COMMONWEALTH GRANTS COMMISSION

INDIGENOUS FUNDING INQUIRY

FINAL SUBMISSION

From: **Aboriginal Health & Medical Research Council of NSW**

Submission No.: **IFI/SUB/0081**
Date Received: **18/01/2001**

The Secretary
Commonwealth Grants Commission
Cypress Court
5 Torrens Street
Canberra ACT 2612

Attention: Mr John Barker File Reference: 2000/0369

Dear Mr Barker,

Re: Submission – Indigenous Funding Inquiry

Please find enclosed the AH&MRC submission to the Inquiry. The hard copy and attachments will be forwarded by post. Please contact me if you have any queries. As I mentioned to you by phone, the AH&MRC was unable to attend the meeting in Sydney due to the Partnership meeting being scheduled for the same day.

Thank you for your patience in this matter.

Yours faithfully

Sandra Bailey
Chief Executive Officer

January 17, 2001

Enc.

ABORIGINAL HEALTH & MEDICAL RESEARCH COUNCIL OF NSW

SUBMISSION

TO THE

COMMONWEALTH GRANTS COMMISSION
INQUIRY INTO INDIGENOUS FUNDING

ON

ABORIGINAL HEALTH

January 2001

INTRODUCTION

This Inquiry has been directed to

> *"inquire into and <u>develop a method that can be used to determine the needs of groups of indigenous Australians</u> relative to one another across government and government-type work 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 Main Findings of the Indigenous Funding Inquiry – Draft Report (37-58) concerning health are perceptive and pertinent. However, these findings are not new to the Aboriginal community controlled health services (ACCHS) and raise many of the same issues which have been conveyed with some gravity over three decades by ACCHS to governments, health departments, health services, royal commissions and special inquiries. Many of them relate to areas on which the Aboriginal community controlled health services have developed very clear positions and directions for improvement. Some of the issues are being addressed while others stagnate under the wider imperative for governments to retain political power in the short term. The Aboriginal Health & Medical Research Council of NSW (AH&MRC) contends that these are the areas which will require a major departure from historical practice on the part of governments in the future.

This submission will focus on the way in which Aboriginal health needs are determined and addressed in NSW. The submission does not deal in any detail with the issue of conventional resource distribution other than to say that the NSW Aboriginal Health Forum is developing a resource allocation policy for Aboriginal health. This submission will provide a comprehensive account of the Aboriginal health policy, process, structures, and services in NSW. Included are

- Background **- The philosophy, role and structure of the AH&MRC is outlined.**
- Policy Context **- Aboriginal health policy, process, planning and partnerships in NSW are established through a number of key documents. These documents incorporate the agreed approach to the assessment of need of groups of Aboriginal people and Torres Strait Islanders. The cross referencing between government and government-type work and services provided or funded by the Commonwealth and the State with Commonwealth financial assistance is understood and accommodated in this body of agreed policy.**
- Aboriginal community controlled health services **– This submission discuss the importance of Aboriginal community control in assessing and addressing health needs and the organisational structures initiated and supported by Aboriginal community controlled health services to represent their interests at local, regional, state and national levels.**
- Health Status, the Assessment of Need and Resourcing **- Within the context of assessing need, this submission will broach the definitions of Aboriginal health, the method for measuring the current health status of Aboriginal people and the assessment of need. This involves issues such as research and data collection, the ownership of information. The assessment of need and the level of resourcing is discussed, including the proportion of this which is allocated for ACCHS and specific funding programs.**
- Access to Health Services **– Access issues are significant and relate to the vital role of Aboriginal community controlled health services and the holistic culturally appropriate service that only they can provide.**

AH&MRC BACKGROUND

The Aboriginal Health and Medical Research Council of NSW is the recognised peak body of Aboriginal community controlled health and health related services representing the Aboriginal community on health matters in NSW and is the NSW state affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO). The

Aboriginal Health Resources Committee, (now the AH&MRC) was proposed by the *NSW Taskforce into Aboriginal Health* in 1983 as a measure which would ensure a greater degree of control by Aboriginal people over health resources which affect them.[1] It's role was to advise Ministers for Health and Ministers for Aboriginal Affairs at State and Federal levels on Aboriginal health policy, programs and needs as well as to support and encourage the establishment of Aboriginal community controlled health services. The AH&MRC is comprised of more than 50 Aboriginal health organisations in NSW (including Winnunga Nimmityjah in the Australian Capital Territory) and the Board of Directors is elected by members of the Aboriginal community.

The AH&MRC secretariat is accountable to it's member organisations and the Board of Directors, and the principle of local Aboriginal community control is paramount in every aspect of AH&MRC business.[2] The AH&MRC has an independent Health Ethics Committee which analyses all health research and collection of data relating to Aboriginal people and was engaged as a consultant by OATSIH to develop draft protocols for the routine collection of health data on Aboriginal people. It has also been engaged as internal consultants to NACCHO on the effects of the GST and FBT reforms upon Aboriginal community controlled health services, a copy of which was provided to government.

The AH&MRC has entered into a formal partnership arrangement with the NSW Department of Health through the *NSW Aboriginal Health Partnership Agreement*. In addition to this Partnership the AH&MRC has partnership arrangements with the NSW Corrections Health Service, the NSW Ambulance Service, the NSW Health Care Complaints Commission (HCCC), the AIDS Council of NSW (ACON), the International Centre for Eye Care Education (ICEE) and the Australian College of Health Service Executives (ACHSE). The AH&MRC works constantly to support of member organisations in the provision of health services and to ensure Aboriginal community representation on numerous committees and working groups at local, regional, state, national and sometimes international levels.

RELEVANT POLICY FRAMEWORK IN NSW

1. **National Aboriginal Health Strategy 1989** The *National Aboriginal Health Strategy 1989* (NAHS) was commissioned by the Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health and was the first national policy document relating to Aboriginal health. The Working Party was established in December 1987 and it's report received bipartisan endorsement from the Joint Ministerial Forum in June 1990. It was the product of extensive consultation with Aboriginal communities and federal and state governments by the joint Working Party.

The NAHS recommended a number of strategies to address the appalling situation in Aboriginal health and the *ad hoc* nature in which governments had previously responded to the problems. In particular, the NAHS acknowledged that ACCHS are the most efficient and effective means of delivering health services to Aboriginal people. The NAHS recommended that governments work in partnership with Aboriginal community controlled health services and establish State/Territory tripartite fora and a national Council for Aboriginal Health, in an attempt to create, for the first time, formal dialogue between governments and the Aboriginal community controlled health sector.

