

## CHAPTER 6

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### HEALTH

1. We have addressed Indigenous health by examining:
  - (i) **primary health care** — including services provided by general practitioners, community health, hospital non-admitted patients, accident and emergency services, dental health, and preventative and public health programs (including elements of environmental health);
  - (ii) **acute care services** — including services normally provided in a hospital and support services such as patient transport; and
  - (iii) **aged and community care** — including residential care, home and community care and assessment services.

2. The focus of our work has been on primary health care as improving services and increasing the use of these services will enable Indigenous people to improve their health status most rapidly. Better primary health care for Indigenous people will change the pattern of use of acute care facilities. It will lead to reductions in the late presentation of illnesses requiring hospital care, and will reduce the use of hospitals for primary care.

3. In this Chapter, we present an overview of Indigenous people's health characteristics and highlight the circumstances that impact on their health outcomes. We then provide an overview of health programs and funding, followed by a detailed look at primary health care, an outline of possible needs assessment approaches and draw together the main issues and themes. We also outline needs assessment processes and issues in both acute care, and aged and community care. More detailed information on health is in the Supporting Material to this Report.

#### HEALTH CHARACTERISTICS AND CIRCUMSTANCES OF INDIGENOUS AUSTRALIANS

4. The health status of Indigenous Australians is much poorer than that of other Australians. It is also poorer than in other Indigenous societies with similar historical circumstances. Key indicators of Indigenous health status are as follows.

- (i) Based on data covering the period 1997 to 1999, life expectancy at birth was 55.6 years for Indigenous males (76.2 for all Australian males) and 63.0 years for Indigenous females (81.8 for all Australian females)<sup>1</sup>. This is a difference of over 19 years between Indigenous and non-Indigenous Australians. In New Zealand, the gap between Maori and non-Maori life expectancy rates is 5 to 6 years; in Canada, the gap between Indigenous and non-Indigenous people is 7 years; and in the United States of America, the gap between native Americans and others is 3.5 years<sup>2</sup>.
- (ii) In 1999, the Infant Mortality Rate (IMR) for Indigenous Australians was over two and a half times the average Australian rate (14.1 deaths per 1000 live births compared to 5.7)<sup>3</sup>. Babies born to Indigenous mothers are almost twice as likely as non-Indigenous babies to be of low birth weight<sup>4</sup>. Of 8151 births to Indigenous mothers in 1997, 13.1 per cent were of low birth weight<sup>5</sup>. Low birth weight babies are more likely to have poor health and die in childhood.
- (iii) The rate of hospitalisation in public hospitals for Indigenous people is around twice that of non-Indigenous people<sup>6</sup>.

5. While there have been improvements in Indigenous health status over the past thirty years, there is no consistent trend.

- (i) Indigenous life expectancy is not increasing at the same rate as non-Indigenous life expectancy. Consequently, the gap between Indigenous and non-Indigenous life expectancy is increasing<sup>7</sup>. For example, between 1989 and 1999, the average age at death for non-Indigenous people increased by 2.7 years for males and 2.8 years for females<sup>8</sup>. In the same period, the average age at death for Indigenous people increased by 1.6 years for males and 0.9 years for females. While average age of death is not the same as life expectancy at birth, an increase in the average age of death is an indication that people are, on average, living longer.
- (ii) IMRs for Indigenous Australians were significantly reduced during the 1970s, but this trend has not continued. In the 1970s, the Indigenous

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<sup>1</sup> ABS, *Deaths, Australia 1999*, No 3302.0, p74 and p91.

<sup>2</sup> C Dow, and Dr J Gardiner-Garden, '*Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*', *Social Policy Group Background Paper 15*, Parliamentary Library, Canberra, 1998.

<sup>3</sup> ABS, *Deaths, Australia 1999*, No 3302.0, p75.

<sup>4</sup> AIHW/ABS, *The Health and Welfare of Aboriginal and Torres Strait Islander People*, ABS No 4704.0, p85.

<sup>5</sup> AIHW, *Australia's Health 2000*, AIHW No 19, p182.

<sup>6</sup> AIHW, *Hospital Morbidity Database*, 1996-97.

<sup>7</sup> J Deeble, et al, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, Canberra, 1998, p44.

<sup>8</sup> ABS, *Deaths, Australia 1999*, No 3302.0, pp82-83.

IMR was over 80 deaths per 1000 live births. By 1981, it had fallen to around 26 deaths per 1000 live births<sup>9</sup>, a rate equivalent to that experienced by other Australians in the 1940s and 1950s. Since 1981, improvements have been gradual but the Indigenous rate has remained about two and half times that of the total population.

- (iii) Data for Western Australia, South Australia, and the Northern Territory (the only States with reliable mortality information<sup>10</sup>) show that, compared with five years ago, age-specific death rates for Indigenous people have fallen (indicating an improvement in health status) in all age groups except 15-24 years and 45-54 years<sup>11</sup>.
- (iv) In general, over the last 20 years, there has been a shift in the pattern of morbidity and mortality. Chronic diseases (such as diabetes and heart disease) are now the leading cause of the higher morbidity and mortality in the Indigenous population, rather than acute infections and communicable diseases as was the case over 20 years ago<sup>12</sup>.

**Table 6-1** DEATHS FROM SELECTED CAUSES, 1997-1999<sup>(a)</sup>

Cause of Death	Indigenous	Total	Indigenous Standardised Mortality Rate <sup>(a)</sup>
	No.	No.	Rate
Diseases of the circulatory system	603	51 303	2.7
External causes (includes injury)	311	8 361	2.3
Malignant neoplasms (includes cancer)	281	35 053	1.3
Diseases of the respiratory system	150	9 613	3.4
Endocrine, nutritional, and metabolic diseases (includes diabetes)	146	4 100	6.2
Diseases of the digestive system	98	4 221	4.0
All causes	1 976	128 102	2.1

(a) Standardised using the age-specific death rate of the Australia population at June 1999, in five year age groups from 0-4 years to 75 years and over. The SMR is derived using the ratio of observed deaths to expected deaths.

Source: ABS, *Deaths, Australia 1999*, No 3302.0, p77.

6. Indigenous people in all age groups suffer from most diseases at a greater rate than non-Indigenous people. The major causes of Indigenous hospital separations<sup>13</sup> were diseases of the kidney and urinary tract (often related to renal dialysis), pregnancy and

<sup>9</sup> ABS, *Deaths, Australia 1999*, No 3302.0, pp75-76.

<sup>10</sup> Data for these three States may not be representative of that for other States. Conclusions about the national picture based on data for these three States must therefore be viewed with caution.

<sup>11</sup> ABS, *Deaths, Australia 1999*, No 3302.0, pp74-75.

<sup>12</sup> House of Representatives Standing Committee into Community Affairs, *Health is Life*, Commonwealth of Australia, Canberra, 2000, p159.

<sup>13</sup> A hospital separation is that point in time when a patient is discharged, transferred to another facility or dies.

childbirth, respiratory system (often due to poor environment) and the digestive system<sup>14</sup>. Table 6-1 contains standardised mortality ratios (SMR)<sup>15</sup> for the main causes of Indigenous deaths. Together, these causes account for over 80 per cent of Indigenous deaths. The table also shows that the Indigenous death rate is over twice that of the wider population and that it varies between causes. The greatest difference is for endocrine, nutritional and metabolic diseases (includes diabetes), where the rate of death is 6 times higher for Indigenous people.

7. Reliable mortality data for Indigenous people are available only for Western Australia, South Australia and the Northern Territory. They show that regardless of where Indigenous people live, morbidity and mortality rates are consistently above those experienced by non-Indigenous people. However, there are some regional differences. Table 6-2 shows that the non-Indigenous death rates on the basis of ARIA<sup>16</sup> are fairly constant, regardless of remoteness, but the rates for Indigenous people increase — from twice the rate in highly accessible areas to over three times the rate in remote and very remote regions. Table 6-3 shows standardised death rates by State for the Indigenous and non-Indigenous populations. The largest differences are in Western Australia and the Northern Territory.

**Table 6-2** AGE STANDARDISED DEATH RATES FOR INDIGENOUS AND NON-INDIGENOUS POPULATIONS BY ARIA, 1994–1998

		Age standardised death rate per 100 000 population					
	Indigenous status	Highly accessible	Accessible	Moderately accessible	Remote	Very remote	Total
Males	Indigenous	1 416	1 667	2 146	2 392	2 164	2 006
	Non-Indigenous	761	876	792	760	707	778
	Total males	765	892	811	844	1 043	799
Females	Indigenous	1 010	1 317	1 099	1 701	1 492	1 384
	Non-Indigenous	502	539	489	473	463	506
	Total females	505	558	500	545	777	522

Note Data presented is for the unusual residents of Western Australia, South Australia and the Northern Territory combined.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

8. Detailed mortality data for small geographic areas are generally not available. However, Western Australia, one of the three States with reliable Indigenous

<sup>14</sup> AIHW, *National Hospital Morbidity Database, 1996-97*.

<sup>15</sup> The SMR provides an indication of the differences in the level of mortality that is not due to the age-sex structure of the population. A SMR above 1 indicates that, after adjusting for the age-sex structure of the population, there were more deaths from that cause than in the comparable non-Indigenous population.

<sup>16</sup> Based on the Accessibility/Remoteness Index of Australia (ARIA) developed by the National Key Centre for Social Applications of Geographical Information Systems at the University of Adelaide. This classification of localities measures accessibility and remoteness in terms of a location's road distance from service centres with populations of 5000 or more. Each location in Australia is classified into one of five categories: highly accessible; accessible; moderately accessible; remote; or very remote.

statistics, provided the data in Table 6-4. They show that for the more remote regions, the overall mortality rate increases with remoteness and is more pronounced in specific disease categories.

**Table 6-3** INDIRECT STANDARDISED DEATH RATES, 1999<sup>(a)</sup>

	Deaths per 1000 population						
	NSW	Vic	Qld	WA	SA	NT	Aust
Indigenous							
Males	14.9	20.4	17.8	22.3	17.2	25.8	18.3
Females	8.4	10.1	10.9	12.9	12.6	17.8	11.1
Persons	11.3	14.6	14.0	17.2	14.7	21.5	14.3
Non-Indigenous	5.6	5.8	6.1	5.7	5.6	6.4	5.8
Total Australia	6.1	5.9	6.2	5.9	5.8	9.9	6.0
Indigenous mortality index (Australia = 1)	0.79	1.02	0.98	1.20	1.03	1.50	1.00
Ratio of Indigenous to Non-Indigenous rate	2.02	2.52	2.30	3.02	2.63	3.36	2.47

(a) The ISDR is the number of deaths per 1000 people, calculated as the ratio of observed deaths to expected deaths.

Source: ABS, *Deaths, Australia 1999*, No 3302.0, Tables 6.4 to 6.10.

**Table 6-4** STANDARDISED RATIOS FOR KEY HEALTH CONDITIONS —  
INDIGENOUS POPULATION OF WESTERN AUSTRALIA

ATSI Region	All Causes	Ratios <sup>(a)</sup>					Admissions due to infectious and parasitic disease
		Injury	Respiratory	Circulatory	Endocrine	Neoplasms	
Perth	65	60	55	110	80	80	45
Narrogin	80	55	65	50	75	85	80
Geraldton	80	95	80	78	105	90	130
South Hedland	120	115	150	50	105	140	165
Broome	100	90	90	35	130	95	90
Derby	120	110	105	60	145	125	155
Kununurra	135	155	125	50	95	105	145
Warburton	105	175	105	25	85	90	190
Kalgoorlie	140	110	210	25	130	90	140

(a) A ratio over (under) 100 indicates that there is a higher (lower) incidence than would be expected for this cause. The rates have been standardised to the State Indigenous population.

