

Aboriginal health in Victoria

Research summary

Identifying the determinants of physical and mental health



VicHealth is committed to helping close the health gap between Aboriginal and non-Aboriginal Victorians. As part of this commitment, VicHealth established a focus on improving Aboriginal health as a key priority area for action during 2009–2013.

This research summary presents a synopsis of the latest published research examining the health status of Aboriginal Victorians. It describes the burden of disease that arises from preventable chronic conditions, the risk factors that contribute to this disease, and the social and economic factors that influence Aboriginal health and wellbeing.

Other research summaries in this series are available at www.vichealth.vic.gov.au/publications.

While the overall health of world populations is improving, there are significant inequalities between different population groups across and within countries. In Australia, Aboriginal¹ and non-Aboriginal people experience vastly different health outcomes.

In fact, the greatest differences in health between peoples within a country anywhere in the world exist here in Australia (CSDH 2008). 'Indigenous people are generally less healthy than other Australians, die at much younger ages, have more disability and a lower quality of life' (AIHW 2008a, p. 62).

The gap in health status between Aboriginal and non-Aboriginal Australians is demonstrated by a significantly lower life expectancy for Aboriginal men and women. This is largely the result of unequal access to resources and opportunities necessary for good health. These include factors such as income, quality housing, education and participation in community activities (VicHealth 2009).

Introduction

In the 2006 census 30,143 Victorians identified themselves as Aboriginal, representing 0.6 per cent of the total Victorian population. Victorian Aboriginal people make up 6.6 per cent of the total Australian Aboriginal population (ABS 2007).

These are some features of the Victorian Aboriginal population:

- A lower life expectancy at birth than non-Aboriginal people (see page 2), which is similar elsewhere in the country (ABS & AIHW 2008).
- A median age of 21 years compared with a median age of 37 years for the non-Aboriginal population (ABS 2008; ABS & AIHW 2008).
- Almost half of Victoria's Aboriginal population lives in metropolitan areas (47 per cent), with 53 per cent living in rural and regional areas (DrugInfo Clearinghouse 2009).
- The population is growing at a faster rate than the non-Aboriginal population (VicHealth 2005). Victoria has the highest Aboriginal population growth rate in the country (ABS 2006).
- Aboriginal people are in the minority within their communities wherever they live in Victoria (Hall 2009).

¹ In this research summary, the term 'Aboriginal' is used to refer to both Aboriginal and Torres Strait Islander peoples.

Aboriginal life expectancy

Accurately determining life expectancy of Aboriginal Australians was difficult because of unclear or inadequate data. The common practice in the past of using indirect methods indicated a 17 year life expectancy gap between Aboriginal and non-Aboriginal Victorians (ABS & AIHW 2008)². Newer methods now indicate a life expectancy gap between Aboriginal and non-Aboriginal Australians of 11.8 years for men and 10 years for women (ABS 2006). However, there is currently not enough information to produce reliable estimates in Victoria using this method. It is important to note that the differences in numbers reflect the better methods available to measure the gap in life expectancy; it does not mean the life expectancy gap has been reduced.

Key definitions and concepts

Health is often defined in Australia as 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity' (WHO 1978, p. 1).

Describing the health of Aboriginal Victorians involves looking at individual characteristics and behaviours, as well as the broader social, economic and environmental factors that influence health. It is also important to understand the 'history of colonisation and the subsequent disadvantage experienced [by Aboriginal people] over more than two centuries' (VicHealth 2008, p. 6).

Aboriginal people view health as something that connects all aspects of life. It is 'not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life' (National Health Strategy Working Party 1989, p. x).

Self reported health

Self reported health is a measure of how people perceive their health to be on a scale from poor to excellent. It is a useful indicator of the general health of a population (The Allen Consulting Group 2008).

Self reported health is a strong predictor of the likely use of the health care system, and a strong indicator of mortality. When adjusted for age differences, self reported health reveals that Aboriginal Australians (30 per cent) are twice as likely as non-Aboriginal Australians (15 per cent) to perceive that their health is only fair or poor (AIHW 2008b).

The burden of chronic disease for Aboriginal Victorians

Four preventable chronic conditions are among the biggest direct contributors to the life expectancy gap between Aboriginal and non-Aboriginal Victorians (Victorian Government Department of Human Services 2009). These are cardiovascular disease, diabetes, cancer and mental illness.

