

**COMMONWEALTH GRANTS COMMISSION**

**INDIGENOUS FUNDING INQUIRY**

**SUBMISSION**

**From: National Aboriginal Community Controlled Health  
Organisation.**

**Submission No.: IfI/SUB/27**

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**NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH  
ORGANISATION (NACCHO)**

**SUBMISSION TO THE COMMONWEALTH GRANTS COMMISSION  
INDIGENOUS FUNDING INQUIRY**

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***NACCHO is the national peak body in Aboriginal health, representing about one hundred Aboriginal community controlled health services throughout Australia.***

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**Executive Summary**

All available data shows that the state of Aboriginal health remains appalling. There are a number of reasons for this, including lack of access by Aboriginal people to appropriate primary health care.

This lack of access reflects the low level of funding currently available for the provision of appropriate primary health care services for Aboriginal people. While there is ample evidence that the available funding is not distributed equitably across the Aboriginal population, this issue is very much secondary to the overall inadequacy of the funding currently provided for Aboriginal health.

No Aboriginal community is over-resourced, and redistributing current funding between Aboriginal communities is not the answer. What is required is the provision of an adequate overall level of funding, based on need, which can then be distributed equitably across communities.

The latest estimate of the funding shortfall in Aboriginal health is in the region of \$230 million per year. Until there is political will on the part of governments to meet this shortfall and provide the resourced to make appropriate primary health care available to all Aboriginal people, little will change.

Australia is now unique among developed nations in its failure to substantially impact on indigenous health outcomes. Both Commonwealth and State/Territory Governments need to understand and recognise that change *is* achievable - and affordable. As a nation, Australia can and should rise to the challenge. Governments must either act decisively to remove the stain of Australia's continuing neglect of Aboriginal and Torres Strait Islander peoples and rescue international credibility, or bury the truth and rationalise their inaction. That is the inescapable choice now facing this nation.

**Background**

*Aboriginal health*

The state of Aboriginal health remains appalling. All of the indicators of socio-economic and health status (education, income and employment levels, infant mortality, life expectancy, adult morbidity and mortality rates) clearly show Aboriginal people to be by far the most disadvantaged group in Australia. For example, life expectancy for Aboriginal people is 15 to 20 years below that of other Australians, infant mortality is 2 to 4 times higher, and adult death rates are 3 to 4 times higher<sup>1</sup>. The improvements in Aboriginal infant mortality over the past 20 years have been offset by devastating losses of Aboriginal adults to heart and kidney disease, diabetes and injury.

The lack of progress Australia has made in improving Aboriginal peoples' health is in contrast to the significant gains being made in the health status of Indigenous peoples elsewhere in the world<sup>ii</sup>. Aboriginal people's capacity to gain from additional health care resources is consequently very high.

Over the past 20 to 30 years there have been several major inquiries into the health of Aboriginal people<sup>iii</sup>. It has become clear that the appalling, and in some respects worsening, state of Aboriginal health is embedded in the history of dispossession and alienation experienced by Aboriginal people, and in ongoing poverty and disadvantage. This has led to continuing, and in some cases increasing, high levels of illness and death arising from poverty-related and lifestyle-related problems.

Improving Aboriginal health is not just about improving the physical well-being of an individual. It is about working towards 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. It is also based on the need to acknowledge the reality that Aboriginal people have never ceded sovereignty of their land nor their rights to self-determination.

There is no simple, quick-fix medical solution to Aboriginal health – the solutions lie in assisting Aboriginal people being able to enjoy their right to self-determination. All relevant inquiries and studies have shown conclusively that culturally appropriate, comprehensive primary health care, based on maximum community participation, is the best way of addressing Aboriginal health.

### ***Aboriginal community controlled health services***

Aboriginal community controlled health services (ACCHSs) are primary health care services initiated, planned and managed by local Aboriginal communities, aiming to deliver high quality, holistic, and culturally appropriate health care. They are also often known as Aboriginal Medical Services, or AMSs.

In keeping with the philosophy of self-determination, Aboriginal communities around Australia have been establishing these services since the early 1970s. Over one hundred ACCHSs are now operating across Australia, in all States and Territories. These range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurse practitioners to provide the bulk of primary care services. The services form a network, but each is autonomous and independent both of one another and of government. The integrated primary health care model adopted by ACCHSs is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails.

