CHAPTER 2

PRIMARY HEALTH CARE

1. The importance of primary health care to improving the health circumstances of Indigenous people is well documented and was often noted in submissions and consultations. In the Report, the Commission noted that improved access to primary health care for Indigenous people would make a real and sustainable difference to health status. The Commission suggested that a reasonable goal would be to get Indigenous access to primary care services to a level commensurate with need.

2. This section provides further information on the types of primary health care services available and the means by which they are funded. It examines the pattern of service use and provides background information on key issues raised in the Report.

Provision and Funding Arrangements for Primary Health Care

3. There are a number of different primary health care providers and several different funders. Primary health care is available to Indigenous people through General Practitioners (GPs), State health services, hospital outpatient services (termed the mainstream) and Aboriginal Community Controlled Health Services (ACCHSs). The Royal Flying Doctor Service (RFDS) is also a key service provider in a number of areas. Funds for these services are provided by all levels of government, as well as through private contributions.

4. Commonwealth funding for primary health services is through Medicare, the Pharmaceutical Benefits Scheme (PBS), direct grants to State health providers, health care grants to the States, public health programs and direct grants to ACCHSs, RFDS and other providers. Attachment A contains a summary of Commonwealth programs and the methods used to distribute funds for each program.

5. ***Medicare and GP services.*** The private sector, mainly through GPs, is an important primary health care provider. GPs are the main providers of primary care services to the general population. The location of GPs correlates with the location of the total Australian population, meaning that most GPS are located in urban areas and large towns.

6. Medicare provides access to free treatment as a public patient in a public hospital and free or subsidised treatment by private practitioners[1]. This can occur through the patient paying the medical practitioner and subsequently claiming the payment back (which may involve the patient covering a gap between the payment required by the doctor and the amount they can claim) or through the doctor 'bulk billing'. Bulk billing aims to improve the access of low income patients to medical practitioners. Although Medicare is provided to people on demand, individuals or families must have a Medicare card and corresponding number to claim Medicare benefits.

7. ***Pharmaceutical Benefit Scheme (PBS).*** The PBS provides a subsidy for a range of prescription medicines. The Commonwealth provides the pharmacist with a refund for part of the cost of the drug. Patients bear the reminder of the cost. The size of the patient contribution and the refund provided to pharmacists varies according to the patient's entitlement status and the cost of the medicine. Concession cards are available to eligible applicants, including low income earners. There is also a PBS 'safety net' which means that, after a certain amount has been paid for pharmaceuticals over a year, concession holders receive free pharmaceuticals, and non-concession holders become entitled to concession rate. The safety net level is lower for concession holders. To receive a concession rate individuals need to have a health care card and number.

8. ***Aboriginal Community Controlled Health Services (ACCHSs).*** ACCHSs[2] are Indigenous community based corporate bodies that provide a variety of health services in different parts of the country. ACCHSs vary in both size and the range of primary health care services they provide. All attempt to provide a comprehensive range of services in a holistic way in a culturally secure environment. ACCHSs are represented at the national level by the National Aboriginal Community Controlled Health Organisation (NACCHO) and there are peak bodies in each State.

9. The Report noted that effective community control of services contributed to improving access to and effectiveness of primary care services. ACCHSs increase Indigenous access to primary health care. The care provided is culturally sensitive and services can be flexible and responsive to the needs of the community (for example services may have an outreach service). Because service delivery is integrated and holistic, many primary care services are usually available in one place.

10. There is considerable diversity among ACCHSs in terms of the type of service, the range of activities conducted and the links with other health service providers. In a remote area they may be the sole provider of health services; in some urban regions they may adopt largely a advisory and referring role; and in other urban and rural areas they may be large services providing comprehensive primary health care. Many provide health services to non-Indigenous Australians, particularly in rural and remote areas. (Table 2-7 shows that in 1998-99 approximately 10 per cent of all episodes of care were services for non-Indigenous people.)

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[1] Although, as will be discussed shortly, there have been moves recently that enable some salaried doctors to claim against Medicare.

[2] Also known as Aboriginal Medical Services (AMSs).

11. The first ACCHS was established in Redfern in 1971, staffed by volunteer Indigenous and non-Indigenous health professionals. Other early ACCHSs were located in urban regions. Over time a network of over 100 ACCHSs has formed across Australia, increasingly in more remote locations. The distribution of ACCHSs varies across and within States. For example, there are relatively few ACCHSs in Queensland, and much fewer in the south of Western Australia than in the north of the State. Some ACCHSs were located in areas where there were no State services.

12. In 1995 responsibility for the delivery of the Commonwealth's Indigenous-specific health program was transferred from ATSIC to the then Department of Human Services and Health. The Government established the Office for Aboriginal and Torres Strait Islander Heath (OATSIH) within the Department of Health and Aged Care (DHAC) as a focus for work on Indigenous health.

13. The Commonwealth, through OATSIH, is the key funder of ACCHSs. The Commonwealth provides both base funding and funds for initiatives that target specific health issues. States may also provide funds for ACCHSs through mainstream and Indigenous-specific programs.

14. The allocation of funds to ACCHSs by OATSIH reflects historical funding levels and distribution[3]. Before the transfer of the Indigenous-specific health program, ATSIC funded ACCHSs on an annual grants basis following submission of applications. Decisions on funding levels and control of payments largely rested with ATSIC Regional Councils. Funding from ATSIC was just one of a number of sources of funds for many organisations. Many services gained initial funding and then expanded through a submission based approach where the capacity of an organisation to address identified need was a key aspect in gaining funding. That is, no consideration of relative need of the region to be serviced was necessary to gain funding.

15. In more recent times, the overall needs of communities have been assessed in more detail, as has their experience or capacity to manage and deliver services. Moves made by OATSIH towards need based funding for ACCHSs include:

(i) A 1995-96 rebasing exercise. The aim was to ensure that services providing a similar level of service received comparable funding. It focussed on existing staffing levels rather than need for or growth of services. As a result all ACCHSs were able to pay their staff award wages.

(ii) The introduction of service activity reporting whereby ACCHSs provide information to OATSIH about service use. OATSIH intends to use this information to assist in targeting funds on the basis of the population serviced and the demand for services.

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[3] Australian National Audit Office, *Audit Report No.13, Performance Audit, The Aboriginal and Torres Strait Islander Health Program,* ANAO, Canberra, 1998.

(iii) The distribution of funds for new services since 1997-98 through the Remote Communities Initiative used the *1992 Housing and Infrastructure Needs Survey*[4] (HINS) survey, data from State Health Departments and State health planning forums to identify communities in need.

(iv) Funds for new or expanded services through the Primary Health Care Access Program (PHCAP) will be distributed according to Regional Plans. More information concerning this process is provided in the section on PHCAP and Attachment B.

16. ***State services.*** States provide primary health care for Indigenous people through a range of different providers including:

(i) community health clinics;

(ii) hospital outpatient services;

(iii) multipurpose centres (these services provide a range of services including primary, home and community care and aged care and are usually located in rural and remote areas); and

(iv) nursing outposts and remote area services (these provide primary health care and are usually staffed by nurses and Aboriginal Health Workers. Most have access to doctors on a visiting basis only).

17. There are differences both between and within States in the form the service takes. For example:

(i) In Queensland services in remote areas are largely provided by Queensland Health, often through very small outpatient clinics and small hospitals. The exception is Cape York and the Torres Strait where the communities are serviced by 'primary health care centres' and have no outpatient clinics and only one hospital located on Thursday Island.

(ii) In Western Australia the pattern of service delivery differs within the State. In rural and remote areas there is a network of small hospitals that provide accident and injury and outpatient services. There are also community health clinics in larger towns. Some remote communities have nursing outposts that provide primary health care services. These nursing posts do not generally have a permanent GP on staff although they may receive visiting services.

(iii) In the Northern Territory most primary health care services in remote areas are provided by Territory Health Services through about 70 Remote Area Health Clinics. Most of these clinics are staffed by

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[4] ATSIC, *1992 National Housing and Community Infrastructure Needs Survey*, ATSIC, Canberra, 1992.

nurses and Aboriginal Health Workers and do not have a permanent doctor on staff, although doctors may fly in on a regular basis.

18. Some State health services may be designated as Aboriginal health services or have a significant proportion of clients that are Indigenous. In such circumstances there are differing levels of Indigenous input into the service. For instance, the Commission was told that while primary care services in the Torres Strait are not community controlled, there is strong Indigenous input into the service through advisory boards and Indigenous participation in service delivery.

19. State services, in particular State community health services, may also receive OATSIH funds. The extent to which State community health services receive funds from OATSIH differs between States.

20. ***Royal Flying Doctor Service (RFDS).*** In addition to its emergency and patient transfer services, the RFDS provides primary health care services through clinics and access to pharmaceuticals through Medical Chests. Such services are targeted at people located in rural and remote areas where no other primary care is available. The Indigenous population makes up approximately 40 per cent of all RFDS service contacts[5]. The organisation has an Aboriginal and Torres Strait Islander Health Strategy and lists the improvement of Aboriginal and Torres Strait Islander health as a goal[6].

21. The Commonwealth makes a significant contribution to the running costs of the RFDS ($19.57 million in 1999). This occurs through a variety of programs including Rural Health Support Education and Training grants; pharmaceutical grants; grants for capital purposes; operational grants; and grants through the National Health Strategy. RFDS services are also funded through grants from State governments and private donations.