Source: Office of Aboriginal Health, Health Department of Western Australia, *Aboriginal Definition of Health Need*, February 2001, p149.

9. Hospital data for 1996-97 show that for most diseases, the number of hospital separations per 1000 Indigenous people increased with remoteness<sup>17</sup>. The main exception was separations related to disorders of the kidney and urinary tract. In the less populous States, separations for this disorder were generally higher in metropolitan areas and large rural towns. This in part reflects the location of renal dialysis units and the movement of people needing this service to those locations.

10. In most States, the differences between urban and remote areas were greatest for environmental related conditions<sup>18</sup>. In New South Wales, hospital separation rates for these conditions were 5 to 10 times higher in remote areas than in Sydney. In most other States, the rates were 3 to 5 times higher. Separations for disorders relating to alcohol and drug misuse also tended to be higher in remote areas.

11. **Risk factors.** Indigenous people more commonly experience risk factors that contribute to ill health. Such factors are as follows.

- (i) Environmental factors — many Indigenous communities are located in remote areas with poor housing, water supply and waste disposal. Further details are in the Housing and Infrastructure Chapters.
- (ii) Social factors — studies have found that about 50 per cent of Indigenous people smoke, compared to 24 per cent of non-Indigenous people. While Indigenous people are less likely to drink alcohol than the non-Indigenous population, those that do are more likely to do so at hazardous levels<sup>19</sup>. Many Indigenous people raised concerns with us about the rise of drug related activities, and other forms of substance abuse or misuse in communities, particularly among the young.
- (iii) Cultural factors — these can vary significantly and include a historical legacy of barriers to access to health services, poor cultural security, diversity of language, differing views of how health care should be provided and the dislocation of families that continue to impact on many Indigenous people.
- (iv) Emotional wellbeing — a lack of appropriate mental health and substance misuse services was often raised as a priority in submissions, during consultations and in regional health plans. This need is supported by data that show there were about twice as many

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<sup>17</sup> AIHW, *National Hospital Morbidity Database, 1996-97*.

<sup>18</sup> Includes the following major diagnostic categories: respiratory system; ear, nose, mouth and throat; skin subcutaneous tissue and breast; infectious and parasitic disease; and eye disease and disorders.

<sup>19</sup> AIHW/ABS, *The Health and Welfare of Aboriginal and Torres Strait Islander People*, ABS No 4704.0, p52 and p54.

hospital separations as expected for mental disorders and self-inflicted injury among Indigenous people<sup>20</sup>.

- (v) Geographic factors — a larger proportion of Indigenous people live in rural and remote areas, and are therefore often some time and distance away from health care.

12. Indigenous people's access to and use of health services is also different from the wider population. Briefly, some of these differences are as follows.

- (i) Primary health care — low use of private General Practitioners (GPs) shown through low use of Medicare (41 per cent of the Australian average rate) and the Pharmaceutical Benefits Scheme (PBS) (33 per cent of the average rate). High use of non-admitted patient services at hospitals (over twice the rate) and of community and public health care (over 5 times the rate) can be seen as an offset to the lower use of Medicare<sup>21</sup>.
- (ii) Acute care — high use of admitted patient services, low use of private hospitals and private health insurance. Hospital separation rates also increase with remoteness.
- (iii) Aged and community care — due to low life expectancy, many Indigenous people are considered to be elderly at ages below that of the wider population and tend to use these services at a younger age. There is also a lower use of residential care and higher use of home and community care.

**13. The health outcomes for Indigenous Australians are much poorer than for other Australians. The health status of Indigenous people in remote areas is poorer than that of Indigenous people in urban and rural areas.**

## POLICY, PROGRAMS AND FUNDING

14. Indigenous health policy is focused on improving access to all services. In doing so, the aim is to provide appropriate and effective care. The Commonwealth's Indigenous Health Strategy aims to:

- (i) develop the infrastructure and resources required to achieve comprehensive and effective primary health care for Indigenous people;

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<sup>20</sup> Data for 1996-97. Mental illness includes alcohol and drug related conditions, depression, and psychosis.

<sup>21</sup> AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra

- (ii) improve the evidence base for health interventions;
- (iii) address some of the specific health issues and risk factors impacting on Indigenous health status; and
- (iv) improve communication with primary health care services, Indigenous people and the general population<sup>22</sup>.

15. **Programs and funding.** Health care services are provided by public, private and community organisations. Public provision of services is largely a State government responsibility, although the Commonwealth is the key funder and plays a role in developing national policy directions and priorities. Figure 6-1 shows how the programs funded by the Commonwealth fit together.

16. In 1998-99, approximately \$50.3 billion was spent on health services in Australia. There was:

- (i) \$23.7 billion (or 47 per cent) Commonwealth funds;
- (ii) \$11.5 billion (23 per cent) State and local government funds; and
- (iii) \$15.1 billion (30 per cent) from the non-government sector<sup>23</sup>.

Over a third of health expenditure is directed to acute care (hospital) services.

17. An overview of how Indigenous people use health services can be drawn from data collected by the Australian Institute of Health and Welfare (AIHW) for its report on expenditure on health services for Indigenous people. The first report in this series was based on 1995-96 data. Preliminary results from the second report, which are based on 1998-99 data, allow us to make some comparisons between the two years<sup>24</sup>.

18. As the main Commonwealth programs are Medicare and PBS, it spends less per person on Indigenous people through its direct programs than it does on non-Indigenous people. The States in turn (mainly through hospitals) spend more per person on Indigenous people through their direct programs than they do on non-Indigenous people. This is shown in Table 6-5.

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<sup>22</sup> See the Commonwealth Department of Health and Aged Care, *Annual Report 1999-2000*, DHAC.

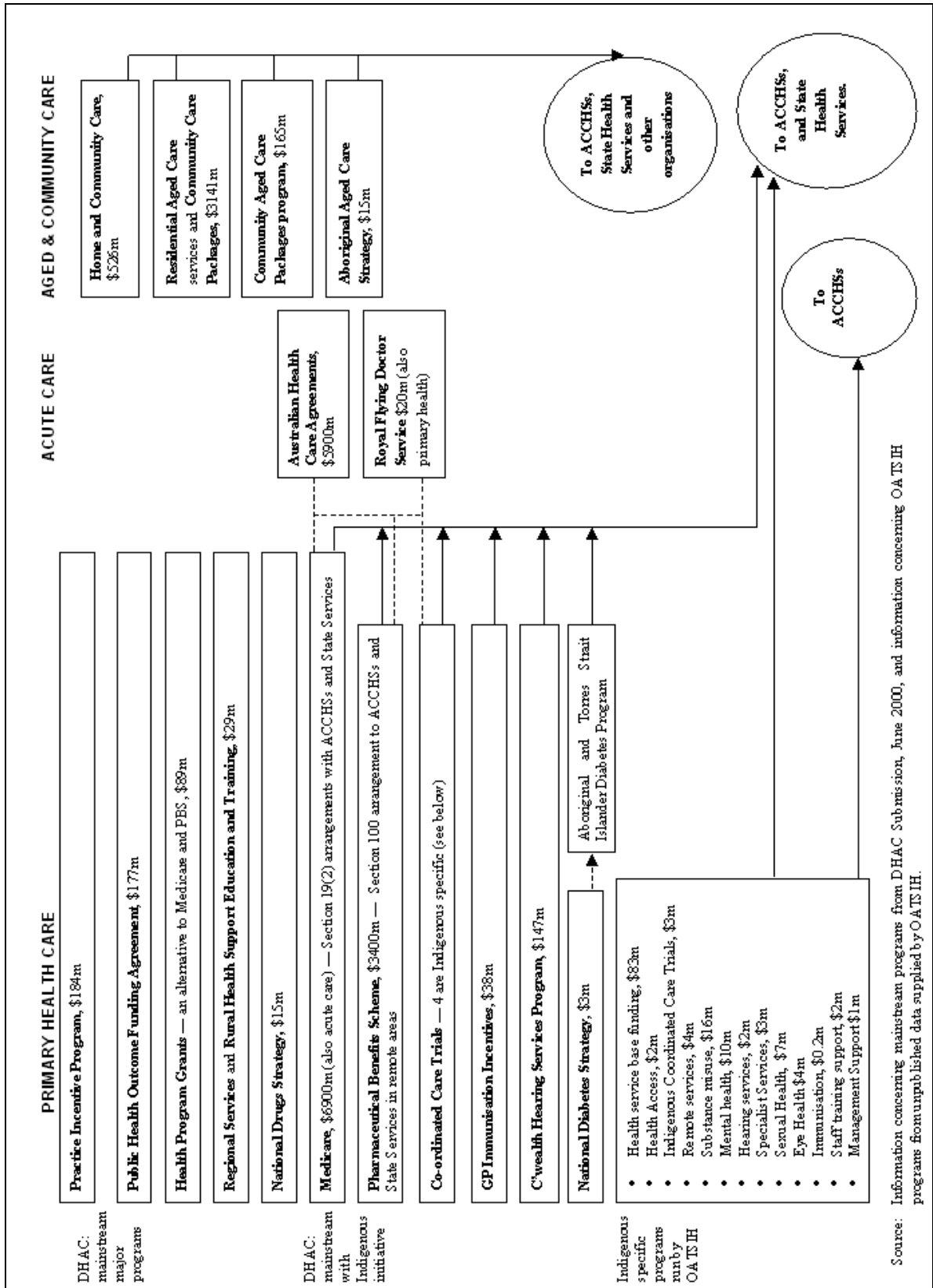
<sup>23</sup> The non-government sector includes health insurance funds, workers compensation insurers, compulsory motor vehicle third-party insurers, fees charged to individuals, and funds raised from other non-government sources by health institutions.

Reference: AIHW, Health Expenditure Bulletin, No 16, *Australia's Health Services Expenditure to 1998-99*, AIHW, 2000, Table 4, p5.

<sup>24</sup> AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra



Figure 6-1 OVERVIEW OF MAJOR COMMONWEALTH PROGRAMS, 1999-2000



**Table 6-5** SOURCES OF FUNDING GOVERNMENT AND NON-GOVERNMENT PROGRAMS FOR INDIGNEOUS PEOPLE, 1998-99

	Indigenous	Non-Indigenous	Ratio
	\$pc	\$pc	Indigenous/non-Indigenous
State and local government	1 390	504	2.76
Commonwealth			
Direct	651	796	0.82
Indirect	736	399	1.84
Total	1 388	1 195	1.16
Private	287	818	0.35
Total	3 065	2 517	1.22

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

19. The AIHW estimates that in 1998-99, for every dollar spent on health services for a non-Indigenous person, about \$1.22 was spent on an Indigenous person. This is much less than would be expected given the health status of Indigenous people relative to non-Indigenous people, but appears to have improved since 1995-96 when it was measured at \$1.08. Because different methods were used in developing the estimates, it is not clear whether this is an accurate reflection of the real change over this period. More detailed discussions on the expenditure on health services for Indigenous people will be in the AIHW's publication due for release shortly. Table 6-6 shows estimated expenditure on health services for Indigenous and non-Indigenous people in 1998-99.

20. Expenditure on health through non-government services for non-Indigenous people accounts for close to 26 per cent of total expenditure compared to less than 5 per cent for Indigenous people. The difference is largely due to the much lower use of private services by Indigenous people.

21. The 1998-99 data show that most expenditure on Indigenous people is through public hospitals (47 per cent of total expenditure on government services) and community and public health services<sup>25</sup> (29 per cent). Medicare and PBS expenditure on Indigenous people is much less than for non-Indigenous people. This matter is discussed later in the Chapter.

