Health and Aged Care Portfolio

Submission

to the

Commonwealth Grants Commission's

Inquiry into Indigenous Funding

Commonwealth Department of
Health and
Aged Care

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EXECUTIVE SUMMARY

The Health and Aged Care Portfolio (the Portfolio) welcomes the Indigenous Funding Inquiry as an important recognition of the need to ensure appropriate targeting of resourcing for Aboriginal and Torres Strait Islander Health, and of the complexities involved in appropriate targeting.

Within the Portfolio, although the Office of Aboriginal and Torres Strait Islander Health (OATSIH)[1] has specific responsibility to meet the health needs of Aboriginal and Torres Strait Islander people, all programs have a shared responsibility for appropriate health service delivery to this health disadvantage group.

Aboriginal and Torres Strait Islander people experience the lowest health status of any group within the Australian community. Life expectancies for both men and women are 15-20 years below those of other Australians whilst diseases of the circulatory system, respiratory illness, injury and cancer continue to be leading causes of death amongst Indigenous Australians.

There are a number of inter-related factors which impact on poor health among Aboriginal and Torres Strait Islander people, and its persistence. The relationship between these factors is complex and current evidence does not allow us to assess the relative importance of one factor over another. It is likely that different determinants may be major or less significant for different health problems.

This general observation suggests that we need to be cautious in attributing excess morbidity or mortality among Indigenous people to any one cause. Explanatory frameworks that point to one set of factors, such as specific risk factors, to the exclusion of others, such as access to good quality health care, are unlikely to lead to effective action. To make a significant impact on health status, relevant portfolios need to work collaboratively across all governments and with the community sector to address all factors.

Partnerships are regarded as the key to achieving improved access and improved health status: partnerships between different spheres of government, the community sector and the Aboriginal and Torres Strait Islander Commission (ATSIC). Partnership arrangements under the Aboriginal and Torres Strait Islander Health Framework Agreements were signed between the Commonwealth, State/Territory governments, ATSIC and the Aboriginal community controlled health sector between 1996 and 1999. With the exception of the Torres Strait, these Agreements are due to expire on 30 June 2000. Following an in-principle commitment from all Australian Health ministers in August 1999 to extend the agreements for a further period, these Agreements will be re-negotiated during 2000.

The Portfolio wishes to raise two issues in relation to the terms of reference for the Inquiry.

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[1] OATSIH is the organisational unit that administers the funds appropriated to Outcome 7 – Improved health status for Aboriginal and Torres Strait Islander peoples. For brevity, Outcome 7 will be referred to throughout the submission as the Aboriginal and Torres Strait Islander Health program.

First, the terms of reference require the Commission to ‘inquire into and develop a method that can be used to determine the needs of groups of indigenous Australians relative to one another …’. The Portfolio notes that the biggest allocation question in relation to improving equity is what total level of resources within the national health system is required to meet the health needs of Aboriginal and Torres Strait Islander people. Improving equity of funding is crucial to ensuring access to services and programs at a level commensurate with need. It is within this context that the relative resource requirements between groups of Indigenous people can be considered.

Second, the terms of reference do not cover community services. It is suggested that the Commission consider expanding the scope of the Inquiry to cover these. Both the Commonwealth, through the Family and Community Services portfolio, and the States and Territories make significant investments in community services for Aboriginal and Torres Strait Islander peoples. Community services contribute to the stability and well-being of communities and families and complement the functional areas being covered by the Inquiry.

The Australian health system

The Australian health system aims to provide health services for all Australians and is funded by the Commonwealth Government, the State and Territory governments and private expenditure. The health needs of Indigenous Australians are largely met through the funding and delivery of mainstream health services, with services specially targeting Aboriginal and Torres Strait Islander people complementing these mainstream services.

The health system is financed from a combination of public and private funds. Public funds account for approximately 69 percent of total health expenditure and are sourced from the Commonwealth, State and Territory, and local governments. Private funds are sourced from health insurance schemes, other insurance schemes, and out-of-pocket payments by private citizens (See Section 2, Table 1).

Government expenditure on health services for Aboriginal and Torres Strait Islander people 1995-96[2]

It is estimated that, in 1995-96 (the only financial year for which there is system-wide comparative expenditure data) for all services and all sources of funds, recurrent expenditures for Aboriginal and Torres Strait Islander people, who make up about two per cent of the population, were $853 million, or about 2.2 per cent of total health spending. Therefore, on a per capita basis, expenditure from within the overall health system on the health of Aboriginal and Torres Strait Islander people was almost the same as that for other Australians with the ratio of Indigenous to non-Indigenous per capita funding being about 1.08: 1. This was despite their much greater needs for health services.

When only public funding was taken into account, expenditure on Aboriginal and Torres Strait Islander peoples was around 3 per cent. However, the higher rate of government spending did little more than compensate for a much lower rate of private spending. Aboriginal and Torres Strait Islander people, who generally are on lower than average incomes, have less capacity to pay for health services. Aboriginal and Torres Strait Islander

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[2] This section largely draws on J Deeble, C Mathers, L Smith, J Goss, R Webb and V Smith, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People,* AIHW and NCEPH, Canberra, 1998.

people relied much more on government funded services than did the general population, though no more so than other Australians of like socio-economic status.

The Commonwealth and State/Territory governments contributed approximately equal amounts to the overall expenditure on Aboriginal and Torres Strait Islander health in 1995-96 (see Section 2, Figure 4). However, the States distributed around 80 per cent of ACCHS expenditure. The Commonwealth distributed the balance largely through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and grant funding to Community Controlled Aboriginal Health Services (ACCHS). Aboriginal and Torres Strait Islander people received relatively little in the way of benefits from the MBS and the PBS, with per person benefits in 1995-96 being only 27 and 22 per cent respectively compared to non-Indigenous people. This is in part compensated by grants to the ACCHS.

The pattern of health expenditure in 1995-96 – reflecting service use by Aboriginal and Torres Strait Islander people – was quite different to the average for the non-Indigenous population. There was much more reliance on publicly-provided hospital and community health services and lower access to private doctors, private hospital care, private dentists, PBS funded medicines and ancillary services.

National averages for 1995-96 disguised a very uneven distribution of both Commonwealth and State/Territory funding provided for health services for Aboriginal and Torres Strait Islander people. When only expenditure on health services for Aboriginal and Torres Strait Islander peoples is considered, both the levels of State/Territory per capita funding, and the relative Commonwealth/State contributions to those payments were much more uneven than those for per capita expenditure for the whole population in each jurisdiction (see Section 2, Figures 7 and 8). This was partly a result of the cost of delivering services in remote regions, with around one third of Aboriginal and Torres Strait Islander peoples living in remote areas compared with only 3 per cent of the general population. Adjusting expenditure levels to take account of the additional costs of providing services in remote areas makes a noticeable difference but anomalies still remain.

Private funding

Private expenditure is lower for Aboriginal and Torres Strait Islander people than for non-Indigenous people. This reflects the relative capacity of Indigenous people to pay for health services. As noted above, Aboriginal and Torres Strait Islander people are more likely to use publicly-provided services and less likely to use private practicing GPs, dentists, ancillary services and private hospitals (which often require private contributions). This low private expenditure and greater reliance on publicly provided services is comparable to that for other Australians of similar socio-economic status. Private expenditure is not likely to be a significant source of funding for health services for Aboriginal and Torres Strait Islander peoples in the short to medium term.

Portfolio programs within the scope of the inquiry

Apart from services funded through the Aboriginal and Torres Strait Islander Health and Aged Care programs, all other funding is provided through mainstream programs (See Table, Portfolio programs within the scope of the Inquiry, next page).[3] Some mainstream programs include Indigenous specific initiatives aimed at improving Aboriginal and Torres Strait Islander peoples' access to mainstream services or improving the links between community controlled and mainstream services. Both mainstream and targeted programs may involve both spheres of government and may be either demand driven or provide funding in response to submissions. The Portfolio is directly involved in deciding on-the-ground distribution of only a small proportion of program funds. For many programs, the Portfolio's role is in setting strategic directions and outcomes for funding.

Of the $22.4 billion to be distributed in 1999-2000, $17,492.3 million or (78.3 per cent) will be distributed through the Commonwealth's major funding arrangements as follows:

- Australian Health Care Agreements: $5,900 million mostly for acute but with some to primary care
- Medicare Benefits Scheme: $6,900 million mostly for primary care but includes some for acute care;
- Pharmaceutical Benefits Scheme: $3,400 million mostly for primary care but includes some for acute care; and
- Private Health Industry: $1,292 million for a mix of primary, acute and aged care.

Of the remainder, $4,123 million or (18.4 per cent) will go to aged and community care and $747.73 million or (3.3 per cent) will support primary health care, including $175 million through the Office for Aboriginal and Torres Strait Islander Health.[4]

Most funding ($15,768 million or 70.5 per cent) is appropriated as Commonwealth Own Purpose Outlays (COPOs), with Medicare, PBS and grants provided through the Aboriginal and Torres Strait Islander Health program comprising the majority of these appropriations. Special Purpose Payments (SPPs) account for $6,595 million (29.5 per cent) and mostly comprise the Australian Health Care Agreements and the Public Health Outcome Funding Agreements.[5]

In large part, funding is recurrent. However, some capital funding ($14.7 million) is provided through the Aboriginal and Torres Strait Islander Health program for once-off purposes such as major capital works, the replacement of vehicles and service equipment, time-limited developmental and support projects, minor repairs and maintenance works, and the implementation of computer based patient information systems. A further $4.66 million will be distributed through the Aboriginal and Torres Strait Islander Aged Care Strategy.

Overall, identifying precisely what share of Portfolio funding supports the health of Aboriginal and Torres Strait Islander people is not straightforward. Apart from the

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[3] For the purposes of this Submission, 'mainstream program' is used to cover benefits and services that may be accessed by any member of the general population, subject to any criteria or restrictions applicable to the general population.

[4] Commonwealth Department of Health and Aged Care, administrative data. A complete summary of programs within the scope of the Inquiry is at Table 2 in Chapter 3.

[5] The discipline of population health encompasses the description of the health of populations; the methods that are used to describe and compare the health characteristics of populations and evaluate interventions; and health related interventions which are directed at populations rather than individuals, or have effects on populations rather than (or as well as) individuals. The Public Health Outcome Funding Agreements will provide $177 million in total nationally in 1999-2000.

Aboriginal and Torres Strait Islander Health program, few programs can readily identify from administrative data sets the portion of funding that supports the health of individual Aboriginal and Torres Strait Islander people.

Basis of current distribution

Current funding distribution largely reflects current patterns of access to benefits and services. Given the many barriers to access experienced by Aboriginal and Torres Strait Islander people, the funding distribution does not necessarily represent optimal distribution across the areas of primary care/population health, acute care, and aged and community care or, indeed, actual need in each of the categories.

Significant barriers face Aboriginal and Torres Strait Islander people in accessing care – particularly in the primary care sector – including:

- cultural and social factors
- locational factors
- poor linkages between health services
- the lack of a population focus
- workforce issues
- financial barriers

These are inter-related issues. The role played by different barriers to access varies across Australia. Nevertheless, poor access to health services is a problem for all Aboriginal and Torres Strait Islander communities, whether they are in metropolitan, other urban or rural and remote communities. Significant improvements are starting to be seen as a result of recent strategies to increase access to services and programs funded by the Portfolio.

In addition to the question of overall resource levels, there are issues around the balance of funding between the various sectors within health (primary health care, acute and aged care). There is mounting evidence that much of the illness amongst Aboriginal and Torres Strait Islander people is preventable and that better access to appropriate primary health care programs and services would assist in reducing the level of illness. For example, a recent study of hospital use for potentially preventable conditions found that age specific acute hospital separation rates for ambulatory sensitive conditions were 1.7 to 11 times higher for the Aboriginal and Torres Strait Islander populations studied.[6]

A priority therefore is reform of health financing to improve Aboriginal and Torres Strait Islander peoples' access to appropriate primary health programs, services and benefits and at the same time to achieve more rational distribution of funds between sectors.

Significant improvements to access are being achieved through the Indigenous specific initiatives developed by mainstream programs. For example, for Medicare this is in part being achieved through removing impediments to access by reviewing and making changes to entitlement criteria or enrolment procedures and testing new ways of funding and

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[6] Stamp KM, Duckett SJ, and Fisher DA 'Hospital use for potentially preventable conditions in Aboriginal and Torres Strait Islander and other Australian populations', *Australian and New Zealand Journal of Public Health*, Vol.22, No.6, 1998, pp.673-78.

delivering services. For the Pharmaceutical Benefits Scheme (PBS), better access is being achieved through the use of Section 100 of the *National Health Act*. In this case, the Minister has approved arrangements for remote services to order pharmaceutical supplies in bulk through community pharmacies, provided that they comply with relevant state government legislation. In addition, funding for the Aboriginal Coordinated Care Trials involves pooling and a more flexible use of funds across sectors, as well as increased resources through a capitation payment in lieu of MBS and PBS payments in locations where access to these sources of funding have mostly been very poor.

Other initiatives are aimed at making services more responsive to the particular needs of Aboriginal and Torres Strait Islander people by targeting community service obligations, developing more appropriate therapeutic models, improving the integration and community responsiveness of services, or bringing new services to remote communities through specialist outreach services.

These initiatives are not necessarily separate or permanent programs but sometimes time-limited components within mainstream arrangements.

As well as initiatives developed in the context of mainstream programs, there are programs designed specifically to provide primary health care to Aboriginal and Torres Strait Islander people. However, such Indigenous-specific programs are also designed so as to complement, rather than to replace or duplicate, mainstream arrangements. For example, funding through the Primary Health Care Access Program will be provided for a region so that Commonwealth funding *as a whole* – including Medicare and other sources of primary health care-related grant funding - rises to a level commensurate with the Indigenous population's need. In each region planning needs to occur to ensure that existing funding (from Commonwealth and State/Territory sources) and new funding are applied most effectively (see **Appendix B** for further details).

Backing up such initiatives is the development and funding of a workforce strategy to ensure that there is a long term approach to producing and maintaining a health workforce that is highly skilled and culturally appropriate.

Current distributional mechanisms

The bulk of the $24.2 billion program funds to be distributed by the Portfolio in 1999-2000 is subject to legislative or other constraints, for example, entitlement programs with funding being distributed according to predetermined eligibility criteria. For only a small portion ($336.2 million or 1.5 per cent) does the Portfolio have some degree of discretion in the on-the-ground distribution of the funds. These funds are mostly administered as grant programs with funding distribution mechanisms ranging from needs-based funding formulas to submission based applications.

The rules governing entitlement are often built into legislation:

- MBS and PBS and the Hearing Services Program are restricted by legislation to providing personal benefits, vouchers, or services as community services obligations;
- under the *Health Insurance Act 1973,* Health Program Grants must be directed to approved organisations providing approved health services;

- Regional Health Services that include aged care must be jointly approved by the Commonwealth and the relevant State/Territory as required by the *Aged Care Act 1997*;

- the legislation governing the Aged and Community Care Program has established a planning and allocation system that controls the quantum and distribution of services. The legislation also controls the amount of funding paid to service providers to provide care for individual users of services; and

- the two mainstream incentives programs for doctors are demand driven against eligibility requirements.

Funds under the Australian Health Care Agreements and the Public Health Outcome Funding Agreements are directed to purposes agreed with the States and Territories. In these cases the Commonwealth uses other policy levers (eg workforce measures, alternative administrative arrangements etc) to increase access to appropriate services, which in turn increases funding allocations. In addition, under the National Illicit Drugs Strategy, part of the funds for Non-Government Organisations Treatment Grants is directed to two States under the Public Health Outcome Funding Agreements. Further funding for some projects is administered by the NSW Health Department, and only the remaining funding is provided to non-government organisations directly.

Needs assessment methods

Needs assessment methods vary across Portfolio programs within scope of the Inquiry. They range from the well-established processes for the Australian Health Care Agreements enshrined in bi-lateral agreements with the States and Territories, to consultations drawing on available data and the experience of expert advisors and local health workers and the perspectives of partnership arrangements.

The differing approaches also illustrate the need for analysis to focus on both need (demand) factors and barriers to appropriate access (supply) as this enables the Portfolio to respond to need through the most appropriate mix of policy levers and practical solutions. Therefore, while there are some are similarities within approaches there is no common methodology (See Section 3.5; Table 3 in Section 3.5 summarises the approaches).

Development and use of indexes of relative need

The Commission is required to 'derive indexes of relative need that could be used to determine distributions of resources … based on its assessments of relative need.'

Principles for the development of indexes of relative health need

As with the Commission's work on assessing general revenue grant relativities, it is suggested that the development of indexes of relative health need for Aboriginal and Torres Strait Islander peoples should be informed by clearly articulated principles. Principles that could be applied are as follows.

Any index of relative health need should:

i) aim to achieve equal access when there is equal need in the short term and, in the longer term, for equality of outcomes;

ii) take into account the readiness of communities to benefit, including investing to build capacity where this is needed and providing a means for communities in 'perpetual decline' to catch up;

iii) ensure that the capacity of communities beginning to make health gains is not jeopardised by redistribution that would reduce funding;

iv) take account of current legislation, regulations, and account of current partnerships where these are improving health outcomes; and

v) fully acknowledge the limitations of poor quality data would have on the feasibility of developing an index, and the usefulness of any indexes developed.

Measuring need

The Commission is required to 'derive indexes of relative need that could be used to determine distributions of resources … based on its assessments of relative need.'[7] Given that the 'indexes of relative need' will be used to measure *relative health funding need*, then we suggest that only those indicators that significantly drive costs of health service and program delivery should be considered.

The Commission has been set a difficult task. As yet it has not been possible to fully assess the level of *overall* resources needed to make significant and sustainable improvements to the health of Aboriginal and Torres Strait Islander peoples, let alone relative resource needs within that population group.

Within Commonwealth funded health programs there are three broad factors that are generally considered responsible for determining costs for any given population grouping:

- *health status* as it relates to the requirement for certain services or levels of service to be provided to meet particular health needs;

- *cost of delivery* in specific locations, which takes into account cost differentials as a result of delivering services in remote areas, delivering services to dispersed populations, or the loss of economies of scale when delivering to small population groups; and

- *income* as it relates to the ability to contribute to some of the costs of health care through private expenditure.

Much of the work that has been done to date on differentiating populations' need for health care has used health status as the main determinant. The logic is that a sicker population will have a greater need for health care. The issue is, how is health status measured, and do

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[7] Commonwealth Grants Commission, *Indigenous Funding Inquiry*, Information Paper No. 1, Attachment A.

measures of relative health status necessarily measure the extent of need for resources at a local level?

A number of measures of health status are available: mortality, morbidity, and self-reported health status. Despite its shortcomings, relative health status has been used to construct several models for measuring relative need, for populations as a whole, and for the Aboriginal and Torres Strait Islander populations as a whole as compared with the rest of the Australian population.[8] However, health status has not been used to compare needs within an Indigenous population: the relationship between health status and cost is not well enough understood at this stage to utilise these measures at such a fine level. This issue is discussed at greater length in the body of the submission.

For remote, dispersed and/or particularly small populations, the costs of providing a given level of services are usually much higher than for other populations. Costs will be driven by higher prices of goods and services, but also by higher staff to population ratios arising from the diseconomies of scale associated with servicing small, dispersed populations.[9]

On average, Aboriginal and Torres Strait Islander people are concentrated in the lower deciles of spectrum of income distribution. Therefore, they face higher financial barriers to accessing health care. There might be some variation in income distribution between Indigenous populations that the Commission might wish to investigate. However, variations in income between Indigenous populations are likely to be much smaller than variations between Indigenous populations as a whole and the rest of the Australian population.

If the Commission wishes to explore more sophisticated models of resource allocation, then we suggest it might like to consider estimating relative need between populations or regions by identifying a range of existing services in different settings that are judged to be providing an appropriate level of health care to a defined Aboriginal or Torres Strait Islander population (in non-remote regions this might be a number of separate services). This could be informed by a theoretical model of an appropriate level of service for a given population based on, say, staff to population ratios. This would provide essentially a normative estimate of need. The next step would involve modelling how this service mix and associated costs might change with factors such as health status, the population's degree of remoteness/isolation and income. This work would be an extension of some modelling work the Portfolio has undertaken to estimate overall resource requirements for primary health care services. The Portfolio has not as this stage extended that work to look at variations between regions.

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[8] Commonwealth Department of Health and Aged Care, *Aboriginal and Torres Strait Islander Health Care: How Much Should Australia Spend?*, unpublished work-in-progress.

[9] Beaver C, Mayston D, McDermott R, Warchivker I, Mooney G & Wiseman V (1996), *Needs-based Allocation of Health Care Resources to Remote Australia*, The report of a research project funded by the Commonwealth Department of Human Services and Health, Territory Health Services. McDermott, R. (1995), Improving Equity and Efficiency in the Bush: A Needs-based Method for Healthcare Resource Allocation in Remote Communities, *Australian Journal of Rural Health*, Vol.3, pp.72-79. Commonwealth Grants Commission 1999, *Report on General Revenue Grant Relativities, 1999, Volume II, Methods, Assessments and Analysis*, Canberra. McDermott, R. & Beaver, C. (1996), Equitable Provision of Health Services to Aboriginal and Torres Strait Islander People of Queensland, *Australian and New Zealand Journal of Public Health*, Vol.20, No.20, pp.13-15. Wakerman, J. (1999),‘Access to Health-Care Services in Remote Areas’, Unpublished paper. Wakerman, J., Bennett, M., Healy, V. & Warchivker, I. (1997), *Review of Northern Territory Government Remote Health Services in Central Australia*, Menzies School of Health Research, NT.

In some locations health status and relative income data may be available, but the Commission would need to gather information to enable modelling of the relationship between these factors and the cost of health service before such factors could be applied to estimating relative resource needs.

Methodological issues raised by the Commission

The Commission has asked for advice on various issues including:

- *whether links should be made between health needs and the impacts of housing and education in measuring need* Evidence shows that action is required across all of these areas in order for the health status of Aboriginal and Torres Strait Islander people to improve. An all-of-Government composite index (if this is what is intended) may mask inequities in some areas and may imply that an area receiving high levels of resources for education and housing would be less deserving of resources for health. If people are sick, or require health interventions that will prevent them from becoming sick, they should be entitled to receive it, whether or not their education or housing is deficient.

- *how the mix of Commonwealth, State, local government and community involvement in meeting need should be dealt* Responsibilities for funding parts of the health system are more often shared than clearly separated. Where there is clearly a shared responsibility for funding, then it is appropriate to include all sources in calculations of relative spending and the gap between spending and need. This applies as much to the various sources of Commonwealth funding as it does to State government funding.

- *how a needs-based distribution of funds might be structured, and whether such a formula should start with the area of greatest need and work backwards until available funds are exhausted* The Portfolio sees the development 'indexes of relative need' as separate from policy and program decisions around what level of total funds might be available in any area. Relative need should inform the distribution of resources and 'indexes of relative need' would be useful to identify resource gaps and areas in greatest need. However the strategies to fill those gaps will depend on the total quantum of resources available and the particular program strategies that are put in place to meet need.

How the Portfolio might use indexes of relative need to improve equity

As current levels of funding are inadequate to meet the greater than average needs of Aboriginal and Torres Strait Islander people, the Portfolio would not be looking to apply such indexes to the redistribution of existing funding. Rather, the Portfolio would find such indexes useful as benchmarks for policy development, as a source of information in deciding the distributing funds of 'new' funds, and to assist with planning including identifying priority areas for targeting initiatives to improve access.

When targeting new funding, the Portfolio considers both the health needs and the readiness of service providers and the community to utilise funds effectively to improve health outcomes. Funding would not necessarily be directed away from a community with high relative needs and low capacity, but a low state of readiness might influence the nature of investment in that community. Initially, it might be appropriate to invest in building capacity, through establishing and training community governance structures, health planning, providing essential infrastructure and services and so on. In time, once this base is established, the emphasis might shift more towards additional service delivery.

Regions as the basis for needs analysis and funds distribution

For Aboriginal and Torres Strait Islander health, regional planning processes are in place in every state and territory under the Aboriginal and Torres Strait Islander Framework Agreements.

In keeping with shared responsibilities and the emphasis on working in partnerships, planning regions have been agreed through collaborative negotiations. Factors taken into consideration in deciding the regions include Aboriginal language groups, communities of interest, the geographic locations of indigenous communities, and existing mainstream health regions. In short, the regions are those that make most sense to the players involved in or affected by planning, including the Aboriginal and Torres Strait Islander people and communities affected.

Aged and Community Care planning is also conducted on a regional basis. Residential and community care is planned according to regions determined under the *Aged Care Act 1997*. In general, they are aligned to health planning regions used by State Governments. Home and Community Care uses HACC regions agreed with State Governments.

In most other programs, ‘regions’ are not used for planning purposes, either because the programs are demand driven (eg, MBS, PBS, and Practice Incentives Program and General Practice Immunisation Incentives), or submission based with ‘communities’ applying on the basis of self-assessed need against program criteria. The latter are likely to have national or state-wide catchments. While Divisions of General Practice are regionally based, their boundaries do not generally coincide with other administrative boundaries, and the term ‘regional’, in ‘Regional Health Services Program’ refers broadly to regional/rural, not to a focus on specific regions. Overall, ‘communities’ and the concept of ‘remoteness’, as measured by the Rural, Remote and Metropolitan Areas Classification (RRMA)[10] and the Accessibility/Remoteness Index (ARIA), are often seen as more relevant than ‘regions’.[11]

However, as more Aboriginal and Torres Strait Islander Regional Health Plans are completed with data collected and analysed according to these regions, the Portfolio’s programs are expected to move to make more use of these to inform needs analysis and planning.

Therefore, the Portfolio suggests that the Commission consider carrying out its regional analysis in a way that allows its “indexes of relative need” to be available for the Aboriginal and Torres Strait Islander health planning regions. Where regional data is available, this would make the Commission’s task easier and it would make the Commission’s analyses of greater use for policy and planning purposes.

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[10] *Rural, Remote and Metropolitan Areas Classification* 1991 Census Edition, Department of Primary Industries and Energy and Department of Human Services and Health, AGPS, Canberra 1994.

[11] *Accessibility/Remoteness Index of Australia (ARIA)*, Commonwealth Department of Health and Aged Care, Occasional Papers Series No. 6, 1999.

Data

The lack of good quality data on Indigenous health and health care has been an issue for many years and continues to constrain effective policy development, planning and program evaluation.

As a number of recent major reports detail the problems at length and describe the efforts to address them,[12] we have chosen not to rehearse the issues but to suggest some data sources of possible use to the Commission and to provide details of the major initiatives to improve the quality or use of data.

Together these initiatives provide a multi-pronged attack on the issue as follows:

- A multi-agency National Health Information Management Group subcommittee will drive implementation of the 1997 Aboriginal and Torres Strait Islander Health Information Plan, '*… This time, let's make it happen*', the recommendations of which cover infrastructure, technical aspects, and national commitment.

- All jurisdictions will continue to report to the Australian Health Ministers' Advisory Council against the National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health (covering health status, community involvement and social supports). In addition, agreement on the indicators has opened the way to including performance measures for Aboriginal and Torres Strait Islander peoples in mainstream health agreements.

- The report *Expenditures on Health Services for Aboriginal and Torres Strait Islander people* will be updated every two years.

- Annual Service Activity Reporting for Aboriginal Community Controlled Health Organisations (ACCHOs) funded by the Portfolio will combine monitoring of activity, resource needs assessment, staffing levels, some indication of the quality of health service provision, and information on the Aboriginal and Torres Strait islander population of each health service area.

- A strategic research framework for Indigenous health issues is being developed under the auspices of the National Health and Medical Research Council.

- The Portfolio has adopted the Accessibility/Remoteness Index of Australia (ARIA) as a standard geographic classification and the ABS have agreed to produce estimates using

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[12] AIHW, *The Aboriginal and Torres Strait Islander Health Information Plan*, AIHW, 1997; Kate Ross, *Population Issues, Indigenous Australians*, ABS, 1996; ABS/AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 1999; NHIMG/AIHW, *National Summary of the 1998 Jurisdictional Reports against the Aboriginal and Torres Strait Islander Health Performance Indicators*, 2000.

ARIA and incorporate this measure into the Australian Standards Geographical Classification (ASGC).

- The Portfolio and the ABS will ensure that the 2001 and 2004 National Health Surveys will produce Aboriginal and Torres Strait Islander estimates.

1. INTRODUCTION

The Health and Aged Care Portfolio (the Portfolio) welcomes the Indigenous Funding Inquiry as an important recognition of the need to ensure appropriate targeting of resourcing for Aboriginal and Torres Strait Islander Health, and of the complexities involved in appropriate targeting.

1.1 Background

The Australian health system aims to provide health services for all Australians, and is funded by the Commonwealth Government, the State and Territory governments and private expenditure. The health needs of Indigenous people are largely met through the funding and delivery of mainstream health services. Indigenous specific services which complement mainstream services are also an important part of the health system.

Broadly, the objective for the health of the Australian people is to provide equity of access to an Australian health system that promotes good health at low cost. The Portfolio's objective for the health of Aboriginal and Torres Strait Islander people is:

> To raise the health status of Aboriginal and Torres Strait Islander peoples by ensuring access to effective high quality health care and population health programs.

Within the Portfolio, although the Office of Aboriginal and Torres Strait Islander Health (OATSIH) has specific responsibility to meet the health needs of Aboriginal and Torres Strait Islander people, all programs have a shared responsibility for appropriate health service delivery to this health disadvantage group. This coordinated approach is based on four strategic planks. These are:

- developing the infrastructure and resources necessary to achieve comprehensive and effective health care for Indigenous Australians;
- addressing some of the specific health issues and risk factors affecting the health status of Indigenous Australians;
- improving the evidence base which underpins the health interventions; and
- improving communication with health care services, Indigenous Australians and the general population.

Aboriginal and Torres Strait Islander people experience the lowest health status of any group within the Australian community. Life expectancies for both men and women are 15-20 years below those of other Australians whilst diseases of the circulatory system, respiratory illness, injury and cancer continue to be leading causes of death amongst Indigenous Australians.[13]

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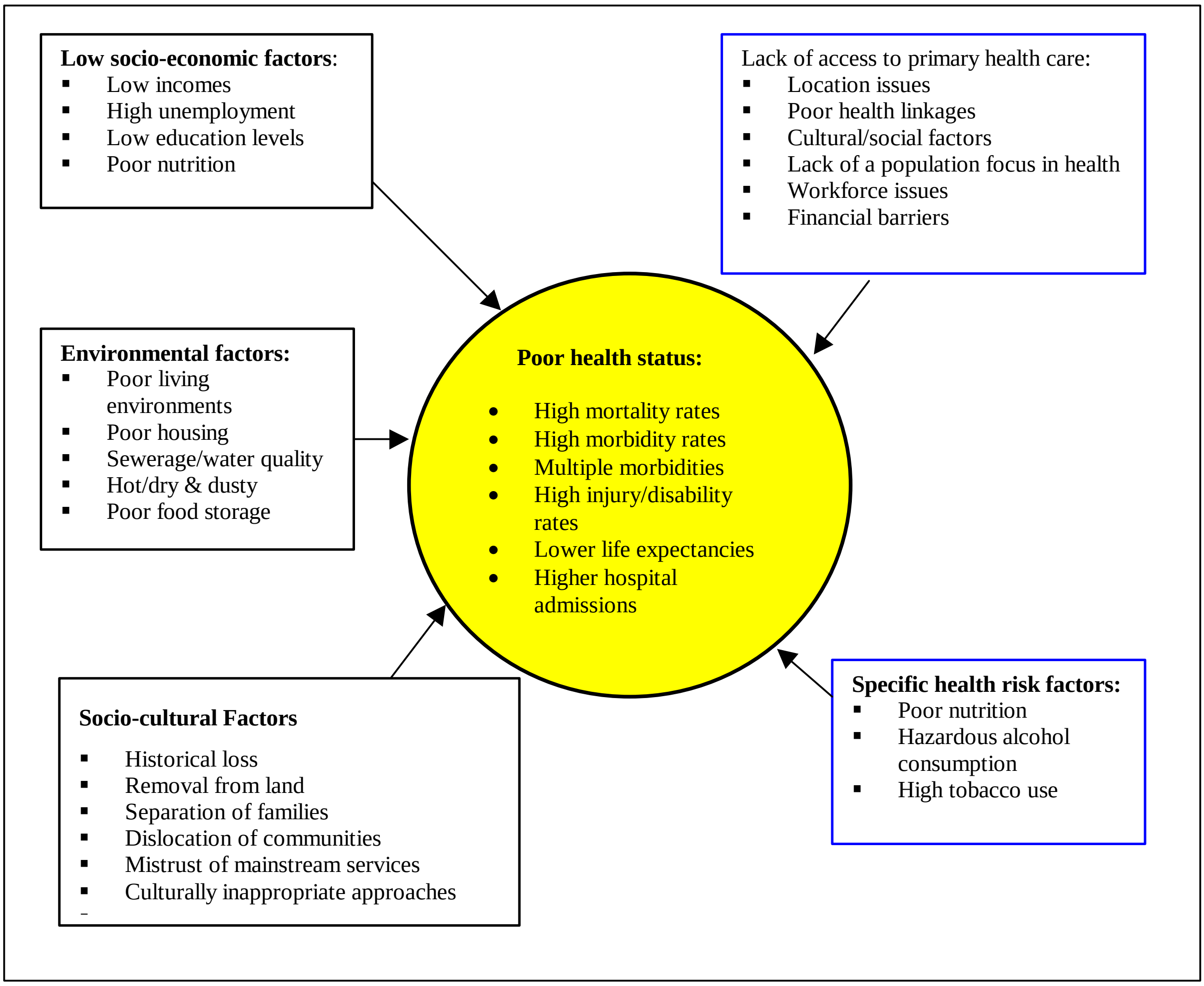
[13] For further details on the health status of Aboriginal and Torres Strait Islander people, see Commonwealth Department of Health and Aged Care, *Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health*, Commonwealth Department of Health and Aged Care, Canberra, 1999.

