be a significant step towards ensuring consideration of Indigenous needs in two crucial areas in Indigenous health.

Whilst the Australian Government has rejected the Uluru Statement, it cannot ignore the need to involve Indigenous people in efforts that directly relate to closing the gap and on issues that have a high impact on Indigenous people's lives. An Aboriginal and Torres Strait Islander Commonwealth Advisory Group with membership supported by peak Indigenous organisations would go some way to meeting this need and Government obligation.

Conclusion

The 2018-19 Budget is make or break to address the gap in life expectancy. Whilst the Turnbull Government cannot itself be blamed for the current flat lining in Indigenous mortality, it is their responsibility to lead and implement a plan to turn the situation around.

The budget proposals are not radical in the sense that they have been talked about for many years, and have the support of key health and medical associations across Australia. If the proposals are adopted, fully funded and implemented, they provide a pathway forward where improvements in life expectancy can be confidently predicted.