More than two-thirds of Aboriginal people living in non-remote areas suffer from at least one chronic condition (ABS 2006) and this is increasing (Griew, Tilton et al. 2008).

More trips to hospital

A greater burden of disease also means more visits to hospital for treatment. Time away from work, families and communities creates a further burden and contributes to a cycle of disadvantage. Effective primary health care can prevent unnecessary visits to hospital (WHO 2008) and help stop the cycle of disadvantage.

Cardiovascular disease, diabetes (and associated renal failure), cancer and mental ill health are among the most frequent reasons Aboriginal Victorians are admitted to hospital (Victorian Government Department of Human Services 2008).

In Victoria, 18.5 per cent of trips to hospital for Aboriginal Victorians were avoidable, compared with 4.2 per cent for non-Aboriginal Victorians, indicating inequality in access to primary health care services (The Allen Consulting Group 2008).

Cardiovascular disease

Cardiovascular disease is any disease of the heart or blood vessels. This includes hypertension (high blood pressure), coronary heart disease and heart failure (Australian Better Health Initiative 2009).

Cardiovascular disease is the leading cause of death and disability for Aboriginal Victorians (Victorian Government Department of Human Services 2008):

- Of all Aboriginal deaths in Australia during 2002 and 2005, 27 per cent were due to cardiovascular disease (AIHW 2008).
- 63 per cent of deaths of Aboriginal Australians due to cardiovascular disease occur before the age of 65 years, compared to 10 per cent of non-Aboriginal Australians (Penm 2008).
- The median age at death from cardiovascular disease for Aboriginal Australians is 60 years, compared to 81 years for the general population (ABS 2002).
- 15 per cent of Aboriginal Victorian adults report that they have cardiovascular disease, about 1.5 times the number of non-Aboriginal people (Hall 2009).
- High blood pressure is the most commonly reported form of cardiovascular disease (Penm 2008).

It is estimated that more than six years of the life expectancy gap could be removed if Aboriginal Australians experienced the same level of cardiovascular health as non-Aboriginal Australians (ABS 2002). There is potential to make this reduction now, simply by making existing medical treatments equally available to Aboriginal Australians:

- Aboriginal Australians are more likely to die from a heart attack without being admitted to hospital. They are also more than twice as likely to die even if admitted to hospital (AIHW 2006).
- Aboriginal Australians have a significantly lower chance of receiving key investigations and treatments for heart disease such as angiography, angioplasty or bypass surgery (AIHW 2006).

Diabetes

Diabetes occurs among Aboriginal Australians at around three times the rate of the non-Aboriginal population (Diabetes Australia Vic 2008):

- Diabetes is one of the leading causes of death and disability for Aboriginal men and women (Victorian Government Department of Human Services 2008).
- Aboriginal Victorians are hospitalised for diabetes at more than twice the rate of non-Aboriginal Australians (AIHW 2008).

² This estimate was obtained by combining NSW and Victorian data.

Cancer

Cancer is one of the leading causes of disease burden for Aboriginal Australians (Vos, Barker et al. 2007):

- Aboriginal people have higher incidences of preventable cancers (Hall 2009).
- Aboriginal people diagnosed with cancer are significantly less likely to receive surgery, chemotherapy and radiotherapy than non-Aboriginal patients and are much more likely to die from cancer (Hall 2009).
- Participation in cancer screening is lower among Aboriginal Victorians than the wider Victorian population (Victorian Government Department of Human Services 2008).

Mental illness

Mental illness is broadly understood to mean 'clinically recognisable symptoms or behaviours that are associated with distress and interference with one's ability to cope with normal life stresses and contribute to one's community' (Australian Government Department of Health and Ageing 2005).

For many Aboriginal Australians, mental illness is linked to experiences of grief, loss and trauma (Victorian Government Department of Human Services 2009).

Mental illness is estimated to contribute 15 per cent of the burden of disease for Aboriginal Australians. This is second only to cardiovascular disease (Vos, Barker et al. 2007):

- More than a quarter of Aboriginal Australians are reported to have some form of mental illness (Victorian Government Department of Human Services 2009).
- Twice as many Aboriginal Australians (21.4 per cent) suffer high or very high levels of psychological distress compared to non-Aboriginal Australians (10 per cent) (Victorian Government Department of Human Services 2008).
- One study found that one in five Aboriginal Victorians suffering high levels of psychological distress were not able to work or undertake their usual activities for at least one day in the four weeks prior to reporting (AIHW 2008). Reasons for distress included physical health problems, the death of family or friends, and alcohol related problems (AIHW 2008).