The NAHS was evaluated in 1994 and, commenting on the implementation of the NAHS Recommendations, reported:

[1] Report of the Aboriginal Taskforce on Aboriginal Health in NSW, 1982-83, Ch.6, p.66, rec.6.3,
[2] See A Brief Outline in the AH&MRC Monograph Series Vol.1 No. 1 (1999) *Primary, Secondary and Tertiary Health Care Services to Aboriginal Communities*, p.12

> "The committee established to evaluate the National Aboriginal Health Strategy found little evidence of it. Instead, the Committee found only traces of where the strategy had been – small amounts of money (compared with the need) spent on housing and health services." [3]

The NAHS Evaluation finding that the NAHS had not been implemented was followed by the transfer of Aboriginal health from ATSIC to the Commonwealth Department of Health, under the portfolio of the Minister for Health, leaving ATSIC with responsibility for environmental health. The Commonwealth Department of Health signed a *Memorandum of Understanding 1996 (*MOU)[4] with ATSIC outlining the arrangements for the transition of Aboriginal health from ATSIC to the Department of Health and Aged Care. It showed that ATSIC has a specific responsibility in these arrangements to ensure that Aboriginal community control in health is supported; to review and monitor the effectiveness of the *Memorandum of Understanding*; and to have carriage of environmental health for Aboriginal people. ATSIC is a signatory to the NSW Aboriginal Health Framework Agreement and is member of the Aboriginal Health Forum.

The NAHS Evaluation Committee recommended that the Commonwealth reaffirm it's commitment to the principles underlying the NAHS including: acceptance of Aboriginal people's holistic view of health; recognition of the importance of local Aboriginal community control and participation; and intersectoral collaboration.[5]

The principles of the NAHS (1989) are still relevant to Aboriginal health and underpin the current *NSW Aboriginal Health Partnership Agreement 2001* and the *NSW Aboriginal Health Framework Agreement* 1996/2001.[6]

2. NSW Aboriginal Health Partnership **The AH&MRC has a Partnership Agreement with the NSW Minister for Health[7] and the NSW Department of Health. The Partnership provides the Minister for Health with agreed positions on Aboriginal health policy, strategic planning and broad resource allocation issues. The guiding principles include observance of the principles espoused in the *National Aboriginal Health Strategy 1989*, especially self-determination, a partnership approach and intersectoral collaboration.**

The purpose of the Partnership is to ensure that the expertise of the Aboriginal community controlled health sector is brought to the health care processes and that Aboriginal health retains a high priority in the health system. Throughout the state, Local/Area level Aboriginal Health Partnerships between ACCHS and the respective Area Health Service will seek to improve health outcomes for Aboriginal people by promoting co-operation and collaboration between Aboriginal community controlled health services and Area Health Services. Sub-committees and working parties comprising other relevant stakeholders, answerable to the Local/Area Aboriginal Health Partnership, operate in a collaborative manner addressing the particular health needs of their communities.

The *NSW Aboriginal Health Partnership* has jointly developed very important health documents that include the following:

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[3] The National Aboriginal Health Strategy: An Evaluation, 1994, p.2
[4] MOU also currently under review.
[5] ibid, p.2
[6] NSW Agreement on Aboriginal and Torres Strait Islander Health is still in final draft, awaiting the endorsement of ATSIC.
[7] NSW Aboriginal Health Partnership Agreement 2001

- ***NSW Aboriginal Health Policy – Ensuring Progress;***
- ***NSW Aboriginal Health Strategic Plan;***
- ***NSW Aboriginal Mental Health Policy;***
- ***NSW Aboriginal Family Health Strategy*****;**
- ***NSW Aboriginal Health Information Guidelines*****;**
- ***NSW Aboriginal Health Promotions Directions Paper;*** **and**
- ***NSW Aboriginal Health Employment Strategy;***

These documents were accomplished through the collaborative efforts of the stakeholders and express obligatory practice for Area Health Services and the NSW Health Department.

3. **NSW Aboriginal Health Policy** The first initiative of the Partnership was the development of the *NSW Aboriginal Health Policy - 'Ensuring Progress'* (Policy). The Policy recognises the significant reports relating to Aboriginal health over the past ten years or more and promotes respect for a whole of life view of health, the practical exercise of the principles of Aboriginal self-determination, partnership, cultural understanding and recognition of trauma and loss in Aboriginal communities. It consolidates the many recommendations from numerous major reports and reinforces the NSW Government's commitment[8] to work in Partnership with the AH&MRC in restoring the health and social, emotional and cultural harmony and well-being of Aboriginal people in NSW.

4. **Local Aboriginal Health Plans** The *NSW Aboriginal Health Partnership Agreement* 1995 provided for the development of *Local Aboriginal Health Plans* (LAHP). This was in recognition that the existing District[9] Health Plans did not specifically cover all aspects of Aboriginal health and health service delivery. The LAHP are crucial in the process of improving Aboriginal health in NSW. They provide a way for the considered views of the local Aboriginal community, that reflect local conditions and needs, to be heard. The Plans inform the development of the *Regional Aboriginal Health Plans and State Summary* and the *NSW Aboriginal Health Strategic Plan*. The AH&MRC is committed to the implementation of the *Aboriginal Health Plans*, knowing that they reflect the needs as identified by each local Aboriginal community and are outcome oriented.[10]

5. **NSW Aboriginal Health Strategic Plan**

> "The *NSW Aboriginal Health Strategic Plan 1999* is an initiative under the *NSW Aboriginal Health Partnership Agreement* and the *NSW Aboriginal and Torres Strait Islander Health Agreement 1996.* It's purpose is to present strategies to improve health outcomes for Aboriginal and Torres Strait Islander peoples and to address the issues raised in the Aboriginal health planning process[11] in NSW."

