

COMMONWEALTH GRANTS COMMISSION

INDIGENOUS FUNDING INQUIRY

FINAL SUBMISSION

**From: National Centre for Epidemiology and Population
Health**

Submission No.: IFI/SUB/0060

Date Received: 21/12/2000

THE AUSTRALIAN NATIONAL UNIVERSITY



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The Secretary
Commonwealth Grants Commission
5 Torrens Street
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Dear Sir/Madam

Thank you for the opportunity to respond to the Commission's *Draft Report of the Indigenous Funding Inquiry*. Our response is attached.

Regards

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Fellow

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December 20, 2000

Response to Commonwealth Grants Commission Draft Report

Australian National University

December 2000

- 1 Overall, the Commission has taken a sensible approach to the many complex issues raised by the Inquiry. It rightly argues that there is everywhere evidence of high absolute Indigenous need. Though confined by the Terms of Reference to addressing matters only of relative Indigenous need, the report raises many important issues in relation to absolute need and equity. There are however a number of matters that are of concern. Some of these are general and some related to specific ideas and recommendations.
- 2 At the general level, articulating measurement of need in terms of “outcome” in health is somewhat confusing. If by “outcome” the Commission in fact means health status or burden of disease then that terminology should be used. The “health outcomes” movement has major and ever-growing visibility in Australia and overseas and relates specifically to *changes in health status achieved as a result of intervention*. We doubt if this relatively narrow meaning is what the Commission had in mind.'
- 3 We find the concept of 'weighted health status' (p 68) somewhat confusing. It appears to combine conventional health status measurement with some assessment of: (a) contributing or causal factors, grouped under environmental, social and lifestyle effects, and (b) the likely returns to expenditure on treatment or prevention, as measured by the health gains. This is a very tall order indeed, involving as it does the four steps of:
 - quantifying Indigenous morbidity and mortality,
 - identifying causal factors,
 - estimating their relative contribution to health status; and
 - assessing their susceptibility to intervention.

As pointed out in our first submission we have grave doubts about our current ability to meet these demands at the national level, let alone for any lower level jurisdiction (eg ATSIC region). Not only are there no data available to quantify Indigenous morbidity and mortality for most states, but the other three steps far exceed the ability of epidemiology to attribute ill health as a whole to specific social and environmental causes, or measure susceptibility to intervention at that level.

- 4 We also find the separation of “social” and “lifestyle” effects misleading. Recent advances in social epidemiology demonstrate that the notion that “lifestyle effects” on morbidity and mortality are in some way separate from “social effects” is completely flawed. Lifestyle effects are in fact social effects mediated through behaviours¹. Treating them as separate gives further credence to the notion that lifestyle effects are

¹ See for example, L Berkman and I Kawachi, A Historical Framework for Social Epidemiology; in L Berkman and I Kawachi (eds), Social Epidemiology. Oxford University Press, 2000.

largely a matter of choice and up to *individuals* to change. There is ample evidence that, in the absence of substantive changes to their social conditions, the socially disadvantaged cannot simply change their “lifestyle”, for example in response to health promotion programs. This is why health promotion programs which target “lifestyle factors” have *very little effect* on the socially disadvantaged, and may in fact have led to a widening of health differentials between the rich and the poor.

- 5 Thus, while the idea of a multi-dimensional measure of need in health is attractive the concept of “weighted health status”, as presented, is problematic. As outlined in our original submission, the data problems involved in even describing Indigenous health status are currently formidable, partly because of the under-identification of Aboriginal people in the records of mainstream health services, partly through the bias inherent in all service based statistics (they reflect accessibility and service organisation just as much as 'need') and partly because self-reported data incorporate perceptions of health and illness which are culturally determined. Even the most obvious indicator of outcome - death- is satisfactorily recorded in three states only and then only at the aggregate level. Importantly, *they cannot be meaningfully disaggregated at the (ATSIC) regional level*. The Commission has recognised these difficulties but there are few suggestions in the draft report about how the necessary data might be obtained. It is also unclear how the establishment of any “minimum standards of service” would be divorced from the problem of highly variable and badly measured need.
- 6 In its recent restructuring of health care purchasing, New Zealand is likely adopting an Index of Deprivation – the most recent version of which is the NZDep96 – not unlike the experimental index of Indigenous Socio-economic Disadvantage being sought by the Commission. The NZDep96 has been under development for over a decade. It is an area-based measure of deprivation on a scale of 1 (least deprived) – 10 (most deprived) that combines nine variables from the 1996 New Zealand census that reflect eight dimensions of deprivation, such as education, income and occupation^{2,3}. It can be applied to a “meshblock”, which is a small geographical unit comprising a median of just 90 people². Data show that those at the lower (more deprived) end of the scale have a marked increase in avoidable mortality rates over those at the most advantaged end³. The index is now used in a number of health related research and policy settings. However, importantly, NZDep96 is being used to assess differentials among and between *all of the citizens of New Zealand* with a view to a fairer allocation of health care resources based on need (defined as avoidable mortality).
- 7 Community controlled service delivery is often considered an uncontested “good”. In fact, there is little evidence that community control delivers better health outcomes for Indigenous people. As the Commission notes in the Draft Report, the relative effectiveness of ACCHSs has never been evaluated. At the same time there is evidence that Indigenous people do not always prefer community controlled services. For example, a recent study of Indigenous aged care needs in the ACT showed that 50% of

² Crampton P. 1999. Third sector primary health care. A report prepared for the National Health Committee.