The contribution of risk factors

Four risk factors are estimated to make the greatest contribution to the disease burden suffered by Aboriginal Australians (Vos, Barker et al. 2007). These are tobacco, physical inactivity, nutrition and security of food supply, and alcohol.

Tobacco

Smoking contributes more to the burden of disease for Aboriginal Victorians than any other single risk factor (Hall 2009). Smoking is estimated to account for 10 per cent of the health gap between Aboriginal and non-Aboriginal people (Vos, Barker et al. 2007):

- Of Aboriginal Victorian adults, 52 per cent smoke and the vast majority of these smoke daily (AIHW 2008).
- Of Aboriginal Victorian adults, 24 per cent are ex-smokers (AIHW 2008).
- Only 24 per cent of Aboriginal Victorian adults have never smoked (AIHW 2008).
- Smoking rates among Aboriginal Victorians have not declined in the past 10 years (Victorian Government Department of Human Services 2008).

Smoking also is detrimental to the health of others due to second-hand smoke or passive smoking (Victorian Government Department of Human Services 2008):

- Between birth and 14 years of age, 53 per cent of Aboriginal children live in a household with regular smokers, compared to 35 per cent of non-Aboriginal children (AIHW 2008).
- Compared to 9 per cent of non-Aboriginal children, 28 per cent of Aboriginal children live with a regular smoker who smokes at home indoors (AIHW 2008).

Smoking in pregnancy harms unborn children. It is associated with premature birth, stillbirth, some birth defects and sudden infant death syndrome (SIDS) (US Department of Health and Human Services 1989). It is a major contributing factor to infants being born with a low birth weight:

- Of Aboriginal mothers in Victoria, 38 per cent reported that they were smokers at the time their babies were born compared to 9 per cent of non-Aboriginal mothers (Victorian Government Department of Human Services 2008).

Physical inactivity

Physical inactivity is responsible for 8.4 per cent of the total disease burden for Aboriginal Australians (Vos, Barker et al. 2007)³:

- Of Aboriginal Australian adults living in non-remote areas in 2004–05, 32 per cent reported doing moderate or vigorous exercise in the two weeks prior to reporting (Penm 2008).
- Of Aboriginal Australian adults living in non-remote areas in 2004–05, 49 per cent reported that they had not done any physical activity in the two weeks prior to reporting (Penm 2008).
- Between 1995 and 2005, the proportion of Aboriginal people living in non-remote areas who undertook moderate or high levels of exercise dropped significantly, from 30.3 per cent to 24.3 per cent (Steering Committee for the Review of Government Service Provision 2009).

Structural barriers such as limited access to facilities and high costs associated with transport, membership and uniforms can decrease participation in sport. Racism can also exclude participation of Aboriginal people in community-based activities (Thorpe & Browne 2009).

In 2002, while two-thirds of non-Aboriginal Australians took part in sport and physical recreation activities, less than half the Aboriginal population participated (Thorpe & Browne 2009).

Nutrition and security of food supply

Unhealthy eating can lead to being overweight or obese, which is the second highest level of disease risk among Aboriginal Australians (Vos, Barker et al. 2007).

Diet-related issues such as high blood cholesterol, high blood pressure and low fruit and vegetable intake are major contributors to the Aboriginal Australian disease burden (Vos, Barker et al. 2007):

- More than half (56 per cent) of the Aboriginal Australian population consumed less than the recommended two serves of fruit and five serves of vegetables per day (Penm 2008).
- Around one in seven Aboriginal Australians do not eat any fruit and/or vegetables on a daily basis (Penm 2008).

³ Physical inactivity and unhealthy eating both contribute to high body mass, and given this, high body mass is not explored separately other than to note that 58.5 per cent of Aboriginal Victorians are overweight or obese compared to 48.2 per cent of all Victorians (Victorian Government Department of Human Services 2008).

- Of Aboriginal Victorians, 58.5 per cent are overweight or obese compared to 48.2 per cent of all Victorians ([Victorian Government Department of Human Services 2008]).

Exclusive breastfeeding is recommended by the World Health Organization as the best source of food for infants up to six months of age (WHO 2009):

- In Victoria, while most Aboriginal mothers (85 per cent) initiate breastfeeding after birth, only 32 per cent of mothers are still breastfeeding when their babies are six months old (Thorpe & Browne 2009).

