



MEDIA RELEASE

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TODAY IS THE DAY

“Let there be no more excuses”, said Mr Councillor, Chair of the National Aboriginal Community Controlled Health Organisation (NACCHO) which represents over 140 Aboriginal community controlled health services across Australia.

Today NACCHO encourages ordinary Australians to take the time to make a commitment to the *Close the Gap* Campaign.

“We know that many Australians are upset and embarrassed by the health reality of Australia’s First People. But they feel helpless to do anything about it. They incorrectly believe that heroic efforts have been made, huge amounts of money spent and all to no avail” said Mr Councillor. “The truth is that not enough funds are made available for Aboriginal peoples’ health given their levels of disease.”

NACCHO refers all Australians to the conclusions of large volumes of independent evidence commissioned by government and non-government bodies, as outlined in its report to the Attorney General’s Department released earlier this year. On health matters, politicians have confused the public that the levels of funding given to meet health needs are adequate, when this is not the case.

The Howard Government’s intent is to suggest that health services alone are insufficient because health is determined by social and economic circumstances.

“Surely this is not to suggest that access to antibiotics and other medicines, vaccination, nutrition support, surgery, hearing aids and other health interventions don’t improve people’s health? Of course not, yet this is the implication made by this Government for Aboriginal peoples”, said Ms Dea Thiele, Chief Executive Officer for NACCHO.

“In all these aspects of health care, Aboriginal peoples have less access. If access to blood pressure medicines were enhanced for example, Aboriginal peoples death rates could be reduced by 50%.”

“Internationally, access to comprehensive primary health care is a significant determinant of lower mortality, not just through the provision of medical care, but because these services also influence social and economic circumstances of Aboriginal peoples.” said Ms Thiele. NACCHO has compiled evidence that shows that whilst access to both health and social services are necessary to address Aboriginal peoples differential health status, there is international evidence that primary health care is ‘equity producing’, contributing to lower mortality and partially mitigating the association between socioeconomic factors (like income inequality) and mortality.

Aboriginal community-controlled health services, are supported by all Australian governments, and perform a vital function as torchbearers of primary health care in Australia and are a true example of Aboriginal peoples taking responsibility for their own health.

For 6 years the Australian Medical Association has been calling for the annual shortfall in funding to primary health care services such as Aboriginal Community Controlled Health Service to be closed. Each year the government has with great fanfare given a small amount but this has barely kept up with increases in mainstream funding. Thus, in these last 6 years over \$2.4 billion that the AMA claims was needed has not been spent.

At least an additional \$460 million a year is needed to ensure Aboriginal peoples can access primary health care to the same level as other Australians.

The NACCHO/Oxfam Health Equity Plan which includes the \$460 million into integrated primary health care is a comprehensive list of what needs to be done. \$460 million is the key because this will help transform health services so that they can get on with the job at hand to serve the health needs of their communities.

One of the key issues the funding will address is workforce. Health professionals working in the Aboriginal and Torres Strait Islander Health sector have to accept lower pay rates than their colleagues in the mainstream health system. This has led to extreme understaffing of services so that even basic services are often limited. “We know from the NT intervention, that we can attract a workforce into our services if there was parity on employment conditions.” said Ms Thiele.

NACCHO asserts that focus groups Australia-wide have found Australians are highly compassionate about the poor health of Aboriginal peoples and feel motivated when they hear positive stories of improvements in the health of Aboriginal people as a result of better resourced health services. “And there are lots of those stories!” said Ms Thiele

“If all Australians get behind this today and the politicians listen providing us with sufficient funds, you will see a difference. I promise you this. It can be done. It is not rocket science.” Said Mr Councillor.

Please find attached: the Health Equity Plan

For more information:

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'Equality in Health'

CLOSE THE GAP



Plan for closing health policy gaps to complement existing Federal Government priorities for Aboriginal peoples and Torres Strait Islanders¹