There are a number of inter-related factors which impact on poor health among Aboriginal and Torres Strait Islander people, and its persistence (see Figure 1).

Figure 1: Factors impacting on Aboriginal and Torres Strait Islander health status



Source: Department of Health and Aged Care

The relationship between these factors is complex, and current evidence does not allow us to assess the relative importance of one factor over another. It is likely that different determinants may be major or less significant for different health problems.

This general observation suggests that we need to be cautious in attributing excess morbidity or mortality among Indigenous people to any one cause. Explanatory frameworks that point to one set of factors, such as specific risk factors, to the exclusion of others, such as access to good quality health care, are unlikely to lead to effective action. To make a significant impact on health status, relevant portfolios will to need to work collaboratively across all governments and with the community sector to address all factors.

While the task required to improve the health status of Aboriginal and Torres Strait Islander people is considerable, progress has been made in a number of important areas. Although still unacceptably high, the infant mortality rate has improved from being 20 times higher than the non-Indigenous rate to between 3 and 5 times higher. Death rates from cardiovascular disease, lung cancer, injury and homicide amongst men have been declining since 1995. Deaths from parasitic infection and acute respiratory disease amongst children have also fallen, with improvements being reported in particular regions for specific diseases and illnesses.

Partnerships are regarded as the key to achieving improved access and improved health status: partnerships between different spheres of government, the community sector and the Aboriginal and Torres Strait Islander Commission (ATSIC).

The partnership approach and focus of effort adopted by the Portfolio recognises:

- that spheres of government are jointly responsible for responding to the needs of Aboriginal and Torres Strait Islander peoples;
- the need to work closely with the Aboriginal Community Controlled Health Services, which play a major role in providing services, providing policy and program advice and also facilitating the participation of Aboriginal Torres Strait Islander people in policy and program development and service delivery;
- that collaboration with mainstream health providers and services (both public and private) and with health professionals and educational institutions is essential;
- the importance of working with ATSIC which has responsibility for providing housing and essential infrastructure services and programs to the Indigenous community; and
- the need for collaboration between portfolios to improve health outcomes, in particular housing, education, employment and family services.

Partnership arrangements under the Aboriginal and Torres Strait Islander Health Framework Agreements were signed between the Commonwealth, State/Territory governments, ATSIC and the Aboriginal community controlled health sector between 1996 and 1999. With the exception of the Torres Strait, these Agreements are due to expire on 30 June 2000. Following an in-principle commitment from all Australian Health ministers in August 1999 to extend the agreements for a further period, these Agreements will be re-negotiated during 2000.

The Portfolio believes that in order to take into account priorities and concerns of Aboriginal and Torres Strait Islander communities, health strategies require effective mechanisms for Aboriginal and Torres Strait Islander participation and need to take account of the principles of self-determination.

From a Portfolio perspective, two of the key successes of the Aboriginal and Torres Strait Islander Health Framework Agreements have been the forging of effective intersectoral links at regional and national levels and the involvement of local communities in planning and priority setting.

The partnership approach is proving successful: it has produced positive outcomes and should be further developed and built upon in the coming years. There is also a clear acknowledgment that collaboration is not easy, it requires constant effort, goodwill, flexibility and often compromise by all parties. At both the Commonwealth level and across

States and Territories progress through collaboration has varied and fluctuated, as can be expected with most new approaches.

1.2 Terms of reference

The terms of reference require the Commission to:

> inquire into and develop a method that can be used to determine the needs of groups of indigenous Australians relative to one another across government and government-type works and services provided or funded by the Commonwealth, or by the States, Territories or local government with Commonwealth financial assistance through specific purpose payments.

The Commission has noted that:

> The aim of the inquiry is to provide information that will help the Commonwealth Government:

- better understand the needs of indigenous people across the various regions of Australia for the key services; and

- direct its expenditure on services for indigenous people to better target those in greatest need.[14]

Improving the equity of funding supporting the health of Aboriginal and Torres Strait Islander peoples is one of the objectives for this Portfolio, because equitable funding is required to enable access to services and programs at a level commensurate with need.

Hence, the Portfolio considers that the biggest allocation question in relation to improving equity is what total level of resources is required to meet the health needs of Aboriginal and Torres Strait Islander people. It is within this context that relative resource requirements between groups of Indigenous people can be considered.

The terms of reference do not cover community services. It is suggested that the Commission consider expanding the scope of the Inquiry to cover these. Both the Commonwealth, through the Family and Community Services portfolio, and the States and Territories make significant investments in community services for Aboriginal and Torres Strait Islander peoples. Community services contribute to the stability and well-being of communities and families and complement the functional areas being covered by the Inquiry.

Services funded by the Family and Community Services portfolio include: the family networking program, childcare, disability services, youth services. In addition, ATSIC funds, for example, night patrols, link up, and legal services. Consideration might also be given to sport and cultural funding, especially as in some jurisdictions these may be included with community services.

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[14] Commonwealth Grants Commission, *Indigenous Funding Inquiry*, Information Paper No.1, February 2000, pp.8, 1-2.

1.3 Outline of submission

This initial submission does not attempt to provide the Commission with all of the information requested. The Portfolio sees the Inquiry as an iterative process and welcomes the opportunity to work with the Commission throughout the coming year.

Section 2, ‘The Australian Health System’ concentrates on enabling a better understanding of how the Australian health system works – the players involved, their funding responsibilities and the various partnership arrangements which contribute to providing health services for Aboriginal and Torres Strait Islander people.

In Section 3, details of the Commonwealth’s role in responding to Indigenous health needs are provided. Programs within the scope of the Inquiry are identified as they relate to population health, primary care, acute care and to aged and community care, together with details of how current funds are distributed, generally and for Indigenous people.

Section 4 provides the Commission with the Portfolio’s perspectives on the development and use of an index of relative need. Some principles that might guide this endeavour are identified, some possible approaches discussed, and methodological issues raised by the Commission are addressed. Finally, ways in which the Portfolio might make use of an index of relative need are canvassed.

Central to the Commission’s terms of reference is the notion of regional distribution. Section 5 considers the regions currently used by the health sector for planning and data collection purposes.

Finally, Section 6 briefly reiterates the well-known data limitations that continue to undermine our capacity to clearly articulate and identify health and service needs limitations and then outlines some data sources the Commission could draw on. There are significant initiatives in progress to begin rectifying the limitations and some of these are described.

The Portfolio appreciates the work involved in the task before the Commission. In 1998 the Portfolio commissioned the National Centre for Epidemiology and Population Health to determine public expenditures on health services for Aboriginal and Torres Strait Islanders. This comprehensive report, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*[15] for the first time identified all government and non-government resources committed to Aboriginal and Torres Strait Islander peoples’ health care. It provides a wealth of information to inform service planning, program evaluation or policy development decisions, and is a benchmark of national and state based expenditure against which future expenditure can be monitored.

Both this benchmark study and work in progress to update it will provide essential information for the Commission. The second edition of the report is due to be released in November 2000.

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[15] Deeble et al.

2. THE AUSTRALIAN HEALTH SYSTEM

This Section provides an overview of the health system and the funding arrangements and share of expenditure supporting Aboriginal and Torres Strait Islander health.

The health system is financed from a combination of public and private funds. Public funds account for approximately 69 percent of total health expenditure and are sourced from the Commonwealth, State and Territory, and local governments. Private funds are sourced from health insurance schemes, other insurance schemes, and out-of-pocket payments by private citizens.

The health needs of Indigenous people are largely met through the funding and delivery of mainstream health services. Services specifically targeting Aboriginal and Torres Strait Islander people complement these mainstream services.

It is estimated that, in 1995-96 (the only financial year for which there is system-wide comparative expenditure data) for all services and all sources of funds, recurrent expenditures for Aboriginal and Torres Strait Islander people, who make up about two per cent of the population, were $853 million, or about 2.2 per cent of total health spending.

When only public funding was taken into account, expenditure on Aboriginal and Torres Strait Islander peoples was around 3 per cent. However, the higher rate of government spending did little more than compensate for a much lower rate of private spending with Aboriginal and Torres Strait Islander people on lower incomes having less capacity than the average Australian to pay for health services.

2.1 The Australian Health system: governments and the private sector

The aim of the national health care funding system is to give universal access to health care while allowing choice for individuals.

Under the Constitution the Commonwealth is responsible for providing individual benefit programs and the States/Territories are responsible for delivery of a large proportion of health services. The responsibilities of the two spheres of government are complemented by the private sector which also plays a significant role in funding and providing health services.

Government and non-government sector expenditure on health services for 1997-98 totalled $47.3 billion and accounted for 8.4 per cent of Gross Domestic Product with the Commonwealth contributing 45 per cent of the total (including grants to States and Territories) and 31 per cent being contributed by the non-government sector (Table 1).[16] The non-government component includes around 10.9 per cent from private health insurance funds and around 18.8 per cent self funded, as well as health expenditure by workers compensation and compulsory motor vehicle third party insurance funds.

Expenditure covered services provided by doctors, hospitals, pharmaceuticals, dental, physiotherapy, and other allied health services, community and public health, and nursing homes.

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[16] Expenditure figures for 1998-99 are expected to be available later this year.

Table 1: Total health services expenditure, current prices, by source of funds, 1997-98 ($ million)

Source of Funds	Amount ($ million)	% of Total
Commonwealth	15,945	33%
Commonwealth grants to State and Territories	5,543	12%
State and Local	11,159	24%
Non-government	14,620	31%

Source: Australian Institute of Health and Welfare, *Health Expenditure Bulletin No. 15*

The Commonwealth has a leadership role in policy making, particularly in national issues like population health, research and national information management. In addition, the Commonwealth provides a range of grants to government and non-government bodies in order to achieve specific health care objectives.

The States and Territories are primarily responsible for the delivery and management of public health services and for maintaining direct relationships with most health care providers, including the regulation of health professionals. They deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental health, maternal and child health and environmental health programs.

The State and Territory governments directly fund a broad range of health services. The Commonwealth funds most medical services out of hospital, and most health research. The Commonwealth, States and Territories jointly fund public hospitals and community care for aged and disabled persons.

All levels of Government – plus consumers and the non-government sector – have some role in funding, administering, or providing aged care for older people. Residential aged care is financed and regulated by the Commonwealth Government and provided mainly by the non-government sector (by both non-profit and for-profit providers). The Commonwealth, States and Territories jointly fund and administer community care (such as delivered meals, home help and transport). Some State, Territory or local governments provide some community services.

Private sector funding currently accounts for about one third of health expenditure. The Commonwealth Government considers that strong private sector involvement in health services provision and financing is essential to the viability of the Australian health system. For this reason the Commonwealth Government provides a 30 per cent subsidy to individuals who acquire private health insurance.

A key component of the Australian health care system is private health insurance which can cover private and public hospital charges (public hospitals charge only patients who elect to be private patients in order to be treated by the doctors of their choice), and a portion of medical fees for inpatient services. Private insurance can also cover allied health / paramedical services (such as physiotherapists' and podiatrists' services) and some aids and appliances such as spectacles.

Non-government non-profit organisations play a significant role in health services, public health and health insurance.

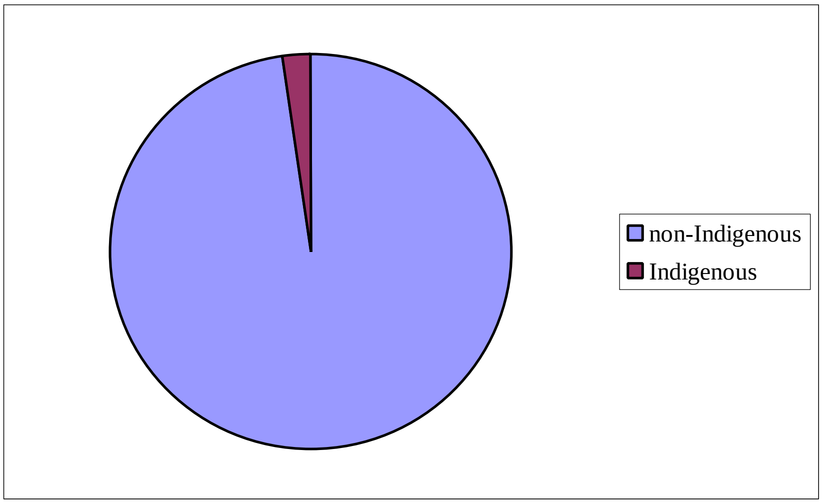
The peak consultative body between Commonwealth, State and Territory governments is the Australian Health Ministers' Conference. The Australian Health Care Agreements are bilateral agreements between the Commonwealth and each State and Territory, with the broad parameters being agreed multilaterally by the Australian Health Ministers' Conference. Strategic public health and other partnerships are negotiated in similar ways.

2.2 Government expenditure on health services for Aboriginal and Torres Strait Islander people 1995-96

The report on *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, covering the period 1995-96, provides the only data covering system-wide expenditure on Aboriginal and Torres Strait Islander peoples and the total Australian population. This Section discusses the report's key finding on government health expenditures pertinent to the Inquiry. Unless otherwise stated, the source for each of the Figures presented below is data drawn from the report.

In 1995-96 Australians spent $39.4 billion on health care. Of that, it is estimated that for all services and all sources of funds, recurrent expenditures for Aboriginal and Torres Strait Islander people (who make up about two per cent of the population) were $853 million, or approximately two per cent of total health spending (Figure 2).

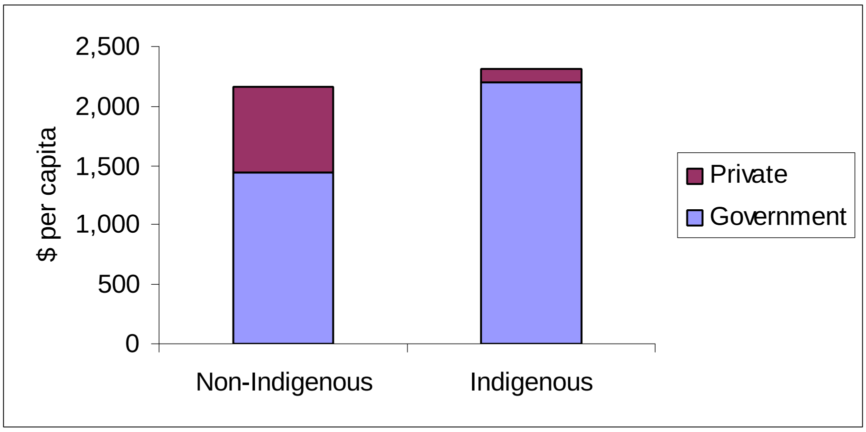
Figure 2: National expenditure on health services for Indigenous and Non-Indigenous people, 1995-96



Source: Deeble *et al*, pp.10, 23, 63.

Therefore, on a per capita basis, expenditure on the health of Aboriginal and Torres Strait Islander people was almost the same as that for other Australians with the ratio of Indigenous to non-Indigenous per capita funding being about 1.08: 1 (Figure 3). This is despite Aboriginal and Torres Strait Islander people's much greater needs for health services.

Figure 3: Estimated public and private expenditure on health services for Indigenous and non-Indigenous people, per capita 1995-96



While expenditure levels were about the same, there were significant differences in the source of those funds. For the population as a whole, private sources of spending accounted for about one-third of the total, whereas for the Aboriginal and Torres Strait Islander population, spending from private sources was, on average, negligible. This largely reflected relative income, with Indigenous people on lower than average incomes having less capacity to pay for health services

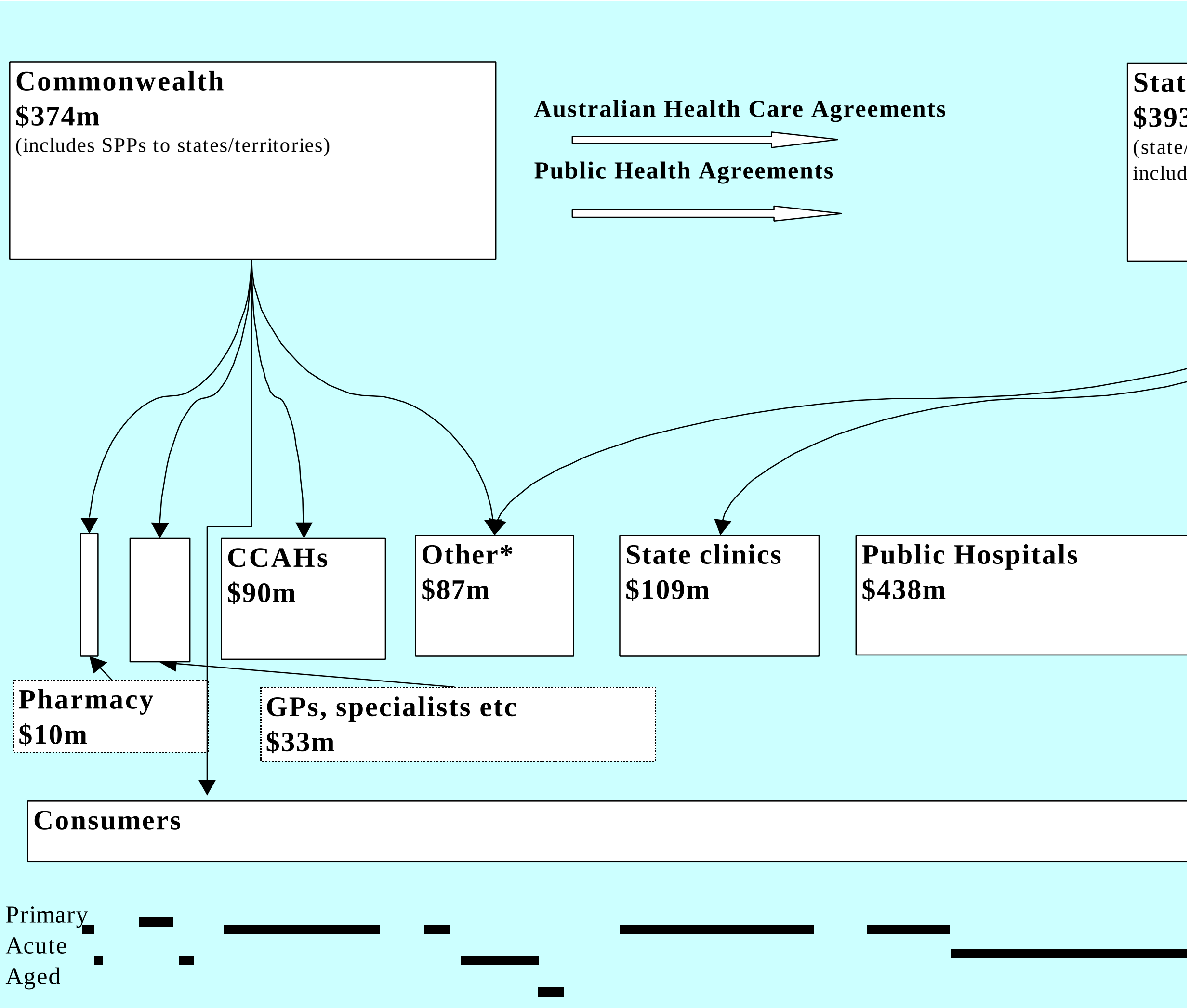
Aboriginal and Torres Strait Islander people therefore relied much more on government funded services than did the general population, though no more so than other Australians of like socio-economic status.

Of total government health funding of $26.6 billion in 1995-96, around 3 per cent or $810 million was spent on providing health services for Aboriginal and Torres Strait Islander people as compared with approximately 2 percent of total health expenditure. However, the higher rate of government spending did little more than compensate for the much lower rate of private spending.

2.2.1 Mapping government expenditure

The components of overall government 1995-96 expenditures on Aboriginal and Torres Strait Islander health, the purposes of the expenditures (primary care, acute care, aged and community care), responsibilities for these purposes, and the broad categories of services covered by the expenditures are mapped in Figure 4 (next page).

Figure 4: Aboriginal and Torres Strait Islander health care – source of governmen



* Other = nursing homes, public health programs, patient travel, mental institutions

** Excludes administration and research

2.2.2 Commonwealth and State/Territory contributions to government funding

The Commonwealth and State/Territory governments contributed approximately equal amounts to the overall expenditure on Aboriginal and Torres Strait Islander health.

The Commonwealth contributed to health care through:

- Specific Purpose Payments (SPPs; around 57 per cent of total Commonwealth contributions) to the States and Territories which mostly comprise:
    - Australian Health Care Agreements comprising over 50 per cent of Commonwealth expenditure on Indigenous health compared with about 33 per cent for the non-Indigenous population; and
    - Public Health Outcome Funding Agreements;[17] and
- Commonwealth Own Purpose Outlays (COPOs; (43 per cent of total Commonwealth contributions)[18].

2.2.3 Distributing government funding

In contrast, the States distributed around 80 per cent of total government expenditure on Aboriginal and Torres Strait Islander health to services provided by:

- public hospitals (55.3 per cent of total government funding on Aboriginal and Torres Strait Islander health);
- state community health clinics (13 per cent of total government funding on Aboriginal and Torres Strait Islander health); and
- a range of other programs including mental health institutions, patient transport, population health initiatives, dental services and ancillary services.

The Commonwealth distributed the balance of total government expenditure on Aboriginal and Torres Strait Islander health through:

- the Medicare Benefits Schedule (MBS);
- the Pharmaceutical Benefits Scheme (PBS);
- grant funding to Aboriginal Community Controlled Health Services (ACCHS); and
- a range of other programs including nursing home benefits, general practitioner programs, and research.

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[17] These agreements cover the following eight program areas: HIV/AIDs and related diseases; the National Women's Health Program; Alternative Birthing Services; Female Genital Mutilation; BreastScreen Australia; National Cervical Screening Program; National Immunisation Program; and the National Drug Strategy. Aboriginal and Torres Strait Islander Peoples are a specific target group under these Agreements.

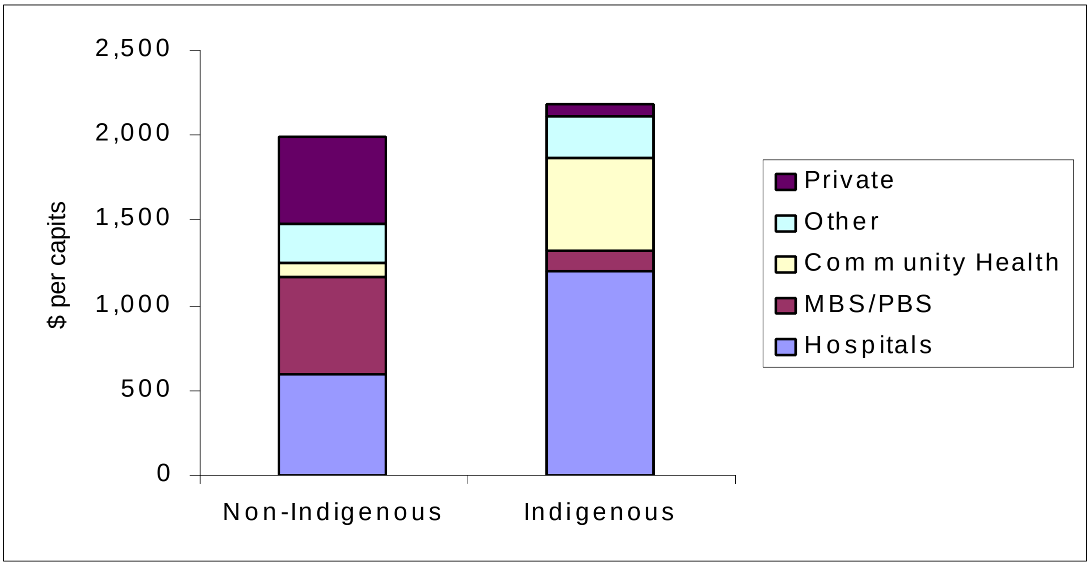
[18] The Commonwealth also contributes indirectly through untied Financial Assistance Grants to the States and Territories.

Aboriginal and Torres Strait Islander people received very little from the two largest Commonwealth programs of MBS and the PBS, with per person benefits in 1995-96 being only 27 and 22 per cent respectively compared to non-Indigenous people. This was in part compensated for by targeted community-based primary health care programs funded through the largest single source of Commonwealth expenditure – grants to Aboriginal Community Controlled Health Services.[19]

2.2.4 *Expenditure as a reflection of use*

As can be seen in Figure 5, the pattern of expenditure in 1995-96 – reflecting service use by Aboriginal and Torres Strait Islander people – was quite different to the average for the non-Indigenous population. There was much more reliance on publicly-provided hospital and community health services and lower access to private doctors, private hospital care, private dentists, PBS funded medicines and ancillary services.

Figure 5: Sources of health care expenditure, per capita 1995-96



Source: Deeble et al. P.63.

2.2.5 *Relative Commonwealth/State contributions to government expenditure in each State and Territory 1995-96*

National averages disguise a very uneven distribution of both Commonwealth and State/ Territory funding across the States and Territories. This is true of funding for the general population as well as funding for Aboriginal and Torres Strait Islander peoples.

Figure 6 shows the relative Commonwealth/State contributions to 1995-96 per capita health expenditures for the general population for each State and Territory. A range of factors influence the relative levels of the contributions, including the nature of the programs from which funding is obtained, differences in service provision levels, and the cost structures (eg, costs are higher in some regions or for service to small or dispersed populations).

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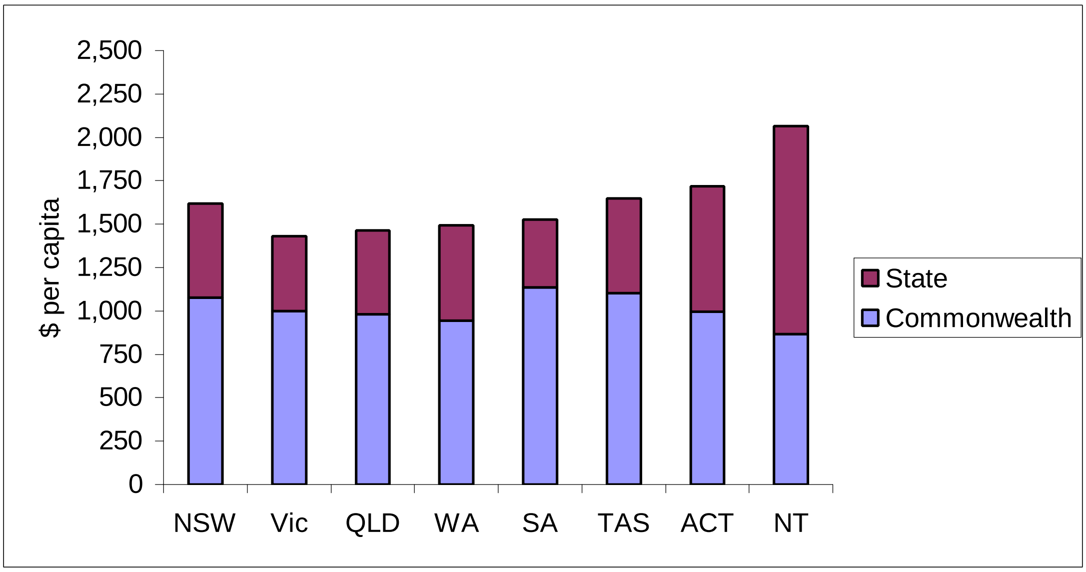
[19] See Figure 10 for a definition of 'primary health care'.

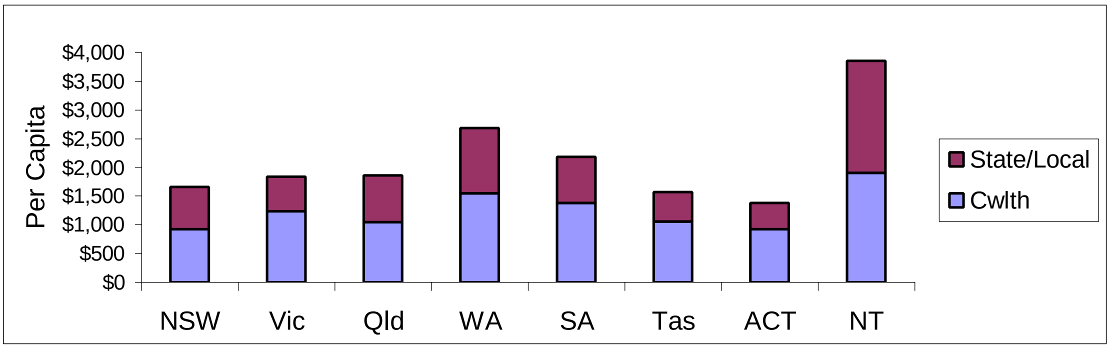
Figure 6: Government per capita general population expenditure by State/Territory, 1995-96



Source: AIHW, 1999, Table A1-16

When only the component of this expenditure used for health services for Aboriginal and Torres Strait Islander peoples is considered, both the levels of State/Territory per capita funding, and the relative Commonwealth/ State contributions to those payments are much more uneven than those for per capita expenditure for the whole population in each jurisdiction (Figure 7).

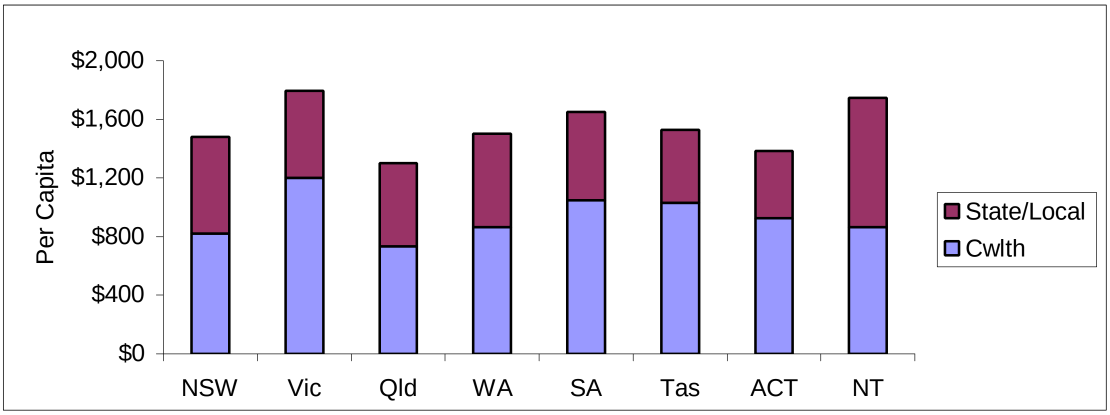
Figure 7: Commonwealth/State funding for Indigenous health care, per capita 1995-96



Source: Deeble et al, pp.109,120-23

This is partly a result of the cost of delivering services in remote regions, with around one third of Aboriginal and Torres Strait Islander peoples living in remote areas compared with only 3 per cent of the general population. Adjusting expenditure levels to take account of the additional costs of providing services in remote areas makes a noticeable difference, but anomalies still remain (Figure 8).