The conceptual framework of the Plan incorporates strategic directions, addressing some of the most pressing Aboriginal health issues. It was developed around the key health issues as identified by the local Aboriginal communities during the local Aboriginal health planning

[8] Reconciliation and Change – The Carr Government's Commitment to Aboriginal People, 1999
[9] District Health Services preceded the Area Health Services, the NSW public health system.
[10] The agreed template used for the development of Local Aboriginal Health Plans is attached.
[11] NSW Aboriginal Health Strategic Plan, 1999, Fig. 3, p.4

process and provides strategies to address these critical issues. Furthermore, the Plan identifies as outcomes

> "the restoration of the social, emotional and cultural harmony and wellbeing of Aboriginal people, families and communities" and "the practical application of the principle of Aboriginal self determination".[12]

These are considered in the context of a number of cross-sectional considerations relating to structures, resources and reporting requirements.[13] The Plan was endorsed by the NSW Aboriginal Health Forum and formally launched by the State and Federal Ministers for Health in October, 1999. It incorporates the areas of need as identified in the *Local Aboriginal Health Plans* and provides an agreed blueprint for action by relevant stakeholders and the basis for the Forum's work plan. The implementation of the Plan is monitored by the Forum.

6. NSW Aboriginal & Torres Strait Islander Health Agreement

> "A major impediment to reform in Aboriginal health has been a lack of co-ordination between Federal and State governments, with consequent "buck-passing" and difficulties in the relationship between governments and Aboriginal organisations. In order to overcome these obstacles, Framework Agreements were signed in each State and Territory."[14]

The *NSW Framework Agreement* was signed in August, 1996. The parties to the Framework are NSW Health, AH&MRC, Commonwealth Department of Health and Aged Care and ATSIC. It provides for joint planning and the development of regional Aboriginal health plans (below), recognising the development of *Local Aboriginal Health Plans* under the NSW Partnership as a first step in this process. The Framework is currently being revised, however, the Aboriginal Health Forum has continued to meet and operate under the auspice of the 1996 Agreement. The original *Framework Agreement* has been revised although most changes are superficial and in keeping with the 1996 agreement with no major departures anticipated.[15]

7. Regional Aboriginal Health Plans and State Summary **The *Regional Aboriginal Health Plans* have been developed pursuant to the *Framework Agreement* (above). The Regional Plans incorporate the *Local Aboriginal Health Plans* into Area Health Service boundaries and also include the *Area Health Service Aboriginal Health Strategic Plans*. The *State Summary* combines information drawn from all these plans and identifies the key issues affecting Aboriginal health in NSW. It includes strategies to address these issues and summarises existing initiatives. The members of the NSW Aboriginal Heath Forum are committed to working together to address these issues.[16] The *Main Findings* refer to regional planning being a 'top-down approach'.[17] This is not the case in NSW where the planning process commences with the local Aboriginal community developing their own plans which were encompassed within the Regional Plans.**

8. Overview The above contextual background encompasses, most importantly, the universal recognition of the unique and indispensable role of ACCHS and that governments need to work in equal Partnership with the Aboriginal community

[12] ibid.
[13] NSW Aboriginal Health Strategic Plan, 1999, p.1
[14] General Practice in Australia: 2000, Commonwealth Dept. of Health & Aged Care, p.83
[15] Revised NSW Agreement on Aboriginal & Torres Strait Islander Health is in final draft and awaiting endorsement by ATSIC.
[16] *From the Ground Up* Summary – NSW Aboriginal Health Regional Plans, October 2000
[17] Main Finding 41

controlled health sector. It is based on the principle that Aboriginal community controlled health services are absolutely essential to the improvement of Aboriginal health and that Local Aboriginal communities are in the best position to identify their own needs and determine the priorities.[18]

The current agreements, policy documents and plans represent the culmination of a concerted effort by all stakeholders to arrive at an agreed approach, consistent with the *National Aboriginal Health Strategy (1989*). This has involved the considerable efforts of Aboriginal community controlled health services over many years, without remuneration, to ensure that Aboriginal health issues are appropriately addressed. It has also involved state and federal Ministers for Health giving their commitment to and actively promoting this joint process in Aboriginal health above party political agendas. A great deal of mutual trust and commitment has been invested over the past seven years, during which changes in governments and turnover of staff in key bureaucratic positions have contributed to the delay in consolidating progress. However, despite these delays, the NSW Aboriginal Health Partnership and the Forum have achieved significant and positive outcomes within an agreed approach.

The development of an equal Partnership in NSW; the development of a definitive Policy on Aboriginal Health; the formal inclusion of the Commonwealth Department through the Framework Agreement; the endorsement by the Aboriginal Health Forum of the *NSW Aboriginal Health Strategic Plan* and the finalisation of practical local and regional Aboriginal Health Plans are all joint achievements.[19] What is required now is for the parties to work jointly to implement the relevant policies, plans and procedures as agreed.

ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES

The definition of an Aboriginal community controlled health service is

> "an incorporated Aboriginal community organisation which has rules preventing the distribution of property to individual members of the organisation; which is governed by an Aboriginal board of management elected by a local Aboriginal community membership; and, provides culturally appropriate primary health care and health related services to the Community which it serves."[20]

Whilst the concept of Aboriginal community control has been increasingly misrepresented, if not maligned, in recent publications it's meaning is clearly understood and documented by the Aboriginal community controlled health sector. One attitude with which Aboriginal communities have had to contend, and which sometimes typifies government responses to Aboriginal community controlled structures, was described in evidence to the House of Representatives Standing Committee on Family and Community Affairs during the Inquiry into Indigenous Health.

> "There are constant contradictions about where power is. When the Aboriginal community attempts to organise itself to have power, the community development professionals and a lot of the health professionals dive under that and say 'they don't represent the community we go down to the least organised part of Aboriginal

[18] See Local Aboriginal Health Plans

[19] The NSW Regional Aboriginal Health Plans State Summary was signed by all parties on 11.12.00

[20] Constitution of the AH&MRC

society and we will work with them."[21]

Similarly, any suggestion that there is a lack of clarity and a tendency to overuse the term to the extent that it is a "buzz phrase" and can mean "all things to all people"[22] must be viewed as an aberration of the principle.

The definition of Aboriginal community control was determined by the NACCHO membership comprising over one hundred ACCHS and is clearly articulated in the *NACCHO Memorandum of Association 1997*. The term is not used with flagrant indifference, as is sometimes asserted, nor is the Aboriginal community an obscure entity which is impossible to identify, and consequently, impossible to represent. Such assumptions are ill conceived and cast blanket aspersions on the collective integrity of Aboriginal communities and individuals.

It would appear that the divisions which occur naturally and frequently within the wider Australian community and the parliamentary structures are only viewed as a problem by governments and bureaucrats when they are dealing with Aboriginal people. The Aboriginal community controlled health structures were developed and defined by Aboriginal communities. They accommodate diversity and anticipate the possibility for division but allow local Aboriginal communities to resolve their own issues relating to representation.