<sup>25</sup> OATSIH funded community controlled health services are included in this category.

**Table 6-6** ESTIMATED GOVERNMENT AND PRIVATE EXPENDITURE ON HEALTH SERVICES, 1998-99

	Indigenous		Non-Indigenous		Ratio Indigenous/ non-Indigenous
	\$m	\$pc	\$m	\$pc	
Government services					
Public hospitals – admitted patients	457	1 125	10 278	558	2.02
Public hospitals – non-admitted patients	125	307	2 562	139	2.21
Mental institutions	26	64	465	25	2.53
Residential high level aged care	40	99	3 853	209	0.47
Community and public health	355	874	3 137	170	5.14
Patient transport	43	106	577	31	3.39
Medicare and other medical <sup>(a)</sup>	73	179	8 632	468	0.38
PBS medicines	25	61	3 611	196	0.31
Administration and research	41	101	1 324	72	1.40
<b>Total government</b>	<b>1 185</b>	<b>2 917</b>	<b>34 439</b>	<b>1 868</b>	<b>1.56</b>
Non-government services					
Private hospitals	10	25	4 092	222	0.11
Dental and other professional	17	42	3 928	213	0.20
Other	33	82	3 963	215	0.38
<b>Total non-government</b>	<b>60</b>	<b>148</b>	<b>11 982</b>	<b>650</b>	<b>0.23</b>
<b>Total</b>	<b>1 245</b>	<b>3 065</b>	<b>46 421</b>	<b>2 518</b>	<b>1.22</b>

(a) Optometrical and Medicare dental included.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

22. The 1998-99 data allow some regional comparisons of expenditure using ARIA. They show some regional differences in the pattern and level of expenditure. Table 6-7 shows the following.

- (i) For both the Indigenous and the non-Indigenous population, Medicare and PBS expenditure decreases with increasing remoteness. Expenditure on Indigenous people is lower than for non-Indigenous people in every ARIA category. For the Indigenous population, access to Medicare and PBS is relatively poor everywhere. The lowest per person expenditure on non-Indigenous people (remote and very remote categories) is higher than that for the highest expenditure category for Indigenous people (highly accessible).

- (ii) Expenditure by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the Department of Health and Aged Care (DHAC) is highest on a per person basis in remote ARIA categories. It is double the amount per person spent in other ARIA categories.
- (iii) Expenditure per person on public hospitals increases with increasing remoteness for the Indigenous population but is similar across all ARIA categories for the non-Indigenous population.

**Table 6-7** ESTIMATED EXPENDITURE PER PERSON FOR SELECT HEALTH SERVICES, 1998-99

ARIA Category	Medicare	PBS	OATSIH	Public hospitals
	\$	\$	\$	\$
<b>Indigenous</b>				
Highly accessible	157	58	212	692
Accessible	156	61	227	1 028
Moderately accessible	143	53	98	1 048
Remote <sup>(a)</sup>	84	23	687	1 652
Very remote	84	23	296	1 582
<b>Total</b>	<b>143</b>	<b>53</b>	<b>295</b>	<b>1 051</b>
<b>Non-Indigenous</b>				
Highly accessible	367	163	23	510
Accessible	289	125	24	606
Moderately accessible	275	119	11	632
Remote <sup>(a)</sup>	197	93	74	617
Very remote	197	93	32	595
<b>Total</b>	<b>351</b>	<b>163</b>	<b>32</b>	<b>532</b>
<b>Ratio Indigenous to non-Indigenous</b>				
Highly accessible	0.43	0.36	9.22	1.36
Accessible	0.54	0.49	9.46	1.70
Moderately accessible	0.52	0.45	8.91	1.66
Remote <sup>(a)</sup>	0.43	0.25	9.28	2.68
Very remote	0.43	0.25	9.25	2.66
<b>Total</b>	<b>0.41</b>	<b>0.33</b>	<b>9.22</b>	<b>1.98</b>

(a) Remote and very remote ARIA categories are combined for Medicare and PBS.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

**23. Total resources for Indigenous health are greater in urban areas than in rural and remote regions. This is similar to health financing for all Australians but does not match the pattern of needs for Indigenous health funding.**

## PRIMARY HEALTH CARE

24. Improved access to primary health care would make a real and sustainable difference to health status for Indigenous people. A reasonable goal is to give Indigenous people a level of access to primary care services that is commensurate with their need.

### *Use of Primary Health Care by Indigenous People*

25. Primary health care is available to Indigenous people through private GPs, State health services, hospital non-admitted patient services and Aboriginal Community Controlled Health Services (ACCHSs)<sup>26</sup>. The Royal Flying Doctor Service (RFDS) is also a key service provider in some areas. Commonwealth funding for primary health services is through Medicare, the PBS, direct grants to State health providers, health care grants to the States, public health programs and direct grants to ACCHSs.

26. Indigenous and non-Indigenous people have very different patterns of use of primary health care services. The differences are shown in Table 6-8.

**Table 6-8** COMPARISON OF INDIGENOUS AND NON-INDIGENOUS PATTERNS OF PRIMARY HEALTH SERVICE USE<sup>(a)</sup>, 1998-99

	Indigenous	Non-Indigenous	Total expenditure	
	%	%	\$m	%
Acute care – non admitted patient services	20.1	13.8	2 687	14.0
Community and public health	57.2	16.9	3 492	18.2
Patient transport	6.9	3.1	620	3.2
Medicare and other medical	11.8	46.6	8 705	45.5
PBS drugs and appliances	4.0	19.5	3 636	19.0
<b>Total</b>	<b>100</b>	<b>100</b>	<b>19 140</b>	<b>100</b>

(a) Based on expenditure patterns.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

27. The critical difference between Indigenous peoples' use of primary health care and others is the low use of Medicare and PBS. This is partly due to the location of services — it is difficult to gain access where there are no doctors or pharmacies. But the low use of these services in all other regions suggest that Indigenous people do not visit or use GP services to the same extent as others even where services are available.

<sup>26</sup> The ACCHS's are Indigenous community based corporate bodies that provide a different variety of primary health services in different parts of the country.

### Mainstream Program Funding

28. Most mainstream primary health services are more highly concentrated in metropolitan and large urban regions — GPs, specialists and related providers are near the population.

29. Table 6-9 shows estimated expenditure per person on Medicare and the PBS for 1995-96 and 1998-89. It shows that while the Commonwealth spends less than average on each Indigenous person through these programs, the amount of expenditure has increased since 1995-96. However, the apparent changes may be due to changes in methods of estimating the expenditure as well as changes in service use. During the period, the Commonwealth has introduced a number of initiatives to increase Indigenous access to Medicare and PBS, and the data suggest that these policies are working. We can conclude, *albeit* with some caution, that initiatives to improve Indigenous people's access to Medicare and PBS are working.

30. Nevertheless, while there are some increases in expenditure, Medicare and PBS still remain far below the expected level, given the health needs of Indigenous people. Expenditure through Medicare is 41 per cent of that on each non-Indigenous person. Expenditure through the PBS is around 33 per cent. A breakdown of Medicare expenditure shows differences in the level of expenditure for different types of services. For example, expenditure on specialists through Medicare is 21 per cent of that spent on each non-Indigenous person, while expenditure on GPs is 56 per cent of that spent on each non-Indigenous person.

**Table 6-9** ESTIMATED MEDICARE AND PBS EXPENDITURE PER PERSON, INDIGENOUS AND NON-INDIGENOUS, 1995-96 AND 1998-99

	1995-96			1998-99		
	Indigenous \$pc	Non-Indigenous \$pc	Ratio	Indigenous \$pc	Non-Indigenous \$pc	Ratio
<b>Medicare</b>						
GP	44	130	0.34	71	126	0.56
Pathology	15	48	0.31	27	54	0.49
Imaging	16	49	0.33	23	57	0.39
Specialist	13	104	0.13	24	113	0.21
Total Medicare	88	331	0.27	143	351	0.41
<b>PBS</b>	27	123	0.22	50	151	0.33
<b>All benefits</b>	115	454	0.25	194	501	0.39

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

31. **It is critical for the Commonwealth to increase Indigenous people's access to Medicare and PBS.** The ways the Commonwealth is attempting to improve access to these services is discussed later in this Chapter.

### *Indigenous-specific Programs Funding*

32. There are a number of Commonwealth Indigenous-specific primary health services and initiatives that are managed by the OATSIH. Table 6-10 shows the expenditure for 1995-96 to 1999-2000 on these services and initiatives.

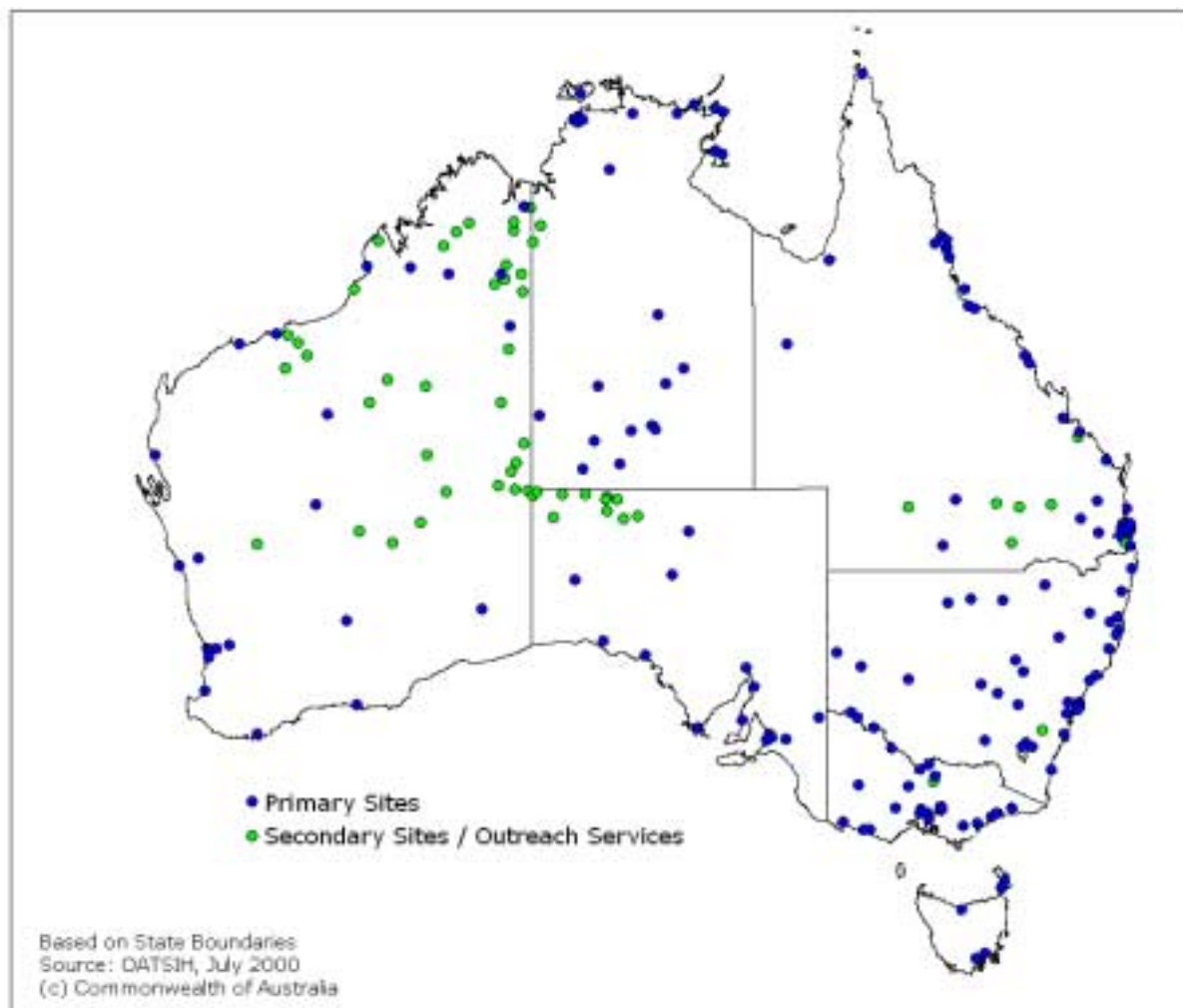
**Table 6-10** OATSIH FUNDING FOR SERVICES — 1995-96 to 1999-2000<sup>(a)</sup>