Figure 8: Commonwealth/State funding for health care, per capita 1995-96 (adjusted for remoteness)

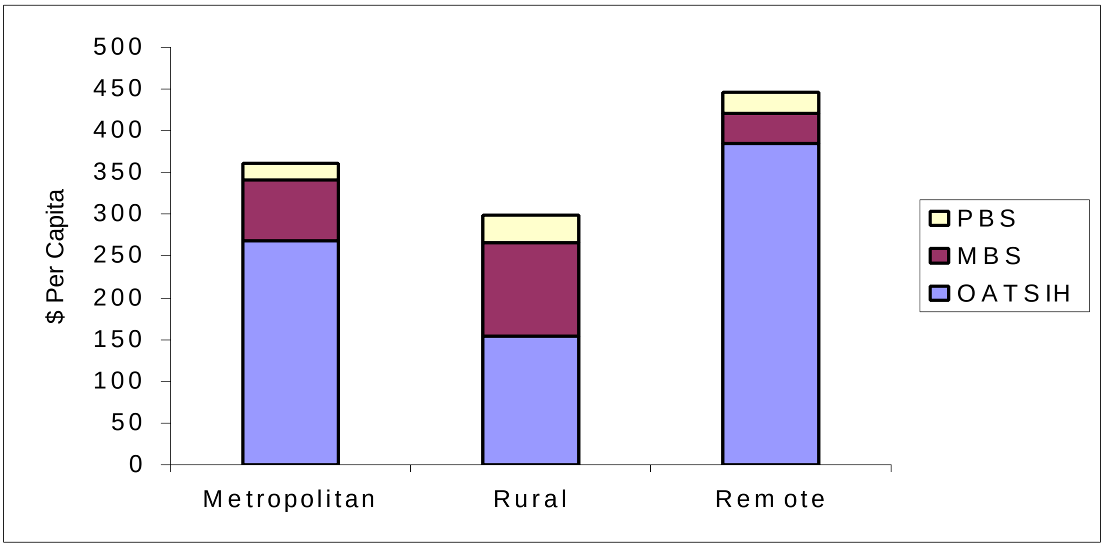


Source: Deeble et al, pp.109, 120-23; AIHW, 1999, Table A1-16

2.3 Regional distribution of Commonwealth funding

In 1997-98 the main sources of Commonwealth funding for Aboriginal and Torres Strait Islander primary health care were estimated to be distributed across urban, rural and remote regions in the ratios described in Figure 9.

Figure 9: Main sources of direct Commonwealth funding for Aboriginal and Torres Strait Islander Primary Health Care by region, 1997-98



Source: Deeble 1998

2.4 Private funding

Private expenditure is lower for Aboriginal and Torres Strait Islander people than for non-Indigenous people. As noted above, Aboriginal and Torres Strait Islander people are more likely to use publicly-provided services and less likely to use private practicing GPs, dentists, ancillary services and private hospitals (which often require private contributions). This low private expenditure and greater reliance on publicly provided services is comparable to that for other Australians of similar socio-economic status.[20]

The 1995 *National Health Survey* estimates that 18,700 Indigenous Australians were covered by private health insurance and 5,643,000 non-Indigenous Australians had private health cover, that is, Indigenous Australians represented 0.3 per cent of the total population with private health cover in 1995. Assuming take-up rates were proportionally equal for Indigenous and non-Indigenous Australians, 0.3 per cent of expenses of total Federal Government 30 per cent Rebate for private health insurance is spent on Indigenous Australians with private health insurance.[21]

Private expenditure is not likely to be a significant source of funding for health services for Aboriginal and Torres Strait Islander peoples in the short term.

2.5 Government funding since 1995-96

Since 1995-96 all governments have committed to improving efforts through the Aboriginal and Torres Strait Islander Health Framework Agreements. The second edition of the report on *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, due to be released in November 2000, is expected to show a significant increase in spending, both in aggregate terms and as a proportion of total health spending for Australia as a whole.

Compared to the 1993-98 Medicare Agreements, the 1998-2003 Australian Health Care Agreements provide for higher levels of ongoing funding to the States and Territories, as well as a higher level of real growth in funding over the life of the Agreements. Total funding of about $23.4 billion was provided to the States and Territories under the Medicare Agreements, with funding over the five years to 1997-98 increasing by about 17 per cent in real terms. Total funding of $31.3 billion is estimated to be provided to the States and Territories under the Australian Health Care Agreements, with funding over the five years to 2002-03 increasing by about 25 per cent in real terms.

Commonwealth Budget measures since 1995-96 have seen spending on Indigenous specific primary health care programs increase, with funding through the Aboriginal and Torres Strait Islander Health program increasing from $115 million in 1995-96 to $170 million in 1999-00.

In 1999-2000 a new needs-based funding allocation mechanism was introduced through the Aboriginal and Torres Strait Islander Primary Health Care Access Program (PHCAP). In part, the measure will sustain services established as a result of the Aboriginal Coordinated Care Trials, but also begins to draw on some of the experiences of the Trials in testing new ways to finance health care (the Trials are summarised at **Appendix A**).

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[20] Deeble *et al* 1998, p.57.

[21] Australian Bureau of Statistics (1995) *National Health Survey: Aboriginal and Torres Strait Islander Results* ABS, Canberra. As the 1998 *Health Insurance Survey* does not distinguish Indigenous status, the 1995 *National Health Survey* is the only source for estimates of the Indigenous population with private health cover.

Under the PHCAP funds are also targeted to areas where needs have been identified through regional planning processes. Funding levels will be are increased over time up to a benchmark rate, in line with capacity to effectively utilise the funds to meet the community's needs. The benchmark rate is based on the size of the local population, and a factor that takes account of the poorer health status - and therefore higher need - of Aboriginal and Torres Strait Islander peoples as compared with the rest of the population as a whole. There is an additional loading in remote areas in recognition of the extra costs associated with delivering services in those locations. Funding is provided through a mixture of MBS and grant funding.

Some of the main aspects of the initiative are:

- Funding is conditional on regional planning having been completed;
- Total Commonwealth funding levels (of which the PHCAP forms a part) are calculated on the basis of relative health need of the Aboriginal and Torres Strait Islander population (as compared with non-Indigenous Australians) and the additional costs of providing services in remote areas;
- Funding calculated on a per capita basis;
- Total Commonwealth funding is taken to include the potential for a region to access Medicare, and other equivalent Commonwealth grant funding;
- Funding is conditional on States/Territories meeting their funding responsibilities in this area.

A more complete description of the program is at **Appendix B**.

Access to Medicare and the PBS has also been improved through several initiatives including access to pharmaceuticals in remote areas (under section 100 of the *National Health Act*), access to Medicare in Aboriginal Medical Services (under sub-section 19(2) of the *Health Insurance Act*), new primary health care items on the MBS and streamlined enrolment and claiming processes.

Other changes to funding arrangements for Aboriginal and Torres Straight Islander health include payments under the National Illicit Drug Strategy to organisations, some of which are Indigenous organisations. In the area of population health a number of initiatives with a specific Indigenous focus are being progressed in the areas of nutrition, injury and chronic disease.

The Portfolio recognises that general practitioners are the major providers of primary health care in Australia and as such are well placed to implement early intervention and health promotion activity for the Australian population generally and for Aboriginal and Torres Strait Islander people and people in rural areas specifically. The Commonwealth is working with key stakeholders including the Joint Advisory Group on General Practice and Population Health to enhance the early intervention and health promotion role of general practice. The Joint Advisory Group is expected to pay particular attention to the role of general practice in addressing the early intervention needs of Aboriginal and Torres Strait Islander people. Other initiatives include direct funding to general practitioners and Divisions of General Practice for which assist in ensuring primary care services in rural and remote areas (see further Section 3, Portfolio programs within the scope of the Inquiry, and **Appendix C** and **Appendix D**).

3. PORTFOLIO PROGRAMS WITHIN THE SCOPE OF THE INQUIRY

This Section identifies programs considered by the Portfolio to fall within the scope of the Inquiry. The share of funding expended on Aboriginal and Torres Strait Islander health by these programs is considered, together with how this is influenced by the mechanisms used to distribute the funding and by current patterns of access to benefits and services. The Section ends with an overview of the range of needs assessment approaches used by these programs.

Apart from services funded through the Aboriginal and Torres Strait Islander Health program and the Aboriginal and Torres Strait Islander Aged Care Strategy, all other funding is provided through mainstream programs. Some mainstream programs include Indigenous specific initiatives aimed at improving Aboriginal and Torres Strait Islander peoples' access to mainstream services or improving the links between community controlled and mainstream services. Both mainstream and targeted programs may involve both spheres of government and may be either demand driven or provide funding in response to submissions. The Portfolio is directly involved in deciding on-the-ground distribution of only a small proportion of program funds.

For most programs, funding distribution largely reflects current patterns of access to benefits and services. Given the many barriers to access experienced by Aboriginal and Torres Strait Islander people, funding distribution does not necessarily represent optimal distribution across the health care system or, indeed, fully align with actual need in each of the categories.

Needs assessment methods vary across the Portfolio. The differing approaches reflect the type of program and the need for assessments to focus on both need (demand) factors and barriers to appropriate access (supply), as this enables the Portfolio to respond to needs through the most appropriate mix of policy levers and practical solutions.

3.1 A strategic approach to Aboriginal and Torres Strait Islander health

Within its broad purpose - 'to lead the development of Australia's health and aged care system' – the Health and Aged Care Portfolio seeks, as one of several outcomes, to achieve 'improved health status for Aboriginal and Torres Strait Islander peoples.' Further, the Portfolio has as one of its targets: 'improved life expectancy, health expectancy and infant mortality rates for Aboriginal and Torres Strait Islanders so that they are comparable with the general population.[22]

The Portfolio seeks to address the needs of Aboriginal and Torres Strait Islander people through four broad strategies:

- **Develop the health infrastructure and resources necessary to achieve comprehensive and effective health care;**

  Development of the health care infrastructure requires reforms in the financing of Aboriginal health, improvements in workforce training and availability, coordinated regional planning, data systems and the accountability of services. The development of

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[22] Commonwealth Department of Health and Aged Care (2000) *Portfolio Budget Statements -2000-01,* Commonwealth Department of Health and Aged Care, Canberra, pp.7-8.

innovative service models to improve service provision, particularly in remote areas, is also required.[23]

- **Address specific health issues and risk factors;**

  Development of strategies to address specific health issues focusing on the major causes of excess mortality, or potential causes of excess mortality, where health care interventions can make a major impact (such as mental health, sexual health, diabetes and cardiovascular disease) as well as specific risk factors affecting poor health status in Aboriginal and Torres Strait Islander communities (such as substance misuse and poor nutrition). The Government also gives priority to diseases that contribute to the relative high level of disability within communities (such as otitis media and trachoma).

- **Improve the evidence base that underpins these interventions;**

  This component focuses on a more strategic approach to research, particularly research funded by the National Health and Medical Research Council (NHMRC), and to improving health data and performance measures.

- **Improve communication with primary health care services, Aboriginal and Torres Strait Islander peoples and the general population.**

  The aim of this component is to inform stakeholders, the public, politicians, and the media of Indigenous health initiatives, programs and policies being progressed by the Department and by Indigenous communities. The Government will disseminate information on examples of effective, evidence based approaches to Indigenous health service delivery and health promotion activities to service providers, stakeholder groups, the academic community and Government agencies. The aim is to reduce negative media coverage, encourage positive reporting and inform attitudes to Indigenous health issues, policies, programs and initiatives.

All programs across the Portfolio share responsibility for pursuing these strategies: Aboriginal and Torres Strait Islander people are represented within the client groups of almost all program areas.

In 1994, the Federal Government established the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the then Department of Human Services and Health to give a greater focus on Indigenous health needs in mainstream health programs. In July 1995, following a decision by Cabinet to transfer responsibility for Aboriginal and Torres Strait Islander Health from the Aboriginal and Torres Strait Islander Commission to the Health portfolio, the Office assumed responsibility for providing funding to Aboriginal community controlled health and substance misuse services previously administered by ATSIC.

Within the Portfolio, the Office provides leadership in developing policy, and coordinating initiatives on Aboriginal and Torres Strait Islander health. It collaborates with other areas across the Portfolio to ensure that mainstream programs are responding to the particular health needs of

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[23] Primary health care is defined at Figure 10 below.

Indigenous Australians, that there is complementarity across those initiatives, and that agencies beyond the Portfolio, including Aboriginal and Torres Strait Islander organisations and communities, are appropriately involved. So, for example, the Office works closely with the Health Access and Financing Division and the Health Insurance Commission on promoting better access to Medicare and the Pharmaceutical Benefits Scheme, and with Population Health Division on immunisation and nutrition programs.

The Office also has its major long-term strategy to improve Aboriginal and Torres Strait Islander people's access to comprehensive primary health care services. The aim is to facilitate better access to and involvement in coordinated clinical care, population health and health promotion activities to facilitate illness prevention, early intervention and effective disease management. Australian and international evidence supports this approach, showing that over time it has been demonstrated to lead to real and sustainable improvements in health status for Indigenous communities. This strategy relies on fostering close working relationships with the Aboriginal community controlled health sector, the Aboriginal and Torres Strait Islander Commission (ATSIC) and State/Territory health portfolios.

The network of Aboriginal and Torres Strait Islander primary health care services (including substance misuse services funded through the Office) complements mainstream services. Likewise, Government initiatives in relation to workforce, health financing and improving access to specialist services and care are part of the wider range of initiatives to ensure that, like other Australians, Indigenous Australians have access to a comprehensive range of appropriate health services commensurate with their needs.

Figure 10: Definition of primary health care

What is primary health care?

The World Health Organisation provides the universally accepted theoretical definition, known as the 'Alma Ata Declaration'.

> [Primary health care is]…essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's overall health system, of which it is the central function and main focus, and the overall social and economic development of the community with the national health system bringing care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.

The practice of primary health care

Primary health care is a practical mode of health service delivery that is local and readily available to all members of a given community. It is the first contact point for health services and the most appropriate vehicle to deliver programs that:

- will be socially and culturally acceptable to a given community;
- will enable community involvement and approval regarding health service decision making and delivery; and
- will incorporate a style of practice that is focussed on addressing individual and community needs.

Health promotion and education are a fundamental part of the majority of primary health care programs.

Comprehensive primary health care

Comprehensive primary health care is not confined to clinical/medical care. It is a much broader concept and includes:

- population health/preventative care eg immunisation, antenatal care, screening programs, sexually transmitted disease management;
- primary clinical/medical care covering the treatment of illness, emergency care, management of chronic conditions;
- arranging for visiting medical specialists and allied health professionals and facilitating access to hospital services;
- health promotion programs eg nutrition, substance abuse;
- client and community advocacy;
- health policy, planning and decision making.

3.2 Criteria for inclusion

For the purposes of this submission, the Portfolio has applied the following criteria when considering which of its programs are within the scope of the Inquiry:

IN:	Programs/elements that directly or indirectly provide funding for ongoing health services, including grants and benefits/subsidies to individuals or communities. These may be either ongoing funding or capital; and
OUT:	Programs/elements that provide funding for pilots, or national or state wide infrastructure support (eg, NHMRC research grants).

3.3 Programs within scope of the Inquiry

As noted in Section 2, the Commonwealth's major investments are through the Australian Health Care Agreements and the provision of individual benefit programs via Medicare and PBS. Each of these investments provides support for both primary and acute care, with the Commonwealth's major contribution to acute care being through the Australian Health Care Agreements. In addition, the Commonwealth provides targeted funding to support primary care services and aged care services.

The programs considered within scope of the Inquiry reflect these responsibilities. For 1999-2000 it is anticipated that $22.4 billion will be distributed by these programs as summarised in Table 2 (next page). Appendix A provides more detailed descriptions of the programs.

Apart from services funded through the Aboriginal and Torres Strait Islander Health program and the Aboriginal and Torres Strait Islander Aged Care Strategy, all other funding is provided through mainstream programs. Some mainstream programs include Indigenous specific initiatives aimed at improving Aboriginal and Torres Strait Islander peoples' access to mainstream services or improving the links between community controlled and mainstream services.

Of the $22.4 billion to be distributed in 1999-200, $17,492 million or (78.3 per cent) will be distributed through the Commonwealth's major funding arrangements as follows:

- Australian Health Care Agreements: $5,900 million mostly for acute but with some to primary care
- Medicare Benefits Scheme: $6,900 million mostly for primary care but includes some for acute care;
- Pharmaceutical Benefits Scheme: $3,400 million mostly for primary care but includes some for acute care; and
- Private Health Industry: $1,292 million for a mix of primary, acute and aged care.

Of the remainder, $4,123 million or (18.4 per cent) will go to aged and community care and $748 million or (3.3 per cent) will support primary health care, including $175 million through the Office for Aboriginal and Torres Strait Islander Health [24]

Most funding ($15,768 million or 70.5 per cent) is appropriated as Commonwealth Own Purpose Outlays (COPOs), with Medicare, PBS and grants provided through Aboriginal and Torres Strait Islander Health program comprising the majority of these appropriations. Special Purpose Payments (SPPs) account for $6,595 million (29.5 per cent) and mostly comprise the Australian Health Care Agreements and the Public Health Outcome Funding Agreements.

In large part, funding is recurrent but some capital funding ($9.3 million) is provided through the Aboriginal and Torres Strait Islander Health program for once-off purposes such as major capital works (ie, building clinics or staff housing in remote areas), the replacement of vehicles and service equipment, time-limited developmental and support projects, minor repairs and maintenance works, and the implementation of computer based patient information systems. A further $4.66 million capital funding will be distributed through the Aboriginal and Torres Strait Islander Aged Care Strategy.

Funding via the Public Health Outcome Funding Agreements, the Aboriginal and Torres Strait Islander Health program, and some components of the Australian Health Care Agreements and aged care appropriations, is redistributed through Commonwealth Grants Commission processes through the application of State and Territory relativities to the combined Financial Assistance Grants[25] and Health Care Grants pool. Any change in the distribution of Indigenous funding across the States and Territories would affect relativities between States and impact on the distribution of the Health Care Grants pool.

Details of whether programs within the scope of the Inquiry concern Commonwealth Own Purpose Outlays or Special Purpose Payments and the Commission's treatment of the funding is provided in Appendix B. Information provided in this submission largely covers major sources of expenditure.

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[24] Commonwealth Department of Health and Aged Care, administrative data.

[25] As from 1 July 2000, Financial Assistance Grants will be replaced by the GST Revenue Provisions and budget balancing assistance.

Table 2: Portfolio programs within scope of the Inquiry

Outcome	**Program or Element**	**COPO/ SPP**	**Mainstream/ Indigenous Specific**	**Primary/ Secondary/ Aged and Community Care**	**Capital / Recurrent**	**Est. funding 1999-2000 (total) $m**
1	Public Health Education Research Program (PHERP)	COPO	Mainstream	Primary	Recurrent	9.03
1	National Illicit Drug Strategy – Community Partnerships Initiative	COPO	Mainstream	Primary	Non-recurrent	1.40
1	National Illicit Drug Strategy – Non-Government Organisation Treatment Grants Program	COPO	Mainstream	Primary	Non-recurrent	13.50
1	Family Planning Program	COPO	Mainstream	Primary	Recurrent	14.15
1	Public Health Outcome Funding Agreements	SPP	Mainstream	Primary	Recurrent	177.00
2	Australian Health Care Agreements	SPP	Mainstream	Acute/Primary	Recurrent	5,900.00
2	Medicare Benefits Scheme (Indigenous initiative within mainstream)	COPO	Mainstream	Primary/Acute	Recurrent	6,900.00
2	Pharmaceutical Benefits Scheme – Improving Access to PBS for clients of remote area Aboriginal Medical Services (Indigenous initiative within mainstream)	COPO	Mainstream	Primary/Acute	Recurrent	3,400.00
2	Health Program Grants (Indigenous initiative within mainstream)	SPP	Mainstream	Primary	Recurrent	93.00
2	Practice Incentive Program (PIP) – Facilitating access by AMSs to the PIP (Indigenous initiative within mainstream)	COPO	Mainstream	Primary	Recurrent	184.00
2	General Practice Immunisation Incentives	COPO	Mainstream	Primary	Recurrent	38.00
2	Dementia Education and Support Program	COPO	Mainstream	ACC	Recurrent	1.38
3	Private Health Industry	COPO	Mainstream	Primary/ Acute/ACC	Recurrent	1,292.30
4	Coordinated Care Trials (mainstream funding source, with some Indigenous-specific trials)	COPO	Mainstream	Primary/Acute	Recurrent	15.17
4	General Practice Innovations Funding Pool (Indigenous initiative within mainstream)	COPO	Mainstream	Primary	Recurrent	4.00
4	Fighting Suicide	COPO	Mainstream	Primary	Recurrent	8.00
4	National Diabetes Strategy	COPO	Mainstream	Primary	Recurrent	2.97
5	Royal Flying Doctor Service	COPO	Mainstream	Primary/Acute	Recurrent Capital	17.95 2.5
5 & 8	Regional Health Services	COPO	Mainstream	Primary	Recurrent	27.60
6	Commonwealth Hearing Services Program/Community Services Obligations component (Indigenous initiative within mainstream)	COPO	Mainstream	ACC	Recurrent	26.80
6	Commonwealth Hearing Services Program/Voucher System component	COPO	Mainstream	ACC	Recurrent	120.00
7	Aboriginal and Torres Strait Islander Health	COPO	Specific	Primary	Capital Recurrent	14.70 146.13
8	Aboriginal and Torres Strait Islander Aged Care Strategy	COPO	Specific	ACC	Capital Recurrent	4.66 10.48
8	Community Care Package Program	COPO	Mainstream	ACC	Recurrent	165.00
8	Residential Aged Care Program	COPO	Mainstream	ACC	Recurrent	3,140.50
8	Aged Care Assessment Program	SPP	Mainstream	ACC	Recurrent	36.50
8	Assistance with Care and Housing for the Aged	COPO	Mainstream	ACC	Recurrent	2.60
8	Dementia Support for Assessment Program	COPO	Mainstream	ACC	Recurrent	1.04
8	Day Centre Therapy Program	COPO	Mainstream	ACC	Recurrent	27.70
8	Home and Community Care Program	SPP	Mainstream	ACC	Recurrent	525.57
8	Psychogeriatric Care Units	COPO	Mainstream	ACC	Recurrent	2.60
8	Aged Care National Respite for Carers Program	COPO	Mainstream	ACC	Recurrent	58.20
					Total Capital	**19.36**
					Total Recurrent	**22,365.07**

3.4 Current level of funding

As noted above, 1999-2000 appropriations to the programs within scope of the Inquiry total $22.4 billion. Estimating the portion of this that supports the health of Aboriginal and Torres Strait Islander peoples in any region is difficult and typifies the challenge that will face the Commission throughout the Inquiry in obtaining accurate data. Largely this difficulty stems from:

- the main sources of funding being from mainstream programs where it is often difficult to separate out funding provided for the benefit of Aboriginal and Torres Strait Islander as identification in administrative data is often poor or absent; and

- Commonwealth funding provided to the States through the Australian Health Care Agreements and the Public Health Outcome Funding Agreements are combined with State/Territory funds and services are delivered and managed by the States and Territories. State and Territory Governments have the flexibility to allocate Commonwealth funding according to local needs and priorities.

Information (often down to a regional level) on the level of funds flowing to Aboriginal and Torres Strait Islander health for some programs or program elements is readily available. This generally applies to Indigenous specific programs (eg, Aboriginal and Torres Strait Islander Health program grants) or for Indigenous-specific initiatives within mainstream programs (eg, grants to community organisations or incentives to GPs (eg, treatment grants under the National Illicit Drug Strategy; practice incentives to Aboriginal Medical Services under the Practice Incentive Program).

Data on the contribution from Indigenous use of mainstream programs is less readily available and needs to be derived from a mixture of data from administrative data sets and survey work.

These estimates should be available at national and broad regional levels for the 1998-99 financial year as part of the second report into *Expenditures on Heath Services for Aboriginal and Torres Strait Islander Peoples.*

In this context, it is timely to note some issues raised in the first report on *Expenditures on Heath Services for Aboriginal and Torres Strait Islander Peoples.* The report noted that ‘there is no definitive answer’ to the question of how much is spent on Aboriginal and Torres Strait Islander people, nor is there likely to be while there is continuing and ‘widespread reluctance to single out Aboriginal and Torres Strait Islander people as the only group to be asked about their racial background in a semi-public situation’. At the same time, the report notes that Aboriginal and Torres Strait Islander people’s use is at most a ‘marginal addition’ to the cost of mainstream services given that overall the group represents only 2 per cent of the population. Indeed, apart from the Northern Territory – where Aboriginal and Torres Strait Islander people are 27 per cent of the population, in most areas they comprise much less than 2 per cent.[26]

In this initial submission only broad details of the sources and distribution of funds are provided. No attempt has been made, for example, to look at the distribution of funds to specific regions or

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[26] Deeble et al, pp.3-4.

communities. However, where this might be derived from existing sources, data will be made available should the Commission find it useful.

3.5 Funding distribution mechanisms

3.5.1 Basis of current distribution

Because the Commonwealth's expenditures on health programs and services for Aboriginal and Torres Strait Islander people are mainly indirect and/or demand driven, the distribution of funding reflects current patterns of access. As such it does not necessarily represent optimal distribution and in some cases may act against the development of rational and integrated services and benefits support.

As outlined in Section 2, the report on 1995-96 *Expenditures on Health Services for Aboriginal and Torres Strait Islander People* demonstrated that the pattern of access (and hence the expenditure pattern) for Aboriginal and Torres Strait Islander peoples is quite different to that for the non-Indigenous population. Indigenous people are admitted to hospital about twice as frequently, they use hospital outpatient services at an even higher rate relative to non-Indigenous people and they are major users of publicly provided community health services. Besides, Aboriginal and Torres Strait Islander people benefited very little from mainstream financing schemes such as Medicare and PBS.

The question is whether the balance of funding between primary, acute and aged care is appropriate. There is mounting evidence that much of the illness amongst Aboriginal and Torres Strait Islander people is preventable and that better access to appropriate population health programs and primary health care services would assist in reducing the level of illness. For example, a recent study of hospital use for potentially preventable conditions found that age specific acute hospital separation rates for ambulatory sensitive conditions were 1.7 to 11 times higher for the Aboriginal and Torres Strait Islander populations studied.[27] However, in other areas, Aboriginal and Torres Strait Islander people have very low utilisation rates for some hospital services, despite higher incidence of relevant conditions.

A priority therefore is reform of health financing to improve Aboriginal and Torres Strait Islander peoples' access to appropriate services and benefits and achieve more rational distribution of funds.

As noted in Section 1, there are significant barriers for Aboriginal and Torres Strait Islander people in accessing quality health care in Australia, particularly in the primary care sector. The major barriers to access are:

- *cultural and social factors* The history of dispossession and its impact on emotional and social well-being profoundly shapes the relationship between mainstream health service providers and Indigenous people. Many people, particularly from older generations, have

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[27] KM Stamp, SJ Duckett and DA Fisher, Hospital use for potentially preventable conditions in Aboriginal and Torres Strait Islander and other Australian populations, *Australian and New Zealand Journal of Public Health*, Vol.22, No.6, 1998, pp.673-78.

had poor experiences with the mainstream health system, where they were made to feel unwelcome

- *locational factors* There are obvious access problems in rural and remote communities resulting from physical distance. However, this is also a factor in some urban communities – in particular those on the suburban fringes where there is poor public transport infrastructure;

- *poor linkages between health services* When primary health services do not link well with acute and/or allied health services, for example, service providers take on delivering more specialist components. This increases pressures on limited primary health care resources – these services may also be less skilled in these aspects of health care delivery;

- *the lack of a population focus* Mainstream primary health care services are structured to provide for a patient case-load that is characteristically high volume and low complexity. In contrast there is an increased proportion of Aboriginal and Torres Strait Islander people who have multiple, chronic morbidities and who require more complex management;

- *workforce issues* In general, the mainstream primary health care workforce is neither well equipped to work in a cross-cultural context, nor to deal with the complex multiple morbidities and specific illnesses, now rare in non-Indigenous Australia, that are prevalent in Indigenous communities. There are also significant problems in attracting and retaining appropriately trained and informed practitioners to work in rural and remote areas and/or to work specifically in Aboriginal and Torres Strait Islander health, regardless of location; and

- *financial barriers* Financial barriers are both income-related and structural in nature. Structural barriers encompass problems inherent in health financing systems, such as the provision of health care resources through fee-for-service systems such as the Medical Benefits Scheme.

These are inter-related issues. The role played by different barriers to access varies across Australia. Nevertheless, poor access to health services is a problem for all Aboriginal and Torres Strait Islander communities, whether they are in metropolitan, other urban or rural and remote communities.

Significant improvements to access are being achieved through the Indigenous specific initiatives developed by mainstream programs including:

- *removing impediments to access to Medicare by reviewing and making changes to entitlement criteria or enrolment procedures*: eg, under section 100 of the *National Health Act*, the Minister approved arrangements whereby remote services can order pharmaceutical supplies in bulk through community pharmacies, provided that they comply with relevant state government legislation;

- *testing new ways of funding and delivering services*: eg, the Aboriginal Coordinated Care Trials are testing new ways of funding and delivering primary health care, drawing on funds through both mainstream and Indigenous specific programs. The Portfolio provides a capitation payment in lieu of MBS and PBS payments, in locations where access to these sources of funding have mostly been very poor;

- *developing more appropriate therapeutic models*: eg, the Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan the National Mental Health Strategy, the National Illicit Drug Strategy have encouraged the development of more appropriate interventions including more appropriate therapeutic models and training in emotional and social well being;

- *targeting resources for the provision of specialist outreach services*: eg, improving access to specialist services including for surgeons, ear nose and throat specialists, eye health and renal disease;

- *developing a workforce strategy to ensure that there is a long term approach to producing and maintaining a health workforce that is highly skilled and culturally appropriate*: eg., interventions and activities to improve the availability and capacity of the Indigenous health workforce and facilitate strategies to ensure that the general health workforce is responsive to the needs of Aboriginal and Torres Strait Islander peoples;

- *maintaining community service obligation*: eg, the Australian Hearing Specialist Programs for Indigenous People;

- *improving the integration and community responsiveness of services:* eg, the Regional Health Services Program; and providing a new flexible aged care model through the Aboriginal and Torres Strait Islander Aged Care Strategy. This model provides a constant monthly income for the service to provide a mix of high, low and community services as needed by the community. These services are paid flexible funding, not paid according to the actual level of care provided, rather as a “cashed out” subsidy. The Strategy currently funds 20 operating services, with a further six services approved but not yet operating; and

- *better targeting of population health programs to ensure that the specific needs of Aboriginal and Torres Strait Islander people are taken into account by directly funding Aboriginal and Torres Strait Islander communities:* eg, in the areas of illicit drugs and chronic disease.

There are also Indigenous-specific programs, such as those managed by the Office for Aboriginal and Torres Strait Islander Health, and the Aboriginal and Torres Strait Islander Aged Care Strategy, that work in conjunction with mainstream programs.

3.6 Current distributional mechanisms

The Portfolio is directly responsible for the on-the-ground distribution of funds for only a small proportion of the identified program funds to be distributed in 1999-2000: only $336.2 million (1.5 per cent). These include Aboriginal and Torres Strait Islander Health program grants, funding for illicit drugs, fighting suicide, GP grant programs, and for the Rural Health Support, Education and Training Program. These are grant programs, with funding distribution mechanisms ranging from needs based funding formulas to submission based applications.

Funding distribution for most of the Commonwealth programs within the scope of the Inquiry, $22 billion (98.5 per cent) is not directly determined by the Commonwealth on a payment by payment basis. These programs are largely entitlement programs that rely on access being obtained when there is a need for the particular health or aged care service (See Appendix E).