Aboriginal community controlled health services provide culturally appropriate holistic primary health care commensurate with the level of funding they receive. The inaugural publication of the AH&MRC Monograph Series *Primary Health Care in an Aboriginal community controlled health service* is devoted to this topic. [23] In addition, to the medical services outlined, primary health care within the Aboriginal community controlled health sector means

> "those activities that are necessary to provide social and emotional support to better equip the healing process"[24]

and has much in common with the World Health Organisation definition as stated in the *Alma-Ata Declaration, 1978*.

Aboriginal community controlled health services are initiated within and reflect local Aboriginal community and cultural affiliations. An ACCHS means much more to the Aboriginal community than the definition conveys. For example, an ACCHS is a place:

- where Aboriginal people can access services or simply gather in culturally familiar surroundings;
- where staff are familiar with the problems that clients may have and usually identify with the situation of Aboriginal people generally;
- where there is ready assistance with medical and other problems;
- where referrals can be made to necessary services (of which the client may be unaware);
- where Aboriginal Women's business is understood and respected;
- where Aboriginal Men's business is understood and respected;
- where the culturally dignified return of deceased Aboriginal people to their

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[21] Dr B. Bartlett, Evidence, *Health is Life – Report of the Inquiry into Indigenous Health*, May 2000, Canberra, p.42

[22] *Health is Life – Report of the Inquiry into Indigenous Health*, May 2000, Canberra

[23] Copy attached

[24] AH&MRC Monograph Series Vol.1 No. 1 (1999) *Primary, Secondary and Tertiary Health Care Services to Aboriginal Communities*, p.3

communities is supported and from where funeral arrangements and transport can be co-ordinated (including printing, order of ceremony, gatherings, venues for wakes, etc.);
- where welfare assistance can be accessed in a non-judgmental and non threatening manner;
- where cost free transport to appointments can be accessed;
- where clients are not likely to be judged or discriminated against;
- where the environment is conducive to effortless communication between staff and clients about their health needs;
- where someone is available to accompany a client to access mainstream services (especially in difficult situations involving substance abuse, sexual abuse or violence, and some specialist services);
- of information and education, eg, health promotion, all types of health related information.
- of employment opportunity and transfer of skills;
- of cultural reinforcement, where unity is fostered;
- of community pride and achievement where self esteem is nurtured;
- which provides support for grief, trauma and loss and where crisis intervention can be quickly achieved;
- which supports community events and promotes cultural and social activities such as fund raising for various causes (eg. funerals, projects involving children and youth.); and,
- where a client can discuss their concerns directly with management.

Aboriginal community controlled health services not only remove barriers to Aboriginal people accessing mainstream services, but also reduce the level of hospital admissions through early intervention and health education.[25] A further advantage in an ACCHS is the inherent corporate knowledge of family, community and cultural associations and connections locally, regionally and sometimes nationally, providing a unique resource.

The benefits of Aboriginal community controlled health services have been widely recognised in numerous reports and publications, including the *NAHS 1989*. They are outlined in *General Practice in Australia: 2000,* published by Department of Health and Aged Care[26] and relate to a number of the issues raised in the Main Findings of this Inquiry.

Adequate funding is essential, but not always forthcoming, to support the much needed programs an ACCHS offers and resources, including human resources, are often stretched beyond their limit.[27] (see 'Resourcing' below)

> "In addressing the needs of Aboriginal communities seeking to regain stability and cultural well-being any attempt to further alienate health services from their indigenous base would be counter-productive."[28]

Similarly, it was recognised in *Promotion, Prevention and Early Intervention for Mental Health Monograph*[29] that

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[25] Main Finding 54
[26] Bell, K., Couzos, Dr S., Daniels, Dr J., Hunter, A., Mayers, Dr N., Murray, Dr R., *General Practice in Australia: 2000*, Dept of Health & Aged Care, p.75 (at p.79)
[27] Main Findings 49 & 50
[28] AH&MRC Monograph Series Vol.1 No. 1 1999 *Primary, Secondary and Tertiary Health Care Services to Aboriginal Communities*, p.3
[29] *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Raphael, Prof. B., et al, 2000, Department of Health & Aged Care, p.88

"When (Aboriginal) communities are empowered, Aboriginal peoples and Torres Strait Islanders will be able to determine their own needs in the areas of promotion, prevention and early intervention."

HEALTH STATUS[30], THE ASSESSMENT OF NEED & RESOURCING[31]

1. **Definition of Health** The definition of *Health* was composed and adopted by the National Aboriginal and Islander Health Organisation (NAIHO), now known as NACCHO, in 1979.

> "Health does not simply mean the physical well being of an individual but refers to the social, emotional and cultural well-being of the whole community. For Aboriginal people this is seen in terms of the whole of life view incorporating the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and thus bring about the total well-being of their community."[32]

The In relation to cultural well-being it has been recognised in the National Mental Health Strategy Monograph, *Promotion, Prevention and Early Intervention for Mental Health*, that

> "Aboriginal essence lies at the heart of cultural well-being. It is shaped and expressed in the web of physical, spiritual, political, environmental, economic and ideological inter-relations. Cultural well-being is the outcome of the integrity and harmony of these inter-relations. These inter-relations operate at the individual, family community and societal levels. ..Cultural well-being is affected by the degree and nature of disruption to these inter-relations which in practical terms come in the form of acts and processes of dispossession, physical genocide, attempted cultural genocide, violence, violation and denial of our rights, assimilation, forced separation and incarceration in reserves and prisons, sexual abuse, theft, destruction of our material and economic base, and governments and their departments telling us what's good for us and what we can and can't have or do."[33]

The stated role of this Inquiry involves the development of

> "..a method that can be used to determine the needs of groups of indigenous Australians.."[34]

It is against these definitive expressions that Aboriginal health needs must be assessed.