Program	1995-96		1996-97		1997-98		1998-99		1999-2000	
	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%
Health service base funding	71.768	80	66.034	76	75.377	65	80.477	59	83.145	61
Health access									1.640	1
Co-ordinated Care Trials					3.169	3	8.519	6	3.372	2
Remote services					2.086	2	4.510	3	4.441	3
Substance misuse	17.206	19	13.031	15	15.677	14	16.001	12	16.084	12
Mental health			2.432	3	4.863	4	10.137	7	9.533	7
Hearing services			0.414	0	1.446	1	1.362	1	1.542	1
Specialist services			5.156	6	3.791	3	4.243	3	2.580	2
Sexual health					6.486	6	6.359	5	7.394	5
Eye health							1.559	1	3.580	3
Immunisation									0.179	
Staff training support	1.181	1			2.110	2	2.147	2	2.104	2
Management support					1.068	1	1.375	1	0.897	1
<b>Total</b>	<b>90.156</b>	<b>100</b>	<b>87.069</b>	<b>100</b>	<b>116.073</b>	<b>100</b>	<b>136.690</b>	<b>100</b>	<b>136.492</b>	<b>100</b>

(a) Includes expenditure on non-Indigenous clients. Excludes capital works expenditure. The *1998-99 Service Activity Report* indicates that approximately 10 per cent of all episodes of care were for non-Indigenous people.

Source: Unpublished data provided by OATSIH, DHAC, October 2000 and March 2001.

33. The ACCHSs are the Commonwealth's primary mechanism for funding Indigenous-specific services. In 1999-2000 over 60 per cent of funds listed in Table 6-10 were used to fund the ongoing operation of ACCHSs and a large portion of the other specific initiatives are run through ACCHSs. In 1999-2000, the Commonwealth funded 137 ACCHSs (excluding substance misuse services). Eighty (58 per cent) of these services are located in New South Wales, Victoria, Queensland and the ACT, largely corresponding to the location of the Indigenous population (60 per cent residing in these States). Figure 6-2 shows the location of services funded by OATSIH. Not all these services are ACCHSs. The Commonwealth also provides Indigenous-specific funds to a number of State health services.

**Figure 6-2** HEALTH SERVICES FUNDED BY OATSIH, 1999-2000

34. The Commonwealth has expanded the Indigenous community health care sector significantly over the past decade. New funding included in the National Aboriginal Health Strategy (NAHS), announced in December 1990, added \$47 million for Indigenous-specific health services to provide new community controlled health services. In 1994-95, the Commonwealth allocated a further \$162 million for health over five years to expand existing services and create new ones.

35. In 1996-97, an additional \$20 million over 4 years was provided for mental health and hearing services. In the 1997-98 Budget, an additional \$20 million was provided for remote area services and the Co-ordinated Care Trials. In 1998-99, an additional \$78 million over four years was allocated for the new Primary Health Care Access Program (PHCAP) — to provide for expanded services. Indigenous-specific expenditure on health has increased from \$42 million in 1990-91 to over \$160 million<sup>27</sup> in 1999-2000.

<sup>27</sup> Total expenditure includes capital (around \$20 million) and other non-service costs and therefore does not correspond to figures in Table 6-10.



36. The increase in funding has been used to increase the capacity of existing services, to provide for new services in rural and remote areas, and for specific initiatives. The new PHCAP will continue this trend by providing new and expanded services, initially in central Australia and in South Australia. However, additional funding will be required before similar improvements can be made in other States.

37. In some States and regions, services in discrete Indigenous communities are provided by State government agencies. In these cases, the services would be classified as mainstream community health services.

- (i) In Queensland, services in remote areas are largely provided by Queensland Health, often through very small clinics serviced by regional hospitals and other small hospitals. The exception is Cape York and the Torres Strait where the communities are serviced by 'primary health care centres' and the only hospital is on Thursday Island.
- (ii) In Western Australia, the pattern of service delivery differs within the State. The ACCHSs are concentrated in the top half of the State and most are town based although they provide outreach services. In other rural and remote areas, there is a network of small hospitals that provide non-admitted patient services. There are also community health clinics in larger towns. Some remote communities have nursing outposts that provide primary health care.
- (iii) In the Northern Territory, most primary health care in remote areas is provided by Territory Health Services through Remote Area Health Clinics.

**38. Over the past decade the Commonwealth has increased expenditure on primary health care and is continuing to expand programs in this area through a mixture of additional funds and by increasing access to Medicare and PBS. However, a further significant increase in these funds would be necessary to bring direct Commonwealth expenditure on Indigenous people to the Australian average.**

**39. There is no evidence that any State, region or location has resources excessive to those required to address the health needs of Indigenous people.**

### **MEASURING NEED FOR PRIMARY HEALTH CARE**

40. We have focused on broad indicators to measure need for resources at a regional level. However, below the regional level, the broad indicators are of limited use because it is necessary to match resource inputs with the use to which they will be put. These decisions are best made at the local level and with the aid of local input.

41. We have considered two approaches to measuring health needs — a multi-factor approach and a population approach. They serve slightly different purposes.

The multi-factor model focuses on measuring need in terms of outcomes that could help to identify priorities for additional funding. The population approach focuses on inputs and gives an indication of how well resources in a region match an agreed standard.

### ***The Multi-factor Approach***

42. Many different factors influence health status and the need for services, including:

- (i) socio-economic status;
- (ii) environmental factors (such as housing and infrastructure);
- (iii) socio-cultural factors (such as removal from land, separation of families and mistrust of mainstream services); and
- (iv) poor access to primary health care (including financial barriers and poor health service links).

Measures of need should reflect the variety of influences on the need for resources as well as the capacity of the system to deliver services.

43. We commissioned the Office of Aboriginal Health (OAH) in the Health Department of Western Australia to assist in examining a multi-factor approach to measuring need. They were also asked to consider how it could be used to distribute funds. A copy of their report is available in the volume of Consultants' Reports to this Report.

44. ***The approach.*** A key underlying component of the model OAH developed is that the views and priorities of Indigenous people are reflected in the definitions of need. The notion of need was initially discussed with a group of Indigenous community representatives, service providers, service funders and academics, with the aim of identifying the critical components of an Indigenous view of health need.

45. That discussion, which was assisted by the Social and Public Health Economic Research Group (SHPERe), supported an equal access for equal need principle for the allocation of funds, with need defined by reference to capacity to benefit. Greater weight was given to those conditions for which the greatest health gains could be made. In considering access to services, cultural and other barriers were examined, as were the costs of providing services.

46. ***Principles and aims.*** The key principle behind the multi-factor approach developed by OAH is that resources should be allocated according to where the most good can be done. The definition of 'the good' was subjective and based on the views of the people affected, in this case Indigenous people. The 'good' was defined as better health and the development of community capacity.

47. ***The model.*** The model is based on research into and knowledge of primary health care needs and incorporates several aspects of need.

- (i) *Health status.* This is measured using regional data on mortality and morbidity rates for key diseases.
- (ii) *Capacity to benefit from health resources.* This is included by giving different weights to illnesses and conditions associated with environmental, social, and lifestyle factors, based on relative gains expected from expenditure. A greater weight is given to environmental diseases on the assumption that greater gains can be made in the short term by addressing environmental health needs. Social factors are given a higher weight than lifestyle factors. The weights are based on available data and judgement.
- (iii) *Relative disadvantage.* Greater weight is given to areas of relatively high socio-economic disadvantage to partly reflect the broader social and economic aspects of an Indigenous perspective of health. The ABS Experimental Index of Socio-Economic Disadvantage<sup>28</sup> was used to rank regions into four groups ranging from most disadvantaged to least disadvantaged. Each group was assigned a weight.
- (iv) *Management Economic Social and Human Infrastructure (MESH).* The capacity to manage and deliver services and provide facilities is a key to ensuring that needs are met. This requires an investment in both human and physical infrastructure, which varies between regions. In this model, the need for capacity building is separate from, and does not change the need for resources stemming from health status and relative disadvantage. The inclusion of MESH was seen as a priority. It was measured using the 1997 Survey of Environmental Needs of Aboriginal Communities in Western Australia<sup>29</sup>, and 1999 CHINS data. The model assumes that a certain proportion of funds will be available to meet MESH needs.
- (v) *Additional costs associated with remoteness.* This element is included to allow for differences between regions in the costs of providing services. The ARIA classification was used as a guide to identify areas that are geographically isolated. A cost weight was applied to each ARIA category. The cost weight was based on a survey of a small number of service providers in Western Australia.
- (vi) *Additional costs associated with providing a culturally secure service.* This reflects the cost of addressing cultural considerations that impact on access. It is difficult to measure and more research is needed in this area. As an initial estimate, a cost weight of ten per cent was applied to areas where the use of Indigenous languages is high.

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<sup>28</sup> ABS, 2000, *Experimental Indigenous Socio-Economic Disadvantage Indexes, Report to the Commonwealth Grants Commission.*

<sup>29</sup> Environmental Health Needs Coordinating Committee, *Environmental Health Needs of Aboriginal Communities in Western Australia, the 1997 Survey and its Findings*, 1998.

48. Figure 6-3 contains the formula used for estimating resource need.

49. *Illustration of the model.* Table 6-11 provides illustrative results of applying the model to data for the Western Australian ATSI regions. Reflecting the high priority it gives to capacity building, the calculation assumed that 40 per cent of total funds would be available for the development of MESH.

**Figure 6-3** MULTI-FACTOR MODEL FOR ALLOCATING RESOURCES

$\text{RAI} = \text{popn} \times \{(1 - \text{MESH P}) \times \text{CTB} \times \text{RDI} \times \text{CLI} + (\text{MESH P} \times \text{MESH R})\} \times \text{Remoteness}$	
Where:	<p><b>RAI</b> = <b>R</b>esource <b>A</b>llocation <b>I</b>ndex  <b>Popn</b> = Aboriginal Population  <b>CLI</b> = <b>C</b>ultural/<b>L</b>anguage <b>I</b>ndex  <b>MESH P</b> = Proportion of expenditure available for building MESH  <b>MESH R</b> = MESH relative need  <b>RDI</b> = <b>R</b>elative <b>D</b>isadvantage <b>I</b>ndex  <b>CTB</b> = Capacity to Benefit = (0.5 x EMMI + 0.3 x SMMI + 0.2 x LMMI)</p>
	<p>Where</p> <p><b>EMMI</b> = <b>E</b>nvironmental <b>M</b>ortality and <b>M</b>orbidity <b>I</b>ndex  <b>SMMI</b> = <b>S</b>ocial <b>M</b>ortality and <b>M</b>orbidity <b>I</b>ndex  <b>LMMI</b> = <b>L</b>ifestyle <b>M</b>ortality and <b>M</b>orbidity <b>I</b>ndex</p>

**Table 6-11** ILLUSTRATIVE RESOURCE ALLOCATION INDEX, WESTERN AUSTRALIA

ATSI Region	Population	Population share	RAI	RAI share	Relative per person RAI <sup>(a)</sup>
		%		%	
Perth	17 998	35.4	<b>16 152.13</b>	12.9	1.00
Broome	3 423	6.7	<b>8 883.85</b>	7.1	2.89
Kununurra	4 088	8.0	<b>16 152.40</b>	12.9	4.40
Warburton	2 688	5.3	<b>13 679.71</b>	10.9	5.66
Narrogin	6 204	12.2	<b>9 990.92</b>	8.0	1.80
South Hedland	4 298	8.5	<b>17 368.98</b>	13.8	4.48
Derby	3 958	7.8	<b>19 677.68</b>	15.7	5.53
Kalgoorlie	3 152	6.2	<b>8 262.12</b>	6.6	2.92
Geraldton	5 006	9.9	<b>15 325.09</b>	12.2	3.40
Total	50 815		<b>125 492.87</b>		

(a) This shows the amount a region would receive for every \$ per person spent in the Perth region.