22. ***Summary.*** There are a number of different types of providers of primary health care to Indigenous people. There are differences between States and regions as to how services are provided, such as:

(i) different balances in service provision between GPs, ACCHSs and State services;

(ii) different kinds of State services provide primary health care (for example community health centres and outpatient clinics) and varying levels of Indigenous input into State services;

(iii) in general, a lower number of GPs and a greater reliance on hospitals and primary health care clinics (whether State or ACCHS) in rural and remote areas;

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5 Commonwealth Minister for Aboriginal Affairs, *Social Justice for Indigenous Australians 1994-95*, Australian Government Service, Canberra, 1995, p145.

6 www.rfds.org.au

(iv) varying levels of Commonwealth and State funding in different States and regions — this does not necessarily correspond to the balance between Commonwealth and State service providers; and

(v) the type of service provider available in a location has implications for the funds that can be accessed and thus the type and level of services available. For example, if a remote area is serviced by an ACCHS that receives funding to dispense pharmaceuticals under Section 100 arrangements, individuals living in that area can receive free pharmaceuticals. If the local health service is a State service with no access to Section 100 arrangements, then individuals may have to pay for pharmaceuticals where the cost is not borne by the service provider.

Expenditure on Primary Health Care Services

23. In 1998-99, around $500 million was spent on primary health care for Indigenous people. The amount spent on each Indigenous person was between one and half to two times that spent on each non-Indigenous person. Figure 2-1 below shows the proportion of funds spent on Indigenous people by source of funds for 1995-96. While the data are for 1995-96, data from the *Preliminary Findings of the Report on Expenditure on Health Services for Aboriginal and Torres Strait Islander People 1998-99*[7] show that the pattern is largely unchanged. It can be seen from Figure 2-1 that, for Indigenous people, most expenditure (approximately 61 per cent) on primary health care is through community health facilities the majority of which are State services. The Commonwealth's main programs (Medicare and PBS) are a small component of total expenditure (approximately 10 per cent). This pattern is different from that for non-Indigenous people for whom most expenditure is through Medicare and PBS (approximately 65 per cent).

24. Table 2-1 shows primary health care expenditure by State. It shows that the level of total expenditure on Indigenous people differs between States. These differences reflect, amongst other things, policy differences between States, varying levels of need for services and the different cost of providing services.

25. Table 2-1 shows that there is a wide variation in expenditure per person through State providers and programs. For example, the Northern Territory spends much more per person than other States on community and public health. It has a large number of remote area health services that face higher service delivery costs because they are located in remote areas and service a dispersed population. Expenditure through non-admitted services is much higher in Queensland, Western Australia and the ACT. Queensland and Western Australia have a large network of small hospitals in rural and remote areas.

26. A comparison of the level of expenditure on Indigenous people through Commonwealth and State programs shows that most primary health care is provided

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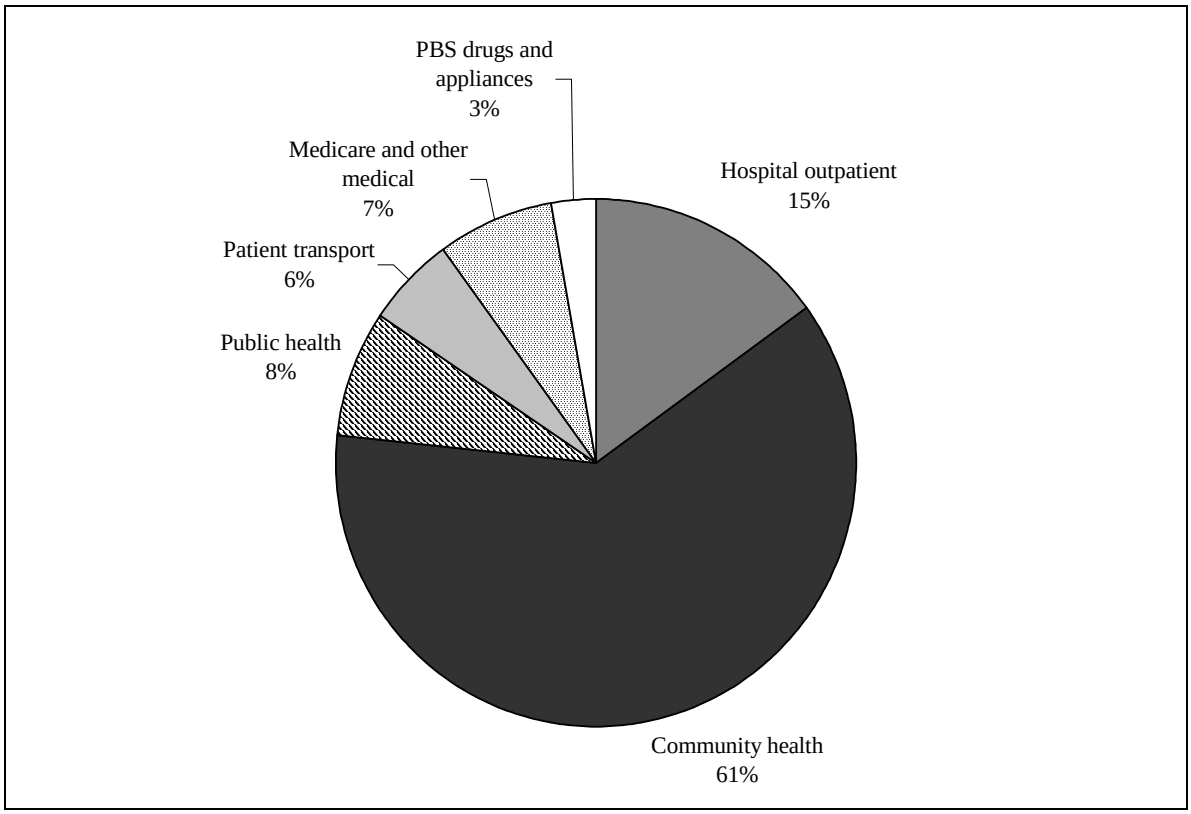
[7] AIHW, *Preliminary Findings of the Report on Expenditure on Health Services for Aboriginal and Torres Strait Islander People 1998-99* (forthcoming), AIHW/DHAC, Canberra, 2001.

through State services (approximately 60 per cent of all government expenditure) and in particular community health services. Funding of ACCHSs is the main focus of Commonwealth expenditure (24 per cent of all government expenditure and 60 per cent of Commonwealth direct expenditure[8]). This high proportion reflects, in part, the low use of Medicare and PBS by Indigenous people.

Figure 2-1 COMPONENTS OF PRIMARY HEALTH CARE EXPENDITURE — INDIGENOUS AUSTRALIANS 1995-96



Source: J Deeble, C Mathers, L Smith, J Goss, R Webb, V Smith, 1998, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, AIHW, Canberra, p61.

27. Details of Commonwealth expenditure in each State on Indigenous people through Medicare and PBS are not available. However, access to, and expenditure on these programs does differ between States and by region. This is largely because of lower access to Medicare and PBS type services in remote regions. Consequently, States or regions with large remote areas receive lower levels of Medicare and PBS funding. For example, in Western Australia, a recent report noted that during the 1996-97 financial year Medicare

[8] This includes expenditure on ACCHSs and State government services through OATSIH. It includes base grant funding and other programs and initiatives listed in Table 2-8.

expenditure was approximately $25 per person in Halls Creek[9]. This compares to a national average of $331 in that year.

28. The *Preliminary Findings of the Report on Expenditure on Health Services for Aboriginal and Torres Strait Islander People, 1998-99* provides a summary of select Commonwealth primary health care programs broken down by area as defined by the ARIA classification[10]. This information is shown in Table 2-2. It confirms that expenditure through Medicare and PBS decreases with increasing remoteness. For Indigenous people expenditure per capita is 53 per cent lower in remote areas than it is in highly accessible areas. This shows that access to services does have some impact on Medicare use. However, expenditure on Indigenous people in highly accessible areas is still about 40 per cent of that of expenditure on non-Indigenous people in the same area. This indicates that there are other barriers which mean that for Indigenous people access to Medicare is poor everywhere. Funding through OATSIH is highest in remote regions and lowest in moderately accessible regions. Data on State expenditure on primary health care are not available. Data on total expenditure on public hospitals shows that expenditure per Indigenous person increases with remoteness, and it could be expected that expenditure on non-inpatient services would operate on a similar basis.

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9 Western Australian Legislative Council, *Report of the Standing Committee on Estimates and Financial Operations in Relation to Environmental Health in Aboriginal Comminutes in the Kimberley Region*, Report 32, Perth, 2000, p23.

10 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 six categories: highly accessible; accessible; moderately accessible; remote; or very remote.