HEALTH EQUALITY FOR ABORIGINAL PEOPLES AND TORRES STRAIT ISLANDERS WITHIN 25 YEARS (2008-2018)²	
Health Targets	
GOAL 1. INCREASE CORE FUNDING FOR CULTURALLY APPROPRIATE PRIMARY HEALTH CARE TO HELP BRIDGE THE GAP IN HEALTH STANDARDS³	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43:a,d,e)⁴</i>	
Target 1	An additional \$460 million per annum for the first 5 years⁵ (\$120 million or 35% of this would be the annualised cost of infrastructure required by higher staffing)^{6,7}
Target 2	Funded program for salary parity for GPs within ACCHSs (\$20 million)⁸
Target 3	Culturally appropriate primary health care services are funded by a needs-based resource allocation formula⁹
GOAL 2. INCREASE THE NUMBER, EFFECTIVENESS & TRAINING OF HEALTH PRACTITIONERS WORKING WITHIN ABORIGINAL HEALTH SETTINGS, AND BUILD CAPACITY OF THE INDIGENOUS HEALTH WORKFORCE	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43a, e, 44e)</i>	
Target 4	An extra 250 doctors, 450 Aboriginal health workers, nurses & other allied health workers delivering culturally appropriate primary health care to set benchmarks¹⁰
Target 5	A 10 year national training plan (\$36.5 million/annum) is supported¹¹
Target 6	Training Centres of Excellence in primary health care sites (\$10 million/annum) established¹²
GOAL 3. IMPROVE THE RESPONSIVENESS OF MAINSTREAM HEALTH SERVICES AND PROGRAMS TO ABORIGINAL PEOPLES AND TORRES STRAIT ISLANDER HEALTH NEEDS	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43a,d,e,f)</i>	
Target 7	Uptake of PBS and MBS increased to at least 1.2 times the per capita utilisation for the non-Indigenous population,¹³ through: <ul style="list-style-type: none"> • a national quality use of medicines scheme for non-remote areas¹⁴ • strategies enhancing the utilisation and relevance of the MBS¹⁵
Target 8	State and federal bilateral financing agreements to commit to health equity within mainstream programs, such as through public health or health care agreements¹⁶
Target 9	Financing systems for population programs delivered through private general practices commit to health equity¹⁷
Target 10	Strategies developed to reduce inequities in access to hospital procedures, cardiac rehabilitation, and specialists access, through an allocation of \$30 million per annum¹⁸
GOAL 4. IMPLEMENT A STRATEGIC MATERNAL AND CHILD HEALTH PLAN	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43a,b,,e,f 44a,b,c)</i>	
Target 11	A national health plan for Aboriginal mothers and babies is developed, costed, and implemented¹⁹
Target 12	Exemplar site initiatives to other Aboriginal primary health care services targeting maternal and child health care to an allocation of \$20 million per annum²⁰
Target 13	A national 'freedom from hunger' scheme for at-risk mothers and babies in remote areas is developed²¹
GOAL 5. PROVIDE GREATER SUPPORT FOR INDIGENOUS-SPECIFIC POPULATION PROGRAMS FOR CHRONIC AND COMMUNICABLE DISEASE	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43a,b,,e,f 44a,b,c)</i>	
Target 14	Federal allocation of \$50 million²² per annum to develop and implement Indigenous-specific population-based strategies, which 'close the gap' in excess disease, for: <ul style="list-style-type: none"> • oral health • substance misuse (eg alcohol & smoking cessation) • vaccine preventable diseases • rheumatic heart disease and rheumatic fever • cancer prevention • men's health • mental health and social and emotional well-being
GOAL 6. INCREASE FUNDING AND SUPPORT FOR HEALTH PROMOTION REGARDING NUTRITION, PHYSICAL ACTIVITY, FRESH FOOD, AND HEALTHY LIFESTYLES	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43c)</i>	
Target 15	The 'Outback Stores' initiative²³ collaboratively intersects with primary health care and public health services through associated community nutrition strategies²⁴
Target 16	Dedicated breakfast programs in rural and remote-area primary schools.²⁵
Target 17	Healthy lifestyle programs proportionately targeted towards Aboriginal and Torres Strait Islander peoples.²⁶
GOAL 7. INCREASE FUNDING AND SUPPORT FOR ADEQUATE HOUSING AND ENVIRONMENTAL HEALTH	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 43c)</i>	
Target 18	\$5 billion over 10 years for a 10-year Indigenous Housing Strategy to bring existing housing to an acceptable standard and to eliminate over-crowding.²⁷
GOAL 8. UTILISE EXISTING AND NEW INDICATORS TO MONITOR THE RIGHT TO HEALTH	
<i>(Link to ICESCR Article 12 General Comment: Right to Health Core Obligations: 52)</i>	
Target 19	Establish targets/benchmarks and specified time frames for health policy objectives and outcomes where the desired level of performance is evident and agreed.²⁸

¹ National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers Conference. National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH, 2003–2013). Framework for Action by Governments. Canberra: Department of Health and Aged Care, 2004; & SCRGSP (Steering Committee for the Review of Government Service Provision). Overcoming Indigenous Disadvantage: Key Indicators 2005, Productivity Commission, Commonwealth of Australia, Canberra, 2005.