50. On these results, a greater than population share of resources would go to all ATSI regions except Perth and Narrogin. For every dollar per person Perth would receive

under this allocation index, Narrogin would receive \$1.80 and Warburton would receive \$5.66. Perth was assessed to have the lowest relative needs (mainly because its weighted health status was relatively better, as was its rank on the index of socio-economic disadvantage) and the lowest cost of providing services. The need for the development of community capacity was also relatively lower. Of the remote regions, Broome and Kalgoorlie would receive close to population shares because their assessed needs are relatively low. For Broome this is mainly because it has relatively low mortality and morbidity rates compared with other remote ATSI regions. For Kalgoorlie it is mainly because its socio-economic disadvantage is not as great as other regions and the costs of providing services are lower than in the more remote ATSI regions.

51. **Limitations and benefits.** The method recognises that there are many influences on need, and that programs will be more effective if there is an investment in capacity to manage and deliver programs and services. It also acknowledges that the link between improving health status and the quantum of resources required is not well understood — some conditions require more resources than others, and some are easier to cure and prevent than others.

52. The absence of regional level data for all States limits the wider use of such a model. A lack of detailed data also requires the weights in the formula to be based on judgement. However, the approach adopted by the OAH (basing the judgement on collaborative discussions with Indigenous people and researchers) provides a means of obtaining a full range of perspectives and illustrates how judgement could be included in decision making.

53. **Potential uses.** The OAH emphasised that this model would be most usefully applied to the distribution of new funds. It suggested that it could be used at the program level or at a higher level of aggregation (such as urban, rural, remote areas) as a guide to where resources should be targeted. As need is identified using weighted health status and relative disadvantage, which are difficult to measure accurately, the approach is probably most useful when there are large differences between groups in those measures.

54. **Future value.** The current use of a multi-factor model may be limited by data deficiencies, the need for judgement and a requirement for further evaluation of the indicators of need and how they are combined. Nevertheless, further consideration of the approach is warranted because it represents a potential means of better informing decisions on the distribution of funds and it illustrates how the notion of capacity to benefit can be operationalised.

### **Population Approaches**

55. Population based approaches are generally based on establishing benchmarks for inputs required to provide services. As such they are based on an equity principle of equal access to services and allow for population differences and the costs of providing services. We examined both population to staff ratios and expenditure benchmarks.

56. **Population to staff.** The relative level of service available to different population groups may be measured using population to staff ratios. Some regional health plans (Central Australian, Northern Territory Top End, and Kimberley) have used this

approach to plan services and identify the areas that are most in need of services. OATSIH has also used it as a guide to estimating the cost of providing better primary health care services.

57. Using population to staff ratios requires assumptions about the type of service offered and the type of staff required. For illustrative purposes, we focused on doctors, nurses and Aboriginal Health Workers (AHW). However, a comprehensive primary health care service also requires other health and welfare workers such as dentists and counsellors.

58. Deriving population to staff ratios requires consideration of how the number of medical staff required to provide a given service is affected by population dispersion and the health status of the relevant population. The need to overcome the effects of population dispersion implies that more doctors, nurses and AHWs are required per person in rural and remote areas. The poorer health status of Indigenous people also increases the number of staff required.

59. The regional plans that have used this approach adjusted population to staff ratios to take account of remoteness and population dispersion. The ratios used in those regional plans were based on the *Review of Northern Territory Government Remote Health Services in Central Australia*<sup>30</sup>. That Review recommended the following ratios as a starting point for remote health services where Indigenous people were a relatively large proportion of the resident population:

- Doctor: 1 per 800 people;
- Nurse: 1 per 250 people; and
- AHW: 1 per 100 people.

60. In 1998, there was an average of one primary health care doctor for every 904 people<sup>31</sup> across Australia. The lower population to doctor ratio in the regional plans reflects the effects of the additional doctors required to overcome the influence of remoteness, population dispersion and the relatively poorer health status of Indigenous people. In 1996, there was one nurse for every 107 Australians<sup>32</sup>.

61. A comparison of these benchmarks with workforce data, classified by RRMA<sup>33</sup>, shows that the actual number of doctors in rural and remote areas is below the national average and benchmarks set in other studies. The gap between the benchmark and the number of people per doctor was greatest in remote areas of South Australia, Queensland, Victoria and New South Wales. Tasmania was the only State in which the number of doctors in remote areas was above the benchmark. The number of people per

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<sup>30</sup> J Wakerman, M Bennett, V Healy, I Warchivker, *Review of Northern Territory Government Remote Health Services in Central Australia*, 1997.

<sup>31</sup> AIHW, *Medical Labour Force 1998*, AIHW No 16, 2000, Table 11, p 21.

<sup>32</sup> AIHW, *Nursing Labour Force 1998*, AIHW No 15, Table 61.

<sup>33</sup> The Rural, Remote and Metropolitan Area classification and the ARIA seek to classify locations on the basis of remoteness. The RRMA classification was the first remoteness classification system developed. In essence, it classifies locations on the basis of population size and distance from nearby centres. It is being replaced by ARIA for most analytical purposes.

doctor in Western Australia fell below the benchmark in all regions. The number of people per nurse was generally below the national average in other rural and all remote areas. In most States, there were more people per nurse in large rural areas than there were in other regions. In Queensland, Western Australia, South Australia and the Northern Territory, there were generally more people per nurse in remote areas than there were in other rural areas. The Supporting Material for this Report contains more information.

62. *Limitations and benefits.* The population to staff approach could be used to identify differences in physical access to services, but it says nothing about where there are other barriers to accessing services. It can mask social and cultural access problems. For example, the number of doctors in metropolitan areas as a proportion of population exceeds the national average. But Indigenous use of private doctors in metropolitan areas is much lower than that of non-Indigenous people in those areas.

63. The main benefit of the population approach is that, once benchmarks have been set, it is transparent. However, setting the benchmarks requires judgement as data on nurses and doctors are only collected in national surveys of the health workforce and on a broad geographic level. Application of the approach also requires accurate details of the population of small communities.

64. *Potential use.* The population approach is most useful at the service provider level for measuring physical access to services and as a broad guide to where there are access problems. The Central Australian Regional Health Plan<sup>34</sup> demonstrates the usefulness of this approach at the low geographic level where data are available. It is difficult to apply at the broad level where there are multiple service providers and Indigenous people do not make up a majority of the population. Data at the broad level can mask significant variations in access to services at a lower level.

65. *Future value.* We see some potential in the development of agreed population to staff ratios to monitor the relative level of service provided in different regions.

66. *Expenditure per person approaches.* Relative service levels can also be compared using per person expenditure levels. This provides a measure of access to funds.

67. In its submission, DHAC<sup>35</sup> noted that in implementing the PHCAP program it intends to use an expenditure benchmark to determine the level of funding for each service. DHAC assume that meeting the higher health needs of Indigenous people requires at least twice the national average per person expenditure on primary health care. It also assumes that overcoming the higher costs of providing services in rural and remote areas requires a further doubling of the national average per person expenditure. That is, they estimate that per person expenditure should be up to four times the national average in rural and remote areas.

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<sup>34</sup> B Bartlett, P Duncan, D Alexander, J Hartwick, *Central Australian Health Planning Study, Final Report*, Plan Health Pty, Ltd, July 1997.

<sup>35</sup> Commonwealth Department of Health and Aged Care Initial Submission, June 2000, pp77-83.

68. In their submission, Deeble, Anderson and Siphthorpe<sup>36</sup> estimated the additional funds required to bring expenditure on Indigenous people up to a level that matched needs. They estimated that, in 1995-96 prices, an additional \$230 million was required. They estimated that given the socio-economic status of Indigenous people and the current pattern of service use, government per person expenditure on Indigenous people should be about double that on non-Indigenous people.

69. The AMSANT submission<sup>37</sup> contained an estimate of the additional Medicare funds required to meet Indigenous health needs. It provided an estimate, based on an assumption that per person expenditure on Indigenous people should be 2.5 times that on non-Indigenous people, which implies that about \$400 million in additional Medicare funds is required.

70. Any approach based on per person expenditure standards must allow for the effects on expenditure requirements of the greater extent of illness among Indigenous people (relative to non-Indigenous people) and the additional costs of providing services in the less accessible areas. It would also be necessary to allow for the higher levels of government expenditure arising because of the lower access of Indigenous people to the private sector.

71. **On the evidence presented to us, the poorer health status of Indigenous people, and their greater reliance on the public health system, would justify at least a doubling of the average per capita government expenditure on non-Indigenous people.** (Other studies have suggested comparable factors of between 2 and 7.) The cost data in the Western Australian study suggest that per person costs in very remote areas can be twice those in highly accessible areas. Consequently, per person expenditure benchmarks that range from double the national average in highly accessible areas to just over four times the national average in very remote areas would not be unreasonable.

72. *Limitations and benefits.* As with most measures of need in the health area, data problems limit the usefulness of the expenditure approach. The complexities of the health system mean it is difficult to establish benchmarks using actual expenditure in regions. This is particularly so for a sub-group of the population such as Indigenous people. At present, expenditure data are only available at the State and broad regional level.

73. *Potential use.* This approach is useful as a guide to where there are physical and other barriers that affect access to services. But it is of limited use when there are large differences between groups in health status and demand for services.

74. *Future.* We see some potential for its use as a general indicator of the required relative level of expenditure on Indigenous people against an agreed benchmark. However, there is a need to develop better indicators of cost weights by region, and a need for discussion about what the benchmark should be.

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<sup>36</sup> Deeble, Anderson and Siphthorpe, National Centre for Epidemiology and Population Health Initial Submission, April 2000, p9.

<sup>37</sup> Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) Final Submission, December 2000.



### *Conclusions About Measuring Need*

75. In considering different ways to measure needs for primary health care, we encountered conceptual and practical difficulties that must be addressed if reliable measures of relative health need are to be developed.

- The funds used to meet the needs of Indigenous people are not easily identified (especially for mainstream programs), making it hard to measure gaps in funding.
- Reliable data to measure health status are not generally available for small areas, and reasonable information at State level is available only in some States.
- Measures that are available may not assist with resource allocation decisions. Some data (for example, hospital separations data) reflect met need and only partially assist in the identification of unmet need and gaps in services.
- Needs may not be met because of systemic or other structural problems - for example, poor access to services. (Structural issues are difficult to factor into broad measures of need.)
- Local variation in needs and the different ways needs are met cannot be reflected in indicators.
- Links between changes in outcomes and the quantum of funds required to achieve them are not fully known.