Table 2-1 GOVERNMENT EXPENDITURES ON PRIMARY HEALTH CARE FOR INDIGENOUS AUSTRALIANS, 1998-99

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	$m	$m	$m	$m	$m	$m	$m	$m	$m
Total Expenditure									
Commonwealth									
MBS	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	58
PBS	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	21
OATSIH[(a)]	20	12	22	24	15	2	1	27	124
Other	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	64
State									
Community and public health services	52	9	47	34	6	7	1	72	228
Hospital–outpatients	15	2	19	12	3	2	1	7	62
Other	3	0	2	3	3	0	0	10	21
Total	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	578
	$pc	$pc	$pc	$pc	$pc	$pc	$pc	$pc	$pc
Per capita Expenditure									
Commonwealth									
MBS	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	143
PBS	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53
OATSIH[(a)]	176	504	196	402	641	143	446	506	305
Other	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	158
State									
Community and public health services	450	381	421	577	259	438	303	1 331	561
Hospital–outpatients	130	85	170	204	129	125	303	129	153
Other	26	0	18	51	129	0	0	185	52
Total	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1 425

(a) From unpublished data provided by OATSIH. Data on episodes of care from the 1998-99 Service Activity Report have been used to exclude an amount relating to non-Indigenous use of services. Those data indicate that 9.45 per cent of all episodes of care were for non-Indigenous clients.

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, 2001.

Medicare and Pharmacuetical Benefits Scheme (PBS)

29. The Indigenous population accesses both these programs at a much lower rate than the non-Indigenous population. Expenditure per Indigenous person through Medicare is 41 per cent of that for a non-Indigenous person, and PBS expenditure per Indigenous person is 33 per cent of that for a non-Indigenous person.

30. The low level of Indigenous access to Medicare is the result of a number of factors. In rural and remote areas there is a lack of facilities that bill Medicare. Geographical Information Systems Cooperative of Adelaide (GISCA) data show that 65 per cent of the Indigenous population in the Northern Territory, 34 per cent in Western Australia and 21 per cent in Queensland are more than 80 kilometres away from a Medicare funded facility[11].

31. Likewise, the low access to PBS partly reflects a lack of physical access to pharmacists in rural and remote areas, where two thirds of the Indigenous population live. GISCA data show 61 per cent of the Indigenous population in the Northern Territory, 24 per cent in Western Australia, 15 per cent in Queensland and 13 per cent in South Australia are situated more than 80 kilometres away from a pharmacist[12].

32. There are also significant cultural barriers to Indigenous people accessing Medicare and PBS. These were identified in detail in the Keys Young Report into Indigenous access to these programs[13]. Table 2-3 summarises the key impediments to Indigenous access to Medicare and PBS identified by the report.

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11 http://www.gisca.adelaide.edu.au/mapservers/hac/pdf/index.htm, October 2000.

12 http://www.gisca.adelaide.edu.au/mapservers/hac/pdf/index.htm, October 2000.

13 Keys Young, *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*, Sydney, 1997.

Table 2-2 ESTIMATED EXPENDITURE PER INDIGENOUS AND NON-INDIGENOUS PERSON BY ARIA FOR SELECT PRIMARY HEALTH CARE PROGRAMS, 1998-99

ARIA Category	Medicare	PBS	OATSIH
	$	$	$
Expenditure per Indigenous person			
Highly accessible	157	58	212
Accessible	156	61	227
Moderately accessible	143	53	98
Remote[a]	84	23	687
Very remote	84	23	296
Total	143	53	295
Expenditure per non-Indigenous person			
Highly accessible	367	163	23
Accessible	289	125	24
Moderately accessible	275	119	11
Remote[a]	197	93	74
Very remote	197	93	32
Total	351	163	32
Ratio[b]			
Highly accessible	0.4	0.4	9.2
Accessible	0.5	0.5	9.5
Moderately accessible	0.5	0.4	8.9
Remote[a]	0.4	0.2	9.3
Very remote	0.4	0.2	9.3
Total	0.4	0.3	9.2

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

(b) Expenditure per Indigenous person divided by expenditure per non-Indigenous person.

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, 2001.

Table 2-3 BARRIERS TO ACCESS TO MEDICARE AND PBS

Service	Barriers to access
Medicare	Approximately 15-40 per cent of Indigenous people had no Medicare Card. While the situation is worst in remote and rural areas, the report also showed that about 15-20 per cent of Indigenous people using health services in urban areas did not have access to a current Medicare Card. This is because of: • mobility — people travel from remote areas where Medicare is not in use to urban areas; • late presentation with illness leading to hospitalisation rather than regular use of a primary health care service; • individuals have previously not seen a private doctor; • institutionalisation — including gaol and children in care; • expired cards — no current addresses to send new cards to; and • the need to provide correct identification and personal details such as names, a fixed address, proof of citizenship and date of birth. The circumstances which many ACCHSs operate under reduce access to Medicare. These include: • the administrative requirements of Medicare and the lack of support and training to ACCHS workers in maintaining them; • some of the services delivered by ACCHSs are not eligible for Medicare — for example, work done by nurses and Aboriginal Health Workers (AHW) and non-clinical work performed by doctors; and • many ACCHSs operate in high cost remote areas and Medicare rebates are not adjusted accordingly.
PBS	There are: • difficulties producing PBS entitlement numbers; • individuals who are eligible but not enrolled — although around 60 per cent of the Indigenous population are entitled to a health care concession card the actual number of cardholders is much lower; • the inability to afford payments and co-payments; • the administration of the safety net; • a lack of physical access; and • inappropriate prescriptions by GPs and specialist doctors.

Source: Keys Young, *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme, Report*, Sydney, 1997.

33. There have been a number of recent initiatives that aim to address the difficulties preventing Indigenous people from accessing Medicare and PBS. These include:

(i) The streamlining of enrolment in Medicare and in claims procedures in remote areas. This includes electronic claiming forms and bulk enrolment.

(ii) Exemptions to Section 19 (2) of the *Health Insurance Act, 1973* allow ACCHSs that have a salaried doctor to bill Medicare. Some State governments have also been adopting this scheme, although the uptake of the scheme by the State services has been slower than expected. Table 2-4 shows progress as of late 2000 on implementing Section 19(2) arrangements between States and the Commonwealth. As the table shows, the funds gained through State services billing Medicare

do not necessarily flow back to that service. An increased administrative load without any immediate benefit may dissuade some State health services from implementing such arrangements.

Table 2-4 PROGRESS ON SECTION 19(2) ARRANGEMENTS[(a)]

State	Nature of agreement
NSW, Vic, SA, Tas	No agreement
Qld	An agreement is in place allowing State run health services to claim Medicare. The funds flow directly back into a community trust fund.
WA	An agreement is in place allowing State run health services to claim Medicare. The funds flow into a State-wide trust fund which is directed towards about 5 health services as determined by regional planning.
NT	In the past the Northern Territory has received Health Program Grants. They are currently discussing arrangements.
ACT	There are no remote health services.

(a) As of late 2000.

(iii) New Medicare items (enhanced primary care items) that assist in covering the cost of the longer consultations that Indigenous patients require.

(iv) Other alternative arrangements have been established such as the cashing out of a notional level of Medicare funding — this occurred with the co-ordinated care trials and will continue through PHCAP (discussed shortly).

(v) Section 100 of the *National Health Act* allows pharmaceuticals to be made available to remote ACCHSs (with appropriately qualified health practitioners) to dispense to patients. Processes are under way to extend the arrangements to some State services in remote areas, and a MOU has been signed in the Northern Territory. Many remote ACCHSs told the Commission that the arrangements had been successful in both relieving the financial pressure on them and increasing the access of Indigenous people to pharmaceuticals. However, it was also mentioned that the extension of these arrangements to State services was not as effective as had been hoped.

34. Table 2-5 shows estimated expenditure per person on Medicare and the PBS before (1995-96) and after (1998-89) the above initiatives were introduced. While Commonwealth expenditure per Indigenous person remains considerably lower than the Australian average per person expenditure, it has increased since 1995-96. Medicare expenditure on Indigenous people has increased from 28 per cent to 41 per cent of that spent on non-Indigenous people. There has been an increase in the level of Indigenous access to PBS funds from 22 per cent to 33 per cent of non-Indigenous use. However, it is difficult to

know whether these changes are due to changes in methods of estimating the expenditure or changes in service use[14].

Table 2-5 ESTIMATED MEDICARE AND PBS EXPENDITURE PER INDIGENOUS AND NON-INDIGENOUS PERSON, 1995–96 AND 1998-99

	1995–96			1998–99		
	Indigenous	Non-Indigenous	Ratio	Indigenous	Non-Indigenous	Ratio
	$	$		$	$	
Medicare						
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
PBS	27	123	0.22	50	151	0.33
All benefits	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, 2001.

35. In the Report the Commission concluded that to the extent that the increase in expenditure figures reflects real change, the recent Commonwealth initiatives concerning Medicare and PBS may have been successful in increasing Indigenous access. Nevertheless expenditure remains at a level far below that which would be expected given their health needs.

Primary Health Care Access Program (PHCAP)

36. The Commonwealth has said that the PHCAP program is a central means by which it will address areas where access to primary health care is poor and/or needs are high. The funding model is based on that used in co-ordinated care trials (CCTs). Both ACCHSs and State services can be funded under this program. The 1998-99 Commonwealth budget made $78.8 million available over 4 years. This is expected to cover the 4 Indigenous CCTs and 8 new or expanded service sites.

37. Submissions to the Inquiry have noted that mainstream funds (in particular Medicare and PBS) not accessed by Indigenous people could be made available through

[14] A discussion of this cause of the change will be contained in AIHW, *Preliminary Findings of the Report on Expenditure on Health Services for Aboriginal and Torres Strait Islander People 1998-99* (forthcoming), AIHW/DHAC, Canberra 2001.

cashing out to increase spending on Indigenous-specific primary health care[15]. PHCAP can be considered as one means of doing this.