The rules governing entitlement are often built into legislation:

- MBS and PBS and the Hearing Services Program are restricted by legislation to providing personal benefits, vouchers, or services as community services obligations;

- under the *Health Insurance Act 1973*, Health Program Grants must be directed to approved organisations providing approved health services;

- Regional Health Services that include aged care must be jointly approved by the Commonwealth and the relevant State/Territory as required by the *Aged Care Act 1997*. Even when aged care is not included, planning and decision making is usually undertaken in close consultation with the States and Territories as often the success of the services depends on putting together a flexible mix of Commonwealth and State programs tailored to each site;

- the legislation governing the Aged and Community Care Program has established a planning and allocation system that controls the quantum and distribution of services. The legislation also controls the amount of funding paid to service providers to provide care for individual users of services; and

- the two mainstream incentives programs for doctors are demand driven against eligibility requirements.

Funds under the Australian Health Care Agreements and the Public Health Outcome Funding Agreements are restricted to purposes agreed with the States and Territories. In these cases the Commonwealth uses other policy levers (eg, workforce measures, alternative administrative arrangements) to increase access to appropriate services, which in turn increase funding allocations. In addition, under the National Illicit Drugs Strategy, part of the funds for Non-Government Organisations Treatment Grants is directed to two States under the Public Health Outcome Funding Agreements, further funding for some projects is administered by the NSW Health Department. Only the remaining funding is provided directly to non-government organisations.

3.7 Needs assessment methods

Needs assessment methods vary across Portfolio programs within scope of the Inquiry. They range from the well-established processes for the Australian Health Care Agreements enshrined in bilateral agreements with the States and Territories, to consultations drawing on available data and the experience of expert advisors and local health workers and the perspectives of partnership arrangements.

The differing approaches also illustrate the need for analysis to focus on both need (demand) factors and barriers to appropriate access (supply), as this enables the Portfolio to respond to needs through the most appropriate mix of policy levers and practical solutions (see summary, Table 3).

3.7.1 Population health

Approximately 80 per cent of Commonwealth funding to States and Territories for population health programs is provided through the Public Health Outcome Funding Agreements (PHOFAs). The remaining 20 per cent consists of other monies for illicit drugs programs and programs for blood borne diseases. Aboriginal and Torres Strait Islander Peoples are specific target groups under the PHOFAs.

Most population health strategies also target Indigenous people with some strategies including an Indigenous specific component. There are Indigenous specific components being developed or already existing in the areas of nutrition, family planning, illicit drugs, injury prevention, immunisation and workforce development.

State and Territory Governments have responsibility under the Agreements for determining needs assessment and funding allocations within individual jurisdictions in order to achieve the agreed outcomes. The resource allocation model used to inform bilateral negotiations with the States and Territories in the current agreement round included relativities that favour Aboriginal Torres Strait Islander communities (eg, Aboriginal and Torres Strait Islander people with low English fluency; dispersion; and isolation). These relativities had a weight of 60 per cent in the funding model. The other three components were standardised mortality ratio, socio-economic index of area, and an index based on the number of Aboriginal and Torres Strait Islander people in the state as a proportion of the total state population.

3.7.2 The public hospital system

Funding to the States and Territories under the Australian Health Care Agreements is adjusted to reflect:

- growth and ageing of the Australian population, estimates of which are regularly updated;
- changes in the private health insurance participation rate;
- underlying demand growth from technological change and increasing consumer expectations by a factor of 2.1 per cent per annum; and
- changes in the costs of hospital outputs.

Allocation arrangements for purchasing of Aboriginal and Torres Strait Islander health services by States and Territory governments include:

- payment of an additional 10 per cent casemix payment for identified Aboriginal and Torres Strait Islander clients (Victoria);
- a specific weighting for Aboriginality in the Resource Distribution Formula used to guide the allocation of global mainstream resources and Aboriginal and Torres Strait Islander program funds to Area Health Services, linked to reporting of strategies adopted (NSW);

- Queensland has included reporting on ten year National Indigenous health targets in its District Health Service Agreements and included the outcomes of joint Regional Planning in its budget submissions and health services procurement processes;
- a requirement for mainstream health services to report annually on a number of specific Aboriginal health attributes in their Funding Agreements, improvements to casemix data and identification of Indigenous clients, institution of an Aboriginal Health Purchasing Taskforce at a senior Cross-Divisional level, and resource allocations based on data regarding need and use for Aboriginal health services (Western Australia); and
- Requiring hospitals and health services to report via their Health Service agreements on their efforts to implement the Aboriginal and Torres Strait Islander Regional Health Plans, and allocation of a 30 per cent loading via hospital casemix funding to improve Aboriginal identification (South Australia).[28]

Bearing in mind the caveats relating to the quality of identification of Aboriginal and Torres Strait Islander people in hospital records, casemix data are beginning to reveal differences in the patterns of public and private hospital use between and within Indigenous and non-Indigenous populations. In 1997-98 the separation rate for Indigenous Australians was 54 per cent higher than for other Australians.[29] However, there was significant variation in relative rates of separation between regions, with rates being approximately the same in highly accessible regions, and around 2.3 times highest for Indigenous Australians in remote regions, although there was not a consistent pattern of increasing relative rates of separation with increasing remoteness (p.16). There were differences between the Indigenous and non-Indigenous populations too in the mix, complexity and severity of conditions for which people were hospitalised. For example:

- 42.8 per cent of Indigenous separations from public and private hospitals combined were accounted for by just three Major Diagnostic Categories (MDCs): Kidney and Urinary Tract (22.4 per cent), Pregnancy, Childbirth & Puerperium (10.7 per cent) and Respiratory System (9.7 per cent). The same three MDCs accounted for only 23.8 per cent of non-Indigenous separations;
- medical (as opposed to surgical and other) Diagnostic Related Groups accounted for 84.4 per cent of Indigenous separations, but only 57.2 per cent of non-Indigenous separations;
- AN-DRG 572 *Admit for Renal Dialysis* accounted for the most Indigenous separations from public and private hospitals at 19.6 per cent of the total, and compared with 6.4 per cent of non-Indigenous separations.[30]

3.7.3 Pharmaceutical Benefits

Barriers to Aboriginal and Torres Strait Islander people's use of PBS-subsidised pharmaceuticals - such as delays in obtaining medicines through standard prescription procedures, distances to community pharmacies from isolated Aboriginal communities, and

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[28] Commonwealth Department of Health and Aged Care for the Advisory Council, ***Jurisdictional Reports to the Australia Health Minister Conference on Progress made Under the Aboriginal and Torres Strait Islander Framework Agreements.***

[29] Nichol, Bill and Lonegan, Joan (1999), 'Hospital Casemix: A Geographic Analysis', paper presented at the Eleventh Casemix Conference in Australia, p.8.

[30] Commonwealth Department of Health and Aged Care 1999, *Hospital Casemix Data and the Health of Aboriginal and Torres Strait Islander Peoples*, Occasional Papers: New Series No.3, July, p.7.

difficulties in demonstrating concessional eligibility - have been well documented through research by Keys Young for the HIC[31] . Deeble *et al* have estimated the ratio of net public expenditure in 1995-96 on PBS medicines and appliances between Indigenous and non-Indigenous people as 0.2:1.[32]

While there is currently no benchmark indicating what the level of expenditure on pharmaceuticals ought to be for this population group, the relative rates of morbidity and mortality would suggest that access is currently very inequitably low. In response to this, the Commonwealth has made PBS pharmaceuticals available to Aboriginal and Torres Strait Islander people in remote areas at no cost to the consumer through Aboriginal health services, and is exploring options to improve access in rural and urban areas.

3.7.4 General Practice

A funding formula is used to calculate the allocation of total funding from the Divisions of General Practice Program to individual Divisions. The formula is primarily based on populations in the postcode areas encompassed by each Division and takes into account components for infrastructure, rural and remote area classifications, a socio-economic index, and Aboriginal and Torres Strait Islander populations. The socio-economic index used in the funding formula is derived from attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. The socio-economic index does not specifically identify Aboriginality, however it does capture those indigenous Australians who fall into lower socio-economic categories. In other program areas for example, the Education and Training of General Practitioners, special arrangements are in place to enable GP registrars to work in Aboriginal Medical Services. Such special arrangements are reflected across the program.

3.7.5 Rural Health

The Commonwealth's Regional Health Services (RHS) Program, covering Multipurpose Centres, Multipurpose Services, the Rural Multipurpose Health and Family Services Network, and Regional Health Service Centres, aims to work with small rural communities to identify local health priorities and look at options to improve access to services relating to these priorities. The Program supports a planned, coordinated and interactive service approach, linking various aspects of health and community care.

Regional planning for such services may be dovetailed, where relevant and appropriate, with the work that is being undertaken through the Office for Aboriginal and Torres Strait Islander Health. One of the very real challenges is that often communities with the greatest need have limited capacity to undertake a needs assessment and the Program is looking at options to redress this issue through the development of resources for these communities and the provision of funding to assist them to determine local priorities.

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[31] Keys Young, *Market research into Aboriginal and Torres Strait Islander access to Medicare and the Pharmaceutical Benefits Scheme*, Report prepared for Health Insurance Commission, 1997.

[32] Deeble J, Mathers C, Smith L, Goss J, Webb R and Smith V (1998), *Expenditure on Health for Aboriginal and Torres Strait Islander People*, Australian Institute of Health and Welfare and the National Centre for Epidemiology and Population Health, Canberra. AIHW Cat. no. HWE6.

There are two main ways a community can be involved in planning for services provided with RHS funding: through a targeting approach, and through a submission driven process. The Program is a balance of the two. Targeting requires a process of working with State and Territory Health Authorities to identify appropriate data, which assists identify regions of high need. In addition, the Program needs to be responsive to innovative submissions and small communities are encouraged to look at their health priorities and identify innovative means to improve access to important services. However, for non-targeted communities to be successful they must demonstrate a high level of innovation and also a process where the successful aspects of the model have potential to be transferable to other communities.

One recent initiative with the potential to assist needs assessment and resource allocation in the future is the Mapping Project Being Undertaken by the National Key Centre for Social Applications of Geographical Information Systems at the University of Adelaide. The National Key Centre for Social Applications of Geographical Information Systems (GISCA) has provided detailed geo-coded information on both location and accessibility in map form, together with an associated report, for a wide range of health and also other services in rural and remote Australia. Commonwealth funded Aboriginal Medical Services are included in this work. Both the maps and the report are being made available in a user-friendly format on the Department's Intranet and Internet sites.

Further details of Rural Health initiatives, including funding for the Royal Flying Doctor Service, are provided at **Appendix D**.

3.7.6 Hearing Services Program

The current legislative framework for the Hearing Services Program comprises the *Hearing Service Administration Act 1997* and associated subordinate legislation which makes provision for the; and the *Australian Hearing Services Act 1991,* which makes provision for the Australian Hearing Service Authority to provide services as Community Services Obligations.

As it is an entitlement program, no needs analysis is carried out for the Hearing Services Voucher System. Although eligible Aboriginal and Torres Strait Islander clients may be seen through the Voucher system, their needs are mainly considered through Community Service Obligations services. These include provision of hearing services to children and young adults under 21 years of age and to eligible adults in remote areas including Aboriginal and Torres Strait Islander people. Hearing services to eligible Aboriginal and Torres Strait Islander people may be provided through the Australian Hearing Services network of hearing centres or within Aboriginal and Torres Strait Islander communities under the Australian Hearing Special Program for Indigenous Australians (AHSPIA).

AHSPIA programs are put in place where local community organisations, schools and health workers/clinics (both State government and community controlled) requests services. The number and type of programs planned and delivered will depend on factors such as: the availability of appropriate hearing screening results supplied by local health workers, nurses, doctors, etc.; the prevalence of individuals in the community with active ear disease and associated hearing loss; the need for individual and/or school based amplification; and the willingness of community members and local support services to participate in ongoing programs.

In summary, this approach takes into consideration both health status and the readiness of the community both on terms of the availability of local health workers to undertake hearing screening and the willingness of community members and local groups to support ongoing programs as such support increases the likelihood of, for example, school based amplification being accepted and maintained.

3.7.7 Aboriginal and Torres Strait Islander Health program

Since July 1995 when responsibility for Aboriginal and Torres Strait Islander health care funding passed from ATSIC to the Health Portfolio, one of the Portfolio's priorities has been to improve the effectiveness of needs assessment. The Portfolio initiated a review of funding arrangements during 1995-96, but due to the dearth of data, it was not possible to undertake a full needs-based analysis and review. The review, therefore, aimed at removing inequalities in funding allocations between existing service providers. In conjunction with the community sector, State/Territory Governments and ATSIC, work commenced on developing a regional planning framework to identify needs and improve the targeting of resources.

The Framework Agreements specify that regional plans "… identify gaps and opportunities in health service provision, and … identify priorities to improve health services (including mainstream services) and environmental health in the region …" (clause 3.6(b), South Australian Agreement).

Regional planning processes are now in place in every state and territory. Regional Planning Forums include representatives from the Commonwealth, State/ Territory government and the Torres Strait, ATSIC (the Torres Strait Regional Authority in the Torres Strait) and the Aboriginal and Torres Strait Islander community controlled health sector.

Planning is intended to identify regions and communities with the greatest need for additional or improved health care services, but also to identify communities with the greatest capacity to make most effective use of additional resources. This does not mean that communities with high need, but lacking capacity, are by-passed. Rather, it will influence the nature and timing of investment in such communities. A community with limited physical infrastructure or experience in managing or delivering health care might need invest in a different mix of services and assets as compared with a community with an existing and effective health care infrastructure. Indicators of capacity, that could influence how additional resources are applied, might include:

- the availability of data to inform service development and expansion;
- expertise and experience in financial and human resource management; health service delivery; co-ordination or purchasing of services; engaging community involvement and ownership;
- clinics; staff housing; health service and financial management systems.

The factors taken into account in planning include demographics, health infrastructure, and health status. To date, the availability and usefulness of this information has varied between jurisdictions. Planning forums consider those factors for which information is available and appropriate for their local circumstances. Over time, the Portfolio envisages that regional plans will be used by both spheres of government, service providers and local communities to guide service delivery and funding decisions.

Regional plans have been completed in South Australia (November 1997), Queensland (July 1999) and Central Australia (July 1997). Regional plans continue to be developed in Western Australia, New South Wales, the top end of the Northern Territory, Victoria, Tasmania and the Australian Capital Territory, with the expectation that each jurisdiction will complete their plans during 2000. Aboriginal and Torres Strait Islander Framework Agreements will expire on 30 June 2000. Forum partners are presently renegotiating agreements for the period until 2003.

Guidelines produced by the OATSIH in 1996 are at **Appendix F**.

The approach to planning varies between the three completed regional plans. Queensland identified the gaps between health indicators for Aboriginal and Torres Strait Islander people and the services on the ground as their preferred approach to prioritising need. Central Australia applied workforce projections based upon health service staff to population ratios to develop a prioritised list of Aboriginal and Torres Strait Islander communities. South Australia developed a list of health priorities within Aboriginal and Torres Strait Islander communities. These priorities were determined through a combination of demographic, health infrastructure and environmental health data and by consulting with Aboriginal and Torres Strait Islander communities.

The first comprehensive report outlining progress made in implementing the commitments made under the Framework Agreements (including regional planning) was presented to the Australian Health Minister Conference in August 1999.[33]

Pending the development of the regional plans various methods of needs analysis have been used for funds distribution:

- Distribution of additional funding for the development of services in remote communities with little if any access to health care was determined with reference to data collected by ATSIC through the *Community Housing and Infrastructure Needs Survey* (CHINS).[34] Criteria were developed to identify communities with least access to health services. Criteria were also defined so as to include only those that could be accommodated within the funds that were available. Priority went to communities more than 45 minutes from a hospital or other significant health service. Within that group, priority went to communities with least access to visiting health services relative to their total population. The program and funding allocation criteria are described in more detail at **Appendix G**.

- Distribution of funding to combat infectious diseases and invest in health infrastructure in Aboriginal and Torres Strait Islander communities was determined with reference to the distribution of the indigenous population (for immunisation) and a comprehensive survey of all existing health hardware (for infrastructure).

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[33] Commonwealth Department of Health and Aged Care, for AHMC, 1999, ***Jurisdictional Reports to the Australia Health Minister Conference on Progress made Under the Aboriginal and Torres Strait Islander Framework Agreements,*** August, Canberra**.**

[34] ABS Cat. no. 4710.0

- The placement of 59 social and emotional well-being counsellor positions under the *Bringing them Home* response was determined following lengthy consultations with Aboriginal communities and the National Aboriginal Community Controlled Health Organisation and took into account geographical spread, and the capacity of existing providers.

Since 1998-99, regional planning, Service Activity Reporting data (for services funded from this program) and reviews of capital infrastructure needs, have increasingly provided data that has enabled needs-based targeting of funding.

3.7.8 Aged and Community Care

Apart from the Aboriginal and Torres Strait Islander Aged Care Strategy, all aged care funding is provided through mainstream programs. Some mainstream programs include Indigenous specific initiatives aimed at improving Aboriginal and Torres Strait Islander peoples access to mainstream services.

Data on the contribution from Indigenous use of mainstream programs is not readily available and needs to be derived from a mixture of data from administrative data sets and survey work. These estimates should be available at national and broad regional levels for 1998–99 as part of the second report into *Expenditures on Health Services for Aboriginal and Torres Strait Islander Peoples*.

The Department has set itself the target of providing aged care services appropriate to the proportion of the group within the target population. At June 1999, 0.72 per cent of high care services and 0.54 per cent of low care services went to Indigenous Australians. As Indigenous people represent 2.31 per cent of the target group for these services this shows an under representation of Indigenous people. However, 2.99 per cent of people receiving Community Care Packages were Indigenous, showing the strong preference Indigenous Australians have for staying at home and receiving care in their community.[35] Information on individual care recipients is collected in the course of making payments to services.

Aged and community care planning is conducted on a regional planning basis. Residential and community care is planned according to regions determined under the *Aged Care Act 1997*. In general they are aligned to health planning regions used by State Governments. The Home and Community Care (HACC) Program uses HACC regions agreed with State Governments.

Aged Care Planning and Advisory Committees in each State and Territory provide advice on the regional distribution of aged care places (and therefore funding). The *Aged Care Act 1997* designates a number of groups as people with special needs. Aboriginal and Torres Strait Islander peoples are one of these groups and services specifically for this group are created each allocation round.

Individual communities within planning regions are not specifically targeted for aged care places. However, places within regions can be targeted to special needs groups and the ability of proposals put forward in the approvals round to meet the needs of this group is noted as part of the assessment process.

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[35] Commonwealth Department of Health and Aged Care (1999) *Annual Report 1998-99*, Commonwealth Department of Health and Aged Care, Canberra, p.225.

Table 3: Summary of needs assessment approaches

Program	Needs assessment approaches
Public Health Outcome Funding Agreements; other population health programs	The resource allocation model used for current agreements included: • weighted relativities favouring Aboriginal Torres Strait Islander communities (eg, low English fluency; dispersion; and isolation) • standardised mortality ratio • socio-economic index of area; and • index based on the number of Aboriginal and Torres Strait Islander people in the state as a proportion of the total state population.
Australian Health Care Agreements	Funding under the Agreements is adjusted to reflect: • growth and aging of Australian population (estimates regularly updated) • changes in the private health insurance participation rate • underlying demand growth from technological change and increasing consumer expectations by a factor of 2.1 per cent per annum; and • changes in the costs of hospital outputs.
Pharmaceutical Benefits Scheme: Improving access to PBS for clients of remote area Aboriginal Medical Services	Identification of barriers created by both policy and practical causes; eg, • delays in obtaining medicines through standard prescription procedures • distances to community pharmacies from isolated Aboriginal communities; and • difficulties in demonstrating concessional eligibility. More broadly, the issue of distance to a community pharmacy relates back to problems in the recruitment and retention of pharmacists in rural and remote areas and the viability of pharmacies in these areas.
Divisions of General Practice Program	Funding formula based on: • overall population in postcode areas within Division • Aboriginal and Torres Strait Islander populations • existing infrastructure • rural and remote area classifications; and • a socio-economic index (income, educational attainment, unemployment, jobs in relatively unskilled occupations)
Australian Hearing Special Program for Indigenous Australians	The number and type of programs planned and delivered depends on: eg, • availability of appropriate hearing screening results supplied by local health workers, nurses, doctors, etc.; • prevalence of individuals in the community with active ear disease and associated hearing loss; • need for individual and/or school based amplification; and • willingness of community members and local support services to participate in ongoing programs.
Aged and Community Care: Residential care Aboriginal and Torres Strait Islander Aged Care Strategy	Aged Care Planning Advisory Committees in each State and Territory provide advice on the regional distribution of aged care places. • A comprehensive planning framework aims to provides 100 residential aged care places (covering high and low care places – formerly known as nursing home and hostel places), and community care packages for every 1,000 people aged 70 years and over in each planning region; • The *Aged Care Act 1997* designates particular groups (including Aboriginal and Torres Strait Islander people) as 'people with special needs'. New places are released specifically targeted to 'people with special needs', with new services specifically for Aboriginal and Torres Strait Islander people created in each allocation round. In the most recent round (November 1999) 225 community care packages were allocated to such services. • For Aboriginal and Torres Strait Islander communities, adjusted to the number of people aged 50 years and over to recognise the age structure and health status of communities. ▪ Needs assessment determined through consultation between the Commonwealth, States and Territories, and local Aboriginal communities taking into consideration:; distance from other facilities; health status; community and family wishes, and cultural and linguistic needs.
Aboriginal and Torres Strait Islander Health	Uses a range of needs assessment tools, often developed with the States/Territories, the community sector and ATSIC. Regional plans are the key mechanism for determining needs and priorities - these take account of demographics, health status, existing services and specific health service requirements identified in each area. Funding allocations for various clients of the program take account of factors such as population, health status, service and infrastructure requirements, cost of delivery (particularly in remote areas) and the capacity utilise mainstream funding.

4. DEVELOPMENT AND USE OF INDEXES OF RELATIVE NEED

The Commission is required to 'derive indexes of relative need that could be used to determine distributions of resources … based on its assessments of relative need.'

This Section first considers some principles that could be used to inform this work, principles in part derived from the Commission's acknowledgments of the limitations of 'equalisation in practice' and of their methodology for assessing general revenue grant relativities. The challenges involved in developing useful indexes are discussed, and advice offered on a range of methodological issues raised by the Commission in the discussion paper, *Indigenous Funding Inquiry*, Information Paper No.1. Finally, some ways in which the Portfolio might use indexes of relative need to improve equity are canvassed.

The Portfolio suggests that an index for each of the components of health care (primary care, acute care, aged and community care) would be more useful than a single index.

When the relative health resource needs of the Indigenous population, as compared with the rest of the population, are considered, the Portfolio and other analysts use only those indicators that significantly drive costs of health service and program delivery: population, health status; cost of delivery; and income. The Portfolio suggests that, when considering the relative needs *between* Indigenous communities, the range of useful indicators is even narrower: population; cost of service delivery; and possibly income. The issues associated with using health status is an indicator of relative need, and an alternative but untested method for including a broader range of indicators, are described.

As current levels of expenditure are not considered adequate to meet the greater than average needs of Aboriginal and Torres Strait Islander people across all programs, the Portfolio would not be looking to apply such indexes to the redistribution of already thinly spread existing funding. Rather, the Portfolio would find such indexes useful as benchmarks for policy development, especially in relation to identifying areas in need of increased targeting of funds or in deciding how to distribute funds 'new' funds, and to assist with planning including identifying priority areas for targeting initiatives. The timing and nature of investment in health services will also be influenced by factors other than need, including the capacity to utilise funds effectively to provide the required services or programs.

4.1 Principles for the development of indexes of relative health need

It is suggested that the development of any indexes of relative health need for Aboriginal and Torres Strait Islander peoples should be informed by clearly articulated principles.

The Commission's work on assessing general revenue grant relativities is informed by 'the principle of fiscal equalisation'. Defining the 'need' to be equalised, and the 'purpose' of equalisation are crucial to that work. Just as important are the Commission's acknowledgments of the limitations of 'equalisation in practice' and of their methodology. These limitations point to some of the principles that should underpin the development of any index of relative health need for Aboriginal and Torres Strait Islander peoples.[36]

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[36] Commonwealth Grants Commission, *Report on General Grant Relativities 1999*, vol.1, pp.4-13.

Principles that could be applied are as follows.

Any index of relative health need should:

i) *aim to achieve equal access when there is equal need in the short term and, ultimately, for equality of outcomes*

Equalising funding will not lead to equity of health outcomes unless the funding provides equitable access to services and other forms of support.

ii) *take into account the readiness of communities to benefit, including investing to build capacity where this is needed and providing a means for communities in 'perpetual decline' to catch up*

Achieving equal access where there is equal need will not flow from simply providing grants to communities. The rate of moving towards this is likely to be different in different locations as the readiness of communities varies depending on barriers that may be created by health system, the availability of an appropriately trained workforce, the base of health services available to build on, the availability of information and effectiveness of communication with communities, and the level of community interest and engagement. It is often necessary to invest in building capacity where this is required and to provide a means for communities in perpetual decline to catch up.

iii) *ensure that the capacity of communities beginning to make health gains is not jeopardised by redistribution that would reduce funding*

Few Aboriginal and Torres Strait Islander communities are adequately resourced. Care needs to taken that, as a consequence of the development of potentially useful indexes, resources are not directed away from the few services adequately resourced and achieving positive results. This would only result in even more communities being under-resourced to the overall detriment to the health of Aboriginal and Torres Strait Islander people. In addition, communities more advanced with their planning processes – including the development of good local data – should not be held back by a requirement that increased resources be distributed to those in great need without regard to their ability to make effective use of the funds.

iv) *take account of current legislation, regulations, and account of current partnerships where these are improving health outcomes*

As described in the preceding Sections, much of the Commonwealth's expenditure on Aboriginal and Torres Strait Islander health flows from policy and legislation covering mainstream services. It is neither realistic, nor desirable, to consider undoing such arrangements. Further, partnerships are regarded as the key to achieving improved access and improved health status, and much effort has been put into developing appropriate partnerships which are beginning to demonstrate progress. Any recommendations by the Commission should build on current arrangements where these are contributing positively to improving health status.

v) *fully acknowledge the limitations of poor quality data would have on the feasibility of developing an index, and the usefulness of any indexes developed.*

The Commission acknowledges that, in making its relativities assessments, ‘it will not shrink from assessing a disability if there is not a perfect set of data available to measure it’. Statistics may be combined with ‘less precise information and anecdotal evidence … [with] frequently a big role for judgement’.

A paucity of good data continues to undermine our capacity to clearly articulate and identify health and service needs. For any index of relative need to have integrity and gain acceptance, the process and methodology must be transparent, with data limitations and the exercise of judgement clearly articulated at all stages. Otherwise, there is a danger that the process will aggregate differentiation out of the equation.

4.2 Measuring need

The Commission is required to ‘derive indexes of relative need that could be used to determine distributions of resources … based on its assessments of relative need.’[37] Given that the ‘indexes of relative need’ will be used to measure *relative health funding need*, then we suggest that only those indicators that significantly drive costs of health service and program delivery should be considered.

The Commission has been set a difficult task. As yet it has not been possible to fully assess the level of *overall* resources needed to make significant and sustainable improvements to the health of Aboriginal and Torres Strait Islander peoples, let alone relative resource needs within that population group. Work is continuing in the Portfolio to get a better handle on these costs. Therefore any benchmarks developed by the Commissions at this stage could both assist in improving the targeting of resources and contribute to our work on refining estimates of absolute resource needs.

Approaches to need and the allocation of resources were recently reviewed by Deeble *et al*[38]. They identify four key elements of equity: : the prevalence of disease, the consequences of disease, the efficacy of treatment, and people’s access to treatment. . Though intuitively relative health status would seem to be an indicator of relative need for health services, the researchers were able to demonstrate that relative rates of mortality, for example, tell us little about any of these four elements.

As an alternative, they suggest asking: ‘what expenditure would be needed to ensure that, for any given health problem (illness, injury etc), Indigenous people receive the same average health expenditure per case as the same problem receives in the non-Indigenous population?’ This model would also require that costs to individuals were equal, so it require that people in the same socio-economic position should be treated equally, while more public funding should go to disadvantaged groups than to those with more capacity to pay for services themselves.

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[37] Commonwealth Grants Commission, *Indigenous Funding Inquiry*, Information Paper No. 1, Attachment A.

[38] Deeble *et al* 1998, pp.50-53.

Deeble *et al* suggest that two sets of data are required to operationalise this approach: 'estimates of total health expenditure by disease or health problem and estimates of the incidence and/or prevalence of health problems in the Indigenous and non-Indigenous populations.' For the Commonwealth Grants Commission's purposes, one would need to further distinguish between the incidence and/or prevalence of health problems *within* Indigenous populations.

We would suggest, however that elements of equity identified by Deeble *et al* (the prevalence of disease and its consequences, plus the efficacy of treatment and people's access to it) should be at the heart of the Commission's deliberations.

Within Commonwealth funded health programs there are three broad factors that are generally considered responsible for determining costs for any given population grouping. These factors are:

- *health status* as it relates to the requirement for certain services or levels of service to be provided to meet particular health needs;

- *cost of delivery* in specific locations, which takes into account cost differentials as a result of delivering services in remote areas, delivering services to dispersed populations, or the loss of economies of scale when delivering to small population groups; and

- *income* as it relates to the ability to contribute to some of the costs of health care through private expenditure.

All these factors play a significant role in determining equitable health resource requirements for Aboriginal and Torres Strait Islander peoples when their needs are considered in the context of the needs of the general population. However, in the case of this Inquiry, the requirement is to look at the relative funding needs 'between Indigenous people in different regions'. This is a much harder question.

4.2.1 Estimating resource requirements based on health status

Much of the work that has been done to date on differentiating populations' need for health care has used health status as the main determinant. The logic is that a sicker population will have a greater need for health care. The issue is, how is health status measured, and do measures of relative health status necessarily measure the extent of need for resources at a local level? For example, two local populations might have the same health status at an aggregate level, but the mix of illness in each might mean that more expensive health services are needed in one area as compared with the other.

A number of measures of health status are available: mortality, morbidity, and self-reported health status:

- *Mortality* is usually expressed as the rate of deaths per 100,000 people (the crude mortality rate). Relative mortality is the mortality rate of the population in question divided by the mortality rate of the population to which it is being compared (the rate ratio). Mortality rates and rate ratios are often adjusted to remove variation attributable to the different age structures of the populations being compared (aged-adjusted mortality Apart from issues of data quality, the main problem with this measure is that, while a higher death rate might reasonably be argued to indicate a higher need for health care, it does not necessarily show *how much* additional health care is needed.

- The main source of *morbidity* data, at least for the Aboriginal and Torres Strait Islander populations, is the rate of hospital separations. There are three main problems here: firstly, use of hospitals (acute care) does not necessarily say anything about the quantity of resources needed in other parts of the health system (for example in primary health care). Secondly, utilisation will be determined by degrees of access as much as by relative need for hospital based care. Thirdly, the completeness of identification of Aboriginal and Torres Strait Islander people in hospital separation data is variable, and often poor (See further Section 6).

- *Self-reported health status* is compromised for at least two reasons: firstly, people assess their own health according to their expectations, rather than some objective measure of what it is to be healthy. Secondly, instruments used to gather self-reported data are often not suited to gathering and comparing information from heterogeneous populations: questions are, of necessity, framed in a particular cultural context, and their interpretation might vary from one population to the next. The *National Aboriginal and Torres Strait Islander Survey* and the *National Health Survey* have been used to measure Indigenous people's relative health status, but the results have been very much open to question.[39]

Despite its shortcomings, relative health status has been used to construct several models for measuring relative need, for populations as a whole, and for Indigenous as compared with non-Indigenous populations, but not to our knowledge to compare needs within an Indigenous population. These models provide very crude indicators of resources requirements.[40]

Most authors also acknowledge the shortcomings of Standardised Mortality Ratios (SMRs) as measures of relative need, but ultimately revert to using them because they are simple, available, and for want of a better alternative. SMRs were used in Britain to distribute health care funding from the nineteen-seventies; they have been used to inform regional distribution of health care funding in New South Wales and Queensland to give additional weight to Aboriginal and Torres Strait Islander populations. Recently SMRs were used to construct a model for estimating an equitable distribution of general practitioners in Australia (Wilkinson & Symon 2000). [41]

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[39] Australian Bureau of Statistics and National Centre for Epidemiology and Population Health, *Self-assessed Health Status, Indigenous Australians*, Occasional Paper, Canberra, 1994.

