National Aboriginal Community Controlled Health Organisation Submission to:

Committee Secretary
Senate Select Committee on Men's Health

The National Aboriginal Community Controlled Health Organisation (NACCHO) through this submission, humbly request that the Senate Select Committee on Men's Health consider the following:

First and foremost NACCHO asserts that; Aboriginal Men's Health must be viewed holistically and it also be noted that

1. Aboriginal males see their health as formed by a complex set of social, behavioural and genetic factors.
2. Health status is not an individualised issue. Aboriginal males locate their health within complex social relationships, between each other, to their families and within the broader socio-political context of their communities. **(Central Australian Aboriginal Congress)**

"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.

"Aboriginal health related services" means those services covered by the Aboriginal holistic definition of health including, but not restricted to, such services as health promotions and disease prevention services, substance misuse, men's and women's health, specialised services to children and the aged, services for people with disabilities, mental health services, dental care, clinical and hospital services and those services addressing, as well as seeking the amelioration of, poverty within Aboriginal communities.

"Primary Health Care" has always been a continuing integral aspect of our Aboriginal life, and is the collective effort of the local Aboriginal community to achieve and maintain its cultural well being. Primary health care is a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status. Primary health care is an Aboriginal cultural construct that includes essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to Communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination.

The provision of this calibre of health care requires an intimate knowledge of the community and its health issues, with the community itself providing the most effective and appropriate way to address its main health problems, including promotive, preventative, curative and rehabilitative services. (Adapted from the W.H.O. Alma-Ata Declaration 1978)

Primary health care is the first level of contact of individuals, families and the community with the health care system and in Aboriginal communities this is usually through an Aboriginal Community Controlled Health Service (ACCHS) or satellite Aboriginal community health clinic that it services. Primary health care, within the holistic health provision of an ACCHS, provides the sound structure to address all aspects of health care arising from social, emotional and physical factors. It incorporates numerous health related disciplines and services, subject to its level of operation, available resources and funding.

In addition to the provision of medical care, with its clinical services treating diseases and its management of chronic illness, it includes such services as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, programs and necessary support services to address the effects of socio-somatic illness and other services provided in a holistic context.

Primary Health Care is all inclusive, integrated health care and refers to the quality of health services. It is a comprehensive approach to health in accordance with the Aboriginal holistic definition of health and arises out of the practical experience within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities.

Mortality

Between 1996-2001, the estimated difference in life expectancy between Indigenous Australian Men and non- Indigenous Australian Men is approximately 17 years.

Life expectancy at birth for Indigenous Australian Men is estimated to be 59.4 years compared to 76.6 years for non- Indigenous Australian Men.

During 1999-2003, in Western Australia, South Australia, Queensland and the Northern Territory 75% of Indigenous Australian Men died before the age of 65 years compared to 26% of non – Indigenous Australian Men.

Major impediments to producing a complete picture of Indigenous mortality in Australia are the incomplete identification of Indigenous status in death records, and the experimental nature of the population estimates. As a result, the 2,279 deaths registered in 2006 where the deceased person was identified as Indigenous is certainly an underestimate of the actual number of Indigenous deaths. (ABS)

Assessment by the ABS of the completeness of recording of Indigenous

deaths is based on a comparison of registered Indigenous deaths with an estimate of the expected number of Indigenous deaths for the particular jurisdiction. The estimated completeness of identification of Indigenous people in death registrations has improved generally in recent years, but was still generally quite poor in 2002-2006.

Australia-wide, only 55% of Indigenous deaths were identified correctly - the Northern Territory (90%) was the only jurisdiction with a reasonable proportion of Indigenous deaths identified correctly. The proportions for the other jurisdictions were: NSW (45%), Victoria (32%), Queensland (51%), WA (72%) and SA (62%). Estimate weren't available for Tasmania and the ACT. Reflecting the various levels of under-identification of Indigenous status in death registrations it is possible that the true figures could be up to 30% higher than those presented here.

The poor coverage, coupled with the need to update the procedures for estimating coverage based on population figures derived from the 2001 census, has meant that the recent ABS publications do not include detailed tables of Indigenous deaths, nor information about overall death rates. As a result, there is no consistency about the extent of information available for recent years. Reflecting this, readers should be aware that the following sections vary in terms of the years to which they relate.

Standardised death rates (SDRs)

After adjusting for the differences in the age structures of the Indigenous and non-Indigenous populations and for the incomplete identification of Indigenous status in death registrations, the numbers of deaths of Indigenous people in 2000-2004 were around four times higher than the numbers expected from the age-sex-specific death rates for the total Australian populations. (The ABS warns that the projected numbers of deaths should be interpreted with caution).