38. Under PHCAP Commonwealth and State funds are pooled and priorities are determined in collaborative forums that involve the Commonwealth, the State and the community controlled sector.

39. The Commonwealth contribution to an area is determined by estimating what the area would notionally receive under Medicare. Estimates of this contribution allow for health status and remoteness and may be up to 4 times the average Medicare payment per capita.

40. The State contribution is determined by negotiation. The only requirement is that States do not reduce the level of funding in an area. States can notionally or actually pool funds.

41. The program can be used to fund community controlled or State providers. Funds must be used for primary health care purposes but service providers are given the flexibility to choose the mix of services. An optimal benchmark funding level will be determined for each site. In the first instance sites will be funded at a level below the benchmark, with funding raised to the benchmark over time. This is so that the capacity of the service to use the funds is gradually developed.

42. To be eligible to receive funding an area must have demonstrated needs (as identified in regional plans[16] or through the CCTs) and a demonstrated capacity to use funds. There must also be community involvement and States must contribute to the pool.

43. As well as the former Indigenous CCT sites, four areas in Central Australia (Warlpiri, Northern Barkly, Anmatjere, and Eastern Arrernte) and four areas in South Australia (parts of the Northern and Far Western region, Wakefield region, Riverland, Hills, Mallee and Southern region and the North Metropolitan regions) will be funded using existing PHCAP budget commitments. South Australia and Central Australia were chosen as they finished their regional plans first.

44. Aspects of PHCAP such as funds pooling, equivalent Medicare and PBS funding and community input are similar to strategies used by the CCTs. Information concerning the use and effectiveness of these strategies in the CCTs can be found in

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15 For example, submissions to the Inquiry from the National Centre for Epidemiology and Population Health initial submission, April 2000, p15; the Australian Medical Association, final submission, February 2001, p1; the National Aboriginal Community Controlled Organisation, initial submission, May 2000, p10; the Aboriginal Medical Services Alliance Northern Territory, final submission, December 2000, pp3-12; Queensland Health, initial submission, May 2000, pp2-3; Northern Territory Government, initial submission, April 2000, p29; and the Commonwealth Department of Health and Aged Care, initial submission, April 2000, pp78-9.

16 Not all regional plans have been completed and those that have take different approaches to identifying need. The two plans that cover the Northern Territory use population to staff ratios to identify gaps in service provision. Queensland used data on morbidity rates to identify areas of high need. Many plans used local knowledge and consultation with communities and service providers to identify gaps in current service provision. While regional plans are used to identify priorities within a region, there is presently no way of comparing priorities and need across regional plans.

Attachment C. In Katherine West pooled trial funds were used to employ a doctor thereby increasing access to Medicare. In Tiwi funds were used to increase the number of mental health workers.

45. The PHCAP was a topic of discussion in some submissions. While most supported the program in concept, questions were raised about some aspects of it.

46. Deeble and Sibthorpe noted that the funding model (cashing out of Medicare) has not been evaluated over the long term[17] and that it is unclear whether it will improve health outcomes and access to services.

47. The Northern Territory Government said that while it fully supports the approach the proposed roll out is too slow[18]. It thought more sites could be funded and that the proposed time frame to get services up to full funding levels could be shortened.

48. During the Commission's consultations some organisations argued that the CCTs (on which the funding model for PHCAP is based) were administratively complex. Consultations also raised the questions surrounding the concept of capacity to benefit used for the allocation of PCHAP funds. In particular it was noted that those areas that finished regional plans get funded first, implying that those who are in greater need but do not have collaborative forums may miss out on funding.

49. In Chapter 6 of the Report the Commission concluded that:

(i) expanding PHCAP in accordance with regional plans was potentially an effective way of increasing access of Indigenous people to Medicare;

(ii) there was a danger in that some areas might miss out as they have not finished regional plans and/or are not working collectively — people who suffer are the Indigenous clients; and

(iii) this is only one solution and others need to be pursued.

ACCHSs

50. In 1997-1998 there were 100 ACCHSs affiliated with NACCHO. About 60 per cent are located in New South Wales, Victoria and South-east Queensland. This roughly accords with the distribution of the Indigenous population. Table 2-6 shows the distribution of ACCHS by State. In Western Australia ACCHS are concentrated in the top half of the State and are mainly in towns. In the Northern Territory over half are located in towns.

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17 The National Centre for Epidemiology and Population Health, final submission, December 2000, p6.

18 Northern Territory Treasury, final submission, January 2001, p.6.

Table 2-6 DISTRIBUTION OF ACCHSs BY STATE — 1997-98

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of ACCHSs	21	24	18	18	6	1	1	11	100

Source: NACCHO, *Annual Report 1997-98*, NACCHO, Canberra, 1998, p10.

51. Table 2-7 shows data on Indigenous and non-Indigenous episodes of care in ACCHSs. On average across Australian about 10 per cent of contact is with non-Indigenous clients. This varies between States, with over 15 per cent non-Indigenous clients in Queensland and considerably less than 10 per cent in Victoria, Tasmania, South Australia and the Northern Territory. The level of non-Indigenous use may also vary between services within the same State, depending on the local context of health services. For example, during consultations some ACCHSs said that up to 40 per cent of their clients where non-Indigenous as the ACCHS was the only bulk-biller in town.

Table 2-7 EPISODES OF CARE IN ACCHS — 1998-99

State	Non-Indigenous as a share of total episodes of care	Indigenous episodes of care		
		Male	Female	State share of total episodes of care
	%	%	%	%
NSW and ACT	11.11	40.29	59.71	24.59
Vic and Tas	6.87	37.03	62.97	13.91
Qld	16.93	35.78	64.22	12.90
WA	9.42	44.87	55.13	23.29
SA	4.24	39.32	60.68	13.10
NT	5.44	39.59	60.41	12.22
Total	9.45	40.10	59.90	100.00

Source: Unpublished data from the Service Activity Report for 1998-99 provided by OATSIH, DHAC, October 2000.

OATSIH Programs

52. Table 2-8 contains a list of programs and expenditure by OATSIH. The ACCHSs are the Commonwealth's primary mechanism for funding Indigenous-specific services. Close to 60 per cent of funds listed in Table 2-8 are used to fund the ongoing operation of ACCHSs and a large portion of the rest was for specific initiatives.

Table 2-8 OATSIH GRANT EXPENDITURE BY PROGRAM, 1995-96 TO 1999-2000[(a)]

	1995-96		1996-97		1997-98		1998-99		1999-00	
	$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
Total	90.156	100	87.069	100	116.073	100	136.690	100	136.492	100

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

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

53. Not all sites funded by OATSIH are ACCHSs. OATSIH also provides funding to a number of State health services. Table 2-9 shows that there are over twice the number of OATSIH funded primary care services than there are ACCHSs across Australia. ACCHSs comprise only 20 per cent of services funded in Tasmania, 37 per cent of funded services in Queensland, and 86 per cent of funded services in Victoria.

Table 2-9 NUMBER OF ACCHSs AND OATSIH FUNDED PRIMARY CARE SERVICES

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of ACCHSs	21	24	18	18	6	1	1	11	100
All primary care services funded by OATSIH	42	28	49	33	17	5	2	34	210

Source: NACCHO, *Annual Report 1997-98*, NACCHO, Canberra, 1998, p10 and DHAC, *Annual Report 1998-99*, DHAC, Canberra, 1999, p175.

54. The Commonwealth has increased its expenditure on the Indigenous community health care 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 the next five years to expand existing services and create new ones.

55. 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 CCTs. In 1998-99 an additional $78 million over four years was allocated for the new PHCAP — to provide for expanded services. The cumulative result of these increases in spending is that the Commonwealth has increased Indigenous-specific funding for health from $42 million in 1990-91 to $160 million in 1999-2000.

56. Most additional Commonwealth funding has gone to new programs. Some such programs address specific health issues (such as sexual, mental, ear and eye health) and others fund new services (such as the remote communities initiative and PHCAP). As a consequence, other than the rebasing exercise in 1995-96, existing services have largely only been able to expand their services through funding for specific health issues — 'body parts funding'. New base grant funding such as the remote area initiative has gone towards forming new ACHHSs.

57. Attachment D shows OATSIH expenditure by ATSIC Region and by State for 1998-99. The data show that in 1998-99 most OATSIH Health service funding[19] went to the Northern Territory and Western Australia (22 per cent of grant expenditure), followed by New South Wales (17 per cent) and Queensland (16 per cent). New South Wales and Queensland received a lower than population share of OATSIH funding. The ACT received a population share while the remaining States received a greater than population share. Data on morbidity show the level of hospital separations is high in the four States in which most OATSIH grants are targeted. The Northern Territory, Western Australia and Queensland have high hospitalisation rates mainly because of relatively higher rates of hospitalisation compared to Indigenous people in other States.