[40] Commonwealth Department of Health and Aged Care, *Aboriginal and Torres Strait Islander Health Care: How Much Should Australia Spend?*, unpublished work-in-progress.

[41] Beaver, Carol, Mayston, David, McDermott, Robyn, Warchivker, Ilan, Mooney, Gavin & Wiseman, Virginia 1996, Needs-based Allocation of Health Care Resources to Remote Australia, The report of a research project funded by the Commonwealth Department of Human Services and Health, Territory Health Services; Deeble, J. 2000, 'Expenditures on Aboriginal and Torres Strait Islander health', (unpublished paper); McDermott, R. 1995, 'Improving Equity and Efficiency in the Bush: A Needs-based Method for Healthcare Resource Allocation in Remote Communities', Australian Journal of Rural Health, Vol.3, pp.72-79; McDermott, R. & Beaver, C. 1996, 'Equitable Provision of Health Services to Aboriginal and Torres Strait Islander People of Queensland', Australian and New Zealand Journal of Public Health, Vol20, No.20, pp.13-15; McDermott, R., Plant, A. & Mooney G. 1996, 'Has access to hospital improved for Aborigines in the Northern Territory?', Australian and New Zealand Journal of Public Health, 20, 6, pp.589-593.

Recently, Professor John Deeble has argued that, if relative rates of mortality are to be used as a *proxy* measure of relative health care need, then at least they should be used in their 'crude' form, rather than adjusted for differences in the structures (in terms of age and sex) of the populations being compared. Professor Deeble reasons that the health system has to respond to the needs of actual populations – not populations constructed for ease of comparison on a theoretical level with another.[42]

Use of crude relative morbidity (hospital separation rates) also has merits. This approach adopts relative crude rates of hospital separations as a proxy of morbidity, and of relative need. There are sufficient data to allow comparison of rates of hospital separations, for the Aboriginal and Torres Strait Islander population as compared with the remainder of the Australian population, for individual Diagnostic Related Groups (DRGs).[43]

It might be argued that some DRGs are better indicators of need for primary health care services than others, for example DRGs that represent conditions that are potentially avoidable through better primary health care interventions. Stamp, Duckett & Fisher examine rate ratios for 'ambulatory sensitive conditions' amongst acute hospital separation data, and conclude that the results have something to say about 'possible deficits in primary health care delivery.'[44]

It has to be acknowledged too, that this measure – like all those described above – rests on a number of assumptions that are open to challenge. The main difficulty is that rates of hospital separation relate not only to rates of illness, but also to degrees of access. The model does not adjust for different degrees of access to hospital care for Aboriginal and Torres Strait Islander people as compared with the rest of the population.

Each of these approaches has been used at one time or another, but only as a means of arriving at crude measures of relative need at broad, aggregate levels, where the differences in health status between the respective populations is very large. Thus, for example, they have been used to determine measures of relative need for the Aboriginal and Torres Strait Islander populations as a whole, as compared with the rest of the Australian population. The relationship between health status and cost is not well enough understood at this stage to utilise these measures at any finer level.

4.2.2 Cost of service delivery in different locations

For remote, dispersed and/or particularly small populations, the costs of providing a given level of services might be much higher than for other populations. Costs will be driven by higher prices of goods and services, but also by higher staff to population ratios arising from the diseconomies of scale associated with servicing small, dispersed populations.[45]

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[42] Deeble, J. 2000, 'Expenditures on Aboriginal and Torres Strait Islander health', (unpublished paper).

[43] Australian Bureau of Statistics 1997, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 4704.0, Canberra.

[44] Stamp K.M, Duckett S.J, and Fisher D.A (1998) Hospital use for potentially preventable conditions in Aboriginal and Torres Strait Islander and other Australian populations, *Australian and New Zealand Journal of Public Health*, Vol.22, No.6, pp.673-78.

[45] Beaver C, Mayston D, McDermott R, Warchivker I, Mooney G & Wiseman V (1996), *Needs-based Allocation of Health Care Resources to Remote Australia,* The report of a research project funded by the Commonwealth Department of Human Services and Health, Territory Health Services. McDermott, R. (1995),

4.2.3 Ability to use private expenditure to contribute to the cost of health care

On average, Aboriginal and Torres Strait Islander people are concentrated in the lower deciles of spectrum of income distribution. Therefore, they face higher financial barriers to accessing health care. There might be some variation in income distribution between Indigenous populations that the Commission might wish to investigate. However, variations in income between Indigenous populations are likely to be much smaller than variations between Indigenous populations as a whole and the rest of the Australian population.

4.3 Suggested approaches

Given that both spheres of government aim to cater for the needs of Aboriginal and Torres Strait Islander peoples within the general health system, we suggest that the Commission consider developing its formula in such a way as to take account of their health resource requirements in that context.

As the Commission’s formula will only look at the needs of groups of Indigenous people relative to each other, it is suggested that the Commission consider factors such as population size and cost of service delivery in particular areas in the first instance. These are the factors that will give an indication of the most significant relative resource requirements.

In some locations health status data may be available. However, unless the differences in health status are very large (as is the case Aboriginal and Torres Strait Islander peoples and the rest of the population), then the Commission would need to gather information to enable more precise modelling of the relationship between these factors and the cost of health service before using such factors to estimate relative resource needs.

The Commission might like to consider estimating relative need between populations or regions by identifying a range of existing services in different settings that are judged to be providing an appropriate level of health care to a defined Aboriginal or Torres Strait Islander population (in non-remote regions this might be a number of separate services). This could be informed by a theoretical model of an appropriate level of service for a given population based on, say, staff to population ratios. This would provide essentially a normative estimate of need. The next step would involve modelling how this service mix and associated costs might change with factors such as health status, the population's degree of remoteness/isolation and income. This work would be an extension of some modelling work the Portfolio has undertaken to estimate overall resource requirements for primary health care services. The Portfolio has not as this stage extended that work to look at variations between regions.

Improving Equity and Efficiency in the Bush: A Needs-based Method for Healthcare Resource Allocation in Remote Communities, *Australian Journal of Rural Health*, Vol.3, pp.72-79. Commonwealth Grants Commission 1999, *Report on General Revenue Grant Relativities, 1999, Volume II, Methods, Assessments and Analysis*, Canberra. McDermott, R. & Beaver, C. (1996), Equitable Provision of Health Services to Aboriginal and Torres Strait Islander People of Queensland, *Australian and New Zealand Journal of Public Health*, Vol.20, No.20, pp.13-15. Wakerman, J. (1999),‘Access to Health-Care Services in Remote Areas’, Unpublished paper. Wakerman, J., Bennett, M., Healy, V. & Warchivker, I. (1997), *Review of Northern Territory Government Remote Health Services in Central Australia*, Menzies School of Health Research, NT.

4.4 Possible Indexes for Measuring Health Needs

The Commission has asked whether needs should be measured on a broad functional level (health needs) or on a narrow activity level (eg, diabetes control).

The Portfolio notes that the health function is a very broad, covering funding for hospitals, MBS, PBS, population health, aged and community care as well as mental health. Factors that might be relevant to assessing needs in one component of the health care sector might not necessarily apply to other components. Also, a relatively high level of expenditure in one component of the health sector might not mean that less is required in the same location for other components. For example expenditure on health care as a whole might be high compared to other locations due to high rates of hospital usage (acute care) and very low usage of primary health care. It is possible that this high hospital utilisation might be attributable to inadequate primary health facilities in the region. So in this case the relatively high rate of expenditure on health care as a whole might in fact disguise a need for even higher expenditure in another part of the health system.

We therefore suggest that a single index for all health care would be less helpful than separate indexes for the main components of health care. Our suggestion would be at a minimum to have three indexes for:

- primary health care;
- acute care; and
- aged and community care.

This would be consistent with the broad split of funding and delivery responsibilities between the Commonwealth and the States and with major statistical analyses, making the indexes more useful for policy and planning purposes.

The Portfolio also contends that indexes for separate components within the primary health care category would not be helpful, for three fundamental reasons:

1. clinical, community based health services, population health programs and mental health services are often delivered by the same agencies, often by the same health professionals. The Portfolio is attempting to encourage a holistic approach to delivering primary health care – separate indicators and resource allocation processes could work against this objective.

2. the ‘drivers’ of need for these categories of care are not likely to be sufficiently different to justify separate indexes of need (eg, is the relative need for primary health care likely to be significantly different than the relative need for public health care?), and

3. the data are not of sufficient quality to distinguish needs for the various categories, even if it were desirable from a policy perspective to do so.

4.5 Links between needs

The Commission has asked whether links should be made between health needs and the impacts of housing and education in measuring needs.

There is clearly a relationship between housing and education on the one hand, and health status on the other. Evidence shows that action is required across a whole range of areas (health care services, environmental health, housing, education, employment) in order for the health status of Aboriginal and Torres Strait Islander people to move closer to that of the general population.

However, we have concerns that an all-of-Government composite index (if this is what is intended) may mask inequities in some areas and would prefer separate indexes for separate functional areas.

We are also concerned that a single index may imply that an area receiving high levels of resources for education and housing would be seen to be less deserving of resources for health. On the grounds of equity, we believe that if people are sick, or require health interventions that will prevent them from becoming sick, they should be entitled to receive it, whether their education or housing is deficient or not. In the same way we would also see it as clearly inequitable to deny a group of people housing and education services because they were receiving a high level of health services.

Health status could be used to identify areas in need of services outside health, for example rates in certain diseases might indicate a need for environmental health measures. Generally, though, health status would not be a good measure of the need for services other than health, because the exact relationships between health status and particular services are not well understood and the time between provision of a service and changes in health status are generally long. There are also a number of more direct indicators that can be used to measure ‘need’ in each of these areas (for example outcomes such as literacy levels, levels of housing availability and quality etc).

4.6 Mix of Commonwealth, State, local Government and Community involvement in meeting needs

The Commission has asked for advice on how the mix of Commonwealth, State, local government and community involvement in meeting need should be dealt.

Responsibilities for funding the various parts of the health system are more often shared than clearly separated. For example, responsibility for funding primary health care for Aboriginal and Torres Strait Islander people is shared by the Commonwealth (mainly through Medicare, the PBS and the Aboriginal and Torres Strait Islander Health program) and the States/Territories (mainly through community health, public health, patient transport, dental services and outpatients’ services in public hospitals). Responsibility for service provision is shared by State/Territory governments, the community sector and private practitioners.

Where there is clearly a shared responsibility for funding, then it is appropriate to include all the various sources in calculations of relative spending and the gap between spending and need. This applies as much to the various sources of Commonwealth funding as it does to State government funding.

4.7 Structuring needs-based distribution

The Commission has asked how a needs-based distribution of funds might be structured, and whether such a formula should start with the area of greatest need and work backwards until available funds are exhausted.

The Portfolio sees the development ‘indexes of relative need’ as separate from policy and program decisions around what level of total funds might be available in any area and the strategies for utilising funds to meet need.

The Portfolio holds the view that relative need should inform the distribution of resources and that ‘indexes of relative need’ would be useful to identify resource gaps and areas in greatest need. However the strategies to fill those gaps will depend on the total quantum of resources available and the particular program strategies that are put in place to meet need.

In health it is recognised that some areas have greater resources than other, but that does not mean that some areas are ‘over resourced’ and can afford to have the resources ‘redistributed’. It also needs to be recognised that in many cases a particular quantum of funds are required to provide a basic set of services to any area and we would have serious concerns about a redistribution of resources that meant that any areas dropped below a reasonable benchmark.

4.8 How the Portfolio might use indexes of relative need to improve equity

The work of the Commission on developing indexes of need provides an opportunity to make a valuable contribution to improving the equitable distribution of funds.

The Portfolio would find such indexes useful as benchmarks for policy development, as a source of information in deciding the distributing funds of ‘new’ funds, and to assist with planning including identifying priority areas for targeting initiatives. As benchmarks, the indexes would provide a useful tool in the evaluation of the Portfolio’s programs and their guiding policies.

As current levels of funding are not considered adequate across all programs to meet the greater than average needs of Aboriginal and Torres Strait Islander people, the Portfolio would not be applying such indexes to the redistribution of existing funding. While a few services are considered to be adequately resourced, care needs to be taken that resources are not directed away from those services achieving positive results. This would only result in even communities being under-resourced to the overall detriment to the health of Aboriginal and Torres Strait Islander health people.

When targeting new funding, the Portfolio considers both the health needs and the readiness of service providers and the community to utilise funds effectively to improve health outcomes. Funding would not necessarily be directed away from a community with high relative needs and low capacity, but a low state of readiness might influence the nature of investment in that community. Initially, it might be appropriate to invest in building capacity, through establishing and training community governance structures, health planning, providing essential infrastructure, services, and so on. In time, once this base is established, the emphasis might shift more towards additional service delivery.

5. REGIONS AS THE BASIS FOR NEEDS ANALYSIS AND FUNDS DISTRIBUTION

The Commission notes that ‘The terms of reference ask for needs to be reported for geographic regions (ATSIC regions if possible) …’.

For Aboriginal and Torres Strait Islander health, regional planning processes are in place in every state and territory under the Aboriginal and Torres Strait Islander Framework Agreements.

Regional health plans have been completed in South Australia, Central Australia (Northern Territory) and Queensland and they will be implemented during 2000 and 2001. It is anticipated that regional plans for the other States and the ACT will be completed before the end of 2000.

In keeping with shared responsibilities and the emphasis on working in partnerships, planning regions have been agreed through collaborative negotiations. Regional Planning Forums in each state and territory include representatives from the Commonwealth, State and Territory governments and the Torres Strait, ATSIC (the Torres Strait Regional Authority in the Torres Strait) and the Aboriginal and Torres Strait Islander community controlled health sector. Where regional plans have been completed there has been extensive consultation with Aboriginal and Torres Strait Islander people and communities to canvas their views.

Factors taken into consideration in deciding the regions include Aboriginal language groups in the Northern Territory (as the best means for service delivery for cultural and social issues), communities of interest in Queensland, in Victoria and WA, boundaries were based upon the geographic locations of indigenous communities, and the smallest jurisdictions, ACT and Tasmania, were considered to be regions of themselves. Existing mainstream health regions were also considered to a greater or lesser extent in most states.

Table 4 summarises the Aboriginal and Torres Strait Islander health planning regions.

Table 4: Aboriginal and Torres Strait Islander Health Planning Regions

State/Territory	Regions
South Australia	9 regions coinciding with the South Australia Health Commission’s regional boundaries
Queensland	39 sub-regions identified from the Department of Health and Aged Care’s Community of Interest profiles
Central Australia Region (NT)	12 health zones incorporating three ATSIC regions and two Territory Health Services Districts
Top End (NT)	10 health service zones incorporating four ATSIC regions and four Territory Health Services Districts
Western Australia	5 regions that mostly align with WA Health Department regions
Victoria	4 natural geographic regions
New South Wales	17 regions based upon the NSW Department of Health’s Areas Health Services
Tasmania	1 whole of State region
ACT	1 whole of Territory region

The correspondence between Aboriginal and Torres Strait Islander health planning regions, State Department of Health Planning Regions and the Australian Standard Geographical Classification is summarised in Table 5 below:[46] In short, the regions are those that make most sense to the players involved in or affected by planning, including the Aboriginal and Torres Strait Islander people and communities affected.

Table 5: Regions for Health and Aboriginal and Torres Strait Islander Planning

State	**State Department of Health Planning Regions**	**Aboriginal and Torres Strait Islander Regional Planning**
New South Wales	9 regions, and 9 sub-regions, are based on SLAs but are not consistent with SSDs.	17 sub-regions are based on NSW Dept of Health Area Health Services. ATSIC regional councils (6) do not correlate with these sub-regions.
Victoria	9 regions are based on LGAs	4 regions based on natural geographic areas, appear to align generally with State Health Regions
Queensland	15 regions are based on SLAs, but are not consistent with SSD	Two sets of regional profiles: 8 regions based on ATSIC boundaries for broad level information; 39 sub-regions based on DHAC community of interest profiles for detailed planning and monitoring. Do not correlate with Health Planning Regions. ATSIC regional councils (7) also do not correlate with these sub-regions.
South Australia	8 regions are based on SLAs and are not consistent with SSD	Regions based on SA Health Commission’s regional boundaries. Some of these regions align with ATSIC regional boundaries.
Western Australia	11 regions are based on SLAs and are not consistent with SSD	5 sub regions correlate with Health regional boundaries. 9 ATSIC regional boundaries do not correlate with WA Department of Health regional boundaries
Tasmania	3 regions are based on SSD and are compatible with SLA boundaries, however, health planning is also based on the whole state	The state is expected to encompass one region, and is consistent with the ATSIC and Tasmanian Health Department approach
Northern Territory	6 health regions based on SLAs, mostly correlates with SSDs.	Zones do not correlate with SLAs, 22 zones are based on language groups.
Australian Capital Territory	Two regions are based on SSDs (compatible with SLA boundaries)	The territory is considered a complete region

Few mainstream programs take regions into account in needs analysis or funds distribution. Australian Hearing Services takes State Health areas into consideration as do aged care and the Regional Health Services Program (where there is joint planning with States or Territories) for NSW but not in other State and Territories where SLAs may be considered. Aged and Community Care planning is conducted on a regional basis. Residential and community care is planned according to regions determined under the *Aged Care Act 1997*. In general, they are aligned to health planning regions used by State Governments. Home and Community Care uses HACC regions agreed with State Governments. It should be noted that the term ‘regional’,

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[46] Electronic maps of the three sets of regions – ATSIC, Regional planning, and State/Territory health regions – are being prepared in such a way that they can be overlaid to compare boundaries. These will be made available to the Commission.

in ‘Regional Health Services Program’ refers broadly to regional/rural, not to a focus on specific regions.

In most other programs, ‘regions’ are not used for program management or planning purposes, either because the programs are demand driven (eg, MBS, PBS, and Practice Incentives Program and General Practice Immunisation Incentives), or submission based with ‘communities’ applying on the basis of self-assessed need against program criteria. The latter are likely to have national or state-wide catchments. Divisions of General Practice are regionally based, although their boundaries do not generally coincide with other administrative boundaries.

In keeping with the principles of the COAG reform processes for Commonwealth/State funding arrangements, under the Public Health Outcome Funding Agreements the State and Territory Governments have the responsibility and flexibility to allocate Commonwealth funding assistance according to local needs and priorities.

Overall, ‘communities’ and the concept of ‘remoteness’, as measured by the Rural, Remote and Metropolitan Areas Classification (RRMA)[47] and the Accessibility/Remoteness Index (ARIA), are often seen as more relevant for program development purposes than ‘regions’[48].

As more Aboriginal and Torres Strait Islander Regional Health Plans are completed with data collected and analysed according to these regions, the Portfolio’s programs are expected to move to make more use of these to inform needs analysis and planning.

The Portfolio considers that the Commission should consider carrying out its regional analysis in a way that allows its indexes of relative need to be available for the Aboriginal and Torres Strait Islander health planning regions. Where regional data is available, this would make the Commission’s task easier and it would make the Commission’s analyses of greater use for policy and planning purposes.

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[47] Department of Primary Industries and Energy and Department of Human Services and Health, *Rural, Remote and Metropolitan Areas Classification,* 1991 Census Edition, , AGPS, Canberra 1994.

[48] Commonwealth Department of Health and Aged Care, *Accessibility/Remoteness Index of Australia (ARIA*), Occasional Papers Series No. 6, 1999.

6. DATA

The lack of good quality data on Indigenous health and health care has been an issue for many years, and continues to constrain effective policy development, planning and program evaluation. A number of recent major reports detail the problems at length and describe the efforts to address them.[49]

This Section, therefore, focuses on data sources of possible use to the Commission and briefly outlines some of the major initiatives now in place aimed at improving the quality and use of expenditure and needs assessment data.

6.1 Data constraints

Planning and resource allocation models are only as useful as the data that are available to support them. The lack of good quality data on Indigenous health and health care has been an issue for many years, and continues to constrain effective policy development, planning and program evaluation. Information has been incomplete because of a lack of identification of Aboriginal and Torres Strait Islander people in administrative data systems, and because of ineffective gathering of Aboriginal and Torres Strait Islander people's status even when systems are in place to record it.

Issues in respect of specific collections have included:

- improving but inconsistent recording of the Aboriginal and Torres Strait Islander population in the Census of Population and Housing[50];
- incomplete recording of Aboriginal and/or Torres Strait Islander status on birth, death and hospital separation records;
- no systematic record of Aboriginal and/or Torres Strait Islander people's use of Medicare or the PBS;
- a lack of rigorous self-reported health status information, and
- little consistent data on the use of community-based health services.

Nevertheless, these issues are receiving attention from Commonwealth, State and Territory Governments, particularly through a multi-agency National Health Information Management Group sub-committee. Significant progress has been made in improving and validating births, deaths and morbidity data. The key issue of Aboriginal and Torres Strait Islander identification is being approached on a number of fronts, ranging from the addition of identification fields on records forms and data bases, training and support for data collection staff, through to audits and validation studies on hospital administrative and other data sets. A number of recent major reports detail the problems at length and describe the efforts to address them.

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[49] AIHW, *The Aboriginal and Torres Strait Islander Health Information Plan*, AIHW, 1997; Kate Ross, *Population Issues, Indigenous Australians*, ABS, 1996; ABS/AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 1999; NHIMG/AIHW, *National Summary of the 1998 Jurisdictional Reports against the Aboriginal and Torres Strait Islander health performance indicators*, 2000. Aboriginal and Torres Strait Islander Health and Welfare Information Unit, *Assessing the Quality of Identification of Aboriginal and Torres Strait Islander People in Hospital Data.* AHMAC, AIHW and ABS, Canberra, 1999

[50] ABS, *Census of population and housing: selected family and labour force characteristics for statistical local areas*, Australian Bureau of Statistics, Canberra, 1996.

6.2 Available sources

Following is a summary of the main sources of data that might be used to estimate need for or access to health care services, together with caveats on their current usefulness.

6.2.1 Population

- The national Census of Population and Housing remains the principle source of data on the size and distribution of the Aboriginal and Torres Strait Islander population, as well as information on income distribution.

  - The 1996 Census showed a 33 per cent increase in the Aboriginal and Torres Strait Islander population since the previous Census in 1991. This increase can not be explained through natural growth and points to problems with the identification of Aboriginal and Torres Strait Islander people in previous data collections. About half of this can be attributed to demographic factors and it is likely that changes in identification had occurred by 1996.

6.2.2 Income

- The primary source of statistics on income for Aboriginal and Torres Strait Islander families at the regional level is the 1996 Census. However there are problems with this data as outlined in 6.2.1.

6.2.3 Births and deaths

- Births (including midwives collections) and Deaths Registers (State/Territory)

  - Mortality data is not available nationally due to the incomplete recording of Indigenous status in the death records of some jurisdictions. The rate of identification varies by area: data from Queensland, Western Australia, South Australia and the Northern Territory are deemed to be adequate for reporting.[51] Mortality data are usually presented as a rate (eg deaths per 100,000 people), and given the problems of inconsistent recording of Indigenous status in population statistics outlined above, any rate calculations would also be flawed not only by incomplete recording of the numerator, but also by a shifting denominator.

6.2.4 Health service use

- Hospital separations data (State/Territory)

  - Public hospitals represent over 50 per cent of health services expenditure for Aboriginal and Torres Strait Islander people. The wording of the Indigenous status question used in hospital data collections varies with jurisdiction. The level of identification is variable and varies with region, ranging from 55 per cent to 100 per cent accuracy. Identification

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[51] AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 1999*.

tends to be most accurate in areas with high proportions of Aboriginal and Torres Strait Islander people.[52]

- Commonwealth Hearing Services
  - Australian Hearing Services collects aggregate numbers of Indigenous clients serviced, although it obviously relies on the recording skills of the AHS hearing health practitioners to keep accurate numbers. AHS also keeps data on non-Indigenous clients (viz client records), so it is possible to compare Indigenous and non-Indigenous usage. Data is collected at the community level and can be reported as such by AHS if requested. AHS distinguishes between Indigenous and non-Indigenous clients as part of it's reporting requirements to the Commonwealth for CSOs.

- Cancer registries (State/Territory and collated nationally by the AIHW) Indigenous identification is very poor in most State and Territory Cancer registries. Only Western Australia and the Northern Territory Cancer registries are confident enough to publish tables by Indigenous status, with a caveat stating that the data are not complete. Cancer registries obtain their data from a number of sources, including hospitals, pathology labs and Births, Deaths and Marriages Registries. The situation is not the same across all States and Territories, but the main problems are that few pathology labs record Indigenous status and hospitals do not actively pursue non-responses to Indigenous status question.

- Communicable Diseases Register (State/Territory and collated nationally)
- Australian Child Immunisation Register (National collection– HIC)
- Insulin-dependent Diabetes Register (National collection – which the AIHW is currently establishing).
- The Bettering the Evaluation And Care of Health (BEACH)[53] study provides sample data on private GP services.
  - GPs are selected for inclusion on a random basis, so only relatively small numbers are included from non-metropolitan areas limiting analysis potential for regional areas. About 1.1% of encounters were reported to be with Indigenous persons in the survey's first year. It is not know whether this relatively low proportion reflects non-response to the Indigenous Status question.

- Data are available on Commonwealth funded Aboriginal primary health care services through the annual Service Activity Reporting. Data include episodes of health care provided, to Indigenous and non-Indigenous clients, and some data on staffing (in the first 1997/98 data collection this was limited to OATSIH funded positions and State/Territory Government funded positions). Preliminary analysis of this data does show some a higher level of service activity in remote areas relative to urban areas. See Appendix H.

  Data on Aged Care Assessment Program minimum data set provides record of assessment of the number of assessments undertaken for Indigenous people. Data collected by Aged Care

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[52] AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 1999.*

[53] Britt, Helena, *BEACH: Bettering the evaluation and care of health: a study of general practice activity*, Australian Institute of Health and Welfare and the University of Western Sydney, Canberra, 1999.

Assessment Team regions. Reasonable accuracy in linking primary diagnosis of Indigenous people assessed.

- The Aged and Community Care program collects extensive administrative data on individual care recipients in the course of making payments to services. The program has conducted three surveys of client information on people using Home and Community Care services, the most recent in 1998. Program administrative data forms the basis of the analysis done in the Department's annual report of the proportion of care recipients from ATSI backgrounds. The AIHW and the Productivity Commission also use this administrative data to analyse access of ATSI people to aged and community care.

6.2.5 Health service expenditure

- In 1998, the first nation wide report which identified the level of resources (from all sources) used for Aboriginal and Torres Strait Islander people's health care was published. For the first time there is a benchmark of national expenditure against which future years' expenditure can be monitored.[54]

6.2.6 Health status

- The *National Health Priority Areas Reports* provide biennial reports to Health Ministers on each of the National Health Priority Areas: cancer control, injury prevention and control, cardiovascular health, diabetes mellitus, and mental health. They include sections on Indigenous populations and a survey of relevant indicators and assessment of data issues, availability and coverage in relation to these (see Bibliography). However, much of the data from these reports are also subject to the same caveats that apply to hospital separations data.

- Self assessed health status:

    - the *National for Aboriginal and Torres Strait Islander Survey* was conducted by the ABS in 1994 as part of the Commonwealth Government's response to the recommendations of the Royal Commission into Aboriginal Deaths in Custody;

    - the 1995 *National Health Survey* also provided information on self assessed health status. This sample included an Indigenous sample supplementation of 1100 people which brought the Indigenous sample up to 2200 people. However, in the analysis data from remote Indigenous communities was excluded due to the poor quality of the responses to many of the self assessed health questions.

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[54] Deeble J, Mathers C, Smith L, Goss J *et al*, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, AIHW, NCEPH, 1998.

6.3 Initiatives to improve Aboriginal and Torres Strait Islander health data

As well as the work of the National Health Information Management Group sub-committee referred to above, there are several initiatives to improve the quality or use of data.

6.3.1 National performance indicators and targets

The Portfolio has worked closely with state and territory governments and the community sector in developing the *National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health* that all Ministers agreed to in August 1997 (see Appendix I). Now, for the first time, there is a mechanism to annually measure progress of all governments in improving Aboriginal and Torres Strait Islander health. The 52 performance indicators cover nine areas ranging from health status measures to community involvement and social supports.

All jurisdictions have now provided two reports to Australian Health Ministers' Advisory Council. In light of these, the indicators are being refined to improve their usefulness, reliability, validity and ability to monitor data against emerging needs.

Agreement on the set of national performance indicators has opened the way to including performance measures for Aboriginal and Torres Strait Islander peoples in mainstream health agreements. Indicators of Aboriginal and Torres Strait Islander health are included in the Australian Health Care Agreements, a subset of which is relevant to the acute care sector and will be published in an annual performance report under the Agreements. Another subset has been included in the reporting requirements of the Public Health Outcome Funding Agreements and will be published in an annual performance report.

6.3.2 Estimates of health expenditure

In July 1988 the Australian Health Ministers' Conference agreed that the report *Expenditures on Health Services for Aboriginal and Torres Strait Islander people* should be updated every two years. The AIHW has been contracted by the Department to produce the second report, which will be published in November 2000. The broad aim is to identify expenditure on Aboriginal and Torres Strait Islander health in comparison with the expenditure on the health of the rest of the Australian population for the 1998-99 financial year, and to compare the findings with the first report. The second report will contain more information on Indigenous private sector expenditure and improvements to the primary health care expenditure data. It will also include new sections on a regional breakdown and an expanded comparison with people of like socio-economic status.

The National Public Health Partnership, comprising all State, Territory and Commonwealth chief public health officers, has commissioned a report on expenditure on public health activity. It is intended that such a report be published regularly to assist in monitoring the level of investment in public health activities.

6.3.3 Service Activity Reporting

OATSIH, in partnership with the National Aboriginal Community Controlled Health Organisation, jointly conduct an annual Service Activity Reporting data collection for services funded by the Office. This combines monitoring of activity, resource needs assessment, staffing levels, and information on the Aboriginal and Torres Strait Islander population of the health service area. The National Aboriginal Community Controlled Health Organisation and the OATSIH will have access to particular subsets of data arising from the collection. A specific report will be provided to each service that participated. A summary of the national level data from the first collection is at **Attachment H**. A second collection (1998/99) is currently being returned by services for analysis.

6.3.4 Strategic research framework for Indigenous health

A strategic research framework for Indigenous health issues is being developed by the Research Agenda Working Group under the auspices of the National Health and Medical Research Council. This is in recognition of the historically poor links between Aboriginal and Torres Strait Islander health research funding and known health priorities. The framework is based on the need to ensure the sustainability and transferability of research in the area, and to ensure that there is an appropriate level of community participation.

6.3.5 Portfolio funding to improve capacity and data

The Aboriginal and Torres Strait Islander Health and Welfare Information Unit (funded jointly with AIHW and the ABS), in conjunction with the National Centre for Aboriginal and Torres Strait Islander Statistics, undertakes projects to improve identification in health system administrative data sets, for example: assessing information in hospital separation data; improving identification in vital statistics (births and deaths) collections; and developing a training package for hospital data collection staff on the importance of identification in health records.

To assist in improving the capacity of the community controlled sector to collect data and manage patient care, OATSIH funds the acquisition or upgrade of patient information and health planning computing applications. Less than one third of community-controlled organisations currently operate such computerised systems, and continuing reliance on manual records limits the sector’s ability to provide detailed reporting.

The Department of Health and Aged Care has entered into a funding partnership with the ABS to enhance the quality of the National Health Survey. Both the 2001 and 2004 surveys will be supplemented to enable the production of Aboriginal and Torres Strait Islander estimates.

6.3.6 Classifying remoteness and accessibility

The Department of Health and Aged Care has funded the National Key Centre for Geographical Information Systems (GISCA) to develop a measure of accessibility and remoteness for Australia. This classification, Accessibility/Remoteness Index of Australia (ARIA) has been adopted by the Department as a standard geographic classification. The index is explained in *Department of Health and Aged Care Occasional Papers: New Series No. 6.*

ARIA classifies Australia into 12 levels of remoteness, where 12 is the most remote. The 12 level index is then used to construct a 5 level classification of accessibility ranging from highly accessible (Sydney, Melbourne, etc) through to Extremely Remote (Halls Creek). ARIA will provide another useful tool when assessing relative need for resources, accessibility of services and can be useful when producing factors to allow for the additional cost structures for remote areas.