It is possible that the standardised mortality ratios (SMRs) based on the projected numbers of deaths may over-estimate the differences between Indigenous and total population mortality, but it is likely that the true ratios will be closer to these estimates than to those based solely on death registrations.

For those jurisdictions with reasonable information about Indigenous deaths, the median age at death in 2006 ranged from 45.4 years for Indigenous males living in the NT to 59.3 years for those living in NSW. (The median age at death is the age below which 50% of people die. Because the measure partly reflects the age structures of the respective populations, it is a less precise measure than age-specific death rates.)

These levels are around 20 years less than those for non-Indigenous males, which were generally around 76-78 years.

In 2002-2006 the age-specific death rates were higher for Indigenous people

than for non-Indigenous people across all age groups, but the rate ratios were particularly high in the young and middle adult years. (These ratios, being based on the numbers of deaths registered, are likely to underestimate the true differences between death rates for Indigenous people and the total population by around 30 %.)

For deaths identified as Indigenous in 2000-2004, cardiovascular disease was the leading cause of death for Indigenous males living in Queensland, WA, SA and the NT. The number of deaths recorded for Indigenous males was 3.1 times the number expected from the age-cause-specific rates for non-Indigenous males. The estimates quoted here have not been adjusted for the likely under-identification of Indigenous people in death registration systems, so SMRs could be up to 30% higher.

For Indigenous males, the next most frequent causes of death were injuries (including transport accidents, intentional self-harm and assault) (SMR 2.8), malignant neoplasms (cancers) (SMR 1.5), diseases of the respiratory system (SMR 4.1), and endocrine, nutritional and metabolic disorders (mainly diabetes) (SMR 7.5). (Source; Australian Bureau of Statistics ABS)

The National Aboriginal Community Controlled Health Organisation (NACCHO) implores the Senate Select Committee on Men's Health to consider the following;

1. That consideration is given to rectifying the obvious anomalies that limit the Australian Bureau of Statistics data interpretation, thus enabling the life expectancy of Aboriginal Men to be both true and correct. (Inaccurate Data impinges upon the effectiveness of service delivery for Aboriginal Men. Hence efforts to "Close the Gap" in life expectancy between Aboriginal and non Aboriginal Men could therefore be diminished.)

2. To assist in addressing the Social and Emotional needs of Aboriginal Men, any National Men's Health Strategy should include the establishment of resources such as Brother to Brother support programs incorporating appropriate counselling resources to nurture men and to address their social issues as part of a holistic approach to the wellbeing of their communities. To enable this to occur, national funding for such programs should be directed to Aboriginal Community Controlled Health Services. The Central Australian Aboriginal Congress Aboriginal Male Health Branch is a recommended model.

3. To assist with treatment services and general support programs for Aboriginal Men's Health in metropolitan, rural, regional and remote areas, it is recommended that NACCHO be funded to pursue the development of an Aboriginal men's 1800 phone help line staffed by appropriately trained Aboriginal men to support them with their social and emotional well being needs.

4. Develop strategies to improve Aboriginal Men's participation within the health workforce.
5. Develop a coordinated and integrated approach to improve Partnerships on collaboration across the health and health related sectors including correctional and educational services.

6. The National Aboriginal Community Controlled Health Organisation (NACCHO) would like to support both the following Submission's to the Senate Select Committee on Men's Health:
   - **"Aboriginal Male Health- Brothers Supporting Brothers- a central Australian Aboriginal perspective." (Central Australian Aboriginal Congress Inc.)**
   - **Submission to the Senate Select Committee on Men's Health by " Indigenous health providers and researchers" co-signed by Dr Alex Brown, Dr Mark Wenitong and Dr Mick Adams (NACCHO Chair)**
   - In their "Submission" Drs Brown, Wenitong & Adams state: "*We would also like to draw the Senate Select Committee's attention to A National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males."*

NACCHO commends to the Senate Select Committee on Men's Health to be included in its deliberations **"A National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males (2004, the Office of Aboriginal and Torres Strait Islander Health, Canberra)**

The National Aboriginal Community Controlled Health Organisation (NACCHO) would like to thank the Senate Select Committee on Men's Health for the opportunity to submit on a health issue of National importance.

NACCHO avails itself to discuss this "Submission" at the discretion of the Senate Select Committee on Men's Health.