58. Within New South Wales the greatest proportion of OATSIH funding on Health services (29 per cent) went to the Sydney ATSIC Region. This is followed by Murdi Paaki (Bourke) (26 per cent), and Many Rivers (Coffs Harbour) (18 per cent). Most funds in Queensland went to the South East Queensland (Brisbane) (35 per cent) and Cairns and District (25 percent). Most funds in Western Australia are concentrated in the top half of the State. About 34 percent of funding went to Kullari (Broome), Malarabah (Derby) and Wunan (Kununurra). About 55 per cent of funds in South Australia went to the Nulla Wimila Kutju (Port Augusta) region, 27 percent to Nulla Wimila Kutju (Adeliade), and the remaining 17 per cent to Wangka-Willurrara (Ceduna). In the Northern Territory 32 per cent of funds went to Garrak-Jarru (Katherine)/Yappakurlangu (Tennant Creek) and 24 per cent went to the Yilli Rreung (Darwin) and Jabiru region.

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[19] Health services includes Health base grant funding, Co-ordinated care trials, Remote services, Substance misuse services, Staff training and Management support.

59. Attachment D also shows data on Health strategies[20] by ATSIC Region. It shows that most funding went to Queensland (21 per cent), New South Wales (18 per cent) Western Australia and the Northern Territory (17 per cent). The Regional distribution is different to that for Health services. Most Health strategies funds went to metropolitan ATSIC Regions except in the Northern Territory where approximately 29 per cent of funds in that State went to Alice Springs.

Elements of Comprehensive Primary Health Care

60. From an Indigenous perspective, the delivery of comprehensive primary health care goes beyond simply the provision of basic clinical services and addresses the broad wellbeing of an individual. Submissions and consultations raised the following issues as crucial elements of comprehensive primary care, and as areas of great concern and need in the Indigenous community.

61. ***Environmental Health.*** Chapter 6 of the Report noted that poor environmental health is a key cause of poor health for Indigenous Australians. In the Report the Commission concluded that:

(i) poor environmental health is a key cause of poor health in Indigenous communities particularly in rural and remote areas;

(ii) responsibility for environmental health is blurred both between different levels of government and also within governments between departments; and

(iii) this is one area that requires more attention and better coordination of effort by governments.

62. *Need for improved environmental health.* Consultations and submissions also noted that poor environmental health was a key cause of poor health, particularly in rural and remote areas. For example, the medical service at one community noted that in the 3 months prior to the Commissions visit all deaths in the community had been related to infectious and parasitic diseases that were easily preventable. The key environmental problems that this community (and many others) listed were:

(i) Housing — overcrowding and homelessness were major problems. Housing quality was very poor. Most houses did not have hot water and other basic facilities.

(ii) Dust — roads were not sealed and the area was prone to dust problems.

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[20] Health strategies includes Mental health, Hearing services, Specialist services, Sexual health, Eye health, and Immunisation.

(iii) Water quality — the ground water was undrinkable and the community had to rely on surface water of which there was not always enough.

(iv) Electricity — there was a need for an upgrade of the system as it had reached its capacity.

(v) Sewerage — the sewerage system was in urgent need of repair and was not working adequately.

(vi) Dog control — there was a need for a dog control program to help stop the spread of parasitic diseases but funds were not available.

(vii) Access to good food — food was expensive and of poor quality.

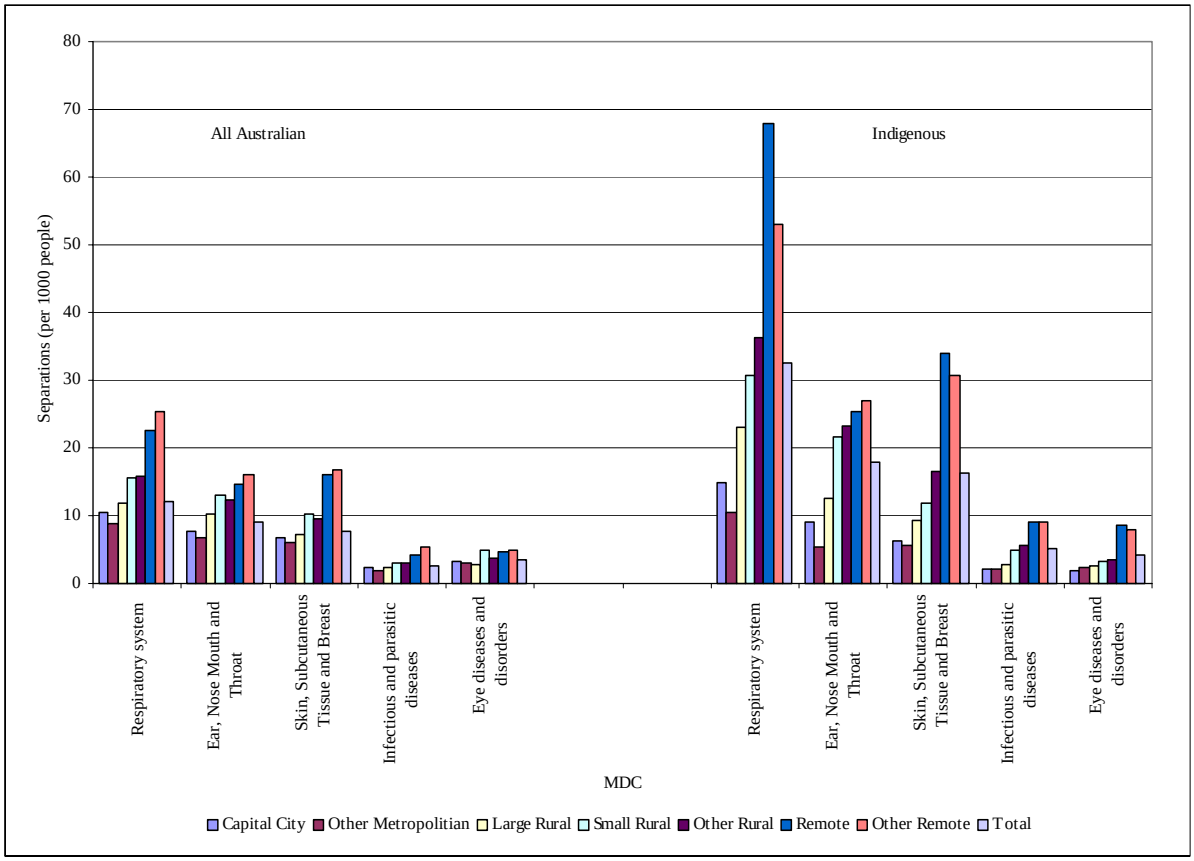
63. Figure 2-2 shows that hospitalisation rates for key environmental health related conditions are higher for Indigenous Australians than non-Indigenous Australians. Hospitalisation rates also show that the difference between the Indigenous population and the all-Australian rate is greatest in more remote areas. The rates for all-Australians and Indigenous Australians generally increase with remoteness.

64. Attachment E shows in detail the rates of hospitalisation for key environmental related conditions for Indigenous people by State and by RRMA. It shows that rates are generally higher in rural and remote regions. In New South Wales, rates were 5 to 10 times higher in remote areas than in Sydney. In most other States, rates were 3 to 5 times higher. The least contrast between remote and metropolitan rates was in South Australia. It also shows that rates are highest in Western Australia, South Australia and the Northern Territory. In all States, except the ACT, diseases of the respiratory system were the most frequent cause of a hospital separation for an environmental related condition. The other two most significant causes were diseases of the ear, nose and throat and diseases of the skin, subcutaneous tissues and breast.

65. The Commission's work on housing shows that the average need per household is greatest in rural and remote areas, particularly in the Jabiru, Nhulunbuy, and Apatula ATSIC regions (Northern Territory), Cooktown and Torres Strait regions (Queensland), and the Derby region (Western Australia). The infrastructure work shows that need is also greatest in the remote and sparsely populated regions such as Nhulunbuy, Jabiru and Aputula (Northern Territory), Kununurra and Broome (Western Australia) and the Torres Strait and Cooktown Regions (Queensland). This regional pattern is broadly consistent with the higher number of hospital separations in remote areas as shown by Figure 2-2.

66. *Responsibility for service provision.* During consultations it was noted that although needs for environmental health were high there were often no funds to employ environmental health workers and institute programs such as dust control or dog control. Similarly, it was often noted that while capital funds are made available for housing and infrastructure, funding for recurrent maintenance tended to be inadequate.

Figure 2-2 HOSPITAL SEPARATIONS FOR KEY ENVIRONMENTAL HEALTH CONDITIONS, 1996-97



Source: AIHW, *Morbidity Database 1996-97*

Environmental health is highly intersectoral, embracing a broad range of subjects and a number of different departments in each level of government. In general, the Commonwealth's role in environmental health focuses on strategic direction at a national level, while the States and local government have direct responsibility for the management of environmental health and public health activities as described by their relevant Public Health Acts. Table 2-10 shows the broad areas of service delivery that impact on health and housing outcomes, which level of government or agency provides each service, and what associated environmental health processes or activities are provided.

67. Table 2-10 indicates it is often not clear which agency is responsible for environmental health issues. The Commission concluded that the overall planning and coordination of services for many communities needs to be addressed. It noted that there are planning mechanisms in place in housing and primary health care, but an overall strategic approach, that would help maximise outcomes, is missing. This leads to many environmental health issues falling through the cracks.

68. *Summary*. The data show that Indigenous people suffer from environmental related conditions at a much greater rate than non-Indigenous people. Indigenous Australians in rural and remote areas suffer from environmental related diseases at a much greater rate. In practice there are several different government departments and levels of government responsible for meeting environmental health needs.