76. Measuring needs for Indigenous people, a small group within the total population, is difficult. Progress is being made through detailed regional health planning to identify areas with poor access. In spite of the difficulties, further development of measures of need is required to assist decision making and to assist governments to better direct funding to areas with the greatest access problems. We have suggested two approaches, a multi-factor model and a population approach that should be further explored.

### *Specific Primary Health Issues*

77. As the redistribution of existing funding would not necessarily improve outcomes, we considered other ways in which they may be improved. These include improving the effectiveness of service delivery, improving access to all forms of primary health care, improving environmental health, and workforce changes.

78. *Partnerships, planning and community control.* A feature of the current approach to improving Indigenous health outcomes is the importance placed on effective agreements and partnerships between levels of government and Indigenous communities, both within the health sector and in other areas.

79. This is addressed through the development of partnership arrangements that focus on Indigenous health. A national framework is used to co-ordinate service delivery and to identify priorities. It also provides a forum for the collection of data and co-ordination of research into Indigenous issues. Components of the national framework include:

- (i) a national Indigenous health advisory body (the Aboriginal and Torres Strait Islander Health Council);
- (ii) a Memorandum of Understanding with ATSIC that aims to ensure that all primary and environmental health programs are co-ordinated effectively; and
- (iii) specific Indigenous framework agreements with the States, ATSIC and the community controlled sector.

80. The framework agreements set out the responsibilities of the various parties, contain some commitments and set performance criteria. A State forum has been established in each State, with members from the Commonwealth, State and community controlled health services.

81. The State forums have been used to develop regional plans that aim to co-ordinate service delivery, and identify needs and gaps in service delivery. Because the plans are developed at a local level, they are better placed to detect need, preferences and service delivery arrangements at that level. The regional plans form the foundation for expansion of services, and the plans are in place for most States. This approach, particularly as it embraces Indigenous participation and decision making, is an integral part of improving access to services.

82. ***Improving access to mainstream services.*** Governments aim to address access in a number of ways, both through mainstream and specifically targeted programs. Mainstream programs can and are being improved in a number of ways.

- (i) ***Improving access to Medicare.*** These changes include streamlining of enrolment and claims procedures, changing arrangements to allow ACCHSs that have a salaried doctor and some State Health Services to claim Medicare, introducing new Medicare items that assist in covering the cost of longer consultations, and alternative arrangements such as the cashing out of a notional level of Medicare funding (shown to have worked in the Co-ordinated Care Trials (CCTs)).
- (ii) ***Access to PBS.*** Through changes that allow medicines to be made available directly through some ACCHSs. This is happening in rural and remote areas and ways of doing more in urban areas are being considered.
- (iii) ***General practice initiatives.*** There are a number of initiatives that can be used to fund increased access of Indigenous people to GPs and other health services. However, there is no clear government

sponsored strategic approach to the planning and provision of such programs for Indigenous people.

83. Efforts to improve access to mainstream services are essential to improve health outcomes for Indigenous people. This is particularly important in urban and rural areas where the majority of Indigenous people live and where mainstream services are widely provided, but are not so widely used. Improvements in mainstream services are necessary if Indigenous-specific services are to be better targeted to areas where mainstream services do not operate.

84. *Improving access to Indigenous-specific services.* Outcomes can be improved by ongoing support for existing services and through the expansion of new services leading to better targeting of funds.

85. *Existing ACCHSs.* Many of these organisations commented on how complex, fragmented and short-term funding arrangements adversely affect their operations.

- (i) Funds provided for specific health programs may not reflect the health priorities of a community and cause a lack of flexibility in service provision. As a result, the services provided can be determined by the purpose of the funds and not by local health priorities. This can make it more difficult to provide a holistic service.
- (ii) The administration of specific purpose funds and Medicare claims is complex, time consuming and costly. Many ACCHSs pointed to the reporting tasks arising from their 20 to 30 program grants.

86. On the other hand, funding agencies noted that it was necessary for funding arrangements to be able to target priority health concerns and to be accountable to Parliaments.

87. Issues associated with fragmented and specific funding arrangements were addressed partly by the CCTs. The trials pooled Commonwealth (including Medicare and PBS) and State funds and some non-government services, and allocated them to a single body that planned the services and purchased health services on behalf of the Indigenous clients. This also increased transparency. The evaluations of the individual trials generally supported the approach taken.

88. *New services – PHCAP.* This 1998-99 budget initiative is intended to be the central means by which the Commonwealth will expand services in areas of high need and sustain services developed through the CCTs. It is based on joint funding between the Commonwealth and States, cashing out of Medicare, capacity building and significant community input, all underpinned by needs identified through State and regional planning processes.

89. The regional planning process is an essential step, and the completion of the planning process is a prerequisite for funding. Within regions, for example central Australia, the regional plan is being used to identify need and set priorities. This means that funds will be allocated according to need within the region. It is possible that regions with

high health needs and high needs for community capacity building but whose plans are not yet complete, may not be funded. It is not yet clear how these areas will have their needs addressed or in what timeframe funds may begin to become available.

90. *Environmental health.* The importance of environmental health was highlighted during our Inquiry, particularly the links between poor environmental conditions and poor Indigenous health outcomes in rural and remote areas. The significance of environmental health is also highlighted in regional plans, the evaluations of the individual CCTs and in other reports. Environmental health tends to be ill-defined, containing elements of health, housing, infrastructure and education. It is also characterised by having no specific government or departmental agency responsible for it. As a result, there is no strategic approach to dealing with the issues.

91. We have addressed environmental health in more detail in the Infrastructure Chapter and in the Supporting Material. This section outlines only the issues and findings that are generally the responsibility of health portfolios.

92. The provision of targeted housing and infrastructure projects through ATSIC's NAHS program and the expansion of primary health care facilities through PHCAP forms the Commonwealth's major funding for environmental health. ATSIC and the enHealth Council<sup>38</sup> also have a key role in monitoring and co-ordinating environmental health issues within the Commonwealth and with the States.

93. The ability of existing and expanded primary health care services to reduce infectious and parasitic diseases and other environmental health relation conditions can be compromised if environmental health issues are not dealt with. Ways of addressing environmental health concerns include the following.

- (i) An increased emphasis on co-ordinating program delivery, both within and across agencies and jurisdictions. This could include increased co-ordination of environmental health programs with the expansion of ACCHSs and other services, for example the roll out of the PHCAP could be factored into the selection of NAHS projects.
- (ii) Better professional development of Aboriginal Environmental Health Workers (AEHW), generally employed in public health programs in the States, and Aboriginal Health Workers (AHW) employed in the community health setting. This could include joint efforts between the Commonwealth and the States to provide accredited training and ongoing professional support for AEHWs and to ensure that links between them and AHWs are promoted.

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<sup>38</sup> The enHealth Council aims to provide National leadership on environmental health issues. It includes representatives from the Commonwealth, the States, the Australian Institute of Environmental Health, the environmental protection sector, the public health sector and the community (including the Indigenous community).

94. *Health workforce issues.* The health workforce is critical for effective service delivery. Problems are not restricted to primary health care and many workforce issues affect the cost, availability and quality of services, including:

- (i) difficulty in recruiting and retaining health practitioners in rural and remote areas;
- (ii) difficulty in recruiting trained Indigenous staff;
- (iii) a lack of training for non-Indigenous health professionals in the social, cultural and medical circumstances of Indigenous people; and
- (iv) lack of consistency in training and recognition of AHWs across the States.

95. Attracting GPs to rural and remote areas can require considerable incentives and health services in those areas need the financial resources to offer such incentives. Some health services noted that the recent changes to fringe benefits taxation obligations will increase their costs, but it is too early yet to measure any such increases. Nor is it yet clear how recent Commonwealth mainstream initiatives aimed at attracting doctors to rural and remote areas have impacted on Indigenous access to GP services.

96. *Aboriginal Health Workers.* AHWs are increasingly part of the community health care delivery sector and are an important element for effective service delivery. Their role is to increase trust in medical services, avoid the breakdown in communications that can occur between non-Indigenous medical staff and Indigenous communities, and provide some continuity of care.

97. There are a number of key issues surrounding AHWs that focus on their role, training and career structure.

- (i) The services that an AHW provides are diverse and special training, for example in mental health, may be required to respond to a community's needs. Such training is not always accessible.
- (ii) There is a lack of consistency between States concerning the role, training, recognition and career structure of AHWs. Introducing AHW registration such as that in the Northern Territory may help achieve greater consistency within and between States.
- (iii) AHW training needs to be integrated with other vocational education and training. This would enable AHWs to obtain advanced standing or recognition of prior learning for completed courses.
- (iv) There are concerns that some AHWs employed by an ACCHS or a State health service in some Indigenous communities may be funded through CDEP.

98. **Summary.** The most important factors that will contribute to improving access to and the effectiveness of primary health care services for Indigenous people are:

- working partnership arrangements and effective community control of services;
- the continual improvement of mainstream services and support for programs that address reasons for poor access to services;
- the expansion of community controlled services based on regional health plans;
- a stronger focus on environmental health issues; and
- continued efforts to deal with workforce issues.

### ACUTE CARE

99. The Indigenous population uses public acute care at a greater rate than the non-Indigenous population due to their poor health status and late presentation with illness. However, Indigenous people use private hospitals at a significantly lower rate than non-Indigenous people. Table 6-12 shows hospital expenditures on Indigenous people compared to non-Indigenous people.

**Table 6-12** HOSPITAL EXPENDITURES ON INDIGENOUS AND NON-INDIGENOUS PEOPLE, 1998-99

	Indigenous				Non-Indigenous				Ratio Indigenous/ non-Indigenous
	Govt.	Private	Total	Per person	Govt.	Private	Total	Per person	
	\$m	\$m	\$m	\$	\$m	\$m	\$m	\$	
Admitted patients	443	14	457	1 125	9330	947	10 278	558	2.02
Non-admitted patients	124	1	125	307	2 247	316	2 562	139	2.21
Private hospitals	2	8	10	25	1 052	3 040	4 092	222	0.11
<b>Total</b>	<b>569</b>	<b>24</b>	<b>592</b>	<b>1 457</b>	<b>12 629</b>	<b>4 303</b>	<b>16 932</b>	<b>919</b>	<b>1.59</b>

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

100. The greater use of acute health care by Indigenous people is an important issue for a number of reasons.

- (i) The need for acute care is often the result of a late intervention into illness — complications and co-morbidities have already developed.
- (ii) The provision of acute care services to treat diseases that would be more effectively dealt with earlier by a GP is relatively expensive.
- (iii) Hospitals may not always provide culturally appropriate care and individuals may need to travel long distances from their community.
- (iv) There is limited scope to specifically address Indigenous needs because of the inflexibility of the funding of acute care. They are essentially demand driven services.

101. Nonetheless, measures can be taken to ensure that hospitals are culturally appropriate and that support services, in particular patient assisted travel schemes, are operating effectively.

### ***Service Funding and Provision***

102. Hospitals are mainstream services and in rural and remote areas there are often small hospitals with a high proportion of Indigenous patients. The type of services hospitals provide vary according to their location, with large facilities in urban centres providing a much broader range than small facilities in rural and remote centres. The relationship between population size and services offered leads to specific difficulties for Indigenous people because they more frequently live in small rural towns and remote locations.

103. Table 6-13, which shows expenditure classified by ARIA category, shows the higher use of public hospitals by Indigenous people in rural and remote areas. Both per person expenditures and the ratio of Indigenous to non-Indigenous per person expenditure increases with remoteness. This is due to higher hospital separation rates in remote and very remote regions and to higher costs.