Having limited access to safe, healthy and culturally acceptable food – known as ‘food insecurity’ – has an impact on eating patterns (VicHealth 2009):

- Of Aboriginal Victorians, 21 per cent ran out of food and could not afford to buy more in the previous 12 months (2004–05) compared to 5 per cent of non-Aboriginal Victorians (Thorpe & Browne 2009).

Alcohol

The pattern of alcohol use is different between Aboriginal and non-Aboriginal people (Victorian Government 2008):

- Alcohol was associated with approximately 7 per cent of all Aboriginal Australian deaths and over 6 per cent of the total disease burden for Aboriginal Australians (Vos, Barker et al. 2007).
- Aboriginal Australians are less likely to be drinkers than non-Aboriginal Australians (Victorian Government 2008; ABS & AIHW 2008).
- Aboriginal Australians who do drink are more likely to drink at harmful levels (ABS & AIHW 2008).
- Of Aboriginal Victorians, 58 per cent report drinking at levels considered to pose short-term risk⁴ at some time in the year prior to reporting (AIHW 2008).
- The rates of chronic or high risk⁵ drinking were similar for both Aboriginal and non-Aboriginal Australians in 2004–05 (ABS & AIHW 2008).

Risk factors are also linked: chronic or high risk alcohol consumption is associated with higher rates of tobacco smoking and high levels of psychological distress (ABS & AIHW 2008).

The social and economic determinants of health

While individuals are able to make some choices about health behaviours, it is the social and economic conditions in which they live that have a far greater influence on health (Carson, Dunbar et al. 2007). Established determinants of health include educational attainment, social and community connections, income and employment, housing and freedom from race-based discrimination.

Aboriginal Victorians also experience historical disadvantage, along with the dispossession of land, culture and identity that followed colonisation (National Health Strategy Working Party 1989; Carson, Dunbar et al. 2007; VACKH 2009).

‘The socioeconomic disadvantage experienced by Aboriginal and Torres Strait Islander peoples compared with other Australians places them at greater risk of exposure and vulnerability to health risk factors such as smoking and alcohol misuse, and other risk factors such as exposure to violence.

‘However, socioeconomic disadvantage alone does not explain all the differences in health status that exist between Indigenous and non-Indigenous Australians. Numerous other aspects of the living, working and social conditions of Indigenous Australians, along with a reduced sense of control over their own lives, may help to explain the generally poorer health of Aboriginal and Torres Strait Islander peoples’ (AIHW 2008, p. 67).

Educational attainment

Poor health reduces the educational attainment of Aboriginal Australians (Carson, Dunbar et al. 2007). It is therefore not clear ‘whether higher levels of educational attainment lead to better health, or better health leads to higher educational attainment’ (Carson, Dunbar et al. 2007, p. 148). The path between educational attainment and health for Aboriginal people is complex and less well understood than that of non-Aboriginal people.

Mainstream education can have a detrimental impact on the emotional and social wellbeing of Aboriginal Australians. Such education is usually delivered to an Aboriginal minority and can be culturally and linguistically alienating with significant implications for the wellbeing of Aboriginal young people (Carson, Dunbar et al. 2007).

‘Education systems in Australia and elsewhere, historically-speaking, often aimed to reduce Indigenous peoples’ power and authority over their children, and helped to lower the status of Aborigines in society.

‘These systems often devalued Indigenous laws, languages and cultures, and most importantly, denied the basis on which people legitimated their ownership of the vital economic resources of land and sea.

‘The education system has been, in other words, heavily implicated in the processes of dispossession and cultural genocide which were major causes of increasing ill health’ (Boughton 2000, cited in Carson, Dunbar et al. 2007, p. 145).

It is generally understood that people with lower educational attainment rate their own health more poorly and report a number of illnesses more often than those with a bachelor degree or higher (VicHealth 2008).

Further, it is thought that ‘better education leads to better overall self-assessed health status, which in turn leads to higher labour force participation’. In particular, having a degree or a higher qualification strongly improves labour force participation (VicHealth 2008, p. 3).

⁴ Those considered at short-term risk have consumed ‘five or more (for females) or seven or more (for males) standard drinks on any one occasion in the last 12 months’ (ABS & AIHW 2008, p. 140).