Table 2-10 BROAD AREAS OF RESPONSIBILITY FOR ENVIRONMENTAL HEALTH

Service type or issue	Service provider	Environmental health activities or considerations
Primary Health Care	DHAC, State and local government	Health prevention programs, immunisation, links to other providers
Public Health Care	State and local government	Inspection of food and accommodation premises, swimming pools, dog control. Employment of Environmental Health Officers
Housing	ATSIC, DFACS through State government and Indigenous housing authorities	Ongoing maintenance for effective use of housing, health housing initiatives, defining building standards
Water	ATSIC and State governments	Water testing, functionality in the home
Sewerage	ATSIC and State governments	Ongoing maintenance, septic management
Solid Waste Removal	ATSIC and local governments	Collection and management – often via CDEP
Dust	ATSIC and local governments	Landscaping and traffic management
AEHWs	State and local government	Employment and training of environmental health workers whose role is to monitor, fix or coordinate work in communities
Building approval and inspection	Local government	Building and infrastructure work inspections against standards
Development of community or town plans	ATSIC and/or State governments should coordinate	Planning that takes account of cultural issues, the location and environmental issues
Use of appropriate technology	ATSIC and other agencies	Research and adoption of appropriate technologies or practices

69. ***Mental health and substance misuse.*** Mental health and substance misuse has emerged as a prominent issue in reports such as the Royal Commission into Aboriginal Deaths in Custody[21], Bringing Them Home[22] and Ways Forward[23]. The emotional and social wellbeing of Indigenous people and a lack of appropriate mental health and substance misuse services was often raised as a priority in submissions and consultations. There is, however, a lack of data that could be used to measure Indigenous need in this area.

70. *Need for services.* Hospital separations for mental illness and substance misuse related disorders can be considered as an indicator of need. However, they only measure needs that have been met and do not capture undiagnosed illness or illness that does not result in hospitalisation. In 1996-97 there were about twice as many hospital separations as expected for mental disorders among Indigenous people (the category of mental illness includes alcohol and drug related conditions, depression, psychosis and other conditions). Hospital separations from self-inflicted injury for the Indigenous population were about twice the rate as those in the non-Indigenous population. Table 2-11 shows Indigenous separations for mental disorder, self-inflicted injury and injury inflicted by others.

Table 2-11 INDIGENOUS HOSPITAL SEPARATIONS FOR MENTAL DISORDERS, SELF INFLICTED INJURY AND INJURY INFLICTED BY OTHERS, 1996-97

	Number of Indigenous separations		Age standardised separation ratio		Per cent of all separations	
	Males	Females	Males	Females	Males	Females
	No.	No.	No.	No.	%	%
Mental disorders	4045	2867	2.5	1.6	6.4	3.5
					Per cent of all injury separations	
Self inflicted injury, suicide	319	434	2.1	1.8	4.0	7.0
Injury purposefully inflicted by others, homicide	1980	2119	6.5	20.1	25.1	34.1

(a) Age standardised hospital separation ratio is equal to hospital separations identified as Indigenous divided by expected separations, based on all Australian rates. A ratio above 1 indicates that, after adjusting for the age-sex structure of the Indigenous population there are more separations for that cause than in the Australian population.

Source: ABS/AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People*, AIHW/ABS cat. No. 4704.0, Canberra, 1999, pp112 and 114.

21 E Johnstone, *National Report: Overview and Recommendations; Royal Commission into Aboriginal Deaths in Custody*, Canberra, 1991, see especially recommendations 264-66, 282-83, 285-88.

22 HREOC, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*, HREOC, Canberra, 1997, pp374-76.

23 P Swan and B Raphael, *Ways Forward, National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*, Canberra, 1995.

71. Data on hospital separations by State and RRMA for 1996-97 show that separations for alcohol/drug disorders are generally higher in small rural, other rural and remote areas than they are in capital cities, metropolitan areas and large rural centres. This is most clearly the case in New South Wales, with separations in other remote areas about 12 times the rate in the capital city. In Victoria, separations are highest in other rural regions, at about 6 times the rate in large rural regions. In Queensland the highest rates are in remote centres at 7 times the rate in metropolitan areas. The rate in other remote areas and other rural centres is similarly high. In South Australia the rates are highest in small rural centres, at 6 times that of the capital city and 9 times that of large rural centres. In the Northern Territory, rates increase with remoteness with remote centre rates 10 time higher than those in the capital city Western Australia did not have such a strong pattern of hospital separations increasing with remoteness — it has consistently high rates across regions. While small rural and remote centres had rates about 1.4 times that of the capital city, the lowest rate was in other remote areas.

72. Another source of information on the need for social and emotional wellbeing services is the Indigenous results of surveys of drug use. The National Drug Household Survey[24] showed that while a lower proportion of adult Indigenous people drink alcohol than non-Indigenous people, those who do are more likely to consume it at hazardous levels. The survey also showed that 1.5 per cent of Indigenous people surveyed reported recently suffering a mental disorder. However, the survey relied on self-reporting and may present a distorted picture[25].

73. Another possible approach to measuring Indigenous need for social and emotional wellbeing services would be to examine access to Indigenous mental illness and substance misuse workers and programs. The CHINS[26] provides information on the access of communities to mental health and substance misuse workers and the conduct of substance misuse programs. However, this information was only gathered for communities with a population above 50 located 10 kilometres or more from the nearest hospital (315 communities with a total population of 67 223). Attachment F shows the results of the survey, which indicates that the number of communities without physical access to such services increases with remoteness. Large numbers of Indigenous people lack access to these services in the Northern Territory, Queensland, Western Australia, and to a lesser extent in South Australia and New South Wales.

74. Despite the lack of data, researchers generally believe that there is considerable need for mental health and substance misuse services for the Indigenous population across Australia. Key concerns raised in consultations and submissions included:

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[24] Commonwealth Department of Human Services and Health, *National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander People Supplement*, 1994, DHFS, Canberra.

[25] For example, it is frequently remarked that Indigenous people are overly optimistic about their health status.

[26] Community Housing and Infrastructure Needs Survey, produced by ABS on behalf of ATSIC, Canberra, 1999.

(i) Mainstream mental health and substance misuse services often fail to respond to the needs of Indigenous clients. For instance, it was often said that Indigenous patients in mainstream mental health services are frequently misdiagnosed because of a lack of understanding of Indigenous history and culture, and that mainstream services need to be made culturally accessible and effective.

(ii) The lack of Indigenous-specific services and programs, including counselling, rehabilitation and detoxification services.

(iii) In rural and remote areas there is often a lack of access to any form of mental health and substance misuse services, especially detoxification and rehabilitation services.

(iv) The need to direct resources towards training and supporting AHWs in mental health and substance misuse issues.

75. Indigenous-specific services provision. OATSIH administers a social and emotional wellbeing program and a substance misuse program. Funds (over $2.5 million) from the National Mental Health Strategy and the National Suicide Prevention Strategy have been transferred to OATSIH for its Social and Emotional Wellbeing program.

76. The social and emotional wellbeing program establishes regional centres and some counselling positions. These centres develop and deliver education packages, develop information systems, provide training and clinical support to AHWs and other workers, and improve links between services. By 1998-99, 11 such centres had been established and 50 counselling positions finalised.

77. Through its substance misuse program, OATSIH funds 69 specific substance misuse services or projects, including education and prevention strategies, and treatment and rehabilitation services. There are 22 residential services funded. The type of service funded varies considerably across regions. For example, in Queensland most OATSIH funded services are residential, while only 30 per cent of funded services in Western Australia are residential. The type of service in an area affects the level of funding received as residential and home and community services are funded differently.

78. Table 2-12 shows the distribution of funds by State through mental health and substance misuse grants for 1998-99. In 1999-2000 a new mental health grant was provided through the Government's response to the ‘Bringing them Home’ report.

Table 2-12 OATSIH GRANT EXPENDITURE ON MENTAL HEALTH AND SUBSTANCE MISUSE SERVICES, BY STATE, 1998-99

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	$m	$m	$m	$m	$m	$m	$m	$m	$m
Mental health	1.6	2.0	1.7	1.9	1.2	0.2	0.2	1.4	10.1
Substance misuse	2.3	1.6	3.2	2.3	2.9	0.8	0.1	2.8	16.0
Total	4.0	3.6	4.9	4.1	4.1	1.0	0.3	4.2	26.1

Source: Unpublished data, OATSIH, DHAC, October 2000.

79. Aboriginal Hostels Limited (AHL) operate a number of hostels around Australia including hostels specialising in substance misuse and rehabilitation hostels. Table 2-13 outlines their distribution across the country. Generally AHL provide capital and associate funding for such services and OATSIH covers staffing costs.

Table 2-13 DISTRIBUTION OF AHL SUBSTANCE MISUSE REHABILITATION HOSTELS ACROSS AUSTRALIA, 1998-99

	NSW	Northern Old	Southern Qld	WA	SA	Vic/ Tas	Central Aust	Northern Aust	Aust
Number of hostels	5	6	3	3	3	4	1	4	29
Beds	111	137	56	50	31	42	10	74	511
Percentage of hostels	24	29	14	17	25	27	13	29	22

Source: AHL, *Aboriginal Hostels Limited Annual Report1999-2000,* AHL, Canberra, 2000, pp 77-84.