Some of the benefits that properly resourced Aboriginal community controlled health services can deliver include:

- significantly improved access - because the local community has ownership and control of the service, and because service delivery is flexible and responsive (for example, outreach services are often a feature) , Aboriginal people are more likely to access the care they need;
- the full range of primary health care services is available in one place – service delivery is integrated and holistic, rather than being built around different specialties or “body parts”;
- the care provided is culturally appropriate – the organisation is run by Aboriginal people, employs Aboriginal or culturally aware non-Aboriginal people, and delivers care in a sensitive and inclusive way;

- the sector is both cost effective and cost efficient; it delivers value for money – based on local knowledge, services are targeted at areas of local need;
- the sector represents a major source of education training, achievement, and pride, for Aboriginal people;
- the knowledge required to improve Aboriginal health status is not innate; it must be acquired. The community controlled sector has developed a large pool of knowledge and expertise about Aboriginal health issues, which enables it not only to deliver appropriate care, but also to advocate effectively for Aboriginal people in health;
- in practical terms, the Aboriginal community controlled health service sector provides leadership in primary health care in Australia in areas such as evidence-based medicine (with the development of clinical care guidelines based on systematic reviews of available evidence), and use of information technology for purposes such as patient recall.

In accordance with the National Aboriginal Health Strategy and commitments made in the Framework Agreements, Aboriginal primary health care services should be Aboriginal community controlled in structure wherever this is feasible.

In practical terms, the benefits of a strong Aboriginal community controlled health sector are already being demonstrated through health gains such as measurable improvements in immunisation rates and reductions in STD rates in several areas with Aboriginal community controlled health services. Valuable partnerships are also being developed at national, state, regional and local level between the Aboriginal community controlled health sector and other players such as hospitals, GPs, specialists, other health and community organisations, academic institutions, and so on. Improved and more flexible resourcing to increase Aboriginal access to appropriate primary health care services offers the potential for greater gains in the future.

### ***Service delivery in the ACCHS sector***

Good information about service delivery in the ACCHS sector has recently become available through the introduction of new annual service activity reporting arrangements for Commonwealth-funded Aboriginal primary health care services. This is a joint initiative undertaken by NACCHO and the Commonwealth Department of Health and Aged Care, through its Office for Aboriginal and Torres Strait Islander Health.

Under the new arrangements, all funded services have completed a detailed report covering their activities for the 1997-98 financial year. Although the information gathered through this process is not comprehensive, it does profile the work of services and provides a sound basis not only for service accountability, but for identifying and addressing resource gaps, identifying areas of strategic importance, and supporting continuing quality enhancement.

The 106 services that participated in service activity reporting (nearly of which were ACCHSs), covered an estimated total health service population of 410,000 Aboriginal and Torres Strait Islander people. This figure exceeds the ABS 1996 Census estimate of the total Aboriginal and Torres Strait Islander population. While undercounting of the Aboriginal population at Census time is well recognised, ACCH services are likely to have reported overlapping population boundaries to define their activity. It should not be concluded that the majority of Aboriginal and Torres Strait Islander people have access to ACCHSs.

The total staffing for all the services, funded through the Department of Health and Aged Care and State/Territory Governments, was less than 1,500. This does not count some staff funded from elsewhere, such as Medicare-funded doctors, but the numbers of these are small. Available data indicates that there are fewer than 200 doctors working in ACCHSs across Australia. In view of the vastly greater health care needs of Aboriginal people where morbidity rates are generally two to three times that of the population as a whole, it is clear that 1,500 health care staff, including 200 doctors, cannot meet the comprehensive primary health care needs of all Aboriginal people.

In fact, many areas with significant Aboriginal populations do not have ACCHSs, and even where there are services, they are not currently resourced at a level to enable them to provide comprehensive care to the whole Aboriginal community in their catchment areas. For example, the whole of the greater Sydney areas has only three ACCHSs – in Redfern, Mt Druitt, and Campbelltown. Many Aboriginal people in the greater Sydney area cannot physically access these three services, nor is there capacity to provide for this need.

