COMMONWEALTH GRANTS COMMISSION

INDIGENOUS FUNDING INQUIRY

SUBMISSION

From: Department of Health and Aged Care

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COMMONWEALTH OF AUSTRALIA

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Mr A G Morris
Chairman
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Cypress Court
5 Torrens Street
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Dear Mr Morris

Indigenous Funding Inquiry - Draft Report

Thank you for the opportunity to respond the draft report of the Indigenous Funding Inquiry, and to attend the conference held in November last year.

As the Department indicated at the conference, we are supportive of the major conclusions, directions and principles outlined in the draft report in so far as they relate to Indigenous health issues. There were also some parts of the draft report which we thought needed further consideration and it is these areas that are the focus of our further submission

The Department's response to the draft report is enclosed. We stand ready to discuss our response, or related issues in more detail with the Commission.

Yours sincerely

D.W. Borthwick
Acting Secretary

January 2001

DEPARTMENT OF HEALTH AND AGED CARE

SUBMISSION IN RESPONSE TO
COMMONWEALTH GRANTS COMMISSION
INQUIRY INTO INDIGENOUS FUNDING DRAFT REPORT
JANUARY 2001

In general, the Department is supportive of the major conclusions, directions and principles outline in the draft report in so far as they relate to Indigenous health issues. Notwithstanding the considerable additional resources directed toward Indigenous health in recent years, total per capita expenditures on health for Indigenous people is only marginally more than that for the total population, and is much lower than could be expected given their health status and location.

The Department would like to respond to a number of particular issues raised by the draft report. These are addressed below.

Financing Arrangements

Chapter 5 (Intergovernmental Issues and Possible Ways Forward) outlines some common themes and overarching principles to guide future funding arrangements. The Department supports these, and notes that they are consistent with the approach that the Government has taken with the Framework Agreements and the Forums in each state and territory. This approach has guided recent developments in service delivery development, such as the coordinated care trials and the Primary Health Care Access Program (PHCAP).

The possible approaches to change outlined in Chapter 5 (Intergovernmental Issues and Possible Ways Forward) include suggestions for improving the operation of existing SPPs and strengthening the conditions of new SPPs. While we appreciate that many, including Indigenous communities, may feel that some conditions and reporting requirements can seem to have limited affect in directing how and where resources are allocated, the ability of the Commonwealth to enter into agreements with the States and Territories that have tight conditions and terms is in actually rather limited. The Australian Health Care Agreements (AHCAs), for example, constitute a significant portion of state budgets, and for the states there is a very strong imperative to retain as much flexibility as possible. However, improved access to health programs for Indigenous peoples is recognised in the AHCAs and Public Health Outcome Funding Agreements (PHOFAs) as a core national priority and both agreements contain specific Indigenous performance indicators that the States are required to report on. Moreover, as indicated at the conference convened by the Commission, State spending, especially on acute care has been at a relatively high level (reflecting the complex health needs that are presented in hospital settings).

There has been a recent trend to increase the flexibility afforded states in financial grants from the Commonwealth; for example the PHOFAs broadband a number of grants for population

health programs, while maintaining accountability through agreed performance indicators.

A further factor in maintaining accountability is the need for data through which performance can be monitored. At this stage, this is compounded by the lack of data in some basic areas, such as an Indigenous identifier in Medicare data and the issues around the quality of hospital data. The Department is continuing to work with state governments and the Indigenous community on such issues.

The draft report supports funds pooling. The Aboriginal and Torres Strait Islander coordinated care trials have demonstrated the benefits of funds pooling. The national evaluation of the trials will be available shortly, and the Commission may wish to consider the lessons from the trials, being cognisant that this is only one of a number of approaches that can be drawn up to improve the effectiveness of Indigenous health programs.

The key need is to get coordination of effort and this central to the approach that the Government has taken not only through the coordinated care trials, but more significantly the implementation of PHCAP. The emphasis is on working with jurisdictions and Indigenous communities to ensure that funding is related to regional needs, and to develop a coordinated and integrated approach to expanding services at the local level.

The draft report also raises the idea of state level Indigenous controlled bodies being responsible for allocating funds to regional or local service delivery processes. We do not support this approach in the health arena:

- One perspective is that such a body would add another layer of administration and accountability without commensurate benefit (or at least benefit that could not be achieved more effectively by other collaborative means).

- More significantly in terms of overall effectiveness, the health system is complex, and services for Indigenous people are provided by both Indigenous specific and mainstream programs. It is important therefore, that the whole health system works well for Aboriginal and Torres Strait Islander people. An integrated approach to both mainstream and Indigenous specific health care programs is needed, which would not be fostered by this particular approach.

- We would suggest, therefore, that a more productive approach, recognising the contributions that all parties can and need to bring is through the partnership approach which is central to the Framework Agreements, and regional planning, all of which are manifested in the roll out of PHCAP. While this approach is still in the initial stages of translating the Agreements into developments in service delivery at the regional and local level, the progressive implementation of PHCAP will see this occur.

To help you gain a better appreciation of the above perspectives it might help to give an illustration from the Northern Territory to show how effective this collaborative approach can be.

The Framework Agreement commits the partners to joint regional planning to identify need and provide a more equitable and rational basis for the allocation of additional resources. The partners meet regularly as the NT Aboriginal Health Forum and the decision to approve the

first four priority zones for the implementation of PHCAP in Central Australia was based on the advice of the Forum.