⁵ Long-term risk was measured by the number of people reporting high levels of average daily consumption of alcohol in the week prior to reporting (ABS & AIHW 2008, p. 140). High levels for males would be greater than 29 standard drinks per week and greater than 15 standard drinks per week for females (AIHW 2009).

Victorian statistics indicate that:

- for 22.8 per cent of Aboriginal Victorians, year 12 or equivalent is the highest year of school completed, compared to 44 per cent of non-Aboriginal Victorians (ABS 2007)
- young Aboriginal Australians are about 15 times less likely to have a bachelor degree or above and around 23 per cent less likely to have a certificate or diploma (AIHW 2008).

Social and community connections

Social connection is broadly defined as having supportive relationships, involvement in community and group activities and civic engagement (VicHealth 2009).

Engaging in meaningful social connections is a determinant of social and emotional wellbeing and a prerequisite for good physical health (Keleher & Armstrong 2005).

Information on social and community connections among Aboriginal Australians indicates that:

- in a time of crisis, 90 per cent of Aboriginal Australians report having support
- involvement with an Aboriginal organisation is reported by 26 per cent of Aboriginal Australians
- around 87 per cent of Aboriginal Australians aged over 15 years were not removed from their natural family and 44 per cent reported that their relatives were not removed from their natural family
- in the 12 months prior to reporting, 68 per cent of Aboriginal Australians participated in at least one cultural event (AIHW 2008).

Income and employment

Lower income levels and employment status explain from one-third to one-half of the gap in self-assessed health between Aboriginal and non-Aboriginal Australians (Carson, Dunbar et al. 2007).

Income

Aboriginal Australians are more likely to have lower incomes than non-Aboriginal Australians (AIHW 2008):

- The average weekly income for Aboriginal Australian families is \$395 compared to \$665 for non-Aboriginal families (VACKH 2009).
- In 2002, only 7 per cent of Aboriginal Australian adults were in the highest individual income bracket compared to 20 per cent of non-Aboriginal Australians (AIHW 2008, p. 768).

Income is also related to education and housing:

- Aboriginal Australians who complete year 12 are more likely to have a higher income than those who only complete year 9 (AIHW 2008).
- Aboriginal Australians who own their own home are more likely to have a higher income than those who rent (AIHW 2008).

Employment

Aboriginal Victorians are less likely to participate in the labour force (63.7 per cent) compared to non-Aboriginal Victorians (73.7 per cent) (AIHW 2008):

- In 2006, 15.8 per cent of Aboriginal Victorians were unemployed compared to 5.4 per cent of the overall Victorian population (The Allen Consulting Group 2008).
- Of Aboriginal Australians who are unemployed, 91 per cent report having trouble finding work. The main reason reported for this is due to insufficient education, training and skills (AIHW 2008).

Unemployment increases the burden of financial stress on Aboriginal families:

- Unemployment means that people are less able to buy goods and services that can create health and it has detrimental psychological and social impacts (AIHW 2008).
- In 2004–05, 49 per cent of Aboriginal Australians aged over 15 years reported being unable to raise \$2000 within a week in a time of crisis (AIHW 2008). This compared to 10.1 per cent of the wider Victorian population aged over 18 years in 2007 (Victorian Government Department of Human Services 2008).

Housing

Access to adequate housing impacts on health. Issues around inadequate housing are particularly significant for Aboriginal Australians because of the association between shelter and dispossession from land (Carson, Dunbar et al. 2007).

Key issues related to the adequacy of housing include:

- availability
- affordability
- security of tenure
- overcrowding
- functionality, in terms of design and construction and ongoing maintenance
- the immediate surroundings of houses and community including accessibility to services and cultural suitability (Carson, Dunbar et al. 2007; VicHealth 2008).

Recent housing data indicates:

- of Aboriginal Victorian households, 54 per cent are living in rented dwellings, while 40 per cent are living in dwellings that were owned, either with or without a mortgage (ABS 2008)
- Aboriginal people are more likely to move house than non-Aboriginal people. In the 2006 census, 34.2 per cent of Aboriginal Australians were living at a different address one year prior to the census, compared to 17 per cent of non-Aboriginal Australians
- of Aboriginal Australians, 65.1 per cent were at a different address five years before the census compared to 42.6 per cent of non-Aboriginal Australians (Hall 2009)
- there is an average of three people living in Aboriginal Victorian households compared to 2.6 for non-Aboriginal households (ABS 2008)
- of Aboriginal households, 9.1 per cent are classified as overcrowded, compared to 3.1 per cent of all households (Hall 2009).