In 1997-98, the 106 Commonwealth-funded Aboriginal primary health care services participating in service activity reporting provided 860,000 episodes of health care to their clients.

The data from the service activity reporting process demonstrates that the care provided by ACCHSs is much broader than, and qualitatively different to, the care available to Aboriginal people through mainstream services such as general practice clinics.

In the ACCHS sector, acute and chronic disease care was supplemented with coordinated preventive health care interventions, health promotion, mass screening, advocacy and transport services. Recall and reminder functions feature as a prominent activity of these services. Ninety three percent of all services offered clinical reminders to Aboriginal and Torres Strait Islander clients.

The vast majority of Commonwealth-funded Aboriginal primary health care services provided transport services to Aboriginal clients. Nearly all provided Aboriginal staff to act as advocates and/or interpreters, and most services arranged for referred Aboriginal clients who were being transported long distances by air or bus to be picked up on outward and return journeys if required.

The majority of services also provided letters of support for clients who needed public housing or who faced eviction; emergency food aid for families in need; accommodation at a safe house of women's shelter for victims of family violence; free medications and/or meeting the patient co-payment at the local pharmacy; and retrieval of the deceased bodies of those who died away from their communities.

The vast majority of employees within ACCHSs are Aboriginal. The first round of service activity reporting data shows that in 1997-98, around 71% of employees in ACCHSs were Aboriginal or Torres Strait Islander people, making the services more attractive and accessible to Aboriginal clients. Nearly all of these were non-medical staff. They included managers and administrative staff, large numbers of Aboriginal Health Workers, some nursing staff, a small number of other allied health workers, and support staff such as drivers and cleaners. By contrast, an independent survey in 1995 reported that 63.5% of State health services did not employ Aboriginal people.

## **Funding for Aboriginal health**

### ***The overall inadequacy of funding for Aboriginal health***

Contrary to popular belief, Commonwealth Government expenditure on Aboriginal health is not high. Taking Medicare expenditure, Pharmaceutical Benefits Scheme (PBS) expenditure, Aboriginal health funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), and other Commonwealth programs into account, the Commonwealth currently spends significantly less per head on the health of each Aboriginal person than on the health of each non-Aboriginal person.

Approximately 63 cents per head is spent by the Commonwealth on health services to Aboriginal and Torres Strait Islander people, for each dollar spent per head on the health of other Australians (\$472 per capita for Aboriginal and Torres Strait Islander people, compared with \$748 per head for non-Indigenous people)<sup>iv</sup>. Only a portion of the 63 cents is spent on culturally acceptable and effective services to Aboriginal people.

As the *House of Representatives Standing Committee Inquiry into Indigenous Health (1999)* reported:

*“the level of expenditure on Aboriginal and Torres Strait Islander health...is not excessive and would generally seem to be insufficient to meet the present level of need for health and related services.”<sup>v</sup>*

The current low level of accessibility to appropriate primary health care for Aboriginal people contributes to poor health status. Lack of meaningful access to primary care is also contributing to a higher dependence by Aboriginal people on hospital-based care,<sup>vi</sup> a result of failed prevention and the immediate burden of disease. This is expensive to the health care system and less than optimal for the individuals concerned.

Equitable access to appropriate primary health care, complemented by other reforms, has the potential to bring about real long-term improvements to Aboriginal health outcomes.

Organized and comprehensive preventive health care delivered by primary health care services is potentially very cost effective. This is particularly true in delivering comprehensive programs to the Aboriginal population who suffer a greater burden and risk for disease.

When the risk is high, the benefit from an intervention (that is the reduction in absolute risk for the disease) will be greater. This is true when the relative risk reduction of the intervention remains constant (and is independent of risk status) which is usually the case.<sup>vii</sup>

For example, screening 20,000 people with a low risk for renal disease will prevent one case of end-stage renal failure (ESRF),<sup>viii</sup> but the same screening applied to high-risk Aboriginal clients could prevent at least 40 cases of ESRF. This translates to a considerable reduction in cost relativities.

#### ***Funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH)***

The Aboriginal and Torres Strait Islander Health Program administered by OATSIH is only a minute element of Commonwealth health expenditure - only 0.8% in 1995-96<sup>ix</sup>. Most Commonwealth health expenditure on Aboriginal people is through this very small, capped program, which is unable to meet the needs of Aboriginal and Torres Strait Islander people across Australia for adequate access to appropriate primary health care.