104. The Australian Health Care Agreements (AHCAs) between the Commonwealth and States provide the basis for the Commonwealth's contribution to the operation of public hospitals. The AHCAs do not explicitly link funding to the Indigenous population but recognise the Indigenous population as a target group.

105. The agreements include some performance measures designed to demonstrate the extent of Indigenous people's access to acute care services. They state that the agreements will:

- (i) be implemented consistent with the principles outlined in the Aboriginal and Torres Strait Islander Health Framework Agreement;
- (ii) develop and refine high level performance indicators, including indicators of Indigenous health; and
- (iii) report against and refine the set of National Aboriginal and Torres Strait Islander health performance indicators.

**Table 6-13** DISTRIBUTION OF PUBLIC HOSPITAL EXPENDITURE FOR ADMITTED PATIENTS, 1998-99

ARIA category	Indigenous		Non-Indigenous		Per person ratio
	\$m	\$pc	\$m	\$pc	
Highly accessible	120	692	7743	510	1.36
Accessible	82	1028	1300	606	1.70
Moderately accessible	43	1048	463	632	1.66
Remote	43	1652	134	617	2.68
Very remote	136	1582	93	595	2.66
Total	424	1051	9733	532	1.98

(a) ARIA categories do not add to the total as \$3.2 million Indigenous-specific expenditure and \$74.4 million of non-Indigenous expenditure is excluded because no ARIA code could be allocated.

(b) Expenditure where Indigenous status is not reported has been allocated between Indigenous and non-Indigenous using the same proportion as for identified separations in the remote regions.

(c) Figures have been adjusted for under-identification of Indigenous people.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

106. The allocation among the States of the base health care grants (the bulk of Commonwealth financial assistance to the States for health) reflects population growth and ageing, hospital output costs, private health insurance coverage and growth in demand. Funds are thus largely distributed according to the structure of the population and historical levels of service use and cost. Funding is also provided through the AHCA for the quality improvement, national mental health projects and national palliative care projects.

107. Under AHCA arrangements, the States determine the method for distributing acute care resources between regions. In all States except New South Wales, this occurs according to a form of casemix funding. Victoria, Queensland (for rural services), Western Australia, South Australia and the Northern Territory all include a factor to account for the additional costs of providing services to Indigenous Australians. All States, except the ACT (where it is not relevant) and Tasmania, attempt to account for the additional costs of providing services in rural and remote areas.

**108. The Commonwealth's ability to influence the regional distribution of acute care funds according to Indigenous need is limited.**

109. States are also responsible for the administration of patient assisted travel schemes that subsidise travel and accommodation costs for people travelling from rural or remote areas to hospital and some specialist services. This scheme is particularly important for Indigenous people. Table 6-14 shows expenditure on Indigenous and non-Indigenous people by State.

### *Measuring Need*

110. Hospital separation rates can be used as a measure of need for acute care, but their use is limited because they measure needs that are met rather than the total need for



services. Further, for Indigenous people, the rate of hospital separations reflects other factors, such as poor access to primary health care or poor environmental health conditions.

**Table 6-14** EXPENDITURE ON PATIENT TRANSPORT<sup>(a)</sup>, 1998-99

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Indigenous	8.1	1.0	8.4	3.7	1.3	1.1	0.1	11.7	35.3
Non-Indigenous	248.6	95.6	116.3	20.5	31.0	14.6	7.4	6.9	541.1
\$ per person									
Indigenous	70	40	75	62	55	70	25	216	87
Non-Indigenous	40	21	35	11	21	32	24	50	29
Ratio	1.75	1.90	2.14	5.64	2.62	2.19	1.04	4.32	3.00

(a) This includes expenditure on patient transport schemes and emergency transport, including RFDS and ambulance transport.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

111. Hospital separations data show that:

- (i) Indigenous people use hospitals much more than the non-Indigenous population — Indigenous people have twice as many hospital separations per 1000 people as non-Indigenous people;
- (ii) hospitals most frequently provide treatment for diseases of the kidney and urinary tract (renal dialysis), pregnancy and childbirth, diseases of the respiratory system and diseases of the digestive system; and
- (iii) there is greater use of hospitals in remote regions for all conditions except renal dialysis — patients requiring dialysis often have to relocate from remote areas to urban centres to receive treatment. Almost a quarter of Indigenous admissions are for renal dialysis. The proportion of admissions for renal dialysis is highest in the Northern Territory, followed by Queensland and Western Australia.

112. Due to the limited flexibility in hospital funding and service provision, we have not considered how to measure needs for acute health services *per se*. We have looked at aspects of services that are more readily able to influence effective outcomes for Indigenous people, including measures taken to improve cultural accessibility and the effectiveness of support services. We have looked at indicators that describe:

- (i) patient transport — including transport and accommodation schemes, and emergency transport to hospitals; and
- (ii) ways to make hospital services more culturally accessible — for example, whether there are Indigenous liaison officers, whether Indigenous people have input into decision making processes and the

provision of cross-cultural training to non-Indigenous staff. For example, all staff employed by the New South Wales health districts receive this type of training

113. Available data suggest the following:

- (i) Expenditure on patient assisted transport differs between States (see Table 6-14), probably due to differences in demand, but also because of differences in the level of cost (to patients) and in administration and eligibility criteria. This suggests that Indigenous people in different States do not have equal access to patient travel schemes.
- (ii) Over 14 000 people in 589 discrete communities (mainly remote communities in Western Australia and the Northern Territory) do not have access to an emergency airlift service<sup>39</sup>.
- (iii) Indigenous membership on hospital boards (a National Aboriginal and Torres Strait Islander health performance indicator) varies between nearly 100 per cent of Boards in New South Wales to zero in the ACT and Tasmania (Queensland and South Australian data not available)<sup>40</sup>.

114. There is evidence that patient assisted travel schemes are not operating effectively because of overly restrictive eligibility criteria and inconsistent eligibility criteria and payments across States. Such schemes are crucial to ensuring the equitable access of the Indigenous population to acute care services. Further details are contained in the Supporting Material to this Report.

**115. Acute care services provide care to all Australians. Indigenous people use hospitals more than expected, partly due to poor primary health care services and because they present late in the disease process and tend to require greater care. Improved support services such as patient transport and liaison officers would assist Indigenous people gain a better service.**

### *Acute Care Issues*

116. The major issues raised concerning the provision of acute care services for Indigenous people were the higher use of services, access to renal dialysis and poor access to specialist services.

117. *Use of services.* Due to greater use, per person expenditure on Indigenous people in public acute care is about twice that of non-Indigenous people. The average Diagnostic Related Group (DRG) cost weight of Indigenous patients is lower because of high numbers of low cost DRGs (renal dialysis in particular) and fewer high cost DRGs.

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<sup>39</sup> ATSIIC (produced by ABS), *Community Housing and Infrastructure Needs Survey 1999*.

<sup>40</sup> The National Health Information Management Group for Australian Health Ministers' Advisory Council, *National Summary of the 1998 Jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators*, AIHW, Canberra, 2000.

However, there is evidence that within DRGs, Indigenous patients have higher costs per episode and higher costs per day.

118. **Renal dialysis.** Access to renal dialysis emerged as a major issue in all regions, especially in rural and remote areas. We understand that there are moves to provide renal dialysis machines in some primary health care settings. Such provision would make their use more flexible and culturally accessible.

119. **Specialist services.** Indigenous people access Medicare funding for private specialist consultations at one-fifth the rate of non-Indigenous people<sup>41</sup>. Most specialist care for Indigenous people in rural and remote areas occurs through referral to a hospital specialist, requiring patients to travel long distances and affecting continuity of care.

120. Recent initiatives to improve specialist services in remote communities may address the reliance of Indigenous people on hospital specialists. OATSIH is funding three pilot projects in specialist workforce development. These projects provide a range of specialist services to remote Indigenous communities and involve education, training and skill transfer to AHWs, general practitioners and nurses.

## AGED AND COMMUNITY CARE

121. Aged and community care is a priority area in a number of regional plans. Indigenous people place a high value on the presence of elderly Indigenous people in their communities, partly because it contributes to social cohesion. This creates a need for elderly Indigenous people to receive care in their communities. However, access to services is difficult because Indigenous people are more likely to live in rural and remote regions, and the numbers of elderly people are small.

### *Service Provision and Funding*

122. **Residential care.** Mainstream residential care services are largely provided by non-government organisations, although States provide a small proportion of residential care services. The Commonwealth provides subsidies for residential care and approves the distribution of residential care places. The size of the subsidy it provides for each place reflects the health care needs of the resident.

123. There are also 21 aged care hostels run by Aboriginal Hostels Ltd (AHL). Table 6-15 shows the distribution of the hostels by State. AHL received \$3.275 million in 1999-2000 through the aged care subsidy and nursing home subsidy from DHAC to assist in meeting the needs of aged Indigenous people.

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<sup>41</sup> AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra.

**Table 6-15** DISTRIBUTION OF AHL AGED CARE HOSTELS, 1999-2000

	NSW	Vic	WA	SA	North Qld	South Qld	Central Australia	Northern Australia	Total
Aged care hostels	3	1	5	2	2	5	2	1	21
Bed numbers	38	9	79	35	25	89	63	24	362

Source: *Aboriginal Hostels Ltd Annual Report, 1999-2000*, AHL, Canberra, 2000, pp78-85.

124. **Community care.** There are three programs concerned with community care:

- (i) Home and Community Care (HACC) is the largest home care program. It caters for both the aged and disabled, with approximately 70 per cent of clients being aged.
- (ii) Community Options Projects (COPS) operate within HACC and provide case managed packages for more highly dependent individuals.
- (iii) Community Aged Care Packages (CACP) provide case managed packages as an alternative to residential care.

125. In 2001, HACC is to be funded by the Commonwealth (\$569.3 million, which is 63 per cent of government expenditure) and by the States (\$339.2 million or 37 per cent)<sup>42</sup>. Some additional funding comes from fees collected by service providers.

126. Commonwealth funding is formula based, using the previous financial year's amount indexed for inflation plus a growth allowance (currently 6 per cent per year). The Commonwealth also applies an equalisation strategy and assumes that each State collects fee revenue equal to 20 per cent of total HACC expenditure. The equalisation strategy aims to equalise the interstate distribution of funds per person in the target population<sup>43</sup>. Table 6-16 shows the distribution of HACC expenditure per Indigenous and non-Indigenous elderly person.

127. **Flexible service delivery.** About 30 to 40 per cent of Indigenous people requiring aged care services have their needs met through Indigenous-specific or mainstream flexible care delivery services. A flexible care service delivers a mix of residential and community based services. Such services aim to be more responsive to a community's needs and can readily adjust the mix of high and low care services as the care required varies. Flexible care services are particularly effective in rural and remote areas where aged care facilities may not operate. Table 6-17 shows the distribution of mainstream flexible care services.

<sup>42</sup> Productivity Commission, *Report on Government Services 2001*, Productivity Commission, 2001, Table 12A.30.

<sup>43</sup> The Commonwealth uses the ABS *Disability, Ageing and Carers Survey* and ABS population estimates to establish the target population. The *Disability, Ageing and Carers Survey* is conducted each five years, and the most recent results were published in 1998.

**Table 6-16** ESTIMATED EXPENDITURE ON HACC SERVICES, 2000-01<sup>(a)</sup>

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Total HACC expenditure	(\$'000)	284.8	258.2	155.1	87.1	79.0	25.6	12.7	6.0	908.5
Funding ratio – C'wealth to State		1.6	1.6	2.0	1.7	1.7	1.6	1.1	3.0	1.7
Expenditure per Indigenous person over 50 years	(\$)	614.0	645.6	329.9	457.9	638.6	118.0	191.6	539.0	504.3
Expenditure per person over 70 years <sup>(b)</sup>	(\$)	480.6	596.9	541.2	623.2	499.3	573.0	730.2	1545.0	542.1

(a) Includes respite care.