The ABS have agreed to attempt to produce estimates using the ARIA remoteness index and incorporate this measure into the Australian Standards Geographical Classification (ASGC).

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8. APPENDICES

Appendix A	Aboriginal Coordinated Care Trials
Appendix B	Primary Health Care Access Program
Appendix C	Portfolio programs within the scope of the Inquiry
Appendix D	Recent Initiatives to Improve Access
Appendix E	Funding: Distribution, classification of payments and CGC treatment
Appendix F	Regional Planning
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Appendix I	Interim National Performance Indicators

APPENDIX A: ABORIGINAL COORDINATED CARE TRIALS

Description

Aboriginal Coordinated Care Trials were established as a result of a general call for proposals for coordinated care trials following the 1995 Council of Australian Government's agreement to test reforms to the health and health-related community services system. These reforms were designed to:

- Introduce greater flexibility across programs and jurisdictions;
- Better meet consumer needs while maintaining universality and quality;
- Test new ways of delivering health and community services; and
- Improve care management for people with multiple and/or ongoing needs who are not well served by usual arrangements and have difficulty in accessing the optimal mix of services.

The trials were planned as a way to test the benefits of two interventions applied to people with complex or chronic health care needs:

- Funds pooling - the models varied, but involved **pooling funds**, which would otherwise be used by the trial participants from a range of programs, including Medicare Benefits and Pharmaceutical Benefits, hospitals and Home and Community Care. This cross-program funds pooling involved both Commonwealth and State/Territory contributions, as well as joint management of the operation of the trials

- the pool of funds, no longer constrained by the specific rules of its program of origin, was used for the second intervention - **service substitution**. A care coordinator, usually a GP or someone else (such as an Aboriginal Health Worker for indigenous specific trials), prepared a care plan in consultation with the individual participant and then obtained the agreed services, which would be paid for from the fund pool. Thus a more flexible and appropriate mix of services, in line with an integrated care plan, could be substituted for the original separate program services, where cost incentives may have previously led to less appropriate and more disconnected services choices.

The main purpose of the Aboriginal Coordinated Care Trials was to develop and assess innovative service delivery and funding arrangements based upon community and individual care coordination through pooling of funds from State and Commonwealth agencies. The primary hypothesis tested was:

That the coordination of care for Aboriginal and Torres Strait Islander peoples and communities, where care is accessed through individuals and/or community care plans, and funds pooled from Commonwealth, State and joint programs, will result in improved individual and community health outcomes taking into account the four dimensions of health.

These arrangements were expected to contribute to:

- Improved community and client health;
- Improved access to primary health services;

- Better delivery of services which are individually and collectively more responsive to clients' and community assessed needs, and which take into account the cultural, social and clinical requirements; and
- More efficient ways of funding and delivering services.

While sharing many of the features of the general trials, Aboriginal trials had some important distinct features:

- Most were funded in respect of an entire community rather than chronically ill individuals;
- MBS and PBS equivalent contributions to the funding pool were at national average rates rather than an estimate of what would otherwise have been spent on services for the enrolled population, in recognition of historically very low levels of MBS and PBS usage by Indigenous clients in those sites;
- Greater emphasis was given to empowering communities as well as individuals to take control of their own health needs. All Aboriginal trials were implementing generic and individualised care plans with their client populations, coordinated at the local level. Trials also initiated new population health programs dealing with issues such as antenatal care and childhood immunisation.

Four trials for predominantly Aboriginal populations were:

- Wilcannia (Far West Ward Aboriginal Medical Service) (NSW),
- Tiwi Islands (Tiwi Health Board and Territory Health Services) (NT),
- Katherine West (Katherine Health Board, Territory Health Services) (NT),
- Perth/Bunbury (a two site trial, Derbarl Yerrigan Health Service, South West Aboriginal Medical Service, Health Department of WA) (WA).

These trials finished at the end of December 1999. However, services initiated during the trial period continue to be funded in year 2000, with longer term service arrangements to be agreed and put in place once the national evaluation of Aboriginal trials is completed (due in August 2000).

Target populations:

Tiwi	2,000
Katherine West	3,060
Perth/Bunbury	1,990
Wilcannia	1,000

Dates

	Date agreement signed		
Trial	**Development Phase (followed by Live Phase)**	**Live Phase (to 30 Dec 1999)**	**Duration of Live Phase (months)**
Tiwi Islands, NT	20 February 1997	5 December 1997	25
Katherine West, NT	12 November 1997	1 July 1998	18
Wilcannia, NSW	7 February 1997	5 February 1998	23
Perth/Bunbury, WA	18 March 1997	17 September 1998	15

Total Commonwealth funding

	Development Phase	**Live Phase**	
Trial	**Infrastructure only**	**Infrastructure**	**Funds pool MBS & PBS**
Tiwi Islands, NT	$395,520	$1,385,539	$2,235,208
Katherine West, NT	$617,962	$1,359,171	$2,462,305
Wilcannia, NSW	$456,326	$876,335	$1,028,193
Perth/Bunbury, WA	$2,508,501	$1,182,528	$1,591,207

Note: Infrastructure covered costs such as information technology, evaluation, support to fund holders and other operational costs associated with the Trials. The level of funding for WA is higher than the other trials due to the larger Development Phase and greater number of sites involved in this phase.

MBS and PBS per capita rates (funds pool)

Per Capita Usage	**1996**	**1997/98**	**Increase %**
MBS	$330.05	$338.10	2.4
PBS	$206.40	$261.60	26.7
Total	$536.45	$599.70	11.8

Note: WA and Tiwi Trials have received PBS/MBS capitation at the increased rate (national average based on 1997/98 data) as their enrolled clients represented at least 90 per cent of the target population. Wilcannia and Katherine West Trials have not met the 90 per cent requirement and received the PBS/MBS capitation at the 1996 lower rate for the duration of the trial.

How the distribution of capitation and other sources of funds were derived

The initial Commonwealth contributions to the funds pools were set at a rate equivalent to the national average of MBS and PBS usage ($536.45 per capita per year, being $330.05 for MBS and $206.40 for PBS, based on 1996 data). An increase to reflect changes to the national average rate of usage was approved in early 1999 (to $599.70 per capita per year, based on 1997/98 data), for trials that had enrolled at least 90 per cent of their target populations. This level of Commonwealth contribution was provided in addition to any other Commonwealth health funding provided for the area.

This approach recognised historically low access to MBS and PBS by the target populations. Had the general trials' methodology been adopted for these trials (historical MBS/PBS use of individuals enrolled), the Commonwealth's contributions would have been minimal.

Other contributions to the funds pool – from States and Territories, joint Commonwealth/ State programs (such as HACC) and some Commonwealth grants - were in general determined at the level of resources historically provided for trial sites through the programs included in pooling arrangements. These included primary health services (eg, NT government run clinics, RFDS in Wilcannia), specialists' services (eg, RFDS in Wilcannia) and hospital services.

The approach to pooling of hospital funding varied in each trial. In Wilcannia, the total budget of the small Wilcannia hospital was included. However, the pooling remained notional, meaning that NSW Area Health Service funds that previously had been allocated to the hospital were assigned to the pool, but on condition that they were used for their original purpose. Therefore, there was no real scope for service substitution. In the NT it was agreed that any savings in hospitals' budget linked to a decrease in hospital utilisation by the trial's population would be paid into that trial's funds pool (this occurred for Tiwi trial). In WA, the State provided an up-front contribution calculated on the basis of WA state average hospital cost per capita adjusted with a weighting of 2.8 to reflect the higher average morbidity of Aboriginal populations covered by the trial.

In terms of levels of funding, the amounts provided by State Governments included pooled funding from community health clinics of $4.4m in the case of Tiwi and $3.1m in the case of Katherine West. While most trials provided notional pooling for hospital services (eg $1.4m for Tiwi), in the case of Western Australia hospital funds of $4.0m were provided direct to the funds pool.

The Evaluation Framework

The evaluation of the trials is being undertaken at both national and local level. All trials have appointed local evaluators to evaluate the trial in its local context and feed into the national evaluation. The final national evaluation report is expected in August 2000.

Following consultation with trial sponsors and other stakeholders, the national evaluator (KPMG) produced a national evaluation plan and guidelines in July 1997. The plan states as its primary hypothesis:

> That the coordination of care for Aboriginal and Torres Strait Islander peoples and communities, where care is accessed through individuals and/or community care plans, and funds poled from Commonwealth, State and joint programs, will result in improved individual and community health outcomes taking into account the four dimensions of health.

Related to this is a series of secondary hypotheses that primary hypothesis will be influenced by:

- Reform of the health system
  - Access to services
  - Appropriate services
  - Organisational development-local and system wide
  - Appropriate funding and administration

- Empowerment
  - Individuals' involvement in their care plan
  - Community planning

Lessons learnt from the process to date

While the final national evaluation report will not be available until August 2000, lessons emerging from the experiences so far can be grouped around the following themes:

- The funding mechanism (funds pooling with a community based organisation as a fundsholder) seems to have contributed to:
    - increased local control over health resources and ability to apply them according to identified and emerging needs at the community level;
    - transparency of funding and increased incentives to develop cooperative arrangements between spheres of government, as well as ‘locking in’ funding commitments;
    - greater flexibility and scope for service substitution, to match communities’ health priorities.
- The following issues need to be considered in extending this model:
    - whether pooling funds on a ‘notional’ basis delivers any real benefits;
    - whether the transaction costs of pooling (including the process of ‘billing back’ MBS and PBS usage to the pool) outweigh the benefits;
    - the costs of negotiations between numerous parties, and the need for an agreed mechanism to allow adjustments to funding in the longer term;
    - the appropriateness of the capitation rate adopted for the trials and the relationship with other Commonwealth funding:
        - (for example, the Trials’ capitation rate was equivalent to MBS plus PBS average usage, whereas under the Primary Health Care Access Program, capitation-based grant funding can be at up to twice the rate of use of MBS (and twice as high again in remote areas), but net of funding from other Commonwealth sources, such as other grants, and potential to access MBS through mainstream mechanisms.
- Capacity issues and the need for phased implementation over a period of time:
    - All trials accumulated funds pool surpluses as a result of longer than anticipated development and establishment stages and slower start up of service delivery (although by the end of December 1999 most were operating at levels commensurate with their recurrent levels of funding).
    - This was particularly evident in remote sites where there had been little pre-existing infrastructure. However, a similar pattern also emerged in an urban area where an

established Aboriginal Medical Service was implementing a new method of health service delivery with a substantially expanded budget.

Views on the future of the funding model

The future application of the funding model or its components are being considered in two areas:

- Further coordinated care trials, including some that specifically target Aboriginal populations, are being developed. A very similar approach to funding is envisaged. Therefore, subject to final decisions about the second round trials' proposals, at least some aspects of the model are likely to be tested further in that context.
- The model is being considered in developing the framework for the implementation of the Primary Health Care Access Program, including future arrangements for former trial sites.

APPENDIX B: PRIMARY HEALTH CARE ACCESS PROGRAM

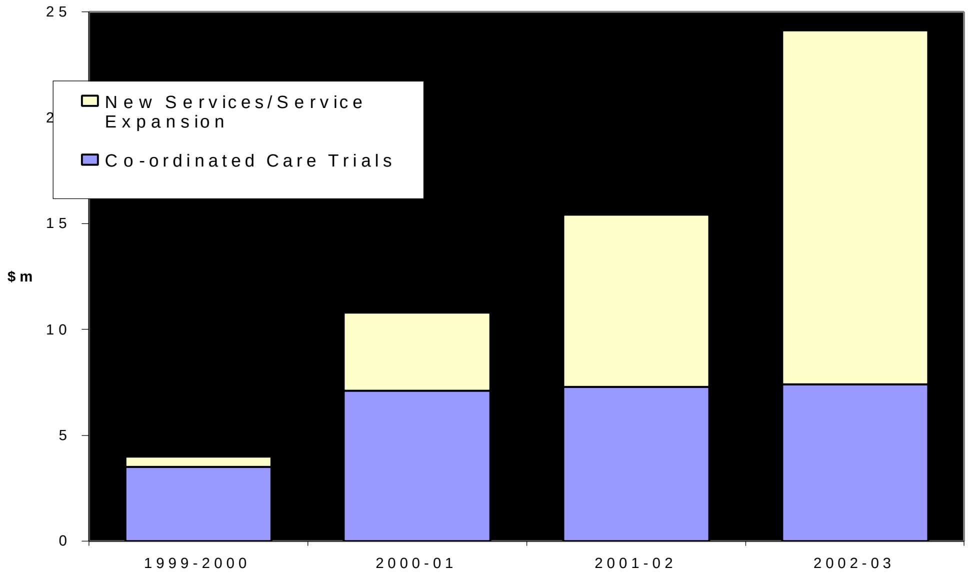
1. Introduction

The 1999-2000 Budget measure “Improving Access to Primary Health Care for Aboriginal and Torres Strait Islander Peoples” (PHCAP) provided funding to enable a planned and coordinated expansion of comprehensive primary health care services. The key features of the measure, as described in documentation surrounding the Budget, are at **Attachment 1**.

The major components of this measure are for expanding services in areas of high need identified through regional planning, and for sustaining services established as a result of the Aboriginal Coordinated Care Trials. Through joint processes established under the Aboriginal and Torres Strait Islander Health Framework Agreements, regional plans have been completed in several jurisdictions. These plans identify relative needs for better access to health care, and therefore priorities and opportunities for further investment by both the Commonwealth and the States/ Territories.

The Budget allocations between these two areas are as follows:

Service expansion and continuation of former Coordinated Care Trials - Primary Health Care Access Program



Note: Coordinated Care Trials only required 6 months additional funding in 1999-00

2. Progress To Date

2.1 Aboriginal Coordinated Care Trials

Though the Coordinated Care Trials have formally concluded, the Minister has approved funding to sustain services established as a result of the Trials through 2000. This will enable the evaluations to be completed and longer term funding arrangements negotiated between the various funders and providers once the evaluation reports have been considered.

2.2 Expansion of primary health care

The planned phases of development are:

- Completion of regional planning;
- Identification of priority regions, or zones within regions;
- Development of implementation plans within priority regions/zones;
- First stage implementation/service delivery phase;
- Review and consideration for further expansion phases.

Regional planning had been completed in South Australia and the Central Australian region of the Northern Territory for a number of years and a plan was completed for Queensland prior to the 1999-00 Budget announcement. These three regions are eligible to receive funding under the measure.

To date, there have been detailed discussions with the Aboriginal and Torres Strait Islander Health Planning Forums in South Australia and the Northern Territory and with individual Forum members about the initiative, particularly about the financial framework and the roles and responsibilities of the various parties. Achieving consensus amongst all members of the partnerships for each step in the implementation process is an essential but slow procedure.

Forums in these jurisdictions have used the completed regional plans to identify regions where implementation should proceed first. A first round of regions/zones have been identified by the planning forums in South Australia and the Northern Territory. These were selected on the basis of need (measured by relative funding shortfall compared with PHCAP benchmarks), and capacity to effectively utilise additional funds (measured by completion of regional plans and readiness to implement expanded services).

The South Australian Partnership prioritised all regions and then identified the first five regions to commence implementation in 2000-01. The Northern Territory forum identified four ‘zones’ within the Central Australian region as priorities for funding under this initiative.

Initial discussions have been held with the Queensland Partnership Forum.

3. The Financial Framework

<u>Overall resource requirements</u>

The broad level of need for funding for comprehensive primary health care has been determined by calculating the cost of providing for ratios of professional health staff to population (and associated on-costs), and factoring in other related costs (eg, non-health care staff costs). Staff:patient ratios were derived from recommendations contained in a range of publications including the Central Australia Planning Study and AIHW’s report on Australian Medical

Workforce Benchmarks. This indicates a resource requirement significantly greater than current combined Commonwealth/State/Territory funding.

The Commonwealth funding provided through this measure contributes to the overall costs of providing comprehensive primary health care. The Commonwealth's benchmark contributions through the program have been determined on a base of the resources provided to the rest of the population through MBS, adjusted to take account of the greater health needs of Aboriginal and Torres Strait Islander people and the higher costs of providing services in remote areas. (About one-third of Aboriginal and Torres Strait Islander people live in remote areas, as compared with about three per cent of other Australians). Need has been assumed to be related to the high rate of illness of the Aboriginal and Torres Strait Islander populations, compared with the general population.

Sources of funding

The measure is based on the understanding that responsibility for providing the funding required to produce this level of access rests with both Commonwealth and State/Territory Governments. States' contributions are mainly provided through community health clinics, outpatients' departments of public hospitals, pubic health measures and patient transport. Commonwealth contributions are provided mostly through the MBS and PBS (though at much lower rates for the Indigenous population than for the rest of the population) and through programs administered by the Office for Aboriginal and Torres Strait Islander Health.

Access to pharmaceuticals is being improved through mainstream mechanisms. For example, the 'section 100' arrangements have opened up access in remote areas. The department is looking at options for improving access in rural and urban areas.

Medicare is being made to be more responsive through streamlined enrolling and claiming processes, and the addition of new items to the MBS such as care planning and case conferencing. However, health care is provided by a range of professionals in most Aboriginal health organisations, and only some of the services can be funded from Medicare. Complementary funding is needed for those services that cannot be subsidised through Medicare, and this, in part, substitutes for what the general population accesses through Medicare.

Benchmarks

The Commonwealth's benchmark contributions were set at a rate based on MBS average rates, the relative levels of illness, and adjusted for a remote areas by a weighting that recognises the extra costs of providing services in such locations.

The Commonwealth's contribution takes account of potential access to Medicare, and existing grant funding provided in lieu of MBS (for example OATSIH Health Program funding and Health Program Grants).

This Commonwealth contribution will approach the target level over time, at a rate that has regard for local capacity to utilise funds effectively.

Models of funding

Communities will be able to access such funding either through:

1. a ‘full capitation’ model (similar to that which has operated through the Aboriginal Coordinated Care Trials – amounts claimed from MBS by the enrolled population are charged back from the service funding pool), or

2. a mix of Medicare and grant funding (with the grant component only covering what Medicare doesn’t cover). Under this model a community would receive a lesser amount of grant-type funding, but retain full capacity to access Medicare through conventional means (the ‘mixed’ model).

What funds are for

Funding will be used to provide comprehensive primary health care services, including clinical care, illness prevention and early intervention activities. In many circumstances it will also be necessary to invest in building communities’ capacity to deliver expanded health care. This might be used to develop expertise in financial and human resource management, health service delivery and coordination, and engaging community involvement, or for acquiring clinics, staff housing, health service or financial management systems. In these circumstances the quantum and proportion of funds going towards service delivery might increase over time.

Estimating the service population

The ‘full capitation’ approach will require an organisation to have an ‘enrolled’ population, as has applied to date with the Coordinated Care Trials. Service population estimates will also be required for organisations accessing funds through the mixed model. These will generally be based on regional planning information or alternative data (where it ids more up-to-date and robust). Verification of service population and services delivered to that population will be required over time.

Whichever funding model applies, enrolment or enumeration of the service population might take some time, depending on the existing capacity of service providers. An organisation’s access to Commonwealth funding is expected to increase with its capacity to substantiate its service population and account for the services delivered.

- For example, funding might commence at, say half the target per capita rate, in respect of a community’s estimated population of 2,000. Access to further Commonwealth funding might increase towards the full target as the fund holder enrols (in the case of the full capitation model) or otherwise records the service population on the basis of its contact with the health service. Information on the services provided with the funding would also be required.

Funded organisations will be required to work with the HIC to ensure that the service population is enrolled in Medicare, and therefore able to receive support through that mechanism, as well as through grant funding.

Who will be involved

This measure will contribute to a more integrated health system, rather than establish a separate stream in parallel with existing services. In any particular zone or region, all potential funders, fund holders and service providers can potentially be involved, as well as Aboriginal and Torres Strait Islander community representatives.

Accountability arrangements

Service accountability will be based both on financial and outputs measures, with data provided as a by-product of an organisation's standard administrative data collection activity, wherever possible. Where services are jointly funded, the department will work with the various parties to develop accountability arrangements that meet both Commonwealth and State/Territory requirements.

As a parallel but longer term step, the department will work with the other parties on a project to define and cost the components of primary health care. This project is expected to provide information on the cost of providing appropriate services as well as providing better information on the costs of providing services in different locations.

3. Next Steps

The next steps will involve developing local implementation plans for the first round of sites. These will guide the development of new or expanded services. The following information will be gathered as part of this process:

- the precise gaps in services, and how they are intended to be filled;
- the contributions of all potential funders, including State/Territory governments;
- the organisation(s) that plan to hold funds;
- the agencies that will provide additional services;
- the model of funding under the PHCAP ('full capitation' or 'mixed' model);
- the timeframe for implementation;
- identification of any additional support needed to build the capacity to manage funds and/or service delivery;
- building or other infrastructure requirements.

Where existing planning is sufficiently detailed, and where all relevant stakeholders are agreed, there might be scope to establish or expand services reasonably quickly. However, it is likely that in most cases further consultation with communities will be needed.

5. Review

The program was established on the understanding that it was only a first step in enhancing access to primary health care services for Aboriginal and Torres Strait Islander people.

At the time Cabinet agreed to the initiative, a review of the implementation of the program and an assessment of the additional information available through regional plans completed after the 1999-2000 Budget was requested.

The review will advise Cabinet on:

- the fully developed financial framework;
- progress with implementation of the new arrangements in targeted regions;
- needs identified through completed regional planning;
- what has been achieved from past investment in primary health care, including co-ordinated care trials; and
- proposals for future action to improve access to primary health care.

The Review will incorporate directions emerging from the revised National Aboriginal and Torres Strait Islander Health Strategy and the Aboriginal Coordinated Care Trials.

HEALTH AND AGED CARE

Aboriginal and Torres Strait Islander Primary Health Care Access Programme Expense ($78.812m)

	1999-00	2000-01	2001-02	2002-03
Health and Aged Care	6.8	16.0	22.5	33.5

Explanation

This measure will take forward the Government's commitment to address the poor health of Aboriginal and Torres Strait Islander people by enabling better access to comprehensive primary health care services. This measure is expected to make a sustainable difference to the health of Aboriginal and Torres Strait Islander people in the longer term.

This measure provides for the establishment of a framework for a planned and coordinated expansion of comprehensive primary health care services, which includes clinical care, population health and education and health promotion activities. Funds will be invested in areas where needs have been identified through completed joint Commonwealth/State/community regional health plans or where existing coordinated care trials have established that there is both a need and capacity to utilise funds effectively to deliver the required mix of services (including clinical care, population health an education and health promotion activities).

The new arrangements will involve continuing collaboration with the Aboriginal community controlled health sector, State and Territory governments, general practice and other health professionals. They will bring about a better integration of general practice and mainstream health providers in delivering services for Indigenous people.

Further Information

This Commonwealth funding will be conditional on States and Territories providing resources to meet their funding obligations in this area, and will be subject to output-based accountability arrangements.

APPENDIX C: PORTFOLIO PROGRAMS WITHIN THE SCOPE OF THE INQUIRY

Outcome	**Program or Element**	**Description (Purpose)**	**Mainstream/ Indigenous Specific**	**Population/ Primary, Acute, Aged/ Community Care**
1	Public Health Education Research Program (PHERP)	Funding mainly contributes to infrastructure development for the delivery of innovative education and research programs in public health. As part of this funding support has been provided for: - innovative specialised Indigenous health education and research programs; - integrating Indigenous health education into mainstream programs; - Indigenous public health research & research training; and - programs which are specifically designed to address Aboriginal and Torres Strait Islander health issues.	Mainstream	Primary
1	National Illicit Drug Strategy – Community Partnerships Initiative	To encourage quality practice in community action to prevent illicit drug use and to build on existing activity occurring across Australia. In particular, projects funded under this Initiative should demonstrate a strong emphasis on national capacity building and support empowerment of local communities.	Mainstream	Primary/ Population

Outcome	Program or Element	Description (Purpose)	Mainstream/ Indigenous Specific	Population/ Primary, Acute, Aged/ Community Care
1	National Illicit Drug Strategy – Non-Government Organisation Treatment Grants Program	This Program provides funding to non-government organisations (NGOs) to establish and operate new treatment services for users of illicit drugs with a particular emphasis on filling geographic and target group gaps in the coverage of existing treatment services. Funding has also been allocated for expanding and upgrading existing non-government treatment services to strengthen the capacity of NGOs to achieve improved service outcomes and to increase the number of treatment places available.	Mainstream	Primary/ Population
1	Family Planning Program	Provision of sexual and reproductive health education, training and services	Mainstream	Population health and primary
1	Public Health Outcome Funding Agreement	Contributes to the national public health effort through the provision of broadbanded Commonwealth assistance to States and Territories for particular population health initiatives and activities.	Mainstream	Population health and primary
2	Australian Health Care Agreements	The Australian Health Care Agreements provide the basis for the Commonwealth Government's financial contribution to public hospitals.	Mainstream	Acute/Primary

Outcome	Program or Element	Description (Purpose)	Mainstream/ Indigenous Specific	Population/ Primary, Acute, Aged/ Community Care
2	Medicare Benefits Scheme	The Medicare Benefits Scheme is designed to provide financial assistance to people who incur medical expenses in respect of professional services rendered by qualified medical practitioners, participating optometrists and eligible dentists. • Directions under Section 19(2) of the Act have been made for AMSs, thereby allowing Medicare benefits to be paid for services provided by medical practitioners working at the AMS. • The 1999 Budget saw the introduction of Enhanced Primary Care items which provide a Medicare benefit for voluntary health assessments for people aged 75 years and over. A health assessment includes assessment of a patient's health as well as their physical, psychological and social function. The item also covers assessment of the need for preventative health care, education and community services. This is the first time that the Medicare Benefits Schedule has specifically recognised the needs of Aboriginal and Torres Strait Islander people.	Mainstream (Indigenous initiative within mainstream) (Indigenous initiative within mainstream)	Primary/Acute
2	Pharmaceutical Benefits Scheme – Improving Access to PBS for clients of remote area Aboriginal Medical Services (AMSs)	The purpose of the Pharmaceutical Benefits Scheme is to provide timely, reliable and affordable access for the Australian community to necessary and cost effective medicines.	Mainstream	Primary/Acute

Outcome	**Program or Element**	**Description (Purpose)**	**Mainstream/ Indigenous Specific**	**Population/ Primary, Acute, Aged/ Community Care**
2	Health Program Grants	Health Program Grants (HPGs) are sanctioned under Part IV of the *Health Insurance Act 1973* and are an alternative to the MBS or PBS. HPGs are provided to a variety of organisations for the provision of approved health services. • The provision of general practitioner services to people in rural and remote areas of the Northern Territory. The payment of the grant allows the services to be provided free-of-charge as there are difficulties in claiming Medicare Benefits. • The provision of pathology services for Australian residents who reside in the Northern Territory, who are unable, or find it difficult for a variety of reasons, to claim Medicare pathology benefits, or allow Medicare benefits to be claimed on their behalf.	Mainstream (Indigenous initiative within mainstream) (Indigenous initiative within mainstream)	Primary
2	Practice Incentive Program (PIP) – Facilitating access by AMSs to Incentives	The Practice Incentive Program provides an additional source of funding to encourage general practices to undertake activities that enhance patient care. • The Department is facilitating appropriate accreditation assessment of Aboriginal Medical Services	Mainstream (Indigenous initiative within mainstream)	Primary

Outcome	Program or Element	Description (Purpose)	Mainstream/ Indigenous Specific	Population/ Primary, Acute, Aged/ Community Care
2	General Practice Immunisation Incentives	The General Practice Immunisation Incentives Scheme provides financial incentives to GPs who monitor, promote and provide age appropriate immunisation services to children under the age of seven years in their practices. The Department and the Health Insurance Commission are working to ensure greater access to the scheme by Aboriginal Community Controlled Medical Services.	Mainstream	Primary
2	Dementia Education and Support Program	To provide education and support services to people with dementia and their carers in each State and Territory under the Dementia Education and Support Program.	Mainstream	Primary/ACC
3	Private Health Industry	A viable private health insurance industry to improve the choice of health services for Australians.	Mainstream	Primary/Acute/ ACC
4	General Practice Innovations Funding Pool	To fund Divisions of General Practice to support innovative proposal, which have the potential for national application and address important areas of national priority. • A component of the Primary Health Care priority area is to improve access to health services for Aboriginal and Torres Strait Islanders.	Mainstream (Indigenous initiative within mainstream)	Primary
4	Fighting Suicide	To prevent premature death from suicide among young people; to reduce rates of injury and self harm; to reduce the incidence and prevalence of suicidal ideation and behaviour; and to enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.	Mainstream	Primary

Outcome	**Program or Element**	**Description (Purpose)**	**Mainstream/ Indigenous Specific**	**Population/ Primary, Acute, Aged/ Community Care**
4	National Diabetes Strategy	To reduce the incidence and prevalence and the impact of complications of diabetes in Australia, and to reduce the social, economic and health costs of this disease on the community	Mainstream	Primary
4	Coordinated Care Trials (mainstream funding source, with some Indigenous-specific trials)	To test whether better health and wellbeing outcomes can be achieved for people or populations with complex or chronic care needs by allowing greater flexibility in the use of funds to support care planning and coordinated provision of services	Mainstream	Primary/Acute
5	Royal Flying Doctor Service	To provide a range of health care and other related services to rural and remote communities	Mainstream	Primary/Acute
5	Rural Health Support Education and Training (RHSET) Program	To improve access by remote and rural communities to appropriate health services through the promotion of support, education and training of rural and remote health workers. Improve the rates of retention and recruitment of rural health workers (including Aboriginal health workers) through increased education, training and support opportunities.	Mainstream (Indigenous initiative within mainstream)	Primary
5 & 8	Regional Health Services	Increase access to health and aged care services for people in rural and remote areas – in particular, increase access to services that can address local priorities.	Mainstream	Primary

Outcome	Program or Element	Description (Purpose)	Mainstream/ Indigenous Specific	Population/ Primary, Acute, Aged/ Community Care
6	Commonwealth Hearing Services Program/Community Services Obligations component	Services to children under 21, eligible adults with complex rehabilitation needs, eligible adults living in remote areas and eligible Aboriginal and Torres Strait Islander people and research and noise related activities are funded as Community Service Obligations (CSOs). A component of the CSOs is the Australian Hearing Specialist Programs for Indigenous people that target, in particular, ear disease and hearing loss prevention in young children, including the detection of early episodes of acute otitis media to prevent the onset of chronic otitis media.	Mainstream (Indigenous initiative within mainstream)	Primary, Aged and Community Care
6	Commonwealth Hearing Services Program/Voucher System component	To reduce the consequences of hearing loss on the community by providing high quality cost effective hearing services to eligible clients. Although eligible Aboriginal and Torres Strait Islander clients may be seen through the Voucher system, their needs are mainly considered under the Community Service Obligations (see above).	Mainstream	Primary, Aged and Community Care
7	Aboriginal and Torres Strait Islander Health	To improve the health status of Aboriginal and Torres Strait Islander people by improving their access to high quality health care services (including clinical care, population health and health promotion programs, residential substance misuse services, and social and emotional wellbeing counselling), developing the skills and capacity of the health workforce, improving the quality and availability of health data for Aboriginal and Torres Strait Islanders, and developing and implementing specific health strategies to address major causes of illness.	Specific	Primary

Outcome	Program or Element	Description (Purpose)	Mainstream/ Indigenous Specific	Population/ Primary, Acute, Aged/ Community Care
8	Aboriginal and Torres Strait Islander Aged Care Strategy	To improve the financial viability of Indigenous care services and the care delivery to older Indigenous people, especially in remote communities.	Specific	Aged and Community Care
8	Community Care Package Program	Provision of individually tailored packages of care services to frail aged people assessed as requiring a range of care services in their own homes. Care packages are targeted to older people who have complex care needs and who require significant management services. Groups of places are targeted to Aboriginal and Torres Strait Islander people.	Mainstream	Aged and Community Care
8	Residential Aged Care Program	The purpose of the Residential Aged Care Program is to promote quality residential care appropriate to the needs of older people. Groups of places are targeted to Aboriginal and Torres Strait Islander people.	Mainstream	Aged and Community Care
8	Aged Care Assessment Program	To ensure that frail older people gain access to key and support services appropriate to their needs, and improve the coordination of age care services with other health and community support services.	Mainstream	Aged and Community Care
8	Assistance with Care and Housing for the Aged	To assist financially and disadvantaged older people who are renting or who are homeless to meet both their accommodation and support needs.	Mainstream	Aged and Community Care
8	Dementia Support for Assessment Program	To assist Aged Care Assessment Teams in rural areas to maintain their capacity to assist people with dementia.	Mainstream	Aged and Community Care
8	Day Centre Therapy Program	Day Therapy Centres provide a wide range of therapy services to frail older people living in the Community and to residents of Commonwealth funded residential aged care facilities.	Mainstream	Aged and Community Care

Outcome	**Program or Element**	**Description (Purpose)**	**Mainstream/ Indigenous Specific**	**Population/ Primary, Acute, Aged/ Community Care**
8	Home and Community Care Program	To provide a comprehensive, co-ordinated and integrated range of basic maintenance and support services for frail aged people, younger people with a disability and their carers. To support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care. To provide flexible, timely services that respond to the needs of consumers.	Mainstream	Aged and Community Care
8	Psychogeriatric Care Units	To raise the quality of care for residents with dementia and challenging behaviours by providing expert assessment, diagnosis, advice and support services to older people and the carers, nursing homes, hostels and Aged Care Assessment Teams.	Mainstream	Aged and Community Care
8	Aged Care National Respite for Carers Program	The National Respite for Carers Program contributes to the support and maintenance of caring relationships between carers and their dependent family members or friends. It facilitates access to information, respite care and other support or assistance appropriate to carers' individual needs and circumstances, and those of the people they care for. Some respite services and some Carer Respite Centres specifically target indigenous carers.	Mainstream	Aged Care Community Care

APPENDIX D: RECENT INITIATIVES TO IMPROVE AND MEASURE ACCESS TO HEALTH CARE

1. Medical And Pharmaceutical Benefits

1.1 Subsection 19(2) of the *Health Insurance Act 1973*

Under subsection 19(2) of the *Health Insurance Act 1973*, clients of some 103 Aboriginal and Torres Strait Islander Health Services can claim Medicare benefits for primary health care services. Based on results of a survey of AMSs presently being undertaken (47 per cent so far surveyed), it is estimated that $6.9 million will be paid in MBS payments.

