COMMONWEALTH GRANTS COMMISSION

INDIGENOUS FUNDING INQUIRY

FINAL SUBMISSION

From: **National Aboriginal Community Controlled Health Organisation (NACCHO)**

Submission No.: IFI/SUB/0084
Date Received: 30/01/2001

ACN 078 949 710

Mr Bob Searle
Secretary
Commonwealth Grants Commission
Cypress Court
5 Torrens Street
CANBERRA ACT 2612

Dear Mr Searle

Re: Commonwealth Grants Commission's Indigenous Funding Inquiry

Please find enclosed NACCHO's written response to the Commission's draft report on the above Inquiry. This is provided as follow up to the verbal comments provided by NACCHO representatives to the Inquiry's Canberra Conference in November 2000.

NACCHO would like to congratulate the Commission and its staff on the high quality of the draft report. NACCHO welcomes the report, and we will be keen to contribute to the debate and policy discussions which are sure to result from the final report of the Inquiry.

I would also like to personally congratulate the Commission, and particularly the Chairman, for taking a firm and independent public stand with regard to the findings and recommendations of the Inquiry.

Yours sincerely

Puggy Hunter
Chairperson

ACN 078 949 710

National Aboriginal Community Controlled Health Organisation (NACCHO)

Response to the draft report of the Commonwealth Grants Commission's Indigenous Funding Inquiry

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NACCHO generally supports the findings and recommendations of the report relating to Aboriginal health issues (Chapter 6). NACCHO congratulates the Commission for presenting a comprehensive and balanced analysis of the issues, demonstrating the Commission's high level of understanding of this complex area.

NACCHO is pleased that the report acknowledges (Paragraphs 6 to 15):

- The poor health status of Aboriginal people.
- The need to address this by improving access to primary health care, and by improvements in housing and related infrastructure, environmental health, nutrition and education.
- The importance of Aboriginal involvement and decision making in improving access to services.
- The difficulties with getting reliable data and establishing reliable indicators in Aboriginal health.

NACCHO is especially pleased that the Commission has acknowledged the key point (Paragraph 15) that:

"We could find no evidence that any area had excessive resources relative to its total needs. This makes redistribution of existing resources from one area to another problematic."

The comments below relate mainly to areas of the report which NACCHO believes could be improved, but these comments should be seen in the context of NACCHO's overall strong support for the report.

The report discusses two possible approaches to measuring resource needs in Aboriginal health (Paragraphs 18 to 26):

1) Multi-factor model - This model would take into account:

- weighted health status (morbidity and mortality rates weighted according to cost-effectiveness of addressing various conditions)
- relative socio-economic disadvantage
- capacity to manage resources
- remoteness and consequent higher cost of delivering services
- barriers that Aboriginal people face in accessing existing services

NACCHO comments:

While most of these factors are important in terms of need for health care, the model is very complex and a great deal of effort could be put into measuring and calculating components of the model – effort that could better be put into addressing the glaring need for improved access to health care.

The calculations by Deeble for the AMA, which established the need for at least an additional $245 million per year to be spent on Aboriginal health, were based largely on health status, disadvantage, and remoteness. The calculations are relatively simple but are sufficient to establish the ballpark level of expenditure that is needed. More complex models and calculations are likely to come to very similar conclusions and have the potential to delay action.

Specific aspects of the model are also problematic. For example, how would "capacity to manage resources" be assessed? This has the potential to be very paternalistic). Also, with regard to barriers to access to existing services, the report makes the assumption that we should concentrate on "the costs of overcoming these barriers"; whereas NACCHO's view is that these barriers support the need for alternative, culturally appropriate forms of service delivery.

2)   Minimum level of service model –

This model concentrates on establishing the cost of the inputs required to deliver a minimum standard of service in each area.

NACCHO comments:

This is somewhat similar to what OATSIH's Output Costing Project aims to do. NACCHO's position has been that any model based on costing out inputs and outputs of primary health care needs to be based on a model of the core functions of Aboriginal primary health care services, developed and endorsed by the sector itself. NACCHO has also pointed out that it is not a simple task to establish the costs required in each area, as communities may have varying needs and preferences with regard to how their health care should be delivered.

The concept of "minimum level of service" also needs to be clarified. Does this mean that Aboriginal people should be satisfied with a lower level of health care than that available to others? Given the health care status of Aboriginal people, and the unmet need for access to health care, it would be much better, in NACCHO's view, to focus on "optimal" rather than "minimum" standards.

The report then goes on to discuss measures of access to mental health and substance misuse services, acute care, including patient transport and hospital services, and aged and community care.

NACCHO comments:

The report acknowledges (Paragraph 31) the need for improved access by Aboriginal people to patient transport services and emergency airlift. NACCHO has repeatedly raised the need

for improved funding for and access to Patient Assistance Transport Schemes (PATS) – see our original submission to the Inquiry.