(b) Does not include Indigenous people between the ages of 50 and 70.

Source: Productivity Commission, *Report on Government Services 2001*, Productivity Commission, Canberra, 2001, Tables 12A.30 and 12A.14.

**Table 6-17** DISTRIBUTION OF MAINSTREAM FLEXIBLE AGED CARE SERVICES

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
No. of flexible care delivery services	89	23	48	25	26	3	0	41	255

Source: Productivity Commission, *Report on Government Services 2001*, Canberra, 2001, p559.

128. The Commonwealth's Aboriginal Aged Care Strategy (AACS) aims to expand the delivery of flexible aged care services that meet the needs of communities. There are 26 such services across Australia. Most funding is recurrent funding for established services. Flexible ongoing funding is calculated by assessing the needs of a community for residential care places, Commonwealth funded community care places and respite care. The funding required to provide these services is then pooled. The community uses the funds to provide the aged care services it considers appropriate.

### *Measuring Need*

129. The size and distribution of the aged and disabled<sup>44</sup> Indigenous population are the main factors affecting need for these services. Consequently, a population-based approach to planning aged care services (including allowances for differences between regions in the cost of providing services) is the most appropriate. Health status and cultural and social issues also influence the need for care, but these are difficult to measure and can change over time.

130. The age at which service providers consider Indigenous people to be aged differs but it begins in the 45 to 55 years range. This is because Indigenous people

<sup>44</sup> Many of the services that cater for the aged also cater for the disabled. However, little is known about the extent and distribution of the Indigenous disabled population. Due to the tendency of Indigenous people to experience higher rates of illness and suffer from age related diseases at an earlier age, it is likely that rates of disability are also higher than in the non-Indigenous population.

experience the diseases and disabilities of aging at a younger age and have a lower life expectancy. Table 6-18 shows the 1996 and projected 2006 differences in the age distribution of the Indigenous and non-Indigenous populations. The proportion of Indigenous people over 70 is less than one-fifth that of the non-Indigenous population.

**Table 6-18** POPULATION AGE DISTRIBUTION, 1996 AND 2006<sup>(a)</sup>

	Age group (years)					
	50-69		70 and over		Total	
	'000	%	'000	%	'000	%
Indigenous population						
1996	28.9	7.5	5.9	1.5	386.0	100.0
2006 <sup>(b)</sup>	41.2	8.8	6.8	1.5	469.1	100.0
Total population						
1996	3 245.0	17.7	1 510.9	8.3	18 310.7	100.0
2006 <sup>(b)</sup>	4 388.0	21.5	1 847.1	9.1	20 366.2	100.0

(a) As at 30 June of the year indicated.

(b) Assumes no change in the propensity to identify as Indigenous.

Source: AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, AIHW, Canberra, 1999, p41, Table 3.17.

131. Commonwealth aged care policy aims to provide 90 residential aged care places and 10 Community Aged Care Packages (CACP) per 1000 aged people by the year 2011. This includes Indigenous people over fifty (rather than 70).

132. Table 6-19 shows the distribution of the aged Indigenous population (defined as aged 50) by ATSI region. Remote regions have a marginally higher proportion of older Indigenous people.

133. There are limited data concerning the need for HACC services in the Indigenous community. With the recent introduction of the HACC Minimum Data Set, information on Indigenous use of, and need for, HACC services should improve. In distributing funding to the States, the Commonwealth largely uses the disability, ageing and carers data (in relation to the goal of equalising per person funding between States) which at present does not have adequate information concerning the Indigenous population and may not fully account for Indigenous needs.

134. The Indigenous people's desire to see elders remaining in communities can be assisted through a stronger emphasis on community based care.

### Issues

135. **The main issues raised concerned the future growth of the elderly Indigenous population, a different pattern of service use, issues impacting on the provision of HACC services, and access to assessment services.**

136. **Growth of the Indigenous elderly population.** The number of older Indigenous people will increase, particularly if health status is improved. However, it will not increase at the same rate as the elderly non-Indigenous population. It is important that with the overall increased need for aged and community care occurring in the coming decades, the Indigenous population is not marginalised in its access to services.

**Table 6-19** INDIGENOUS PEOPLE OVER 50 BY ATSI REGION, 1996

ATSI Region		ATSI Region		ATSI Region		ATSI Region	
	No. %		No. %		No. %		No. %
Sydney	3109 9	Wangaratta	1056 10	Roma	712 8	Alice Springs	468 11
Coffs Harbour	2237 9	Tamworth	1042 10	Mount Isa	705 11	Derby	467 12
Brisbane	2084 8	Ballarat	1034 9	Jabiru	674 9	Kununurra	453 11
Wagga Wagga	1684 9	Rockhampton	931 8	Cooktown	669 12	South Hedland	441 10
Cairns	1362 9	Aputula	878 12	Katherine	663 9	Tennant Creek	357 10
Perth	1285 7	Darwin	803 9	Port Augusta	581 10	Warburton	348 13
Townsville	1221 8	Bourke	773 11	Nhulunbuy	569 8	Broome	328 10
Hobart	1110 8	Torres Strait	767 13	Geraldton	518 10	Kalgoorlie	268 9
Adelaide	1100 9	Queanbeyan	732 8	Narrogin	500 8	Ceduna	132 7

Note: The percentage figures are the over 50 population in each region as a percentage of the total population of the region.

Source: ABS, Census: Indigenous Profile, 1996.

137. **Different pattern of service use.** Indigenous people access residential care at a lower rate than they access home care services and packages. In 1997-98, less than 1 per cent of residents in nursing homes and hostels were identified as Indigenous. In contrast, Indigenous people comprised 2.3 per cent of HACC and 3.1 per cent of CACP clients<sup>45</sup>. These figures could indicate a preference for home based care or difficulty with access to residential care. Table 6-20 shows Indigenous people as a percentage of residential care, CACPs and HACC clients.

138. **Provision of HACC services.** HACC is the largest program providing care in the home. Issues that impact on HACC planning for Indigenous people include:

- (i) elderly Indigenous people are more likely to use home care services if they are provided by other Indigenous people;
- (ii) HACC services in Indigenous communities may provide a much broader range of services, including very high levels of care and palliative care (this leads to pressure on resources); and
- (iii) poor, unsafe or overcrowded housing can compromise home based care.

<sup>45</sup> Productivity Commission, *Report on Government Services 2000, Vol III*, 2000, Productivity Commission, p981 and p1012.

**Table 6-20** INDIGENOUS PEOPLE AS A PERCENTAGE OF RESIDENTIAL CARE, CACPs AND HACC CLIENTS, 1999-2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	%	%	%	%	%	%	%	%	%
Indigenous over 50 as proportion of target population <sup>(a)</sup>	1.9	0.6	3.5	3.8	1.4	3.3	1.0	63.6	2.3
<i>Residential care</i>									
Indigenous people as a per cent of people in nursing home care	0.4	0.2	1.0	2.2	0.7	0.4	0.1	48.9	0.7
Indigenous people as a per cent of people in hostel care	0.4	0.2	1.5	1.3	0.8	0	0.3	62.4	0.8
Indigenous people as a per cent of total residential care	0.4	0.2	1.2	1.8	0.7	0.2	0.2	53.3	0.7
<i>Community and home care</i>									
Indigenous people as per cent of CACP recipients	1.9	0.4	3.9	7.7	2.1	5.3	0	65.7	3.1
Indigenous people as per cent of HACC clients	2.5	0.6	2.2	2.9	1.8	0.7	0.3	47.9	2.2

(a) Defined as Indigenous people over 50 and non-Indigenous people over 70.

Source: Productivity Commission, *Report on Government Services 2001*, Productivity Commission, Canberra, 2001, Tables 12A.14 and 12A.37.

139. The procedures used to determine the appropriate level of care for the aged (ACAT teams) are not well accessed by Indigenous people. Only 6 per cent of older Indigenous people were assessed in 1998-99, compared to 11 per cent of older non-Indigenous people<sup>46</sup>. This low rate of use seems to be primarily due to a lack of knowledge of the role of assessments teams, and a reluctance to participate in conventional aged care arrangements or cultural issues. (Physical accessibility in the rural and remote areas does not seem to be a major issue because the number of assessments of non-Indigenous older people in rural and remote areas compares well with the proportion of the elderly population that lives in those areas.) Including Indigenous liaison officers with ACAT teams may help address this difficulty.

## CONCLUSIONS

140. The main findings relating to health services are as follows.

- (i) The health outcomes for Indigenous Australians are much poorer than for other Australians. The health status of Indigenous people in remote areas is poorer than that of Indigenous people in urban and rural areas.

<sup>46</sup> DHAC Annual Report, 1998-99, p214.



- (ii) It is critical for the Commonwealth to increase Indigenous people's access to Medicare and PBS.
- (iii) Over the past decade the Commonwealth has increased expenditure on primary health care and is continuing to expand programs in this area through a mixture of additional funds and by increasing access to Medicare and PBS. However, a further significant increase in these funds would be necessary to bring direct Commonwealth expenditure on Indigenous people to the Australian average.
- (iv) There is no evidence that any State, region or location has resources excessive to those required to address the health needs of Indigenous people.
- (v) On the evidence presented to us, the poorer health status of Indigenous people, and their greater reliance on the public health system, would justify at least a doubling of the average per capita government expenditure on non-Indigenous people.
- (vi) Total resources for Indigenous health are greater in urban areas than in rural and remote regions. This is similar to health financing for all Australians but does not match the pattern of needs for Indigenous health funding.
- (vii) In considering different ways to measure needs for primary health care, we encountered conceptual and practical difficulties that must be addressed if reliable measures of relative health need are to be developed.
  - The funds used to meet the needs of Indigenous people are not easily identified (especially for mainstream programs), making it hard to measure gaps in funding.
  - Reliable data to measure health status are not generally available for small areas, and reasonable information at State level is available only in some States.
  - Measures that are available may not assist with resource allocation decisions. Some data (for example, hospital separations data) reflect met need and only partially assist in the identification of unmet need and gaps in services.
  - Needs may not be met because of systemic or other structural problems - for example, poor access to services. (Structural issues are difficult to factor into broad measures of need.)
  - Local variation in needs and the different ways needs are met cannot be reflected in indicators.

- Links between changes in outcomes and the quantum of funds required to achieve them are not fully known.
- (viii) Measuring needs for Indigenous people, a small group within the total population, is difficult. Progress is being made through detailed regional health planning to identify areas with poor access to services. In spite of the difficulties, further development of measures of need is required to assist decision making and to assist governments to better direct funding to areas with the greatest access problems. We have suggested two approaches, a multi-factor model and a population approach that should be further explored.
- (ix) The most important factors that will contribute to improving access to and the effectiveness of primary health care services for Indigenous people are:
- working partnership arrangements and effective community control of services;
  - the continual improvement of mainstream services and support for programs that address reasons for poor access to services;
  - the expansion of community controlled services based on regional health plans;
  - a stronger focus on environmental health issues; and
  - continued efforts to deal with workforce issues.
- (x) Acute care services provide care to all Australians. Indigenous people use hospitals more than expected, partly due to poor primary health care services and because they present late in the disease process and tend to require greater care. Improved support services such as patient transport and liaison officers would assist Indigenous people gain a better service.
- (xi) The Commonwealth's ability to influence the regional distribution of acute care funds according to Indigenous need is limited.
- (xii) Indigenous people's desire to see elders remaining in communities can be assisted through a stronger emphasis on community based care.