1.2 Indigenous Access To Enhanced Primary Care

The Enhanced Primary Care (EPC) Package was announced in the 1999/2000 Budget as a way of improving health care to older Australians, including Indigenous Australians, and people with chronic conditions. 21 new Medicare items were introduced as part of the EPC Package, which now provide Medicare rebates for GP involvement in patient care beyond the face-to-face consultation and with other health professionals. These fall into one of the three following categories:

- Annual Health Assessments for older Australians aged 75 years and over***, or Indigenous Australians aged 55 years and over***;
- The development of multi-disciplinary care plans for people with chronic conditions across all age groups; and
- Involvement in multi-disciplinary case conferencing for people with chronic conditions.

The new Health Assessment Items include Nos. 700 to 706, with Items 704 and 706 specifically for Indigenous Australians over the age of 55 years. Health Assessments are designed to assess the person’s physical, psychological and social function and whether preventative health care and education should be offered to improve the person’s well being. Health Assessments can be carried out in either the GP’s surgery or at the person’s home, with part of the assessment being undertaken by a health professional other than the GP, but under the supervision of the GP. Item 704 covers the Health Assessment at the GP surgery and 706 in the Indigenous person’s home.

At the end of May 2000, a total of 46,874 Health Assessments had been completed across Australia. Of these, 405 were claimed under the Indigenous items – 274 for the surgery item 704 and 112 for the home item 706.

The new care planning and case conferencing items are available to people of any age who have chronic conditions requiring multi-disciplinary care. These items are a significant opportunity to target better care towards Aboriginal and Torres Strait Islander peoples. The Department is developing specific strategies to promote uptake of these items by Indigenous peoples, including working with the National Aboriginal Community Controlled Health Organisation and the State Based Organisations of Divisions in the roll-out of education and awareness to support general practitioners in the use of the items.

1.3 Streamlined enrolment and billing procedures

The Health Insurance Commission (HIC) has collaborated with several State and Territory governments, and community organisations, to enable entire communities to be enrolled in Medicare – a vital step in facilitating access to subsidised medical treatment. The Department and the HIC are also investigating ways to streamline Medicare claiming arrangements, particularly in remote areas, where this has been found to hinder access to Medicare.

1.4 Voluntary Identifier

A discussion paper has been developed on the introduction of a voluntary identifier for Aboriginal and Torres Strait Islanders on the Medicare enrolment database. Such an identifier would not improve access in itself, but would provide information that will assist the planning and delivery of health programs to ensure they better meet the health needs of Aboriginal and Torres Strait Islander people.

1.5 Pharmaceutical benefits in remote areas

Under section 100 of the *National Health Act 195*3, the Minister approved the supply of PBS medicines to clients of remote area Aboriginal Medical Services (AMSs). The arrangements were initially made available to Commonwealth funded remote area Aboriginal health services just over a year ago but have since been offered for similar services funded/operated by the States/Territories. Agreement on participation has been reached with the Northern Territory and negotiations are under way with other States.

1.6 Practice Incentive Program

The PIP aims to recognise general practices that provide comprehensive, quality care, and which are working towards meeting the Royal Australian College of General Practitioners (RACGP) *Entry Standards for General Practices*.

There are presently 17 AMSs registered and receiving payments through the PIP scheme. Payments made to AMSs up to the third quarter of 1999/2000 total $134,000.

The Department is facilitating discussions between the recognised accreditors and the Aboriginal community controlled health sector to ensure more culturally appropriate accreditation assessment of AMSs.

1.7 General Practice Immunisation Incentives

The Department and the HIC are working cooperatively to ensure greater access to the scheme by Aboriginal Community Controlled Medical Services, to ensure they receive the maximum amounts for the immunisation activity they are undertaking.

By the end of May 2000, 55 AMSs were registered with the GPII and 39 have received payments totalling $157,101. The HIC is examining ways to extend access to other eligible AMSs through the National Immunisation Committee.

The GPII Scheme is currently being evaluated. As part of the evaluation, the consultants have been asked to look at any problems of access by Aboriginal and Torres Strait Islander groups.

2. General Practice Initiatives

2.1 GP Education, Support and Community Linkages component and the EPC Taskforce

$8.1 million has been allocated over 2 years for the GP Education, Support and Community Linkages component of the EPC Package. The aim of this component is that all GPs across Australia have the opportunity to participate in education and training around the use of the MBS items for EPC by 2002, as well as assistance in developing strategies to effect a multi-disciplinary team approach to the care of older people and those with chronic conditions.

To assist with the development and implementation of this component, Minister Wooldridge asked the General Practice Partnership Advisory Council (GPPAC) to form a sub-Committee with 3 representatives from GPPAC, as well as representatives from an State Based Organisation (SBO), the ADGP, the Australian Health Care Association, the Council on the Ageing, the community sector, NACCHO and a health consumer. The sub-Committee, named the EPC Taskforce, provides advice to the Minister and the Department on a range of issues related to the roll-out of the education and training component.

2.2 Implementation Plans for State Based Organisations

To effect the roll-out of the GP Education, Support and Community Linkages component of the EPC Package, the Commonwealth has contracted the State Based Organisations (SBOs) in each State and Territory to develop and implement education strategies as well as develop the community linkages with key stakeholders and community care providers. In developing their proposals the SBOs had to work closely with their Divisions of General Practice to ensure that implementation plans took into account the different issues facing different regions within each State and Territory. Because of the particular health needs of the Indigenous population and the specific Indigenous items for Health Assessment, the Commonwealth required that the SBOs consult and collaborate with the Aboriginal community controlled health sector through the appropriate state-level peak body in the development of their implementation plans. Divisions of General Practice have also been required to consult with their Aboriginal Medical Services at the local level.

2.3 Clinical Audit Package

A Request for Tender was recently sent to a limited number of organisations seeking their interest in the development and trialing of a Clinical Audit Package for the MBS items for EPC. A specific requirement of this Tender was that attention be given to the issues of cultural sensitivity in relation to indigenous patients and that the successful tenderer would be expected to consult with the Aboriginal community controlled health sector through NACCHO in developing the Clinical Audit package.

2.4 Doctors in regional areas

The 2000-01 Budget provides $562 million over four years for a *Regional Health Strategy: More Doctors, Better Services*. *More Doctors, Better Services* is an extensive and integrated package of measures designed to provide more doctors and better health services in rural areas. The package includes $10.5 million over four years for Workforce Support for Rural GPs and $49.5 million over four years for More Allied Health Services. This funding will be provided via Divisions of General Practice.

While these are mainstream initiatives, which need to be developed further prior to implementation, improvements in access for indigenous people will occur. The focus of the initiatives is on the supports for GPs (whether provided directly by their local Division of General Practice or via extra allied health services in the community which can complement GPs' services) which can in turn help to attract and retain GPs in rural practice.

The initiatives are consistent with a focus on primary health care and recognise that only by harnessing all sections of the primary care workforce and finding new ways of working together can health services in regional Australia be maximised. It is expected that the More Allied Health Services initiative will include a wide definition of allied health services, including those provided by Aboriginal Health Workers.

2.5 Innovations Funding Pool

The General Practice National Innovations Funding Pool is a mainstream grants program for Divisions of General Practice. The program supports innovative projects which aim to improve general practice and/or aspects of primary care. There have been two submission-based funding rounds to date.

In the First Round (1998-99), five out of 48 projects (8.2per cent of the funds) were specifically directed towards the needs of indigenous people. In the Second Round, three out of 34 projects (3.4 of the funds) were directed specifically towards the needs of indigenous people.

In addition, rural health was a priority area in the Second Round so indigenous health issues are likely to feature in a number of the other approved projects for the Second Round.

2.6 Rural And Remote General Practice Program

The Department funds the Rural Workforce Agencies in each state and the Northern Territory to administer the Rural and Remote General Practice Program (RRGPP). The broad aim of the RRGPP is to increase access to general practice services to rural and remote areas (including Indigenous populations in those areas) by improving the recruitment and retention of GPs.

The RRGPP combines a range of strategies including financial assistance for GPs to relocate to rural and remote areas, skills training, locum services and a variety of support mechanisms for doctors and their families. The extent to which the RRGPP is increasing Indigenous access to general practice services varies between the states, but each Rural Workforce Agency has identified improving access to primary health care services for Indigenous communities as a priority. An evaluation of the program will begin shortly.

2.7 Rural Retention Payments Program

The Rural Retention Payments Program provides a cash incentive for doctors to remain in rural and remote areas with the aim of increasing rates of retention. There are two components to this Program: a central payment system administered by the Health Insurance Commission where payments are based on Medicare activity and longevity, and a flexible payments pool (currently being developed) that will take into account non-Medicare activity, such as work in a rural or remote Aboriginal Medical Service. An evaluation framework is currently being developed.

2.8 Rural Women's General Practice Service

The Rural Women's General Practice Service (previously known as the Fly-In Fly-Out Female GP Service) aims to improve access to primary and secondary health services for women in rural Australia who currently have little or no access to a female general practitioner. It will give women in rural and large remote communities the opportunity to seek health care of their choice.

A model has been developed to target eligible communities. The model identifies localities more than 50km by road from where female general practitioners perform 10 per cent or more of all Medicare billed consultations. As the Service aims to improve the choice of doctor for women in rural Australia, the parameters focus on eligible communities with access to a male doctor. Remote localities with a population over 1,000 are also included.

The Service focuses on larger communities, to ensure the funding provides choice of doctor to the greatest number of women possible, rather than providing increased access to communities in need of general practice services. A range of other Government funded programs, with significantly higher appropriations than the Rural Women's GP Service, tackle the difficult task of putting into place sustainable general practice services in remote communities (such as the Rural and Remote General Practice Program and the Rural Retention Payments Program mentioned above).

As part of the Service, data will be collected and collated to report against a number of program outcomes and indicators, including data relating to patient Aboriginal and Torres Strait Islander background.

3. Aboriginal and Torres Strait Islander Health (OATSIH programs)

Within the context of the overall strategy being pursued by the Portfolio, as outlined in the submission at Part 3.1, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) has put in place the following initiatives since 1996:

3.1 Extra funding

Since 1995-96 funding through the OATSIH has increased to $189.7 million per year, an increase of 51 per cent in real terms. By 2002-03 spending will exceed $211 million per year.

3.2 Extra services

Since 1996, 38 new sites have been approved for additional primary health care services under the ***Remote Communities Initiative***. These sites are in areas that previously had little or no access to services. This measure is described in more detail at Appendix G.

The ***Primary Health Care Access Program*** will inject a further $33.5 million per year into Aboriginal and Torres Strait Islander health by 2002-03. This measure is described in more detail at Appendix B.

3.3 Workforce initiatives

The National Health Workforce Modelling Project will establish measures, benchmarks, or needs—based workforce models to better quantify the appropriate number and mix of skill levels in a range of Indigenous primary care settings.

A National review of Aboriginal Health Worker Training has commenced. The Review will culminate in the development of State and Territory Action Plans together with a National Action Plan aimed at achieving agreement on national training outcomes and priorities for Aboriginal and Torres Strait Islander health. This Review is due to be completed in the second half of 2000.

3.4 Strategies to address specific health issues

An ***immunisation program*** to reduce rates of preventable illness and death associated with pneumococcal and influenza disease provides vaccines free of charge to all Indigenous people fifty years and over and to Indigenous people aged 15 to 50 in high risk groups.

The prevalence of ***Sexually Transmitted Diseases and HIV*** transmission are being addressed by increasing the availability of Polymerase Chain Reaction testing for STDs. Interim funding arrangements for PCR testing are now in place in Queensland, Western Australia, the Northern territory and New South Wales. These will continue until the program is fully implemented nationally. In addition, Aboriginal Medical Services and other private practitioners are able to claim for gonorrhoea and chlamydia PCR testing via the pathology Services Table of the Medicare Benefits Schedule.

A holistic approach to ***mental health*** is being developed by establishing eleven social and emotional wellbeing regional centres and 59 new mental health counselling positions.

New services have been funded in the cross border area of Central Australia to prevent ***petrol sniffing***. This includes funding for new or expanded outstation services and two brokerage services to assist communities to respond to petrol sniffing outbreaks quickly.

A number of resource materials for communities addressing ***alcohol misuse*** have been funded and widely distributed to communities to assist them to put in place appropriate prevention and early intervention strategies. Draft clinical care guidelines for the treatment and management of alcohol related problems are due to be distributed nationally this year. The Office will also implement the findings of the ***Review of the Commonwealth Aboriginal and Torres Strait Islander Substance Misuse Program***, which focuses of early intervention, quality assurance, a coordinated approach to training of substance misuse workers and improved intersectoral collaboration.

Regional service models for ***hearing and eye health*** have been implemented to improve access to specialist services and equipment.

4. Public Hospital Services

4.1 Australian Health Care Agreements

More than half of the Commonwealth's contribution to Aboriginal and Torres Strait Islander health care is in the form of Specific Purpose Payments to the States and Territories, and the two main vehicles for these payments are the AHCAs and the PHOFAs. In terms of Aboriginal and Torres Strait Islander health, there have been two main innovations in recent years. Firstly, Indigenous populations have been explicitly recognised as target groups under the respective agreements. Secondly, the agreements have incorporated a small number of performance measures designed to demonstrate the extent of Indigenous people's access to services provided as a result of the agreements.

The Northern Territory AHCA, for example, includes the following clauses:

- The Commonwealth and the Northern Territory will implement this Agreement consistent with the principles outlined in the Aboriginal and Torres Strait Islander Health Framework Agreement (Clause 18).

- The Commonwealth and the Northern Territory agree to work together to develop and refine appropriate high level performance indicators where these do not presently exist. These indicators could include … indicators of Aboriginal and Torres Strait Islander health (Schedule C, para 3).

- The Commonwealth and the Northern Territory note that in August 1997 all Health Ministers agreed to report against a set of Aboriginal and Torres Strait Islander health performance indicators, noting that further refinement was required. In March 1998 the Australian Health Ministers' Advisory Council (AHMAC) endorsed a refined set of indicators. All jurisdictions will report annually, but refinement will continue over the next two years (Schedule C, para 7).

5. Population Health

5.1 Public Health Outcome Funding Agreements

The PHOFA performance indicators also contain Indigenous specific indicators which have been drawn from indicators in the National Performance Indicators and Targets agreed to by Australian Health Ministers in August 1997.

The PHOFA Indigenous specific performance indicators were drawn from and are consistent with those set out in the *AHMAC National performance indicators and targets to monitor* *governments' efforts to improve Aboriginal and Torres Strait Islander health* signed by all States and Territories in February 1998. These targets include:

- a 20 per cent reduction in the proportion of the Indigenous population who drink hazardous and harmful levels in ten years;
- a 25 per cent reduction in the prevalence of smoking by 2008;
- 85 per cent of Aboriginal and Torres Strait Islander children aged two years and six years old are fully immunised by 2000-06-01 955 of Aboriginal and Torres Strait Islander children aged two and six years who are fully immunised against Hepatitis B by 2000;
- breast screening rates among Aboriginal and Torres Strait Islander females aged 40 –69 the same as coverage rates in the non-Aboriginal and Torres Strait Islander community;
- Pap smear coverage rates among Aboriginal and Torres Strait Islander females aged 20 – 69 years is the same as coverage rates in the non-Aboriginal and Torres Strait Islander community by 2001.

The Commonwealth will develop an annual performance report against the shared outcomes specified in the PHOFAs twelve weeks after the end of each financial year with the first for the current funding round due in October 2000. This will report progress towards agreed targets, outcomes achieved and initiatives undertaken during that financial year. After consultations and discussions with States and Territories regarding the content of the report, it will be made publicly available via the Internet. Each jurisdiction will also provide an annual performance report against the agreed performance indicators twelve weeks after the end of the financial year.

5.2 Other initiatives

Continuing and increasing efforts are being made to improve the appropriateness of mainstream population health programs for Indigenous people. Some examples of these efforts are provided below:

- The National Public Health Partnership, *Best Practice Guidelines for National Public Health Strategy Development, Audit and Evaluation with Aboriginal and Torres Strait Islander Communities Project* is just about to go out to tender. The project will deal with the issue of improving consultation processes with Indigenous stakeholders for strategy development.
- The National Public Health Partnership, Legislation Reform Working Group is currently working on the *Public Health Law and Indigenous Health Project* (PHILP). The purpose of PHILP is to improve the appropriate use of legislative strategies in response to key public health determinants of Indigenous people's health and improve knowledge about the impact of laws that impact on the public health status of Indigenous peoples nationally.
- The National Public Health Partnership is establishing an Aboriginal Working Group to provide advice on how mainstream programs can better focus and target Indigenous health issues.

6. Rural Health

Since 1996, the Commonwealth Government has introduced a broad range of initiatives to improve access to health services in rural and remote Australia. The programs involved have been targeted at the general rural population. They also benefit the Indigenous population in terms of improved levels of health services and access to those services, including access to emergency rural services provided by the Royal Flying Doctor Service. In particular, the 2000-2001 Regional Health Strategy Budget package provides $562 million over four years to redress the historical imbalance between rural and city health. This package builds on previous major Budget initiatives in this area.

At the same time, four programs funded through the Office of Rural Health have specific elements that focus on Aboriginal and Torres Strait Islander health related issues. The Regional Health Services Program is described at 3.6.6. Other programs are as follows:

6.1 Royal Flying Doctor Service

On 1 July 1998, the Commonwealth and the Royal Flying Doctor Service (RFDS) signed a five-year funding agreement for approximately $83 million to provide a range of health care and other related services to rural and remote communities. The agreement provides approximately $17 million per annum over the five-year period.

The agreement was based on the development of a purchaser/provider model in which the purchasers, the Commonwealth and the States and the Northern Territory, would meet the RFDS's total operating costs while the RFDS would be responsible for its capital requirements.

Among the other RFDS initiatives that the Commonwealth funds, the following is a recent and significant addition that will strengthen the provision of health services to the Indigenous communities in the Derby region.

6.1.1 Kimberley Doctors

On 9 February 2000, the Minister approved funding of $600,000 per annum for 3 years for the RFDS to employ three additional medical officers for the Kimberley region of Western Australia.

The project will also address some of the needs identified in the Kimberley Regional Aboriginal Health Plan, which include strengthening the provision of aerial medical escorts and enhancing the primary health care clinics in the remote Indigenous communities of Gibb River Road. One of the new medical officers will be rostered for primary care duties in the Derby area allowing the other two doctors to visit the Gibb River Road communities or provide medical escorts for aerial evacuations and transfers.

6.2 University Departments of Rural Health

Over the next four years, $16.3 million has been allocated for the expansion of the University Departments of Rural Health (UDRH) Program. Ongoing funding for the seven existing UDRHs is $9.7 million per annum.

Objectives of the Program include:

- to embrace a strong public or population health focus and to address Indigenous health issues; and

- to provide training to ensure that health professionals become culturally aware and sensitive to Aboriginal health issues.

Most UDRHs employ Aboriginal academics, provide cultural awareness training to all staff and students who undertake placements, and provide training for Aboriginal Health Workers.

In 1998-99 in South Australia $500,000 was provided to the UDRH to establish partnerships with the Pika Wiya Aboriginal controlled health organisation in Port Augusta and to assist with capital works for the health centre. Up to 15 medical and allied health students per year can undertake placements at Pika Wiya.

6.3 Central Australian Rural Health Training Unit

Funds were provided in 1999-2000 to the Central Australian Rural Health Training Unit to provide training for Aboriginal Health Workers. Funding for this Program was provided jointly through Rural Health, the Office of Aboriginal and Torres Strait Islander Health, as well as the Northern Territory Health Service.

7. Mental Health

7.1 The National Mental Health Strategy

The NMHS, begun in 1992, has resulted in substantial changes in the delivery arrangements for mental health services across Australia. The Second National Mental Health Plan, endorsed by all Health Ministers in July 1998, provides a five-year framework (1998-2003) for activity at the national, State and Territory levels. The Commonwealth is providing $28 million over three years for national reform initiatives, and a further $250 million through the Australian Health Care Agreements to States/Territories for service reform consistent with the Second Plan. The Plan builds on achievements to date and identifies further priority areas for reform within three key themes: mental health promotion and illness prevention; the development of partnerships in service reform, and the quality and effectiveness of service delivery.

7.2 The National Suicide Prevention Strategy

The new NSPS builds on the achievements of the NYSPS. Living is For Everyone (LIFE) provides a four-year strategic framework (2000-2004) for action by all levels of government and the community. The Commonwealth has provided $39.2 million for this work. LIFE aims to: reduce suicides, suicidal thinking, suicidal behaviour, injury and self-harm; enhance resilience in individuals, families and communities; increase support to those affected; and extend and enhance community and scientific understanding of suicide and its prevention. It is comprised of three elements: areas for action; gathering the evidence; and partnerships in action.

Proportionally, 40 per cent of administered NSPS funds will be retained by the Branch for national level activities and 60 per cent allocated to the Department's State/Territory offices to support community, Indigenous and rural activities, liaison with State/Territory governments and community organisations and for the development of community models of suicide prevention. The funding allocations were derived by applying a 5 per cent base allocation to each category for each State and Territory and then distributing the balance according to the Australian Health Care Agreement funding distribution for community projects and strategic development. The Indigenous Australian project category funding was allocated by State and Territory Indigenous Australian population percentages. The NSPS implementation guidelines propose that a minimum of 10 per cent of the budget (across both national and local programs) be directed towards suicide prevention initiatives for Indigenous Australians.

7.3 Indigenous Australian Mental Health Programs Funded under the NMHS & NYSPS

Indigenous Australians-specific projects funded recently or currently by the Mental Health Branch exceed $2.5 million and include:

- $532,500 for five projects to trial, evaluate and disseminate innovative responses to rural youth suicide (NSW, Vic, SA, NT);
- $1 million for a range of regional and community projects to build young people’s self esteem and participation to prevent suicide (SA);
- $200,000 to develop, implement and evaluate a community based model of youth suicide prevention (Qld);
- $160,000 for an alcohol and drug rehabilitation centre (NSW);
- $158,000 for a demonstration project providing support to families (NT);
- $150,000 a mental health training program for Aboriginal Health Workers (WA);
- $73,000 for an Integrated Aboriginal Mental Health Service model development (NSW); and
- $248,000 for two community-based Aboriginal Community Health Worker services (NT).

In addition, there have been a number of other projects undertaken in both urban and rural and remote areas, not as Indigenous specific initiatives but which, nevertheless, have provided services to Indigenous Australians (eg: pilot projects to make more effective use of the psychiatric workforce, Kids Help Line, ConneXions).

8. Aged and Community Care

The Aboriginal and Torres Strait Islander Aged Care Strategy (the Strategy) was developed through an interdepartmental committee to address concerns about the delivery of aged care services to Aboriginal and Torres Strait Islander Peoples. The Strategy provided for the review of existing services and those with approvals in principle to assess whether these services could be restructured to better meet community need. It also provided for the establishment of new services in areas of high need where there was no existing service provision.

To ensure an equitable distribution of residential and Community Care Places, the Government has established a comprehensive planning framework which aims to provide 100 residential aged care places and Community Care Packages for every 1,000 people aged 70 years and over in each planning region. Planning statistics at the regional level take account of the age structure and health status of Aboriginal and Torres Strait Islander communities by including figures on Aboriginal and Torres Strait Islander people aged 50 – 69 years.

To assist Aboriginal Torres Strait Islander organisations to develop aged care services to meet their needs the Department is currently developing a strategy to assist such organisations to make competitive applications in the 2000 Aged Care Approvals Round. Existing services are also being assisted through the accreditation process. The Department has transferred $0.5M to Aboriginal Hostels Limited (AHL) for this purpose.

Other initiatives to improve access to aged care services for Aboriginal and Torres Strait Islander peoples have occurred on at a State/Territory level. An example of such an initiative is the employment of a Koori Development Worker in Victoria to assist Aboriginal people to access Community Care Packages. In the first 12 months of this project in metropolitan Melbourne the number of Aboriginal people accessing CCPs increase from nil to forty-three.

Home and Community Care services are particularly appropriate for Aboriginal and Torres Strait Islander people as services are delivered in the community by community members. The National Aboriginal and Torres Strait Islander HACC Reference Group was set up in 1997 to provide advice to the national HACC Program to ensure that Aboriginal and Torres Strait Islander people are catered for appropriately by this mainstream program.

APPENDIX E: FUNDING DISTRIBUTION, CLASSIFICATION OF PAYMENTS AND CGC T

Outcome	Program or Element	Is Funding Distribution Determined in Legislation?	What Funding Distri Methods Are Use
1	Public Health Education Research Program (PHERP)	No	Universities/consortiums been funded on a five yea The criteria for distributi funding has largely been their demonstrated collab effort, geographic dispers degree of diversification, particularly in rural and r areas.
1	National Illicit Drug Strategy – Community Partnerships Initiative	No	Funding is provided throu open application and asse process
1	National Illicit Drug Strategy – Non-Government Organisation Treatment Grants Program	No	Grants are provided follo open tender process
1	Family Planning Program	No	Grants are provided unde submission process
1	Public Health Outcome Funding Agreement	No	Weighted capitation resou allocation formula is basi distribution of Commonw funding between the Stat Territories. Weighting in measures for Aboriginalit rurality in each jurisdicti
2	Australian Health Care Agreements: Component listed as SPPs in Commonwealth Final Budget Outcome 1998-99: - Base Health Care Grants - Other Medicare – Mental Health and Critical and Urgent Treatment Waiting List Initiative	*Health Care (Appropriation) Act 1998*	Health Care Grants under based formula

Outcome	**Program or Element**	**Is Funding Distribution Determined in Legislation?**	**What Funding Distrib Methods Are Use**
	- Other Medicare – other components - Medicare Related Payments		
2	Medicare Benefits Scheme	*Health Insurance Act 1973*	Demand driven program
2	Pharmaceutical Benefits Scheme – Improving Access to PBS for clients of remote area Aboriginal Medical Services (AMSs)	*National Health Act 1953* and the *National Health (Pharmaceutical Benefits) Regulations 1960*	Demand driven program
2	Health Program Grants	*Health Insurance Act 1973*	Some of the grants are de driven (funding based on calculation formula) and c are indexed grants.
2	Practice Incentive Program (PIP) – Facilitating access by AMSs to the PIP	No	Demand driven – paymen on practice size and partic in the incentive tiers.
2	General Practice Immunisation Incentives	No	General practices apply to participate in the program Payments are calculated periodically using Austra Childhood Immunisation (ACIR) and Medicare dat
2	Dementia Education and Support Program	No	Grants are provided under submission process
3	Private Health Industry	*Health Insurance Act 1973* and *National Health Act 1953*	Demand Driven; Grants a provided following open t process
4	General Practice Innovations Funding Pool	No	Grants are provided under submission process
4	Fighting Suicide	No	Grants are provided under submission process
4	National Diabetes Strategy	No	Funding is provided throu open application and asse process
4	Coordinated Care Trials (mainstream funding source, with some Indigenous-	No	Sites were selected on the an assessment of submiss

Outcome	Program or Element	Is Funding Distribution Determined in Legislation?	What Funding Distrib Methods Are Use
	specific trials)		For the Aboriginal trials, Commonwealth contribut funds pools in respect of I and PBS were paid on pe basis, at national average usage.
5	Royal Flying Doctor Service	No	
5	Rural Health Support Education and Training (RHSET) Program	No	Grants are provided unde submission process.
5 & 8	Regional Health Services	Flexible care provision for aged care services is covered by the *Aged Care Act 1997*	Grants provided under su process; some targeting o need ares.
6	Commonwealth Hearing Services Program/Community Services Obligations component	*Australian Hearing Services Act 1991*	Demand driven
6	Commonwealth Hearing Services Program/Voucher System component	*Hearing Service Administration Act 1997*	Demand driven program
7	Aboriginal and Torres Strait Islander Health	No	Approved services receiv ongoing funding at an agr 'Base' level (subject condi grant). New services are approved in accordance w regional plans, with alloca determined with reference resource models; service l are agreed by negotiation. funding provided as grant submission process.
8	Aboriginal and Torres Strait Islander Aged Care Strategy	No	Grants applications by submission. Paid accordin agreed building schedules Funding paid monthly as out subsidy according to t allocated number and typ places

Outcome	Program or Element	Is Funding Distribution Determined in Legislation?	What Funding Distrib Methods Are Use
8	Community Care Package Program	*Aged Care Act 1997*	Distribution of care place packages) is decided with Aged Care Approvals rou process which is essential needs based formula.
8	Residential Aged Care Program	*Aged Care Act 1997*	Distribution of care place decided within the Aged Approvals round process essentially a needs based
8	Aged Care Assessment Program	*Aged Care Act 1997*	Determined by the Commonwealth in conjur with State/Territory Gove
8	Assistance with Care and Housing for the Aged	No	This is a 'no growth' prog limited to a small number providers, decisions on fu distribution are only an is service should close
8	Dementia Support for Assessment Program	No	Grants are provided unde submission process
8	Day Centre Therapy Program	No	**?**
8	Home and Community Care Program	*Home and Community Care Act 1985*	Joint Commonwealth/Stat shared, utilising needs ba funding formula
8	Psychogeriatric Care Units	No	Grants are provided unde submission process
8	Aged Care National Respite for Carers Program	No	Submission based grants assessment based on popu and service data among o things

APPENDIX F: REGIONAL PLANNING

In 1996, the Commonwealth, State and Territory Governments, ATSIC and the Aboriginal community controlled health sector commenced negotiating Aboriginal and Torres Strait Islander Framework Agreements. These organisations constitute State and Territory Forums who are responsible for the implementation of the agreements. Under the agreements, each jurisdiction made the following commitments:

- funding for Aboriginal and Torres Strait Islander community controlled health services (including substance misuse services);
- improved outcomes for mainstream services;
- linkages between community controlled and mainstream services including innovation in coordinated care;
- increased levels of resources allocated to reflect the level of need;
- joint planning;
- access to both mainstream and Aboriginal and Torres Strait Islander specific health and health-related services that reflect their higher level of need; and
- data collection and evaluation.