In terms of health needs the intolerable health status of Aboriginal people is indisputable. The NACCHO Submission to this Inquiry[35], which has the endorsement of the AH&MRC, succinctly outlines the appalling status of Aboriginal

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[30] Main Finding 38
[31] Main Finding 50
[32] *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, – DHAC 2000
[33] Collins, L., 1994, cited in NSW Health Aboriginal Mental Health Strategy, 1997, and cited in *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, – DHAC 2000
[34] Terms of Reference, Pp.83 & 84
[35] NACCHO Submission to the Commonwealth Grants Commission Indigenous Funding Inquiry, 1 May 2000.

health, as do numerous other statistical and health reports. It is not necessary to repeat the picture here. The Deeble Report states:

> "One issue on which there seems to be both professional and popular agreement is that Aboriginal and Torres Strait Islander people have a greater need for health services than other Australian citizens."[36]

The *Deeble Report* was commissioned by the Commonwealth Department of Health and Aged Care to:

> "..identify baseline data on the allocation and expenditure on Aboriginal health by Commonwealth, State and Territory governments and to develop a mechanism for the continuing collection and reporting of such data to inform the planning, monitoring and evaluation of allocation and expenditure."[37]

It is relevant here because it raises a number of the issues pertinent to this Inquiry. Additionally, in a subsequent paper, prepared for the Australian Medical Association[38], Deeble estimated that $245million per annum is required to meet Aboriginal health needs. This assessment was calculated on the basis of available mortality figures alone and did not take account of the broader range of social and economic determinants.

The Report on Aboriginal and Torres Strait Islander Health Expenditures defined the 'ideal' formula as one which took into account not only the prevalence of illness but also its impact on sufferers, the efficacy of treatment or prevention and any barriers to accessing those measures for different groups of people.[39]

The *Deeble Report* recognised the limitations of simply using mortality data and couched its findings in terms of the investment required in the health sector only. The socio-economic determinants of health weren't factored into the calculations nor was it claimed that they would be remedied by the investment.

In 1989 the NAHS Working Party stressed that environmental issues are 'integral to health services infrastructure'. The Aboriginal Health Development Group, reporting to the Governments on the implementation of the NAHS reiterated that:

> **"Adequate housing and associated essential services are recognised as being an integral part of living conditions necessary to enhance health status."**

The Development Group "guesstimated" that, on available data, the cost of around $2.5billion was required to meet Aboriginal and Torres Strait Islander community needs for infrastructure services.[41]

In 1990 the Joint Ministerial Forum resolutions, adopting the NAHS recommendations, noted:

[36] Deeble, J., et al, *Expenditures on Health Services for Aboriginal & Torres Strait Islander People*, 1998, Commonwealth Department of Health and Aged Care, Ch.4, p.41
[37] ibid, Ch.1, p.1
[38] Deeble, J., - *A need-based formula for Aboriginal and Torres Strait Islander Health, 2000* (commissioner by the Australian Medical Association)
[39] ibid, p.1
[40] Australian Bureau of Statistics – Indigenous Vital Statistics Working Group, NSW
[41] *Report of the Development Group to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health*, 1989, p.25

“..that a high priority is to be given to public health to bring the Aboriginal and Torres Strait Islander communities to a standard comparable to the general Australian community for the provision of basic services such as housing, clean water and safe waste disposal, roads, power and communications and that appropriate resources be provided to a public health program to match that commitment.”[42]

In terms of addressing environmental conditions, the *NAHS Evaluation (1994)* estimated that as much as $2 billion would be needed in funding just to meet the backlog in housing and essential services in remote and rural communities in Australia. This was in 1994, and did not take account of urban areas.[43] **It also recommended that a ‘human rights based approach to funding should be adopted.’**[44]

2. Aboriginal Health Data

The accuracy of any assessment not only depends on the proper formula but also the availability and reliability of data. In Aboriginal health the under enumeration of Aboriginal deaths and of the Aboriginal population suggest that the available figures may actually be much higher.

Referring to the problems of estimation, Deeble found that:

> “The main problem in estimating expenditures on Inidgenous people is under-identification in the records of mainstream health services.[45]

NSW is no exception. A lack of data on Aboriginal health, but particularly baseline data, has made it difficult to measure need and to assess outcomes.[46] Data collection has been impeded by the under identification of Aboriginality in mainstream service collections and the NSW Aboriginal Health Partnership is working to improve this situation.[47] The AH&MRC is also currently represented on a committee with the ABS, Registry of Births, Deaths and Marriages, ATSIC and the NSW Department of Health,[48] seeking to correct the under-identification of Aboriginality within the Department of Health and the funeral industry. The quality and reliability of baseline Aboriginal health data in NSW will only improve when these issues can be resolved.

With regard to data from Aboriginal community controlled health services, the AH&MRC has also routinely been involved in the development of national and state health outcome performance indicators and reporting requirements on service provisions from each ACCHS. Also, NACCHO has approved ethical procedures for the collection, use and dissemination of data. These procedures protect the rights of the local Aboriginal community to own and control their own information by ensuring that there must be agreement before data is released.[49]

Service Activity Reporting (SAR) is a process for reporting against performance indicators and grant conditions. It was developed to be an assessment of health

[42] The National Aboriginal Health Strategy: An Evaluation, 1994, p.81
[43] ibid, p.32
[44] The National Aboriginal Health Strategy: An Evaluation, 1994, p.3
[45] Deeble, 1998, p.x
[46] Main Finding 40
[47] NSW Aboriginal Health Information Strategy, NSW Aboriginal Health Information Guidelines & MOU, 1998
[48] Australian Bureau of Statistics – Indigenous Vital Statistics Working Group, NSW
[49] National Aboriginal & Torres Strait Islander Health Data Protocols for the Routine Collection of Standardised Data on Aboriginal and Torres Strait Islander Health, 1997

needs of ACCHS as opposed to health status of Aboriginal people. The SAR is completed annually by ACCHS and returned to the Office of Aboriginal and Torres Strait Islander Health or NACCHO.

A crucial deficiency in area of Aboriginal health is the failure to resource the Aboriginal community controlled health sector in it's repeated attempts to introduce a comprehensive data collecting process on the health of Aboriginal people. The Framework Agreement recognises Aboriginal ownership of it's health data and provided the basis upon which all such matters should proceed. The matter was raised in evidence by the AH&MRC to the House of Representatives Inquiry into Indigenous Health[54], that the Aboriginal community controlled health sector is

> "...in the process of seeking funds to have all our AMSs trained, to try and get an epidemiologist working in each AMS and to do our own recruitment and ourown collection of data to be channelled through and then passed on to AHIW and the NHMRC, so it is in hand. The only problem again is what Harry [Quick] has mentioned: that when we go looking for funds for it, there are no funds for us to proceed. If we could have the carriage of that process, we would be getting those data back diretly to the scientists here today and other people, but it has been stifled. "[55]

It is disconcerting that in spite of the AH&MRC's submission to the Parliament on this important matter, there is no reference at all in the final Report, *Health is Life.*

In relation to resourcing issues the Main Findings of this Inquiry indicate that:

> "Targeted annual health funding for Indigneous people is about $230million out of a total health budget of about $50billion. Total per capita expenditure on health for Indigenous people is only marginally more than for the total population, and is much lower than expected given their health status and location."[57]

Whilst 28% of the Aboriginal population resides in NSW it has the lowest level of funding per capita for Aboriginal health compared to any other state or territory. This disparity was discussed by the first Council for Aboriginal Health meeting in 1992 prior to it's premature review.[58] During discussions, indications were given that this had been a purely historical approach on the part of government, particularly the bureaucracy. ACCHS representatives have raised the concern with governments, seeking redress on numerous occasions prior to and since that meeting. However, to date the inequity remains.