Based on annual reporting by the Commonwealth Health Department<sup>x</sup>, the Commonwealth has gradually increased expenditure over recent years through the Aboriginal and Torres Strait Islander Health Program. However, it is important to note that these increases have not all gone into direct grants to services – indeed, the proportion of OATSIH funding expended as direct grants to services has been decreasing in recent years, as shown by the table below.

**Direct grants as a proportion of total OATSIH expenditure, 1996-97 to 1998-99<sup>xi</sup>**

<b>Financial Year</b>	<b>Total OATSIH expenditure</b>	<b>Direct grants from OATSIH</b>	<b>Direct grants as a proportion of total OATSIH expenditure</b>
1997-98	\$130.6m	\$104.8m	80.2%
1998-99	\$155.0m	\$112.8m	72.8%

***Aboriginal access to mainstream programs***

Aboriginal people have a right to equitable access to mainstream programs, and mainstream programs have a responsibility to ensure equitable access for Aboriginal people. There is very clear evidence that Aboriginal access to mainstream Commonwealth health funding programs is extremely limited, and there are concerns about the appropriateness of both Commonwealth and State funded mainstream services. There are also major queries about the new public health funding arrangements and whether and how these arrangements will address Aboriginal health issues.

***Aboriginal access to Medicare and the Pharmaceutical Benefits Scheme (PBS)***

The limited Aboriginal-specific health funding provided by the Commonwealth Government is insufficient to meet the high level of unmet need in Aboriginal primary health care, and this funding needs to be seen as a complementary ‘gap-closing’ measure.

Aboriginal people need to also have equitable access to Medicare, which (along with the PBS) is the major source of funding for primary health care for the Australian population. Medicare is intended to be a universal scheme, accessible to everyone in the community as a citizenship right. While Medicare fee-for-service arrangements appear to work fairly well for the general community and mainstream service providers, the model of short consultations in a private practice setting does not fit with the needs of Aboriginal people for holistic, comprehensive care in a culturally appropriate setting<sup>xii</sup>. The result, as indicated by the table below, is that the Commonwealth spends only 27 cents per person from Medicare on Aboriginal and Torres Strait Islander people, for each Medicare dollar spent per head on other Australians<sup>xiii</sup>.

***Estimated benefit payments for Indigenous and non-Indigenous people through Medicare and the Pharmaceutical Benefits Scheme, per person, 1995-96<sup>xiv</sup>***

	<b>Indigenous \$</b>	<b>Non-Indigenous \$</b>	<b>Ratio</b>
Medicare	88	331	0.27:1
PBS	27	123	0.22:1

Given the huge excess burden of acute and chronic disease, Aboriginal people should be accessing primary health care at much higher rates than the general community, but they are unable to do this because of the lack of resourcing for appropriate service provision.

Aboriginal people currently have very limited access to mainstream Commonwealth funded health care. Access by Aboriginal people to private general medical practices, which are the first point of contact with the health care system for most Australians, is limited. While the average Australian sees a GP five times per year<sup>xv</sup>, Aboriginal and Torres Strait Islander people average fewer than two GP consultations a year<sup>xvi</sup>.

Many Aboriginal health services have difficulty attracting and retaining doctors. A 1995 study of the medical workforce in Australia showed that while there was one doctor for each 372 people in Australia overall, Aboriginal communities averaged only one Aboriginal health service doctor for each 676 Aboriginal people.<sup>xvii</sup> Aboriginal access to privately practising doctors is also limited, as Aboriginal people often do not attend private clinics for cultural and other reasons, and Aboriginal people are more likely to live in rural and remote areas where there are fewer doctors.

There is an urgent need to increase access by Aboriginal people to appropriate primary health care. The cultural, locational, financial, and other barriers to access by Aboriginal people to mainstream services have been comprehensively described in a recent study<sup>xviii</sup>, and it is clear that for many Aboriginal people these barriers are very significant. In many cases Aboriginal people are not comfortable attending a private general practice, and will do so only where there is no alternative and their health problem has become extreme. Some private medical practices do not bulk bill, and this creates a financial barrier for Aboriginal people, a large proportion of whom experience extreme and life-long poverty. Distance and lack of transport also represent physical access barriers, particularly (but not only) for Aboriginal people in remote areas.