The regional planning process is the main means by which Forums can make a difference by identifying relative needs and improving access to existing services or the establishment of new ones.

The Department developed regional planning guidelines to assist Forums to:

- identify gaps and opportunities in health services provision; and
- identify priorities to improve health services (including mainstream services) and environmental health in the region.

The guidelines achieve this by helping jurisdictions with a number of activities. It helps to weigh the services in a region and their capacity to deliver health care to Aboriginal and Torres Strait Islander population, against the population's needs. It helps to form the basis for decisions about how many new funds that might become available to a region will be distributed. It does not rely on new funds being available, but also identifies opportunities to improve the way existing services are delivered. It is being as much about mainstream services and environmental health infrastructure as primary health care services specifically for Aboriginal and Torres Strait Islander people.

The guidelines provided a step by step approach to regional planning. This included establishing the process, data collection for regional profiles, data collection during consultation, identification of priorities, implementation of priorities, monitoring and evaluation.

In the guidelines, the Department identified the following six outcomes of the regional planning process that it would report against to the Australian Health Ministers Conference and the Australian Aboriginal and Torres Strait Islander Council. The regional planning process aims to achieve the following.

- To allow for full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities
- To generate and present data to facilitate analysis and decision making and where possible, improve the quality of the data available.
- To identify priorities, on the basis of transparent measures of relative need, in regions or communities within regions, where some action could be taken to, improve health status and/or access to health services
- To involve all players in identifying problems and devising cooperative, coordinated solutions to health issues, including the mainstream sector and those responsible for environmental health.
- To inform funding decisions with respect to new and existing health services for Aboriginal and Torres Strait Islander peoples.

Regional planning was anticipated to be an interactive process, with each succussive round of planning being adjusted to take account of lessons learnt from the experience of the one before. It was considered that the regional planning process would improve over time. It was acknowledged that the use of data would be restricted by what was available but the planning process itself might provide the impetus to improve data to aid future changes.

The introduction of a regional planning process required Forum members to work collaboratively for the first time to determine priorities for indigenous health in their jurisdiction. The process was always going to require a great deal of goodwill, commitment and patience given it was the first cooperative approach to indigenous health planning. However, it was considered important to commence the process and to produce regional plans within a reasonable timeframe which, while not prefect, could be enhanced in future planning rounds.

This was based upon two reasons. First, the state of Aboriginal and Torres Strait Islander health is such that it needed to be approached with some urgency. The various players, and especially Aboriginal and Torres Strait Islander people themselves, would lose interest and faith in planning if it is seen to be protracted and slow to produce change.

The second reason why regional planning was not be unduly delayed is that it would inform the distribution of new funds that might become available for new or expanded services. The Department believed it would be in a stronger position to recommend allocations of any new funds to States or regions where regional planning had been completed, and has done so with a number of initiatives.

The first comprehensive report to the Australia Health Minister Conference was produced in August 1999. It is titled “Jurisdictional Reports to the Australia Health Minister Conference on Progress made Under the Aboriginal and Torres Strait Islander Framework Agreements". Jurisdictions did not report against the six outcomes but against the seven commitments articulated in the Framework Agreements. Although it does not provide a measure of jurisdiction progress against the six outcomes, it does provide an indication of their progress towards achieving their commitments.

Regional plans have been completed in South Australia (November 1997), Queensland (July 1999) and Central Australia (July 1997). Regional plans continue to be developed in Western Australia, New South Wales, the top end of the Northern Territory, Victoria, Tasmania and the Australian Capital Territory, with the expectation that each jurisdiction will complete their plans during 2000. Aboriginal and Torres Strait Islander Framework Agreements will expire on 30 June 2000. Forum partners are presently renegotiating agreements for the period until 2003.

APPENDIX G: REMOTE COMMUNITIES INITIATIVE

SUMMARY OF THE PROCESS FOR IDENTIFYING REMOTE COMMUNITIES WITH LEAST ACCESS TO HEALTH CARE SERVICES

1. Program Funds allocated in 1996/97 Budget

In the 1996/97 Federal Budget, the Government committed $24 million over four years to assist approximately 35 communities that have little or no access to primary health care services.

The Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS) had used the Housing and Infrastructure Needs Survey (HINS) database to identify 186 communities of 50 or more people that did not have in their immediate vicinity any of the following: a hospital, a health care centre or an Aboriginal medical service.

While the HINS database had some limitations, it was the best available indication of the level of health services available to remote Aboriginal and Torres Strait communities. The HINS data showed several regions where the needs appeared highest:

Northern Territory:	Arnhem Land and Central Australia;
Queensland:	Torres Strait and Cape York; and
Western Australia:	East Kimberley and the Pilbara.

There were also communities in NSW and SA. The HINS data for this purpose did not include any communities in Victoria, Tasmania and the Australian Capital Territory.

The limitations of the HINS data included the following:

- The survey did not capture every remote Aboriginal community;
- The database was four years old at the time it was used for this purpose;
- The HINS communities examined were populations of 50 or more people, and therefore excluded clusters of smaller communities which can be counted as one community for the purposes of providing better access to health care;
- HINS did not record the level of visiting/mobile health services in remote communities.

Therefore, the HINS data was supplemented with the most contemporary data from NT, Queensland, NSW, WA and SA health departments on the communities with the least access to health care services. Of the eighteen communities identified through this round of planning, 13 were on the initial HINS list.

2. Framework Agreements/Joint Planning

All members (or potential members) of Aboriginal and Torres Strait Islander Health Planning Forums in WA, SA, NT, Queensland and NSW were contacted and given the opportunity to help identify remote communities which had no access or very poor access to primary health care services.

In SA and Queensland the nominated communities and associated data were agreed through the Forums under the Framework Agreements. In WA the Western Australian Department of Health and ATSIC had input into the identification of needs.

Data on 45 communities were provided through this process. The Office has identified the Torres Strait Islands as a priority region for improving access to health care services. At that time a separate Agreement was being negotiated with the Torres Strait Regional Authority, the Queensland Department of Health and the Commonwealth. Discussions were held with the relevant stakeholders on the priorities for the Torres Strait Islands in February 1997.

In the NT, Territory Health Services and this Department's Darwin Office provided data.

3. Remote communities have been identified

Each State nominated the following number of communities:

WA	16
SA	2
NSW	14
Queensland	13
TOTAL	**45**

The criteria set out in this attachment were applied to each of the 45 nominated communities. On the basis of these criteria 17 communities were identified as having least access to health care services (excluding the Torres Strait Islands).

The number of communities meeting the criteria from each State were as follows:

WA	10
SA	1
NSW	2
Queensland	4
Sub-Total	**17**
Torres Strait Islands	1
TOTAL	**18**

Another group of three communities that did not meet the criteria but were close to the threshold populations and/or levels of service provision, were further investigated for their access to primary health care services. Two of these communities were in Queensland and one in NSW.

4. Criteria used to prioritise the nominated communities

The broad criterion for prioritising communities was one of access to basic health services. The actual parameters were determined largely by the availability of funds: that is, if less funds were available, then the parameters would have had to be tighter. Alternatively, if more funds were available then the parameters could have been relaxed, so that for example communities less than 45 minutes from significant health services could have been included, or the standards of minimum services availability made more stringent.

The criteria used to select the communities with least access were as follows:

- Priority went to communities furthest (as measured by travelling time by road or sea) from a hospital or other significant health services. Given that around thirty communities could be accommodated, all communities more than 45 minutes from a hospital or other significant health services received priority. Note some communities, which were submitted as having no access to say a doctor, were excluded if they were 45 minutes or less from mainstream health care services.

Priority then went to communities that did not have a minimal level of basic primary health care available:

- Communities with a population below 100 that do not have at least a fortnightly visit from a nurse or general practitioner (GP).

- Communities with a population of over 100 that do not have a resident nurse or AHW, and fortnightly visits from a GP.

- Communities with a population of over 200 that do not have a resident nurse, plus supporting health workers, and weekly visits from a GP.

- Communities with an indigenous population of 500 or more were considered on a case by case basis for the adequacy of the services provided and the level of access to mainstream services. For example, in some communities the mainstream services provided might be considered inadequate for the combined indigenous and non-indigenous population.

The criteria are not prescriptive with respect to what additional services will be provided to each community.

APPENDIX H: SERVICE ACTIVITY REPORTING - SUMMARY OF MAJOR FINDINGS OF THE 1997-1998 SURVEY

- 106 Commonwealth funded Aboriginal primary health care services participated in the 1997-1998 SAR. This represents a 96 per cent response rate to the survey.
- These services covered an estimated total health service population of 410,000 Aboriginal and Torres Strait Islander people. Note: this includes some overlap in population between the services.
- The location of these primary health care services ranges from very remote locations to major cities (Fig1).

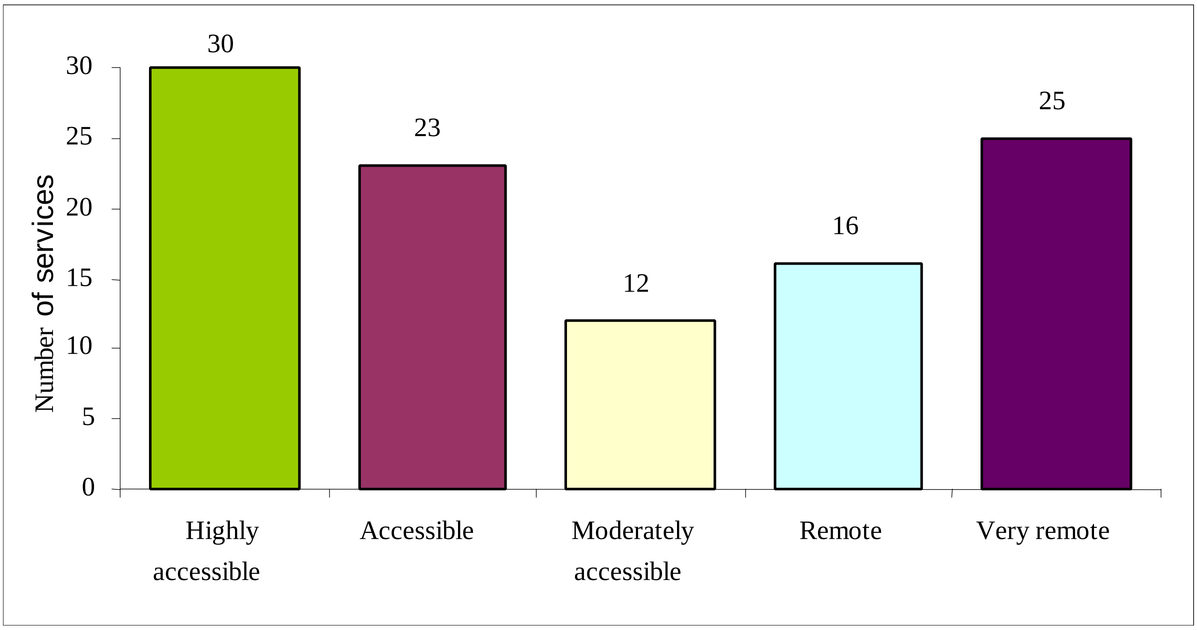


Figure 1: Number of Aboriginal primary health care services per ARIA[55] category*

- It is estimated that 860,000 episodes[56] of health care were provided by 106 Aboriginal primary health care services in 1997-1998. On average about 8, 400 episodes of care were provided by each service and about 2 episodes of care were provided to each indigenous person in each health service area.
- 90 per cent of all episodes of care were for indigenous clients and 61 per cent of these were for female clients.

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[55] ARIA denotes Accessibility/Remoteness Index of Australia, an index of the degree of access a location has to key services.

[56] An episode of health care is defined as contact with an individual client by one or more staff to provide health care for sickness, injury counselling, health education or screening.

Figure 2: The average number of episodes of care provided to Aboriginal and Torres Strait Islander clients by Aboriginal primary health care services (grouped by OATSIH funding category)

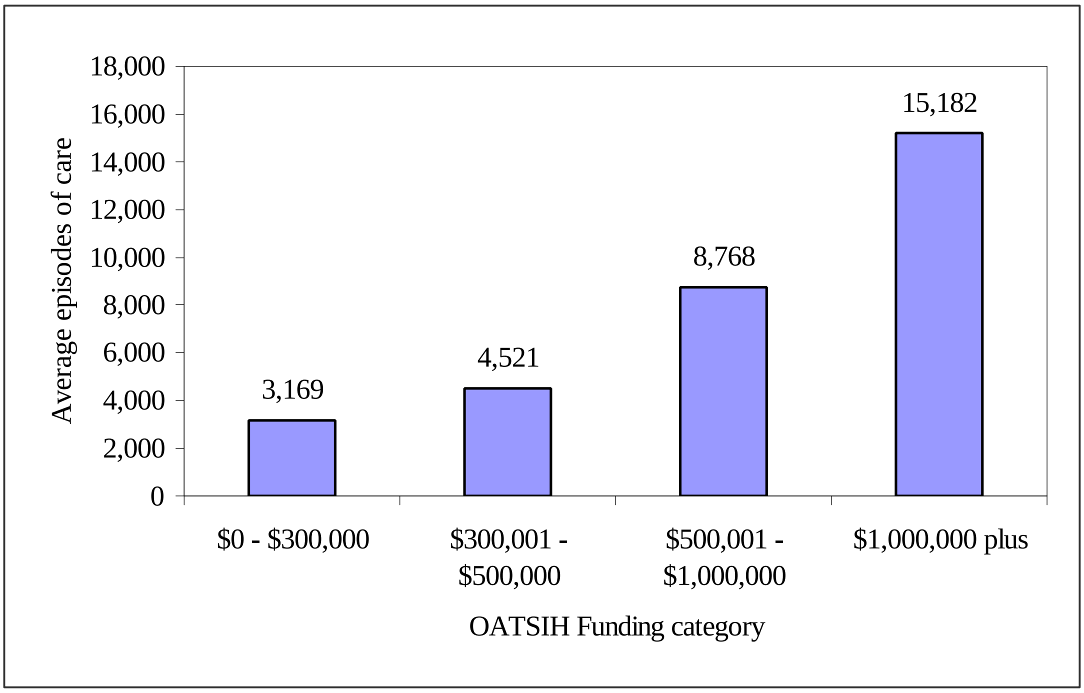
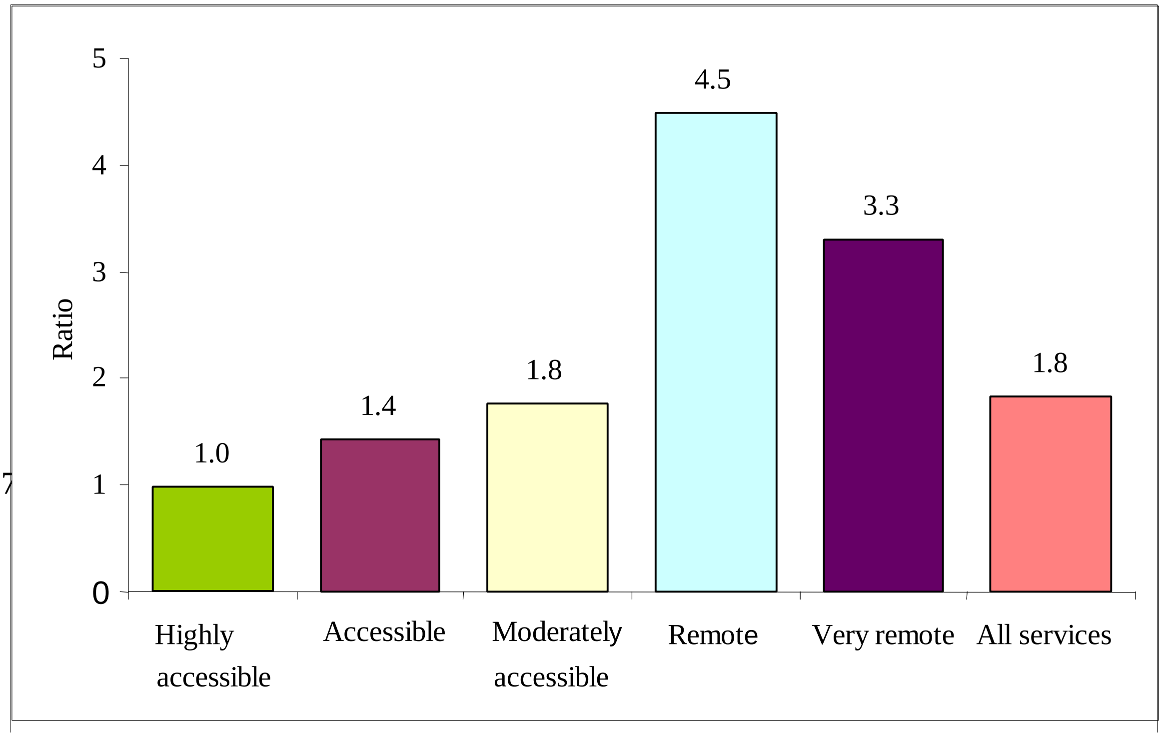


Figure 3: Ratio of Aboriginal and Torres Strait Islander episodes of care by Indigenous health service area population (per ARIA category)



- OATSIH and State/Territory governments funded about 1,500 full-time equivalent staff positions in Aboriginal primary health care services. 71 per cent of these positions were held by Aboriginal or Torres Strait Islander people. OATSIH funded 78 per cent of all government funded positions.

Figure 4: The average number of government funded staff per Aboriginal primary health care service by State

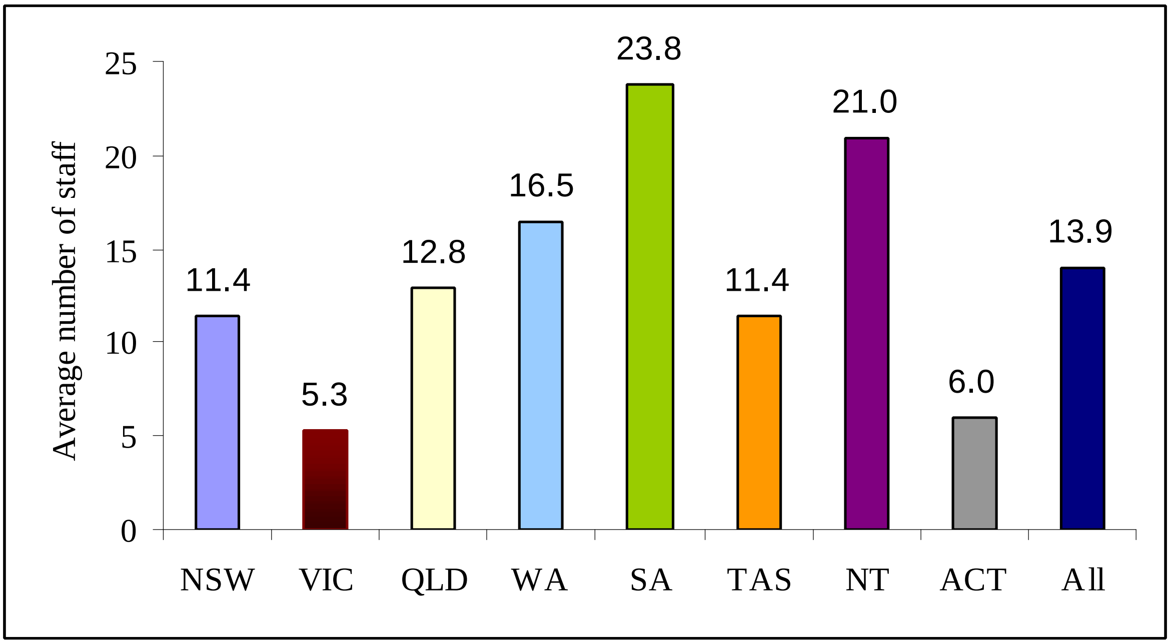
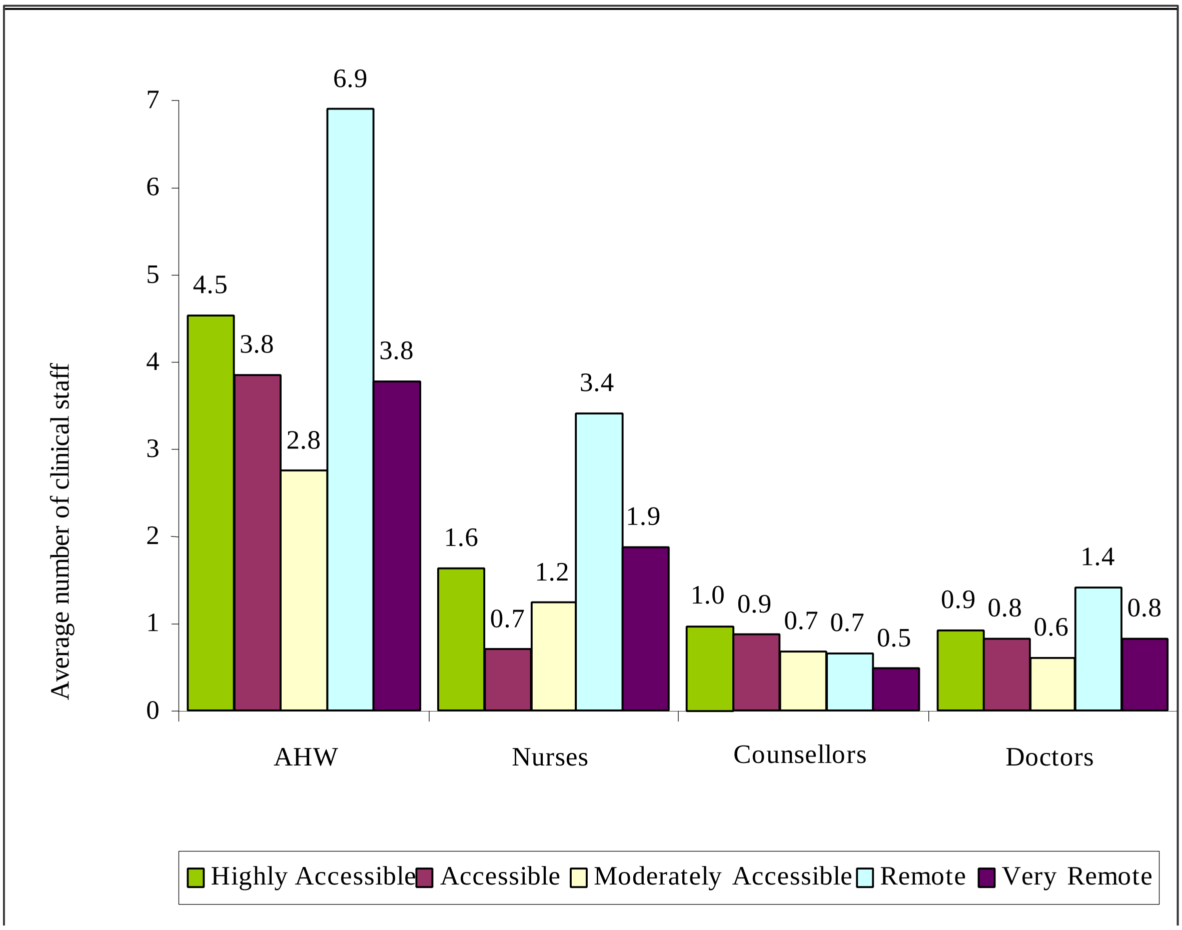


Figure 5: The average number of government funded staff per Aboriginal primary health care service by ARIA category



- In addition to providing primary health care for individuals, services reported undertaking the following additional activities:
  - 62% advocacy
  - 73% group activities
  - 64% health promotion
  - 67% mass screenings
  - 78% transport
  - 41% of services indicated that they used computers for patient information and recall.

Caveats for the 1997-98 Service Activity Reporting

The 1997-98 Service Activity Reporting (SAR) was the first of a regular annual collection of service information from Commonwealth funded Aboriginal Primary Health Care Services. While this data collection provides valuable information, it needs to be recognised that there were problems encountered with the first run of this questionnaire. The wording of some questions and layout of some aspects of the questionnaire caused problems in responses. It is important to articulate these issues so that people are aware of any limitations of this particular collection.

The 1997-98 Service Activity Reporting questionnaire collected a set of key indicators for the services and did not aim to provide a comprehensive set of statistics on the activities of the services or their needs.

The SAR only covered Commonwealth funded Aboriginal Primary Health Care Services. It excluded other services it currently funds, such as substance misuse residential services.

In analysing the data all parties need to be aware of the following:

1. Episodes of care and service population figures were often estimates and while these are thought to be reasonable, there has been no 'audit' to check the accuracy of these figures.

2. The question on staffing in the 1997-98 SAR has some specific data limitations. The staffing questions were limited to OATSIH and State Government funded positions. It did not include all funding sources and therefore is not a complete picture. The extent of this under count varies from service to service. Some services also provided staff numbers rather than full-time equivalent positions and there were significant problems in separating out which positions were funded by OATSIH and State Government compared to other sources of funding. Given these limitations staffing data from the 1997-98 SAR should be used cautiously.

3. The questionnaire was sent to services late in 1998 and most did not complete their forms until May-June 1999. While information such as episodes of care and staffing was generally answered in terms of the 1997-98 financial year, answers to many of the other questions reflect the situation at the time the form was completed.

APPENDIX I: INTERIM NATIONAL PERFORMANCE INDICATORS

Category one: life expectancy and mortality

Indicator 1.1:	Life expectancy at birth by sex.
Indicator 1.2a	Age-standardised all-causes mortality rates by sex.
Indicator 1.2b	Age-specific all-causes mortality rates by sex.
Indicator 1.3a	Age-standardised all-causes mortality rate ratio by sex.
Indicator 1.3b	All causes age-specific rate by ratio by sex.
Indicator 1.4	Chance of dying between 20 and 54 years by sex.
Indicator 1.5	Number of stillbirths to Aboriginal and Torres Strait Islander mothers per 1000 total births to Aboriginal and Torres Strait Islander mothers.
Indicator 1.6	Death rate of Aboriginal and Torres Strait Islanders from birth to one year old.
Indicator 1.7a	Age-standardised mortality rates for ischaemic heart disease and rheumatic heart. Disease by sex for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islanders.
Indicator1.7b	Age-standardised mortality rates of injury and poisoning by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7c	Age-standardised mortality for pneumonia by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7d	Age-standardised mortality rates from diabetes by sex for Aboriginal and Torres Strait Islanders and non-Aboriginal and Torres Strait Islanders.
Indicator 1.7e	Age-standardised mortality rates for cancer of the cervix among Aboriginal and Torres Strait Islander women and non-Aboriginal and Torres Strait Islander women.

Category two: morbidity

Indicator 2.1	Notification rates for selected vaccine preventable diseases: pertussis, measles, hepatitis B.
Indicator 2.1b	Notification rate for meningococcal infection.
Indicator 2.2	Crude notification rates for gonorrhoea and syphilis by sex.
Indicator 2.3	Percentage of Aboriginal and Torres Strait Islander children at school entry having >25dB hearing loss averaged over three frequencies.
Indicator 2.4	Proportion of Aboriginal and Torres Strait Islander newborns with birth weight <2500g, per 1000 live births.
Indicator 2.5	Age-standardised all-causes hospital separation rate ratio by sex.
Indicator 2.6a	Age-standardised hospitalisation rate and ratio by sex for acute myocardial infarction.
Indicator 2.6b	Age-standardised hospitalisation rate ratio by sex for injury and poisoning.
Indicator 2.6c	Age-standardised hospitalisation rate ratio by sex for respiratory diseases.

Indicator 2.6d	Age-standardised hospitalisation rate ratio by sex for diabetes.
Indicator 2.6e	Age-standardised hospitalisation rate ratio by sex for tympanoplasty.

Category three: access

Indicator 3.1	Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is <30minutes routine travel time from a full-time permanent primary care service by usual means of transport.
Indicator 3.2	Proportion of Aboriginal and Torres Strait Islander peoples whose ordinary residence is <one hour’s travel time from a hospital that provides acute inpatient care with the continuous availability of medical supervision.
Indicator 3.3	Overall per capita annual expenditure by governments on primary, secondary and tertiary health care services for Aboriginal and Torres Strait Islander peoples compared with expenditure for the total population.
Indicator 3.4	Case fatality ratio of hospital separations to deaths for sentinel conditions for Aboriginal and Torres Strait Islander peoples compared with non-Aboriginal and Torres Strait Islander people.
Indicator 3.5	Proportion of primary care services, and the resources allocated to these services.
Indicator 3.6	Extent of community participation in health services
Indicator 3.7	a) What number of local or regional health/hospital boards have Aboriginal and Torres Strait Islander members? b) Is this membership mandated by terms of reference?
Indicator 3.8	Proportion of communities with usual populations of <100, within one hour’s usual travel time to primary health care services
Indicator 3.9	Per capita recurrent expenditure by government on health care services to communities with populations <100, as compared with expenditure for the general population.

Category four: health service impacts

Indicator 4.1	Expenditure on, and description of, health promotion programs specifically targeting Aboriginal and Torres Strait Islander peoples.
Indicator 4.2	Number of Pap smears among Aboriginal and Torres Strait Islander females aged 18-70 years as a proportion of the female Aboriginal and Torres Strait Islander population in that age group.
Indicator 4.3	Proportion of Aboriginal and Torres Strait Islander children aged two years and six years old that are fully immunised as recorded in the Australian Childhood Immunisation Register (ACIR).
Indicator 4.4	Proportion of Aboriginal and Torres Strait Islander peoples aged >50 years who have received pneumococcal vaccine in the last 6 years compared with the Aboriginal and Torres Strait Islander population in that age group.
Indicator 4.5	Proportion of children aged two and six years who are fully immunised against Hepatitis B as recorded in the National Childhood Immunisation Register.

Indicator 4.6	Extent of support for the development and implementation of protocols and effective detection and management systems for conditions such as asthma, diabetes, cardiovascular disease, chronic renal disease, chronic respiratory conditions and hypertension.
Indicator 4.7	Age-standardised Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander accident and emergency activity rates for lacerations, fractures, trauma, respiratory infections, skin infections and nutritional disorders.
Indicator 4.8	Proportion of total consultations by condition and care provider.

Category five: workforce development

Indicator 5.1	Number of Aboriginal and Torres Strait Islander peoples who have: a graduated in the previous year; and b training in key health related fields.
Indicator 5.2	Number and proportion of Aboriginal Health Workers who graduated in the previous year or are participating in accredited training.
Indicator 5.3	Proportion of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in: a Aboriginal health services; and b Other organisations providing primary care for Aboriginal and Torres Strait Islander peoples on a given date.
Indicator 5.4	Number of vacant funded FTE positions for doctors, nurses and Aboriginal Health Workers in hospitals where >25% of separations are Aboriginal and Torres Strait Islander peoples on a given date.
Indicator 5.5	Number of Aboriginal identified positions in the health sector.
Indicator 5.6	Proportion of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander.
Indicator 5.7	Proportion of accredited hospitals for which the accreditation process required Aboriginal cross-cultural awareness programs for staff to be in place.

Category six: risk factors

Indicator 6.1	Proportion of Aboriginal and Torres Strait Islander peoples aged >13 years who currently smoke by age and sex.
Indicator 6.2	Proportion of Aboriginal and Torres Strait Islander peoples with a Body Mass Index >25, by sex and age.
Indicator 6.3	Proportion of Aboriginal and Torres Strait Islander peoples who reported usually consuming >4 drinks on the occasions when they drank alcohol in the last two weeks relative to the total numbers who reported on consumption.

Category seven: intersectoral issues

Indicator 7.1	Proportion of households where the after-tax income available to the household after paying the mortgage or rent is less than the amount specified by the poverty line.
Indicator 7.2	Proportion of dwellings where one or more Aboriginal and Torres Strait Islander adults is the usual resident, and over the last 4 weeks had reliable electricity or gas supplies, reliable water supplies and reliable sewerage or adequate alternatives.

Category eight: community involvement

Indicator 8.1	Establishment of a forum representing the Aboriginal health sector, ATSIC and state jurisdiction in each State and Territory.
Indicator 8.2	Cooperative community planning with the implementation of the regional planning processes.

Category nine: quality of service provision

Indicator 9.1	Critical incidence reporting and complaints mechanisms at all levels of health services.