³ Health Funding Authority. 2000. Striking a Better Balance. A Health Funding Response to Reducing Inequalities in Health.

respondents favoured “clustered” residential accommodation in mainstream services⁴. Only 32% favoured an Indigenous-run organisation. It is critical that various approaches to community control be considered as *options* for improving health service delivery for Indigenous people, especially if broad ranging proposals for increased community control are being considered. Indigenous people, like other Australians, want choice in health services, so any decisions about community control need to acknowledge this.

- 8 While various collaborative arrangements between governments and Indigenous organisations such as those mentioned by the Commission can help create partnerships and improve coordination among public health care agencies, they often do not give adequate recognition to the fact that the majority of primary medical care services to Indigenous people are provided by GPs working in private medical practices⁵. If there are to be improvements in access to and the quality of primary medical care, GPs have to be brought more comprehensively into future arrangements. This could occur through individuals/practices, for example through the Practice Incentives Program, but also through Divisions of General Practice (not mentioned in the Draft Report). Research has shown that Divisions of General Practice have made significant attempts to improve the role of general practice in Indigenous primary health care, but this effort lacks strategic direction and national leadership⁶.
- 9 It makes no sense to seek to involve all GPs in an improved response to Indigenous primary medical care needs, because many of them see very few or no Indigenous clients. We endorse the Commission’s support for alternative approaches to mainstream service delivery. Models such as that being trialed in Melbourne where GPs who *see a significant number of Indigenous clients* are, through their Divisions, encouraged to form a network, provided with training, and backed up with support from a Liaison Officer could be included in consideration of need for capacity building in urban areas with widely dispersed Indigenous populations. Such arrangements fit within the regional planning processes currently being undertaken nationally. They also have the potential to augment community controlled service delivery in areas with widely dispersed Indigenous populations, to provide a comprehensive *system* of primary health care delivery.
- 10 The Commission has divided health care into primary health care, acute care, and aged and community care. Within this framework, secondary (specialist) and tertiary services are seen as “normally provided in hospital”. Specialist services for Indigenous people in cities are not and should not be provided predominantly in hospitals. Since research indicates that private specialist services are, like other Medicare services, under-utilised

⁴ P Dance, R Brown, G Bammer and B Sibthorpe. Needs for residential aged care and other services by the older Indigenous population in the ACT and region. National Centre for Epidemiology and Population Health, November 2000.

⁵ H Britt et al. General Practice Activity in Australia 1998-99. Australian Institute of Health and Welfare and University of Sydney, 1999.

⁶ Sibthorpe B, Meihubers S, Griew R, Lyttle C, Gardner G. Aboriginal health initiatives in Divisions of General Practice during the move to (outcomes based) block grant funding 1998-1999. NCEPH Discussion Paper Number 17, 1999.

by Indigenous people⁷, the Commission needs to specifically address the issue of need for private specialist services where they are available.

- 11 While the evaluations of the Indigenous coordinated care trials may be available to the Commission for their final report, they will not have been able to assess the effectiveness of the model because they *will not have been running for long enough*. While it can be argued that there are hopeful signs of improvements in capacity and some limited service delivery, it will need at least five years before any impacts can be realistically assessed. At the same time, there is evidence from overseas that similar kinds of arrangements have *not* proved effective in terms of either efficiencies or health gains. It is important to trial such arrangements, but also important that they are seen as just that – trials – for a number of years *after* they have been *fully implemented* and not prematurely promoted as a solution to the organisation and financing of health care for Indigenous people. The current fascination with funds pooling and regional purchasing is part of global trend in health care delivery for which there is as yet no evidence that it improves either health or health care. It has however, been shown to greatly increase transaction costs, and to raise major issues about data for informed decision making. Such data are not available for non-Indigenous people in Australia, let alone for Indigenous people.
- 12 The major and important problems in Indigenous administrative capacity may be greatly exacerbated if regional purchasing of health care is imposed on top of other regional responsibilities, without significant long term investment of infrastructure funds.
- 13 Further, there needs to be proper public debate about such arrangements, not just amongst organisations and power brokers. Cashing out (and *de facto* capping) of currently uncapped Medicare entitlements to an organisation that then controls the number and range of services available - effectively a Health Maintenance Organisation or HMO - constitutes a major departure from current understandings among Australians about how their health care is funded and provided. As such, it is worthy of robust and comprehensive public debate, including amongst Indigenous people. This debate has not yet taken place.

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⁷ J Deeble, C Mathers, L Smith, J Goss, R Webb and V Smith. Expenditures on health Services for Aboriginal and Torres Strait Islander People. Commonwealth of Australia, 1998.