The preference for funding remote and isolated Aboriginal communities[59] is reflected in Main Finding 44 where it refers to 'their status and location'. Whilst health status

[50] Main Finding 46
[51] Main Finding 55

[53] Main Finding 55
[54] House of Representatives Inquiry into Aboriginal Health, 1999
[55] ibid, Official Committee Hansard, 1 December 1999, p.1372
[56] Main Finding 50
[57] Main Finding 44
[58] The Council did not meet until two years after the commencement of the NAHS. At the first meeting senior bureaucrats announced that as 2 years had expired the Council's operation was due to be reviewed.
[59] Per Commonwealth definitions

is central to any assessment of need, location is not necessarily a decisive criterion in and of itself.

Deeble[60] reported that:

> " ..the ratio of Indigenous to non-Indigenous expenditure per person varied considerably across the States and Territories. In general, it was highest where the proportion of Aboriginal and Torres Strait Islander population living in remote areas was highest, especially in Western Australia and the Northern Territory. At least some of the difference may thus be explained by the costs of isolation."

It would appear that this historical practice discriminates against the south eastern states of Australia, particularly NSW, given it has the highest Aboriginal population. In addition, the Commonwealth classifications of 'remote and isolated Aboriginal communities' excludes the vast majority of the Aboriginal population in NSW.

Funding patterns tend to ignore that urban and rural Aboriginal communities[61] have the same burden of illness as their counterparts in remote and isolated areas and would suffer the same disadvantage in accessing the otherwise readily available mainstream services. Furthermore, that urban and rural ACCHS have similar problems in recruiting and retaining professional staff.

3. Sources of Funding & Funding Issues

The Deeble Report found that:

> "..the largest single source of the Commonwealth's expenditure was through OATSIHS grants to community controlled Aboriginal Health Services." [but they] ..received very little [funding] from the two largest Commonwealth programs of Medicare and the Pharmaceutical Benefits Scheme. Per person, their benefits under Medicare were only 27 per cent of the average for non Indigenous people and the proportion was only 22 per cent for prescribed drugs. OATSIHS programs offset much of the difference. However, the total Aboriginal Health Service grants, Medicare benefits and Pharmaceutical Benefits was still bout $100 per person less than other Australians received from Medicare and Pharmaceutical Benefits alone."[62]

The NACCHO Submission to this Inquiry[63], discusses Medicare (MBS) and the Pharmaceutical Benefits Schemes (PBS) and the issues in some detail. As the AH&MRC endorses this Submission it seems pointless to reiterate these here. NACCHO has been involved in efforts to increase utilisation of these schemes by Aboriginal people.[64]

In relation to Aboriginal funding from the Commonwealth, the NACCHO Submission states that approximately 63 cents per head is spent by the Commonwealth on health services to Aboriginal and Torres Strait Islander people, for each dollar spent per head on the health of other Australians. Of this 63 cents, only a small portion is spent on culturally acceptable and effective services to Aboriginal people. This indicates that the most acceptable means of delivering health services to Aboriginal

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[60] Deeble, J., et al, *Expenditures on Health Services for Aboriginal & Torres Strait Islander People*, 1998, Commonwealth Department of Health and Aged Care, p.viii

[62] ibid, p.
[63] NACCHO Submission to the Commonwealth Grants Commission Indigenous Funding Inquiry, 1 May 2000.
[64] Main Finding 45

people is being generally neglected in favour of mainstream services which have been shown to not adequately meet the health needs of Aboriginal people, as evidenced by continuing poor health status of Aboriginal people.

At the State level, Aboriginal health funding is provided to ACCHS through the Aboriginal Non-Government Organisation (NGO) Funding Program. This was established in 1987 following the NSW Ministerial Committee of Review[65] and comprises the three areas of Dental Health, Public Health and Drug and Alcohol.

Of major concern to ACCHS is the convenient designation of the Aboriginal NGO Program as 'supplementary funding' with no built in CPI provision nor associated employment costs like superannuation and award wages, quite apart from any necessary vehicle or other resources to provide services. Consequently, ACCHS are being told to meet these costs from within their own budgets. This situation has created virtually insurmountable difficulties for ACCHS with staff being laid off on a number of occasions.

In one ACCHS push bikes were actually being used to carry sensitive ear testing equipment, and in another, a Coles shopping trolley was used, because no on-costs had been provided under the Commonwealth funded program. It is incumbent upon funding bodies when planning such programs to carry out realistic costing in order to provide appropriate funding to support service delivery.

Equally inappropriate is the 2% annual 'Efficiency dividend' imposed on ACCHS. In reality these accounting measures have devastating consequences in the ACCHS sector with either staff positions eventually having to be eliminated to comply with industrial obligations to staff or, for smaller ACCHS, the actual rejection of the grant due to financial impositions upon the Service. Whilst such programs may have relevance within mainstream services or departments they are unconscionable when applied to health funding the ACCH sector.

In May 2000 the House of Representatives Standing Committee recommended in its final report, *Health is Life Report*[66], that:

> "The Committee is proposing that a new funding approach be developed which provides for a pooling of Commonwealth, State, Territory and community funds at the regional level, and that the community play the primary role in determining the allocation and use of these funds."

This recommendation and early intimations that funding priorities will be determined at the regional level by the 'Aboriginal community representatives' and relevant stakeholders give rise to some concern for the ACCH sector. The following history is given to illustrate the nature of that concern.