80. ATSIC also provides some funds towards social and emotional wellbeing services. The Link Up program ($11.25 million over 4 years) provides assistance and support for Indigenous people separated from their families to undertake family tracing and reunion activities. Night patrol services are funded through the Legal Aid and Law and Justice Programs and are often subsidised through the CDEP program.

81. *Summary*. While there is limited data on the need for services to address the social and emotional wellbeing of Indigenous Australians, there is substantial evidence that there is need for such services. Mainstream services do not seem to be reliably addressing the circumstances of Indigenous people and many Indigenous people lack physical access to substance misuse and mental health services. The programs operated through OATSIH go some way to addressing this situation.

82. ***Preventative and public health programs.*** Preventative health and health promotion programs are an important element of improving the health status of Indigenous people. Health services often use funding from OATSIH for the provision of public and preventative health programs. Many OATSIH strategies that aim to address specific health issues have a component that addresses public and preventative health. For example, the nutrition, renal disease, cardiovascular disease, diabetes, sexually transmitted disease and hearing strategies all fund, in part, public and preventative health services.

83. The Commonwealth invests in mainstream population health activity through Public Health Outcome Funding Agreements (PHOFA) funding, direct grants to States, direct grants to community organisations and through supporting population health activity undertaken by GPs and their Divisions.

84. The most significant distribution of resources for public health occurs through PHOFAs. The PHOFAs are bilateral funding agreements between the Commonwealth and each State which provide broadbanded and special purpose funding from the Commonwealth to the States for a range of public health programs. Eight public health program areas have been broadbanded (or pooled).

85. The distribution of Commonwealth base funding to the States draws on a resource allocation formula which takes account of a range of factors, including population; Indigenous population; levels of mortality; socio-economic factors; the extent of remoteness; and other factors that affect the cost of delivering services. This formula has been developed to reflect key determinants of health and wellbeing in communities.

86. Performance monitoring data is the major source of accountability information under the PHOFAs. Reference is made to the Indigenous population as a special target group and to the Aboriginal and Torres Strait Islander Health Framework Agreements. Indicators for the National Drug Strategy, National Childhood Immunisation Register, Breastscreen, National HIV AIDS Strategy and the National Women's Health Program include references to the Indigenous population.

87. The NACCHO submission expressed concern that there is a lack of accountability in the application of the PHOFA process to public health for the Indigenous population[27]. They argued that while the Commonwealth is required to report on Indigenous indicators, there are no process indicators or any requirements to report on engagement or collaboration with Indigenous communities and organisation.

88. *Summary*. Public and preventative health programs are an important part of improving health outcomes for Indigenous people. They are a necessary component of providing comprehensive primary health care. There are concerns, however, that mainstream public health funding is not adequately accountable for addressing the need of Indigenous people.

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[27] NACCHO, initial submission, May 2000, pp8-9.

89. ***Dental services.*** Lack of access to dental services was raised in consultations and submissions. There is also evidence indicating that the Indigenous population has poorer dental health than non-Indigenous population. For example:

- Indigenous Australians experienced a higher rate of complete tooth loss than non-Indigenous Australians. Oral health status is worse in non-metropolitan areas, with a higher percentage of complete tooth loss in non-capital (14.8 per cent) compared to capital city (9.2 per cent) locations[28]; and

- the percentage of dentates (people who have some teeth) who wear a denture was higher among Indigenous people than non-Indigenous people when adjusted for age.

90. Poor dental health has a relationship to other significant health issues affecting Indigenous people. There is a relationship between renal failure and rheumatic heart disease through periodontic disease; periodontal disease involving bone loss and heart disease; and periodontal disease and the chances of stroke[29].

91. There are a number of indicators suggesting that Indigenous people experience difficulties accessing adequate dental care. For example, compared to a similar category of non-Indigenous people, Indigenous patients using public dental services had higher rates of extraction services. This is in addition to public patients having about twice the rate of extraction as patients in private practice. A higher rate of those having extractions points to less favourable outcomes for Indigenous Australians[30].

92. Data indicate that rural and remote communities have poorer access to dental services:

(i) Outside capital cities the availability of dentists declines. The rate of practising dentists per 100 000 population varies considerably between the capital city (51.0) and rest of the State (28.6)[31].

(ii) People in rural areas have much longer waiting times for routine services at both public and private surgeries. For example, up to 2.5 years in rural New South Wales against 7.5 months in Sydney[32].

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28 AIHW Dental Statistics Research Unit, *Newsletter Vol. VII, No. 1 August 1996: Trends in Dental Practice By Geographic Location*, Adelaide, 1996.

29 Western Australia Legislative Council, *The Provision of Health Services in the Kimberley Regions of Western Australia: Dental Health — Save Your Smile*, Report of the Standing Committee on Estimates and Financial Operations, Report 33, 1990, p9.

30 Brennan, D. S. and R. D. Carter, *Adult Access to Dental Care — Indigenous Australians*, AIHW, Canberra, 1998, p2.

31 AIHW, Dental Statistics Research Unit, *Newsletter Vol. VII, No. 1 August 1996: Trends in Dental Practice By Geographic Location*, Adelaide, 1996.

Because Indigenous people are more likely to live in rural and remote areas, they are also more likely to experience problems accessing the dental services that these regions have.

93. A report on the provision of dental health services in the Kimberly region[33] noted that there are a number of measures that can be taken to improve the dental health of Indigenous people. The two most important are:

(i) preventative initiatives — fluoridated water, education through public health programs targeting children and caregivers, and nutrition programs such as community store programs; and

(ii) improvement to the dental health services — establishment of dental centres; providing equipment to communities so that dentists could visit readily; using final year dental students; training AHWs in dental health; and increasing the use of dental auxiliaries.

94. The Commonwealth Dental Health Program, which concentrated on providing measures to improve access to dental services for disadvantaged Australians, was abolished in 1996. The States are largely responsible for the provision of dental services.

95. OATSIH funds some dental services and dental education courses. They will provide funds if the State agrees to jointly fund the project but not otherwise. A few years ago the Commonwealth provided capital grants to establish facilities. No recurrent funds were provided for an ongoing service, as dental health is a State responsibility. In some areas this has resulted in the presence of dental facilities but no provision of services.

96. *Summary*. Indigenous communities across Australia are concerned with a lack of access to dental services. There is evidence that indicates that the Indigenous population has poorer oral health than the non-Indigenous population. Poor oral health has a relationship to health conditions that are prevalent in the Indigenous population.

Workforce Issues

97. The health workforce is critical for the delivery to Indigenous Australians of effective primary health care services.

98. ***Lack of health practitioners in remote areas.*** Table 2-14 shows the distribution of nurses, doctors and pharmacists across States and rural, remote and

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[32] NRHA, *Draft Position Statement for comment — Dental Health in Rural Communities*, www.ruralhealth.org.au/dental/htm, p2.

[33] Western Australia Legislative Council, *The Provision of Health Services in the Kimberley Regions of Western Australia: Dental Health — Save Your Smile*, Report of the Standing Committee on Estimates and Financial Operations, Report 33, 1990.

metropolitan areas. There is a lack of nurses and pharmacists, as well as doctors and specialists, working in rural and remote areas.

Table 2-14 DISTRIBUTION OF PRIMARY CARE MEDICAL PRACTIONERS (1988), REGISTERED NURSES AND PHARMACISTS (1996)[(a)]

	Capital city	Other metro centre	Large rural centre	Small rural centre	Other rural area	Remote zone	Total
Number							
Registered nurses	114 236	11 503	14 417	11 534	15 277	4 719	17 1684
Primary care practitioners	14 656	1 530	1 235	1 140	1 914	378	20 852
Community pharmacists	7 635	815	673	672	1 173	159	11 126
Hospital and clinical pharmacists	1 518	108	123	103	63	24	1 940
Percentage							
Registered Nurses	9.5	8.0	12.8	9.4	6.2	8.2	9.1
Primary care practitioners	1.2	1.1	1.1	0.9	0.8	0.7	1.1
Community pharmacists	0.6	0.6	0.6	0.5	0.5	0.3	0.6
Hospital and clinical pharmacists	0.13	0.08	0.11	0.08	0.03	0.04	0.10

(a) This table uses the RRMA geographical classification of locations. Both the ARIA and the RRMA classifications 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.

Source: AIHW, *Medical Labour Force 1998*, AIHW, Canberra, 2000, Table 12, AIHW, *Pharmacy Labour force 1998*, AIHW, Canberra, 2000, Tables 12 and 18, and AIHW, *Nursing Labour Force 1998*, AIHW, Canberra, 1999, Table 61.

99. Table 2-15 shows the change in numbers of primary care practitioners working in ACCHSs between 1995 and 1998. While the number of primary care medical practitioners working in ACCHSs has increased, in New South Wales, Queensland, Western Australia (as well as Australia overall), this increase has been greatest in metropolitan areas.

Table 2-15 PRIMARY CARE PRACTITIONERS WORKING IN ACCHSs[(a)], 1995 AND 1998

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
ACCHS 1995	111	63	50	81	88	21	14	84	512
ACCHS 1998	152	118	86	212	29	9	2	91	698
Per 10 000 Indigenous people, 1988	13.3	50.4	7.8	36.4	12.6	5.7	6.1	17.0	17.4
Percentage working in metropolitan areas 1995	64.9	77.8	48.3	47.2	66.7	75.0	100.0	27.0	57.5
Percentage working in metropolitan areas 1998	82.3	76.3	59.7	61.2	58.4	31.0	100.0	27.6	62.7

(a) First second or third job in an ACCHS.