### ***State/Territory resourcing for Aboriginal and Torres Strait Islander health***

Such resourcing is delivered both through Aboriginal-specific programs, and through the provision of mainstream programs, particularly hospital-based programs, which are accessed by Aboriginal and Torres Strait Islander people.

NACCHO has some concerns about the transparency and accountability of States and Territories for the provision of health care to Aboriginal and Torres Strait Islander people.

The Deeble report estimated total per capita expenditure by States and Territories on the health of Aboriginal and Torres Strait Islander people in 1995-96 at \$1,753 per head, compared with \$785 for each non-Indigenous person, a ratio of 2.23:1<sup>xix</sup>. The accuracy of this estimate is questionable given that the paucity of data on Aboriginal and Torres Strait Islander uptake of mainstream services (due to the lack of standard protocols for identification of Aboriginality, etc) led to a need to base the estimate on assumptions and projections from the limited robust data available.

However, it is notable that on Deeble's findings, the majority of this expenditure was in the hospital sector (inpatient and outpatient services), and it is certainly likely that Aboriginal people have an uptake of hospital-based care at significantly higher rates than their non-Aboriginal counterparts, due to higher morbidity and lack of access to primary care. This high level of uptake of hospital care inflates the overall expenditure figures for Aboriginal health, concealing the real level of inequality of access to appropriate health care.

The reliance by Aboriginal people on hospital-based care is both expensive to the system and inappropriate for the community. In many cases admission to hospital reflects a failure of early intervention in the primary care setting. For this reason, any consideration of the adequacy of expenditure on Aboriginal health should consider primary care separately from hospital based care, rather than rolling the two together. There is a clear need to shift the emphasis on resourcing for Aboriginal health away from the hospital sector and towards the primary health care sector. This will in many cases require State/Territory Governments to restructure their health care funding and consider cashing out some of the resources currently tied up in hospital based care, so that these resources can contribute to better provision of primary care in the community.



Although Aboriginal and Torres Strait Islander people have relatively high levels of uptake of hospital based services (as outlined above), there are major concerns regarding the appropriateness of and access to hospital-based services. There are also major concerns regarding the quality and cultural safety of State/Territory funded Aboriginal health clinics.

### ***Patient Assistance Travel Schemes (PATS)***

NACCHO is particularly concerned to see issues relating to the Patient Assistance Travel Schemes (PATS) addressed and draws the Committee's attention to these issues.

From 1978 to 1987, the Commonwealth administered the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), to provide financial assistance for people in isolated areas who needed to access specialist medical care more than 200 km away from home. The scheme proved extremely difficult to administer, and was seen by some as the Commonwealth stepping into an area of State responsibility.

From 1987, the Commonwealth IPTAAS scheme was terminated, and funds transferred to the States to administer their own Patient Assistance Travel Schemes. A range of different arrangements and eligibility criteria for PATS have operated in the various States and Territories.

There are serious concerns that the PATS programs are built on restrictive eligibility criteria, with particular emphasis on rigid distance criteria. The schemes are bureaucracy-focused, rather than patient-focused. There is little flexibility or discretion to consider the individual needs of patients, particularly the severity of their condition, their socio-economic status, the urgency of accessing a service, etc. The particular needs of Aboriginal people are generally not taken into account.

In addition, the PATS programs are underfunded and are not meeting the needs of patients. Many patients are unable to access the schemes, and of those who are, many are still faced with financial hardship because PATS provides a subsidy but not full reimbursement of all costs.

Patient travel across State/Territory borders can create enormous difficulties in terms of identifying which jurisdiction is to be held responsible for providing support. Entitlements also differ between States and Territories, leading to anomalies and inequities.

There are also problems with the administration of the schemes, including inconsistent application of eligibility guidelines, poor availability of information about the schemes for both users and administrators, and the poor quality of data available from the schemes.

It has been suggested by some that it may be more effective and cost-effective to make funding available to bring specialists to remote areas wherever possible, in preference to transporting patients to the specialists.