The next section of the report (Paragraphs 34 to 44) outlines roles, responsibilities, and resource allocation in Aboriginal health, covering:

- Commonwealth and State areas of funding responsibility
- Levels of expenditure (based on the Deeble report)
- The role of various services providers including ACCHSs, private GPs, State health clinics, hospitals, RFDS, aged care services
- The fact that funds are provided on a program by program basis, which means a "body parts" approach, but that there are some moves towards alternatives such as funds pooling
- The fact that distribution of resources varies between programs and is sometimes based on various definitions of need, and in other cases mainly historically based.

NACCHO comments:

NACCHO members have consistently observed that Aboriginal access to health care services bears little or no relationship with "need", however measured.

The next section of the report deals with **"Major issues and themes"**, including:

- **Co-ordination of service provision and partnership arrangements (Paragraphs 46 to 49): The report notes the importance of effective agreements and partnerships between levels of Government and Aboriginal communities.**

NACCHO comments:

NACCHO has long acknowledged the importance of "intersectoral collaboration" and this was a key theme in the National Aboriginal Health Strategy (NAHS). The "buck-passing" between Commonwealth and States is a major impediment to reform in Aboriginal health. The Aboriginal Health Framework Agreements are intended to address this area, and it is an area that NACCHO, its affiliates and member services have all been actively working on. The issue with the Framework Agreements is the lack of commitment in some areas to true consultation (eg the need for engagement of all partners in decisions about resource allocation), and lack of commitment to adequate needs-based funding for Aboriginal health.

- **Primary health care services (Paragraphs 50 to 79): The report notes that "it is crucial to ensure effective primary health care is provided to all" and acknowledges Deeble's finding for the AMA that at least another $245 million per annum is needed.**

NACCHO comments:

Poor access to Medicare is noted in the report, along with the reasons for this and the range of initiatives being undertaken to address this, and the limitations on these measures

(Paragraphs 55 to 57). While the measures being undertaken to improve access to Medicare are welcome, they cannot in themselves ensure equitable access to primary health care for Aboriginal people. Greatly increased resourcing for Aboriginal primary health care is needed.

The report also comments (Paragraph 56) that uptake of Medicare by ACCHSs is slower than expected. What is the data to support this?

The report notes poor access to the PBS, along with the reasons for this, and includes a discussion of the Section 100 program (Paragraphs 58 to 59). The report notes the success of Section 100 in remote areas but states that: "since this reform is unlikely to be applied in urban areas where medicine is dispensed through private pharmacists, other options should be examined." NACCHO's position has always been that Section 100 is needed and can and should be made available in all areas. The program uses private pharmacists as the supply route, and has been successfully implemented in remote centres such as Alice Springs and Kalgoorlie where several private pharmacies operate. The Government, the Pharmacy Guild, and NACCHO are now undertaking discussions under the auspices of the Australian Pharmaceutical Advisory Council, around the potential to extend the program to non-remote areas.

The report notes (Paragraph 60) that "mainstream health services are not always culturally appropriate" (NACCHO would say this is a huge understatement); and discusses the need for community involvement and the role of, and funding for, the ACCHS sector. There is a comment in the report (Paragraph 62) that some ACCHSs, particularly in rural and remote areas, also provide services to non-Aboriginal people. In fact, all ACCHSs would provide some services to non-Aboriginal people, and the Service Activity Reporting (SAR) data shows that the average is around 10% of ACCHS consultations being provided for non-Aboriginal people.

The report also states (Paragraph 64) that ACCHSs vary considerably in terms of size and the variety of activities conducted, and consequently the funding required. It would be more accurate to say that ACCHSs vary considerably in terms of their funding base, and consequently in their size and the range of activities they conduct.

It is noted that "during consultations some parties raised the issue of the need to evaluate the outcomes of ACCHSs" (Paragraph 66). This refers to looking at the health outcomes from the ACCHS sector (which goes beyond the activity data from the SAR). The Commission needs to acknowledge the complexity of the task – there are many contributors to the poor health status of Aboriginal people including environmental and lifestyle issues which are not always within the power of ACCHSs to address.

NACCHO strongly supports the statement at Paragraph 67: "We believe greater involvement by Indigenous people in the delivery of primary health care services, based on a holistic rather than a body parts approach, is important. There is also a need to ensure that funding for community based medical services is provided in the most effective manner, and this could include long term agreements and the pooling of funds where appropriate."

The report discusses the Primary Health Care Access Program (Paragraphs 70 to 72) and notes that the $78.8 million made available over 4 years (1999 Federal Budget) is expected to cover services in SA, Central Australia, and parts of Queensland. However, NACCHO understands that about half of this allocation has already been earmarked for continuing the 4 Aboriginal co-ordinated care trial sites (WA, Tiwi, Katherine West, and Wilcannia), and Departmental costs also need to be taken out, so there is actually considerably less than this available for new services under the PHCAP.

- **Acute care services (Paragraphs 80 to 91):**

NACCHO comments:

It is noted that hospital funding is usually weighted for the higher costs of providing care to Aboriginal people, but that many people argue that the weightings are inadequate (Paragraphs 83 to 85). It is important to improve the accountability to ensure that such weightings are used to actually provide adequate care to Aboriginal patients, encompassing both clinical care and social and cultural issues (eg Aboriginal involvement in hospital boards, Aboriginal liaison officers in hospitals, accommodation for family members, etc).