Source: AIHW, *Medical Labour Force 1998*, AIHW, Canberra, 2000, Table 29, p37 and AIHW, *Medical Labour Force 1995*, AIHW, Canberra, 1997, Table 79, p118.

100. Table 2-16 shows the composition of the labour force in ACCHSs. It shows that AHWs comprise the greatest proportion of workers in ACCHSs across Australia, although there is some fluctuation in this between States. The next most frequent worker in an ACCHS is a nurse, followed by GPs. There is, however, considerable difference in the balance between the proportion of doctors and nurses across States. In New South Wales, the ACT and Queensland the proportion of doctors employed is marginally higher than the proportion of nurses. In South Australia, 10 per cent of employees are nurses while only 4 per cent are doctors, and in Western Australia 14 per cent of those employed are nurses and 8 per cent doctors. Also notable is the high proportion of non-clinical workers, ranging from 38 per cent of employees in New South Wales to 52 per cent in the Northern Territory.

101. ***Difficulty recruiting trained Indigenous staff.*** There is no data across jurisdictions as to the proportion of doctors and nurses who identify as Indigenous. Professional registration boards do not record Indigenous status. However, there is some anecdotal evidence and some data acquired through one-off surveys collated for the report on National Performance Indicators for Aboriginal and Torres Strait Islander Health[34].

102. In that report, New South Wales said that, based on 1994 registrations, 0.28 per cent of registered nurses and 1.01 per cent of State Enrolled Nurses identified as Indigenous. An EEO survey of health services identified 0.2 per cent of the New South Wales medical workforce as Indigenous. Queensland reported that 0.3 per cent of their

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[34] AIHW, *National Summary of the 1998 Jurisdictional Reports Against the Aboriginal and Torres Strait Islander Health Performance Indicators*, The National Health Information Management Group for the Australian Health Minister's Advisory Council, AIHW cat. no. IHW 5, pp40-41.

medical workforce was Indigenous and 1 per cent of their nursing workforce identified as Indigenous. Western Australia reported reported that 3 doctors in the State identified as Indigenous. South Australia reported that 6 nurses (0.09 per cent of the nursing workforce) identified as Indigenous. The Northern Territory reported that one doctor and one nurse identified as Indigenous. These data show that the number of qualified Indigenous health professionals is well below a population share.

Table 2-16 COMPOSITION OF ACCHS WORKFORCE, 1998-99

Number (% of staff in brackets)	NSW & ACT	VIC & TAS	QLD	WA	SA	NT	TOTAL
AHW	97 (28%)	57 (25%)	71 (24%)	124 (28%)	80 (33%)	90 (26%)	518 (27%)
GP	27 (8%)	11 (5%)	25 (8%)	34 (8%)	9 (4%)	26 (7%)	132 (7%)
Nurse	25 (7%)	17 (7%)	24 (8%)	59 (14%)	25 (10%)	26 (7%)	176 (9%)
Specialist	3 (1%)	2 (1%)	4 (1%)	1 (0.3%)	0	0	10 (1%)
Dentist	14 (4%)	5 (2%)	10 (3%)	3 (1%)	1 (0.4%)	2 (1%)	34 (2%)
Dental assistant	22 (6%)	8 (4%)	15 (5%)	3 (1%)	1 (0.4%)	2 (1%)	51 (3%)
Counsellor	4 (1%)	10 (4%)	12 (4%)	5 (1%)	9 (4%)	8 (2%)	48 (3%)
Substance misuse worker	11 (3%)	14 (7%)	1 (0.3%)	12 (3%)	9 (4%)	11 (3%)	58 (3%)
Environmental health worker	0	2 (1%)	0	17 (4%)	3 (1%)	0	22 (1%)
Allied health	10 (3%)	4 (2%)	12 (4%)	4 (1%)	4 (2%)	9 (3%)	44 (2%)
Other non-clinical staff (a)	132 (38%)	102 (44%)	126 (42%)	155 (40%)	104 (42%)	186 (50%)	804 (43%)
Total	346	230	300	416	245	361	1897

(a) Includes drivers, CEOs, receptionists, accountants, book-keepers, trainers, domestics etc.

Source: Unpublished SAR data, OATSIH

103. ***Aboriginal Health Workers (AHWs).*** The Report concluded that there were a number of issues surrounding AHWs, including an absence of a standardised role and training; a lack of training support and opportunities; a lack of incentives for AHWs; and the employment of AHWs using the CDEP program.

104. Table 2-17 is a compilation of information on AHWs employed across States. There is limited data on the distribution of AHWs across Australia.

Table 2-17 AHWs EMPLOYED BY STATE[(a)]

	NSW/ACT	Vic	Qld	WA	SA	Tas	NT
Total AHWs	n. a.	132	348	n. a.	97	n. a.	237
Number employed in ACCHSs	97	86 (65%)	71 (20%)	124	80 (82%)	n. a.	90 (38%)

(a) This table is compiled from a number of sources and encompasses data between the years of 1998 and 2000.
Source: Regional plans and unpublished data from OATSIH.

105. ***Access to GP services.*** Most primary care in Australia is delivered through GPs, however, this is not the case for the Indigenous population. Improving Indigenous access to GPs would considerably improve Indigenous access to primary health care and also to Medicare funding. Two types of initiatives aim to increase Indigenous access to GPs. The first aim to increase the cultural accessibility of GPs in areas where they may be present but not accessed, and the second aims to increase the number of GPs in rural and remote areas.

106. *Increasing cultural accessibility.* In contrast to the non-Indigenous population, there is a low level of Indigenous access to private general practitioners in urban areas. In urban areas, poor Indigenous access to primary health care services is not a result of physical inaccessibility of services, but of other, more complex and less understood barriers, including aspects of Medicare administration discussed earlier.

107. The Report of the General Practice Strategy Review Group noted that there are several ways in which GP services to the Indigenous community can be improved[35], including:

- increased collaboration and cooperation between GPs and other health service providers, which is beginning to occur;
- consideration of the establishment of a network to link and support doctors working in Indigenous health; and
- a delineation and enhancement of existing payments systems, outside fee for service, that offer some opportunity to provide holistic health care — this has occurred to a certain extent through the enhanced primary care Medicare item.

108. There are a number of mainstream programs that can be utilised to increase Indigenous access to GP services, including funding for Divisions of General Practice, State

35 The General Practice Strategy Review Group, *Report — Changing the Future Through Partnerships*, Commonwealth Department of Health and Aged Care, Canberra, 1999.

Based Organisations and the Australian Divisions of General Practice (funding for services includes a $2.45 loading per Indigenous person in the catchment area); the Practice Incentives Program; the General Practice Immunisations Incentives; and the Practice Innovations Funding Pool.

109. A number of Commonwealth, State and regional projects involving GPs and General Practices have occurred under the above programs. The following list illustrates the type of initiatives that have been undertaken:

(i) DHAC is facilitating appropriate accreditation and assessment of ACCHSs so that they can receive funding through the Practice Incentive Program.

(ii) The establishment of organisations and partnerships, for example:

- the State peak body for Divisions of general practice in Victoria has signed an MOU with the State peak body for ACCHSs;
- in the Northern Territory, a General Practice Forum has been established to provide a framework within which GPs and Territory Health Services can jointly deal with planning, policy and strategic matters at a Territory-wide level; and
- the formation of the Central Australian Aboriginal Health Workers Association through Divisions and Project Grants Program funding with the Central Australian Rural Practitioners Association key in its establishment.

(iii) A number of divisions run some form of Indigenous Australian Health program. These programs may be general or focused on a particular condition or disease (such as diabetes) or other actions (such as increased coordination with ACCHSs, training AHWs, health promotion and education, and improving clinical services and service delivery).

110. While some GP initiatives have been undertaken with the aim of improving the provision of primary health care to Indigenous people, they have tended to be small, and as the Review of General Practice Strategy noted, there is no national framework for Indigenous-specific initiatives of divisions of general practice and general practices.

111. *Increasing physical accessibility.* In rural and remote areas, providing incentives, ongoing support, and appropriate training can help attract and retain doctors. Current mainstream initiatives aiming to increase the number of GPs in rural and remote areas include the Regional Health Strategy (distributes funds via divisions of general practice); the Rural and Remote General Practice program (aims to improve the recruitment and retention of GPs); the Rural Retention Payments Program; and the Rural Women's GP Service.

112. All the above programs are mainstream programs. It is as yet unclear as to how they will impact on Indigenous access to GPs in rural and remote areas. However, because a third of Indigenous people live in rural and remote areas (compared to only 14 per cent of the non-Indigenous population) it may be assumed that an increase in numbers of GPs in these regions will improve Indigenous access.

113. ***Summary.*** As noted in the Report, the Commission is aware that difficulties surrounding the health workforce, in particular low numbers in rural and remote areas, affect the provision of primary care services to Indigenous Australians. The influence of recent mainstream initiatives aiming to attract and retain staff in rural and remote areas on Indigenous access to primary health care is not yet clear. The low rate of Indigenous access to GP services is not only a result of low numbers of GPs in rural and remote areas, but also because of cultural barriers.