NACCHO believes there is an urgent need for a review of all Patient Assistance Travel Schemes with a view to ensuring that the schemes better meet the needs of patients. The review should also examine the potential role of the Commonwealth in ensuring national consistency and resolving cross-border issues, and explore how the schemes can best meet the needs of Aboriginal people.

### **Public health funding**

The Public Health Outcome Funding Agreements (PHOFAs) are also an area of concern. These agreements have been signed under the National Public Health Partnership process, which seeks to clarify the roles and relationships of the Commonwealth and the States/Territories on public health issues, and among other things, has led to a “broadbanding” of public health funding provided by the Commonwealth to States/Territories.

There is a need to ensure that the considerable public health funding provided by the Commonwealth is channelled effectively to the areas of greatest need, and many Aboriginal communities are in dire need of public health programs and measures. However, NACCHO is concerned that there is a lack of accountability in the application of the PHOFA process to Aboriginal health. While the Commonwealth requires States/Territories to report on Aboriginal indicators, there appear to be no process indicators, and no requirements to report on engagement or collaboration with Aboriginal communities and organisations. There is a need to ensure that in developing and implementing public health programs funded through the PHOFA process, State/Territory Governments fulfil their responsibilities to collaborate with other players, including Aboriginal communities and organisations, as required under the Framework Agreements in Aboriginal and Torres Strait Islander Health.

### **Maldistribution of current funding**

There is an urgent need for funding decisions in Aboriginal health to be based on agreed, effective needs-based planning processes.

Aboriginal access to mainstream health programs (such a private GP care, hospital care, pharmaceutical care), is dependent on the availability and proximity of services, rather than on community need. Compounding this, current funding for Aboriginal-specific health care services is ad hoc and historically based, rather than needs-based.

This has led to a situation where, *within the context where there is vastly inadequate overall funding available for Aboriginal health, and nearly all Aboriginal communities have inadequate access to primary health care*, there are also considerable inequities between Aboriginal communities in terms of their access to health services. The Deeble study confirmed that per-capita expenditures on services to Aboriginal and Torres Strait Islander people vary considerably across States/Territories:

### **Gross expenditures on services to Aboriginal and Torres Strait Islander people by State/Territory and Commonwealth Governments, per person, 1995-96<sup>xx</sup>**

<b>Gross expenditures per person (\$)</b>			
<b>State</b>	<b>Commonwealth</b>		<b>Total</b>
	<b>AMS</b>	<b>Other</b>	
New South Wales	1,334	226	1,669
Victoria	1,326	226	1,870
Queensland	1,518	226	1,891
Western Australia	2,152	226	2,748
South Australia	1,500	226	2,226
Tasmania	1,227	226	1,574
ACT	659	226	979
Northern Territory	3,221	226	3,882
<b>Australia</b>	<b>1,753</b>	<b>226</b>	<b>2,232</b>

Although some of the differences may be attributable to the additional costs of remote area service delivery, these figures indicate the lack of a nexus between population and expenditure, let alone need and expenditure. There have been no mechanisms in the past to measure unmet need in Aboriginal health care, to model the costs of meeting this need, and to ensure equity in overall allocations from all sources. The latter is an important point, as indicated by a recent Audit Office analysis of a sample of services which showed that the OATSIH grant as a proportion of total income varies greatly between services.<sup>xxi</sup> In moving towards needs based funding, the total funding picture will need to be taken into account.

Although all parties acknowledge and agree on the need to move to needs-based funding, progress towards this is painfully slow. A recent Audit Office report noted that OATSIH had no timeframe in place for the implementation of needs-based funding, and recommended that such a timeframe be established.<sup>xxii</sup>

### ***Moves towards needs-based planning***

There are several initiatives underway which might assist in the implementation of needs-based funding:

1. The development of regional planning under the Framework Agreements provides an opportunity for all parties to examine current service provision, assess unmet need, and make joint decisions on the equitable allocation of new funding.
2. The implementation of Service Activity Reporting for OATSIH-funded primary health care services also provides an opportunity to identify areas of need, by benchmarking infrastructure and staffing levels against population and throughput figures.
3. OATSIH, in liaison with NACCHO, is also developing an Output Costing Project which seeks to provide better information on the range of comprehensive Aboriginal primary health care outputs and their costs. This is intended to help in establishing what level of funding is needed globally, and for individual components of primary health care, and may help to assess funding requirements in various locations.