Observations and conclusions (Paragraphs 94 to 107)

- "…It is clear that health status will not be improved without greater access to health services and concurrent improvements in other areas such as housing, infrastructure, environmental health, nutrition, education and training" (Paragraph 95). *Comment: Agree.*

- Measuring need is complex, and the Commission is looking at two possible approaches – the multi-factor model and the minimum level of service model (Paragraphs 96 to 97). *See earlier comments.*

- "…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" (Paragraph 98). *Comment: Agree.*

- "…there is no evidence to suggest that any State, region or location has resources excessive to that needed to address Indigenous health need. We note that the Commonwealth has slowly increased expenditure on primary health care and is continuing to expand programs in this area… We will consider whether there are ways in which this could happen faster" (Paragraph 99). *Comment: Agree.*

- "…The need for access to a minimum level of service is greater in rural and remote areas. Indigenous access to the main sources of funding for primary health, Medicare, and PBS is poor. While the ACCHSs are able to fill the gaps to some extent, they are only part of the answer" (Paragraph 100). *Comments: All Aboriginal people need equitable access to appropriate primary health care services, not only those in rural and remote areas. Cultural barriers can be just as problematic as distance barriers, if not more so. ACCHSs have a huge role in providing primary health care to Aboriginal people – the SAR data for 1998-99 shows this sector provided almost one million occasions of service over the twelve month period. With improved funding for the ACCHS sector, ACCHSs could fill far more of the gaps than they do now, and could be an even bigger part of "the answer".*

- "…partnership arrangements… are a key to ensuring effective service provision" (Paragraph 101).

- "Poor access to primary health care must be addressed. This would require a co-ordinated approach that should include greater involvement by Indigenous peoples in the delivery of services, continuation of initiatives to include Medicare funds more effectively, and reform to PBS arrangements" (Paragraph 102). *Comment: Agree.*

- "Services that support Indigenous access to acute care [hospital] services, such as patient transport, accommodation, and follow up care require substantial improvement…" (Paragraph 103). *Comment: Agree.*

- "…The flexible forms of provision through [aged and community] care packages have improved responsiveness to Indigenous need, suggesting that a greater focus on this type of delivery would help improve access for Indigenous people" (Paragraph 104). *Comment: Agree.*

- Paragraph 105: "Health outcomes will only improve with concurrent advancement in education, housing, and environmental health.." *Comment: Agree.* "There are examples where special initiatives are working, including the co-ordinated care trials in health…" *Comment: Our understanding is that the mainstream co-ordinated care trials have not shown improved health outcomes or any other major gains; the Aboriginal co-ordinated care trials, which are funded differently, have improved access to primary health care, but this is likely to be simply through the injection of considerable new funding into the areas in question, rather than to the co-ordinated care model itself.*

- "Mainstream delivery systems must provide effective and accessible services for Indigenous people…" (Paragraph 106). *Comment: Agree, but mainstream services can never be a substitute for ACCHSs. The model of service delivery with ACCHSs is quite unique, as demonstrated by the SAR data.*

- Paragraph 107: "It is important to attract an appropriate number of qualified health specialists to more remote areas, to improve the training of all health professionals in the delivery of services in a culturally appropriate manner and to emphasises the importance of the education and training of Indigenous health professionals". *Comment: Agree that these are all important issues, but they are not just issues for remote areas – workforce issues and shortages are important across all areas in Aboriginal health, urban, rural and remote.*

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UPDATE ON ACTIVITIES OF COMMONWEALTH-FUNDED ABORIGINAL PRIMARY HEALTH CARE SERVICES (DERIVED FROM 1998-99 SERVICE ACTIVITY REPORTING DATA)

Across the 110 Services that provided Service Activity Reporting data for 1998-1999, approximately 1,060,000 episodes of health care were provided to an estimated total health service population of 515,000 Aboriginal and Torres Strait Islander people. (This population estimate includes some overlap between services).

A broad set of indicators (rather than a comprehensive set of activity statistics) was reported on by each Service. A National Summary report was prepared jointly by OATSIH and NACCHO and reports are being prepared for each Service showing how they compare with their State/Territory averages.

Nearly 40% of Services were classified using the ARIA system as 'Remote' or 'Very Remote' - predominantly in NT, WA and SA.

By far the majority of Services provide health related community support services (such as transport to medical appointments, community development work, support for public housing, legal/prison advocacy services, women's and men's groups) in addition to their primary health care caseloads – and as such are unique in this respect. Further, most directly address certain substance misuse issues in their communities.

Seventy per cent of Services operate 'outreach' services to communities beyond their immediate locations. Sixty per cent operate some form of dental service and seventy-seven per cent, some form of hearing services.

Approximately one third provide clinical services to prisons nearby.

Staffing is predominantly Indigenous (68%) but nearly all doctors, dentists, specialists, and even nurses, are non-Indigenous. Few Services have dedicated accountants or book-keepers, trainer/educators - and extremely few have 'Information Technology/Data' positions or Environmental health workers'.

Completed forms for over one half of all Services have already been received for the 1999/2000 year. NACCHO and OATSIH will meet soon to set new directions for SAR reporting.