² 10 year health and infrastructure plan providing the basis for a generational change in health status over 25 years.

³ Based upon the principles of the AHMAC endorsed NSFATSIH (2004) and the National Aboriginal Health Strategy (NAHS, 1989). Other sources include: Health Is Life, House of Representatives Report on the Inquiry into Indigenous health, 2000; Commonwealth Grants Commission, Report on Indigenous Funding, 2001; Dwyer J, Silburn K, Wilson G. National strategies for improving Indigenous health and health care. Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 1. Commonwealth of Australia, 2004. The 2007 AMA Report Card expressed this as:

"All Australian Governments must commit to Aboriginal community controlled health services as the preferred option for providing appropriate and accessible comprehensive primary health care for Aboriginal and Torres Strait Islander peoples."

⁴ Committee on Economic, Social, and Cultural Rights. General comment No.14. The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social, and Cultural Rights. United Nations doc E/C.12/2000/4, 4th July 2000.

⁵ This is the cost incurred in providing Medicare services to the level required, medicines that are not currently being provided, dental services and medical consumables including appliances that cannot currently be accessed. This is the estimate for a Primary Health Care Access Program (PHCAP) type 'cashed-out' allocations, based on the 'missing millions' but adjusted for need. From *Access Economics for the 2004 AMA Report Card*, and from recommendations in the Commonwealth Grants Commission, Report on Indigenous Funding, 2001. (Chapter 5: 'Improving the allocation of funds to meet Indigenous needs').

⁶ The cost per capita for Indigenous-specific primary healthcare service delivery should be approaching \$1,300 per capita, compared to the current spending of only \$300 per capita. (Econotech Pty Ltd. Costings models for Aboriginal and TSI health services. Commonwealth of Australia, 2004)

⁷ Current proportionate total federal health budget is less than 0.8% and of this only 75% reaches ACCHSs.

⁸ Australian Medical Association (AMA) Indigenous Health Taskforce, 2007.

⁹ This is recognised in the NSFATSIH but there has been no progress and funding remains historically determined. Moreover, increases in allocations to OATSIH in the last 5 years have been in line with global health budget increases thus maintaining the same pattern of funding differentials.

¹⁰ AMA Report Card 2004. Estimated workforce shortfall. This is much higher when considering pro-rata shortfalls (that is according to the proportion of people who are Aboriginal in the population).

¹¹ Ibid. Note also 9th NRHA conference recommendation: *"The Australian Government should fund health training institutions and the States so that Cultural Security Training can be provided for all primary health care workers in rural and remote areas who deliver services to Aboriginal clients, their families and communities. The target is to have all such workers provided with this training and support within five years."*

¹² AMA Indigenous Health Taskforce Workplan, 2007.

¹³ The 1.2 times increase is the factor used by Access Economics.

¹⁴ An outcome of the pilot QUMAX Program under the 4th Community Pharmacy Agreement. The AMA 2007 Report Card recommended:

"To improve access for Aboriginal and Torres Strait Islander people to all Medicare rebated services and the PBS for example by reducing to zero the PBS and MBS safety nets for Aboriginal and Torres Strait Islander peoples."

¹⁵ These include MBS items that recognize the AHW workforce; consumer and health provider implementation strategies for health checks; incentive payments to GPs within ACCHSs; Medicare training programs, changes to the safety net-threshold, etc. Another example comes from the 9th National Rural health conference: *"Because Aboriginal people suffer substantially greater health disadvantage than non-Indigenous people, it is proposed that the maximum number of visits eligible for subsidy under the Extended Primary Care items of Medicare be increased from 5 to 10 for them"*.

¹⁶ There is strong evidence that untied federal grants to the states leads to neglect of Aboriginal peoples, and this situation needs to be corrected. See also: Couzos S, Thiele D. The International Covenant on Economic, Social and Cultural Rights and the right to health: is Australia meeting its obligations to Aboriginal peoples? *Med J Aust.* 2007 May 21;186(10):522-4; Commonwealth Grants Commission, Report on Indigenous Funding, 2001.