However, the availability of new funding is the limiting factor in these efforts. NACCHO has made it clear that it would be unacceptable to attempt to remedy existing funding inequities by redistributing existing funding across States/Territories or across services. Any moves towards needs-based funding must be made through the allocation of new funding to areas of highest unmet need; funding for existing services must not be reduced.

### ***How much new funding is needed?***

Deeble has recently provided the Australian Medical Association with a methodology and calculations for needs-based funding in Aboriginal health, based on available data. Deeble has estimated that an increase of at least \$240 million per year in overall expenditures is required in order to provide a per capita allocation of resources to the health care of Aboriginal and Torres Strait Islander people which is the same as that consumed by other Australians with similar levels of health and socio-economic need.<sup>xxiii</sup>

Needs-based funding cannot be implemented in a context where containment of Government expenditure is the major objective, and funding increases for Aboriginal primary health care are only incremental. Community needs across the country cannot be met within current funding levels. A

move to needs-based funding will require a major injection of new resources into Aboriginal health, which in turn will require political will.

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- <sup>i</sup> Australian Bureau of Statistics/Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People*, March 1997.
- <sup>ii</sup> Australian Medical Association, *Submission to the House of Representatives Inquiry into Indigenous Health*, February 1998.
- <sup>iii</sup> Eg *National Aboriginal Health Strategy, Report of the Royal Commission into Aboriginal Deaths in Custody*, etc.
- <sup>iv</sup> Deeble et al, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, May 1998, p.11 (Table 2.2).
- <sup>v</sup> House of Representatives Standing Committee Inquiry into Indigenous Health (September 1999) *Discussion Paper*, Page 8 (2.11).
- <sup>vi</sup> Deeble et al, *op cit*, p.16 (Table 2.7).
- <sup>vii</sup> Glasziou PP, Irwig LM An evidence based approach to individualising treatment. *BMJ* 1995 Nov 18;311(7016):1356-9.
- <sup>viii</sup> Barratt A, Craig J, Cumming R, Irwig L, Salked G. A feasibility study of the early detection and treatment of renal disease by mass screening. University of Sydney, Department of Public Health and Community Medicine, October 1999.
- <sup>ix</sup> Joint Commonwealth/NACCHO Aboriginal Health Financing Working Group, Working Paper, 14 April 1998 (unpublished).
- <sup>x</sup> Annual Reports, Department of Health and Family Services/Department of Health and Aged Care
- <sup>xi</sup> Commonwealth Department of Health and Aged Care, *Agreement on Aboriginal and Torres Strait Islander Health: Outcomes Report 1999*, p.8.
- <sup>xii</sup> Keys Young (November 1997), *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*.
- <sup>xiii</sup> Deeble et al, *op cit*, p.22 (Table 2.13).
- <sup>xiv</sup> Adapted from Deeble et al, *op cit*, p. 22, Table 2.13.
- <sup>xv</sup> *The Government's Response to the Reviews of General Practice: General Practice – Foundation for the Future*, (June 1998), p.5.
- <sup>xvi</sup> Deeble et al, *op cit*, p.20 (Table 2.11).
- <sup>xvii</sup> Australian Institute of Health and Welfare, *Medical Labour Force 1995*.
- <sup>xviii</sup> Keys Young, *op cit*, November 1997.
- <sup>xix</sup> Deeble et al, *op cit*, p.16 (Table 2.7).
- <sup>xx</sup> Deeble et al, *op cit*, p. 23 (From Table 2.14)
- <sup>xxi</sup> Australian National Audit Office (November 1998), *The Aboriginal and Torres Strait Islander Health Program, Department of Health and Aged Care*, Audit Report No. 13, Performance Audit, p. 66.
- <sup>xxii</sup> Australian National Audit Office, *op cit*, p. 60.
- <sup>xxiii</sup> Deeble, J (April 2000), *How much is needed? A need-based funding formula for Aboriginal and Torres Strait Islander Health* (commissioned by the Australian Medical Association)