Race-based discrimination

Race-based discrimination can be defined as 'those behaviours and practices that result in avoidable and unfair inequalities across groups in society based on race, ethnicity, culture or religion' (VicHealth 2009, p. 14)⁶.

⁶ More information about race-based discrimination can be found in VicHealth's *Ethnic and race-based discrimination as a determinant of mental health and wellbeing* (VicHealth 2007) and *Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria* (VicHealth 2009) at www.vichealth.vic.gov.au/publications.

Individuals can experience multiple forms of discrimination (VicHealth 2005), such as:

- racist taunts and insults, physical violence, being refused service in shops and poor expectation of academic ability at school (Priest & Paradies 2009)
- differential treatment in hospital care (AIHW 2006).

The experience of discrimination has a negative impact on health and wellbeing (VicHealth 2005; Paradies, Harris et al. 2008; VicHealth 2008):

- race-based discrimination is known to be associated with poor mental health, physical health and self-rated health. It is particularly associated with an increased risk of anxiety and depression and has possible associations with diabetes, obesity and cardiovascular disease.

The ways in which race-based discrimination can lead to ill health include:

- **reduced access to resources that can create and protect health such as education, employment, housing, good medical care and social support**
 - **increased exposure to factors that intensify health risks**
 - **direct physical assault causing injury**
 - **stress and emotional responses that impact poorly on mental health**
 - **risky health behaviours such as smoking, alcohol and other drug use (Paradies, Harris et al. 2008).**
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A survey examining race-based discrimination found that:

- of Victorian respondents, 25 per cent were more likely to be concerned if a relative married someone with an Aboriginal background as compared to marrying someone from another cultural background
- of Victorians, 1.7 per cent 'identified Indigenous Victorians as not belonging' despite the fact that they are the original inhabitants of the land (VicHealth 2007, p. 36).

While there is little information on Aboriginal Victorians' experience of discrimination, a recent report from South Australia (Gallagher, Ziersch et al. 2009) identified that:

- for Aboriginal people, 93 per cent reported experiencing racism at least sometimes and 66 per cent experienced racism often
- racism was more often experienced in formal settings such as justice or education.

Land, culture and identity

'Land is an essential part of an Aboriginal view of health, with personal identity considered inseparable from place. Interaction with country is understood to enable an adult to develop mastery and control over their lived environment' (Burgess & Morrison 2007, cited in VicHealth 2008). Given this relationship, it is clear that disconnection from land has a profound effect on identity for Aboriginal people.

Land

In the 200 years following European settlement in Australia, Aboriginal people were denied rights to their own land. Early policies of extermination and massacre were followed by policies of 'protection' and assimilation including forced removal from land (VicHealth 2005). For many Aboriginal people, this caused an irreparable disconnection with land:

- In Victoria today, only 0.04 per cent of land (100km² out of 227,416km²) is Aboriginal-owned or controlled (Steering Committee for the Review of Government Service Provision 2009).
- Of Aboriginal Australians living in non-remote areas, 60 per cent recognise a specific area as their homelands or traditional country, but the majority of these (73 per cent) did not live on their homelands (AIHW 2008).
- The number of Aboriginal Australians who do not recognise their homelands is highest in inner-regional areas (40 per cent) (AIHW 2008).

Culture and identity

Aboriginal Australians are as varied in culture as any other population, with many different cultural and language groups and social systems (VicHealth 2005):

- Just over half (54 per cent) of Aboriginal Australians identify with a tribal group or clan (AIHW 2009).
- Of Aboriginal Australians, 21 per cent report that they speak an Aboriginal language (AIHW 2008).
- The majority of Aboriginal Australians participated in at least one cultural event in the past 12 months (AIHW 2008).

Today, Aboriginal people's identity is derived from cultural heritage and the ability to survive despite the odds, rather than from the negative factors that resulted directly from colonisation (VicHealth 2005).

Conclusion: preventing ill health and unequal health outcomes

This research summary provides a foundation for understanding the most important issues for Aboriginal Victorians' health and wellbeing. The next step is to take action.

VicHealth and the Victorian Government Department of Health have developed *Life is health is life: taking action to close the gap – Victorian Aboriginal evidence-based health promotion resource*. This resource provides an overview of the evidence for interventions that will address the issues described in this research summary. It will be available in April 2011.

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