¹⁷ Such as Divisions of GP programs, Practice Incentive Programs, etc which do not currently establish targets or benchmarks. In addition, accreditation requirements must recognize service provision to Aboriginal peoples and Torres Strait Islanders. The 2007 AMA Report card recommended:

"All Australian Governments must commit to make it part of the accreditation process that all government funded and private health services provide culturally appropriate services to Aboriginal and Torres Strait Islander peoples. ...[All providers to have] a Charter detailing the level of service an Aboriginal and Torres Strait Islander patient will receive, including arrangements to ensure cultural issues are recognised and addressed within each service, [and] a system to provide interpretation and cultural support where necessary for patients."

¹⁸ NACCHO 2007 Budget submission (sourced from Professor Ian Ring).

¹⁹ NACCHO. What's needed to improve child health in the Aboriginal and Torres Strait Islander Population, June 2003. www.naccho.org.au [accessed June 2007]. See also: Couzos S. 'Practical measures that improve human rights' -Towards health equity for Aboriginal children. *Health Promotion Journal of Australia* 2004;15:186-92.

²⁰ Based on the Australian Government Exemplar site initiatives which enhance core primary health care with outcomes reported at: Panaretto KS, Lee HM, Mitchell MR, et al. Impact of a collaborative shared antenatal care program for urban Indigenous women: a prospective cohort study. *Med J Aust* 2005; 182: 514-519.

²¹ NACCHO. What's needed to improve child health in the Aboriginal and Torres Strait Islander Population, June 2003. Other programs modelled on USA and UK initiatives include: National Health Service. *Healthy Start*. November 2006. www.healthystart.nhs.uk/ [Accessed Jan 2007]; Food and Nutrition Service. About women, infants and children. Washington (DC): US Department of Agriculture; 2005. Available at: www.fns.usda.gov/wic [Accessed January 2007].

²² The quantum of funding may be an underestimate and requires further investigation.

²³ Minister for Families, Community Services and Indigenous Affairs. New Company to Offer Better Food and Business Opportunities to Indigenous Communities. Media Release. August 2006. www.atsia.gov.au/Media/media06/5706.aspx [Accessed Jan 2007].

²⁴ For example, intersectoral linkages could include the development of national consistency to the conduct of market basket surveys in rural and remote locations (Kate Burns, Deakin University 0392517273); and local nutritional education programs. Note also 9th Rural Health Conference:

"The Remote Indigenous Stores and Takeaways (RIST) Project needs to collaborate closely with Indigenous Business Australia and its Outback Stores work to ensure that the price and quality differentials in fresh food are reduced as a matter of urgency. This can be done through resourcing stores in remote areas to better manage the perishable supply chain, providing additional resources and support including training for remote area store managers, and further work on market basket surveys, 'food hardware' and nutrition programs, and freight improvement initiatives. Progress on this work should be assessed at a national forum on food in remote communities in mid-2008."

²⁵ Based on UK and USA programs: The National School Fruit Scheme. An Evaluation Summary. London (UK): Department of Health; 2001 [Accessed Jan 2007]. Available at: www.dh.gov.uk/assetRoot/04/01/92/32/04019232.pdf; Food and Nutrition Service. *About Women, Infants and Children*. Washington (DC): US Department of Agriculture; 2004 [cited 2004 March 17]. Available at: www.fns.usda.gov/wic.

²⁶ "Healthy Active Australia" initiatives (2007 Federal Budget), and complementary COAG Obesity Action Plan. <http://www.healthysactive.gov.au/> [Accessed June 2007]

²⁷ Commonwealth Grants Commission Report on Indigenous Funding (2001) and updated by ACOSS in consultation with National Shelter and Indigenous Policy Advisers. This complements the 10 year Housing Ministers Conference plan "Building a Better Future: Indigenous Housing to 2010".

²⁸ Targets and Benchmarks are currently lacking. Such core targets and 'right to health' indicators would supplement the Aboriginal and Torres Strait Islander Health Performance Framework: *Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2006 Report. Canberra: AHMAC, 2006.* For example, the core obligation for the right to access essential medicines, could be measured using quality use of medicine indicators, already developed. These are the *Dept of Health and Aging, Manual of Indicators to measure the QUM component of Australia's National Medicines Policy, 2nd edition, 2002.*