In the NT a Forum working group on PHCAP was established to focus on this initiative and to consider the policy and implementation issues at a Territory wide level. The working group has representation from all four partners and has developed agreed policy on joint funding arrangements, the nature of comprehensive primary health care, a process of calculating the current primary health care resources from both funders, funds pooling arrangements and joint processes to engage the communities. The funding arrangements are being formalised through a Memorandum of Understanding between the Commonwealth and the NT to ensure transparency and that funds are "locked in".

The Forum partners have agreed on a local planning process to determine the best use of the current and proposed additional resources which ensures that there is local flexibility to take account of local needs and maximise the resources available. The planning process will engage the local communities in the planning of their local services and will concurrently consider the most appropriate short and longer term arrangements so that individuals and communities can take greater responsibility for their health. By its nature the process will contribute to building community capacity and in considering options will take into account the community capacity and the extent to which the community wishes to participate in the management of the local services.

The Department also notes that the Framework Agreements are agreements with states and the community sector, rather than agreements with the states only. The members of the State Forums are the Commonwealth, state, ATSIC, and the community controlled health sector.

Primary Health Care

The draft report notes that Aboriginal and Torres Strait Islander peoples' access to primary health care must be improved, and suggests a faster approach to addressing this. The objective of the PHCAP is to address this issue through an integrated approach across both the mainstream and Indigenous specific parts of the health system; it incorporates a mix of grant funding and MBS funding to contribute to service delivery, PBS access and local system development. It is not clear what the Commission means by 'a faster approach'. However, the Department would like to note that these there are some factors constraining factors the rate at which service expansion can be achieved.

There is a need to build a robust primary health care system that Aboriginal and Torres Strait Islander people can and will use. The rate at which expansion can occur is influenced not only by overall available funds, but the rate at which arrangements that make effective use of funds can be developed, and the need to take account of the capacity of Indigenous communities to be actively involved.

Time is required to build partnerships, develop Regional Plans into local plans to drive planning and service development, and develop funding and other arrangements with state bodies. In some cases, the establishment of capacity (of local communities and services to participate in planning, delivery and management) and infrastructure (such as capital works development) is necessary.

While clinical services using external service providers can be increased without establishing this base, it is harder to effectively utilise funds for broader population health aspects of comprehensive primary health care in the absence of local community capacity development. There are already significant funds in the forward estimates to allow a comprehensive process of service system development to take place in some areas. Expansion beyond the currently identified areas will require investment of further funding over realistic timeframes, possibly with full development occurring over a period of a decade.

Measures of need

With regard to the two proposed measures of relative need outlined in the draft report, it is likely that the Minimum Level of Service model is probably the best in the short to medium term.

Multi Factor Model of Indigenous Health Need

It would be beneficial to have a model that responded to the multiple factors that influence the costs of Indigenous health services. However, the main issue with this model is the availability of data, particularly the lack of robust information about the relationship between the factors identified and health service costs. It does not seem probable that the information required for this model would be available in the short to medium term, nor is it available for the rest of the health system. Considerable development of information and data would be required before this model would be workable. The Department does not believe that the data required to enable this model to distinguish between regions could be developed to a point such that this would be a viable tool at this stage.

The Department also considers that in the unlikely event that a meaningful model could be developed, it would need to differentiate between need and capacity to use funding. The two should be separated; funding should be related to health needs (which is independent of capacity), while capacity to utilise funding is related to the rate at which funding for a particular region or jurisdiction increases.

Minium Level of Service

The Department considers that this model is probably the best approach for the short to medium term, although even in this instance it is not clear how sensitive this model would be to regions with dispersed populations, and the additional costs of service delivery in such areas.

This model is relatively simple, but incorporates the two key factors in determining resource levels for Indigenous health: health status and costs of delivery. It is similar to that developed for PHCAP.

Further work is required around establishing the costs of services in remote locations with dispersed populations. The Commission and the Department have had some discussion around this issue, and we would welcome your contributions in this area.

Comprehensive Primary Health Care

The draft report suggests that a 'holistic' rather than 'body parts' approach should be taken to Indigenous health. We believe that there is come confusion about the type of health approach that is required, and would like to take the opportunity to clarify the nature of the current arrangements. The framework of comprehensive primary health care incorporates a broad range of activities, and targeting specific conditions is one of its prongs. The key components of a comprehensive primary health care system can be described as:

- primary clinical/medical care covering he treatment of acute illness, emergency care and the management of chronic conditions
- population health and illness prevention strategies, for example, immunisation, antenatal care, screening programs and the prevention of infectious diseases
- specific programs to improve health, for example, nutrition, mental health and substance misuse
- facilitating access to secondary and tertiary health services, and
- client/community assistance and advocacy on health related matters within the health and non-health sectors.

This approach is consistent with the World Health Organisation's Alma Ata declaration 1978, and it underpins the approach taken to Indigenous health by the Government. While the system does not yet have the capacity to provide comprehensive primary health care in all regions, it is the long term objective and there are examples around Australia services are being delivered in this way.

Within primary health care services targeted strategies provide a mechanism to enable conditions that cause high rates of morbidity, mortality or disability to be addressed. These strategies provide evidenced-based approaches to enable effective intervention and prevention for a range of conditions.

While the Government funds Aboriginal Community Controlled Health Services (ACCHSs) for providing a flexible range of services to meet community health needs, it also provides some additional funds to enable services to target particular health conditions. These targeted funds enable an emphasis to be placed on providing services, such as immunisation, hearing health, sexual health and eye health, that otherwise might not have been able to be covered within the previous funding service base of the service.

Around 90% of the funds that the Office for Aboriginal and Torres Strait Islander Health provides to ACCHSs can be used flexibly to enable a range of health services to be delivered, with the additional 10% of funding provided to services for targeted health strategies.