The transition for the carriage of Aboriginal health from ATSIC to the Department of Health and Aged Care was considered essential at the time by the vast majority of ACCHS throughout the country. The action to seek such a transition was not due to any deficiency in the elected arm process within ATSIC but an acknowledgement of the lack of relevant health expertise within the administration of ATSIC. Admittedly, ATSIC had only 6 staff specifically employed in the health area compared to the two hundred plus staff employed in OATISH today. Of equal importance at the time was

[65] Ministerial Committee of Review into Aboriginal Health Services, 1987, NSW
[66] *Health is Life*, Report of the House of Representatives Standing Committee on Family and Community Affairs, 2000, p.14

the function of the ATSIC Councils having responsibility for approving routine applications for recurrent funding for ACCHS as well as allocating priorities for all programs in Aboriginal Affairs. This posited ACCHS with their specific health programs, determined by various Agreements, Strategies and Policies (in particular the NAHS), against all other Aboriginal organisations within the Arts, Employment, Housing, Legal Services, Land Rights, Environmental Health and Welfare.

Invariably, any increase in expenditure to redress ill-health in a given application, whether determined by formal health needs analyses or departmental programs, were not examined on their merits and funding was seen to be the sole discretion of the Councils. Whilst having discretionary judgement most increases were determined by ATSIC central office by an across the board percentage (%) increase, linked closely to CPI, whether such expenditure met established needs or not.

The very specialised expertise to evaluate health issues was not available within the ATSIC administration at that time and it was an imposition to have committed Councillors, without specific experience or expertise in health, making evaluations and judgements on complex aspects within each ACCHS application. Councillors with an interest in the organisation whose funding proposal was to be discussed had to exclude themselves from any discussion on their submissions thus precluding the opportunity to give guidance about the relevant policy context. There were inordinate delays in the process to approve routine budgets, whilst salaries had to be met and allocated grants had to be immediately accepted. Yet, the ACCHS had to await the completion of the evaluation process of all applications covering every aspect of Aboriginal life and circumstance.

The ATSIC Act (1989) and the Memorandum of Understanding (MOU) between ATSIC and the Federal Health Department have specific provisions for Regional Councils to provide input through their regional Plans for every aspect of Aboriginal life and circumstance within their region. Advising, planning and monitoring of all government expenditure for Aboriginal people is explicit in the Act. In the MOU involvement of Regional Councils in every aspect of Aboriginal Affairs entitles ATSIC Regional Councils to ensure that all government expenditure is monitored and that, for example one area of responsibility, namely, health, is closely evaluated. However, apart from environmental health, ATSIC does not have carriage of health and its role in health is one of advising, monitoring and suggesting priorities for health expenditure.

The current discussion about the introduction of ATSIC Regional Authorities within NSW is a matter concerning the Aboriginal communities in those areas. Suggestions have been made to AH&MRC member organisations that it is envisaged that such a new regional body would have carriage for Aboriginal health in regions within NSW and would have the discretionary capacity to close ACCHS if they so chose. Such a situation would be counterproductive and unacceptable. Any attempt to promote regional autonomy at the expense of local autonomy should be carefully examined in light of the widely acknowledged importance of local Aboriginal community control in the improvement of Aboriginal health and the emphatic endorsement of this principle in every relevant document on Aboriginal health since 1979. Similarly, any process whereby ATSIC Regional Councils again have actual oversight and evaluation of ACCHS budgets and routine health processes with funding responsibilities for ACCHS would be rejected for the same reasons that the transition was effected in 1995.

The ACCH sector requires ATSIC's assistance to enable closer scrutiny of secondary (hospital) and tertiary (specialist) levels of health care provided by State

and Federal governments. Such a process will ensure monitoring of access and equity in health care provision for Aboriginal people.

Likewise, the suggestion of Area Health Services determining Aboriginal health allocations at the regional level defies the existing Partnership arrangements at State and Local/Area levels in NSW. These Partnerships were developed in order to bring the health expertise of the Aboriginal community controlled health services to the health care processes with the aim of addressing Aboriginal health problems in their areas and of implementing health policy and strategic plans. The co-ordination of resources to maximise outcomes can also be achieved through this structure.

One important factor in the ACCH sector is its capacity to have economies of scale and low administration costs with a very high proportion of its allocated funding being directed channelled into health services. This capacity to be cost effective should attract the attention of governments especially in light of the ever spiralling staff numbers within the health bureaucracy.

There are already agreed Performance Indicators and Outcome orientated procedures that ensure that the ACCH sector can responsibly self regulate and provide value for money in the provision of its services.

It was probably due to some of these contributing economic factors that the Parliamentary Standing Committee on Indigenous Health at its meeting in NSW asked the representatives from the ACCH sector for a response to the suggestion of funding the ACCH sector directly.

If such a positive program were implemented it would need to be introduced over a five year period with adequate training programs to accommodate the transition. It was also recommended by the ACCH sector representatives present that it should be done preferably at the State/Territory level where most of the health programs are initiated and government policy implemented and constructive relationships currently exist between the State Office of OATSIH and the NSW Department of Health.

Whilst such a suggestion has much merit, potential for government savings and opportunities for major advancement in Aboriginal primary health and associated statistics, it would require a comprehensive evaluation at the most senior level and probably such an exercise is beyond the parameters of this enquiry other than to examine its possibilities for future directions.

The following quote is an example of one occasion where the government demonstrated it's reluctance to fund the sector for the provision of urgently needed specialist services.

> " ..It came to a head recently where a surgeon in northern NSW retired and offered his services to the Aboriginal community in lung and cardio-vascular matters. He wrote to Senator Herron, and Senator Herron referred him to us [AH&MRC]. We accepted his offer, and arranged a schedule to fly him all over the northern part of the state. When we wrote to the Department of Health and Aged Care through OATSIH, we were informed that they could not help us. We were only after $5000 for air fares. This man gave his services free, and they

> said they could not help us because they did not see us as a service-providing body, that we were only a co-ordinating organisation."[67]

The absence of any recommendation relating to the direct funding of the Aboriginal community controlled health sector in the final report of the Standing Committee, *Health is Life*, is in itself conspicuous.

ACCESS ISSUES

In it's Submission to this Inquiry, NACCHO noted:

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

In a submission to the Inquiry into Indigenous Health by the House of Representatives Standing Committee, Walgett AMS encapsulates the barriers to access to equitable, effective and timely health services.

> "Barriers to access
> - the covert racism that exists with the health care system, stereotyping of Aboriginal people as being lazy, dirty and wasting their money.
> - Ignorance by health professionals about Aboriginal culture, particularly family ties and family structures…
> - Lack of access [to] public transport, especially in remote and rural areas."

Regrettably, in many instances, mainstream health services still reflect racist attitudes. All health care systems have their own cultures embedded within them and cultural barriers are profound enough to discourage Aboriginal people from accessing mainstream services and can be a potent disincentives to access.

The most far reaching effect of institutional racism is the refusal by the public health sector at all levels (funding, education and service provision) to acknowledge Aboriginal community controlled health services as legitimate providers to Aboriginal people. This lack of recognition was acknowledged in the *Inquiry into Indigenous Health Discussion Paper*[68], referring to states assuming responsibility for funding and service delivery, namely:

> "However, given the degree of difficulty the community controlled services have experienced in accessing State funding and in gaining acceptance from mainstream providers it may be that such an approach would ultimately lead to the disenfranchising of the community controlled sector."

It may be of assistance to draw attention to this Council's position in the AH&MRC Monograph Series[69] It is consistent with the NAHS in advocating that primary health care in the Aboriginal community is only culturally appropriate through the ACCH sector

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[67] Official Committee Hansard – House of Representatives Standing Committee on Family and Community Affairs – Indigenous Health, Commonwealth of Australia,1.12.99, p.1368

[68] Commonwealth of Australia - House of Representatives Standing Committee on Family and Community Affairs– Inquiry into Indigenous Health - Discussion Paper, 1999, p.16 para. 2.65

[69] AH&MRC Monograph Series Vol.1 No. 1 (1999) *Primary, Secondary and Tertiary Health Care Services to Aboriginal Communities*

with secondary (hospital) and tertiary (specialist) care being the responsibilities of the health departments and Area Health Services. Where primary health care services to Aboriginal people exist outside of the ACCH sector it is by default due to lack of resourcing and funding by governments and Area Health Services.

Main Finding 42 of the Draft Report of this Inquiry deals with Indigenous people's poor access to adequate primary health care. These barriers were identified in the *Local Aboriginal Health Plans* and described in the *NSW Aboriginal Health Strategic Plan* when addressing access issues.

"The National Aboriginal Health Strategy 1989 recognised Aboriginal community controlled health services as being the 'most efficient and effective way to deliver holistic primary health care to the Aboriginal community'. This approach incorporates the principles of Aboriginal community control and cultural appropriateness. The principle of Aboriginal community control is also an integral part of the NSW Aboriginal Partnership. The NSW Department of Health is committed to improving health outcomes for Aboriginal people through greater access to both mainstream and Aboriginal specific health and related programs.

"The range of primary health care providers in NSW comprises of Aboriginal community controlled health services, health services provided through the public health system and general practitioners (GP's). Studies reveal that while Aboriginal people under utilise the public health system and GP services, their use of in-patient services is high. A range of issues impact on the access to and utilisation of primary health care services, including distance, cost, lack of information cultural insensitivity. In some regions access to GP's who bulk bill is non-existent. Access to specialist services throughout many parts of NSW is severely limited by distance and availability.

"Improving access to health services involves effective networking within the Partnership structure. The strategies in this Plan are aimed at addressing the obstacles through a partnership approach." [70]

A number of strategies have been jointly developed to address these issues. Another significant barrier to access to health services is availability of transport. The majority of Aboriginal people in NSW rely on public transport to access health services. In all areas, urban, rural and remote, there are difficulties in obtaining timely and affordable transport. The reliance on public transport increases the need for overnight accommodation in addition to travel costs.

Following the revision of the Isolated Patients' Transport Accommodation Assistance Scheme (IPTAAS) in NSW, there is still concern about the necessity for patients to meet costs in advance and that the scheme is not a full refund scheme. At this stage criteria to enable advance payments in situations of financial hardship to the patient are so restrictive that the scheme may still be inaccessible to Aboriginal people needing specialist services.

A further issue of concern is the obligation for Area Health Services (AHS) to provide culturally sensitive and accessible health services to the entire population residing in that geographic area, including Aboriginal people. This must be achieved through their global budget. It is unconscionable for AHS to be competing for funding which is allocated for Aboriginal specific programs and/or NGO programs. It is of great concern that some AHS are successfully competing with ACCHS for such funding in an attempt to duplicate the role of the ACCHS in the delivery of primary health care. As stated previously, only ACCHS can provide culturally appropriate primary health care to Aboriginal people.

[70] NSW Aboriginal Health Strategic Plan, 1999, p.7

Finally, access to health services by Aboriginal inmates of correctional centres in NSW is being addressed within a Partnership Agreement between the AH&MRC and the NSW Corrections Health Service (CHS) as well as a series of service agreements between individual ACCHS and the CHS. The CHS is committed to the principle of Aboriginal community control and the *NSW Aboriginal Health Strategic Plan* and has completed it's own *Aboriginal Health Strategic Plan*.[71](copy attached).

CONCLUSION

As stated in the introduction, the issues raised in the Main Findings are not new to Aboriginal people and the Aboriginal community controlled health services in particular. In preparing this submission the most distressing fact is that in January 2001, so many reports, recommendations and plans remain unimplemented.

In the words of the Chairperson of NACCHO, Mr Puggy Hunter:

> "We've got enough reports sitting on shelves. Time and time again government inquiries have recommended greater self determination, environmental improvements, and the involvement of Aboriginal people at all levels of health service delivery. It's time for the Government to put their money where their mouth is and stop the rhetoric."[72]

These reports unanimously echo what Aboriginal community controlled health services have been calling for since 1971.

> "There appears to be a fundamental lack of urgency in the Federal Government's approach to Aboriginal health. It is a *steady as she goes* approach. But [this] is not good enough when Aboriginal people are dying 15 to 20 years younger than the rest of the population."[73]

The criticism that vast amounts of funding are continually expended in Aboriginal health with out any tangible evidence of improvement only jeopardise the actual funding for crucial programs, further protracting the deplorable situation of Aboriginal health.

The intolerable status of Aboriginal health and the complex causative factors are not in dispute and whilst it is acknowledged that tangible benefits may not be immediately statistically evident, the necessity for sound planning and policy development have provided a solid structure to ameliorate ill health in the Aboriginal community.

The basic tenet within the NAHS 1989 is that the ACCH sector should have unfettered responsibility for primary health care, and that governments and departments assume their rightful role in providing Secondary (hospital) and Tertiary (specialist) health Care.

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